Staff Side Evidence to the NHS Pay Review Body 2016-17 [1]

1 Introduction

1.1 The NHS trade unions are pleased to make a submission to the Pay Review Body for the 2016/17 pay round and confirm their general commitment to the pay review body process of pay determination for the Agenda for Change workforce.

1.2 However, we highlight the fact that the submission is being made in the absence of a remit letter from the departments of health across the four UK countries. This is a regrettable situation and this omission, together with the Treasury's continued policy of public sector pay restraint, reinforces previous Staff Side warnings about risks to the independence of the pay review process.

2 Recommendations

2.1 We call on the Pay Review Body to:

- Make observations on the impact of the continued policy of pay restraint on recruitment and retention and recommend an uplift that restores the loss in earnings already incurred through cumulative years of below-inflation pay awards
- Make observations on the Treasury proposal to target the pay uplift, by making differential awards for different groups of staff, and consider Staff Side's warnings that targeting would be a difficult endeavour given the paucity of data on vacancies and recruitment and retention problems; the negligible measurable impact of a small pay award as well as the danger of unintended consequences through targeting one group at the expense of others. In particular, we would draw attention to the evidence on the previous use of non-consolidated awards, targeted awards to staff at the top of pay bands and removable progression points. These have been highly unpopular and divisive among NHS staff. Staff Side therefore call for a universal pay uplift as the fairest outcome and one which is expected by NHS staff
- Make observations on the Treasury's call for a renewed focus on progression pay within the context of ongoing talks on the review of Agenda for Change
- Recommend that the NHS should adopt the principle that the NHS across the UK should be a Living Wage employer and for this round should apply the November 2015 Living Wage rate in all four countries, deleting spine points as necessary
- Recommend that the talks on the review of the AfC structure take particular account of the introduction of the Living Wage; country-specific approaches to the Living Wage and how these could be standardised; the prospect of a £9 an hour statutory minimum wage for employees aged 25 years and older by 2020
- Make observations on options for the merging of Bands 1 and 2 as part of the Agenda for Change review
- Press governments in the Wales, England and Northern Ireland administrations to resume collection of vacancy data

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

- Recommend a standard data collection methodology across the four countries building on Scotland's model and extending it to all the main Agenda for Change job families including paramedics, healthcare scientists and technical support roles.
- Recognise the many and interconnected challenges facing the NHS workforce, including increasing use of agency staff, stagnating wage levels, declining morale and motivation and increased staff shortages. Staff Side believes that the situation requires a wide-ranging workforce strategy to tackle these issues as a whole and that the PRB has an important part to play in developing this strategy.

3 Policy and economic context

'Refresh' of the collective agreement

3.1 Settlement of the dispute over the 2014-15 pay settlement for NHS staff in England included an agreement to hold talks on the balance between pay structure, progression and the annual pay uplift. The Staff Council has agreed that these talks will be a broad 'refresh' of Agenda for Change and will be held on a without prejudice basis, with acknowledgement that any potential changes would be subject to wide consultation and democratic agreement within each of the trade unions. As to four-country scope, there will be a 'watching brief' for Scotland, Cymru/Wales and Northern Ireland with a view to those countries making decisions at a later stage about whether or not they wish to implement any changes which may arise. The first topic for talks will be about the architecture of the pay bands and will give Staff Side the opportunity to pursue long-standing issues such as reducing the length of time to reach the full 'rate for the job'; creating better links between pay bands and the JE scheme; and removing pay 'overlaps'.

3.2 Holding these discussions at a time when the Treasury is planning to restrain NHS pay will certainly be challenging and it may well be the case that no changes to structure are possible until members' pay recovers from years of real-terms cuts. However, all the trade unions see the talks as an opportunity to address historic problems with the pay structure and explore whether there are changes we could make to the structure that would benefit both members and the NHS.

3.3 Progress has been made in talks over the summer of 2015, although capacity of all parties is an issue. This may further be affected by the imposition of the Junior Doctors' contract, particularly if key individuals are involved in both sets of contract reform talks.

3.4 The current focus of the AfC structural talks is pay progression, starting with a joint examination of local policies introduced in response to the 2013 flexibilities and a comparison with the systems in place in Scotland, Wales and Northern Ireland.

3.5 Recalibrating the Agenda for Change pay scales on a four country basis, with a coherent system for progression is an ambitious project. Reaching agreement over the philosophy that should underpin pay and progression will be key, and will require consensus among the memberships of all the NHS trade unions; between unions and employers; and then between unions and employers and the Government about potential funding. It is therefore vital that the Staff Council has the space to undertake the talks, which could prove pivotal in the future of NHS pay.

3.6 We would hope that by the conclusion of the pay round for 2016-17, the talks have progressed such that there is clarity about potential future architecture. In this context, targeting pay at particular parts of the current structure would be at best irrelevant and at worst could create further anomalies that would require unpicking in any new system.

3.7 Staff Side view this as a strong argument for a universal recommendation for pay for 2016-17.

Continued support for the Agenda for Change agreement

3.8 Since the NHS Staff Council introduced flexibilities covering Agenda for Change staff in England in 2013, there have been few proposals made by trusts to move away from the collective Agenda for Change agreement at local level. There are still isolated examples where the trade unions at national level have intervened to prevent breaches to the agreement, but our view is that these examples are aberrations arising from reaction to a particular set of financial circumstances in particular trusts, rather than an overt wish from employing organisations to undermine collective agreements and introduce local or regional pay within the NHS.

3.9 The current talks on pay structure may be a factor in continued confidence in and application of Agenda for Change.

3.10 Other medium-term threats to universal application of Agenda for Change to NHS staff (currently, only Southend-on-Sea FT continues to 'opt out') include the increase in subcontracting of NHS services.

Threats to equal pay in the NHS

3.11 What is frequently stated as a real and continued issue for members is the perception of the 'downbanding' of their job roles. In response to a Freedom of Information request exercise in England earlier in 2015, UNISON noted there had been a reduction of one or more band for significant numbers of staff in particular trusts[2]. This is in addition to a 2014 RCN report which found a reduction in senior nursing roles through redundancy, non-replacement retirement, or the downbanding of roles, leading to a dangerous loss of experience and skills that are essential to ensuring patient safety and driving up care standards[3].

3.12 Since 2013, NHS trade unions have worked with employing organisations to ensure that workforce re-profiling is done in accordance with the agreed procedures (Annex X of the NHS terms and conditions of service handbook, introduced as part of the England-only AfC flexibilities).

3.13 If undertaken in accordance with Annex X, the re-profiling process will still leave a 'skills surfeit' where staff are working at a reduced level of responsibility/autonomy/ knowledge. If not done correctly (eg where it is not made clear which current tasks/responsibilities are being reduced or removed) this opens the job evaluation scheme

[2] this information has not been published as it has formed the basis for further exploration of workforce reprofiling

[3] RCN (2014) *Frontline First: More than just a number.* www.rcn.org.uk/__data/assets/pdf_file/0007/564739/004598.pdf

to challenge and risks creating pay inequalities. This will be particularly relevant where re-profiling has taken place within a large group of mostly female staff while other smaller (and potentially male-dominated) groups are not re-profiled.

3.14 Staff Side is keen to ensure that trusts follow the equality and equal pay audit recommendations which accompanied the 2013 flexibilities and we ask the PRB to make an observation about the potential equal pay risks of failing to do this.

Targeting of the pay award

3.15 Staff Side notes the letter to Review Body Chairs from Treasury Minister Greg Hands. It communicates a general expectation that pay awards in England should be 'targeted' within a 1% envelope "to support the delivery of public services and to address recruitment and retention pressures."

3.16 Staff Side makes the following observations:

- It is regrettable that the independence of the Pay Review Body has once again been compromised by the restrictive Government pay policy for the public sector and that the PRB is again unable to make a recommendation based on the full range of evidence, particularly the widening gap between public sector and private sector earnings and recruitment and retention problems in the NHS. We strongly oppose the position imposed on the NHS Review Body and its inability to make an independent recommendation on NHS pay in 2016-17
- With regard to the use of targeting, it would be extremely difficult to construct an evidence base to support differential pay awards for different occupational groups or geographical areas given the current lack of high quality data on vacancies, and on recruitment and retention patterns.
- Recruitment and retention difficulties are highly complex and subject to considerable variation at sub-regional and even very local levels. Targeting of pay awards is at best a blunt instrument in this context.
- The scope for differential awards is extremely limited within a 1% envelope because the size of any higher award will be negligible, while the negative impact on morale of a lower award for some staff could be considerable.
- There is a danger of unintended consequences where a pay measure intended to boost recruitment and retention for one group, has a negative effect on recruitment and retention for another group – for example because it drives more staff in that group to compensate for stagnating pay rates by seeking the higher pay rates available through agencies.
- Previous attempts at targeting have caused confusion and bitterness for hard-working and valuable staff affected by removable progression points, non-consolidated awards, pay and increment freezes. This has caused some employers to apply awards for staff above mid-8c as a measure to boost solidarity, morale and staff retention.[4]

[4] www.hsj.co.uk/news/workforce/three-more-trusts-snub-national-pay-agreement/5090049.article#.VfG2viRwbcs

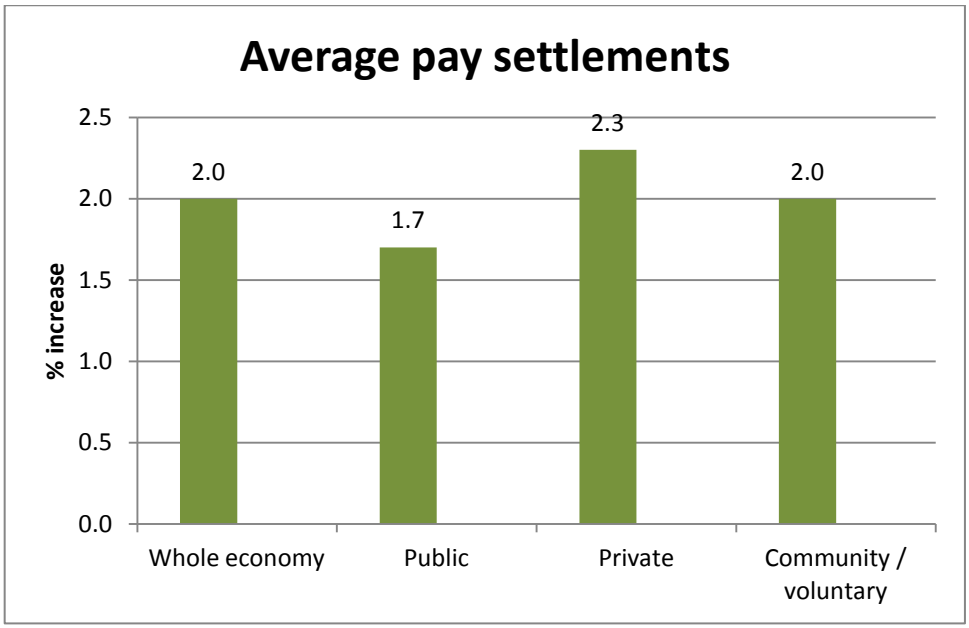
- It is vital that this year there is time and space for the Agenda for Change review talks to progress – any pay award which introduces new differentials or sets up further anomalies would therefore be extremely unhelpful.

