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Evidence for the NHS Pay Review Body

December 2014

Prepared by NHS Pay, Pensions & Employment Services Team

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Executive summary

The drivers of seven day services

The drivers for seven day services can be summarised as:

- Patient safety
- Efficient resource management
- Reflecting 21st century employment best practice
- Meeting the needs of patients

There has always been a demand for NHS services seven days a week – the need for care is not limited to office hours, and many parts of the NHS have traditionally run seven days a week. However, consistently high quality efficient services which go beyond urgent care are not routinely delivered. The Francis report on the poor quality of care provided at Mid Staffordshire NHS Foundation Trust showed clearly that staff and managers must make the care and safety of patients their priority. Patients expect the same quality of NHS services to be *consistently* delivered seven days a week. Strong evidence of higher mortality and morbidity rates at weekends indicate that this is not the case. The current system of delivery means that the absence of crucial services, key decision makers, and other staff at the weekend could delay service delivery throughout the week.

NHS care in the 21st Century is one of 24 hour services, seven days a week, facilitated by social technology – such as social networking and mobile devices - that was not even on the horizon when Agenda for Change was introduced more than ten years ago. A modern NHS must put patients right at the heart of everything it does, and the public rightly expect safe, quality services to be available when they need them. We believe healthcare should be designed around patients in a way which is affordable and flexible and which reflects modern employment practice.

The context

This ambition must, however, be set within the context that public sector pay restraint remains an important element of the Government's fiscal consolidation plans. In the Autumn Statement, published in December 2014, the Chancellor made clear that:

*“Public sector pay restraint in this Parliament is expected to save an estimated £12 billion by 2014-15. The government will need to continue to reform, and take tough decisions on, public sector pay while it continues to reduce the current budget deficit until 2017-18, and would expect to deliver commensurate savings.”*¹

The safety and quality of care depends not only on recruiting and retaining the right staff with the right skills, but on national employment contracts, which cover 1.3 million employed NHS staff, helping to improve performance, quality and productivity.

Delivering the vision of seven day services should improve the clinical outcome for patients and will, over time, make a significant contribution to avoiding additional costs; for example, unnecessary bed blocking because senior decision makers are not available at weekends.

¹ <https://www.gov.uk/government/topical-events/autumn-statement-2014>

National employment contracts to support the delivery of seven day services for emergency, urgent and elective care must be affordable and this means employers must make better use of their pay bill – around £44 billion in total across the employed NHS workforce.

The Healthcare Financial Management Association (HFMA) produced a report² on the costs of delivering seven day services, which suggests that the NHS has not kept pace with other service industries which have moved to deliver services across the week. It states that ‘moving with the times’ will be one of the key drivers for the delivery of seven day services and explains:

“Increasing efficiency in the system: if the quality of emergency care, and the services provided, were the same every day, there would be no backlog of cases requiring urgent action on Mondays. Staff would be used more effectively, and both emergency and elective work would be managed better”.

The move to seven day services is therefore focused on efficient use of existing resources, and is an opportunity for employers to innovate around patients, exploring options that provide for the more efficient delivery of services in a way which is fair to staff and the tax payer. It is not the Government’s intention to introduce seven day *working*. A *seven day service* is not reliant upon existing staff working harder or more frequently, or about more staff. It is about ensuring that the workforce can be scheduled cost effectively to deliver consistently safe care across the seven day week, using more efficient rostering and use of resources (both in terms of people and equipment).

Agenda for Change

When Agenda for Change was introduced in 2004 the intention was to increase staff numbers, drive down waiting times, drive up quality and productivity, and help mitigate the risk of successful challenge under equal pay legislation. However, it is clear that the way in which we pay NHS staff more than ten years on is not as efficient, fair, or rewarding as it could be.

The NHS Pay Review Body, in its 28th report, stated that:

“Agenda for Change needs to respond to the pressures and direction of operational strategy, including provision of seven day service... Progress on a wider seven-day service is urgently needed. The parties should now rapidly negotiate and agree changes to Agenda for Change alongside negotiations with medical staff.”

The negotiations with medical staff have not achieved agreement, and although trade unions representing staff paid under Agenda for Change terms and conditions say that they are always willing to discuss pay reform, they are reluctant to enter into formal talks whilst they are in dispute over the Government’s two year pay settlement for employed staff announced earlier in 2014. The Government has therefore issued remits on contract reform to the NHS Pay Review Body and the Review Body for Doctors’ and Dentists’ Remuneration on 28th August and 30 October 2014 respectively. (See annexes A, B and C).

Changes to employment contracts cannot ensure sustainable delivery of seven day services on their own. It is clear, however, that the current national contracts for NHS staff - in place now for many years and agreed at a time when many services were delivered only during the week - can act as a barrier to the delivery of sustainable seven day services.

The way that the week is separated into ‘plain time’ and ‘unsocial hours’ within Agenda for Change is archaic and out of line with a 24 hours, seven days a week, modern NHS system and

² <http://www.england.nhs.uk/wp-content/uploads/2013/12/costing-7-day.pdf>

most importantly, the needs of patients. Reformed employment contracts should put patients at the heart of everything the NHS does, rewarding staff that make the greatest contribution to patient care, and which provide premium pay rates that reflect modern employment practices better aligned to patient need, and more sustainable to support the NHS of the future.

Our evidence asks, therefore, that the Pay Review Body considers whether the current terms and conditions for around the clock care in Agenda for Change, which are structured around plain time (office hours) and unsocial hours (evenings, nights and weekends), reflect modern employment practice, are sustainable, and help to put patients first.

Unsocial hours and progression pay are two of the most important provisions within Agenda for Change for helping employers ensure staff are available to care for patients outside 'office hours' and to reward staff for what they do for patients – not for time served. We also invite the Pay Review Body to give some consideration to whether the current structure of progression pay reflects modern employment practice and meets our ambition of putting patients first. Robert Francis QC in his report into Mid Staffordshire NHS Foundation Trust said that:

*“Patients must be the first priority in all of what the NHS does by ensuring that, within available resources, they receive effective care from caring, compassionate and committed staff, working within a common culture, and protected from avoidable harm and any deprivation of their basic rights”.*³

It is our view that reformed, fairer and more affordable unsocial hours and progression pay could act as enablers for the delivery of more services in the evenings and weekends to help ensure patients receive the care they need whenever that need may arise.

Evidence to the NHS Pay Review Body

In our evidence we present the strategic and financial context around the barriers and enablers of sustainable seven day services. The bulk of the detailed evidence will be provided by the Arms Length Bodies.

NHS England is driving forward the vision and implementation of seven day services, as part of its wider mission to ensure *high quality care for all, now and for future generations*. NHS England's **NHS Services, Seven Days a Week Forum** has undertaken analysis of the demand and delivery options for seven day services, including commissioning research on workforce modelling and costs. We expect it to reflect this in its evidence. Service reconfiguration is already an important part of how NHS organisations are responding to increasing demand and public expectation within a financially challenging environment. NHS organisations will also need to consider how they strengthen staff engagement so there is a shared understanding about the case for change. At a local level, the solutions and implications for the workforce of delivering seven day services will differ; one size cannot fit all. NHS England is carrying out an assessment of the impact of seven day services which should provide an indication of the potential benefits and costs, and NHS Improving Quality (hosted by NHS England) is supporting 13 pilots which are introducing seven day services.

National policies which oblige employers to demonstrate and evidence how they are improving quality, safety and outcomes all rely on the availability of a skilled and affordable workforce. NHS organisations cannot choose whether to improve outcomes for patients or achieve financial balance – they must do both within available resources.

³ <http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf>

Seven day services is not about extending the exact model of care currently delivered Monday to Friday to Saturday and Sunday, but is about looking critically at how services can be provided differently in a clinically and financially sustainable way. Whilst delivery of seven day services on the ground will reflect local circumstances and business objectives, careful consideration will also need to be paid to the financial impact of the local medical and non-medical workforce.

NHS Employers is in a strong position, as the employers' organisation for the NHS, to provide further detail, informed by trusts, on the barriers and enablers in the current national employment contracts and which provisions employers believe help or hinder the delivery of sustainable seven day services and the recruitment and retention of staff.

Health Education England is responsible for '*ensuring that the shape and skills of the future health and public health workforce evolve to sustain high quality outcomes for patients in the face of demographic and technological change*'. Getting the supply of the right numbers of skilled staff means that all parts of the system, the Department, NHS England and NHS Employers must work together to identify, as early as possible, any future cost pressures. Health Education England will explore in its evidence how the workforce needs to develop in the longer terms and the training plans that need to be in place.

In Chapter One we set out the strategic vision for seven day services, informed by research undertaken by NHS England. The clinical case is proven, but a seamless care pathway depends on a whole system approach between primary, secondary and social care.

The financial context is set out in Chapter Two. The challenging financial environment means that NHS organisations must develop approaches to deliver seven day services without additional costs.

In Chapter Three we examine the current pay system for Agenda for Change staff, focusing on unsocial hours and pay progression as both enablers and barriers for helping deliver sustainable seven day services, compared to pay systems employed by other sectors.

In Chapter Four we set out evidence about workforce planning, which is an important consideration for seven day services, and finally in Chapter Five we draw some conclusions.

Chapter One: NHS Strategy & Introduction

- 1.1. Put simply, the Government's strategy for the NHS seeks to put patients right at the heart of everything the NHS does. The NHS Constitution says:

*"The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion matter most".*⁴

The Case for Seven Day Services

- 1.2. It is the Government's view that patients should be able to depend on the NHS every day – not just Monday to Friday. Accidents do not cease to happen because it is the weekend, and people do not stop being ill at 8pm on a Friday. The NHS must be responsive to patient needs whenever that need might arise. Yet there is evidence that consistent high quality care is not available seven days a week.
- 1.3. The 2013 Dr Foster Guide⁵ sets out concerning statistics about hospital care at weekends which show that *"Patients admitted as emergencies at weekends are less likely to survive their treatment; less likely to get diagnostic tests on the day of admission; and less likely to have emergency operations within a day or two of being admitted. They are also more likely to have to return to hospital shortly after discharge."* According to this report:
- Emergency overall mortality is 20% higher when admitted at a weekend
 - Mortality for patients who had routine surgery is 24% higher if the operation is later in the week and just before the weekend
 - Repairing fractures on the day of admission is 10% lower at weekends
 - Waiting for more than two days for a broken hip replacement is 24% higher on weekends
 - Emergency imaging (MRI scans) on the day of admission is 42% lower at weekends
 - Readmissions are 3.9% higher following treatment at a weekend
- 1.4. The responsibility for driving forward the delivery of seven day NHS services falls to NHS England and is set out in the objectives outlined in the mandate between Government and NHS England for 2015-16.⁶
- 1.5. The mandate between Government and NHS England is structured around five key areas where the Government expects NHS England to make improvements, and each of these areas would be supported by more services being delivered more days of the week:
- Preventing people from dying prematurely

⁴ <https://www.gov.uk/government/publications/the-nhs-constitution-for-england>

⁵ <http://myhospitalguide.drfoosterintelligence.co.uk/downloads/report/Report.pdf>

⁶

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/386221/NHS_England_Mandate.pdf

- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

1.6. Specifically, the mandate states:

“Timely access to services is a critical part of our experience of care. The NHS should be there for people when they need it; this means providing equally good care seven days of the week, not just Monday to Friday. More generally, over the last decade, the NHS has made enormous improvements in reducing waiting times for services. The people of England expect all parts of the NHS to comply with the rights, and fulfil the commitments set down in the NHS Constitution, including to maintain high levels of performance in access to care. NHS England’s objective is to uphold these rights and commitments, and where possible to improve the levels of performance in access to care.”

