

NHS Staff Council

Staff Side

**Staff Side
Evidence to the
Review Body
for Nursing
and other
Professional Staff**

2005

October 2005

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Foreword

The organisations represented on the NHS Staff Council Staff Side submitting this evidence are as follows:

Amicus

British Association of Occupational Therapists (BAOT)

British Dietetic Association (BDA)

British Orthoptic Society (BOS)

Community and District Nursing Association (CDNA)

Chartered Society of Physiotherapists (CSP)

Federation of Clinical Scientists (FCS)

GMB

Royal College of Midwives (RCM)

Royal College of Nursing (RCN)

Society of Chiropractors and Podiatrists (SoCP)

Society of Radiographers (SoR)

Transport and General Workers Union (TGWU)

Unison

Staff Side Evidence to the Review Body for Nursing and other Professional Staff, 2005

This is the first submission of evidence to the Review Body made by the NHS Staff Side since the new pay system, Agenda for Change, started to be implemented across the NHS, and since the remit for the Review Body was changed to include health professional groups other than nursing staff, midwives, health visitors and allied health professionals.

The Staff Side is pleased to present this evidence, which sets out priorities for the Review Body in respect of nurses, midwives and health visitors; the allied health professions; the health care science professions, pharmacists, optometrists, applied psychologists and psychotherapists; and clinical support workers and technicians supporting these groups, for the 2006 pay round.

In summary, the Staff Side is seeking a substantial increase in the current pay scales to provide an above inflation increase, assist recruitment and retention and to close gaps with other public sector comparators.

Given the principle of equal pay for work of equal value which underpins Agenda for Change, and which is included in the Review Body's terms of reference, it is important to note that there is a parallel process for NHS staff outside the Review Body's remit - conducted in the Pay Negotiating Council (PNC). The Review Body will need to have regard for the deliberations of the PNC in respect of a pay claim for 2006.

The environment, NHS services - fast developing and fast changing

Demand for NHS services is increasing. NHS inpatient admissions are increasing by an average of 1.4% per year and outpatient referrals by 1% a year. Between 2004 and 2005, attendances in A&E increased by around 8% to 17.8 million, calls for

ambulances increased by 6.8% to 5.3 million and the National Delivery Rate has risen by 3% to approximately 630,000 births per year¹.

Despite these pressures, substantial progress has been made towards meeting NHS access targets. Current figures for England show that:

- more than 99.9% of general practices are meeting the target that people should be offered an appointment with a GP within 48 hours, or with another primary care professional within 24 hours
- in A&E, more than 98% of patients are seen and treated, or admitted to hospital, within the target time of four hours
- the number of people waiting more than 13 weeks to be seen as an outpatient has fallen to 30,000, a reduction of 363,000 since 2000
- the number of people waiting for admission as an inpatient has fallen to 822,000; the lowest recorded level, down from a peak of 1.3 million in 1998².

Progress towards faster treatment is also being made in Scotland and Wales. In Wales, the number of people waiting longer than a year for admission fell by 86.7% for inpatients and by 99.6% for outpatients between December 2004 and March 2005³. In Scotland, the number of inpatient and day cases waiting more than six months fell from over 5,700 to 1,600 between March 2004 and March 2005, and no inpatients are now waiting more than nine months⁴.

As well as improvement in waiting times, the NHS is also seeing improvements in the quality of care provided:

- Substantial progress has been made towards implementing the National Service Frameworks, for example through the more widespread provision of stop smoking services, and the establishment of multidisciplinary cancer

¹ Healthcare Commission (2005) *State of healthcare, annual report 2005*, London: Healthcare Commission.

² National Health Service (2005) *Chief Executive's report to the NHS: Statistical supplement, May 2005*, Leeds: DH.

³ Healthcare Commission (2005) *State of healthcare, annual report 2005*, London: Healthcare Commission.

⁴ ISDScotland (2005) *Acute activity, waiting times and activity data development information - quarterly statistical update* (press release 29 May 2005), Edinburgh: ISDScotland. Available from www.isdscotland.org

teams. As a result, mortality rates from causes such as heart disease, cancer and suicide have improved significantly.

- Services are being redesigned to make them more convenient for patients. For instance, patients can now access advice from their homes through NHS Direct and NHS 24 in Scotland, and can access NHS walk-in centres.
- Significant progress has been made in strengthening and improving clinical governance, for example through better systems for clinical audit and for the reporting of adverse incidents.

While these improvements to NHS services are welcome, the demands of achieving them have led to continued high levels of pressure for NHS staff. According to the 2004 national staff survey, 43% of staff worked between one and five additional unpaid hours per week, 9% worked between six and ten additional unpaid hours, and 3% worked more than 10 hours unpaid overtime in an average week. In addition, 35% of staff said that they worked extra paid hours in an average week. Of those staff working overtime, the most common reasons given were that they wanted to provide the best care they could for patients; they did not want to let down the people they worked with; that it is impossible to do their job without working extra hours; and that it is necessary to meet deadlines⁵.

The level of expenditure on temporary staff is a further indicator of staffing pressures in the NHS. A recent Healthcare Commission report on ward staffing, based on a survey of 6,000 wards, found that the proportion of ward staffing expenditure spent on temporary staff was 13.2% in the first quarter of 2004/2005, compared to 13.4% in 2000, although within this the amount spent on agency as opposed to bank staff has decreased⁶. Expenditure on bank and agency staff is greatest where vacancy levels are highest. As noted in the Healthcare Commission report, the current high levels of bank and agency staff usage is of concern, as there is a strong negative correlation between the proportion of staffing budgets spent on temporary staff and levels of patient satisfaction.

