

Staff Side Evidence to the NHS Pay Review Body 2017-18¹

Summary and recommendations

The value of the Agenda for Change pay framework has diminished significantly over the last six years, with NHS staff suffering real terms wage cuts of an average of 12.3%.

There is great strength of feeling among both staff and managers that the current pay policy is unsustainable and that a change in direction is long overdue, through a pay award higher than the current 1% limit.

The Government has made significant savings by artificially restricting the ability of NHS pay to keep pace with the cost of living. This also represents lost spending power to the UK economy as over a million people cope with reduced disposable income.

Public sector pay restraint has not only clearly damaged both the finances and morale, but risks inflicting structural problem to the Agenda for Change framework. Our evidence explains that unless action is taken now, minimum wage levels will overtake Agenda for Change pay points. This can only be avoided by a significant pay increase and reform of the Agenda for Change framework.

In addition, different approaches taken to NHS pay awards across the four UK countries has resulted in large and growing anomalies between pay points across the UK. We point out that any pay system must be 'felt fair' by the workforce affected. This will not be the case in the NHS as long as the same jobs are not paid at the same the rate across the UK.

Because of these factors, Staff Side is proposing a comprehensive set of proposals which will:

- **realign** pay scales across the UK to harmonise all Agenda for Change pay points, using using Scotland as a reference point for bands 4-9
- **restructure** Bands 1-3 to pay the Living Wage and maintain pay differentials
- **make a pay award** in line with RPI, applied equally to all staff in Agenda for Change
- introduce a **comprehensive workforce strategy** to tackle the many and inter-related challenges facing the NHS workforce, including increasing use of agency staff, stagnating wage levels, declining morale and motivation and increased staff shortages across the UK

Our evidence provides an update of discussions held between trade unions and employers on reviewing and refreshing Agenda for Change. The NHS trade unions firmly believe that a well-maintained, UK wide pay structure is an essential element of the workforce strategy needed to release capacity and improve productivity. We have been keen to pursue reform of the NHS pay scales through these talks, and have committed significant resources to the project over the last year.

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

The NHS trade unions are engaging in this review of Agenda for Change based on a clear condition that this will result in a coherent UK-wide pay structure.

We have worked with employers to prepare a joint NHS Staff Council update on progress to date, which will be submitted to the NHS PRB as a separate piece of evidence.

In summary we ask the Pay Review Body to:

- acknowledge the impact of pay restraint, combined with heightened workplace pressures on recruitment and retention in the NHS
- recommend our proposed approach based firstly on the realignment of the pay framework, which will provide the foundation both for discussions on the review of the Agenda for Change structure and secondly on a return to a fair, annual, pay award based on RPI
- recommend that compliance with the National Living Wage must be centrally funded and not result in a lower award for staff paid above the lowest rates
- acknowledge the uncertainties caused by the loss of student bursaries and plans for the UK to exit the EU and monitor the impact of both developments
- recommend that NHS Improvement regularly publish information on workforce and agency spend to enable better analysis of workforce dynamics
- note the impact of the agency cap in England and its unintended consequences
- recognise the potentially destabilising impact of the apprenticeship levy, the targets and apprenticeships as a growing form of employment within the NHS. In particular, we ask the PRB to recommend:
 - the development of a national framework for determining apprentice pay should form part of the AFC refresh talks
 - all apprenticeships undertaken within the NHS should be on full Agenda for Change terms and conditions
 - apprentices should also be covered by the Living Wage Foundation Living Wage
 - apprenticeship levy money should be pooled and ring-fenced to the NHS so that any unused funding can be offered out around the NHS rather than lost to other sectors.
- endorse and support Staff Side proposals for a comprehensive workforce strategy for the NHS

1. Introduction

1.1 Recent Staff Side submissions have set out the growing, cumulative losses in real terms as a result of pay constraint in the NHS. This year's submission also draws attention to real terms loss of earnings suffered by NHS staff, showing that real terms median earnings have fallen by 12.3% between March 2011 and 2016. In previous years, we called for a significant pay increase without quantifying that increase.

1.2 This year, Staff Side has chosen to make a specific proposal to the NHS PRB which we will be publicising widely to union members and to the NHS. We believe that NHS staff will welcome this clear statement and widely support our proposals.

1.3 In this year's submission we also repeat our call for a comprehensive workforce strategy to tackle the many and inter-connected challenges facing the NHS workforce. We assert that improved pay needs to go hand in hand with attention paid to other parts of NHS employment – particularly the psychological contract – to aid retention.

1.4 Financial and capacity challenges are putting more and more pressure on staff. Faced with long-term growth in workload, exacerbated by staff shortages and higher intensity of work, we are witnessing dangerously declining levels of morale. The NHS fundamentally depends on the psychological contract with their staff – to provide care and compassion, to go the extra mile, to cope with organisational change and financial challenge.

1.5 Having faced a long period of pay restraint, it is inevitable that a large number of staff are now undertaking agency work as a way of restoring the real value of their earnings. Further restraint will only lead to even more damaging impact to the recruitment, retention and motivation of the most valuable asset the NHS has.

2. Staff Side proposals on pay

Introduction

2.1 The value of the Agenda for Change pay framework has diminished significantly over the recent years, with NHS staff suffering real terms wage cuts. There is great strength of feeling among both staff and managers that the current pay policy is unsustainable and that a change in direction is long overdue.

2.2 The Government has made significant savings by artificially restricting the ability of public sector pay to keep pace with the cost of living. The value of the Agenda for Change pay framework has decreased significantly over the last five years. The Charts below shows the top point of each pay band for the Agenda for Change framework in England and Wales, Scotland and Northern Ireland.

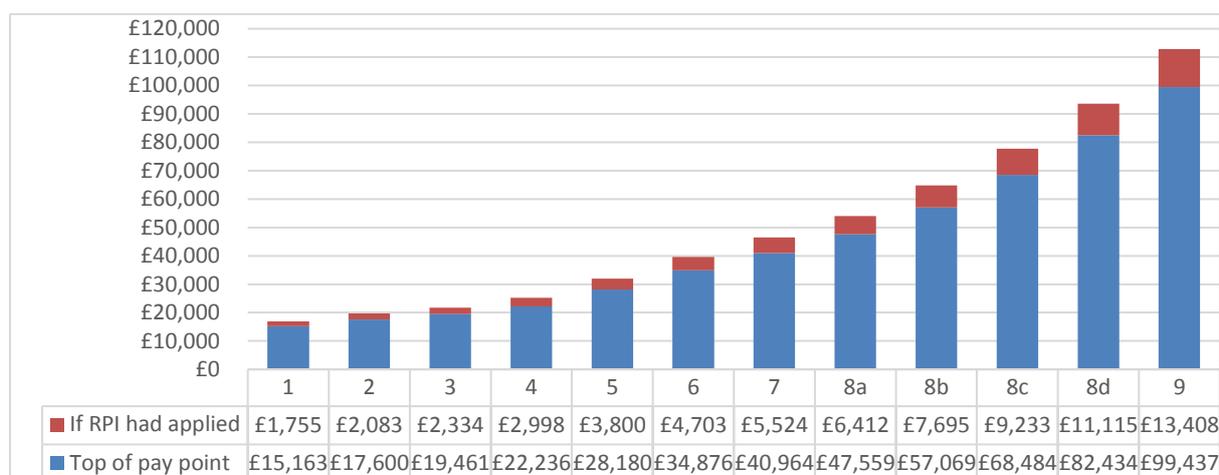
Chart 1: Top point of each pay band in England and Wales, showing difference if RPI had been applied in every year since 2011



Chart 2: Top point of each pay band in Scotland, showing difference if RPI had been applied in every year since 2011



Chart 3: Top point of each pay band in Northern Ireland, showing difference if RPI had been applied in every year since 2011

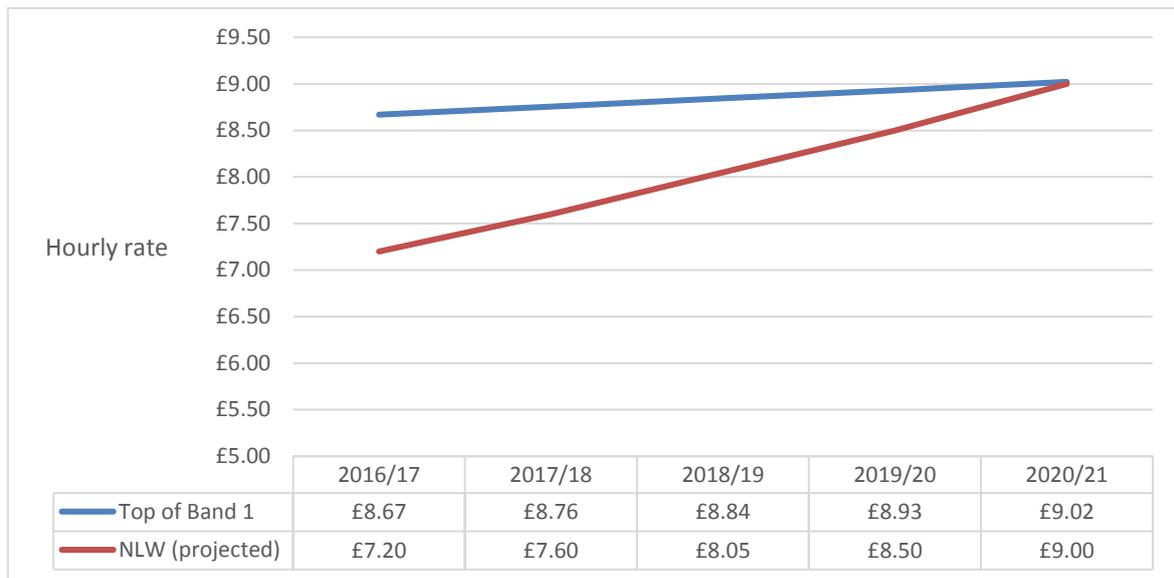


2.3 By combining pay lost per point with the number of full-time equivalent staff in post the scale of cuts becomes apparent. In total, over £4.3 billion has been cut from NHS staff salaries in England alone between 2010 and 2016². This also represents lost purchasing power to the UK economy at a time of slowing economic growth as the disposable income of NHS staff has reduced. This has coincided with mounting recruitment and retention difficulties for key staff groups. Significant steps need to be taken to begin the process of restoring value to the Agenda for Change framework.

2.4 Not only has public sector pay restraint damaged both finances and morale of NHS staff, the point has now been reached at which the pay framework itself has been put at risk. If the value of Agenda for Change pay scales had been increased in line with inflation the lowest bands in the pay framework would have been above the National Living Wage (NLW) until at least 2021.

