



Department  
of Health

# NHS Pay Review Body Review for 2014

Written evidence from the Health Department for  
England – September 2013

February 2014

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# NHS Pay Review Body Review for 2014

Written evidence from the Health Department for  
England – September 2013

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# Contents

Executive summary .....	Page 5
Chapter 1: NHS Strategy and Introduction .....	Page 10
Chapter 2: Economic Context and Outlook for the Economy .....	Page 18
Chapter 3: NHS Finances.....	Page 31
Chapter 4: Non-Medical Workforce Planning and Delivery, including Education and Training Strategy - Policy Context .....	Page 36
Chapter 5: Agenda for Change .....	Page 52
Chapter 6: NHS Pay, Pensions, Additional Benefits and Total Reward.....	Page 64
Annex A: Chief Secretary to the Treasury's Letter on Public Sector Pay 2014-15 .....	Page 76
Annex B: PS(H) NHSPRB Remit Letter 2014-15.....	Page 78
Annex C: Market-facing Pay: How Agenda for Change pay can be made more appropriate to local labour markets .....	Page 81
Annex D: Agenda for Change Agreement .....	Page 83
Annex E: Francis Report .....	Page 84
Annex F: Mid Staffordshire NHS Foundation Trust Public Enquiry Employment Contracts Recommendations.....	Page 86
Annex G: Summary of Benefits and Comparison with 2015 Scheme.....	Page 88
Annex H: Increases in Pensions Contributions.....	Page 91
Annex I: List of activities/products suggested to support the vision for reward in the NHS .....	Page 92

# Executive summary

## Summary

The financial challenge facing the NHS is the biggest in its history. Despite real terms growth in its budget in successive years, it needs to continue to secure improved value from the taxpayers' investment, if it is to meet the growing pressures it faces in the years to come both from an ageing and growing population and the need to improve the quality of care provided. The Francis report on the very poor care provided at Mid Staffordshire NHS Foundation Trust has brought the quality challenges into full relief.

Pay restraint has been, and will continue to need to be, a key part of delivering this. Although the NHS is forecasting significant savings from non-pay elements of expenditure, national pay frameworks and the occupational pension scheme represent about two-thirds of a Trust's total expenditure at local level. Employers are therefore facing the consequences of a stark choice for staff on national pay contracts. This is to either pay staff more, accepting that this may do little to improve the quality of care for patients and is likely to restrict the number of staff employers can afford to employ, or, to reform contracts to enable employers to use their pay bill, as part of their overall employment offer, to maintain safe staffing levels, with stronger links to performance, quality and productivity.

NHS employers say they want 'something for something'. They want to make better use of their pay bill in return for better performance and productivity. The challenge for the NHS is to continue to improve the quality and responsiveness of services, whilst addressing the challenges set out in the Francis report to deliver safe, effective and compassionate care.

## The need for reform

NHS staff are our greatest asset. We know that high- performing staff improve the outcome for patients. We also know that delivering better patient care is not simply about paying staff more, it is about engaging and empowering the entire workforce so we secure a fundamental and permanent shift in culture. We want a workforce that is rewarded fairly for the important life-saving work they do and which supports the very important principle that staff and managers must make the care and safety of patients their priority.

However, employers cannot pay staff more, improve quality and productivity and protect jobs. Careful and prudent management of the NHS pay bill is critical if we are to maintain the right number of front-line staff with the right skills. We believe more

affordable employment contracts can help deliver better care and improve job security.

Currently, Agenda for Change (AfC) provides for annual pay progression, which means employers face a two per cent (about £700m pa) pressure on the pay bill each year even during a pay freeze. Last year, for example, in addition to the one per cent basic pay rise for AfC staff (about £350m), around 60 per cent of NHS staff on AfC pay, terms and conditions received pay progression of between 0.6 and 6.7 per cent averaging at about 3.5 per cent. This is out of step with our wider policy on public sector pay and the ambitions the Chancellor set out in the Spending Round 2013, where he made clear that:

*“...the biggest reform we make on pay is to automatic progression pay. This is the practice whereby many employees not only get a pay rise every year, but also automatically move up a pay grade every single year – regardless of performance. Some public sector employees see annual pay rises of seven per cent. Progression pay can at best be described as antiquated; at worst, it’s deeply unfair to other parts of the public sector who don’t get it and to the private sector who have to pay for it. So we will end automatic progression pay in the Civil Service by 2015-16. And we are working to remove automatic pay rises simply for time served in our schools, NHS, prisons and police. The armed forces will be excluded from these reforms.”*

The priority for this pay round should therefore be support for continued reform of national contracts so that they deliver improvements in performance and productivity, are affordable and fit for purpose. Putting patients at the heart of everything the NHS does means ensuring services are available seven days a week and that staff are rewarded for what they do for patients, not time served. They must also reward appropriate behaviours – compassionate, high quality patient-centred care.

The one per cent that the Government has made available for pay, in the Spending Round, would, in our view, be best deployed in supporting the modernisation of national pay frameworks. In particular, that the reform of AfC should seek to improve the quality of patient care and therefore outcomes by ensuring there is a better balance between pay, performance and productivity, rather than time served. Substantial reforms to progression pay will be taken forward or are already underway across the public sector.

The recruitment and retention picture for the NHS remains strong and measures of staff engagement in the staff survey remain good. During 2012/2013 recruitment, retention, morale and motivation remained strong with, for example, an improved engagement score for all staff in the 2012 NHS Staff Survey, rising from 3.61/5 to 3.68/5. The Government’s view, therefore, remains that basic pay increases should

only be implemented if there is strong evidence that recruitment, retention, morale or motivation issues require this.

The public want and need a health service which is able to respond effectively to their needs whether in hospital or at home. A pay system which is designed around a Monday to Friday working week, with, for example, premium rates for care at the weekends, cannot easily facilitate the delivery of seven day services. National pay systems must of course be fair to staff, but they should also balance the needs of patients and the cost to the tax payer.

### Our ask of the pay review body

Employers want to secure a better balance between pay, performance and productivity. To deliver our aspirations for the prevention of ill health and the delivery of seven day care, national pay frameworks must be fit for purpose, fair to staff and offer the taxpayer the very best value for money. The NHS will be in a stronger position to maintain or increase staffing levels, and therefore protect jobs, if employers are able to make better use of their pay bill.

The NHSPRB is, therefore, invited to:

- consider and make observations on whether the current AfC progression structure, notwithstanding the recent AfC national agreement, can be reformed to help improve performance (so staff are paid for what they do for patients) and productivity
- consider and make observations on whether any pay awards should be made to staff whose performance does not meet local standards
- consider and make observations on whether the AfC structure for 'out of hours' payments supports the Department's ambition for seven day services (particularly relevant to Sir Bruce Keogh's Mortality Review)
- consider and make observations on whether the distribution of any pay award should take account of the differential impact on staff of the current AfC progression structure
- consider, if they believe an award is justified, how any such award might be made dependent on the partners (NHS Staff Council) reaching agreement on further AfC reform. In particular, how in the current economic climate and within the context of the overall expenditure on pay and pensions, AfC might be made more affordable. We propose that any such recommendation is tied to progress on AfC reform, with the parties invited to report on progress in their evidence to the NHSPRB next year, effectively deferring any award

The content of our evidence this year reflects the new NHS architecture. As set out in the Parliamentary Under Secretary of State for Health's remit letter, the

Department will provide high level evidence focusing on the economic and financial (NHS funding) context and strategic policy with separate evidence provided by:

- NHS Employers – on recruitment, retention, motivation and morale for employed NHS staff on AfC pay, terms and conditions
- Health Education England - on education, training and workforce capacity
- NHS England - on affordability and funding constraints & reform of the workforce to help deliver NHS priorities

The subsequent chapters of the Department's evidence, therefore, set out:

- in Chapter 1, how our pay strategy, based on fit for purpose, affordable national pay contracts, supports delivery of Department of Health priorities to improve productivity, value for money, delivery and performance
- in Chapter 2, the general economic outlook for the UK economy which, describes that, while recovery is underway, it remains uncertain and that public sector pay restraint remains an essential component of fiscal consolidation plans
- in Chapter 3, that, despite the NHS benefitting from real terms growth from the SR, the financial challenge remains the biggest in NHS history with transformational change required to reduce long term cost pressures requiring unprecedented productivity improvements and decreased demand on the NHS
- in Chapter 4, our high level strategy and policy context for workforce planning; current information sources and how they are being used; how we are increasing the number of midwives and health visitors to improve maternity and family services; our continuing commitment to developing healthcare apprenticeships; how we are reducing our reliance on international migration; the impact of recent reviews including Compassion in Practice, Francis, Cavendish, Keogh and Berwick
- in Chapter 5: an update on AfC including what employment freedoms are available to NHS FTs and NHS Trusts, progress with the High Cost Area Supplement review and the increased importance of your recommendation in *Market Facing Pay...* that “AfC...is kept under review to ensure it continues to be fit for purpose, reflects modern practice and can respond to changing labour markets”. We describe how the changes we have agreed to AfC will help deliver some of the Francis recommendations but that we need to go further including extending plain time working and reforming progression pay given the Government's concerns about its lack of fairness. We also update on the effect of the Equalities Act on AfC and proposed changes to NHS redundancy terms



- in Chapter 6: our progress with pensions reform and our total reward strategy

# Chapter 1: NHS Strategy and Introduction

## NHS Strategy and Introduction

- 1.1 No exposition of the overall strategy for the NHS could be complete without a prominent role for the recommendations of the Francis Inquiry into the events at the Mid Staffordshire NHS Foundation Trust<sup>1</sup> which provide a humbling reminder that while NHS staff deserve to be rewarded fairly for their work, care and compassion need to be at the heart of all that the NHS does. The implications of the report are explored in Chapter 4.
- 1.2 The Department of Health Business Plan for 2013-2015<sup>2</sup>, updated in June 2013, sets out the Government's priorities for the NHS:
- to enable better health and wellbeing for all helping people live healthier lives by improving our public health system; protecting people's health by ensuring we have the capabilities and policies in place to address threats to public health; promoting health and wellbeing to deliver better health outcomes and tackle health inequalities across all ages
  - to enable better care for all helping people get better and ensuring people are treated with dignity and respect and supporting a patient-led NHS, reforming social care; working with the NHS and care sector to strengthen people's ability to make meaningful choices about their care and support the integration of services around the individual; getting the basics right on safety in health and care; a greater focus on health outcomes
  - to enable better value for all providing better quality care by improving productivity and ensuring value for money for the taxpayer; reducing bureaucracy; supporting the NHS to save up to £20 billion to reinvest in frontline services; simplifying regulation of the development and adoption of new medicines and treatments
  - to deliver successful change delivering the transition to a more autonomous and accountable system by making sure the new partnership organisations, clinical commissioning groups and health and wellbeing boards are ready to take on their new responsibilities; continuing our own transformation into a smaller, more purposeful organisation, with a clear sense of its role in health and care

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<sup>1</sup> <http://www.midstaffpublicinquiry.com/report>

<sup>2</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/225611/Secretary\\_of\\_State\\_priorities\\_in\\_Business\\_Plan\\_2013-15.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/225611/Secretary_of_State_priorities_in_Business_Plan_2013-15.pdf)

- to work with our partners achieving strategic clarity, building a common sense of purpose by developing strong relationships with our external stakeholders and establishing effective ways of working with the new organisations in the health and care system; playing our full role in delivering the government's priorities led by other departments

1.3 To support UK growth by reducing direct costs to taxpayers caused by ill health, championing UK strengths in technology and life sciences, maintaining the UK as a world-class location for clinical research and developing the life sciences sector, reducing NHS barriers to innovation and growth and trading on UK health-related expertise. In addition, the Department of Health had the following priorities for 2013-14:

- preventing people from dying prematurely by improving mortality rates for the big killer diseases to be the best in Europe, through improving prevention, diagnosis and treatment
- improving the standard of care throughout the system so that quality of care is considered as important as quality of treatment, through more accountability, better training, tougher inspections and more attention paid to what patients say
- improving treatment and care of people with dementia to be among the best in Europe through early diagnosis, better research and better support, and
  - bringing the technology revolution to the NHS to help people, especially those with long term conditions, manage their health and care
  - improving productivity and ensuring value for money for the taxpayer
  - focusing on improved delivery and performance
  - leading transition to the future system and working together to build a sense of common purpose
  - contributing to economic growth

1.4 2013/14 was a landmark year for the health and care system. On 1 April 2013, NHS England, Public Health England, the NHS Trust Development Authority and Health Education England took up their responsibilities in full. 211 clinical commissioning groups became formally established with GPs and other health professionals assuming leadership and responsibility for commissioning services for their local communities. All these bodies have vital roles in delivering the Government's priorities for the NHS. NHS England in particular is responsible for ensuring that the money spent on NHS services delivers the best possible care for patients.

## NHS Mandate

1.5 The first Mandate<sup>3</sup> between the Government and NHS England setting out the ambitions for the health service from 2013 to 2015 was published in November 2012. The Mandate is structured around five key areas where the Government expects NHS England to make improvements:

- preventing people from dying prematurely
- enhancing quality of life for people with long-term conditions
- helping people to recover from episodes of ill health or following injury
- ensuring that people have a positive experience of care
- treating and caring for people in a safe environment and protecting them from avoidable harm

1.6 The Secretary of State's foreword to the Mandate summed up the challenge facing the NHS as follows:

*“Never in its history has the NHS had to face such a profound shift in our needs and expectations. An ageing population, rising costs of treatments and huge increase in the numbers of us with long-term, often multiple conditions are rewriting our relationship with health and care, all at a time of acute pressure on public finances. These challenges go to the heart of the objectives I am setting the NHS Commissioning Board [now NHS England].”*

## NHS Outcomes Framework

1.7 The NHS Outcomes Framework for 2013/14<sup>4</sup> was also published in November 2012 and set out the outcomes and corresponding indicators used to hold NHS England to account using the same key areas set out in the Mandate as described above.

1.8 These priorities place a new emphasis on prevention and care to go alongside the focus on treatment. Overall this should result in greater integration between health and care and more care being provided in the community.

## Putting Patients at the heart of the NHS

1.9 The NHS Constitution<sup>5</sup> says:

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<sup>3</sup> <http://mandate.dh.gov.uk/>

<sup>4</sup> <https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014>

<sup>5</sup> <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx>

*“The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most”.*

- 1.10 Robert Francis QC, speaking in Stafford about his report on Mid Staffordshire NHS Foundation Trust, concluded with a message for all concerned with the management of NHS hospital services:

*“People must always come before numbers. Individual patients and their treatment are what really matters. Statistics, benchmarks and action plans are tools not ends in themselves. They should not come before patients and their experiences. This is what must be remembered by all those who design and implement policy for the NHS.”*

- 1.11 We need to improve the quality of care in hospitals to ensure safe care. We want the NHS to make better use of their pay bill so that we have safe staffing levels and that staff are freed up to deliver the quality of care that patients expect and need.

## Pay Strategy

- 1.12 The NHS is changing, as is the role of the medical and non-medical workforce to meet the challenges of a modern NHS. Our starting point must be based on putting the patient at the heart of what we do and to sustain and improve quality. The NHS should be responsive to patient needs. Patients need the NHS every day, not just Monday to Friday and not just in hospitals; but increasingly in an integrated way in the community.
- 1.13 One of the most significant principles of the reform of the NHS is decentralisation. As a result, the main incentives for provider financial management and efficiency is derived from tariff setting and a transparent regulatory framework, not from central government controls on providers’ pay and internal processes.
- 1.14 This is a challenging environment where employers seek to deliver efficiency challenges, maintain quality and generate more value from every pound invested in the NHS.
- 1.15 Therefore, the overarching policy aim is to develop an affordable reward strategy for the NHS, covering pay, conditions of service and pensions. The

strategy must provide the employment package that supports the maintenance of a skilled, motivated and caring workforce that can fulfil Government ambitions for the delivery of high quality patient services. Within this strategy, employers must be able to recruit and retain high calibre staff with the right skills and experience to meet the challenging demands created by an ageing population and advances in technology.

- 1.16 Our pay strategy is aimed at ensuring the national pay, terms and conditions of service remain affordable and fit for purpose and, therefore, are able to support employers across the NHS in delivering service priorities. Pay accounts for £45bn of the total NHS budget and pay and pensions accounts for around two-thirds of running costs for typical NHS employers. It is essential that at a time of unprecedented financial challenge, the best possible value for money is obtained from this investment. Pay arrangements in the NHS should enable employers to attract, retain and motivate high quality staff to deliver a first class public service.

