Joint union submission to the NHS Pay Review Body 2020-21[1]

Introduction and scope

1. In 2018 the NHS Staff Council reached agreement on reform of the NHS terms and conditions of service. This agreement resulted in a three-year deal to reform the pay structure spanning 1 April 2018 until 31 March 2021. The joint NHS trade unions are actively involved in implementation of this agreement, largely by working through the NHS Staff Council.

2. As 2020-21 pay round falls within this three-year pay deal, there is no NHS Pay Review Body (NHS PRB) remit to make recommendations on pay. Instead the PRB has been asked by Ministers in the Department of Health and Social Care to take evidence on the implementation of the pay agreement, as well as some specific consideration on the potential use of Recruitment and Retention Premia (RRPs), an existing feature of NHS pay, terms and conditions of service.

3. In addition, at the time of writing, the PRB had received a remit to cover the NHS in England only.

4. Therefore this submission focuses on the implementation of the pay agreement in England whilst providing commentary on recruitment, retention and motivation trends as usual. If a remit is subsequently issued to cover the NHS in other parts of the United Kingdom the joint NHS trade unions will respond to those remits specifically.

Staff Council implementation workstreams

5.. A joint update from the Staff Council on the main work-streams arising from the England pay deal will be issued to the PRB separately. Staff side unions wish to draw attention to two priority areas.

6. Band 1 to band 2: We are concerned that progress is patchy with pockets of staff in some trusts not taking up the offer in the numbers we would expect to see. We know that some staff have been deterred by general (and often unsubstantiated) concerns about the effect on in-work benefits and by poor local management behaviour which has openly discouraged staff from moving to band 2. We believe there is a link between the quality of the engagement with band 1 staff about this aspect of the pay deal and general underlying workplace culture. For example, in some trusts high profile disputes about since-abandoned plans to transfer band 1 staff into wholly-owned subsidiary companies have left a legacy whereby these staff no longer have trust and confidence in their managers' intentions. Staff side unions are working to support our local representatives and we are keen to work through the Staff Council to target support in partnership to where it is needed.

[1] British Association of Occupational Therapists, British Dietetic Association, British and Irish Orthoptic Society, Chartered Society of Physiotherapy, College of Podiatry, Federation of Clinical Scientists, GMB, Royal College of Midwives, Royal College of Nursing, Society of Radiographers, UNISON, Unite.

7. Pay progression: We are still more than a year away from the first wave of pay step reviews taking place for new or promoted staff under the new pay progression system. However, data from the Workforce Race Equality Standard (WRES) show that there continue to be racial disparities in the likelihood of staff being subject to disciplinary proceedings. There is no corresponding national data on racial disparities in the imposition and severity of formal sanctions. However, BAME staff being more likely to face proceedings puts them at higher risk of receiving a sanction. Anecdotal evidence from our representatives suggests that BAME staff often do face longer sanctions than other staff for comparable disciplinary findings. This creates a real risk that decisions about pay step progression could compound racial inequality.

8. Our staff side guide to the new pay progression system for union representatives stresses the importance of ensuring that – before decisions to delay pay progression based on disciplinary sanctions can safely be made – racial disparities within disciplinary processes must be eliminated. The issue has also been highlighted via communications from the Staff Council Equality Diversity and Inclusion Group.

9. The pay progression sub-group has suggested that an indicator on pay progression outcomes should be added to the WRES in order for this issue to be properly monitored and addressed.

10. These areas of concern around band 1 and pay progression reflect the importance of sufficient capacity within local partnerships. The ability to negotiate effectively at the local level is essential to ensuring national pay deal provisions are implemented properly. The staff side unions see an ongoing need to build and improve this capacity and we believe this would be greatly aided by having partnership support structures at regional and sub-regional levels – something we intend to pursue through discussions to shape the People Plan's 'new operating model for the workforce'.

The impact of the pay agreement

11. As stated in a joint report by the King's Fund, the Nuffield Trust and the Health Foundation: "pay and reward are tangible signs of how far staff are valued and have a clear impact on retention". In England the NHS Staff Survey 2018 gave the first national picture of the impact of the pay agreement as it relates to staff satisfaction with their salary, providing a snapshot part way through the first year of the pay agreement. The 2018 survey results showed a 5.1 percentage point increase in the proportion of staff satisfied with their salary with 36.3% stating they were satisfied, compared to 31.2% in 2017. However, since the results do not capture where respondents are employed within their pay band, we cannot judge whether satisfaction is differentiated within pay bands and particularly whether satisfaction is different according to whether respondents are at the top of their pay band.