1.7. NHS England established the ‘NHS Services, Seven Days a Week Forum’ (The Forum) to provide evidence and insight to support commissioners and providers in their move to make routine NHS services available seven days a week. This Forum produced a report of its initial findings in December 2013⁷, where it presented the evidence base for change, and set out its proposals for moving forward. In this report Professor Sir Bruce Keogh, the National Medical Director states:

“It is also clear that the lack of many seven day services has an adverse effect on measurable outcomes in each of the five domains of the NHS Outcomes Framework: mortality amenable to healthcare, treatment of long term conditions, outcomes from acute episodes of care, patient experience, and patient safety.”

1.8. The Healthcare Financial Management Association (HFMA) produced a report on the costs of delivering seven day services, on behalf of the NHS Services, Seven Days a Week Forum, in which it states:

“There are four main drivers for seven day services:

- *Reducing mortality: mortality is generally worse at weekends.*
- *Increasing efficiency in the system: if the quality of emergency care, and the services provided, were the same every day, there would be no backlog of cases requiring urgent action on Mondays. Staff would be used more effectively, and both emergency and elective work would be managed better.*
- *Moving with the times: the NHS has not moved in line with other service industries. In most other areas, such as the retail sector, there is now no difference between a weekend and a weekday: why should the NHS be different?*
- *The compassionate argument: patients should be entitled to receive the same standard of care regardless of the day of the week. Furthermore patients should be able to access care over the weekend if they need it regardless of whether it is an emergency. The potential benefits are a reduction in suffering and /or the provision of peace of mind.”⁸*

⁷ <http://www.england.nhs.uk/wp-content/uploads/2013/12/forum-summary-report.pdf>

⁸ <http://www.england.nhs.uk/wp-content/uploads/2013/12/costing-7-day.pdf>

- 1.9. NHS England's *Five Year Forward View*,⁹ published in October 2014, sets out a vision for a modern NHS, including:
- "...over the next several years, NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support jobs and service redesign, and encourage recruitment and retention in parts of the country and in occupations where vacancies are high."*
- 1.10. The Department of Health welcomes the vision outlined in the Forward View and looks forward to working with its partners to ensure that the NHS can meet the challenges it faces over the next five years and beyond. The vast majority of the proposals in the Forward View will be for NHS England and its partners, including local Clinical Commissioning Groups, to take forward. However, the Department is aware that the workforce implications of seven day services mean that employment contracts must be affordable in order to help organisations realise the vision of seven day services. It is important to stress therefore that all parts of the system (Department of Health, NHS England, NHS Employers, Health Education England and other stakeholders) are working towards a common goal of affordable high quality healthcare every day of the week and all recognise that collaboration is essential to avoid unintended consequences.

Caring for patients is a team effort

- 1.12 The Francis Inquiry into the appalling events at the Mid Staffordshire NHS Foundation Trust provides important context for considering the barriers and enablers of seven day services. In the Department's response *'Hard Truths – The Journey to Putting the Patient First'*¹⁰ we recognised that staffing levels must take into account available evidence, and local circumstances, as well as the acuteness and dependency of the patients being cared for. This can change from ward to ward and in different clinical settings.
- 1.13 Staffing levels must be flexible and responsive to local need and supported by the right culture, environment and education. Health Education England (HEE) plays a crucial role in planning and developing the workforce to ensure that there is a suitable supply of health professionals. It is working with commissioners and healthcare providers to ensure that workforce plans are integrated with service and financial planning, so that there are sufficient healthcare staff to meet the needs of patients and local communities.
- 1.14 There is no 'one size fits all' approach to the delivery of seven day services, as acknowledged by The Forum in its initial findings. Local affordable solutions need to be found. The nature of services offered locally seven days a week will depend on demographic demand, existing provision, and local organisational strategy. NHS organisations will need to put in place their own local seven day services strategies informed by obligations under employment and equalities legislation, based on their unique understanding of their patient requirements and their service priorities.
- 1.15 Caring for patients whenever that need might arise is a team effort. For example, the availability of allied health professionals, including physiotherapists and radiographers, to

⁹ <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

¹⁰

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270103/35810_Cm_8777_Vol_2_accessible_v0.2.pdf

support medical and nursing staff during the diagnosis, treatment, and discharge process is critical. Whilst our evidence concentrates on the Agenda for Change (AfC) workforce, how care is organised and delivered by *all* employed staff whether to provide emergency /urgent or elective care is crucial. A survey by the Forum indicates that availability of consultant doctors, diagnostic services, multi-disciplinary teams, and intermediate care is much lower at the weekend than during the week, and that 99% of hospitals reported additional barriers to discharging patients at the weekend.¹¹

“Multidisciplinary working enables the effective care of patients with complex clinical presentations. Where early medical or surgical assessment is supported with input from care professions including nursing, physiotherapy, occupational therapy, speech and language therapy, and pharmacy and social care, a management plan can be implemented that addresses all of the patient’s care needs up to and including preparation for their discharge. Reduced provision at weekends will naturally inhibit the ability of any of these services to care for patients during that time; whether to assess a new admission and implement a management plan, or to facilitate discharge for a patient who is otherwise ready to leave the hospital.”¹²

- 1.16 We know that multi-disciplinary teams of medical and non-medical staff will be required to deliver safe and effective care seven days a week, and therefore expect that there will be many consistencies between the evidence presented to the NHS Pay Review Body and to the Review Body for Doctors’ and Dentists’ Remuneration (DDR); neither review body should consider its remit in isolation.

The care pathway is not just about the NHS

- 1.17 The NHS is, of course, available to all citizens 24 hours a day seven days a week, and there will be examples (explored by NHS England) where employers are making effective and high quality seven day services a reality. To deliver seamless care for patients, the whole care system - not just the NHS - must be organised around the patient. Secondary care services cannot be delivered effectively, safely, and efficiently in isolation; the support of mental health, primary care and social care is vital.
- 1.18 Discharge from hospital and the support given following discharge was identified as a key recommendation in the final report of the public inquiry into the Mid Staffordshire NHS Foundation Trust, accepted by Government in November 2013:
- “The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.”¹³*
- 1.19 The Forum’s Clinical Standards, which describe the quality of care patients should receive every day of the week (see Annex D), take a holistic approach, including Mental Health, Diagnostics, Interventions, and Community, Primary and Social Care. It is our view that alignment across primary, community and secondary health services, and

¹¹ <http://www.england.nhs.uk/wp-content/uploads/2013/12/Survey-acute-hospitals-data.pdf>

¹² <http://www.england.nhs.uk/wp-content/uploads/2013/12/evidence-base.pdf>

¹³ <http://www.midstaffspublicinquiry.com/report>

social care, will help to maximise the benefits of adopting clinical standards, prevent admissions and re-admissions, and support safe, timely discharge.

- 1.20 The Government's ambition is to make joined up care the norm by 2018. The Better Care Fund of £3.8bn was announced in June 2013 and is the biggest ever financial incentive for councils and the local NHS to jointly plan and deliver health and care services. Better Care Fund plans have set out how areas will achieve seven day services in social care and health to support patients being discharged and prevent people being unnecessarily admitted at weekends. This is a significant step towards truly joined-up services for people who need support from both sets of professionals. Delivering care that is centred on the individual's needs, rather than what the system wants to provide, is one of the Government's key priorities). Our aim is for NHS and social care staff to work together to provide seven day services and better data-sharing so that people can safely leave hospital as soon as they are ready.
- 1.21 The Government is also committed to improving access to GP services. In September 2013 the Government announced that £50m was being invested by NHS England in 20 pilot sites to test improved and innovative access to GP services, as part of the first wave of the Prime Minister's Challenge fund. This includes longer opening hours – such as evening and weekend hours – but also different ways of accessing services, for example use of Skype consultations.
- 1.22 A second wave of the Prime Minister's Challenge Fund has now been announced. Another £100 million will be invested in new pilots, which will have the minimum requirement that they must be open 8am– 8pm on weekdays (or equivalent) and offer improved access at weekends.

Delivering seven day services – one size cannot fit all

- 1.23 It would be inappropriate for the Department to dictate the mix and number of staff that are required by employers to provide safe care across seven days. Employers are best placed to determine the skill mix of their workforce and have the freedom to deploy staff in ways appropriate for local needs and conditions. It is however appropriate for Government to ensure the right systems are in place so the NHS has access to the right supply of staff with the right skills and that the workforce required to deliver seven day services is affordable. If the workforce is too expensive we risk reductions in front line staff. Conversely, if the workforce is paid too little, there is a risk that staff motivation and morale will fall with staff choosing to work outside the NHS. Both outcomes carry the risk of less and lower-quality health care, and the inability to meet the aims of seven day services.

Efficient use of resources

- 1.24 The Government believes that, when opening up more NHS services seven days a week, it is better for patients and a more efficient use of resources to also extend seven day services to non-urgent and elective care, where appropriate. This will provide greater patient choice, better responsiveness to patient demand, improved care pathways, and a more efficient use of resources.
- 1.25 For example, the Taxpayers Alliance made the following observation on NHS diagnostic services: *“Many NHS Trusts are not adequately utilising expensive diagnostic ...*

equipment, if NHS Trusts are to establish genuine efficiency, the management of machines must be improved.”¹⁴

- 1.26 However, it would be for local organisations to determine *which* elective services they extend to seven days per week. This decision should be based on:
- Patient need – Do their patients want an appointment outside conventional working hours?
 - Patient convenience – Are there other services available to support the delivery of this service seven days a week, such as public transport?
 - Improved care pathway – Will seven day delivery of this service shorten the care pathway?
 - Pathway cost – Will seven day delivery of this service increase pathway costs?
 - Maintenance – Is there still capacity for maintenance and down-time for equipment?
 - Alternatives – Are there better ways of improving care pathways?
- 1.27 It is important to stress that our view of “seven day services” is *not* about “seven day working”. In order to safeguard the well-being of staff, deliver safe care, stay within budgets, and comply with Working Time Legislation, we do not intend NHS organisations to implement the same configuration of services over seven days that they currently deliver Monday to Friday. Instead, this is about more intelligent rostering and resource management over seven days to increase efficiency of the service, not place more pressure on the system or staff.

