Review Body for Nursing and Other Health Professions

Twenty-Second Report on Nursing and Other Health Professions 2007

Chair: Professor Gillian Morris

Cm 7029

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

**Presented to the Scottish Parliament by the
First Minister and the Minister for Health and Community Care**

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

**By Command of Her Majesty
March 2007**

Cm 7029

£25.00

Review Body for Nursing and Other Health Professions

The Review Body for Nursing and Other Health Professions (NOHPRB) is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health, the First Minister and the Minister for Health and Community Care of the Scottish Parliament and the First Minister and the Minister for Health and Social Services of the National Assembly for Wales on the remuneration of the following staff groups employed in the National Health Service:

(i) Nurses, Midwives and Health Visitors;
(ii) The Allied Health Professions;
(iii) The Health Care Science Professions;
(iv) Pharmacists, Optometrists, Applied Psychologists and Psychotherapists;
(v) Clinical Support workers and technicians supporting these groups;

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

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

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

the Health Departments' output targets for the delivery of services, as set out by the Government;

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

the Government's inflation target;

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

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

The Review Body is also required to take careful account of the economic and other evidence submitted by the Government, staff and professional representatives and others.

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

Reports and recommendations should be submitted jointly to the Prime Minister, the Secretary of State for Health, the First Minister and the Minister for Health and Community Care of the Scottish Parliament and the First Minister and the Minister for Health and Social Services of the National Assembly for Wales.

Members of the Review Body are:

Professor Gillian Morris *(Chair)*
Mr Philip Ashmore
Mrs Lucinda Bolton
Professor Richard Disney
Ms Wilma MacPherson, CBE
Professor Alan Manning
Mr Ian McKay
Ms Sharon Whitlam

The secretariat is provided by the Office of Manpower Economics.

Contents

Summary of Recommendations and Main Conclusions

We are pleased to present our recommendations on the pay of nursing staff and staff in other health professions from 1 April 2007. We have carefully reviewed all the evidence we have received. In arriving at our recommendations, we have examined data on recruitment and retention, morale and motivation, funding, the Government's inflation target, and other relevant economic indicators. We have also had regard to the principle of equal pay for work of equal value and legal obligations on the NHS, including anti-discrimination legislation. Lack of evidence prevented us giving detailed consideration to the Health Departments' output targets. The key issues and recommendations are summarised below.

- This year's review has taken place against a backdrop of the ongoing implementation of the Agenda for Change (AfC) pay system for the NHS. Although progress has been made since our last review, implementation is still not complete throughout Great Britain and we have concluded that our recommendations should therefore concentrate on the level of the basic pay award.

- The parties have all sought a one-year only pay award. **We consider that the award should be for one year only.**

- We do not consider that it is necessary this year to amend the existing position of the pay structure of our remit group relative to the external market. We are mindful in this regard of the need for the service to continue to recruit, retain and motivate suitably able and qualified staff. We have sought, therefore, to maintain the position of our remit group as far as we judge affordability constraints permit. **We therefore recommend an increase in the Agenda for Change pay rates of 2.5 per cent from 1 April 2007.**

- We consider that we should maintain the relative value of the differentials provided by the high cost area supplements (HCAS). **We recommend that the existing minimum and maximum HCAS for Inner London, Outer London and the Fringe be increased by 2.5 per cent from 1 April 2007.**

- The Staff Side asked us to consider a case for the introduction of a new HCAS for South Cambridgeshire. We do not believe that sufficient evidence was submitted on the extent of the labour market difficulties being caused for local NHS employers for us to make a recommendation that the existing HCAS boundaries be redefined. We have set out in Chapter 4 the type of evidence that we would find essential in order to consider any submissions relating to the introduction of new HCAS in future.

- We were asked to consider new national Recruitment and Retention Premia (RRP) for pharmacists and radiographers by the individual staff bodies representing those groups. We do not recommend any RRPs this year, but we would emphasise that under the AfC Agreement local employers may pay a local RRP where specified criteria are met. With regard to pharmacists, we believe that the case for a national RRP warrants proper investigation and have asked the parties to consider jointly undertaking further research and to involve our secretariat. With regard to radiographers, we do not believe that the general shortage of radiographers would be addressed by the introduction of an RRP.

- We have faced difficulties in obtaining sufficiently robust, up-to-date information in a number of crucial evidential areas, particularly the past and current earnings of our remit group, the morale of the workforce, and the relationship between affordability, the Departmental Expenditure Limits (DELs) and the tariff uplift in England. We have asked our secretariat to discuss with the appropriate bodies what better data can be provided to us for our next review in the areas of recruitment and retention, morale and motivation, the level and composition of earnings and affordability. **We recommend that the Health Departments and other relevant bodies should review the timing of the key surveys which inform our review to see whether we can be provided with more timely data. The Health Departments should report back to us before the beginning of our next review on the feasibility of providing more timely data.**

- Given the emphasis by the Health Departments on their earnings' projections, we are concerned about the quality of the information underpinning these projections that has been supplied to us. **We strongly urge the Departments for our next review to ensure better explanations of projected earnings growth.**

- We do not know this year what the true picture on staffing is because of Trusts' reactions to the NHS' current financial problems. Given the importance of the Knowledge and Skills Framework (KSF) to the success of AfC and to restructuring to meet the future agenda of the NHS, we would strongly urge the parties to ensure that the KSF is fully implemented and appropriately resourced as soon as possible. We also urge the Health Departments in allocating funding to take a longer-term view of training and development, both in respect of trainees and staff in post.

PROFESSOR GILLIAN MORRIS *(Chair)*
MR PHILIP ASHMORE
MRS LUCINDA BOLTON
PROFESSOR RICHARD DISNEY
MS WILMA MACPHERSON, CBE
PROFESSOR ALAN MANNING
MR IAN MCKAY
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OFFICE OF MANPOWER ECONOMICS

15 February 2007

Chapter 1: Introduction and Background

Introduction

1.1 This is our twenty-second report on the remuneration of nurses and other health professionals[1]. A full list of staff groups covered by our remit is in Appendix A. During this review we have been served by a secretariat provided by the Office of Manpower Economics (OME). We are grateful to our officials for their help and support.

1.2 We have again this year followed the broad structure of our most recent reports. In this chapter, we set out our approach to this year's review, the context in which we have carried it out and the sources of evidence we have received. We also consider the composition of the workforce in relation to which we have been asked to make recommendations. In each chapter of the report, we set out the statistical evidence at our disposal, the evidence we have received and our comments and recommendations, where appropriate (also summarised on pages vi to viii). Chapters 2 to 7 analyse the evidence we have received in relation to the key considerations we are required to take account of under our terms of reference. Chapter 8 reviews the evidence from the parties on how they believe we should structure our recommendations in the light of the evidence they have submitted.

The context for our review this year

Our general approach

1.3 We believe it important to remind the parties of the principles which we and our predecessors have traditionally applied in reaching our recommendations. Firstly, we work independently to agreed terms of reference. Secondly, we base our recommendations on very careful consideration of all the evidence. Finally, we consider that our recommendations form a coherent package and believe they should be implemented in full.

Agenda for Change

1.4 Although national rollout of Agenda for Change (AfC) commenced in 2004, it was clear from our own informal observations during our summer 2006 visits programme that the rate of progress of assimilation of staff into the new AfC pay structure varied considerably between England, Scotland and Wales. The parties' evidence for this review confirms our observations. In England, the Department of Health reported that as at the end of April 2006, over 99 per cent of staff had been assimilated, with 4.7 per cent requiring pay protection. In Scotland, the Scottish Executive Health Department (SEHD) said that at the end of October 2006, 40 per cent of staff including bank staff, and 55 per cent excluding bank staff and those requiring job evaluation rather than job matching, had now been assimilated. In Wales, the National Assembly for Wales (NAW) told us that over 98 per cent of staff had now been matched and 57 per cent had been assimilated. Assimilation is therefore nearly complete in England, although some Staff Side bodies have made clear to us that within this general headline, the assimilation of some staff groups is lagging behind. Wales and Scotland still have some way to go to complete assimilation.

[1] Our remit was expanded as part of the Agenda for Change agreement of January 2003. Immediately prior to that, we were the Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine. Throughout this report we have used the term 'our remit group' to denote all the groups in our current remit.

1.5 Furthermore, although implementation of the Knowledge and Skills Framework (KSF) was due to have been completed by October 2006, it was also clear to us during our visits that further progress was still required by all three countries to implement fully this key element of AfC. The parties' evidence has now confirmed this. As we said in our last report, the KSF is key to the success of AfC. The KSF provides the means of recognising the skills and knowledge needed to be effective in a particular post; it ensures staff have clear and consistent objectives to help them develop; it provides for an annual appraisal and development review; and it determines the knowledge and skills required in a post before the postholder can progress through the two pay gateways within each pay band.

1.6 We also said in our last report that we believed our recommendations should concentrate on the level of the across-the-board pay award, setting aside any issues that might relate to structural change in the pay system, given that the process of implementation of AfC was not yet complete. Although progress has been made since our last review, implementation is still not complete throughout Great Britain. This variation from country to country in the rate of assimilation into AfC pay bands, and the further work needed in all three countries to implement the KSF, leads us again to the conclusion that our recommendations should concentrate on the level of the basic pay award. Until implementation is complete and it becomes possible, based on adequate evidence, to assess the impact and costs of the AfC structure and its impact on recruitment, retention and morale, there is no evidential basis on which we can recommend any structural changes to it.

Recommendations sought by the parties

1.7 The Health Departments and NHS Employers have argued again this year in favour of a simple, across-the-board, one-year only pay award. They are also arguing for the same level of uplift for both our remit group and for doctors and dentists, who fall within the remit of the Review Body on Doctors' and Dentists' Remuneration.

1.8 Although the Staff Side bodies are primarily seeking a recommendation on the across-the-board pay award for our remit group, we have also received evidence from individual staff bodies in support of national recruitment and retention premia for two groups of staff, and from the joint Staff Side in support of the introduction of a new high cost area supplement. We consider these proposals in Chapter 4. The Staff Side has put down a marker about reducing the number of incremental points in each pay band and a corresponding increase in their value over time. We consider the Staff Side's evidence on this issue in more detail in Chapter 2. UNISON has asked us to call for an equality impact assessment of the new unsocial hours scheme being negotiated under AfC and due to be introduced in April 2007. As a new scheme has yet to be agreed, we restrict ourselves at this stage to asking the parties to consider how any new scheme will be evaluated in due course.

Evidence for the review

1.9 We have undertaken our review this year in broadly the same manner as in previous years. We have carefully considered the evidence we have received and have commissioned our own research to support our deliberations. The Workforce Survey, a regular annual survey undertaken this year on our behalf by ORC International, was again commissioned to provide information on the recruitment and retention picture for our remit group (see Chapter 3). The Workforce Survey report is available on OME's website – http://www.ome.uk.com.

1.10 Once again this year we have not received sufficiently detailed evidence in relation to the specific aspects of our remit as they affect Scotland and Wales or how implementation of AfC has differed in those countries. In particular, the pay uplift proposal from those countries seems to be based on a desire to maintain consistency with England regardless of the different affordability position of each country. We discuss this further in Chapter 6.

1.11 A variety of evidence is available to inform our reviews, some of which we collect ourselves. The key workforce data available for this round are set out below and we comment further on the age of some of this data in the next paragraph:

Data	**Source to:**	**Data relating available**	**Results publicly NOHPRB report submitted (February 2007)**	**Age of data when**
NHS Staff Survey Commission	Healthcare December 2005	October to	15 March 2006	14 months
NHS Vacancy Survey	Information Centre (IC)	31 March 2006	29 July 2006	11 months
NHS Non-Medical Workforce Census	IC	30 September 2005	24 April 2006	17 months
NHS Earnings Survey[2]	IC	August 2004 (biennially)	30 August 2005	Up to 2 1/2 years
Workforce Survey	OME	31 March 2006	September 2006	11 months
Estimates of average earnings and pay drift from financial returns[3]	DH	Financial returns for 2004/05	January 2006	22 months

Key problems with the evidence

1.12 We have faced difficulties in obtaining sufficiently robust and/or up-to-date information in a number of crucial areas. We address these difficulties in greater detail in later chapters, but they include the following issues:

[2] The last published NHS Earnings Survey was undertaken in August 2004. An Earnings Survey was undertaken in August 2006, but the results are not yet available. It is hoped that the new Electronic Staff Records (ESR) will provide 2007 earnings data in time to inform the Review Body on the 2008/09 pay uplift.

[3] In late January 2007, the Department of Health sent us their estimates of average earnings for 2005/06 and their projections for future years based on the recently available 2005/06 financial returns from Trusts. This data arrived too late for us to probe it further with the Department. The data can be found at Appendix G along with the Department's original projections.

- the past and current earnings of our remit group. The last published NHS Earnings Survey was undertaken in August 2004. The latest provisional estimates of earnings based on Trust financial returns available from the Department of Health relate to March 2005 and our attempts to engage the Department of Health in a discussion of our own analysis of later official data available from the Office for National Statistics (ONS) met with little success. We discuss the Department of Health's estimates and projections of earnings and pay drift and our own attempts to reconcile their figures with those available from the Annual Survey of Hours and Earnings (ASHE) data in more detail in Chapter 7[4];

- the lack of up-to-date information on the morale of the workforce. The most recent NHS Staff Survey relates to the last quarter of 2005 and we have had to rely on the more recent staff surveys undertaken by the various Staff Side bodies to get a more up-to-date picture;

- the well-publicised financial problems within the NHS. We have endeavoured to understand the affordability evidence presented to us by the Department of Health, but we have been unable to clarify some fundamental issues. We had hoped that NHS Employers would have been able to provide us with their own independent view of affordability this year, but their evidence relies on the Department of Health's assessment of what is an affordable pay uplift; and

- the conclusions to be drawn from the NHS vacancy data. The data on vacancies are clouded this year by the unusual measures being taken within the NHS to tackle financial deficits.

1.13 Where evidence is out of date we have sought data elsewhere, particularly evidence on the average earnings increases of our remit group, given the Health Departments' emphasis on this aspect of the evidence for affordability purposes this round. We comment in more detail in Chapters 7 and 8 on the difficulties we have encountered with data this round, but for the future:

We recommend that the Health Departments and other relevant bodies should review the timing of the key surveys which inform our review to see whether we can be provided with more timely data. The Health Departments should report back to us before the beginning of our next review on the feasibility of providing more timely data.

1.14 Although affordability has been part of our terms of reference for some years now, it has been given exceptional prominence in this year's evidence from the Health Departments and from NHS Employers. There has been considerable public attention over the past year on the level of deficits within the NHS in England and examination of those deficits by various external bodies, such as the House of Commons Health Committee[5]. We consider in the relevant chapters of the report the funding available to the Health Departments, the evidence provided by the parties in support of their arguments, and the implications of the funding difficulties faced by the NHS for our recommendations this year. We also discuss in greater detail the concerns we have about the shortcomings of this evidence and the difficulties this has created for our deliberations.

[4] In late January 2007, the Department of Health sent us their estimates of average earnings for 2005/06 and their projections for future years based on the recently available 2005/06 financial returns from Trusts. This data arrived too late for us to probe it further with the Department. The data can be found at Appendix G along with the Department's original projections.

[5] House of Commons Health Committee: Report on NHS Deficits, 13 December 2006, HC 73-I & HC 73-II.

1.15 We have set out at the front of this report our terms of reference and have carefully considered the evidence relating to each issue specified in our remit. We have applied our judgement in determining the weight we should give to conflicting evidence or to the differing interpretations of the data that the parties have put forward.

Timing of our Report

1.16 Following the publication of our Twenty-First Report, our secretariat consulted the parties on the date for the receipt of written evidence for this year's review, prior to finalising this year's review timetable. It was therefore disappointing that the Health Departments' evidence was received more than two weeks late. Such delays make it more difficult for us to carry out our work in a timely fashion, but more importantly, credibility in the review process will be seriously undermined unless all parties adhere to the determined timetable. We are grateful to those who submitted their original written evidence on time and who adhered to our deadlines for supplementary evidence. We hope that next year, all parties will be able to do so.

1.17 We would also like to remind all the parties that evidence submitted to us cannot be considered fully until it is freely available to other parties. We would emphasise that the timing of our report depends upon all parties sharing information quickly and continuing to work together to a mutually acceptable timetable.

Parties giving evidence and visits made for the Twenty-Second Review

1.18 We received written and oral evidence from the three Health Departments for Great Britain, NHS Employers (NHSE), the NHS Staff Side (Staff Side), Amicus, the Chartered Society of Physiotherapy (CSP), the Royal College of Midwives (RCM), the Royal College of Nursing (RCN), the Society of Radiographers (SoR), the Transport and General Workers' Union (T&G) and UNISON. Written evidence was also received from the Federation of Clinical Scientists (FCS) and the British Orthoptic Society (BOS). We are grateful to the parties for the evidence they have given us, much of which included results from external research commissioned by the parties themselves. Individual staff organisations echoed the points raised in the joint Staff Side evidence, but also raised a number of concerns particular to their members.

1.19 During summer 2006 we visited a number of Trusts and Heath Boards across Great Britain to talk to managers, staff representatives and a wide variety of staff groups to hear their views about our recommendations for 2006/07 and those issues we should take into account when formulating our proposals for 2007/08. These discussions were wide-ranging and touched upon such issues as AfC, the financial situation in the NHS, recruitment and retention, morale and motivation, the KSF and training and development.

1.20 We always try to make our visit programme as representative as possible and last year we visited organisations providing acute, mental health, community care and ambulance services. Visits are an essential part of the review process and afford us a valuable reality-check of what life is like for our remit group 'on the ground'. We wish to thank again all those involved in organising our visits, and those staff who found the time to come and tell us their views so frankly.

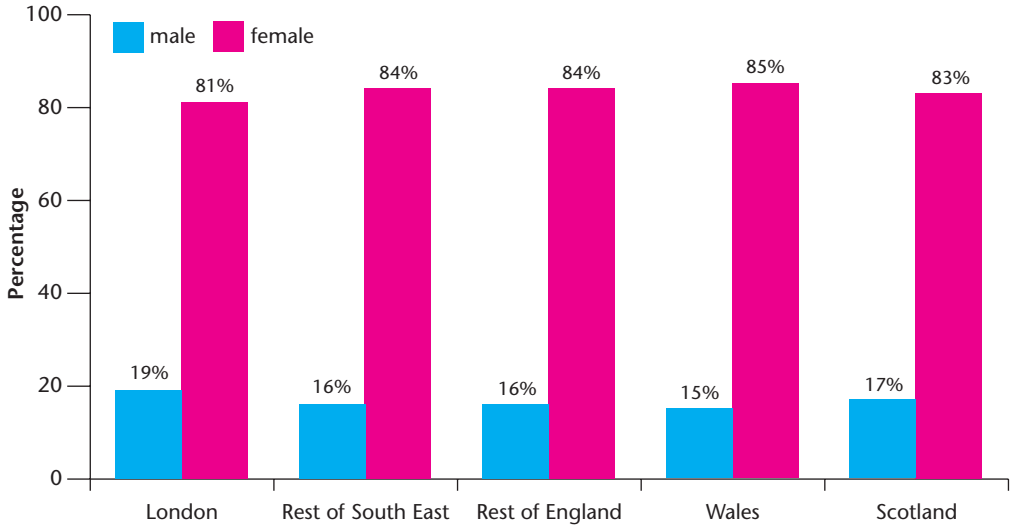
Composition of the workforce

1.21 Our remit covers a large group of staff in a wide range of occupations. As at September 2005, the headcount for our remit group was 1,002,832 staff, which represented a workforce of 797,433 Full-Time Equivalents (FTE). Since September 2004, the remit group had increased by 2.3 per cent and the equivalent FTE workforce had increased by 2.6 per cent.

1.22 Statistics on the composition of our remit group are given in Figures 1.1 to 1.4 below. The data are taken from the Labour Force Survey (LFS) datasets, March 2005 – February 2006. The figures are derived from a special exercise undertaken by OME, which used precise definitions of the NOHPRB remit group. The whole economy figures are also taken from the LFS over the same time period, and are based on all those in employment aged 16 or over.

1.23 Figure 1.1 shows the NOHPRB remit group by gender. It is clear that the large majority of nurses and other health professionals in our remit are female, and for all regions less than a fifth of staff are male. This compares to a split of 52 per cent male and 48 per cent female in the workforce for the whole economy.

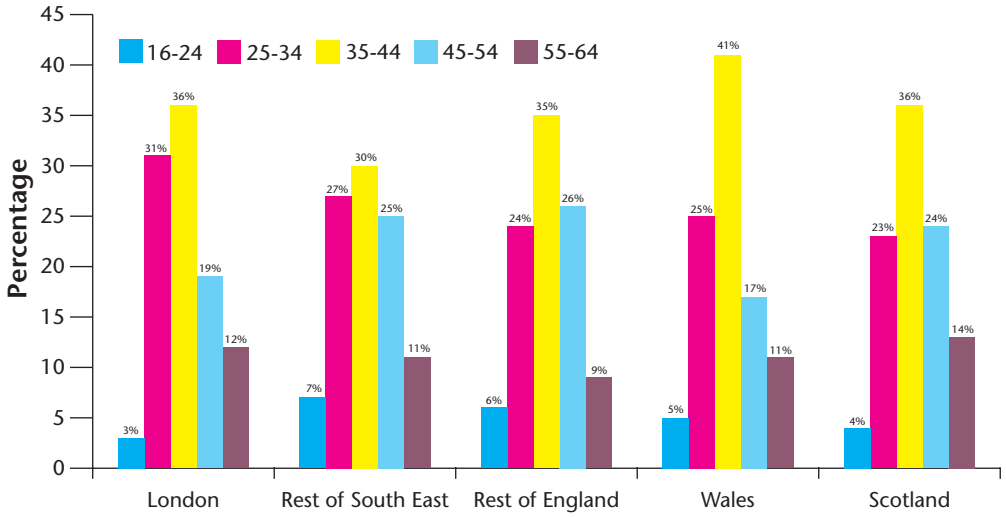
Figure 1.1: Gender Breakdown of NOHPRB Staff by region 2005



Source: Labour Force Survey, 2005.

1.24 Figure 1.2 shows the percentage directly employed in the NOHPRB remit by age. The largest proportion are aged 35-44 for all regions and countries. While London and Wales appear to have the 'youngest workforces' both still have around 30 per cent of their staff aged 45 and above, which compares to about 40 per cent in the whole economy.

Figure 1.2: Age Distribution of NOHPRB Staff by region 2005

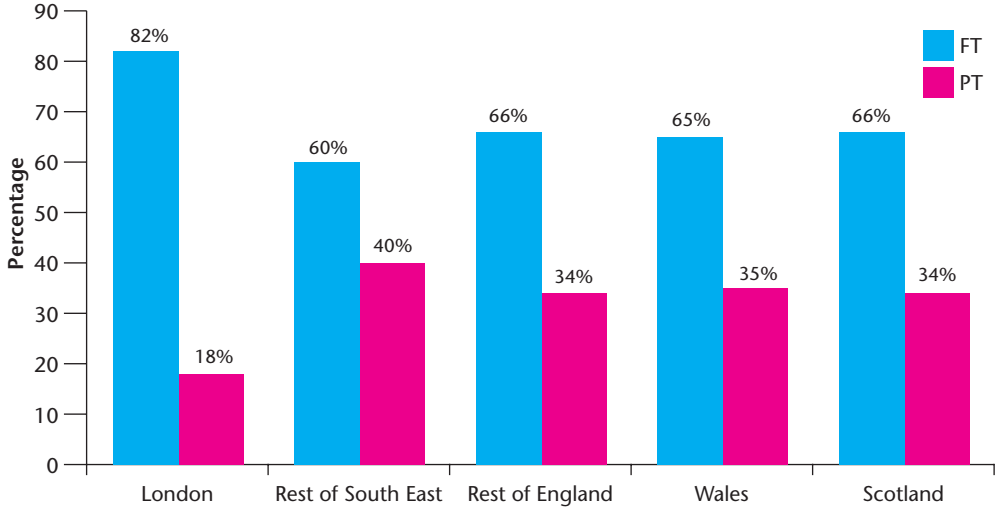


Source: Labour Force Survey, 2005.

1.25 Figure 1.3 shows the remit group by full-time and part-time status, where part-time refers to people working 30 hours or less. All regions have around a third of staff working part-time hours with the exception of London where only 18 per cent of staff work part-time and the rest of South East England, where almost 40 per cent do. This compares to around a quarter of those employed in the whole economy working part-time.

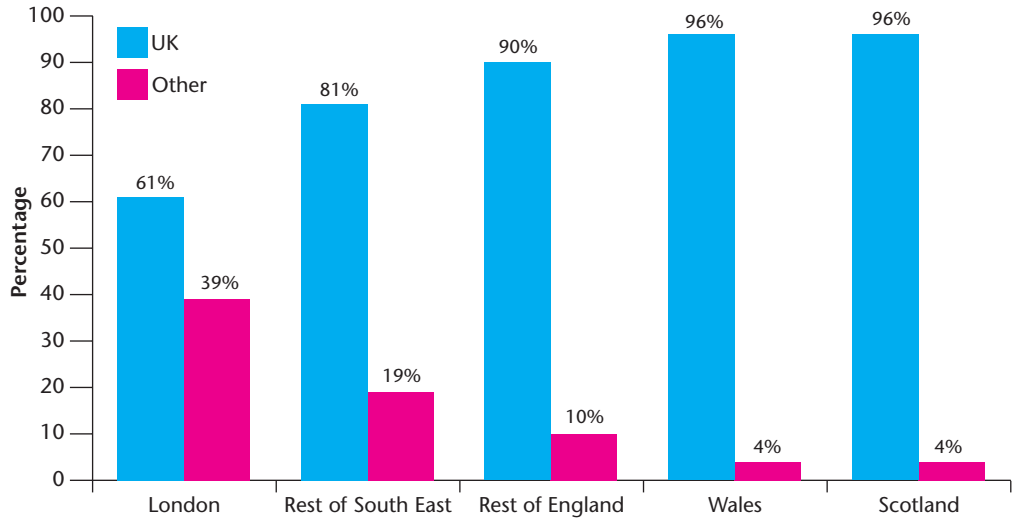
1.26 The majority of staff working in the NHS were born in the UK. However almost 40 per cent of staff in London and 20 per cent of staff in the rest of South East England were born elsewhere (Figure 1.4). This compares to nearly 10 per cent of those working in the whole economy being born elsewhere.

Figure 1.3: Full-Time or Part-Time (NOHPRB Staff) by region 2005



Source: Labour Force Survey, 2005.

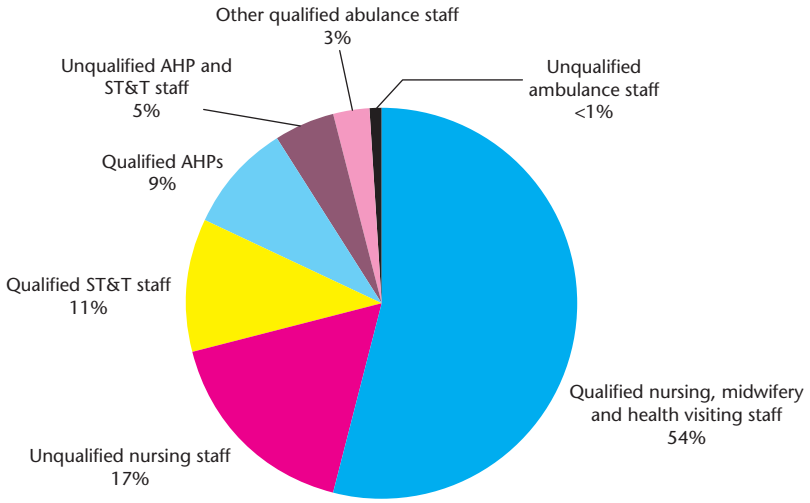
Figure 1.4: Whether UK born (NOHPRB Staff) by region 2005



Source: Labour Force Survey, 2005.

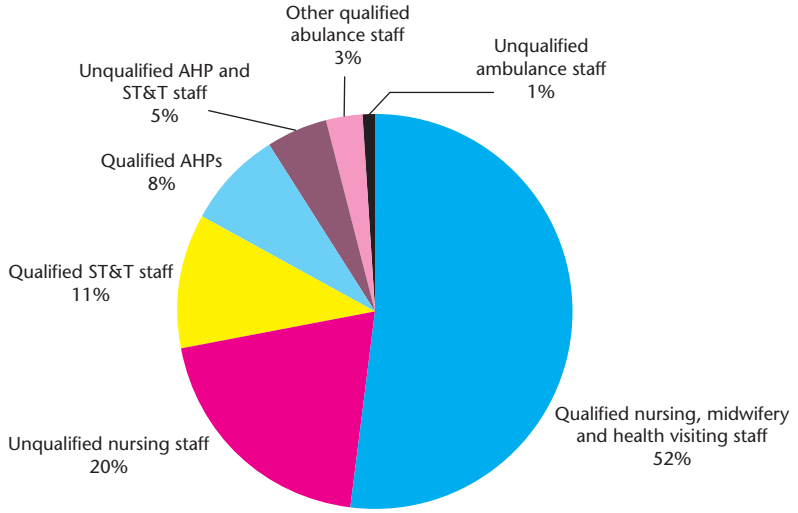
1.27 The composition of the remit group in England, Scotland and Wales by main occupation are shown in Figures 1.5 to 1.7. Data are not collected on a consistent national basis and so do not allow a Great Britain comparison to be made. Latest available data are for September 2005.

Figure 1.5: The composition of the NOHPRB remit group in England by main staff group (FTE), September 2005



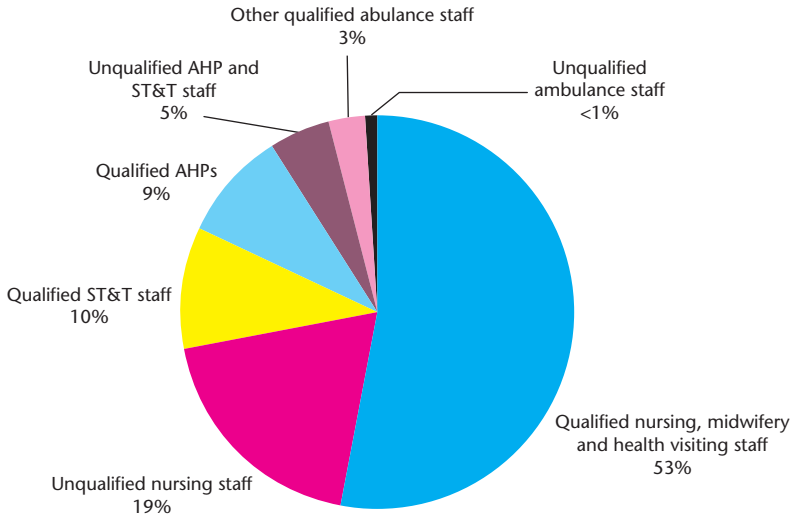
Source: NHS Health and Social Care Information Centre, Non-Medical Workforce Census September 2005.

Figure 1.6: The composition of the NOHPRB remit group in Scotland by main staff group (FTE), September 2005



Source: ISD Scotland, Non-Medical Workforce Census September 2005.

Figure 1.7: The composition of the NOHPRB remit group in Wales by main staff group (FTE), September 2005



Source: Key Health Statistics for Wales, September 2005.

Chapter 2: Equal Pay and Related Areas

Introduction

2.1 Our remit places two specific requirements on us in respect of equal pay and related areas. Firstly, there is a general requirement that in reaching our recommendations, we should take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief, and disability. Secondly, there is a specific requirement to have regard to the principle of equal pay for work of equal value in the NHS. This chapter sets out the evidence we have received in respect of these areas. We comment on the points raised by the parties later in the chapter.

Evidence from the Parties

The Health Departments

2.2 The **Department of Health** said it was important that staff were rewarded fairly for their work and the NHS job evaluation scheme contained in Agenda for Change (AfC) was being used to help ensure that staff received equal pay for work of equal value. The Department said that over 99 per cent of staff in England had been assimilated onto the new pay arrangements in AfC at the end of April 2006.

2.3 We asked the Department whether it was confident that the AfC pay scales were consistent with the recent ECJ judgment[6] in the case of *Cadman* v. *Health & Safety Executive* and the Employment Equality (Age) Regulations 2006 (the 'Age Discrimination Regulations'). The Department said that the ECJ had re-affirmed that rewarding experience was a legitimate objective with the caveat that there might be some cases where an employee could provide evidence capable of giving rise to serious doubts as to whether a particular pay system really did appropriately reward useful experience. The judgment made clear that where a pay system was based on job evaluation, it was the system itself which must be justified, not the way it treated specific individuals. The Department said that it was confident that the AfC job evaluation system, underpinned by annual personal review to support progression through the grade, was demonstrably consistent with *Cadman* and the Age Discrimination Regulations. In response to the Staff Side's request for us to consider a reduction in the number of increments over time, coupled with an increase in their value, the Department said that the system should be allowed to bed in before any changes were contemplated.

2.4 We asked the Department for views on a proposal by the Staff Side that data from the Computer Assisted Job Evaluation System (CAJE) should become a standard piece of evidence each year and that we should support the continued operation of CAJE. The Department said that as the Staff Side had indicated, there were few, if any, real conclusions that could be drawn from the CAJE data unless the numbers of staff covered by a match, not merely the number of matches, were included. Indeed, it could in some cases be misleading as a match could be to one job or to a few hundred jobs. Given this limitation and the expenditure on maintaining the system, the Department considered that it would be worth exploring in more detail what the Staff Side were considering would be "standard" evidence for the future. The Department explained that whilst CAJE had the functionality to include gender and ethnicity, recording these data in CAJE was a matter for individual NHS employers. It pointed out that gender/ethnicity information was available from most payroll systems.

[6] Case C-17/05 *Cadman* v. *Health & Safety Executive,* judgment of the European Court of Justice, 3 October 2006.

2.5 Responding to UNISON's concerns about future possible recruitment and retention issues for certain staff groups in the light of job matching outcomes, the Department said that this was a matter for NHS Employers. The Department believed there was adequate monitoring of AfC outcomes and that monitoring arrangements were set out in the AfC agreement. The Department did not believe that it was part of our role to commission an equal pay audit of AfC outcomes, as proposed by Amicus. With regard to Amicus' proposal that we should seek evidence next year on the distribution of staff across the pay bands, the Department said that its evidence already included data on pay and earnings. It was continually looking at how this could be improved using data from the new Electronic Staff Record (ESR) as it rolled out across the NHS.

NHS Employers (NHSE)

2.6 **NHSE** said that significant numbers of cases, generally pre-dating AfC, had been lodged by staff against NHS organisations under equal pay legislation. The AfC agreement set out fair pay and improving all aspects of equal opportunity and diversity as key objectives.

2.7 The NHS Staff Council had set up the Equalities and Diversity Sub Group (EDSG) to examine how equalities issues relating to AfC could be looked at in a partnership way. The EDSG would be conducting an equality impact assessment following the implementation of AfC, but lack of central information pending the full roll-out of the ESR was a problem. The EDSG was looking at how national monitoring could be conducted and at the information available from CAJE and e-KSF. In future, the ESR would be the best way of collecting information on workforce gender and ethnicity; the NHS Staff Council had already made clear employers' duty to collect equality information but individuals may choose not to categorise their ethnicity to their employer. A review of the equality strands of the AfC terms and conditions handbook was also being undertaken to ensure that it was consistent with best practice and developments in equalities legislation. The review would take account of new legislation, for example, the European Directive on Age, and legal precedents such as *Cadman* v. *HSE.*

2.8 NHSE told us that employers' representatives were working with trades unions on the NHS Staff Council's Job Evaluation Group (JEG) to monitor job evaluation outcomes collected through CAJE and to ensure that the system remained fit for purpose.

2.9 Responding to the Staff Side's proposals on future CAJE data, NHSE said that it was important CAJE was used and the system needed to be maintained in order to evaluate new jobs, but like the Department of Health, NHSE stressed that CAJE data did not relate to individual posts. Funding to maintain CAJE post-2010 would need to be discussed with the Department. If the parties agreed that it would be useful, NHSE said that it would be content to provide us with updates from CAJE to inform our evidence and to help identify trends. NHSE said that the JEG's consistency monitoring sub-group was happy to consider requests to monitor specific groups of outcomes. NHSE said that it was not our role to carry out an equal pay audit of AfC outcomes.

2.10 NHSE said that it had yet to consider fully the implications of the recent ECJ judgment in *Cadman*, but its general view was that there remained a reasonable justification for the length of AfC pay scales on the grounds that they rewarded loyalty, improved motivation, encouraged recruitment and retention and recognised experience and had been collectively agreed for this purpose. It was important that pay progression was underpinned by the Knowledge and Skills Framework and development review process. Any changes to incremental scales would have significant cost implications, would reduce the scope for career progression and would alter the carefully negotiated architecture of AfC.

2.11 Staff bodies generally supported the objectives underlying AfC, but a number of them[7] expressed concerns about aspects of its implementation such as the process of job matching and consistency checking, and the slow progress of assimilation for some groups such as radiographers. There were perceptions that some pay banding outcomes were:

- unfair, inappropriate and not fully reflective of roles or responsibilities;
- determined by the available budget or subject to pressure from Trusts to alter skill mix or establishment because of lack of funding; or
- inconsistent for similar jobs in different Trusts.

2.12 We were asked to make recommendations about some specific issues. The joint **Staff Side** and **UNISON** thought that the CAJE data would provide useful indicators of pay-related issues in future years and we were asked to recommend an update of the data each year as a standard piece of evidence for our review. They also asked us to support their recommendation that the CAJE system should continue to be operated by individual NHS organisations and that NHSE should provide for the long-term ability of the system to be interrogated and monitored on an ongoing basis. UNISON drew our attention to the problems it believed should be investigated regarding the job matching of Band 4 nurses, ambulance despatch staff and occupational therapists, as it considered that this could have a potential impact on the future recruitment and retention of these groups. UNISON also called for further monitoring of AfC outcomes and a requirement to report back to us next year. **Amicus** asked us to invite evidence next year on the distribution of staff across the pay bands and for us to seek to determine whether any differential spread in outcomes could be justified with a view to making a recommendation on salary progression for negatively affected groups. Amicus said that recruitment and retention problems which may have led to claims for a Recruitment and Retention Premia might in fact arise from poor access to salary progression through the AfC pay bands.

2.13 The **T&G** told us it was concerned there was a significant pay gap between men and women working in the ambulance service, but acknowledged it was difficult to draw any definite conclusions from the 2005 Annual Survey of Hours and Earnings survey data because of the much smaller number of females in the sample. It confirmed that it would be monitoring the data in future years to determine whether there was a trend over time.

2.14 Amicus believed that AfC should be independently audited by an organisation with appropriate expertise. It proposed that the Office of Manpower Economics commission an equal pay audit of AfC outcomes. UNISON said it expected to see future monitoring and equality impact work undertaken to ensure that access to pay progression was not subject to gender bias.

[7] Staff Side, Royal College of Nursing, Royal College of Midwives, Amicus, Society of Radiographers, T&G, Federation of Clinical Scientists and British Orthoptic Society.

2.15 The Staff Side and UNISON also directed our attention to the possible implications of *Cadman* v. *HSE*. Staff Side said this decision had raised serious doubt as to whether the number of incremental points in the AfC pay scales could be objectively justified. Staff Side was seeking a reduction in the number of increments over time and a corresponding increase in their value. UNISON also asked us to consider recommending a reduction in the number of incremental pay points in each pay band. In the light of *Cadman*, it was desirable that the NHS should move progressively to reduce the number of incremental points to a maximum of five in each band, rather than waiting for what UNISON considered to be the inevitable legal challenge. The Government should provide funding for this to happen and the NHS Staff Council should agree the precise mechanism for the changes.

2.16 Finally, NHSE and UNISON described the difficulties that had arisen with the two different mechanisms for determining the pay uplift for staff covered by AfC under this Review Body and the Pay Negotiating Council (PNC). NHSE said that equal pay for work of equal value was central to the AfC framework and it would be unsustainable to have differential uplifts to the national pay spines. NHSE, the Health Departments and other national stakeholders had been discussing the scope for harmonised arrangements in the future. One of the options being discussed was an extension to our remit. UNISON referred to the feeling among PNC groups last year that they had been 'disenfranchised'. It was consulting internally on the option of a widened role for this Review Body; another option might involve moving towards a wholly negotiated structure for NHS pay.

