



NHS  
Pay Review  
Body

# NHS Pay Review Body

Enabling the delivery of healthcare services every day of the week – the implications for Agenda for Change

*Chair:* Jerry Cope



# **NHS Pay Review Body**

Enabling the delivery of healthcare services every day of the week – the implications for Agenda for Change

*Chair: Jerry Cope*

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

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

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

**July 2015**



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[www.gov.uk/ome](http://www.gov.uk/ome)

You can download this publication from [www.gov.uk/government/publications](http://www.gov.uk/government/publications)

Print ISBN 9781474122313

Web ISBN 9781474122320

Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office.

ID 19061501 07/15

Printed on paper containing 75% recycled fibre content minimum.

Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office.

## NHS Pay Review Body

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

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

- the need to recruit, retain and motivate suitably able and qualified staff;
- regional/local variations in labour markets and their effects on the recruitment and retention of staff;
- the funds available to the Health Departments, as set out in the Government's Departmental Expenditure Limits;
- the Government's inflation target;
- the principle of equal pay for work of equal value in the NHS;
- the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

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

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

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

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

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

Members of the Review Body are:

- Jerry Cope (Chair)
- Professor David Blackaby
- Joan Ingram
- Graham Jagger
- Colin Kennedy
- Janet Rubin MBE
- Professor Anna Vignoles

The secretariat is provided by the Office of Manpower Economics.

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# NHSPRB Report 2015: Enabling the delivery of healthcare services every day of the week – the implications for Agenda for Change

## Executive summary

### *Introduction and our remit*

This report sets out our conclusions and observations on the remit given to us by the United Kingdom Government, the Welsh Government and the Northern Ireland Executive on the barriers and enablers within the Agenda for Change pay system, for delivering healthcare every day of the week in a financially stable way. More specifically the Review Body was asked to make observations on:

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

The Department of Health further clarified *affordable* to mean *at no increase to the pay bill per full time equivalent (FTE) member of staff*.

We welcome the opportunity to consider this important remit and hope our report will assist all parties in working together to make progress on the expansion of seven-day services for the benefit of patient care. We are clear that our role was to provide observations on the core issues and to help parties to move forwards. We thank all parties for their evidence and contribution to this remit.

The Review Body on Doctors' and Dentists' Remuneration (DDRB) were also given a remit on contractual reform to support the delivery of healthcare every day of the week in a financially sustainable way. The remit to DDRB asked that they have regard to the read-across to the remit given to NHSPRB on Agenda for Change staff groups.

Each of the United Kingdom countries are at different starting points and have some different priorities in regards to their approach to seven-day services. This report is focused on what we have identified as the core issues – although these core issues are common to all the countries there are also variations in approach. It will therefore be for each country to decide how they wish to move forward and where there may be scope to work together on common issues.

The evidence from the **Department of Health** and **NHS Employers** provided some early stage options for reviewing unsocial hours definitions and premia. These had not yet been fully modelled or costed. All parties were clear that any formal proposals will need to be negotiated through the National Staff Council.

### *The vision for seven-day services*

The argument for the implementation of seven-day services to tackle the "weekend effect" on patient outcomes, including mortality rates, is compelling. **All parties are in agreement on their desire to improve patient care and support the implementation of a wider seven-day service where there is an identified clinical need to do so. This should provide a positive basis for future discussions and progress on the expansion of seven-day services.**

Whilst the NHS England 10 clinical standards are clear about the need for increased consultant presence and availability of diagnostics, the changes for the corresponding Agenda for Change staff groups required to support this have not been spelt out in detail.

A move to deliver more services over seven days is likely to offer up potential efficiencies in the healthcare system – for example from reduced length of stay in hospital and better utilisation of assets and resources. In the context of the financial constraints that trusts and health boards are



operating under it will be important and helpful to identify these. The early adopter sites offer a ready-made opportunity to analyse cost savings and benefits to the service. **Further work is needed to identify in more detail the potential productivity gains and efficiencies in the system that a move to seven-day services might release, alongside the improvements in patient care.**

### *The Agenda for Change pay structure*

The Agenda for Change pay system has been in operation for over 10 years and there is some scope to review and modernise it. There are elements within the unsocial hours package for core Agenda for Change staff and the Ambulance Service that may not support the delivery of optimal shift patterns for the best benefit of the patient. **The pay structure should work to support and incentivise behaviours to ensure that shifts are scheduled principally around the needs of the patient rather than skewed by rules around shifts and payments.**

However, **the national Agenda for Change pay system presents no contractual barrier to the delivery of seven-day services; seven-day working is already well established for a number of core staff groups; and has been used at seven-day case study and early adopter sites across the United Kingdom.** This is different from the position for consultants, where there is an opt-out clause on non-emergency working at evenings and weekends included in their contract. The national Agenda for Change pay framework already has flexibility to enable local variation and it will be important to make greater use of the mechanisms available to support service delivery.

The barrier presented to us is one of affordability. In the view of the Department of Health and NHS Employers the cost of the unsocial hours premia makes the delivery of seven-day services prohibitive. There are undoubtedly affordability aspects to the expansion of seven-day services. However, from the experiences at pilot sites these are largely due to the need to invest in extra resources, in particular additional staff, to provide services in the extra hours. At this stage, without a clearer indication of the likely increase in staff numbers and the level of unsocial hours needing to be worked, it is difficult to predict the cost implications accurately. **As well as providing efficiencies, the move to seven-day services is likely to require more resources, namely more staff, and there are affordability aspects to consider for all countries. More analysis to model the likely scenarios in terms of increase in staff numbers and increase in unsocial hours would help the parties to understand better the cost implications.**

Looking simply at unsocial hours premia, and assuming static workforce numbers, an expansion of seven-day services and increase in unsocial hours could only be introduced at no increase in pay bill per FTE by reducing the premia paid to those staff already working these hours. That would, for much of this group, which include midwives, ambulance workers and many nurses, in practice amount to a cut in their total earnings. While we cannot estimate figures with any accuracy, it seems likely that at least some of these staff would not be prepared to work their current unsocial hours under such circumstances.

### *Approaches to unsocial hours pay*

The Incomes Data Services (IDS) study has shown that unsocial hours are generally compensated for either in base pay or through unsocial hours rates. However, approaches vary and are tailored to the needs of the organisation. **There is not an overall typical pay approach or rate for out of hours service provision. The unsocial hours reward package is designed around the needs of the organisational service model. For the NHS this should be based on patient and service need.**

Appropriate comparators for the NHS workforce within the United Kingdom are difficult to identify. Out of the sectors surveyed, the evidence suggests that some Agenda for Change unsocial hours premia rates are towards the upper end of the spectrum, for example for the premia for bands 1 to 3. There could be scope for extending core time into the evening and

there are also anomalies within the qualifying rules for unsocial hours premia, for example the mechanism to pay unsocial hours premia for the whole shift when only half of the time has been worked during unsocial hours. There is therefore a case for some adjustment of the existing system in these areas which could offer up some savings. But in other areas Agenda for Change unsocial hours premia are not out of line. In overall terms therefore, **whilst some adjustments could be made, we have not found enough evidence to support wholesale changes to unsocial hours definitions and premia in isolation from the wider Agenda for Change pay system.**

### *Recruitment, retention and motivation*

We have commented in our previous reports on the issue of the lack of detailed workforce planning and vacancy data across the NHS in the United Kingdom and the big problem that this already presents. In the context of delivering an increased service, and across a multitude of service providers, the need to close information gaps on vacancy data and improve workforce planning becomes more acute. It will be essential to consider what roles are required, and the impact on resources, before embarking on a significant move towards the expansion of seven-day services. Trusts and health boards should work to identify the scale of their requirements. Without this forward planning there is a risk that there will not be sufficient trained staff resources across the required groups to deliver an increased seven-day service. Resource requirements for the expansion of seven-day services are not fully incorporated into local workforce plans and education commissions, and it takes a number of years to train suitably skilled and qualified staff. If changes are introduced without the appropriate workforce planning then the short-term impact on staff levels could see agency costs increase. **We note that those responsible for workforce planning and commissioning of training are not yet fully linked into local plans for seven-day services. Given the number of years it takes to train suitably skilled and qualified staff we believe a substantial barrier to the expansion of seven-day services could be insufficient numbers of appropriately trained staff.**

Culture change will form a key component to shifting the mind-set of staff from a Monday to Friday ethos to seven-day delivery. The availability and delivery of patient services across seven days will need to become the new norm for NHS staff. There will be advantages and disadvantages for all staff in moving to a culture of seven-day services, and this will be dependent on individual circumstances. We can see potential benefits in terms of flexibility, work-life-balance and increased job satisfaction from providing high quality patient care. However, good management practice and staff engagement are crucial to realise these potential benefits, and these will require discussion locally.

If it is decided to pursue changes to premia, and revised rates are not pitched at the correct level there could be a significant impact on recruitment and retention. It will be important for all countries in the United Kingdom to consider the impact of any proposed pay changes and it would be useful to model scenarios based on typical shift patterns. Maintaining staff engagement will be key to the successful expansion of seven-day services and many staff will currently be reliant on unsocial hours premia as part of their overall earnings package. Taken in isolation, the options for unsocial hours definitions and premia from the Department of Health and NHS Employers, would reduce the pay and risk the good will of staff who are already working across seven days. **There is a case for some adjustments to Agenda for Change unsocial hours definitions and premia. However, if done in isolation, this could risk the morale and motivation of staff, damage employee relations, exacerbate existing shortages, and, in particular, risk the good will of staff already working across seven days.**

## *Conclusion*

As it stands the national Agenda for Change pay system is not the principal barrier to achieving the improvements offered by the expansion of seven-day services. However, we recognise the need to ensure services are cost effective, and there will be some trade off between putting seven-day services in place quickly and uniformly, and questions of affordability.

We have previously recommended that the Agenda for Change pay structure is ready for review and it seems to us that discussions about unsocial hours definitions and premia are better taken forward as part of negotiation on the pay system as whole, with the aim of agreeing a balanced package. Ideally this should include a review of the length of pay scales, overlapping bands with shared spine points, progression and improved links between reward and performance, including incentives for staff at the top of their pay band. Such discussions may be more productive if staff and employers have stability in pay; a multi-year pay deal could perhaps provide this. **Although some changes could be made to unsocial hours definitions and premia, any major changes should be wrapped into a wider review of the Agenda for Change pay structure to formulate a balanced package.**

Previous discussions on contract changes have taken time to deliver and it will be important for parties to get together quickly and decide if an agreement can be reached. Whilst the recent pay agreement in England included a commitment between parties to discuss a review of Agenda for Change, this did not include unsocial hours definitions and premia. The parties should give early consideration to including these in discussions. The pay agreement in Wales also included a review of Agenda for Change as part of the work of the Welsh Government's Review of the NHS workforce.<sup>1</sup> There is no such agreement in place in Northern Ireland and consideration will need to be given on how they might pursue this. **The parties should set a deadline to come to an agreement on a balanced package or decide if that is not possible. May 2016 is a date that parties have already agreed to work to in England. Wales and Northern Ireland will need to factor this in as appropriate for their individual circumstances.**

## *Transition and implementation issues*

Adverse changes in levels of earnings will, in our view, require some pay protection. The scale cannot be quantified without a better understanding of the proposals and how these may affect groups and individuals. Understanding the impact of shift patterns is key; the existing case study, early adopter and Vanguard sites could provide ready-made test beds for more detailed analysis. A similar modelling approach to that used to analyse working patterns for junior doctors could be useful here. **In order to maintain safe staffing levels and ensure staff are treated fairly, some transitional funding will be needed to cushion adverse impacts on those significantly affected by any adjustments to the pay system. The Department and other NHS bodies should develop their understanding of the scale of one-off funding that may be needed to implement any transition to an updated pay system.**

Staff engagement, and by this we mean staff being involved in the design and delivery of services as equal partners with management, is a key success factor from the case study and early adopter sites and a theme from the IDS case studies. Successful local implementation of pay-related changes requires support to line managers, as well as good design of the system by the HR function. Resource for local line managers is essential and use of early implementer sites could help with this process. **Staff engagement and involvement in changes to services is critical and the quality of local implementation will be key to delivering successful change. The Department of Health and employers should consider how far they should bolster the**

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<sup>1</sup> Originally the *NHS Workforce commission*, the commission is due to report findings in 2016. More information on the terms of reference and members of the commission is available from:  
<http://gov.wales/about/cabinet/cabinetstatements/2015/nhsworkforce/?lang=en>

capacity of line managers, as well as consider the use of Early Implementer sites to identify lessons. These will help to build the confidence of staff in the capacity locally to deliver such change.

Based on the evidence a key contractual barrier to expanding seven-day services appears to be the opt-out clause on non-emergency working at evenings and weekends in the consultant contract. The way in which that barrier is dealt with will impact on the willingness of our remit group to embrace change. **It will be important for the morale and motivation of our remit group that changes to reward packages between the two groups (medical and non-medical) are regarded as fair**, and supporting multi-disciplinary services for the benefit of patient care.

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

*17 June 2015*

## Summary of NHSPRB Observations

*Observation 1 (Chapter 2):* All parties are in agreement on their desire to improve patient care and support the implementation of a wider seven-day service where there is an identified clinical need to do so. This should provide a positive basis for future discussions and progress on the expansion of seven-day services.

*Observation 2 (Chapter 2):* Further work is needed to identify in more detail the potential productivity gains and efficiencies in the system that a move to seven-day services might release, alongside the improvements in patient care.

*Observation 3 (Chapter 3):* The pay structure should work to support and incentivise behaviours to ensure that shifts are scheduled principally around the needs of the patient rather than skewed by rules around shifts and payments.

*Observation 4 (Chapter 3):* The national Agenda for Change pay system presents no contractual barrier to the delivery of seven-day services; seven-day working is already well established for a number of core staff groups; and has been used at seven-day case study and early adopter sites across the United Kingdom.

*Observation 5 (Chapter 3):* As well as providing efficiencies, the move to seven-day services is likely to require more resources, namely more staff, and there are affordability aspects to consider for all countries. More analysis to model the likely scenarios in terms of increase in staff numbers and increase in unsocial hours would help the parties to understand better the cost implications.

*Observation 6 (Chapter 4):* There is not an overall typical pay approach or rate for out of hours service provision. The unsocial hours reward package is designed around the needs of the organisational service model. For the NHS this should be based on patient and service need.

*Observation 7 (Chapter 4):* Whilst some adjustments could be made, we have not found enough evidence to support wholesale changes to unsocial hours definitions and premia in isolation from the wider Agenda for Change pay system.

*Observation 8 (Chapter 5):* We note that those responsible for workforce planning and commissioning of training are not yet fully linked into local plans for seven-day services. Given the number of years it takes to train suitably skilled and qualified staff we believe a substantial barrier to the expansion of seven-day services could be insufficient numbers of appropriately trained staff.

*Observation 9 (Chapter 5):* There is a case for some adjustments to Agenda for Change unsocial hours definitions and premia. However, if done in isolation, this could risk the morale and motivation of staff, damage employee relations, exacerbate existing shortages, and, in particular, risk the good will of staff already working across seven days.

*Observation 10 (Chapter 6):* Although some changes could be made to unsocial hours definitions and premia, any major changes should be wrapped into a wider review of the Agenda for Change pay structure to formulate a balanced package.

*Observation 11 (Chapter 6):* The parties should set a deadline to come to an agreement on a balanced package or decide if that is not possible. May 2016 is a date that parties have already agreed to work to in England. Wales and Northern Ireland will need to factor this in as appropriate for their individual circumstances.

**Observation 12 (Chapter 6):** In order to maintain safe staffing levels and ensure staff are treated fairly, some transitional funding will be needed to cushion adverse impacts on those significantly affected by any adjustments to the pay system. The Department and other NHS bodies should develop their understanding of the scale of one-off funding that may be needed to implement any transition to an updated pay system.

**Observation 13 (Chapter 6):** Staff engagement and involvement in changes to services is critical and the quality of local implementation will be key to delivering successful change. The Department of Health and employers should consider how far they should bolster the capacity of line managers, as well as consider the use of Early Implementer sites to identify lessons. These will help to build the confidence of staff in the capacity locally to deliver such change.

**Observation 14 (Chapter 6):** It will be important for the morale and motivation of our remit group that changes to reward packages between the two groups (medical and non-medical) are regarded as fair.

# Chapter 1 – Introduction

## Introduction

- 1.1 In this report we set out our conclusions and observations on the seven-day services remit given to us by the United Kingdom Government, the Welsh Government and the Northern Ireland Executive. We summarise the evidence provided by the parties, and provide our analysis of this and other relevant data and information. We also include findings from our commissioned research. We hope that this report assists all parties in working together to make progress on the expansion of seven-day services for the benefit of patient care.
- 1.2 In this introduction we describe the report structure, our remit and approach to this work. We also include our sources for evidence and the context of relevant developments in the NHS.

## Structure of the report

- 1.3 This report is divided into six chapters, which consist of:
  - **this introduction** – setting out the remit, our approach and context for the report;
  - **the vision for seven-day services** – the case for change, priority services and staff groups, configuration of services and possible efficiencies;
  - **the Agenda for Change pay structure** – barriers and enablers in the existing pay structure;
  - **approaches to unsocial hours pay** – evidence from the parties on possible options, the Ambulance Service, sectors across the United Kingdom and the health sector internationally;
  - **impact of change** – recruitment, retention and motivation;
  - **conclusion** – considerations and next steps.
- 1.4 The appendices comprise of:
  - Appendix A – remit letters;
  - Appendix B – composition of our remit group;
  - Appendix C – call for evidence;
  - Appendix D – parties website addresses;
  - Appendix E – NHS England 10 Clinical Standards for seven-day services;
  - Appendix F – Agenda for Change unsocial hours payments;
  - Appendix G – NHS Employers’ summary of the estimated savings for their nine potential models;
  - Appendix H – international unsocial hours rates sources;
  - Appendix I – joint letter from NHSPRB and DDRB Chairs to the Secretary of State for Health;
  - Appendix J – list of previous reports published by the Review Body;
  - Appendix K – key to the abbreviations used in this report.

## The remits<sup>2</sup>

- 1.5 The Chief Secretary to the Treasury wrote to us on 31 July 2014 and confirmed that the NHSPRB would not be asked to make recommendations on a pay award for Agenda for Change staff in England for the 2015/16 pay round. The letter advised that the Review Body would be taken up on our offer to look into how a thorough review of the Agenda for Change pay structure might better support the NHS and the challenges it faces in

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<sup>2</sup> Copies of the remit letters are contained in Appendix A of this report.

terms of both patient care and affordability.<sup>3</sup> The Chief Secretary to the Treasury advised that the remit would be set out in the letter from the Parliamentary under Secretary of State for Health.

1.6 The detail of the remit for England was set out in the 28 August 2014 letter from the Parliamentary under Secretary of State for Health. This letter reaffirmed that the NHSPRB would not be required to report or make recommendations on pay for 2015/16. The letter asked the Review Body for 2015/16 to make observations on the barriers and enablers within the Agenda for Change pay system, for delivering healthcare every day of the week in a financially stable way, i.e. without increasing the existing spend.<sup>4</sup> More specifically the Review Body was asked to make observations on:

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

## Position of the Devolved Administrations

### Wales

1.7 The Minister for Health and Social Services wrote to us on 26 November 2014 confirming that the Review Body would not be required to report on, or make recommendations for, the year 2015/16 on the remuneration of employed Agenda for Change staff; the recruitment, retention and motivation of staff; and regional/local variations in labour markets. The letter asked that the observations requested by the Department of Health in respect of the Agenda for Change pay system and seven-day services, be extended to Wales.

### Northern Ireland

1.8 In his letter of 5 December 2014 the Minister for Health Social Services and Public Safety advised that the Northern Ireland Executive would not be seeking a recommendation from the Review Body on pay for 2015/16. The Minister asked for the Northern Ireland Executive to be included in the seven-day services remit.

### Scotland

1.9 The Scottish Government did ask the Review Body to report and make recommendations on pay for 2015/16.<sup>5</sup> The Scottish Government confirmed in their evidence for the pay round that they did not wish to be included in the seven-day services remit.<sup>6</sup>

## Remit to the Review Body on Doctors' and Dentists' Remuneration

1.10 The Parliamentary under Secretary of State for Health wrote to the Review Body on Doctors' and Dentists' Remuneration (DDRB) on 30 October 2014 providing a remit on contractual reform to support the delivery of healthcare every day of the week in a financially sustainable way. The remit to DDRB asked that they take account of progress

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<sup>3</sup> We observed in our 28th report: *We urge the parties to agree quickly a thorough review of the Agenda for Change pay structure, including the operation of incremental scales, so that it might better support the challenges facing the NHS in terms of both patient care and affordability. We suggest that if the parties find it difficult to agree we would be prepared to look into this if given an appropriate remit and evidence.* The 28th NHSPRB report is available from: <https://www.gov.uk/government/publications/nhs-pay-review-body-28th-report-2014>

<sup>4</sup> This was subsequently clarified to mean no increase in pay bill per FTE.

<sup>5</sup> The NHSPRB Scotland Report was published on 12 March 2015 and is available from: <https://www.gov.uk/government/publications/nhs-pay-review-body-scotland-report-2015>

<sup>6</sup> The Scottish Government set up a Sustainability and Seven-day Services Taskforce in April 2014. The taskforce published its interim report on 6 March 2015. The report is available from: <http://www.gov.scot/Publications/2015/03/7764>



already made towards contract reform for members of their remit group and also that they have regard to the read-across to the remit given to NHSPRB on Agenda for Change staff groups.

### Our comment on the remit

- 1.11 We sought to clarify what the constraint *without increasing existing spend* meant in practice. The Department of Health confirmed in their supplementary evidence that this meant at *no increase to the pay bill per full time equivalent (FTE) member of staff*. We understand this to mean that there is no restriction on an increase in staff numbers, should this be justified and cost effective, as long as the pay bill for each FTE stays the same or is lower.
- 1.12 Whilst the remits from England, Wales and Northern Ireland were the same, it is clear from their evidence that they are all at different starting points and have some different priorities in regards to their approach to seven-day services. Our report is focused on what we have identified as the core issues – although these core issues are common to all the countries there are also variations in approach. It will therefore be for each country to decide how they wish to respond to the observations in our report as suits their particular circumstances and where there may be scope to work together on common issues.
- 1.13 The **Department of Health** and **NHS Employers** provided some early proposals for possible options on pay reform for unsocial hours definitions and premia in their evidence submissions. These proposals are at a very early stage and have not yet been fully developed, modelled or costed. Both parties stated that these were not formal proposals and presented them as indicative options to be considered. The proposals are set out under the parties' evidence in Chapter 4 of this report, where we explore approaches to unsocial hours pay. We are clear that any formal proposals will need to be negotiated between the parties through the National Staff Council, and all parties were consistent on this position.
- 1.14 As well as the focus on unsocial hours definitions and premia, the evidence from the Department of Health made reference to the in-built cost of incremental progression and the need for a wider ranging review. Whilst other parties, such as NHS Employers and Providers, also made reference to incremental pay progression, again in the context of the need for a wider review of Agenda for Change, we did not receive detailed evidence on this area from all the parties and it was not included in the remit. Our focus for the report is therefore on unsocial hours definitions and premia.
- 1.15 We refer to seven-day services throughout this report and it is important to clarify this. We understand the aim of 'seven-day services' as a move towards the delivery of potentially more and/or different services over seven days and this will not necessarily mean delivering all services every day of the week at every location. This could range from the extension of a weekday service into the evening, the addition of a Saturday service or moving to a full 24/7 service. The NHS is already running a number of services over seven days and there are a variety of Agenda for Change staff groups who are required to work shifts during these times. For some of our remit group the change will therefore be minimal whereas for others it could be more significant. In order to embed the change successfully, this will involve both medical and non-medical staff groups changing existing working practices. We see the remit given to DDRB and progress for the medical staff group as key components of enabling change across the NHS, and for our own remit group.
- 1.16 The remit group for this report covers 1,219,007 (headcount) Agenda for Change staff across England, Wales and Northern Ireland. The detailed composition of the remit group can be found at Appendix B of this report.

