

# NHS Employers' evidence to the Nurses and Other Health Professions Review Body 2006/07

September 2005

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# 1. NHS Employers

## Who we are

- 1.1. We are a new organisation, which started work on 1 November 2004, when we took over responsibility from the Department of Health for much of the NHS human resources agenda. We have four key roles:
  - negotiating on behalf of employers
  - representing employers
  - supporting employers
  - promoting the NHS as a good employer.
- 1.2. NHS Employers has national responsibility within England for conducting negotiations on behalf of employers on issues such as NHS pay and conditions. We also provide NHS organisations at a local level with advice and support on employment issues by sharing good practice and by promoting strong networking arrangements. Our role in relation to staff in your remit groups is described further in section 3.
- 1.3. Our aim is to become the national resource on NHS workforce issues. NHS Employers is part of the NHS Confederation but has its own director, policy board and assembly. We set our own strategy and work programme and have our own decision-making powers, but we are ultimately accountable to the chief executive and trustees of the NHS Confederation.
- 1.4. The Department of Health, which remains responsible for developing policy and standards for the health and social care workforce, has set the broad framework within which NHS Employers operates. However, it is the employers themselves who drive the agenda that NHS Employers follows.
- 1.5. NHS Employers is an England-only initiative. However, a protocol has been developed by NHS Employers and the Health Departments in England, Wales, Scotland and Northern Ireland. The Department of Health in England may provide observers at pay negotiations while the Devolved Administrations each provide negotiating representatives. However, NHS Employers provides the 'machinery' for on-going negotiations on a UK basis by way of a secretariat.

## About our evidence

- 1.6. This evidence is based primarily on information collected from employers by way of a questionnaire designed to collect evidence on issues related to the remit of the Nurses and Other Health Professions Review Body (NOHPRB), the Doctors' and Dentists' Review Body (DDRb) and the Pay Negotiating Council (PNC). Our objective was to seek a 'whole workforce view' from employers. A copy of our letter seeking information and the questionnaire is at Annex A.
- 1.7. We received responses which represented the views of between one third and one half of employers. Some responses were sent on behalf of the HR community in a strategic health authority (SHA), others represented the views of a single trust or primary care trust (PCT). The most striking result was the degree of commonality in replies. Although with any set of information returns there is always some diversity of opinion, we are confident this evidence represents the views of employers covering the majority of the 1.3 million staff employed by the NHS. Where opinion differed significantly we have indicated this.
- 1.8. This evidence, which represents the views of NHS employers in England only, has been approved by the NHS Employers policy board.

## Foundation trusts

- 1.9. NHS foundation trusts (NHS FTs) are implementing Agenda for Change together with the rest of the NHS, offering staff the opportunity to transfer to new, more flexible terms and conditions. There are a range of specific local freedoms under the Agenda for Change agreement which allow NHS FTs to act independently, allowing them the opportunity to innovate in order to develop the workforce for the delivery of high-quality patient care – using their ability to develop new ways of recognising, acknowledging, rewarding and retaining staff.
- 1.10. We wished to see whether NHS FTs would present a different view to other employers. However, our survey suggests that NHS FTs currently have no specific concerns relating to pay modernisation that differ markedly from other NHS organisations.

## 2. The economic context

### Background

- 2.1. We recognise that the definitive sources of evidence on the economic context and affordability will be the Treasury and the Health Departments. However, in advance of their allocations for 2006/07, employers will have to take a view on the affordability of their workforce. The following indicators, which are publicly available, together with the current financial positions indicated by the returns to our questionnaire, have helped us form a view on affordability for the sector.
- 2.2. Recent evidence shows the UK economy is experiencing an economic slowdown. Data from the Office for National Statistics showed that GDP grew just 0.5 per cent between April and June. As a result, year-on-year growth stood at 1.8 per cent, its weakest rate since the first three months of 2002.
- 2.3. The volume of retail sales in the three months May to July 2005 was 0.7 per cent higher than in the previous three, the highest such growth since November 2004. However, annual growth remained the lowest for more than six years. Compared with the same period a year ago, sales in the three months to July 2005 were up 1.3 per cent, the lowest annual growth since February 1999.
- 2.4. Labour market statistics published in September 2005 show the trend in both employment and unemployment is broadly flat. The employment rate and the number in employment increased slightly on the previous quarter, and the previous year. The number of unemployed increased slightly over the previous quarter and year, but the unemployment rate remained unchanged at 4.7 per cent. The claimant count increased for the seventh consecutive month. The average number of vacancies was down on the previous quarter and down over the year.
- 2.5. In addition, UK house prices dipped by 0.2 per cent in August according to the Nationwide Building Society, while annual house price growth fell to 2.3 per cent, the lowest level since May 1996. Other recent house price surveys have also indicated that the property market has slowed sharply in 2005. The Halifax indicated that there had been a significant downward trend with house prices increasing by only 2.1 per cent in the first eight months of this year compared with a 12.5 per cent rise in the same period of 2004.
- 2.6. Given the evidence on the current state of the economy, pay increases in other sectors are unlikely to rise. This is supported by recent evidence on the level of pay settlements.