12. These results suggest that the pay uplifts for Agenda for Change staff are a significant step in the right direction. The pay agreement however does not make up for lost earnings over the period of pay restraint since 2010 and it should be noted that the staff satisfaction with salary is still lower than previous years.

13. The NHS PRB has previously stated that "the starting point for future monitoring arrangements should be the AfC agreement's key objectives. These were to: support attraction and recruitment; support retention; increase staff engagement; support the use of apprenticeships; support new training pathways and focus on careers; map out work on

consistency for bank working; and improve the health and wellbeing of staff to improve attendance."

14. This monitoring work is important but the effect of the 2018 agreement can only be properly assessed where the framework has been implemented in full, in good faith, and without other material attacks on the pay, terms and conditions of the NHS workforce.

15. A number of detrimental features of employment in the NHS have emerged over recent years. The combined effect is that the NHS pay refresh is less effective than it might otherwise have been. If NHS staff witness, or are subject to, attacks on NHS employment both the material financial effect and the demonstrative intent of the agreement will suffer.

16. These range from changes to contract, such as the creation of wholly owned subsidiaries, outsourcing of key services such as laundries and catering, through to misuse of the core NHS contract particularly relating to job evaluation.

Removal of NHS pay, terms and conditions

- Creation of wholly owned subsidiaries
- Outsourcing of staff to private contractors
- Creation of apprentice contracts where the role is not job evaluated and paid at NHS rates

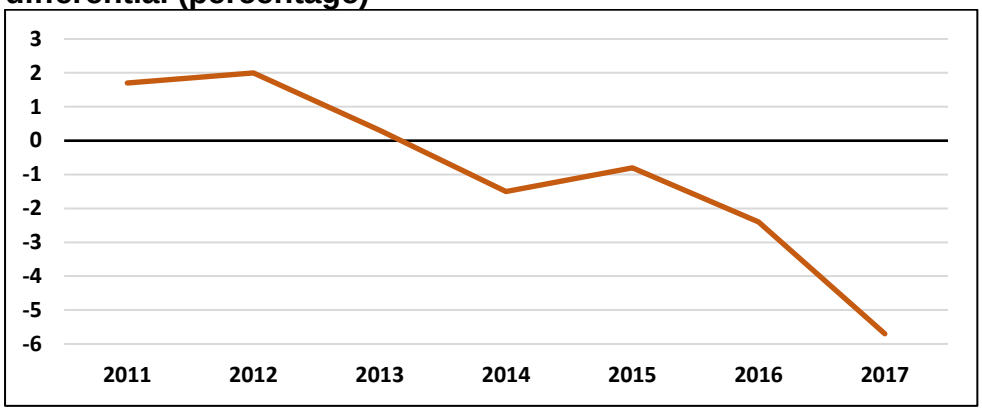
Frustrating access to full NHS pay, terms and conditions

- No or inappropriate use of NHS handbook job evaluation process when setting pay bands for roles, with a major area of concern around non-registered support staff being inappropriately banded
- Preventing staff from requesting job evaluation of their actual role
- Proactive attempts to artificially remove elements of role descriptions, resulting in downbanding, without any genuine change in role
- Unjustified delay in the implementation of Band 1-2 transition work

Public sector pay differential

17. As we look ahead to the end of the pay agreements and towards the 2021/22 pay round it is important to understand labour market trends. One important indicator is the comparison between public sector and private sector with rates in the public sector pay falling below comparable private sector rates. Official estimates demonstrate that overall public sector pay rates are uncompetitive. According to the most recent ONS modelling public sector pay (including overtime and bonuses) was 5.74% below comparable private sector rates in 2017 (the latest year for which figures are available).

Figure 1: ONS weighted estimate of the public/private percentage pay differential (percentage)[2]

