

# **NHS PAY REVIEW BODY**

## **Twenty-Third Report 2008**

***Chair: Professor Gillian Morris***

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

Presented to the Scottish Parliament by the First Minister and the Cabinet  
Secretary for Health and Wellbeing

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 the Minister for Health, Social Services & Public Safety

By Command of Her Majesty

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## **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 & Public Safety of the Northern Ireland Executive, on the remuneration of all staff paid under Agenda for Change (AfC) 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 & Public Safety of the Northern Ireland Executive.

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

Members of the Review Body are:

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

The secretariat is provided by the Office of Manpower Economics.

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## Summary of Recommendations and Main Conclusions

We are pleased to present our recommendations on the pay of NHS staff within our remit group from 1 April 2008. We have carefully reviewed all the evidence we have received. In arriving at our recommendations, we have examined data on recruitment and retention, morale and motivation, funding, the Government's inflation target, and other relevant economic indicators. We have also had regard to the principle of equal pay for work of equal value and legal obligations on the NHS, including anti-discrimination legislation. Lack of evidence prevented us giving detailed consideration to the 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 key issues and recommendations are summarised below:

- Since we last reported, our remit has been widened to include all staff paid under Agenda for Change (AfC) and extended to cover Northern Ireland. We note that there is very little detailed workforce data on the new staff groups whose pay was previously determined by the Pay Negotiating Council. It is clear to us that the evidence in this area must be improved and **we strongly urge the Health Departments to work with the other parties and our secretariat to ensure better data in time for our next review.** In the meantime, in the absence of detailed data for these groups, we have had to assume that the data available to us reflects the position for the whole of our remit group.
- The parties have all sought a one-year only pay award while their talks about a multi-year pay deal continue separately and in parallel to our review. **We consider that the award should be for one year only because that is the basis on which we have received evidence from the parties.**
- In reaching our conclusions, we have sought to maintain the relative position of the pay structure, balancing the effect of our recommendation both on those who continue to advance up the pay scale and on those who have reached the top of their pay band. There is evidence of declining levels of morale within the NHS and we are concerned that declining morale would have an adverse effect both on the NHS's ability to meet service delivery targets and on its ability to recruit and retain staff in the longer term. For these reasons, we believe a pay award above that sought by the Health Departments is necessary. **We therefore recommend an increase in the Agenda**

**for Change pay rates of 2.75 per cent from 1 April 2008.**

- We believe that our recommendation is consistent with the Government's inflation target and when added to the long-term average figure for pay drift is consistent with the growth in pay bill per head that we have been told would be affordable by the Department of Health.
- The tighter budgetary positions of Scotland, Wales and Northern Ireland have not led those countries to propose a lower pay uplift than in England. We have therefore been given no reason to differentiate between the countries in making our recommendation. Given the Health Departments' wish to retain a common pay structure throughout the UK, **we recommend that Northern Ireland aligns its pay scales by 31 March 2008 to reflect the uplift which was eventually implemented in England, Scotland and Wales in 2007-08.**
- We consider that we should maintain the relative value of the differentials provided by the high cost area supplements (HCAS). **We recommend that the existing minimum and maximum HCAS for Inner London, Outer London and the Fringe be increased by 2.75 per cent from 1 April 2008.**
- The joint Staff Side asked us to consider again the case for a new HCAS for South Cambridgeshire. We do not believe that we have sufficient evidence to justify recommending a HCAS for this area. Our reasons are set out in detail in Chapter 3. In the event that we were to consider on a future occasion that a new HCAS was justified, **we would welcome clarification from the parties as to how the geographic boundaries applicable to such a payment should be defined.**
- We were asked by Unite, supported by the joint Staff Side, to consider a new national Recruitment and Retention Premium (RRP) for pharmacists. The evidence suggests to us that the problem with pharmacists appears to be one of retention rather than recruitment, and that the retention issue appears to be more prominent once pharmacists have been in the service for three years or more. We cannot support the proposal put forward by Unite, but **we recommend that the parties address the problem with the retention of pharmacists before the next Review Body round**

**and reach a workable solution.** We have set out an alternative approach for consideration by the parties based on the concept of a retention bonus, similar to the ‘golden handcuff’ payments which are paid in some private sector organisations. The details are set out in Chapter 3. **We ask the parties to report back to us on progress, with a view to us considering the making of a formal recommendation next year if insufficient progress has been made.**

- Unite and UCATT have also presented a case for the national RRP currently paid to qualified maintenance craft workers to be extended to the building trades. We do not consider that the evidence presented to us supports this case, nor do we consider, on the basis of the criteria we have set out in previous reports, that there is currently sufficient evidence to justify the continuation of a national RRP for maintenance craft workers. Our reasons are set out in detail in Chapter 3. In accordance with our duty to have regard to the principle of equal pay for work of equal value in the NHS, **we urge the parties to review their decision to continue this RRP in order to ensure that the integrity of the AfC pay system is upheld, and to subject all other national RRPs to regular and robust review.**
- **We recommend that existing national RRPs be increased by 2.75 per cent from 1 April 2008.**
- **We recommend that the Health Departments report back to us each year using a standardised and comparable format on how the NHS has measured and achieved its efficiency savings targets and how staff have contributed to the achievement of those targets.** We also set out in more detail in Chapter 5 what types of evidence on affordability we would find helpful in future.
- We would like to raise again our concerns about the quality of the NHS vacancy data collected on behalf of the Health Departments and we note the Staff Side’s concerns about the inadequacies of that data. **We have asked our secretariat to continue discussing with the stakeholders ways of improving the workforce data available to us and to investigate further with the Information Centre the uses of the Electronic Staff Records computer system.**

- Graduate unemployment is a matter of concern to us and **we would ask the Health Departments in particular to do all they can to ensure that the skills of the newly qualified are not being permanently lost to the NHS. We also ask the parties, and the Health Departments and NHS Employers in particular, to consider what evidence they can provide in the future to demonstrate how the NHS's longer term recruitment and retention needs for all groups of staff have been taken into account in workforce planning.**
- We have received nothing of detail from the Health Departments on how staff workload is changing from year to year and **we ask them to consider what evidence they can provide for the next round.**
- We continue to believe that the Knowledge and Skills Framework (KSF) is crucial to the efficient delivery of current and future services. Until the KSF is fully implemented, neither the NHS nor its staff will reap the benefits that AfC was designed to deliver. We regard this as a crucial issue and **we urge the parties to work together to ensure the KSF's relaunch is a success. We trust that funding for education and training in all four countries will be safeguarded in 2008-09 and beyond.** We are also concerned at the low level of staff appraisals being carried out (around 60 per cent); a properly functioning appraisal system for all staff is vital both for morale and to inform training needs, as well as ensuring a safe and appropriate service.
- We have been unable, on the basis of what we have received, to give detailed consideration this year to the morale and motivation of our remit group in Scotland, Wales and Northern Ireland. It would help our consideration of morale and motivation if we could have more detailed evidence from those countries and we would ask them to keep our secretariat informed about the work they have underway to provide such evidence in the future.

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OFFICE OF MANPOWER ECONOMICS

4 April 2008

## CHAPTER 1 – INTRODUCTION AND BACKGROUND

### Introduction

1.1 Since we last reported in February 2007, our remit has been widened to include all staff paid under Agenda for Change (AfC) and extended to cover Northern Ireland<sup>1</sup>. Previously two different mechanisms existed for determining the pay uplift for staff covered by the AfC pay spines: our Review Body (the Review Body for Nursing and Other Health Professions) which covered non-medical clinical staff and their support workers, and the Pay Negotiating Council (PNC) which covered all other staff on AfC terms and conditions. The parties agreed that this dual system had proved unsatisfactory because of the requirement for the pay uplift outcomes for both mechanisms to be the same in order to maintain the integrity of the AfC pay structure. Following discussions between the Health Departments, NHS Employers<sup>2</sup> (NHSE) and the unions, there was agreement to extend the coverage of our remit to include the staff groups covered by the PNC and to change the Review Body's name to reflect the wider remit group. The Secretary of State wrote to our Chair on 26 July 2007 notifying her of the revised terms of reference and this letter can be found at Appendix H. With the addition of the former PNC staff groups to our remit, our recommendations now cover around 1.3 million staff (headcount), an increase of 300,000.

1.2 The extension of our remit to include these groups and to cover the four countries of the United Kingdom (UK) poses new challenges for us and for the parties. We note that there is very little detailed workforce data on the new staff groups whose pay was previously determined by the PNC. It is clear to us that the evidence in this area must be improved and we strongly urge the Health Departments to work with the other parties and our secretariat to ensure better data in time for our next review. In the meantime, in the absence of detailed data for these groups, we have had to assume that the data available to us reflects the position for the whole of our remit group. Given the very diverse nature of the ex-PNC staff groups, we need better and more detailed data in the future.

1.3 The amendment of our remit has also seen the removal of the former reference to “output targets” and its replacement with the need for us to have regard to “the overall strategy that the National Health Service (NHS) should place patients at the heart of all it does and the mechanisms by which that is to be achieved”. We welcome this change as in

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<sup>1</sup> In Northern Ireland social care workers are covered by AfC terms and conditions and so fall within our remit.

<sup>2</sup> NHS Employers represents employers in England.

past reports we have noted that the Health Departments have been unable in evidence to clarify the relationship between pay and output targets. The Health Departments have not specifically addressed this new requirement in our remit, although it was a recurrent general theme and an important part of their evidence on affordability that pay increases above what had been budgeted for would impact on patient care. If we are to give full consideration to this new aspect of our remit, we would ask the Health Departments in particular to provide us with more detailed evidence which goes beyond their simple suggestion that there is a trade-off between the delivery of enhanced services and higher pay for staff.

1.4 This is our twenty-third report and throughout we have used the term ‘our remit group’ to denote all the groups in our current remit. The coverage of our remit can be found in Appendix A.

1.5 We have again this year followed the broad structure of our recent reports. In this chapter, we set out the context for this year’s review, including our approach to the review and the sources of evidence we have received. We also consider the composition of the workforce in our remit. In each chapter of the report, we set out the statistical evidence at our disposal, a summary of the evidence we have received and our comments and recommendations.

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

1.7 We commented in our last two reports that we had some concerns about how we could meet the requirements in AfC regarding the interface between the pay of our remit group and the pay of staff groups outside our remit, i.e. those covered by the Review Body on Doctors’ and Dentists’ Remuneration (DDRB) and by the PNC respectively. Our remit has now been changed to include the staff groups formerly covered by the PNC, but we still have concerns about the interface with the DDRB’s remit group. As before, we have based our recommendations solely on the evidence we have received in respect of our own remit group.

It is important to emphasise that the two Review Bodies operate entirely independently and that both we and the DDRB make our recommendations based on the evidence before us.

### **The context for our review this year**

#### *The Government's reaction to our recommendation for 2007-08*

1.8 Announcing the Government's acceptance of the public sector Pay Review Body reports on 1 March 2007<sup>3</sup>, the Chancellor of the Exchequer said "...we have today accepted the public sector pay review body reports to be implemented in two stages, and the armed forces in full, from 1 April. The overall awards come within the inflation target, at 1.9 per cent, demonstrating our total determination to maintain discipline and stability and to continue with an 11th year of sustained economic growth." On 2 March 2007, the then Secretary of State for Health confirmed<sup>4</sup> that our recommendation and that made by the DDRB were being accepted and that "...to ensure consistency with the Government's inflation target, and in line with other parts of the public sector, the awards will be staged. All awards which represent an increase up to and including 1.5 per cent will be paid in full from 1 April. But all awards which represent an increase above 1.5 per cent will be paid in two stages, with 1.5 per cent from 1 April and the balance from 1 November. The Government recognise that the staff affected will be disappointed that their award is not being paid in full from 1 April. But we believe that this approach is fair for staff, consistent with the Government's inflation target and affordable for the NHS." Having announced initially that the pay award would also be staged in Scotland, Wales and Northern Ireland, each of those countries subsequently decided to pay the award in full from 1 April 2007.

#### *Subsequent developments*

1.9 Following the Government's announcement about the pay award for our remit group, talks commenced within the NHS Staff Council about the pay uplift for 2007-08 for staff covered by the PNC. These talks were held over the course of last spring and summer against the background of the unions' angry reaction to the staging of the pay uplift for Review Body staff, with various unions consulting their members about taking industrial action. The talks eventually led on 2 August 2007 to an offer to staff in England which would be read across, where relevant, to those staff covered by the Review Body. The offer targeted a £400 flat rate uplift for staff on pay points 1-7 of AfC, awarded an additional £38 to staff on pay points 8-18, and made funding for training projects of £25 available to Trusts for each member of

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<sup>3</sup> Hansard 1 March 2007, Column 1047-1048

<sup>4</sup> Hansard 2 March 2007, Column 108WS

staff not requiring clinical professional registration. In addition, a payment of £38 per year from 2007-2010 would be paid to AfC clinical staff in bands 5-8A towards their mandatory professional registration fees. The pay elements of this revised package were said by the Department of Health to raise the total average value of the NHS pay award for 2007-08 from 1.9 per cent to just under 2.0 per cent. All parties (i.e. the four Health Departments, NHSE and the unions) said they were also committed to entering into talks about a multi-year pay deal covering all or part of the next Comprehensive Spending Review (CSR) period, i.e. 2008-09 to 2010-2011. These talks would cover the existing AfC pay structure and conditions of service, career development, security for staff and productivity.

1.10 The new offer was eventually agreed by the majority of the unions and the 2007 award formally signed off by the NHS Staff Council<sup>5</sup>. Scotland and Wales subsequently agreed to pay the £400 flat rate uplift and £38 to staff on pay points 8-18. At the time of writing, the parties' talks on a multi-year pay deal were continuing separately and in parallel to our review. Northern Ireland has not implemented the deal agreed in England. As the benefits of maintaining a UK-wide pay structure for our remit group have been stressed to us by many of the parties in both written and oral evidence, we would urge the Executive in Northern Ireland to re-align the AfC pay scales by 31 March 2008 to reflect the uplift which was eventually implemented in England, Scotland and Wales in 2007-08.

#### *Our general approach*

1.11 Each year we remind the parties of the principles which we and our predecessors have traditionally applied in reaching our recommendations and, in view of the events following the submission of our last Report, we believe it particularly important to emphasise them again this year. Firstly, we work independently to agreed terms of reference. Secondly, we base our recommendations on careful consideration of all the evidence. Finally, we consider that our recommendations form a coherent package which should be implemented in full.

1.12 Given these principles, it was extremely disappointing that the Government decided to stage our pay uplift recommendation for 2007-08 in England with no clear explanation of why this was necessary in order to keep the award for our remit group in line with or below the Government's CPI inflation target. We have yet to see the economic rationale for public

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<sup>5</sup> Details of the revised award and amended pay scales can be found in NHS Employers' Pay Circular (AfC) 4/2007, issued on 17 October 2007, at [www.nhsemployers.org](http://www.nhsemployers.org)

sector pay in general, and the pay uplift of our remit group in particular, being capped at two per cent. We find this lack of clarity surprising and disappointing, particularly when Scotland, Wales and Northern Ireland felt able to implement the pay award in full.

1.13 In their evidence to us for this review, the unions have made clear that many of their members saw the Government's staging of our last recommendation as undermining the independent Review Body process. The unions have called for our independence and integrity to be fully respected in this round. For our part, we have, as always, approached our task on the basis that we are independent. We have given very careful consideration to all the evidence which has been presented to us and having done so, we have formulated a coherent package of recommendations which we believe should be implemented in full. The Review Body process will only continue to operate successfully if there is support for it amongst all the stakeholders based on a confident expectation that evidence-based recommendations will be implemented. We hope that confidence will be restored this year.

#### *Agenda for Change*

1.14 Once again it was clear to us during our summer 2007 visit programme that the rate of assimilation of staff into the AfC pay structure still varied considerably between England, Scotland, Wales and Northern Ireland. The parties' evidence for this review confirms our observations. In England, NHSE reported that the last figures (as at March 2006) reported to the NHS Staff Council<sup>6</sup> showed that 99 per cent of staff had been assimilated. Using detailed data from the NHS Information Centre (IC) showing the exact proportion of each pay band by estimated incremental point, an estimated 2.6 per cent of our remit group is on pay protection. Band 2, with 5.9 per cent, has the highest proportion of staff on pay protection. Data from the IC also shows that 24.1 per cent of all staff on AfC are at the top of their pay band and will therefore not benefit from incremental pay progression next year.

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<sup>6</sup> NHSE told us that the Department of Health no longer collects any information on assimilation.

**Table 1.1 Proportion of each pay band by estimated incremental point.**

	Estimated percentage of each pay band on pay protection	Percentage of staff at the top of their payscale (i.e. will not get an increment next year), by band
Band 2	5.9%	22.7%
Band 3	1.8%	20.3%
Band 4	2.5%	39.2%
Band 5	1.0%	25.5%
Band 6	2.7%	24.9%
Band 7	2.1%	14.8%
Band 8a	2.4%	22.3%
Band 8b	2.6%	22.9%
Band 8c	3.9%	23.9%
Band 8d	1.9%	20.6%
Band 9	1.9%	12.7%
Total	2.6%	24.1% (weighted)

*Source: NHS Information Centre, NHS Earnings Estimates for England, April – June 2007.*

1.15 Elsewhere in the UK, the Scottish Government Health Directorates (SGHD) said that assimilation was expected to be concluded by December 2007. The Welsh Assembly Government (WAG) told us that 91 per cent of staff had been assimilated by July 2007 with 1.5 per cent on pay protection. The Department of Health and Social Services & Public Safety in Northern Ireland (DHSSPSNI) reported that progress was being made towards concluding the implementation of AfC by the end of March 2008. Assimilation therefore appears to be almost complete in England and Scotland, although some staff side bodies have made clear to us that within this general headline, the assimilation of some staff groups is lagging behind. Wales and Northern Ireland still have a little way to go to complete assimilation.

1.16 It was also clear to us during our visits programme that further progress was still required by each country to implement the Knowledge and Skills Framework (KSF). This key element of AfC was due to have been completed by October 2006, but the parties' evidence confirmed that progress had been much slower than expected. Chapter 4 sets out the parties' evidence on the work that has been undertaken to relaunch the KSF and to complete its implementation in each country. For now we would simply repeat the points made in our last report. The KSF is key to the success of AfC: it provides the means of recognising the skills and knowledge needed to be effective in a particular post; it ensures staff have clear and consistent objectives to help them develop; it provides for an annual appraisal and development review; and it determines the knowledge and skills required in a post before the postholder can progress through the two pay gateways within each pay band.

We therefore welcome the parties' efforts to re-launch the KSF and hope that by the time of our next review they can report that it is being fully used across the UK. We also welcome the Department of Health's commitment to increase the Multi Professional Education and Training budget by six per cent, announced as part of the NHS Operating Framework for England for 2008-09<sup>7</sup>. We would welcome evidence for our next review on how this funding increase is being used to support the KSF; for example, one way might be to consider the introduction of individual training accounts for all staff. We trust that funding for education and training in all four countries will be safeguarded in 2008-09 and beyond.

1.17 Although progress has been made since our last review, implementation of AfC is not yet fully complete in some countries and has only just been completed in others. This variation from country to country in the rate of assimilation onto AfC pay bands, and the further work needed in all four countries to implement the KSF, leads us again to the conclusion that our recommendations should concentrate on the level of the basic pay award. Until implementation is complete and it becomes possible to assess the impact and costs of the AfC structure and its impact on recruitment, retention and morale, there is no evidential basis on which we can recommend any structural changes to it. We therefore believe, once again this year, that our recommendations should concentrate on the level of the across-the-board pay award, setting aside any issues that might relate to structural change in the pay system.

1.18 Following the evidence we received from the staff side organisations about the need for an equality audit of AfC, NHSE told us that the IC had been commissioned by the Equalities and Diversity Sub-Group of the Staff Council to look at the equality impact assessment of the implementation of AfC. The IC had identified three main sources of data for use in assessing the impact of AfC:

- NHS Workforce Census
- NHS earnings survey
- Electronic Staff Record (ESR)

The aim of the research was to determine whether AfC had been implemented equitably; to look at whether an equality audit toolkit could be developed; and to identify an appropriate methodology for future similar analysis. In its supplementary evidence to us, UNISON said that this work was due for publication in February 2008, but at the time of writing, it was not

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<sup>7</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_081094](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094)

available to us.

1.19 We note the parties' evidence on the establishment of the Equalities and Diversity Sub-Group of the NHS Staff Council. We welcome the establishment of this group and that it will be undertaking an equality impact assessment of the implementation of AfC. We look forward to receiving evidence on the outcomes for our next review. We hope that the Group will also be able to consider whether similar jobs have had broadly similar AfC banding outcomes across the UK.

1.20 The Department of Health told us that there were approximately 13,000 equal pay claims lodged against NHS organisations and a number of test claims were progressing through the Employment Tribunal process. NHSE confirmed there were significant numbers of pre-AfC equal pay cases still pending. There was no additional NHS funding available to meet any additional costs arising from equal pay issues. NHSE stressed that NHS organisations had a duty not to divert funds from patient services to settle claims until liability had been established. One case in particular had been singled out as a test case to decide on national issues. Other cases were on hold pending the outcome of this.

1.21 We continue to note progress towards meeting the Government's target that every NHS Trust in England should be offered the opportunity to apply for NHS Foundation Trust status by 2008. We also note the figures available at the time of writing from the Department of Health showing that 88 NHS Foundation Trusts have now been authorised out of 394 Trusts in England. We understand that those Trusts which are currently authorised are using the agreed AfC pay scales, but we also understand this is not mandatory under the more flexible financial governance regime under which Foundation Trusts operate. As more Trusts are authorised in the future and perhaps begin to explore these financial flexibilities, this may begin to impact on the usage of the national AfC pay scales. We cannot tell what implications this might have for our recommendations in the future, but we will watch developments with interest.

1.22 The joint Staff Side reiterated their concern, raised with us last year, that the AfC pay scales may not be consistent with the European Court of Justice (ECJ) decision in *Cadman v HSE*<sup>8</sup> and asked us to consider the progressive reduction in the number of increments within

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<sup>8</sup> Case C-17/05 *Cadman v Health and Safety Executive*, judgment of the European Court of Justice, 3 October 2006.

each band while increasing their value accordingly. The Department of Health on the other hand did not consider that the principles enunciated by the ECJ of themselves necessitated a reduction in the number of incremental points and pointed out that *Cadman* had not yet been heard in the domestic courts following the ECJ decision. The NHSE was of the view that there remained a reasonable justification for the length of AfC pay scales on the ground that they reward loyalty, improve motivation, encourage recruitment and retention and recognise experience and were collectively agreed for this purpose. NHSE also noted that pay progression is underpinned by the KSF development review process. We note that AfC is intended to operate on the basis of the KSF and development review process but the evidence before us, which we discuss in Chapter 4, suggests that, in many cases, this is not happening in practice. Given the crucial role of KSF in this and other contexts, the continued delay in its implementation, which we noted last year, is highly regrettable. We urge all parties, including the Department of Health, to ensure that the steps being taken to re-launch the KSF result in pay progression under AfC operating as envisaged.

1.23 NHSE makes the valid points that any changes to AfC's incremental scales would have significant cost implications, would reduce the scope for career progression and would alter the carefully negotiated structure of AfC. Staff may have expressed dissatisfaction with the architecture and value of incremental progression, but the system was negotiated and supported by all the parties, it has only been in place a relatively short time and is not even fully in place yet throughout the UK. We have seen no evidence to suggest that reducing the length of the pay scales is necessary for recruitment or retention purposes and no other evidence to suggest that such action is necessary at this time. The parties have already agreed to review, as part of their discussions on a multi-year pay deal, the number of incremental pay points in the AfC payscales, the opportunities for incremental progression and the structure at the bottom of the pay spine.

#### *Recommendations sought by the parties*

1.24 In the evidence submitted to us, the Health Departments and NHSE have argued again this year in favour of us recommending a simple, across-the-board, one-year only pay award. The parties' talks about a multi-year pay deal would continue separately and in parallel to our review.

1.25 Although the staff side bodies are primarily seeking a recommendation on the across-the-board pay award for our remit group, we have also received evidence from individual

staff bodies in support of national recruitment and retention premia (RRPs) for two groups of staff, pharmacists (also supported by the joint Staff Side) and building craft workers, and from the joint Staff Side in support of the introduction of a new high cost area supplement. We consider these proposals in Chapter 3. The joint Staff Side also asked us to recommend a reduction in the number of incremental points in each pay band, an issue which we have addressed in paragraphs 1.22 and 1.23 above. Various other proposals for pay recommendations have been made by specific staff side organisations which we consider later in the report. We note the parties' evidence that final proposals are being discussed on the introduction of a new unsocial hours scheme. We also note the Royal College of Midwives' request that we should consider the forthcoming review of on-call arrangements. We are a little surprised that on-call arrangements have not been considered as part of the discussions about a new unsocial hours scheme. As they appear not to have been, we hope that the parties can make speedy progress with their review once discussions get underway and that funding is made available to ensure a new set of arrangements satisfactory to all the parties.

#### *Evidence for the review*

1.26 We have undertaken our review this year in broadly the same manner as in previous years. We have carefully considered the evidence we have received and have commissioned our own research to support our deliberations. The Workforce Survey, a regular annual survey undertaken this year on our behalf by ORC International, was again commissioned to provide information on the recruitment and retention picture for our remit group (see Chapter 2). The Workforce Survey report is available on the Office of Manpower Economics' (OME) website<sup>9</sup>

1.27 We also facilitated two pieces of work on pharmacists in an attempt to advance the parties' consideration of Unite (Amicus)'s case for a national RRP for qualified pharmacists. A small study was commissioned from Incomes Data Services (IDS) to provide some information about the remuneration available to qualified pharmacists working in the community retail sector. Our secretariat also funded analysis by the NHS Pharmacy Education and Development Committee of the National NHS Hospital Pharmacy Staffing Establishment and Vacancy Survey 2007. The report from IDS and the analysis of the Vacancy Survey can also be found on the OME website. The findings from these two pieces of work are discussed in more detail in Chapter 3.

1.28 Following the comments made in our last report about the evidence we received from Scotland and Wales, it is clear that both countries have made efforts to address our concerns and for this we are grateful. However we would stress that all the parties who submit evidence to us should focus their evidence very clearly on the specific elements of our remit. We particularly want the Health Departments and NHSE to explain more clearly how their pay uplift proposals relate to other demands on spending in the context of their evidence on affordability. As last year, the support from Scotland and Wales, plus Northern Ireland this year, for the same level of pay uplift as that proposed by the Department of Health seems to be based on the desire to maintain consistency with England regardless of the different affordability position of each country. We discuss this further in Chapter 5.

1.29 We were disappointed that NHSE's evidence this year seemed largely to repeat that of the Department of Health in key areas such as affordability. We hope that NHSE will be able to offer an authoritative independent view in this key area in the next round.

1.30 A variety of evidence is available to inform our reviews, some of which we collect ourselves. In Chapter 1 of last year's report we raised various concerns about the age of some of the key workforce and financial data that is available for our consideration each round. At the time we submitted our last report in February 2007, this data ranged in age from 11 months to nearly 30 months old. We recommended that the Health Departments and other relevant bodies should review the timing of the key surveys which inform our review to see whether we could be provided with more timely data. We also asked the Health Departments to report back to us for this review on the feasibility of providing more timely data. The Department of Health's detailed response can be found at Appendix F.

1.31 The message from the Department was that improvements were underway in all areas to address our concerns, with the ESR being a key platform for the delivery of more accurate and timely workforce and earnings data. We were promised sight in January 2008 of provisional data from the Healthcare Commission's NHS Staff Survey for 2007 and while we appreciate the Healthcare Commission's positive response to our request for earlier data, there are inevitable limitations in the use we can make of provisional data. Nevertheless, we are grateful for the efforts of the Department of Health and others to address our information needs. Although we have yet to see any significant benefits, we fully support these ongoing

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<sup>9</sup> <http://www.ome.uk.com>

efforts to improve the evidence base, particularly in relation to the ex-PNC staff groups. We will ask our secretariat to monitor this work closely and to keep us informed.

### **The labour market in Northern Ireland**

1.32 In response to the extension of our remit to Northern Ireland, the OME commissioned a series of background reports on the labour market there, and, in particular, on how it compares with that of the rest of the UK. This work has been funded by the DHSSPSNI and carried out by an independent research body, the Economic Research Institute of Northern Ireland (ERINI). We have received the first two reports in this research programme and they are available on the OME website. They both deal with the general background, providing information respectively on sources of labour market data for the Province<sup>10</sup> and a comparison of the Northern Ireland and Great Britain labour markets<sup>11</sup>. A third report covering a more detailed comparison of the labour markets at regional level will be available later this year. ERINI's work for 2008-09 will concentrate on the specific labour market for our remit group and other groups added to the remit of other Pay Review Bodies.

1.33 At this stage, therefore, we can only note some particular general aspects of the labour market in Northern Ireland, and, in particular, the key differences from the rest of the UK. As with the UK generally, the employment level in Northern Ireland has reached a record high; the unemployment rate is well below the UK average, and is the lowest of all the regions. However, the employment rate remains below the national average, and economic inactivity is above average, with a lower proportion of the inactive actually wanting to work. The public sector accounts for a much higher proportion of overall employment than in the UK overall. Some 42 per cent of all female workers are employed in the sector, with 25 per cent employed specifically in health and social work – a higher proportion than is employed in health and social work in the rest of the UK. Although in general terms earnings in Northern Ireland are lower than in the UK generally, the public sector is by far the more attractive earnings option, and on average public sector workers can earn nearly a third more than those in the private sector. This, and the high proportion of female workers in the

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<sup>10</sup> Jessica Bennett *Sources of labour market information for Northern Ireland*. London: OME, July 2007. Available from: <http://www.ome.uk.com/downloads/OME%20Report%201%20-%20Sources%20of%20Labour%20Market%20Information%20for%20NI%20-%20Final%20Draft%20-%20Sept%202007.doc>

<sup>11</sup> Jessica Bennett. *The labour market: a Northern Ireland and Great Britain comparison*. London: OME, December 2007. Available from: <http://www.ome.uk.com/downloads/The%20labour%20market%20A%20Northern%20Ireland%20and%20GB%20comparison.doc>

higher-paying public sector, means that there is no gender pay gap overall. Compared to Great Britain, Northern Ireland has a younger workforce. Finally, gross value added per head, a measure of productivity, is only 80 per cent of the UK average, making Northern Ireland the third least prosperous region in the UK as a whole.

1.34 Looking ahead, ERINI raises the likelihood of a 're-balancing' of employment in the public and private sectors as a result of a slower growth in public expenditure. This may, in turn, initially slow the rate of growth in overall employment. Even so, ERINI notes that health and social work, which has experienced the biggest rise in public sector employment so far this decade, is forecast to continue to rise.

### **Timing of our Report**

1.35 Following the publication of our Twenty-Second Report, our secretariat consulted the parties on the date for the receipt of written evidence for this year's review, prior to finalising this year's review timetable. In August, the Department of Health contacted our secretariat and that of the DDRB to advise that the Department would not be in a position to finalise its affordability evidence until the CSR had been concluded and announced in October. The Department said that it would therefore need to delay the submission of evidence and to agree a revised timetable. It hoped to be in a position to submit the Government's comprehensive evidence by the end of October. The Department recognised that the Review Bodies were already working to tight timetables and that delaying the evidence would have a knock-on effect on the subsequent stages in the round and, ultimately, might risk jeopardising the timing of the Review Bodies' reports. The Department therefore asked that change to the timetable should be agreed and all the parties notified as soon as possible.

1.36 It was unfortunate for this year's timetable that the Health Departments were not able to finalise their affordability evidence until the conclusion and announcement of the CSR. We have tried to minimise the delay to the timetable that has inevitably occurred because the parties' evidence was submitted a month later than originally planned. We hope that next year the timetable can revert to that of the past few years with evidence being submitted by all parties at the end of September.

1.37 We would also remind all the parties that evidence submitted to us cannot be considered fully until it is freely available to other parties. We would emphasise that the timing of our report depends upon all parties sharing information quickly and continuing to

work together to a mutually acceptable timetable.

### **Parties giving evidence for the Twenty-Third Review**

1.38 We received written and oral evidence from the following organisations:

- the four UK Health Departments;
- NHSE;
- the NHS Staff Side (joint Staff Side)<sup>12</sup>;
- the Chartered Society of Physiotherapy (CSP);
- the GMB;
- the Royal College of Midwives (RCM);
- the Royal College of Nursing (RCN);
- the Society of Chiropractors and Podiatrists (SCP);
- the Society of Radiographers (SoR);
- Union of Construction, Allied Trades and Technicians (UCATT);
- UNISON;
- Unite (Amicus section) and Unite (T&G section).

1.39 Written evidence was also received from the British and Irish Orthoptic Society (BIOS) and the Northern Ireland Public Service Alliance (NIPSA).

1.40 We are grateful to the parties for the evidence they have given us, much of which included results from external research commissioned by the parties themselves. Individual staff organisations echoed the points raised in the joint Staff Side evidence, but also raised a number of concerns particular to their members.

1.41 We have briefly summarised the parties' written evidence in the relevant chapters. The detailed submissions are available from the parties whose website addresses are listed in Appendix G.

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<sup>12</sup> The joint Staff Side evidence represents the views of the following staff side organisations: UNISON, Unite (Amicus section and TGWU section), GMB, UCATT, RCN, RCM, CSP, SoR, British Association of Occupational Therapists, SCP, Community and District Nursing Association, British Dietetic Association, Federation of Clinical Scientists and the British and Irish Orthoptic Society.

## **Visits made for the Twenty-Third Review**

1.42 During summer 2007 we visited nine Trusts and Health Boards across the UK to talk to managers, staff representatives and a wide variety of staff groups and hear their views about our recommendations for 2007-08 and those issues we should take into account when formulating our proposals for 2008-09. These discussions were wide-ranging and touched upon such issues as the staging of the pay award, the financial situation in the NHS, recruitment and retention, morale and motivation, the KSF and training and development.

1.43 We always try to make our visit programme as representative as possible and last year we visited organisations providing acute, mental health, community care and ambulance services. Visits are an essential part of the review process and afford us a valuable reality-check of what life is like for our remit group 'on the ground'. It was particularly useful to be able to visit a Trust in Northern Ireland for a familiarisation visit and on a few other visits to be able to meet some staff from the groups formerly covered by the PNC. We wish to thank again all those involved in organising our visits, and those staff who found the time to come and tell us their views so frankly.

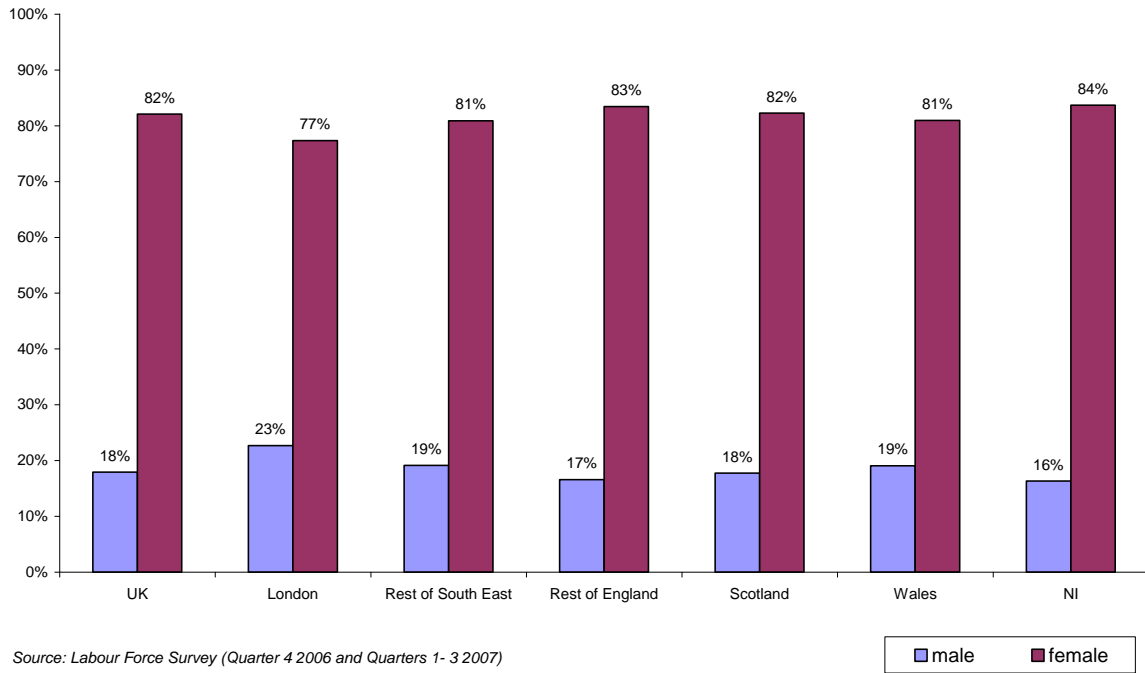
## **The Composition of the Workforce**

1.44 Our remit covers a large group of staff in a wide range of occupations. As at September 2006, the headcount of our remit group was 1,311,729, which represented a workforce of 1,065,052 Full-Time Equivalents (FTEs).

1.45 Statistics on the composition of our remit group are given in Figures 1.1 to 1.4 below. The data are taken from the Labour Force Survey (LFS) datasets, October 2006 to September 2007. The figures are derived from a special exercise undertaken by OME, which used precise definitions of the NHSPRB remit group. The whole economy figures are also taken from the LFS over the same time period, and are based on all those in employment aged 16 or over.

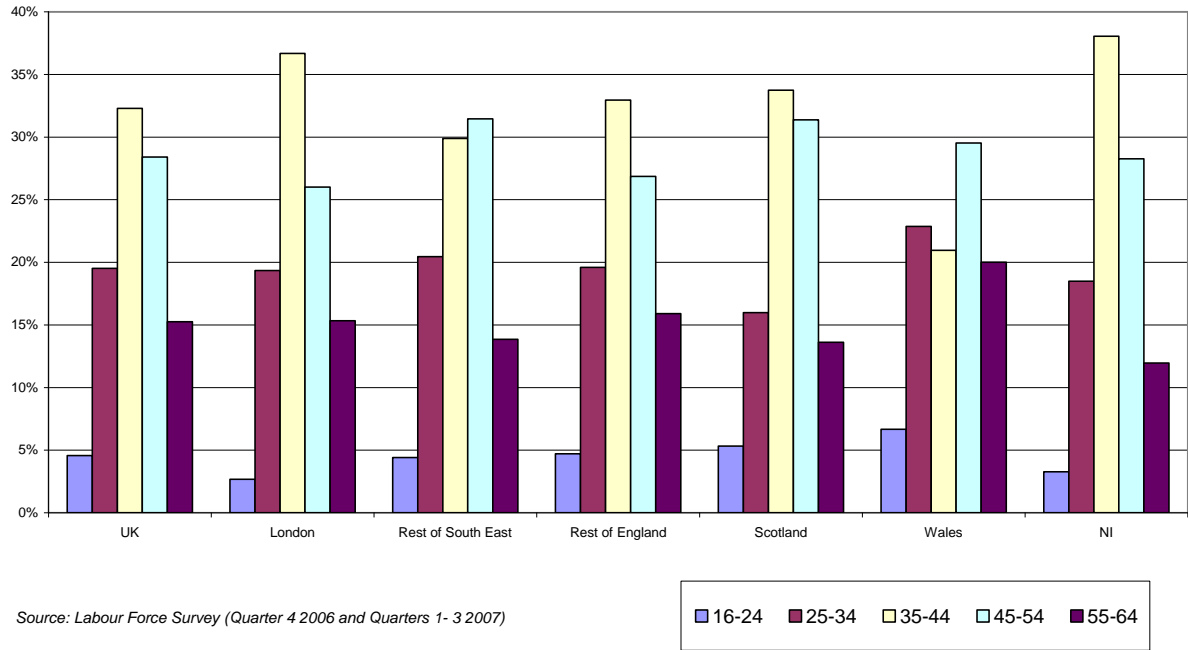
1.46 Figure 1.1 shows our remit group by gender. It is clear that a large majority of the NHS staff in our remit are female, and for all regions except London less than a fifth of staff are male. This compares to a split of 52 per cent male and 48 per cent female in the workforce for the whole economy.

Figure 1.1: Gender Breakdown of NHSPRB Staff by region, 2007



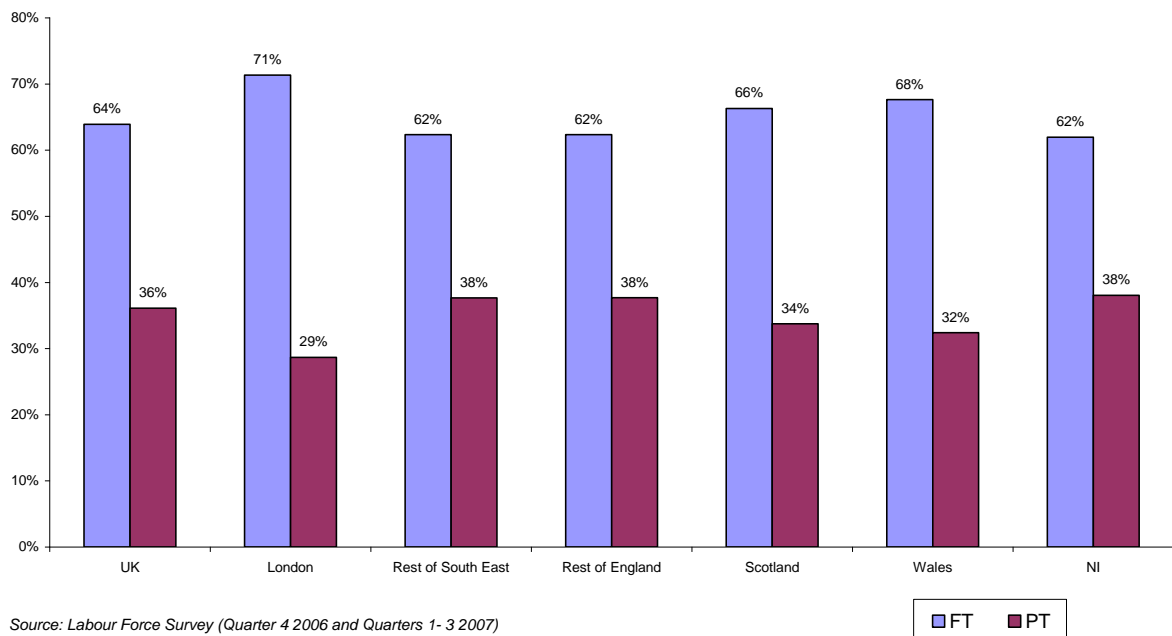
1.47 Figure 1.2 shows the percentage directly employed in our remit by age. The largest proportion are aged 35-44 for all countries and regions, except the Rest of South East England and Wales where the largest proportion of the NHSPRB remit are aged 45-54. While London and Northern Ireland appear to have the ‘youngest workforces’, both still have 41 and 40 per cent respectively of their staff aged 45 and above, which compares to about 40 per cent in the whole economy.

Figure 1.2: Age Distribution of NHSPRB staff by region, 2007



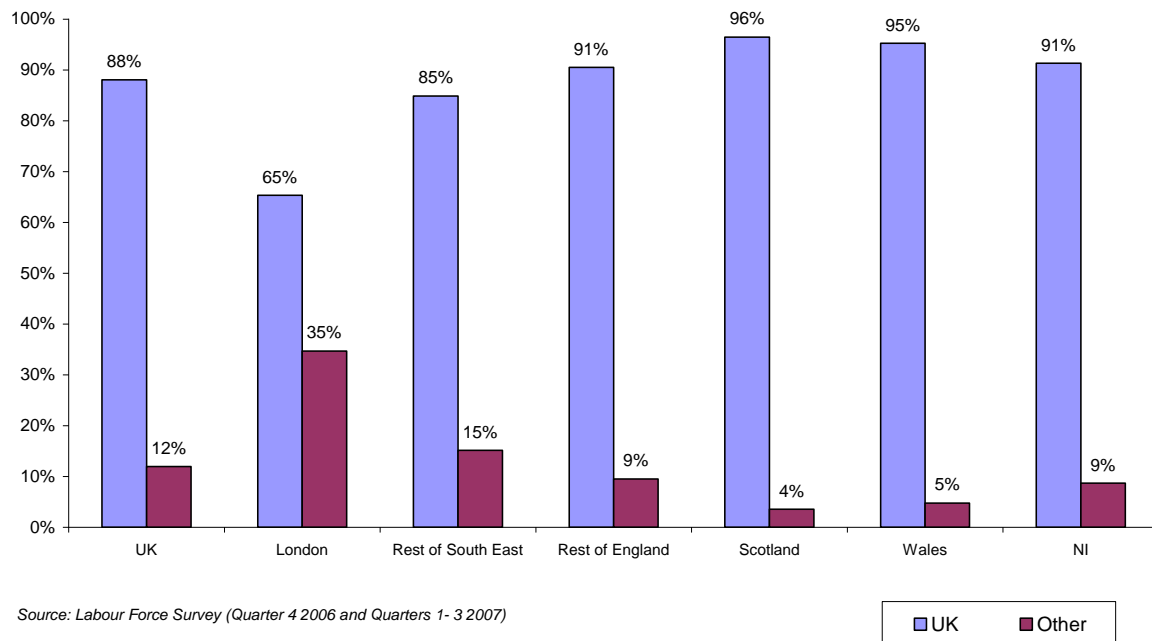
1.48 Figure 1.3 shows the remit group by full-time and part-time status, where part-time refers to people working 30 hours or less. All regions have slightly more than a third of staff working 30 hours or less except London and Wales who have less, with only 29 and 32 per cent respectively of their staff working part-time. This compares to around a quarter of those employed in the whole economy working part-time.

