Implementing Agenda for Change for NHS Contractors Staff in England

A best practice guide

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Document Purpose	Best Practice Guidance		
ROCR Ref:		**Gateway Ref:**	7676
Title	Implementing Agenda for Change for NHS Contrators Staff in England : A best practice guide		
Author	DH, Pay and Pensions Branch		
Publication Date	January 2007		
Target Audience	Directors of HR, Directors of Finance		
Circulation List			
Description	This best practice guide is for the attention of those NHS employers who have contracted out soft facilities management services who employ staff who are not yet in reciept of terms and conditions no less favourable than Agenda for Change, as per the national agreement.		
Cross Ref	N/A		
Superseded Docs	N/A		
Action Required	Trust are asked to consider the advice given in this best practice guide		
Timing	Please consult the main body of the document for information relating to timing		
Contact Details	Pay and Pension Branch Quarry House Quarry Hill Leeds LS2 7UE 0113 254 5705		
For Recipient's Use			

Contents

1. What is the two-tier agreement?

1. The two-tier workforce agreement is a joint statement about the implementation of Agenda for Change for NHS Contractors staff. It was published in October 2005 and is endorsed by the following parties:
    - The Department of Health
    - NHS Employers
    - The Confederation of British Industry (CBI)
    - Business Services Association (BSA)
    - Unison
    - GMB
    - Transport & General Workers Union (TGWU)
    - Amicus

2. It is intended as a statement of good practice on how the private sector contractors can implement an equitable system of minimum standards on pay and conditions and co-operation on workforce issues in NHS contracts for services described as soft facilities management (Soft FM).

Which staff groups are within the remit of the agreement?

3. The joint statement applies to Soft FM services that have traditionally been provided by NHS organisations but are now provided by contractors staff working solely under a contract with one or more NHS Contracting Authorities to provide services to the NHS on or to NHS sites. It also applies to such contracts that relate to the provision of sterile service, including but not limited to the NHS Decontamination Programme. It does not apply however to staff under contracts to which Retention of Employment applies or whom Independent Sector Treatment Centres employ. Please note that it applies to both staff working in all sectors of the NHS.

4. The definition of what constitutes a “Soft FM” service is a matter for agreement between the NHS Contracting Authority, appropriate staff-side representatives and, if the relevant services contract is in force at the date of the joint statement, the contractor.

5. Services normally regarded as soft FM are:
    - Catering
    - Cleaning and domestic services
    - Porters
    - Linen and laundry services
    - Switchboard and reception services (unless within the scope of hard FM services in the contract specification)

(Services for the maintenance of land, buildings and equipment will normally be regarded as not constituting soft FM services and will therefore be outside the scope of the agreement)

Why Implement?

6. In simple terms, it is good HR practice to treat non-NHS staff working in the organisation, often with close patient contact, in similar ways to the directly employed staff. This will promote a positive attitude and support high standards in services such as cleaning and catering.

7. This agreement is an extension of the Cabinet Office 'Code of Practice on Workforce Matters in Public Sector Service Contracts' that was published in March 2005.

8. Although there are financial costs for NHS organisations in this agreement the national parties believe there are real benefits for the NHS. Some of the visible benefits of implementation of the code include:

    - Staff in these groups make a significant contribution to the quality of the patient experience. Improvements to the skill, quality and morale of this section of the workforce should pay real dividends in the quality of service to patients.

    - Harmonisation of terms and conditions for all staff working within and supporting the NHS

    - The differentials between contractor staff and directly employed staff on AfC terms were causing increasing industrial relations tensions in many trusts with industrial action threatened in a number of areas. Implementation of the agreement should address those problems and end the increasing tensions surrounding the pay and conditions of contracted support staff

    - Co-operation on workforce issues including opportunities for training and career progression and facilitating recruitment into higher skilled jobs

    - Facilitating the modernisation of the services

    - To encourage positive industrial relations and partnership working

    - These staff have traditionally been amongst the lowest paid in the community. There should be social, economic and health benefits to improve pay for these staff.

9. As public bodies, individual NHS contracting authorities are required to make a rational decision about implementation of the code, taking account of any relevant considerations that may or may not prevent them from implementing the agreement.

What does it involve?

10. The agreement is in two parts: an interim agreement lasting from 1 October 2005 to 30 September 2006 and a full agreement from 1 October 2006.