### Staff Engagement

- 1.17 Our pay strategy also includes improving staff engagement. There is a complex relationship between overall pay and levels of staff engagement, morale and motivation. Other factors have a much greater impact on levels of engagement in the short term for example overall organisational culture, interaction with line managers, employee voice and the handling of organisational change. The scores in the 2012 NHS Staff Survey<sup>6</sup> suggest some progress is being made despite the pressures on NHS staff, rising from 3.61/5 to 3.68. There was variation across the service which means there is plenty of scope for improvement.
- 1.18 From 2010, the Department highlighted the importance of staff engagement in the NHS through its publications and by supporting events with NHS Employers to raise the profile of the issue in the service including support for the Government's "Engaging for Success Taskforce"<sup>7</sup>. The Department also introduced a new measure of staff engagement, building on measures of staff motivation and satisfaction.
- 1.19 Since 2010, the Department has worked with NHS Employers to develop resources to support staff engagement including a staff engagement toolkit<sup>8</sup> which was an important part of the overall HR strategy for the NHS. In addition, the NHS has been encouraged to develop, sustain and improve staff

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<sup>6</sup> <http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2012-Results/>

<sup>7</sup> <http://www.engageforsuccess.org/>

<sup>8</sup> <http://www.nhsemployers.org/EmploymentPolicyAndPractice/staff-engagement/Staff-engagement-toolkit/Pages/Staff-engagement.toolkit.aspx>

engagement through measurement in the NHS Staff Survey and by setting national objectives including:

- in 2011 and 2012, a national target for improving staff engagement in the Operating Framework
- in 2011, Staff Pledge 3 in the NHS Constitution which refers to the need to "engage staff in decisions which affect them"
- in 2013 passing responsibility for the Staff Survey to NHS England

- 1.20 The 2011 NHSPRB Report cited research commissioned by the Department from Professor Michael West of Aston University, which demonstrated correlations between levels of staff engagement and HR outcomes such as absence levels, organisational performance and quality measures such as patient satisfaction and mortality.
- 1.21 During 2012 specific attention was paid to the "advocacy" dimension of staff engagement within the NHS Staff Survey and organisations are ranked on this on the staff survey website. This concept is being developed further via the "Friends and Family" test<sup>9</sup> for staff alongside that for patients. NHS England intend to link results of organisations on the advocacy question within the staff survey to the payment stream for NHS organisations.
- 1.22 There has been a particular focus, post the Francis report on Mid Staffordshire NHS Foundation Trust, on the cultural challenges to staff engagement, development of local values and issues of employee advocacy. The Francis report highlighted the potential negative impact on patients of staff disengagement as set out in Section B "The culture of the trust" (pages 151 – 184) and Section C "Experiences and perceptions of staff" (pages 185 – 205). It emphasised the need for leaders to create a culture that supports engagement. Staff engagement has been woven into work on the nursing strategy known as the 6Cs<sup>10</sup>, especially around engaging staff in the delivery of compassionate care. Work is ongoing on the delivery of this strategy including areas such as appraisal.
- 1.23 CQC's regulatory regime is also seeking to make use of measures of staff engagement as part of the Chief Inspector's assessment of the organisational health of providers. Consultation<sup>11</sup> is underway on changes to the way CQC regulates, inspects and monitors care. This includes a vision of a 'well-led' service, with effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation, and an open, fair and

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<sup>9</sup> <http://www.england.nhs.uk/2013/07/30/nhsfft/>

<sup>10</sup> <http://www.england.nhs.uk/tag/6cs>

<sup>11</sup> [http://www.cqc.org.uk/sites/default/files/media/documents/cqc\\_consultation\\_2013\\_tagged\\_0.pdf](http://www.cqc.org.uk/sites/default/files/media/documents/cqc_consultation_2013_tagged_0.pdf)

transparent culture that listens and learns from people's views and experiences to make improvements. Inspections would encompass an assessment of aspects of governance, leadership and culture to assess whether a service is 'well-led'.

- 1.24 The importance of staff engagement is also being promoted by the NHS Leadership Academy in their recently published, refreshed version of *'the Health NHS Board'*<sup>12</sup>. This sets out what boards need to put in place to help them develop a responsive, insightful approach to issues in their organisations, including advice on effective staff engagement. The Academy is also developing and implementing a leadership development offer that places a strong emphasis on shaping positive cultures and engaging staff.
- 1.25 The NHS Leadership Academy was established in 2012 as a national hub for leadership development and talent management. Through leadership development, it aims to improve leadership behaviours and skills and ultimately lead to better patient care, experience and outcomes. Starting in September 2013, the Academy has launched a suite of five leadership development programmes that together represent the first national approach to leadership development in the NHS, designed to develop outstanding leaders for every tier across the healthcare system 'from ward to board'.
- 1.26 Building on evidence (West et al) that found a significant reduction in patient standardised mortality rates in organisations with high staff engagement (in turn associated with high levels of effective and engaging leadership), all of the Academy's leadership development programmes will contain components on the values and behaviours required in a new integrated health care system focused around the needs of patients, carers and service users and in ways which liberate, engage and motivate staff to provide a compassionate and personal health care experience. These behaviours are congruent with NHS values and uphold the NHS Constitution, which itself states:

*"Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported."*

- 1.27 Staff engagement is critical if employers in the NHS are to carry staff with them as they seek to meet their efficiency targets, maintain quality and deliver the best outcomes for patients. In 2010 the Department commissioned NHS Employers to research, promote and support employers to embed staff engagement within their organisations. Based on data from the 2012 NHS

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<sup>12</sup> <http://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf>



Staff Survey, it appears that staff engagement and job satisfaction (78 per cent) has held up well. Overall staff satisfaction with pay has remained positive although less than in 2011. Staff willingness to recommend the NHS as an employer has improved from 51 per cent to 55 per cent, suggesting there is an understanding of the overall and relative value of the NHS total reward package.

# Chapter 2: General Economic Context<sup>13</sup>

## Summary

- 2.1 The Government's economic strategy set out in the June Budget 2010 is designed to protect the economy through this recent period of global uncertainty and provide the foundations for recovery. This strategy is restoring the public finances to a sustainable path and the deficit has been reduced by a third in the three years from 2009-10. The UK is seen as a relative safe haven, with low market interest rates helping keep interest payments lower for households, businesses and the taxpayer. This strategy has helped the Government equip the UK to compete in the global race.
- 2.2 The UK economy grew by 0.2 per cent over the course of 2012 and the Office for Budget Responsibility (OBR) forecast the UK to grow by 0.6 per cent in 2013. The UK economy is recovering from the biggest financial crisis in generations; of the developed economies only Japan experienced a deeper recession and a decade of growth built on unsustainable levels of debt.
- 2.3 Three key factors first set out in the OBR's November 2011 *Economic and fiscal outlook* have resulted in a more subdued and uneven recovery than expected. The impact of the financial crisis on GDP and underlying productivity has been greater than expected. The euro area sovereign debt crisis and global uncertainty have damaged confidence and reduced external demand. Commodity price driven inflation since 2011 has reduced real incomes and raised business costs.
- 2.4 The OBR forecast inflation of 2.8 per cent in 2013 and 2.4 per cent in 2014 and forecast it to return to target by early 2016. The Bank of England's latest inflation forecast, published in the August *Inflation Report* is little changed compared to the May report. The Monetary Policy Committee (MPC) expect inflation to be above the two per cent target for much of the next two years.
- 2.5 Labour market figures strengthened in the second quarter of 2013 after a weak start to the year. The OBR expects employment to continue to rise over the forecast period although with slower growth than that seen over 2012. The unemployment rate remained flat over the quarter, in line with market expectations, but is down on the year and down from the peak of 8.4 per cent in the final quarter of 2011. Wage growth remains weak although total pay increased above two per cent in the three months to June for the first time

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<sup>13</sup> HMT Chapter accurate as of 16/8/2013

since late 2011 driven by unusually strong bonus payments made in April 2013.

- 2.6 The Government remains committed to reducing the deficit and addressing the permanent structural deterioration in the public finances caused by the lasting impact of the financial crisis. Implementation of the fiscal consolidation plans is well underway. By the end of 2012-13, around 70 per cent of the annual fiscal consolidation planned for the Spending Review 2010 period will have been achieved, with around 65 per cent of the spending and around 90 per cent of the tax consolidation in place.
- 2.7 The OBR's March 2013 *Economic and fiscal outlook* concluded that the Government remains on course to meet the fiscal mandate to achieve cyclically-adjusted current balance by the end of the rolling, five-year forecast period. The OBR also forecast that public sector net debt as a percentage of GDP will be falling in 2017-18, two years later than set out in the supplementary debt target. The Government's judgment is that significant changes to the path of consolidation in the short term would constrain the operation of the automatic stabilisers, limiting their ability to support the economy.
- 2.8 Public sector pay restraint has been a key part of the fiscal consolidation so far. Budget 2013 announced that public sector pay awards in 2015/16 will be limited to an average of up to one per cent.

## Economic context and outlook for the economy

### Growth

- 2.9 The Government inherited the largest deficit since the Second World War and of the major economies only Japan experienced a deeper recession. Across the world, recovery over the past four years has been slower than forecast.
- 2.10 The OBR's October 2012 *Forecast evaluation report* showed that the shortfall in growth compared to its June Budget 2010 forecast could largely be explained by private consumption, investment and net trade, in roughly equal measure, reflecting shocks from commodity prices, financial conditions and confidence.
- 2.11 The Government's strategy is designed to protect the economy through this period of global uncertainty, to maintain market confidence in the UK and to lay the foundations for a stronger more balanced economy in the future. The Government is taking decisive action through: monetary activism and credit easing, stimulating demand, maintaining price stability and supporting the flow

of credit in the economy; deficit reduction; reform of the financial system; and a comprehensive package of structural reforms.

- 2.12 Compared with Autumn Statement 2012, the OBR's March 2013 *Economic and fiscal outlook* revised down its forecast for GDP growth in 2013 to 0.6 per cent from 1.2 per cent and GDP growth in 2014 to 1.8 per cent from 2.0 per cent reflecting smaller contributions to growth from net trade and consumption.
- 2.13 Risks to UK growth have become more balanced. Global risks have started to ease. As the Funding for Lending Scheme begins to gain traction, UK credit conditions have improved. There are signs of increasing momentum. The Bank of England revised up its forecast for growth and maintained its forecast for inflation in August's quarterly *Inflation Report*. The Bank of England believe "a recovery appears to be taking hold."
- 2.14 The Government is delivering ambitious structural reforms to enable the UK to compete in a rapidly changing global economy. These reforms are a key part of the Government's economic strategy, alongside fiscal consolidation, monetary activism, and reform of the financial system.
- 2.15 Since November 2010, the Government has set out a programme of structural reforms to remove barriers to growth for businesses and equip the UK to compete in the global race. These reforms span a range of policies, including improving the UK's infrastructure, cutting red tape, root and branch reform of the planning system and boosting trade and inward investment.
- 2.16 Budget 2013 announced a further reduction in corporation tax to 20 per cent by 2015, £18 billion of additional capital investment over the next Parliament, and a major housing package worth £5.4 billion to support home ownership, new development and affordable housing.
- 2.17 The UK is not immune to what happens elsewhere. As our biggest trading partner the euro area represents more than 40 per cent of UK exports. The successful implementation of a comprehensive resolution to this crisis remains a key priority for the global economy.

**Table 1: Forecasts for GDP growth 2013 to 2015**

Forecasts for GDP growth (per cent)	2013	2014	2015
OBR (March Budget 2013)	0.6	1.8	2.1
IMF WEO Update (July 2013)	0.9	1.5	-
Avg. of independent forecasters (July)	1.0	1.7	2.1

### Inflation

2.18 Despite the difficult current conditions, inflation has fallen significantly since its peak in September 2011. CPI inflation peaked at 5.2 per cent in September 2011 but fell back in 2012 as past rises in commodity and energy prices and VAT dropped out of the twelve month comparison. Inflation over the second quarter of 2013 was 2.7 per cent.

2.19 Compared to the *May Inflation Report*, the outlook for inflation in the August report is similar, as the stronger demand outlook is assumed to be largely matched by an expansion in effective supply capacity. CPI inflation is likely to remain close to three per cent in the near term, reflecting the impact of past increases in import prices and the persistent contribution of administered and regulated prices. Inflation is forecast to fall back towards target in the latter part of the forecast period as external price pressures fade.

**Table 2: Forecasts for CPI Inflation 2013 to 2015**

Forecasts for CPI Inflation (per cent change on a year earlier)	2013	2014	2015
OBR (March Budget 2013)	2.8	2.4	2.1
IMF WEO April 2013)	2.7	2.5	2.2
Avg. of independent forecasters (July 2013)	2.5	2.4	2.2

### Affordability

2.20 The Government inherited the largest deficit in post-war history due to the financial crisis and unsustainable pre-crisis increases in public spending. The historically high level of borrowing risked undermining fairness, growth and

economic stability in the UK. In 2010 the Government set out clear, credible and specific medium-term fiscal consolidation plans to return the public finances to a sustainable path.

- 2.21 The Government's fiscal strategy has been effective in providing protection against a challenging backdrop of global uncertainty and fiscal vulnerabilities. This has restored fiscal credibility, allowing activist monetary policy and the automatic stabilisers to support the economy, and is consistent with the approach recommended by international organisations.
- 2.22 The Government remains committed to reducing the deficit and addressing the permanent structural deterioration in the public finances caused by the lasting impact of the financial crisis. By the end of 2012-13, around 70 per cent of the annual fiscal consolidation planned for the Spending Review 2010 period will have been achieved, with around 65 per cent of the spending reductions predicted by 2014-15 and around 90 per cent of the tax consolidation in place. 80 per cent of the total consolidation in 2015-16 will be delivered by lower spending with current spending reduced by a further £11.5 billion.
- 2.23 As a result, the Government has made significant progress in reversing the unprecedented rise in borrowing between 2007-08 and 2009-10. The deficit has been reduced by a third as a percentage of GDP in the three years from 2009-10.
- 2.24 The UK's fiscal vulnerabilities argue strongly in favour of maintaining a credible path of deficit reduction. Despite significant progress since 2010, the UK is forecast to have the largest structural deficit in the EU in 2013. Among the G7, only the US and Japan are forecast to have larger structural deficits in 2013. Clear and credible consolidation plans remain essential for reducing the risk of a costly loss of market confidence in the UK.
- 2.25 In February 2013, Moody's downgraded the UK sovereign credit rating from Aaa to Aa1 with stable outlook. Among the G7, only Canada and Germany are now rated AAA by all three major credit rating agencies; Canada and Germany had the lowest pre-crisis structural deficits in 2007.
- 2.26 The credit rating is one of many important benchmarks, but near historic low gilt yields continues to reflect the market-tested credibility earned by the Government's economic strategy.
- 2.27 The implication of fiscal consolidation for departmental spending levels can be seen in the table below, which shows resource DEL budgets for each department from the Public Expenditure Statistical Analyses 2013. An

estimated £166 billion in 2011-12 was spent on public sector pay, around 50 per cent of departmental resource spending.

**Table 1.5 Resource DEL excluding depreciation, 2008-09 to 2015-16**

	National Statistics							
	2008-09 outturn	2009-10 outturn	2010-11 outturn	2011-12 outturn	2012-13 outturn	2013-14 plans	2014-15 plans	2015-16 <sup>(1)</sup> plans
<b>£ million</b>								
<b>Resource DEL excluding depreciation by departmental group</b>								
Education	46,637	49,385	50,568	50,265	50,239	52,442	53,181	53,168
NHS (Health)	86,671	93,237	96,260	99,070	101,416	105,519	108,340	110,372
Personal Social Services (Health) <sup>(2)</sup>	1,261	1,362	1,471	-	-	-	-	-
Transport	5,436	5,652	5,176	4,679	4,315	3,986	3,621	3,198
CLG Communities	4,084	4,299	3,649	1,745	1,309	2,561	2,085	1,134
CLG Local Government <sup>(3)</sup>	29,487	30,798	28,735	29,764	27,576	16,242	13,330	11,820
Business, Innovation and Skills	16,329	17,321	17,029	16,231	15,467	14,871	13,776	13,000
Home Office	9,009	9,268	12,288	11,904	11,199	10,977	10,359	9,901
Justice	8,633	8,529	8,614	8,453	8,067	7,216	6,793	6,235
Law Officers' Departments	712	697	658	611	591	597	532	519
Defence	25,410	27,587	28,090	28,142	26,415	26,470	24,386	23,896
Foreign and Commonwealth Office	1,946	2,022	2,091	2,052	1,987	1,920	1,158	1,102
International Development	4,742	5,234	5,909	6,167	6,105	8,556	8,273	8,499
Energy and Climate Change	288	1,216	1,146	1,144	1,117	1,375	1,078	952
Environment, Food and Rural Affairs	2,219	2,261	2,175	1,981	1,887	1,932	1,695	1,559
Culture, Media and Sport	1,502	1,457	1,471	1,473	2,059	1,239	1,134	1,098
Work and Pensions	7,689	8,549	8,685	7,286	7,117	7,612	7,412	5,988
Scotland	23,901	24,852	25,587	25,189	25,341	25,672	25,691	25,655
Wales	12,610	13,289	13,615	13,475	13,265	13,705	13,690	13,635
Northern Ireland	8,894	9,293	9,597	9,437	9,461	9,617	9,633	9,622
Chancellor's Departments	4,132	4,048	3,758	3,642	3,262	3,635	3,456	3,265
Cabinet Office	1,772	1,962	2,025	2,045	2,074	2,136	2,279	1,995
Small and Independent Bodies	1,649	1,587	1,552	1,624	1,394	1,468	1,434	1,295
Spending commitments not yet in budgets <sup>(1)</sup>	-	-	-	-	-	-	-	1,100
Reserve	-	-	-	-	-	2,200	2,800	2,800
Special Reserve	-	-	-	-	-	400	1,800	1,000
Green Investment Bank	-	-	-	-	-	1,000	-	-
OBR allowance for shortfall	-	-	-	-	-	-1,200	-1,000	-
Adjustment for Budget Exchange <sup>(4)</sup>	-	-	-	-	-	-1,700	-1,200	-
<b>Total resource DEL excluding depreciation</b>	<b>305,012</b>	<b>323,905</b>	<b>330,149</b>	<b>326,380</b>	<b>321,663</b>	<b>320,700</b>	<b>315,700</b>	<b>312,900</b>

<sup>(1)</sup> Figures are consistent with Table 1 of the Spending Round 2013 document (Cm8639) published on 26 June 2013.

<sup>(2)</sup> Personal Social Services (Health) are grants previously paid by the Department of Health that are now included in CLG Local Government's budget.

<sup>(3)</sup> Figures from 2013-14 onwards reflect adjustment to departmental plans for changes to local government funding for business rates retention and council tax localisation.

<sup>(4)</sup> Departmental budgets in 2013-14 and 2014-15 include amounts carried forward from 2012-13 through Budget Exchange. These increases will be offset by any deposits at Supplementary Estimates in future years so are excluded from spending totals.

## Labour market

2.28 Headline labour market figures strengthened in the second quarter of 2013 after a weak start to the year. Employment increased on the quarter to its highest recorded level, driven predominantly by an increase in the number of employees. Employment increased by 69,000 on the quarter and is up 301,000 over the year. The OBR expects employment to continue to rise over the forecast period, but at a slower pace than the increase over 2012. Unemployment decreased slightly over the quarter (-4,000) and is down 49,000 over the year. The unemployment rate remained unchanged, in-line with market expectations but is down 0.2 percentage points compared to the

same period last year and down from the peak of 8.4 per cent in the final quarter of 2011. The OBR expect the unemployment rate to increase over 2013 reaching 8.05 per cent by the end of 2014.

