# Staff Side Evidence to the NHS Pay Review Body

# September 2011

## 1. INTRODUCTION

NHS Staff Side[1] has set out information about the recruitment, retention, morale and motivation of staff in the NHS Pay Review Body's (NHSPRB) remit and also about the political, economic and social factors that are affecting NHS staff.

We draw on separate trade union surveys of members, the NHS Staff Survey and from research on national pay determination undertaken by Ian Kessler, Fellow at Green Templeton College, University of Oxford.

## 2. SUMMARY

**2.1** The submission of staff side evidence to the NHS Pay Review Body is made at a time of great uncertainty and turmoil both within the NHS and the wider economy. As the UK economy struggles to recover from recession, the NHS faces reduced budgets, alongside rising demand and costs as well as major structural and policy reforms.

**2.2** While much of the reorganisation and reforms faced by the NHS apply solely to England, the implications for the NHS as a whole are significant, particularly those relating to pay determination. Staff side are alarmed over the promotion of competition and provisions to encourage local pay bargaining. This would threaten the national pay agreement, resulting in fragmented and unequal systems which would be expensive to implement. This would result in industrial instability and ultimately be to the detriment of recruitment and retention, morale and motivation and patient care. This year's evidence is accompanied by research from Ian Kessler, Fellow at Green Templeton College, University of Oxford. Summarised in section 10, this research describes the advantages of national pay determination and clearly sets out the dangers of any development of local pay bargaining.

**2.3** NHS staff earning more than £21,000 face the second year of a pay freeze, with a £250 uplift awarded to those earning less than £21,000. Meanwhile RPI inflation has not been lower than 4.4% for more than a year. High levels of inflation are continuing to erode earnings for NHS staff, with RPI inflation standing at 17 times the value of the most recent pay award. As a result of rising inflation and the pay freeze, a typical band 5 worker at the top of their scale has sacrificed £1,000 in earnings in 2011. Based on inflation projections, this will rise to almost £3,000 in 2012. In real terms, the value of an average NHS full-time salary is at its lowest level for 11 years. Continued erosion of NHS earnings is simply unsustainable.

**2.4** The £250 award for the lowest paid NHS staff has gone some way to cushioning the impact of rising inflation – yet evidence shows that inflation is running at a higher level for the lower paid. This is combined with benefit and welfare cuts which are detrimental to low income working households, particularly those with children.

**2.5** While private sector earnings have started to recover after the recession, we are concerned that public sector earnings – including in the NHS – have slumped. We repeat the warning made by the Institute for Fiscal Studies, that a further period of pay freeze

[1] British Association of Occupational Therapists, British Dietetic Association, British Orthoptic Society, Chartered Society of Physiotherapy, Federation of Clinical Scientists, GMB, Royal College of Midwives, Royal College of Nursing, Society of Chiropodists and Podiatrists, Society of Radiographers, UCATT, Unison, Unite.

would cause labour market distortions, "with implications for the quality and composition of the public sector workforce."

**2.6** The NHS labour market is in a state of flux. In the medium to long-term, the number of new entrants will decrease due to cuts in training commissions. The supply of healthcare staff has been squeezed in recent years due to a significant drop in immigration. There is also a great deal of uncertainty about the predictably of supply due to the ageing profile of the NHS workforce. Meanwhile, staff attitudes to working in the NHS are being shaken by the pay freeze, pensions reforms, the impact of budget constraints and organisational restructuring - the long-term impact of these factors are yet to be felt.

**2.7** Faced with these uncertainties, we unfortunately have to restate our concerns about both the collection of NHS labour market data and the future of workforce planning. Firstly, we are concerned that both the NHS Information Centre in England and Statistics Wales have not produced data on turnover or vacancies. Secondly, given the challenges described above, we repeat our concerns about the future of workforce planning. The shift towards a greater role for local employers and commissioners in determining and planning the future number of health professionals to be trained will create a huge risk of undersupply for the NHS.

**2.8** The lack of data on turnover and vacancies is particularly troubling given the evidence that we cite of the many number of trusts operating recruitment freezes, leaving posts unfilled as well as the extent of NHS staff working additional hours – often unpaid. This situation is masking the true extent of vacancies and skills gaps. We urge the NHS to adopt a consistent approach to data collection across the UK, in a manner that gives an accurate picture of the number of key data such as vacancies, turnover and the use of bank and agency staff within NHS trusts.

**2.9** As the demand for NHS services continues to grow and staff face greater pressures and higher workloads, their morale and motivation has slumped. While staff remain as dedicated as ever to their work and to the NHS, a range of surveys undertaken by trade unions, the Department of Health and other organisations paint a pessimistic picture, with many staff fearing for the quality of patient care.

**2.10** This year has seen action from individual Trusts to restrict staff moving up the Agenda for Change pay scale. Trade unions have resisted and will continue to oppose such moves. Increases in the paybill due to incremental rises are well within the allocated budget and should be honoured.

**2.11** If the outcome of this year's pay round is once again a £250 rise for staff earning £21,000 or less and a pay freeze for all others, the difference between points 15 and 16 will be eroded to a nominal £122. While the average gap between pay points is 3.6%, the increase between points 15 and 16 would be worth 0.6%. We draw the PRB's attention to the potential for disparities within the NHS pay system – particularly the cliff-edge effect – and request that the body reviews this situation.

**2.12** Staff in the NHS are facing ever increasing workloads, while dealing with the personal consequences of squeezed household incomes due to rising inflation and slow wage growth. While staff side recognises the NHSPRB's remit, we clearly signal our opposition to the pay freeze currently covering the majority of the NHS workforce and emphasise that the £250 uplift for the remaining workforce is not sufficient. Staff side trade unions wish to set out its

expectation that a fair award is made after the pay freeze. Given the organisational upheavals, reforms to pension schemes and the pressures from reduced budgets, further attacks on NHS pay risk damaging recruitment and retention in the NHS – and ultimately patient care.

## 3. RECOMMENDATIONS

**3.1** Our evidence shows that NHS staff are feeling under pressure from the impact of high inflation and pay freezes. This pressure is being intensified by anxieties about pension reforms, job security and organisational restructuring.

**3.2** Pay restraint has meant that NHS staff have already sacrificed a great deal as the gap between salaries and the cost of living continues to rise. Staff side clearly signals opposition to the pay freeze which covers the majority of the NHS workforce and emphasises that the £250 uplift for the remaining workforce is not sufficient. We ask the PRB to consider the impact of pay restraint on the workforce and to support staff side's expectation that a fair award is made after the pay freeze.

**3.3** We ask the PRB to study the findings and implications of the paper produced by Ian Kessler and that it considers the value of national pay determination particularly its contribution to recruitment and retention, ensuring a fully staffed, safe NHS.

**3.4** We also call on the PRB to recognise the value of the UK wide application of Agenda for Change and that support for the agreement is necessary to ensure its continued integrity and durability in underpinning fair and equal pay.

## 4. POLICY AND ECONOMIC CONTEXT

**4.1** The NHS is arguably facing the most challenging period since its inception. For at least the next four years, the organisation must contend with reduced budgets yet rising demand and costs. The NHS must also make efficiency savings on a scale rarely achieved in either the public or private sector. At the same time, a highly controversial reorganisation of health services and shift in health policy will irrevocably change the NHS in England, serving to illustrate the huge differences in devolved health policy and provision.

**4.2** These challenges have far-reaching implications for healthcare staff working in the NHS. Budget reductions have so far resulted in pay freezes for many staff, downbanding, recruitment freezes, redundancies, changes in work patterns and out of hours arrangements. These pressures are set to continue while health reforms will have the potential to lead to significant change in the way NHS staff work, where they work and how they are rewarded.

### Economic context

**4.3** As the UK emerges from the worst recession in 70 years, the prospect of a self-sustaining recovery is far from certain. Unemployment is high and job vacancies are few, while the level of economic activity is sluggish at best.

**4.4** The combination of high inflation, weak earnings growth and fiscal tightening has caused a fall in real disposable income, contributing to a decline in consumer spending. There are also signs that households are seeking to reduce their debt levels, resulting in further reductions in spending. The Office for Budget Responsibility (OBR) projects that real

household disposable incomes in 2011 will contract for a second year in a row, forecasting a fall of 0.4% this year. According to the Institute for Fiscal Studies (IFS), UK households are currently experiencing the most severe protracted fall in incomes since the 1970s. Business confidence is also weak, with the combined result being subdued GDP growth. The UK economy is projected by the IFS to grow by around 2% per year for the next five years

**4.5** In terms of economic policy, the UK government's programme is dominated by cuts in public spending plus tax increases, aiming to eventually close what they believe to be the 'structural deficit' in public spending. However, low levels of economic growth will make it increasingly difficult to pay off debt just as the demands on the state are increasing rapidly due to an ageing population.

**4.6** During the recent recession, employment did not fall as much as previous recessions, partly because businesses retained staff through short-time working and wage cuts and other mechanisms. However, this means that private sector employers have the capacity to respond when the economy does return to growth, without hiring new people. There has been some growth in private sector employment since March 2010, but this has so far been dominated by a jump in part-time working rather than full-time.

**4.7** Youth unemployment stands at a historically high level of around 20%[2] and young people face an increasingly competitive job market, rising housing costs and higher fees for university and college.

**Policy context**

**4.8** The UK Coalition Government's economic strategy, which centres on public spending cuts amounting to £81 billion and tax rises amounting to £29 billion by 2014-15, is designed to boost investor confidence and create space for a rise in domestic investment by the private sector, leading to growth in manufacturing and exports.

**4.9** The Government has also introduced important fiscal changes in the June 2010 and March 2011 Budgets and the October 2010 Spending Review which saw child benefits frozen, cuts to child tax credits and caps on housing benefit. The June 2010 Budget also increased VAT to 20% and made the announcement that benefits, tax credits and public service pensions would increase in line with consumer prices rather than the retail price index which means they rise at a lower than they would have done otherwise. Other measures, such as an increase in the personal tax allowance, mean a complicated pattern of winners and losers from the changes as a whole, but households with children more likely to lose from the changes than those without. Further cuts to welfare spending and changes to the benefits system coming in over the next three years will further reduce incomes and again, households with families and lone parents in particular will face the biggest squeeze.

**NHS policy**

**4.10** The introduction of the Health and Social Care Bill will radically alter the way the NHS in England is run, funded and held accountable. The Bill also points the English NHS in a direction which is divergent to that taken in the other UK countries, where in general, health policy concentrates less on the promotion of competition and promotes the integration of health and social care provision.

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[2] www.statistics.gov.uk/pdfdir/yplm0711.pdf

**4.11** Staff Side unions have all individually expressed strong concerns about the Health and Social Care Bill in England. Trade unions have signalled their opposition to the promotion of competition over cooperation and over provisions to encourage local commissioning consortia and Foundation Trusts to enter local pay bargaining. Staff side believes that this will break down the national pay agreement, resulting in fragmented, inconsistent systems, which would be costly to develop and result in industrial instability.

**4.12** There are mounting cuts to both services and jobs across the UK. Funding for the NHS in England is to increase in real terms by just under 0.1 per cent per year until 2015, but faces a target of £20 billion efficiency savings over the same period. The NHS in Scotland faces a real terms cut of 3.3% by 2011/12.[3] Funding for Northern Ireland is to be cut by 2.6% in real terms by 2014/15[4], while Wales will see a cumulative cut of 8.3% by 2012/13.[5]

**4.13** As a result of reduced budgets, waiting lists are creeping up while more and more services are being rationed. Staff are being hit by redundancies as well as vacancy freezes, down-banding, restructuring and delayed recruitment. During the deficit crisis of 2006-07, the NHS dealt with its £500 million shortfall by cutting around 20,000 posts and reductions in the training budget. Just as the NHS was recovering from these deficit-led cuts which had done so much to undermine staff morale and damage service delivery and workforce planning, we are returning to dangerous cuts in services and staff.

**NHS Pay and Reward Policy**

**4.14** In December 2010, NHS Employers put a proposal to the Staff Side which consisted for a 'job guarantee' in return for a two-year freeze on incremental profession for Agenda for Change staff.[6] Following consultation through the relevant internal, democratic processes, this offer was rejected by all NHS trade unions. Staff Side cited the following factors as reasons for the rejection:

- the value of pay for most NHS staff would be reduced by the pay freeze in operation from April 2011
- inflationary pressures were set to increase over the year and would further reduce the value of NHS pay
- the Government's pre-budget statement had identified a 3% rise in pension contributions in the years to 2013/14
- the proposal contained no detail of the levers which could be put in place to either deliver an effective job guarantee or to 'unfreeze' pay progression at the end of the agreed period – exacerbated by the fact that the existing NHS structures in England (through which such levers may previously have been operated) were subject to planned dissolution
- the proposal was for England only and would have far-reaching consequences for the future of UK wide NHS pay terms and conditions
- the proposal would deliver the 'no compulsory redundancy' clause for staff in Bands 1-6 only

[3] www.bmj.com/content/342/bmj.d2982.full.pdf
[4] www.dhsspsni.gov.uk/final_appleby_report_25_march_2011.pdf
[5] www.guardian.co.uk/healthcare-network/2011/jun/01/kings-fund-predicts-cut-welsh-nhs-spending
[6] with additional proposals for staff outside Agenda for Change

**4.15** In short, NHS staff felt that the employers' first response to the reduction in their financial settlement from Government was to seek further cuts to the value of pay and had little faith in the ability of employers to either enforce the 'job guarantee' or to unfreeze pay after two years.

**4.16** The making and rejection of this proposal has caused a level of mistrust between employers and staff – employers feeling aggrieved that their proposal was resoundingly rejected and staff feeling embittered that the proposal was made in the first place. It has contributed to a climate where staff – particularly those in English Foundation Trusts – fear that employers are actively seeking to target areas of their terms and conditions as a cost-saving measure. This fear has been heightened by the actions of a small number of Foundation Trust employers who have imposed local changes to Agenda for Change, outside of the existing flexibilities identified in the agreement. This is doubtless one of the factors in the drop in morale and motivation evidenced in chapter seven.

**4.17** Through the NHS Staff Council, the trade unions have sought to re-establish progressive dialogue with the employers in order to ensure Agenda for Change continues to receive the commitment of all parties.

**4.18** In relation to pre-Agenda for Change equal pay cases, the UK Governments have continued to decline the opportunity to settle outstanding claims at a national level, meaning that there are still a large number of outstanding claims. The Hartley Employment Tribunal judgement identified the NHS Job Evaluation Scheme as a crucial tool in the delivery of equal pay[7]. In response to concerns raised by the Staff Side, the Job Evaluation Group produced guidance in August 2011 reminding organisations of the need to maintain adequate skills and capacity in relation to the Job Evaluation Scheme. In March 2011, the NHS Staff Council Equal Pay toolkit was developed by the Equality and Diversity Group and published for use across the NHS.

**4.19** There are a growing number of trusts moving staff from on-call systems to shift models of service provision, in addition to downbanding. Both are resulting in cuts in remuneration for a wide range of different staff members.