Striking the right balance between pay and non-pay benefits

- 1.28 Communicating the full package of benefits – beyond pay – that are on offer to staff (known as ‘Total Reward’) can be an effective way for employers to respond to recruitment and retention challenges¹⁵. Within NHS organisations the package offered to staff extends beyond simply a basic salary. Additional benefits should be explored and communicated to make NHS employment a more competitive package against higher salaried posts elsewhere.
- 1.29 Pay alone cannot deliver increased efficiency or quality. The role of the overall reward package offered to staff is to support the delivery of the objectives of an organisation by developing the right incentives to reward those who deliver the most, and building staff engagement with the goals of the organisation. Total Reward is not yet a dominant concept in the NHS approach to reward management, but is becoming an increasingly important part of the Human Resource toolkit as employers seek to meet increasing demand.
- 1.30 How local staff are organised to provide care and services means striking the right balance across the employment offer (pay and non-pay) to attract and retain staff. The value to the employee of his/her employment goes beyond the salary on offer, and includes the financial benefits (e.g. pension) as well as “intangible” non-financial benefits. The world of work is not static: organisations evolve in response to a range of internal and external pressures and employees’ needs from work change over time in response

¹⁴ <http://www.taxpayersalliance.com/NHSMachines.pdf>

¹⁵ <https://ids.thomsonreuters.com/hr-in-practice/case-studies/trinity-chiesi-pharmaceuticals-%E2%80%93-improving-staff-retention-2008?keyword=total|reward|recruitment|retention&index=19&content=58743>

to their own individual circumstances. Building a culture of Total Reward relies upon employers to determine those pay and non-pay elements which staff value, and develop a process of sustained staff engagement which, amongst other benefits, allows staff to better understand their reward package.

- 1.31 We would like to see NHS organisations maximising the value of the NHS package of benefits on offer to staff, through better communication and giving staff greater choices. We believe that the generous package of benefits already on offer to staff is not fully appreciated and communicated by employers.

Employment freedoms

- 1.32 Employers are free to determine the terms and conditions, including pay, of the staff they employ. Therefore they have the freedom to innovate and design pay systems to suit their local circumstances. In practice, however, most employers prefer to rely on national UK-wide pay frameworks. National pay contracts are therefore an important part of the debate on how organisations translate the national vision for seven day services into local business objectives.
- 1.33 Against this background, in examining the pay barriers and enablers for delivery of seven day services, the affordability and sustainability of the national pay contract as a whole is a very important element. Unsocial hours pay costs at least £1.8bn for employed non-medical staff a year, and the current system of incremental pay progression within AfC has a cost pressure of over £550m per year. Consideration to both these elements of the contract is essential to ensure the national pay contract is not only an enabler of seven day services, but also sustainable enough to support the NHS of the future. We examine this in more detail in Chapter 3.

Financial and clinical sustainability are not mutually exclusive

- 1.34 The drivers for the introduction of AfC in 2004, and the current financial context more than a decade later are very different. The Government has made clear that its priority is to protect the front line, with particular focus on clinical staff. There are over 13,300 more clinical staff since 2010 and we want to protect those increases (see Chapter 4 on Workforce Planning).
- 1.35 In order to sustain funding for the NHS, whilst meeting commitments to reduce the budget deficit, the Government has had to make very difficult decisions, rejecting pay recommendations made by the NHS Pay Review Body (NHSPRB), and the Review Body for Doctors' and Dentists' Remuneration (DDR), and cutting other Government departments by 24%. In the face of the unprecedented financial challenge, increasing demand, and an ageing population, employers need to make better use of their pay bill if they are to keep patients at the heart whilst continuing to improve quality and better outcomes within financial constraints.
- 1.36 In a national health care system where pay accounts for over 60% of NHS Trusts' total expenditure, the use of resources in one area must necessarily be balanced by a reduction in other areas. Any consideration of the barriers and enablers must therefore consider the overall pay package - the interaction between the current system of incremental progression and out of hours pay, and how that might be managed differently within the existing pay envelope (see Chapter 3 on pay system options).

Employment contracts helping to put patients first

- 1.37 The development and introduction of AfC in 2004 was informed by wider objectives, not just the creation of a single unified pay system. The intention was to increase staff numbers, drive down waiting times, drive up quality and productivity, and mitigate risk of successful challenge under equal pay legislation.¹⁶
- 1.38 Some aspects of AfC now appear counter intuitive when set alongside this intention. For example, until 31 March 2013 sick pay arrangements included premium pay rates for staff unable to attend work due to sickness absence and whose normal pattern of work included unsocial hours. Similarly, AfC provides for premium pay rates based on the 2004 agreement of what, at that time constituted ‘out of hours’: it is important to first explore whether, more than a decade on, that definition still stands.
- 1.39 In terms of business objectives, employers must ensure they make sound staffing decisions which deliver the right outcomes for patients, to the highest quality in a financially sustainable way. Rostering decisions should be based on effective and efficient teams, and the cost of those teams should not be a barrier to safe care. Therefore, the way in which employment contracts specify premium rates (for medical and non-medical staff) for periods of work should not act as a barrier and prevent NHS organisations from putting in place the necessary teams to deliver safe patient care across seven days.
- 1.40 It is the Department’s view that premium rates of pay for certain periods of working ‘unsocial hours’ can incentivise staff to volunteer for such shifts, and therefore act as an enabler for the delivery of seven day services. However, simultaneously, rates of pay should not inadvertently create a barrier to affordable safe staffing levels 24 hours a day, seven days a week. The question therefore, is not *whether* premium rates should be paid, but rather:
- In a 21st century 24 hour seven-days-per-week service, what time periods should realistically be considered as “out of hours”?
 - How do the out of hours pay rates compare to rates paid in other health and social care service employers, as well as wider service sectors?
 - What are the NHS services that should, or *need* to, be available in local organisations at different times over seven days?
 - Is it possible, at a national level, to determine the staffing levels required to deliver extended services over seven days at a local level, in a consistently safe and efficient manner to the right quality. Are there capacity issues with this?
 - Is the reliance on agency staff that are often paid highly inflated rates justified, and is there a more sustainable approach for resourcing teams?
 - Should employment contracts be much more flexible to meet the needs of patients, staff and employers?
 - How will NHS services be delivered in the future and how can we enable growth, innovation, and improvement by reforming employment contracts?

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http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculares/DH_4003838

- 1.41 We present evidence to support the consideration of these questions later in our evidence. This will be supported by more detailed evidence from NHS Employers and the Foundation Trust Network. NHS England will describe the vision and clinical case for delivering seven day services and will provide detail on work designed to test and cost how this vision might best be implemented on the ground.
- 1.42 There is no data or evidence we can immediately point to which would indicate that staff choose particular working patterns *because* they attract premium pay rates. It is more likely that a range of issues will inform working patterns, not least the basic requirement of staff rotas. Other issues will of course include pay, career aspirations, family responsibilities and other commitments outside of work.

Working in partnership

- 1.43 The Government welcomed the NHSPRB's 28th report, which said that more progress should be made on seven day services: *"Progress on a wider seven-day service is urgently needed. The parties should now rapidly negotiate and agree changes to Agenda for Change alongside negotiation for medical staff."* Partnership working is very important. National negotiations allow for a transparent exchange of views about the rationale for change, putting patients first, and how change can be achieved in a way which is fair to staff and the taxpayer. Within the NHS Staff Council, there is a shared commitment to work collaboratively for the benefit of patients and staff. Under the auspices of the NHS Staff Council the intention of the partners is:

"To ensure a fair system of pay for NHS employees which supports modernised working practices. The provisions recognise that modern forms of healthcare rely on flexible teams of staff providing patient care 24 hours a day, 7 days a week, 365 days a year and applying a wide range of skills"¹⁷.

Summary

- 1.44 In our evidence we provide a picture of the economic and strategic policy context in exploring the barriers and enablers of seven day services. The unique nature of the Government's remit on seven day services, which is dependent on multi-disciplinary teams and alignment of care systems, means we have also included information - albeit rather limited - on other staff groups and care organisations which are important to the care pathway. It is our view that delivering seven day services is not dependent on more money and more staff, rather it is an opportunity for employers to look critically at how care is organised. The role of employment contracts should be to reward those staff that make the greatest contribution, and to provide sufficient flexibility for employers to innovate for the benefit of patients in a way which is fair to staff and the tax payer.
- 1.45 Multi-disciplinary teams of medical and non-medical staff are necessary to deliver safe and effective care seven days a week. We cannot therefore examine the barriers and enablers of seven day services for one group of staff without also giving careful consideration to the wider workforce and the underpinning contractual arrangements.

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http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/AfC_tc_of_service_handbook_fb.pdf

The consideration of the same remit by the Review Body for Doctors' and Dentists' Remuneration is necessary in order to understand the barriers and enablers across the health team. It is therefore important to examine the issues in collaboration rather than in parallel.

- 1.46 More detailed separate evidence will be provided by:
- NHS Employers – on those provisions employers believe act as a barrier or enabler to seven day services and the opportunities reformed employment contracts could create as part of the local delivery of seven day services.
 - NHS England – on the ambition, vision and role of seven day services, underpinned by evidence on the case for change, learning from early adopter sites and case studies which aim to identify the potential cost including workforce implications.
 - Health Education England –on education, training and workforce capacity to help realise the vision of seven day services.
 - The Foundation Trust Network – evidence from their member organisations on pay and non-pay issues they believe represent barriers or enablers to delivering seven day services.

Chapter 2 – The Financial Context¹⁸

Funding Growth

- 2.1 This chapter sets out the financial position for the NHS in 2015/16.
- 2.2 Between 1999/00 and 2010/11 NHS revenue expenditure increased by an average of 5.4 per cent in real terms. The first three years of the current spending review period (2011/12 to 2013/14) have shown subdued growth, averaging 1.2 per cent per year in real terms. Table 2.1 shows:
- Outturn NHS revenue expenditure figures from 1999/00 to 2013/14
 - Revenue Departmental Expenditure Limits (RDEL)

Table 2.1 – NHS Revenue Expenditure: England - 1999/00 to 2015/16

Year ⁽⁴⁾		Revenue ⁽⁵⁾ Net NHS Expenditure ⁽⁶⁾ £bn	% increase	% real terms increase ⁽⁷⁾
<u>RB Stage 1</u>⁽¹⁾				
1999/00	Outturn	39.3	-	-
2000/01	Outturn	42.7	8.6	6.2
2001/02	Outturn	47.3	10.8	9.1
2002/03	Outturn	51.9	9.8	7.0
<u>RB Stage 2</u>⁽²⁾				
2002/03	Outturn	56.9	-	-
2003/04	Outturn	61.9	8.7	6.6
2004/05	Outturn	66.9	8.1	4.8
2005/06	Outturn	74.2	10.9	7.9
2006/07	Outturn	78.5	5.8	3.0
2007/08	Outturn	86.4	10.1	7.0
2008/09	Outturn	90.7	5.0	2.5
2009/10	Outturn	97.8	7.8	5.1
2010/11	Outturn	102.0	4.3	1.5

¹⁸ This evidence has been updated to reflect the Autumn 2014 statement, announced on 3/12/14 and latest financial figures. It therefore differs from evidence provided by DH to the Review Body for Doctors' & Dentists' Remuneration on contractors in September 2014.