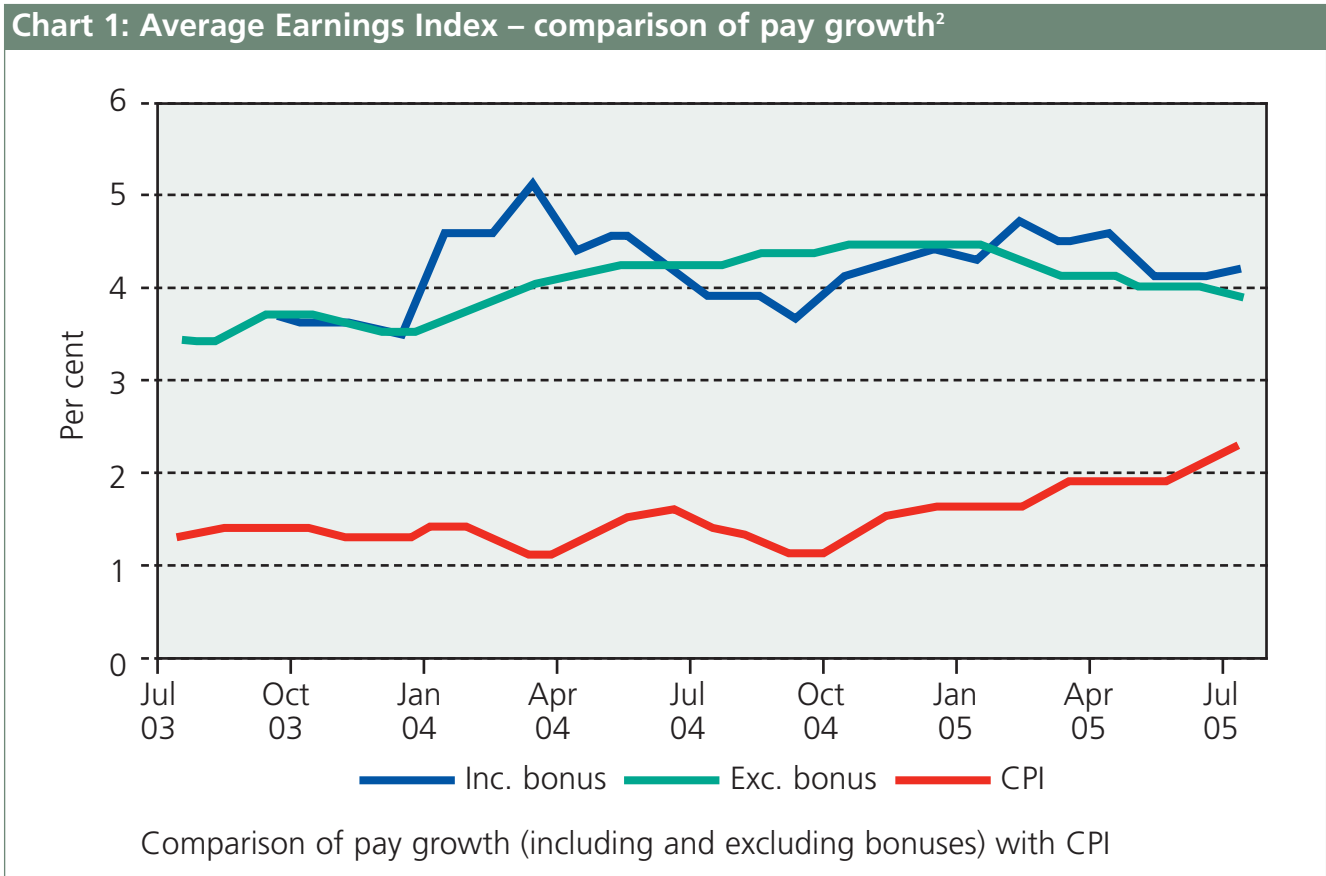
## Pay settlements

- 2.7. Evidence from the latest IDS Pay Report (September 2005) shows that the median pay settlement level for the three months to July was 3.1 per cent. The median increase for the three months to June was 3.2 per cent and the level of pay settlements for the past four months has remained steady.
- 2.8. The range of settlements remained on trend with the lower quartile being 3.0 per cent, slightly ahead of the current RPI inflation rate for the past few months. This means that over three-quarters of pay settlements in the last three months have been above the inflation rate.
- 2.9. The public sector median for the three months to June was 3.0 per cent. The figures up to July have not been given due to the lack of public sector settlements in July. This compared to a private service sector median in the three months to June of 3.0 per cent.
- 2.10. In 2004 a large proportion (around two-thirds) of employees in the public sector were covered by long-term pay agreements and this has continued into 2005. Recently, long-term deals have provided for annual increases of 2.5 to 3 per cent per year.<sup>1</sup>

## Average earnings

- 2.11. Average earnings (seasonally adjusted, excluding bonuses), as measured by the Average Earnings Index three-month average, rose by 3.9 per cent in the year to July 2005. This is down from 4.0 per cent in June. Including bonuses, average earnings rose by 4.2 per cent in the year to July, up from 4.1 per cent in June.

<sup>1</sup> Incomes Data Services Ltd, February 2005: *Pay in the public services 2005*



- 2.12. Looking at the private and public sectors separately, the annual average earnings growth (excluding bonuses) shows that both public and private sector earnings growth remain above current inflation rates. In the three months to July 2005, pay growth (excluding bonuses) in the private sector remained at 3.8 per cent. Over the same period, public sector pay growth increased 0.2 percentage points to 4.6 per cent. In addition, average earnings in the health sector increased by 4.6 per cent, in line with public sector pay growth<sup>3</sup>. Including bonus payments, private sector growth stood at 3.9 per cent compared with 5.5 per cent for the public sector.
- 2.13. The evidence tends to show that public sector earnings growth remains consistently higher than private sector earnings growth despite overall average earnings falling.