Figure 1.3: Whether NHSPRB staff work Full-Time or Part-Time by region, 2007



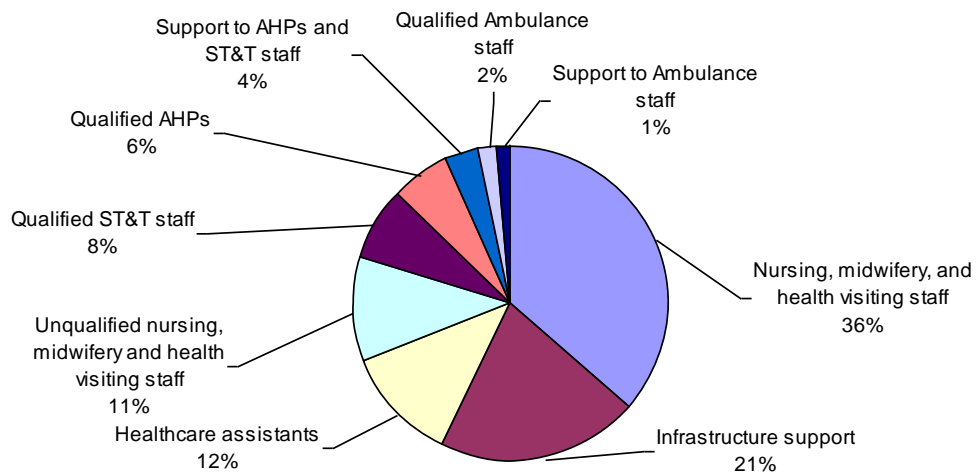
1.49 The majority of staff working in the NHS were born in the UK. However 35 per cent of staff in London and 15 per cent of staff in the Rest of South East England were born elsewhere (Figure 1.4). This compares to ten per cent of those working in the whole economy being born elsewhere.

Figure 1.4: Whether NHSPRB staff are UK born, by region, 2007



1.50 The compositions of the remit group in England, Scotland, Wales and Northern Ireland by main occupation are shown in Figures 1.5 to 1.8. Data are not collected on a consistent national basis and so do not allow a UK comparison to be made. Latest available data for England, Scotland and Wales are for September 2006, while Northern Ireland has data available for March 2007. Please note that infrastructure support includes staff who were previously covered by the PNC and we are hoping to be able to get more detailed information on these groups in the future.

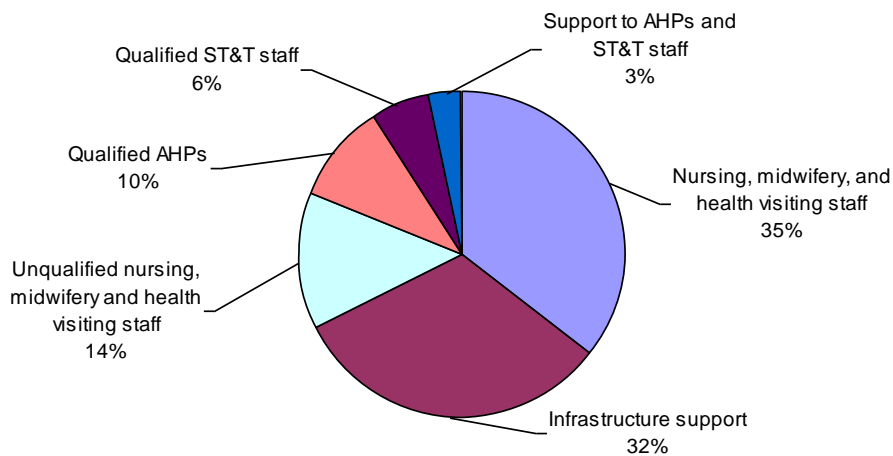
**Figure 1.5: The composition of the NHSPRB remit group in England by main staff group (FTE), September 2006**



Source: NHS Information Centre, Non-Medical Workforce Census September 2006

Notes: Percentages sum to more than 100% due to rounding

**Figure 1.6: The composition of the NHSPRB remit group in Scotland by main staff group (FTE), September 2006**

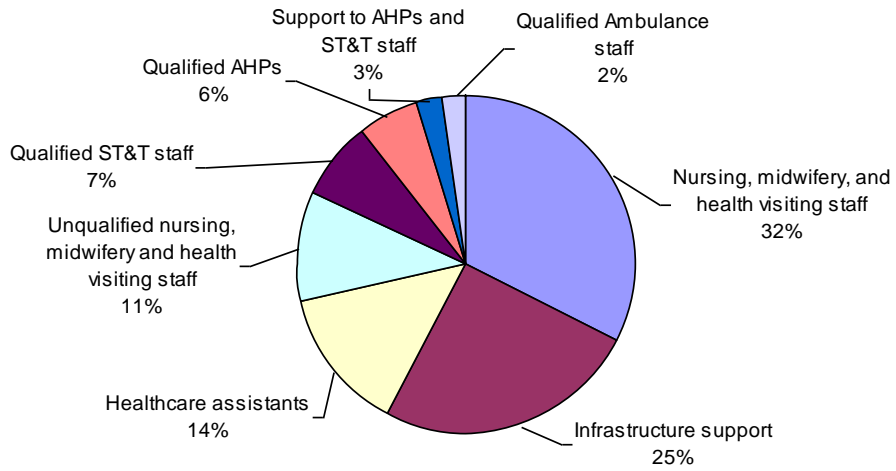


Source: ISD Scotland, Non-Medical Workforce Census, September 2006

Notes: 1. Ambulance data for Scotland was not published due to a discrepancy in the data

2. Healthcare assistants are included within the support data for individual professions

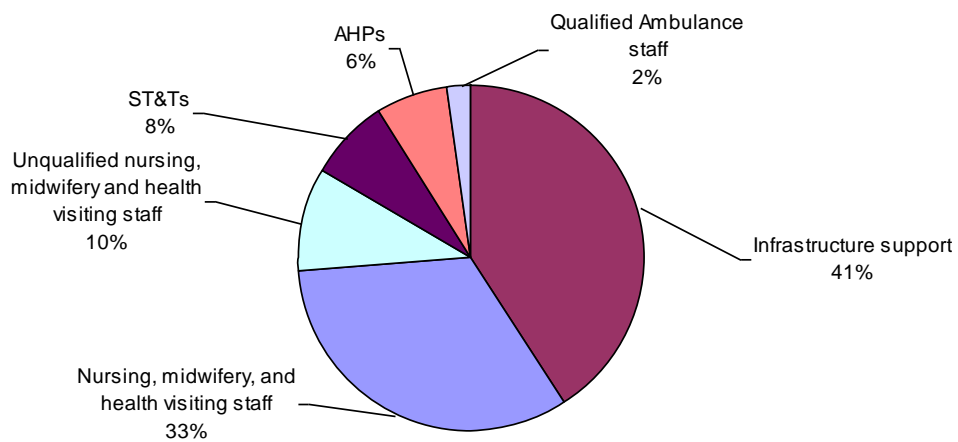
**Figure 1.7: The composition of the NHSPRB remit group in Wales by main staff group (FTE), September 2006**



Source: Key Health Statistics for Wales, September 2006.

Notes: Support to Ambulance staff make up less than 1% of the NHSPRB remit in Wales

**Figure 1.8: The composition of the NHSPRB remit group in Northern Ireland by main staff group (FTE), March 2007**



Source: Department of Health, Social Services and Public Safety, NI

Notes: 1. Data on AHPs and ST&Ts include both qualified and support, as they cannot be separated  
 2. Healthcare assistants are included in the support data for individual professions  
 3. Support to Ambulance staff make up less than 1% of the NHSPRB remit in Northern Ireland

## CHAPTER 2 – RECRUITMENT AND RETENTION

### Introduction

2.1 In this chapter we review:

- the key results of the 2007 Workforce Survey carried out by the Office of Manpower Economics (OME);
- vacancies in the NHS and the general economy, including the NHS Vacancy Survey; and
- evidence from the parties.

As there is clearly a strong link between some aspects of recruitment and retention and issues affecting morale and motivation, there is some overlap of the evidence covered in this chapter and that in Chapter 4.

### OME 2007 Workforce Survey<sup>13</sup>

2.2 Again last year OME carried out a Workforce Survey covering Trusts and Health Boards in Great Britain. Summary results are included in this chapter; full results can be found on the OME website at <http://www.ome.uk.com>. There are two parts to the survey: Part a, the Telephone Survey, covers recruitment and retention issues as reported by managers in Trusts or Health Boards in Great Britain; Part b, The Main Data Collection, covers joining, turnover and wastage rates as a proportion of staff in post.

#### a) The Telephone Survey

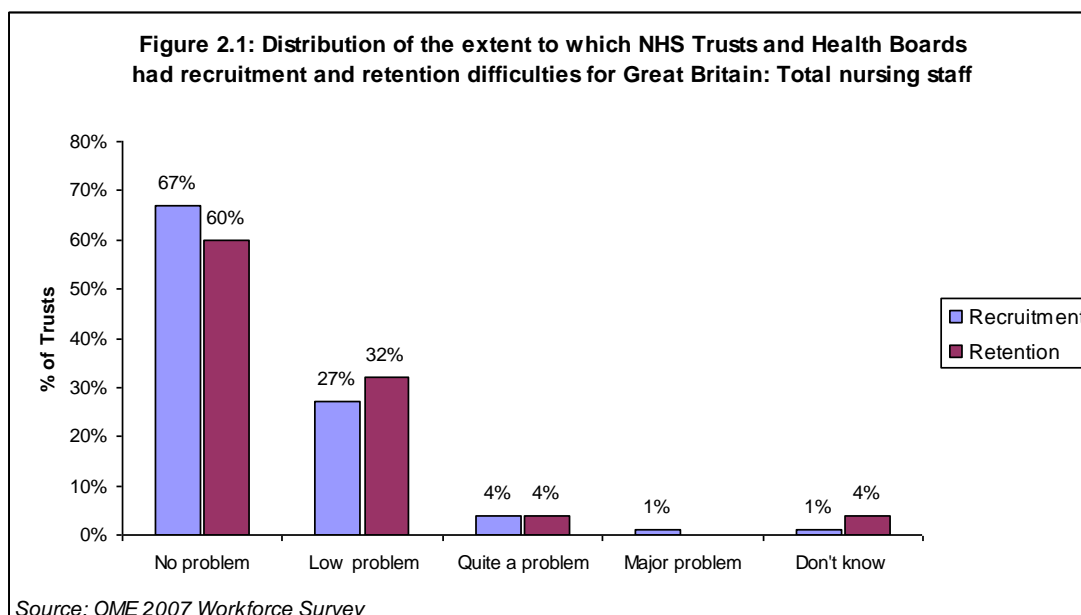
2.3 The 2007 Workforce Survey provided an opportunity for Trust and Health Board managers to indicate the extent to which they had recruitment and retention difficulties for staff in each grade<sup>14</sup>. This part of the survey was carried out separately from the main data collection exercise as a ten-minute telephone interview between April and June 2007. All 431 Trusts in Great Britain (394 in England, 23 in Scotland and 14 in Wales) were contacted to take part in this survey. Of these, 288 completed interviews were achieved (265 in England, 15 in Scotland and 8 in Wales), giving a 67 per cent response rate overall.

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<sup>13</sup> Note that the Workforce Survey did not include data on the new staff groups whose pay was previously determined by the 'Pay Negotiating Council'.

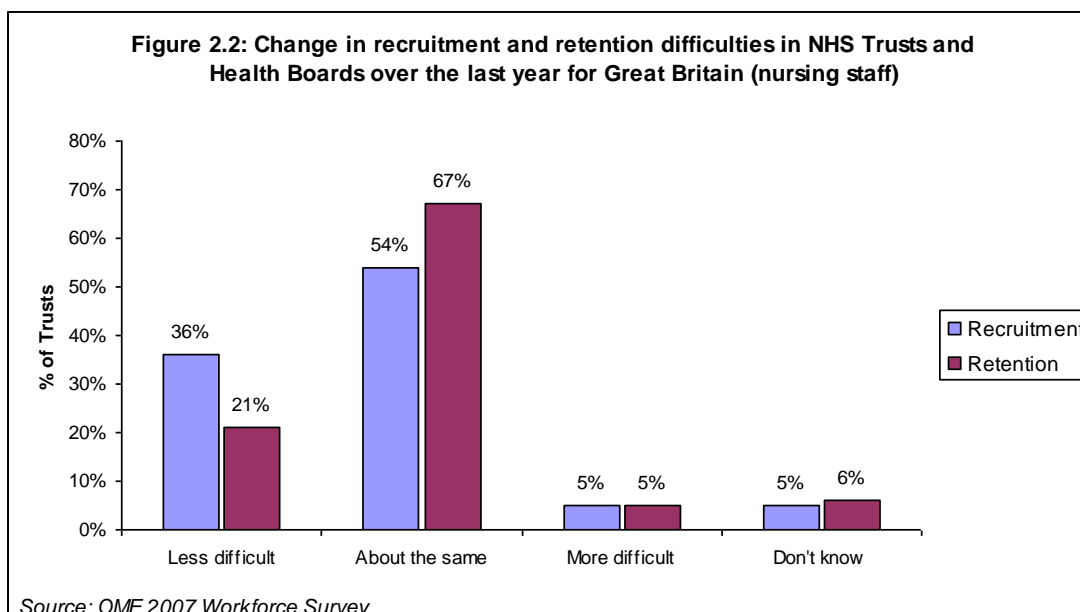
### *Nursing staff, midwives and health visitors*

2.4 The vast majority of Trusts had either ‘no problem’ or a ‘low problem’ with recruiting or retaining nursing staff. Just five per cent (as compared to eight per cent in 2006) and four per cent (six per cent in 2006) said that they either had ‘quite a problem’ or a ‘major problem’ with recruitment and retention respectively (Figure 2.1).



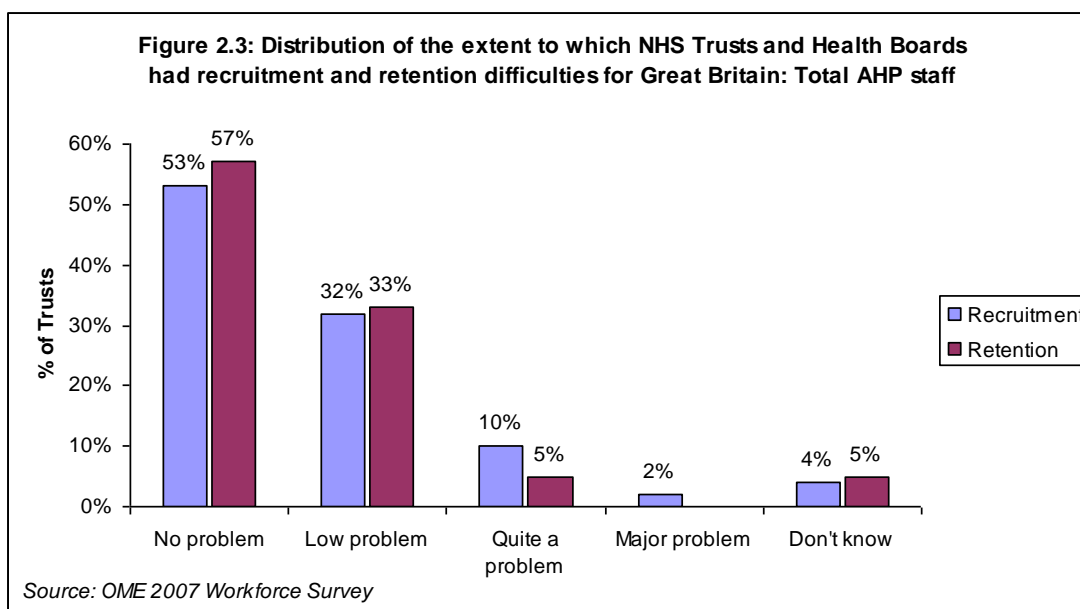
2.5 Figure 2.2 shows that on the whole recruitment and retention appeared to be improving, with over a third of Trusts and Health Boards reporting that recruitment of nurses was ‘less difficult’ in 2007 than in 2006 and around a fifth of Trusts and Health Boards reporting that retention was less difficult compared with only five per cent reporting greater difficulties in each case in 2007 (10 – 11 per cent in 2006).

<sup>14</sup> Results are presented on an aggregate basis for Trusts and Health Boards and do not, unless otherwise indicated, necessarily mean that a majority of Trusts and Health Boards, for example, indicated a specified view.



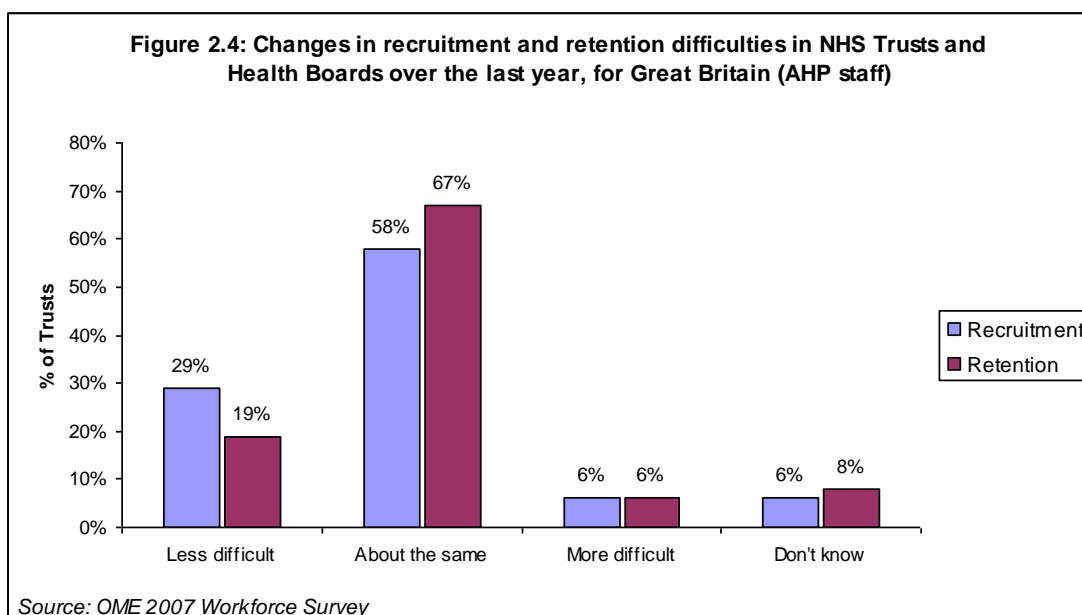
### Allied Health Professionals (AHPs)

2.6 Ten per cent (17 per cent in 2006) of Trusts and Health Boards said they had ‘quite a problem’ recruiting AHP staff, while just two per cent (one per cent in 2006) had a ‘major problem’ in doing so. Over half of Trusts and Health Boards had ‘no problem’ recruiting such staff (see Figure 2.3).



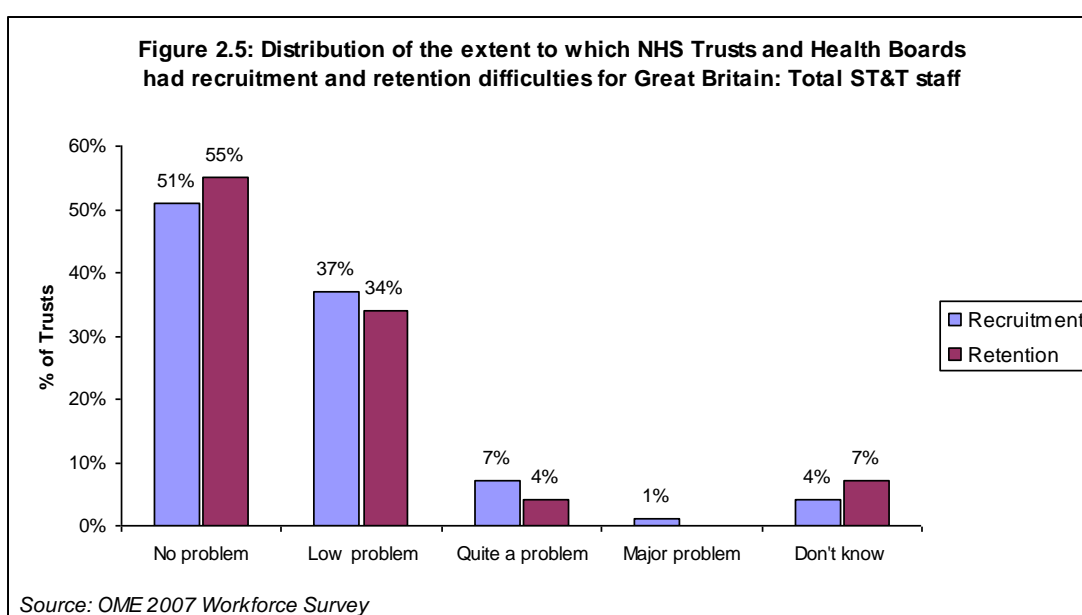
2.7 The recruitment situation for AHP staff appears to have improved since last year (Figure 2.4). Only six per cent thought recruitment had become ‘more difficult’ than last year, while nearly 30 per cent said it had got ‘less difficult’. Retention problems also appear

to have improved a little since last year. While 19 per cent felt that retention was ‘less difficult’ than last year, just six per cent felt it had got ‘more difficult’.

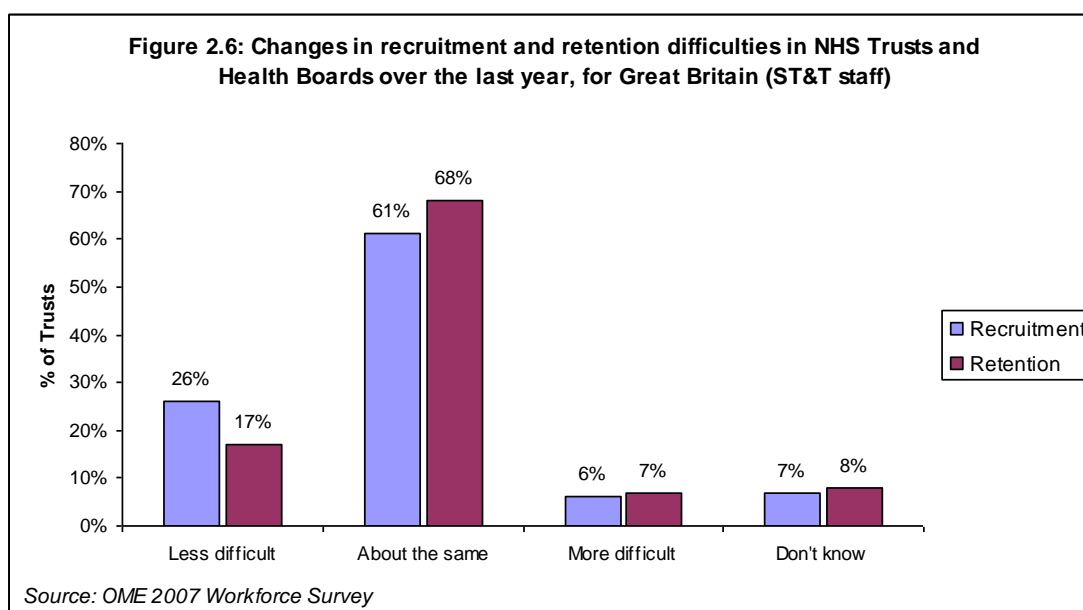


*Other Scientific, Technical and Therapeutic (ST&T) staff*

2.8 Eight per cent of Trusts and Health Boards had ‘quite a problem’ or a ‘major problem’ with recruitment of ST&T staff (compared with 12 per cent in 2006), while over a third had a ‘low problem’ and over half ‘no problem’ (Figure 2.5). Nearly 90 per cent of Trusts and Health Boards felt they had ‘no problem’ or a ‘low problem’ with retaining ST&T staff, and just four per cent of Trusts and Health Boards recorded they had ‘quite a problem’ and virtually no Trusts or Health Boards reported that they had a ‘major problem’.



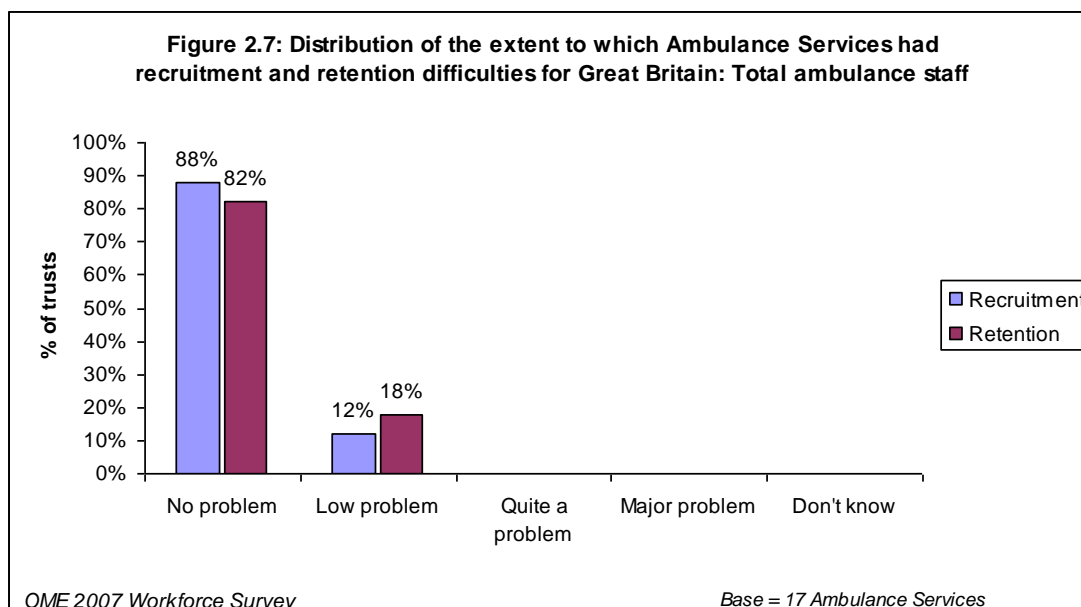
2.9 The recruitment situation for ST&T staff appears to have improved since last year (Figure 2.6). Just over a quarter of Trusts and Health Boards said recruitment had got ‘less difficult’ while only six per cent thought it had become ‘more difficult’ than last year. Retention problems also appear to have improved a little since last year. While 17 per cent felt that retention was ‘less difficult’ than last year, seven per cent felt it had got ‘more difficult’.



### *Ambulance staff*

2.10 Seventeen Ambulance Services participated in the telephone interview. Care should be taken when interpreting the results because of the low number of available participants.

2.11 Eighty eight per cent of Ambulance Services had ‘no problem’ with recruitment, while 12 per cent had a ‘low problem’. As in 2006, none had ‘quite a problem’ or a ‘major problem’. Retention of ambulance staff appeared to be similar to recruitment, although slightly more Ambulance Services recorded they had a ‘low problem’ compared with recruitment.



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

2.12 The survey was sent to all 408 Trusts in England and Wales, including Ambulance Trusts, in June 2007. Of these, 251 (62 per cent of Trusts in England and Wales) made returns that were included in the analysis. Unfortunately, throughout the analysis a high proportion of Trusts were unable to say where joiners had come from and where leavers were going and this non-response should be borne in mind when interpreting these results.

2.13 The Information Statistics Division of the Scottish Government Health Directorates collects separate data from Scottish Health Boards on joiners and leavers. However, as a result of the dissolution of NHS Argyll & Clyde from 1 April 2006, turnover and joining figures for Scotland were much higher than would be expected and have therefore not been analysed here.

2.14 Some common definitions:

- **Joining rate** - Number of joiners as a proportion of staff in post.
- **Turnover rate** - Number of leavers as a proportion of staff in post.
- **Wastage rate** - Leavers excluding transfers to other NHS Trusts, as a proportion of staff in post.
- **Matched sample** - Based on English and Welsh Trusts only that supplied comparable data in both 2006 and 2007.

2.15 A matched sample comparison with the results of the 2006 Workforce Survey was produced. The matched sample results should be used when comparing workforce survey data in England and Wales between the two years 2006 and 2007, because these will be less affected by changes in the composition of the samples between years.

2.16 The 2007 Workforce Survey shows falls in the joining and turnover rates for all aggregated staff groups (see Box 2.1, Table B and Table D respectively). The wastage rate too fell for all aggregated staff groups (Box 2.1, Table D). The wastage rate is the measure on which to focus when assessing the rate of exits from the NHS altogether.

### **Occupational analysis**

#### *Wastage*

2.17 The average wastage rate for the NHSPRB remit group as a whole was 8.1 per cent. The highest rate of wastage amongst qualified workers, at 11.7 per cent, was pharmacists<sup>15</sup>, followed by occupational therapists (9.7 per cent) and clinical psychologists (8.8 per cent). The lowest rates of wastage were recorded for paramedics (2.0 per cent), ambulance technicians (5.0 per cent), and diagnostic radiography and nurse consultants, managers and school nurses (both 5.2 per cent).

#### *Turnover*

2.18 The average turnover rate for the NHSPRB remit group as a whole was 9.8 per cent. The highest rates of turnover among qualified staff were occupational therapists (14.6 per cent), pharmacists (14.4 per cent) and physiotherapists (11.6 per cent) and the lowest rates of turnover were for paramedics (2.0 per cent), ambulance technicians (5.1 per cent) and diagnostic radiographers (6.9 per cent).

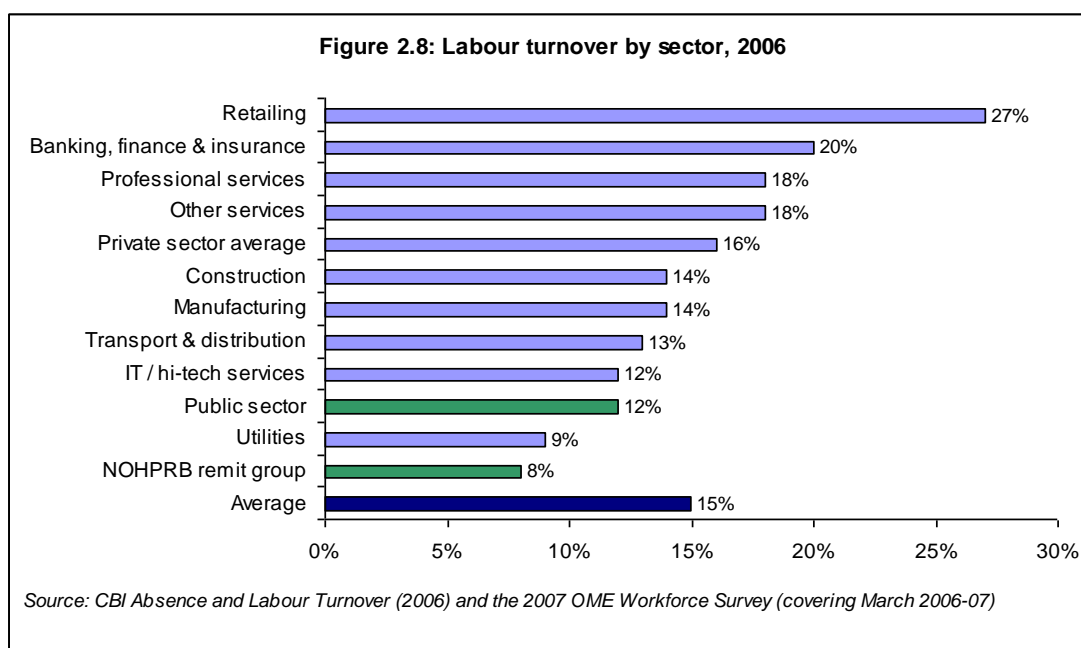
2.19 Typically there were higher rates of wastage, turnover and joining among the staff supporting qualified professionals.

### **Sectorial analysis**

2.20 Both the Chartered Institute of Personnel and Development (CIPD) and the Confederation of British Industry (CBI) have published their whole economy labour turnover figures for 2006. According to the CIPD's annual *Recruitment, retention and turnover survey*, the median labour turnover rate for 2006 was 18.1 per cent, compared with 18.3 per

cent in 2005, 15.7 per cent in 2004 and 16.1 per cent in both 2003 and 2002. By contrast, in its survey of absence and labour turnover, *Attending to Absence*, the CBI gives a figure of 15 per cent for average labour turnover during 2006, the same as 2005 and only marginally below its findings over the previous three years.

2.21 The average wastage rate for the NHSPRB remit group as a whole, calculated from the full Workforce Survey sample in England and Wales, was 8.4 per cent<sup>15</sup>. This is charted against sectorial rates recorded in the CBI's *Absence and Labour Turnover Survey 2006* below (Figure 2.8).



<sup>15</sup> We discuss pharmacists in more detail in chapter 3.

## Box 2.1: 2007 Workforce Survey

### Recruitment

#### **A - Staff joining rates (Whole sample)**

Main staff group	England and Wales (in the year to 31 March 2007)
NHSPRB	9.0%
Nurses	8.3%
AHPs	12.5%
ST&T	11.2%
Ambulance	5.4%

#### **B - Staff joining rates in the year to 31 March (Matched sample)**

Main staff group	England and Wales only	
	2006	2007
NHSPRB	11.9%	8.9%
Nurses	11.2%	8.1%
AHPs	15.7%	12.3%
ST&T	12.7%	11.3%

### Retention

#### **C - Turnover and wastage rates (Whole sample)**

Main staff group	England and Wales (in the year to 31 March 2007)	
	Turnover	Wastage
NHSPRB	10.2%	8.4%
Nurses	9.9%	8.2%
AHPs	11.8%	9.3%
ST&T	11.8%	10.0%
Ambulance	5.3%	4.6%

#### **D - Turnover and wastage rates in the year to 31 March (Matched sample)**

	England and Wales only			
	Turnover		Wastage	
	2006	2007	2006	2007
NHSPRB	10.7%	9.8%	8.4%	8.1%
Nurses	10.3%	9.6%	8.2%	7.9%
AHPs	12.7%	11.4%	9.5%	8.6%
ST&T	11.4%	11.0%	9.3%	9.1%

#### **E - Turnover rates and wastage rates in the year to 31 March, by selected occupational groups (Matched sample)**

	England and Wales only			
	Turnover		Wastage	
	2006	2007	2006	2007
Midwives	7.9%	6.9%	6.4%	5.4%
Health Visitors	8.1%	8.2%	5.9%	6.5%
District Nurses	8.9%	7.7%	6.4%	6.8%
Other general 1 <sup>st</sup> and 2 <sup>nd</sup> level registered	9.8%	8.7%	7.4%	7.0%
Nurse consultants, managers, school nurses	7.2%	7.1%	4.6%	5.2%
Nurse auxiliaries and assistants	12.2%	12.1%	10.7%	10.3%
Pharmacy	14.5%	14.4%	11.1%	11.7%
Occupational therapy	15.5%	14.6%	10.9%	9.7%
Physiotherapy	14.5%	11.6%	10.4%	8.3%
Diagnostic radiography	8.1%	6.9%	5.8%	5.2%
Therapeutic radiography	9.8%	7.7%	7.1%	5.8%

<sup>16</sup> The wastage rate is used when comparing turnover rates in the private sector because their turnover rate does not include internal transfers and is therefore equivalent to our definition of wastage - 'leavers excluding transfers to other NHS Trusts, as a proportion of staff in post'.

## NHS Vacancy Surveys

**Table 2.1: 2007 vacancy rates and the percentage point change since 2006.**

	ENGLAND		SCOTLAND <sup>1</sup>		WALES		NORTHERN IRELAND	
	Vacancy rate in 2007	Percentage point change <sup>2</sup>	Vacancy rate in 2007	Percentage point change <sup>2</sup>	Vacancy rate in 2007	Percentage point change <sup>2</sup>	Vacancy rate in 2007	Percentage point change <sup>2</sup>
Qualified Nursing, midwifery and Health Visiting staff	0.5%	-0.4%	0.5%	-0.2%	0.4%	-0.7%	0.9% <sup>3</sup>	+0.3% <sup>3</sup>
Support to nursing staff	0.4%	-0.2%	0.4%	-0.3%	0.7%	+0.2%		
Qualified AHPs	0.7%	-0.9%	1.0%	-0.6%	1.2%	-0.6%	1.6% <sup>4</sup>	-0.8% <sup>4</sup>
Qualified ST&Ts	1.0%	-0.6%	-	-	0.4%	-0.5%		
Support to AHPs and ST&T staff	0.5%	-0.3%	0.8% <sup>5</sup>	+0.1%	0.4%	+0.2%		
Ambulance staff	0.3%	-1.2%	-	-	0.0%	-1.9%	-	-
Administrative and Clerical staff	0.6%	-0.2%	-	-	1.0% <sup>6</sup>	+0.2%	1.0%	-0.1%

Source: NHS Information Centre; ISD Scotland; StatsWales; and the Department of Health, Social Services & Public Safety in Northern Ireland

<sup>1</sup> Scotland only provides data for nurses and AHPs.

<sup>2</sup> The percentage point change between the 2006 and 2007 vacancy rates.

<sup>3</sup> This figure includes qualified and unqualified nursing staff.

<sup>4</sup> This figure is for professional and technical staff and includes all AHPs and ST&Ts, including support.

<sup>5</sup> Only includes support to AHP staff.

<sup>6</sup> Excludes paramedics: paramedics in Wales appeared to have a 0% vacancy rate in 2007.

- Numbers are not available or are based on fewer than five vacancies.

2.22 The three-month vacancy rates in England fell for all the main staff groups in March 2007 compared with the previous year. However difficulties remain in certain key groups, such as learning disabilities and pre-registration pharmacy trainees, which had vacancy rates of 5.6 and 2.2 per cent respectively. The picture was mixed for the other three countries of the UK, with some main staff groups seeing the vacancy rate rise by up to 0.3 percentage points.

### *The data*

2.23 NHS Vacancy Surveys are commissioned for England, Scotland, Wales and Northern Ireland: the surveys asked Trusts and Health Boards how many vacancies, as at 31 March 2007, they had actively been trying to fill, which had lasted for three months or more. The results are expressed both as a percentage of staff in post and as the actual number of three-month vacancies. The staff in post figures come from the September 2006 non-medical workforce censuses. Scotland provides only vacancy data for nurses and AHPs and in 2006 and 2007 was unable to publish detailed data as it was still in the process of implementing Agenda for Change. Northern Ireland produces figures for very broad staff groups only. All figures are based on Full-Time Equivalents (FTE).

### *Problems*

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

2.25 As last year, Staff Side set out in their evidence why they treat vacancy rates published by the Health Departments with caution. They repeated their concerns because they did not believe the data had improved since last year: they suggested that while the majority of professions had experienced a reduction in vacancy rates, these were attributable to job cuts and recruitment freezes, rather than a reduction in staff shortages. Furthermore they were again concerned about the way in which vacancy data are compiled by the Health Departments. They argued that the figures were not a truly representative picture as they only showed posts that had been vacant for three months or more and the data were not detailed enough to highlight recruitment difficulties affecting specific bands and specialties within staff groups.

## **Results**

### *(a) England (Figure 2.9).*

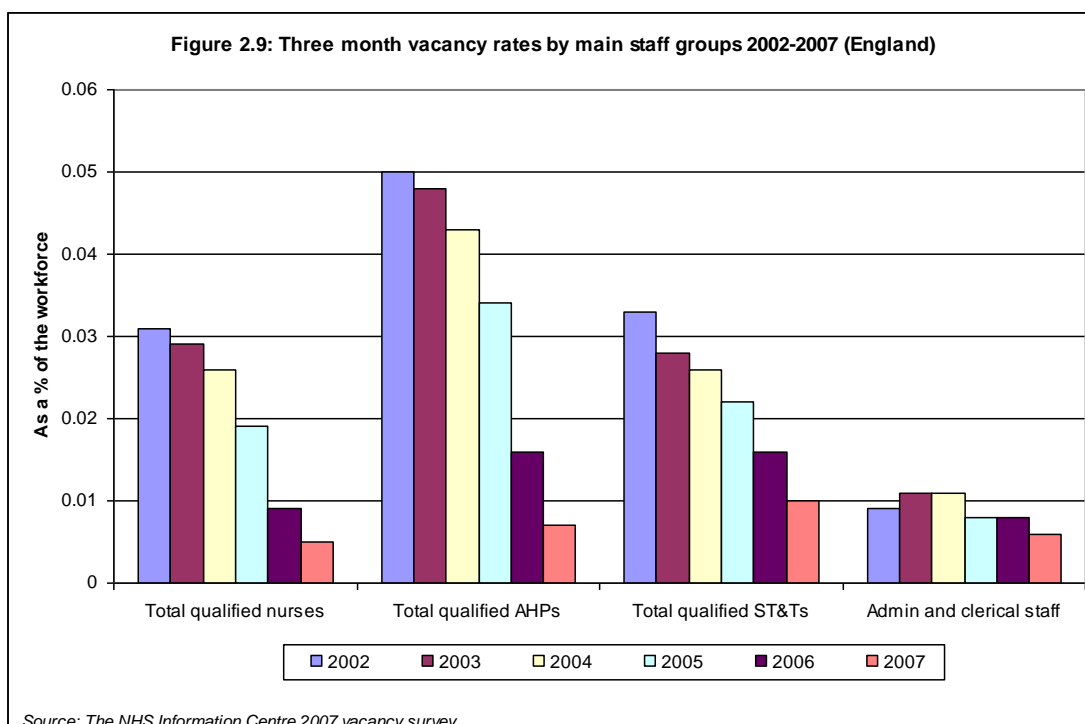
2.26 For qualified nurses, midwives and health visitors as a whole the vacancy rate was 0.5 per cent, a fall of 0.4 percentage points since 2006. There were 1,695 vacancies in 2007, 1,189 fewer than in 2006. This is at least the sixth successive year in which this vacancy rate had fallen. Vacancy rates fell for all the qualified nursing staff groups with the exception of community learning disabilities (+2.1 percentage points) and other learning disabilities (+4.5 percentage points) and their vacancy rates were above average in 2007.

2.27 For qualified AHPs, the vacancy rate was 0.7 per cent in 2007, a fall of 0.9 percentage points (466 vacancies) compared with 2006, and also the fifth consecutive year this rate had fallen. Although rates have fallen for all AHPs, difficulties remain among certain key groups. In orthoptics/optics and dietetics, vacancy rates are relatively high compared to other AHP professions with rates at 1.3 per cent and 1.1 per cent respectively, but there are relatively few vacancies in these fairly small specialisms.

2.28 For qualified ST&T staff, the 2007 vacancy rate was one per cent, a fall of 0.6 percentage points since 2006, the sixth consecutive year this rate had fallen. Virtually all the professions included in ST&T staff experienced a fall in their vacancy rate between 2006 and 2007.

2.29 This is the first year that the group ‘administrative and clerical staff’ have been included in our remit. Unfortunately, while this is a large group of staff (around a quarter of a million people), there is very little detailed data collected on them and they are therefore referred to as one group even though this includes ancillary staff, administrative and clerical staff, maintenance and estates staff and others (such as junior managers and chaplains).