**Resource
Budgeting -
Aligned⁽³⁾**

2009/10	Outturn	94.4	-	-
2010/11	Outturn	97.5	3.2	0.4
2011/12	Outturn	100.3	2.9	1.1
2012/13	Outturn	102.6	2.3	0.6
2013/14	Outturn	106.5	3.8	1.9
2014/15	Plan	110.4	3.7	1.5
2015/16	Plan	113.0	2.4	1.0

1. Expenditure figures from 1999-00 to 2002-03 are on a Stage 1 resource budgeting
2. Expenditure figures from 2003-04 to 2009-10 are on a Stage 2 resource budgeting basis.
3. Expenditure figures from 2009-10 to 2015-16 are on an aligned basis following the government's Clear Line of Sight programme.
4. Expenditure figures are not consistent over the period (1999-00 to 2015-16) and this should be noted when making comparisons between years.
5. Revenue is quoted gross of non-trust Depreciation and Impairments; prior to September 2007, revenue was quoted net of non-trust Depreciation and Impairments. This brings DH in line with HMT presentation of the statistics.
6. Expenditure excludes NHS (AME)
7. Real terms increase has been calculated using GDP as at 03/12/2014

Share of resource going to pay

2.3 Table 2.2 shows the proportion of the increased funding that has been consumed by the Hospital and Community Health Services (HCHS) paybill over time. Note that the HCHS workforce comprises staff working within hospital and community health settings; it therefore excludes General Practitioners, GP practice staff and General Dental Practitioners.

Table 2.2 – Increases in Revenue Expenditure and the proportion consumed by Paybill

Year	Increase in Revenue Expenditure	Increase in HCHS Provider paybill	Proportion of revenue increase on paybill	Increase in HCHS paybill due to prices		Increase in HCHS paybill due to volume	
	(£bn)	(£bn)	(%)	(%)	(£bn)	(%)	(£bn)
2001/02	4.6	2.4	51	7.0	1.4	4.7	1.0
2002/03	4.6	2.4	51	5.0	1.1	5.5	1.3
2003/04	6.5	2.6	41	5.0	1.3	5.4	1.4
2004/05	5.0	4.5	91	5.0	2.3	5.0	2.3
2005/06	7.3	2.5	34	5.4	1.5	3.4	1.0
2006/07	4.3	1.3	30	4.3	1.4	-0.3	-0.1

2007/08	7.9	1.3	16	3.5	1.2	0.2	0.1
2008/09	4.4	2.5	57	3.0	1.1	4.0	1.4
2009/10	7.1	2.8	39	1.8	0.7	5.1	2.1
2010/11	3.0	1.5	49	2.4	1.0	1.2	0.5
2011/12	2.8	-0.5	-18	0.9	1.5	-1.2	-2.0
2012/13	2.3	0.6	26	1.5	0.4	0.1	0.2
2013/14	3.9	0.5	13	2.3	0.3	1.3	0.2
Average	4.9	1.9	37	3.6	1.2	2.6	0.7

1. Revised 2010/11 to 2012/13, following accounts restatements and exclude inter-company eliminations
2. Excludes ALB and DH core staff expenditure
3. Excludes GPs
4. Volume & Price estimates changes methodology in 2010/11 to make use of a more detailed staff group breakdown from ESR
5. Figures may not sum due to rounding.

2.4 HCHS pay is the largest cost pressure, on average, between 2001/02 and 2013/14, increases to the HCHS paybill have consumed 37 per cent of the increases in revenue expenditure. Of this 37 percentage points, pay effects have consumed around 23 percentage points and volume effects around 14 percentage points. As pay represents such a large proportion of NHS resources, managing the paybill is key to ensuring the NHS lives within the funding growth it has been assigned in the next year.

Pressures on NHS funding growth

- 2.5 Different priorities compete for limited funding growth given to the NHS. They are grouped into three categories:
- baseline pressures
 - underlying demand
 - service developments
- 2.6 Baseline pressures cover the cost of meeting existing commitments that are essential for delivery of NHS services. They do not cover underlying demand, or increased levels of activity, which may arise due to demographic pressures or medical advance. Service developments are new areas of activity which arise due to new policies or ministerial commitments.
- 2.7 HCHS paybill pressures are the largest component of the baseline pressures and usually form the first call on NHS resources. Managing baseline pressures effectively allows the NHS to treat a growing, ageing population whilst making best use of the funding available.

Allocation of resources

2.8 Table 2.3 shows how funding increases have been allocated across baseline pressures, demand and service developments in previous Spending Review periods.

Table 2.3 – Disposition of Revenue Increase across Expenditure Components

	Outturn			Plan	
	SR2004	CSR2007	First 3 years of SR10	2014/15	2015/16
	£bn	£bn	£bn	£bn	£bn
Activity Growth	2.9	1.1	1.2	1.0	1.8
Service Development	1.6	1.7	0.4	0.9	0.0
HCHS Pay (Price only Component)	1.7	2.0	0.5	0.3	0.4
Secondary Care Drugs	0.3	0.4	0.3	0.4	0.3
Other (including central budgets)	0.3	0.1	0.1	1.1	-0.6
Primary Care Drugs	0.3	0.3	-0.1	0.2	0.2
General Dentistry, Ophthalmic and Pharmaceutical Services	0.2	0.2	0.1	0.1	0.1
Procurement	0.1	0.1	0.7	0.4	0.1
General Medical Services	0.1	0.2	0.0	0.0	0.2
Funding for Social Care			0.4	0.2	1.1
Productivity	-0.3	-0.3	-0.6	-0.6	-0.6
Average annual increase in revenue	7.2	5.7	3.9	3.9	3.4

Note:

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

2.9 2013-14 saw a significant reduction in paybill per FTE drift, despite gross pressures from increments worth approaching 2% of the paybill. However, such low levels of drift are unlikely to be permanent. Apparent levels of drift were significantly affected by the temporary costs of managerial exit packages, associated with the NHS reform, in 2012/13 making 2013/14 earnings seem low in comparison. Furthermore, 2013/14 saw a significant increase in the HCHS workforce – likely in response to the Francis Report and

addressing unsafe staffing risks. The increase in workforce growth was particularly strong for non-medics which neutralised the contribution of medical workforce expansion to higher drift compared to recent years. As recruitment tends to be towards the lower end of the pay scales this also had a depressing impact on average experience and hence pay levels which translated into lower drift. Future recruitment patterns are critical to expectations for drift and depend on decisions by individual employers influenced by expectations for affordability constraints and how these are managed. Despite recent increases to NHS budgets, there will still be pressure on resources and limits to affordable recruitment levels. As such, the expectation is that pay drift will increase from its 2013/14 level. However, it is not clear that it will immediately fully return to its earlier levels, but note that it will be increased by around 0.2 percentage points due to changes in the NHS pension scheme employer contribution rate in 2015/16.

- 2.10 The difficulty of allocating resources is therefore more acute than it has been in the previous 10 years. As shown in table 2.3, Of the £3.4bn increased revenue resources available, demand pressures consume £1.8bn, even after an assumption that demand growth will be lower than in recent years due to the Better Care Fund. With the cost pressures being absorbed by improved productivity, £0.4bn additional revenue resource is assumed to be available for pay.

Agency Spend

- 2.11 In 2013-14 NHS Trusts spent approx. £1.2bn on agency staff, and NHS Foundation Trusts spent approx. £1.4bn on agency staff¹⁹. There is concern that locally budgets are so limited due to large agency expense that this poses a barrier to employing more permanent staff.
- 2.12 The Department would like to see local organisations examine their agency spend and determine the reasons for such high spend locally:
- Is this a procurement issue, and could better agency rates be negotiated?
 - Are employers using regional and national frameworks to manage agency costs and ensure quality?
 - Is there a human resourcing issue which is preventing availability of permanent or bank staff? Is this due to lack of staff locally, inefficiency of recruitment exercises, resistance to appoint to permanent posts, or availability of bank staff for example?
- 2.13 Reducing agency spend is a focus for:
- The ongoing DH Strategic Workforce Review
 - Planning in respect of the forthcoming Spending Review round

¹⁹ <https://www.gov.uk/government/publications/department-of-health-annual-report-and-accounts-2013-to-2014>

- 2.14 Data from the London Procurement Partnership (LPP)²⁰ shows that approximately 40% of all of their region's nursing agency staff shifts fall during "unsocial hours" (nights, weekends, and bank holidays), showing that – at least within London – the demand for agency staff is high during unsocial hours. Similar data from across the nation would help inform the drivers for the high agency spend seen in the NHS, and better understand whether there is a link between seven day services and agency costs.
- 2.15 Additionally, in May 2014 a national collaborative framework was introduced which reduced enhancements to nursing agency rates for nights, weekends and bank holidays for the London region. The LPP report that the removal of these enhanced rates appear to have had no impact on the willingness and availability of agency staff to work at these times. We would strongly recommend that national frameworks are used when commissioning agency staff, to help keep costs down, ensure quality, and make services more affordable.
- 2.16 Introducing additional services at weekends could increase agency spend to fill the gap if permanent staff are unwilling or unable to change their working patterns to cover new weekend shifts. There is therefore a crucial requirement for robust staff engagement plans, and less reliance on agency staff through better procurement and human resources process, and more efficient use of local bank staff.

Financial Balance

- 2.17 Even after the extra funds announced in Autumn Statement 2014 the challenge for the service to deliver quality care to an ageing and growing population with limited resources is very hard. Therefore, achieving financial balance in 2015-16 is reliant upon the Better Care Fund diverting activity from the acute sector, high levels of labour productivity, and a continued bearing down on prices for procurement, drugs, and pay.

Conclusion

- 2.18 The NHS has received a better SR settlement than almost all other parts of the public sector, including a commitment to real terms increases in health spending in 2014-15 and 2015-16. However this still represents the biggest financial challenge in the history of the NHS.
- 2.19 The NHS is delivering on this challenge and has so far met its savings targets in 2011/12, 2012/13, and 2013/14. There is still work to do in shifting the focus from centrally driven savings to transformational changes which will reduce the long term cost pressures on NHS services. Any move to deliver seven day services must be cost neutral.