Our Comment

2.17 In our last report, we discussed in some detail how we would be approaching the requirement in our remit to have regard to the principle of equal pay for work of equal value. We had some concerns about how we could meet the requirements in AfC regarding the interface with the pay of staff groups outside our remit (those covered respectively by the Doctors' and Dentists' Review Body (DDRB) and the PNC). These concerns remain and we note that the parties themselves are now considering future pay arrangements for the PNC staff groups. We hope these discussions result in a practical solution that all parties can support. In the meantime and given our continuing concerns here, we have proceeded in the same way this year as last, basing our recommendations solely on the evidence we have received in respect of our remit group. The Health Departments and NHSE have said in their written evidence that they are seeking the same pay uplift figure for both our remit group and the DDRB's remit group. However, it is important to emphasise that the two Review Bodies operate entirely independently. Both we and the DDRB make our recommendations based on evidence and there is no reason why the same conclusion should be reached by the two Review Bodies.

2.18 We asked the parties to address in their written evidence and at oral evidence sessions whether they wished to draw to our attention any issues relating to equal pay or other discrimination issues relating to pay. As discussed earlier in this chapter, some Staff Side bodies have raised possible equality concerns surrounding certain aspects of the implementation of AfC. We have been asked as a result to support various proposals, such as the continued operation in the longer term of the CAJE system by the NHS, and to undertake certain actions ourselves, such as an equal pay audit of AfC outcomes. However, whilst we wish to be kept informed of measures being taken in this regard, it is not our role to oversee the proper implementation and operation of AfC and to ensure it achieves its objective of providing equal pay for work of equal value. This is a matter for the parties working in partnership.

2.19 To that end, we are pleased that the NHS Staff Council has set up the EDSG and that the EDSG will be conducting an equality impact assessment following the implementation of AfC. It is right that the parties should assess the initial impact of AfC and that this should also be monitored going forward. How this is done, at what frequency and what information and resources are required to achieve it, should be a matter for discussion between the parties in the NHS Staff Council. We have been asked to support the continuation of the CAJE system as a source of information on AfC outcomes, although all parties acknowledge the limitations of the system. It may be that CAJE has a role to play at least until the ESR is fully rolled out, but we believe that the parties, through the NHS Staff Council, should discuss information needs for monitoring purposes. NHSE has told us that the consistency monitoring sub-group of the NHS Staff Council's JEG would be happy to consider requests to monitor specific groups of CAJE outcomes, if this would be helpful. We welcome this and ask the Staff Side bodies that have raised concerns with us about particular groups to pursue them through this mechanism.

2.20 We would ask the parties to update us in evidence each year on the broad outcomes of the equality impact monitoring exercises and we will continue to ask the parties each year whether there is any evidence of any equal pay issues or other discrimination issues relating to pay emerging which we need to consider. We also remind the parties of our comment in last year's report that given the wide nature of our remit, the parties should ensure that the data they collect go beyond gender considerations alone to look at other areas of potential discrimination such as age, race and disability.

2.21 Accurate data are key to a proper assessment of the impact of AfC and it is clear from the parties' evidence that information will not be available centrally until the ESR is fully rolled out. Amicus has asked us to invite evidence for next year on the distribution of staff across the pay bands and for us to consider making a recommendation on salary progression in the light of such information. Accurate data on the distribution of staff across pay bands is a matter of concern to us and we will discuss this in more detail in Chapters 7 and 8. However, the mechanism for salary progression through and between pay bands is an agreed part of the AfC structure and its proper application is a matter for the parties to oversee, not us. That said, we would expect the system to operate as agreed, not only because of any contractual entitlements to which it may give rise, but also because of the likely consequences, initially for staff morale and in the longer term for retention, if it does not.

2.22 Late in the round UNISON drew our attention to the joint Staff Side's concerns about what was said to be the SEHD's decision to exclude cohorts of senior managers from the AfC agreement. The Staff Side considered this raised new equal pay issues. We note that the SEHD views the situation differently. To the extent that any equal value issues may arise as a result of the SEHD's action which affect any of the staff falling within our remit, we would encourage the parties to discuss and resolve these issues quickly and amicably.

2.23 Several Staff Side bodies indicated their belief that AfC pay scales may not be consistent with the ECJ decision in *Cadman* v. *HSE*. They have suggested that the NHS should move over time to reduce the number of increments in each pay band. The Department of Health and NHSE on the other hand have indicated their belief that AfC pay scales are consistent both with *Cadman* and with the Age Discrimination Regulations. It is important for all sides to remember that pay progression under AfC is underpinned by the KSF and development review process, rather than being automatic. Given the crucial role of the KSF in this and other contexts, the delay in its implementation is regrettable. We urge all parties, including the Health Departments, to give renewed emphasis to completing the implementation of KSF expeditiously and to ensuring that development reviews are being conducted in accordance with the AfC agreement.

Chapter 3: Recruitment and Retention

Introduction

3.1 In this chapter we review:

- the key results of the 2006 Workforce Survey carried out by the Office of Manpower Economics (OME) (the results are reviewed further in Appendix F);
- vacancies in the NHS, including the NHS Vacancy Survey; and
- evidence from the parties.

As there is clearly a strong link between some aspects of recruitment and retention and issues affecting morale and motivation, there is some overlap of the evidence covered in this chapter and that in Chapter 5.

OME 2006 Workforce Survey

3.2 Again last year OME carried out a Workforce Survey covering Trusts and Health Boards in Great Britain. Some summary tables are reproduced in Appendix F and summary results are included in this chapter. Full results appear on the OME website at http://www.ome.uk.com. There are two parts to the survey: Part a, The Telephone Survey, covers recruitment and retention issues as reported by managers in Trusts or Health Boards in Great Britain; Part b, The Main Data Collection, covers joining, turnover and wastage rates as a proportion of staff in post.

a) The Telephone Survey

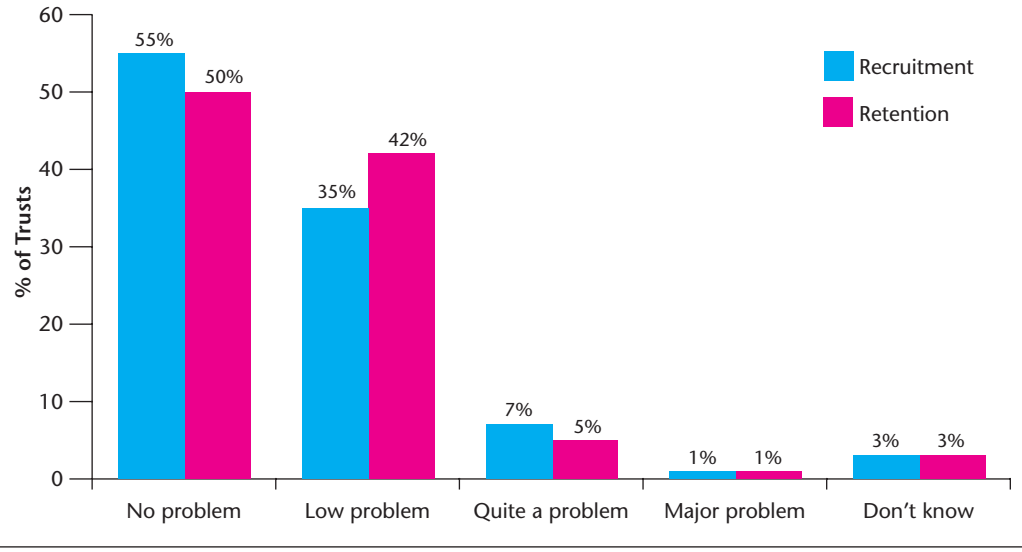
3.3 The 2006 Workforce Survey provided an opportunity for Trust and Health Board managers to indicate the extent to which they had recruitment and retention difficulties for staff in each grade[8]. This part of the survey was carried out separately from the main data collection exercise as a ten-minute telephone interview between June and August 2006. All 601 Trusts in Great Britain (564 in England, 14 in Wales and 23 in Scotland) were contacted to take part in this survey. Of these, 401 completed interviews were achieved (377 in England, 13 in Wales and 11 in Scotland), giving a 67 per cent response rate overall.

Nursing staff, midwives and health visitors

3.4 As shown in Figure 3.1, the vast majority of Trusts and Health Boards had either 'no problem' or a 'low problem' with recruiting or retaining staff. Just eight per cent (as compared to 24 per cent in 2005) and six per cent (15 per cent in 2005) said that they either had 'quite a problem' or a 'major problem' with recruitment and retention respectively.

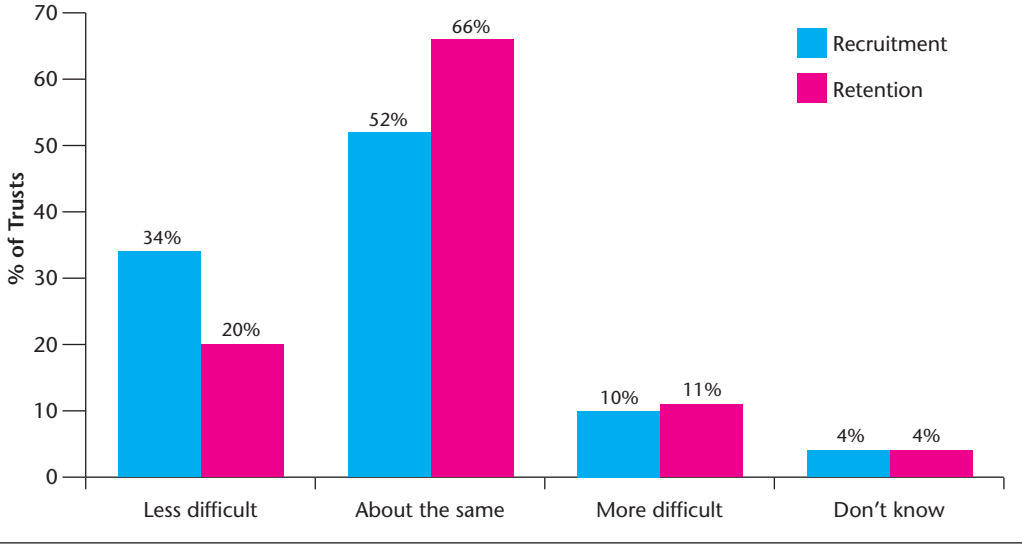
[8] Results are presented on an aggregate basis for Trusts and Health Boards and do not, unless otherwise indicated, necessarily mean that a majority of Trusts and Health Boards, for example, indicated a specified view.

Figure 3.1: Distribution of the extent to which NHS Trusts and Health Boards had recruitment and retention difficulties for Great Britain (nursing staff)



3.5 On balance recruitment and retention appeared to be improving, with a third of Trusts and Health Boards reporting that recruitment was 'less difficult' in 2006 than in 2005 and a fifth of Trusts and Health Boards reporting that retention was 'less difficult' (Figure 3.2).

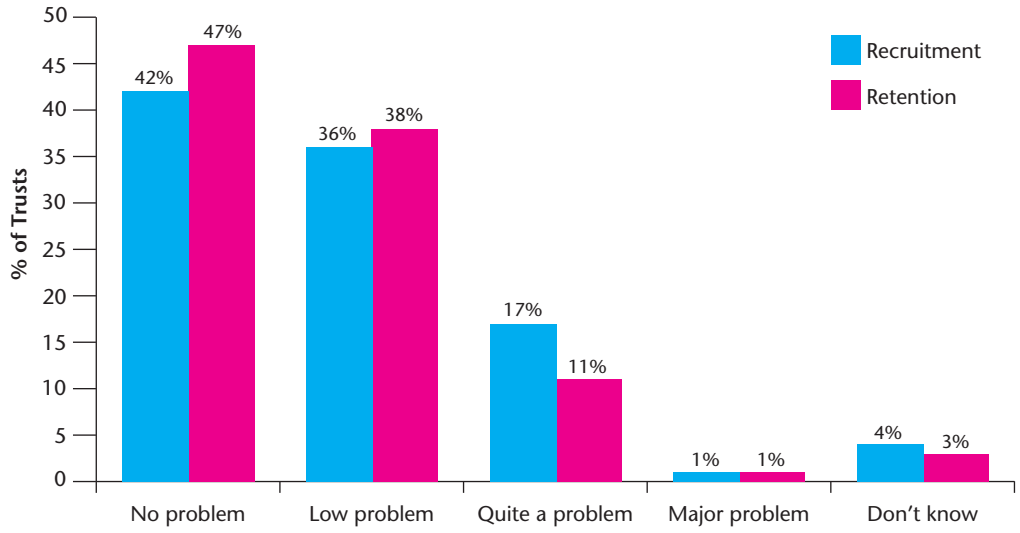
Figure 3.2: Change in recruitment and retention difficulties in NHS Trusts and Health Boards over the last year for Great Britain (nursing staff)



Allied Health Professionals (AHPs)

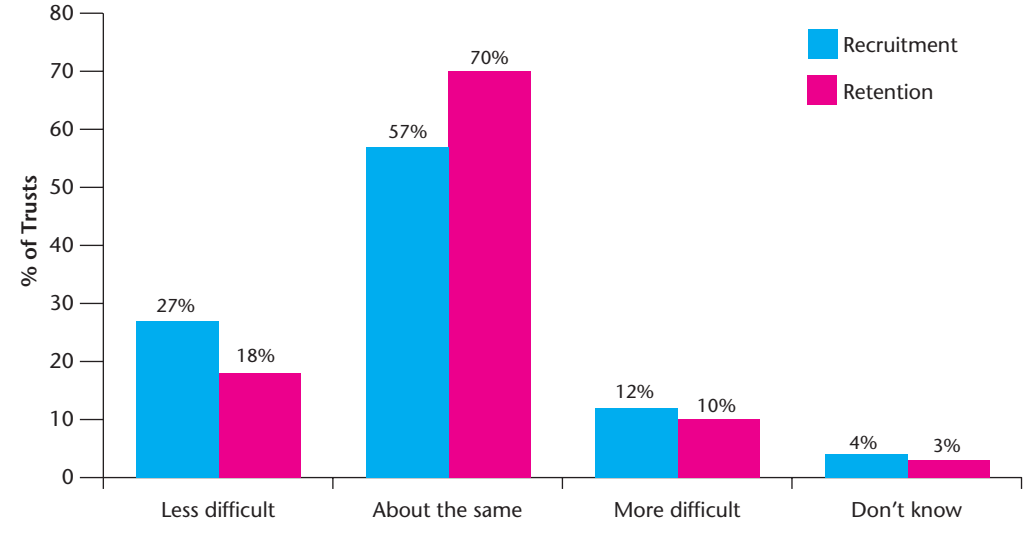
3.6 For AHP staff 17 per cent (34 per cent in 2005) of Trusts and Health Boards said they had 'quite a problem' recruiting AHP staff, while just one per cent (five per cent in 2005) had a 'major problem' in doing so (Figure 3.3). Over 40 per cent of Trusts and Health Boards had 'no problem' recruiting such staff. Retention of AHPs, as with nurses, appears to be less of a problem than their recruitment. Eighty-five per cent of Trusts and Health Boards had 'no problem' or a 'low problem' with retention, while only one per cent had a 'major problem'.

Figure 3.3: Distribution of the extent to which NHS Trusts and Health Boards had recruitment and retention difficulities for Great Britain (AHP staff)



3.7 On balance, the recruitment and retention situation for AHP staff appears to have improved since 2005 (Figure 3.4).

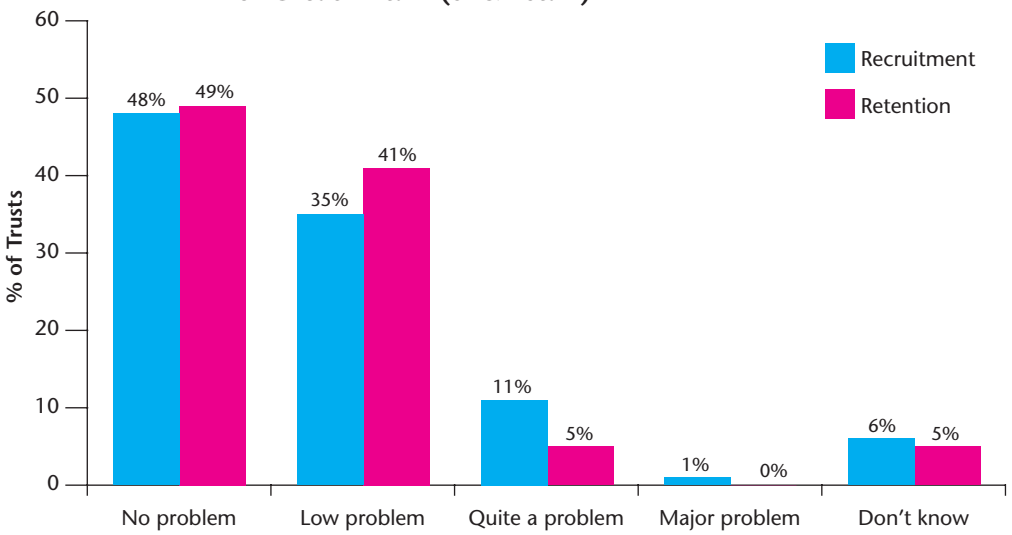
Figure 3.4: Changes in recruitment and retention difficulties in NHS Trusts and Health Boards over the last year, for Great Britain (AHP staff)



Other Scientific, Technical and Therapeutic (ST&T) staff

3.8 As with nursing and AHPs, Trusts and Health Boards were asked how they would assess the recruitment and retention situation of their ST&T staff. Twelve per cent of Trusts and Health Boards answered that they had 'quite a problem' or a 'major problem' with recruitment, while just over a third had a 'low problem' and nearly half felt they had 'no problem' (Figure 3.5). This compares to almost a quarter of Trusts and Health Boards reporting they had 'quite a problem' or a 'major problem' in 2005. Retention of ST&T staff again appeared to be less of an issue than recruitment.

Figure 3.5: Distribution of the extent to which NHS Trusts and Health Boards had recruitment and retention difficulties for Great Britain (ST&T staff)



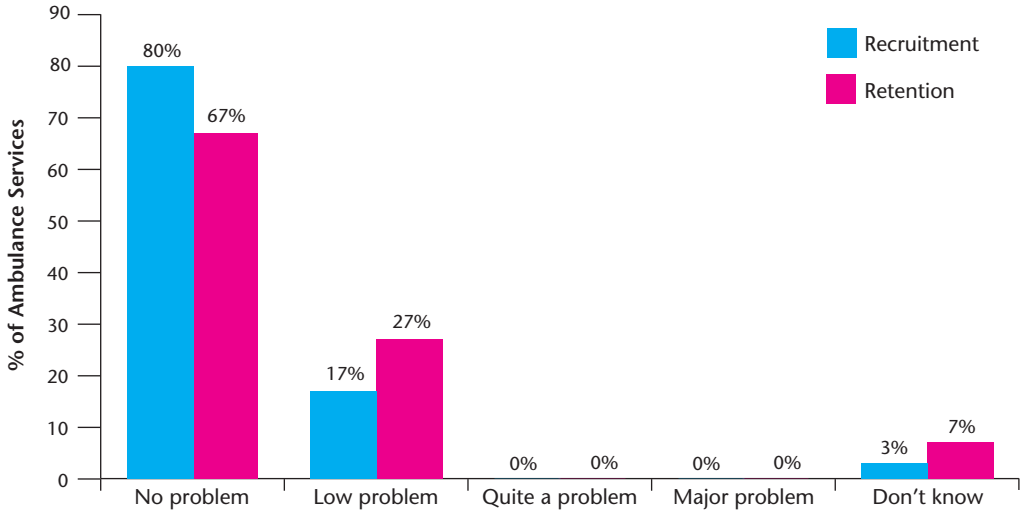
3.9 The recruitment situation for ST&T staff appears to have marginally improved since last year. Eight per cent thought recruitment had become 'more difficult' than last year, while 18 per cent said it had got 'less difficult'. Retention problems also appear to have improved a little since last year.

Ambulance staff

3.10 Thirty Ambulance Services participated in the telephone interview, of which 20 were Ambulance Trusts. Care should be taken when interpreting the results because of the low number of available participants.

3.11 Eighty per cent of Ambulance Services answered that they had 'no problem' with recruitment, while 17 per cent recorded that they had a 'low problem'. No Ambulance Service answered that they had 'quite a problem' or a 'major problem' (three per cent in 2005) (Figure 3.6). Retention of ambulance staff appeared to be similar to recruitment, although more Ambulance Services recorded they had a 'low problem' compared with recruitment.

Figure 3.6: Distribution of the extent to which Ambulance Services had recruitment and retention difficulties for Great Britain (ambulance staff)



b) Main Data Collection – Joining, Turnover and Wastage rates.

3.12 The survey was sent to 578 Trusts in England and Wales, including Ambulance Trusts, in June 2006. Two hundred and seventy-eight Trusts responded, giving a response rate of 48 per cent, which was similar to the response rate for the 2005 survey. Unfortunately, throughout the analysis a high proportion of Trusts were unable to say where joiners had come from and where leavers were going and this non-response should be borne in mind when interpreting these results.

3.13 The Information Statistics Division (ISD) of the Scottish Executive Health Department collects separate data from Scottish Health Boards on joiners and leavers in Scottish Health Boards. In contrast to the England and Wales Workforce Survey, these data show staff movements over the year to 30 September 2005 (rather than to 31 March 2006) and additionally include staff movements *between* Health Boards. It is not possible to say whether joiners were newly qualified staff, returners to NHS Scotland or joiners from the NHS in England or Wales. Similarly, no information was recorded about the destination of leavers. As the Scottish data are collected on a different time and turnover basis from the Workforce Survey they are presented separately from the English and Welsh turnover information.

3.14 Turnover information in England and Wales is looked at in terms of results for the sample as a whole and a matched sample comparing 2006 with 2005. The matched sample results take into account any changes in the composition of the sample, so that like Trusts are compared with like Trusts in the two years. For the reasons above, it is not possible to include Scottish data in the matched analysis.

3.15 Some common definitions:

England and Wales	• Year to 31st March 2006.
	• Staff in post figures are based on the end of year figures (31st March 2006).
Scotland	• Year to 30th September 2005.
	• Staff in post are based on the average over the year to September 2005[9].
	• Wastage rates are not possible to calculate, as Scotland does not collect information on whether leavers join the NHS in England or Wales.
	• The joining and turnover rates include staff movements between Scottish NHS Health Boards.
Joining rate	• Number of joiners as a proportion of staff in post.
Turnover rate	• Number of leavers as a proportion of staff in post.

3.16 A matched sample comparison with the results of the 2005 Workforce Survey was produced. The matched sample results should be used when comparing workforce survey data in England and Wales between the two years 2005 and 2006, because these will be less affected by changes in the composition of the samples between years.

3.17 The 2006 Workforce Survey shows falls in the joining rates for all staff groups overall (Box 3.1, Table B). The turnover rate also fell for all staff groups, with the highest fall seen among the ST&T staff group (Box 3.1, Table D). The wastage rate fell for all staff groups as well, with the exception of AHPs, where it remained the same, and ambulance staff where the wastage rate rose (Box 3.1, Table D). The wastage rate is the best measure of the percentage of staff leaving the NHS.

Occupational analysis

Wastage

3.18 The average wastage rate for the NOHPRB remit group as a whole was 8.4 per cent. The highest rate of wastage, at 11.4 per cent in 2006, was for pharmacists, followed by occupational therapists (10.8 per cent). The lowest rate of wastage was recorded for medical physicists (4.6 per cent) followed by pathologists (5.8 per cent) and diagnostic radiographers and RSCNs[10] (both 6.1 per cent). The wastage rates of all ambulance staff by grade were under five per cent except for the grade trainee ambulance personnel, which stood at seven per cent in 2006.

Turnover

3.19 The average turnover rate for the NOHPRB remit group as a whole was 10.7 per cent. The highest rates of turnover were among occupational therapists (15.1 per cent), pharmacists (14.5 per cent) and dieticians (13.6 per cent) and the lowest rates were for medical physicists (5.6 per cent), pathologists and operating theatre staff (both 7.5 per cent).

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[9] Staff in post figures also include those joining or leaving for another staff specialty within the same NHS board.

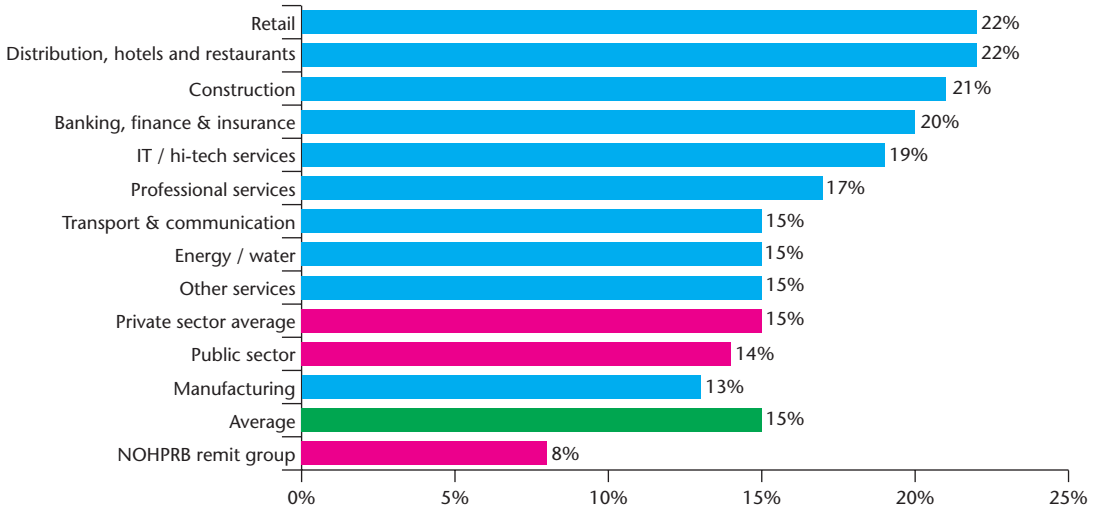
[10] Registered Sick Children Nurses.

3.20 Typically there were higher rates of wastage, turnover and joining among the staff supporting qualified professionals.

Sectorial analysis

3.21 Both the Chartered Institute of Personnel and Development (CIPD) and the Confederation of British Industry (CBI) have published their whole economy figure for labour turnover for 2005. According to the CIPD's annual *Recruitment, retention and turnover survey*, the median labour turnover rate for 2005 was 18.3 per cent, compared with 15.7 per cent in 2004 and 16.1 per cent in 2003 and 2002. In its survey of absence and labour turnover, *Who cares wins*, the CBI gives a figure of 15 per cent for average labour turnover during 2005, only marginally below its findings over the previous three years. The average wastage rate for the NOHPRB remit group as a whole, calculated from the full Workforce Survey sample in England and Wales, was 8.4 per cent[11]. This is charted against sectorial rates recorded in the CBI's Absence and Labour Turnover Survey 2006 below (Figure 3.7).

Figure 3.7: Labour turnover by sector, 2005



Source: CBI Absence and labour turnover and 2006 Workforce Survey.

[11] The wastage rate is used when comparing turnover rates in the private sector because their turnover rate does not include internal transfers and is therefore equivalent to our definition of wastage – 'leavers excluding transfers to other NHS Trusts, as a proportion of staff in post'.

Box 3.1: 2006 Workforce Survey

Recruitment

A – Staff joining Trusts as a proportion of staff in post (for sample as a whole)

Main staff group	England and Wales (in the year to 31 March 2006)	Scotland (in the year to 30 September 2005)
NOHPRB	12.1%	11.8%
Nurses	11.5%	11.9%
AHPs	16.1%	14.2%
ST&T	13.2%	11.7%
Ambulance	9.9%	14.4%

B – Staff joining Trusts as a proportion of staff in post in the year to 31 March (Matched sample)

Main staff group	England and Wales only	
	2005	2006
NOHPRB	13.7%	12.0%
Nurses	13.0%	11.4%
AHPs	17.6%	16.3%
ST&T	15.2%	12.3%
Ambulance	12.8%	9.7%

Retention

C – Turnover rates and wastage (sample as a whole)

Main staff group	England and Wales (in the year to 31 March 2006)		Scotland (in the year to 30 September 2005)	
	Turnover	Wastage	Turnover	Wastage
NOHPRB	10.5%	8.4%	9.9%	–
Nurses	10.5%	8.4%	10.1%	–
AHPs	12.2%	9.5%	10.0%	–
ST&T	11.0%	9.0%	8.3%	–
Ambulance	5.3%	4.1%	11.6%	–

D – Turnover rates and wastage in the year to 31 March (Matched sample)

	England and Wales only			
	Turnover		Wastage	
	2005	2006	2005	2006
NOHPRB	11.1%	10.7%	8.8%	8.4%
Nurses	10.8%	10.5%	8.6%	8.2%
AHPs	12.9%	12.6%	9.8%	9.8%
ST&T	12.8%	11.3%	10.5%	9.0%
Ambulance	4.3%	3.4%	2.8%	3.2%

E – Turnover rates and wastage in the year to 31 March, by selected occupational groups

	England and Wales		Scotland	
	Turnover	Wastage	Turnover	Wastage
Midwives	8.3%	6.6%	8.1%	–
Health Visitors	9.5%	7.2%	11.0%	–
District Nurses	9.5%	7.7%	9.9%	–
Nurse auxiliaries and assistants	11.9%	10.5%	11.0%	–
Pharmacy	14.5%	11.4%	*	–
Dietetics	13.6%	10.1%	9.9%	–
Occupational therapy	15.1%	10.8%	11.1%	–
Diagnostic radiography	8.0%	6.1%	*	–
Therapeutic radiography	10.6%	8.2%	*	–
Medical physicists	5.6%	4.6%	*	–

** Scotland does not provide disaggregated data for these occupational groups.*
– not available.

Vacancies in the NHS – the NHS Vacancy Survey

Summary

3.22 The three-month vacancy rates in England, Wales and Scotland fell for all the main staff groups in March 2006 compared with the previous year. The only exception was ambulance staff in England, for which the three-month vacancy rate rose by 0.7 percentage points. However, difficulties remain for certain key groups, such as therapeutic radiography which had a vacancy rate of 4.8 per cent.

The data

3.23 NHS Vacancy Surveys are commissioned for England, Scotland and Wales: the surveys ask Trusts and Health Boards how many vacancies, as at 31 March 2006, they had actively been trying to fill, which had lasted for three months or more. The results are expressed both as a percentage of staff in post and as the actual number of three-month vacancies. The staff in post figures come from the September 2005 non-medical workforce censuses. Scotland only provides vacancy data for nurses and AHPs and in 2006 was unable to publish detailed data as it was still in the process of implementing Agenda for Change (AfC). All figures are based on Full-Time Equivalents (FTE).

Problems

3.24 It is best to focus on **trends** rather than absolute levels of vacancies. This is because the true **level** of vacancies can be masked by re-structuring the work or staff mix, and by the use of short-term appointments, bank or agency staff. Vacancies can also be used by management to influence and justify budgets, i.e. to ensure resources are maintained at higher levels, and vacancies can remain unfilled for a long period of time because of unusually long recruitment processes, e.g. waiting for references from previous employers or checks against professional registers. Furthermore, some vacancies may be left open in order to accommodate staff who are temporarily not working, e.g. on maternity leave or unpaid leave, and posts are required for their return.

3.25 Staff Side suggested that while the majority of professions had experienced a reduction in vacancy rates, these were attributable to job cuts and recruitment freezes, rather than a reduction in staff shortages. Furthermore they were again concerned about the way in which vacancy data are compiled by the Health Departments. They argued that the figures were not a truly representative picture as they only showed posts that had been vacant for three months or more and the data were not detailed enough to highlight recruitment difficulties affecting specific bands and specialties within staff groups.

Results

(a) England

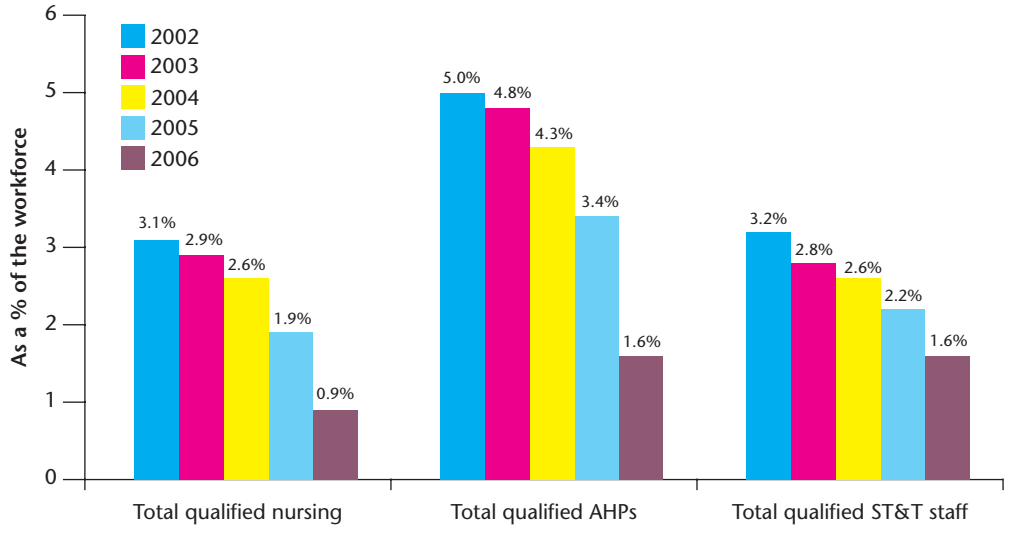
3.26 For qualified nurses, midwives and health visitors as a whole the vacancy rate was 0.9 per cent, a fall of one percentage point since 2005[12]. This is at least the fifth successive year in which this vacancy rate had fallen (Figure 3.8). Vacancy rates fell for all the qualified nursing staff groups; however vacancy rates were still above average for community and other psychiatry, which stood at 1.6 per cent and 1.5 per cent respectively.

[12] The 2005 figures also relate to 31 March.

3.27 For qualified AHPs the vacancy rate was 1.6 per cent in 2006, a fall of 1.8 percentage points compared with 2005, and the fourth consecutive year this rate had fallen. Although rates have fallen for all allied health professions, difficulties remain among certain key groups. In therapeutic radiography and occupational therapy, vacancy rates are relatively high compared to other NHS non-medical professions with rates at 4.8 per cent and 2.3 per cent respectively.

3.28 For qualified Scientific Therapeutic and Technical (ST&T) staff the 2006 vacancy rate was 1.6 per cent, a fall of 0.6 percentage points since 2005, the fifth consecutive year this rate had fallen. Of the professions included in ST&T staff both multi-therapies and pre-registration pharmacy trainees saw a small increase in their vacancy rates to 8.6 and to 2.9 per cent respectively.

Figure 3.8: Three-month vacancy rates for main qualified staff groups 2002/06 (England)



Source: The Information Centre 2006 vacancy survey.

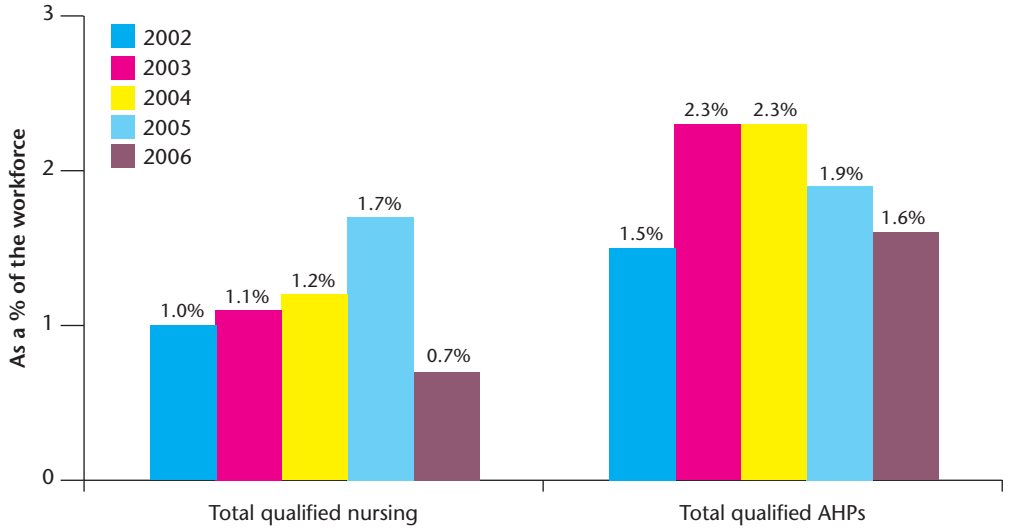
(b) Scotland[13]

3.29 For qualified nurses, midwives and health visitors in Scotland as a whole, the three-month vacancy rate was 0.7 per cent in 2006, a fall of one percentage point over 2005. This is the first year that vacancy rates had fallen for over five years (Figure 3.9).

3.30 For qualified AHPs the vacancy rate was 1.6 per cent in 2006, a fall of 0.3 percentage points compared with a year previously and the second time they had fallen since peaking in 2003 and 2004.

[13] Scotland only provide vacancy data for nursing and AHPs.

Figure 3.9: Three-month vacancy rates for main qualified staff groups 2002/06 (Scotland)



Source: ISD Scotland, 2006 vacancy survey.

(c) Wales

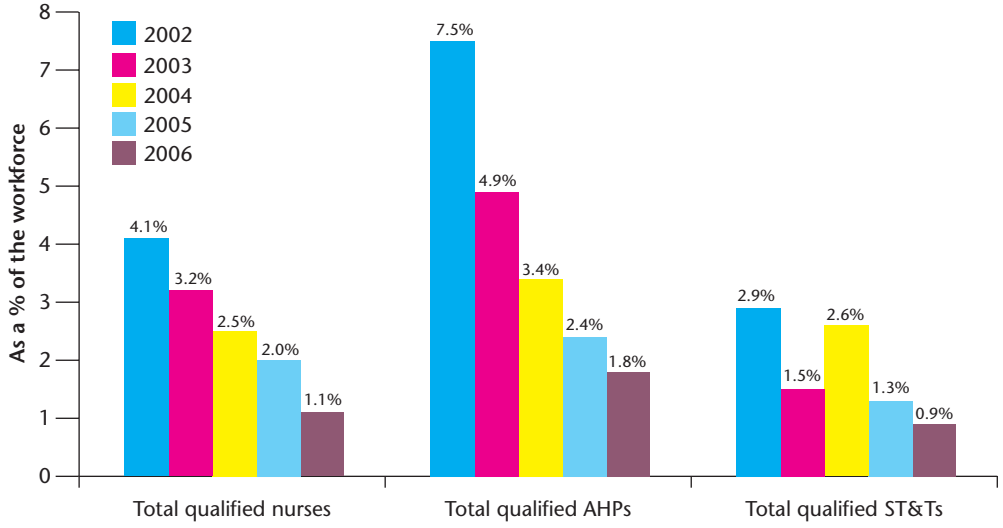
3.31 For qualified nurses, midwives and health visitors as a whole the vacancy rate was 1.1 per cent in 2006, a fall of nearly one percentage point since March 2005. This is the fourth successive year that this vacancy rate had fallen (Figure 3.10).

3.32 For qualified AHPs the vacancy rate was 1.8 per cent in 2006, just over half a percentage point less than in 2005 and the fourth successive year that this vacancy rate had fallen.

3.33 For other qualified ST&T staff the vacancy rate was 0.9 per cent, a fall of almost half a percentage point since 2005.

3.34 Vacancy rates have a tendency to be more volatile for AHPs and ST&Ts in Wales than in England or Scotland because of the smaller numbers involved. This means that a small change in the levels can result in a large change in the percentage.

Figure 3.10: Three-month vacancy rates for main qualified staff groups 2002/06 (Wales)



Source: National Assembly for Wales; StatsWales vacancy statistics, 2006 vacancy survey.

Vacancies in the NHS – Other Sources of Vacancy data

3.35 Although data from the NHS Vacancy Survey suggested falling vacancy rates in recent years, it is useful to know how this compares to experience elsewhere in the economy. The Office for National Statistics (ONS) provides a breakdown of vacancy rates by broad industry grouping. While the ONS data are on-the-day vacancies and therefore not directly comparable with the three-month vacancies from the NHS Vacancy Surveys, it can still be used as a useful indicator of trends. The vacancy rates over the period Aug-Oct 2002 to Aug-Oct 2006 are presented in Table 3.1.

