Staff Side Evidence to the NHS Pay Review Body 2013-14

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1. Introduction

The NHS in England is undergoing the most significant structural and policy changes since its inception in 1948. While these reforms have dominated the headlines, the service is also facing important structural changes elsewhere in the UK, for example through closer integration of health and social care. Across the whole of the UK, the NHS is also under pressure as a result of budget cuts and demands to make savings while continuing to strive for quality improvements and better patient engagement. Staff Side is clear that these priorities can only be achieved with the engagement of NHS staff. The NHS workforce is committed to providing high quality patient care, and contributing to both improving service delivery and efficiency savings, yet they have already sacrificed enough through their personal pay over recent years.

The NHS trade unions are strong supporters of the independent review body system and national pay determination. However, both the government's pay policy and their declared support for some form of local pay pose serious challenges to the system of pay determination in the NHS.

Firstly, as acknowledged in the NHS PRB's report for 2012/13 – not only does the government's policy of pay restraint risk damaging morale and motivation, but it also encroaches on the independence of the pay review body itself.

Secondly, uncertainty and apprehension over the future of Agenda for Change and national pay determination have been sown by the Treasury-led review on market-facing pay, the development of a 'pay consortium' in the South West of England and local initiatives by various trusts to weaken the Agenda for Change agreement.

These developments and challenges threaten to undermine the long-term features and benefits of the current system of national pay determination in the NHS merely for short-term objectives. National pay bargaining, allied to Agenda for Change, is a transparent, fair and equitable system.

This submission highlights the current experience of staff working in the NHS. They are dealing with job losses, pay freezes, budget cuts and an increase in unpaid overtime to fill the gaps in service provision the cuts are causing. We demonstrate how this combination of factors is having a clear detrimental impact on morale and motivation on the NHS workforce.

[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.

2. Recommendations

We ask the Review Body to:

- record the tremendous role that the workforce has played in meeting the expanding demands on the NHS in the context of restricted resources
- recognise that the impact of inflation consistently running well above NHS pay awards for year upon year together with a two year pay freeze imposed on staff above pay point 15 has taken a damaging toll on the living standards of NHS staff
- recognise that efforts by some employers to erode terms and conditions of NHS staff has reduced the extent to which staff are prepared to make further compromises on pay
- make a recommendation to raise NHS pay rates that both protects their real value against prevailing inflation rates and makes a significant contribution toward addressing the major deterioration in NHS earnings that has seen the majority of staff suffer a 9% cut in living standards over the last two years alone
- make a recommendation for an additional pay rise for staff earning up to £21,000 in recognition of the additional pressures that inflation has placed on workers at the bottom end of the pay scale. In addition to any other awards, this should recognise £250 as the barest minimum uplift
- address the erosion of the differential between Agenda for Change points 15 and 16 by recommending additional rises above point 15 to smooth out the steps between points
- reiterate the concerns the PRB expressed in its 26th report about the failure of the Department of Health to collect vacancy data and press for resumption of data collection as early as possible, and ensure consistency of data collection across all four countries
- acknowledge the strains that cuts to the service, despite expanding demand, are placing on the workforce and patient care
- acknowledge the major financial surpluses recorded by the NHS over recent years
- confirm its often stated position that incremental pay increases are in no way a substitute for annual pay increases since they represent reward for increased skill and experience agreed under the Agenda for Change framework
- recommend that the Health Departments develop a central system for establishing where High Cost Area Supplements (HCAS) and Recruitment and Retention Premia (RRP) payments are made across the UK, along with the level and applicability of payments
- recognise that this submission is made in ignorance of without prejudice to the recommendations from the forthcoming review on market-facing pay

3. Local and market-facing pay

The NHS industrial relations landscape has been dominated this year by various challenges to Agenda for Change and national pay determination. As set out in the Joint Staff Side submission to the PRB's call for evidence on a market-facing remit on pay in local areas, the NHS trade unions oppose any attempts to break up national pay determination and introduce local pay structures. We view the Chancellor of the Exchequer's call for market-facing pay in the public sector as an attempt to drive down public sector pay in lower cost areas of the country. As the public sector, including the NHS, has a largely female workforce such proposals would impact on a large percentage of the total female workforce.

We stated that national pay determination, allied to Agenda for Change, has proven itself as a robust, effective and efficient pay system. It is the most effective and appropriate way of ensuring discipline and control over pay settlements, of delivering cost efficiency and providing transparency and fairness. We also pointed out that the current system is the most appropriate for the NHS and has sufficient flexibilities to respond to local conditions. By setting a floor pay rate and allowing for adjustments in high cost areas or local areas with particular recruitment difficulties, the pay system allows geographic variations in the UK labour market.

The current system provides a level playing field, preventing a race to the bottom or the top on pay and avoids damaging competition for staff. It minimises transactional costs involved in pay determination and removes pay as a source of industrial relations conflict at an organisational level. The system is also equality-proof, both promoting a sense of fairness and ensuring equal pay for work of equal value. In turn, these factors facilitate staff mobility across the NHS and prevent highly expensive equal pay claims.

Since we submitted our evidence, further reports have been published demonstrating the disadvantages of local pay and the potential damage it would cause. For example, the New Economics Foundation report, *The economic impact of local and regional pay in the public sector* examines the Government's arguments for localising public sector pay and the potential economic impact of the policy[2]. It finds that these arguments are not supported by the evidence, and that the policy would have a significant negative impact on the economy which could reach almost £10 billion.

A report by Incomes Data Services (IDS) looks at claims that public sector pay crowds out the private sector[3]. *Crowding out: fact or fiction?* explains that the government's argument for regional pay rests on their assertion that private sector pay varies by region, and therefore public sector pay should do the same in order to avoid some regions with weak private sector employment being 'crowded out' by the public sector. However, IDS found that private sector pay does not show significant variations across regions. Therefore, the government would simply be unfairly disadvantaging the public sector, rather than bringing public and private sectors in line with each other. The report also shows that instead of the public sector 'crowding out' private sector employment in some regions, the public sector reacts to the local

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[2] www.tuc.org.uk/tucfiles/345/EconImpactPublicSector.pdf

[3] www.unison.org.uk/file/IDS%20research%20report%20for%20UNISON%20on%20crowding%20out%20July%202012%20%282%29.pdf

population: the number of nurses, local government workers, teachers and doctors is a reflection of how many people live in a particular area. Finally, job creation in the private sector is not affected by public sector pay in the regions. The report says:

> *"For this project IDS has looked at examples of job creation and job losses in the North East, and also to a lesser extent in the South West, over the course of the first half of 2012. In no cases have we found job creation in either region to be inhibited by public sector pay level. It is just not on the radar."*

By contrast, the right-leaning thinktank Policy Exchange published a report calling for localised pay which repeats claims that workers in the public sector earn around 7% an hour more than their private sector counterparts[4]. However, as clearly demonstrated by Incomes Data Services, the existence of a 'pay premium' is hard to ascertain due to the differences between the private and public sectors in terms of their gender, age and occupational compositions.

Local initiatives being developed by individual and groups of NHS trusts are also threatening the guarantees and benefits currently delivered by Agenda for Change and national pay structures. The South West Consortium of 20 trusts has set out plans which consider breaking away from the Agenda for Change framework[5]. Other changes proposed include reducing annual leave, adding extra working hours, reducing incremental pay, and reducing sick pay benefits. The Consortium has stated that if a deal cannot be reached, trusts may consider dismissing staff and rehiring them on new terms in order to force through the changes.

Staff Side has vehemently opposed these proposals. We believe that the proposals would have a detrimental impact on the South West economy. The region has areas

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[4] www.policyexchange.org.uk/publications/category/item/local-pay-local-growth?category_id=24

[5]

2Gether NHS Foundation Trust
Devon Partnership NHS Trust
Dorset County Hospital NHS Foundation Trust
Dorset Healthcare University NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust
North Bristol NHS Trust
Northern Devon Health Care NHS Trust
Plymouth Hospitals NHS Trust
Poole Hospitals NHS Foundation Trust
Royal Bournemouth and Christchurch Hospitals NHS Trust
Royal Cornwall Hospitals NHS Foundation Trust
Royal Devon and Exeter NHS Foundation Trust
Royal United Hospital Bath NHS Trust
Salisbury NHS Foundation Trust
Somerset Partnership Trust
Taunton and Somerset NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
Weston Area Health NHS Trust
Yeovil District Hospital NHS Trust

of high deprivation and any weakening of the spending power of the NHS workforce in the region will seriously damage the local economy. At a time when local businesses are struggling in a difficult economic climate, driving down the wages of thousands of health care workers will have a devastating impact.

The plans will also have serious implications for patient care. If changes to pay, terms and conditions are imposed in the South West while neighbouring areas continue to pay existing rates, employment patterns are likely to respond accordingly across the borders. The South West could lose skilled staff to higher paying areas, with a damaging impact on the quality of care delivered to NHS patients in the South West. This could drive up health inequalities in the region compared to the rest of the UK.

Regional pay will also necessitate local negotiations resulting in expensive and inefficient negotiating every year for employers. The proposals by the Consortium could result in a large number of unfair dismissal claims after any potential 'dismiss and re-engage' process. Regional pay also places employers at risk of expensive equal pay claims.

We are aware that trusts in other areas of the country are considering forming similar groups and are likely to follow suit if the South West trusts do succeed in introducing regional terms and conditions.

The trade unions have stated they will not enter into local negotiations on nationally agreed terms and conditions. Agenda for Change is a national agreement and therefore changes must be discussed and agreed via national negotiations.

In addition, the NHS Staff Council has been involved in negotiations on Agenda for Change over proposals submitted by NHS Employers to alter the agreement in England. This summary describes the current situation with these ongoing negotiations.

The proposals put forward by NHS Employers seek changes to incremental progression and sick pay in return for a renewed commitment on job evaluation and agreed principles to tackle downbanding.

In order to inform these negotiations, the trade unions undertook a detailed and extensive survey of its activists during the summer of 2012 on each element of the proposals. The findings show significant support for continued efforts by the NHS Staff Council to find a negotiated solution at national level, with over two-thirds of all respondents supporting further national negotiations. However, this is conditional on a commitment from employers to retaining the national Agenda for Change agreement.

Given the support for continuing national discussions, staff side is currently exploring which elements of the proposal could be taken forward. This would be contingent on clarification of the employers' commitment to Agenda for Change and withdrawal from or suspension of involvement by trusts in the South West Consortium.

Strong opposition to the South West Consortium, led by the NHS trade unions, has gained support from the TUC and the BMA, many MPs and councillors. Trade union members, activists and health care workers have demonstrated their anger and opposition by signing petitions, attending meetings and marches and writing to councillors, MPs and Trust Chief Executives to explain this anger and anxiety.

Similar levels of opposition and organised campaigns are emerging in other areas of the country, in response to growing calls for regional or local pay in the public sector, for example with an increasing number of councils passing motions against the concept of localised pay. The opposition campaigns highlight the damaging impact localised pay would have on regional economies, on staff morale and industrial relations.

Opposition to market-facing pay has also been recorded by the governments in Scotland Wales and Northern Ireland. The Scottish Government has stated that it is opposed to the introduction of market facing pay and that this is based on a number of factors including the potential impact on public services, economic activity and on equity grounds.

The Northern Ireland Finance Minister has opposed the market facing pay proposals, stating they would have a "damaging impact on Northern Ireland's economic recovery." Similarly, the Welsh Government has stated that it is "strongly opposed to so-called regional or 'market-facing' pay policies" and that such a policy would be "economically damaging and socially divisive."

By setting out their opposition to local pay in the public sector, these statements underline the support for national pay determination in the UK and the potential damage caused by undermining the national agreement.

4. Joint Survey of NHS trade union members

This submission draws extensively from the 2012 Joint Staff Side Survey of members. The survey, undertaken by IDS, was administered in the summer of 2012 and published in September. It is based on 34,691 responses from an online survey, as well as telephone interviews with 30 individuals representing a range of professions within the NHS. This submission highlights key findings from the IDS report, which is submitted separately (RCN publication code 004 333).

5. Recruitment And Retention

- UK employment in the NHS fell by 11,000 or 0.7% between June 2011 and 2012.
- The Joint Staff Side survey shows that while NHS staff are worried about job security, a third have very seriously considered leaving their job.
- The main drivers for considering leaving the NHS are workload and stress, the changing nature of the NHS and staff shortages. Other factors include staff feeling undervalued due to levels of pay and anxiety about proposed changes to their pension scheme.

5.1 Workforce numbers

The Labour Force Survey shows that UK employment in the NHS as at June 2012 fell by 11,000 or 0.7% on the previous year. Between June 2010 and June 2012, employment has fallen by 42,000 or 2.6%. While the UK countries have different

methods of measuring workforce numbers, further breakdown shows that all areas of the UK have experienced a fall in workforce levels.

- **England:** 1,078,463 staff in post (headcount) as at May 2012, a drop of 13,537 or 1.2% over the year[6].
- **Scotland:** 153,427 staff in post (headcount) as at June 2012, a drop of 1,885 or 1.2% over the year.[7]
- **Wales:** 78,131 staff in post (headcount) as at September 2011, a drop of 1,021 or 1.3% over the year.[8]
- **Northern Ireland:** 61,743 staff in post (headcount) as at June 2012, a drop of 638 or 1% over the year.[9]

The King's Fund quarterly report for May 2012 publishes findings from a survey of 136 finance directors[10]. This showed that 35 of the 136 surveyed said they had plans to reduce staff numbers and that these amounted to nearly 4,200 staff for the 28 directors able to quantify plans. The report states that: "If typical across the NHS, this is likely to mean a larger reduction in staff this year than the [official] fall between 2010 and 2011 of more than 14,900 – previously the biggest fall for more than a decade."

5.2 NHS retention

Chart 1 demonstrates the likelihood of NHS staff thinking about leaving their post in the NHS, with a third having considered it very seriously, compared to just a quarter in 2007. Table A shows that very few (10%) have thought about leaving to take up a different position with the same trust or organisation, while a third (34%) would think about leaving to take up a post in the private sector, either within or outside health care. Just one in six (16%) have considered leaving for a job in different NHS organisation.