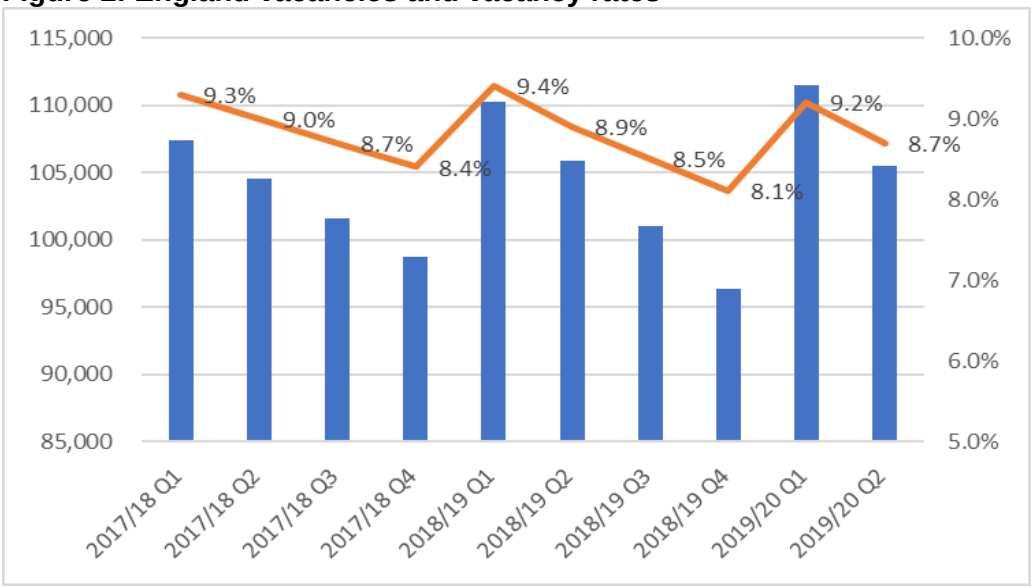


Recruitment and retention

18. There is no doubt that NHS services across the UK are facing major staff shortages. Figure 2 shows levels of vacancies and vacancy rates from 2017/18 to the second quarter of 2019/20 in England. At this time, the number of vacancies stood at 105,518, equating to a vacancy rate of 8.7%. Moreover, the rate stands higher than that in certain occupations, notably nursing, which faces a vacancy rate of 12.1%. The King's Fund and Picker Institute warn that the "deepening crisis in NHS staffing could cause a deterioration in the quality of care. The findings have significance for policy makers and managers in terms of the urgent need to address the workforce and NHS capacity issues."[3]

19. With around one in ten members of staff leaving every year, staff numbers are not keeping pace with the number of people they are expected to care for. Our members repeatedly tell us that there are not enough staff to do their job properly.

Figure 2: England vacancies and vacancy rates



Source: NHS Digital

[2] ONS, *Public versus private sector earnings in the UK: 2011 to 2017 (model B),* 07 October 2019 www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/adhocs/10665publicversusprivatesectorearningsintheuk2011to2017

[3] Picker Institute (2018) *The risks to care quality and staff wellbeing of an NHS system under pressure*

Morale and wellbeing

20. Analysis of the NHS staff survey for England shows that "staff experience was associated with sickness absence rates, spend on agency staff and staffing levels, indicating that staff wellbeing is impacted negatively by a workforce that is overstretched and supplemented by temporary staff. Patient experience was also negatively associated with workforce factors: higher spend on agency staff, fewer doctors and especially fewer nurses per bed, and bed occupancy."[4]

21. The situation is clearly taking its toll on staff, as highlighted in the 2018 NHS Staff Survey for England, with 39.8% of respondents reporting being unwell as a result of work-related stress in the previous 12 months. In addition, 56.6% said they had gone to work when ill, and close to three in five were working extra unpaid hours on a weekly basis.

22. Sickness absence levels can be seen as a proxy indicator for the wellbeing of staff. NHS Employers have said that: "Sickness absence is a major focus of wellbeing strategies in the NHS. It is measured nationally and is therefore one of the key available indicators for the wellbeing of staff."[5]

23. Analysis by the King's Fund shows that sickness absence rates in the NHS in England are higher than in the rest of the economy as a whole, running 2.3 percentage points higher than in the rest of the economy[6]. NHS staff sickness rates rose from 3.8% in April 2018 to 4.1% in April 2019. This is the highest level in more than a decade and represents more than 1.4 million full-time equivalent (FTE) days lost in that month alone.

24. Anxiety, stress, depression and other psychiatric illnesses are the most common reasons for absence, accounting for nearly a quarter of the staff absences in April 2019, followed by musculoskeletal problems.

Long hours working

25. Health Education England has highlighted the effects of long hours and difficult shift patterns on the mental health of NHS employees, with 76% of 'frontline' staff experiencing 'mental distress' at work[7]. Meanwhile, the Guardian's healthcare network survey suggests that staff absences create a negative spiral by increasing the pressure on those who are still at work[8].