Interim Regime

11. From **1 October 2005** soft FM staff will get a minimum of £5.65 per hour with supervisors receiving a minimum of £5.93 per hour. In addition staff would receive an additional 2 days leave. Contractors will pay the costs of increasing pay from current rates to £5.55 per hour and the cost of the additional leave. NHS organisations will be expected to contribute the remaining 10 pence per hour increase.

12. From **1 April 2006** soft FM staff will get a further increase to a minimum of £5.88 per hour (the current AfC minimum) with supervisors receiving a minimum of £6.17 per hour. In addition those working in the London area will receive a one-off payment of £500 in inner London, £375 in Outer London and £125 in London fringe areas. NHS organisations will be expected to bear the cost of the increase from the original pay rates (before the increase to £5.65) to £5.88 and the cost of the one-off high cost area payments.

Full regime

13. The full regime which should come into effect from **1 October 2006** (but not before) means that soft FM staff should have contracts with:

- Terms and conditions no less favourable overall than AfC (excluding pension provisions)

- Basic pay no less than the equivalent AfC pay band but beyond that there is flexibility for contractors to design their own system provided the overall package is **no less favourable than AfC**

- Use of an agreed evaluation scheme (i.e. the AfC Job Evaluation scheme or equivalent) to ensure **equal pay for work of equal value**

- A career development scheme linked to pay progression (i.e. the NHS Knowledge and Skills Framework or equivalent)

14. It is expected that existing contracts between NHS organisations and contractors should be amended to encompass these terms and any new contract should be on this basis.

15. All NHS contracting authorities, contractors and unions are being encouraged to implement this agreement as it is an important step forward as part of the NHS workforce reforms.

2. Getting started

16. Where initial discussions about the implementation of the agreement have not already taken place, the expectation is that contracting authorities are encouraged to initiate local joint discussions with both the contractor and relevant staff side representation.

17. If any of the parties are experiencing difficulty embracing the terms of the Agreement it is advised that these should be communicated as early as possible thereby ensuring that all parties can work together to reach an understanding that will enable an agreement to be reached within an agreeable timescale.

18. The parties to the national Joint Statement have drawn up a protocol that seeks to address the situation where one or more of the parties are not engaging in discussions, this can be found at Annex 1.

3. Financing Implementation

How did we arrive at the £75 Million figure for the tariff?

19. The cost to the NHS of implementing the full regime have been estimated to be around £75m in 2006/07. Detailed analysis carried out in partnership with the other signatories to the agreement was carried out on information requested from contractors engaged in 75 per cent of the contracts providing soft FM services to the NHS. All estimates were uplifted to 100 per cent and focused on five key areas:

    a) Basic Pay
    b) High Cost Area Payments
    c) NIC & Pension Costs
    d) Annual Leave Costs
    e) Cost of Reduction in Hours

These additional costs were reflected in the changes to the 2006/07 tariff.

Factors to note when negotiating a price

20. It is vital that both the contractor and the NHS contracting authority enter into an open and detailed discussion about the increased costs of the contract. Agreeing arrangements that are “equivalent” to AfC will require detailed negotiation between the parties. Extra costs must only be directly related to the implementation of the agreement and should not include any management or administration fees. In view of the financial pressures faced by NHS organisations, the expectation is that the NHS contracting authorities may seek to mitigate the extra costs involved by discussions with contractors about the scope for improvement in the quality of service provision and other efficiencies during discussions on the contract variation.

21. Any legal requirement in terms of the uplift in the statutory national minimum wage is strictly outside the realms of the two-tier agreement and extra costs of this should not be included in any revision to contract price.

Case Study 1

Tameside and Glossop Acute Services NHS Trust

22. Tameside and Glossop Acute Services NHS Trust tendered its Domestic and Portering Services in December 2004. At that date the Services were predominantly outsourced but the Trust retained a number of directly employed portering staff. Two hundred (200) staff were employed in the private sector and twenty (20) staff were directly employed by the Trust.

23. As the financial implications of AfC (AFC) were not clear at the date of tender, the Trust required all tenderers to price their tender at April 2005 prices, excluding the impact of AFC. Tender documents were drawn up with the full involvement of the Trust's staff and their Union representatives. Staff and Union representatives were also fully involved with the evaluation of the tenders, including visiting demonstration sites where tenderers were already operating, and being part of the team which received presentations from the tenderers on their service proposals.