²⁰ Published data link unavailable, but LPP happy to share data on request.

Chapter 3 – Current Pay Systems & Seven Day Services

- 3.1. The current NHS employment contracts were constructed around a 9am-5pm working week. This is now out of line with modern employment practice in many UK service sectors, including many parts of the health and social care sector. The NHS should be there when patients need it, and patients should be able to receive the same quality of care regardless of the time they visit a hospital or if they need care in their own homes.
- 3.2. Employment contracts should act as an enabler of safe, efficient care. Paying staff premiums for working unsocial hours can act as enabler by incentivising them to work these shifts. The tension, however, is that the pattern of unsocial hours, and the applicable premium pay rates have become part of NHS culture, and proposals to change premium pay rates is likely to be met with resistance. Despite this, we do not have evidence that premium pay rates, based on the current definition of unsocial hours, are in themselves necessary to recruit and retain the staff the NHS needs, or that premium pay rates lead to better patient care. Indiscriminate use of premium pay rates at levels which may be higher than is necessary to attract and retain staff, and which are not aligned to patient need, could act as a barrier to sustainable seven day services and service innovation.
- 3.3. In Chapter One, we posed the questions:
 - In a 21st century 24 hour seven-days-per-week service, what time periods should realistically be considered as “out of hours”?
 - How do the out of hours pay rates compare to rates paid in other health and social care service employers, as well as wider service sectors?
 - Should employment contracts be much more flexible to meet the needs of patients, staff and employers?
 - How will NHS services be delivered in the future and how can we enable growth, innovation, and improvement by reforming employment contracts?
- 3.4. In this chapter, we set out the current arrangements for paying staff for evenings and weekends. In line with the NHSPRB remit, we have focused on Agenda for Change staff, but it is important to emphasise that caring for patients is a team effort and the availability of medical and non-medical staff consistently across seven days is crucial. The structure of unsocial hours and progression pay within medical and non-medical contracts can act as barriers and enablers for seven day services. The Pay Review Bodies will want to consider carefully the read across to the evidence presented to both the NHSPRB and DDRB.
- 3.5. Reform of unsocial hours pay, to bring it more in line with modern employment practice could help make the workforce more affordable and encourage employers locally to take a more innovative approach to the delivery of health care across seven days. We believe that the reform of unsocial hours pay should not be considered in isolation. The combined

impact of premium pay rates and the current system of progression pay should be considered in order to better understand how reforms across both systems could better reward and incentivise staff, for the benefit of patients. We believe that pay reform should be an enabler for the delivery of safe high quality care across seven days by redistributing pay in a more fair and performance-enhancing way, within the existing pay budget.

Agenda for Change

3.6. Agenda for Change (AfC), introduced under a previous Government in 2004, is the current UK wide national grading and pay system for most employed NHS staff with the exception of doctors, dentists and very senior managers. AfC is a national collective agreement. Changes agreed by the NHS Staff Council (a partnership of NHS Employers and NHS Trade Unions) and endorsed by UK Health Ministers are incorporated into the employment contracts of employed staff who are subject to the AfC pay framework.²¹

Agenda for Change Unsocial Hours Pay

3.7. AfC separates working hours into plain time and 'unsocial hours', based on the day and hours worked. Working hours are paid at different rates depending on the AfC payband. These are set out in Table 3.1. Staff only receive one rate of unsocial hours payment for each hour worked.

Table 3.1: Unsocial hours payments for AfC staff

Unsocial Hours Payments		
Column 1	Column 2	Column 3
Pay band	All time on Saturday (midnight to midnight) and any week day after 8pm and before 6am	All time on Sundays and Public Holidays (midnight to midnight)
1	Time plus 50%	Double time
2	Time plus 44%	Time plus 88%
3	Time plus 37%	Time plus 74%
4-9	Time plus 30%	Time plus 60%

²¹

<http://www.nhsemployers.org/PayAndContracts/AgendaForChange/TermsAndConditionsOfServiceHandbook/Pages/Afc-Handbookrp.aspx>

- 3.8. AfC also includes the provision that “where a continuous night shift or evening shift on a weekday (other than a public holiday) includes hours outside the period of 8pm to 6am, the enhancements in column 2 should be applied to the whole shift if more than half of the time falls between 8pm and 6am.” We understand that employers believe this provision is neither appropriate nor in line with practice elsewhere, and is an unnecessarily expensive historic provision.
- 3.9. The rates paid for working unsocial hours in AfC are higher for lower paid staff. It would be helpful to consider the rationale for this approach and if the differential in the rate of unsocial hours between lower and higher paid staff is appropriate. In addition, whether the rates and times of pay for working unsocial hours are comparable with similar premium payments in other employment sectors. We explore these issues later in this chapter.

Ambulance Staff

3.10. The AfC premium pay for working unsocial hours set out in Table 3.1 do not apply to ambulance staff that are employed in ambulance organisations in England and Northern Ireland. These staff would have been subject to the provisions of the Ambulance Whitley Council had they been on Whitley contracts before Agenda for Change, and they now receive the premium pay rates set out in Table 3.2.²²

Table 3.2: Unsocial hours payments for Ambulance staff

Average unsocial hours per week (bands 1-7 this is 7pm-7am mon-fri & any time on weekends and bank hols) (bands 8-9 this is 10pm-7am Mon-fri & time worked outside 9am-1pm on sat & sun, plus any time on bank hols)	Percentage of basic salary	
	Pay bands 1-7	Pay bands 8 & 9
Up to 5	Local agreement	Local agreement
More than 5 but not more than 9	9%	9%
More than 9 but not more than 13	13%	10%

²²

<http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/General%20Whitley%20Council%20Conditions%20of%20Service.pdf>

More than 13 but not more than 17	17%	10%
More than 17 but not more than 21	21%	10%
More than 21	25%	10%

3.11. Premium pay rates for ambulance staff cost around £130m a year, which is approximately 16% of the paybill for ambulance staff. Around 97% of ambulance staff claim premium pay rates for shift working.

Agenda for Change Pay Progression

3.12. The pay spine for staff covered by AfC is divided into nine pay bands. All staff covered by this pay system are assigned to one of these pay bands on the basis of job weight, as measured by the NHS Job Evaluation Scheme. Within each pay band there are a number of pay points to allow for pay progression in post. Staff progress from point to point on an annual basis to the top point in their pay band, subject to meeting local performance and appraisal standards and demonstrating the agreed knowledge and skills appropriate to that part of the pay band.

3.13. Over 50 per cent (620,000 headcount) of NHS staff receive annual incremental pay increases averaging over three per cent, which costs the NHS around £800m gross a year for the medical and non-medical workforce; over £550m for AfC staff. Around 565,000 (headcount) of NHS staff are at the top of their pay band and no longer receive incremental progression, which includes around 50% of nurses, midwives and health visiting staff.

3.14. The current system of incremental progression is not fit for purpose, is unfair, and is unaffordable. Once staff are fully achieving the requirement of their role, they should still be able to access rewards for excellence. The current incremental system in AfC has no mechanism for this.

3.15. Increments should also be consistent and not unfairly award higher incremental pay to staff at higher grades. For example, staff that earn around £50,000 a year get on average 4.3% increases through progression pay, while staff that earn around £14,500 per year get incremental pay of around 2.5% per year. A typical nurse can expect seven years of pay progression, with basic salary increases of around £900 per year. A typical medical consultant can expect 19 years of pay progression, with basic salary increases of around £1,400 per year. Table 3.3 sets out the Agenda for Change pay bands, and the average increments per band, which highlights how the percentages increase between the pay bands.

Table 3.3: Average Agenda for Change Progression Pay figures

AfC Band	% at Top of Band	# FTEs at Top of Band	Avg Progression Value (for those progressing)	
			%	£*
Band 1	83%	22k	2.5%	359
Band 2	47%	67k	2.8%	429
Band 3	50%	62k	2.8%	499
Band 4	51%	41k	2.6%	519
Band 5	43%	97k	3.8%	918
Band 6	41%	68k	3.7%	1,080
Band 7	49%	51k	3.5%	1,222
Band 8a	56%	20k	3.7%	1,578
Band 8b	59%	9k	4.4%	2,241
Band 8c	58%	5k	4.5%	2,703
Band 8d	58%	3k	4.5%	3,300
Band 9	50%	1k	4.8%	4,180
All	48%	445k	3.4%	886

* impact on full time basic pay.

Examining the Costs - AfC

3.16. From available and published earnings data, it is difficult to discern the full scale of payments made directly relating to unsocial hours, due to how such payments are recorded, and their tendency to be bundled together with other areas of pay. For AfC, there are three main payment streams in which pay for work done in unsocial hours is captured: i) Shift Working Payments, ii) Overtime, and iii) On Call. (Note this differs from medical staff, for whom unsocial hours pay is wrapped up within Additional Programmed Activity (PAs).)

3.17. Based on the definitions provided in the Health & Social Care Information Centre (HSCIC) earnings publication the data we have drawn upon is defined below²³:

i) **Shift Working Payments:**

“Any form of payment for unsocial hours and shift working. Includes night, weekend and bank holiday time. Includes Agenda for Change payments for outside normal hours work.”

Some, but not all, of the Shift Work Payments category will relate to unsocial hours.

ii) **Overtime:**

“Any payment for additional time beyond the standard FTE for the grade is captured here.”

Overtime takes priority over all other non-basic pay categories, and it is not possible to extract which hours of the week each overtime payment relates to. This means there will be some work done in unsocial hours which is recorded as ‘overtime’ instead.

iii) **On Call:**

“Any form of payment for staff either on-call or standing-by, whether on Whitley Council or Agenda for Change terms. It includes payments made when staff are actually called into work.”

For costing unsocial hours, we assume all on call payments relate to unsocial hours periods, though there may be small exceptions to this.

3.18. The area where the bulk of unsocial hours payments are captured is in Shift Working Payments, which are paid on top of basic pay. By looking at shift working payments, it is possible to say that: Around 42% (around 435k) of non-medical staff currently receive some form of shift working payments. Table 3.4 shows shift working payments by staff group for non-medical staff and shows that around £1.8bn is spent on shift working payments, the majority of this relates to non-medical staff. However not all shift working payments relate to unsocial hours.