## Our approach

1.17 Our approach is evidence-based and takes into account our standing terms of reference.<sup>7</sup> On 19 September 2014 we issued a call for evidence to the parties that usually contribute to our pay rounds. The call for evidence set out the factors from the remit letter and included our interpretation of the issues for consideration to inform the parties' submissions.<sup>8</sup> We are grateful to the following parties for their submissions:

- Department of Health, England;
- NHS England;
- Health Education England;
- NHS Employers;
- NHS Providers (formerly the Foundation Trust Network);
- Welsh Government;
- Northern Ireland Executive;
- Joint Staff Side;
- Royal College of Nursing;
- Royal College of Midwives;
- Unison;
- Unite the Union;
- Society of Radiographers;
- Chartered Society of Physiotherapists; and
- Federation of Clinical Scientists.

1.18 Copies of the parties' evidence are available from their websites which are listed in Appendix D.

1.19 Oral evidence sessions were held over two days in March 2015 with:

- the Parliamentary under Secretary of State for Health, officials from the Department of Health and HM Treasury representatives;
- NHS England;
- Health Education England;
- NHS Employers;
- NHS Providers;
- Welsh Government;
- Northern Ireland Executive; and
- Joint Staff Side.

1.20 In addition to the call for evidence from the parties, the Office of Manpower Economics (OME) also commissioned specific research on seven-day working practices and payments from Incomes Data Services (IDS).<sup>9</sup> This research undertook surveys and a number of case studies in different sectors from across the United Kingdom. Desk-based research from our secretariat provided additional information across the health sector internationally. The outcomes from the research are considered in more detail in Chapter 4 of this report.

1.21 Our work programme to produce this report included eleven meetings from December 2014 to June 2015 in which we considered and discussed the written and oral evidence, examined research findings and formed our conclusions and observations.

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<sup>7</sup> Our standing terms of reference can be found at page iii of this report.

<sup>8</sup> A copy of the call for evidence is set out in Appendix C of this report.

<sup>9</sup> The report is available from: <https://www.gov.uk/government/organisations/office-of-manpower-economics/about/research>

- 1.22 In addition to our meetings we undertook four fact finding visits to case study sites featured in the NHS England publication, *Equality for all: Delivering safe care – seven days a week*.<sup>10</sup> The trusts and health boards we visited are listed below:
- Royal Free Hampstead Trust – 24 hour, Seven-day Microbiology services;
  - Guy’s and St Thomas’ NHS Foundation Trust – Seven-day Respiratory Physiotherapy services;
  - Heart of England NHS Foundation Trust – Seven-day Therapy service; and
  - Aneurin Bevan University Health Board – Pan Gwent Frailty Programme.
- 1.23 These visits provided a valuable insight to how service change has been managed locally, the benefits obtained for both patients and staff and gave an opportunity to explore the issues faced in embedding such change. We extend our thanks to all those involved in organising the visits and the staff who gave up their time to answer our questions and discuss the issues with us.
- 1.24 NHS England has been using the experiences of healthcare providers to pilot new ways of working, inform thinking and future service developments. A number of these are referred to in this report, these include:
- Seven-day services case studies featured in the *Equality for all: Delivering safe care – seven days a week* – examples of service delivery models that are being used across the NHS to deliver clinical services outside the standard working hours and across the weekend period.
  - Eight volunteer trusts piloting the financial implications of introducing seven-day services for acute and emergency care – research carried out by the Healthcare Financial Management Association (HFMA)<sup>11</sup> for the NHS Services, Seven-days a Week Forum.<sup>12</sup>
  - Early Adopters<sup>13</sup> – the 13 sites who are testing and developing new models of seven-day services and care.
  - 29 Vanguard sites – looking at the New Care Models Programme<sup>14</sup> as one of the first steps towards delivering the *Five Year Forward View*<sup>15</sup> and supporting service integration. These are at a very early stage of development and have not yet communicated any learning about implementation.

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<sup>10</sup> Available from: <http://www.nhsiq.nhs.uk/resource-search/publications/nhs-imp-seven-days.aspx>

<sup>11</sup> Representative body for finance staff in healthcare. The report is referred to in more detail in Chapter 3 of this report and is available from: <http://www.england.nhs.uk/wp-content/uploads/2013/12/costing-7-day.pdf>

<sup>12</sup> Forum set up by NHS England to provide evidence and insight to support commissioners and providers to move towards routine services being available seven days a week. More information on the Forum and its findings are available from: <http://www.england.nhs.uk/ourwork/qual-clin-lead/7-day-week/>

<sup>13</sup> More information about Early Adopters is available from: <http://www.nhsiq.nhs.uk/improvement-programmes/acute-care/seven-day-services.aspx>

<sup>14</sup> More information on the Vanguard Sites and the New Care Models Programme is available from: <http://www.england.nhs.uk/ourwork/futurehhs/Syfv-ch3/new-care-models/>

<sup>15</sup> *The NHS Five Year Forward View* was published on 23 October 2014 and is available from: <http://www.england.nhs.uk/ourwork/futurehhs/>

## Context

- 1.25 The challenges currently facing the NHS provide important context for this report. It is clear that the difficult financial climate and resource constraints within the NHS continue to prevail and these challenges are likely to continue for the foreseeable future.<sup>16</sup> The NHS across the United Kingdom is operating in a context of rising demand pressures with an increasing and ageing population with health needs of varying complexity. Trusts and health boards are under pressure to meet safe staffing levels whilst working within challenging financial and affordability constraints. There are a number of competing priorities to manage and difficult decisions about where best to invest resources.
- 1.26 We note that the industrial relations climate within the NHS over the last 12 months has been difficult, with action taken over decisions made on pay. Indeed action has remained ongoing in Northern Ireland relating to the 2014/15 award. The 2015/16 pay agreement in England and the two year 2014/15 and 2015/16 deal in Wales have improved the industrial relations position in those countries. However, the strength of feeling around pay remains high and has been made clear to us both through our visits and the evidence received from the Joint Staff Side and individual trade unions.
- 1.27 Finally, we are submitting this report to a new government. The new government will be considering their vision and priorities for the NHS as well as their approach to pay. This will clearly have implications for progress on the expansion of seven-day services and the response to the observations in our report. We hope this report will provide a useful basis for all parties to consider how they can move forward and make progress in this area for the overall benefit to patient care.

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<sup>16</sup>The challenges facing the NHS have been set out in a number of recent reports:  
The Institute for Fiscal Studies (IFS) published the report *Challenges for Health Spending* on 3 February 2015, available from: <http://www.ifs.org.uk/publications/7556>  
The Kings Fund published a two part report *The NHS under the coalition government. Part One: NHS Reform* was published on 6 February 2015 and is available from:  
<http://www.kingsfund.org.uk/publications/nhs-under-coalition-government>  
*Part Two: NHS Performance* was published on 26 March 2015 and is available from:  
<http://www.kingsfund.org.uk/publications/nhs-performance-under-coalition-government>

## Chapter 2 – The Vision for Seven-day Services

### Introduction

- 2.1 In this chapter we examine the parties' evidence on the rationale behind the expansion of seven-day services. This explores the case for change; which services this might encompass and how they might be configured, including the staff groups required; and the potential to realise productivity or efficiency gains.

### Evidence from the parties – the case for change

- 2.2 The **Department of Health** told us that 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.
- 2.3 The Department of Health pointed out that, whilst patients expect the same quality of NHS services to be consistently delivered seven days a week, there was strong evidence of higher mortality and morbidity rates at weekends.
- 2.4 The Department of Health pointed to the 2013 Dr Foster Guide which set out concerning statistics about hospital care at weekends:
- Emergency overall mortality was 20 per cent higher for patients admitted at a weekend;
  - Mortality for patients who had routine surgery was 24 per cent higher if the operation is later in the week and just before the weekend;
  - The likelihood of repairing fractures on the day of admission was 10 per cent lower at weekends;
  - The likelihood of waiting for more than two days for a broken hip replacement was 24 per cent higher on weekends;
  - The likelihood of getting emergency imaging (MRI scans) on the day of admission was 42 per cent lower at weekends;
  - Readmissions were 3.9 per cent higher following treatment at a weekend.
- 2.5 **NHS England** told us that a substantial body of national and international evidence points to significant variation in health outcomes for patients admitted to hospitals at the weekend. In the NHS in England, this variation is seen in mortality rates, patient experience, length of hospital stay and re-admission rates. NHS England told us that early findings from a recent analysis<sup>17</sup> of Hospital Episode Statistics linked to Office for National Statistics data from 2013/14 indicate a clear "weekend effect". The study used a similar approach to the mortality analysis for data from 2009/10. The data from the analysis is shown in table 2.1 below.

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<sup>17</sup> Study conducted by University Hospitals Birmingham (UHB) and University College London through the Quality and Outcomes Research Unit at UHB.

**Table 2.1 – Analysis of the risk of 30 day mortality**

Admission Day	30 day mortality when compared to Wednesday admissions			
	2009/10		2013/14	
Friday	0%	↔	2%	↑
Saturday	11%	↑	10%	↑
Sunday	16%	↑	15%	↑
Monday	2%	↑	5%	↑

1. The weekend effect remains even if people who die within 3 days of admission are excluded.
2. While the overall number of patients admitted at the weekend is lower, the proportion of very sick patients is higher, on average, than during the week. There is an increased proportion of elderly and young admissions. On a risk score of 0=lowest risk of death to 4=highest risk, the proportion of low risk patients is constant throughout the week, but the proportion of high risk patients increases by 25 per cent on a Saturday and 30 per cent on a Sunday.
3. The ratio of harm to no harm incidents increases at weekends.
4. For the 2009/10 data the Wednesday to Saturday and Wednesday to Sunday differences are highly statistically significant.
5. For the 2013/14 data the Wednesday to Monday, Wednesday to Friday, Wednesday to Saturday and Wednesday to Sunday are all highly statistically significant.

Source: NHS England

2.6 NHS England told us that the model of integrated seven-day services across a number of specialties at the Acute Medical Unit in Epsom General Hospital achieved a reduction in average length of stay from fifteen days to two days in less than six months, and patients were now regularly discharged on the weekend. NHS England told us that diagnostics had been highlighted as important in supporting seven-day service delivery and the need to identify those diagnostics that are of clinical necessity over seven days and have the greatest impact on patient outcomes.

2.7 **Health Education England** told us that it supported the view that a move towards seven-day services for the NHS would provide better, safer and more responsive services to patients and lead to a more efficient use of NHS resources. Health Education England recognised that, in some settings, the NHS already provided continuous services over seven days and many staff on Agenda for Change contracts already provide care over seven days a week.

2.8 **NHS Employers** told us that the Francis Report<sup>18</sup> had noted patients felt more vulnerable at weekends when staff absences and shortages were more noticeable, and it was becoming apparent that a five-day service model was no longer fit for purpose in providing safe, efficient care, or in meeting the public’s expectations for standards of care. NHS Employers said that a move towards seven-day services for the NHS would provide better, safer and more responsive services for patients and lead to a more efficient use of NHS resources. NHS Employers stated that seven-day service provision would potentially enable NHS organisations to make more productive use of high-cost diagnostic equipment and operating theatres which tended not to be fully utilised at weekends or evenings.

2.9 NHS Employers referred to the summary of initial findings from the Seven Days A Week Forum<sup>19</sup> which had underlined the higher mortality rates for patients admitted to hospital at the weekend. The causes included:

- variable staffing levels in hospitals at the weekend;
- fewer decision makers of consultant level and experience;

<sup>18</sup>The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published on Wednesday 6 February 2013. Available from: <http://www.midstaffspublicinquiry.com/report>

<sup>19</sup>Forum set up by NHS England to provide evidence and insight to support commissioners and providers to move towards routine services being available seven days a week. More information on the Forum and its findings are available from: <http://www.england.nhs.uk/ourwork/qual-clin-lead/7-day-week/>

- a lack of consistent support services, such as diagnostics; and
  - a lack of community and primary care services that could prevent some admissions and support timely discharge.
- 2.10 NHS Employers told us that evidence from case studies had shown relatively small steps from departments in organisations could have big long-term benefits. Of the initiatives reported so far<sup>20</sup> emerging themes were:
- junior medical and nursing staff are better supported and the opportunities for training increased;
  - patient safety (at all times) is improved;
  - hospital admissions and the average length of stay are reduced; and
  - reductions in bed occupancy reduce nursing costs, and release resources for extra support elsewhere at weekends, for example physiotherapy.
- 2.11 **NHS Providers** told us that the clinical case has been, and was being made by NHS England and others; delivering more services seven days a week “would improve clinical outcomes, with the added benefit of providing a much more patient focussed service”.<sup>21</sup> NHS Providers told us that it welcomed the delivery of more NHS services over seven days as it meant better, consistent care for patients.
- 2.12 The **Welsh Government** told us that there was general consensus that there is a clear need for 24/7 care in the community to support people to be cared for in home settings. The Welsh Government stated that areas requiring strengthening in the acute hospital setting needed to be seen through a quality and safety lens, which included timely diagnosis, treatment and discharge. The Welsh Government advised that some situations in which it needed seven-day services to make a positive impact may include:
- Improved community and primary care services, including community pharmacy, district nursing, palliative care and ‘hospital at home’ type services.
  - GP cover for nursing and care homes.
  - Senior clinical decision makers available for hospital in-patients.
  - ‘Face-to-face’ clinical review is needed for all acute medical, surgical or post-operative patients or for patients that are fit for discharge.
  - Timely access to diagnostics and therapies.
- 2.13 The Welsh Government believed that whilst there was a need to deliver more services across seven days, it wanted any changes to improve NHS healthcare. The Welsh Government believed there was an important distinction between running equitable unscheduled care over seven days, and using elective NHS facilities seven days a week. The Welsh Government explained that there was more work to do to assess actual demand from the public, although being better able to schedule activity into the early evenings and on Saturday mornings was judged to be something that would be welcomed by patients and families alike.
- 2.14 The **Northern Ireland Executive** told us that whilst seven-day services was an ambition for the health service in Northern Ireland, there were clear cost implications and the financial position made the expansion of seven-day services problematic in the short-term. The Northern Ireland Executive explained that it could only consider expansion of seven-day services on a cost neutral basis in net terms. The Northern Ireland Executive said the introduction of more services over seven days needed to be where it was appropriate, with trusts having the flexibility to make decisions about where seven-day services were necessary. The Northern Ireland Executive’s aim was to make this a possibility for trusts where they felt able to do so.

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<sup>20</sup> These were mainly, but not exclusively, in acute services in the hospital sector.

<sup>21</sup> NHS England (December 2013), NHS Services, Seven Days a Week Forum: Summary of Initial Findings, London p5. Available from: <http://www.england.nhs.uk/wp-content/uploads/2013/12/forum-summary-report.pdf>

- 2.15 The **Joint Staff Side** told us that the NHS trade unions support the impetus and rationale for seven-day services, where it can be evidenced as enhancing clinical and service outcomes and that many of its members already work on a seven day basis.
- 2.16 The **Royal College of Nursing** told us that there is a strong body of national and international evidence showing the higher risk of mortality from being admitted to hospital at the weekend. The Royal College of Nursing believed it was likely this could be attributed to system and infrastructure factors such as the lack of availability of diagnostic and specialist interventions over the weekend, as well as the reduction in staff, the reliance on less experienced staff and the increase in staff stress over the weekend. The Royal College of Nursing told us that in 2011 Dr Foster Intelligence published findings showing higher mortality rates at the weekend and attributed this risk to lack of consultant-grade presence.
- 2.17 The Royal College of Nursing told us that it believed the public have a right to expect that the treatments and care they need would be available to them when they need them and in ways that address their individual situations and circumstances. The Royal College of Nursing said that for this to happen, the United Kingdom's healthcare systems must facilitate both extra resources and a shift of a sizeable amount of care from acute to community settings.
- 2.18 The **Royal College of Midwives** told us that it had not seen any evidence that women and their partners would want clinic appointments on evenings and weekends bearing in mind that, legally, pregnant women have a right to time off work to attend antenatal appointments.
- 2.19 **Unison** told us that staff side unions accept that improving patient services is a valid driver to look at the re-configuration of services but were concerned the evidence so far focused only on emergency care and supporting diagnostic services. Unison stated that to ensure depth to this work and for the 'vision' of seven-day services to be a success it needed to include social care and the whole health economy.
- 2.20 **Unite** told us that it supported all initiatives that are clinically evidenced to improve services for patients. Unite said that in some areas there was clinical evidence for seven-day services, for example in pharmacy, but in others there may not be the demand for the services to justify the expense.
- 2.21 The **Society of Radiographers** told us that it recognised the need for seven-day working and had, for many years, worked with local NHS trusts to implement agreed systems of work.
- 2.22 The **Chartered Society of Physiotherapists** told us changes to existing service organisation should be introduced to have a positive impact on patient care and to improve the quality, timeliness, accessibility and efficiency of service provision. The Chartered Society of Physiotherapists said that meeting quality standards was unlikely to be cost-neutral. The Chartered Society of Physiotherapists stated that many of its members had been involved in developing and implementing six- or seven-day services, or have extended the hours of a service. In its experience introducing seven-day services does not necessarily achieve improved quality outcomes for patients or efficiencies in service delivery.
- 2.23 The **Federation of Clinical Scientists** told us that it strongly supported the objective of reducing the unacceptable variance in patient outcomes. The Federation of Clinical Scientists said that it would be keen to discuss both at national and local level how to deliver more effectively what the healthcare system needs. The Federation of Clinical Scientists recognised the economic and clinical wisdom of using high capital cost



diagnostic and therapeutic equipment and facilities over an extended time, however, believed that more intensive use of equipment was likely to increase failure rates, shorten usable lifetime and necessitate earlier capital re-investment.

## Evidence from the parties – delivery of services

- 2.24 The **Department of Health** told us the move to seven-day services was focused on efficient use of existing resources and 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. The Department of Health said NHS organisations were not expected to implement the same configuration of services currently delivered Monday to Friday over seven days. Instead, this was 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.
- 2.25 The Department of Health told us that the (seven-day services) Forum’s Clinical Standards describe the quality of care patients should receive every day of the week and these took a holistic approach, including Mental Health, Diagnostics, Interventions, and Community, Primary and Social Care.<sup>22</sup> The Department of Health believed that alignment across primary, community and secondary health services, and social care, would help to maximise the benefits of adopting clinical standards, prevent admissions and re-admissions, and support safe, timely discharge.
- 2.26 The Department of Health told us that there was no ‘one size fits all’ approach to the delivery of seven-day services and local affordable solutions would need to be found. The nature of services offered locally seven days a week would depend on demographic demand, existing provision, and local organisational strategy. The Department of Health stated that employers were best placed to determine the skill mix of their workforce and had the freedom to deploy staff in ways appropriate for local needs and conditions.
- 2.27 **NHS England** told us that urgent and emergency care services are recognised widely as a key area that should expand provision to seven days a week and evidence had shown Accident and Emergency (A&E) attendance could be reduced by an average of 11 per cent through measures such as co-locating an urgent care centre (UCC) or providing a GP-led service within A&E departments. NHS England said services which would deliver the greatest clinical benefits, if extended to every day of the week were:
- condition triage, assessment and treatment;
  - access to diagnostics;
  - end of life care;
  - condition specific units (e.g. stroke units);
  - mental health services;
  - therapy services (physiotherapy and occupational therapy );
  - major trauma units; and
  - access to procedures (e.g. interventional radiology).
- 2.28 NHS England told us that the 10 clinical standards developed by the Forum describe minimum standards of care for urgent and emergency care services in acute settings that patients should expect to receive in all health communities. NHS England said that these were being embedded in the NHS Standard Contract and it had taken further practical steps by asking commissioners to put in place contracts with providers containing an action plan to prepare for implementation of the standards in Service Development and Improvement Plans (SDIPs). NHS England told us that trusts were encouraged to work together with commissioners to agree which hospital provides each of the 10 clinical standards across their local health economy, exploring new ways of working.

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<sup>22</sup>The NHS England 10 Clinical Standards for seven-day services are included in Appendix E of this report.

- 2.29 NHS England told us that as medical services move to seven day delivery, so too will demand for Allied Health Professionals' (AHP) services, diagnostic services and services in areas such as pharmacy. NHS England said there would be a need for all staff groups to deliver seven-day services, and that skill-sharing, and the development of new and extended roles which can support provision, would be critical.
- 2.30 **Health Education England** told us there was not yet clarity, nationally or locally, on the service models that will be used to underpin the wider implementation of seven-day services. As a result, NHS providers were not yet reflecting this in their local workforce forecasts, on which the overall Health Education England plans are based. Hence it did not yet have a detailed view of the impact of seven-day services on the future demand and supply of NHS staff.
- 2.31 **NHS Employers** told us more senior doctors, decision makers and support staff need to be present and working in the hospital more of the time, if patient outcomes are to be equally good every day of the week, and at all times of the day. NHS Employers said this would mean that, over time, more staff would need to work later in the evenings and weekends. NHS Employers stated that there will need to be ready access to services such as pharmacy and physiotherapy, and that these, together with appropriate access to radiology and pathology services, would allow decisions on a patient's care to be made at the right point. NHS Employers told us that the future development of seven-day services could not be restricted only to the hospital sector but needed to cover the whole healthcare system; hospital services could not function efficiently at the weekend if community and primary care services were not equally accessible.
- 2.32 **NHS Providers** told us that a proper assessment of local context, including demand, would be important. For some services, in some areas, delivering six-day services may be more appropriate. NHS Providers said that it was also crucial that the implementation of a seven-day service was appropriately phased, costed, and funded, to avoid destabilising the clinical and financial viability of NHS providers.
- 2.33 The **Welsh Government** told us that the Primary Care Plan had been launched by the Deputy Health Minister in November 2014 and would develop primary care services in Wales by including all those organisations and services in communities which can help to improve the quality of care at or as close to home as possible. Under the plan:
- Healthcare will be planned and delivered locally – assessment, treatment and ongoing care will be available in, or as close as possible to, people's homes, with rapid and more local access to more specialist clinical advice.
  - Access to services will be improved – more use of modern technology and better information, advice and assistance to support effective self care and care from a wide range of the right professionals, including pharmacists and nurses, on the same day, either face-to-face, on the phone, by e-mail, or instant/video messaging.
  - Quality of services will be improved – to support improved health and self care, there will be more co-production of care, more integrated teams of health and social care professionals working around the person, who are trained to provide a wider range of more personalised care, acting on feedback on patient experience and peer review.
  - A skilled local workforce – the development of a national plan for the development of a re-modelled primary care workforce working together to deliver care, based on an understanding of need and the numbers and mix of skills needed.
  - Strong leadership – a national programme of work to support local action. A national professional lead for primary care will be appointed.
- 2.34 The **Northern Ireland Executive** said that a possible delivery model for seven-day services may involve spreading resources for a traditionally five day service over seven days but did not wish this to be at the expense of the weekday service. The Northern

Ireland Executive did not want to be prescriptive about the services and it would be important for trusts and employers to work together to identify these. At this stage there had been no priority areas identified, although there were some examples, such as physiotherapy, pharmacy and radiography services, where work was already taking place across seven days. The Northern Ireland Executive said it would be for the Commissioner and local healthcare providers to decide on the delivery of services and level of local flexibility, and there may be different service levels subject to demand.

