NHS Pay Review Body

Review for 2011

Written Evidence from the Health Departments for the United Kingdom of Great Britain and Northern Ireland

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November 2010

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DEPARTMENT OF HEALTH EVIDENCE TO THE NHS PAY REVIEW BODY

EXECUTIVE SUMMARY

1. For 2011/12 and 2012/13, the Government has announced a **pay freeze for all public sector workers earning basic salaries of more than £21,000 a year**. The Government has also made a commitment to protect those on low incomes, and has announced that **workers earning basic salaries £21,000 or less a year should receive uplifts of a minimum of £250 a year**. The NHS Pay Review Body (NHSPRB) is asked to make recommendations on the amount of that uplift, as it applies to appropriately-paid staff under the Agenda for Change Pay Framework.

2. The NHSPRB has also signalled that it wishes to return to the issue of a **possible national recruitment and retention payment for pharmacists** under Bands 6 and 7 of Agenda for Change. This evidence also covers that issue.

3. In this evidence, **the Government proposes that:**

   - **the 2011/12 uplift for NHS staff earning £21,000 or less a year should be a flat rate of £250 – that is, the recommended minimum which the Government has proposed for workers earning up to that amount, across the public sector. This flat rate uplift should apply irrespective of an individual's position on the Agenda for Change payscales, recognising that people not on the top of paybands will also receive increments of between 2.2% and 3.8%. It would equate to percentage increases of between 1.22% and 1.83% for these points on the payscale, which the Government considers to be wholly appropriate in all the circumstances;**

   - **there is no case for a national recruitment and retention payment or premium for Bands 6 and 7 pharmacists, in the light of reducing levels of unfilled vacancies across the country among this staff group, and the demonstrable signs of success in the initiatives which have been introduced to address issues of recruitment and retention.**

4. The Government's proposals this year are inevitably shaped by wider economic and job market conditions, and in particular by the **vital need to reduce the deficit through spending control and pay restraint across the public sector**. However, the Government's longstanding aim in pay policy remains in place: to set uplifts at the correct and appropriate levels to ensure the recruitment, retention, and effective motivation of high quality NHS staff. The Government strongly believes that its proposed uplifts will achieve this, within the limits of affordability.

5. The vital need for pay restraint in the NHS was strongly signalled in the Government's **White Paper of July 2010, *Equity and Excellence: Liberating the NHS***. The White Paper builds on the core values and principles of the NHS, and sets out the direction of travel towards a Service which remains comprehensive and free at the point of use, while:

   - putting patients at the heart of everything the NHS does;
   - focussing on improved outcomes rather than bureaucratic processes; and
   - empowering clinicians and other NHS staff to innovate.

6. The Department and the NHS have embarked on a major programme of reform, and aim to deliver better outcomes for patients by an empowered front-line workforce. This is an

ambitious journey, with vastly improved and responsive healthcare services the clear destination. This journey is, however, starting at a time of necessary austerity across the public sector and, moreover, when the need to reduce the public deficit is the Government's over-riding aim. The Government is clear that unaffordable pay uplifts at this time will hamper the deficit reduction programme and divert funding away from frontline service delivery across the public sector. They would also have the potential to seriously affect the likelihood of the Government's achieving its long-term aims for improving the NHS.

7. Inevitably, as a result of the record debt, the NHS will employ fewer staff at the end of this Parliament; although rebalanced towards clinical staffing and front-line support rather than excessive administration. As part of ensuring funding is focused on delivering front line services, the NHS will deliver management cost reductions of at least 45% by 2013/14.

8. The NHSPRB will also wish to consider the effects of its recommendations on cross-NHS work towards improving **productivity and efficiency** – work which is vital if the Service is to meet the increasing demands of technological and demographic changes, and absorb increasing (non-pay) costs. The Department of Health's programme to improve Quality, Innovation, Productivity and Prevention (QIPP) programme is central to the achievement of the £20 billion of savings, which the NHS is working to achieve by the end of the present Spending Review period. Much as is the case for the White Paper programme, unaffordable pay uplifts now could endanger that vital work – much to the long-term detriment of the NHS and the public its serves.

9. **A flat rate, consolidated uplift of £250 for all NHS staff earning basic salaries of £21,000 or less a year – as the Government is proposing - would increase the total paybill by £130 million. Each additional uplift of £100 for these staff would increase the paybill by approximately £50 million. <u>In the light of the over-riding imperative to reduce the deficit, and the demands on the NHS set out above, the Government does not consider any additional uplifts in addition to the flat rate £250 to be justified or affordable this year.</u>**

10. Issues of affordability – and therefore of deficit-reduction – are central to the Government's evidence this year. However, the Government would also stress the following factors that support an uplift of no more than £250.

11. **The recruitment and retention position is healthy** – both among staff earning basic salaries of £21,000 or less, and across the NHS more generally.

12. Over a period when unemployment in the general economy is increasing – 7.7% in October 2010, compared to 5.4% in October 2007 - the NHS's non-medical workforce has increased in headcount terms by 5% (from 1,120,548 in 2008, to 1,176,831 in 2009). Almost all these staff are paid under Agenda for Change.

13. Of that number, 40% are on basic pay of £21,000 or less - 443,000 staff by headcount. These include unqualified nurses and healthcare assistants (98% of whom are paid £21,000 or less a year), administrative and clerical staff (63%), and maintenance/works staff (46%). They are paid under Agenda for Change Bands 1-3, and the lower part of Band 4 (that is, pay points 1-15).

14. Identifying movements in the numbers of staff earning basic salaries of £21,000 or less is not wholly straightforward. However, clear indications of movements in the numbers of

staff employed in relevant categories are available from the NHS Workforce Census for the year ended 30 September 2009:

- the number of support staff for doctors and nurses rose by 6%, compared to 2009 (from 286,254 to 303,424); and
- the number of other infrastructure support staff, excluding managers, rose by 6.9% over the same period (from 179,151 to 191,442).

15. Although these numbers clearly include limited numbers of staff earning over £21,000, they clearly show **increased levels of NHS employment among staff paid under Bands 1-4 of Agenda for Change**.

16. As well as increased numbers of staff employed, **vacancy rates are falling** among the staff categories which are relevant to this evidence. In March 2010 the three-month vacancy rate for all non-medical NHS staff was 0.5% - an improvement on the 0.6% for the same period in 2009. Among staff paid £21,000 or less a year:

- vacancy rates among unqualified nurses fell from 0.4% to 0.3%; and
- those among healthcare assistants, and support, administrative, and estates staff fell from 0.4% to 0.2%.

17. **Levels of staff motivation and satisfaction, as demonstrated by survey results, are also healthy**. The NHS Staff Survey showed rises in staff satisfaction ratings for 2009, compared to 2008, as follows:

- for nurses and healthcare assistants, staff satisfaction rose from 3.48 to 3.49, while "intention to leave" fell from 2.48 to 2.42; and
- for administrative and clerical staff, satisfaction rose from 3.63 to 3.67, while "intention to leave" fell from 2.57 to 2.52.

18. In addition, a new Staff Survey question covering people's engagement with their jobs was introduced in 2009, and has produced healthy scores across all staff groups, with an average across the NHS of 3.86 out of 5.

19. In considering **junior pharmacists**, the Government continues to consider that, although there have undoubtedly been problems in some geographical areas, there is not a national problem which requires the solution of a national Recruitment and Retention Premium. Employers have access to local recruitment and retention *premia* where these are considered to be necessary, and new guidance on the use of such *premia* was issued to the Service in November 2009.

20. Work by the Department and the Strategic Health Authorities (SHAs), including the work of the Pharmacist Numbers Task and Finish Group and the Modernising Pharmacy Careers Programme, have significantly improved the position over the last two years, with the results that:

- three-month vacancy rates among junior pharmacists at Agenda for Change Bands 6 and 7 are lower this year than previously (for Band 6, 11% this year compared with 20% in 2009; for Band 7, 13% this year compared with 14% in 2009); and

- training numbers across all SHAs have increased by 45% - 693 placements in 2010, compared to the low point of 477 in 2007.

21. In summary, on the key issue which the NHSPRB is asked to consider this year, **the Government strongly believes that a flat rate £250 uplift is the right figure for NHS staff earning £21,000 or less. In the light of the imperative to reduce the deficit, and the coming financial and other demands on the NHS, the Government does not consider higher uplifts to be necessary. In any event, the Government believes that, notwithstanding the wider financial position, considerations of recruitment and retention, and evidence on motivation levels, make £250 the correct uplift in any event.**

22. **The Government also believes that a flat rate increase of £250, regardless of an individual's position on the Agenda for Change payscales, is the most straightforward, fairest, and most equitable way to reward NHS staff earning £21,000 or less in 2011/12**.

23. The Government's evidence is detailed in the following chapters:

- Chapter 1 covers the Government's pay policy, and its wider approach to the NHS;
- Chapter 2 covers NHS finances;
- Chapter 3 sets out the wider economic position;
- Chapter 4 cover total reward in the NHS; and
- Chapter 5 covers planning and delivery for the NHS non-medical workforce; and
- the statistical annexes include pay metrics.

CHAPTER 1: INTRODUCTION - THE GOVERNMENT'S PAY POLICY AND WIDER APPROACH TO THE NHS

1.1 The Coalition Government has guaranteed that health spending will increase in real terms in every year of this Parliament. However, with that protection comes the same obligation for the NHS to cut waste and transform productivity as applies to other parts of the public sector.

1.2 NHS pay must also been seen within the wider context of the current economic situation and cannot be immune from the serious economic challenges we face. The massive deficit and growing debt means that difficult decisions have to be made and it is right that the NHS plays its part, through pay restraint, in reducing the public sector pay bill. Restraint now will help to protect jobs in the NHS, support the quality of services the NHS provides and ensure that every penny saved is spent on front-line services.

1.3 However, the Government is also committed to protecting those on low incomes. Therefore, on 22 June, as part of the Emergency Budget, the Chancellor announced a two year pay freeze from 2011/12 for public sector workforces, except for those earning a full-time equivalent of £21,000 or less, where the Government will seek increases of at least £250 per year.

1.4 The Chief Secretary to the Treasury wrote to the Chairs of the Pay Review Bodies on 26 July 2010 to set out the Government's position on public sector pay (a copy of that letter is at Annex B). He made clear that:

- for those groups of workers paid above £21,000, the Government will not submit evidence or seek recommendations on pay uplifts for 2011/12. It will, however, provide information about recruitment, retention and other aspects of the affected workforces as appropriate; and
- for those groups of workers paid £21,000 or less, we will look to the Pay Review Bodies to provide recommendations on 2011/12 uplifts.

White Paper, '*Equity and Excellence: Liberating the NHS*'

1.5 The need for NHS pay restraint has therefore been made very clear. At the same time, the Government has set out its ambitious vision for the Service of the future. The White Paper of July 2010 builds on the core values and principles of the NHS - a comprehensive service, available to all, free at the point of use, and based on need, not ability to pay. It sets out how:

- patients will be put at the heart of everything the NHS does - having greater choice and control helped by easy access to the information they need about the best GPs and hospitals, and in charge of making decisions about their care;
- there will be a clear focus on the continuous improvement of what really matters to patients - the outcome of their healthcare. Success will be measured, not through bureaucratic process targets, but against results that matter to patients – such as improving cancer and stroke survival rates; and
- clinicians will be empowered and liberated to innovate, with the freedom to focus on improving healthcare services. Front-line staff will have more control.

Healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients.

1.6 The implementation of the reforms set out in the White Paper will be subject to broad consultation. The Government has already published consultation documents seeking views on:

- the NHS Outcomes Framework (published on 19 July);
- commissioning for patients (22 July);
- increasing democratic legitimacy (22 July); and
- freeing providers and economic regulation (26 July).

These consultations are now closed, and the Department is considering the responses received. The Government's response and the Health Bill will be introduced shortly.

1.7 Two further public consultations were launched on 18 October:

- *Liberating the NHS: An Information Revolution*: and
- *Liberating the NHS: Greater Choice and Control*.

A further consultation, on the move to a provider-led education and training system, will be launched shortly (see below). In addition, a Public Health White Paper will be published later this year.

Quality, Innovation, Productivity and Prevention (QIPP)

1.8 The current and forecast economic climate demands the efficient use of resources. For some time, the NHS has understood the need to make extremely challenging improvements in productivity and efficiency. To meet increasing demand, stemming partly from the fact that our population is ageing, and to absorb increasing costs, the NHS needs to concentrate on improving productivity and eliminating waste while focusing relentlessly on clinical quality. Work has already begun on releasing up to £20 billion of efficiency savings by the end of the current Spending Review period. These savings will be reinvested in front-line services: meeting the current financial challenge and the future costs of demographic and technological change, and ensuring that the NHS continues to deliver year-on-year quality improvements. Achieving this ambition will be extremely challenging.

1.9 To help achieve these savings, the existing Quality, Innovation, Productivity and Prevention (QIPP) initiative will continue with even greater urgency, but with a stronger focus on general practice leadership. The QIPP initiative is identifying how efficiencies can be driven, and services re-designed, to achieve the twin aims of improved quality and efficiency.

1.10 QIPP is working at national, regional and local levels to support clinical teams and NHS organisations in improving the quality of the care they deliver, while making efficiency savings which can be re-invested in the Service.

Assessing the Future Health Workforce Needs in England

1.11 The White Paper also sets out the Government's vision of a provider-led workforce planning, education and training system, in which the professions have the leading

roles in commissioning education and training, and work with employers to ensure a multi-disciplinary approach.

1.12 In the new system:

- healthcare employers and their staff will agree plans and funding for workforce development and training, and their decisions will determine education commissioning plans;
- education commissioning will be led locally and nationally by the healthcare professions, through Medical Education England for doctors, dentists, healthcare scientists, and pharmacists. Similar mechanisms will be put in place for nurses and midwives and the allied health professions;
- the professions will have a leading role in deciding the structure and content of training, and quality standards;
- all providers of healthcare services will pay to meet the costs of education and training, and transparent funding flows will support a level playing field between providers;
- the NHS Commissioning Board will provide national patient and public oversight of healthcare providers' funding plans for training and education, ensuring that these plans reflect its strategic commissioning intentions. GP consortia will provide this oversight at local level; and
- the Centre for Workforce Intelligence (CfWI) will act as a consistent source of information and analysis, informing - and informed by - all levels of the system.

1.13 A public consultation on these proposed changes to the education and training system will be published later this year. This will be based on the following principles:

- the need for simpler and more efficient education and training arrangements;
- greater market orientation; and
- the need for decisions to be driven by healthcare providers themselves, with strong clinical leadership.

The aim will be to deliver appropriate investment in workforce education and training, whilst ensuring better outcomes for patients and value for money and with appropriate checks, balances and accountability.

1.14 It is clear that effective workforce planning is key to delivering the right workforce to deliver the Government's vision. The CfWI's information and analysis will support NHS organisations in their workforce planning, assisting them in taking a long-range approach to improving skills and resources. This will enable the Department, and NHS bodies at all levels to understand workforce demand and supply in greater depth, and thereby to improve their workforce planning strategies.

Conclusion

1.15 The Government has embarked on a major programme of reform to deliver better outcomes for patients from an empowered front line workforce. The Department has recently completed a number of consultations, and will be taking forward its responses to those, and to the other consultations which are running or still to run. The Department will be in a better position to report on these - and on their detailed implications for the Service and its workforce - in the next round of evidence.

CHAPTER 2: NHS FINANCES

2.1 This chapter sets out the financial position for the NHS in 2011/12, and the costs of meeting a £250 uplift for staff earning basic salaries of £21,000 or less.

Economic Context

2.2 The recent deterioration in the economy has led to substantial falls in employment and vacancies, and rising unemployment and redundancies. The October 2010 ONS Labour Market Statistics Publication quotes an unemployment rate of 7.7%, compared to 5.2% in October 2002, 4.7% in October 2004, and 5.4% in October 2007.

2.3 The weak general labour market will make it easier to recruit and retain a high-quality workforce for the NHS, than it was following the 2002, 2004 and 2007 Spending Reviews.

Public Sector Pay Freeze

2.4 The two-year pay freeze for public sector workers is primarily aimed at reducing the deficit. But it is also a response to the weak labour market, and to the relative growth in public sector earnings over the course of the recession (Chapter 3 below considers the general economic context). As it is anticipated that demand growth for Agenda for Change staff will fall over the next year, recruitment difficulties are not expected. Indeed, the recruitment and retention of Agenda for Change staff is not seen as problematic in the short-term even if there are significant pay increases in the private sector.

Funding Growth

2.5 The NHS has seen large increases in funding over the past 10 years, with an average real terms growth in revenue expenditure of 5.3% per year between 2000/01 and 2010/11. Table 2.1 shows the NHS revenue figures from 2000/01 to 2010/11, and the Revenue Departmental Expenditure Limits (RDEL) as agreed in the 2010 Spending Review for the years 2011/12 to 2014/15 (SR 2010):

Table 2.1: NHS REVENUE SINCE 2000/01

		NHS Revenue Expenditure (£bn)	Cash Growth	Real growth	Proportion of revenue expenditure consumed by paybill
2000/01	**Outturn**	42.7			45.9%
2001/02	**Outturn**	47.3	10.8%	8.5%	46.4%
2002/03	**Outturn**[1]	51.9	9.8%	6.6%	46.8%
2002/03	**Outturn (rebased)** [2]	55.4			
2003/04	**Outturn**	61.9	11.7%	8.8%	43.6%
2004/05	**Outturn**	66.9	8.1%	5.3%	47.1%
2005/06	**Outturn**	74.2	10.9%	9.1%	45.9%
2006/07	**Outturn**	78.5	5.8%	2.4%	45.0%
2007/08	**Outturn**	86.4	10.1%	7.2%	42.4%
2008/09	**Outturn**	90.7	5.0%	2.3%	43.2%
2009/10	**Estimated outturn**	97.8	7.8%	6.2%	
2009/10	**Estimated outturn (aligned)**[3]	96.0			
2010/11	**Plan (aligned)**	99.8	4.0%	1.1%	
2011/12	**RDEL**	102.6	2.9%	0.9%	
2012/13	**RDEL**	105.2	2.5%	0.2%	
2013/14	**RDEL**	108.2	2.8%	0.2%	
2014/15	**RDEL**	111.1	2.7%	0.0%	

(1) Expenditure figures from 2000/01 to 2002/03 are on a Stage 1 resource budgeting basis.
(2) Expenditure figures from 2003/04 to 2008/09 are on a Stage 2 resource budgeting basis, this means cost of capital and cost of new provisions are included in the RDEL.
(3) Expenditure figures from 2010/11 are on an aligned basis. Aligned means that cost of capital is no longer included in RDEL and new provisions are included in Annually Managed Expenditure rather than RDEL.

2.6 The Departmental Expenditure Limits (DEL) set by HM Treasury represent absolute limits on NHS expenditure. There is no flexibility to bring forward expenditure.

2.7 Table 2.2 below shows the cash increases in the NHS revenue expenditure over the last eight years, and the proportion of the revenue expenditure increases consumed by paybill. This proportion is further broken down by:

- the proportion that went on price increases (that is, on wage increases); and
- the proportion that went on volume increases (that is, on employing extra staff).

Between 2000/01 and 2008/09, increases in paybill prices have on average accounted for 31.4% of the cash increases in NHS revenue expenditure.

Table 2.2: INCREASE IN REVENUE EXPENDITURE AND PROPORTION CONSUMED BY PAYBILL

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

The NHS Paybill

2.8 Pay is one of the most significant cost pressures, accounting for more than 40% of NHS revenue expenditure and around 60% of hospital and community health services (HCHS) expenditure. As pay represents such a large proportion of the NHS budget, managing the paybill is key to ensuring that the NHS is able to cope with future slow-down in funding growth.

Pressures on NHS Funding Growth

2.9 Competing priorities call upon the Department's available limited funding. Funding is analysed in two broad areas:

- baseline pressures
- underlying demand and service developments

2.10 Baseline pressures cover the costs of meeting existing commitments that are essential for the NHS: they do not cover additional and new activity. Baseline pressures are the first call on NHS resources. The HCHS paybill (including pay settlement) forms a significant part of these baseline pressures, along with prescribing (primary care and hospital) and primary care services.

2.11 Underlying demand is pressure due to general growth in activity levels. Demand has grown on average by 2.7% p.a. in the last 10 years. Service development covers policy and manifesto commitments to improve quality. Service development over the current SR period includes:

- the cancer drugs fund
- 4,200 sure start health visitors
- expanding access to talking therapies

Allocation of resources in past Spending Reviews

2.12 Table 2.3 shows how the increases in revenue in past Spending Reviews have been deposited across different components. Approximately 35% has been deployed to higher pay (rows 3 & 9) and 48% to activity growth and service developments (row 2). In the past, non-pay baseline pressures have consumed less than 20% of available resources.

2.13 Table 2.3 also shows (row 1) that the level of resource available in 2011/12 is significantly less than in previous years.

2.14 The final column shows how the SR2010 settlement for 2011/12 might be distributed under a "do nothing" scenario if we assume that:

- pay drift continues at its historic average 1.6% p.a.;
- the pay freeze applied for all those except on Agenda for Change pay points 1-15; and
- a £250 pay uplift for all those on Agenda for Change pay points 1-15.

Table 2.3: DISPOSITION OR REVENUE INCREASE ACROSS EXPENDITURE COMPONENTS

Row No.	Component of Expenditure	SR2002	SR2004	CSR 2007	Indicative disposition in 2011/12 "do nothing" scenario
1	**Average annual increase in revenue (£bn)[1]**	**£7.4bn**	**£7.0bn**	**£5.3bn**	**£2.9bn**
2	Activity Growth and Service Developments[2]	39%	60%	44%	-12%
3	Hospital and Community Services Pay (Price only Component)	29%	23%	35%	33%
4	Secondary Care Drugs	4%	4%	7%	25%
5	EEA Medical Costs, Welfare Food & NHS Litigation	3%	4%	2%	8%
6	Primary Care Drugs	5%	4%	5%	8%
7	General Dentistry, Ophthalmic and Pharmaceutical Services	3%	3%	4%	4%
8	Prices	1%	2%	1%	0%
9	General Medical Services	16%	1%	3%	6%
10	Funding for Social Care[3]				28%

Notes (1) Average growth over each SR period in 2011/12 prices. (2) in the past activity growth and service development has driven workforce growth under do nothing scenario , presented here it assumes the discretionary spend reduces (3) the NHS has transferred some funding from the health capital budget to health revenue to be spent on measures to support social care which also benefits health. This funding is £798m in 2010/11 including reablement, designed to help people stay independent as long as possible.

2.15 The indicative disposition for 2011/12 shows the problems that arise with lower levels of resources available in 2011/12. The forecast growth in non-discretionary, baseline pressures at rows 4, 5, 6, 7 & 8 and increased support to social care would leave just 20% available for pay increases and activity growth and service developments.

2.16 Even with the pay freeze, historic drift and the £250 low pay award will require approximately £950 million (one third) of available resources.

2.17 In the past, with flat productivity, workforce growth has grown in line with activity growth and service improvements. Table 2.3 shows that if labour productivity remained

flat, the level of activity would have to fall with possible negative impact on staffing levels. In fact, the QIPP agenda to deliver higher productivity, procurement savings and reduce management costs will allow for activity growth and service improvements, but the higher the level of pay growth the tighter that balance becomes.

Conclusion

2.18 The funding available to the NHS is fixed and extremely tight compared with the recent past (as shown above in Table 2.1). In such circumstances, increases in pay will reduce the funds available for service developments and activity growth and reduce the derived demand for staff.

2.19 Although the Department of Health plans unprecedented savings in non-pay costs through QIPP, the level of non-discretionary demand led pressures such as drugs bill, EEA medical costs and litigation means the continuation of pay drifts and pay proposals for Agenda for Change bands 1-4 might impact adversely on staffing levels. The Department of Health has ambitious plans to reduce the number of managers and administration staff, primarily in SHAs and PCTs to protect front-line services but reductions in clinical posts cannot be ruled out.

2.20 The Department believes that the proposals made in this evidence are a prudent balance between the public's aspirations for continuing NHS service improvements on the one hand, and the supply, motivation and morale of the workforce on the other.
The workforce enjoys excellent levels of recruitment and retention, as demonstrated by historically low vacancy rates. And, as a result of workforce reforms over recent years, staff have benefitted from a good overall remuneration package.

CHAPTER 3: EVIDENCE ON THE GENERAL ECONOMIC CONTEXT

Summary

3.1 The Spending Review announced by the Chancellor on 20 October gave the full details of the spending side of the Coalition Government's deficit reduction plan which was set out in the June Budget. This is an urgent priority to secure economic stability at a time of continuing uncertainty in the global economy and put Britain's public services and welfare system on a sustainable long-term footing.

3.2 The Coalition Government inherited one of the most challenging fiscal positions in the world. As tax receipts fell away during the financial crisis, it became clear that levels of public spending were unaffordable. In the twenty years to 2006/07 public spending averaged around 40% of GDP and this increased to a historically high level of 48% by 2009/10. Receipts by contrast did not exceed 40% over the whole period, and fell to 37% in 2009/10.

3.3 As a result of this imbalance between levels of spending and tax receipts Britain's deficit last year was the largest in its peacetime history at 11% of GDP, and the state was borrowing one pound for every four it spent. Consequently, the UK currently spends £43 billion on debt interest.

3.4 Tackling the deficit is therefore essential and this is why the Government's plans, at the June Budget and Spending Review, bring about a significant acceleration in the reduction of the structural deficit over the course of the Parliament.

3.5 The global financial crisis had a marked effect on UK Gross Domestic Product (GDP) resulting in a fall of 5% in 2009.[1] Output has expanded over the first half of 2010, with quarter-on quarter GDP growth of 0.4% in 2010Q1 and 1.2% in 2010Q2. The latest estimate from the ONS suggests output grew by 0.8% in 2010 Q3. In its June Budget forecast, the Office for Budget Responsibility (OBR) expected GDP growth to strengthen through 2010, growing by 1.2% over the whole of 2010 rising to above-trend rates from 2010 as the private-sector led recovery gathers pace.

3.6 Apart from affordability constraints, labour market indicators still support pay restraint in 2011/12. Vacancies remain subdued: in the third quarter of 2010, the level of vacancies in the economy was still nearly 35% lower than in the first quarter of 2008. Unemployment is still above its pre-recession level and is forecast to remaining elevated reaching a peak of 8.1% by the end of 2010 before falling thereafter.

3.7 The weaker labour market has also had an impact on private sector pay. Over the course of the recession[2], earnings in the public sector (AWE – public sector excluding financial services, total pay) grew by 4% while private sector earnings fell by more than 2% on average.[3] IDS figures show that over the course of the recession, less than 5% of total public sector settlements were pay freezes compared to around 20% in the private sector.[4] The three months to August 2010 was the first time in two years that regular pay growth in the private sector was above that in the public sector. The OBR set out

[1] Source: ONS
[2] 2008 Q1 – 2009 Q3
[3] ONS – Average Weekly Earnings
[4] IDS – Pay Database

in its Budget 2010 forecast that it expects average earnings to remain subdued in the near term, then to pick up as growth recovers.

3.8 The workforce reduction and wage restraint witnessed in the wider labour market has highlighted the relative competitiveness of the total public sector package. Indeed, the overall value for the public sector reward package, including pension provision, has remained generous in recent years.

3.9 Because of this, the June Budget announced a two year pay freeze from 2011-12 for public sector workforces, except for those earning a full-time equivalent salary of £21,000 or less, where the Government will seek increases of at least £250 per year. The implications of the Budget announcement from the Government's perspective are that:

- for those groups of workers paid above £21,000, the Government will not submit evidence or seek recommendations on pay uplifts. It will however, provide information about recruitment, retention and other aspects of the affected workforces as appropriate; and
- for those groups of workers paid £21,000 or less, the Government will look to the Pay Review Bodies to provide recommendations on uplifts;

3.10 It is for the Pay Review Bodies to recommend on the size of the uplift for those earning £21,000 or less, though the Government has announced that it intends to deliver an uplift of at least £250. When considering their recommendations, Review Bodies may want to consider:

- the level of progression pay provided to the workforce;
- the potential for payments to be more generous for those on the lowest earnings;
- how best to avoid leapfrogging between those earning just under £21,000 with those earning just over £21,000, potentially through the use of a taper; and
- that following the fiscal consolidation announced in the June Budget and Spending Review, decisions on pay will have cost pressure implications for departments within their settlement.

3.11 The Government also asked Will Hutton to lead a Review of Fair Pay in the Public Sector, making recommendations on tackling disparities between the lowest and highest paid in public sector organisations. The Review will publish its interim findings in late November.

Economic context and outlook for the economy

3.12 The global credit crisis had a significant impact on economic growth across all major economies. In the UK, GDP fell by 5% in 2009.[5] Output has expanded over the first half of 2010, with quarter-on quarter GDP growth of 0.4% in 2010Q1 and 1.2% in 2010Q2. The latest estimate from the ONS suggests output grew by 0.8% in 2010 Q3. In its June Budget forecast, the OBR expected GDP growth to strengthen through 2010, rising to above-trend rates from 2010 as the private-sector led recovery gathers pace. The OBR forecast GDP to grow by 1.2% over the whole of 2010, followed by growth of 2.3% in 2011. From 2012 onwards GDP growth picks up as monetary policy continues to support demand, reaching 2.9% in 2013. Growth then eases in 2014 and

[5] Source: ONS

2015 as demographic changes reduce the growth of the potential labour supply, though actual growth remains above trend. The table below summarises OBR, Bank of England and independent forecasts for GDP growth over this period:

Table 3.1: Forecasts for GDP growth 2010 to 2012

Forecasts for GDP growth (per cent)	**2010**	**2011**	**2012**
OBR (June 2010 Budget)	1.2	2.3	2.8
Bank of England mode projection for Q4 (Aug. 2010)	2.7	3.0	3.1
Avg. of independent forecasters (Oct 2010)[6]	1.5	1.9	

3.13 However, there remains significant uncertainty about the prospects for economic growth.[7] To illustrate the uncertainty around the central projection, the OBR's June Budget forecast presented fan charts based on past forecast errors. The distribution set out in the June Budget forecast suggested that the probability of growth in 2010 falling within 1 percentage point of the central projection (1.2%) is 70%. The probability that GDP growth in 2011 is within 1 percentage point of the central projection (2.3%) falls to below 40% to around 30% in 2014. Another indication of the uncertainty around the prospects for GDP growth is given by the range of available independent forecasts; the latest independent forecasts for GDP growth in 2011, for example, range from 1% to 2.8%.

Inflation

3.14 Boosted by higher import prices and the reversal of the VAT cut, CPI inflation increased from 1.1% in September 2009 to 3.7% in April 2010. Since then CPI inflation has moderated slightly, falling back to 3.1% in July, at which rate it has remained in August and September. RPI inflation picked up from -1.4% in September 2009 to 5.3% in April 2010 as the large reduction in mortgage interest payments in late 2008 and early 2009 fell out of the annual comparison, and has since eased to 4.6% in September. Part of the current gap between CPI and RPI inflation can also be explained by methodological differences in the way the two series are constructed (the 'formula effect').

3.15 For the June Budget, the Office for Budget Responsibility forecast CPI inflation to stay around 3% in the near term, before declining to around 2.7% by the end of 2010 as the upward pressure from higher import and fuel prices moderates. Once the short-term effects of the VAT increase have passed through, the output gap and cuts in public spending are assumed to place downward pressure on inflation. The OBR forecast CPI inflation to fall back to a little under 2% in early 2012 before settling at the 2% target over the medium term. The table below sets out the OBR forecasts for inflation for the June Budget, against latest figures from the Bank of England and the average of independent forecasters.

[6] "Forecasts for the UK economy: A comparison of independent forecasts" September 2010, compiled by HM Treasury

[7] As noted by the Office for Budget Responsibility in its pre-Budget forecast document, *"Our judgement is that, at this stage of the economic cycle, the outlook is even more uncertain than usual"*. See *Pre-Budget forecast*, Office for Budget Responsibility, June 2010.

Table 3.2: Forecasts for CPI Inflation 2010 to 2012

Forecasts for CPI Inflation (per cent change on a year earlier)	Q4 2010	Q4 2011	Q4 2012
OBR (June 2010 Budget)	2.7%	2.4%	1.9%
Bank of England mode projection (August 2010)	3.0%	2.2%	1.4%
Average of independent forecasters (October 2010)	2.8%	2.5%	-

3.16 In its August 2010 Inflation Report, the Bank of England judged that the forthcoming increase in VAT was expected to keep CPI inflation above the 2% target until the end of 2011. The Report noted that as the temporary effects adding to inflation dropped out of the twelve-month comparison, downward pressure on wages and prices from the persistent margin of spare capacity is likely to bring inflation below the target for a period.

Labour market context

3.17 Most labour market indicators have stabilised or started to recover through the first half of 2010 and employment has risen sharply in recent months. However, there are some signs that labour demand has not fully recovered yet. Vacancies remain well below their pre-recession level, and inflows into the claimant count have ticked up in recent months. As published alongside the June Budget, the OBR forecast is for employment to recover modestly through the second half of 2010 before rising to its previous peak in 2013/14.

Employment and unemployment

3.18 Having continued to fall in the first quarter of 2010, LFS employment rose by 178,000 in the three months to August 2010 (following a record increase in the three months to July 2010). Both full-time and part-time employment were up, rising by 35,000 and 143,000 respectively. However, the employment level (29.16m) remains around 400,000 below its previous peak reached in the three-months to May 2008.

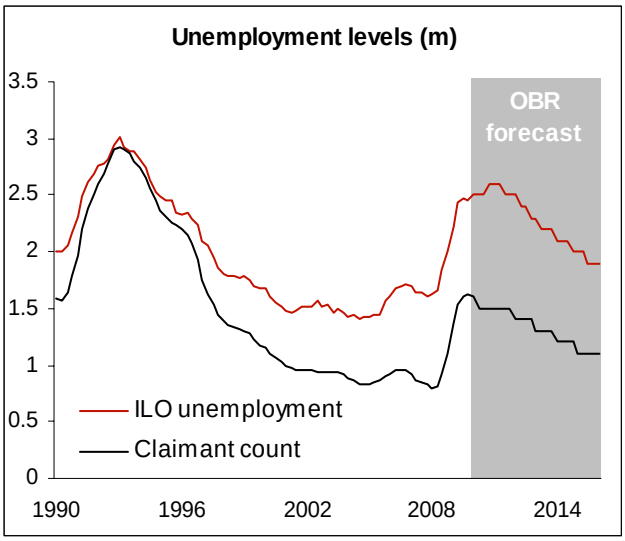
3.19 ILO unemployment fell modestly in the three months to August 2010 and has now remained broadly flat since mid-2009. The ILO unemployment rate fell from 7.8 to 7.7%, its lowest since the three months to May 2009. Having fallen by 153,000 over the six months to July 2010, the claimant count rose marginally in August and September 2010. Inflows to the claimant count have ticked up in recent months, while off-flows have fallen back a little.

- *The private sector*

3.20 23.11 million people were employed in the private sector in the second quarter of 2010, 640,000 less than at the start of 2008. However, private sector employment has risen by more than 300,000 over the first half of this year. Redundancies have fallen back markedly compared to the first half of 2009, and the decline has been broad-based across all industries except public administration, education and health. The Bank of England Agents' summary of business conditions has reported since late 2009 that private sector employers do not anticipate further significant cuts to headcount.

3.21 In the three months to August 2010, total vacancies in the economy were more than 35% below their level in the first quarter of 2008, and they remained low across all industries. Private business surveys of firms' employment intentions are close to their average levels over the past decade, consistent with moderate employment growth through the second half of 2010.

- *The OBR forecast*



3.22 At Budget 2010, the OBR forecast a modest recovery in employment in the second half of 2010. Even so, for 2010 as a whole economy employment was forecast to be around ½% lower than in 2009. From 2011, as GDP growth is forecast to gather momentum and demographic factors boost the population of working age, employment is expected to rise more rapidly, reaching 30 million by 2015. In the near term the forecast increase in employment is not enough to offset the rise in the population of working age with the result that the ILO unemployment rate is projected to continue to rise, reaching a peak of 8.1% by the end of the 2010. Thereafter, the more rapid increase in employment should be sufficient to lower unemployment, so that the ILO unemployment rate falls to 6% in 2015. Claimant count unemployment is projected to fall throughout the forecast period.

3.23 At Budget 2010, the OBR also forecast a reduction in general government employment of 490,000 by 2014-15. The OBR will release a revised forecast on 29 November. Individual employers in the public sector will determine the workforce implications of spending settlements in their areas.

Average earnings

3.24 Average earnings growth has started to recover from the record lows seen through 2009, driven by a recovery in the private sector. However, whole economy earnings growth still remains well below its long-term average. Pay growth has picked up slightly in recent months in the private sector, while it has started to slowdown in the public sector. In the three months to August 2010, regular earnings growth in the private sector overtook that in the public sector for the first time since mid-2008. However, the sectoral gaps in pay remains wide.

- *2009*

3.25 Regular pay for private sector employees[8] grew by 1.2% in 2009, less than a third of the average growth rate over the previous eight years. Regular pay drift – the component of earnings growth that is linked to factors such as overtime – was the first factor to weigh down on regular pay growth at the start of 2009. Lower pay settlements – the regularly negotiated element of earnings growth – accounted for the remaining

[8] ONS, Average Weekly Earnings

part of the slowdown: over the recent recession, nearly a third of all settlements in the private sector were pay freezes, well above the historical average[9]. Total pay actually fell by 0.9% in 2009 (against a 2000-2008 average growth rate of 4.2%), as bonuses fell by 18.6% on a year earlier.

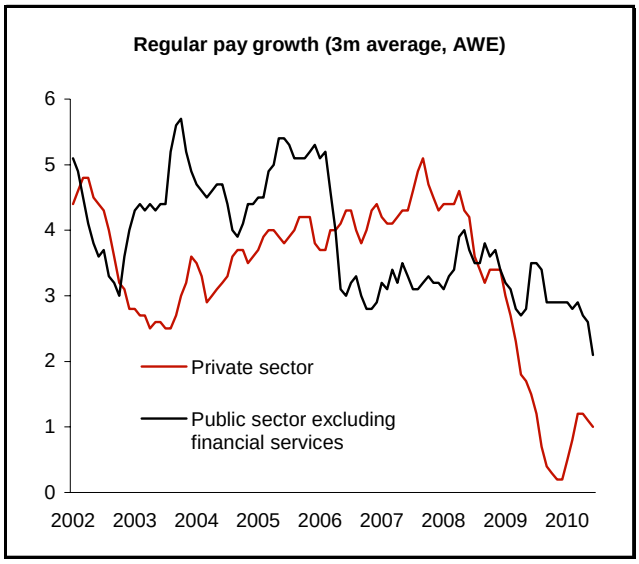
3.26 The ONS estimates that regular pay growth was 3.0% in the public sector (excluding financial services classified in the public sector) in 2009, having averaged 4.2% from 2000 to 2007. Pay freezes were not as widespread as in the private sector, but did account for around one-fifth of all settlements in 2009. Total pay growth averaged 2.8% in 2009.

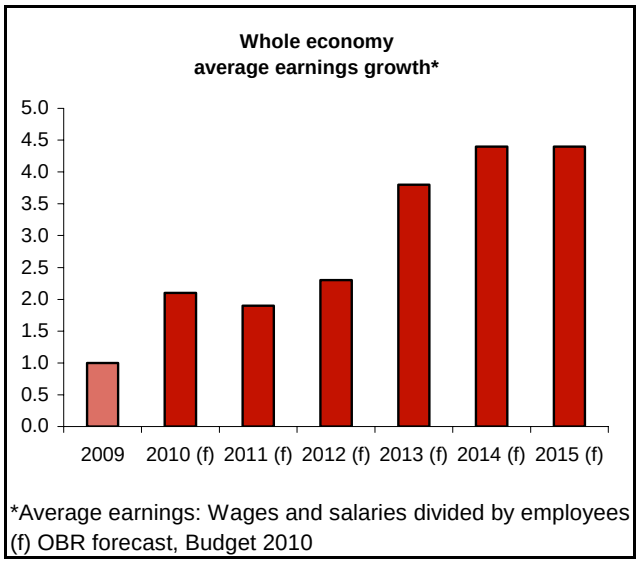
- *2010*

3.27 Whole economy earnings growth recovered a little in early 2010, driven by the private sector. Growth in earnings including bonuses picked up in the first quarter of 2010 (in part driven by a recovery in financial sector bonuses). Regular pay growth was 1.7% in the private sector, up 1½ percentage point since the end of 2009. Regular pay growth was 1.6% in the public sector (excluding financial companies classified in the public sector), and has eased for five consecutive months.

- *The private sector*

3.28 Settlements have started to recover in the private sector, as pay freezes become less widespread (15% of all settlements were pay freezes in the three months to August 2010, compared to a third over the recession). The Bank of England Agents' summary of business conditions reported in October 2010 that some of their contacts "*had wished to acknowledge their workforces' understanding, following a period of pay freezes and shorter working hours, by awarding pay increases, albeit modest ones,*" but only a few of them "*were budgeting for a marked increase in pay settlements due early 2011 to reflect RPI*".[10].





3.29 As set out in its pre-Budget and Budget 2010 forecast, the OBR expects whole economy average earnings growth to remain subdued in the near-term, but then pick up

[9] Income Data Services Pay Online settlements database
[10] Bank of England, Agents' summary of business conditions, October 2010, http://www.bankofengland.co.uk/publications/agentssummary/agsum10oct.pdf

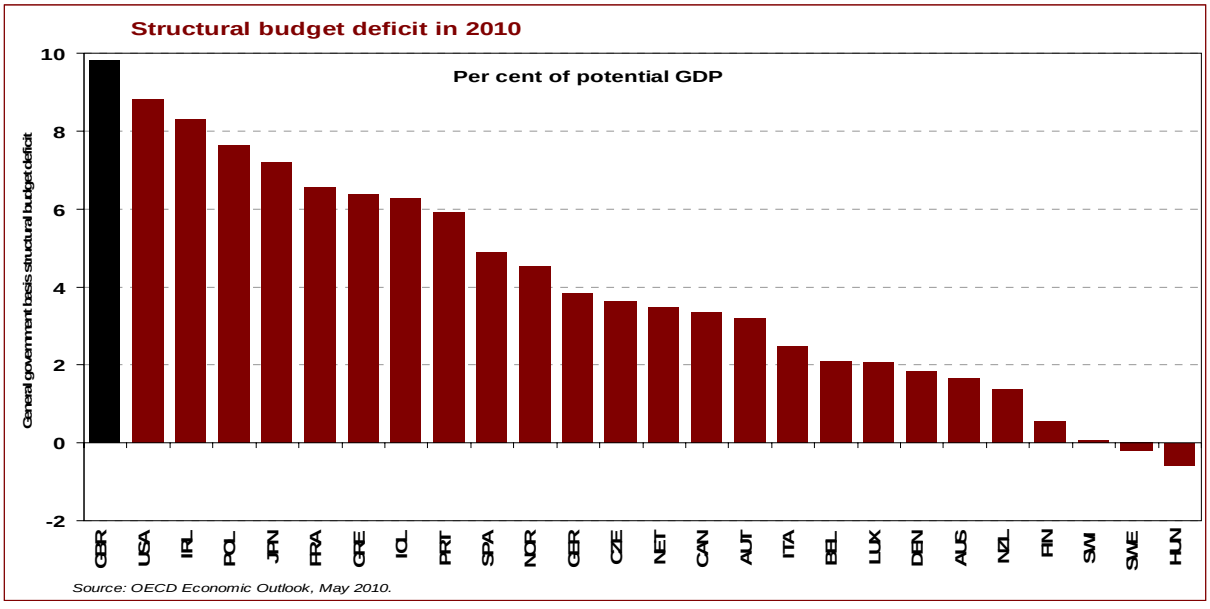
progressively as productivity growth recovers. High RPI inflation since the start of this year could also put upward pressure on settlements. The August 2010 Bank of England Agents' summary of business conditions indicated that the impact of higher inflation has been limited to-date, but that a growing number of contacts expressed concerns about future pay rounds, especially were inflation not to fall back.

Affordability and Spending Review 2010

3.30 The public finances have been profoundly affected by the financial crisis. Between 2002 and 2007 the UK financial system had become one of the most highly leveraged in the world.[11] Consequently, the UK was particularly vulnerable to the financial instability caused by the financial crisis. The UK saw the deepest and longest recession since the Second World War with output falling by more than 6% according to the latest estimate from the ONS.

3.31 The spending plans in the 2007 Comprehensive Spending Review were based on these unsustainable revenue streams. From 2001 onwards, public spending grew steadily as a share of the economy and a structural budget deficit began to emerge. As tax receipts fell away during the financial crisis, it became clear that levels of public spending were unaffordable. In the twenty years to 2006/07 public spending averaged around 40% of GDP and this increased to a historically high level of 48% by 2009/10. Receipts by contrast did not exceed 40% over the whole period, and fell to 37% in 2009-10.

3.32 As a result, the overall budget deficit reached 11% of GDP in 2009/10 and the scale of the fiscal challenge in the UK is on some measures larger than in any other advanced economy. In May, the IMF estimated that the UK's structural deficit will be the highest among all the OECD countries and the 27 EU Member States as depicted in the graph below.[12]



3.33 In response to these economic developments the Government set out plans for a significant acceleration in the reduction of the structural current budget deficit over the

[11] Speech by Mervyn King, Governor of the Bank of England, at the Lord Mayor's Banquet for Bankers and Merchants of the City of London at the Mansion House, 16 June 2010.
[12] *European Commission Spring Forecast*, May 2010.

course of the Parliament at the June Budget. The Government set out a forward-looking fiscal mandate to achieve cyclically-adjusted current balance by the end of the rolling, five-year forecast horizon. At this Budget the end of the forecast horizon is 2015/16. The fiscal mandate is supplemented by a target for net debt as a share of GDP to be falling at a fixed date of 2015/16, ensuring that the public finances are restored to a sustainable path. The Government's plans are consistent with the G20 agreement that countries with serious fiscal challenges should accelerate the pace of consolidation.

3.34 The greater proportion of the Government's fiscal consolidation will come from a reduction in public spending rather than an increase in taxation. This approach is consistent with OECD and IMF research, which indicates that fiscal consolidation efforts that that are driven more by spending restraint are more successful in promoting growth.[13]

3.35 Of the £81 billion of savings required by 2014/15, over £30 billion were announced in detail at the June Budget, including:

- £11 billion of welfare reforms;
- £3.3 billion from a two year freeze in the public sector starting in 2011/12;
- £6 billion of efficiency savings in 2010/11; and
- £10 billion from lower debt interest payments compared to the cost had there been no consolidation.

3.36 The Spending Review sets out the remaining spending reductions required to deliver the Government's consolidation plans. Table 3.3 sets out the capital and current Spending Review envelopes and how these break down between Departmental Expenditure Limits and Annually Managed Expenditure as a result of the decisions in the Spending Review.

Table 3.3: Total Managed Expenditure

	£ billion				
	Plans	Forecasts			
	2010-11	2011-12	2012-13	2013-14	2014-15
CURRENT EXPENDITURE					
Resource Annually Managed Expenditure	294.6	307.8	319.5	329.1	344.0
Resource Departmental Expenditure Limits	342.7	343.3	345.0	349.6	348.7
Public sector current expenditure	637.3	651.1	664.5	678.6	692.7
CAPITAL EXPENDITURE					
Capital Annually Managed Expenditure	7.8	7.3	6.7	6.4	6.9
Capital Departmental Expenditure Limits	51.6	43.5	41.8	39.2	40.2
Public sector gross investment	59.5	50.7	48.5	45.6	47.1
TOTAL MANAGED EXPENDITURE	696.8	701.8	713.0	724.2	739.8
Spending Envelope for Spending Review 2010[1]		**641.6**	**646.7**	**651.6**	**660.9**
Of which:					
Resource spending envelope		591.6	598.9	606.7	614.5
of which Annually Managed Expenditure		*248.4*	*253.9*	*257.2*	*265.8*
of which Departmental Expenditure Limits		*343.3*	*345.0*	*349.6*	*348.7*
Capital spending envelope		50.0	47.8	44.8	46.4
of which Annually Managed Expenditre		*6.5*	*6.0*	*5.6*	*6.2*
of which Departmental Expenditure Limits		*43.5*	*41.8*	*39.2*	*40.2*

[1] The envelope is defined as Total Managed Expenditure less BBC domestic services, National Lottery, net expenditure transfers to EU institutions and debt interest.

3.37 At an estimated £164 billion in 2009/10, spending on public sector pay represents about 50% of department spending allocations (Resource DEL) with Pay Review Body

[13] See *UK Article IV Consultation*, IMF, May 2009 and *Economic Outlook No.81*, OECD, June 2007.

workforces making up about 45% of the total public sector paybill.[14] Managing public sector pay carefully is central to the Government's plans for fiscal consolidation. With a backdrop of rising demand for public services, pay restraint will be absolutely crucial to protect service quality in a tighter environment for spending. And obtaining better value for money from the paybill is now even more important.

3.38 Furthermore, following the fiscal consolidation plans set out at the June Budget and Spending Review, Pay Review Body recommendations on pay will have cost pressure implications for departments within their Spending Review settlement.

Total reward and public service pensions

3.39 When taking decisions on pay, it is important to consider the overall value for the public sector reward package, including pension provision, which has remained generous in recent years. A study by the Institute for Fiscal Studies estimates the average public sector pay premium at around 5% (controlling for age, gender and skills) though there are significant differences between workforces and at regional level.[15]

3.40 Healthy levels of recruitment and retention depend on a range of factors in addition to base pay awards. For example, a "total reward" approach draws together all the financial and non-financial investment an employer makes in its workforce. It emphasises all aspects of reward as an integrated and coherent whole, from pay, pension and benefits through flexible working to learning and development and the quality and challenge of the work itself.

3.41 Occupational pensions are a form of deferred pay, paid to employees upon their retirement rather than when it is earned. They are a more significant part of the total reward package in the public sector than in the private sector, for two main reasons:

- coverage: the public sector workforce has far greater access to defined benefit occupational schemes than private sector workers (90% participation by serving employees versus 15% as at 2007[16]); and
- the value of employers' contributions: in the public sector on average these are set at higher percentages of pay than in the private sector.

3.42 The Independent Public Service Pensions Commission (IPSPC) led by Lord John Hutton published an interim report on 7 October. The report highlights the importance of providing good quality pensions to public servants, rejects a race to the bottom in pension provision, but concludes that there is a clear rationale for public servants to make a greater contribution if their pensions are to remain fair to taxpayers and employees, and affordable for the country. The Government accepted these conclusions as part of the Spending Review and in response to the Commission's interim recommendations, the Government will:

[14] Source: PESA 2008/9 Table 5.3 on pay and PESA 2008/9, HM Government, http://www.hm-treasury.gov.uk/d/press_66_09.pdf. Public sector pay outturn: £157.7bn. Public sector expenditure on services (TME, less accounting adjustments): £592.6bn. RDEL: £321.25bn

[15] IFS Green Budget: February 2010 www.ifs.org.uk/budgets/gb2010/10chap9.pdf

[16] Calculated from Occupational Pension Schemes Survey (OPSS) 2007, First Release and ONS Labour Market Statistics (August 2008)

- commit to continue with a form of defined benefit pension;
- await Lord Hutton's final recommendation before determining the nature of that benefit and the precise level of progressive contribution required;
- carry out a public consultation on the discount rate used to set contribution rates in the public service pension schemes;
- implement progressive changes to the level of employee contributions that lead to an additional saving of £1.8 billion a year by 2014/15, equivalent to three percentage points on average, to be phased in from April 2012;
- exempt the armed forces from this increase in employee contributions;
- launch a consultation on the Fair Deal policy, which Lord Hutton noted can create a barrier to the plurality of public service provision and make it more difficult to achieve innovation, to report by Summer 2011, informed by Lord Hutton's final recommendations on structural reform; and
- seek engagement with all stakeholders including trade unions.

CHAPTER 4: TOTAL REWARD - PAY, ADDITIONAL BENEFITS, AND PENSIONS

Introduction

4.1 The NHS workforce enjoys a competitive reward package, of which pay forms an element. This chapter considers issues which are relevant to that package:

- basic pay for Agenda for Change staff, and issues of possible "leapfrogging" in pay uplifts this year;
- other elements of financial reward including mileage allowances and "on call" payments under the Agenda for Change Pay Framework (including recent changes to those elements);
- recruitment and retention premia (please note that the issue of such premia for junior pharmacists is discussed in chapter 5 below);
- the Knowledge and Skills Framework;
- pensions; and
- total reward in the NHS.

The NHS Reward Package

4.2 The NHS employs approximately 1.3 million people, and 70% of its costs relate to pay and benefits. The broad range of benefits available to all NHS staff includes childcare, flexible working, and continual professional development. These benefits, coupled with effective social partnerships and sound employment practices, have enabled the Service to improve staff recruitment and retention, and help staff deliver transformational change.

4.3 The Department meets with the main health unions and NHS Employers on a regular basis through the Social Partnership Forum, with a view to discussing, debating and supporting the development and implementation of the workforce implications of policy. Additionally, the Department has a contract with NHS Employers to provide services to NHS employing organisations, including the provision of guidance and support on good employment practice, with a view to continuing improvements to the working lives of NHS staff as a path to better patient care.

4.4 Increasingly, the Department's ability to understand and tailor the NHS reward package is informed by data from the Electronic Staff Record (ESR) programme, which provides a single integrated HR and Payroll solution to NHS organisations[17]. Additionally, ESR provides staff with direct access to sections of their personal records, includes a Learning Management tool giving staff direct access to selected education and training opportunities and career development, and enables trusts to record staff training.

Pay – Agenda for Change Staff

4.5 As discussed in Chapter 1, in the light of the vital need for pay restraint the Government has imposed a two-year pay freeze for all public sector workforces from 2011/12. However, to protect the lower paid this will not apply to those earning a full-time equivalent salary of £21,000 or less, who will receive an annual salary increase of at least £250. **The Department's position is that all staff earning £21,000 or less**

[17] ESR covers HCHS staff in Trusts, PCTs, Care Trusts, SHAs and some arms-length bodies

should receive a flat rate increase of £250. This meets the Government's objective of ensuring that the lowest paid are protected from the freeze. In percentage terms, the rise would amount to 1.83% at pay point 1 of Agenda for Change, falling to 1.22% at point 15, the last point below £21,000.

Staff Earnings

4.6 Annex C shows the Agenda for Change pay scale from 1 April 2010. Staff within Agenda for Change currently have a basic salary minimum of £13,653 at the bottom of Band 1, rising to £97,478 at the top of Band 9. This makes the minimum wage for NHS workers £6.98 per hour (from April 2010) which is over 20% above the October 2009 national minimum wage of £5.80 per hour.