4 Pay and Prices

Pay Settlements and Average Earnings

Pay settlement trends across the economy

4.1 Pay settlements across the economy have been running at between 2% and 2.5% over most of the last year. This level of settlements is well below the long-run median of between 3% and 3.5%.



Source: Labour Research Department, settlements over year to July 2015

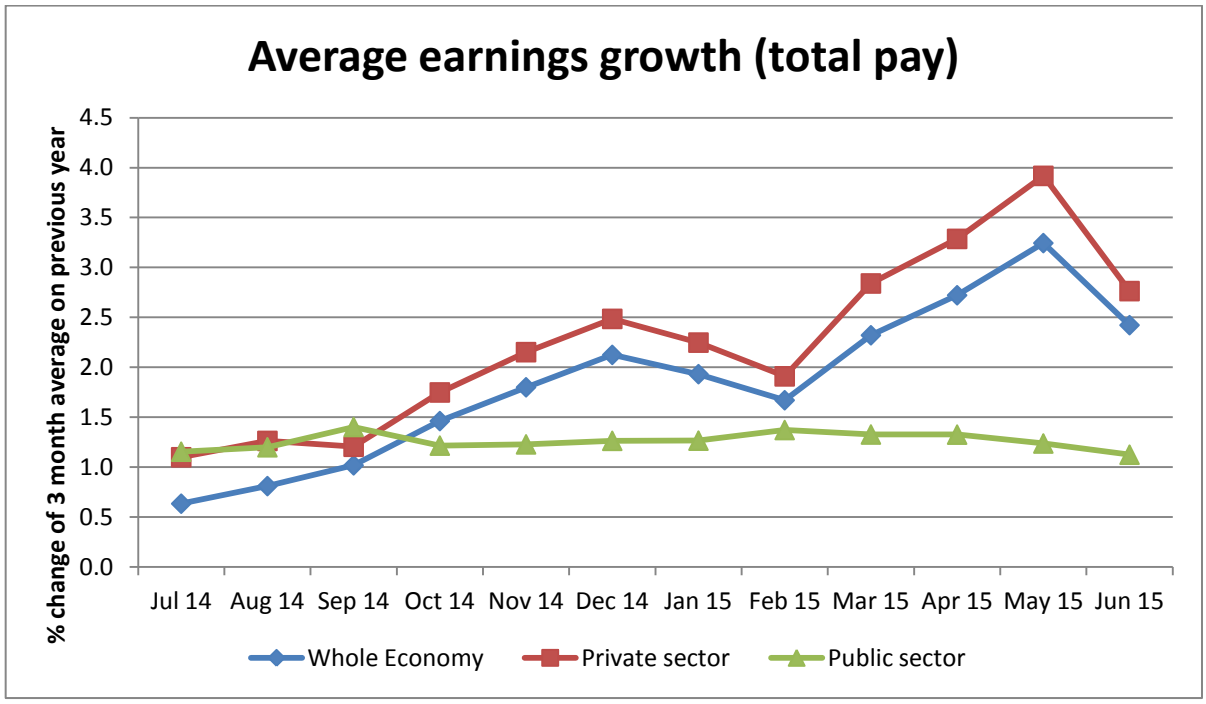
4.2 Since April 2010, a growing gap has opened up between private and public sector settlements. While the public sector has experienced a pay freeze followed by a 1% pay cap, average private sector settlements have frequently been running at 2.5%. However, major public sector deals such as the 2.2% multi-year increase for NJC local government staff in January 2015 have now raised the average recorded across the public sector to 1.7%.

4.3 Private sector rates are predicted to return to rates double that of the public sector over the coming year, with private sector employers expecting settlements of 2% over 2015[5] while public sector rates are forecast at 1% to March 2016 and voluntary sector rates are forecast to average 1.4%[6].

[5] Pay forecasts for the private sector, February 2015, XpertHR
[6] CIPD, *Labour Market Outlook*, Spring 2015 www.cipd.co.uk/hr-resources/survey-reports/labour-market-outlook-spring-2015.aspx

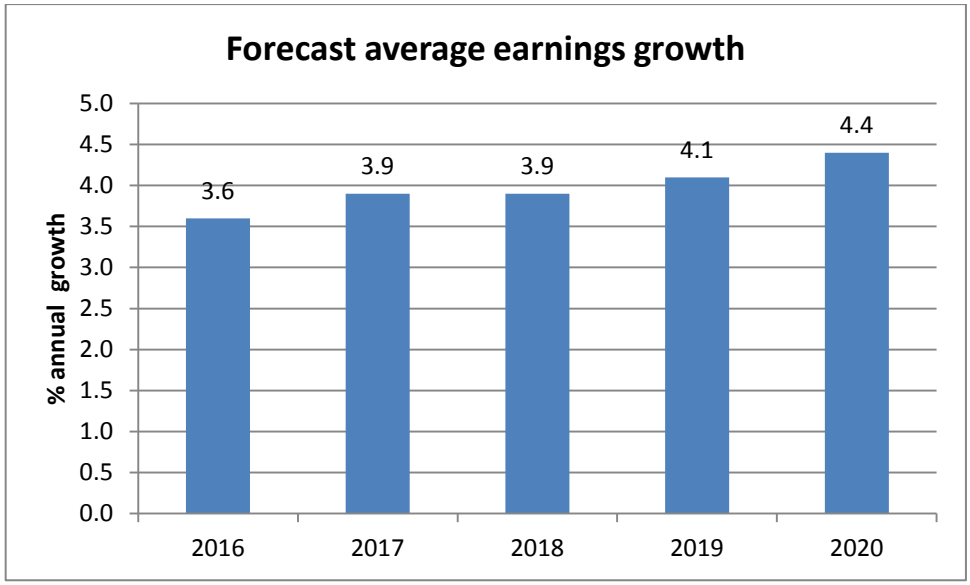
Average earnings trends across the economy

4.4 The graph below shows three month trends in average earnings growth over the last two years. Since April 2013, private sector earnings growth has been running ahead of the public sector every month except two. Over recent months, the private sector rate has accelerated sharply while the public sector rate has flattened out. In June 2015, the rate across the whole economy was 2.4%, private sector growth was 2.8% and average public sector earnings rose by 1.1%.



Source: Office of National Statistics, Labour Market Statistics, August 2015

4.5 Office for Budget Responsbility forecasts of average earnings are that growth will have reached 4.4% in 2020, as set out in the graph below[7].



[7] Office for Budgetary Responsibility (2015) *Economic and Fiscal Outlook July 2015* http://budgetresponsibility.org.uk/economic-fiscal-outlook-july-2015/

Earnings growth by occupation

4.6 The Annual Survey of Hours and Earnings (ASHE) provides data that can form useful comparators for changes in average earnings by occupational group. The table below shows the change in median gross annual pay for full-time staff and with health professionals and associates falling behind most other groups.

Table 1: ASHE data on changes in median gross annual pay for full-time employees

Job Type	Annual % change 2013/14
All employees	**0.1**
Managers, directors and senior officials	0.7
Professional occupations	1.1
Science, research, engineering and technology professionals	0.3
Health professionals	-0.3
Teaching and educational professionals	1.0
Business, media and public service professionals	1.8
Associate professional and technical occupations	0.2
Science, engineering and technology associate professionals	1.0
Health and social care associate professionals	-0.6
Protective service occupations	-0.7
Culture, media and sports occupations	1.4
Business and public service associate professionals	0.7

Loss of tax credits – impact on NHS staff

4.7 For staff on NHS Agenda for Change pay rates and part of a couple claiming tax credits, the impact of the changes to thresholds and the earnings taper from 1 April 2016 will be considerable and painful. On 2015/16 pay rates, the losses extend as far as Band 6 depending on the composition of the household.

4.8 The new ‘national living wage’ of £7.20 an hour for those aged 25 and over from April 2016 will have no effect for NHS staff in 2016 as pay point 2 is currently £7.72 an hour.

4.9 The raising of the tax-free personal allowance from £10,600 to £11,000 in April 2016 is worth an additional £80 a year for staff paying at least basic rate tax in 2015/16. But this will do little to offset tax credit losses which run into thousands of pounds a year for some staff, depending on their hours and family circumstances.

4.10 The tax credit changes apply UK-wide. The examples below show some of the larger losses based on AfC England pay points. For ease of illustration they assume that the NHS

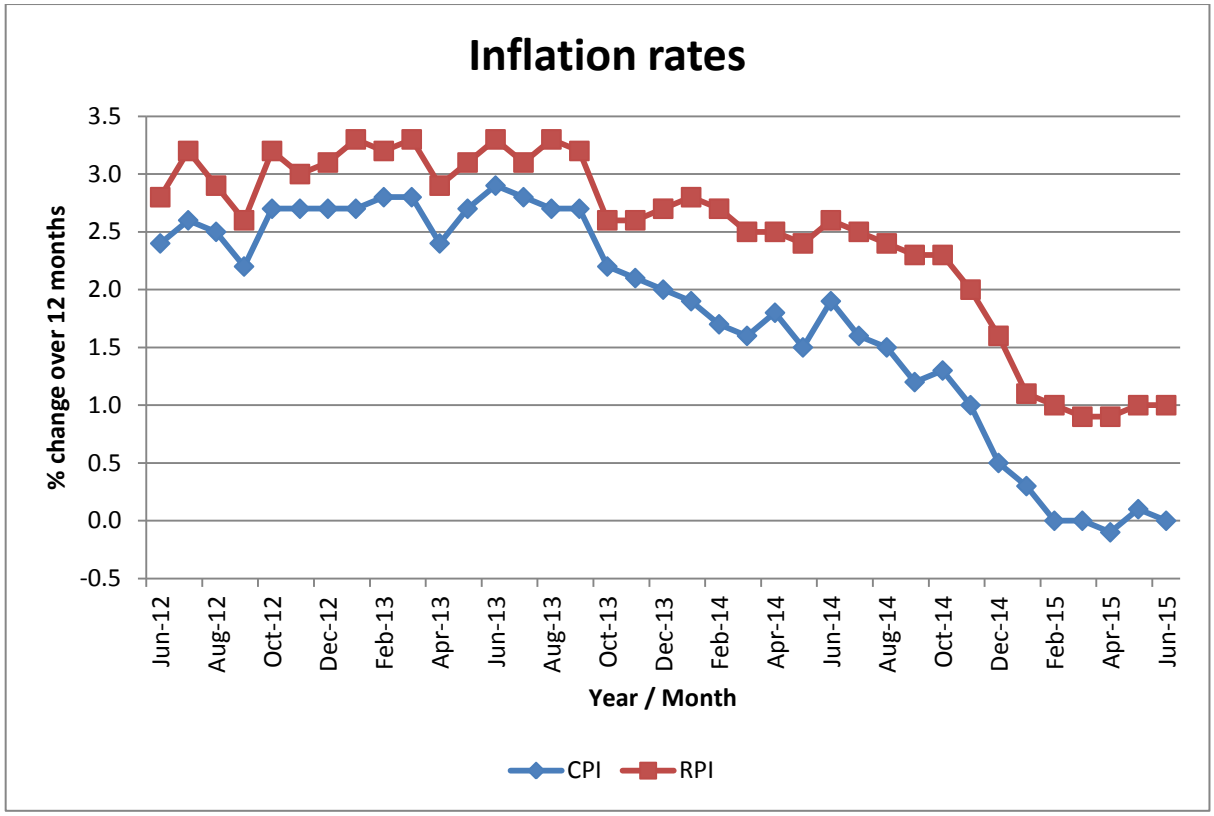
employee is the sole earner when in a household with somebody else of working age. However, where the other person in the household is working, losses will vary as their earnings and hours will be combined for the purposes of calculating tax credits.