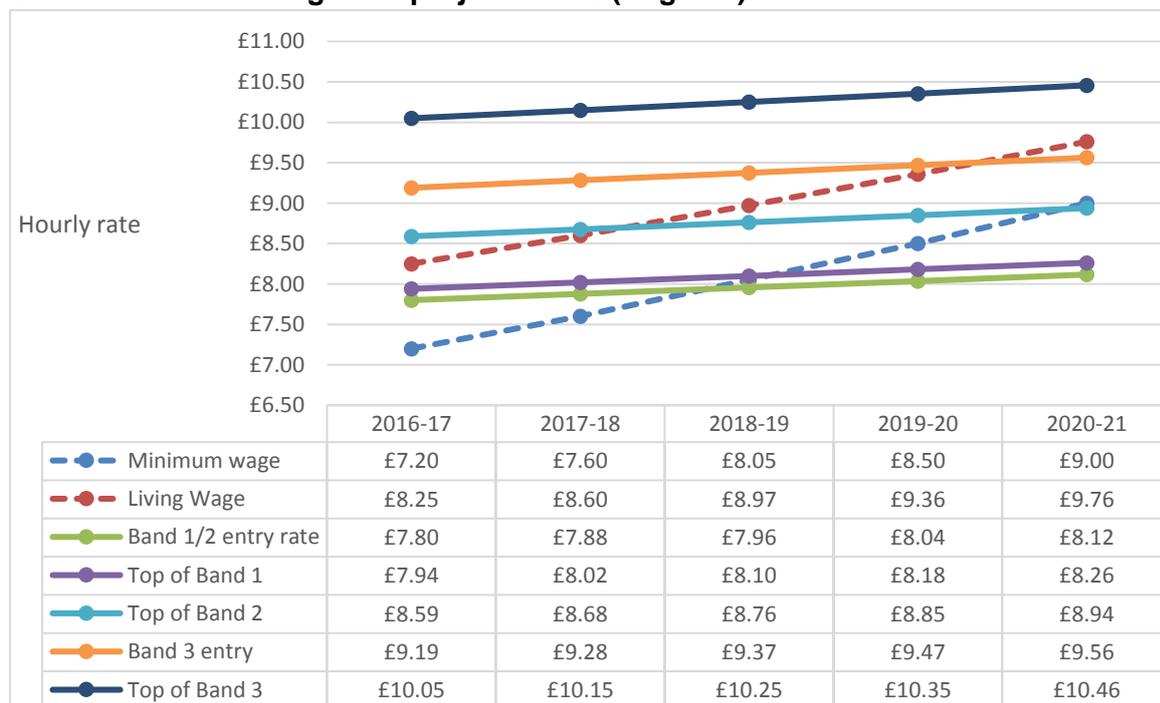
² Difference between RPI and salary rates in each year, multiplied by FTE per point.

Chart 4: Projected National Living Wage hourly rate and AfC Band 1 point 2 hourly rate if uprated in line with inflation since 2011



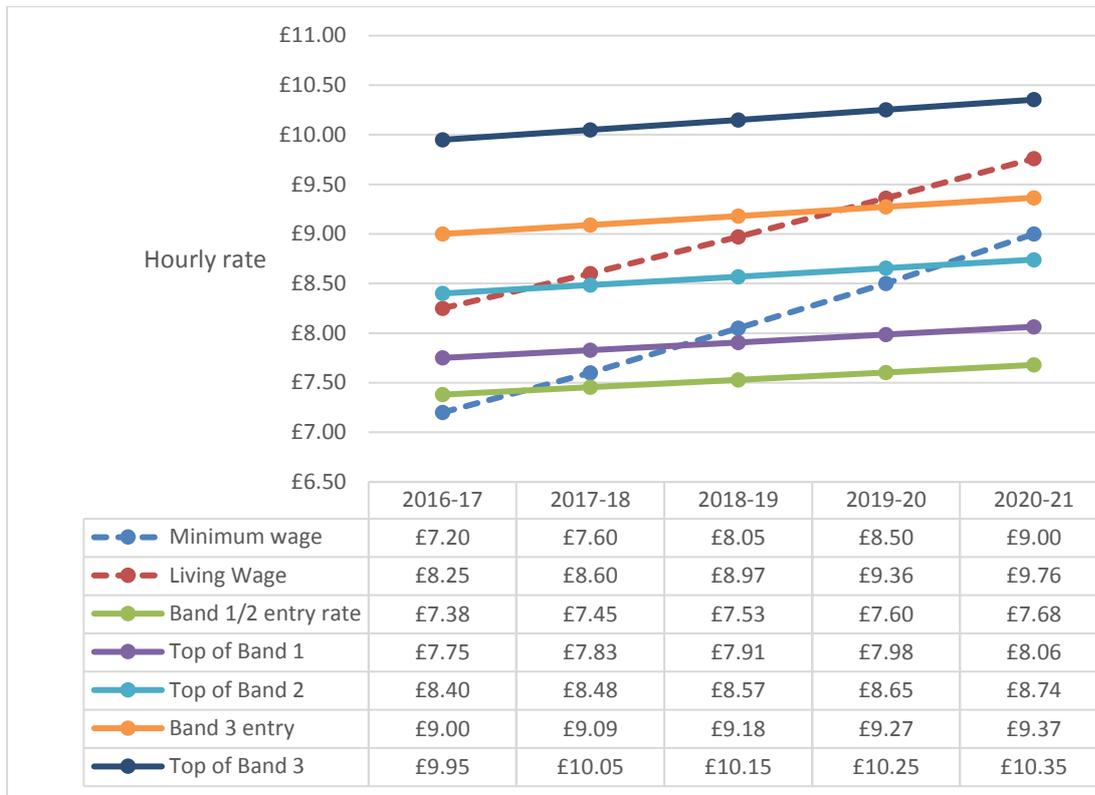
2.5 As things currently stand, minimum wage levels are set to overtake the predicted pay points in Agenda for Change (current points plus current 1% Government public sector pay policy).

Chart 5: Minimum wage and projected AfC (England)



2.6 This is at its most acute in Northern Ireland, as shown in Chart 5, where Agenda for Change rates will be overtaken by the legal minimum in the next pay year, 2017/18. Action must be taken to ensure the pay structure is fit for purpose.

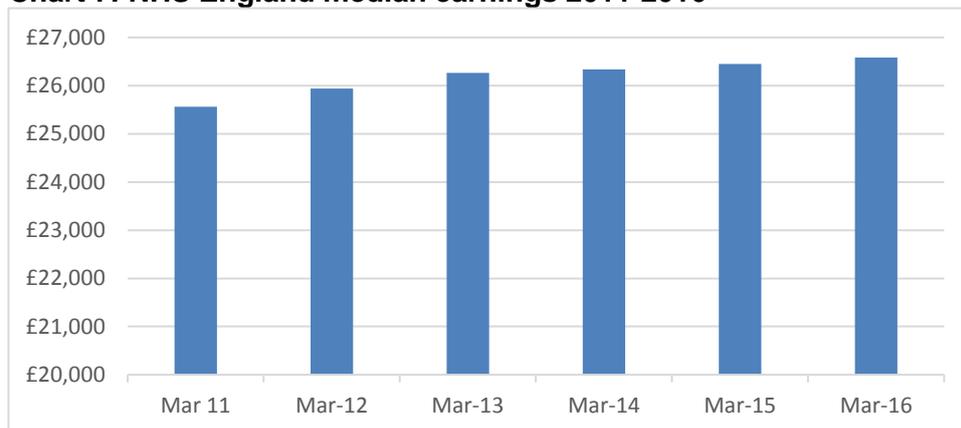
Chart 6: Minimum wage and projected AfC (Northern Ireland)



Earnings in the NHS workforce

2.7 Using data for NHS England for illustrative purposes to examine the impact of pay restraint on NHS staff, Chart 17 shows nominal growth of 7.1% for median earnings between 2011 and 2016, compared to RPI growth of 19.4%.

Chart 7: NHS England median earnings 2011-2016



2.8 In real terms, therefore, median earnings fell by 12.3% between 2011 and 2016

The Staff Side proposals on pay

2.9 Staff Side remains committed to the fundamental principles of Agenda for Change yet the pay points are being eroded due to pay restraint. This situation means there is a worrying risk of structural damage being inflicted to the Agenda for Change framework. Since it will be difficult to address this situation in one year, NHS staff look to the PRB to recommend to a phased approach to restoring value to the pay structure.

2.10 We ask the PRB to recommend a phased approach based firstly on the realignment of the pay framework, which will provide the foundation both for discussions on the review of the Agenda for Change structure and for a return to a fair, annual, pay award. The Staff Side proposals on pay therefore contain two key elements:

- A **realignment** in order to deal with structural issues and ensure the framework is fit for purpose. This entails:
 - a. **returning** to a UK-wide pay scale using Scotland as a reference point for bands 4-9
 - b. **restructuring** Bands 1-3 to pay the Living Wage and maintain pay differential
- A **pay award** in line with RPI, applied equally to all staff in Agenda for Change

Realignment of the Agenda for Change framework

a) Return to UK-wide pay scales

2.11 There are huge benefits to UK-wide terms and conditions and pay structure. Professor Ian Kessler, in his review of national pay determination in the NHS, shows that national pay determination allied to Agenda for Change ensures a 'level playing field' for pay and conditions. The structures guarantee transparency and consistency which are essential to the sustainability of a fair pay system by facilitating mobility within and between organisations and reducing employee uncertainties and risks associated with movement to new locations³. He also concludes that the Agenda for Change framework, underpinned by a comprehensive national job evaluation system guarantees equal pay for work of equal value.

2.12 If no action is taken now, the current differences between pay scales across the four UK countries will not only become entrenched, but intensified as a result of the Government's pay policy. At the moment there is a 2.4% difference between the first pay point of Band 5 in Scotland and that in Northern Ireland. While this may not currently represent a large enough incentive to promote movement across borders, goodwill and motivation will be undermined if the NHS pay system is not 'felt fair' by its workforce as they see that the same job is not being paid at the same the rate across the UK.

2.13 Staff Side have been involved in detailed discussions to review and refresh the Agenda for Change structure. Staff Side are fully committed to agreeing changes to a UK pay structure that make it simpler to explain, understand and operate; with shorter pay bands, fewer points and no overlaps between bands; that make it fair and affordable for now and the future. The NHS trade unions are engaging in the AfC review based on a clear condition that this will result in a coherent UK-wide pay structure. In order to successfully continue with this review, it is therefore vital that we build on structural coherence within the AfC framework with the same pay points across the UK.

2.14 We are therefore calling for a return to UK-wide pay scales within the Agenda for Change pay framework. **The first phase in our approach is therefore levelling the playing field by matching all pay points across the UK to those currently in place in Scotland.**

b) Restructure bands 1-3 to enable a Living Wage Agenda for Change

2.15 Staff Side strongly supports the Living Wage in the NHS (as defined by the Living Wage Foundation). The benefits to employers of Living Wage implementation have been well-documented and include reduced rates of labour turnover and sickness and increased motivation, morale and psychological wellbeing of staff⁴. Last year Staff Side stated its strong belief that Living Wage compliance should be embedded in the pay architecture of AfC. We repeat that belief this year and go further in suggesting how this could practically be maintained.