4.7 Details of the average basic and total earnings for NHS staff are provided in the NHS Information Centre's quarterly earnings survey. The most recent survey, published in September 2010, analyses earnings for the period from April to June 2010. For this evidence, the Department has compared the earnings in that period of groups of NHS staff which include significant numbers of those with average basic pay of £21,000 or less, with the same period in 2009. This shows that **for those groups basic pay has risen by an average of 3.6% and total earnings by 2.3%**. The figures for representative staff groups are as follows:

Table 4.1: AVERAGE BASIC PAY AND TOTAL EARNINGS BY STAFF GROUP

	BASIC PAY			TOTAL EARNINGS		
	Apr-Jun 09	Apr-Jun 10	*% change from last year*	Apr-Jun 09	Apr-Jun 10	*% change from last year*
Qualified Nurses	£29,000	£30,000	*3.4*	£33,500	£34,400	*2.7*
Unqualified Nurses	£16,300	£16,900	*3.7*	£20,000	£20,600	*3.0*
Qualified Ambulance Staff	£25,600	£26,300	*2.7*	£38,000	£37,700	*-0.8*
Unqualified Ambulance Staff	£17,300	£17,800	*2.9*	£22,800	£22,900	*0.4*
Healthcare Assistants	£15,200	£15,800	*3.9*	£18,900	£19,400	*2.6*
Unqualified ST&T Staff: Allied Health Professionals	£17,000	£17,700	*4.1*	£18,000	£18,800	*4.4*
Unqualified ST&T Staff: Other (including healthcare scientists)	£17,500	£18,500	*5.7*	£19,400	£20,300	*4.6*
Former Pay Negotiating Council Groups						
Admin & Clerical	£20,600	£21,400	*3.9*	£22,000	£22,800	*3.6*
Maintenance & Works	£21,300	£21,800	*2.3*	£27,800	£27,700	*0.3*

4.8 All staff groups have seen an increase in *average basic earnings* over the last year. With the exception of qualified ambulance staff, all staff groups have also seen an increase in *average total earnings*. (The earnings of qualified ambulance staff are

particularly variable as their additional payments, which vary over time according to service need, are significantly higher than those of other groups.)

Distribution of Staff across Paybands

4.9 Approximately 45% of Agenda for Change staff (headcount) are in Bands 1-4, and most of these staff earn £21,000 or less. The top two pay points within Band 4 are above £21,000, and 44% of those in Band 4 are on pay points which will be subject to the pay freeze. Around 45% of Agenda for Change staff are in Bands 5-7, and 10% in Bands 8 and 9, all of whom will be subject to the pay freeze). These figures are based on the staff groups used in the pay metrics for September 2009. The full tables are attached at Annex D.

The Effects of the Government's Uplift Proposals

4.10 The Government's proposal is that all staff earning £21,000 or less should receive a flat rate increase of £250. The current value of each pay point for those staff, the value of each increment, and the total value of the incremental rise and £250 uplift combined, are as follows.

Table 4.2: The Effects of the Government's Uplift Proposals

Pay Point	Basic Pay per FTE (£)	Value of increment (£)	Value of increment (%)	Total increase if pay £250 to all below £21k (£)	Total increase if pay £250 to all below £21k (%)
1	13653	355	2.6%	605	4.4%
2	14008	356	2.5%	606	4.3%
3	14364	415	2.9%	665	4.6%
4	14779	415	2.8%	665	4.5%
5	15194	416	2.7%	666	4.4%
6	15610	535	3.4%	785	5.0%
7	16145	608	3.8%	858	5.3%
8	16753	365	2.2%	615	3.7%
9	17118	486	2.8%	736	4.3%
10	17604	548	3.1%	798	4.5%
11	18152	425	2.3%	675	3.7%
12	18577	673	3.6%	923	5.0%
13	19250	683	3.5%	933	4.8%
14	19933	621	3.1%	871	4.4%
15	20554	622	3.0%	872	4.2%

The minimum increase for staff who are due to receive an increment *in addition to* the £250 uplift is therefore 3.7%. The average value of increments for staff on pay points 1-15 is 3%.

Tapering/Leapfrogging

4.11 The NHSPRB has asked for the Department's views on the tapering of any award, and the possible risk of "leapfrogging".

4.12 Only those staff earning £21,000 or less will receive an uplift, and there is some risk that these staff might "leapfrog" those staff above them who receive no uplift. This might bring the fairness of the system into question. "Leapfrogging" can be addressed

by tapering uplifts, though the need for this will only occur if either those at lower pay points receive a significantly greater increase than those higher up, or if those at the top receive a payment which will take them above those whose pay is frozen.

4.13 The Government's position is that all staff earning £21,000 or less should receive a flat rate increase of £250. This would remove any risk of leapfrogging, as all pay points would receive the same uplift. At first sight, there may appear to be a problem at point 15, the highest pay point at which staff would receive an increase. However, the difference between point 15 (£20,554) and point 16 (21,176) is £622. No "leapfrogging would then take place and, even if a similar flat rate uplift be awarded in April 2012 (the second year of the pay freeze), point 15 will still be lower than point 16. Any recalibration of the system which might prove to be necessary to address the proximity of the pay points may be carried out following the end of the pay freeze.

Agenda for Change – Terms and Conditions

4.14 Since 2004, all directly-employed NHS non-medical staff on national terms (other than Very Senior Managers) have been paid in accordance with Agenda for Change. Based around objective job evaluation, and with specific regard to equal pay requirements, the framework covers around 1.1 million NHS staff in jobs ranging from porters, cleaners and ward clerks, to Nurse Consultants, biomedical scientists and Finance Managers.

4.15 Under Agenda for Change, staff are placed in one of nine pay bands on the basis of their knowledge, responsibility, skills and effort needed for the job - rather than on the basis of their job title. They should receive annual appraisal and development reviews and have personal development plans. Their pay increases in annual steps from minimum to maximum in their pay band, except that there are two developments gateways, at which staff are required to demonstrate the applied knowledge and skills needed for particular jobs. Staff also enjoy the same basic conditions of service (working hours, leave, etc.) as everyone else in their pay band. Local or national recruitment and retention premia (RRP) may be used to pay specific groups, where this is necessary, and there are three high-cost area supplements (inner London, outer London and fringe).

4.16 The job evaluation scheme provides a structured method of comparing job demands to allocate jobs within the structure. It covers the diverse demands present in NHS posts, and is supported by equal pay principles to ensure that all jobholders are treated fairly. In addition, through the Knowledge and Skills Framework (KSF), staff are rewarded for developing their roles and taking on greater responsibility, which provides opportunities for career progression and movement through the pay band. Information on the simplification of the KSF is at paragraphs 4.32-4.37.

4.17 The NHS Staff Council has recently completed work on updating two areas of Agenda for Change terms and conditions of service:

4.18 New rates of mileage allowances in the NHS were agreed with the unions in July 2008. At that time, it was agreed that a further review would take place to agree a new system for re-imbursement of the cost of business travel, and that review has now been completed. The trade unions are currently seeking final agreement of the recommendations from the review from their members. The proposed new system is simpler and easier to use. It applies the same reimbursement rate to all staff regardless of how many business miles they travel and it has built-in reviews, to ensure

that payments continue to cover any costs that staff incur. If approved, the new system will take effect from 1 July 2013. Further details of the new system can be found on the NHS Employers website at http://www.nhsemployers.org/PayAndContracts/AgendaForChange/mileage/Pages/Mileagepaymentsreview.aspx

4.19 On-call payments are the only components of non-medical NHS staff terms and conditions which have not been incorporated into Agenda for Change. The NHS Staff Council set up a sub-group to review on-call arrangements across the NHS, and its review has been completed following consultation on principles to support new local arrangements. The new principles which this has established will provide a more consistent approach to on-call across the NHS to meet equal pay requirements, while still giving organisations the flexibility to meet local needs. They cover key areas including the definition of on-call, availability and equal pay issues, and detailed issues of frequency, time off in lieu and public holidays. These principles have now been published, and new arrangements may be negotiated locally and implemented from April 2011. Further details are available on the NHS Employers website at http://www.nhsemployers.org/PAYANDCONTRACTS/AGENDAFORCHANGE/ONCALLREVIEW/Pages/ReviewOfOn-CallArrangements.aspx.

Recruitment & Retention Premia (RRPs)

The Use of General and Long Term RRPs

4.20 In the past, the NHSPRB has expressed an interest in the Department's data on the use of RRPs in the NHS. An analysis was provided last year, and this year the Department has sought to provide further analysis and year-on-year comparisons (subject to caveats on the data, which are set out later in this section).

4.21 The Department has analysed the proportion of staff in receipt of a General or Long Term RRP by staff group and Agenda for Change band, as at June 2010. It has also compared the payment of RRPs both across and within each of SHA regions to assess the extent of regional variation. (see Annex E). This is based on data extracted from the Electronic Staff Record (ESR), which records RRPs as being either "general" or "long term", as follows:

- "general" RRPs are short-term payments, awarded on a one-off basis or for a fixed term, and it is assumed that these payments relate to local RRPs only;
- "long term" RRPs are awarded on a long-term basis, and become an integral part of basic salary - they are pensionable and count for the purposes of payments linked to basic pay, such as overtime and unsocial hours payments. It is assumed that these payments relate to both local and national RRPs.

4.22 The supplementary section Annex E provide a breakdown of the June 2010 results:

- for those types of post that are deemed eligible for a Long Term (National) RRP according to Table 20 of the Agenda for Change Terms and Conditions of Service Handbook; and

4.23 In respect of General RRPs:

- the proportion of non-medical staff receiving a General RRP was 0.26% in June 2010, little different, 0.01% lower, compared to June 2009;
- there was not a significant shift in the distribution of staff receiving a General RRP across staff group or Agenda for Change band;
- at June 2010, nearly 50% of staff receiving a RRP were in the nursing and midwifery group, 17% in the administrative and clerical group and 12% belonged to the Allied Health Professionals group;
- 69% of staff receiving a RRP were in Bands 5, 6 and 7, with 17% of payments being made to staff below Band 5;
- on average, organisations in East Midlands and South Central appeared to be using General RRPs to a greater extent than other regions, as a means to address short-term recruitment and retention issues; and
- of the job roles within Agenda for Change recorded as receiving a General RRP on ESR, those with the highest proportion of staff receiving a payment (greater than 3%) were Radiographers (Therapeutic) and Chaplains.

4.24 In respect of Long Term RRPs:

- the total proportion of non-medical staff receiving a Long Term RRP in June 2010 was 5.4%, compared to 5.8% in June 2009;
- this was a result of decreases in the proportion of staff receiving a RRP in the nursing and midwifery and Allied Health Professionals groups. These reductions were mainly in Bands 5, 6 and 7;
- there was not a significant shift in the distribution of staff receiving a Long Term RRP across staff group or AfC band;
- at June 2010, 66% of staff receiving a RRP were in the nursing and midwifery group;
- 80% of RRPs were received in Bands 5, 6 and 7, with 14% of payments being made to staff below Band 5;
- on average, organisations in the East of England, South East Coast, South Central and the South West appeared to be using Long Term RRPs at a significantly higher rate than other regions to address long-term recruitment and retention issues; and,
- of the job roles recorded as receiving a Long Term RRP on ESR, those with the highest proportion of staff receiving a payment (greater than 80%) were plumbers, fitters, mechanics and electricians.

4.25 There are some caveats to these results. On analysing the specific RRP payments made in June 2010, there were some apparent anomalies:

- of the staff receiving a General RRP, 20% were recorded as receiving relatively small monthly payments of less than £10 (per FTE). The RRP payment received as a proportion of basic salary was on average 6.5%, but there were cases where the RRP payment recorded was a significantly higher proportion of the basic salary. Some 2% of RRP payments recorded were greater than 30% of basic salary (though just less than half of these were marginally over 30%); and
- of those staff receiving a Long Term RRP, 5% were recorded as receiving monthly payments of below £10 (per FTE). The RRP payment recorded as a proportion of basic salary on average was 3.6%, but again there were instances where this

proportion was significantly higher. Some 0.2% of RRP payments recorded were greater than 30% of basic salary.

4.26 These anomalies have been highlighted to indicate the range of RRP payments suggested by the ESR data. The Agenda for Change Terms and Conditions of Service Handbook suggests (at paragraph 5.13) that the combined value of any nationally and locally awarded recruitment and retention premia should generally not exceed 30% of basic salary (subject to discretion). The high values of recorded RRP in relation to basic salary therefore indicate the possibility of some error in the entry of payments in the ESR. All of these cases have been included in the analysis because there is not a clear threshold for exclusion given the distribution of the data.

4.27 There were also instances of staff apparently receiving a negative RRP – though these staff represented only 0.01% of the total non-medical population. This may have resulted from corrections made for overpayments in previous months.

4.28 The Department continues to examine the robustness of the ESR data with a view to improving its quality.

The National RRP Review

4.29 The Employment Tribunal, in its judgement on the *Hartley v Northumbria Healthcare NHS Trust and Others* (2008) equal pay test case, ordered that existing national RRPs should be reviewed by the NHS Staff Council before 1 April 2011, and that if they were not so reviewed they should cease to have effect from that date. In response, NHS Employers (on behalf of the Staff Council) has commissioned an independent review.

4.30 Following a competitive tendering exercise, the Institute for Employment Studies was commissioned to carry out the review, which will provide a detailed assessment of whether the labour market information available at national and regional level across the UK, combined with analysis of evidence from a range of NHS organisations, provides an objective and evidence-based case for a:

- national RRP (NRRP) payable to qualified maintenance craft operatives and technicians with full electrical, plumbing and mechanical craft qualifications and, if judged necessary, at what value;
- an NRRP for employed healthcare chaplains and, if judged necessary, at what value; and
- an NRRP at any value for the list of job roles set out in Table 20 of Annex R of the Agenda for Change Terms and Conditions Handbook.

4.31 The review will produce a report for consideration by the NHS Staff Council in mid-November 2010, which it is intended will influence any necessary changes before 1 April 2011. The Department should be able to share the research findings with the NHSPRB, following their presentation to the NHS Staff Council. The NHSPRB will wish to note that, as an interim measure, the Department has produced "Top Ten Tips" for NHS organisations in using local RRPs, a copy of which is at Annex F.

The Knowledge and Skills Framework (KSF) - Simplification

4.32 In their reports on Agenda for Change, both the National Audit Office (NAO) and the Public Accounts Committee (PAC) highlighted the need to improve the NHS's use of

the KSF. Both made a number of recommendations. The Department updated the NHSPRB on progress last year. Further progress has been made since then on implementation.

4.33 In its report, the NAO noted that "the [KSF] is viewed by trust managers and staff as too complicated and as a consequence some trusts are discouraged from making the best use of this tool." The Department, through NHS Employers and in partnership with NHS trade unions, has worked to review and simplify the guidance for using the KSF, and this has resulted (among other improvements) in practical guidance on the amount of supporting documentation which staff need to bring to their KSF reviews.

4.34 The Department and NHS Employers also commissioned an independent review of the KSF's structure, which was carried out by the Institute for Employment Studies (IES). The Executive Summary to the IES's report is at Annex G. Its recommendations, which have been broadly accepted by the NHS Staff Council, included:

- the need for a stronger link between KSF and staff appraisals;
- simplification of the KSF to allow greater flexibility, and to meet local needs; and
- the need for better support for NHS organisations in delivering KSF at local levels.

4.35 The Department subsequently appointed IES to work with relevant stakeholders to develop and agree the re-design and simplification of the KSF whilst maintaining its core aims and principles. IES took this forward by setting up a small technical group of experts from the Service, with a larger reference group made up of senior stakeholders including the trades unions. A wide variety of models used in the NHS was considered including those of organisations that achieved above average results in the NHS staff survey for the take-up and effectiveness of appraisal and personal development plans.

4.36 IES has now completed its work, which was endorsed by the NHS Staff Council in September 2010. Its core conclusion was that, while the KSF is a positive force in the NHS, its guidance needed to be simplified if it is to serve as a practical guide for managers and staff. To implement the necessary improvements, NHS Employers in England have now given the flexibility to retain the original approach or use a new simplified approach in which:

- the language of the core dimensions has been simplified;
- six core dimensions have been retained;
- optional dimensions on leadership and management have been inserted;
- the use of specific dimensions and post outlines has been made optional; and
- new guidance and model documents for all staff and managers have been developed to enable an effective integrated appraisal/development review process.

4.37 A communication strategy is now being rolled out by the Department, NHS Employers and the NHS Staff Council, which will support the effective implementation of the improved KSF across NHS England. The other UK countries are also progressing their own improvements to the KSF.

The NHS Pension Scheme

4.38 The current NHS Pension Scheme (NHSPS) is a defined benefit occupational scheme linked to salary. Benefits for most staff in the 1995 Section of the NHSPS are based on 1/80ths of pay for each year of service, includes a separate lump sum, life assurance, ill

health, partner and dependent benefits. Unreduced pensions are payable at the normal pension age of 60, based on the best of the last three years' pensionable pay. Since April 2008, most staff can increase their separate lump sum payment by commuting (or giving up) some of their pension.

4.39 Cost-sharing arrangements were introduced in April 2008, which means that any further improvement in the value of benefits to employees following the four-yearly valuation exercise would need to be paid for by increasing staff contributions, changes to the benefit structure or a mixture of the two.

4.40 Regulations came into effect from 1 October 2009 to allow all contributing members of the 1995 Section of the Scheme a choice (described as the *NHS Pension Choice Exercise*) to either remain in the 1995 Section, or transfer their accrued service to the 2008 Section of the Scheme. The 2008 Section, open to new entrants since April 2008, has a normal pension age of 65, a 1/60th pension but no automatic lump sum, but members are able to commute part of their pension in order to secure a lump sum payment. Pensions in the 2008 Section are based on an average of the best three consecutive years in the last 10 years.

4.41 As part of the Pension Choice Exercise, eligible members of the 1995 Section receive a personalised pension statement, which compares benefits in the 1995 and 2008 Sections of the NHSPS, as well as an explanatory guide and a DVD to help inform their decision. The Pension Choice Exercise is due to end on 31 March 2012. Each Strategic Health Authority region will see two periods of Choice activity with staff aged 50 and over offered Choice during 2010/2011 and staff aged 49 and younger during 2011/2012. The first stage (for those over 50) has now been successfully completed and approximately 5% of staff have elected to transfer to the 2008 Section of the NHSPS.

<u>The Emergency Budget of June 2010</u>

4.42 The Government announced in the Emergency Budget that it intended to change the indexation of public sector pensions and tax relief on individual pension contributions. In particular, the price indexation of public service pensions will change from RPI to CPI. The Government believes that this will provide a more appropriate reflection of recipient's actual inflation experiences. It will also ensure consistency with the inflation target used by the Bank of England. While the CPI is generally - but not always - lower than RPI, the NHS Pension Scheme will continue to be protected against price increases and uprated in line with state second pensions.

4.43 This change does not just impact on members of the NHS Pension Scheme, but on all members of occupational pension schemes and recipients of the state retirement pension. It will also apply to Government benefits and tax credits.

<u>Changes to the Tax Relief on Employee Pension Contributions</u>

4.44 The Government provides generous tax relief to save for a pension, to encourage individuals to take responsibility for retirement planning and to recognise that pensions are less flexible than other forms of saving. The cost of tax relief net of income tax paid on pensions paid doubled under the last Government to around £19 billion a year by 2008/09.

4.45 To ensure that pensions tax relief remains fair and affordable, the Government confirmed in the June Budget that it would proceed with the previous Government's aim to reduce the cost of pensions tax relief by about £4 billion a year. In the 2010 Budget, the Government announced plans to achieve this through an approach that limits the amount of tax relief which is received by those who make the highest pension contributions.

4.46 In October 2010, the Government announced that the annual allowance for tax-privileged pension saving will be reduced from £255,000 a year to £50,000 a year, from April 2011. These changes will impact on both public and private sector contributors to occupational pension schemes. The Lifetime Allowance will also be reduced from £1.8 million to £1.5 million, from April 2012. A consultation on options enabling people to meet tax charges from their pensions will commence in November 2010.

4.47 To protect individuals who exceed the annual allowance due to a one-off "spike" in accrual, the Government will allow individuals to offset this against unused allowance from previous years. These tax changes will largely impact on high earners, for example those earning around £100,000 or more a year. Initial analysis of the proposals suggest that staff on Agenda for Change will not be affected by these changes. However, the NHS has the most members likely to be affected – in the region of 10,000 – primarily GPs, medical consultants and very senior managers.

<u>The Review of Public Service Pension Schemes</u>

4.48 On 20 June 2010, the Government announced the establishment of an Independent Public Service Pensions Commission (IPSPC), led by Lord Hutton of Furness.

4.49 The Commission published an interim report on 7 October. This highlights the importance of providing good quality pensions to public servants, rejects a race to the bottom in pension provision, but concludes that there is a clear rationale for public servants to make a greater contribution if their pensions are to remain fair to taxpayers and employees, and affordable for the country. At the Spending Review, the Government accepted these conclusions. In response to the Commission's interim recommendations, the Government will:

- commit to continue with a form of defined benefit pension;
- await Lord Hutton's final recommendation before determining the nature of that benefit and the precise level of progressive contribution required;
- carry out a public consultation on the discount rate used to set contribution rates in the public service pension schemes;
- implement progressive changes to the level of employee contributions that lead to an additional saving of £1.8 billion a year by 2014-15, equivalent to three percentage points on average, to be phased in from April 2012;
- exempt the armed forces from this increase in employee contributions;
- launch a consultation on the Fair Deal policy, which Lord Hutton noted can create a barrier to the plurality of public service provision and make it more difficult to achieve innovation, to report by summer 2011 informed by Lord Hutton's final recommendations on structural reform; and
- seek engagement with all stakeholders including trade unions.

4.50 As the new public service pension arrangements become clear, and in light of the current pay freeze and financial challenges facing the public services, communicating

the value of the NHSPS as part of the overall reward package will become increasingly important for employers and staff. Exploratory work is under way, with the aim of ensuring that the value of pensions and the total reward package are fully communicated to staff. This is likely to include:

- the development and delivery of Annual Benefit Statements (ABS) for all staff, which shows the value of personal and family benefits;
- the opportunity to expand ABS to include details of the overall reward package (annual leave, redundancy benefits etc); and
- the development of flexible benefits (for example, the ability to "sell" annual leave).

Total Reward

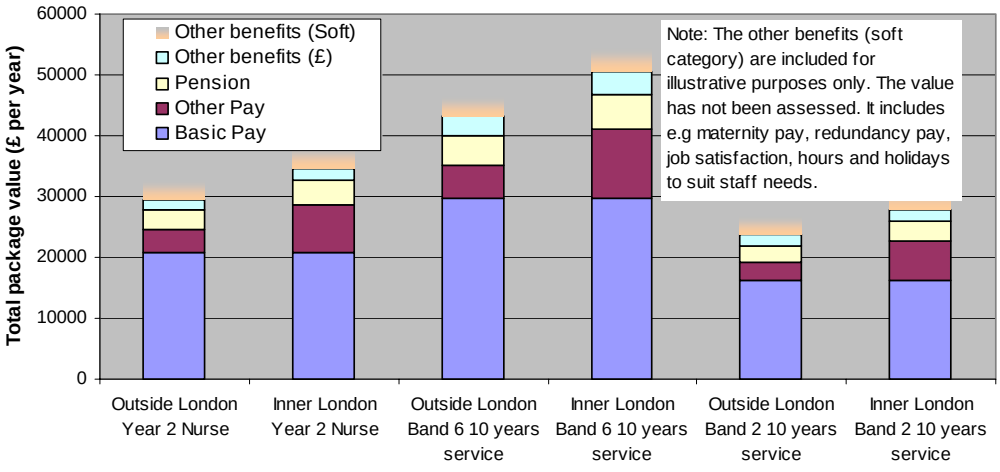
4.51 The Department strongly believes that the general NHS reward package remains highly competitive and is a valuable retention and recruitment tool. The current package includes:

- a generous final salary pension;
- maximum annual leave entitlement of 41 days holiday (compared with 28 days statutory entitlement;
- sick pay entitlement for most staff based on 6 months half and 6 months full pay;
- maternity leave;
- a no fault injury benefit scheme; and
- service-related entitlement to redundancy pay of up to 2 years' salary.

4.52 The following table expresses the value of the total employment package for nurses in monetary terms, at various career stages. As well as basic pay, it includes a representative value of current employer pension contributions at the actual rate paid. It also includes the value of the additional holiday allowances, and of sick pay provisions (based on average sickness absence levels), in excess of statutory provision.

Table 4.3

Value of Total NHS Reward Package (2009/10)



4.53 For a Band 6 nurse outside London with 10 years' service, the value of these benefits over statutory provision, along with employer pensions contributions, is over £10,000.

These elements form nearly 20% of the value of the total reward package such that the basic pay of a Band 6 nurse comprises only around 70% of their total reward.

4.54 **In summary, the Government believes that the NHS continues to offer a comprehensive reward package and would draw the NHSPRB's attention to the following recent changes:**

- **earnings continue to rise across the NHS's Agenda for Change workforces;**
- **revisions have recently been made to terms and conditions covering motor mileage and on-call arrangements being taken forward in partnership;**
- **the need for employers to make use of recruitment and retention premia remains low, with little significant year-on-year change;**
- **the revised Knowledge and Skills Framework is addressing the concerns raised by the NHS in the past;**
- **pensions provision, leave arrangements and sick pay remain very competitive; and**
- **career development opportunities remain strong**.

4.55 **Even during these difficult economic circumstances, the NHS reward package continues to be highly attractive, and the Department believes that the NHSPRB should take full account of this in considering its recommended uplifts for lower paid staff**.

CHAPTER 5: NON-MEDICAL WORKFORCE, PLANNING & DELIVERY

Introduction

5.1 As chapters 1-4 have made clear, the Government regards issues of affordability as central to NHS pay uplifts this year. However, the Government considers that NHS workforce-specific issues of staffing levels, recruitment and retention, and staff motivation remain fully relevant to the consideration of the 2011/12 uplifts.

5.2 The Government considers that the evidence in these areas supports its strong conviction that a flat rate uplift of £250 is appropriate for NHS staff earning basic salaries of £21,000 or less:

- recruitment and retention is healthy;
- staff numbers across all groups have risen - the headline figures from the 2009 NHS Workforce Census show that the overall HCHS non-medical workforce has grown by 5% from 1,120,548 in 2008 to 1,176,831 in 2009;
- hard-to-fill, three month vacancy figures are low and continue to fall; and
- staff survey results continue to improve, with figures for job satisfaction rising, staff engagement high, and fewer staff considering leaving.

5.3 This chapter provides detailed commentary in these areas, as well as updating the NHSPRB on the generality of non-medical workforce planning.

5.4 For 2011/12, the NHSPRB has been asked to consider uplifts for staff earning basic salaries of £21,000 or less only; other staff employed under Agenda for Change are subject to the general pay freeze which is in force across the public sector. The NHSPRB will therefore be most concerned about the staffing, recruitment and retention, motivation, and workforce planning issues which are directly relevant to lower-paid NHS staff. However, this information could not be adequately considered in isolation from wider issues and movements affecting the Agenda for Change workforce. The Government has therefore undertaken to provide relevant information about all Agenda for Change staff in this evidence. This chapter is therefore structured as follows:

- information about the generality of non-medical workforce planning, staffing levels, recruitment and retention, and staff satisfaction. This includes a consideration of the role of the new Centre for Workforce Intelligence (paragraphs 5.6 to 5.27).
- information on these issues which is directly relevant to staff under Agenda for Change earning £21,000 or less (paragraphs 5.28 to 5.48);
- information on these issues which concerns staff under Agenda for Change earning *over* £21,000 (paragraphs 5.49 to 5.69).

5.5 The chapter concludes with a detailed discussion of issues affecting junior pharmacists (paragraphs 5.70 to 5.76).

General Workforce Issues

Non-Medical Workforce Planning in the NHS

5.6 Non-medical workforce planning work is broadly divided as follows:

- qualified staff (qualified nurses; scientific, therapeutic and technical staff, etc.), which must take account of the training lead times for staff to attain qualification (typically three-year undergraduate courses); and
- unqualified staff (healthcare assistants, support workers etc), which do not normally rely on such long lead times and can therefore be more flexible.

5.7 Workforce planning for qualified non-medical staff works to medium-term time horizon (typically around 5 years), so that undergraduate training commissions can be set. The Department has been pursuing a policy of self sufficiency for the non-medical workforce, so that specific staff groups have been targeted for increased commissions over the past few years (see Table 5.1).

Table 5.1: Time series of non-medical training commissions

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11 (planned)
Nursing	20,308	21,199	19,352	20,664	20,829	20,327
Midwifery	1,819	1,990	2,071	2,272	2,482	2,493
Allied Health	7,460	7,103	6,650	6,580	6,674	6,466
Professionals	885	1,059	1,054	1,131	1,220	1,114
Healthcare Scientists	3,498	2,848	2,598	3,043	3,266	3,350
Technicians	0	1,124	1,001	1,302	1,198	1,480
Community Nursing New roles	0	0	618	1,249	1,385	1,542
Total	34,100	35,323	33,344	36,241	37,054	36,772

5.8 The increased number of training commissions over recent years has been a factor in the growth of the non-medical workforce (see Annexes H and I).

5.9 Since 2000, we have seen a significant increase in the NHS workforce of 26% more staff – including 64,000 (22%) more qualified nurses employed in the service.

Increase in Capacity

5.10 Supply and demand for non-medical staff groups is currently in broad balance. However, some specific imbalances do exist, and a number of specific types of staff are included on the Home Office Shortage Occupation list[18]. These include:

- pre-registration pharmacists working in the NHS or hospitals;
- registered pharmacists working in the NHS or hospitals;
- specialist nurses working in operating theatres;
- operating department practitioners;
- specialist nurses working in neonatal intensive care units;
- Health Professions Council (HPC) registered diagnostic radiographers;
- HPC-registered therapeutic radiographers;
- nuclear medicine technologists;

[18] www.ukba.homeoffice.gov.uk/sitecontent/documents/workingintheuk/shortageoccupationlist.pdf

- radiotherapy technologists;
- speech and language therapists at Agenda for Change bands 7+ or their independent sector equivalents; and
- HPC-registered orthoptists.

The Centre for Workforce Intelligence (CfWI)

5.11 To better understand the future demand for non-medical staff, and to develop supply strategies to meet this demand, the Department established the CfWI to provide expert analysis and intelligence on workforce planning. Set up in January CfWI has a broad remit for providing long-term and strategic scenario planning for the whole health and social care workforce, based on research, evidence and analysis, to build strong leadership and capability in workforce planning. It will provide an easily accessible route to NHS and social care planners, clinicians and commissioners seeking workforce planning and development expertise to improve NHS and social care services.

5.12 The CfWI will focus on three key strategic areas:

- workforce intelligence to the health and social care system;
- leadership within that system, to help senior leaders drive workforce planning, to strengthen the influence of workforce planners and provide better co-ordination; and
- support to the NHS, the supply of relevant resources, and the identification of best practice in improving the effectiveness of workforce planning at local, regional and national levels.

5.13 The CfWI will publish its first report on the non-medical workforce in autumn 2011. This will analyse the likely short-term output from training over the next few years, and compare its supply forecasts with estimated levels of demand. The CfWI will then model longer-term demand for non-medical staff considering factors such as:

- population growth and change;
- changes to morbidity;
- service level and design;
- the role of doctors;
- workforce participation;
- retirements and attrition; and
- migration.

5.14 The outputs of this project will enable DH, SHAs, PCTs and trusts to understand non-medical demand and supply in greater depth, and thereby improve their workforce planning strategies. The Government will draw on the CfWI's work in future evidence to the NHSPRB.

The Workforce Census, Staff Numbers, and Vacancies – General Considerations

5.15 The NHSPRB will wish to be aware of the following, in considering the statistical and other material which is presented in this evidence.

Census and ESR data sources

5.16 The NHSPRB has previously highlighted the importance of the NHS providing more regular, monthly or quarterly, workforce information on staff in post and turnover, perhaps using the Electronic Staff Record (ESR). The DH supports this ambition. From July 2010 the NHS Information Centre (NHS IC) has therefore published experimental, provisional monthly NHS workforce data. As expected with provisional, experimental statistics, some figures may be revised from month to month as data issues are uncovered and resolved. The monthly workforce data is not directly comparable with the annual workforce census because it is based on data from the ESR. That data includes some staff, such as *locum* doctors, who do not appear on the Census; while other staff who do appear on the Census including primary care and bank staff, are not recorded on the ESR.

5.17 Because of concerns over consistency and the experimental nature of the new monthly ESR data, our current evidence to the Review Body continues to rely on the annual census returns. In future, more monthly workforce statistics may be available. However, this data would have some limitations, such as seasonal variation in staff numbers due to different and staggered recruitment cycles.

Vacancy data sources

5.18 Data drawn from the annual vacancy survey, based on a snap shot on 31 March and published in August, shows that the trend in declining vacancy rates over recent years has continued. For the non-medical workforce as a whole, the three-month vacancy figure has fallen from 0.6% in 2009, to 0.5% in 2010 (see Annex J).

5.19 The Pay Review Body had expressed an interest in the use of the NHS Jobs website to provide more detailed information on vacancies, including applications. The Department is pleased to report that the NHS IC have put in place plans to move away from an annual vacancy survey, and extract data from a re-tendered NHS Jobs service/website that would be published each September. As well as information on vacancies over time (ie not simply a snap shot), use of NHS Jobs data has the benefit of providing information on the period a vacancy has been standing and information on number of applicants.

Turnover data source

5.20 Information on staff turnover, which was provided in previous years by the NHS Information Centre was from a one-off collection outside of its central data collection programme. The NHS Information Centre will not be repeating this collection, partly on the grounds of available resources. The Department considers that the annual collection of data on staff numbers and vacancy levels provides sufficient material for the assessment of trends in NHS staff movements.

<u>The NHS Staff Survey – General Considerations and Improvement Work</u>

5.21 In its 24th Report, the NHSPRB asked Health Departments to consider adopting the same core questions on morale and motivation for their respective staff surveys to improve the comparability between administrations (paragraphs 4.20-4.21). The NHSPRB also asked that Health Departments should consider including questions on Productivity and Workload (paragraphs 4.60–4.62).

5.22 These requests were considered by the NHS Staff Survey Improvement Board in England, which was tasked with carrying out a review with the aim of better reflecting the commitments made in the NHS Constitution. In the course of this review, the Office of Manpower Economics requested the inclusion of a number of additional questions to be added with the aim of providing more explicit feedback on motivation, attitudes to Agenda for Change, levels of satisfaction with the total NHS benefits package, and the use of recruitment and retention premia.

5.23 In conducting its review, the Board was guided by the following criteria in its decisions:

- maintaining a reasonable size of questionnaire (the core questions should be no longer than the current 12 sides of A4);
- including only items with high reliability and validity, which have been cognitively tested;
- including only items that have relevance for improvement in service quality, safety and patient experience; and
- retaining items that are already fit for purpose in these terms because of the importance of being able to measure change year-on-year.

5.24 The application of the key criteria meant that there was little scope for new content without losing or replacing existing content. For these reasons the Board focussed only on those items which were deemed as being a high priority by OME: overall measures of motivation; and satisfaction with the total benefits package.

5.25 The Board recognised the benefits of a direct overall measure of staff motivation, but felt that this would be of limited use to NHS trusts. The Board was also mindful of the existing established measures which help in providing an assessment of staff motivation and morale - *ie* job satisfaction, intention to leave, and the new measure of staff engagement with their jobs. On this basis, the Board decided against the inclusion of an additional question on staff motivation in the 2010 Staff Survey.

5.26 As regards staff satisfaction with the total benefits package, the proposals dovetailed with proposals to the Board to support assessment of the NHS Constitution covering fairness of pay and conditions. In considering possible changes, the Board looked at the questions suggested by OME and a range of questions in use in other staff surveys (in Scotland and Wales, and across the whole Civil Service). In this, the Board took account of concerns from the Care Quality Commission (which currently manages the Staff Survey), and from the Survey Advice Centre at Aston University Business School. The latter bodies believed that the inclusion of new “opinion-style” questions in the current climate could potentially bias the way staff respond to subsequent questions in the Survey. In view of these concerns the Board decided to add its preferred question (the OME question) to the question bank, and to make it available for local use rather than including it among the national core questions.

5.27 The Board has also considered how the Staff Survey may support the assessment of the staff elements of the NHS Constitution, including the scope available for measuring staff attitudes on productivity and efficiency. Some possible questions were recommended to the Board by Aston Business School. The Board was concerned about the ability of these suggested questions to add value, given their subjective and general nature. For these reasons, the Board decided not to include productivity among the

issues covered in the 2010 Survey's core questions, but to make them available for local use. The Board will review the findings from any NHS organisations which choose to take up these questions, with a view to informing future developments.

Workforce Issues - Staff Earning £21,000 or Less

Definition

5.28 For the purposes of this evidence, "staff earning £21,000 or less" per FTE are identified as those with an Agenda for Change pay point which implies full-time basic earnings of £21,000 or less. This equates to pay point 15 or lower in the 2010/11 payscales.

5.29 High Cost Area Supplements and other additional earnings are excluded under this definition:

- earnings received to offset the cost of working in expensive areas should not reduce the likelihood of low earners receiving any income protection; and
- additional earnings beyond basic salary which reflect additional work should also not reduce the likelihood of low earners receiving any income protection. This has a parallel in the clarification that the treatment of those earning £21,000 or less applies on a per FTE basis: earning £21,000 or less through working part-time does not qualify an individual from preferential treatment.

5.30 This is consistent with the annex to the Chief Secretary to the Treasury's letter of 26 July 2010 to Pay Review Body Chairs, which concerned the treatment of employees earning £21,000 or less.

5.31 There are around 443,050 people (headcount) on or below pay point 15 of Agenda for Change - around 40% of the Agenda for Change workforce (357,878 or around 38% of the AfC workforce on an FTE basis). The paybill groups containing the most staff earning £21,000 or less are:

- unqualified nurses and healthcare assistants (of whom, approximately 98% of staff will fall into this category);
- administrative and clerical staff (approximately 63% of staff will fall into this category); and
- maintenance and works staff (approximately 46% of staff will fall into this category).

5.32 Further details of how these figures were calculated are at Annex K.

Staff Numbers and Vacancies – Staff Earning £21,000 or Less

5.33 There has been a steady increase in the size of the Agenda for Change workforce, as the headline findings from the 2009 Staff Census demonstrate:

Table 5.2: Headcount at 30 September

Staff Group	2008	2009	Increase	% Increase
HCHS non-medical workforce	1,120,548	1,176,831	56,283	5.0%
Infrastructure Support staff (excluding managers)	179,151	191,442	12,291	6.8%
Support to Clinical Staff (excluding bank staff)	334,826	352,583	17,757	5.3%

5.34 In addition to this increase, three-month vacancy levels are generally falling. Figures for staff categories likely to be earning £21,000 or less are as follows:

Table 5.3: Three-month vacancy rate

Staff Group	March 2009	March 2010	% change
Admin & estates staff	0.4%	0.2%	-0.2%
Unqualified nurses	0.4%	0.3%	-0.1%
Unqualified S, T & T staff	0.3%	0.4%	+0.1%
Healthcare assistants and support with LDP definitions	0.5%	0.3%	-0.2%

The NHS Staff Survey – Staff Earning £21,000 or less

5.35 The key score for job satisfaction in the NHS Staff Survey is regarded as one of the key indicators of staff motivation and morale. This score has remained consistently high, and has increased again this year among all staff - from 3.51 to 3.53 in the 2009 Survey (on a scale of 1-5, where 1 is low and 5 high). This is its highest level in the last five years. The majority of staff groups show broadly similar improvement. **Among staff earning £21,000 or less, scores for job satisfaction were as follows:**

- **the figure for unqualified nurses has risen from 3.48 in 2008 to 3.49 in 2009;**
- **that for administrative and clerical staff rose from 3.53 to 3.54; and**
- **that for maintenance staff from 3.51 to 3.55.**

5.36 The key score for staff who stated an intention to leave jobs has shown even greater improvement. Among all staff, this has decreased from 2.59 in 2008 to 2.54 in 2009 (again on a scale of 1-5), and is the lowest it has been in the last five years. **Among staff earning £21,000 or less, figures for intention to leave were as follows:**

- **the figure for unqualified nurses has fallen from 2.48 in 2008 to 2.42 in 2009;**
- **that for administrative and clerical staff from 2.57 to 2.52; and**
- **that for maintenance staff from 2.45 to 2.35.**

5.37 From 2009, the Survey includes a new key score on staff engagement with their jobs. This assessment is based on the extent to which staff demonstrate vigour, dedication and absorption in their work. The Survey showed high levels of staff engagement with their jobs across all staff groups in the NHS (3.86 on a scale of 1-5). **Among staff**

earning £21,000 or less, scores for staff engagement with their jobs were as follows:

- **unqualified nurses were above the NHS average at 3.93;**
- **as were maintenance staff at 3.89; while**
- **administrative and clerical staff were below average at 3.78.**

5.38 The Survey also provides insights into staff perceptions of workload. These cover staff working additional hours (paid and unpaid), levels of support in achieving work/home life balance, and staff views on time to carry out jobs. The tables in Annex L show the selected Survey scores. In summary:

- the percentage of staff in the earning £21,000 or less group working no additional paid hours is broadly in line with the average for the NHS as a whole at 71%, compared to the NHS average of 73%. Of these groups, administrative and clerical staff have the highest percentage of those working no extra hours with 82%, and unqualified nurses the lowest with 64%;
- the percentage of staff working no additional unpaid hours varies by staff group. However, the levels reported remain broadly comparable to those seen in the previous years. Greater numbers of unqualified nurses (74%), administrative and clerical (63%), and maintenance staff (68%) work no additional unpaid hours compared to the national average of 47%;
- the percentage of staff who do not disagree (i.e. they agree, or neither agree nor disagree) that their trust is committed to helping staff balance their work and home life are again comparable to the average for all NHS staff (81%) with administrative and clerical (88%) and maintenance (84%) higher and unqualified nurses (79%) lower than the average. Similar findings exist for support from immediate line managers, with all three groups at or above the average; and
- nationally, almost three quarters (72%) of all NHS staff do not disagree that they do not have the time to carry out all their work. The figure is lower among unqualified nurses and assistants (63%), administrative and clerical (65%), maintenance (63%) and ambulance staff (67%). These figures have reduced since 2008 for all staff groups listed.

5.39 The forthcoming 2010 Staff Survey will run between September and December 2010. Trusts will receive local level aggregated data by February 2011, and nationally aggregated data will be available in late March 2011.

<u>Workforce Education and Training – Staff Earning £21,000 or Less</u>

5.40 The Department's longstanding policy is to work closely with the professions and other key partners to ensure that the non-medical workforce is appropriately-trained and has access to realistic and achievable career pathways. The focus for the workforce at Agenda for Change pay Bands 1-4 is on improving training and development as a means of empowering and enabling talented and motivated staff to progress. This serves to improve service quality and innovation, to support skill mix developments, and to help provide staff with fulfilling and rewarding jobs.

5.41 In line with those aims, the Department in 2009/10 had a target to recruit an extra 5000 apprentices as part of a wider Government initiative. This was achieved and exceeded. The Coalition Government continues to support the Apprenticeship Programme and are investing further money in 2011. NHS Apprenticeships will be used as a career-

entry route and pathway for people who, while talented and motivated, may lack the qualifications needed for direct entry to degree course. The NHS Apprenticeship route could take them relatively rapidly to Band 3 or Band 4, and those with the necessary aptitude and motivation could proceed to a degree course (with the potential for a year or so off the length of their course under Accreditation of Prior Education and Learning).

5.42 At Bands 1-4, the Department has also worked in partnership with the relevant Sector Skills Council, Skills for Health, to prioritise several clinical support roles and develop clear frameworks for careers progressions supported by defined competencies and robust education and training pathways.

5.43 In addition, the NHS Knowledge and Skills Framework continues to provide support for the development of staff. It shows staff what they have been employed to do; reviews their use of knowledge and skills; and identifies skills gaps under an annual system of reviews and development plans. The Framework has recently been reviewed and a new simplified version is being launched.

Workforce Data Improvement – Staff Earning £21,000 or less

5.44 In its 24th Report (paragraph 2.29), the NHSPRB suggested that data should be further disaggregated with the aim of improving the level of detail available to the NHSPRB on former Pay Negotiating Council Groups. The NHSPRB suggested that each Home Nation should follow a common framework for classifying job roles, using the Northern Ireland model as a starting point - but with a greater specificity in the administrative and clerical category to include job roles such as Clinical Coders, and those in finance and Human Resources.

5.45 The Department produced a report in 2009 to that end. This set out plan to work more closely with OME in:

- commissioning surveys;
- establishing contacts and networks with the Devolved Administrations with a view to improving the sources and consistency of data; and.
- establishing contacts with the unions and/or professional bodies to consider the scope for pooling detailed data.

5.46 Having considered these suggested actions with the NHSPRB's officials and statistician, the Department decided that it would be more productive to achieve these aims through data quality improvements within the Electronic Staff Record (ESR). It is felt that the latter could provide a level of detail which is comparable to that of the Northern Ireland model. The ESR has the potential to provide a high level of detail on job role and area of work, as the following illustrates:

- Annex M provides a list of the ESR job role categories associated with each staff group currently used in the pay metrics; and
- Annex M illustrates 12 out of the 147 categories of "area of work" under which staff belonging to Admin and Estates and Support Worker occupations (as defined by occupation code) are categorised in the ESR. These results must be treated with caution, as we do not know the staff mix associated with each area of work, or how accurately these staff are recorded against area of work. The categories of area of

work included also illustrate the potential for overlap, such as in the Corporate and Finance areas.

5.47 However, in considering this data, it should be borne in mind that:

- the job role and area of work categorisations have only been universally available in ESR since 2008;
- the Department is currently unable to assess how accurately organisations use and maintain these fields in ESR; and
- there are several known issues of inconsistent data entry and overlapping descriptions.

5.48 In the longer term, the Department wishes to improve the use of the job role and area of work fields in ESR, and to use the ESR to provide pay metrics at a lower level of detail than is the present practice. The NHS Information Centre is currently piloting this approach, beginning with Healthcare Scientists.

Workforce Issues - Staff Earning Over £21,000

Staff Numbers and Vacancies - Staff Earning Over £21,000

5.49 The 2009 Staff Census showed that there has been a steady increase in the size of the workforce in these groups, as follows:

Table 5.4: Headcount at 30 September

Staff Group	2008	2009	Increase	%age increase
Qualified nurses	346,377	353,570	7,193	2.1
Allied Health Professionals	71,301	73,953	2,652	3.7
Physiotherapists	21,114	21,984	870	4.1
Qualified radiographers	15,636	16,278	642	4.1
- Diagnostic radiographers	13,423	13,940	517	3.9
- Therapeutic radiographers	2,213	2,338	125	5.6
Qualified pharmacists	14,432	15,369	937	6.5
Qualified healthcare scientists	31,028	32,378	1,350	4.4

5.50 The latest NHS Vacancy survey also shows a general fall in three-month vacancies, as follows:

Table 5.5: Three- month vacancy rates

Staff Group	March 2009	March 2010	% change
Qualified nurses (including midwives)	0.7%	0.6%	-0.1
Allied Health Professionals	0.7%	0.5%	-0.2
Diagnostic Radiographers	0.4%	0.4%	0.0
Therapeutic Radiographers	0.7%	0.8%	+0.1
Pharmacists	1.5%	0.9%	-0.6
Pre-registration pharmacy trainees	1.6%	0%	-1.6
Physiotherapists	0.5%	0.3%	-0.2
Healthcare scientists	0.6%	0.4%	-0.2

NHS Staff Survey Results – Staff Earning Over £21,000

5.51 As set out above, the key score of job satisfaction in the NHS Staff Survey is regarded as one of the key indicators of staff motivation and morale. It remains consistently high and increased again this year - from 3.51 to 3.53 in the 2009 Survey – and for the majority of staff is now the highest it has been in the last five years (the exceptions to this are ambulance staff, whose score has fallen to 3.08, down from 3.10 in 2008).

5.52 The key score for staff intention to leave jobs has also improved, from 2.59 in 2008 to 2.54 in 2009 – the lowest it has been in the last five years. The exceptions to the generally positive trend are management staff, among whom intention to leave increased from 2.57 in 2008 to 2.59 in 2009.

5.53 The new key score on staff engagement with their jobs shows high levels of staff engagement with their jobs across all staff groups in the NHS (3.86 out of 5). Ambulance staff are the least likely to report being engaged with their jobs, at 3.60 out of 5.

5.54 As the tables at Annex L show, the Survey additionally demonstrates that:

- the percentage of staff under the NHSPRB's remit who work additional paid hours is broadly comparable to those of the NHS as a whole. Ambulance staff are, as in previous years, the exception, with only 21% of staff working no additional paid hours, compared to the NHS average of 73%;
- although the percentage of staff working additional unpaid hours varies by staff group, the levels reported remain broadly comparable to previous years. Managers are the exception in this case, with only 14% of staff working no additional unpaid hours, compared to the national average of 47% for all staff groups;
- the percentages of staff who do not disagree that their trust is committed to helping its staff to balance their work and home lives are again comparable to the average for all NHS staff (81%). The exception is ambulance staff, of whom just under half disagree their trust is committed to helping them. Similar findings exist for support from immediate line managers, although ambulance staff reported a comparatively more positive score (64%) than that for help in achieving work life balance; and
- nationally, 72% of all NHS staff do not disagree that they do not have the time to carry out all their work. This rises to 79% for nurses, and to 78% for managers, but is lower among unqualified nurses and assistants (63%), administrative and clerical (65%), maintenance (63%) and ambulance staff (67%). These figures have reduced since 2008 for all staff groups listed, apart from qualified nurses.

<u>Workforce Education and Training – Staff Earning Over £21,000</u>

5.55 For the non-medical professions, the Department remains committed to shifting from vocational to professional education.

5.56 To that end, the Department is working closely with the Nursing and Midwifery Council (NMC) to ensure that entry to the nurse profession will be graduate only by 2013. After a lengthy consultation process with the profession, education providers, employers and the Royal Colleges, the NMC has published new educational standards for the educational programmes of the Higher Educational Institutes, and some of the new programmes which will result will be offered to students from September 2011.

5.57 The Department believes that graduate nurses will be better equipped to meet the challenges they face, whether these be in prescribing, in being parts of self-directed nursing teams, or in the provision of more effective, evidence-based care safely and confidently. A high importance is being placed on opportunities to widen participation in nursing programmes, including through more creative and transparent ways of recognising existing education and learning. The Department has therefore welcomed the NMC's plans to increase the amount of Prior Experiential Learning which may contribute towards the achievement of a programme, from 33% to 50%.

5.58 The Department is also supporting the Midwifery 2020 project, which was established by the Chief Nursing Officers for England, Wales, Northern Ireland and Scotland to set the direction for midwifery. Over the coming decade, Midwifery 2020 will identify the changes needed to ways of working, and midwives' roles, responsibilities and training and development requirements

5.59 In addition, each SHA is looking at the supply of local midwives, including attrition rates from training, and have developed appropriate recruitment, retention and return strategies. Local initiatives have also been designed in many areas to increase numbers

of midwives including leadership development in maternity services to support succession planning; return to practice courses; retention plans for midwives due to retire; maternity support; and midwifery mentors to provide support to ensure that newly-qualified and recently-returned midwives can integrate fully into the NHS.

5.60 More generally, the Department has commissioned the Universities and Colleges Admission Service (UCAS) to monitor application rates to non-medical courses. This will include an annual report on applicants and applications to health-related undergraduate programmes. This will replace the previous reports provided by the Nursing and Midwifery Admissions Service, through which applications for nursing and midwifery diploma-level courses were made. The new UCAS reports will cover a much wider area of health-related courses, and the Department will draw on them for workforce planning, and education commissioning and policy development purposes. The intention is to produce this report annually, in the spring after the annual university recruitment cycle has closed. The first report – which covers England only - covers the 2009 cycle: the majority of applicants in that cycle will have started their courses in September 2009, and the report also includes applicants deferring to start in 2010. It also contains some comparative data for 2008.

5.61 For applications and accepts to non-medical undergraduate programmes, the report shows that application rates are increasing heavily across the board. Headline numbers are as follows:

Table 5.6: Applications to undergraduate programmes

Programme	Applications 2009	Ratio of Acceptances
Nursing (degree)	42,679	6.1
Nursing (diploma)	52,471	4.1
Midwifery	20,646	10:1
Allied Health Professionals:		
Physiotherapists	12,200	8:1
Podiatrists/Chiropodists	803	2:6
Occupational Therapists	5,132	4:1
Diagnostic Radiographers	6,249	6:1
Therapeutic Radiographers	1,129	4:1
Speech and language Therapists	3,254	6:1

5.62 Of 95,150 applications[19] in England for a place on a nursing course in 2009, 42,679 (45%) were for degree places, and 52,471 (55%) for diplomas.

5.63 In the past, the NHSPRB has asked the Department to consider possible methods of assessing the quality of applicants. This was discussed with UCAS, and it was agreed that given the diversity of the relevant fields, any such analysis could not be produced to a required standard.

5.64 The Department recognises the importance of the availability of training and development opportunities for the morale of staff at all levels. The Multi Professional Education and Training (MPET) levy, which funds central investment in the development of the workforce, was increased by £135 million (2.9%) to £4,782 million in 2010/11. The DH's Service Level Agreement (SLA) with SHAs of MPET requires

[19] Source – UCAS Annual Report for Applicants and Applications to Health Related Undergraduate Programmes 2009, P48.

them to ensure that opportunities are available for staff at all levels to progress in line with national policy priorities set out in the Operating Framework, and to ensure that their investment decisions take into account the Quality, Innovation, Productivity and Prevention agenda. They are also required to put plans in place to develop their wider workforces to deliver the recommendations of the Leitch report (*Prosperity for All in the Global Economy – World Class Skills*) and the report of the Widening Participation in Learning Unit (*Learning for a Change in Healthcare*). The SLA also requires SHAs to provide investment and opportunities for staff to receive appropriate training to enable implementation of new ways of working to support new roles.

5.65 The number of students entering training to become a nurse or midwife in England each year has increased by over 370 (1.6%) since 2008/09 to 23,311 in 2009/10.

5.66 Pending the changes in 2013, there are two routes into nursing – via a degree course or a diploma course, as shown in the table above. Both lead to registration with the Nursing and Midwifery Council, enabling graduates to work as nurses in the UK. In recent years, there has been a switch from diploma to degree commissions. Actual commissions to nurse diploma courses have remained steady, with 16,779 actual commissions in 2000-01, decreasing slightly to 15,076 in 2009-10. Over the same period, degree commissions increased from 2,144 to 5,753 – an increase of 168%. See Annex N for further details.