- 2.29 In the second quarter of 2013, the overall LFS employment level was 205,000 above its pre-recession peak in the three months to May 2008, but the employment rate at 71.5 per cent was 1.5 percentage points lower than its pre-recession peak. The recovery of the level of employment over this period was driven by strong increases in part-time employment (up 572,000) and self-employment (up 346,000) while full-time employment and the number of employees have fallen by 367,000 and 183,000 respectively.
- 2.30 The performance of other labour market indicators are providing mixed signals on the recovery in labour demand. Average earnings growth remains weak, with regular pay growth (excluding bonuses) at 1.1 per cent. However the number of vacancies increased by 58,000 over the year to 533,000 in the three months to June 2013, the highest level since late 2008.

### Employment and unemployment

- 2.31 The increase in the level of employment of 301,000 over the year to the second quarter of 2013 continues to give indications of a positive change in the composition of employment, with the number of employees increasing by 299,000 while self employment is down by 20,000. The increase saw those working full-time increase by 306,000 while those working part-time fell by 4,000. It is also notable that the increase of employment has been driven by women, which increased by 225,000 over the period.
- 2.32 The ILO unemployment rate, which rose from a low of 5.2 per cent in the first quarter of 2008 to peak at 8.4 per cent (2.66m people) in the final quarter of 2011, has subsequently fallen to 7.8 per cent in the second quarter of 2013.
- 2.33 Long term unemployment (unemployment of 12 months or more) increased by 28,000 over the year up to the second quarter of 2013 to stand at 909,000.
- 2.34 Working age inactivity (16-64) was down by 105,000 over the year at 22.3 per cent. This has been driven entirely by the fall in female inactivity, which has fallen by 148,000 over the year while male inactivity has increased by 43,000.
- 2.35 Youth unemployment (16-24) increased by 15,000 in the second quarter of 2013 to 973,000 (21.4 per cent). Excluding those that are in full-time education, the level is 676,000 (or 19.8 per cent).



2.36 The claimant count (the number of people claiming Jobseeker's Allowance) continues to fall, declining by 29,200 in July 2013. July was the ninth consecutive month the claimant count has fallen. Table 4 summarises these statistics:

**Table 4: Labour market statistics summary (Levels in 1,000's, rates in %)**

	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013 Q2</b>
<b>Employment level (All aged 16 and over)</b>	28,960	29,019	29,166	29,519	29,777
<b>Employment rate (All aged 16-64)</b>	70.9	70.5	70.5	71.1	71.5
<b>Unemployment level (All aged 16 and over)</b>	2,390	2,476	2,564	2,548	2,514
<b>Unemployment rate (All aged 16 and over)</b>	7.7	7.8	8.1	7.9	7.8
<b>Youth unemployment level (All aged 16-24)</b>	912	932	986	992	973
<b>Youth unemployment rate (All aged 16-24)</b>	19.1	19.8	21.1	21.2	21.4
<b>Claimant Count</b>	1,528	1,496	1,534	1,585	1,496

2.37 The latest public and private sector employment figures available are for the first quarter of 2013. These show that private sector employment rose by 46,000 on the quarter and was up by 544,000 over the year. This more than offset the fall in public sector employment which decreased by 22,000 on the

quarter and by 112,000 over the year. This takes into account reclassifications of education corporations in the second quarter of 2012<sup>14</sup>.

## Public and Private Sector Earnings

- 2.38 Average total pay growth (including bonuses) increased by 2.1 per cent in the three months to June, the first time the rate has been above two per cent since late 2011. However this is likely to be due to unusually strong bonus payments made in April with some businesses reporting that they paid bonuses in March 2012 but in April in 2013. Regular pay growth (excluding bonuses) rose by 1.1 per cent over the same period. Between June 2012 and June 2013 the Consumer Price Index increased by 2.9 per cent, meaning that real pay growth continued to be negative over this period.
- 2.39 Average total private sector pay has recovered somewhat from its large decline in 2009 but remains mostly weak, growing by just two per cent in 2010 and 2.5 per cent in 2011, compared to above four per cent prior to the recession. Private sector pay growth weakened in 2012 and into the first quarter of 2013. Total private sector pay strengthened in the second quarter of 2013 to grow by 2.6 per cent in the three months to June on the year; however this is likely to be due to the unusually high bonus payments in this period. Average private sector regular pay grew by 1.4 per cent in 2010 and gained some strength in 2011 and at the beginning of 2012. However, it weakened in the latter half of 2012 and into 2013, growing by just 0.8 and 1.2 per cent in the first and second quarters of this year.
- 2.40 Public sector (excluding financial services) average regular pay was 2.3 per cent in 2010 and 1.8 per cent in 2011. While this recovered slightly in the middle of 2012, growing by 2.4 per cent in the three months to September 2012, it weakened towards the end of the year and grew by 1.4 per cent and 1.2 per cent in the first and second quarters of 2013 respectively.
- 2.41 The sharp drop in bonuses seen in 2009 put more downward pressure on total pay (pay including bonuses), while there were some tentative increases in the levels during 2010 and 2011, it has remained mostly subdued. Bonus pay in the private sector continued to be weak throughout 2012, falling on average by 1.6 per cent compared to average growth of 10.6 per cent in 2011. Bonus pay has seen large fluctuations during 2013 with a fall of 8.1 per cent in March 2013 but an extremely large single month increase in April 2013 of 62.3 per cent likely due to the timing of annual bonus payments.

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<sup>14</sup> <http://www.ons.gov.uk/ons/rel/pse/public-sector-employment/q1-2013/stb-pse-2013q1.html>

2.42 Table 5 sets out the differences in regular and total pay growth across years in the public and private sector.

**Table 5: Total pay and Regular pay (excluding Bonuses) growth<sup>15</sup>**

	Total Pay, annual growth			Regular pay, annual growth		
	All	Private	Public <sup>16</sup>	All	Private	Public <sup>17</sup> Error ! Bookmark not defined.
2009	-0.1%	-1.0%	2.8%	1.8%	1.2%	3.0%
2010	2.4%	2.0%	2.2%	1.9%	1.5%	2.3%
2011	2.4%	2.5%	1.5%	2.0%	2.0%	1.8%
2012	1.4%	1.4%	1.7%	1.7%	1.8%	1.6%
<i>Three months to June 2013</i>	2.1%	2.6%	1.2%	1.1%	1.2%	1.2%

2.43 Despite the pay freeze, average earnings in the public sector (as measured by the ONS) still display positive growth for a number of reasons: the provision of £250 to those earning £21,000 or less, upwards pay drift due to

<sup>15</sup> Source: ONS, AWE; HMT calculations annual percentage change for quarter one.

<sup>16</sup>Public Sector excluding financial services

<sup>17</sup>Public Sector excluding financial services

constrained recruitment, and the fact that some three year pay deals only ended in September 2011.

## Public Sector Pensions

- 2.44 When considering changes to remuneration, it is important to consider the overall value of the public sector reward package. As set out above, pay in the public sector continues to be above that of the private sector on average. However, there are many reasons aside from pay that may drive an individual's decision as to whether they will work in the public or private sector.
- 2.45 One major factor in the overall reward package is pension provision. In the last few decades pension provision in the public and private sectors has diverged, in response to pressures around longevity, changes in the business environment and investment risk. This has led to a sharp decrease in the provision of defined benefit schemes in the private sector. Around 85 per cent of public sector employees are members of employer sponsored pension schemes, compared to only 35 per cent in the private sector.
- 2.46 Following a fundamental review of public service pension provision by the Independent Public Service Pensions Commission, the Government is introducing key changes to the pension element of the remuneration package. New public service pension schemes will be introduced in April 2015, which will:
- calculate pension entitlement using the average earnings of a member over their career , rather than their salary at or near to retirement
  - calculate pension benefits based on Normal Pension Age linked to the member's State Pension Age
  - include an employer cost cap mechanism, where unforeseen changes in scheme costs are shared by members and employers (based on two per cent of the scheme's total pensionable pay bill)
- 2.47 The changes being introduced through the Public Service Pensions Act 2013 will save an estimated £65 billion by 2061-62.
- 2.48 Wider changes to public service pension provision have also taken place. Progressive increases in the amount that members contribute towards their public service pension began in April 2012. Members will contribute an average of 3.2 percentage points more, phased in over three years (increases will be finalised in April 2014). This will deliver £2.8 billion of savings a year by 2014-15.
- 2.49 Protections from the impact of the contribution changes have been put in place for the lowest paid. Those earning less than £15,000 will see no

increases; and those earning up to £21,000 (£26,000 for teachers) will not see increases of more than 1.5 percentage points by 2014-15.

- 2.50 Public service pensions will remain among the best available and will continue to offer members guaranteed, index linked benefits in retirement that are protected against inflation. Private sector workers buying benefits in the market would have to contribute over a third of their salary each year to buy an equivalent pension.
- 2.51 Putting together the evidence on pension provision and pay levels – and recognising that there will be significant variation between and within individual workforces – the overall remuneration of public sector employees is above that of the market. The Government is therefore clear that any changes to public service pensions, including the progressive increase in contributions from 2012-13, do not justify upward pressure on pay.

# Chapter 3: NHS Finances

## Funding Growth

- 3.1 This chapter sets out the financial position for the NHS in 2014/15.
- 3.2 Between 1999/00 and 2010/11 NHS revenue expenditure increased by an average of 5.5 per cent in real terms. The first two years of the current spending review period (2011/12 and 2012/13) have shown subdued growth, averaging 0.7 per cent per year in real terms.
- 3.3 Table 3.1 shows:
- outturn NHS revenue expenditure figures from 1999/00 to 2012/13
  - revenue Departmental Expenditure Limits (RDEL), as agreed in the 2010 and 2013 Spending Reviews, for 2013/14 to 2015/16

**Table 3.1 – NHS Revenue Expenditure since 1999/00**

Year		Revenue Net NHS Expenditure <small>(5)(7)</small> £bn	% increase	% real terms increase <small>(7)</small>
<b>RB Stage 1<sup>(1)</sup></b>				
1999/00	Outturn	39.3	-	-
2000/01	Outturn	42.7	8.6	7.9
2001/02	Outturn	47.3	10.8	7.9
2002/03	Outturn	51.9	9.8	7.3
<b>RB Stage 2<sup>(2)(4)</sup></b>				
2003/04	Outturn	61.9	-	-
2004/05	Outturn	66.9	8.1	5.2
2005/06	Outturn	74.2	10.9	8.9
2006/07	Outturn	78.5	5.8	2.8
2007/08	Outturn	86.4	10.1	7.4
2008/09	Outturn	90.8	5.0	2.2
2009/10	Outturn	97.8	7.8	4.9
<b>Resource Budgeting - Aligned<sup>(3)</sup></b>				
2009/10	Outturn	94.4	-	-
2010/11	Outturn	97.5	3.2	0.6
2011/12	Outturn	100.3	2.9	0.6
2012/13	Outturn	102.6	2.3	0.8
2013/14	Plan	106.7	4.1	1.7
2014/15	Plan	109.6	2.7	0.8
2015/16	Plan	111.9	2.1	0.2

1. Expenditure figures from 1999-00 to 2002-03 are on a Stage 1 resource budgeting basis.

2. Expenditure figures from 2003-04 to 2009-10 are on a Stage 2 resource budgeting basis.

3. Expenditure figures from 2009-10 to 2010-11 are on an aligned basis.

4. Figures from 2003/04 include a technical adjustment for trust depreciation

5. Expenditure excludes NHS (AME)

6. GDP as @ 27/06/2013

7. Revenue is quoted gross of non-trust Depreciation and Impairments; prior to September 2007, revenue was quoted net of non-trust Depreciation and Impairments. This brings the Department of Health in line with HMT presentation of the statistics.

## Share of resource going to pay

3.4 Table 3.2 shows the proportion of the increased funding that has been consumed by the Hospital and Community Health Services (HCHS) paybill over time.

**Table 3.2– Increases in Revenue Expenditure and the proportion consumed by Paybill**

Year	Increase in Revenue Expenditure (£bn)	Increase in HCHS Paybill (£bn)	Proportion of revenue increase on paybill (%)	Increase in HCHS paybill due to prices		Increase in HCHS paybill due to volume	
				(%)	(£bn)	(%)	(£bn)
2001/02	4.6	2.4	51	7.0	1.4	4.7	1.0
2002/03	4.6	2.4	51	5.0	1.1	5.5	1.3
2003/04	6.5	2.6	41	5.0	1.3	5.4	1.4
2004/05	5.0	4.5	91	5.0	2.3	5.0	2.3
2005/06	7.3	2.5	34	5.4	1.5	3.4	1.0
2006/07	4.3	1.3	30	4.3	1.4	-0.3	-0.1
2007/08	7.9	1.3	16	3.5	1.2	0.2	0.1
2008/09	4.4	2.5	57	3.0	1.1	4.0	1.4
2009/10	7.1	2.8	39	1.8	0.7	5.1	2.1
2010/11	3.0	1.5	49	3.1	1.1	1.2	0.4
2011/12	2.8	-0.5	-18	0.9	1.5	-1.2	-2.0
2012/13	2.3	0.6	26	1.0*	0.4*	0.5*	0.2*
<b>Average</b>	<b>5.0</b>	<b>2.0</b>	<b>39</b>	<b>4.2</b>	<b>1.2</b>	<b>2.8</b>	<b>0.8</b>

\*. Provisional

1. Revised 2010/11 to 2012/13, following accounts restatements and exclude inter-company eliminations

2. Excludes ALB and Department of Health core staff expenditure

3. Excludes GPs

4. Pay (price element) methodology changed from last year's evidence to maintain consistency of series.

5. Volume & Price estimates changes methodology in 2010/11 to make use of a more detailed staff group breakdown from ESR

6. Figures may not sum due to rounding.

3.5 On average, between 2001/02 and 2012/13, increases to the HCHS paybill have consumed 39 per cent of the increases in revenue expenditure. Of this 39 per cent, pay effects have consumed around 23 per cent and volume effects around 16 per cent.

3.6 HCHS pay is the largest cost pressure, accounting for 45 per cent of revenue expenditure in 2012/13. On average it has also accounted for around 39 per cent of the increases in revenue expenditure since 2001/02. As pay represents such a large proportion of NHS resources, managing the paybill is key to ensuring the NHS lives within the funding growth it has been assigned in the next three years.



## Pressures on NHS funding growth

3.7 Different priorities compete for limited funding growth given to the NHS. They are grouped into three categories:

- baseline pressures
- underlying demand
- service developments

3.8 Baseline pressures cover the cost of meeting existing commitments that are essential for delivery of NHS services. They do not cover underlying demand, or increased levels of activity, which may arise due to demographic pressures or medical advance. Service developments are new areas of activity which arise due to new policies or ministerial commitments.

3.9 HCHS paybill pressures are the largest component of the baseline pressures and usually form the first call on NHS resources. Managing baseline pressures effectively allows the NHS to treat a growing, ageing population whilst making best use of the funding available.

## Allocation of resources

3.10 Table 3.3 shows how funding increases have been allocated across baseline pressures, demand and service developments in previous Spending Review periods.

**Table 3.3 – Disposition of Revenue Increase Across Expenditure Components**

	Outturn			Plan	
	SR2004 £bn	CSR2007 £bn	First 2 years of SR10 £bn	2013/14 £bn	2014/15 £bn
Activity Growth	2.9	1.1	0.8	2.2	1.8
Service Development	1.6	1.7	0.3	0.5	0.5
HCHS Pay (Price only Component)	1.7	2.0	0.2	0.9	0.7
Secondary Care Drugs	0.3	0.4	0.3	0.4	0.0
Other (including central budgets)	0.3	0.1	-0.1	0.6	-0.5
Primary Care Drugs	0.3	0.3	-0.2	0.4	0.2
General Dentistry, Ophthalmic and Pharmaceutical Services	0.2	0.2	0.2	0.1	0.1
Procurement	0.1	0.1	0.9	0.3	0.1
General Medical Services	0.1	0.2	0.1	0.1	0.2
Funding for Social Care			0.5	0.2	0.2
Productivity	-0.3	-0.3	-0.4	-1.2	-1.3
<b>Average annual increase in revenue</b>	<b>7.2</b>	<b>5.7</b>	<b>3.7</b>	<b>4.2</b>	<b>2.5</b>

Note:

SR2004 and CSR2007 activity growth numbers exclude purchases of healthcare from non NHS bodies, whereas they are included in the SR10 figures.

- 3.11 There are £2.5bn of increased revenue resources available in 2014/15 for the NHS to meet in-year pressures. This is lower than the previous three spending review periods, lower than the first two years of this spending review and lower than the planned disposition of resources for 2013/14.
- 3.12 The difficulty of allocating resources is therefore more acute than it has been in the previous 10 years. Of the £2.5bn available, demand pressures consume £1.8bn, even after an assumption that demand growth will be lower than in recent years due to the transformational activities being undertaken as part of the NHS Quality, Innovation, Productivity and Prevention Challenge (QIPP). The remaining £0.7bn is assumed to be available for pay, with other cost pressures being absorbed by improved productivity (more than four times the rate of the previous two Spending Reviews).
- 3.13 A £0.7bn pay pressure is equivalent to an increase in pay costs of 1.5 per cent.
- 3.14 Any increases in pay costs above this level would therefore have to be afforded by further increases in productivity and fewer staff employed. It is unclear how much further the NHS can go in reducing the number of non-clinical staff given the large reductions over the past three years and there is a real risk that underlying pay pressures in the system, even before any pay rise will have an adverse impact on the affordable clinical workforce.

## Productivity

- 3.15 Improvements in workforce productivity are essential to helping deliver the efficiency savings in this, and the next, spending review period. So far workforce productivity gains have contributed 12 per cent of the total savings made in 2011/12 and 2012/13, compared to 23 per cent which has come from pay restraint. The workforce productivity share of total savings is expected to grow to 26 per cent in 2013/14 and 2014/15.
- 3.16 Despite improved productivity performance in the last two years, there still exists wide labour productivity variation at Trust level.<sup>18</sup> Levelling up performance as well as shifting the average Trust performance upwards will help achieve the workforce productivity gains that are required. The level of resource assumed available for pay is predicated on this increased level of productivity in 2014/15.

