Department of Health

Review Body for Nursing and Other Health Professions

Review for 2006

Written Evidence from the Health Departments for Great Britain

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September 2005

SCOTTISH EXECUTIVE

Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Review Body for Nursing and Other Health Professions

Review for **2006**

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EXECUTIVE SUMMARY

1. Following the establishment of NHS Employers on 1 November 2004, the Government evidence will provide a high-level strategic overview of the issues affecting the Review Body's remit groups. NHS Employers will provide separate evidence to represent the views of employers.

2. It is four years since the last evidence to the Review Body. Since then, the Government has been working in partnership with the Unions to develop a new pay structure, called Agenda for Change, for non-medical NHS staff including NOHPRB remit groups. Agenda for Change is the most significant reform of NHS pay since the creation of the health service in 1948 and represents an additional investment of £1billion per annum. Supported by the NHS Job Evaluation scheme it promises fair pay for all non-medical NHS staff based on the principle of equal pay for work of equal value. Annual leave, working hours, pay for working outside normal hours will all be harmonised. The Knowledge and Skills Framework ensures that all NHS staff will receive an annual appraisal and development review.

3. Managers, staff and the unions are currently working to implement Agenda for Change across the NHS during 2005/06. The final impact on the Review Body's remit groups is not yet clear, but staff in this remit group will receive an average of 2.3% from the reform package in the first year, October 2005 to October 2006.

4. Average earnings in the NHS have continued to grow strongly by about 5.2% in the period 1998/99 to 2003/04, mainly driven by the reform and investment in medical wages. Earnings growth for the NOHPRB remit group for the period 1998/99 to 2003/04 shows that average wages for all non-medical staff, qualified nurses and AHPs have risen slightly below the national average of 4.5% over the period (4.3% p.a. increase for non medical staff, 4% for qualified nurses and 4.3% for AHPs).

5. As a result of Agenda for Change investment, it is expected that average earnings growth for this remit group is likely to be strong in the second half of 2005-06 and in 2006-07. This will be achieved as the remaining staff assimilate to the new pay system, and those who gain access to incremental progression through the reform start to move through their new pay bands. Some staff may make further gains in 2006-07 when the system of payment for unsocial hours is harmonised.

6. The significant recent investment in pay, the prospects for future earnings growth and the sustained period of low inflation have been reflected in strong improvement in recruitment and retention and reduced vacancy rates and these are forecast to continue in the future. There are some staff shortages in specific geographic areas and in some specific staff groups but research by Aberdeen University

commissioned by the Department of Health confirmed that these reflect the fact that the labour market for nursing is local rather than national. We believe this is also the case for AHPs but the evidence on this was less clear and will be kept under review. Agenda for Change was designed to allow the NHS to deal with those matters locally and to provide national mechanisms to deal with major issues. These flexibilities in the form of recruitment and retention premia and high cost area supplements need time to take effect. Therefore, we believe it is too early to seek any changes to national recruitment and retention premia or high cost area supplements.

7. It is our intention to see a rigorous process implemented to monitor the use of local recruitment and retention premia and the effects of high cost area supplements over the coming year. This could then provide evidence that could be useful in determining if there is a need for any changes in the 2007/08 pay round.

8. Our preferred approach for the future is therefore to move towards an x plus y approach to pay uplifts, where x would represent a national increase for all pay bands and y would represent an uplift based upon specific flexibilities for any given remit group or local need. We would welcome the Review Body's views on such an approach.

9. In the meantime, however, our priority is to ensure the effective establishment of Agenda for Change, a sustained period of stable recruitment and retention within the remit groups and to embed reform within NHS service delivery. To achieve this we propose that all pay bands across Agenda for Change should receive the same uplift. We therefore recommend a modest general pay uplift of no more than 2.5% for all remit groups, which seeks to balance affordability and the need to maintain stable inflation in the economy at large with the need to maintain the significant recent progress in recruitment and retention.

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CHAPTER 1: BACKGROUND, CONTEXT AND RECOMMENDATIONS FOR 2006/07 PAY ROUND

A SUMMARY

1.1 Following the establishment of NHS Employers from 1st November 2004, the Department's evidence will have a more high-level strategic focus to reflect new roles and relationships.

1.2 It is four years since the Government last provided evidence to the Review Body, as all parties were committed to a three-year pay deal from 2003 to 2006. During the intervening years since the last evidence, the Government and trade unions have worked in partnership to develop new terms and conditions including a new pay framework for this remit group. That partnership has been a successful one and has resulted in the most significant reform of NHS pay since the creation of the NHS. The agreement is known as Agenda for Change.

1.3 This chapter provides the Review Body with the background to the current developments affecting the pay and conditions of service of the remit groups. It also sets out the context within which those developments are operating and provides the Government's recommendation for the pay uplift for 2006/07.

1.4 The Review Body is reminded that since the last time evidence was submitted four years ago, there have been significant changes in the system. Significant power has been devolved to NHS organisations in line with *Shifting the Balance of Power.* In addition, the approach to workforce planning has changed with a move away from nationally prescribed targets for nursing, therapists and other health professional numbers to much greater reliance on local planning to maximise workforce capacity to support the delivery of services.

1.5 The Department of Health is developing a workforce strategy for health and social care aiming for publication by Autumn 2005. The developing strategy involves significant engagement with a wide range of stakeholders and needs to take account of a rapidly developing policy agenda.

1.6 In the meantime two interim statements on the workforce strategy have been issued. The first *Delivering the NHS Improvement Plan: The Workforce Contribution* was published in November 2004; the second *A Workforce Response to Local delivery Plans: A Challenge for NHS Boards* was released in August 2005. The essential message in these statements is that NHS employers should place more emphasis on working differently and more productively, rather than aim to increase staff numbers alone. A combination of good human resources practices with a focus on high impact service delivery changes will provide the best means for meeting the challenging demands facing the NHS.

1.7 Average earnings in the NHS have continued to grow strongly by an average of 5.2% in the period 1998/99 to 2003/04, mainly driven by the reform and investment in medical wages. The average wage growth for non-medical staff has risen by around

4.3%, which is slightly below the national average of 4.5%. However, we have invested around £1bn in new pay arrangements for this remit group through Agenda for Change and staff in this remit group will receive an average of 2.3% from that reform package during the first year, October 2005 to October 2006. This is in addition to the 3.225% annual uplift. Therefore, total average non-medical earnings growth in 2005-2006 is now running at 5.525%.

1.8 Earnings growth for the NOHPRB groups is likely to continue to be strong in the second half of 2005-06 and in 2006-07 as the remaining staff assimilate to the new pay system, and those who gain access to incremental progression through the reform start to move through their new pay bands. Some staff may make further gains in 2006-07 when the system of payment for unsocial hours in harmonised.

1.9 The Review Body is reminded that in addition to the annual pay uplifts awarded following Review Body recommendations, NOHPRB staff who are not yet at the top of their pay scale can expect to progress up the pay scale based upon demonstrable skills. The table at **Annex A** illustrates the combined effect of incremental rises and Review Body awards on an individual's pay by taking some hypothetical examples over a five-year period. For example, a basic grade radiographer starting on 1 April 2001 on the minimum of the scale (£16,510) would have progressed up the pay scale and by 1 April 2005 would be receiving £21,723 – an increase in basic salary of 36.5% over four years.

1.10 According to the Office of National Statistics' Annual Survey of Hours and Earnings (ASHE), average earnings growth across the whole economy from 1997/98 to 2003/04 was 4.47%, compared with 3.79% for nurses, midwives and other associate professionals in the same period. Against this background of stable inflation, workforce growth, the overall strong recruitment position (with low vacancy rates), and expected earnings growth for Agenda for Change, we recommend that a modest general pay uplift of no more than 2.5% for all staff should be sufficient to meet NHS needs and ensure continued workforce stability during this period of change.

B AGENDA FOR CHANGE

1.11 The major development since the Government last presented evidence to the Review Body is the agreement of Agenda for Change. We have spent four years working in partnership with the trade unions to implement the new pay structure that ensures fair pay arrangements for non-medical staff. This very successful partnership resulted in the agreement in November 2004 to roll out Agenda for Change nationally with effect from 1st October 2004.

1.12 In line with the agreement reached, Agenda for Change is now being implemented across the NHS with the aim of full implementation by the 30th September 2005. During this period of implementation and early application, the Government do not believe it is appropriate to make any changes that may affect the balance of the agreement at this time.

1.13 Agenda for Change provides a number of benefits to the remit group. All of these benefits are contained within the agreement and are expected to take effect during the coming years. The main benefits that can be expected are:

- higher pay
- fair pay based on the important principle of equal pay for work of equal value
- opportunities for NHS staff to develop into new roles and appropriate reward for those who take on additional responsibilities
- harmonisation of hours, leave and other conditions of service
- it will enable staff working across the range of clinical and managerial roles, to identify and follow clear career pathways
- annual appraisal and performance review to support career planning and personal development.

1.14 At this stage of implementation, we believe it is too early to identify the affects of these benefits. We firmly believe there is a need to wait until the new pay system is fully implemented and bedded down before making changes to the current direction or approach. Therefore, we believe now is not the time to seek any changes to Agenda for Change national arrangements.

1.15 However, we are aware of some early concerns amongst some staff groups. For example, the Society of Radiographers have expressed their concern about whether Agenda for Change will be successful in delivering an increase in the number of trained radiographers to the NHS. To address these concerns, NHS Employers, in partnership with the UK Health Departments and Staff organisations have agreed to monitor through the NHS Staff Council the average hourly rates of pay at all levels for staff groups whose hours have increased. In addition, NHS Employers and the UK Health Departments will look at the evidence for the use of recruitment and retention premia from 2006 onwards in relation to shortage groups such as radiographers.

1.16 Through such monitoring, we hope to be able to identify specific issues for specific staff groups within the Review Body remit groups. Where these may exist, we may seek to put forward a case for targeted increases for specific groups or indeed targeted increases in the recruitment and retention premia for different staff groups.

1.17 Therefore we are looking at ways of gathering evidence that would enable us to move towards an *x* + *y* approach, where *x* would represent a national increase for all pay bands and y would represent an uplift based upon specific flexibilities for any given remit group or local need. We would welcome the Review Body's views on such an approach.

1.18 At this stage, it is too early to say how that may work, but we would hope to continue our partnership approach with the trade unions in order to reach an agreed position where at all possible.

C RECOMMENDATIONS FOR THE 2006/07 YEAR

1.19 The following chapters, annexes and statistical table provide more information to support the Governments' position. Within this time of stable inflation, a position for the 2006/07 year of allowing the reform element of Agenda for Change to take effect and given the fact that average earnings in the NHS have continued to grow strongly and that earnings growth for the NOHPRB groups is likely to continue to be strong, we would ask the NOHPRB this year:

- to recommend a fair and affordable increase for 2006/07 of no more than 2.5% across all pay bands
- to avoid making any changes to the current recruitment and retention premia and high cost area supplements for 2006/07
- to recognise the local pay components of Agenda for Change and the further work we propose to monitor this situation.

CHAPTER 2: AGENDA FOR CHANGE

A Introduction

2.1 After four years of discussion and a high degree of partnership working, the UK Health Departments, unions and professional bodies concluded the Agenda for Change agreement on the 23rd November 2004. The agreement represents a major reform of the pay system for all non-medical NHS staff (excluding senior managers and chief executives) based upon the principle of equal pay for work of equal value.

2.2 This chapter provides an overview of the components of the Agenda for Change agreement and the moves towards implementation across the NHS.

B Agenda for Change

The System

2.3 Agenda for Change is the most significant reform of NHS pay since the creation of the health service in 1948. Supported by the NHS Job Evaluation scheme it delivers fair pay for non-medical NHS staff based on the principle of equal pay for work of equal value. Annual leave, working hours, pay for working outside normal hours will all be harmonised. The Knowledge and Skills Framework ensures that all NHS staff will receive an annual appraisal and development review that will support the principle of pay progression.

2.4 The system is based upon the concept of job evaluation. This means that pay is determined on the basis of the skills needed for the post to be undertaken. The NHS Job Evaluation Scheme has been developed as a means of fairly rewarding people by measuring their job-related skills, knowledge and responsibilities. The scheme has been developed especially for NHS staff and is being used to help ensure that staff receive equal pay for work of equal value. The detailed assessment of each post using the job Evaluation Scheme will determine the correct pay band for each post, and so the correct basic pay.

2.5 Agenda for Change has also delivered a new NHS minimum wage for all non-medical staff of £5.88 per hour. This compares favourably with the October 2005 national minimum wage of £5.05 per hour.

How it works

2.6 Staff are placed in one of nine pay bands (see **Annex B**) on the basis of their knowledge, responsibility, skills and effort needed for the job rather than on the basis of current job title. They will all receive annual appraisal and development reviews and a personal development plan. After full assimilation (subject to protection arrangements), all staff will enjoy the same basic conditions of service (working hours, leave etc) as everyone in the same pay band.

2.7 Within each band, there will be a number of pay points. As staff successfully develop their skills and knowledge they will normally progress through one pay point each year, up to the maximum in their pay band. At two defined 'gateway points' in each pay band, progression will be based on demonstrating the agreed knowledge and skills appropriate to that part of the pay band using the NHS Knowledge and Skills Framework.

2.8 In addition to basic pay, there will also be enhancements in the form of extra pay for staff in high cost areas (high cost area supplements) and additional pay for people in posts where recruitment and retention of staff is difficult (recruitment and retention premia).

2.9 All parties continue to work in partnership to harmonise arrangements for the payment for work undertaken in unsocial hours. An interim scheme is in place as the discussions continue.

The NHS Knowledge and Skills Framework and Pay Progression

2.10 The NHS Knowledge and Skills Framework is a tool which provides a means of recognising the skills and knowledge that a person needs to apply to be effective in a particular NHS post. The framework will be applicable across the range of posts in the NHS ensuring better links between education and development and career and pay progression.

2.11 The aim is that all staff will:

- have clear and consistent development objectives
- be helped to develop in such a way that they can apply the knowledge and skills appropriate to their job
- be helped to identify and develop knowledge and skills that will support their career progression and encourage lifelong learning

2.12 Each year, staff will have a development review meeting with their manager where they will agree a personal development plan. This plan will identify development needs and describe how learning will be supported. Everyone in post will be expected to develop their skills and knowledge.

2.13 There are two identified points in each pay band known as gateways. Personal development plans will be used to help staff ensure that by the time they reach these gateways, they are applying the appropriate knowledge and skills for the job. Pay progression at these gateways will be linked to the demonstration of knowledge and skills set out in the KSF outline for the post:

- **The first gateway** in each pay band will be after one year in post.
- **The second gateway** will vary between pay bands but will fall between the top three points of the pay band.

2.14 This system of pay progression, supported by the NHS Knowledge and Skills Framework, provides an annual opportunity for staff to move up into the next pay

point within the pay band. In this way, staff will be rewarded for the continued development of skills and knowledge. It also means that the annual pay uplift is only one element of the pay increase for staff who successfully develop their skills and knowledge.

C. CONCLUSION

2.15 Agenda for Change is in the process of being rolled out nationally, with the aim of full implementation by 30th September 2005. The system will take time to bed down and to iron out transitional issues as they emerge. The new system provides opportunities for pay progression and enhancements to basic pay. Pay Protection will remain in force until 31st March 2011. Work is underway to harmonise unsocial hours.

2.16 For these reasons, we believe that no changes should be made to the structure of the new pay system at this time. We would recommend that in order to maintain current recruitment and retention levels that the Review Body should provide for an increase of no more than 2.5% across all pay bands for 2006/07.

CHAPTER 3: RECRUITMENT & RETENTION, MOTIVATION, LOCAL PAY AND TOTAL REWARD PACKAGE

A. INTRODUCTION

3.1 The Government remains committed to support NHS staff to deliver a high quality health service to the public. It is recognised that the most valuable asset to the NHS remains its' staff, and it is important that they are rewarded fairly for the work they do. The new pay system within Agenda for Change has been designed to provide that fair system.

3.2 This chapter provides further information on how within the new pay system, issues of recruitment and retention are being addressed, how the new pay arrangements can support work towards motivating staff and describes the approach we are taking towards local pay issues. In addition, there is further information about how this might begin to be considered within a total reward package.

B. RECRIUTMENT AND RETENTION

General position

3.3 In the last evidence submitted to the Review Body in 2001, the challenge of increasing the NHS workforce was clearly set out. The aim was to improve the working lives and remuneration systems available for all staff in this remit group. Since that time there has been considerable activity including;

- agreement of Agenda for Change
- continued investment to increase the number of students entering pre-registration training
- sustained activity to improve recruitment and retention including development of childcare provision as part of the Improving Working Lives initiative
- inter-government agreements to facilitate international recruitment from India, Spain and the Philippines.

3.4 These initiatives have led to significant increases in the size of the NHS workforce and sustained reductions in vacancy rates. Tables 1 to 8 detail the growth in pay review body professions and reduction in vacancies.

3.5 Over the next year we expect to see an increase in the number of staff retiring from the NHS and a reduction in international recruitment activity as global labour markets become more competitive. Despite these challenges we expect the increased output from training and stronger retention to provide for low level growth across this remit group. In addition we expect to see increased investment in assistant and advanced practitioners and further development of new roles breaking down traditional demarcations between professions and improving patient focused care.

3.6 There is an encouraging picture across the NHS of increased recruitment, improved retention and success in encouraging returns to the service. For example, over

18,500 nurses and midwives have returned to practice between 1999 and 2004. Overall vacancy rates are falling (see Paragraph 3.16 below) and the numbers of qualified staff are increasing, for example as at September 2004 there were 301,877 full time equivalent NHS nurses, an increase of 55,866 since 1997. Where there are local pressures we are beginning to see local mechanisms to address them. For example, the Department is moving toward a system where workforce planning is determined by aggregating the requirements of local health communities as expressed in their own Local Delivery Plans. There will be less reliance on the development of nationally set targets, with the Department focusing on providing national models and assumptions where needed and ensuring that local plans are sufficiently integrated, coherent and realistic to deliver national objectives.

3.7 The evidence provided by the Health and Social Care Information Centre (Statistical Tables 1-8) sets out the position in relation to workforce numbers. Targets were originally set to expand workforce numbers and at halfway through the NHS Plan period there has been massive growth, with most of those key targets now attained. (See paragraphs 3.17 to 3.20).

3.8 However while sufficient numbers still need to come through to replenish and refresh the workforce, this and any overall expansion must increasingly also be linked to growth in productivity. Improving productivity and efficiency are critical to the successful delivery of services. As part of the spending review 2004, the Department of Health committed to achieving annual efficiency benefits in England of at least £6.5 billion by 2007/08. Up to £2.9 billion of the expected gains are expected to come from making better use of staff time (Productive Time). Productive Time aligns the modernisation strategies for People (Pay and Workforce Reform), Process (10 High Impact Changes) and Technology (NHS Connecting for Health) in order to maximise service improvement.