- 2.35 The **Joint Staff Side** told us that there is a lack of clarity around the proposed objectives of the seven day care model and implications for the workforce. The Joint Staff Side said there had been no modelling of the impact of seven-day services on staff numbers, safe skill mix, the occupations affected or staff working patterns. The Joint Staff Side stated that there was a need to ensure senior staff with the appropriate decision-making authority (medical and non-medical staff) were available to support healthcare teams, that staff are fully trained and resourced to face new roles and demands, that necessary equipment is made available and maintained, and that wards, teams and departments are safely staffed.
- 2.36 The **Royal College of Nursing** told us that any decision about seven day care should involve a service specification, from which a whole workforce model can be developed setting the types of disciplines or professions and settings involved. The Royal College of Nursing stated that case studies also point to the need to consider seven-day services in the context of local requirements and circumstances; seven-day care may be more appropriate in some areas and contexts than others and it would not be appropriate to impose requirements or targets.
- 2.37 The Royal College of Nursing said that providing seven-day care would require extra resources, not only in acute services, but in community and primary services in order to create and support the development of a system-wide, integrated approach, as well as an increase in support or 'back office' services such as Finance, HR and maintenance.
- 2.38 The **Royal College of Midwives** told us that the Government needed to determine what precisely was meant by seven-day services and how that affects different occupational groups, and that this should be done in partnership with NHS trade unions. The Royal College of Midwives said that seven-day services should be determined following research and evidence of the demand from service users, and designed around that evidence.
- 2.39 **Unison** told us there was ambiguity about how the vision will be translated into practice, taking into account the cost and staffing implications. Unison said that many of its members across the United Kingdom already deliver services and care for patients within the NHS seven days a week, and are a flexible and committed workforce.
- 2.40 **Unite** told us that providing seven-day services would need more staff and funding. Unite believed that it would be impossible to deliver the same level of service by spreading the existing five day workforce over seven days. Unite said in many areas spreading health services across weekends made no sense unless other services are also running and that non-NHS services need to be operating and integrated. Unite told us that hospital staff reported there would need to be a link up with social care over seven days or many hospital discharges could be blocked. Unite health visitors also stated that without other council services, such as social work, available it would be difficult for them to operate.
- 2.41 The **Society of Radiographers** told us that without full consideration of the social consequences, appropriate staffing levels and consideration of the wider implications for employment, the hoped-for service improvements would not emerge. The Society of Radiographers said that virtually all of the diagnostic and, to a limited extent, treatment services, can be delivered 24/7, and whilst the current focus was on A&E and urgent

care, this was only one of a raft of services that could be operational over a seven day week. The Society of Radiographers said that due to the many integrated systems operating within a hospital, and the variation between trusts, there was no 'one size fits all' and the tendency was to produce bespoke systems to meet local need.

- 2.42 The **Chartered Society of Physiotherapists** told us that services must be based on the principles of integrated service delivery, in the interest of patient care, across teams, professions, settings and sectors. The Chartered Society of Physiotherapists said that these must be properly funded and resourced, including action to achieve effective staffing levels and skill mix, and with investment in staff development and support to ensure successful implementation.
- 2.43 The **Federation of Clinical Scientists** told us there was considerable scope to better support 24/7 working through the more widespread and imaginative use of technology, particularly communications and Information Technology. The Federation of Clinical Scientists believed there was considerable scope for more innovative approaches to work in healthcare and "working differently", by open discussions and effective partnership working between unions and employers.

### **Our comment**

- 2.44 The argument for the expansion of seven-day services to tackle the "weekend effect" on patient outcomes, including mortality rates, is compelling. This is an area where all parties are in agreement, and this common desire to improve patient care provides a positive basis in which to frame further discussions. From the feedback we received at our visits to case study sites, and from the evidence presented from the Joint Staff Side and individual trade unions, it is clear that, where a case can be made on the grounds of clinical need and improvements to service, staff are generally willing to support and help enable the change to seven-day services.

#### ***Observation 1***

**All parties are in agreement on their desire to improve patient care and support the implementation of a wider seven-day service where there is an identified clinical need to do so. This should provide a positive basis for future discussions and progress on the expansion of seven-day services.**

- 2.45 There is however, a lack of detail on which Agenda for Change staff groups will be required to extend over seven days; in what ways staff will be deployed in terms of skill levels, numbers and working times; and at what scale. The NHS England 10 clinical standards set out the minimum standards of care for urgent and emergency care services in acute settings that patients should expect to receive in all health communities. The standards are clear about the need for increased consultant presence and availability of diagnostics, but as yet the changes for the corresponding Agenda for Change nursing, scientific, therapeutic and technical (for example pharmacists and physiotherapists), and administrative staff groups required to support this have not been spelt out in detail. It is noteworthy that a number of these groups are already delivering care over seven days.

- 2.46 We recognise that there is not intended to be a 'one size fits all' model for the delivery of seven-day services, and that there will be local variation dependent on patient need and priority. For example, geographical differences will provide important context for any chosen delivery model; what is appropriate for a large inner city hospital will differ from a small community hospital. These differences in approaches will mean that the frequency of weekend working, and the types of shift that staff are required to work, will vary subject to location, job type and the service being delivered. To ensure that weekday outcomes are not compromised as an unintended consequence of service changes, systems and approaches will need to be designed carefully. As we have been told, simply spreading the existing workforce and model of service over seven days will not produce the desired benefits in all cases.
- 2.47 Whilst the initial focus is on improving urgent and emergency care in order to reduce mortality rates, nonetheless there will be consequences for other service areas. A number of related services will need to move in tandem, in order for the system to work effectively and ensure existing blockers to improved patient flow and throughput are removed. This will include related services within the hospital setting, and improved integration and access to social care services outside of the hospital. These are not yet described beyond individual case studies and it will be imperative that these wider service changes are aligned, to ensure a move to seven-day services can be successfully implemented. There are examples of integrated services across the United Kingdom and these may be well placed to provide best practice examples and to test out different models of service delivery.
- 2.48 There appears to be potential for efficiencies in the healthcare system through a move to seven-day services, for example from improved patient care, better patient flow through the system, reduced length of stay in hospital and better utilisation of assets and resources. In the context of the financial constraints that trusts and health boards are operating under it will be important and helpful to identify these. We appreciate that such productivity gains are difficult to measure, and recognise that all parties are uncertain whether such changes could offer up any meaningful savings to be reinvested elsewhere. The early adopter sites offer a ready-made opportunity to analyse cost savings and benefits to the service.

***Observation 2***

**Further work is needed to identify in more detail the potential productivity gains and efficiencies in the system that a move to seven-day services might release, alongside the improvements in patient care.**

## Chapter 3 – The Agenda for Change Pay Structure: Barriers and Enablers

### Introduction

- 3.1 In this chapter we explore the parties' evidence on the existing mechanisms in the Agenda for Change structure that act as barriers or enablers to the introduction of more services over seven days.

### Evidence from the parties

- 3.2 The **Department of Health** told us that it must continue to invest in and protect the NHS frontline. The cost of the pay bill equates to approximately 60 per cent of local NHS expenditure and is a critical element of how employers are able to extend services in an affordable way. The Department of Health stated that the NHS employment contracts, in place for more than a decade, do not reflect the significant increase in demand for NHS services, and in public expectations around quality and responsiveness.
- 3.3 The Department of Health told us that the way that the week is separated into 'plain time' and 'unsocial hours' within Agenda for Change is out of line with a 24/7 modern NHS system and the needs of patients. Employers want greater flexibility to schedule services seven days a week within their available financial resources and the current contractual arrangements are perceived as a barrier to the affordability of delivering services seven days a week. The Department of Health believed that if there were changes to the periods of plain time working and the rates payable for premium time working, employers would be more able to schedule their staff to provide services into the evenings and at weekends within existing budgets. This could mean more affordable opportunities for employers to develop and utilise a flexible workforce; and less reliance on agency staff.
- 3.4 The Department of Health stated that premium pay rates can incentivise staff to provide care at evenings and weekends, but do not reflect modern employment practice. The Department of Health believed that unaffordable premium pay rates stifle innovation and act as a barrier to the delivery of seven-day services. The Department of Health told us that this did not mean premium pay rates have no place in the NHS, but that they should be affordable and better targeted. The Department of Health said that it would be right to consider whether the current rates and the periods they apply to are necessary to retain and recruit staff, and whether they are appropriate for the aspirations of a modern NHS. The Department of Health also pointed to the provision within Agenda for Change which allows a whole shift to be paid at unsocial hours rates where more than half the shift falls within unsocial hours.
- 3.5 The Department of Health stated that this is not an issue limited to the Agenda for Change staff groups. A key barrier in the consultant contract was the right of consultants to opt out of non-emergency work in the evenings and at weekends, which meant higher costs for trusts by employing consultants (sometimes the same consultants) at much higher, extra-contractual rates during those times.
- 3.6 The Department of Health told us it did not believe that the reform of out of hours pay can be considered in isolation from the wider pay system. The Department of Health believed that 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. The Department of Health told us that unsocial hours pay costs at least £1.8 billion for employed non-medical staff a year, and the current system of incremental pay progression within Agenda for Change has a cost pressure of over £550 million per

year. The Department of Health believed 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.

- 3.7 **NHS England** told us the scale of financial and quality pressures in the NHS is unprecedented. NHS England said NHS providers and commissioners face difficult choices when deciding where to invest resources in order to maximise the outcomes for patients and value for taxpayers. NHS England stated that the move to deliver services seven days a week should therefore not be viewed in isolation from the other changes taking place. NHS England told us they had identified a number of constraints, including, Agenda for Change staff pay, consultant and GP contracts, and working time, which constrain staffing and create uplifts for weekend work, thus increasing the cost.
- 3.8 **Health Education England** told us the out of hours payments for staff do not reflect the reality of care in many specialties, and the contractual right for consultants to refuse non-emergency work at weekends and in the evening does not reflect the patient-centred NHS, jointly aspired to in the Five Year Forward View. Health Education England recognised that there was a consensus among employers that they are looking for more flexibility around conditions of service, including unsocial hours arrangements, to give them more scope to address local challenges. Health Education England supported the need for joint (employer and staff-side) discussion and agreement on the changes that will be needed to terms and conditions, to support a concerted effort towards establishing seven-day services on a wider basis.
- 3.9 **NHS Employers** told us that the statutory consultation on the 2015/16 national tariff, launched in November by Monitor and NHS England, had indicated NHS provider organisations would be required to deliver efficiency savings of 3.8 per cent during 2015/16. NHS Employers said this was a demanding challenge, and an impact assessment of the proposed efficiency factor suggested that almost half of providers were forecast to end 2015/16 with a deficit if the efficiencies were delivered in full; if only 3 per cent efficiencies are delivered, almost three-quarters of providers were forecasted to be in deficit.
- 3.10 NHS Employers confirmed that many of the staff covered by the Agenda for Change agreement already had seven-day working patterns. This was a reality for nurses, midwives, radiographers, clinical support staff, porters and cleaners. NHS Employers said there was no contractual barrier to prevent staff working over seven days. They told us that working patterns had always been determined locally and were not dependent on national agreements.
- 3.11 NHS Employers told us that, in their HR Barometer Survey, 60 per cent of responders said that the Agenda for Change unsocial hours provisions needed to be reviewed, whilst over 26 per cent listed the cost of paying unsocial hours enhancements as being a barrier to implementing more seven-day working. NHS Employers believed that in a 24/7 service like the NHS, there was a need for more hours in the week to be paid at plain time, and for enhancements to be at a lower level. They said employers were concerned that the current level of pay enhancements will not be sustainable in the longer term and will serve to make comprehensive seven-day working unaffordable.
- 3.12 NHS Employers told us that, if all working hours were paid at plain time, employer costs would reduce by around £1.44 billion, or 4.2 per cent of the pay bill. However, they pointed out that this was not a model that had been advocated by many employer representatives. There was a range of views amongst members of NHS Employers about how the unsocial hours pay enhancements should be recast to be more supportive of seven-day working; feedback ranged from a small minority who suggested no hours of the week should attract any enhancements, to those seeking only minor adjustments to

the current provisions. In response to the NHS Employers online survey, 82 per cent agreed that the NHS needed to continue to pay enhancements for some unsocial hours working. There was strong support for paying some enhanced rates for working at night, Sundays and public holidays, though many would like to see the rates for these periods reduced from their current levels. There was less support for needing to pay extra for evening and Saturday working.

- 3.13 NHS Employers told us that they are looking for more flexibility around conditions of service to provide more scope to address local challenges. In the recent Health Service Journal (HSJ)/NHS Employers HR Barometer survey, over 80 per cent of responders agreed that there was a need for a review of Agenda for Change. Key priorities included changes to the pay structure with shorter pay scales, and adjustments to the incremental progression system building upon the changes agreed by the NHS Staff Council in 2013.
- 3.14 NHS Employers stated that, whilst the relatively high cost of unsocial hours premia need to be addressed, it was not the most significant challenge. The bigger barriers related to workforce supply of some key staff groups, particularly medical staff and, to a lesser extent, nurses.
- 3.15 **NHS Providers** told us that they have previously highlighted the need for an overhaul of NHS pay, terms and conditions. NHS Providers believed that the current terms and conditions do not adequately match reward with performance or enable smooth transitions between health and social care. NHS Providers stated that pay accounts for between 60 and 85 per cent of a provider's expenditure, and a sustainable balance must be found, where the costs of national staff contracts of delivering new models of care, including more seven-day services, are adequately resourced, and quality of patient care can be maintained. In response to a recent survey of members, just under three-quarters suggested they would not be able to deliver more seven-day services within the existing budget without reform of Agenda for Change.
- 3.16 NHS Providers were clear that there were barriers unconnected with Agenda for Change that affected seven-day services. The consultant doctor contract was seen as the biggest barrier, and in particular the right to decline non-emergency work outside of core hours. This was stated as a contractual barrier, not an affordability barrier.
- 3.17 NHS Providers told us that most providers of NHS care saw a national agreement on pay, terms, and conditions as a potential enabler for seven-day services, but only if sufficient flexibility to meet local circumstances, and to deliver new models of care (like seven-day services), was built in. NHS Providers believed that premiums paid for unsocial hours need to be reviewed, and overall reduced. There was a broad consensus amongst providers, that evenings Monday to Friday and all day Saturday needed to be redefined as core hours. NHS Providers acknowledged that this would require a big cultural change but believed that such a shift is needed if the NHS is to meet the needs and expectations of today's patients.
- 3.18 The **Welsh Government** told us that the Welsh NHS continues to face significant challenges, including rising costs, increasing demand, an ageing population, and a growth in the number of people experiencing chronic conditions. The independent report published by the Nuffield Trust in June 2014<sup>23</sup> concluded that, without taking action to manage demand on NHS services, the NHS in Wales would face a funding gap of around £1.2 billion by 2016. The Welsh Government explained that by maintaining the productivity and efficiency measures already taken, this could be reduced to £221 million. The Welsh Government told us the report also commented that maintaining a focus on the pay costs would be a key component of meeting the substantial future financial challenge.

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<sup>23</sup> A copy of the report *A decade of austerity in Wales? The funding pressures facing the NHS in Wales to 2025/26* is available from: <http://www.nuffieldtrust.org.uk/publications/decade-austerity-wales>



- 3.19 The Welsh Government told us the clinical treatment areas that have begun to extend working patterns across seven days have achieved local buy-in and there have been no known issues or barriers resulting from existing contracts and terms and conditions of service. The Welsh Government explained that the independent review of the NHS workforce to be undertaken in Wales in 2015 will consider new models of delivery based on service and patient need and an analysis will be undertaken of the barriers experienced by such models and associated ways of working. The Welsh Government stated that flexibility around conditions of service will be critical in developing new models of delivery, and it may be that unsocial hours pay enhancements are an area needing reform. The Welsh Government said, however, at this stage there was no firm evidence to confirm that the existing premia would act as a barrier to extending working patterns. The Welsh Government confirmed that contract reform could be one of the key enablers of seven-day services but that this must apply across the whole workforce, including medical and dental staff.
- 3.20 The **Northern Ireland Executive** told us that a preliminary assessment by the Department had identified a plan to deliver financial balance for 2015/16 and address all unavoidable cost pressures, but that this could only be achieved if there are no service developments and if a significant savings delivery target is achieved. As such, any move to deliver seven-day services in the NHS in Northern Ireland must be cost neutral. The Northern Ireland Executive confirmed that there was not an expectation that there should be a flat rate of pay across seven days without any premia, but that there was scope to make the payments more effective and minimise costs. The Northern Ireland Executive confirmed that any change to terms and conditions would need to be balanced against what the wider reward package offers.
- 3.21 The **Joint Staff Side** told us that unsocial hours payments are an important and integral part of the Agenda for Change agreement, as they perform a critical function in compensating for increased cost of caring responsibilities during evenings, nights and at weekends; for travel to and from work during unsocial hours; for the impact on health; and the impact on family life. All trade unions were consistent on their views on this in their evidence. The Joint Staff Side believed the review was being driven by a wish to amend current Agenda for Change pay arrangements; in particular to reduce current unsocial hours pay provisions, rather than to extend and improve services.
- 3.22 The **Royal College of Nursing** told us that nursing staff already provide a seven-day service, ensuring that the NHS operates at weekends and nights. The Royal College of Nursing said that its members were committed to seven-day services and the majority will, over their careers, work unsocial hours. This meant working hours at nights and weekends that the majority of other NHS staff were not required to do, and that they expected fair compensation.
- 3.23 The Royal College of Nursing said that specialist nurses who work in advanced and extended roles often worked across organisational boundaries, leading multidisciplinary teams and providing expert knowledge and advice, while senior nurses undertake vital management and leadership, as well as clinical roles. It told us that many specialist and senior roles were often limited to five day weekday working and in some cases senior nurse deployment in acute areas at weekends was limited as employers were reluctant to pay enhanced rates for this work.
- 3.24 The **Royal College of Midwives** told us that midwives and maternity support workers have always worked shifts and provided care on that basis and will continue to do so. The Royal College of Midwives strongly objected to any reforms of unsocial hours payments that would disadvantage a substantial section of the NHS workforce. The Royal College of Midwives believed the payments provided fair compensation for the increased costs of travel and childcare at nights and on weekends. The current system enabled

midwives to work nights and weekends and without unsocial payments many midwives and maternity support workers would be unable to afford the increased costs of working at these times.

- 3.25 The Royal College of Midwives told us that any proposals to change the existing Agenda for Change agreement, including unsocial hours payments, must be discussed through the NHS Staff Council. All trade unions were clear and consistent on this position in their evidence. The Royal College of Midwives believed the unsocial hours payments were fair compensation and the enabler for seven-day services. The Royal College of Midwives believed that additional costs for providing seven-day services could not be recouped from further pay restraint.
- 3.26 **Unison** told us that it recognised the unprecedented financial challenges faced by the NHS but was disappointed the focus of the remit was on cuts to unsocial hours payments rather than on building seven-day services around the needs of the patient. Unison believed that shift payments serve as an incentive for NHS staff to work unsocial hours and that an increase in payments for unsocial hours could offset some of the cost-of-living pressures on staff and act as an enabler for extension of seven-day services. Unison stated that in many cases NHS staff already work flexibly and deliver care for patients seven days a week.
- 3.27 **Unite** told us that the Agenda for Change agreement already provided ample flexibility to deliver a seven-day service but that services needed to be funded. Unite stated that there was flexibility within Agenda for Change to introduce new job roles for the future and to run these through the job evaluation process, and that this had been little used in the last 10 years. Unite believed that advanced practitioners could fulfil a number of roles which are currently carried out by other categories of staff. Unite stated that the unsocial hours agreement was only six years old and that current terms and conditions more than adequately reflected 21st century employment best practice, it considered the premia to be the key enabler to the delivery of seven-day services.
- 3.28 The **Federation of Clinical Scientists** told us that the current provisions within Agenda for Change are flexible and fit for purpose to support 24/7 service provision to meet NHS England's aim of improvements for patients. The Federation of Clinical Scientists stated that the Agenda for Change terms and conditions provided adequate facilities and mechanisms to support broader seven-day services whilst mitigating the detrimental impact on work-family balance when much of the rest of society works five days. The Federation of Clinical Scientists believed that since the inception of Agenda for Change, revisions have already reduced the rewards to staff for engaging in those 24/7 services. The Federation of Clinical Scientists told us it was a matter for local employers and unions representing the staff to work in partnership to deliver the clinical services patients need. The Federation of Clinical Scientists stated that its members were dedicated to delivering innovation and new ways of working but that this must be in a context of partnership rather than simply seeking to remove costs from the system.
- 3.29 All trade unions were clear in their evidence that they considered the provision of unsocial hours payments as a fundamental part of providing a fair and competitive reward package.

### **Our comment**

- 3.30 Employee reward should consider not just the level of pay but the entire employment package which includes wages, pensions and working conditions. National and international evidence reveals that employees are generally compensated for working unsociable hours, reflecting factors such as increased worker costs, disruptions to family life, effects on worker physical and mental health and overall employee well-being. Payments are an enabler for service delivery and are an important element of the

earnings package for staff. There is, however, no specific consensus about how high these payments need to be and for what periods they need to be paid, these vary across industries and countries reflecting differences in work practices and culture. We explore market approaches and rates in more detail in Chapter 4 of this report.