26. These pressures have been recognised within the interim NHS People Plan for England which stated that "The culture of the NHS is being negatively impacted by the fact that our people are overstretched…The theme of staffing pressures causing stress and burnout also runs through the recent Health Education England report on NHS staff and learner wellbeing[9] which sets out some of the most serious causes of harm to our people's mental health and wellbeing."[10]

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[4] Picker Institute (2018) The risks to care quality and staff wellbeing of an NHS system under pressure
[5] www.nhsemployers.org/retention-and-staff-experience/health-and-wellbeing/action-on-sickness-absence/vital-signs-to-sickness-absence
[6] www.kingsfund.org.uk/blog/2019/10/nhs-sickness-absence
[7] www.hee.nhs.uk/sites/default/files/documents/NHS %28HEE%29 - Mental Wellbeing Commission Report.pdf
[8] www.theguardian.com/society/2018/mar/18/hospitals-staff-shortage-nursing-nhs-rcn-patient-care-sarah-johnson-survey
[9] www.hee.nhs.uk/our-work/mental-wellbeing-report
[10] www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

- The NHS Staff Survey 2018 for England reports that 58% of staff work additional unpaid hours
- The RCN Employment Survey 2019 shows that 79% of NHS nursing staff respondents reported working in excess of their contracted hours at least once a week. Of those who work excess hours, over half (57%) said these hours are usually unpaid
- UNISON's *Just another day* snapshot survey showed that on the day in question 38% worked longer than their contracted hours, rising to 53% among ambulance staff and 48% among nurses and midwives
- 63% of respondents to a survey of Unite respondents reported they frequently or always worked more than their contractual hours.

27. Unpaid overtime represents an enormous goodwill contribution by a workforce that is approaching its breaking point. Staff side strongly believes that workers should be paid for all the hours they work.

Recruitment and retention premia

28. In the 2019 round the Government asked the NHS PRB to consider the use of recruitment and retention premia (RRP) in the NHS, particularly relating to IT staff. The Government has repeated a version of this request for the 2020 round.

29. The NHS trade unions have previously given a cautious welcome to the use of RRP. In the last round we stated that:

"Local and national RRPs are an embedded part of the Agenda for Change contract and we have no principled opposition to their use. The strong view of the joint NHS trade unions is that the reduction in use of RRPs is almost entirely as a result of a lack of dedicated funding. We would welcome the views of the NHS Pay Review body on:

- Reviewing clear and consistent criteria for the introduction of national RRPs
- Reviewing clear and consistent criteria for evaluation of national RRPs, and
- criteria for extending or winding up
- Reviewing the case for additional funding to support national and local RRPs, as
- well as considering the risks to the wider workforce of funding RRPs from within existing pay policy settlement."

These views largely stand. However, given that the Government has repeated its desire for the PRB to examine recruitment and retention premia the joint NHS trade unions have decided to re-visit the operation of RRPs in greater detail.

Current Recruitment and Retention Premia arrangements

30. Recruitment and Retention Premia are a set of interconnected arrangements outlined in multiple sections of the NHS pay, terms and conditions handbook. It has been some time since they have been reviewed. It is clear that they are not well used; NHS Digital figures show that about 0.6% of all NHS staff receive some kind of RRP payment. RRPs can be national or local, long-term or short-term. It is not clear from the NHS Digital figures what the split of payments is, though to the best of our understanding there are no national RRPs in use in England.

National RRPs

31. The clearest guidance is on the application of national RRPs, in section 5 of the NHS pay, terms and conditions:

> "5.3 Recruitment and retention premia may also be awarded on a national basis to particular groups of staff on the recommendation of the NHS Pay Review Body (NHSPRB) where there are national recruitment and retention pressures. The Review Body must seek evidence or advice from NHS employers, staff organisations and other stakeholders in considering the case for any such payments."

32. For these payments the process is reasonably clear, but the issue remains one of money. Any benefit reached through funding a national RRP through targeting part of the funding meant to support an overall pay award would have unintended consequences, not least a negative reaction in other parts of the workforce. It would not be acceptable for recurrent workforce funding to be diverted to support RRPs, not least because these payments are reviewable on an annual basis and could be removed. At an absolute minimum, any discussion on national RRPs must be underpinned by a discussion about where additional funding for temporary pay arrangements would be found.

Local RRPs

33. The process for approving local RRPs is less obvious as it lies across several sections and appendixes of the handbook. The purpose, process for approval, limits, and process for review or ending the payments are not easy to find in one place. Reviewing these sections of the handbook is a matter for NHS Staff Council, but it is fair to say that the process is rather opaque and this could be a factor in why local RRPs are not widely used.