3.9 Although there is no local target on efficiency, national payment tariffs will reduce annually by 1.7% from 2005-06, requiring organisations to implement efficiencies to deliver their service within budgets. Organisations currently above national tariffs will need to realise further efficiency gains to eliminate overspend.

3.10 Overall, the funding to organisations will still be increasing over time and individual local efficiency savings will be recycled into providing a proportion of increased capacity or service provision requirements.

3.11 With issues such as demography that will impact not only the UK but the global workforce, we have ensured that the service has the ability to attract additional capacity from outside the UK to fill gaps, including a focus on the European Union (EU). For example over 1,000 nurses have been recruited by agreement with Spain. The employment of international healthcare professionals has made a significant contribution to the workforce of the NHS. All recruitment has been underpinned by a Code of Practice, which was updated and strengthened in 2004.

3.12 As health professionals work in an increasingly global market where demand for their services continues to increase. Therefore, the NHS will need to continue to be recognised as an attractive employer in the international arena, as well as in the UK. It is anticipated that the entry of new member states to the EU in May 2004 will also

increase the number of health professionals from the EU who come and work with in the NHS.

3.13 We are continuing the implementation of the employer of choice strategy, making the NHS an attractive working environment where people would want to come into for a career. This will further improve recruitment, retention and morale will ensure that the NHS encourages and supports a thoroughly diverse workforce and reduces waste caused by high turnover and inappropriate use of agency staff. The NHS is already an excellent employer offering excellent terms, conditions and career opportunities. It is now aspiring to be a World Class employer.

Reduction in vacancies

3.14 In our evidence to the Review Body in 2001, we set out the challenging targets of the NHS Plan for expanding the workforce and our strategy to deliver that growth. Our objective for an NHS that has the staff it needs, where they are needed with secure and sustained growth for future demand, have been largely met.

3.15 We said this goal can be achieved by attracting and training the healthcare professionals for the future, investing in their development, creating pleasant working environments and by having management and leadership that respect staff and involve them in the delivery of services. A range of measures, at the time some in their infancy, such as *Improving Working Lives* and increasing training places has meant that in 2005, results of the vacancy surveys across all groups of staff are very encouraging, as is seen in the table at paragraph 3.16 below and Statistical Table 8.

3.16 The three-month vacancy rates for March 2005, which shows vacancies not filled for the first three months of 2005, show a decline in the vacancies within the NHS in each of the main staff groups, compared with the previous year. These are shown in the table below. This demonstrates the continued improvements being made to recruitment and retention.

	Vacancy Rate	
	March 2004	March 2005
Qualified nursing (excluding practice nurses), midwifery and health visiting staff	2.6%	1.9%
Qualified Allied Health Professionals	4.3%	3.4%
Qualified scientific, therapeutic and technical staff	2.6%	2.2%

Increasing the workforce

3.17 The NHS Plan and *'Delivering the NHS Plan'* targets for increasing the NHS nursing workforce have all been achieved early and the NHS Plan targets for increasing nurses and midwives entering training has been achieved. There are more qualified nurses working in the NHS than ever before. As at September 2004 there were 301,877 full time equivalent NHS nurses, an increase of 55,866 since 1997.

3.18 The number of nurses entering training, has seen a 67% increase between 1996-7 and 2004-5. By the end of March 2004 over 18,500 former nurses, midwives and health visitors had returned to work in the NHS since February 1999.

3.19 Therapists, Healthcare Scientists and other health professionals have also seen a significant growth in numbers. The number of therapists and scientists employed in the NHS has increased by 26,984 full time equivalent since September 1997 and by 15,500 since 2001. By the end of March 2004 over 1,450 former allied health professionals and over 450 healthcare scientists returned to work in the NHS since April 2001.

3.20 The paramedic workforce has continued to grow (from 6,364 full time equivalents in 1997 to 7,353 in 2004) and there are generally a number of applicants for each paramedic training place. However, demand for ambulance services is growing by around 6% a year, and it is likely that this trend will continue. Recruitment will need to keep pace with this. In particular, there is a growing demand for skilled and experienced paramedics to train to become Emergency Care Practitioners (ECPs), leading to increasing demands on training facilities, trainers and clinical supervisors in addition to the loss of these clinicians into the ranks of the new Practitioner. For some, ECPs are being trained by the ambulance trust and then employed by the PCTs or other urgent care provider - such as GPs or Out of Hours services. There is a need for this to be done in a planned way to avoid recruitment problems.

3.21 Where we are aware of concerns, for example with radiographers, we are looking into them. The members of the Society of Radiographers (SOR) voted against Agenda for Change in both September 2003 and 2004. However, SOR in common with the other NHS unions endorsed Agenda for Change through collective agreement on 23 November 2004 at the NHS Staff Council meeting.

3.22 The major concern for radiographers was the increase in hours from 35 to 37.5 per week, to bring them into line with nurses and other NHS staff. The protection arrangements written into the agreement mean that hours for radiographers will gradually increase over a seven-year transition period with most radiographers not working the 37.5 hours per week until 2011, depending on their starting point.

3.23 It is still too early to assess the impact of Agenda for Change. However, NHS Employers, in partnership with the UK Health Departments and Staff organisations have agreed to monitor the average hourly rates of pay at all levels for staff groups whose hours have increased through the NHS Staff Council. In addition, NHS Employers and the UK Health Departments will look at the evidence for the use of recruitment and retention premia from 2006 onwards in relation to staff groups such as radiographers.

Examples of recruitment and retention initiatives

<u>Affordable housing</u>

3.24 As was outlined in our last evidence to the Review Body, we also continue to take steps around affordable housing, recognising the potential recruitment and retention

impact this may have on the remit group of the Review Body. The availability of affordable accommodation is a significant factor affecting recruitment and retention in areas where house prices are highest.

3.25 The current key worker programme, *Key Worker Living*, started on 1 April 2004. It focuses on those delivering frontline public services, such as health workers and teachers, in areas where house prices are highest (e.g. London, the South East and East of England) where there are recruitment and retention issues. It builds on the foundations of the Starter Home Initiative (SHI) and extends housing assistance to key workers at different life-stages, not just first time buyers. Within health, staff groups have been prioritised for assistance, with clear emphasis on clinical grades.

3.26 Regarding health workers, three products are available as follows:

- Homebuy - which provides an equity loan up to a limit of £50K. As at the end of June 2005, funding for Homebuy was virtually fully committed.
- Intermediate renting - a rent between social and open market rates (these are new build schemes).
- Shared ownership of newly built properties - the purchaser buys at least 25% of the home and pays a reduced rent on the remaining share.

3.27 The response from key workers to the Key Worker Living scheme has been very good. Monitoring reports to the end of July 2005 show that 1,770 health workers have completed on property purchases, or exchanged, under "market purchase homebuy" and a further 577 are at an advanced stage of home purchase. Figures on shared ownership and intermediate renting of new build accommodation are awaited.

3.28 Looking to the future, the Deputy Prime Minister presented a five-year plan *Sustainable Communities: Homes for All* in January 2005. The Plan proposes to assist 81,900 working people and families get a foot on the property ladder by 2010. Out of that total, we would expect 15,000 NHS staff to benefit from the programmes for Key Worker Low Cost Home Ownership and the new First Time Buyers initiatives. In addition, NHS staff will have opportunities under a separate and more widely available Low Cost Home Ownership Initiative and from schemes provided via planning obligations imposed by local authorities.

3.29 The Plan proposes that the supply of houses for the First Time Buyer Initiative will be on land from the public sector where it is surplus to requirements. Within the First Time Buyer Initiative, it is expected that 3,000 NHS staff will be assisted. The attraction is that groups who are not eligible for the current Key Worker Living scheme could be included. The expectation is that at least 15,000 NHS staff will benefit from these schemes.

3.30 The Office of the Deputy Prime Minister is discussing with the Council for Mortgage Lenders the possibility of levering in private finance for equity loans. The outcome is expected to be known in the next few weeks.

Skills Escalator

3.31 The NHS Plan sets out a vision of a modernised NHS with many more staff, working differently. It describes how services will be redesigned around the patient's journey and how this will radically improve the patient's experience. *"The NHS Improvement Plan, "Putting people in the heart of public services (June 2004)"* builds on the patient centred vision set out in the NHS plan and focussed on the need for a more personalised service, based on choice.

3.32 The skills escalator is the workforce development strategy linking together lifelong learning, recruitment and retention, pay modernisation and changing workforce programme to deliver the objective of a growing and changing NHS workforce required to achieve these ambitions for the NHS. It is about attracting a wider range of people to work within the NHS by offering a variety of career and training step on and step off points. It is also about encouraging all staff, through a strategy of lifelong learning to renew and extend their skills and knowledge, enabling them to move on the escalator. Meanwhile, efficiencies and skill mix benefits are generated by delegating roles, work and responsibilities to the most appropriate level.

3.33 *Working Together, Learning Together (November 2001)* set the vision and strategy for lifelong learning, to develop and maintain a workforce fit for the future. The framework is intended for use by employers and SHA's/WDC's to ensure staff are equipped with the skills and knowledge to work flexibly in support of patients and are supported to realise their potential. The lifelong learning framework concept underpins the skills escalator.

3.34 There are clear links between learning and educational developments in the NHS and the skills escalator. These range from work being carried out on improving adult literacy and numeracy skills through to the multi-professional director development programme.

3.35 The Skills Escalator in managed by Skills for Health, the Sector Skills Council for health, on behalf of the Department of Health.

Continuing Professional Development

3.36 Post registration learning and continuing professional development (CPD) is vital to the delivery of the NHS Improvement Plan. It is essential to encourage and support the workforce to work differently and take on new roles to deliver service improvements

3.37 The Department of Health has held a series of events to support the development and delivery of post registration learning in the NHS. In 2003, DH held two "Learning for Delivery" events. A report is available on the DH website at http://www.dh.gov.uk

3.38 These events made connections between post qualification learning and service planning. They enabled Strategic Health Authorities and their key strategic partners (NHS Trusts, PCTs, Higher Education Institutions, regulatory and professional bodies) to identify national and local priorities and actions to support the post registration learning agenda. One of the key outcomes was the establishment of a

Strategic Health Authority Continuing Professional Development Network. The network has improved the collaboration across and between SHAs, the local NHS and DH

3.39 A "Learning for Improvement" event was held in December 2004. This event provided an opportunity to explore ways in which Continuing Professional Development can support the delivery of the NHS Improvement Plan objectives:

- Health Improvement
- Access
- Patient Experience
- Chronic Disease management.

3.40 DH is working in partnership with Skills for Health to develop a framework and systems to support multi-professional learning. This work links closely with the development of the NHS Career Framework and NHS Knowledge & Skills Framework.

3.41 CPD will support recruitment and retention by building a learning environment in every health organisation and promoting wider goals for lifelong learning, thus giving staff the opportunity to develop skills, gain greater job satisfaction and enable career progression.

Conclusion

3.42 In summary, the general picture is one of a very encouraging recruitment, retention and return position. We have put in place important building blocks in Agenda for Change to ensure that the position is maintained and improved.

3.43 However, we also need to ensure that Agenda for Change has time to establish itself to asses the impact of this major reform to the pay system. This will be backed up by monitoring by NHS Employers, in partnership with the UK Health Departments of the average hourly rates of pay at all levels for staff groups whose hours have increased. NHS Employers and the UK Health Departments will look at evidence for the use of recruitment and retention premia from 2006 onwards in relation to shortage groups such as radiographers.

C. MOTIVATION

Improving working lives

3.44 In our last evidence to the Review Body, the Department of Health reported that by putting *Improving Working Lives* (IWL) Standard into practice the NHS will address many of the issues that impact on staff morale and motivation. The IWL standard makes it clear that every member of staff in the NHS is entitled to work in an organisation which can prove that it is investing in more flexible, supportive and family friendly working arrangements that will improve diversity, tackle discrimination, harassment and bullying, and develop the skills of all its staff to improve patient services.

3.45 The IWL initiative has provided NHS Trusts with a measured framework to create well-managed, flexible working environment through policy making, good communication and ultimately partnership between staff and managers. With over 600 NHS Employers already at Practice level of Improving Working Lives accreditation, substantial progress has been made in the drive to make the NHS the employer of choice, not only for the future workforce, but for existing staff, and the many staff now returning to the NHS. The third and final stage of IWL accreditation, Practice Plus, was rolled out nationally in June 2004. NHS organisations will be required to achieve Practice Plus by 31st March 2006.

3.46 There has been significant involvement, particularly from nurses at all levels in the IWL agenda, not only in the assessment and accreditation process, but also in the development, design and implementation of modern employment practices, leading to improvements in the standards of care. It is important to continue this effective partnership in moving to Practice Plus level - a crucial step on the journey towards model employer.

Helping with childcare arrangements

3.47 The development of a childcare strategy for the NHS mentioned in our last evidence is a key part of our wider strategies to improve the working lives of staff in the NHS.

3.48 The NHS workforce is predominately female, with over 80%[1] of all non-medical staff being female, so childcare is an important recruitment and retention tool. Over the last few years, childcare/carer strategies have become the norm in the NHS. The Health Information Centre (HIC) undertook a survey of NHS childcare provision for the Department of Health at the end of 2004. The survey reports encouraging improvements in access to childcare for NHS staff. The key findings include:

- 97% of the NHS organisations who responded provided access to a childcare co-ordinator;
- 11,700 nursery places, for children under 5 years, are provided for NHS staff;
- 69% of nurseries were open for 11 hours or more on weekdays, 4% were open during the weekend, and 6% on Bank Holidays. Organisations commented that their opening reflected the needs of users;
- Two-thirds (66%) of organisations gave staff the option to access childcare vouchers. Of those who did not, 61% intended to make them available to staff by the end of 2005;
- 78% of organisations intended to extend their existing provision, of which 38% hoped to make more nursery places available; and

[1] Percentage of staff where gender is known, based on headcount as at 30 September 2004

- 84% of organisations provided access to holiday play schemes. Staff in 56% had access to after school clubs.

Understanding staff views

3.49 Evidence from the second Healthcare Commission's staff survey – albeit spanning all staff groups, medical and non-medical - reinforces last year's results and shows that in key areas e.g. job satisfaction, the position has been one of consolidation and in some cases improvement.

3.50 For example, staff receiving training is up from 89% in 2003 to 93% in 2004. Employees' feeling of fairness and trust have diminished in the private sector, whilst 61% of staff in the NHS felt that their employer acted fairly with regard to career progression or promotion, regardless of ethnicity, gender, religion, sexual orientation, disability or age.

3.51 The 2004 NHS Staff Survey (the results of which are summarised at **Annex C**) is very encouraging in its response to these initiatives. For example:

- Employee attitude to job satisfaction suggests improvements in HR and management practices in the NHS.
- Retention remains steady with only 25% considering looking for a new job in the next year.
- NHS national staff survey 2004 indicated that staff in the NHS are generally fairly satisfied compared with a downward trend in job satisfaction in the private sector since 2001.
- 53% of all staff agreed or strongly agreed that if they did leave their job, they would want to stay in the NHS, compared with 52% in 2003.

3.52 This year, staff were asked to indicate reasons for wanting to leave their jobs. Of those who indicated that they were considering leaving their job, 40% said it would be due to career development, 21% for a change of career, 40% because they are unhappy with their current job, 18% for family or personal reasons, 2% would be entering full time education, 9% said they didn't want to work in the NHS, 6% due to retirement and 18% for other reasons.

3.53 Organisational climate was shown in the 2003 survey, as well as much previous research, to be strongly related to the performance of trusts, and innovation. A positive organisational climate is also associated with high levels of staff wellbeing and satisfaction, which are themselves indicators of performance and staff retention. The results in the 2004 survey suggest that in the majority of organisations, the general feeling is more positive than negative, and if anything this positive feeling is increasing.

3.54 The NHS National Staff Survey can be found on the Healthcare Commission's website at www.healthcarecommision.org.uk/staffsurveys/

D. LOCAL PAY

Context

3.55 The Review Body has been asked to have regard to regional and local labour markets and their effects on recruitment and retention. The Government wants to see public sector pay systems that increase the sector's flexibility and responsiveness, so that the public sector contributes to increased overall flexibility of the economy as a whole.

Research evidence

3.56 In January 2005, the Department of Health commissioned Aberdeen University to conduct research into the effectiveness of regional pay to help address localised recruitment and retention issues for various staff groups. The research found that the pattern of vacancies differed between non-medical staff and doctors.

3.57 In the case of nurses and allied health professionals, the highest vacancies are found in the London. The lowest average vacancy rates for nurses are recorded in Yorkshire and Humberside, whilst for AHPs they are in the South East and West Midlands. The research suggested that there is a local labour market in England for nurses, but the case for AHPS, including radiographers, was inconclusive.

3.58 The research built an econometric model to estimate the relationship between staff vacancies (for nurses, AHPs and doctors) and the 'gap' between NHS wages and wages of comparator private sector groups. The work found a significant relationship between nurse vacancies and the gap between nurse and private sector wages. This supports the use of area premia such as the 'High Cost Area Area Supplement' and local recruitment and retention premia for nurses. The work did not find a significant relationship between AHP vacancies and variation in the difference between AHP and private sector wages. We suspect this may be for two reasons (1) AHPs should not be modelled as a homogenous group with similar labour market characteristics or (2) AHPs may work partly in a national labour market where their decision on where to work depends partly on the local labour market / local relative pay and partly on the national labour market. Relatively low numbers of each type of AHP make it difficult to model at specific occupation level.

Action taken

3.59 The findings of the Aberdeen study were very interesting and confirmed our previously held belief that this remit group (especially nurses) are subjected to local labour market forces. We are currently considering the detail of the Aberdeen work in order to determine what further steps we may wish to take.

3.60 However, Agenda for Change was designed to allow local organisations to deal with the flexibilities of a local labour market through mechanisms such as local recruitment and retention premia and the high cost are supplements, which are already built into the pay system. It is our contention that Agenda for Change delivers a system capable of dealing with local variations in the labour market.

3.61 As Agenda for Change is currently being implemented within the NHS, we do not believe it would be appropriate to make any changes to the system at this early stage or to agree further national recruitment and retention premia. As part of the ongoing implementation of Agenda for Change it is our intention to work with the trade unions, professional representative organisations and NHS Employers to develop robust mechanisms to monitor the use of recruitment and retention premia and high cost area supplements across the NHS.

3.62 Through such monitoring, we hope to be able to identify whether there are national issues for specific staff groups within the Review Body remit groups. Where these may exist, we may seek to put forward a case for targeted increases for specific groups or indeed targeted increases in the recruitment and retention premia for different staff groups.

3.63 Therefore we are looking at ways of gathering evidence that would enable us to move towards an *x + y* approach, where *x* would represent a national increase for all pay bands and y would represent an uplift based upon specific flexibilities for any given remit group or local need. We would welcome the Review Body's views on such an approach.