- 3.31 The Agenda for Change pay system was implemented from 2004 with a key driver being to ensure equal pay compliance. The system was designed to provide a fair and consistent reward structure for non-medical staff groups working across the NHS. The structure is underpinned by a robust job evaluation system where staff roles are allocated to the appropriate band according to the requirements and demands of the role. The pay system operates by providing consistent levels of base salary across the bands with additional payments available where applicable to particular circumstances, for example overtime; High Cost Area Supplements (HCAS) for staff working in inner and outer London and the fringe;<sup>24</sup> and Recruitment and Retention Premia (RRP) payable for an individual post or specific group of posts where market pressures suggest there is an identified need. These additional payments include the mechanism to compensate staff who are required to work their shifts during unsocial hours.<sup>25</sup>
- 3.32 There are a number of mechanisms available within Agenda for Change to compensate staff for working unsocial hours, which include:
- Unsocial hours premia for non-medical staff, with the exception of ambulance staff (rates vary by pay band and time worked);
  - Unsocial hours premia for ambulance staff (rates vary by pay band and average number of unsocial hours worked);
  - On-call payments; and
  - Overtime payments.
- 3.33 Details of the payment rates are included in Appendix F of this report.
- 3.34 The existing Agenda for Change premia rates were implemented in 2008, following a previous pilot of the model currently in place for the Ambulance Service. This approach was deemed inappropriate for other Agenda for Change workforce groups, because frequent changes in work patterns made it difficult to predict accurately the level of unsocial hours payments. The rates for the Agenda for Change premia were influenced by the systems that preceded it, and the requirement to introduce arrangements that were equal pay compliant, cost effective and ensured a minimal requirement for transitional pay protection.
- 3.35 The Agenda for Change pay system has features that could be driving sub-optimal behaviours among staff and managers. For example, the mechanism where staff are paid unsocial hours premia rates for the *whole* of their shift where more than half of the hours are worked during unsocial hours, rather than paying premia solely for the unsocial hours worked. This outcome may encourage managers to organise shifts on the basis of cost to avoid this possibility. An example under the Ambulance Service approach, is that staff receive the relevant percentage rate as soon as they reach the minimum threshold of unsocial hours worked. This means that where staff reach the threshold to receive the higher level payment there can be no incentive for them to work additional unsocial hours beyond this. This can lead to difficulties in covering weekend shifts. In our view decisions around shift patterns should be designed around the needs of the patients and not be skewed by rules around shifts and payments.

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<sup>24</sup> More details are in Annex H of the Agenda for Change Terms and Conditions Handbook, available from: <http://www.nhsemployers.org/your-workforce/pay-and-reward/pay/pay-in-high-cost-areas>

<sup>25</sup> Unsocial hours are defined in the NHS Terms and Conditions Handbook as those hours outside of Monday to Friday 6am to 8pm. There are separate arrangements in place for the unsocial hours compensation for Ambulance Service staff and these are explored in more detail in Chapter 4 of this report.

### **Observation 3**

**The pay structure should work to support and incentivise behaviours to ensure that shifts are scheduled principally around the needs of the patient rather than skewed by rules around shifts and payments.**

- 3.36 The Agenda for Change Terms and Conditions of Service handbook<sup>26</sup> refers only to the weekly working hours for NHS staff on Agenda for Change contracts, and is silent regarding the days of the week that staff may be required to work. Local arrangements are likely to differ, with some posts advertised with an expectation of shift work across the seven day week, whereas others may specify Monday to Friday working. Whilst some employers may include a variation clause within a contract to change working arrangements, this may not be the case for all employers and any requirement for local contract variations would be a matter for individual employers to manage and agree with their staff.
- 3.37 In practice there are a number of core Agenda for Change staff groups who are already working their hours across seven days. These include nurses, midwives and paramedics. The case studies and early adopter sites that have implemented seven-day service delivery models have also utilised the existing reward mechanisms within the Agenda for Change contract to introduce the changes and compensate staff for working unsocial hours. This is also true of the examples of seven-day services that are already being delivered in Wales and Northern Ireland.
- 3.38 As it stands the national Agenda for Change pay system is not therefore acting as a contractual barrier to the implementation of seven-day services. This is different from the position for consultants, where there is an opt-out clause on non-emergency working at evenings and weekends included in their contract. Exploring this issue further is a matter for our counterparts in the DDRB, but it does set the Agenda for Change staff position in context. Whilst there will always be local issues to address, the existing Agenda for Change terms and conditions do enable seven-day working, and many Agenda for Change staff already support the provision of services over seven days.
- 3.39 For the NHS it is likely that there will be a variety of service models required subject to local requirements. It will be important to make greater use of the existing flexibilities such as Annex K<sup>27</sup> and Recruitment and Retention Premia (RRP), which in our view provide an appropriate degree of flexibility. The central pay framework already has flexibility to enable local variation and to support service delivery.

### **Observation 4**

**The national Agenda for Change pay system presents no contractual barrier to the delivery of seven-day services; seven-day working is already well established for a number of core staff groups; and has been used at seven-day case study and early adopter sites across the United Kingdom.**

- 3.40 The barrier that has been presented to us by the Department of Health, NHS Employers and Providers is one of affordability. In their view the cost of the unsocial hours premia makes the delivery of seven-day services prohibitive. Both NHS Employers and Providers believe that decisions around shift patterns and staff rostering are being influenced by cost implications and this is hindering service innovation and improved delivery. There is

<sup>26</sup>The NHS Agenda for Change Terms and Conditions Handbook is available from: <http://www.nhsememployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook>

<sup>27</sup>Annex K in the NHS Terms and Conditions handbook provides additional freedoms within the Agenda for Change framework for Foundation trusts and other trusts with earned autonomy in England.

a view from the Department and some employers that current rates and definitions are out of line with the wider market and that the NHS has not moved on with modern employment practice. We explore this premise in more detail in Chapter 4 of this report.

- 3.41 However, there is an important preliminary point on a move to seven-day services, based on experience so far. In February 2013 NHS England commissioned the Healthcare Financial Management Association (HFMA)<sup>28</sup> to undertake a costing exercise to support the NHS Services, Seven Days a Week Forum's finance and costing work stream. The aim was to cost the financial implications of introducing seven-day services for acute and emergency care and supporting diagnostics in the NHS. Eight foundation trusts were selected; they were all successful foundation trusts with an interest in seven-day services, and in that sense were untypical, but they did provide a reasonable spread and mix of different size hospitals in different locations (London, large conurbations and more rural). The report<sup>29</sup> showed that the potential costs of implementing seven-day services varied. In most cases, the costs of implementing seven-day services were typically in the order of 1.5 to 2 per cent of total income or, expressed another way, a 5 to 6 per cent addition to the cost of emergency admissions.
- 3.42 Whilst the unsocial hours premia did add cost to delivery, the biggest cost was as a result of the requirement to recruit additional medical staff to cover the extra hours being worked. On the basis of these experiences a move to seven-day services is likely to require an investment in extra resources, namely additional staff. There will therefore be an affordability aspect to consider, regardless of whether unsocial hours premia are changed.
- 3.43 It was clarified in the evidence from the Department of Health that the aim is to move to seven-day services at no increase to the pay bill *per full-time equivalent (FTE)*. Our understanding of this is that, whilst the pay bill cost per FTE should remain the same, the component parts that make up the pay bill could change. If based on static workforce numbers, a move to seven-day services and an increase in unsocial hours could only be introduced at no increase in pay bill per FTE by reducing the level of pay of those staff who are already working these hours. On the other hand, if more staff were employed to meet the expansion of out of hours services, it is likely these staff will on average be more expensive than the current employed staff. This is because the new staff shift patterns would have a higher proportion of unsocial hours working, and again means that this could only be introduced at no increase in pay bill per FTE by reducing the level of pay of those staff who are already working these hours. We discuss the potential impact of making changes to unsocial hours definition and premia in Chapter 5 of this report.
- 3.44 The evidence presented told us that, based on the existing per FTE pay bill, the current spend on unsocial hours premia represents 4 per cent of the pay bill in England. This information was not made available to us for Wales or Northern Ireland. This was offered as an indication of the top end of savings that could be achieved from changing unsocial hours rates, however employers were clear that they were not seeking a complete removal of these so in reality savings would be less. At this stage, without a clearer indication of the likely increase in staff numbers and the level of unsocial hours needing to be worked it is difficult to predict accurately what the cost implications would be and the potential proportion of the pay bill that unsocial hours could represent.

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<sup>28</sup> Representative body for finance staff in healthcare.

<sup>29</sup> The HFMA report is available from: <http://www.england.nhs.uk/wp-content/uploads/2013/12/costing-7-day.pdf>

*Observation 5*

As well as providing efficiencies, the move to seven-day services is likely to require more resources, namely more staff, and there are affordability aspects to consider for all countries. More analysis to model the likely scenarios in terms of increase in staff numbers and increase in unsocial hours would help the parties to understand better the cost implications.

## Chapter 4 – Approaches to Unsocial Hours Pay

### Introduction

4.1 This chapter includes information about approaches to unsocial hours pay in other sectors and in healthcare systems at home and abroad. This information can be used to provide context for comparisons with our remit group. This includes research carried out on our behalf by Incomes Data Services (IDS) into unsocial hours practice in other sectors in the United Kingdom<sup>30</sup> as well as research by our secretariat into unsocial hours practice in other countries.

### Evidence from the parties

4.2 As outlined in Chapter 2, the Department of Health and NHS Employers are looking to support the delivery of an affordable seven-day service for the NHS. In December 2013, Sir Bruce Keogh said “There are encouraging examples for NHS organisations that have moved to making healthcare services more accessible seven days a week to avoid compromising safety and patient experience. We need to accelerate the pace and spread of these changes. In doing so, we can ensure the NHS leads the world in providing equality of access to consistent, high quality healthcare, seven days a week”.<sup>31</sup> The Department of Health and NHS Employers provided some initial options for consideration for making changes to unsocial hours pay. As discussions are still at a high level we have focused on the principles underlying the options rather than the details themselves.

4.3 The **Department of Health’s** options included the principles of;

- Changing the periods which are considered unsocial and attract premium pay rates, either in the evenings or at weekends.
- Changing the premia rate paid for working unsocial hours.
- Changing who is eligible for each rate, for example, paying a flat payment for all bands or restricting unsocial hours pay for staff above a certain band.
- Paying flexibility premiums rather than unsocial hours premiums, to reward staff for flexibility and a willingness to work shift patterns that are more unsocial.
- Revising progression pay alongside changes to unsocial hours, seeking a pay system which is better able to target resources.

4.4 **NHS Employers** provided three models for adjusting the periods which are considered unsocial and attract premium pay rates, and three models for changing the premia pay rates. These can be combined to produce nine options,<sup>32</sup> for which indicative savings ranged from £90 million (0.3 per cent of Agenda for Change pay bill) to £1.1 billion (3.2 per cent of Agenda for Change pay bill). These were not the only possible options, but they illustrate some possibilities for changing the start of the night time window from 8pm to 10pm, changing Saturday day to plain time from up to time and a half, changing Sunday day to plain time from up to double time, and changing the unsocial hours premia rates.

Time Models:

- Model 1
  - Plain time will be from 6am to 10pm, Monday to Friday.

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<sup>30</sup>The report is available from: <https://www.gov.uk/government/organisations/office-of-manpower-economics/about/research>

<sup>31</sup>NHS England’s Sir Bruce Keogh sets out plan to drive seven-day services across the NHS, more information available from: <https://www.england.nhs.uk/2013/12/15/sir-bruce-keogh-7ds/>

<sup>32</sup>The NHS Employers’ summary of the estimated savings for their nine potential models is shown in Appendix G of this report.

- Premium Rate 1 will be paid from 10pm to 6am, Monday to Friday and for all hours on Saturday.
- Premium Rate 2 will be paid all hours on Sundays and Bank Holidays.
- Model 2
  - Plain time will be from 6am to 10pm, Monday to Saturday.
  - Premium Rate 1 will be paid from 10pm to 6am Monday to Saturday.
  - Premium Rate 2 will be paid all day Sunday and on Bank Holidays.
  - The main feature of this model is that unsocial hours payments on Saturday are identical to payments on Monday to Friday.
- Model 3
  - Plain time will be from 6am to 10pm, Monday to Sunday.
  - Premium Rate 1 will be paid from 10pm to 6am Monday to Sunday.
  - Bank Holidays will be paid at Premium Rate 2.
  - This model is similar to Model 2 but Sunday is also aligned with Monday to Saturday.

#### Pay Models:

- Model A
  - The current rates for unsocial hours for Agenda for Change staff.
  - Premium Rate 1 is paid for Nights and Saturdays.
  - This rate is doubled for Sundays and Bank Holidays.
- Model B
  - Simplifies the current two-tiered premium rate structure by removing Premium Rate 2 and using Premium Rate 1 as a single tier rate.
  - The rate continues to vary by band.
- Model C
  - Retains the two-tier premium rate structure, but halves the premium rates on each band.
  - The rate continues to vary by band.

### Ambulance Service

- 4.5 The NHS already has an alternative package for unsocial hours working for the Ambulance Service staff. Ambulance Service staff are paid on Agenda for Change terms and conditions (banding), but have different arrangements for unsocial hours payments (set out in Annex E of the Agenda for Change Terms and conditions handbook). Instead of applying a retrospective system, the Ambulance Service agreement applies a prospective system, based on agreed work patterns that vary only occasionally.
- 4.6 Pay enhancements apply to ambulance staff whose working pattern in standard hours (excluding overtime and work arising from on-call duties), is carried out during the following times:
- Staff in pay bands 1 to 7: any time worked before 7:00 am or after 7:00 pm Monday to Friday, and any time worked on Saturdays, Sundays or Bank Holidays;
  - Staff in pay bands 8 and 9: any time worked before 7:00 am or after 10:00 pm Monday to Friday, any time worked before 9:00 am or after 1:00 pm on Saturdays and Sundays, and any time worked on Bank Holidays.
- 4.7 Pay enhancements for ambulance workers are based on the average number of hours worked outside these times during the standard working week, and are paid as a fixed percentage addition to basic pay in each pay period. The percentages paid are shown in table 4.1.



**Table 4.1 – Unsocial hours pay enhancements for ambulance staff**

Average unsocial hours	Percentage of basic salary	
	Pay bands 1–7	Pay bands 8 & 9
Up to 5	Local agreement	Local agreement
More than 5 but no more than 9	9%	9%
More than 9 but not more than 13	13%	10%
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%

Source: NHS Terms and conditions of service handbook – Annex E table 11

4.8 In practice this means if ambulance staff work six of their hours as unsocial hours they would receive the same pay as staff working eight unsocial hours. There is also no distinction with regards to pay between working at night, on a Saturday or on a Sunday. This is fundamentally different from unsocial hours pay arrangements covering other Agenda for Change staff; where staff working on a Sunday receive a higher premium (60 per cent for bands 4-9) than staff working on a Saturday or at night (30 per cent for bands 4-9).

### IDS research

4.9 IDS were commissioned to undertake case studies to research unsocial hours practices in other sectors in the United Kingdom. This helped us form a view on whether current NHS unsocial hours practices were out of line with the wider market. Whilst the IDS research is not intended to be representative of all companies in all sectors, we believe it to be a reasonable summary of the sectors surveyed.<sup>33</sup>

4.10 IDS found that premium payments on top of basic pay have traditionally been used to compensate staff for working unsocial hours. However, as 24/7 operations have become more prevalent since the late 1990s, unsocial hours working arrangements and the associated premiums across many sectors of the economy have changed.

4.11 Overall unsocial hours premia are highest for Sunday and then night working, followed by hours worked on Saturdays. Payments are generally higher for junior staff than senior staff (as a proportion of basic pay), and in some cases senior staff do not receive any premia. However, the level and incidence of unsocial hours payments vary by sector and type of work.

4.12 IDS found there were different approaches to unsocial hours pay across different sectors; some sectors consolidated unsocial hours pay into a higher base salary, some sectors used shift patterns, some paid a premium per hour worked whilst a few did not pay any unsocial hours premium.

4.13 An overview of IDS' research findings on unsocial hours and overtime payments by sector is provided on the following pages in table 4.2, followed by current unsocial hours premia rates for NHS staff in table 4.3.

<sup>33</sup> Full details of the methodology can be found in Appendix 1 of the IDS report.

Table 4.2 – Overview of IDS research findings on unsocial hours and overtime payments (sectors)

Sector	Night window	Nights/evenings	Saturdays	Sundays	Bank holidays	Overtime
<b>Actuaries</b>						
	N/A	T (evenings)	N/A	N/A	N/A	TOIL
<b>Air ambulances</b>						
- pilots	N/A	T	T	T	T	TOIL
- paramedics	AfC	AfC	AfC	AfC	AfC	TOIL or AfC
- senior managers	None	None	None	None	None	None
- doctors/consultants	Varies depending on contract between air ambulance and the individual doctor and/or their NHS trust. Some volunteers who receive none					
<b>Airline industry</b>						
- pilots	T+14% average for captains; T+17% average for first officers					
- cabin crew	T+25% for domestic flights; T+50% or more for international flights					
- customer service	Range T+5% – T+25%					
- engineering	Typical shift premia T+8% – T+12% for technicians; T+6% – T+8% for supervisory/junior managers; none for senior/middle managers					
- operations	Varies by airport and airlines, worth around T+10% – T+15% at larger airlines					
<b>Breakdown services</b>						
- Forecourt and garage staff*	9.30pm to 5.30am	T+33%; T+100% Sat and Sun	Shift patterns; two-shift, T+15%; three-shift, T+25%			T+50%; T+100% Sun
<b>Call centres</b>						
- call centre agents	8pm to 8am	T+10%–T+50%	T+5% – T+40%		T+15% –T+100%	T+35% –T+100%
<b>Care homes</b>						
- care and nursing staff	8pm to 8am	T+33% or cons.	T+33% or cons.	T+50% or cons.	T+50% or T+100%	–
<b>Central government</b>						
- below management	8pm to 8am	–	–	T+100%	T+100%	T+50%; T+100% Sun
<b>Engineering</b>						
- manual workers	10pm to 6am	Typical shift premia T+33% for continuous shifts covering days and nights, 7 days; 33% for night shifts			T+100%	T+50% Mon-Sat; T+100% Sun
- white-collar staff	10pm to 6am	See overtime	See overtime	See overtime	See overtime	As above
<b>Fire service</b>						
- operational staff	Shift duty covers shifts 24 hours, 7 days no premia				T+100%+TOIL	T+50% (T+100% Bank hols.)
- station managers	Shift premia 20% (flexible duty system)				TOIL	None

Table 4.2 – Continued (sectors)

Sector	Night window	Nights/evenings	Saturdays	Sundays	Bank holidays	Overtime
<b>IT and e-commerce</b>						
- IT and e-commerce staff	Call out payments for evenings and weekends vary significantly					T+50% Mon-Sat; T+100% Sun
<b>Local government</b>						
- national terms	8pm to 6am	T+33%	T+50%	T+50%	T+100%+TOIL	T+50% Mon-Sat; T+100% Sun
- local terms	10pm to 6am	T+33%	See above but some examples of variations (+/-) and consolidation			T+50% Mon-Sat; T+100% Sun
<b>Pharmaceuticals</b>						
- manufacturing staff	Typical shift premia 37% for continuous; 31% for nights; 24% for three-shift; 16% for two-shift					T+50% Mon-Sat; T+100% Sun
<b>Police</b>						
- federated ranks	8pm to 6am	10%	T	T	T	T+33% (casual); T+50% (planned)
<b>Prison service</b>						
- operational staff	Unsocial hours payment worth T+17% (fair and sustainable contract); consolidated (closed scales)					
- managers	Unsocial hours payment worth T+15% (fair and sustainable contract); cons. + Required Hours Addition of £5,529 (managers E-G) (closed scales)					
<b>Private hospitals</b>						
- nursing & care staff	Common in the independent hospitals sector, paid at lower rates than in the NHS					
- doctors & consultants	Very few directly employed					
- consultants	Self-employed, unsocial hours work by consultants covered by fees charged					
<b>Restaurants, pubs and fast food</b>						
- hourly-paid staff	-	T	T	T	T	T
<b>Retail</b>						
- retail assistants	11pm to 6am	T+27% (T+32% inc. cons.)	T	T+50%	T+50%	T+50%
<b>Road transport</b>						
- drivers	-	T+20%	T	T	-	T
- warehouse workers	10pm to 6am	T+30% (T+36% inc. cons.)	T	T (T+20% inc. cons)	-	-

\*As set out by the Motor Vehicle Retail and Repair National Joint Council agreement (see section 2.4).

**Definitions:**

T = plain time; TOIL = time off in lieu; Cons. = consolidated; AfC = NHS Agenda for Change pay system.

Table 4.2 – Continued (case studies)

Organisation	Night window	Nights/evenings	Saturdays	Sundays	Bank holidays	Overtime
<b>BMI Healthcare*</b>						
- directly employed staff	After 7pm	Range T to T+100% depending on staff group/site	Range T to T+100% depending on staff group/site	Range T to T+100% depending on staff group/site	Range T to T+100% depending on staff group/site	Varies by site, but most commonly T+50% Mon-Fri; T+100% Sat & Sun
<b>Camden Council**</b>						
- service provider staff*** - practitioners & managers	10pm to 7am, Mon-Fri****	T+23% TOIL	T+23% (after 5pm) TOIL	T+23% (after 5pm) TOIL	T+10% (T+50%) TOIL	T+10% (T+50%) TOIL
<b>Devon Air Ambulance Trust</b>						
- paramedics	7pm to 7am	T+25%	T+25%	T+25%	T+25%	TOIL of AfC rates*****
- pilots	7pm to 7am	T	T	T	T	TOIL
- operational managers	7pm to 7am	TOIL	TOIL	TOIL	TOIL	TOIL
- head office & shops	6pm to 8am	TOIL	T	TOIL	TOIL	TOIL
<b>London Underground</b>						
- admin and office staff	–	TOIL	T+50%	T+100%	n/a	TOIL
- operational staff	–	Consolidated	Consolidated	Consolidated	Consolidated	T+25%
- management	–	Consolidated	Consolidated	Consolidated	Consolidated	TOIL
<b>Nissan Manufacturing UK</b>						
- office staff	10pm to 6am	33% or 20%	See overtime	See overtime	See overtime	T+50% Mon-Sat;
- manufacturing staff	10pm to 6am	Shift premiums	Shift premiums	Shift premiums	Shift premiums	T+100% Sun
- senior staff	10pm to 6am	33% or 20%	See overtime	See overtime	See overtime	£9,811 a year

\*Terms vary by site.

\*\*In addition some staff are eligible for T+15% if working a highly disruptive working pattern, or T+10% for 'lower' levels of disruption.

\*\*\*Normal hours are defined as between 7am and 10pm, Mondays to Fridays, and 8am to 5pm on Saturdays and Sundays.

\*\*\*\*Staff below point 25 (current salary up to £22,212).

\*\*\*\*\*Paramedics most commonly opt for payment at AfC overtime rates.

#### Definitions:

T = plain time; TOIL = time off in lieu; AfC = NHS Agenda for Change pay system.

**Table 4.3 – Current unsocial hours rates for NHS staff**

Staff Group	Night Window	Nights	Saturdays	Sundays and Public Holidays
Agenda for Change Band 1	8pm to 6am	T+50%	T+50%	T+100%
Agenda for Change Band 2	8pm to 6am	T+44%	T+44%	T+88%
Agenda for Change Band 3	8pm to 6am	T+37%	T+37%	T+74%
Agenda for Change Bands 4 – 9	8pm to 6am	T+30%	T+30%	T+60%
Consultants	7pm to 7am	T+33% or a reduction in hours (a three-hour Programmed Activity rather than four hours)		
Junior Doctors	7pm to 8am	Juniors receive a non-pensionable banding supplement of between 20-100% of basic pay, which is designed to compensate for extra hours worked and for more intense working patterns.		