3.36 It is notable that the industry within which our remit group falls, 'health and social work' has recently seen vacancy rates falling, which is in line with the NHS Vacancy Surveys. In 2001 the 'health and social work' sector had one of the highest vacancy rates and was joint fourth in the table. By 2006 the sector had fallen to 11th position in the table, below sectors such as 'education'.

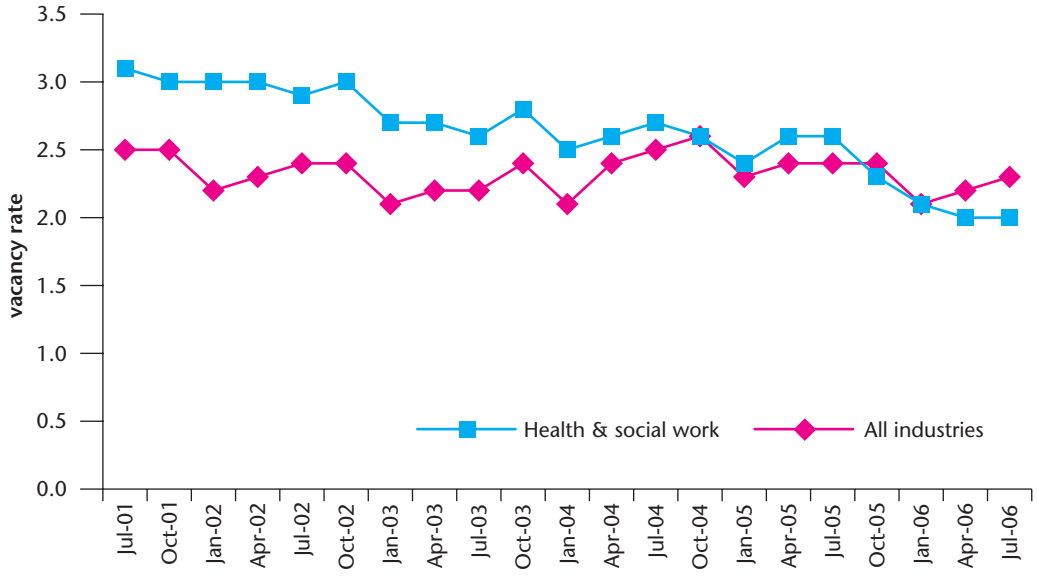
Table 3.1: Vacancy rates by Industry

Industry	Aug-Oct 2002 (%)	Aug-Oct 2003 (%)	Aug-Oct 2004 (%)	Aug-Oct 2005 (%)	Aug-Oct 2006 (%)
Financial Intermediation	2.2	2.5	3.1	3.2	3.8
Mining & Quarrying	1.3	1.8	1.9	2.1	3.3
Retail trade & repairs	3.6	3.2	3.5	3.3	3.1
Hotels & restaurants	3.4	3.3	3.2	3.2	3.0
Real Estate & business activities	2.2	2.2	2.6	2.4	2.9
Transport, storage & communications	3.3	3.1	2.8	2.5	2.6
Chemicals & man-made fibres	2.7	1.6	2.1	2.5	2.4
Wholesale trade	2.2	2.4	2.6	2.0	2.2
Education	1.7	1.9	1.9	2.0	2.1
Other services	2.3	2.4	2.5	2.1	2.0
Health & social work	**2.9**	**2.7**	**2.7**	**2.5**	**1.9**
Electricity, gas & water supply	1.1	1.4	1.7	1.4	1.9
Food, drink & tobacco	2.9	3.1	2.9	1.5	1.9
Construction	1.7	2.1	2.1	1.8	1.8
Engineering & allied industries	1.5	1.4	1.9	1.6	1.7
Other manufacturing	1.8	1.7	2.0	2.0	1.6
Public Administration	1.2	1.3	1.3	1.3	1.4
Base metals & metal products	1.1	1.5	1.5	1.2	1.3
Textile, leather & clothing	1.5	1.1	1.9	0.9	0.8

Note:
ONS Data can be found at http://www.statistics.gov.uk/downloads/themes_labour/latestdata.xls

3.37 Figure 3.11 presents the time series for vacancy rates in 'health and social work' and 'all industries' sectors. It shows that while there was no marked trend for the whole economy in recent years, vacancy rates in the health and social work sector had converged towards those for the whole economy and fell below the whole economy vacancy rate in 2006.

Figure 3.11: Trends in vacancy rates



Source: Office for National Statistics; vacancy rates by industry.

3.38 The biggest problem with this analysis is that the industry group 'health and social work' is much broader than the NHS. Not all the workers within that category are within our remit or linked to it through the Pay Negotiating Council and AfC pay spines, although we estimate that just under half of the industry is in the NOHPRB remit group working in the public sector.

Evidence from the Parties

The Health Departments

3.39 The **Department of Health** told us there was clear evidence of a healthy recruitment and retention position with the service not experiencing problems finding suitably qualified staff. Low vacancy rates demonstrated the attractiveness of the professional positions within the service and the ability of the NHS to retain its staff.

3.40 The Department said that AfC, increasing investment in students entering pre-registration training, the *Improving Working Lives* (IWL) initiative and other recruitment and retention measures had all led to more staff working in the NHS than ever before. More than 381,000 qualified nurses now worked in the NHS (excluding GP practice nurses), almost 81,000 more than in 1997. Record numbers of nurses were in training with the number of students entering training to become a nurse or midwife in England increasing by over 65 per cent since 1996/97. In 2002 the ratio of applicants to acceptances on nursing degree courses had stood at 2.03 and the latest available data for 2005 showed this had increased to 2.36. Initiatives (student grants and loans) were in place to support all students. Commenting on the Royal College of Midwives' (RCM) suggestion for a £10,000 non-means tested bursary for student midwives, the Department said this was unaffordable (with an additional estimated cost of £17.5 million) and unnecessary in terms of recruitment. The Department told us that it was part of an Inter-Departmental Group that had been set up to implement the recommendations in Sir Alan Langlands' report, *Gateway to the Professions*, around widening participation, improving information for potential and existing students and ensuring that students had access to sources of financial advice.

3.41 The Department said that we would have seen reports that some newly qualified healthcare professionals were experiencing difficulties finding employment within the NHS. There had also been stories in the media about significant compulsory redundancies. The extent of such difficulties was not reflected in information from NHS Employers (NHSE). In reality, the situation varied quite substantially across the country, but it was clear that newly qualified staff in certain professions, such as nursing and physiotherapy, were finding it more challenging to secure their first job than in the recent past. This was a complex situation as the NHS was now moving towards more of a steady state, where there was a closer match between affordable demand and supply. A number of Trusts were experiencing financial difficulties and where Trusts were reducing posts, it was mainly being done through recruitment freezes, reducing the use of agency staff and redeploying staff in different ways. In some cases, productivity gains might mean that fewer staff were needed to deliver the same service outcomes.

3.42 The NHS would continue to need to recruit new staff to replace those who retired or took career breaks. The number of retirements would increase over the coming years and students about to qualify needed to understand that jobs were available, but perhaps not in their first choice of specialty or local Trust, and so they needed to be open minded about where they worked. Employers could ensure the NHS retained the skills of newly qualified clinicians by offering more part-time appointments or reconfiguring services so that more senior posts were made available to junior staff, with additional supervision where necessary. In summary, the Department said that numbers were up, applications outnumbered places, and although the position was more challenging than in the past, the majority of those entering training were guaranteed a job at the end.

3.43 The extra investment in nurse education meant that the NHS no longer needed to rely on recruiting junior nurses from abroad and so general nursing posts banded at 5 and 6 under AfC were no longer on the Home Office shortage occupation list.

3.44 More generally, the healthy recruitment and retention position was demonstrated by the beginning of a decline in spending on agency staff.

3.45 On vacancies, the Department explained that data were collected on vacancies lasting three months or more as this period distinguished these vacancies from normal staff turnover. The data continued to be collected in this form to ensure they were consistent and comparable on a year-by-year basis. The latest vacancy rates for March 2006 showed that the recent declining trend had continued. For example, the three-month vacancy rate for qualified nurses (including midwives) had fallen from 3.4 per cent in March 2001 to 0.9 per cent in March 2006. Similarly, the three-month vacancy figure for qualified AHPs had fallen from 4.3 per cent in March 2001 to 1.6 per cent in March 2006. This was further evidence that workforce supply and affordable demand were now more closely aligned and there were no longer national staff shortages in the main clinical groups. The ambulance workforce had continued to grow and in general, ambulance services did not have recruitment issues and turnover of staff remained low.

3.46 The majority of employers now used NHS Jobs to advertise their vacancies and NHSE were able to extract real time data about the number of vacancies being advertised by staff group, grade and location. We were told that taken together, the NHS Vacancy Survey and data from NHS Jobs gave a clear picture of vacancies that NHS organisations were trying to fill. Commenting on the vacancy figures the Chartered Society of Physiotherapy (CSP) had quoted from their survey, the Department said that they only covered senior physiotherapists and caution was needed when extrapolating results to cover the entire physiotherapy population. The Department added that the real number of physiotherapy vacancies in the NHS was the number of vacancies that the NHS was prepared to fund.

3.47 The **Scottish Executive Health Department** (SEHD) said that the nursing and midwifery workforce in Scotland had reached a record level of 55,000 in total and was continuing to grow. It was on track to meet the target of attracting 12,000 registered nurses and midwives into the NHS in Scotland by September 2007. Long-term vacancies provided an indication of trends in recruitment and retention and here the March 2006 long-term vacancy rate was 0.7 per cent of the nursing and midwifery establishment, indicating that Scotland was not experiencing difficulties in recruiting and retaining these groups. Record numbers of students were also in training (up by 18.3 per cent between 2001 and 2005) and various initiatives were in place to support recruitment and retention for newly qualified nurses and midwives. Diploma students in Scotland currently receive a non-means tested bursary[14]. Spend on agency staff had now plateaued at £26.4 million from a high of £29.7 million in 2003/04. Various workforce initiatives designed to support, develop and retain the workforce and improve services to patients were also in place.

3.48 On AHPs, Scotland was on track to achieve its target to increase numbers by 1,500. Between 2001 and 2005, the total Whole-Time Equivalent (WTE) numbers of AHPs had increased by 18.6 per cent. Vacancy rates for AHPs were generally stable.

3.49 Data on healthcare scientists showed that between 2001 and 2005, the number of qualified WTE staff had grown by 8.7 per cent. Qualified pharmacist numbers had increased by 32.8 per cent between 2001 and 2005, with numbers in training rising by 33.7 per cent.

3.50 The vast majority of Scottish employers had reported a stable recruitment and retention position, but with the perennial difficulty of recruiting in remote and rural areas. To date, employers had not used Recruitment and Retention Premia (RRPs), which indicated that recruitment and retention remained fairly healthy in Scotland.

3.51 The **National Assembly for Wales** (NAW) said there had been a 28 per cent increase in WTE NHS staff since 1997. The number of qualified nurses had increased by 38.8 per cent. Nurse training places had increased from 2,664 in 1999 to 3,770 in 2005. The level of student attrition from three-year nurse training had improved significantly from 17 per cent in 1999 to 11 per cent in 2005. The three-month vacancy rate at March 2006 for qualified nurses, midwives and health visitors was 1.1 per cent, down from 2.0 per cent in 2005. The three-month vacancy rate for qualified AHPs at March 2006 was 1.8 per cent, down from 2.4 per cent in March 2005.

3.52 NAW said that changes in workforce demand, new ways of working and increasing financial constraints meant there were currently fewer posts available for new therapy and nursing graduates. Workforce planning based on need rather than affordability from 2001 onwards had resulted in commissioned student numbers exceeding the number of funded posts available on qualification. The implementation of AfC during 2004/06 had influenced and reduced staff turnover which in turn had blocked posts. Together with a general slowing in the labour market and a reduction in early retirements, fewer novice posts were now available. Pay modernisation had required organisations to review skill mix and develop new roles which often included role substitution in response to shortages in key professions. Trusts were also having to address financial deficits and were looking carefully at all vacant posts and especially the need to establish new professional posts. The professions affected by a lack of jobs for those just graduating were physiotherapy, occupational therapy, therapeutic radiography, dietetics, speech and language therapy and clinical psychology. NAW was working with Trusts and Local Health Boards to promote the creation of posts suitable for new recruits and the current shortages of posts would be taken into account in future commissioning of student places.

[14] These bursaries also apply to diploma students in England and Wales.

NHS Employers (NHSE)

3.53 **NHSE** told us that its evidence was based upon information collected from NHS employers by way of a survey questionnaire[15]. Employers had reported that recruitment and retention were generally improving or remaining stable, helped by a fall in staff turnover in most areas. However, there were some areas of concern and these varied across professional groups and geographical locations. Most employers had reported that non-pay solutions were as important as pay in improving recruitment and retention, especially the introduction of flexible working, but also education, training and development, and childcare provisions.

3.54 In a recent NHSE recruitment and retention survey, 10 per cent of respondents had said they were anticipating redundancies in the next 12 months, with a further 25 per cent indicating the potential for redundancies. This was against a backdrop of 39 per cent of respondents indicating that they had had recruitment freezes in the last 12 months.

3.55 NHSE said that information gathered from nearly 200 employers in March and April 2006 had indicated that relatively few people had lost their jobs and some of the figures quoted in the media had been misleading. Where Trusts were making reductions, it was typically by natural wastage, freezing vacancies, scrutiny of new appointments, reduced usage of agency and temporary staff, and redeploying staff in different ways.

3.56 More clinical staff were graduating than in recent years and these newly qualified health professionals faced a more difficult labour market. Newly qualified physiotherapists and nurses in particular were facing difficulties and there was anecdotal evidence that diagnostic radiographers, speech and language therapists and dieticians were also affected by graduate unemployment. Greater mobility and flexibility was required of job applicants because of this increased competition.

Staff Bodies

3.57 Evidence from the joint **Staff Side** said that the financial deficits in some Trusts were having an important impact on staff. Although the exact number of job losses was hard to quantify and estimates varied, the volatility within the service was clear and thousands of staff in both clinical and non-clinical professions were now working with the very real threat of redundancy hanging over them. Cuts to agency staff meant that remaining staff were increasingly stretched, while cuts amongst administrative and clerical staff meant clinical staff suffered the knock-on effects. The requirement for virtually all NHS Trusts to achieve financial balance by the end of 2006/07 had triggered a reactive and short-term response from some Trusts which had contributed to the wave of job cuts. The current lack of job security in some parts of the NHS – whether perceived or real – threatened to have an adverse effect on the ability of the NHS to be able to recruit and retain staff in the future.

3.58 The number of training posts for nurses and occupational therapists had been cut and there had been a reduction in recruitment across the NHS. A survey of Trust chief executives earlier in 2006 had found that 75 per cent of acute hospital Trusts had been forced to freeze recruitment as a result of their current financial position. This needed to be taken into account in vacancy rate calculations and the knock-on effect for staff morale and motivation.

[15] This survey represented the views of NHS employers in England only. All subsequent references to the NHSE survey reflect this.

3.59 Looking at vacancy levels, Staff Side discussed a number of reasons why the figures from the NHS Vacancy Survey were not considered to be robust, including:

- true vacancy levels could be underestimated through use of bank or agency staff;
- during a vacancy freeze (such as now) vacancy rates improved;
- if a Trust was not 'actively' trying to recruit into a post then technically there was no vacancy;
- vacancies were hidden if the post was filled by someone not fully qualified for the job;
- the data were limited to posts that were vacant for three months or more and did not reveal the extent of vacancies in specialist areas at any one time; and
- the data were not detailed enough to highlight recruitment difficulties affecting specific bands and specialties within staff groups.

3.60 The 2006 NHS Vacancy Survey had found that the vacancy rates for the main staff groups had fallen in March 2006, compared with 2005. For example, qualified nursing, midwifery and health visiting staff had a vacancy rate of 0.9 per cent in March 2006, which was down from 1.9 per cent in March 2005.

3.61 Staff Side gave these reductions a cautious welcome, but stressed that the figures hid worrying underlying trends of job cuts, recruitment freezes and redundancies. We were asked to note figures which varied considerably from those in the NHS Vacancy Survey, including:

- the highest levels of nursing vacancies in the survey were again in psychiatric nursing (1.5 per cent) and for qualified AHPs, the highest vacancy rates were again for therapeutic radiographers (4.8 per cent);
- evidence gathered from Heads of Midwifery (HOMs) in July 2006 by RCM showed that over 70 per cent did not consider their establishment to be adequate;
- occupational therapy had the second highest vacancy rate within the non-medical workforce and this was decreasing at a slower rate than other AHP professions;
- findings from the CSP's workforce survey of physiotherapy managers revealed that the UK on-the-day vacancy rate at 30 June 2006 for qualified staff was 3.8 per cent. The CSP had also been told that Trusts were freezing vacant physiotherapy posts to tackle their deficits and this combined with vacant posts meant that 4.6 per cent of funded establishment posts were vacant at 30 June 2006. This compared to the 1.1 per cent vacancy rate on 31 March 2006 reported in the NHS Vacancy Survey;
- the British Orthoptic Society's (BOS) evidence showed there had been an increase in vacancies of four per cent in 2006 over 2005; additional hours worked by staff equated to a staffing shortfall of five per cent; vacancies and additional hours together equated to a shortfall of almost 10 per cent;

- the NHS Vacancy Survey showed there had been an increase in vacancies for ambulance staff from 0.7 per cent in 2005 to 1.4 per cent in 2006; and

- the Society of Radiographers' (SoR) survey of department managers had reported that 54 per cent of departments had current vacancies and were actively recruiting.

3.62 **UNISON** said one of its success criteria for AfC was better recruitment and retention, i.e. reduced turnover, vacancy rates and attrition from training. Workforce statistics showed that staff turnover in almost all groups (except ambulance) had fallen in the last year, but whether this was as a result of better pay was unclear. It was likely that staff in Scotland and Wales and in parts of England were still awaiting the outcomes of their AfC matching, job evaluation and assimilation, or the outcome of their reviews. It would be necessary to monitor turnover for a longer period to see if this trend was sustained.

3.63 UNISON presented the results from its 2006 Pay Survey covering ambulance staff, professions allied to medicine, professional and technical staff, nursing and midwifery, and health care assistants (see paragraph 5.30 for more details). They reported that 61 per cent said that staffing numbers had decreased, with only five per cent saying they were better than the previous year.

3.64 UNISON said that many of these findings differed from those in the OME's 2006 Workforce Survey because many Trusts had put vacancy freezes in place to avoid the need for compulsory redundancies. The findings from the two surveys did agree that recruitment of Bands 5-7 staff was now more difficult and a significant majority of our remit group was in those bands.

3.65 The **Royal College of Nursing's** (RCN) survey of temporary workers (based on 530 responses) had found that 11 per cent of respondents did bank/agency work to ensure there were enough staff to provide cover in their main work area. The main reasons respondents gave for taking up bank/agency work exclusively was to gain flexibility in working hours, because of childcare responsibilities and to allow more choice over when they worked.

3.66 In this year's Labour Market Review for the RCN, Professor Jim Buchan argued that the labour market was moving from a period of growth to a time of potential shortage caused by financial constraints in the NHS, restrictions on international recruitment and the continued ageing of the nursing labour force. Recent surveys had indicated there were likely to be significant reductions in intakes to pre-registration nurse education this year. International inflow was now markedly reducing as a result of Band 5 and 6 nurses being taken off the shortage list, whilst the outflow of nurses from the UK had remained stable in terms of overall numbers. Professor Buchan argued that health care reforms might be threatened by cut backs in nursing numbers. In particular, the objective of prioritising NHS primary care developments might be compromised and constrained by inadequate numbers of community trained nurses.

3.67 In conclusion, the RCN said that while there was evidence of some reduction in the use of temporary nursing staff, they were still being used as a proxy for filling vacancies and to enable employers to avoid paying overtime. NHS employers would need to consider recruitment and retention strategies for nurses as they started to compete against new employers in other sectors.

3.68 The **Royal College of Midwives** (RCM) said that it had surveyed 216 HOMs in July 2006 seeking information on issues including staffing levels, recruitment and retention. The survey had a response rate of 53.2 per cent and the RCM's evidence was based on its findings. There had been some welcome and some not so welcome news. Although conventional indicators seemed to be moving in the right direction, these seemed to be disguising the filling of vacancies with unqualified midwives. The key findings included:

- long-term vacancy rates had fallen from 59 per cent of vacancies in 2005 to 53 per cent in 2006;

- there were improvements in the headline vacancy rates in the regions with the largest problems, including London and the South East, although London vacancy rates were still high at 7.2 per cent;

- UK vacancy rates had fallen from 4.1 per cent of establishment in 2005 to 3.25 per cent in 2006;

- the number of midwives recruited from overseas had fallen dramatically in 2006;

- over 70 per cent of HOMs did not consider their midwifery establishment adequate for the level of activity undertaken in their Trust;

- only 16 per cent of HOMs considered recruitment and retention to be a greater problem this year, while just over a third considered it to be less difficult. For the fifth year in succession, heavy workloads and stress were the first and second most important reasons cited as factors contributing to recruitment and retention problems; and

- almost one-fifth of the maternity workforce were Maternity Care Assistants (MCAs) in Band 2 or 3 (an increase of 675 per cent since 2005). The RCM said this might explain many of the figures above and the substantial drop in vacancy rates. Although MCAs were widely used and were popular as a cost effective complement to midwives, there was some evidence they were being used at the expense of more costly/experienced staff. Their increased usage was a major feature of the RCM's evidence this year.

3.69 The RCM said 47 per cent of respondents to its survey of midwifery educationalists (to which 15 had responded) had reported that student midwives were experiencing difficulties getting work or were anxious about their work prospects. Despite these difficulties, the RCM said there were supply side problems with training commissions down slightly in 2006. A survey of 900 student midwives revealed that 89 per cent considered finance to be the biggest obstacle to joining the profession with 39 per cent stating they could not afford the course. The RCM said that student midwives tended to be older than most students and 75 per cent of respondents had one child or more and were much less able to take on part-time employment to earn money. From the existing age profile of the workforce, there was a clear need to recruit more and younger midwives to sustain the profession. To address this, the RCM said it had consistently called for an annual non-means tested bursary of £10,000 per annum for all student midwives. They told us that given the supply and demand factors, they believed £10,000 was a reasonable figure and should attract recruits and improve retention whilst being affordable.

3.70 **Amicus** was also concerned about whether the NHS Vacancy Survey disguised real vacancy rates, and said it had consistently expressed scepticism about the value of the data when considered in isolation, particularly in the light of vacancy freezes and job cuts. For example, the NHS Vacancy Survey had reported a vacancy rate for speech and language therapists of 1.1 per cent, but the Royal College of Speech and Language Therapists had estimated the level of vacancies to be between 20–30 per cent. Similar concerns were raised about the data for applied psychologists. Amicus was therefore seeking a more considered approach and asked us to encourage discussions between NHSE and Staff Side with a view to developing a formula for determining the real vacancy rate. Amicus also highlighted for us the impact of the current financial pressures in the NHS on staff in three particular service areas – health visiting, mental health and speech and language therapy.

3.71 The **Society of Radiographers** (SoR) said that although the diagnostic radiography workforce had grown by 31 per cent between 1995 and 2005, and the therapeutic workforce by 64 per cent over that period, radiography had historically suffered an acute shortage of qualified staff. Rising demand for these services and new targets meant ever-greater numbers of radiographers were required. Perceptions about the NHS were now changing with job security and career development under threat. The NHS had attracted and retained staff to date, but without a decent pay award and RRP, it would not continue to do so in the future.

3.72 A survey in September 2006 of department managers in England, to which 232 had responded, had found there were restrictions on recruitment in 28 per cent of radiography departments. Posts had been disestablished in 30 per cent of departments, with the bulk of frozen and disestablished posts in Bands 5 and 6. SoR said this might account for the shortage of jobs for graduating radiographers in 2006. Fifty-five per cent of department managers reported actively trying to fill vacancies which were primarily in Bands 6 and 7.

3.73 The **Chartered Society of Physiotherapy** (CSP) said the NHS Vacancy Survey as at March 2006 showed that the three-month vacancy rate for qualified physiotherapists had fallen from 2.9 per cent in 2005, to 1.1 per cent. In Scotland, the vacancy rate at September 2005 was 1.0 per cent and in Wales 2.0 per cent. These figures were not a truly representative picture as they only showed posts which had been vacant for three months or longer and which employers were actively trying to fill. Scotland collected information for both three-month vacancies and on-the-day and this showed that the three-month vacancy rate at September 2005 was 1.0 per cent, while the on-the-day rate was 4.4 per cent. Given the current financial climate in the NHS and the severe restrictions on recruitment, it was not surprising that so few posts had been identified as vacant by the NHS Vacancy Survey. This did not reflect the true demand for physiotherapists.

3.74 Since 2004 the CSP had been tracking the employment status of all physiotherapy graduates in the UK. The situation was far more serious in 2006 than in 2005. A survey of graduates in July 2006, to which 591 responded (62 per cent), suggested that over 90 per cent were still looking for junior NHS posts.

3.75 Financial pressures meant these graduates were increasingly likely to seek alternative careers. Inadequate workforce planning at national and local level had failed to create sufficient junior jobs to absorb the increasing output of graduates. The number of jobs was continuing to expand rapidly, but many of these had been senior and specialist posts which new graduates could not fill.

3.76 Responses to the CSP's July 2006 UK workforce survey of senior physiotherapy managers in the NHS, which covered an estimated 42 per cent of qualified staff in post, had found that a combined total of 415 WTE posts were either vacant or frozen, i.e. 4.7 per cent of establishment. This was far in excess of the vacancy rates reported by the NHS Vacancy Survey of 1.1 per cent as at March 2006.

3.77 Looking at the OME's 2006 Workforce Survey for AHPs, of those who said that AHP recruitment was a problem, over 50 per cent specified that physiotherapy was a particular problem, rising to 54 per cent in London and 80 per cent in the North East. Forty-eight per cent reported quite a problem or a major problem with retention of physiotherapists. The OME survey also showed that the wastage rate from the NHS for physiotherapists was 9.9 per cent. The CSP said this was likely to reflect the many employment opportunities for physiotherapists outside the NHS.

3.78 In 2005 Loughborough University had undertaken a detailed study of the reasons why AHPs (including physiotherapists) stayed in, left or returned to the NHS. This had found that those who had left the NHS earned on average more than those remaining in it and physiotherapists rated NHS pay more negatively than other AHPs. The study concluded that "Higher pay levels could therefore help with retention and return...".

3.79 In conclusion, the CSP called on us to support its request for all stakeholders to work together to ensure that more robust and detailed workforce data were collected, for example, by grade and clinical specialty, in order to improve workforce planning. We were also asked to use our influence with the Department of Health, NHS Employers and other stakeholders to address the serious problem of unemployment amongst physiotherapy graduates. It was also essential not to reduce any further the number of student training places to avoid entering a cycle of workforce boom and bust.

3.80 The **T&G** said that over the last decade, the number of qualified ambulance staff had risen by 25 per cent and the number of support staff by 98 per cent. We were told that violence towards staff had an impact on recruitment and retention and that the highest turnover and wastage rates in England and Wales amongst ambulance staff were for trainee ambulance personnel (turnover nine per cent and wastage seven per cent), followed by ambulance technicians (turnover six per cent and wastage four per cent). The OME's 2005 Workforce Survey had shown that just over half of the leavers from the trainee grade were leaving for non-NHS employment, which illustrated the need for a clear focus and strategy for the recruitment and retention of ambulance staff.

3.81 The **Federation of Clinical Scientists** (FCS) commented that Lord Carter in his *Report of the Review of NHS Pathology Services in England* (August 2006) had said that pathology healthcare science had not benefited from the "More Staff Working Differently" initiative to deliver the NHS Plan. Instead it had seen a 10 per cent year on year activity growth with a reducing healthcare scientist workforce. The current level of funding allocated to Strategic Health Authorities (SHAs) to commission training places had not been increased sufficiently to preserve trainee numbers in line with long-term workforce planning. Some SHAs had asked local Trusts to fund training posts and as a consequence, a significant number of advertised trainee vacancies had been withdrawn during the recruitment process. For example, 30 per cent (10 posts) of the expected trainee posts in Clinical Biochemistry in England had been withdrawn in autumn 2006 because of the current funding difficulties.

3.82 Although successive Secretaries of State had insisted that AfC was fully funded, SHAs' training budgets had not benefited from those uplifts. We were strongly urged to recommend a direct and proportionate uplift to the resources available to the SHAs to fund all necessary training activity.

3.83 The **British Orthoptic Society** (BOS) told us that its data suggested that combined vacancies and additional hours worked indicated a workforce shortfall of almost 10 per cent[16]. A large number of respondents to its survey had indicated an inability to recruit staff because of a shortage of applicants. Many Trusts had applied a vacancy freeze, putting a major strain on services, and many of these frozen posts had since been disestablished. Workload had increased and further demands were being placed on the service through the introduction of new targets.

Our Comment

3.84 We note that the recruitment and retention information suggests no overall staffing difficulties, although we are aware that there are still some difficulties within certain groups and regions. OME's Workforce Survey shows wastage rates (i.e. exits from the NHS) falling and the NOHPRB remit group has a wastage rate seven percentage points below the average of 15 per cent for the whole economy. Trust managers also indicated that staffing problems seemed to be improving.

3.85 The three-month vacancy rates have decreased since last year. While we recognise that vacancy rates remain high for some groups such as therapeutic radiography, all main staff groups, with the exception of ambulance staff, experienced fewer three-month vacancies in 2006 compared with 2005. However the NHS vacancy data available is far from ideal and we have sympathy with the Staff Side's concerns about the quality of the vacancy data currently collected on behalf of the Health Departments. Discussions have taken place on how to improve the data available and there is hope that the new Electronic Staff Records (ESR) computer system, currently being implemented in Trusts across England and Wales, will provide more robust and detailed workforce data for those countries, including further information on vacancies.

3.86 In considering this picture on recruitment and retention and vacancies, we have noted the concerns expressed by Staff Side that the falls in vacancy, wastage and turnover rates could be due to job cuts and recruitment freezes, rather than a genuine reduction in staff shortages. We understand that some re-structuring of posts and staffing levels may well be a consequence of the process of modernising services and adapting to AfC and that this may lead to some posts being cut. We are concerned, however, with the Department of Health's view that newly qualified clinicians can be deployed into senior posts. What is clear to us is that re-structuring can take place effectively only if the Knowledge and Skills Framework is in place.

3.87 As a result of Trusts' reactions to the current financial problems facing them, we do not know what the true picture on staffing is and the position will not become clearer until the immediate financial issues are resolved. Recruitment and retention and by implication vacancies are a key part of our remit, but in our view this does not mean just looking at the current situation. The current improvements in vacancy and wastage rates may not reflect the longer-term ability to recruit. We therefore need to look at what may happen to recruitment and retention in the future. Having said that we do not consider that it is our role to comment on the appropriate level of establishment. The nature of the services provided by the NHS, and the number of staff required to provide those services, are outside our remit. We have not, however, seen any evidence to suggest that the Health Departments or NHSE have appropriate workforce planning in place to look at recruitment and retention in the longer-term.

[16] Includes Northern Ireland.

3.88 We note RCM's request for an annual non-means tested bursary of £10,000 per annum for all student midwives, but we are unsure about the extent to which student bursaries are a matter for the Review Body. While we would be concerned if the level of the bursary was affecting the number of midwives training, we also have to ask the broader question of why special consideration is needed for student midwives when other health professions have equally long training periods. We have previously engaged in discussions with the Department of Health on how to take forward recommendation 16 of Sir Alan Langlands' report on *Gateway to the Professions* (see paragraph 3.40), and the Department has said it will continue to monitor the situation.

Chapter 4: Recruitment and Retention Premia and High Cost Area Supplements

Introduction

4.1 The Agenda for Change (AfC) agreement contains provisions governing the operation of recruitment and retention premia (RRPs) designed to address labour market difficulties affecting specific occupational groups. The premia therefore apply to posts and not individuals. The agreement notes that such premia may be awarded on a national basis to particular groups of staff on the recommendation of the Pay Review Body for Nursing and Other Health Professions and/or the Pay Negotiating Council, where there are national recruitment and retention pressures. There was some discussion this year with the Department of Health about our role in relation to national RRPs and we say more about this later in the chapter. AfC provides that where it is agreed that an RRP is necessary for a particular group the level of payment should be specified or, where the underlying problem is considered to vary across the country, guidance should be given to employers on the appropriate level of payment. In making such recommendations, we are required to seek evidence or advice from NHS Employers (NHSE), staff organisations and other stakeholders. In addition, the parties have agreed under AfC that some posts will automatically attract RRPs. In this round, Amicus has presented a case for the introduction of a national RRP for pharmacists and the Society of Radiographers (SoR) has presented a case for a national RRP for radiographers. The parties' evidence is summarised below and our comments can be found later in the chapter.

4.2 We are required, under our general remit, to have regard to regional/local variations in labour markets and their effects on the recruitment and retention of staff. In addition, AfC provides for a system of high cost area supplements (HCAS) covering Inner London, Outer London and the Fringe. The value of these supplements to individual staff is based on a percentage of their salary, with a minimum and maximum cash payment. The percentages, minima and maxima depend on area, with Inner London attracting the highest supplement and the Fringe areas of London the lowest.

4.3 The value of the supplements is to be reviewed annually, based on our recommendations for staff within our remit group. In addition, it is open to us to make recommendations on the future geographic coverage of HCAS and on the value of such supplements. Here we set out the evidence we have received on these issues from the parties and summarise the evidence from the joint Staff Side and UNISON seeking the introduction of a new HCAS for South Cambridgeshire. Again, our comments can be found later in the chapter.

Evidence from the Parties

The Health Departments

4.4 The **Department of Health** said that AfC had delivered a flexible pay system that enabled the payment of RRPs and HCAS. This flexible approach to local labour markets enabled the NHS to recruit and retain staff where it was competing in a diverse labour market.

4.5 With regard to local pay, the Department said that the findings from a study it had commissioned from Aberdeen University in 2005[17] had confirmed its belief that our remit group (and nurses especially) were subject to local labour market forces. AfC was designed to allow local organisations to deal with the flexibilities of a local labour market through mechanisms such as local RRPs and HCAS. The Department said that the Aberdeen study provided a useful starting point in analysing regional pay but it was thought sensible to allow AfC to be implemented fully before conducting any further research. The Department was currently scoping the options for further research on the use of pay flexibilities within the AfC agreement.

4.6 Commenting on the Staff Bodies' case for an HCAS for South Cambridgeshire, the Department said that it did not have any evidence in support of this. It said that the Market Forces Factor (MFF) already provided funding to pay the excess labour cost of delivering services in high wage cost areas. If South Cambridgeshire were to introduce an HCAS, it would not receive any further central funding.

4.7 The Department said that it did not propose any changes to national RRPs for our remit group in this round as AfC was still new and settling down, but it would gather evidence for our remit group for the next review. Responding to Amicus' separate submission on a new RRP for pharmacists, we were told that the evidence put forward was not reinforced by employers which suggested that more research in this area was needed. Commenting on the SoR case for a new national RRP for radiographers, the Department told us that the argument for radiographers was difficult given the underlying problem was a shortage of radiographers and therefore an RRP was unlikely to solve the problem. Again the Department felt that this was an area where further research would be useful.

4.8 Commenting on our role in relation to the setting of new/existing RRPs, the Department initially said that responsibility for national RRPs rested with the NHS Staff Council. It later acknowledged that the AfC agreement did flag that we should periodically review RRPs, but said that it was difficult to understand at this stage how we would be adequately informed to set them. Moreover, it was still too early to make those judgements. Setting national RRPs depended on a wide range of information including vacancy rates, external labour markets, housing prices and agency spend, as well as management issues in organisations. It added that the NHS Staff Council was in the process of commissioning some independent research to analyse information on the recruitment and retention position of qualified craft workers in the NHS. This would be presented to the Executive NHS Staff Council who would then decide whether the existing national RRP was still justified. This work was expected to be completed by March 2007.

4.9 The **Scottish Executive Health Department** (SEHD) said that the facility within AfC to pay an RRP on a regional basis addressed any need for flexibility within NHSScotland.

4.10 The **National Assembly for Wales** (NAW) said that it believed that AfC already had built in mechanisms to deal with the local variations in the local labour market, for example recruitment and retention premia, and therefore it would not advocate the introduction of regional pay.

[17] The full title of this report is: Regional pay for NHS medical and non-medical staff by Professor Bob Elliott of Aberdeen University's Health Economics Research Unit (HERU). It is due to be published later this year.

NHS Employers (NHSE)

4.11 **NHSE** told us employers had reported that in the main they had not needed to use RRPs to address recruitment difficulties as non-pay solutions, especially flexible working, were as important as pay in improving recruitment and retention. The parties to the AfC agreement had agreed to review the nationally determined RRPs already in existence under AfC. NHSE provided the terms of reference for our information and suggested that these set out the issues that needed to be taken into account when future national RRPs were considered. The current review was looking initially at premia for qualified maintenance craftsmen and technicians, but could in time be extended to other groups. To ensure that equal pay for work of equal value was maintained, all national RRPs needed to be objectively justified on labour market grounds.

4.12 Responding to Amicus' separate submission on an RRP for pharmacists, NHSE told us that employers had indicated that this was not a national problem and did not think that an RRP would be a useful tool in addressing the shortages. Addressing SoR's submission for an RRP for radiographers, NHSE said they would not support a new RRP as they did not think there was any evidence to suggest that increasing pay would improve the recruitment of this group.

4.13 Commenting on the Staff Bodies' case for an HCAS in South Cambridgeshire, NHSE said that the MFF adjustment ensured that Trusts in areas with higher costs received additional resource which could be passed on to staff as a local RRP, where necessary. The AfC agreement allowed local employers to introduce an HCAS following consultation with neighbouring employers and the relevant Strategic Health Authority (SHA). However the costs of this would have to be met by the employer as no separate funding was provided for HCAS.

Staff Bodies

4.14 Evidence from the joint **Staff Side** said that AfC contained the flexibility to react to regional and local labour market conditions and Staff Side did not believe that introducing new local pay arrangements would benefit the NHS whilst AfC was bedding in. Commenting on SoR's case for an RRP for radiographers and Amicus' case for an RRP for pharmacists, Staff Side told us that it did not take a view on an individual organisation's evidence for RRPs and it was up to us to decide.

4.15 Staff Side said that there was still clear evidence that vacancy problems were significantly worse in London and the South East across the professions. There were some labour market pressures outside these areas, but they were best dealt with using the RRP provisions in AfC. Staff Side noted that we had invited evidence last year on the issue of HCAS and in particular, on the degrees of pay variation that would be appropriate in London and elsewhere. It said that a review of the boundaries between Inner and Outer London was currently underway and the findings would be reported to us next year.

4.16 Staff Side said it was providing evidence this year for the introduction of an HCAS for South Cambridgeshire. It asked us to comment on its merit and also to consider it as a template for future arguments in favour of an HCAS. The case, supported by the management and staff side project leads at Addenbrookes NHS Foundation Trust, was that:

- Cambridge was part of the London commuter belt;
- the cost of property for mid-range housing was proportionally higher than surrounding areas, based on a ratio of distance from London;
- rents in Cambridge were significantly higher than the surrounding areas;
- other groups received pay supplements reflecting the higher costs of living in Cambridge; and
- some groups already received RRPs.

4.17 The conclusion drawn from this evidence was that the situation for South Cambridgeshire had worsened relative to areas where HCAS was paid. The relevant parties were requested to redefine the HCAS boundaries to include the Cambridge and South Cambridgeshire travel-to-work areas. Responding to how additional HCAS would be funded, Staff Side said that overall funding would be a policy decision for the Government. The mechanism of funding could use a similar approach to the formula for funding London HCAS.

4.18 Staff Side said that the NHS Staff Council Executive would be reviewing the justification for national RRPs for qualified maintenance staff and healthcare chaplains. We were asked to recommend the same uplift in all allowances for 2007, i.e.:

- minima and maxima value of HCAS;
- alternating/rotary shift allowances; and
- national RRPs for qualified maintenance craftsmen and technicians and healthcare chaplains.

4.19 **UNISON** said it commended the evidence put to us for the introduction of a new HCAS for South Cambridgeshire. We were also asked to consider whether this might be a useful template for future evidence.

4.20 UNISON provided examples of where local RRPs had been used around the country, having been agreed by staff side and management after taking into consideration the impact on the surrounding health economy. The SHAs, Trusts and Staff Side Leads had agreed a process (the 'Pan London Agreement') by which RRPs should be introduced, and a similar agreement had been reached in South East London. This demonstrated that recruitment and retention problems could be addressed in a way that satisfied the local health economy, in a way that regional pay negotiations could not.