3.64 At this stage, it is too early to say how that may work, but we would hope to continue our partnership approach with the trade unions in order to reach an agreed position where at all possible.

Summary

3.65 In summary therefore, we have some evidence of a local labour market at work for some of the remit group but need to look further at others. There is evidence that the workforce continues to grow and that there is a need to address local labour market forces within the system. In partnership with the Unions we have agreed Agenda for Change as a means of addressing these issues, but we believe there is a need to allow time for the agreement to be fully implemented and bed down before we can fully assess the impact.

E. TOTAL REWARD PACKAGE

3.66 Pay and non-pay rewards for public sector staff should support and help drive service delivery and reform while being affordable, fair and providing VFM. Pay reform in the NHS has been designed to motivate and reward performance, recognising pay as one element of a broader reward package offered to staff.

3.67 Recent strategies such as *Improving Working Lives*, the *Childcare Strategy* and *Continuing Professional Development*, offer a range of benefits designed to demonstrate that staff are valued, motivate and boost morale of the workforce and improve staff recruitment and retention.

3.68 NHS staff reward is not limited to current pay. Most staff belong to the NHS Pension Scheme and pay contributions equivalent to 6% of their pensionable pay. In addition, their employers now pay 14% of pensionable pay to the Scheme. In return

contributors receive a pension at age 60 of up to half their final salary at the normal pension age of 60 for life, with a tax free one-off payment equal to three times the annual pension. A range of survivor benefits is also available for dependents.

3.69 The Government's 2002 Green Paper, Simplicity, Security and Choice: Working and saving for retirement, recognised major increases in longevity and a declining birth rate, and recommended that Normal Pension Age across the public sector should increase to 65. The consultation document issued as part of this review can be found at http://www.dwp.gov.uk/consultations/consult/2002/pensions/gp.pdf.

3.70 The NHS Pension Scheme is currently under review by a partnership of NHS Employers and NHS Staff Side. The government has been clear from the outset of its commitment to maintaining a defined benefit scheme of a type that is becoming rare in the private sector. Under the 2002 proposals, the change in pension age would not affect any service for existing staff until 2013. The current proposals envisage recycling much of the saving from the increase in normal pension age into scheme improvements including:

- 1/60th accrual to replace current 1/80th accrual
- improved partner benefits covering same sex and unmarried partners
- improved pension purchase arrangements

3.71 NHS Employers will report to DH when the partnership review with the NHS Staff Side is complete. This report is now expected in spring 2006.

F. CONCLUSION

3.72 In general, we believe there is a positive picture of increased recruitment and improved retention of staff. The new Agenda for Change agreement should also help to improve the position for staff within this remit group.

3.73 A number of initiatives are now in place to support recruitment, retention, return and motivation of staff. Help is available with finding housing in high cost areas, providing childcare facilities and giving staff the opportunity for pay progression.

3.74 Turning to local pay, the Aberdeen study shows local labour markets at play. Agenda for change attempts to address them by allowing local NHS employers flexibility through high cost area supplements and recruitment and retention premia. We want to wait and see the effect of these changes and therefore we see no need to introduce any new arrangements or local pay mechanisms at present.

3.75 As a result we would ask the Review Body

- to recommend a fair and affordable increase for 2006/07 of no more than 2.5% across all pay bands to maintain the current healthy position on recruitment, retention and workforce growth

- to avoid making any changes to the current recruitment and retention premia and high cost area supplements for 2006/07

- to recognise the local pay components of Agenda for Change and the further work we propose to monitor this situation.

CHAPTER 4: THE GOVERNMENT'S PLANS FOR PUBLIC SPENDING LIMITS & DELIVERY OF SERVICES AND OUTPUT TARGETS

Introduction

4.1 This chapter sets out the financial context for our recommendations, including the Departmental Expenditure Limits (DELs) for 2005/06 until 2007/08 as announced in the Chancellor's 2005 Budget Statement.

4.2 As detailed in the earlier chapters, the primary argument for this year's recommendation is the healthy recruitment and retention position. However, it is also crucial to consider the constraints of affordability. Around two thirds of health service spending is on pay, so even very small changes in pay have a substantial effect on the ability of PCTs to manage the substantial non-pay spending pressures that the health service faces.

4.3 The annual pay bill increases as staff numbers increase, however, there are other reasons for the increase; the annual settlement, an element of pay reform and pay drift. Between 2002/03 and 2003/04 the pay bill for qualified nursing staff rose from £8,085 billion to £8,677 billion, an increase of 7.3% and the corresponding staff numbers rose by 4.5% from 279,287 to 291,925. The basic settlement was 3.225%. For the period 2001/02 to 2002/03, the nurses salary scale was uplifted by 3.6%, staff numbers increased by 4.9% and the nurses pay bill rose by 8.9%.

4.4 The key points of the plan for spending limits are:

- Current financial pressures. Even in the current period of unprecedented funding growth, the NHS has faced financial difficulties. In 2004/05 the NHS has failed to achieve overall financial balance. The audited accounts show that the NHS as a whole will end 2004/05 with an overall deficit of around £250 million.

- On top of these existing challenges, NHS reforms such as payment by results, patient choice, Foundation Trusts and practice based commissioning will create significant new financial risks. Individual NHS trusts will find that their income becomes far more volatile and unpredictable, as money follows the patient and patients exercise their right to choose alternative providers. NHS organisations will need flexibility over their finances in order to manage these risks and avoid running up deficits or breaching their statutory spending limits. In the light of the likely slowdown in overall NHS funding from 2008/09, this makes it even more important to be cautious in terms of additional spending commitments imposed on the NHS.

- Likely resource constraints going forward. In 2002, the Chancellor accepted Derek Wanless's "fully engaged" spending recommendation for the five years to 2007/08, which was for annual average spending growth of 7.1%. By 2007/08 the Government will have achieved its aim of bringing UK health spending up to the European average. No decisions have yet been taken for the Comprehensive Spending Review which will allocate resources for the period from 2008/09 to 2010/11. However historically (since 1948) average spending growth on health has been at a rate of 3.1%.

4.5 An analysis of progress against the Department's Public Service Agreement (PSA) targets is contained in the fifteenth annual *Departmental Report*[2] published on 21 June 2005. Further information on progress in service improvement is set out in the 2005 *Chief Executive's Report to the NHS*[3].

The Health Departments' and the Government's Plans for Spending Limits

(NB: The figures quoted here are for England only, see chapters 6 and 7 for Wales and Scotland respectively)

4.6 Pay awards for NHS staff must be set within a framework that considers:

- The Department of Health's spending limits set by the Chancellor in his Budget statement;
- The effect of the Government's challenging plans against a range of output targets for the delivery of services including those of the Public Service Agreement and the NHS Plan; and
- The anticipated rate of inflation in the economy as a whole.

4.7 Pay costs are not funded separately by the Department of Health. The pay bills are met at PCT level from the overall funding for PCTs which is made available in the unified allocation. This allocation covers around 80% of the total DEL (78.6% in 2004/5). Any large increases in pay will inevitably have an affect on the amount available for PCTs to spend on commissioning new services. Pay is an integral part of the total cost of any patient service and PCTs routinely need to make decisions on what services to commission based upon patient need. Currently, approximately 60% of a Trust's budget is spent on pay.

4.8 If excessive pay awards are agreed, there would be an inevitable impact upon the cost of the patient services delivered by NHS providers. The PCT commissioners would have to consider the impact of such increased costs when determining their commissioning strategies. Higher costs could mean the PCTs not investing in some service areas. Exactly what areas would be at risk from a large pay deal is impossible to say as decisions would be made locally. However, it is clear PCTs would need to consider slowing down some priorities and changing others.

4.9 In previous years the Review Body has asked about the opportunity cost of relative pay increases. The specific effect is a matter for local decision but the Review Body may wish to be aware that for each additional 0.1% increase in NHS pay translates as the equivalent of:

- 1000 Nurses; or
- 525 Doctors; or
- 30,000 elective procedures.

[2] Available on the Department of Health website at http://www.dh.gov.uk
[3] Available on the Department of Health website at http://www.dh.gov.uk

4.10 The areas of business PCTs could look at in response to a large pay deal could include:

- Achievement of PSA targets
- Implementation of NICE
- Not increasing staff numbers

4.11 The DELs for 2003/04 and beyond are shown in the table below.

Departmental Expenditure Limits [1]

	NHS DEL (£m)	Cash Growth (£m)	Cash Growth	GDP Deflator [2]	Real Terms Growth
2003/04	63,001	-	-	-	-
2004/05	69,706	6,705	10.6%	1.98%	8.5%
2005/06	76,387	6,681	9.6%	2.50%	6.9%
2006/07	84,324	7,937	10.4%	2.70%	7.5%
2007/08	92,643	8,319	9.9%	2.70%	7.0%

Notes: (1)Figures are consistent with the resources announced by the Chancellor in the 2004 Spending Review.
(2)As at 16 March 2005.

4.12 These increases are not a benchmark for pay settlements. Moreover, the growth in revenue funding, to fund pay amongst other things, is less than the overall average growth of 7.3% real terms. Average real terms growth in capital is 23.2% per year and the average real terms growth in revenue is 6.5% per year over the 5-year period (2003/04 to 2007/08). The use of the overall DEL also needs to be considered against the Government's ongoing commitment to the modernisation of the NHS, in particular the objectives set out in the NHS Plan including PSA Targets and the impact of underlying demand pressures such as clinical negligence, EEA medical costs, access to NHS dentistry and NHS Connecting for Health.

4.13 This sets out the range of things that need to be funded from overall NHS growth, not necessarily what PCTs could cut due to a higher pay award. A lot of it is demand led:

- Delivery of the standards and targets set out in the NHS Plan, Public Service Agreements and National Service Frameworks;

- Implementation of NICE appraisals and guidelines

- The increasing demand for services supplied by GPs and dentists.

- The year-on-year rises in demand for hospital services shown by the increases in emergency admissions and attendances at A&E departments; attendances at A&E Departments have increased from 2002/03 by 18% in 2003/04 and a further 8% in 2004/05. The number of emergency admissions has increased from 2002/03 by 8% in 2003/04 and a further 12% in 2004/05.

- The cost and demand for drugs, with drugs bill pressures up provisionally 3% per year from 2004/05. Whilst a PPRS renegotiation limited increases in 2004/05, the long run trend remains at about 10%. Currently approximately 15% of annual budget is spent on the drugs bill.

- The costs of increasing staff numbers, training opportunities, and medical school places;

- The three major programmes of NHS pay reform embodied in 'Agenda for Change', the new consultant contract and the new GMS contract. Approximately 1-5% of annual budget is spent on GMS.

- The resources to meet demand in terms of capital investment for new hospitals and equipment, the IT infrastructure; and training and development for the growing NHS workforce.

4.14 The increase in NHS resources until 2007/08 provides a fixed funding envelope for the NHS. There will be no resources over and above this to fund any excess costs arising from pay settlements. It is therefore crucial that pay increases are no more than necessary to meet the recruitment and retention needs of the NHS, in order to ensure resources are available to deliver growth in capacity, service improvements and pay modernisation.

Public Service Agreement (PSA) Targets and the New Planning Framework

4.15 In line with the cross-Government timetable attached to the 2004 Spending Review, a new Department of Health PSA was agreed which covers the financial years 2005/06 to 2007/08. This PSA, which is set out at **Annex D**, forms the basis for the national targets for the NHS and social care which were issued in July 2004 in *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06 – 2007/08.* The Planning Framework describes the vision for services over the three-year period, and identifies the national priorities and targets which NHS organisations will build into their local plans.

4.16 The new Planning Framework:

- Sets out a focused set of national priorities, reducing the number of new national targets from 62 in the last planning round to 20 for the three years to 2007/08;

- Includes a framework for local target setting. Fewer national targets create more headroom for local targets set in response to local population needs; and

- Incorporates the *Standards for Better Health*, which were published after a three-month public consultation. The standards set out the levels of quality and safety that all NHS patients can expect from the services they receive. They also set the agenda for continuous improvements in quality and safety across the full spectrum of NHS healthcare.

Output Targets

4.17 Output targets provide a clear focus for planning and delivery and for measuring the return on the unprecedented levels of investment the Government is committing to such improvements. The targets form part of the wider context within which the Review Body considers its recommendations and the Review Body's remit requires it to have regard to the Health Departments' output targets for the delivery of services, as well as the funds available within Departmental Expenditure Limits, and the need to recruit, retain and motivate those staff within its remit. However, as we have previously reported, the link between pay and output targets is multi-faceted and we do not believe it is possible to quantify in any precise way the impact which the NOHPRB's recommendations on pay in one year will have had on the achievement of output targets in the next. Nor would it be meaningful to attempt to do so given the complex factors at play.

4.18 Affordability, and the other cost pressures, are crucial factors in any consideration of the links between pay and output targets. If the extra resources which have been committed by the Government are diverted into unnecessarily large pay increases the service improvements necessary to meet output targets cannot be delivered;

Summary and Conclusions

4.19 The Government is committed to modernising services for patients and improving the working life of NHS staff, including modernising the pay system. Although the headline figures show large growth in the DELs, a responsible approach to pay is crucial if we are to achieve all the objectives set out in the NHS Plan. The Government's commitments to the modernisation of the NHS and the range of additional cost pressures set out above, including increased activity and expansion of the workforce in line with NHS Plan targets, mean that there will be significantly less money available than may first seem.

4.20 Therefore:

- affordable pay settlements are an essential part of delivering the agenda for improvements for patients and staff set out in the NHS Plan; and

- the Government's commitment to keep public spending within the DELs and to invest in pay modernisation needs to be a key factor in determining pay in the coming year.

CHAPTER 5: GOVERNMENT EVIDENCE ON THE GENERAL CONTEXT

5.1 The 2004 Spending Review (SR04) set out Government targets and expenditure plans for the three years from 2005/06 to 2007/08 for the whole public sector, including the sectors covered by the Pay Review Bodies (PRBs). Within this context, the PRBs will want to make recommendations about the appropriate resource allocation to pay in the context of government objectives, the affordability constraints of SR04 and the recruitment, retention and motivation position of their sectors.

SR04

5.2 SR04 made announcements about the need to deliver efficiency improvements of at least £20 billion per year across the public sector by 2007/08 with the aim of releasing resources to front-line service delivery.

5.3 The implementation of these changes will involve making use of, for example, information technology initiatives, relocation of staff and changes to working practices. Much of the planned efficiency gains will come from more productive use of working time in the relevant sectors. The Department of Health has been set a target to deliver efficiency benefits worth £6.5 billion by 2007/08 (equivalent to 2.7% per year) as part of SR04. These benefits include both cost efficiency and the value of service quality improvements and will be made in the following areas:

- Productive Time (freeing up the time of front-line staff)
- Procurement
- Adult Social Care
- Corporate Services (eg finance, HR and IT)
- Public Policy, Funding & Regulation (Central Departments and Arms Length Bodies)

5.4 Up to £2.9 billion of the expected gains are expected to come from the Productive Time work stream.

Affordability

5.5 SR04 was significantly tighter than SR02. Within tight affordability constraints, it is important that resources needed for service improvement are not absorbed by pay, except to the extent necessary to help run an effective public sector. The Government considers it important that pay rises in the public sector are set at sustainable rates.

Recruitment, retention and motivation

5.6 Within what is affordable, pay increases should be at levels which are necessary to respond to the particular circumstances and requirements of the group concerned, where the outcome would be to improve service delivery by addressing specific recruitment and retention problems, support diversity and equal pay or where significant reform is to be achieved.

Local Pay

5.7 Local pay arrangements can be an effective way of addressing local recruitment and retention pressures, and can ensure resources are targeted to where they are needed most. More information on local pay is provided elsewhere in the evidence.

5.8 The Government wants to see public sector pay systems that increase the sector's flexibility and responsiveness, so that the public sector contributes to increased overall flexibility of the economy as a whole. The Government notes in particular that while the existence of high quality public sector jobs in a region can play a vital role in ensuring the economic prosperity of that region, if pay rates are misaligned the prosperity of the region can be damaged. For example, if public sector pay rates are high relative to those in the private sector then more productive labour will be sucked in to the public sector and economic growth and prosperity will be hampered.

5.9 Evidence of public sector pay surpassing private sector pay could include information about private sector pay in comparable jobs in the local area or evidence of large numbers of applications for public sector jobs in the area compared with what might be expected in the private sector or elsewhere in the public sector.

Earnings growth and pay-bill growth

5.10 There are several pay metrics used across the public sector, each of which is designed to provide different information about the impact of a pay decision.

5.11 The **Average Earnings Index** measures the speed at which earnings are growing across the whole economy, in the public and private sectors. This is a paybill per head measure obtained by dividing the total amount paid by the total number of employees paid.

5.12 However, PRBs will want to exercise caution when using the AEI in pay considerations if their pay remit group has witnessed any changes in composition. As a paybill per head measure, the index is very sensitive to skill and workforce composition and a change in either of these will produce a mis-leading picture of pay growth. For example, if a sector has recently undergone a programme of up-skilling, the AEI will increase even if earnings growth remained unchanged. Similarly, if paybill savings are reallocated back into the paybill the AEI will be depressed and will mask the true level of earnings growth. Therefore AEI cannot be guaranteed to provide a true picture of earnings growth at either a whole economy level or for a subset, requiring care to be taken with any comparison.

5.13 Rather, for a picture of how average earnings of existing employees remaining at the same grade have changed over time, it is more appropriate to consider **earnings growth**. This is calculated through a bottom-up approach which identifies all the elements of increases, including progression increases, bonuses, allowances, overtime and any other elements of take-home pay that affect those staff within a grade. It is therefore a good indication of how an individual's pay packet will be affected by pay progression and revalorisation.

5.14 To understand how a decision affects just revalorisation, **headline award/basic settlement** should be considered, as this is simply the average headline increase in base pay and excludes these other elements of take-home pay such as performance bonuses and progression. As an earnings growth measure it is not sensitive to compositional changes.

5.15 However, despite the compositional problems of a paybill per head measure, **paybill** and **paybill per head** should still be considered, as they give a good measure of affordability through providing an indication of the funding required by the employer to implement the pay deal. Paybill records the earnings increases, and includes the net effect of all other increases received from the pay system such as bonuses and changes to non-pay elements such as pensions, NICS, etc. Aggregate paybill will also include any notional pay-bill savings from staff turnover (ie, when those leaving or promoted are replaced by employees paid at a lower point on that pay range) reallocated to pay as well as reflecting compositional changes. Paybill per head divides the paybill by the total number of full time equivalent staff employed by the organisation.

5.16 Given the different strengths and weaknesses of each of the above measures, it is clearly critical to consider all these metrics when making pay recommendations.

Inflation

5.17 Inflation is the rise in the price level over time which results in a general fall in the purchasing power of money. The Office of National Statistics (ONS) calculates inflation using several measures.