## 5 PAY AND PRICES

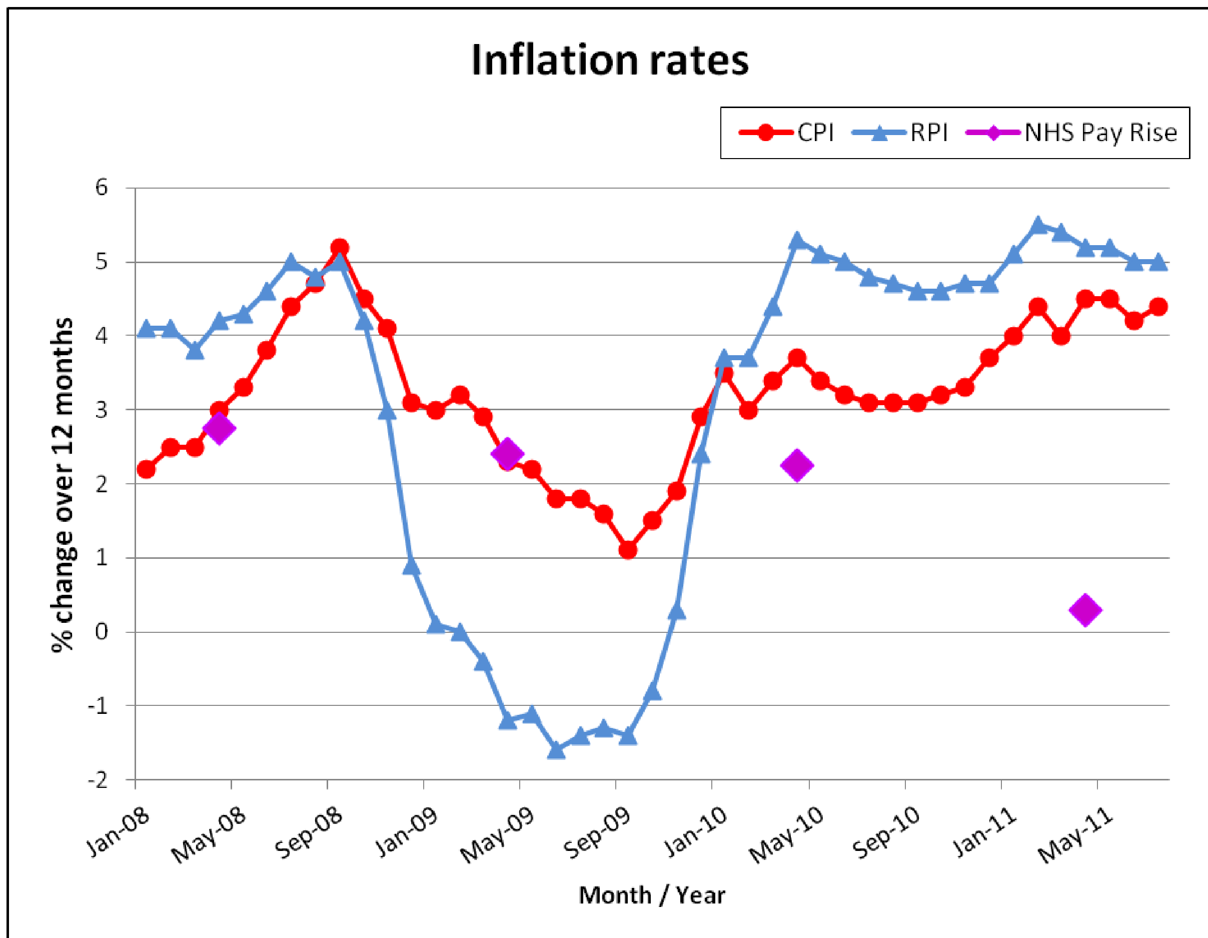
### Inflation

**5.1** Both Retail Price Index (RPI) and Consumer Price Index (CPI) inflation have been running ahead of NHS pay awards for the great majority of the last three years. In fact, monthly RPI figures have been above the annual pay award for 67% of the period since January 2008, while monthly CPI figures have surpassed awards for 79% of that time.

**5.2** However, the most striking aspect of the inflation picture is the yawning gap opening up over the last year between inflation and NHS pay awards. The combined impact of a pay freeze for all staff except those earning £21,000 or less and consistently rapid inflation is that RPI inflation now stands at 17 times the value of the most recent pay award, which amounted to a 0.3% increase in the NHS paybill.[8]

[7] Hartley and others v Northumbria Healthcare NHS Foundation Trust 2009

[8] NHS Employers Submission to the NHS Pay Review Body 2011/12, November 2010, p3

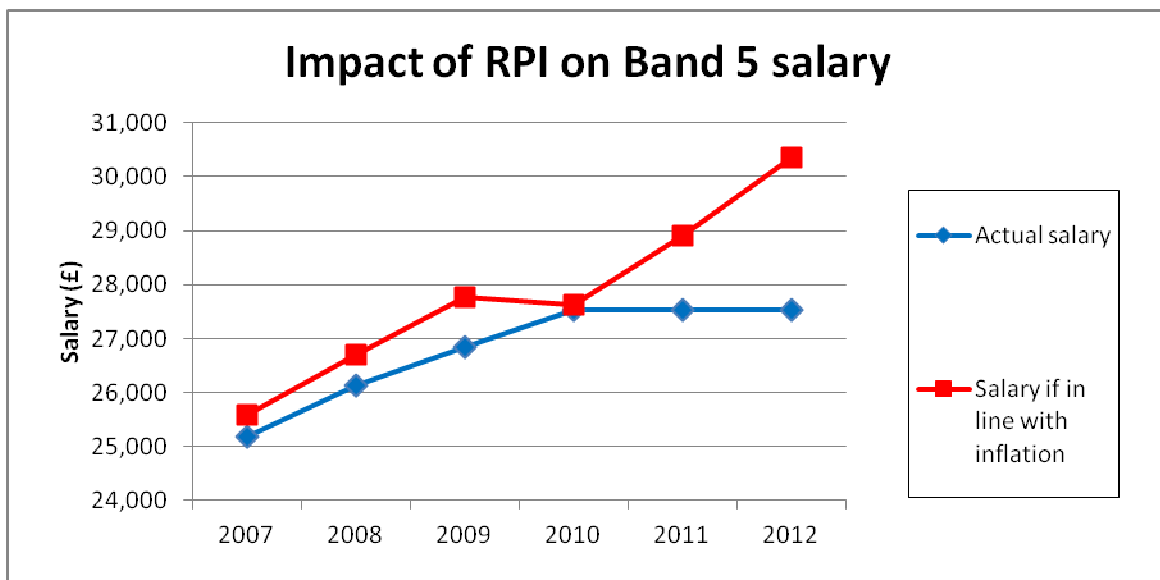



*Source: Office of National Statistics*

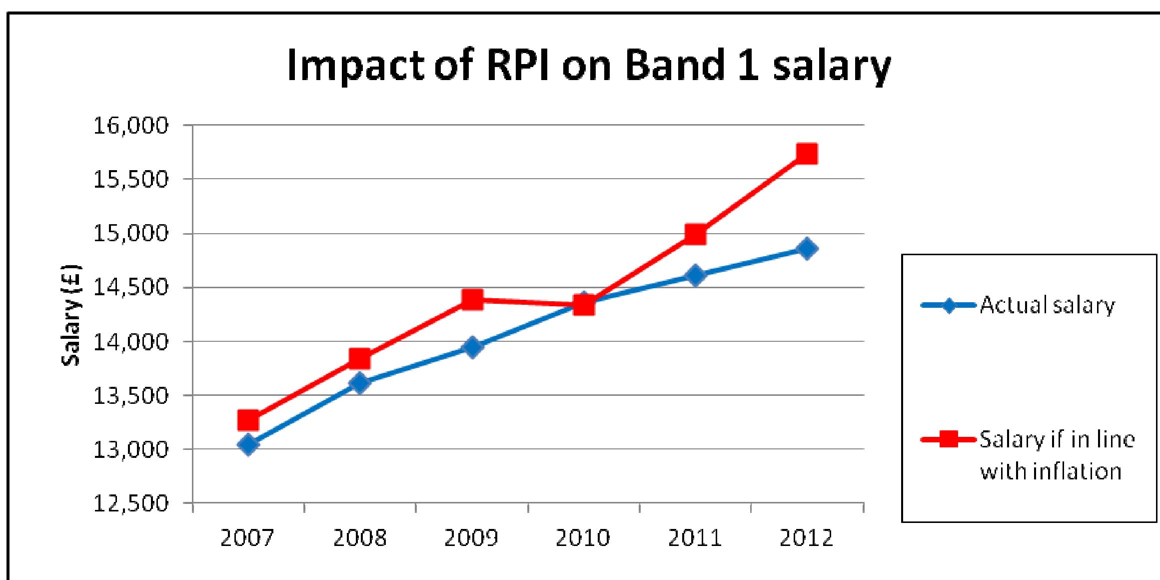
**5.3** RPI has not been lower than 4.4% for over a year and during most of that time it has exceeded 5%. That picture is set to continue, with the Treasury average of independent forecasts showing an RPI average of 5.3% and CPI average of 4.5% for the remainder of the year.[9] RPI inflation is set to fall to 3.3% and CPI inflation to 2.2% by the fourth quarter of 2012, but this scenario would still mean a giant gap between inflation and pay awards for the next 19 months if a further pay freeze is imposed.

**5.4** The effect of inflation on wages of NHS staff can be seen in the diagrams below. Taking the salary of a Band 5 worker at the top of their scale in April 2006 it shows how their actual salary increased through to April 2010 and then illustrates their salary as remaining flat until April 2012. In contrast, the diagram also tracks their salary if it had increased in line with the yearly Retail Price Index. The gap between the two initially grew steadily before closing to approximate parity when RPI was declining in 2009. However, since then the combined impact of surging inflation and the pay freeze has seen the gap expand to over £1,000 in 2011 and on current inflation projections the gap will almost hit £3,000 next year, cutting 9% off the value of a Band 5 worker's wage.

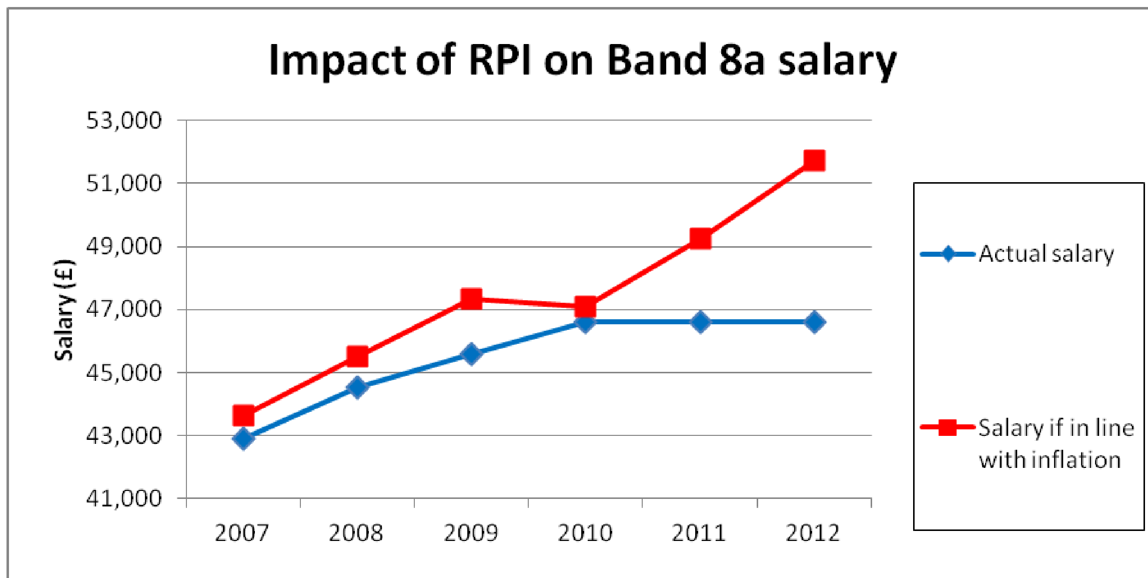
[9] HM Treasury, Forecasts for the UK Economy, August 2011



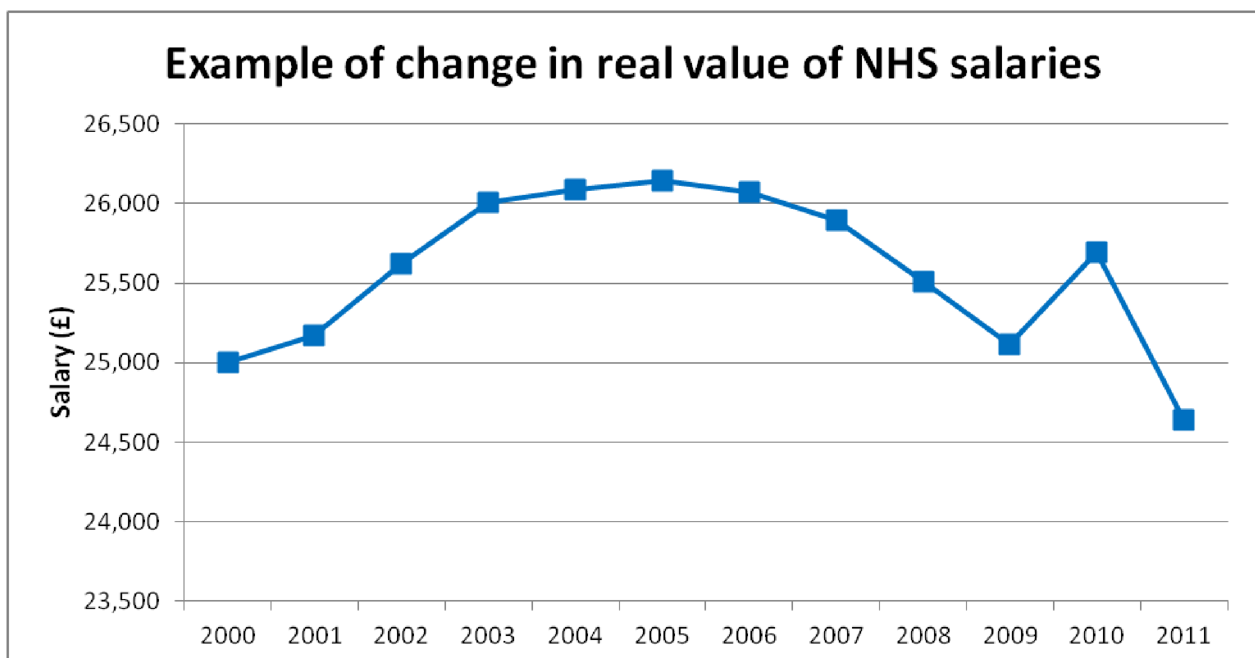

**5.5** Even for the lowest paid staff in the NHS the picture is very similar. An employee at the top of Band 1 (who received the £250 increase in 2011 and for the purposes of the graph below are assumed to receive a further £250 increase in 2012), is set to see the gap between their actual salary and an RPI indexed salary hit £875 next year. Therefore, staff on just £14,864 will have seen inflation take a 6% bite out of the value of their wages.




**5.6** For higher paid staff, such as an employee at the top of Band 8a, the differential is anticipated to hit over £5,000 next year – a loss of 10% to the value of their salary.




**5.7** The longer term impact on NHS wages is illustrated by the diagram below, which takes a wage of £25,000 in the year 2000 and tracks the net impact of pay awards and inflation as an example of how its real value has grown and declined. The exercise shows that the real value of the wage grew to a high of £26,146 by 2005, but the gap between inflation and the pay award has been so dramatic that the real value has now actually dipped below to £24,637 – below its value 11 years ago.




**5.8** Staff Side has consistently maintained that the RPI measure of inflation represents the best measure of changes in prices faced by NHS staff, as it includes the housing costs that form a significant part of most employee's expenditure. The results of the latest Croner Reward cost of living survey backs up this assertion as its analysis of the required income to

maintain a family's standard of living found a 5.3% increase over the year to March 2011 (the RPI figure for the same period was 5.4%).[10] The great majority of that increase (4.4%) occurred in the final six months to March 2011.

**5.9** The Croner Reward survey also breaks down the required income to maintain existing standard of living according to eight different income categories. The results of this breakdown show that yet again the lowest income group saw the biggest rise in required income at 6.6% over the year. The 2011 results compounded the 2010 figures, which showed the lowest income group suffering by far the greatest hardship with an increase in costs of 6%.

**5.10** That evidence has been bolstered this year by the detailed Institute of Fiscal Studies study of inflation for low income households.[11] It found that the greater tendency of such households to spend a higher proprtion of their income on fuel and water meant that, on average, lower income households had higher inflation rates than higher-income households. For example, over the 10 year period studied, the group within the second lowest income decile experienced a 41% increase in prices while the highest income decile experienced a 33% increase. The study also went on to note that this differential is likely to continue given the forecasts from the Department of Energy and Climate Change that point to price increases in domestic fuel above that of general inflation over the short term.

**Inflation components**

**5.11** The changes in the price of components of the Consumer Price Index over the year to June 2011 as defined by the Office of National Statistics are shown in the tables below.

| **Item** | **% increase over year to June 2011** |
|---|---|
| Alcohol beverages & tobacco | 9.6 |
| Transport | 7.9 |
| Food & non-alcoholic beverages | 6.9 |
| Education | 5.3 |
| Restaurants & Hotels | 4.5 |
| Housing & Household Services | 4.3 |
| Furniture, household equipment and maintenance | 4.0 |
| Health | 3.6 |
| Miscell. Goods & Services | 1.9 |
| Communication | 1.7 |
| Clothing & Footwear | 1.5 |
| Recreation & Culture | 0.5 |
| **All Items** | **4.2** |

*Source: Office for National Statistics, Focus on Consumer Price Indices Data for June 2011*

[10] Croner Reward, Cost of Living Regional Comparisons, March 2011
[11] Levell P and Oldfield Z, *The spending patterns and inflation experience of low-income households over the past decade*, Institute of Fiscal Studies, June 2011

**5.12** For the second consecutive year, transport figures among the largest factors, driven principally by a 15.1% increase in the costs of fuels and lubricants alongside a 12.2% increase in the cost of air transport. The scale of rises in the cost of basic food and drink requirements is also apparent in that this dimension of cost was the third biggest contributor among 12 price components.