4.21 **Amicus** believed that a second round of evidence was required to look at the need for RRPs for particular occupations, but in the absence of a second round, Amicus attached an RRP claim for pharmacists. It had been produced by the Guild of Healthcare Pharmacists Section of Amicus and it was hoped that it might act as a template for similar claims in the future.

4.22 We were told that the negotiators of AfC had agreed that there was prima facie evidence that an RRP was necessary for pharmacists in recognition of the market forces preventing the recruitment and retention of staff. Data from the Royal Pharmaceutical Society Workforce Census 2003 was presented showing:

- nearly 80 per cent of the profession worked in the private sector;
- the profession was becoming predominantly female;
- while the register had been increasing by 2.4 per cent a year, the number actively employed had fallen;
- it was reported that 25 per cent of pharmacists actively employed were classified as a retail locum;
- nine per cent of the 2003 census expressed a desire to work abroad in the future; and
- mobility across sectors was comparatively low.

4.23 Under AfC, staff previously on Healthcare Pharmacy Grade D had tended to be banded at 7 where the starting salary was around 25 per cent lower and the top of the band 10 per cent lower than under Grade D. The starting salary was therefore a particular problem and the complete salary range for both Bands 6 and 7 were insufficient. Under the old pay structure, most pharmacists within three years were paid over £31,000, whereas under AfC, salaries after three years were in the region of £27,000. Starting salaries in the community sector were in the region of £31,000 to £35,000 with many posts advertised at higher rates. Community starting salaries were therefore more comparable to Band 8 pay scales.

4.24 The NHS Pharmacy and Education Development leads had undertaken a survey in 2005 of all pharmacy trainees leaving the NHS in eight regions or countries. A total of 35 out of 44 questionnaires had been returned. The survey showed that the majority were moving to community pharmacy and the most cited reason was for a higher salary. Starting salaries were in excess of £30,000, compared to a hospital starting salary of £22,886, with 10 per cent earning in excess of £41,000.

4.25 Amicus said that the Information Centre's vacancy data showed that vacancy rates were similar across all regions, with the highest figures in the East Midlands and Yorkshire rather than the traditional NHS "blackspots", emphasising a national rather than a local problem. It said that the decline in the national vacancy rate from 3.2 per cent in March 2005 to 2.1 per cent in March 2006 was likely to be the result of the NHS's short-term financial difficulties. Pharmacy remained one of the professions in the survey with the highest vacancy rate. Data from the July 2004 survey by the NHS Pharmacy Education and Development Committee showed that:

- 16.2 per cent of junior pharmacy posts were vacant, with locums filling an additional 13.5 per cent of posts;
- 21 per cent of pharmacists had left their employing hospital in the previous year and 10 per cent had left the hospital service;

- job evaluation would no longer permit the service to deal with the problem through regrading posts and enhancing salaries; and

- hospital pharmacists were recruited on a national, rather than a local basis.

4.26 The reduction in hours worked by pharmacists under AfC also meant an additional 4.8 per cent of staff were needed to make up the shortfall. Changes in reciprocity agreements with Australia and New Zealand had significantly reduced the number of short-term locums available.

4.27 On the basis of this evidence, we were asked to recommend an increase in the number of pharmacists being trained in hospitals, the introduction for Band 8 staff of a system similar to that for senior medical staff to recognise unsocial hours, and a national RRP for Band 6 and 7 staff equivalent to four incremental steps, i.e. £3,834 for Band 6 and £4,244 for Band 7. Although Band 6 and 7 salary ranges would remain below commercial rates, it would provide the service with better opportunities to recruit and more importantly, to retain experienced pharmacists. Amicus said that this sum had been calculated by comparing salary progression under Whitley and AfC. The number of incremental points claimed was equivalent in cash terms to the loss of pay suffered by pharmacists at their second career stage, as the minimum of Band 7 was lower than their comparative Whitley grade would have been.

4.28 The **Society of Radiographers** (SoR) said that its survey of department managers in England conducted in September 2006 gave a good overview of the situation amongst radiographers in the current climate of rapid change and severe financial restraint. Thirty-eight per cent of departments had yet to complete the AfC assimilation process and Knowledge and Skills Framework (KSF) was not yet underway for most staff. Morale was low and the threat to jobs was recognisable. The loss of established posts in radiotherapy was particularly disturbing and would impact upon the increased use of radiotherapy in treatment regimes. The survey had reinforced the SoR's view that the combination of lack of financial support for AfC and NHS deficits was in danger of distorting and depleting an already fragile job market.

4.29 Over the next 20 years a significant proportion of the workforce was due to retire, resulting in a loss of expertise within a relatively short time. The SoR considered that the likely impact of various Government initiatives on its members, the demand for radiography services and the high proportion of members due to retire all illustrated the immediate need to encourage retention of the existing workforce, both to allow breathing space for new recruits to develop and in order to meet Government targets.

4.30 Although pay was not the only answer, it would be a major boost to confidence and support a workforce that was under threat and whose morale was in decline. It would go some way towards retaining the allegiance of the current workforce to the NHS at a time when drift from retiring members and the loss of new blood would seriously threaten service delivery and the pace of current reforms. Without sufficient incentive to retain the current workforce to allow time for finances to improve and service delivery models to bed down, the future for NHS radiography services was bleak. The clear evidence of staff and skills shortages justified a national RRP of 15 per cent. This figure represented an amount which recognised the refusal of the Department of Health, in the SoR's view, to honour key terms of the AfC agreement, in particular the protection of hours. It also represented compensation for late assimilation onto AfC terms and conditions; recognition of staff persevering in work with reduced staff; lack of access to professional development; and the need to retain key skills required to deliver the change agenda.

4.31 The **British Orthoptic Society** (BOS) said that RRPs had been used in some Trusts and not in others with the result that services in those Trusts not using RRPs had suffered and Trusts had found it impossible to recruit staff.

Our Comment

4.32 Last year we considered that there seemed to be some evidence supporting the case for wider geographical pay variation than currently exists. However we have received little new information on local pay in this year's evidence to help us develop our consideration of this aspect of our remit. We understand the Department of Health's view that AfC needed to be fully implemented before further research was carried out. We therefore invite further evidence on this issue next year, including the degree of pay variation that would be appropriate in London or elsewhere and how the NHS funding regime might accommodate such variation.

4.33 We have considered the Staff Side's case for an HCAS in South Cambridgeshire. We do not believe that sufficient evidence was submitted on the labour market difficulties being caused for local NHS employers by relative cost differences for us to make a recommendation to redefine the HCAS boundaries. The type of evidence that we would find essential includes some areas set out by NHSE in Annex B of their written evidence, giving the terms of reference for the NHS Staff Council's review of existing national RRPs[18], coupled with the 1st criterion listed in paragraph 3.10 of the AfC final agreement. Evidence we would therefore want to consider, although this is not a definitive list, includes:

- vacancy rates/staff turnover;
- national and local labour market information;
- experience of recent recruitment exercises;
- evidence that costs for the majority of staff living in the travel to work area covered by the proposed new or higher supplement are greater than for the majority of staff living in the travel to work area of neighbouring employers and that this is reflected in comparative recruitment problems; and
- destination of leavers[19].

4.34 We also note the point made by the Department of Health that the MFF is already provided to help pay for the higher labour costs of delivering services in high cost areas and were a HCAS to be awarded, Trusts would not receive any further central funding. We are unsure how Trusts currently use their additional MFF funding, for example, whether Trusts are using it to address recruitment and retention difficulties as opposed to the funding being treated simply as part of the general funding which can be applied for any purpose. We would ask the parties, and particularly the Department of Health and NHSE, to provide more evidence for the next review on how the MFF is being used at local level.

4.35 In the meantime, we feel there is no case to suggest that the relative value of the differentials provided by the HCAS should be reduced, as would be the case were they not revalorised at least in line with our basic recommendation.

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[18] While this review is focused on RRPs, the fundamental purpose of both RRPs and HCAS is the same, that is to address relative recruitment and retention difficulties.

[19] We have been told that this information will be available once the new Electronic Staff Records system is in place.

We recommend that the existing minimum and maximum High Cost Area Supplements for Inner London, Outer London and the Fringe be increased by 2.5 per cent. The new minima and maxima from April 1 2007 are set out in Appendix C.

4.36 We do not propose any changes either to the existing coverage of HCAS or to the percentage proportions of basic salary that currently apply.

4.37 We noted in paragraph 4.8 the views expressed by the Department of Health about our role in relation to RRPs. We set out our role in some detail in our report last year (Paragraphs 4.17 – 4.21, Twenty-First Report on Nursing and Other Health Professions 2006). The parties did not dispute our interpretations last year and we do not propose to modify them. We also propose to adhere to the analytical approach set out in paragraph 2.22 of last year's report in relation to justifying pay differences in respect of specific staff groups.

4.38 With regards to Amicus' claim for a new RRP for pharmacists, we have looked at the evidence presented to us and note that pharmacists were originally placed on the list for an RRP by the AfC negotiators; that there is an alternative and well-established private sector labour market for pharmacists; and that there is some evidence of recruitment difficulties across the country and of significant differences between the pay available in the public and private sectors. While we are not currently in a position to take a view on whether an RRP is appropriate, we believe that the case for an RRP for pharmacists warrants proper investigation. We therefore support the Department's proposal for further research next year. We would ask the parties to consider this jointly and to involve our secretariat. Separately, we would like to emphasise that there is scope under AfC as it stands for local employers and staff bodies to agree the need for an RRP to address *local* recruitment and retention problems.

4.39 SoR has proposed a new national RRP for radiographers again this year. While we accept that there are recruitment difficulties for this profession, the main cause of the recruitment problems seems to be an international shortage of radiographers. We do not believe that the general shortage of radiographers will be addressed by the introduction of an RRP as unlike pharmacists there is not a significant external market for radiographers at present. There is a wider issue than pay to be addressed here, such as how to make the profession more attractive with a challenging career path and how to reduce the wastage rate for trainees. In any case, in order for us to consider introducing an RRP for any staff group, we would need to see more robust evidence submitted, as set out in the paragraphs above.

4.40 Part of SoR's case for an RRP rests on compensating radiographers for the additional hours worked under AfC. This is not something that an RRP is designed to address. The additional hours formed part of the wider AfC agreement and the parties agreed a transitional arrangement on how the change from a 35-hour to a 37.5-hour week would be phased in. Concerns about how this agreement is being implemented in practice should be discussed between the parties. It is not a matter on which we can make a recommendation, although we would be concerned if there was evidence that the agreement was being undermined and this was having a knock-on effect on morale and then recruitment and retention.

4.41 We note Staff Side's request for us to uplift the national RRPs for qualified maintenance craftsmen and technicians and healthcare chaplains (paragraph 4.18). These groups are not within our remit and we make no recommendation in this regard.

Chapter 5: Morale, Motivation and Training

Introduction

5.1 In our view, matters of morale, motivation and training are fundamental to our deliberations by virtue of their relevance to other areas, particularly the recruitment and retention of staff and service delivery. The evidence we have received this year is somewhat patchy and some of it does not take account of recent developments in the NHS. We discuss these limitations further in our comments later in the chapter.

Sources of data

5.2 In evidence to us from the Department of Health and NHS Employers (NHSE) relating to morale and motivation, there was a general reliance upon the data contained within the Healthcare Commission's 2005 National NHS Staff Survey for England, carried out between October and December 2005. The rest of this section discusses that survey in more detail. The evidence from the Scottish Executive Health Department (SEHD) and the National Assembly for Wales (NAW) is considered at the end of this section.

England

5.3 The NHS Staff Survey covered all 570 NHS Trusts and 25 Strategic Health Authorities in England, with a total of 58 per cent of NHS staff responding to the survey. The survey covered a wide range of topics, including: work-life balance; training; work pressure; job satisfaction; staff intention to leave their organisation; and staff views towards the organisations in which they work. It is important to note that the 2005 NHS Staff Survey was carried out before the full impact of the well-publicised funding difficulties in the NHS became public. The results do not therefore reflect the impact of Trusts' actions to tackle their financial difficulties. In addition, the process of assimilation to Agenda for Change (AfC) was far from complete. The Staff Survey for 2006 should shed light on how the funding pressures have affected staff attitudes and how staff now view their new pay structure.

5.4 The survey covered all staff in our remit who were grouped under the following occupational categories: all nursing staff (i.e. registered nurses; midwives; health visitors; healthcare assistants[20]); Allied Health Professions (AHPs); Scientific, Technical and Therapeutic staff[21] (ST&T); paramedics; and ambulance technicians.

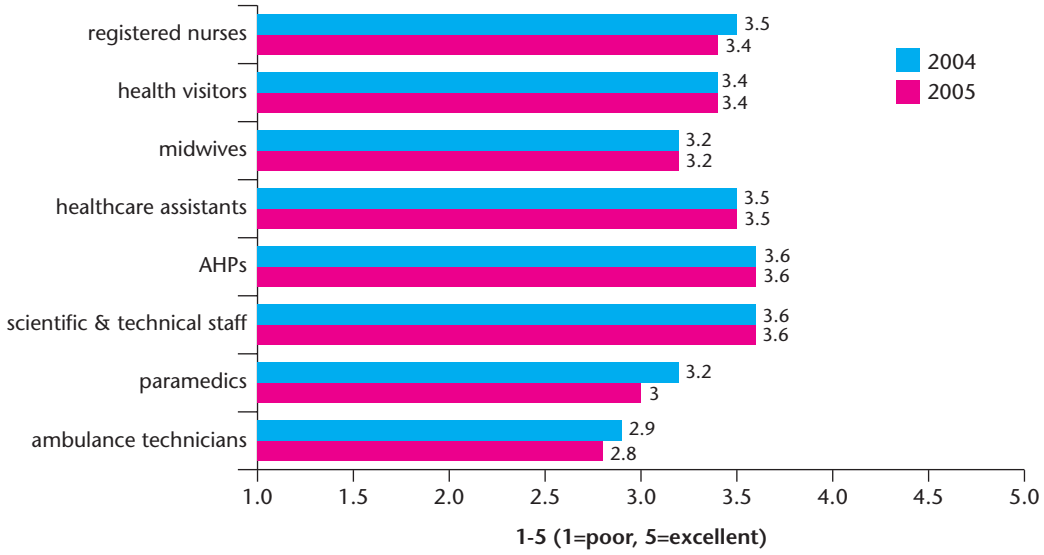
5.5 Staff were asked many questions that can be used as an indication of their motivation and morale and results from these can be grouped together to provide a view on issues such as the *quality of work-life balance, job satisfaction* and *work pressure* within the organisation.

5.6 The average scores for **work-life balance** were derived from level of agreement responses to three statements: *My Trust is committed to helping staff balance their work and home life; My immediate manager helps me find a good work-life balance*; and *I can approach my immediate manager to talk openly about flexible working*. Individual responses were each scored between 1 and 5, where 1 represents poor work-life balance and 5 an excellent work-life balance. The average work-life balance scores derived from the 2005 survey for our remit group were mostly slightly better than neutral (in the 3.0 to 3.5 area), broadly similar to those from the 2004 survey for most staff groups (see Figure 5.1). Ambulance technicians (2.8) and paramedics (3.0) had the lowest agreement scores and, along with registered nurses, each experienced small decreases in such scores since 2004.

[20] Includes auxiliary nurses.

[21] Includes healthcare scientists.

Figure 5.1: Work-life balance

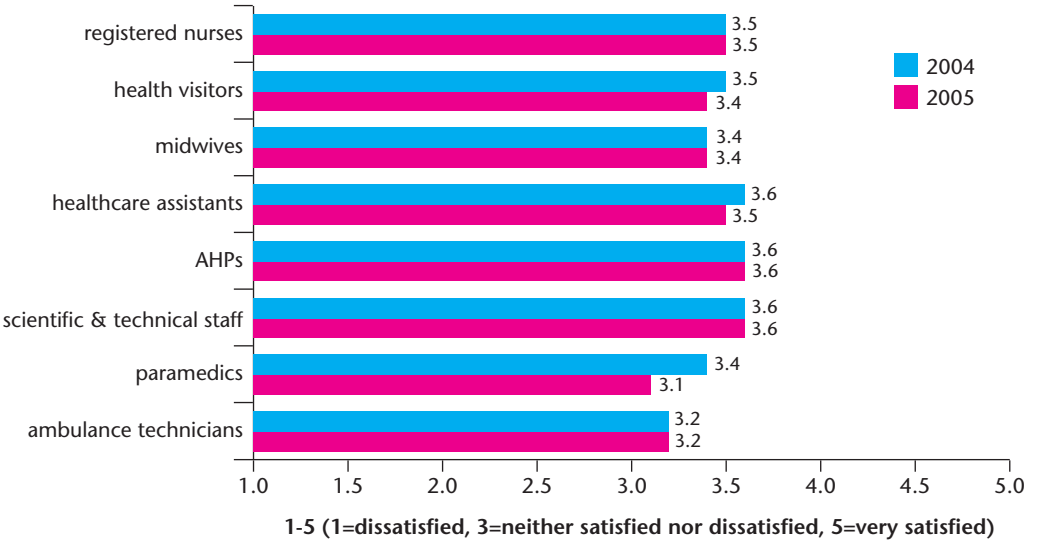


Source: NHS National Staff Survey 2005.

5.7 Staff were asked a series of questions to determine **job satisfaction:** *recognition for good work; support from immediate manager; freedom to choose own method of working; support from work colleagues; amount of responsibility; opportunities to use abilities; and the extent Trust values work* and an average satisfaction score was computed for each staff group (1 = very dissatisfied through to 5 = very satisfied).

5.8 High job satisfaction is generally associated with good performance, patient satisfaction, staff well-being and low levels of absenteeism and turnover. Most of our staff groups had a score of around 3.5, equivalent to half the sample being "satisfied" and the other half "neither satisfied nor dissatisfied" (see Figure 5.2). Paramedics (3.1) and ambulance technicians (3.2) had the lowest average job satisfaction scores, and the score for paramedics was down by over 0.2 from its 2004 level.

Figure 5.2: Job satisfaction

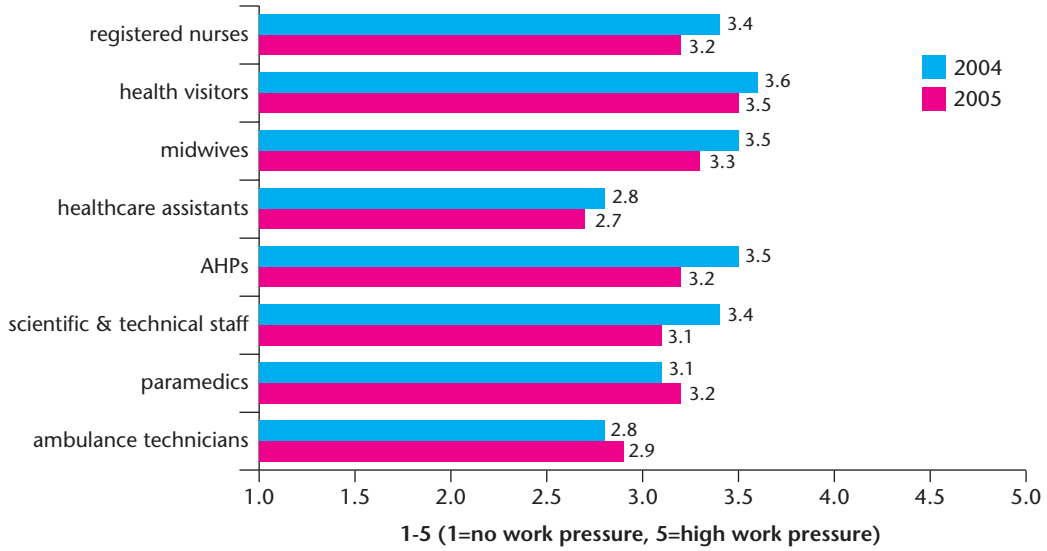


Source: NHS National Staff Survey 2005.

5.9 Average **work pressure** agreement scores were computed across four questions: *being unable to meet all the conflicting demands on time; being asked to do work without adequate resources to complete it; being required to do unimportant tasks which prevent completion of more important ones; and not having the time to carry out all the work.* The Healthcare Commission equates an average score of 1 to virtually no pressure and 5 to high feelings of pressure.

5.10 The scores indicate that the amount of work pressure felt by staff was more spread out than the scores for job satisfaction (see Figure 5.3). The average scores for most groups were in the 3-3.5 area with respondents, on average, more likely to agree with the four statements about work pressure than to disagree with them. In contrast, healthcare assistants and ambulance technicians tended to feel a little less pressure, with average scores below 3. Health visitors felt the most work pressure with an average score of 3.5. All the staff groups, with the exception of ambulance technicians and paramedics for which scores increased slightly, experienced modest falls in their average work pressure scores between the 2004 and 2005 surveys. According to the Healthcare Commission[22], work pressure is the best predictor of stress in the NHS and predicts, in turn, absenteeism and poor performance.

Figure 5.3: Work pressure



Source: NHS National Staff Survey 2005.

5.11 Individual staff bodies have also undertaken their own surveys. These have provided some useful and often more recent additional information on motivation and morale. We would be interested to see further data from all the parties next year when the full impact of the financial deficits is included.

[22] Page 24 of the National Survey of NHS staff 2005 Summary of Key Findings at: http://www.healthcarecommission.org.uk/_db/_documents/National_survey_of_NHS_staff_2005_-_Summary_of_key_findings.pdf

Scotland and Wales

5.12 In their evidence, the SEHD and the NAW both reported that there had been a response rate of around a third to their staff surveys for 2006 and 2005 respectively. We have not analysed these survey results in detail, as the response rates were low. The SEHD and NAW highlighted for us the key points arising from their surveys and these are summarised in the following section.

Evidence from the Parties

The Health Departments

5.13 The **Department of Health** said that the NHS's most valuable asset was its staff and it remained committed to supporting them to deliver a high quality health service to the public. On the measures taken under the *Improving Working Lives* initiative, the Department said that NHS organisations had been working towards embedding good HR practice, including help with childcare, across all staff groups.

5.14 The Department said that the 2005 NHS Staff Survey[23] had found that staff were generally satisfied with their jobs. The survey had revealed sustained improvements in key areas such as training, learning and development, access to flexible working, support for staff with dependents and safety at work. The Survey had found that staff believed their employers had a generally positive attitude to work-life balance with 73 per cent of staff reporting that they had used at least one flexible working option. The proportions of staff receiving training was up from 89 per cent in 2003 to 95 per cent in 2005.

5.15 The Department noted, however, that the Survey would not reflect staff attitudes in the light of the recent reports of redundancies which would not be picked up until the 2006 Survey results were available in March 2007. Responding to the Staff Side bodies' concerns that financial pressures in the NHS were resulting in increased workload for staff, the Department said it had no evidence of this. Responding to the T&G's concerns about violence towards ambulance staff, the Department said that a range of measures had been introduced to protect ambulance staff. In 2005/06 there were 1,690 fewer physical assaults against NHS staff in England as a whole than in 2004/05 and 229 fewer assaults against ambulance staff.

5.16 The Department said that the Knowledge and Skills Framework (KSF) was being closely monitored by the NHS Staff Council to ensure it was being used effectively to improve training and development for individuals. Continuing Professional Development (CPD) was vital in creating a workforce able to deliver more flexible and personalised health and social care services. CPD would give staff the opportunity to develop skills, gain greater job satisfaction and enable career progression.

[23] Further details of the Survey can be found at http://www.healthcarecommission.org.uk/nationalfindings/surveys/staffsurveys/2005nhsstaffsurvey.cfm

5.17 Responding to the Staff Side bodies' concerns about the impact of the current financial difficulties on the KSF and training, the Department told us that whilst it was acknowledged that financial constraints would impact on any process of implementing and embedding a new system, there were few direct costs associated with the KSF. Organisations should already have carried out awareness training and developed KSF outlines – KSF monitoring results from September 2006 showed that 72 per cent of staff (on a return of around 350,000) had received a full KSF post outline, 18 per cent had had a development review using KSF, 28 per cent had a current personal development plan and eight per cent had undertaken supported development linked to the KSF. The resource required for development review was primarily time for managers and staff to discuss work progress and agree any development needs. This should not be a new cost. The KSF development review should not take any longer than any good appraisal system.

5.18 The Department said that training needs resulting from the KSF process would be targeted at the precise requirements of staff. Some Early Implementer sites had found that effective use of the KSF had supported appropriate spend on training and had improved their ability to target funding. The KSF therefore gave organisations an effective tool to support training spend and decide on resources. The Department said it accepted that access to CPD was not always easy, but funding was a matter for local employers. There had never been a guarantee to fund all the training staff wanted.

5.19 Responding to the Staff Side's concerns about the KSF, the Department said that the future profile of the KSF and the completion of implementation would depend largely on the importance given to it by board level managers and staff side representatives. There was a clear requirement in AfC to monitor the KSF locally using data on progress on KSF outlines, use of the KSF and development reviews, provision of support for training and development and progression of staff through pay band gateways. These data had been requested by NHSE, on behalf of the Staff Council, as quarterly returns from March 2006. From 2007, the information gathered would need to enable analysis by occupational group, age, pay band, ethnicity, disability and gender. The information would be used by the NHS Staff Council to ensure equity and to provide support to employers and local staff representatives.

5.20 The Department told us that the e-KSF could also report on all KSF data in the format requested by the Staff Council and over 37 per cent of organisations were using the e-KSF tool. There would also be an interface between the e-KSF and the Electronic Staff Record (ESR) which was rolling out from November 2006 allowing detailed data from the ESR to be imported into e-KSF and also for the ESR to be updated from the e-KSF in terms of development review. The AfC agreement and the subsequent Staff Council agreements therefore offered a comprehensive methodology for KSF monitoring and the Department did not think anything further was needed at this stage.

5.21 The **Scottish Executive Health Department** (SEHD) said that NHSScotland was still in the process of implementing KSF, but was making good progress. At September 2006, around 35 per cent of staff either had post outlines agreed or in development. There had been a 33 per cent response rate to the latest staff survey in 2006. Amongst the key positive indicators were a high level of intention to remain working for NHSScotland, good use of staff's skills and abilities, and satisfaction with the overall benefits package in comparison to views on pay. Areas for improvement included low levels of general job satisfaction and communication, particularly around change management.

5.22 The **National Assembly for Wales** (NAW) said there had been a 33 per cent response rate to its 2005 Staff Survey. Positive factors for job satisfaction included having the opportunity to use one's abilities, being given responsibility and being able to decide how to do one's own work. Areas to be addressed in coming months included communication between management and staff, workload, work-life balance and using the survey data as a key predictor for recruitment and retention.

NHS Employers (NHSE)

5.23 **NHSE** said employers had reported in their responses to NHSE's questionnaire that morale had deteriorated among staff as a result of uncertainty due to perceived threat of job losses. The financial position of some employing organisations, NHS reconfiguration and the negative publicity surrounding the NHS were cited as the cause of this deterioration. The Staff Survey for 2005 had indicated that job satisfaction was slightly down from 2004. NHSE said that morale problems would not be addressed by additional pay: high pay awards would only cause continuing financial difficulties for Trusts and thus exacerbate the difficulties and uncertainties for staff. Morale problems would only be overcome when Trusts achieved financial balance. Turnover was arguably a better measure of morale than the national Staff Survey, but this varied considerably from Trust to Trust.

5.24 Responding to Staff Side bodies' concern that PCTs in England would not be required to survey their staff in 2006 because of NHS reorganisation, NHSE said that it understood the practical difficulties for the newly merged PCTs, established on 1 October 2006. Returns from these organisations were likely to be severely compromised. On the Staff Side's call for confirmation of the future profile, implementation and monitoring of the KSF, NHSE emphasised the same points as the Department of Health about the need for local prioritisation by Trust boards, the existing monitoring arrangements agreed under AfC and by the Staff Council, and the need for resources for future KSF support and monitoring.

Staff Bodies

5.25 The joint **Staff Side** reported that the NHS Staff Survey in England for 2005 had found that 56 per cent of staff were working unpaid extra hours, while in Wales the figure was as high as 75 per cent of the workforce. In England, 36 per cent of staff had reported suffering from work-related stress (around 40 per cent in Wales). There had been fewer appraisals or performance development reviews for NHS staff in 2005. Most staff had undergone some form of mandatory training, but 79 per cent had found some difficulties accessing training, most commonly because of difficulties in taking time off, lack of cover or funding, or because training was timed inconveniently.

5.26 Staff Side noted the drop in overall levels of job satisfaction for NHS staff in 2005. The average score for intention to leave the NHS had increased to 2.66 in 2005 from 2.57 in 2004, with career development and more pay given as the two most common reasons. The Staff Side said they were concerned that PCTs in England would not be required to survey their staff next year due to reorganisation.

5.27 The NHS Trade Unions had jointly commissioned an Ipsos-MORI research project to look at issues affecting the morale and motivation of healthcare workers, particularly exploring their views on problems with financial deficits in the NHS, broader healthcare reform issues and AfC. The project had consisted of four discussion groups involving activists in their respective unions held in July 2006 in Cardiff, Edinburgh, Manchester and London, and the analysis was based on the perceptions of participants. Findings had suggested that morale was low amongst NHS employees, largely due to on-going changes at national and local levels, compounded by financial problems and funding shortages. Participants had said, however, that there were many aspects of working for the NHS, such as its public sector ethos and key terms and conditions, that motivated people to remain.

5.28 Staff Side concluded that the morale of the workforce was a very real concern and asked us to take note of the impact of the current environment in the NHS, the impact of organisational change and the rapid pace of untested reforms. Staff Side said that as the morale and motivation of staff continued to be diminished by the slow pace of improvement in a number of issues affecting their working lives, pay would become a more important factor affecting recruitment and retention.

5.29 On the KSF, Staff Side told us that the Ipsos-MORI research had also shown a concern among participants that the current financial problems in the NHS and long-term under-funding might mean that KSF became difficult to implement in reality. In March 2006, Lord Warner had confirmed that all ring-fenced funding for NHS Learning Accounts and NVQs would cease in 2006/07, yet part of KSF was to develop staff, which would entail training and this would incur extra costs. KSF fostered an expectation that staff would be promoted and progressed along pay bands. Staff Side said this might not be possible for all employees because of the under-funding and pending redundancies. The KSF was an integral part of the AfC system and the Staff Side said they would welcome confirmation that the KSF would continue to have a high profile and would be implemented and monitored.

5.30 **UNISON** told us that it had carried out its own survey of its members across the UK during June/July 2006, including questions on AfC, staffing levels and morale and motivation. The sample was based on its sector committees covering ambulance, nursing and midwifery, allied health professionals, and scientific and technical. Combined membership of the sector committees was 60 and the overall response rate was 85 per cent. Results from the survey included:

- 78 per cent of respondents said that morale had worsened over the previous year;
- 62 per cent said that they would not or probably would not recommend the NHS as a career;
- 84 per cent said their workload and pressure had increased;
- 46 per cent of staff reported working more than five additional hours per week;
- 58 per cent said that increased workload had increased their stress levels, resulting in a detrimental effect on relationships outside work;

- 45 per cent indicated that stress had affected their health;
- 23 per cent felt it had had a negative impact on patient care;
- 61 per cent said they were worried or very worried about job security;
- 51 per cent had considered leaving their job and 37 per cent said it was because of pay. Of those considering leaving, 40 per cent said they had considered working outside the NHS and healthcare; and
- 66 per cent said they stayed in the NHS because they liked their job, their colleagues and the patient contact.

5.31 UNISON said that we had a unique role to play in reflecting on low morale and sending a positive message to staff. It urged us to acknowledge our role in areas outside pay and to note the concern over the future training and development of staff.

5.32 On the KSF, UNISON told us there were serious concerns about its sustainability, given that the current financial crisis had resulted in a freezing of training budgets and planned training provision had been severely cut. Many parts of the NHS had been forced to raid their training budgets in order to pay their debts. UNISON said there was a real fear that without sufficient commitment and proper resourcing, employers would at best pay lip service to the KSF.

5.33 The **Royal College of Nursing** (RCN) said that findings from its postal survey of 4,500 members (of whom 55 per cent had responded) had shown that while there was support for the principles of AfC, its implementation had led to perceptions of inconsistency and unfairness. Members felt that financial pressures were influencing the implementation of AfC and there were fewer opportunities for nurses to progress. Thirty-seven per cent of respondents had no KSF outline and only one in four respondents were happy with the introduction of KSF or satisfied with the way AfC had been implemented in their organisation. Those most dissatisfied with their banding were senior nurse managers and specialist nurses and it was likely that their attitudes would affect more junior colleagues and morale and motivation more generally. RCN also pointed to the findings of the Ipsos-MORI report for the joint Staff Side which said that the salary expectations of participants had been raised by AfC, but they now felt disillusioned. The RCN asked us to consider the long-term impact of factors affecting morale in deciding our pay recommendation.

5.34 The **Royal College of Midwives** (RCM) said it had conducted a survey in July 2006 of all Heads of Midwifery (HOMs) in the UK of whom 115 had responded (response rate 53 per cent). In response to the question 'Are your staff happy?', 53 per cent had said yes while 38 per cent had said no. The survey had also indicated that Trusts could enact policies which improved staff morale, particularly those relating to training, involvement, flexible retirement and childcare. However, responses had suggested that many midwifery units felt overworked and under pressure and unable to benefit from some of the policies in place because of staff shortages and/or budgetary constraints. In a further survey, conducted in December 2006, 42 per cent of the 102 HOMs responding reported that their training budget had been cut; of those, 68 per cent had suffered cuts of 50 per cent or more.

5.35 The **Society of Radiographers** (SoR) said that a lack of finance was hampering AfC's implementation, at the expense of members' support and confidence in the NHS as an employer and their workplace morale. The SoR membership was reluctantly willing to work with AfC in the recognition that it would reward career development within the KSF, but any benefits had yet to be realised and had been overshadowed by cuts and the threat of redundancies.

5.36 The SoR said it had surveyed its 547 department managers in England over a two week period in September 2006; 232 (42 per cent) had responded. The survey had revealed that 38 per cent of radiography departments had yet to complete the AfC implementation process and this lack of progress on assimilation had had a direct bearing on morale and confidence in the management of AfC. The KSF was not yet underway for most staff with only 50 per cent of outlines drawn up so far.

5.37 The **Chartered Society of Physiotherapy** (CSP) had undertaken a workforce survey of senior physiotherapy managers in the NHS across the UK in July 2006. It received responses from 202 organisations covering 42 per cent of the current whole-time equivalents (WTE) qualified physiotherapy workforce in the UK. The CSP said that the findings in relation to training budgets raised serious concerns. Sixty per cent of respondents had said that the training budget for physiotherapy staff for 2006/07 had been significantly reduced; 77 per cent that the training budget for physiotherapy staff was inadequate to meet their KSF development needs; and 82 per cent that the training budget for physiotherapy staff was inadequate to meet their CPD needs.

5.38 The CSP said it was clear that KSF was not being given enough support from employers. Some had suspended all development activities and most had severely retrenched their training. Most physiotherapists ended up funding themselves to develop advanced practice and specialist skills.

5.39 The CSP said that staffing shortages and financial problems in the NHS were having a negative impact on staff morale. In its survey, 79 per cent of respondents said that physiotherapy staff were experiencing significantly increased workloads and stress than a year ago and 67 per cent had said that motivation and morale had fallen significantly in the past year. We were asked to recognise the demotivating impact on staff of the financial problems facing the NHS and to take account of their impact on workload and stress.

5.40 The **T&G**, reporting on behalf of its ambulance service members, remained concerned about the use of temporary workers and the negative impact that continually changing staff had on team working, and said that future organisational changes meant use of agency staff was likely to increase. Its members were particularly concerned about increased violence towards staff. The current financial context in the NHS was likely to impact negatively on staff development and the T&G was concerned that short-term strategies were overriding the long-term workforce planning needs that were integral to AfC. There was a real need for us to recognise the impact on staff morale of the issues currently facing the service.

5.41 The British Orthoptic Society (BOS) had conducted a workforce review in September 2005 (response rate 97 per cent) and reported that many Heads of Service had admitted to losing motivation to develop services as recruitment was so difficult. Only three per cent of staff time during the sampling period was spent on CPD. The BOS said there was no doubt that the current financial climate had had a significant effect on the morale and motivation of orthoptists.

Our Comment

5.42 We note from our own analysis of the 2005 NHS Staff Survey for England (undertaken between October and December that year) that the results are very broadly similar to those for 2004 and paint a picture that, on balance, is generally positive. However, it is difficult for us this year to place any great reliance on the 2005 Survey's results as they pre-date the effects on morale of more recent key developments – the outcomes of AfC assimilation and any subsequent appeals, and the effect on staff of the actions Trusts have taken to address the NHS's funding difficulties. As the Department of Health itself acknowledges, the impact of the funding pressures on staff will not be known until the 2006 Survey results become available in March 2007. We are concerned that the 2006 Survey will be less representative than usual because of the decision to make optional the participation of PCTs undergoing reorganisation, highlighted to us by the joint Staff Side. We have made further enquiries of the Healthcare Commission about this and we reluctantly accept the Healthcare Commission's argument that as most PCTs merged and reconfigured on 1 October 2006, to have conducted the survey in the immediate aftermath would have made the data unreliable. We look forward to the data series being re-established from 2007.

5.43 In view of the current uncertainties around the state of morale amongst our remit group, our secretariat is pursuing with the Healthcare Commission whether there is scope to bring forward the time period during which the NHS Staff Survey is undertaken each year. We would find it extremely helpful to have a more up-to-date picture of the current state of morale than the currently timed Survey permits. The more recent surveys provided by the Staff Side bodies paint a far gloomier picture of the overall level of morale and motivation amongst our remit group and NHSE also reported that morale was deteriorating. This negative picture was highlighted to us again by all the Staff Side bodies during oral evidence. As we do not have more timely information from the NHS Staff Survey to inform our deliberations, we must place greater reliance on the findings from the more recent surveys carried out by the Staff Side bodies.

5.44 The evidence from all the parties makes clear that there are funding pressures at the moment in the NHS and the Staff Side bodies have stressed that this is resulting in higher workload for existing staff because of the current vacancy freezes. We would like a better understanding of whether the workload of our remit group is changing and would ask the parties to consider what evidence they can provide on this for the next round. We would be concerned if increased workload is adversely affecting morale because of the possible consequences for service delivery, recruitment and retention. NHSE confirm that employers are reporting morale to have deteriorated among staff because of the current state of uncertainty about job losses. Evidence from the Staff Side bodies also points to degrees of dissatisfaction with the implementation of AfC and a more general concern about what is seen as the raiding of training budgets to help solve the current financial difficulties. This latter aspect was highlighted very clearly in the Health Committee's recent report on "NHS Deficits"[24] where the Committee expressed considerable concern that Strategic Health Authorities are making major budget savings through cuts in education and training. The Committee noted the effect this was having and would have in the future on staff morale and the availability of skilled staff in the NHS. The Secretary of State told the Committee that the cut in the education and training budget "...is not one that you could sustain long term. If you repeat reductions in training and education year in, year out, sooner or later you find yourself with an absolute shortage of the skilled people on whom the NHS completely depends."[25] The Committee noted however that the Secretary of State did not indicate how long the cuts in the training programme would continue. We further note the concern amongst various Staff Side bodies about the impact these cuts in training budgets will have on the effective implementation of the KSF for existing staff.

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[24] HC 73-I and HC 73-II published 13 December 2006.

[25] Health Committee Report on NHS Deficits, paragraph 190.

5.45 We commented in Chapter 1 that the KSF is key to the success of AfC and so we would urge the parties to ensure that it is fully implemented as soon as possible and then operated effectively. We note that Scotland and Wales are further behind in their implementation of the KSF than England and we hope that they can now move this forward quickly. The KSF is a key part of the overall AfC package and is clearly significant to staff. The financial and non-financial resources needed to support the KSF locally are not something for us to determine, but they need to be adequate to support identified training and development needs. The Department of Health told us that there were few direct costs associated with the KSF, but resources (such as providing backfill) need to be made available to allow staff time to learn and practice the skills needed to deliver a better service to patients.