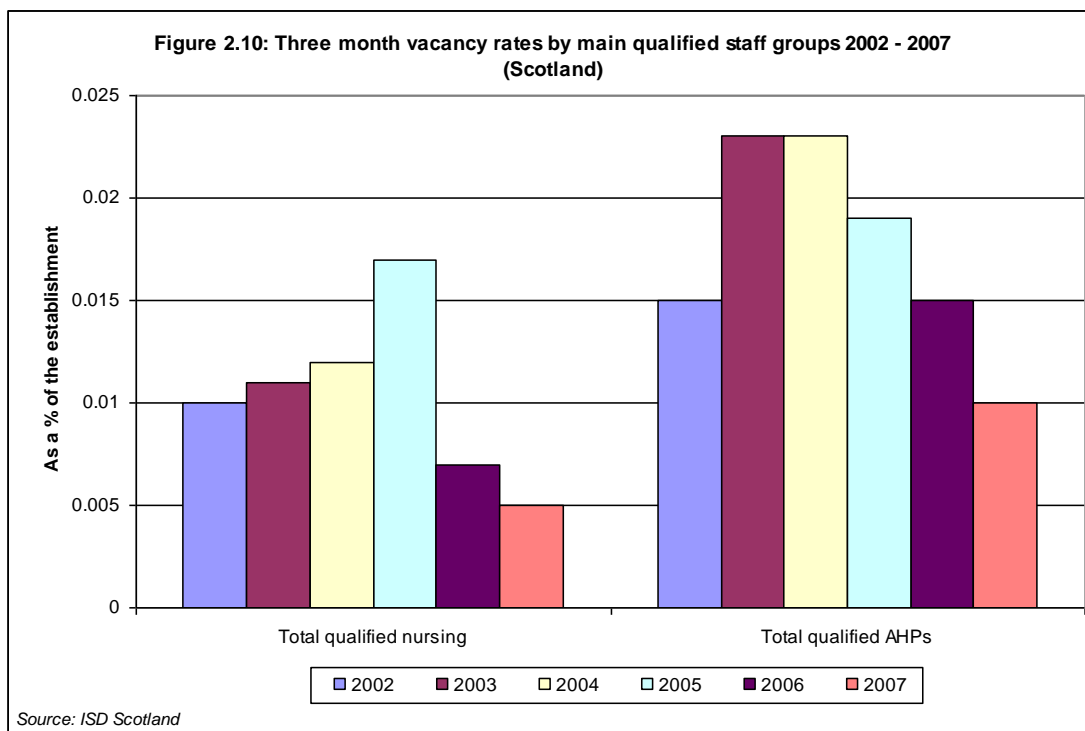
2.30 For administrative and clerical staff the vacancy rate was 0.6 per cent in 2007, a fall of 0.2 percentage points (488 vacancies) compared with 2006, and also the fourth consecutive year this rate had fallen or stayed the same.



*(b) Scotland (Figure 2.10).*

2.31 For qualified nurses, midwives and health visitors in Scotland as a whole, the vacancy rate was 0.5 per cent in 2007, a fall of 0.2 percentage points over 2006. There were 209 vacancies in 2007, 78 fewer vacancies than in 2006. This is the second year that vacancy rates have fallen since peaking in 2005.

2.32 For qualified AHPs the vacancy rate was 1.0 per cent in 2007, a fall of 0.6 percentage points (39 vacancies) compared with a year previously and the third time they have fallen since peaking in 2003 and 2004.



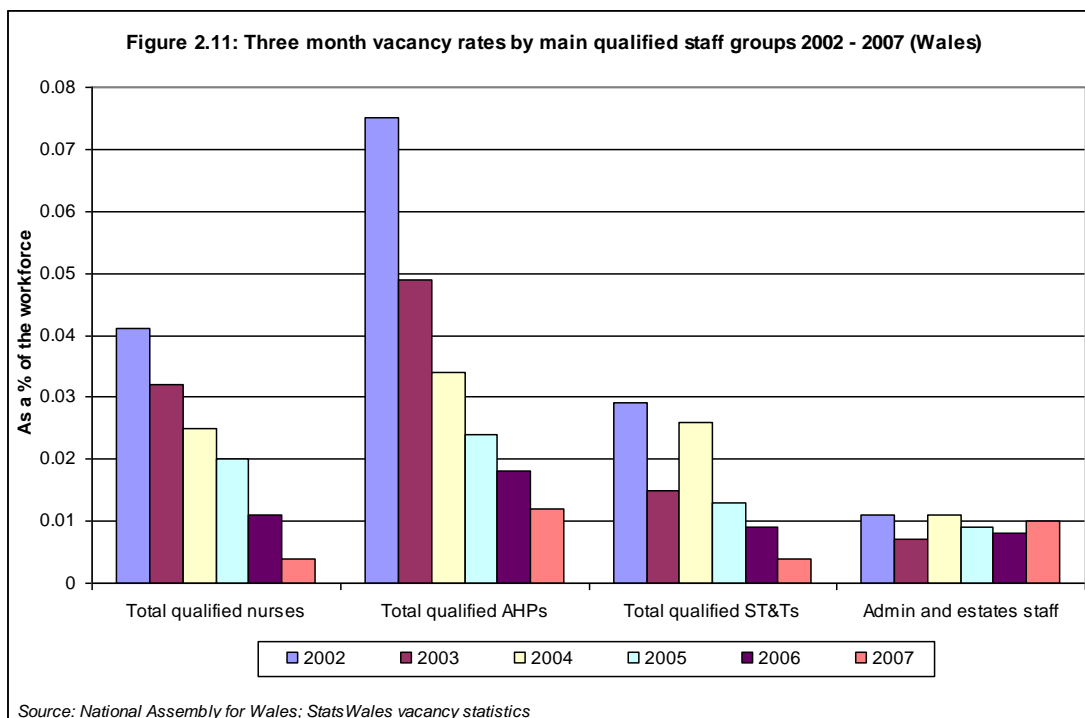
*(c) Wales (Figure 2.11).*

2.33 For qualified nurses, midwives and health visitors as a whole the vacancy rate was 0.4 per cent in 2007, a fall of 0.7 percentage points since March 2006. There were 94 vacancies in 2007, 134 less than in 2006. This is the fifth successive year that this vacancy rate had fallen.

2.34 For qualified AHPs the vacancy rate was 1.2 per cent in 2007, just over half a percentage point less than in 2006 (down 24 vacancies) and the fifth successive year that this vacancy rate had fallen. For other qualified ST&T staff the vacancy rate was 0.4 per cent, a fall of half a percentage point since 2006. There were nine vacancies in 2007, nine fewer than in 2006. 2007 is the third year in succession that vacancy rates have fallen.

2.35 For administrative and estates staff the vacancy rate was one per cent in 2007, 0.2 percentage points higher than in 2006 (up 31 vacancies). This is the first year vacancy rates have risen for this group of staff since 2004, although they have remained generally the same, at around one per cent, since at least 2002.

2.36 Vacancy rates have a tendency to be more volatile for AHPs and ST&Ts in Wales than in England or Scotland because of the smaller numbers involved.



*(d) Northern Ireland (Figure 2.12).*

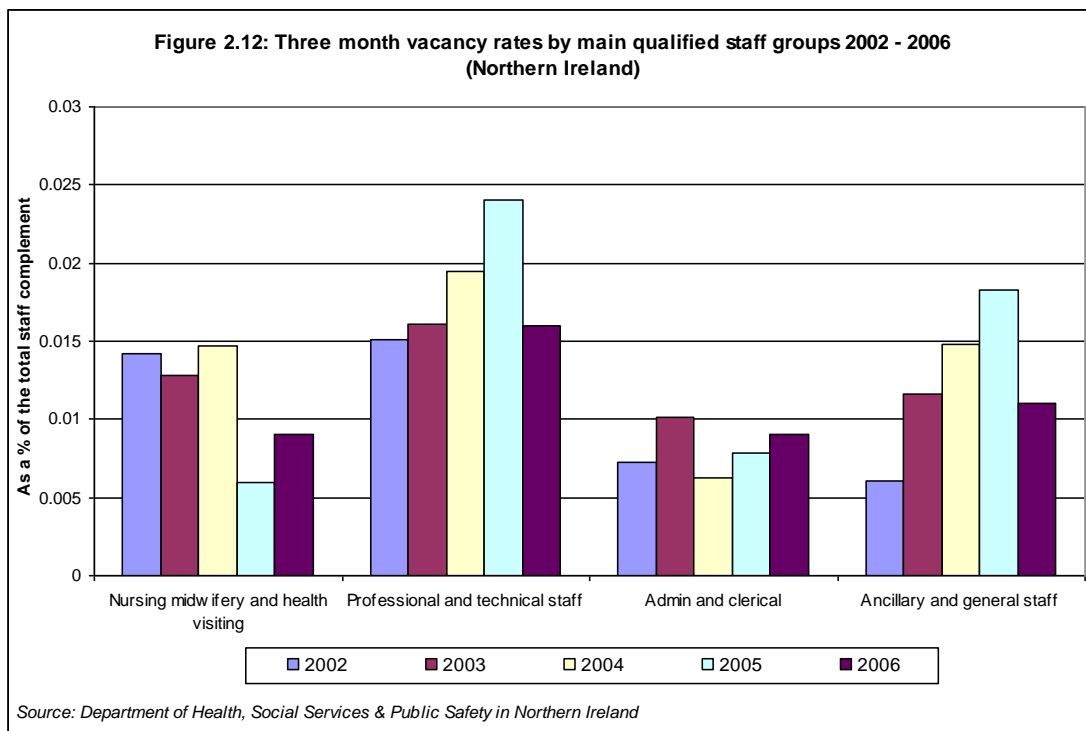
2.37 This is the first year that Northern Ireland has been included in our remit. Northern Ireland defines staff groups differently to the other three countries when reporting vacancy data. Like Scotland, data is also obtained for posts vacant for less than three months, but to ensure comparability with England and Wales only data relating to vacancies of three months or more are included in our analysis.

2.38 For nurses, midwives and health visitors as a whole (qualified and unqualified) the vacancy rate was 0.9 per cent in 2006, an increase of 0.3 percentage points since March 2005. There were 157 vacancies in 2006, 52 more than in 2005, in which year the vacancy rate for nurses was particularly low in a Northern Ireland context.

2.39 For professional and technical staff the vacancy rate was 1.6 per cent in 2006, 0.8 percentage points less than in 2005 (down 42 vacancies) putting a stop to the upward trend of recent years.

2.40 For administrative and clerical staff the vacancy rate was 0.9 per cent in 2006, 0.1 percentage points higher than in 2005 (up 15 vacancies). This was the second year vacancy rates rose for this group of staff.

2.41 For ancillary and general staff the vacancy rate was 1.1 per cent in 2006, 0.7 percentage points lower than in 2005 (down 38 vacancies). This is the first year vacancy rates had fallen for this group of staff in at least four years.



### Vacancies in the NHS – Other sources of vacancy data

2.42 Data from the NHS vacancy surveys suggest that the overall vacancy rates seem to have fallen in recent years; however it is useful to know how this compares to experience elsewhere in the economy. The Office for National Statistics (ONS) provides a breakdown of vacancy rates by broad industry grouping. While the ONS data are on-the-day vacancies and therefore not directly comparable with the three-month vacancies from the NHS Vacancy Surveys, they can still be a useful indicator of trends. The vacancy rates over the period August-October 2003 to August-October 2007 are presented in Table 2.2.

**TABLE 2.2: Vacancy rates by industry**

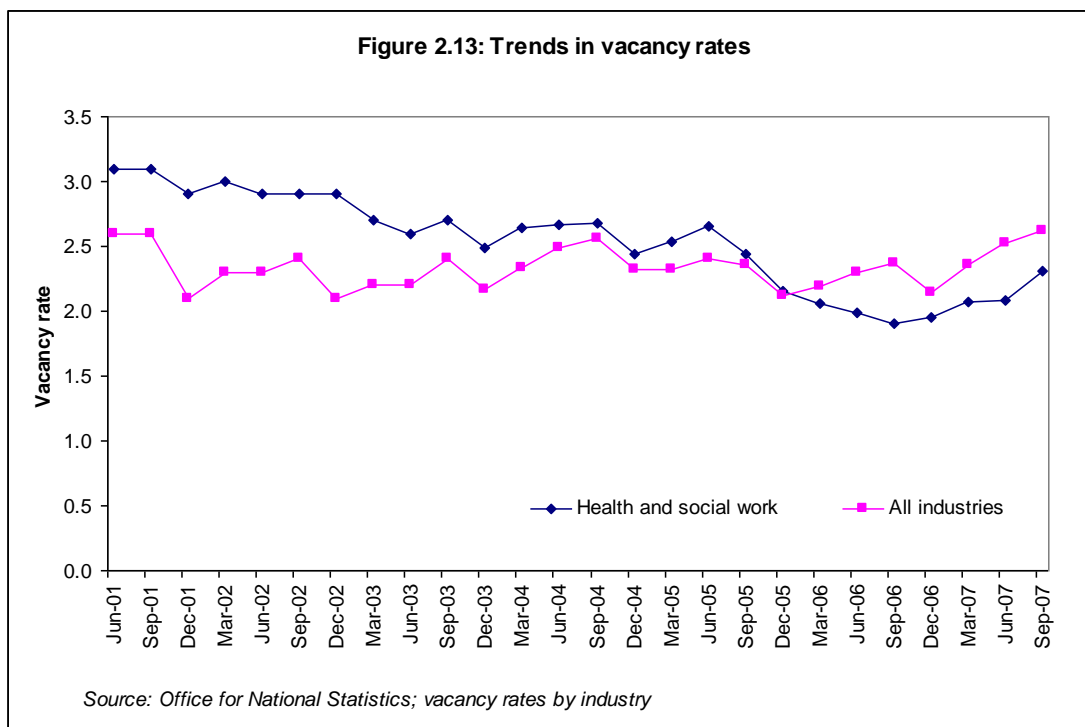
Industry	Aug-Oct 2003 (%)	Aug-Oct 2004 (%)	Aug-Oct 2005 (%)	Aug-Oct 2006 (%)	Aug-Oct 2007 (%)
Financial Intermediation	2.5	3.1	3.2	3.8	4.3
Retail trade & repairs	3.2	3.5	3.4	3.1	3.3
Hotels & restaurants	3.3	3.3	3.2	3.0	3.3
Transport, storage & communications	3.1	2.8	2.5	2.5	3.2
Mining & Quarrying	1.8	1.9	2.1	3.3	3.0
Real Estate & business activities	2.2	2.6	2.4	2.8	2.7
W/Sale trade	2.4	2.6	2.0	2.2	2.5
Chemicals & man-made fibres	1.6	2.0	2.4	2.5	2.5
Engineering & allied industries	1.4	1.9	1.6	1.7	2.4
<b>Health &amp; social work</b>	<b>2.7</b>	<b>2.7</b>	<b>2.4</b>	<b>1.9</b>	<b>2.3</b>
Other services	2.4	2.5	2.1	2.0	2.3
Education	1.9	1.8	1.8	2.0	2.2
Electricity, gas & water supply	1.4	1.7	1.5	2.0	2.1
Food, drink & tobacco	3.1	2.9	1.6	1.9	2.1
Construction	2.1	2.0	1.7	1.8	2.0
Other manufacturing	1.7	2.0	2.0	1.6	1.9
Public Administration	1.3	1.2	1.3	1.4	1.5
Base metals & metal products	1.5	1.5	1.2	1.3	1.5
Textile, leather & clothing	1.1	1.9	1.0	0.9	1.3

Note: ONS data can be found at <http://www.statistics.gov.uk>

2.43 It is notable that the industry within which our remit group falls, ‘health and social work’, has seen vacancy rates rise between 2006 and 2007, which is in contrast to previous years and to the NHS vacancy surveys. However, the majority of other industries in the economy have also seen vacancy rates increase this year according to ONS data and while the ‘health and social work’ sector had one of the highest vacancy rates in 2003, it has since fallen to 10<sup>th</sup> position in the table.

2.44 Figure 2.13 presents the time series for vacancy rates in ‘health and social work’ and ‘all industries’ sectors. It shows that while there has been no marked trend for the whole economy in recent years, vacancy rates in the health and social work sector have converged towards those for the whole economy and fell below the whole economy vacancy rate in 2006.

2.45 The biggest problem with this analysis is that the industry group ‘health and social work’ is much broader than the NHS and thus our remit group. ONS estimated that 27 per cent of the health and social work industry is part of our remit group.



## Evidence from the Parties

### *The Health Departments*

2.46 The **Department of Health** told us that there was continuing clear evidence of a healthy recruitment position with the service not experiencing problems finding suitably qualified staff for the services being delivered.

2.47 The Department told us that while the 2006 workforce census showed that there had been a small fall in the overall NHS workforce of 1.3 per cent since 2005, there had been a significant increase in the NHS workforce of 26 per cent since 1997, including over 25 per cent more qualified nurses.

2.48 The Department told us that in the 12 months to 31 March 2007 there had been 2,330 compulsory redundancies of which 82 per cent were of non-clinical staff. There were 230 compulsory nurse redundancies, which was 9.9 per cent of the total compulsory redundancy total. In the first quarter of 2007-08 there had been 766 compulsory redundancies and 87 per cent of those were non-clinical staff. The Department added that any redundancies, though unfortunate, needed to be seen in the context of a total NHS workforce of 1.3 million.

2.49 The Department said that low vacancy rates demonstrated the attractiveness of the professional positions within the services and the ability of the NHS to retain its staff. The

2007 vacancy rate for qualified nurses, midwives and health visitors was 0.5 per cent, the lowest rate since records were first collected in 1999.

2.50 The Department expected to see modest workforce growth over the Comprehensive Spending Review period of around one per cent per year, but this would depend on local decisions about how to implement service improvements. In some cases, productivity gains might mean fewer staff were needed to deliver the same outcomes.

2.51 The Department said that while the situation varied quite substantially across the country, it was clear that newly qualified staff in certain professions, such as nursing and physiotherapy, were finding it more challenging securing their first job than in the recent past.

2.52 The **Scottish Government Health Directorates** (SGHD) said it was clear that staff numbers across our remit groups were increasing. This year there had again been record numbers of nurses and midwives working in NHS Scotland, as well as record numbers of students training for careers in nursing and midwifery. AHP, healthcare scientist and pharmacy staff numbers had also increased, as had a number of the ex-Pay Negotiating Council (PNC) groups such as administrative and clerical, ancillary and estates staff. They told us this increase in staff numbers also needed to be seen against a backdrop of decreasing vacancy levels, indicating the overall strength of the recruitment and retention position in Scotland.

2.53 The **Welsh Assembly Government** (WAG) said that there were no significant recruitment and retention difficulties and the majority of employers said the situation had improved or stayed the same over the last 12 months. Total staffing as at 30 September 2006 had increased since the previous year and the recruitment of student nurses was the best in the UK with around 8-10 applications for every training post.

2.54 The **Department of Health and Social Services & Public Safety in Northern Ireland** (DHSSPSNI) told us that the Health and Social Care (HSC) workforce fell overall during the early 1990s but rose from 1997 onwards. The main reason for the fall was a decline in the numbers of staff in the works and maintenance group and also in the ancillary and general staff group. Excluding these two groups, the HSC workforce had followed a general upward trend with an increase in staff of approximately 1,000 a year for the period

1990-2006. Northern Ireland had lower vacancy rates than England across the majority of staff groups. DHSSPSNI said that these figures disguised the difficulties that were being experienced in a number of specialty areas where vacancy rates could run at a much higher level.

#### *NHS Employers (NHSE)*

2.55 **NHSE** told us that employers had reported that recruitment and retention was generally stable and was helped by the continued minimal rate of staff turnover in most areas. There were however areas of concern which varied across professional groups and geographical locations and tended to be in relation to recruitment of specialist / advanced practice healthcare professionals, skilled senior managers and skilled support functions including finance and IT. Most employers also reported that non-pay solutions were having a positive impact on recruitment and retention, particularly flexible working practices.

#### *Staff Bodies*

2.56 The joint **Staff Side** told us that while vacancy rates had been dropping in England over the past five years, they treated these figures with caution as they were hiding an underlying trend of job cuts, recruitment freezes and redundancies. They added that the impact of short-term recruitment freezes and job cuts to balance the books could have a serious long-term impact on the demand and supply of healthcare workers for the UK.

2.57 Staff side reminded us about their concerns about the inadequacies of the vacancy data, in particular:

- where a return was not received from a Trust or a Health Board it was not counted and this had the effect of distorting the percentage vacancy rate figure;
- the true level of vacancies could be underestimated if Trusts or Health Boards used short-term bank or agency staff;
- during a vacancy freeze, such as the one currently being experienced, the vacancy rate improved;
- the Department of Health data only provided information on posts that had been vacant for three months or more and did not reveal the true extent of vacancies in specialist areas at any one time; and

- Department of Health data was not detailed enough to highlight recruitment difficulties affecting specific bands and specialties within wider staff groups.

2.58 The **Royal College of Nursing** told us that turnover had reduced from 26 per cent five years ago to 16 per cent in 2006-07. This was the lowest rate of annual job change recorded in these surveys since 1992-93.

2.59 The **Royal College of Midwives (RCM)** said that its staffing survey showed that midwives were now suffering the second highest number of long-term vacancies experienced since 2000. RCM told us that anecdotal evidence suggested many newly qualified midwives were facing difficulty in finding full-time posts; many were offered bank or part-time posts only. It would be grateful if we would consider raising this matter with the Department of Health, especially given the Social Partnership Forum's commitment to graduate employment.

2.60 The **Society of Radiographers (SoR)** said that student attrition continued to be of concern and whilst the numbers of radiography students had increased significantly this had been in tandem with a consistently high attrition rate. SoR said that the reason for high attrition rates was multi-factorial, but there had not been a lowering of the entry standard.

2.61 The **Chartered Society of Physiotherapy** asked us to support its request that both long-term and on the day vacancy data should be collected in England and Wales to provide a more accurate picture of the overall vacancy situation.

2.62 **Unite (T&G)** told us that recruitment and retention was influenced by a wide range of factors. One indication of the general view that staff held about their employment was whether they had considered leaving the NHS. An NHS staff survey commissioned by the Staff Side from Incomes Data Services showed 60 per cent of NHS staff had considered leaving their current position with 35 per cent fairly seriously and 25 per cent very seriously. Ancillary and maintenance staffs were most likely to mention levels of pay as a reason for considering leaving at 23 per cent. It said there was also the issue of whether the NHS could attract and retain new people into the service – for example, the OME Workforce Survey had indicated a very high turnover of trainee ambulance technicians.

2.63 The **British and Irish Orthoptic Society** said that over ten per cent of the total workforce was due to retire in the next five years. Many orthoptic managers reported that they had significant difficulty recruiting staff. The shortage of graduates had a major effect on filling Band 5 posts and the uncertainty of many Trust finances meant that Band 6 and 7 posts were also vacant with no applicants.

2.64 The **Northern Ireland Public Service Alliance** told us that the proximity of many workers to the land border with the Republic of Ireland and the continuing development of the Irish Economy, including its public services and relative levels of pay, were providing opportunities for cross border labour movement, almost exclusively in a one-way direction to the Republic of Ireland.

### **Our Comment**

2.65 We note that the recruitment and retention evidence suggests no overall problems with staffing, although it is clear that there are still some difficulties with certain professional groups and regions. The OME Workforce Survey shows that the average wastage rate (i.e. exits from the NHS) for the NHSPRB remit group<sup>17</sup> was 8.4 per cent, relatively low when compared to the 15 per cent turnover recorded in the whole economy. Trust managers also indicated that recruitment and retention difficulties were less difficult than last year.

2.66 On the whole, the three-month vacancy rates have fallen since last year. Vacancy rates in the health and social work sector have also converged towards those for the whole economy and in 2006 fell below the economy vacancy rate for the first time in over five years. All main staff groups in England and Scotland saw fewer three-month vacancies in 2007 compared with 2006, with the exception of support to AHP and ST&T staff in Scotland (see Table 2.1). The picture was more varied in Wales and Northern Ireland, but vacancy rates tend to be more volatile in those countries because of the smaller numbers involved. Again we would like to raise our concerns about the quality of the NHS vacancy data collected on behalf on the Health Departments and we note the Staff Side's concerns about the inadequacies of the data. We have asked our secretariat to continue discussing ways of improving the workforce data available to us with stakeholders and to investigate further with the Information Centre the uses of the new Electronic Staff Records computer system.

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<sup>17</sup> Although this excludes the staff groups that used to be under the PNC.

2.67 We note that there is very little detailed workforce data on the new staff groups which previously came under the old PNC. We note that at present the Information Centre analyses data for this large and very diverse group of staff under broad and limited categories – such as administrative and clerical staff, and ancillary and estates staff. This is insufficient for our needs and it is clear to us that the data should be further disaggregated. We strongly urge the Health Departments to work with the other parties to ensure better data in time for our next review. In the meantime, in the absence of detailed data for these groups, we have had to assume that the data we do have available to us reflects the position for the whole of our remit group.

2.68 We note the Staff Side's concern that the impact of short-term recruitment freezes and job cuts could have a serious long-term impact on the demand for and supply of NHS staff. We said last year that we did not know what the true picture on staffing was, in the light of Trusts' actions to address the NHS's financial deficits, and as the effects of these actions were still being reflected in the most recent NHS vacancy data, we remain in the same position this year. We note that training budgets were cut last year, and we are concerned about how this will affect our remit group in the future. Furthermore, we received no evidence on the quality of staff, nor the quality of applicants and we ask that parties provide us with evidence on these matters for our next review.

2.69 Recruitment and retention is a key part of our remit and in our view this does not mean just looking at the current situation. As we said last year, we do not consider it is our role to comment on the appropriate level of establishment; however we note various parties' concerns that many newly-qualified staff in certain occupations are facing increasing difficulty finding full-time permanent posts. Graduate unemployment is a matter of concern to us and we would ask the Health Departments in particular to do all they can to ensure that the skills of the newly-qualified are not being lost permanently to the NHS. We would also ask the parties, and the Health Departments and NHSE in particular, to consider what evidence they can provide us with for future reviews to demonstrate how the NHS's longer term recruitment and retention needs for all groups of staff have been taken into account in workforce planning.

## CHAPTER 3 – RECRUITMENT AND RETENTION PREMIA AND HIGH COST AREA SUPPLEMENTS

### Introduction

3.1 The Agenda for Change (AfC) agreement contains provisions governing the operation of recruitment and retention premia (RRPs) designed to address labour market difficulties affecting specific occupational groups. The premia therefore apply to posts and not individuals. The agreement notes that such premia may be awarded on a *national* basis to particular groups on our recommendation and / or that of the Pay Negotiating Council where there are national recruitment and retention pressures<sup>18</sup>. Where it is agreed that an RRP is necessary for a particular group the level of payment should be specified or, where the underlying problem is considered to vary across the county, guidance should be given to employers on the appropriate level of payment. In making such recommendations we are required to seek evidence or advice from NHS Employers (NHSE), staff organisations and other stakeholders. In addition, the parties have agreed under AfC that some posts will automatically attract RRP. In this round, Unite (Amicus) has presented a case for the introduction of a national RRP for pharmacists and both Unite (Amicus) and UCATT have presented a case for the national RRP currently paid to qualified maintenance craft workers to be extended to include the building trades. The parties' evidence is summarised below and our comments can be found at the end of each section.

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

3.3 The value of the supplements is to be reviewed annually, based on our recommendations for staff within our remit group. In addition, it is open to us to make recommendations on the future geographic coverage of HCAS and on the value of such supplements. Here we set out the evidence we have received on these issues from the parties

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<sup>18</sup> Separately there is scope for local employers and staff bodies to agree on the need for an RRP to address *local* recruitment and retention problems.

and summarise the evidence from the joint Staff Side and UNISON seeking the introduction of a new HCAS for South Cambridgeshire. Again, our comments can be found later in the chapter.

## **High Cost Area Supplements (HCAS)**

### **Evidence from the Parties**

#### *The Health Departments*

3.4 The **Department of Health** told us that Ministers had agreed that from 31 March 2008 the lower level of HCAS would increase by £284 in Inner and Outer London. This was to avoid deterring some workers from working out of hours, as the extra earnings could force them over the threshold to pay higher pension contributions. The Department said it was for us to decide the impact this change would have on the areas to which we must have regard and to make recommendations accordingly. It proposed that any further increases, aside from this specific agreement, should be consistent across HCAS groups.

3.5 Commenting on Staff Side's case for a HCAS for South Cambridgeshire, the Department of Health said it did not consider this to be a national matter. The AfC agreement allowed local parties, should they agree, to introduce, extend or amend high cost area payments. Therefore if the parties followed the correct processes, they were able to introduce HCAS payments locally. However, parties should note that there would be no further funding through the tariff. Any HCAS would have to be funded from local weighted allocations including the Market Forces Factor (MFF) which provides funding to pay the excess labour cost (pay and non pay) of delivering services in areas with a high cost of living and where wages in potential competing employers may be higher. It was therefore down to the Trust and to local parties to agree whether an HCAS payment would deliver the best value for staff and patients given the other options available to them and the level of their funding.

3.6 The Department of Health also said that there was a further question of whether the appropriate mechanism was a HCAS payment for all staff. Such a payment would only be appropriate if there were recruitment difficulties for every single staff group. Otherwise consideration should be given to targeted action, in terms of local RRP, to the specific staff groups they were having difficulty recruiting, for example nursing groups and admin staff. The Department of Health said it understood that the Trust putting forward the case had begun using RRP for Health Care Assistants and qualified nurses from Bands 2 to 7.

Similar to HCAS, the funding for this was within the MFF aspect of the tariff funding which was currently with organisations.

### *NHSE*

3.7 **NHSE** told us that under the AfC agreement it was open to the local parties to agree to extend or amend HCAS payments. However, the manner in which funding was allocated to the NHS via weighted allocations, which included the MFF, meant there would be no additional resources available to organisations which were brought into a re-designated HCAS zone. As a result of changes to the level of NHS pension contributions payable by individuals, the national parties to the pensions review had agreed that the minimum level of HCAS payments would increase by £284 in Inner and Outer London (but not the Fringe) from 31 March 2008. NHSE said that they were not looking for further changes to the value of, or the geographical coverage of HCAS payments, save for being uprated in line with the generic award.

### *Staff Bodies*

3.8 The joint **Staff Side** said that up-to-date figures had now been provided to put forward the case for an HCAS in South Cambridgeshire and asked us to consider its merits. The case, supported by the management and staff side project leads at Cambridge University Hospitals NHS Foundation Trust<sup>19</sup>, was that:

- Cambridge was part of the London commuter belt;
- the cost of property for mid-range housing was proportionally higher than the surrounding areas, based on a ratio of distance from London;
- Department of Health data showed that Cambridge University Hospitals NHS Foundation Trust had the second highest level of staff turnover within the East of England Strategic Health Authority (SHA);
- support workers had suffered extremely high turnover rates currently running at just in excess of 50 per cent; and

- the East of England SHA was not aware of any Trust within its area utilising RRPs, except Cambridge University Hospitals NHS Foundation Trust which paid RRPs to medical training officers, nursing, midwifery, physiotherapy and radiography staff.

3.9 Staff Side also asked that we recommend the same significantly above inflation uplift for the minima and maxima value of HCAS as for pay.

### **Our Comment**

3.10 We have considered the Staff Side's case for a HCAS in South Cambridgeshire. We do not believe that we have sufficient evidence to justify this. In order for NHS employers or staff organisations to implement a HCAS, paragraph 3.10 of AfC requires there to be evidence that costs for the majority of staff living in the travel to work area covered by the proposed new supplement are greater than for the majority of staff living in the travel to work area of neighbouring employers and that this is reflected in comparative recruitment problems. We consider that these tests also apply to our deliberations. We have not received any data relating to vacancy rates in Cambridge University Hospitals NHS Foundation Trust and neighbouring Trusts for our remit group and cannot, therefore, assess whether there are comparative recruitment problems. We have been given turnover data but turnover does not, of itself, show that there are problems with recruitment; moreover, this data applies to medical, as well as non-medical staff, and is therefore of limited utility.

3.11 We note that Cambridge University Hospitals NHS Foundation Trust is already in receipt of funding derived from the MFF. The aim of the MFF is to take account of unavoidable differences in the cost of providing services across the country, including labour costs. It is the individual Trust's decision as to how spend the additional resource, including whether to award any market supplements. It is therefore open to Trusts in South Cambridgeshire, under paragraph 3.10 of AfC, to pay a HCAS without a recommendation from us (and the Department of Health has told us that no additional resources would be available to fund a HCAS even if it were introduced following our recommendation). We note that at present Cambridge University Hospitals NHS Foundation Trust is using the funding freedom of the MFF to pay local RRPs to selected staff groups which they have particular problems recruiting or retaining, although we have not been told whether these are proving successful in dealing with the problem. We agree with the Department of Health that

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<sup>19</sup> Addenbrookes Hospital, which has proposed the HCAS extension, forms part of Cambridge University Hospitals NHS Foundation Trust.

local RRPs are the appropriate mechanism where recruitment problems are confined to particular groups. Although it may be unduly onerous to require evidence that there are recruitment problems with every single staff group, as the Department suggests, we accept the general point that HCAS are blunt instruments whereas RRPs can be targeted and are therefore likely to be a more effective use of resources unless the vast majority of staff groups are affected.

3.12 Finally, in the event that we were to consider on a future occasion that a new HCAS was justified, we would welcome clarification from the parties as to how the geographic boundaries applicable to such a payment should be defined.

3.13 We note the parties' agreement that from 31 March 2008 the lower level of HCAS will increase by £284 in Inner and Outer London. We feel there is no case to suggest that the relative value of the differentials provided by the HCAS should be altered any further, as would be the case were they not revalorised in line with our basic recommendation.

**We recommend that the existing minimum and maximum high cost area supplements for Inner London, Outer London, and the Fringe be increased by 2.75 per cent. The new minima and maxima from 1 April 2008 are set out in Appendix B.**

## **Recruitment and Retention Premia (RRPs)**

### **Pharmacists**

3.14 The case for a national RRP for pharmacists was presented to us by Amicus last year. In our report we noted that pharmacists were originally placed on the list for an RRP by the AfC negotiators; that there was an alternative and well-established private sector labour market for pharmacists; and that there was some evidence of recruitment difficulties across the country and of significant differences between the pay available in the public and private sectors. We concluded that we were not then in a position to take a view on whether a national RRP for pharmacists was appropriate, but believed that the case for one warranted proper investigation. We asked the parties to consider jointly what further research should be undertaken and to involve our secretariat.

3.15 As the parties appeared to be making no progress, OME discussed with the Department of Health, NHSE and Unite (Amicus) how some of the current information gaps about the labour market for pharmacists might be addressed. It was agreed that a useful initial step would be to investigate what remuneration packages were currently available to pharmacists working in the private sector in retail pharmacy outlets within the community. Incomes Data Services (IDS) was subsequently commissioned to investigate and submitted its report in late November 2007.

3.16 In addition to the IDS report, OME also funded the national NHS Hospital Pharmacy Staffing Establishment and Vacancy Survey, run by the NHS Pharmacy Education and Development Committee (NHSPEDC)<sup>20</sup>.

### **A summary of the pharmacist studies commissioned by OME, in consultation with the parties**

3.17 The main findings of the IDS review of remuneration for pharmacists in the private sector, which surveyed arrangements in seven major pharmacy chains, were:

- the typical median basic salary for a pharmacy manager was £40,000. The typical median salary for an experienced pharmacist was £37,726 and £34,201 for a newly-qualified pharmacist;
- two out of the seven survey participants made location, recruitment and retention payments. These included London Weighting payments ranging between £1,480 and £4,520 a year, and “Golden Hello”s up to a maximum of £5,000;
- the North East, East Anglia and the South West SHAs were highlighted as areas where recruitment and retention difficulties were most apparent; and
- for managers, bonus payments ranged from £725 to £1,100 as a lump sum, or up to 20 per cent of basic pay. For experienced pharmacists and newly-qualifieds, these figures were five to 20 per cent, or an average of £225 in cash.

3.18 The main findings of the National NHS Hospital Pharmacy Staffing Establishment

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<sup>20</sup> Both reports can be found on the NHS Pay Review Body page on the OME website: [www.ome.uk.com](http://www.ome.uk.com)

and Vacancy Survey were:

- there had been a slight increase in the total pharmacist vacancy rate<sup>21</sup> from 11.7 per cent across Great Britain in 2006 to 12.03 per cent in England and Wales in 2007<sup>22</sup>, although the analysis for 2007 did not include Scotland.
- vacancy rates for Band 6 and Band 7 pharmacists were 17.2 per cent and 18.0 per cent respectively; and
- a geographical variation was apparent for qualified pharmacists, see Table 3.1 below, with particularly high vacancy rates for Band 6 pharmacists in West Midlands, South East Coast, South Central and South West SHAs.

**Table 3.1: Current vacancy rates (% posts not permanently occupied) by Band and geographical area.**

	Band 9	Band 8d	Band 8c	Band 8b	Band 8a	Band 7	Band 6	ALL
North East SHA	0%	1.41%	14.66%	9.28%	15.55%	22.03%	18.25%	16.40%
North West SHA	7.97%	4.77%	7.50%	8.30%	14.88%	11.87%	16.46%	12.75%
Yorkshire and the Humber SHA	0%	1.54%	4.78%	2.06%	4.61%	38.24%	15.28%	12.61%
East Midlands SHA	0%	0%	0%	0.64%	7.39%	14.63%	10.00%	8.46%
West Midlands SHA	0%	28.57%	0%	3.71%	11.58%	15.84%	29.48%	14.10%
East of England SHA	0%	0%	12.32%	9.91%	7.66%	23.97%	15.17%	13.96%
London SHA	8.68%	0%	6.08%	10.12%	6.90%	13.58%	13.98%	10.69%
South East Coast SHA	0%	0.42%	3.09%	0%	6.42%	11.27%	27.36%	11.97%
South Central SHA	0%	0%	0.30%	8.53%	8.60%	26.85%	24.16%	16.11%
South West SHA	0%	0%	0%	1.15%	5.41%	23.68%	22.26%	12.97%
Wales	0%	9.09%	1.53%	8.45%	2.70%	8.80%	7.29%	5.79%
<b>Total</b>	<b>4.13%</b>	<b>2.51%</b>	<b>5.44%</b>	<b>6.28%</b>	<b>8.09%</b>	<b>18.03%</b>	<b>17.22%</b>	<b>12.03%</b>

## Evidence from the Parties

### *The Health Departments*

3.19 Commenting on the research undertaken by OME, the **Department of Health** told us that local flexibility was the key. It favoured continued monitoring of its improving data to assess the extent to which local RRP's were being used for pharmacists.

3.20 The Department of Health told us that it remained convinced that the balance of all the evidence did not point to a national RRP being the right solution for pharmacists. In broad

<sup>21</sup> A vacant post is defined as a post 'not permanently occupied'; some vacant posts may be filled by agency staff / locums. The vacancy rate is therefore the percentage of posts not permanently occupied.

<sup>22</sup> Scotland was not included in the 2007 survey because Agenda for Change had not been fully implemented in May 2007, the date in respect of which data was requested.

terms it argued that:

- it did not believe national pay levels were the main driver behind potential recruitment and retention problems. Other factors such as limited supply versus increasing demand for pharmacists in the NHS were key;
- the evidence suggested, and this was highlighted in the "National NHS Hospital Pharmacy Staffing Establishment and Vacancy Survey 2007", that there was not a consistent vacancy picture across England. Applying a national RRP would not represent a proportionate response to these regional variations;
- the "National NHS Hospital Pharmacy Staffing Establishment and Vacancy Survey 2007" used, as its default calculation of "vacancy rate", the percentage of posts not permanently occupied – meaning posts covered by locums were considered vacant when calculating the vacancy rate. The survey also took place at a time when there was likely to be temporarily high staff turnover as it fell just before the annual recruitment cycle. This provided for a worst case scenario position;
- by comparison the standard NHS Workforce Vacancy Survey showed a reduction in long term (three month) vacancy rates (now standing at 1.4 per cent) suggesting that while Trusts might have occasional short term difficulties, long term vacancies remained small;
- if a national RRP was to be used in the NHS, a likely consequence was that community pharmacy employers would respond by increasing community pharmacists' pay, causing unnecessary additional costs which could lead to a reduction in pharmacy posts and services;
- the Department acknowledged the IDS survey showed that pay in community pharmacies might be higher than in hospitals; however, the nature of work undertaken by newly registered hospital pharmacists and community pharmacists differed significantly. Whilst hospital pharmacists might have more demanding clinical roles, they had access to more support and advice in their place of work. Often, community pharmacists worked longer hours, were more autonomous and were frequently the pharmacist in charge; and

- the NHS Workforce Review Team had highlighted that the majority of training placements were in the community which impeded the supply chain for hospitals. Adjusting any imbalance between hospital and community training placements could help solve any emerging difficulties with the supply of pharmacists to hospitals. This was a matter for SHAs as part of their workforce planning.

3.21 The Department of Health told us that although it was hard to identify exactly the group of staff from existing data sources, it knew many people trained in the NHS as pharmacists and then left to set up as independent contractors (high street pharmacists) rather than staying in the NHS as band 6 and 7 pharmacists. So, for example, a comparison of the 2005 and 2006 census showed that the peak age for joiners to the NHS was 23 (around 140 had joined) and the peak age for leavers was 26 (around 80 had left). The Department said that if the National NHS Hospital Pharmacy Staffing Establishment and Vacancy Survey 2007 was suggesting there were vacancies at band 6 and 7, it was probable that these were being filled fairly easily otherwise they would have shown up in the NHS Vacancy Survey.

3.22 The Department of Health said that it had consulted NHSE, which did not view a national RRP as the appropriate way forward for pharmacists. So, taking all these factors into account, the Department said it was strongly of the opinion that there should not be a national RRP for pharmacists. It would work closely with OME, NHSE and pharmacy colleagues to refine the measures reported to understand more about the supply and demand of registered pharmacists in NHS employment, commissions for pre-registration pharmacist training and the extent of application of local RRP.

3.23 The **Scottish Government Health Directorates** (SGHD) told us that the application of an RRP for pharmacists, qualified maintenance craftspersons and technicians was currently being discussed through the Scottish Terms and Conditions Committee. This was in line with the agreement to discuss any such RRP on a Scotland-wide basis and in partnership. The SGHD confirmed that the Scottish Government was not looking for us to make any recommendation on an RRP for pharmacists.

3.24 Commenting on the case for an RRP for pharmacists, the **Welsh Assembly Government** (WAG) told us that there were no significant recruitment and retention issues within Wales. However, there were on occasions some limited problems in filling posts. This

was often a geographical issue that could be resolved, if need be, with a local RRP. On balance, Wales did not hold the view that a national RRP was required. There would be great anxiety however if a national RRP was applied in England only, as this would have a detrimental effect on future recruitment and retention within Wales.

3.25 The **Department of Health and Social Services & Public Safety in Northern Ireland** (DHSSPSNI) said there were some staff groups who had been paid an RRP applied at a national level and there was concern that the setting of the national premia did not reflect the recruitment market locally for Health and Social Care (HSC). A survey of HSC employers in Northern Ireland showed strong support for a reduction in the categories of national RRP. With regard to local pay, DHSSPSNI told us that it ensured the use of RRPs by local employers was carefully regulated to avoid pay inflation.

3.26 Commenting on Unite's case for a RRP for pharmacists, DHSSPSNI said that there were no significant recruitment and retention issues for pharmacists within the HSC in Northern Ireland. The DHSSPSNI's view was that there should not be a UK-wide national RRP, but that the facility within the AfC agreement should be used when there was evidence of local workforce difficulties.

#### *NHSE*

3.27 **NHSE** said that in view of the need to ensure that the integrity of the AfC system was maintained and equal pay principles upheld, it was important that any national RRP was objectively justified. Key to this was establishing that the same recruitment and/or retention problems were evidenced across all parts of the NHS. Taking this into account, employers had told NHSE that in view of the different local labour market conditions across England, the general presumption must be that recruitment and retention issues were most appropriately dealt with at a local level through the flexibilities provided in the agreement.

3.28 Commenting on OME's research investigation, NHSE said that its substantive evidence had acknowledged that in some places there were recruitment and retention difficulties affecting qualified pharmacy staff. Notwithstanding the research, NHSE said it remained their view that local recruitment and retention problems were best addressed at local employer level.

3.29 We were told that the AfC agreement had provided for national RRPs to be made to

pharmacists, who at assimilation to the new pay system would otherwise have been on pay protection (Annex R of the AfC handbook). Whilst it seemed that most employers were not making use of the RRP for pharmacists, a minority were using local pay supplements. Some were based on Annex R but others were a response to local pressures. NHSE had been told that local employers were not persuaded that pay supplements were necessarily required for this group and some were clearly concerned about possible equal pay risks. NHSE also said that level of pay was only one of the factors that influenced recruitment and retention. For pharmacists, the NHS offered scope for career development, new patient centred roles, learning and development opportunities and scope for flexible working. These should continue to make the NHS competitive in the pharmacy labour market.