⁵ Healthcare Commission (2005) *NHS national staff survey 2004: summary of key findings*, London: Healthcare Commission.

⁶ Healthcare Commission (2005) *Acute hospital portfolio review – ward staffing*, London: Healthcare Commission.

Over the next three years access targets for the NHS will become even more demanding. In particular, the government has said that by the end of 2008 no patient will have to wait longer than 18 weeks between the time they are referred for a hospital operation by their GP and the time they have that operation.

At the same time, the commissioning and delivery of NHS services in England are being reformed on an unprecedented scale and at an unprecedented pace. By 2008 elective patients in England will be able to choose to be treated by any provider, whether public or private sector, that meets NHS quality standards and prices. This change will be underpinned by the introduction of a new financial system. Capacity will be increased by expanding private sector provision, for example through independent sector treatment centres in England. Primary care trusts and strategic health authorities in England are to be reconfigured, and by 2008 the government wants all acute and specialist trusts in England to take on foundation status.

The pace of change is similarly fast in Scotland and Wales, where NHS services are also being re-organised, in different ways and reflecting devolution. In Scotland a structural re-organisation has recently been implemented and a major programme of acute hospital reconfiguration is underway. In Wales Health Boards are being merged only 18 months after they were created.

These reforms mean that NHS staff will have to adapt to further structural change and continue developing appropriate new ways of working. Fragmentation and the creation of a more competitive climate within the NHS is likely to put strain on a harmonised pay system and this may in turn affect recruitment and retention. The extent to which the new private providers of NHS care are permitted to recruit staff who work in NHS organisations may also make recruitment and retention of staff by NHS employers more difficult.

A further challenge for staff will be the delivery of the government's efficiency agenda. The Department of Health has committed to achieving £6.47 billion worth of

efficiency savings per year by 2007/2008 in England⁷. Of this, up to half is expected to be achieved through changes in work practices to use staff time more productively, for instance through the greater use of IT and workforce remodelling. Similar efficiency agendas are also being pursued in Scotland and Wales.

Staff will have a pivotal role in delivering the government's ambitious agenda for improving public health and supporting patients in managing complex conditions.

Staff Side believes the constant change in NHS structures and ways of working, coupled with increasing demand for more and better services, is the essential backdrop for this year's evidence. The impact on staff in terms of morale and motivation must be taken into consideration by the Review Body in their recommendations for pay for 2006.

With this backdrop in mind, the Staff Side calls on the Review Body to help provide stability through their recommendations. In particular, by urging the departments of health not to introduce further changes to the pay structure and system, and by resisting recommending adding or deleting pay points. Such selective interventions by the Review Body in the past have caused problems and could only add to uncertainty.

Agenda for Change, equal pay and equal value

NHS employers across the UK started to implement Agenda for Change on 1 December 2004, with pay terms and conditions backdated to 1 October 2004. The new pay system is the result of the biggest overhaul of NHS-wide pay, terms and conditions in over 50 years.

Progress in implementing Agenda for Change has been slower than anticipated. In September 2005, 58% of staff in England had been assimilated to the new pay bands and 78% of jobs had been matched. Northern Ireland had matched 33% of jobs,

⁷ HM Treasury (2004) *Releasing resources to the front line: independent review of public sector efficiency*, London: HMSO.

Scotland 45% and Wales 53%. No staff had been assimilated in Northern Ireland or Scotland. Wales had assimilated 20% staff.

While the pace of implementation has improved in September, significant numbers of staff have not yet been assimilated. Moreover, the figures mask a large variation in assimilation and matching rates between employers. Delays seem to be mainly associated with lack of effective and engaged leadership at executive level, capacity and resources, the state of payroll facilities, and issues to do with commitment, for example problems with partnership structures and processes⁸. The agreed timeline of 30 September 2005 is a challenge for a significant number of employers. The NHS Staff Council Executive has agreed a joint statement on assimilation in England (see Appendix 1).

However, it should also be noted that the 60% of the workforce assimilated in England represents over half a million people. The fact that they have been assimilated to a new pay system within a year is a great achievement for partnership working and for all those concerned. This is the largest exercise of its kind in Europe and probably the world. This is not a mere tinkering with the old system. It is a massive transformation project.

Given the slow pace of assimilation, it is too early to make any assessment of the impact of Agenda for Change pay levels on any particular staff group, or to make any meaningful comparisons between the Whitley pay system and Agenda for Change.

It will not be possible to assess the full impact of Agenda for Change until assimilation is complete. The Staff Side believes this is a strong reason for a one year pay award.

Agenda for Change was designed to overcome historic pay inequalities the NHS had faced by ensuring that equal pay for work of equal value was embedded into the system. Until assimilation is completed it is not possible to monitor the

⁸ Joint letter from Recovery and Support Unit and Agenda for Change Delivery Board Chairs to Strategic Health Authority (England) Directors of Performance, 11 July 2005

outcomes and to ensure that this aspect has been successful. Monitoring information needs to be shared and easily available to both sides.

There are serious concerns that given the current financial situation of many NHS organisations and other demands, such as the consultants' contract, that implementation of Agenda for Change may not be fully funded. Staff Side seek reassurances that full funding will be provided.

While pension arrangements are not included in the remit of the Review Body it is important to note that all public sector occupational pension schemes are under review, including the NHS Pension Scheme. One of the most contentious aspects of the review is the government's stated intention to raise the normal retirement age to 65 for all public sector employees including NHS staff.