**5.13** The changes in the price of components of the Retail Price Index over the year to June 2011 as defined by the Office of National Statistics are shown in the tables below.

| **Item** | **% increase over year to June 2011** |
|---|---|
| Personal expenditure | 8.0 |
| Alcohol and tobacco | 7.8 |
| Food and catering | 6.4 |
| Travel and leisure | 5.9 |
| Consumer durables | 4.3 |
| Housing and household expenditure | 2.6 |
| All goods | 6.3 |
| All services | 4.8 |
| **All items** | **5.0** |

*Source: Office for National Statistics, Focus on Consumer Price Indices Data for June 2011*

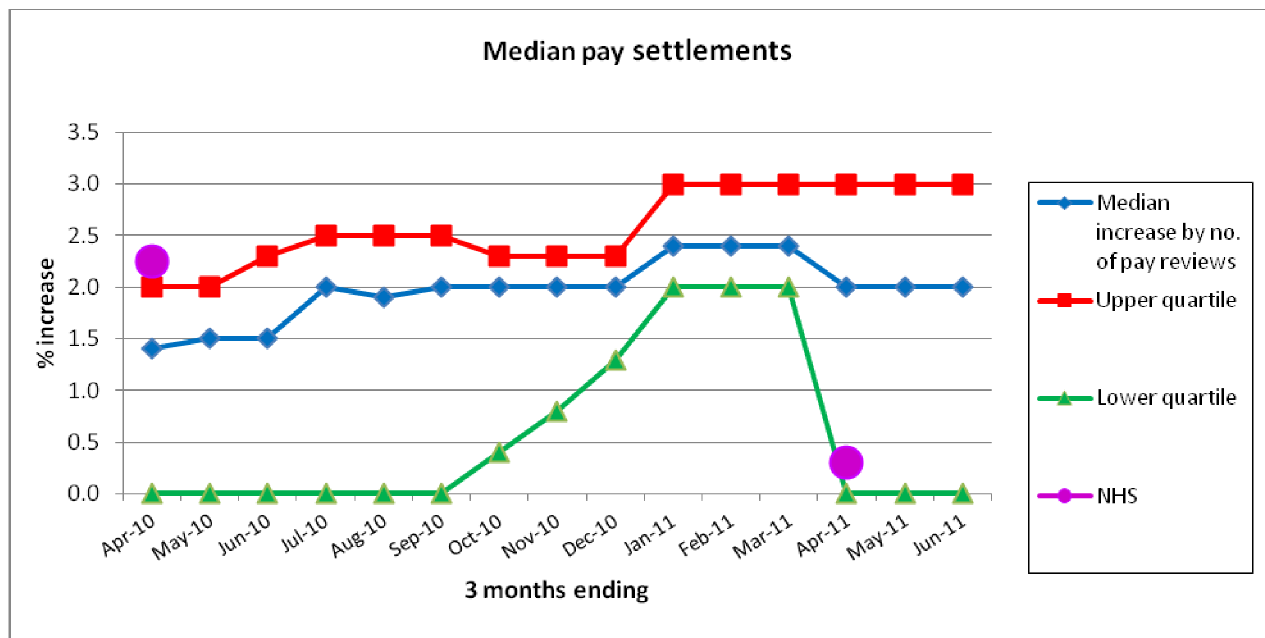
**5.14** Within the RPI data, it is apparent that electricity and gas costs have returned to strong growth of between 4% and 6%. The housing costs omitted by the CPI have seen rent rise by 2.3% over the year alongside mortgage interest payments at 3.8%. Households have faced 10.9% rises in the cost of clothing and footwear, 8.7% rises in the cost of motoring and 7.7% in travel fares covering rail and bus travel. The July RPI figures are used to fix the increase in rail fares for next year and with RPI coming in at 5%, train operating companies will be allowed to raise fares by an average of 8% in 2012. The RPI also confirms the explosion of basic food costs, with food element of the 'food and catering' category jumping by 7.3%.

**5.15** Though not specifically assessed by CPI or RPI figures, childcare costs represent a key area of expenditure for many staff. The annual Daycare Trust survey for 2011 found that childcare costs have typically increased by more than the average wage.[12] The average yearly expenditure for 25 hours nursery care per week for a child under two is £5,028 in England, £5,178 in Scotland and £4,723 in Wales. These figures represent a 9.9% increase in England, 18.5% increase in Scotland and 16.5% increase in Wales.

[12] Daycare Trust, Holiday Childcare Costs Survey 2011, January 2011

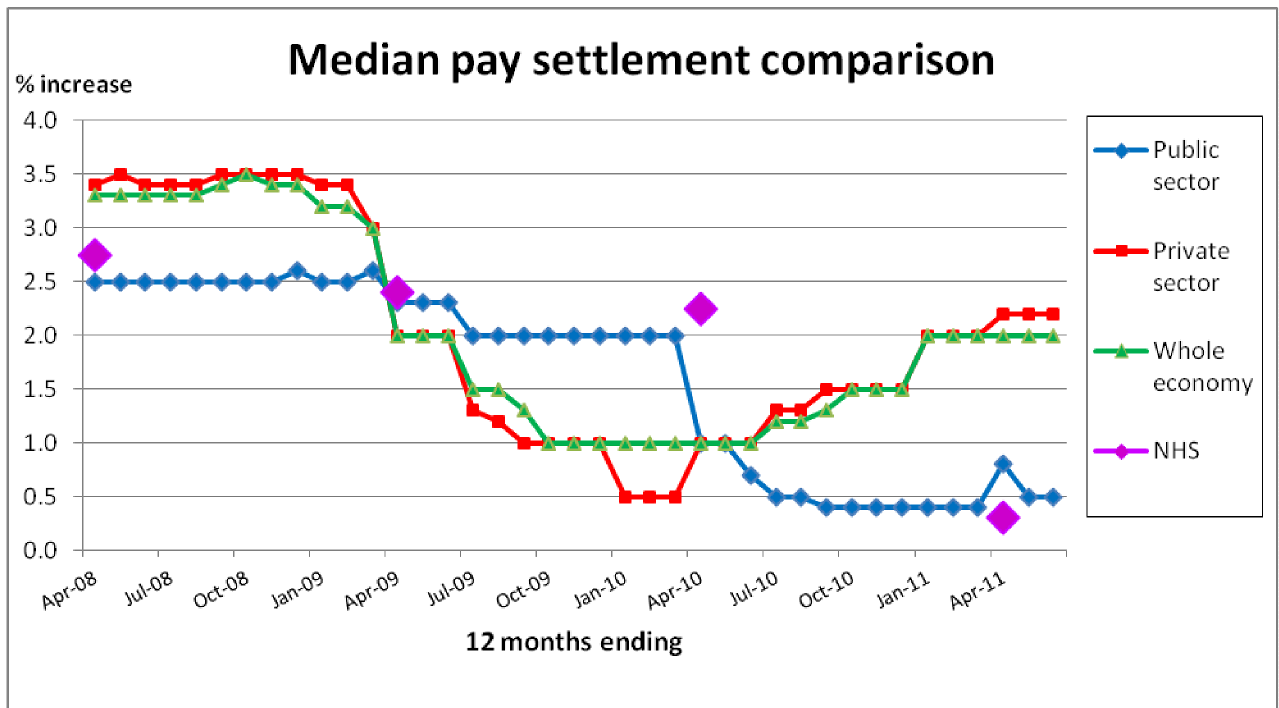
**Pay settlements**

**5.16** Median pay settlements across the UK economy have continued their growth since bottoming out in mid 2009. Over the last year they have grown from 1.4% in April 2010 to 2% in June 2011.




*Source: Industrial Relations Services*

**5.17** The reason for the growth is almost entirely down to the private sector, which has seen growth rise from 0.5% in March 2010 to 2.2% in June 2011, just as the public sector rate has slumped from 2% to 0.8% over the same period. The diagram below shows that the NHS has closely tracked the public sector rate, but fell below even the public sector rate in April 2011.



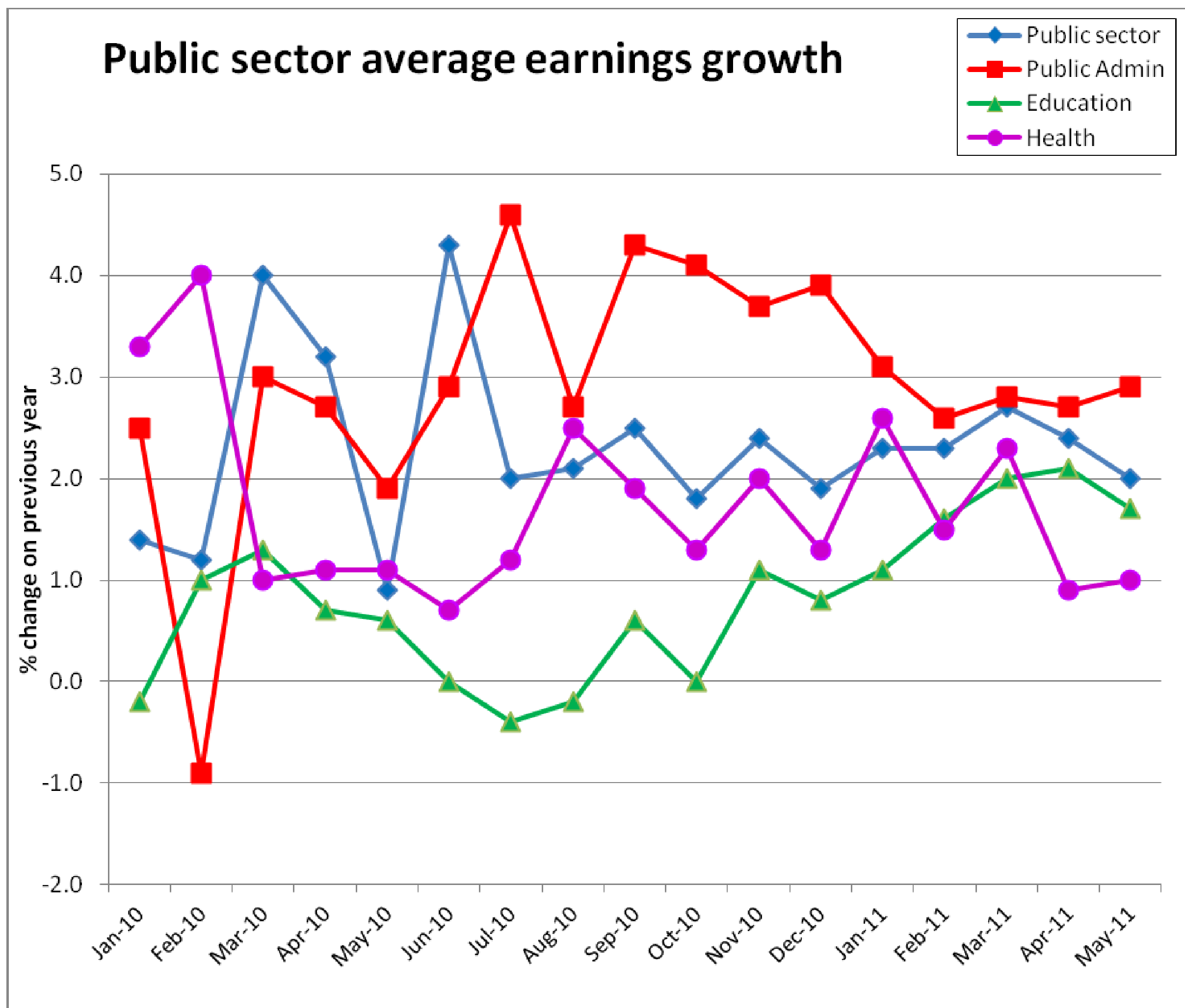

*Source: Industrial Relations Services*

**5.18** The latest forecast of pay settlements for the coming year indicates that the private sector rate is set to grow further to 2.5%, widening the gulf with NHS staff once more.[13]

### Earnings comparisons

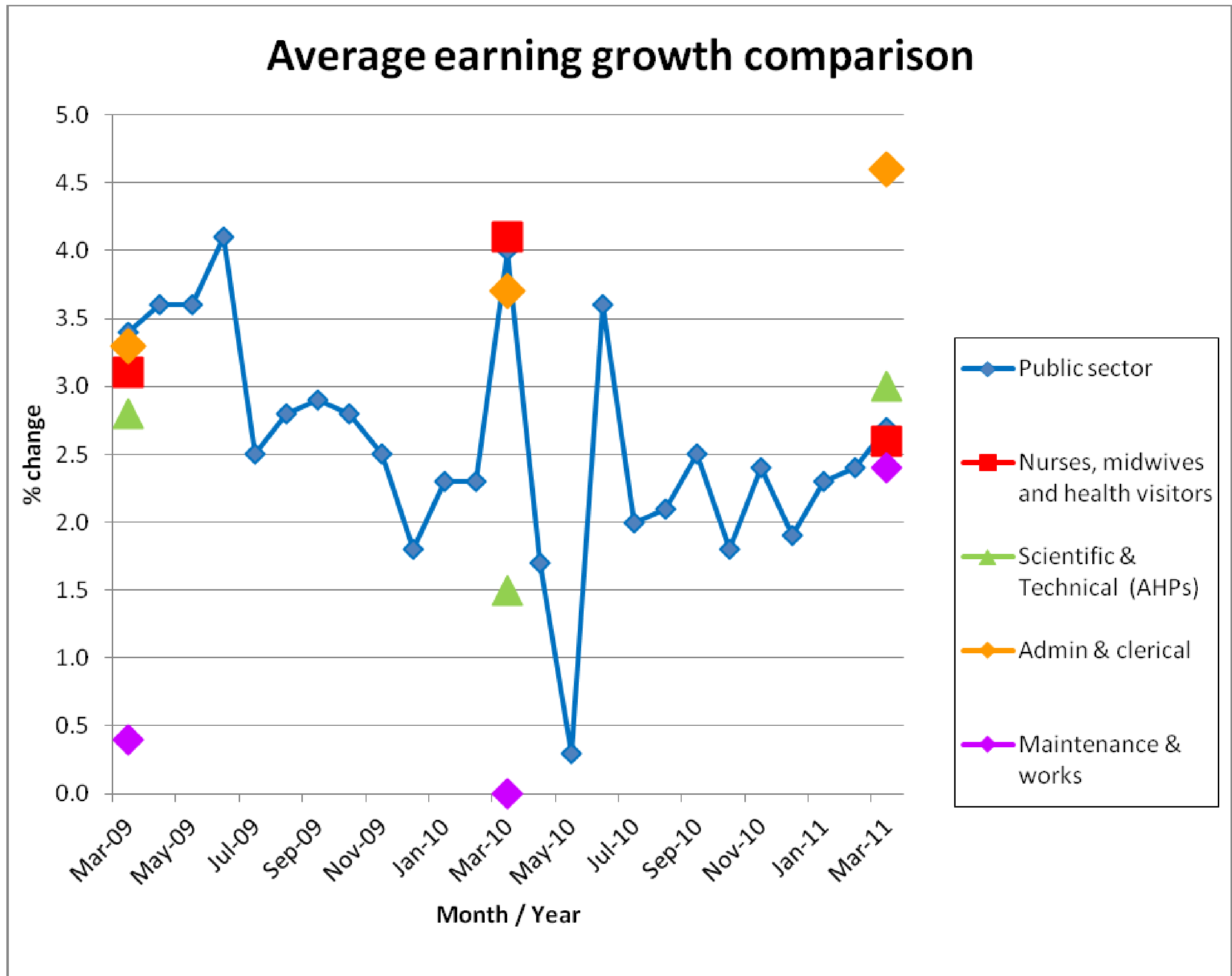
**5.19** The graph below shows how average earnings growth in health has dipped below the average public sector rate over the last year, falling from 4% in February 2010 to 1% by May 2011 where it is now running significantly below all other areas of the public sector.

[13] XpertHR Salary Survey, June 2011




*Source: Office of National Statistics – % change in single month average earnings including bonuses compared to previous year*

**5.20** When earnings growth of key NHS occupational groups in England are compared against the public sector average it is apparent that over the last three years, earnings growth of the four occupational groups listed have been at or below the public sector average rate on 9 out of 12 occasions.