5.46 The wider implications of reductions in training opportunities also need to be borne in mind. A number of the Staff Side bodies told us they feared a return to a boom-bust cycle whereby staff numbers expanded and were then allowed to contract until shortages became a problem. The Secretary of State herself acknowledged to the Health Committee the dangers of this happening if reductions in the education and training budget were sustained. Newly qualified staff who are unable to find a post within a reasonable period of time are likely to be totally lost to the service. As we commented in Chapter 3, in our deliberations, we are not only concerned with the immediate position on recruitment and retention, but we also look at the factors which are likely to influence the situation in the longer term. We would therefore urge the Health Departments to take a longer term view of training and development, both in respect of trainees and staff in post, and to ensure appropriate resources are in place to support them. Training budgets should not always be seen as a soft target if funding problems arise because of the longer term problems this may cause for NHS service delivery. Beyond training and the KSF and the positive impact these should have on staff morale, NHS employers also need to continue the positive momentum built up through implementing the principles underlying *Improving Working Lives*.

5.47 NHSE told us that morale problems will not be addressed by high pay awards because they would lead to further staff cuts. However we must also bear in mind that a relatively low award will do nothing to improve morale. The level of pay and pay awards, both in absolute terms and relative to levels elsewhere in the economy, send a powerful message about the value of staff who are working in a challenging environment. In considering the morale aspect of our remit this year, we have tried to take a view of the risk posed to the achievement of the NHS's service delivery targets in the light of the parties' evidence on the impact of the funding problems facing the service and the challenges that lie ahead from the Government's ongoing reform programme. We have then considered how our pay recommendations might further affect any such risk. Morale is likely to have a direct effect on the quality of service provided to patients and is also linked to recruitment and retention. A deterioration in morale is likely to adversely affect the ability of the NHS to recruit and retain high quality staff, both in the short and longer term.

Chapter 6: The Funds Available to the Health Departments

Introduction

6.1 Our remit requires us to have regard to the funds available to the Health Departments in reaching our recommendations. The evidence we have received on these 'affordability' issues is reviewed in this section. As might be expected, the Health Departments and NHS Employers (NHSE) have submitted the bulk of the evidence on this aspect of our remit.

6.2 Our remit also requires us to have regard to the Health Departments' output targets for the delivery of services. The Department of Health said that though affordability and other cost pressures were crucial factors in any consideration of the links between pay and output targets, it was not possible to quantify in any precise way the impact of our recommendations on pay in one year on the achievement of output targets in the next. Moreover, it did not consider that it would be meaningful to attempt any such quantification, given the complex factors at play. In such circumstances, we have been unable to give detailed consideration to this aspect of our remit, although we note the Department's general point that unnecessarily large pay increases may prejudice the delivery of service improvements.

Evidence from the Parties

The Health Departments

6.3 In their evidence on the fiscal context, the **Health Departments** said that this round's pay awards would set the baseline for the forthcoming Comprehensive Spending Review (CSR07), covering the years 2008/09 to 2010/11, and so the awards would have much longer-lasting affordability implications. The rate of growth in public spending under CSR07 was set to slow substantially and given this tightening, recent growth rates in pay were unsustainable if Departments were to fund their spending priorities.

6.4 For reasons of affordability, settlements needed to be off-set against other drivers of the paybill. It was therefore critical to take into account all the factors that would increase earnings when determining the annual pay uplift, such as payments arising from restructuring of the pay system, targeted payments to aid recruitment and retention, local pay, the net effect of progression payments, and bonus payments. The combined effects of reform, incremental progression and pay uplifts were the factors that determined affordability.

6.5 The **Department of Health** said that around two-thirds of NHS spending went on pay and so even very small changes here would have a substantial effect on Primary Care Trusts' (PCTs) ability to manage their non-pay spending pressures. The annual paybill increased as staff numbers increased, but also because of the annual pay settlement, an element of pay reform and pay drift.

6.6 Key challenges ahead included:

- *Financial pressures* – the NHS had ended 2005/06 with over 170 organisations in deficit, compared to 159 in 2004/05. The net deficit had increased from £259 million in 2004/05 to £512 million in 2005/06. The NHS had a duty to achieve financial balance overall and so deficits in a minority of Trusts were a national rather than a local problem, with other organisations required to run surpluses to release resources and cash to assist those which were struggling. Although the NHS was determined to achieve overall financial balance this year, a significant minority of Trusts would have deficits. For these Trusts, financial recovery plans would extend into 2007/08 and so the level of the pay award would be a crucial factor in determining whether there would be more or fewer redundancies in these organisations.

- *Pay drift* – analysis from the first tranche of data from the Electronic Staff Record (ESR – covering around 128,000 staff) suggested that 79 per cent of staff under AfC were below their scale maxima. Until pay systems stabilised, there would be considerable pressure on earnings and paybill over the next few years as the large numbers of staff who had been recruited at the bottom of the pay scales started to move up them.

- *Pension liabilities* – any increase in salary had an equivalent impact on pension costs for employers who currently contributed around 14 per cent of salary.

6.7 The Department said that pay costs were not funded separately, but were met at PCT level from their overall funding. Decisions about dealing with additional pay pressures would be made locally, but in the event of high pay awards creating cost pressures, Trusts and PCTs would have to consider where savings could be made and such savings would be a mixture of cutting existing services, less investment in new services and reducing the number of staff in post. Each additional 0.5 per cent increase in pay for our remit group added around £107 million to the paybill, which nationally would fund 3,300 qualified nurses, or 1,200 doctors or 51,000 elective procedures. Although £107 million might be a small percentage if spread across all Trusts, it would mean less funding for other aspects of the Trusts' expenditure or lead to a deficit which would be unacceptable.

6.8 The Department's DEL provided for real terms growth in 2007/08 of 6.4 per cent and for cash growth of 9.2 per cent, but these were not benchmarks for pay settlements. The paybill was one of many financial pressures on the DEL, which had to meet the Government's commitment to modernise the NHS and various underlying demand pressures, such as implementation of NICE guidelines, increasing demand for the services of GPs, dentists and hospital services, increasing cost of and demand for drugs, costs of training and developing NHS staff, and capital/IT investment. A broad breakdown of NHS non-pay expenditure and pressures was also provided.

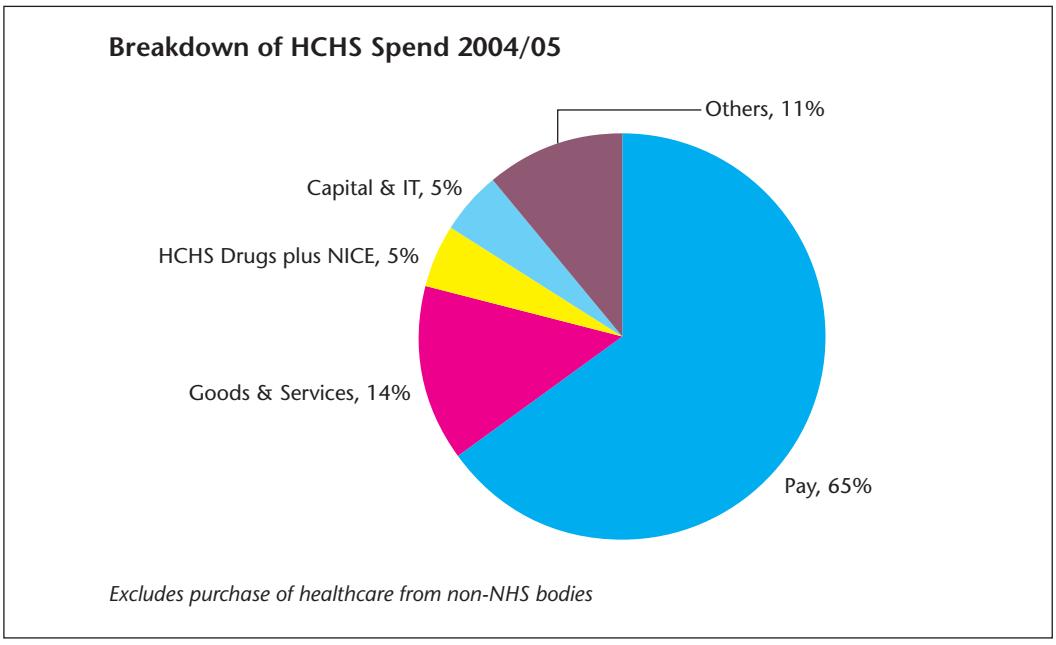
Table 6.1: Departmental Expenditure Limits[1]

	NHS DEL (£m)[3]	Cash Growth (£m)	Cash Growth %	GDP Deflator[2]	Real Terms Growth
2003/04	64,183	–	–	–	–
2004/05[4]	69,306	5,123	8.0%	2.72%	5.1%
2005/06	77,847	8,541	12.3%	2.12%	10.0%
2006/07	84,387	6,540	8.4%	2.44%	5.8%
2007/08	92,173	7,786	9.2%	2.66%	6.4%

Notes:
1. Figures are consistent with the 2006 Department of Health Report.
2. GDP deflator as at 30 June 2006.
3. NHS DEL figures now include technical adjustment for Trust depreciation.
4. Includes a technical adjustment in 2004/05 for provision of £1,497 million.

6.9 In response to our request for a more detailed explanation of the composition of the DEL for 2007/08, the Department provided us with the following information:

"The following summarises the cost pressures across all areas of PCT responsibility. It includes cost pressures that increase unit costs (inflationary and some quality improvements) as well as those that are volume related. This section sets out the breakdown of Hospital & Community Health Services (HCHS) expenditure, plus the estimated inflationary cost pressures based on the figures underpinning the uplift to the national tariff.



HCHS cost pressures (covered by the tariff) that increase unit costs

HCHS Cost Pressures Table	Baseline	Uplift (%)	Cost
Pay (inc. settlement, drift & reform)	~£33bn	–	~£1.4bn
Price inflation plus NHS Litigation	~£7bn	Prices: 2.7%	~£0.4bn
HCHS drugs plus NICE	~£3bn	Drugs: 12.5%	~£0.5bn
Capital & IT	~£2bn	–	~£0.4bn
TOTAL – excluding efficiency	**~£45bn**	–	**~£2.7bn**

In addition to the above cost pressures, there is expenditure of around £5.7 billion covering Workforce Development Confederation expenditure, external contracting and consultancy services and miscellaneous spend. We therefore expect there will be a small increase in costs of these services but they are excluded from the national tariff.

Other costs

Other Cost Pressures	Baseline	Uplift (%)
FHS Drugs	~£7bn	Medium term trend ~8% to 10%
Emergency activity	~£11bn	Medium term trend ~4%
Mental Health, Community and Learning Disability	~£10bn	Expected underlying trend ~1% – 2%

Other priorities

- Making progress towards the 18 week target;
- Hospital infections – including MRSA and Clostridium Difficile;
- Public Health and reducing inequalities;
- Implementing Our Health Our Care Our Say;

Efficiency target

The efficiency target is to deliver around £1.4 billion (2.5%)."

6.10 The Department also provided data illustrating how pay as a percentage of revenue spend on HCHS had risen from 61 per cent to 65 per cent between 2002/03 and 2004/05. The Department said that if pay's share continued to rise, there would be less revenue spend available for investment in services.

6.11 The Department told us that the Payment by Results (PbR) tariff was the price that Trusts were paid for providing services commissioned by PCTs and other Trusts. Around 40 per cent of HCHS expenditure was covered by PbR and so it could be broadly assumed that 40 per cent of activity covered by our remit group would be PbR activity. The tariff uplift took account of pay, inflation on goods and services, hospital drugs costs, capital charges, clinical negligence contributions, IT, and NICE recommendations. These increases in costs were in part offset by an assumed efficiency improvement of 2.5 per cent. The Department believed that the tariff had been set at a level that was sufficient to cover the costs of providers, but which was also affordable by PCTs. The tariff uplift for 2007/08 would be five per cent projected increase in costs minus 2.5 per cent efficiency.

6.12 Details of the pay, price and reform uplift to the tariff in 2007/08, published by the Department of Health on 19 December 2006, are set out below:

Annex D[26]: Pay, price and reform uplift to the tariff in 2007/08

	2007/08 (over 2006/07 baseline)		Assumptions
Baseline	**55,130**		
Increase in pay and prices	**£m**	**%**	
Pay	950	1.7	Pay settlement and drift totalling 2.5%
Non-pay inflation (prices)	315	0.6	GDP 2.7% in 2007/08
Clinical Negligence Costs	125	0.2	
Secondary care drugs	390	0.7	Assumes growth of 12.5%
Revenue cost of capital	230	0.4	
Gross pay and price increase	2,010	3.6	
Efficiency	–1,380	–2.5	Assumes 2.5% efficiency
Net pay and price increase	**630**	**1.1**	
Reform and quality			
Consultant Contract	50	0.1	
NCCG reform	10	0	
Agenda for Change	395	0.7	
NICE appraisals and guidelines	150	0.3	
Investment in new capital	120	0.2	
Total reform and quality	**725**	**1.3**	
Information Technology			
NHS Connecting for Health	30	0.1	
Total information technology	**30**	**0.1**	
	Overall	***2.5***	

6.13 The Department said in conclusion that although the headline figures showed large growth in the DEL for 2007/08, a responsible approach to pay was crucial if it was to achieve all the objectives set out in the NHS Plan and maintain financial balance. The Government's commitments to the modernisation of the NHS and the range of additional cost pressures it had outlined meant there was significantly less money available than it might seem.

[26] Payment by Results guidance 2007/08, published by Department of Health, 19 December 2006.

6.14 The **Scottish Executive Health Department** (SEHD) said that staffing costs accounted for around 60 per cent of its total expenditure on health and a substantial portion of the additional funding for health in Scotland would go towards staff costs. This reflected the very significant investment made in staff pay in recent years. The recent increases in staff pay had had a major impact on NHS Boards' budgets and excessive pay uplifts on top of these would adversely affect the ability to develop and extend patient services. Each 0.5 per cent rise in the paybill equated to £24 million in Scotland, the equivalent of employing 800 nurses or 260 doctors. The funding provisions for 2007/08 showed real terms growth of 5.07 per cent, but this could not be seen as a benchmark for pay settlements. The indicative standard increase for NHS Boards in 2007/08 was six per cent and this had to be used to meet NHS modernisation commitments and various demand pressures. No specific paybill increases had been identified within these figures and it was for NHS Boards to manage financial pressures (including paybill) within the provision. The SEHD told us that Scotland did have tariffs, but only for cross boundary finance flows between Health Boards. The money involved was not insignificant (about 10 per cent of total acute spending by Health Boards), but it was not the same as the tariff in England.

6.15 The **National Assembly for Wales** (NAW) said the NHS continued to face a difficult financial outlook in 2007/08. NHS organisations in Wales were currently forecasting deficits equating to approximately 1.5 per cent of their 2006/07 allocation. The cost of a one per cent pay increase for hospital and community NHS staff was approximately £23 million, equivalent to 650 qualified nurses. In 2007/08 NAW expected to provide further funding for pay modernisation of 0.6 per cent for the costs of incremental increases of AfC and 0.2 per cent for the non-consultant career grade contract. There was also concern that central funding for the implementation of AfC might not be sufficient. Current estimates of the shortfall varied between £17 million and £27 million. There was no flexibility to manage NHS pay awards in 2007/08 above a two per cent planning figure for the pay uplift which had been assumed in its figures. The NAW told us there was no tariff in Wales, but the National Finance Agreement was the equivalent process which set out the estimated increases in baseline NHS costs to be used in the annual planning process. The Agreement for 2007/08 said that a planning assumption of a two per cent increase in pay should be used and that in addition, there was a full-year effect of the 2006/07 pay awards. The impact of pay awards was therefore a 1.51 per cent increase in total HCHS costs. For planning purposes, the Agreement also said that the impact of incremental drift under AfC was estimated at 0.81 per cent. The total increase for pay and non-pay costs for the HCHS in the 2007/08 Agreement was 6.23 per cent.

NHS Employers (NHSE)

6.16 **NHSE** reminded us that despite record increases in funding, the NHS had recorded a net overspend of £250 million in 2004/05 and a substantial overspend, equivalent to around £512 million net, for 2005/06. This net overspend represented less than one per cent of the total NHS spend and affected a minority of organisations, but it signified a gradual deterioration in the position over the last few years. The latest figures from Monitor, the Foundation Trust regulator, reported a £24 million net deficit across Foundation Trusts.

6.17 NHSE said evidence suggested that the main causes of NHS deficits were inherited debts, failure to manage excess capacity through reconfiguration and in a few cases, loss of financial control and poor governance. Staff issues had not been a major factor and NHSE said it did not accept that pay was the main cause of the deficits. The financial difficulties faced by some NHS organisations had resulted in them reviewing their workforce numbers in an attempt to save money. NHSE had gathered information between March and May 2006 which indicated that a significant minority of organisations were planning a reduction in posts. A small number of organisations with the largest deficits had outlined plans for actual redundancies.

6.18 Given the evidence, NHSE asked us to consider carefully the impact that any pay increase deemed unaffordable by NHS employers would have on an already difficult financial position. All organisations were facing pressures and the NHS had a duty to achieve financial balance overall. Deficits in a minority of organisations often required other organisations to release resources to maintain overall balance across a health economy.

6.19 In their original written evidence, submitted in late September 2006 before the publication of the final tariff uplift figure for 2007/08, NHSE had said that a pay award in line with the Consumer Prices Index inflation target was the most that could be afforded. NHSE said that affordability was also dependent upon an appropriate increase in the pay element in the tariff. Following publication by the Department of Health of the tariff uplift for 2007/08 on 19 December 2006, NHSE told us it had been difficult for them to assess what level of uplift would be affordable before then as this depended on a combination of the level of resources available to individual organisations via the tariff and the extent of their prior commitments. At the time NHSE submitted their written evidence in September 2006, they had made a straightforward assumption that the tariff increase could be converted into the pay uplift for the proportion of revenue spent on staff. When the tariff uplift was published in December 2006, NHSE had sought the opinion of the Department of Health as to the affordability of a pay uplift. The Department had advised that, given the costs of other factors, such as pay modernisation (around 80 per cent of staff would expect an incremental uplift during 2007/08), the most that could be afforded was 1.5 per cent. Given the Department of Health's advice, which was based on the interaction of business and workforce models held by the Department, NHSE said they would not wish to pursue a recommendation that ultimately became unaffordable for employers, risking the viability of jobs and service commitments. Based on the indications of affordability discussed above, NHSE said they believed that 1.5 per cent was the best indication they had of what would be affordable.

Staff Bodies

6.20 The joint **Staff Side** said that the Department of Health was committed to achieving £6.47 billion of efficiency savings each year by 2007/08, in part through the reallocation of staff time and workforce remodelling. Efficiency agendas were also being pursued in Scotland and Wales. Staff Side noted that although in cash terms the NHS's budget for 2006/07 was over 50 per cent higher than in 2002/03, many NHS bodies in England were having to make significant cuts to their budgets. The main reason for the financial distress appeared to be changes of emphasis by Government: until recently, the main priority had been to reduce waiting lists, but financial stringency now had a higher priority.

6.21 Staff Side said that the overall NHS deficit needed to be placed in perspective. Staff Side calculated that the net debt for 2005/06 was equivalent to a person earning £20,000 having an unpaid Visa bill of £150. The gross deficit was equivalent to the same person having an unpaid Visa bill of £380, but also having £230 in the bank. Despite the significant additional resources that had been allocated to the NHS, spending was still well below that of other industrial countries.

6.22 Staff Side said that the requirement for virtually all NHS Trusts to achieve financial balance by the end of 2006/07 had triggered a reactive and short-term response from some Trusts which had contributed to the recent wave of job cuts. Trusts could be given more time to resolve their financial problems or the level of the tariff could be increased. We were asked to consider the view that the financial deficits of a minority of NHS organisations should not adversely impact on the pay award for the whole of the NHS workforce.

6.23 **UNISON's** evidence also discussed the substantial deficits being experienced by some Trusts in England, and in the NHS in Wales and Scotland, the reasons why these had arisen and the implications for staff in terms of increased pressure with vacancy freezes and redundancies. It quoted statements from Ministers that it claimed supported the view that the deficits were manageable.

6.24 The **Royal College of Midwives** (RCM) told us that notwithstanding the complexity of the NHS coming in on budget, it was clear that the overspend had led to a round of cuts, closures and redundancies, with birth centres particularly affected. Examples were given of where redundancies were taking place and birth centres were under threat. The RCM also pointed to a Ministerial statement that the NHS was on track to achieve a net financial balance by the end of the year.

6.25 **Amicus** referred to the Staff Side's analysis of the deficit crisis which Amicus believed was the result of changes in the Government's approach to dealing with overspending Trusts. Amicus considered that there was no reason why these Trusts should not have been allowed to bring their finances into balance over a longer period of time with money effectively "advanced" from future allocations. There was also no reason why Trusts in balance should themselves be forced into crisis through the "top slicing" of their funds to offset those Trusts which were in deficit. Amicus commented that the deficits crisis was a handy backdrop to the Treasury's attempts to depress the size of awards by the Pay Review Bodies.

Our Comment

6.26 Our terms of reference require us to have regard to the funds available to the Health Departments, as set out in the Government's Departmental Expenditure Limits (DELs). Consideration of the funding implications of our recommendations for 2007/08 has taken place against the background of substantial injections of new money into the NHS, but also this year the well-publicised financial difficulties of the service. The NHS budget has doubled since 1997 and the DELs now show overall average growth of 6.7 per cent in real terms in England over the five year period 2003/04 to 2007/08. For 2007/08, the growth in the DELs for England, Scotland and Wales is set out in the following table:

	Real terms growth (%)	Cash growth (%)
England	6.4	9.2
Scotland	5.07	7.86
Wales	4.2	7.0

6.27 Despite this increased funding, it is clear that there are considerable financial pressures on the service. Six-month figures published by the Department of Health on 9 November 2006 forecast a net deficit of £94 million for the NHS in England in 2006/07 (£1,179 million gross deficit). The figures also show that 175 organisations were forecasting a deficit for the year (around one-third of the total) with half of the gross deficit concentrated in six per cent of organisations. The Department has told us that the financial recovery plans of those Trusts in deficit will extend into 2007/08.

6.28 The Health Departments have emphasised to us again this year that growth funding should not be regarded as a benchmark for pay settlements. We agree. We do not consider, however, that in making our recommendations we must be constrained by whatever figure Departments tell us is available for pay. Indeed, adopting such a role would be a dereliction of our responsibilities as specified in our remit. We do not see our role as merely allocating a fixed pay envelope across the remit group. Nor do we believe that the pay settlement for our remit group should bear the brunt of financial difficulties that are attributable to a range of factors, although clearly pay must play its part.

6.29 Financial deficits in parts of the NHS have been an issue for some years now. In its recent report[27] on NHS Deficits, the Health Committee concluded that the increases in the underlying deficits incurred by PCTs and hospital Trusts had many causes: the effects of changing accounting procedures, the contribution of the funding formula, the effect of Government policies, poor management by the Department of Health (including unrealistic estimates by the Government of the cost of AfC, the new GP and consultant contracts), poor local financial management and in some cases large inherited debts. Different witnesses appearing before the Committee gave different weight to the importance of different factors. We said last year that it was not evident to us how far we could factor into our considerations the funding problems of a minority of NHS organisations when we are considering the level of a national pay recommendation. The Department of Health has pointed out to us that as the NHS as a whole must be in balance, the deficits of the minority of Trusts must affect what is affordable at the national level, because if some Trusts run deficits, others must run surpluses. We accept that, and as last year our consideration of affordability should therefore be focussed at national level.

[27] HC 73-I and HC 73-II.

6.30 In taking this approach, we need to begin by understanding the composition of the total funding envelope for the NHS, the various costs it has to support and how the numbers employed and the level of pay interact with those other costs. Here the Departments have provided us with their DELs for 2007/08. The Department of Health has also made clear the importance of the tariff uplift for 2007/08 under PbR for the overall affordability of the pay uplift. The PbR guidance for 2007/08, published on 19 December 2006, indicates that 1.7 per cent has been built into the tariff uplift for increased pay, plus 0.7 per cent for AfC. The overall 2.5 per cent tariff uplift also assumes efficiency savings of 2.5 per cent. We have sought clarification from the Department at various stages of our review about how the tariff figures relate to the DEL and although the Department has provided additional information, we have been disappointed that our specific questions have not been addressed. We are particularly concerned about the lack of clarity here given that the Department has emphasised that the level of the pay award will be a crucial factor in determining the number of redundancies in Trusts that will be subject to financial recovery plans (see paragraph 6.6).

6.31 The Department told us that the level of the tariff increase should be the key determining factor for the level of the pay increase. Nothing we have seen in the evidence from the Department explained clearly to us why the pay element has been set at the level it has. Moreover, in the medium to longer term, the average earnings of our remit group would need to move broadly in line with average earnings in the types of jobs that our remit group might alternatively choose. If they do not, over time the NHS will become uncompetitive and unable to attract and retain sufficient numbers of good quality staff. As we said earlier in the report, when we frame our pay recommendations, we must look beyond the immediate position on recruitment and retention to the positioning of our groups in the longer term compared to the wider economy. In the longer term therefore, the level of earnings needed to attract and retain sufficient numbers of good quality staff should determine the pay element of the tariff, not the other way round.

6.32 Moreover, the cost framework set by the Department of Health for England seems to be driving what we have been told is affordable for all three countries and yet the tariff as it will be applied in England does not apply in Scotland and Wales. The evidence from Wales indicates that a two per cent pay uplift would be affordable, but the evidence on affordability from both Scotland and Wales has provided little real clarity on why those two countries can afford the same pay uplift as England when their level of funding growth in 2007/08 is lower than in England. Furthermore, as AfC is being implemented more slowly in Scotland and Wales, those countries will have to bear the costs of assimilating staff onto the new pay structure over the coming year, despite having less funding growth than England.

6.33 The Department of Health has stressed to us that pay settlements need to be off-set against other drivers of the paybill and that we need to take into account all the factors that increase earnings when determining the annual pay uplift because the combined effects of reform, incremental progression and pay uplifts determine affordability. If we are to give affordability full and proper consideration, we must first understand how different levels of pay award affect the total funding envelope, and as we discussed above, we are still unclear on this for all three countries. Second, we need to understand and have confidence in the data on earnings for our remit group so we can then assess the impact of any recommendation on the paybill. We discuss this crucial issue in more detail in the next chapter.

6.34 Affordability constraints are a very important element of our remit and we asked in our last report for more specific evidence for this round. We do not consider that we have been provided with evidence of sufficient clarity to assist our deliberations, despite the exceptional prominence given to affordability issues this year by the Health Departments and NHSE. For our next review, we would ask them to provide more specific evidence on the funding pressures, the composition of the budget and, for England, the link between the tariff and the DEL. In last year's report we gave some examples of the types of information we would find helpful – an analysis of the actual and potential funding pressures; how outturn projections compared with original assumptions underpinning the budget; the reasons for any variances; a breakdown of the paybill in terms of basic pay, overtime, and progression etc; and an analysis of the impact of changes in the numbers and composition of the workforce. It was unhelpful that this information was not made available to us this year and we have asked our secretariat to discuss in more detail with the Health Departments and NHSE what evidence may be made available to us to inform our next review.

6.35 In asking us to recommend a pay uplift of 1.5 per cent, the Department of Health has estimated that this will deliver growth in average earnings for our remit group of 4.0 per cent. We therefore note that the evidence from the Health Departments implies that earnings growth of 4.0 per cent is affordable for all three countries, although the basis for concluding that a 1.5 per cent uplift would produce this figure is unclear, as we shall discuss in more detail in the next chapter.

Chapter 7: Pay and Prices

Introduction

7.1 In this chapter we review the evidence we have received on pay and prices and comment on the points that have been put to us. Our remit requires us to have regard to the Government's inflation target[28]. With different emphases, the parties have provided us with general macro-economic evidence on, in particular, trends in inflation, average earnings, and pay settlements, and these data are updated regularly by our secretariat. These indicators provide part of the context to our work, but they are by no means the only factors we take into account. We have also received evidence specific to the pay of our remit group covering, in particular, relative earnings levels and movements.

Evidence from the Parties

The Health Departments

7.2 Describing the current economic context, the **Health Departments** said that the UK economy stood in a sound position with growth in 55 consecutive quarters. Labour market conditions continued to be favourable, as despite record employment levels and high oil prices, there was no significant upward pressure on wages.

7.3 We were provided with the Treasury's analysis of recent trends in inflation, examining movements, their causes, the extent to which they were temporary and the implications for wage setting in the public sector.

7.4 The Treasury's analysis concluded that the recent increase in headline inflation rates was in large part due to the temporary impact of higher oil prices, and measures of 'underlying' inflation which stripped out the impact of oil were much lower. So far there had been no evidence of higher headline inflation rates feeding through into higher pay settlements in the private sector and because of the discipline of wage-setters, this had also been the case in the public sector. It was important to continue to ensure that public sector pay increases did not contribute to inflationary pressures in the economy going forward. Discipline in pay settlements needed to continue through pay awards which took account of underlying inflation and were consistent with the achievement of the Consumer Prices Index (CPI) inflation target of two per cent. The Pay Review Bodies (PRBs) should therefore base their pay settlements on the achievement of the CPI inflation target of two per cent.

7.5 In response to the Staff Side bodies' focus on the Retail Prices Index (RPI) as the appropriate measure of inflation, the Department said that although the CPI excluded some elements of housing costs, it was the more appropriate inflation measure as it took account of substitution between goods in response to relative price changes and it was the internationally standard measure.

7.6 Turning to improvements in pay, the **Department of Health** said the public sector paybill had increased by around six per cent a year in nominal terms since 1997, due to expansion of the workforce and growth in average pay levels. In the NHS, over £1 billion had been invested in Agenda for Change (AfC), benefiting the remit group with significant increases in average pay and earnings per head. The Department set out for us an illustration of the combined effects of growth in average pay and in workforce numbers and provided pay figures to illustrate that the paybill for our remit group had increased by just over £2.1 billion last year. The Department said that this translated into healthy improvements in the earnings for our workforce of around five per cent in the last year.

[28] Defined as an increase in the twelve-month Consumer Prices Index (CPI) of 2 per cent.

7.7 The Department estimated that the earnings per Full-Time Equivalent (FTE) of qualified nursing staff had grown by 5.8 per cent over the 2004/05 figures. This strong growth was expected to continue in 2006/07 with a further 5.1 per cent increase bringing average earnings per FTE to £30,892. The Department said incremental progression would keep individual earnings growth strong in 2007/08.

7.8 The Department said that the incremental pay system under AfC provided an annual pay increase for those moving up to the next increment, regardless of any national pay uplift. The national uplift would also increase the value of each pay point. The Department said this revalorisation of pay points and the effect of incremental progression were important factors that needed to be taken into account when considering the affordability of any pay uplift. In addition to basic pay, staff in high cost areas received high cost area supplements (HCAS) and where recruitment and retention was difficult, staff received recruitment and retention premia (RRPs).

7.9 The Department told us that there were a number of pay points within each pay band. As staff successfully developed their skills and knowledge, they would normally progress through one pay point each year, up to the maximum in their pay band. At two defined 'gateway points' in each pay band, progression would be based on demonstrating the agreed knowledge and skills appropriate to that part of the pay band, using the NHS Knowledge and Skills Framework (KSF). For the majority of jobs, the Department considered that the present maxima were sufficient to ensure that the NHS was able to recruit and retain the staff it needed. Employers had the option of using RRPs, but there was little evidence to date of their widespread use.

7.10 Asked to explain the purpose of incremental pay scales, the Department told us that the AfC system and incremental progression were designed to reward additional experience and expertise gathered through the year and demonstrated by the KSF. The system recognised the efforts by staff to develop and maintain skills and attempted to provide reward for it. However, the Department said that it was not appropriate to ignore the cost of the incremental increase for the NHS when determining an affordable pay uplift.

7.11 The Department noted that last year we had expressed some reservations about taking all elements of earnings growth into account, but the Department said that it was difficult to assess affordability without taking into account everything affecting cost pressures. Pay drift caused by pay progression and the benefits of pay reform were essential components of the NHS's increased costs in the coming year. Experience from six Early Implementer sites had suggested that the cost of progression would be in the range 0.4 per cent to 1.2 per cent in 2006/07, and 0.2 per cent to 0.3 per cent in 2007/08. The Department referred us to its pay projections (see Table 7.1) which it said demonstrated the effect of pay drift on the increase in average earnings in any given year. From this, it estimated that a 1.5 per cent pay uplift in 2007/08 would represent an average increase in earnings for our remit group of 4.0 per cent. The Department said that unplanned pay drift had been very low during the implementation of AfC, and may have been negative in 2003/04. It was expected to return towards historic levels of around 1.3 per cent during 2006/07 and 2007/08, but the rate of bounce-back was uncertain.

7.12 We have sought clarification from the Department as to how these various figures were calculated and also discussed them at the Department's oral evidence session, but it remains unclear to us exactly how they are derived. The Department has told us that earnings growth is made up of settlement plus drift. Drift was factored into three different parts of the paybill model. First, workforce growth projections by staff group. Workforce growth was projected to be higher for higher paid groups than for lower paid groups, resulting in upward occupational drift. Second, the expected costs of AfC relating to incremental drift, for which the original estimates remained the best available (see paragraph 7.15 below). Third, an estimate of remaining drift, including grade drift, other incremental drift and non-salary earnings drift, based on historical evidence and analysis of expected pressures. It acknowledged, however, that pay drift was difficult to predict.

7.13 The Department's detailed paybill and earnings figures submitted with its original written evidence are set out at Appendix G of the report. Late in the round (late January 2007) the Department of Health sent us new estimates of average earnings for 2005/06 and projections of earnings for future years based on the recently available 2005/06 financial returns from Trusts. These data arrived too late for us to probe them further with the Department or to incorporate them into our account of the evidence in this chapter other than in Table 7.1. The new estimates are shown in red in Table 7.1 below. The full data are also set out at Appendix G. A summary of the Department's figures is set out below:

Table 7.1: Actual and projected percentage growth in NOHPRB paybill, paybill per head, and average earnings, 2001/02 to 2007/08

	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2007/08
Basic Award	3.7	3.6	3.225	3.225	3.225	2.5	(0)	(1.5)
Paybill[29]	11.1	9.1	8.2	15.8	8.7 7.6	6.7	3.9	5.4
Paybill/Head[30]	6.6	4.2	3.6	12.2	5.9 4.9	5.3	2.5	4.0 4.1
Earnings/Head[31]	5.4	4.2	3.4	7.6	5.9 4.9	5.2 5.3	2.5 2.6	4.0
Implied pay drift	1.7	0.6	0.2	4.4	2.7 1.7	2.7 2.8	2.5 2.6	2.5 2.5

Source: Department of Health
Note: Shaded areas are estimates. Figures in red are the Department's estimates submitted in late January 2007.

7.14 Asked whether the pay reform introduced by AfC had been costed and thought worth the price, the Department said that it was difficult to assess affordability without taking into account the effects of all issues affecting cost pressures. Analysis of data from a very small number of Early Implementer sites in 2004 had suggested that 24 per cent of staff would gain access to incremental progression while four per cent would lose it following assimilation to AfC. The Department said that the broad scale of the effect had been confirmed by a Strategic Health Authority exercise in 2005 which had suggested that the net effect on incremental progression would add around 0.55 per cent to the paybill in 2005/06. More recently, early data from electronic staff records had suggested that around 80 per cent of our remit group had access to incremental progression, though this might be the result of recent high levels of recruitment, as well as AfC.

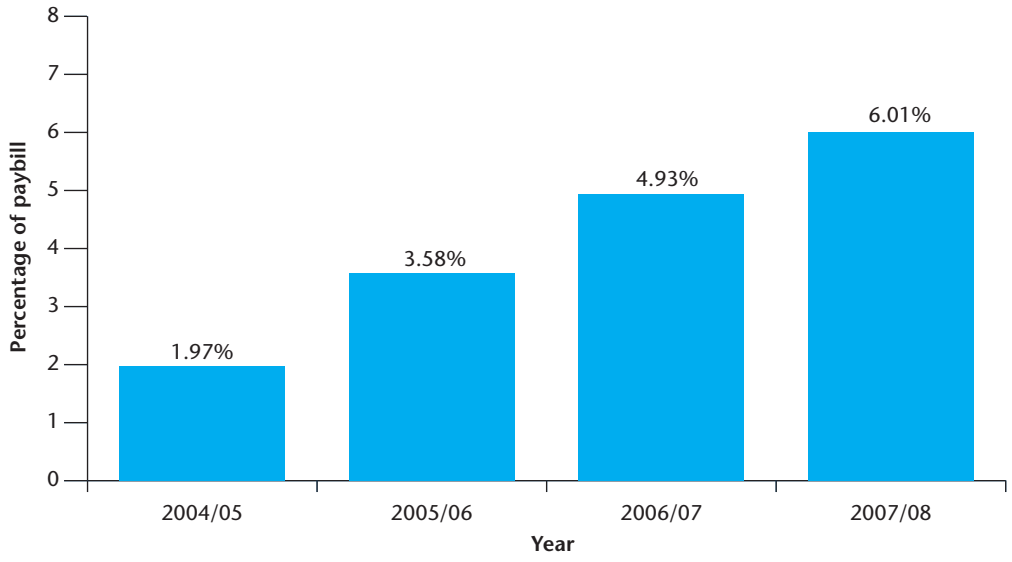
[29] 'Paybill' includes staff salaries, allowances, overtime payments, bonuses, ERNIC, employers' pensions contributions.

[30] 'Paybill per head' is paybill divided by the number of whole-time equivalent (WTE) employees.

[31] 'Earnings per head' is paybill excluding on-costs (e.g. ERNIC and employers' pensions contributions), divided by the number of WTE employees.

7.15 The Department said that the original pre-implementation estimates of the costs of progression under AfC remained the best available national estimates. In response to our further request for a more detailed explanation of the costings for AfC, the Department provided us with the following information:

Figure 7.1: Agenda for Change costs as a percentage of the paybill



Source: Department of Health evidence

7.16 The Department told us that the data[32] were based on the original 2002 costings which were still relevant because they became the funding envelope which it had agreed to invest in the new pay system each year over the period. The costings were based on detailed modelling using test results from job evaluation. These figures have been divided by current estimates of the paybill to generate the chart. The precise figures were 1.97 per cent for 2004/05, 3.58 per cent for 2005/06, 4.93 per cent for 2006/07 and 6.01 per cent for 2007/08, but because estimates of paybill changed, the precise percentages moved a little with time. The Department had undertaken a number of exercises since 2002 to try to establish where it was in relation to the funding envelope. The two main ones were the data from the "12 Early Implementer" sites in 2004 and the sample of 28 NHS sites involved in national roll-out in 2005. These new estimates had not made the funding envelope redundant because it remained the amount the Department had agreed to invest and the amount it was trying to manage costs against. As reported to us last year, monitoring of the costs of implementation in 28 sample sites in 2005 suggested that initial assimilation cost was higher than expected. However, this did not mean that the profile in subsequent years would necessarily be higher than the original assumptions. The research into assimilation costs would have captured mainly the effect of the initial step up onto the new pay system, while the additional cost in later years was primarily due to pay progression within the system.

[32] The data in *Figure 7.1* covers October to October each year.

7.17 The Department drew our attention to the broader reward package for NHS staff, including *Improving Working Lives*, the *Childcare Strategy, Continuing Professional Development*, the level of holiday entitlement and the NHS Pension Scheme. The Department set out the proposed changes to the NHS Pension Scheme and said it was not arguing that pay should be reduced on account of the proposed improvements to the value of the Scheme, but NHS pensions were a very valuable benefit which we might wish to take into account in assessing pay levels needed for recruitment and retention. We were told that the Government was moving in the direction of placing far more emphasis on total reward and that deliberation on the level of the overall pay award should be within this context.

7.18 The Department said that pay reform had delivered benefits to our remit group in the form of higher earnings and the continuing effect of reform, including incremental progression, would mean a continuing healthy rise in average earnings. The total package on offer to NHS staff, including the NHS Pension Scheme, was a very competitive one.

7.19 Responding to the Staff Side's proposed pay uplift, the Department said that pay and reward systems should primarily consider labour market indicators such as recruitment and retention data, morale and motivation and comparator pay levels. The Department believed that following the introduction of AfC, the NHS now had a fair pay system and that a general 1.5 per cent uplift was appropriate for 2007/08. Commenting on concerns about the differences in earnings between our NHS groups and other professions, the Department said that it was necessary to know patterns of part-time working, overtime, unsocial hours, etc in different professions in order to compare earnings accurately. The Department said that the report[33] cited by various Staff Side bodies that nurses and midwives had done worse than other groups in recent years was out of date and did not include the effect of pay improvements under AfC.