Table 2: Impact of tax credit changes

Current AfC band and pay point	Work/family circumstances	Annual loss of income from April 2016
Band 1/2, pay point 3	Working at least 16 hours a week, in a couple and one person qualifies for the disability element OR Working anything over 16 hours a week, in a couple, with one child OR two children OR three children	-£1,859.61
Band 3, pay point 9	Working at least 16 hours a week, in a couple and one person qualifies for the disability element OR Working anything over 16 hours a week, in a couple, with one child OR two children OR three children	-£2,042.24
Band 4, pay point 13	Working at least 16 hours a week, in a couple with one child OR working anything over 16 hours a week with two children OR three children	-£2,194.49
Band 5, pay point 18	Working anything over 16 hours a week, in a couple, with two children OR three children	-£2,403.44
Band 6, pay point 24	Working at least 30 hours a week, in a couple, two children	-£1,609.57
Band 6, pay point 27	Working at least 30 hours a week, in a couple, three children	-£3,030.22

Inflation

4.11 RPI inflation has been running between 2.5% and 3.5% over most of the last three years, but went into sharp decline during the autumn of 2014. The latest inflation figures to June 2015 put RPI at 1% and CPI at 0%.



Source: Office for National Statistics

4.12 Between 2010 and 2014 the cost of living, as measured by the Retail Price Index, rose by a total of 19.8%.

4.13 Although the Consumer Prices index (CPI) is the most widely reported measure of inflation in the UK, Staff Side continues to contend that the most accurate indicator of changes in the cost of living facing NHS workers is the Retail Price Index (RPI) since it includes rises in mortgage payments, rents, and council tax. This is particularly important since the price of housing is one of the biggest issues facing employees and their families. Across the UK, house prices rose by 5.7% in the year to May 2015, while rents rose by 5.6% in the year to June[8].

4.14 In addition, the CPI is less targeted on the experiences of the working population than RPI, since CPI includes non-working groups excluded by RPI – the top 4% of households by income, tourists and most notably pensioner households where 75% of income is derived from state pensions and benefits. Furthermore CPI uses a flawed statistical technique that consistently under-estimates the actual cost of living rises faced by employees[9].

4.15 Given all these issues it is unsurprising that RPI remains the most widely used basis for pay negotiations across the public and private sectors. It is also used in a large number of contracts and in index-linked gilts issued by the Government.

[8] LSL Property Services. *Buy to Let Index*, June 2015
www.lslps.co.uk/news/market-intelligence
[9] www.unison.org.uk/content/uploads/2014/11/TowebMain-findings-Summary-of-Consumer-Price-Indices-Report2.pdf

4.16 While not specifically assessed by CPI or RPI figures, childcare costs represent a key area of expenditure for many NHS staff and one which will become an even more important consideration for staff with the extension of seven day services. The annual Family and Childcare Trust survey for 2015 found that the cost of a part-time nursery place for a child under two has increased by 33% since 2010[10]. Over the last year, a nursery place for 25 hours a week has risen by 5.1% to £6,003 a year. The cost of part-time care from a childminder has also risen by 4.3% to £5,411 a year.

Forecast inflation rates

4.17 The Treasury average of independent forecasts predicts that RPI inflation will rise by 1.1% in 2015, climb to 2.4% in 2016 and then accelerate to 3% or more every year between 2017 and 2018. The medium term forecast put the expected rates at the following levels. If these rates turn out to be correct, the cost of living NHS staff face will have grown by over 13% by the end of 2019. In addition, if inflation reaches above 2%, there is an increasing likelihood that the Bank Rate will increase and consequential mortgage costs will push up the cost of living.

Table 3: RPI forecasts

Year	%
2015	1.1
2016	2.4
2017	3.0
2018	3.2
2019	3.0

Source: HM Treasury Forecasts for the UK Economy, May 2015

Additional cost of living factors affecting NHS staff

4.18 NHS face additional costs due to pension employee contribution increases, rises in professional fees and National Insurance contributions.

Table 4: Pension employee contribution rate increases 2011-2016

Tier	2011/12 %	2012/13 %	2013/14 %	2015/16 %	Total increase before tax relief (%)
1	5.0	5.0	5.0	5.0	0.0
2	5.0	5.0	5.3	5.6	0.6
3	6.5	6.5	6.8	7.1	0.6
4	6.5	8.0	9.0	9.3	2.8
5	6.5	8.9	11.3	12.5	6.0
6	7.5	9.9	12.3	13.5	6.0
7	8.5	10.9	13.3	14.5	6.0

[10] Family and Childcare Trust, *Childcare Costs Survey 2015*
www.familyandchildcaretrust.org/childcare-cost-survey-2015

- Pension contributions have increased for most Agenda for Change staff since 2011/12 as shown in Table 4

- The Nursing and Midwifery Council raised its registration fees by 20% from 1 February 2015, following a 32% rise in February 2013.

- The Health and Care Professionals Council raised its renewal fees by 12.5% from 1 August 2015.

- The General Pharmaceutical Council will raise its fees for pharmacists by 4% from 15 October 2015. The fee for pharmacy technicians will rise by 9%

- From April 2016 defined benefit occupational pension schemes will see an end to 'contracting out' from the state second pension. The impact of this is that the tax relief currently enjoyed by staff will be removed and staff will effectively see a reduction in earnings as they will have to pay an extra 1.4% in National Insurance Contributions for salary between the lower earnings limit and the upper accrual point (£5,824-£40,040 on 2015/16 rates). The table below shows the range of losses for NHS staff using the current NI thresholds, using current AfC rates in England for illustrative purposes.

Table 5: Impact of National Insurance changes

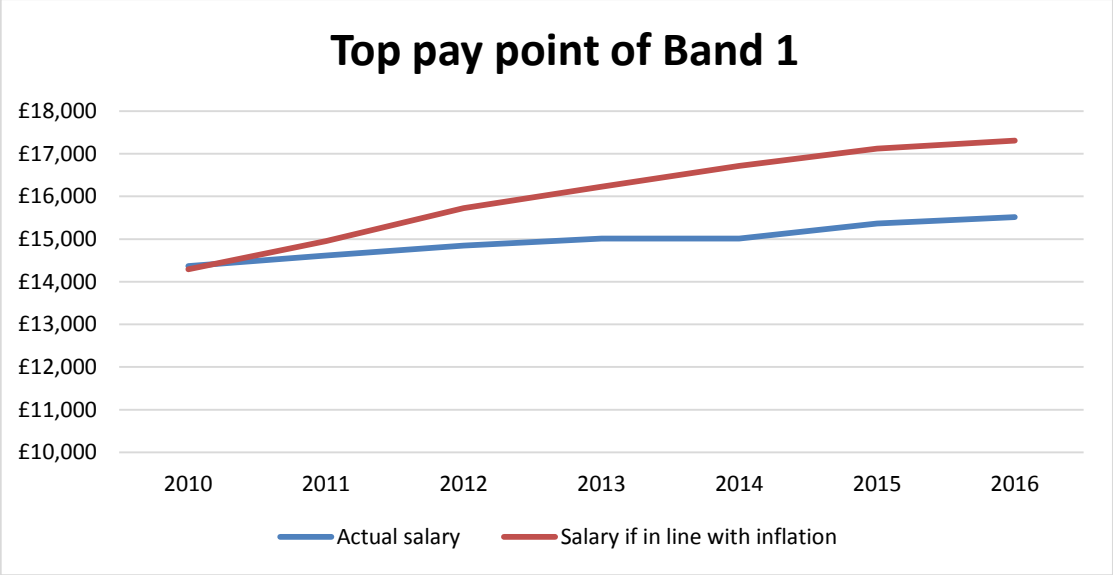
Pay point (AfC England)	**£pa**	**Reduction in take-home pay pa**
2	£15,100	£129
3	£15,363	£134
12	£19,461	£191
23	£28,180	£313
34	£40,964	£479
52	£89,640	£479