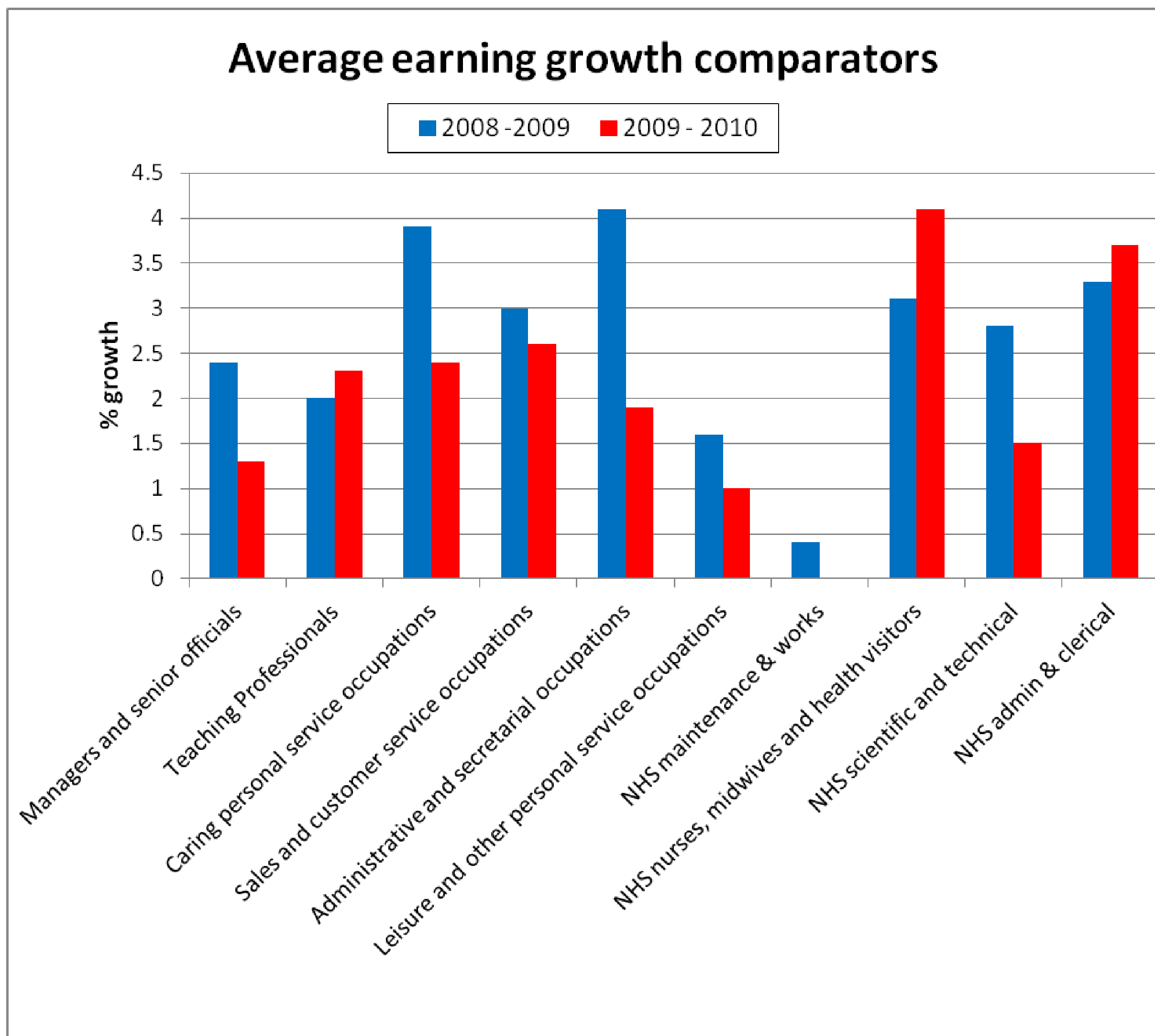



*Source: Office of National Statistics (% change in single month average public sector earnings including bonuses compared to previous year) & NHS Information Centre Staff Earnings Bulletins (% change in three month to March median full time equivalent total earnings compared to previous year)*

**5.21** The latest UNISON health member survey asked employees who had considered leaving the NHS over the last year to indicate the type of job they would seek in the external labour market.[14] The results showed that the most popular choice was admin/secretarial work (34% of the sample), followed by caring services (24%), retail (22%), teaching (22%), management (20%) and leisure services (14%). This information gives us some reasonable comparators for examining earnings growth in the NHS against earnings growth for these occupations as defined in the Annual Survey of Hours Earnings. The results show a fluctuating picture, with comparators showing marginally greater earnings growth between 2008 and 2009 and slightly lower growth between 2009 and 2010, when the effect of the recession on the private sector was at its greatest. Unfortunately, Annual Survey of Hours Earnings (ASHE) data for 2011 is not released until the end of this year, therefore, a comparison cannot yet be made with the most up to date NHS earnings data. However, the data available does show that, even before the pay freeze imposed last year, the NHS was showing approximate parity with the best comparators and therefore it is reasonable to

[14] UNISON member survey, June 2011

assume that, with the bounce back of private pay settlements, the NHS is now likely to be losing ground to these comparators.




*Source: Annual Survey of Hours and Earnings (% change in median gross annual pay for full time staff at Marchof 2009 and 2010 compared to previous year) and NHS Information Centre Staff Earnings Bulletins (% change in three month to March 2009 and 2010 median full time equivalent total earnings compared to previous year)*

**5.22** Forecasts of average earnings predict that average earnings growth for 2011 will stand at 2.5% and expand to 3% in 2012.[15] This is well above the 1% rate in the health sector as recorded at June 2011.

**Pensions**

**5.23** The coalition government commissioned Lord Hutton to undertake a review of structural changes in public sector pension systems. The interim report demonstrated that

[15] HM Treasury, Forecasts for the UK Economy, August 2011

incremental changes introduced by the Labour Government in the past decade were set to reduce the share of public sector pensions in GDP by 2040. These changes typically involved a higher retirement age and higher contributions, often to the disadvantage of new entrants. The Hutton report recommended a change from final salary schemes to career-average benefits, increased contributions and a higher retirement age. These proposals come on top of the change introduced from April 2011, in the measure used to uprate pensions – from RPI to CPI. This is a substantial change for pensions, for example if CPI averages just 1% less than the RPI, then the pensions will be 9% lower after 10 years and 18% lower after 20 years than would have been the case with RPI updating.

**5.24** At the end of July 2011, the Department of Health began a formal consultation on the imposition of higher pension contributions across the workforce. Staff earning up to £26,557 will pay 0.6 percentage points more from April 2012 and those earning between £26,558 and £48,982 will pay an extra 1.2 percentage points. Contribution rates will increase by almost two percentage points for staff earning between £48,983 and £69,931 and 2.35 percentage points for those earning between £69,932 and £110,273. Further increases will follow in 2014. For many staff, the amount of money removed from their pay packet as pension contributions will rise by 50%.

**5.25** The final dimension of proposed changes will be the linking of the retirement age to the staged increases in the state pension to 68. Therefore, as a package, the pension changes planned by the government would mean that NHS staff work longer, pay more and get less.

**5.26** While it has been proposed that the increase in contributions is tapered, with staff earning less than £15,000 not making any additional contributions – this exemption applies to just three pay points on the Agenda for Change pay scale. Current proposals would see staff earning £21,000 or less paying an extra 1.5% on average. It is expected that staff above that threshold will pay an additional 3% on average.

**5.27** Given that most staff currently pay around 6% of their total salary as pension contributions, the increases could mean a 50% increase in contributions for a significant number and a rise of 25% even for the low-paid. This is a substantial loss of earnings coming on top of the erosion in wages caused by inflation during the pay freeze.

**5.28** Individual staff side surveys demonstrate the dangers of pensions reforms. A survey of over 300 GMB members conducted in 2010 showed that 34% would leave the NHS pension scheme if a 3% contribution increase was applied. Among members with full-time equivalent earnings of less than £21,176, 43% said they would leave the scheme if this level of increase was applied.

**5.29** A survey of 7,904 RCN members found that among the 6,046 nursing staff working in the NHS and with membership of the NHS scheme, 11% said they would definitely or probably leave the NHS pension scheme if contributions increased by 1-3%. Just over half (55%) said they would probably or definitely not leave, while a third said they were not sure.

**5.30** When asked about intentions if contributions rose by 3% or more, 29% that they would probably or definitely leave the scheme. Just over a third (35%) said would not leave, but the same number said they were not sure (36%). Members were also asked whether a move from a career-average scheme would change their intentions, a larger number said

they would think about moving – 30% said they would definitely or probably leave. Almost 30% said they would not leave and 42% said they were not sure.

**5.31** While these surveys were conducted at a time when details about proposed reforms were emerging and being discussed, they demonstrate a growing sense of uncertainty and anxiety about increased contributions to the NHS scheme.

**Conclusion**

**5.32** The most striking aspect of the latest economic data is the sheer scale of the devaluation of NHS staff wages caused by inflation during a period of near total pay freeze. The best projections available suggest that inflation will have cut out between 6% and 10% from the value of staff wages by the end of the two-year pay freeze.

**5.33** While the £250 increase for staff earning £21,000 or less has made a small contribution to cushioning the impact on low paid staff, the reduction in the value of their wage is still severe and plainly has a greater impact on their ability to afford to cover the most basic aspects of expenditure on housing, food and energy. Furthermore, the available evidence once again suggests that inflation for the low-paid is running at an even higher level than the RPI.

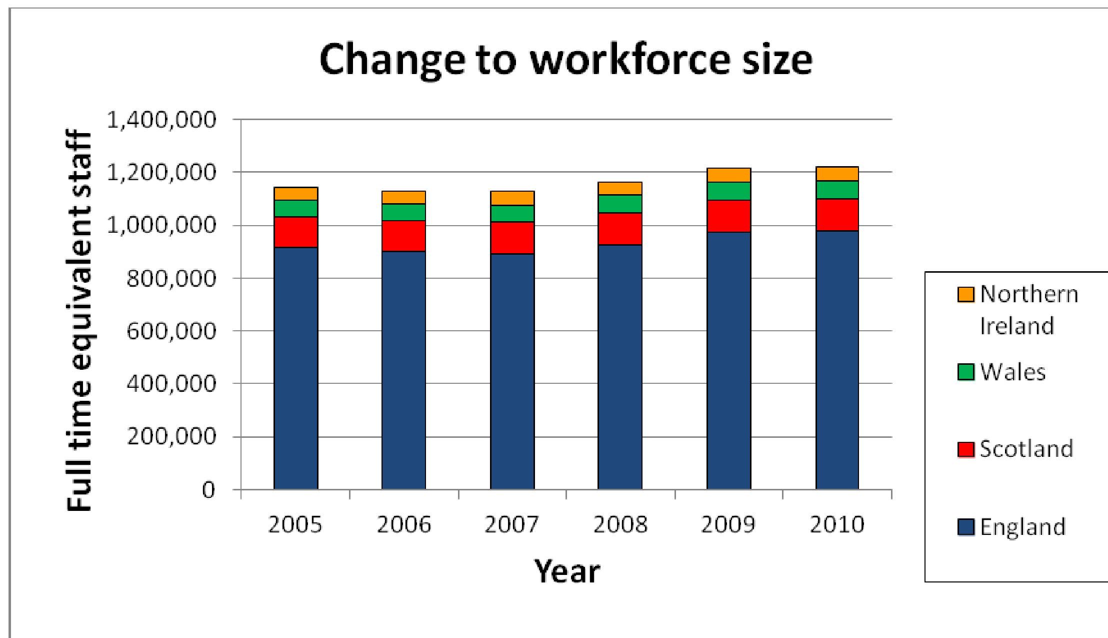
**5.34** The other clear development is the surging ahead of private sector pay settlements in comparison to the public sector and the available indicators for health sector and NHS earnings growth also suggest that they are falling behind even general public sector rates. The attractiveness of a career in the NHS will have certainly declined during the last year relative to the private sector and careful attention will need to be paid to whether the service continues to lag behind the public sector in general.

**5.35** The Institute for Fiscal Studies (IFS) took a detailed examination of the public sector pay freeze policy and warned that "reducing public sector pay by too much over too prolonged a period might lead to a fall in the average skill level of public sector employees, making it more difficult to provide efficiently public services of the desired quality."

**5.36** The IFS goes on to state that "pay freezes ultimately cause labour market distortions, with implications for the quality and composition of the public sector workforce. If private sector employment does begin to increase, recruitment of more able workers from the public sector will be easier when public sector pay is relatively less attractive; moreover, any difficulties that arise in recruiting new staff to the public sector (or, indeed, freezes in recruitment) will lead to a public sector workforce that is ageing and losing its most able employees to the private sector."

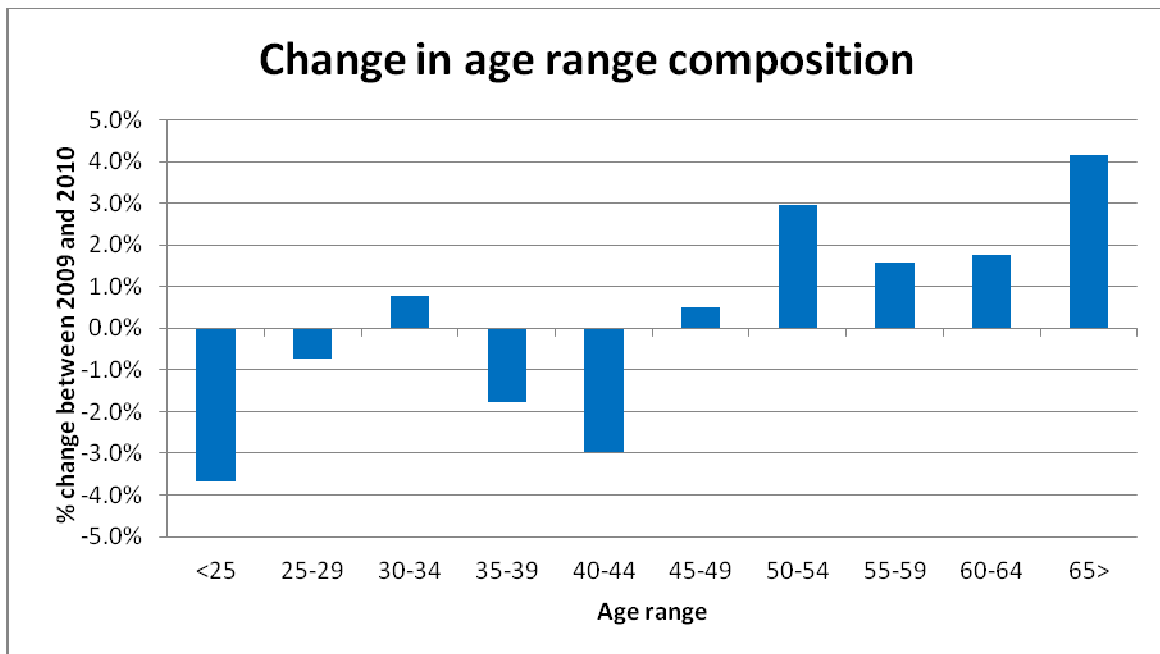
## 6 RECRUITMENT AND RETENTION

**6.1** The total size of the NHS non-medical workforce plateaued over 2009/10, showing a marginal growth across the UK of 0.4% to 1,219,217 full time equivalents. This was principally due to the workforce in England, which grew by 0.8% as the other three countries all recorded a decline. The Northern Ireland workforce fell by 0.3%, Wales declined by 0.6% and, most dramatically, the workforce in Scotland dropped by 2.2%.




*Source: England – NHS Information Centre, Scotland – NHS Scotland, Wales - StatsWales, Northern Ireland – DHSSPSNI Workforce Census 2010*

**6.2** Analysing the change in the composition of the workforce in England by age range shows a striking picture. As demonstrated in the graph below, between 2009 and 2010, all age groups under 44 except the 30-34 group sustained a fall in whole time equivalent numbers, while all age groups of 45 and over recorded a rise. This ageing profile of the NHS workforce comes despite the apparent pressure to release older workers through such mechanisms as voluntary redundancy schemes introduced to deal with financial demands placed on the service. It will be worth tracking this composition to establish whether it represents a worrying trend for the NHS in attracting younger staff.




*Source: NHS Information Centre, NHS England Staff 2000-2010 (non-medical), 22 March 2011*

**Vacancy data**

**6.3** It is a matter of great concern that the NHS Information Centre has not produced revised figures for turnover or vacancy in the NHS this year. While it is appreciated that consideration may need to be given to rationalising the data reporting 'burden' on trusts, vacancy figures in particular are vital to considering the state of the health service and ultimately the decision making over staff pay awards.

**6.4** Therefore, the only new statistics available for 2011 are those for Scotland, which recorded a small increase in nursing and midwifery vacancies from 0.8% in September 2010 to 1% in March 2011, while Allied Health Professionals rose from 1.3% to 2.1% over the same timeframe. [16]

**Staff views**

**6.5** Several trade unions have undertaken member surveys this year, canvassing staff working in the NHS on a range of issues.