Source: NHS Terms and conditions of service handbook, Department of Health Evidence

- 4.14 In all respects the unsocial hours premia paid for Agenda for Change staff on bands 1 to 3 appear to be at the upper end when compared to the sectors covered by the IDS report. The premia for bands 4 to 9 appear to be in line with the other sectors for nights and Saturday, but are at the higher end for Sundays. Whilst some sectors covered by the IDS report do not pay a premia for Saturday, the majority still do.
- 4.15 IDS identified **local government** as having recently made changes to some unsocial hours working payments, partly as a result of ongoing funding pressures. Employers have reduced overtime premiums, and many councils have also increased their 'plain-time hours', thereby limiting the scope for overtime and unsocial hours working. About a quarter of the London councils surveyed had moved the start of premium time back to 10pm on a weeknight (from 8pm). **Camden Council**, in particular, recently introduced a number of changes to payments for unsocial hours working as part of a wider package of changes. Staff moved across to the new system on a voluntary basis, receiving a one-off payment. Unsocial hours premia were reduced by ten percentage points to 23 per cent for night work, and plain-time working hours are now defined as between 7am and 10pm Monday to Friday, and 8am to 5pm on Saturday and Sunday. This was part of the council's 'Camden Plan 2012-2017' and delivered savings of around £2 million a year and provided a means of avoiding redundancies.
- 4.16 In **engineering and manufacturing**, shift working is common, and semi-skilled and skilled workers generally receive percentage premiums on top of their basic pay as compensation. The IDS report said that the most common approach to reward shift working is by applying a percentage premium to the basic rate of pay and, in general the more 'unsocial' the hours, and the more frequent the shift rotation, the greater the premium. Shift work is less common for white collar engineering staff than for manual workers, since these staff tend to work regular hours. Where engineers or senior managers work unsocial hours this is usually to respond to incidents, and they typically receive overtime pay for these hours. For example at **Nissan**, office based staff normally work a day shift from 7:55am to 4:40pm Monday to Thursday and 7:55am to 2:25pm on Friday, but on occasion may need to come in early to speak to staff on a night shift or for a conference call.
- 4.17 **Retail, restaurants, pubs and fast food** are areas of the economy where, over the past two decades, opening hours have been extended. The IDS research indicated that there has been a trend away from paying premia, particularly at the weekend. However the ability of employers in these sectors to avoid offering unsocial hours premia without unduly harming recruitment and retention partly reflects the nature of the labour market

in which they operate. The IDS findings suggest that the expansion of participation in higher education has created a ready supply of student workers who on the whole have fewer caring responsibilities and are more amenable to working patterns traditionally seen as unsocial.

- 4.18 The **Police** service was given as an example of a sector paying no unsocial hour premia at weekends and fairly low rates for nights (10 per cent). However, historically there was a recognition that all officers might expect to work unsocial hours and a 9 per cent allowance for this was consolidated into basic pay in the late 1970s. In 1978 the report of the Edmund-Davies' Committee stated that: "Although consolidation does remove from pay a specific identifiable element for working unsocial hours, it should not be forgotten in the future that police pay does contain such an element."<sup>34</sup>
- 4.19 In general the IDS report indicates that different employers have different policies for compensating unsocial hours working. The common feature, however, is that employers choose their policy, whether that be consolidation, shift working, hourly premia or overtime, based on their business needs, and the labour markets in which they operate. For example, in the police, where all officers need to be highly trained and the employer needs to operate a 24/7 service, the allowances have largely been consolidated. For engineering and manufacturing, there is a frequent but variable need for shift working, and trained staff need to be available, so the unsocial hours premia incentivise workers to do shift working when the employer needs it, but not otherwise. The retail and fast food sector, whose opening hours will be flexible based on market demand and who can train most of their workers rapidly, have a much more adaptable approach to paying unsocial hours premia, if at all.
- 4.20 The key variables for unsocial hours working are: definitions of the night time window, rewards for night time working, rewards for Saturday working, rewards for Sunday working and rewards for Bank holiday working. The IDS research shows that it is still common to pay unsocial hours premia for each of these unsocial periods.
- 4.21 From the information in the IDS report, summarised in figure 4.1, we can see that there is some variation in the definitions of the night window across sectors. It appears that the 'standard' night window starts between 8pm and 10pm for most sectors and ends between 6am and 7am. For the definition of a night window the NHS does not currently appear to be out of line; however neither would a start time of 10pm be out of line.

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<sup>34</sup>Independent review of police officer and staff remuneration and conditions, available from: <http://webarchive.nationalarchives.gov.uk/20130312170833/http://review.police.uk/publications/945287?view=Binary>

**Figure 4.1 – Night shift window**

Night Shift Window	Start	End	6pm	7pm	8pm	9pm	10pm	11pm	12am	1am	2am	3am	4am	5am	6am	7am	8am	9am
Junior Doctors	7pm	8am		■	■	■	■	■	■	■	■	■	■	■	■	■		
Consultants	7pm	7am		■	■	■	■	■	■	■	■	■	■	■	■			
Call Centres	8pm	8am			■	■	■	■	■	■	■	■	■	■	■	■		
Care Homes	8pm	8am			■	■	■	■	■	■	■	■	■	■	■	■		
Central Government	8pm	8am			■	■	■	■	■	■	■	■	■	■	■	■		
Local Government (national terms)	8pm	6am			■	■	■	■	■	■	■	■	■	■				
Police	8pm	6am			■	■	■	■	■	■	■	■	■	■				
Agenda for Change Staff	8pm	6am			■	■	■	■	■	■	■	■	■	■				
Breakdown Services	9:30pm	5:30am				■	■	■	■	■	■	■	■	■				
Engineering	10pm	6am				■	■	■	■	■	■	■	■	■				
Local Government (local terms)	10pm	6am				■	■	■	■	■	■	■	■	■				
Road transport	10pm	6am				■	■	■	■	■	■	■	■	■				
Retail	11pm	6am					■	■	■	■	■	■	■	■				
Restaurant, pub and fast food	12am	5am						■	■	■	■	■	■					
Airline Pilots	1am	7am							■	■	■	■	■	■				

Source: OME Analysis of IDS Report

### Transition and implementation issues from IDS case studies

4.22 The IDS case studies provided some commentary on issues to consider and their reflections for transition and implementation of changes to pay and work patterns. In particular a recurrent theme was making changes as part of a balanced package and the importance of local level staff engagement before and during transition. The highlights from these are listed in table 4.4 below.

**Table 4.4 – IDS case studies: transition and implementation issues**

<b>BMI Healthcare</b>	<ul style="list-style-type: none"> <li>• May use compensation payment to facilitate implementation of planned changes.</li> <li>• Staff would not be 'red-circled'<sup>35</sup> on current terms.</li> <li>• Staff have considerable choice over shift patterns and requests for change are generally agreed – enabling staff to balance work and family responsibilities.</li> <li>• Offers flexibility around shift times and working hours when it comes to religious or other commitments.</li> </ul>
<b>Camden Council</b>	<ul style="list-style-type: none"> <li>• Changes introduced as part of a package, with improvements in some areas.</li> <li>• Staff asked to move across to new system on a voluntary basis.</li> <li>• Incentive payments available to staff moving across before March 2013 (between £500 and £1,000 depending on grade).</li> <li>• As part of the changes staff earning below £25,000 receive an extra £250 per year on an on-going basis (excluded from base pay but pensionable).</li> </ul>
<b>London Underground</b>	<ul style="list-style-type: none"> <li>• Important to consider transition and implementation carefully as there are many issues involved.</li> <li>• Important to get both staff and the trade unions on board in order to help the workforce see the potential benefits.</li> </ul>
<b>Nissan Manufacturing UK</b>	<ul style="list-style-type: none"> <li>• Getting the unions on board is key to transition and implementation.</li> <li>• Seeking volunteers to work shifts, rather than requesting staff, helps to implement changes more easily.</li> </ul>

Source: IDS Report

## International research

- 4.23 International comparisons are fraught with difficulty due to the inherent problem of ensuring like-for-like comparison across countries. As such, caution should be used when any direct comparisons are made. The roles and responsibilities of staff are varied across countries, as are other benefits, bonuses, taxes and allowances.
- 4.24 It is our understanding, based on desk research, that outside of accident and emergency services most international public healthcare systems are, at the moment, not generally providing a comprehensive 24/7 service. Many countries are, however, looking at expanding more services into weekends and evenings. Sir Bruce Keogh argues that as the biggest integrated healthcare system in the world, the NHS is better placed than others to resolve the issues [around fully integrated seven-day services].<sup>36</sup>
- 4.25 Most countries pay premia to incentivise unsocial hours working, but the level of these premia varied from country to country. In general, Sundays and bank holidays received the highest rate of premia, followed by Saturdays then Night time hours.

<sup>35</sup> Staff being paid above the maximum of a salary range for their position and protected from reductions in pay for a period of time.

<sup>36</sup> NHS England's Sir Bruce Keogh sets out plan to drive seven-day services across the NHS, more information available from: <https://www.england.nhs.uk/2013/12/15/sir-bruce-keogh-7ds/>



**Table 4.5 – International unsocial hours rates for the health sector**

Country	Night Window	Nights	Saturdays	Sundays
Australia (Queensland)	6pm – 7:30am	T+20%	T+50%	T+75%
Australia (Western)	6pm – 7:30am	T+35%	T+50%	T+75%
Canada	Varies	C\$1.75 - C\$5 per hour	C\$1.35 – C\$3.25 per hour	C\$1.35 – C\$3.25 per hour
New Zealand	8pm – 6am	T+25%	T+50%	T+50%
Philippines	10pm – 6am	T+10%	T+30%	T+30%
Spain (Castilla-La Mancha)	10pm – 8am	€2.91 – €4.09 per hour	€6.76 – €9.36 per hour	€6.76 – €9.36 per hour
<b>United Kingdom</b>	<b>8pm – 6am</b>	<b>T+30% to T+50%</b>	<b>T+30% to T+50%</b>	<b>T+60% to T+100%</b>
USA (Chicago)	Unknown	T+20%	\$2.25 per hour in addition to any night premia	\$2.25 per hour in addition to any night premia
USA (Texas)	3pm – 7am	Up to T+15%	T+5% in addition to any night premia	T+5% in addition to any night premia

Note: T – plain time

Source: Various, see Appendix H

## Our comment

- 4.26 Appropriate comparators for the NHS workforce within the United Kingdom are difficult to identify. Although not a direct comparator, local government perhaps offered the closest example in terms of the breadth of roles covered, despite the absence of many professional health roles. Furthermore, as integration of services continues, increasingly local government staff will be working closely alongside NHS staff. Comparing the workforce of the NHS with the retail sector, as suggested in some of the evidence, seems to us to be inappropriate. The NHS staff groups consist of a large number of graduate entrants into a particular career path, undergoing focussed training, for example nursing or physiotherapy. Most of them expect to work for many years in the NHS. By contrast, some parts of the retail sector are highly flexible, employing a large number of part-time staff and a student workforce, who often require less training, might combine the work around their other commitments, and will not always make a long-term career with their immediate employer. Direct comparisons with the police are also inappropriate as unsocial hours pay has been largely consolidated into a higher base pay, because this matched the employers' need to offer a 24/7 service, provided by highly-trained career police officers.
- 4.27 The IDS study showed that there is no clear pattern in approaches to unsocial hours pay in the United Kingdom. However, these hours are generally compensated for either in base pay or through unsocial hours rates. Out of the groups IDS surveyed, many had undergone or were undergoing some review of their approach to unsocial hours pay in order to complement a more 24/7 approach to service delivery and/or working. Where change had been successfully implemented this had been done with general recognition of the importance of culture change, the health and wellbeing of staff, and the requirement to pay premium rates to incentivise and secure unsocial hours working. Local level staff engagement was often mentioned as being needed before and during the transition. Camden council offered an interesting example – they had introduced a new pay system for new entrants, maintaining the legacy system for existing employees

but offered an incentive for staff to move across to that new system. Whilst they had extended plain-time working hours, they continued to pay premium for hours considered unsocial (weekdays after 10pm, weekends after 5pm and Bank Holidays).

- 4.28 High-level comparisons with healthcare systems internationally suggest that the unsocial hours' premia for the NHS staff group are not out of line with other countries. Internationally, unsocial hours premia are still seen as a core part of encouraging staff to work at night and weekends in healthcare systems. Similar to the United Kingdom, other countries are increasingly looking to make more services available at weekends and into the evenings. However, providing a large number of services at weekends and at night is not widespread, with the exception of accident and emergency provision in large hospitals.
- 4.29 Looking at the sectors surveyed, whilst some other employers share the Agenda for Change definition of plain-time hours as running up to 8pm, there are also employers who use a 10pm definition, as suggested by NHS Employers and neither time would be seen as out of line. Paying premia after 10pm and on Saturday and Sunday are still the accepted practice and eliminating this would bring the NHS out of line with many sectors. Some of the sectors covered by the IDS report do not pay a premia for working on Saturdays and this may be the area, in certain sectors, in which we will see further movement towards plain time in the future. The current Agenda for Change unsocial hours premia rates appear to be at the upper end of the spectrum. However, if premia were reduced by 50 per cent, as outlined in one of the NHS Employers options (as offering the most savings), this would leave the NHS as an outlier at the lower end.

**Observation 6**

**There is not an overall typical pay approach or rate for out of hours service provision. The unsocial hours reward package is designed around the needs of the organisational service model. For the NHS this should be based on patient and service need.**

- 4.30 There is nonetheless room within the current unsocial hours premia package to review some of the existing arrangements to ensure that these do not act as a barrier to optimal shift patterns. For example, reviewing the mechanism to pay unsocial hours premia for the whole shift when only half of the time has been worked during unsocial hours.
- 4.31 We note that staff in bands 1 to 3, who receive higher percentage premia, are often towards the top of the premia rates in comparison to the other sectors that IDS considered. It is not uncommon to offer different unsocial hours premia rates for different jobs within the same sector; for example, pilots and cabin crew receive different premia. However the NHS has four different rates depending on pay band, and it is not clear to us that these different rates are currently justified to support the patient and service need.
- 4.32 Whilst some adjustment of the existing system might be sensible, the comparisons with wider practice do not yield a strong case for unilateral change. It is however likely, when the extent and nature of seven-day services is quantified and defined, changes to plain time definitions and unsocial hours premia rates could well be introduced without endangering secure staffing. In the context of the NHS, this may offer up some modest savings. But we are clear, that with some exceptions we have not found enough evidence to support wholesale changes to premia in isolation. However, as we discuss in future chapters, this could be taken forward in the context of a wider discussion on Agenda for Change.

**Observation 7**

**Whilst some adjustments could be made, we have not found enough evidence to support wholesale changes to unsocial hours definitions and premia in isolation from the wider Agenda for Change pay system.**

## Chapter 5 – Impact of Change: Recruitment, Retention and Motivation

### Introduction

- 5.1 In this chapter we explore the workforce planning implications of the expansion of seven-day services as well as the impact of proposals to redefine unsocial hours definitions and reduce out of hours premia on the recruitment, retention, morale and motivation of our remit group.

### Recruitment and retention

#### *Evidence from the parties*

- 5.2 The **Department of Health** told us that there was little evidence that premium pay rates, based on the current definition of unsocial hours, were in themselves necessary to recruit and retain the staff the NHS needs, or that premium pay rates lead to better patient care. The Department of Health said that 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 service innovation.
- 5.3 The Department of Health stated that the NHS has much to offer its staff in addition to pay, and improved HR capability to promote a total reward approach to the employment offer would help employers engage with, recruit, and retain the workforce they need. The Department of Health believed that a much stronger emphasis on staff engagement, together with a more fair, flexible and affordable employment package in step with modern employment practices would help employers recruit and retain the skilled staff they need to deliver quality care seven days a week in a sustainable way.
- 5.4 The Department of Health told us that the reliance upon more expensive agency staff to work unsocial shifts would need to reduce to enable sustainable seven-day services, and employers would need to put more emphasis on the importance of good rostering and staff engagement. The Department of Health stated that introducing additional services at weekends could increase agency spend to fill the gap if permanent staff were unwilling or unable to change their working patterns to cover new weekend shifts. The Department of Health believed there was therefore a crucial requirement for robust staff engagement plans, and less reliance on agency staff through better procurement and more efficient use of local bank staff.
- 5.5 The Department of Health did not want to deter employers from using agency staff altogether; simply to reduce the expenditure on agency staffing. The Department of Health told us there were times when agency provided a valid source of temporary staffing. However, it would like to incentivise employers to use effective workforce planning and roster management in the first instance, to deliver seven-day services. The Department of Health explained that where temporary staffing was required, and the local bank staff were not an option, agency costs needed to be better managed to ensure that this does not place an additional barrier to seven-day services.
- 5.6 The Department of Health told us that in 2013/14 NHS trusts had spent approximately £1.2 billion on agency staff, and NHS Foundation trusts spent approximately £1.4 billion on agency staff.<sup>37</sup> There was a concern that locally budgets were so stretched, partly due to large expenditure on agency costs, that this was posing a barrier to employing more permanent staff. Data from the London Procurement Partnership (LPP) showed that

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<sup>37</sup> Similar data was not available for Wales or Northern Ireland.

approximately 40 per cent of all of their region's nursing agency staff shifts fell during "unsocial hours" (nights, weekends, and bank holidays), showing that – at least within London – the demand for agency staff is high during unsocial hours.

- 5.7 The Department of Health stated that 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 had reported that the removal of enhanced rates had not appeared to impact on the willingness and availability of agency staff to work at these times. The Department of Health told us that reducing agency spend was a high priority.<sup>38</sup>
- 5.8 **NHS England** told us national occupational shortages<sup>39</sup> are recognised, along with other local constraints relative to particular workforce issues in parts of England. NHS England stated that recruitment of health and social care professionals and introducing flexible working arrangements were identified as barriers to change; seventy six per cent of respondents to their survey felt major changes in culture were required to achieve seven-day services and that changes need to be owned and led by staff. NHS England believed there was also a risk if seven-day services were implemented in different geographies at different times, since this may affect staff movement from one area to another. NHS England said that, to combat this, implementation should be as even as possible to avoid disruption to the local workforce.
- 5.9 **Health Education England** told us that in December 2014 the second Workforce Plan for England<sup>40</sup> was published, which set out the £5 billion investment that will be made in education and training programmes for 2015/16. The Plan is built upon the needs of local employers, providers, commissioners and other stakeholders who, as members of the Local Education and Training Boards (LETBs), have shaped the thirteen local plans that are the basis of the plan for England. The Plan had allowed Health Education England to significantly expand the future workforce in key priority areas, such as nursing, paramedic, primary care and emergency medicine. Overall, it is commissioning more education and training than ever before, with over 50,000 doctors in training and over 37,000 new training opportunities for nurses, scientists, and therapists.
- 5.10 Health Education England told us that the development of seven-day services would impact upon a range of different types of staff, particularly those in support/diagnostic services, and different models of care will emerge that have the potential to impact on workforce planning across the health workforce. Health Education England said that in order to improve the quality of care to patients, the NHS needed to change, and this transformation required changing the way it educates, employs and deploys its people. Health Education England confirmed that service transformation can be driven through the expansion of existing roles or through encouraging commissioners and employers to create jobs for staff in different locations – such as increasing community based nursing.
- 5.11 Health Education England advised us that, increasingly, it will need to invest in entirely new roles and professions to help deliver more holistic care across different teams and settings. For example, Physician Assistant roles are trained to perform a number of duties, including taking medical histories, performing examinations, diagnosing illnesses, analysing test results and developing management plans. Going forward, it would continue to engage and seek advice from LETBs, stakeholders and the Workforce Advisory

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<sup>38</sup>The Department of Health announced new measures to reduce the spend on Agency on 3 June 2015. More information is available from: <https://www.gov.uk/government/news/clampdown-on-staffing-agencies-charging-nhs-extortionate-rates>

<sup>39</sup>For social workers, specialist nurses, nurses generally, medical radiographers, GPs, and others such as emergency medicine consultants, haematology, consultants, old-age consultants, old-age psychiatry consultants, general medicine specialists, rehabilitation medicine specialists, psychiatry, clinical neurophysiologists.

<sup>40</sup>Investing in People: Workforce Plan for England, Health Education England 2015, available from: <http://hee.nhs.uk/wp-content/blogs.dir/321/files/2014/12/Investing-in-People-Workforce-Plan-for-England-2015-16.pdf>

Board to ensure it invests in areas likely to deliver the greatest transformation, whilst continuing to provide high quality care for patients. Health Education England told us that it would explore more innovative approaches to post-registration education to enable the non-medical workforce to realise local ambitions; for example, supporting nurses to look after the whole person in different settings, by funding post-registration courses in psychiatry, mental health and the physical therapies.

- 5.12 **NHS Employers** told us that it was not possible to make an assessment of the impact on issues such as recruitment and retention, or the potential for changes to staff availability to work different working patterns as a result of changes to the payment system. NHS Employers told us that any changes to existing pay or conditions of service could have a differential impact on NHS organisations in terms of recruitment, retention, motivation and behaviours of the workforce. They stated that, for this reason, it would be important that any changes provide employers with some flexibility to enable them to adjust national provisions to meet local operational challenges.
- 5.13 NHS Employers told us it would be important for employers to ensure the equality impact is fully considered and assessed for staff who may be required to change working patterns. They said employers would need to be particularly sensitive to ensure that changes to current contractual arrangements do not disadvantage particular groups of staff who could be asked to work some weekends. This could include staff with child care responsibilities, and others who want to reserve a Saturday or Sunday for religious worship. They told us that employers had noted the inherent conflict between the need for more flexible staff deployment (including more weekend and evening working) and the need to support the family and carer needs of a predominantly female workforce.
- 5.14 **NHS Providers** recognised that non-basic pay, including unsocial hours premiums, make a significant contribution to the pay of many staff and suggested any implementation of reforms to Agenda for Change should be appropriately phased. They believed there was a need to work through the implications of essential reform of Agenda for Change for recruitment and retention, and that a phased approach might help mitigate the risks, allowing the definition of unsocial hours and the premiums paid to be gradually changed. NHS Providers told us that even with reform of unsocial hours payments, it is more than likely that NHS staff would continue to be well rewarded relative to workers in other sectors who provide seven-day services.
- 5.15 The **Welsh Government** told us that the NHS Wales Planning Framework<sup>41</sup> makes clear the joint intent of the Welsh Government and NHS Wales to raise the ambition and effectiveness of workforce planning. The Welsh Government said the need for effective medium-term planning was particularly important as the NHS in Wales faces some of the biggest challenges and opportunities since its creation, including a rising elderly population, inequalities in health, enduring austerity, increasing numbers of patients with chronic conditions and medical staffing pressures.
- 5.16 The Welsh Government confirmed that the NHS in Wales does not routinely record or collect agency data based on days or times of the week. The Welsh Government told us that general observations provided by nurse banks suggested that it is not so much that the demand for agency staff is greater at the weekend but that there is a greater availability of agency staff. The Welsh Government believed that this was partly perhaps because of the additional pay rate available, but also due to the greater flexibility staff may have at the weekend to work additional shifts that they could not work during the week.

