Staff Side Evidence to the NHS Pay Review Body 2014-15

1. Introduction

Staff Side continues to oppose the Government’s instruction to the NHS Pay Review Body (PRB), both in relation to the cap on the paybill for Agenda for Change (AfC) staff and the restriction of the PRB’s remit. The PRB’s remit is now restricted to taking account of the economic climate, minimising its ability to reflect the impact of the Government’s policies on the NHS workforce.

Staff Side fully understands the economic context, but we remain extremely concerned about the erosion in the real value of pay due to high levels of inflation combined with low awards and changes to NHS pensions over the last few years.

AfC staff have not had a real-terms pay increase since 2006, with the exception of one eight-month period when Retail Price Index (RPI) was negative. This means that by 2014 AfC staff will have lost between eight per cent and 12 per cent of their purchasing power based on their 2010 pay rates.

The Treasury’s announcement of two further years of pay caps for NHS staff at an average of one per cent a year up to 2015-16 is impacting heavily on staff morale, at a time when many are also coping with NHS restructuring, heavy workloads and work intensification.

The pay cap, changes to benefits and welfare payments and rising inflation are affecting all workers, but lowest paid workers are hardest hit. Staff Side believes that as a minimum, the NHS should commit to at least the Living Wage for all employees across the UK as a way of protecting lowest paid workers.

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

- Staff Side calls on the PRB to protect the lowest paid staff by ensuring that no members are paid below the level set for the Living Wage and that to ensure that all AfC staff receive a pay uplift of at least one per cent. We also call on the PRB to ensure that high cost area supplements (HCAS) are increased by at least one per cent.
- We ask the PRB to acknowledge the volume of work already undertaken in the last year to deliver the Staff Council work programme and maintain AfC.
- We call on the PRB to recommend a strong policy position from central Government, supporting AfC as the standard package of terms and conditions for all providers of NHS services. This would mitigate industrial tension, promote consistency of treatment for staff in the four UK countries, and free up capacity at all levels to work on the longer term workforce challenges facing the NHS.
- Staff Side asks the PRB to recommend that the Staff Council undertakes initial discussions to investigate the potential benefits of sub-Staff Council structures in England particularly in relation to supporting the national agreement and preventing further divergence of approach between England and the other three UK countries.
- We invite the PRB to consider the main findings and recommendations made in the Work Foundation 10 year retrospective of Agenda for Change and its central recommendation that any attempt to “dismantle AfC as a national framework would be seriously misplaced and that effort would be best expended on improving on and adapting its core provisions through a process of negotiation and consent”.
- Staff Side calls on the PRB to acknowledge that work is needed to improve data collection on vacancy levels to enable effective workforce planning.
- We ask the PRB to take steps to analyse the extent and impact of changes to working conditions on the NHS workforce, in terms of pay, terms and conditions. We urge the PRB to undertake independent research to analyse the financial impact of cuts to on-call payments, unsocial hours payments, changes in shift patterns and down banding on NHS employees in the immediate and longer term.
- Staff Side calls on the PRB to assess the longer term impact of the pay freeze and to consider the impact on the attractiveness of the NHS as an employer.
- Staff Side calls on the PRB to assess the prospects for career progression in the NHS given the increasing number of staff at the top of each AfC pay band, the use of down banding and squeezed training budgets.
- Staff Side calls on the PRB to re-visit the agreement made at the time that AfC was introduced that there should be coordination between the different NHS pay review bodies on equality issues. This review should assess the proportion of funds allocated to key groups of staff across the different spines and the equality implications of this allocation.
- We call on the PRB to review the structure of AfC, relating to the size and spacing of incremental pay points.
- Staff Side calls on the PRB to recognise the impact of the NHS work environment and organisational culture and the public sector pay policy on NHS staff and their levels of work engagement. We call on the PRB to acknowledge that staff engagement is deteriorating and to acknowledge that failure to improve risks negatively impacting on recruitment and retention and ultimately, patient care.
3. **Policy and economic context**

3.1 **The NHS**
Recent developments have left the NHS across the UK in a state of uncertainty – for the public as well as staff. So many questions have been raised about its culture and available resources that the public understandably feel anxious about the current state of the NHS and its future. Staff feel overwhelmed by the pace and extent of change and under pressure from increased workloads and staff shortages.

In England, the implementation of the Health and Social Care Act 2012 concluded huge organisational restructuring in the NHS. In the short-term, the reforms affected the employment of around 45,000 staff across more than 400 organisations in the NHS, local Government, public health, the Department of Health and its arm’s length bodies (ALBs). More than 10,000 NHS staff have been made redundant in the past three financial years meaning a huge loss of experience and skills.\(^2\)

While the implementation of the Act concluded the technical aspects of the reorganisation, the longer term implications for health care delivery and the employment of NHS staff are still to be seen. The developments, allied to efficiency programmes will mean ongoing restructuring and service design, while the Francis Report into care at Mid Staffordshire NHS Foundation Trust Hospital warned of the passive management culture that constant reorganisations perpetuate in the NHS.

Other reforms in England include the replacement of NHS Direct with a new NHS 111 service. The new service was launched in March 2013, and problems began almost immediately with ambulances and out-of-hours GPs called in to provide emergency cover. NHS 111 was an attempt to cut the cost per call by using non-clinical staff to handle the majority of call time and the changes have left the service in disarray with a demoralised workforce.

The NHS continues its struggle to find efficiency savings and despite Government claims that these savings be made and services not harmed in the process, the Francis Inquiry and Keogh Review into 14 NHS Trusts in England have both intensified concerns over patient care. The Keogh Review into 14 Trusts identified concerns about skill mix, support for staff, a fear of raising concerns and staffing levels – all of which impact on patient care and safety.

The Francis Report details a culture in which the needs of patients are too often sidelined for the self interest of the system, placing financial balance above patient care. If nothing else, the Francis report should have alerted policy makers to the fact that staffing levels cannot be traded for quality. However there have been falling staffing levels and a dilution of skills mix across almost all parts of the UK since 2010.

Falls in staffing levels and diluted skills mix have occurred as the NHS has faced massive clinical pressure on services and in particularly on A&E services. The number of patients going to accident and emergency departments reached an all-time high in the winter of 2012/13. Meanwhile, claims that the Care Quality Commission has covered up failures have shaken the public’s trust in the NHS, leading staff to feel under ever more scrutiny and pressure.

Poor care is never acceptable and trade unions do not defend any examples of bad patient care. But the lessons from the Francis Inquiry and the Keogh Review are clear: the NHS needs to employ enough trained staff and engage them. Staff need the necessary resources and support to do their

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\(^2\) Department of Health, *Tracking staff moves during transition*, April 2013
job properly but the NHS Staff Surveys for England, Wales and Northern Ireland showed that while the majority of staff (78 per cent England; 68 per cent Wales; 84 per cent Northern Ireland) feel satisfied with the quality of care they provide to patients, far fewer (55 per cent England; 57 per cent Wales; 63 per cent Northern Ireland) reported being able to do their job to a standard they are personally pleased with. Alarmingly, less than half (30 per cent England; 27 per cent Wales; 47 per cent Northern Ireland) said there are enough staff in their trust for them to do their job properly. Staff are overworked and are having to deal with greater stress caused by staff shortages.

Recent union surveys and the NHS Staff Surveys show that morale is being tested, following several years of reorganisations, pay cuts and pay freezes. Only around one third of staff in England, Wales and Northern Ireland are satisfied with their level of pay, according to the NHS Staff Surveys. Meanwhile, the National Audit Office has pointed to the overwhelming contribution made by the pay freeze to efficiency savings in the NHS and warns that ‘sustaining the savings made through pay restraint may not be easy in the longer term and may have a detrimental effect on staff morale and productivity’.  3

This year the NHS trade unions concluded an agreement with NHS Employers in England to make alterations to AfC to enable pay progression to be more closely linked to performance and to modify out of hours sickness payments. Yet despite this agreement, we heard through the Spending Review announcement in June the intention that public sector workers should no longer receive incremental pay progression. This not only risks undermining the efforts made by both trade unions and employers to come to an agreed position to amend AfC and but also serves to heighten anxiety among NHS staff about their pay, terms and conditions. The announcement came at a time when all public sector workers feel under an unfair level of pressure, made to feel like an almost privileged class and wrongly accused of being one of the main causes of the public deficit.

3.2 Update on AfC and related issues

3.2.1 Amendments to AfC (England)
This year, the NHS Staff Council reached agreement to amend AfC in England effective from 31 March. The package of changes included:

- removing unsocial hours payments during periods of sick leave
- stopping accelerated progression for new Band 5 entrants
- creating closer links between pay progression and performance and introducing an Annex W to identify the content of Local Incremental Pay Progression Policies
- introducing a new Annex X to set out how organisations should approach workforce re-profiling.

The decision to effectively ‘trade’ elements of their terms, conditions and pay package in order to preserve the national agreement was a difficult one for NHS staff. Within the Staff Side the decision was contentious and not unanimous. However, since the agreement was reached, all Staff Side trade unions have actively participated in signing off those amendments to the NHS Terms and Conditions handbook required to effect the change, and remain committed to working in partnership at local level to ensure that local implementation of the changes accurately reflect the Staff Council revisions. This includes providing guidance to organisations about the data they will need to collect and analyse at local level in order to monitor and report on any equal pay or equalities issues arising from implementation of the new provisions.

3 National Audit Office (2012), Progress in making NHS efficiency savings
There is still an outstanding issue about the implications of the change to unsocial hours’ payments during sick leave for ‘Annex E’ arrangements – this issue is described in Appendix 1 at the end of the document.

3.2.2 Impact of the changes to AfC

In reaching agreement on these amendments to AfC, the trade unions were very clear that staff wanted to preserve the national system, but that this was not ‘at any cost’ – members were very clear in all of the trade union consultations that they did not see this agreement as the start of a process where terms and conditions would diminish with subsequent rounds of negotiations. Consultations also raised concern about the capacity of the service to deliver robust local incremental pay progression policies and also to use Annex X to support structural change within staff groups and organisations. Staff Side has raised the need for the Staff Council to monitor implementation and the impact of changes via relevant sub-groups.

In order to preserve as far as possible the UK-wide approach to AfC, the Staff Council worked hard to incorporate the England-only changes into the existing terms and conditions handbook. However, Staff Side remain very concerned about the impact of making England-only changes to the agreement, both in terms of the nuanced position in relation to four-country bargaining but also in considering longer term morale and motivational issues for staff in England who are all too aware of the emerging differences in the political approaches to the NHS workforce.

Last year we reported that in England we were experiencing the impact of a policy vacuum, where downward cost pressures on employers coupled with lack of policy prescription on AfC meant that we were trapped in a cycle of local disagreements on changes to terms and conditions. Since the recent amendments to AfC, the number of NHS organisations seeking to break away from the national agreement has dropped dramatically (including the South West Consortium who confirmed in April/May that they would not proceed with changes outside AfC). However, the changes themselves were not the only factor in these organisations pledging renewed support for AfC. Our fear is that the support gained from employing organisations could be only a temporary reprieve from ‘breakaways’, given financial pressures; the continued lack of policy prescription in England; the ideological opposition to national systems from some opinion-formers within the NHS; and the spread of competition from non-NHS providers as the Health and Social Care Act beds down. The Staff Side would argue that having clear Government policy which supported Agenda for Change as the standard package of terms, conditions and pay used (or mirrored) by all providers of NHS services would remove uncertainty for providers and staff, ensure that procurement decisions were based on value not cost and would also free up capacity for partners at local and regional level to hold progressive discussions about how AfC could be used to drive and support workforce change including:

- skill mix and staffing levels
- workforce considerations in moving focus from acute to community settings
- potential changes to service delivery models
- long-term reconfiguration and planning.