7.20 The **Scottish Executive Health Department** (SEHD) said that pay modernisation was expected to help the SEHD deliver its objectives of improved productivity, enhanced services to the public, service re-design, improved recruitment and retention and improved management and development of staff. The valuable part played by the NHS Pension Scheme in the NHS remuneration package was highlighted, alongside the benefits of the whole reward package and this, plus the wide range of workforce initiatives underway in Scotland, must be taken into account when looking at pay. SEHD said that pay clearly played an important part in the initiatives to improve health in Scotland, but it was only one element. The **National Assembly for Wales** (NAW) also said that the benefits of the total reward package for NHS staff should be considered when deciding the annual pay uplift, especially as the NAW was looking for a low uplift this year.

NHS Employers (NHSE)

7.21 **NHSE** provided us with a range of general economic data for 2006. On earnings, data for the Average Earnings Index (AEI) showed that the overall rate of increase in the whole economy had been generally falling and since March 2006, private sector earnings growth had been higher than that in the public sector. This might indicate a reversal of the more recent trend for public sector earnings to run ahead of the private sector, partly due to the reversal of strong earnings growth in the health and social work sector during 2005.

[33] The Earnings of Workers Covered by Pay Review Bodies: Evidence from the Labour Force Survey – Report for the Office of Manpower Economics by Gerald Makepeace and Oscar Marcenaro-Gutierriez, November 2005.

7.22 As well as average earnings growth, NHSE said it was important for us to consider the impact of both current and future inflation levels. The Bank of England's August 2006 inflation report suggested that higher domestic energy prices and university tuition fees would raise CPI further above the two per cent target over the next few months, but CPI would gradually move back towards target as energy and import prices moderated.

7.23 Responding to the Health Departments' arguments on total reward, NHSE said it would welcome some consideration by us of the total rewards available to staff. NHSE also noted that the research cited by various Staff Side bodies (*see further below*) suggesting unfavourable pay comparisons for our remit group compared to other groups covered the period prior to AfC implementation.

Staff Bodies

7.24 The joint **Staff Side** noted recent data (August 2006) showing the rise in RPI and CPI inflation. The Staff Side's evidence also looked at the large rises over the past 12 months in the components of the indices that relate to housing and energy costs. Housing, energy and utility increases were all unavoidable costs which adversely impacted on NHS staff, particularly the lower paid.

7.25 Staff Side said that all parties were aware of the Chancellor's desire for the PRBs to base pay settlements on the achievement of the CPI inflation target, rather than RPI. However, CPI excluded a number of items included in the RPI, mainly related to housing costs which had been rising relatively rapidly over the last few years. We were requested to take into account the real rise in the cost of living for NHS staff, including the rising costs in energy, housing, council tax and travel. We were also asked to take into account that these rises disproportionately affected the lower paid.

7.26 Regarding the Department of Health's arguments on Total Reward, the Staff Side said that pension benefits and terms and conditions such as annual leave and career development had been negotiated within the AfC agreement. These elements did not form part of the Pay Review Body process and Staff Side believed the Department was simply trying to put pressure on us to keep the pay award low. Staff Side's view was that the Pay award should be decided independently of any other terms and conditions or ongoing negotiations. With regard to the Department of Health's data on earnings growth, Staff Side said this included the time period when there would have been adjustments because of AfC implementation. These were not evidence of pay increases, but simply corrections for historical inequality in pay levels in individual cases.

7.27 **UNISON's** evidence reviewed data on various economic factors which it said needed to be taken into account when looking at the impact of the rising cost of living on NHS staff – economic growth, inflation, fuel and energy costs, transport costs, house prices, council tax, food, childcare costs and pay. The above-inflation increases in key areas supported UNISON's claim for a pay award substantially above the rate of inflation. This was particularly relevant for low paid staff who proportionately paid far more for any cost of living increases than those on the higher pay bands[34]. In UNISON's July 2006 Pay Survey, 17 per cent of respondents had reported having a second job, with 54 per cent stating they had to work overtime to sustain their standard of living. UNISON therefore said that it was calling for a minimum flat rate payment for those in Bands 1, 2 and 3, thus giving a higher percentage for the lowest paid. UNISON emphasised that it saw the RPI, rather than the CPI, as the most robust measure of inflation.

[34] UNISON provided three case studies demonstrating how last year's 2.5 per cent increase had been nullified by increased living expenses.

7.28 Looking at whether AfC had delivered better pay, UNISON said that recent monitoring of the number of staff requiring pay protection in the second year of AfC showed that 4.7 per cent of the NHS workforce in England had protected pay against a target of five per cent. UNISON said that most staff had received some sort of increase as a result of assimilation, although it was likely to be around the average figure of a two per cent increase overall (excluding annual pay awards). Elsewhere in the economy, average pay rises in local authorities were five per cent, with rail workers awarded 3.2 per cent. UNISON's 2006 Pay Survey had found that 64 per cent of respondents felt they were better off than a year ago, but 54 per cent were dependent on unsocial hours to sustain their standard of living. A significant number of staff also continued to work an additional job. UNISON said it believed that the reliance on additional and unsocial hours payments underlined the need for an above inflation pay award.

7.29 The **Royal College of Nursing** (RCN) said its survey evidence showed clearly that AfC had not fully satisfied its members where pay was concerned. There was still a feeling of unfairness in the health sector, and even more so when nurses' earnings were compared to other professions in the public sector. Its survey of temporary workers had found that many nurses needed to do temporary work in addition to their substantive role because they could not afford to live on a nurse's salary with the rising cost of living.

7.30 The **Royal College of Midwives** (RCM) said labour market data indicated that demand for labour was expanding, but the supply of labour was expanding faster for various reasons, including immigration and a return to work of many long term sick and older people. Data on pay indicated a reversal of previous trends with private sector earnings now rising faster than the public sector. Public sector earnings growth was lower due to lower basic increases in the public sector this year. The RCM noted the picture of rising inflation with RPI (its preferred measure) now over three per cent and set to stay there for the majority of this pay round, then starting to drop from the middle of 2007. Even the Government's preferred measure of CPI had risen to 2.5 per cent at June 2006.

7.31 **Amicus** said that media commentators had interpreted the Chancellor's letter to PRB Chairs of 13 July 2006 (see Appendix H) as meaning a two per cent overall ceiling on public sector pay increases. The premise of this argument was that public sector workers could be treated unfairly if their salary increases were the Government's main instrument to control inflation in the absence of a broader policy extending to the private sector. Earnings traditionally rose at 0.5 to one per cent above the rate of inflation and by linking any pay recommendation to inflation, health workers would fall behind other employees.

7.32 The **Chartered Society of Physiotherapy** (CSP) said that a paper by the Office of Manpower Economics (OME) in summer 2006 had found that for staff supporting scientific and therapeutic professionals, pay drift had been negative. The CSP said that a significant overall pay rise was needed to ensure that these staff, who were amongst the lowest paid in the NHS, were fairly paid.

7.33 The **T&G** said it was clearly unacceptable for ambulance staff, who were a relatively low paid group, to be facing a real decline in their earnings at a time of improved service delivery, greater job flexibility and major organisational changes. Staff could not be expected to face real pay cuts when the cost of living was rapidly rising and job demands were increasing.

7.34 **Various staff bodies**[35] raised with us again this year the issue of pay comparability, citing various research and data which they said demonstrated adverse comparisons between the pay of our remit group and that of other comparable public sector groups, e.g. police, teachers and fire-fighters, or, in more general terms, that of comparable private sector groups, e.g. train drivers. Some also highlighted how other PRB groups had done better in recent years than non-PRB public sector workers, but that nurses and midwives had done worse in each year. The staff bodies said that concerted action was needed to close the gaps and we were urged to address the need for a significant pay rise for NHS workers covered by our remit.

7.35 Looking at pay data from the Annual Survey of Hours and Earnings (ASHE) for 2005, the **Staff Side** noted that some groups within the PRB framework had gained far more than others and asked us to address the inequality in pay between the professional groups covered by the NOHPRB framework and other public sector workers and those in comparable occupations in the private sector. From its analysis of the Labour Force Survey, the **RCN** said it was concerned that the variation in earnings in the public sector might be attributed to systematic sex discrimination in the public sector, with the female dominated profession of nursing being valued considerably lower than the male dominated profession of the police. The **RCM** said there was evidence that midwives' pay was not keeping pace with comparable groups in the private sector and asked us to address this. **Amicus** considered that the Band 5 salary range compared unfavourably with starting salaries for graduates in other parts of the economy.

Evidence from Official Statistics and Our Comment

7.36 We are grateful to the parties for drawing our attention to the economic data that they consider relevant to our deliberations. These data fall under two separate headings dealing with macro-economic and micro-economic evidence respectively. The former concerns the general economic conditions within which we are making our recommendations; for example, the state of the UK labour market overall, and inflation, pay settlements, and average earnings in the wider economy. The micro-economic data are more closely concerned with our remit group and primarily cover issues such as pay comparability and pay drift. Below we consider the evidence relating to these areas provided either by the parties or from other sources available to us.

Macro-economic Data

7.37 The macro-economic evidence provided by the parties is inevitably superseded as the review round progresses but our secretariat regularly updates us with the latest data as they are published. These cover the labour market, inflation, pay settlements and average earnings. The latest data available to us were those published up to the end of January 2007.

Labour Market

7.38 The total level of employment in the UK labour market increased to just over 29 million during 2006, around $^1/_4$ million higher than a year earlier. Earlier in the year unemployment levels rose on both the International Labour Organisation and the claimant count measures, reflecting job growth somewhat below the increase in the number of economically active people in the economy. The very latest data (to November 2006) showed a second slight fall in unemployment levels on previous months, but it is too soon to judge whether this amounts to a tightening labour market trend going forward. There were some other positive signs, as both vacancy and redundancy data paint a marginally better picture than twelve months ago.

[35] The joint Staff Side, RCN, RCM, T&G.

7.39 Immigration, particularly from the EU Accession Countries, has been an important feature of the UK labour market over 2006, increasing its capacity to grow without stoking inflationary wage pressures. It has enabled HM Treasury to raise its trend growth assumption. We expect, however, the Bank of England's Monetary Policy Committee will wish to keep the situation under close review and will continue to take action to address any emerging capacity constraints.

Inflation, Settlements and Earnings

7.40 Table 7.2 below sets out the latest data on key inflation, settlement and earnings data at the time we reached our recommendations. In order to smooth some of the effects of month-on-month volatility in the inflation measures, we have also looked at the averages for the latest quarter.

Table 7.2: Latest data on inflation, settlements and earnings

Inflation measures[36]	**Percentage change on the same month a year ago – December 2006**	**Percentage change on the same quarter a year ago – Fourth quarter of 2006**
CPI	3.0	2.7
RPI	4.4	4.0

Headline Average Earnings	**Three months to November 2006**[37]
Whole Economy	4.1
Private Sector	4.2
Public Sector	3.2

Settlements	**Three months to November 2006**[38]
Lower Quartile	2.9
Median	3.0
Upper Quartile	3.75

7.41 CPI is the Government's preferred inflation measure and the index upon which its two per cent annual inflation target is based. *Figure 7.2* shows that the index was around target in the early months of 2006, before rising to settle around 2.4 per cent over the summer and autumn. It has since risen from this level and reached 3.0 per cent in the twelve months to December 2006. The main upward pressures on the index recently have come from the higher costs in the areas of transport, furniture and household goods, recreation and culture. The pressures are expected to weaken over 2007, and the Bank of England has taken action to raise interest rates in order to bring CPI back to target. Its latest central projection for inflation[39] suggests that CPI will fall to two per cent during summer 2007. The average of new independent forecasts published by HM Treasury[40] puts CPI at target in the last quarter of 2007.

[36] Consumer Prices Index (CPI) and Retail Prices Index (RPI). *Source: Office for National Statistics.*

[37] Headline rate of increase in the Average Earnings Index (AEI), three-month average including bonus effects, percentage change on the same months a year earlier. *Source: Office for National Statistics.*

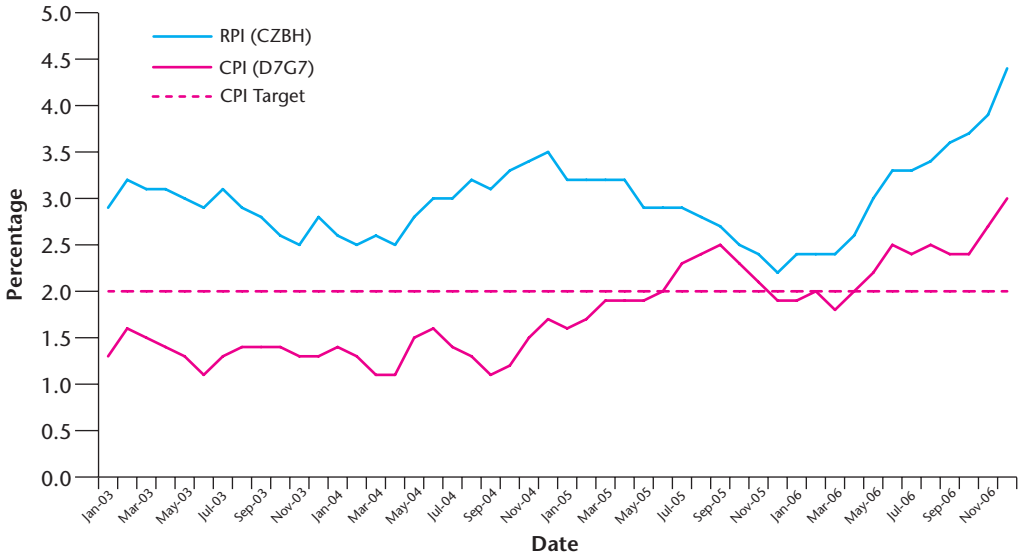
[38] Three-month median, and upper and lower quartiles. *Source: Incomes Data Services (IDS).*

[39] Bank of England Inflation Report. November 2006.

[40] Forecasts for the UK Economy. A comparison of independent forecasts. HM Treasury. January 2007.

7.42 The other key inflation indicator is the all-items RPI, which includes aspects of housing costs that are excluded from the CPI. RPI also moved up during 2006 and had reached 4.4 per cent in the year to December. Many of the upward pressures are similar to those affecting CPI, but RPI has additionally been influenced by increases in housing costs from, for example, higher house prices and mortgage interest payments. Forecasters' expectations are that RPI will remain around four per cent in the early months of 2007, falling back to three per cent in the fourth quarter.

Figure 7.2: Inflation: CPI and RPI



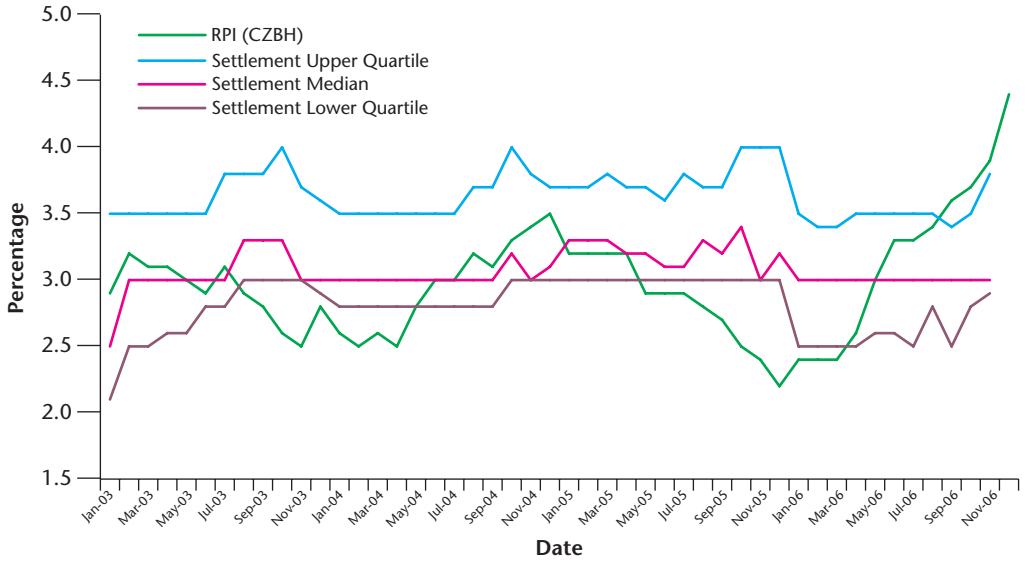
Source: Office for National Statistics

7.43 It is clear that inflation is much higher than a year ago, although the indices are probably now approaching their peak. In these circumstances, any increase in pay rates at the level proposed by the Health Departments and NHS Employers would imply a lower than inflation settlement this year. However, as we pointed out last year, our recommendations are not, automatically or otherwise, linked to any macro-economic index. This includes the inflation indices. Indeed, had our recommendations over the years been linked purely to inflation, nurses' pay would be considerably lower than it is now[41].

7.44 We have also looked at settlement data from a number of sources, focussing on the median of base pay awards and the lower and upper quartiles. The data in *Figure 7.3* show a high degree of consistency with the median of awards staying at three per cent during 2006. It is notable that the median has remained static despite considerable variation in the level of inflation. The lower and upper quartiles appear slightly more reactive to changes in RPI, but the relationships are not strong. It has been suggested by some commentators that recent levels of RPI will raise the settlement median, but it is too early for this effect to have become clear. We have noted analysis in the Bank of England's Inflation Report that indicates that changes in inflation rates affect the *direction* of movement in settlement levels, but that the relationship is far from one-to-one as far as *levels* are concerned. We also note that settlement levels vary considerably between different sectors of the economy, ranging from pay freezes in some areas to over eight per cent in others. Inflation is clearly not the only, or even possibly the most important, influence on settlement levels, and the labour market, ability to pay, and increases in the National Minimum Wage are amongst the factors that employers also take into account.

[41] This is also true for the economy as a whole: from April 1997 to April 2006, CPI grew by 13.8 per cent and RPI by 25.7 per cent, but whole economy headline earnings rose by 45.6 per cent.

Figure 7.3: Settlements & Inflation: Median, Lower and Upper Quartile Settlements and RPI

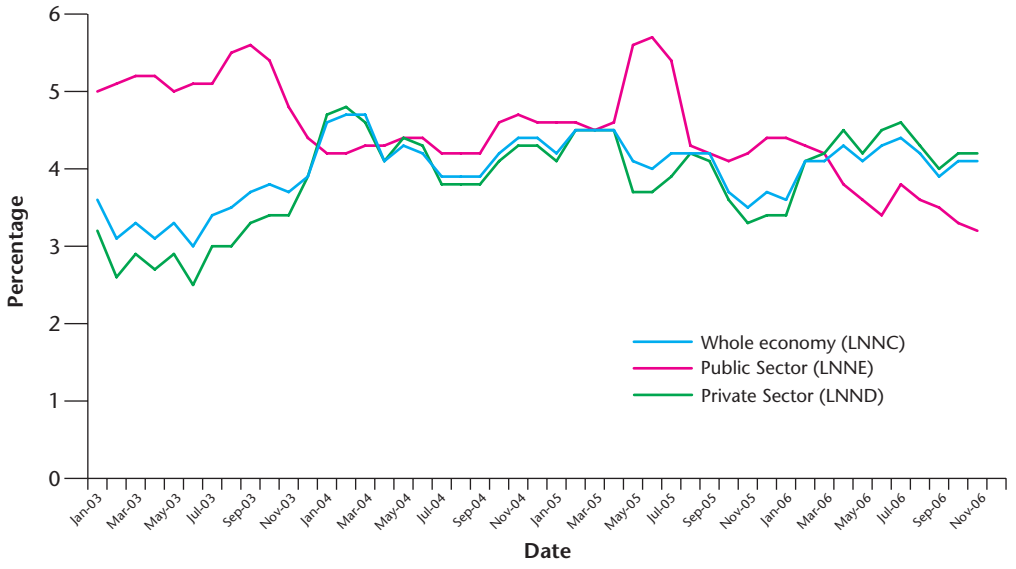


Sources: IDS Pay Reports: Office for National Statistics

7.45 The 'headline' rate of average earnings growth in the whole economy, including bonus effects, lay between 4.1 per cent and 4.4 per cent for most of 2006. The latest data for the three months to November 2006 put the rate at 4.1 per cent (*Figure 7.4*). Again, different sectors of the economy fare differently. The public sector rate of increase has fallen reasonably steadily over the previous twelve months, and was 3.2 per cent in November 2006. Having generally had a rate of increase above the private sector in recent years, public sector earnings growth has been below that of the private sector for most of 2006. The latest private sector figure is 4.2 per cent. Looking at earnings data *excluding* bonus effects does not materially affect this picture, although the overall rates of earnings increase are somewhat lower than the headline figures. When we look at the evidence on public sector pay growth as a whole and the average earnings growth for our remit group, they are currently delivering modest levels of earnings growth which are easily compatible with the Bank of England's view as to the level of earnings growth that is consistent with meeting the inflation target.

7.46 Forecasters do not anticipate much change in whole economy average earnings growth in 2007, and expect the rate to average 4.3 per cent in the fourth quarter compared to their 4.2 per cent expectation for the fourth quarter of 2006. In the short term, it is likely that recent large bonus payments will lift average earnings growth in the private sector, and, consequently, the whole economy rate. The Bank of England has noted that the maximum level of whole economy earnings growth compatible with the inflation target is 4.5 per cent to 4.75 per cent. However, its focus tends to be on earnings growth excluding bonuses – which it calls 'regular pay' – and there have been no signs of a pick-up in this index, which has averaged around 3.8 per cent for the last twelve months, well within the Bank's 'ceiling'.

Figure 7.4: Headline Average Earnings Including Bonuses (seasonally adjusted)



Source: Office for National Statistics

7.47 The difference between increases in basic pay solely from annual settlements and the resulting changes in average earnings is traditionally defined as 'pay drift'. Whilst it can be quite volatile, typically this difference is positive (that is, earnings increase faster than basic pay awards) and lies between one and two percentage points for the whole economy (*Figure 7.5*). As at November 2006, the traditional definition of pay drift gives annual rates in the whole economy, public sector and private sector of 1.1 per cent, 0.2 per cent, and 1.2 per cent respectively.

Figure 7.5: Levels of Pay Drift

Sources: Office for National Statistics: Industrial Relations Services

Micro-economic Data

Comparative Earnings Levels

7.48 We again received evidence from the staff bodies comparing the pay of remit staff with that of other employee groups outside the NHS. It is difficult to know what conclusions we should draw from these analyses, or what weight we should give them in reaching our recommendations, particularly as the parties themselves do not agree on the groups that would constitute the most appropriate external comparators. For our part, we believe the emphasis should be on the levels of pay necessary to recruit, retain and motivate staff of sufficient quality to meet service delivery requirements, both now and in the future.

7.49 Clearly, broad comparisons have some part to play in deciding appropriate pay levels, particularly over the longer term, but it is important to choose the most relevant comparators. In our view, these are most likely to be the occupations from which staff are recruited, and the occupations that they enter upon leaving the NHS. Ideally, data on the previous employment of joiners could be collected via payroll, and those on leaver destinations could best be collected through exit interviews. However, NHS employers do not seem to conduct these analyses in any systematic way. This issue exercised our predecessors over many years, but no progress has been made to fill what is a fundamental gap in our knowledge. This is deeply disappointing.

7.50 In the absence of exit interview information we have considered various alternative sources. The information collected as part of our annual workforce survey, reviewed in detail in Chapter 3, was one possibility but it is not sufficiently robust for this purpose, whilst data from the Electronic Staff Records system may be helpful in future but are not yet available. In the meantime, we are therefore examining the prospect for using ASHE data to determine a methodology for identifying the source and destination of people joining or leaving our remit group, and their earnings. This may provide useful aggregate data, but sample size issues will inevitably arise in respect of specific remit specialisms.

7.51 Finally, it is difficult to identify the appropriate 'anchor points' in the NHS pay structure from which salaries at different stages in an NHS employee's career might be compared with those elsewhere in the economy. One obvious such 'point', however, is the graduate starting rate, and this has been raised in evidence by some of the staff bodies. Analysis by Incomes Data Services[42] showed that employers expected the median graduate starting salary in 2006 would be £22,000, up 2.8 per cent on 2005. Public sector employers expected to pay a median of £21,500. *Table 7.3* shows the graduate starting salaries for nursing and allied health professions and for a selection of other public sector occupations.

[42] IDS Executive Compensation Review. Research File 73. Pay and Progression for Graduates 2006. February 2006.

Table 7.3: Graduate pay of public sector professions, 2006

Public Sector Group	Graduate Starting Pay £pa
Fast-stream Civil Servant (DTI)	23,100 (outside London)
Police Officer	21,009 (excluding overtime)
Hospital Doctor	20,741
Armed Forces' Officer	20,877 (adjusted for X Factor and Pensions)
School Teacher	19,641 (England & Wales, outside London)
Nurses & AHPs	19,166 (minimum rate, Pay Band 5)
Prison Service (Intensive Development Scheme)	17,744 (excluding geographical allowances)

Source: OME analysis.

7.52 IDS also collects the pay of graduates three and five years after graduation and compares them with current graduate starting rates to calculate the 'salary lead' from progression. The median annual earnings of people three years after graduation was £30,000, a salary lead of 40.5 per cent. For those five years after graduation the corresponding figures were £35,000 and 66.7 per cent, respectively. Both the medians and salary leads were slightly lower in the public sector overall and appear to be significantly lower for nurses and AHPs judging from the salary scales. To the extent that starting rates and progression influence the career choice of school-leavers, these are important comparisons and we would welcome further evidence on these comparisons for the next round.

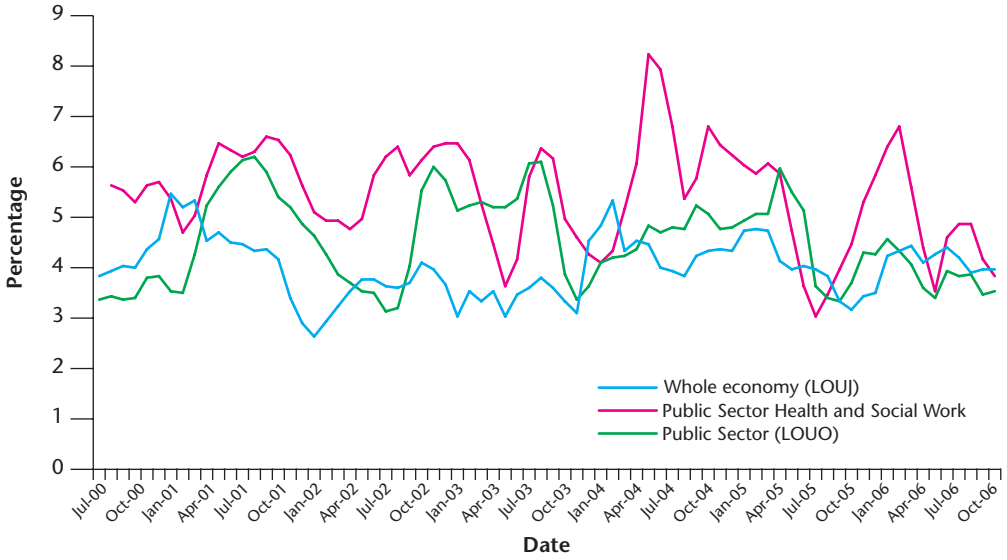
7.53 Career choice and recruitment and retention will also be influenced by potential lifetime career earnings, taking account of items of deferred pay such as pensions, and other benefits such as annual leave and family-friendly policies. Indeed the Health Departments and NHSE have drawn attention to the total reward package available to NHS staff and argued that this package is very competitive. We were told that the Government was moving in the direction of placing far more emphasis on total reward and that the level of the overall pay award should be determined within that context. We agree that the total reward package available is likely to be important in determining recruitment and retention and morale. But these benefits are difficult to value. Moreover, the employee's perception of the value of the package is at least as important as the cost of providing it and those perceptions will differ between individuals and groups. These may be issues we will need to look at more closely in future, particularly in relation to any impact on long term recruitment and retention, as we discussed in Chapter 3, but to do so we will need much more detailed information on how such benefits can be valued and how they compare with benefits available in other occupations.

Comparative Earnings Movements

7.54 In this section we look at evidence on the movement in the average earnings for our remit group over time, typically taking 1999/2000 as the base year as data constraints do not allow us to take our analysis back further.

7.55 We point out above that levels of pay settlement vary by sector, reflecting their differing economic circumstances. The same is true of earnings movements. In *Figure 7.6* we show the percentage increases in the average earnings indices[43] for the whole economy, public sector, and public sector health and social work, which includes our remit group. Over the period July 2000 to November 2006 annual earnings growth in public sector health and social work has usually been ahead of growth in the wider economy, and in the public sector as a whole. Overall, over this period, the earnings of public sector health workers had increased by about 45 per cent, more than 10 percentage points higher than the rest of the public sector, and 17 percentage points higher than the private sector. These data need to be interpreted with care, however, as the 'public health' index includes large groups who are not in our remit, such as doctors and dentists and social workers.

Figure 7.6: Average earnings indices including bonuses not seasonally adjusted but smoothed using 3-month moving average

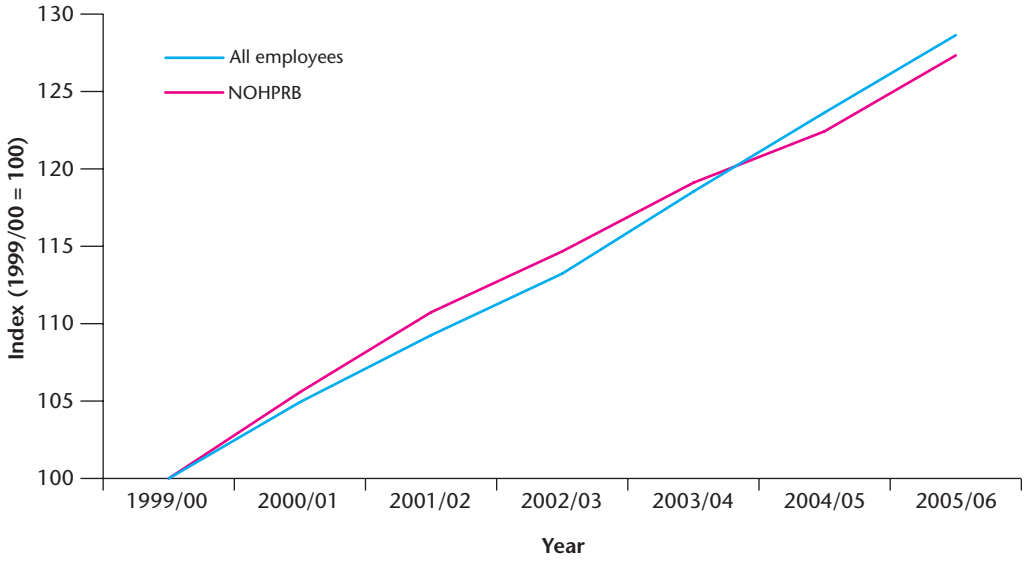


Source: Office for National Statistics

7.56 We have disaggregated the data further using ASHE. ASHE is considered by the Office for National Statistics (ONS) to be the most appropriate source for annual changes in earnings, and for data on the earnings of full-time employees. *Figure 7.7* charts the earnings growth of all employees across the economy and the NOHPRB remit group as a whole. In the case of this latter series, with assistance from ONS we have been able to identify closely those employees who are specifically within our remit group, for example by excluding private sector nursing and AHP staff.

[43] Data for public sector health and social work are not published in a seasonally adjusted form and are only available from July 1999.

Figure 7.7: Index of mean gross annual pay for full-time employees



Source: ASHE from the Office for National Statistics

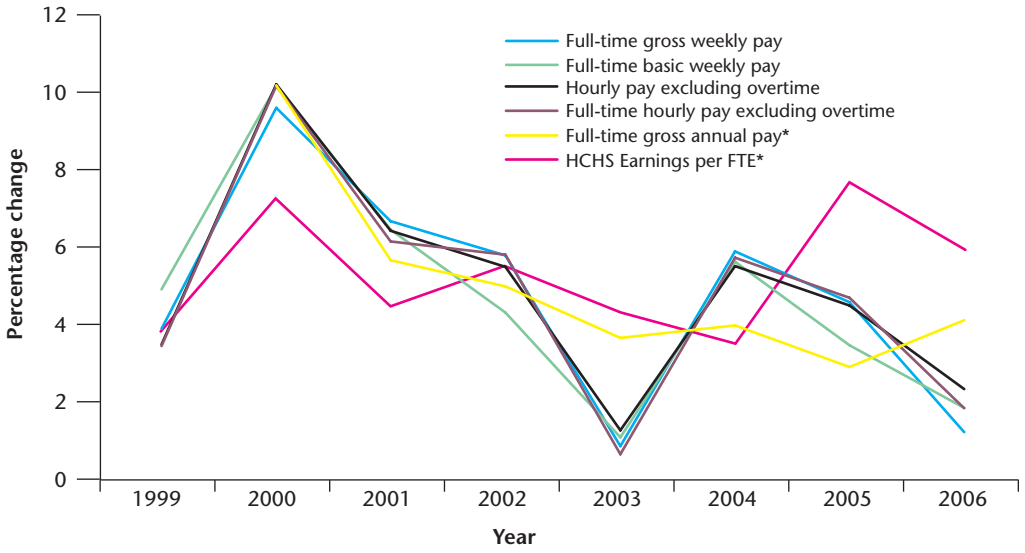
7.57 *Figure 7.7* shows that for the period 1999/2000 to 2005/06, the median annual earnings for full-time employees in our remit group have grown by over a quarter, in line with the growth for *all* full-time employees. *Figure 7.8* shows the same data in terms of the year-on-year percentage change in gross annual earnings for these groups.

Figure 7.8: Year on year percentage change in mean gross annual pay for full-time employees

Source: ASHE from the Office for National Statistics

7.58 The ASHE data also enable us to look at percentage movements in pay using a variety of different measures e.g. annual, weekly and hourly pay. These are set out in *Figure 7.9*. They show that the different measures have moved broadly together, exhibiting similar trends. We have also included the percentage change figures provided by the Department of Health for their estimate of earnings of FTE employees. We note that whilst the Department's data reasonably closely track those derived from ASHE in the earlier years of the analysis, since 2004 a gap has arisen between the sets of data and projections.

Figure 7.9: NOHPRB Remit Group Year on Year Percentage Change in Mean Earnings



Sources: Annual Survey of Hours and Earnings, Office for National Statistics; HCHS Earnings per FTE from DoH Evidence.

Series as at April of each year unless marked in the key with an asterisk, in which case series relates to the entire year ending in April.

7.59 Asked to comment on the divergence, the Department told us that its figures for 2004/05 included the provisions made by NHS organisations for AfC costs incurred in 2004/05, but not actually paid out to staff until 2005-06. The divergence between the Department's data and ASHE therefore appears to result from the Department moving to the use of projections rather than outturns. The Department subsequently told us that estimates twelve months ago suggested that AfC had cost £120 million more than originally planned in the first twelve months due to increased staff pay and at least £100 million more than planned as a result of indirect costs (for example, increased holiday entitlement and the subsequent need to expand staff capacity). However, these indirect costs were based on Trust estimates rather than actual payroll records. The Department said that analysis of 2005/06 accounts data for non-Foundation Trusts suggested that HCHS pay costs overall had been running at less than the original assumptions.

Pay Drift

7.60 Finally, we have examined levels of pay drift for nursing staff. The results of analyses since 1980 are set out below.

Table 7.4: Pay Drift Estimates for Nursing Staff since 1980[44]

Analyst	Period Covered	Average Measured Drift (% pa)
Elliot & Duffus	1980/92	+0.8 (Males); +1.7 (Females)
OME	1992/2000	+1.6
OME	2000/01 to 2004/05	+0.7
Department of Health		+1.6
OME	2005/06	+0.8
Department of Health (projections)	2005/06	+2.7
	2006/07	+2.7
	2007/08	+2.5

7.61 We note a consistency in the picture for nursing staff for the period 1980 to 2000, with drift averaging around 1.6 per cent per annum. Department of Health figures suggest that this broad picture was maintained through to 2004/05, although OME estimates show the average falling in the early years of this decade to around 0.7 per cent per annum. For the more recent years, the Department estimates drift rising to 2.7 per cent, largely as a result of pay modernisations introduced under AfC and the additional scope for progression for staff previously at their scale maximum. It expects this to ease back to 2.5 per cent in 2007/08.

7.62 The Departments have placed great emphasis in their evidence on the level of pay drift for our remit group, and have argued that this should be taken into account in determining an appropriate level of basic pay uplift. We have felt it important, therefore, to examine first, the basis for this argument, and second, the levels of pay drift that the Department of Health has calculated going forward.

7.63 We considered in our last report the argument that drift should influence the level of our basic award[45]. We noted that three factors were likely to be important in driving drift: the one-off costs of assimilation to the new pay structure; incremental progression; and overtime, shift and unsocial hours payments. Our view was that the new pay structure was partly designed to address equal pay concerns, and the costs of equality-proofing the NHS pay system should not influence the level of subsequent basic awards. Indeed, it is not, in our view, appropriate to consider these costs as in some way 'additional', as the likelihood is that the Service would have faced substantial equal pay problems, and associated costs, had there not been a move to a new pay system. Neither did we consider that the increases in an individual's pay that result from incremental progression should be taken into account in determining the basic pay uplift, though the overall increase in the paybill would have a bearing on the general affordability of a pay award. In our view incremental progression was designed to reflect the extra knowledge and skills that staff gained with service. Finally, premium payments for working overtime, shifts or unsocial hours were clearly compensation payments for abnormal working, and should similarly be excluded from considerations around the basic pay uplift.

[44] With the exception of the Department of Health's figures, calculations are based on the difference in nurses' annual earnings according to NES/ASHE less the value of the base award for that year. The Department's figures are based on Trusts' historic financial returns and the Department's own projections.

[45] Twenty-First Report on Nursing and Other Health Professions 2006, paragraphs 7.46 to 7.50.

7.64 Our views on these issues have not changed. In fact, they are reinforced by the conclusions of the OME's recently commissioned research into the causes of pay drift[46], one conclusion of which was that a great deal of what might be termed pay drift is better thought of as pay 'drive' associated with the desire to modernise the pay structure. The term 'pay drive' covers pay additions that derive from deliberate employer pay strategies, such as moves to variable pay and targeted market premia, policies to address equal pay concerns, and systems to reward skill acquisition. There are also labour force influences which can cause pay drive, for example changes to workforce composition from employers' policies designed to increase skill levels. These pay drive factors probably account for a great deal of the difference between base pay awards and average earnings outcomes.

7.65 There may still, however, be a residual element that might properly be termed 'drift' that reflects weak managerial control of pay systems. In the context of AfC, if earnings have been growing faster than originally intended by the negotiators, then it could be argued that these unanticipated costs should in part at least be reflected in the base pay award, were it possible to identify its magnitude. It is also the case that our remit requires us to take account of affordability. Clearly, we must have regard to the ability of employers to meet the paybill increases that arise from base pay adjustments and additional pay increases, whatever their cause. For these reasons we must look at the likely earnings outcomes of base pay recommendations, and that leads us to examine those additional pay increases that arise, as it were, automatically from the NHS pay system. Consequently, we have sought to examine levels of pay drift/drive for our remit group.

7.66 Pay drift/drive figures are generally derived by comparing the percentage increases in average earnings with the increases in base pay settlements. Whilst this is the approach traditionally adopted, there are considerable problems of definition: settlements and earnings do not measure the same things; it is not always easy to 'price' settlements, and the factors influencing average earnings growth include non-pay issues such as workforce composition. Consequently, estimates of drift/drive might vary depending on what definition of average earnings and base pay award are used, and also by which year's data is analysed. By way of example, in *Table 7.5* we set out our calculations of pay drift/drive for our remit group since 1999/2000 alongside those produced by the Department of Health. Our earnings data are derived from special runs commissioned from ONS. The Department uses earnings data from Trust financial returns. The settlement data are common to both analyses.

[46] The issues are discussed in depth in the 2006 IDS research report *An assessment of the causes of pay drift in UK organisations* available on the OME website www.ome.uk.com.