> *"It's hard to maintain motivation and optimism and to lead staff in a way that takes the service forward. I'm looking outside the NHS for the first time ever."*
>
> **Radiographer, Band 8**

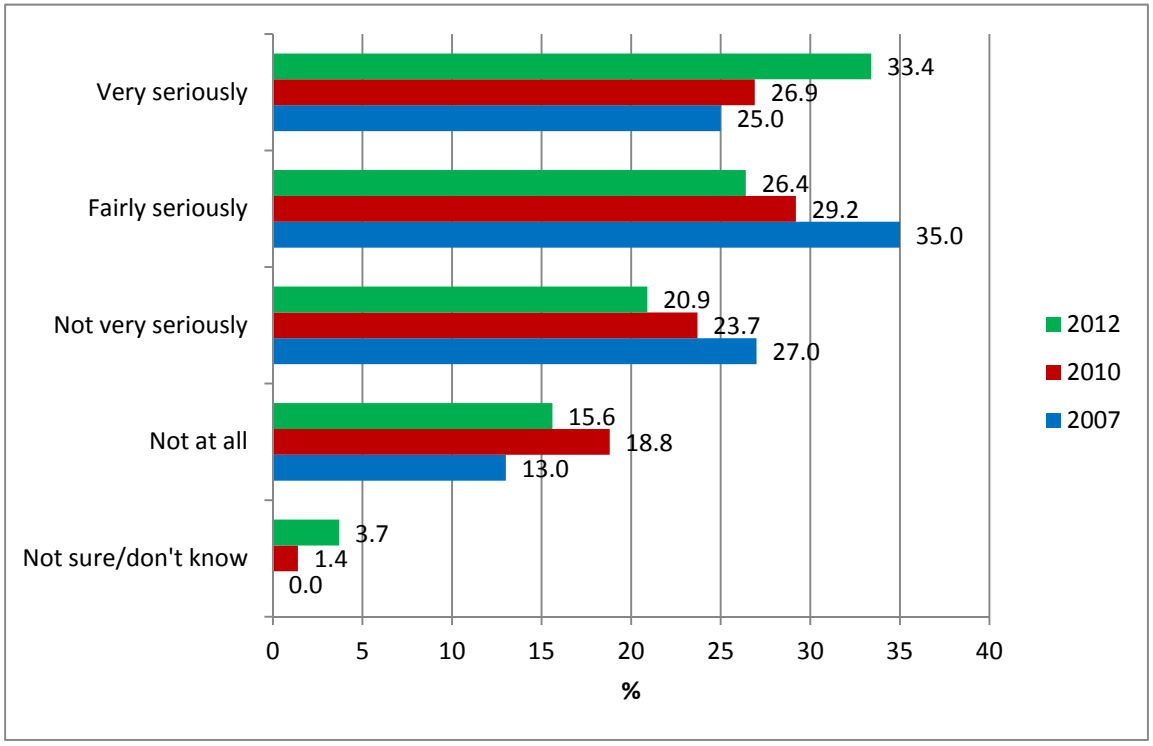
A significant number of respondents (19%) reported that they had considered leaving their post but not to take up other employment or pursue self-employment, but for other reasons perhaps linked to retirement or looking after children or a relative. This

[6] NHS Information Centre
[7] ISD Scotland
[8] Statswales
[9] Department of Health, Social Services and Public Safety
[10] www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Quarterly-monitoring-report-the-king%27s-fund-may2012.pdf

suggests a high number of NHS workers contemplating stepping away from the world of work altogether. One speech and language therapist stated in the telephone interviews that the service had been affected by cuts to posts, meaning that the remaining staff are constantly being asked to work extra shifts, concluding: *" I don't need this, so will retire."*

These findings are similar to those in the 2011 NHS Staff Survey which showed that just under a third of all staff (31%) reported that they often felt like leaving their organisation (up from 29% in 2010)[11]. Around a fifth (22%) indicated that they would probably look for a job at a new organisation in the next 12 months (21% in 2010), and 16% said they would leave their organisation as soon as they could find another job, a slight increase from 2010 (15%).

Chart 1: Over the last 12 months, how seriously have you considered leaving your current position in the NHS? (2007, 2010 and 2012)



Source: IDS Joint staff side NHS trade union membership survey 2012

[11] www.nhsstaffsurveys.com

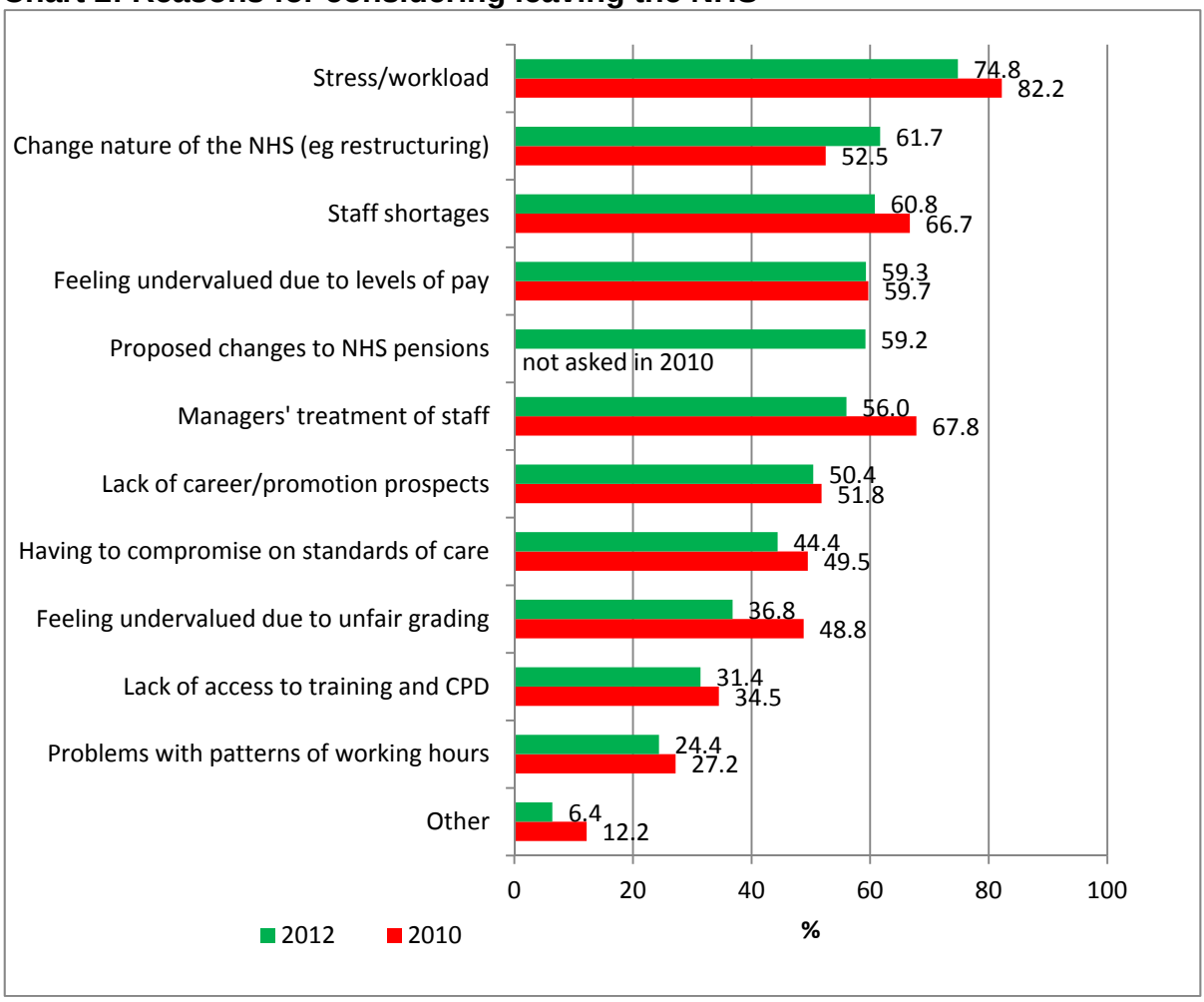
Table A: Alternative career options for respondents considering leaving the NHS

	n	%
Take up a private sector position completely outside the health service	3,176	18.1
Take up a post in another trust or organisation within the NHS	2,872	16.3
Leave the NHS and take up a post in the private or independent health care sector	2,827	16.1
Take up a public sector position completely outside the health service	2,036	11.6
Take up another position within your trust/organisation	1,679	9.6
Take up self-employment outside the health care sector	1,645	9.4
Other (eg retirement or look after children or a relative)	3,342	19.0
Total	**17,577**	**100**

Source: IDS joint staff side NHS trade union membership survey 2012

Chart 2 presents reasons given for considering leaving current employment, with stress and workload (75%), the changing nature of the NHS such as restructuring (62%) and staff shortages (61%) being the main reasons in both this survey and the one undertaken in 2010. Other reasons commonly given were feeling undervalued due to levels of pay (60%), and managers' treatment of staff (56%). In a new option proposed this year, three fifths (60%) cited the proposed changes to NHS pensions as a key reason for leaving.

Chart 2: Reasons for considering leaving the NHS

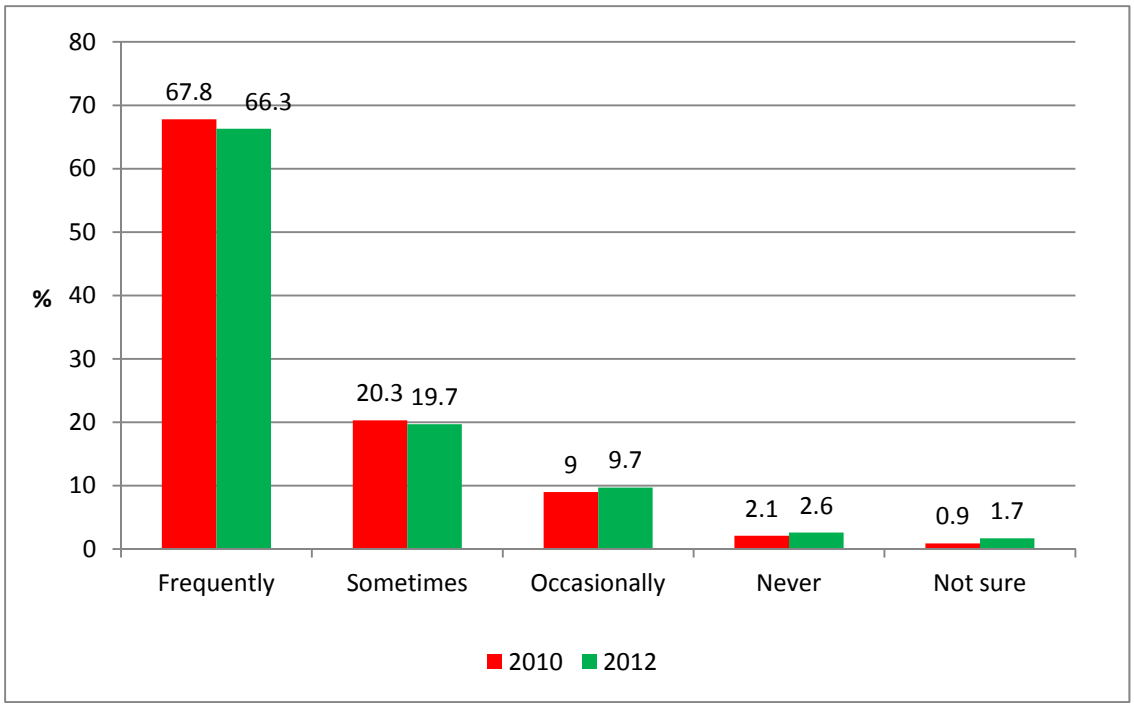


Source: IDS joint staff side NHS trade union membership survey 2012

5.3 Staff Shortages

Chart 2 indicates that staff shortages are a major concern for staff working in the NHS, cited as a key reason by 61% of respondents considering leaving the NHS. Chart 3 goes on to show that two-thirds of all respondents reported that staff shortages have occurred frequently in the previous year and that one-fifth said they have occurred sometimes. A very small number (3%) stated that staff shortages never occur in their working area or department.

Chart 3: Frequency of staff shortages in the last 12 months. 2010 and 2012



5.3.1 Shortage groups

In their twenty-sixth report the PRB referred to occupations and job titles that have been on the Shortage Occupation List continuously since first recommended in 2008 – including specialist nurses working in operating theatres, operating department practitioners, HPC-registered diagnostic radiographers, HPC-registered therapeutic radiographers and sonographers. The PRB asked parties to highlight where pay plays a specific role in such groups' recruitment and retention as opposed to weaknesses in establishing sufficient training commissions, in workforce planning, and in making available appropriate education and training.[12] We would argue that all these factors contribute to the issue and present evidence below that such shortages continue to occur, using radiography as an example.

There is a 7.6% vacancy rate against established therapeutic radiography posts in the UK.[13] Attrition from pre-registration therapeutic radiography education programmes remains high at around 35% since 2007.[14] From 2011-2016, radiotherapy activity is expected to increase by a further 50% in England alone.[15] Substantial increases in all staff will be needed to meet this required increase in activity. The above vacancy rate and the anticipated increased requirement for the radiotherapy workforce make it imperative that work continues to reduce attrition; that workforce planners across the UK accurately map future workforce

[12] NHS Pay Review Body, Twenty-Sixth Report 2012
[13] Society and College of Radiographers and IPEM, *Report on the Census of the Radiotherapy Workforce in the UK 2011*
[14] College of Radiographers, *Approval and Accreditation Annual Report,* 2011
[15] Department of Health, *Radiotherapy in England* (pending publication)

requirements; and that health boards and trusts have the funds available to use local recruitment and retention premia as appropriate.

The vacancy rate for sonographers in the UK is around 11%.[16] Anecdotal reports suggest that departments are finding it difficult to fill sonographer vacancies. Known issues include the lack of statutory registration, no central workforce planning and ad hoc training arrangements. The reorganisation of the NHS in England is likely to make the situation more difficult as strategic health authorities, who attempted to keep an overview of training in their area, are abolished. The introduction of 'any qualified provider' will fragment the ultrasound service and it is unlikely that many private providers will wish to take up the training of sonographers as it will increase their costs. Lack of trained sonographers to deliver services increases the strain on existing staff to meet targets, thereby increasing the risk of musculoskeletal injury.

5.4 Recommendations

We ask the Pay Review Body to:

- record the tremendous role that the workforce has played in meeting the expanding demands on the NHS in the context of restricted resources
- acknowledge the strains that cuts to the service despite expanding demand are placing on the workforce and patient care
- reiterate the concerns the PRB expressed in its 26th report about the failure of the Department of Health to collect vacancy data and press for resumption of data collection as early as possible.