We would welcome acknowledgement from the PRB that clear policy expectations on use of Agenda for Change would mean resources and expertise could be directed towards addressing longer term workforce challenges.

Cost pressures in Wales have resulted in discussions between ministers, health boards and trade unions on future changes to terms and conditions. The discussions are at present exploratory and it is not yet known whether and how these could affect the AfC agreement, but raise the prospect of further uncertainty amongst the workforce.
3.2.3 Continued partnership work on AfC
Although much capacity was taken up with discussion, agreement and implementation of the England-only changes to AfC, NHS trade unions have continued to work in partnership with employers to deliver the Staff Council work programme. The following pieces of work are of particular relevance:

• agreement of the new Injury Benefit Scheme and incorporation in to the AfC handbook (and other relevant sets of terms and conditions)
• National Recruitment and Retention Premia (NRRP) – survey of employing organisations to investigate the impact of withdrawal of NRRP
• High Cost Area Supplement – scoping of tender proposal for information gathering and analysis on the HCAS project
• Job Evaluation – continued work by the Job Evaluation group to update job profiles and the JE handbook; further training delivered
• Mileage – production of materials and guidance to support the implementation of the new harmonised arrangements (agreed 2010 for implementation July 2013)
• Equal pay – work is ongoing via the Equality and Diversity Subgroup on the review of the Equality Delivery System.

Country-wide partnership bodies in Scotland, Wales and Northern Ireland are still active in maintaining AfC, which – coupled with the strong political commitment to the national agreement – may be a factor in the better progress on harmonisation of terms including mileage rates, on-call experienced in those countries. With the dissolution of the English Strategic Health Authorities, this divergence may grow, and the Staff Side would like the Review Body to support us in calling for the NHS Staff Council to undertake exploratory work to look at whether partnership structures may be appropriate at either an all-England or other sub-Staff Council level.

3.2.4 Work Foundation Report: Ten Years of AfC
This year, we submit a ten-year retrospective review of AfC conducted by The Work Foundation. This review sets out to reflect on the extent to which AfC remains ‘fit for purpose’ and whether it has delivered its core objectives. Among the report’s conclusions, the authors find that many of AfC’s features have been shown to have “an enduring, robust, practical and comprehensive impact characterised by a high degree of consent.”

It goes on to state that AfC should be judged according to its capacity to “evolve and adapt to the changing environment” and reasons that it should be characterised as “an organism or flexible, adaptive system….which should sustain it through the current set of changes and whose which are yet to come.”

The authors acknowledge that problems do exist with the agreement but that these problems can be “attributed more to implementation rather than the core design of the system.” Staff Side welcomes this paper and calls on the PRB to support the central recommendation made in the report that any attempt to “dismantle AfC as a national framework would be seriously misplaced and that effort would be best expended on improving on and adapting its core provisions through a process of negotiation and consent.”

3.2.5 Pensions
This has been another significant area of work over the last year. The tripartite review of the impact of Working Longer was established this year and populated via Staff Council structures. As well as conducting both a literature review and its own research on the impact of increasing the Normal Pensionable Age for NHS Staff, the Review Group requested evidence from stakeholders by 9
September 2013. In addition to evidence submitted by individual trade unions, the Staff Side will also submit the analysis of a joint survey of trade union members once published. The survey reflects the high level of concern from NHS staff about their ability to cope with working for additional years, and the capacity for the NHS to cope with an older workforce and will be submitted as supplementary evidence once finalised. Agreement has also been reached on the new Governance arrangements for the NHS Pension scheme. These fulfil the requirements of the Hutton Review and subsequent legislative changes.

Discussions are also ongoing about the scheme valuation and the potential impact of this on future contribution rates.

Agreement in principle was reached around the turn of the year on extending Pension Scheme Access to non-NHS providers of NHS clinical services. Work to finalise the agreement has been held up for several months awaiting HM Treasury approval. We understand that the delay is due to volume and choreography of the various elements of pension policy (including New Fair Deal) rather than any substantive issues, and have used the time to work to develop the package of advice, guidance and communication material which will need to explain and implement the agreement. However, given the policy drive towards new and longer contracts being awarded to a wider variety of providers, it is imperative that a clear policy position is available soon in order that new provisions can be taken into account within the procurement process.

3.2.6 Recommendations
Staff Side calls on the PRB to:

• acknowledge the volume of work already undertaken in the last year to deliver the Staff Council work programme and maintain AfC
• recommend that a strong policy position from central Government, supporting AfC as the standard package of terms and conditions for all providers of NHS services, would mitigate industrial tension, promote consistency of treatment for staff in the four UK countries, and free up capacity at all levels to work on the longer term workforce challenges facing the NHS
• recommend that the Staff Council undertakes initial discussions to investigate the potential benefits of sub-Staff Council structures in England particularly in relation to supporting the national agreement and preventing further divergence of approach between England and the other three UK countries
• consider the main findings and recommendations made in the Work Foundation 10 year retrospective of Agenda for Change and its central recommendation that any attempt to “dismantle AfC as a national framework would be seriously misplaced and that effort would be best expended on improving on and adapting its core provisions through a process of negotiation and consent”.
3.3 The NHS non-medical workforce in numbers

The non-medical workforce has shrunk across almost all parts of the UK since 2010.

<table>
<thead>
<tr>
<th>Country</th>
<th>Date</th>
<th>No. full-time equivalent</th>
<th>% annual change</th>
<th>% change since 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>March 2013</td>
<td>940,358</td>
<td>-0.43</td>
<td>-2.38</td>
</tr>
<tr>
<td>Scotland</td>
<td>March 2013</td>
<td>119,410</td>
<td>1.65</td>
<td>-1.93</td>
</tr>
<tr>
<td>Wales</td>
<td>September 2012</td>
<td>66,091</td>
<td>0.13</td>
<td>-1.05</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>March 2012</td>
<td>50,234</td>
<td>1.33</td>
<td>0.18</td>
</tr>
</tbody>
</table>

In England, some of the decrease in staffing numbers is explained by redundancies incurred as a result of the transition of duties and responsibilities to new NHS organisations. This transfer on 1 April 2013 involved approximately 45,350 staff involved in the transition, with 10,094 full time posts made redundant during this time.4

While the Scottish Government has a no compulsory redundancy policy for the public sector, the Scottish Government announced in 2010 that they intended to reduce the number of senior management posts in NHS Scotland by 25 per cent by 1 April 2015. NHS Boards have so far realised a 16.1 per cent reduction (212.4 whole time equivalent (WTE) posts).

There have also been losses to frontline posts, as acknowledged by the Foundation Trust Network, which has reported that Foundation Trusts in England aim to spend £500 million recruiting 10,000 additional frontline clinical staff this year as a short term measure to address shortages. This would mean the recruitment of 4,133 nurses, 1,134 permanent consultants and 1,273 junior doctors. The remaining 3,400 extra posts would be made up of health care assistants, ambulance paramedics, and social care and theatre staff. It states that the investment this year is a ‘short term fix’ to deal with ‘operational pressures’ and that nursing numbers would subsequently fall by four per cent.

4 National Audit Office (2013) Managing the Transition
From April 2013, Local Education and Training Boards (LETBs) took responsibility for workforce planning and commissioning education and training under the leadership of Health Education England. The table below shows Health Education England’s planned commissioning levels for September 2013/14.

At the time of writing, very few LETBs had produced commissioning places, however two examples from the North West and East Midlands show an overall drop of 1.1 per cent in the North West between 2011/12 and 2015/16 and a small increase of 0.5 per cent in the East Midlands.

<table>
<thead>
<tr>
<th>Commission Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nursing, midwifery and health visiting</strong></td>
<td>23,219</td>
</tr>
<tr>
<td>Of which Adult</td>
<td>12,014</td>
</tr>
<tr>
<td>Of which Children’s</td>
<td>2,145</td>
</tr>
<tr>
<td>Of which Mental Health</td>
<td>3,094</td>
</tr>
<tr>
<td>Of which Learning Disability</td>
<td>627</td>
</tr>
<tr>
<td>Of which Midwifery Commissions</td>
<td>2,536</td>
</tr>
<tr>
<td>Of which Health Visitors</td>
<td>2,803</td>
</tr>
<tr>
<td><strong>Allied health professional commissions</strong></td>
<td>7,148</td>
</tr>
<tr>
<td>Of which Chiropodists</td>
<td>362</td>
</tr>
<tr>
<td>Of which Diagnostic Radiographers</td>
<td>1,053</td>
</tr>
<tr>
<td>Of which Dietitians</td>
<td>329</td>
</tr>
<tr>
<td>Of which Occupational Therapists</td>
<td>1,569</td>
</tr>
<tr>
<td>Of which Operating Department Practitioners</td>
<td>818</td>
</tr>
<tr>
<td>Of which Orthoptists</td>
<td>76</td>
</tr>
<tr>
<td>Of which Paramedics</td>
<td>406</td>
</tr>
<tr>
<td>Of which Physiotherapists</td>
<td>1,466</td>
</tr>
<tr>
<td>Of which Prosthetists/Orthotists</td>
<td>30</td>
</tr>
<tr>
<td>Of which Speech and Language Therapists</td>
<td>666</td>
</tr>
<tr>
<td>Of which Therapeutic Radiographers</td>
<td>373</td>
</tr>
<tr>
<td><strong>Clinical psychology commissions</strong></td>
<td>553</td>
</tr>
<tr>
<td><strong>Pharmacy commissions</strong></td>
<td>958</td>
</tr>
<tr>
<td>Of which Pharmacists</td>
<td>641</td>
</tr>
<tr>
<td>Of which Pharmacy Technicians</td>
<td>317</td>
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</table>

<table>
<thead>
<tr>
<th>North West</th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>2011/12 (Actual)</td>
</tr>
<tr>
<td>Nursing</td>
<td>3,175</td>
</tr>
<tr>
<td>Midwifery</td>
<td>231</td>
</tr>
<tr>
<td>Allied Health Professions</td>
<td>1,114</td>
</tr>
</tbody>
</table>

Source: North West LETB Workforce Development and Education Commissioning Strategy 2013/14 to 2015/16
Looking just at nursing, midwifery and health visiting commissions, the RCN’s Labour Market Review reports that this year, there are roughly 5,000 fewer places than in 2009/10 across the UK. However, this trend will be reversed in 2013/14 with a three per cent increase across all UK countries. Commissioned places are set to rise by two per cent in England, by 10 per cent in Wales, five per cent in Northern Ireland and four per cent in Scotland.