### *Staff Bodies*

3.30 Commenting on OME's research the joint **Staff Side** said that the national NHS Hospital Pharmacy Staffing Establishment and Vacancy Survey report had provided evidence of the need to do something to attract pharmacists to the NHS. An effective RRP could be a useful tool to do this, particularly in the short-term. They added that a failure of the research from their point of view was that there was no attempt to find out the reasons why pharmacists were less attracted to working in the NHS. If pay was the issue, then an RRP would be the right response.

3.31 **Unite (Amicus)** told us that it had raised the question of additional research into an RRP for pharmacists at NHS Staff Council. Unfortunately NHSE had responded negatively stating they did not have the resources to carry out additional research, and would instead canvass members for views.

3.32 Commenting on OME's additional research, Unite said that the differential between the NHS starting rate for a newly qualified pharmacist at Band 6 and the median starting rate for those newly qualified in the community retail sector was £10,743. The comparative differential for Band 7, usually obtained after three years or more was £28,313 compared to £37,726, a difference of £9,413. This was why Unite's evidence last year had called for a national RRP equivalent to four increments for Band 6 and for Band 7 to give new starting salaries of £27,388 and £32,704 respectively.

3.33 In an exit survey of those leaving NHS pharmacy carried out by the NHS Pharmacy Education and Development leads, Unite said that the most cited reason for leaving was

higher salary, shortly followed by saving to pay off debts. From the academic year 2006-07 the course fees had been increased to £3,000 per academic year for the four year pharmacy course. This almost equated to the four year £10,000 "loyalty" bonus currently offered by Lloyds to those staff who remained for three years after their registration year. A local study in the North East had found that a quarter of newly-qualified hospital pharmacists in the region had left the hospital sector within four months of starting their post, with most moving to the community sector.

3.34 Using the figures from the NHSPEDC research, Unite calculated that the NHS was probably spending between £5 million and £12 million a year on locums<sup>23</sup>. Even with this use of agency and locum staff there remained a large number of unfilled places – the total vacancy rate had increased from last year and in particular the Band 6 and 7 vacancy rates.

3.35 Unite said that as part of the shift to more community-based care, there would be an increased amount of patient and service user contact taking place within community pharmacy, and more opportunities to use specialist knowledge and be involved as part of a wider healthcare team, which was one of the major attractions of remaining in the NHS despite the lower pay, as demonstrated in research undertaken by Aston University<sup>24</sup>.

3.36 Unite noted that local RRP payments were available under AfC; however it believed there was a national problem with the recruitment and retention of pharmacists. It therefore sought a recommendation for a national RRP for NHS pharmacists, targeted at Band 6 and 7.

### **Our Comment**

3.37 We have considered Unite's claim for a new national RRP for pharmacists. As last year we have looked at the evidence presented to us and note that pharmacists were originally placed on the list for an RRP by the AfC negotiators; there is also an alternative and well-established private sector labour market for pharmacists, which pays significantly more than the NHS. High vacancy rates (up to 18 per cent) and wastage rates (up to 11.7 per cent) relative to other professions in the NHS support the view that there is a particular problem with the recruitment and retention of pharmacists at Bands 6 and 7.

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<sup>23</sup> Figures calculated by using the minimum and maximum range figures given by IDS (£12.60 and £27.30) then multiplying by the number of locums, and then by 37.5 for the per week figure. This was then multiplied by 52 to calculate the per year figure.

<sup>24</sup> *Pharmacy Undergraduate Students: Career Choices & Expectations Across a Four-Year Degree Programme* Wilson K et al Aston University Published by the Royal Pharmaceutical Society (2006).

3.38 We note the Health Departments' and NHSE's views that they do not believe a national RRP is the way forward and that local flexibility is the answer. However, there seems to be doubt over whether Trusts are willing to implement local RRPs because of the difficulties surrounding them, including the threat of equal pay claims. We are surprised that little attempt has been made to collect evidence on the use of local RRPs, the problems of implementing them, or, indeed, their effectiveness. We strongly urge the Health Departments and NHSE to probe these issues in more detail and to offer guidance to Trusts on using local RRPs. However, although the severity of the recruitment and retention problems of pharmacists is likely to vary across the UK and although the only evidence we have is for England and Wales, that evidence suggests the problem is widespread<sup>25</sup>. For example even the area in England with the lowest overall vacancy rate, East Midlands SHA, has a vacancy rate of 8.46 per cent. We therefore feel the way forward is to suggest a national solution at this point, although effective use of local RRPs in reducing vacancy levels would obviate the need for a UK-wide solution.

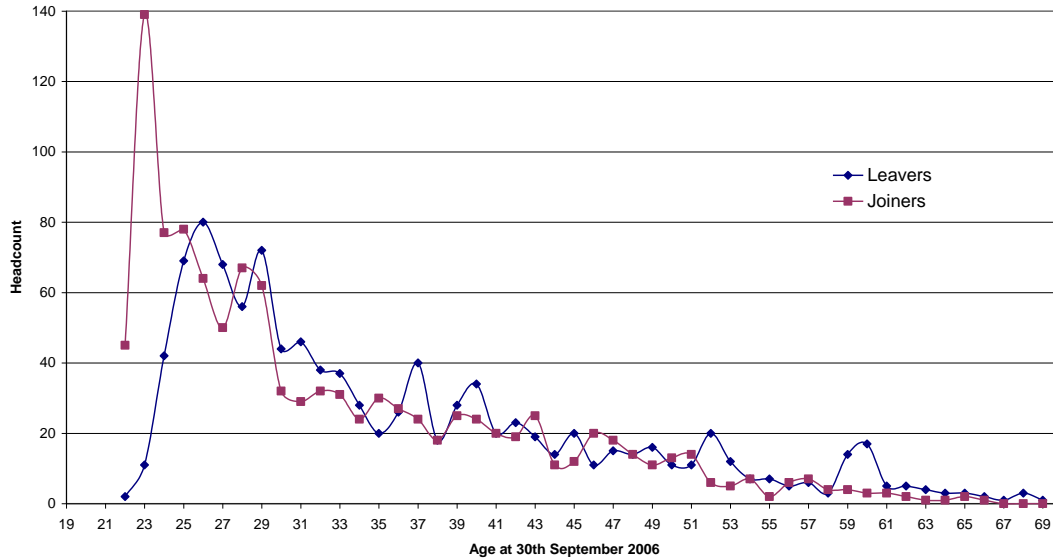
3.39 In its evidence Unite suggested that the existing pay spine be used to award a national RRP for pharmacists in bands 6 or 7 equivalent to four increments, with a total value of around £4,000.

3.40 We have considered this proposal. The evidence submitted to us supports the view that vacancy rates are higher in bands 6 and 7. However, the evidence also suggests that the problem with pharmacists appears to be one of retention rather than recruitment, and that the retention issue appears to be more prominent once pharmacists have been in the service for three years or more, as shown in Figure 3.1. Consequently, if we were to award a national RRP as Unite suggests, there is a real possibility that newly qualified pharmacists would continue to join the NHS, receive around an extra £4,000 per year, and yet still leave to join the private sector after a few years of service, particularly as private sector wages would still be significantly higher even with the RRP. Consequently, the NHS could end up paying up to £12,000 for pharmacists who would have been in their employ even without the RRP. We have therefore concluded that we cannot support the proposal put forward by Unite.

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<sup>25</sup> We note that discussions on the recruitment and retention of pharmacists are taking place in Scotland.

Figure 3.1: Estimated headcount of qualified NHS pharmacist joiners and leavers from the 2005 and 2006 NHS non-medical census



Source: The NHS Information Centre

3.41 Nevertheless, we believe that there is a problem with the retention of newly-qualified pharmacists reaching their third year of service in the NHS, especially as it is at this point that a pharmacist is considered ‘experienced’. Indeed, the Department of Health’s evidence acknowledges that many people train in the NHS and then leave to set up as independent contractors. The Department’s evidence also makes clear that the need to address new career goals in both community pharmacy and managed sector pharmacy has been recognised and guidance has been issued on the development of consultant pharmacist posts in the NHS and pharmacists with special interests in community pharmacy. The Department told us it was likely that these development opportunities would be a more powerful motivator for career choice than pay per se. We accept these points, but if pharmacists are currently leaving the service just as they become experienced, these initiatives are not being given the time to bed in and produce results.

3.42 The evidence in Table 3.1 suggests the need to concentrate RRP on pay bands 6 and 7. **We therefore recommend that the parties address the problem with the retention of pharmacists before the next Review Body round and reach a workable solution.** We believe it is possible to implement an effective solution that is financially attractive but costs considerably less than the RRP proposed by Unite. We have therefore considered an alternative approach for consideration by the parties based on the concept of a retention bonus, similar to the ‘golden handcuff’ payments which are paid in some private sector organisations. In our view this bonus should be paid to newly-qualified pharmacists who

remain in the NHS for five years. The aim of offering such a bonus after five years' service would be to increase the supply of pharmacists to the NHS beyond the point at which they often leave, and to enable experienced pharmacists to pass on their expertise to the newly qualified pharmacists who join after them.

3.43 We acknowledge that there are issues with our alternative approach that would need to be resolved, such as what would happen if a pharmacist took a career break, and we have therefore made a proposal rather than a recommendation this year to give parties a chance to discuss the options. However, **we ask the parties to report back to us on progress, with a view to us considering the making of a formal recommendation next year if we believe insufficient progress has been made.**

### **Building craft and maintenance craft workers**

#### **Evidence from the Parties**

##### *The Health Departments*

3.44 The **Department of Health** told us it did not support a national RRP for building craft workers. A report for the NHS Staff Council by Greenwich University<sup>26</sup> ('the Greenwich report') had upheld the payment of a national RRP to craft workers, but its remit did not extend to building craft workers. Consequently it would not be appropriate to draw the same conclusion for both craft and building craft workers.

3.45 The Department also told us that the Government was supporting the move towards a more independent NHS which could make its own local decisions. This included supporting local decisions on whether RRPs were the most appropriate solution to any local recruitment and retention issues. For example, the MFF was designed to provide funding to enable local health economies to pay RRPs if they felt that this was necessary. The Department said that the payment of a national RRP may also raise equal pay concerns in areas where there were no problems recruiting or retaining these workers.

3.46 The **SGHD** said that there was already an RRP in place in Scotland for staff who required full electrical, plumbing and mechanical craft qualifications. The application of an

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<sup>26</sup> *Review of NHS national recruitment and retention payment for craft workers: A report for the NHS Staff Council*, Professor Geoff White and Ms Sue Milsome, University of Greenwich Work and Employment Research Unit, April 2007.

RRP for pharmacists, qualified maintenance craftspersons and technicians was currently being discussed through the Scottish Terms and Conditions Committee. This was in line with the agreement made in Scotland to discuss any such Premia on a Scotland-wide basis and in partnership.

3.47 Commenting on Unite and UCATT's submission for a national RRP for building craft workers, **WAG** said there were no recruitment and retention problems and it was not needed, but comments had been made about the consistency of craft workers having one but building crafts not. In relation to craft workers (acknowledging the Greenwich research) **WAG** said this was not needed either.

3.48 Commenting on Unite and UCATT's submission for a national RRP for building craft workers, **DHSSPSNI** told us that there were no recruitment and retention problems in the building crafts engaged in the HSC in Northern Ireland and there were very low turnover rates in this staff group. Comparisons had been made locally about a national premium for maintenance craft workers but none for building crafts. Notwithstanding the Greenwich research, **DHSSPSNI** said that it held the view that there was no justification locally for the maintenance craft national premium and there was no evidence to support a national premium for building crafts. Accordingly it did not wish to see the national premia extended to building crafts.

#### *NHS Employers (NHSE)*

3.49 **NHSE** said that they had commissioned the University of Greenwich Business School (UGBS), on behalf of the NHS Staff Council, to undertake research to support the NHS Staff Council's review of the national RRP for qualified maintenance craft workers. The main findings were that the national RRP should continue to be paid for this group and that the payment of a national RRP to the building trades, or at least the wood trades, should be considered. The NHS Staff Council had subsequently endorsed UGBS's recommendation that the existing national RRP for maintenance craft workers was justified and could continue. However employer representatives did not consider sufficient evidence had been established to justify the introduction of a new national RRP for building craft workers, although they accepted that in some places local labour market pressures might justify a locally agreed supplement.

### *Staff Bodies*

3.50 **Staff Side** told us that further discussion would be had at the NHS Staff Council regarding the extension of the RRP to the building trades within the NHS.

3.51 **Unite (Amicus)** said it was pleased that the University of Greenwich's independent findings that the national RRP should continue to be paid to qualified maintenance craft workers had in the end been endorsed by the NHS Staff Council despite initial obstacles being put in place by NHSE. The review had also found evidence to support the extension of the RRP to the building trades, for much the same reasons as applied to the continuation of the RRP for maintenance craft workers. Unite said it was therefore seeking a recommendation that the national RRP should be extended to the building trades.

3.52 **UCATT** provided evidence to support a case for a national RRP for building craft workers:

- the maximum NHS building craft worker's pay was £4964 or 28.8 per cent lower than the average building craft workers' annual pay across all sectors;
- the boom in the construction industry was set to continue meaning a need for 241,000 more construction workers by 2011, representing a ten per cent increase in the workforce;
- private construction pay agreements continued to increase above inflation;
- the NHS building trades workforce was ageing. According to the IDS NHS staff survey, only 5.8 per cent of ancillary and maintenance staff were under 30 years of age; and
- many of the terms and conditions that made up for poorer pay in the NHS in the past were now diminishing and failing to lure young workers.

3.53 **UCATT** told us that NHS maintenance craft workers received a national RRP to supplement their wages, but this did not apply to the building trades, despite many of the economic factors that led to craft workers receiving such payments being similar. This was

inequitable, created resentment amongst colleagues and left the NHS as an uncompetitive employer. UCATT pointed out that the failure to pay a national RRP to building craft workers had obvious equal pay implications; female building craft workers that UCATT had in membership could clearly legally compare themselves in terms of work of equal value with their male maintenance craft workers.

### **Our Comment**

3.54 We do not consider that the evidence presented to us supports the case for a national RRP for building craft workers. The Greenwich report recommended that the payment of a national RRP to the building trades, or at least the wood trades, should be considered. However the 15 case studies on which the report was based showed that vacancy rates were lower than for other NHS jobs and that labour turnover is much lower among building craft workers than other NHS occupations. The report warns that these figures are unreliable because the sample sizes were so small and notes that UCATT itself did not consider that 15 case studies would provide sufficient data to decide whether a national RRP should be paid to building craft workers. It may be that more extensive research would demonstrate the need for a national RRP but this cannot be assumed. Where local recruitment and retention difficulties exist it is, of course, open to local employers and staff bodies to agree an RRP at a local level.

3.55 UCATT has argued that it is inequitable to pay a national RRP to maintenance craft workers when no such payment is made to building craft workers alongside whom they commonly work. It has also pointed out that this situation may give rise to equal pay claims, a concern which we share. The decision to continue the payment of a national RRP to maintenance craft workers was made by the NHS Staff Council on the basis of the recommendation to this effect in the Greenwich report prior to this group coming within our remit. We do not consider that the Greenwich report provides sufficient evidence to justify the continuation of a national RRP for maintenance craft workers on the basis of the criteria which we have previously set out.<sup>27</sup> Whilst we draw no conclusions as to the appropriate outcome, in accordance with our duty to have regard to the principle of equal pay for work of equal value in the NHS, we urge the parties to review their decision in order to ensure that the integrity of the AfC pay system is upheld. We would also like to stress the importance of regular and robust reviews of national RRP's in general and that this should be done for all other groups where national RRP's currently exist.

### **Uplift to existing RRP**

3.56 **Staff Side** asked that we recommend the same significantly above inflation uplift as for pay for national RRP for qualified maintenance craftsmen and technicians and healthcare chaplains. Pending the review that we recommend for maintenance craft workers and other groups, **we recommend that existing national RRP be increased by 2.75 per cent from 1 April 2008.**

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<sup>27</sup> Twenty-First Report on Nursing and Other Health Professions, 2006, paragraph 2.22.

## CHAPTER 4 – MORALE, MOTIVATION AND TRAINING

### Introduction

4.1 In our view, matters of morale, motivation and training are fundamental to our deliberations by virtue of their relevance to other areas, particularly the recruitment and retention of staff and service delivery. Once again the evidence we have received from the Joint Staff Side on the one hand and the Health Departments and employers on the other has been markedly different in its assessment of the state of morale within the Service. The importance of the Knowledge and Skills Framework (KSF) to overall morale has also been highlighted, as evidence has shown that depressed training budgets and a consequent lack of progress with KSF has led to a perceived lack of opportunities for career development.

### Sources of data

4.2 In evidence to us from the Department of Health and NHS Employers (NHSE) relating to morale and motivation, there was a general reliance upon the data contained within the Healthcare Commission's 2006 National NHS Staff Survey for England, carried out between October and December 2006, before the staging of last year's pay award. The rest of this section discusses that survey in more detail. The evidence from the Scottish Government Health Directorates (SGHD), the Welsh Assembly Government (WAG) and the Department of Health and Social Services & Public Safety in Northern Ireland (DHSSPSNI) is considered at the end of this section.

4.3 In the original evidence we received we were presented with extracts from the Department of Health's "What Matters to Staff" study. Unfortunately however, there were inconsistent interpretations of the results we were shown. As the full and final version of the study was not available at the time of writing, we take no account of it.

### *England*

4.4 Between October and December 2006 the Healthcare Commission conducted the 2006 National NHS Staff Survey of NHS staff in England. Primary Care Trusts which were reconfigured in October 2006 were not required to participate in that year's survey. A total of 128,328 NHS staff responded to this survey, a response rate of around 54 per cent, a further decrease when compared to 58 per cent in 2005 and 60 per cent in 2004. The survey covered a wide range of topics, including: work-life balance; training; work pressure; job satisfaction; and staff views towards the organisations in which they worked, including intentions to leave.

4.5 The survey covered all staff in the NHSPRB remit<sup>28</sup> who were grouped under the following occupational categories: all nursing staff (i.e. registered nurses; midwives; health visitors; healthcare assistants<sup>29</sup>); Allied Health Professions (AHPs); Scientific, Technical and Therapeutic staff<sup>30</sup> (ST&Ts); paramedics; ambulance technicians; administration and clerical staff<sup>31</sup>; and maintenance / ancillary staff.

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

4.7 The average scores for **work-life balance** were derived from level of agreement responses to three statements: *My Trust is committed to helping staff balance their work and home life; my immediate manager helps me find a good work-life balance; and I can approach my immediate manager to talk openly about flexible working*. Individual responses were each scored between 1 and 5, where 1 represents poor work-life balance and 5 an excellent work-life balance. The average work-life balance scores derived from the 2006 survey for the NHSPRB remit groups were mostly slightly better than neutral (in the 3.0 to 3.5 area), broadly similar to those from the 2005 survey for most staff groups (see Figure 4.1). Ambulance technicians (2.8) midwives and paramedics (3.1) had the lowest agreement scores. All staff groups, with the exception of paramedics and ambulance technicians, experienced either small decreases or remained the same in such scores since 2005.

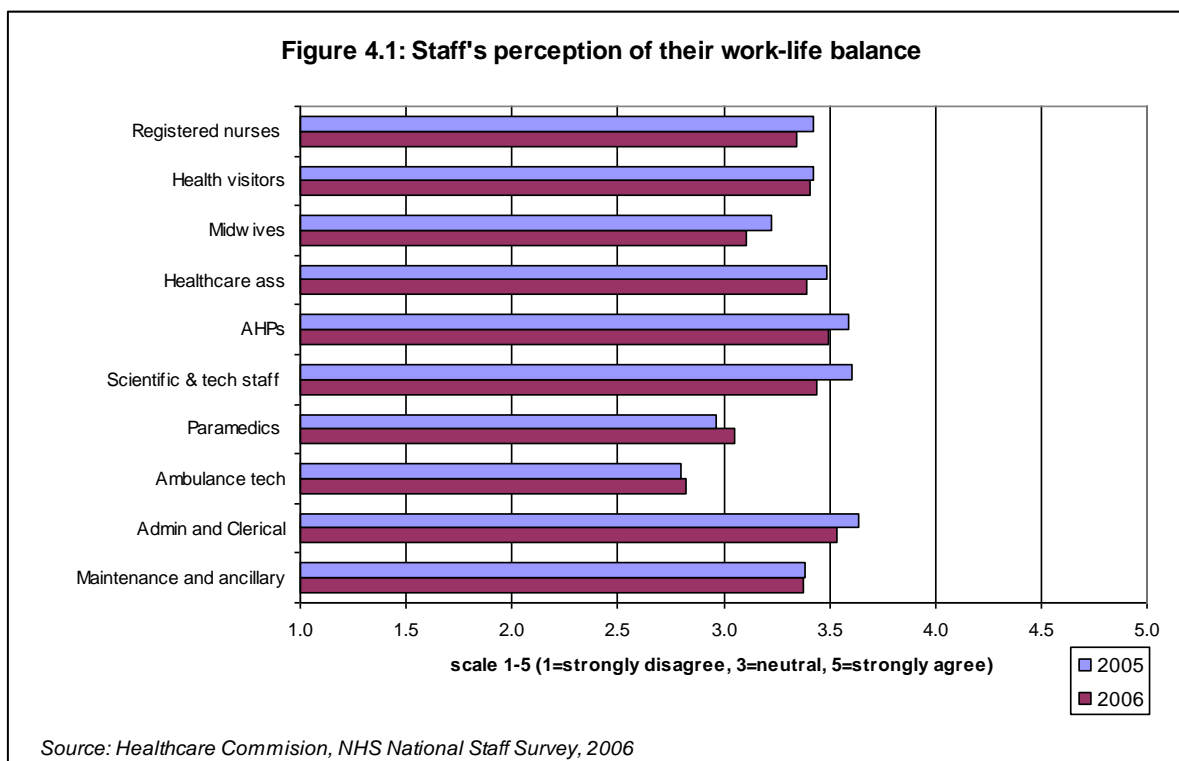
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<sup>28</sup> Patient transport services and ambulance control staff are not reported here because of the small numbers involved. General managers are also excluded from the analysis, as some of them will not be in the NHSPRB remit.

<sup>29</sup> Includes auxiliary nurses

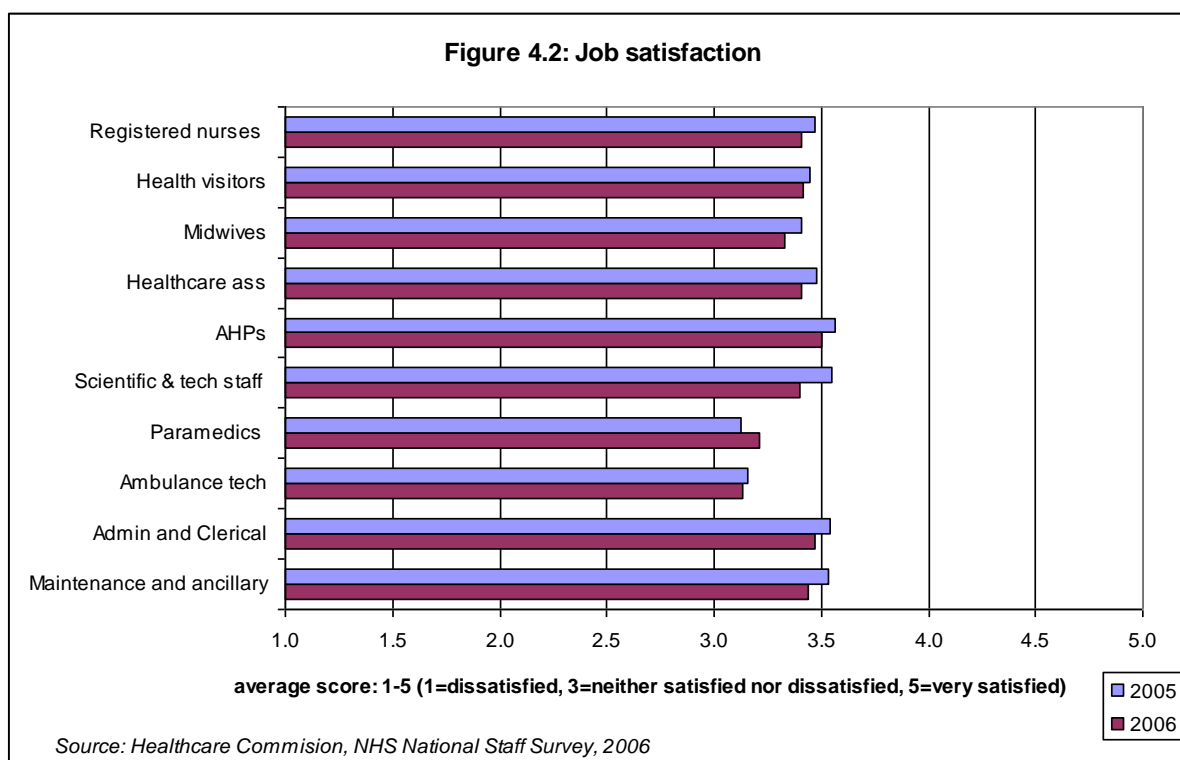
<sup>30</sup> Includes healthcare scientists

<sup>31</sup> includes central and corporate services



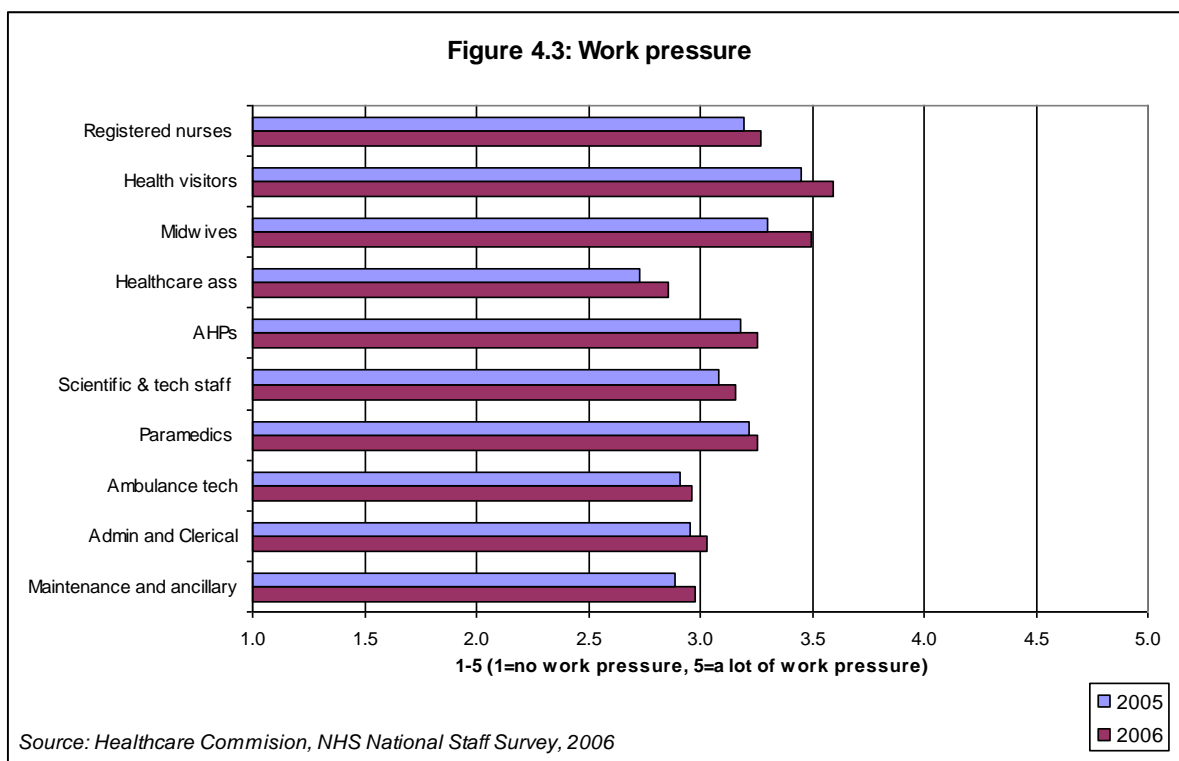
4.8 Staff were asked a series of questions to determine **job satisfaction**: *recognition for good work; support from immediate manager; freedom to choose own method of working; support from work colleagues; amount of responsibility; opportunities to use abilities; and the extent Trust values work*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

4.9 High job satisfaction is generally associated with good performance, patient satisfaction, staff well being and low levels of absenteeism and turnover. All NHSPRB staff groups had a score of between 3.1 and 3.5, the latter equivalent to half the sample being “satisfied” and the other half “Neither satisfied nor dissatisfied” (see Figure 4.2). **Ambulance technicians** (3.1) and **paramedics** (3.2) had the lowest average job satisfaction scores. All scores had either fallen by 0.1 or remained the same since 2005, the only exception being **paramedics** who saw theirs increase by 0.1.



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

4.11 The scores indicate that the amount of work pressure felt by staff was slightly more spread out than the scores for job satisfaction (see Figure 4.3). The average scores for most groups were in the 3.0-3.3 area with respondents, on average, slightly more likely to agree with the four statements about work pressure than to disagree with them. In contrast, **healthcare assistants** tended to feel a little less pressure, with average scores below 3. **Health visitors** and **midwives** felt the most work pressure with average scores of 3.6 and 3.5 respectively. All the staff groups experienced modest increases in their average work pressure scores between the 2005 and 2006 surveys. According to the Healthcare Commission work pressure is the best predictor of stress in the NHS and results in absenteeism and poor performance.



4.12 Individual staff bodies have also undertaken their own surveys, including a NHS staff survey undertaken by Incomes Data Services (IDS) on behalf of the joint NHS trade unions. We discuss these further below.

4.13 The WAG undertakes a NHS staff survey biennially, which is similar to the English NHS staff survey. They told us that arrangements were underway for the 2007 survey and a report of the findings would be included in next year's evidence. In the interim, a questionnaire had been sent to employers in Wales and one of the findings reported was that the majority of employers felt that morale had stayed the same over the previous 12 months.

4.14 The DHSSPSNI said they were currently investigating the possibility of commissioning a NHS staff survey, similar to the one run by the Healthcare Commission in England. However, no information was provided in its evidence this year on the motivation or morale of NHS staff in Northern Ireland. SGHD have also run similar NHS staff surveys in the past but, like Northern Ireland, no up to date information was provided on the motivation or morale of Scottish NHS staff in its evidence this year.

## **Evidence from the Parties**

### *The Health Departments*

4.15 The **Department of Health** said that the NHS Staff Survey provided a measure of staff satisfaction derived from a range of factors and was therefore an accurate picture of staff morale. The Department said that job satisfaction scores had remained fairly constant over the four years of the NHS Staff Survey to 2006. The Survey had also shown that the percentage of NHS staff working extra hours had dropped from 76 per cent in 2003 to 70 per cent in 2006. The Department said there was a strong correlation between staff satisfaction and patient satisfaction, but that staff satisfaction was about much more than pay. In supplementary evidence, the Department added that it did appreciate the importance of pay to staff, but it considered it not to be the issue that it was in the late 1990s.

4.16 In its supplementary evidence, the Department acknowledged that there was anecdotal evidence from the joint staff side that suggested that at the moment KSF was not being applied stringently and KSF reviews were not always happening. However, it also cited evidence from a number of NHS organisations where KSF was successfully being applied. The Department said that there would be a number of KSF relaunch events to support more effective use of the KSF including its role in appraisal, staff development and identification of individual and organisational training needs. The Department said that it expected the relaunch to increase the number of proper KSF reviews.

4.17 The **SGHD** said that it could not be certain that all Boards would have fully implemented KSF by March 2008. However it said that there had been significant recent progress and of an estimated 39,000 required post outlines, around 29,000 had either been approved or were awaiting approval. Over 1,200 staff had a personal development plan based on the KSF and had had a KSF-based personal development review. Discussions were underway on the next NHS Scotland Staff Opinion Survey, to be run in 2008.

4.18 The **WAG** said the implementation of KSF had been slower than desired and there was clearly a need to refocus and re-energise work on KSF. However, all Trusts had implemented the Electronic Staff Records (ESR) system and the E-KSF interface, which would help with implementation. The Staff Survey was due to take place between September and October 2007.

## *NHSE*

4.19 **NHSE** said results from its survey of employers showed that staff morale was among the four most important factors listed by employers in assessing what pay uplift there should be for staff. **NHSE** acknowledged that recent NHS reconfiguration, financial problems and workforce reductions had had an impact on staff morale. However, many NHS employers were reporting that various indicators showed signs of improvement in staff morale. Where this was not happening, this was due to re-organisation or re-configuration. The **NHSE** survey showed that morale had remained broadly stable for the last 12 months.

4.20 In its supplementary evidence, **NHSE** added that views on morale among employers were largely dependent on local factors and in general there had been no significant deterioration of morale reported. **NHSE** stressed that whilst employers would be concerned by any deterioration in levels of morale amongst their staff, there was a clear view that solutions to problems of low morale would not be found in simply giving a higher pay award. Indeed, **NHSE** said that a pay award which Trusts found unaffordable would only cause further problems that would impact adversely on morale, such as reductions in posts, vacancy freezes and failure to meet healthcare and financial targets. **NHSE** also cited the Healthcare Commission Staff Survey, which it said showed that overall staff satisfaction in the NHS remained high and staff continued to have a positive view of working in the NHS.

4.21 **NHSE** said that its survey showed that some employers felt **KSF** needed simplification. However, the majority of responses were positive on **KSF**, with many highlighting the benefits in enabling organisations to identify and prioritise staff development directly linked to organisational requirements.

## *Staff Bodies*

4.22 The joint **Staff Side** cited a staff survey carried out on its behalf by **IDS**, which it said had shown 61 per cent of staff reporting worse morale than last year. Eighty per cent of staff reported their workload had increased over the year. Eighteen per cent of staff had received no training in the past year, rising to 40 per cent for ancillary and maintenance/admin and clerical staff. Sixty per cent of staff had considered leaving in the past year. The most common reasons for staying were that staff felt they were doing something worthwhile and the NHS Pension Scheme. Only four per cent reported staying because they were satisfied with current pay and conditions and just six per cent because of good career prospects.

4.23 Staff Side concluded that the morale and motivation of the workforce was important not only to ensure good quality service delivery but also to ensure the recruitment and retention of a happy and motivated workforce. We were asked to note the low levels of morale and motivation among staff and the impact of increased stress levels and workload.

4.24 On the KSF, the Staff Side said that the IDS survey had found that 55 per cent of NHS staff had received a KSF outline and 56 per cent had had an appraisal with their line manager in the last 12 months. By comparison, the 2005 Healthcare Commission Staff Survey had found that 61 per cent of staff had had an appraisal, down from 64 per cent in 2004. Staff Side told us that a small, high level group of Strategic Health Authorities (SHAs), Trade Unions, NHSE and the Department of Health had been established to work with employers and managers to assess the KSF. Staff Side stressed the importance of KSF in maintaining the principles of Agenda for Change (AfC) and urged us to continue our support for its implementation.

4.25 **UNISON** told us that it had carried out its own survey of its members across the UK during June and July 2007, to which nearly 1,850 members had responded. This had shown that in 63 per cent of workplaces morale was low or very low and in 71 per cent of workplaces morale had deteriorated since 2006. Eighty per cent of staff had said their workload had increased and 74 per cent of those had said this was down to additional duties/responsibilities placed on them, 58 per cent due to insufficient sickness, maternity and holiday cover, 46 per cent due to vacancy freezes and redundancies and 45 per cent due to pressure to meet government targets. In addition, 64 per cent of staff said that they would probably or definitely not recommend their occupation/profession as a career in the NHS; 56 per cent of staff were fairly or very worried about their job security; and 54 per cent of staff had fairly or very seriously considered leaving their current position. For those who had considered leaving, 53 per cent attributed their feelings to being undervalued in terms of pay.

4.26 On the KSF, UNISON told us that training had been particularly seriously affected by deficits within the NHS. The UNISON survey had found that the number of staff who had received more than three days training in the past year had fallen from 48 per cent in 2006 to 31 per cent in 2007. UNISON also pointed to reorganisation and movement of experienced staff within SHAs as factors which had hampered KSF implementation.

4.27 UNISON said that this trend of decreasing training opportunities raised questions

about the sustainability of the KSF, which was a key strand of AfC with the potential to deliver a modern, responsive NHS for all countries of the UK through workforce development and service redesign. UNISON echoed the Staff Side's support for the work of the high level group formed to look at KSF.

4.28 The **Royal College of Nursing** (RCN) said that findings from its own survey showed a downward trend in the morale of nurses: more than four in five nurses saw workload as too heavy and their pay poor; there was significant deterioration in optimism surrounding job security and access to training and professional development; and a reduction in NHS nurses' sense of job satisfaction and feeling that work was valued.

4.29 The RCN encapsulated this as follows: "Nurses in 2007 feel much less secure in their employment, feel there are fewer opportunities open to them to advance their careers or move on from their current grade and fewer also think that their employer is doing all they can to support their development".

4.30 The **Royal College of Midwives** (RCM) said that its own survey of Heads of Midwifery (HoMs) showed 60 per cent of midwives had reported morale as lower in 2007 than in 2006. In addition, almost 60 per cent would not recommend midwifery as a career.

4.31 The RCM said that implementation of KSF was progressing but was still not complete. Over 50 per cent of midwives had benefited from KSF. However, a lack of funds for training, lack of support and managerial concerns that KSF was overly bureaucratic had stalled full implementation. In addition, 40.5 per cent of HoMs considered their staff to be happy, compared to 52.8 per cent in 2006. Almost 60 per cent of midwives had considered leaving the profession because of stress and heavy workloads; extra responsibilities and insufficient staff were the main cause of heavy workloads

4.32 The **Society of Radiographers** (SoR) said that the staging of last year's award and financial cuts (in particular to training and development) had had a negative impact on morale and may also have contributed to an increase in attrition rates.

4.33 The SoR told us that KSF had failed to get going in the majority of departments. Managers were saying it had been set aside due to lack of time, lack of finance and the need to achieve clinical targets. The SoR told us that there was an apparent lack of urgency

amongst NHS managers to ensure its successful implementation. Many department managers now questioned the worth of KSF and perceived it as a chore rather than a development tool.

4.34 The **Chartered Society of Physiotherapy (CSP)** said that 46 per cent of its members had told the IDS survey their workload had increased a lot since last year. Forty per cent of members said stress and workloads were having a detrimental effect on their relationships and over a quarter of members cited a detrimental effect on their health. Seventy eight per cent said that motivation and morale had decreased over the past year. Sixty per cent had fairly seriously or very seriously considered leaving their current position in the NHS.

4.35 In the CSP's own survey in April 2007, 70 per cent of CSP members had said that the training budget for physiotherapy staff was inadequate to meet KSF development needs. The CSP told us that lack of funding for training had badly affected physiotherapists attempting to introduce new ways of working and to improve quality of care within existing roles.

4.36 **UNITE (T&G)** said that the IDS staff survey showed that ancillary and maintenance staff were the most likely to report worsening morale and motivation. Seventy two per cent of T&G members believed morale was worse or a lot worse than last year. Physical violence towards ambulance staff was of particular concern.

4.37 The IDS survey had also shown that 62 per cent of AHPs had received their KSF outlines and personal development plans but only 28 per cent of ambulance staff and 36 per cent of ancillary and maintenance staff had done so.

4.38 **UNITE (Amicus)** cited the Staff Side IDS survey figures showing that 61 per cent of staff had reported their morale and motivation to be worse than last year. UNITE said that this had risen to 65 per cent among its members. UNITE told us that a second year of experiencing a pay cut in real terms would accelerate this downward trend in morale and motivation.

4.39 The **GMB** said that in its own survey, to which 732 people had responded, 70 per cent of members had reported worse morale than for the previous year and six in ten would not recommend their occupations. Seventy six per cent of GMB members reported an increased workload.

4.40 One in five GMB members had received no training last year according to the GMB survey, whilst only 43 per cent had a KSF outline.

4.41 UCATT said that 81 per cent of its members felt that workload had increased over the past year, according to the IDS survey. Sixty one per cent felt that morale had decreased over the last year.

4.42 The **Northern Ireland Public Service Alliance** said that AfC assimilation in Northern Ireland was behind the rest of the UK. It told us that the delay in the application of matching/assimilation and consequently development of KSF had disadvantaged many Northern Ireland Health and Social Care employees. This had had an adverse impact on the morale of members.

### **Our Comment**

4.43 This year, as previously, the picture of morale across the NHS painted by the Staff Side, the Department of Health and NHSE are quite different and based on interpretations of different survey-based evidence. We welcome the more comprehensive and in-depth approach taken by the Staff Side in their evidence this year. While the NHSE survey is based on managers' views of the morale of their staff, the IDS survey which underpins much of the Staff Side evidence gives a more direct insight into the state of staff morale. In addition, as last year, the IDS survey gives a more up-to-date view than that provided by the Healthcare Commission survey on which much of the Department of Health's evidence relies and which pre-dates the staging of last year's pay award. As last year therefore, we must place greater emphasis in forming our view of morale across the NHS on the more recent Staff Side evidence than that provided by the Healthcare Commission survey.

4.44 The IDS survey covers a year marked in particular by cuts in training budgets and this has undoubtedly affected morale across the NHS, although it appears that the staging of last year's pay award has also had a significant effect. In its evidence, the Department of Health acknowledged that staff workload had increased, but pointed out that staff working extra hours had dropped from 76 per cent to 70 per cent (paid or unpaid), according to the Healthcare Commission's NHS Staff Survey. We do not view this continuing high level as a particular cause for comfort and we found it surprising that the Department should apparently view it as such. How workload is changing from year to year is relevant to our deliberations and although the unions have provided some evidence for our consideration, we have

received nothing of detail from the Health Departments. We would therefore ask the Health Departments to consider what evidence they can provide on workload for our consideration in the next round.

4.45 From the evidence we have seen, our view is that morale has indeed declined across the NHS over the past year and our discussions with staff and managers during our visits last year to a number of NHS organisations across the UK support this view. Workload, the effects of the staging of the award and lack of training opportunities appear to have been the key factors, and again this was echoed during many of our visits last summer. We are also concerned at the low level of staff appraisals being carried out (around 60 per cent<sup>32</sup>); a properly functioning appraisal system for all staff is vital both for morale and to inform training needs, as well as ensuring a safe and appropriate service.

4.46 While there is a marked difference in the views taken by Staff Side and the Department of Health of morale across the Service, both sides paint a common picture of the state of implementation of the KSF. We emphasised last year our view that KSF is vital to the success of AfC. We continue to believe that KSF is crucial to the efficient delivery of current and future services, so it is disappointing to note that cuts in funding appear to have continued to slow its effective implementation. Staff Side emphasise the effects of decreased funding on the KSF, exacerbated by a perceived lack of enthusiasm for it among managers. We therefore welcome the relaunch of the KSF and the importance placed on it by both the Health Departments and the Staff Side in their evidence this year and we urge both sides to work together to ensure that the relaunch is successful. As we said in Chapter 1, we welcome the Department of Health's commitment to increase the Multi Professional Education and Training budget by six per cent, announced as part of the NHS Operating Framework for England for 2008-09<sup>33</sup>. We would welcome evidence for our next review on how this funding increase is being used to support the KSF throughout the NHS. We trust that funding for education and training in all four countries will be safeguarded in 2008-09 and beyond.

4.47 We have been unable, on the basis of what we have received, to give detailed consideration this year to the morale and motivation of our remit group in Scotland, Wales and Northern Ireland. It would help our consideration of this aspect of the remit if we could have more detailed evidence from those countries and we would ask them to keep our

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<sup>32</sup> This is for all NHS staff groups – Source: NHS Staff Survey, Healthcare Commission, 2006.

<sup>33</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_081094](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094)

secretariat informed about the work they have underway to provide such evidence in the future.

4.48 There is certainly evidence of a decline in staff morale in England and we are concerned at the possible impact this may have in the longer term on both service delivery and on recruitment and retention in the NHS. Staff Side's evidence, reinforced by our own visits, shows 61 per cent of staff say that their morale has declined. Although recruitment and retention data does not indicate that staff are leaving, it may be (though we have no direct evidence of this) that people are staying despite their low morale, due to a lack of practical alternative employment. Our remit now requires us to have regard to 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 achievement of this strategy requires good morale amongst the staff who are required to deliver the service, particularly when the NHS still faces challenging service delivery targets. We have therefore tried to take a view on how our recommendations on pay might pose a risk to the achievement of those targets, given that morale is likely to affect the quality of service provided to patients.