6. Morale and Motivation

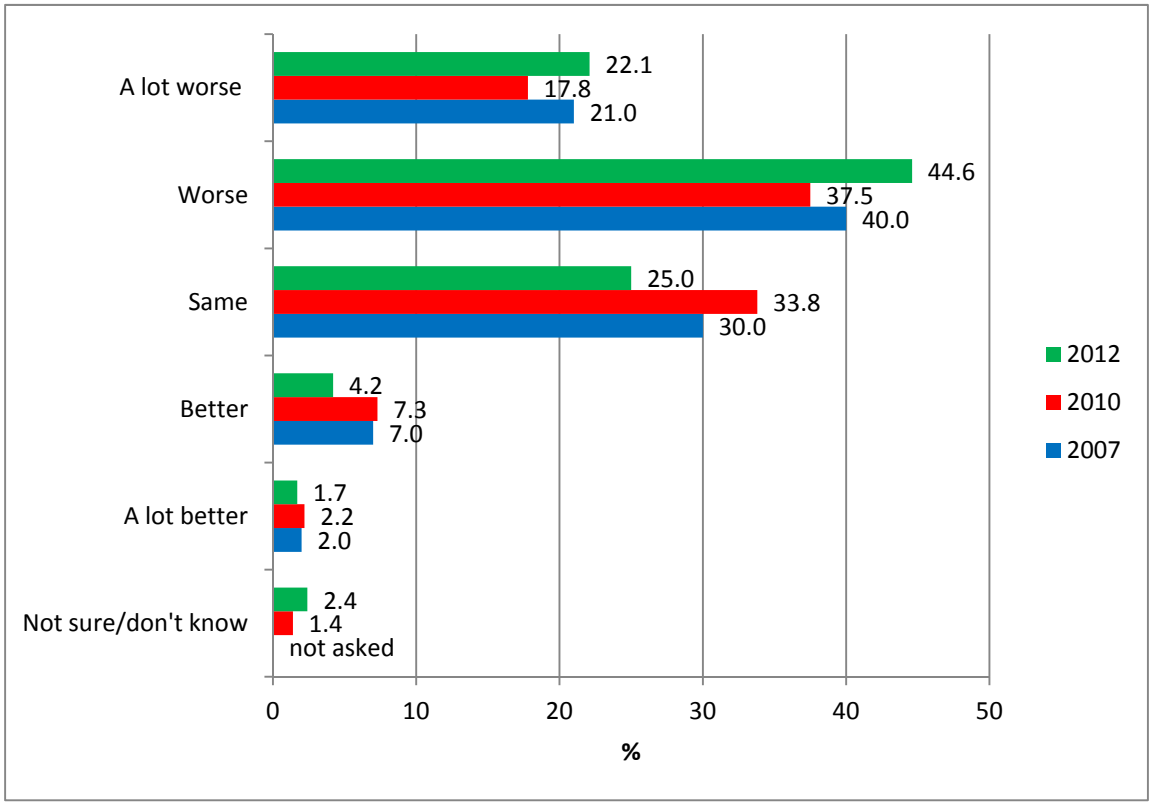
- Two-thirds of members questioned for the Joint Staff Survey stated that morale is worse than a year ago.
- This drop in levels of morale is attributed in most part to increased workplace stress, NHS restructuring and reorganisation, changes to pension entitlements and the falling value of take-home pay.
- Declining morale and motivation is taking its toll on endorsement of the NHS as a place of work, with just 8% of respondents stating they would recommend their occupation as a profession in the NHS.
- Increased workload, lack of cover and staff shortages are also contributing to worsening levels of morale and motivation with around half of respondents pointing to increased stress levels detrimental to relationships in and outside work and to their own health.

[16] Society and College of Radiographers, *Ultrasound workforce survey analysis,* 2011

- Restructuring and reorganisation in the NHS is making a big impact on the employment experience of many NHS staff, identified by many as a contributor to worsening workplace morale. The survey confirmed that restructuring is prevalent in the NHS, with over half stating that their workplace has been through a restructuring exercise in the previous 12 months.
- Members also report widespread reductions in posts, vacancy freezes and downbanding of posts.

Our series of joint union surveys have shown a pattern of declining morale and motivation among NHS staff over recent years. However, this year's survey shows a even more marked decline than in previous years, with two-thirds (67%) stating their morale and motivation was worse or a lot worse than 12 months previously, compared to 55% in 2010 and 51% in 2007.

Chart 4: Changes in levels of morale



Source: IDS joint staff side NHS trade union membership survey 2012

We also asked respondents about levels of morale and motivation within their workplace. Section 4 showed that stress is a major factor in prompting NHS staff to consider leaving their jobs, and the survey reinforces the damage caused by stress, cited by over three-quarters of respondents (78%) as the reason for declining workplace morale. Other workplace factors include the impact of restructuring and reorganisation in the NHS (59%) and dissatisfaction with the level of care NHS staff

feel they are able to provide (46%). Other issues are more to do with staff terms and conditions, including concerns about changes to NHS pensions (56%), levels of pay (55%) and job security (48%).

Table B: Reasons for a decline in workplace morale*

n=24,549

	n	%
Increased workplace stress	22,353	77.7
Restructuring and reorganisation	16,829	58.5
Changes to pension entitlements	16,073	55.9
Falling value of take-home pay	15,881	55.2
Threats to job security	13,694	47.6
Dissatisfaction with the quality of care you are able to provide	13,206	45.9
Attacks on terms and conditions	12,456	43.3
Reduced career prospects	9,932	34.5
Threat of local pay	7,532	26.5
Threat of privatisation	5,448	18.9
Other	2,207	7.7

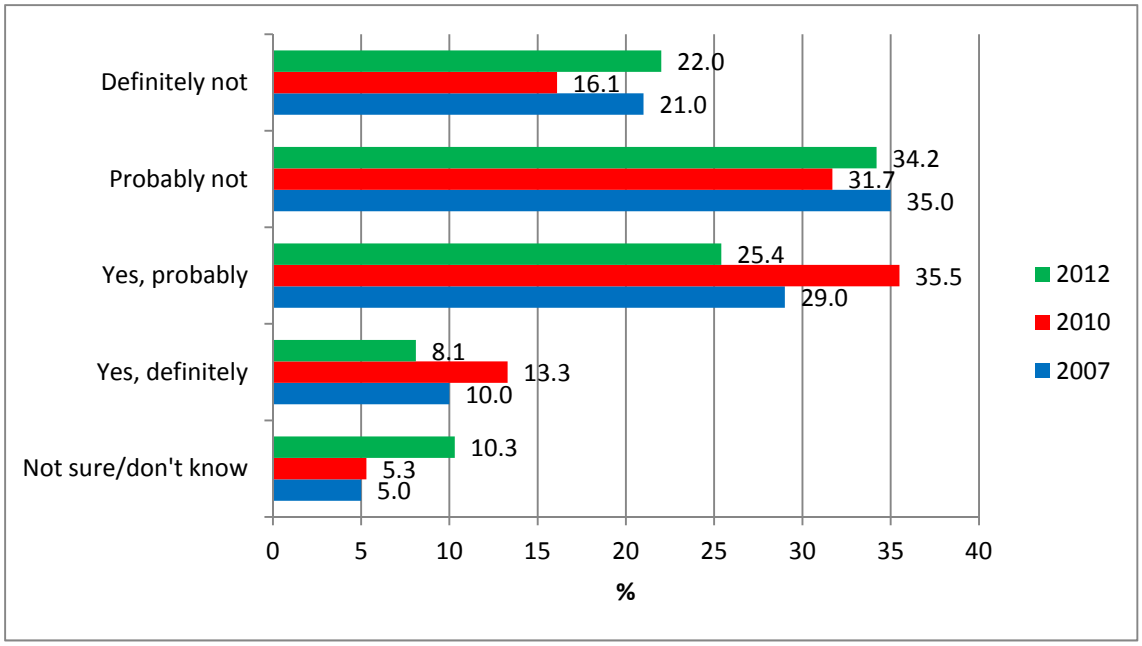
* Respondents were able to select more than one response

Source: IDS joint staff side NHS trade union membership survey 2012

This decline in morale and motivation is clearly having an impact on the level of support for the NHS as a place of work. Chart 5 shows results from the question: *"Would you recommend your own occupation or profession as a career in the NHS?"* Just one in 12 (8%) would definitely recommend their occupation or profession and a quarter would probably endorse it, leaving a worryingly high proportion (54%) who would definitely or probably not recommend it to someone else.

> *"I wouldn't encourage a child of mine to work in the NHS because of the lack of security."*
>
> **Community midwife, Band 6**
>
> *"The NHS as a place to work over the next few years will be very challenging. It will be very hard for young people, being expected to work harder for less money and to pay more into the pension scheme. It will be hard to recruit staff. And if you work longer, where are the jobs for young people?"*
>
> **Health care assistant, Band 3**

Chart 5: Would you recommend your own occupation or profession as a career in the NHS?



Source: IDS joint staff side NHS trade union membership survey 2012

6.1 Workload

Chart 2 above demonstrates that high levels of stress and workload are the main reasons prompting NHS staff to think about leaving their posts, cited by three-quarters of those respondents who have considered leaving.

Further findings in Table C show that the majority of respondents reported that their individual workload has increased in the last 12 months, with around half (53%) stating it has increased a lot and 28% that it has increased a little.

Table D shows that the main reason reported for NHS staff dealing with increased workloads is having to take on additional duties and responsibilities (75%) and in turn this appears to be due to staffing shortages either linked to lack of cover (47%), vacancy freezes (38%) or recruitment problems (18%).

The telephone interviews undertaken by IDS reveal that recruitment freezes or deleted posts are widespread in their organisations. Typical statements include one from a Band 6 physiotherapist who reported that a permanent recruitment freeze had been put in place in their workplace, as well as a cut in staffing of one in six. Another physiotherapist in a different organisation reported a recruitment freeze, as well as the deletion of six posts replaced by lower-banded staff. A Band 8 community nurse manager and a Band 7 nurse both reported that as people are retired, they are not being replaced while a Band 5 paramedic and a Band 7 community midwife both reported that no empty posts are being filled. A Band 7 speech and language therapist similarly reported that posts have been deleted, leading to a 50% cut in staffing levels.

One consequence of recruitment freezes and deleting posts is a reported increase in the use of temporary bank staff. For example, a Band 3 administrative officer reported that 12% of permanent staff are to be replaced with bank staff and that bank working is to be extended from nurses and health care assistants to other types of staff including physiotherapists, radiographers, IT and HR staff.

Table C: Changes to individual workload

Compared with this time last year, individual workload has...	**n**	**%**
Increased a lot	15,926	52.8
Increased a little	8,566	28.4
Stayed the same	4,175	13.8
Decreased a little	560	1.9
Decreased a lot	259	0.9
Not sure/don't know	665	2.2
Total	**30,151**	**100**

Source: IDS joint staff side NHS trade union membership survey 2012

Table D: Reasons for increased workload*
n= 24,549

	n	**%**
Additional duties and responsibilities	18,499	75.4
Insufficient sickness, maternity or holiday cover	11,440	46.6
Vacancy freezes	9,227	37.6
Pressure to meet government targets	8,536	34.8
Recruitment problems	4,481	18.3
Redundancies	1,533	6.2
Other	3,562	14.5

* Respondents were able to select more than one response

Source: IDS joint staff side NHS trade union membership survey 2012

Table E looks at the impact of increased workload, with almost three quarters (72%) reporting a negative impact on morale, as well as increased stress levels which lead to a detrimental impact on both relationships within and outside work (49%) and on NHS workers' health (44%). Further findings from the 2011 NHS staff survey showed that almost half (45%) reported that they do not have time to carry out their work.

The telephone interviews also probed further on the impact of recruitment freezes and deleted posts on workload, with many respondents describing the negative impact on both staff and patients. For example, a Band 6 physiotherapist said that staffing cuts had hit one in six of the team, that waiting lists had been extended and

that the job had become more stressful. A Band 7 midwife reported that one in 20 jobs had been cut, that staff had been asked to work extra shifts paid as plain time only and that complaints and litigation had increased. A Band 3 health care assistant stated that 2 out of 15 posts had been cut, resulting in low staff morale.

Table E: Impact of increased workload*
n=24,413

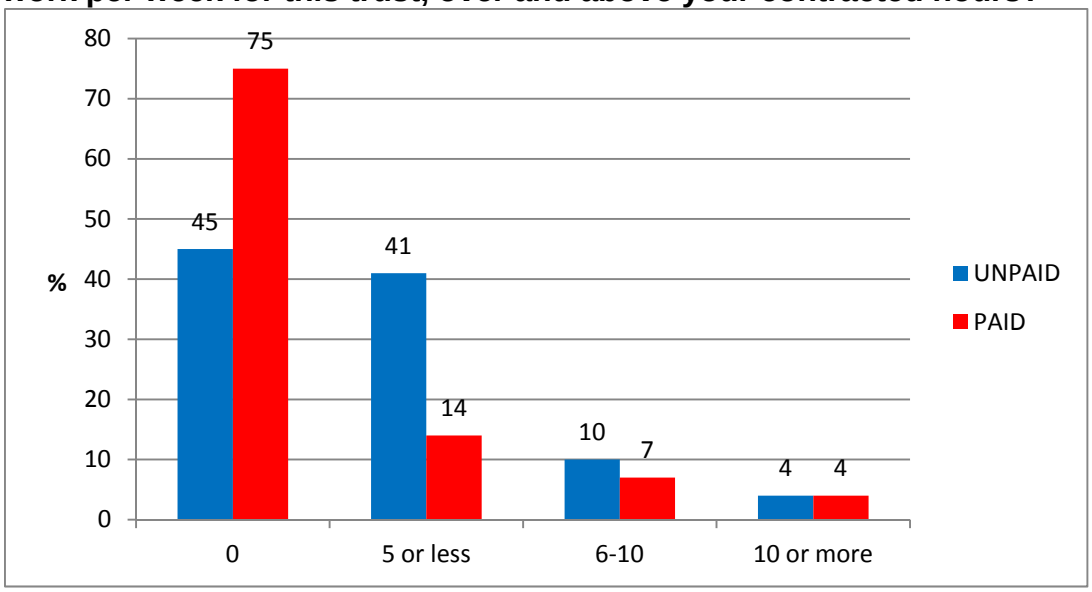
	n	%
Negative impact on morale	17,433	71.4
Increased stress levels leading to detrimental effect on relationships within/outside work	11,936	48.9
Increased stress levels leading to detrimental effect on health	10,672	43.7
Increased intention to leave the NHS	8,820	36.1
Negative impact on patient care	8,334	34.1
Fewer opportunities to work flexibly/fewer hours	5,188	21.3
Job is more interesting and stimulating	2,067	8.5
Little or no effect	1,435	5.9
Other	646	2.6

* Respondents were able to select more than one response

Source: IDS joint staff side NHS trade union membership survey 2012

The 2011 NHS staff survey asked respondents about working additional hours and found that while three-quarters (75%) reported that they do not usually work *paid* additional hours in their job, just over half (55%) reported that they regularly work *unpaid* hours. Two-fifths (41%) of all staff stated that they regularly work up to 5 hours a week, revealing the widespread reliance on staff working unpaid overtime within the NHS.

Chart 6: On average, how many additional PAID and UNPAID hours do you work per week for this trust, over and above your contracted hours?



Source: NHS Staff survey 2011

6.2 Restructuring

As stated above, six in ten (59%) of those reporting a decline in workplace morale pointed to restructuring as a major contributor. The survey confirmed that restructuring is prevalent in the NHS, with over half (55%) of all respondents stating that their workplace has been through a restructuring exercise in the previous 12 months.

Respondents were asked how their organisation was responding to the financial challenges. Two thirds (65%) replied that restructuring or reorganisation of services is ongoing within their workplace or department, and similar numbers said there has that their organisation has put in place a recruitment freeze (61%) and reductions in posts (59%). Almost a third (31%) told us that there have been cuts to services.

In addition, around a quarter said that downbanding (25%) or changes to terms and conditions (27%) are being implemented. Downbanding is becoming an increasingly worrying issue for NHS staff as found in a recent survey of union activists and local staff sides undertaken by Staff Side. This showed that almost two-thirds (63%) of all joint staff sides responding to the survey reported that downbanding had taken place or had been proposed in their organisation.