Vacancies and shortages

Once again, due to the paucity of published information on vacancies and shortages, we are unable to comment in any depth on vacancies and workforce shortages. However, the Care Quality Commission (CQC) reported that out of the NHS hospitals investigated in 2012 in England, 15 per cent were non-compliant on staffing standards highlighting the effect of inadequate staffing on patient care. The CQC stated that: ‘Issues to do with staffing emerge as a key driving factor in many instances of non-compliance, both in terms of the numbers of staff available and in the support they are given to do their job. The non-availability of temporary staff and organisations leaving vacancies open for a number of months – particularly for qualified staff – can lead to compromises in the quality of care given to people, and staff training and supervision.’

Data from NHS Scotland shows that total nursing and midwifery vacancies were 1,673 WTEs as at June 2013, an increase of 688 (70 per cent) since June 2012 and of 1,116 since September 2010. Vacancies for Allied Health Professionals stood at 457 as at June 2013, an increase of 147 (47 per cent) since June 2012 and 330 (260 per cent) since September 2010. Data is unavailable for the three other UK countries.

There are emerging signs of shortages in certain specialisms, for example for therapeutic radiographers and sonographers. The vacancy rate for qualified therapeutic radiographers was 6.1 per cent as of 01/11/2012. This is a slight easing of the situation when compared with 7.6 per cent the year before. However, there continues to be pressure on this occupation, with an increasing demand as a result of the increasing prevalence of diseases such as cancer. At the moment there are not enough therapeutic radiographers to meet demand, and optimal radiotherapy treatment levels are not being met.

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5 The CQC standards state that: “In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.” Care Quality Commission (2010) Summary of regulations, outcomes and judgement framework


www.cqc.org.uk/sites/default/files/media/documents/20120626_cqc_market_report_issue_1_for_website_final_0.pdf

7 Society and College of Radiographers and IPEM, Report on the Census of the Radiotherapy Workforce in the UK 2012
There also continue to be challenges in therapeutic radiography education retaining students for the length of the course; attrition from training remains relatively high compared to other AHP courses.\(^8\) In relation to ultrasound, available data from the Department of Health in England indicates a five per cent annual increase in demand for the activity conducted by sonographers.\(^9\) In April 2013, the *Herald* newspaper ran an editorial on the shortage of diagnostic radiographers (and in particular sonographers) in Scotland. Some pregnant women were being expected to make a return trip of 200 miles for antenatal scans due to difficulty recruiting a sonographer locally.\(^10\)

### 3.4 The economy and wages

The combination of high inflation, weak earnings growth and fiscal tightening continues to push down real disposable income. In fact, the Institute for Fiscal Studies (IFS) reports that across the UK economy, workers are 15 per cent worse off than they would have been if the pre-crisis wage trends had continued. The IFS states that much of the fall in pay is due to widespread nominal wage cuts for workers staying in the same jobs, rather than being driven by inflation outpacing pay growth or people losing high paid jobs and taking worse paid roles.

Pay restraint across the public and private sectors has had a weakening impact on consumer demand and the labour market. Disposable income is falling as is household consumption which makes up around two thirds of gross domestic product (GDP), meaning that economic recovery will be even more elusive if workers continue to have little money to spend.

The prolonged squeeze on real pay in the private sector is linked to structural problems in the sector, due in large part to low productivity levels and low rates of investment and this is blocking economic growth. In turn, lack of growth is impacting on public spending levels and once again, this is a problem which originated in the private sector being outsourced to the public sector with its workforce bearing the brunt.

### 3.5 Recommendations

Staff Side asks the PRB to acknowledge that vacancy figures from Scotland indicate that vacancy levels are rising, and that work is needed to improve data collection on vacancy levels to enable effective workforce planning.

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\(^10\) www.heraldscotland.com/comment/herald-view/we-need-scotland-wide-radiography-solution.20951478


www.lochaber-news.co.uk/News/Pressure-mounts-over-baby-scan-crisis-25042013.htm
4. **Pay and prices**

4.1 **Inflation**

For the purposes of capturing the true value of cost of living pressures on NHS staff, Staff Side uses the RPI measure of inflation which incorporates a broader range of goods than the Consumer Price Index (CPI).

When the CPI was introduced in 2003, the Government made it clear that RPI would continue to be used as the index to which changes in benefits, tax credits and tax allowances would be linked.

However, this position was eroded by the current Government when the index for uprating of benefits, tax credits and public service pensions was switched to CPI in April 2011. Substituting CPI for RPI in the analysis of this report reduces the apparent slowdown in median earnings, however the overall trend is similar.

RPI remains in use for the indexing of private contracts, tax allowances and Government gilts, and for workers the key issue is that RPI continues to be used as a benchmark for the great majority of pay negotiations and for student loan calculations.

4.2 **Using RPI in NHS pay bargaining**

Staff Side has consistently maintained that the RPI measure of inflation represents the best measure of changes in prices faced by NHS staff, as it includes the housing costs that form a significant part of most employee’s expenditure.

This position is based on the fact that:

- RPI is more closely tied to the inflation faced by employees than CPI
- RPI includes the housing costs that form a major component of costs faced by most workers yet are omitted from CPI
- RPI is not based on a statistical technique that understates inflation and skews the figures for CPI.

RPI inflation ran above five per cent through almost the entirety of 2011. It subsequently went through a decline but since mid 2012 has stabilised around the three per cent mark. Although the one per cent uplift in NHS pay in April 2013 went some way to close the gap between the cost of living and NHS pay rates, the rate of increase in the cost of living that has opened up during 2010 has been sustained over the last four years.
The graph below shows that NHS pay awards have been significantly below CPI and RPI over the last four years. Since November 2009 the monthly RPI figures have been above the annual pay award for 95 per cent of the period to May 2013, while monthly CPI figures have surpassed awards for 98 per cent of that time.

Medium range forecasts from the Treasury suggest that inflation rates will continue to take additional bites out of the value of NHS wages and impact significantly on the lower pay bands of AfC if the annual rise is limited to one per cent. The Treasury average of independent forecasts places RPI inflation in the region of three per cent right up until 2017. The medium term forecast puts the expected rates at the following levels:

<table>
<thead>
<tr>
<th>Year</th>
<th>RPI forecast %</th>
<th>Cumulative increase in cost of living %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>3.2</td>
<td>3.2</td>
</tr>
<tr>
<td>2014</td>
<td>2.9</td>
<td>6.2</td>
</tr>
<tr>
<td>2015</td>
<td>3.3</td>
<td>9.7</td>
</tr>
<tr>
<td>2016</td>
<td>3.3</td>
<td>13.3</td>
</tr>
<tr>
<td>2017</td>
<td>3.6</td>
<td>17.4</td>
</tr>
</tbody>
</table>
If these rates turn out to be correct, the cost of living faced by NHS employees will have grown by 17 per cent by the end of 2017, as reflected by the graph below showing the cumulative impact of inflation forecasts.

While the future state of the economy is hard to predict, the May 2013 Bank of England inflation report described the economic recovery as ‘weak and uneven’ with inflation running above target for at least two more years due to external price pressures and ‘administered and regulated prices.’

### 4.3 Impact on NHS wages

The effect of inflation on the wages of NHS staff can be seen in the charts below; we have used as examples of staff on the top of their AfC bands, to avoid the complication of incremental pay rises.

Taking the salary of a Band 5 worker at the top of their scale in April 2006 it shows how their actual salary increased through to April 2010 and then illustrates their salary as remaining flat with a small uplift in April 2013. In contrast, the diagram also tracks their salary if it had increased in line with the yearly RPI.

In March 2013 the Chancellor of the Exchequer announced a further year of the continued one per cent cap on the pay uplift of public service workers until 2016. Using the independent Treasury forecasts on inflation we have shown in the graph the impact of inflation on a Band 5 salary up to 2016 with a capped one per cent pay award every year up to April 2016.

---

www.bankofengland.co.uk/publications/Pages/inflationreport/infrep.aspx
The chart below shows that the gap between the two initially grew steadily before closing to approximate parity when RPI was declining in 2009. However, since then the combined impact of surging inflation and the pay freeze for Band 5 in 2011 and 2012 has seen the gap continue to grow to over £4,000 in 2013 and on current inflation projections even with a one per cent uplift inflation will take out 13 per cent of the value of a Band 5 worker’s salary by the end of 2014. By 2016 even with continual one per cent uplifts every year, inflation is set to strip 17 per cent out of the value of a Band 5 salary.

![Band 5 with 1% uplift](chart1.png)

If no uplift is awarded, the gap between inflation and a Band 5 salary will continue to soar. Using predicted inflation figures for next year, inflation will have taken over 14 per cent off the value of a salary of a member of staff on the top of Band 5 by the end of 2014 and this percentage would increase to over 19 per cent by 2016 if a pay freeze were to be imposed.

![Band 5 with no uplift](chart2.png)

For the lowest paid staff in the NHS the picture is very similar. We highlighted in our evidence to the PRB last year that from April 2013 an employee on pay point 1 of AfC (outside of London) would not be earning the Living Wage. Figures from the Health and Social Care Information Centre (HSCIC) for England identify that there are currently over 19,000 employees outside of London on this pay point.
Staff Side is calling for a fair pay rise for all, which delivers the Living Wage for all staff in the NHS and we have costed out this proposal for the PRB in Chapter 4.

For the purposes of showing the detrimental impact inflation has had on the lowest paid in the NHS we have used an example of someone at the top of Band 1. With a one per cent uplift to their current pay in 2014 there is still a gap of over £2,000 between their actual salary and an RPI indexed salary. Therefore inflation will have taken a 12 per cent bite out of the value of their wages. Using predicted inflation figures, a Band 1 worker with a capped one per cent uplift in pay every year by 2016 will have seen 19 per cent stripped out of the real value of their wages.

The impact of a pay freeze on Band 1 workers would be even more devastating. An employee at the top of Band 1 would see the gap between their actual salary and salary in line with inflation grow to over £2,300 and inflation will have taken 13 per cent out of the real value of their wages. By 2016 with a pay freeze this gap would grow to over £3,500 and 19 per cent respectively.
The chart below shows the impact of awarding a £250 lump sum to a Band 1 salary (for staff salaries £21,000 and under). Inflation still appears to strip 12 per cent off the value of a Band 1 salary.

This trend continues for employees at the top of Band 3 on AfC. Even with a one per cent uplift in 2014-15 inflation will have stripped £2,400 (11 per cent) from a Band 3 salary and by 2016 this will have grown to £3,479 (15 per cent).
For higher paid staff, such as an employee at the top of Band 8a even with a one per cent uplift the differential is anticipated to hit over £7,600 next year – a loss of 12 per cent to the value of their salary.

The longer term impact on NHS wages is illustrated by the chart below, which takes a wage of £25,000 in the year 2000 and tracks the net impact of pay awards and inflation as an example of how its real value has grown and declined. The exercise shows that the real value of the wage grew to a high of £26,146 by 2005, but the gap between inflation and the pay award has been so dramatic that the real value has now actually dipped below to £22,966 and this trend is set to continue into 2014.

The Croner Reward cost of living survey provides a rare indicator of the impact of inflation on differing income groups as it analyses the required income to maintain a family’s existing standard
across eight income groups. The 2010 and 2011 reports showed that the lowest income group experienced bigger percentage rises in required income than any other income group at six per cent and 6.6 per cent respectively, though this tendency was arrested in 2012, when the lowest income groups saw their required income growth drop below the average to 5.2 per cent.