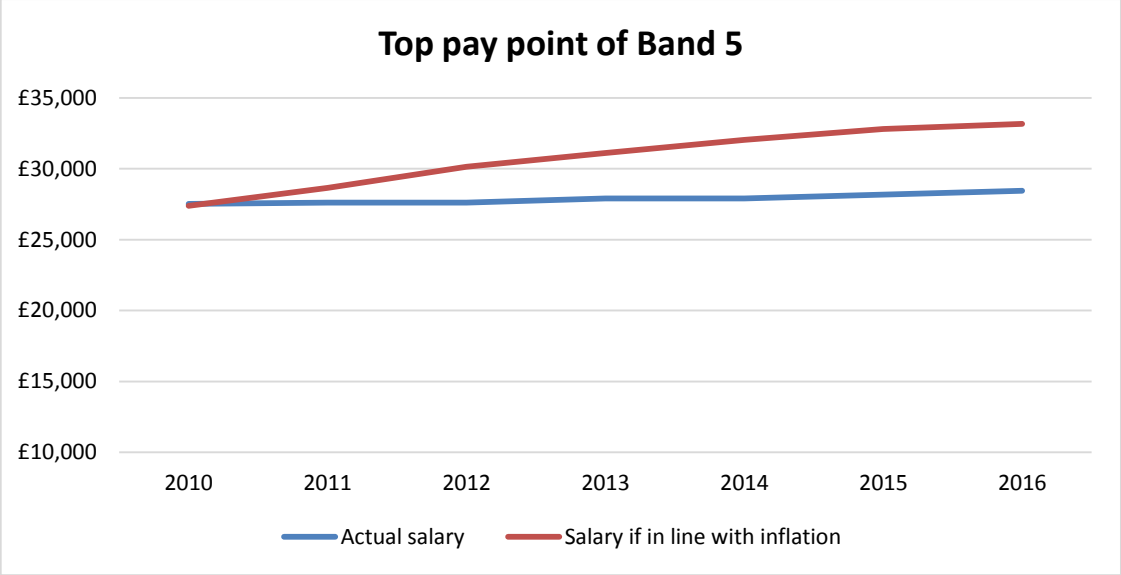
NHS Earnings

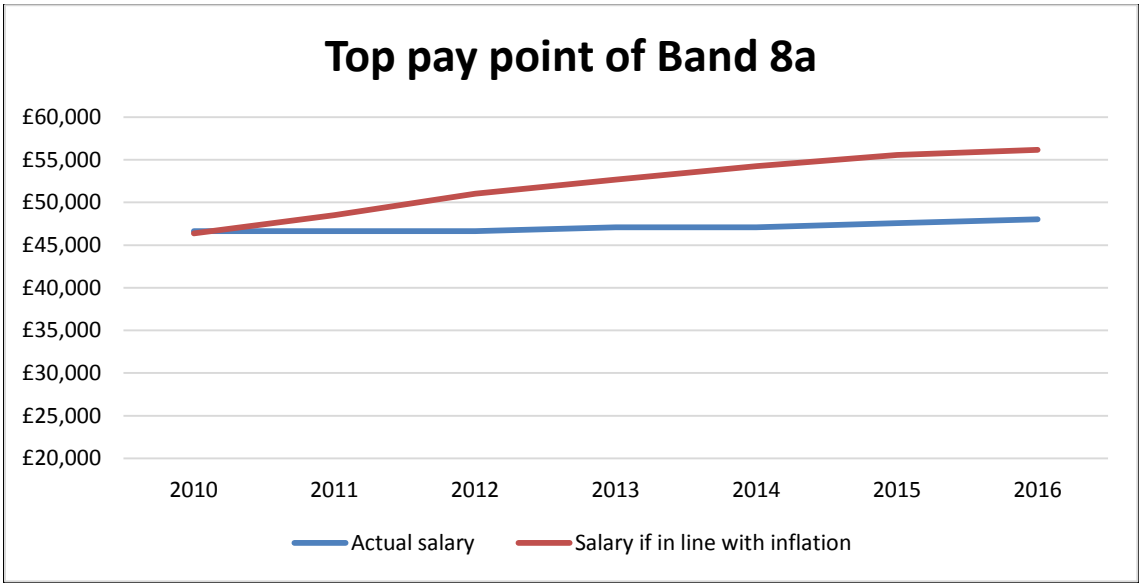
4.19 The following table and charts use data for England to illustrate the impact of pay restraint on Agenda for Change salary levels since 2010. These assume a 1% pay uplift for 2016-17 and show the gap between actual and projected salaries if they had been subject to an annual consolidated uplift in line with RPI inflation.

Table 6: Real terms (RPI) lost earnings 2010-2016

Band	Point	Monetary loss	Loss of earnings % of 2016/17 salary (assuming 1% uplift in 2016/17)
1	3	£1,790	-11.5
2	8	£2,165	-12.2
3	12	£2,678	-13.8
4	17	£3,742	-16.8
5	23	£4,713	-16.6
6	29	£5,869	-16.8
7	34	£7,163	-17.6
8a	38	£8,137	-16.9
8b	42	£9,604	-16.8
8c	46	£12,202	-18.0
8d	50	£14,688	-18.0
9	54	£17,717	-18.0







4.20 The impact of pay restraint is clearly being felt by NHS staff, as evidenced in this year's union membership surveys. Among respondents to the RCN survey working in the NHS (of whom 61% are the main breadwinner in their household) almost a third (32%) reported having struggled with gas and electricity bills in the last year, half (51%) had worked extra hours to earn more money to help with bills and other everyday living expenses and 40% had worked night or weekend shifts. A further third had borrowed money and 20 per cent had taken an additional job to cope with living expenses. Meanwhile, the Unite survey shows that 77.5% of members surveyed reported that they feel worse off compared to the changes in the cost of living.

Conclusions

4.21 Growth in demand, or spending in the economy is now beginning to show in wage rises, rather than new jobs as growth in employment levels begins to slow down. Average earnings are now growing at the fastest rate since February 2009 and due to near-zero inflation, real terms pay rises are at their highest level since November 2007. Competition for workers is growing up after a long slump, with the number of openings per jobseeker almost back at pre-recession levels.

4.22 As strong demand and a tight labour market puts upward pressure on pay in the rest of the economy and a return to positive inflation once again starts to erode the buying power of NHS wages, there is a very real risk to recruitment and retention.

4.23 As Simon Stevens, Chief Executive of NHS England has acknowledged[11]:

> *"NHS staff have made a huge sacrifice during this period of global economic recession and austerity. But the health service has for the most part continued to perform incredibly well during that period.*
> *"Over the medium term, the NHS has to pay in line with pay rates across the rest of the economy if we're going to be able to continue to attract some of the best and most committed staff for nursing jobs and other jobs across hospitals and primary care in England"*
> *"We know there are more pressures and people are working incredibly hard and that's why we've got to change."*

4.24 We support the statement in the Five Year Forward View that "as the economy recovers, NHS pay will need to stay broadly in line with private sector wages, to avoid frontline staff shortages."[12]

Recommendations

4.25 We call on the Pay Review body to:

- Make observations on the impact of the continued policy of pay restraint on recruitment and retention and recommend an uplift that restores the loss in earnings already incurred through cumulative years of below-inflation pay awards
- Make observations on the use of targeting the pay uplift, making differential awards for different groups of staff, and consider Staff Side's warnings that targeting would be would be a difficult endeavour given the paucity of data on vacancies and recruitment and retention problems; the negligible measurable impact of a small pay award as well as the danger of unintended consequences through targeting one group at the expense of others. In particular, we would draw attention to the evidence on the previous use of non-consolidated awards, targeted awards to staff at the top of pay bands and removable progression points. These have been highly unpopular and divisive among NHS staff.

[11] Nursing Times (2014) *Nurses will quit without 'competitive' pay, concedes Simon Stevens, 23 October 2014 www.nursingtimes.net/home/specialisms/leadership/nurses-will-quit-without-competitive-pay-concedes-simon-stevens/5076080.article*
[12] NHS England (2015) *Five Year Forward. www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf*

5 The Living Wage

5.1 Staff Side believes the time is right for the PRB to build on the incorporation of the Living Wage in Scotland and Wales by making a comprehensive recommendation to apply the Living Wage consistently in the NHS across the UK.

5.2 A growing number of NHS employers are using the freedoms available to them within AfC to unilaterally implement the Living Wage[13] – recent examples include the Royal Wolverhampton Hospitals Trust and the Airedale Foundation Trust[14]. Many more are exploring the issue and are committed to its principles. These initiatives are often recruitment and retention measures or reflect acceptance of the moral case for the living wage – or both.

5.3 The security of knowing that NHS pay at the bottom of the AfC structure will track movements in the accredited Living Wage would be a real benefit to the morale and wellbeing of many thousands of hardworking low paid NHS staff.

5.4 The Living Wage Foundation-accredited level is currently set at £7.85 outside London and £9.15 in London. It is calculated to ensure the bare minimum needed for an acceptable standard of living. It assumes full take-up of current tax credits and in-work benefits, and that households have access to social housing.

5.5 The benefits to employers of Living Wage implementation have been well-documented and include reduced rates of labour turnover and sickness and increased motivation, morale and psychological wellbeing of staff[15].

5.6 Failure to pay a Living Wage to staff whose working lives are devoted to the health and wellbeing of our population can no longer be justified. Staff Side believes that this an essential measure which combines social policy and service efficacy, and therefore stands apart from the current debate on targeting of pay awards. We believe Living Wage compliance should be embedded in the pay architecture of AfC with maintenance measures applied by the Review Body as a matter of course in each pay round.

Implementation of the Living Wage

5.7 AfC pay point 2 in England would currently require an uplift of £249 pa or 1.6% to reach the Living Wage. If we assume a 1% uplift as part of this year's pay round the additional increase needed would be £98.

5.8 Figures obtained from the HSCIC suggest there are around 42,700 FTE employees in England on pay point 2. If all of these needed another £98 pa increase it would cost £4.2 million.

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[13] UNISON FoI research found a third of Trusts already apply the Living Wage – and many others stated they agreed with its principles but would want to apply it as part of a national settlement

[14] www.hsj.co.uk/hsj-local/acute-trusts/the-royal-wolverhampton-nhs-trust/trust-agrees-living-wage-pay-rise-for-460-staff/5088173.article#.VfFi3iRwbcs; http://www.hsj.co.uk/news/workforce/three-more-trusts-snub-national-pay-agreement/5090049.article#.VfG2viRwbcs

[15] www.geog.qmul.ac.uk/livingwage/pdf/Livingwagecostsandbenefits.pdf

5.9 However, in London the HCAS boosts salaries for the lowest paid staff significantly above the London Living Wage, so no additional increase would be required. Taking these staff out of the equation brings the cost down to around £3.7million – a modest uplift in the context of the total paybill.

5.10 Introduction of the Living Wage may create issues in terms of differentials for example raising point 2 to achieve the current Living Wage in England would leave only a £14 differential with point 3.

5.11 In Northern Ireland rises would currently be required at points 1, 2 and 3 but we are not currently able to estimate the cost.

5.12 The Living Wage is due for its annual uprating in November 2015 with employers expected to implement it within six months. We are therefore asking the Review Body to reflect this new rate in its pay recommendations for April 2016 and recommend the minimum necessary adjustments to pay points in all four countries, including deletions, where necessary.

Implications for Band 1

5.13 Staff Side believes that Band 1 is no longer fit for purpose. It leaves the lowest paid staff with virtually no pay progression headroom and does not reflect the increasing complexity of jobs at this level. This is reflected in the fact that many employers have updated the job descriptions for their traditionally Band 1 jobs to reflect their additional responsibilities which feed through into evaluation at Band 2.

5.14 This is an issue Staff Side wish to be addressed as part of the review of pay band architecture within the UK Agenda for Change review talks.

5.15 Separately in Scotland the Scottish Terms and Conditions Committee (STAC) of the NHS Staff Council has initiated a review of whether the current Band 1 configuration is fit for purpose and what changes may be necessary to meet current and future service delivery needs.

5.16 The NHS trade unions are clear that applying the Living Wage comprehensively across the UK will have a major impact on Band 1 because of the shortness of the band and could leave Band 1 in England, Wales and Northern Ireland with just one pay point.

5.27 Staff Side believes there is a strong case for merging Band 1 into Band 2 as a pragmatic and positive measure to benefit the retention, motivation and morale of our lowest paid staff such as cleaners and domestics who provide vital services in ensuring hygiene and preventing infection.

New minimum wage rate for 25 years plus

5.18 In the July Budget the Chancellor announced a new statutory minimum wage rate for those aged 25 and over of £7.20 an hour from April 2016, set to rise to £9 an hour by 2020. While it has no effect in the NHS this year, it will start to impact considerably as we travel towards a £9 an hour minimum. For example, point 2 on the England bands will need a 17% uplift over the next five years to get to £9 an hour by 2020. Point 3 will need a 14.5%

increase and point 4 will need an 11.5% increase. The increases needed are not consistent with a 1% pay cap, or appropriate to be addressed through targeting. They require structural change.