Table F: Responses to financial challenges – all respondents

n= 28,717

How is your workplace/department responding to the financial challenges facing the NHS?	**n**	**%**
Restructuring/reorganising services	18,693	65.1
Recruitment freezes	17,471	60.8
Reduction in posts	17,016	59.3
Cutting services	8,914	31.0
Changes to terms and conditions	7,802	27.2
Down-banding	7,091	24.7
Outsourcing	3,819	13.3
Other	2,205	7.7

** Respondents were able to select more than one response*

Source: IDS joint staff side NHS trade union membership survey 2012

Telephone interview respondents also told us that they have been directly affected by restructuring over the previous year or were anticipating such changes in the near future. These included the merger or relocation of departments, services or hospitals and/or the reorganisation of managerial structures. Respondents noted that such restructuring often results in downbanding of staff.

For example, a Band 8 orthoptist reported that restructuring has resulted in the service being managed with a combined managerial/operational role. They reported feeling vulnerable, since the employer is looking to downband certain roles. A Band 7 nurse reported the senior management roles in the team have been restructured and downbanded, followed by administration and clinical. The nurse was worried that Band 7s would be the next set of staff to face downbanding. A Band 8 radiographer told interviewers: *"Patients are affected because staff are demoralised due to downbanding. They're going to notice a deterioration in services."*

7. Pay and Prices

- The significant gap between NHS wage growth and inflation has been sustained over the last year.
- Inflation projections stand well above the 1% pay cap limit imposed by the government.
- By 2013, inflation will have stripped between 8% and 12% out of the value of NHS wages.
- Big increases in gas and electricity prices have been among the most important factors driving inflation.
- The gulf between private and public sector pay settlements has grown ever greater over the last year.
- Average earnings in the private sector have also been running ahead of the public sector for most of the last year.
- Pension contribution increases are likely to lead to a further reduction in take home pay of up to 6% by 2015.
- The Joint Staff Side survey shows that the proportion of staff stating that they are worse off financially than 12 months previously rose from 56% in 2010 to 84% in 2012.
- Just over half of all respondents currently rely on some additional form of payment to supplement their basic salary in order to sustain their standard of living, particularly unsocial hours payments and overtime. However, NHS staff report that there have been recent reductions to these additional forms of payments.
- Over half (55%) state that the falling level of take-home pay is contributing to declining morale while the majority (78%) regard the current public sector policy as unfair and an even higher number (89%) view the proposals for 2013/15 as unfair.

7.1 Background

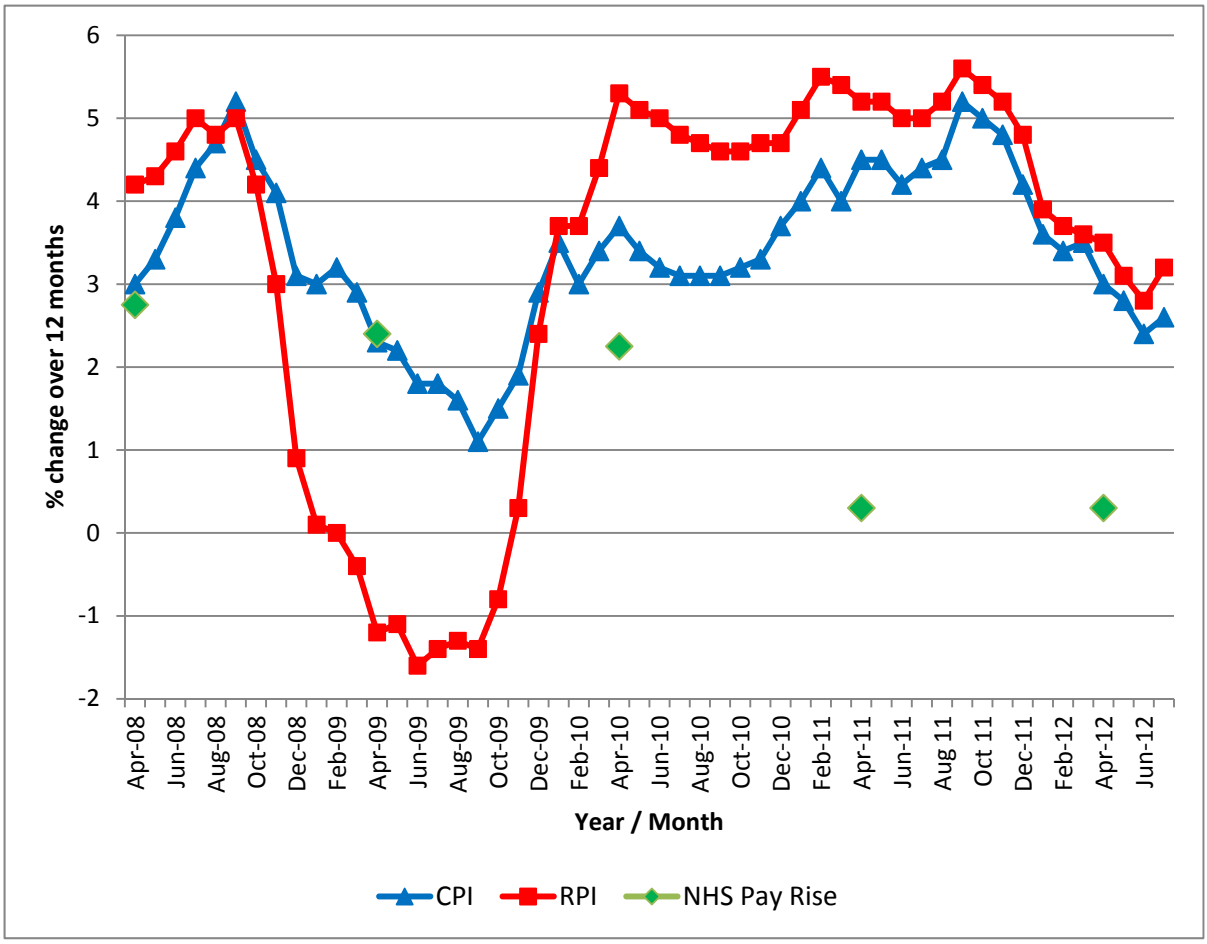
Last year's submission to the Pay Review Body was made against the background of the worst recession since the Second World War. Other parties made the observation that the economic slowdown and the consequent rise in unemployment as well the slow growth in private sector wages are likely to have resulted in decreased turnover. The private sector is showing signs of picking up, with both employment and pay awards starting to recover. The headline whole economy pay award as measured by XpertHR stands at 2.5% for the three months to 31 July 2012. In the three months to June 2012, the employment rate for those aged from 16 to 64 was 71%, up 0.4 percentage points on the quarter. There were 29.48 million people in employment aged 16 and over, up 201,000 on the quarter.

7.2 Inflation

While inflation has declined from its peaks in 2011, when it consistently exceeded 5%, the graph below illustrates that the huge gap between the NHS pay award and the rate of increase in the cost of living that opened up during 2010 has been sustained over the last year. The scale of that gap is reflected in the fact that even the Consumer Price Index (CPI) measure of inflation is currently 10 times that of the latest pay award.

Taking a look back on inflation over the last four years shows the sustained nature of the damage to pay rates caused by price rises. Monthly Retail Price Index (RPI) figures have been above the annual pay award for 73% of the period that has elapsed over the last four years, while monthly CPI figures have surpassed awards for 83% of that time.

Chart 7: Inflation rates compared to NHS pay awards



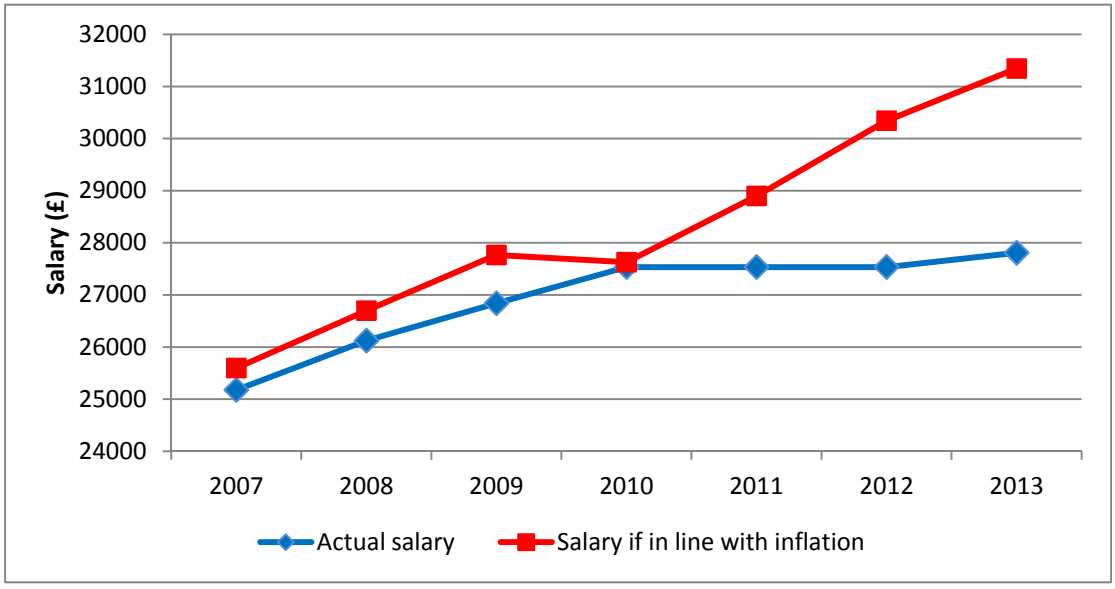
Source: Office of National Statistics

The Treasury average of independent forecasts for the remainder of 2012 suggests that inflation measures will fall a little further, with RPI hitting an average of 2.3% and

CPI running around the 1.9% mark[17]. Looking further ahead to 2013, inflation is expected to stabilise, with RPI at 2.5% and CPI at 2% by the fourth quarter. However, even if this return to more modest inflation rates turns out to be true, inflation for 2013 would still be taking additional bites out of the value of NHS wages if the annual rise is limited to 1%. Over the entire course of the proposed 1% public sector cap from 2013 to 2015, medium range forecasts from the Treasury suggest that RPI will be running at 2.6% in 2014 and climbing to 3% by 2015.

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, the first diagram shows how their actual salary increased through to April 2012 and then shows their salary for April 2013 if it were raised by the 1% cap requested by the government. 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 virtual pay freeze is expected to see the gap widen to over £3,500 next year, slicing over 11% out of the value of a Band 5 worker's wage.

Chart 7: Impact of RPI on Band 5 salary



For higher paid staff, such as an employee at the top of Band 8a, the differential is anticipated to reach over £6,400 next year – a loss of 12% to the value of their salary.

Charts 8 and 9 show that by 2012 the gap between actual salary and RPI reached £875 or 6% for a Band 1 worker and the gap was £1,495 or 7% for a Band 3 worker. Next year, an employee at the top of Band 1 (who received the £250 increases in 2011 and 2012) is set to see the gap between their actual salary and an RPI indexed

[17] HM Treasury, Forecasts for the UK Economy, August 2012

salary hit £1,246. Therefore, staff currently on just £14,864 will have seen inflation take an 8% slice out of the value of their wages.

Chart 8: Impact of RPI on Band 1 salary

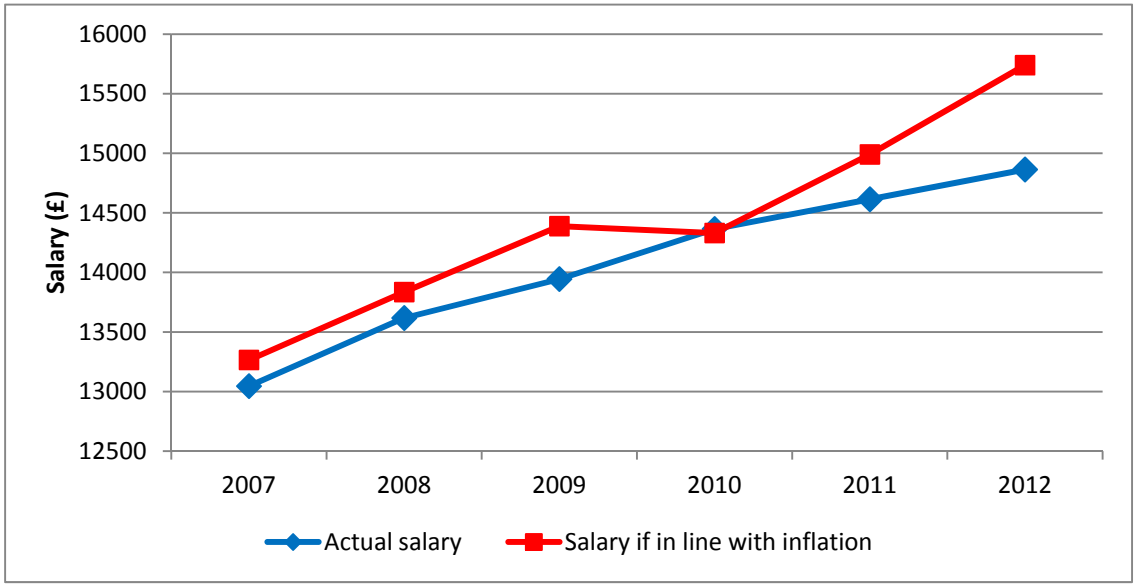
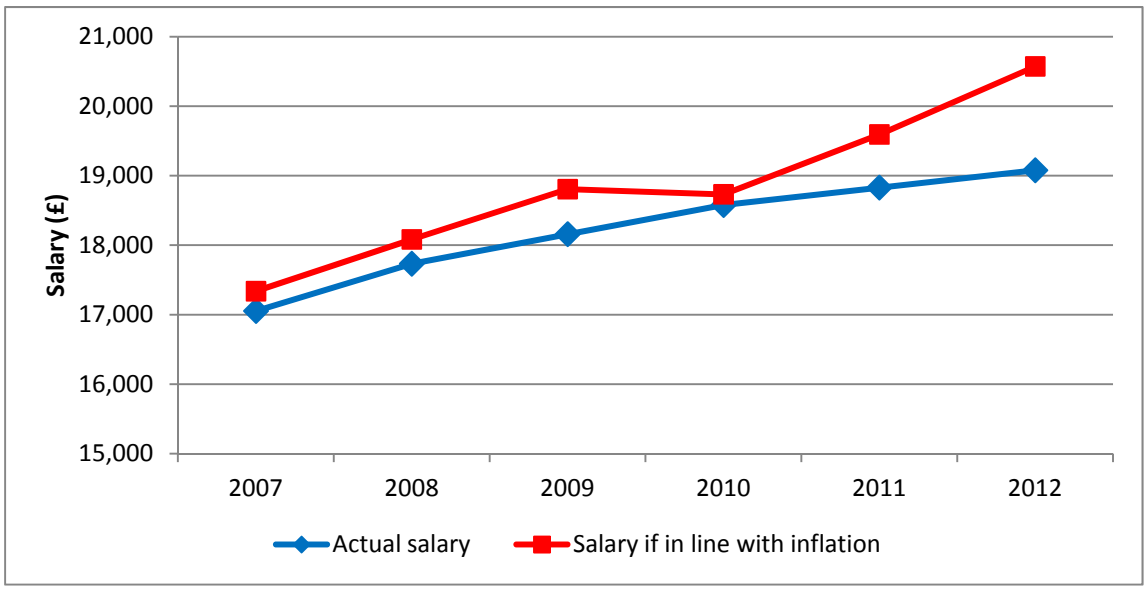
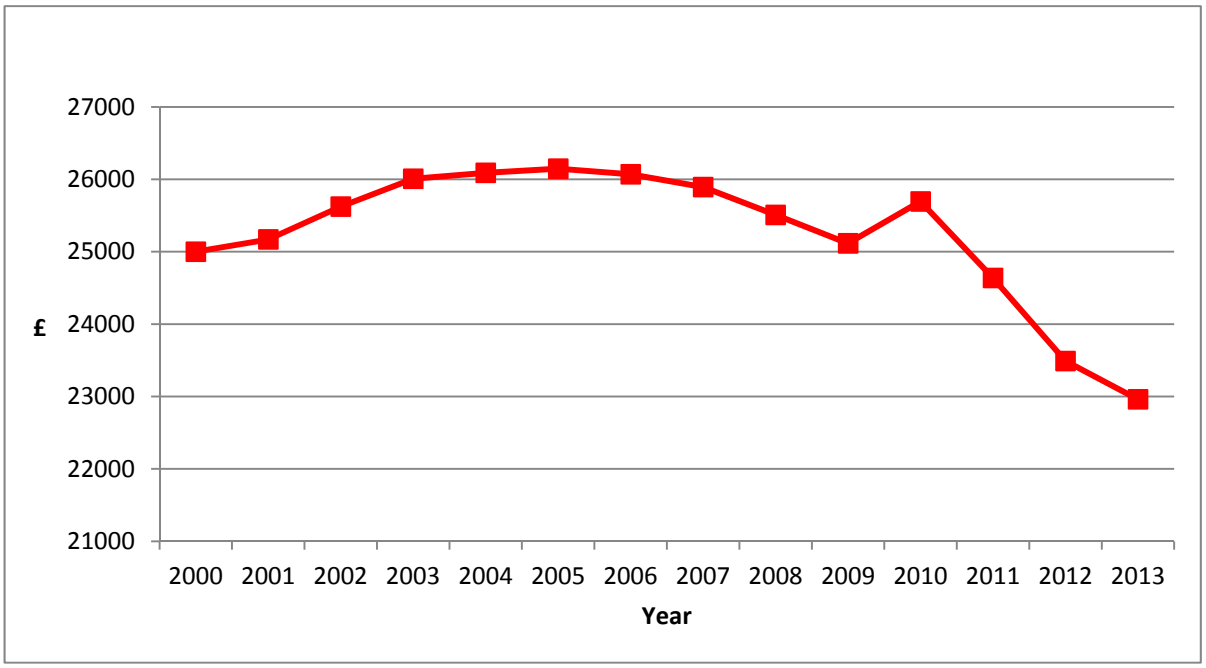