5.67 The number of training commissions for allied health professionals increased by 94 (1.4%) in 2009/10 to 6,674, compared with 2008/09, while the number of training commissions for healthcare scientists and technicians increased by 312 (7.5%) to 4486 in the same period.

Midwives and Health Visitors

5.68 In the wider healthcare policy environment, there are some particular new challenges for the Agenda for Change midwifes and health visitor workforces. The White Paper, *Equity and Excellence: Liberating the NHS*, includes commitments to extending maternity choice, and to the facilitation of safe, informed choices throughout pregnancy and in childbirth. This will mean the development of new provider networks, with the aim of co-ordinating work towards offering expectant mothers and their families a broader choice of services, and facilitating movement between the different services they may want or need. These commitments supersede specific commitments made in the past to expand the numbers of midwives.

5.69 However, the Coalition Agreement includes a commitment to increase the number of Sure Start health visitors by 4,200. An extensive programme of work is now under way with a view to increased capacity as quickly as possible. This is being carried out in parallel with work towards the development of outcome measures which are in line with the Government's policy for improving and demonstrating improvements in health.

Junior Pharmacists

5.70 The NHSPRB remains interested in possible short-term national Recruitment and Retention *Premia* (RRP) for pharmacists paid at Agenda for Change pay Bands 6 and 7. Last year, the former Secretary of State recognised that there were difficulties in recruiting and retaining junior hospital pharmacists, but rejected the national RRP on the following grounds:

- recruitment and retention issues varied widely across England;
- the devolved administrations in Scotland, Wales and Northern Ireland made clear that a national RRP was not necessary; and
- that local recruitment and retention difficulties would be best addressed by increasing supply, and by using local recruitment and retention *premia* where needed, alongside other local initiatives to support the training and development of junior pharmacists.

5.71 That remains the Department's position, and the NHSPRB will note that the following short to medium-term actions have been taken to address high vacancy rates amongst junior hospital pharmacists:

- close monitoring of recruitment, retention, and training numbers;
- the issue and promulgation of new guidance about the use of local RRPs in November 2009 (a copy of this is at Annex F);
- highlighting the NHSPRB's views about use of remuneration to address retention problems amongst junior hospital pharmacists, by letter from the Department to NHS Chief Executives in September 2009 (Janet Monkman, Director of the NHS Professional and Provider Programme, also wrote to workforce directors encouraging increasing the training commissions, referring to NHSPRB's interest in the vacancy rates for junior pharmacists); and
- work with the SHAs to identify and spread best practice in the retention of pharmacy staff, with a particular focus on the retention of new registrants on completion of their training.

5.72 According to the latest data from the 2010 Pharmacy Establishment and Vacancy Survey and other sources (see Annex O), these measures have had demonstrable success:

- the levels of three-month vacancy rates amongst junior hospital pharmacists at Band 6 and 7 are lower this year than previously, as there is an increased supply of newly-registered pharmacists and improved retention of NHS-trained pharmacists on registration;
- there has been a significant rise in establishment numbers at Band 7 and 8, in both trusts and PCTs, rather than an increase in the numbers of dis-established or frozen posts;
- there remains considerable variation in vacancy rates at both Band 6 and 7 across the four Home Nations, between SHAs in England, and between individual trusts and PCTs;
- training numbers across all SHAs have increased substantially, and appear to be relatively stable for 2011/12. Training numbers have increased by 45% in England since their low point in 2007/08 - 693 placements were recruited to in 2010, compared to 477 in 2007/08**;**
- this indicates that the supply of newly registered pharmacists will be maintained at levels significantly above those seen in 2007; and
- however, there are some early indications that planning numbers for training commissions for 2011/12 and 2012/13 may be reducing slightly in the light of financial pressures, and that retention at registration may also be slightly reduced. The situation will continue to be monitored through 2010/11. Table 17 in Annex O refers.

5.73 The Department considers that these indicators show the positive effects of the short-term measures which have been put in place to improve the recruitment and retention position. The three-month vacancy rate is certainly much improved at Band 6 (and, to a lesser degree, at Band 7). The attrition rate during the pre-registration year (Band 5) remains low at around 2% and the retention rate on registration has improved among the 2008/09 cohort (see Table 18 in Annex O). Moreover, the Department considers that the continuing variation in vacancy rates at trust, SHA and national levels continues to argue against application of a national, compared to a local, RRP approach.

5.74 All that said, there is clear evidence that the demand for pharmacists has increased significantly over the last 5 years in both the NHS and community pharmacy, due to a range of factors including:

- changing demographics;
- developments in commissioning of both public health and medicines usage services; and
- in community pharmacy, increases in the numbers of new pharmacies with longer opening hours.

5.75 In addition to the short and medium-term supply and retention measures described above, a number of longer-term policy strategies are being implemented to allow for the more effective and efficient use of pharmacists' time and to increase training capacity in the NHS. These include:

- changes to medicines legislation and to allow more effective use of pharmacists' time;
- Departmental working through the CfWI to increase capacity and capability across the NHS and social care, designed to improved strategic planning and ensure that the development of the pharmacy workforce is more closely linked with wider planned service developments in the future. (This should reduce the risk of demand led by service development imperatives running ahead of supply, which appears to have been a contributory factor in the past to vacancy difficulties amongst junior pharmacists);
- recognition of the important contribution of the pharmacy workforce to the QIPP agenda;
- the use of established structures to ensure that pharmacy thrives within hospitals and other parts of the NHS, including the Modernising Pharmacy Careers Programme (MPC) Board, the SHA-led NHS Pharmacists Numbers Task and Finish Group, and the Department's Workforce Leadership Group; and
- wider Departmental work through the MPC Board, Medical Education England, and the CfWI to increase capacity and capability in the NHS by planning and using its workforce more effectively and efficiently; and
- work to explore ways in which NHS training capacity may be increased by allowing the NHS to train for its own needs (at trust and PCT levels), and by increasing individuals' abilities to work across different healthcare sectors at junior levels.

5.76 **In summary, the Department believes that the available evidence points to the continuation of the current approach, and away from a centrally-imposed national UK-wide recruitment and retention premium**.

ANNEX A

PAY METRICS (ENGLAND) FOR NHSPRB REMIT

Historical figures

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

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

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

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

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

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

Projected figures

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

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

Pay bill projections for 2009/10 and 2010/11 have been calculated for each staff group by applying the general pay uplift, workforce growth, estimated earnings drift and estimated on-costs drift to the 2008/09 baseline.

Earnings drift for each staff group has been estimated using a combination of analysis of historical earnings growth together with estimates of the cost of specific drivers. These drivers include recent and planned NHS pay reform. Other drift will arise from changes to national pay arrangements; changes in skill mix, changes in distribution over bands/incremental points; local pay decisions; and changes in additional earnings e.g. overtime, use of recruitment & retention premia and bonuses.

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

Pay Metrics for NHSPRB Remit

HCHS Paybill (£million)[1]

	2000/01	2001/02	2002/03	2003/04	2004/05[2,5]	2005/06[2]	2006/07[2]	2007/08[2]	2008/09[2,3]	2009/10[4]	2010/11[4]
Qualified Nursing	6,699m	7,427m	8,085m	8,677m	9,923m	10,548m	10,968m	11,421m	12,148m	13,058m	13,762m
Unqualified Nursing,HCA and Support[6]	2,250m	2,512m	2,740m	2,946m	3,406m	3,731m	3,757m	3,890m	4,062m	4,430m	4,608m
ST&Ts[7]	2,616m	2,919m	3,199m	3,538m	4,115m	4,452m	4,785m	4,956m	5,326m	5,902m	6,335m
Admin & Clerical	2,161m	2,444m	2,724m	3,000m	3,604m	4,007m	4,199m	4,376m	4,839m	5,479m	5,757m
Maintenance & works	235m	240m	239m	237m	266m	270m	269m	283m	294m	316m	318m
Ambulance Staff	395m	433m	478m	524m	747m	890m	779m	844m	925m	1,030m	1,098m
Managers	1,187m	1,331m	1,571m	1,777m	2,247m	2,414m	2,341m	2,285m	2,428m	2,846m	2,784m
Total remit[8]	15,588m	17,362m	19,164m	20,825m	24,425m	26,443m	27,232m	28,266m	30,173m	33,220m	34,826m

Growth in HCHS Paybill[1]

	2000/01	2001/02	2002/03	2003/04	2004/05[2,5]	2005/06[2]	2006/07[2]	2007/08[2]	2008/09[2,3]	2009/10[4]	2010/11[4]
Qualified Nursing	8.4%	10.9%	8.9%	7.3%	14.4%	6.3%	4.0%	4.1%	6.4%	7.5%	5.4%
Unqualified Nursing,HCA and Support[6]	4.1%	11.6%	9.1%	7.5%	15.6%	9.5%	0.7%	3.5%	4.4%	9.1%	4.0%
ST&Ts[7]	10.0%	11.6%	9.6%	10.6%	16.3%	8.2%	7.5%	3.6%	7.5%	10.8%	7.3%
Admin & Clerical	8.7%	13.1%	11.4%	10.2%	20.1%	11.2%	4.8%	4.2%	10.6%	13.2%	5.1%
Maintenance & works	2.0%	2.2%	-0.8%	-0.5%	12.0%	1.5%	-0.4%	5.3%	4.0%	7.6%	0.5%
Ambulance Staff	8.6%	9.6%	10.2%	9.6%	42.7%	19.0%	-12.4%	8.3%	9.6%	11.4%	6.6%
Managers	12.5%	12.2%	18.0%	13.2%	26.5%	7.4%	-3.0%	-2.4%	6.3%	17.2%	-2.2%
Total remit[8]	8.3%	11.4%	10.4%	8.7%	17.3%	8.3%	3.0%	3.8%	6.7%	10.1%	4.8%

HCHS Paybill per FTE (£)[1,9]

	2000/01	2001/02	2002/03	2003/04	2004/05[2,5]	2005/06[2]	2006/07[2]	2007/08[2]	2008/09[2,3]	2009/10[4]	2010/11[4]
Qualified Nursing	26,142	27,901	28,947	29,722	32,870	34,274	35,675	37,126	38,515	40,499	42,221
Unqualified Nursing,HCA and Support[6]	12,655	13,529	14,246	14,815	16,980	18,183	19,448	20,766	21,388	22,484	23,454
ST&Ts[7]	23,701	25,214	26,028	27,210	29,864	30,998	33,022	33,580	34,326	35,862	37,374
Admin & Clerical	15,192	16,258	17,132	17,473	19,659	20,919	22,583	23,862	24,913	26,030	27,134
Maintenance & works	19,586	20,449	20,164	20,682	23,545	24,687	25,619	27,870	29,126	30,424	31,707
Ambulance Staff	25,100	26,559	27,983	30,006	40,117	45,360	35,896	38,876	40,012	42,073	43,856
Managers	48,925	50,650	50,806	52,567	62,418	64,289	66,800	65,368	63,998	66,939	69,724
Total remit[8]	21,082	22,456	23,547	24,334	27,444	28,851	30,288	31,650	32,577	34,169	35,560

Growth in HCHS Paybill per FTE[1,9]

	2000/01	2001/02	2002/03	2003/04	2004/05[2,5]	2005/06[2]	2006/07[2]	2007/08[2]	2008/09[2,3]	2009/10[4]	2010/11[4]
Qualified Nursing	6.0%	6.7%	3.7%	2.7%	10.6%	4.3%	4.1%	4.1%	3.7%	5.2%	4.3%
Unqualified Nursing,HCA and Support[6]	2.4%	6.9%	5.3%	4.0%	14.6%	7.1%	7.0%	6.8%	3.0%	5.1%	4.3%
ST&Ts[7]	6.5%	6.4%	3.2%	4.5%	9.8%	3.8%	6.5%	1.7%	2.2%	4.5%	4.2%
Admin & Clerical	4.6%	7.0%	5.4%	2.0%	12.5%	6.4%	8.0%	5.7%	4.4%	4.5%	4.2%
Maintenance & works	4.7%	4.4%	-1.4%	2.6%	13.8%	4.9%	3.8%	8.8%	4.5%	4.5%	4.2%
Ambulance Staff	5.1%	5.8%	5.4%	7.2%	33.7%	13.1%	-20.9%	8.3%	2.9%	5.1%	4.2%
Managers	8.4%	3.5%	0.3%	3.5%	18.7%	3.0%	3.9%	-2.1%	-2.1%	4.6%	4.2%
Total remit[8]	5.8%	6.5%	4.9%	3.3%	12.8%	5.1%	5.0%	4.5%	2.9%	4.9%	4.1%

HCHS Earnings per FTE (£)[1,9]

	2000/01	2001/02	2002/03	2003/04	2004/05[2,5]	2005/06[2]	2006/07[2,10]	2007/08[2,10]	2008/09[2,3]	2009/10[4]	2010/11[4]
Qualified Nursing	23,427	24,733	25,702	26,342	27,697	28,784	29,863	31,150	32,335	34,002	35,425
Unqualified Nursing,HCA and Support[6]	11,609	12,256	12,899	13,394	14,563	15,528	16,532	17,670	18,211	19,149	19,951
ST&Ts[7]	21,268	22,378	23,138	24,136	25,189	26,062	27,666	28,204	28,854	30,148	31,397
Admin & Clerical	13,795	14,588	15,376	15,665	16,738	17,745	19,077	20,186	21,082	22,028	22,941
Maintenance & works	17,590	18,169	17,959	18,392	19,893	20,790	21,512	23,432	24,503	25,602	26,663
Ambulance Staff	22,442	23,492	24,792	26,511	33,606	37,750	29,976	32,524	33,499	35,225	36,699
Managers	43,021	44,135	44,344	45,760	51,581	52,954	54,848	53,858	52,985	55,361	57,593
Total remit[8]	18,968	19,980	20,968	21,628	23,173	24,275	25,400	26,597	27,406	28,743	29,891

Growth in HCHS Earnings per FTE[1,9]

	2000/01	2001/02	2002/03	2003/04	2004/05[2,5]	2005/06[2]	2006/07[2,10]	2007/08[2,10]	2008/09[2,3]	2009/10[4]	2010/11[4]
Qualified Nursing	4.9%	5.6%	3.9%	2.5%	5.1%	3.9%	3.8%	4.3%	3.8%	5.2%	4.2%
Unqualified Nursing,HCA and Support[6]	1.4%	5.6%	5.3%	3.8%	8.7%	6.6%	6.5%	6.9%	3.1%	5.2%	4.2%
ST&Ts[7]	5.4%	5.2%	3.4%	4.3%	4.4%	3.5%	6.2%	1.9%	2.3%	4.5%	4.1%
Admin & Clerical	3.5%	5.7%	5.4%	1.9%	6.8%	6.0%	7.5%	5.8%	4.4%	4.5%	4.1%
Maintenance & works	3.6%	3.3%	-1.2%	2.4%	8.2%	4.5%	3.5%	8.9%	4.6%	4.5%	4.1%
Ambulance Staff	4.1%	4.7%	5.5%	6.9%	26.8%	12.3%	-20.6%	8.5%	3.0%	5.2%	4.2%
Managers	7.4%	2.6%	0.5%	3.2%	12.7%	2.7%	3.6%	-1.8%	-1.6%	4.5%	4.0%
Total remit[8]	4.7%	5.3%	4.9%	3.1%	7.1%	4.8%	4.6%	4.7%	3.0%	4.9%	4.0%

HCHS workforce (FTE)[1]

	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11[4]
Qualified Nursing	256,276	266,171	279,287	291,925	301,877	307,744	307,447	307,628	315,410	322,425	325,951
Unqualified Nursing,HCA and Support[6]	177,796	185,687	192,370	198,868	200,615	205,207	193,208	187,349	189,936	197,035	196,472
ST&Ts[7]	110,384	115,767	122,903	130,043	137,789	143,606	144,899	147,583	155,174	164,563	169,499
Admin & Clerical	142,263	150,317	158,978	171,707	183,338	191,528	185,947	183,368	194,236	210,501	212,151
Maintenance & works	12,016	11,758	11,831	11,479	11,289	10,932	10,487	10,146	10,100	10,401	10,025
Ambulance Staff	15,755	16,320	17,076	17,455	18,627	19,610	21,703	21,706	23,109	24,475	25,025
Managers	24,253	26,285	30,914	33,810	36,007	37,549	35,041	34,955	37,937	42,509	39,931
Total remit[8]	739,399	773,141	813,854	855,799	889,973	916,548	899,091	893,087	926,210	972,220	979,364

Growth in HCHS workforce (FTE)[1]

	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11[4]
Qualified Nursing	1.4%	2.2%	3.9%	4.9%	4.5%	3.4%	1.9%	-0.1%	0.1%	2.2%	1.1%
Unqualified Nursing,HCA and Support[6]	1.3%	1.7%	4.4%	3.6%	3.4%	0.9%	2.3%	-5.8%	-3.0%	3.7%	-0.3%
ST&Ts[7]	3.4%	3.3%	4.9%	6.2%	5.8%	6.0%	4.2%	0.9%	1.9%	6.1%	3.0%
Admin & Clerical	3.0%	3.9%	5.7%	5.8%	8.0%	6.8%	4.5%	-2.9%	-1.4%	8.4%	0.8%
Maintenance & works	-3.0%	-2.6%	-2.1%	0.6%	-3.0%	-1.6%	-3.2%	-4.1%	-3.3%	3.0%	-3.6%
Ambulance Staff	2.1%	3.3%	3.6%	4.6%	2.2%	6.7%	5.3%	10.7%	0.0%	5.9%	2.2%
Managers	7.0%	3.7%	8.4%	17.6%	9.4%	6.5%	4.3%	-6.7%	-0.2%	12.1%	-6.1%
Total remit[8]	2.1%	2.4%	4.6%	5.3%	5.2%	4.0%	3.0%	-1.9%	-0.7%	5.0%	0.7%

NOTES:

1. Figures are for NHS staff in England only, and exclude Agency staff.
2. Includes estimates for the breakdown of the paybill by staff group for Foundation Trusts (all years from 2004/05 onwards).
3. Pay bill figures from 2008/09 NHS Financial Returns and Foundation Trusts Consolidated Accounts.
4. Shaded figures are projections and therefore subject to change.
5. In 2004/05, responsibility for NHS Pensions Indexation shifted from HMT to NHS employers.
6. Unqualified Nursing, HCA and Support includes Ancillary staff (e.g. cleaners and porters).
7. Scientific, Therapeutic and Technical staff (ST&T) includes Allied Health Professionals and Healthcare Scientists.
8. This total includes a small number of 'Other' staff which do not fall into any of the above staff groups (0.03% of NHSPRB workforce in 2008/09).
9. The workforce numbers are taken from published data which represents a snapshot as at 30th September for each specific year. It must be noted that the profile of workforce growth during each year may affect the average earnings and paybill per FTE. We are investigating how we can adjust for this in the future.
10. These figures have been adjusted slightly since the previous version of the metrics in line with on-costs differentials using the NHS Accounts.

ANNEX B

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

TO: Chairs of the Pay Review Bodies

26 July 2010

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

PUBLIC SECTOR PAY 2011-12

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

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

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

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

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

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

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

DANNY ALEXANDER

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

Definition of employees earning £21,000 or less

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

Size of increase

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

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

ANNEX C

AGENDA FOR CHANGE PAY SCALES 2010/11

Pay bands and pay points on the second pay spine in England from 1 April 2010

Point	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8				Band 9
								Range A	Range B	Range C	Range D	
1	13,653	13,653										
2	14.008	14,008										
3	14,364	14,364										
4		14,779										
5		15,194										
6		15,610	15,610									
7		16,145	16.145									
8		16,753	16,753									
9			17,118									
10			17,604									
11			18,152	18,152								
12			18,577	18,577								
13				19,250								
14				19,933								
15				20,554								
16				21,176	21,176							
17				21,798	21,798							
18					22,663							
19					23,563							
20					24,554							
21					25,472	25,472						
22					26,483	26,483						
23					27,534	27,534						
24						28,470						
25						29,464						
26						30,460	30,460					
27						31,454	31,454					
28						32,573	32,573					
29						34,189	34,189					
30							35,184					
31							36,303					
32							37,545					
33							38,851	38,851				
34							40,157	40,157				
35								41,772				
36								43,388				
37								45,254	45,254			
38								46,621	46,621			
39									48,983			
40									51,718			
41									54,454	54,454		
42									55,945	55,945		
43										58,431		
44										61,167		
45										65,270	65,270	
46										67,134	67,134	
47											69,932	
48											73,351	
49											77,079	77,079
50											80,810	80,810
51												84,688
52												88,753
53												93,014
54												97,478

Note: with effect from 1 April 2010 pay spine point 20 in pay band 5 has been removed. The incremental date of staff on the removed pay spine point (20) will change to 1 April. Staff on pay spine point 20 on 31 March 2010 will move to the new pay spine point 20 on 1 April 2010 and will have a new incremental date of 1 April 2011. Staff on pay spine point 21 and above on 31 March 2010 will have their pay spine point re-numbered but will retain their existing incremental date where applicable and will progress to the next pay spine point on their normal incremental date. Pay spine point 20 and all the following pay spine points have been renumbered and the total pay spine is reduced from 55 to 54 points.

ANNEX D

DISTRIBUTION OF AGENDA FOR CHANGE STAFF ACROSS PAY BANDS

Table 1: Proportion of FTEs by pay band by staff group (Sept 2009)

	Band: 1	2	3	4	5	6	7	8a	8b	8c	8d	9	Total
All AfC Staff Groups	**3.4%**	**16.1%**	**13.9%**	**9.5%**	**21.5%**	**17.1%**	**11.3%**	**3.8%**	**1.9%**	**1.0%**	**0.5%**	**0.1%**	**100.0%**
Qualified nursing	0.0%	0.1%	0.2%	0.2%	45.8%	31.0%	17.7%	3.5%	1.1%	0.3%	0.1%	0.0%	100.0%
Unqualified nursing, HCA and support	15.6%	46.9%	31.2%	5.4%	0.6%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
ST&Ts	0.2%	8.0%	8.6%	7.4%	16.3%	25.7%	20.0%	7.6%	3.4%	1.6%	1.0%	0.2%	100.0%
Admin & Clerical	0.8%	21.7%	23.3%	26.7%	11.6%	8.7%	4.9%	1.5%	0.6%	0.2%	0.1%	0.0%	100.0%
Maintenance & works	4.3%	16.1%	15.4%	39.6%	13.2%	5.4%	4.5%	0.9%	0.5%	0.0%	0.0%	0.0%	100.0%
Ambulance	0.0%	1.3%	20.1%	19.3%	42.0%	13.3%	3.2%	0.4%	0.3%	0.1%	0.0%	0.0%	100.0%
Managers	0.0%	0.0%	0.2%	0.7%	2.1%	9.4%	21.3%	23.5%	19.3%	13.5%	7.8%	2.2%	100.0%

Table 2: Number of FTEs by pay band by staff group (Sept 2009)

	Band: 1	2	3	4	5	6	7	8a	8b	8c	8d	9	Total
All AfC Staff Groups	**31,384**	**148,849**	**128,576**	**88,209**	**205,379**	**163,929**	**108,058**	**36,644**	**18,536**	**9,861**	**5,326**	**1,370**	**946,122**
Qualified nursing	3	207	542	679	140,461	95,142	54,362	10,753	3,393	1,057	249	38	306,887
Unqualified nursing, HCA and support	29,074	87,682	58,190	10,089	1,160	407	139	29	8	6	1	1	186,786
ST&Ts	265	13,193	14,178	12,204	26,753	42,280	32,918	12,480	5,593	2,699	1,620	381	164,563
Admin & Clerical	1,586	45,746	49,049	56,125	24,443	18,269	10,340	3,211	1,223	348	144	17	210,501
Maintenance & works	450	1,671	1,604	4,115	1,375	565	473	92	48	5	2	1	10,401
Ambulance	5	329	4,929	4,719	10,276	3,250	773	96	82	14	2	-	24,475
Managers	2	20	85	278	912	4,015	9,053	9,984	8,189	5,732	3,308	931	42,509

Note: Excludes paybill metric staff group 'others' as they are not identified in the ESR extract. This excludes 311 FTEs and 364 Headcount. Bank staff are also excluded.

Table 3: Proportion of headcount by pay band by staff group (Sept 2009)

	Band:												
	1	2	3	4	5	6	7	8a	8b	8c	8d	9	Total
All AfC Staff Groups	**4.3%**	**17.3%**	**14.0%**	**9.1%**	**20.6%**	**17.0%**	**10.9%**	**3.5%**	**1.7%**	**0.9%**	**0.5%**	**0.1%**	**100.0%**
Qualified nursing	0.0%	0.1%	0.2%	0.2%	45.8%	32.1%	17.1%	3.2%	1.0%	0.3%	0.1%	0.0%	100.0%
Unqualified nursing, HCA and support	18.8%	46.0%	29.2%	5.2%	0.6%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
ST&Ts	0.1%	8.7%	9.0%	7.3%	15.0%	25.6%	20.6%	7.6%	3.4%	1.6%	0.9%	0.2%	100.0%
Admin & Clerical	0.9%	25.1%	24.0%	25.4%	10.4%	7.8%	4.4%	1.3%	0.5%	0.1%	0.1%	0.0%	100.0%
Maintenance & works	6.7%	16.3%	15.0%	38.2%	12.7%	5.3%	4.4%	0.9%	0.4%	0.0%	0.0%	0.0%	100.0%
Ambulance	0.0%	1.4%	20.9%	19.3%	41.6%	13.0%	3.1%	0.4%	0.3%	0.1%	0.0%	0.0%	100.0%
Managers	0.0%	0.1%	0.2%	0.7%	2.2%	9.5%	21.6%	23.6%	19.1%	13.3%	7.6%	2.2%	100.0%

Table 4: Headcount number by pay band by staff group (Sept 2009)

	Band:												
	1	2	3	4	5	6	7	8a	8b	8c	8d	9	Total
All AfC Staff Groups	**46,945**	**188,322**	**152,710**	**99,699**	**231,174**	**190,952**	**122,182**	**40,198**	**19,959**	**10,573**	**5,623**	**1,438**	**1,109,774**
Qualified nursing	3	249	629	781	161,836	113,416	60,455	11,314	3,505	1,086	253	41	353,570
Unqualified nursing, HCA and support	43,691	106,595	67,638	11,974	1,307	460	159	31	9	7	1	1	231,874
ST&Ts	283	16,739	17,309	14,163	28,955	49,479	39,763	14,792	6,507	3,172	1,807	412	193,381
Admin & Clerical	2,226	62,550	60,022	63,319	26,021	19,443	10,895	3,345	1,262	368	155	18	249,623
Maintenance & works	732	1,794	1,646	4,200	1,392	583	483	95	48	5	2	1	10,981
Ambulance	6	367	5,363	4,951	10,682	3,328	791	98	82	15	2	-	25,684
Managers	3	28	104	312	980	4,243	9,636	10,522	8,546	5,920	3,402	965	44,661

Note: Excludes paybill metric staff group 'others' as they are not identified in the ESR extract. This excludes 311 FTEs and 364 Headcount. Bank staff are also excluded.

ANNEX E

USE OF GENERAL AND LONG TERM RRP BY STAFF GROUP AND AFC BAND

Table 1: % FTEs receiving a General RRP by staff group

Staff Group	June 2009	June 2010
Add Prof Scientific and Technic	0.36%	0.29%
Additional Clinical Services	0.15%	0.11%
Administrative and Clerical	0.14%	0.16%
Allied Health Professionals	0.48%	0.43%
Estates and Ancillary	0.21%	0.21%
Healthcare Scientists	0.47%	0.60%
Nursing and Midwifery Registered	0.39%	0.38%
Students	0.06%	0.12%
No Staff Group specified	0.00%	0.00%
Total	**0.27%**	**0.26%**

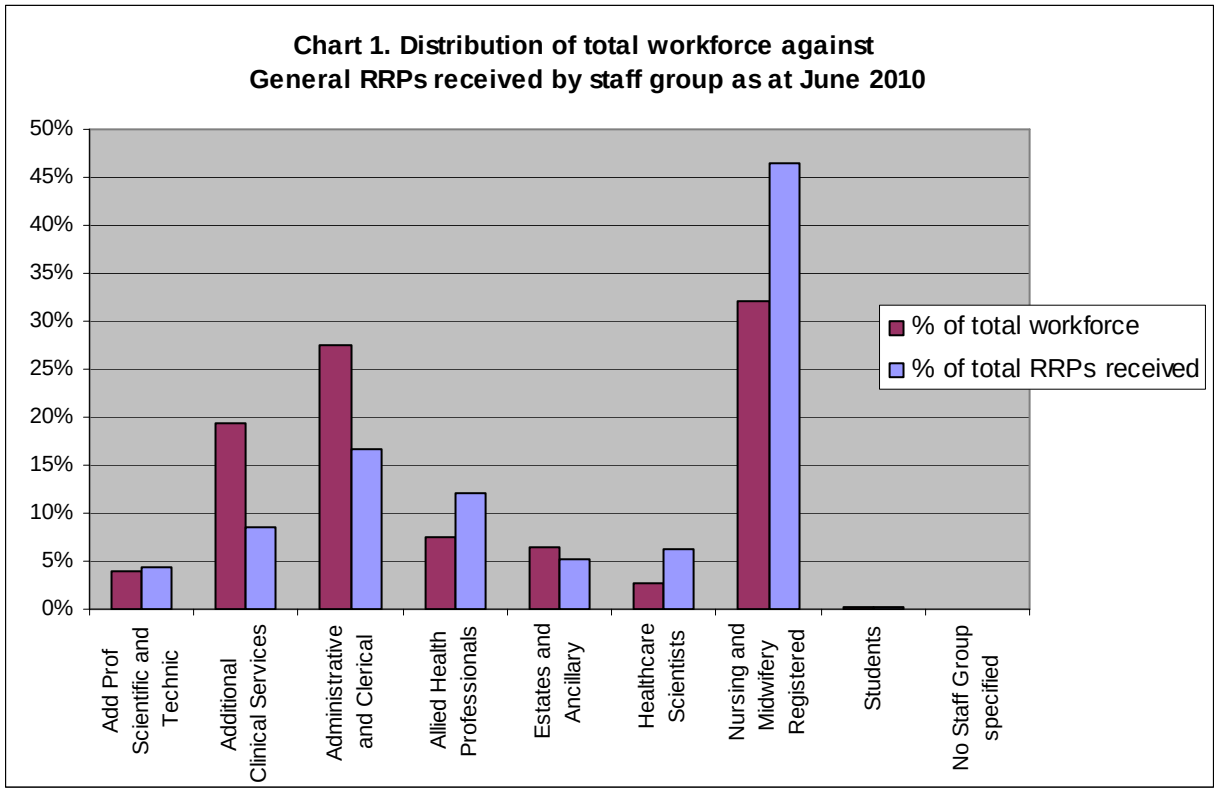


Table 2: % FTEs receiving a General RRP by AfC Band

AfC Band	June 2009	June 2010
Band 1	0.00%	0.00%
Band 2	0.05%	0.04%
Band 3	0.20%	0.18%
Band 4	0.17%	0.17%
Band 5	0.32%	0.31%
Band 6	0.42%	0.43%
Band 7	0.37%	0.35%
Band 8a	0.40%	0.37%
Band 8b	0.25%	0.22%
Band 8c	0.32%	0.30%
Band 8d	0.36%	0.29%
Band 9	0.47%	0.97%
No Band specified	0.63%	0.73%
Total	**0.27%**	**0.26%**

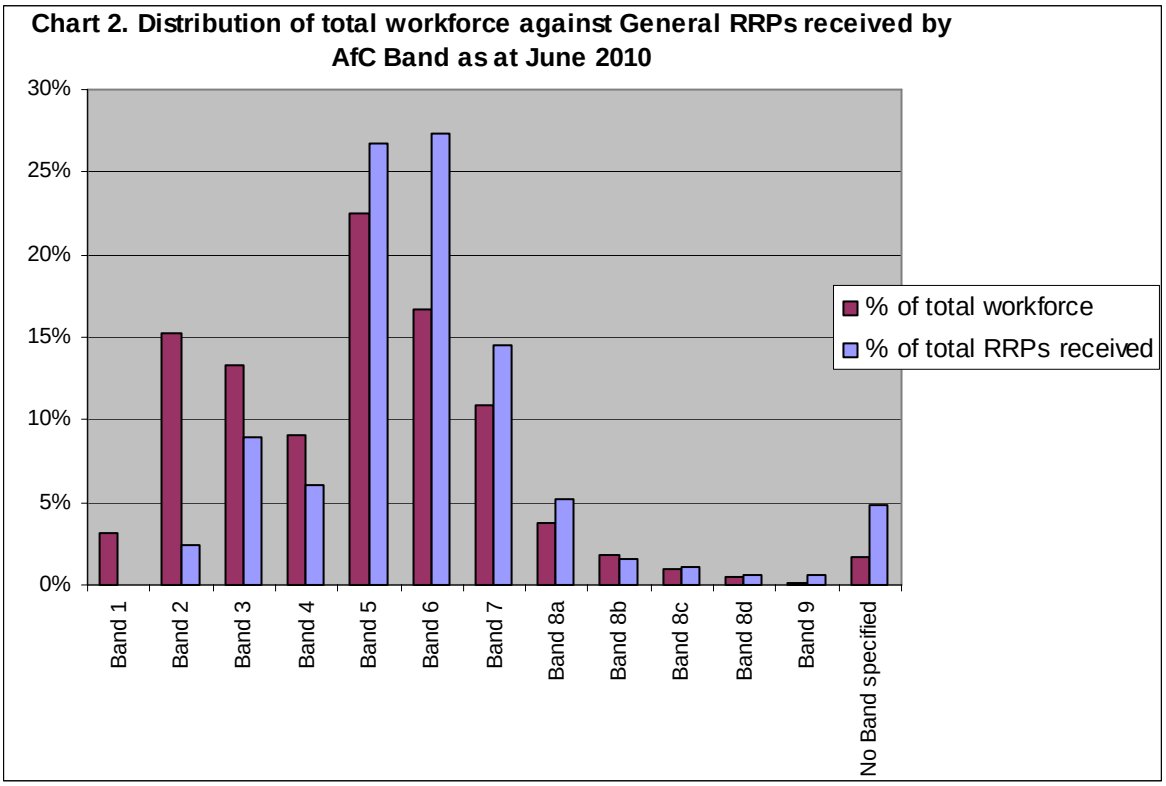


Table 3: % FTEs receiving a Long Term RRP by staff group

Staff Group	June 2009	June 2010
Add Prof Scientific and Technic	3.9%	3.9%
Additional Clinical Services	1.8%	1.8%
Administrative and Clerical	0.9%	0.9%
Allied Health Professionals	8.5%	7.9%
Estates and Ancillary	7.3%	7.2%
Healthcare Scientists	0.8%	0.7%
Nursing and Midwifery Registered	11.9%	11.2%
Students	1.8%	1.7%
No Staff Group specified	3.6%	3.9%
Total	**5.8%**	**5.4%**

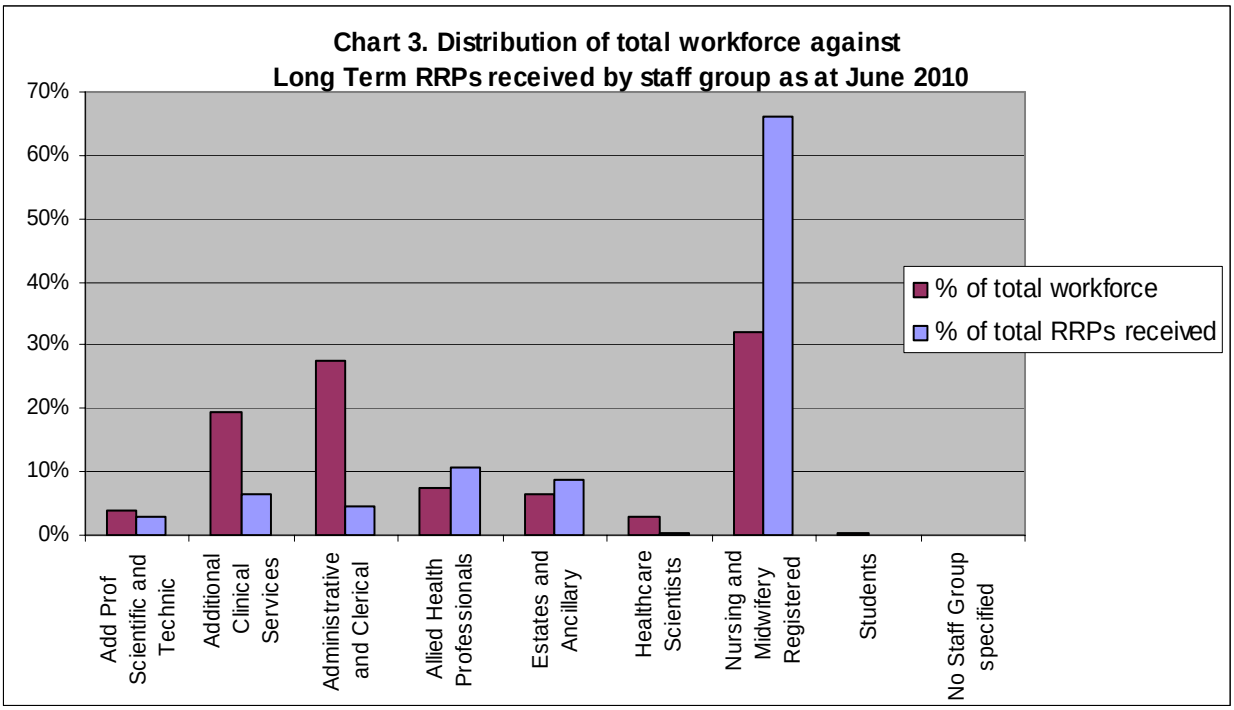
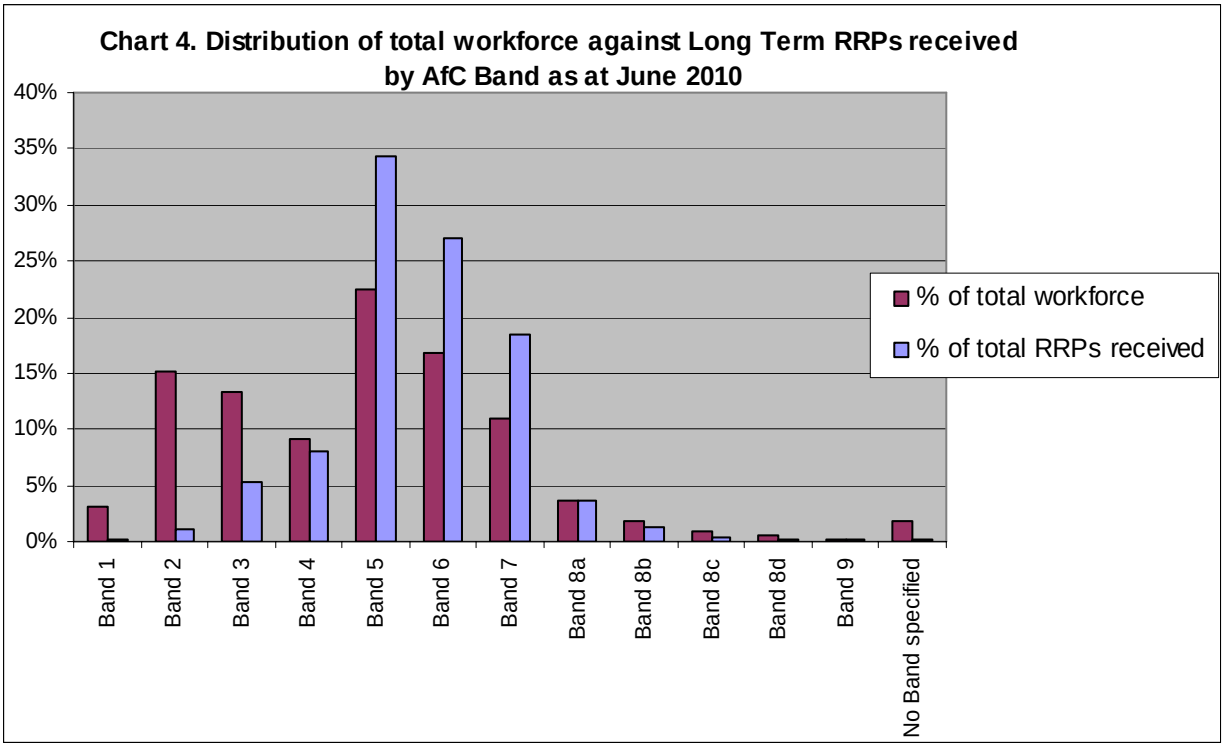


Table 4: % FTEs receiving a Long Term RRP by AfC Band

AfC Band	June 2009	June 2010
Band 1	0.2%	0.2%
Band 2	0.4%	0.4%
Band 3	2.2%	2.1%
Band 4	5.2%	4.9%
Band 5	9.0%	8.3%
Band 6	9.4%	8.8%
Band 7	9.7%	9.2%
Band 8a	5.6%	5.3%
Band 8b	3.6%	3.6%
Band 8c	2.5%	2.5%
Band 8d	1.8%	2.0%
Band 9	3.4%	3.5%
No Band specified	0.3%	0.4%
Total	**5.8%**	**5.4%**



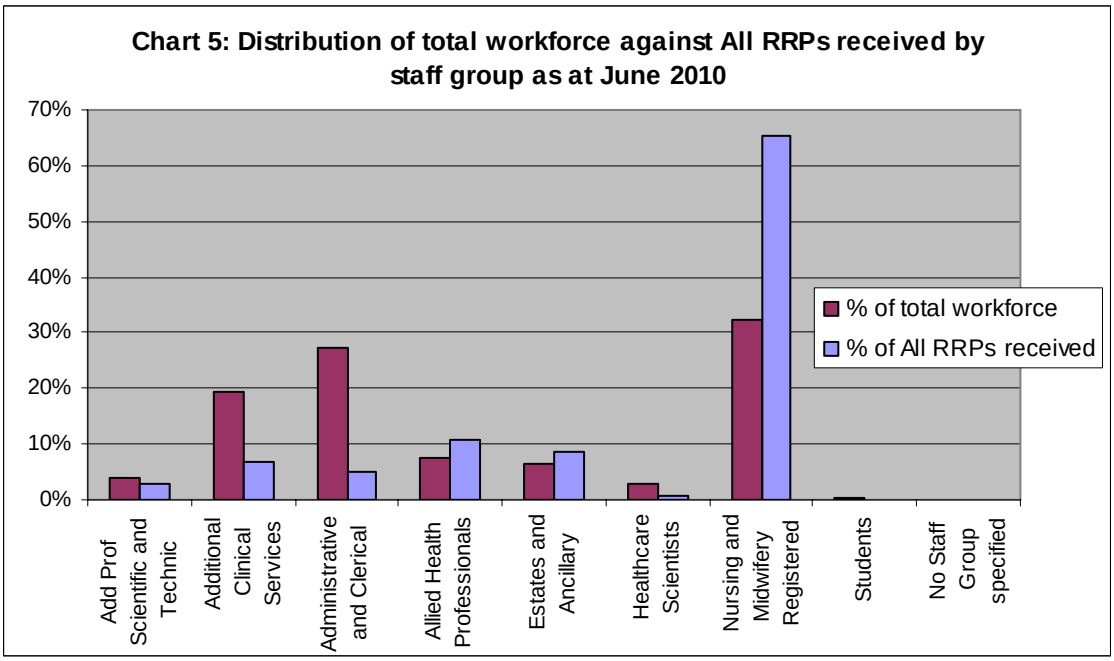


Chart 5: Distribution of total workforce against All RRPs received by staff group as at June 2010
70%
60%
50%
40%
30%
20%
10%
0%
% of total workforce
% of All RRPs received
Add Prof Scientific and Technic
Additional Clinical Services
Administrative and Clerical
Allied Health Professionals
Estates and Ancillary
Healthcare Scientists
Nursing and Midwifery Registered
Students
No Staff Group specified

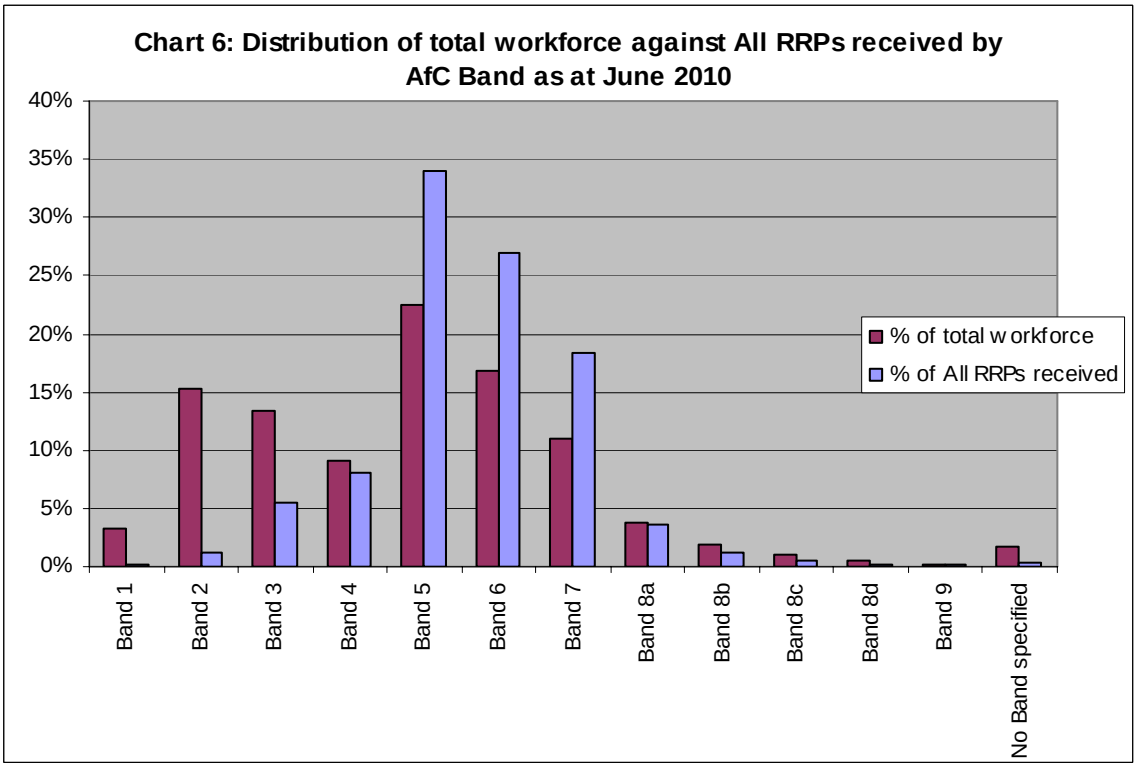


Chart 6: Distribution of total workforce against All RRPs received by AfC Band as at June 2010
40%
35%
30%
25%
20%
15%
10%
5%
0%
% of total workforce
% of All RRPs received
Band 1
Band 2
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8a
Band 8b
Band 8c
Band 8d
Band 9
No Band specified

Use of General and Long Term RRPs by region

Table 1: % staff FTEs receiving a General RRP by SHA region

SHA	June 2009	June 2010	Standard deviation of the Trust %s within each SHA (June 2010)	% of Trusts within each SHA that have %s outside the normal range (i.e. more than 3 standard deviations above the SHA average) (June 2010)
North East	0.06%	0.06%	0.1%	4.0%
North West	0.02%	0.04%	0.1%	4.7%
Yorkshire and the Humber	0.06%	0.08%	0.1%	0.0%
East Midlands	1.13%	1.11%	3.5%	4.3%
West Midlands	0.07%	0.06%	0.2%	4.4%
East of England	0.17%	0.19%	0.5%	2.4%
London	0.11%	0.16%	0.4%	2.7%
South East Coast	0.21%	0.20%	0.4%	7.1%
South Central	1.20%	1.03%	3.7%	4.0%
South West	0.26%	0.24%	1.3%	4.9%
Special Health Authorities	0.81%	0.60%	3.3%	8.3%
Total	**0.27%**	**0.26%**		

Table 2: % staff FTEs receiving a Long Term RRP by SHA region

SHA	June 2009	June 2010	Standard deviation of the Trust %s within each SHA (June 2010)	% of Trusts within each SHA that have %s outside the normal range (i.e. more than 3 standard deviations above the SHA average) (June 2010)
North East	1.2%	1.2%	1.5%	4.0%
North West	1.1%	1.0%	1.6%	4.7%
Yorkshire and the Humber	0.7%	0.7%	0.6%	0.0%
East Midlands	4.1%	3.8%	9.2%	0.0%
West Midlands	1.4%	1.4%	2.4%	2.2%
East of England	12.0%	10.7%	11.1%	0.0%
London	2.7%	2.6%	4.5%	4.1%
South East Coast	18.9%	18.0%	14.5%	0.0%
South Central	15.7%	14.7%	13.3%	0.0%
South West	11.2%	11.2%	16.1%	0.0%
Special Health Authorities	5.5%	5.4%	4.4%	0.0%
Total	**5.8%**	**5.4%**		

Supplementary note investigating the proportion of eligible Agenda for Change staff receiving a Long Term Recruitment & Retention Premium

1. It was found that 5.4% of all Agenda for Change staff were recorded on ESR as receiving a Long Term RRP in June 2010.

2. Table 20 of the Agenda for Change Terms & Conditions of Service Handbook lists 15 different types of post that are eligible for this type of payment based on prima facie evidence from work on the job evaluation scheme and consultation with management and staff representatives.

3. The following work investigates whether that 5.4% aligns with the proportion of staff receiving the National RRP who are eligible for it; and sets out to understand how this is distributed across the different types of post.

4. It was decided that the best method of identifying the different types of post in ESR was by occupation code, given this is how staff are classified by the Information Centre in the Census publication. The NHS Occupation Code Manual v.8.1 created by the IC was used to reconcile each of the 12 different types of post with the most appropriate occupation codes.

Conclusions and Issues

5. 3.9% of all staff eligible for a RRP received this payment in June 2010. This is likely to be an underestimate of the actual proportion receiving an RRP due to:
    - Difficulties in isolating those specific posts eligible for an RRP from similar occupations. The occupation codes can cover more than one group of staff (a list of the posts included within each occupation code are indicated in the 'Results' section);
    - Problems obtaining the correct qualification of staff. E.g. there is currently no differential occupation code for some qualified staff, new entrants and team leaders; we would have to do further exploratory work to deduce the level of staff i.e. by AfC band;
    - Data issues. The method of identification of staff in ESR (be it occupation code, staff group, job role or area of work) leads to variations in the numbers in each post dependent on the methodology.

6. The overall percentage of eligible staff receiving a National RRP varied across each of the types of post. The table below details the proportion of RRPs received. The types of post receiving significantly higher proportions of RRP were Qualified Maintenance Crafts persons and Technicians, Estates/Works Officers and Chaplains. Biomedical scientists had a significantly lower proportion at 0.4%. These results will be subject to the isolation problems described above,

7. The overall proportion of RRPs received by the 'eligible' subset appears low when compared to the proportion of all non-medical staff receiving a Long Term RRP.

However, nurses were not included in this analysis, and they (along with midwives) accounted for approximately 32% of the total workforce in June 2010 with 11.2% of staff receiving a RRP. This, coupled with the difficulty in excluding inappropriate posts from the analysis, is likely to account for the differences.

Results

8. The table below shows the percentage of staff receiving a Long Term RRP against each type of post for June 2010. The proportion of staff receiving a General RRP has also been included to indicate whether this has been used as a payment instead of a Long Term RRP; however this does not appear to be the case.

Eligible types of post	Occupation codes used in ESR	% of staff receiving a Long Term RRP	% of staff receiving a General RRP
Chaplains[1]	S1X, S9X	16.6%	0.7%
Clinical Coding Officers[1]	G2A, G2B	0.9%	0.1%
Cyto-screeners	T5B, T5U	6.1%	1.4%
Dental Nurses, Technicans, Therapists and Hygienists	S1R, S4R, S7R, S8R, S9R	1.0%	0.1%
Estates/Work Officers[1]	G0B, G1B, G2B, G3B	23.2%	0.5%
Financial Accountants, Invoice Clerks and Payroll Team Leaders[1]	G0A, G1A, G2A	0.9%	0.2%
Biomedical Scientists	T2A-T2F, T2U, T3A-T3F, T3U	0.4%	0.5%
Pharmacists	SAP, S0P, S2P, S4P, S5P, S8P, S9P	1.9%	0.5%
Qualified Maintenance Craftspersons & Technicians[1]	G3B	41.9%	0.9%
Qualified Medical Technical Officers	T4A-T4H, T4J-T4N, T4P-T4U	1.6%	0.6%
Qualified Midwives (new entrants)[3]	N2C	11.0%	0.3%
Qualified Perfusionists	T6H, T6U	11.9%	0.5%
Total (of all eligible job roles)		**3.9%**	**0.3%**

Notes:
1.The occupation codes used as identifiers for these types of post cover a broad range of occupations i.e. Accountants, Invoice Clerks and Payroll Team Leaders have been mapped to Admin and Estates Central Functions but they will only be a subset of this group. The results for these types of post may be distorted as a result of this.
2.As a consequence of point 1, there is overlap between the occupation codes used i.e. G2A which relates to Admin & Clerical staff (Central Functions) is used as an identifier for Clinical Coding Officers and Finance staff.
3.This group will include Midwives who are not new entrants.

*Note that the results in the above table are not directly comparable to those in Annex D as different methodologies of identifying staff type have been used in ESR.

ANNEX F

LOCAL RECRUITMENT AND RETENTION PREMIA: TOP TEN TIPS FOR NHS ORGANISATIONS

The Agenda for Change pay system provides employers with local flexibility to pay recruitment or retention supplements in response to local labour market pressures.

" A recruitment and retention premium is an addition to the pay of an individual post or group of posts where local market pressures would otherwise prevent the employer from being able to recruit or retain staff in sufficient numbers for the posts concerned at the normal salary for the job of that weight. (*Paragraph 5.1 of the Conditions of Service Handbook)*

Guidance on applying for and paying local Recruitment and Retention Premia (RRP) has already been approved for organisations in Scotland 1, Wales 2 and Northern Ireland3. In England the London NHS Partnership has developed Pan-London guidance with the aim of ensuring a consistent and collaborative approach to the payment and review of local RRP's.

These are the top ten issues which employers in collaboration with local staff side should be considering.

1. Consider the types of posts that you have difficulty recruiting to.

Local premia may help to address difficulties in recruiting to posts which are particularly influenced by local labour market pressures. These tend to be jobs for which there is also considerable demand outside of the NHS and the wider health sector. Examples of these could be jobs in IT, finance, HR, administration, estates and pharmacy.