5.19 Staff Side believes that employers would welcome a nationally agreed solution to the Living Wage which would create a level playing field and be more effective and efficient than individual approaches.

5.20 We would be happy to expand upon the issue of the Living Wage in oral evidence as by then the November Living Wage uplift will have been announced.

Recommendations

5.21 We call on the Pay Review Body to:

- Recommend that the NHS should adopt the principle that the NHS across the UK should be a Living Wage employer and for this round should apply the November 2015 Living Wage rate in all four countries, deleting spine points as necessary
- Recommend that the talks on the review of the AfC structure take particular account of the introduction of the Living Wage; country-specific approaches to the Living Wage and how these could be standardised; the prospect of a £9 an hour statutory minimum wage for employees aged 25 years and older by 2020
- Make observations on options for the merging of Bands 1 and 2 as part of the AfC review

6 Vacancies, Recruitment and Retention

6.1 In its 2014 report the NHS PRB commented that:

> *"The need for improved and consistent data collection on vacancy and attrition levels to enable effective workforce planning has been a longstanding concern for us since the collection of vacancy data in England ceased in 2011. It is increasingly apparent that there is a need for better data so that trusts can closely monitor the adequacy of their staffing levels to ensure high quality and safe patient care. Trusts need this information to make their decisions, and we need these data in making our recommendations and observations."*

6.2 As a result the PRB went on to recommend that:

> *"The parties should take urgent steps to provide data on both long-term and short-term vacancies, to be available for consideration for our next review. We would expect the data available to allow us to identify whether there are any current and/or developing problems in specific geographies or sustained shortages in specific occupations."*

England vacancy data

6.3 It is encouraging that the Health and Social Care Information Centre (HSCIC) has made steps to provide an indication of vacancy levels in the NHS in England. However, this is experimental publication of NHS vacancy statistics created from vacancy adverts obtained from NHS Jobs, the main recruitment website for the NHS.

6.4 HSCIC warn that these figures are merely an insight to recruitment in the NHS which should be treated with caution, and that 'users are discouraged from attempting to draw any conclusions from this data at this time'.

6.5 Staff Side repeats its call for full data to be made available to allow for a proper analysis of vacancy data in the NHS in England.

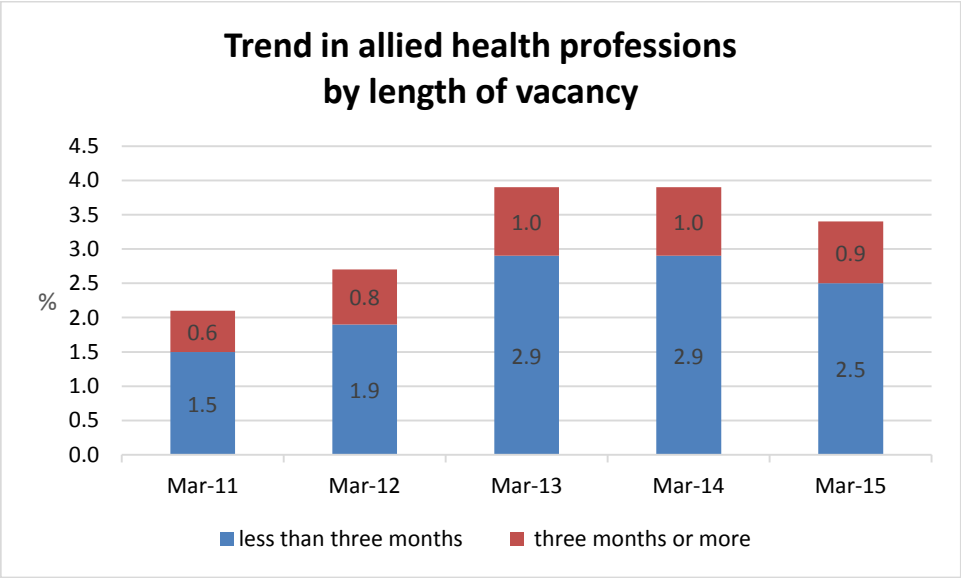
Scotland vacancy data

6.6 Scotland collects quarterly official vacancy data, although nursing and midwifery and allied health professions are the only occupational groups within the scope of Agenda for Change that are covered.

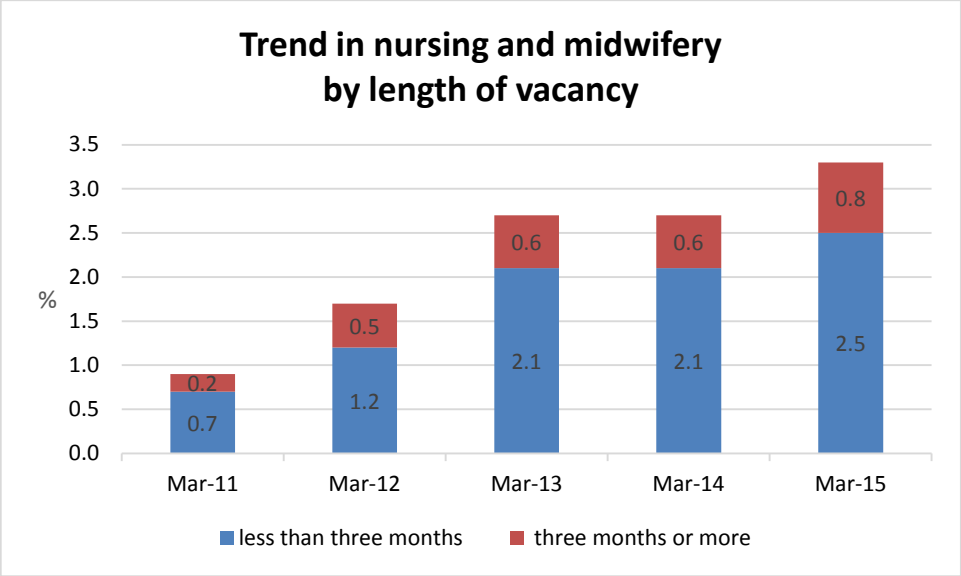
Table 7: Vacancy rates: full-time equivalents

	Allied Health Professionals %	Nursing and Midwifery %
March 2011	2.1	1.0
March 2012	2.8	1.8
March 2013	4.2	2.7
March 2014	3.9	2.7
March 2015	3.5	3.2

6.7 The latest statistics from Scotland suggest that vacancy levels remain stubborn. The vacancy rate as a percentage of establishment for allied health professional posts is 3.5% with those vacant for three months or more running at 0.9% in March 2015. The overall vacancy rate is down slightly from 3.9% the previous year though the long term rate is almost unchanged from 1% in March 2014. However there has been a clear rise since March 2011 when the overall rate was 2.1% and the long-term rate was 0.6%. The highest overall vacancy rates were found in physiotherapy (5.1%), dietetics and therapeutic radiography (both 4.2%).



6.8 The vacancy rate for nursing and midwifery posts in March 2015 was 3.2% overall with those vacant for three months or more running at 0.8%, up from 2.7% and 0.6% respectively in March 2014, and 1% and 0.2% in March 2011.



6.9 The use of agency nursing and midwifery staff in terms of whole-time equivalents increased by 53% in the year to March 2015, while the WTE use of bank staff rose by 8%.

6.10 Total hours of bank and agency staffing combined for nursing and midwifery in Scotland have increased by 41% since 2010/11 as the table below illustrates.

Table 8: Use of bank and agency nursing and midwifery staff, NHS Scotland

Year	Total hours used
2010/11	6,152,769
2011/12	6,316,730
2012/13	7,147,905
2013/14	7,912,130
2014/15	8,671,596

6.11 During 2014/15, 9.8% of nursing and midwifery staffing in Scotland was accounted for by vacant posts or fulfilled by bank and agency staffing, comprising 6.5% bank staffing, 3% vacant posts and 0.3% agency posts.

Northern Ireland

6.12 Vacancy data compiled by the Department of Health, Social Services and Public Safety for September 2014 shows an overall vacancy rate across the health and social care workeforce of 2.8% (up from 2.3% in March 2014) and a long-term (three months+) vacancy rate of 0.9%.

6.13 For professional and technical staff the overall vacancy rate was 3.8% and the long-term rate was 1.2%. For nursing and midwifery it was 3.1% overall with a long-term rate of 1% and for estates services it was 3.1% overall and 0.7% long-term.

Evidence from union members

6.14 This year the NHS trade unions have gathered evidence on vacancies and staffing pressures through our member surveys and the NHS Staff Survey for England.

6.15 The 2014 NHS survey found that half of all respondents (49%) said they were unable to manage conflicting demands on their time, while 46% stated that staffing issues were impinging their ability to their job.

6.16 UNISON's survey of 10,589 NHS staff found that:

- 64% of respondents said that there had been frequent staff shortages in their workplace in the previous year; 21% said there had sometimes been shortages.
- 68% said there are not enough staff in their unit to do the work required.
- The primary means of addressing staff shortages was hiring of bank/agency or NHS Professionals staff followed by attempts to recruit permanent staff from within the UK, as well as restructuring or reorganisation of service delivery
- 21% reported that their employer was doing nothing to address staff shortages

6.17 In some cases financial pressures in the NHS are exerting a downward pressure on what is recorded as a vacancy with a third of respondents to UNISON survey reporting their employer was freezing posts.

6.18 The RCN's survey found that 45% of respondents reported recruitment freezes while 54% reported that the number of registered nurses had decreased over the previous year, while the number of health care assistants had decreased in their workplace. In addition, 65% of respondents reported that they were too busy to provide the level of care they would like and 69% feel under too much pressure at work.

6.19 Focus groups conducted among 132 CSP members also revealed deep-seated concerns about staffing levels among physiotherapy staff and in particular the impact both on existing physio staff (longer and less flexible working hours, stress levels, morale) and patient care (poorer quality care). These concerns are allied to falling satisfaction with the quality of care they feel able to give patients, due to staffing, targets and a lack of professional autonomy. Half of all members interviewed had recently considered leaving their current job, based primarily on the desire to find less stressful or more rewarding/satisfying roles within physiotherapy, either within or outside the NHS.

6.20 In UNISON's annual safe staffing snapshot survey of 10 February 2015 of the 5,100 respondents working in nursing and midwifery services reported that[16]:

- 65% reported that elements of care could not be provided due to understaffing
- 45% reported inadequate staff numbers to deliver safe dignified compassionate care
- 42% were caring for eight or more patients at a time while four in ten were working alongside bank or agency staff on the day of the survey.

[16] www.unison.org.uk/content/uploads/2015/04/TowebRed-Alert-Unsafe-Staffing-Levels-Rising1.pdf

- 97.5% respondents said their employer frequently uses bank and agency staffing to cover for long-term unfilled vanacies, chronic short staffing or permanent colleagues on long-term absence.
- Almost half of respondents said that staffing levels have got worse since May 2010 while only 5% said they had got better. Half said they had considered leaving their profession due to staffing levels.