5.18 The **Consumer Price Index** (CPI) measures the average change from month to month in the prices of consumer goods and services and has replaced the **Retail Prices Index excluding mortgage payments (**RPIX) in its use as the Bank of England's inflation target since the Pre Budget Report in November 2003. The Chancellor wrote to the Chairs of the Pay Review Bodies to inform them of the change.

5.19 The CPI measure of inflation has certain clear strengths for pay purposes over the old RPIX measure because of the way it is calculated – in particular it takes account of consumer behaviour in terms of substitution away from more expensive goods and brands. Therefore, CPI is a better measure of the amount on average needed to keep people as well off as before, than the RPIX.

5.20 Nonetheless, the RPIX will remain available and can be taken into account in pay negotiations in the private sector and elsewhere. The RPIX is calculated as the weighted average of changes to the prices of a 'basket' of goods that represent the expenditure of UK households, but excludes mortgage interest payments. This makes it less sensitive to changes in interest rates.

5.21 The **Retail Price Index** (RPI) is similar to the RPIX, but includes mortgage interest payments.

5.22 The data in **Annex E** provides percentage changes in CPI, RPI and RPIX. It is important to note that too much emphasis should not be placed on a single month's inflation figure. Monthly movements in the CPI and other inflation measures can reflect several different factors and for this reason it is the underlying trends that should be considered.

5.23 The data shows that CPI and RPIX inflation has been controlled at low levels over the last 12 months. Indeed, inflation over the past 3 years has remained relatively steady, with CPI averaging at 1.3% and RPIX averaging at 2.4% per annum. Treasury anticipates that this period of stable inflation will continue.

5.24 Government expects CPI inflation to return to target by mid 2006. The forecast for RPI (in September) is for inflation to fall in 2005/06 and 2006/07, before rising again 2007/08 and remaining constant at 2¾% thereafter. This is in line with the July average of independent forecasts, which predict CPI will be 2% in 2005 and also 2% in 2006. The comparable figures for the RPI (of which RPIX is a derivative) are 2.5% in 2005 and 2.3% in 2006.

Economic Context

5.25 PRB recommendations are forward looking and therefore information about the future prospects of the economy is particularly important. The macro-economy is in a strong position. GDP growth in the UK has now been unbroken for 50 consecutive quarters, which - on the basis of quarterly national accounts data - is the longest sustained expansion on record. Economic growth is expected to remain strong with the Budget forecasting GDP growth between 3 and 3.5% for 2005/6 and between 2.5 and 3% for 2006/7. The UK is currently benefiting from its longest period of sustained low and stable inflation since the 1960s. Interest rates, at 4.75%, are low by historical standards, and long-term interest rates are around their lowest levels in over 40 years. As regards the labour market, unemployment levels are close to their lowest levels since the 1970s and employment is at a record high. This strength in the economy is not resulting in any significant upward wage pressure in the private sector as the data on earnings growth shows.

CHAPTER 6: EVIDENCE FROM THE NATIONAL ASSEMBLY FOR WALES

A. Summary

This Chapter has been prepared by the Health and Social Care Department (NHS Wales) to complement the evidence from the other Health Departments and draws attention to any policies that are distinctive to Wales.

B. Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century.

6.1. In May the new Health and Social Care Strategy for Wales for 2005/2015 was issued. It sets out the vision for the next ten years and what must be done to achieve it. It continues along the path set out in Improving Health in Wales and Building for the Future. It also draws on the recommendations of the Wanless Review and Making the Connections and also reflects the excellent work undertaken locally in preparing Local Health, Social Care and Well-Being Strategies and Local Action Plans.

6.2. Designed for Life recognises that health services in Wales will in the coming years be more explicitly organised around three regional networks to focus upon the delivery of care services, based on models of managed clinical networks. It is intended that by April 2006, all three regional offices of the Health and Social Care Department will have finalised their overall programme for re-organising the secondary care sector.

6.3. The transition to a new pattern of health services will require a restructuring of the workforce, new ways of working, changes in practice and improved efficiency, as well as greater support for carers and for supporting service users to do more for themselves. These key changes must be brought together in a process of managed change and innovation in employment practices, skills, job definitions, education and training and staff location to support reconfiguration and service improvement.

6.4. The strategy also makes it explicit that there is a real requirement to establish a new process for workforce planning and commissioning of education. An integrated model of whole system workforce re-design will be developed as part of the National Leadership and Innovation Agency to enable improved alignment between the strategic direction of the service and the development of workforce capacity and capability in Wales.

6.5. A Workforce Development, Education and Commissioning Unit will be established by 1 April 2006 to provide strategic leadership and action. It will have the following core functions:

- workforce planning, education and training commissioning, workforce development, development of standards in education and training, changing the workforce and working with social care

- and will be set up as part of the National Leadership and Innovation Agency

6.6. It will also make explicit the connection between innovation/best practice in service delivery and educators who are able to respond and offer modern teaching, learning and career development solutions.

6.7. The Strategy will be backed by a proposed investment plan that will see capital spending tripled in the next 3 years, rising to £309m in 2007/08. It envisages major secondary care rationalisation. Medical Royal Colleges are driving change by refusing to back specialist services that are too scattered. The secondary care plans to be produced by the Regional Offices will also propose centralising specialist services.

6.8. Mid and West Wales are due to deliver theirs by September, S.E.Wales by December and N.Wales by March 2006. There is not sufficient revenue to staff all the new units proposed under the capital spending plan and new hospitals are expected to produce savings.

6.9. Key milestones for 2006:

- recruit 3000 extra nurses and 400 doctors

- access to primary care staff within 24 hours of requesting an appointment

- 95% of patients to spend less than 4 hours in A&E

- 80% of GP practices to achieve at least 700 points in the quality and outcomes framework

- 15% reduction in delayed transfers compared to 2004/05

- new NHS financial information strategy

- all patients to be seen within 12 months for a first outpatient appointment.

C. Strategic Background

6.10. After significant investment and major change implementation, combined with the 'Second Offer' scheme, waiting times in Wales have now fallen substantially. The recently amended consultants' contract and Agenda for Change are expected to be vital facilitators of further modernisation and renewal. Recruitment and retention of staff and their continued commitment and motivation are important elements of this continuous change and improvement process.

6.11. Staff numbers have increased significantly in recent years and continue to do so. Commissioned training places have and are increasing for longer term growth.

D. Human Resources Strategy

6.12. A new revised HR / Workforce strategy for Wales, 'Designed to Work', is close to completion and will be published shortly. This strategy has been developed to integrate with and support the aims of Designed for Life.

6.13. It will particularly concentrate on the Organisational Development, training and staff development needed to support the major structural and systems changes expected over the coming years and will aim to motivate and involve staff in the creation of a world class health service in NHS Wales. Pay modernisation generally and Agenda for Change in particular, will also be important elements of this strategy.

E. Agenda for Change

6.14. Agenda for Change is in the process of implementation in NHS Wales. Significant amounts of job matching, evaluation and assimilation have been achieved. It is anticipated that the bulk of implementation will be complete by end December 2005 with the remainder completed by end March 2006.

6.15. It is too early to accurately assess the impact of A4C on staff and employers in Wales; a full picture is unlikely to emerge for several months. Initial feedback is generally very positive although those groups of staff gaining less than others or having increased working hours are less supportive.

6.16. The impact of the Knowledge and Skills Framework is expected to be beneficial although this will be a long term gain. KSF implementation is progressing well with all organisations now using the E-KSF tool and producing development outlines.

6.17. WAG is part of the unsocial hours review process; an interim scheme is in place as the discussions continue.

6.18. The total Agenda for Change package is seen to be an important element of encouraging staff to participate willingly in major change initiatives and WAG would not wish that NOHPRB destabilise this in any way.

6.19. A Benefits Realisation Framework initiative has recently been launched creating strong links between pay modernisation and service innovation and improvement. Trusts and LHBs (primary care organisations) have now committed formally to modernisation plans linked to pay modernisation with an expectation of radical and imaginative initiatives. These plans will form the basis of a long term performance management process through Regional Offices and the Pay Modernisation Unit.

6.20. Further development and training events with PMU and the National Leadership and Innovation Agency will help to drive through this process and ensure that organisations are properly equipped to deliver the expected modernisation outcomes.

F. Recruitment and Retention and Skills Shortages

6.21. Evidence is that with certain local exceptions recruitment and retention are generally good at present. Shortages are generally specific and local or are being addressed on a longer term basis by increased training provision. Most employers feel that the full implementation of Agenda for Change plus the use where necessary of Recruitment and Retention Premia, will cater for most difficulties.

6.22. Nurse recruitment appears to be improving in Wales. The nationally collated data shows that the number of nurses employed by the NHS in Wales has risen whilst vacancies are falling. The main area of concern at present appears to be difficulties in recruiting mental health nurses. This is an all Wales problem and may need addressing by a regional RRP.

6.23. In the 2004 NHS Wales Trust workforce plans the turnover rate for nursing staff was reported for the year ending September 2003. Adult branch nursing turnover rate was 4.7%; 1.5% of the turnover was due to the retirement of staff. 540 out of 11370 nurses left the NHS in Wales during the year. All other branches in nursing had a similar turnover rate. 4.7% turnover is low. During the same period 326 experienced nurses joined the adult branch and 665 newly qualified staff.

6.24. Wales has a national Recruitment and Retention Strategy and Action Plan which was presented at the Employment Practices Group. Trusts in Wales are required to produce a local recruitment and retention action plan to underpin the strategy. Trusts have access to HOWIS recruitment website, return to practice courses and the NHS Wales Open Week which assists them in the recruitment of staff.

G. Recruitment and Retention Premia

6.25. Thus far few Recruitment and Retention Premia have been requested through the all-Wales RRP process. Initial indications are that RRPs may be required in the south Wales M4 corridor to address the issue of needing additional Trust bank nurses to avoid expensive private agency nurses. Some Trusts in this area have very high agency nurse costs and are creating strategies to reduce this significantly. RRPs may be used to maintain or boost bank nurse rates in order to attract staff from agencies whilst reducing overall costs.

6.26. Agency Nurse utilisation in Wales has shown a steady increase. To address this issue an Agency Nurse NHS Wales Project Board was established in December 2004 led by the Chief Executive of Ceredigion NHS Trust. The Director of the RCN and Head of Health Wales Unison are members of the partnership project board. The project's remit is to develop a tender that will reflect the need for an All Wales Contract which will have fixed prices which the agencies must meet. Good progress is being made with this initiative.

6.27. RRPs will be carefully monitored and will form an important part of evidence to NOHPRB in future years. RRPs are centrally approved in Wales in order to maintain fairness and consistency and avoid 'leapfrogging' and escalating costs by neighbouring organisations.

6.28. There is concern in Wales from organisations close to the border with England – particularly with south east Wales Trusts close to Bristol area and north east Wales Trusts close to Cheshire, Manchester and Merseyside – that Foundation Trust status in those areas will lead to disadvantageous labour market conditions making recruitment and retention in these parts of Wales particularly difficult.

H. Financial Strategy

6.29. Over recent years, NHS pay and price inflation has equated to an average of 4% per annum. In addition, unavoidable cost pressures associated with workforce or clinical developments have increased the annual funding requirements. In any year these can typically add anything over 5% to the increased costs of the NHS.

6.30. While NHS settlements in earlier years have generally funded the majority of cost increases, all NHS Trusts have needed to make additional efficiencies of about 1% per annum to meet local cost pressures. In 2005/06 the need to fund pay modernisation costs has meant that additional cost pressures have not been funded, resulting in a 3.31% funding shortfall on hospital and community services budgets. This equates to approximately £95m.

6.31. NHS Trusts were required to contribute to efficiency programmes as part of addressing the deficits inherited by Local Health Boards from the former Health Authorities. All Trusts have reported that they have had to absorb cost pressures arising from clinical developments, for example to maintain pathology and radiology accreditation.

6.32. Within primary care, Local Health Boards are facing pressures in meeting the costs of the Quality and Outcomes Framework of the new GMS Contract. Savings from the price reduction on 4 generic drugs and the cost of branded medicines under the Purchase Price Regulation Scheme have been used to part fund the new Pharmacy Contract and LHBs are needing to cover prescribing cost and volume increases from within the 2% increase in prescribing allocations in 2005/06.

6.33. The NHS in Wales will therefore enter the next three-years with a level of resources that will challenge commissioners and providers in their efforts to make changes while maintaining service levels and quality. Financial discipline is essential.

6.34. A financial environment will be created that encourages Health and Social Care to innovate and change without going down the expensive, inequitable and unsustainable route of market mechanisms. In addition, linking to performance management, it will be necessary to ensure that poor performance is not rewarded and good performance is.

6.35. As a result the financial regime in Wales will be reviewed. Key proposals that will be considered will include incentives e.g. the introduction of standard tariffs for activity.

6.36. The Programme Budgeting Project will enable the NHS better to understand the current utilisation of resources and plan investments for the future. It will also develop further work on costing case mix activity, which will be of particular importance in helping NHS Trusts in Wales to cost the activity needed to achieve the new waiting times targets.

6.37. The NHS will also need to use financial information alongside performance data to make the most of the funding currently invested in services. At a time of limited financial growth, improved productivity e.g. through reduced length of stay, increased daycase rates and better use of physical resources, will be essential if this strategy is to be delivered.

The following figures are from the Assembly's draft Budget tables and must be taken as provisional until the Assembly votes its final Budget for 2006/07 in December.

	Health DEL* £M	Cash Growth £m	Cash Growth %	GDP deflator (1)	Real Terms Growth
2003/04	3,982				
2004/05	4,279	297	7.5	2.09	5.3
2005/06	4,628	349	8.2	2.50	5.5
2006/07	4,987	359	7.8	2.70	4.9

**Figures at draft Budget Stage*
(1) GDP Deflators as at 30 June 2005

6.38. The Assembly is committed to continue to introduce pay modernisation for all NHS staff groups alongside the new contractual arrangements being introduced in the other UK countries. Following the introduction of the new Consultants Contract (December 2003) and Agenda for Change (October 2004) the Assembly is negotiating the introduction of the Non-Consultant Career grades and a revised unsocial hours regime under Agenda for Change. The Assembly also has its own targets for growth in NHS staff in Wales.

6.39. Employers in Wales have been surveyed about their wishes for the 2006/07 pay round.

There was a high degree of agreement on two issues:-

- A **long term** rather than short term settlement was preferable. Most organisations would prefer another three year deal although a minority would

prefer two years. None wished for a one year only deal. The main reasons for this view were the need for long term stability during a period of major pay and conditions change, the need for better long term planning and forecasting and the desire to avoid adversely impacting on staff morale due to the uncertainty created by annual awards which may be implemented well after the normal due date of April 1st each year.

- An **identical level of pay uplift** across all staff groups including doctors and dentists. This was seen to be important from a fairness and morale maintenance perspective even though most doctors have recently benefited from structural changes which were considerably more generous than the Agenda for Change settlement for other NHS staff.

I. Conclusion

6.40. The Welsh Assembly Government notes the HM Treasury views of pay movements in other public sector and private sector employers and their preference for a one year deal. Taking into account all the evidence above and that recruitment and retention are benign, the Assembly concurs with the Department of Health recommendation for a modest general pay uplift of no more than 2.5%.

CHAPTER 7: EVIDENCE FROM THE SCOTTISH EXECUTIVE HEALTH DEPARTMENT

SUMMARY

7.1 This chapter has been prepared by the Scottish Executive Health Department (SEHD) to complement the evidence from the Department of Health in England and the National Assembly for Wales. It sets out where circumstances, initiatives and polices within NHS Scotland (NHSS) are distinctively different from elsewhere in Great Britain (GB) and confirms SEHD's endorsement of evidence given elsewhere that represents a Great Britain position.

7.2 The evidence sets out:

A the context within which health services are delivered in Scotland;
B an overview of the NHSScotland workforce covered by the Review Body's remit;
C the position in terms of recruitment and retention in NHS Scotland across each sector covered by the Review Body, including international and e-recruitment;
D initiatives in place to develop staff in NHS Scotland;
E staff governance in Scotland;
F the current position on regional pay;
G the current position in Scotland on Agenda for Change;
H workforce performance and effectiveness;
I affordability and the competing demands for investment.

A THE SCOTTISH CONTEXT

7.3 Over the past year three reports have helped set the current context for health service priorities in Scotland.

7.4 In May 2005 Professor David Kerr delivered his report *Building A Health Service Fit for the Future* outlining a framework for service change over the next twenty years. The report looks towards a health service anchored in communities, built on fully integrated services, and more responsive to the healthcare needs of an ageing population. The main themes are:-

- More care in the future will be delivered in a non-hospital setting, through staff like health visitors, practice nurses, physiotherapists, pharmacists and family doctors. Community-based care delivered through agencies such as Community Health Partnerships will be pivotal to delivering this agenda.

- Currently care can be reactive, hospital centred and geared towards acute conditions. The future focus will be on integrated, anticipatory care, embedded in communities and geared towards long term conditions.

- Priority should be given to care in deprived areas to reduce health inequalities.

- Emergency care will be separated from planned care so that planned care can be taken forward faster for patients and with fewer cancellations for them because of emergencies.

- Everyone needs to take more responsibility for their own wellbeing and adopt preventative measures.

- More regional planning for hospital based services, with new networks of hospitals sharing the responsibility for providing key elements of acute care.

7.5 The report has been endorsed in principle by the Scottish Executive, which will publish its full response in October 2005.

7.6 Professor Kerr's report was preceded in December 2004 by the publication of *Fair to All, Personal to Each – The Next Steps for NHS Scotland,* which outlined enhanced targets for access to health services in Scotland:

- No patient will wait more than 18 weeks from GP referral to an outpatient appointment;

- No patient will wait more than 18 weeks from a decision to undertake treatment to the start of that treatment – down from the current 9 month maximum wait guarantee;

- Patients will be able to rely on shorter maximum waits for specific conditions:

  - 18 weeks from referral to completion of treatment for cataract surgery;
  - 4 hours from arrival to discharge or transfer for accident and emergency treatment;
  - 24 hours from admission to a specialist unit for hip surgery following fracture; and
  - 16 weeks from GP referral through a rapid access chest pain clinic or equivalent, to cardiac intervention.

7.7 An additional target for diagnostic tests has since been announced:

  - No patient will wait more than 9 weeks for any MRI or CT scan and other diagnostic tests.

7.8 In August 2005, the *National Workforce Planning Framework 2005* was published. This framework will build on the baseline report published in 2004 and will support workforce planning at NHS Board and regional level. The regional workforce plans will be published in January 2006 and NHS Board plans published in April 2006. Guidance in the form of a Health Department Letter (HDL) will shortly be issued to Boards to assist their planning.