All public sector reviews with similar issues to the NHS Pension review have been stalled since the general election, awaiting a negotiated framework for further talks on a scheme-specific basis. Negotiations are likely to have reached a crucial stage by April 2006. The current benefits of the NHS Pension Scheme, including retiring at 60 and the fact that it is a "final salary" scheme, are very attractive aspects of working for the NHS. If these benefits are perceived to be under threat, this is likely to influence how staff feel about any pay award and thus impact on recruitment and retention.

The Review Body is asked to note that the impact on staff morale of the government's proposals to increase the normal pension age to 65 and for alternatives to a final salary scheme has already been significant. The effect on staff motivation and morale cannot be underestimated.

Recruitment, retention, motivation and morale

Recruitment and retention are the key challenges for all professional staff groups in the NHS.

Below, Staff Side outlines some of the crucial developments NHS professional staff groups are involved with, highlights how changes are affecting specific staff groups, and reflects on trends in NHS staffing numbers.

Nursing and midwifery staff

Nursing and midwifery staff are at the forefront of delivering the government's health care reforms, and there has been a continued expansion of their roles at all levels. In May 2005 the RCN launched a report on a joint survey with the Department of Health to find out more about nurses working in advanced and extended roles⁹. Key findings from the survey reveal:

- a nursing background is essential to undertake these roles, they are *maxi* nurses not *mini* doctors
- nurses are very positive about these new roles and are keen for further role expansion
- nurses are leading multidisciplinary teams, working across organisational boundaries and co-ordinating packages of care
- the roles are having a positive impact on patient care, and levels of job satisfaction are high among post holders
- the roles create important career development opportunities that allow nurses to retain significant patient contact.

Nurse prescribing is now well established and the role of non-registered nurses has also continued to expand, albeit with only patchy recognition.

⁹ Royal College of Nursing (2005) *Maxi nurses: nurses working in advanced and extended roles promoting and developing patient-centred health care*, London: RCN.

The number of nursing staff, midwives and health visitors working in the NHS grew between 1997 and 2005 by 74,907¹⁰. Between 1997 and 2004, the NHS qualified nursing/midwifery workforce across the UK increased by between 10% (in Scotland) and 23% (in England)¹¹. The growth in nursing staff has been at all levels, for example an increase of 20% in registered nurses, 18% in traditional nursing assistants and almost 80% in staff designated as health care assistants. The numbers of health visitors, midwives and specialists has remained broadly stable, but the number of midwives according to the NMC, has reduced by 942 to 32,745. The Staff Side believes the NHS is failing to develop its non-registered nursing workforce who could be an expanded pool from which to recruit registered nurses.

A significant contributor to the growth in the number of nurses is international recruitment. Nurses recruited outside the UK represent about 45% of new entrants to the UK register. In 2005 there was a reduction in numbers of nurses recruited from outside the UK for the first time in seven years. This might reflect specific difficulties in securing adaptation placements last year. However, if this were to become a trend, there would be significant supply implications¹².

The Staff Side believes that successes in increasing the growth in the nursing workforce demonstrate that a planned approach to improving recruitment and retention can work and should continue. There is, however, no room for complacency.

At the same time as numbers have grown, as the recent Healthcare Commission review of ward staffing points out¹³, services themselves have been expanded and reconfigured, so an increase in the number of nurses does not necessarily mean an increase in staffing levels. At the same time that the workforce size has increased, so has the range, volume and complexity of care.

¹⁰ Government Statistical Service (2005) *Staff in the NHS 2004*, London: GSS. Available at www.statistics.gov.uk

¹¹ Buchan J (2005) *UK Labour Market Commentary 2004-05– interim report*. London: RCN.

¹² Buchan J (2005) *UK Labour Market Commentary 2004-05– interim report*. London: RCN.

¹³ Healthcare Commission (2005) *Acute hospital portfolio review – ward staffing*, London: Healthcare Commission.

Midwives have consistently suffered from higher vacancy rates than other NHS professions, reaching almost 12% in some regions.¹⁴

An ageing nursing workforce is a critical and growing challenge, particularly in the community/primary care sector, with an increase in retirement rates likely to have a marked impact over the next ten years. However, demand is expected to continue to increase in the longer term. The Wanless Review of long term health care demands estimated that an additional 100,000 nursing posts would be needed in the next decade¹⁵.

Other health professionals

Other health professionals are playing an equally critical role in modernising health services and their roles are also changing and expanding.

Physiotherapists are delivering very significant and innovative change in services for patients. They are central to the government's ability to deliver its 18 week waiting list target and a range of other current priorities, including reducing orthopaedic waiting lists; interventions to prevent hospital admission; and rehabilitation and independence for older people. Their role in stroke and cardiac care, long term conditions, children's services, promotion of public health and the government's new muscular skeletal strategy is vital to progressing the NHS modernisation agenda.

Occupational therapists are playing a leading role in delivering integrated care, increasingly working across health and social care boundaries. Recent policy initiatives from the Department of Health, in particular the Case Management approach recommended in the *Management of Long-term Conditions* strategy and the delivery of the *Expert Patient Programme*, call for occupational therapists' expertise. Major health and social care policy developments depend on strengthening service delivery in non-hospital settings.

¹⁴ Royal College of Midwives (2005) *Vacancy survey*, (unpublished).

¹⁵ Wanless D (2002) *Securing our future health: taking a long term view*, London: HMSO.

In technical and scientific areas, technological developments, greater investment in technology, and demanding targets for diagnostic tests are placing greater demands on an expanded workforce.