Table 3.4 Shift Working Payments by non-medical Staff Group

Staff group	% of Staff Group receiving any payment	Mean payment in the period to those who received this pay	Mean payment to all staff in this group
Total HCHS non-medical staff	41.8%	£3,433	£1,433

²³ <http://www.hscic.gov.uk/article/2021/Website-Search?productid=16315&q=earnings&sort=Relevance&size=10&page=1&area=both#top>

Qualified nursing, midwifery & health visiting staff	60.8%	£3,868	£2,350
Qualified midwives	79.4%	£3,962	£3,146
Qualified health visitors	1.3%	£542	£7
Qualified school nurses	2.2%	£1,934	£43
Total qualified scientific, therapeutic & technical staff	21.2%	£1,514	£322
Qualified allied health professions	18.7%	£1,346	£252
Qualified therapeutic radiography staff	14.7%	£229	£34
Qualified diagnostic radiography staff	46.4%	£1,800	£835
Qualified speech & language staff	1.5%	£725	£11
Qualified healthcare scientists	23.2%	£2,003	£465
Other qualified scientific, therapeutic & technical staff	23.9%	£1,445	£345
Qualified ambulance staff	97.1%	£6,108	£5,932
Support to clinical staff	40.7%	£3,126	£1,273
Support to doctors & nursing staff	43.3%	£3,232	£1,399
Support to scientific, therapeutic & technical staff	21.3%	£1,500	£319
Support to ambulance staff	74.2%	£3,927	£2,914
NHS infrastructure support	21.2%	£2,595	£550
Central functions	5.1%	£2,210	£112
Hotel, property & estates	54.1%	£2,647	£1,431
Senior managers	1.2%	£868	£11
Managers	3.5%	£2,911	£102

Data taken from HSCIC earnings publication for 2013-14.

3.19. Based on a one-off extract from the Electronic Staff Record team, it is possible to further examine the components of the Shift Work Payments. Adjusting for employer on-costs, Table 3.5 shows the costs incurred from payments recorded under elements which can be attributed to unsocial hours.

Table 3.5 Unsocial Hours Shift Work Cost by Staff Group

AfC Professions	Unsocial Hours Shift Work Cost - £m	On Call cost - £m	Agg Unsocial cost (exc Overtime) - £m
Qualified nursing, midwifery & health visiting staff	843	42	884
Total Qualified scientific, therapeutic & technical staff	50	104	154
Qualified Allied Health Professions	18	44	62
Qualified Healthcare Scientists	13	41	54
Other qualified scientific, therapeutic & technical staff	19	19	37
Qualified ambulance staff	128	1	130
Support to clinical staff	470	10	480
Support to doctors & nursing staff	398	5	403
Support to scientific, therapeutic & technical staff	21	5	26
Support to ambulance staff	51	1	51
NHS infrastructure support	140	32	172
Central functions	15	8	23
Hotel, property & estates	117	12	129
Senior managers	0	5	5
Managers	4	8	12
Total	£1.6bn	£0.2bn	£1.8bn

- 3.20 Table 3.5 shows a cost of around £1.6bn from the unsocial hours elements of Shift Working Payments.
- 3.21 With On Call included, this gives a total estimated cost of unsocial hours for non-medical staff of **at least £1.8bn**. Note that this figure would be higher with Overtime payments for unsocial hours work, which cannot currently be quantified. This represents approximately 4% of NHS paybill - 5% of non-medical paybill.

Comparisons with other Employment Sectors

- 3.22. As explained earlier in our evidence, delivery of seven day services is not about encouraging the NHS workforce to work increasingly long or unsafe hours, which could put at risk the wellbeing of staff and patients. Instead, a successful seven day service might, in many cases, require more staff to work more flexibility within their contracted hours for the benefit of patients. To develop options for delivering this in a financially sustainable way, it may be useful to look across the economy at how other sectors pay staff for work delivered during unsocial times.
- 3.23. Many staff in the NHS already work during unsocial hours, including during the weekends. However, consistent delivery across seven days has not historically been considered a priority, and the existing contractual unsocial premium payment arrangements for NHS staff were not designed with the purpose of facilitating the delivery of affordable seven day services.
- 3.24. The HFMA report on the costs of delivering seven day services suggests that the NHS has not kept pace with other service industries which have moved to deliver services across the week. It states that ‘moving with the times’ will be one of four key drivers for the delivery of seven day services going forward, referred to earlier in Chapter One.
- 3.25. In 2013/2014, the Department of Health commissioned *Incomes Data Services (IDS)* to provide information on unsocial hours in a range of public and private sector organisations.²⁴ The report was drawn from surveys conducted in 2013 with employers from a number of sectors, including retail, call centres, housing and social care, other public services and other organisations.
- 3.26. The report offers a number of insights into how others sectors treat work delivered during unsocial hours. Some key information is included at table 3.6.

²⁴ “Unsocial Hours Payments: A research report for the Department of Health from Income Data Services” January 2014

Table 3.6: Unsocial Hours in other Sectors

	Proportion from sample that pay a premium for unsocial hours (where applicable)	Typical unsocial payments (where applicable)		
		Evenings and Night Work	Saturdays	Sundays
NHS – Agenda for Change	All	<p>Staff receive scaling hourly rates depending on their pay band (with evenings considered 8pm-6am) i.e.:</p> <p><i>Pay bands 1-3 (lowest paid):</i></p> <p>-Scales between time plus 37% and T+50%</p> <p><i>Pay bands 4-9 (middle to highest paid):</i></p> <p>-T + 30%</p>		<p><i>Bands 1-3:</i></p> <p>-Between T+100% and T+74%</p> <p><i>Bands 4-9:</i></p> <p>-T+60%</p>
NHS - Ambulance Staff	All	<p>Provides salary uplift based on the average number of unsocial hours worked, with different uplifts and qualifying hours for lower/middle earners and for higher earners.</p> <p>For pay bands 1-7, unsocial hours include 7pm-7am and any time on weekends:</p> <ul style="list-style-type: none"> - Up to 5 hours: local agreement - Over 5: the uplift scales between 9% (for between 5 and 9 hours) up to 25% for 21 hours plus <p>For Pay bands 8 & 9, unsocial hours are between 10pm-7am & outside 9am-1pm on the weekend:</p> <ul style="list-style-type: none"> - Up to 5 hours: local agreement - Over 5: 9% for up to 13 hours and 10% for 13 hours plus 		
Police	All	T+ 10% (between 8 p.m. and 6 a.m.)	Plain Time	

Housing and Social Care: Care Assistants and Supervisors	43% pay premiums for night working, 33% for Saturdays & 66% Sundays	T+33%	T+33%	T+50%
Housing and Social Care: Nurses or Care Home managers	A small minority of care organisations pay night premiums, and fewer weekend premiums			
Engineering: - Manual Workers	Common (shift premiums)	T+33%	+15% (weekend work uncommon)	
Retail	Most	T+33% (mostly between 10pm-5am or 11pm-6am)	Plain Time	T+50%
Call Centres	42%	Significant Variation		
Senior Staff Professionals in Legal and Finance	Very unusual for unsocial hours payments to be made, with compensation generally reflected in higher basic and salaries and earnings packages.			

3.27. The IDS report highlights that a number of important changes to unsocial hours have taken place in recent years across different employment sectors. For example, in the retail sector, the introduction of extended weekend services has led to a reduction in the amount paid for work during unsocial periods, a process which has more recently stabilised. It is entirely reasonable for patients to expect health and social care services to have moved with the times and that they will receive the same quality of care seven days a week. NHS employment contracts, in place for more than a decade, do not reflect the significant increase in demand for NHS services and public expectations around the quality and responsiveness to their needs. It is our view that employment contracts for NHS staff should help put patients front and centre by ensuring that pay rates effectively incentivise and appropriately reward staff for what they do for patients based on patient need across seven days.

- 3.28. Unsocial hours payments in the NHS are generally more generous when compared to the sectors outlined in IDS's report. Many employers surveyed do not offer unsocial hours payments at all, particularly to staff in the higher grades, such as the nurses and homecare managers in the Housing and Social Care sector. These health and social care employers only pay unsocial hours premiums to staff in the lowest grades within the organisations. This is not reflected in AfC where premium pay rates remain markedly higher than the norm. For example, the treatment of Saturday at plain time appears to be the norm for many employers, which seems out of line with AfC where working Saturdays is considered comparable to working nights.
- 3.29. In addition, in other sectors, payments for Sundays are rarely paid above time plus 50% (AfC ranges from time plus 60% to double time).
- 3.30. Above AfC Band 4, payments for night work appear more in-line with other sectors, at broadly time plus a third. However, timings for night work vary - for example in the retail sector night shifts typically start around 10pm-11pm - compared to 8pm under AfC.
- 3.31. Notable exceptions include the police and housing and social care nurses and care home managers, who receive much lower payments (or in the case of nurses and care home managers, rarely any). This raises the question of whether all AfC staff should be treated the same, or whether an NHS which delivers services seven days a week should vary the approach to unsocial hours for staff depending on their role in the organisation (e.g. managerial staff vs support staff).

Sustainable Options for Future Pay

- 3.32. Earlier we asked whether the existing system of out of hours pay is appropriate in a 24 hour system providing care every day of the week, and whether the current system is consistent with modern employment practice so that employers neither pay too much nor too little in order to recruit and retain the staff the NHS needs.
- 3.33. Considering the comparisons drawn from the IDS research, and the desire to move towards a more sustainable and fair system of pay which is fit for a modern NHS where services are delivered seven days a week, we explore a number of options. We do not focus on any particular option, nor are the options exhaustive, but this is an opportunity to examine the current pay system and consider flexibilities that could be introduced to support pay reform and enable more affordable and sustainable seven day services.
- 3.34. We do not believe that the reform of out of hours pay can be considered in isolation to the incremental pay system. Any options for change should be considered as part of an employment package which is financially sustainable and which seeks to better target available pay resources.
- 3.35. In terms of unsocial hours' pay premiums, options for change range from removing premium pay rates entirely, to matching practice in comparable industries. It would be helpful if the Pay Review Body could consider the following options and how reform could help employers continue to recruit and retain the staff they need within available resources.

Option: Removing unsocial hours rates

3.36. The current AfC unsocial hours payments cost an estimated additional £1.8bn per year at least. Extending plain time working would bring the NHS more in line with, for example, the police force – which treat all days as plain time and where staff only receive additional pay of 10% for working between 8pm and 6am. Whilst the estimated cost of unsocial hours' payments is at least £1.8bn, the impact should 'plain time' and 'unsocial hours' be distributed differently is difficult to estimate with any degree of accuracy due to the distribution of employer on-costs, (and the costs of On Call and Overtime relating to unsocial working) included within the paybill data.

Option: Paying a flat rate for all staff

3.37. Staff paid under AfC are paid at different rates for unsocial hours depending on the pay band. Introducing a flat rate of unsocial hours pay for all staff regardless of the payband could be perceived as a more fair and sustainable arrangement. This could encourage rostering based on service need rather than cost. Alternatively, removing unsocial hours enhancements for staff above a certain payband would bring AfC in line with practice within some private health and social care organisations. Ambulance staff could also be included within AfC terms and conditions that apply to other employed staff, rather than being paid on a separate system. This could help streamline unsocial hours pay and provide more flexible options for employers.