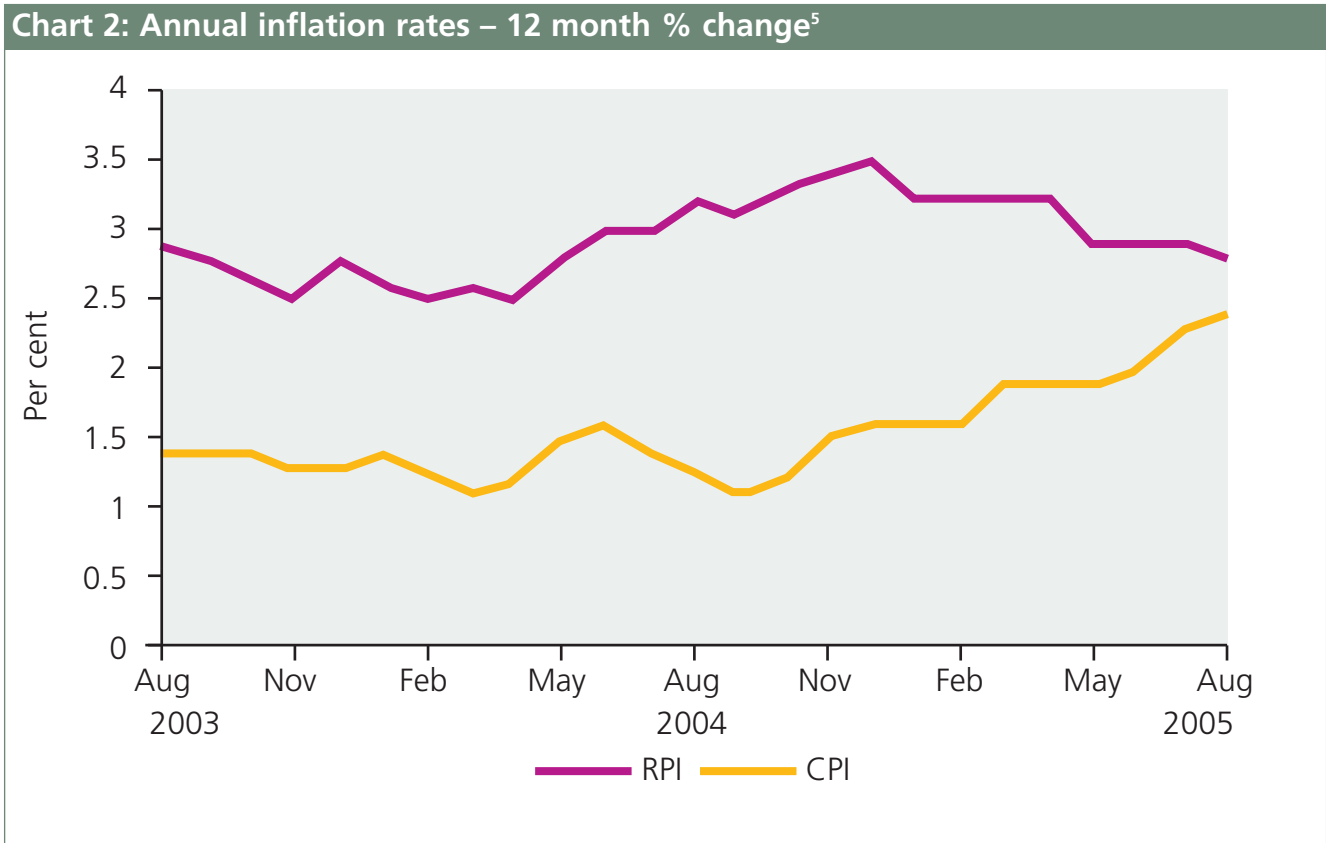
<sup>2</sup> Office for National Statistics  
<sup>3</sup> Office for National Statistics

- 2.14. The higher rate of growth in the public sector is a consequence of two factors: first, the extra payments and new salary structures to actively solve recruitment and retention problems for key workers; and second, the extra money beyond basic pay increases resulting from pay modernisation.<sup>4</sup> In the NHS, therefore, the growth in average earnings has not been derived solely from the 2003/04 to 2005/06 pay settlements but also from access to higher incremental ranges by way of Agenda for Change which will continue to raise average earnings until the new system reaches maturity.
- 2.15. Given that pay modernisation in the NHS is nearing completion and most staff have witnessed significant increases in their earnings over the period, it seems unrealistic to assume that future pay uplifts would be anywhere near the current level of earnings growth experienced in the public sector. An uplift in line with inflation and current pay settlements would seem more appropriate.

## Inflation

- 2.16. In addition to the figures on average earnings growth, it is important to consider the impact of both current and future inflation levels.
- 2.17. The Consumer Price Index (CPI) annual inflation, the Government's target measure, rose to 2.4 per cent in August, from 2.3 per cent in July. This was the highest CPI figure since the start of the official series in January 1997 and is mainly a result of a large increase in petrol prices, reflecting movements in crude oil prices.
- 2.18. As an internationally comparable measure of inflation, the CPI shows that the UK inflation rate is slightly above the average for the European Union as a whole. A provisional figure for the inflation rate for the enlarged EU 25 in July was 2.1 per cent, compared with the UK figure of 2.3 per cent in July.
- 2.19. The Retail Price Index (RPI) inflation rate fell slightly in August to 2.8 per cent, from 2.9 per cent in July. This was mainly due to a downward influence from housing components excluded from the CPI. RPIX inflation, the all items RPI excluding mortgage interest payments, fell slightly to 2.3 per cent in August, from 2.4 per cent in July.

<sup>4</sup> Incomes Data Services Ltd, August 2005: IDS Pay Report 935



2.20. Evidence from the July IDS pay report shows that RPI inflation is forecast to slow down towards 2 per cent by the end of 2005 and then stabilise at around that rate for much of 2006. The main factors affecting this are stagnant or falling house prices and slower economic growth.

**Financial situation in the NHS**

2.21. The 2004 Spending Review set spending plans to 2007/08 that protected increased resources delivered in previous Spending Reviews. The expenditure plans as set out in Table 1 represent an annual average increase of 7.1 per cent in real terms between 2005/06 and 2007/08 – a total increase of 23 per cent in real terms over the period.

**Table 1: Planned net NHS expenditure (England)<sup>6</sup>**

	Net NHS spending (£billion)
2005/06	76.4
2006/07	83.8
2007/08	92.1

5 Office for National Statistics

6 Department of Health: Departmental Report 2005

- 2.22. No money within the departmental budgets is specifically allocated to spend on annual pay increases. The pay bills are met at a PCT level from the overall allocation of funding for PCTs. Therefore, any further large increases in pay will have an effect on the amount available for PCTs to spend on additional services.
- 2.23. Views from NHS employers indicate that there are real concerns over the affordability of the current position. A recent survey by the NHS Confederation revealed that 93 per cent of NHS chief executives do not believe the current workforce reforms are affordable.
- 2.24. The Department of Health is currently in the process of conducting a review of the cost impact of Agenda for Change on the NHS. The analysis covers a sample of 28 organisations, one from each strategic health authority area, and covers the full breadth of organisations in the NHS, excluding foundation trusts. The aim of this exercise is to analyse whether the actual costs of implementing Agenda for Change fall within the initial evaluation of the cost and the amount of funding provided to trusts.
- 2.25. The NHS star ratings, recently published by the Healthcare Commission, reported that almost a quarter of all trusts failed the key target on financial management to break even by year end (2004/05). This resulted in a total overspend of almost £500 million. While this is small for the overall budget of the NHS, it is significant for some individual organisations. 24 per cent of PCTs failed to achieve financial balance, with one in three acute trusts also failing on this measure. For the first time in four years there was a fall in the number of acute hospital trusts with three stars, partly reflecting difficulties in meeting the indicator relating to financial performance.
- 2.26. Future policy developments in the NHS may also increase the financial pressure on organisations from 2005/06. Examples of this include the implementation of Payment by Results and the new commissioning arrangements.
- 2.27. Given the evidence above, we would ask the Review Body to consider carefully the impact that any pay increase deemed unaffordable by NHS employers would have on an already difficult financial position.