However, long term studies of the impact of inflation on different income groups still suggest that low income groups suffer disproportionately. For example, the Institute for Fiscal Studies published a report in 2011 which found that the greater tendency of low income households to spend a higher proportion of their income on fuel and water meant that, on average, lower income households had higher inflation rates than higher-income households. Over the 10 year period studied, the group within the second lowest income decile experienced a 41 per cent increase in prices while the highest income decile experienced a 33 per cent increase. The study also went on to note that this differential is likely to continue given the forecasts from the Department of Energy and Climate Change that point to price increases in domestic fuel above that of general inflation over the short term.

4.4 Inflation components
The changes in the price of components of the Consumer Price Index over the year to May 2013 as defined by the Office of National Statistics are shown in the tables below.

<table>
<thead>
<tr>
<th>Item</th>
<th>% increase over year to May 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>19.7</td>
</tr>
<tr>
<td>Alcoholic beverages and tobacco</td>
<td>6.2</td>
</tr>
<tr>
<td>Food and non-alcoholic beverages</td>
<td>3.1</td>
</tr>
<tr>
<td>Communication</td>
<td>2.7</td>
</tr>
<tr>
<td>Transport</td>
<td>4.6</td>
</tr>
<tr>
<td>Restaurants and hotels</td>
<td>2.5</td>
</tr>
<tr>
<td>Health</td>
<td>2.4</td>
</tr>
<tr>
<td>Housing, water, electricity, gas and other fuels</td>
<td>4.2</td>
</tr>
<tr>
<td>Furniture, household equipment and maintenance</td>
<td>0.6</td>
</tr>
<tr>
<td>Recreation and culture</td>
<td>1.6</td>
</tr>
<tr>
<td>Clothing and footwear</td>
<td>0.7</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics, Consumer Price Indices, April 2013

The most recent CPI figures were heavily affected by a 19.7 per cent jump in education prices, mainly due to rises in university tuition fees. However, over most of the last year, electricity and gas prices have been a heavy contributor to inflation; household utility bills saw some of the highest rises, with gas prices up by 8.5 per cent, electricity by 7.7 per cent and water by 4.5 per cent.

Transport costs were also a very significant contributor to the rate, with rail prices up by an average of 4.7 per cent. In addition, the transport services element of the transport category, which measures the costs of travelling by road, rail, air and sea (rather than motoring costs) was running at 9.1 per cent in May.

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12 Croner Reward, Cost of Living Regional Comparisons, March 2012
13 Levell P and Oldfield Z, The spending patterns and inflation experience of low-income households over the past decade, Institute of Fiscal Studies, June 2011
The changes in the price of components of the RPI over the year to May 2013 as defined by the Office of National Statistics are shown in the tables below.

<table>
<thead>
<tr>
<th>Item</th>
<th>Average % increase to May 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seasonal food</td>
<td>9.1</td>
</tr>
<tr>
<td>Personal expenditure</td>
<td>5.2</td>
</tr>
<tr>
<td>Consumer durables</td>
<td>4.5</td>
</tr>
<tr>
<td>Alcohol and tobacco</td>
<td>4.4</td>
</tr>
<tr>
<td>Food and catering</td>
<td>3.8</td>
</tr>
<tr>
<td>Housing and household expenditure</td>
<td>3.5</td>
</tr>
<tr>
<td>Mortgage interest payments and council taxes</td>
<td>3.2</td>
</tr>
<tr>
<td>Travel and leisure</td>
<td>0.9</td>
</tr>
<tr>
<td>All goods</td>
<td>2.5</td>
</tr>
<tr>
<td>All services</td>
<td>4.0</td>
</tr>
<tr>
<td>All items</td>
<td>3.1</td>
</tr>
</tbody>
</table>

*Source: Office for National Statistics, Consumer Price Indices, May 2013*

RPI reflected much the same trends apparent in CPI. However, a closer look at the housing costs element of RPI that is omitted by CPI shows that over most of the year rental inflation ran well ahead of mortgage interest payments. However, mortgage interest payments jumped dramatically to 6.6 per cent in October 2012, outpacing rent, which remained steady at three per cent.

Though not specifically assessed by CPI or RPI figures, childcare costs represent a key area of expenditure for many staff. Union surveys have consistently found that around a third of staff have child caring responsibilities. An example of this is shown in the chart below taken from UNISON’s Pay Survey 2013, completed by over 16,000 UNISON members working within the NHS. It highlighted that over 70 per cent of the people that took part had some form of sharing, domestic personal caring responsibility for children.

*Source: UNISON Pay Survey 2013*
Recent changes to the in-work benefits and tax credit system have had a negative impact on household income as highlighted by the Resolution Foundation.\textsuperscript{14} With wages stagnating and tax credits no longer providing an additional support to families, households with an income of only £21,000 after tax are struggling with the increasing rise in the cost of basic food and goods.

Universal Credit is the new system of calculating in-work benefits and is calculated on post tax net income; this means any tax cuts (for example an increase in personal allowance) will reduce the Universal Credit they receive. There is also what is known as a Universal Credit taper set at 65 per cent, which means a family’s post tax income will receive 65 per cent less back in Universal Credit.\textsuperscript{15}

This is a change from the former tax credit system where families were assessed on pre-tax income, which meant changes in personal allowance rates had no impact on how much tax credit a family received. This new system is likely to have a severe impact on the income of lower earning households, who will receive far less support back from in-work tax credits. This was also reflected in UNISON’s pay survey with 12 per cent indicating that changes to tax credit rates will impact on their household.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{chart.png}
\caption{Which change in benefit will impact on your household the most?}
\end{figure}

\textit{UNISON Pay Survey 2013}

The Resolution Foundation found that due to the high cost of childcare and a reduction in tax credits and benefits, a typical middle income family with two children under five would be financially better off if one parent worked full time and the other worked part time and took on part time caring responsibility for their children for the remainder of the week, as they would then be below the benefits threshold to get assistance for childcare\textsuperscript{16}. If both parents worked full time a majority of their net income would go on childcare costs.

\textsuperscript{14} The Resolution Foundation (2013), \textit{Squeezed Britain 2013}  
www.resolutionfoundation.org/publications/squeezed-britain-2013/

\textsuperscript{15} The Resolution Foundation (2013), \textit{Will future tax cuts reach struggling working households?}  
www.resolutionfoundation.org/publications/will-future-tax-cuts-reach-struggling-working-hous/

\textsuperscript{16} Based on a couple (both who work full time) with two children on between £17,000 & £41,000 gross annual household income
As identified in last year’s evidence the annual Daycare Trust survey for 2013 found that nursery care costs continue to rise.\textsuperscript{17} For children under two years old nursery costs rose by 4.2 per cent to £106.38 per week for a part-time place. The annual expenditure for a part-time nursery place would therefore be £5,546 per year. A full-time place would cost over £11,000 a year. Childcare costs for a child aged two and over rose by 6.6 per cent, with an average weekly cost of £103.96 for a part-time place in nursery. The steepest rise in childcare was for older children, which rose by nine per cent. The survey calculated for a family with two school age children; care before and after school would cost around £4,000 a year.

The trust reports that this rise in childcare costs is particularly hard for families on lower incomes that have been affected by a 10 per cent drop in support for childcare through the tax credit system and tax credit rises capped below inflation at one per cent.

4.5 Pay settlements
Median pay settlements across the UK economy have been fluctuating between the two per cent and 2.5 per cent mark over the last year.

\begin{center}
\begin{figure}
\centering
\includegraphics[width=\textwidth]{median_pay_settlements.png}
\caption{Median pay settlements}
\centering
\end{figure}
\end{center}

\textit{Source: Industrial Relations Service}

The scale of the disparity in pay settlement growth between the public and private sectors is shown by the chart below. In April 2010 public and private growth was equal at one per cent, but public and private settlements then began moving in opposite directions and by mid 2011 the public rate had dropped to zero while the private rate was heading toward 2.5 per cent. This position was maintained through 2012 and though the gap has narrowed slightly in 2013, private sector pay settlements are still double those of the public sector.

\textsuperscript{17} Daycare Trust (2013) \textit{Holiday Childcare Costs Survey 2013} www.daycaretrust.org.uk/pages/childcare-costs-surveys.html
This deterioration in the competitive position of public sector pay rates is likely to continue given forecasts of private sector pay settlements that predict the private sector rate will grow at 2.5 per cent over the coming year. Research by XpertHR revealed that 2012 has proved to be a better year for pay awards in the private sector, with the median basic award in the 12 months to 31 August 2012 standing at 2.5 per cent, compared with 2.2 per cent over the same period one year ago. However, the range of pay awards remains similar, with half of all deals continuing to be worth between 1.5 per cent and three per cent.

4.6 Earnings comparisons
Since April 2011, the long apparent disparity between public and private pay settlements has also asserted itself in average earnings. Prior to September 2012, private sector average earnings had been growing at or above the rate of public sector earnings for all but two months. Since September 2012, public sector growth has been running ahead of the private sector. However, this has been almost entirely driven by the decision in June 2012 to reallocate employees of English further education and sixth form college corporations from the public to the private sector. Official estimates of the impact on earnings growth suggest that, if this adjustment had not been made, the public sector would have continued to lag behind private sector earnings growth for the great majority of the period.

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18 Private sector pay forecasts for 2012: the XpertHR survey www.xperthr.co.uk
Average earnings growth is sometimes used as a basis to argue that the public sector continues to see improvements in pay that are not matched by the private sector and particularly as a basis for attacking pay progression.

The flaw in these arguments, aside from the simple distortion of staff allocation noted above, is that the use of average earnings growth for comparisons does not simply reflect changes due to pay settlements and pay progression.

Changes in the average are affected by a multitude of factors that affect the composition of the public and private workforce. Any changes that swell the lower paid end of the workforce and/or reduce the proportion of higher paid employees, such as differences between the sectors in recruiting staff on part time or zero hours contracts, or redundancies that hit the most recent recruits hardest, will act as a downward pressure on the average.

Average earnings growth does not offer any kind of sound basis for judging actual changes in the pay packet of a worker in the public or private sector. Pay settlement data forms a much sounder basis for comparison as it eradicates the differences in workforce composition that affects average earnings growth comparisons. However, it is easy to see from the graph above why the Government and employers are less keen to make comparisons on this basis, as private sector pay settlements have averaged 2.5 per cent for most of the last year, against the public sector average of zero per cent.
The charts below go some way to end the myth that public sector salaries outstrip those in the private sector when comparing salaries. Research by Incomes Data Services on the ‘public sector pay premium’ highlights that staff within the public sector on lower pay bands were largely level with the private sector, however as the pay bands increase public sector pay drops significantly behind the private sector.

![Graph 5: Public v private salaries by IDS job level & sector](image)

When reviewing average earnings growth comparisons between key NHS occupational groups and the public sector average, it becomes apparent that over the last year to March 2013 a proportion of occupational groups have lagged behind the public sector average.

Earnings for NHS infrastructure support occupations were consistently above the public sector average. However this group contains some of the lowest paid and highest paid staff on AfC, such as senior managers are included in this group, which distorts the average earnings growth.