Chart 9: Impact of RPI on Band 3 salary



The longer term impact on NHS wages is illustrated by Chart 10 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 increased to £26,146 by 2005, but the gap between inflation and the pay award has been so dramatic that the real value has now actually dropped to £23,490 – significantly below its value 11 years ago.

Chart 10: Example of change in real value of NHS salaries



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. RPI also remains the most widely used measure as the basis for pay negotiations across the public and private sectors[18].

The results of the latest Croner Reward cost of living survey back up the assertion that RPI is the most relevant measure as its analysis of the required income to maintain a family's standard of living identified a 5.7% increase over the year to March 2012[19].

The Croner Reward survey also breaks down the required income to maintain existing standard of living according to eight different income categories. The 2010 and 2011 reports showed that the lowest income group experienced bigger percentage rises in required income than any other income group at 6% and 6.6% respectively, though this tendency was arrested in 2012, when the lowest income groups saw their required income growth drop below the average to 5.2%

However, long term studies of the impact of inflation on different income groups still suggest that low income groups suffer disproportinately. For example, the Institute of Fiscal Studies published a report in 2011 which found that the greater tendency of low income households to spend a higher proportion of their income on fuel and water meant that, on average, lower income households had higher inflation rates than higher-income households[20]. Over the 10 year period studied, the group within

[18] Incomes Date Services, *Pay in the Public Sector 2007*
[19] Croner Reward, *Cost of Living Regional Comparisons*, March 2012
[20] Peter Levell and Zoe Oldfield, *The spending patterns and inflation experience of low-income households over the past decade*, Institute of Fiscal Studies, June 2011

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.

7.3 Inflation components

The changes in the price of components of the Consumer Price Index over the year to July 2012 as defined by the Office of National Statistics are shown in the tables below.

Table G: Consumer Price Index July 2012

Item	% increase over year to July 2012
Housing, water, electricity, gas and other fuels	6.1
Education	5.1
Alcoholic beverages and tobacco	5.0
Communication	4.4
Furniture, household equipment and maintenance	3.5
Restaurants and hotels	3.2
Health	3.0
Food and non-alcoholic beverages	2.1
Transport	1.3
Clothing and footwear	0.1

Source: Office for National Statistics, Consumer Price Indices, July 2012

The leading position of the housing, water, electricity, gas and other fuel category has been driven mainly by the 15.4% surge in gas prices and 8% rise in electricity prices. The transport sector has dropped out of its position as one of the top inflationary factors over the last two years, but the total figure masks the fact that rail and road costs have been running in the 4% to 7% bracket over the last year.

The changes in the price of components of the Retail Price Index over the year to July 2012 as defined by the Office of National Statistics are shown in the table below.

Table H: Retail Price Index July 2012

Item	% increase over year to July 2012
Personal expenditure	5.5
Alcohol and tobacco	4.7
Consumer durables	4.9
Food and catering	2.6
Housing and household expenditure	3.6
Travel and leisure	1.5
All goods	2.7
All services	4.3
All items	3.2

Source: Office for National Statistics, Consumer Price Indices, July 2012

Within the RPI data, the same trends are apparent, with gas prices up by 15.7% and bus/coach fares up by 5.3%. A closer look at the housing costs element of RPI that is omitted by CPI also shows the over most of the year rents have been rising much faster than mortgage interest payments. However, in July mortgage costs reasserted themselves, running at 2.2% compared to the 3.4% faced by people in rented accommodation. The unexpected resurgence of RPI hit commuters as average rail price rises for 2013 are pegged to the July RPI rate plus 3% in England and RPI plus 1% in Scotland.

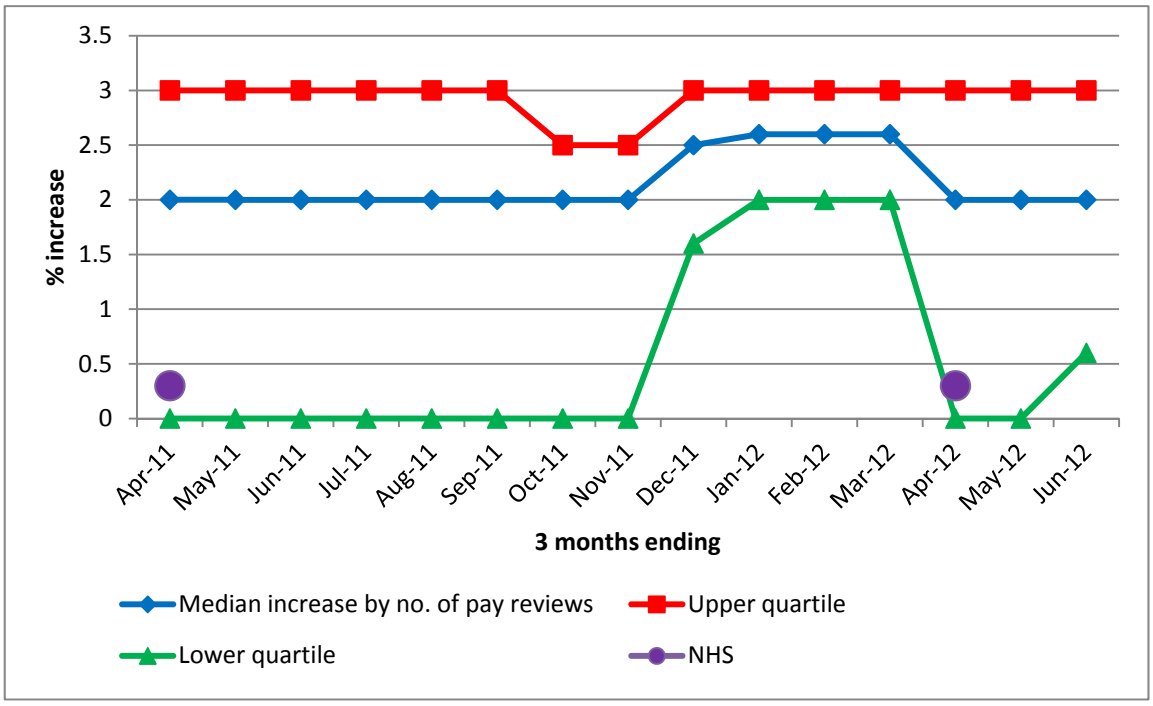
While not specifically assessed by CPI or RPI figures, childcare costs represent a key area of expenditure for many staff (union surveys have consistently found that around a third of staff have child caring responsibilities). Therefore, it is also worth noting that the annual Daycare Trust survey for 2012 found that nursery care costs for children under two rose 5.8% to the point that average yearly expenditure stands at £5,103 and childcare costs for a child aged two and over rose 3.9%[21]. The Trust also reported that the government's decision to cut the maximum level of support available through the childcare element of working tax credit from 80% to 70% of costs meant that low income families were receiving £500 less a year.

7.4 Pay settlements

Median pay settlements across the UK economy showed an upswing in late 2011 and early 2012, before slipping back in April 2012 to 2%, where they have remained.

[21] Daycare Trust, *Holiday Childcare Costs Survey 2012*, January 2012 www.daycaretrust.org.uk/pages/holiday-childcare-costs-survey-2012.html

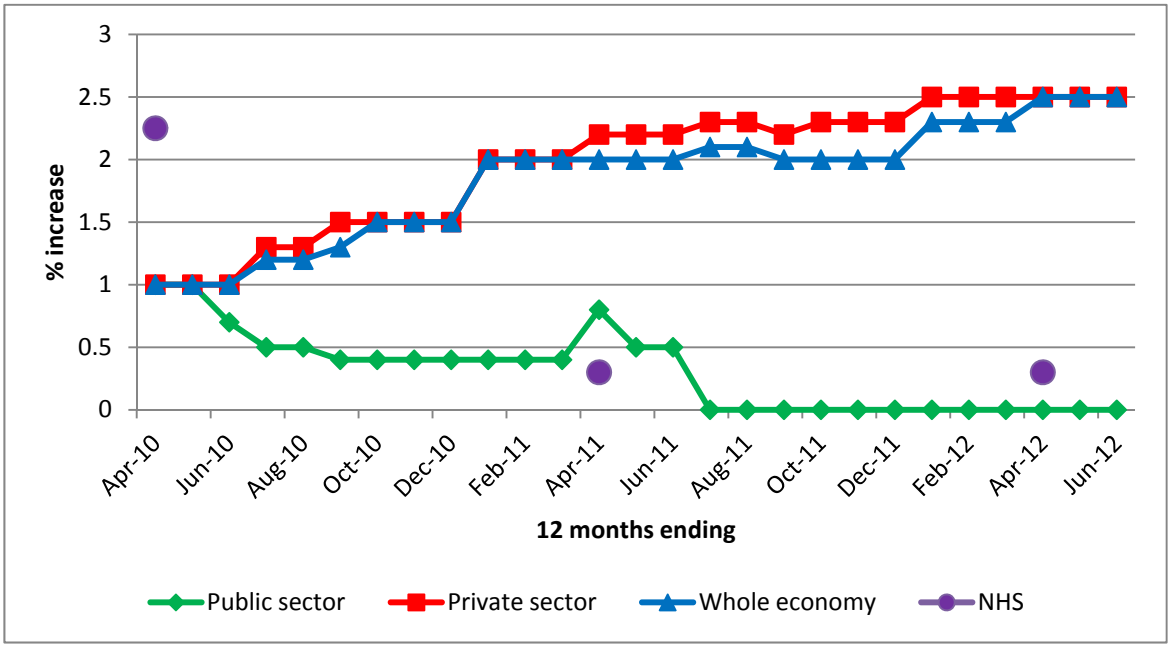
Chart 11: Median pay settlements



Source: Industrial Relations Services

The scale of the disparity in pay settlement growth between the public and private sectors is shown by Chart 12 below. Since April 2010 when public and private growth was equal at 1%, public sector pay settlements have dropped to 0% while private sector settlements have climbed to 2.5%.