## CHAPTER 5 – THE FUNDS AVAILABLE TO THE HEALTH DEPARTMENTS

### Introduction

5.1 Our remit requires us to have regard to the funds available to the Health Departments in reaching our recommendations. As might be expected, the Health Departments have submitted the bulk of the evidence on these ‘affordability’ issues, though we have also received some evidence from NHS Employers (NHSE) and from the staff sides. Our revised remit also requires us to have regard to 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. As we said in Chapter 1, the Health Departments have not specifically addressed this new requirement in our remit, although it was a general recurrent theme and an important part of their evidence on affordability that pay increases above what had been budgeted for would impact on patient care.

5.2 The evidence we have received from the parties on ‘affordability’ is reviewed below.

### Evidence from the Parties

#### *The Health Departments*

5.3 We were told that the Departmental Expenditure Limits (DELs) represented absolute limits on NHS expenditure. The **Department of Health** and the **Scottish Government Health Directorates** (SGHD) said there was a commitment to continue the ambitious programmes of service improvements in the NHS and that many of these improvements were dependent on staff, but if pay costs were higher than planned, other costs would need to be lower. However many non-staff costs were not easily controlled and so higher pay would lead to lower levels of employment, risking delivery of services and improvements to NHS care.

5.4 The **Department of Health** provided its DELs for the period up to 2010-2011 covered by the Comprehensive Spending Review 2007 (CSR07):

**Table 5.1: Departmental Revenue Expenditure Limits to 2010/11**

Year		Revenue NHS Expenditure	Cash Growth	Cash Growth %	% real terms increase
		£m	£m		
2005/06	Outturn	74,168	7,294	10.9	8.6
2006/07	Estimated outturn	78,356	4,188	5.6	2.8
2007/08	Estimated outturn	86,848	8,492	10.8	7.9
2008/09	Plan	92,642	5,793	6.7	3.9
2009/10	Plan	98,499	5,858	6.3	3.6
2010/11	Plan	104,833	6,334	6.4	3.7

1. Figures may not sum due to rounding

Source: *Written Evidence from the Health Departments*, November 2007

5.5 The Department told us that average real terms growth in NHS revenue funding of 3.7 per cent per annum for the CSR07 period was significantly less than the 6.1 per cent average real terms revenue growth between 1997-98 and 2007-08. In order to make the overall NHS programme affordable, the NHS also had to deliver annual average efficiency savings of three per cent per year. Similarly, average cash growth across the CSR07 period was less than during CSR04.

5.6 The Department told us that the NHS had ended the 2006-07 financial year with a net surplus of £515 million. In supplementary evidence, the Department told us that the forecast surplus for 2007-08 had increased to £1.8 billion<sup>34</sup>, but stressed that this was still a forecast. The Department said that it could not afford to commit the underspend for new expenditure because it needed to allow NHS organisations to plan on the basis of making use of their surpluses, either to provide flexibility against future risk or to deliver programmes that had been delayed. Surpluses were also not uniform across all organisations and a small number of organisations were still in deficit. Around £350 million of the surplus was estimated to relate to technical accounting items which could not be used for other expenditure such as pay and around £190 million would be required in 2008-09 to meet the full year cost of the staged pay award in 2007-08. NHS organisations were also expected to continue to make modest surpluses in future years.

<sup>34</sup> See [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_080967](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080967)

5.7 We were provided with figures (Table 5.2) showing the recent trends in the Hospital and Community Health Services' (HCHS) paybill. The Department said that around two-thirds of expenditure within the HCHS and approximately 46 per cent of total NHS spend was on pay, so even very small changes in pay would have a substantial effect on the affordability constraints of NHS organisations.

**Table 5.2: Trends in the HCHS paybill**

	2003/04	2004/05	2005/06	2006/07
<b>DDRB</b>	6,142m	7,077m	7,571m	7,930m
<b>NHSPRB</b>	20,825m	24,425m	26,443m	27,497m
<b>Total HCHS</b>	<b>26,967m</b>	<b>31,502m</b>	<b>34,015m</b>	<b>35,428m</b>

Source: *Written Evidence from the Health Departments*, November 2007 (Paybill reference: 071012)

Notes: 1. Part of the 2004/05 growth is due to a transfer of pension responsibilities from HMT to the Department of Health.

2. Figures exclude agency costs.

3. Figures include AfC costs.

5.8 The Department set out its plans for NHS expenditure, reflecting the outcome of CSR07 and showing the pressures over the next three years divided into three categories: baseline pressures, underlying demand and service developments. The costs of these were summarised as:

**Table 5.3: Cost pressures on NHS over the next three years (£bn)**

	2008/09	2009/10	2010/11
Baseline pressures*	3.1	3.9	3.7
Underlying demand	1.2	0.7	1.4
Service improvements	1.4	1.4	1.2
<b>Total forecast expenditure</b>	<b>5.8</b>	<b>5.9</b>	<b>6.3</b>
<b>Departmental expenditure limit</b>	<b>5.8</b>	<b>5.9</b>	<b>6.3</b>

\* Net of 3% efficiency (Figures may not sum due to rounding).

Source: *Written Evidence from the Health Departments*, November 2007

5.9 The Department said this showed that overall costs would match the increase in funding available within the DEL, assuming the NHS also delivered annual average efficiency savings of three per cent per year. "Baseline pressures" were the first call on resources and consisted of unavoidable cost increases, including increased pay and the rising cost of drugs, goods and services. These were expected to consume around 60 per cent of the additional resources available and of that 60 per cent, around 49 per cent would be taken up by pay, 18 per cent by drugs costs, and eight per cent by the cost of goods and services. "Underlying demand" covered the need for the NHS to deliver year on year increases in activity. "Service improvement" covered work under Department's Public Service Agreements such as the reduction in waiting times for cancer treatment, tackling healthcare-

associated infections, and improving access to primary care. The different cost pressures had been modelled using different combinations of long term trend, underlying population growth, demand for healthcare and inflationary uplifts, as discussed in the NHS Operating Framework and National Tariff documentation. In response to our request to decompose further the figures in this table, the Department provided us with the following:

#### CSR Process

**Plans for NHS expenditure, and hence the contents of the table (see *Table 5.3*), are the outcome of the CSR settlement between the Department of Health (DH) and HM Treasury (HMT).**

**In the CSR, the Department “bids” for resources to meet unavoidable cost pressures and improve services. HMT’s role is to scrutinise DH spending plans, looking for potential efficiencies and challenging individual programmes that might not deliver good value for money.**

The DH bid for resources from HMT is traditionally split into 3 categories:

- Baseline Pressures
- Underlying Demand
- Service Improvements

**These are described in the Department’s original written evidence (paragraphs 2.18 to 2.28). They are net of an ambitious 3% efficiency target agreed with HMT. The individual programme items are given in Table A1 in Annex A. (See *Appendix E of this report*.)**

#### Pay Pressure

**The pay pressure of a 1.5% settlement for doctors and 2% for the NHSPRB remit group plus average drift across the NHS at 1.6% plus various elements of pay reform was set at an early stage in the CSR process and underpins the figures in this table. Other elements of the table are based on what can then be afforded following these levels of increase.**

**The pay pressure arising from different levels of settlement will feature in each of the three main CSR areas / lines of the table. The “baseline pressure” will include the cost of increasing pay for the planned workforce in 2007/8. The additional cost arising from paying the growing workforce a higher settlement will be contained in the “underlying demand” and “service improvement” lines.**

**A higher settlement can only be afforded by cutting back on service development or by increasing workforce productivity. Both could potentially result in lower levels of employment. The pressures from a higher award are illustrated in Table A2, in Annex A (see *Appendix E of this report*), which includes a breakdown of the cost of a pay bill settlement between a baseline pressure and the additional cost from the growing the workforce.**

5.10 The Department told us that the NHS Operating Framework, Primary Care Trust allocations and the national tariff for 2008-09 had been published in December 2007<sup>35</sup>. It provided us with Table 5.4 below which showed that the 2.8 per cent uplift assumption in the tariff on pay was based on the Department's recommendations to us and to the Review Body on Doctors' and Dentists' Remuneration (DDRB) of a 2.0 per cent and 1.5 per cent headline settlement respectively:

**Table 5.4: Tariff uplift**

	2008/09 over 2007/08 baseline		Assumptions
	£m	%	
<b>Baseline</b>	<b>59,540</b>		
<b>Increase in pay and prices</b>			
Pay	1,640	2.8	Pay settlement in line with DH recommendation to the Pay Review Bodies: 1.5% DDRB and 2% NHSPRB. Also include pay drift and staging.
Non-pay inflation	350	0.6	GDP Deflator at 2.75%.
Drugs	400	0.7	Includes NICE
Clinical Negligence	210	0.4	Forecast local contributions
Revenue cost of capital	210	0.4	PFI; depreciation; cost of capital
<b>Gross pay and price</b>	<b>2,810</b>	<b>4.7</b>	
Efficiency	-1,790	-3.0	Assumes 3.0% efficiency
<b>Net pay and price</b>	<b>1,020</b>	<b>1.7</b>	
<b>Quality and reform</b>	<b>330</b>	<b>0.6</b>	To cover costs of tackling HCAI, pay reform/legislation, staff security and local cost of delivering the IM&T programme.
<b>Overall</b>		<b>2.3</b>	

Figures may not sum due to rounding

Source: *Supplementary evidence from the Department of Health*

5.11 The Department provided us with the estimated cash outturns for pay uplifts ranging from 1.5 per cent to 4.0 per cent:

<sup>35</sup> See [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_081094](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094)

**Table 5.5: HCHS non-medical Paybill (£million)**

	2007/08	2008/09										
		1.50%	1.75%	2.00%	2.25%	2.50%	2.75%	3.00%	3.25%	3.50%	3.75%	4.00%
NHSPRB Paybill	29,133m	30,722m	30,799m	30,876m	30,953m	31,030m	31,107m	31,184m	31,261m	31,338m	31,415m	31,492m
Increase		1,589m	1,666m	1,743m	1,820m	1,897m	1,974m	2,051m	2,128m	2,205m	2,282m	2,359m
Baseline pressures based on DH financial plans		3,100m	3,100m	3,100m	3,100m	3,100m	3,100m	3,100m	3,100m	3,100m	3,100m	3,100m
Baseline pressures based on a range of pay settlement		2,946m	3,023m	3,100m	3,177m	3,254m	3,331m	3,408m	3,485m	3,562m	3,639m	3,716m
Increase/reduction in funding for service improvements		154m	77m	0m	-77m	-154m	-231m	-308m	-385m	-462m	-539m	-616m

Note: 2007/08 is projected outturn

Source: Supplementary evidence from the Department of Health

5.12 The Department said that the three per cent efficiency target for England was based on the assumption that savings were cash releasing, but that these had already been factored into (netted off) its analysis of cost pressures.

5.13 The Department said it did not believe that it was practicable to have a target for growth per head of paybill. This increase in the paybill was an important part of its deliberations on a suitable pay award, but the Department said that it also considered a wide range of other factors, such as recruitment and retention, morale, the wider reward package and the impact of the pay award on service delivery.

5.14 The **SGHD** said that over the CSR07 period, NHSScotland's real terms revenue funding growth would be an average of 1.3 per cent per annum, significantly less than the 5.7 per cent real terms revenue growth between 1997-98 and 2007-08. The SGHD's DELs were:

**Table 5.6: DELs to 2010-2011**

Year	Revenue NHS Expenditure £m	Cash Growth £m	Cash Growth %	% real terms increase
2005/06	8,356	644	8.35	6.12
2006/07	9,065	709	8.48	5.55
2007/08	9,692	627	6.91	4.0
2008/09	10,135	443	4.57	1.29
2009/10	10,503	368	3.63	0.85
2010/11	10,950	447	4.25	1.46

Source: Written Evidence from the Health Departments, November 2007

5.15 The SGHD said that the following health resource budget was being proposed to the Scottish Parliament:

**Table 5.7: Proposed Health Resource Budget 2008-09 to 2010-2011**

Year	Health Resource Expenditure	Cash Growth (includes 2.7% GDP)	Cash Growth (includes 2.7% GDP)
	£m	£m	%
<b>2008/09</b>	10,124	426	4.39
<b>2009/10</b>	10,513	389	3.84
<b>2010/11</b>	10,930	417	3.97

*Source: Supplementary Evidence from the SGHD*

5.16 Two per cent cash releasing efficiencies would also need to be generated (previously one per cent). The SGHD said that around two-thirds of expenditure within the HCHS was pay and so even very small changes in pay had a substantial effect on affordability constraints. Baseline pressures were expected to consume around 70 per cent of the additional resources available and a significant proportion of that would be taken up by pay. The cost of service developments totalling £217 million in 2008-09 also had to be met from these additional resources: improving health and better public health (£103 million), access support for the NHS (£90 million), education and training (£17 million) and clean hospitals/MRSA screening (£7 million). The remaining funds would fund pay awards, the increased costs generated through demographic changes and medical advances, increased drugs costs and general price inflation. The total NHSScotland pay bill for 2006-07, including agency staff, was £4.6 billion. In relation to our remit group, the total paybill was £3.6 billion. Each additional 0.5 per cent increase in the paybill for our remit group would cost around £18 million and any pay award above two per cent would require a consequential reduction in NHS service developments.

5.17 In response to our request for further clarification of its affordability figures, the SGHD provided us with the information set out at Appendix E.

5.18 The **Welsh Assembly Government (WAG)** said that Wales as a whole had been given average real terms growth of 1.8 per cent, but the Health budget would be less than this. The health figures were:

**Table 5.8: Health and Social Services DELs 2004-05 to 2008-09**

	<b>Health DEL £M</b>	<b>Cash Growth £M</b>	<b>Cash Growth %</b>	<b>GDP deflator (1)</b>	<b>Real Terms Growth</b>
2004/05	4,469	403	9.9 <sup>(2)</sup>	2.76	7.0
2005/06	4,671	202	4.5	2.11	2.4
2006/07	4,888	217	4.6	2.87	1.7
2007/08	5,141	253	5.2	3.25	1.9
<b>2008/09</b>	<b>5,353</b>	<b>212</b>	<b>4.1</b>	<b>2.75</b>	<b>1.3</b>

Source: Supplementary evidence from WAG

(1) GDP Deflators as at 30 September 2007.

(2) Cash growth of 9.9% in 2004/05 includes a transfer to meet increased employers' pension contributions.

5.19 We were told that a two per cent pay award would be covered within the 2.7 per cent inflation costs. WAG said that the various pressures expected to arise in 2008-09 meant there was no flexibility to afford pay increases in excess of its planned increase in the NHS pay bill. Around £91 million was expected to fund pay awards for current staffing levels, Agenda for Change (AfC) incremental drift (planned as 1.2 per cent) and the cost of the introduction of the new unsocial hours scheme. The cost of incremental drift for AfC staff and unsocial hours had been estimated at £24.5 million and £12 million respectively, leaving £54.5 million for pay awards which allowed for an overall 2.1 per cent award in 2008-09 covering all NHS employed staff, i.e. AfC staff, consultants, staff and associate specialist doctors, junior doctors and salaried dentists.

5.20 In response to our request for further clarification of its affordability figures, the WAG provided us with the information set out at Appendix E.

5.21 The **Department of Health and Social Services & Public Safety in Northern Ireland** (DHSSPSNI) said that under the CSR07, the Northern Ireland Executive's DEL would grow by 1.2 per cent in real terms per annum and by 1.7 per cent if the reduced baseline was taken into account. A three per cent efficiency saving target had to be achieved in 2008-09. The DHSSPSNI's budget would increase by 3.8 per cent in 2008-09 and its additional resources amounted to £285 million. Of this, £228 million was required to meet inescapable cost pressures, including £91 million for the increased costs of the Health and Social Care<sup>36</sup> (HSC) pay bill. The remaining £57 million was for service development. The £91 million available for pay had to meet the cost of awards, incremental drift for AfC staff and consultants, the introduction of the new unsocial hours scheme under AfC, the new contract for staff and associate specialist doctors, plus changes to grade and skill mix. We were told that pay reform consequentials were expected to cost £18 million leaving £73

million to meet the costs of pay awards – sufficient to meet an overall 2.3 per cent award in 2008-09. We were told that for our remit group a two per cent pay uplift would be affordable.

5.22 In response to our request for further clarification of its affordability figures, the DHSSPSNI provided us with the information set out at Appendix E.

### *NHSE*

5.23 **NHSE** told us that the definitive sources of evidence on affordability were HM Treasury and the Health Departments. NHSE's review of cost drivers and financial planning assumptions being made across individual NHS organisations for the period of the CSR07 had identified a shortfall in funding of between 0.8 and 3.2 per cent for each of the coming three years to be managed over and above the 2.5 per cent Gershon efficiency target required under CSR04. CSR07 now required a three per cent efficiency target, 0.5 per cent more than in CSR04, and the higher figure had not yet been worked through in NHS organisations' forward plans. NHSE said that the financial position of each NHS organisation was different and cost pressures would vary considerably depending on the individual organisation. It was not therefore possible to calculate an exact level of pay uplift which would be affordable to employers, but an 'average' award of over two per cent would not be manageable within the financial tolerance of many employers. NHSE told us that a headline uplift of two per cent in conjunction with 1.6 per cent additional cost pressures on NHS pay budgets would require additional efficiency savings over and above the new three per cent efficiency target, but according to NHSE's evidence, this would be affordable.

5.24 NHSE said that employers had stressed that affordability was dependant on an appropriate increase in the tariff for 2008-09. NHSE told us that the tariff did not increase or decrease the level of funding available across the NHS as a whole: it was purely a mechanism for determining the level of funding which must be paid between respective commissioning and providing organisations. Employers were very clear that any further cost pressure through unfunded pay increases would almost certainly impact on services and lead to cost savings elsewhere, such as a reduction in posts and vacancy freezes, impacting on planned growth and leading to a reduction in capacity. The forecast surplus for 2007-08 was not a recurrent resource and was not available for the pay uplift. NHSE also highlighted for us

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<sup>36</sup> Social care staff are paid under AfC terms and conditions in Northern Ireland and therefore fall within our remit group.

their view that phasing annual pay awards created a ‘hidden’ recurrent cost pressure against future years’ funding and was demoralising for staff.

### *Staff Bodies*

5.25 In their evidence, the joint **Staff Side** evidence highlighted the sharp turnaround in the NHS’s financial position in England from an overspend in 2005-06 to a growing surplus for 2007-08 (and similarly in Scotland). The Staff Side cited shedding jobs, cutting training budgets and public health spending, plus the top-slicing of organisations’ budgets as the main means of delivering this financial turnaround. However, since the pay bill was about 70 per cent of most NHS organisations’ budgets, the Staff Side said it was clear that NHS staff had footed the bill for the dramatic turnaround from deficit to surplus in under a year. It was unfair for NHS staff to continue to pay for historic financial problems in the NHS with a below inflation pay award.

5.26 The Staff Side said that last year the Health Departments and NHSE had argued that managing the financial crisis was a compelling reason for constraint when considering the pay award for 2007. This, plus the tough public sector pay policy, had had a very damaging impact on staff morale. In the Staff Side’s view, true affordability was a relative term and a function of political willingness and policy choice and any surplus generated greater headroom for a fair pay award. With Departmental funding due to rise by four per cent per annum over the next three years and three per cent efficiency savings agreed as part of the CSR07 settlement, the Staff Side said that staff should share in this seven per cent growth rate. The Staff Side argued that an above inflation pay award was not only affordable to Government, but they could not afford to pay staff a below inflation award if they wanted to retain a motivated workforce and increase efficiency and improve quality, safety and access to services.

### **Our Comment**

5.27 As the Health Departments have stressed the importance of affordability in making our recommendation for 2008-09, we want to set out the type of evidence that we would need in order to reach a fully informed view on what is an affordable pay uplift. For us to be constrained by a pre-determined figure assumed in the tariff (which does not in any case affect Scotland, Wales or Northern Ireland) or set by the Health Departments would amount to a total abdication of our responsibilities, as defined by our remit. It is not our role merely to allocate a fixed funding envelope. Rather we are asked to recommend a cash award taking

account of all aspects of our remit. Therefore we need a clear understanding of what cash is available in order to be able to estimate what can be afforded for pay, taking into account the numbers of staff in our remit group that the Health Departments consider it appropriate for the NHS as a whole to employ. The Health Departments have provided some important information in relation to funding, but we also need to be shown how estimates of funding pressures have been calculated. Broad figures shown as funding pressures that appear on the face of it simply to balance the numbers are not persuasive. We need to understand clearly how the expected total cash requirement in each country, plus the proposed pay uplift, equals the available cash growth.

5.28 The Department of Health has provided figures showing cost pressures for England over the next three years – baseline pressures and the cost of underlying demand and service improvements. We have asked the Department for a clearer explanation of the composition of these figures, but the responses we have received take us no further forward. We cannot avoid the conclusion that we are being asked to accept the Department's budgeted figures on trust which, given the Department's emphasis on the affordability of our recommendation, is not an acceptable approach on which to base a decision. As NHSE's evidence on affordability appears to rely on the Department of Health's assessment of what is an affordable pay uplift, we have no independent view from employers to assist us.

5.29 Moreover, the new efficiency saving targets of three per cent in England and Northern Ireland, two per cent in Scotland and 2.5 per cent in Wales appear to have been set centrally. We do not know what assumptions have been made about how these efficiency targets are to be achieved and the role to be played by staff in achieving them in terms either of productivity or pay. We also note the size of the year-on-year efficiencies required of the NHS (around £3 billion in England) compared to the effect of an extra one per cent on the pay bill (around £300 million) which we are told would lead to cuts in services.

5.30 In addition to the lack of clarity about the funding pressures which the Department of Health's DEL must support, there is also a lack of clarity about the relationship between the real terms and cash growth figures in the DEL on the one hand and the figures for the uplift for pay in the tariff of 2.8 per cent and the overall tariff uplift of 2.3 per cent on the other. Nothing we have seen in the evidence from the Department of Health has explained these various inter-relationships clearly to us or why the pay element in the tariff has been set at the level it has. We commented last year that the pay element of the tariff should be dependent

on the level of earnings needed in the longer term to attract and retain sufficient numbers of good quality staff, rather than the other way round, and we have seen no evidence to indicate that the pay element was set this way. As we said last year, if over the medium to longer term the pay of our remit group does not move broadly in line with the pay of the types of jobs that our remit group might alternatively choose, over time the NHS will become uncompetitive and unable to attract and retain sufficient numbers of good quality staff. Affordability has to be seen within this wider context; it is about priorities and if the available money is insufficient, the whole burden should not be borne by the pay of current members of staff.

5.31 The Department of Health has stressed to us again this year that we need to take account of all the factors (incremental progression, etc.) that increase earnings when determining the annual pay uplift because it is these factors combined which determine affordability. Understanding paybill costs however is only one element in our consideration of affordability. The Department has said it judged average earnings growth of 4.6 per cent in 2008-09 to be affordable. Whether this figure is also affordable in Scotland, Wales or Northern Ireland is unclear to us.

5.32 Although there has been some attempt to address our concerns about affordability evidence for this round, we still have not been provided with evidence of sufficient clarity to assist our deliberations. In our last report we set out the types of evidence that we would find helpful and we repeat them here:

- funding pressures, i.e. an analysis of actual and potential funding pressures;
- the composition of the budget, including how outturn projections compared with original assumptions and the reasons for any variances;
- a breakdown of the paybill in terms of basic pay, overtime, progression, etc.;
- an analysis of the impact of changes in the numbers and composition of the workforce;
- for England, the link between the tariff and the DEL;
- the dependency between numbers of staff, the wage bill and new service delivery targets for the NHS, including the contribution to be made by staff productivity, skill mix requirements and planned efficiencies; and
- what cost assumptions are built into the planned efficiency savings targets and how achievement is measured year on year.

5.33 We have asked our secretariat to continue discussions with the Health Departments about what evidence may be made available to us to inform our next review. It would also be helpful if each of the four Health Departments could provide its evidence in a consistent format. We found the evidence from the DHSSPSNI to be in the most useful format this year.

5.34 Last year the background to our deliberations on the pay uplift for our remit group was the level of financial deficit within the NHS, particularly in England, and the service's efforts to restore financial balance. The Department of Health told us very clearly last year that our recommendation had to be set within the context of these deficits and the likely consequences for service delivery if we recommended a higher than expected award. The information available to us when we submitted our last report in February 2007 indicated that the NHS in England was forecasting a deficit for 2006-07 of £94 million. The NHS eventually reported a surplus for 2006-07 of £515 million. At the beginning of November 2007 when the Department of Health submitted its written evidence for this round, we were told that the NHS in England was forecasting a surplus for 2007-08 of £983 million which at the turn of the year had been revised to a projected surplus of £1.8 billion. The Department has stressed to us that this higher forecasted underspend cannot be committed for new expenditure.

5.35 Notwithstanding the Department's position on the projected surplus, it is a fact that the evidence suggests that, unlike last year, the financial situation within the NHS in England is projected to improve markedly. Within the overall projected surplus of £1.8 billion, the figures showed that 25 organisations<sup>37</sup> were forecasting a deficit for 2007-08, based on projections at the turn of the year, compared to 175 organisations for 2006-07 when we submitted our last report. Last year the Department of Health pointed out to us that as the NHS as a whole must be in balance, the deficits of a minority of Trusts must affect what was affordable at the national level because if some Trusts ran deficits, others must run surpluses. We accepted that point, but as the NHS as a whole in England is projected to be in surplus this year to the sum of £1.8 billion, there is no deficit at national level for us to take into account in our deliberations this time. We must also make clear, once again, that our consideration of affordability is focused at national level and not on the position of individual Trusts or groups of Trusts. At a national level the NHS in England is forecasting a surplus of

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<sup>37</sup> See [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_080967](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080967). Foundation Trusts report separately on their financial position and are not reflected in the figures here.

around two per cent of its revenue expenditure. The position is less clear for Scotland, Wales and Northern Ireland.

5.36 Our terms of reference require us to have regard to the funds available to the Health Departments, as set out in the Government’s Departmental Expenditure Limits (DELs), and the overall strategy of putting patients at the heart of the NHS. In summary, the information we have been given on each country’s DEL is as follows:

**Table 5.9: Health Departments’ DELs for 2008-09**

2008-09	Real terms growth (%)	Cash growth (%)
England	3.9	6.7
Scotland	1.29	4.57
Wales	1.3	4.1
Northern Ireland	1.2 (or 1.7 if reduced baseline taken into account)	3.8

*Source: Written Evidence for the Health Departments, November 2007, and supplementary evidence from the Health Departments.*

5.37 We note that the overall level of funding for each country under the CSR07 settlement has been reduced compared to recent years. We also note that despite the much smaller level of both real terms and cash growth in Scotland, Wales and Northern Ireland compared to England, all three countries support the Department of Health’s proposed two per cent pay uplift and are keen that the principle of UK-wide pay scales should be maintained. Although we have received further evidence from all four countries in response to our request for clarification of their positions, it remains unclear to us how each country will be able to afford the same increase. As AfC has been implemented more slowly in Scotland, Wales and Northern Ireland, we are also unclear how the costs of assimilating the remaining staff onto the new pay structure impacts on their overall budgets, given their smaller levels of funding growth.

5.38 We note the Staff Side argues that “...true affordability is a relative term and a function of political willingness and policy choice.”. What is clear to us from both the Health Departments’ written evidence and the discussions at oral evidence is that there are always competing demands for the funding available to the NHS. We understand this and we

understand that staff pay should not automatically be the top priority. But it also seems clear to us that the demand for NHS services could always potentially soak up any given level of funding. Last year the service still faced deficits. This year a surplus is forecast for England. The amount available for pay depends on choices and a balance has to be struck. It is also a matter of choice that Scotland, Wales and Northern Ireland want the same pay uplift figure as England, despite their affordability positions being very different.

5.39 In reaching our recommendation on the pay uplift we have tried to ensure that we are fair to the taxpayer as both funder and user of the NHS and fair to the staff who deliver the service. We have also considered the longer term impact that our recommendation may have on the recruitment and retention of good quality staff without whom the service cannot be provided. This is particularly important given the damage to morale in general and the possible longer term effects on the service which may arise as a result of education and training monies being diverted elsewhere in recent years.

5.40 We understand that budgetary assumptions must be made by the Health Departments, but as we said earlier, we do not consider that we are constrained by those assumptions or that what is affordable for pay should be the residual amount available after other priorities have been met. The pay settlement for our remit group should not alone bear the brunt of any financial difficulties in the NHS nor should the settlement be expected to subsidise service delivery. The Government cannot simply state that the NHS will achieve demanding new targets, such as delivering improved cancer services and a maximum 18 weeks from referral to treatment for patients needing elective care in England, without identifying how this is to be achieved. We discuss our conclusions on the level of an affordable uplift in chapter 7.

## CHAPTER 6 – PAY AND PRICES

### Introduction

6.1 Our remit requires us to have regard to the Government's inflation target<sup>38</sup>. In this chapter we review the evidence we have received on pay and prices and comment on the points that have been put to us. With different emphases, the parties have provided us with general macroeconomic evidence on, in particular, trends in inflation, average earnings, and pay settlements, and these data are updated regularly by our secretariat. These indicators provide part of the context to our work, but they are by no means the only factors we take into account. We have also received evidence specific to the pay of our remit group covering, in particular, relative earnings levels and movements.

### Evidence from the Parties

#### *The Health Departments*

6.2 In order to help us set their evidence in context, we asked the Health Departments for a statement outlining the Government's public sector pay policy. The **Department of Health** provided us with the following:

The Government's policy is that pay should be set at levels that allow public services to recruit, retain and motivate a workforce with the right skills needed to deliver the Government's objectives.

It is the Government's policy that pay settlements should:

- be consistent with the achievement of the Government's inflation target of 2 per cent;
- be affordable;
- represent value for money for taxpayers; and
- reflect the labour market position of workforces and support economic growth in all regions.

This does not mean that there is a number which is the target for pay settlements. What it does mean is that settlements need to support low and stable inflation and macroeconomic stability and at the same time recruit and retain a workforce that delivers the Government's objectives. This means pay settlements will need to reflect the position of individual

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<sup>38</sup> Defined as an increase in the twelve-month Consumer Prices Index (CPI) of two per cent.

workforces in respect of recruitment, retention and motivation. Pay settlements will also need to be affordable and so will need to take account of the departments' ability to fund settlements from within their budgets.

The measures outlined in the Government's written evidence papers are consistent with the Government's public sector pay policy.

6.3 The Department of Health provided us with the Treasury's analysis of recent trends in inflation, examining movements, their causes, the extent to which they were temporary, future forecasts and the implications for wage setting in the public sector. The Treasury's forecast showed that the Consumer Prices Index (CPI) would fall back to two per cent in 2008, which was the Government's target. Public sector pay settlements should therefore reflect both this expectation and this target.

6.4 The Department told us that the CPI formula better allowed for substitution between goods in response to relative price changes, unlike the Retail Prices Index (RPI), and it was the international standard measure. The CPI gave a better picture than RPI of spending patterns in the UK. Over the medium term, the long-run difference between the CPI and RPI was expected to be around  $\frac{3}{4}$  percentage points of which around  $\frac{1}{2}$  percentage point was accounted for by the different formulae used to calculate each measure. The exclusion of housing costs, council tax and mortgage interest payments from the CPI accounted for part of the remaining difference.

6.5 The Department told us the Government was keen that the Pay Review Bodies (PRBs) should consider the impact of the headline award on:

- paybill per head growth, which gave an indication of changes in average earnings; and
- paybill growth, which reflected the total cost to the employer.

6.6 Looking at improvements in NHS pay, the Department said that the Government had delivered its commitment on pay to Agenda for Change (AfC) staff which it said had all benefited from at least a ten per cent pay increase over the first three years (2003-04 to 2005-06) of the new contract, with most staff pay increasing by more. The Department told us it was important to avoid comparing basic pay increases with inflation. Whilst workers at the top of pay scales would rightly only receive the basic award, good opportunities for incremental progression remained with latest data from the NHS Electronic Staff Record

(ESR) suggesting that around 76.5 per cent of staff would move to a higher incremental point in 2008-09 receiving increases worth an additional 2.2-6.7 per cent. The Department said that its pay metrics for our remit group showed that a pay uplift of two per cent in 2008-09 would deliver average growth in earnings per full-time equivalent (FTE) of around 4.5 per cent which the Department said was well above the underlying CPI inflation rate and current average earnings increases in both the private and public sectors.

6.7 We were told that the Department's financial planning was based on pay settlements of two per cent for our remit group and 1.5 per cent for the remit group of the Review Body on Doctors' and Dentists' Remuneration. These figures included an average of 1.6 per cent pay drift across the Hospital and Community Health Services sector (HCHS). Forecasts of pay drift were derived from incremental, grade, occupation and non-base-pay drift, plus drift from the estimated costs of reform. Implementation of AfC (which the Department had expected would increase drift) had coincided with high levels of recruitment (which was expected to reduce drift initially). The Department said it was therefore very difficult to produce reliable estimates of drift for any past single year and it was even more difficult to forecast future drift. The introduction of the ESR should provide more robust information and the Department would be updating its modelling to provide estimates of earnings and pay drift for future PRB rounds, starting from the next review.

6.8 In response to our requests for clarification, the Department told us in supplementary evidence, and confirmed at oral evidence, that its 2008-09 estimate of long-term pay drift (i.e. incremental, grade, occupation and non-base-pay drift) for our remit group was 1.5 per cent. As well as this extra pay growth which would arise from any given pay settlement, the Department also considered that the settlement should take account of extra cost pressures arising from the additional 0.9 per cent for the changes to the unsocial hours agreement and adjustment of the high cost area supplement (HCAS) band in London (0.3 per cent) and the full year effect of the staged settlement in 2007-08 (0.6 per cent). The total increase in average earnings for our remit group in 2008-09 would therefore be 2.4 per cent above the basic settlement. The **Welsh Assembly Government** (WAG) told us that incremental drift was about 1.2 per cent for AfC staff, based on the best information it had available.

6.9 The **Department of Health's** detailed paybill and earnings figures submitted with its main and supplementary evidence are set out at Appendix D of the report.

6.10 The Department argued that its own data sources, e.g. from the NHS Financial Returns, represented a more accurate national picture of NHS employee earnings than data from the Annual Survey of Hours and Earnings (ASHE). The NHS Information Centre (IC) had recently published average earnings statistics using sample data from the ESR, but this data remained experimental. The Department therefore believed that its own metrics provided the best estimate of earnings growth for the moment, although it would increasingly rely on ESR data in the future.

6.11 For reasons of affordability and in the interests of re-balancing pay growth between the public and private sectors, the Department told us that when determining settlements, it was critical that all factors that would increase earnings were taken into account, such as:

- payments arising from the restructuring of pay systems;
- targeted payments to aid recruitment and retention;
- the net effect of progression payments; and
- bonus payments.

6.12 Responding to our previous concerns as to the long term implications for the recruitment and retention of a workforce of sufficient quality were the pay of our remit group to become out of line with comparable occupations, the Department said that it was not straightforward to calculate the correct “market rate” for a public sector worker, but the indirect influence of pay levels could be seen through recruitment, retention and morale. Pay also had to be recognised as only one aspect of a wider total reward package and an important part of this package was the pension. The increasing attractiveness of this package for public sector workers had reversed the significant recruitment and retention problems of the 1990s. The broad range of benefits in the NHS included childcare, flexible working, continual professional development and staff being valued.

6.13 The Department said that changes to the NHS Pension Scheme from 1 April 2008 represented an improvement in the value of NHS pensions once longevity was taken into account. Staff would pay tiered contributions with the majority of staff paying 6.5 per cent. The higher contributions represented a transfer of reward from current to deferred pay rather than a reduction in net remuneration. Employer contributions were projected to be unchanged at 14.0 per cent. The Department said that the NHS Pension Scheme would remain one of the most attractive available and the envy of many in the public and private

sectors. The closure of defined benefit schemes by some other employers meant that the overall NHS employment package was becoming even more attractive and the Department said that we should take account of the value of deferred pay, i.e. the pension package and its increased value relative to pension provision outside the public sector, when reaching a recommendation on any increase in current pay. This view was echoed by the **Scottish Government Health Directorates** (SGHD).

#### *NHS Employers (NHSE)*

6.14 As with affordability, **NHSE** told us that the definitive sources of evidence on the economic context were HM Treasury and the Health Departments. We were also told that the increase in staff contributions to the NHS Pension Scheme from 1 April 2008 would pay for the increases in the value of the benefits received.

#### *Staff Bodies*

6.15 The joint **Staff Side** evidence said that our role was potentially being undermined as the Pre-Budget Report committed the Treasury to “public sector pay settlements consistent with the Government’s achievement of the Government’s inflation target of two per cent”, yet recent economic research<sup>39</sup> showed there was no link between public sector pay increases and inflation in the wider economy. Although the Department of Health’s evidence had demonstrated that 22 per cent of staff would not benefit from incremental progression, this figure had been obtained by averaging. Each band should however be weighted to give an accurate figure which revealed, for example, that around 42 per cent of staff in band 4 were at the top point.

6.16 The Staff Side emphasised that the pay scales agreed through AfC had always been intended as an encouragement and reward for staff developing their skills and never as a substitute for an adequate pay rise.

6.17 The Staff Side stressed that the differences between the rate of RPI and CPI over past months had underlined the importance of including mortgage interest payments and council tax in line with the RPI to gain a true indication of the actual financial pressures facing NHS staff. The differences also highlighted that recent pay awards had failed to keep up with the real cost of living with NHS staff effectively having had real terms pay cuts. In deciding the

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<sup>39</sup> *Public Sector Pay Policy, A Report for The Council of Civil Service Unions*, Incomes Data Services (IDS), August 2007

2008-09 award, we were asked to take into account the surging level of prices (particularly such fundamental costs as housing, transport, energy and food) that went well beyond recent NHS pay rises. We were also asked to consider the deterioration of NHS pay relative to private sector settlements. In its evidence, **Northern Ireland Public Service Alliance** (NIPSA) highlighted that pressure on salaries in Northern Ireland was currently greater than elsewhere in the UK due to increases in house prices and domestic rates.

6.18 With regard to the Government's argument that pay should be offset against the recent beneficial pension deal, the joint **Staff Side** said that the average NHS pension in payment was £5,180<sup>40</sup> per annum. Pay was the current monetary reward for staff's work and what they lived on day to day. Pay and pensions together made up the overall reward package, but there were different processes for determining each and one could not be cut to pay for the other. NHS staff would be paying more to retain their existing benefits through the revised contribution arrangements and new joiners having to work until 65 instead of 60. Employers' contributions however would be capped at existing levels and going forward, the NHS trade unions had agreed to introduce cost sharing arrangements to limit the level of employer contributions funded by the NHS. In the Staff Side's view, the Total Reward package included compensation, benefits, work-life balance, performance and recognition, development and career opportunities. Evidence from the NHS Staff Survey plus other union surveys had shown the dramatic drop in access to training and professional development last year. Access to flexible working was improving, but workload was increasing which was having a negative impact on working lives. The Staff Side considered that staff should expect access to training and continuing professional development as well as flexible working without being expected to have a pay cut in real terms in return.

6.19 The Staff Side evidence (and evidence from various individual unions) also raised with us again this year the issue of pay comparability. They considered that the Government's public sector pay policy had created a gap with earnings growth in the private sector. We were told that data from ASHE 2006 had shown that other public sector groups (e.g. police and teachers) had gained far more than our remit group. ASHE also showed higher weekly earnings of various private sector groups. The Staff Side considered that this reflected the value placed on employees within society and raised equality issues as the earnings of male dominated professions tended to be higher than female dominated professions, both within and outside the public sector. The 2006 survey by the Association of

Graduate Recruiters (AGR) had shown that there would be continual pressure on NHS graduate recruitment within a tightening market and when pay for graduate nurses was already below that for other public sector groups. The Staff Side pointed out that the Department had stressed that the earnings of a newly qualified nurse had risen faster than those of a primary school teacher over the last ten years, but the same figures showed that the starting salary for a primary school teacher was still higher than that of a newly qualified nurse. In addition, the average earnings of nurses overall continued to lag behind all other public sector comparators (police, social workers and teachers) according to ASHE data.

6.20 The Staff Side said that pay pressure coming from higher settlements for other public and private sector groups signified the need for this year's award to be significantly better than last year. We were asked to consider the inequality in pay between the professional groups covered by our remit and between public and private sector pay and the effect this might have on the ability to recruit good quality NHS employees in the future.

### **Evidence from Official Statistics and Our Comment**

6.21 The parties have provided us with a range of economic data. This has been updated by our secretariat as our review has proceeded and new figures have become available. In addition to macroeconomic data on pay and inflation, we have also received micro-level information on pay comparability. We have also carried out our own analyses. Below we comment on these two areas, starting with the macroeconomic data.

#### ***Macroeconomic data***

6.22 The macroeconomic data we have received relates to official data on the labour market, earnings and inflation, supplemented by data from specialist commentators on basic pay settlements. The latest information at our disposal was that available in February 2008. We do not, automatically or otherwise, link our recommendations to any particular set of macroeconomic indices. Rather they are based on our judgement of the appropriate level of pay adjustment for remit staff after consideration of all the evidence we receive, of which the macroeconomic data is only a part.

#### ***General Context and the Labour Market***

6.23 Having grown at an above-trend 3.1 per cent in 2007, gross domestic product is expected to slow sharply this year, with the average of forecasts for 2008 expecting an

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<sup>40</sup> The National Health Service Pension Scheme Valuation as at 31 March 2004 and published December 2007.

outturn of 1.8 per cent<sup>41</sup>. This is below the levels of recent years and likely to have implications for the public finances in the year ahead.

6.24 The implications for the labour market are not yet clear. Latest data to December 2007 show the employment level at a record high of 29.39 million, with annual employment growth of one per cent. Unemployment on both main measures has fallen. Other positive signs are an increase in the number of vacancies, whilst the redundancy rate is lower than a year earlier. The current buoyancy of the labour market probably reflects higher economic growth last year and it is unlikely to be maintained in 2008.

#### *Inflation, Earnings and Settlements*

6.25 In *Table 6.1* we set out the latest available data on inflation, earnings and settlements. As usual, we have also looked at quarterly inflation data as it smoothes the effects of month-on-month volatility in the data.

**Table 6.1: Latest data on inflation, settlements and earnings**

<b>Inflation Measures<sup>42</sup></b>	<b>Percentage change on the same month a year ago – January 2008</b>	<b>Percentage change on the same 3 months a year ago – 3 months to January 2008</b>
CPI	2.2	2.1
RPI	4.1	4.1
<b>Headline Average Earnings</b>	<b>Three months to December 2007<sup>43</sup></b>	
Whole economy	3.8	
Private Sector	4.0	
Public Sector	3.3	
<b>Pay Settlements</b>	<b>Three months to December 2007<sup>44</sup></b>	
Lower Quartile	3.0	
Median	3.4	
Upper Quartile	4.1	

<sup>41</sup> Forecasts for the UK Economy. A comparison of independent forecasts. HM Treasury. January 2008.