Support to clinical staff (administration and clerical) is another group that saw faster earnings growth than the public sector average, however this in part can be explained by the fact that average earnings for this occupational group falls far below £21,000 per annum and therefore this group would have benefited from the £250 uplift awarded to them in April 2011 and 2012, as well as a one per cent uplift in April 2013. It is important to note that this occupational group is now on a downward trajectory and has seen their growth fall by 0.6 per cent in 12 months.

Nurses, midwives, health visitors, scientific and technical staff, and ambulance staff were all well below the public sector average.

Forecasts of average earnings predict that average earnings growth for 2013 will stand at 2.4 per cent (well above the current 1.5 per cent rate in the health sector) and expand to three per cent.
While earnings growth in NHS has kept pace in comparison to other occupations in recent years, this has now slowed and it is reasonable to assume that with the bounce back of private pay settlements, the NHS is now likely to be losing ground to these comparators. The Annual Survey of Hours and Earnings (ASHE) produced by the Office for National Statistics (ONS) also highlights that average earnings for the four NHS occupational areas highlighted in the graph below are now falling behind from previous years.

Reviewing average earnings for some NHS occupations can be problematic when comparing them with private sector counterparts, as some of the ONS occupational classifications from the ASHE survey contain a variety of jobs with no guarantee of comparing like with like.
Moreover, since the ASHE survey presents earnings in April each year, the data does not take full account of the impact of bonuses paid between December and March which are mainly paid in the private sector.

Source: Annual Survey of Hours and Earnings (% change in median gross annual pay for full time staff at March 2011 and 2012 compared to previous year) and NHS Information Centre Staff Earnings Bulletins (% change in three month to March 2011 and 2012 median full time equivalent total earnings compared to previous year)
The ASHE survey also highlighted a fall in average hourly earnings over the last 3 years across all regions. The graph below identifies that the devolved nations of Wales and Northern Ireland are notably below the UK average.

![Graph showing the fall in average hourly earnings of employees in real terms, 2009-2012 (%)](image)

Source: Annual Survey of Hours and Earnings (ASHE) - Office for National Statistics
4.7 Real earnings
The chart below shows the economy-wide impact of high inflation and low pay settlements on earnings across the economy between 2007 and 2011. On average, median hourly earnings have declined by around 2.7 per cent, but the diagram showing the scale of decline for each point on the income range reveals that there has been a marked trend for earnings losses to hit the lowest paid hardest. The exceptions to this are the bottom two per cent of the workforce, which have had some protection through the national minimum wage.

![Real Earnings Growth, 2007 - 2011](chart)

This picture has been confirmed by household spending figures, which show that weekly household spending is at its lowest level in real terms for 14 years and analysts do not expect spending to recover to its pre-crisis level until 2016-17. 19

4.8 Staff in the lower pay bands
Staff Side evidence to the PRB last year clearly highlighted the impact inflation has had on the real value of NHS pay and particularly the impact this has had on the lower pay bands.

Currently the Scottish Government’s NHS pay policy commits employers covered by it to apply a Scottish Living Wage of £7.45 per hour from April 2013. This means that in Scotland pay point 1 on AfC is no longer used. The Welsh Government’s NHS pay policy is also to pay the Living Wage of £7.45 per hour; however some NHS staff are still being paid on pay point 1. Northern Ireland and England have no current Government pay policy regarding the Living Wage in the NHS.

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Historically the lowest pay point on AfC has always been above the Living Wage, however this changed in November 2012 when the Living Wage rose from £7.20 an hour to £7.45 an hour. The up-rating of the Living Wage figure each year takes into account the rises in living costs. As a consequence of the current economic climate, wage increases are falling behind living costs. Therefore, to protect low paid workers against the effects of this, their pay would need to increase significantly.

The Living Wage takes some account of what is happening to wages generally, to prevent a situation where Living Wage employers are required to give pay rises that are too far out of line with general pay trends. It is an hourly rate which is set independently and is calculated according to the basic cost of living. NHS staff on pay point 1 of Bands 1 and 2 who receive a High Cost Area Supplement (HCAS) are already paid the Living Wage, so for the purposes of our costings we have excluded staff on pay point 1 within London.

Since the one per cent pay uplift in April 2013 NHS staff on AfC pay point 1 of Bands 1 and 2 who live outside of London are now earning below the Living Wage. Following a recent Freedom of Information request to the Health and Social Care Information Centre the number of those employed in NHS staff roles (England only) on pay point 1 and therefore earning below the Living Wage was 19,915 by headcount.

Staff Side has calculated that all staff on pay point 1 would need uplift in salary of 14p per hour in to bring them up to the Living Wage. If we used the figures below (excluding London) this would cost a total of £5.49m to the NHS pay bill.

**Workforce figures in England for staff on AfC on pay point 1, including London figures**

Using standard publication data:

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>London</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of staff (roles) on spine point 1</td>
<td>22,152</td>
<td>2,237</td>
</tr>
<tr>
<td>Sample size</td>
<td>1,047,946</td>
<td>150,781</td>
</tr>
<tr>
<td>Percentage</td>
<td>2.1</td>
<td>1.48</td>
</tr>
</tbody>
</table>

*NHS Information Centre, workforce figures in England on AfC pay point 1, December 2012*

The number of NHS staff paid below the Living Wage increases by a small amount if those staff covered under Annex U are included, as trainees are only paid a percentage of their salary while they are in training. There are approx 327 NHS trainees on pay point 1 (outside of London) that are currently paid below the Living Wage, therefore to bring them in line it would cost an additional £87,309 to the NHS pay bill.

To pay the Living Wage by raising pay point 1 for members of staff and Annex U trainees up to the Living Wage would cost in total approximately £5.58m.

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20 Centre for Research in Social Policy, Loughborough University
www.lboro.ac.uk/research/crsp/mis/thelivingwage/
Workforce figures in England for staff on AfC on pay point 1, including London figures

Including staff roles normally excluded from publications\textsuperscript{21}:

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>London</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of staff (roles) on spine point 1</td>
<td>22,491</td>
<td>2,249</td>
</tr>
<tr>
<td>Sample size</td>
<td>1,054,187</td>
<td>151,609</td>
</tr>
<tr>
<td>Percentage</td>
<td>2.13</td>
<td>1.48</td>
</tr>
</tbody>
</table>

Source: NHS Information Centre, workforce figures in England on AfC pay point 1, December 2012

The table below shows the bottom pay points on AfC and the number of staff that would require £273 uplift in order to deliver the Living Wage.

<table>
<thead>
<tr>
<th>AfC Pay Scales</th>
<th>Salary (£) 1 April 2013</th>
<th>Living Wage £7.45 per hour</th>
<th>Difference to pay (£)</th>
<th>Headcount England only (excl London)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay Point 1</td>
<td>14,294</td>
<td>14,567</td>
<td>-273</td>
<td>20,242</td>
</tr>
<tr>
<td>Pay Point 2</td>
<td>14,653</td>
<td>N/A</td>
<td>-273</td>
<td></td>
</tr>
<tr>
<td>Pay Point 3</td>
<td>15,013</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Band 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay Point 1</td>
<td>14,294</td>
<td>14,567</td>
<td>-273</td>
<td></td>
</tr>
<tr>
<td>Pay Point 2</td>
<td>14,653</td>
<td>N/A</td>
<td>-273</td>
<td></td>
</tr>
<tr>
<td>Pay Point 3</td>
<td>15,013</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Characteristics of NHS staff on pay point 1 and not currently paid the Living Wage were that they are predominately female, part-time and a high proportion of staff were between the age ranges of 19-24 years old.

Source: NHS Information Centre, Pay Point 1 by Age Range, July 2013

\textsuperscript{21} This includes staff records normally excluded from national earnings publications as they fail to meet validity screening. These records are however deemed relevant to this data request, and include staff paid less than £14,527.50, possibly due to payment arrangements such as those covered by Annex U of the NHS Terms and Conditions Handbook.
Research from the Living Wage Foundation and The Resolution Foundation has found that by paying the Living Wage operational costs of private and public sector organisations have been cut, staff turnover has fallen, absenteeism went down and employers felt the quality of work from their staff increased.\(^\text{22}\) The Resolution Foundation also identified savings to the Treasury by paying the Living Wage, as it would reduce the need to rely on in-work benefits and increase tax yield from income tax and employer’s national insurance contributions.\(^\text{23}\)

<table>
<thead>
<tr>
<th>Breakdown of potential public sector savings from raising all low paid workers to the Living Wage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee NICs</strong></td>
</tr>
<tr>
<td><strong>Tax credits</strong></td>
</tr>
<tr>
<td><strong>Means tested benefits</strong></td>
</tr>
<tr>
<td><strong>Income tax</strong></td>
</tr>
<tr>
<td><strong>Employer NICs</strong></td>
</tr>
</tbody>
</table>

**Source:** Resolution Foundation Squeezed Britain 2013

### 4.9 Other factors affecting staff living standards

Following the Hutton review of public sector pensions, pension contribution increases have added another component to the decline in take home pay. From union surveys we know that a high proportion of NHS staff pay into the NHS pension scheme, although this year a small percentage of staff in UNISON’s pay survey indicated that they have deferred from the NHS pension scheme, which is a worrying trend for the sustainability of the pension scheme. There is a danger that pensions could become an unaffordable luxury and as evidenced in last year’s IDS joint union Staff Side survey, NHS staff are seeing a fall in take home pay and increased workloads in an environment of diminishing resources.

During 2012/13 employee contribution increases were introduced for staff who earned in excess of £26,557. The following contribution rates have been set for 2013/14 and were payable from 31 March 2013. This means that a nurse at the top of Band 5 has had their take home pay reduced by around £552 (after tax relief). Pensions contributions are set to increase again next year, and currently the Government has disclosed a 0.13 per cent shortfall in the NHS pension yield as at April 2013. Staff Side have asked for a full report on the reasons for this, however it is expected some of

\(^{22}\) The Living Wage Foundation [www.livingwage.org.uk/](http://www.livingwage.org.uk/)

the reasons are a combination of job losses following reorganisations, depression in pay growth and scheme member opt outs. It is Staff Side’s position that any cash loss as a direct outcome of Government policy to reduce the workforce and depress pay should not be passed onto NHS staff in increased contributions above those already proposed.

<table>
<thead>
<tr>
<th>Tier</th>
<th>Pensionable pay (whole-time equivalent) paid in 2012/13</th>
<th>Contribution rate in 2013/14 %</th>
<th>Proposed contribution rate in 2014/15 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Up to £15,278.99</td>
<td>5.0</td>
<td>5.0</td>
</tr>
<tr>
<td>2</td>
<td>£15,279.00 to £21,175.99</td>
<td>5.3</td>
<td>5.6</td>
</tr>
<tr>
<td>3</td>
<td>£21,176.00 to £26,557.99</td>
<td>6.8</td>
<td>7.1</td>
</tr>
<tr>
<td>4</td>
<td>£26,558.00 to £48,982.99</td>
<td>9.0</td>
<td>9.3</td>
</tr>
<tr>
<td>5</td>
<td>£48,983.00 to £69,931.99</td>
<td>11.3</td>
<td>12.5</td>
</tr>
<tr>
<td>6</td>
<td>£69,932.00 to £110,273.99</td>
<td>12.3</td>
<td>13.5</td>
</tr>
<tr>
<td>7</td>
<td>£110,274.00 and over</td>
<td>13.3</td>
<td>14.5</td>
</tr>
</tbody>
</table>

Source: NHS Pension Scheme: 2013/14 Tiered Employee Contributions Year Two of Three

4.10 A longer term view
Pay settlements in the private sector are currently higher between 2.5-3 per cent, in comparison to the public sector. Public sector pay is reform higher on the Coalition Government’s agenda with proposed pay caps at one per cent for the next two years, it is therefore likely that the attractiveness of a career in the NHS will have declined relative to the private sector. Careful attention will need to be paid to whether the NHS continues to lag behind comparable occupations. Staff Side calls on the PRB to give due attention to labour market dynamics and assess the longer term impact of the pay freeze and other factors such as workload, career progression and the work environment on the attractiveness of the NHS as an employer.