Funding for local RRPs in England

34. In previous years the NHS trade unions have contended that the lack of local RRPs is a result of a lack of dedicated funding. However, recent work by Staff Side suggests that the picture is a complex one. NHS trusts in England receive funding for their workforce as part of the NHS tariff, determined by NHS Improvement. There appears to be no direct relationship between the cost commitments that providers face in terms of pay, terms, and conditions and the funding they receive to cover those costs.

35. For example, trusts do not receive additional funding to cover the cost of HCAS payments. However, most trusts paying HCAS payments currently receive additional funding broadly comparable to their HCAS zone through the Market Force Factor (MFF).

36. The MFF can be seen as a proxy for likely additional recruitment and retention costs faced by trusts as measured by private sector labour market information (using ONS Annual Survey of Hours and Earnings data). However, some trusts receive additional payments through the MFF adjustment but do not themselves pay HCAS.

37. Therefore, because there is no direct relationship between contractual NHS pay arrangements and the NHS tariff it follows that there is also no direct relationship between
38. additional money received by trusts because they are predicted to face recruitment and retention difficulties and whether the trust actually pays staff at a higher rate designed to account for those recruitment and retention difficulties.

39. This short overview highlights the complexity of the issue, and as such the joint NHS trade unions would welcome NHS PRB observations on the operation of RRPs, including

funding arrangements and the suitability of the existing NHS tariff system in relation to national and local NHS pay arrangements.

40. We would also invite the PRB to consider the issue of RRPs within the context of the direction of travel highlighted by the Interim People Plan which sets out the expectation that as Integrated Care Systems (ICSs) develop, they will take on responsibility for workforce planning in their areas. We ask the PRB to consider whether joint partnership bodies, with an overview of workforce planning in ICS areas should take responsibility for assessing the need, scope and level of RRPs.

High Cost Area Supplements

41. Annex 1 includes further detail on HCAS. This shows that the system has not been revised since it was introduced in 2004. Much of the system is a result of evolution rather than design and there are occasional calls for change to the system.

42. Initial work undertaken by Staff Side unions demonstrates there is a technical case for some reform to HCAS as a matter of general maintenance, together with a wider debate to be had about funding assumptions for high cost areas and inter-relationships with RRPs.

43. The Staff Side unions intend to do further work on the structure, geographical scope and value of HCAS including seeking discussions through the Staff Council on the funding routes and Handbook mechanisms for effecting change.

Annex 1

Current HCAS arrangements

HCAS is a set of interconnected arrangements outlined in multiple sections of the handbook covering:

- Nature of payment
- Areas of payment
- Amount of payment
- Mechanics for varying or introducing payment