³ Kessler (2012) *National Pay Determination in the NHS: Resilience and Continuity*
www2.rcn.org.uk/.../National_Pay_Determination_in_the_NHS_Final.pdf

⁴ www.livingwage.org.uk/business-case-living-wage-5

2.16 The Living Wage is calculated to ensure the bare minimum needed for an acceptable standard of living. However, it is difficult to accurately predict the exact level of the Living Wage, as defined by the Living Wage Foundation, from year to year⁵. Seeking to base a pay policy on this would create uncertainty, not only for employees on the lowest pay points but also for employers.

2.17 Instead of pegging the base of Agenda for Change to Living Wage levels, a more stable approach would be to restructure Bands 1-3 so that the pay structure not only delivers the real Living Wage now but continues to do so into the medium term.

2.18 This will help the NHS compete with other prospective employers and avoid structural issues such as the salary sacrifice issues covered in section 3.

2.19 Staff Side has developed proposals for a new structure for Bands 1-3, which would involve resetting all points in these bands as a proportion of the top pay point in band 3. This would result in fewer spine points in Band 1-3. These merged points are represented as salary values within the current spine point system in the salary chart below. Staff Side would be pleased to provide further details of these proposals to the Pay Review Body.

Application of an annual pay award

2.20 The next phase builds on the realignment of Bands 4-9 and restructure of Bands 1-3, with the application of an annual pay award which will go some way to recompensing NHS staff for the real terms wage cut suffered over the last five years and reassert the principle of an annual pay uplift which keeps up with the cost of living. This will provide some level of confidence to NHS staff of a meaningful award for 2017/18.

2.21 Staff Side believes RPI is the most fair way of measuring changes to the cost of living. We believe that RPI (1.9% as of July 2016) should therefore be applied to the entire realigned framework in order to determine salaries for 2017/18.

2.22 Using the principles outlined in 1a-b) and 2) above, the salary framework for Agenda for Change for 2017/18 (UK wide) would be as in the figure below.

⁵ Staff Side predictions of Living Wage Foundation Living Wage growth are based on ONS predictions of median earnings growth, combined with the Living Wage Foundation “stretch” mechanism. We assume a stable basket of goods.

Table 1: Staff Side pay structure proposal for 2017/18 – UK wide

Spine	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9
1	£18,683	£18,849										
2	£18,683	£18,849										
3	£18,683	£18,849										
4		£18,849										
5		£18,849										
6		£18,849	£19,677									
7		£19,263	£19,677									
8		£19,263	£20,092									
9			£20,092									
10			£20,092									
11			£20,713	£20,280*								
12			£20,713	£20,713								
13				£21,399								
14				£22,095								
15				£22,512								
16				£22,640	£22,640							
17				£23,114	£23,114							
18					£24,045							
19					£25,013							
20					£26,036							
21					£27,070	£27,070						
22					£28,160	£28,160						
23					£29,292	£29,292						
24						£30,189						
25						£31,244						
26						£32,298	£32,298					
27						£33,353	£33,353					
28						£34,539	£34,539					
29						£36,253	£36,253					
30							£37,308					
31							£38,495					
32							£39,812					
33							£41,196	£41,196				
34							£42,581	£42,581				
35								£44,295				
36								£46,008				
37								£47,987	£47,987			
38								£49,436	£49,436			
39									£51,940			
40									£54,841			
41									£57,742	£57,742		
42									£59,323	£59,323		
43										£61,959		
44										£64,860		
45										£69,210	£69,210	
46										£71,187	£71,187	
47											£74,154	
48											£77,779	
49											£81,733	£81,733
50											£85,689	£85,689
51												£89,801
52												£94,112
53												£98,630
54												£103,363

*Point 11 (Band 4) would be detached from point 11 (Band 3) if Bands 1-3 were restructured separately from the rest of the pay structure

3. Staff Side Policy Positions

In this section we set out our policy positions on key aspects of pay, terms and conditions that provide context to and inform our pay claim.

Targeting

3.1 In last year's submission to the Pay Review Body, we opposed the proposal to target the pay award. We stated that:

- It would be extremely difficult to construct an evidence base to support differential pay awards for different occupational groups or geographical areas given the current lack of high quality data on vacancies, and on recruitment and retention patterns
- Recruitment and retention difficulties are highly complex and subject to considerable variation at sub-regional and even very local levels. Targeting of pay awards is at best a blunt instrument in this context.
- The scope for differential awards is extremely limited within a 1% envelope because the size of any higher award will be negligible, while the negative impact on morale of a lower award for some staff could be considerable.
- There is a danger of unintended consequences where a pay measure intended to boost recruitment and retention for one group, has a negative effect on recruitment and retention for another group – for example because it drives more staff in that group to compensate for stagnating pay rates by seeking the higher pay rates available through agencies.
- Previous attempts at targeting have caused confusion and bitterness for hard-working and valuable staff affected by removable progression points, non-consolidated awards, pay and increment freezes.

We repeat these objections and continue to reject the proposal to target the pay award.

3.2 Staff Side would also object to a pay award that achieved compliance with the National Living Wage for staff in lower pay bands at the expense of those in higher pay bands. The National Living Wage (NLW) is a social policy and a government priority which must be fully funded by the UK Governments.

3.3 Staff Side calls on the PRB to recommend that any restructuring needed to achieve compliance with the living wage must be centrally funded separately and in addition to the Government's stated position of 1% annual pay awards. It must also be factored in to the government's budgeting for the English NHS in order that the uplift applies to devolved governments via the Barnett formula.

Salary Sacrifice

3.4 It is a breach of minimum wage law for a salary sacrifice scheme to reduce an employee's salary below the minimum wage rate.

3.5 It is possible for employees to access childcare vouchers and essential items such as cycling safety equipment through salary sacrifice. If an employee does so, however, this could bring their basic pay below minimum wage levels.

3.6 Staff Side strongly encourages the PRB to make recommendations that ensure the lowest paid points in Agenda for Change are set high enough above minimum wage levels to ensure equitable access to salary sacrifice benefits.

High Cost Area Supplements

3.7 The HCAS section of the Agenda for Change agreement exists to recognise higher costs faced by NHS staff living and working within defined areas. It is clear that in HCAS areas, as in the rest of the United Kingdom, the value of Agenda for Change has not kept pace with the cost of living. However, HCAS cannot in itself be a replacement for fair, annual, pay awards to maintain value of the entire framework and protect NHS staff from cost of living increases. If Agenda for Change as a whole is increased, and HCAS thresholds adjusted accordingly, then the value of HCAS will also increase.

3.8 In previous years the PRB has uplifted HCAS thresholds in line with the overall pay award. Staff Side would support the continuation of that approach.

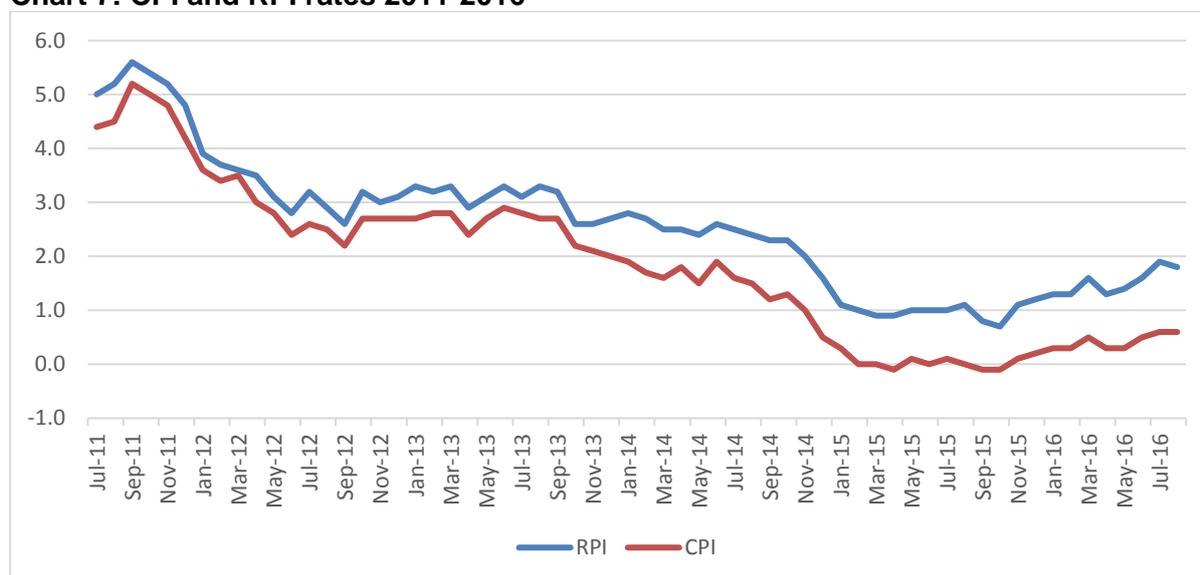
4. Economic context – pay and prices

4.1 This section sets out the economic context to the impact of the Treasury cap on pay for NHS staff⁶. Earnings have lagged behind the cost of living for several years and will continue to fall behind inflation if the Pay Review Body abides by the cap set for this year's award. At the same time, the labour market is tightening, NHS salaries are falling behind other professions while NHS bodies have admitted significant challenges in recruitment and retention.

Inflation

4.2 RPI inflation - which Staff Side uses as the most appropriate measure in pay determination dropped from 5% in 2011, to around 3% between 2012 and 2014. On both the RPI and CPI measure, inflation then decelerated and since 2015 rates have stabilised with CPI around zero and RPI around 1%. However, over recent months inflation has edged up again and the latest inflation figures to July 2016 put RPI at 1.9% and CPI at 0.6%.

Chart 7: CPI and RPI rates 2011-2016



Source: Office for National Statistics

4.3 Between the start of 2011 and the close of 2015 the cost of living, as measured by the Retail Prices Index, rose by a total of 19.4%.

4.4 Staff Side believes that RPI remains the most accurate measure of inflation faced by employees. It is widely acknowledged that CPI consistently understates the real level of inflation as it fails to adequately measure one of the main costs facing most households in the UK – housing. Almost two-thirds of housing in the UK is owner occupied, yet CPI almost entirely excludes the housing costs of people with a mortgage.

4.5 CPI does not fully match the experiences of the working population as it covers non-working groups excluded by RPI – most notably pensioner households where 75% of income

⁶ Economic analysis was carried out in August-early September 2016. Figures could be overtaken by updated information from ONS and HM Treasury.

is derived from state pensions and benefits, the top 4% of households by income and tourists.