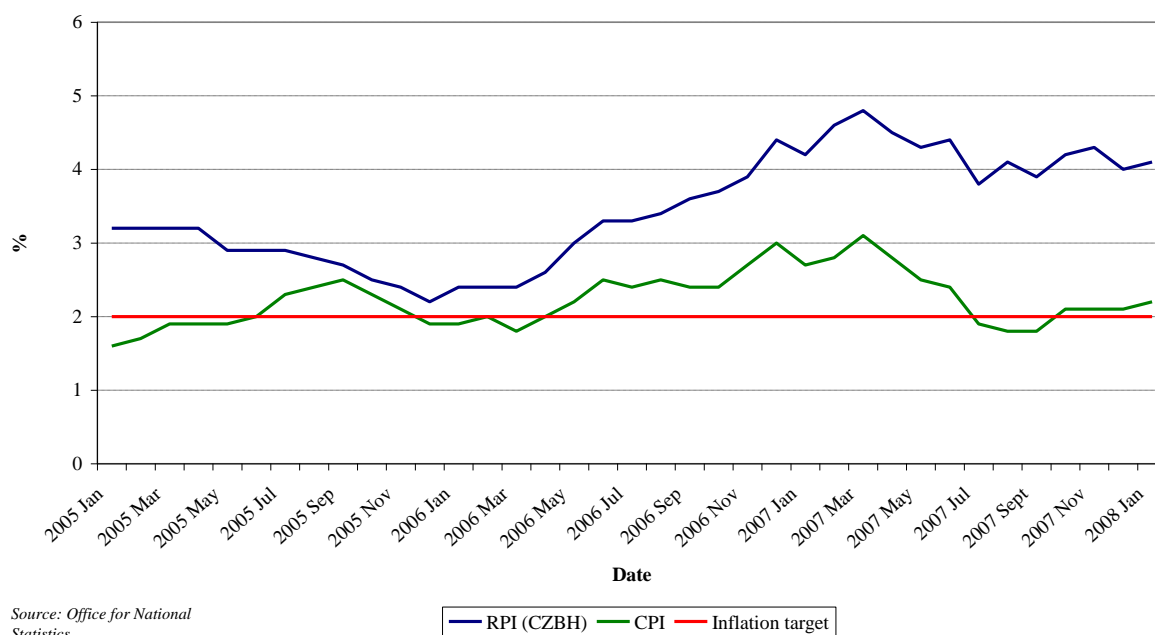
<sup>42</sup> CPI and RPI. *Source: Office for National Statistics*

<sup>43</sup> Headline rate of increase in the Average Earnings Index (AEI), three-month average including bonus effects; percentage change on the same months a year earlier. *Source: Office for National Statistics*

<sup>44</sup> Three-month whole economy median, upper and lower quartiles. *Source: Incomes Data Services (IDS)*

6.26 The recent track of the key inflation indicators CPI and RPI is shown in *Figure 6.1*.

**Figure 6.1: Inflation: CPI and RPI**



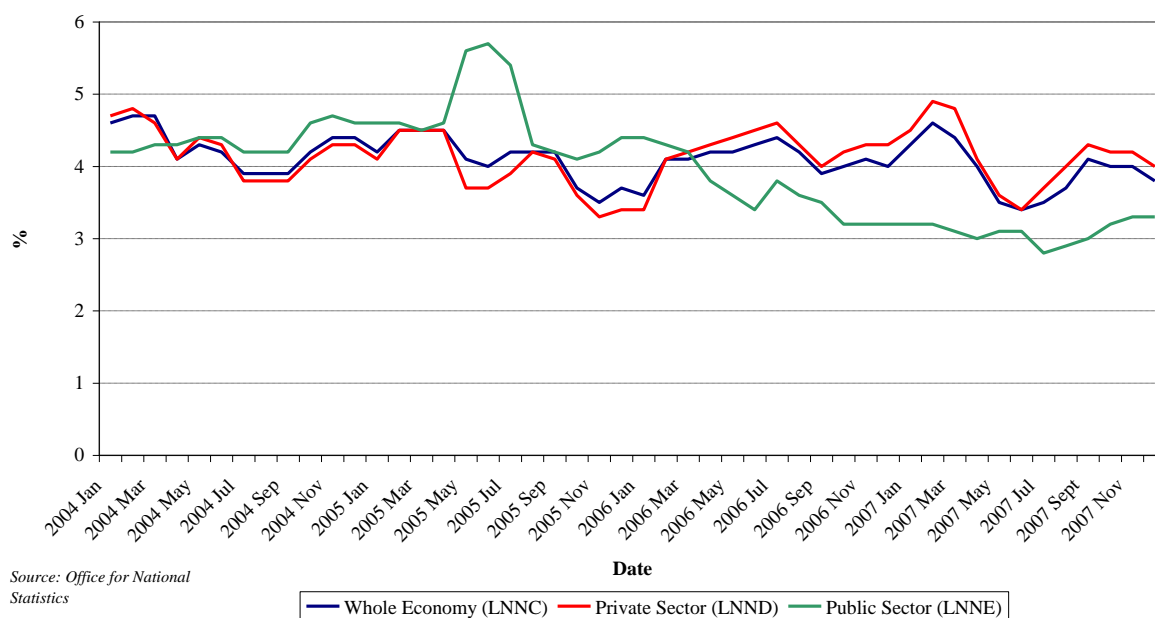
6.27 CPI is the index upon which the Government’s two per cent inflation target is based. Driven in large part by higher energy costs, CPI was significantly above its target in the first half of 2007, before declining steadily during the summer. In recent months it has been marginally above target at 2.1 per cent. Looking ahead, the central projection in the Bank of England’s February 2008 *Inflation Report* suggests a marked upward movement in CPI in the short term to around three per cent before falling back towards a level slightly above target in early 2009. The Report noted the emergence of substantial upward pressures on inflation in the short term stemming from higher energy, food and import prices. The Bank’s Governor has warned that CPI may breach its upper band of 3.0 per cent<sup>45</sup> on at least one occasion in 2008, possibly more, necessitating an explanatory letter to the Chancellor of the Exchequer. More immediately, technical changes announced by the Office for National Statistics (ONS) concerning the way in which changes in electricity and gas prices are included in the calculation of the index will lead to a temporary upturn in the measure.

6.28 RPI, which remains the key inflation measure in the minds of pay bargainers, also rose rapidly during the early months of 2007, but the impact of interest rate increases used to bring CPI back to target, and continued rises in house prices meant a somewhat smaller

decline in the index thereafter than was the case with CPI. Looking ahead, similar upward pressures will affect RPI, although in this case the effects will be tempered to an extent by downward pressures on the index from housing and mortgage interest payments, neither of which feature in CPI. The average of forecasts currently has RPI falling through the year to 2.5 per cent in the last quarter, only marginally above the expected rate for CPI. In the light of the Governor's comments there are considerable risks that RPI will be higher than forecast. This year's forecasts are therefore considerably more uncertain than usual.

6.29 We have set out recent trends in seasonally adjusted average earnings including bonus effects – the headline rate – in *Figure 6.2*. The data cover the whole economy and public and private sectors separately.

**Figure 6.2: Headline Average Earnings Including Bonuses (seasonally adjusted)**



6.30 Public sector earnings growth has stayed around three per cent for much of the year, some way below growth in the private sector. Public sector earnings growth has been below that of the private sector since early 2006. Whole economy earnings growth has hovered around four per cent.

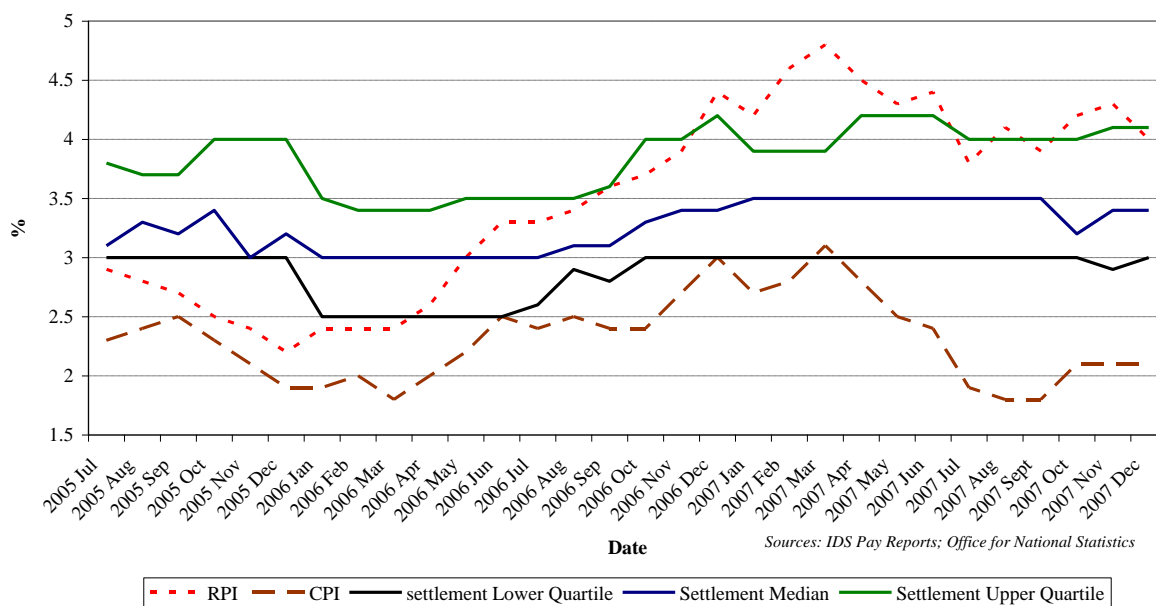
6.31 It is clear, juxta-positioning earnings growth with RPI trends, that at various stages during the year the average employee in the economy as a whole has suffered a real reduction in earnings, with the reduction larger for the public sector as a whole. It is worth noting that

<sup>45</sup> Speech by Mervyn King to IoD South West and CBI, Bristol, 22 January 2008

real falls in earnings this year are unlikely to be felt evenly across the economy, or even across just the private sector. For example, earnings growth varies substantially between industries, reflecting their specific economic circumstances – average earnings growth in the utilities sector for example increased by around 12 per cent in the year to November 2007, whereas in the food sector, average earnings fell by around one per cent during the same period. Within industries, there are likely to be substantial variations between individual organisations, and, within organisations, between individual employees.

6.32 Whilst the official data give us a useful framework within which to consider the real and relative *earnings* of our remit group, we have also examined pay settlement data as these have a bearing on the relative position of the NHS pay *structure* in respect of the wider market. We have looked at data from a range of pay specialist organisations, focussing on the median, upper and lower quartiles. We have reproduced data published by one of these commentators, Incomes Data Services (IDS), in *Figure 6.3* alongside the CPI and RPI trend.

**Figure 6.3: Settlements & Inflation: Median, Lower and Upper Quartile Settlements  
CPI and RPI**



6.33 The data show a distinct pick up in the median settlement rate, and the upper and lower quartiles, starting in late 2006. Since then, the median has settled at around 3.5 per cent, with the upper and lower quartiles respectively about half a percentage point above or below this figure. It is difficult to judge the exact cause of this upward adjustment. Some commentators have suggested that it reflects the pick up in RPI. This is possible, although we observe no hard and fast causal relationship between the data. Others consider that a buoyant labour market may have had a bearing on increasing settlement levels; however,

such an effect would also be expected also to appear in earnings growth which, on the contrary, remains rather subdued.

6.34 As with earnings, pay settlements vary across the economy. In broad terms, currently the settlement median in the public sector is 2.5 per cent, three per cent in engineering and manufacturing, and nearer four per cent in some private sector services.

### *Microeconomic data*

6.35 The microeconomic data we have received and analysed looks at the experience of our remit group over time and relative to others in the labour market. The Health Departments have drawn our attention to the effect of pay drift on the earnings of our remit group, and to the growth of their earnings over time and relative to others in the economy. We look at each of these in turn.

### *Pay Drift*

6.36 Pay drift is a term which is used by different people to mean different things but in essence it is the difference between base pay awards and average earnings outcomes. It arises for various reasons: it may be the result of deliberate employer pay strategies, or it may arise from moves to variable pay and targeted premia, the operation of incremental scales, and changes in the grades and composition of the workforce.

6.37 One of the elements in the Departments' argument for their proposed two per cent basic pay uplift for our remit group is that good opportunities for incremental progression remain for the majority of NHS staff which will increase their average earnings growth well above the current underlying rate of CPI and above the current level of average earnings increases in the wider economy. We note the Department of Health's argument that the prospect of significant incremental progression will soften the impact of below-inflation pay awards and that many staff on AfC contracts will see rises of between 2.2 and 6.7 per cent as a result of incremental progression. As we said last year, it is not, in our view, appropriate to take what is gained by incremental progression into account in determining the basic pay uplift, although the costs generated by incremental progression across the remit group will have a bearing on the affordability of a pay award. We also note in passing that some quarter of our remit group will receive only the basic uplift as they are at the top of their pay bands.

6.38 Similarly, we do not believe that targeted payments to aid recruitment and retention or payments from restructuring the pay system should be taken into account when determining the basic settlement. As we said in our last report, the new AfC pay structure was partly designed to address equal pay concerns and the cost of equality-proofing the NHS pay system should not influence the level of subsequent basic awards. Payments made to address recruitment and retention difficulties reflect specific labour market problems and the need to maintain service delivery and it would not be appropriate to offset the earnings derived from such payments against the basic pay uplift. We are not aware of bonus payments being widely available within the NHS, but it would again be inappropriate for the earnings increases generated by payments to a few individuals to affect the basic level of uplift. Finally, as we made clear last year, premium payments for working overtime, shifts or unsocial hours are clearly compensation payments for abnormal working, and should similarly be excluded from considerations around the basic pay uplift, although as with incremental progression, the cost of such payments do have a bearing on overall affordability.

6.39 The Department of Health is arguing this year that average earnings for our remit group in 2008-09 will be increased by 0.6 per cent (in England) as a result of the full-year payment of the 2007-08 pay award and by 0.3 per cent because of the expected changes to the unsocial hours scheme and the agreed adjustment to the HCAS band for London to reflect the new staff contribution arrangements for the NHS Pension Scheme. They have no bearing on our consideration of the basic pay uplift other than the impact of such costs on overall affordability. Staff would be penalised twice if we reduced our recommended pay uplift to account for the 0.6 per cent full-year cost of this year's staged award. The costs of the new unsocial hours scheme have been agreed by the parties to deliver compensation for working abnormal hours. Again, staff (many of whom may not work unsocial hours) should not then be penalised for receiving these payments by seeing a reduction in the basic pay uplift. Finally, the agreed adjustment to the HCAS band in London was designed to prevent staff being deterred from working out of hours or being unreasonably penalised for doing so and has no bearing on the basic pay uplift of our remit group.

6.40 Accurate estimates of the impact of pay drift are important because they tell us how any given pay uplift will translate into a growth in the average pay bill per head which the Department of Health has noted (see paragraph 6.5) is a key indicator of the impact of our recommendations. Over recent years, the Department has given us several estimates of pay drift, both based on past trends and on its projections of the impact of AfC on incremental

progression. In our last report<sup>46</sup> we set out our own calculations of pay drift for our old remit group in the period 1999-2000 to 2006-07 using ASHE data. This showed that the average annual pay drift figure was relatively close to the long-term average annual figure of 1.6 per cent seen between 1980 and 2000. We note that the Department's pay drift estimate for our remit group in 2008-09 of 1.5 per cent is also broadly in line with this figure. We have also commissioned work which use the New Earnings Survey (NES)/ASHE panel data set to provide alternative estimates of pay drift. This work can be found on the Office of Manpower Economics' (OME) website<sup>47</sup>. The conclusion of that work is that pay drift for nurses and midwives is around 1.5 per cent. Given the consistency between the various estimates, we will use the figure of 1.5 per cent as our estimate of pay drift in considering the appropriate pay uplift.

### *Pay Comparability*

6.41 Pay comparability, whilst not explicitly in our remit, is an unavoidable part of any consideration of recruitment and retention of workers of the appropriate quality. Pay comparability has two components: first, whether pay among our remit group is similar to workers who are undertaking similar jobs and have similar skills and qualifications; and second, whether the relative value of the total employment package of workers who are in our remit group compensates for any difference in pay that we observe from such comparators.

### *Comparative Earnings Movements*

6.42 We point out above that levels of pay settlement vary by sector, reflecting their differing economic circumstances. The same is true of earnings movements. In *Figure 6.4* we show the percentage increases in the average earnings indices<sup>48</sup> for the whole economy, public sector, and public sector health and social work, which includes our remit group. Over the period August 2000 to November 2007 annual earnings growth in public sector health and social work has usually been ahead of growth in the wider economy, and in the public sector as a whole; however it appears that the earnings gap seems to be getting narrower. Overall, over this period, the earnings of public sector health and social workers had increased by about 55 per cent, almost 13 percentage points higher than the rest of the public sector, and 21 percentage points higher than the private sector. These data need to be interpreted with care, however, for two reasons. First, the 'public health' index includes groups who are not

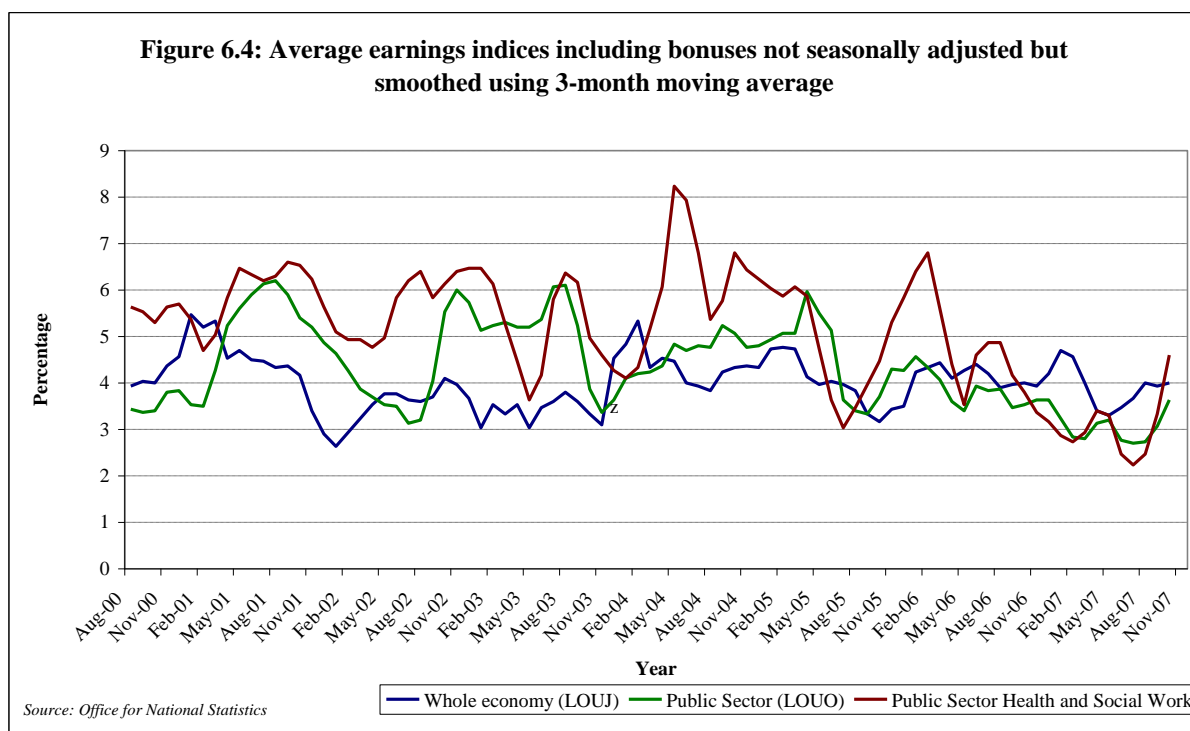
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<sup>46</sup> Twenty-Second Report on Nursing and Other Health Professions 2007, paragraph 7.67

<sup>47</sup> [www.ome.uk/com](http://www.ome.uk/com)

<sup>48</sup> Data for public sector health and social work are not published in a seasonally adjusted form and are only available from July 1999.

in our remit, such as doctors, dentists and social workers<sup>49</sup>: we estimate that around 85 per cent of those in the ‘public health’ index are also covered under the NHSPRB remit group<sup>50</sup>. Second, such comparisons can be very sensitive to the time period considered.



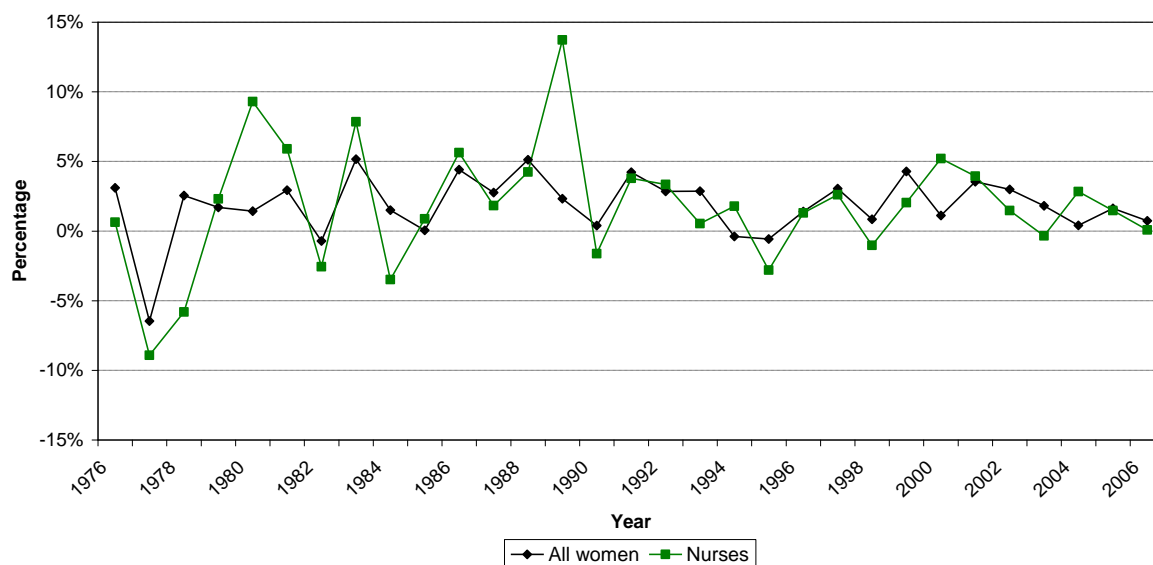
6.43 To obtain a longer term perspective on how the wages of our remit group have moved relative to those of others in the economy OME commissioned an analysis of nurses’ earnings from 1975 using the NES/ASHE panel data. Full details of this work are available on the OME website<sup>51</sup>. As data on all of our remit group are not easily identifiable in this data set, nurses employed in the NHS are used as proxy for the whole of the remit group. The analysis is restricted to women aged 20-59 inclusive. *Figure 6.5* below plots the year on year changes in the real hourly earnings of nurses together with the changes in overall female pay. Fluctuations in real pay seem to have been more marked for nurses than for other women pre-1984 but since the instigation of the Pay Review Body have become more muted.

<sup>49</sup> Our revised remit does, however, include social care workers in Northern Ireland.

<sup>50</sup> On the basis that there are 1,456,000 included in ‘public sector health and social work’ and 1,261,421 (Headcount) in the NHSPRB remit group (1,261,421 / 1,456,000 \* 100 = 86.6%) – figures are for GB.

<sup>51</sup> [www.ome.uk.com](http://www.ome.uk.com)

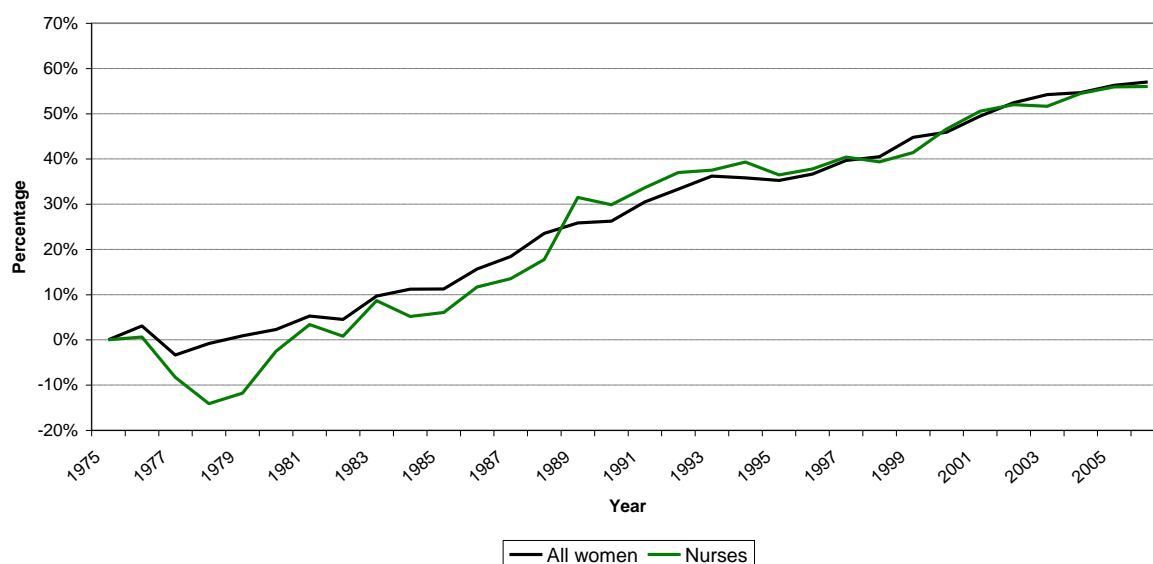
**Figure 6.5: Year on year changes in real pay**



Source: R. Disney and A. Gosling (2008) Estimates of the wage experience profiles for full and part-time nurses and of the year on year changes in their wages. To be published on the OME website.

6.44 *Figure 6.6* shows the cumulative effect of these changes. This suggests that nurses' pay relative to all females fell in the late seventies, then in the eighties caught up a bit, fell behind slightly and finally pushed a bit ahead in 1989. Since then nurses' real wage growth has actually been lower than that of other women but their relative pay at the end of the period (2006) was roughly the same as at the beginning (1975).

**Figure 6.6: Cumulative increase in real pay since 1975**



Source: R. Disney and A. Gosling (2008) Estimates of the wage experience profiles for full and part-time nurses and of the year on year changes in their wages. To be published on the OME website.

### *Comparative Earnings Levels*

6.45 We again received evidence from the staff bodies comparing the pay of remit staff with that of other employee groups outside the NHS. As we said in our last report, it is difficult to know what conclusions we should draw from these analyses, or what weight we should give them in reaching our recommendations, particularly as there is no agreed consensus amongst the various parties to this review on which groups would constitute the most appropriate external comparators. In the absence of any consensus, we have again carried out some analysis of our own which attempts to bring greater rigour to the comparison exercises. We are constrained by the data that is available which means that we have been forced to focus in the main on a subset of our remit group, namely nurses and midwives. While the results presented below should be seen as no more than suggestive of the true position, we believe that they give a more accurate picture than the comparisons offered to us by the parties. We would welcome similar systematic evidence on pay comparisons from the parties.

6.46 In making comparisons, it is difficult to identify the appropriate ‘anchor points’ in the NHS pay structure from which salaries at different stages in an NHS employee’s career might be compared with those elsewhere in the economy. One obvious such ‘point’, however, is the graduate starting rate, and this has been raised in evidence by some of the staff bodies. Latest data from the AGR Graduate Recruitment Survey<sup>52</sup> indicate the median of graduate starting salaries across the country was £23,500 in 2007. The public sector median was reported as £21,500. Separate analysis by IDS<sup>53</sup> showed that employers expected the median graduate starting salary in 2007 would be £22,000, the same as 2006. Public sector employers expected to pay a median of £21,196. *Table 6.2* shows the graduate starting salaries from these surveys as well as those for nursing and allied health professions (AHPs) and for a selection of other public sector occupations.

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<sup>52</sup> The AGR Graduate Recruitment Survey 2007. Summer Review

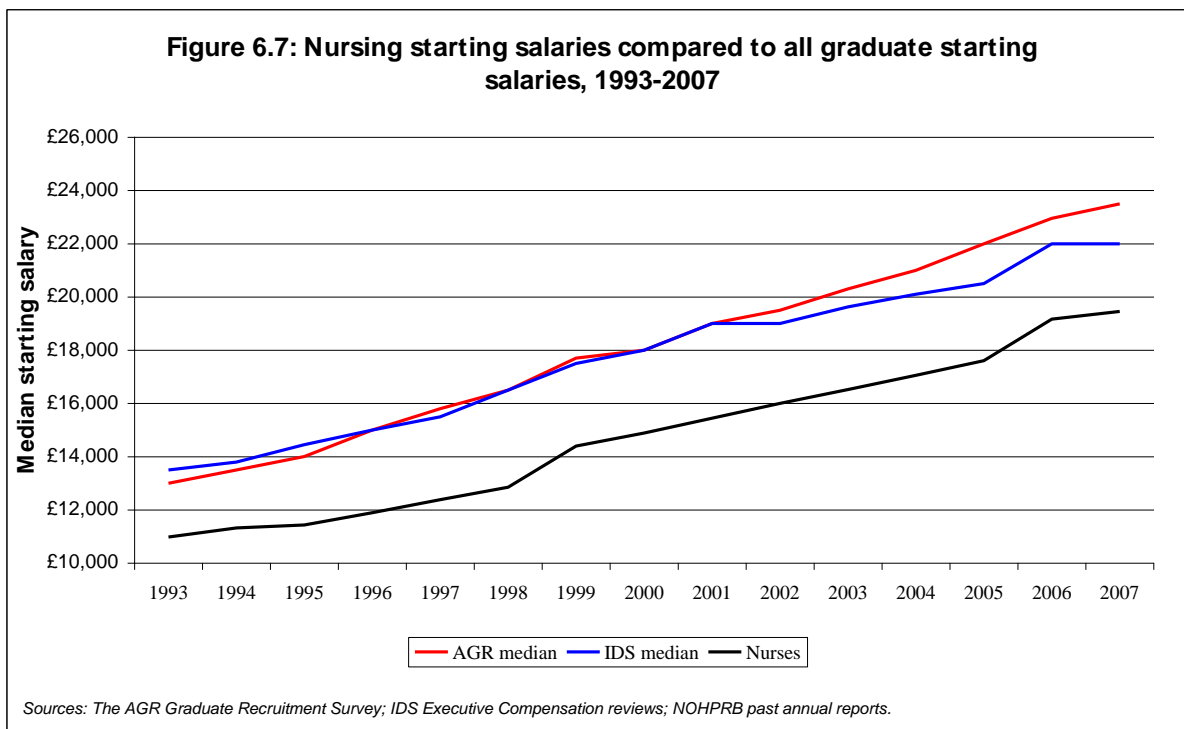
<sup>53</sup> IDS Executive Compensation Review. Research File 76. Pay and Progression for Graduates 2007. March 2007

**Table 6.2: Graduate pay of public sector professions, April 2007**

	Graduate starting pay	Graduate pay after:	
		1 year	3 years
Fast-stream Civil Servant (BERR) <sup>1</sup>	£23,300	£24,300	£25,800
Police Officer <sup>2</sup>	£21,534	£24,039	£26,988
Hospital Doctor <sup>3</sup>	£21,391	£26,532	£30,002
Armed Forces' Officer <sup>4</sup>	£22,680	£27,260	£28,698
School Teacher <sup>5</sup>	£20,133	£21,726	£25,278
<b>Nurses &amp; AHPs<sup>6</sup></b>	<b>£19,683</b>	<b>£20,261</b>	<b>£21,494</b>
IDS median, all graduates	£22,000		£30,000
IDS median, public sector	£21,196		£29,575
AGR median, all graduates	£23,500		

1. Figures are 2007 salaries for outside London and assume sustained successful performance.
2. Excludes overtime payments, from December 2007.
3. Hospital doctors expect to progress from Foundation year 1 to Foundation year 2 after one year and then to speciality registrar after the second year.
4. Adjusted for X factor.
5. Outside London and assumes satisfactory performance. Pay rates from September 2007.
6. Outside London, AfC rates from November 2007.

6.47 The AGR and the IDS surveys include a high proportion of large private sector companies, which tend to offer higher levels of pay. So whilst the two surveys provide a consistent benchmark against which to judge movements in starting pay over time, it is our view that the *trends* in the differentials between nurses' and all graduates' starting pay are more relevant than absolute pay levels. *Figure 6.7* therefore compares nursing starting pay since 1993 with other graduates. If the AGR survey is used, the data show a gradual increase in the differential between nursing starting salaries and that of other graduates; however when looking at IDS data, the opposite is true. This may be because the AGR data contain a high level of 'blue chip' companies while the IDS data have a wider coverage, including the public sector.



6.48 IDS also collects the pay of graduates three and five years after graduation and compares them with current graduate starting rates to calculate the ‘salary lead’ from progression. The median annual earnings of people three years after graduation was £30,000, a salary lead of 35.6 per cent. For those five years after graduation the corresponding figures were £33,488 and 50.7 per cent, respectively. Both the medians and salary leads were slightly lower in the public sector overall and appear to be significantly lower for nurses and AHPs judging from the salary scales. To the extent that starting rates and progression influence the career choice of school-leavers, these are important comparisons and we would again welcome further evidence on these comparisons for the next round.

6.49 Career choice and recruitment and retention will also be influenced by potential lifetime career earnings, taking account of items of deferred pay such as pensions, and other benefits such as annual leave and family-friendly policies. The Departments have suggested that we “...should take account of the value of deferred pay; the pension package and its increased value relative to pension provision outside the public sector when reaching a recommendation on any increase in current pay”. The implication is that we should moderate our uplift to acknowledge the unspecified value of the total reward package. The difficulty for us, as we mentioned last year, is that we have received no comprehensive evidence on the value of the package and how it compares with packages provided by other employers and

we therefore have insufficient evidence to support the Departments' view that the NHS total reward package is of higher value than that of an unspecified group of comparators.

6.50 Late in the round, the Department of Health sent us a report it had commissioned from IDS looking at the typical packages available to employees in a range of occupations, which IDS had benchmarked against total reward packages for NHS healthcare assistants on pay band 2 and nurses and graduate trainee NHS managers on pay band 5. Comparisons between groups can often be somewhat arbitrary; a natural benchmark is to take groups with similar skills or characteristics, or to take evidence on the jobs from which our remit group are recruited or the jobs to which exitors go. The IDS study does not make clear whether the benchmark was derived from these criteria or from people with a similar salary in the private sector. In view of the time at which we received the IDS study and its limited scope, we cannot place any weight on it.

6.51 If we were in future to take the value of the total reward package into account in reaching our recommendations, we would at least want to see the following types of evidence:

- the value of packages to *individual* employees and how this develops in response to changing circumstances (e.g. age, family responsibilities). Clearly, the value to employees cannot just be assumed to be equal to the cost to employers;
- valuing intangible benefits, i.e. those that do not involve a quantifiable cost to the employer or benefit to the employee.

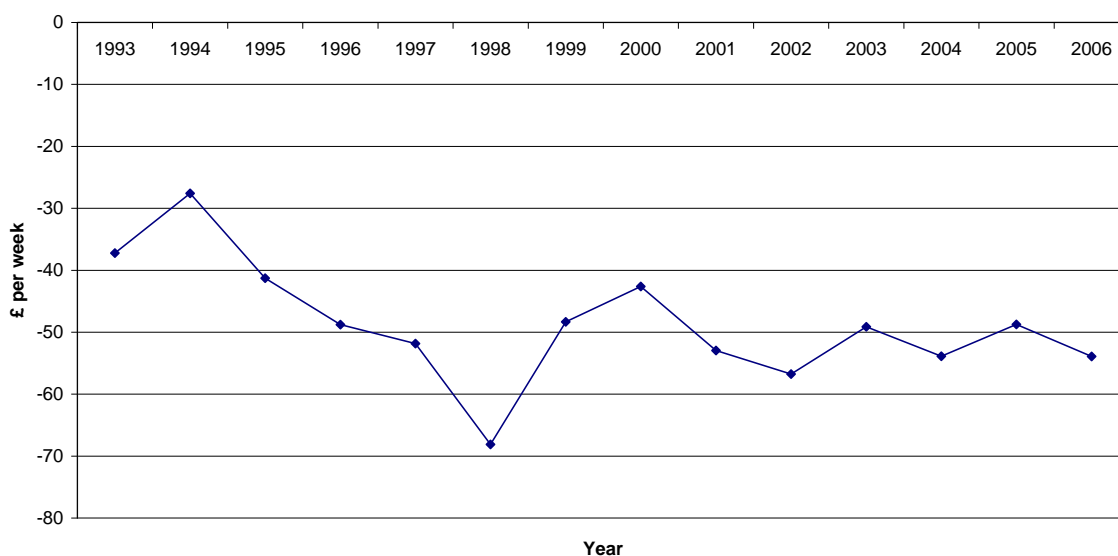
6.52 In the meantime, an alternative approach is to look at the pay of comparable *people* rather than looking at comparable *jobs*. In this respect we note the conclusions of recent work carried out by the OME updating previous research that it published in 2005, and referred to in our 2006 report. Part of this research uses Labour Force Survey data to control for workforce characteristics (age, gender, education, location) to carry out a like for like comparison of the pay of NHS nursing staff with that of employees sharing the same characteristics in the rest of the economy. The results are shown in *Figure 6.8* below and the full report can be found on the OME website<sup>54</sup>. The graph shows, in £ per week, the discrepancy between the average pay of nurses and midwives working in the NHS and the average pay of a 'representative' worker with similar skills and other characteristics working

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<sup>54</sup> [www.ome.uk.com](http://www.ome.uk.com)

elsewhere in the economy. The negative amounts, which have remained roughly constant since the early 1990s, show that the average pay of this group within our remit group lies somewhat below that of comparable workers. Whilst we have some reservations about this approach and we would certainly not put any reliance on the precise numbers, it does paint a reasonably consistent picture over the years suggesting that the average earnings of nursing staff are below that of equivalent employees elsewhere. This suggests, to some extent at least, the relative value of the rest of the nursing employment package is already factored into their pay rates.

**Figure 6.8: The difference between average pay of nurses and midwives and that of other workers with similar characteristics**



Source: OME: the earnings of workers covered by Pay Review Bodies, Makepeace & Marcenaro-Gutierrez 2005; and updated by OME in 2007

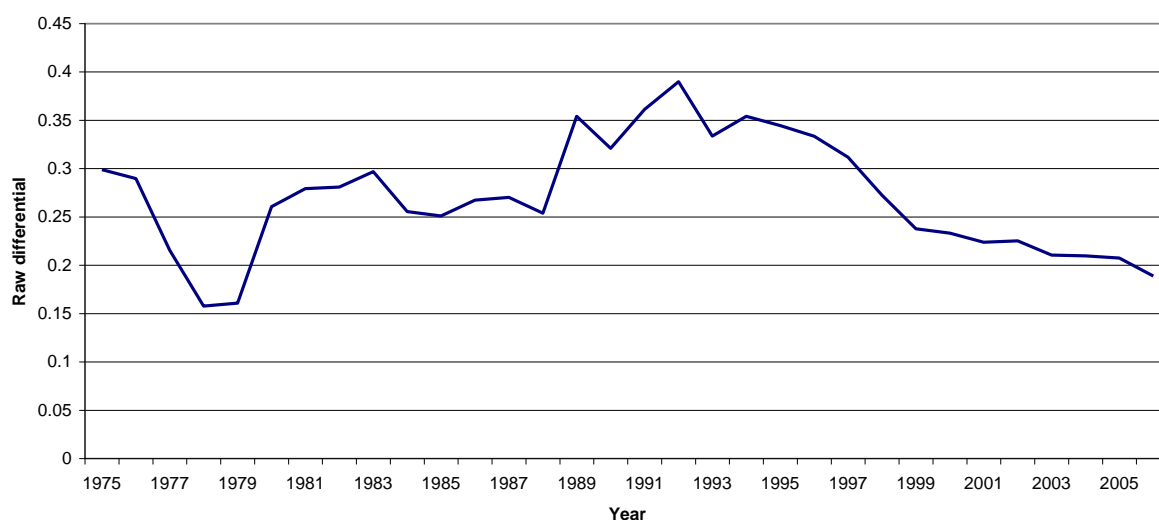
6.53 Another way of looking at comparable people is to compare nurses with those who have been or could be nurses. This is what we do below in *Figure 6.9*. Here we look at the pay of members of our remit group relative to those who have exited or who subsequently join our remit group – the argument being that the pay of ‘entrants’ and ‘exitors’ relative to ‘stayers’ gives an immediate guide to the value of alternative options that are available to our remit group.

6.54 We have repeatedly asked the Departments for information from employment records on the previous job information of entrants, and subsequent job information of exitors, from our remit group, in order to make this type of comparison. The Departments, while agreeing that such information would be valuable, have been unable to provide it. In order to undertake such an analysis, what is required is information that tracks the same workers from

period to period (known as ‘panel’ data) rather than a series of snapshots of different workers at different points in time.

6.55 The NES/ASHE is just such a panel, and it has proved possible to use this data to identify a significantly large sub-set of our remit group – female nurses and midwives working in the NHS – and to compare their average earnings over time with those of a ‘control’ group of exitors and entrants, that is workers who are undertaking other jobs at the point of comparison but who can be identified as having been in the past or will be in the future nurses and midwives in the NHS. *Figure 6.9* measures the difference between the average pay of female nurses and midwives working in the NHS in any given year from 1975 to 2006 and the average pay of women working in the private sector who are identified as working in *some other year* of the data as a public sector nurse or midwife. So, for example, in 2006 the average nurse earned just under 20 per cent more than the comparator group, as compared to 1991 when the average nurse earned 35 per cent more than the comparator group. Some of this comparator group may at the point of comparison be working as a nurse in the private sector, but the majority have other jobs, varying from cleaners to office managers. In the earlier decades, the year-on-year change in this average differential reflects closely various public sector pay policies and pay restructuring. However, from the early 1990s until 2006, the positive raw ‘premium’ to public sector nurses and midwives is eroded almost continuously relative to the comparators, notwithstanding the AfC pay reform. This implies that, although AfC raised nurses’ and midwives’ pay, the pay of the comparator group rose faster (and our further investigation suggest that this did *not* arise from faster pay growth among private sector-employed nurses and midwives).

**Figure 6.9: Pay of female nurses and midwives in the public sector - relative to all female workers in the private sector who have ever been or will become nurses or midwives**



Source: Calculated from NES/ASHE panel data

6.56 Much of the difference in pay between nurses and the comparator group stems from differences in skills, qualifications and the jobs they do and this may be changing over time – for example, the decline in relative pay of NHS nurses and midwives in the last decade could have arisen because of the use of less qualified staff or the appointment of younger, lower paid staff. Indeed the changing relative pay of NHS nurses and midwives may *induce* changes in the quality of the respective workforces, as noted in the context of teachers by Nickell and Quintini<sup>55</sup> (2002). By using statistical techniques, it is possible to adjust the differential to allow for the changing composition of workers in the NHS sector relative to the composition of the comparator group of exitors and entrants<sup>56</sup>. When this adjustment for composition is made, the pay differential remains roughly constant from 1997 to 2006 at around 15 per cent. Therefore whether we adjust for the changing composition of the NHS workforce or not, it is apparent that the pay of female nurses and midwives in the NHS relative to the natural comparators of exitors and entrants has at best remained constant.

6.57 On comparative earnings, there is no evidence that our remit group has done better than average in recent years when compared to other, similar, workers, notwithstanding the introduction of AfC. AfC has led to significant above average pay increases for some groups within our remit, but this is not the case for our remit group as a whole.

<sup>55</sup> Nickell, S and Quintini, G. The Consequences of the Decline in Public Sector Pay in Britain: a little bit of evidence. *Economic Journal* 112. F107-18. 2002.

<sup>56</sup> For details see R. Disney and A. Gosling ‘Changing public sector wage differentials in the UK’, Institute for Fiscal Studies Working Paper 2008/02.

6.58 In terms of pay and earnings, there is general agreement in the evidence that pay drift is 1.5 per cent.

6.59 The evidence that we have received and collected on pay and prices, coupled with the macroeconomic outlook, suggest a good deal of uncertainty as to the future path of key economic variables. Inflation indicators are likely to be above target in the near term before falling later in the year.

6.60 We take note of these findings in discussing our recommendations in Chapter 7.

## CHAPTER 7 – LEVEL AND STRUCTURE OF 2008-09 PAY RECOMMENDATIONS

### Introduction

7.1 The evidence reviewed in the earlier chapters sets the broad context within which we consider our pay recommendations. In this chapter we outline the evidence we have received from the parties concerning the overall level and structure of our basic pay award. Issues around geographical and occupational pay differentiation are dealt with in Chapter 3.

7.2 We have reviewed the evidence on equal pay and related equality issues in Chapter 1. No issues requiring action were raised with us this year and we have outlined in earlier reports<sup>57</sup> the process by which we will address them in the future.

### Evidence from the Parties

#### *The Health Departments*

7.3 The **Health Departments** confirmed that they were seeking a single year recommendation from us and each country supported a two per cent increase for our remit group.

7.4 The **Department of Health** said that it judged average earnings growth of 4.6 per cent in 2008-09 to be affordable and that given the wider evidence available, it also judged that a basic uplift of two per cent was an appropriate adjustment to the Agenda for Change (AfC) structure. The Department said that this figure was sufficient to recruit, retain and motivate the staff needed to meet forecast future demand, taking into account current low vacancies and the excellent overall remuneration package, including retention of the final salary pension scheme. Any recruitment and retention problems tended to occur at hotspots and the general pay award was not the most cost-effective manner of dealing with them. The Department told us that the recurrent costs of a two per cent uplift were affordable in the next, much tighter, Comprehensive Spending Review (CSR) period and that two per cent struck the right balance between spending on pay and spending on improved service delivery. It also took account of the need to maintain public sector pay policy and protect macro-economic stability.