### **Proposal for uplift**

- 2.28. Responses to the questionnaire issued by NHS Employers indicate that the majority view was that a pay award in excess of 2.5 per cent (in line with inflation forecasts) would be deemed unaffordable by the NHS.
- 2.29. A minority of respondents indicated that no pay award would be affordable and that any pay increase would cause significant problems given the current funding deficits.

- 2.30. Most respondents indicated that a pay award higher than 2.5 per cent would have detrimental consequences and would lead to a deferment of developments coupled with workforce reductions (through natural wastage or vacancy freezes) and service reconfiguration to reduce costs. Most organisations with deficits are already working towards driving out inefficiencies and have recovery plans and cash releasing efficiency saving (CRES) programmes in place.
- 2.31. The common view from employers in the NHS is that most resources should be spent on a generic pay award for all NHS staff. Employers are almost unanimous in their agreement that both medical and non-medical staff should receive the same level of generic award. They feel that equity is particularly important in valuing all parts of the workforce and that there should be greater convergence between the two pay systems.
- 2.32. In relation to more targeted awards there is some feeling amongst employers that Agenda for Change needs time to bed down properly before the need for more targeted awards can be identified. They also feel that enhancements are already available to compensate for geographical differences and more targeted awards, via recruitment and retention premia.
- 2.33. In addition, a multi-year award would be looked on favourably by employers. Provided it was at an affordable level, they feel it would help create a climate of stability which will assist service and financial planning, and will remove the element of doubt from staff and their representatives about the level of forthcoming pay awards.

## Conclusion

- 2.34. The current evidence shows signs of an economic slowdown in the economy with average earnings falling, pay settlements remaining stable and inflation forecast to fall towards the end of the year.
- 2.35. Affordable pay settlements are necessary to ensure the current financial position in the NHS does not worsen. A pay uplift of 2.5 per cent in line with inflation targets is the most that could be supported by employers in the NHS.

## 3. Agenda for Change

### Introduction

- 3.1. Since December 2004, the NHS has been implementing Agenda for Change – the most significant reform of pay since the creation of the NHS in 1948. The NHS has been working to implement the new pay system to the timetable agreed by the NHS Staff Council in November 2004. This has been an enormous change management exercise, and employers working in partnership with local staff-side representatives are moving towards assimilation of around 1.3 million staff onto Agenda for Change.

### NHS Employers' role

- 3.2. NHS Employers' general responsibilities in respect of Agenda for Change are:
- to conduct any required national negotiations
  - to support employers at local level with appropriate advice and guidance and to articulate the aspirations of and concerns of employers; and
  - to support the NHS in the implementation of the new pay system.
- 3.3. Specifically, we have responsibility for:
- providing advice on implementation based on the experiences of NHS organisations
  - supporting the work of any sub-committees of the NHS Staff Council such as those on Job Evaluation, the Knowledge and Skills Framework, Health and Safety and Equalities and Diversity
  - conducting a review of unsocial hours payments
  - negotiating any new arrangements. Negotiations are now led by NHS managers supported by NHS Employers staff.
- 3.4. It is not the role of NHS Employers to performance manage NHS organisations over the implementation of Agenda for Change. The performance management role remains with strategic health authorities (SHAs) and the Department of Health at national level.
- 3.5. NHS Employers remains committed to working in partnership with the NHS staff-side organisations and the Department of Health to ensure that the Agenda for Change agreement is successfully implemented. Partnership working is a fundamental theme of Agenda for Change, which applies at all levels from local to national. The parties on the newly established NHS Staff Council and its executive continue to work constructively to resolve issues as they arise.

## New remit for the Review Body

- 3.6. The Agenda for Change agreement is intended to apply to all directly employed NHS staff except the most senior board-level managers and medical and dental staff.
- 3.7. We recognise the new agreement means an extended remit that requires the Review Body to make recommendations on the remuneration of all health professionals and their support staff who are directly employed in the NHS. Healthcare scientists, pharmacists, psychologists, speech and language therapists and ambulance paramedics, amongst others, are added to your remit group.
- 3.8. Your revised remit requires the Review Body to take into account the principle of equal pay when making its recommendations. The consequence of this is that, in order to maintain the integrity of the pay bands and ensure equal pay, the agreement requires that the general pay uplift for staff covered by the Review Body will also have application to staff outside the remit. Employers would, therefore, ask that when considering issues of financial impact your recommendations take account of this.

## Background

- 3.9. Implementation of Agenda for Change began in 12 NHS organisations in England in June 2003. The experience of these early implementer (EI) sites was monitored and reviewed by the Agenda for Change partners. The review, which took account of the findings of the Review Body's report on early implementation, found that most parts of the system had worked well and that managers and staff were generally positive about its impact. However, given a change of this magnitude and complexity, a number of issues were identified during the EI phase which meant some changes were negotiated before the final collective agreement was reached and endorsed by the NHS Staff Council in November 2004.
- 3.10. National roll-out of Agenda for Change began on 1 December 2004, with pay and most terms and conditions backdated to 1 October 2004. The aim is for staff to be assimilated, except for those who choose to remain on local contracts, by 30 September 2005.
- 3.11. The system of unsocial hours payments tested in the EI sites was found to have significant weaknesses. This was based on agreeing unsocial hours patterns in advance, paying them at fixed rates based on broad payment bands, and staff then working flexibly within those bands.