24. Throughout the tender process, the Trust and tenderers were open with staff about the basis of the tenders and that both parties would address issues raised by AFC post contract award, once the implications of AFC were clear.

25. The Trust awarded the contract to ISS Mediclean Ltd in July 2005 and entered into an AFC agreement with ISS as part of the tender award. The key elements of the AFC agreement were as follows:

    a) If the Department of Health require that all staff working within a hospital operated by an NHS Trust (whether employed by an NHS Trust or otherwise) shall be employed on terms and conditions that comply with AfC, then as soon as practicable, the Contractor and Trust shall meet to discuss the implications of any such decision in order to agree the steps that need to be taken.

    b) The above discussion to include the adjustments that need to be made to place the Contractor in no better or worse position than it would have been had the decision not occurred.

    c) The Contractor shall comply with reasonable requests and requirements of the Trust in negotiating the impact of the decision.

d) The AFC agreement set out the matters that would be taken into account in determining the cost impact of the decision.

26. In July 2005 the 200 staff employed by the previous private sector employer and the 20 staff employed by the Trust were transferred to the employment of ISS. By that date the staff previously employed by the Trust had been assimilated onto AFC terms and conditions but the staff previously employed in the private sector remained on the terms and conditions agreed by the previous employer.

27. When the Department of Health issued the Joint Statement on AfC and NHS Contractor's Staff in October 2005, the Trust served notice to ISS that it wished to implement the provisions of the Joint Statement. ISS confirmed by return its intention to implement the Joint Statement. The AFC agreement signed between the Trust and ISS was used as the framework for negotiating the impact of these changes for the 200 staff who transferred from the previous private sector employer to ISS. A Variation to the Trust's contract with ISS was signed in March 2006 which implemented the agreement with effect from 1st April 2006. The financial implications of the agreement were shared between the Trust and ISS in accordance with the provisions of the Joint statement.

28. The factors that contributed most to the successful implementation of AFC across the ISS workforce were as follows:

- Full engagement by the Trust and ISS of staff and their union representatives at all parts of the process pre- and post-contract.

- An understanding by the Trust and ISS of the benefits of a single tier workforce and a commitment by both parties to meeting the cost of implementation.

- Honesty and transparency with staff about the process and timescale for implementation.

- The drawing up of a clear agreement in advance of letting the contract that governed how issues relating to AFC would be handled post contract.

- Clear financial forecasting by ISS that enabled the Trust to predict the financial consequences as early as possible and to take these into account in financial planning.

Michael Dean (Director of Facilities)

Case Study 2

A Contractors View - The Homerton University Hospital NHS Foundation Trust

29. Part of the bid specification for Homerton NHS Hospitals in 2004 included details of a pay agreement which had been signed on behalf of ISS Mediclean, and UNISON. The pay agreement made a commitment that for all Non NHS employees that by 1st April 2006 the terms and conditions will be harmonised with those of staff performing equivalent duties under NHS terms and conditions prevailing at the time.

30. When Medirest were awarded the hotel services contract from the 1st March 2005, the Trust during the consultation meeting with the employees confirmed their commitment behind implementation of AfC for all employees.

31. A number of meetings were held with the Trust, Unison and Medirest to agree the assimilation process. The job descriptions for Medirest employees were submitted to the Trust who in turn matched them against the national profiles. Over 90% of our employees fell into band 1 categorisation.

32. The documentation that had previously been used by Homerton NHS Hospitals for the implementation of AfC was adapted and simplified for use to implement AFC for Medirest staff. The assimilation pack became a job profile, review form, and a letter explaining what AfC is, and the value of the terms and conditions pre and post assimilation to the individual employee.

33. Every employee was met with on an individual basis to fully explain the process and answer any questions that they may have.

34. All employees were issued with a new contract of employment following the assimilation process.

35. Currently Medirest are working with the Trust to agree a sensible assimilation process of the Knowledge and Skills framework.

36. The process was very seamless and received well by all employees. This was due to two main factors: firstly the commitment and belief by the Trust that all employees working at the hospital should receive comparable terms and conditions of employment and secondly we worked in partnership with the Trust, and local trade union representatives to share best practise and agree a sensible and workable solution for Medirest.