**6.6** One of the most striking aspects of these results was that the proportion of staff who have considered leaving their current position in the health service. The UNISON survey found that this number has grown from 67% to 79% over the last year and the proportion giving fairly or very serious consideration jumped from 42% in 2010 to 57% in 2011. The RCN survey found that just over a third (35%) said they were seeking alternative employment or retirement compared to a quarter (24%) in 2009.

**6.7** These responses have perhaps been influenced by opportunities opening up for voluntary redundancy but they also reflect how staff feel about their daily working lives and the reward that they receive for it.

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[16] NHS Scotland Workforce. ISD Scotland, 28 June 2011

**6.8** It was also apparent that the main factors that keep staff attached to the NHS, such as commitment to their job, enjoyment of their job and the pension scheme, have all weakened in the estimation of staff, while the negative factor in simply not being able to find other employment was on the rise.

**6.9** Just over half of UNISON members also reported that their department or workplace had experienced some level of recruitment and retention difficulty over the last year, while a third stated that there had been no or few problems. Similarly, over the course of the year, 42% observed that recruitment and retention problems had grown more acute, 37% of workplaces had experienced no change and just 2% had experienced an improvement.

**6.10** These results may have less to do with employers struggling to find applicants for posts (except in certain particular specialist roles) and more to do with the widespread use of recruitment freezes reported by 49% of staff in the UNISON survey and 40% in the RCN survey. Consequently, these surveys show the extent to which staff perceive a failure to fill posts traditionally filled in their workplace in contrast to the official vacancy statistics which record problems with filling advertised posts, hiding the actual reality on the ground for staff coping with increased demands.

**6.11** Since September 2010, the Society of Radiographers (SoR) has undertaken several surveys of vacancy rates among different radiography specialisms. The most recent, conducted in May and June 2011, on sonographers showed that the vacancy rate across ultrasound departments is 10.9%. The two main reasons for vacancies are that departments are waiting for a trainee to qualify or that they are unable to recruit suitable applicants. Other SoR surveys conducted in autumn 2010 showed an average 3 months or over vacancy rate of mammographers of 8.1% in breast screening departments and a vacancy rate of 8.4% for therapeutic radiographers.

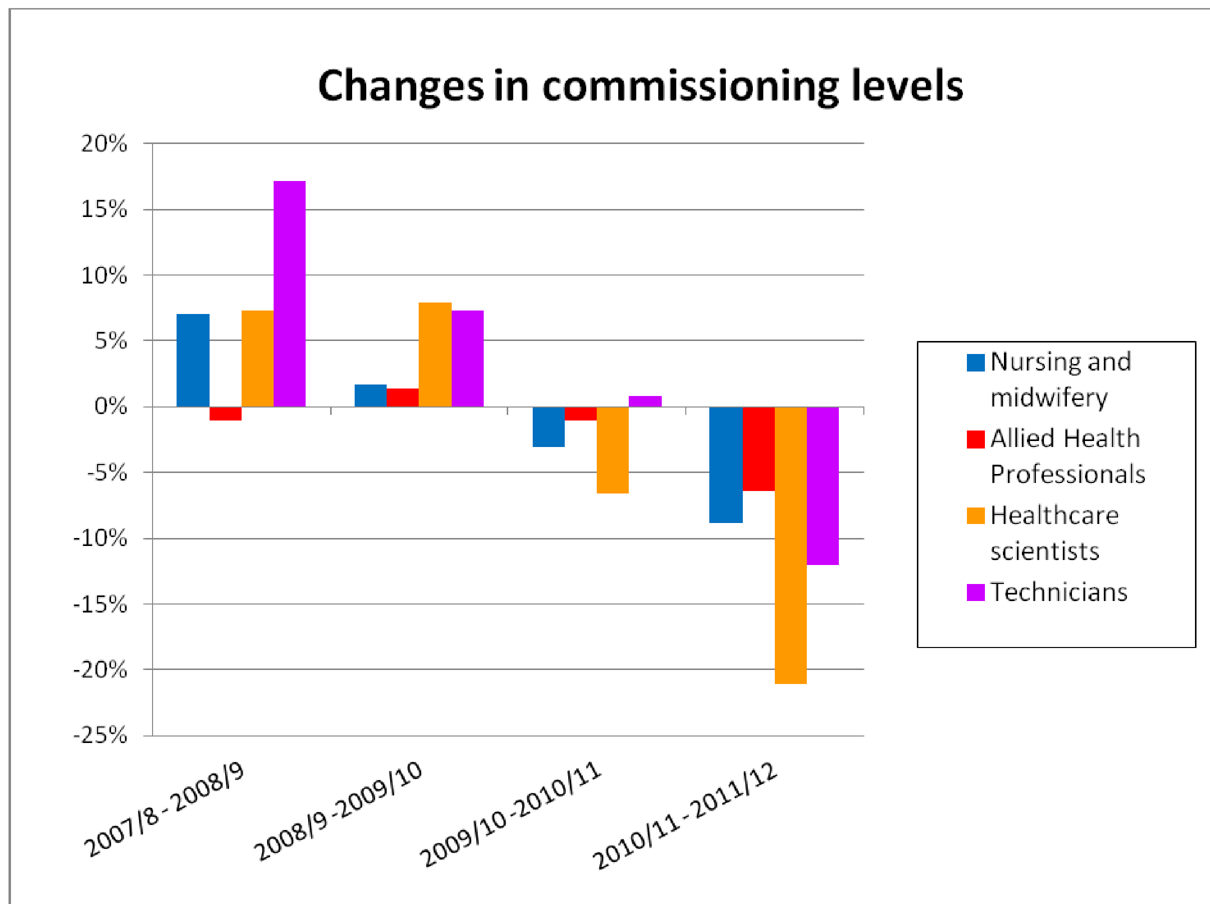
**6.12** The Royal College of Midwives survey of Heads of Midwifery (HOM) conducted in July 2011 also tells a complex story. Eight in ten (79%) said that there were vacancies in their trust or board, with 67% of those vacancies over 3 months old. The survey reports that many trusts are just not recruiting midwives, but where appointments are being made HOMs have little problem recruiting to those posts. However, the sheer competition for posts and the fact that more experienced midwives are not moving between posts means that newly qualified midwives are struggling to find jobs. Similarly, a survey by the Chartered Society of Physiotherapy (CSP) of senior physiotherapy managers in the NHS across the UK showed that 54% of respondents had already experienced or expected a reduction in the number of Band 5 posts available to new graduates.

**6.13** Other findings from the CSP survey, conducted in August 2011 show that around half (48%) of managers said some or all vacant posts are automatically cut from the funded establishment and a further 57% said some or all vacant posts are automatically frozen. Three quarters (72%) said that vacancy control procedures are causing significant delays to the filling of some vacant posts with a further 18% stating that this was happening with most or all posts. The majority of respondents (82%) reported that banding of some or all vacant posts had to be reviewed and two thirds (67%) said that after review, some or all vacant posts were downbanded. Just over a quarter (28%) stated that there had been a reduction in the number of Band 8 physiotherapy posts in their organisation in the past year and just under half (47%) reported a reduction in Band 7 posts. In terms of the impact on the quality of care – a quarter (26%) said patient safety was sometimes compromised due

to inadequate staffing levels and a third (36%) said quality of care was suffering due to our loss of senior posts in this financial year. While most (78%) said they expect demand for physiotherapy services to increase in this financial year, a high number (66%) also said they do not expect to have sufficient resources to meet demand for physiotherapy. Almost a half (46%) also reported that inadequate physiotherapy staffing levels are obstructing them from redesigning and modernising the service.

### Workforce projections

**6.14** Future shortages in key elements of the NHS workforce are transparent in the latest figures on commissioning. The graph below illustrates how commissioning levels in England between 2010/11 and the anticipated rates for 2011/12 are set to plummet. Nursing and midwifery commissions will be down by 8.9%, allied health professional commissions by 6.4%, technicians by 12% and healthcare scientists by 21.1%. The only exception to this picture will be community nursing, which, after two years of decline, is set to see an increase almost entirely driven by the commitment to raise the number of health visiting staff.




*Source: Non-Medical Education and Training Commissions*

**6.15** The NHS Workforce Review Team formerly produced regular projections of supply and demand for major occupational groups in England until its replacement by the Centre for Workforce Intelligence (CfWI). While the CfWI has not yet produced such detailed forecasts

of supply and demand, it has produced a paper on the workforce risks and opportunities facing the nursing and midwifery workforce.[17] In addition to the rapid decline in commissioning that will hit the NHS in three years from now, when the current cohort of nursing and midwifery graduates, the report identifies two further threats to the NHS that are set to constrict its supply nursing and midwifery staff.

**6.16** Firstly, international admissions of nurses to the Nursing and Midwifery Council register has collapsed from between 10,000 and 16,000 per year around a decade ago to 2,500 per year in 2008/9.[18] Simultaneously the migration of UK nurses (principally to Australia) has risen to the point that the outflow of nurses is over five times higher than the inflow. This trend has been driven by the choking off of immigration from outside the EU when registered nurses were deleted from the shortage occupations list in 2005 combined with introduction of the points based work permit system and increases in training costs.

**6.17** The ageing of the NHS workforce detailed earlier in this chapter has also long been apparent in the field of nursing and midwifery. In 2004, 9.2% all nurses and health visitors were aged over 55 and that figure has grown every year to 2009, when it stood at 12.8%. Similarly, 40 to 45% of the midwifery workforce will reach retirement age in the next ten years.

**6.18** The CfWI report also draws particular attention to the impact of any potential negative change in the NHS pension on mental health and learning disability nursing, as mental health officer status means that most staff over 55 would be entitled to retire immediately.

**Conclusion**

**6.19** The size of the NHS workforce has flattened out over the last year after a period of growth and the shrinkage seen in Scotland, Wales and Northern Ireland is likely to spread to England over the next few years.

**6.20** While last year's vacancy figures for the NHS were low and data from Scotland suggests a small increase has taken place in 2011, complacency is misplaced as clear damaging trends are emerging that threaten the future supply of key occupational groups to meet the demands placed on the service. A short-term, cost-driven slashing of commissioned places across almost all occupations requiring professional training is taking place at the expense of long-term medical needs. For nursing and midwifery, that trend is compounded by a squeeze on international recruitment that formerly filled the gap in domestic recruitment and an ageing workforce that is set to ramp up retirements.

**6.21** Additionally, survey results back up the view that official vacancy figures tell a very partial story. The reality on the ground, where recruitment freezes are so prevalent, is that staff feel acute recruitment problems in that posts that have traditionally been filled in their workplace are not being replaced, leaving them to cope with ever increasing demands placed on them.

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[17] Dunkley L and Haider S, Centre for Workforce Intelligence, *Nursing and Midwifery Workforce Risks and Opportunities*, July 2011

[18] Buchan J and Seccombe I, *A decisive decade: The UK nursing labour market review 2011,* RCN

**6.22** Unsurprisingly, against this background, clear signs are emerging that the desire of staff to stay within the NHS is weakening and a strengthening labour market would allow many to act on their discontent, feeding through to rising leaving rates.

## 7 MORALE, MOTIVATION AND TRAINING

### Demand and productivity

**7.1** The demands on the NHS show no signs of abatement. The latest figures on hospital episode statistics in England show all forms of activity up in the year to April 2011 in comparison to April 2010. As shown by the table below, increases range from ordinary admissions up 1.6% to day case episodes up 3%.

| England - rolling 12 month period comparison | | | |
|---|---|---|---|
| | **May 10 to April 11** | **May 10 to April 11** | **% change** |
| Total Finished Consultant Episodes | 16,844,224 | 17,197,010 | 2.1% |
| Ordinary Episodes | 11,351,899 | 11,537,656 | 1.6% |
| Day Case Episodes | 5,492,325 | 5,659,354 | 3.0% |
| Finished Admission Episodes | 14,561,318 | 14,826,209 | 1.8% |
| Emergency Admissions | 5,184,150 | 5,272,031 | 1.7% |

*Source: NHS Information Centre, Provisional Monthly Hospital Episode Statistics for Admitted patient care, outpatient and Accident & Emergency data May 2010 – April 2011*

**7.2** The latest measure of healthcare productivity published by the Office for National Statitics (ONS) puts productivity growth at 0.7% in 2009, driven mainly by output growth measured at its highest level since at least 1996.[19] However, the ONS generally paints a negative picture of productivity, showing an average decline of 0.2% a year since 1996.

**7.3** However, while the ONS is the most widely quoted source on NHS productivity, the Centre for Health Economics (CHE) based at the University of York, provides more accurate figures as it assesses every output activity conducted by the NHS (based on 6,630 categories) rather than extrapolating results from a sample of activities and its quality measure relies less on the subjectivity of survey data.

[19] Office of National Statistics, *Public service output, inputs and productivity: healthcare*, April 2011

**7.4** The CHE has presented a more favourable view than the ONS of productivity in the health service, with productivity virtually flat or growing since 2003.[20]

| Productivity Growth | 2004/5 – 2005/6 | 2005/6 – 2006/7 | 2006/7 – 2007/8 |
|---|---|---|---|
| Primary and secondary care | 1.64% | 0.4% | 1.41% |
| Total NHS | -0.08% | 3.85% | 0.43% |

**7.5** The CHE states that “not only are more patients being treated, but the quality of the care they receive has been improving,” with survival rates improving for patients admitted to hospital as both electives and non-electives, while waiting times have been falling, both for outpatient appointments and for admission to hospital.

**7.6** The CHE puts the differential between its figures and the ONS figures down to three main factors:

- The ONS measure of output is not comprehensive, capturing around 80% of activity. In particular much community care activity is omitted, where growth has been above average. This biases the ONS productivity measure downwards.
- The ONS measure of labour inputs does not account for the contribution of non-NHS (eg agency) staff. There have been recent reductions in the use of non-NHS staff. Omitting their reducing contribution biases the ONS productivity measure downwards.
- The ONS estimates of productivity for the latest year are based on projections based on the first quarter’s data. The accuracy of these projections cannot be established until the actual data is available.

**7.7** The demand and productivity picture therefore shows that NHS staff are facing greater pressures and they have been delivering more with the resources available over a substantial period. At the same time, the recruitment section of this report shows that the size of the workforce has been flattening out and recruitment freezes are becoming ever more commonplace.

**Survey results**

**7.8** The latest staff attitude survey conducted for the Department of Health found that there has been a massive expansion of the proportion of staff who think that patient care has deteriorated over the previous year, jumping by a third to 28% in the space of just six months between spring and winter 2010.[21] Optimism about the future has also slumped with the proportion of staff who expect patient care to get worse over the next few years growing from 39% to 49%.

[20] Castelli A, Laudicella M, Street A, and Ward P, *Getting out what we put in: productivity of the English National Health Service*, Health Economics, Policy and Law, 2011

[21] NHS Staff Tracking Research – Winter 2010, GfK NOP Social Research, June 2011

**7.9** The survey revealed that NHS staff remain as dedicated as ever to their work, with 89% stating that they are proud to work for the NHS. However, the lowest levels of pride were among the groups that had seen the greatest decline in the quality of patient care, which suggests a dwindling away of the dedication that the NHS relies on as the predicted decline in quality of care asserts itself ever stronger.

**7.10** A recent survey conducted among over 1,000 public sector workers by the recruitment consultants Badenoch and Clark showed that 80% of respondents working in the NHS said that morale was average to poor while 48% said that maintaining morale has been their greatest challenge over the last six months. A third (30%) also said they were working longer hours in the wake of budget cuts.[22]

**7.11** Almost three-quarters (71%) of orthoptic staff surveyed by the British and Irish Orthoptic Society (BIOS) reported that they were experiencing significantly higher workloads than a year ago, and the same number said they had higher stress levels. Meanwhile, 76% said they expected demand for orthoptic services to increase in the forthcoming financial year, but the same number stated that they did not expect to have sufficient resources to meet this demand. The RCM Heads of Midwifery survey, meanwhile found that two-thirds (63%) reported that the numbers of deliveries had increased in the last 12 months yet a similar number (59%) said that the funded establishment was inadequate for the level of activity in their unit.

**7.12** The CSP survey of physiotherapy managers showed that 73% reported that physiotherapy staff are experiencing significantly increased workloads compared to a year ago and that 70% said that physiotherapy staff are experiencing significantly increased stress levels compared to a year ago.

**7.13** The RCN survey found that 82% of NHS staff were experiencing increased workloads, and 71% were under increased stress. Just under half (46%) said that they had fewer opportunities to work flexibility, four in ten (41%) work in excess of their contracted hours several times a week and a further 17% do so every shift. The majority of staff (92%) regularly work extra hours and of these – one third (32%) usually work four or more hours a week overtime. And with 50% stating that overtime is usually unpaid, these findings illustrate the sheer scale of the NHS's reliance on staff prepared to work additional hours.