6.21 A 2015 CSP survey of members showed the following results:

- 63% felt they did not have enough time or resources to do the job
- just under three quarters had observed 'frequent' staff shortages
- two thirds frequently or always worked more than their contractual hours, with over 40% saying they were all unpaid
- the main reasons for doing this overtime were to maintain quality of care (72%), paperwork (70%), that it was otherwise impossible to do their jobs (57%) and staffing (31%)

6.22 The Unite 2015 survey of members showed that:

- 67% of respondents stated that staff shortages occurred 'frequently' and a further 20% stated they occurred 'sometimes' in their workplace
- 67% of respondents 'frequently' or 'always' work more than their contracted hours in a typical week and of these 43% stated that additional hours are usually unpaid

6.23 Results from the 2015 British and Irish Orthoptic Society survey of members:

- 75% reported that they did not have enough resources to carry out their job, either in time or equipment or both
- Over 70% said morale in the department was worse than last year, particularly having to deal with continual change and increasing pressure to work harder with fewer resources
- Over 65% work between 5-10 hours overtime per week, with 60% of those stating these hours are not paid

6.24 Results from the BDA survey show that

- 72% of respondents stated that their workload requires them to work over and above their contracted hours.
- Of this extra work, 3.4% stated this is usually paid, 58% stated it is unpaid and 39% stated that is taken as TOIL.
- The main activities undertaken during unpaid time are direct patient contact (27%) and indirect patient activity (44%).

Other evidence

6.25 A report from the Health Education England Nursing Supply Steering group, published in May 2014, found vacancies in around 10% of permanent nursing posts, with around 60% of these being filled by temporary and agency staff.[17]

[17] Health Education England (2014) *NHS Qualified Nurse Supply and Demand Survey* http://hee.nhs.uk/wp-content/uploads/sites/321/2014/05/NHS-qualified-nurse-supply-and-demand-survey-12-May1.pdf

6.26 Further evidence comes from the King's Fund Quarterly monitoring report for July 2015[18]. Three quarters of NHS Trust **Finance Directors** in England say they are planning to increase permanent nursing staff numbers in the next six months.

6.27 Only one in ten of the Finance Directors said they think the new controls the government has announced will significantly reduce spending on agency staff. The report also stated that staff morale tops the list of Finance Directors' concerns for the fourth quarterly survey in a row.

International recruitment

6.28 International recruitment is becoming more prevalent. Between January 2015 and March 2015 alone 2,499 certificates of sponsorship were used to recruit overseas nurses via the 'resident labour market test'[19].

6.29 However, there are a number of factors working to limit how far NHS organisations can rely on this route to filling vacancies, particularly for nurses.

6.30 Currently the majority of nurses are recruited to the UK from within the European Economic Area but this is likely to change when the proposed Nursing and Midwifery Council (NMC) English language requirements for EEA nurses come into effect. The NMC estimates that as many as 50 per cent of EEA nurses might not in future make it onto the register because of this requirement.

6.31 Furthermore, changes to immigration rules mean that nurses and some other health professionals recruited from outside the EEA since 2011 will have to return to their home country after six years if they do not earn over £35,000 a year. The RCN has estimated that over 3,000 nurses fall into this category and has pointed that the £35,000 threshold is meant to reflect higher skills across the economy yet given that so many nurses fall short of this level of earnings, this demonstrates the huge gap between NHS earnings and levels of salaries and skills in the rest of the economy.[20]

Recommendations

6.32 We ask the Review Body to:

- Press governments in the Wales, England and Northern Ireland administrations to resume collection of quarterly vacancy data

- Recommend a standard data collection methodology across the four countries building on Scotland's model and extending it to all the main Agenda for Change job families including paramedics, healthcare scientists and technical support roles.

[18] King's Fund, *Quarterly monitoring report July 2015*
www.kingsfund.org.uk/projects/quarterly-monitoring-report
[19] Migration Advisory Committee (2015) *Call for evidence review of tier 2*
www.gov.uk/government/consultations/call-for-evidence-review-tier-2-route
[20] www.rcn.org.uk/newsevents/news/article/uk/rcn-report-shows-immigration-rules-will-cause-chaos-and-cost-the-nhs-millions

7 Morale and Motivation

7.1 Results from the NHS Staff Survey for England and union members show high levels of work-related stress in the NHS worforce:

NHS England Staff Survey: 40% reported suffering work-related stress
UNISON: 47% of have suffered from work-related stress and 57% have suffered, or witnessed a colleague suffer some form of violence, harassment or bullying in the last year at work.
Unite: 79% have experienced work-related stress over the previous year
RCN: 48% had worked between two and five times and 15% had worked 5 or more times when not feeling well enough to do so with 47% those saying that the mean reason was work-related stress.

7.2 Results also show low levels of morale among the workforce:
CSP: almost two thirds reported a fall in morale, with downbanding, staffing levels, pay and the quality of care they felt able to provide being key factors
Unite: 80% stated that morale and motivation is worse in their own workplace compared to 12 months previously; the main reasons being workplace stress and the falling value of take home pay
UNISON: 77% said cuts to take-home pay have affected their morale at work and 67% said that morale had worsened over the last year in their workplace, with 58% saying it is low or very low.

7.3 Union membership surveys asked respondents about if they had considered leaving their jobs or if they were seeking new jobs:

- **UNISON:** 83% have considered leaving in the past year. And 65% have done so fairly or very seriously.
- **CSP** 51% have considered leaving their current jobs ‘seriously’ or ‘very seriously’.
- **RCN:** a third (32%) of all respondents working in the NHS were seeking a new job and of these just two thirds would consider a job in the NHS, with the remainder looking to leave completely.
- **Unite:** 51% of respondents had considered leaving their position in the NHS

Recommendations
7.4 We call on the Pay Review Body to:

- Reflect on the impact of pay restraint on the declining state of morale and motivation across the NHS workforce

8 Implications of recent pay awards at the NHS senior clinical leader level

8.1 In this section we bring the attention of the NHSPRB to the recent treatment of career level specialist clinical staff, clinical leaders and service managers over pay rounds since 2011.

Profile of affected staff

8.2 There are 47 profiles at Agenda for Change Bands 8C to 9, pay points 41 to 54.[21] Forty of these are clinical professional roles, many with additional leadership or service management responsibilities or are generic roles but demand a high degree of health related specialist function. Only seven could be described as purely generic meaning employable across many areas of activity outside the NHS.

8.3 These staff:

- represent a high level of public and personal expenditure in training to the highest professional levels;
- usually enter the NHS at post-graduate or post-doctorate level and undertake roles alongside or leading medical consultant colleagues.
- deliver the quality, innovation and service improvement agenda including 7 day services

[21] www.nhsemployers.org/your-workforce/pay-and-reward/pay/job-evaluation/national-job-profiles

Table 9: Recent changes to pay and conditions

Pay Circular	Overall impact	Differential impact to bands 8C-9
2/2010	2.25% or £420 (points 1-15)	2.25%
5/2010	Locally harmonised on-call arrangements	Many lost “Interim Regime” enhancements e.g. for high frequency consultant on-call cover shared with medical colleagues. *
2/2011	From 01-04-2011: Start of 2 years pay freeze £250 (points 1-15 only). 0% for rest	0% uplift
2/2012	From 01-04-2012: Further £250 (points 1-15 only). 0% for rest	0% uplift
1/2013	From 01-04-2013: 1% uplift for all following NHSPRB recommendation in line with Govt evidence	1% uplilft
2/2013	BUT: In England performance conditional incremental progression at all points introduced.	Top 2 points of each scale are non-recurring, removable (but pensionable)
1/2014	Those not at top of scale only get incremental progression. Those at top of scale get non-consolidated, non-pensionable 1%	Progression at top 2 points removable. Those at top of scale get non-consolidated, non-pensionable 1%
1/2015	For England only: ** Uplift to points 1-8. 2014 non-consolidated 1% removed. Points 9-42: 1% uplift Points 1-33: Incremental progression	2014 non-consolidated 1% removed. Points 43-54: 0% uplift Points 34-54: Incremental progression held for 1 year. ***
2/2015	Changes in England to redundancy arrangements linked to awards in 1/2015: Floor salary of £23,000 Removal of employer’s top up of actuarial reduction buy-out for those able to take early retirement of grounds of redundancy.	Ceiling salary of £80,000. (Impacts 8D & 9 staff with 24 or more years’ service. Loss of redundancy pay between £3k & £37k.) Impacts this group disproportionately as they tend to be older and thence more likely to be eligible.

8.4 As well as pay restraint, many have experienced marked increases in NHS pension contributions and the introduction of tiered contributions: in order to deliver the Treasury requirement of 9.8% employee contribution yield.

Table 10: Increase in contribution rates

Year	Contribution rate for points 41-46 %	Contribution rate for points 47-54 %
2011-2012	6.5	7.5
2012-2013	8.9	9.9
2013-2014	11.3	12.3
2014-2019	12.5	13.5

8.5 Additionally year-on-year reductions in pensions contribution Annual Allowance and Life Time Allowance now mean that this level of staff are in scope for potentially punitive tax bills should they receive appropriate pay enhancements for taking on much needed additional leadership duties. This was detailed in a KPMG briefing for NHS Employers indicating that the reduced Annual and Lifetime Allowances may now impact on staff at pensionable pay as low as £66,700.[22]

8.6 Unite has recently conducted a survey of members working in the NHS. Key findings for senior professional staff:

- In common with members at lower bands, 79% feel worse off than 12 months ago.
- A high proportion of this group (73%) are at top of scale
- A higher proportion than lower bands (85%) frequently or always work more than contracted hours.
- 45% report 2-6 additional hours per week and 34% more than 6.
- 78% reported that these are additional hours are usually unpaid, 16% reported taking time in lieu. (Note: Bands 8 and 9 are not entitled to overtime payments.)

8.7 These results show a group of experienced, highly trained, informed and dedicated healthcare professionals who care a great deal about their professions and delivery for patients who are struggling with high workload. They are feeling the real terms impact of the cumulative attrition to pay and increased costs of pensions resulting for some in 2015 in an actual pay cut.

> *"Last year's pay award meant those in at top scale point in higher bands lost the non-consolidated 1% and took a pay cut. This is despite the year before Jeremy Hunt said 'everyone gets a pay rise' either their entitled increment or 1%'. So the 2015 salary scales are identical to 2013 for higher bands."*
>
> ***Healthcare Scientist, Agenda for Change band 8d***

[22] www.nhsemployers.org/case-studies-and-resources/2015/08/annual-and-lifetime-allowance-factsheet-for-employers

"I appreciate I am relatively well paid but I am the family breadwinner. The pay freeze, increase in pension contributions, cost of living and loss of child benefit has hit our family income hard. We are drawing on savings to cover regular bills and the cost of supporting our children through university. Pressures at work are due to increased demand on mental health services, exacerbated by cutbacks in social care and voluntary sector."