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<sup>18</sup> <http://www.nuffieldtrust.org.uk/publications/anatomy-health-spending-201112-review-nhs-expenditure-and-labour-productivity>

## Conclusion

- 3.17 The NHS has received a better Spending Review settlement than almost all other parts of the public sector, including a commitment to real terms increases in health spending in 2014-15 and 2015-16. However, although generous compared to other departments, this represents the biggest financial challenge in the history of the NHS.
- 3.18 The NHS is delivering on this challenge and has so far met its savings targets in 2011/12 and 2012/13. There is still work to do in shifting the focus from centrally driven savings to transformational changes which will reduce the long term cost pressures on NHS services.
- 3.19 Pay competes for fewer available resources. To restrict pay cost growth to 1.5 per cent in 2014/15, workforce productivity must increase faster than at any time over the last three Spending Review periods. Alongside this, reductions in the growth rate of demand are required to retain financial balance. Any increase in pay costs above 1.5 per cent risks significant reductions in clinical staff to balance the financial position, which in turn may harm the ability to maintain access to and quality of NHS services to the public.

# Chapter 4: Non-Medical Workforce Planning and Delivery, including Education and Training Strategy – Policy Context

## High Level Strategy and policy context for workforce planning

- 4.1 *Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery*<sup>19</sup>, published in January 2012, set out the Government’s vision for the new education and training system.
- 4.2 Health Education England (HEE) is the new national body that has taken on responsibility for education, training and development across the NHS and public health system. Its role is to provide national leadership for education and training. It is accountable for the investment of education and training resources, which in 2013/14 total around £4.9 billion. HEE’s primary focus is on professionally qualified healthcare and public health staff whose education and training is funded through the multi-professional education and training budget which HEE is responsible for.
- 4.3 HEE took on its full range of functions and responsibilities on 1 April 2013, including the responsibility for delivery of the Secretary of State’s duty to ensure an effective system is in place for education and training, as set out in the Health and Social Care Act 2012.
- 4.4 On 1 April 2013, 13 local education and training boards (LETBs) were also established by HEE across England. Each LETB has taken on responsibility for managing workforce planning, education commissioning and provision on behalf of healthcare providers in their geographical area. The LETBs include senior provider leadership and reflect the important partnerships needed on education and training, with representation from the education, research and innovation sectors, commissioning organisations and local government. HEE is managing its relationship with each LETB through an annual accountability agreement. These set out the agreed priorities and deliverables for each LETB, and reflect any areas for development against the LETB authorisation framework.

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<sup>19</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/216421/dh\\_132087.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216421/dh_132087.pdf)

## HEE mandate

4.5 HEE was issued with a mandate by the Secretary of State for Health on 28 May 2013. *Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values: a mandate from the Government to HEE*<sup>20</sup> sets out the key priorities for HEE from April 2013 to March 2015. It is centred around the five domains of the education outcomes framework:

- excellent education
- competent and capable staff
- flexible workforce, receptive to research and information
- NHS values and behaviours
- widening participation

4.6 The mandate provides details of the strategic objectives of the Government in the areas of workforce planning, health education, training and development for which HEE and the LETBs have responsibility. It aligns with the mandate for NHS England and the Francis report, as well as the requirements of the NHS, Public Health and Social Care Outcomes Frameworks<sup>21&22</sup>. It also reflects the increasing importance of public health and requires HEE to take into account the development of Public Health England's (PHE) strategy and the Secretary of State's four priorities:

- preventable mortality
- long-term conditions
- 'being caring'
- dementia

4.7 HEE will provide its own evidence and in doing so will address the priorities set out in the mandate.

## Education Outcomes Framework

4.8 The Education Outcomes Framework (EOF)<sup>23</sup> sets the outcomes that the Secretary of State expects to be achieved from the reformed education and training system. The outcomes are set in terms of the impact for patients, users of services and carers.

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[https://www.gov.uk/government/uploads/systems/uploads/attachments/data/file/203332/29257\\_2900971\\_Delivering\\_Accessible.pdf](https://www.gov.uk/government/uploads/systems/uploads/attachments/data/file/203332/29257_2900971_Delivering_Accessible.pdf)

<sup>21</sup> <https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency>

<sup>22</sup> <https://www.gov.uk/government/publications/the-adult-social-care-outcomes-framework-2013-to-2014>

<sup>23</sup> <https://www.gov.uk/government/publications/education-outcomes-framework-for-healthcare-workforce>

- 4.9 The framework was published on 28 March 2013 and will be used to measure improvements in education, training and workforce development and the impact on the quality and safety of services for patients. The EOF is a 'living document' which will evolve during the life of the HEE mandate. While HEE is responsible for a number of areas within the EOF, in other areas progress is dependent on the entire health and care system working effectively.

### The Centre for Workforce Intelligence

- 4.10 The Centre for Workforce Intelligence (CfWI) is an independent body providing advice, information and tools to support workforce planning and development to the health and care system. CfWI will provide national and strategic intelligence and consider international implications.
- 4.11 CfWI aims to provide an accessible route to NHS and social care planners, clinicians and commissioners seeking workforce planning and development expertise to improve NHS and social care services. It supports long-term and strategic scenario planning for the whole health and social care workforce, based on research, evidence and analysis.
- 4.12 CfWI focuses on three key, strategic areas, by providing:
- workforce intelligence to the health and care system to enable it to make better decisions. This intelligence spans the "here and now" to horizon scanning
  - supporting HEE in their role as leaders of the workforce planning and education and training system
  - the support, resources and best practice to improve the effectiveness of workforce planning at local, regional and national levels

### Workforce Planning and Education and Training Commissioning

- 4.13 The Health and Social Care Act 2012 placed a duty on all organisations that deliver care funded by the NHS to provide data on their current workforce and to share their anticipated future workforce needs. It does this through the duty placed on:
- the Secretary of State to put in place an effective education and training system
  - providers of NHS-funded care to co-operate within the new education and training system
  - service commissioners, via NHS England and clinical commissioning groups (CCGs), to ensure service providers with whom they contract have regard to education and training when carrying out their functions

- 4.14 The majority of the workforce is employed in delivering commissioned healthcare services. The responsibility for planning the future workforce extends to service commissioners, who need to be able to articulate their strategic intentions clearly, so that providers can translate these into service delivery proposals. Furthermore, service commissioners need to have regard for the workforce implications of their commissioning intentions and consider the viability and achievability of their commissioning plans.
- 4.15 Fundamental to the operation of the reformed system for the planning, commissioning and delivery of education and training will be the process of securing, analysing and managing information, both about the current workforce and about future workforce needs. Workforce planning in this more diverse NHS requires continued access to high quality, comprehensive and complete workforce information to enable HEE, LETBs and CfWI to fulfil their roles. The Workforce Information Architecture work stream (WIA) was established to review, improve and test the arrangements for handling the data and intelligence that will be necessary for the reformed system to operate effectively. This includes a requirement for all providers of NHS-funded care to participate in the new education and training system and provide information on their current workforce and future workforce requirements.

## Information Sources

### NHS Electronic Staff Record (ESR)

- 4.16 ESR is the integrated human resource, payroll and learning management system for all hospitals in England and Wales (apart from two), and for those social enterprises which use it as their HR and Payroll system. It enables the capture of up to date workforce information, securely and confidentially, in a timely and consistent format.
- 4.17 The Department of Health, HEE, LETBs, the Health and Social Care Information Centre (HSCIC) and a limited number of other bodies, including NHS Employers, access summary data from its warehouse for a range of purposes, such as understanding the size and shape of the current workforce, planning the future workforce, pay bill modelling, sickness absence. This model of centrally sourced workforce information significantly reduces the submission burden on local NHS service providers in relation to the annual workforce census and monthly workforce publication, and supports the drive to improve back office efficiency.

- 4.18 The contract for the provision of ESR will be re-procured to ensure continuity of service and by engaging users in developing future requirements we anticipate its continued widespread use. It is currently available for all NHS employers including successor bodies providing NHS-funded services, such as social enterprises. It is not used by general practitioners and other primary care providers.

## Fundamental Data Review

- 4.19 The Government made a commitment in the White Paper *Equity and Excellence: Liberating the NHS*<sup>24</sup> to

*“...initiate a fundamental review of data returns, with the aim of culling returns of limited value, to ensure that the NHS information revolution is fuelled by data that are meaningful to patients and clinicians when making decisions about care, rather than by what has been collected historically”.*

- 4.20 The Fundamental Review covered all national data returns requested by the Department of Health and its Arm’s Length Bodies (ALBs) from NHS organisations and recommended that 76 (25 per cent) of the returns be discontinued and estimated that this would reduce the burden on the NHS by approximately £10m per annum. Following consultation, a number of central returns were discontinued, including the Annual NHS Vacancy Collection and the General Practitioners Practice Vacancy Survey.
- 4.21 The Department of Health is working with NHS England, HEE and the HSCIC on the design of the WIA for the new education and training system, which includes some vacancy data as part of the workforce Minimum Data Set.
- 4.22 NHS Jobs, an electronic jobs board for the NHS, may provide some useful data in the form of adverts opened and closed to be used as a proxy for data on vacancies<sup>25</sup>. The system holds data on (the number of) advertisements. However, the data available from NHS Jobs will not be able to identify when posts are filled or where posts have been vacant for three months directly, but the dates associated with the adverts should provide a useful proxy measure.

## Published Workforce Statistics

### Annual Workforce Statistics

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<sup>24</sup> <https://www.gov.uk/government/publications/liberating-the-nhs-white-paper>

<sup>25</sup> There are a number of factors that should be taken into account: not all adverts are vacancies (as some trusts recruit into pools so that they may appoint immediately as a post becomes available); some adverts are standing adverts and are not linked to a specific vacancy; jobs may be re-advertised as new vacancies; and some adverts are for multiple posts. Furthermore, if an advert did directly correlate to one post, there is no guarantee that the appointment will be recorded on NHS Jobs.



- 4.23 The HSCIC publishes annually the NHS Workforce Census. The Census covers HCHS and primary care staff, and records the numbers of NHS staff employed in England within the main occupational groups on 30 September each year.
- 4.24 The annual Census provides the best means of viewing medium and long-term trends in workforce numbers. Full Time Equivalent (FTE) figures are the best measure of real changes in the NHS as they reflect service capacity rather than the number of people.
- 4.25 A summary of the data on the non-medical workforce from the latest annual workforce census published in March 2013 is shown at Table 4.1 below.

**Table 4.1 - NHS HCHS and General Practice Workforce as at 30 September each specified year**

England	full time equivalent & percentages			
	2011	2012	Change 2011-2012	% change 2011- 2012
<b>Total HCHS non-medical staff</b>	<b>936,563</b>	<b>931,263</b>	<b>-5,301</b>	<b>-0.6%</b>
<b>Total qualified nursing staff</b>	<b>321,143</b>	<b>319,755</b>	<b>-1,388</b>	<b>-0.4%</b>
Qualified nursing, midwifery & health visiting staff	306,346	305,060	-1,286	-0.4%
GP practice nurses <sup>6</sup>	14,797	14,695	-102	-0.7%
<b>Total qualified scientific, therapeutic &amp; technical staff<sup>4</sup></b>	<b>131,742</b>	<b>132,869</b>	<b>1,127</b>	<b>0.9%</b>
Qualified Allied Health Professions	62,937	63,198	261	0.4%
Qualified Healthcare Scientists	29,061	28,760	-301	-1.0%
Other qualified scientific, therapeutic & technical staff	39,743	40,911	1,167	2.9%
<b>Qualified ambulance staff<sup>4</sup></b>	<b>17,855</b>	<b>17,755</b>	<b>-100</b>	<b>-0.6%</b>
<b>Support to clinical staff</b>	<b>290,590</b>	<b>289,165</b>	<b>-1,425</b>	<b>-0.5%</b>
Support to doctors & nursing staff	225,858	225,585	-273	-0.1%
Support to scientific, therapeutic & technical staff	51,763	51,299	-464	-0.9%
Support to ambulance staff	12,970	12,282	-687	-5.3%
<b>NHS infrastructure support</b>	<b>189,800</b>	<b>186,208</b>	<b>-3,591</b>	<b>-1.9%</b>
Central functions	96,842	95,017	-1,825	-1.9%
Hotel, property & estates	56,344	55,541	-803	-1.4%
Manager & senior manager	36,613	35,650	-963	-2.6%
<b>Other non-medical staff or those with unknown classification</b>	<b>231</b>	<b>205</b>	<b>-25</b>	<b>-11.0%</b>
<b>Other GP practice staff<sup>6</sup></b>	<b>69,812</b>	<b>70,851</b>	<b>1,039</b>	<b>1.5%</b>

Notes:

4 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.

6 Practice staff counts for 2010 & 2011 have been revised to provide a 100% census, with estimated numbers for those practices with null returns. Further details can be found in the data quality statement/methodology.

Note, this will affect any related totals and comparisons with years prior to 2010

Source: 2013 Health and Social Care Information Centre.

## Monthly Workforce Statistics

- 4.26 The HSCIC also continues to publish monthly workforce data. This covers HCHS staff working in NHS organisations and staff in social enterprises in England who use ESR. Data is taken from the annual census for the two FTs who do not use ESR and included in the data published monthly. The data includes some staff, for example, those working as locums, who do not appear on the Census.

## NHS Reforms

- 4.27 The structural changes in the NHS from April 2013 are impacting on how the HSCIC report the data. The HSCIC are consulting stakeholders on which new bodies should be included in the annual workforce Census publication. Some Non Departmental Public Bodies, for example Monitor and the Care Quality Commission (CQC) have always been and will continue to be excluded from NHS workforce publications.

## Staff Groups

### Midwives

- 4.28 The number of FTE qualified midwives in the NHS has increased by 415 from 20,519 to 20,935 between September 2011 and September 2012.
- 4.29 From April 2013, responsibility for workforce planning has been mandated to HEE. The mandate includes a commitment to maintaining midwifery training numbers to ensure patient needs are met. Early indications suggest that LETBs are planning to maintain the current level of midwifery training commissions at around 2,500.
- 4.30 The Department of Health will continue to work with the Royal College of Midwives and other organisations to make sure we have an appropriately resourced and skilled maternity workforce based on the most up to date evidence.

### Health visitors

- 4.31 As part of the Coalition Agreement, the Government committed to increase the number of health visitors by 4,200 by April 2015 against a May 2010 baseline of 8,092, and to transform services for families. This is a high visibility, high interest area in cross-Government priorities to support families.

- 4.32 The increase will be the biggest percentage workforce growth we have delivered in recent years and is a challenging commitment – especially as health visitors have first to be trained as nurses or midwives.
- 4.33 The *Health Visitor Implementation Plan 2011-2015 – ‘A Call to Action’*<sup>26</sup> (Feb 2011), set out a four year transformational programme of recruitment and retention, professional development and improved commissioning.
- 4.34 From 1 April 2013, NHS England took on responsibility for health visiting workforce growth and service transformation as part of its Mandate objective to *improve the standards of care and experience for women and families during pregnancy and the early years of their children’s life*. At the same time HEE, as part of its Mandate with the Department, took on responsibility for delivering sufficient training places to support delivery of the additional 4,200 health visitors.
- 4.35 The *National Health Visitor Plan: progress to date and implementation 2013 onwards*<sup>27</sup> published in June 2013 set out how partner organisations will work with the profession, families and communities in the new health landscape, to achieve the Government’s health visiting commitment.
- 4.36 The 4,200 FTE growth requires around 6,000 additional nurses and midwives to train as health visitors during the three years 2011 - 2014 (compared to the pre-2010 training rate of around 500 a year). Full time health visitor training courses take a year to complete.
- 4.37 Good progress is being made. The annual census shows there was an increase of 445 between September 2011 and 2012 and the latest monthly figures, May 2013, show the number of FTE health visitors has increased by 1,056 (13.1 per cent) over the May 2010 baseline to a total of 9,149.
- 4.38 It will be Autumn of this year before we see the next significant increase in the total workforce, as the 2,526 students who began their health visiting training in 2012/13 graduate and take up posts. For 2013/14, 2,690 training places have been commissioned to provide a further boost to health visitor numbers in 2014/15.

## Reform of Pharmacy Education

- 4.39 Currently, pharmacists are required to complete a four-year masters level degree, followed by a one-year pre-registration training programme and successfully pass a national registration exam. Recognising the bigger

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<sup>26</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213759/dh\\_124208.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213759/dh_124208.pdf)

<sup>27</sup> <https://www.gov.uk/government/publications/health-visitor-vision>

contribution that we want pharmacists to make towards delivery of safe and effective use of medicines and the public health strategy we have been working towards developing the current scientific focus of the degree programmes to include additional clinical education and training for pharmacists. The integration of the two phases of pharmacy pre-registration education and training would result in a 5-year masters level degree that includes work based assessments, with graduating pharmacists eligible for full registration with the General Pharmaceutical Council (GPhC).

- 4.40 We expect that if the reforms are implemented the HEE Local Education and Training Boards planning processes will inform student numbers for pharmacy in the same way as they do for medical and dental trainees. The Department of Health is working with HEE, the Higher Education Funding Council for England (HEFCE) and the Department of Business, Innovation and Science on the affordability of implementing the reform proposals. We anticipate publishing a full impact assessment towards the end of the year and a final technical consultation on the preferred funding options in the new year.

### Pharmacy Student numbers

- 4.41 There has been considerable growth in pharmacy student numbers over the last decade or so; first year entrants to pharmacy degree courses in England have increased from 1,439 in 1998 to 3,238 in 2011. To date the provision of pre-registration training posts in hospitals and community pharmacies has kept pace with graduate numbers. All graduates who want to register with the GPhC have been able to complete their training and sit the GPhC registration exam. However, we are aware that this is unlikely to continue. We expect the excess supply of pharmacy students who have graduated but who are not able to register to begin to manifest itself over the next 2-3 years, although we do not expect significant excess this year. Department of Health analysts predict this over-supply could rise to 300-400 per year by 2016. The Minister for Universities and Science has asked HEFCE to work with HEE to consider how they could best address the misalignment, including considering options for the implementation of student intake controls and they have recently begun a consultation<sup>28</sup> on possible options.