B. THE NHS SCOTLAND WORKFORCE

Nursing and midwifery staff

Workforce Numbers

7.9 There are over 54,000 nurses and midwives in NHS Scotland representing 43.3% of the whole workforce. New roles and responsibilities are already extending and changing the traditional definition of the nurse/midwife as changes in the medical workforce and redesign of health services underscore their increasingly pivotal role.

7.10 The number of registered (qualified) nurses and midwives in NHS Scotland is currently at record levels. During the period from September 2001 to March 2005 the registered complement increased from 36,425.3 WTE to 40,028 WTE. This represents an overall increase of 9.9%. Conversely, the non-registered workforce has decreased over the same period by 0.9% although overall nurse numbers are increasing with the development of a richer skill mix of registered to non-registered staff.

7.11 In excess of 3,000 registered staff join NHSScotland each year, which means that the Executive remains on track to achieve the Partnership Agreement commitment of attracting 12,000 nurses and midwives into NHS Scotland by 2007.

Vacancies

7.12 Nursing and midwifery vacancies have been increasing slowly since 2000. All vacancies for registered posts increased from 3.6% (March 2001) to 4.5% (March 2005). Long term vacancies (over 3 months) indicate where there has been difficulty in recruiting to certain posts. The most recent statistics show that while there has been an increase in 2005, these rates remain at under 2% in a staff group making up just under half of the whole NHS Scotland workforce. In the same period long term vacancies increased from 0.5% to 1.7%.

7.13 Vacancies for non-registered posts mirror the increase witnessed for registered staff. In the period from March 2001 to March 2005, all non-registered vacancies increased from 2.5% to 3.3%, with hard to fill vacancies rising from 0.4% to 1.2%.

7.14 The following tables show the vacancy rates in each year from 2001 to 2005.

Vacancies as a percentage of establishment (at 31st March)

	2001	2002	2003	2004	**2005**
Registered	3.6	4.0	3.9	4.0	**4.5**
Non-registered	2.5	2.6	2.7	2.7	**3.3**

Long term vacancies as a percentage of establishment (at 31st March)

	2001	2002	2003	2004	**2005**
Registered	0.5	1.0	1.1	1.2	**1.7**
Non-registered	0.4	0.5	0.9	0.9	**1.2**

7.15 While vacancy rates show an increase since 2001, this is offered against a backdrop of record staff numbers, record numbers of students in training, as well as a significant reduction in the use of agency nurses across NHSScotland.

Turnover

7.16 Turnover within the nursing profession remains relatively stable. Turnover for registered nurses and midwives fell from 6.7% in 2001/02 to 6.6% in 2003/04. Conversely, the turnover rate for non-registered staff has increased from 9.8% to 11.0% over the same period.

Bank Usage

7.17 The number of staff working on nurse banks in Scotland has been increasing. The bank provides an excellent option for nurses who prefer a greater choice over the hours they work, for example, allowing flexibility for nurses towards the end of their career who still wish to provide a service contribution. In addition between 500 to 600 bank nurses go on to take up substantive roles in NHSScotland each year. The bank therefore offers a route into a nursing and midwifery career with NHS Scotland, particularly for newly qualified staff and returners.

7.18 The average WTE of registered bank usage in Scotland has increased from 680.5 WTE (2001-02) to 1,117.6 WTE (2004-05). The corresponding costs also rose from £17.3m to £34.6m.

7.19 Similarly there has been an increase from 933.1 WTE to 1,474 WTE in the use of non- registered staff over the same period, with associated costs rising from £13.9m to £26.9m. The increase in the number of bank staff used is in line with recommendations made within the Report and Action Plan of the Nationally Co-ordinated Nurse Bank Arrangements project (Scottish Executive 2005) and reflects the Scottish Executive's policy to reduce the reliance on agency nurses in NHSScotland.

Agency Usage

7.20 Until this year there had been a rising trend in the usage and associated spend on agency staff. Figures show agency usage for registered staff increased from an average WTE of 438.7 WTE in 2001-02 to 648.1 WTE in 2004-05. Associated costs also rose from £9.2m to just over £23m.

7.21 However the usage and associated spend for non-registered agency staff has reduced since 2001. The average WTE reduced from 379.6 WTE in 2001/02 to 215.1 WTE in 2004/05 with costs also falling from £4.8m to £3.8m.

7.22 The Scottish Executive remains committed to reducing the costs associated with agency nurses and in the year to March 2005 there was a significant reduction in agency spend of £3.3m, a fall of 11.1%.

7.23 Additionally, a national contract for the provision of agency nurses is now in place across the whole of NHSScotland. To date direct savings of £2.4m have been achieved and it is anticipated that the contract will deliver further savings of £7m per annum by 2006-07.

Pre-registration students

7.24 Significant investment has been made in recent years to increase the complement of the nursing and midwifery workforce, informed by robust workforce planning techniques that match supply with demand from employers. The Student Nurse Intake Planning (SNIP) exercise is undertaken annually in partnership with key stakeholders including the Royal College of Nursing, the Royal College of Midwives and Unison.

7.25 Since 2001 the annual intakes for pre-registration student nurses and midwives has increased, resulting in year on year record numbers of students in training. The number of students in training has increased from 8,217 in 2001 to 9,264 in 2004, an overall increase of 12.7%.

Allied Health Professions (AHPs)

7.26 Over the last 10 years demand for the Allied Health Professions has been increasing, primarily because of service delivery changes. The demand has been in response to changing demography, waiting time standards, pay modernisation and health improvement amongst others.

Workforce Numbers

7.27 The number of registered (qualified) allied health professionals in NHS Scotland is currently at record levels. During the period from September 2001 to March 2005 the registered complement increased from 6,112.9 WTE to 7,075.8 WTE. This represents an overall increase of 15.8%. Likewise the non-registered workforce has increased over the same period by 22.6%. This increasing trend reflects the investment made to build the capacity of the Allied Heath Professions in Scotland. Looking back over the past decade there has been an average 43.9% rise in WTE posts over all the registered Allied Health Professions, with the rate of increase slowing over the last 5 years to 17.7%.

7.28 The Partnership Agreement of 2003 gave a commitment to increase the number of AHPs in NHS Scotland by 1500, which equates to 300 per annum over the lifetime of the Agreement. NHS Scotland is broadly on target to achieve this with 849 new AHPs in post by end March 2005.

Vacancies

7.29 AHP vacancies have remained fairly stable in recent years. All registered vacancies decreased from 5.5% (March 2001) to 5.2% (March 2005). Long term vacancies (over 3 months) indicate where there has been difficulty in recruiting to certain posts. In the same period long term vacancies increased from 1.6% to 1.9%. The highest

level of long term vacancies were in radiography at 3.5% and speech and language therapy at 3.4% at March 2005.

7.30 Non-registered vacancies have decreased. In the period from March 2001 to March 2005 all non-registered vacancies decreased from 3.5% to 3.2% although long term vacancies rose slightly from 0.7% to 0.8%.

Turnover

7.31 The turnover rate for registered AHPs has risen slightly from 7.0% in 2001/02 to 7.1% in 2002/03. The professions with the highest average turnover rates are occupational therapists (9.2%), physiotherapists (8.0%) and speech and language therapists and arts therapists (6.4%).

Students in Training

7.32 The number of places in pre-registration courses is generally determined by Higher Education Institutions. However a one-off specific action was undertaken by the Scottish Executive in 2002-03 to fund an additional 65 undergraduate students in the key priority areas of radiography, physiotherapy, occupational therapy and speech and language therapy. There is also a fast track pilot 2-year postgraduate diploma in therapeutic radiotherapy directly sponsored by the Scottish Executive. This aims to produce 30 therapy radiographers by 2006.

7.33 In line with the investment made to help build capacity within the Allied Health Professions workforce, the number of students commencing pre-registration training increased from 812 in 2001 to 894 in 2004. This represents an increase in excess of 10% over that period.

Healthcare Scientists

Workforce Numbers

7.34 Statistical data for Healthcare Science staff is currently collected in Scotland under the heading of the *Scientific, Therapeutic and Technical* group. This in turn can be broken down further into Scientific and Professional staff (including data on Clinical Scientists) and Technical staff (including Biomedical Scientists and Medical Technical Officers).

7.35 Scientific and Professional staff account for 1.7% of the NHSScotland workforce while Technical staff account for 5.1% (headcount).

7.36 As part of our workforce planning framework we will be capturing more robust detailed information for all Healthcare Science staff to improve our analysis of supply trends. Currently, we are able to offer some intelligence on Biomedical Scientists and Clinical Scientists. Baseline intelligence on Biomedical Scientists in Scotland indicates they have increased steadily from 1,991.9 WTE in 2001 to 2143.9 WTE at March 2005. This represents a growth of 7.6%.

7.37 Clinical scientists pose a particular challenge for workforce planning as in many areas they are small in number and have specialist skills. In some areas, such as physics and engineering, only small numbers of graduates are trained and the sustainability of some courses requires careful monitoring.

7.38 Total numbers in training in recent years are set out in the table below. All schemes now last 4 years to state registration.

Numbers in Training

IN TRAINING	**2002-03**	**2003-04**	**2004-05**
Clinical Scientists :			
- Medical Physics	10	8	13
- Biochemistry	6	8	9
- Molecular Genetics	5	6	9
- Cytogenetics	4	5	7
- Microbiology	3	3	4

Factors affecting the demand for staff in the sectors covered by the Review Body

7.39 Currently there are a number of known and anticipated factors which can be expected to drive a continued need for increased staff numbers working with increasingly extended skill sets.

- **Policy priorities** - such as improving standards on waiting times. As patients are treated more quickly with improved journey times through the NHS system enhanced clinical teams are needed to support the additional activity. Meeting these targets will require a mix of workforce redesign, improved efficiency and effectiveness, and workforce growth.

- **Legislative changes** - There are a number of statutory and regulatory requirements which impact on the capacity of the workforce and drive the demand for workforce, such as working time regulations and new mental health legislation.

- **Demographic changes** - Changes in the size of the population and age structure affect the demand for healthcare and, in turn, the healthcare workforce. Scotland has both a declining and ageing population and workforce, and a growing number of elderly patients with chronic conditions often with complex co-morbidity. These trends, coupled with increasing feminisation of the workforce, fuel a continuing demand for increased numbers of staff.

- **Patterns of ill health** - Scotland's health in general compares poorly to other countries in the UK and beyond. The overall health of the nation naturally has an impact on future workforce needs.

- **Service redesign and new role development** drive an increasing need for the workforce to maximise its skills in the provision of a wider range of services delivered in more responsive ways.

- **Technological advances** – Advances in technology will have an impact on the workforce both in terms of increased demand for healthcare as well as more efficient interventions that help increase workforce productivity. These also impact on the levels of skills and competencies required to deliver health services that meet patient need.

- **Increased patient and public expectation -** People are becoming more aware of their health status, their potential health problems, and the range of treatments available. This increased awareness of individual health is naturally resulting in increased support for and development of self-care. This in turn means that people seek out advice through appropriate professionals: often through the GP gateway thus increasing demand for nursing and therapy staff and also scientific staff, where specific tests are required.

- **Review of Pensions -** Possible legislative changes could have an effect on the age of retirement and staff in future could work longer than the current retiral age.

- **Pay Modernisation –** new pay arrangements will impact on every individual member of staff's contribution to service delivery and Agenda for Change will provide a powerful platform for re-designing the workforce to support the further modernisation of the NHS.

- **Modernising Medical Careers** will deliver a modernised and focused career structure for doctors through a major reform of postgraduate medical education and training. These new approaches to training will reduce the availability of clinical time at junior doctor level and will lead to greater demand for extended scope roles in the wider clinical team.

Workforce planning

7.40 The *Scottish Health Workforce Plan 2004 Baseline (Scottish Executive, April 2004)* marked the beginning of a crucial phase in workforce planning. Since then significant progress has been made. Three important publications and new legislation have provided a fresh context within which to plan future workforce needs.

7.41 *Fair to All, Personal to Each – The Next Steps for NHS Scotland (Scottish Executive, December 2004)* builds on existing commitments to improve patients' access to healthcare by setting new targets to further reduce waiting times across NHSScotland. These new standards have workforce implications.

7.42 In January 2005 the Health Committee of the Scottish Parliament reported on its inquiry into workforce planning in NHSScotland with the publication *Reshaping the NHS? Workforce Planning in the National Health Service in Scotland*. This noted that while encouraging initial work had been undertaken to develop workforce planning in NHSScotland there were still barriers to be overcome to ensure effective

planning. It also noted the impact that workforce issues have on the design of services.

7.43 In May 2005 the Scottish Executive published *Building a Health Service Fit for the Future: A National Framework for Service Change in the NHS in Scotland* on the shape of Scotland's health services over the next 20 years. This provides the overall vision for the future shape of NHSScotland in years to come. A key aspect is planning the workforce required to deliver the services envisaged over the next twenty years.

7.44 From 30 September 2004 the NHS Reform (Scotland) Act 2004 made it a statutory duty for all NHS Boards to have in place arrangements for workforce planning. That duty underscores the fact that strategic workforce planning cannot be done at national level alone. The Act also obliged NHS Boards to collaborate across boundaries where appropriate. Regional workforce planning arrangements are now well established, with workforce planning capacity in place and operating in each Board. Baseline workforce profiles have already been produced for each Board and regional and Board workforce plans will follow by the end of this financial year.

7.45 The *National Workforce Planning Framework (Scottish Executive, August 2005)* establishes the framework within which future staff numbers will be planned based on workforce projections made by each NHS Board and by the three workforce planning regions. This framework will allow NHSScotland to align workforce planning with service and financial planning, education and training, regulatory support and organisational structures. Initial regional workforce plans will be produced by January 2006, with Board workforce plans following by April 2006.

C. RECRUITMENT AND RETENTION

7.46 This section outlines initiatives which have been put in place to address recruitment and retention issues affecting the groups covered by the Review Body and covers the wider commitments made as part of the Scottish Executive's 2003 Partnership Agreement.

7.47 *A Partnership for a Better Scotland: Partnership Agreement May 2003* established recruitment targets for NHS Scotland by 2007 including:

- bringing 12,000 nurses/midwives into NHSScotland by September 2007;
- establishment of 54 nursing consultant posts by September 2007;
- 1,500 extra allied health professionals, such as radiographers, physiotherapists, dieticians and chiropodists by September 2007.

Scotland is currently on track to deliver these commitments.

7.48 The general aims of the Scottish Executive Health Department's recruitment and retention policy is to improve the health and well being of the people of Scotland through the delivery of high quality patient care. To achieve this we are committed to increasing the capacity of the NHS workforce within the Health Service in

Scotland. The Scottish Executive is rigorously pursing several initiatives which will enable NHS Scotland Health Boards, as exemplar employers, to improve their ability to be an attractive career option and recruit and retain more health service staff.

7.49 A number of initiatives have been introduced or are currently being developed to meet these targets.

Nursing and midwifery

7.50 The recruitment and retention of nurses and midwives is a key priority which is supported in a number of ways, as follows:

- *Facing the Future* is the banner under which a range of initiatives, themed around careers, flexibility, leadership, new roles, education and training and working conditions, are taken forward in partnership with the professions to improve recruitment and retention of nurses and midwives in Scotland.

- Under its *Strategy for Nursing and Midwifery - Caring for Scotlan (SEHD 2001),* NHS Scotland is working towards the Partnership Agreement commitment of 54 nurse consultant posts by 2007. Currently there are 29 nurse consultants in post, 4 vacant posts and a further 16 approved. The posts include the retention of a clinical caseload combined with leadership, service development, education and research opportunities, and have been deployed in such diverse areas as cancer care, child protection and family planning*.*

- The *Framework for Nursing in General Practice (SEHD 2004)* provides a clear structure for the safe and effective development of practice nursing roles whilst promoting good employment practice. It builds on a consensus of the strengths and development needs of practice nurses.

7.51 The *Nursing, Midwifery and Allied Health Professions Research and Capability Scheme* is designed to provide a system of nursing, midwives and allied health professional patient care based on high quality research evidence. An essential feature of the scheme is partnership and joint funding between SEHD, the Scottish Higher Education Funding Council and NHS Education for Scotland. It enables nurses, midwives and AHPs to develop their careers in research while continuing to contribute to NHSScotland.

Allied Health Professionals

7.52 In 2002 the Scottish Executive published the *Allied Health Professions (AHP) Strategy – Building on Success: Future Directions for the Allied Health Professions (Scottish Executive, 2002).* This strategy provides an action plan to address the key leadership, career development and recruitment and retention issues facing the allied health professions. Initiatives include:

- a return to practice scheme;

- skill mix changes;

- post graduate ‘e’ learning;

- the provision of development opportunities for support workers including alternative routes to state registration; and

- the development of advanced practitioner and consultant roles forming new career pathways.

7.53 In addition, proposals to implement the Partnership Agreement commitment in relation to the allied health professions include a support and development scheme targeted at new graduates, experienced practitioners and those taking up hard to fill posts and the teams that have supported that post.

Health Care Scientists

7.54 The *Scottish Forum for Healthcare Science* facilitates the development of the Healthcare Science Workforce in Scotland. The forum is currently identifying ways in which recruitment measures can be improved, with a view to making the NHS a more attractive career option when compared with the industrial and academic sectors.

Public Health Workforce

7.55 Specific initiatives on recruitment and retention for the public health workforce include:

- launch of the UK voluntary register for public health specialists;

- publication of a guide to national occupational standards for the practice of public health;

- co-ordinated programmes and activities in support of the practitioner and wider public health workforce in Scotland;

- two specialist training posts in public health for non-medics; and

- support for approximately 36 staff, mostly from the NHS, who wish to apply to the voluntary register.

International and ‘e’ Recruitment

7.56 Infrastructure and guidance is currently being developed on the international recruitment of qualified nurses into NHS Scotland and the independent sector. This will include requirements to apply ethical and efficient recruitment and retention practices. A pilot is now underway with the recruitment of Spanish nurses by NHS Glasgow.

7.57 Research has shown that a third of people looking for work now prefer to use the internet as a first choice. NHS Scotland will look to exploit this with the use of ‘e’ vacancy boards on Scotland’s Health on the Web (SHOW): http://www.show.scot.nhs.uk. We are currently piloting ‘e’ vacancy boards for all

staff at NHS Greater Glasgow and are expanding the pilot to include Lothian and Grampian. Full roll-out is expected by January 2006. Vacancies on the board will provide more than just job information on screen; they will be fully interactive and candidates will be able to complete application forms online and receive job information packs by email.

Conclusion

7.58 Recruitment and retention across these cohorts is relatively healthy. We believe any remaining pressures arise from non-pay rather than pay factors. We have now agreed beneficial changes to remuneration and working conditions for the majority of these staff and we believe remaining recruitment and retention issues are to do with a misalignment between supply and demand and the availability of attractive posts in terms of professional content. We are therefore of the view that the key focus should now be on generating more effective workforce planning that produces a healthy supply of candidates for posts in the future, coupled with service redesign that ensures Scotland can offer sufficiently attractive jobs.