Local premia may enable the NHS to better compete with employers outside of the NHS for staff when individuals get better levels of pay outside of the NHS in their locality.

The use of local premia will not necessarily be effective where there is a shortage in supply of a particular profession of skill.

Ensure that there is information available on the current and future supply of a particular profession prior to making a decision to award a local premia. It will be important to ascertain whether such premia should be awarded on a **short term basis** where the requirement for RRP is expected to reduce in the forseeable future or on a **long-term basis** where the need for such a payment is not expected to reduce significantly in the foreseeable future.

2. Know your local labour market

Local employers are best able to assess the local labour markets in which they operate, e.g. whether there are local skills shortages, the extent of external competition, what other

employers are paying for comparative jobs, whether new employers have been established in the locality as well as housing and travel costs which can impact on recruitment.

Information should be collected about pay and conditions offered by other employers in the area. This may include monitoring Information from local press recruitment advertisements or from the job centre. Which other local employers are also advertising similar posts?

Speak to other NHS organisations and access the labour market intelligence that is available from a number of sources including Strategic Health Authorities.

Funding is available in local PCT budgets to reflect local labour market forces and could be used to support funding of local RRPs. The staff index of the "Market Forces Factor" (MFF), an index of the relative differences in unavoidable costs faced by NHS organisations, is based on variation in wages in the private sector. The MFF takes into account the direct costs of employing staff as well as additional expenditure associated with higher than average turnover and vacancies in areas where NHS pay rates are below the going rate for the area as a whole. The staff index is the largest part of the MFF, making up 67% of it. Full details about the MFF can be found in PbR and the Market Forces Factor on the Department of Health website.

3. Advertise all new vacancies with NHS Jobs

NHS Jobs attracts more visits than any other recruitment web site. Vacancies can be advertised in real time thus eliminating any unnecessary delay.

NHS Jobs also has a facility which enables newly qualified healthcare professionals to post their profiles. This enables recruiting organisations to be aware of the pool of newly qualified professionals that are seeking work within the NHS.

4. Consider why recruitment is difficult.

Issues to consider may include:-

- The number and quality of the applications that were received.
- Checking relevant national vacancy data to ascertain whether this is a local or national problem
- The extent to which the level of pay is the problem and, if applicable, what other sectors are paying for an equivalent post
- Are there any non-pay improvements which could be made to the employment package (e.g. training opportunities, childcare, non-cash benefits, support with relocation),

- Are there any planned increases in the supply of staff within the profession that will negate the need for a longer term solution.

5 Consider retention difficulties

Where retention of staff is proving difficult consideration may be given to whether a pay premium would improve the situation.

- Is there any evidence of the reason why staff are leaving e.g. from exit interviews, staff surveys or other feedback sources
- Is there evidence to indicate that pay is a major factor or can retention problems be addressed by other means e.g. ensuring non-pay benefits such as childcare support, training and development, improved job design and flexible working have been developed within your organisation.
- Is this a national or local problem? Are turnover/wastage rates consistent with local, regional or national trends?

6. Work in partnership with local trade unions representatives

It is important to discuss with local staff side representatives about how to address local recruitment or retention problems. If it is agreed that the local problem can be addressed most effectively through a pay supplement, the employer should consult in partnership with local staff side representatives about the appropriate level to set the pay supplement. A decision should also be made on whether short term or long term supplements are likely to be needed and what the agreed process will be for reviewing these.

7. Consult with Local NHS Organisations and the Strategic HA

Where it has been decided that a local RRP be introduced, it is necessary to talk to local NHS employers perhaps via local HRD networks, the Strategic Health Authority, trades unions and other stakeholders, before implementing and reviewing any premium. The aim should be to avoid wasteful competition between neighbouring NHS organisations and to take a collaboration and consultative approach to the payment of local RRP's.

8. Remember Equal Pay considerations

To be consistent with equal pay for equal value, it is essential that any decision to award a local RRP needs to be objectively justified. This means that local employers need evidence to support the case that paying a premium at the agreed level is necessary to address local recruitment or retention problems.

It is essential that organisations ensure that a consistent policy for the payment and review of RRPs is agreed and adhered to across the organisation and that all related policy has been subjected to the appropriate equality impact assessment. It is imperative that all records of such payments and the evidence to formally approve them are held centrally.

9. Review Annually

Once RRPs are awarded irrespective of whether they have been deemed short term or long term, they should be reviewed annually to ensure that the RRP continues to be needed. This should be done in partnership with the relevant service/department heads and trade union representatives.

To support this review organisations should put in place a formal monitoring process to ascertain:

- whether the additional payments have allowed the NHS organisation to reduce its vacancy rates and turnover;
- the likely impact on vacancies of removing or reducing a recruitment and retention premium;
- Any changes in local labour market circumstances such as supply and demand
- The impact of any service redesign or skill mix reviews

10. Change or adjust when recruitment or retention premia is no longer applicable

Should local labour market conditions change or where an individual moves to a different post that does not attract an RRP, their entitlement to the additional payment should end. Short-term premia should be reduced or withdrawn as soon as possible consistent with the protection period in Section 5 of the Handbook. Long-term premia should be adjusted or withdrawn for anyone offered a qualifying post after the decision to withdraw or reduce the premium has been made.

ANNEX G

EXECUTIVE SUMMARY OF THE REVIEW OF THE KSF

Recommendations

Our recommendations are classified into three categories. These are to:

- Clarify the strategy, policy direction and principles of the KSF and related appraisal and development processes.
- Simplify the design and streamline the KSF components, paperwork and process, while also supporting greater flexibility and adaptation to suit local circumstances.
- Increase and improve support to deliver the principles of KSF into operating practice at the local level.

The specific changes recommended under each heading are described in the Figure below.

I. Strategy: Clarify the policy direction and principles of the KSF and related appraisal and development processes.
1. Either define and promote a new integrated appraisal and development model approach, that can be tailored and adapted locally; or clearly specify how the KSF and PDR/P ideally should link in with other aspects of performance management.
2. Ensure in either case a new 'front end' of trust and personal objectives on the KSF process.
3. Update the KSF principles and specify that all AfC staff should have a two-way appraisal discussion and PDR/PDP at least once per annum, and KSF or an equivalent competency framework needs to be an integral component. Clarify the common aspects of the national framework and those which can/should be tailored/adapted locally.
4. Either remove the direct link between KSF and pay, or make it only operate at the second gateway point. Produce more specific guidance on when and how increments can be withheld.
5. Conduct work nationally to facilitate links at the local level between use of KSF and other CPD, revalidation and training frameworks and initiatives.
6. Strengthen accountability. Senior national NHS figure to write to all trust chief executives to reinforce need for all managers and staff to have appraisal and PDR/P using KSF or similar quality framework, and establish this as a KPI for trusts. Work to improve monitoring arrangements eg through specific question in National Staff Survey
II Design: simplify and streamline the KSF components, paperwork and process, while also supporting greater flexibility and adaptation to suit local circumstances.
1. Make explicit that the specific dimensions are optional and decide if the core dimensions are to be compulsory or voluntary. If voluntary, decide whether and how some type of quality approval process for alternative competency frameworks might

operate. Focus on the core dimensions moving forward.

2. Review and refresh the core dimensions. In particular consider the need to incorporate more behavioural language/criteria and possibly re-brand them as competencies; whether a leadership/management dimension should be included; and whether the equality and diversity dimension differentiates adequately.

3. Consider moving from levels and detailed examples of each dimension to a simpler indicators/contra indicators format. Move away from detailed examples of application in post outlines and in PDRs, relaxing the requirement for each example to be evidenced in favour of a broader, all round assessment of competence/contribution.

4. Design a compressed/shorter, summary post outline format. Develop model national band outlines and suggested post outlines for the most numerous jobs. Longer-term, consider the integration of job profiles for evaluation purposes and the KSF post outlines.

5. Form a small national working party to update/improve/streamline the KSF/PDR/P paperwork as a whole.

6. Make explicit that flexibility from year to year and between different types of job is desirable within the national KSF framework, rather than not permitted. In particular emphasise the need for quality two-way conversations.

7. Develop a team- based adaptation of the KSF and PDR/P process.

III Operation: Increase and improve support to deliver the principles of KSF into operating practice at the local level.

1. Produce national training packages for KSF/appraisal for managers and staff that can be used/adapted locally.

2. Produce a series of communication and operating guides to the KSF process which can be used/adapted locally, targeted specifically at:

- boards and chief executives (why it is important, how to achieve high coverage)

- reviewing managers (route map through the process, do’s and don’ts, tips)

- staff (how to use it to best personal advantage).

3. Continue with improvements to the functionality and flexibility of the e-KSF. Target marketing of it to trusts that are already improving coverage of appraisal/KSF. Consider the development of a range of alternative and simpler administration options eg using existing HRIS, spreadsheet packages etc.

4. Develop and promote national operating best practice guidelines eg no more than 10 staff reviewed by any one manager, reviewing managers have to be trained, etc.

5. Establish a re-launch communications campaign with national material development but emphasis on regional and local delivery. Follow up with regular progress reports and guidance in newsletters, etc. Develop and provide model communications packs for managers and staff to use on appraisal/KSF.

6. Refresh the structure and resourcing of KSF support and decision making. Create

smaller, more focused implementation teams with clear targets for increasing coverage and quality of the KSF/appraisal process. Attempt to increase resources at the local level and encourage and promote web-based, self-help networks. Promote regional 'buddying' of high and low coverage trusts and creation of regional 'hit squads'.

The Executive Summary

- Institute for Employment Studies has undertaken an independent review of the NHS Knowledge and Skills Framework, the personal development and progression strand of the Agenda for Change pay reforms. The study was undertaken on behalf of the Executive of the NHS Staff Council in the second half of 2009.
- The aims have been to identify barriers to the implementation of the KSF and to make recommendations to support more widespread and effective use.
- The work has been guided by a Project Management Group and has involved stakeholder interviews, an extensive literature review, a series of case study visits and a wider practice survey.

Stakeholder Interviews

- There was near unanimous support expressed for the principles of the KSF and the view that the current inconsistent application was unacceptable. However, there were widely differing opinions on the changes required.
- The majority felt that the KSF was an over-engineered and complex process which needs to be simplified and operated in a more flexible manner. A minority argued for the KSF's removal.
- Others believed that the KSF had largely suffered from poor implementation and so higher prioritisation, improved guidance and training support were necessary.
- The KSF was felt to have worked well where senior management made it a priority, there was an appraisal culture, it was well integrated with other appraisal and development processes and was supported by effective training.

Literature Review

- Earlier studies have highlighted that the KSF is key to delivering on the objectives of AfC. But, they also found implementation hampered by the complexity of the process, low prioritisation and weak management skills. The volume of criticism of the process has grown.
- There is powerful research evidence in the NHS and externally that staff development and appraisal processes can have a major positive impact on service outcomes. But a significant number of large employers, from all sectors, are similarly frustrated with these processes for being complex and resource-intensive.
- Common changes made externally include: incorporating organisation and personal performance goals; simplifying the core process and competency frameworks; focusing on development rather than pay outcomes (competency-related pay

progression is still not common); involving and supporting line managers and employees; and allowing for local flexibility.
- The KSF is unusual in that there is no personal objective setting component or link to wider goals. The use in the NHS of both job profiles for job evaluation purposes and KSF post outlines for development processes is also uncommon.

Case Study Findings

- Case research was carried out in 11 trusts from around the country. They were selected using national data on the incidence of appraisal and PDRs, with the first six having high rates of coverage, and the second five relatively low rates.
- The experiences and advice from the first phase trusts centred on "the universal basics" of good appraisal and development practice, pursued consistently and persistently. They all found KSF initially challenging, but senior management example-setting and regular monitoring helped to ensured widespread implementation.
- KSF was positioned as an integral part of a wider performance appraisal process in these trusts, closely tied to personal and departmental and trust goals, helping to give direction and meaning to the KSF.
- The KSF was also generally linked effectively to other development and HR processes, such as professional competency frameworks and NVQs.
- They had also practiced a partnership and two-way approach to the process, with extensive communications and staff involvement and training.
- The approach to implementation and operation was described as "practical, pragmatic", with simple, clear route maps provided. Most had simplified and standardised post outlines and concentrated on the core KSF dimensions.
- A number had introduced variations to the national process to suit managers and more junior staff. Some had also developed their own operating rules.
- The second phase trusts had often faced difficult financial and operating circumstances, but some had historically had high rates of appraisal coverage.
- Most had attempted KSF implementation "by the book", with less attention to simplification and prioritisation. The complexity of the KSF and unclear relationship to appraisal had reinforced management scepticism of these types of process.
- Often in conjunction with new leadership, the majority of the second phase trusts were already planning or making changes, introducing simplified appraisal and development processes to support the trust vision and goals.
- In doing so they had at best adapted the KSF and used it in an optional, supporting role, in some cases moved away from it altogether, devising alternatives they believe are more relevant and useful.

Survey Findings

- An internet survey was carried out to secure the views of a wider range of stakeholders and trusts. 330 respondents took part. More than two-thirds believed the KSF requires change, but they do not want it to be withdrawn.

- The poor quality of appraisals, PDRs and PDPs was seen as at least as important an issue as the levels of overall coverage of the KSF.
- Only 36% of respondents felt KSF was well integrated with appraisal, and 87% felt that it was not well integrated with other training and development.
- Communication and employee understanding of the KSF was felt to be weak. The complexity of design and operation was by far the largest perceived barrier to implementing the KSF.
- Desired changes were most commonly about simplifying the KSF, for example by removing the additional dimensions. Obtaining stronger senior manager commitment was also seen as important, with greater 'consequences' for failure.
- The KSF's link to pay was not felt to operate in practice. More respondents wanted to see a strengthening of this link, rather than removing it. Stronger links to CPD and revalidation processes were also regarded as key, along with training of employees and reviewing managers.

Conclusions on the KSF

- This study has confirmed and extended the findings from earlier investigations to demonstrate that, five years after the principles of the KSF were set out, the gap between the intended policy and the actual practice remains unacceptably wide.
- In at least one-third of trusts key aspects of the KSF and appraisal processes are simply not happening at all, and the rate of expansion in coverage has been slow in recent years. Even where these processes operate, our survey found that they cover more than 75% of staff in only one in three organisations.
- We also found commonly expressed concerns with the quality of the process. A quarter of those surveyed rated the quality of PDRs and PDPs in their trusts as low.
- Given that almost everyone consulted supports the core principles of KSF – essentially, to support service development by investing in the development of all employees – then change is essential, in order to better achieve these intentions and overcome the current barriers.
- The service and performance benefits of operating appraisal and development processes in healthcare settings are strongly evident from research studies, and in this study we encountered plenty of examples of mangers we interviewed and staff we spoke to who had realised the benefits of using the KSF and were strongly committed to the process. But there needs to be far more of them enabled to do so.
- Changes to the KSF and its use are also essential to reflect changes in the NHS since 2004, particularly the devolvement of authority to the local level and the growth of Foundation Trusts. This in our view renders as outmoded an implementation strategy based on securing compliance with a totally uniform, detailed and relatively inflexible, NHS-wide KSF model.
- Our case research clearly shows that an increasing number of trusts are modifying, or even abandoning the KSF. Without changes, then this trend will undoubtedly intensify.
- The juxtaposition of the sophisticated KSF system and the reality of the management and operating processes and cultures in the NHS has led to it's, at best, patchy

implementation. The operational challenges at the individual trust level have to be addressed by this review's outcomes.

- It is also in the area of policy objectives and intentions that we see some of the most important barriers to KSF implementation. We identify three key policy questions to address.

1. How does the KSF relate to wider performance appraisal/management and should it form a part of one integrated process? It could be argued that all of the central effort behind KSF has in recent years has been akin to trying to move the whole 'horse' of performance management forward by just pulling one of its legs, the KSF competency framework. In future, a more effective approach may be to:
    - commit in principle to every NHS employee having an at least annual appraisal meeting and a personal development plan; and
    - develop a national model for a fully integrated performance appraisal and development process (with KSF embedded in it).

2. Is the KSF primarily a developmental or a pay-related process? We would support making the KSF unequivocally a support system for staff development. If any pay link is retained then this should only occur at the second gateway.

3. Is the KSF to be implemented as "tablets of stone" or used flexibly "as a supporting framework"? We believe that KSF needs to become the latter, for people to use and adapt because it is useful and saves them time and effort, rather than because they feel that they are forced to. Trusts should in future adhere to and be able to 'buy in' to the approach at a number of levels:
    - at a minimum to adhere to the core principles of the KSF;
    - optionally to use an improved KSF process, or to use an alternative which meets certain common standards. National frameworks could also be developed to address necessary differences in practice efficiently, for example, how the KSF could be applied in a team context.

Recommendations

Our recommendations are classified into three categories. These are to:

- Clarify the strategy, policy direction and principles of the KSF and related appraisal and development processes.
- Simplify the design and streamline the KSF components, paperwork and process, while also supporting greater flexibility and adaptation to suit local circumstances.
- Increase and improve support to deliver the principles of KSF into operating practice at the local level.

The specific changes recommended under each heading are described in the Figure below.

Figure: Recommended Changes and Actions

I. **Strategy**: **Clarify the policy direction and principles of the KSF and related appraisal and development processes.**

1. **Either** define and promote a new integrated appraisal and development model approach, that can be tailored and adapted locally; **or** clearly specify how the KSF and PDR/P ideally should link in with other aspects of performance management.

2. Ensure in either case a new 'front end' of trust and personal objectives on the KSF process.

3. Update the KSF principles and specify that all AfC staff should have a two-way appraisal discussion and PDR/PDP at least once per annum, and KSF or an equivalent competency framework needs to be an integral component. Clarify the common aspects of the national framework and those which can/should be tailored/adapted locally.

4. **Either** remove the direct link between KSF and pay, **or** make it only operate at the second gateway point. Produce more specific guidance on when and how increments can be withheld.

5. Conduct work nationally to facilitate links at the local level between use of KSF and other CPD, revalidation and training frameworks and initiatives.

6. Strengthen accountability. Senior national NHS figure to write to all trust chief executives to reinforce need for all managers and staff to have appraisal and PDR/P using KSF or similar quality framework, and establish this as a KPI for trusts. Work to improve monitoring arrangements eg through specific question in National Staff Survey

II **Design: simplify and streamline the KSF components, paperwork and process, while also supporting greater flexibility and adaptation to suit local circumstances**.

1. Make explicit that the specific dimensions are optional and decide if the core dimensions are to be compulsory or voluntary. If voluntary, decide whether and how some type of quality approval process for alternative competency frameworks might operate. Focus on the core dimensions moving forward.

2. Review and refresh the core dimensions. In particular consider the need to incorporate more behavioural language/criteria and possibly re-brand them as competencies; whether a leadership/management dimension should be included; and whether the equality and diversity dimension differentiates adequately.

3. Consider moving from levels and detailed examples of each dimension to a simpler indicators/contra indicators format. Move away from detailed examples of application in post outlines and in PDRs, relaxing the requirement for each example to be evidenced in favour of a broader, all round assessment of competence/contribution.

4. Design a compressed/shorter, summary post outline format. Develop model national band outlines and suggested post outlines for the most numerous jobs. Longer-term, consider the integration of job profiles for evaluation purposes and the KSF post outlines.

5. Form a small national working party to update/improve/streamline the KSF/PDR/P paperwork as a whole.

6. Make explicit that flexibility from year to year and between different types of job is desirable within the national KSF framework, rather than not permitted. In particular emphasise the need for quality two-way conversations.

7. Develop a team- based adaptation of the KSF and PDR/P process.

III Operation: Increase and improve support to deliver the principles of KSF into operating practice at the local level.

1. Produce national training packages for KSF/appraisal for managers and staff that can be used/adapted locally.

2. Produce a series of communication and operating guides to the KSF process which can be used/adapted locally, targeted specifically at:

- boards and chief executives (why it is important, how to achieve high coverage)

- reviewing managers (route map through the process, do's and don'ts, tips)

- staff (how to use it to best personal advantage).

3. Continue with improvements to the functionality and flexibility of the e-KSF. Target marketing of it to trusts that are already improving coverage of appraisal/KSF. Consider the development of a range of alternative and simpler administration options eg using existing HRIS, spreadsheet packages etc.

4. Develop and promote national operating best practice guidelines eg no more than 10 staff reviewed by any one manager, reviewing managers have to be trained, etc.

5. Establish a re-launch communications campaign with national material development but emphasis on regional and local delivery. Follow up with regular progress reports and guidance in newsletters, etc. Develop and provide model communications packs for managers and staff to use on appraisal/KSF.

6. Refresh the structure and resourcing of KSF support and decision making. Create smaller, more focused implementation teams with clear targets for increasing coverage and quality of the KSF/appraisal process. Attempt to increase resources at the local level and encourage and promote web-based, self-help networks. Promote regional 'buddying' of high and low coverage trusts and creation of regional 'hit squads'.

Next Steps

In order to move forward we would envisage two further work phases being involved:

- a re-design and development phase; followed by
- a re-launch, communication and implementation phase.

Immediate next steps might be as follows:

- Discuss, agree and prioritise recommended changes at national level with all stakeholders. Develop detailed development and implementation plan.

- Reform national KSF structure into a tighter policy group and series of small action teams, with one focused on the re-design recommendations and one on the operating improvements.
- Each team is briefed on the nationally agreed changes and then works through an intensive and compressed process of approximately three meetings to work up the agreed recommendations into actionable proposals.
- Policy group agrees and integrates proposals and agrees final implementation plan. It also establishes success measures and monitoring arrangements for the revised KSF process.
- Re- launch campaign and communications, probably with phased implementation of the changes.

ANNEX H

NHS STAFF BY OCCUPATION CODE STAFF GROUPS 2000-2009 - FTE

NHS staff by occupation code staff groups 2000-2009

England as at 30 September each year — full time equivalent and percentages

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Change 2000-2009	Annual % Change 2000-2009	Change 2008-2009	% Change 2008-2009
Total employed non-medical staff	**739,399**	**773,141**	**813,854**	**855,799**	**889,973**	**916,548**	**899,091**	**893,087**	**926,210**	**972,220**	**232,821**	**2.8%**	**46,009**	**5.0%**
Qualified nursing, midwifery & health visiting staff	**256,276**	**266,171**	**279,287**	**291,925**	**301,877**	**307,744**	**307,447**	**307,628**	**315,410**	**322,425**	**66,149**	**2.3%**	**7,015**	**2.2%**
Total qualified scientific, therapeutic & technical staff [5]	**89,632**	**93,085**	**98,397**	**102,912**	**108,585**	**113,214**	**114,492**	**117,107**	**122,059**	**128,331**	**38,699**	**3.7%**	**6,272**	**5.1%**
Qualified Allied Health Professions	44,594	46,284	48,151	50,478	53,311	55,133	55,711	57,065	59,455	61,865	17,271	3.3%	2,410	4.1%
Other qualified scientific, therapeutic & technical staff	45,038	46,801	50,245	52,434	55,274	58,082	58,782	60,042	62,603	66,466	21,428	4.0%	3,863	6.2%
Qualified ambulance staff	**14,104**	**14,255**	**14,978**	**15,355**	**16,587**	**17,417**	**15,723**	**16,535**	**16,889**	**17,214**	**3,110**	**2.0%**	**325**	**1.9%**
Support to clinical staff	**234,683**	**249,198**	**262,671**	**277,178**	**284,394**	**291,663**	**283,198**	**274,608**	**284,367**	**301,235**	**66,552**	**2.5%**	**16,869**	**5.9%**
Support to doctors & nursing staff	194,659	205,827	216,235	226,955	231,652	237,889	228,084	221,270	226,952	239,017	44,358	2.1%	12,065	5.3%
Support to scientific, therapeutic & technical staff	32,594	34,982	37,920	41,481	44,089	44,708	43,906	43,113	45,533	49,129	16,535	4.2%	3,597	7.9%
Support to ambulance staff	7,429	8,388	8,515	8,743	8,653	9,066	11,209	10,225	11,882	13,088	5,659	5.8%	1,207	10.2%
NHS infrastructure support	**144,048**	**149,598**	**158,026**	**167,916**	**178,098**	**186,137**	**177,871**	**176,858**	**187,177**	**202,703**	**58,655**	**3.5%**	**15,526**	**8.3%**
Central functions	65,965	69,277	72,730	78,784	85,498	90,387	87,856	86,772	92,106	101,983	36,017	4.5%	9,876	10.7%
Hotel, property & estates	53,830	54,036	54,382	55,323	56,593	58,201	54,975	55,131	57,135	58,211	4,381	0.8%	1,077	1.9%
Manager & senior manager	24,253	26,285	30,914	33,810	36,007	37,549	35,041	34,955	37,937	42,509	18,256	5.8%	4,573	12.1%
Other non-medical staff or those with unknown classification	**656**	**834**	**495**	**512**	**432**	**373**	**359**	**351**	**308**	**311**	**-345**	**-7.2%**	**2**	**0.8%**

Notes:

Full time equivalent figures are rounded to the nearest whole number.

Nursing and midwifery figures exclude students on training courses leading to a first qualification as a nurse or midwife.

To make the census data comparable with the Review Body for Nursing Staff and Other Health Professionals definitions, qualified Allied Health Professionals (AHPs) now include Speech & Language Therapists (previously these were included in Other Qualified ST&T staff). For comparability historical data has been reassigned to match the revised definition.

The numbers of AHPs will not match those published in previous years.

In 2006 ambulance staff were collected under new, more detailed, occupation codes. As a result, qualified totals and support to ambulance staff totals are not directly comparable with previous years.

ANNEX I

NHS STAFF BY OCCUPATION CODE STAFF GROUPS 2000-2009 - HC

NHS staff by occupation code staff groups 2000-2009

England as at 30 September each year — headcount and percentages

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Change 2000-2009	Annual % Change 2000-2009	Change 2008-2009	% Change 2008-2009
Total employed non-medical staff	**919,252**	**962,528**	**1,013,199**	**1,063,846**	**1,101,797**	**1,130,949**	**1,092,886**	**1,085,524**	**1,120,548**	**1,176,831**	**257,579**	**2.5%**	**56,283**	**5.0%**
Qualified nursing, midwifery & health visiting staff	**316,752**	**330,535**	**346,537**	**364,692**	**375,371**	**381,257**	**374,538**	**376,737**	**386,112**	**395,229**	**78,477**	**2.2%**	**9,117**	**2.4%**
Total qualified scientific, therapeutic & technical staff [5]	**105,910**	**110,241**	**116,598**	**122,066**	**128,883**	**134,534**	**134,498**	**136,976**	**142,558**	**149,596**	**43,686**	**3.5%**	**7,038**	**4.9%**
Qualified Allied Health Professions	54,788	57,001	59,415	62,189	65,515	67,841	67,483	68,687	71,301	73,953	19,165	3.0%	2,652	3.7%
Other qualified scientific, therapeutic & technical staff	51,122	53,240	57,183	59,877	63,368	66,693	67,015	68,289	71,257	75,643	24,521	4.0%	4,386	6.2%
Qualified ambulance staff	**14,755**	**14,855**	**15,609**	**15,957**	**17,272**	**18,117**	**16,176**	**17,028**	**17,451**	**17,922**	**3,167**	**2.0%**	**471**	**2.7%**
Support to clinical staff	**307,225**	**325,890**	**344,524**	**360,666**	**368,285**	**376,219**	**357,877**	**346,596**	**355,010**	**377,617**	**70,392**	**2.1%**	**22,607**	**6.4%**
Support to doctors & nursing staff	257,136	271,978	287,098	298,752	303,630	310,441	291,098	281,894	286,254	303,424	46,288	1.7%	17,170	6.0%
Support to scientific, therapeutic & technical staff	41,800	44,602	48,030	52,230	55,025	55,715	54,307	53,259	55,689	59,831	18,031	3.7%	4,142	7.4%
Support to ambulance staff	8,289	9,310	9,396	9,684	9,630	10,063	12,472	11,443	13,067	14,362	6,073	5.7%	1,295	9.9%
NHS infrastructure support	**173,733**	**179,783**	**189,274**	**199,808**	**211,489**	**220,387**	**209,387**	**207,778**	**219,064**	**236,103**	**62,370**	**3.1%**	**17,039**	**7.8%**
Central functions	77,628	81,439	85,706	92,257	99,831	105,565	101,860	100,177	105,354	115,818	38,190	4.1%	10,464	9.9%
Hotel, property & estates	70,849	70,920	71,274	72,230	73,932	75,431	70,776	71,102	73,797	75,624	4,775	0.7%	1,827	2.5%
Manager & senior manager	25,256	27,424	32,294	35,321	37,726	39,391	36,751	36,499	39,913	44,661	19,405	5.9%	4,748	11.9%
Other non-medical staff or those with unknown classification	**877**	**1,224**	**657**	**657**	**497**	**435**	**410**	**409**	**353**	**364**	**-513**	**-8.4%**	**11**	**3.1%**

Notes:

Nursing and midwifery figures exclude students on training courses leading to a first qualification as a nurse or midwife.

To make the census data comparable with the Review Body for Nursing Staff and Other Health Professionals definitions, qualified Allied Health Professionals (AHPs) now include Speech & Language Therapists (previously these were included in Other Qualified ST&T staff). For comparability historical data has been reassigned to match the revised definition.

The numbers of AHPs will not match those published in previous years.

In 2006 ambulance staff were collected under new, more detailed, occupation codes. As a result, qualified totals and support to ambulance staff totals are not directly comparable with previous years.

SUMMARY OF THREE MONTH VACANCIES IN THE NHS IN ENGLAND BY MAIN STAFF GROUP AND AREA OF WORK

England

	March 2005	March 2006	March 2007	March 2008	March 2009	March 2010
	Rate [2]	Rate [2]	Rate [2]	Rate [2]	Rate [2]	Rate [2]
Total qualified nursing, midwifery and health visiting staff	1.9%	0.9%	0.5%	0.5%	0.7%	0.6%
Acute, elderly & general care	1.7%	0.8%	0.4%	0.5%	0.6%	0.5%
Paediatrics	1.7%	1.1%	0.7%	0.6%	0.4%	0.7%
Learning difficulties	2.3%	0.8%	1.2%	0.2%	0.3%	0.2%
Psychiatry	2.8%	1.5%	0.7%	0.6%	0.9%	1.0%
Midwives	1.8%	1.0%	0.5%	0.8%	1.0%	1.2%
District nurses	1.8%	0.7%	0.5%	0.2%	0.5%	0.5%
Health visitors	2.1%	0.6%	0.2%	0.3%	0.3%	0.9%
School nurses	1.9%	0.6%	0.4%	0.4%	0.5%	0.4%
Other qualified nurses	1.5%	0.7%	0.8%	0.3%	0.8%	0.4%
Total unqualified nurses	1.1%	0.7%	0.4%	0.4%	0.4%	0.3%
Total ST&T staff	2.4%	1.5%	0.8%	0.4%	0.7%	0.5%
of which:						
Qualified Allied Health Professionals	3.4%	1.6%	0.7%	0.5%	0.7%	0.5%
Chiropody/podiatry	3.0%	0.6%	0.7%	0.1%	0.6%	0.2%
Dietetics	3.1%	1.3%	1.1%	0.4%	0.9%	0.5%
Occupational Therapists	3.9%	2.3%	1.0%	0.6%	1.1%	0.7%
Orthoptics/optics	1.0%	0.5%	1.3%	0.6%	0.5%	0.5%
Physiotherapists	2.9%	1.1%	0.4%	0.3%	0.5%	0.3%
Diagnostic Radiographers	3.4%	1.6%	0.7%	0.6%	0.4%	0.4%
Therapeutic Radiographers	6.0%	4.8%	0.9%	1.0%	0.7%	0.8%
Art, Music and Drama Therapists	3.0%	1.3%	0.4%	0.8%	0.7%	0.3%
Speech & language therapy	2.5%	1.1%	0.8%	0.6%	0.6%	0.5%
Qualified healthcare scientists	2.1%	1.5%	0.9%	0.6%	0.6%	0.4%
Clinical Biochemistry	1.8%	1.2%	0.5%	0.5%	0.4%	0.3%
Cyto/Histopathology	2.1%	1.7%	0.8%	0.3%	0.4%	0.3%
Cyto-screeners	2.2%	0.8%	0.9%	0.0%	0.0%	0.2%
Genetics	0.9%	0.9%	0.5%	0.4%	0.1%	0.0%
Haematology	1.9%	1.1%	0.9%	0.1%	0.6%	0.1%
Microbiology	1.6%	1.0%	0.8%	0.3%	0.3%	0.2%
Other life sciences	1.5%	1.8%	1.5%	0.3%	0.5%	0.2%
Audiology	4.8%	3.2%	0.8%	0.8%	0.7%	0.4%
Cardiology	3.2%	1.9%	1.8%	1.3%	1.0%	1.3%
Renal Dialysis	1.8%	1.4%	0.0%	0.0%	0.0%	0.0%
Respiratory Physiology	1.2%	1.0%	1.2%	0.3%	0.5%	0.8%
Neurophysiology	1.5%	2.7%	0.7%	2.0%	1.2%	0.7%
Other Physiological Sciences	1.5%	1.8%	1.7%	1.0%	4.6%	1.3%
Rehabilitation Engineering	0.5%	0.6%	1.5%	0.4%	0.2%	0.2%
Nuclear Medicine and Diagnostic Radiology	3.0%	1.2%	1.4%	0.5%	2.3%	1.3%
Radiotherapy Physics	2.8%	1.8%	0.6%	0.3%	0.3%	0.3%
Equipment management and Development	1.5%	2.1%	0.6%	0.7%	0.3%	0.3%
Maxillofacial Prosthetics	7.7%	1.6%	0.0%	0.0%	0.6%	0.0%
Other Physical Sciences	1.5%	1.5%	0.7%	1.5%	0.8%	0.1%
Other Healthcare Science Professions	1.1%	2.0%	0.8%	2.3%	0.8%	0.3%
Total Other qualified ST&T staff	2.2%	1.7%	1.1%	0.5%	1.0%	0.8%
Multi-therapies	0.3%	8.6%	0.8%	0.0%	0.0%	1.6%
Clinical psychology	2.7%	2.2%	1.2%	0.5%	0.9%	1.1%
Psychotherapy	1.8%	1.8%	0.8%	0.0%	0.7%	0.6%
Registered pharmacists	3.1%	2.1%	1.4%	1.0%	1.5%	0.9%
Pre-registration pharmacy trainees	2.3%	2.9%	2.2%	0.3%	1.6%	0.0%
Other qualified pharmacy staff	1.6%	1.3%	0.8%	0.2%	0.5%	0.4%
Dental	1.7%	0.9%	1.0%	0.3%	0.3%	0.1%
Operating theatre staff	2.4%	2.4%	1.6%	0.5%	1.1%	1.2%
Other qualified ST&T staff	1.8%	0.7%	0.6%	0.4%	1.3%	0.6%
Total unqualified ST&T staff	1.0%	0.8%	0.5%	0.3%	0.3%	0.4%
Total all other staff	0.9%	0.8%	0.6%	0.4%	0.4%	0.3%
Health care assistants & support staff with LDP definitions	1.5%	0.9%	0.7%	0.7%	0.5%	0.3%
Other health care assistants and support staff	0.8%	0.6%	0.6%	0.2%	0.3%	0.4%
Admin & estates staff	0.8%	0.8%	0.6%	0.4%	0.4%	0.2%
Ambulance staff	0.7%	1.4%	0.3%	0.1%	0.3%	0.2%
Other staff	2.4%	1.9%	1.7%	0.7%	0.3%	0.6%

Notes:

2. Three month vacancy rates are three month vacancies expressed as a percentage of three month vacancies plus staff in post from the previous September medical & dental and non-medical workforce censuses (full time equivalent)

Percentages are calculated on unrounded figures

.. Not applicable

The NHS Information Centre for health and social care Vacancies Survey March 2010

ANNEX K

NUMBER AND PROPORTION OF STAFF BY FTE EARNING UNDER £21K PER FTE BY PAY METRIC GROUP AND CONSOLIDATED SELECTED JOB ROLES (SEPT 2009)

		Estimated FTEs					
Paybill Group	Consolidated Job Role	Under £21k	Over £21k	Total	% Under £21k	% of Paybill Group in Job Role	% of Paybill Group Under £21k in Job Role
Qualified Nursing	Community Nurse	146	37,734	37,880	0%	12%	12%
	Community Practitioner	14	13,237	13,251	0%	4%	1%
	Enrolled Nurse	45	3,506	3,550	1%	1%	4%
	Manager	-	606	606	0%	0%	0%
	Midwife & Related Roles	9	21,018	21,027	0%	7%	1%
	Modern Matron	1	4,810	4,811	0%	2%	0%
	Nurse Consultant	-	1,031	1,031	0%	0%	0%
	Nurse Manager	1	11,921	11,922	0%	4%	0%
	Practitioner	3	587	590	1%	0%	0%
	Sister/Charge Nurse	10	30,679	30,689	0%	10%	1%
	Specialist Nurse Practitioner	7	21,431	21,438	0%	7%	1%
	Staff Nurse	436	157,314	157,751	0%	51%	37%
	Other	516	1,824	2,340	22%	1%	43%
	Qualified Nursing Total	**1,188**	**305,699**	**306,887**	**0%**	**100%**	**100%**
Unqualified Nursing, HCA and Support	Assistant	7,791	14	7,805	100%	4%	4%
	Associate Practitioner	386	49	435	89%	0%	0%
	Clerical Worker	2,948	25	2,974	99%	2%	2%
	Community Nurse	528	182	710	74%	0%	0%
	Cook	1,790	63	1,853	97%	1%	1%
	Driver	2,051	9	2,060	100%	1%	1%
	Health Care Support Worker	36,430	746	37,176	98%	20%	20%
	Healthcare Assistant	78,852	784	79,636	99%	43%	43%
	Helper/Assistant	3,598	62	3,660	98%	2%	2%
	Housekeeper	9,057	14	9,071	100%	5%	5%
	Nursery Nurse	2,954	1,231	4,185	71%	2%	2%
	Porter	7,676	22	7,698	100%	4%	4%
	Receptionist	583	4	588	99%	0%	0%
	Social Care Support Worker	1,929	123	2,051	94%	1%	1%
	Staff Nurse	297	274	571	52%	0%	0%
	Supervisor	1,394	110	1,504	93%	1%	1%
	Support Worker	19,954	73	20,027	100%	11%	11%
	Support, Time, Recovery Worker	621	50	672	93%	0%	0%
	Technician	587	30	617	95%	0%	0%
	Telephonist	674	7	682	99%	0%	0%
	Other	2,091	720	2,812	74%	2%	1%
	Unqualified Nursing, HCA & Support Total	**182,194**	**4,592**	**186,786**	**98%**	**100%**	**100%**
ST&Ts	Art Therapist & Related Roles	12	364	376	3%	0%	0%
	Assistant Psychologist	228	759	987	23%	1%	1%
	Associate Practitioner	561	477	1,038	54%	1%	2%
	Biomedical Scientist	85	12,663	12,748	1%	8%	0%
	Chaplain	0	556	556	0%	0%	0%
	Chiropodist/Podiatrist & Related Roles	26	3,237	3,262	1%	2%	0%
	Clinical Psychologist	39	6,754	6,793	1%	4%	0%
	Counsellor	5	810	814	1%	0%	0%
	Dental Surgery Assistant	710	1,183	1,894	38%	1%	2%
	Dietitian & Related Roles	30	3,409	3,438	1%	2%	0%
	Health Care Support Worker	1,074	155	1,229	87%	1%	3%
	Healthcare Assistant	849	70	918	92%	1%	2%
	Healthcare Scientist	94	4,640	4,734	2%	3%	0%
	Helper/Assistant	11,261	695	11,956	94%	7%	31%
	Medical Laboratory Assistant	6,327	173	6,499	97%	4%	18%
	Occupational Therapist & Related Roles	278	13,023	13,301	2%	8%	1%
	Orthoptists & Related Roles	11	740	751	1%	0%	0%
	Pharmacist	168	7,274	7,443	2%	5%	0%
	Phlebotomist	1,330	43	1,373	97%	1%	4%
	Physiotherapist & Related Roles	227	17,870	18,097	1%	11%	1%
	Practitioner	185	3,224	3,409	5%	2%	1%
	Psychotherapist	21	1,290	1,311	2%	1%	0%
	Diagnostic Radiographer & Related Roles	87	12,080	12,167	1%	7%	0%
	Therapeutic Radiographer & Related Roles	9	2,074	2,083	0%	1%	0%
	Social Care Support Worker	433	206	639	68%	0%	1%
	Social Worker	44	844	889	5%	1%	0%
	Specialist Practitioner	18	640	657	3%	0%	0%
	Speech and Language Therapist & Related Role	121	6,009	6,130	2%	4%	0%
	Students	473	719	1,192	40%	1%	1%
	Technical Instructor	2,187	970	3,157	69%	2%	6%
	Technician	7,232	19,368	26,600	27%	16%	20%
	Trainee Practitioner	348	1,257	1,605	22%	1%	1%
	Trainee Scientist	50	722	773	7%	0%	0%
	Other	1,369	4,376	5,745	24%	3%	4%
	ST&Ts Total	**35,888**	**128,675**	**164,563**	**22%**	**100%**	**100%**

		Estimated FTEs					
Paybill Group	Consolidated Job Role	Under £21k	Over £21k	Total	% Under £21k	% of Paybill Group in Job Role	% of Paybill Group Under £21k in Job Role
Admin & Clerical	Accountant	249	1,871	2,120	12%	1%	0%
	Adviser	978	3,612	4,590	21%	2%	1%
	Analyst	574	3,470	4,043	14%	2%	0%
	Call Operator	949	260	1,209	78%	1%	1%
	Clerical Worker	69,141	13,842	82,983	83%	39%	55%
	Control Assistant	1,180	257	1,437	82%	1%	1%
	Manager	409	13,351	13,760	3%	7%	0%
	Medical Secretary	8,492	9,050	17,542	48%	8%	7%
	Officer	25,003	27,325	52,327	48%	25%	20%
	Personal Assistant	1,994	3,240	5,234	38%	2%	2%
	Receptionist	7,008	70	7,078	99%	3%	6%
	Secretary	7,937	1,925	9,862	80%	5%	6%
	Senior Manager	16	2,004	2,020	1%	1%	0%
	Technician	596	1,854	2,449	24%	1%	0%
	Other	2,014	1,832	3,846	52%	2%	2%
	Admin & Clerical Total	**126,540**	**83,962**	**210,501**	**60%**	**100%**	**100%**
Maintenance & Works	Assistant	825	71	896	92%	9%	18%
	Building Craftsperson & Carpenters	246	399	646	38%	6%	5%
	Building Officer	29	262	291	10%	3%	1%
	Driver	235	3	238	99%	2%	5%
	Electrician	142	488	630	23%	6%	3%
	Engineer	89	398	488	18%	5%	2%
	Fitter	29	172	200	14%	2%	1%
	Gardener/Groundsperson	359	28	386	93%	4%	8%
	Housekeeper	177	-	177	100%	2%	4%
	Maintenance Craftsperson	857	1,619	2,475	35%	24%	19%
	Mechanic	73	287	359	20%	3%	2%
	Painter/Decorator	123	111	234	53%	2%	3%
	Plumber	32	86	118	27%	1%	1%
	Porter	339	-	339	100%	3%	7%
	Supervisor	80	467	548	15%	5%	2%
	Support Worker	457	73	530	86%	5%	10%
	Technician	107	656	763	14%	7%	2%
	Other	366	717	1,083	34%	10%	8%
	Maintenance & Works Total	**4,565**	**5,835**	**10,401**	**44%**	**100%**	**100%**
Ambulance	Health Care Support Worker	895	8	904	99%	4%	12%
	Healthcare Assistant	4,139	58	4,198	99%	17%	57%
	Paramedic	159	9,060	9,219	2%	38%	2%
	Paramedic Manager	-	1,171	1,171	0%	5%	0%
	Paramedic Specialist Practitioner	-	821	821	0%	3%	0%
	Technician	1,767	4,482	6,250	28%	26%	24%
	Trainee Practitioner	54	762	816	7%	3%	1%
	Other	233	864	1,097	21%	4%	3%
	Ambulance Total	**7,248**	**17,227**	**24,475**	**30%**	**100%**	**100%**
Managers	Accountant	1	793	794	0%	2%	0%
	Adviser	3	347	351	1%	1%	1%
	Analyst	3	327	331	1%	1%	1%
	Clerical Worker	63	622	685	9%	2%	25%
	Manager	83	21,051	21,134	0%	50%	33%
	Officer	48	1,105	1,153	4%	3%	19%
	Senior Manager	5	15,712	15,716	0%	37%	2%
	Other	49	2,297	2,346	2%	6%	19%
	Managers Total	**256**	**42,253**	**42,509**	**1%**	**100%**	**100%**
	AfC HCHS Total	**357,878**	**588,244**	**946,122**	**38%**	**-**	**-**

Note: Excludes paybill metric staff group 'others' as they are not identified in the ESR extract. This excludes 311 FTEs and 364 Headcount. Bank staff are also excluded.

ANNEX L

NHS STAFF SURVEY 2009

The NHS staff survey is an established key source of robust, independent and credible evidence on staff views of working in the NHS. The 2009 NHS staff survey is the 7th annual survey of its kind. Almost 290,000 NHS staff were invited to take part in the survey and approximately 160,000 employees responded – a 55% response rate (same as in 2008).

Table A	**Staff Job Satisfaction**			**diff 2008/2009**
	2007	**2008**	**2009**	
All NHS Staff (inc. medics)	3.44	3.51	3.53	0.03
Qualified Nurses	3.39	3.45	3.50	0.04
Unqualified Nurses and Assistants	3.39	3.48	3.49	0.01
ST&T	3.47	3.53	3.55	0.02
Admin & Clerical	3.45	3.53	3.54	0.01
Maintenance	3.47	3.51	3.55	0.04
Ambulance staff	3.07	3.10	3.08	-0.02
Managers	3.70	3.79	3.77	-0.02

Table B	**Staff Intention to Leave**			**diff 2008/2009**
	2007	**2008**	**2009**	
All NHS Staff (inc. medics)	2.73	2.59	2.54	-0.05
Qualified Nurses	2.80	2.69	2.65	-0.04
Unqualified Nurses and Assistants	2.63	2.48	2.42	-0.06
ST&T	2.71	2.59	2.56	-0.03
Admin & Clerical	2.75	2.57	2.52	-0.05
Maintenance	2.53	2.45	2.35	-0.10
Ambulance staff	2.66	2.57	2.55	-0.02
Managers	2.73	2.57	2.59	0.02

Table C	**Staff engagement with their jobs**			**diff 2008/2009**
	2007	**2008**	**2009**	
All NHS Staff (inc. medics)	n/a	n/a	3.86	n/a
Qualified Nurses	n/a	n/a	3.90	n/a
Unqualified Nurses and Assistants	n/a	n/a	3.93	n/a
ST&T	n/a	n/a	3.84	n/a
Admin & Clerical	n/a	n/a	3.78	n/a
Maintenance	n/a	n/a	3.89	n/a
Ambulance staff	n/a	n/a	3.60	n/a

Table D	Percent of staff working no additional PAID hours.			Change (since 2008)
	2007	2008	2009	
All NHS Staff (inc. medics)	**71**	**70**	**73**	**2.4**
Qualified Nurses	68	66	67	0.9
Unqualified Nurses and Assistants	65	62	64	1.8
ST&T	75	75	75	0.1
Admin & Clerical	82	80	82	2.2
Maintenance	63	64	67	2.7
Ambulance staff	19	21	21	-0.3
Managers	87	86	88	2.5

Table E	Percent of staff working no additional UNPAID hours.			Change (since 2008)
	2007	2008	2009	
All NHS Staff (inc. medics)	**46**	**47**	**47**	**0.4**
Qualified Nurses	35	35	34	-1.1
Unqualified Nurses and Assistants	73	73	74	0.7
ST&T	42	43	44	0.9
Admin & Clerical	62	63	63	0.4
Maintenance	73	71	68	-3.3
Ambulance staff	76	74	74	-0.7
Managers	13	14	14	0.2

Table F	Percent of staff who do not disagree that their trust is committed to helping staff balance their work and home life.			Change (since 2008)
	2007	2008	2009	
All NHS Staff (inc. medics)	**78**	**80**	**81**	**0.9**
Qualified Nurses	73	76	75	-0.3
Unqualified Nurses and Assistants	75	77	79	1.4
ST&T	81	83	82	-1.0
Admin & Clerical	86	88	88	0.1
Maintenance	83	84	84	-0.3
Ambulance staff	50	52	51	-1.5
Managers	80	84	84	-0.3

Table G	Percent of staff who do not disagree that their immediate manager helps them find a good work-life balance.			Change (since 2008)
	2007	2008	2009	
All NHS Staff (inc. medics)	**82**	**83**	**84**	**1.0**
Qualified Nurses	80	81	82	0.7
Unqualified Nurses and Assistants	82	84	84	0.7
ST&T	84	85	85	0.0
Admin & Clerical	87	88	88	-0.1
Maintenance	81	82	84	1.5
Ambulance staff	59	65	64	-0.5
Managers	83	86	86	0.4
Table H	**Percent of staff who do not disagree that they do not have time to carry out all their work.**			**Change (since 2008)**
	2007	**2008**	**2009**	
All NHS Staff (inc. medics)	**74**	**73**	**72**	**-0.4**
Qualified Nurses	79	78	79	0.3
Unqualified Nurses and Assistants	65	63	63	-0.6
ST&T	76	75	75	-0.8
Admin & Clerical	68	66	65	-1.7
Maintenance	66	65	63	-1.8
Ambulance staff	67	68	67	-0.4
Managers	80	80	78	-1.8

Source: NHS Staff Surveys 2007, 2008 and 2009

ANNEX M

OCCUPATION CODES USED TO IDENTIFY THE DIFFERENT TYPES OF POST IN ESR AND OCCUPATION DESCRIPTIONS

Eligible types of post	Occupation codes used in ESR	Types of post the occupation codes relate to
Chaplains	S1X, S9X	Other ST&T staff (Therapists and Helper/Assistants)
Clinical Coding Officers	G2A, G2B	Admin & Clerical staff (Central Functions and Hotel, Property & Estates)
Cyto-screeners	T5B, T5U	Cyto-screener (Cyto/Histopathology, Other Healthcare Science Professions)
Dental Nurses, Technicans, Therapists and Hygienists	S1R, S4R, S7R, S8R, S9R	Dental staff (Therapist, Technician, Tutor, Student/Trainee, Helper/Assistant)
Estates/Work Officers	G0B, G1B, G2B, G3B	Hotel, Property & Estates staff (Senior Manager, Manager, Admin & Clerical & Maintenance & Works)
Financial Accountants, Invoice Clerks and Payroll Team Leaders	G0A, G1A, G2A	Central Functions staff (Senior Manager, Manager & Admin & Clerical)
Biomedical Scientists	T2A-T2F, T2U, T3A-T3F, T3U	Biomedical Scientists (including Advanced Practitioners) - Life Sciences/Pathology and Other Health Care Science professions
Pharmacists	SAP, S0P, S2P, S4P, S5P, S8P, S9P	Pharmacists (Consultant Therapist/Scientist, Manager, Scientist, Technician, Assistant Practitioner, Student/Trainee, Helper/Assistant)
Qualified Maintenance Craftspersons & Technicians	G3B	Hotel, Property & Estates staff (Maintenance & Works)
Qualified Medical Technical Officers	T4A-T4H, T4J-T4N, T4P-T4U	Technicians (Life Sciences/Pathology, Physiological Sciences, Clinical Engineering & Physical Sciences,Other)
Qualified Midwives (new entrants)	N2C	Registered Midwife
Qualified Perfusionists	T6H, T6U	Perfusionist (Cardiology and Other)

Examples of Area of Work covered in ESR (Sept 2009)

Area of Work	% of FTEs below 21K
Catering	95%
Domestic Services	99%
Estates	48%
Facilities	78%
Finance	34%
Human Resources	38%
Linen Services	96%
Portering Services	97%
Security	82%
Telephone Services	90%
Transport	87%
Corporate	25%

Notes

1. Data was extracted from the ESR DW based on occupation codes G* and H2* which are the family of codes representing Administration and Estates Staff and Support Workers respectively, and the codes which most resemble the PNC groups.
2. The data taken was a snapshot as at September 2009.
3. Staff earning less than 21K were determined by their AfC spinal point.

ANNEX N

NMET COMMISSIONS

Pre-Registration Nursing and Midwifery Training Commissions

Year	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	Increase 2000/01 to 2009/10	% increase 2000/01 to 2009/10
NURSING												
Degree	2,638	3104	3252	3611	4279	3238	4006	4062	4262	5753	**3,115**	**118.1%**
Diploma	17,383	18,652	19,704	20,673	20,737	17,070	17,193	15,290	16,402	15,076	**-2,307**	**-13.3%**
Total	***20,021***	***21,756***	***22,956***	***24,284***	***25,016***	***20,308***	***21,199***	***19,352***	***20,664***	***20,829***	**808**	**4.0%**
MIDWIFERY												
Degree	494	621	709	753	895	891	983	1,307	1,944	1,977	**1,483**	**300.2%**
Diploma	604	525	724	716	744	397	540	412	0	0	**-604**	**-100.0%**
Sub Total	*1,098*	*1,146*	*1,433*	*1,469*	*1,639*	*1,288*	*1,523*	*1,719*	*1,944*	*1,977*	**879**	**80.1%**
18 month diploma	789	732	677	757	735	531	467	352	328	505	**-284**	**-36.0%**
Total	***1,887***	***1,878***	***2,110***	***2,226***	***2,374***	***1,819***	***1,990***	***2,071***	***2,272***	***2,482***	**595**	**31.5%**
N&M TOTAL	**21,908**	**23,634**	**25,066**	**26,510**	**27,390**	**22,127**	**23,189**	**21,423**	**22,936**	**23,311**	**1,403**	**6.4%**

Training commissions for Healthcare Scientists & Technicians

Year	**2000/01**	**2001/02**	**2002/03**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**Increase 2000/01 to 2009/10**	**Percentage Increase since 2000/01**
Scientists	581	439	764	1,029	1,200	885	1,059	1,054	1,131	1,220	**639**	**110.0%**
Technicians	702	1,420	2,491	3,183	3,478	3,498	2,848	2,598	3,043	3,266	**2,564**	**365.2%**

AHP Training Commissions 2000/01 to 2009/10

Year	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	% Increase 2000/01 to 2009/10
Physiotherapy	1,473	1,780	2,157	2,343	2,357	2,400	2,193	2,038	1,812	1,805	**22.5%**
Occupational Therapy	1,385	1,563	1,692	1,822	1,925	1,961	1,820	1,634	1,662	1,732	**25.1%**
Radiography	761	948	1,227	1,411	1,461	1,555	1,398	1,306	1,423	1,447	**90.1%**
Diagnostic	597	730	942	1,105	1,158	1,241	1,090	1,038	1,128	1,108	**85.6%**
Therapeutic	164	218	285	306	303	314	308	268	295	339	**106.7%**
Orthoptics	58	60	45	59	73	68	59	64	71	79	**36.2%**
Speech Therapy	558	553	597	630	740	797	758	770	794	804	**44.1%**
Prosthetics & Orthotics	26	27	30	29	35	27	24	26	29	29	**11.5%**
Dietetics	217	237	279	353	306	386	413	384	388	385	**77.4%**
Chiropody	345	345	427	451	559	446	438	428	401	393	**13.9%**
TOTAL	**4,823**	**5,513**	**6,454**	**7,098**	**7,456**	**7,640**	**7,103**	**6,650**	**6,580**	**6,674**	**38.4%**

ANNEX O

THE PHARMACY STAFFING ESTABLISHMENT AND VACANCY SURVEY (PEVS) 2010 AND OTHER DATASETS

Background

The Pharmacy Staffing Establishment and Vacancy Survey (PEVS) is carried out annually by the NHS Pharmacy Education and Development Committee (NHS PEDC), with a census date of 31 May. The survey sample is all Chief Pharmacists in NHS trusts (acute and mental health) and primary care organisations in England, Northern Ireland, Scotland and Wales. In 2010, a response rate of 100% was achieved. Data collected for pharmacists, pharmacy technicians, pharmacy assistants and administrative and clerical staff is as follows:

- staffing establishment (reported by chief pharmacists)
- all vacancies (and 3 month vacancies)
- locums*
- frozen and dis-established posts*

*new data for 2010.