The ambulance service is facing ever increasing demands and is also seeking to modernise its service delivery.

Demands on ambulance services are increasing by 6-7% per annum, an extra 250,000 to 300,000 responses each year. The majority of these are not life threatening. Ambulance services have evolved to enable ambulance practitioners (paramedics and technicians) to handle this greater demand more efficiently. A higher level of training and development is now required to ensure practitioners have the broader knowledge and skills they need to deal with the ever wider range of clinical conditions they are faced with.

The recent ambulance review report recognised the new demands facing paramedics and technicians, and recommended that it would be even more efficient for ambulance practitioners themselves to “see and treat” in many cases¹⁶.

The total numbers of staff in the non-nursing groups covered by the Review Body has continued to expand to meet the demands of the changing service. The number of staff in the health professionals group has risen by 178,157 since 1997¹⁷.

Vacancy levels

The growth in numbers of nursing and other professional staff is just one part of the picture. Vacancy levels can highlight recruitment and retention issues. The Department of Health’s vacancy survey 2005 found the three month vacancy rates for the main staff groups fell in March 2005 compared with the previous year:¹⁸

¹⁶ Department of Health (2005) *Taking healthcare to the patient: transforming NHS ambulance services*, London: DH.

¹⁷ Government Statistical Service (2005) *Staff in the NHS 2004*, London: GSS. Available at www.statistics.gov.uk

¹⁸ Department of Health (2005) *NHS vacancy survey 2005*, London: DH.

- Qualified nurses: three month vacancy rate of 1.9% in March 2005, a decrease from 2.6% in March 2004.
- Qualified allied health professionals: three month vacancy rate of 3.4% in March 2005, a decrease from 4.3% in March 2004.
- Qualified scientific, therapeutic and technical staff: three month vacancy rate of 2.2% in March 2005, a decrease from 2.6% in March 2004.

Staff Side gives these reductions a cautious welcome.

NHS Partners' report for the Office of Manpower Economics (OME), *High Cost Area Supplements and Recruitment & Retention Premia*¹⁹, suggests that the vacancy ratio, determined in the DH's annual vacancy survey, is an "impure" measure of the actual vacancy rate. Also, while all areas seem to have experienced reductions in vacancy rates, there is some evidence to suggest this may be because fewer staff are moving to new jobs while they wait for their job evaluation under Agenda for Change.

Additionally, some areas still have above average vacancy levels, which is a cause of concern. It is clear that in some specialist areas vacancy levels have a major impact on the ability of the NHS to meet patient needs. Staff Side expresses particular concern over emergency care, mental health and midwifery.

As at 2005, evidence gathered by the Royal College of Midwives showed:

- 74% of UK maternity units reported some level of staffing shortage (78% in England)
- UK vacancies represent 3.1% of funded establishment (3.4% for England)
- long term vacancies now represent 59% of vacancies
- London has vacancy rates of almost 12%, and the South East almost 9%. The West Midlands is also a cause for concern with vacancy rates at around 4.4%²⁰.

¹⁹ NHS Partners Research and Information (2005) *Report for the Office of Manpower Economics: High Cost Area Supplements and Recruitment and Retention Premia*, London: NHS Partners

²⁰ Royal College of Midwives (2005) *Vacancy survey*, (unpublished).

The highest levels of nursing vacancies are in psychiatric nursing (2.8%), learning disability (2.3%) and health visiting (2.1%). Figures are not available by grade, but for health care assistants the level is lower than average at 1.5%.

For professions allied to medicine the highest vacancy rates are for therapeutic radiographers (6%), orthoptists (4.9%) and occupational therapists (3.9%). A survey just completed by the British Dietetic Association (BDA) indicates a vacancy rate of 9% of dieticians, 92% of which were in “front line clinical grades”.

Among the scientific and technical groups the highest rates are pharmacists (4.2%) and operating theatre staff (3.8%).

There is not a recruitment problem for ambulance staff, but the increased professionalism required of paramedics and technicians could see this change. In addition the much higher rate of ill-health retirement for ambulance staff, due to the physical side of their practitioner roles, needs to be taken into account.

The OME Survey of NHS Units is the main independent source of data on recruitment and retention in the NHS. In 2004 the OME asked employers to rate their experiences of recruiting and retaining nursing and other professional staff²¹. Their findings are set out in table 1 below.

Table 1. Percentage of employers reporting problems with recruitment and retention of nursing and other professional staff 2004

	Recruitment	Retention
No problem	5%	8%
Low problem	42%	61%
Quite a problem	48%	28%
Major problem	6%	3%

²¹ Office of Manpower Economics (2004) *Workforce Survey Results for Nursing Staff, Midwives and Health Visitors 2004, Workforce Survey Results for Professions Allied to Medicine 2004 and Workforce Survey Results for Scientific, Technical and Therapeutic Staff 2004*, London: OME. Available at www.ome.uk.com

While the OME received a poorer response to its 2004 survey than previous years, the findings are still significant. Over half of all employers report that they have “quite” or a “major problem” with recruitment and almost a third with retention. In an internal survey of Heads of Midwifery carried out earlier this year, the RCM found that the main causes of harder recruitment are heavy workloads and stress.

The RCM’s findings have been reflected in the findings of groups such as AHPs. The PAM (PTA) Staff Side evidence to the PRB for 2003 included findings from a survey of AHP staff which showed that after pay, low staffing levels and high stress levels were the most important reasons for people leaving the NHS.