Option: Changing the periods which are considered “unsocial” and attract premium pay rates

- 3.38. In line with retail, the police, and most housing and social care services, premium pay rates for working Saturdays could be paid at plain time and night shifts could begin at 10pm rather than 8pm.
- 3.39. Treating Saturdays in the same way as nights appears out of touch with public expectations that a range of services should be available at times convenient to them. Additionally, one could argue that nights are more 'unsocial' than for example working on Sundays, due to the scientific evidence which describes the negative physiological impact that night shifts can have.²⁵ Targeting premium pay rates at just night shifts, or on night shifts and Sundays, and making Saturdays and evenings 'plain time' would bring the NHS in line with more modern employment practice and potentially enable seven day services by making the delivery of additional urgent, emergency and elective care at these times more affordable.

Option: Lowering the rates for Sundays and bank holidays

²⁵ <http://www.pnas.org/content/111/6/E682>

3.40. Premium pay rates for working Sundays and bank holidays could be reformed to bring the NHS more in line with other sectors. This would reflect that the NHS *is* a seven day service, whilst still recognising that these particular hours may be perceived as more ‘unsocial’ and that this approach would continue to compensate staff for working hours which wider employment practice generally recognise as ‘unsocial’.

Option: Flexibility premiums rather than unsocial hours premiums

- 3.41. A radical approach to out of hours payments could focus on rewarding staff for flexibility. For example, the AA operate a 24 hour service with pay linked to flexibility, with pay levels informed by the degree of how flexible the member of staff is to working ‘unsocial’ shift patterns. Higher premium pay rates are targeted at those staff whose contracts reflect a flexibility and willingness to work shift patterns which are considered more ‘unsocial’ (as opposed to staff who are only available for shifts within a ‘more social’ 12 hour period), i.e. s where staff are willing to work *any* shift within a 24 hour period.
- 3.42. Such a change would require a cultural change to the way that the NHS manages 24 hours a day / seven days a week care, but it could provide the flexibility needed to support seven day services in the NHS of the future.

Option: Revising Progression Pay alongside changes to unsocial hours

- 3.43. The current system of incremental progression pay costs over £550m per year for AfC staff and is neither fair nor affordable within the current economic climate. NHS Employers and HR professionals believe the existing system of pay progression could be revised to make it fairer, more competitive, more attractive to employers and new starters, and more rewarding to staff who excel in their role.
- 3.44. If the existing pay system were re-designed in order to deliver a much more streamlined and affordable pay progression system with reformed premium pay rates aligned with best employment practice and which better reflects the ‘price’ necessary to ensure patient care across seven days and nights, this could help employers achieve a better balance across base pay, progression pay and premium pay rates. A more modern and sustainable pay system which is better able to target pay resources around performance and premium pay rates, could help employers meet increasing demands for greater productivity and quality whilst achieving financial balance.

Conclusion

- 3.45. Government is clear that pay restraint right across the public sector remains a critical part of fiscal consolidation plans. The current AfC pay system can act as both a barrier and enabler of seven day services, with an inbuilt annual incremental pay pressure of over £550m and payments relating to premium rates of around £1.6bn every year, rising to at least £1.8bn when including on call, and likely higher due to un-costed overtime payments.

- 3.46. Premium pay rates can incentivise staff to provide care at evenings and weekends, but do not reflect modern employment practice. The premium rates on offer, plus the times of the day and week in which they are applied, are out of date and a potential barrier to affordable seven day services.
- 3.47. Recent reform of the AfC progression pay system makes incremental pay dependent on staff meeting local performance standards. However, benefits realisation will take time as employers develop, implement and manage new local appraisal and performance arrangements, which seek to reward staff for what they do for patients and how they care for patients. This an important first step and demonstrates that there is a shared understanding between trade unions and employers that employment contracts should incentivise staff to provide the very best care for patients. However, with nearly a million more over 65s, and the rapidly increasing demand for NHS services, we believe that change to progression pay and unsocial hours pay is necessary if employers are to afford the workforce the need to put patients first every day of the week.
- 3.48. Reforming the way staff are paid unsocial hours *and* progression pay could potentially create opportunities to develop a fairer, more affordable, and sustainable system for rewarding staff and providing care across seven days, and we look forward to the PRBs views on the options presented here.

Chapter 4 – Workforce Planning

- 4.1. Further consideration needs to be applied to what additional percentage of the workforce would need to be in work at which times, and this would be based on the nature of services to be delivered over seven days (urgent, emergency and elective).
- 4.2. NHS England will provide evidence around the potential workforce implications for seven day services. NHS England will also provide case studies on early adopter sites where services are being provided seven days a week. It has also commissioned Deloitte to prepare three models of seven day services: an urban, suburban, and rural model. This will provide evidence on the implications for the workforce based on estimates of the additional frontline, clinical and managerial staff that may be required to deliver these local service models.
- 4.3. The pilots will consider the workforce implications of the clinical standards agreed by NHS England (see Annex D), but as we explained earlier in our evidence, one delivery model will not suit all local organisations. The exact impact on the workforce will depend on the model of seven day services and the approach to rostering taken by individual organisations.
- 4.4. The current NHS workforce statistics are set out below, which the Pay Review Body may find helpful. It is the Government's view that we must continue to invest in and protect the NHS frontline. The cost of the paybill – approximately 60% of local NHS expenditure - is a critical element of how employers are able to extend services in an affordable way. NHS England is aware that any increase in the workforce must be affordable. National employment contracts should help mitigate the risk that employers pay staff too much or too little with no discernible impact on the patient experience or outcomes. How ever services are configured and delivered locally, affordable national employment contracts could be an important enabler for the delivery of safe, efficient care across the whole week.

Latest NHS workforce statistics²⁶

- 4.5. These show:
 - The total number of professionally qualified clinical staff in the NHS in August 2014 was 569,318 which is an increase of 13,369 since May 2010
 - The total number of doctors (not including locums) in the NHS in August 2014 was 103,751 which is an increase of 8,331 since May 2010

²⁶ NHS Workforce Statistics - August 2014, Provisional statistics published 25 November 2014
<http://www.hscic.gov.uk/searchcatalogue?productid=16025&topics=0%2fWorkforce&sort=Relevance&size=10&page=1#top>

- The total number of qualified nursing, midwifery and health visiting staff in the NHS in August 2014 was 311,670 which is an increase of 877 since May 2010
 - The number of infrastructure support staff has reduced by 21,056 since May 2010
- 4.6. The demand to deliver additional services at weekends will place additional pressure on the pay bill, under the current contractual arrangements for paying premium pay rates for staff that work unsocial hours. Therefore, in order to deliver seven day services in a cost neutral sustainable way it is important to look at the terms of Agenda for Change and ensure that they are fit for purpose now and in the future, as set out in Chapter 3.

Chapter 5 - Conclusion

- 5.1. The NHS is facing the biggest financial challenge in its history; yet this should not stand in the way of progress towards delivering higher quality, more integrated and safer services to patients. The case for delivering consistent, properly-staffed, joined-up care every day of the week has been made – and it is clear that this would not only improve access for patients, but also deliver care in a more efficient way.
- 5.2. To ensure that the NHS can cope with increasing demand within a financial challenging environment, changes need to be made to the way in which we pay staff. NHS employment contracts should reflect modern employment practice, both in terms of how staff are remunerated for plain time and unsocial hours, and how the system of progression pay should allow employers to reward those staff that make the greatest contribution to patient care.
- 5.3. Agenda for Change has an inbuilt annual pressure of over £550m because of the incremental pay system, with an additional cost of at least £1.8bn for working ‘unsocial hours’. If employers are to make seven day services a reality with the existing workforce they need to be able to make better use of the pay bill. Premium pay rates based around historic working patterns, together with an unfair and unaffordable system of incremental pay, can act as a barrier to innovation. Affordable employment contracts are essential if employers are to meet increasing demand for the same levels of safe and efficient care seven days a week. This will be an important enabler for putting patients right at the heart of everything the NHS (and wider care systems) does. The Pay Review Body is asked to give some consideration to the following potential barriers (which are not exhaustive) to sustainable seven day services:
- the periods of time classed as ‘unsocial’ in the NHS working week, given the nature of the service, patient needs, and modern societal norms
 - the rates of pay on offer for unsocial hours in the NHS, and whether they reflect the approach taken by other similar organisations
 - the structure of progression pay in Agenda for Change, and whether this is fair, affordable and sustainable
- 5.4. The annual cost of operating the current incremental pay system and premium pay rates means that maintaining the status quo, in our opinion, is not an option. The financial challenge employers face demands a much more creative approach and much greater scrutiny of whether the distribution of pay – including unsocial hours premiums - across the medical and non-medical staff groups makes the best use of the pay bill for the benefit of patients.
- 5.5. The NHS has much to offer its staff in addition to pay. Improved HR capability to promote a total reward approach to the employment offer will help employers engage with, recruit, and retain the workforce they need. A much stronger emphasis on staff engagement, together with a more fair, flexible and affordable employment package in step with

modern employment practices will, we believe, help employers recruit and retain the skilled staff they need to deliver quality care seven days a week in a sustainable way.

Annex A- Chief Secretary Treasury letter

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

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

31 July 2014

Dear Review Body Members

PUBLIC SECTOR PAY 2015-16

I would like to thank you for your work on the 2014-15 pay round. I am strongly convinced of the role of the pay review bodies in determining national pay awards in the public sector and appreciate the important part the pay review bodies have played over the last four years. For a number of review bodies this has included providing expert advice and oversight of wider reforms to pay policy and systems of allowances, in addition to the annual award. I am confident the changes brought about by the pay review body recommendations in these areas are making a significant contribution to the improvement and delivery of public services.

2. You will have seen that for the 2014-15 pay round there were some review body recommendations which, after careful consideration, the Government decided were unaffordable at this time. I hope you will appreciate this was a difficult decision and that the Government continues to greatly value the contribution of the pay review bodies in delivering robust, evidence-based pay outcomes for public sector workers.

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3. The Autumn Statement of 2013 highlighted the important role in consolidation that public sector pay restraint has played. The fiscal forecast shows the public finances returning to a more sustainable position. However, the fiscal challenge remains and the Government believes that the case for continued pay restraint across the public sector remains strong. Reasons for this include:

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

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

4. As you are aware, for 2014-15 the Government adopted an approach by which all staff in the NHS received at least an additional 1% of their basic pay. All staff not eligible to receive incremental pay have been given a 1% non-consolidated payment in 2014-15. Other staff will have received an increase worth at least 1% through incremental progression.