Main factors affecting inflation

4.6 The changes in the price of components of the Retail Prices Index over the year to July 2016 are shown in Table 2.

Table 2: RPI average increase 12 months to July 2016

Item	%
Personal expenditure	3.3
Consumer durables	2.7
Housing and household expenditure	2.4
Mortgage interest payments & council tax	1.9
Travel and leisure	1.8
Food and catering	-0.9
All goods	-0.1
All services	2.7
All items	1.9

Source: Office for National Statistics, Consumer Price Inflation Reference Tables, July 2016

4.7 The slowdown in the overall inflation rate over recent years has been driven by declines in energy prices after years of strong growth, along with falls in food prices. However, the biggest cause has been the major fall in oil prices. Nonetheless, some costs are rising significantly, such as a 5.5% rise in clothing and footwear and a 3.4% rise in housing costs.

4.8 The price of housing remains one of the biggest issues facing NHS employees and their families. Across the UK, house prices rose by 8.1% in the year to May 2016, taking the average house price to £211,230⁷. However, the picture varied across the nations of the UK, with England experiencing the biggest increase at 8.9%, while Northern Ireland, Scotland and Wales experienced increases of 5.9%, 4% and 3.6% respectively. Latest estimates of the ratio between average house prices and average earnings stands at 11.8 in England (14 in London), 8.7 in Wales, 8.4 in Scotland and 7.1 in Northern Ireland demonstrating the growing unaffordability of housing to many workers including those in the NHS.⁸

4.9 Annual rents rose by 1.8% over the 12 months to May 2016⁹. In recent months, the growth rate has slowed, mostly due to an increase in supply in response to landlords completing purchases of buy-to-let properties before the introduction of the stamp duty surcharge. However, as there is an overall shortage of properties, the long-term prospect is for an increase in rents.

⁷ Office for National Statistics, House Price Index March 2016, published May 2016

⁸ Office for National Statistics, Trends in the UK Housing Market, 2014

⁹ LSL Property Services. Buy to Let Index, May 2016

4.10 Although they are not specifically assessed by inflation figures, childcare costs represent a key area of expenditure for many NHS staff. According to analysis of Labour Force Survey data, 7% of NHS staff have dependent children under the age of two while a further 12% have dependent children between the ages of two and four. It is therefore worth noting that the annual Family and Childcare Trust survey for 2016 found that the cost of a part-time nursery place for a child under two has been growing by an average annual rate of 5.3% since 2010 and it now costs £6,072 per year to place a child in nursery care for 25 hours a week¹⁰. Mean annual earnings for NHS AfC staff in England were estimated to be £26,581 as at March 2016. This means that childcare costs can represent around a quarter (23%) of average annual earnings.

4.11 Current inflation rates mask longer term changes in the cost of living that have taken place since 2010 (19.4% between 2010 and 2015). For instance, while food prices have risen by 14% over this period, there have been major rises in certain foodstuffs.

Table 3: RPI 2010-2015 across main components

Item	% Change 2010 - 2015	Item	% Change 2010 - 2015	Item	% Change 2010 - 2015
Butter	36.8	Gas	23.3	Rail fares	29.5
Fish	23.4	Electricity	23.0	Bus and coach fares	24.2
Beef	23.1	Mortgage interest and council tax payments	20.4		
Fruit	22.9				
				All items	19.4

Source: Office for National Statistics

Impact on NHS staff

4.12 With such a range of cost of living increases, on top of an increase to National Insurance payments that cancelled out the 2016/17 pay award for many staff, many NHS employees report feeling worse off than they did 12 months. This is borne out in findings from union surveys:

- **UNISON:** nearly two-thirds of respondents reported they felt worse off than they did 12 months ago.
- **Unite:** 79% reported they felt worse off than 12 months previously

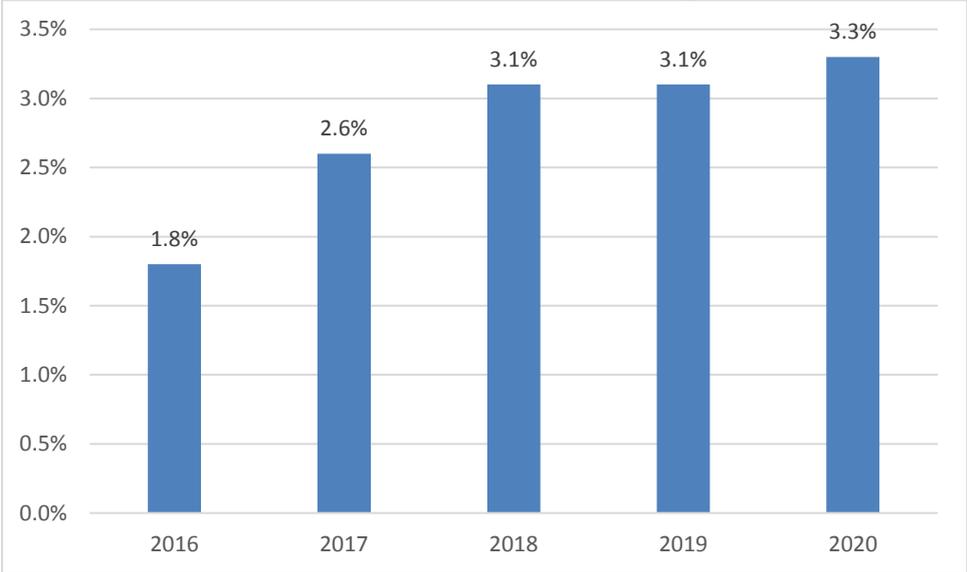
4.13 For staff at the top of band 8a, the 2016/17 pay award took their basic pay into the next NHS Pension employee contribution tier, meaning that the employee contribution for those employees has now increased from 9.3% to 12.5%. This increase means that the employees in this band have seen an overall reduction in their taxable pay.

¹⁰ Family & Childcare Trust, Childcare Costs Survey 2016

Forecast inflation rates

4.14 The Treasury average of independent forecasts predicts that RPI inflation will rise by 1.8% in 2016, climb to 2.6% in 2017 and then accelerate to 3% or over every year between 2018 and 2020, following the pattern shown in Chart 8. This will mean that the cost of living faced by NHS workers will have grown by almost 15% by the close of 2020.

Chart 8: Forecast annual increase in cost of living



Source: HM Treasury Forecasts for the UK Economy, May 2016

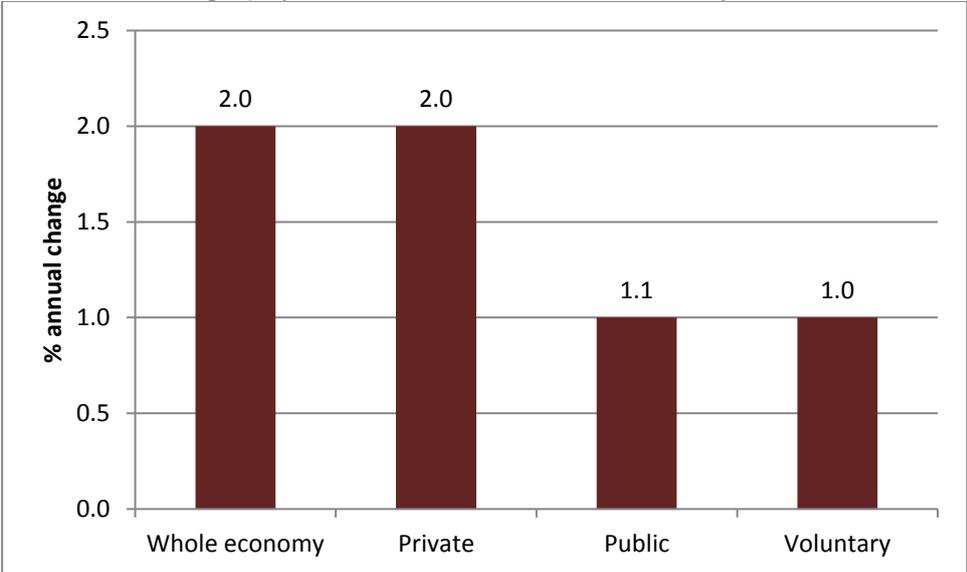
Average earnings and pay settlements

4.15 This outline of pay settlements and average earnings provides a picture of trends across the economy and comparisons between the public and private sectors. It goes on to look at the specific trends for major occupations, differing rates across the countries of the UK / English regions, and draws comparisons for the low and high-paid. Finally, it provides a round-up of average pay settlements by sector¹¹.

Pay settlement trends across economy

4.16 According to latest figures from the Labour Research Department, pay settlements across the economy stand at 2%, the same in the private sector and just 1% in the public and voluntary sectors.

Chart 9: Average pay settlements, 12 months to July 2016



Source: Labour Research Department, settlements over year to July 2016

4.17 According to research by the CIPD published in their *Summer Outlook*, the planned median basic pay increase over the 12 months to June 2017 is 1.1%¹². This is down from the 1.7% reported in spring 2016, showing increased uncertainty among employers mostly as a result of Brexit and the impact of the National Living Wage. However, CIPD do not think it should be concluded that there is an underlying weakening in pay expectation and expect that settlements will centre around 2%.

¹¹ Economic analysis was carried out in August-early September 2016. Figures could be overtaken by updated information from ONS and HM Treasury.

¹² CIPD Labour Market Outlook, Summer 2016
www.cipd.co.uk/binaries/labour-market-outlook_2016-summer-2016.pdf

Graduate salary comparisons

4.18 The Association of Graduate Recruiters Survey 2015 shows that the average graduate starting salary was £28,000. After three years of employment the median graduate salary was £35,000¹³.

4.19 More detailed breakdown of graduate earnings can be found in the report from High Fliers, Graduate Market Report 2016.¹⁴ That analysis shows the median graduate starting salary in 2016 was £30,000.

4.20 Although some professions, notably banking, finance and law, pay much higher than the NHS, it is notable that graduate starting salaries in IT, consumer goods, professional services and the armed forces all had median averages between £29,000 and £30,300. Almost half (45%) of all reported graduate starting salaries were between £25,001 and £30,000.

4.21 Most degree-entry roles in the NHS are graded at Band 5 where salaries are much lower than comparators elsewhere in the economy and continued pay restraint will only make this worse.