In terms of turnover rates (percentage of staff leaving, including to other NHS units) and wastage (percentage of staff leaving to non-NHS employment, including retirements) the OME survey found that turnover fell from 14-12% from 2003, while wastage remained stable at around 10%.

The NHS does not have good information on where people who leave its employment go. The available data appear to show that the main destination for leavers is other NHS employment with apparently only 8% going to non-NHS employment. Staff Side believes these findings could reflect growing stability generated by Agenda for Change as staff wait for assimilation to new pay bands rather than changing jobs.

The evidence suggests that shortages of nursing and other key professional staff are still not resolved. As there are some problems with reliability affecting both the Department of Health’s vacancy survey and OME survey other indicators have to be taken into account. For example, it is important, therefore, to understand what features of staff’s working lives influence their decision to stay in their profession, and particularly in the NHS.

The NHS (England) conducted its first staff attitude survey in 2003 and undertook a second survey in 2004²². The survey is used to assess the performance of the NHS as

²² Healthcare Commission (2005) *NHS national staff survey 2004: summary of key findings*, London: Healthcare Commission.

an employer, and to monitor the implementation of national policies to improve the working lives of staff. Staff who feel dissatisfied with their job are more likely to leave the organisation, which leads to staff shortages and greater strain on remaining staff.

The 2004 survey indicates a number of improvements in human resource and management practice. For instance, the proportion of staff that had received an appraisal in the previous 12 months rose from 60% in 2003 to 63% in 2004. The proportion of staff with personal development plans rose slightly from 49% in 2003 to 51% in 2004. And there have been improvements in reported levels of team working: while 41% of staff had been working in well-structured teams in 2003, this had risen to 43% by 2004.

However, no change was reported in the amount of work pressure felt by staff, and the proportion of staff suffering from work-related stress dropped only slightly from 39% in 2003 to 36% in 2004. There was no change between 2003 and 2004 in the proportion of staff who had suffered other work-related injuries or illnesses.

14% of staff had been attacked by patients or their relatives in 2004, compared with 15% in 2003, and 27% had been bullied, harassed or abused by patients or their relatives, compared with 28% in 2003.

There was no change in staff views about their employers' attitudes towards work-life balance, or the range of flexible working options on offer to them. In fact, the proportion of staff requesting flexible working options from their employers had decreased since 2003 from 33% to 26%.

There was no change between the 2003 and 2004 surveys in reported levels of job satisfaction. The average satisfaction score of 3.5 out of five indicated that staff in the NHS are generally fairly satisfied. However, there was a slight increase in satisfaction levels with the climate of the organisation, for example perceptions about communication within the organisation, and employee involvement in decision making and patient care.

There was little change in the proportion of staff (33% in 2004) that often thought about leaving their current employer, or the proportion who said that they would probably look for a new job in the next year (25%). However, some additional questions in the 2004 survey shed new light on these findings: of those considering leaving their jobs, 44% gave a negative reason for doing so (40% were unhappy with their current job, 9% no longer wanted to work in the NHS). Other common reasons were career development (40%), change of career (21%), and family or personal reasons (18%).

Staff surveys show how important the working environment is in relation to recruitment and retention. However, the evidence shows that pay also remains a key factor. Staff Side believes gains from Agenda for Change will need to be consolidated in the award for 2006 and that a one year pay award is the best way to do this.

Labour markets, high cost area supplements, and recruitment and retention premia (RRPs)

The Staff Side is aware the Treasury has required Review Bodies to review progress made on introducing regional pay flexibility into public sector pay systems. The NHS needs a national pay system to ensure equity, prevent destructive pay competition between employers, and help preserve a national health service. A national structure is also needed for career progression and to prevent the shifting of shortages. In addition, non-pay initiatives appear more successful than local pay supplements in tackling local variations in vacancy rates. The Staff Side recognises, however, the need for a way to compensate staff in higher cost areas and to allow employers to recruit and retain effectively. This facility is available under the Agenda for Change structure.

The Staff Side believes that the degree of localisation of pay in the private sector is exaggerated.

The Staff Side remains unconvinced of the case for a radical localisation of pay in the NHS as advocated by a few economists and occasionally echoed by other commentators. Recruitment and retention strategies can be used to address key shortages without opening the ‘Pandora’s box’ of regional pay.

Under Agenda for Change new arrangements have been introduced for compensating staff in high cost areas. Staff now qualify for percentage supplements (up to a fixed cap) in inner and outer London, as well as the fringe areas of London. The Staff Side believes this new system is an improvement on past attempts to address these issues, such as the Cost of Living payments scheme introduced for registered staff only in 2001.

These new arrangements are designed to compensate staff for working in areas which have a higher cost of living than the national average and ensure that the NHS is able to recruit and retain staff effectively. In addition, further local supplements can be paid where agreed locally, provided they do not exceed 30% of salary. The Staff Side is not aware of many employers exercising this option.

Foundation trusts are not subject to this limit, can offer other non-pay packages, and can introduce team bonus schemes linked to individual targets. The Staff Side is not yet aware of any foundation trust implementing these new approaches and remains sceptical of the benefits of such systems.

The Staff Side recommends that there be no fundamental changes to the new system of high cost area supplements this year, but that the cap should be adjusted in line with the overall pay uplift.

The Staff Side is of the view however that the current system of percentage payments unfairly discriminates against the lower paid staff who face the same high costs as those who are better off. The Staff Side will return to this matter in future years and asks the Review Body to note we will be seeking a review of these arrangements.