The number of staff at the top of each AfC pay band has increased in recent years, and for some NHS occupational groups, this can mean that well over half are at the top of their band. Alongside this, the growing use of down banding across the NHS means reduced opportunities for career progression across many health occupations. Staff Side therefore calls on the PRB to examine this situation further and assess the impact on both actual and perceived career prospects in the NHS.

When AfC was agreed, the system allowed for three pay spines and three methods of pay determination ie doctors and dentists, nurses and other health professions and the third for other NHS staff (except some highly-graded senior managers). The latter two have since merged. The agreement stressed the need for coordination between PRBs on equality issues. Additionally, recent changes to AfC on incremental pay have changed the dynamics of pay determination across the NHS. Staff Side believes it is time to revisit this approach, and assess to the proportion of funds allocated to key groups of staff across the three original pay spines and the equality implications of this allocation.

The final year of the 2008/11 agreement provided for the reduction of of the length of Pay Band 5. It also provided for further talks on proposals to reduce the number of incremental pay points (starting with Pay Bands 6 and 7). Staff Side calls for this agreement to be revisited as part of a wider examination of the structure of AfC and the length of pay bands.

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24 Incomes Data Services www.idspay.co.uk
25 Annex A: Full text of the three-year pay agreement reached by the parties www.ome.uk.com/NHSPRB_Reports.aspx
4.11 Conclusion

The most striking aspect of the latest economic data is the sheer scale of the devaluation of NHS staff wages caused by inflation. The best projections available suggest that inflation will have cut out between eight per cent and 12 per cent from the value of salaries between 2010 and 2014.

Our data has shown that household incomes are likely to be significantly impacted by changes to the in-work tax credits system under a system of Universal Credit. As this is a newly adopted Government Policy from 1 July 2013, the evidence for this will be seen in the coming months especially as inflation continues to rise, and added to this the high percentage rise of year on year childcare costs felt by families across the UK.

While the one per cent uplift increase across the AfC payscales has made a small contribution to the salary of NHS staff, the impact on low paid staff is still a major concern for Staff Side. The reduction in the value of their wage is still severe, especially for those on pay point 1 and plainly has a greater impact on their ability to afford to cover the most basic aspects of expenditure on housing, food and energy and childcare costs. Furthermore, the available evidence once again suggests that inflation for the low-paid is running at an even higher level than the RPI. There is a rising public awareness and clear moral case for bringing in a Living Wage for low paid NHS staff. This is an achievable goal as Scotland has already shown and such an outcome would serve the purpose of re-harmonising all the UK countries under the same pay regime.

4.12 Recommendations

Staff Side calls on the PRB to assess the longer term impact of the pay freeze and to consider the impact on the attractiveness of the NHS as an employer.

Staff Side calls on the PRB to assess the prospects for career progression in the NHS given the increasing number of staff at the top of each AfC pay band, the use of downbanding and squeezed training budgets.

Staff Side calls on the PRB to re-visit the arrangement made at the time that AfC was introduced that there should be coordinated between the different NHS pay review bodies on equality issues. This review should assess the proportion of funds allocated to key groups of staff across the different spines and the equality implications of this allocation.

Staff Side calls on the PRB to review the structure of AfC, relating to the size and spacing of incremental pay points.

Staff Side calls on the PRB to protect the lowest paid staff in the NHS by awarding an increase that brings staff on Pay Band 1 up to at least the level set for the Living Wage.
5. **NHS Finances**

5.1 **State of financial accounts: England**

England NHS finances continue to face pressure from the Government’s austerity programme, with NHS funding only increasing by 0.1 per cent in real terms in 2015-16.  

The Institute for Fiscal Studies (IFS) has analysed departmental budgets in this year’s ‘Green Budget’. The chart below taken from this publication shows a very small increase in the real value of the NHS budget.  

**Change in real value of departmental budgets 2010-15**

![Chart showing change in real value of departmental budgets 2010-15](source: Institute for Fiscal Studies)

As funding pressures continue within the NHS, without additional funding to help secure the long term financial sustainability of patient services, NHS organisations continue to look towards cutting

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26 Spending Round 2013, June 2013  
27 The IFS figures are based on departmental budgets adjusted by the GDP deflator. Since the deflator only calculates inflation for goods and services produced within the UK, this means that its accuracy depends on the rise in prices of imports showing a similar pattern. However, the substantial difference in forecasts for the GDP deflator and retail inflation suggests that this is not the case (for instance, RPI for 2015 is forecast to stand at 3.2 per cent while the GDP deflator is predicted to reach just 1.8 per cent). Particularly in areas of NHS operations where imported goods account for major costs, such as pharmaceuticals and hospital equipment, the flaws in the GDP deflator cast doubt on whether the budget of the NHS is being protected from a real terms decline.
their workforce in order to gain savings or alternatively by trying to gain efficiency savings through greater productivity.

Joint union surveys have consistently shown that members of staff in the NHS have been identifying year on year increases in workloads and stress attributed largely to vacancy freezes, redundancies and staff shortages. In addition these surveys have also identified the decline in morale and motivation within the NHS workforce due to these increased workloads and pressure from managers to keep meeting annual financial and Government targets in an environment of dwindling resources.

In the latest Government spending review in June 2013, the Chancellor introduced a £3.8 billion pooled budget for Health and Social Care services which will be shared between the NHS and Local Authorities. While we welcome the move towards more integrated health and social care it seems this pooled budget will come from the existing NHS budget, with no additional funding. Greater integration may save the NHS money and resources in the long term but this is an immediate cut in budget and is likely to lead to serious issues in the short term at the very least and it is quite clear that the NHS budget is neither ring-fenced nor protected as the Government claim. We are also alarmed about the announcement of a 10 per cent cut in administration budgets. While we have little information on this announcement, we are concerned about the impact on team working and productivity with the NHS – administration cannot simply be cut without a knock-on effect on other parts of the service.

‘Frontline services’ can only be effective with good support from other parts of the NHS including administration, finance, procurement, record keeping, IT, management, staff training and HR. Staff Side campaigns for the contribution of all staff in the NHS to be recognised and fairly rewarded.

In the most recently published annual accounts from October 2012 the NHS in England recorded a surplus of almost £1.6 billion for the 2011/12 financial year, furthermore in the quarter running from July to September 2012, SHAs and PCTs were recording an overall surplus of £1.184 million and their accounts were highlighting that the NHS has delivered a further £1.2 billion of savings through Quality, Innovation, Productivity and Prevention (QIPP).  

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28 David Flory, Deputy NHS Chief Executive, The Quarter, Q2, 2012-13
As identified in last year’s Staff Side evidence, the chart below shows the NHS in England has achieved a surplus in every one of the last six financial years and the cumulative value of those surpluses now stands at almost £8.6 billion.

The Foundation Trust Sector delivered a surplus before exceptional items of £540 million for the year ended 31 March 2013. This was £159 million ahead of plan and a £31 million improvement on last year. Cash balances continued to grow strongly and the sector had £4.5 billion on the consolidated balance sheet.²⁹

The number of Foundation Trusts in deficit rose from 15 to 16 trusts, which stayed in line with the consistently low level seen over the last three financial years.

5.2 State of financial accounts: Scotland

In 2011-12, Scotland committed £11.7bn to health spending - a third of the country’s total budget. The Scottish Government continues to protect the 14 territorial health boards, which provide frontline services, from the worst of public sector cuts by setting out real terms increases in their core funding.

Audit Scotland reported that by the end of the 2011-12 financial year, all 23 Scottish NHS boards had broken even, which they are all obliged to do.³⁰ Indeed a small surplus was recorded for NHS Scotland as a whole, though the surpluses were small at less than 1 per cent of budget for all but one health board. However beneath these headlines, nine frontline boards concluded the year with an underlying recurring deficit. Total efficiency saving forecasts for 2011-12 were also realised, although many boards were heavily reliant on finding one-off, non-recurring savings to meet their end of year targets, rather than building on sustainable long-term cost-reductions.

²⁹ Monitor, Performance of the Foundation Trust Sector, March 2013
wwwaudit-scotland.gov.uk/docs/health/2012/nr_121025_nhs_finances.pdf
The Auditor General for Scotland has called for the Scottish Government to allow NHS boards to focus on more long term planning, rather than solely on year end break-even targets, to ensure long-term sustainability.31

5.3 State of financial accounts: Wales
The NHS in Wales met its challenging financial targets in 2011-12 by a combination of significant £285 million worth of savings reported by NHS bodies and some additional funding from the Welsh Government. The additional funding consisted of £133 million funding uplift to all Health Boards to address NHS cost pressures and £24.4 million of advances from 2012-13 funding to four Health Boards to ensure they achieved break even.

5.4 State of financial accounts: Northern Ireland
The written evidence from the Department of Health, Social Services and Public Safety (DHSSPS) in Northern Ireland from October 2012 highlighted that the DHSSPS budget allocations provided for eight per cent cash uplift by the end of the four year budget period in 2014/15. Budget allocations included £35 million to meet anticipated increases in the DHSSPS pay bill. Interestingly the department in last year’s evidence to the PRB identified that they had put aside part of the funding in order to address the erosion for the differential between AfC pay points 15 and 16, however this was not addressed by the PRB in their recommendations and therefore this allocation of money was under spent.

5.5 NHS Transition in England and the future financial position
The Treasury Spending Round announced in June 2013 specified an expansion of the Department Expenditure Limit from £113.0 billion in 2014/15 to £115.1 billion in 2015/16. This represented an increase of 1.8 per cent, and projections of the GDP deflator meant that the Government was able to claim that it was meeting its promise to increase the budget in real terms in the most minimal way possible, with an increase of 0.1 per cent. However, as outlined earlier in this chapter, the flaws of the GDP deflator mean that even this claim is open to serious doubt. It is also worth noting that the £3.8 billion pooled budget taken from the NHS budget for Health and Social Care services is a further cut in real terms to the NHS allocated budget.

Following the Health and Social Act 2012 there has been widespread reform of the health system in England. Most of these changes came into effect on 1 April 2013 which included the creation of new commissioning structures and groups, as well as the continuing policy of financial restraint of finding £20 billion worth of efficiency savings in the four years up to 2014-15.