**7.14** The RCN survey also showed that three quarters (72%) have seen caseloads increased in their ward or department and one third (32%) reported a deterioration in the quality of care over the last 12 months.

**7.15** The UNISON 2011 Pay Survey uncovered a similar picture. 85% of staff experienced an increase in workload over the last year, 83% suffered an increase in stress and 37% saw a decline in the quality of care for patients against 10% who saw an improvement. The full results of the questions posed on working conditions are shown below.

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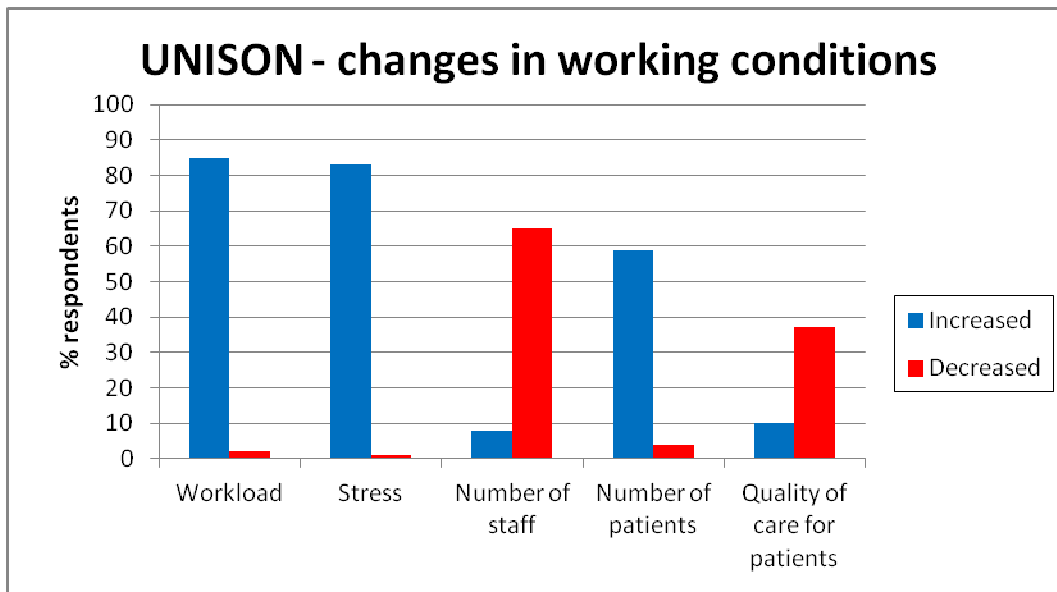
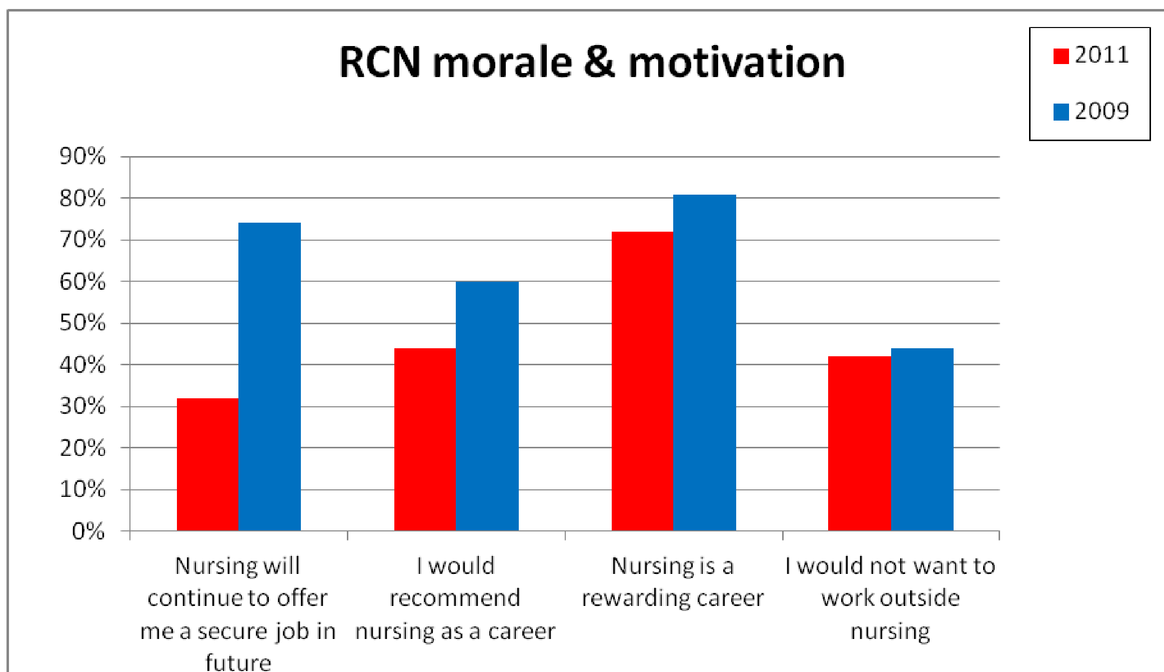
[22] Badenoch and Clark, July 2011. *Re-branding the state: the public sector brand in an age of cuts, strikes and reforms*
http://insight.badenochandclark.com/wp-content/uploads/Summer-2011-Public-sector-workplace-study.pdf

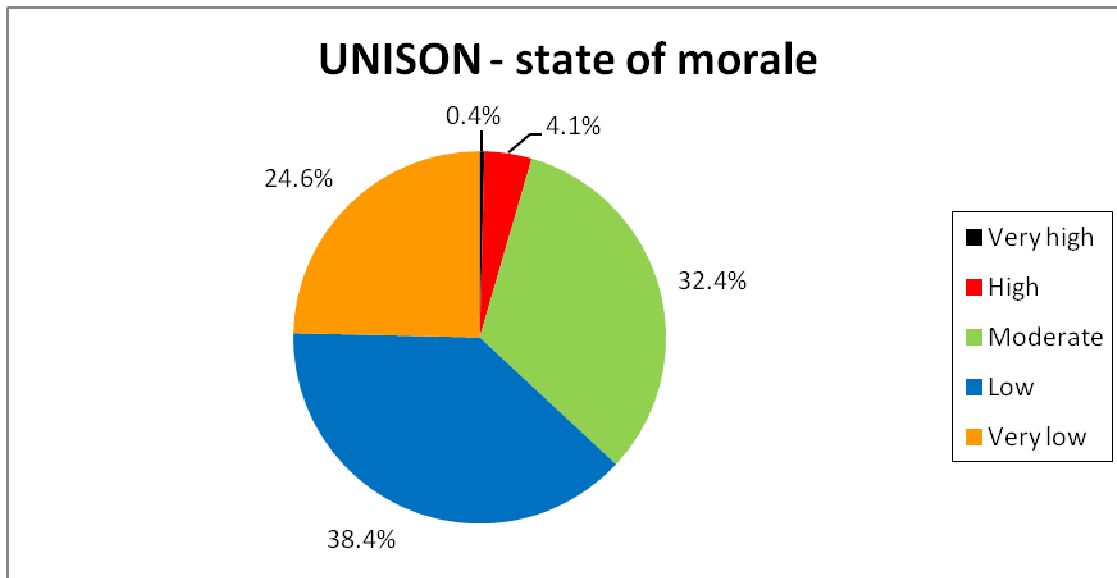



**7.16** In this context of rising pressures combined with a near total pay freeze, the responses to the questions posed on morale and motivation were unequivocal. The results from the RCN survey are particularly stark, with just 32% of members stating that nursing would continue to offer a secure future in the future, compared to 74% in 2009.

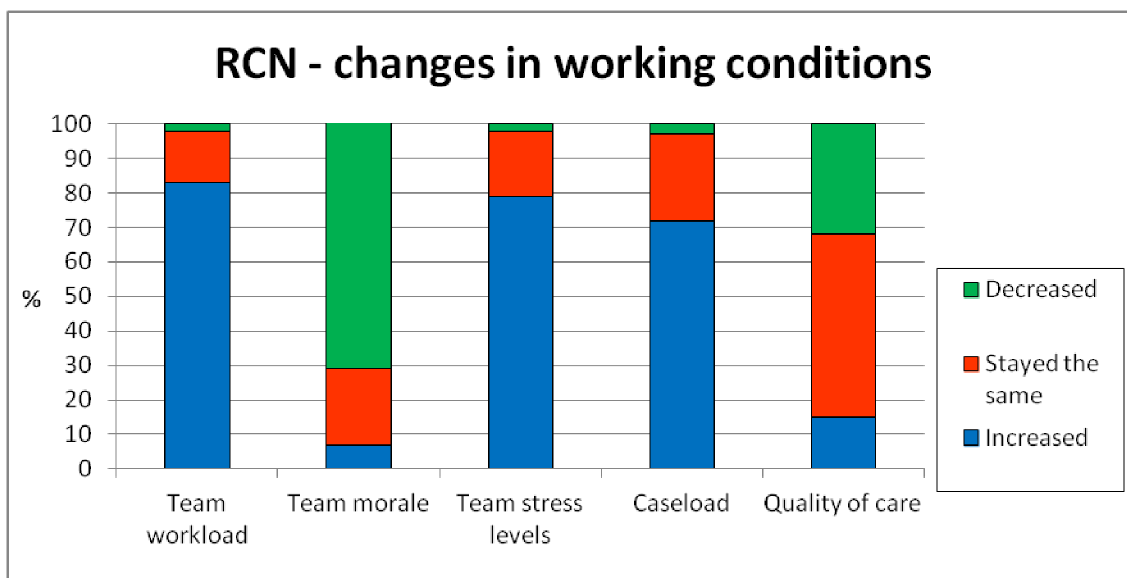



**7.17** Respondents to the UNISON survey were asked to score their current level of motivation in their work between one and ten, with ten representing the highest level of motivation. The resulting average motivational score deteriorated from 5.77 in 2010 to 5.28 in 2011.

**7.18** Similarly, the UNISON survey showed that morale has slumped over the last year, with the proportion of staff describing morale in their workplace as low or very low jumping from 53% in 2010 to 63% in 2011 and squeezing the proportion of staff who feel they work in a high morale workplace to less than 5%.




**7.19** The RCN survey also showed that the majority of staff felt that morale had decreased among their team (71%) while stress had increased (78%). A high number also thought that team workload (83%) and caseloads (72%) had increased.




**7.20** The mood has shifted markedly over whether members would recommend their occupation or profession as a career in the NHS. The UNISON survey showed that compared to a year ago, staff were fairly evenly split over the issue, but this year 57% stated that they would not recommend such a career and 36% expressed their support. The RCN survey

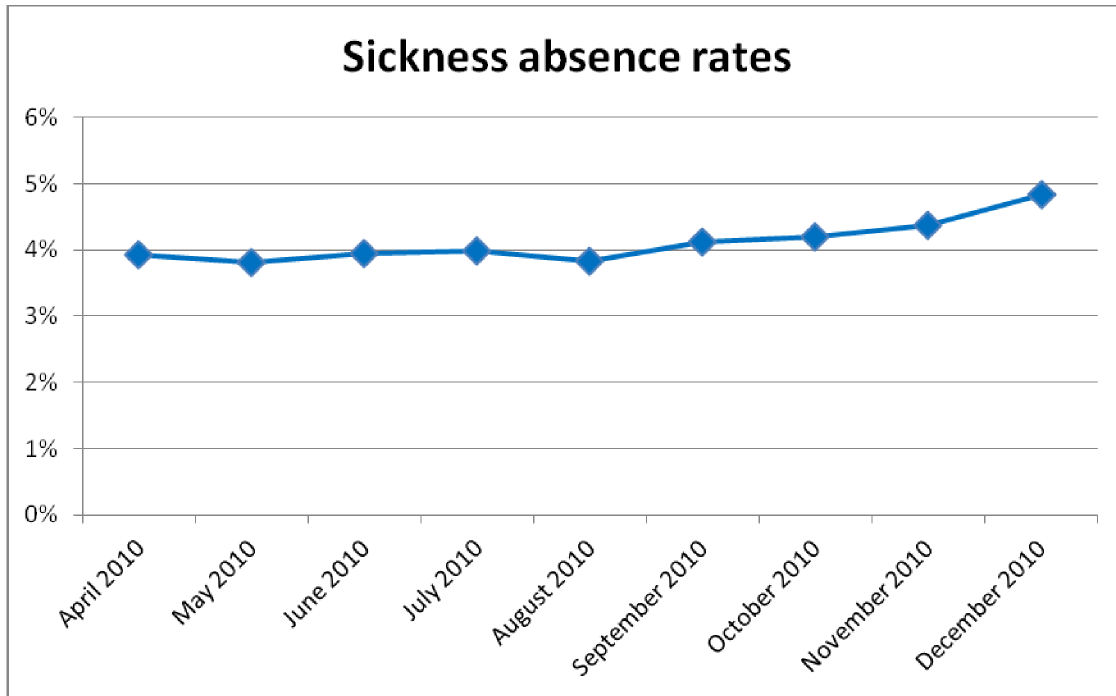
showed that 44% would recommend nursing as a career compared to 59% in 2009 and 69% said they were enthusiastic about their job most days, compared to 80% in 2009.

**7.21** A recent survey conducted by the Society of Radiographers examined changes to sickness absence policies, in particular demonstrating their negative impact on staff morale. Conducted in imaging and radiotherapy departments, the survey found that NHS organisations are increasingly introducing absence monitoring schemes which can lead to withholding of sick pay formal interviews, disciplinary proceedings and in some case dismissals. The majority of schemes do not distinguish between absence due to work related injuries absence due to work related illness and other types of absence. Around three-quarters of departments reported that changes were leading to a deterioration in the quality of working life for vulnerable staff groups (such as pregnant women, employees with dependents, long-term illnesses or work-related injuries). These changes, which are driven by the pressure to find cost savings, is leading to a worsening of staff morale, with around two-thirds of departments (63%) reporting that changes to policies had a negative impact on morale. In addition, three-quarters of respondents (76%) stated that policy changes were leading to 'presenteeism,' with more staff working when ill.

**7.22** Both the RCN and RCM surveys looked at bullying, harassment and violence in the NHS. Among RCN members, a quarter (26%) said they had personally experienced bullying or harassment from a team member or manager and 22% said that it had increased over the last 12 months. 32% stated they had personally experienced harassment or violence form a patient or client or their family and 20% said it had increased. Among Heads of Midwifery, the RCM found that a third (31%) said they had been complaints about bullying or harassment in the unit and three-quarters (75%) said their employees had been subject to verbal or physical abuse in the last 12 months.

**Sickness absence**

**7.23** The stresses that have contributed toward this disturbing picture of morale across of the service have clearly taken their toll on sickness absence rates. Over the last year, sickness absence rose substantially from a three month average of 3.9% to 4.5% by the end of 2010, before falling away slightly in 2011. The single months figure of 4.8% for December 2010 was the highest level for at least one and a half years (monthly statistics are not available from the Information Centre prior to April 2009).




*Source: Office for National Statistics*

## 8 THE FUNDS AVAILABLE TO THE HEALTH DEPARTMENTS

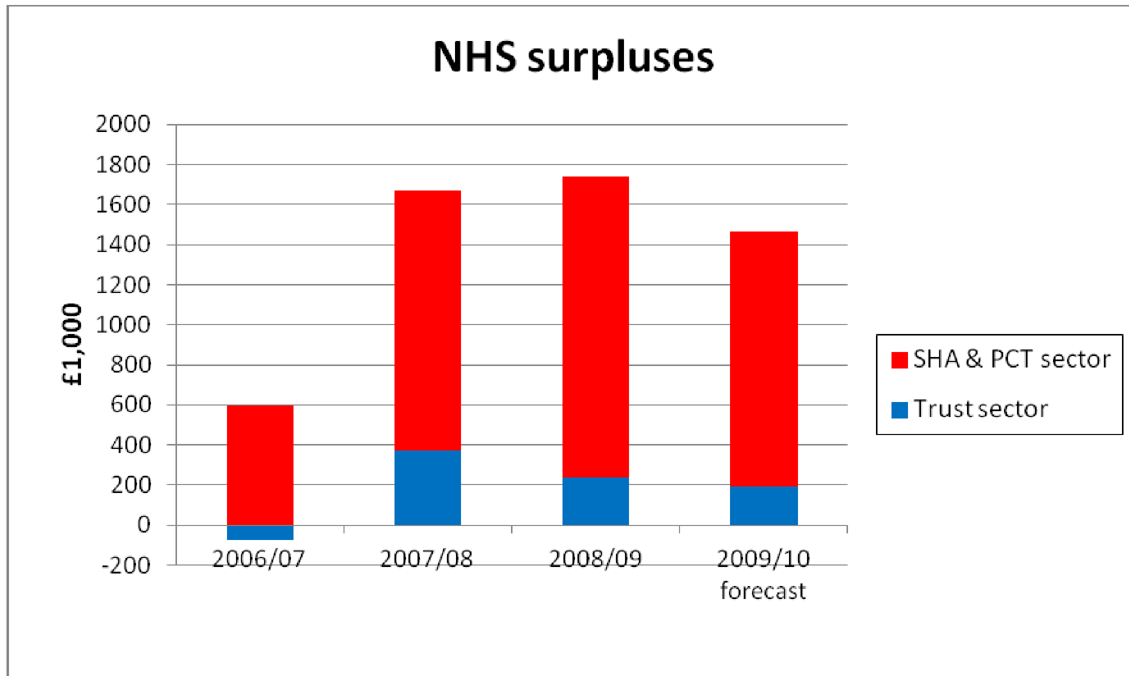
### State of financial accounts

**8.1** The NHS in England recorded a surplus of almost £1.5bn for the 2010/11 financial yearor 1.5% of NHS resources.[23] Therefore, as the graph below shows, the NHS in England has achieved a surplus in every one of the last five financial and the cumulative value of those surpluses now stands at almost £7bn.