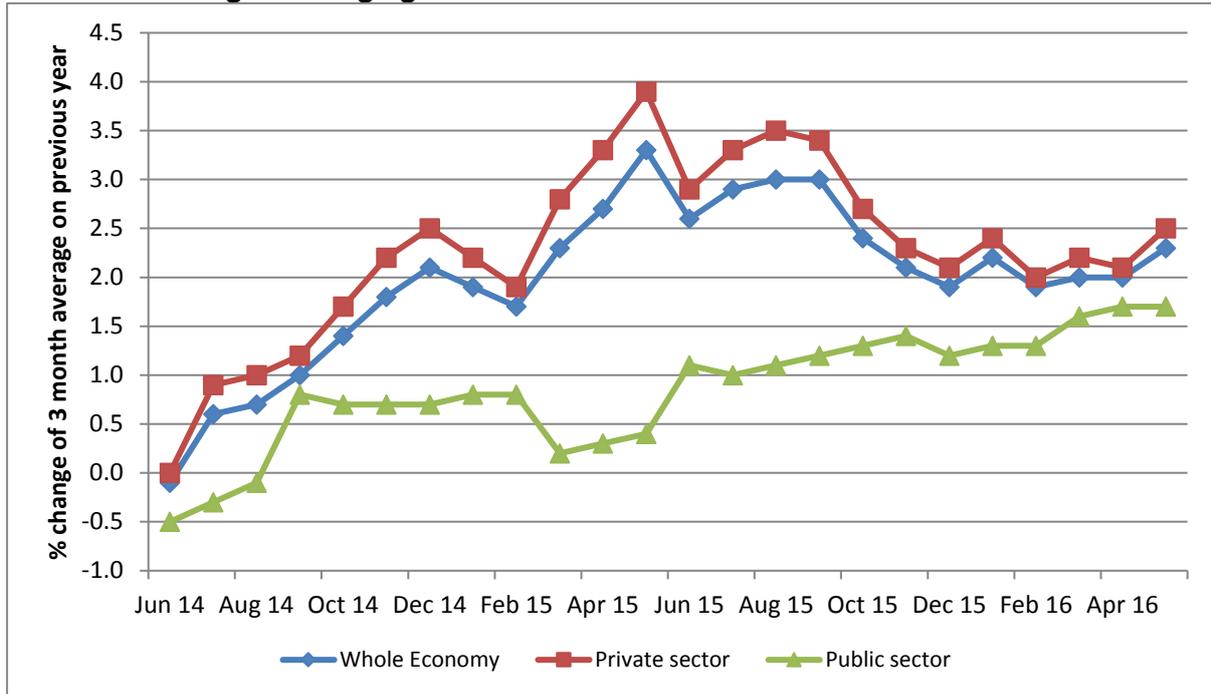
Average earnings trends across economy

4.22 The graph below shows trends in average weekly earnings growth over the last two years. Since the start of 2014, earnings growth has fared much better in the private sector than the public sector and while the gap has narrowed in recent months, the cumulative difference is stark. Across the economy, growth stood at 2.3% and 2.4% in the private sector, while average public sector weekly earnings rose by 1.7% in May 2016.

¹³ www.agr.org.uk/Press-Releases/agr-annual-survey-gender-diversity-a-challenge-in-a-growing-graduate-market#.V-UEjuYbcs

¹⁴ www.highfliers.co.uk/download/2016/graduate_market/GMReport16.pdf

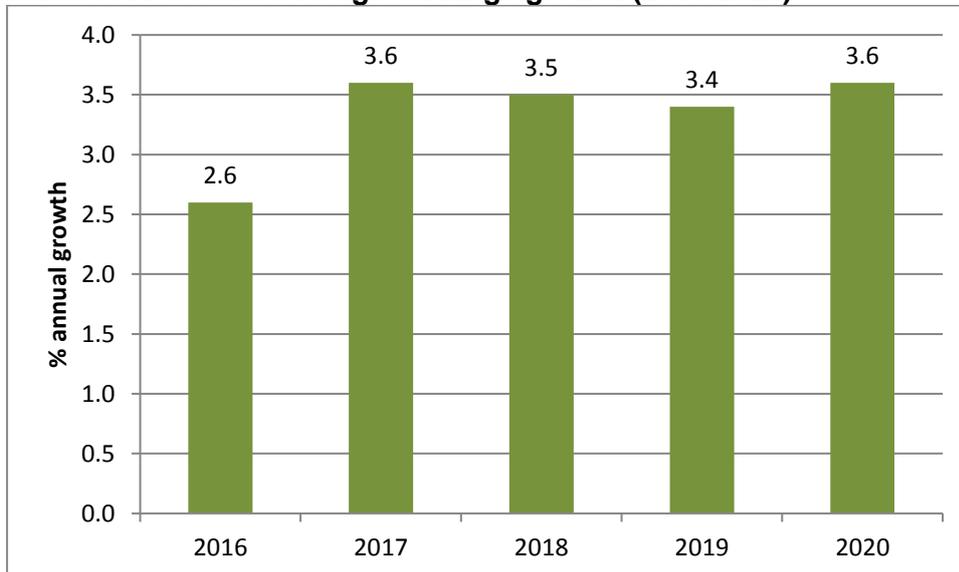
Chart 10: Average earnings growth 2014-2016



Source: Office for National Statistics, Labour Market Statistics, July 2016

4.23 Office for Budget Responsibility forecasts of average earnings anticipate that growth will stand at 2.6% during 2016 and jump to 3.6% by 2017, where it is set to broadly remain until 2020 following the pattern shown in Chart 11¹⁵.

Chart 11: Forecast average earnings growth (2016-2020)



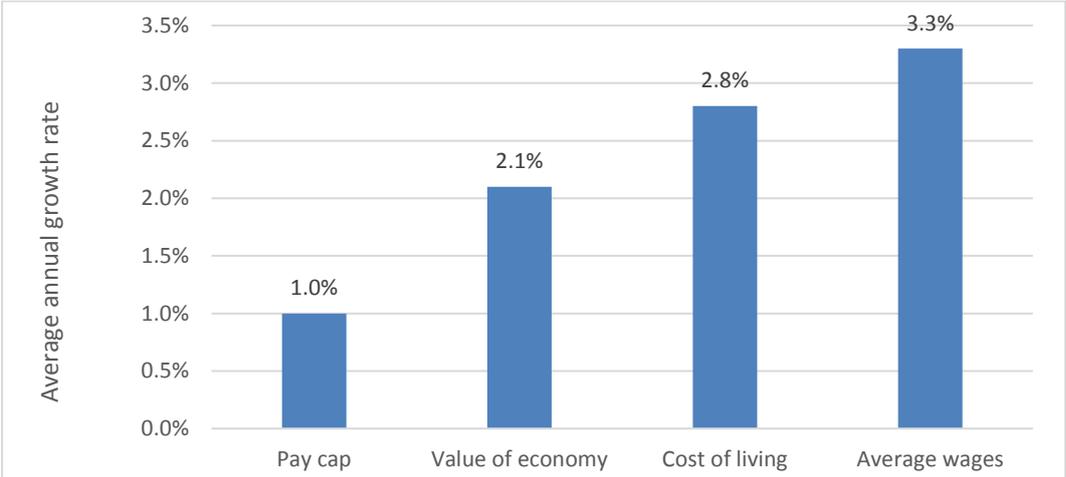
Source: Office for Budgetary Responsibility

¹⁵ Office for Budgetary Responsibility, Economic and Fiscal Outlook, March 2016

Overall outlook

4.24 Examining the outlook over the next four years - the lifetime of the current pay cap – GDP is predicted to grow by 2.1% per year¹⁶, the cost of living (RPI) is due to grow at 2.8% a year¹⁷ and average earnings growth is expected to be 3.3% per year over this period¹⁸. Meanwhile, the pay sector pay policy limits any annual pay uplift to 1% meaning NHS pay will continue to fall behind the cost of living and economic growth.

Chart 12: Average annual GDP, inflation and earnings forecasts (2016-2020)



¹⁶ Office for Budgetary Responsibility (2016), *Economic and Fiscal Outlook*, March 2016

¹⁷ HM Treasury (2016), *Forecasts for the UK Economy*, May 2016

¹⁸ Office for Budgetary Responsibility (2016), *Economic and Fiscal Outlook*, March 2016

5. Vacancies, recruitment and retention

England vacancy data

5.1 NHS Digital has begun to publish experimental publication of NHS vacancy statistics created from vacancy adverts obtained from NHS Jobs, the main recruitment website for the NHS. This is in the absence of full vacancy data.

5.2 Over the period August 2015 - October 2015, NHS Digital reported 82,323 total advertised vacancies and of these, 57% are non-medical roles and 8% are medical and dental roles. One third (34%) have no occupational codes applied, making firm conclusions difficult to draw from the data. However, looking just at the 47,311 non-medical roles advertised, 39% are for qualified nursing and midwifery roles, 23% in infrastructure support roles, 21% in support to clinical roles and 16% in qualified scientific, therapeutic and technical roles.

Scotland vacancy data

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

Table 4: Vacancy rates: full-time equivalents, Scotland

	Allied Health Professionals %	Nursing and Midwifery %
March 2011	2.1	1.0
March 2012	2.8	1.8
March 2013	4.2	2.7
March 2014	3.9	2.7
March 2015	3.5	3.3
March 2016	3.7	3.6

5.4 Vacancy levels in Scotland remain high, with the vacancy rate as a percentage of establishment for allied health professional posts standing at 3.7% with those vacant for three months or more running at 1% in March 2016. The highest overall vacancy rates were found in physiotherapy (5.3%), orthotics (5.3%) and occupational therapy (4.7%).

5.5 The vacancy rate for nursing and midwifery posts in March 2016 stood at 3.6% overall with those vacant for three months or more running at 0.7%. The highest level of vacancies are reported in health visiting with a vacancy rate of 8.6%, compared to 7.1% in 2015.

5.6 The use of bank nursing and midwifery staff in terms of whole-time equivalents has increased by 40% between 2010/11 and 2015/16, while the FTE use of agency staff has trebled

5.7 Total hours of bank and agency staffing combined for nursing and midwifery in Scotland have increased by 45% since 2010/11 as Table 5 illustrates.

Table 5: Use of bank and agency nursing and midwifery staff, NHS Scotland

Year	Bank (Average FTE)	Agency (Average FTE)	Total hours used
2010/11	3,065	91	6,152,769
2011/12	3,159	81	6,316,730
2012/13	3,574	92	7,147,905
2013/14	3,933	124	7,912,130
2014/15	4,256	191	8,671,596
2015/16	4,287	277	8,900,060

5.8 During 2015/16, 10.2% of all nursing and midwifery staffing in Scotland was accounted for by vacant posts or fulfilled by bank and agency staffing, comprising 6.5% bank staffing, 3.3% vacant posts and 0.4% agency posts.

Northern Ireland

5.9 Vacancy data compiled by the Department of Health, Social Services and Public Safety for March 2015 shows an overall vacancy rate across the health and social care workforce of 3.6% (up from 2.3% in March 2014) and a long-term (three months+) vacancy rate of 1.5%.

5.10 The highest rate was found in the ambulance occupational family, standing at 10.9%. For professional and technical staff the overall vacancy rate was 5% and the long-term rate was 1.5%. For nursing and midwifery it was 3.8% overall with a long-term rate of 1.5% and for estates services it was 3% overall and 0.8% long-term.

Other evidence on vacancies

5.11 The 2015 NHS Survey for England found a third of all respondents (31%) said they were unable to manage conflicting demands on their time (29% in 2014), while 48% stated that staffing issues were impinging on their ability to their job (46%) in 2014.

5.12 The 2015 NHS Survey for Scotland showed similar findings, with 33% stating they were unable to manage conflicting demands (32% in 2014) and 45% stated they were not enough staff in the workplace for them to do their job properly (unchanged since 2014).