- 3.12. NHS employers reported that the system was difficult to apply effectively at local level especially in securing cover for some shifts where working patterns were very variable and there were pressures on overall staffing. The concerns of staff in relation to rewards for covering extra shifts and managers in relation to covering shifts at short notice and the misuse of rota systems was noted by the Review Body in their report: *Key lessons learned from the early implementers of Agenda for Change in England 2003* (May 2004).
- 3.13. The final agreement on Agenda for Change (November 2004) committed the unions and employers to reviewing the system of unsocial hours payments and to agreeing and implementing a harmonised replacement system by April 2006. In order to allow sufficient time for the review, the unions and employers agreed an 'interim regime' of payments based upon existing Whitley arrangements (allowing existing payments to continue) to be effective until a new system has been agreed.
- 3.14. A three-year pay deal which delivered pay increases on the old Whitley pay scales of 3.225 per cent to cover the years 2003/04, 2004/05, 2005/06 was agreed alongside the decision to implement Agenda for Change. This has ensured above inflation increases for your remit group over this period.

### Progress on implementation

- 3.15. Since December 2004, NHS managers and staff representatives have been working in partnership on the matching and assimilation process to ensure the new pay system is implemented according to the final Agenda for Change agreement reached by the NHS Staff Council.
- 3.16. It is important to recognise the enormous challenges faced by NHS organisations as they assimilate staff to the new system; NHS Employers is working closely with all key stakeholders including the Department of Health to support organisations and help facilitate a smooth transfer to the new system.
- 3.17. At the end of August, 78.3 per cent were already matched to their Agenda for Change pay band and 58.6 per cent had been assimilated to their pay band and have received any back pay to which they were entitled. NHS Employers recognises that having over 541,312 staff on the new pay system in ten months is a considerable achievement for the NHS, with local management and staff representatives working hard to complete job evaluations and develop Knowledge and Skills Framework (KSF) outlines. It is recognised that the task will not be finished in all organisations by the original target date of 30 September, and NHS Employers is working with the Department of Health and trade unions on the development of a managed process for completion of assimilation.

## Job evaluation

- 3.18. The Job Evaluation Scheme (JE) has been extensively tested and its operation reviewed by independent experts. The review of experience in early implementer sites, undertaken by the national Agenda for Change partners, concluded that the scheme is robust, fair, equality proofed and fit for purpose.
- 3.19. A number of modifications and improvements to the scheme and associated processes have been agreed and an updated *Job evaluation handbook* has been published to support national roll-out.
- 3.20. There are now over 330 national job profiles on the Computer Aided Job Evaluation (CAJE) system. For all posts not covered by a national job profile, trusts have been advised to carry out local job evaluations.

## Knowledge and Skills Framework

- 3.21. Integral to the new pay system is the NHS Knowledge and Skills Framework (KSF) and the Development Review Process. The Agenda for Change agreement outlines the requirement for the NHS KSF to be applied to all NHS jobs covered by the agreement no later than October 2006.
- 3.22. NHS Employers will continue to work with the KSF Group (a sub-committee of the NHS Staff Council) to support the implementation of this important element of the Agenda for Change system. This includes the population of a national reference library of full KSF post outlines and the generation of further advice and guidance based on practical experience to assist employers with the implementation of this element of the agreement.

## Benefits realisation

- 3.23. The new pay system has been agreed with a view to delivering a variety of benefits for staff and patients. There have been a wide variety of developments that demonstrate the potential for the new system to contribute to deliver these benefits. They include:
  - new roles – for example, assistant practitioners in radiography
  - changing roles
  - extending roles – for example, emergency care practitioners
  - improved team working through harmonisation of terms and conditions – for example, in operating theatres
  - new ways of working
  - over time, improved recruitment and retention.

- 3.24. There is some anxiety among employers that with efforts being concentrated on practical implementation, the wider benefits of pay reform will not be realised. NHS Employers would argue that pay reform is an enabler and a tool to support service modernisation rather than simply an end in itself. It is, however, important that assimilation is delivered without compromising the quality or integrity of the process, or it is likely that organisations will face difficulties in delivering these benefits in the future. Equally, it is unrealistic to expect that those benefits are going to be realised across whole organisations at one time, as it is unlikely to match the organisation's own service modernisation programme. It is important that organisations do utilise the benefits of pay reform as appropriate; NHS Employers will be working with local organisations to ensure that this learning is shared.

### Progress on unsocial hours

- 3.25. A joint sub-group of the Executive of the NHS Staff Council is currently investigating a range of suggestions for the future working of this element of the pay scheme. In accordance with the final agreement, employers and unions need to reach agreement on a new system which is consistent with the principle of equal pay for work of equal value; creates the incentives necessary for the provision of a high standard of service to patients; seeks to avoid the need for pay protection; and is affordable. NHS Employers is responsible for the process and is representing the interests of NHS employing organisations in all the negotiations surrounding it.
- 3.26. The sub-group intends to test options in two stages:
- 'bench testing' – examining in particular the costs and profile of the options in terms of the proportion of staff who would gain against the proportion of staff whose earnings (from unsocial hours) would need to be protected
  - 'live testing' in NHS sites, to confirm the results of 'bench testing' and to establish, so far as is possible from a limited trial, the effect on staff (and middle/line management) behaviours.
- 3.27. The group is proposing that 'live' testing should be confined to individual departments or groups/teams of staff in a range of NHS organisations, to limit the impact on organisations and to make the management of testing and the collection of data easier.
- 3.28. NHS Employers believes that any new system must help employers to make it easier to organise staffing to support increased patient access to high-quality services.

- 3.29. We consider that local organisations must have adequate time to implement new arrangements and do not have time to undertake highly complex calculations for back adjustments of unsocial hours payments. A practical implementation timetable will be essential and if the necessary preparatory work cannot be completed by April 2006, the implementation date will need to be reviewed. The sub-group is discussing the implications if implementation were to start in October 2006.
- 3.30. NHS Employers will keep the Review Body informed of developments on the review of unsocial hours.