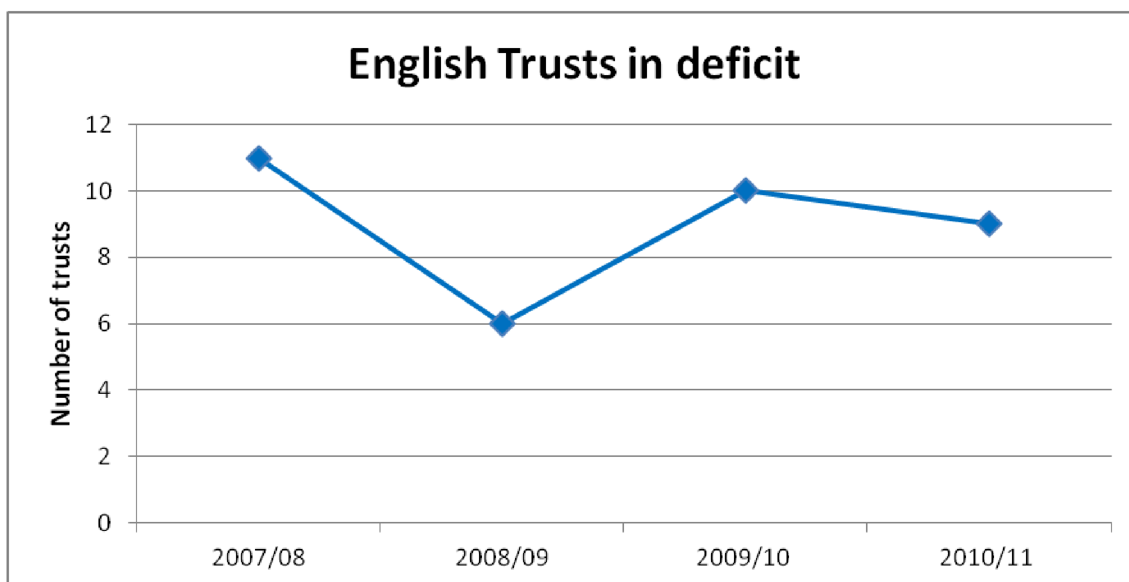
**8.2** However, even these figures are an underestimate of the total surplus since trusts drop out of the financial statement when they become foundation trusts. The collective financial position of foundation trusts is less transparent than those of trusts under direct Department of Health control. However, data provided for the House of Commons Health Committee indicates that these Trusts enjoyed a further £669m surplus between 2007 and 2009.[24]

[23] NHS Deputy Chief Executive David Flory, The Quarter, Q4 2010/11

[24] Public Expenditure on Health and Personal Social Services 2009, Memorandum received from the Department of Health containing Replies to a Written Questionnaire from the House of Commons Health Committee, January 2010




**8.3** Just nine out of 349 trusts in England recorded a deficit in 2010/11, which stayed in line with the consistently low level seen over the last four financial years.




**8.4** In Scotland in 2009-10, the NHS recorded a £42m surplus on its £10.4bn resource Departmental Expenditure Limit, with none of the 22 health boards registering a deficit. [25] The surplus was partly down to an efficiency programme that is reported to have delivered £368 million savings between 2008 and 2010 against board level efficiency targets alone. Accounts for 2010-11 will be released at the end of 2011.

**8.5** Operating within a Departmental Expenditure Limit of £6bn for health and social services, the three NHS trusts in Wales recorded a small surplus £126,000 while the seven

[25] NHS Scotland, Annual Report 2009/10, December 2010

health boards registered a surplus of £451,000.[26] None of the trusts or health boards suffered a deficit for the 2009-10 financial year.

**8.6** The new Northern Ireland accounts are due to be released shortly, but as its stands the latest accounts for 2009/10 show it as the only country within the UK recording a financial deficit, since its expenditure exceeded the Departmental Expenditure Limit by £109m.[27]

**8.7** However, the major surpluses recorded by the NHS as a whole make it clear that the service has managed its resources effectively to stay well within its budget. Therefore, the financial challenges that it faces are not down to the service's costs expanding beyond its allocated funds but the political decision to impose a budget on the NHS for the next three years that fails to meet the level of anticipated demand.

**Future financial position**

**8.8** The Comprehensive Spending Review announced in 2010 specified an expansion of the Department Expenditure Limit from £103.8 billion in 2010/11 to £114.4 billion in 2014/15. This represented an increase of 2.65% a year, but on projections of Consumer Price Index at the time this was acknowledged to represent a real terms increase of barely 0.1% a year. Since then, projections of CPI have increased and it now stands at 4.2%, while Retail Price Index inflation stands at 5%. Therefore, the government's funding now represents a cut to the NHS budget in real terms.

**8.9** Historically, the NHS has received budget increases in the order of 4% above inflation to deal with both the rate of inflation in its costs and the expansion of demand on the service. Therefore, even before the increase in inflation rates, NHS chief executive David Nicholson had claimed that the NHS in England would need to make savings of £15 to £20 billion over the three years to 2014 to stay within its budget.

**8.10** The Scottish Government has so far pledged to pass on Barnett consequentials to NHS Scotland, but the Comprehensive Spending Review for 2012-15 has yet to be published. In 2011-12, efficiency targets for territorial health boards have been raised from 2 to 3%. The NHS in Wales has to save just over £1 billion over the next three years.

**Impact of incremental rises**

**8.11** The change to the NHS paybill from the net impact of staff leaving the service and those remaining receiving an incremental boost to their wage in recognition of their increased experience, expertise and contribution is estimated to account for 1.4% of the total paybill.[28] This is lower than the figure calculated by Department of Health in last year's evidence submission which itself was challenged by the review body in supplemenary questions.

**8.12** Therefore, with the £250 increase for staff earning £21,000 of less adding just 0.3% to the NHS paybill, the total pay related pressure on costs amounts to 1.7% - well below the 2.65% annual increase in the NHS budget.

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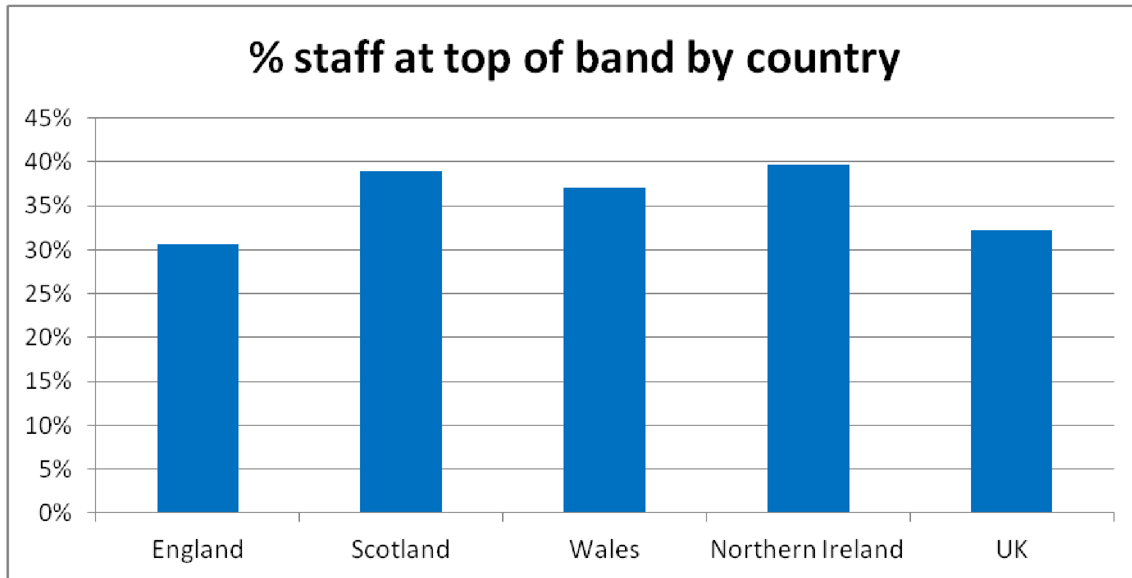
[26] NHS (Wales) Summarised Accounts 2009-10, March 2010

[27] Department of Health, Social Services and Public Safety, Resource Accounts for the year ended 31 March 2010

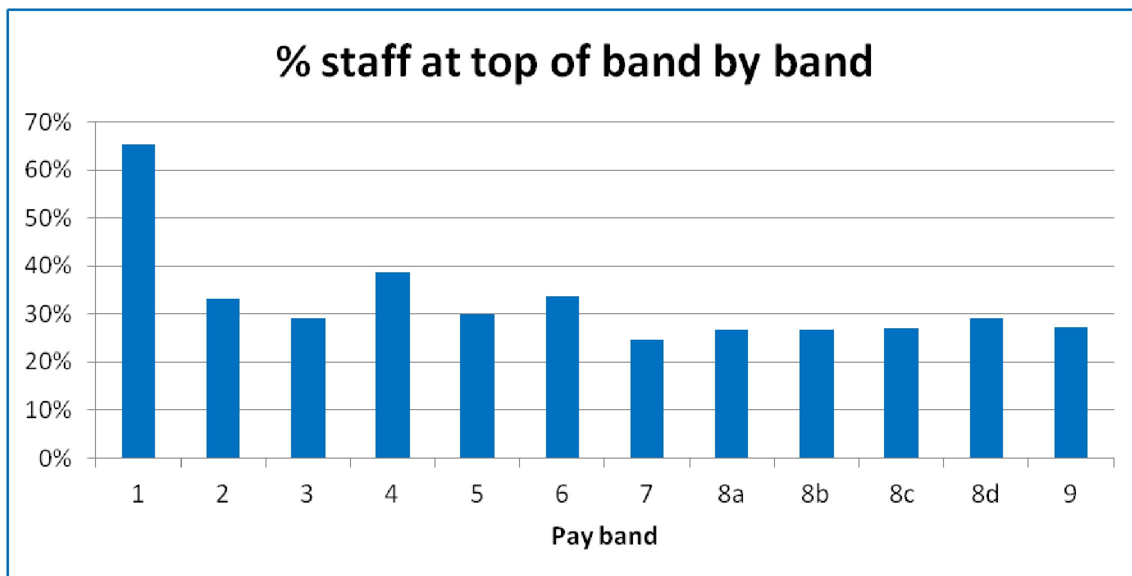
[28] UNISON, *Waving or drowning? A workforce on the brink of change*, November 2010, Appendix ii – incremental rise calculations

**8.13** The diagram below shows the proportion of staff who receive no benefit from incremental progression as they are at the top of their pay band. Averaging at 32% across the UK, England has the lowest proportion at 30%, while Scotland, Wales and Northern Ireland are all well above the average. Northern Ireland has almost 40% of its staff at the top of their pay band, Scotland has 39% and Wales has 37%.




*Source: Responses to the NHS Pay Review Body's supplementary questions from the Department of Health, the Welsh Assembly Government, the Scottish Government Health Department, Department of Health and Social Services and Public Safety in Northern Ireland*

**8.14** The graph below reflects the fact that staff in pay bands one to four are particularly likely to stand at the top of their band. On average, 36% of staff in bands one to four are at the top of their band in comparison to 30% of staff in band five to nine.



### Impact of workforce changes

**8.15** Anticipated future financial pressures are plainly pushing Trusts towards attempting to reduce their workforce. To gauge the scale of their intentions, the TUC lodged Freedom of Information requests with every NHS employer across the UK in early 2011 and received responses stating that employers planned on cuts in the order of 53,000 jobs within the next five years. However, around a third of employers stated that they were not yet in a position to outline their plans and so these omissions suggest that the real figure may be closer to 80,000 (5% of the total NHS workforce). If these plans were to be carried out through voluntary redundancy or failure to fill vacant posts, then based on an average NHS earnings figure of £31,521 (calculated through weighted average earnings of the main occupational groups, including doctors), the ultimate reduction in basic salary paybill costs would be in the region of £2.5 billion a year.

### National Recruitment and Retention Premia

**8.16** The NHS Staff Council has completed the review of National Recruitment and Retention Premia (NRRP). As reported last year, the Institute of Employment Studies were engaged in 2010 to undertake an independent review of the payments currently in place (as advised by the Review Body following the Hartley Judgement[29]) and found no grounds for continuing with these payments at a national level. An agreement was reached at the Staff Council to withdraw NRRP over a period of two years, subject to a review of the recruitment and retention status among the relevant occupational groups during the second year. Appendix A contains details of issues for particular occupational groups that unions would like the Review Body to consider – this includes a reiteration of the argument for a national RRP for pharmacy staff which received a previous support from the Review Body.

**8.17** In circumstances where occupational groups who have been in receipt of NRRP are still subject to market pressures, local partnerships will be advised to apply the process outlined in Annex J of the Handbook to identify and agree an appropriate Local Recruitment and Retention Premia. The Staff Council Executive, in making the agreement, identified that there was a need to look separately at the NRRP for Chaplains, work that will be undertaken before the end of 2011. RRP for separate staff groups are examined in Appendix A.

### Conclusion

**8.18** NHS accounts show that the service has been recording substantial surpluses over a sustained period and the number of trusts or health boards currently facing a deficit is extremely small. With the cumulative value of these surpluses standing at £7bn in England alone over the last five financial years, this suggests a certain level of accumulated reserves have been built up by trusts and health boards. However, even given the financial straitjacket now being placed on the service, increases in the paybill due to incremental pressures are well within the allocated budgetary rises and must be seen in the context of a likely squeeze on the scale of the workforce along with its associated paybill costs.

[29] Hartley and others v Northumbria Healthcare NHS Foundation Trust 2009

## 9 Knowledge & Skills Framework

### Simplified Guidance published

**9.1** In an effort to improve the rate of progress with implementation of the Knowledge and Skills Framework and appraisal levels across the NHS workforce, the NHS Staff Council commissioned the development of some new guidance on the KSF. The guidance *Appraisals and the KSF made simple – a practical guide* published in November 2010, is designed to provide a simpler, more flexible tool to help employers tailor the KSF to fit with their organisational objectives and to support staff appraisals and development.

**9.2** The guidance draws on existing good practice from those organisations that have achieved KSF implementation and made it work for them. It does not undermine or contradict the original KSF principles, and organisations are free to decide whether they wish to make use of the simplified guidance or continue to use the fuller version in the original KSF handbook.

### 9.3 Implementation – a progress report

In addition to being a key component of the Agenda for Change pay, terms and conditions of employment contract, the process of KSF and appraisal is the central driver to support Pledge 2 of the NHS Constitution, ie to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed.

#### 9.3.1 England

While it is still too early to gauge the impact of the new, simplified KSF guidance, the most recent NHS Staff Survey for England (2010) shows some improvements in KSF implementation. A total of 77% of staff had an appraisal (or a KSF development review). This is markedly higher than in 2009 (69%). Despite this increase, only a third (34%, compared to 31% in 2009), of all staff felt that their review was “well structured” in that it improved how they worked, set clear objectives and left them feeling their work was valued.

We sincerely hope that the simplified KSF guidance will help to accelerate what is currently slow progress, so that full implementation can be achieved and the benefits of KSF can be properly realised. Clearly in terms of the quality of the process, we are still a long way from achieving a satisfactory standard across the board.

#### 9.3.2 Wales

NHS Wales reports that a gap remains between achieving full implementation of the KSF. Results for 2010/11 indicate a downward trend in the level of appraisals/performance development reviews (PDSRs).

NHS Wales had adopted a series of measures to help achieve full implementation, with PDRs to form part of its national workforce statistics, and monitoring improvements will become part of the Annual Quality Framework review process.