### Apprenticeships

- 4.42 The Department of Health is committed to supporting NHS Apprenticeships. HEE's objective is to support flexible methods for entering training and employment, such as the development of healthcare apprenticeships, in conjunction with LETBs and other relevant parties.

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<sup>28</sup> <http://www.hefce.ac.uk/news/newsarchive/2013/name,83024,en.html>

## Non-medical and undergraduate medical tariffs in secondary care

- 4.43 The Department has confirmed that funding for clinical education and training will move to a tariff based payment system. The aim of the tariffs is to provide a more transparent, fair and consistent basis for the funding of clinical placements. The tariffs will be applicable at a national level and based on activity rather than local funding agreements.
- 4.44 Tariffs for non-medical and undergraduate medical placements in secondary care were introduced from April 2013. Prior to the introduction of the tariff for non-medical clinical placements there was no specific funding and it was for Strategic Health Authorities (SHAs) to decide whether to fund any support for the placements. Funding varied across SHAs and was estimated at approximately £22m nationally.
- 4.45 The tariff payment mechanism will ensure that all non-medical clinical placements are funded, with estimates suggesting an increased funding envelope of approximately £120m. The additional funding will be generated from savings realised from the introduction of a tariff for undergraduate medical placements.
- 4.46 Other additional benefits of the tariff mechanism include:
- greater freedom for students and universities in choosing clinical placements
  - increased focus on quality, rather than the costs of the placement
  - certainty for Trusts around the funding of clinical placements and the income this will generate
- 4.47 To reduce the financial instability due to the introduction of a tariff, there will be a phased movement to operating under full tariff. The tariff for 2013-14, and a number of subsequent years, will therefore be transitional and calculated to 'cushion' the losers towards the tariff prices and correspondingly to limit gainers to what can be afforded during the transition period.

## International Dimension

### Reducing the reliance on international migration of skilled occupations in shortage

- 4.48 In the past, the NHS has relied on immigration to bolster domestic workforce supply. The UK has been moving towards self-sufficiency for a number of years and there has been significant investment in training to increase the UK supply of health professionals.

- 4.49 Following a consultation in 2012 the Migration Advisory Committee recommended an overall reduction of six non-medical health roles listed on the National Shortage Occupation List (NSOL) in Table 4.2.

**Table 4.2 NSOL**

NSOL from 14 Nov 2011 (non-medical posts)	NSOL from 06 Apr 2013 (non-medical posts)
13 posts	7 posts
specialist nurse working in operating theatres operating department practitioner specialist nurse working in neonatal intensive care units HPC-registered diagnostic radiographer HPC-registered therapeutic radiographer sonographer nuclear medicine technologist radiotherapy technologist cardiac physiologist clinical neurophysiologist clinical vascular scientist respiratory physiologist sleep physiologist	specialist nurse working in neonatal intensive care units HPC registered diagnostic radiographer HPC registered therapeutic radiographer sonographer nuclear medicine technologist radiotherapy technologist clinical neurophysiologist

- 4.50 This recommendation suggests that the increased investment and focus by the Department of Health over recent times has gone some way to remedying the structural skill shortages that exist within the sector.
- 4.51 The Department of Health will continue to monitor the position of these shortage staff groups as part of its responsibility to ensure strategic supply for the NHS in England. Additionally, HEE has been specifically tasked to reduce the number of health roles on the shortage occupation list by March 2015.

## Recent Reviews

### Compassion in Practice

- 4.52 The nursing, midwifery and care staff vision and strategy for England<sup>29</sup>, *Compassion in Practice*, was launched in December 2012 by the Chief Nursing Officer for England and the Department of Health. It recommends a range of actions to help the local NHS determine the appropriate staffing levels for a particular health and social care setting. This includes using evidence based tools to determine staffing levels and publishing them every six months; staffing levels discussed by Trust Boards in public twice a year; and discussing any proposed changes to nursing and midwifery skill mix at Board level.

<sup>29</sup> <http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf>

- 4.53 Staffing is not just about numbers. It is also about how staff work and ensuring the right staff are in place to meet the needs of their patients. Local healthcare providers are best at deciding how to organise the skill mix of their workforce to achieve better outcomes in both patient care and value for money, including using evidence based guidance and tools to inform appropriate staffing levels and ensure productivity improvements. Local providers will be responsible for assuring the safety and quality of changes in the size and shape of the workforce.
- 4.54 The number of staff on wards will vary according to skill mix, clinical practice and local factors and it is right that nurse leaders have the freedom to agree their own staff profiles. This gives flexibility to respond dynamically to changes in patient demand and workforce supply.

### Francis Inquiry

- 4.55 Robert Francis QC published his report into the care provided by Mid Staffordshire NHS Foundation Trust in February 2013. The Francis Inquiry examined the commissioning, supervisory and regulatory organisations in relation to their monitoring role at Mid Staffordshire and considered why the serious problems at the Trust were not identified and acted on sooner.
- 4.56 The Inquiry report discussed the issue of staffing levels and recommended the use of tools to ensure safe staffing rather than mandating either at system or specific level. Recommendations included evidence-based benchmarks and guidance and input from clinicians, professional bodies and patient and public representatives. The Department of Health agrees with Robert Francis that there is a need for evidence-based guidance and tools to inform appropriate staffing levels.
- 4.57 The Government published its initial response to the Francis Inquiry on 26 March 2013. In *Putting Patients First*<sup>30</sup>, the Secretary of State pledged that
- “every patient will be treated in a hospital judged on the quality of its care and the experience of its patients. They will be cared for in a place with a culture of zero harm by highly trained staff with the right values and skills”.*
- 4.58 *Putting Patients First* includes plans to:
- put in place a culture of zero harm and compassionate care
  - detect problems quickly
  - hold health and social care professionals to account

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<sup>30</sup> <https://www.gov.uk/government/news/putting-patients-first-government-publishing-response-to-francis-report>

- improve the leadership and motivation of NHS and social care staff

4.59 The Department will be publishing a further report in response to the Francis Inquiry in the Autumn. That response will include, for example, commitments to address Francis recommendations 193 – 195 about improving standards for appraisal and support for nurses and nurse leadership, such as:

- the introduction by the Nursing and Midwifery Council of improved standards of appraisal and support for nurses to complement local appraisal processes which, in due course, will be further enhanced by an effective and proportionate revalidation process
- the linking of pay progression to quality of care provided helping embed the NHS Staff Council's agreement that automatic pay progression would come to an end
- ensuring Directors of Nursing have access to sufficient nurses trained with the capacity to deliver safe, patient focused care, as is already required by CQC, with nurse leaders eg Ward Managers overseeing all aspects of care from cleanliness to allocation of staff

### Camilla Cavendish Review

4.60 Following publication of the Francis report, the Secretary of State asked Camilla Cavendish to lead an independent review<sup>31</sup> into valuing and supporting healthcare assistants and support workers in the NHS and social care settings. Camilla was asked to:

- consider what can be done to ensure that all people using services are treated with care and compassion by healthcare and care assistants
- make recommendations about the recruitment, training and development, management and support of those staff, who do a challenging and vital job

4.61 The independent review ran for fourteen weeks and the report was published on 10 July 2013. The review makes a number of recommendations on how the training and support of both healthcare assistants who work in hospitals, and social care support workers who are employed in care homes and people's own homes, can be improved to ensure they provide care to the highest standard. It proposes that all healthcare assistants and social care support workers should undergo the same basic training, based on the best practice that already exists in the system, and must achieve a standard 'certificate of fundamental care' before they can care for people unsupervised.

<sup>31</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/212732/Cavendish\\_Review\\_ACCESSIBLE\\_-\\_FINAL\\_VERSION\\_16-7-13.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212732/Cavendish_Review_ACCESSIBLE_-_FINAL_VERSION_16-7-13.pdf)



- 4.62 The Department of Health is determined to ensure that compassionate care is at the heart of a modern NHS and social care system and so will consider the recommendations very carefully and provide a formal response to the Review, along with the response to the Francis report, in the Autumn.

### Keogh Mortality Review

- 4.63 Sir Bruce Keogh (NHS Medical Director) conducted a review into the quality of care and treatment provided by 14 hospital Trusts, and a report was published on 16 July 2013<sup>32</sup>.
- 4.64 The review set out to identify any sustained failings in the quality of care and treatment being provided to patients at these Trusts. From the review Sir Bruce has identified eight national ambitions for improvements aimed to tackle underlying causes of poor care as well as individual recommendations for each of the 14 Trusts. All will be inspected again within the next 12 months by the new Chief Inspector of Hospitals, Professor Sir Mike Richards.
- 4.65 Sir Mike will have a clear remit to inspect staffing levels and report if they are appropriate and the Department of Health will work with NICE, CQC and NHS England to review the use of evidence-based guidance and tools to inform staffing decisions locally.

### Professor Don Berwick Review

- 4.66 Professor Don Berwick, a renowned international expert in patient safety, was asked by the Prime Minister to carry out a review of patient safety following publication of the Francis report. Professor Berwick's report<sup>33</sup> follows five months of intensive work to examine the lessons for NHS patient safety from healthcare and other industrial systems throughout the world. The report echoes the Keogh Mortality Review in saying that staffing levels cannot be dictated from the centre, but that boards and local leaders should take responsibility for ensuring that clinical areas are adequately staffed.

## Administrative Staff

### Reduction in administrative staff is adversely impacting frontline jobs

- 4.67 The statistics do not support this claim – the attached graph at Table 4.3 shows the FTE counts of two 'support' staff groups:

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<sup>32</sup> <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>

<sup>33</sup> <https://www.gov.uk/government/publications/berwick-review-into-patient-safety>

- Central Functions (the 'admin and clerical' grouping within the Infrastructure Support group)
- Support to doctors and nurses (a sub-group within the 'Clinical Support' staff group)

4.68 The graph shows the decrease in the FTE of these two staff groups over the past three years, since April 2010, as a percentage of the levels as at April 2010, the key points being that:

- the size of the Support to Doctors and Nurses group has been fairly steady over the past two years at around 2 per cent less than April 2010
- the size of the Central Functions group has seen a steady reduction, the last year being around 8 per cent to 10 per cent less than April 2010

4.69 Patient care in the 21<sup>st</sup> Century is very different to what it used to be. There are now more clinical staff working in the NHS than there were in May 2010, including:

- over 4,300 more doctors
- over 1,000 more health visitors
- over 1,300 more midwives

4.70 In contrast, the number of administrative staff has fallen by over 23,400. This is creating savings that will help protect frontline NHS services for future generations.

4.71 Ultimately, however, it is for providers to determine locally how many staff they need to deliver safe, effective and compassionate care. The Government and other national organisations recognise the importance of safe staffing in the provision of safe, high quality care and we are working to support the development of evidence-based tools to ensure safe staffing.

4.72 We are also making sure that nurses' time is freed up from bureaucratic burdens so that they are able to spend more time providing patients with safe, effective and compassionate care. That is why the NHS Confederation is undertaking a review of burdens across NHS providers with the aim of reducing the burden by a third. We will also implement the recommendations of the Fundamental Review of Data Returns<sup>34</sup>, published in March 2013, to reduce the amount of data compiled by frontline staff so that they can concentrate on what really matters.

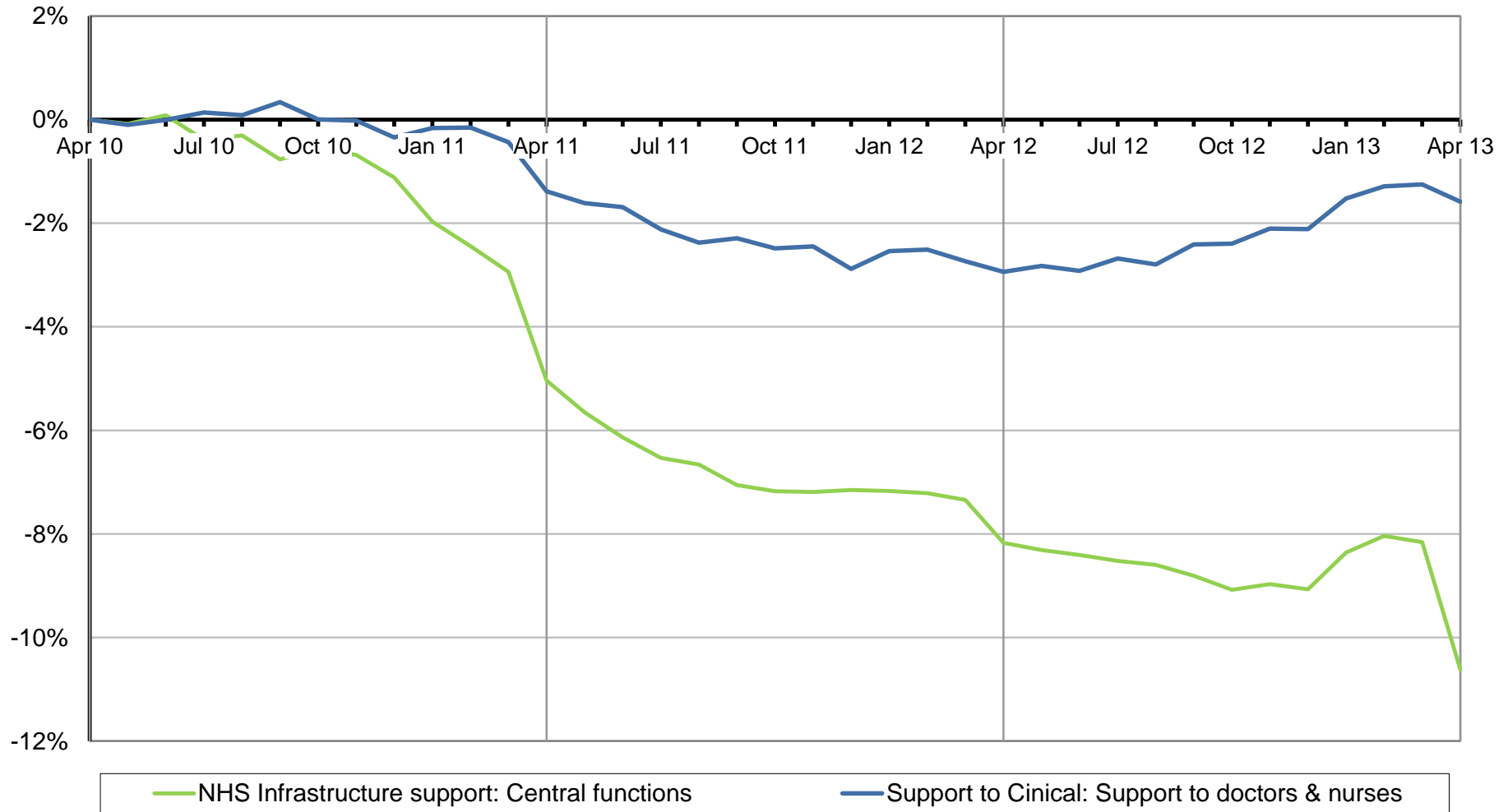
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[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/170873/FDR\\_cons\\_response\\_v0\\_23\\_clean.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170873/FDR_cons_response_v0_23_clean.pdf)

Table 4.3

Proportional change in full time equivalent staff: baseline April 2010



# Chapter 5: Agenda for Change

- 5.1 Agenda for Change (AfC), introduced under the last Administration in 2004, is the current UK wide national grading and pay system for most employed NHS staff with the exception of doctors, dentists and very senior managers. AfC is a national collective agreement. Changes agreed by the NHS Staff Council (a partnership of NHS Employers and NHS trade unions) and endorsed by UK Health Ministers, are incorporated into the national employment contracts of AfC staff. Under AfC, all staff (1.1m headcount) have annual development reviews against various knowledge and skills frameworks. The Job Evaluation Scheme (JES) determines the correct pay band for each post<sup>35</sup>.

## Evolution of Agenda for Change

- 5.2 NHS Trusts' powers and duties derive from statute. It was therefore necessary to give them expressly the power to set terms and conditions for their staff in the NHS and Community Care Act 1990 (paragraph 16 of Schedule 2). A NHS Trust was therefore given the power to do anything which appeared to it to be necessary or expedient for the purpose of or in connection with the discharge of its functions, and in particular, to employ staff on such terms as it thought fit. NHS Trusts are then able, subject to contract and employment law, to set terms and conditions in the same way as other employers, albeit deriving from statute rather than the common law.
- 5.3 The legislation which provided for the establishment of FTs was the Health and Social Care (Community Health and Standards) Act 2003, with the equivalent power for FTs to employ staff is set out in section 18 of the Act.
- 5.4 All Trusts have the freedom to determine the terms and conditions of the staff they employ, including pay. NHS Trusts, but not FTs, can be subject to Directions or Regulations of the Secretary of State for Health. However, successive Governments have chosen not to make any Directions or Regulations relating to terms and conditions or pay.

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<sup>35</sup> <http://library.nhsggc.org.uk/mediaAssets/Staff/JE%20Handbook.pdf>

5.5 FTs have additional flexibilities under Annex K of the NHS terms and conditions of service handbook. Annex K was introduced at the same time as AfC in 2004, and sets out that employers have:

*“(i) the ability to offer alternative packages of benefits of equivalent value to the standard benefits set out in this agreement, among which the employee can make a personal choice (e.g. greater leave entitlements but longer hours).”*

5.6 This agreement means that FTs cannot provide alternative benefits which are less than the standard benefits set out in the Handbook. We understand that employers across the NHS want the flexibility to pay less than the standard benefits set out in the NHS handbook.

5.7 Employers need to make better use of their pay bill, which can be about two thirds of all local employer expenditure.

5.8 All NHS employers can move away from national pay frameworks, if they believe that is the right decision for their staff, patients and delivery of quality health care services. However, employers cannot do so unilaterally, they must consult staff and/or staff representatives and seek agreement.

### Local employment contracts

5.9 If employers want to introduce local contracts for existing staff, the same principles apply; employers must consult staff and/or staff representatives and seek agreement.