Chart 12: Median pay settlement comparison



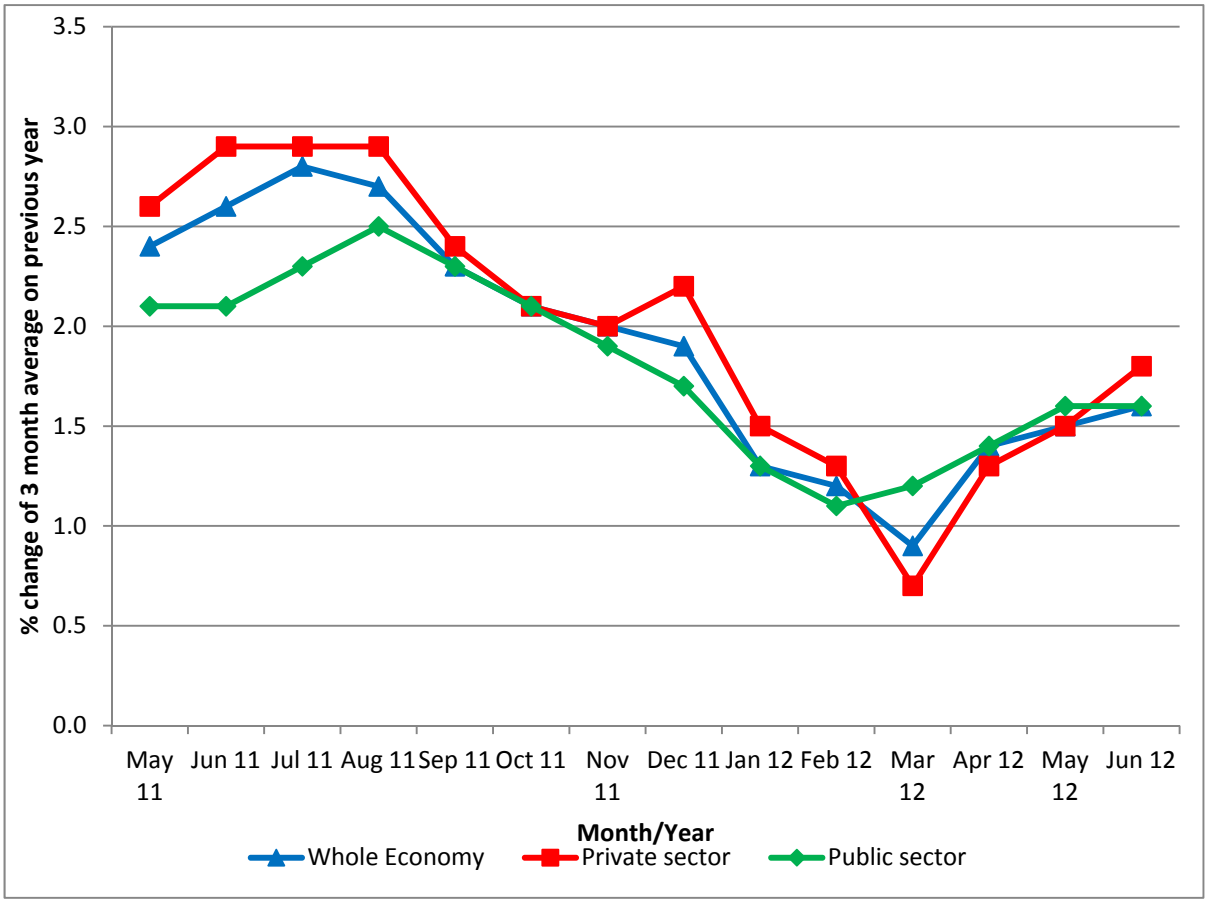
Source: Industrial Relations Services

This deterioration in the competitive position of public sector pay rates is likely to continue given forecasts of private sector pay settlements that predict the private sector rate will grow at 2.5% over the coming year especially if the government's proposed 1% cap on public sector rates is applied[22].

7.5 Earnings comparisons

Over the last year, the disparity long apparent between public and private pay settlements has also asserted itself in average earnings. The graph below shows that average earnings have been growing faster in the private sector than the public sector during 10 of the last 14 months.

Chart 13: Average earnings



Source: Office of National Statistics, Labour Market Statistics, August 2012

Forecasts of average earnings predict that average earnings growth for 2012 will stand at 1.7% (well above the current 0.6% earnings growth rate in the health and social care sector) and expand to 2.4% in 2013[23].

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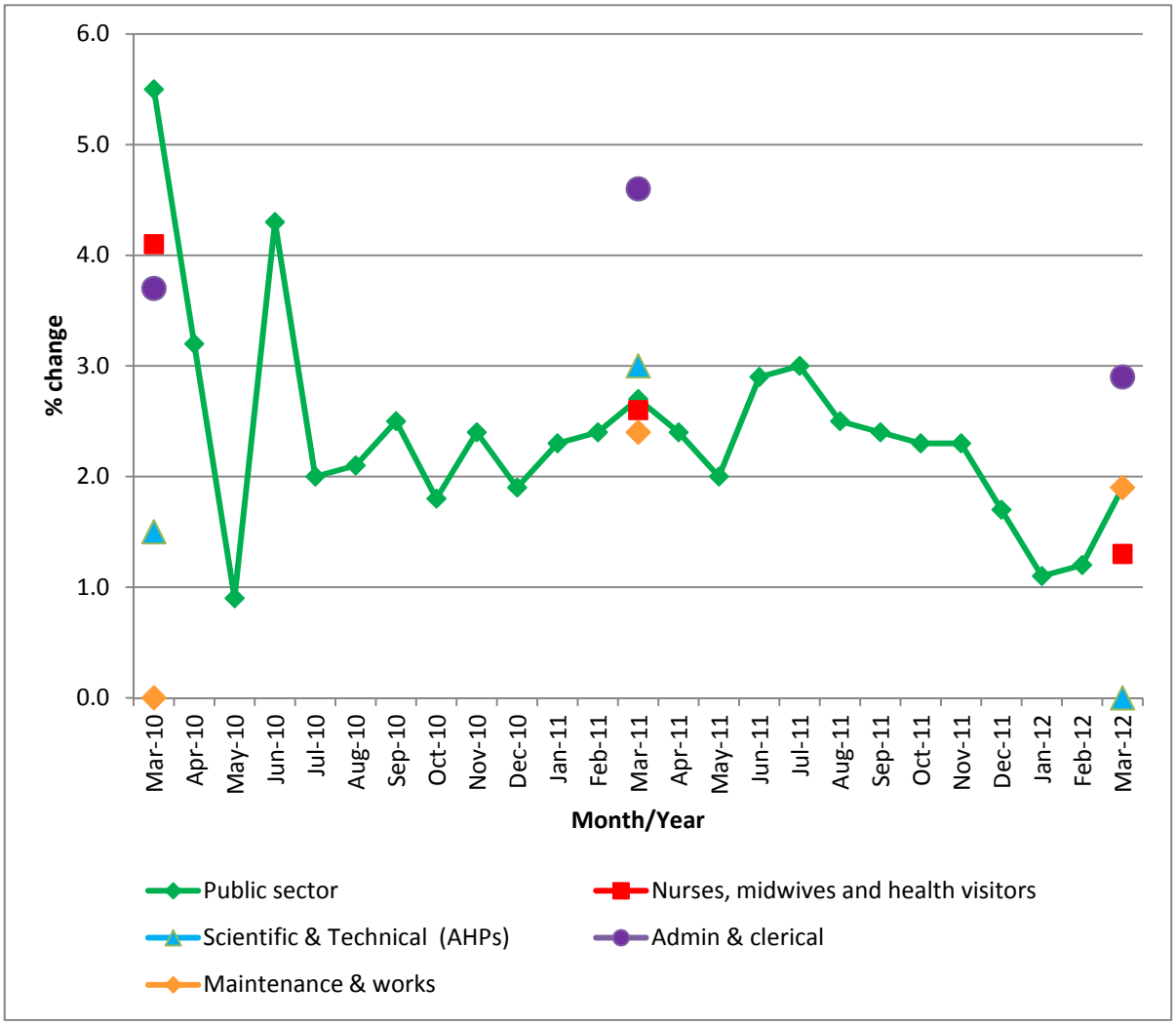
[22] Private sector pay forecasts for 2012: the XpertHR survey
[23] HM Treasury, *Forecasts for the UK Economy,* August 2012

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, most occupational groups have lagged behind the public sector average.

The graph below demonstrates that, among the four occupational groups listed, average earnings growth has been at or below the public sector average on nine out of 12 occasions. Over the last year, only administrative and clerical staff saw earnings grow faster than the public sector average, while nurses, midwives, health visitors, scientific and technical staff, and maintenance and works staff were at or below the average.

Chart 13: Average earning growth comparison



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

The data above has provided a comparison of NHS earnings against the wider economy. However, it is also worth noting the backdrop of chief executive pay within

the NHS and the wider economy for the potential impact on staff perceptions of fairness and consequently morale.

In 2011, when the majority of NHS staff were still enduring a pay freeze, NHS chief executives in England on median salaries in the £156,000 range saw their salary rise by 1.6%[24]. In Scotland and Northern Ireland, average rises were 1.7% and 2.1% respectively (Wales was not included in the analysis as the scale of role reorganisation did not allow a sound comparison across two years).

The latest analysis of executive director remuneration among the FTSE 100 companies also indicates that chief executives received an average 12% increase in their take home pay last year.[25] The survey showed that the rise was five times the increase in average earnings across the economy and chief executives have seen their income grow from 47 times their employees' average earnings in 1998 to 139 times in 2011.

7.6 Staff in the lower pay bands

The Rowntree Foundation Minimum Income Standard for 2012 is £8.38 an hour (single person) and £9.39 an hour (for a couple with two children, both working full-time)[26]. This means that all staff on the bottom six points of the Agenda for Change pay scale are earning less than the annual minimum income standard (MIS) for a single person of £16,385. Changes to the welfare system and in particular to tax credits have compounded this problem and mean that staff on low wages have to pay significantly more for their childcare than in previous years.

The proportion of staff earning less than the MIS has risen dramatically since last year, when pay levels below the MIS were confined to the bottom three points of the pay scale. In addition, whereas last year the bottom point fell £843 short of the MIS, it now falls £2,230 short. Staff Side believes that no NHS employee should be paid less than the MIS and therefore, we support additional increases for staff on points 1-6 to bring them closer to the minimum standard.

Adjustments also need to be considered to the pay points on the Agenda for Change pay scale immediately above point 15 following two successive years of £250 rises for staff earning £21,000 or less and a pay freeze for all others, as the gap between points 15 and 16 has been eroded to a nominal £122. While the average gap between pay points is 3.6%, the increase between points 15 and 16 is worth 0.6%. As a minimum way of addressing the issue, the award of £250 for staff at point 16 and £125 for staff at point 17 (in addition to the general recommended uplift) would serve to smooth out this differential, leaving the gap between 15 and 16 at 1.8% and the gap between 16 and 17 at 2.3%. The graph below shows the smoothing effect of the proposals.

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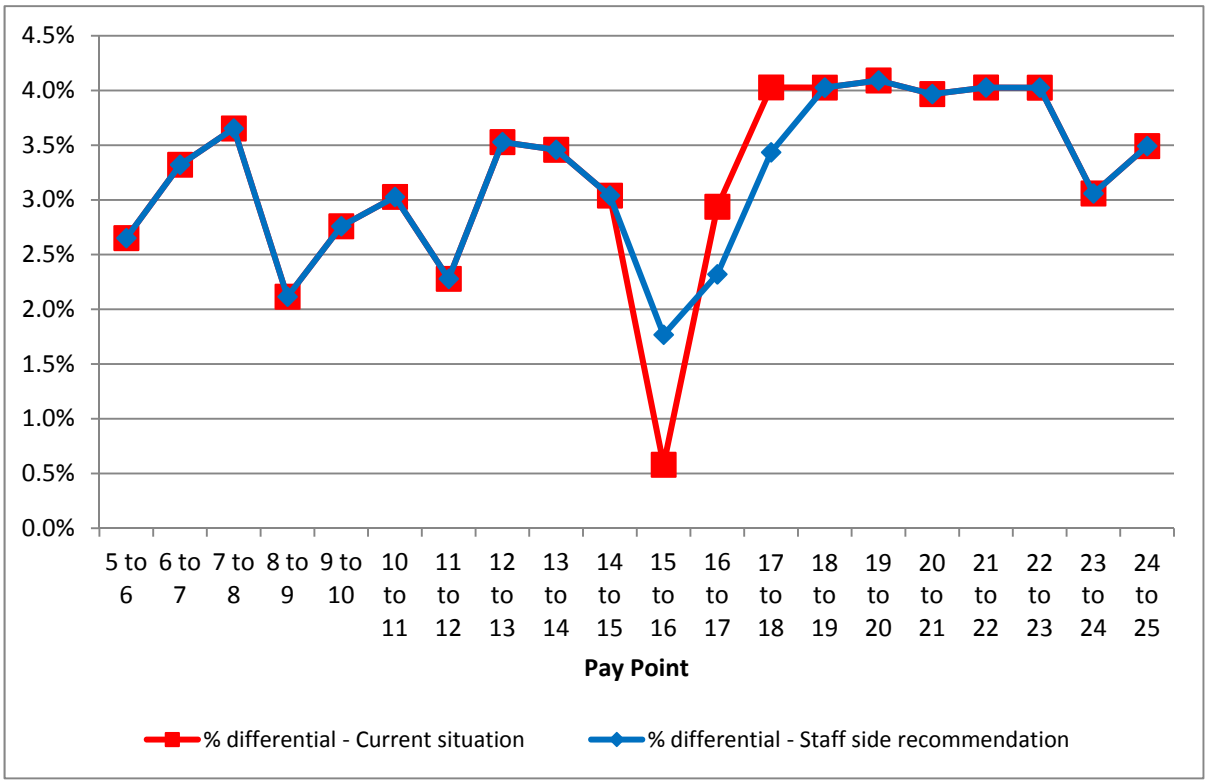
[24] Incomes Data Services, *NHS Boardroom Pay Report 2012*, February 2012
[25] Manifest/MM&K, *Executive Director Total Remuneration Survey*, June 2012
[26] Joseph Rowntree Foundation, *A Minimum Income Standard for the UK in 2012*, July 2012

Chart 14: Increment differentials



7.7 Other factors affecting staff living standards

Pension contribution increases add another dimension to the declining cost of living experienced by NHS staff. Over the 2012/13 period, employee contribution increases have been introduced for staff who earn in excess of £26,557 that reduced their take home pay by between 1.5% and 2.4% in line with the table below. Therefore all staff at the top of band 5 or above will experience even further reductions in the value of their wages over 2012/13 in addition to the inflationary impact outlined in section 2.1 above.

Table I: Changes to the NHS Pension Scheme 2012/13

FT Equivalent Pensionable Pay	Current % Contribution (before tax relief)	2012/2013% Contribution (before tax relief)	Total Increase (before tax relief)
Up to £15,000	5%	5%	0%
£15,001 to £21,175	5%	5%	0%
£21,176 to £26,557	6.5%	6.5%	0%
£26,558 to £48,982	6.5%	8%	1.5%
£48,983 to £69,931	6.5%	8.9%	2.4%
£69,932 to £110,273	7.5%	9.9%	2.4%
Over £110,273	8.5%	10.9%	2.4%

Source: UNISON, What the proposed new NHS Pension Scheme could mean to you

When likely contribution rate increases are added for the 2013/15 period, it is anticipated that staff earning in excess of £15,000 will experience rises varying between 0.6 and 6% over the three year period, as set out below. [These projected rates apply to England, Wales and Northern Ireland, as rates in Scotland may be the subject of separate discussions].

Table J: Changes to the NHS Pension Scheme 2012/15

FT Equivalent Pensionable Pay	Current % Contribution (before tax relief)	2012/2013% Contribution (before tax relief)	2013/2014% Contribution (before tax relief)	2014/2015% Contribution (before tax relief)	Total Increase (before tax relief)
Up to £15,000	5%	5%	5%	5%	0%
£15,001 to £21,175	5%	5%	5.3%	5.6%	0.6%
£21,176 to £26,557	6.5%	6.5%	6.8%	7.1%	0.6%
£26,558 to £48,982	6.5%	8%	9%	9.3%	2.8%
£48,983 to £69,931	6.5%	8.9%	11.3%	12.5%	6%
£69,932 to £110,273	7.5%	9.9%	12.3%	13.5%	6%
Over £110,273	8.5%	10.9%	13.3%	14.5%	6%

Source: UNISON, What the proposed new NHS Pension Scheme could mean to you

Tables K and L shows in current pay terms the ranges of cuts in take home pay that have been experienced, and are likely to be experienced by NHS staff as a result of increased pension contributions, showing for example that NHS staff on Band 5 have experienced a decrease in take home pay of £319 this year followed by another £212 next year.