5.13 The Northern Ireland Survey showed that 36% of all respondents stated they were unable to manage conflicting demands (43% in 2012) and 49% stated they were not enough staff in the workplace for them to do their job properly (46% in 2012).

Impact on recruitment and retention from NHS bursary changes

5.14 The future impact of changes to NHS bursaries in England on recruitment and retention is unknown. An open letter sent to the Prime Minister, and signed by a coalition of major health organisations including the BMA, SCP, SOR, RCN, RCM, UNISON and Unite, warns that the changes are an 'untested gamble with the future of the workforce that have not been properly risk assessed.' It goes on to state:

The plans to switch to a system of loans threatens to reduce the supply of future nurses, midwives and AHPs at a time when patient demand is rising. While loans and tuition fees exist within other parts of higher education, it is important to recognise that those changes occurred after more than a decade of phased introduction. The impact will be worse in health because there are no transition arrangements. There is no safety net for the NHS, these proposals will have a detrimental effect on the current and future NHS workforce, and also on the quality of patient care and safety provided in England.

5.15 UNISON and the National Union of Students commissioned an impact assessment which predicted that the changes would cost the NHS more in the long run, rather than save money¹⁹. The report estimates annual losses of around 2,000 graduates resulting from a 71% increase in student costs, meaning the NHS would be likely to become even more reliant on agency and overseas recruitment to make up the shortfall.

Impact on recruitment and retention of the EU referendum

5.16 The UK's vote to leave the EU could have major implications for the NHS in the future. Freedom of movement and mutual recognition of professional qualifications within the EU means that many health professionals currently working in the UK have come from other EU countries. The introduction of new restrictions may directly prevent EU-born NHS staff from working in the UK, or have an indirect impact as EU-born staff may choose to leave the UK due to uncertainty created before new rules are put in place on migration restriction.

5.17 It is possible that this may lead to specific occupations being placed on the Migration Advisory Committee's shortage occupation list, which currently enables employers to recruit nurses and midwives from outside the European Economic Area in order to deal with staffing shortages.

Recommendations

5.18 We urge the Pay Review Body to

- monitor the impact of both the loss of student bursaries and plans for the UK to exit the EU
- acknowledge the impact of pay restraint, combined with heightened workplace pressures on recruitment and retention in the NHS.

¹⁹ London Economics (2016) *The Impact of the 2015 Comprehensive Spending Review on Higher Education Fees and Funding Arrangements in Subjects Allied to Medicine*
<http://londoneconomics.co.uk/blog/publication/the-impact-of-the-2015-comprehensive-spending-review-on-higher-education-fees-and-funding-arrangements-in-subjects-allied-to-medicine-may-2016/>

6. Overtime, bank and agency spend

6.1 Reducing agency spending in the NHS is increasingly becoming a pivotal issue. The 2014/15 pay dispute in the NHS involved discussions of the growing agency spend and how this money could be better used to reward permanent members of staff. The cost of agency staffing in the NHS has substantially increased in the last few years with 2014/15 seeing NHS providers in England alone spend £3.3 billion on agency staffing²⁰.

6.2 During 2015 the Royal College of Midwives (RCM) and the Royal College of Nursing (RCN) both published reports about the growing amount of money spent on agency staff in midwifery²¹ and nursing²². Both reports looked at the agency spending from 2012-2014 and found that the spending on agency staff has increased substantially over during that time. Crucially, both reports found that the data for many organisations is consistently high which indicates that some organisations are reliant on agency staff to form part of their established workforce and are not using agency just to cover temporary gaps in the rota. This shows that NHS organisations need to do far more to recruit permanent staff.

6.3 In November 2015 following instructions from the Department of Health, Monitor introduced a mandatory cap on the hourly rates paid for agency staff and an annual ceiling for agency spending for each trust. The cap was introduced over time, with nursing and midwifery staff affected first and other professions added later and the rate of the hourly cap was reduced over time.

6.4 The initial findings show that so far the cap has not been very successful. Significantly, Monitor allows organisations to break the cap on 'exceptional safety grounds'. In March 2016 the Nursing Times²³ found that 85% of acute trusts exceeded the cap in the first three months with over 60,000 breaches of the cap in total. They found that more than 20 trusts had gone over the cap for more than 100 shifts a week.

6.5 Worryingly, these breaches were before Monitor reduced the cap further which may mean that there have been even more breaches in recent months.

6.6 NHS Professionals' report on the impact of the cap on the temporary staffing market found that while some trusts had eliminated agency usage completely, others had more than doubled their agency spend. Moreover, providers not covered by the regulator rules continue to significantly increase their agency spend.

Understanding patterns of agency spend

6.7 Staff Side conducted further analysis on the impact of agency rules. It should be noted that many of these changes only came in in April or July 2016. Since data lag is typical (and understandable) in the NHS, it is not yet clear whether enough information is available to make a solid judgement as to what effect this has had on the workforce. To this end, Staff Side looked at individual instances of agency spending cap being breached, as well as the number of trusts breaching the cap in a given week.

²⁰ www.gov.uk/government/news/clampdown-on-nhs-staffing-agency-costs

²¹ www.rcm.org.uk/news-views-and-analysis/news/the-cost-of-agency-staff

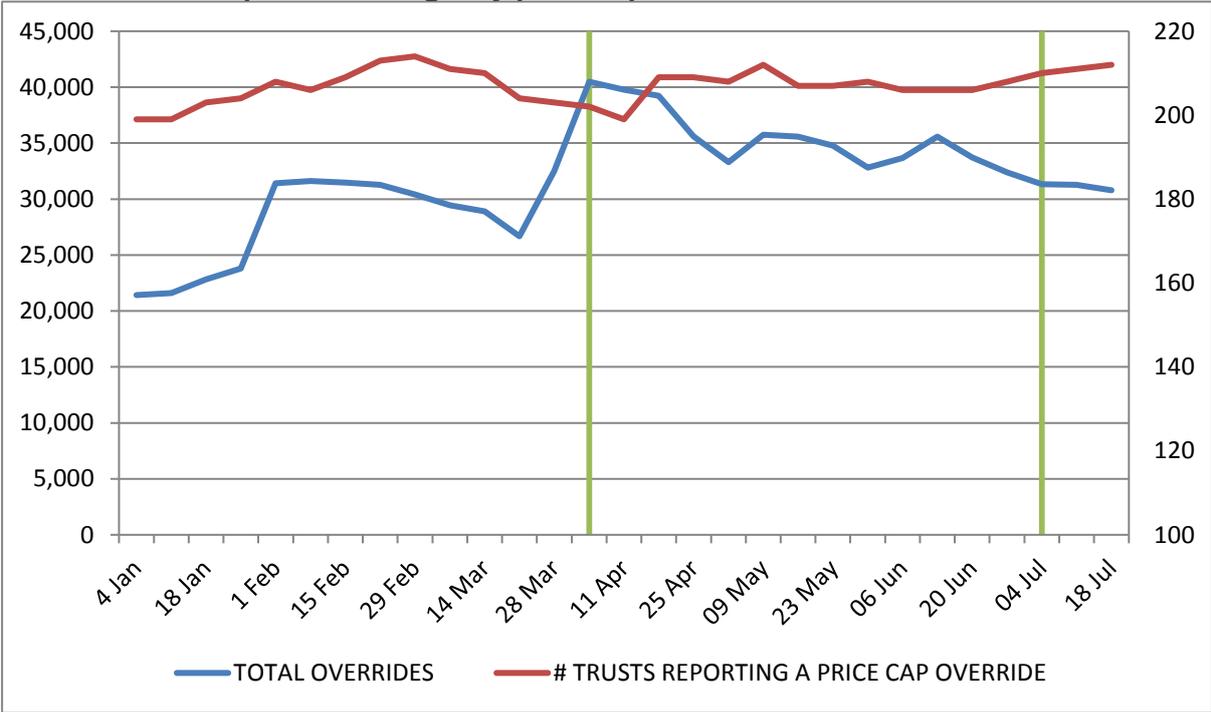
²² www2.rcn.org.uk/_data/assets/pdf_file/0005/608684/FF-report-Agency-spending_final_2.pdf

²³ www.nursingtimes.net/news/workforce/exclusive-trusts-breach-agency-cap-on-60000-occasions/7003024.article?blocktitle=Most-popular&contentID=-1

6.8 We first looked at the number of price cap overrides, both individual instances and numbers of Trusts. With the data we have, both figures are higher than the start of the year²⁴. In general, it appears that whilst some trusts have made progress in meeting agency rules, in the trusts which are not the problem is getting worse.

6.9 In Chart 13 the red line (right-hand axis) measures overall Trust breaches of price cap. The blue line (left-hand axis) measures individual instances of the cap being breached. The green line indicates the point in time at which the rules on mandatory use of approved frameworks and price caps (1 April 2016) and rules on maximum wage rates (1 July) were introduced.