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<sup>41</sup> The NHS Wales Planning Framework is available from:  
<http://www.wales.nhs.uk/sitesplus/documents/986/NHS%20Wales%20Planning%20Framework%202013-14.pdf>

- 5.17 The **Northern Ireland Executive** told us that it had no evidence on how a reduction in unsocial hours premia would affect recruitment and retention and that this would need to be looked at. The Northern Ireland Executive were clear that any consultation on changing terms and conditions would need to consider this and an equality impact assessment would be required.
- 5.18 The **Joint Staff Side** told us that after several years of pay restraint, NHS workers have faced a real terms pay gap of around 15 per cent since 2010 and any further changes to their detriment would cause further upset, and damage recruitment and retention. The Joint Staff Side said that any changes to unsocial hours payments would have a damaging impact on the earnings of many NHS staff, with other far-reaching consequences for staffing levels during unsocial hours. The Joint Staff Side stated that the NHS is currently under pressure and struggling to meet rising demand and to ensure safe staffing levels. The Joint Staff Side believed that the impact of contract reform on staffing supply was difficult to predict and risked proving to be a dangerous experiment which could undermine the need for safe staffing levels and stability in staff recruitment and retention. If unsocial hours premia were removed for weekends, evenings or nights, the Joint Staff Side believed staff would prefer to work through an agency.
- 5.19 The Joint Staff Side told us that time and resources must be employed to understand fully the workforce planning implications of the extension of seven-day services.
- 5.20 The **Royal College of Nursing** told us that three quarters of nursing staff who do shift work were reliant on shift premia, and imposed changes to terms and conditions would cause further distress and risk industrial upset at a time of great uncertainty and upheaval. The Royal College of Nursing believed that, during a time of acute recruitment problems in the NHS, imposed changes would simply lead to nurses choosing not to work unsocial hours and short-term gains from lower premia would be eclipsed by increased agency and bank usage, higher staffing costs and poorer quality of care. The Royal College of Nursing told us that the nursing workforce is predominantly female, and a large proportion have caring responsibilities, looking after children, grandchildren and other relatives. The Royal College of Nursing said that flexibility and levels of pay were therefore important factors when making choices about working unsocial hours and changes to working patterns or pay levels to the detriment of nursing staff were likely to damage recruitment and retention prospects in the NHS.
- 5.21 The Royal College of Nursing said that there are significant barriers to flexibility and ensuring safe staffing levels. These included an over-reliance on agency and bank nursing staff, limited access to training and continuing professional development (CPD) and considerable levels of stress in the workplace, with nursing staff reporting heavy workloads, staff shortages and feeling pressured to work beyond their scope. The Royal College of Nursing told us that seven-day care is inextricably linked to workforce planning, and will require detailed consideration of the impact on the whole workforce, in terms of number of staff needed in the short- and medium-terms; skill levels and decision-making authority; learning and development needs; and the impact of seven day care on psychological, physical and emotional health and on work-life balance, including travel and caring responsibilities.
- 5.22 The **Royal College of Midwives** told us that a clear consideration for seven-day services, particularly if it means an increase in activity, will be workforce planning. There was already a long-term shortage of midwives in England and many services are reliant on agency staff and the good will of existing staff to cover the service as it stands.
- 5.23 **Unison** told us that there would be a change in staff behaviour if there were any cuts to unsocial hours payments, with staff seeking not to work these hours or to leave the NHS. Unison said the lack of information about extension to services meant it was impossible to establish what staff groups would be needed and where there may be skills-mix and

occupational group short-falls. Unison stated it was hard to imagine that extending services, without ensuring change is organic and reflected in workforce planning, would do anything other than exacerbate existing staffing issues. Unison believed that the lack of vacancy data (held and published) by NHS England, the Northern Ireland Executive and the Welsh Government made workforce planning impossible. Unison told us that the over-reliance on bank and agency staff, particular skills gaps and the population of those about to retire were all issues that needed to be addressed urgently, and pose a major risk to the success of any service extension.

- 5.24 Unison said that trusts were already having recruitment and retention problems in certain staff groups, and seven-day services would increase demand within hard to recruit groups including physicians and radiologists. There was a real difficulty in recruiting to posts within the London area, which has emerged over the last few years following the removal of occupational therapists from the shortage occupation list.<sup>42</sup> Unison told us that a report by NHS Employers, looking at NHS qualified nurse supply and demand, had highlighted that 83 per cent of organisations surveyed reported experiencing qualified workforce supply shortages and 39 per cent of organisations had between 1-50 FTE hard to fill nursing vacancies. Trusts were having to recruit from other European Union (EU) Countries to try and fill their posts.
- 5.25 Unison reported that, according to the IDS Staff Survey results,<sup>43</sup> 36.4 per cent of staff stated they were reliant on unsocial hours premia and 49.8 per cent of these said they would leave the NHS if payments were removed or reduced; 71 per cent would seek not to work the hours.
- 5.26 **Unite** told us that disciplines that already provide extended day working are currently struggling to fill posts, and if a seven-day service is to be introduced, a phased approach would be required, where dedicated training and mentoring should take place. Unite stated that there is currently a shortfall of senior scientists, scientist managers and consultants of between 7 and 11.5 per cent, and the like for like replacement of staff is not taking place. Unite said that instead cheaper, lower grades are being introduced to the service with insufficient time and resources for training and development, which in turn leads to a rise in clinical risks. Unite believed that the introduction of seven-day services would make this problem even worse. Unite told us that workforce planning is poor with no clear indication of what employers want for their future workforce, and this had to be a first step.
- 5.27 The **Society of Radiographers** told us that in its experience an extension to services required a comparable increase in staffing in order to maintain continuity. The Society of Radiographers said the increase was not only for core staff to operate the service, but also for support services, in order to ensure the same level of service to patients irrespective of time of attendance. The Society of Radiographers stated that the current shortage of qualified staff in diagnostic radiography, ultrasound, mammography and radiotherapy, meant employers were struggling to recruit sufficient numbers to maintain the quality to ensure that they retain a comprehensive service.
- 5.28 The **Chartered Society of Physiotherapists** told us that adequate staffing levels was one of the key issues affecting the ability of physiotherapy services to provide an effective seven-day physiotherapy service. The Chartered Society of Physiotherapists said that most physiotherapy services have a staffing establishment based on the provision of a five-day service, and revised roster systems or shift patterns could not compensate for inadequate staffing levels; attempting to do so would cause significant problems for staff. The

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<sup>42</sup>The shortage occupation list is an official list of occupations for which there are not enough resident workers to fill vacancies. The Migration Advisory Committee (MAC) regularly reviews the list and calls for evidence of which occupations should be included or removed.

<sup>43</sup>The NHS staff survey on pay and conditions was carried out by IDS for the Joint Staff Side NHS trade unions in 2014.

Chartered Society of Physiotherapists believed this was likely to raise health and safety concerns, increase stress, absence levels, turnover and labour costs, reduce productivity and raise the overall cost of the seven-day service provision. A survey of its members revealed that, if unsocial hours premia were reduced, 44 per cent of staff would seek not to work the hours and 15 per cent would leave the NHS.

- 5.29 The **Federation of Clinical Scientists** told us that unless staff numbers (and associated costs) increased significantly the spreading of work more uniformly across 24/7 would undermine the vast number of inter-individual interactions and collaborations that are vital to so much of the operational, innovative and developmental work of healthcare professionals. The Federation of Clinical Scientists stated that there had been no workforce planning towards that objective, and there would be a major shortage of healthcare professionals to support such a working model.

### **Our comment**

- 5.30 There are potential consequences to reducing the rates of the Agenda for Change unsocial hours premia and extending core time hours. The danger is that this could have a negative impact on recruitment and retention. Reduced premia rates may no longer offer sufficient incentive for staff to work these hours given the challenges of delivering care and the increased pressure and stress that some staff groups are already experiencing, as evidenced in staff attitude surveys. The risk is exacerbated by the fact that there are already shortages in some staff groups.
- 5.31 Setting an appropriate incentive for Agenda for Change staff to work during unsocial hours will therefore be key to ensure reliable staffing levels. The Ambulance Service provides an example within the NHS where a different system is already in operation. Unsocial hours are paid upfront as part of the overall salary package based on the number of unsocial hours worked, rather than claimed back as a result of the number of hours and time worked used for other Agenda for Change staff. The Ambulance Service is experiencing considerable recruitment and retention issues and has reported difficulties filling weekend shifts.
- 5.32 The reward approach will need to be sufficient to support and respond to variations in service models. The design of services and working arrangements will vary by locality and/or professional group depending on the number and frequency of unsocial hours that are required to be worked and based on the needs of the patient. The evidence considered in Chapter 4 has shown that there is some scope to review the existing approach to premia and also sets out the range of practice used in other sectors.
- 5.33 The pay proposals presented from the Department of Health and NHS Employers are at an early stage and have not yet been fully developed or worked through. Neither the Welsh Government nor the Northern Ireland Executive were at the stage of developing proposals for pay changes, but both parties were interested in how the current system could be modernised and improve the affordability of seven-day services. Going forward it will be important for all countries in the United Kingdom to consider the impact of any proposed pay changes, and would be useful to model scenarios based on typical shift patterns. This could help all parties increase their understanding of individual impacts and the percentage of pay that could be lost or gained through changes to unsocial hours definitions and premia.
- 5.34 Whilst Chapter 4 showed that premia in bands 1 to 3 were at the higher end of the range compared to the sectors surveyed, many of these staff will be reliant on these payments to maintain their earnings. Table 5.1 shows the percentage of the Agenda for Change workforce currently working some unsocial hours, by band and role type, illustrating the potential for differential impacts of changes to unsocial hours definitions and premia. The numbers and types of staff affected, and the extent of any reductions in earnings will be



sensitive to the design of any new unsocial hours system. It may be the case that changes could be made to the evening window without impacting greatly upon large numbers of staff, however the change for some individuals could be significant. If more wide ranging changes are made then the effects are likely to be more significant both in terms of the number of staff affected and their change in income. At this stage, more modelling will need to be done to understand the extent and nature of the impacts of any changes on particular groups and individuals.

**Table 5.1 – Percentage of current workforce working unsocial hours by staff group (FTE)**

Staff Group	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	Total
Central functions	9%	11%	6%	2%	2%	1%	1%	1%	1%				3%
Hotel, property & estates	74%	62%	49%	18%	12%	3%	1%	3%					56%
Managers			17%	8%	4%	4%	1%	1%	1%	1%			1%
Qualified nursing, midwifery & health visiting staff				78%	84%	59%	37%	21%	11%	4%			65%
Qualified Scientific, therapeutic and technical staff (STT)				18%	34%	24%	14%	10%	9%	6%	3%	2%	21%
Senior managers								1%	1%	0%			<1%
Support to doctors and nursing staff	55%	62%	51%	14%	9%	6%	5%	3%					47%
Support to STT staff	36%	35%	24%	17%	13%	3%	7%						24%
Unknown Staff Group		46%	30%										32%
Total	68%	55%	40%	12%	64%	41%	23%	10%	5%	2%	1%	<1%	42%

1. Based on NHS Employers analysis of data extracted from the live electronic staff record (ESR) system and the ESR data warehouse for the financial year 2013/14.
2. Staff are defined as being an 'unsocial hours worker' if greater than 0.49% of their total earnings was earned for work on a Night, Saturday, Sunday or Bank Holiday. (This may represent as few as 7 hours unsocial hours work over the course of a year)
3. This provides an upper estimate of the proportions of staff working unsocial hours. Proportions of staff working unsocial hours on a regular basis will be lower.
4. Staff with incompatible staff groups and band information have been allocated in the 'Unknown staff group' category.
5. Numbers with less than 5 people working unsocial hours (FTE) have been suppressed.

- 5.35 We have commented in our previous reports on the issue of the lack of detailed workforce planning and vacancy data across the NHS in the United Kingdom and the big problem that this already presents. The Kings Fund published its report; *Workforce Planning in the NHS*<sup>44</sup> on 29 April 2015, and the findings support this position.<sup>45</sup> Some of the key conclusions from the report include:
- The information needed to guide workforce planning locally and nationally has not kept pace with the growing plurality of providers delivering NHS-commissioned services. There are large data gaps on primary and community care, use of agency and bank staff, vacancy rates, and independent and voluntary sector providers.
  - Although recent reforms have put Health Education England in control of planning the training of the workforce of the future, there needs to be a more joined-up approach to workforce planning today, with a national strategy that covers all NHS-commissioned services. This will avoid the current piecemeal approach to addressing workforce pressures.
- 5.36 In the context of delivering an increased service, and across a multitude of service providers, the need to close information gaps on vacancy data and improve workforce planning becomes more acute. The evidence from Health Education England demonstrated that it was not confident at this stage that trusts were factoring seven-day services into their requirements. As plans are in the early stages in Wales and Northern Ireland, this may also be the case here. The Welsh Government approach appears to be focused on changing service configuration and investing in new roles, embedded in its Prudent Healthcare principles.<sup>46</sup>
- 5.37 It will be essential to consider what roles are required, and impact on resources, before embarking on a significant move towards the expansion of seven-day services. Trusts and health boards focusing on this now could help to identify the scale of the change, the requirement for new types of roles, and what the impact will be for individual staff groups, as well as addressing the substantial lead time required to produce newly qualified recruits for many of the Agenda for Change staff groups. Without this forward planning there is a risk that there will not be sufficient trained staff resource across the required groups to deliver an increased seven-day service.
- 5.38 All parties are united in their desire to see agency costs driven down and are working together to achieve this. There is insufficient evidence available for us to provide an informed comment on whether the implementation of seven-day services would increase or reduce agency spend. However, if resource requirements for the expansion of seven-day services are not fully incorporated in local workforce plans and education commissions then it is likely to take a number of years to train suitably skilled and qualified staff. If changes are introduced without the appropriate workforce planning then the short-term impact on staff levels could see agency costs increase.
- 5.39 However, it is also possible that implementing changes to staff working patterns, and moving to a flexible working approach across seven days, could help to reduce agency use. For example, if staff are better able to plan their shift patterns there may be less need for short-term agency cover. But, this will be dependent on ensuring there are sufficient staff numbers in place to cover a seven-day delivery model.

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<sup>44</sup> A full copy of the Kings Fund report is available from:  
<http://www.kingsfund.org.uk/publications/workforce-planning-nhs>

<sup>45</sup> The NHSPRB and DDRB Chairs wrote a joint letter to the Secretary of State for Health on 26 May 2015 in regards to the findings of the Kings Fund report and the issue of workforce planning in the NHS. A copy of the letter is contained at Appendix I of this report.

<sup>46</sup> The principles and key concepts behind prudent healthcare are available from:  
<http://gov.wales/topics/health/nhswales/prudent-healthcare/?skip=1&lang=en>  
<http://www.prudenthealthcare.org.uk/>

- 5.40 Whilst there is evidence of increased agency spend in London at weekends, data on the time of the week agency staff are used was not available nationally. This is unfortunate as it could have provided key information about the shift times which are typically more difficult to fill, and given a potential indicator of the typical NHS market rate for unsocial hours shifts. If employers are at present needing to find cover for these shifts via agency workers, then it might imply that current premia rates are not sufficiently attractive or the shifts are not flexible enough. If it is decided to pursue changes to premia, and revised rates are not pitched at the correct level, there could be a significant impact on recruitment and retention, leading to an increase in agency costs and impacting on overall service outcomes.

#### **Observation 8**

**We note that those responsible for workforce planning and commissioning of training are not yet fully linked into local plans for seven-day services. Given the number of years it takes to train suitably skilled and qualified staff we believe a substantial barrier to the expansion of seven-day services could be insufficient numbers of appropriately trained staff.**

## **Morale and motivation**

### *Evidence from the parties*

- 5.41 The **Department of Health** told us it was appropriate 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. The Department of Health stated that if the workforce was too expensive it risked reductions in front line staff and conversely, if the workforce was paid too little, there was a risk staff motivation and morale would fall with staff choosing to work outside the NHS. The Department of Health said that both outcomes carry the risk of less and lower-quality healthcare, and the inability to meet the aims of seven-day services.
- 5.42 The Department of Health said that it 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 choice. The Department of Health believed that the generous package of benefits already on offer to staff was not fully appreciated and communicated by employers. The Department of Health told us that case studies have shown that staff engagement is key, and permanent staff were willing to change their working patterns to deliver better care and improve general performance of a service.
- 5.43 **NHS Employers** told us that there were other potential barriers to the delivery of seven-day services that needed to be considered at local level, these included:
- staff engagement and communications and working with unions to address local issues;
  - cultural and organisational change – the need for leadership, changing attitudes to weekend and evening working, promotion of NHS and organisational values;
  - staffing levels and appropriate skill mix and effective handover arrangements;
  - managing rota and shift planning;
  - ensuring an adequate workforce supply to provide additional capacity, taking account of the costs and availability of suitably trained staff and future workforce planning;
  - equality and diversity issues – fairness to all staff groups, implications/impact on families, religious observance, older people, childcare etc;
  - occupational health and wellbeing of staff; and
  - support for staff – support services such as maintenance, IT and HR, need to be available.

- 5.44 NHS Employers believed the move towards more seven-day services needed a wider culture change across the NHS, in addition to resolving the financial, workforce and service design challenges.
- 5.45 **NHS Providers** told us that there was a need for a fundamental change, whereby providers of NHS care and their staff see the NHS as a 24/7 service, not a 9am till 5pm Monday to Friday service, with only emergency services outside of those hours.
- 5.46 The **Joint Staff Side** told us that a large proportion of the workforce receive unsocial hours payments and that they rely on them to sustain their standard of living. The Joint Staff Side said since the publication of other parties' evidence there had been a huge amount of adverse reaction from NHS staff to the proposals. The Joint Staff Side said that whilst there was a general acceptance among staff of the need for seven-day services in some areas of the NHS, there was anger about the prospect of reduced terms and conditions, particularly after consecutive years of below cost of living pay rises.
- 5.47 The Joint Staff Side wished to record the trade unions' strong objections to any changes to Agenda for Change to the detriment of NHS staff. The Joint Staff Side believed that seven-day services should be built around the needs of the patient and any additional costs should not be met at the expense of the workforce either through diluted skill mix, increased workloads, pay restraint or changes to unsocial hours payments.
- 5.48 The **Royal College of Nursing** told us that a large proportion of nursing staff working shifts rely on unsocial hours payments to sustain their standard of living and any reduction or removal would have a large financial impact. The Royal College of Nursing said it objected in the strongest terms to any reforms to unsocial hours payments which disadvantage the largest occupational group in the NHS workforce. Preliminary polling of its members had indicated the strength of feeling on the issue of unsocial hours pay among nursing staff who work shifts, with three-quarters of respondents to one survey and two-thirds in another survey stating they would seek not to work unsocial hours if payments were removed or reduced.
- 5.49 The Royal College of Nursing told us that full consideration needed to be given to the relationship between shift working and physical and mental health and wellbeing. The Royal College of Nursing said that shift working is disruptive to family and social life, to sleep patterns and is associated with a range of adverse physiological and physical symptoms.
- 5.50 The **Royal College of Midwives** told us it had commissioned research to investigate members views on pay and working conditions and this had shown midwives and maternity support workers were disengaged from the service and did not feel valued by their trust. The Royal College of Midwives said it was particularly concerned that morale and motivation were at an all-time low and this was not the time to further cut pay, terms and conditions. The Royal College of Midwives believed that units were overworked and understaffed – staff were not feeling valued, are redeployed to other areas of work to cover essential services and units were reliant on bank and agency staff. The Royal College of Midwives told us that improving staff engagement could save on litigation costs, sickness absence rates and have a direct impact on patient outcomes.
- 5.51 **Unison** told us that the Incomes Data Services (IDS) NHS staff survey 2014 had identified that staff morale was worse than it was 12 months ago, that staff were regularly working over their contracted hours and did not have enough time and resources to deliver the best care they can for patients. Unison said that over half of the respondents to the survey had indicated that they relied on additional payments to sustain their standard of living due to the decreasing value of basic pay. Unison told us the percentage of respondents relying on these forms of payments had increased by nearly 10 per cent in

the last two years, emphasising not only the degree to which the value of NHS pay had fallen, but that staff on the lower bands rely on unsocial hours payments as a valuable source of supplementary income.

- 5.52 Unison said that the 'seven-day services vision' required the good-will and buy-in from staff. Unison told us that it was very concerned any changes to unsocial hours premia would further disenfranchise staff who already felt desperately undervalued. Unison believed this would worsen the morale of the workforce and industrial relations in the sector, and jeopardise plans to move towards a re-configuration of the service. Unison said a reduction or removal of unsocial hours premia would seriously impede the NHS' ability to cover shifts, and ensure service delivery is built around patient needs.
- 5.53 **Unite** told us that a well-treated and happy workforce was crucial to the quality of services and vital for meeting the needs of patients. Unite thought that the proposals to cut unsocial hours payments and reform incremental progression would have the opposite effect.
- 5.54 Unite raised other issues to be considered, such as increases in childcare costs since it is more expensive to access childcare during unsocial hours, and the lack of nursery and school care. Unite told us that staff may face risks such as less safe journeys to work and poor access to public transport. Unite said that working irregular shifts could have an impact on the physical and mental health of staff.
- 5.55 The **Society of Radiographers** told us that shift working can be detrimental to health and have an adverse effect on work life balance, especially for a predominantly female workforce. The Society of Radiographers said that 80 per cent of its membership was female and a full examination was required of how seven-day working, with a 24 hour commitment, will affect this sector of the working population.
- 5.56 The Society of Radiographers said that consideration should also be given to transport and equipment issues; not all hospitals are accessible by public transport, and many that are have a reduced service out of hours and at weekends. The Society of Radiographers said that many patients who require access to services have long-term conditions and often require assistance. In its view consideration would therefore need to be given to accessibility, competent and intelligent booking of appointments, and potentially, a revision of transport requirements for the patient. The Society of Radiographers told us that if complex equipment is intended for use 24/7, equal consideration will need to be given to maintenance and replacement.
- 5.57 The **Chartered Society of Physiotherapists** told us that changes to established working patterns, particularly where they are imposed, can cause a considerable amount of stress. The Chartered Society of Physiotherapists said that in the longer term, if working patterns infringe too much on employees' personal lives, health or in some cases their professional identities, then it will inevitably lead to long-term recruitment and retention difficulties. The Chartered Society of Physiotherapists believed it was therefore in the interests of both employees and management that the needs of existing employees were accommodated as far as possible when introducing new working patterns and hours. The Chartered Society of Physiotherapists stated that consultation on proposals must include the ability for members to influence the organisation with regard to new working patterns and hours and to achieve consensus on how these would be implemented and operated.
- 5.58 The **Federation of Clinical Scientists** told us that more attention should be given to the positive possibilities afforded by technology, particularly Information Technology for staff to work flexibly. The Federation of Clinical Scientists also believed that specific attention must be given to the provision of 24/7 services by an ageing healthcare workforce.