A number of occupations covered by the Nursing and Other Health Professions Review Body have also been designated as potentially needing some sort of national premia, including midwives and pharmacists. The Staff Side believes these issues are best addressed by direct negotiation between the parties concerned, since the impact on other relativities needs to be taken into account.

The Staff Side generally supports the conclusions and analysis set out in NHS Partners' research for the OME, which concluded that there is no strong case for major change to the new system. There are, however, issues around higher living costs in some areas that are not currently covered by the supplements. There are also some areas outside London and the South East where there are higher than average vacancy rates.

NHS Partners argues that consideration should be given to paying supplements in areas designated high cost, according to the NHS Staff Market Forces Factor, and which have higher vacancy levels and staff turnover. The Staff Side believes this suggestion deserves further consideration as part of the overall review of Agenda for Change.

In the interim, negotiations should take place at local level under the existing provisions in those areas where there is an identifiable problem of high costs such as some areas adjacent to London and other hotspots in the country.

Fairness and comparability

The Staff Side recognises that there has been a significant improvement in real pay for NHS staff since 1997 and further increases will be achieved through implementation of Agenda for Change. The Staff Side welcomes these increases and believes they are central to improving recruitment and retention in the NHS. The Staff Side also believes that the Review Body has a responsibility to ensure that NHS staff share in the pay growth in the economy as a whole, and to reduce the pay gap with other public service professionals for reasons of equity.

The relative position of NHS professional staff compared to other public service professionals has improved since 1997, but pay gaps remain with key comparators. The Staff Side believes these pay gaps are unjustifiable and unless closed will, over time, damage morale and affect the NHS's ability to recruit and retain.

The main groups Staff Side believes NHS professional staff should be compared with are: for registered staff, police, teachers and social workers; and for non-registered staff, local authority care staff. These groups have roles which require broadly similar qualifications and responsibilities at a similar level, and should be treated in an equitable manner.

The Review Body should also have regard for other relevant comparators, for example other emergency services for ambulance staff, non-NHS employers for some scientific staff groups, and local authorities for occupational therapists. In most cases there are still some pay gaps, although these are less than in the past.

Teaching

From September 2005 a classroom teacher's salary will be £19,161 per annum. This compares with £18,698 per annum for a newly qualified registered professional. Initially, teachers' pay increases on the basis of incremental progression followed by performance-based progression. Teachers can expect to progress to £28,005 within six years. There is a facility for a faster rate of progression for outstanding performers and for additional increments for staff who take on additional responsibilities.

A significant number of teachers also qualify for various types of payment related to their areas of work and this system is under review. A small number are employed in schools which operate outside the national system. The Staff Side draws attention to the problems that have been experienced in some of these schools.

The Staff Side accepts that the greater role of performance pay in the teachers' pay system complicates comparisons.

Police

New pay scales for police constables have been agreed for implementation from 2005. In addition, under the 2002 reform of pay scales competence-related payments may be paid.

Under Agenda for Change a newly registered professional will be placed on a minimum of £18,698 per annum. This compares with a starting salary of £20,397 on entry for a police constable and £22,770 following completion of training.

These gaps continue throughout the scale. For example, a police sergeant starts on £32,025 rising to £35,991 compared to £26,948 rising to £35,227 for a specialist.

Social workers

Local authority social workers can be placed on a range of points within the national pay structure. According to research by Income Data Services²³ (IDS) in 2004 the median entry point for a newly qualified social worker is £19,092. Staff can progress to £31,434 as senior social workers or higher if they specialise. Data for 2005 will take into account a 2.95% increase in local authority scales and is likely to show a bigger gap of around 5% between social workers and NHS professional staff. Staff Side will share this data as soon as it is available.

Percentage gaps with key comparators

The percentage gap between the starting salary for a registered professional and other public sector professionals is as follows:

- police: 9.1%
- teacher (graduate entry): 2.5%
- social worker (median): 2.1%.

The Agenda for Change Pay Band 5 salary has been used here.

At more senior levels it is hard to make a comparison due to the various differences in the pay systems, especially teachers.

²³ Sources for salary comparisons are relevant Review Body Reports and the Income Data Services report, *Pay in the public services 2004*.

The Staff Side research indicates, however, that there are higher pay maxima for both teachers and police. The Staff Side believes the Review Body should take account of this in its deliberations.

The minimum salary for non-registered staff under Agenda for Change will be £11,789 per annum. It is difficult to compare these staff with local authority care staff as they are now employed either on national pay ranges under the previous national pay structure for manual staff, or on locally determined points on the national spine. Staff in post before the implementation of single status have protected minima.

From April 2005 the protected national salary for ‘care assistants’ is £11,649 and for ‘home helps’ is £12,018. According to a recent Income Data Services survey the median salary for senior care assistants on local rates is £15,900 and for home care staff £11,500²⁴. These staff should gain from implementation of the Local Authority Job Evaluation Scheme, but this has been delayed for many areas.

Graduate salaries

Entry salaries for graduates continue to rise and now range from an average of £20,415 per annum in the public sector to £20,769 in the private sector²⁵.

- the hourly rate of pay for graduates in the private sector was around 8% higher than for graduates in the public sector in Spring 2005
- the graduate pay differential is higher than it was in 1994 when private sector graduates earned just 2% more than public sector graduates
- this differential applies across the country with eight out of the 13 UK regions showing that private sector graduates had higher hourly pay than public sector graduates.

²⁴ Sources for salary comparisons are relevant Review Body Reports and the Income Data Services report, *Pay in the public services 2004*.