D. STAFF DEVELOPMENT

7.59 The Knowledge and Skills Framework (KSF), which is part of *Agenda for Change*, will apply to all staff covered by the Review Body. KSF will provide a much improved and more consistent structure for personal and team development across NHS Scotland. As well as supporting effective learning and development, KSF will promote diversity and equality, while providing all staff with the same opportunities.

7.60 As well as KSF, there are a number of profession-specific development initiatives underway across NHS Scotland, including:

- A joint framework for developing new nursing and AHP roles which will fully utilise skills and present greater career opportunities

- A clinical leadership programme to support the training and development needs of nurses and midwives, to which NHS Scotland has committed £2.7 million over the last 2 financial years and a clinical leadership programme for AHPs supported by funding of £200K

- Clinically focused and evidence based competency and skills-based courses for maternity professionals, provided locally by midwives and other maternity care professionals.

- A development programme for newly qualified nurses, midwives and AHPs which will provide support for new practitioners in the first year of joining NHS Scotland.

- A succession planning nurse/midwife/AHP consultant development programme has been commissioned and a number of programme places across NHS Scotland will be funded.

E. STAFF GOVERNANCE

7.61 Staff governance is a key policy area and NHSScotland as employers are now legally accountable under the NHS Reform (Scotland) Act 2004 for ensuring staff governance in the same way as they are responsible for clinical and financial governance. The Staff Governance Standard has been revised in partnership and recently reissued as part of a comprehensive tool kit which includes a self assessment audit tool, staff survey and associated guidance. The Standard specifies that staff are entitled to be:

- well informed;
- involved in decisions which affect them;
- treated fairly and consistently; and
- provided with an improved and safe working environment.

7.62 Individual Health Board compliance with the Standard is monitored by Audit Scotland.

7.63 Partnership Information Network (PIN) policy and practice are minimum standards of best practice, prepared and agreed in partnership, which NHS Scotland employers are expected to meet or exceed as part of their delivery of the Staff Governance Standard. The publication of the fixed-term contracts PIN earlier this year was preceded by twelve PINs, covering various areas of employer/employee relations such as Family Friendly Policies, Dignity at Work, Equal Opportunities and Management of Employee Conduct. A number of these are now under review and being updated.

7.64 New PIN guidelines on managing recruitment and staff induction are currently in preparation. The Managing Recruitment PIN contains a model exit interview form and guidance on how this should be used in relation to the recruitment process. This document should be complete and ready for issue to NHS Scotland in autumn 2005.

7.65 Healthy Working Lives: Improving Health, Improving Safety, Improving Patient Care presents an action plan to help make NHS Scotland the employer of choice by actively promoting staff and public health, removing workplace inequalities and maximising employment opportunities.

7.66 *OHS Extra* - a £500,000 project - will shortly be piloted in NHS Fife and NHS Lanarkshire. This will provide access for staff to physiotherapy, occupational therapy and counselling services aimed at improving staff health and reducing sickness absence. An on-line health improvement and occupational health screening project is being piloted by Greater Glasgow Primary Care Operational Division. The project is designed to provide evidence to show that health promoting activities can improve health, reduce sickness absence and improve productivity. Both of these pilot projects link directly to NHS Scotland's commitment to reduce sickness absence over the period 2005-06 to 2007-08.

7.67 SEHD has worked with staff and NHSScotland employers to introduce occupational health and safety standards of care to bring health and safety to the fore and

encourage year on year improvement in service provision to protect staff from harm. Over £1m has been spent on projects aimed at reducing accidents and incidents, including £370K on violence and aggression. This resulted in the December 2003 launch of the *Gonnae no dae that* zero tolerance campaign posters and CDs. This was repeated in December 2004 with £400,000 funding to tackle violence and aggression locally. SEHD is in the process of developing a strategy for action to tackle violence and aggression towards staff and is working with colleagues in the Scottish Executive to promote a culture shift in behaviour attitudes to make clear that abusive behaviour towards public sector staff is unacceptable.

7.68 In addition the law has been strengthened to make it a criminal offence to interfere with an emergency worker during the course of an emergency: this includes ambulance staff and other NHS staff working in an emergency situation. A highly acclaimed latex, hand and glove policy has issued and SEHD is working in a UK context to promote a UK Manual Handling Passport. SEHD is also working with the Department of Health in England to develop a pre-employment check programme and intends to work with NHS Wales to develop a violence and aggression training passport.

7.69 The Staff Governance Standard sets a framework for ensuring that NHS Scotland is an exemplar employer, supporting, protecting and developing its staff to the maximum. In this way it serves to motivate and incentivise staff to join and stay in the NHS through non-pay mechanisms, an important compensating factor when considering the level of pay award which should be provided.

F. REGIONAL PAY

7.70 The new *Agenda for Change* pay and conditions system contains provisions for recruitment and retention premia. These premia are available to NHS Boards both on a long term and short term basis and on a national or local basis. In our view these provisions address any need for regional flexibility within Scotland in terms of pay, and we are not therefore currently considering any further measures on this front. We are also aware that a number of non-pay factors, such as the general quality of life, the working environment experienced by staff, the local infrastructure in relation for example to schooling and local property prices can be as important as pay in determining recruitment and retention outcomes across different regions.

G. PROGRESS ON IMPLEMENTATION OF *AGENDA FOR CHANGE*

7.71 There is an expectation that *Agenda for Change* will bring an overall increase in pay and benefits for the great majority of staff. This is a significant investment which it is estimated will lead to an overall increase in the total NHSScotland pay bill of around £190m in 2005-06, although the actual costs will not be known until staff are fully assimilated onto the new system.

7.72 As with the rest of the NHS in the UK, NHSScotland is currently going through the process of assimilating staff onto the new pay system. In moving towards implementation of the new system NHS Scotland has adopted a thorough and rigorous approach which will introduce *Agenda for Change* through a partnership based approach which ensures the matching, evaluation, and assimilation processes

are applied to staff in full accordance with the provisions laid out in the *Agenda for Change* agreement. There has therefore been a high level of consistency checking aimed at ensuring that staff are treated consistently and fairly as they go through the assimilation process. This rigorous approach is designed to minimise the number of job evaluation reviews.

7.73 The final agreement on *Agenda for Change* published in November 2004 did not include agreement on future arrangements for unsocial hours payment under the new system, and negotiations on these arrangements are currently ongoing at UK level. The Scottish Executive is fully participating in these discussions and has provided a financial costing model which can be used to estimate the costs of the different options under consideration by the UK review group.

Pay modernisation and benefits realisation

7.74 The Scottish Executive Health Department issued a Health Department Letter (HDL(2005)28) on delivering the benefits of Pay Modernisation in July 2005 **(**available at http://www.show.scot.nhs.uk/sehd/mels/HDL2005_28.pdf **)**. The HDL asked Boards to submit Pay Modernisation Benefits Delivery Plans by 30 September 2005. This will allow the Department to measure the effective delivery of the 3 strands of pay modernisation (Consultant Contract, *Agenda for Change* and GMS contract).

H. WORKFORCE PERFORMANCE AND EFFECTIVENESS

7.75 Delivering improved workforce performance and effectiveness in NHSScotland is seen as increasingly important, particularly following the significant investment in pay reform. A Workforce Performance and Effectiveness Group has been established to provide:

- an assessment of the impact on productivity of pay modernisation;
- formal advice and recommendations on action to be taken to increase productivity and effectiveness in health;
- new models of organising skills and resources;
- the creation of productivity measures for NHSScotland;
- guidance to NHS Boards on practices and evidence relevant to productivity and effectiveness in NHSScotland.

7.76 The Scottish Executive published its Efficient Government Plan *Building a Better Scotland: Efficient Government – Securing Efficiency, Effectiveness and Productivity* on 29 November 2004. The Efficient Government Plan contains measures to deliver £745m of annually recurring cash-releasing efficiency savings and £300m of recurring time-releasing savings by 2007-08.

7.77 The Workforce Performance and Effectiveness Group has helped to develop workforce productivity measures in relation to consultant productivity and reducing sickness absence for all staff which have subsequently contributed to time-releasing

savings announced under the Efficient Government Initiative. These savings amount to £38.3m in 2005-06, £81m in 2006-07 and £128.7m in 2007-08.

I. AFFORDABILITY

7.78 A substantial and sustained injection of new resources has been invested in health services in Scotland. It is clearly vital that NHS Scotland recruits and retains well trained and motivated staff, which this additional investment should allow. Staffing costs account for about 60% of total expenditure on health in Scotland and clearly a substantial portion of the additional funding will go towards staff costs. This reflects the very significant investment made in staff pay over the last two years. The costs of pay awards for NHS Scotland staff have to be set within a framework which considers:

- The totality of funding set for the Scottish Executive Health Department;
- The Scottish Executive's commitment to deliver the key national priorities and other standards set out in *Building a Better Scotland*; and
- The government's inflation target for the economy as a whole of 2.5%.

7.79 There is no doubt that the recent significant increases in staff pay have had a major impact on Health Boards' budgets and that excessive pay uplifts on top of these would have an opportunity cost on the ability of Boards to develop and extend responsive services to patients. Each rise of 0.5% in the paybill equates to £24 million in Scotland, which is equivalent to employing an extra 800 nurses or 260 doctors. This inevitably would have to be taken from key priorities such as health improvements, tackling health inequalities, providing the most efficacious drugs or reducing waiting times.

7.80 The Scottish Executive Health Department's provision for 2005-06 to 2007-08 are set out in the following table:

	2005-06	**2006-07**	**2007-08**
Total (£m)	8814	9545	10293
Cash Growth (£m)	752	731	748
Cash Growth (%)	9.33%	8.29%	7.84%
GDP Deflator	2.50%	2.70%	2.70%
Real Terms Growth	6.66%	5.45%	5.01%

7.81 These increases cannot be seen as a benchmark for pay settlements. The use of the overall provision needs to be considered against the Scottish Executive's ongoing commitment to the modernisation of NHSScotland, in particular the priorities set out in *Building a Better Scotland* and the impact of underlying demand pressures. These include, among other things:

- Meeting growing demand for health services – providing fairer access to more services locally and adopting medical advances;

- Developing, improving and meeting the additional costs associated with the demand led primary care services;

- Expanding diagnostic capacity and throughput and reduce waiting times for outpatient, inpatient or day case treatment;

- Improving the quality of NHS services to better meet the needs of patients, with particular priority to cancer, coronary heart disease, stroke and mental health;

- Growth in the number of prescriptions and the prescribing of new drugs. Costs are expected to continue to rise by 10-12% per year, which will account for around £90 million per year;

- Securing a more flexible workforce – equipping them to deliver a more patient-focused service;

- Resources to meet demand for capital investment for new hospitals and equipment, the IT infrastructure, and training and development of the NHSScotland workforce.

7.82 NHS Boards have been allocated revenue allocations for 2005-06 comprising a minimum increase of 7.0% with an average increase of 7.6% and a maximum increase of 9.2%. NHS Boards have been notified of indicative increases averaging 7.25% for 2006-07 and 6.5% for 2007-08. The allocation encompasses the estimated cost of assimilation of staff to the new AfC pay bands.

7.83 The Scottish Executive is committed to improving health and revitalising the NHS and community care services in Scotland. New initiatives are being developed to create a step change in improving health. Pay clearly plays an important part in this process but it is only one element.

7.84 The level of any pay award being considered should take account of:

- The totality of funding available to the Scottish Executive Health Department. The increases in NHS resources shown above provide a fixed budget for the NHS in Scotland. There are no resources over and above this to fund any excess costs arising from pay settlements.

- The Department's ongoing commitment to the modernisation of NHSScotland.

- Affordability and the competing demands for investment.

- The Government's inflation target of 2.5%.

J. CONCLUSION

7.85 SEHD supports the Health Departments' recommendation of a general uplift of no more than 2.5%, which we believe fairly balances affordability with the continuing requirement to secure sufficient levels of recruitment and retention.

ANNEXES TO MAIN DOCUMENT

ANNEX A

IMPACT OF INCREMENTAL RISES ON PAY FOR NOHPRB STAFF

The table below illustrates the combined effect of incremental rises and Review Body awards on pay by taking some hypothetical examples of staff groups over a five-year period.

Column (a) shows the actual basic pay at 1 April each year from 2001. An individual would progress incrementally each year as well as receiving a pay award based on Review Body recommendations and the figures include both elements.

Column (b) expresses the total annual increase as a percentage.

Column (c) shows the cumulative percentage increase over basic pay at 1 April 2001.

Comparisons for 2004 are based on staff with incremental date before 1 October, and based on assimilation to next equal or higher pay point in their Agenda for Change pay band

Grade	Year	Actual Basic Salary £	Annual % increase[1]	Cumulative % increase
D Grade Nurse	2001 (minimum)	£15,445		
	2002 (1st increment)	£16,545	7.1%	7.1%
	2003 (2nd increment)	£17,660	6.7%	14.3%
	2004 (3rd increment)	£18,830	6.6%	21.9%
	2004 (AfC band 5-point 19)	£19,180	1.9%	24.2%
	2005 (AfC band 5-point 20)	£20,458	6.7%	32.5%
Basic Grade Radiographer	2001 (minimum)	£15,920		
	2002 (1st increment)	£17,745	11.5%	11.5%
	2003 (2nd increment)	£18,970	6.9%	19.2%
	2004 (3rd increment)	£20,415	7.6%	28.2%
	2004 (AfC band 5-point 21)	£20,458	0.2%	28.5%
	2005 (AfC band 5-point 22)	£21,723	6.2%	36.5%
Midwife	2001 (minimum)	£16,510		
	2002 (1st increment)	£18,970	14.9%	14.9%
	2003 (2nd increment)	£20,450	7.8%	23.9%
	2004 (3rd increment)	£22,015	7.7%	33.3%
	2004 (AfC band 5/6 – point 24)	£22,483	2.1%	36.2%
	2004 (AfC band 5/6 – point 25)	£24,198	7.6%	46.6%
Speech and Language Therapist	2001 (minimum)	£15,244		
	2002 (1st increment)	£16,424	7.7%	7.7%
	2003 (2nd increment)	£17,629	7.3%	15.6%
	2004 (3rd increment)	£18,925	7.4%	24.1%
	2004 (AfC band 5-point 19)	£19,180	1.3%	25.8%
	2005 (AfC band 5-point 20)	£20,458	6.7%	34.2%
MLSO 1 (Biomedical Scientist)	2001 (minimum)	£15,244		
	2002 (1st increment)	£16,424	7.7%	7.7%
	2003 (2nd increment)	£17,629	7.3%	15.6%
	2004 (3rd increment)	£18,925	7.4%	24.1%
	2004 (AfC band 5-point 19)	£19,180	1.3%	25.8%
	2005 (AfC band 5-point 20)	£20,458	6.7%	34.2%

Notes:

[1] The NOHPRB headline award for 1st April 2002 was 3.6%, and for 1st April 2003, 2004 and 2005 it was 3.225%.

ANNEX B

Pay Bands and Pay Points on Second and Third Pay Spines

From 1 April 2005

Point	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8				Band 9
								Range A	Range B	Range C	Range D	
1	11,494	*11,494**										
2	11,879	11,879	*12,044**									
3	12,209	12,209										
4	12,539	12,539	*12,539**									
5		12,924										
6		13,309	*13,144**									
7		13,694	13,694	*13,914**								
8		14,189	14,189									
9		14,739	14,739	*14,739**								
10			15,069									
11			15,509	*15,289**								
12			16,004	16,004								
13			16,389	16,389	*16,389**							
14				16,994	*17,049**							
15				17,598	*17,598**							
16				18,148								
17				18,698	18,698							
18				19,248	19,248	*19,523**						
19					19,798							
20					20,458	*20,458**						
21					21,118							
22					21,723	*21,448**						
23					22,328	22,328						
24					23,208	23,208	*22,768**					
25					24,198	24,198	*24,198**					
26						25,188						
27						26,068	*25,628**					
28						26,948	26,948					
29						27,828	27,828					
30						28,817	28,817					
31						30,247	30,247					
32							31,127	*31,127**				
33							32,117	*32,117**				
34							33,217	*33,217**				
35							34,372	34,372				
36							35,527	35,527	*35,527**			
37								36,957	*36,957**			
38								38,387	*38,387**			
39								40,036	40,036			
40								41,246	41,246	*41,246**		
41									43,336	*43,336**		
42									45,756	*45,756**		
43									48,176	48,176		
44									49,496	49,496	*49,496**	
45										51,695	*51,695**	
46										54,115	*54,115**	
47										57,745	57,745	
48										59,395	59,395	*59,395**
49											61,870	*61,870**
50											64,894	*64,894**
51											68,194	68,194
52											71,494	71,925
53												74,925
54												78,521
55												82,291
56												86,240

***Pay rates in italic are special transitional points which apply only during assimilation to the new system. They are shown here for convenience.**

ANNEX C

NHS national Staff Survey results 2004

- Latest survey results indicate, the NHS is making year on year improvements in what are considered to be the most important aspects of HR:

    - Staff receiving training is up from 89% in 2003 to 93% in 2004;
    - Staff receiving appraisals rose from 60% to 63%;
    - Staff reporting access to counselling services has risen significantly from 73% to 80% in 2004;
    - Staff believe employer committed to equal opportunities risen from 69% to 73%;
    - Staff report access to childcare co-ordinators up from 30% to 35% in 2004 and to subsidised childcare from 22% to 25% in 2004;

- Employee attitude to job satisfaction suggests improvements in HR and management practices in the NHS.

- Retention remains steady with only 25% considering looking for a new job in the next year.

- NHS national staff survey 2004 indicated that staff in the NHS are generally fairly satisfied compared with a downward trend in job satisfaction in the private sector since 2001.

- Employees' feeling of fairness and trust have diminished in the private sector, whilst 61% staff in the NHS felt that their employer acted fairly with regard to career progression or promotion, regardless of ethnicity, gender, religion, sexual orientation, disability or age.

- The proportion of staff in the NHS requesting flexible working options has decreased since 2003 (from 33% to 26%). This is a likely reflection of an increase in staff with dependents who report access to childcare coordinator in the 2004 survey (35% compared with 30% in 2003), and to subsidised childcare (25% compared with 22% in 2003).

ANNEX D

SPENDING REVIEW 2004 PUBLIC SERVICE AGREEMENT

The aim of the Spending Review 2004 Public Service Agreement is to transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities.

The objectives of the SR2004 Public Service Agreement are:

Objective I: Improve the health of the population. By 2010 increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women.

1. Substantially reduce mortality rates by 2010:
    - from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole;
    - from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole; and
    - from suicide and undetermined injury by at least 20%.

2. Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.

3. Tackle the underlying determinants of health and health inequalities by:
    - reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less;
    - halting the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole. Joint target with the Department for Education and Skills and the Department of Culture, Media and Sport; and
    - reducing the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health. Joint target with the Department for Education and Skills.