All the PEVS data is reported by Agenda for Change band. The following information extracted from 2010 PEVS focuses primarily on 2010 data for pharmacists, in particular Band 6 and 7, together with data from 2008 and 2009 to identify trends. The full PEVS report will be published in November 2010.

It should be noted that the PEVS data is often compared with the NHS Information Centre Workforce Census that routinely reports significantly lower vacancy rates – the datasets collected are compared by the NHS Pharmacy Education and Development Committee, see following paper "Differences between the National NHS Pharmacy Staffing Establishment & Vacancy Survey data (carried out by NHS PEDC) and the NHS Information Centre's NHS Workforce Census and NHS Workforce Vacancy Survey data". It is likely that differences in data definitions (especially the definition of 3 month vacancy) and the timing of the data collection (May for the PEVS and March for the NHS IC census) mean that the situation reported in the PEVS data present a worst case scenario with regard to vacancies. The data are however a valid indication of the position with regard to recruitment and retention of NHS pharmacists, giving useful trend information, now over three years. The PEV Survey also provides the detail necessary to isolate specific issues, e.g. junior pharmacists employed in NHS Trusts, which may otherwise be masked in more general NHS IC data.

Other datasets analysed include training numbers and retention on registration for the 2008 and 2009 – these are collected by the NHS PEDC annually and the 2010 figures are currently being finalised and validated.

Key Findings for England

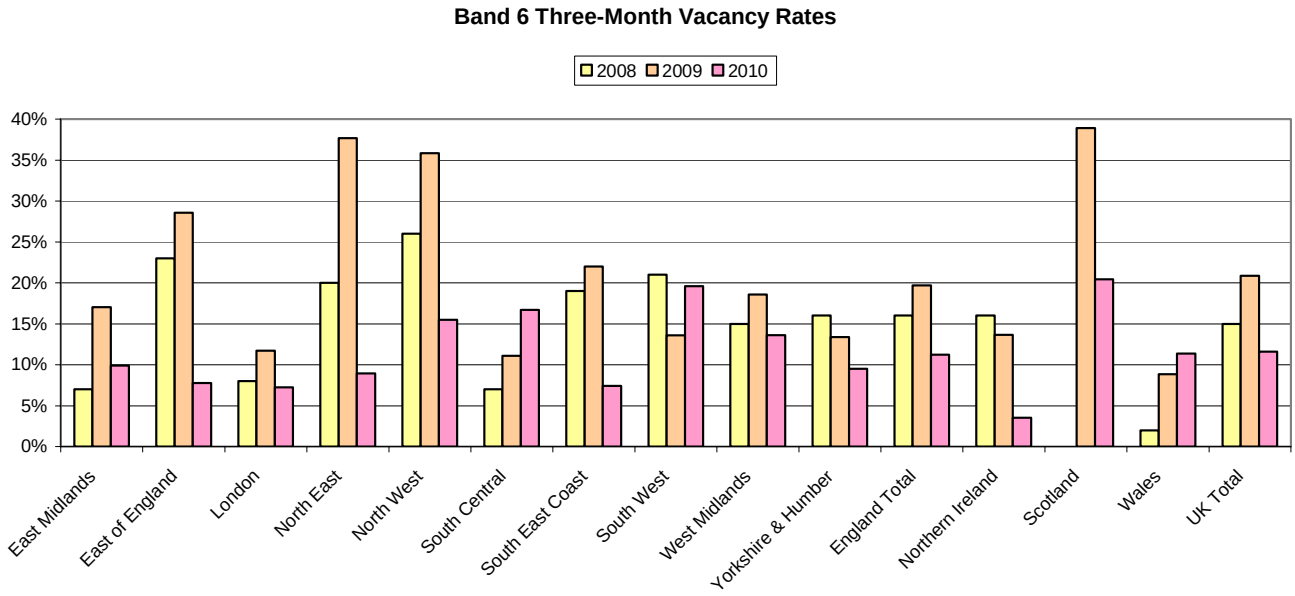
- For NHS Trusts in England the Band 6 three month vacancy rate is 11% (7-20% range across SHAs) compared with 20% in 2009, with the position improving in 8 SHAs and worsening in 2.

- The Band 7 three month vacancy rate for NHS Trusts in England is 13% (5-26% range across SHAs) compared with 14% in 2009, with the position improving in 5 SHAs and worsening in 5**.**
- For primary care organisations across the 4 countries Band 6 posts are rarely if ever used; at Band 7 the England 3 month vacancy rate is 13% (0%-35% range across SHAs) compared with 19% in 2009.
- On average across England 77% (53-89% range across SHAs) of NHS Trusts have no or one Band 6 vacancies, whilst 23% (11-47% range across SHAs) have 2 or more vacancies. Similarly at Band 7 80% (46-95% range across SHAs) of NHS Trusts have no or one vacancies and 20% (5-54%) have two or more vacancies.
- There continues to be significant variation in vacancy rates across the SHAs in England and between the four UK countries. This year the data have been analysed to identify variations between individual trusts across England indicating local, as well as regional and national, variation in recruitment and retention.
- Band 7 and 8 posts in both NHS Trusts and primary care organisations in England have increased by around 18% between 2008 and 2010, with a small decrease in Band 6 posts over the same period and a significant fall in Band 5 (pre-registration) posts in 2007/08.
- A total of 52 Band 6 and 45 Band 7 posts, representing around 3% of the Band 6 and 7 establishment, have been either frozen or dis-established since May 2009. This suggests that improvements seen in 2010 vacancy rate figures are due largely to improved recruitment and retention.
- There has been a 45% increase in Band 5 training posts across England and a moderate improvement in retention on registration since 2008, with a positive impact on the vacancy level at Band 6. Preliminary (and as yet incomplete) data from the 2010 exit surveys of those registering currently suggests that retention in the NHS at registration may have fallen back in 2010 – a range of reasons are provided.

Band 6 and 7 vacancy data

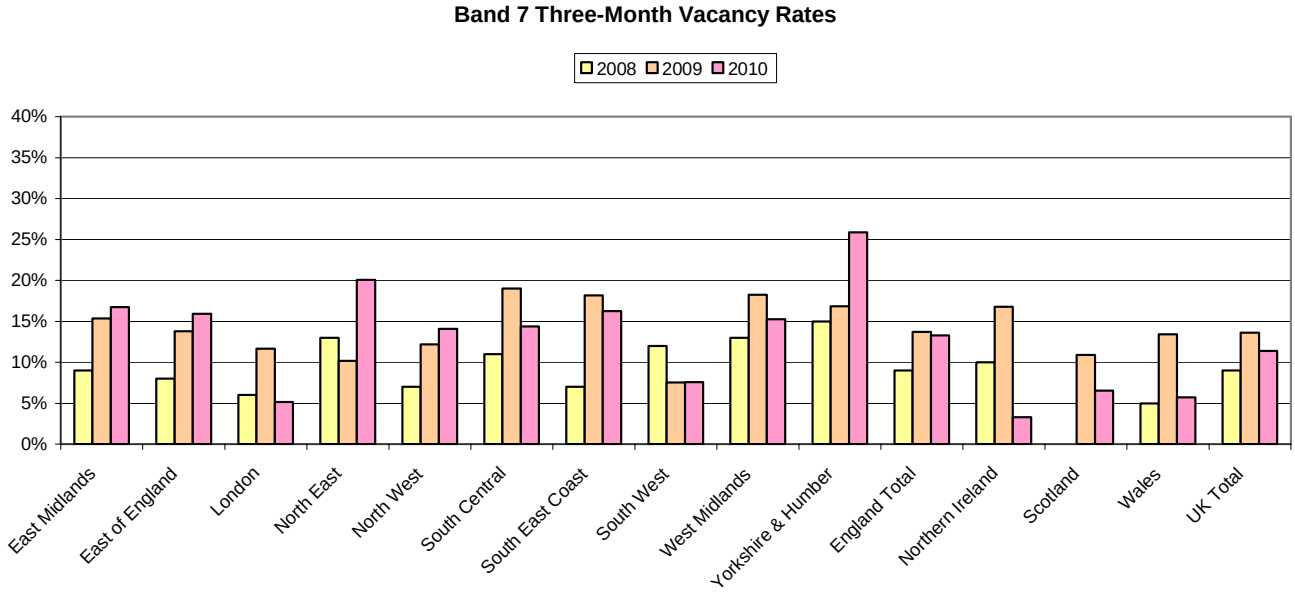
The following charts demonstrate the 3 month vacancy rates for NHS Trusts in each Strategic Health Authority (SHA) and the total for England, and compare these data with the vacancy rate in Scotland, Northern Ireland and Wales. The 2010 data are compared with 2008 and 2009 for Band 6 (Table 1) and Band 7 (Table 2). Table 3 details the data used to generate tables 1 and 2.

Table 1 NHS Trusts: Band 6 three month vacancy rates 2008 – 2010



For NHS Trusts in England the Band 6 three month vacancy rate is 11% (range across SHAs 7-20%) compared with 20% in 2009, with the position improving in 8 SHA's and worsening in 2.

Table 2 NHS Trusts: Band 7 three month vacancy rates 2008 – 2010



The Band 7 three month vacancy rate for NHS Trusts in England is 13% (range across SHAs 5-26%) compared with 14% in 2009, with the position improving in 5 SHAs and worsening in 5.

For primary care organisations across all four countries Band 6 posts are rarely if ever used. However, at Band 7 the England 3 month vacancy rate is 13% (range across SHAs 0%-35%) compared with 19% in 2009. See Table 9 for the datasets.

Data collected relating to posts dis-established and "at risk" in 2010 (see Table 11) demonstrates that whilst there has been a small reduction in the number of band 6 and 7 posts being recruited to (circa 3%), since the last data collection in 2009, this will have had little impact on the overall vacancy rate. Improvements seen in 2010 figures are therefore due to improved recruitment and retention.

Locum use

In 2010, 57% of Band 7 three month vacancies and 58% of Band 6 three month vacancies were filled with a locum in England. The use of locums varies from 9 to 100% of vacancies across the different SHAs and bands, with locum use highest at Band 7. See Table 12 for details.

Variations in vacancy rates

There continues to be variation between SHA vacancy rates (See Tables 1 and 2 above and Table 9) and between country vacancy rates at Band 6 and 7 in both NHS Trusts and Primary Care Organisations. There is also variation between 3 month vacancy rates across the four countries – see Table 3.

Table 3: Three month vacancy rates in NHS Trusts across England, Northern Ireland, Scotland and Wales:

	2008 Band 7	**2008 Band 6**	**2009 Band 7**	**2009 Band 6**	**2010 Band 7**	**2010 Band 6**
England	9%	16%	14%	20%	13%	11%
Northern Ireland	10%	16%	17%	14%	3%	4%
Scotland	-	-	11%	39%	7%	20%
Wales	5%	2%	13%	9%	6%	11%
UK Total*	**9%**	**15%**	**14%**	**21%**	**11%**	**12%**

**Scotland is excluded in 2008 as Scotland did not participate in the 2008 survey.*

Furthermore, there is considerable variation between vacancy rates in individual Trusts across all SHAs, indicating that there are local/ geographical issues in relation to recruitment and/or retention. On average across England 77% (range 53-89%) of NHS Trusts have no or one Band 6 vacancies whilst 23% (range 11-47%) have 2 or more vacancies. Similarly at Band 7 80% (range 46-95%) of NHS Trusts have no or one vacancies and 20% (range 5-54%) have two or more vacancies. The range data is illustrated below in Table 4. See also Table 13.

Thus, whilst overall Band 7 vacancy has dropped from 14% to 13% in England, looking across England, 80% of Trusts have no vacancies at this level.

Table 4: Band 6 and 7 three month vacancy rates in Trusts for different SHAs

	Band 7		Band 6	
SHA	**0 or 1 vacancy**	**2 or more vacancies**	**0 or 1 vacancy**	**2 or more vacancies**
East Midlands	46%	54%	78%	22%
South West	95%	5%	53%	47%
Yorks & Humber	75%	25%	89%	11%
England	**80%**	**20%**	**77%**	**23%**

The variation is further highlighted by comparing the positions for individual NHS Trusts between 2009 and 2010; four examples are highlighted in the Table 5 below. This demonstrates that the vacancy position in individual trusts can vary between years with some trusts maintaining consistently high or low rates and others reversing the position over 12 months.

Table 5: Band 6 Vacancy numbers 2009 and 2010

			2009		2010	
	SHA	**Trust**	**Total Posts**	**Posts Vacant for more than 3 months**	**Total Posts**	**Posts Vacant for more than 3 months**
Consistently low vacancy rate	Yorkshire & Humber	Trust A	24	0	22	0
Consistently high vacancy rate	East Midlands	Trust B	8	6	8	4
High rate ’09 to low rate in ‘10	North East	Trust C	17	10	16	1
Low rate in ’09 to high rate in ‘10	North West	Trust D	6	0	8	4

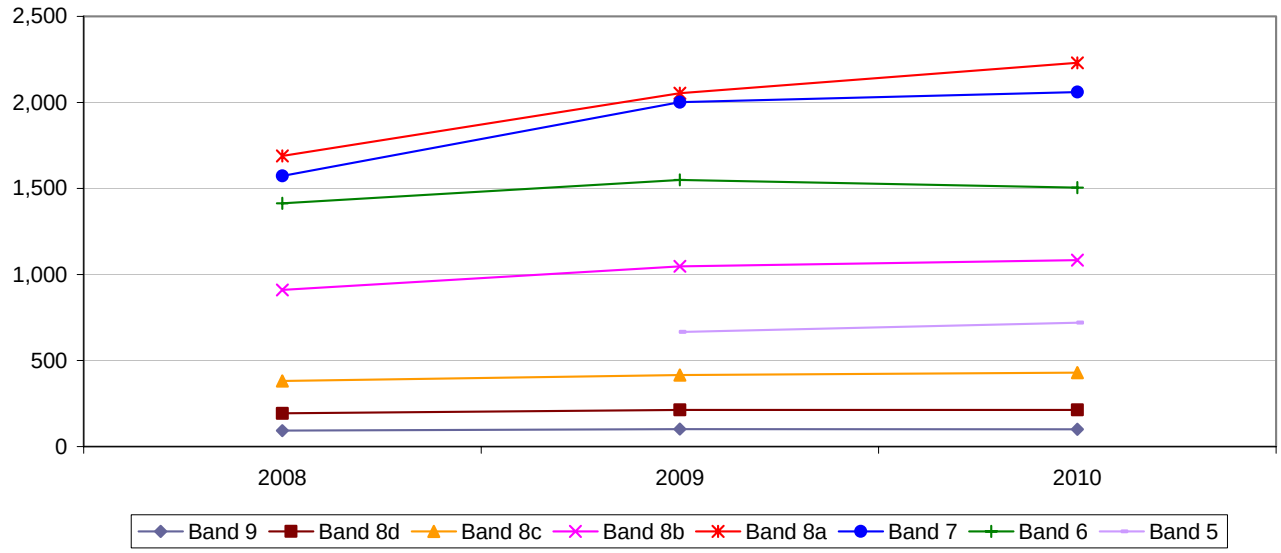
**Figures rounded to whole numbers*

Established posts: trends

Table 6 below demonstrates the changes in establishment numbers between 2008 and 2010 for NHS Trust Bands 5 (pre-registration trainees), 6,7, 8 (a, b, c and d) and 9 in England. There has been a significant growth in Band 7 and 8a posts in NHS Trusts between 2008 and 2010, but no growth in Band 6 posts. Table 7 shows the number of additional posts in primary care organisations. Full PCT datasets are provided in Table 14. Furthermore, Band 7 and 8 posts in PCTs have increased, but, as primary care organisations train very few Band 5 and Band 6 pharmacists, they recruit heavily from amongst the NHS Trusts. See Table 15 and 16.

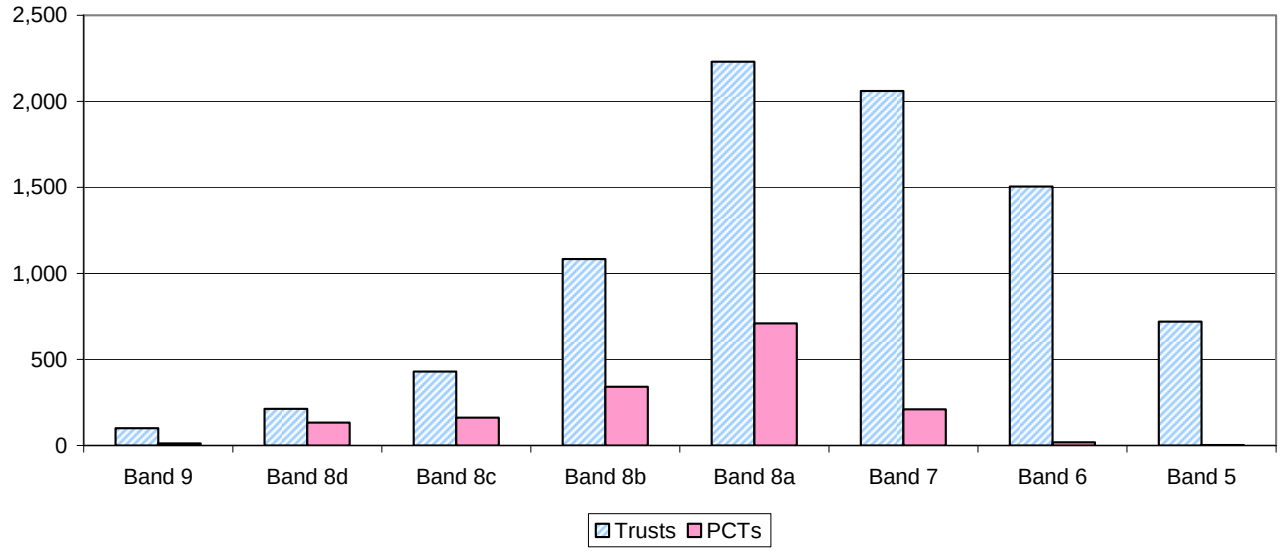
The DH strategy to increase the commissioning of Band 5 pre-registration posts, and to improve in the NHS retention on registration, has eased the situation somewhat at Band 6, but increases in band 7 and 8 establishments in Trusts and PCTs have limited the overall impact at Band 7, where supply is just is potentially lagging behind demand.

Table 6: Trend in Number of Established Posts in Trusts



Additional information, not plotted in Table 6 relating to training numbers is provided in Table 17.

Table 7: Number of Established Posts in 2010



Discussion

Overall the trends revealed in 2010 PEV survey are heading in the right direction with regard to the immediate challenge of Band 6 and 7 three month vacancy rates. Steps to increase training numbers (at Band 5) and retention at registration have positively influenced Band 6

three-month vacancy levels. Three month band 7 vacancy rates have also improved slightly, despite significant increases in establishment at this level in Trusts and PCTs across England.

There continues to be variation in three month vacancy rates at national level between England, Northern Ireland, Scotland and Wales and across England at SHA and Trust level. For the first time this year the data has been analysed at trust leve,l demonstrating wide variation between three month vacancy rates across different Trusts in each SHA.

Data relating to frozen and dis-established posts indicate that improvements in three month vacancy rates can be attributed to improvements in recruitment and retention, not simply to a falling establishment level.

Training numbers at Band 5 have increased significantly since the low point in 2007 and so far have been sustained at pre 2009 levels for 2011. There are early signs that education and training cuts may impact on the recruitment to Band 5 training posts in 2012, but as yet there is no sign that demand for Band 6 and 7 posts is falling. Current levels of dis-established or frozen posts do not indicate a reduction in demand in 2009/10.

Analysis of establishment figures, as well as vacancy rates, this year indicate that demand for Band 7 and 8 posts grew in 2008, in both trusts and PCTs in England. This would have contributed to the three month vacancy rates noted by the NHS PRB. This has, to some extent, been ameliorated by increasing supply of Band 6, newly registered, pharmacists. It does, however, indicate the need for better strategic planning of the pharmacist workforce to ensure that demand does not run significantly ahead of supply in the future..

It is not possible from the PEVS data to identify turnover amongst Band 6 and Band 7 pharmacists, but this should be considered as part of the ESR project.

Differences between the National NHS Pharmacy Staffing Establishment & Vacancy Survey data (carried out by NHS PEDC) and the NHS Information Centre's NHS Workforce Census and NHS Workforce Vacancy Survey data

Background

The NHS Pharmacy Education & Development Committee (NHS PEDC) has surveyed the NHS pharmacy workforce for several years; the activity started because workforce information made available centrally (e.g. English SHA data) and from HR departments was proving to be incomplete and/or inaccurate. The purpose of the National NHS Pharmacy Staffing Establishment & Vacancy Survey is to provide a picture of workforce requirements to provide NHS pharmacy services within NHS organisations (the Staffing Establishment), and the extent of the vacancy rates within this requirement, both of which can then be used to inform workforce planning activity and, in turn, discussions at local and SHA/home country level, to inform both workforce planning and education commissioning of trainee places at SHA/home country level.

Issue

As a result of differences between the data reported by the NHS Information Centre's (NHS IC's) NHS Workforce Census and NHS Workforce Vacancy Survey for England, and those reported in the National NHS Pharmacy Staffing Establishment & Vacancy Survey carried out by the NHS PEDC, the Department of Health in England asked the NHS PEDC to work with the NHS IC to explain the discrepancies between the two English data sets. The two organisations have met on three occasions over the last 12 months and carried out some subsequent work (see below and attached). This paper serves to explain the discrepancies and actions being taken to try to streamline some activities.

Table 8. Key differences between the two data

	NHS Information Centre	**National NHS Pharmacy Staffing Establishment and Vacancy Survey**
1. Data collection date	Staff in post 30 September 2008; Vacancy rates 31 March 2009	31 May 2009
2. Data source	Human Resources departments in NHS organisations, using the ESR	Pharmacy departments / Chief Pharmacists in NHS organisations
3. How is vacancy rate calculated?	Total vacancy rates are calculated using: (total number of FTE vacancies) divided by the (FTE staff in post plus total number of vacancies). Three month vacancy rates are calculated using: (number of 3 month FTE vacancies) divided by the (FTE staff in post plus number of 3 month vacancies). The resulting total or three month ratio is expressed as a percentage. The FTE staff in post figures are taken from the workforce census results that were collected in the previous September.	Number of vacancies (FTE) as percentage of Staffing Establishment (FTE). Headcount numbers are **not** collected.
4. How is a vacancy defined?	A vacancy is defined as one which employers are actively trying to fill as at 31st March. A three month vacancy is defined as one which has lasted three months or more and which employers are actively trying to fill as at 31st March. Thus the emphasis is on vacancies which employers are finding hard to fill, rather than on normal staff turnover. It is acknowledged that with the introduction of the total vacancies, the denominator for both the three month rate and total vacancy rate should be based on staff in post plus total vacancies however in order to preserve the time series of three month data for comparability the above methods have been used.	"A post which is not currently filled by a permanently-employed member of NHS staff". Actual vacancies and 3-month vacancies are collected.
5. Definitions and coding issues	Terms / Codes used are not always clearly defined e.g. • Manager – Pharmacy • Pre-registration Pharmacy Trainee • MTOs • Technicians	• Pharmacist • Pharmacy Technician • Pre-registration Trainee Pharmacist • Pre-registration Trainee Pharmacy Technician • Pharmacy Assistant Clearly understood by the pharmacy community.
6. Data collected	NHS Vacancy Survey covering NHS staff (medical and dental, and non-medical) for all NHS organisations. Total numbers in group only e.g. total number of pharmacists	Above groups broken down into Agenda for Change Bands. Data are collected separately for acute & mental health NHS trusts and PCTs, and then amalgamated.
7. Reasons for carrying out the survey	The vacancy survey supplies evidence to Nursing Pay Review Body and to monitor NHS Planning and Priorities Framework Targets at national and regional level to help balance supply and demand of workforce numbers. The Workforce Census collection informs the national workforce planning agenda and key customers and stakeholders include the DH, the 10 SHAs, Deaneries, NHS Employers and other national workforce planning bodies.	To provide a picture of workforce requirements to provide NHS pharmacy services within NHS organisations, and to inform workforce planning activity & discussions.

ESR = Electronic Staff Record

Note: The NHS IC is unlikely to carry out its vacancy survey/report in this way beyond 2010; it is considering getting its vacancy information from alternative administrative sources (e.g. NHS Jobs) in the future, but this is not yet confirmed. NHS IC is likely to continue to look at posts which are being actively recruited into (N.B. Pre-registration trainee pharmacist posts are recruited using the National Recruitment Scheme and **NOT** via NHS Jobs)

Further explanations / implications of the differences & actions being taken

1. Data collection dates

Rather than duplicating data collection activity, the NHS IC requests vacancy information on 31 March each year and uses the Staff in Post figures from the census in September of the previous year to calculate the percentage of vacancies. The NHS IC acknowledges the limitations of this (see below), and as the Electronic Staff Record (ESR) develops, more frequent and timely data collection will be carried out. The NHS PEDC asks for Vacancy data and Staffing Establishment data on 31 May each year.
It is acknowledged that data collection at this time of year is likely to reflect some of the highest vacancy rates in the calendar year, just before the cohorts of pre-registration trainee pharmacists and pre-registration trainee pharmacy technicians qualify, particularly for Band 6 pharmacist posts and Band 4 pharmacy technician posts. 31 May continues to be the preferred data collection date as accurate trend data over the last few years would be lost if the date is changed. The NHS IC and NHS PEDC are in agreement with this; because other things are different, particularly the definition of a vacancy and the methods of vacancy calculations, a direct comparison between the two sets of data would still not be possible even if the dates were aligned.

In addition, following a meeting early in 2009, it was agreed that the NHS PEDC would collect data from two or three trusts in each SHA (a District General Hospital-type trust and a large teaching trust) on 31 March 2009 as well as 31 May 2009 so that the data obtained could both be compared with the NHS IC report based on data from 31 March, and also with the NHS PEDC data collection exercise on 31 May (see separate report).

2. Data source

Whatever the data source, NHS staff completing returns need to have been appropriately trained and/or have access to clear guidance notes for definitions and coding usage to enable consistent usage and a meaningful return. HR departments have to deal with a host of NHS posts whereas pharmacy departments will have a deeper understanding of pharmacy workforce issues. (See below).

3. How is vacancy rate calculated?

The NHS IC calculates the total vacancy rate as the total number of FTE vacancies on 31 March 2009 as a proportion of the sum of FTE staff in post as at September 2008 plus total number of vacancies in March; i.e. vacancy figures and staff in post figures are collected at different times of the year. The NHS IC acknowledges that this definition is limited because it does not take into account vacant posts in September 2008 or use Staffing Establishment, which better reflects the workforce required. NHS IC aspires to using the Electronic Staff Record (ESR) to obtain Staffing Establishment data and change its calculation of vacancy rates to being a proportion of Staffing Establishment in the future. (The ESR already has the

ability to capture Staffing Establishment information; however, the ESR is not currently being used for this purpose by many NHS organisations).

NHS PEDC calculates the vacancy rate on 31 May as a proportion of Staffing Establishment on 31 May, so better reflects the vacancies as a proportion of staffing required to deliver services at the time.

4. How is a vacancy defined?

The NHS IC defines a vacancy as "A vacancy is defined as one which employers are actively trying to fill as at 31st March".

The NHS PEDC defines a vacancy as "A post which is not currently filled by a permanently-employed member of NHS staff".

Until recently, the NHS IC only collected 3-month vacancy data. A three month vacancy is defined as "one which has lasted three months or more and which employers are actively trying to fill as at 31st March". Thus the emphasis is on vacancies which employers are finding hard to fill, rather than on normal staff turnover.

The NHS PEDC only collected actual current vacancy rates. For the last two years, both organisations have collected actual and 3-month vacancy data, thus facilitating more meaningful comparisons.

4.1. Limitations of the above definitions.

There are limitations to both of the above definitions of a vacancy:
There are a number of reasons why an NHS organisation may not be actively recruiting into a vacant post on the date of the survey:

1. **The post has already been filled but the new incumbent has not yet started.** This is often the case for Band 6 pharmacist posts, as pre-registration trainee pharmacists are often recruited early in the new year to fill posts in August of the same year on registration.

2. **Financial pressures (end of financial year or fiscal climate generally) mean that the post is not being recruited into.**

3. **The post is being filled on a temporary basis by locum/agency staff.** This is often the case for pharmacists, as
it is difficult to recruit into Band 6 posts between summer periods when newly qualified staff complete their training, therefore preventing NHS organisations from investing in recruitment rounds which they perceive as likely to be unsuccessful.

Maternity leave

A post filled by a member of staff who is on maternity leave would be classed as a vacancy under the NHS IC definition if a short-term recruitment process is under way to cover the M/L, but not if it isn't.

The post would not be classed as vacant using the NHS PEDC definition, as it is currently filled by a permanently employed member of NHS staff (who happens to be on M/L).

Locum/agency staff

A post filled by a locum or agency staff would be classed as a vacancy under the NHS IC definition if a recruitment process is under way, but not if it isn't.
The post would be classed as vacant using the NHS PEDC definition, as it is not currently filled by a permanently employed member of NHS staff.

This difference is important as anecdotally, pharmacy managers report that the use of locum/agency staff can limit their service provision, particularly during evening / weekend shifts, as locum staff choose when they want to work rather than when the service is required. In addition, it is more difficult to cover a vacancy at more senior levels, where specialist expertise and / or consistent input is required to deliver a particular service; often more senior vacancies are left vacant for this reason.

5. Definitions and coding issues

The pharmacy community understands that there are three staff groups requiring professional training and or registration to meet with professional body requirements, who may be in training, making the following five groups:

- Qualified pharmacist
- Pre-registration trainee pharmacist
- Qualified pharmacy technician
- Pre-registration trainee pharmacy technician
- Pharmacist assistant (who may or may not be in training)

The NHS Information Centre's coding guidance refers to pharmacy staff collectively. To those within the pharmacy community it is unclear what is meant by terms such as:

- Manager – pharmacy (could be a pharmacist or not?)
- Pre-registration pharmacy trainee (could be either a pre-registration trainee pharmacist or pre-registration trainee pharmacy technician)
- Technician (could be a pharmacy technician or another type of technician)

Actions:

1. NHS PEDC has met with the NHS IC's Workforce Information Review Group (WIRG) and is currently reviewing coding definitions to provide clear guidance of codes to be used for various staff groups. This piece of work should be completed in the first half of 2010, after which HR departments should have clearer coding guidance, and pharmacy departments will be better equipped to work with HR departments to achieve greater consistency and accuracy of pharmacy workforce information.

2. The NHS IC intends to gather workforce data more frequently and in a more timely way in future. E.g. from July 2010 onwards, the current proposal out for consultation is for **monthly** Staff In Post figures to be made available using an extract taken directly from ESR (April's figures will be available in July, May's figures available in August, and so on). NHS PEDC will be able to request access to this information when required. In the longer term, NHS PEDC could use it to feed the workforce staff in post numbers into the vacancy survey data.

This would ensure pharmacy departments work with HR departments to ensure accurate collection and coding of pharmaceutical staff at source and reduce pharmacy departments burden on completing the survey.

3. NHS PEDC and NHS IC have agreed to continue to work together to increase mutual understanding and streamline processes as far as is practicable.

Table 9 Datasets: NHS Trusts Band 6 and 7 3 month vacancy rates

	2008		2009		2010	
SHA	**Band 7**	**Band 6**	**Band 7**	**Band 6**	**Band 7**	**Band 6**
East Midlands	9%	7%	15%	17%	17%	10%
East of England	8%	23%	14%	29%	16%	8%
London	6%	8%	12%	12%	5%	7%
North East	13%	20%	10%	38%	20%	9%
North West	7%	26%	12%	36%	14%	15%
South Central	11%	7%	19%	11%	14%	17%
South East Coast	7%	19%	18%	22%	16%	7%
South West	12%	21%	8%	14%	8%	20%
West Midlands	13%	15%	18%	19%	15%	14%
Yorkshire & Humber	15%	16%	17%	13%	26%	10%
England	**9%**	**16%**	**14%**	**20%**	**13%**	**11%**
Northern Ireland	10%	16%	17%	14%	3%	4%
Scotland	-	-	11%	39%	7%	20%
Wales	5%	2%	13%	9%	6%	11%
UK Total*	**9%**	**15%**	**14%**	**21%**	**11%**	**12%**

**Scotland is excluded in 2008 as Scotland did not participate in the 2008 survey.*

Table 10 Datasets: PCT/LHB Band 6 and 7 3 month vacancy rates

	Band 7			Band 6		
	2008	**2009**	**2010**	**2008**	**2009**	**2010**
East Midlands	11%	7%	0%		0%	0%
East of England	7%	8%	9%		0%	0%
London	27%	18%	26%	23%	28%	0%
North East	0%	100%	0%			
North West	15%	22%	11%	0%		
South Central	15%	26%	0%	0%		
South East Coast	23%	26%	14%	0%	0%	0%
South West	45%	6%	0%		0%	0%
West Midlands	36%	0%	35%		0%	
Yorkshire & Humber	15%	27%	22%			
England Total	**19%**	**19%**	**13%**	**16%**	**15%**	**10%**
Northern Ireland	0%	0%	0%			
Scotland		19%	12%		53%	11%
Wales	0%	17%				
UK Total	**18%**	**19%**	**12%**	**16%**	**21%**	**10%**

Table 11 Datasets: Number of Posts De-established and "At Risk" since 31st May 2009 in Trusts

	NHS Trusts	NHS Trusts	Primary Care	Primary care
	Band 7	**Band 6**	**Band 7**	**Band 6**
East Midlands	(126) 5	(81) 1	(9) 1	(1) 1
East of England	(148) 4	(101)4	(18) 1	(2) 0
London	(403) 8	(317)16	(30) 3	(5) 1
North East	(91) 2	(54) 3	(3) 0	(0) 0
North West	(207) 9	(168) 6	(47) 3	(0) 1
South Central	(113) 4	(87) 8	(14) 0	(0) 0
South East Coast	(108)2	(88) 2	(13) 0	(1) 0
South West	(127) 4	(107) 5	(13) 0	(1) 0
West Midlands	(120) 3	(110) 3	(3) 0	(0) 0
Yorkshire & Humber	(136) 6	(105) 4	(15) 5	(0) 0
England Total	**(1578)45**	**(1218)52**	**(166) 11**	**(10) 3**

Table 12 datasets: Locum Use

	Band 7	**Band 6**
East Midlands	(21) 13	(8) 1
East of England	(24) 17	(8) 9
London	(21) 33	(23) 21
North East	(18) 3	(5) 5
North West	(29) 16	(26) 9
South Central	(16) 7	(15) 4
South East Coast	(18) 10	(6) 13
South West	(10) 4	(21) 3
West Midlands	(18) 15	(15) 10
Yorkshire & Humber	(35) 3	(10) 5
England	**(209) 120**	**(137) 80**
Northern Ireland	(6) 2	(3) 3
Scotland	(15) 14	(27) 6
Wales	(4) 1	(8) 0
United Kingdom	**(234) 137**	**(174) 89**

(Number of 3-month vacancies in brackets)

Table 13 Datasets: Proportion of Trusts in Each SHA with a Band 7/6 Vacancy Problem

	Band 7		Band 6	
SHA	**0 or 1 vacancy**	**2 or more vacancies**	**0 or 1 vacancy**	**2 or more vacancies**
East Midlands	46%	54%	78%	22%
East of England	77%	23%	82%	18%
London	90%	10%	83%	17%
North East	82%	18%	88%	13%
North West	76%	24%	71%	29%
South Central	80%	20%	67%	33%
South East Coast	80%	20%	83%	17%
South West	95%	5%	53%	47%
West Midlands	76%	24%	75%	25%
Yorkshire & Humber	75%	25%	89%	11%
England	**80%**	**20%**	**77%**	**23%**
Northern Ireland	50%	50%	80%	20%
Scotland	69%	31%	64%	36%
Wales	88%	13%	67%	33%
UK Total	**79%**	**21%**	**76%**	**24%**

*Excludes those with no posts in the appropriate band
**Posts vacant for more than 3 months

Table 14 Datasets; NHS Trusts Number of Established Band 7/6 Posts in each SHA

	2008		2009		2010	
	Band 7	**Band 6**	**Band 7**	**Band 6**	**Band 7**	**Band 6**
East Midlands	117	79	124	76	126	81
East of England	122	115	146	111	148	101
London	353	351	377	342	403	317
North East	83	62	84	62	91	54
North West	155	191	193	173	207	168
South Central	97	87	104	83	113	87
South East Coast	84	80	100	78	108	88
South West	108	99	117	99	127	107
West Midlands	110	101	112	107	120	110
Yorkshire & Humber	120	112	125	112	136	105
England Total	**1,349**	**1,277**	**1,481**	**1,242**	**1,578**	**1,218**
Northern Ireland	144	80	182	88	182	85
Scotland	-	-	268	158	223	131
Wales	79	57	70	62	77	71
UK Total	**1,572**	**1,414**	**2,001**	**1,550**	**2,060**	**1,504**

*Scotland is excluded in 2008 as Scotland did not participate in the 2008 survey
**Figures rounded to whole numbers

Table 15 Datasets: Number of Band 7 & 6 Posts in PCT/LHBs***

	Band 7			Band 6		
	2008	**2009**	**2010**	**2008**	**2009**	**2010**
East Midlands	9	8	9	0	10	1
East of England	15	12	18	0	1	2
London	24	29	30	9	10	5
North East	1	1	3	0	0	0
North West	47	44	47	2	0	0
South Central	12	12	14	1	0	0
South East Coast	13	16	13	1	1	1
South West	12	16	13	0	2	1
West Midlands	3	2	3	0	2	0
Yorkshire & Humber	18	18	15	0	0	0
England Total	**155**	**156**	**166**	**12**	**25**	**10**
Northern Ireland	4	2	2	0	0	0
Scotland	-	34	43	-	5	8
Wales	7	2	-	0	0	-
UK Total	**166**	**194**	**210**	**12**	**30**	**19**

Table 16 Datasets: Number of Band 8 Posts in PCT/LHBs***

	Band 8d			Band 8c			Band 8b			Band 8a		
	2008	**2009**	**2010**	**2008**	**2009**	**2010**	**2008**	**2009**	**2010**	**2008**	**2009**	**2010**
East Midlands	6	6	6	13	16	15	31	32	27	33	38	39
East of England	12	16	16	19	18	20	18	23	23	37	47	43
London	25	29	27	20	21	20	40	46	45	78	85	86
North East	5	5	4	3	3	5	24	28	29	34	39	27
North West	15	15	14	16	17	16	57	55	56	59	81	85
South Central	10	9	9	10	5	7	17	19	22	25	30	34
South East Coast	6	9	12	9	10	12	20	18	16	35	53	46
South West	8	6	8	7	10	11	15	9	22	18	20	45
West Midlands	7	12	14	13	15	20	25	21	24	68	80	84
Yorkshire & Humber	3	7	6	20	20	19	18	18	17	63	69	71
England Total	**96**	**115**	**115**	**130**	**135**	**144**	**266**	**270**	**281**	**451**	**541**	**561**
Northern Ireland	4	1	1	1	3	3	6	4	2	17	10	23
Scotland	-	13	17	-	15	16	-	52	59	-	146	125
Wales	1	0	-	18	18	-	6	8	-	35	39	-
UK Total	**101**	**129**	**133**	**149**	**171**	**163**	**278**	**334**	**342**	**503**	**736**	**709**

***Data was not collected for Scotland in 2008. Data is not available for Band 5 for 2008. In 2010 data for LHBs for Wales was provided with the trusts data. Figures may not add up due to rounding.

Table 17 datasets: (Band 5) Pre-registration commissions 2006 - 2010

SHA						Planned (Aug 10)
	06/7	**07/8**	**08/9**	**9/10**	**10/11**	**11/12**
East Midlands		36	37	38	39	38
East of England		49	66	68	75	72
London		118	185	194	216	205
North East		26	35	40	39	37
North West		52	64	68	74	72
South Central		34	32	39	44	44
South East Coast		34	37	38	44	44
South West		26	28	34	40	35
West Midlands		45	42	45	51	51
Yorks & Humber		57	55	62	71	64
Total	**540**	**477**	**581**	**626**	**693**	**662**

Table 18 datasets: retention rates at registration

SHA	**% Retention 07/08**	**% Retention 08/09**	**% Retention 09/10**
East Midlands	76	73	76*
East of England	74	63	59*
London	49	50	47*
North East	64	82	68*
North West	73	74	67*
South Central	63	85	73*
South East Coast	60	75	55*
South West	85	83	88*
West Midlands	64	74	61*
Yorks &Humber	43	55	51*
Overall	**60**	**64**	**59***

* Still to be confirmed

PART 2:

DEVOLVED ADMINISTRATIONS

CHAPTER 6: EVIDENCE FROM THE WELSH ASSEMBLY GOVERNMENT

6.1 This Chapter represents the contribution from the Health and Social Services Directorate (NHS Wales) and complements the Chapters from the other Health Departments.

NHS Reform in Wales

6.2 There are many factors converging which require NHS Wales to urgently work to modernise, redevelop and balance front line hospital, community and primary care services and staffing. In addition, the significant financial challenges now facing the whole of the UK economy over the forthcoming years require urgent and radical action to be taken in order to create a sustainable health service for Wales.

6.3 Health policy is increasingly focusing on health care delivered closer to home; through integrated working across health and social care; with greater involvement of patients in decisions about their health and health care, as well as more public accountability and engagement of patients and communities in the design and delivery of services.

6.4 The NHS reform programme has created seven integrated Local Health Boards and three Trusts which abolish the boundaries between different organisations within the Health Service which hinder achievement of the above policy.

Five Year Service, Workforce and Financial Strategic Framework

6.5 The Framework develops coherent local, regional and all-Wales service, workforce and financial plans for the next five years. Delivering workforce change to empower the front line and modernise the workforce is a key component of this work and critical to its success is the engagement of staff and their representatives in the development of jointly owned solutions.

6.6 The aim of the Framework is to improve health and transform health services, to create a health system that is fit for purpose, one that is not just clinically and financially sustainable but that embeds excellence in all it does and places the patient at the centre of its planning. It sets out what is required to improve health outcomes, system performance and financial sustainability identifying workforce modernisation as a key area for achievement.

6.7 Empowering the front line will require modernising and aligning the workforce to make it more sustainable. There is a need to ensure the necessary skill-mix of workforce to provide required care sustainability and deploy workforce rationally to meet the activity demands required locally.

Total Staffing

6.8 As at 30 September 2009 there were:

- 21,585 qualified nursing, midwifery and health visiting staff in post, 159 (0.7%) more than the previous year;

- 11,202 scientific, therapeutic and technical staff in post, 360 (3.3%) more than the previous year; and
- 16,151 administrative and estates staff in post, 95 (0.6%) more than the previous year but a decrease in senior managers of 95 (8.9%) to 970 and a decrease in maintenance & works of 50 (4.1%) to 1,174.

Reduction in Vacancies

6.9 The latest information on NHS posts as at 30 September 2009 that have been vacant for three months or more, shows that the overall number of vacancies reported continues to fall. 170 posts had been vacant which represents a 24% decrease on the 224 vacancies reported 6 months earlier.

NHS Trust staff vacancies

	30 Sep 2009		30 Sept 2008		31 March 2008	
	Per Cent	Number	Per cent	Number	Per cent	Number
All qualified nurses, midwives and HVs	0.2	36.2	0.2	35.3	0.5	102.3
Unqualified Nurses, Midwives and Health Visitors	0.0	0.0	0.0	1.3	0.2	13.7
All qualified Allied Health Professionals	0.4	17.1	0.4	17.2	0.8	32.6
All qualified Scientific and Technical staff (a)	0.3	6.3	0.5	12.3	1.0	22.7
All qualified Healthcare Scientists	0.2	5.0	0.7	15.2	0.7	14.3
All unqualified Scientific and Technical staff	0.2	2.0			0.4	7.5
All other staff (excluding medical and dental	0.1	29.5	0.3	81.8	0.7	172.8

6.10 Looking in more detail at Allied Health Professionals Group, the figures are as follows:

	30 Sep 2009		30 Sept 2008		31 March 2008	
	Per cent	Number	Per cent	Number	Per cent	Number
Qualified Allied Health Professionals:						
Chiropodists	0.4	1.0	0.4	1.0	-	-
Diagnostic Radiographers	0.4	4.0	0.1	0.7	0.6	4.8
Therapeutic Radiographers	3.3	4.5	0.6	0.7	2.3	2.7
Dietetics	0.2	0.6	0.4	1.0	1.0	2.5
Occupational Therapists	0.4	5.1	0.6	6.5	0.8	8.1
Orthoptists/Optics	0.0	0.0	0.0	0.0	1.5	1.0
Physiotherapists	0.1	1.0	0.2	3.0	0.6	7.4
Speech and language therapists	0.2	1.0	1.1	4.4	1.6	6.0
Pharmacists	**-**	**-**	**1.0**	**4.8**	**1.9**	**8.2**

Staff Earning Under £21,000

6.11 The following table shows the number of staff (26,826) as at April 2010 by band and spine point who earn less than £21,000.

AfC Band	AfC Spinal Point	TOTAL FTE	Basic Salary
Band 1	1	147.72	£ 13,653
Band 1	2	413.71	£ 14,008
Band 1	3	1429.47	£ 14,364
Band 2	1	1034.87	£ 13,653
Band 2	2	1186.09	£ 14,008
Band 2	3	990.67	£ 14,364
Band 2	4	803.02	£ 14,779
Band 2	5	2475.47	£ 15,194
Band 2	6	1584.44	£ 15,610
Band 2	7	663.61	£ 16,145
Band 2	8	4538.79	£ 16,753
Band 2	no spine point	2.60	
Band 3	10	1056.77	£ 15,610
Band 3	11	1136.08	£ 16,145
Band 3	12	2749.40	£ 16,753
Band 3	6	577.02	£ 17,118
Band 3	7	758.99	£ 17,604
Band 3	8	1439.15	£ 18,152
Band 3	9	897.84	£ 18,577
Band 4	11	349.94	£ 18,152
Band 4	12	430.78	£ 18,577
Band 4	13	989.19	£ 19,250
Band 4	14	706.63	£ 19,933
Band 4	15	466.47	£ 20,554

Workforce Strategy

6.12 The overall direction of change is the development and implementation of a strategic workforce modernisation framework to ensure that NHS Wales has strategies in place to re-balance the workforce to support whole systems change through a shift from hospital to community and primary care supported by an increased proportion of the workforce who deliver care out of hospital. This should not only focus on future commissioning numbers but also clearly demonstrate progress to develop and retrain existing staff for new and extended roles.

6.13 The aims of the workforce modernisation programme are to:

- develop a strategic view of the workforce configuration and workforce numbers required to meet future, high quality, citizen centred service need, identifying solutions and facilitating implementation

- promote and encourage systems/processes where staff can be appropriately trained, developed, supported and empowered to deliver new models of care
- promote policies that will ensure that NHS Wales as part of the wider public sector, becomes an employer of choice which will be essential to attract and retain a committed and competent workforce.

6.14 An agreed baseline will be established to measure progress against a number of performance targets, for example: all organisations are expected to work towards achievement of a 10% increase in the proportion of staff providing services in a community setting, to be achieved between 2010 to 2013.

6.15 Last year we launched a new framework to provide guidance to nurses to help them develop fulfilling careers within the NHS in Wales and support modernising of services to improve patient care. The framework was developed in association with frontline nurses.

6.16 The Post Registration Career Framework sets out for the first time clear guidance for nurses in planning their future careers and provide opportunities for a highly skilled workforce.

6.17 New roles will be developed including a new 'rural practitioner' under the Rural Health Plan – multi-skilled professionals who will cover services across NHS Healthcare and social care to serve rural communities.

6.18 In the last year, a further 148 nurses, pharmacists and other health professionals commenced non medical prescribing programmes. This has led to these practitioners being able to conduct their own clinics which releases medical resources to be devoted to other more urgent clinical needs, meaning enhanced efficiency and service improvement.

6.19 Development of a new role of a Maternity Care Support Worker is also improving patient care by freeing up the time of more senior staff.

Annual Operating Framework Target for Workforce Redesign

6.20 All organisations must demonstrate changes to skill mix across all grades and bands which maximise the use of flexibilities available under the provisions of Agenda for Change and medical contracts. This skill mix change must ensure that staff are only deployed in roles and in a band which require their level of skill, knowledge and experience. This skill mix change must reflect growth in staff in Bands 1-4 of 3% per annum between 2010-2013.

6.21 Progress will be assessed through:

- baseline analysis of the full time equivalent and basic pay by A4C band and grade for medical staff, in the 12 month period to 1 April 2010. This will be repeated in the 12 month period to 31 March 2011;
- the number of medical staff positions; and

- analysis of average basic pay per employee, which will be expected to have reduced by 1% between 1 April 2010 and 31 March 2011. This figure will be adjusted to take account of pay awards and incremental drift.

6.22 This target represents intent to see a shift from the current pattern of skill mix to a more balanced workforce utilising all staff appropriately. The annual percentage will be dependent upon local factors; however the requirement to demonstrate change is essential.

6.23 Staff in all A4C bands should be supported to develop competencies to the maximum of the band descriptors. Additional competencies and training would be expected for those roles banded at assistant practitioner (band 4).

6.24 The AOF target refers to the whole workforce and all professions.

Education and Training Commissioning

6.25 The current economic climate provides new challenges to do more with what we have, but we are committed to ensuring appropriate numbers of training places are available. The number of training places for the academic year commencing September are based on what the NHS have determined will be their requirements for 2013 and beyond. The new places, in conjunction with students already undertaking training courses, bring the number of students in training to 6419 compared with last year's figure of 6387.

6.26 The places include an increase in community health nursing from 123 in 2009/10 to 170 in 2010/11, an increase of 38%, reflecting the NHS restructuring and the shift to provide more services closer to people's homes.

Agenda for Change

6.27 Good progress was made in agreeing KSF Post Outlines prior to the recent NHS Reforms in Wales with over 70% of staff having an agreed Outline as recorded via eKSF.

6.28 Evidence since then indicates that only about 20-30% of staff have used the system to record personal development reviews using eKSF. This has coincided with the period of NHS Reform in which the great majority of our NHS organisations have been through mergers with consequent changes in management arrangements. Concerns had also been expressed that the KSF documentation was daunting and inflexible. We have therefore been waiting for the outcome of the Institute of Employment Studies work as commissioned by the Social Partnership Forum in England.

6.29 Now that the report is available and been accepted by the NHS Staff Council, the Welsh Partnership Forum has commissioned a small Task Group to recommend the way forward in Wales under the direction of our National Leadership and Innovation Agency on making effective use of the KSF as part of our staff performance and development processes and in the context of the significant challenges facing NHS Wales as a whole in the coming years. This is expected to report by Spring 2011.

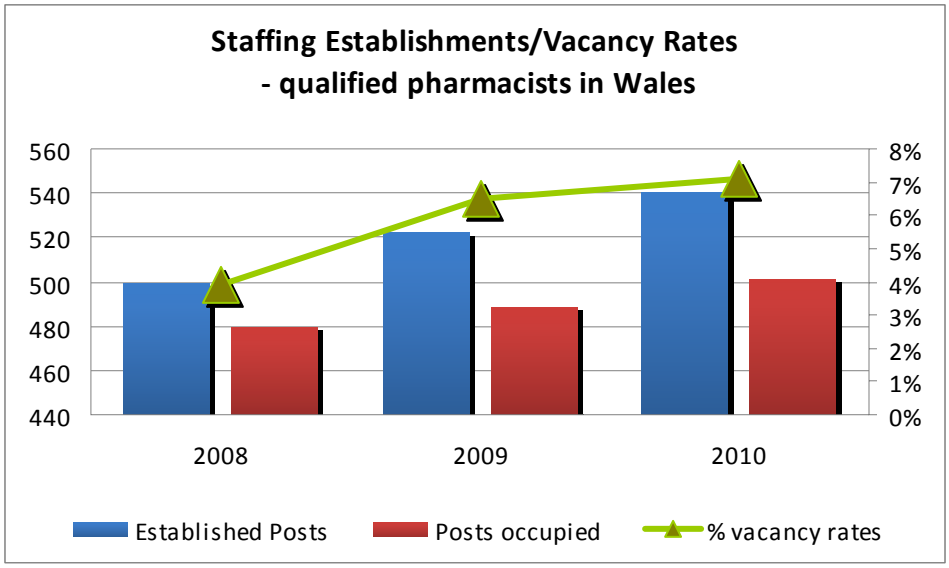
Pharmacy Vacancies Managed Service 2008-2010

6.30 Pharmacy in the managed service continues to have difficulty in recruitment due to competition from the community sector for pharmacists. Some recent work has been undertaken comparing the vacancy rates for pharmacists in Wales with elsewhere in the UK.