²⁵ Office for National Statistics, *Labour Force Survey*, available from www.statistics.gov.uk/ssd/surveys/labour_force_survey.asp

Even within the public sector health care workers do not compare favourably. The most recent Labour Force Survey²⁶ showed that public sector graduates earned gross hourly pay of £15.67 per hour in Spring 2005. Based on a 37 hour week this equates to an approximate annual salary of just over £30,000. This compares to the starting salaries at Band 5 of £18,698.

The Association of Graduate Recruiters announced in a press release on 12 July 2005 that the median starting salary for graduates across all sectors was £22,000, a rise of 4.8% on the previous year.

There is a large and diverse private and independent employment sector for many NHS professionals, particularly physiotherapists, ranging from private hospitals to sports clinics and charities. There is considerable competition for physiotherapists, particularly at senior clinical grades.

For most professions the graduate labour market is extremely competitive with other parts of the public sector and the private sector. Even with the expansion of higher and further education there is some doubt whether the NHS can compete.

Affordability and economic considerations

Affordability

The 2004 Spending Review²⁷ sets targets for NHS spending up to 2007/2008. Spending is set to increase by an average 2.5% in real terms during 2006/2007 and 2007/2008.

²⁶ Office for National Statistics, *Labour Force Survey*, available from www.statistics.gov.uk/ssd/surveys/labour_force_survey.asp

²⁷ HM Treasury (2004) *Spending review: stability, security and opportunity for all: investing for Britain's long-term future*, London: HMSO. Available at www.treasury.gov.uk

Departmental Expenditure Limits (£bn)

	2004/5	2005/6	2006/7	2007/8	annual growth rate
DH	71.5	78.5	86.8	94.4	6.9%
(Of which					
NHS)	69.4	76.4	83.8	92.1	7.1%

The Spending Review reinforces the government's commitment to improve public service performance. In the 2001 report the Nursing Staff Review Body said that: "*it is vital to bear in mind that the Government's objectives cannot be delivered without sufficient numbers of appropriately qualified and well motivated staff*".

The Chief Executive's Report to the NHS in May 2005²⁸ details how extra funding of £6.7 billion in 2004/2005 has been used. Around £2 billion has been invested in pay to attract and retain more staff and the Chief Executive's report shows how staff numbers are growing. Over 1.3 million people are now employed in the NHS. Growth in the total NHS workforce has increased by an average of 3.9% every year since 2000. Since 1999 233,710 more staff have been employed, and 67,880 more qualified nursing, midwifery and health visiting staff.

However, at the same time the range of services is growing, waiting times and waiting lists are falling, and there is evidence that demand for services is increasing. The 2004 Spending Review shows 450,000 more operations than in 1997 and 860,000 more elective admissions²⁹.

Economic considerations

The all items retail prices index rose by 2.8% in the year to August 2005, down from 2.9% July.

²⁸ National Health Service (2005) *Chief Executive's report to the NHS: Statistical supplement, May 2005*, Leeds: DH.

²⁹ HM Treasury (2004) *Spending review: stability, security and opportunity for all: investing for Britain's long-term future*, London: HMSO. Available at www.treasury.gov.uk

Pay settlements were running at a level of around 3% in the second quarter of 2005. The Industrial Relations Services (IRS) Pay Intelligence describes the median as 3%³⁰. IDS estimates the median settlement level for the three months to July 2005 as 3.2%³¹. Public sector awards average 3%, unchanged since April 2004.

The UK labour market is currently fairly flat, sustaining both high levels of employment and low unemployment³². Numbers in employment are only slightly down from the record high achieved in December 2004 to February 2005. Employment growth has been particularly positive for women. However, continuing uncertainty in the Middle East means unpredictable and rising oil prices. This coupled with the aftermath of terrorist activity in the UK, and the impact on the retail trade and tourist industry, means it is not possible to forecast an ongoing flat but stable economy.

Recent increases in fuel prices have been significant and current levels of mileage allowance, mainly for community-based staff, do not adequately compensate NHS staff. The price of a litre of petrol has risen from 80p to £1.00 in the last two years. A strong sense of resentment is growing as staff feel they are effectively subsidising the NHS for their work travel. Inevitably, this is affecting morale and could impact on motivation. The Staff Side is seeking an interim uplift of 10% in mileage allowance and a review in six months when it should be possible to determine whether the current level is a high point.

Staff Side is of the view that the NHS can not afford not to award a substantial pay increase in 2006 if staff vital to delivering expanding health services are to be retained and recruited in increasing numbers.

Staff Side asks the Review Body to take into consideration a climate of increasing economic uncertainty including the impact of rising petrol prices.

³⁰ Industrial Relations Services (2005) *Employment Review* 82, available from www.irsemploymentreview.com

³¹ Income Data Services (2005) *IDS Pay Report 934, August 2005*, London: IDS.