Nature of payment

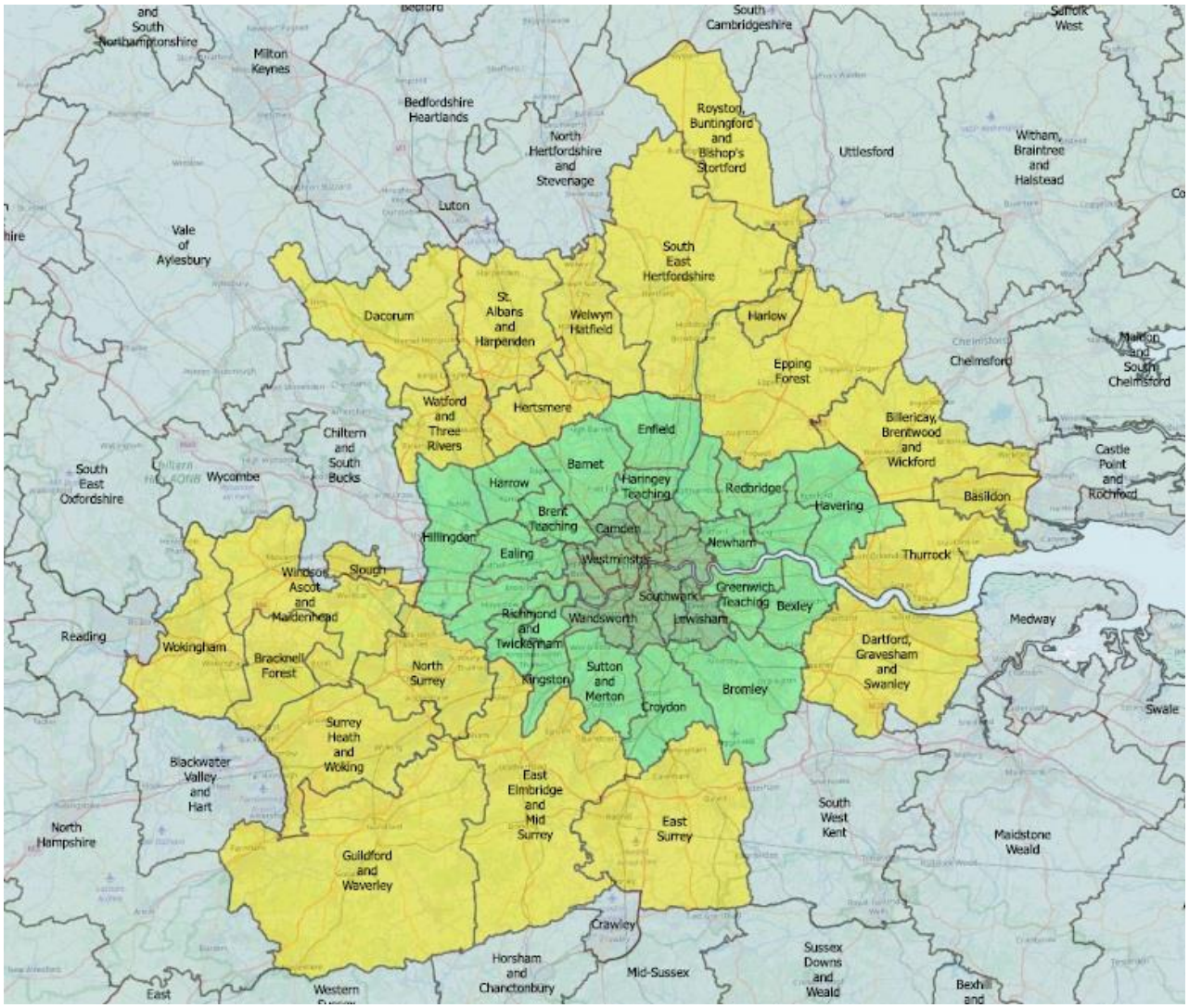
Section 4 of the handbook sets out the terms on which HCAS payments are made. Specifically:

- HCAS is expressed as a proportion of basic pay, but subject to a minimum and maximum level of extra pay
- HCAS is pensionable
- HCAS does not count as basic pay for the purposes of calculating the rate of overtime payments, unsocial hours payments, on-call availability payments or any other payment, excluding sick pay.
- However, any long-term recruitment and retention premia count toward basic pay for the purpose of calculating HCAS
- A number of clauses are transitional, relating to the introduction of the Agenda for Change system. The section specifically ends all previous payments for London weighting, fringe allowances and cost of living supplements in the NHS

Currently an estimated 200,000 posts in England attract a HCAS payment – a significant proportion of the overall workforce.

Areas of payment

Annex 8 of the handbook specifies the zones of HCAS payments. These are defined as inner London, outer London and fringe areas. All specified payment areas are based on the 2005 Primary Care Trust geographical boundaries within Strategic Health Authorities.



As of 2019 NHS Employers made a small edit to the handbook, linking the list of PCTs to a Office of National Statistics map that contains a postcode and address search function.

Amount of payment

The value of HCAS for each of the payment zones is described in Annex 9.
The minimum and maximum rates are described for the course of the full three-year pay agreement in England. In each year the minimum and maximum payments increase by the 'headline' pay award for that year, the consolidated pay increase made to the top of Bands 2-8c.

Area	1 April 2018	1 April 2019	1 April 2020
Inner London	20% of basic salary, subject to a: minimum payment of £4,326 and a maximum payment of £6,663	20% of basic salary, subject to a: minimum payment of £4,400 and a maximum payment of £6,777	20% of basic salary, subject to a: minimum payment of £4,473 and a maximum payment of £6,890
Outer London	15% of basic salary, subject to a: minimum payment of £3,659 and a maximum payment of £4,664	15% of basic salary, subject to a: minimum payment of £3,722 and a maximum payment of £4,743	15% of basic salary, subject to a: minimum payment of £3,784 and a maximum payment of £4,822
Fringe	5% of basic salary, subject to a: minimum payment of £1,000 and a maximum payment of £1,733	5% of basic salary, subject to a: minimum payment of £1,017 and a maximum payment of £1,762	5% of basic salary, subject to a: minimum payment of £1,034 and a maximum payment of £1,791

Theoretically, additional hybrid rates are available. Section 4 states that employers who employ staff in more than one high cost area zone can agree locally a harmonised rate of payment across their organisation, provided they agree with neighbouring employers if the proposed rate would exceed the average rate payable in their area (Section 4:4.6).
We have seen no evidence of hybrid rates being used, but there's no requirement on employers to notify Staff Council of the practice.