Overall vacancy rates for pharmacists in England vs Wales from 2008-2010:

	2008			2009			2010		
	No. FTE established posts	No. filled	Vac rate	No. FTE established posts	No filled	Vac rate	No. FTE established posts	No filled	Vac rate
England	6612.66	5693.98	13.9%	7064.53	6035.17	14.6%	7329.18	6459.12	11.9%
Wales	499.43	479.93	3.9%	522.38	488.60	6.5%	539.88	501.74	7.1%

6.31 Overall pharmacist vacancy rate in Wales remains lower than any other region or devolved administration in the UK.



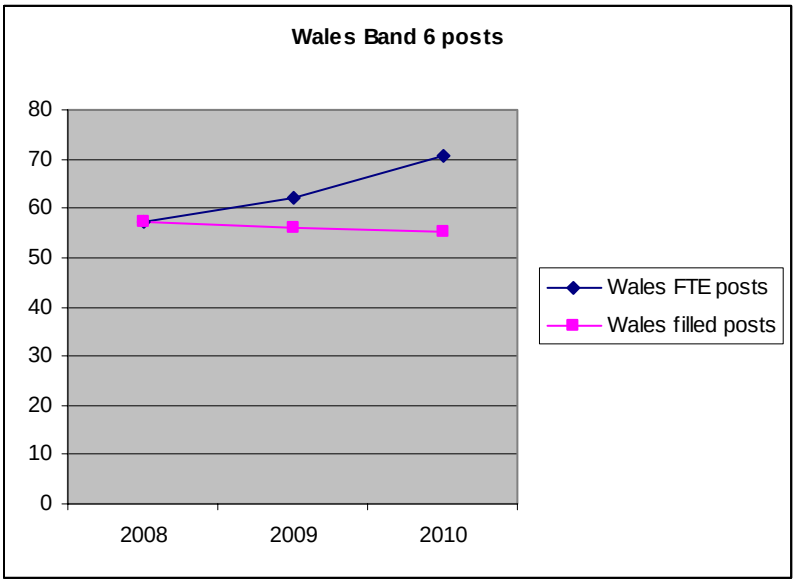
Rate of growth of established pharmacists posts 2008-2010 England vs Wales

6.32 Rate of growth in FTE posts has decreased in 2009-2010 compared to 2008-2009 however there has been consistent growth from 2008-2010.

	2008 – 2009		2009 -2010	
	Increase in FTE posts	% increase of 2008 posts	Increase in FTE posts	% increase of 2009 posts
England	451.87	6.8%	264.65	3.7%
Wales	23.95	4.6%	17.5	3.3%

Band 6 Pharmacists

	2008			2009			2010		
	No. FTE established posts	No. filled	Vac rate	No. FTE established posts	No filled	Vac rate	No. FTE established posts	No filled	Vac rate
England	1275.64	977.01	23.4	1241.95	938.87	24.4%	1218.09	1027.29	15.7%
Wales	57.4	57.4	0	62.30	56.20	9.8%	70.50	55.31	21.5%



6.33 Welsh vacancy rate for Band 6 pharmacist in 2010 is 21.5%.

- Most Band 6 pharmacist posts in Wales are training posts and carry a requirement to study for the Diploma in Clinical Pharmacy. They are 2 year posts fixed term.
- These posts are partly funded by NLIAH. This principle of funded band 6 posts attached to a Diploma in Clinical Pharmacy course of study has served us well in Wales and has attracted many recruits eg in 2008 the vacancy rate for band 6 posts in Wales was 0%

- Workforce returns resulted in an increase in the number of commissioned band 6 posts in the 2009 intake however the pre-reg pharmacist commissioned posts number, our main recruitment pool to band 6 pharmacist, did not increase until the following year due to the recruitment time lines.
- Last year a delay in the allocation from NLIAH combined with increasingly complicated recruitment procedures at Health Board level resulted in delayed advertisement of posts compared to those in England or those in community pharmacy.
- The result was an inability to recruit to all the posts advertised plus some commissioned posts did not even get to advert as they were blocked by the Health board and therefore increased the vacancy rate.

6.34 Increasingly pre-registration pharmacists – our main recruitment pool into band 6 posts - state increasing student debt and the need to earn more money as reasons for leaving the NHS and moving to community.

6.35 We believe that this increase was brought about by the particular circumstances outlined above and should not be repeated next year but we will continue to monitor the position closely.

Band 7 Pharmacists

6.36 The rate of vacancies at band 7 has fallen from 2009-2010.

6.37 The number of band 7 posts although increased from 2009 levels is still not as high as in 2008.

	2008			2009			2010		
	No. FTE established posts	No. filled	Vac rate	No. FTE established posts	No filled	Vac rate	No. FTE established posts	No filled	Vac rate
England							1577	1283.68	18.63%
Wales	86.86	81.72	5.9%	72.4	58.2	19.6%	77	68.6	10.9%

Information taken from:
National NHS Pharmacy Staffing Establishment and Vacancy Survey 2010 (personal communication)
National NHS Pharmacy Staffing Establishment and Vacancy Survey 2009
National NHS Pharmacy Staffing Establishment and Vacancy Survey 2008

Action taken by Health Boards

6.38 Pharmacy in Wales is active in reviewing skill mix and constantly reviews which service delivery roles can be undertaken by different members of staff in the pharmacy team.

6.39 Officials are currently looking at the gap in employment packages/salaries for newly qualified pharmacists between community and the managed sector with a view to suggesting an alternative remedy to recruitment and retention premia.

Midwives

6.40 The number of midwifery training places has increased in each of the last three years, with an increase from 110 in 2009 to 123 in 2010 indicating an identified increasing demand for midwives based upon anticipated retirement patterns of current staff and on predicted increase in the birth rate. In terms of numbers employed there were 1227 wte in 2009 compared with 1322.8 wte in 2008 – the re-configuration of services means that some management posts have been merged. There were no vacancies at 30/09/2009 compared with 3.0 wte vacancies at 30/09/2008 (0.2%).

NHS Wales Staff Survey

6.41 In view of the major reorganisation of NHS Trusts and LHBs, consideration is currently being given to the format and timing of the next All Wales NHS Staff Survey.

Finance

6.42 Annual growth in the Health and Social Services revenue budget has reduced from 5.2% in 2007/08 to 2.6% in 2010/11. The planning assumptions were for a reduction of 3% a year from 2011/12 onwards. Normal operational cost pressures add 3.5-4.5% to NHS operating costs each year, so the increasing gap between costs and funding is pushing up the requirement for savings well beyond the reach of basic efficiency and productivity savings.

6.43 Patient demands are becoming more complex overall, with an upward pressure on average "per capita healthcare costs" as a consequence of changing demography (this trend is expected to accelerate with the projected growth in the over 85 cohort of the population). In addition NHS cost inflation typically runs at 1-2% above RPI because of the impact on nationally negotiated pay awards and its dependence on high cost consumables (eg blood products) which are subject to high levels of annual cost inflation.

6.44 Even with growth of 2.6% in 2010/11 there was insufficient new funding to meet the impact of previous NHS pay awards. The NHS is targeting savings of £436m to break-even this year. Planning assumptions for the next 3 years from 2011/12 will require NHS organisations to reduce their costs by 7%pa or 19.6% over this period. This equates to a reduction of £1.1 billion on the current revenue budget over the next three years in addition to the current years target.

6.45 Following the announcement of the Comprehensive Spending Review, it is likely to take a number of weeks for the Assembly Government to work through the detail of the settlement and to make difficult decisions about its individual portfolio budgets. The total Assembly Budget (capital and revenue) is set to fall by around 3.1% per year on average and by 12% over the coming 4 years. This means that the Budget in 2014/15 will be £1.8 billion lower in real terms than it is this year.

6.46 The scale of the real terms reduction for the Health budget will become clear by the end of November/ beginning of December and at that point the outline financial plans for 2011/12 and beyond will need to be reviewed and revised as necessary to start to

progress next year's resource planning process (service capacity, workforce and finance) to be able to target its completion by early in the new calendar year.

Recommendation

6.47 **On the key issue which the NHSPRB is asked to consider this year, the Assembly Government agrees with the arguments set out in Chapter 4 of the Evidence and consequently believes it would be appropriate for a flat rate increase of £250 to be awarded to NHS staff in Wales earning less than £21,000 for 2011/12. On the basis of the figures in paragraph 6.9 this would cost about £8.0 million.**

CHAPTER 7:EVIDENCE FROM THE SCOTTISH GOVERNMENTHEALTH DIRECTORATES

Introduction

7.1 The following evidence has been prepared by the Scottish Government Health Directorates (SGHD) and informed by NHSScotland employers. It confirms the Scottish Government's endorsement of evidence given elsewhere that represents a Great Britain position.

7.2 The Scottish remit letter from the Cabinet Secretary for Health and Wellbeing to the NHS Pay Review Body (NHSPRB) submitted with this evidence, confirmed that, for 2011/12, the Scottish Government has announced a pay freeze for all public sector staff earning basic salaries of over £21,000 per annum. The Scottish Government has also made a commitment to protect those staff on low incomes and has already announced that no member of staff in the public sector should be earning less than the living wage of £7.15 per hour. We have also announced that staff earning basic salaries of less than £21,000 per annum should receive a minimum annual increase of £250. The remit given to the NHSPRB, therefore, seeks a recommendation on the level of uplift to be applied to those Agenda for Change staff who earn under £21,000 per annum.

7.3 The NHSPRB has also stated that it would wish to consider again the issue of a national recruitment and retention premium payment for hospital pharmacists at band 6 and 7 level of Agenda for Change. Our evidence this year, therefore, is in line with the remit and is set out as follows:

A. The Scottish Context
B. Resources, Affordability and Pay
C. Economic and Labour Market Conditions in Scotland
D. Workforce
E. Workforce Planning
F. Employee Experience, Morale and Motivation
G. Issues From Previous Reports (Pharmacists)
H. Conclusions

Section A – The Scottish Context

7.4 All pay policy for NHS staff in Scotland must be set within the context of the finance made available by Spending Review outcomes. The constraints of the Spending Review already mean that efficiency savings will have to be delivered by Boards in Scotland and this is addressed in more detail in the Resources, Affordability and Pay section of our evidence.

7.5 The Scottish Government recognises the need to exercise pay restraint in the public sector over the next few years whilst supporting the lowest paid staff where possible. As well as designing a pay policy which supports these aims, the Scottish Government wishes to go further in protecting the most vulnerable members of staff and has therefore announced the introduction of a minimum "living wage" rate of

£7.15 per hour for all public sector staff in Scotland. For Agenda for Change staff, this will mean not using Point 1 on the pay scale and ensuring all staff are on at least Point 2 which equates to £7.16 per hour.

7.6 In facing the challenges of the future, we are also committed to ensuring that resources are concentrated on frontline services. With this in mind, we have announced that we intend to reduce the number of senior managers in NHS Scotland by 25% over the next 4 years. This will mainly affect the NHSScotland Executive and Senior Management cohorts and is therefore outwith the remit of the Pay Review Body, although some of the target group for this exercise may include more senior non-clinical band 8 and 9 Agenda for Change staff.

7.7 In the context of tightening budgets, a stable and committed NHS Scotland workforce will be key to delivering the Scottish Governments policy objectives. Recognising the concerns that staff may have currently, the Cabinet Secretary for Health and Wellbeing has given three key assurances. First, that there will be no compulsory redundancies in NHS Scotland for the life of this Parliament; secondly, that quality of care will continue to be the guiding principle behind all decisions; and, thirdly, that by the end of the current Parliament there will be more people working in NHS Scotland than there were at its beginning.

7.8 Even in times of serious financial challenge the Scottish Government continues to set an ambitious agenda for continuous improvement in the NHS. NHS Scotland's Healthcare Quality Strategy (which can be found at: *www.scotland.gov.uk/Publications/2010/05/10102307/8*) was launched in May 2010 setting out the drivers for realising the shared aim of delivering the highest quality healthcare services to the people of Scotland. These drivers are framed around three Quality Ambitions: Safe, Effective and Person Centred care. The Quality Strategy builds upon existing foundations of quality in NHS Scotland and is a development of the policy direction set out in Better Heath, Better Care (2007). The Quality Strategy is based on three key Quality Ambitions. These are;

- Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.
- No avoidable injury or harm to people from healthcare they receive, with an appropriately clean and safe environment provided for the delivery of healthcare services at all times.
- The most appropriate treatments, interventions, support and services provided at the right time to everyone who will benefit, with wasteful or harmful variation eradicated.

7.9 The approach used to implement the Quality Strategy is grounded in the principles of mutuality and co-production, working with and through people to create and sustain a culture where quality thrives and where the contribution of every individual is recognised and valued at all levels. This reinforces the values of cooperation and collaboration with staff, patients, public and partners. Staff are valued and it is important that leadership is recognised at all levels and supported to do what they came into the NHS Scotland to do.

7.10 The implementation of the Quality Strategy will mean staff will be supported to make the changes needed to provide the highest quality healthcare. In order to achieve this, we will need to have a renewed focus on issues fundamental to our professional and clinical values such as clinical excellence, empathy and compassion for everyone working with and for NHSScotland. Staff who feel valued, respected and involved have been shown to deliver higher quality care for their patients. There is a recognised correlation between staff experience and wellbeing, and patient experience and wellbeing.

7.11 The Scottish Government is establishing the Quality Alliance Board to begin to make the necessary changes to streamline structures and reporting arrangements to maximise impact around quality. Everyone working with and for NHSScotland, Scottish Government Health Directorates, and all those working in partnership with NHSScotland throughout each patient's journey in Local Authorities and in the Third Sector, will be invited to be part of the Quality Alliance. Functioning as a virtual community, it will enable people to exchange ideas, share developments and network to maintain engagement, momentum and pace towards our Quality Ambitions. The implementation of the Quality Strategy is a shared responsibility.

7.12 An implementation framework is being developed to support three ambitious Quality Programmes, each aligned to one of the three Quality Ambitions. Each will be linked to the Quality Alliance Board. A number of high level Quality Outcome Measures are being developed as part of the Quality Measurement Framework.

7.13 Linked to this, the Better Together Programme is a national improvement programme central to the delivery and achievement of the principles and ambitions laid out in the national Healthcare Quality Strategy. The programme supports NHS Boards to gather and use patient experience data to influence and inform service planning, delivery and redesign. During 2009-10, 15 NHS Boards participated in the first year of this work by procuring and delivering patient experience surveys involving randomly selected patients that had an overnight stay in an acute care setting between October 2008 and September 2009. The 15 surveys have been analysed and collated into one document which was published in September, with 15 Board reports and 96 site level reports finalised and released in October. These Boards are all developing action plans focusing on the areas that patients have told them should be improved. A second inpatient survey will be undertaken in 2010-11.

7.14 Further work is being led by this programme regarding the quality of the experience of patients living with long term conditions as well as considering how to access and gather the experiences of those not included in the two national surveys. The programme is also tasked with leading work on developing a mixed portfolio approach to gathering and analysing patient experience.

7.15 Person centred care can only be delivered if the patient experience is fully explored and understood and therefore this programme of work will continue to mature to ensure that staff and their partners have the capacity and capability to undertake consistent and reliable activities to gather and understand patient experience and that they are mainstreamed and sustainable across the whole system.

7.16 *A Force for Improvement* published at the beginning of 2009 is the workforce framework for NHSScotland and implementation has been steadily progressing to ensure cohesion and coherence in delivering care by developing existing practice and extending best practice to fill gaps in delivery, evidencing change and ensuring consistency across NHSScotland.

7.17 The workforce framework works in synergy with the NHS Scotland Healthcare Quality Strategy. The framework is being used as a tool to support workforce changes underpinning improved services for patients and their families and seeking to achieve best value through a sustainable, affordable and safe workforce.

7.18 We are investing in the workforce to maintain and develop skills, morale and motivation and involving staff in making changes work in every setting including across team and agency boundaries. We recognise the importance of knowing what impact the workforce is making and to demonstrate that we are developing workforce measures as part of the Quality Measurement Framework. We already have a wealth of evidence from NHS Boards about the progress they have made against the actions in the framework and we need to sustain that progress and build on it working in partnership across the health and social care agenda and across the wider public sector.

Section B – Resources, Affordability And Pay

7.19 This section sets out the financial context including assumptions on funding available in 2011-12. It also highlights the challenges the Scottish Government Health Directorates face in a period of reduced funding growth whilst demand for services continues to increase alongside higher expectations of service quality.

<u>Background</u>

7.20 In June 2010 as part of the UK Emergency Budget, the Chancellor set the scene for public sector pay over the next two years announcing a pay freeze for public sector staff earning in excess of £21k. The budget also heralded increased costs in respect of both standard rate VAT (increase from 17.5% to 20% from January 2011) and changes to national insurance contributions thresholds.

7.21 The scale of the total reduction in the Scottish Government budget for 2011-12 has required tough decisions to be taken about expenditure across government and careful consideration of pressures and priorities in all portfolios. However, the health budget has received the full Barnett consequentials of £280 million towards its resource budget. This has lifted the resource budget by 2.7% to £10.8 billion. Notwithstanding the increase in NHS funding, issues such as the ageing population, new technology and the cost of drugs mean that the NHS will still face considerable budget pressures.

7.22 These pressures mean that the NHS will need to deliver maximum value from our investment through a focus on increased efficiency while protecting the quality of care.

7.23 Conditions in the Scottish labour market have deteriorated significantly since the economy fell into recession. Weaker demand in the economy has contributed to a decline in employment levels.

7.24 Recent developments again point to an uncertain economic picture. While the recovery in the UK and the euro-area has gained momentum, in countries that were quicker to come out of recession, such as the US and Japan, there are increasing signs of a slowdown in activity.

Financial Position

7.25 The financial position in 2010-11 is already challenging and requiring NHS Boards to make savings of 3.1% in 2010-11 to ensure financial breakeven.

7.26 The full extent of additional funding available to NHSScotland was confirmed at the Draft Budget 2011-12 announcement on 17 November 2010.

7.27 NHS Boards will have around 1% additional cash funding in 2011-12 after taking account of Government priorities and commitments such as the abolition of prescription charges, to meet cost pressures and service demands.

7.28 First call will be meeting known cost pressures within the system; these include increased costs in respect of pay, supplies, drugs etc. Due to significant operating pressures such as demographics, drugs and technology together with cost pressures arising from incremental pay progression, NHSScotland will not survive on the funding uplift alone. In 2011-12, it is expected that these NHS cost pressures will significantly exceed the formula consequences discussed above.

7.29 It is therefore estimated that NHS Boards will again need to deliver and retain a minimum of 3% efficiency savings to achieve financial balance. To achieve these efficiency savings required consideration will require to be given to real issues around staff reductions, sustainability of services, training of new nurses, role of local general hospitals, and so on – issues which will put NHSScotland under pressure

Pay

7.30 Against the background described above, the NHSPRB has been asked to provide a recommendation on the level of uplift to be applied to those Agenda for Change staff who earn under £21,000 per annum taking account of the Scottish Government's pay policy which recommends a minimum £250 flat rate uplift across the public sector.

7.31 For NHSScotland Agenda for Change staff, a £250 flat rate increase for those currently earning less than £21,000 would equate to a percentage increase of between 1.2% and 1.8%. In 2010/11 there are an estimated 51,000 whole time equivalent staff earning less than £21,000 and who would, therefore, qualify for the £250 flat rate uplift. This equates to some 40% of all Agenda for Change staff. The estimated cost of applying the £250 uplift in Scotland would be some £17m.

7.32 This is a significant cost for the NHS Scotland budget given the current financial climate and the need for Boards in 2011/12 to find savings to ensure a financial

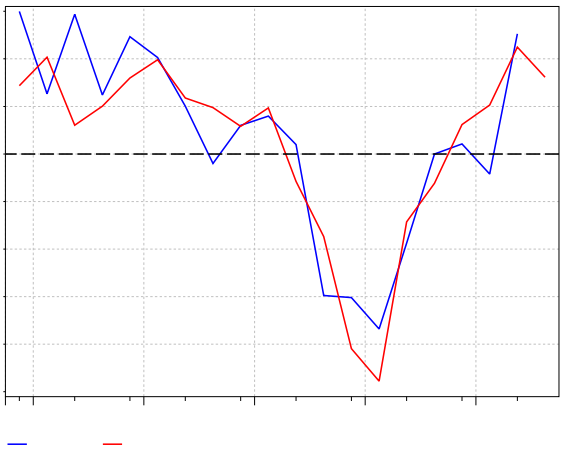
breakeven position as highlighted in the evidence above. These affordability issues are central to the Scottish Government's evidence this year. The Scottish Government has already made a commitment to the lowest paid by introducing a living wage of £7.15. Taking this into account, as well as the healthy recruitment and retention situation, and contrasting this with the constrained financial position which NHS Scotland will face, the Scottish Government considers the 2011/12 uplift for NHS staff earning under £21,000 a year should be a flat rate not exceeding £250.

Section C – Economic And Labour Market Conditions In Scotland

7.33 In the middle of 2009, the recession associated with the global financial crisis came to an end with the world economy entering the recovery phase. Unprecedented economic stimulus packages in most advanced economies acted to accelerate the return to GDP growth and support private sector activity. Conditions within the financial sector have improved since the recession, although the intensification of fears over the fiscal position of a number of euro-area economies led to a degree of instability in financial markets in the first half of 2010.

7.34 The Scottish economy exited recession during Q4 2009 with growth of 0.1% after five consecutive quarters of decline. Over the course of the recession, the Scottish economy has performed marginally better than that of the UK, with Scottish output declining by 5.7% during the downturn compared to 6.4% for the UK.

7.35 However, the recovery stalled in Q1 2010 with Scottish GDP falling by 0.2%, highlighting the volatility of output in the early stages of recovery. This was followed by strong growth in Q2 2010, with Scottish output expanding by 1.3% over the quarter, broadly similar to growth of 1.2% for the UK. Provisional data for UK GDP for Q3 2010 indicate that the recovery continued at a robust pace of 0.8%.



Growth Forecasts

7.36 The International Monetary Fund (IMF) forecast that global growth will rebound strongly in 2010 and 2011, having declined in 2009 – the first annual contraction of the post-war period. However the recovery is expected to be driven by emerging economies rather than advanced economies. Indeed, advanced economies are

expected to grow by just 2.7% and 2.2% in 2010 and 2011 respectively, compared to 7.1% and 8.4% in emerging and developing countries over the same period.

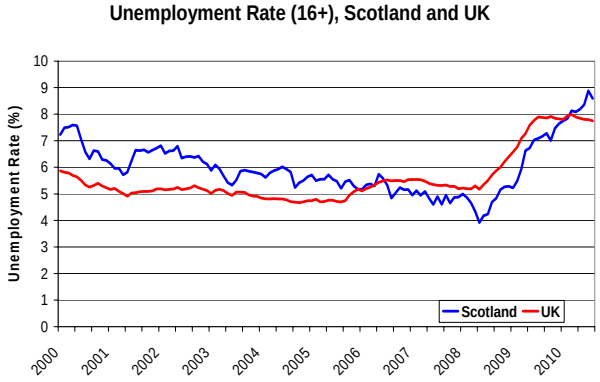
7.37 Considerable uncertainty remains surrounding the outlook for GDP growth in the near and medium term. Fears that high levels of government debt may lead to sovereign default and difficulties in meeting interest payments in some peripheral euro-area countries caused uncertainty in financial markets. These fears were eased following the intervention from the EU and IMF, although many countries, in particular Greece, still face inflated yields on debt and will continue to do so until the process of fiscal rebalancing is complete.

7.38 On the 20th October, the UK Chancellor delivered his Comprehensive Spending Review (CSR) which details how the UK Government will meet the cuts in spending outlined in the June 2010 Budget. The majority of budget tightening (73%) will come from reductions in government spending, the rest (27%) will come through increasing taxes. The plan is to eliminate the structural budget deficit by 2014/15, implying a balanced budget when the effects of fluctuations in growth around its long-term sustainable rate are taken into account. The impact that these spending cuts and tax increases will have on the economy is one of the key risks to the economic outlook in the UK and Scotland.

7.39 In the June 2010 Budget, the Office for Budget Responsibility judged that the UK economy would grow by 1.3% in 2010 as the private sector recovery takes hold. UK GDP growth during 2011 and 2012 has been revised down given the lower contribution expected from the public sector. Medium term growth is expected to be stronger than previously forecast as a result of higher private sector investment. However, if the private sector is not able to offset the planned retrenchment in the public sector, there is a risk that cutting public spending to the degree outlined in the Budget could potentially lead to further falls in GDP and a possible 'double-dip' recession.

7.40 For Scotland, independent forecasts expect growth in output of around 1% in 2010. The recovery is then expected to gain further momentum in 2011, with growth in output of around 2%.

The Labour Market



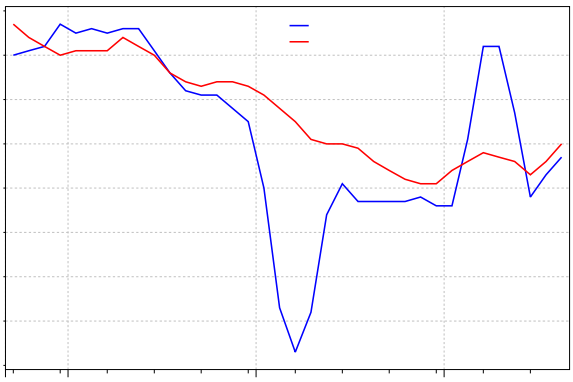
7.41 The decline in Scottish output during the recession led to a sharp deterioration in the Scottish labour market. Despite the economy emerging from recession in the final quarter of 2009, conditions within the Scottish labour market have continued to weaken over the first seven months of 2010. The Scottish unemployment rate is now 8.6%, up from 4% prior to the recession. This contrasts with the UK as a whole where unemployment has remained broadly stable at around 8% for the past year.

7.42 The continued rise in unemployment in Scotland has also been associated with an increase in employment. This is due to an increase in the flow of people moving into the labour market, with some gaining employment whilst others continue to seek work. However the overall level of employment in Scotland remains around 50,000 lower than at the same point last year.

Wages

7.43 Falling GDP growth and unemployment rates led to a significant reduction in nominal wage growth. In the year to April 2010, annual wage growth (excluding bonuses) slowed significantly before recovering slightly to just under 2%.

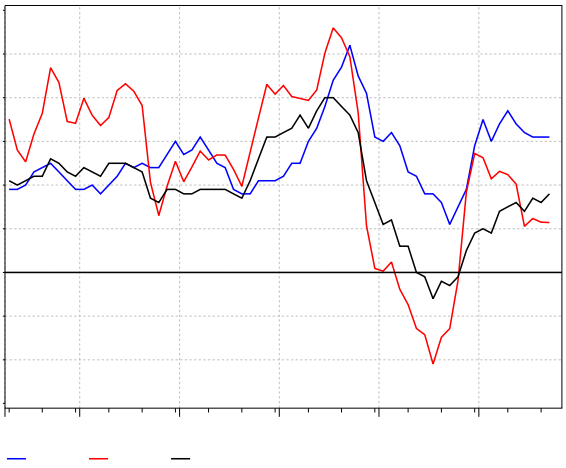
7.44 Annual growth in UK earnings including bonuses was less than consumer price inflation from May-July 2008 until December-February 2010, meaning that during this period the purchasing power of wages declined in real terms.



Inflation

7.45 Consumer price inflation fell sharply during the economic downturn, in line with the contraction in demand associated with constrained credit and greater economic uncertainty. Inflation has since risen to a peak of 3.5% but has since fallen and has been stable at 3.1 % since July 2010, (more than 1% point above the inflation target of 2%). The reason that inflation is so high is due to a number of temporary factors, including rises in food and fuel prices over the past year. The fall from the peak of 3.5% indicates that the impact of some of these temporary factors may be beginning to subside.

7.46 Yet inflation is expected to remain above the UK Government target of 2% in the medium term as higher import costs and the rise in VAT at the beginning of 2011 feed into higher prices. However throughout 2011 inflationary pressures are expected to ease as the continued weakness in consumer spending weighs down on prices.



Outlook

7.47 There is considerable uncertainty surrounding the outlook for the UK and Scottish economies. Business surveys, which give an indication of conditions in the economy before official statistics are published, report that growth in Scotland may have weakened in Q3 2010, particularly towards the end of the quarter. Looking further forward, the key risk to the outlook is the impact of fiscal consolidation on GDP growth as there is a risk that the measures outlined in the June Budget and Comprehensive Spending Review could lead to further contractions in GDP. Scottish forecasters expect growth to remain below trend during 2010 before the recovery gathers pace in 2011 and 2012.

7.48 The extent to which GDP growth will create jobs is also uncertain. Although the Scottish economy exited recession during Q4 2009, the labour market is yet to show convincing signs of stabilisation. Low levels of employment in the medium term imply that the weak pay growth observed over the past year could continue, leading to a reduction in real wages if growth continues at a rate below inflation.

7.49 CPI inflation is expected to remain above the UK Government's target rate in the short term, particularly as a result of the planned VAT increase at the start of 2011. As some of the more temporary factors feed through, the continued weakness in consumer spending is expected to weigh down on prices in the medium term.

Section D – The Workforce

7.50 This year we have again supplied the tables on which statistical elements of the Workforce narrative are based. All tables have been compiled using data collected by our Information and Statistics Division (ISD) who, as part of NHS National Services Scotland provide a national specialist intelligence service for NHS Scotland. The tables can be found at the back of the evidence and individual tables are cross referenced, as appropriate, in the text.

7.51 We have noted the Review Body's comments in previous reports on the helpfulness of having detailed information on all staff groups within its remit and have been progressively working with analytical colleagues on the detail and transparency of information gathered.

7.52 It should be noted that data has been collected in its current form only since 2007 when Agenda for Change was considered to be implemented in Scotland to the extent necessary to facilitate meaningful data gathering using Agenda for Change classifications. It is therefore not always possible to make direct comparisons to pre-2007 data. Whilst this has been done where it is possible and appropriate, contrasts in this section are generally limited to 2007 onwards, when like for like comparisons can be made. The information in the following section is based on the most recent available data which is from September 2009 and is presented throughout this section first in whole time equivalent (WTE) and then in headcount form.

<u>General Workforce Data</u>

7.53 For general background, Tables 1 and 2 give information on the overall numbers of staff in NHS Scotland as well as those groups which fall under the Agenda for Change system. These tables show a general upward trend in staff numbers over the last few years. The key points to note with regard to Agenda for Change staff are as follows:

- The number of WTE Agenda for Change staff working in NHS Scotland as at September 2009 was 123,100.5. This represents an increase of 2,813.4 (2.3%) over the September 2008 figure and 5,461.9 (4.6%) over the September 2007 level.
- In headcount terms, the number of staff working in NHS Scotland as at September 2009 was 148,281. This is an increase of 3,340 (2.3%) over the September 2008 figure and 6,350 (4.5%) over the September 2007 level.

7.54 The steady increase in staff numbers over this period reflects the significant investment made to date in building capacity across NHSScotland.

<u>Turnover</u>

7.55 We have again included information on turnover (Table 3). As can be seen, the overall level of turnover in NHS Scotland has steadily gone down over the last three years from 11.5% in 2007 to 10.9% in 2008 to 8.8% in 2009.

Nursing and Midwifery Staff

7.56 The nursing and midwifery workforce in Scotland reached a record level of 58,429.1 WTE (68,681 in headcount) as at September 2009 (Tables 4 and 5).

- In WTE terms there were 58,429.1 nursing and midwifery staff working in NHS Scotland in September 2009. This figure represents a rise of 679.5 (1.2%) over the September 2008 level. Because nurses and midwives have been monitored closely as a discreet group of staff for some time it is possible to make comparisons with more historic figures (Tables 6 and 7). Comparing the 2009 WTE figure with the September 2004 figure reveals an increase of 3,908.2 (7.2%), and to the September 1999 figure reveals an increase of 7,055.6%, (13.7%) over that time period.
- With regard to headcount, there were 68,681 nursing and midwifery staff working in NHS Scotland in September 2009. This represents an increase of 716 (1.1%) over the September 2008 level. Comparing the 2009 figure to September 2004 reveals an increase of 3,859 (6.0%), and to September 1999 gives an increase of 7,054 (11.4%).

Vacancy Rates

7.57 The overall level of nursing and midwifery vacancies (Tables 8 and 9) has remained virtually unchanged from 1,471.5 (2.5%) in September 2008 to 1,476.3 (2.5%) in September 2009. This is lower than both 5 years previously (3.7% in September 2004) and 10 years previously (2.8% in September 1999) (Table 10).

7.58 The vast majority of these vacancies are for less than three months. The over three month vacancy rate, which we believe gives more of an indication of trends in recruitment and retention, has also stayed more or less stable recently, increasing marginally from 0.6% in September 2008 to 0.7% in September 2009. Again, this is low in historical terms when compared to the level at September 2004 (1.1%) and September 1999 (1.0%) (Table 11).

7.59 The forgoing figures would seem to indicate that NHSScotland is not experiencing difficulties in recruiting and retaining nursing and midwifery staff

Bank Usage

7.60 It is Scottish Government policy to utilise the flexibility offered by the nurse bank to, among other things, secure value for money by decreasing the use of more expensive agency staff.

7.61 The number of people registered as bank nurses has increased in NHS Scotland. Bank use in 2009/10 represented 3,526.2 WTE nurses (6.88 million hours divided by 1,950 – the equivalent of one WTE nurse). See Table 12. This is slightly down on the 2008/09 level of 3,565.8: but taking a longer term view is part of a considerable upward trend from the 2001/02 level of 1,613.5 WTE nurses. However, Bank usage still only accounted for 5.5% of the total NHS Scotland nursing and midwifery capacity in 2009/10.

Agency Usage

7.62 It is Scottish Government policy to reduce the usage of agency staff and a national, i.e. Scottish, contract (Best Procurement Initiative) was introduced to ensure best value and savings against the use of agency nurses.

7.63 Spend on Agency nursing staff has fallen steadily every year since a high of £29.7m in 2003/04 to £8.18m in 2009/10 (Table 13). Agency staff now only account for 0.3% of the total nursing and midwifery capacity (Table 14). The use of the national contract has already realised savings and ceasing the use of "premium rate" agencies will encourage nurses and midwives to register with local nurse banks or contracted agency providers.

Pre-Registration Students in Training

7.64 The Scottish Government controls annual intake numbers for student nurses and midwives. The annual intake is usually determined by running a supply and demand model based in part on longer term (5 years) demand projections from NHS Boards and analysis of current stock in training, student attrition and retirement rates. There is input from key stakeholders including the professional organisations (RCN, RCM and Unison) and from Care Homes, Hospices, practice nurses, the Scottish Prison Service and independent hospitals. Wider uncertainties around the whole of the public sector landscape and finances have made it more difficult for NHS Boards to make meaningful workforce projections this year for the longer term. The basis on which student nurse and midwife intake for 2011/12 will be determined this year is therefore still under consideration.

7.65 Student numbers are provided on a financial year basis with figures published the following October. The latest published figures available, therefore, are for the financial year 2008/09 and show there were 9,499 students training across NHSScotland. This shows a decline from a high of 9,909 in 2006/07, but in the longer term is 513 (5.7%) above the number of students in training 5 years ago in 2003/04 (8,986) and 2612 (37.9%) above the number 10 years ago (6,887). More detailed information is provided at Table 15.

Allied Health Professionals

7.66 The Allied Health Professionals (AHP) group is made up of staff delivering Art Therapy, Dietetics, Occupational Therapy, Orthoptics, Orthotics, Physiotherapy, Podiatry, Prosthetics, Radiography and Speech and Language Therapy services (Tables 16 and 17).

- In WTE terms, as at September 2009 there were 9,579.5 AHP staff working in NHS Scotland. This represents a rise of 336.7 (3.6%) over the September 2008 level and a rise of 628.8 (7.0%) over the September 2007 level.
- In headcount, as at September 2009 there were 11,777 AHP staff working in NHS Scotland. This represents a rise of 435 (3.8%) over the September 2008 level and a rise of 796 (7.2%) over the September 2007 level.

Vacancy Rates

7.67 The number of AHP vacancies as at September 2009 (Table 18) stood at 336.3 or 3.4% of the total establishment. This is a small decrease from September 2008 (Table 19) when there were 377.4 vacancies (equating to 3.9% of the establishment), and a notable decrease since September 2007 (Table 20) when there were 453.4 vacancies representing 4.8% of the establishment.

7.68 With regard to long term vacancies (over 3 months) these have increased slightly to 120.8 (1.2%) in September 2009 from 91.6 (1.0%) in September 2008, but decreased slightly from the September 2007 level of 180.8 (1.9%).

7.69 The figures quoted above are within a range to be expected from year on year variability and do not show any significant upward trend. NHS Scotland does not, therefore, appear to have difficulties in recruiting and retaining AHP staff.

7.70 As can be seen from Tables 18,19 and 20, within the AHP job family there is some variability in vacancy levels year on year. It is important to bear in mind that as these are small staff groups, a relatively small number of vacancies can have a big effect on the percentage figure. Vacancy rates in Orthotics have been consistently above the AHP average over the three year period but at 7.2% currently this is not at a level which would cause alarm.

Other Staff Groups

7.71 Whilst we will continue to work with statistical colleagues on an ongoing basis to develop effective information gathering in NHS Scotland, vacancy data is not currently collected for staff groups other than nurses, midwives and AHPs. It is worth highlighting that vacancy data on hospital pharmacists, however, is expected to be collected annually by statistical colleagues at Information Services Division with the first set of data being available at September 2010 – to be published in January 2011. Evidence on other staff groups is only presented in terms of staff numbers.

Healthcare Scientists

7.72 The Healthcare Science staff group is made up of staff delivering Biomedical Science, Clinical Psychology, Clinical Science, Clinical Technology as well as other highly specialised healthcare science services (Tables 21 and 22).

- As at September 2009 there were 5,593.8 WTE healthcare science staff in post in NHS Scotland. This represents and increase of 435.4 (8.4%) over the September 2008 level and 441 (8.6%) over the September 2007 level.
- In headcount, the September 2009 figure of 6,290 represents a rise of 509 (8.8%) over the September 2008 level, and a rise of 530 (9.2%) over the September 2007 level.

Other Therapeutic Staff

7.73 Under the heading Other Therapeutic Staff is grouped staff delivering Clinical

Psychology and Counselling, Genetic Counselling, Optometry, Therapeutic Play and Pharmacy services (Tables 23 and 24). Pharmacy staff are included in the general figures for this group but pharmacy staffing more generally is dealt with in Section G which picks up on issues from previous Reports.

- As at September 2009 there were 3,322.2 WTE other therapeutic staff in post in NHS Scotland. This represents an increase of 187.1 (6.0%) over the September 2008 level and 568.6 (20.6%) over the September 2007 level.
- In headcount, the September 2009 figure of 3947 represents a rise of 225 (6%) over the September 2008 level and a rise of 682 (20.9%) over the September 2007 level.

Personal & Social Care Staff

7.74 The Personal and Social Care staff group covers Chaplaincy, Health Promotion, Sexual Health and Social Work (Tables 25 and 26).

- As at September 2009 there were 763.3 WTE personal and social care staff in post in NHS Scotland. This represents an increase of 70.9 (10.2%) over the September 2008 level and 213.4 (38.8%) over the September 2007 level.
- In headcount, the September 2009 figure of 901 represents a rise of 75 (9.1%) over the September 2008 level and a rise of 197 (28.0%) over the September 2007 level.

Medical and Dental Support Staff

7.75 This staff group is made up of Physician Assistants, Theatre Services staff and Dental Care Practitioners (Tables 27 and 28).

- As at September 2009 there were 1,667.4 WTE medical and dental support staff in post in NHS Scotland. This represents an increase of 227.8 (15.8%) over the September 2008 level and 595.1 (55.5%) over the September 2007 level.
- In headcount, the September 2009 figure of 1,928 represents a rise of 261 (15.7%) over the September 2008 level and a rise of 690 (55.7%) over the September 2007 level.

Administrative and Support Services

7.76 This heading encompasses Central Function and Administrative Clinical Support Staff. Also General Services, Hotel Services, Maintenance and Estates Staff and Sterile Services Staff (Tables 29 and 30).

- As at September 2009 there were 39,474.5 WTE administrative and support services staff in post in NHS Scotland. This represents an increase of 1,592.5 (4.2%) over the September 2008 level and 2,531.8 (6.9%) over the September 2007 level.
- In headcount, the September 2009 figure of 50,269 represents a rise of 1,931 (4%) over the September 2008 level and a rise of 3,172 (6.7%) over the September 2007 level.

Emergency Services

7.77 Emergency Services staff include Ambulance Care Assistants, Drivers, Emergency Medical Dispatch Centre Controllers, Paramedics and Technicians (see Tables 31 and 32).

- As at September 2009 there were 3,703.5 WTE emergency services staff in post in NHS Scotland. This represents an increase of 145.8 (4.1%) over the September 2008 level and 173.7 (4.9%) over the September 2007 level.
- In headcount, the September 2009 figure of 3,836 represents a rise of 155 (4.2%) over the September 2008 level and a rise of 181 (4.9%) over the September 2007 level.

Section E – Workforce Planning

7.78 In NHSScotland The "Six Steps Methodology to Integrated Workforce Planning" is the high-level approach endorsed by the workforce planning community across Scotland. The six steps comprise:

Step 1 – Defining the plan
Step 2 – Mapping Service Change
Step 3 – Defining the Required Workforce
Step 4 – Understanding Workforce Availability
Step 5 – Developing an Action Plan
Step 6 – Implement, Monitor and Refresh

7.79 More detailed background can be found at - www.healthcareworkforce.nhs.uk.

7.80 Work is continuing on a Nursing and Midwifery Workload and Workforce Planning Tool for each workforce area. Although development continues, the tool as it stands is being utilised and is proving to be useful in informing staffing numbers.

7.81 Similar work is being undertaken for the Allied Health Professions and the Health Care Science Professions.

NHS Board Workforce Projections

7.82 Future demand for NHS staff groups is estimated by NHS Boards in their workforce plans and workforce demand projections, which take into account factors such as changing models of care and patient demography. Following agreement with the Cabinet Secretary for Health and Wellbeing it has been decided to review the current workforce demand projection process. This is to ensure that in planning the future NHS Scotland workforce, it is fully integrated within Boards, and that we understand the implications when actions taken for one group have unintended consequences for others. Board planning also needs to take into account the potential impacts of work underway, including future service needs and policy drivers, Midwifery 2020 and reshaping the medical workforce.

7.83 This review is being taken forward using examples from NHS Education for

Scotland's work on dental workforce modelling to consider how best service-based workforce scenario planning could be taken forward at a national level: and to consider how best to develop a national model for building balanced skill mix within clinical teams. The outcome of this review will have a positive impact on workforce and service planning in that we are moving towards Boards being able to project their future workforce needs by service area instead of the current silo approach.

NHS Board Projected Staff in Post Changes in 2010-11

7.84 All NHS Boards were asked to provide workforce projections for 2010-11, to enable the Scottish Government and NHS Boards to assess the current workforce and skills mix to ensure this is appropriate to meet current and future needs. The statistics provided by NHS Boards, which are projections based on management information, show that Boards are projecting an overall reduction across all staff groups of 3,790 whole time equivalent by the end of this year. The largest percentage reductions are in management (7.5%), Administrative Services (4.1%) and Support Services (4.0%). The largest whole time equivalent reduction is in Nursing and Midwifery of 1523 WTE (-2.6%). Dentistry staff groups were the only group to see an increase (0.25). The reduction in whole time equivalent posts will be achieved largely through vacancy management and natural turnover. As mentioned at the beginning of this evidence, there will also be a 25% reduction in senior manager levels.

7.85 We have made clear to NHS Boards that any proposals for service redesign must benefit patients and that any reductions in workforce costs should have no impact on frontline services or the quality of patient care. To ensure that quality is delivered NHS Boards workforce plans will be scrutinised by the newly convened National Scrutiny Group. The National Scrutiny Group, as announced by Cabinet Secretary on 3 June, was set up to monitor Boards' progress with planned workforce changes and to ensure full staff side engagement in the change process. The NSG has now met twice (4 August and 9 September), chaired by Cabinet Secretary and the next meeting is scheduled for 10 November.

Section F – Employee Experience, Morale And Motivation

7.86 The Scottish Government is clear that, although there is a reduction in the level of recruitment across NHSScotland, there is a need to ensure that NHSScotland is able to provide high-quality safe and effective care through an empowered and flexible workforce which understands the diverse needs of the population and which chooses to work for, and remains committed to, NHS Scotland.

7.87 This approach is strengthened by the long standing commitment to partnership working in NHSScotland, of which we are proud. This leads to better informed and shared decisions, which in turn deliver a better standard of service to patients and their families. Nottingham University is undertaking research to understand how partnership operates in NHS Scotland. NHS Scotland's partnership approach merits careful assessment because it is the most established national partnership agreement in the NHS, it provides for ambitious levels of staff involvement, it creates important and distinct institutions for modernising health services, and it receives significant support from the Scottish Government, employers and staff representatives.

7.88 Together, in partnership, a programme of work is being undertaken to support the employee experience across NHSScotland, which in turn will lead to benefits in the patient experience. Much of this work is based on the NHS Scotland Staff Survey findings.

Staff Survey

7.89 The NHS Scotland 2008 staff survey took place between 20 October 2008 and 21st November 2008. This survey was significantly shorter than the last survey to ensure that staff were encouraged to participate. It consisted of 31 national questions and up to 10 Board specific questions that ensured that the survey was relevant to staff and focused on local issues. This year, for the first time, NHS Scotland was able to compare the results of the survey with the 2006 results thus allowing the development of trend data.

7.90 The overall response rate had improved compared with the 2006 response rate of 33%, and the final response rate for the 2008 Staff Survey was 37%. A total of 58,381 staff completed the staff survey compared with 49,206 in 2006 - an increase of 9175.

7.91 When comparing the questions highlighted in last years submission, the following improvements can be noted:

- 76% are satisfied with the support they get from work colleagues compared with 74% in the 2006 survey;
- 73% feel their job makes good use of their skills and abilities (72%);
- 76% feel that they have the information they need to do their job well (75%).

7.92 The number of staff to say they are clear about what they are expected to achieve in their job remains at 80% across both surveys.

7.93 There is also evidence that staff continue to be satisfied with the overall benefits package increasing from 58% to 62%; and that staff felt that they had an increased sense of equality of opportunity rising from 45% to 62%. These positive findings are reflected in the fact that 77% (70%) of respondents intended to be working for their NHS Board in a year's time, 55% (43%) would recommend NHS Scotland as a good place to work and 85% would "go the extra mile" when asked to at work.

7.94 There is also a 10% reduction in the number of staff stating that they had experienced a violent incident in the last 24 months. However it is recognised that the 2008 rate of 18% is still unacceptable and NHS Boards are continuing to develop interventions that will address this issue via their staff survey action plans.

7.95 The staff survey for 2010 took place in November although the results will not be available until December.

Working Well

7.96 A total of 42 projects across 19 NHS Boards were supported by the £1m Working

Well Challenge Fund 2009/10. These projects encompassed action to influence the workforce culture, the engagement and commitment of staff, health and wellbeing and staff safety; including a specific focus on reducing incidents of violence and aggression against staff. Implementation of the Healthcare Quality Strategy means that a healthy, motivated and engaged workforce will be even more crucial in helping to deliver the sustainable delivery of quality healthcare over the longer term. Support provided to NHSScotland through the Working Well Challenge Fund enables NHS Boards to develop and share good practice in relation to the employee experience, which in turn leads to improvements in the patient experience.

7.97 Complementing the Working Well programme, NHSScotland employers and the Scottish Government jointly established the OHSS Forum to oversee occupational health and safety services for staff working in NHSScotland and to develop a new strategy for occupational health and safety for staff within NHS Scotland. This Strategic Framework, which is being developed in partnership, will make the linkages and demonstrate the contribution which occupational health and safety makes to ensuring a good working experience through promoting health and well-being, helping to prevent illness, and supporting people to return to work from illness; recognising that work can be part of the recovery process. High standards of occupational health and safety across NHSScotland will benefit employee health and wellbeing and lead to a better patient experience.

Dignity at Work

7.98 The Dignity at Work project was a national project established to provide NHS Scotland employers with practical tools to tackle negative behaviors in the workplace and promote dignity at work. One of the main thrusts for the work of the project was a recognition that the reported levels (perceived or actual) of bullying across the organisation are unacceptable both in terms of personal cost to individuals as well as organisational costs associated with sickness absence, lost productivity and reputation damage. NHS Boards received the Dignity at Work Toolkit in January 2010.

National Uniform

7.99 The delivery of a consistent, cost effective National Uniform across NHS Scotland provides staff with the professional corporate image that they deserve. The new uniform replaces the previous 250 styles and 100 colours with one unisex style in 7 shades. We have met the needs of staff by providing a better quality, fit for purpose uniform. The consistent colour coding across NHSScotland meets the needs of patients and the public to identify staff by their role. The short-sleeved style helps minimise the risk of infection and cross contamination. Bulk purchasing from a single supplier suggests savings of 33% on previous spend, accounting for inflation and same demand level.

Absence Management

7.100 For the third successive year in a the annual Sickness Absence rate fell. It is now at 4.75%, down from 5.55% in 2006/07. Scottish Government and NHS Boards are working in partnership with the trades unions to promote attendance rather than just managing absence. NHS Scotland’s approach to promoting attendance is moving

from reactive interventions to proactive health promotion and support for staff. NHS Boards will continue to be supported by Scottish Government through a national programme of sharing best practice and developing new approaches to attendance management.

Migration Advisory Committee

7.101 NHS Scotland Boards have fully delegated authority over employment issues, including how they manage unfilled posts. In their work to restructure and redesign services to ensure high quality patient care, Boards are actively managing their workforce to minimise vacancies. However, where vacancies do occur, some of these may be filled either through redeployments or by advertising the posts, while some others may be left unfilled.

7.102 Bi-annual submissions of hard to fill vacancy numbers and supporting evidence were made to the Migration Advisory Committee (MAC) who are commissioned by the UK Government to recommend occupations to be included in a National and Scottish Shortage Occupation Lists (NSOL & SSOL). This process involved asking Boards to help with the collection and analysis of long term and hard to fill vacancy data and evidence. Working with NHS Boards, Skills for Health and devolved administrations, a comprehensive list with supporting evidence was submitted on 2 occasions during the year, to ensure that the position across NHSScotland was taken into account in the development of the shortage occupation lists. Although not all hard to fill professional occupations were accepted for inclusion on either list, those successful professions were given the opportunity to recruit from outwith the EEA ensuring there was sufficient staff to provide the necessary person centred care.

Knowledge and Skills Framework

7.103 Implementation of the Knowledge and Skills Framework (KSF) in Scotland is being performance managed and is progressing very well. KSF was a Health Efficiency Access Treatment (HEAT) target for all Health Boards who were required to ensure that all substantive, permanent staff in post at 31 March 2008 had a Personal Development Plan (PDP) in place by 31 March 2009. This target has been achieved which is a key milestone towards full implementation of the KSF.

7.104 The next phase of implementation involves a new KSF HEAT target which has been agreed for delivery by March 2011. This requires that at least 80% of AfC staff have development reviews and PDPs completed and recorded on the electronic on-line tool which supports the KSF processes and is known as “e-ksf”. The e-ksf system will hold information relating to staff competence levels, development review, as well as learning and development information. This information will be invaluable for service and workforce planners and will realise many benefits from the investment. In addition, key equality and diversity reporting in respect of access to learning and development will only be available through e-ksf, as will information related to progress through pay gateways.

7.105 It is expected that the effect (impact) of having KSF and eKSF fully implemented will be improved training and job satisfaction for staff which will result in improved recruitment and retention. Through time, the KSF will help manage role redesign to

ensure that new roles required to enable service redesign can be appropriately and effectively developed.

NHS Pension and Total Rewards

7.106 As with England and Wales, the NHS pension scheme in Scotland continues to be an integral part of the NHS remuneration package and is considered an invaluable recruitment and retention tool. Pension benefits and employee contributions in the Scottish NHS Pension Scheme mirror that of the scheme in England and Wales.

7.107 Current member contributions vary from 5% to 8.5% of pay with higher earners paying more for their benefits. The current employer contribution rate is 13.5% of pay. Again, as with England and Wales, arrangements have been put in place so that future increases in scheme costs may be shared between employer and employees. The scheme is currently undergoing its 4 yearly valuation and any resulting contribution changes are expected to be implemented from April 2012. However, it should be noted that the UK Government's recent announcements have somewhat complicated this picture. Specifically, these were:

- a change in annual indexation from one based on the Retail Price Index to one based on the Consumer Price Index (July 2010) (see para 7.111);
- a review of the discount rate used to assess pension scheme liabilities as part of the scheme valuation process that determines pension contributions (October 2010) (see para 7.113); and
- the expected staged introduction of increases in employee contribution rates from April 2012 of an average of 3.2 % of pensionable pay (UK Government Comprehensive Spending Review October 2010) (see para 7.113):

7.108 A consultation on the review of the Discount Rate is expected to be concluded by March 2011 but in the meantime work on scheme valuations has been suspended.

7.109 Members in the "1995 section" of the scheme in Scotland are currently part of an exercise through which those eligible can opt to move their benefits to "2008 section" of the scheme, if they believe it would be more beneficial to them. The exercise is almost complete in Scotland. Key characteristics of the 2008 section of the scheme are: a higher accrual rate (1/60th); a facility for members to take part of their pension from age 55 and to continue work and accrue further pension; and a normal pension age of 65. Those who retired from the 1995 section between 1 April 2008 and 30 September 2009 (who will not have been eligible for the choice exercise) can rejoin the 2008 section and accrue further pension after a waiting period which in most cases will be 2 years.

Changes – current and potential

7.110 Pensions policy is reserved to the UK Government and three significant announcements have been made that have a bearing on the NHS pension scheme:

- a move to annual indexation of benefits based on the Consumer Price Index (CPI) rather than the Retail Price Index (RPI);
- proposals for a change in arrangements for pensions tax relief;

- an independent review of UK public service pensions by the Independent Public Service Pensions Commission, led by Lord Hutton.

7.111 Though the CPI can be higher than the RPI, in recent years it has been lower. Indeed, it has been estimated that, on average, the annual differential is 0.75 percentage points and Lord Hutton's Commission recently estimated that this could reduce public service pension expenditure by over 10% by 2030.

7.112 Under proposed changes to pensions tax relief, the new annual tax allowances for tax relief on pension contributions is to be set at £50,000 from April 2011. As part of the assessment the increase in a defined benefit scheme pension will be converted to a notional contribution so that it can be measured against the new allowance. It is expected that this is most likely to affect those earning in excess of £100,000.

7.113 Lord Hutton's independent review has completed its initial stage, which culminated in publication of an interim report on 7 October 2010. The report makes it clear that the Commission believes that the status quo is not tenable and that public sector pension provisions need to be reformed for the longer-term. It also suggests that public sector workers should be expected to pay more for their pensions in the short-term and that the Discount Rate used in unfunded scheme valuations should be reviewed both of which were included in the UK Government Spending Review.

7.114 The Scottish Government welcomes the thoroughness of the report and intends to continue to engage fully on the review. The Scottish Government's engagement will include discussing both the interim and final report with key stakeholders, including trade union partners.