5. Unfortunately, the NHS trade unions are not prepared to negotiate an affordable alternative, although we are still open to new proposals. Therefore it is our intention to take the same approach in 2015-16. As a result, the NHSPRB will not be asked to make recommendations on a pay award for Agenda for Change staff in the 2015 pay round.

6. I note that the NHSPRB's observation that a thorough review is required of the Agenda for Change pay structure so that it might better support the challenges facing the NHS in terms of both patient care and affordability. We

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plan to take up your offer to look into this and the Department of Health will write shortly with more details.

7. I look forward to your reports, and reiterate my thanks for the invaluable contribution made by the NHS Pay Review Body during the course of this Parliament.

A handwritten signature in black ink, which appears to read 'Danny Alexander'. The signature is fluid and cursive.

DANNY ALEXANDER

Annex B – Remit Letter NHSPRB



Department
of Health

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

*Richmond House
79 Whitehall
London
SW1A 2NS*

Tel: 020 7210 4060

POC5 883481

Jerry Cope
Chair, NHS Pay Review Body
Office of Manpower Economics
Level 8
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8AE

28th August 2014

Dear Jerry,

NHS Pay Review Body Remit 2015/16

I am writing as a follow up to the letter you received from the Chief Secretary to the Treasury, Danny Alexander on 31st July 2014 confirming the Government's approach to reforming NHS employment contracts.

I should first wish to add my own thanks to those of the Chief Secretary for the robust and independent advice that the Government receives from the NHS Pay Review Body (NHSPRB). I can assure you that we value this advice very highly and attach considerable importance to the role of the NHSPRB, informed as it is by expert, impartial and independent judgement. This is true even where, as in the previous review round, the continuing need for pay restraint right across the public sector to support fiscal consolidation, together with the unprecedented financial challenge facing the NHS meant that we are not able to accept your recommendations.

Following the Government's announcement of a two year pay settlement for employed Agenda for Change (AfC) staff in England, the NHSPRB is not required to report or make recommendations for the 2015/2016 year on:

- the remuneration of employed AfC staff, including High Cost Area Supplements and Recruitment and Retention Premia;

- the recruitment, retention and motivation of suitably able and qualified staff; and
- regional/local variations in labour markets and their effects on recruitment and retention of staff.

National employment contracts are a critical element of how we put patients right at the heart of everything the NHS does, providing potentially a seamless pathway of care no matter what day of the week. I was pleased that the NHSPRB's 28th report said that more progress should be made on seven day services, "*Progress on a wider seven-day service is urgently needed. The parties should now rapidly negotiate and agree changes to Agenda for Change alongside negotiation for medical staff... We suggest that if the parties find it difficult to agree we would be prepared to look into this if given an appropriate remit and evidence*".

There is a strong case for seven day services on the grounds of both patient safety and quality of patient care. For example, recommendations of the *NHS Services, Seven Days a Week Forum*¹ accepted by NHS England, explore the consequences of the non-availability of clinical services across the seven day week and that availability needs to be achieved in a clinically and financially sustainable way.

For 2015/2016 the NHSPRB is asked to make observations on the barriers and enablers within the AfC pay system, for delivering health care services every day of the week in a financially sustainable way, i.e. without increasing the existing spend. The NHSPRB is asked to make observations on:

- affordable 'out of hours' working arrangements; and
- any transitional arrangements.

In considering these propositions, the NHSPRB should have regard to its normal terms of reference plus developments in other sectors which provide seven day services.

Although the NHSPRB's remit covers the whole of the United Kingdom, for this particular remit, we ask that you make observations for England only. It is for each of the devolved administrations to make their own decisions about the nature of the remit appropriate for its workforce for 2015/2016 and to communicate their intention to you directly.

In view of the work to which the NHSPRB is committed to support the pay review round in the devolved administrations, a realistic timetable for you to report on your work on contract reform would be July 2015.

¹ Summary of Initial Findings – First Published December 2013 - <http://www.england.nhs.uk/wp-content/uploads/2013/12/forum-summary-report.pdf>

As always, my officials will be happy to work closely with your secretariat to ensure you have all the information you need to assist your task of providing independent observations on reforms that are crucial to this vital area of service provision.

Best wishes,

A handwritten signature in black ink, appearing to read 'DR DAN POULTER'. The signature is stylized with a long horizontal stroke extending to the right.

DR DAN POULTER

Annex C – Remit Letter DDRB



Department
of Health

POC5 896552

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

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

Professor Paul Curran
Chair
Review Body on Doctors' and Dentists' Remuneration
Office of Manpower Economics
Level 8, Fleetbank House
2-6 Salisbury Square
London
EC4Y 8AE

30 OCT 2014

Dear Professor Curran,

Further to the letter you received from the Chief Secretary to the Treasury, Danny Alexander on 31st July 2014 and my letter of 26th August 2014 confirming the remit for independent contractor doctors and dentists, I am writing now to confirm the remit for employed doctors and dentists.

As I set out in my letter of 26th August, following the Government's announcement of a two year pay settlement for employed doctors and dentists in England the DDRB is not required to report or to make recommendations or observations for the 2015/2016 year on:

- the remuneration of employed doctors and dentists;
- the recruitment, retention and motivation of suitably able and qualified staff; and
- regional/local variations in labour markets and their effects on recruitment and retention of staff.

National employment contracts are a critical element of how we put patients right at the heart of everything the NHS does, providing a seamless pathway of care no matter what day of the week. In recent reports, the DDRB has identified the need for contract reform for consultants and for doctors and dentists in training. During 18 months of discussions and negotiations, NHS Employers and the BMA have done a significant amount of work to design reward packages for consultants and juniors to facilitate services and training across the seven day week. The Government is disappointed that these negotiations have not resulted in agreements acceptable to all parties. The Chief Secretary, in his letter of 31 July, noted the DDRB's offer to consider contractual arrangements at an appropriate stage of the negotiations. I am therefore now asking the DDRB to make observations and recommendations that take into account the work undertaken during negotiations.

There is a strong clinical case for seven day services. For example, recommendations of the *NHS Services, Seven Days a Week* Forum¹ accepted by NHS England, explore the consequences of the non-availability of clinical services across the seven day week and state that availability needs to be achieved in a clinically and financially sustainable way.

For 2015/16, **for consultants**, DDRB is asked to make observations, based on information and data presented on pay-related proposals for reforming the consultant contract to better facilitate the delivery of health care services seven days a week in a financially sustainable way i.e. without increasing the existing spend. In the context of the policy aim to deliver financially sustainable seven day services, the DDRB is asked to consider and critique proposals from the Department and the NHS Employers, taking account of views from all parties.

The DDRB should also consider the following, including work already completed by the DDRB and work undertaken by the parties to the negotiations:

- the work by the DDRB on the payment of clinical excellence awards (CEAs), and the Government’s response to that;
- proposals for pay progression to be linked to responsibility and performance; and
- arrangements in other sectors which provide seven day services.

For **doctors and dentists in training**, DDRB is asked to make recommendations on new contractual arrangements including a new system of pay progression with, as DDRB has proposed, “*a strengthened link between pay and better quality patient care and outcomes*”. In doing so, DDRB should consider information submitted including:

- proposals for pay structures that include the ending of time-served incremental progression;
- information on the working patterns of doctors in training; and
- how the current pay envelope could be used differently to increase basic pensionable salaries, providing appropriate reward of additional work, while supporting services and training across the seven day week.

In undertaking both strands of this work, the DDRB should have regard to the Heads of Terms agreed by the parties prior to the contract negotiations. It should also have regard to the read-across to the work that the Government has asked the NHS Pay Review Body to undertake to make observations on the barriers and enablers within the Agenda for Change pay system for delivering health care services every day of the week in a financially sustainable way.

¹ Summary of Initial Findings – First Published December 2013 - <http://www.england.nhs.uk/wp-content/uploads/2013/12/forum-summary-report.pdf>

In considering your observations on seven day services, the Government would also wish to consider the extent to which they would read-across to other medical staff groups such as specialty doctors and associate specialists.

Although the DDRB's remit covers the whole of the United Kingdom, for this particular remit, we ask that you make observations for England only. It is for each of the devolved administrations to make decisions about the nature of the remit appropriate for their workforces for 2015/2016 and to communicate their intention to you directly.

In view of the work to which the DDRB is committed to support the pay review round in Scotland and the work on independent contractors, a realistic timetable for you to report on your work on contract reform would be July 2015.

Patients should be placed right at the heart of everything we do, and the way that the NHS organises and manages the workforce should be built around patients and their needs. I'd like to conclude by reemphasising the clinical case for seven day service provision, which has the potential to reduce mortality rates in the evenings and at the weekends, speed up diagnosis and discharge times and reduce the amount of time that patients need to spend in hospitals overall.

As always, my officials will be happy to work closely with your secretariat to ensure you have all the information you need to assist your task of providing independent observations and recommendations on reforms that are crucial to this vital area of service provision.

with Best wishes,



DR DAN POULTER

Annex D – Clinical Standards

Clinical Standards for Seven Day Services, agreed by NHS England.

<p>1. Patient Experience</p>	<p>Patients, and where appropriate families and carers, must be involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and ongoing care that reflect what is important to them. This should happen consistently, seven days a week.</p>
<p>2. Time to first consultant review</p>	<p>All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon possible but at the latest within 14 hours of arrival at hospital.</p>
<p>3. Multi-disciplinary Team review</p>	<p>All emergency inpatients must have prompt assessment by a multi-professional team to identify complex or on-going needs, unless deemed unnecessary by the responsible consultant. The multi-disciplinary assessment should be overseen by a competent decision-maker, be undertaken within 14 hours and an integrated management plan with estimated discharge date to be in place along with completed medicines reconciliation within 24 hours.</p>
<p>4. Shift handovers</p>	<p>Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant incoming and outgoing shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.</p>
<p>5. Diagnostics</p>	<p>Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, echocardiography, endoscopy, bronchoscopy, and pathology. Consultant-directed diagnostic tests and their reporting will be available seven days a week:</p> <ul style="list-style-type: none"> • Within 1 hour for critical patients;

	<ul style="list-style-type: none"> • Within 12 hours for urgent patients; and • Within 24 hours for non-urgent patients.
6. Intervention / key services	<p>Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant speciality guidelines, either on site or through formally agreed networked arrangements with clear protocols, such as:</p> <ul style="list-style-type: none"> • Critical care; • Interventional radiology; • Interventional endoscopy; and • Emergency general surgery.
7. Mental health	<p>Where a mental health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week:</p> <ul style="list-style-type: none"> • Within 1 hour for emergency care needs • Within 14 hours for urgent care needs
8. On-going review	<p>All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks.</p> <p>Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.</p>
9. Transfer to community, primary and social care	<p>Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.</p>
10. Quality Improvement	<p>All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high quality, safe patient care, seven days a week.</p>