## 4. Recruitment and retention

### Headline information

- 4.1. Vacancy survey figures from the Health and Social Care Information Centre show encouraging decreases, as follows:
- Qualified nurses: three-month vacancy rate of 1.9 per cent in March 2005, a decrease from 2.6 per cent in March 2004.
  - Qualified allied health professionals: three-month vacancy rate of 3.4 per cent in March 2005, a decrease from 4.3 per cent in March 2004.
  - Qualified scientific, therapeutic and technical staff: three-month vacancy rate of 2.2 per cent in March 2005, a decrease from 2.6 per cent in March 2004.
- 4.2. Furthermore, the Department of Health *NHS hospital and community health services (HCHS) non-medical workforce census*, as of 30 September 2004, revealed the following:
- Non-medical staff represented 1,101,797 of the HCHS staff. This group has grown by 2.4 per cent a year on average since 1994.
  - There were 543,670 professionally qualified non-medical staff in the NHS, including:
    - 397,515 qualified nursing, midwifery and health visiting staff (including GP practice nurses), representing an increase of 2.9 per cent since September 2003
    - 128,883 qualified scientific, therapeutic and technical staff, representing an increase of 5.6 per cent since September 2003
    - 17,272 qualified ambulance staff, representing an increase of 8.2 per cent since September 2003.
  - A further 368,285 staff worked in support to clinical staff, an increase of 2.1 per cent since September 2003. 303,630 were supporting doctors and nurses; 55,025 were supporting scientific, therapeutic and technical services; and 9,630 were supporting ambulance services.

### NHS Employers recruitment and retention survey

- 4.3. During June and July 2005 NHS Employers conducted a recruitment and retention survey.
- 4.4. Having assumed responsibility for recruitment and retention strategies and NHS Careers from the Department of Health, NHS Employers wanted to give NHS trusts the opportunity to influence the NHS recruitment and retention strategy for the first time, and to ensure that work plans for the forthcoming year are tailored to meet the needs of employers.

- 4.5. The survey was designed to enable NHS Employers to make sure that its priorities are set by the organisations it serves and to inform a detailed picture of the recruitment and retention issues faced by individual trusts.
- 4.6. The survey was designed by NHS Employers working with NHS Partners Research and Information – a professional HR research and consultancy organisation. A paper-based survey was sent to 452 HR leads within the NHS, with an option to complete the survey on-line.
- 4.7. 155 surveys were returned to NHS Partners Research and Information in early July 2005, giving a response rate of 34 per cent. Responses were received from all different types of NHS organisations.

### Views from the NHS

- 4.8. Employers report that recruitment and retention is generally improving or remaining stable and is helped by a fall in staff turnover in most areas. There are, however, some concerns in particular professional groups. Employers indicated that the top two positions that were hardest to fill were for allied health professionals (AHPs) (66 per cent) and nursing and midwifery (62 per cent).
- 4.9. National shortages were identified within radiography, senior physiotherapists, midwifery and mental health nursing. There are also some geographical variations.
- 4.10. The main reason given for difficulties in filling posts is a lack of experienced senior/specialist staff.
- 4.11. 43 per cent of responding organisations indicated that they were over-subscribed with applications for vacancies. Nursing and midwifery (39 per cent) and AHPs (28 per cent) were second and third on the list for groups for which there is over-subscription of applicants, with the wider healthcare team being first. The main reason given for over-subscription (and the apparent contradiction with the findings of recruitment difficulties with these groups) was the availability for more newly qualified applicants than available junior posts.
- 4.12. Overall, it is thought that national recruitment and retention premia are not always appropriate, since the most common cause of a national shortage is the lack of trained and experienced staff rather than the inability to attract them to the NHS. It is also reported that national recruitment and retention premia are only useful where there is widespread competition with non-NHS organisations, which is seldom the case with your remit group.

- 4.13. International recruitment has also been a useful vehicle for maintaining workforce numbers, with 53 per cent of respondents to the NHS Employers recruitment and retention survey indicating that they use international recruitment. Of these, 91 per cent were using international recruitment for nurses, 43 per cent for AHPs and 23 per cent for radiographers.
- 4.14. Employers indicate that in the current climate of challenging recovery plans, a higher than expected and unfunded pay award would lead to extended vacancies and freezing of posts with a subsequent reduction of services and developments. Indeed, in the recent recruitment and retention survey by NHS Employers, 10 per cent of respondents were anticipating redundancies in the next 12 months, most likely to be managers (43 per cent) and the wider healthcare team (30 per cent). A further 25 per cent indicated the potential for redundancies. This is against the backdrop of 39 per cent of respondents indicating that they had had recruitment freezes in the last 12 months of which nursing and midwifery (45 per cent) and AHPs (33 per cent) were two of the main groups.

### **Improving Working Lives**

- 4.15. Non-pay solutions can be as important as pay in improving recruitment and retention – especially the introduction of flexible working practices. Trusts report that good line management goes a long way to support retention; sometimes this is irrespective of what someone could earn elsewhere.
- 4.16. Initiatives under the Improving Working Lives (IWL) banner have been well received and many trusts cited positive staff survey reports. Flexible working, education, training and development and childcare provisions are the areas of IWL which appear to have had the most significant positive effects on retention. This is discussed further in section 5.

## 5. Morale and motivation

### Employer views

- 5.1. Many NHS employers report positive signs that the morale of staff working in their organisations is improving. Progress has already been made towards creating a culture of effective communication – NHS employers are listening to staff and responding to their legitimate concerns and aspirations.
- 5.2. NHS employers recognise that investment in staff is also investment in patient care. Many employers reported that the Improving Working Lives (IWL) standard has had a positive impact on staff morale and motivation, enabling them to tackle issues at a local level to ensure that staff are supported and developed. Flexible working, in particular, was cited as a positive benefit for the NHS and the majority of staff. For example, employers have reported some retention gains as a result of this initiative, whilst other employers have said that staff involvement has improved and offered opportunities to influence how money is being spent.
- 5.3. Within the IWL framework employers are also helping staff to achieve a healthy work–life balance by introducing modern employment practices such as:
  - childcare provision and support for carers in the workplace
  - flexible careers
  - flexible retirement
  - improved access to training and development
  - healthy workplaces
  - staff involvement
  - partnership working.