The reported cost of the NHS Transition reforms was £1.1 billion; over 10,000 full time staff were made redundant with an average redundancy payment of £43,350, however the Department of Health’s estimate of savings as a result of the reforms is £2.4 billion.33 These savings were made due to reduced administration costs and reduced spending by strategic health authorities. The wider benefits of the reforms are still not known, however the Department of Health have a view that the newly created arm’s length bodies are to have more accountability of their own finances. What is clear however is that the process of NHS reform in England has created a great amount of uncertainty within the NHS workforce with regard to job security.

33 National Audit Office, Managing the transition to the reformed health system, July 2013
Historically, the NHS has received budget increases in the order of four per cent above inflation to deal with both the rate of inflation in its costs and the expansion of demand on the service due to an aging and growing population. The Nuffield Trust have identified that pressures on the NHS will grow at around 4 per cent a year up to 2021/22 and if NHS funding is held flat in real terms, the NHS in England could have a funding gap of £44 to £54 billion by 2021/22.34 A majority of efficiency savings highlighted by the Nuffield Trust was through productivity savings.

5.6 Impact of incremental rises
NHS staff receive an incremental boost to their wage in recognition of their increased experience, expertise and contribution. The actual ‘rate for the job’ is the top of the pay band and staff will usually start at the bottom of the band and then after gaining experience (and sometimes ongoing training) will, over time, go through the pay bands to the top. Many staff will then remain at the top of the band until they are promoted, change jobs or their job is re-graded. Staff can be at this level for many years where they are considered to be performing the full range of duties and have achieved the right level of competence.

Each AfC pay band or pay range has a number of points and each year, staff below the maximum point of their pay band or pay range can expect progression to the next highest point. There are also two points on each pay band, known as gateways when there is an assessment of the knowledge and skills that staff are applying in their jobs.

Pay progression at the two gateways is linked to the demonstration of applied knowledge and skills. The values of these points increase in steps of around three per cent.

The first gateway in each pay band is after one year in post. The second gateway will vary between pay bands as follows:
- Pay Band 1 before final point
- Pay Bands 2-4 before first of last two points
- Pay Bands 5-7 before first of last three points
- Pay Band 8 ranges A-D before final point.

There are no automatic incremental pay increases in the NHS. Under the AfC Agreement and in particular following the changes agreed in England from 1 April 2013, NHS employers, working in partnership with local Staff Sides and using the national guidelines, can develop local criteria linked to appraisals to enable them to monitor staff performance and competencies. Where employers have not developed these systems or staff are not receiving appraisals, then staff will not be held back from incremental progression. Staff Side have argued for years that all staff should be receiving appraisals and the right level of training and support to enable them to do their job well.

The chart below shows the proportion of staff who receive no benefit from incremental progression as they are at the top of their pay band, averaging at 42 per cent across the UK.

England has the lowest proportion at 40 per cent, while Scotland, Wales and Northern Ireland are all well above the average. Northern Ireland has 53 per cent of its staff at the top of their pay band, Scotland has 51 per cent and Wales has 48 per cent.

![Staff at the top of their pay band by country](chart1.png)

Source: Responses to the NHS PRB’s 27th Report from the Department of Health, the Welsh Assembly Government, the Scottish Government Health Department, Department of Health and Social Services and Public Safety in Northern Ireland

The chart below reflects the fact that staff in pay bands one to four are particularly likely to stand at the top of their band. On average, 53 per cent of staff in bands 1 to 4 are at the top of their band in comparison to 42 per cent of staff in band 5 to 9.

![Percentage of staff at the top of their pay bands](chart2.png)

Source: Responses to the NHS PRB’s 27th Report from the Department of Health, the Welsh Assembly Government, the Scottish Government Health Department, Department of Health and Social Services and Public Safety in Northern Ireland
5.7 Impact of workforce changes

Anticipated future financial pressures are plainly pushing Trusts and Boards towards attempting to reduce their workforce. The table below shows findings from three union surveys, highlighting that NHS organisations are responding to financial constraints by restructuring or reorganising services, as well as recruitment freezes, reductions in and down banding of posts.

<table>
<thead>
<tr>
<th></th>
<th>Unite % survey respondents</th>
<th>UNISON % survey respondents</th>
<th>RCN % survey respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restructuring/reorganising services</td>
<td>75</td>
<td>54</td>
<td>24</td>
</tr>
<tr>
<td>Recruitment freezes</td>
<td>54</td>
<td>41</td>
<td>51</td>
</tr>
<tr>
<td>Reduction in posts</td>
<td>54</td>
<td>46</td>
<td>44</td>
</tr>
<tr>
<td>Changes to terms and conditions</td>
<td>38</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Cutting services</td>
<td>31</td>
<td>26</td>
<td>n/a</td>
</tr>
<tr>
<td>Down banding</td>
<td>29</td>
<td>28</td>
<td>n/a</td>
</tr>
<tr>
<td>Outsourcing</td>
<td>17</td>
<td>12</td>
<td>n/a</td>
</tr>
<tr>
<td>Redundancies</td>
<td>n/a</td>
<td>14</td>
<td>6</td>
</tr>
</tbody>
</table>

It is particularly worrying that the Unite survey showed such a high proportion of respondents stating they there have been changes to terms and conditions within their workplace. When prompted further, the main changes reported related to unsocial hours payments and on-call payments. Given the widespread reliance on these payments, it appears that a significant proportion of the NHS workforce is facing a reduction in take-home pay in addition to stagnant wage growth.

The surveys also reported the widespread use of cuts to posts. This is of particular concern as the publication of the Francis Report in February 2013 and the Keogh Review in July 2013 both highlighted the impact of understaffing in the NHS.

The Francis Report into the Mid Staffordshire Foundation Trust provides lessons not only for the hospital itself, but for the Government and for all NHS organisations.

The report identified the need for safe staffing levels and appropriate and right skill mixes in order to deliver high quality, compassionate and dignified patient care. This is a key area that trade unions have been actively campaigning on for the last few years, and particularly through demands for safe staffing levels.

Both reports identified a direct correlation between the quality of care received in specified hospital trusts with staffing levels. The Francis report also highlighted the devastating consequences of financial pressures bearing down on the hospital and the accumulative impact of putting finance before patient care, through organisational savings.

Union surveys have consistently shown a system under pressure, exacerbated by staff shortages. This has also been identified in a recent strategic review of the NHS nursing workforce by the Centre for Workforce Intelligence, who highlight that there will be a shortfall in nursing staff by 2030 due to an aging population and an increase level of demand on the service.  

35 Centre for Workforce Intelligence (2013), A strategic review of the future healthcare workforce: informing the nursing workforce

The over reliance on staff to work extra hours is now the norm in the NHS rather than the exception. It is this over reliance on staff to go the extra mile for little recognition which is now eroding the goodwill of the NHS workforce. Added to this is the detrimental impact on the workforce of care within the NHS being vilified by the media; stories about poor patient outcomes have become daily news stories.

5.8 Conclusion

NHS accounts show that much of the NHS has been recording surpluses over a sustained period and the number of trusts or health boards currently facing a deficit is extremely small. This suggests a certain level of accumulated reserves have been built up by trusts and health boards. Increases in the paybill for due to incremental progression are well within the allocated budgetary rises.

The decline in morale and motivation across the NHS workforce is an exceptionally worrying trend that shows no sign of improving, especially as the NHS is currently under pressure to deliver efficiency savings through workforce productivity. In light of the Francis report it is paramount that NHS organisations recognise that they cannot continue to burden their staff with increased workloads and rely on their goodwill to work extra hours in order to meet financial targets.

5.9 Recommendations

- We ask the PRB to take steps to analyse the extent and impact of changes to working conditions on the NHS workforce, in terms of pay, terms and conditions.
- We urge the PRB to undertake independent research to analyse the financial impact of cuts to on-call payments, unsocial hours payments, changes in shift patterns and down banding on NHS employees in the immediate and longer term.
6. Morale and motivation in the NHS workforce

This section looks at findings from the NHS Staff Surveys for England, Wales and Northern Ireland\(^{36}\), as well as union membership surveys to provide an insight in levels of motivation and morale among the NHS workforce.

We use the following union membership surveys:

- The Chartered Society of Physiotherapy (CSP) membership survey for 2013. Online survey members working in the NHS or related social enterprise companies: 3,082 responses.
- Royal College of Nursing membership survey for 2013. Online survey of 9,636 members, with findings for the 6,584 respondents working for the NHS presented here.
- Unite membership survey 2013 of 2,793 members across the UK
- UNISON membership survey for 2013. Online survey of 16,113 members working in the NHS.

Firstly, the NHS Staff Survey for England showed some encouraging signs on levels of motivation, with the overall score on staff motivation having edged up slightly from 3.76 to 3.82 between 2011 and 2012 (with one being the lowest and five the highest score). However, it is somewhat alarming that only around half (55 per cent) of all staff would recommend their organisation as a place to work. Similarly, just 48 per cent of respondents to the Wales Survey and 56 per cent of respondents to the Northern Ireland Survey indicated they would recommend their organisation as a place to work. Just under a third (29 per cent) of respondents to the Northern Ireland Staff Survey stated they often think about leaving their organisation and 15 per cent stated they would look for another job in the next 12 months.

The CSP membership survey found that almost two thirds (66 per cent) of respondents stated that morale and motivation in their workplace was worse compared to 12 months ago, with 18 per cent saying it was ‘a lot worse’. The main reasons given are shown in the chart below: increased workplace stress (84 per cent); dissatisfaction with the quality of care staff feel able to provide (70 per cent); and the level and extent of restructuring and reorganisation (66 per cent).

The UNISON survey showed that three quarters (75 per cent) of respondents believed workplace morale was worse than 12 months previously while the Unite survey of its members found that morale and motivation was worse for two thirds (68 per cent) of its respondents. The Unite survey found that the four main reasons for falling morale and motivation are: increased workplace stress (76 per cent); restructuring and reorganisation (64 per cent); the falling value of take home pay (61 per cent); and attacks on terms and conditions (56 per cent).

\[^{36}\text{The last Scotland staff survey was conducted in 2010 and results from the latest survey are expected in October 2013}\]
These surveys suggest that the main sources of anxiety and concern among the NHS workforce are increased workplace stress levels and the extent of reorganisation and restructuring within the NHS.

The union surveys also pointed to cuts to terms and conditions as impacting on morale and motivation. In particular, the CSP survey found that 53 per cent of respondents cited the falling value of take home pay as leading to worsening morale and motivation. In addition, eight in ten (82 per cent) feel that their pay levels relative to the cost of living have seen them becoming worse off over past 12 months, while three quarters (77 per cent) feel their household finances have deteriorated.

The UNISON survey found that almost eight in ten respondents (79 per cent) stated they feel worse off compared to 12 months previously. Similarly, the RCN Survey shows that 83 per cent stated that their household income had stayed the same or reduced in the previous 12 months, while 88 per cent said their expenditure had gone down. Almost two-thirds (64 per cent) of respondents to the RCN survey also stated they were increasingly worried about their financial situation.

The UNISON research found that 66 per cent of respondents said they were ‘very’ or ‘fairly’ worried about their job security while half (52 per cent) of RCN respondents stated they were anxious about redundancies and threats to job security.

This level of anxiety about work pressures, workloads, standards of living and job security is clearly impacting on how the NHS is viewed as a career choice. For example the Unite Survey showed that above half (56 per cent) of all respondents said that they would probably not or definitely not recommend their own occupation or profession as a career in the NHS. Other surveys are just as
negative, with just 39 per cent of RCN members and 34 per cent of UNISON members stating they would recommend their career or profession.