Section G – Issues From Previous Reports

7.115 The recommendation in the PRB's 24th Report for an RRP for Band 6 and 7 Pharmacists was rejected by all four Health Departments at the time. The PRB again addressed the issue as part of their consideration on whether to seek a remit to reopen the three year pay deal in 2010-11. In the document published on 10 December 2009, the Review Body suggested "the Government and other parties may wish to reconsider the matter".

7.116 We recognise the importance of this issue and, following on from the Review Body's comments, the Scottish Government has done considerable further work in reconsidering our decision not to apply a national RRP. We have, as detailed in the Cabinet Secretary's letter to the Review Body of 21 January this year, developed an Action Plan around Band 6 pharmacist staffing. The Action Plan suggests a range of short term measures which we feel have enabled all parties to gain a better understanding of the issues involved and thereby consider the most appropriate action for addressing any recruitment and retention difficulties which are highlighted. The plan also shares some ideas around best practice for recruiting Band 6 level pharmacists and offers further ideas around how recruitment may be improved. A copy of the plan has already been shared with the NHSPRB. Dr Clayden, the Director for Health Workforce in Scotland, also attended the NHSPRB away day on 14 July 2010 and gave a presentation on progress.

7.117 Part of the Action Plan involved the collection of quarterly establishment and vacancy data. The vacancy data collected over the course of the year revealed a certain pattern which saw Band 6 vacancy levels rising in Spring and Summer as staff gained promotion or moved on and then falling in Autumn as new graduates emerged to take up posts in the service. The 40.5% Band 6 vacancy rate in May 2009 revealed by the PEVS survey therefore fell to 19% in October 2009. According to the data we collected, Band 6 vacancy levels then rose slightly to 24.5% in April 2010 before, encouragingly, falling back to 18.9% in July.

7.118 We have also been collecting data on Band 7 vacancies this year which reached a high of 15.2% in April before falling back to 7.6% in July.

7.119 It is also worth noting the variability of the situation around the country. As at 31 July, for instance, whilst Lothian had a 40% Band 6 vacancy rate, Greater Glasgow and Clyde had a rate of 3.29%. And this pattern is repeated around the country with comparable Boards reporting very different positions. For example, Borders, Dumfries and Galloway, Fife and Lanarkshire Health Boards are all reporting no vacancies at band 6 or 7 level which confirms there is no Scotland wide recruitment issue. We do recognise there may be some local issues, however, and as such it remains open to any Board to apply for a local RRP through the agreed Scottish procedure if this was felt appropriate. NHS Western Isles made an application for a local RRP for pharmacists earlier this year but following discussions in the Scottish Terms and Conditions Committee, which includes employer and staff side representation, it was agreed by all parties that providing a joint service in conjunction with NHS Greater Glasgow and Clyde would provide a more sustainable long term solution. The two Boards are currently working to take this approach forward and the results will be shared across Scotland as a further example of good practice.

7.120 We recognise the importance of monitoring pharmacy establishment over the longer term and have been working with our Information Services Division who have now put arrangements in place to collect specific pharmacy establishment and vacancy data as part of their ongoing statistical monitoring of NHS Scotland. They are currently collecting data on the position as at 30 September 2010, although this will not be available until the beginning of December. We will continue to monitor the situation carefully as we move forward.

7.121 The Review Body will also wish to be aware that over the last year, both the Cabinet Secretary and Scottish Government officials have met with Scottish staff side pharmacy representatives on several occasions to discuss the position with pharmacy vacancies and wider issues around pharmacy staffing in NHS Scotland. We are open to holding further discussions as necessary.

7.122 Given the falling vacancy levels, the variability of the position around the country and the questions which have been rehearsed in previous submissions to the Review Body about whether a national RRP is necessary, the Scottish Government remains firmly of the view that a national RRP is not the correct approach in this instance.

Section H – Conclusions

7.123 In formulating our evidence to the Review Body we have taken into account the information available to us on recruitment and retention for the groups covered by the Pay Review Body, the non-pay employment environment which NHS Scotland staff are working in and the considerable financial challenges which NHS Scotland faces over the coming years.

7.124 On recruitment and retention it is clear that staff numbers across groups covered by the Review Body have increased considerably in recent years. Whilst overall numbers are projected to decrease slightly, there remains more staff in post in NHS Scotland than there were in 2007. Vacancy rates in the staff groups where this is monitored are low in historical terms and it seems reasonable to assume that an increased emphasis on vacancy management locally where staff numbers are decreasing will put further downward pressure on vacancy rates. NHS Scotland would therefore appear to be in a strong position in recruitment and retention terms.

7.124 With regard to non-pay employment issues, the Scottish Government remains committed to making NHS Scotland an attractive place to work. The partnership structures which we have developed in Scotland are acknowledged to be valuable by all sides. By allowing staff to be involved in decisions which affect them we help to create a well informed and committed workforce and through programmes such as Working Well and Dignity at Work we promote a supportive working environment where staff are encouraged to be healthy, motivated and engaged.

7.125 In financial terms, although the NHS has been shielded from the degree of savings required of other public services, NHS Scotland is still faced with having to make 3.1% savings in 2010/11 and it is anticipated the service will have to make a further 3% saving in 2011/12. Any increased costs associated with pay will be unwelcome as Boards seek to balance competing claims on resources to meet their objectives in the provision of healthcare.

7.126 The Scottish Government has already made a commitment to the lowest paid by introducing a living wage of £7.15. Taking this into account, as well as the healthy recruitment and retention situation, and contrasting this with the constrained financial position which NHS Scotland will face, the Scottish Government considers the 2011/12 uplift for NHS staff earning under £21,000 a year should be a flat rate of £250. The Scottish Government also feels there remains no case for the introduction of a national recruitment and retention premium payment for Band 6 and 7 Pharmacists.

Table 1 - NHS Scotland: Overall Workforce Summary (Whole Time Equivalent) by Year

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
All NHSScotland staff (including GPs & GDs)	..	..	..	..	..	..	..	..	..	..
All NHSScotland staff (excluding GPs & GDs)	..	..	..	..	..	..	..	**130,245.0**	**133,095.3**	**135,757.9**
Medical (Hospital, community and public health services)	7,701.4	8,004.7	8,586.6	8,793.4	9,063.0	9,261.6	9,600.0	10,251.6	10,752.6	10,680.5
General medical practitioners (GPs) [1]	3,876.3	3,941.3	3,941.9	3,991.3	3,991.7	4,065.2	..	..	..	..
Dental (Hospital, community and public health services)	462.7	459.4	485.9	498.7	504.1	523.1	560.9	569.1	603.7	641.4
General dental services [2,3]	..	..	..	..	..	..	..	..	..	..
Management Grades (non AfC)								1,785.8	1,451.9	1,335.6
All Agenda for Change Staff								**117,638.6**	**120,287.1**	**123,100.5**
Medical and dental support	x	x	x	x	x	x	x	1,072.3	1,439.6	1,667.4
Nursing and midwifery	51,291.6	52,214.4	53,177.5	54,097.0	54,520.9	55,434.3	56,783.9	57,050.4	57,749.6	58,429.1
Allied health professions [4]	6,955.9	7,230.7	7,655.3	8,089.3	8,277.2	8,593.9	8,842.2	8,951.5	9,242.8	9,579.5
Other therapeutic services	x	x	x	x	x	x	x	2,753.6	3,135.1	3,322.2
Personal and social care	x	x	x	x	x	x	x	549.9	692.4	763.3
Healthcare science	x	x	x	x	x	x	x	5,152.8	5,158.4	5,593.8
Emergency services [5]	2,631.7	2,743.1	2,873.8	3,091.3	3,139.3	3,240.6	..	3,529.8	3,557.7	3,703.5
Administrative services [6]	18,943.8	19,819.9	21,106.9	22,318.5	23,235.6	24,275.8	..	22,950.9	23,514.2	24,713.3
Support services	11,942.2	11,253.2	11,599.2	12,341.0	12,246.0	12,506.7	12,645.1	13,961.9	14,367.9	14,761.2
Unallocated / not known	x	x	x	x	x	x	x	1,665.5	1,429.4	567.2

Notes:
1. WTE information for general medical service is not available for 2006 onwards. Historical GP WTE figures are coded and need careful interpretation in the light of the coding system. This is explained further at http://www.isdscotland.org/isd/3842.html under "Whole Time Equivalent (WTE)".
2. Due to improvements in the collection of information on the salaried service, figures for 2005 include salaried dentists not previously recorded.
3. Information is not collected on the working hours of dentists in the General Dental Service.
4. To allow a comparable trend with 2007 information, adjustments have been made. For the period 1997 to 2006 play staff/specialists and rehabilitation/clinical support assistants have been excluded.
5. To allow a comparable trend with 2007 information, adjustments have been made. For the period 1997 to 2005 ambulance control officers have been included. At present 2006 information is not available due to discrepancies with these data.
6. To allow a comparable trend with 2007 information, adjustments have been made. For the period 1997 to 2005 ambulance control officers have been excluded. At present 2006 information is not available due to discrepancies with these data.
Source:
Scottish Workforce Information Standard System (SWISS) - 2009 extract taken on 12th October 2009.
GP workforce information is sourced from the GP Contractor Database (GPCD) - 2009 extract taken 5th November 2009.
General Dental Services workforce information is sourced from the Management Information and Dental Accounting System (MIDAS) - 2009 extract taken 30th October 2009.
Medical and dental workforce information for hospital, community and public health services (HCHS) is sourced from the medical and dental workforce census (MEDMAN) prior to 2008.

Table 2 - NHS Scotland: Overall Workforce Summary (Headcount) by Year

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
All NHSScotland staff (including GPs & GDs)	..	..	..	..	..	..	..	**162,113.0**	**165,551.0**	**168,994.0**
All NHSScotland staff (excluding GPs & GDs)	..	..	..	..	..	..	..	**155,668.0**	**158,978.0**	**162,266.0**
Medical (Hospital, community and public health services)	8,714.0	9,038.0	9,608.0	9,773.0	10,023.0	10,212.0	10,500.0	11,128.0	11,783.0	11,797.0
General medical practitioners (GPs) [1]	4,253.0	4,346.0	4,360.0	4,447.0	4,456.0	4,553.0	4,626.0	4,721.0	4,916.0	4,942.0
Dental (Hospital, community and public health services)	611.0	606.0	648.0	634.0	635.0	659.0	701.0	695.0	752.0	812.0
General dental services [2,3]	2,002.0	2,048.0	2,078.0	2,112.0	2,156.0	2,267.0	2,434.0	2,546.0	2,703.0	2,761.0
Management Grades (non AfC)								1,914.0	1,503.0	1,377.0
All Agenda for Change Staff								**141,931.0**	**144,941.0**	**148,281.0**
Medical and dental support	x	x	x	x	x	x	x	1,238.0	1,667.0	1,928.0
Nursing and midwifery	61,560.0	62,357.0	63,335.0	64,293.0	64,822.0	65,781.0	67,099.0	67,345.0	67,965.0	68,681.0
Allied health professions [4]	8,484.0	8,825.0	9,294.0	9,829.0	10,078.0	10,495.0	10,845.0	10,981.0	11,342.0	11,777.0
Other therapeutic services	x	x	x	x	x	x	x	3,265.0	3,722.0	3,947.0
Personal and social care	x	x	x	x	x	x	x	704.0	826.0	901.0
Healthcare science	x	x	x	x	x	x	x	5,760.0	5,781.0	6,290.0
Emergency services [5]	2,739.0	2,848.0	2,981.0	3,202.0	3,267.0	3,370.0	..	3,655.0	3,681.0	3,836.0
Administrative services [6]	22,142.0	23,173.0	24,697.0	26,196.0	27,380.0	28,773.0	..	27,452.0	28,252.0	29,635.0
Support services	17,598.0	16,543.0	16,977.0	17,991.0	17,731.0	18,054.0	18,229.0	19,645.0	20,086.0	20,634.0
Unallocated / not known	x	x	x	x	x	x	x	1,886.0	1,619.0	652.0

Notes:
1. WTE information for general medical service is not available for 2006 onwards. Historical GP WTE figures are coded and need careful interpretation in the light of the coding system. This is explained further at http://www.isdscotland.org/isd/3842.html under "Whole Time Equivalent (WTE)".
2. Due to improvements in the collection of information on the salaried service, figures for 2005 include salaried dentists not previously recorded.
3. Information is not collected on the working hours of dentists in the General Dental Service.
4. To allow a comparable trend with 2007 information, adjustments have been made. For the period 1997 to 2006 play staff/specialists and rehabilitation/clinical support assistants have been excluded.
5. To allow a comparable trend with 2007 information, adjustments have been made. For the period 1997 to 2005 ambulance control officers have been included. At present 2006 information is not available due to discrepancies with these data.
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Source:
Scottish Workforce Information Standard System (SWISS) - 2009 extract taken on 12th October 2009.
GP workforce information is sourced from the GP Contractor Database (GPCD) - 2009 extract taken 5th November 2009.
General Dental Services workforce information is sourced from the Management Information and Dental Accounting System (MIDAS) - 2009 extract taken 30th October 2009.
Medical and dental workforce information for hospital, community and public health services (HCHS) is sourced from the medical and dental workforce census (MEDMAN) prior to 2008.

Table 3 - NHS Scotland: Staff Turnover Trend – % of Leavers Between 1 January and 31 December

	2007	2008	2009
All staff [2]	**11.5**	**10.9**	**8.8**
Medical and dental staff	9.8	10.7	10.7
Medical and dental support	7.2	9.6	8.7
Nursing and midwifery	9.2	9.4	7.8
Allied health professions	12.0	10.8	9.6
Other therapeutic services	10.5	16.4	14.2
Personal and social care	7.5	10.3	8.1
Healthcare science	13.6	10.0	7.2
Emergency services	5.1	5.3	4.1
Administrative services	13.5	12.0	9.0
Senior Managers	10.3	11.1	8.0
Support services	15.8	14.5	10.7

Source: Scottish Workforce Information Standard System (SWISS)
Notes:
1. All staff includes Senior Managers, Medical and dental staff and Unallocated/Not Known staff.

Table 4 - NHS Scotland: Nursing and Midwifery Staff (Whole Time Equivalent) as at 30 September

	2007	2008	2009	Change 08 - 09
Nursing and midwifery staff [1]	**57,050.4**	**57,749.6**	**58,429.1**	**1.2%**
Nursing [1]	**49,575.9**	**54,059.2**	**55,358.5**	**2.4%**
Midwifery [1]	**2,796.9**	**2,983.2**	**3,002.8**	**0.7%**
Adult	33,748.9	36,604.8	35,899.4	-1.9%
Blood Transfusion Service	156.5	57.1	248.2	334.6%
NHS 24	374.5	357.0	353.0	-1.1%
District nurses	443.4	445.1	515.1	15.7%
Community General nurses	4,188.0	4,715.1	4,798.7	1.8%
Family planning nurses	22.8	26.0	30.5	17.3%
Mental health	7,245.8	8,019.9	8,882.9	10.8%
Bank	-	24.5	19.2	-21.5%
Learning disabilities	905.3	1,023.4	1,123.6	9.8%
Midwifery	2,796.9	2,983.2	3,002.8	0.7%
Public health nurses	144.3	150.3	199.7	32.9%
Other nurses	155.8	175.4	176.1	0.4%
Paediatrics	684.5	813.9	1,440.2	76.9%
Training and administration	-	54.1	101.2	87.2%
School nurses	270.1	286.5	306.5	7.0%
Treatment room nurses	90.7	97.6	115.6	18.5%
Health visitors	1,145.3	1,208.5	1,139.8	-5.7%
Staff nursery	-	-	8.8	x
Not assimilated	**4,677.6**	**707.2**	**67.8**	**-90.4%**

Source: Scottish Workforce Information Standard System (SWISS), data extracted 12/10/2009.

Table 5 - NHS Scotland: Nursing and Midwifery Staff (Headcount) as at 30 September

	2007	2008	2009	Change 08 - 09
Nursing and midwifery staff [1]	**67,345.0**	**67,965.0**	**68,681.0**	**1.1%**
Nursing [1]	**58,370.0**	**63,400.0**	**64,836.0**	**2.3%**
Midwifery [1]	**3,500.0**	**3,735.0**	**3,768.0**	**0.9%**
Adult	39,297.0	42,427.0	41,530.0	-2.1%
Blood Transfusion Service	257.0	92.0	388.0	321.7%
NHS 24	583.0	546.0	543.0	-0.5%
District nurses	503.0	513.0	590.0	15.0%
Community General nurses	5,666.0	6,398.0	6,490.0	1.4%
Family planning nurses	72.0	74.0	84.0	13.5%
Mental health	7,904.0	8,726.0	9,661.0	10.7%
Bank	-	32.0	26.0	-18.8%
Learning disabilities	1,001.0	1,125.0	1,226.0	9.0%
Midwifery	3,500.0	3,735.0	3,768.0	0.9%
Public health nurses	169.0	185.0	239.0	29.2%
Other nurses	182.0	203.0	205.0	1.0%
Paediatrics	845.0	1,016.0	1,741.0	71.4%
Training and administration	-	61.0	111.0	82.0%
School nurses	385.0	413.0	442.0	7.0%
Treatment room nurses	138.0	143.0	173.0	21.0%
Health visitors	1,368.0	1,446.0	1,377.0	-4.8%
Staff nursery	-	-	10.0	x
Not assimilated	**5,475.0**	**830.0**	**77.0**	**-90.7%**

Source: Scottish Workforce Information Standard System (SWISS), data extracted 12/10/2009.

Table 6 - NHS Scotland: Nursing and Midwifery Staff (Whole Time Equivalent) - Pre 2007

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006 [2]
All nursing and midwifery staff	**51,889.4**	**51,461.0**	**51,085.7**	**51,373.5**	**51,291.6**	**52,214.4**	**53,177.5**	**54,097.0**	**54,520.9**	**55,434.3**	**56,783.9**
Senior Nurse Managers[1]	**212.0**	**133.9**	**117.9**	**102.6**	**63.9**	**56.0**	**44.0**	**35.6**	**33.2**	**28.8**	**..**
Hospital Specialties[2]	**45,358.8**	**44,893.5**	**44,399.0**	**44,485.2**	**44,210.3**	**44,791.5**	**45,263.8**	**45,779.4**	**46,026.9**	**46,739.1**	**47,469.4**
Registered	**29,515.0**	**29,431.5**	**29,318.0**	**29,521.0**	**29,545.5**	**29,928.3**	**30,293.7**	**30,961.6**	**31,417.1**	**32,170.2**	**33,074.1**
Acute	14,717.4	14,863.0	15,029.7	15,361.3	15,549.4	15,863.2	16,114.3	16,766.4	17,278.1	18,040.7	..
Midwives	2,408.4	2,406.1	2,354.5	2,367.5	2,377.1	2,339.9	2,334.9	2,365.1	2,392.2	2,411.2	..
Other Maternity	327.7	315.9	310.4	309.4	312.7	303.1	279.9	277.8	284.8	280.8	..
Mental Illness	5,618.1	5,609.5	5,601.6	5,498.5	5,437.2	5,564.4	5,686.6	5,733.4	5,734.0	5,709.5	..
Learning Disabilities	1,329.6	1,276.3	1,197.2	1,178.3	1,139.3	1,045.5	967.6	863.5	821.0	821.1	..
Care of the Elderly	3,964.4	3,760.3	3,573.4	3,505.7	3,385.5	3,309.8	3,294.7	3,266.9	3,212.8	3,165.1	..
Paediatrics	1,149.4	1,194.4	1,239.3	1,299.4	1,343.3	1,438.5	1,544.6	1,599.3	1,602.1	1,649.6	..
Infection Control	-	-	-	-	-	61.9	70.1	89.3	92.1	92.3	..
Other	-	6.0	12.0	1.0	1.0	2.0	1.0	-	-	-	..
Non registered	**15,843.8**	**15,462.1**	**15,081.0**	**14,964.2**	**14,664.9**	**14,863.1**	**14,970.1**	**14,817.7**	**14,609.9**	**14,568.9**	**14,395.3**
Acute	5,215.0	5,230.4	5,295.9	5,426.3	5,459.2	5,712.7	5,867.5	6,048.9	6,072.6	6,260.1	..
Other Maternity	751.5	701.9	682.6	686.7	648.8	610.7	603.8	581.2	601.0	578.8	..
Mental Illness	3,909.5	3,764.2	3,699.0	3,642.0	3,588.0	3,667.4	3,704.8	3,642.2	3,575.1	3,529.4	..
Learning Disabilities	1,633.1	1,580.6	1,436.2	1,338.9	1,245.5	1,214.1	1,107.4	943.7	879.6	835.0	..
Care of the Elderly	3,942.4	3,798.6	3,553.3	3,462.9	3,312.8	3,241.5	3,243.3	3,173.7	3,060.5	2,933.8	..
Paediatrics	392.4	379.8	381.1	369.9	373.6	386.0	406.9	421.2	417.2	408.8	..
Infection Control	-	-	-	-	-	-	-	-	-	-	..
Healthcare assistant	-	6.6	32.9	37.5	36.9	30.8	36.4	6.8	3.9	23.0	..
Other	-	-	-	-	-	-	-	-	-	-	..
Community Specialties[2]	**5,967.1**	**6,048.6**	**6,140.9**	**6,304.8**	**6,392.0**	**6,723.5**	**6,919.6**	**7,216.7**	**7,305.7**	**7,457.8**	**8,198.7**
Registered	**5,412.4**	**5,458.1**	**5,553.1**	**5,697.1**	**5,757.2**	**6,048.1**	**6,226.1**	**6,451.6**	**6,554.5**	**6,693.0**	**7,071.9**
Health visitor	1,426.4	1,442.6	1,459.0	1,464.4	1,460.1	1,487.7	1,503.4	1,473.2	1,489.1	1,479.5	..
Grades G & above - Whitley only	1,308.8	1,307.5	1,317.3	1,310.6	1,310.6	1,315.9	1,277.2	1,265.1	1,263.3	1,248.7	..
Below Grade G - Whitley only	117.6	135.1	141.7	153.9	149.5	171.8	226.3	208.1	225.8	230.8	..
District nurse	1,780.0	1,799.7	1,852.5	1,939.8	1,935.8	1,999.7	2,008.4	2,012.3	2,027.1	2,048.5	..
Grades G & above - Whitley only	1,008.3	1,001.7	1,011.8	1,027.3	1,018.4	1,033.7	1,020.3	1,036.1	1,024.3	1,031.9	..
Below Grade G - Whitley only	771.7	798.0	840.7	912.5	917.4	966.0	988.1	976.2	1,002.8	1,016.6	..
Community midwife	308.0	291.9	302.6	289.5	286.4	301.1	306.7	321.2	299.9	303.6	..
Combined duty nurse - including midwifery	409.8	378.6	338.2	305.9	264.8	218.9	197.4	176.6	165.7	147.1	..
Combined duty nurse - not including midwifery	24.4	19.4	19.5	17.3	16.1	14.7	12.7	14.3	16.9	16.2	..
Community psychiatric nurse	449.4	484.7	499.4	587.0	627.2	703.4	739.6	877.9	921.1	998.7	..
Community learning disability nurse	151.8	146.3	139.5	133.3	128.5	123.6	103.6	99.9	101.1	100.1	..
School nurse	287.3	277.2	284.4	277.5	289.0	309.8	302.6	294.0	300.7	305.2	..
Clinic nurse	207.1	209.0	204.3	201.4	200.3	199.3	200.1	203.8	209.5	194.3	..
Other	368.3	408.6	453.6	481.2	549.1	689.9	851.5	978.6	1,023.5	1,099.8	..
Non registered	**554.8**	**590.5**	**587.9**	**607.6**	**634.8**	**675.4**	**693.5**	**765.1**	**751.2**	**764.8**	**1,126.8**
Auxiliary/assistant	536.0	568.9	576.9	593.8	607.4	634.2	649.2	712.7	691.8	696.9	..
Nursery nurse	18.8	21.6	10.9	13.8	27.3	41.2	44.4	52.3	59.4	67.9	..
Other Specialties[2]	**351.4**	**385.0**	**427.8**	**480.9**	**625.4**	**643.4**	**950.1**	**1,065.3**	**1,155.1**	**1,208.5**	**1,093.6**
Registered	**183.6**	**221.4**	**244.8**	**275.8**	**363.1**	**392.9**	**695.8**	**813.6**	**901.7**	**942.0**	**858.0**
Occupational Health	-	-	-	-	87.5	95.1	111.1	127.5	114.7	121.1	..
Blood Transfusion Service	43.8	51.7	52.2	64.5	61.2	59.2	67.4	64.8	78.0	83.7	..
NHS24	-	-	-	-	-	-	244.3	346.8	380.5	374.3	..
Other	139.8	169.8	192.6	211.3	214.5	238.6	273.0	274.6	328.6	362.9	..
Non registered	**167.9**	**163.6**	**183.0**	**205.1**	**262.3**	**250.5**	**254.3**	**251.7**	**253.3**	**266.6**	**235.6**
Occupational Health	-	-	-	-	-	-	-	-	-	1.0	..
Blood Transfusion Service	124.8	121.2	123.2	121.8	164.5	159.1	155.9	139.2	143.9	141.2	..
Other	43.1	42.4	59.8	83.3	97.8	91.5	98.4	112.5	109.4	124.4	..

Notes:
1 Nursing management - all nurses on clinical grades are excluded from this category. Some senior nurse managers are employed on senior management grades and are not included in the nursing total.
2 The figures are presented in the same groupings as for previous years and the details for employees who have been assimilated to Agenda for Change have been 'mapped back' as far as possible to the coding used under Whitley to ensure consistency in trend data. Where this has not been possible the data are not shown for 2006.

Table 7 - NHS Scotland: Nursing and Midwifery Staff (Headcount) - Pre 2007

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
All nursing and midwifery staff	**62,455**	**61,943**	**61,353**	**61,627**	**61,560**	**62,357**	**63,335**	**64,293**	**64,822**	**65,781**	**67,099**
Senior Nurse Managers[1]	**217**	**138**	**122**	**105**	**66**	**56**	**44**	**36**	**40**	**29**	**..**
Hospital Specialties[2]	**54,232**	**53,558**	**52,816**	**52,750**	**52,355**	**52,748**	**53,092**	**53,479**	**53,752**	**54,447**	**55,061**
Registered	**34,460**	**34,311**	**34,120**	**34,254**	**34,293**	**34,552**	**34,861**	**35,541**	**36,105**	**36,934**	**37,862**
Acute	17,273	17,417	17,591	17,901	18,134	18,394	18,636	19,281	19,882	20,710	..
Midwives	3,003	2,988	2,936	2,947	2,968	2,911	2,902	2,945	2,979	3,016	..
Other Maternity	420	404	380	383	386	375	346	342	353	346	..
Mental Illness	6,099	6,083	6,065	5,953	5,872	5,989	6,116	6,191	6,200	6,190	..
Learning Disabilities	1,433	1,381	1,290	1,265	1,223	1,121	1,039	935	897	899	..
Care of the Elderly	4,835	4,575	4,333	4,236	4,088	3,967	3,917	3,859	3,791	3,713	..
Paediatrics	1,397	1,457	1,513	1,568	1,621	1,729	1,830	1,894	1,903	1,961	..
Infection Control	-	-	-	-	-	64	74	94	100	99	..
Other	-	6	12	1	1	2	1	-	-	-	..
Non registered	**19,772**	**19,247**	**18,696**	**18,496**	**18,062**	**18,196**	**18,231**	**17,938**	**17,647**	**17,513**	**17,199**
Acute	6,761	6,742	6,769	6,884	6,902	7,166	7,306	7,434	7,468	7,644	..
Other Maternity	1,027	951	916	919	861	805	785	753	777	749	..
Mental Illness	4,490	4,331	4,259	4,193	4,110	4,189	4,214	4,138	4,052	3,997	..
Learning Disabilities	1,819	1,760	1,593	1,487	1,385	1,346	1,226	1,045	973	932	..
Care of the Elderly	5,130	4,929	4,596	4,462	4,257	4,134	4,116	4,011	3,829	3,638	..
Paediatrics	545	527	523	505	500	515	537	548	542	528	..
Infection Control	-	-	-	-	-	-	-	-	-	-	..
Healthcare assistant	-	7	40	46	47	41	47	9	6	25	..
Other	-	-	-	-	-	-	-	-	-	-	..
Community Specialties[2]	**7,562**	**7,756**	**7,872**	**8,150**	**8,281**	**8,690**	**8,968**	**9,351**	**9,461**	**9,615**	**10,497**
Registered	**6,560**	**6,699**	**6,821**	**7,056**	**7,149**	**7,508**	**7,766**	**8,075**	**8,216**	**8,354**	**8,843**
Health visitor	1,605	1,648	1,680	1,698	1,709	1,756	1,799	1,789	1,825	1,826	..
Grades G & above - Whitley only	1,453	1,473	1,496	1,498	1,506	1,527	1,498	1,503	1,510	1,501	..
Below Grade G - Whitley only	152	175	184	200	203	229	301	286	315	325	..
District nurse	2,242	2,271	2,321	2,456	2,450	2,533	2,553	2,574	2,599	2,631	..
Grades G & above- Whitley only	1,161	1,155	1,160	1,174	1,166	1,181	1,179	1,205	1,190	1,210	..
Below Grade G - Whitley only	1,081	1,116	1,161	1,282	1,284	1,352	1,374	1,369	1,409	1,421	..
Community midwife	346	331	346	331	331	343	349	364	343	351	..
Combined duty nurse - including midwifery	463	429	381	348	301	250	224	197	185	167	..
Combined duty nurse - not including midwifery	25	21	20	18	17	18	15	16	19	17	..
Community psychiatric nurse	468	507	524	624	664	742	783	929	982	1,065	..
Community learning disability nurse	159	153	146	140	137	130	108	104	106	105	..
School nurse	385	382	395	388	403	429	424	414	423	421	..
Clinic nurse	310	313	312	310	312	310	303	308	324	287	..
Other	557	644	696	743	825	997	1,208	1,380	1,410	1,484	..
Non registered	**1,002**	**1,057**	**1,051**	**1,094**	**1,132**	**1,182**	**1,202**	**1,276**	**1,245**	**1,261**	**1,654**
Auxiliary/assistant	978	1,029	1,035	1,073	1,089	1,114	1,128	1,191	1,154	1,160	..
Nursery nurse	24	28	16	21	43	68	74	85	91	101	..
Other Specialties[2]	**444**	**491**	**543**	**622**	**858**	**863**	**1,231**	**1,427**	**1,569**	**1,690**	**1,518**
Registered	**218**	**266**	**296**	**344**	**458**	**483**	**840**	**1,037**	**1,179**	**1,277**	**1,168**
Occupational Health	-	-	-	-	106	114	132	153	137	144	..
Blood Transfusion Service	56	69	70	86	87	82	94	91	107	111	..
NHS24	-	-	-	-	-	-	288	453	525	561	..
Other	162	197	226	258	265	287	326	340	410	461	..
Non registered	**226**	**225**	**247**	**278**	**400**	**380**	**391**	**390**	**390**	**413**	**350**
Occupational Health	-	-	-	-	-	-	-	-	-	1	..
Blood Transfusion Service	171	169	170	176	275	266	264	239	242	244	..
Other	55	56	77	102	125	114	127	151	148	168	..

Notes:

1 Nursing management - all nurses on clinical grades are excluded from this category. Some senior nurse managers are employed on senior management grades and are not included in the nursing total.

2 The figures are presented in the same groupings as for previous years and the details for employees who have been assimilated to Agenda for Change have been 'mapped back' as far as possible to the coding used under Whitley to ensure consistency in trend data. Where this has not been possible the data are not shown for 2006.

Table 8 - NHS Scotland: Nursing and Midwifery Vacancies as at 30 September 2009

	Establishment	Staff in Post	Vacant for: Posts under review	Total Vacancies	Less than 3 months	3 months or more	Unknown	Vacancies as a percentage of establishment: Total	3 months or more
Nursing and midwifery staff	**59,905.4**	**58,429.1**	**38.8**	**1,476.3**	**1,006.1**	**410.1**	**60.1**	**2.5%**	**0.7%**
Hospital (All AfC Bands)	**43,216.5**	**42,181.9**	**27.9**	**1,034.7**	**709.7**	**289.8**	**35.2**	**2.4%**	**0.7%**
Adult	32,316.1	31,491.5	19.5	824.6	567.7	221.7	35.2	2.6%	0.7%
Paediatrics	1,221.9	1,154.6	-	67.3	59.0	8.3	-	5.5%	0.7%
Mental health	6,195.1	6,085.1	5.4	110.0	53.7	56.2	-	1.8%	0.9%
Learning disabilities	549.0	543.4	-	5.6	4.0	1.6	-	1.0%	0.3%
Midwifery	1,996.8	1,969.6	3.0	27.2	25.3	1.9	-	1.4%	0.1%
Other nurses	937.7	937.7	-	-	-	-	-	0.0%	0.0%
Community (All AfC Bands)	**10,574.8**	**10,184.3**	**6.2**	**390.6**	**264.0**	**108.1**	**18.5**	**3.7%**	**1.0%**
Health visitors	1,060.0	1,026.6	1.0	33.4	23.5	9.9	-	3.2%	0.9%
District nurses	4,077.0	4,031.6	0.6	45.4	33.0	10.9	1.5	1.1%	0.3%
Public health nurses	177.8	154.8	-	22.9	16.1	6.3	0.5	12.9%	3.6%
School nurses	264.0	257.5	1.4	6.5	5.4	1.1	-	2.5%	0.4%
Paediatrics	90.6	82.9	-	7.7	6.7	1.0	-	8.5%	1.1%
Mental health	2,164.1	2,059.1	0.2	105.0	76.6	18.4	10.0	4.9%	0.9%
Learning disabilities	465.0	453.5	-	11.5	7.5	3.0	1.0	2.5%	0.6%
Midwifery	227.8	222.6	-	5.2	2.6	2.6	-	2.3%	1.1%
Other nurses	1,990.5	1,895.7	-	94.9	48.7	41.7	4.5	4.8%	2.1%
Combined hospital/community (All AfC Bands)	**4,195.1**	**4,155.9**	**-**	**39.2**	**24.2**	**8.6**	**6.5**	**0.9%**	**0.2%**
Health visitors	32.2	32.2	-	-	-	-	-	0.0%	0.0%
Paediatrics	187.6	187.6	-	-	-	-	-	0.0%	0.0%
Mental health	434.9	426.7	-	8.2	8.2	-	-	1.9%	0.0%
Learning disabilities	28.8	23.3	-	5.5	5.5	-	-	19.1%	0.0%
Midwifery	792.2	786.8	-	5.4	3.6	1.8	-	0.7%	0.2%
Other nurses	2,706.2	2,699.4	-	6.8	2.8	-	4.0	0.3%	0.0%
Other/Not applicable (All AfC Bands)	**1,851.2**	**1,839.3**	**1.7**	**11.9**	**8.2**	**3.7**	**-**	**0.6%**	**0.2%**
Not assimilated	**67.8**	**67.8**	**3.0**	**-**	**-**	**-**	**-**	**0.0%**	**0.0%**

Source: Scottish Workforce Information Standard System (SWISS). ISD(M)36

Table 9 - NHS Scotland: Nursing and Midwifery Vacancies as at 30 September 2008

	Establishment	Staff in Post	Vacant for: Posts under review	Total Vacancies	Less than 3 months	3 months or more	Unknown	Vacancies as a percentage of establishment: Total	3 months or more
Nursing and midwifery staff	**59,221.1**	**57,749.6**	**44.7**	**1,471.5**	**1,106.1**	**344.7**	**20.7**	**2.5%**	**0.6%**
Hospital (All AfC Bands)	**44,164.8**	**43,090.0**	**39.7**	**1,074.8**	**823.2**	**242.6**	**9.0**	**2.4%**	**0.5%**
Adult	33,570.8	32,745.5	30.3	825.3	652.7	168.6	4.0	2.5%	0.5%
Paediatrics	798.9	717.2	-	81.7	53.3	28.4	-	10.2%	3.6%
Mental health	5,735.2	5,619.1	8.4	116.1	79.4	31.7	5.0	2.0%	0.6%
Learning disabilities	433.6	425.9	-	7.7	4.2	3.5	-	1.8%	0.8%
Midwifery	2,644.2	2,600.2	1.0	44.0	33.6	10.4	-	1.7%	0.4%
Other nurses	982.1	982.1	-	-	-	-	-	0.0%	0.0%
Community (All AfC Bands)	**9,970.4**	**9,627.6**	**5.0**	**342.7**	**256.4**	**78.5**	**7.8**	**3.4%**	**0.8%**
Health visitors	1,140.1	1,097.9	-	42.3	36.1	6.2	-	3.7%	0.5%
District nurses	3,899.9	3,862.5	-	37.4	29.1	8.1	0.2	1.0%	0.2%
Public health nurses	130.6	114.4	-	16.2	8.9	7.3	-	12.4%	5.6%
School nurses	240.9	232.0	-	8.9	8.1	0.8	-	3.7%	0.3%
Paediatrics	69.5	67.9	-	1.6	-	1.6	-	2.3%	2.3%
Mental health	1,810.0	1,766.7	3.0	43.3	30.4	9.9	3.0	2.4%	0.5%
Learning disabilities	533.8	518.8	-	15.0	11.6	3.4	-	2.8%	0.6%
Midwifery	193.7	183.0	-	10.7	6.5	4.2	-	5.5%	2.2%
Other nurses	1,890.3	1,784.5	-	105.8	89.6	14.6	1.6	5.6%	0.8%
Combined hospital/community (All AfC Bands)	**1,668.8**	**1,643.2**	**-**	**25.6**	**5.6**	**17.1**	**2.9**	**1.5%**	**1.0%**
Health visitors	52.0	52.0	-	-	-	-	-	0.0%	0.0%
Paediatrics	8.8	8.8	-	-	-	-	-	0.0%	0.0%
Mental health	425.6	422.6	-	3.0	3.0	-	-	0.7%	0.0%
Learning disabilities	55.5	52.3	-	3.2	-	3.2	-	5.8%	5.8%
Midwifery	140.0	140.0	-	-	-	-	-	0.0%	0.0%
Other nurses	983.3	967.4	-	15.9	2.0	13.9	-	1.6%	1.4%
Other/Not applicable (All AfC Bands)	**2,710.0**	**2,681.6**	**-**	**28.4**	**20.9**	**6.5**	**1.0**	**1.0%**	**0.2%**
Not assimilated	**707.2**	**707.2**	**-**	**-**	**-**	**-**	**-**	**0.0%**	**0.0%**

Source: Scottish Workforce Information Standard System (SWISS). ISD(M)36

Table 10 - NHS Scotland Nursing and Midwifery Vacancies as at 31 March

Vacancies as a percentage of establishment

	1996	1997	1998	1999 [5]	2000	2001	2002	2003	2004	2005 [7]
Corrected Total [2]	**3.6**	**3.4**	**3.4**	**2.8**	**2.3**	**3.2**	**3.6**	**3.5**	**3.7**	**4.2**
Reported Total [3]	**3.6**	**3.4**	**3.4**	**2.8**	**2.3**	**3.2**	**3.6**	**3.5**	**3.7**	**4.2**
Registered	**3.7**	**3.6**	**3.5**	**3.1**	**2.6**	**3.6**	**4.0**	**3.9**	**4.0**	**4.5**
Nurse Managers [6]	3.3	2.4	1.7	2.3	1.9	3.2	3.1	1.4	1.2	x
Senior Nurse Managers [7]	x	x	x	x	x	x	x	x	x	22.2
Education	-	4.4	-	-	-	x	x	x	x	x
General (Acute)	**4.0**	**3.7**	**4.1**	**3.9**	**3.2**	**2.9**	**5.3**	**4.4**	**4.8**	**5.6**
ITU	2.6	4.0	2.9	3.2	2.8	2.4	6.8	8.2	..	..
A&E	1.3	3.3	4.0	5.2	2.2	2.7	3.7	3.1	..	..
Theatre	2.1	2.3	4.6	4.4	3.3	3.9	5.3	6.3	..	..
Other general	4.4	3.8	4.1	3.8	3.2	2.8	5.2	3.9	..	..
Care of the Elderly	6.4	6.1	5.5	4.3	4.0	4.5	4.3	4.8	3.7	5.5
Infection Control	x	x	x	x	x	x	x	2.3	8.7	1.1
Paediatrics	6.5	3.4	4.8	1.9	2.0	2.4	5.7	4.8	2.9	2.7
Midwifery	1.9	1.3	1.3	2.1	1.1	1.3	2.4	3.2	1.0	1.8
Maternity	0.8	3.5	1.4	1.1	3.0	1.2	5.5	3.0	6.2	4.4
Combined Duty Nurse	x	x	x	x	x	0.4	0.7	0.3	3.5	0.6
Health visiting	3.3	2.0	2.2	2.7	1.7	4.6	4.5	3.8	4.7	2.9
District nursing	0.9	1.3	1.6	2.0	2.7	3.1	3.3	2.1	3.1	2.9
Mental health	3.6	3.8	3.3	2.3	1.7	3.7	3.2	2.8	3.5	3.0
Learning disabilities	3.0	7.2	2.9	2.1	1.9	2.9	3.8	4.6	4.4	5.0
Other Community	2.9	2.8	2.5	1.3	0.8	3.5	2.4	5.0	5.0	3.6
Other registered [8]	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**15.4**	**10.2**
Registered - specialty not known [9]	**x**	**x**	**x**	**x**	**x**	**7.1**	**x**	**x**	**x**	**x**
Non registered [10]	**3.5**	**2.8**	**3.1**	**2.1**	**1.7**	**2.5**	**2.6**	**2.7**	**2.7**	**3.3**
Auxiliaries and assistants	3.4	2.8	3.1	2.0	1.7	2.1	2.7	2.7	2.7	3.3
Nursery nurses	5.9	0.8	4.1	2.8	0.3	2.1	0.2	1.6	x	1.5

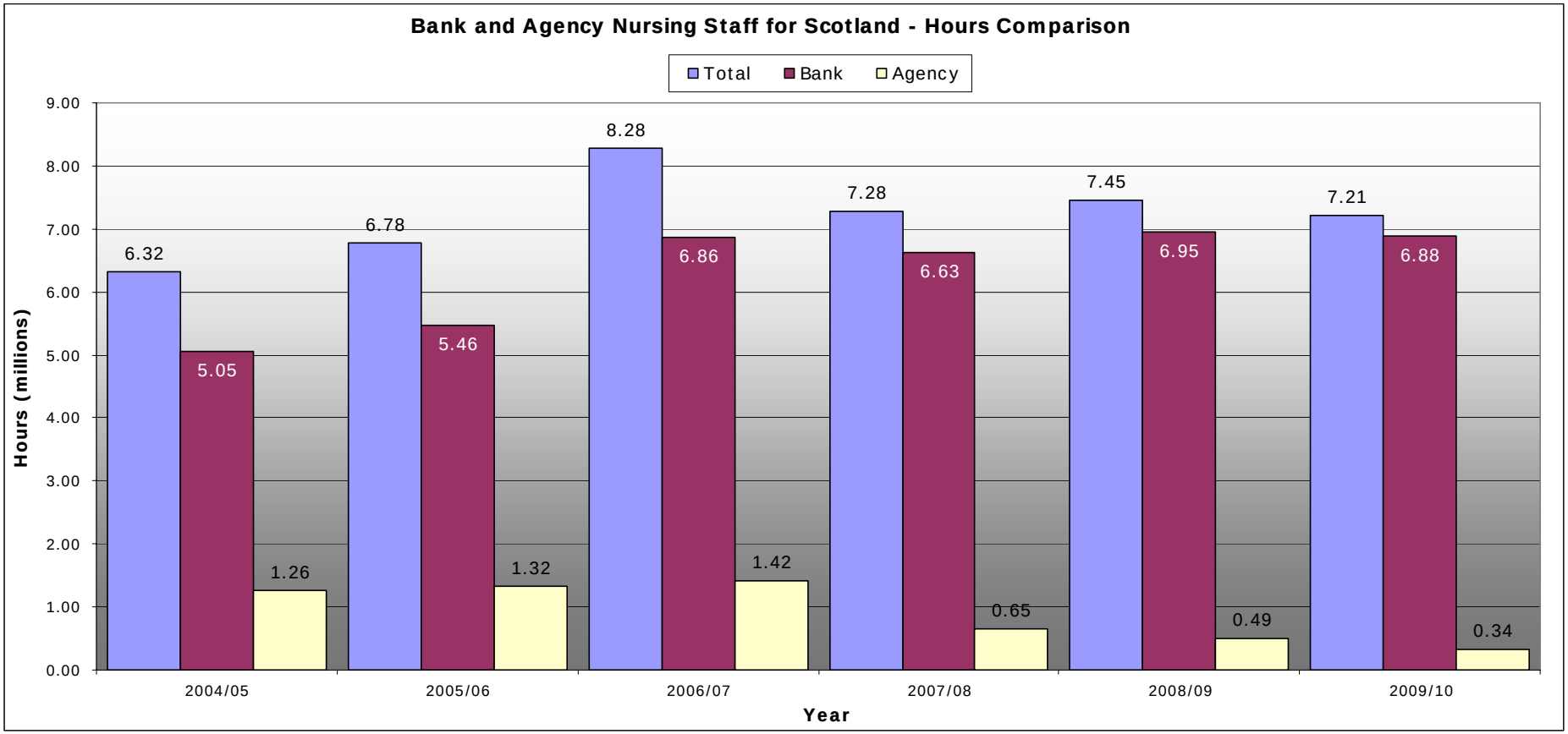
Notes:
1 Excludes nurses in training. 2 Estimated figures are based on staff in post extracted from Payroll. 3 Response Rate: 1996 (78%), 1997 (83%), 1998 (86%), 1999 (94%), 2000 (94%), 2001(98%), 2002 (97%), 2003 (100%), 2004 (100%) and 2005 (100%).
4 The vacancy figures relate to posts vacant at 31 March, irrespective of when the vacancy arose. 5 Data are at 30 April. 6 Includes Senior Nurse Managers, Nurse/Midwife Consultants and those on grades H and I (except Infection Control Nurses, Health Visitors and District Nurses). 7 The data collection was revised in 2005. Vacancies for senior nurse managers can be explicitly identified. Other nurse manager vacancies are recorded under the appropriate specialty. 8 New category introduced in the 2004 collection which includes qualified nursing posts not covered in the above categories. 9 North Glasgow unable to fully break down qualified nursing by specialty. 10 Is not the summation of categories below as some trusts were unable to give a detailed breakdown.

Table 11 - NHS Scotland: Nursing and Midwifery Vacancies Over 3 Months as at 31 March

	1996	1997	1998	1999 [5]	2000	2001	2002	2003	2004	2005 [7]
Corrected Total [2]	**0.9**	**1.0**	**0.8**	**1.0**	**0.6**	**0.5**	**0.9**	**1.0**	**1.1**	**1.6**
Reported Total [3]	**0.9**	**1.0**	**0.8**	**1.0**	**0.6**	**0.5**	**0.9**	**1.0**	**1.1**	**1.6**
Registered	**0.9**	**1.0**	**0.8**	**1.1**	**0.7**	**0.5**	**1.0**	**1.1**	**1.2**	**1.7**
Nurse Managers [6]	0.8	0.3	0.6	0.4	0.4	1.3	1.2	0.2	0.6	x
Senior Nurse Managers [7]	x	x	x	x	x	x	x	x	x	7.8
Education	-	4.4	-	-	-	x	x	x	x	x
General (Acute)	**0.6**	**0.9**	**0.9**	**1.4**	**0.7**	**0.5**	**1.5**	**1.3**	**1.6**	**2.1**
ITU	0.6	1.2	0.7	1.3	0.9	0.4	3.8	2.9	..	..
A&E	0.3	0.8	1.1	0.7	0.3	0.2	1.0	0.8	..	..
Theatre	0.4	0.5	1.1	1.6	0.8	1.3	2.5	1.3	..	..
Other general	0.6	1.0	0.9	1.4	0.7	0.5	1.1	1.2	..	..
Care of the Elderly	2.4	1.5	0.8	0.9	1.4	1.1	1.0	1.2	1.3	2.8
Infection Control [7]	x	x	x	x	x	x	x	2.3	4.4	-
Paediatrics	1.0	1.1	0.9	0.5	0.5	0.2	0.9	1.9	0.3	0.3
Midwifery	0.6	0.4	0.5	0.7	0.4	0.0	0.7	0.8	0.3	0.7
Maternity	0.2	2.4	0.5	0.2	0.7	0.2	2.5	1.5	1.3	-
Combined Duty Nurse	x	x	x	x	x	0.4	-	0.3	1.5	0.6
Health visiting	1.3	0.5	0.4	0.6	0.6	0.8	1.0	1.1	1.4	0.8
District nursing	0.4	0.5	0.5	0.6	1.0	0.2	0.1	0.4	1.1	0.3
Mental health	1.6	0.9	1.0	1.1	0.5	0.9	0.7	0.7	0.9	0.7
Learning disabilities	1.2	4.6	1.5	1.3	0.9	1.4	2.0	2.5	0.4	1.3
Other Community	0.4	0.1	0.7	0.7	0.0	0.0	0.1	0.7	1.6	0.2
Other registered [8]	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**1.5**	**9.1**
Registered - specialty not known [9]	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
Non registered [10]	**0.8**	**0.8**	**0.6**	**0.7**	**0.5**	**0.4**	**0.5**	**0.9**	**0.9**	**1.2**
Auxiliaries and assistants	0.8	0.8	0.6	0.7	0.5	0.4	0.6	0.9	0.9	1.2
Nursery nurses	0.5	0.3	0.3	0.5	-	-	0.2	-	x	1.5

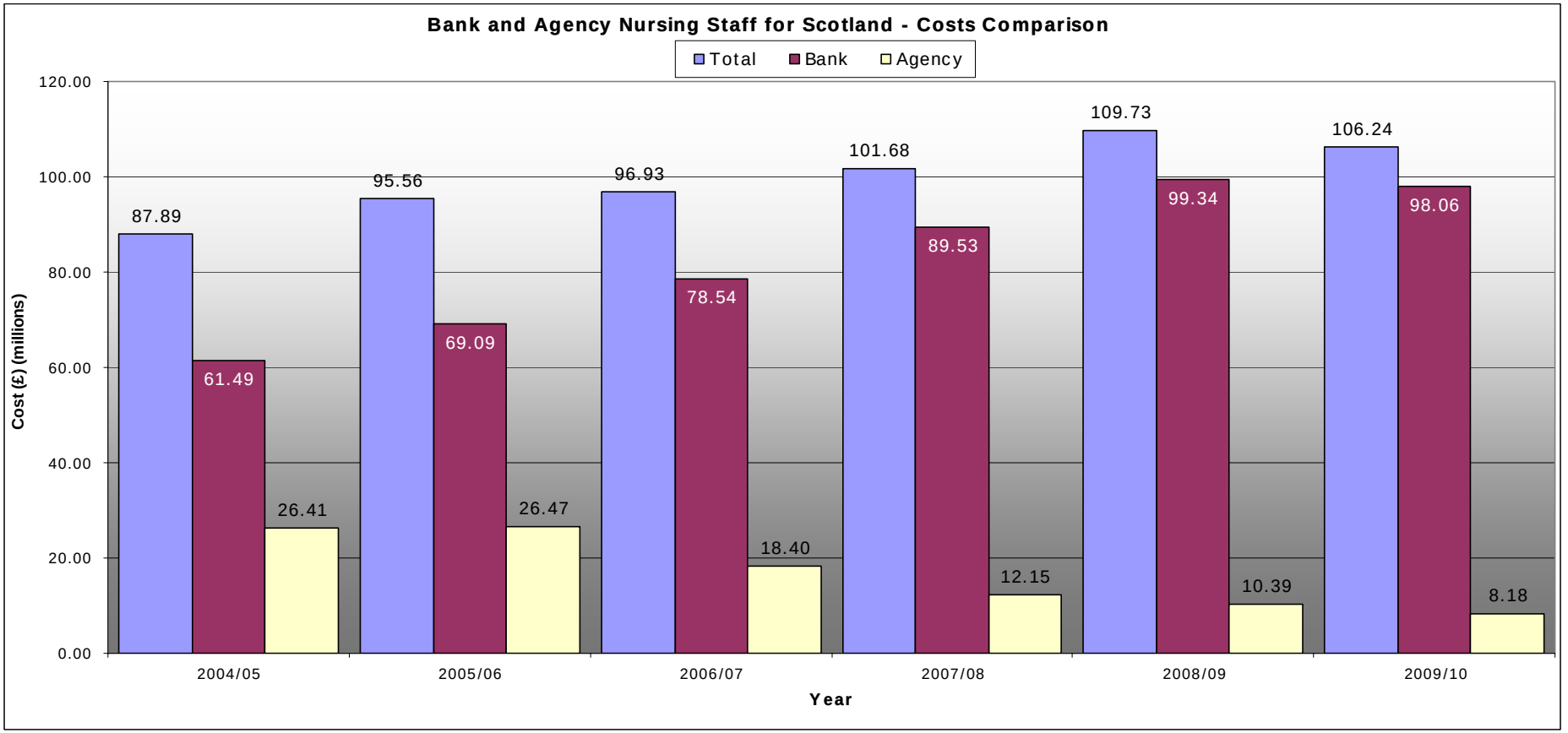
Notes:
1 Excludes nurses in training. 2 Estimated figures are based on staff in post extracted from Payroll. 3 Response Rate: 1996 (78%), 1997 (83%), 1998 (86%), 1999 (94%), 2000 (94%), 2001(98%), 2002 (97%), 2003 (100%), 2004 (100%) and 2005 (100%). 4 Refers to post that became vacant before 1 January. 5 Data are at 30 April. 6 Includes Senior Nurse Managers, Nurse/Midwife Consultants and those on grades H and I (except Infection Control Nurses, Health Visitors and District Nurses). 7 The data collection was revised in 2005. Vacancies for senior nurse managers can be explicitly identified. Other nurse manager vacancies are recorded under the appropriate specialty. 8 New category introduced in the 2004 collection which includes qualified nursing staff not covered in the above categories. 9 North Glasgow unable to fully break down qualified nursing by specialty. 10 Is not the summation of categories below as some trusts were unable to give a detailed breakdown.