### The NHS Staff Survey

- 5.4. The second national survey of NHS staff was conducted by the Healthcare Commission during October and November 2004. The survey results show improvements in terms of staff satisfaction and some elements of IWL such as childcare support. Overall, the results showed:
  - 73 per cent were generally satisfied
  - 93 per cent had received training and development opportunities in the previous 12 months
  - good results in team working (93 per cent) and personal development planning (51 per cent).
- 5.5. Results from the survey will enable each NHS organisation to inform local improvements in working conditions and practices and can also be used by employers to compare themselves to other similar NHS organisations.

5.6. The tables below are extracts from the Healthcare Commission NHS Staff Survey which give a more detailed breakdown for staff in your remit group.

<b>Some examples of the tables from the Healthcare Commission NHS Staff Survey 2004</b>				
	<b>Job satisfaction</b> What is the extent to which my employer values my work		<b>Job satisfaction</b> I have the freedom to choose my own methods of work	
<b>Breakdown by group: all trusts</b>	<b>Very satisfied/satisfied %</b>	<b>Very dissatisfied/dissatisfied %</b>	<b>Very satisfied/satisfied %</b>	<b>Very dissatisfied/dissatisfied %</b>
Nurses (inc midwives, health visitors etc)	45	26	65	12
Healthcare assistants/auxiliary nurses	52	21	60	11
Allied health professionals	45	24	75	8
Scientific and technical	48	23	75	9
Paramedics	36	37	65	12
Ambulance technicians	23	38	44	21
	<b>Job satisfaction</b> I get support from my immediate manager		<b>Job satisfaction</b> I get recognition for good work	
<b>Breakdown by group: all trusts</b>	<b>Very satisfied/satisfied %</b>	<b>Very dissatisfied/dissatisfied %</b>	<b>Very satisfied/satisfied %</b>	<b>Very dissatisfied/dissatisfied %</b>
Nurses (inc midwives, health visitors etc)	60	18	45	26
Healthcare assistants/auxiliary nurses	64	16	51	24
Allied health professionals	64	17	45	25
Scientific and technical	63	18	50	24
Paramedics	49	23	36	38
Ambulance technicians	40	32	27	41

**Some examples of the tables from the Healthcare Commission NHS Staff Survey 2004**  
 (cont)

Breakdown by group: all trusts	Flexible working My immediate manager helps me find a good work-life balance		Appraisals Did your appraisal or performance review leave you feeling your work was valued?	
	Strongly agree/agree %	Strongly disagree/disagree %	Yes %	No %
Nurses (inc midwives, health visitors etc)	54	18	77	23
Healthcare assistants/auxiliary nurses	59	15	80	20
Allied health professionals	56	15	78	22
Scientific and technical	54	15	77	23
Paramedics	43	28	63	37
Ambulance technicians	32	39	61	39

**Some examples of the tables from the Healthcare Commission NHS Staff Survey 2004**  
(cont)

	Personal development plans In the past 12 months, did you agree a PDP plan with your manager?		Training In the past 12 months, have you received any training? Taught courses internal and external	
	Yes %	No %	Yes %	No %
<b>Breakdown by group: all trusts</b>				
Nurses (inc midwives, health visitors etc)	59	41	81	19
Healthcare assistants/auxiliary nurses	51	49	64	36
Allied health professionals	65	35	85	15
Scientific and technical	53	47	76	24
Paramedics	49	51	80	20
Ambulance technicians	29	71	73	27

## 6. Pensions

### General comparisons

- 6.1. NHS Employers is reviewing the NHS Pension Scheme with the trade unions. This review is about to go into a new phase with the commencement of scheme-specific negotiations across all public service pension schemes. This may lead to changes in the pensions package available to staff. One of the key issues that will be addressed is the Government's proposal to increase the normal pension age to 65 (NPA65). Regardless of the outcome of those discussions, the NHS Pension Scheme will remain a defined benefit (DB) arrangement offering an excellent package of benefits.
- 6.2. These are considerably better than what is available in the private sector where pension arrangements, where offered to new entrants, are typically on a defined contribution (DC) basis with a lower employer contribution than for the NHS scheme. Most private sector defined benefit arrangements have closed to new entrants.
- 6.3. The Government Actuary's Department's (GAD) Survey of Occupational Pensions 2004 found that the average employer contribution for DC pensions in the private sector was 6 per cent. NHS employers pay 14 per cent. NHS staff pay 6 per cent of salary compared with an average of 3.7 per cent for DC schemes and 4.9 per cent for private sector DB schemes.
- 6.4. The Pensions Policy Institute study of occupational pension provision in the public sector found that standard public sector benefits such as those received by NHS staff were worth up to 6 per cent of salary more than typical private sector DB schemes. This figure increased significantly when compared with those in DC arrangements or having no pension arrangements (up to 20 per cent). Even if NPA65 is introduced, public sector schemes such as the NHS scheme will still be worth 3–18 per cent of salary more than private sector comparators.
- 6.5. GAD found that there are now a larger number of public rather than private sector workers in DB schemes (5 million active members in the public sector compared to 4.8 million in the private sector) even though public sector workers only make up a quarter of the workforce.
- 6.6. It has been argued that higher value pension schemes in the public sector compensate for lower pay rises. It is extremely difficult to assess whether public sector workers are being paid more or less than private sector workers because of problems with comparing occupations, hours worked and so on. The Labour Force Survey 2004 found that graduate pay levels are not lower for public than private sector workers in almost all regions of the country with the exception of London, the East and South East.

- 6.7. Arguably, in the past the value of pensions has not been recognised by staff or employers and their value in recruiting and retaining staff has been less than might be expected given the level of investment. Public awareness of the cost of pensions and the need to save more for retirement means that staff now have a better understanding of the value of the NHS pensions package. The considerable benefit that pensions represent, and the guaranteed continuance of DB arrangements in the NHS at a time when the private sector now generally offers only DC arrangements, is expected to have an increasingly positive impact on recruitment and retention.