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<sup>57</sup> Twenty-First Report on Nursing and Other Health Professions 2006 and Twenty-Second Report on Nursing and Other Health Professions 2007 – available on the OME website: [www.ome.uk.com](http://www.ome.uk.com)

7.5 We were urged not to misinterpret the forecast surplus for 2007-08 in England as a signal that the NHS could afford higher pay rises. Financial balance was not uniform across the NHS with a significant minority of NHS organisations<sup>58</sup> still facing serious financial challenge and a surplus of around 0.5 per cent (around £500 million) being maintained year on year as a cushion. The Department stressed that continued service improvements would be jeopardised by higher pay recommendations, possibly resulting in job losses.

7.6 Although we had not been persuaded in the past to take account of pay progression in assessing headline pay increases, the Department said it remained convinced that the prospect of significant incremental progression softened the impact of below inflation pay awards. This was particularly relevant in the NHS where most staff joined to pursue a full career and where many staff on AfC contracts would see rises of between two per cent and nearly seven per cent without any increase in headline pay. The Department said that careers for nurses and other healthcare professionals on AfC contracts remained attractive and it had no evidence on which to take a different view of the situation for the ex-Pay Negotiating Council (PNC) staff groups.

7.7 The Department said that the AfC pay framework should not be altered at present as the NHS needed more time to explore the opportunities offered through the Knowledge and Skills Framework (KSF) and use of local recruitment and retention premia (RRPs).

7.8 Responding to the joint Staff Side proposal (see further below) for all clinical professional registration fees to be paid by the employer, the Department said that it did not support the introduction of a contribution to registration costs.

7.9 Responding to UNISON's proposal for a flat rate increase for staff in pay bands 1 to 3 (see further below), the Department said it did not support the proposal on a number of grounds. The Department said its vacancy survey showed that vacancy rates for both qualified and non-qualified staff had both fallen to a low of 0.6 per cent in 2007 demonstrating a healthy recruitment and retention picture for all non-medical staff. The trades unions supported the AfC principles of equity. A flat rate increase could distort the pay structure whereas a uniform percentage uplift aligned with AfC principles. The

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<sup>58</sup> 25 organisations, as reported on 30 November 2007 by the Director General for NHS Finance, Performance and Operations, in *The Quarter, 2007-08*, see [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_080967](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080967)

Department said that the NHS offered competitive reward packages for all staff. Only about one per cent of staff were at the bottom of AfC band 1 and they were paid 12.8 per cent above the national minimum wage. They also had access to other benefits such as the NHS final salary pension scheme, incremental progression and clear career pathways. Finally, the Department said it was unaware of any employers having difficulty recruiting at these grades because of the pay levels. Individual employers could use local RRP, funded by the Market Forces Factor element in the tariff, if they were experiencing local difficulties.

7.10 Responding to Unite's (Amicus) proposal (see further below) for a reduction in the working week for NHS staff to 35 hours, the Department said that it did not support the proposal. The 2.5 hour reduction would mean a 6.5 per cent reduction in workforce capacity which would be very costly and unsustainable without offsetting gains elsewhere.

7.11 The **Scottish Government Health Directorates** (SGHD) said that its resources would be increasing at a significantly lower level over the next three years, but a two per cent pay rise was affordable. Staff numbers for both our former remit group and the ex-PNC staff groups were increasing and vacancy levels were decreasing. The SGHD emphasised that pay was just part of the overall reward package needed to recruit, retain, incentivise and motivate the workforce. It was not a stand alone issue.

7.12 The **Welsh Assembly Government** (WAG) said that in view of the impact of the CSR07, no recruitment and retention problems and with vacancy rates continuing to fall across the board, a two per cent increase was recommended for our remit group.

7.13 The **Department of Health and Social Services & Public Safety in Northern Ireland** (DHSSPSNI) said that the Northern Ireland Executive was committed to implementing UK national pay policy and the Department of Health's rationale for a pay settlement in the region of two per cent should apply to Northern Ireland, although the Executive reserved its position.

#### *NHS Employers (NHSE)*

7.14 **NHSE** said employers did recognise that the level of the pay uplift needed to take account of cost of living pressures and the impact on staff morale, but organisations would also have to deliver efficiency gains over and above the new CSR target of three per cent to finish the financial year in balance. NHSE suggested that an award of up to two per cent was

affordable. With the cost of incremental progression adding a further 1.6 per cent to the pay bill (according to the Department of Health's figures), NHSE believed that average earnings growth of around 3.6 per cent was the most that would be affordable, although this would be challenging and require additional efficiency savings or cost reductions.

7.15 We were told that employers favoured a generic percentage increase for AfC staff and had almost unanimously wanted medical and non-medical staff to receive the same pay award. A significant number of employers had supported targeting extra pay to staff in the lowest pay bands, but NHSE said that the deal negotiated with the unions to settle the 2007-08 pay round had already targeted extra pay to those working in the lowest pay bands through a flat rate increase. Affordability for all NHS Trusts was linked to the level set for pay in the 2008 tariff (with those not covered by the tariff being subject to similar financial constraints) and further cost pressures through unfunded pay increases would almost certainly impact on services and be likely to lead to a reduction in posts, vacancy freezes, an adverse impact on planned growth and reduced capacity. NHSE stressed that time was needed to allow AfC to settle down and for the NHS to realise the benefits of the new pay system. There was no support amongst employers for changes to the structure of the pay system.

7.16 With regard to Unite (Amicus)'s proposal on employers paying clinical professional registration fees, NHSE told us that all parties had agreed to review the current £38 payment in 2010 and there were no plans to look at the issue beforehand. On Unite's proposal to reduce the working week to 35 hours, NHSE said that employers would have real concerns on affordability and productivity grounds alone. Alongside the efficiency savings already required, a cut in working hours would not be sustainable without offsetting gains elsewhere.

### *Staff Bodies*

7.17 In their joint evidence, the **Staff Side** said that last year's award had been significantly below the rate of inflation and had failed to compensate staff for the big increases in their cost of living, while staging of the award in England had reduced its value even further. We were told that there was strong evidence and widespread acceptance that the morale of NHS staff had fallen and continued to fall and research had shown that dissatisfaction with pay ranked as a major reason why staff felt unhappy and demotivated. In the Incomes Data Services NHS Staff Survey, 93 per cent of respondents had thought the 2007 award of 2.5 per cent was low or very low, with 94 per cent believing that staging was

unfair. The Staff Side considered that a significant pay increase would go a long way towards restoring morale and making staff feel valued.

7.18 The Staff Side believed that the lower staff turnover rates this year were due to continuing recruitment freezes and measures to reduce staff costs which together had temporarily hidden the higher rates of former years. NHS finances had now recovered to create a net surplus and CSR07 had been relatively generous to the NHS. Furthermore, NHS productivity was improving significantly and a target of three per cent per annum had now been incorporated into plans for the CSR07 period. The Staff Side considered that such gains should be shared by staff and reflected in their pay.

7.19 The Staff Side said that their evidence presented a compelling case for a pay award significantly above inflation (Retail Prices Index (RPI)) for 2008-09. Commenting on the Department of Health's remarks that improvements in pay through the introduction of AfC had helped the NHS along its journey of transformation, the Staff Side said that two consecutive below inflation awards would take the whole process backwards. Staff Side stressed that they continued to support the UK-wide AfC agreement and asked us to recommend a pay uplift that applied uniformly to NHS staff across the UK.

7.20 Staff Side also stressed that there was a growing imbalance and inequity between the pay of NHS staff and that of those in comparable roles in the public and private sector and the more this gap grew, the more NHS staff would feel undervalued and demotivated. We were asked to address this pay imbalance in our recommendations.

7.21 The Staff Side also asked us to recommend that where clinical registration was a mandatory requirement of practice, the registration fees should be paid by the employer for all NHS staff in the UK. This followed the Department of Health's accepted proposal this year for payment of £38 per year towards professional registration fees for clinical staff in bands 5-8A until 2010.

7.22 **UNISON** told us that its Pay Survey had indicated that the majority of ancillary staff were in pay band 1 or 2 while the majority of administration and clerical staff were in bands 2-4. Whilst UNISON recognised that restructuring AfC pay bands was not within our remit, it believed, with reference to the wider debate on income poverty, that the abolition of band 1

was a necessary step towards achieving UNISON’s “living wage” target of £6.75 per hour. Abolition would mean a minimum hourly rate of £6.43.

7.23 UNISON said that it was in favour of “mixed” pay awards/settlements comprising both a flat rate and a percentage based increase. This was because percentage based increases enabled higher paid staff to accommodate cost of living increases with less effect on their standard of living. They also maintained pay differentials. UNISON said there should be a flat rate increase for pay bands 1-3 inclusive which was equal to any percentage based increase to pay point 14. The overall award should also restore the value of wages eroded by last year’s below-inflation award. The **GMB** said it supported UNISON’s call for a flat rate increase for pay bands 1-3.

7.24 **Unite (Amicus)** said it was also seeking a recommendation for a reduction in the working week for NHS staff to 35 hours in order to tackle the increase in staff workload.

7.25 The **Royal College of Midwives (RCM)** asked that we recommend that midwives in England who had lost money compared to those in Scotland, Wales and Northern Ireland as a consequence of last year’s staged award should be compensated for their lost earnings. We should also consider the implications for midwives in other countries of the payment of a proportion of professional registration fees in England.

7.26 The **Northern Ireland Public Service Alliance (NIPSA)** called for our recommendations to restore the cuts in real pay for AfC staff and to provide for a 2008 pay increase that at least matched the average growth in whole-economy earnings.

### **Our Comment**

7.27 We are grateful to the parties for setting out their preferred options regarding the level and structure of this year’s award. This has helped us to simplify the nature of our review and to establish the parameters within which to consider the other evidence we have received. At one end, the Health Departments and NHSE have asked for a recommendation of no more than two per cent. At the other, the majority of the staff side bodies are seeking an uplift significantly above the current rate of RPI. We note the general agreement that we should recommend an award for one year only and we have received evidence from the parties only on that basis.

7.28 We also note that the Health Departments and NHSE want no changes to the structure of the pay system this year, whereas the Staff Side are seeking a reduction in the number of incremental points in the AfC pay scales. Our comments on this proposal were set out in Chapter 1.

7.29 In addition, the Staff Side have sought a recommendation that clinical professional registration fees should be paid in full by employers across the UK. Leaving aside the apparent contradiction of the Department of Health's rejection of the principle of employers paying these fees, but in fact paying £38 towards them as part of its pay deal last year, we have seen no evidence to suggest a need to pre-empt the planned review of the current arrangement in 2010. We note that the £38 is currently being paid in England only. Whether the planned review decides to maintain, extend or scrap any payment, we would ask the parties to ensure that it involves representatives from all four countries.

7.30 UNISON and the GMB have proposed a flat rate pay uplift for our remit group in pay bands 1, 2 and 3. Unite (Amicus) has also proposed that all staff should move to a 35 hour week. These proposals are not supported by the Health Departments or by NHSE. As we said in Chapter 1, until implementation of AfC is complete and it becomes possible to assess the costs of the AfC structure and its impact on recruitment, retention and morale, there is no evidential basis on which we can recommend any structural changes to it. The targeted award for lower paid staff which formed the core of the eventual settlement of the 2007-08 pay round was the result of specific negotiations between the parties. There is no common agreement amongst the parties this year for us to take this same approach for 2008-09 and we do not consider it appropriate to do so without more robust evidence demonstrating a labour market need to target pay bands 1-3. We will of course consider any such evidence presented to us for future reviews.

### **Summary and Conclusions**

7.31 In summary, the **Department of Health** makes the case that a basic pay uplift of two per cent is sufficient to recruit, retain and motivate the staff needed by the NHS. A majority of staff will continue to benefit from incremental progression next year on top of the basic pay uplift and NHS staff also benefit from an excellent total pay and benefits package, including the NHS Pension Scheme. We should not rely on the projected surplus of £1.8 billion in 2007-08 to fund the pay uplift as this money is non-recurring and is already committed or needed for other service priorities. Average long-term pay drift for our remit

group is now estimated to be 1.5 per cent and we should take this, plus the full year effect of this year's staged award and costs such as the new unsocial hours scheme, into consideration when assessing affordability. The tariff uplift for 2008-09 is based on a pay uplift for our remit group of two per cent. Anything higher would jeopardise service delivery and possibly result in job losses. A pay uplift of two per cent takes account of the need to maintain public sector pay policy and protect macro-economic stability. The **SGHD**, the **WAG** and the **DHSSPSNI** all support the Department's proposed two per cent uplift, despite their own affordability positions being much tighter under CSR07, as they are concerned to maintain a UK-wide pay structure. **NHSE** believes that a pay uplift of up to two per cent is affordable, but will require efficiency savings above the new target of three per cent in 2008-09. How difficult these will be to achieve will vary according to each individual NHS organisation.

7.32 The joint **Staff Side** evidence stressed that last year's pay award did not compensate staff for rising living costs, and pay is now a major reason why staff feel unhappy and demotivated. The Health Departments' official data on vacancy levels continues to be misleading because of Trusts' actions to tackle financial deficits which have resulted in vacancy freezes, job cuts and redundancies. Last year the Department of Health argued for a low award because of the need to rectify financial deficits. Given the projected surplus for this year of £1.8 billion, the Department could not argue that none of it was available to fund the pay award. Staff should be rewarded for their part this year in turning round the deficit and for their contribution next year to meeting the higher efficiency target of three per cent. A pay uplift significantly above the RPI was sought to recognise the current level of low morale, to retain staff currently in the service and to continue to attract new recruits, to recognise the recent increases in the costs of living and to go some way to addressing the pay gap between NHS staff and comparator groups.

7.33 We make our recommendations in line with our terms of reference which are specified in the preface to this report. In considering the pay uplift for 2008-09, we have paid particular regard to the need to recruit, retain and motivate suitably able and qualified staff, the funds available to the Health Departments and the Government's inflation target. We have reviewed the evidence on equal pay and other issues in Chapter 1. No issues requiring action were raised with us this year and we have previously outlined the process by which we will address them in the future. The issues raised with us relating to regional/local variations in labour markets were not designed to impact on our general award. We noted in paragraphs 1.3 and 5.1 that the Health Departments did not specifically address the new requirement in

our remit that we should have regard to 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. We would remind the Health Departments in particular that if we are to give full consideration to this new aspect of our remit, they must provide us with more detailed evidence which goes beyond the simple suggestion that there is a trade-off between the delivery of enhanced services and higher pay for staff.

7.34 The Health Departments and employers have emphasised the currently healthy recruitment and retention position and the need for an award that is affordable. The Staff Side have emphasised deteriorating morale and increased workload pressures as threats to the future recruitment and retention position and, therefore, the need for an award that recognises the concerns of staff. In reaching our conclusions, we have sought to maintain the relative position of the pay structure, balancing the effect of our recommendation both on those who continue to advance up the pay scale and on those who have reached the top of their pay band. **We recommend an increase in the Agenda for Change pay rates of 2.75 per cent from 1 April 2008.** Our reasoning is set out below.

7.35 We begin our considerations by looking at the position on recruitment, retention and morale. As discussed in Chapter 2, although the current recruitment and retention position suggests no lack of supply of labour of the required quality in general, some difficulties appear to be emerging for certain groups. We must therefore look beyond the immediate position and take a longer-term view. There may be no widespread recruitment and retention problems apparent now, but the improvements in vacancy and wastage rates still probably owe much to Trusts' ongoing reactions to the financial problems in the NHS in recent years. The figures may not reflect the NHS's longer-term ability to recruit and retain a skilled workforce. It is for this reason that we believe a pay award above that sought by the Health Departments is necessary.

7.36 Our view is strengthened when we consider the evidence on morale. This has several strands. First, we cannot ignore the evidence on declining levels of morale within the NHS, discussed in Chapter 4. The staging of last year's pay award in England appears to have brought various staff grievances into sharper focus and thus exacerbated its impact. As we have commented in previous years, declining morale will have an adverse effect both on the NHS's ability to meet service delivery targets and on its ability to recruit and retain staff in the longer term. Second, we noted in Chapter 1 that some 24 per cent of staff (around

300,000 people) are at the top of their pay bands and will not benefit from increments. They will, therefore, receive only the basic pay award and an award below the current rate of inflation, even as measured by the CPI, would further erode the morale of this important, experienced group. This erosion is likely to be compounded by the fact that many employers have failed to implement the KSF and the (already worryingly low) proportion of staff receiving even an appraisal appears to have fallen. KSF is intended to be the route whereby staff and their managers are able on an annual basis to identify development needs and agree how learning will be supported. Development objectives may include the acquisition of skills and knowledge in preparation for higher graded posts, an aspect of KSF which is particularly important to those at the top of their pay bands and essential to service delivery. Until KSF is fully implemented neither the NHS nor its staff will reap the benefits that AfC was designed to deliver. We regard this as a key issue to be addressed. Finally, we are mindful of the role of staff, many of whom have faced increased workloads, in achieving the turnaround of the NHS finances and the 2.5 per cent efficiency saving this year. We believe that the pay award should recognise the contribution made by staff to these improvements.

7.37 We discussed in Chapter 5 the efficiency savings targets set by the Health Departments. **We recommend that the Departments report back to us each year using a standardised and comparable format on how these efficiency savings have been measured and achieved and how staff have contributed to the achievement of those targets.**

7.38 Given our belief that we should not allow AfC pay scales to slip significantly out of line with the wider market, we have looked at pay settlements and earnings elsewhere in the economy. The interquartile range for settlements in the economy as a whole is currently between three and 3.5 per cent, with public sector settlements running somewhat lower than this. Earnings growth in the private sector is around four per cent and in the public sector around 3.3 per cent. We are also conscious that real incomes across the board are likely to be squeezed over the coming year as the economy adjusts to higher energy and import prices. Taking these factors into account, a pay award of 2.75 per cent, while below the current economy-wide settlement median, would, once combined with likely levels of pay drift, lead to an increase in average earnings at least in line with the economy-wide average.

7.39 Our terms of reference require us to have regard to the Government's inflation target and Government evidence has emphasised the danger that high public sector pay awards

would threaten the achievement of that target and endanger macro-economic stability. We have yet to see the economic rationale for the view that public sector pay in general, and the pay uplift of our remit group in particular, at the levels being considered would threaten macro-economic stability. We have certainly seen no evidence which would support that view. We also note that the public sector pay settlements agreed in the last pay round are now delivering average public sector earnings growth well below the private sector and well within the levels the Bank of England believes is compatible with achieving the inflation target. We believe that our recommendation of 2.75 per cent is consistent with the Government's inflation target.

7.40 Finally we consider whether our recommendation is affordable within the funds available to the Health Departments, as set out in the Government's Departmental Expenditure Limits (DELs). We consider first the position in England where we have the most detailed information. As we discussed in Chapter 5, although we have received more detailed "affordability" evidence this year, we are no clearer as to how the figures it contains were reached. We were not satisfied with the Department of Health's explanation as to how it came to the conclusion that a two per cent pay uplift was the limit of what the NHS could afford in 2008-09, nor is it sufficient to tell us that this is the figure that has been used to calculate the tariff. Once again this year, we must reiterate the point that for us to be constrained by a pre-determined figure contained in the Health Departments' budget or in the tariff would amount to a total abdication of our responsibilities, as defined by our remit. Our recommendations in the last two years have given considerable weight to the Department's affordability concerns, particularly as the service as a whole was running a deficit. This year the evidence we have seen suggests that the pressures on affordability have lessened and the service as a whole is in surplus, suggesting some increased scope for pay uplifts. At the same time we recognise that there will always be competing demands for the funding available to the NHS, that there will be a reduction in the overall level of increase in funding for health under CSR07, and that the NHS is facing demanding service delivery targets. We have tried to balance these factors in making our judgement. In doing so we note that adding the long term average figure for pay drift of 1.5 per cent to our recommended pay uplift produces a figure which is consistent with the growth in pay bill per head that we have been told would be affordable by the Department of Health.

7.41 The evidence we have received from Scotland, Wales and Northern Ireland suggests that they will be facing tighter affordability constraints than England, although other factors,

such as pay drift, may vary. These tighter budgetary positions have not led them to propose a lower pay uplift than in England. This is no doubt driven by their wish to maintain a common national pay structure throughout the UK. It does, however, suggest that what is affordable is more a matter of choice than arithmetic.

7.42 These are the factors that we have balanced in coming to our judgement that the pay uplift for 2008-09 should be 2.75 per cent. Even though the DELs for Scotland, Wales and Northern Ireland are due to increase by a smaller amount than in England, each of the Health Departments has argued for the same award. We have therefore been given no reason to differentiate between the countries in making our recommendation. Given this wish to retain a common pay structure throughout the UK, **we recommend that Northern Ireland aligns its pay scales by 31 March 2008 to reflect the uplift which was eventually implemented in England, Scotland and Wales for lower paid staff in 2007-08.**

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

7.44 Finally, the evidence we received from the parties asked that we recommend for one year only. Although we are aware that discussions have been taking place about a multi-year deal, we have not been asked to recommend for more than one year. Our recommendations are therefore in respect of pay year 2008-09.

## **COVERAGE OF THE NHS PAY REVIEW BODY (NHSPRB)**

The NHSPRB's recommendations currently apply to all staff employed in the NHS<sup>59</sup>, with the exception of doctors, dentists and very senior managers.

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<sup>59</sup> Paid under Agenda for Change.

## RECOMMENDED LEVELS OF HIGH COST AREA SUPPLEMENTS

Area	Level at <i>(31<sup>st</sup> March 2008)</i> <sup>1</sup>	Recommended level <i>(1<sup>st</sup> April 2008)</i>
Inner London	20% of basic salary, subject to a minimum payment of £3,752 and a maximum payment of £5,779	20% of basic salary, subject to a minimum payment of £3,855 and a maximum payment of £5,938
Outer London	15% of basic salary, subject to a minimum payment of £3,174 and a maximum payment of £4,045	15% of basic salary, subject to a minimum payment of £3,261 and a maximum payment of £4,156
Fringe zone	5% of basic salary, subject to a minimum payment of £867 and a maximum payment of £1,503	5% of basic salary, subject to a minimum payment of £891 and a maximum payment of £1,544

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<sup>1</sup> *the national parties to the pensions review agreed that the minimum level of HCAS payments would increase by £284 in Inner and Outer London (but not the Fringe) at 31 March 2008. The current level figures therefore reflect this.*

## APPENDIX C

### FULL TIME EQUIVALENT STAFF NUMBERS AT SEPTEMBER 2006\*

#### Nursing, midwifery and health visiting staff

	ENGLAND		SCOTLAND		WALES		NORTHERN IRELAND		GREAT BRITAIN	
	Number	%	Number	%	Number	%	Number	%	Number	%
Qualified staff	307,447	77.2	41,026	72.2	21,042	75.4	13,825	77.0	383,340	76.5
Support staff	90,765 <sup>1</sup>	22.8	15,758 <sup>2</sup>	27.8	6,859 <sup>3</sup>	24.6	4,141 <sup>4</sup>	23.0	117,523	23.5
Total	398,212	100	56,784	100	27,901	100	17,966	100.0	500,863	100.0

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

	ENGLAND		SCOTLAND		WALES		NORTHERN IRELAND		GREAT BRITAIN	
	Number	%	Number	%	Number	%	Number	%	Number	%
Qualified AHP staff <sup>(5)</sup>	50,561	34.9	6,636	35.0	3,732	36.8	2,761 <sup>7</sup>	44.5	63,690	35.3
Qualified ST&T staff <sup>(6)</sup>	63,931	44.1	8,461	44.6	4,736	46.7	3,450 <sup>8</sup>	55.5	80,578	44.7
Support to AHP and ST&T staff	30,407 <sup>9</sup>	21.0	3,854 <sup>10</sup>	20.3	1,664 <sup>11</sup>	16.4	- <sup>12</sup>	0.0	35,925	19.9
Total	144,899	100	18,951	100	10,132	100	6,211	100	180,193	100

#### Ambulance staff

	ENGLAND		SCOTLAND		WALES		NORTHERN IRELAND		GREAT BRITAIN	
	Number	%	Number	%	Number	%	Number	%	Number	%
Ambulance Paramedics	15,723 <sup>13</sup>	58.4	- <sup>14</sup>	-	1,404 <sup>13</sup>	97.2	903 <sup>15</sup>	92.0	18,030	61.4
Support to Ambulance staff	11,209 <sup>16</sup>	41.6	- <sup>14</sup>	-	40 <sup>16</sup>	2.8	79 <sup>16</sup>	8.0	11,328	38.6
Total	26,932	100	- <sup>14</sup>	-	1,444	100	982	100	29,358 <sup>14</sup>	100

#### Support staff

	ENGLAND		SCOTLAND		WALES		NORTHERN IRELAND		GREAT BRITAIN	
	Number	%	Number	%	Number	%	Number	%	Number	%
Healthcare assistants	100,051	100	- <sup>17</sup>	-	9,094	100.0	- <sup>17</sup>	-	109,145 <sup>17</sup>	100

#### Infrastructure support

	ENGLAND		SCOTLAND		WALES		NORTHERN IRELAND		GREAT BRITAIN	
	Number	%	Number	%	Number	%	Number	%	Number	%
Total infrastructure support <sup>(18)</sup>	174,871 <sup>19</sup>	100	36,960 <sup>20</sup>	100	16,201 <sup>21</sup>	100	17,461 <sup>22</sup>	100	245,493 <sup>23</sup>	100

Sources: NHS Information Centre Non-medical workforce census, England; Scottish Government Health Directorates, Scotland; National Assembly for Wales, Wales; Department of Health, Social Services & Public Safety, Northern Ireland.

\* Except Northern Ireland whose data refers to March 2007.

### **England**

1. Includes nursing assistants / auxiliaries and nursery nurses.
9. Includes support ST&T staff.
13. Includes managers, paramedics and qualified ambulance personnel.
16. Includes ambulance trainees.
19. Excludes the estimated 3,000 senior managers not included in the NHSPRB remit.

### **Scotland**

2. Includes all non-registered nursing and midwifery staff including healthcare assistants, nursing assistants / auxiliaries and nursery nurses.
10. Includes all assistants, unqualified staff and those in training.
14. Due to a discrepancy in their data, Scottish Ambulance Service data are currently unavailable.
17. Scotland and Northern Ireland healthcare assistants are included within support to each profession.
20. Excludes the estimated 1,200 senior managers not included in the NHSPRB remit.

### **Wales**

3. Includes nursing assistants / auxiliaries and nursery nurses. Also includes nurse learners, as they are not specifically identified in the Welsh figures.
11. Includes helpers / assistants and students / trainees.
13. Includes managers, paramedics and qualified ambulance personnel.
16. includes ambulance trainees.
21. Excludes the estimated 216 senior managers not included in the NHSPRB remit.

### **Northern Ireland**

4. Includes nurse support staff, student midwives and student health visitors.
7. Excludes art / music / drama therapy.
8. Excludes art / music / drama therapy.
12. Support workers are included in the qualified AHP and ST&T figures, as they cannot be separately identified.
15. Includes managers, all ambulance personnel and others.
16. Includes ambulance trainees.
17. Scotland and Northern Ireland healthcare assistants are included within support to each profession.
22. Excludes the estimated 197 senior managers not included in the NHSPRB remit.

### **All**

5. Includes qualified AHP workers in the following professions: Chiropody, Dietetics, Occupational Therapy, Othoptics/Optics, Physiotherapy, Radiography, and Art/Music/Drama Therapy.
6. Includes qualified ST&T workers in the following professions: Speech and Language Therapy, Multi-therapies, Clinical Psychology, Psychotherapy, Pharmacy, Dental, Operating Theatres, Social Services, Other ST&T staff and all Qualified Healthcare Scientists.
18. This figure includes all staff who used to be included under the Pay Negotiating Council and consists of Ancillary staff (for example, cleaners and porters), Administration and Clerical staff (for example, receptionists and office support staff), Maintenance and Estates staff (for example, plumbers and builders) and Other staff (for example, staff working in IT, HR or finance and chaplains). It is difficult to compare detailed data across countries due to different definitions being used by Health Departments.
23. May be slightly different than the total of tables 1-5, due to rounding.

## THE DEPARTMENT OF HEALTH'S PAY METRICS

### Annex A of the Department of Health's Main Written Evidence, submitted on 1 November 2007

#### Historical figures

1. The historical pay metrics (up to and including 2005/06) have been estimated using pay bill data from NHS financial returns, NHS accounts, and Foundation Trust annual reports, together with workforce statistics from the annual NHS workforce census.
2. Figures for 2006/07 are based on provisional financial returns and Foundation Trust annual reports together with workforce numbers from the September 2006 NHS census. These figures are best estimates based on an incomplete set of returns which are in the process of validation. Figures for 2007/08 are projections (see below).
3. The pay bill figures include all employees of Trusts, Primary Care Trusts, Strategic Health Authorities and Foundation Trusts in England. They do not include agency staff, contractors' employees, GPs, other GP practice staff or family dentists and their staff.
4. The pay bill figures come from the NHS financial returns and Foundation Trust annual reports. The latter do not include a breakdown by staff group, so this has been estimated using the NHS financial returns. Pay bill per full-time equivalent (FTE) employee has been calculated by dividing pay bill by the FTE number of staff.
5. Earnings and earnings per FTE figures have been estimated from the pay bill and pay bill per FTE figures using NHS accounts data together with the NHS Pension Scheme and National Insurance rates and thresholds which apply to NHS employers. These figures have been re-estimated this year to reflect more accurately the appropriate NI rates. This has not changed the all HCHS figures, but has re-distributed NI costs between staff groups. This has resulted in higher earnings and average earnings figures for NHSPRB staff and lower figures for DDRB staff.
6. Some minor changes have also been made to 2004/05 figures. This takes account of some small errors identified in the Financial Returns.
7. Note that, in years when the number of staff in higher paid staff groups has grown by more than the number in lower-paid groups, the average earnings figure for all staff has increased as a result.

8. Pay bill and pay bill per FTE figures had a step increase in 2004/05 when responsibility for the cost of pensions indexation was transferred from the Treasury to NHS employers.

#### Projected figures

9. Figures for 2007/08 and 2008/09 have been projected from the 2006/07 estimates.
10. The workforce FTE figures for each staff group are supply projections produced by the NHS Workforce Review Team for DDRB staff, and demand projections produced by DH for NHSPRB staff. These have been selected as the best available forecasts. Projections for medical and dental groups have been modelled individually, taking into account information on current numbers employed by the NHS, age profiles, historical retirement trends, training numbers, international recruitment, wastage, historical career trends and participation rates as appropriate.
11. Projections for 2007/08 have been calculated for each staff group by applying the general pay uplift, projected workforce growth, estimated earnings drift and estimated on-costs drift to the 2006/07 estimates. Projections for 2008/09 have been calculated in a similar way, based on the 2007/08 projections, but with a range of general pay uplift figures.
12. Earnings drift for each staff group has been estimated using a combination of analysis of historical earnings growth together with estimates of the cost of specific drivers. These drivers include recent and planned NHS pay reform and the forthcoming national changes to minimum holiday entitlement. Other drift will arise from previous changes to national pay arrangements; occupation and grade drift (skill mix change); local pay decisions; and use of other earnings, eg use of overtime, use of recruitment & retention premia and bonuses.
13. The cost of Agenda for Change was estimated before implementation using a complex model based on data from the NHS Earnings Survey. Estimates were made of how the old Whitley grades would map to the Agenda for Change bands and of how each incremental point would map to the new points. It was then estimated how costs would develop over time as staff moved up the incremental points. In addition, estimates were made of the impact of changes to overtime rates, high cost area payments, annual leave and standard hours. Subsequently the impact of assimilation was monitored, first in the Early Implementers and later in a sample of 28 other organisations.
14. On-costs drift has been estimated using the projected earnings per FTE figures together with expected increase in employers' pension contribution rate and the published and expected national insurance rates and thresholds relevant to NHS employers.

Pay metrics for NHSPRB remit (England)

HCHS non-medical Paybill (£million) <sup>1</sup>	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 <sup>2,5</sup>	2005/06 <sup>2</sup>	2006/07 <sup>2,3</sup>	2007/08 <sup>4</sup>	2008/09 <sup>4</sup>				
											0.00%	1.00%	1.50%	1.75%	2.00%
Qualified nursing	5,738m	6,181m	6,699m	7,427m	8,085m	8,677m	9,923m	10,548m	10,971m	11,832m	12,436m	12,562m	12,625m	12,656m	12,687m
Unqual & support <sup>6</sup>	1,934m	2,162m	2,250m	2,512m	2,740m	2,946m	3,406m	3,731m	3,882m	4,184m	4,373m	4,418m	4,440m	4,451m	4,463m
ST&Ts <sup>7</sup>	2,172m	2,379m	2,616m	2,919m	3,199m	3,538m	4,115m	4,452m	4,725m	5,144m	5,370m	5,424m	5,451m	5,465m	5,479m
Admin & Clerical	1,865m	1,989m	2,161m	2,444m	2,724m	3,000m	3,604m	4,007m	4,173m	4,431m	4,501m	4,548m	4,571m	4,582m	4,594m
Main. & works	229m	231m	235m	240m	239m	237m	266m	270m	281m	297m	299m	302m	304m	305m	305m
Ambulance Staff	355m	364m	395m	433m	478m	524m	747m	890m	946m	1,024m	1,101m	1,113m	1,118m	1,121m	1,124m
Managers	952m	1,055m	1,187m	1,331m	1,571m	1,777m	2,247m	2,414m	2,381m	2,521m	2,547m	2,573m	2,586m	2,592m	2,599m
Total remit <sup>8</sup>	13,267m	14,388m	15,588m	17,362m	19,164m	20,825m	24,425m	26,443m	27,497m	29,575m	30,772m	31,085m	31,242m	31,320m	31,398m

Unqual & support - unqualified nursing, HCA and support

Growth in HCHS non-medical Paybill <sup>1</sup>	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 <sup>2,5</sup>	2005/06 <sup>2</sup>	2006/07 <sup>2,3</sup>	2007/08 <sup>4</sup>	2008/09 <sup>4</sup>				
											0.00%	1.00%	1.50%	1.75%	2.00%
Qualified nursing	1.5%	7.7%	8.4%	10.9%	8.9%	7.3%	14.4%	6.3%	4.0%	7.9%	5.1%	6.2%	6.7%	7.0%	7.2%
Unqual & support <sup>6</sup>	13.1%	11.8%	4.1%	11.6%	9.1%	7.5%	15.6%	9.5%	4.0%	7.8%	4.5%	5.6%	6.1%	6.4%	6.7%
ST&Ts <sup>7</sup>	7.0%	9.5%	10.0%	11.6%	9.6%	10.6%	16.3%	8.2%	6.1%	8.9%	4.4%	5.4%	6.0%	6.2%	6.5%
Admin & Clerical	5.6%	6.7%	8.7%	13.1%	11.4%	10.2%	20.1%	11.2%	4.2%	6.2%	1.6%	2.6%	3.2%	3.4%	3.7%
Main. & works	0.3%	0.8%	2.0%	2.2%	-0.8%	-0.5%	12.0%	1.5%	4.1%	5.8%	0.7%	1.7%	2.3%	2.5%	2.8%
Ambulance Staff	6.4%	2.7%	8.6%	9.6%	10.2%	9.6%	42.7%	19.0%	6.4%	8.2%	7.6%	8.7%	9.3%	9.5%	9.8%
Managers	4.5%	10.7%	12.5%	12.2%	18.0%	13.2%	26.5%	7.4%	-1.3%	5.9%	1.0%	2.0%	2.6%	2.8%	3.1%
Total remit <sup>8</sup>	4.8%	8.4%	8.3%	11.4%	10.4%	8.7%	17.3%	8.3%	4.0%	7.6%	4.0%	5.1%	5.6%	5.9%	6.2%

HCHS non-medical Paybill per FTE (£) <sup>1</sup>	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 <sup>2,5</sup>	2005/06 <sup>2</sup>	2006/07 <sup>2,3</sup>	2007/08 <sup>4</sup>	2008/09 <sup>4</sup>				
											0.00%	1.00%	1.50%	1.75%	2.00%
Qualified nursing	23,210	24,661	26,142	27,901	28,947	29,722	32,870	34,274	35,685	37,287	38,317	38,704	38,898	38,994	39,091
Unqual & support <sup>6</sup>	11,198	12,364	12,655	13,529	14,246	14,815	16,980	18,183	20,091	21,002	21,577	21,798	21,908	21,964	22,019
ST&Ts <sup>7</sup>	21,017	22,256	23,701	25,214	26,028	27,210	29,864	30,998	32,606	33,975	34,704	35,057	35,234	35,322	35,410
Admin & Clerical	14,025	14,527	15,192	16,258	17,132	17,473	19,659	20,919	22,443	23,390	23,888	24,133	24,255	24,316	24,378
Main. & works	18,001	18,713	19,586	20,449	20,164	20,682	23,545	24,687	26,783	27,908	28,506	28,796	28,941	29,014	29,086
Ambulance Staff	23,745	23,877	25,100	26,559	27,983	30,006	40,117	45,360	43,591	45,556	46,795	47,279	47,521	47,642	47,763
Managers	43,577	45,114	48,925	50,650	50,806	52,567	62,418	64,289	67,964	70,850	72,354	73,097	73,469	73,654	73,840
Total remit <sup>8</sup>	18,760	19,934	21,082	22,456	23,547	24,334	27,444	28,851	30,583	31,922	32,737	33,070	33,236	33,320	33,403

Growth in HCHS Paybill per FTE <sup>1</sup>											2008/09 <sup>4</sup>				
	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 <sup>2,5</sup>	2005/06 <sup>2</sup>	2006/07 <sup>2,3</sup>	2007/08 <sup>4</sup>	0.00%	1.00%	1.50%	1.75%	2.00%
Qualified nursing	1.0%	6.3%	6.0%	6.7%	3.7%	2.7%	10.6%	4.3%	4.1%	4.5%	2.8%	3.8%	4.3%	4.6%	4.8%
Unqual & support <sup>6</sup>	11.9%	10.4%	2.4%	6.9%	5.3%	4.0%	14.6%	7.1%	10.5%	4.5%	2.7%	3.8%	4.3%	4.6%	4.8%
ST&Ts <sup>7</sup>	3.6%	5.9%	6.5%	6.4%	3.2%	4.5%	9.8%	3.8%	5.2%	4.2%	2.1%	3.2%	3.7%	4.0%	4.2%
Admin & Clerical	4.7%	3.6%	4.6%	7.0%	5.4%	2.0%	12.5%	6.4%	7.3%	4.2%	2.1%	3.2%	3.7%	4.0%	4.2%
Main. & works	4.8%	4.0%	4.7%	4.4%	-1.4%	2.6%	13.8%	4.9%	8.5%	4.2%	2.1%	3.2%	3.7%	4.0%	4.2%
Ambulance Staff	8.1%	0.6%	5.1%	5.8%	5.4%	7.2%	33.7%	13.1%	-3.9%	4.5%	2.7%	3.8%	4.3%	4.6%	4.8%
Managers	2.5%	3.5%	8.4%	3.5%	0.3%	3.5%	18.7%	3.0%	5.7%	4.2%	2.1%	3.2%	3.7%	4.0%	4.2%
Total remit <sup>8</sup>	3.9%	6.3%	5.8%	6.5%	4.9%	3.3%	12.8%	5.1%	6.0%	4.4%	2.6%	3.6%	4.1%	4.4%	4.6%

HCHS non-medical Earnings per FTE (£) <sup>1</sup>											2008/09 <sup>4</sup>				
	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 <sup>2,5</sup>	2005/06 <sup>2</sup>	2006/07 <sup>2,3</sup>	2007/08 <sup>4</sup>	0.00%	1.00%	1.50%	1.75%	2.00%
Qualified nursing	21,042	22,329	23,427	24,733	25,702	26,342	27,697	28,784	29,989	31,374	32,246	32,566	32,726	32,807	32,887
Unqual & support <sup>6</sup>	10,430	11,451	11,609	12,256	12,899	13,394	14,563	15,528	17,123	17,913	18,410	18,593	18,684	18,730	18,776
ST&Ts <sup>7</sup>	19,054	20,181	21,268	22,378	23,138	24,136	25,189	26,062	27,431	28,617	29,239	29,531	29,677	29,751	29,824
Admin & Clerical	12,715	13,327	13,795	14,588	15,376	15,665	16,738	17,745	19,032	19,855	20,285	20,488	20,590	20,640	20,691
Main. & works	16,320	16,976	17,590	18,169	17,959	18,392	19,893	20,790	22,557	23,533	24,044	24,285	24,405	24,465	24,525
Ambulance Staff	21,528	21,566	22,442	23,492	24,792	26,511	33,606	37,750	36,420	38,102	39,155	39,544	39,739	39,836	39,933
Managers	38,485	40,075	43,021	44,135	44,344	45,760	51,581	52,954	56,021	58,444	59,711	60,308	60,606	60,756	60,905
Total remit <sup>8</sup>	17,044	18,124	18,968	19,980	20,968	21,628	23,173	24,275	25,741	26,897	27,591	27,866	28,004	28,073	28,141

Growth in HCHS non-medical Earnings per FTE <sup>1</sup>											2008/09 <sup>4</sup>				
	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 <sup>2,5</sup>	2005/06 <sup>2</sup>	2006/07 <sup>2,3</sup>	2007/08 <sup>4</sup>	0.00%	1.00%	1.50%	1.75%	2.00%
Qualified nursing	1.0%	6.1%	4.9%	5.6%	3.9%	2.5%	5.1%	3.9%	4.2%	4.6%	2.8%	3.8%	4.3%	4.6%	4.8%
Unqual & support <sup>6</sup>	11.9%	9.8%	1.4%	5.6%	5.3%	3.8%	8.7%	6.6%	10.3%	4.6%	2.8%	3.8%	4.3%	4.6%	4.8%
ST&Ts <sup>7</sup>	3.6%	5.9%	5.4%	5.2%	3.4%	4.3%	4.4%	3.5%	5.2%	4.3%	2.2%	3.2%	3.7%	4.0%	4.2%
Admin & Clerical	4.7%	4.8%	3.5%	5.7%	5.4%	1.9%	6.8%	6.0%	7.3%	4.3%	2.2%	3.2%	3.7%	4.0%	4.2%
Main. & works	4.8%	4.0%	3.6%	3.3%	-1.2%	2.4%	8.2%	4.5%	8.5%	4.3%	2.2%	3.2%	3.7%	4.0%	4.2%
Ambulance Staff	8.1%	0.2%	4.1%	4.7%	5.5%	6.9%	26.8%	12.3%	-3.5%	4.6%	2.8%	3.8%	4.3%	4.6%	4.8%
Managers	2.4%	4.1%	7.4%	2.6%	0.5%	3.2%	12.7%	2.7%	5.8%	4.3%	2.2%	3.2%	3.7%	4.0%	4.2%
Total remit <sup>8</sup>	3.9%	6.3%	4.7%	5.3%	4.9%	3.1%	7.1%	4.8%	6.0%	4.5%	2.6%	3.6%	4.1%	4.4%	4.6%

### HCCH non-medical workforce<sup>1</sup>

	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08 <sup>9</sup>	2008/09 <sup>9</sup>
Qualified nursing	247,238	250,651	256,276	266,171	279,287	291,925	301,877	307,744	307,447	317,334	324,558
Unqual & support <sup>6</sup>	172,674	174,874	177,796	185,687	192,370	198,868	200,615	205,207	193,208	199,243	202,676
ST&Ts <sup>7</sup>	103,351	106,887	110,384	115,767	122,903	130,043	137,789	143,606	144,899	151,419	154,724
Admin & Clerical	132,958	136,900	142,263	150,317	158,978	171,707	183,338	191,528	185,947	189,431	188,440
Main. & works	12,715	12,333	12,016	11,758	11,831	11,479	11,289	10,932	10,487	10,650	10,501
Ambulance Staff	14,936	15,250	15,755	16,320	17,076	17,455	18,627	19,610	21,703	22,471	23,537
Managers	21,854	23,378	24,253	26,285	30,914	33,810	36,007	37,549	35,041	35,585	35,196
Total remit <sup>8</sup>	707,203	721,767	739,399	773,141	813,854	855,799	889,973	916,548	899,091	926,482	939,982

### Growth in HCCH non-medical workforce<sup>1</sup>

	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08 <sup>9</sup>	2008/09 <sup>9</sup>
Qualified nursing	0.5%	1.4%	2.2%	3.9%	4.9%	4.5%	3.4%	1.9%	-0.1%	3.2%	2.3%
Unqual & support <sup>6</sup>	1.0%	1.3%	1.7%	4.4%	3.6%	3.4%	0.9%	2.3%	-5.8%	3.1%	1.7%
ST&Ts <sup>7</sup>	3.3%	3.4%	3.3%	4.9%	6.2%	5.8%	6.0%	4.2%	0.9%	4.5%	2.2%
Admin & Clerical	0.8%	3.0%	3.9%	5.7%	5.8%	8.0%	6.8%	4.5%	-2.9%	1.9%	-0.5%
Main. & works	-4.4%	-3.0%	-2.6%	-2.1%	0.6%	-3.0%	-1.6%	-3.2%	-4.1%	1.6%	-1.4%
Ambulance Staff	-1.6%	2.1%	3.3%	3.6%	4.6%	2.2%	6.7%	5.3%	10.7%	3.5%	4.7%
Managers	2.0%	7.0%	3.7%	8.4%	17.6%	9.4%	6.5%	4.3%	-6.7%	1.6%	-1.1%
Total remit <sup>8</sup>	0.9%	2.1%	2.4%	4.6%	5.3%	5.2%	4.0%	3.0%	-1.9%	3.0%	1.5%

#### Notes:

1. Figures for NHS Staff in England only & exclude agency
2. Includes estimates for Foundation Trusts
3. Provisional NHS financial return figures for 2006/07 have been used to estimate growth. Final figures are expected November 2007.
4. Figures in grey are projections and subject to change. Growth includes hangover from staging settlement in the previous year. This results in an additional 0.6% increase in earnings for the year above that due to pay uplift and drift.
5. In 2004/05 responsibility for the cost of pensions indexation shifted from HMT to NHS employers.
6. Unqualified nursing, HCA and support includes ancillary staff (e.g cleaners and porters)
7. ST&T - Scientific and Therapeutic and Technical staff. This includes AHPs, PAMs, healthcare scientists and other groups working in scientific, therapeutic and technical areas.
8. This total includes a small number of other staff (less than 0.5% of NHSPRB workforce) who do not fit into any of the above sub-groups
9. Workforce figures for 2007/08 and 2008/09 are projections and subject to change

## **Revised NHSRB pay metrics (revision to Annex A) submitted on 5 December 2007**

The pay metrics submitted in Annex A of the 2008/09 DH NHS Pay Review Body evidence have now been revised to take account of final financial data for 2006/07 that has recently (November 2007) become available.