#### 9.3.3 Scotland

NHS Scotland continues to progress towards full implementation of the KSF and to accelerate the process, implementation is linked to performance targets for NHS Boards. 85% of staff have received a development review and the focus of KSF implementation is

now to turn to monitoring how embedding the KSF supports the delivery of quality services through NHS Scotland's Quality Strategy.

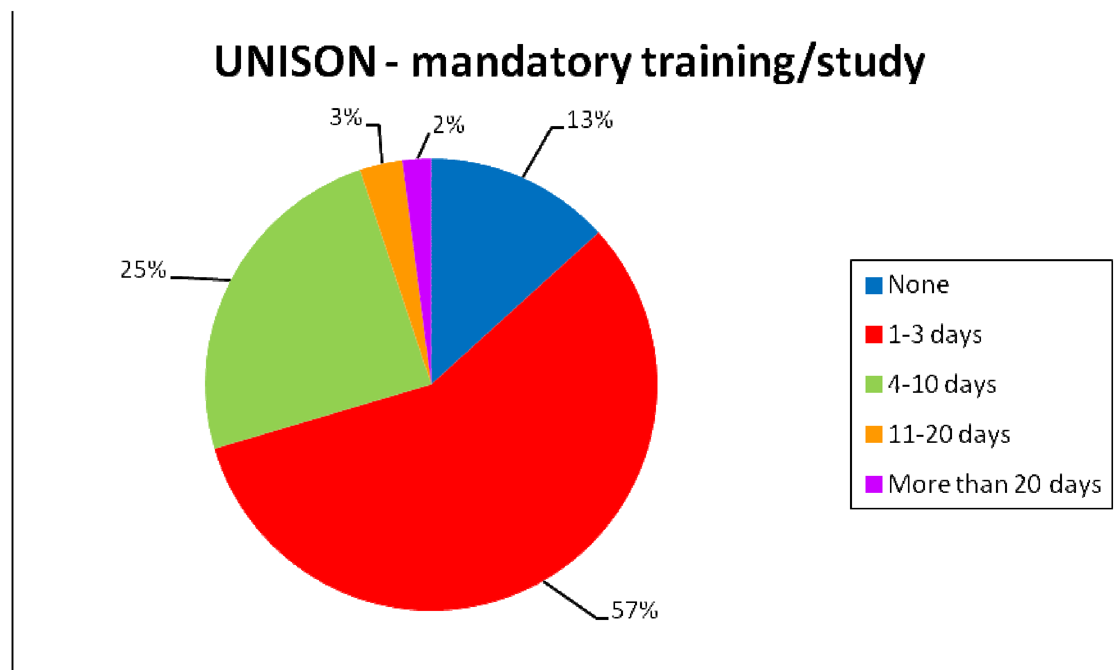
**9.3.4 Northern Ireland**

Action is being taken to reinvigorate efforts to achieve full implementation of the appraisal/KSF development review process across all health and social care organisations. However, there is no appointed project lead with responsibility for promoting the KSF across Northern Ireland and monitoring statistics are not currently available.

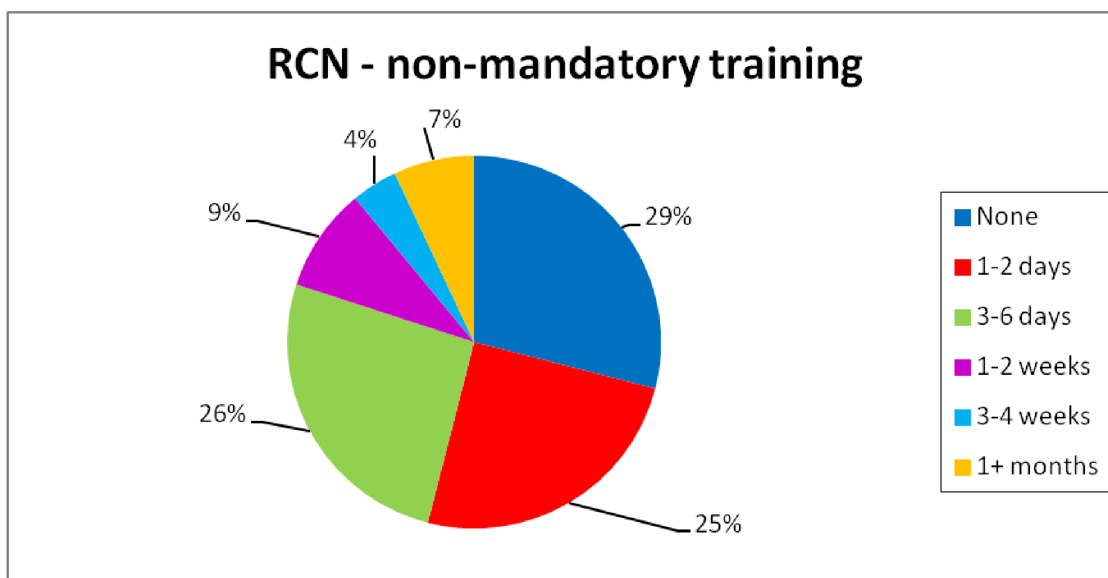
**Survey results**

**9.4** Last year's UNISON pay survey found an improvement in the proportion of staff who receive no mandatory workplace training or academic study, as the figure fell from 22% in 2008 to 13% in 2010. However, this year's survey showed a flattening out of the trend, with the proportion holding steady at 13% (see diagram below).

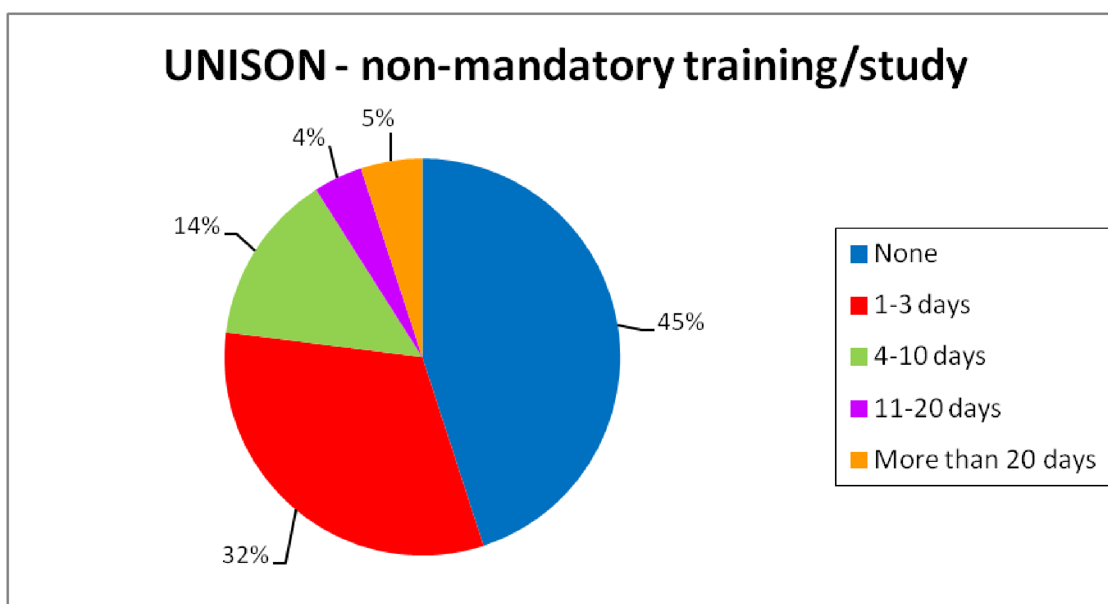
**9.5** The occupational groups most heavily represented within this category were the 20% of both administrative/clerical and ancillary maintenance staff who have received no training or study time. The position also appears bleaker in Wales, where 26% have received no mandatory training, and Scotland, where 22% have had no such training over the last year.




**9.6** This year's RCN survey found that just 5% of NHS nursing staff had received no mandatory training over the previous 12 months. However, 29% had received no other non-mandatory training or CPD. The majority of members (64%) said that the amount of training or CPD had increased or stayed the same over the year, but a significant number (36%) stated it had decreased.




**9.7** Among UNISON members, 45% of respondents had received no non-mandatory workplace training or academic study at all (see diagram below). That situation was even more problematic for staff in bands one to four, as 57% had received no training.

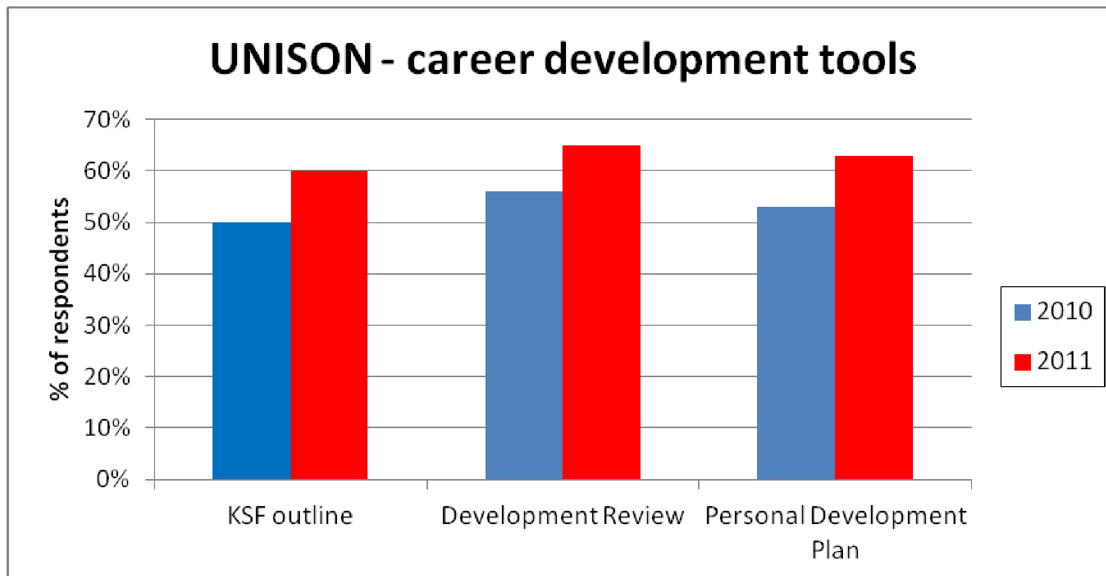



**9.8** Among UNISON members, estimates of changes in the amount of training compared to 12 months ago indicated that 9% had experienced an improvement while 30% had experienced a decline. Among RCN members, a fifth (20%) said it had increased over the previous year, just over a third (36%) reported that it had decreased and the remainder (43%) said it had stayed the same. The RCM Heads of Midwifery survey, meanwhile found that 41% will be forced to cut training budgets over the next 12 months.

**9.9** The UNISON survey showed that the proportion of staff who had received a Knowledge and Skills Framework (KSF) post outline grew from 50% to 60%, the proportion who had received an appraisal/development review with their line manager jumped from 56% to

65%, the prevalence of Personal Development Plans (PDP) rose from 53% to 63% and, of those, 62% had a PDP based on their KSF post outline (see figure below).

**9.10** According to the RCN survey, 64% had a personal training and development plan (58% in 2009) and of those – their manager was involved in drawing the plans up in 79% of cases (78% in 2009). Just over two thirds (69%) have had an appraisal in the last 12 months compared to 57% in 2009.




## 10 National Pay Bargaining and Agenda for Change

**10.1** Appendix B is a paper from Ian Kessler, Reader in Employment Relations at the Saïd Business School and Fellow at Green Templeton College, University of Oxford.

**10.2** This paper looks at the features of national pay determination NHS and argues that the resilience and continuity of the pay determination machinery is largely down to its efficiency and effectiveness in dealing with the diverse goals and overlapping or separate forms of accountability of the multiple stakeholders ie government, taxpayers, patients and service users as well as employees, managers and their representatives. The efficiency and effectiveness of the national wage setting model lies in the way it generates and sustains discipline and control; cost efficiency and effectiveness; and transparency and consistency. The paper also looks at Agenda for Change and concludes that it represents a vast improvement on the previous fragmented and complex national arrangements, and provides a firm basis for taking forward important substantive issues, particularly equal pay and new ways of working.

**10.3** Kessler looks at past experiences of trust based bargaining in the 1990s and finds that this made limited headway at that time. The lessons learnt from this experience are that the risks of greater local pay determination, including major transactional, relational and pay bill costs, far outweigh any immediate gains. This is a particularly important factor in this period of financial constraint.

**10.4** The main components of NHS pay determination risk being undermined by what Kessler describes as the 'permissive nature' of the Health and Social Care Bill for England,

which allows contracts between purchaser consortia and providers to depart from national pay and conditions; the assumed acquisition of Foundation status by all NHS trusts with discretion to determine pay and conditions; and the 'right to provide' encouraging services provision from social enterprises and other providers, potentially beyond national NHS national agreements and systems.

**10.5** Staff side welcomes this paper, which supports its view that national pay determination is essential for fair pay for NHS staff. National pay determination, supported by the pay review body mechanism, provides industrial stability, prevents unequal pay problems and aids recruitment and retention within the NHS. Local pay bargaining has been shown to be inefficient, as local trusts are forced to implement their own pay and reward systems, and too often result in highly damaging competition for staff.

**10.6** We call on the pay review body to consider the impact of health policy reforms on pay determination in the NHS and the long-term implications for the workforce, including industrial relations, equal and fair pay outcomes, transparent pay setting, recruitment and retention.

## Appendix A Recruitment and Retention Premia

### A.1 Pharmacists

There continues to be a need to address shortages in the pharmacy workforce and we advise the NHSPRB that Unite the Union will again be submitting evidence regarding the continuing problems in the recruitment and retention of pharmacists. This evidence suggests that problems would be alleviated by the payment of a Recruitment and Retention Premium and will support the previous recommendation of the NHS PRB, which Staff Side believes should have been implemented by the government.

This position has been strongly supported by the July 2011 Centre for Workforce Intelligence report into the pharmacy workforce.[30] This emphasises that the problem of staff shortages for the pharmacy workforce has not been dealt with and argues that a national RRP is needed:

> *"There is evidence to suggest that NHS pre-registration trainee pharmacists move to community pharmacy upon qualification, potentially because starting wages are on average higher. In their longitudinal study of pharmacy careers, Willis, Seston and Hassell (2010) found that 50.5% of hospital pharmacist respondents earned under £25,000, while amongst those employed in the community sector only 5% earned under £25,000. Other evidence indicates that upon completing pre-registration pharmacist training, a number of staff are moving into non NHS sectors, indicating that the NHS may be losing staff to other more highly paid sectors after training provision (NHS Pharmacy Education and Development Committee, 2010). Public sector pay restraints may mean that recruitment into Band 6 posts continues to be challenging.*
>
> *CfWI recommends that recruitment and retention mechanisms are researched and established in order to retain a greater number of band 6 staff. This is supported by the findings of the national NHS Pharmacy Staffing Establishment and Vacancy survey (2010), which highlighted significant vacancy rates at Bands 6 and 7."*

### A.2 Estates and Maintenance

The estates and maintenance RRP is in the process of being removed over two years, costing staff in these grades £3,277 per annum. In response to this, there is evidence that individual Trusts are negotiating local RRP arrangements due to concerns about the impact on their workforce.

[30] Centre for Workforce Intelligence, *Workforce Risks and Opportunities – Pharmacy,* July 2011 www.cfwi.org.uk/documents/workforce-risks-and-opportunities-pharmacy

Hull and East Yorkshire Hospitals NHS trust has already implemented a premium and Unite the Union reports that negotiations are at advanced stages for a London wide RRP.

At the same time two major private sector companies providing building maintenance in the NHS, Skanska and Interserve, have both agreed to keep the national RRP for their staff working in the NHS. Unite has had several other approaches from companies seeking to do the same.

Staff Side therefore strongly recommends that the PRB makes a recommendation for the NHS staff council to commission an early independent review of local RRP arrangements and the evidence for a national RRP no later than September 2012, before the national RRP is withdrawn.

**A.3 Building Craft Workers**

UCATT's submission to the NHSPRB highlights the relatively low pay levels for building craft workers in the NHS compared to the private sector, as well as the low number of young people entering the sector and the ageing profile of the workforce, warning of an imminent skills shortage.

National RRPs are to be phased out, despite evidence of recruitment difficulties, skills shortages and a failure to train new entrants into the sector. As with estates and maintenance workers, local RRPs are being paid in some areas including Greater Manchester, Central Scotland, South Wales, Berkshire, Nottinghamshire and West Midlands. This demonstrates that the need for remedial action remains and as such, UCATT urges the PRB to recommend a national RRP for building craft workers.