### **Pensions as a component of pay**

- 6.8. NHS Employers agrees with the trade unions that pensions are deferred pay. It is important when considering appropriate levels of remuneration to look at both current and deferred pay. The proportion of pay currently deferred to pay for pensions is 20 per cent of pensionable payroll of which staff pay 6 per cent and employers 14 per cent.
- 6.9. GAD is currently conducting its four-yearly valuation of the NHS Pension Scheme. The Government Actuary will make a recommendation about the level of contribution required for the next four years.
- 6.10. NHS Employers believes that the review bodies should take into account pension costs of both employers and employees when considering levels of pay increases. Any increases in employers' contributions are an increase in deferred pay and should be seen as part of any overall pay award. So if, for instance, the Government Actuary recommended an increase in the employers' contribution rate, this needs to be considered alongside any pay recommendation.

# Annex A

## Pay Review Body Questionnaire



A part of the NHS Confederation  
working on behalf of the 

**To: NHS trust chief executives**

**CC: Trust HR directors  
Strategic health authority chief executives**

### **Evidence to Pay Review Bodies 2006/07 Questionnaire seeking NHS employer views**

NHS Employers will be submitting evidence on your behalf to the Doctors and Dentists Review Body (DDRB) and the Review Body for Nursing and Other Health Professions (NOHPRB) and the Pay Negotiating Council in September 2005 for the 2006/07 pay round.

During the period 2003/04 to 2005/06 a three-year pay deal has been in place for the majority of NHS staff. The agreement, which awarded 10 per cent over three years (at 3.225 per cent each year), has provided wage stability and certainty during a period of pay reform for the majority of staff.

The NHS Confederation historically has submitted evidence to the Review Bodies based on advice from its HR Committee. This role has been subsumed by NHS Employers which has taken on some responsibilities for producing evidence from the Department of Health.

We envisage that employers' evidence will be fuller than in the past. In addition to recommendations on rates of pay, it will contain: updates on the latest position on Agenda for Change; juniors' hours and their contracts; progress with contract negotiations on non-consultant career grades; and contract issues relating to consultants, GP registrars and salaried GPs. It will also contain employer views on pay and workforce issues such as recruitment retention and return.

Our evidence may also need to reflect a diversity of views and opinion. However, it must support both with evidence as the Review Bodies have in the past been critical of unsupported assertions and tend to disregard them. The evidence will be submitted on behalf of employers in England only.

This questionnaire gives service managers the opportunity to make their views known and help us provide sound evidence-based argument. After receiving your evidence we will collate it into a representative report and assess what scope there might be for joint evidence with NHS unions and staff organisations. That process will take place during July and August.

Your views are very important. Please consult with your networks locally to obtain as broad a consensus as possible. Separate attachments may be returned with the questionnaire.

Please return this questionnaire to: [payreview06@nhsemployers.org](mailto:payreview06@nhsemployers.org)  
by Wednesday 22 June 2005

# Evidence to Pay Review Bodies 2006/07

## Questionnaire seeking NHS employer views

### Priorities for the 2005/06 pay round

Please enter your responses in the box below the question. Boxes will expand as you type.

#### 1. Affordability/finance

- 1.1 What level of pay award (excluding incremental steps) could be deemed affordable for 2006/07? Please express this as a percentage increase to your pay bill.

- 1.2 What would be the impact on services of a higher pay award than expected? Please give examples: e.g. effect on bed capacity, planned recruitment or planned service developments.

#### 2. Distribution of awards

- 2.1 Would you agree that we should aim to reach joint agreement with staff organisations for a multi-year award?

If so, please state preference for a two-year or a three-year arrangement given that NHS funding has been indicated for 2006/07 and 2007/08 only.

- 2.2 Should the majority of resources be spent on a generic award (a percentage pay uplift for all staff), or a targeted award (e.g. as regional pay, national recruitment and retention premium, London weighting or high-cost area payment)?

- 2.3 Do you think that the same generic level of award is desirable for both doctors and Agenda for Change staff?

### 3. Contract specific issues

3.1 Consultant contract – are there any structural pay related issues to report (on either the 2003 contract or its predecessor)? Please state which contract you are commenting on.

3.2 Contracts for doctors in training (including GP registrars) – do you have any evidence about the operation of the current banding system as hours of work reduce in the run up to 2009?

3.3 Pay range for employed GPs – is the current range adequate/appropriate? Can you provide evidence to support its use in practice?

### 4. Shortage groups – recruitment and retention

4.1 Is the recruitment situation improving or deteriorating and what is the evidence for this?

4.2 Which staff groups have the worst recruitment and retention problems? (please be as specific as possible, e.g. 'school nurse' rather than 'nurse').

4.3 Are staffing shortages/recruitment difficulties in the groups named above local, regional or national?

4.4 Would a national recruitment and retention premium help employers to compete in external labour markets for any of these groups?

4.5 Retention problems – what are the reasons for staff leaving the service? What proportions go to: a) other NHS employers b) work outside the NHS c) retire?

4.6 If you have difficulties with recruitment and retention locally, what action are you taking to improve recruitment and retention at local level?

4.7 What are the trends in use of agency staff – higher or lower use – and what are the reasons for this a) for doctors b) for nurses c) for other staff?

## 5. Evidence of benefits from pay modernisation

5.1 Have you been able to introduce new working practices as a result of pay modernisation? (please provide examples)

## 6 Morale/motivation issues

6.1 What has been the impact of Agenda for Change implementation on staff?

6.2 What has been the impact of the consultant contract on the consultant body?

6.3 Is there evidence of improvements from the Improving Working Lives initiative? Please describe the initiative and the effect on staff.

6.4 Do you have evidence of other non-pay solutions that are working?

For example: changes to terms and conditions of service such as reduced hours or extended leave.

**7. Foundation trusts**

7.1 Are there any special issues that are of relevance to foundation trusts, which have not been covered above?

**8. Other comments**

8.1 Please add below any other comments/evidence you wish to put forward. Evidence may be attached as separate documents.

This evidence is submitted on behalf of: .....

.....NHS trust/SHA or network

Contact name:..... Position: .....

Telephone number:..... e-mail: .....

## Contact us

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