Mechanics for varying or introducing payment

Responsibilities for the different aspects of the HCAS system are described in Section 4. There are roles for the PRB, NHS Staff Council, and some flexibility for local employers.

NHS Pay Review Body

The NHS Pay Review Body is able to make recommendations on the geographic coverage of high cost area supplements and on the value of such supplements (Section 4:4.8).

NHS Staff Council

Review Annex 9 (payment values) annually in line with NHS Pay Review Body recommendations (Section 4:4.3).

Local NHS employers or staff groups

Able to propose an increase in the level of high cost area supplement for staff in that area, or (in the case of areas where no supplement exists) to introduce a supplement. This can only be implemented where:

- there is evidence that costs for the majority of staff living in the travel to work area, covered by the proposed new or higher supplement, are greater than for the majority of staff living in the travel to work area of neighbouring employers and that this is reflected in comparative recruitment problems;
- there is agreement amongst all the NHS employers in that area;
- there is agreement with trades unions/staff organisations.
  (Section 4:4.9)

Issues with the existing system

The Staff Side unions have undertaken a detailed analysis of the historical development of London allowances in the NHS from which we have drawn two broad conclusions. The first is that the HCAS system owes more to evolution than it does to design. The second is that although a history of London weighting in the NHS provides some explanation of the quirks of the system it does not provide a justification for them. We are simply left with "a number of unhappy compromises."

Those compromises, combined with the fact the system has not been reviewed in nearly two decades, have led to a number of issues.

These range from the technical and reasonably simple to fix through to fundamental questions about what HCAS is supposed to be for and how it relates to existing arrangements for the organisation and funding of the NHS.

Nature of payment

HCAS does not in practice work in the way that it is described. The handbook describes HCAS as being paid at a proportion of basic pay but it is now effectively a two-tier flat rate payment.

For example, by the end of the current three-year pay agreement the following distribution will apply for inner London payments, leaving only staff on top of band 4, band 5 and entry point to band 6 having a variable payment.

All staff in Bands 1-3	£4,473
Staff on entry point of Band 4	£4,473
Staff at full rate of Band 4	Variable payment, 20% of basic
Staff in Band 5	Variable payment, 20% of basic
Staff at entry point of Band 6	Variable payment, 20% of basic
Staff at intermediate and full rates of Band 6	£6,890
Staff in Bands 7-9	£6,890

The issue is even more stark in Outer London. By 2021 only three pay points will receive variable payment. The entire rest of the workforce receives one of two flat-rate payments.

All staff in Bands 1-4	£3,784
Staff on entry point of Band 5	£3,784
Staff at intermediate and full rates of Band 5	Variable payment, 15% of basic
Staff at entry point of Band 6	Variable payment, 15% of basic
Staff at intermediate and full rates of Band 6	£4,882
Staff in Bands 7-9	£4,882

Areas of payment

Definitions
On 1 April 2013 clinical commissioning groups (CCGs) replaced primary care trusts (PCTs) as the primary commissioner of National Health Service services in England. The handbook has never been updated to reflect this change to the NHS funding arrangements.
Some of the old PCT footprints have directly comparable Clinical Commissioning Groups but others have a more complicated set of successor organisations and it is not clear what approach employers in those areas have used.

Fringe anomalies
The inclusion or exclusion of areas in the fringe zone is particularly erratic. The map above shows two large gaps in the fringe belt that otherwise wraps around the outer London zone: Chiltern and South Bucks, and South West Kent. This reflects a chequered history arising from previous fudges and layering on top of pre-existing systems from other sectors. But there is no current rationale for why some areas on the edge of London are included and some are not.

Funding
The most recent version of the NHS market forces factor uses travel to work areas (TTWAs) in place of primary care trust (PCT) areas to estimate the non-medical-and-dental staff component of the payments.

This now means – so far as we can make out - that all trusts in the greater London TTWA receive the same proportion of payment for employing staff in and around London, regardless of whether they are paying inner, outer or fringe HCAS payments

Service changes
Reforms to service delivery are occurring across the London area as a result of the formation and maturing of sustainability and transformation partnerships (STPs) and integrated care systems (ICSs); through mergers of Clinical Commissioning Groups (CCGs); and through specific, centrally-driven programmes such as the reconfiguration of pathology services into multi-trust networks.