Chart 13: NHS Improvement Agency price cap overrides 2016

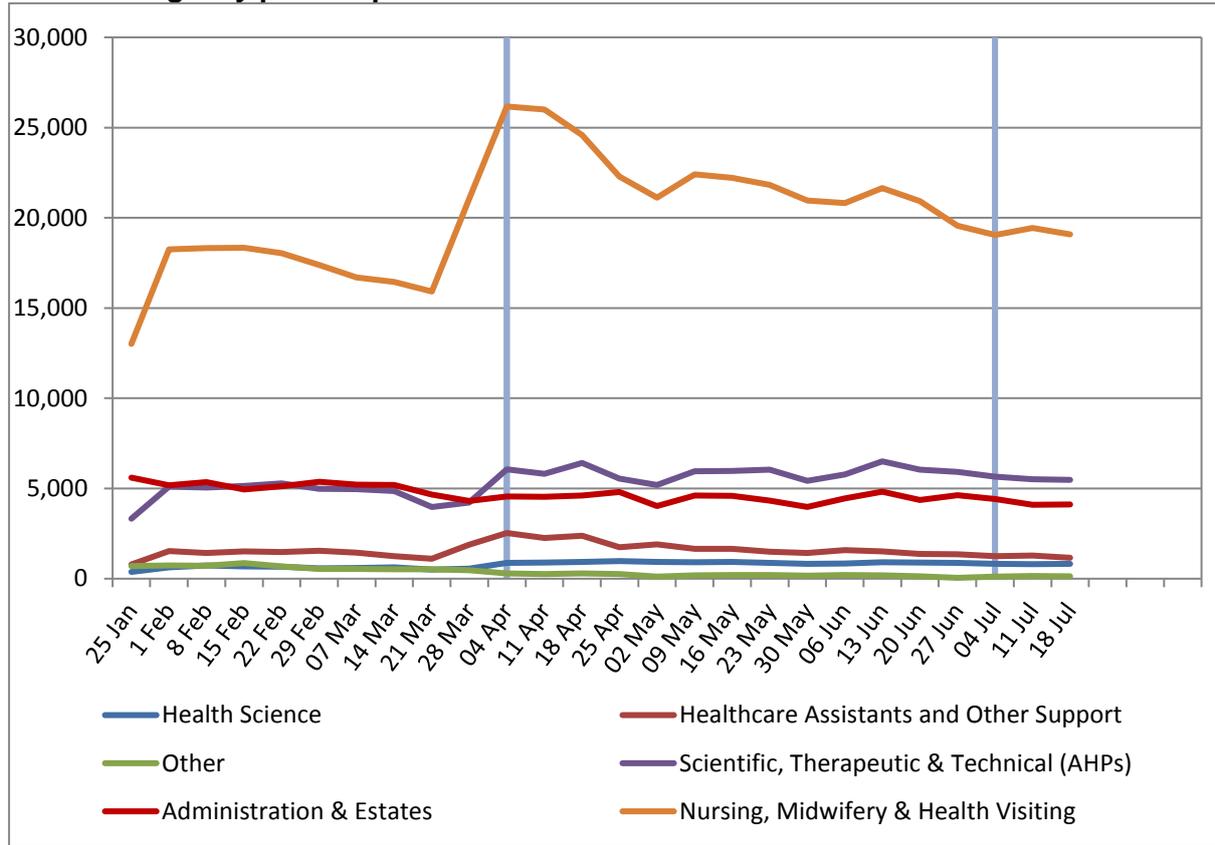


6.10 It is worth noting that the reduction in the number of trusts reporting a cap override (29 Feb-25 April) took place against a massive rise in the number of individual shifts filled by breaking the price cap (14 March-1 April). It may be the case that a relatively small number of employers fixing their staffing issues within Agency regulations causes a shortfall elsewhere in the health workforce.

6.11 Chart 14 shows that there are marked differences in changes of the use of price cap overrides by occupational group. Whilst spikes are noticeable in many groups, nursing family roles are by far both the largest, and most dynamic, group.

²⁴ www.gov.uk/government/publications/foi-weekly-breaches-of-agency-rules-by-trust-since-january-2016

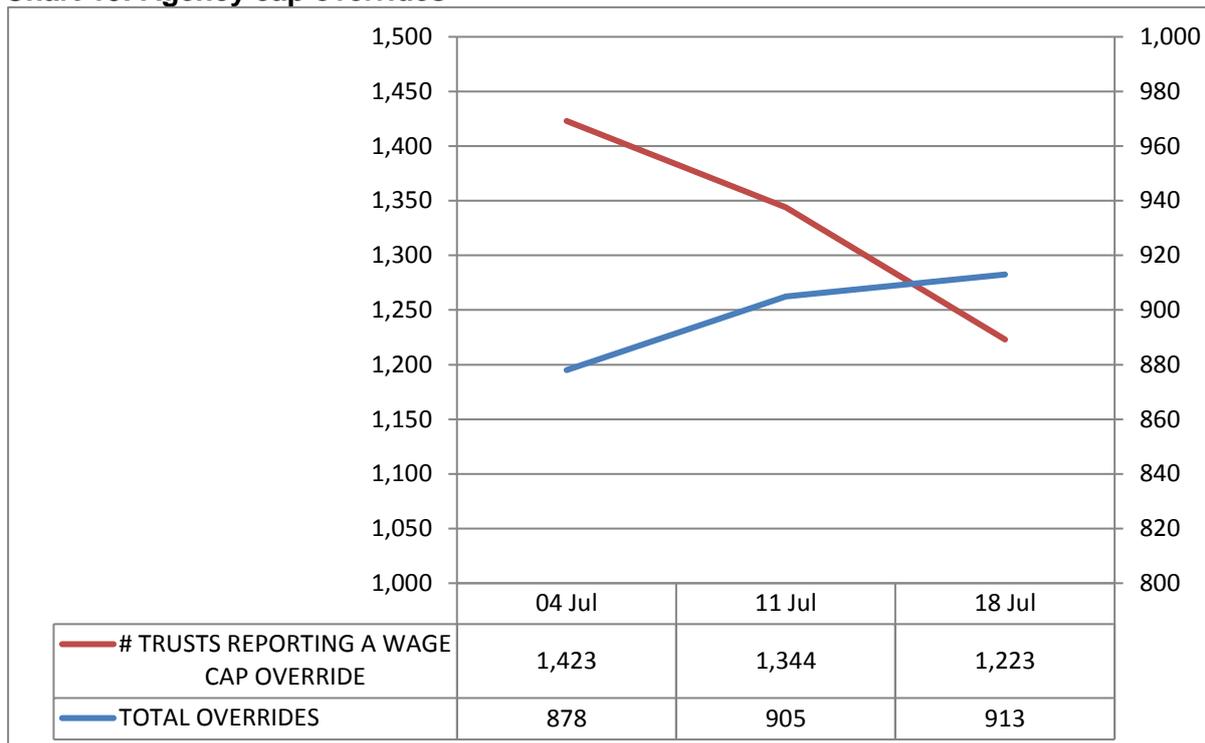
Chart 14: Agency price cap - individual instances of overrides 2016



6.12 Staff Side had access to a much smaller sample of data for breaches of the salary cap, shown in Chart 15. Only three weeks of data was available in the FOI that we used, so caution should be used in trend analysis. However it appears that as the numbers of Trusts breaching the cap has decreased, the actual instances of shifts covered by cap-breaching agency staffing has increased. The problem has simply moved around.

6.13 Again, this suggests that it may be the case that efforts made to reduce breaches of the agency rules in some trusts makes cap-breaching in the remaining trusts more prevalent. This does seem to suggest that the shortfall in the NHS workforce is chronic and while agency caps will focus the attention of trusts, it is simply not possible for all employers to meet all the requirements at the same time. However we acknowledge that this remains speculative.

Chart 15: Agency cap overrides



6.14 Until better, more complete data on the interaction between establishment numbers, bank use, overtime spend, and agency spend (including cap breaches) is published it is difficult to provide a more carefully considered analysis.

Effectiveness of the agency rules

6.15 Staff Side agrees that the use of agency staff in the NHS has reached inappropriate levels and should be controlled but we do not believe that NHS Improvement’s rules will do this in a safe and sustainable way.

6.16 As the King’s Fund identifies: *“the major risk we see is that the solution being pursued by the national bodies fails to address the underlying issue of shortage of supply; in recent years providers have increasingly been forced to rely upon more expensive temporary staff to fill vacancies because they simply cannot recruit sufficient permanent staff”*.²⁵

6.17 Furthermore in February 2016 the National Audit Office concluded that the agency spending caps are unlikely to address fully the underlying causes of the increased demand for temporary staff. Amyas Morse, the head of the National Audit Office said: *“Given the size of the NHS, workforce planning will never be an exact science, but we think it clearly could be better than it is. Equally, the way in which staff shortfalls are filled can be, and often is, unnecessarily costly and inefficient. Since clinical staff are the NHS’s main resource and cost, these shortcomings are serious and the current arrangements do not achieve value for money”*.²⁶

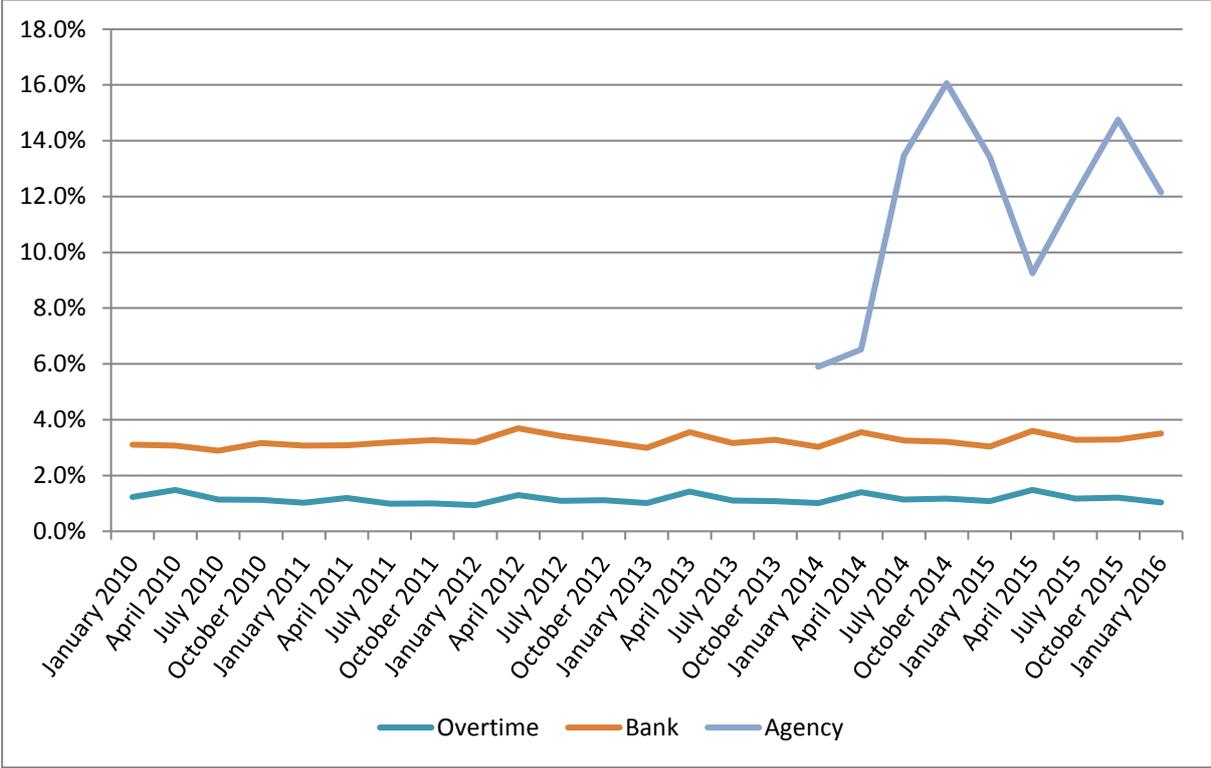
²⁵ www.kingsfund.org.uk/blog/2016/03/nhs-agency-staff-spend

²⁶ www.nao.org.uk/report/managing-the-supply-of-nhs-clinical-staff-in-england/

6.18 Staff Side also conducted an FOI exercise to try to understand agency spend in individual trusts. An FOI request was sent to 186 NHS organisations across all four UK countries. Responses have been received from 133 (70%) to date with some organisations also providing incomplete data.

6.19 This has been laid against information obtained from NHS Digital on average bank and overtime spend per month. Although data on bank and overtime is available from January 2010 due to resource limitations the FOI request only covers quarterly data from January 2014 until April 2016.

Chart 16: Agency, Bank and Overtime spend as a percentage of spend on non-medical staff



6.20 We had assumed that as agency rules were announced, and then enforced, bank and overtime would increase as trusts sought ways of ensuring there were no staff shortages.