Table 7.5: NOHPRB remit group pay drift/drive estimation

	Settlement	Percentage change in …			Implied Drift/Drive Measures (Percentage point differences)		
		ASHE Mean Full-time Annual Earnings	ASHE Mean Full-time Weekly Earnings	DoH HCHS Earnings per FTE			
	(A)	*(B)*	*(C)*	*(D)*	*(B-A)*	*(C-A)*	*(D-A)*
1999-0	4.7	10.1	3.8	7.2	5.4	-0.9	2.5
2000-1	3.4	5.6	9.5	4.4	2.2	6.1	1.0
2001-2	3.7	4.9	6.6	5.4	1.2	2.9	1.7
2002-3	3.6	3.6	5.7	4.2	0.0	2.1	0.6
2003-4	3.225	3.9	0.7	3.4	0.6	–2.5	0.2
2004-5	3.225	2.8	5.8	7.6	–0.4	2.6	4.4
2005-6	3.225	4.0	4.5	5.9	0.8	1.2	2.6
2006-7	2.5	na[a]	3.6[b]	5.2	na[a]	1.1[b]	2.7
Cumulative to 2005-6 (only)	*27.9*	*40.2*	*42.6*	*44.7*	*10.0*	*11.9*	*13.6*
Average Annual to 2005-6 (only)	*3.6*	*4.9*	*5.2*	*5.4*	*1.4*	*1.6*	*1.8*

a 2006/07 gross annual earnings data will not be available until ASHE 2007 is published.

b ASHE 2006 is unlikely to have captured the effect of the 2006/07 NOHPRB pay settlement, implementation of which was delayed. Therefore, we have added 2.5 per cent to column C for 2006/07 and to the resulting drift figure. The actual figures according to ASHE were 1.1 per cent and –1.4 per cent respectively.

Shaded cells denote DoH projections (as opposed to actuals)

Sources: Special analysis derived from ASHE, and DoH evidence.

7.67 It is clear from *Table 7.5* that, no matter which earnings source is used, pay drift/drive is highly volatile year-to-year. It is also clear that the ASHE and Department's earnings data do not show the same picture as regards annual earnings growth, and, consequently, the levels of pay drift/drive that are derived from them. Having said that, the average annual drift/drive figures in the table are relatively close to the annual 1.6 per cent figure that separate analyses calculated for the period 1980 to 2000, shown in *Table 7.4.* Indeed, if we used the revised estimates of earnings and drift recently supplied to us by the Department (see *Table 7.1*), their annual average figure would be closer to the historic average shown in *Table 7.5.*

7.68 Given the emphasis that the Health Departments place on pay drift in their evidence this year, it is clearly important that they provide accurate figures based on transparent and comprehensible analysis which unpacks its various components. This they have not been able to do. It is unclear, therefore, why we should place more confidence in the Department of Health's earnings data as opposed to those based on ASHE, or why we should give particular credence to the Department's drift/drive calculations.

7.69 This issue becomes particularly problematic when we look at the Department's calculations where they are based on earnings estimates, as these often differ from the actual outturns, and the estimates themselves differ from year to year. We have compared the Department's figures set out in its evidence for the current review, and reproduced earlier in this chapter in *Table 7.1* above, with the estimates it provided in evidence to our last review. Considerable differences are apparent between the two sets of figures. For example, last year the earnings per head percentage change figure in respect of 2004/05 was estimated at 5.1 per cent respectively. This year we are told that the 2004/05 outturn was 7.6 per cent. Last year the Department estimated the paybill increase for 2005/06 as 9.2 per cent, in its original written evidence for this year; this estimated figure was reduced to 8.7 per cent, and in the Department's late January submission of revised estimates, the figure is reduced further to 7.6 per cent. There are also differences in respect of the 2006/07 paybill increases.

7.70 In addition, the Department's earnings-based drift/drive calculation for 2005/06 is derived from an earnings percentage change estimate considerably above that derived from ASHE. We cannot understand this figure, and the Department has been unable to explain it to us. Even if we were to accept that pay drift/drive would be higher than the historic trend in that year because of the cost of assimilating staff to the new pay structure, it is difficult to understand the Department's view that drift will be at a similar level in 2006/07, given that assimilation is already complete.

7.71 For the coming financial year the Department estimates drift/drive at 2.5 per cent, which it uses, inter alia, to justify its arguments for a base pay award of 1.5 per cent to give an average earnings increase of 4.0 per cent. Given the year-on-year changes to the estimates that we have already seen, and without an adequate explanation of how the 2007/08 figure is derived, we are unable to be fully confident as to its accuracy.

7.72 In summary, we are being asked by the Health Departments to come to a decision without adequate information, and in this regard, it is disappointing that NHSE have also been unable to assist our understanding about what is happening to pay on the ground. We do not know the cost of AfC over and above costs that would have been incurred had there been no new pay structure. Nor do we know what share of the estimated difference between base pay and earnings is 'drive' and which 'drift'. We cannot understand the Department of Health's estimates of a range of pay measures, and note that the figures are subject to variation with each new projection. We have received no adequate explanation of why the Department's projections of average earnings growth derived from the HCHS are so very high when the figures from ASHE and the HCHS had been closely aligned previously, although this is fundamental to getting a true picture of the level of pay drift/drive.

7.73 It is clear to us that the evidence in this area must be improved, and we strongly urge the Health Departments to ensure better data in time for our next review, and to be able to address the criticisms set out here. This applies equally to the health authorities in the devolved bodies. In the meantime, in the absence of persuasive evidence to the contrary, we consider it appropriate to assume that pay drift in 2007/08 will revert to its long-term average. The Department is forecasting unprecedented pay drift levels, but the figures it submitted to us in late January 2007 indicate that pay drift may have reverted to its long-term average.

7.74 Finally, we would observe that our role is to take a longer-term view about the appropriate pay relativities to deliver the level and standard of labour force the NHS wants. Whatever the niceties of this debate, the fact is that determining the basic pay uplift on the basis of earnings increases for staff already within the system would, over time, result in the NHS pay structure falling behind the market. This would especially be felt at the bottom and top of pay bands, with detrimental effects both for the recruitment of new staff, and the retention of experienced staff who do not benefit from incremental progression. The result would be that at some point these problems would need to be addressed through a 'catch-up' award, introducing unnecessary volatility into NHS pay.

Chapter 8: Level and Structure of 2007/08 Pay Recommendations

Introduction

8.1 The evidence reviewed in the earlier chapters sets the broad context within which we consider our pay recommendations. In this chapter, we outline the evidence we have received from the parties concerning the overall level and structure of our basic pay award. Issues around geographical and occupational pay differentiation are dealt with in Chapter 4.

Evidence from the Parties

The Health Departments

8.2 Evidence from the **Health Departments** said that within the total reward package, pay increases should be at levels which were affordable and necessary to respond to the particular circumstances of the group involved. The Government relied on the Pay Review Bodies (PRBs) to recommend affordable pay awards sufficient to recruit, retain and motivate key public sector workers. In recent years, there had been major growth in workforce numbers and modernisation of pay structures which had led to significant increases in both average salaries and in the overall paybill of public sector workforces. As the public sector entered a period of tighter spending growth, it was important that pay growth was restrained and the right balance between public and private sector pay levels was restored. The correct balance could be achieved with a reward system that ensured recruitment and retention was stable, morale and motivation were good and the workforce was capable of delivering high quality public services.

8.3 The **Department of Health** said that the annual cost of public sector pay accounted for around a quarter of Government expenditure and the annual paybill for our remit group alone amounted to over £21 billion. Our recommendations therefore made a significant impact on the overall Government pay strategy, public finances, the Government's ability to meet other spending pressures and the level of inflation in the wider economy.

8.4 The Department said it was asking us to make recommendations within the context of the overall UK economic position which remained sound. "Core" inflation remained consistently below the two per cent target for Consumer Prices Index (CPI) inflation and pay restraint in the next financial year remained key to healthy growth in the economy as a whole. In addition to recruitment and retention issues, pay awards must be set within a framework that considered the spending limits set by the Chancellor in the Budget, the achievement of financial balance in the NHS at the end of 2006/07, the Government's output targets for service delivery, and the Government's aim of achieving the two per cent CPI inflation target. The Department said that its evidence had demonstrated the healthy recruitment and retention position amongst our remit group. The Department said it was clear that recruitment was not a problem and some re-balancing of the workforce was taking place with some Trusts reducing their number of posts. This demonstrated the fine line the NHS needed to tread to ensure costs could be contained at the same time as improving services. High pay awards would bring added cost pressures which would inevitably lead Trusts to consider if they could sustain current staff numbers and services.

8.5 Although we had discounted the Department's arguments last year about taking the NHS deficit issue into account when making our recommendations, it remained the Department's contention that this was a major issue in determining affordability. The combination of headline pay increases and underlying earnings growth determined affordability. As the NHS as a whole had to achieve and maintain financial balance, deficits in a minority of employers were a national rather than a local problem. We could not fulfil our remit in relation to affordability and the inflation target without taking into account the level of earnings and earnings growth in the NHS. We had been provided with detailed information on the improvements to pay levels for our remit group since 1997/98 and the Department said that our remit group continued to see a high level of average earnings growth which was expected to continue in 2007/08.

8.6 The Department said that in 2006/07 the NHS had to repay the overspend of £512 million and it was clear already that financial balance would only be achieved by some reductions in posts. In the light of the good recruitment and retention position, low vacancies and against the background of financial pressures facing the NHS, the Department said an affordable pay settlement was vital. Pay was only one element of the total reward package and it was the entire total reward package that allowed employers to recruit, retain and motivate their workforce. The level of the overall pay award should be considered within this context and the total package on offer to our remit group, including the NHS Pension Scheme, was a very competitive one. Taking all factors into account, especially the financial pressures on the NHS, the Department believed that an affordable level of pay uplift for our remit group for 2007/08 was 1.5 per cent. This would lead to an increase in average earnings of 4.0 per cent for our group, which was comparable with the whole economy. The Government believed that current pay arrangements were more than adequate for a 1.5 per cent pay uplift not to have an adverse impact on retention or future recruitment. In setting the increase in the tariff for 2007/08 the Department had allowed for an increase in the pay element of 1.7 per cent, which covered the pay settlement and drift, and a further 0.7 per cent increase to cover Agenda for Change (AfC) costs. We note that the Department has now advised NHSE *(see further below)* that these calculations would at most support a pay settlement of 1.5 per cent.

8.7 Should the pay uplift be more than 1.5 per cent, the Department said that the NHS would face hard decisions including reducing overtime, reducing staff numbers, delaying service changes and/or reducing existing services. The Department said it was clear that employers in the NHS were interested only in an affordable pay uplift. A one-year only uplift was sought.

8.8 The Department said that it was seeking a similarly affordable pay award of 1.5 per cent from the Doctors' and Dentists' Pay Review Body.

8.9 With regard to the ECJ judgment in *Cadman* v. *HSE*[47], the Department of Health said the judgment had confirmed that rewarding experience was a legitimate objective. The Department was confident that AfC scales were consistent with the ECJ judgment and as AfC had only been in place for two years, it believed that the system should be allowed to bed in before any changes were contemplated. The Department also said that it was difficult to understand why Amicus was proposing a reduction in hours to 35 per week as Amicus had been a party to the AfC agreement and staff were still currently changing their hours to the standardised 37.5.

[47] Case C-17/05 *Cadman* v. *Health and Safety Executive*, 3 October 2006.

8.10 The **Scottish Executive Health Department** (SEHD) said that the level of any pay award should take account of the totality of funding available to the SEHD, where there was a fixed budget with no additional resources to fund excess costs arising from pay settlements. The SEHD said that the picture on a wide range of workforce issues was positive and improving. The vast majority of employers had reported a stable recruitment and retention position, although the perennial difficulty of recruiting in remote and rural areas remained an issue. The SEHD said that it supported the Department of Health's recommendation of a one-year only general uplift of 1.5 per cent. It believed this was fair and affordable and balanced the need to meet the recruitment and retention needs of NHSScotland, the need to ensure resources were available to deliver growth in capacity and service improvements, and the need to maintain financial balance. The SEHD said that the level of any award should take account of the level of earnings growth resulting from pay modernisation whereby NHS staff would benefit from both a cost of living increase and the new pay arrangements under AfC.

8.11 The **National Assembly for Wales** (NAW) said that employers in Wales had been surveyed about the 2007/08 pay round and there had been a high degree of agreement that the level of pay uplift should be in line with, or below, the CPI inflation target and the same uplift was desirable for AfC staff, medical and dental staff. NAW said that in view of the good recruitment and retention position, low vacancies, growth in average earnings for all NHS staff (including additional earnings amounting to approximately £30 million or roughly an additional one per cent), and the continuing financial pressures within the NHS (in part due to the higher than expected costs of AfC), it recommended an uplift for 2007/08 of no more than 1.5 per cent.

NHS Employers (NHSE)

8.12 In its original written evidence, submitted at the end of September 2006, **NHSE** told us the majority view from employers responding to its questionnaire was that a pay award that did not exceed the CPI inflation target was the most that could be afforded. Any further cost pressure through unfunded pay increases would almost certainly impact on staff numbers and service provision. A significant minority of respondents had indicated that no pay award would be affordable. Some mentioned figures below inflation, such as one per cent, and others stressed that affordability was dependent on an appropriate increase in the pay element in tariff references prices for 2007/08. Some employers would be making redundancies whatever the level of settlement, but most respondents had indicated that a pay award higher than inflation would lead to further reductions in posts, possible redundancies, vacancy freezes, reduction in capacity/growth and failure to meet health care and financial targets. Despite this, many employers had acknowledged that a below inflation award would be detrimental for staff morale and motivation.

8.13 Employers believed that unless there was a clear recruitment and retention problem, differential pay awards were divisive and had a detrimental effect on morale and team working and therefore both medical and non-medical staff should receive the same level of award.

8.14 NHSE said that the overall level of average earnings growth in the NHS needed to be factored into decisions about the recommended level of uplift as this would impact on overall affordability and on the remuneration of individual employees. Negotiations were also taking place for a new system of unsocial hours payments with implementation expected from April 2007 and this was expected to add approximately 0.3 per cent to the paybill for non-medical staff. Sample data suggested that around 45 per cent of staff were working some form of unsocial hours.

8.15 In their original written evidence, NHSE had told us that a pay award in line with the CPI inflation target was the most that could be afforded by employers in the NHS and employers had made clear that, to be affordable, any pay award would need to be reflected in the pay element of the tariff. At that time, the level of the 2007/08 tariff uplift was not yet known, but NHSE thought that the uplift was unlikely to exceed the target rate for CPI of two per cent.

8.16 Following the Department of Health's publication on 19 December 2006 of the final tariff uplift figure for 2007/08, NHSE told us that what they originally said had been based on a straightforward assumption that the tariff increase could be converted into the pay uplift for the proportion of revenue spent on staff. When the information about the tariff had become available, NHSE had sought the opinion of the Department of Health as to the affordability of a pay uplift and had been advised that, given the costs of other factors, such as pay modernisation, the most that could be afforded was 1.5 per cent. Given that the Department of Health's advice was based on the Department's business and workforce models, NHSE said that they would not wish to pursue a recommendation that ultimately became unaffordable for employers, risking jobs and service commitments. Based on the Department's indications of affordability, NHSE said they now believed that 1.5 per cent was the best indication they had of what would be affordable.

8.17 With regard to UNISON's proposal for a flat rate increase for staff in pay bands 1, 2 and 3 (*see further below*), NHSE said that AfC had made a significant contribution to addressing low pay in the NHS. The lowest rate of pay was currently £6.03 per hour, well ahead of the National Minimum Wage of £5.35 per hour. NHSE said it preferred to maintain the pay structure as it was, but to find ways of encouraging local employers to develop staff to take on more demanding roles to enable them to progress into higher pay bands. Knowledge and Skills Framework (KSF) would help to support this process. Around 60,000, 200,000 and 130,000 staff were in pay bands 1, 2 and 3 respectively and any additional pay to these groups would therefore be costly and would inevitably result in a lower general award to all staff.

8.18 With regard to Amicus' proposal to introduce a 35 hour week, NHSE said it was important that the new pay structure had a period of stability and time to bed down. On affordability and productivity grounds alone, NHSE said that it could not support this proposal. NHSE said that any reduction in hours under AfC was a matter for discussion at the Executive of the NHS Staff Council.

Staff Bodies

8.19 Evidence from the joint **Staff Side** described significant achievements of NHS staff in meeting NHS objectives against what they said was a background of ever more demanding targets, an unprecedented pace and scale of reform, and a challenging financial environment. Organisational change on such a massive scale was leading to continuing high levels of pressure on NHS staff. Increases in costs of living, including housing costs, energy, utilities and travel, were all unavoidable for NHS staff and disproportionately affected the low paid. Using the CPI did not take into account the impact of real time price hikes on day to day costs. Evidence on morale and motivation had highlighted a drop in the overall level of job satisfaction since 2004 and high satisfaction was known to be associated with good performance, satisfaction of patients, wellbeing of staff and low levels of absenteeism and turnover. The Staff Side's Ipsos-MORI research had highlighted that pay had not been a primary motivating factor for staff working in the NHS because of the satisfaction derived from the NHS's public sector ethos and staff's sense of vocation. Yet in a climate where many of the other compensatory factors for accepting lower pay (such as opportunities for flexible working and training and development) were felt to be under threat, pay was likely to become a more important factor in recruiting and retaining staff.

8.20 Staff Side said that only a cautious welcome could be given to the reductions in vacancy levels because the figures hid worrying underlying trends of job cuts, recruitment freezes and redundancies. Moreover, the figures demonstrated that recruitment and retention was much more of a problem in Inner London. Retention figures might also be artificially enhanced for the time being because of the general lack of job security in the NHS. The Ipsos-MORI research had found that staff were disillusioned because their salary expectations of AfC had not been met. It had also found that staff were less happy with the value of the incremental awards under AfC and this, together with the implications of *Cadman* v. *HSE*, meant the Staff Side was seeking a reduction in the number of increments over time and a corresponding increase in their value. Research commissioned by the Office of Manpower Economics[48] covering the period 1993-2003 had indicated that nurses and midwives had done relatively worse than other PRB groups (doctors, police[49] and armed forces). This differential gap between our remit group and those covered by other PRBs should be addressed. Taken altogether, Staff Side said they believed their evidence presented a compelling case for a significant above inflation increase in pay and all related allowances for 2007. A one-year only deal was sought.

8.21 Staff Side reminded us that AfC had been implemented to provide equal pay for work of equal value and the cost of AfC should not be used to inhibit future pay awards. The Department of Health's argument that a 1.5 per cent pay award would give an overall uplift of four per cent was incorrect because it was based on the supposition that all NHS staff would receive an increment, which was not the case. Furthermore, all increments were part of the AfC framework and were rewards for increased experience and achieved competencies, not part of a fair cost of living increase. Staff Side felt that an award below the rate of inflation would negate the benefits gained by the implementation of AfC and would have a very negative impact on morale.

8.22 **UNISON** asked us to recognise the evidence supporting the role of staff in achieving significant improvements to service delivery, meeting Government targets, waiting times, increased flow of patients and the reduction in cancelled operations. We were also asked to note the negative impact of untested Government reforms on NHS staff and the huge uncertainties and insecurities placed on staff by the increasing fragmentation of the NHS.

8.23 In the light of its overview of the current climate of innovation and change within the NHS, UNISON argued for a substantial pay award, significantly above the rate of inflation. This would recognise staff contribution to patient care. It would also go some way to rewarding the workforce for their continued input into the growth and development of the NHS and address some of the potential recruitment, retention and morale risks posed by the massive programme of change currently underway within the health service. As AfC remained an unfinished product in terms of implementation and because of the continued uncertainties and future developments that may impact on earnings, UNISON said it was calling for a one-year only national pay award. This would enable us to look at a more stable and more developed AfC structure in next year's pay round. A minimum flat rate payment for staff in bands 1, 2 and 3 was also sought to give them a higher percentage or minimum payment for the lowest paid. UNISON accepted that this year was an extremely challenging one for the NHS, but it believed the need to value and reward staff's continued commitment to the NHS was vital if the Government's modernisation targets were to be achieved.

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[48] The Earnings of Workers Covered by Pay Review Bodies: Evidence from the Labour Force Survey – Report for the Office of Manpower Economics by Gerald Makepeace and Oscar Marcenaro-Gutierrez, November 2005.

[49] Police pay is not recommended by a Review Body.

8.24 The **Royal College of Nursing** said that its evidence gave powerful support to the central message from the Staff Side about the importance of pay. It asked us to consider the long term impact of the factors currently affecting morale and to award a significantly above inflation uplift in AfC pay scales and all related allowances for 2007/08 to help restore morale.

8.25 The **Royal College of Midwives** said that we must take into account the Government's declared intention to increase choice and support for women during childbirth. Although the indicators of recruitment, retention and morale seemed favourable, they did not seem to be having the desired effect of increasing the midwifery workforce in order to expand choice and provision.

8.26 **Amicus** said it was seeking a one year pay award of a substantial increase which was above the cost of living and would rest comfortably in the upper quartile of salary increases for the second quarter of 2007. It was seeking a 35 hour week for staff covered by the Pay Negotiating Council and because of the need to avoid the introduction of pay inequalities, Amicus said it was therefore also seeking the introduction of a 35 hour working week for all health service staff. Responding to the Department of Health's arguments about earnings growth, Amicus said that some staff were at the top of their band and would enjoy no incremental progression. The Department of Health should not be seeking for NHS staff to subsidise current service provision through a comparatively inferior pay uplift. The figure Amicus was seeking was linked to wages in the wider economy and not the cost of living.

8.27 The **Chartered Society of Physiotherapy** said demand for qualified physiotherapists remained high and would continue to grow in future years and there were still significant vacancies at senior levels within the NHS. It asked us to recommend significant increases in both pay and cash-based allowances, such as on-call, standby and London Weighting and High Cost Area Supplements.

8.28 The **T&G** urged us to address the need for a significant pay rise for NHS workers to address the pay gap with other public and private sector groups.

Our Comment

8.29 We are grateful to the parties for setting out their preferred options regarding the level and structure of this year's award. This has helped us to simplify the nature of our review and to establish the parameters within which to consider the other evidence we have received. At one end, the Health Departments and NHSE have asked for a recommendation of 1.5 per cent. At the other, the majority of the Staff Side bodies are seeking an uplift significantly above the current rate of RPI.

8.30 We note the general agreement that there should be no changes to the structure of the pay system this year and that we should recommend an award for one year only.

8.31 UNISON has proposed a flat rate pay uplift for our remit group in pay bands 1, 2 and 3. Amicus has also proposed that all staff should move to a 35 hour week on equity grounds as they are seeking this for their members who are covered by the Pay Negotiating Council. These proposals are not supported by the Health Departments or by NHSE. As we said in Chapter 1, until implementation of AfC is complete and it becomes possible, based on adequate evidence, to assess the impact and costs of the AfC structure and its impact on recruitment, retention and morale, there is no evidential basis on which we can recommend any structural changes to it.

Summary and Conclusions

8.32 Our role is to make recommendations that are fair to all stakeholders, taking into account all the circumstances and in line with our terms of reference. We have therefore carefully considered the arguments put to us in evidence and summarised here and in the previous chapters of this report.

8.33 In summary, the **Department of Health's** case is that record levels of recruitment have helped the NHS to reach a position where workforce demand and supply are now closely matched. Recruitment and retention are very healthy with no problems finding suitably qualified staff and vacancy levels continuing to fall. The total package on offer to NHS staff, including the NHS Pension Scheme, is a very competitive one. AfC has delivered higher earnings and will continue to deliver a healthy rise in average earnings through incremental progression. Pay drift will be 2.5 per cent for our remit group in 2007/08 and the combined effects of pay drift plus the pay uplift are factors that we should take account of in determining affordability. Given the financial pressures on the NHS, a 1.5 per cent pay uplift is all that is affordable. A 1.5 per cent pay uplift will lead to an increase in average earnings of 4.0 per cent for our remit group. The **SEHD** and the **NAW** have also described improving recruitment and retention positions, and despite having less cash growth in 2007/08 than England, they support a pay uplift of 1.5 per cent.

8.34 Similarly, **NHSE** describe a generally healthy recruitment and retention position, but note that morale has deteriorated due to the current uncertainty about possible job losses. Based on advice from the Department of Health, NHSE has now said that a pay uplift of 1.5 per cent is the most that is affordable under the tariff increase for 2007/08.

8.35 The joint **Staff Side** evidence and the evidence from the individual staff side bodies considered that the Health Departments' official data on vacancy levels was misleading because of Trusts' current actions to tackle the financial deficits throughout the NHS through such actions as vacancy freezes, job cuts and redundancies. The true picture was of higher vacancy levels and increased workload for staff in post. Morale was very low with staff concerned about their workload, their ability to deliver good patient care and their ability to progress. There were also some concerns about job security. The implementation of AfC had also resulted in varying degrees of dissatisfaction. There was concern about the delayed implementation of the KSF and the impact that cuts in training budgets were having on the number of new training places, the ability of new graduates to find a first post and the ability of staff in post to undertake training for the KSF and for continuing professional development. A pay uplift significantly above the RPI was sought to recognise the current level of low morale, to retain staff currently in the service and to continue to attract new recruits, to recognise the recent increases in the costs of living and to go some way to addressing the pay gap between NHS staff and comparator groups.

8.36 In coming to our conclusions, we have been hampered by a lack of reliable and up to date information on our remit group, as we discussed in paragraph 1.12. We are particularly concerned by the quality of the data on earnings presented to us by the Health Departments. Late in January 2007 the Department of Health sent us new estimates of earnings for 2005/06 and their projections for later years. While this new data has not led us to change our recommendations or our analysis of the path of earnings and the level of pay drift, it has confirmed us in the view that the data presented to us on these key variables leaves much to be desired.

8.37 We make our recommendations in line with our terms of reference which are specified in the preface to this report. In considering the pay uplift for 2007/08, we have paid particular regard to the need to recruit, retain and motivate suitably able and qualified staff, the funds available to the Health Departments and the Government's inflation target. We have reviewed the evidence on equal pay and related issues in Chapter 2. No issues requiring action were raised with us this year and we have outlined the process by which we will address them in future. The issues raised with us relating to regional/local variations in labour markets were not designed to impact on our general award. As we stated in paragraph 6.2, we were unable to give detailed consideration to the Health Departments' output targets for the delivery of services, although we note the Departments' general point that unnecessarily large pay increases may prejudice the delivery of service improvements.

8.38 The Departments and employers have emphasised the need for an award that is affordable. We have balanced this concern against the desirability of amending the existing position of the pay structure of our remit group relative to the external market. In reaching our conclusion, we have sought to maintain the relative position of the pay structure as far as affordability constraints allow. **We recommend an increase in the Agenda for Change pay rates of 2.5 per cent from 1 April 2007.** Our reasoning is set out below.

8.39 We believe that we should approach our task of recommending a pay uplift by considering whether it is necessary to amend, either up or down, the existing position of the AfC pay structure relative to the economy as a whole. Our starting point this year has been that the median of pay settlements for the economy as a whole was around three per cent at the time we made our decision. Unless we have reasons to change the relative pay position, this suggests that we should recommend a pay uplift of three per cent. There are several reasons why such an increase might not be appropriate:

- *If the level of pay drift was such that the earnings of our remit group would grow significantly faster or slower than earnings elsewhere in the economy.* As we discussed in Chapter 7, we have been unable to understand how the levels of pay drift projected by the Department of Health were derived or the extent to which their estimates and projections of pay drift resulted from factors which we have called pay drive and which, in our view, are not relevant to determining the basic pay uplift. We do not believe that we should base our recommendations on the Department's projections and believe it would be more prudent to assume that pay drift will be around its average historic levels. Therefore, the level of earnings currently experienced by our remit group does not suggest the need to change the relative position of the pay structure. As we noted in Chapter 7, over the last five or six years the average earnings of our remit group have moved broadly in line with earnings in the economy as a whole.

- *If a pay uplift at the average settlement level would have harmful repercussions such that it endangered the achievement of macro-economic stability by contributing to an inflationary spiral.* The Chancellor has drawn our attention to this danger. We acknowledge the importance of avoiding an inflationary spiral, but we do not believe that a recommendation at or below the median level of pay settlements would fuel one. We note that the public sector pay settlements agreed in the last pay round are now delivering average public sector earnings growth well below that of the private sector and well within the limit that the Bank of England believes is compatible with achieving the inflation target. There are no considerations here which would lead us to reduce the relative pay position of our remit group.

- *If inflation, settlements and earnings growth elsewhere in the economy were likely to change significantly from current levels.* Given that we are making recommendations that will come into effect in the next financial year, we must try to ensure that the pay structure of our remit group does not get out of line with the rest of the market. As we discussed in Chapter 7, the latest figures show that inflation is much higher than a year ago although the indices are probably now approaching their peak. We note that most forecasters expect that inflation will fall during the coming year, possibly quite sharply. There is some likelihood that the growth of settlements and earnings elsewhere in the economy may pick up in reaction to the increase in inflation in the short term. But the size and duration in any pick up is unclear and most forecasters do not anticipate much change in average earnings growth in 2007. Though faster growth in settlements and earnings elsewhere in the economy would point to a higher award, on balance, we do not believe the most recent figures provide grounds for a recommendation above the current median level of settlements.

- *If there were evidence that there was an over or under supply of labour of the required quality at existing wage rates.* As we have discussed in Chapter 3, while the current recruitment and retention position suggest no lack of supply, we must look beyond the immediate position and take a longer-term view. There may be no recruitment and retention problems apparent now, but the recent improvements in vacancy and wastage rates probably owe much to Trusts' reactions to current financial problems and may not reflect the NHS's longer-term ability to recruit and retain a skilled workforce. Similarly we should not ignore the widely acknowledged declining levels of morale within the NHS, as discussed in Chapter 5. Declining morale will have an adverse effect on the NHS's ability to recruit and retain in the longer-term and to meet its service delivery targets. There is a case for a lower than average award on the basis of the current staffing position. However, taking into account the longer-term implications for recruiting and developing a skilled workforce and evidence of declining morale, we do not believe that, on balance, we should significantly reduce the relative position of our remit group.

- *If the funds available meant that the increase was unaffordable.* As we discussed in Chapter 6, we have had great difficulty in understanding how the Departments have come to the conclusion that a 1.5 per cent pay uplift was the limit that the NHS could afford. We accept that the cash increase of 9.2 per cent in the Departmental Expenditure Limit for England cannot be taken as a benchmark for pay increases, that there are substantial pressures on NHS resources and that a minority of Trusts face severe financial difficulties. We understand that the Payment by Results guidance published in December 2006 by the Department of Health indicates that 1.7 per cent has been built into the tariff uplift for increased pay, plus 0.7 per cent for AfC, and the Department of Health has subsequently advised NHSE that a pay uplift of 1.5 per cent is the most that could be afforded. However, for us to be constrained by a pre-determined figure contained in the tariff would amount to a total abdication of our responsibilities, as defined in our remit. However, we do accept that there are sufficient affordability concerns for us to recommend a pay uplift below the median level of settlements.

8.40 These are the factors that we have balanced in coming to our judgement that the pay uplift for 2007/08 should be 2.5 per cent. Even though the DELs for Scotland and Wales are due to increase by a smaller amount than in England, each of the Health Departments has argued for the same award. We have therefore been given no reason to differentiate between the countries in making our recommendation.

8.41 As we explained in Chapter 1, we have no evidential basis on which to recommend any changes to the AfC pay structure. We are therefore making no recommendations that would alter the basic pay differentials within that pay structure.

8.42 Finally, we agree with the parties that we should recommend for one year only and consequently our recommendations cover the pay year 2007/08.

APPENDIX A

COVERAGE OF THE NURSING AND OTHER HEALTH PROFESSIONS REVIEW BODY (NOHPRB)

i) Nurses, Midwives and Health Visitors

ii) Allied health professional groups

Art Therapists
Drama Therapists
Music Therapists
Chiropodists/Podiatrists
Dieticians
Occupational Therapists
Orthoptists
Orthotists
Prosthetists
Physiotherapists
Radiographers
Speech and Language Therapists
Ambulance Paramedics

iii) The professions in healthcare science

Engineering and the physiological sciences:

Clinical Engineers
Medical Physicists
Medical Physics Technologists
Nuclear Medicine Technologists
Critical Care Technologists
Radiotherapy Technologists
Rehabilitation Engineers
Clinical Measurement Technicians
Vascular Technologists
Medical Illustrators
Renal Dialysis Technologists
Technologists in Equipment Management

Physiological sciences:

Audiological Scientists
Hearing Therapists
Audiological Technicians
Cardiology Physiologists
Cardiographers
Clinical Perfusionists
Gastroenterology Technicians

Neurophysiologists
Respiratory Physiologists

Life Sciences:

Biomedical Scientists
Cytology Screeners
Medical Laboratory Assistants
Phlebotomists
Clinical Biochemists
Clinical Cytogeneticists
Molecular Geneticists
Cytogenetics and Molecular Genetics Assistants
Clinical Embryologists
Clinical Microbiologists
Clinical Scientists (in haematology)
Clinical Scientists (in immunology and histocompatibility)
Post-mortem Technicians
Quality Assurance Scientists

iv) Other healthcare professions

Healthcare Pharmacists, Hospital Optometrists, Clinical Psychologists, Adult and Child Psychotherapists;

Family therapists with a minimum training requirement of at least three years to diploma level or equivalent in family therapy;

Operating Department Practitioners

v) Clinical support workers and technicians

Clinical support workers and technicians who directly support the work of the professions outlined above:-

Nursing Auxiliaries, Health Care Assistants and Maternity Assistants (supporting Nurses, Midwives and Health Visitors);

Assistant Psychologists and Child Psychotherapists (supporting Clinical Psychologists and Child Psychotherapists);

Dental Nurses, Hygienists, Therapists and Technicians;

Medical Laboratory Assistants, Assistant Technical Officers, Senior Assistant Technical Officers (supporting Healthcare Scientists);

Operating Department Assistants (supporting Operating Department Practitioners);

Pharmacy Technicians and Assistants;

AHP Helpers, AHP Assistants and Technical Instructors, Speech and Language Therapist Assistants and Ambulance Technicians.

APPENDIX B

RECOMMENDED NATIONAL SALARY SCALES FROM 1 APRIL 2007[50]

Point	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8				Band 9
								Range A	Range B	Range C	Range D	
1	12,076											
2	12,481	12,481										
3	12,827	12,827										
4	13,174	13,174										
5		13,579										
6		13,983	*13,810**									
7		14,388	14,388									
8		14,907	14,907									
9		15,485	15,485									
10			15,832									
11			16,294	*16,063**								
12			16,815	16,815								
13			17,219	17,219								
14				17,855								
15				18,490	*18,490**							
16				19,067								
17				19,645	19,645							
18				20,223	20,223							
19					20,801							
20					21,494							
21					22,187							
22					22,823	*22,534**						
23					23,458	23,458						
24					24,383	24,383						
25					25,424	25,424						
26						26,464						
27						27,388	*26,926**					
28						28,313	28,313					
29						29,237	29,237					
30						30,277	30,277					
31						31,779	31,779					
32							32,704					
33							33,744					
34							34,899	*34,899**				
35							36,112	36,112				
36							37,326	37,326				
37								38,828				
38								40,330	*40,330**			
39								42,064	42,064			
40								43,335	43,335			
41									45,530			
42									48,072	*48,072**		
43									50,616	50,616		
44									52,002	52,002		
45										54,313		
46										56,856	*56,856**	
47										60,669	60,669	
48										62,402	62,402	
49											65,003	
50											68,180	*68,180**
51											71,646	71,646
52											75,114	75,114
53												78,718
54												82,497
55												86,457
56												90,607

***Pay rates in italic are special transitional points which apply only during assimilation to the new system. They are shown here for convenience.**

[50] The recommended rates from 1 April 2007 have been calculated as follows: we have taken the rates applicable at October 2004 as our base, as this date reflects the intended national rollout of the new Agenda for Change pay system. We have applied the 3.225 and 2.5 per cent increases agreed by the parties as the 1 April 2005 and 2006 uplifts to the base respectively, and further applied our recommended uplift from 1 April 2007. The resulting figures have been rounded up to the nearest pound.

APPENDIX C

RECOMMENDED LEVELS OF HIGH COST AREA SUPPLEMENTS

Area	Current level (1 April 2006)	Recommended level (1 April 2007)
Inner London	20% of basic salary, subject to a minimum payment of £3,383 and a maximum payment of £5,638	20% of basic salary, subject to a minimum payment of £3,468 and a maximum payment of £5,779
Outer London	15% of basic salary, subject to a minimum payment of £2,819 and a maximum payment of £3,946	15% of basic salary, subject to a minimum payment of £2,890 and a maximum payment of £4,045
Fringe zone	5% of basic salary, subject to a minimum payment of £846 and a maximum payment of £1,466	5% of basic salary, subject to a minimum payment of £867 and a maximum payment of £1,503

APPENDIX D

FULL TIME EQUIVALENT STAFF NUMBERS AT SEPTEMBER 2005

Nursing, midwifery and health visiting staff

	ENGLAND		WALES		SCOTL
	Number	%	Number	%	Number
Qualified staff	307,744	75.8	20,698	73.5	39,834
Unqualified staff	98,203[1]	24.2	7,454[2]	26.5	15,635[3]
Total	405,947	100.0	28,152	100.0	55,469

Allied Health Professionals (AHPs) and Scientific Therapeutic & Technical (ST&T) staff

	ENGLAND		WALES		SCOTL
	Number	%	Number	%	Number
Qualified AHP staff[4]	50,070	34.9	3,539	36.5	6,358
Qualified ST&T staff[5]	63,144	44.0	4,116	42.4	8,077
Unqualified AHP and ST&T staff	30,392	21.2	2,043[6]	21.1	3,586[7]
Total	143,606	100.0	9,698	100.0	18,021

Ambulance staff

	ENGLAND		WALES		SCOTL
	Number	%	Number	%	Number
Ambulance Paramedics	8,110	41.4	746	53.5	1,153
Other Qualified staff	9,307[8]	47.5	518[8]	37.1	899[9]
Trainee Ambulance personnel	2,193	11.2	131	9.4	776[10]
Total	19,610	100.0	1,395	100.0	2,828

FULL TIME EQUIVALENT STAFF NUMBERS AT SEPTEMBER 2005 (CONTINUED)

Healthcare assistants*

	ENGLAND		WALES		TOT
	Number	%	Number	%	Number
Healthcare assistants	104,123	100.0	8,584	100.0	112,707
Total	104,123	100.0	8,584	100.0	112,707

Sources: Health and Social Care Information Centre – non-medical workforce census; National Assembly for Wales; and ISD Scotland.

* Healthcare assistants for England and Wales are included separately because they cannot be split by staff group.

England

1. Includes nursing assistants/auxiliaries and nursery nurses.
8. Includes managers and qualified ambulance personnel.

Wales

2. Includes nursing assistants/auxiliaries, nursery nurses and nurse learners.
6. Includes helpers/assistants and student/trainees.
8. Includes managers and qualified ambulance personnel.

Scotland

3. Includes all non-registered nursing and midwifery staff including healthcare assistants, nursing assistants/auxiliaries and nursery nurses.
7. Includes all assistants, unqualified staff and those in training.
9. Includes technicians.
10. Includes care assistants, excludes drivers / chauffeurs.

All

4. Includes qualified AHP workers in the following professions: chiropody, dietetics, occupational therapy, orthoptics/optics, physiotherapy, radiograp
5. Includes qualified ST&T workers in the following professions: speech and language therapy, multi-therapies, clinical psychology, psychotherapy, p other ST&T staff and all qualified healthcare scientists.

APPENDIX E

Breakdown of estimated[a] 2006/07 paybill[b] for Great Britain

PAYBILL FOR NURSING & MIDWIVES

	Cost	
	Cash	**As a percentage of paybill[c][d]**
	£ million	%
Pay[e]	13,122	98.0
London allowance	268	2.0
Sub-total[c][d]	13,389	100.0
Employers' on-costs[f]	2,905	–
Agency staff costs	448	–
Total[c]	**16,742**	–

PAYBILL FOR ALLIED HEALTH PROFESSIONS

	Cost	
	Cash	**As a percentage of paybill[c][d]**
	£ million	%
Pay[e]	1,946	98.1
London allowance	38	1.9
Sub-total[c][d]	1,984	100.0
Employers' on-costs[f]	436	–
Agency staff costs	123	–
Total[c]	**2,543**	–

PAYBILL FOR SCIENTIFIC, TECHNICAL, PROFESSIONAL & THERAPEUTICS

	Cost	
	Cash	**As a percentage of paybill[(c)(d)]**
	£ million	%
Pay[(e)]	2,613	98.2
London allowance	49	1.8
Sub-total[(c)(d)]	2,662	100.0
Employers' on-costs[(f)]	585	–
Agency staff costs	126	–
Total[(c)]	**3,373**	–

PAYBILL FOR AMBULANCE STAFF

	Cost	
	Cash	**As a percentage of paybill[(c)(d)]**
	£ million	%
Pay[(e)]	879	98.5
London allowance	14	1.5
Sub-total[(c)(d)]	892	100.0
Employers' on-costs[(f)]	199	–
Agency staff costs	1	–
Total[(c)]	**1,092**	–

Source: Health Departments

(a) Estimates are based on uplifted 2005/06 provisional accounts figures from the Health Departments and estimated staff numbers at 30 Sept 2005, and are subject to revision. The split into pay, London allowance, employers' costs and agency costs is based on the proportional split from the Health Departments' 1997 FIS10 exercise.