## Our comment

- 5.59 All parties recognise the cultural barriers to change and see this as one of the key issues to overcome. Culture change will form a key component to shifting the mind-set of staff from a Monday to Friday ethos to seven-day delivery. The position will need to evolve so that the delivery of patient services across seven days becomes the new norm for NHS staff.
- 5.60 There are two broad groups of staff working in the NHS at the moment – those who work predominately Monday to Friday only, who are committed to this arrangement and may have been attracted to a role for that reason; and those such as midwives, ambulance workers or many nurses who are already working a variation of 24/7 to deliver a seven-day service.
- 5.61 There is a risk that some staff may leave as a result of a change to seven-day services, and we were told of examples where this had happened at some of the case study sites. This appeared to be a minority of staff, and in general most had embraced the clinical need for change and recognised the importance of improving care through changes to service delivery. This is, however, based on a small number of experiences at particular sites and it would be unwise to draw any general conclusions. It is more likely that staff behaviour will be driven by local market conditions and how much they are involved in forming the procedures around allocating new shift patterns.
- 5.62 For those staff already delivering services over seven days there will be no change to their working culture, and having more staff groups available 24/7 is likely to make their role easier. However, these staff groups will be resistant to a reduction in the unsocial hours premia which they currently receive. The definition of unsocial hours working and requirement to compensate staff for working these hours has long been embedded in the NHS. There is an expectation among staff that certain hours should attract premia pay, which in turn is an important part of their earnings. It is likely that reducing premia will make some staff more reluctant to cover particular shifts, leading to either staffing shortages or increased use of agency workers.
- 5.63 More generally, there will be advantages and disadvantages for all staff of moving to a culture of seven-day services, and this will be dependent on individual circumstances. We can see potential benefits from the expansion of seven-day services for staff in terms of flexibility, work-life balance and increased job satisfaction from providing high quality patient care. However, good management practice and staff engagement are crucial to realising these potential benefits. The benefits that make the position attractive for some staff will need to be balanced against the fact that there will be others who do not want to work at night or over the weekend. Indeed, some individuals may have chosen to undertake a particular role because it is a Monday to Friday post and does not require unsocial hours working.
- 5.64 The ability for staff to have a role in managing the local shift patterns, and choosing how and when they work, has been key to the success at pilot sites. It is important that the learning from these sites can be shared for the benefit of others, and that local management are prepared to embrace and support flexible employment practices that can support the delivery of seven-day services and make arrangements more attractive for staff, for example, team based self-rostering, and contracts for weekend or term-time only working.
- 5.65 There are a number of other issues around seven-day services that will be important for NHS staff, if their commitment to the culture change is to be secured. These include: access to staff facilities during weekends and evenings, the availability and requirement for support staff such as administrative and maintenance staff to support the delivery of services, the reliability and availability of transport for travelling to and from work, the

availability and additional cost of childcare services over the weekend, health and wellbeing support for staff and ensuring access to training and development opportunities for staff working shifts. Most of these issues can only be planned and resolved locally.

- 5.66 The enhancement of services will also have implications for training as new multi-skilled roles are developed to respond to and deliver new service models. This could provide opportunities for the career development of existing staff. Health Education England, the Welsh Government and the Northern Ireland Executive will need to consider their individual requirements and develop and invest in appropriate training packages to respond to this.
- 5.67 Maintaining staff engagement will be key to the successful expansion of seven-day services. The proposals on unsocial hours definitions and premia from the Department of Health and NHS Employers, as they stand, would reduce the pay and risk the good will of core staff groups, like nurses and midwives, who are already working across seven days. Many staff will currently be reliant on these payments as part of their overall earnings package. Our remit group are already working in a climate of increased pressure on the service and against the backdrop of lower real wages as a result of the recent period of pay restraint. There has been recent industrial action over pay across the United Kingdom, and the industrial relations climate remains sensitive.
- 5.68 The expansion of seven-day services is a key part of wider service change across the NHS as it considers how it can continue to evolve and respond to emerging and changing patient needs to deliver quality patient care. In the context of these changes it seems sensible to consider a review of unsocial hours definitions and premia so that the payment system is designed to offer appropriate incentive and support service delivery. However, in order to ensure appropriate balance between patient needs; the effects on staffing and individuals; and affordability, our view is this should not be considered in isolation and should be incorporated in a more general review of the Agenda for Change reward package. This will provide all parties with the opportunity to consider how the structure as a whole can be reviewed to ensure that it can continue to support the NHS of the future and offer a competitive employment package that enables the recruitment and retention of the skilled and qualified staff the service needs.
- 5.69 We are pleased to see the general agreement between the parties on the clinical importance of providing seven-day services, and the shared commitment to helping the NHS provide a high quality service for patients. We also note, and have flagged in other reports, that there are aspects of wider Agenda for Change pay arrangements that may need to be revisited, given that it is more than 10 years since they came into effect. Given the need for better understanding of the implications of seven-day services in different localities, which will require local discussions, we think that time allows for national discussion of unsocial hours definitions and premia to take place in the context of wider discussion of Agenda for Change pay arrangements. We are strengthened in this view by the recognition from all of the Health Departments, that the first step for the expansion of seven-day services is considering the position of DDRB remit staff. It is also significant that, as set out in Chapter 3, the major costs of any move to seven-day services looks likely to come from the need for extra staff to cover the extra hours to be worked, whatever unsocial hours definitions and premia are eventually agreed. In the circumstances, it seems to us unwise to review Agenda for Change unsocial hours definitions and premia in isolation.

*Observation 9*

There is a case for some adjustments to Agenda for Change unsocial hours definitions and premia. However, if done in isolation, this could risk the morale and motivation of staff, damage employee relations, exacerbate existing shortages, and, in particular, risk the good will of staff already working across seven days.



## Chapter 6 – Conclusion

### Introduction

- 6.1 In this concluding chapter we set out some further observations on how the parties could move forward. In making these observations we note that the position of the Devolved Administrations may differ and that progress could be made on a United Kingdom-wide basis, or by the individual countries; this is for the countries to decide, however we see these as core issues for all to consider.

### The case for change

- 6.2 We note that the case for change – on the grounds of improving patient outcomes at weekends – is compelling. Given that the availability of our remit group is not identified as the principal barrier to achieving these improvements, our view is that negotiations over Agenda for Change should not delay continued local implementation of seven-day services.
- 6.3 A key point however is to ensure that seven-day services are cost effective, bearing in mind the need to recruit and retain, and to maintain the morale and motivation of staff. How quickly and uniformly seven-day services are required to be in place will inevitably have to be traded-off against affordability. If the priority is affordability, for example, then the slower and less uniform the pace of change. We note that the costs of seven-day services are principally in employing more staff, including consultants.<sup>47</sup> Chapter 5 set out our views on the importance of robust workforce planning to support the extension of services over seven days and the need for sufficient workforce numbers to deliver this.

### Balanced package of reform

- 6.4 The proposals given to us focused on the cost of unsocial hours premia. As set out in Chapter 3, in our view the aim of not increasing the pay bill per FTE can only be met by reducing the pay of those staff that already work over seven days if unsocial hours definitions and premia are looked at in isolation. It is also our view that Agenda for Change is not a barrier to seven-day services in contractual terms. Chapter 4 showed that, in comparison to practice in other sectors, there may be scope for the parties to discuss some adjustments to unsocial hours definitions and premia. However, in general terms the principle of using premium payments is well used in other sectors. Chapter 5 sets out why we feel that unilateral changes to unsocial hours definitions and premia would be risky, in light of the potentially negative impact on recruitment and retention and morale and motivation, and the generalised lack of data and understanding about impacts on individuals.
- 6.5 In our last two reports we recommended that the Agenda for Change pay structure is ready for review. There have been some changes but the pay structure itself, namely the pay spine and system of progression, has not been fundamentally reviewed since the inception of Agenda for Change in 2004. This is now timely to ensure the pay structure can continue to adapt and meet the needs of the service. Table 6.1 sets out the rationale behind a review of the pay structure in more detail. As demonstrated by the findings from the Incomes Data Services (IDS) research,<sup>48</sup> unsocial hours definitions and payments have been reviewed in other sectors since the late 1990s, as 24/7 operations have become more prevalent. In many cases this was part of a review of the overall reward package.

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<sup>47</sup>The Healthcare Financial Management Association (HFMA) costings report referred to in Chapter 3, available from: <http://www.england.nhs.uk/wp-content/uploads/2013/12/costing-7-day.pdf>

<sup>48</sup>The findings of the IDS research are explored in detail in Chapter 4 of this report.

**Table 6.1 – Agenda for Change pay structure: areas for review**

Agenda for Change Pay Issue	Reason for Review
Length of scales	To ensure fairness and equality as scales are long; the length of time to reach the rate for the job.
Overlapping bands with shared spine points	To clarify the rate for the job at each pay band, to remove disincentives for promotion.
Progression	To ensure rigour in the application of the Knowledge and Skills Framework.
Large and increasing proportion of staff at the top of the pay band	To provide incentives for those staff at the top of the bands.

- 6.6 It seems to us therefore, that discussions about unsocial hours definitions and premia are better taken forward as part of negotiation on other parts of the pay system, with the aim of agreeing a balanced package of updates to Agenda for Change. Employers could seek to make adjustments to unsocial hours definitions and premia and this may offer up some savings but there is not enough evidence to support wholesale change to premia. A wider canvass for future discussions could give greater space for a negotiation to deliver benefits for patient care that all parties could agree to. Ideally this should include a review of the length of pay scales, overlapping bands with shared spine points, progression and improved links between reward and performance, including incentives for staff at the top of their pay band. Such discussions may be more productive if staff and employers have stability in pay; a multi-year pay deal could perhaps provide this.
- 6.7 We feel it is crucial however that any balanced package is led by service need and staff engagement, and is supported by a commitment to staff development and training. We also feel it is crucial to establish priorities as an early next step, and we discuss this later in this chapter. To inform any review of a pay structure, the organisation must understand where it wants to go and how best to design a reward system to support and underpin this.

**Observation 10**

**Although some changes could be made to unsocial hours definitions and premia, any major changes should be wrapped into a wider review of the Agenda for Change pay structure to formulate a balanced package.**

**Priorities and timescale**

- 6.8 A commitment was made between the parties to discuss reform of Agenda for Change, as part of the recent 2015/16 pay agreement in England. This did not include unsocial hours definitions and premia. We suggest therefore that the parties give early consideration to including these in the discussions. The pay agreement in Wales also included a review of Agenda for Change as part of the work of the Welsh Government’s Review of the NHS workforce.<sup>49</sup> There is no such agreement in place in Northern Ireland and consideration will need to be given on how they might pursue this.

<sup>49</sup> Originally the *NHS Workforce commission*, the commission is due to report findings in 2016. More information on the terms of reference and members of the commission is available from: <http://gov.wales/about/cabinet/cabinetstatements/2015/nhsworkforce/?lang=en>

**Observation 11**

The parties should set a deadline to come to an agreement on a balanced package or decide if that is not possible. May 2016 is a date that parties have already agreed to work to in England. Wales and Northern Ireland will need to factor this in as appropriate for their individual circumstances.

**Implementation and transition**

- 6.9 We were asked in the remit letters to make observations on transitional arrangements. We note that the Department of Health and NHS Employers are unclear on the impact of their pay proposals on particular staff groups and how they would manage the impact. Understanding the impact of shift patterns is key; the existing case study, early adopter and Vanguard sites could provide ready-made test beds for more detailed analysis. A similar modelling approach to that used to analyse working patterns for junior doctors could be useful here.
- 6.10 Given the early stage of the proposals given to us, we observe that one-off additional transitional funding may well be required to help smooth any changes in the levels of earnings, through pay protection. At this stage the scale of this is not possible to quantify without a better understanding of the proposition and how it may affect groups and individuals, as outlined above.

**Observation 12**

In order to maintain safe staffing levels and ensure staff are treated fairly, some transitional funding will be needed to cushion adverse impacts on those significantly affected by any adjustments to the pay system. The Department and other NHS bodies should develop their understanding of the scale of one-off funding that may be needed to implement any transition to an updated pay system.

- 6.11 Staff engagement, and by this we mean staff being involved in the design and delivery of services as equal partners with management, is seen as a key success factor from the case study and early adopter sites and a theme from the IDS case studies. The pilots show the gains in quality of patient care from involving staff locally moving, wherever possible, for example to a team based self-rostering approach and to identify problems. This requires sustained commitment to make this happen on the ground.
- 6.12 There is low confidence among staff in the NHS of the capacity for embedding HR changes. For example, changes to the Knowledge and Skills Framework have not been fully embedded two years since the national renegotiation. Successful local implementation of pay-related changes requires support to line managers, as well as good design of the system by the HR function. Resource for local line managers is essential and use of early implementer sites could help with this process.

**Observation 13**

Staff engagement and involvement in changes to services is critical and the quality of local implementation will be key to delivering successful change. The Department of Health and employers should consider how far they should bolster the capacity of line managers, as well as consider the use of Early Implementer sites to identify lessons. These will help to build the confidence of staff in the capacity locally to deliver such change.

## Links with DDRB remit

- 6.13 During our evidence gathering we heard that a key contractual barrier to expanding seven-day services appears to be the opt-out clause on non-emergency evening and weekend working in the consultant contract. We also heard that the way in which that barrier is dealt with will impact on the willingness of our remit group to embrace change. We note that the remit given to the DDRB followed ours and proposals put forward in evidence were more developed than those for Agenda for Change.
- 6.14 The two staff groups are paid on different sets of terms and conditions. It is important that changes to pay and reward packages are regarded as fair, and support the configuration of multi-disciplinary teams for the benefit of patient care.

### ***Observation 14***

**It will be important for the morale and motivation of our remit group that changes to reward packages between the two groups (medical and non-medical) are regarded as fair.**

## Appendix A – Remit letters

OFFICIAL



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, appearing to read 'Danny Alexander', with a long horizontal flourish extending to the right.

DANNY ALEXANDER

OFFICIAL  
3



Department  
of Health

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

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Jerry Cope  
Chair, NHS Pay Review Body  
Office of Manpower Economics  
Level 8  
Fleetbank House  
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London  
EC4Y 8AE

28<sup>th</sup> 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 31<sup>st</sup> 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 28<sup>th</sup> 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*<sup>1</sup> 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.

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<sup>1</sup> 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 be 'DR DAN POULTER', with a long horizontal stroke extending to the right.

**DR DAN POULTER**

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



Llywodraeth Cymru  
Welsh Government

Ein cyf/Our ref SF/MD/2235/14

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Chair, NHS Pay Review Body  
Office of Manpower Economics  
8<sup>th</sup> Floor  
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London  
WC1B 4AD

26 November 2014

*Dear Mr Cope,*

**NHS Pay Review Body – remit 2015/16**

I am writing to confirm the Welsh Government's approach in respect of the NHS Pay Review Body's (NHSPRB's) remit for 2015/16.

Following on from my announcement in March of a pay award for Agenda for Change (AfC) staff based on the same quantum as England, positive discussion between NHS employers and staff representatives have now concluded and I was pleased to announce the detail of a two-year pay award on 20 November. As a result of this agreement, the NHSPRB is not required to report on, or make recommendations for, the year 2015/16 on the remuneration of employed AfC staff; the recruitment, retention and motivation of staff; and regional/local variations in labour markets.

Turning to the observations requested by the Department of Health in respect of the AfC pay system and seven day services, we will wish for these to extend to Wales. Therefore, for 2015/16 the NHSPRB is asked to make observations on:

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

My officials will be happy to work with your secretariat to ensure you have all relevant information to provide these observations.

*Yours sincerely,*  
*Mark Drakeford*

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

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

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FROM THE MINISTER FOR HEALTH,  
SOCIAL SERVICES AND PUBLIC SAFETY  
Jim Wells MLA



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Mr Jerry Cope  
Chair  
NHS Pay Review Body  
Office of Manpower Economics  
8th Floor  
Fleetbank House  
2-6 Salisbury Square  
LONDON  
EC4Y 8JX

Our Ref: SUB/1063/2014

Date: 5 December 2014

Dear Mr Cope

**NHS Pay Review Body Remit 2015/16**

I wish to convey my thanks to the NHS Pay Review Body for its work on the 2014/15 pay round. My Department values the work of the pay review body in this important role. This is true, even where, as in the previous round we were unable to accept your recommendation due to the exceptionally challenging financial position in which we find ourselves and HM Treasury's call for continued pay restraint.

The Northern Ireland Executive has endorsed the principle of adherence to the UK Government's public sector pay policy and enforcement of pay growth limits is devolved to the Executive within the overarching parameters set by HM Treasury. The financial situation within Northern Ireland continues to present challenges which we are seeking to manage and it is within this context that I believe that pay restraint will continue to be required for 2015/16. Therefore I am not seeking a recommendation from the pay review body specifically in relation to pay.

However, in common with the remit provided by the Department of Health in England, I would ask NHSPRB to make observations on the barriers and enablers within the AfC pay system, for delivering health care services over seven days of the week in a financially sustainable way ie without increasing the existing spend. The NHSPRB are, in addition, asked to make observations on:

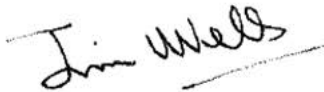
- affordable 'out of hours' working arrangements; and
- any transitional arrangements.

In considering these propositions, the NHSPRB should have regard to its normal terms of reference plus developments in the other sectors which provide seven day services. I would expect the Review Body's observations for Northern Ireland to follow the same timetable as that for England and be included in their report in July.

Working for a Healthier People



My officials are happy to work closely with your secretariat to provide you with all the necessary Northern Ireland specific information to enable you to make independent observations on this key area of service delivery.



**Jim Wells MLA**  
**Minister for Health Social Services and Public Safety**

## Appendix B – Composition of our remit group

- B1 Tables B1 to B7 show the composition of our remit group in each country and in the United Kingdom as a whole as at September 2013.<sup>50</sup> Detailed categories of staff in each country have been aggregated into broad staff groups, to enable cross-United Kingdom comparisons to be made.
- B2 Staff categories used in each administration’s annual workforce census have been grouped together by our secretariat. We have had to be mindful of the differences between the four datasets, and even these broad staff groups contain inconsistencies: some ancillary staff in England and Wales are categorised in the census as healthcare assistants and support staff, but have job roles that fit better in the broad group “administration, estates and management”.

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<sup>50</sup>The most recent date for which United Kingdom-wide data were available at the time of writing.

## NHS full time equivalent non-medical workforce as at 30 September 2013

**Table B1: Qualified nurses and midwives**

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Qualified nurses, HVs and midwives	307,692	Nurses & midwives bands 5-9	41,869	Qualified nurses, HVs and midwives	21,923	Qualified nursing & midwifery	14,178	<b>385,661</b>

**Table B2: Nursing, healthcare assistants and support staff**

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Unqualified nurses	61,201	Nurses & midwives bands 1-4	15,500	Unqualified nurses	6,332	Nurse support staff	4,014	
Healthcare assistants and support staff	122,030			Healthcare assistants and support staff	9,699			
	<b>183,231</b>		<b>15,500</b>		<b>16,031</b>		<b>4,014</b>	<b>218,775</b>

**Table B3: Professional, technical and social care**

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Qualified AHPs	64,377	Medical & dental support	1,908	Qualified AHPs	4,545	Professional & technical	7,014	
Qualified healthcare scientists	27,287	AHPs <sup>51</sup>	9,672	Qualified healthcare scientists	2,136	Social services	6,723	
Other qualified ST&Ts	41,802	Other therapeutic services	3,683	Other qualified ST&Ts	2,741	Home helps	1,825	
Unqualified ST&Ts	39,313	Personal & social care	909	Unqualified ST&Ts	2,194			
		Healthcare science	5,324					
	<b>172,778</b>		<b>21,498</b>		<b>11,616</b>		<b>15,562</b>	<b>221,454</b>

<sup>51</sup> In Scotland's published statistics from the 1st April 2013, paramedics have been reclassified from emergency services staff to allied health professions. However, for comparisons with the other countries of the United Kingdom, paramedics are classified here as Ambulance staff.

**Table B4: Ambulance**

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Qualified ambulance	17,815	Emergency services <sup>52</sup>	3,708	Qualified ambulance	1,380	Ambulance	1,070	
Unqualified ambulance	6,902			Unqualified ambulance	120			
	<b>24,717</b>		<b>3,708</b>		<b>1,499</b>		<b>1,070</b>	<b>30,994</b>

**Table B5: Administration, estates and management**

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Admin & clerical	201,161	Administrative services	24,503	Clerical and administration	12,176	Admin & clerical	11,044	
Maintenance & estates	8,944	Support services	13,777	Maintenance & works	959	Estates services	690	
Manager	24,430			Managers	1,384	Support services	4,840	
Senior Manager	10,157			Senior managers	600			
	<b>244,692</b>		<b>38,281</b>		<b>15,120</b>		<b>16,574</b>	<b>314,667</b>

**Table B6: Other**

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Others	4,380	Unallocated/not known	1,135	Others	131	Generic	27	5,674

**Table B7: Total NHS non-medical workforce**

	England	Scotland	Wales	Northern Ireland	United Kingdom
<b>FTE</b>	<b>937,490</b>	<b>121,990</b>	<b>66,320</b>	<b>51,428</b>	<b>1,177,229</b>
<b>Headcount</b>	<b>1,078,425</b>	<b>143,810</b>	<b>78,362</b>	<b>62,220</b>	<b>1,362,817</b>

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

<sup>52</sup> In Scotland's published statistics from the 1st April 2013, paramedics have been reclassified from emergency services staff to allied health professions. However, for comparisons with the other countries of the United Kingdom, paramedics are classified here as Ambulance staff.



## Appendix C – Call for Evidence

### NHS Pay Review Body

#### Special remit on seven-day services in the NHS: call for evidence

##### Overview

The Parliamentary under Secretary of State for Health has asked the NHS Pay Review Body (NHSPRB) to consider the barriers and enablers within the Agenda for Change pay system for delivering healthcare services every day of the week in a financially sustainable way. NHSPRB has been asked to submit observations, for England only, by July 2015.

##### Remit on seven-day services in the NHS

Details of the remit were included in the letter from the Parliamentary under Secretary of State for Health dated 28 August 2014 (Annex A).

NHSPRB is asked to make *observations* for England only on the barriers and enablers within the Agenda for Change pay system, for delivering healthcare services every day of the week in a financially sustainable way, i.e. without increasing the existing spend. Specifically, NHSPRB is asked to make *observations* on:

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

In considering these arrangements, NHSPRB should have regard to its normal terms of reference (Annex B) plus developments in other sectors which provide seven-day services. The report should be made by July 2015.

At the time of writing, the remit letters for the Devolved Administrations have not been received. There is a chance that some or all of the Devolved Administrations may wish to be included in this remit. We will inform the parties promptly should this prove to be the case.