Table K: Impact of increased pension contributions on take home pay 2012/13

FT Equivalent Pay	**Contribution**		**Decrease in take home pay from previous year**	
	Before tax	**After tax**	**Lower**	**Upper**
Up to £15,000	5.0%	4.0%	£0	£0
£15,001 to £21,175	5.0%	4.0%	£0	£0
£21,176 to £26,557	6.5%	5.2%	£0	£0
£26,558 to £48,982	8.0%	6.4%	£319	£588
£48,963 to £69,931	8.9%	5.34%	£705	£1,007
£69,932 to £110,273	9.9%	5.94%	£1,007	£1,588
Over £110,273	10.9%	6.54%	£1,588	£2,160

Table L: Impact of increased pension contributions on take home pay 2013/14

FT Equivalent Pay	Contribution		Decrease in take home pay from previous year	
	Before tax	After tax	Lower	Upper
Up to £15,000	5.0%	4.0%	£0	£0
£15,001 to £21,175	5.3%	4.24%	£36	£51
£21,176 to £26,557	6.8%	5.44%	£51	£64
£26,558 to £48,982	9.0%	7.2%	£212	£392
£48,963 to £69,931	11.3%	6.78%	£705	£1,007
£69,932 to £110,273	12.3%	7.38%	£1,007	£1,588
Over £110,273	13.3%	7.98%	£1,588	£2,160

The budget is also set to have a major impact on the standard of living of NHS staff. Tax and benefit reforms set for implementation over the 2012/13 financial year amount to a £4.1 billion increase in government revenues, which equates to a £160 cut in income for every household[27]. Looking further ahead to 2013/14, tax and benefit reforms are set to increase government revenue by a further £9.8 billion, which equates to a £370 cut in income for every household.

[27] Institute for Fiscal Studies, *Tax and Benefit Reforms due in 2012-13 and the Outlook for Household Incomes*, March 2012

Table M: Estimated revenue effect of tax and benefit reforms due in 2012-13

	2012–13 estimated revenue effect (£ million)	*2013–14 estimated revenue effect (£ million)*
Announced by previous government	**+935**	**+1,715**
Freeze higher-rate income tax threshold	+590	+1,310
Freeze inheritance tax threshold	*+55*	*+145*
Tobacco duty escalator	+50	+30
Alcohol duty escalator	+120	+110
Company car tax: extend bands	*+120*	*+120*
Announced in June 2010 Budget	**+2,415**	**+4,655**
Tax credits		
Taper family element of Child Tax Credit immediately after child element	+475	+445
Introduce disregard of £2,500 for falls in annual income	+245	+510
Reduce backdating for new claims and changes of circumstances from 3 months to 1 month	+345	+355
Abolish 50+ element of Working Tax Credit	+45	+50
Benefits		
CPI-index most benefits and tax credits (*and public sector pensions*)	+1,375	+1,405
Increase Basic State Pension by highest of average earnings growth, CPI inflation and 2.5%	–1,570	–1,610
Freeze Child Benefit	+625	+625
Index Housing Benefit deductions for non-dependants with prices	+75	+75
Corporate taxes		
Capital allowances: decrease main rate to 18% and special rate to 8%	*+600*	*+1,600*
Reduce Annual Investment Allowance to £25,000	*+200*	*+1,200*

	2012–13 estimated revenue effect (£ million)	*2013–14 estimated revenue effect (£ million)*
Announced in 2010 Spending Review	**+2,190**	**+4,385**
Time-limit contributory Employment and Support Allowance to one year for those in Work-Related Activity Group	+455	+820
Freeze maximum Savings Credit award	+55	+55
Withdraw Child Benefit from families containing a higher-rate income taxpayer from January 2013	+600	+2,435
Freeze basic and 30-hour elements of Working Tax Credit	+565	+565
Increase work requirement for Working Tax Credit to 24 hours per week for couples with children	+515	+510
Announced in 2011 Budget	**–965**	**–1,785**
Income tax and National Insurance		
Increase personal allowance and cut basic-rate limit by £630 (so higher-rate threshold is unaffected)	–920	–1,060
CPI-index some direct tax thresholds	+45	+45
Reduce contracted-out National Insurance rebates	+640	+630
Corporation tax		
Reduce main rate to 25%	*–400*	*–700*
Other tax and benefit changes	*–330*	*–700*
Announced in 2011 Autumn Statement	**–475**	**+850**
Freeze council tax in England	–675	0
Freeze fuel duties until 1 August 2012; then raise by 3.02p per litre	+90	+525
Freeze couple and lone parent elements of Working Tax Credit	+265	+290
Pension Credit: increase standard minimum income guarantee and raise Savings Credit threshold	negligible	negligible
Other tax changes	*–155*	*+35*
Total 'giveaway'	–4,050	–4,070
Total 'takeaway'	+8,150	+13,890
Grand total	**+4,100**	**+9,820**

Table M above sets out the components of tax/benefit changes. It shows that the main improvements in household income are derived from real term increases in income tax personal allowances for those aged under 65 increased as well as real term cuts in average council taxes across. The principal negative factor bearing on household incomes in 2012/13 is the CPI linking of most benefits and tax credits, while 2013 will also see the major impact deriving from withdrawal of child benefits from families containing higher rate income taxpayer.

Chart 15: Distributional impact of tax and benefit reforms to be introduced in 2012/13 by income decile group

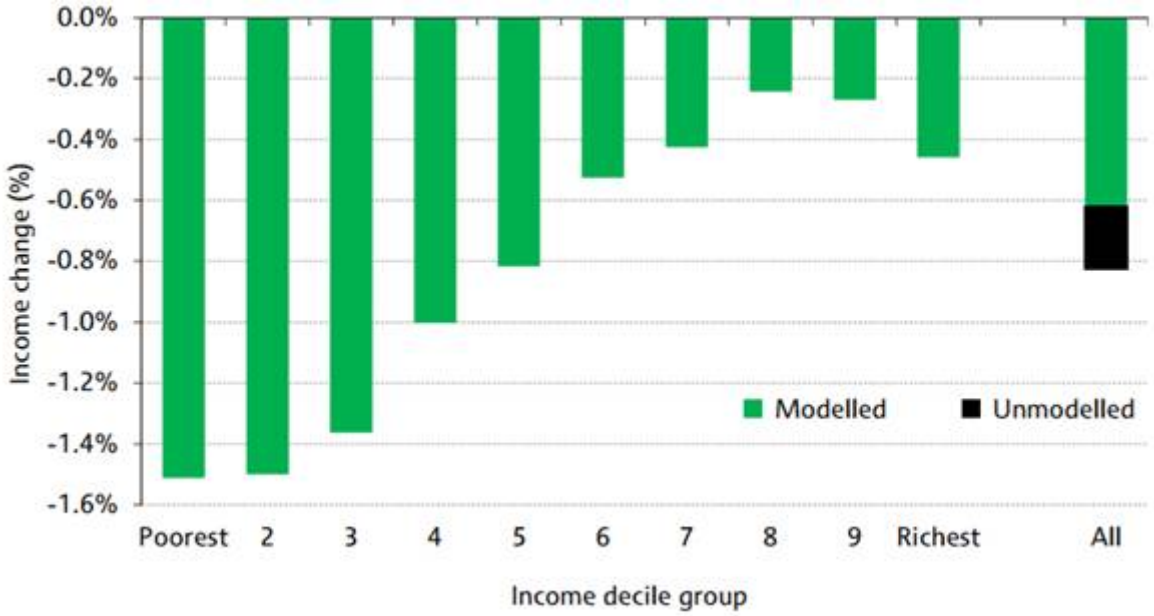


Chart 15 above shows that the poorest will be hit hardest by the 2012/13 tax and benefit reforms. The poorest 10% of households are set to see a 1.5% reduction in their income and the scale of the impact falls as income level rises, with the exception of the richest 20% of the population.

Chart 16: Distributional impact of tax and benefit reforms to be introduced in 2012/13, by household type and work status

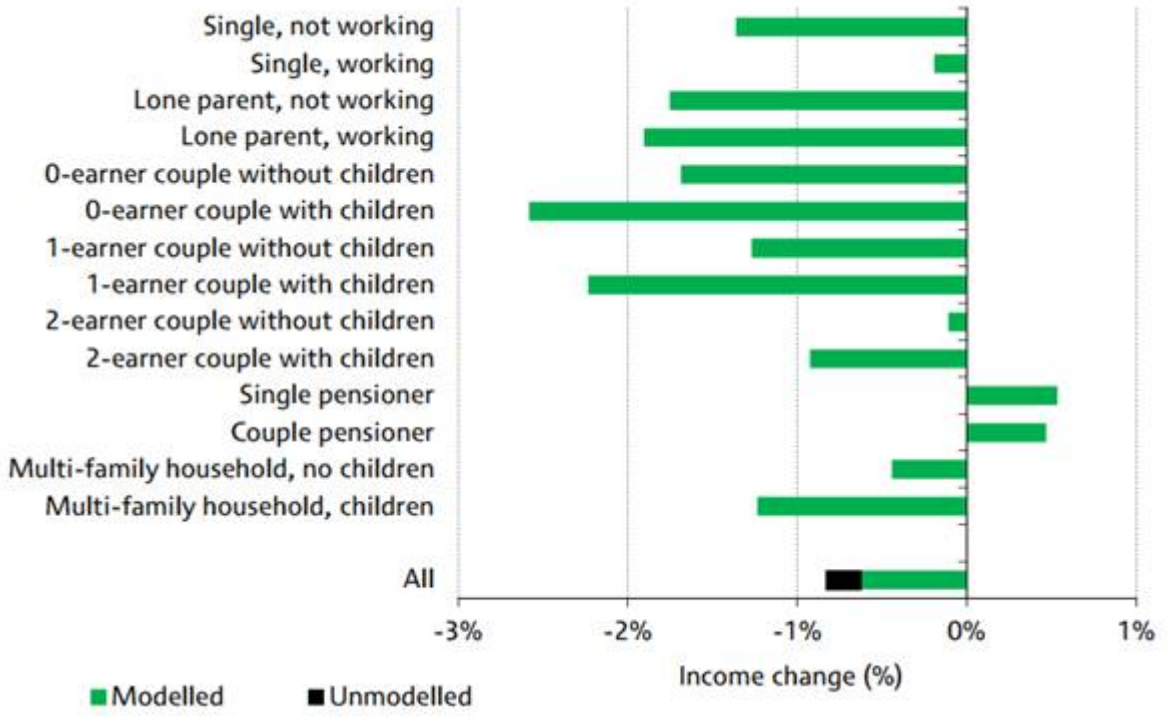


Chart 16 above also shows the disproportionate effect on households with children. On average, households with children are set to lose about 1.4% of their net income as a result of the 2012/13 tax and benefit reforms, which means a net loss of £530 a year.[28]

7.8 Survey Results

One of the most notable points to arise from the joint staff side survey was the upsurge in the number of respondents reporting that they felt worse off than 12 months previously. In fact, the proportion asserting that their pay had declined relative to the cost of living rose from 56% in 2010 to 84% in 2012. The telephone interviews elicited the finding that a worrying number of staff are unable to find enough money to pay water and electricity bills.

> *"It's devaluing the role, I know a lot of women who are doing other jobs and bank shifts to supplement their income."*
>
> **Midwife, Band 7**
>
> *"I'm 52 and just working towards retirement, I'm grinning and bearing it for the pension, albeit reduced."*
>
> **Community midwife, Band 6**

[28] Institute for Fiscal Studies, *Tax and Benefit Reforms due in 2012-13 and the Outlook for Household Incomes*, March 2012

"Pay is not very important [in motivating me to remain in the NHS] but the fact that pay is frozen makes you sigh and say 'What's coming next?'"

Orthoptist, Band 7

In addition, the survey showed that the proportion of staff relying on some additional form of payment to supplement their basic salary in order to sustain their standard of living had also grown since 2010 to reach 54% of the workforce in 2012. Of those respondents who reported they do rely on some form of additional income, two thirds (67%) rely on unsocial hours payments and a third (37%) rely on overtime.

The survey also asked about levels of satisfaction with different employment aspects, including pay, job security, staff members' ability to carry out their job to a high standard and hours worked. Among these factors, the lowest levels of satisfaction by far were recorded for levels of pay, with just a quarter (26.5%) stating they are very or fairly satisfied and a half (50%) that they are fairly or very dissatisfied. By contrast, NHS staff appear to be more at ease with hours worked, with just under half (47%) stating they are very or fairly satisfied and a quarter (26%) that they are fairly or very dissatisfied. The survey's findings relating to satisfaction with pay levels mirror those found in the NHS staff survey conducted for the Department of Health. This found that in 2011, just over a third of staff were satisfied with their level of pay (38%, down from 42% in 2010), while a similar number (34%) were dissatisfied (33% in 2010).

The findings on levels of satisfaction with pay are mirrored in further questions in the IDS survey which asked respondents about their attitudes to the government's pay policy. This showed that the majority (78%) regard the current policy as unfair and an even higher number (89%) view the proposals for 2013/15 as unfair. Among the 30 respondents questioned for the telephone interviews, 23 expressed anger with the current pay freeze, while the remaining seven said they felt resigned to the situation.

7.9 Recommendations

We ask the Pay Review Body to:

- recognise that the impact of inflation consistently running well above NHS pay awards for year upon year together with a two year pay freeze imposed on staff above pay point 15 has taken a damaging toll on the living standards of NHS staff
- recognise that efforts by some employers to erode terms and conditions of NHS staff has reduced the extent to which staff are prepared to make further compromises on pay
- make a recommendation to raise NHS pay rates that both protects their real value against prevailing inflation rates and makes a significant contribution toward addressing the major deterioration in NHS earnings that has seen the majority of staff suffer a 9% cut in living standards over the last two years alone

- make a recommendation for an additional pay rise for staff earning up to £21,000 in recognition of the additional pressures that inflation has placed on workers at the bottom end of the pay scale. This addition should recognise £250 as the barest minimum uplift
- address the erosion of the differential between Agenda for Change points 15 and 16 by recommending additional rises above point 15 to smooth out the steps between points.

8. The funds available to the health departments

- It is anticipated that NHS finances will be under acute pressure from the Government's reduction in the NHS financial settlement.
- Nonetheless, the NHS in England recorded a surplus of £1.6bn for the 2011/12 financial and foundation trusts have recorded a further surplus of £0.4bn.