(b) Excludes students on Project 2000 courses, and senior nurses and senior midwives.

(c) Totals may not equal the sum of components because of rounding, and percentages have been calculated from unrounded figures.

(d) Excluding employers' national insurance contributions and superannuation, agency staff, students on Project 2000 courses and senior nurses and senior midwives.

(e) Includes basic pay, overtime, special duty payments, pay-related and non pay-related allowances, none of which are separately identifiable.

(f) Employers' national insurance contributions and superannuation.

APPENDIX F

WORKFORCE SURVEY, 2006

Introduction

1. Again this year OME has carried out a Workforce Survey covering Trusts in Great Britain. For more information please see Chapter 3 paragraphs 3.2 to 3.19 or for the full results please go to the OME's website at *http://www.ome.uk.com*

Box 3.1: 2006 Workforce Survey

Recruitment

A – Staff joining Trusts as a proportion of staff in post (for sample as a whole)

Main staff group	England and Wales (in the year to 31 March 2006)	Scotland (in the year to 30 September 2005)
NOHPRB	12.1%	11.8%
Nurses	11.5%	11.9%
AHPs	16.1%	14.2%
ST&T	13.2%	11.7%
Ambulance	9.9%	14.4%

B – Staff joining Trusts as a proportion of staff in post in the year to 31 March (Matched sample)

Main staff group	England and Wales only	
	2005	2006
NOHPRB	13.7%	12.0%
Nurses	13.0%	11.4%
AHPs	17.6%	16.3%
ST&T	15.2%	12.3%
Ambulance	12.8%	9.7%

Retention

C – Turnover rates and wastage (sample as a whole)

Main staff group	England and Wales (in the year to 31 March 2006)		Scotland (in the year to 30 September 2005)	
	Turnover	Wastage	Turnover	Wastage
NOHPRB	10.5%	8.4%	9.9%	–
Nurses	10.5%	8.4%	10.1%	–
AHPs	12.2%	9.5%	10.0%	–
ST&T	11.0%	9.0%	8.3%	–
Ambulance	5.3%	4.1%	11.6%	–

– not available

D – Turnover rates and wastage in the year to 31 March (Matched sample)

	England and Wales only			
	Turnover		Wastage	
	2005	2006	2005	2006
NOHPRB	11.1%	10.7%	8.8%	8.4%
Nurses	10.8%	10.5%	8.6%	8.2%
AHPs	12.9%	12.6%	9.8%	9.8%
ST&T	12.8%	11.3%	10.5%	9.0%
Ambulance	4.3%	3.4%	2.8%	3.2%

E – Turnover rates and wastage in the year to 31 March, by selected occupational groups

	England and Wales		Scotland	
	Turnover	**Wastage**	**Turnover**	**Wastage**
Midwives	8.3%	6.6%	8.1%	–
Health Visitors	9.5%	7.2%	11.0%	–
District Nurses	9.5%	7.7%	9.9%	–
Nurse auxiliaries and assistants	11.9%	10.5%	11.0%	–
Pharmacy	14.5%	11.4%	*	–
Dietetics	13.6%	10.1%	9.9%	–
Occupational therapy	15.1%	10.8%	11.1%	–
Diagnostic radiography	8.0%	6.1%	*	–
Therapeutic radiography	10.6%	8.2%	*	–
Medical physicists	5.6%	4.6%	*	–

* Scotland does not provide disaggregated data for these occupational groups.
– not available

Table 1

Summary of joiners data for *all Nursing staff* in England and Wales only: as a percentage of staff in post at year en Weighting Zone.

Matched Sample

Nursing	Joiners in the year to 31 March 2006								
	Newly qualified[2]		Transfers from within NHS		Re-entrants		Other		Don't k
	2005 %	2006 %	2005 %	2006 %	2005 %	2006 %	2005 %	2006 %	2005 %
Total	1.2	1.0	3.1	2.7	0.3	0.2	4.2	2.9	4.3
By country/region									
Wales	0.6	0.2	0.9	0.2	0.1	0.2	2.7	1.0	5.1
England	1.2	1.1	3.4	3.0	0.3	0.2	4.3	3.2	4.2
– North East	1.0	1.1	2.3	1.9	0.3	0.0	2.9	2.8	2.2
– North West	2.0	1.6	3.9	3.6	0.4	0.3	2.8	3.2	2.7
– Yorkshire and the Humber	0.6	0.2	5.1	5.3	0.0	0.0	2.1	2.0	8.3
– East Midlands	1.3	2.6	5.3	3.0	1.4	0.0	4.8	3.4	2.8
– West Midlands	0.8	0.5	3.2	3.1	0.1	0.4	5.6	3.4	4.2
– East of England	0.9	0.3	1.1	0.1	0.3	0.1	5.2	2.5	9.8
– London	1.0	1.3	3.9	4.1	0.6	0.7	5.4	4.5	2.8
– South East	1.4	1.6	2.8	3.0	0.2	0.1	4.8	3.6	4.1
– South West	1.8	0.6	3.2	1.2	0.2	0.1	3.8	1.4	4.7
By London Weighting Zone									
Inner London	0.4	0.6	2.4	4.1	0.1	0.1	7.5	5.2	4.2
Outer London	1.5	1.9	5.3	4.0	1.0	1.3	3.1	3.6	1.9
London Fringe zone	0.4	0.6	3.5	3.0	0.1	0.0	1.9	3.7	10.2
Rest of England and Wales	1.2	1.0	3.0	2.6	0.3	0.2	4.1	2.8	4.3

(1) All figures have been rounded independently, and percentages have been calculated from unrounded figures.
(2) For nursing auxiliaries and assistants, an entrant direct from full-time or part-time education.
(3) The sum of the individual categories may not equal 'Total joining' as changes in working may not be accounted for in the individual columns.

Table 2

Summary of leavers data for *all Nursing staff* in England and Wales only: as a percentage of staff in post at year e Weighting Zone.

Matched Sample

Nursing	Leavers in the year to 31 March 2006										
	Retirement		Transfers to other NHS units		To non-NHS employment[2]		Other		Don't know		Total le
	2005 %	2006 %	2005 %	2006 %	2005 %	2006 %	2005 %	2006 %	2005 %	2006 %	2005 %
Total	1.2	1.0	2.3	2.3	1.0	0.9	2.7	2.4	3.7	3.9	10.8
By country/region											
Wales	0.9	0.7	0.3	0.3	0.2	0.4	0.5	0.3	4.5	5.4	6.5
England	1.2	1.0	2.5	2.6	1.1	0.9	3.0	2.7	3.6	3.8	11.3
– North East	0.9	1.1	1.9	2.6	0.8	0.8	2.0	1.1	3.4	1.9	9.0
– North West	1.6	0.7	2.7	2.4	0.9	0.9	1.8	1.3	2.8	3.1	9.8
– Yorkshire and the Humber	1.1	1.0	4.1	6.5	0.6	0.4	1.4	2.3	3.9	4.0	11.2
– East Midlands	1.4	1.4	3.1	2.2	1.2	1.3	2.3	2.7	2.4	2.2	10.4
– West Midlands	0.9	0.7	1.9	2.2	1.0	1.2	3.5	3.4	4.1	4.3	11.3
– East of England	0.6	0.5	2.8	0.9	0.4	0.1	3.7	2.4	4.9	5.4	12.5
– London	1.3	1.1	2.2	2.1	1.1	0.9	4.7	4.5	3.2	3.6	12.6
– South East	1.2	1.2	2.5	3.4	1.5	1.2	3.7	3.6	3.6	3.7	12.5
– South West	1.7	1.6	2.2	1.2	1.4	0.6	2.6	1.4	4.4	5.7	12.3
By London Weighting Zone											
Inner London	0.7	0.8	2.0	1.2	0.7	0.7	4.8	6.0	3.4	3.3	11.6
Outer London	1.9	1.4	2.4	2.9	1.5	1.0	4.5	3.0	3.4	4.2	13.7
London Fringe zone	1.3	1.6	3.3	2.6	2.1	3.1	3.2	5.6	6.1	3.6	16.0
Rest of England and Wales	1.1	0.9	2.2	2.4	0.9	0.8	2.5	2.1	3.7	4.0	10.5

(1) All figures have been rounded independently, and percentages have been calculated from unrounded figures.
(2) Including leavers who take up appointments in the non-NHS health-care sector, including private hospitals and clinics, residential and nursing ho
(3) Total leaving excluding transfers to other NHS units as a percentage of staff in post.

Table 3

Summary of joiners data for *all AHP staff* in England and Wales only: as a percentage of staff in post at year end[1] Weighting Zone.

Matched Sample

AHP	Joiners in the year to 31 March 2006								
	Newly qualified[2]		Transfers from within NHS		Re-entrants		Other		Don't k
	2005 %	2006 %	2005 %	2006 %	2005 %	2006 %	2005 %	2006 %	2005 %
Total	1.8	1.5	4.2	3.5	0.4	0.2	5.1	4.1	6.1
By country/region									
Wales	1.6	0.9	1.2	0.4	0.1	0.0	4.2	1.5	7.9
England	1.8	1.6	4.6	3.8	0.4	0.2	5.2	4.4	5.9
– North East	3.2	3.0	3.7	1.7	1.2	0.1	3.1	1.6	3.2
– North West	3.1	2.8	4.3	5.4	0.3	0.2	2.5	4.4	3.7
– Yorkshire and the Humber	1.1	0.1	5.3	4.4	0.0	0.0	5.4	0.4	5.6
– East Midlands	2.9	1.3	6.3	3.9	1.0	0.0	3.6	4.9	3.7
– West Midlands	0.9	1.2	4.5	4.6	0.3	0.2	7.4	5.4	5.7
– East of England	0.8	1.0	1.7	0.3	0.4	0.3	2.3	2.4	14.4
– London	0.5	1.3	7.6	6.7	0.5	0.9	12.6	10.3	2.5
– South East	2.1	1.8	3.3	2.7	0.0	0.0	5.1	5.0	7.5
– South West	1.4	0.9	5.1	1.6	0.3	0.1	3.3	0.6	8.5
By London Weighting Zone									
Inner London	0.7	1.7	7.1	4.8	0.2	0.1	17.3	14.4	2.3
Outer London	0.2	0.6	6.7	7.6	0.7	1.6	6.0	4.3	6.4
London Fringe zone	3.2	0.5	4.5	1.7	0.0	0.0	2.3	4.7	16.8
Rest of England and Wales	1.9	1.6	3.9	3.2	0.4	0.1	4.4	3.5	6.0

(1) All figures have been rounded independently, and percentages have been calculated from unrounded figures.
(2) For the related grades, an entrant direct from full-time or part-time education.
(3) The sum of the individual categories may not equal 'Total joining' as changes in working may not be accounted for in the individual columns.

Table 4

Summary of leavers data for *all AHP staff* in England and Wales only: as a percentage of staff in post at year end[1] Weighting Zone.

Matched Sample

AHP	Leavers in the year to 31 March 2006										
	Retirement		Transfers to other NHS units		To non-NHS employment		Other		Don't know		Total le
	2005 %	2006 %	2005 %	2006 %	2005 %	2006 %	2005 %	2006 %	2005 %	2006 %	2005 %
Total	0.9	0.7	3.1	2.8	1.3	1.1	2.9	2.8	4.7	5.1	12.9
By country/region											
Wales	0.7	0.7	0.7	0.6	0.1	0.5	0.5	0.5	8.1	10.4	10.1
England	0.9	0.8	3.4	3.0	1.5	1.2	3.2	3.0	4.3	4.5	13.2
– North East	0.8	1.0	3.2	2.8	1.4	0.7	1.9	2.0	2.5	2.4	9.8
– North West	0.8	0.8	3.7	4.0	1.4	1.6	1.6	1.2	2.9	2.3	10.4
– Yorkshire and the Humber	1.4	0.7	2.0	3.5	1.6	0.7	2.4	3.2	4.2	3.3	11.7
– East Midlands	1.4	1.1	4.6	3.0	0.6	0.7	2.5	2.9	2.3	3.5	11.5
– West Midlands	0.8	0.5	2.3	2.2	1.1	1.0	3.1	3.4	4.1	4.6	11.4
– East of England	0.3	0.5	1.1	1.1	1.8	0.1	2.7	3.1	10.1	6.7	15.9
– London	0.9	0.5	5.7	5.0	2.6	1.8	6.9	6.4	3.6	6.9	19.7
– South East	1.3	1.1	4.5	3.6	1.5	1.9	4.3	4.1	4.4	4.1	16.0
– South West	0.8	0.9	2.6	1.1	1.4	0.8	2.3	1.2	5.7	7.9	12.9
By London Weighting Zone											
Inner London	0.8	0.5	4.6	3.1	2.3	2.6	9.5	9.5	3.5	6.5	20.7
Outer London	0.8	0.4	5.6	6.1	2.5	0.8	3.2	2.2	6.0	9.1	18.1
London Fringe zone	1.4	1.8	4.6	5.8	3.5	6.2	3.9	2.5	7.8	0.7	21.1
Rest of England and Wales	0.9	0.8	2.8	2.5	1.1	0.9	2.4	2.4	4.6	4.9	11.9

(1) All figures have been rounded independently, and percentages have been calculated from unrounded figures.
(2) Total leaving excluding transfers to other NHS units as a percentage of staff in post.

Table 5

Summary of joiners data for *all ST&T staff* in England and Wales only: as a percentage of staff in post at year end Weighting Zone.

Matched Sample

ST&T	Joiners in the year to 31 March 2006								
	Newly qualified[2]		Transfers from within NHS		Re-entrants		Other		Don't k
	2005 %	2006 %	2005 %	2006 %	2005 %	2006 %	2005 %	2006 %	2005 %
Total	0.6	0.6	3.6	2.6	0.3	0.2	5.7	3.8	5.1
By country/region									
Wales	0.1	0.2	1.3	0.3	0.1	0.0	3.6	1.4	8.2
England	0.6	0.6	3.8	2.9	0.4	0.2	5.8	4.1	4.8
– North East	1.1	1.6	4.3	3.0	0.2	0.1	5.2	1.9	2.2
– North West	0.6	0.5	3.5	2.7	0.6	0.3	3.2	4.5	3.9
– Yorkshire and the Humber	2.5	0.0	5.3	3.5	0.0	0.0	3.2	1.1	5.9
– East Midlands	0.6	0.7	4.2	2.9	0.9	0.0	5.6	4.9	2.7
– West Midlands	0.4	0.4	4.4	2.9	0.0	0.2	6.8	4.9	5.2
– East of England	0.0	0.1	1.2	0.1	0.4	0.3	4.3	1.4	10.4
– London	0.7	1.2	5.0	4.3	0.8	0.7	9.1	5.5	3.4
– South East	0.5	0.7	2.5	3.1	0.1	0.1	6.6	5.0	5.1
– South West	0.5	0.6	4.0	1.6	0.5	0.0	5.1	1.2	5.4
By London Weighting Zone									
Inner London	1.0	1.6	3.6	2.6	0.8	0.4	11.7	6.6	2.8
Outer London	0.1	0.3	7.0	7.1	0.8	1.2	4.5	3.5	4.9
London Fringe zone	0.0	0.0	3.5	1.3	0.0	0.0	0.8	3.1	13.4
Rest of England and Wales	0.6	0.5	3.4	2.4	0.3	0.1	5.3	3.6	5.0

(1) All figures have been rounded independently, and percentages have been calculated from unrounded figures.
(2) For the related grades, an entrant direct from full-time or part-time education.
(3) The sum of the individual categories may not equal 'Total joining' as changes in working may not be accounted for in the individual columns.

Table 6

Summary of leavers data for *all ST&T staff* in England and Wales only: as a percentage of staff in post at year end Weighting Zone.

Matched Sample

ST&T	Leavers in the year to 31 March 2006										
	Retirement		Transfers to other NHS units		To non-NHS employment		Other		Don't know		Total le
	2005 %	2006 %	2005 %	2006 %	2005 %	2006 %	2005 %	2006 %	2005 %	2006 %	2005 %
Total	1.5	1.0	2.4	2.2	1.2	1.1	4.0	2.8	3.8	4.2	12.8
By country/region											
Wales	0.8	0.7	0.5	0.6	0.1	0.5	1.0	0.7	6.7	7.9	9.1
England	1.5	1.0	2.5	2.4	1.3	1.1	4.3	3.0	3.6	3.9	13.2
– North East	1.2	0.4	3.3	3.6	1.0	1.4	3.6	1.9	2.6	1.9	11.7
– North West	1.4	1.0	3.1	3.0	1.1	1.6	2.3	1.6	3.7	2.9	11.7
– Yorkshire and the Humber	1.2	1.2	2.3	3.1	0.9	1.0	3.7	3.3	3.8	2.2	11.9
– East Midlands	0.5	1.2	3.4	2.2	1.4	0.4	4.0	3.4	2.2	1.2	11.5
– West Midlands	3.9	1.7	2.3	2.0	1.1	0.8	5.6	3.0	2.7	4.7	15.7
– East of England	0.2	0.4	1.3	0.8	0.9	0.2	3.2	2.5	6.3	4.1	11.9
– London	0.4	0.8	3.6	3.1	0.9	1.3	6.6	4.9	3.8	5.2	15.4
– South East	0.9	0.5	1.8	2.6	2.2	1.5	4.4	4.1	3.7	2.8	13.0
– South West	1.0	1.3	1.7	0.4	1.3	1.0	2.4	0.6	4.1	7.9	10.5
By London Weighting Zone											
Inner London	0.5	0.6	2.9	2.9	0.6	1.2	7.5	6.3	4.1	4.9	15.6
Outer London	0.3	1.1	4.6	3.4	1.3	1.3	5.0	2.4	3.9	5.6	15.1
London Fringe zone	1.4	0.8	2.6	2.8	2.8	2.8	2.3	4.5	7.6	3.2	16.7
Rest of England and Wales	1.6	1.0	2.2	2.1	1.2	1.0	3.7	2.4	3.7	4.1	12.4

(1) All figures have been rounded independently, and percentages have been calculated from unrounded figures.
(2) Total leaving excluding transfers to other NHS units as a percentage of staff in post.

APPENDIX G

ANNEX B OF THE DEPARTMENT OF HEALTH'S ORIGINAL EVIDENCE SUBMITTED ON 17 OCTOBER 2006

Historical Pay Metrics

Historic pay metrics in this annex are estimated on the basis of data from the financial returns and foundation trust annual reports, together with staff numbers from the workforce census. These cover all staff and salary costs, including employers' NI and pension contributions. The paybill figures do not include the cost of Agency staff. The pay metrics cover the following staff groups: qualified nursing; HCA & support; ST&Ts; and ambulance staff. This is broadly the same as the remit of the NOHPRB group, although it does include support staff who are not covered by NOHPRB. These groups are dictated by the groups collected within the Financial Returns and cannot be separated further.

The high increase in paybill per head and earnings per head for non-medical staff in 2004/05 (in particular ambulance staff), resulted from Agenda for Change. Projected increases in paybill reflect the recent removal of nurses from the Home Office shortage list.

Projected Pay Metrics

Workforce projections are central to paybill forecasting. The paybill forecasts use projections of workforce supply produced by the Workforce Review Team. Workforce projections use census 2005 data as a baseline and represent full-time equivalent staff numbers, current projections are provisional. Projections for key workforce groups are modelled individually, taking into account information such as existing workforce numbers and age profiles, historical retirement trends, training numbers, international recruitment, return to practice, and participation rates as appropriate.

Projected pay metrics are shaded in grey. The base year for projections is 2004/05, this is the most recent year for which financial returns are available. To project forward, assumptions on workforce numbers (see above), pay settlement, pay reform, employer NI and pension contributions and pay drift are applied to the baseline data. Projections are produced on a year on year basis. Forecasts for 2005/06 and 2006/07 use the agreed settlement figures for the respective years. The effects of different levels of settlement in 2007/08 are shown in the forecasts. Assumptions on pay reform and pay drift used are shown in the tables below:

Paybill and Earnings per head (FTE)

Paybill per head (FTE) is derived using full-time equivalent staff numbers. Paybill figures include the "on-costs" of employment. On-costs are estimated using figures in financial returns (these are not broken down by staff group or grade). These costs are then stripped out to give an estimate of average earnings per head (FTE).

HCHS Paybill by staff group (£million)[1]

	1997/8	1998/9	1999/0	2000/1	2001/2	2002/3	2003/4	2004/5[2,3]	2005/6[4,5]	2006/7[4,5]
Qualified nursing	5,652	5,738	6,181	6,699	7,427	8,085	8,677	9,899	10,682	11,308
Unqualified nurses, HCAs and support	1,710	1,934	2,162	2,250	2,512	2,740	2,946	3,406	3,688	3,904
ST&Ts	2,030	2,172	2,379	2,616	2,919	3,199	3,538	4,115	4,540	4,931
Ambulance Staff	333	355	364	395	433	478	524	747	833	925
Total NOHPRB[6]	9,725	10,199	11,086	11,961	13,291	14,502	15,685	18,167	19,742	21,068

Growth in HCHS Paybill[1]

	1997/8	1998/9	1999/0	2000/1	2001/2	2002/3	2003/4	2004/5[2,3]	2005/6[4,5]	2006/7[4,5]
Qualified nursing	–9.3%	1.5%	7.7%	8.4%	10.9%	8.9%	7.3%	14.1%	7.9%	5.9%
Unqualified nurses, HCAs and support	74.3%	13.1%	11.8%	4.1%	11.6%	9.1%	7.5%	15.6%	8.3%	5.9%
ST&Ts	4.1%	7.0%	9.5%	10.0%	11.6%	9.6%	10.6%	16.3%	10.3%	8.6%
Ambulance Staff	2.7%	6.4%	2.7%	8.6%	9.6%	10.2%	9.6%	42.7%	11.4%	11.1%
Total NOHPRB[6]	2.5%	4.9%	8.7%	7.9%	11.1%	9.1%	8.2%	15.8%	8.7%	6.7%

HCHS Paybill Per FTE (£)[1]

	1997/8	1998/9	1999/0	2000/1	2001/2	2002/3	2003/4	2004/5[2,3]	2005/6[4,5]	2006/7[4,5]
Qualified nursing	22,975	23,210	24,661	26,142	27,901	28,947	29,722	32,791	34,710	36,499
Unqualified nurses, HCAs and support	10,006	11,198	12,364	12,655	13,529	14,246	14,815	16,980	17,973	18,900
ST&Ts	20,287	21,017	22,256	23,701	25,214	26,028	27,210	29,864	31,612	33,241
Ambulance Staff	21,965	23,745	23,877	25,100	26,559	27,983	30,006	40,117	42,464	44,654
Total NOHPRB[6]	18,276	18,950	20,243	21,351	22,761	23,710	24,573	27,572	29,197	30,736

Growth in HCHS Paybill Per FTE[1]

	1997/8	1998/9	1999/0	2000/1	2001/2	2002/3	2003/4	2004/5[2,3]	2005/6[4,5]	2006/7[4,5]
Qualified nursing	–8.6%	1.0%	6.3%	6.0%	6.7%	3.7%	2.7%	10.3%	5.9%	5.2%
Unqualified nurses, HCAs and support	76.6%	11.9%	10.4%	2.4%	6.9%	5.3%	4.0%	14.6%	5.9%	5.2%
ST&Ts	2.4%	3.6%	5.9%	6.5%	6.4%	3.2%	4.5%	9.8%	5.9%	5.2%
Ambulance Staff	2.2%	8.1%	0.6%	5.1%	5.8%	5.4%	7.2%	33.7%	5.9%	5.2%
Total NOHPRB[6]	3.0%	3.7%	6.8%	5.5%	6.6%	4.2%	3.6%	12.2%	5.9%	5.3%

HCHS Earnings Per FTE (£)[1]

	1997/8	1998/9	1999/0	2000/1	2001/2	2002/3	2003/4	2004/5[2,3]	2005/6[4,5]	2006/7[4,5]
Qualified nursing	20,760	20,972	22,280	23,371	24,673	25,613	26,236	27,770	29,385	30,892
Unqualified nurses, HCAs and support	9,041	10,119	11,342	11,494	12,142	12,776	13,262	14,551	15,393	16,178
ST&Ts	18,331	18,991	20,141	21,221	22,329	23,064	24,049	25,323	26,795	28,168
Ambulance Staff	19,847	21,457	21,583	22,453	23,502	24,772	26,482	33,895	35,869	37,710
Total NOHPRB[6]	16,513	17,123	18,351	19,152	20,191	21,040	21,755	23,407	24,777	26,074

Growth in HCHS Earnings Per FTE[1]

	1997/8	1998/9	1999/0	2000/1	2001/2	2002/3	2003/4	2004/5[2,3]	2005/6[4,5]	2006/7[4,5]
Qualified nursing	–8.5%	1.0%	6.2%	4.9%	5.6%	3.8%	2.4%	5.8%	5.8%	5.1%
Unqualified nurses, HCAs and support	76.7%	11.9%	12.1%	1.3%	5.6%	5.2%	3.8%	9.7%	5.8%	5.1%
ST&Ts	2.5%	3.6%	6.1%	5.4%	5.2%	3.3%	4.3%	5.3%	5.8%	5.1%
Ambulance Staff	2.3%	8.1%	0.6%	4.0%	4.7%	5.4%	6.9%	28.0%	5.8%	5.1%
Total NOHPRB[6]	3.1%	3.7%	7.2%	4.4%	5.4%	4.2%	3.4%	7.6%	5.9%	5.2%

Notes:
1. Figures for NHS Staff only & exclude agency.
2. Includes estimates for Foundation Trusts.
3. Includes £334m "other" provision, assumed to be for Agenda for Change.
4. Figures are projections and are subject to change. Actual outturn paybill figures for 2005/06 are not yet available.
5. Current workforce projections from 2006 onwards use 2005 Census FTE as a baseline.
6. The total NOHPRB metrics cover qualified nursing, HCA & support, ST&Ts, and ambulance staff. This is broadly the same as the remit of the NOHP who are not covered by NOHPRB.

Supplementary evidence submitted in late January 2007 (Annex B)

EVIDENCE FOR DDRB AND NOHPRB FOR 2007/08 PAY ROUND -UPDATED HCHS PAY METRICS

Introduction

1. The pay metrics have been updated to reflect:

   - the effects of 2005-based workforce projections for medical staff; and
   - provisional outturn pay bills for 2005/06.

2. The impact of the revised figures have had no impact on the assumptions included for pay drift.

Workforce Projections for medical staff

3. The revised medical workforce numbers for 2006/07 and 2007/08 are higher than previous projections for all groups except registrars, where they remain the same and 'other' hospital medical grades, where they are lower.

2005/06 provisional outturn pay bill

4. The provisional outturn accounts data for 2005/06 shows that total HCHS pay bill was £434m (1.3%) lower than forecast. The difference between the forecasts and provisional outturn figures vary between staff groups.

Growth in earnings per FTE 2005/06

5. Earnings growth in 2005/06, as calculated by earnings by full time equivalent (fte) was higher than projected for NCCGs (other career grades and other hospital medical grades), but lower than projected for consultants and doctors in training.

6. In relation to consultants, the fact that earnings growth is lower may largely be a reflection of the 3% reduction in the average number of programmed activities (down from 11.17 PAs in 2004/05 to 10.83 in 2005/06).

7. In relation to doctors in training, the most likely explanation for the negative drift is the reduction in working hours to comply with the EWTD and increased recruitment to replace the lost hours leading to larger numbers of staff on the lower pay points.

8. Earnings growth was higher than projected for ambulance staff, unqualified nurses, healthcare assistants & other support staff, but lower than projected for qualified nurses, and for scientific, therapeutic & technical staff. (Whilst it was expected that Agenda for Change would benefit some groups such as ambulance staff and unqualified nurses more than others, our pay model at present does not allow this level of detailed disaggregation in our projections, which assumed equal impact on all non-medical staff groups).

9. Given the financial challenges the NHS has faced, it is likely that for 2005/6, the workforce growth used in the metrics has been over-stated by using the September-on-September growth which may have represented a peak, rather than an average in numbers (the basis for the modelling) and that the metrics therefore understate the growth in average earnings.

Impact on pay metrics for 2006/07 and 2007/08

10. The new M&D workforce projections proportionately affect total pay bill and total earnings figures, but do not affect pay bill per fte and earnings per fte figures for each staff group.

HCHS Paybill by staff group (£million)

	1997/8	1998/9	1999/0	2000/1	2001/2	2002/3	2003/4	2004/5[1,2]	2005/6[1,3]	2006/7[4,5]
Qualified nursing	5,652	5,738	6,181	6,699	7,427	8,085	8,677	9,899	10,502	11,120
Unqualified nurses, HCAs and support	1,710	1,934	2,162	2,250	2,512	2,740	2,946	3,406	3,735	3,955
ST&Ts	2,030	2,172	2,379	2,616	2,919	3,199	3,538	4,115	4,452	4,836
Ambulance Staff	333	355	364	395	433	478	524	747	867	964
Total NOHPRB[6]	9,725	10,199	11,086	11,961	13,291	14,502	15,685	18,167	19,556	20,874

Growth in HCHS Paybill

	1997/8	1998/9	1999/0	2000/1	2001/2	2002/3	2003/4	2004/5[1,2]	2005/6[1,3]	2006/7[4,5]
Qualified nursing	–9.3%	1.5%	7.7%	8.4%	10.9%	8.9%	7.3%	14.1%	6.1%	5.9%
Unqualified nurses, HCAs and support	74.3%	13.1%	11.8%	4.1%	11.6%	9.1%	7.5%	15.6%	9.7%	5.9%
ST&Ts	4.1%	7.0%	9.5%	10.0%	11.6%	9.6%	10.6%	16.3%	8.2%	8.6%
Ambulance Staff	2.7%	6.4%	2.7%	8.6%	9.6%	10.2%	9.6%	42.7%	16.1%	11.1%
Total NOHPRB[6]	2.5%	4.9%	8.7%	7.9%	11.1%	9.1%	8.2%	15.8%	7.6%	6.7%

HCHS Paybill Per FTE (£)

	1997/8	1998/9	1999/0	2000/1	2001/2	2002/3	2003/4	2004/5[1,2]	2005/6[1,3]	2006/7[4,5]
Qualified nursing	22,975	23,210	24,661	26,142	27,901	28,947	29,722	32,791	34,126	35,891
Unqualified nurses, HCAs and support	10,006	11,198	12,364	12,655	13,529	14,246	14,815	16,980	18,203	19,144
ST&Ts	20,287	21,017	22,256	23,701	25,214	26,028	27,210	29,864	30,998	32,601
Ambulance Staff	21,965	23,745	23,877	25,100	26,559	27,983	30,006	40,117	44,221	46,507
Total NOHPRB[6]	18,276	18,950	20,243	21,351	22,761	23,710	24,573	27,572	28,922	30,452

Growth in HCHS Paybill Per FTE

	1997/8	1998/9	1999/0	2000/1	2001/2	2002/3	2003/4	2004/5[1,2]	2005/6[1,3]	2006/7[4,5]
Qualified nursing	–8.6%	1.0%	6.3%	6.0%	6.7%	3.7%	2.7%	10.3%	4.1%	5.2%
Unqualified nurses, HCAs and support	76.6%	11.9%	10.4%	2.4%	6.9%	5.3%	4.0%	14.6%	7.2%	5.2%
ST&Ts	2.4%	3.6%	5.9%	6.5%	6.4%	3.2%	4.5%	9.8%	3.8%	5.2%
Ambulance Staff	2.2%	8.1%	0.6%	5.1%	5.8%	5.4%	7.2%	33.7%	10.2%	5.2%
Total NOHPRB[6]	3.0%	3.7%	6.8%	5.5%	6.6%	4.2%	3.6%	12.2%	4.9%	5.3%

HCHS Earnings Per FTE (£)

	1997/8	1998/9	1999/0	2000/1	2001/2	2002/3	2003/4	2004/5[1,2]	2005/6[1,3]	2006/7[4,5]
Qualified nursing	20,760	20,972	22,280	23,371	24,673	25,613	26,236	27,770	28,898	30,383
Unqualified nurses, HCAs and support	9,041	10,119	11,342	11,494	12,142	12,776	13,262	14,551	15,585	16,382
ST&Ts	18,331	18,991	20,141	21,221	22,329	23,064	24,049	25,323	26,282	27,633
Ambulance Staff	19,847	21,457	21,583	22,453	23,502	24,772	26,482	33,895	37,337	39,259
Total NOHPRB[6]	16,513	17,123	18,351	19,152	20,191	21,040	21,755	23,407	24,547	25,836

Growth in HCHS Earnings Per FTE

	1997/8	1998/9	1999/0	2000/1	2001/2	2002/3	2003/4	2004/5[1,2]	2005/6[1,3]	2006/7[4,5]
Qualified nursing	–8.5%	1.0%	6.2%	4.9%	5.6%	3.8%	2.4%	5.8%	4.1%	5.1%
Unqualified nurses, HCAs and support	76.7%	11.9%	12.1%	1.3%	5.6%	5.2%	3.8%	9.7%	7.1%	5.1%
ST&Ts	2.5%	3.6%	6.1%	5.4%	5.2%	3.3%	4.3%	5.3%	3.8%	5.1%
Ambulance Staff	2.3%	8.1%	0.6%	4.0%	4.7%	5.4%	6.9%	28.0%	10.2%	5.1%
Total NOHPRB[6]	3.1%	3.7%	7.2%	4.4%	5.4%	4.2%	3.4%	7.6%	4.9%	5.3%

Notes:
All figures are for NHS Staff only & exclude agency.
1. Includes estimates for Foundation Trusts.
2. Includes £334m "other" provision, assumed to be for Agenda for Change.
3. 2005/06 pay bill figures are provisional.
4. Figures are projections and are subject to change.
5. Current workforce projections from 2006 onwards use 2005 Census FTE as a baseline.
6. 'Total NOHPRB' figures include qualified nurses; unqualified nurses, healthcare assistants & other support staff; Scientific, professional & technica the NOHPRB remit group, although it does include ancillary staff and some ST&T staff outside the remit group.

APPENDIX H

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

13 July 2006

Dear Pay Review Body Chair,

INFLATION EVIDENCE FOR PAY REVIEW BODY RECOMMENDATIONS

Each year the treasury submits evidence to Pay Review Bodies on the Government's general approach to pay and includes information on various economic indicators. The attached paper[51] provides an interim update on the inflation part of this evidence.

Since the Government established its monetary policy framework in 1997, the UK has benefited from its longest period of sustained low and stable inflation since the 1960s, As a consequence, interest rates have been at record lows, benefiting millions of public sector workers as well as households on the rest of the economy.

Against this background of historically low inflation and interest rates, CPI inflation increase last year to reach a peak of 2.5 per cent in September 2005. Since then it has dropped back, and stood at 2.2 per cent in May 2006. Recent increases in inflation rates have in large part been due to the temporary impact of higher oil prices. Once the impact of oil (and other goods with volatile prices) is stripped out, underlying or 'core' inflation has remained consistently below 2 per cent and has been falling since August 2005.

However, in recent months goods price inflation has picked up as a result of these temporary price increases. This means it is important to remain vigilant to the risk of higher pay settlements feeding through into higher inflation going forwards.

51 The paper can be viewed at http://www.hm-treasury.gov.uk/documents/taxation_work_and_welfare/public_sector_pay/tax_pay_index.cfm.

It will be important to ensure that public sector pay increases do not contribute to inflationary pressures in the economy going forwards. To do so would risk converting a temporary increase in inflation into a permanent increase. The Pay Review Bodies should therefore continue to base their pay settlements on the achievement of the inflation target of 2 per cent.

Yours sincerely,

GORDON BROWN

APPENDIX I

PREVIOUS REPORTS OF THE REVIEW BODY

NURSING STAFF, MIDWIVES AND HEALTH VISITORS

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

PROFESSIONS ALLIED TO MEDICINE

First Report on Professions Allied to Medicine	Cmnd. 9257, June 1984
Second Report on Professions Allied to Medicine	Cmnd. 9528, June 1985
Third Report on Professions Allied to Medicine	Cmnd. 9783, May 1986
Fourth Report on Professions Allied to Medicine	Cm 130, April 1987
Fifth Report on Professions Allied to Medicine	Cm 361, April 1988
Sixth Report on Professions Allied to Medicine	Cm 578, February 1989
Seventh Report on Professions Allied to Medicine	Cm 935, February 1990
Eighth Report on Professions Allied to Medicine	Cm 1411, January 1991
Ninth Report on Professions Allied to Medicine	Cm 1812, February 1992
Tenth Report on Professions Allied to Medicine	Cm 2149, February 1993
Eleventh Report on Professions Allied to Medicine	Cm 2463, February 1994
Twelfth Report on Professions Allied to Medicine	Cm 2763, February 1995
Thirteenth Report on Professions Allied to Medicine	Cm 3093, February 1996
Fourteenth Report on Professions Allied to Medicine	Cm 3539, February 1997
Fifteenth Report on Professions Allied to Medicine	Cm 3833, January 1998
Sixteenth Report on Professions Allied to Medicine	Cm 4241, February 1999
Seventeenth Report on Professions Allied to Medicine	Cm 4564, January 2000
Eighteenth Report on Professions Allied to Medicine	Cm 4992, December 2000
Nineteenth Report on Professions Allied to Medicine	Cm 5346, December 2001

NURSING STAFF, MIDWIVES, HEALTH VISITORS AND PROFESSIONS ALLIED TO MEDICINE

Twentieth Report on Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine	Cm 5716, August 2003
Twenty-First Report on Nursing and Other Health Professions	Cm 6752, March 2006

APPENDIX J

GLOSSARY

AEI	Average Earnings Index
AfC	Agenda for Change
AHPs	Allied Health Professions
ASHE	Annual Survey of Hours and Earnings
BOS	British Orthoptic Society
CAJE	Computer Assisted Job Evaluation
CBI	Confederation of British Industry
CIPD	Chartered Institute of Personnel and Development
CPD	Continuing Professional Development
CPI	Consumer Prices Index
CSP	The Chartered Society of Physiotherapy
CSR	Comprehensive Spending Review
DDRB	The Doctors' and Dentists' Review Body
DEL	Departmental Expenditure Limit
Department	The Department of Health
Departments	The Health Departments
EDSG	Equalities and Diversity Sub Group
ESR	Electronic Staff Record
FCS	The Federation of Clinical Scientists
FTE	Full-Time Equivalent
HC	Headcount
HCA	High Cost Areas
HCAS	High Cost Area Supplements
HCHS	Hospital and Community Health Services
Health Departments	The Department of Health, the Scottish Executive Health Department and the National Assembly for Wales
HOMs	Heads of Midwifery
IC	Information Centre
IDS	Incomes Data Services
ISD	Information Statistics Division
IWL	Improving Working Lives
JEG	Job Evaluation Group

KSF	Knowledge and Skills Framework
LFS	Labour Force Survey
MCA	Maternity Care Assistant
MFF	Market Forces Factor
NAW	The National Assembly for Wales
NHS	National Health Service
NHSE	NHS Employers
NOHPRB	Review Body for Nursing and Other Health Professions
NVQ	National Vocational Qualification
OME	Office of Manpower Economics
ONS	Office for National Statistics
PAMs	Professions Allied to Medicine
PbR	Payment by Results
PCT	Primary Care Trust
PNC	Pay Negotiating Council
PRBs	Pay Review Bodies
RCM	The Royal College of Midwives
RCN	The Royal College of Nursing
RPI	Retail Prices Index
RRP	Recruitment and Retention Premium
SEHD	The Scottish Executive Health Department
SHA	Strategic Health Authority
SoR	The Society of Radiographers
ST&T	Scientific, Technical and Therapeutic
T&G	Transport and General Workers' Union
WTE	Whole-Time Equivalent

Printed in the UK by The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office
ID5521335 03/07 361072 19585

Printed on Paper containing 75% fibre content minimum.

Published by TSO (The Stationery Office) and available from:

Online
www.tsoshop.co.uk

Mail, Telephone, Fax & E-mail
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ISBN 978-0-10-170292-8