Clinical Psychologist, Agenda for Change band 8c

"We are implementing 7 day working which has caused stress to staff and which will additionally affect my own quality of life. I am concerned that I and other senior managers are getting burn out as we are working hard to support our staff and ensure good patient care. I do many, many hours of unpaid extra work - because I care about the dept - but I am not entitled to any pay for this. I missed 8.5 days AL last year because of work priorities and have over 400 hours of lieu time which is impossible to take. In addition I have 'lost' child benefit and on call payments have reduced to a ridiculous figure that non NHS staff would not even contemplate working for. I pay 40% tax on on-call work and it is unfair that the sessional allowance is so poor "

Pharmacist, Agenda for Change band 8c

"The first year in the NHS (24 years) I have experienced a pay cut as I am at top of scale and my 1% 'bonus' was withdrawn. "A bit sick of it all and whilst recognising that there is a need to watch costs feel that we are being lied to."

Clinical Psychologist, Agenda for Change band 8c

"I have been a nurse since 18. I am a senior manager but still a nurse, I feel senior managers are being punished for being the best we can be, achieving and wanting to develop others and the services. I've also developed business skills, leading and acquiring tenders for several million pound contracts, but feel very unvalued."

Senior Nurse Manager, Agenda for Change band 8c

8.9 Conclusions

- NHS staff at senior clinical, clinical leadership and manager levels have been hit disproportionately in multiple aspects of their "reward package".
- These are key staff for the future well-being of the NHS and the patients it and they serve.
- The negative impact on the morale of this group in particular represents a high risk for the NHS, including to its cost effectiveness and ability to use its limited resources to best clinical effect.

9 Productivity

9.1 Improving productivity is increasingly becoming a pivotal issue in the NHS and across the economy as a whole. The drive to improve productivity has become a national priority while in the NHS, significant funding challenges combined with an increased demand for services due to the ageing population and increasing birth rate make this of particular

importance. These challenges are combined with other NHS priorities such as the Government's drive for more services to operate seven days a week.

9.2 Staff Side agrees that productivity in the NHS needs to be improved and argue that productivity can only be improved by utilising the existing workforce. We argue that productivity cannot be improved by continuously relying on the goodwill of NHS staff and there are three key ways of improving productivity in the NHS:

- incentivise staff to work bank and overtime shifts rather than relying on agency staff;
- improve sickness absence by implementing the findings of the Boorman report and retain older workers by implementing recommendations made by the Working Longer Group; and
- invest in NHS staff by improving skills, training and development opportunities and end the interference with the independence of the Pay Review Body to allow for NHS staff to be properly rewarded and valued.

9.3 It is clear that the Government and NHS organisations are not investing in NHS staff and this is negatively impacting on productivity. The Government and NHS organisations need to change their approach to NHS staff; an investment in NHS staff is an investment in improved productivity and improved care.

Incentivise staff to work bank and overtime shifts

9.4 The cost of agency staffing in the NHS has substantially increased in the last few years with 2014/15 seeing NHS providers spend £3.3billion on agency staffing in England, while in Wales agency and locum spend for 2014/15 is £87.7 million. This represents an increase of 78% compared to the same period last year and is at the highest level in the past four years. In England, the Department of Health has instructed Monitor to introduce a mandatory cap on the hourly rates paid for agency staff and an annual ceiling for agency spending for each trust; however both of these caps will only apply to nursing, midwifery staff and health visitors. Staff side agrees that the use of agency staff in the NHS has reached inappropriate levels and should be controlled but we do not believe that Monitor's proposals will do this in a safe and sustainable way. We believe there are two safe, sustainable and effective ways to reduce agency spending, first, to eliminate the staff shortages and second, to incentivise existing staff to work bank or overtime.

9.5 We were pleased to read in the PRB's report 'Enabling the Delivery of Healthcare Services Every Day of the Week - the Implications for Agenda for Change' that the PRB identified that the main barrier to expansion of services is the numbers of staff. We agree with the PRB that without the appropriate numbers of staff to deal with the rising demand for services there would be an increase in the cost of agency staff:

> *"If changes are introduced without the appropriate workforce planning then the short-term impact on staff levels could see agency costs increase. We note that those responsible for workforce planning and commissioning of training are not yet fully linked into local plans for seven-day services. Given the number of years it takes to train suitably skilled and qualified staff we believe a substantial barrier to the expansion of seven-day services could be insufficient numbers of appropriately trained staff"* [23]

[23] NHS Pay Review Body (2015) *Enabling the delivery of healthcare services every day of the week*

9.6 In the meantime, we recommend that as a short term solution trusts could reduce their agency spending by using their own staff and incentivising staff to work overtime or on the bank rather than using agency staff. There is a single harmonised rate of overtime set out in Agenda for Change (time and a half for all overtime apart from public holidays which is double time). We understand that it is difficult to get authorisation to pay overtime rates and that bank rates are too low. By not authorising overtime or paying bank at a fair rate the result is that trusts have to use agency staff, which costs them more money.
Indeed, the 'Review of Operational Productivity in NHS Providers' report by Lord Carter of Coles identified that bank staff are not remunerated in a way to attract them from moving from agencies[24].

9.7 We would like to reiterate the comments made by the NHSPRB in their report on seven day services:

> *"The pay structure should work to support and incentivise behaviours to ensure that shifts are scheduled principally around the needs of the patient rather than skewed by rules around shifts and payments."*

9.8 Staff Side would be interested to understand the PRB's views on agency spending in the NHS, in particular to understand the data employers have about the use of agency staff. For example, the cost per hour, the cost of agency fees, variations by region, variations by day of the week, variations by time of the day, variations by different professional groups etc. The data can then be analysed to work out if there are particular causes for the increased agency spend rather than putting a crude cap on the agency spend, as Monitor wish to do. In particular, the trade unions are interested in the cost of fees to agencies, rather than the total amount of agency fees combined with the wages paid to staff.

Sickness Absence and the Ageing Workforce

9.9 The Boorman Report (November 2009) sets out key recommendations to improve the health and wellbeing of the NHS workforce, including the cost savings that can be gained from investing in staff health and wellbeing[25]. The report found that organisations that prioritised staff health and wellbeing performed better, with improved patient satisfaction, stronger quality scores, better outcomes, higher levels of staff retention and lower rates of sickness absence. The report estimated that the NHS could reduce current rates of sickness absence by a third and this would mean an additional 33.4 million working days a year for NHS staff equivalent to 14,900 WTE staff with an estimated annual direct cost saving of £555 million.

9.10 The Health and Social Care Information Centre's latest report into NHS sickness absence rates in England shows that[26]:

- Between January and March 2015 the average sickness absence rate was 4.44%, an increase from the same period in 2014;

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www.gov.uk/government/publications/enabling-the-delivery-of-healthcare-services-every-day-of-the-week

[24] Department of Health (2015) *Review of Operational Productivity in NHS Providers: An independent report for the Department of Health by Lord Carter of Coles*

[25] Department of Health (2009) *NHS Health and Wellbeing: Final Report* http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108907.pdf

[26] Health and Social Care Information Centre (2015) *NHS Sickness Absence Rates January 2015 to March 2015 and Annual Summary 2009-10 to 2014-15*

- The North East HEE region had the highest average sickness absence rate for January - March 2015 at 5.15%. North central and East London HEE region had the lowest average at 3.61%;
- Ambulance staff were the staff group with the highest average sickness absence rate for January - March 2015 with an average of 6.78%. This was followed by Healthcare Assistants and other Support Staff (6.58%); Nursing, Midwifery and Health Visiting Staff (5.19%). Nursing, Midwifery and Health Visitor Learners had the lowest average at 1.22%;
- Among types of organisation, Ambulance Trusts had the highest average sickness absence rate for January - March 2015 with an average of 6.44%. Clinical Commissioning Groups had the lowest average for this period, with a rate of 2.78%.

9.11 It is clear that there is still work to be done to reduce sickness absence rates in the NHS, and given the huge potential for savings the recommendations of the Boorman Report should be implemented across the NHS.

9.12 The Working Longer Group was established to assess the impact of working beyond 60 in the NHS and to consider how NHS staff will continue to provide safe and quality care when they are working longer. The Interim Report of the Working Longer Group made eleven recommendations that will help organisations utilise the skills and knowledge of experienced staff by giving them the necessary support to work longer[27].

9.13 It is important that the recommendations of the Boorman Review and the Working Longer Group are implemented because productivity in the NHS can only be improved by utilising the existing workforce.

Investment in Staff is an Investment in Productivity

9.14 The Francis Report into Mid Staffordshire NHS Foundation Trust emphasised the importance of organisational culture that promotes high quality care. Many research studies have shown that the more positive experiences of staff within an NHS organisation, the better the outcomes for that trust, both in terms of patient care and in terms of financial performance for the trust.

9.15 A key way of improving productivity is to improve staff engagement. In the Kings Fund research 'Employee Engagement and NHS Performance' (2012) the authors analyse the data from the NHS Staff Survey which indicates employee engagement and how it is linked to a variety of individual and organisational outcome measures, including staff absenteeism and turnover, patient satisfaction and mortality, and safety measures, including infection rates. The results from their research clearly found that the more positive the experiences of staff within an NHS trust the better the outcomes for that trust. Engagement has significant associations with patient satisfaction, patient mortality, infection rates, Annual Health Check scores, staff absenteeism and turnover. They conclude that the more engaged staff members are, the better the outcomes for patients and the organisation more generally.[28]

[27]National Staff Council (2014) Working Longer Review: Preliminary findings and recommendations report for the Health Departments www.nhsemployers.org/~/media/Employers/Documents/Pay%20and%20reward/WLR%20Preliminary%20findings%20and%20recommendations%20report.pdf

[28] West M and Dawson J (2012) *Employee Engagement and NHS Performance*, The Kings Fund

9.16 These results were replicated in other research conducted by West and Dawson that found there were particular factors that were important in ensuring good staff engagement. In particular, they found that good staff management is a key factor in engagement. This includes having well-structured appraisals, setting out clear objectives and ensuring the employee feels valued by the employer. This is followed through in team working, so the team have a good understanding of their shared objective and work interdependently to meet those objectives. The research has shown that good, supportive line management is key. Conversely, high levels of work pressure and stress can lead to dissatisfaction and disengagement.[29] All these factors were linked to patient satisfaction, patient mortality and staff absenteeism and turnover, and better performance on the Annual Health Check. Training and development is another important factor; where employees received training, learning and development that is relevant to their job there were better outcomes. In particular health and safety training and equality and diversity training were found to be important.[30]