Table 12 - NHS Scotland: Bank and Agency Hours for Financial Period 1 April to 31 March



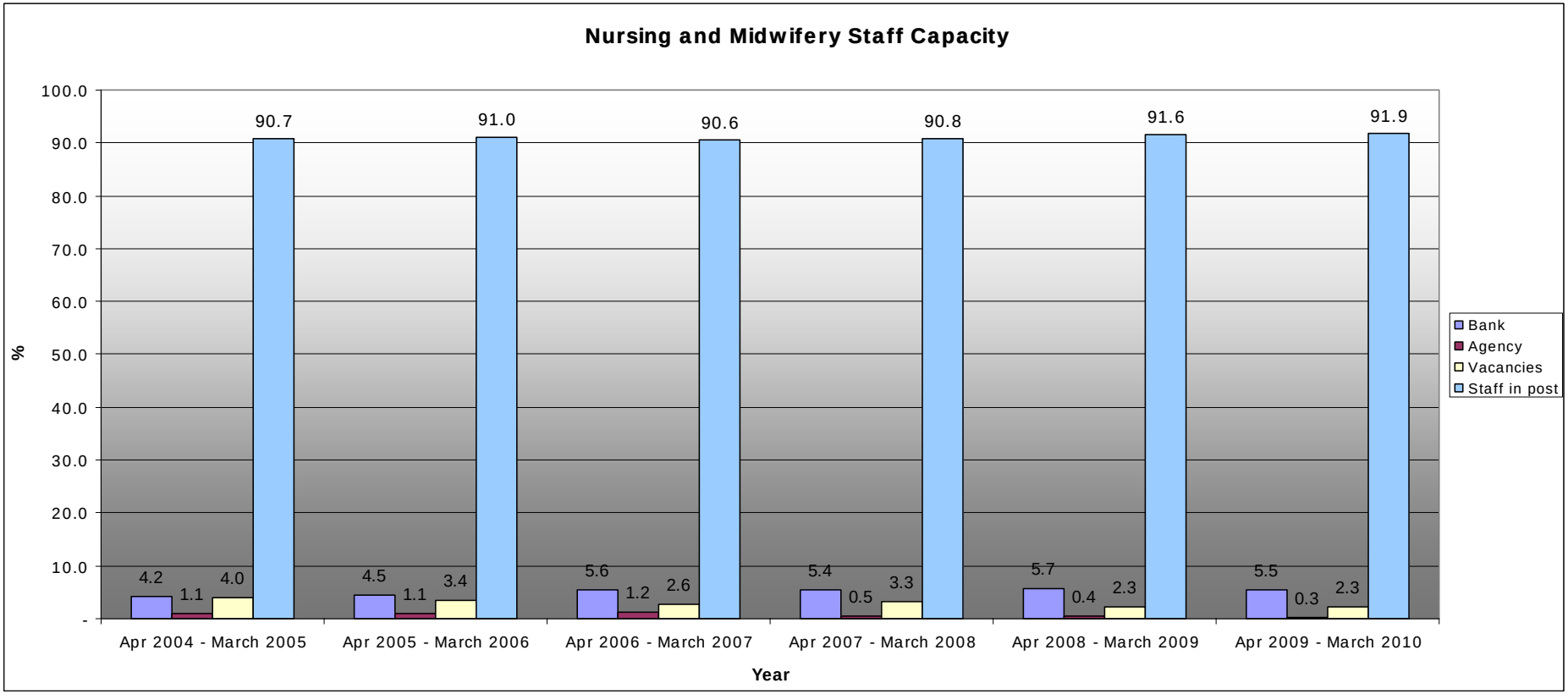
Source: Scottish Workforce Information Standard System (SWISS).

Table 13 - NHS Scotland: Bank and Agency Spend for Financial Period 1 April to 31 March



Source: Scottish Workforce Information Standard System (SWISS).

Table 14 - NHS Scotland: Nurse and Midwifery Staff Capacity



Source: Scottish Workforce Information Standard System (SWISS).

Table 15 - NHS Scotland: Nurse and Midwifery Student Intake and Students in Training

	1980/81	1985/86	1990/91	1995/96	1996/97	1997/98	1998/99	1999/2000	2000/2001	2001/2002	2002/2003	2003/2004	2004/2005	2005/2006	2006/2007	2007/2008	2008/2009
Intakes [1]																	
Initial entrant	..	**2707**	**2779**	**2377**	**2575**	**2538**	**2783**	**2866**	**3242**	**3365**	**3395**	**3608**	**3698**	**3592**	**3391**	**3437**	**3260**
General/adult	..	1,828	1,846	1,584	1,746	1,679	1,843	1,891	2,203	2,378	2,414	2,581	2,680	2,654	2,476	2,460	2,398
Mental illness/Mental health	..	534	578	392	414	428	441	463	539	510	486	567	575	542	522	595	427
Learning disabilities	..	139	149	88	69	80	102	86	68	50	66	61	68	45	51	33	34
Children	..	98	-	145	157	180	214	235	226	222	217	213	190	178	170	170	207
Midwifery [6]	x	x	x	168	189	171	183	191	206	205	212	186	185	173	172	179	194
Other	..	108	206	-	-	-	-	-	-	-	-	-	-	-	-	- -	
Student nurse: enrolled [2]	..	**805**	**204**	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Conversion student [3]	..	**1,362**	**1,182**	**453**	**637**	**705**	**651**	**596**	**513**	**494**	**472**	**364**	**185**	**201**	**134**	**158**	**111**
General/adult	..	405	396	246	350	435	421	378	365	341	328	264	86	130	60	55	28
Mental illness/Mental health	..	159	161	61	132	109	104	96	75	68	84	63	30	37	28	60	30
Learning disabilities	..	39	57	14	23	30	23	21	9	12	4	1	5	3	6	5	5
Children	..	61	124	52	53	41	35	28	13	25	9	3	11	3	7	10	12
Midwifery [6]	..	698	444	80	79	90	68	73	51	48	47	33	53	28	33	28	36

	1980	1985	1990	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
In Training [4]																	
First level course [5]	**6,100**	**7,336**	**7,916**	**6,191**	**6,346**	**6,612**	**6,887**	**7,216**	**7,833**	**8,217**	**8,717**	**8,986**	**9,264**	**9,726**	**9,909**	**9,660**	**9,499**
General/adult	4,735	5,873	6,301	4,120	4,314	4,566	4,718	4,981	5,385	5,757	6,187	6,394	6,715	7,113	7,315	7,152	6,884
Mental illness/Mental health	909	1,007	1,280	1,019	936	939	1,011	1,059	1,184	1,199	1,205	1,262	1,280	1,408	1,386	1,345	1,388
Learning disabilities	177	229	297	259	219	206	213	202	184	150	157	139	152	138	144	106	102
Children	267	202	38	337	396	413	448	506	582	576	598	608	593	545	550	522	560
Midwifery [6]	x	x	x	456	481	488	497	468	498	535	570	583	524	522	514	535	565
Other	12	25	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Student nurse: enrolled [2]	**3,288**	**1,185**	**534**	**-**	**-**	**-**	**-**	**-**	-	-	-	-	-	-	-	-	-
Post registration	**2,950**	**2,623**	**1,899**	**696**	**1,214**	**1,517**	**1,955**	**2,329**	**2,244**	**2,074**	**2,205**	**1,859**	**1,644**	**1,401**	**1,251**	**1,094**	**1229**
General/adult	1,500	1,250	730	386	483	670	731	712	601	582	627	480	395	269	202	129	103
Mental illness/Mental health	330	260	238	107	139	205	185	154	116	115	139	121	99	65	64	71	81
Learning disabilities	32	42	42	19	29	41	40	39	26	22	16	4	6	6	11	9	8
Children	-	-	109	62	86	86	69	44	36	24	28	12	11	16	14	11	16
Midwifery [6]	1,088	1,071	780	122	126	108	114	118	101	80	81	69	62	68	59	49	48
Specialist Nursing Practice	x	x	x	x	51	134	436	848	971	896	969	899	819	754	691	609	717
Specialist Community Nursing Practice	x	x	x	x	300	273	380	414	393	355	345	274	252	223	210	216	256
Health Visitor	**70**	**116**	**87**	**122**	**155**	**146**	**120**	**168**	**167**	**296**	**215**	**210**	**194**	**181**	**161**	**124**	**126**
District Nurses	**7**	**110**	**87**	**123**	**123**	**122**	**122**	**123**	**135**	**156**	**138**	**144**	**129**	**128**	**109**	**82**	**86**

Notes: 1. Intakes of student nurses and midwives commencing in that financial year. Sourced from NHS Education for Scotland's 'Annual Statistical Supplement'. 2. Enrolled nursing training ended in 1994. 3. Comprises students on first to first level and second to first level conversion courses only. 4. Between 1980 and 1991 data relate to staff in training who appear on payrolland are at 30 September. From 1995 the data originates from NHS Education for Scotland and are at 31 October. 5. For 1975 to 1991 comprises nurses and midwives in training employed by health boards. After 1991, comprises nurses and midwives in training at higher education institutions. This total includes: 3-year, shortened, honours degree and conversion courses. 6. Prior to 1992/93 there was no direct entry course for midwifery. All courses were for nurses converting to midwifery.

Source: National Manpower Statistics from payroll (NAMS), ISD Scotland, NHS Education for Scotland

Table 16 - NHS Scotland: Allied Health Professionals Staff (Whole Time Equivalent) as at 30 September 2009

	2007	2008	2009	% Change 08 - 09
Allied health professionals	**8,951.5**	**9,242.8**	**9,579.5**	**3.6**
Arts therapy (art/music/drama)	32.0	34.9	33.6	-3.5
Assimilated	29.6	34.3	33.6	-1.8
Not assimilated	2.3	0.6	-	-100.0
Dietetics	574.5	600.8	652.8	8.6
Assimilated	517.0	596.0	652.8	9.5
Not assimilated	57.5	4.8	-	-100.0
Occupational therapy	2,161.4	2,136.4	2,161.7	1.2
Assimilated	1,836.1	2,110.9	2,161.7	2.4
Not assimilated	325.2	25.4	-	-100.0
Orthoptics	72.2	73.1	81.9	12.1
Assimilated	69.5	72.1	80.9	12.2
Not assimilated	2.6	1.0	1.0	-
Orthotics	34.7	44.8	46.7	4.2
Assimilated	19.0	43.8	46.7	6.5
Not assimilated	15.7	1.0	-	-100.0
Physiotherapy	2,527.4	2,631.7	2,709.8	3.0
Assimilated	2,235.3	2,611.7	2,709.3	3.7
Not assimilated	292.1	20.1	0.5	-97.6
Podiatry	703.6	725.1	735.3	1.4
Assimilated	637.3	719.0	733.6	2.0
Not assimilated	66.3	6.1	1.8	-70.9
Prosthetics	7.8	12.8	11.8	-7.8
Assimilated	7.8	12.8	11.8	-7.8
Not assimilated	-	-	-	x
Radiography	1,836.8	1,929.0	2,033.3	5.4
Assimilated	1,563.0	1,906.5	2,032.7	6.6
Not assimilated	273.8	22.5	0.6	-97.4
Speech and language therapy	941.8	972.6	1,003.4	3.2
Assimilated	801.6	948.3	1,001.9	5.7
Not assimilated	140.2	24.3	1.5	-93.9
Multi skilled	59.3	81.5	109.1	33.8

Source: Scottish Workforce Information Standard System (SWISS), data extracted 03/10/2008 and 13/10/2009.

Table 17 - NHS Scotland: Allied Health Professionals Staff (Headcount) as at 30 September 2009

	2007	2008	2009	% Change 08 - 09
Allied health professionals	**10,981.0**	**11,342.0**	**11,777.0**	**3.8**
Arts therapy (art/music/drama)	45.0	49.0	51.0	4.1
Assimilated	40.0	47.0	51.0	8.5
Not assimilated	5.0	2.0	-	-100.0
Dietetics	704.0	742.0	809.0	9.0
Assimilated	631.0	736.0	809.0	9.9
Not assimilated	73.0	6.0	-	-100.0
Occupational therapy	2,584.0	2,579.0	2,611.0	1.2
Assimilated	2,203.0	2,548.0	2,611.0	2.5
Not assimilated	381.0	31.0	-	-100.0
Orthoptics	104.0	104.0	111.0	6.7
Assimilated	100.0	103.0	110.0	6.8
Not assimilated	4.0	1.0	1.0	-
Orthotics	38.0	49.0	53.0	8.2
Assimilated	21.0	48.0	53.0	10.4
Not assimilated	17.0	1.0	-	-100.0
Physiotherapy	3,188.0	3,306.0	3,412.0	3.2
Assimilated	2,834.0	3,283.0	3,411.0	3.9
Not assimilated	354.0	23.0	1.0	-95.7
Podiatry	867.0	899.0	929.0	3.3
Assimilated	786.0	891.0	925.0	3.8
Not assimilated	81.0	8.0	4.0	-50.0
Prosthetics	8.0	13.0	12.0	-7.7
Assimilated	8.0	13.0	12.0	-7.7
Not assimilated	-	-	-	x
Radiography	2,181.0	2,278.0	2,386.0	4.7
Assimilated	1,861.0	2,251.0	2,385.0	6.0
Not assimilated	320.0	27.0	1.0	-96.3
Speech and language therapy	1,189.0	1,221.0	1,268.0	3.8
Assimilated	1,019.0	1,193.0	1,266.0	6.1
Not assimilated	170.0	28.0	2.0	-92.9
Multi skilled	73.0	102.0	135.0	32.4

Source: Scottish Workforce Information Standard System (SWISS), data extracted 03/10/2008 and 13/10/2009.

Table 18 - NHS Scotland: Allied Health Professionals Staff Vacancies as at 30 September 2009

				Vacant for:				Vacancies as a percentage of establishment	
	Establishment	Staff in Post	Posts under review	Total Vacancies	Less than 3 months	3 months or more	Unknown	Total	3 months or more
Allied Health Professional Staff	**9,961.8**	**9,579.5**	**46.0**	**336.3**	**203.4**	**120.8**	**12.1**	**3.4%**	**1.2%**
Arts therapy (art/music/drama)	35.6	33.6	-	2.0	2.0	-	-	5.6%	0.0%
Dietetics	700.4	652.8	0.9	46.7	25.8	17.4	3.5	6.7%	2.5%
Occupational therapy	2,266.3	2,161.7	10.0	94.7	59.5	33.4	1.8	4.2%	1.5%
Orthoptics	92.1	81.9	-	10.2	6.6	2.6	1.0	11.1%	2.8%
Orthotics	50.3	46.7	-	3.6	3.6	-	-	7.2%	0.0%
Physiotherapy	2,814.4	2,709.8	21.5	83.0	53.4	28.1	1.5	3.0%	1.0%
Podiatry	751.6	735.3	2.4	13.9	4.9	9.0	-	1.8%	1.2%
Prosthetics	11.8	11.8	-	-	-	-	-	0.0%	0.0%
Radiography	2,097.4	2,033.3	11.2	52.9	30.3	18.3	4.3	2.5%	0.9%
Speech and language therapy	1,034.7	1,003.4	-	31.3	19.3	12.0	-	3.0%	1.2%
Multi skilled	110.1	109.1	-	1.0	1.0	-	-	0.9%	0.0%

Source: Scottish Workforce Information Standard System (SWISS). ISD(M)36

Table 19 - NHS Scotland: Allied Health Professionals Staff Vacancies as at 30 September 2008

				Vacant for:				Vacancies as a percentage of establishment	
	Establishment	Staff in Post	Posts under review	Total Vacancies	Less than 3 months	3 months or more	Unknown	Total	3 months or more
Allied Health Professional Staff	**9,637.0**	**9,242.8**	**16.9**	**377.4**	**285.3**	**91.6**	**0.5**	**3.9%**	**1.0%**
Arts therapy (art/music/drama)	34.9	34.9	-	-	-	-	-	0.0%	0.0%
Dietetics	635.4	600.8	1.5	33.1	24.5	8.6	-	5.2%	1.4%
Occupational therapy	2,257.0	2,136.4	12.1	108.6	85.9	22.7	-	4.8%	1.0%
Orthoptics	74.5	73.1	-	1.4	-	1.4	-	1.9%	1.9%
Orthotics	48.8	44.8	-	4.0	3.0	1.0	-	8.2%	2.0%
Physiotherapy	2,744.9	2,631.7	-	113.2	89.6	23.5	-	4.1%	0.9%
Podiatry	741.9	725.1	1.0	15.8	7.0	8.3	0.5	2.1%	1.1%
Prosthetics	13.8	12.8	-	1.0	1.0	-	-	7.2%	0.0%
Radiography	1,998.3	1,929.0	1.3	68.0	51.1	16.9	-	3.4%	0.8%
Speech and language therapy	1,005.9	972.6	1.0	32.4	23.2	9.2	-	3.2%	0.9%
Multi skilled	81.5	81.5	-	-	-	-	-	0.0%	0.0%

Source: Scottish Workforce Information Standard System (SWISS). ISD(M)36

Table 20 - NHS Scotland: Allied Health Professionals Staff Vacancies as at 30 September 2007

				Vacant for:				Vacancies as a percentage of establishment	
	Establishment	Staff in Post	Posts under review	Total Vacancies	Less than 3 months	3 months or more	Unknown	Total	3 months or more
Allied Health Professional Staff	**9,421.0**	**8,951.5**	**16.2**	**453.4**	**268.4**	**180.8**	**4.2**	**4.8%**	**1.9%**
Arts therapy (art/music/drama)	33.0	32.0	-	1.0	-	1.0	-	3.0%	3.0%
Dietetics	602.5	574.5	0.6	27.4	15.1	10.7	1.6	4.5%	1.8%
Occupational therapy	2,285.2	2,161.4	3.0	120.9	80.7	40.1	-	5.3%	1.8%
Orthoptics	77.6	72.2	-	5.4	3.0	2.4	-	7.0%	3.1%
Orthotics	42.7	34.7	-	8.0	3.5	4.5	-	18.7%	10.5%
Physiotherapy	2,659.9	2,527.4	5.1	127.4	77.8	47.6	2.0	4.8%	1.8%
Podiatry	732.1	703.6	2.0	26.5	15.0	11.5	-	3.6%	1.6%
Prosthetics	7.8	7.8	-	-	-	-	-	0.0%	0.0%
Radiography	1,926.0	1,836.8	1.8	87.4	40.5	46.3	0.6	4.5%	2.4%
Speech and language therapy	993.9	941.8	3.7	48.5	31.8	16.7	-	4.9%	1.7%
Multi skilled	60.3	59.3	-	1.0	1.0	-	-	1.6%	0.0%

Source: Scottish Workforce Information Standard System (SWISS). ISD(M)36

Table 21 - NHS Scotland: Healthcare Sciences Staff (Whole Time Equivalent) as at 30 September 2009

	2007	2008	2009	% Change 08 - 09
Healthcare science staff	**5,152.8**	**5,158.4**	**5,593.8**	**8.4**
Biomedical sciences	2,605.7	3,334.6	3,401.5	2.0
Clinical physiology	134.3	223.1	376.9	68.9
Clinical sciences	606.1	797.9	948.6	18.9
Clinical technology	250.6	617.3	815.7	32.1
Other healthcare science staff	3.0	11.0	25.7	133.2
Not assimilated	1,553.1	174.4	25.3	-85.5

Source: Scottish Workforce Information Standard System (SWISS)

Table 22 - NHS Scotland: Healthcare Sciences Staff (Headcount) as at 30 September 2009

	2007	2008	2009	% Change 08 - 09
Healthcare science staff	**5,760.0**	**5,781.0**	**6,290.0**	**8.8**
Biomedical sciences	2,929.0	3,755.0	3,833.0	2.1
Clinical physiology	152.0	250.0	433.0	73.2
Clinical sciences	687.0	913.0	1,101.0	20.6
Clinical technology	267.0	659.0	868.0	31.7
Other healthcare science staff	3.0	11.0	27.0	145.5
Not assimilated	1,722.0	193.0	28.0	-85.5

Source: Scottish Workforce Information Standard System (SWISS)

Table 23 - NHS Scotland: Other Therapeutic Staff (Whole Time Equivalent) as at 30 September 2009

	2007	2008	2009	% Change 08 - 09
Other therapeutic staff	**2,753.6**	**3,135.1**	**3,322.2**	**6.0**
Clinical psychology and counselling [1]	691.6	1,023.6	1,113.3	8.8
Genetic counselling	2.6	9.2	9.7	5.7
Optometry	22.3	35.3	42.1	19.3
Pharmacy	1,511.7	1,903.4	2,072.3	8.9
Play specialists	62.8	65.9	75.1	14.1
Not assimilated	462.6	97.8	9.8	-90.0

Source: Scottish Workforce Information Standard System (SWISS)

Table 24 - NHS Scotland: Other Therapeutic Staff (Headcount) as at 30 September 2009

	2007	2008	2009	% Change 08 - 09
Other therapeutic staff	**3,265.0**	**3,722.0**	**3,947.0**	**6.0**
Clinical psychology and counselling [1]	821.0	1,228.0	1,340.0	9.1
Genetic counselling	4.0	13.0	14.0	7.7
Optometry	36.0	64.0	74.0	15.6
Pharmacy	1,749.0	2,206.0	2,413.0	9.4
Play specialists	75.0	80.0	93.0	16.3
Not assimilated	580.0	131.0	13.0	-90.1

Source: Scottish Workforce Information Standard System (SWISS)

Table 25 - NHS Scotland: Personal and Social Care Staff (Whole Time Equivalent) as at 30 September 2009

	2007	2008	2009	% Change 08 - 09
Personal and social care	**549.9**	**692.4**	**763.3**	**10.2**
Chaplaincy	31.0	39.6	35.6	-10.1
Health promotion	441.1	607.5	693.3	14.1
Sexual health	17.6	28.4	31.8	12.1
Social work	2.9	1.0	1.0	-
Not assimilated	57.4	15.9	1.6	-89.9

Source: Scottish Workforce Information Standard System (SWISS)

Table 26 - NHS Scotland: Personal and Social Care Staff (Headcount) as at 30 September 2009

	2007	2008	2009	% Change 08 - 09
Personal and social care	**704.0**	**826.0**	**901.0**	**9.1**
Chaplaincy	63.0	61.0	68.0	11.5
Health promotion	499.0	691.0	786.0	13.7
Sexual health	25.0	39.0	44.0	12.8
Social work	4.0	1.0	1.0	-
Not assimilated	113.0	34.0	2.0	-94.1

Source: Scottish Workforce Information Standard System (SWISS)

Table 27 - NHS Scotland: Medical and Dental Support Staff (Whole Time Equivalent) as at 30 September 2009

	2007	2008	2009	Change 08 - 09
Medical and Dental Support	**1,072.3**	**1,439.6**	**1,667.4**	**15.8%**
Physician assistant	8.0	6.0	-	-100.0%
Theatre services	103.6	134.8	149.8	11.2%
Dental care practitioner	924.2	1,293.9	1,516.0	17.2%
Dental nurse	862.4	1,185.2	1,318.9	11.3%
Dental technician	48.0	75.1	126.9	69.0%
Oral healthcare practitioners	13.8	33.6	70.3	109.4%
Not assimilated	**36.6**	**5.0**	**1.5**	**-69.5%**

Source:
Scottish Workforce Information Standard System (SWISS) - 2009 extract taken on 12th October 2009.
GP workforce information is sourced from the GP Contractor Database (GPCD) - 2009 extract taken 5th November 2009.
General Dental Services workforce information is sourced from the Management Information and Dental Accounting System (MIDAS) - 2009 extract taken 30th October 2009.
Medical and dental workforce information for hospital, community and public health services (HCHS) is sourced from the medical and dental workforce census (MEDMAN) prior to 2008.

Table 28 - NHS Scotland: Medical and Dental Support Staff (Headcount) as at 30 September 2009

	2007	2008	2009	Change 08 - 09
Medical and Dental Support	**1,238.0**	**1,667.0**	**1,928.0**	**15.7%**
Physician assistant	8.0	6.0	-	-100.0%
Theatre services	112.0	143.0	158.0	10.5%
Dental care practitioner	1,074.0	1,512.0	1,769.0	17.0%
Dental nurse	1,005.0	1,389.0	1,552.0	11.7%
Dental technician	49.0	79.0	135.0	70.9%
Oral healthcare practitioners	20.0	46.0	88.0	91.3%
Not assimilated	**55.0**	**17.0**	**12.0**	**-29.4%**

Source:
Scottish Workforce Information Standard System (SWISS) - 2009 extract taken on 12th October 2009.
GP workforce information is sourced from the GP Contractor Database (GPCD) - 2009 extract taken 5th November 2009.
General Dental Services workforce information is sourced from the Management Information and Dental Accounting System (MIDAS) - 2009 extract taken 30th October 2009.
Medical and dental workforce information for hospital, community and public health services (HCHS) is sourced from the medical and dental workforce census (MEDMAN) prior to 2008.

Table 29 - NHS Scotland: Admin and Support Services Staff (Whole Time Equivalent) as at 30 September 2009

	2007	2008	2009	% Change 08 - 09
Total Admin and Support Services	**36,912.7**	**37,882.0**	**39,474.5**	**4.2**
Administrative services	**22,950.8**	**23,514.2**	**24,713.3**	**5.1**
Central functions	11,325.4	14,445.2	15,241.7	5.5
Support to clinical staff	6,604.5	8,076.4	9,342.5	15.7
Not assimilated	5,020.9	992.5	129.1	-87.0
Support services [1]	**13,961.9**	**14,367.9**	**14,761.2**	**2.7**
General services	3,028.0	3,481.5	3,554.3	2.1
Hotel services	7,832.2	8,340.9	8,570.3	2.8
Maintenance and estates	1,742.9	1,915.7	1,963.6	2.5
Sterile services	529.5	595.3	668.1	12.2
Not assimilated	829.4	34.5	5.0	-85.5

Source: Scottish Workforce Information Standard System (SWISS)

Table 30 - NHS Scotland: Admin and Support Services Staff (Headcount) as at 30 September 2009

	2007	2008	2009	% Change 08 - 09
Total Admin and Support Services	**47,097.0**	**48,338.0**	**50,269.0**	**4.0**
Administrative services	**27,452.0**	**28,252.0**	**29,635.0**	**4.9**
Central functions	13,058.0	16,602.0	17,437.0	5.0
Support to clinical staff	8,516.0	10,462.0	12,051.0	15.2
Not assimilated	5,878.0	1,188.0	147.0	-87.6
Support services [1]	**19,645.0**	**20,086.0**	**20,634.0**	**2.7**
General services	3,369.0	3,855.0	3,915.0	1.6
Hotel services	12,894.0	13,587.0	13,988.0	3.0
Maintenance and estates	1,763.0	1,941.0	1,988.0	2.4
Sterile services	587.0	661.0	738.0	11.6
Not assimilated	1,032.0	42.0	5.0	-88.1

Source: Scottish Workforce Information Standard System (SWISS)

Table 31 - NHS Scotland: Emergency Services Staff (Whole Time Equivalent) as at 30 September 2009

	2007	2008	2009	% Change 08 - 09
Emergency services	**3,529.8**	**3,557.7**	**3,703.5**	**4.1**
Ambulance care assistant	862.3	880.1	889.6	1.1
Auxillary	-	-	-	x
Driver	76.1	69.5	73.4	5.7
EMDC / control	274.5	291.0	304.5	4.6
Paramedic	1,233.9	1,255.0	1,309.2	4.3
Technician	999.7	980.1	1,041.9	6.3
Other	81.0	82.0	85.0	3.7
Not assimilated	2.4	-	-	x

Source: Scottish Workforce Information Standard System (SWISS)

Table 32 - NHS Scotland: Emergency Services Staff (Headcount) as at 30 September 2009

	2007	2008	2009	% Change 08 - 09
Emergency services	**3,655.0**	**3,681.0**	**3,836.0**	**4.2**
Ambulance care assistant	931.0	948.0	961.0	1.4
Auxillary	-	-	-	x
Driver	103.0	91.0	97.0	6.6
EMDC / control	280.0	302.0	319.0	5.6
Paramedic	1,247.0	1,269.0	1,323.0	4.3
Technician	1,010.0	989.0	1,051.0	6.3
Other	81.0	82.0	85.0	3.7
Not assimilated	3.0	-	-	x

Source: Scottish Workforce Information Standard System (SWISS)

CHAPTER 8:EVIDENCE FROM THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES AND PUBLIC SAFETY IN NORTHERN IRELAND

Summary

8.1 The Emergency Budget in June 2010 announced a two-year pay freeze from 2011/12 for public sector workforces, except those earning a full-time equivalent of £21,000 or less. The Agenda for Change rates of pay apply to 61,732 staff (49,915 wte) in the Health and Social Care in Northern Ireland and 31,432 (23,175 wte) have full-time equivalent earnings of £21,000 or less.

8.2 The Minister for Health, Social Services and Public Safety wrote to the Chair of the NHS Pay Review Body on 4 October 2010 confirming that the two-year pay freeze will apply in the 2011/12 and 2012/2013 years to Health and Social Care staff groups governed by the NHS Pay Review Body. He also said that he recognised that there will be an increase of at least £250 for HSC staff earning £21,000 or less (subject to the Review Body process in the usual way) and agreed to provide evidence to enable the Review Body to undertake that role in 2011/12.

8.3 This evidence has been prepared by the Department of Health and Social Services and Public Safety (DHSSPS) in Northern Ireland. It sets out where circumstances, initiatives and policies within the Health and Social Care (HSC) in Northern Ireland are different from other parts of the UK NHS and informs the NHS Pay Review Body of developments affecting their complete remit group.

The Northern Ireland Context

Demographics

8.4 Changes in Northern Ireland's demographic structure will have a major influence on the levels of health and social care services needed in the future. Although Northern Ireland currently has a relatively youthful population in a UK context, Northern Ireland is expected to follow the trend of most industrialised countries over the next ten years with the proportion of those aged 18 and under falling, while the proportion of those aged 65 and over will increase.

8.5 These population projections, along with levels of deprivation in Northern Ireland, will have implications for the local health sector. It is expected that the ageing population will increase demand for health professionals.

The Labour Market

8.6 The global economic downturn continues to have a severe impact on the Northern Ireland labour market. Deterioration in private sector business activity, persistent economic inactivity and increases in claimant count for unemployment are particular causes for concern.

8.7 While the local unemployment rate (at 7.0%20) is currently the fourth lowest of the UK regions, the number of claimants (aged 18 and over) has increased by 9.6% in Northern Ireland over the year to September 2010. Scotland was the only other UK

[20] Source: Office for National Statistics, June-August 2010.

region to experience an annual increase in the number of claimants but its increase was marginal in comparison. Economic inactivity is a persistent feature of the Northern Ireland labour market - it is the highest of any UK region at 28.5% and this can only partly be explained by Northern Ireland's high full-time education participation. The level of long-term unemployment and incapacity claims are significant obstacles to reducing the level of economic inactivity.

8.8 The reductions in Northern Ireland's current and capital spend announced in the 2010 Spending Review reflect the tighter public expenditure environment in the coming years. In addition, the announcement of public sector job cuts may well have a greater adverse impact in Northern Ireland due to the local reliance on the public sector in terms of employment.

The Cost of Living

8.9 Figures produced by the Office for National Statistics (ONS) suggested that in 2004 the cost of living in Northern Ireland was 4.7% lower than the UK average. However, Northern Ireland's cost of living was above that of the North East of England, Scotland and Wales. It should be noted that ONS do not produce regional cost of living figures regularly and that the above estimate is now very dated. More recent survey evidence published by Croner Reward21 indicates that consumer prices have since increased by more in the UK (5.7% p.a.) than in Northern Ireland (5.1% p.a.). This suggests that Northern Ireland's cost of living has marginally reduced further relative to the UK as a whole since 2004.

The Public Sector Workforce

8.10 The public sector in Northern Ireland employs 223,551 people or 28.7% of all those in employment. Pay Review Bodies (PRB) health staff groups account for 66,030 (29.5%) of public sector employee jobs in Northern Ireland.

8.11 Monitoring returns to the Equality Commission22 provide insight into recruitment difficulties experienced by both the public and private sectors. The most recent number of applicants per post filled recorded for the public sector as a whole in 2008 was eleven – compared to a ratio of six for the private sector. There are, however, significant variations within the public sector with the number of applicants per post filled lower than average in the education sector (6.1) and higher for security-related occupations (15.2). There are, on average, 12.2 applicants per post filled in the health sector.

Public Sector Pay

8.12 Public sector pay in Northern Ireland accounts for a significant share of the Departmental Expenditure Limit (DEL) budget. Estimates for the 2010-11 financial year indicate that pay costs will account for 50 per cent of Resource DEL. This means that each one per cent increase in the total pay bill would equate to additional annual costs of £45m.

[21] Source: Croner Reward (2010) Cost of Living Comparisons – September 2010.
[22] Monitoring Report No.19 can be accessed at: www.equalityni.org/archive/pdf/MonitoringReportNo19_FINAL_081209.pdf.

8.13 Overall public sector earnings in Northern Ireland, at £583.40 per week23, are below the UK average (£604.80) but are higher than five other regions – the North East, Wales, Yorkshire and Humber, the West Midlands and the North West. At the level of individual occupational groups, Northern Ireland public sector earnings are generally at the lower end of the distribution. However, overall average earnings are influenced by occupational groups that cover security personnel whose higher earnings levels are a legacy of the security situation. Excluding security personnel groups, the average public sector wage in Northern Ireland is £555.74, compared to £578.14 for the UK as a whole.

8.14 Public sector earnings in Northern Ireland outstrip those of the private sector, but this is due more to our relatively lower private sector earnings. Overall private sector earnings in Northern Ireland have consistently been the lowest of the UK regions and at £456.80 per week, are 21% below the UK average of £581.20. In addition, for each major occupational group, with the exception of managers/senior officials and personal service occupations which are lower in Wales and the North East respectively, private sector earnings in Northern Ireland are the lowest of all the UK regions.

8.15 Although most regions (except London and the South East) exhibit a pay differential in favour of the public sector, the differential is not as pronounced as that found in Northern Ireland.

8.16 While the headline public-private sector earnings differential is 27.7% in Northern Ireland (compared to 4.1% for the UK as a whole), this reduces to 24.2% when the UK occupational structure is imposed.

Northern Ireland Executive Pay Policy

8.17 On the 24th May 2007, the NI Executive endorsed the principle of adherence to the UK Government's public sector pay policy. This means that enforcement of pay growth limits is devolved to the Northern Ireland Executive within the overarching parameters set by HM Treasury in its annual pay guidance circulars. Therefore, the Department of Finance and Personnel (DFP) Minister has the scope, within the parameters of the UK Government's pay policy, to approve pay remits for staff groups in most public bodies in Northern Ireland.

8.18 The Northern Ireland pay remit approval process applies to the staff costs of virtually all public bodies and staff groups that are either partly or wholly funded by the Northern Ireland DEL. 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 within the specific local labour market context.

8.19 The HM Treasury Pay Guidance for 2010 – 11 was published in December 2009 and outlined an Increase for Staff in Post (ISP) range of 0-2 per cent. However, on 22 June 2010 the Chancellor announced a two year pay freeze for public sector workers as part of his Emergency Budget. The pay freeze will be a total freeze in all elements unless there is a clear contractual entitlement to an increase. Locally, the pay freeze will apply immediately to any public sector workforces that have not yet agreed a

[23] Source: Annual Survey of Hours and Earnings (ASHE) 2009.

2010-11 pay award, unless there is a legally enforceable agreement already in place. However, it is expected that the pay freeze will apply to most public sector staff groups from 2011-12 (i.e. health, education, police etc).

8.20 A key feature of implementing pay policy is the need to honour contractual entitlements. Many local staff groups are contractually tied to UK nationally determined pay settlements or have clear contractual entitlements to progression/performance pay. It is therefore not possible to impose a blanket pay freeze without addressing these contractual arrangements first.

The Policy Context

Programme for Government 2008/11 targets

8.21 Under the Northern Ireland Executive's current Programme for Government, Public Service Agreement (PSA) commitments have been set to promote health and address health inequalities and to deliver high quality health and social care services for the population of Northern Ireland.

8.22 Delivery of these commitments is planned on an annual basis through the DHSSPS Priorities for Action (PfA), which specifies – in addition to the relevant three-year PSA targets – a number of "Ministerial" standards, targets and actions for each year. These additional standards, targets and actions are necessary both to help ensure that satisfactory progress is to be made towards the three-year PSA targets, and to ensure that performance is improved in areas which are a priority. These targets – taken together with the detailed resource allocations – provide the framework within which the HSC Board and HSC Trusts prepare their respective commissioning and delivery plans.

8.23 The Priorities for Action document is available on request. Improving productivity remains a key priority for the Department and the HSC across seven key priority areas. Productivity targets include:

- achieving a 3% improvement in hospital productivity year-on-year;
- reducing levels of absenteeism in HSC staff to 5.2% in the year to March 2011;
- ensuring that no more than 2% of operations are cancelled.

8.24 In addition, Priorities for Action 2010/11 includes a seventh priority area which particularly in the current financial context is critical, namely:

- Priority Area 7: Ensure financial stability and the effective use of resources.

Non-Medical Workforce Issues

8.25 Details of the Northern Ireland HSC Workforce Census as at 31 March 2010 are available at http://www.dhsspsni.gov.uk/index/stats_research/work_force/stats-research.htm. An analysis of the overall September 2010 position is set out in the Key Facts Workforce Bulletin also at http://www.dhsspsni.gov.uk/index/stats_research/work_force/stats-research.htm. This shows a 1.5% increase in headcount (0.7% increase in wte) in the period 2006 to 2010. The 2009 to 2010 position shows a reduction in headcount of -1.5% (-1% in

wte); this is a direct consequence to the Review of Public Administration restructuring.

NI Current Vacancies: Changes over Time

8.26 Details of the Northern Ireland HSC Workforce Vacancies as at 31 March 2010 are available at http://www.dhsspsni.gov.uk/index/stats_research/work_force/stats-research.htm. The trend in current vacancies over the period 2003 to 2010 is set out in [DN insert Table ?] The current vacancies rate % in the period 2007 to 2010 are set out below.

Table 1: NI HSC Current Vacancies Rate % (WTE)				
Staff Group	**Mar-07**	**Mar-08**	**Mar-09**	**Mar-10**
Admin & Clerical*	2.3	1.9	1.6	0.9
Estates Services	1.3	1.2	1.3	2.2
Support Services	3.1	3.6	4.4	1.3
Nursing, Midwifery & Health Visiting	3.5	2.2	1.4	1.0
Social Services	2.7	1.7	1.7	1.4
Professional & Technical	4.1	3.5	2.7	1.5
Medical & Dental	2.4	2.4	3.8	2.6

8.27 The Current Vacancies Rate % (WTE) in Bands 1 to Band 4 Admin & Clerical staff is 0.9%.

8.28 Joiners by occupational family in the period March 2009 to March 2010 were as follows:

Joiners March 2009/10

Occupational Family	Headcount	WTE
1 Generic	2	2.0
2 Administration & Clerical	722	653.2
3 Estates Services	33	33.0
4 Support Services	465	312.4
5 Nursing & Midwifery	912	830.6
6 Social Services	739	433.7
7 Professional & Technical	470	416.4
9 Ambulance	15	15.0
Total	3358	2696.26

Joining Rate - based on average staff March 2009/10

Occupational Family	Headcount	WTE
1 Generic	1.6%	1.7%
2 Administration & Clerical	5.8%	6.0%
3 Estates Services	4.9%	4.9%
4 Support Services	6.9%	6.3%
5 Nursing & Midwifery	4.3%	4.6%
6 Social Services	5.6%	5.1%
7 Professional & Technical	6.5%	6.6%
9 Ambulance	1.5%	1.5%

8.29 Leavers by occupational family in the period March 2009 to March 2010 were as follows:

Leavers March 2009/10

Occupational Family	Headcount	WTE
1 Generic	10	7.86
2 Administration & Clerical	805	700.16
3 Estates Services	59	58.96
4 Support Services	401	261.34
5 Nursing & Midwifery	944	780.41
6 Social Services	764	386.37
7 Professional & Technical	347	291.4
9 Ambulance	28	26.88

Leaving Rate - based on average staff March 2009/10

Occupational Family	Headcount	WTE
1 Generic	7.8%	6.8%
2 Administration & Clerical	6.4%	6.4%
3 Estates Services	8.7%	8.7%
4 Support Services	5.9%	5.3%
5 Nursing & Midwifery	4.5%	4.3%
6 Social Services	5.8%	4.5%
7 Professional & Technical	4.8%	4.6%
9 Ambulance	2.7%	2.6%

Staff Earning £21,000 or less

8.30 This equates to fulltime earnings and to pay point 15 or lower in the 2010/11 Agenda for Change pay scales. There is currently 31,432 (23,175 wte) staff with full time earnings of £21,000 or less. These staff groups cover:

- Administrative and Clerical staff – 9,450
- Estates - 420
- Support Services – 6,730
- Unqualified Nurses and Healthcare Assistants – 4,700
- Social Services – 8,113
- Professional and Technical- 1,520
- Ambulance - 500

Workforce Training

8.31 Approximately 50% of HSC staff are in regulated professions. They must hold approved qualifications and be on the register of an appropriate professional body. The DHSSPS is responsible for commissioning the training of regulated staff, largely through the local Universities. The DHSSPS has to ensure that it is commissioning the appropriate numbers of student places to maintain an adequate supply of qualified staff.

8.32 Nursing and Allied Health Professional (AHP) recruitment at undergraduate level remains buoyant.

8.33 In 2010, 4,054 applied to do nursing degree courses, a 28% increase on 2009. Queens University Belfast received three applications for each available place and the University of Ulster received 11 applications for each available place. Entrance requirements have remained unchanged although new nurse education standards will be introduced from 2011 in Northern Ireland Universities.

8.34 Applications for AHP undergraduate study increased by 20% in 2010. The University of Ulster received 8 applications for each available place. No changes were made to the entry requirements for AHP programmes in 2010. The exception is Radiography where in the 2010 admissions cycle students could apply for Radiography Therapeutic and Diagnostic programmes separately.

Regional Workforce Planning Process

8.35 In September 2001, the DHSSPS commenced a series of uni-professional workforce reviews (i.e. a review of each profession separately – such as Medical, Nursing, Dietetics, Dental, Social Services, etc.) covering the main groups employed within the HSC. The workforce planning cycle comprises a major review approximately every three years, with interim update reviews. In this way, the reviews are intended to enable the DHSSPS to gain workforce intelligence on the trends in employment for each professional group and this in turn will inform planning of needs over subsequent years.

8.36 The data collected also covers qualitative information and, together with the data on recruitment and retention, enables the DHSSPS to work with the HSC in developing

strategies to both attract people to working in the health service professions and build their career in that field.

8.37 The purpose of the up-date reviews is to identify any developments which are likely to have an impact on the workforce, and to check back as to whether the workforce is showing the trends predicted in the main review. This is intended to act as an early warning system whereby the DHSSPS can take action as necessary and in this way aim to address potential workforce problems at an early stage.

8.38 The methodology for future workforce reviews has been altered recently with more onus being placed on Trusts to undertake organisational-level workforce planning, integrating financial, service development and workforce planning streams. This will help better inform the regional workforce planning process.

8.39 A series of update reviews covering many of the Allied Health professions, Clinical Psychology and Pharmacy has recently been initiated. HSC Trusts were asked to provide comment on Turnover, Recruitment and Retention Issues, Work-life balance, Working Terms and Conditions and Demand and Service developments. Some early trends are emerging:

- For many of the Allied Health professions it is noted that graduates are having difficulty accessing permanent HSC jobs in this financial climate;
- Trusts are concerned about the long-term effects this will have in respect of succession planning, particularly for specialist posts;
- Graduates are applying for Assistant grade posts then moving when a Qualified post becomes available leading to a degree of churn in the workforce and wasted effort on induction and training;
- Requests for flexible working continue to increase however Trusts find these increasingly difficult to manage in this financial climate, due to limited backfill money available against increasing demand for services and the need to meet Priorities for Action Waiting List Targets.

Productivity

8.40 As in other parts of the UK, it is important to seek sustained improvements in productivity. The 2004 Appleby Report found a significant productivity gap in some aspects of health provision in Northern Ireland compared to similar services in England. A primary measure of productivity has been developed for comparison with England and within Northern Ireland – 'weighted hospital activity per WTE staff'. The target set is that each Trust will be expected to achieve a 3% improvement in hospital productivity, from its 2006-07 base year, for each year over the CSR period.

8.41 Since we started measuring in 2007/08, hospital labour productivity has increased annually by about 3%, however our analysis suggests there are significant further productivity increases to be made.

8.42 The DHSSPS has now developed a range of productivity indicators for all professional groups in the HSC and these are monitored for all Trusts. A number of additional targets and performance indicators have been developed, including sickness absence, skill-mix ratios for nursing and AHP staff, staff turnover and reduction in the proportion of Admin and Clerical staff. Six-monthly reports are produced and

distributed to the Trusts to facilitate benchmarking and assist Trusts to identify areas of best practice and poor performance.

8.43 Productivity issues are also addressed in the workforce planning reviews, which explore potential opportunities for greater skill-mix and different and more efficient ways of working in the delivery of service.

8.44 The following PSA and Ministerial targets will be subject to intensive monitoring by the DHSSPS to ensure satisfactory progress is made:

- **Hospital productivity** (PSA 7.2): each Trust should achieve a 3% improvement in hospital productivity, from its 2006-07 base year, for each year over the CSR period.
- **Day case rate** (PSA 7.2): each Trust should secure improvements in day case rates for a defined range of procedures in accordance with Departmental targets for March 2011.
- **Pre-operative length of stay** (PSA 7.2): each Trust should secure reductions in average pre-operative length of stay in accordance with Departmental targets for March 2011.
- **Absenteeism** (PSA 7.2): each Trust should reduce its level of absenteeism to no more than 5.2% in the year to March 2011.
- **Greater use of generic drugs** (PSA 7.2): the HSC Board should ensure the level of dispensing of generic drugs increases to at least 64% by March 2011.
- **Cancelled operations**: from April 2010, all surgical patients should have appropriate pre-operative assessment, and no more than 2% of operations should be cancelled for non-clinical reasons.

8.45 The Productivity Agenda is extremely complex and this year a number of challenges have come to light. A limitation of the current indicator is that it includes both hospital and community staff as there is currently no way to separate them, however it only takes account of hospital activity. Trusts have highlighted that the current calculation is focused on hospital activity, yet the policy shift is for more work to be carried out in the community with fewer inpatient admissions, therefore a fall in hospital activity does not necessarily equate to lower productivity. In addition some Trusts have closed certain hospital services, again leading to a fall in activity.

8.46 The DHSSPS is not currently able to measure activity carried out in the community as the area is extremely complex. Also recent data provided by the Trusts for another exercise has highlighted the need to capture much more than just WTE staff. Quantifying bank and agency usage, as well as overtime, may become important in future. These limitations in the scope of the available data significantly restrict the scope to assess and demonstrate the savings achieved through productivity gains.

<u>National Recruitment and Retention Premia (RRP)</u>

8.47 The national RRP is paid to all Health and Social Care staff requiring an electrical, mechanical or plumbing qualification; this is despite no evidence of recruitment difficulties. Northern Ireland has participated in the review of National RRPs undertaken by IES on behalf of the NHS Staff Council. Evidence provided to that review showed that recruitment to these particular jobs in the HSC in Northern Ireland has been and remains particularly healthy. Recruitment programmes recorded the following applications:

- 1 Band 4 fitter 19 applicants
- 1 Band 4 fitter 34 applicants
- 1 Band 4 Electrician 46 applicants
- 1 Band 4 Maintenance Fitter 49 applicants

8.48 In the absence of recruitment and retention problems the DHSSPS feels that the continuation of a national RRP is unjustified. Should recruitment difficulties arise these could best be addressed under the local Recruitment and Retention Framework.

8.49 None of the other staff groups listed in Annex R of the NHS Handbook are in receipt of a RRP in Northern Ireland.

Junior Pharmacists

8.50 The NHS PRB remains interested in the possible short-term national RRP for Pharmacists in Band 6 and 7. Last year the DHSSPS Minister rejected the recommendation for a national RRP for this staff group on the grounds that there was no evidence that a national recruitment or retention problem exists. This position has not changed; the DHSSPS's position remains that there are no grounds for the award of a national RRP to Band 6 and Band 7 Pharmacists.

Local Recruitment and Retention Premia

8.51 A Northern Ireland Recruitment and Retention Framework was introduced in 2007 (HSS (AfC) (7) 2007 to address local recruitment difficulties. Under these arrangements there are currently two long term recruitment premia in place. An existing premia of 20% on the basic band 7 for Embryologists employed in the Regional Fertility Clinic was reviewed in December 2009. This premia was found to be effective and has been extended to 2012 when the position will be reviewed again. A 30% premia on the basic band 7 nurse has been introduced to aid recruitment and retention in a particularly hard to fill geographical location on Rathlin Island. This has assisted in the provision of an out of hours nursing service and is working well. This premia will be reviewed in December 2010.

Knowledge and Skills Framework

8.52 While the AfC Knowledge and Skills Framework (KSF) is not mandatory in Northern Ireland Health and Social Care Organisations are continuing to implement the Framework in line with the national agreement. A KSF Project Manager has been appointed and is working closely with all HSC organisations and trade unions across the region to achieve full implementation. A regional group, comprising management and trade union representation from all HSC organisations meets on a regular basis to share knowledge, develop and disseminate good practice and monitor progress. Networks across the UK are strong and involvement in all National Groups is maintained.

8.53 The outcome of the Review of KSF in England has the potential to affect progress within Northern Ireland. Efforts will however be made to minimise any adverse repercussions and ensure that implementation of KSF continues. Progress across HSC organisations is variable ranging from 45% cover to 99% for KSF outlines and 8% to 71% of staff with a completed Personal Development Review. Where

organisations are not showing significant progress in implementation this is due to restructuring under the Review of Public Administration or resourcing issues rather than a reluctance to implement the process. Northern Ireland remains committed to the use of eKSF.

HSC Staff Survey

8.54 The HSC survey took place from 2nd November to 11th December 2009. Around 17,500 staff were surveyed and the overall response rate was 39%, with a total of 6,737 staff across all HSC organisations participating.

8.55 The survey questionnaire comprised 3 themes. The key findings from the questionnaire responses are summarised below against each theme.

8.56 The Resources to Deliver: This theme asked staff about their hours of work, work-life balance and training and induction received. 70% of all respondents worked 30 hours or more, 68% of staff have worked more than their contracted hours in the last 12 months, with 88% agreeing that one of they reasons they did is that they want to provide the best care they can for patients. 41% of staff felt that their organisation was committed to helping staff balance their work and home life. When analysed by Organisation, this figure was between 38-46% in HSC Trusts but notably lower at 15% in the Northern Ireland Ambulance Service (NIAS).

8.57 The Support to do a Good Job: This section covered appraisals and reviews, job satisfaction, views on the respondents employing organisation, equal opportunities and whistle blowing. 55% of staff surveyed did not have an appraisal or a Knowledge and Skills Framework (KSF) review in the previous 12 months. By occupational group who did have an appraisal, medical and dental staff were the highest (70%), and paramedics and ambulance technicians the lowest (7% and 5% respectively). Of the staff who did receive an appraisal, 72% felt that it helped them agree clear objectives for their work.

8.58 Over 2 in 5 staff (43%) feel that they cannot meet all the conflicting demands on their time at work, and only 34% agreed that there are enough staff at their organisation to do their job properly. Almost a third of staff (31%) agreed they often think about leaving their organisation, of those 48% gave the reason for this as not being valued for their work. This figure was highest in the Public Health Agency, where 52% of staff often think about leaving the organisation.

8.59 75% of staff were satisfied by the support they receive from their colleagues and 57% by the support received from their line manager. 21% of staff agree that senior managers try to involve staff in important decisions and 23 % that communication between senior managers and staff is effective.

8.60 7% of staff said that they had experienced discrimination at their organisation in the past 12 months. The three most common reasons stated were religion, ethnic background and age. In relation to Whistle Blowing, 79% of staff said that they would know how to report their concerns if they were concerned about negligence or wrongdoing by staff. When asked if they would have the confidence to report their concerns, 60% said yes, 13% no and 25% did not know.

8.61 A Worthwhile Job and the Chance to Develop: This section of the survey asked staff working in Health and Social Care about opportunities to develop, improving work practices, errors and near misses and violence, bullying and harassment.

8.62 77% of staff said they have an interesting job and that they are satisfied with the quality of care they deliver to patients. 86% feel that their role makes a difference to patients and service users. 39% of staff agreed that their Organisation communicates clearly with staff about what it is trying to achieve. 63% of staff agreed they are able to make suggestions to improve the work of their team or department, but only 27% agreed that senior managers act on staff feedback. In relation to errors, near misses and incidents, 25% of staff said that they had seen an error, near miss or incident that could have hurt patients or service users and 91% said they, or a colleague, had reported it.

8.63 When asked about violence, bullying and harassment at work in the past 12 months, 21% of staff had experienced physical violence from patients or service users (15%), relatives of patients or service users (4%) or other members of the public (2%). Of this group of staff, 69% said they, or a colleague, had reported it. In relation to harassment, bullying or abuse at work, 44% of staff had experienced this from patients or service users (22%), relatives of patients or service users (17%) or other members of the public (5%). Of these staff, 55% said they, or a colleague, reported it. 48% of all staff surveyed have never received training in how to prevent or handle violence and aggression.

8.64 59. This survey has provided a large amount of valuable data that will inform all stakeholders about the experiences of our workforce. This information will be used to improve working practices and conditions, and inform future policy development. Its findings are being taken forward by the Partnership Forum at a strategic level and through the Joint Negotiating Forum at a local level. By repeating the survey bi-annually, we can measure the impact of interventions and policy changes, and by improving the experiences of staff working in Health and Social Care in Northern Ireland, with the aim of improvement in the quality of care provided to patients and service users.

Affordability

[DN: this section to be inserted when the 2011 budget has been agreed]

Summary/Conclusion

[DN: to be amended once the affordability section has been added]

- There is no evidence to support the need for a national RRP for Band 6 and Band 7 Pharmacists.
- In the absence of recruitment and retention problems the DHSSPS feels that the continuation of a national RRP for qualified maintenance staff is unjustified.
- The local arrangement for addressing recruitment and retention difficulties is fully operational and effective. Should recruitment difficulties arise these could best be addressed under the local Recruitment and Retention Framework.

Statistical Information	
Table 1	Agenda for Change Spine Point Summary at 30 June 2010 By Occupational Family
Table 2	Generic Family Multi-Disciplinary Workers on AfC Pay Bands at 30 June 2010
Table 3	Admin HC and WTE by AfC Pay Band and Spine Point
Table 4	Estates Services Family HC and WTE by AfC Pay Band and Spine Point
Table 5	Support Services Family HC and WTE by AfC Pay Band and Spine Point
Table 6	Nursing Midwifery & Health Visiting Family HC and WTE by AfC Pay Band and Spine Point
Table 7	Social Services Family HC and WTE by AfC Pay Band and Spine Point
Table 8	Professional & Technical Family HC and WTE by AfC Pay Band and Spine Point
Table 9	Ambulance Family HC and WTE by AfC Pay Band and Spine Point
Table 10	HSC Vacancies and LT Vacancies by HC and WTE September 2003 to March 2010