5.10 Where NHS employers decide to rely on national pay frameworks, or to negotiate locally to change national contracts or decide to introduce new local contracts, they are responsible for carrying out their own risk assessments to ensure they meet their legal obligations under the Equality Act 2010 and employment law.

### Agenda for Change Flexibilities

5.11 Agenda for Change includes High Cost Areas Supplements (HCAS). The supplements are expressed as a proportion of basic pay (including the value of any long-term recruitment and retention premium), but subject to a minimum and maximum level of extra pay. HCAS apply in Inner London, Outer London and the fringe zones. Following the NHSPRB’s report: *Market-Facing Pay - How Agenda for Change pay*

can be made more appropriate to local labour markets<sup>36</sup> the Government decided not to introduce any new centrally determined local pay rates or zones, but that there should be greater use of existing flexibilities.

## HCAS Review

- 5.12 The NHSPRB made a range of recommendations in its “*Market Facing Pay...*” report (Annex C) including:

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

- 5.13 The Department has asked NHS Employers, on behalf of the NHS Staff Council, to commission researchers to undertake this review. NHS Employers have prepared the specification to underpin a joint commission. The tender seeks to secure a better understanding of the current system of HCAS, the rationale and whether its purpose is, for example, to adjust for market forces or the cost of living. The study is necessarily complex and wide ranging. We are working with the NHS Staff Council to finalise the specification. Following agreement, NHS Employers will put the specification out to tender. We would hope to report good progress soon and will submit the findings as soon as they are available.

## Recruitment and Retention Premia

- 5.14 NHS employers are free to make additional payments of up to 30 per cent on top of basic pay. Employers locally must satisfy themselves that the payment of Recruitment and Retention Premia (RRP) is appropriate, is evidenced and meets their obligations under Equal Pay legislation. The NHS Staff Council developed a short guide, ‘*Local recruitment and retention premia: top ten tips for NHS organisations*,<sup>37</sup> which explains the role of RRP in responding to local labour market pressures.

- 5.15 Other flexibilities include:

- overtime payments

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<sup>36</sup> <http://www.official-documents.gov.uk/document/cm85/8501/8501.pdf>

<sup>37</sup> [https://www.nhsemployers.org/SiteCollectionDocuments/Local%20RRP%20Guidance\\_AP131109v2.pdf](https://www.nhsemployers.org/SiteCollectionDocuments/Local%20RRP%20Guidance_AP131109v2.pdf)

- unsocial hours payments

### Keeping AfC under review

- 5.16 Another recommendation from NHSPRB's *Market-Facing Pay...* report is about ensuring AfC is kept under review:

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

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

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

- 5.17 The NHS terms and conditions of service handbook says that:

*“Nationally, employer and trades union representatives have agreed to work in partnership to maintain an NHS pay system which supports NHS service modernisation and meets the reasonable aspirations of staff”.*

- 5.18 We understand that NHS Employers and NHS trades unions want to work together for the benefit of patients and staff. However, each party may have different aspirations from pay reform, which means that the parties may not be able to respond quickly to requests for change. In the current economic climate, reaching consensus on change can be difficult to achieve. Therefore, PRB observations on those AfC provisions which the partners should usefully address with pace and purpose, would be helpful. . It would also be helpful if the NHSPRB would make recommendations on how any pay award might be made dependent on the partners reaching agreement on AfC pay reform.

- 5.19 The Department is also working hard to deliver more savings from non-pay areas and service transformation and will be setting out ambitious expectations on savings from procurement and outsourcing back office functions. However, we believe there is a need to look carefully at

whether the current national pay framework, introduced in 2004, is able to keep pace with changes in the healthcare system. AfC was designed to meet the requirements of the NHS at a time when most health care was provided by NHS organisations. Health care services are increasingly provided by independent organisations (see section on Any Qualified Providers at paragraphs 5.25 to 5.27) which means that Trusts will be operating in a wider health care market and having to compete with independent organisations that may have greater flexibility in the terms, conditions, pay and pensions they provide for their staff.

- 5.20 Currently, the market rate in NHS pay is set by the national pay award. The NHS has received relatively generous funding over the past decade, and has been protected and will receive real terms growth in 2015, as it has done in the current spending review. There has not been a strong incentive to move away from national pay agreements. Where employers attempt to exercise their employment freedoms to negotiate locally on changes to AfC, they have been met with very strong opposition from NHS trades unions. Many employers prefer to use national pay frameworks but are frustrated that change at national level can often fail to deliver the change employers are looking for.
- 5.21 A stronger presence of independent providers may, over time, challenge national pay systems. The extent to which the impact of competition will be felt by NHS providers is not yet clear, but we expect that many may find themselves in full or partial competition over the next few years.

### Recent developments

- 5.22 In July 2013, NHS FTs stated their intention to Monitor to recruit 10,000 more clinical staff to raise the quality of care. In response, Stephen Hay, Managing Director of Provider Regulation at Monitor, said:

*"In the short term, the sector's balance sheet is in reasonably good shape overall, but we know that the number of FTs in financial distress has increased, as has the number struggling to meet operational demands. However, the outlook on overall funding is uncertain and the spending review has confirmed that financial pressures will increase beyond 2015/16. Our review now suggests the balance of longer term risks has shifted to the downside."*

- 5.23 The intention of FTs is to improve compliance with Accident and Emergency waiting time targets and to maintain staffing levels following



the failures of care highlighted by Sir Bruce Keogh's Mortality Review, his review of urgent and emergency care in England<sup>38</sup> and the Francis Inquiry. Trusts must also continue to deliver on their Cost Improvement Plans which for some is around 4 per cent a year.

### Any Qualified Providers (AQP)<sup>39</sup>

- 5.24 The use of Any Qualified Provider (AQP), or more generally independent providers including Social Enterprise organisations, is part of the wider policy looking to extend the market for delivery of NHS services. This sits with other work, including that by the Cabinet Office Mutuals Team encouraging Social Enterprise organisations. The use of AQP is also within the context of the Fair Playing Field Review conducted by Monitor, which aims to ensure all types of providers of NHS services have equal access to having their services commissioned and that no one type of provider is favoured. Commissioners decide the services based on the best provision for their local population. Providers have to be qualified to make sure they meet standards and must comply with local referral thresholds and pathways. However, one concern has been the difficulty in recruiting staff to deliver services, and the pension access review is important to support providers in recruiting staff.
- 5.25 Choice of AQP is usually where patients are referred by their GP for a particular service and are able to choose from a list of qualified providers who meet NHS service quality requirements, prices and normal contractual obligations. Patient choice of provider is intended to empower patients and carers, improve their outcomes and experience and enable service innovation.
- 5.26 AQP was first introduced for elective services and a patient's right to this choice is included within the NHS Constitution. Following engagement with clinicians, providers, commissioners, patient groups and voluntary organisations, patient choice of provider was extended to a range of community and mental health services in 2012. From April 2013, it has been for CCGs, informed by local needs, to take decisions on where AQP should be extended to further services to benefit their population and patients.

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<sup>38</sup> <http://www.england.nhs.uk/2013/01/18/service-review/>

<sup>39</sup> <http://www.nhs.uk/choiceintheNHS/Yourchoices/any-qualified-provider/Pages/aqp.aspx>

## Pay Reform

- 5.27 We have embarked on an ambitious programme of national pay contract reform right across the non-medical and medical workforce, which includes Heads of Terms for negotiations on changes to the consultant and junior doctor's contracts, including a review of the Clinical Excellence Award Scheme.

## New AfC agreements

- 5.28 The NHS Staff Council reached agreement in February 2013 on changes to how sick pay is calculated for all but the lowest paid staff, linking incremental pay progression more closely to performance and the introduction of new guidance on skills re-profiling.
- 5.29 The new agreement removes the term 'satisfactory' from the NHS terms and conditions of service handbook and gives employers, most for the first time, local control over the performance standards of their staff which they will be responsible for setting. The aim is to align local objectives with those of the organisation and to ensure more emphasis is placed on values, behaviour, so employers are better able to recruit and retain the caring and compassionate staff the NHS needs.
- 5.30 Local performance standards should comply with the principles set out at Annex W of the NHS terms and conditions of service handbook. The agreement says that:

*"Incremental pay progression for all pay points will be conditional upon individuals demonstrating that they have the requisite knowledge and skills/competencies for their role and that they have demonstrated the required level of performance and delivery".*

*"New arrangements for pay progression, linked to employee performance, apply to appraisal objectives from April 2013 for incremental pay progression post April 2014. Employers should ensure that performance appraisal procedures are in line with the new requirements in the new Sections 1(a) England, 6(a) England and Annex W (England)."*

- 5.31 NHS terms and conditions of service Handbook says:<sup>40</sup>

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<sup>40</sup> <http://www.nhsemployers.org/payandcontracts/agendaforchange/agenda-for-change-proposals/Pages/Agenda-for-Change-agreed-amendments-April-2013.aspx>

***‘Criteria for local scheme:*** *Organisations will need to operate an effective process for objective, evidence-based performance appraisal, development and review, recognising team work wherever this is appropriate. Individual performance will need to be monitored throughout the year so that under performance is identified by all concerned and addressed appropriately as soon as possible.’*

- 5.32 Full details about what the AfC agreement includes can be found at Annex D.

### Implementing the agreements on changes to Agenda for Change

- 5.33 The Department has commissioned NHS Employers to work with hospital leaders to develop plans to help the service implement new performance standards. This work includes provision of advice on appraisal which will help our response to the Mid Staffordshire NHS Foundation Trust Public Inquiry (Annex E) which included recommendations about NHS employment contracts (Annex F).

### South West Consortium

- 5.34 Twenty NHS Trusts and FTs joined together to discuss changes to national pay frameworks. This was in parallel with national level talks on reforming AfC. Although the Consortium did not embark on any formal consultations with their staff, national and local NHS trades unions did not engage with the Consortium. Their strong view is and remains that any discussions about changes to national pay frameworks should be led by the relevant national negotiation Councils/Committees.
- 5.35 In August 2012, the Consortium published two discussion documents, *Addressing pay, terms and conditions*<sup>41</sup> and *Economic, financial and service challenge*<sup>41</sup>. The documents are designed to help employers explore, with their staff the financial challenges that face them.
- 5.36 In March 2013, the Consortium published a working document *‘Optimising existing NHS pay, terms and conditions’*<sup>42</sup>. The document is designed to explore existing national terms and conditions and potential changes that might be made without amending or changing any national collective agreements.

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<sup>41</sup> The domain where this information was published is no longer live

<sup>42</sup> The domain where this information was published is no longer live

5.37 The Consortium was supportive of the national agreements reached on changes to AfC and that further discussions about AfC reform should be led at national level by the NHS Staff Council. We understand that the Consortium reserves the right to continue its work if further reform to AfC cannot be achieved at national level.

### Reforming AfC

5.38 The Department is working hard to deliver more savings from non-pay areas and service transformation and will be setting out ambitious expectations on savings from procurement and outsourcing back office functions. However, the proportion of total expenditure on pay and pension is significant and has real impact on the size of the affordable workforce. At the very simple level, employers can either pay fewer staff more or more staff less. Increasing demand means employers need staff to improve performance and productivity.

5.39 Prior to AfC, the NHS used a pay system that dated back to 1948. It was seen as unequal in the way staff were paid and was no longer “fit for purpose”, failing to keep pace with NHS practice. The “Whitley system” was characterised by hundreds of separate pay scales and 650 grades that grouped staff in ways that were increasingly irrelevant to the way the NHS worked.

5.40 The Government committed in the NHS Plan (2000) to invest in pay in the NHS as part of its modernisation programme to increase capacity and drive down waiting lists through substantial modernisation including modernisation of staff pay, terms and conditions.

5.41 Against a backdrop of rising demand for acute services and greater pressure on staffing levels as a result of the new quality standards set out following the Francis report, the NHS needs a pay system which will help drive up performance and support a health care system which must be available 24/7.

5.42 We invite the NHSPRB to consider and make recommendations, building on the current AfC framework, on options for change which remove or reduce the cost of incremental progression (2 per cent), that make a stronger link between performance, pay and productivity, and that the current system of ‘out of hours’ payments reflects the Department’s ambition for delivering, affordable seven day services. The areas, which are not exhaustive, should include recommendations on:

- progression pay
- length of the pay bands
- overlapping pay increments between bands and
- plain time working and 'out of hours' in the context of a 24/7 service

## Equality Act 2010

5.43 The Equalities Act 2010 codified a number of Acts and Regulations that formed the basis of anti-discrimination law in Great Britain. It lists the characteristics that are protected by subsequent provisions in the Act, known as 'protected characteristics', as:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

## New duties placed on public sector employers under the Equality Act 2010

5.44 Section 149 of the Equality Act 2010 says public authorities and those exercising public functions must *have due regard to* the need to:

- eliminate discrimination
- advance equality of opportunity
- foster good relations between those with a protected characteristic and those without

5.45 There are six key principles:

- decision makers must be aware of their duty to have due regard
- the duty must be fulfilled before they make their decision, at the time of the decision and after the decision has been made
- the duty must be exercised in substance, with rigour and with an open mind (meaning the analysis should be reasonable)
- the duty is non-delegable
- it is a continuing duty
- officials must keep adequate records

- 5.46 Specific duties (currently subject to a call for evidence) require public bodies and those exercising public functions to *publish relevant information showing compliance and set equality objectives*.
- 5.47 The NHS Staff Council published Equality Impact Assessments on the AfC agreements on pay progression, sickness absence and Workforce re-profiling. Employers are invited to consider their legal obligations in the context of their own equality duties when implementing the changes locally.<sup>43</sup>

### Equalities legislation and national pay frameworks

- 5.48 The chancellor, George Osborne, confirmed the UK Government's commitment to reforming pay in the public sector.
- 5.49 In the NHS, under AfC, all staff have annual development reviews against knowledge and skills frameworks. The Job Evaluation Scheme (JES) determines the correct pay band for each post. As staff successfully develop their skills and knowledge and subject to meeting local performance standards, they can progress in annual increments up to the maximum of their pay band. For example as shown in Table 5.2:

**Table 5.2: Incremental Pay**

Occupation	Incremental Pay
Typical AfC band 5 qualified nurse	Can expect seven years of pay progression averaging <u>3.9% per year</u> . This equates to basic salary increases of around <u>£900 per year</u> .

- 5.50 Employers are responsible for ensuring that, for example, men and women, white and ethnic minority employees, disabled and non-disabled, of differing age groups and contractual status with comparable lengths of service and doing equal work, or in the same grade or band, receive equal average pay. And, that any difference in pay between men and women, for carrying out work of equal value, can be objectively justified. Employers will want to be clear about their own objectives for rewarding staff, e.g. loyalty, experience, performance or competence. Whilst employers are responsible for meeting their legal obligations under Equalities legislation, if a legal challenge may have repercussive effects across national pay frameworks, successive Governments have chosen to be joined in any

<sup>43</sup> <http://www.nhsemployers.org/PayAndContracts/AgendaForChange/Agenda-for-Change-proposals/Pages/Agenda-for-Change-agreed-amendments-April-2013.aspx>

action, given most NHS staff are subject to national employment contracts.

### Changes to NHS Redundancy Terms

5.51 No good employer wishes to see staff made redundant. Where this is an unavoidable necessity, the NHS has enjoyed excellent contractual redundancy terms (as set out in Section 16 of the NHS terms and conditions of service handbook), including up to two years' pay and "top up" by employers of pension benefits for those aged over 50. Furthermore, staff made redundant in the NHS are able freely to re-enter NHS employment after 28 days of being made redundant. These terms are now seen as inconsistent with modern practices. The Department is therefore seeking to make changes to contractual redundancy terms, introducing them initially to very senior managers in arms-length bodies and, subject to negotiations, followed by roll-out to the wider NHS.

# Chapter 6: NHS Pension Scheme and Total Reward Strategy

## The NHS Pension Scheme (NHSPS)

### Introduction

- 6.1 The Government is undertaking a range of changes to pensions for both public and private sector schemes. This includes changes such as single tier pensions, a review of the State Pension Age within the DWP Pension Bill 2013 and the introduction of auto-enrolment and the Public Services Pension Act 2013. This is a framework Act, building on the precedent of previous legislation relating to public service pensions and based on the recommendations of the Independent Public Service Pensions Commission chaired by Lord Hutton. The Hutton report identified that people are living longer than ever before; today the average 60 year old is expected to live 10 years longer than in the 1970s, and that public service pensions were no longer affordable. As a result of improving life expectancy, the cost of pensions has increased by a third over the last 50 years.
- 6.2 That is why Government's reforms aim to ensure public service pensions are sustainable, affordable and fairer to both public service workers and taxpayers. The proposals for the 2015 scheme ensure that the NHSPS will continue to deliver a fair reward to staff and support the retention and recruitment of staff. The Department continues to work closely with both employers, through the NHS Employers organisation, and the NHS Trades Unions to agree the detailed business rules that will apply so that changes can be implemented from April 2015. The changes, based on the Proposed Final Agreement, are outlined at Annex G and this also provides a comparator to both the 1995 scheme and the 2008 scheme.

### 1995 and 2008 sections of the NHSPS

- 6.3 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, and include 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.

- 6.4 Regulations came into effect from 1 October 2009 to allow all contributing members of the 1995 Section of the Scheme an opportunity (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. It has 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.
- 6.5 As part of the Pension Choice Exercise, eligible members of the 1995 Section received a personalised pension statement, which compared benefits in the 1995 and 2008 Sections of the NHSPS, as well as an explanatory guide and a DVD to help members inform their decision. The Pension Choice exercise was completed on 31 March 2012 and resulted in 3.3 per cent (37,200 members) opting to move from the 1995 to 2008 section. Around two thirds of staff are currently in the 1995 section and a further third now in the 2008 section.