8.1 State of financial accounts

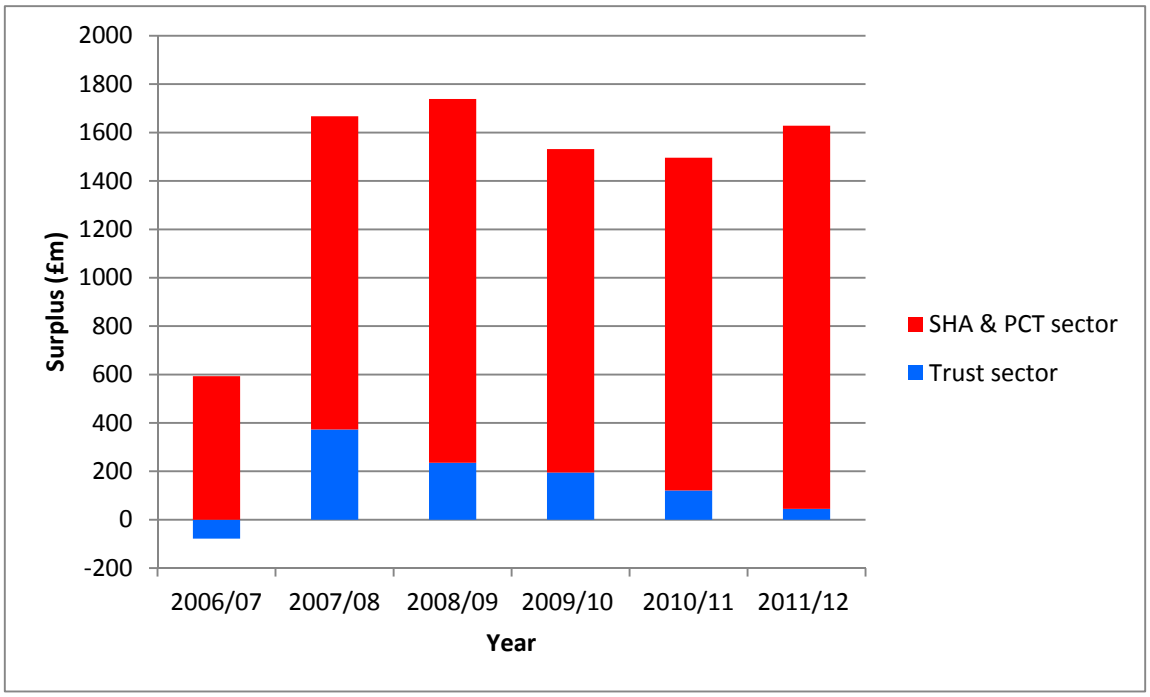
The NHS in England recorded a surplus of £1.6bn for the 2011/12 financial year[29]. This represented an increase on the surpluses that occurred in the previous two financial years. In fact, as the graph below shows, the NHS in England has achieved a surplus in every one of the last six financial years and the cumulative value of those surpluses now stands at almost £8.6bn.

However, even these figures are an underestimate of the total surplus since the 143 foundation trusts now operating in England are not included in the figures. The net surplus for these trusts covering the nine months to 31 March 2012 stood at £509m[30]. It is also worth noting that these trusts collectively enjoy an earnings before interest, tax, depreciation and amortisation margin of 6.1% and hold a cash balance of £4bn, £1.2bn ahead of planned levels.

Therefore, the National Audit Office reported that the combined surplus for Strategic Health Authorities, Primary Care Trusts, NHS Trusts and NHS Foundation Trusts in England was £2.1bn for 2011/12, despite the effects of the first year of the Comprehensive Spending Review on budgets[31].

[29] NHS Deputy Chief Executive David Flory, The Quarter, Q4 2011/12
[30] Monitor, NHS Foundation Trusts: Review of twelve months to 31 March 2012
[31] National Audit Office, *Securing the Future Financial Sustainability of the NHS*, July 2012

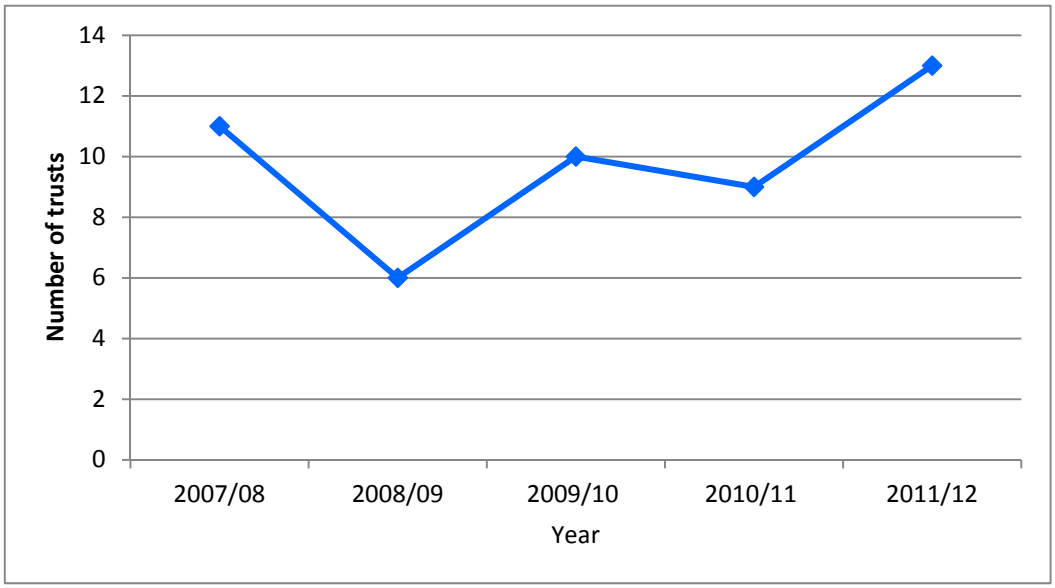
Chart 18: NHS finances



Thirteen of the 107 trusts outside the foundation trust sector in England recorded a deficit for 2011/12 and over the last five years the number in deficit has followed the pattern set out in the graph below. Monitor reported that 15 trusts out of the 143 foundation trusts in England had recorded a deficit for 2011/12.

The publicity given to the deficit faced by trusts such as South London Healthcare suggest that these deficits are frequently a product of particular circumstances, such as the legacy of Private Finance Initiative programmes, rather than showing any great link to paybill pressures.

Chart 19: English trusts in deficit



Operating within a Departmental Expenditure Limit of £6bn for health and social services, the three NHS trusts in Wales recorded a small surplus of £154,000 while the seven health boards registered a surplus of £732,000[32]. None of the trusts or health boards suffered a deficit for the 2010-11 financial year.

The health service in Northern Ireland returned to surplus in 2010/11, recording a £174m surplus on a Resource Expenditure Limit of £3.9bn[33].

The major surpluses recorded by the NHS 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 that fails to meet the level of anticipated demand.

8.2 Future financial position

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. However, CPI and RPI subsequently escalated sharply and even by the end of 2013 RPI is still expected to be running at 2.8%. Therefore, the government's funding has actually represented a cut to the NHS budget in real terms.

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. In England, it has become generally accepted that the NHS will need to make savings in the order of £20 billion over the course of the spending review.

Figures from the National Audit Office also suggest that spending per person will fall by 2.3% in Wales over the course of the Comprehensive Spending Review, by 0.6% in Scotland and 0.4% in Northern Ireland[34].

[32] NHS (Wales) Summarised Accounts 2010-11, March 2011
[33] Department of Health, Social Services and Public Safety, Resource Accounts for the year ended 31 March 2011
[34] National Audit Office, *Healthcare Across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland*, June 2012

8.3 Staff are actively contributing to the efficiency agenda

The four health departments are leading a range of programmes aimed at finding further efficiencies within the health systems. In England, this programme is labelled as the QIPP (Quality, Innovation, Productivity and Prevention) challenge. The Department of Health reported that the QIPP programme saved £5.8bn in 2011/12. Similarly, Scotland has its *Efficiency and Productivity Programme,* which is intended to improve quality and reduce costs in a co-ordinated manner and Wales has its *Efficiency and Innovation Programme* aimed at promoting "innovation and workforce engagement in the way that services are designed."

The NHS workforce has been actively involved in this agenda, working with health organisations to investigate and demonstrate the value of standardising particular patient pathways. Good examples of this include prevention and reduction of admission through A&E departments by improving access to occupational therapy and physiotherapy – The College of Occupational Therapists' *Ten High Impacts* document references 222 bed days which were saved in one trust alone through the provision of an early intervention therapy team[35].

8.4 Impact of incremental rises

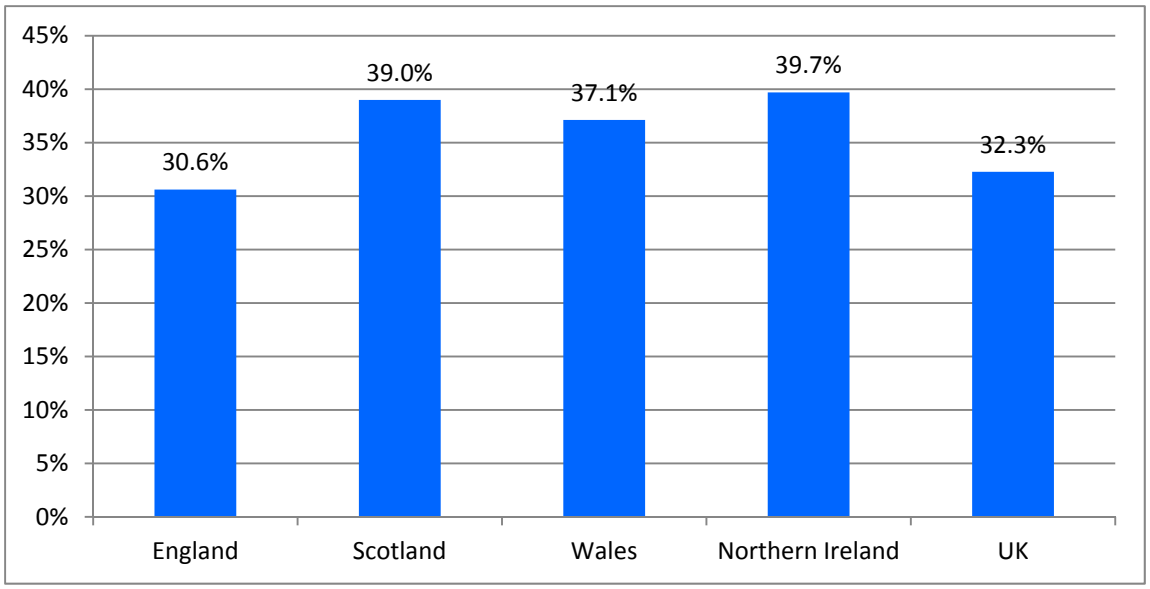
As stated in previous staff side evidence to the NHS Pay Review Body, our analysis of the change to the NHS paybill resulting from the planned incremental increase is that it stands at 1.4% when taking account of the net impact of staff leaving the service and those remaining receiving an incremental boost to their wage in recognition of their increased experience, expertise and contribution.

However, we were interested to note that, after the review body had questioned the 1.6% figure for incremental increases quoted by the Department of Health in its 2010 evidence, the department stated in 2012 that a review had been conducted and it now estimated that incremental rises represent a 1% annual uplift in the wage bill. The accuracy of this figure is crucial if it forms the basis for future funding calculations.

While acknowledging that this rise represents a real cost pressure, staff side supports the position repeatedly asserted by the review body that incremental progression is a separate issue from basic pay and therefore should not be seen as income in lieu of a pay rise. Chart 20 below also illustrates the point that 32% of NHS staff receive no benefit from incremental progression as they are at the top of their pay band. England has the lowest proportion at the top of their band 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%.

[35] www.cot.org.uk/ot-helps-your-client/ot-helps-service-users-high-impacts-ot

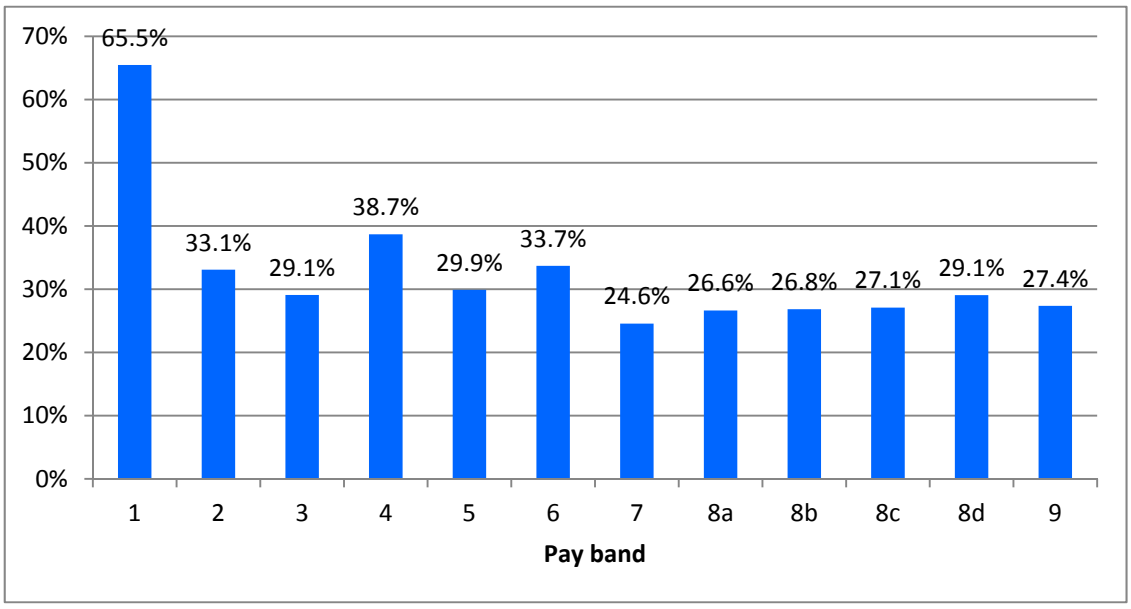
Chart 20: Proportion of staff at top of band by country



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

Chart 21 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 bands five to nine.

Chart 21: Proportion of staff at top of band by pay band



8.5 Impact of workforce changes

Anticipated future financial pressures are plainly pushing Trusts towards attempting to reduce their workforce. In order to gauge the scale of employer 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.

8.6 Recommendations

We ask the Pay Review Body to:

- acknowledge the major financial surpluses recorded by the NHS over recent years
- confirm its often stated position that incremental pay increases are in no way a substitute for annual pay increases since they represent reward for increased skill and experience agreed under the Agenda for Change framework.

9. High Cost Area Supplements And Recruitment And Retention Premia

Staff side submitted extensive evidence in March 2012 in response to the NHS Pay Review Body's call for evidence on proposals for market-facing pay in local areas. This evidence inevitably covered many of the issues that High Cost Area Supplements (HCAS) and Recruitment and Retention Premia (RRP) are designed to address.

However, one of the central point points raised in that document was that Staff Side believes that the current UK wide Agenda for Change pay system, which sets a floor pay rate for the NHS and allows for adjustments in high cost areas or local areas with particular recruitment difficulties, has proven itself as a robust, effective pay system that closely follows the realities of geographic variations in the UK labour market.

At the same time, the point was emphasised at oral evidence with the Pay Review Body that there is a lack of adequate data collected on the use of recruitment and retention premia across the UK and this hinders the ability of the service to judge how well utilised the RRP mechanism is in addressing recruitment issues.

9.1 Recommendations

We ask the Pay Review Body to:

- recommend that the health departments develop a central system for establishing where HCAS and RRP payments are made across the UK, along with the level and applicability of payments.