37. This success story had been used to form the basis of Medirest assimilation of the joint statement that is due to be implemented nationally where local funding has been agreed.

Ian Sarson (Compass Group)

Case Study 3

A Trust View - The Homerton University Hospital NHS Foundation Trust

38. Homerton University Hospital NHS Foundation Trust were involved in local pay discussions between ISS Mediclean & Unison in 2004. An agreement was reached that provided a revised rate of pay but also recognised the need to end pay parity issues that existed not only between NHS & contract staff, but also between differing groups of contract staff meaning a majority of staff were earning significantly less for undertaking the same role. Recognising the rights of employees working for contractors to enjoy the same pay and conditions as those directly employed by the Trust has always been high on the Trusts agenda and it was interesting that following our local agreement the Department of Health brokered a national pay deal for contract staff in 2005 that essentially achieved nearly all that we had set out to achieve in 2004.

39. The Trust was due to tender its ancillary services during 2004 and whilst the subject of AfC was known how this would apply to our local pay and conditions agreement was not fully understood. Therefore the Trust included within the tender documentation a copy of the pay agreement agreeing to negotiate with the successful bidder post contract award. Medirest were awarded the contract for catering and cleaning services in December 2004 and a working party commence soon after the contract start date in March 2005. The working party consisted of staff from the Trust, Unison and Medirest who were empowered to ensure all factors relating to the implementation were fully understood so that an agreement could be achieved in time to meet the agree pay parity date of 1st April 2006.

40. Having created and agreed job descriptions for all posts these were assimilated with most falling within pay bands 1 to 3. This enable the working party to start the process of understanding the financial implications of the change and an accounting exercise followed whereby all parties were able to agree the level of pay uplift for employees. The Trust also insisted on a reduction of hours worked by some staff to a maximum of 43 hours per week, meaning this group of staff cut their working week from over 60 hours without the need to reduce take home pay.

41. As part of the process the Trust wanted to ensure that staff were treated as fairly and reasonably as possible and this included agreeing with the group the information to be contained in the assimilation packs that would be sent to each staff member. Medirest were able to provide a template pack similar to those used by the Trust when

assimilating its own staff and these were issued to employees in advance of their assimilation date of 1st April 2006.

42. In continued partnership we are now looking at the best ways to implement the Knowledge and Skills Framework and have so far agreed outlines for all Medirest posts. However, we need to ensure that the impetus of the early working group is not lost and that we continue to strive to resolve the final issues so that staff are able to demonstrate their competence through providing their development plans and meeting their post outline. Medirest and the Trust are still to agree a mechanism for ensuring staff are developing and how this can be used to measure value for money through increased efficiency.

43. Whilst the results have taken a culmination of months it has only been through the cohesiveness of the working party and the belief that this process was the right way forward that has ensured our success. The Trust could not have achieved this without the support of either Medirest or Unison and I would personally like to thank all those involved for their hard work.

Annex 1

Engagement Protocol: NHS Contractor Staff AfC Joint Statement of Good Practice

Purpose

1. This Protocol has been agreed by the organisations that signed the October 2005 Joint Statement on Good Practice on the implementation of minimum standards of pay, conditions and workforce cooperation for private contractor staff employed on Soft Facilities Management contracts in England. The purpose of the Protocol is to emphasise the importance of local joint engagement on the implementation of the AfC agreement. The Protocol has been written against a background where some NHS Contracting Authorities have indicated an inability to implement the terms of the Joint Statement. In situations such as this it is essential that the other local parties (contractor management and trade unions) understand the nature of the problems and that joint solutions are agreed that will lead to the implementation of the Joint Statement within a reasonable timescale. The Protocol recommends the involvement of ACAS to facilitate local engagement where it is not taking place voluntarily or where joint dialogue has broken down.

2. For clarity, this Protocol will not apply in situations where NHS Contracting Authorities have agreed to the implementation of the Joint Statement but disagreements exist between the contractor and the trade unions about the implementation terms. This is already catered for in the Joint Statement by the Alternative Resolution Procedure (ADR). ADR can only be applied in dispute situations once an NHS Contracting Authority has agreed to implement the Joint Statement.