³² Office for National Statistics (2005) *Labour Market Trends June 2005*, available from www.statistics.gov.uk

Conclusions and recommendations

- 1. Staff Side believes the constant change in NHS structures and ways of working, coupled with increasing demand for more and better services, is the essential backdrop for this year's evidence, and the impact on staff in terms of morale and motivation must be taken into consideration by the Review Body in their recommendations for pay for 2006.*
- 2. With this backdrop in mind, the Staff Side calls on the Review Body to help provide stability through their recommendations. In particular, by urging the Departments of Health not to introduce further changes to the pay structure and system. Also by resisting recommending adding or deleting pay points. Such selective interventions by the Review Body in the past have caused problems and could only add to uncertainty.*
- 3. It will not be possible to assess the full impact of Agenda for Change until assimilation is complete. The Staff Side believes this is a strong reason for a one year pay award.*
- 4. Agenda for Change was designed to overcome historic pay inequalities in the NHS by ensuring that equal pay for work of equal value was embedded in the system. Until complete assimilation it will not be possible to monitor the outcomes and to ensure that this aspect has been successful. Monitoring information needs to be shared and easily available to both sides.*
- 5. There are serious concerns that, given the current financial situation of many NHS organisations implementation of Agenda for Change may not be fully funded. Staff Side seeks reassurance that full funding will be provided.*
- 6. The Review Body is asked to note that the impact on staff morale of the government's proposals to increase the normal pensionable age of NHS staff to 65, and alternatives to a final salary scheme, has already been significant. The effect on staff motivation and morale cannot be underestimated.*

7. *The evidence suggests that shortages of nursing and other key professional staff are still not resolved. As there are some problems with reliability affecting both the Department of Health's vacancy survey and OME survey other indicators have to be taken into account. For example, it is important to understand what features of staff's working lives influence their decision to stay in their profession, and particularly in the NHS.*
8. *Staff surveys show how important the working environment is in relation to recruitment and retention. However, the evidence shows that pay also remains a key factor. Staff Side believes that gains from Agenda for Change will need to be consolidated in the award for 2006 and that a one year pay award is the best way to do this.*
9. *Staff surveys show how important the working environment is in relation to recruitment and retention. However, the evidence shows that pay also remains a key factor.*
10. *The Staff Side remains unconvinced of the case for a radical localisation of pay in the NHS, as advocated by a few economists and occasionally echoed by other commentators. Recruitment and retention strategies can be used to address key shortages without opening the Pandora's box of regional pay.*
11. *The Staff Side recommends that there are no fundamental changes made to the new system of high cost area supplements, but that the cap should be increased in line with overall pay uplift.*
12. *However, the Staff Side is of the view that the current system of percentage payments unfairly discriminates against the lower paid staff who face the same high costs as those who are better off and may wish to review this system in the future.*
13. *A number of occupations within the scope of the Nursing and Other Health Professions Review Body, including midwives and pharmacists, have also*

been designated as potentially needing some sort of national premia. The Staff Side believes that these issues are best addressed by direct negotiation between the parties as the impact on other relativities needs to be taken into account.

14. The Staff Side generally supports the conclusions and analysis set out in the NHS Partners' research for the OME, which concludes that there is no strong case for major change to the new system. There are, though, issues of higher living costs in some areas not currently covered by the supplements. There are also some areas outside London and the South East where there are higher than average vacancy rates.

NHS Partners argue that consideration should be given to paying supplements in areas designated high cost by the NHS Staff Market Forces Factor, and which have higher vacancy levels and staff turnover. The Staff Side believes this suggestion deserves further consideration by the parties as part of the overall review of Agenda for Change.

In the interim, local negotiations should take place under the existing provisions in those areas where there is an identifiable problem of high costs, such as some areas adjacent to London and other housing hotspots in the country.

15. The relative position of NHS professional staff compared to other public service professionals has improved since 1997, but pay gaps remain with key comparators. The Staff Side believes these pay gaps are unjustifiable and unless closed will, over time, damage morale and affect the ability of the NHS to recruit and retain.

16. The Staff Side research indicates, however, that there are higher pay maxima for both teachers and police, and believes the Review Body should take account of this in its deliberations.

- 17. For most professions the graduate labour market is extremely competitive with other parts of the public sector and the private sector. Even with the expansion of higher and further education there is some doubt whether the NHS can compete.*
- 18. Staff Side is of the view that the NHS can not afford not to award a substantial pay increase in 2006 if staff vital to delivering expanding health services are to be retained and recruited in increasing numbers.*
- 19. Staff Side asks the Review Body to take into consideration a climate of increasing economic uncertainty including the impact of rising petrol prices.*
- 20. The Staff Side is seeking a substantial increase in the current pay scales to provide an above inflation increase, assist recruitment and retention and to close gaps with other public sector comparators.*

Appendix 1

This statement is a joint statement from the Department of Health, NHS Employers and Trade Unions on the position in terms of assimilation to Agenda for Change. This provides an agreed single position to implementation in England.

“We are pleased at the great achievement across the NHS in delivering the new Agenda for Change terms and conditions to staff. The position in England is that 80% of jobs were matched to the new grades at the end of August, with around 60% of staff assimilated. This translates into over 540,000 individual staff assimilated and paid on their new grades. Everyone involved, including staff, management and trade unions, can be rightfully proud of the hard work they have put into achieving this level of success while still fully maintaining NHS services. There is no doubt it is a very demanding task, and one that was created, developed and is being delivered in partnership.

This means that by the end of September we expect the significant majority of staff will have moved from their old terms and conditions onto the new, and we can look forward over the next few months to mainstreaming Agenda for Change and allowing it to deliver continued benefits to both staff and patients. It is important that this good work continues, and in particular implementation of the NHS Knowledge and Skills Framework, as this element is a key driver of development for staff and improved services for patients.

We know that everyone is continuing to work positively towards the end-of-September timetable, which remains the target for completion. We expect to see accelerated progress in September in all organisations where completion has not already been achieved.

However, there may be a minority of organisations that will not be able to finish the task by the end of September. In these cases, the parties locally will be required to propose tight timetables to achieve completion of assimilation.

Such plans will need to be agreed with the relevant external authority within a rigorous national framework, and will be performance managed by the Department of Health. NHS Employers and trade unions will provide further support to help organisations achieve completion.”

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