9.17 In their research West et al conclude that:

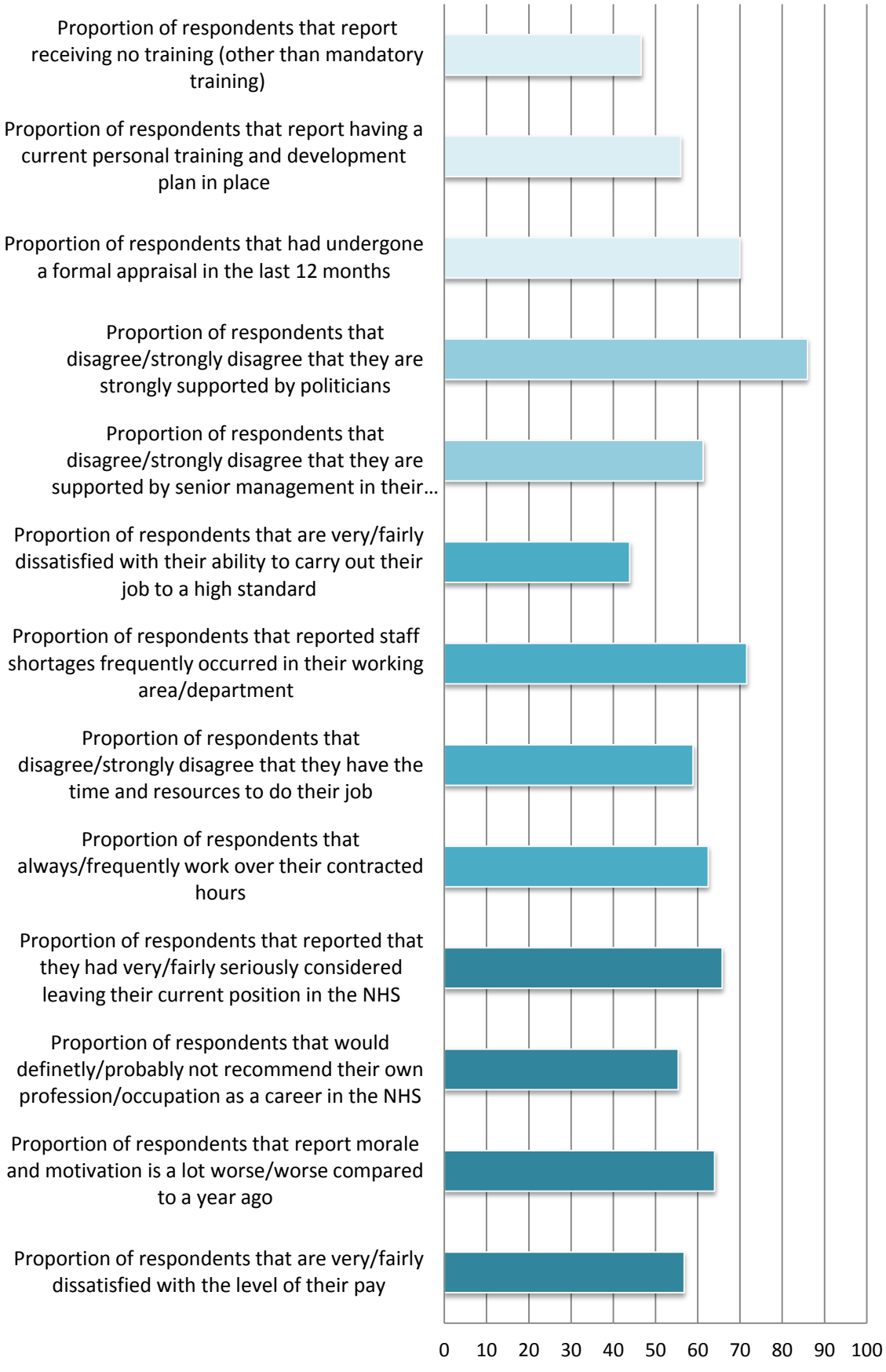
> *"By giving staff clear direction, good support and treating them fairly and supportively, leaders create cultures of engagement, where dedicated NHS staff in turn can give of their best in caring for patients. Such steps produce high quality and improving patient care along with effective financial performance."*[31]

9.18 Indeed, the report by the Treasury 'Fixing the foundations: creating a more prosperous nation' highlights a key way to improve productivity is the need to improve skills.
The 2014 NHS Staff Survey for England found that 83% of staff had an appraisal. Of those to receive an appraisal, only 54% said it helped them improve how they do their job, and only 78% felt the appraisal helped them to agree clear objectives for their work. Worryingly, only 62% said it left them feeling that their work is valued by their organisation. This indicates that effective appraisals are far from widespread in the NHS.

9.19 Moreover, in September 2014 Incomes Data Services (IDS) conducted a survey for Staff Side to accompany our evidence to the Pay Review Body. The graph below shows some of the key results from the survey that show worryingly high numbers of staff are not given training, development and appraisals; do not feel supported; do not feel they have the time and resources available to do their job to a high standard; and have seriously considered leaving the NHS. This is particularly disturbing given that we know that the key to improving productivity in the NHS is going to be through valuing and engaging the existing workforce and equipping them with the skills and resources they need to provide quality NHS services.

[29] West M, Dawson J, Admasachew L and Topakas A (2011) *Staff Management and Health Service Quality – Results from the NHS Staff Survey and Related Data*
[30] West et al (2011) ibid
[31] West et al (2011) bid.

Key Findings from the Income Data Services Survey on Pay and Conditions - September 2014



9.20 It is clear that the UK Government and NHS organisations are not doing enough to engage with staff, value them and equip them with the skills and resources they need. The Government's approach to the NHS and the NHS workforce involves the continued pay freeze and cap; pension changes; NHS restructures; continued references to the 'burden' of public sector workers on taxpayers; undermining collective bargaining e.g. rejecting the recommendations of the Pay Review Body, capping redundancy payments and attacks on the right to strike with the Trade Union Bill. This has contributed to a culture that does not value staff and negatively impacts on productivity. The Government and NHS organisations need to change their approach to NHS staff because an investment in NHS staff is an investment in improved productivity and improved care.

Conclusions

9.21 Improving productivity is increasingly becoming a pivotal issue in the NHS. The significant funding challenges facing the NHS combined with an increased demand for services due to the ageing population and increasing birth rate and the Government's desire to extend more services to seven days a week have made productivity a critical issue.

9.22 Staff Side agrees that productivity in the NHS needs to be improved and argue that productivity can only be improved by utilising the existing workforce. We argue that productivity cannot be improved by continuously relying on the goodwill of NHS staff but have discussed three positive approaches that can be taken to improve productivity: better rates for bank and overtime work; implementing the recommendations of the Boorman Review; and investing in staff through training, development opportunities and pay.
It is clear that the Government and NHS organisations are not investing in NHS staff and this is negatively impacting on productivity. The Government and NHS organisations need to change their approach to NHS staff because an investment in NHS staff is an investment in improved productivity and improved care.

10 The need for a workforce strategy

10.1 Staff Side has set out in this submission its concerns about the impact of pay restraint on recruitment and retention, as well as problems with workforce supply and staffing levels. We believe that that these issues will cause lasting damage to the NHS workforce unless they are dealt with through a long-term, coordinated strategy.

10.2 A workforce strategy should tackle the following issues:

- The impact of wage stagnation on recruitment and retention, morale and motivation
- Future recruitment, including student commissions
- Retention of existing staff including consideration of career progression, training opportunities, health and wellbeing
- Pay and reward of staff delivering NHS services across the UK, across health and social care and those affected by transfer out of the NHS
- Positive approaches to improve productivity: including better rates for bank and overtime work; implementing the recommendations of the Boorman Review; and investment in staff

Appendix: NHS roles banding at 8c, 8d and 9

Agreed NHS National Job Profiles at band 8C and above.
Source: NHS Employers list of proffiles
http://www.nhsemployers.org/your-workforce/pay-and-reward/pay/job-evaluation/national-job-profiles

Profile title	AforC band range	Nature of role
Communications Service Manager	8A - 8C	Generic
PALS Professional Head	8A - 8C	Generic with health sector specialism
Health Records Services Manager	8A - 8C	Generic
Solicitor Consultant	8B - 8C	Generic with health sector specialism
IM&T Service Manager	8a-c	Generic
HR Head Of Service	8b-d	Generic
Chief Finance Manager	8b-d	Generic
Professional Manager, Performance/Operations	8b-c	Generic
Professional Manager, Performance/Operations Higher Level	8c-d	Generic
Head of Arts Therapies (Art, Music, Drama, Dance Movement)	8c-d	Clinical
Arts Therapies Consultant (Art, Music, Drama, Dance Movement)	8c-d	Clinical with leadership / management of service
Counsellor Professional Manager	8a-c	Clinical with leadership / management of service
Counsellor Consultant	8a-c	Clinical
Clinical Psychologist Consultant	8c-d	Clinical, highly specialised
Clinical Psychologist Consultant, Professional Lead/Head of Psychology Services	8d-9	Clinical with leadership / management of service
Radiographer Consultant (Therapy)	8a-c	Clinical with leadership / management of service
Radiographer Consultant (Diagnostic)	8b-c	Clinical with leadership / management of service
Clinical Researcher*	8b-d	Clinical with leadership / management of service
AHP Consultant	8b-9	Clinical with leadership / management of service
Podiatric Consultant (Surgery)	8c-d	Clinical with leadership / management of service
Podiatric Consultant (Surgery) Head of Service	9	Clinical with leadership / management of service
Health Improvement Principal	8a-c	Generic with health sector specialism
Clinical Governance Practitioner (Higher Level)	8a-c	Clinical with leadership / management of service
Public Health Consultant	8d-9	Clinical
Consultant Speech and Language Therapist	8a-c	Clinical with leadership / management of service
Consultant Clinical Scientist Head of Service (Molecular Genetics/Cytogenetics)	8d	Clinical with leadership / management of service
Dental Laboratory Manager	8a-c	Clinical with leadership / management of service
Genetic Counsellor Consultant	8b-d	Clinical
Healthcare Scientist Professional Manager (Career Framework Stage 8)	8a-c	Clinical with leadership / management of service
Healthcare Scientist Principal/Consultant (Career Framework Stage 8)	8a-c	Clinical
Healthcare Scientist Principal (Research) (Career Framework Stage 8)	8a-c	Clinical
Healthcare Science Service Manager (Career Framework Stage 8)	8a-d	Clinical with leadership / management of service
Healthcare Scientist Consultant (Career Framework Stage 9)	8c-9	Clinical
Healthcare Scientist Consultant Head of Service (Career Framework Stage 9)	8c-9	Clinical with leadership / management of service
Healthcare Scientist Consultant Director (Career Framework Stage 9)	8d-9	Clinical with leadership / management of service
Optometrist Consultant, Head of Service	8c-d	Clinical with leadership / management of service
Pharmacist Team Manager	8b-c	Clinical
Pharmacist Consultant	8b-d	Clinical with leadership / management of service
Professional Manager Pharmaceutical Services	8c-9	Clinical with leadership / management of service
Midwife Consultant 8A - 8C	8a-c	Clinical with leadership / management of service
Clinical Researcher	8b-d	Clinical with leadership / management of service
Nurse Consultant	8a-8c	Clinical
Nurse/Midwife Consultant Higher Level	8c-9	Clinical with leadership / management of service
Head of Estates/Assistant Head of Estates	8c-d	Generic with health sector specialism
Director of Estates and Facilities	8d-9	Generic with health sector specialism
Professional Manager (Clinical, Clinical Technical Service)	8b-c	Clinical with leadership / management of service
Professional Manager (Clinical, Clinical Technical Service)	8c-9	Clinical with leadership / management of service