Other findings from the RCN survey show that while many continue to believe nursing is a rewarding career, there is a growing pessimism about nursing as a career in the NHS, with just a third (33 per cent) believing nursing would offer a secure job in the future, and only 38 per cent stating that they would not want to work outside nursing. In fact, just under two-thirds (62 per cent) of RCN members working in the NHS have considered leaving their job in the last year.

Looking at the UNISON survey, a similar number (61 per cent) have also considered leaving their jobs either ‘fairly’ or ‘very’ seriously. The main reasons cited by those who have considered leaving are the changing nature of the NHS (restructuring /reorganisation), staff shortages feeling undervalued due to managers’ treatment of staff and feeling undervalued due to levels of pay. Worryingly, half stated they would leave to take up a position completely outside the NHS.

6.1 Workload
Individual union surveys show increasing workloads and staff under pressure. The CSP survey shows that individual workloads have increased over the past year for the majority (87 per cent) of respondents, rising to ‘a lot’ for half (47 per cent). The Unite survey for 2013 showed that a similar number (85 per cent) said that workloads had increased since last year with 50 per cent saying they had increased a lot. The UNISON survey also showed that the majority (86 per cent) reported that workloads had increased.
The table below shows that the main reasons for increased workload are similar for all three surveys with many citing additional duties and responsibilities, insufficient cover and the impact of vacancy freezes.

<table>
<thead>
<tr>
<th>Reason</th>
<th>CSP % survey respondents</th>
<th>Unite % survey respondents</th>
<th>UNISON % survey respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional duties and responsibilities</td>
<td>71</td>
<td>67</td>
<td>65</td>
</tr>
<tr>
<td>Insufficient sickness, maternity or holiday cover</td>
<td>52</td>
<td>40</td>
<td>46</td>
</tr>
<tr>
<td>Pressure to meet Government targets like waiting times</td>
<td>44</td>
<td>32</td>
<td>48</td>
</tr>
<tr>
<td>Vacancy freezes</td>
<td>40</td>
<td>40</td>
<td>44</td>
</tr>
<tr>
<td>Recruitment problems</td>
<td>19</td>
<td>26</td>
<td>25</td>
</tr>
<tr>
<td>Redundancies</td>
<td>5</td>
<td>5</td>
<td>n/a</td>
</tr>
<tr>
<td>More patients/clients using the service</td>
<td>n/a</td>
<td>n/a</td>
<td>43</td>
</tr>
</tbody>
</table>

Rising workloads and pressures are clearly forcing staff to work additional hours to their contracts. The CSP survey showed that the majority (98 per cent) of respondents stated they work more than their contracted hours, with 38 per cent saying they frequently did so and 35 per cent saying they always did so. Almost two thirds (63 per cent) said these extra hours were all unpaid.

The RCN Survey conducted in 2012 showed similar findings with almost two-fifths (39 per cent) of respondents working in the NHS reporting that they work in excess of their contracted hours several times a week and 21 per cent work in excess of their contracted hours on every shift. Just seven per cent of all respondents report never working additional hours. Of those who reported working excess hours, two thirds (66 per cent) work up to four hours per week. A further 11 per cent of respondents work an additional eight hours each week. Over half all respondents (55 per cent) reported that their additional hours are usually not paid. Similarly, over half of UNISON (54 per cent) respondents stated they work unpaid overtime, thus revealing the huge reliance on staff working unpaid overtime in the NHS.
7. **Staff engagement**

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

The concept of engagement can have different meanings. In the King’s Fund report *Employee Engagement and NHS Performance*, the authors state that employee engagement can include various elements including: psychological engagement; proactivity; enthusiasm and initiative; organisational citizenship behaviours and organisational commitment; involvement in decision making; positive representation of the organisation to outsiders.37

In their research they analyse the data from the NHS Staff Survey for England 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 clearly demonstrate that the more positive the experiences of staff within an NHS trust the better the outcomes for that organisation. 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.

These results were replicated in other research funded by the Department of Health and conducted by West and Dawson that found there were particular factors that were important in ensuring good staff engagement.38 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. All these factors were linked to patient satisfaction, patient mortality and staff absenteeism and turnover, and better performance on the Annual Health Check.

Another key factor is training and development. 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 important.39

Moreover, another important factor in engagement scores is creating a safe working environment. Research has found that in NHS organisations where there are high levels of physical violence, bullying, harassment, abuse and discrimination this creates poorer outcomes in terms of staff turnover, absenteeism and patient satisfaction.40

The Scottish Government have given a commitment to engaging staff within NHS Scotland demonstrated through the recently re launched Staff Governance Standard. Scottish Government is

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39 West M, Dawson J, Admasachew L and Topakas L (2011) *ibid*
40 West M, Dawson J, Admasachew L and Topakas L (2011) *ibid*
doing further work regarding staff engagement through a staff experience project which is currently being piloted in a number of Boards with a view to roll out across NHS Scotland.\(^{41}\)

In 2009 a report was published by the Aston Business School that linked NHS staff survey data to patient survey data and found that the staff survey item that was most consistently linked to patient survey scores was discrimination, in particular discrimination on the basis of ethnic background. They found that high levels of bullying, harassment and abuse against staff related to negative patient experiences.\(^{42}\)

In the research conducted by West et al for the Department of Health, the authors 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. The analysis of the data shows this can be achieved by:

- focusing on the quality of patient care
- ensuring that all staff and their teams have clear objectives
- supporting staff via enlightened human resource management practices such as effective appraisal and high quality training
- creating positive work climates
- building trust
- ensuring team working is effective.

Such steps produce high quality and improving patient care along with effective financial performance."\(^{43}\)

Wide-ranging research has therefore shown that the more positive experiences of staff within an NHS organisation, the better the outcomes for that organisation, both in terms of patient care and in terms of financial performance. Since the Francis Report into the care provided at Mid Staffordshire NHS Foundation Trust emphasised the importance of organisational culture that promotes high quality care, it is important for organisations to take staff engagement seriously and promote a culture that engages and values staff.

The results from the 2012 NHS Staff Survey for England showed interesting results in the context of the research into staff engagement and patient care:

- 63 per cent of staff said that if their friend or relative needed treatment they would be happy with the standard of care provided by their organisation.
- 62 per cent of staff said that care of patients and service users is their organisation’s top priority.
- 83 per cent of staff received an appraisal, however 36 per cent of staff said their appraisal was well structured.
- 40 per cent of staff were satisfied with the extent to which they felt their trust values their work.
- 35 per cent of staff said that communication between senior managers and staff is effective.
- 15 per cent of staff reported experiencing physical violence from patients, relatives or other members of the public.

\(^{41}\) www.staffgovernance.scot.nhs.uk/monitoring-employee-experience

\(^{42}\) Dawson J (2009), *Does the experience of staff working in the NHS link to the patient experience of care? An analysis of links between the 2007 acute trust inpatient and NHS staff surveys*, Aston Business School

\(^{43}\) West M, Dawson J, Admasachew L and Topakas L (2011) *ibid*
• 30 per cent of staff reported that they experienced bullying, harassment and abuse from patients, their relatives or other members of the public.
• 38 per cent of staff are satisfied with their levels of pay.
• 43 per cent of staff said their organisation takes positive action on health and wellbeing.
• 28 per cent of staff felt their managers involve staff in important decisions.

The staff survey works out an overall staff engagement score based on the results from nine questions. The overall engagement score was 3.68 out of five and there was a variation between workplaces, ethnic background, disability and religion.

Moreover, in 2012 Incomes Data Services (IDS) conducted a survey for Staff Side to accompany our evidence to the PRB, with many questions asked about working conditions. The chart below shows the results from two of the key indicators of engagement; if staff received a formal appraisal in the last 12 months; and if staff have received training paid for by their employer (apart from mandatory training) comparing that to two questions indicating staff’s own perceptions with the quality of care they are able to provide and additionally if staff think the current pay policy is fair. The chart shows that for most occupations there is a correlation between staff engagement and perceptions of quality of care.

Key results from IDS joint union survey of members

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44 Incomes Data Services (2012) NHS staff survey on pay and conditions: A research report for the joint staff-side NHS trade unions
As clearly shown through the research cited above, improving staff engagement will improve outcomes for organisations including patient care and sickness absence rates. If the NHS can improve these outcomes they could save substantial amounts of money; for example the NHS Litigation Authority found that between 2011 and 2012 the NHS paid £1.2 billion in clinical negligence compensation claims. Moreover, NHS Employers have calculated that in the NHS there are 10.3 million working days lost to sickness absence which equates to £1.7 billion a year.\textsuperscript{45} Therefore, organisations would economically benefit by improving staff engagement in addition to improving patient outcomes.

Both the IDS staff survey and the NHS staff surveys show that there are links between indicators of engagement and patient care. They also show that there is much work to be done to improve staff engagement and to show that staff are valued. Trusts are not doing enough to improve staff engagement and show staff they are valued.

Moreover, the UK Government’s approach to the NHS and the NHS workforce does not equate investing in staff with investing in patient outcomes. The continued pay freeze and cap; pension changes; NHS restructuring; and continued references to public sector workers versus taxpayers has contributed to a culture that does not value staff and results in staff feeling disengaged from the NHS.

\textbf{7.1 Recommendations}

Staff Side calls on the PRB to recognise the impact of the NHS work environment and organisational culture and the public sector pay policy on NHS staff and their levels of work engagement. We call on the PRB to acknowledge that staff engagement is deteriorating and to acknowledge that failure to improve risks negatively impacting on recruitment and retention and ultimately, patient care.

\textsuperscript{45} NHS Employers (2011) \textit{Generating savings by improving health and well-being: Experiences in NHS trusts} www.nhsemployers.org/Aboutus/Publications/Pages/Generating-savings.aspx
Appendix 1

Annex E discussions
The vast majority of staff receive unsocial hours pay according to the ‘section 2’ arrangements – an hour by hour formula which is precisely related to the hours worked. Around thirty thousand staff (largely ambulance staff) are paid under ‘Annex E’ arrangements which delivers an annual uplift capped at 25 per cent of salary.

On reaching agreement to remove unsocial hours’ payments from sick pay, there emerged a difference of opinion in the NHS Staff Council about whether and how this applied to those staff remunerated for unsocial hours’ work under Annex E of the Handbook. During negotiations, there was no discussion of extending coverage of the agreement to Annex E. Between reaching agreement and drafting changes to the Handbook, employers took the position that the changes would automatically effect this deduction for staff paid under Annex E. Staff side took the view (supported by legal opinion) that, without specific changes to the Handbook, deducting unsocial hours’ payments during periods of sick leave would be unlawful.

In an attempt to avoid resolution of the issue via industrial or legal means, the NHS Staff Council facilitated discussions between trade unions and employers, during which a series of options for deducting the payments were discussed. One of these formed the basis of a formal proposal which was rejected by ambulance staff earlier this month. Employers have announced their intentions to impose the changes, leading to the very real prospect of industrial unrest in the ambulance service this winter. At the time of writing, the Staff Council has reached agreement with all parties that they will hold further talks to explore the risks of imposition.