Pay bill and earnings projections are produced by projecting forwards from a pay bill baseline of the most recent data from the DH financial returns. This year early figures from the 2006/07 financial returns were used to estimate this baseline. These data were incomplete and un-validated.

These data were used in response to the Review Body's request to provide figures based on the 2006/07 financial returns. Last year's metrics used 2005/06 projections from a 2004/05 baseline. Updated figures were then provided in January 2007 using the provisional 2005/06 financial return data as baseline.

As well as updating the pay bill baseline, a number of other small changes have been made to take into account information that has become available since the submission of the 2008/09 DH evidence.

### **Summary of changes:**

1. Pay bill baseline for 2006/07 updated to replace the estimate based on early financial data with final version of these data. This resulted in an overall decrease in earnings growth for the total NHSPRB group of 1.4% in 2006/07, although there is larger decrease for some individual workforce groups e.g. ambulance staff. There is a corresponding decrease in earnings and pay bill projections for 2007/08 and 2008/09.
2. The pay drift estimates for these groups have been revised slightly to take into account recent information on the planned costs of pay reform. This reduces the earnings growth in 2007/08 and 2008/09 by 0.1%.

**Pay metrics for NHSPRB remit (England)**

	HCHS non-medical Paybill (£million) <sup>1</sup>										2008/09 <sup>4</sup>				
	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 <sup>2,5</sup>	2005/06 <sup>2</sup>	2006/07 <sup>2,3</sup>	2007/08 <sup>4</sup>	0.00%	1.00%	1.50%	1.75%	2.00%
Qualified nursing	5,738m	6,181m	6,699m	7,427m	8,085m	8,677m	9,923m	10,548m	10,939m	11,767m	12,342m	12,467m	12,529m	12,560m	12,591m
Unqual & support <sup>6</sup>	1,934m	2,162m	2,250m	2,512m	2,740m	2,946m	3,406m	3,731m	3,758m	4,040m	4,213m	4,256m	4,278m	4,289m	4,299m
ST&Ts <sup>7</sup>	2,172m	2,379m	2,616m	2,919m	3,199m	3,538m	4,115m	4,452m	4,786m	5,212m	5,437m	5,493m	5,520m	5,534m	5,548m
Admin & Clerical	1,865m	1,989m	2,161m	2,444m	2,724m	3,000m	3,604m	4,007m	4,119m	4,374m	4,442m	4,487m	4,510m	4,521m	4,533m
Main. & works	229m	231m	235m	240m	239m	237m	266m	270m	269m	284m	286m	289m	291m	291m	292m
Ambulance Staff	355m	364m	395m	433m	478m	524m	747m	890m	779m	841m	903m	912m	917m	919m	921m
Managers	952m	1,055m	1,187m	1,331m	1,571m	1,777m	2,247m	2,414m	2,341m	2,479m	2,497m	2,523m	2,536m	2,542m	2,549m
Total remit <sup>8</sup>	13,267m	14,388m	15,588m	17,362m	19,164m	20,825m	24,425m	26,443m	27,124m	29,133m	30,260m	30,568m	30,722m	30,799m	30,876m

Unqual & support - unqualified nursing, HCA and support

	Growth in HCHS non-medical Paybill <sup>1</sup>										2008/09 <sup>4</sup>				
	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 <sup>2,5</sup>	2005/06 <sup>2</sup>	2006/07 <sup>2,3</sup>	2007/08 <sup>4</sup>	0.00%	1.00%	1.50%	1.75%	2.00%
Qualified nursing	1.5%	7.7%	8.4%	10.9%	8.9%	7.3%	14.4%	6.3%	3.7%	7.6%	4.9%	5.9%	6.5%	6.7%	7.0%
Unqual & support <sup>6</sup>	13.1%	11.8%	4.1%	11.6%	9.1%	7.5%	15.6%	9.5%	0.7%	7.5%	4.3%	5.3%	5.9%	6.1%	6.4%
ST&Ts <sup>7</sup>	7.0%	9.5%	10.0%	11.6%	9.6%	10.6%	16.3%	8.2%	7.5%	8.9%	4.3%	5.4%	5.9%	6.2%	6.5%
Admin & Clerical	5.6%	6.7%	8.7%	13.1%	11.4%	10.2%	20.1%	11.2%	2.8%	6.2%	1.5%	2.6%	3.1%	3.4%	3.6%
Main. & works	0.3%	0.8%	2.0%	2.2%	-0.8%	-0.5%	12.0%	1.5%	-0.4%	5.8%	0.7%	1.7%	2.2%	2.5%	2.7%
Ambulance Staff	6.4%	2.7%	8.6%	9.6%	10.2%	9.6%	42.7%	19.0%	-12.4%	7.9%	7.4%	8.5%	9.0%	9.3%	9.6%
Managers	4.5%	10.7%	12.5%	12.2%	18.0%	13.2%	26.5%	7.4%	-3.0%	5.9%	0.8%	1.8%	2.3%	2.6%	2.8%
Total remit <sup>8</sup>	4.8%	8.4%	8.3%	11.4%	10.4%	8.7%	17.3%	8.3%	2.6%	7.4%	3.9%	4.9%	5.5%	5.7%	6.0%

	HCHS non-medical Paybill per FTE (£) <sup>1</sup>										2008/09 <sup>4</sup>				
	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 <sup>2,5</sup>	2005/06 <sup>2</sup>	2006/07 <sup>2,3</sup>	2007/08 <sup>4</sup>	0.00%	1.00%	1.50%	1.75%	2.00%
Qualified nursing	23,210	24,661	26,142	27,901	28,947	29,722	32,870	34,274	35,580	37,080	38,027	38,411	38,603	38,699	38,795
Unqual & support <sup>6</sup>	11,198	12,364	12,655	13,529	14,246	14,815	16,980	18,183	19,450	20,277	20,787	21,000	21,107	21,160	21,213
ST&Ts <sup>7</sup>	21,017	22,256	23,701	25,214	26,028	27,210	29,864	30,998	33,026	34,419	35,143	35,500	35,679	35,768	35,857
Admin & Clerical	14,025	14,527	15,192	16,258	17,132	17,473	19,659	20,919	22,152	23,091	23,571	23,812	23,933	23,993	24,054
Main. & works	18,001	18,713	19,586	20,449	20,164	20,682	23,545	24,687	25,622	26,704	27,264	27,541	27,680	27,750	27,819
Ambulance Staff	23,745	23,877	25,100	26,559	27,983	30,006	40,117	45,360	35,896	37,407	38,364	38,751	38,945	39,041	39,138
Managers	43,577	45,114	48,925	50,650	50,806	52,567	62,418	64,289	66,806	69,655	70,956	71,686	72,050	72,233	72,415
Total remit <sup>8</sup>	18,760	19,934	21,082	22,456	23,547	24,334	27,444	28,851	30,168	31,445	32,192	32,520	32,684	32,766	32,847

	Growth in HCHS Paybill per FTE <sup>1</sup>										2008/09 <sup>4</sup>				
	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 <sup>2,5</sup>	2005/06 <sup>2</sup>	2006/07 <sup>2,3</sup>	2007/08 <sup>4</sup>	0.00%	1.00%	1.50%	1.75%	2.00%
Qualified nursing	1.0%	6.3%	6.0%	6.7%	3.7%	2.7%	10.6%	4.3%	3.8%	4.2%	2.6%	3.6%	4.1%	4.4%	4.6%
Unqual & support <sup>6</sup>	11.9%	10.4%	2.4%	6.9%	5.3%	4.0%	14.6%	7.1%	7.0%	4.3%	2.5%	3.6%	4.1%	4.4%	4.6%
ST&Ts <sup>7</sup>	3.6%	5.9%	6.5%	6.4%	3.2%	4.5%	9.8%	3.8%	6.5%	4.2%	2.1%	3.1%	3.7%	3.9%	4.2%
Admin & Clerical	4.7%	3.6%	4.6%	7.0%	5.4%	2.0%	12.5%	6.4%	5.9%	4.2%	2.1%	3.1%	3.6%	3.9%	4.2%
Main. & works	4.8%	4.0%	4.7%	4.4%	-1.4%	2.6%	13.8%	4.9%	3.8%	4.2%	2.1%	3.1%	3.7%	3.9%	4.2%
Ambulance Staff	8.1%	0.6%	5.1%	5.8%	5.4%	7.2%	33.7%	13.1%	-20.9%	4.2%	2.6%	3.6%	4.1%	4.4%	4.6%
Managers	2.5%	3.5%	8.4%	3.5%	0.3%	3.5%	18.7%	3.0%	3.9%	4.3%	1.9%	2.9%	3.4%	3.7%	4.0%
Total remit <sup>8</sup>	3.9%	6.3%	5.8%	6.5%	4.9%	3.3%	12.8%	5.1%	4.6%	4.2%	2.4%	3.4%	3.9%	4.2%	4.5%

	HCHS non-medical Earnings per FTE (£) <sup>1</sup>										2008/09 <sup>4</sup>				
	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 <sup>2,5</sup>	2005/06 <sup>2</sup>	2006/07 <sup>2,3</sup>	2007/08 <sup>4</sup>	0.00%	1.00%	1.50%	1.75%	2.00%
Qualified nursing	21,042	22,329	23,427	24,733	25,702	26,342	27,697	28,784	29,903	31,203	32,010	32,328	32,487	32,567	32,647
Unqual & support <sup>6</sup>	10,430	11,451	11,609	12,256	12,899	13,394	14,563	15,528	16,592	17,313	17,760	17,937	18,025	18,069	18,113
ST&Ts <sup>7</sup>	19,054	20,181	21,268	22,378	23,138	24,136	25,189	26,062	27,778	28,985	29,607	29,903	30,051	30,125	30,199
Admin & Clerical	12,715	13,327	13,795	14,588	15,376	15,665	16,738	17,745	18,791	19,607	20,027	20,227	20,328	20,378	20,428
Main. & works	16,320	16,976	17,590	18,169	17,959	18,392	19,893	20,790	21,598	22,536	23,019	23,249	23,364	23,422	23,480
Ambulance Staff	21,528	21,566	22,442	23,492	24,792	26,511	33,606	37,750	30,096	31,404	32,217	32,538	32,698	32,778	32,858
Managers	38,485	40,075	43,021	44,135	44,344	45,760	51,581	52,954	55,090	57,484	58,714	59,301	59,594	59,741	59,887
Total remit <sup>8</sup>	17,044	18,124	18,968	19,980	20,968	21,628	23,173	24,275	25,400	26,504	27,152	27,423	27,558	27,626	27,694

	Growth in HCHS non-medical Earnings per FTE <sup>1</sup>										2008/09 <sup>4</sup>				
	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05 <sup>2,5</sup>	2005/06 <sup>2</sup>	2006/07 <sup>2,3</sup>	2007/08 <sup>4</sup>	0.00%	1.00%	1.50%	1.75%	2.00%
Qualified nursing	1.0%	6.1%	4.9%	5.6%	3.9%	2.5%	5.1%	3.9%	3.9%	4.3%	2.6%	3.6%	4.1%	4.4%	4.6%
Unqual & support <sup>6</sup>	11.9%	9.8%	1.4%	5.6%	5.3%	3.8%	8.7%	6.6%	6.9%	4.3%	2.6%	3.6%	4.1%	4.4%	4.6%
ST&Ts <sup>7</sup>	3.6%	5.9%	5.4%	5.2%	3.4%	4.3%	4.4%	3.5%	6.6%	4.3%	2.1%	3.2%	3.7%	3.9%	4.2%
Admin & Clerical	4.7%	4.8%	3.5%	5.7%	5.4%	1.9%	6.8%	6.0%	5.9%	4.3%	2.1%	3.2%	3.7%	3.9%	4.2%
Main. & works	4.8%	4.0%	3.6%	3.3%	-1.2%	2.4%	8.2%	4.5%	3.9%	4.3%	2.1%	3.2%	3.7%	3.9%	4.2%
Ambulance Staff	8.1%	0.2%	4.1%	4.7%	5.5%	6.9%	26.8%	12.3%	-20.3%	4.3%	2.6%	3.6%	4.1%	4.4%	4.6%
Managers	2.4%	4.1%	7.4%	2.6%	0.5%	3.2%	12.7%	2.7%	4.0%	4.3%	2.1%	3.2%	3.7%	3.9%	4.2%
Total remit <sup>8</sup>	3.9%	6.3%	4.7%	5.3%	4.9%	3.1%	7.1%	4.8%	4.6%	4.3%	2.4%	3.5%	4.0%	4.2%	4.5%

### HCHS non-medical workforce<sup>1</sup>

	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08 <sup>9</sup>	2008/09 <sup>9</sup>
Qualified nursing	247,238	250,651	256,276	266,171	279,287	291,925	301,877	307,744	307,447	317,334	324,558
Unqual & support <sup>6</sup>	172,674	174,874	177,796	185,687	192,370	198,868	200,615	205,207	193,208	199,243	202,676
ST&Ts <sup>7</sup>	103,351	106,887	110,384	115,767	122,903	130,043	137,789	143,606	144,899	151,419	154,724
Admin & Clerical	132,958	136,900	142,263	150,317	158,978	171,707	183,338	191,528	185,947	189,431	188,440
Main. & works	12,715	12,333	12,016	11,758	11,831	11,479	11,289	10,932	10,487	10,650	10,501
Ambulance Staff	14,936	15,250	15,755	16,320	17,076	17,455	18,627	19,610	21,703	22,471	23,537
Managers	21,854	23,378	24,253	26,285	30,914	33,810	36,007	37,549	35,041	35,585	35,196
Total remit <sup>8</sup>	707,203	721,767	739,399	773,141	813,854	855,799	889,973	916,548	899,091	926,482	939,982

### Growth in HCHS non-medical workforce<sup>1</sup>

	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08 <sup>9</sup>	2008/09 <sup>9</sup>
Qualified nursing	0.5%	1.4%	2.2%	3.9%	4.9%	4.5%	3.4%	1.9%	-0.1%	3.2%	2.3%
Unqual & support <sup>6</sup>	1.0%	1.3%	1.7%	4.4%	3.6%	3.4%	0.9%	2.3%	-5.8%	3.1%	1.7%
ST&Ts <sup>7</sup>	3.3%	3.4%	3.3%	4.9%	6.2%	5.8%	6.0%	4.2%	0.9%	4.5%	2.2%
Admin & Clerical	0.8%	3.0%	3.9%	5.7%	5.8%	8.0%	6.8%	4.5%	-2.9%	1.9%	-0.5%
Main. & works	-4.4%	-3.0%	-2.6%	-2.1%	0.6%	-3.0%	-1.6%	-3.2%	-4.1%	1.6%	-1.4%
Ambulance Staff	-1.6%	2.1%	3.3%	3.6%	4.6%	2.2%	6.7%	5.3%	10.7%	3.5%	4.7%
Managers	2.0%	7.0%	3.7%	8.4%	17.6%	9.4%	6.5%	4.3%	-6.7%	1.6%	-1.1%
Total remit <sup>8</sup>	0.9%	2.1%	2.4%	4.6%	5.3%	5.2%	4.0%	3.0%	-1.9%	3.0%	1.5%

#### Notes:

1. Figures for NHS Staff in England only & exclude agency
2. Includes estimates for Foundation Trusts
3. Pay bill figures taken from final NHS financial returns for 2006/07.
4. Figures in grey are projections and subject to change. Growth includes hangover from staging settlement in the previous year. This results in an additional 0.6% increase in earnings for the year above that due to pay uplift and drift.
5. In 2004/05 responsibility for the cost of pensions indexation shifted from HMT to NHS employers.
6. Unqualified nursing, HCA and support includes ancillary staff (e.g cleaners and porters)
7. ST&T - Scientific and Therapeutic and Technical staff. This includes AHPs, PAMs, healthcare scientists and other groups working in scientific, therapeutic and technical areas.
8. This total includes a small number of other staff (less than 0.5% of NHSPRB workforce) who do not fit into any of the above sub-groups
9. Workforce figures for 2007/08 and 2008/09 are projections and subject to change

## ADDITIONAL AFFORDABILITY EVIDENCE FROM THE HEALTH DEPARTMENTS

***The Department of Health***

Table A1: Breakdown of baseline pressures, underlying demand and service improvements

<b>Baseline Pressures (unavoidable)</b>
<b>Prices</b>
<b>Pay:</b>
Settlement
Drift
Staging
Reform (inc. unsocial hours, NCCG, HCAS)
<b>Family Health Services:</b>
Primary Medical Services
General Dental Services
Pharmaceutical Services
General Ophthalmic Services
<b>Drugs:</b>
Primary Care Drugs
Secondary Care Drugs
NICE Recommendations
<b>EEA Medical costs</b>
<b>NHS Litigation Authority</b>
<b>PFI Revenue costs</b>
<b>Cost of Capital</b>
<b>Central administration</b>
<b>Underlying demand</b>
<b>Mental Health</b>
<b>Accident and Emergency</b>
<b>Non Elective (emergency)</b>
<b>Ambulances</b>
<b>Maternity</b>
<b>Learning Disability</b>
<b>Other community activity</b>
<b>In addition, there will be other activity built into service development</b>
<b>Service improvements</b>
<b>Connection for Health</b>
<b>Working Time Directive</b>
<b>Reducing Cancer waiting times</b>
<b>Increasing palliative Care</b>

**18 week access target**  
**Stroke Strategy**  
**Improving hospital cleanliness and tackling Healthcare associated infection (inc. MRSA screening)**  
**Long Term Conditions**  
**Improving GP Access**  
**Psychological therapy services**  
**R&D, response to Cooksey Review**  
**Maternity services**  
**Strengthening training and development**  
**Pandemic flu preparations**  
**Counter Terrorism**  
**Tackling obesity**  
**Tackling alcohol abuse**  
**Reduce teenage pregnancy**  
**Improving children's and young people's physical and mental wellbeing**  
**Dementia Care**  
**End of Life Care**  
**Improving services for disabled children**  
**Public Health Services**

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Annex A: Table A2: Cost Pressure Arising From NHSPRB remit (England) HCCHS non-medical Paybill (£million)

	2007/08	1.50%	1.75%	2.00%	2.25%	2.50%	2.75%	3.00%	3.25%	3.50%
NHSPRB Paybill	29,133m <sup>1</sup>	30,730m	30,803m	30,876m	30,949m	31,021m	31,094m	31,167m	31,240m	31,313m
Increase		1,597m	1,670m	1,743m <sup>2</sup>	1,816m	1,889m	1,961m	2,034m	2,107m	2,180m
	of which:									
	due to pay	1,151m	1,222m	1,294m <sup>3a</sup>	1,366m	1,438m	1,509m	1,581m	1,653m	1,725m
	due to workforce growth	447m	448m	449m <sup>3b</sup>	450m	451m	452m	453m	454m	455m
Funding available for:										
	Baseline Pressures	3,146m	3,146m	3,146m <sup>4</sup>	3,146m	3,146m	3,146m	3,146m	3,146m	3,146m
	Underlying demand & service improvements	2,620m	2,620m	2,620m <sup>4</sup>	2,620m	2,620m	2,620m	2,620m	2,620m	2,620m
Cost Of Meeting										
	Baseline Pressures	3,003m	3,074m	3,146m	3,218m	3,290m	3,361m	3,433m	3,505m	3,576m
	Underlying demand & service improvements	2,618m	2,619m	2,620m	2,621m	2,622m	2,623m	2,624m	2,625m	2,627m
Surplus shortfall to be made up from service improvements		146m	73m	0m <sup>5</sup>	-73m <sup>6</sup>	-146m	-218m	-291m	-364m	-437m

Notes (1) The baseline for 2007/8 is from the latest pay metrics. (2) The cost of a 2% settlement, plus 1.5% workforce growth and drift assumptions is £1,743m. (3) This cost has two components. (3a) The major cost falls under baseline pressures. This is for a constant workforce. (3b) The cost of paying a growing workforce higher pay will fall under the underlying demand and service developments. (4) The total resource available for baseline pressures and underlying demand and service improvements is £5,766m. (5) This is in balance with a 2% settlement. (6) As we vary the settlement we show either a surplus or deficit against the 2008/9 programme.

The £1,743m figure is different from the pay assumption included in the tariff uplift figure because the tariff includes doctors and agency, but excludes workforce growth and pay reform for the NCCGs.

## The Scottish Government Health Directorates (SGHD)

Showing the “real terms” increase in the Health budget is intended to reflect the additional funding available for new services or developments without the distortion caused by general inflation i.e. pay and price inflation. The measure used as the determinant of the inflationary increase is the GDP market price deflator, published by HM Treasury. This is currently 2.75% for each of the next 3 years.

The Health budget is increasing by an annual average of 4.1% each year over the next 3 years. The average annual cash/real terms increases over the next 3 years are as follows:

	Cash	Real Terms
GDP Deflator	2.75%	-
Growth	1.35%	1.35%
Total	4.10%	1.35%

The GDP deflator is not, however, particularly sensitive to the pressures that need to be met from the Health budget. The overall increase in the Health budget funds pay awards, the increased costs generated through demographic changes and medical advances, the increase in prescribed drugs and hospital drugs, general price inflation and service developments. Efficiency savings has been set at 2% in each of the next 3 years.

## The Welsh Assembly Government (WAG)

### *Summary of Welsh Assembly Government Budget Setting Process*

The funding for NHS pay awards in Wales is met from the Health and Social Services Main Expenditure Group (MEG) of the Welsh Assembly Government budget. There are currently 11 MEGs, each representing the main areas of devolved responsibility for the Welsh Assembly Government. As well as Health and Social Services, other MEGs include Social Justice and Local Government, Economy and Transport, Children, Education, Lifelong Learning and Skills and others.

The allocation of the Welsh Assembly Government budget to MEGs is determined by Welsh Ministers, and approved by the National Assembly for Wales. Welsh Ministers are not constrained by how funding is allocated between UK Government departments in allocating funding to MEGs.

The rest of this briefing focuses on the affordability for NHS pay awards arising from the 2008-09 Welsh Assembly Government final budget settlement for the Health and Social Services MEG.

### *2008-09 Health and Social Services Budget*

The 2008-09 Health and Social Services Revenue Budget is £5,358 million. After taking account of budgetary transfers between MEGs of £5 million, this is a cash increase over 2007-08 baselines of £212 million or 4.1%.

The £212 million cash growth comprises the following main elements:

- £91 million to meet increases in the NHS pay bill
- £12 million for Welsh Assembly Government manifesto commitments
- £189 million for other cost increases, including continuing care, NICE drugs, non pay
- £80 million efficiency saving requirement (reduction)

The Health and Social Services budget will have to meet a range of expected pressures in 2008-09 from this settlement. The Welsh Assembly Government has not yet informed NHS organisations of their allocations for 2008-09, but they have been told to plan on making additional cash-releasing efficiency savings of 2.5% next year. In addition to pay awards and general non-pay inflation, a significant cost pressure expected in 2008-09 is the increasing costs of NHS continuing health care provision, particularly following the Grogan judgement. The full financial impact of continuing care increases in 2008-09 is still being determined. These pressures mean that there is no flexibility within the Health and Social Services budget to afford pay cost increases in excess of the £91 million identified.

### *Pay increase funding*

The £91 million is expected to fund the following increases in pay costs in 2008-09 in NHS Wales:

- Cost of pay awards at current staffing levels
- The additional cost of incremental drift following introduction of Agenda for Change
- The introduction of the unsocial hours element of Agenda for Change.

Funding is already included in baselines for the current estimated costs of the SAS doctors contract. However, if costs exceed current estimates, then the difference in cost will also need to be met from the £91 million pay increase funding.

2007-08 baseline pay costs, extrapolated from 2006-07 NHS trust cost returns, are as follows:

<b>Staff group</b>	<b>2007-08 Baseline £m</b>	<b>Proportion of total %</b>
Consultants	281	11
A4C staff groups	1,849	73
Other NHS staff	414	16
<b>Total</b>	<b>2,544</b>	<b>100</b>

The costs of A4C incremental drift and unsocial hours have been estimated by NHS trusts at £24.5 million and £12 million respectively. This leaves £54.5 million to fund pay awards. Against the overall pay cost baseline, the additional funding allows for an overall 2.1% award in 2008-09.

### *Cash growth versus real growth*

Previous financial information has made references to “real” growth of 1.6% in the Health and Social Services MEG in 2008-09. “Real” growth is intended to reflect the additional funding for new services or developments available after accounting for general inflationary increases. The measure used as the determinant of the general inflationary increase has been the GDP deflator, published by HM Treasury. For 2008-09 this is 2.75%. 4.1% cash growth in 2008-09 therefore becomes 1.3% real growth. However, the GDP deflator is not particularly sensitive to the pressures that need to be met from the Health and Social Services budget. As referred to above, the total commitments against Health and Social Services budgets will exceed the funding increase available, so efficiency requirements of at least 2.5% are required to maintain and develop existing services.

**The Department of Health and Social Services & Public Safety in Northern Ireland**  
**(DHSSPSNI)**

*DHSSPSNI 2008-09 Health and Social Services Budget*

The 2008-09 DHSSPSNI budget is £3949.6m, representing an increase of 3.8% from 2007-08. In addition to the resources allocated by the NI Executive, through the delivery of efficiency savings, entitlement to additional in-year resources and over committing existing budgets, DHSSPSNI has a total of £285m additional resources available in 2008-09.

The £285 million is required to meet the following:

- £228 million to meet inescapable cost pressures including £91m to meet increases in costs of the Health and Social Care pay bill
- £57m for the development and improvement of patient services

The NI Health and Social Services budget will have to meet a range of expected pressures in 2008-09 from this settlement. Each Health and Social Care (HSC) organisation has been told to plan on making cash-releasing efficiency savings of 3% next year. In addition to pay awards and general non-pay inflation, HSC organisations face significant inescapable cost pressures arising from both existing Ministerial commitments and demographic change. These pressures mean that there is no flexibility within the Health and Social Services budget to afford pay cost increases in excess of the £106 million identified without impacting directly on patient care by way of reducing resources available for service improvement. DHSS&PS has already taken the decision to commit more resources than are available to bring forward much needed service improvements in an effort to ensure Northern Ireland's expenditure addresses the recommendations of the Appleby Review of the HPSS (broadly equivalent to Wanless in England). The table below sets out the DHSS&PS budget position for 2008-09 (additional detail is set out after the table).

*DHSSPS 2008-09 BUDGET*

	<b>2008-09</b>
	<b>£m</b>
<b><i>Additional Resources Available:</i></b>	
Additional funds allocated by NI Executive	144.8
Efficiency savings	103
Guaranteed In Year Resources	20
Funded by other Departments	2.4
	<hr/>
	270.2
Over commitment	14.8
	<hr/>
<b>Total Funding available</b>	<b>285</b>
<b><i>Additional Resources Requirements:</i></b>	
Inescapable costs	228
Service Developments	57
	<hr/>
<b>Total</b>	<b>285</b>

**Pay Increase Funding**

The £91m available is expected to meet the costs of the following:

- Costs of pay wards arising during the year
- The additional costs of incremental drift following the introduction of Agenda for Change and the Consultants Contract

- The introduction of the unsocial hours element of Agenda for Change
  - The introduction of the new SAS Doctors contract
  - Changes to grade and skill mix
- Pay reform consequentials are expected to cost £18m leaving £73m to meet the costs of pay awards – sufficient to meet an overall 2.3% award in 2008-09.

**DETAILED BREAKDOWN OF THE 2008-9 RESOURCE REQUIREMENTS: BREAKDOWN of INESCAPABLE COSTS**

		<b>2008-09 £m</b>
<b>1</b>	Pay and Pay Reform consequentials	91,000
<b>2</b>	Non Pay at 2.7%	20,000
<b>3</b>	Pharmaceutical Services - Hospital Drugs	44,000
<b>4</b>	Amended NHS Pension (Superannuation) Scheme	9,000
<b>5</b>	Pandemic Flu Emergency Provision	3,000
<b>6</b>	Medical Workforce Training and Tuition Fees	7,000
<b>7</b>	Renal Services	2,000
<b>8</b>	Child Protection	1,000
<b>9</b>	Children with Complex Needs	2,000
<b>10</b>	Blood Safety	1,000
<b>11</b>	Revenue Consequences of capital investment	22,000
<b>12</b>	GP Contract	0
<b>13</b>	Additional acute costs	2,000
<b>14</b>	Mainstreaming Children and Young People's Package	5,000
<b>15</b>	Demographic Pressures in Primary and Community Services	7,000
<b>16</b>	Capitation	10,000
<b>17</b>	Nursing mentoring	1,000
<b>18</b>	HSC Complaints	1,000
	<b>TOTAL INESCAPABLE COSTS</b>	<b>228,000</b>

BREAKDOWN OF AGREED SERVICE DEVELOPMENT PROPOSALS

		<b>2008-09 £m</b>
<b>1</b>	Mental Health	11,000
<b>2</b>	Learning Dis.	7,000
<b>3</b>	Long Term Conditions: Early Intervention	9,000
<b>4</b>	Cardiovascular	2,000
<b>5</b>	Stroke	2,000
<b>6</b>	Cancer Services	2,000
<b>7</b>	Cancer Control	3,000
<b>8</b>	Public Health	5,000
<b>9</b>	Specialist Drugs	1,000
<b>10</b>	Quality & Safety	2,000
<b>11</b>	Disability	1,000
<b>12</b>	Children	5,000
<b>13</b>	Acute Services	1,000
<b>14</b>	Elective Care Access	4,000
<b>15</b>	Fire	2,000
	<b>TOTAL PLANNED SERVICE DEVELOPMENTS</b>	<b>57,000</b>

## RESPONSE FROM THE DEPARTMENT OF HEALTH ABOUT THE TIMING OF KEY WORKFORCE DATA AVAILABLE TO THE NHSPRB

The NOHPRB in its Twenty-Second Report on Nursing and Other Health Professions 2007 recommended that the Health Departments and other relevant bodies review the timing of key surveys which inform the NOHPRB review to see whether they can provide more timely data.

These main surveys are listed below.

Data	Source	Data relating to:	Results publicly available	Age of data when evidence submitted to the NOHPRB (October 2006)
NHS Staff Survey	Healthcare Commission	October to December 2005	15 March 2006	10 months
NHS Vacancy Survey	Information Centre (IC)	31 March 2006	29 July 2006	6 months
NHS Non-Medical Workforce Census	IC	30 September 2005	24 April 2006	12 months
NHS Earnings Survey	IC	August 2004 (biennially)	30 August 2005	1 or 2 years
Workforce Survey	OME	31 March 2006	September 2006	6 months
Estimates of average earnings and pay drift from financial returns	DH	Financial returns for 2004-05	January 2006	18 months

We have examined the possibility of moving these surveys and, where this was not possible, looked to provide other information to supplement the survey data. For each of the key surveys set out above the situation is as follows.

### NHS Staff Survey

We explored the possibility of bringing forward the Healthcare Commission NHS Staff survey so that results would be available for PRB use in December. However, bringing the survey forward would leave trusts with twelve month old data for their own Annual Health Checks. They were therefore reluctant to move the survey date.

As an alternative the Healthcare commission has agreed that provisional data from this survey will be made available to the PRB in January – giving access to data that is barely one month old. This was detailed at Annex E paragraphs 1-7 of the Departments written evidence submission to the PRB in November.

### NHS Vacancy Survey

We are in discussion with a range of stakeholders to improve the timeliness and coverage of NHS vacancy data to complement the ongoing NHS vacancy survey.

We are looking into the feasibility of pulling down data on vacancies from the NHS Jobs site. This may lead to improved timeliness of data and also further information on vacancy rates by occupation. We are in discussion with NHS Employers as to whether this is possible.

We have noted that the Scottish Executive are able to provide “on the day” vacancy rates in addition to information on longer term vacancies. We are currently examining the

methodology used by the Scottish to gather this data and on the feasibility of extending this to cover England.

We are also in discussion with the NHS Information Centre on the potential for ESR data to give us proxy information on both vacancy numbers and on the length of vacancies.

While all of the above work is still in its early stages, we will provide you with updates as the work progresses.

### **NHS Non-Medical Workforce Census**

The NHS workforce census is run annually with data relating to the position as at September each year. This has traditionally been considered to be the time of year that gives the most accurate snap-shot of the NHS workforce with few staff moves happening within this period. It is also considered to be the most suitable time of year to enable organisations to commit the necessary resources to ensure returns are completed to high standards.

Retaining an annual census as at the end of September will ensure the continuation of a historical data series, which is used for a number of alternative purposes. However, we are currently working with the NHS Information Centre to develop monthly monitoring reports using data from the new Electronic Staff Record (ESR). This would provide the potential for data to be provided that supplements the annual census data and provide trend analysis. ESR is still a new system that currently covers around 80% of the workforce. We expect the implementation phase of the ESR system to be completed in March 2008 and we will continue to work throughout next year on improving the quality and reliability of ESR data. Consequently, for the time being we expect the Workforce Census to continue to be the more relevant source of for the fully validated position of the NHS workforce.

### **NHS Earnings Survey**

The NHS Earnings Survey has been replaced with data coming on stream from ESR. The Information Centre has recently published experimental average earnings statistics using sample data from the NHS ESR, and OME have had access to this data.

As mentioned above, we will increasingly be able to rely on ESR data in future as the data available improves following completion of roll out in 2008. This will allow us to provide the PRB with more timely and robust evidence on NHS earnings.

### **NHS Workforce Survey**

The timing of the NHS Workforce survey is selected by the Office of Manpower Economics. Though as part of increasing the quality and reliability of information to the PRB, we ensured the 2007 survey was given gateway clearance, ensuring an improved response rate.

### **Estimates of average earnings and pay drift from financial returns**

Complete final 2006/07 financial return figures are not available in time to produce average earnings estimates and pay drift figures in the Department's initial written evidence to the Review Body. For example, at that time some organizations have yet to send in returns and data is still undergoing validation. However, in an effort to improve our evidence to the PRB, this year we used early information from available returns in our pay modelling. We will keep this approach under review with an aim to make further improvements in future years. More detail is provided with the new pay metrics submitted as part of our supplementary evidence.

As set out above we are already providing more timely data from the ESR on earnings. Again we expect this will allow us to continue to improve the timeliness and robustness of our evidence on NHS earnings. We are also working on using the improved information from the ESR to improve our estimates of both current and future drift. We will keep the OME secretariat up-to-date with developments in this work and hope to draw on their expertise to further improve this information.

**Other Surveys**

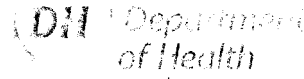
In addition to the above improvements we are looking across the entirety of the information we provide in our evidence to the Pay Review Bodies. We are continually working to improve the coverage, timeliness and relevance of this data and will look to regularly update the OME secretariat with developments in addition to seeking your views to help us focus on the areas of greatest need.

**The parties' website addresses<sup>60</sup>**

The Department of Health	<a href="http://www.dh.gov.uk/en/index.htm">http://www.dh.gov.uk/en/index.htm</a>
The Scottish Government Health Directorates	<a href="http://www.scotland.gov.uk/Home">http://www.scotland.gov.uk/Home</a>
Welsh Assembly Government	<a href="http://new.wales.gov.uk/?lang=en">http://new.wales.gov.uk/?lang=en</a>
The Department of Health and Social Services & Public Safety in Northern Ireland	<a href="http://www.dhsspsni.gov.uk/">http://www.dhsspsni.gov.uk/</a>
NHS Employers	<a href="http://www.nhsemployers.org/">http://www.nhsemployers.org/</a>
NHS Staff Side (joint Staff Side)	<a href="http://www.unison.org.uk/">http://www.unison.org.uk/</a> <a href="http://www.rcn.org.uk">http://www.rcn.org.uk</a>
British and Irish Orthoptic Society	<a href="http://www.orthoptics.org.uk/">http://www.orthoptics.org.uk/</a>
Chartered Society of Physiotherapy	<a href="http://www.csp.org.uk/">http://www.csp.org.uk/</a>
GMB	<a href="http://www.gmb.org.uk/">http://www.gmb.org.uk/</a>
Northern Ireland Public Service Alliance	<a href="http://www.nipsa.org.uk/index.asp">http://www.nipsa.org.uk/index.asp</a>
Royal College of Midwives	<a href="http://www.rcm.org.uk/">http://www.rcm.org.uk/</a>
Royal College of Nursing	<a href="http://www.rcn.org.uk">http://www.rcn.org.uk</a>
Society of Chiropractors and Podiatrists	<a href="http://www.feetforlife.org/">http://www.feetforlife.org/</a>
Society of Radiographers	<a href="http://www.sor.org/">http://www.sor.org/</a>
Union of Construction, Allied Trades and Technicians	<a href="http://www.ucatt.org.uk/">http://www.ucatt.org.uk/</a>
UNISON	<a href="http://www.unison.org.uk/">http://www.unison.org.uk/</a>
Unite (Amicus section)	<a href="http://www.amicustheunion.org/">http://www.amicustheunion.org/</a>
Unite (T&G section)	<a href="http://www.tgwu.org.uk/">http://www.tgwu.org.uk/</a>

<sup>60</sup> The parties' evidence submissions should be available via these website addresses.

From the Rt Hon Alan Johnson MP  
Secretary of State for Health



SofS46937

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26 JUL 2007

Dear Professor Morris

**Revised Terms of Reference for NOHPRB**

This is to notify you of the revised terms of reference for your review body. As you know, to date, some groups of staff paid under the Agenda for Change pay system have been excluded from the remit of your review body. This dual system has proved unsatisfactory as both groups of staff are on the same pay system and discussions have therefore taken place at the NHS Staff Council about a possible solution to bring about a streamlined approach for all staff groups on Agenda for Change.

The agreed approach is to extend the Nursing and Other Health Professionals Pay Review Body remit to include all Agenda for Change staff groups. The review body in the future will be known as the *NHS Pay Review Body*. In addition to this change, you will be aware that it can be agreed to extend the remits of the Pay Review Bodies to include staff working in Northern Ireland. I attach the new terms of reference for the 2008/09 pay round.

I would also like to take this opportunity to personally thank you and the other pay review body members for their continued service in advising the Government on this important issue of remuneration for staff working in the NHS.

I am copying this letter to the Prime Minister, First Ministers of the Scottish Parliament and of the National Assembly for Wales, the First Minister and Deputy First Minister of the Northern Ireland Executive and the joint chairs of the NHS Staff Council.

Yours sincerely  
Alan Johnson

**ALAN JOHNSON**

DC2607

#### **REMIT FOR THE NHS PAY REVIEW BODY – JULY 2007**

*The NHS Pay Review Body 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 & 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\*.*

*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;*
- *of 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 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 & Public Safety of the Northern Ireland Executive and the Prime Minister.*

*\* References to the NHS should be read as including all staff on AFC in personal and social care service organisations in NI.*

**PREVIOUS REPORTS OF THE REVIEW BODY**

**NURSING STAFF, MIDWIVES AND HEALTH VISITORS**

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

## **PROFESSIONS ALLIED TO MEDICINE**

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

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

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

## GLOSSARY

<b>AEI</b>	Average Earnings Index
<b>AfC</b>	Agenda for Change
<b>AGR</b>	Association of Graduate Recruiters
<b>AHPs</b>	Allied Health Professions
<b>ASHE</b>	Annual Survey of Hours and Earnings
<b>BERR</b>	Department for Business, Enterprise and Regulatory Reform
<b>BIOS</b>	British and Irish Orthoptic Society
<b>CBI</b>	Confederation of British Industry
<b>CIPD</b>	Chartered Institute of Personnel and Development
<b>CPI</b>	Consumer Prices Index
<b>CSP</b>	The Chartered Society of Physiotherapy
<b>CSR</b>	Comprehensive Spending Review
<b>DDRB</b>	The Review Body on Doctors' and Dentists' Remuneration
<b>DEL</b>	Departmental Expenditure Limit
<b>Department</b>	The Department of Health
<b>Departments</b>	The Health Departments
<b>DH</b>	Department of Health
<b>DHSSPSNI</b>	Department of Health and Social Services & Public Safety in Northern Ireland
<b>ECJ</b>	European Court of Justice
<b>ERINI</b>	Economic Research Institute of Northern Ireland
<b>ESR</b>	Electronic Staff Record
<b>FTE</b>	Full-Time Equivalent
<b>GDP</b>	Gross domestic product
<b>HCAS</b>	High Cost Area Supplements
<b>HCHS</b>	Hospital and Community Health Services

<b>Health Departments</b>	The Department of Health, the Scottish Government Health Directorates, the Welsh Assembly Government and the Department of Health and Social Services & Public Safety in Northern Ireland
<b>HMT</b>	HM Treasury
<b>HoMs</b>	Heads of Midwifery
<b>HSC</b>	Health and Social Care
<b>IC</b>	NHS Information Centre
<b>IDS</b>	Incomes Data Services
<b>KSF</b>	Knowledge and Skills Framework
<b>LFS</b>	Labour Force Survey
<b>MFF</b>	Market Forces Factor
<b>MPET</b>	Multi Professional Education and Training
<b>NES</b>	New Earnings Survey
<b>NHS</b>	National Health Service
<b>NHSE</b>	NHS Employers
<b>NHSPEDC</b>	NHS Pharmacy Education and Development Committee
<b>NHSPRB</b>	NHS Pay Review Body
<b>NIPSA</b>	Northern Ireland Public Service Alliance
<b>NOHPRB</b>	Review Body for Nursing and Other Health Professions
<b>OME</b>	Office of Manpower Economics
<b>ONS</b>	Office for National Statistics
<b>PNC</b>	Pay Negotiating Council
<b>PRB</b>	Pay Review Body
<b>RCM</b>	The Royal College of Midwives
<b>RCN</b>	The Royal College of Nursing
<b>RPI</b>	Retail Prices Index
<b>RRP</b>	Recruitment and Retention Premium
<b>SCP</b>	Society of Chiropodists and Podiatrists

<b>SGHD</b>	The Scottish Government Health Directorates
<b>SHA</b>	Strategic Health Authority
<b>SoR</b>	The Society of Radiographers
<b>ST&amp;T</b>	Scientific, Technical and Therapeutic
<b>UCATT</b>	Union of Construction, Allied Trades and Technicians
<b>UGBS</b>	University of Greenwich Business School
<b>UK</b>	United Kingdom
<b>WAG</b>	Welsh Assembly Government