### 2015 NHS Pension Scheme position

- 6.6 The main parameters of the new scheme are set out below:
- a pension scheme design based on career average
  - an accrual rate of 1/54th of pensionable earnings each year with no limit to pensionable service
  - revaluation of active members' benefits in line with CPI plus 1.5 per cent per annum
  - a Normal Pension Age (NPA) equal to the State Pension Age (SPA), which applies both to active members and deferred members (new scheme service only). If a member's SPA rises, then NPA will do so too for all post 2015 service. Those within ten years of current NPA are excluded and accrued rights in pre-2015 schemes will also be related to current NPA
  - pensions in payment to increase in line with inflation (currently CPI)
  - benefits to increase in any period of deferment in line with inflation (currently CPI)

- member contributions on a tiered basis to produce a total yield of 9.8 per cent of total pensionable pay in the Scheme<sup>44</sup> (subject to the detailed arrangements for determining future contribution structures)
- optional lump sum commutation at a rate of £12 of lump sum for every £1 per annum of pension foregone up to the maximum limit on lump sums permitted by HMRC
- the current flexibilities in the 2008 section: early/late retirement factors on an actuarially neutral basis, draw down of pension on partial retirement and being able to retire and return to the pension scheme will be included in the 2015 scheme
- ill-health retirement pensions to be based on the current ill-health retirement arrangements but with enhancement for higher tier awards to be at the rate of 50 per cent of prospective service to normal pension age
- spouse and partner pensions to continue to be based on an accrual rate of 1/160th. For deaths in retirement, spouse and partner pensions will remain based on pre-commuted pension.
- the current arrangements for abatement (for service accrued prior to and post 2015) will be retained
- lump-sum on death in service will remain at two times actual pensionable pay
- for members who in the new scheme have a Normal Pension Age higher than 65 there will be an option in the new scheme to pay additional contributions to reduce or, in some cases, remove any early retirement reduction that would apply if they retire before their NPA. Only reductions that would apply in respect of years after age 65 can be bought out and the maximum reduction that can be bought out is for three years (that would apply to a member with a NPA of 68 or higher)<sup>45</sup>

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<sup>44</sup> The Government has determined that the average member contributions will be increased from 6.6 per cent in 2011/12 in stages to 9.8 per cent in 2014/15. Member contribution rates in 2012/13 will increase by amounts between 0 per cent and 2.4 per cent. There will be no increase in 2012/13 for staff with WTE pensionable pay less than £26,558. Further increases in member contributions will be made in 2013/14 and 2014/15 to reach the required 9.8 per cent average contribution level. The Government will formally consult on the increases for those years in due course.

<sup>45</sup> This will be subject to a minimum normal retirement age of 65. Contributions will ordinarily be payable by members but individual employers will be able to choose to provide a contribution in certain circumstances, subject to the conclusions of the Working Longer Review. Where members make earlier retirement contributions, e.g. for retirement from age 65, but subsequently choose to retire, at a different date, their benefits will be actuarially reduced or enhanced to take full account of the extra years of earlier retirement they bought. The cost of earlier retirement will be actuarially neutral, and expressed as a percentage increase in the employee contribution rate, per year of earlier retirement. Periodically, the additional contribution rate will be reviewed, and may change during the period of purchase. The cost of purchase has yet to be calculated but indicative costings are that it would be in the region of 1.2 per cent to 1.5 per cent of salary from 2015 for each year taken early depending on the age of the member when they move into the new arrangements.

- added Years contracts in the 1995 section will continue on compulsory transfer to the 2015 scheme<sup>46</sup>
- additional pension arrangements will continue<sup>47</sup>
- the Public Sector Transfer Club will continue and further consideration will be given to the best way of operating it in the reformed schemes
- an employer contribution cap

6.7 In addition the Proposed Final Agreement outlined the following transitional protection arrangements:

- all accrued rights will be protected and those past benefits will be linked to final salary when members leave the scheme. Existing arrangements with respect to the Uniform Accrual Formula for Mental Health Officers (MHOs) will continue to apply for staff who move to the new arrangements
- the current rules requiring staff in the 1995 scheme to retire, take all benefits and be prohibited from further pension scheme membership will be retained but with the following changes. Staff on taking their 1995 benefits after the age of 55<sup>48</sup>, will be able to defer their 2015 benefits but without the possibility of further accrual in the NHS Pension Scheme
- all active NHS Pension Scheme members in the 1995 arrangements with a current NPA of 60 or 55, who as of 1 April 2012, have 10 years or less to their current NPA or are over their current NPA will have their future benefits protected<sup>49</sup>. This will be achieved by their remaining in the 1995 arrangements on their current benefit terms until they retire
- members in the 1995 arrangements who are within a further three years and five months of their current NPA (i.e. up to 13 years and five months from their NPA), will have limited protection with linear tapering so that for every month of age that they are beyond 10 years of their current NPA, they lose two months of protection. At the end of the protected period, they will be transferred into the

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<sup>46</sup> Already “paid-up” contracts, lump sum contracts and ongoing extra percentage contribution contracts will be maintained within the 1995 section of a member’s NHS Pension Scheme service until their chosen end age for the contract, which is 60 or 65, or 55 for members of the special classes. A member with service in the 1995 scheme could in future elect to receive the benefits accrued via their Added Years contracts at the contract end date rather than upon their retirement. The continuation of ‘Half cost’ and pre 1972 Added Years contracts (taken out by married men) is no longer appropriate and this facility will be removed from 2015 onwards, after a suitable period of notice and publicity for currently active members.

<sup>47</sup> Members with service in the 1995 schemes could in future elect to receive the benefits accrued via their additional pension contracts at the contract end date rather than upon their retirement.

<sup>48</sup> Some staff in the 1995 Scheme have a protected right to a minimum pension age of 50. If they take pension benefits before 55, then legally they must take all benefits.

<sup>49</sup> Including Mental Health Officers and those in special classes.

new pension arrangements. Paragraph 4 also refers to these members

- all active NHS Pension Scheme members in the 2008 arrangements who as of 1 April 2012 have 10 years or less to their current NPA of 65, or are over 65 will be given protection by their being allowed to remain in their current arrangements until they retire. A tapered arrangement (on the same basis as described above) will apply to those within a further three years and five months of their current NPA as of 1 April 2012. However, whilst these members are covered by protection, they will be given a one-off option to opt-out of protection and transfer to the new scheme in 2015. This opt-out is being made available because modelling of the impact of the new scheme on these protected members has suggested that the majority could be better off if they transfer to the new arrangements
- members with protection who leave active service and return within five years will be able to return to their current arrangements with final salary linking if they are in the fully protected group. If they are in the tapered protection group, they will return to the scheme arrangements that they would have been in had they remained in service, again retaining final salary linking. Members not covered by protection will be able to re-link their accrued rights to final salary on retirement if they return within five years. Those who return after more than five years will, as now, be offered the choice of converting their past service to the current scheme terms on a Cash Equivalent Transfer Value (CETV) basis or leaving it as an accrued benefit without final salary linkage

### Progress toward implementation of the 2015 scheme

- 6.8 Good progress has been made in partnership with the NHS Trades Unions and NHS Employers in developing the new arrangements and agreeing the detailed business rules based on the Proposed Final Agreement. Additionally, HMT have a process working across the public service schemes to ensure, where appropriate, there is consistency. We will use this approach to develop the supporting legislation to implement reform to the NHS Pension Scheme. The reforms are based on the proposed final agreement reached with the NHS Trades Unions and published in March 2012. Long-term contribution rates remain under discussion, and all parties are working together to reach a clear set of principles upon which any new proposals can be based.

6.9 The Department of Health have commenced the Valuation process, based on the available 2012 data, using the methodology set out in the draft HMT Valuation Directions enacted through provisions in the Public Services Pension Act 2013. There remain uncertainties about employer contributions from 2015. The valuations need to be complete before the Department can be clear on the level of any pressure on the employer contribution from 2015. There will potentially be further pension pressures in 2016 onwards given the changes in NI and contracting out, stemming from the single tier pension policy. These changes will not have an effect before the next Spending Review.

### Review into working longer

6.10 The NHS Pension Scheme Propose Final Agreement (PFA) included the provision that in the new scheme, for pension accruals post 2015, the NPA should be set equal to the SPA. To support implementation, since September 2012 there has been an on-going tripartite review between the Department of Health, NHS Employers and the NHS trades unions to address the impact of working longer in the NHS, with particular reference to staff working on the frontline and those with physically demanding roles, including the emergency services.

6.11 The initial primary research, carried out by Bath University, identified a number of key findings that might feed into a final set of recommendations to the Department. Further secondary research will provide evidence from NHS organisations, trades unions and NHS employees - the overall aim of this review is to identify and share examples of good practice that will enable staff to continue working to SPA.

### Review on extending access to the NHS Pension Scheme

6.12 Within the recommendations of the Independent Public Service Pensions Commission there was provision to review the Fair Deal policy. After further consultation and discussions with the Trades Unions the Chief Secretary to the Treasury laid a Written Ministerial Statement in the House of Commons on the 4 July 2012 that stated;

*“The Government has reviewed the Fair Deal policy and agreed to maintain the overall approach, but deliver this by offering access to public service pension schemes for transferring staff. When implemented, this means that all staff whose employment is compulsorily transferred from the public service under Transfer of Undertaking (protection of*

*employment) Regulations (TUPE), including subsequent TUPE transfers, to independent providers of public services will retain membership of their current employer's pension arrangements. These arrangements will replace the current broad comparability and bulk transfer approach under Fair Deal, which will then no longer apply."*

- 6.13 The changes to the 'Fair Deal for Staff Pensions' are HMT led and will apply to all members of the public service pension schemes that transfer out of the public sector under TUPE, and to staff that have previously transferred out of the public sector, and who have remained eligible for the current Fair Deal protection. This includes NHS staff with entitlement to contribute to the NHS Pension Scheme (NHSPS). There will also be protection where staff are subsequently transferred to a new employer.
- 6.14 The wider access review, included in the PFA is NHS specific and is being developed in partnership with the Department of Health, HMT, Trades Unions, Independent Sector and NHS Employers - building on the new Fair Deal provisions. It covers the terms of access for non-NHS organisations providing NHS Clinical Services (Independent Providers [IPs]), where they are delivering services under an Alternative Provider Medical Services contract or a NHS Standard Contract - including services procured under 'Any Qualified Provider' and covers both clinical and non-clinical staff delivering the clinical service.
- 6.15 The final approach is subject to ministerial agreement.

### Increases in pension contributions

- 6.16 In addition to the new pension scheme from April 2015, in the Spending Review 2010 Government set forecasts for reducing net public expenditure on public service pensions through phased increases in members' contributions on the current scheme. The target savings to be delivered across all schemes were over a three year period from 2012/13 to 2014/15<sup>50</sup>. The forecast savings for the NHSPS in particular were set out in Annex E of the PFA dated 9 March 2012 for 2012/13, 2013/14 and for 2014/15<sup>51</sup>, attached at Annex H for

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<sup>50</sup> See table A.3 in [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/203828/Spending\\_Review\\_2010\\_-\\_statistical\\_annex.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203828/Spending_Review_2010_-_statistical_annex.pdf)

<sup>51</sup> See Annex E in [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/151957/dh\\_133003.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/151957/dh_133003.pdf)

ease of reference, based on an average 3.2 percentage point increase in member contribution rates being implemented by 2014-15.

- 6.17 The increases in contributions recognise the importance of protecting the lower paid, the progressive nature of contributions and that higher earners should pay higher contribution rates given the tax provisions and higher level of benefits they receive in final salary arrangements. Those earning up to £15,000 will not be required to pay additional contributions.
- 6.18 Last year, some Trades Unions identified concern at the fact that upon moving from point 15 to 16 the combined effects of the pay and increased pension contribution element meant that a very limited number of staff were worse off after the pay increment point due to the increased pension contribution. This anomaly is partly down to the fact that agreement on changes in pension contribution are made in Autumn and the position on pay is not clear until the following March. There is clearly an interplay between the pay scale, pay uplift and the pension contribution required and where there is an uplift for low paid but not for others there will be a difficulty when they move up a tier in the pension contribution as a result of Government policy for increased employee contributions on pensions in April 2012, April 2013 and April 2014. However it would not be possible to resolve this matter by any one of changes in pay or pension as this will simply create a further anomaly in the system. The payslip notification for staff, made available in February 2014, will clarify for all staff the position once the Regulatory consultation is concluded and before implementation. There has been detailed discussion with Trades Unions and employers on the changes to pension contributions and this has not been raised as a matter of concern.
- 6.19 There has been on-going monitoring of the position on opt-outs from the NHSPS - based on both reports from the ESR available data and NHS Business Services Authority (BSA) data - given the changes in pension contributions for employees, the evidence shows that compared to 2011 data there has been no significant change and staff continue to value membership of the scheme. Of course the auto-enrolment position has also affected the opt-out position and it is difficult to disentangle the two things. Overall an increase in scheme membership, in the region of 2.2 per cent – 2.4 per cent.

## Total Reward Strategy

- 6.20 Total Reward is both the tangible and intangible benefits that an employer offers an employee: the financial benefits eg training, career development opportunities, culture and working environment. It is a means of explaining to employees the total value of their employment package.
- 6.21 The Department of Health's vision for total reward within the context of continued pay restraint and fiscal consolidation is one in which NHS organisations have the appropriate capability and capacity to:
- fully utilise the NHS employment package to attract, motivate and retain the staff they need
  - implement local reward strategies that are aligned with their organisational objectives and meet the needs of their workforce
  - ensure employees understand the full value of their total reward package (the tangible and intangible benefits) and the flexibilities within it
- 6.22 NHS Employers is delivering our total reward strategy to deliver the vision described above by:
- engaging with NHS employers and staff, for example, with those involved in the Total Reward Statement pilots
  - ensuring the NHS has access to total reward expertise and is kept up to date with latest developments and leading edge practice supported by a range of products
  - influencing a change in employer behaviour to embrace total reward and share learning
  - ensuring that our total reward approach influences and is influenced by ongoing pay contractual changes and pensions modernisation

### Components of total reward package for NHSPRB staff

- 6.23 Components of the total reward package for NHSPRB staff, updated where appropriate from last year, currently include:
- annual incremental progression of between 0.6 per cent and 6.7 per cent of basic salary;
  - a NHS minimum wage of about £7.31 per hour which is about 18 per cent more than the national minimum wage of £6.19 (since October 2012)
  - a defined benefit pension scheme with a 14 per cent employer contribution and flexible early retirement options from 55 years old;



- immediate life assurance of twice an employee's annual pay and generous death benefits for spouses and dependent children;
- maximum 41 days holiday compared with the 28 days statutory minimum
- sick pay of six months full pay and six months half pay compared with statutory sick pay of £86.70 per week for up to 28 weeks;
- redundancy pay of up to two year's salary with a minimum of 24 years reckonable service compared with the statutory half to one and a half week's pay for each full year of service depending on age
- maternity pay of eight weeks full pay, 18 weeks half pay, 13 weeks statutory maternity pay (SMP) and an optional extra 13 weeks unpaid leave compared with the statutory entitlement of six weeks at 90 per cent of average gross weekly earnings and 33 weeks at the lower of either £136.78 or 90 per cent of average gross weekly earnings
- paternity leave of two weeks starting twenty weeks after the child is born as well as an additional two to 26 weeks if the mother has returned to work. Fathers are also entitled to receive additional paternity pay if the mother has not exhausted her SMP when she returns to work
- the nationally recognised values, diversity and reputation of the NHS including, for example, excellent opportunities for flexible working, career breaks etc

6.24 Annex I provides a list of activities/products that have been suggested to support the vision for reward in the NHS.

### Total Reward Statements

6.25 The Public Service Pension Act 2013 introduces a new legal requirement on public sector schemes to provide benefits information statements to members in pensionable service. For NHS staff in organisations using the ESR this will be enhanced to a Total Reward Statement (TRS). The TRS aims to ensure that staff are fully aware of the benefits they receive as a total remuneration package including pension, pay and leave, as evidence carried out both by HMT and NHS workshops, demonstrates that employees do not understand this fully, and many are not aware they receive 14 per cent employer contribution toward their pension package. For staff in organisations not using the ESR they will receive an annual benefit statement (ABS).

6.26 The core elements of this project's infrastructure are now in place and two pilot exercises have been undertaken, involving the production of

around 90,000 statements to 17 organisations. These exercises aimed to inform the completion/refinement of the IT solution and the finalising of a national rollout strategy.

6.27 Feedback from the pilots has confirmed that:

- the concept appears to be understood by staff and well supported
- the quality of statements is regarded as good
- the technical environment appears generally fit for purpose though some usability refinements are required prior to national rollout
- the Cabinet Office led Government Gateway element of the solution needs simplification if mass use is to be achieved and support costs contained
- there is further work to be undertaken with NHS employers to support the local customisation of statements thus ensuring that the project's benefits are fully realised

6.28 Feedback from employees as part of the evaluation of the technical pilot of TRS undertaken by NHS BSA to assess whether the statement had prompted them to start planning or change their financial plans for retirement; and whether the statement had made them think differently about their overall employment package has shown that:

- 47.5 per cent said that the statement had made them think or act about financial planning for retirement which is supported by comments from the in depth one to one interviews supports this, for example:
  - “The pensions tab made me think “when can I retire?” I am 58 and was already pretty much aware of what I will get – the statement made me feel good as it confirmed my expectations. I didn’t need to seek any further information.”
  - “I realise I can retire now – hadn’t really thought about retiring but am now”
  - “Made me feel more inclined to stay in the pension scheme – knowing what is there already ... It reminded me that financial planning is something I need to do”
  - 47.5 per cent said they now valued their overall package more than before. The remaining 52.5 per cent said that their perception was the same as before receiving the statement

6.29 Following an evaluation of these pilot exercises, it has been determined that the national rollout should commence, once the technical solution has been further refined and we can ensure

improved employer engagement. The statement content will be generated annually to ensure that we achieve optimum impact on NHS employees the initial national rollout is due to take place from September 2014.

# Annex A: Chief Secretary to the Treasury's Letter on Public Sector Pay 2014-15

UNCLASSIFIED



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

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

23 July 2013

Dear Jerry,

## **PUBLIC SECTOR PAY 2014-15**

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

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

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

- a. Recruitment and retention: While recognising some variation between remit groups, the evidence so far is that, given the current labour market position, there are unlikely to be significant recruitment and retention issues for the majority of public sector workforces over the next year.
- b. Affordability: Pay restraint remains a crucial part of the consolidation plans that will help to put the UK back onto the path of fiscal sustainability – and continued restraint in relation to public sector pay will help to protect jobs in the public sector and support the quality of public services.