    Note: Figures will be reviewed following publication of the Public Health White Paper later in 2004

Objective II: Improve health outcomes for people with long-term conditions

4. To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long-term conditions.

Objective III: Improve access to services

5. To ensure that by 2008 no one waits more than 18 weeks from GP referral to hospital treatment.

6. Increase the participation of problem drug users in drug treatment programmes by 100% by 2008; and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes.

Objective IV: Improve the patient and user experience

7. Secure sustained national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider.

8. Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible, by:

    - increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and
    - increasing, by 2008, the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.

ANNEX E

ECONOMIC CONTEXT: LATEST DATA

Inflation

The tables below present the percentage changes in the RPI, RPIX and CPI, both on the year and over the month. As stated in Chapter 5, however, too much emphasis should not be placed on a single month's inflation figure, instead the Review Body should focus on underlying trends.

	CPI (%)	RPI (%)	RPIX (%)
2004	**+1.3**	**+3.0**	**+2.2**

	March 2005	April 2005	May 2005	June 2005	July 2005
CPI	+1.9	+1.9	+1.9	+2.0	+2.3%
RPI	+3.2	+3.2	+2.9	+2.9	+2.9%
RPIX	+2.4	+2.3	+2.1	+2.2	+2.4%

Future Inflation Expectations
The Government expects CPI inflation to return to target by mid 2006. The forecast for RPI (in September) is for inflation to fall in 2005-06 and 2006-07, before rising again 2007-08 and remaining constant at 2¾% thereafter.

	Projections % Change on a year earlier				
	2005-06	**2006-07**	**2007-08**	**2008-09**	**2009-10**
CPI	+1.75	+2	+2	+2	+2
RPI (Sept)	+2.75	+2.5	+2.75	+2.75	+2.75

Average earnings Index[4]
The main source of the data on average growth in individuals' earnings in the UK is the Average Earnings Index (AEI), collected by the Office of National Statistics (ONS). ONS measure of the year-on-year percentage growth in earnings is calculated as the average rate of PPH increase over all employers in whole economy, private and public sectors (as well as broad industrial sectors). The AEI covers both full-time and part-time workers and includes basic pay, shift payments, bonuses and profit-related pay.

The table below provides the headline AEI three-month average figures, which measure the change in the index for the last three months compared with the same period a year earlier. For completeness, the single month rate, comparing the change in the index to that individual month a year earlier, is also provided.

[4] Further technical details and monthly AEI updates can be found at http://www.statistics.gov.uk/CCI/nugget.asp?ID=304&Pos=2&ColRank=2&Rank=640

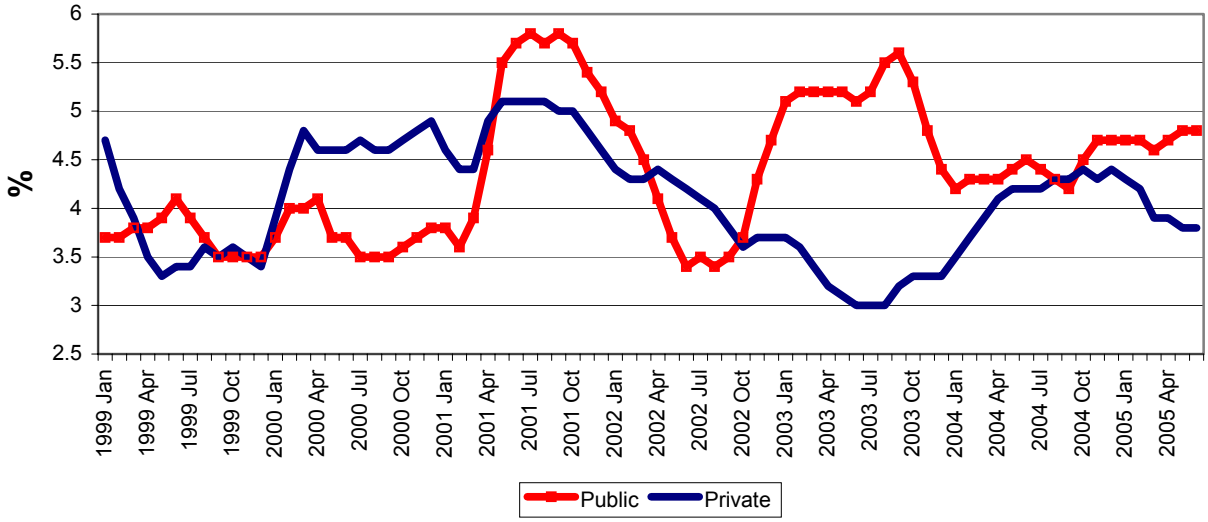
However, as this is a particularly volatile series it should be used with caution in recommendations for future pay.

	Whole Economy		Private Sector		Public sector	
	Average Earnings Index (%) (Excl bonuses)					
	3mth average	Single month	3mth average	Single month	3mth average	Single month
July 2004	4.2	4.2	4.1	4.3	4.4	3.8
Aug 2004	4.3	4.4	4.3	4.5	4.3	4.3
Sept 2004	4.3	4.3	4.3	4.2	4.2	4.5
Oct 2004	4.4	4.5	4.4	4.4	4.5	4.9
Nov 2004	4.4	4.4	4.3	4.3	4.7	4.7
Dec 2004	4.4	4.4	4.4	4.5	4.7	4.5
Jan 2005	4.4	4.2	4.3	4.0	4.7	4.8
Feb 2005	4.3	4.1	4.2	4.0	4.6	4.7
March 2005	4.1	3.9	3.9	3.8	4.6	4.4
April 2005r	4.1	4.1	3.9	3.9	4.7	4.9
May 2005r	4.0	3.9	3.8	3.6	4.8	5.1
June 2005p	4.0	4.0	3.8	3.8	4.8	4.5
	Average Earnings Index (%) (Incl bonuses)					
	3mth average	Single month	3mth average	Single month	3mth average	Single month
July 2004	3.8	3.3	3.7	3.2	4.2	3.7
Aug 2004	3.8	4.1	3.7	4	4.2	4.5
Sept 2004	3.8	3.9	3.7	3.8	4.2	4.4
Oct 2004	4.1	4.2	4	4.1	4.6	4.8
Nov 2004	4.2	4.6	4.1	4.6	4.7	4.7
Dec 2004	4.4	4.3	4.3	4.3	4.7	4.4
Jan 2005	4.3	4.0	4.2	3.9	4.6	4.7
Feb 2005	4.7	5.7	4.7	5.9	4.6	4.6
March 2005	4.5	3.9	4.6	3.9	4.6	4.3
April 2005 r	4.6	4.3	4.6	4.1	4.6	5.0
May 2005 r	4.1	4.1	3.8	3.3	5.6	7.6
June 2005p	4.2	4.1	3.8	4.1	5.6	4.3

(p) = Provisional figures
(r) = Revised

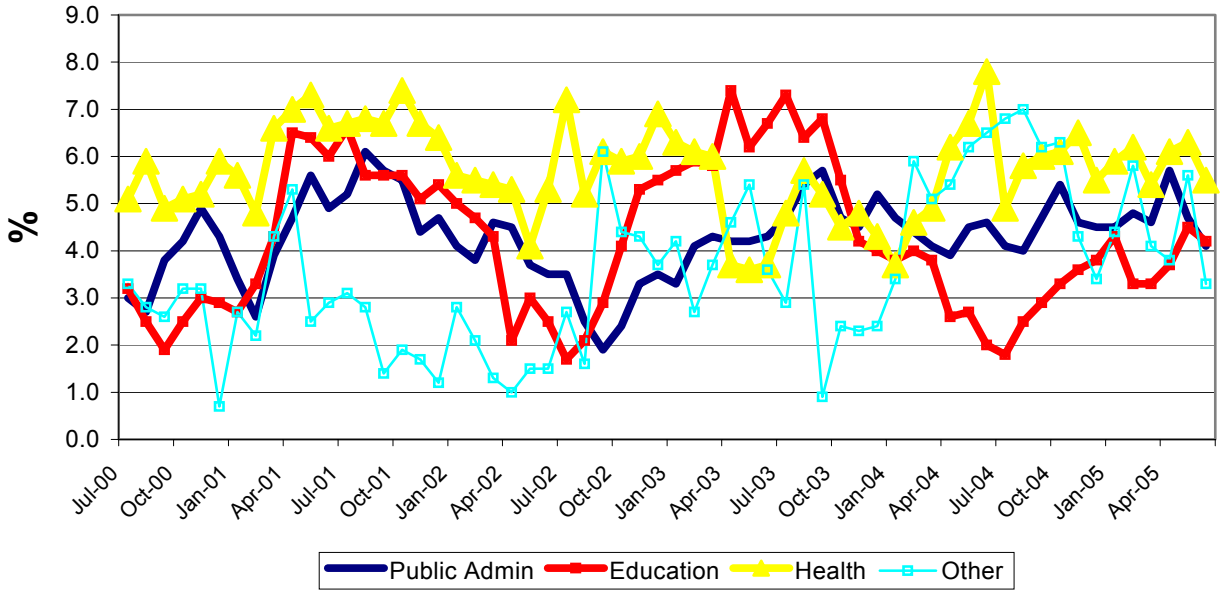
12 month increases in Whole Economy, Private and Public Sectors AEI

Public v Private Sector AEI Exc Bonuses



The graph below breaks down the overall headline AEI growth in the public sector (excluding bonuses) into the broad classification of public sector, public administration, education, health and other.

Public Sector AEI Breakdown



Over the 12 month period, the UK health sector has witnessed amongst the strongest growth in the AEI, with an annualised figure of 6%. Pay increases in the NHS have been in return for contract and workforce reform, which is now being driven through the NHS.

The remaining annualised figures are shown below.

Average Earnings Index (%) excl bonuses					
	Public Sector	**Public Admin**	**Education**	**Health***	**Other**
12 month average	4.5	4.5	3.0	6.1	5.5

* The AEI 'health' category covers more than the NHS just in England. It is based on standard industrial classification category health and social work with any private sector activities stripped out.

Based on the current and expected trends in productivity, the government considers that in the medium term (over the economic cycle), AEI growth for the whole economy around 4.5% to 4.75% is consistent with achievement of the Bank of England's CPI inflation target of 2%[5].

We believe that, in the medium term, public sector pay growth should be broadly in line with the sustainable level of earnings growth for the economy as a whole. However, this may not be an appropriate level for all sectors. It may be appropriate for earnings growth to be above or below these levels, depending on the evidence of recruitment and retention needs of the sector and the labour market conditions prevailing at that time.

[5] The switch from RPI to CPI as the inflation measure for monetary policy purposes does not itself materially change our view of the medium term sustainable rate of whole economy earnings growth.

STATISTICAL TABLES

List of Statistical Tables

Table 1: NHS hospital and community health services: Nursing staff as at 30 September each specified year

											Full time equivalent
	1994	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
England	**353,128**	**335,025**	**335,329**	**332,872**	**334,276**	**340,463**	**348,147**	**360,463**	**376,695**	**393,446**	**403,220**
Qualified nursing, midwifery & health visiting staff	241,358	246,822	248,070	246,011	247,238	250,651	256,276	266,171	279,287	291,925	301,877
Unqualified nursing staff	94,382	82,910	83,651	84,021	84,524	87,443	89,831	92,192	95,051	98,953	98,413
Nurse learners	11,082	4,582	2,671	2,251	2,080	1,881	1,970	2,100	2,277	2,493	2,930
Others	6,307	710	937	589	435	487	69	0	79	75	0
Wales	**25,364**	**24,727**	**23,452**	**23,418**	**23,691**	**23,973**	**24,314**	**24,751**	**25,506**	**26,697**	**27,407**
Qualified nursing, midwifery & health visiting staff	..	..	16,978	17,228	17,180	17,397	17,672	18,088	18,766	19,514	20,126
Unqualified nursing staff	..	..	5,943	6,065	6,414	6,491	6,558	6,562	6,630	7,085	7,134
Nurse learners	..	..	134	106	98	81	84	101	110	98	146
Others	..	..	396.8	18.6	0	3.8	0	0	0	0	0
Scotland	**52,521**	**52,416**	**51,911**	**51,479**	**51,107**	**51,390**	**51,310**	**52,234**	**53,197**	**54,120**	**54,553**
Qualified nursing, midwifery & health visiting staff	35,381	35,380	35,323	35,245	35,234	35,597	35,730	36,425	37,260	38,263	38,907
Unqualified nursing staff	17,140	17,037	16,588	16,234	15,873	15,794	15,580	15,809	15,937	15,858	15,646
Nurse learners	..	..	..	..	..	..	..	..	..	..	..
Others	..	..	..	..	..	..	..	..	..	..	..

Notes:
A new system of classification for NHS non-medical staff was introduced in 1995, 1994 figures are not directly comparable with later years.

Health and Social Care Information Centre Non-Medical Workforce Census

Table 2: NHS Hospital and Community Health Services: Qualified nursing, midwifery & health visiting staff

England as at September 2004 — full time equivalents

	Acute elderly & general	Paediatric nursing	Maternity services	Community psychiatry	Other psychiatry	Community Learning Disabilities	Other learning disabilities	Community services	Education staff	School nursing	Unspecified	*All areas of work*
All qualified nursing, midwifery & HV staff	**166,098**	**15,258**	**24,463**	**13,627**	**27,959**	**3,325**	**4,201**	**43,369**	**1,140**	**1,619**	**820**	**301,877**
Nurse consultant	302	26	44	24	82	13	7	93	16	-	3	609
Manager	3,584	268	376	427	1,102	210	235	1,210	114	15	..	7,542
Reg. sick children nurse	269	9,850	810	..	..	..	..	247	11	..	..	11,186
Registered midwife	..	..	18,835	..	..	..	..	..	19	..	..	18,854
Health visitor	..	..	..	..	..	..	..	10,137	..	..	..	10,137
District nurse	..	..	..	..	..	..	..	10,000	..	..	..	10,000
School nurse	..	..	..	..	..	..	..	..	..	607	..	607
Other 1st level	154,371	4,631	4,169	12,778	25,310	2,987	3,710	20,219	961	932	..	230,067
Other 2nd level	7,572	483	229	398	1,464	115	249	1,463	20	65	..	12,057
Unspecified	..	..	..	..	..	..	..	..	..	..	817	817
All unqualified staff	**47,442**	**2,717**	**3,489**	**2,688**	**19,206**	**4,418**	**8,144**	**9,115**	**80**	**204**	**0**	**97,504**
Nursery nurse	975	894	296	0	26	0	20	1,475	0	44	0	3,730
Nursing assistant/auxillary	46,467	1,823	3,192	2,688	19,180	4,418	8,124	7,640	80	160	0	93,773

Notes: .. not applicable
- zero
Figures are rounded to the nearest whole-number
1 Other 1st and 2nd level include staff coded as Community Psychiatric Nurses (CPN) and Community Learning Disabilities Nurses (CLDN) with a specific recordable community qualification

Source: Department of Health 2004 non-medical workforce census

Table 3: NHS Hospital and Community Health Services: Allied Health Professional Groups (Qualified and Unqualified) as at 30 September each year

full time equivalent

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
England											
All specified staff	39,097	49,588	52,523	53,765	54,938	56,382	58,055	60,568	62,703	65,444	68,930
All Allied health professions	35,565	39,972	42,465	43,378	44,334	45,701	46,946	48,995	50,914	53,167	56,083
All speech & language therapy staff	3,532	3,612	3,848	4,023	4,127	4,249	4,403	4,602	4,767	5,183	5,494
Ambulance paramedics	..	6,004	6,210	6,364	6,478	6,432	6,706	6,971	7,022	7,094	7,353
Wales											
All specified staff	..	..	3,736	3,752	3,826	4,018	4,320	4,502	4,411	4,678	4,962
All Allied health professions	..	..	2,790	2,897	2,944	3,001	3,145	3,338	3,458	3,671	3,914
All speech & language therapy staff	..	..	238	261	265	276	278	293	331	371	383
Ambulance paramedics	..	..	707	595	617	741	897	871	623	636	665
Scotland											
All specified staff	5,571	6,162	6,468	6,830	7,095	7,478	7,607	7,941	8,467	9,046	9,345
All Allied health professions	4,991	5,301	5,468	5,694	5,841	6,125	6,204	6,475	6,875	7,281	7,466
All speech & language therapy staff	580	618	662	712	730	765	810	814	839	861	856
Ambulance paramedics	..	243	338	424	524	587	593	653	754	904	1,023

Notes:
A new system of classification for NHS non-medical staff was introduced in 1995, 1994 figures are not directly comparable with later years.
Full time equivalent figures are rounded to the nearest whole number.
.. Not available

Health and Social Care Information Centre Non-Medical Workforce Census

Table 4: NHS Hospital and Community Health Services Allied Health Professional Groups (Qualified and Unqualified) by Profession as at 30 September 2004

	Full time equivalent		
	ENGLAND	**WALES**	**SCOTLAND**
All specified staff	**68,930**	**4,962**	**9,345**
All Allied health professions	56,083	3,914	7,466
All Chiropody Staff	3,501	254	714
All Dietetics staff	2,783	229	518
All occupational therapy staff	15,780	1,028	1,540
All orthoptics/optics staff	1,096	48	74
All physiotherapy staff	18,396	1,315	2,121
All radiography staff	..	..	1,514
All radiography (diagnostic) staff	12,296	921	..
All radiography (therapeutic) staff	1,754	103	..
All art/music/drama/therapy staff	477	16	26
Sonographer[1]	..	..	83
Orthotist and prosthetists[2]	..	..	93
Technical instructor/Handicraft teacher	..	..	738
Play Staff	..	..	40
Rehabilitation/Clinical support assistant	..	..	5
All speech & language therapy staff	5,494	383	856
Ambulance paramedics	7,353	665	1,023

Notes:
A new system of classification for NHS non-medical staff was introduced in 1995, 1994 figures are not directly comparable with later years.
Full time equivalent figures are rounded to the nearest whole number.
.. Not available
Health and Social Care Information Centre Non-Medical Workforce Census

Scotland:
1. From March 2004 sonographers and sonographers in training are included in these statistics.
2. Prior to 2002, orthotists and prosthetists are included in the technical staff group.
3. High street pharmacists and optometrists are not included.

Source: ISD Scotland. Scottish Standard Payroll System.