##### The parties to the evidence process

While the Review Body would welcome evidence from any party, the following parties are being invited to submit evidence:

- Department of Health
- Foundation Trust Network
- Health Education England
- Joint Staff Side
- NHS Employers
- NHS England

##### Factors to cover in evidence

Submissions of written evidence should cover the specific factors set out in the remit letter (Annex A). The Office of Manpower Economics is commissioning research on seven-day working arrangements in other sectors, but additional evidence would be appreciated. The parties are welcome to submit evidence on any element of the remit; however, a list of questions is included below to assist the parties in focusing their evidence. Background on the work of NHSPRB can be found at <https://www.gov.uk/government/organisations/nhs-pay-review-body>

1. What are the services that the NHS would like to be able to provide seven days a week, but which it does not provide at the moment, and why?
2. What seven-day services/unsocial hours' services are currently provided and what is the cost differential compared to normal working hours?
3. Which staff groups will be needed to provide the desired seven-day services and what will be the impact on staffing levels on each day of the week? (i.e. what is the model for the workforce?)
4. What are the pay, staffing and motivational barriers and enablers to seven-day services in the NHS? Are there examples of how any of these barriers have been overcome?
5. What evidence do you have on the willingness of staff to work on every day of the week? Does willingness vary by staff group, and/or by the availability of premium payments? If so, how?
6. What would be the likely long term impact on recruitment for posts that require seven-day working, compared to posts that do not require seven-day working?
7. What are the implications of equality policies and legislation for seven-day working?
8. What evidence can be provided on the impact for patients of seven-day services?
9. How has the demand for the delivery of seven-day services altered in recent years and what are the reasons for this? How do you see the demand for seven-day services changing in the future both in terms of changing patients' demographics and the additional choices that seven-day services would give to patients?
10. What is the underlying cost model for the delivery of seven-day services? What would be the costs and savings?
11. What are the pay, staffing and motivational issues and costs around any transition to seven-day service provision?

It would be helpful if the details of any external reports or research that are already available, and which you intend to refer to in your evidence, could be submitted as soon as possible, in advance of your main evidence.

### **Submission of evidence**

Submission of written evidence, preferably electronically, is invited by **Friday, 19 December 2014**, to:

**[craig.marchant@bis.gsi.gov.uk](mailto:craig.marchant@bis.gsi.gov.uk)**

Craig Marchant  
Office of Manpower Economics  
8th Floor, Fleetbank House  
2-6 Salisbury Square  
London EC4Y 8JX

Please address any enquiries to Craig Marchant at the above address or telephone 020 7211 8295.

The Office of Manpower Economics provides secretariat and research support to all the Pay Review Bodies.

In the interests of the transparency of the process, NHSPRB asks that written evidence submitted to this review is shared with the other parties and published on the organisations' websites at the time of submission.

## **Next steps**

NHSPRB will consider the written responses to this review and may ask supplementary questions following receipt of the written evidence. Responses to supplementary questions and comments on the other parties' evidence should be made by **Friday, 12 February**. NHSPRB will invite some of the parties to give oral evidence in **March 2015**. It will take into account all relevant factors raised in evidence and will make observations in accordance with its terms of reference. NHSPRB expects to submit its report to Ministers by **July 2015**.

## **NHS Pay Review Body**

**19 September 2014**

## Appendix D – Parties Website Addresses

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

Chartered Society of Physiotherapists	<a href="http://www.csp.org.uk/documents/evidence-submission-pay-review-body-seven-day-services-nhs">http://www.csp.org.uk/documents/evidence-submission-pay-review-body-seven-day-services-nhs</a>
Department of Health	<a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/393071/DH_Evidence_to_NHSPRB.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/393071/DH_Evidence_to_NHSPRB.pdf</a>
Federation of Clinical Scientists	<a href="http://www.acb.org.uk/whatwesay/acb_newspage/2015/02/23/fcs-responds-to-the-nhs-pay-review-body-call-for-evidence-on-7-day-working">http://www.acb.org.uk/whatwesay/acb_newspage/2015/02/23/fcs-responds-to-the-nhs-pay-review-body-call-for-evidence-on-7-day-working</a>
Health Education England	<a href="https://hee.nhs.uk/2014/01/14/nhs-pay-review-body-for-201415-written-evidence-from-health-education-england/">https://hee.nhs.uk/2014/01/14/nhs-pay-review-body-for-201415-written-evidence-from-health-education-england/</a>
Joint Staff Side	<a href="http://www.rcn.org.uk/__data/assets/pdf_file/0006/603897/Staff_side_seven_day_services.pdf">http://www.rcn.org.uk/__data/assets/pdf_file/0006/603897/Staff_side_seven_day_services.pdf</a>
NHS Employers	<a href="http://www.nhsemployers.org/~ /media/Employers/Publications/NHSE-PRB-submission-Dec-2014.pdf">http://www.nhsemployers.org/~ /media/Employers/Publications/NHSE-PRB-submission-Dec-2014.pdf</a>
NHS England	<a href="http://www.england.nhs.uk/wp-content/uploads/2015/01/nhsprb-ddrb-7ds-evidence.pdf">http://www.england.nhs.uk/wp-content/uploads/2015/01/nhsprb-ddrb-7ds-evidence.pdf</a>
NHS Providers	<a href="http://www.nhsproviders.org/influencing-and-policy/nhs-workforce/pay-review-bodies/">http://www.nhsproviders.org/influencing-and-policy/nhs-workforce/pay-review-bodies/</a>
Northern Ireland Executive	<a href="http://www.dhsspsni.gov.uk/ni_evidence_to_pay_review_bodies_special_remit_201516__8211__financial_context.pdf">http://www.dhsspsni.gov.uk/ni_evidence_to_pay_review_bodies_special_remit_201516__8211__financial_context.pdf</a>
Royal College of Midwives	<a href="https://www.rcm.org.uk/sites/default/files/Royal%20College%20of%20Midwives%20Response%20to%20PRB%20Consultation%20on%20Seven%20Day%20Working.pdf">https://www.rcm.org.uk/sites/default/files/Royal%20College%20of%20Midwives%20Response%20to%20PRB%20Consultation%20on%20Seven%20Day%20Working.pdf</a>
Royal College of Nursing	<a href="https://www.rcn.org.uk/__data/assets/pdf_file/0005/603896/RCN_seven_day_working.pdf">https://www.rcn.org.uk/__data/assets/pdf_file/0005/603896/RCN_seven_day_working.pdf</a>
Society of Radiographers	<a href="http://www.sor.org/">http://www.sor.org/</a>
Unison	<a href="https://www.unison.org.uk/upload/sharepoint/Toweb/UNISON%20Evidence%20to%20the%20NHSPRB%202015-16%20seven%20day%20services.pdf">https://www.unison.org.uk/upload/sharepoint/Toweb/UNISON%20Evidence%20to%20the%20NHSPRB%202015-16%20seven%20day%20services.pdf</a>
Unite the Union	<a href="https://api.groupdocs.com/v2.0/shared/files/82e86bd9c976bfcae0adc9db57a49170d5f91e58e728fe049f91d3b386ccfa77?render=true">https://api.groupdocs.com/v2.0/shared/files/82e86bd9c976bfcae0adc9db57a49170d5f91e58e728fe049f91d3b386ccfa77?render=true</a>
Welsh Government	<a href="http://gov.wales/docs/dhss/publications/150320remit2en.pdf">http://gov.wales/docs/dhss/publications/150320remit2en.pdf</a>

## Appendix E – NHS England 10 Clinical Standards for Seven-Day Services

<b>Patient Experience</b>	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.
<b>Time to first consultant review</b>	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.
<b>Multi-disciplinary Team review</b>	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.
<b>Shift handovers</b>	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.
<b>Diagnostics</b>	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: <ul style="list-style-type: none"><li>• Within 1 hour for critical patients;</li><li>• Within 12 hours for urgent patients; and</li><li>• Within 24 hours for non-urgent patients.</li></ul>
<b>Intervention/key services</b>	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: <ul style="list-style-type: none"><li>• Critical care;</li><li>• Interventional radiology;</li><li>• Interventional endoscopy; and</li><li>• Emergency general surgery.</li></ul>
<b>Mental health</b>	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: <ul style="list-style-type: none"><li>• Within 1 hour for emergency care needs</li><li>• Within 14 hours for urgent care needs</li></ul>

<b>On-going review</b>	<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>
<b>Transfer to community, primary and social care</b>	<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>
<b>Quality Improvement</b>	<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>

## Appendix F – Agenda for Change Unsocial Hours Payments<sup>53</sup>

### Core Agenda for Change Rates

Unsocial hours payments		
Pay band	All time on Saturday (midnight to midnight) and any week day after 8 pm and before 6 am	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%

### Ambulance Service Rates

Average unsocial hours	Percentage of basic salary	
	Pay bands 1-7	Pay bands 8 and 9
Up to 5	Local Agreement	Local Agreement
More than 5 but no more than 9	9%	9%
More than 9 but no more than 13	13%	10%
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%

### Overtime

- All staff in pay bands 1 to 7 will be eligible for overtime payments. There is a single harmonised rate of time-and-a-half for all overtime, with the exception of work on general public holidays, which will be paid at double time.
- Overtime payments will be based on the hourly rate provided by basic pay plus any long-term recruitment and retention premia. Part-time employees will receive payments for the additional hours at plain time rates until their hours exceed standard hours of 37½ hours a week.
- The single overtime rate will apply whenever excess hours are worked over full-time hours, unless time off in lieu is taken, provided the employee's line manager or team leader has agreed with the employee to this work being performed outside the standard hours.
- Staff may request to take time off in lieu as an alternative to overtime payments. However, staff who, for operational reasons, are unable to take time off in lieu within three months must be paid at the overtime rate.
- Senior staff paid in pay bands 8 or 9 will not be entitled to overtime payments.
- Time off in lieu of overtime payments will be at plain time rates.

### On-call

- An enhancement of 9.5 per cent will be paid to staff who are required to be on-call an average of one in three of the defined periods or more frequently.
- An enhancement of 4.5 per cent will be paid to staff who are required to be on-call an average of between one in six and less than one in three of the defined periods.

<sup>53</sup> Source: The Agenda for Change Terms and Conditions Handbook, available from: [http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/AfC\\_tc\\_of\\_service\\_handbook\\_fb.pdf](http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/AfC_tc_of_service_handbook_fb.pdf)

- An enhancement of 3 per cent will be paid to staff who are required to be on-call an average of between one in nine and less than one in six of the defined periods.
- An enhancement of 2 per cent will be paid to staff who are required to be on-call an average of between one in twelve and less than one in 9 of the defined periods.
- For these purposes, the average availability required will be measured over a full rota, or over a 13-week period if no standard pattern is applicable. The reference period will not include any periods when the employee is absent from work on either annual leave or sickness absence.
- Where on-call cover is limited or very irregular (averaging less than one in 12) pay enhancements will be agreed locally. These may be fixed or variable, and based on actual or estimated frequencies of on-call work worked, subject to local agreement. To ensure fairness to all staff qualifying under the national rules set out above, locally agreed payments may not exceed the minimum percentage in the national provisions.

Frequency of on-call	Value of enhancements as percentage of basic pay
1 in 3 or more frequent	9.5%
1 in 6 or more but less than 1 in 3	4.5%
1 in 9 or more but less than 1 in 6	3.0%
1 in 12 or more but less than 1 in 9	2.0%
Less frequent than 1 in 12	By local agreement

- For part-time staff and other staff working other than 37½ hours a week excluding meal breaks, the percentage added to basic pay on account of on-call availability will be adjusted to ensure that they are paid a fair percentage enhancement of salary for on-call working. This will be done by adjusting the payment in proportion to their part-time salary so that they receive the same payment for the same length of availability on-call as full-time staff.
- Employees who are called into work during a period of on-call will receive payment for the period they are required to attend, including any travel time. Alternatively, staff may choose to take time off in lieu. However, if for operational reasons time off in lieu cannot be taken within three months, the hours worked must be paid for.
- For work (including travel time) as a result of being called out the employee will receive a payment at time and a half, with the exception of work on general public holidays which will be at double time. Time off in lieu should be at plain time. There is no disqualification from this payment for bands 8 and 9, as a result of being called out.
- By agreement between employers and staff, there may be local arrangements whereby the payment for hours worked during a given period of on-call is subject to a fixed minimum level, in place of separately recognising travel time.
- In addition, where employers and staff agree it is appropriate, the amount paid for work and travel time during periods of on-call may be decided on a prospective basis (e.g. for a forward period of three months) based on the average work carried out during a prior reference period (e.g. of three months). Where these arrangements are agreed, the actual work carried out during a given period would be monitored and, if the average amount assumed in the calculation of the payment is significantly different, the level of payment should be adjusted for the next period; there should be no retrospective adjustment to the amount paid in the previous period.
- Unless locally, it is agreed otherwise, all current on-call arrangements will be protected for groups of employees up to 31 March 2011 irrespective of whether they were nationally or locally agreed.<sup>54</sup> This extended protection will apply to existing staff and new staff during the period of protection.
- On-call payments made under such arrangements should be excluded from the pre and post assimilation pay used in the calculation of any protected level of pay.



<sup>54</sup> See the question and answer guidance in Annex A2 or Annex A2(a) (England and Wales), Agenda for Change Terms and Conditions Handbook.

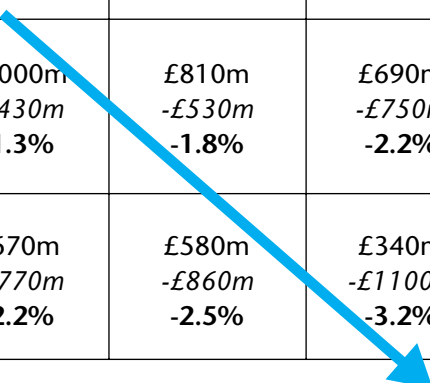


## Appendix G – NHS Employers’ summary of the estimated savings for their nine potential models

Figure G1 provides a summary of the estimated savings for each potential model. The three premium time scenarios have been combined with the three premium rate scenarios to give nine different models. For each of the nine scenarios the table shows the estimated total cost of unsocial hours (assuming current working patterns), the savings as compared to the current arrangements, and the saving expressed as a percentage of the Agenda for Change pay bill.

**Figure G1: Costs for each scenario expressed as a percentage of the Agenda for Change Pay bill**

			Increasing plain time 			
			Premium Time Scenarios			
			1	2	3	
			Early evenings paid at plain time	Early evenings & Saturdays paid at plain time	Early evenings, Saturdays and Sundays paid at plain time	
Decreasing premium rates 	Premium Rate Scenarios	A	Current AfC rates	£1340m -£90m -0.3%	£1150m -£290m -0.8%	£670m -£770m -2.2%
		B	Pay all premium times at current Saturday and Night Rate	£1000m -£430m -1.3%	£810m -£530m -1.8%	£690m -£750m -2.2%
		C	Half current premium rates	£670m -£770m -2.2%	£580m -£860m -2.5%	£340m -£1100m -3.2%



Key:

1. Total cost of unsocial hours for the scenario
2. Cost difference compared to current system
3. Cost difference expressed as a % of Agenda for Change paybill

Reduced Cost

### Theoretical maximum savings possible for comparative purposes (not a proposal)

1. Total cost of unsocial hours
2. Cost difference if all hours paid at plain time
3. Cost difference expressed as a % of AfC paybill

£1440m
-£1440m
-4.2%

Notes:

1. Any changes to unsocial hours pay arrangements may have a consequential impact on other areas of the pay bill. These have not been assessed.
2. Costs include the on-costs (employer national insurance contributions and employer pension contributions) paid at current rates to all scenarios. The marginal impact of on-costs, which will vary by scenario, have not been fully assessed here.

## Appendix H – International unsocial hours rates sources

### **Australia (Queensland) –**

[http://www.qirc.qld.gov.au/resources/pdf/awards/q/q0090\\_ar10.pdf](http://www.qirc.qld.gov.au/resources/pdf/awards/q/q0090_ar10.pdf)

### **Australia (Western) –**

[http://www.health.wa.gov.au/awardsandagreements/docs/WA\\_Health\\_LHMU\\_Enrolled\\_Nurses\\_Assistants\\_Nursing\\_Aboriginal\\_Ethnic\\_Health\\_Workers\\_Ind\\_Agreement\\_2014.pdf](http://www.health.wa.gov.au/awardsandagreements/docs/WA_Health_LHMU_Enrolled_Nurses_Assistants_Nursing_Aboriginal_Ethnic_Health_Workers_Ind_Agreement_2014.pdf)

### **Canada –**

[https://nursesunions.ca/sites/default/files/contract\\_comparison\\_english.pdf](https://nursesunions.ca/sites/default/files/contract_comparison_english.pdf)

### **New Zealand –**

<http://www.nzno.org.nz/Portals/0/Files/Documents/Support/CA/DHB%20NZNO%20MECA%202012%20-%202015%20Searchable.pdf>

### **Philippines –**

[http://www.dole.gov.ph/labor\\_codes/view/4](http://www.dole.gov.ph/labor_codes/view/4)

### **Spain (Castilla-La Mancha) –**

[http://docm.castillalamancha.es/portaldocm/descargarArchivo.do?ruta=2014/01/31/pdf/2014\\_1091.pdf&tipo=rutaDocm](http://docm.castillalamancha.es/portaldocm/descargarArchivo.do?ruta=2014/01/31/pdf/2014_1091.pdf&tipo=rutaDocm)

### **United Kingdom – NHS Employers evidence to NHSPRB**

<http://www.nhsemployers.org/~media/Employers/Publications/NHSE-PRB-submission-Dec-2014.pdf>

### **USA (Chicago) –**

<http://careers.uchospitals.edu/benefits>

### **USA (Texas) –**

[http://www.lbb.state.tx.us/Documents/GAA/General\\_Appropriations\\_Act\\_2014-15.pdf](http://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2014-15.pdf)

## Appendix I – Joint letter from NHSPRB and DDRB Chairs to the Secretary of State for Health



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The Rt Hon Jeremy Hunt MP  
Secretary of State  
Department of Health  
Richmond House  
79 Whitehall  
London SW1A 2NS

26 May 2015

Dear Secretary of State,

### **KING'S FUND REPORT ON NHS WORKFORCE PLANNING**

We are writing as chairs of the NHS Pay Review Body and the Review Body on Doctors' and Dentists' Remuneration (DDRB) to give our perspective on the recent report from the King's Fund on *Workforce Planning in the NHS* (published 29<sup>th</sup> April).

As you would expect, the Review Bodies are very interested in the availability of good, up-to-date NHS workforce data. Such data are essential if we are to make well-evidenced recommendations on how pay and reward can best support NHS policy priorities; most notably, improving services for patients. We have made recommendations on this subject in all our recent reports, most recently as follows from 2014 for the NHS Pay Review Body:

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

and from 2015 for DDRB:

*We urge the four Health Departments to prioritise the publication of vacancy statistics. Vacancy data are fundamental to our being able to fulfil our role as set out in our terms of reference.*

From our experience over several years, we would strongly endorse the concerns raised in the King's Fund Report. Our previous reports have set out our detailed data requirements. There are serious information gaps in key areas such as reliable workforce data for primary care doctors, short and long term vacancy rates, the use of bank and agency staff, locums and the monitoring of training places and quality of new recruits. This means that neither DH, nor its key partners such as NHS England or Health Education England, are able to give us an informed view to identify where problems exist. Hence they cannot offer suggestions about the targeting of resources. The increasing plurality of NHS providers appears to be putting extra strain on the systems that do exist.

We recognise that the DH and NHS have a heavy agenda, and that it is easy to give a lower priority to the nuts-and-bolts business of collecting and monitoring workforce information. However, given the huge investment that the NHS makes in its people, and

the high proportion of its total spending that goes on pay, we believe that getting this information is key to securing value for money and improved services for patients.

We do hope that the department will be able to report some progress on this area in their evidence for the next pay round.

We are copying this letter to Lord David Prior, with whom we look forward to working in his new role as Minister responsible for NHS workforce issues.



**Jerry Cope**  
Chair, NHS Pay Review Body



**Professor Paul Curran**  
Chair, DDRB

## Appendix J – Previous Reports of the Review Body

### NURSING STAFF, MIDWIVES AND HEALTH VISITORS

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

## **Professions Allied to Medicine**

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

## **Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine**

Twentieth Report on Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine	Cm 5716, August 2003
Twenty-First Report on Nursing and Other Health Professionals	Cm 6752, March 2006
Twenty-Second Report on Nursing and Other Health Professionals	Cm 7029, March 2007

## **NHS Pay review body**

Twenty-Third Report, NHS Pay Review Body 2008	Cm 7337, April 2008
Twenty-Fourth Report, NHS Pay Review Body 2009	Cm 7646, July 2009
Decision on whether to seek a remit to review pay increases in the three year agreement – <i>unpublished</i>	December 2009
Twenty-Fifth Report, NHS Pay Review Body 2011	Cm 8029, March 2011
Twenty-Sixth Report, NHS Pay Review Body 2012	Cm 8298, March 2012
Market-Facing Pay, NHS Pay Review Body 2012	Cm 8501, December 2012
Twenty-Seventh Report, NHS Pay Review Body 2013	Cm 8555, March 2013
Twenty-Eighth Report, NHS Pay Review Body 2014	Cm 8831555, March 2014
NHS Pay Review Body: Scotland Report 2015	SG/2015/21

## Appendix K – Abbreviations

<b>A&amp;E</b>	Accident and Emergency
<b>AHP</b>	Allied Health Professionals
<b>CPD</b>	Continuing Professional Development
<b>DDRB</b>	Review Body on Doctors' and Dentists' Remuneration
<b>ESR</b>	Electronic Staff Record
<b>EU</b>	European Union
<b>FTE</b>	Full-time equivalent
<b>HCAS</b>	High Cost Area Supplements
<b>Health Departments</b>	Department of Health; Northern Ireland Executive, Department of Health, Social Services and Public Safety; Scottish Government, Health and Social Care Directorates; and Welsh Government, Department of Health and Social Services.
<b>HFMA</b>	Healthcare Financial Management Association
<b>HSJ</b>	Health Service Journal
<b>HM</b>	Her Majesty's; for example, HM Treasury
<b>HV</b>	Health visitor
<b>IDS</b>	Incomes Data Services
<b>IFS</b>	Institute for Fiscal Studies
<b>LETBs</b>	Local Education and Training Boards
<b>LPP</b>	London Procurement Partnership
<b>MRI</b>	Magnetic Resource Imaging
<b>NHS</b>	National Health Service
<b>OME</b>	Office of Manpower Economics
<b>RPI</b>	Retail Prices Index
<b>RRP</b>	Recruitment and Retention Premia
<b>SDIP</b>	Service Development Improvement Plan
<b>ST&amp;T</b>	Scientific, therapeutic and technical staff
<b>TSO</b>	The Stationery Office
<b>UCC</b>	Urgent Care Centre
<b>UHB</b>	University Hospital Birmingham

ISBN 978-1-4741-2231-3



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