These are causing changes to the way staff are employed and deployed with transfers and relocations of staff as well as staff being expected to work across HCAS boundaries in the course of their employment.

Feedback via the London partnership suggests that employers are finding that the potential to lose HCAS money can act as a barrier to mobility for staff. And that where staff are working cross-boundary local solutions are developing for how they are paid, for example calculating the proportion of time spent in each zone.

The Staff Side unions consider that it is becoming increasingly difficult to conceptualise a clear distinction between inner and outer London as a result of developments in key areas such as house prices, transport links and employer/service re-configurations.

Amount of payment
Staff side unions believe the primary purpose of HCAS is to preserve the relative value of the AfC pay framework in high cost areas by compensating for the additional costs of living and working in these areas.

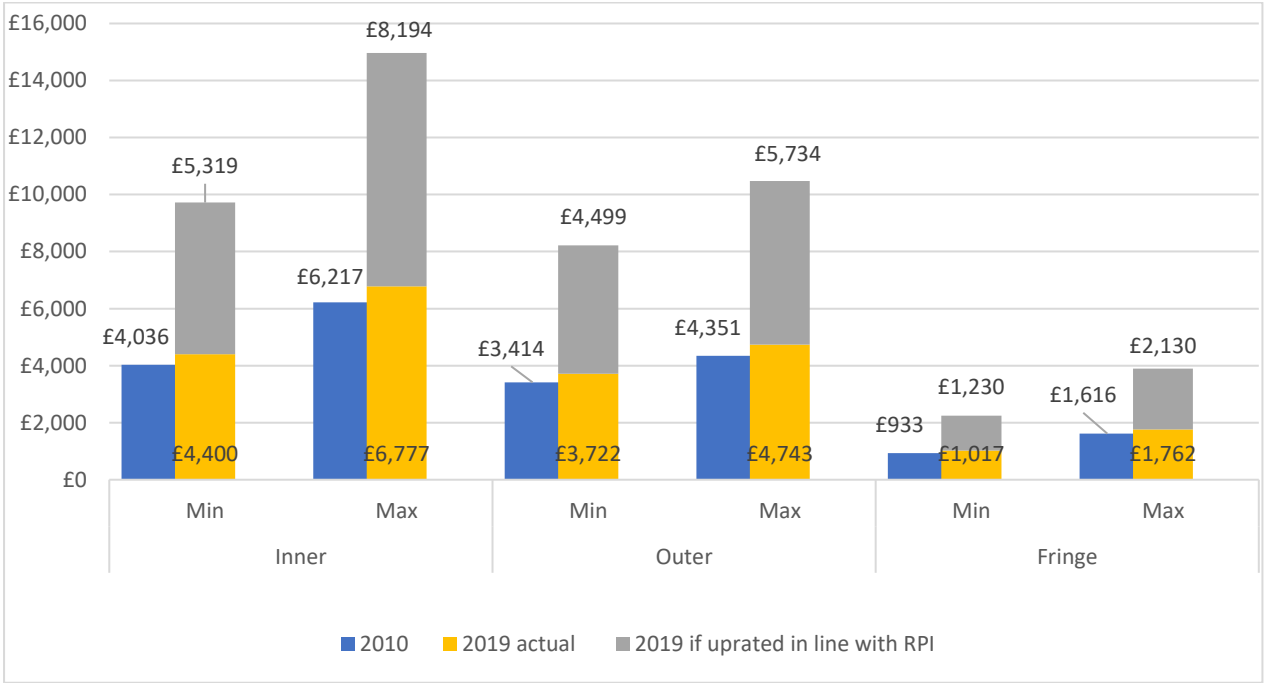
The ONS estimated in 2016 that the cost of living in London was 8.3% higher than in the rest of England[11]. Experimental ONS work also suggests that the cost of living is increasing at a faster rate in London than elsewhere in the UK[12].

The team that produces the calculators for the London Living Wage and the UK Living Wage produced a paper on London weighting in 2016. They found that:

- London Weighting needed to be almost **£7,700 per year in Inner London**,
- It needed to be just over **£6,200 in Outer London**.

Cost of living has increased since 2016. In line with the rest of the structure, HCAS rates have lost value in relation to inflation and the table below shows that the minimum and maximum supplements should be 21% higher to meet their objective based on uprating by RPI since 2010.

Agenda for Change HCAS



[11] ONS UK relative regional consumer price levels for goods and services 2016
[12] ONS feasibility study into producing CPIH consistent inflation rates for UK regions, November 2017