Table 5: NHS hospital and community health services: ST&T staff in England by each specified area of work as at 30 September 2004

full time equivalents

	2004
All Specified staff	***28,373***
All clinical psychology staff	*7,219*
Qualified clinical psychology staff	5,518
Unqualified clinical psychology staff	1,700
All psychotherapy staff	*805*
Qualified psychotherapy staff	723
Unqualified psychotherapy staff	82
All pharmacy staff	*14,177*
Qualified pharmacy staff	11,375
Unqualified pharmacy staff	2,802
All operating theatres staff	*6,172*
Qualified operating theatres staff	4,675
Unqualified operating theatres staff	1,498

Notes:

FTE figures are rounded to the nearest whole number

Source:

Health and Social Care Information Centre Non-Medical Workforce Census

Table 6: NHS hospital and community health services: Qualified nursing, midwifery & health visiting staff, by Government Office Region and by Strategic Health Authority area in England as at 30 September each year

full time equivalent & full time equivalent percentage

GOR code	GOR name	Strategic Health Authority	SHA code	1999	2000	2001	2002	2003	2004	*increase 1999-2004*	% increase 1999-2004
England				**250,651**	**256,276**	**266,171**	**279,287**	**291,925**	**301,877**	**51,226**	**17.0%**
A	**North East Total**			**15,871**	**16,140**	**16,727**	**17,154**	**17,640**	**18,189**	**2,318**	**12.7%**
		County Durham & Tees Valley	Q10	6,571	6,727	6,839	6,910	7,275	7,473	902	12.1%
		Northumberland, Tyne & Wear	Q09	9,300	9,413	9,888	10,243	10,365	10,716	1,416	13.2%
B	**North West Total**			**39,059**	**40,012**	**40,933**	**43,717**	**45,188**	**47,817**	**8,758**	**18.3%**
		Cheshire & Merseyside	Q15	12,783	13,424	14,097	15,612	16,276	16,879	4,096	24.3%
		Cumbria & Lancashire	Q13	10,514	10,449	10,572	11,322	11,490	13,071	2,558	19.6%
		Greater Manchester	Q14	15,763	16,140	16,265	16,783	17,422	17,867	2,104	11.8%
D	**Yorkshire and the Humber Total**			**26,345**	**27,343**	**27,921**	**29,566**	**31,323**	**31,248**	**4,903**	**15.7%**
		North and East Yorkshire and Northern Lincolnshire	Q11	6,605	6,816	6,884	7,688	7,951	8,227	1,622	19.7%
		South Yorkshire	Q23	7,872	8,133	8,345	8,855	9,138	9,432	1,560	16.5%
		West Yorkshire	Q12	11,868	12,394	12,692	13,022	14,233	13,588	1,720	12.7%
E	**East Midlands Total**			**19,217**	**19,456**	**20,138**	**20,871**	**21,322**	**22,288**	**3,072**	**13.8%**
		Leicestershire, Northamptonshire & Rutland	Q25	6,841	6,928	7,000	7,140	7,272	7,691	850	11.0%
		Trent	Q24	12,375	12,528	13,138	13,731	14,050	14,597	2,222	15.2%
F	**West Midlands Total**			**26,344**	**26,837**	**28,219**	**29,793**	**30,732**	**31,908**	**5,564**	**17.4%**
		Birmingham & The Black Country	Q27	12,767	13,147	13,772	14,838	15,288	15,983	3,216	20.1%
		Shropshire & Staffordshire	Q26	6,864	6,921	7,490	7,731	7,985	8,061	1,197	14.8%
		West Midlands South	Q28	6,712	6,768	6,957	7,223	7,460	7,863	1,151	14.6%
G	**East Of England Total**			**21,914**	**22,544**	**23,942**	**25,140**	**25,988**	**27,932**	**6,017**	**21.5%**
		Bedfordshire & Hertfordshire	Q02	5,681	5,784	6,377	6,646	6,818	7,064	1,382	19.6%
		Essex	Q03	6,018	6,096	6,326	6,767	6,858	7,168	1,149	16.0%
		Norfolk, Suffolk & Cambridgeshire	Q01	10,214	10,663	11,239	11,727	12,312	13,700	3,486	25.4%
H	**London Total**			**42,155**	**43,091**	**45,331**	**47,644**	**51,071**	**52,592**	**10,438**	**19.8%**
		North Central London	Q05	9,099	9,097	9,723	9,781	10,501	10,854	1,754	16.2%
		North East London	Q06	7,356	7,250	7,773	8,079	9,416	9,593	2,236	23.3%
		North West London	Q04	10,186	10,440	11,564	12,443	12,627	12,893	2,707	21.0%
		South East London	Q07	8,804	9,445	9,407	10,224	11,024	11,379	2,576	22.6%
		South West London	Q08	6,709	6,860	6,864	7,117	7,503	7,873	1,164	14.8%
J	**South East Total**			**34,031**	**34,622**	**36,534**	**38,295**	**40,283**	**40,538**	**6,506**	**16.0%**
		Hampshire & Isle of Wight	Q17	7,567	7,733	8,286	8,632	9,424	9,398	1,831	19.5%
		Kent & Medway	Q18	6,308	6,378	6,498	6,796	7,079	7,283	975	13.4%
		Surrey & Sussex	Q19	11,228	11,480	12,086	12,831	13,159	13,209	1,981	15.0%
		Thames Valley	Q16	8,929	9,030	9,664	10,036	10,621	10,648	1,719	16.1%
K	**South West Total**			**24,041**	**24,452**	**25,460**	**26,664**	**27,789**	**27,947**	**3,907**	**14.0%**
		Avon, Gloucestershire & Wiltshire	Q20	11,030	11,004	11,331	12,036	12,699	12,892	1,862	14.4%
		Dorset & Somerset	Q22	5,286	5,310	5,599	5,892	6,202	6,205	919	14.8%
		South West Peninsula	Q21	7,725	8,138	8,530	8,737	8,888	8,851	1,126	12.7%
	Special Health Authorities & Other Statutory Bodies			**1,674**	**1,779**	**966**	**444**	**588**	**1,419**	**-256**	**-18.0%**

Notes:
Figures are rounded to the nearest whole number
Due to rounding totals may not equal the sum of component parts
1997-2001 data is estimated based on 2002 organisational structure

Source:
Department of Health Non-Medical Workforce Census

Table 7: NHS hospital and community health services: Qualified allied health professionals by Government Office Region and by Strategic Health Authority area in England as at 30 September each year

full time equivalent & full time equivalent percentage

GOR code	GOR name	Strategic Health Authority	SHA code	1999	2000	2001	2002	2003	2004	*increase 1999-2004*	% increase 1999-2004
England				**39,342**	**40,528**	**42,077**	**43,786**	**45,771**	**48,338**	**8,996**	**18.6%**
A	**North East Total**			**2,176**	**2,293**	**2,378**	**2,444**	**2,613**	**2,750**	**573**	**20.9%**
		County Durham & Tees Valley	Q10	909	956	1,005	1,006	1,054	1,081	172	15.9%
		Northumberland, Tyne & Wear	Q09	1,267	1,337	1,372	1,438	1,559	1,669	402	24.1%
B	**North West Total**			**6,014**	**6,262**	**6,574**	**6,766**	**7,019**	**7,581**	**1,567**	**20.7%**
		Cheshire & Merseyside	Q15	2,037	2,125	2,261	2,300	2,367	2,684	648	24.1%
		Cumbria & Lancashire	Q13	1,576	1,597	1,624	1,657	1,768	1,936	360	18.6%
		Greater Manchester	Q14	2,401	2,541	2,689	2,809	2,884	2,961	559	18.9%
D	**Yorkshire and the Humber Total**			**4,381**	**4,503**	**4,660**	**4,995**	**5,182**	**5,370**	**989**	**18.4%**
		North and East Yorkshire and Northern Lincolnshire	Q11	1,011	1,001	1,029	1,213	1,326	1,393	381	27.4%
		South Yorkshire	Q23	1,304	1,335	1,357	1,464	1,494	1,569	265	16.9%
		West Yorkshire	Q12	2,066	2,167	2,274	2,318	2,362	2,408	342	14.2%
E	**East Midlands Total**			**2,969**	**3,024**	**3,299**	**3,419**	**3,598**	**3,793**	**824**	**21.7%**
		Leicestershire, Northamptonshire & Rutland	Q25	1,012	1,008	1,088	1,151	1,228	1,295	283	21.8%
		Trent	Q24	1,957	2,016	2,211	2,268	2,370	2,498	542	21.7%
F	**West Midlands Total**			**4,016**	**4,114**	**4,226**	**4,390**	**4,650**	**4,933**	**917**	**18.6%**
		Birmingham & The Black Country	Q27	1,849	1,875	1,893	1,987	2,093	2,285	437	19.1%
		Shropshire & Staffordshire	Q26	1,129	1,149	1,206	1,251	1,330	1,385	256	18.5%
		West Midlands South	Q28	1,039	1,091	1,126	1,151	1,228	1,262	224	17.7%
G	**East Of England Total**			**3,621**	**3,698**	**3,902**	**4,127**	**4,320**	**4,466**	**844**	**18.9%**
		Bedfordshire & Hertfordshire	Q02	929	907	957	1,032	1,086	1,115	186	16.7%
		Essex	Q03	951	954	1,065	1,068	1,092	1,106	155	14.0%
		Norfolk, Suffolk & Cambridgeshire	Q01	1,741	1,837	1,880	2,027	2,143	2,245	504	22.4%
H	**London Total**			**6,410**	**6,638**	**6,661**	**6,673**	**6,999**	**7,467**	**1,057**	**14.2%**
		North Central London	Q05	1,423	1,443	1,464	1,399	1,540	1,614	191	11.9%
		North East London	Q06	1,173	1,183	1,146	1,209	1,250	1,336	163	12.2%
		North West London	Q04	1,428	1,573	1,570	1,572	1,627	1,731	303	17.5%
		South East London	Q07	1,250	1,273	1,271	1,369	1,432	1,555	305	19.6%
		South West London	Q08	1,137	1,164	1,209	1,123	1,151	1,230	94	7.6%
J	**South East Total**			**5,573**	**5,670**	**5,951**	**6,217**	**6,391**	**6,781**	**1,208**	**17.8%**
		Hampshire & Isle of Wight	Q17	1,100	1,130	1,210	1,308	1,433	1,469	370	25.2%
		Kent & Medway	Q18	1,015	1,076	1,085	1,114	1,140	1,276	261	20.4%
		Surrey & Sussex	Q19	1,946	1,951	2,032	2,154	2,209	2,358	413	17.5%
		Thames Valley	Q16	1,512	1,513	1,624	1,641	1,609	1,677	165	9.8%
K	**South West Total**			**4,086**	**4,226**	**4,426**	**4,755**	**4,999**	**5,198**	**1,111**	**21.4%**
		Avon, Gloucestershire & Wiltshire	Q20	1,943	1,944	2,001	2,182	2,298	2,400	457	19.0%
		Dorset & Somerset	Q22	882	927	1,020	1,056	1,116	1,150	268	23.3%
		South West Peninsula	Q21	1,261	1,356	1,406	1,516	1,585	1,647	386	23.4%
	Special Health Authorities & Other Statutory Bodies			**95**	**100**	**2**	**0**	**0**	**0**	**-95**	**..**

Notes:
Figures are rounded to the nearest whole number
1997-2001 data is estimated based on 2002 organisational structure
.. Not applicable

Source:
Health and Social Care Information Centre Non-Medical Workforce Census

Table 8: Health & Social Care Information Centre Vacancies Survey March 2005

NHS three month vacancies by Government Office Region & Strategic Health Authority area[a], specified staff groups

Three month vacancy rates and numbers[b,c]

		Qualified nursing, midwifery & health visiting staff		Total Other qualified ST&T Staff		Qualified Allied Health Professionals		Ambulance staff	
		Three month vacancy rate %	Three month vacancy number			Three month vacancy rate %	Three month vacancy number	Three month vacancy rate %	Three month vacancy number
		March 2005				*March 2005*		*March 2005*	
England		**1.9%**	**5,801**	**2.2%**	**1348**	**3.4%**	**1,694**	**0.7%**	**136**
North East Government Office Region Total	**A**	**0.7%**	**132**	**1.3%**	**44**	**0.9%**	**25**	**3.2%**	**20**
County Durham & Tees Valley Strategic Health Authority area Total	Q10	0.7%	51	1.9%	21	0.6%	7	*	2
Northumberland, Tyne & Wear Strategic Health Authority area Total	Q09	0.8%	82	1.1%	24	1.1%	18	3.0%	18
North West Government Ofice Region Total	**B**	**1.1%**	**510**	**1.3%**	**117**	**2.2%**	**168**	**0.1%**	**2**
Cheshire & Merseyside Strategic Health Authority area Total	Q15	0.9%	153	1.3%	46	2.5%	68	0.0%	0
Cumbria & Lancashire Strategic Health Authority area Total	Q13	0.7%	88	1.1%	21	1.7%	34	0.1%	1
Greater Manchester Strategic Health Authority area Total	Q14	1.5%	269	1.4%	50	2.2%	67	0.1%	1
Yorkshire & the Humber Government Office Region Total	**D**	**1.6%**	**495**	**1.9%**	**114**	**2.2%**	**118**	**0.6%**	**13**
North & East Yorkshire & Northern Lincolnshire Strategic Health Authority area Total	Q11	2.7%	190	4.2%	49	2.2%	28	0.0%	0
South Yorkshire Strategic Health Authority area Total	Q23	1.0%	99	0.7%	15	2.1%	34	0.0%	0
West Yorkshire Strategic Health Authority area Total	Q12	1.5%	206	1.7%	50	2.3%	57	1.2%	13
East Midlands Government Office Region Total	**E**	**0.9%**	**193**	**1.0%**	**42**	**1.2%**	**47**	**0.1%**	**2**
Leicestershire, Northamptonshire & Rutland Strategic Health Authority area Total	Q25	1.6%	127	2.3%	36	1.5%	20	-	0
Trent Strategic Health Authority area Total	Q24	0.5%	66	0.2%	7	1.1%	28	0.1%	2
West Midlands Government Office Region Total	**F**	**0.8%**	**269**	**2.0%**	**124**	**3.2%**	**162**	**0.0%**	**1**
Birmingham & The Black Country Strategic Health Authority area Total	Q27	1.0%	154	2.3%	75	3.7%	89	0.1%	1
Shropshire & Staffordshire Strategic Health Authority area Total	Q26	0.6%	51	2.4%	35	3.0%	42	0.0%	0
West Midlands South Strategic Health Authority area Total	Q28	0.8%	64	1.0%	14	2.4%	31	0.0%	0
East of England Government Office Region Total	**G**	**2.7%**	**782**	**3.2%**	**167**	**5.8%**	**273**	**3.0%**	**65**
Bedfordshire & Hertfordshire Strategic Health Authority area Total	Q02	5.0%	368	6.4%	82	7.7%	93	1.0%	5
Essex Strategic Health Authority area Total	Q03	2.6%	193	2.2%	28	7.1%	85	9.1%	60
Norfolk, Suffolk & Cambridgeshire Strategic Health Authority area Total	Q01	1.6%	221	2.2%	56	4.1%	95	0.0%	0
London Government Office Region Total	**H**	**3.8%**	**2,066**	**4.0%**	**493**	**6.6%**	**527**	**0.0%**	**0**
North Central London Strategic Health Authority area Total	Q05	3.9%	439	5.7%	170	5.2%	89	-	0
North East London Strategic Health Authority area Total	Q06	2.3%	229	3.0%	58	7.9%	114	-	0
North West London Strategic Health Authority area Total	Q04	4.5%	606	3.9%	106	7.8%	147	*	0
South East London Strategic Health Authority area Total	Q07	5.3%	640	4.7%	128	7.8%	132	0.0%	0
South West London Strategic Health Authority area Total	Q08	1.9%	152	1.5%	30	3.5%	45	-	0
London Ambulance Service NHS Trust	*RRU*	-	*0*			-	*0*	*0.0%*	*0*
South East Government Office Region Total	**J**	**2.6%**	**1,089**	**2.4%**	**184**	**4.2%**	**295**	**0.4%**	**11**
Hampshire & Isle Of Wight Strategic Health Authority area Total	Q17	3.2%	314	1.1%	19	3.0%	46	0.0%	0
Kent & Medway Strategic Health Authority area Total	Q18	1.7%	125	2.3%	31	2.6%	35	0.0%	0
Surrey & Sussex Strategic Health Authority area Total	Q19	3.1%	422	3.8%	93	5.1%	126	0.6%	6
Thames Valley Strategic Health Authority area Total	Q16	2.1%	228	2.0%	41	5.0%	88	0.6%	5
South West Government Office Region Total	**K**	**0.9%**	**262**	**0.8%**	**42**	**1.5%**	**78**	**1.1%**	**23**
Avon, Gloucestershire & Wiltshire Strategic Health Authority area Total	Q20	1.1%	146	1.0%	29	2.0%	50	1.2%	11
Dorset & Somerset Strategic Health Authority area Total	Q22	0.2%	13	0.8%	8	0.7%	8	4.4%	12
South West Peninsula Strategic Health Authority area Total	Q21	1.1%	102	0.3%	6	1.3%	21	0.0%	0
Special Health Authorities & Other Statutory Bodies Total		0.1%	2	**1.1%**	**20**	-	0	*	0

a. SHA figures are based on Trusts and do not necessarily reflect the geographical provision of healthcare.

b. Three month vacancies are vacancies as at 31 March 2005 which Trusts are actively trying to fill which had lasted for three months or more (whole time equivalents).

c. Three month vacancy rates are three month vacancies expressed as a percentage of three month vacancies plus staff in post (staff in post figures as at 30 September 2004).

Three month vacancy notes:

1. Three month Vacancy Rates are calculated using staff in post from the Non-Medical Workforce Census, September 2004
2. Percentages are rounded to one decimal place.
3. * figures where sum of staff in post (as at 30 September 2004) and vacancies (as at 31 March 2005) is less than 10.
4. - figures where staff in post and vacancies are both nil.

Staff in post notes:

1. Staff in post data is from the Non-Medical Workforce Census September 2004.
2. - zero.

General notes:

1. Vacancy and staff in post numbers are rounded to the nearest whole number.
2. Calculating the vacancy rates using the above data may not equal the actual vacancy rates.
3. Due to rounding, totals may not equal the sum of component parts.
4. Strategic Health Authority figures are based on Trusts and do not necessarily reflect the geographical provision of healthcare.
5. The London Ambulance Service NHS Trust cannot be assigned to a particular Strategic Health Authority.
6. Qualified Allied Health Professional vacancy data includes qualified staff from the following occupational groups: chiropody, dietetics, occupational therapy, orthoptics/optics, physiotherapy, diagnostic and therapeutic radiography and art/music/drama therapy staff.
7. The 2005 Vacancy survey did not receive a valid return from the Lincolnshire & Goole Hospitals NHS Trust. Figures for this Trust have been excluded from all applicable vacancy totals and calculations. Staff in post figures for this Trust are included in the England, Yorkshire & the Humber GOR and North & East Yorkshire & Northern Lincolnshire SHA totals so as to be consistent with other Health & Social Care Information Centre publications.

Sources:

Health & Social Care Information Centre Vacancies Survey March 2005
Health & Social Care Information Centre Non-Medical Workforce Census September 2004