Background

3. At the time that it was agreed all parties to the Joint Statement expected that the relevant NHS Contracting Authorities would initiate the implementation procedures outlined in the Joint Statement and engage with the relevant contractor management and local trade unions to secure agreements effective from the 1 October 2006 deadline.

4. From the evidence that Department of Health has received it is clear that progress on implementing the Joint Statement varies considerably. Some NHS Contracting Authorities have reported successful implementation, some are in discussion about implementation, and others have made no movement to implement

5. This protocol has been produced to support the local engagement process to ensure that constructive discussions are taking place between contracting authorities, contractor management and local trade unions at all relevant NHS Authorities where agreement has not been concluded. All parties to the Joint Statement recognise that there are genuine obstacles to implementation experienced by some authorities, particularly relating to costs. We wish to encourage positive engagement and dialogue to take place in situations such as this so that the nature of the problem(s) can be jointly understood and solutions agreed that lead to implementation of the Joint Statement within a reasonable timescale.

Local engagement and ACAS involvement

6. This Protocol is directed at situations where NHS contracting authorities have indicated an inability to implement the Joint Statement, or where no joint engagement on implementation is taking place. The parties to the Joint Statement believe that in situations such as this, it is essential that NHS contracting authorities initiate local joint discussions to ensure that their reasons for non-implementation are explained and understood and to enable agreements to be reached on a reasonable timescale over which the terms of the Joint Statement can be introduced. This is the principal recommendation of this Protocol.

7. Ideally, the NHS Contracting Authority, contractor and trade unions locally will enter into discussions on the reasons for non-implementation and to agree an implementation plan over a reasonable timescale of their own volition. However, in circumstances where such engagement is not taking place voluntarily, any of the local organisations may wish to seek the assistance of ACAS.

8. The ADR process referred to above already provides for ACAS involvement. However, the parties to the Joint Statement encourage additional involvement from ACAS to help local discussions to begin or to re-open joint dialogue where local engagement has broken down. ACAS provides a range of services, from formal arbitration and conciliation to less formal mediation and facilitation (see Annex 2 for a more detail about the services that ACAS offer). In many situations, the use of ACAS informally as a facilitator may be sufficient to get the local engagement process going.

9. Where any party has concerns about releasing sensitive or confidential information to the other local parties, ACAS will be able to facilitate agreements between the various parties on how the information provided will be shared and used. Concerns about confidentiality or the release of sensitive information should not be used as a reason for non-engagement.

10. Contact details for ACAS can be found at Annex 2.

11. In the spirit of partnership that underpins the AfC agreement, any organisation wishing to seek ACAS involvement should notify the other local parties that it intends to take this action. In addition, local contract management and trade unions should ensure that their relevant national organisations are informed of this to enable them to overview implementation at national level.

Annex 2

How Can ACAS help local organisations to implement the Joint Statement on AfC for NHS Contractors Staff ?

How can ACAS help?

The joint statement signed by the Secretary of State, trade union, employer and contractor representatives provides for dispute resolution which can include appointing an independent person from the ACAS list of arbitrators. ACAS can however become involved at an earlier stage if discussions are proving difficult and are heading towards dispute or indeed if discussions are difficult to arrange and this in itself is the cause of a potential dispute.

Services Available

1. Collective Conciliation

   This is available where the parties are in or close to dispute. It is entirely voluntary so all sides must agree to our involvement. We will discuss the dispute with all parties and agree how we can help. This involves

   - Identifying the issues
   - Finding common ground
   - Holding meetings separately and together to find out how much room there is for negotiation
   - Seeking an agreement which will resolve the dispute

2. Collective Arbitration and Mediation

   This is the role already envisaged in the Joint Statement whereby ACAS appoints an independent person with clear terms of reference who will make recommendations for resolving the dispute. The difference between the two is that in arbitration the parties have agreed in advance that they will accept the recommendations, in a collective mediation they have agreed to seriously consider the recommendations.

3. Facilitation/Joint Problem Solving

   This could take place on a stand alone basis or following a collective conciliation. This would enable the parties too take stock of the situation and identify solutions. It could involve

   - ACAS facilitating or chairing a working group responsible for implementing the agreement

   - ACAS facilitating problem solving meetings to identify how sticking points might be overcome

For more information on how to involve ACAS please contact Gill McCarthy, Area Director, ACAS NW on 0161 833 8503 gmccarthy@acas.org.uk