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

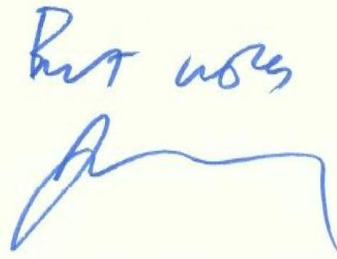
award to particular groups of staff, relative to the rest of the workforce, due to particular recruitment and retention difficulties.

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

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

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

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

A handwritten signature in blue ink, appearing to read 'Danny Alexander', with a stylized flourish underneath.

DANNY ALEXANDER

# Annex B: PS(H) NHSPRB Remit Letter



Department  
of Health

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

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

*Richmond House  
79 Whitehall  
London  
SW1A 2NS*

*Tel: 020 7210 4850*

**06 AUG 2013**

*Dear Jerry,*

## **NHS Pay Review Body Remit 2014/15**

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

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

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

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

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

- NHS Employers – detailed evidence on the recruitment, retention, motivation and morale for Agenda for Change staff;
- Health Education England – detailed evidence on education, training and workforce capacity;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- The level of incremental pay staff that have not reached the top of their pay band will receive
  - the need to recruit, retain and motivate suitably able and qualified staff;
  - regional/local variations in labour markets and their effects on the recruitment and retention of staff;
  - the funds available to the DH, as set out in the Government’s Departmental Expenditure Limits;
  - the Government’s inflation target;
  - the principle of equal pay for work of equal value in the NHS; and
  - the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

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

*Dan Poulter*

**DR DAN POULTER**



## *Annex C: Market-facing Pay: How Agenda for Change can be made more appropriate to local labour markets – summary of recommendations*

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

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

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

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

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

We also expect the parties to consider:

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

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

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

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

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

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

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

# Annex D: Agenda for Change Agreement

<b>AfC Reform Phase one – new arrangements effective from 31 March 2013</b>	
<p><b>i) Remove regularly paid enhancements from sickness benefits for those on pay point 9 and above</b></p>	<p>Sick pay is paid at enhanced rates. The proposal is to remove regularly paid supplements e.g. unsocial hours payments. Staff at the lowest pay points 1 to 8 will be excluded.</p>
<p><b>ii) Linking pay progression much more firmly to – savings dependent on local performance standards. Very broadly, if 10% of staff not already at the top of their pay band did not receive</b></p>	<p>Operating closed gateways at every pay point and allowing employers locally to set performance criteria. For staff in pay the highest pay bands 8C, 8D and 9, pay progression into the last 2 points in the band will become annually earned and once awarded will be dependent upon meeting the appropriate local level of performance in a given year as to whether these points are retained, i.e. non-consolidated pay. Annually earned pay will not be subject to pay protection. Employers can also, with agreement, move staff in pay bands 8C and above onto local spot pay arrangements. This proposal also requires employers to reference the NHS Constitution in any local performance arrangements, which includes very important NHS values around compassion, dignity and respect.</p>
<p><b>iii) Remove accelerated pay progression for new entrants to Pay Band 5</b></p>	<p>Agreement will clarify that the partners still support the principals of professional development, but that accelerated pay is no longer appropriate.</p>
<p><b>iv) Workforce re-profiling</b></p>	<p>Guidance on a partnership approach to workforce re-profiling ('down banding'). Any pay protection will be decided locally based on local agreements.</p>

# Annex E: Francis Report

1. The Francis report challenges the NHS to move beyond championing consistent safe and compassionate care in partnership with patients to actually achieving it.
2. There are many professionals and organisations that already provide an exemplary service, but the Department also knows that there are many organisations and individuals that could do better. While the case of Mid Staffordshire was an extreme one, there is evidence that some of the behavioural issues and examples of poor care that characterised some parts of Mid Staffordshire can also be found in other parts of the NHS. Addressing behaviour of this kind and driving up levels of compassion and safety are a critical part of the Government's strategy for the NHS.
3. In the initial response to the Francis report issued on behalf of the whole health and care system, *Patients First and Foremost*, the Government highlighted a number of issues of importance for the NHS to meet the challenge of Francis, including:
  - leadership at every level from board to ward
  - commitment to improving the safety and quality of care at all levels of the system
  - a culture built on partnership with patients
  - openness and transparency throughout care organisations including candour with patients and transparency about decisions at organisational level
4. The importance of these issues has been further reinforced by a number of reviews conducted to inform the further Government response to the Francis report, including Sir Bruce Keogh's Mortality Review into the quality of care and treatment at 14 Trusts and Professor Don Berwick's patient safety review.
5. Support for staff (by both managers and their peers of both formal and informal kinds) is one of the key defences against the development of the kind of toxic culture seen at Mid Staffordshire. Measures which help to develop mutual support are therefore an important part of the

response to Francis, for example the Department of Health's funding of Schwartz rounds.<sup>52</sup>

6. On **leadership**, the NHS Leadership Academy is developing and launching a number of programmes designed to ensure that there is leadership support at all levels of the NHS and that it is focused on achieving safe, compassionate care through the development of an open, learning-oriented culture.
7. On **safety and quality of care**, the Government has welcomed the publication of the Berwick Review<sup>53</sup> and is committed to addressing the issues it highlights. This includes working with other organisations in the system to review the use of evidence-based guidance and tools for local decisions about staffing levels. The Department is putting in place a number of measures to ensure that patients are better informed and better able to provide feedback on the services they receive. A new Chief Inspector of Hospitals is now in post with a remit to assess the performance of every NHS hospital.
8. On developing a **culture built on partnership with patients**, since *Patients First and Foremost* we have seen many local initiatives to develop this culture, a number of which are captured through the pledges in NHS Change Day<sup>54</sup>:
  - initial results from the 'Friends and Family Test' which asks patients to say whether they would be happy for their friends and family to be treated where they have been
  - a commitment from the Chief Inspector of Hospitals to using patients and carers as part of the new inspection teams for hospitals
  - the Government commission a report from Ann Clywd MP and Professor Tricia Hart on complaints in the NHS

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<sup>52</sup> <https://www.gov.uk/government/news/expansion-of-groundbreaking-scheme-to-support-nhs-staff>

<sup>53</sup> <https://www.gov.uk/government/publications/berwick-review-into-patient-safety>

<sup>54</sup> <http://www.changemodel.nhs.uk/pg/groups/33183/NHS+Change+Day/?community=NHS+Change+Day>

# Annex F: Mid Staffordshire NHS Foundation Trust Public Inquiry Employment Contracts Recommendations

<p><b>Recommendation 7</b></p> <p><b>Putting the patient first</b></p> <p>The patient must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.</p>	<p>All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.</p>	<p>Chapter 21</p> <p><b>Current Position:</b> Need to approach either SPF Francis Sub Group and/or NHS Staff Council for exploratory discussions</p>
<p><b>Recommendation 178</b></p> <p><b>Implementation of the duty</b></p> <p>Ensuring consistency of obligations under the duty of openness, transparency and candour</p>	<p>The NHS Constitution should be revised to reflect the changes recommended with regard to a duty of openness, transparency and candour, and all organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with above principles and these recommendations.</p>	<p>Chapter 22</p> <p><b>Current Position:</b> Need to approach either SPF Francis Sub Group and/or NHS Staff Council for exploratory discussions.</p>
<p><b>Recommendation 194</b></p>	<p>As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up to date knowledge of nursing practice and its</p>	<p>Chapter 23</p> <p><b>Current Position:</b> The recent AfC agreement on linking incremental pay more closely to performance, allows employers the flexibility to develop their own local</p>

	<p>implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such.</p>	<p>performance standards. NHS Employers are developing proposals to support the service to realise the benefits of the agreement.</p>
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# Annex G: Summary of Benefits and Comparison with 2015 Scheme

## Summary of benefits & comparison with 2015 scheme

Feature or Benefit	1995		2008		2015
	Officers	Practitioners	Officers	Practitioners	All staff
<b>Method</b>	Final Salary	CARE	Final Salary	CARE	CARE
<b>Accrual rate</b>	1/80 <sup>th</sup>	1.4% of uprated earnings per year	1/60 <sup>th</sup>	1.87% of uprated earnings per year	1/54 <sup>th</sup>
<b>Retirement Lump Sum</b>	3 x pension plus optional further commutation up to HMRC limit	3 x pension plus optional further commutation up to HMRC limit	Optional 12:1 commutation up to HMRC limit	Optional 12:1 commutation up to HMRC limit	Optional 12:1 commutation up to HMRC limit
<b>Normal Pension Age</b>	60 (or 55 for special classes)	60	65	65	SPA
<b>In-service earnings revaluation</b>	N/A	Pensions Increase + 1.5%	N/A	Pensions Increase + 1.5%	CPI + 1.5%
<b>Deferred benefits revaluation</b>	N/A	Pensions Increase	N/A	Pensions Increase	CPI
<b>Member Contributions</b>	5% - 10.9% depending upon level of pensionable pay or earnings		5% - 10.9% depending upon level of pensionable pay or earnings		TBC but graduated tiers between 5% - 14.5% expected
<b>Death in service</b>	2 x pensionable pay or average annual earnings		2 x reckonable pay or average annual earnings		Same as 2008 section
<b>Survivor benefits</b>	Spouse & partner pension based on accrual of 1/160 <sup>th</sup>		Spouse & partner pension based on accrual of 1/160 <sup>th</sup>		Same as 2008 section
<b>Retirement flexibilities</b>	None. Full retirement from NHS service required before pension can be paid. Unable to re-join the scheme once benefits have been taken.		Early/late retirement factors on an actuarially neutral basis, draw down of pension on partial retirement and ability to retire and return to the scheme		Same as 2008 section
<b>Ill-health retirement</b>	Basic ill-health retirement = no actuarial reduction for early pension payment.  Higher tier ill-health retirement award = enhance pension by 2/3rds of prospective service to NPA.		Basic ill-health retirement award = no actuarial reduction for early pension payment.  Higher tier ill-health retirement award = enhance pension by 2/3rds of prospective service to NPA.		Basic ill-health retirement award same as 2008 section  Higher tier ill-health retirement award = enhance pension by 50% of prospective service to NPA.



## **Rationale for differences between 2008 & 2015 benefits**

CARE methodology and NPA-SPA link is a core design feature across all reformed public service pension schemes. Beyond this, the 2015 scheme differs from the current open 2008 section in two further aspects:

### **(i) Accrual rate & revaluation**

When exploring variations to the reference scheme based on the priorities put forward by unions, the Department undertook extensive modelling to assess the impact of various combinations of accrual rate and indexation.

The modelling considered a range of NHS workers of different ages and at different stages of their careers. Projected pension figures were calculated using typical career paths. Specifically, the modelling looked at projected pension payments at retirement.

The resulting scheme design of a revaluation factor of CPI + 1.5 per cent and an accrual rate of 1/54<sup>th</sup> was considered to provide the fairest balance for the majority of the membership across age ranges within the limitations of the cost ceiling.

### **(ii) Ill-health retirement**

Members of the 2008 scheme retiring on ill-health grounds and who qualify for higher tier awards (with there being no change in the qualifying conditions), receive an enhancement to their pension of 2/3<sup>rd</sup> of prospective service to NPA. The 2015 scheme will reduce this enhancement to 50 per cent. The change is being made in light of the increase in normal pension age from 65 to SPA, which in turn increases the underlying service on which the enhancement is based.

The basic ill-health retirement award mirrors the 2008 section - which provides an unreduced pension based on service accrued without enhancement.

## **Further mitigations in recognition of working longer**

The proposed final agreement committed to a "Working Longer Review" in partnership with NHS employers and trades unions. The purpose of this is to identify and seek mitigation for potential impacts of a later normal pension age.

The retention of substantial ill-health retirement benefits serve a valuable function in mitigating any negative impacts arising from the increase in NPA for those members who may not benefit from the statistical trends of increasing longevity and improved health into later life.

In addition, for members who in the new scheme have a NPA higher than 65 there will be an option in the new scheme to pay additional contributions to reduce or, in some cases, remove any early retirement reduction that would apply if they retire before their NPA. Only reductions that would apply in respect of years after age 65 can be bought out and the maximum reduction that can be bought out is for 3 years (i.e. for those with an NPA of 68 or higher).

## **Transitional protection**

### **(i) Full protection**

All members who are within ten years of their NPA (including special class NPA of 55) as at 1 April 2012 will remain in their current section. Around 25 per cent of the total scheme membership will benefit from full protection.

### **(ii) Partial protection**

All members who are within 13.5 years of their NPA as at 1 April 2012, but not within ten years, will have tapered protection. For every month of age that they are beyond ten years of their normal pension age, they lose two months of protection. At the end of the protected period, they will be transferred to the 2015 scheme for future service. Around 10 per cent of members will qualify for this partial protection.

### **(iii) Option for protected 2008 section members**

2008 Scheme members with full or tapered protection will be offered a one-off opportunity to opt into the new scheme in 2015 if they prefer. This is because they already have a normal pension age of 65 and by being old enough to benefit from protection will therefore have an SPA of 65 or 66. Modelling suggests that the better accrual rate available in the 2015 scheme means that these members may be better off transferring to the new arrangements in 2015 rather than taking advantage of the protection.

### **(iv) Protection for accrued rights**

All staff transferring to the 2015 scheme, either in 2015 or at the expiry of tapered protection, will have their pension rights accrued under their former arrangements fully protected. For benefit calculation purposes, the final salary will be based on pensionable pay at the point of leaving service rather than the point of entering the 2015 scheme.

## Annex H: Increases in Pensions Contributions

Full-time equivalent pensionable pay	Based on PFA data		Contribution rate 2011/12	Contribution rate 2012/13	Contribution rate increase	Contribution rate 2013/14	Contribution rate increase	Contribution rate 2014/15	Contribution rate increase	Contribution rate increase by 2014/15
	% of pensionable pay in the band	Est. no. of members in band '000								
Up to £15,000	3%	100	5.0%	5.0%	0.0%	5.0%	0.0%	5.0%	0.0%	0.0%
£15,001 to £21,175	13%	330	5.0%	5.0%	0.0%	5.3%	0.3%	5.6%	0.3%	0.6%
£21,176 to £26,557	11%	200	6.5%	6.5%	0.0%	6.8%	0.3%	7.1%	0.3%	0.6%
£26,558 to £48,982	43%	540	6.5%	8.0%	1.5%	9.0%	1.0%	9.3%	0.3%	2.8%
£48,983 to £69,931	7%	55	6.5%	8.9%	2.4%	11.3%	2.4%	12.5%	1.2%	6.0%
£69,932 to £110,273	13%	60	7.5%	9.9%	2.4%	12.3%	2.4%	13.5%	1.2%	6.0%
Over £110,273	11%	35	8.5%	10.9%	2.4%	13.3%	2.4%	14.5%	1.2%	6.0%
<b>Contributions as % payroll:</b>			<b>6.6%</b>	<b>8.0%</b>		<b>9.2%</b>		<b>9.8%</b>		<b>3.2%</b>
<b>OBR Nov 2011 est. payroll £bn:</b>				<b>38.36</b>		<b>39.03</b>		<b>39.47</b>		
<b>Additional yield £bn:</b>				<b>0.530</b>		<b>1.023</b>		<b>1.260</b>		

## Annex I: List of Activities/Products Suggested to Support the Vision for Reward in the NHS

Enablers	Description
<b>Education and Training</b>	
<b>Training Programmes</b>	Linking with leading training providers to develop an NHS specific training programme that can be offered nationally at a reduced rate to employers
<b>Seminar sessions</b>	Series of seminar sessions run across the country on a variety of reward topics  Run by different benefit providers and reward consultants
<b>Employer Reward Network</b>	
<b>Employer support network</b>	Develop the existing NHS Employers Reward Engagement Group: <ul style="list-style-type: none"> <li>• update communications</li> <li>• regional events</li> <li>• regular meetings with employers</li> <li>• online forums to discuss pay and reward</li> </ul>

Enablers	Description
<b>NHS Employers team working more collaboratively</b>	
<b>Proactively develop supportive/creative approaches to counteracting emerging issues</b>	To ensure emerging issues are responded to proactively, providing employers with support to implement/develop new approaches to rewarding their staff
<b>National Products and Tools</b>	
<b>Briefing Papers</b>	Provide guidance, ideas and suggestions for how employers can maintain engagement with changes in how they reward staff
<b>Reward Strategy Toolkit</b>	<p>Develop online for employers to adapt locally including the following:</p> <ul style="list-style-type: none"> <li>• business case for reward strategy</li> <li>• template documents</li> <li>• case studies</li> </ul> <p>This would be supported by an implementation plan and plan to add to/update the products regularly</p>

<b>Enablers</b>	<b>Description</b>
	Aon Hewitt consultancy to support the development of the content
<b>Online communication</b>	<ul style="list-style-type: none"> <li>• webinars</li> <li>• online forum</li> <li>• social media</li> </ul>
<b>Guidance on voluntary benefits - 'top available products'</b>	<ul style="list-style-type: none"> <li>• Guidance to advise employers on additional cost effective benefits that can be offered to staff</li> </ul>
<b>Intelligence</b>	
<b>Networking with Reward Experts from other sectors</b>	Discover reward practices in organisations outside of the health service to generate ideas for new ways of rewarding staff and learning that can be transferred to employers. Link with HPMA
<b>Total Reward Statement Development</b>	Assess impact of TRS in year 1 and develop recommendations for how this can be improved to incorporate: <ul style="list-style-type: none"> <li>• more flexibility for local arrangements</li> <li>• flexible benefits</li> <li>• improved access mechanisms</li> </ul>

<b>Enablers</b>	<b>Description</b>
<p align="center"><b>Research into employee understanding of reward package in the NHS</b></p>	<p>Using feedback from the TRS pilot</p> <p>This will provide a basis on which to measure staff understanding and whether or not this improves with the introduction of TRS and other reward initiatives</p>
<p align="center"><b>Research into how flexible reward/benefits can work in the NHS</b></p>	<p>Research on this area which will inform national policy on the flexibility of the reward package</p> <p>This will also inform the future development of the TRS</p>