6.21 This does not appear to be what has happened. This is possibly because the agency caps are so frequently overridden. Staff Side is keen to continue this work to try and understand this complicated area.

6.22 Staff Side also attempted to gather data on the figures spent on agency staff in the NHS. While all NHS organisations across England are required to report this information to NHS Improvement on a weekly basis it is not published on a national level.

6.23 Ultimately, Staff Side believes the publication of bank, agency and overtime spend against total workforce spend by trust and occupational group would be very helpful in understanding workforce dynamics in the NHS. NHS Digital already collects bank and overtime spend per trust and NHS Improvement collects trust reports on agency spend on a weekly basis.

6.24 In the meantime, we believe that a number of scenarios are possible. First, NHS Improvement may crack down on overrides of the agency rules. Whilst that might reduce Trust spending that would cause immediate and critical workforce shortages. Alternatively, a culture of near-permanent cap-overrides could develop. Whilst this would enable suitable staffing levels, in the short term, this is both an expensive and unwise way to provide sustainable staffing levels in the health service. Neither of these options is attractive and both are very likely to exacerbate both recruitment and retention problems.

6.25 A better solution is to properly maintain the value of the Agenda for Change package so that staff feel valued and remain in the system – both in substantive posts and in Bank work.

Conclusions on agency staffing

6.26 The agency rules introduced by Monitor, now NHSI, are a crude instrument to deal with the symptom of a problem rather than taking a more strategic approach to look at the underlying causes of the problem. The NHS has been facing significant funding challenges for the past six years combined with an increased demand for services due to the ageing population, increasing complexity of health needs and increasing birth rate. The existing workforce of the NHS have suffered during this time with changes to their pension and terms and conditions; increased work intensification with many staff reporting frequently working beyond their hours; and pay restraint leading to a significant reduction in the value of pay in the NHS. This has caused both recruitment and retention problems leading to a shortage in every professional group in the NHS.

6.27 It is clear that the Government and NHS organisations are not investing in NHS staff and this is creating a downward spiral were more staff to leave and fewer new staff want to work in the NHS so more money is spent on agency staff to plug the gap. It is imperative that the national NHS bodies and the Government develop a whole workforce strategy that includes reducing agency spending and increasing permanently employed staff (see section 9 on workforce strategy).

6.28 In the meantime, we recommend that as a short term solution, trusts could reduce their agency spending by using their own staff and incentivising staff to work overtime or on the bank rather than using agency staff. There is a single harmonised rate of overtime set out in Agenda for Change (time and a half for all overtime apart from public holidays which is double time). Staff Side understands that it is difficult to get authorisation to pay overtime rates and that bank rates are too low. By not authorising overtime or paying bank at a fair rate the result is that trusts have to use agency staff, which costs them more money.

6.29 Indeed, the ‘Review of Operational Productivity in NHS Providers’ report by Lord Carter of Coles identified that bank staff are not remunerated in a way to attract them from moving from agencies²⁷. Further, in the last report of the PRB they said: “*staff shortages in certain circumstances, and a rise in agency spend to meet short-term demands, are a*

²⁷ Department of Health (2015) *Review of Operational Productivity in NHS Providers: An independent report for the Department of Health by Lord Carter of Coles*
www.gov.uk/government/uploads/system/uploads/attachment_data/file/434202/carter-interim-report.pdf

*pattern across all countries. We were told that work is progressing in each country to control and reduce agency spend and this is encouraging. However, it is unclear how effective a strategy focused on cost caps and use of mandatory frameworks will be, when the demand for staffing cover remains high and training new supply takes a number of years. The rise in agency spend is an example of a labour market in operation when the current level of demand is outstripping supply. This results in higher rates of pay through the agency, with workers consequently deciding where to work and on what terms. Some NHS jobs or overtime may simply need to be made more attractive and flexible to potential staff. In the long run ensuring adequate supply is key to controlling costs and providing effective care to patients”.*²⁸

6.30 NHS Professionals stated that ‘approaches to address the agency rules are inconsistent, but with the general approach being to reduce the average hourly charge, led by the NHS Improvement measure of requiring procurement through approved frameworks. Focus on framework use has taken precedence and consequently has not formed part of a holistic approach to address all of the NHS Improvement aims, such as attracting workers back to the NHS into substantive or bank roles.’

Recommendations

6.31 This section has explored the agency staffing situation and shown that the interaction of the substantive, bank and agency parts of the workforce is complicated, with no simple solutions to the challenge of high agency spending. It will require a comprehensive approach looking at aspects of the problem. Staff Side asks the PRB to:

- recommend that NHS Improvement regularly publish information on workforce and agency spend to enable better analysis of workforce dynamics
- note the impact of the agency cap and its unintended consequences
- make an award which rectifies the decline in value of the AfC structure as a more sustainable means of tackling chronic staffing problems

²⁸ www.gov.uk/government/publications/national-health-service-pay-review-body-29th-report-2016

7. Morale and motivation

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

- **NHS England Staff Survey 2015:** 37% of all staff reported feeling unwell due to work related stress (38% in 2014)
- **Health and Social Care Northern Ireland Staff Survey 2015:** 36% of all staff reported they were injured or felt unwell as a result of work-related stress
- **Unite:** 79% have experienced work-related stress over the previous year

7.2 Results also show low levels of morale among the workforce:

- **Unite:** 80% of respondents said that morale was 'worse' or 'a lot worse' than 12 months ago
- **UNISON:** 56% of respondents reported morale being low or very low in their workplace and only 7% said morale was high or very high. 65% of respondents said morale had fallen over the last 12 months and just 8% said morale had improved.

7.3 Surveys asked respondents about their opinions about working for their organisation now and in the near future:

- **NHS Scotland Survey 2015:** 77% intend to be working with their Health Board in 12 months' time (79% in 2014) and 59% would recommend their organisation as a place to work (61% in 2014)
- **NHS England Staff Survey 2015:** 61% would recommend their organisation as a place to work (59% in 2014); 16% would not (unchanged from 2014).
- **Health and Social Care Northern Ireland Staff Survey 2015:** 61% would recommend their organisation as a place to work (56% in 2012)
- **UNISON:** 81% said they had considered leaving the NHS over the last year. 52% had fairly or very seriously considered leaving their current position. 38% would not recommend their employer to someone looking for a job. 37% would positively recommend their employer.
- **Unite:** 56% of respondents had considered leaving their position in the NHS
- **CSP:** a survey of members who have recently left the NHS found that the main motivations for leaving included dissatisfaction with the quality of care they felt about to provide, workload/stress and resources/staffing.

The Impact on Services

7.4 There is growing evidence of the impact of reduced budgets and service reorganisation on both service quality and staff. The King's Fund warn that 'NHS staff often act as a buffer, working longer hours or more intensely to ensure the people they treat still receive a high-quality service. This can increase staff stress levels and lead to low morale, something that is particularly worrying given that staff wellbeing can have a direct impact on patients' experience of care.'

7.5 The King's Fund have taken this further by looking in-depth at district nursing and mental health services. Their review of transformation programmes implemented in mental health services concluded that cost reductions have come at the expense of patient care. There is evidence of increased variation in care and reduced access to services and as well as far-reaching changes to the mental health workforce including a significant reduction in the number of experienced nurses. This has resulted in staff shortages and insufficient staff skill mix in some areas of care.

7.6 In district nursing, the King's Fund state that activity has increased significantly over recent years, both in terms of the number of patients seen and the complexity of care provided. However, there are significant problems with recruitment and retention of staff, and available workforce data indicates that the number of nurses working in community health services has declined over recent years, and the number working in senior 'district nurse' posts has fallen dramatically, creating a growing demand-capacity gap. The King's Fund state that this is having a negative impact on staff wellbeing, leading to poor morale, stress and fatigue. Some staff are leaving the service as a result. They go on to state that workforce pressures risk compromising quality of care, finding examples of an increasingly task-focused approach, reductions in preventive care, visits being postponed and lack of continuity.

7.7 The majority of NHS staff members have job descriptions which allow for disciplinary action if their work falls below the required standard or breaches their professional Code. Yet, as we outline throughout this evidence, they face huge pressures from staff shortages, poor skill mix and intensive workloads that are acting to undermine their duty of care.

Recommendations

7.8 We ask the PRB to acknowledge the impact of continued pay restraint on morale and motivation in the NHS

8. Pay for apprentices in the NHS

8.1 Employment of apprentices in the NHS continues to grow with policy commitments in all four UK administrations to increase the number of apprenticeships in the economy generally, with an expectation that the public sector will lead by example.

8.2 From April 2017, employers with paybills over £3m will be required to pay 0.5% of paybill into the government's apprenticeship levy. In England this will entitle them to digital apprenticeship vouchers to spend on training and assessment. The levy will be collected from employers across the UK but the devolved administrations are free to decide how to use their share of the funding it raises. Consultations with employers undertaken by the Scottish government suggest that there will be a broader approach in Scotland than the prescribed digital apprenticeship voucher scheme in England. To date there have been no decisions in Northern Ireland and Wales about how the levy funding will be distributed.

8.3 In England alone the levy will extract £200m a year from the NHS and there is considerable concern that, due to the current mismatch between skills shortages and availability of apprenticeships, the NHS will not in the first couple of years be able to recoup all this money. It is expected that any funds unused by NHS employers after 18 months would be redistributed for use by employers in other sectors. This is a particularly perverse prospect in view of the financial situation in the NHS.

8.4 We are concerned about the distorting effects of the imperative for employers to recoup the maximum they can from their levy contribution, and the knock-on impact on recruitment and retention. This is driving some employers to convert all vacancies in Bands 1-4 into apprenticeships with no strategic approach – and no assessment of suitability, the capacity among other staff to support apprentices, or the impact on retention of staff recruited as apprentices. Many employers are looking to divert money currently in their learning and development budgets to meet their levy payments. This will leave a shortfall in funds to support planned learning with particular implications for CPD provision as this cannot be funded through apprenticeships. It will also mean that existing staff may not receive the training they need unless it can be shoe-horned into an apprenticeship programme.

8.5 In England the effects of the levy on the NHS will be compounded by considerably increased targets for apprenticeship starts which will now be set at individual employer level. The government has consulted on statutory targets for public sector employers for the number of apprentices they start **each year** – to be set at 2.3% of each employer's headcount. Across the NHS, this will add up to a target of 28,000 starts per year. In 2015/16, Health Education England reports that there were nearly 20,000 starts.

8.6 The concern about a crude approach based on starts per year is that there is a considerable disincentive for employers to consider investing in higher value apprenticeships which last longer than a year. This is because the employer can only count them as a 'start' in the first year but must continue to invest the resources needed to support them through their whole apprenticeship.

8.7 This was well articulated by NHS Employers in their response to the government's consultation on statutory targets:

“The imposition of recurrent annual targets may actually reduce options for career progression in the support workforce, as apprentices may be employed on short 12-month fixed-term contracts and then replaced by a new batch of

apprentices...Furthermore a desire to meet annual targets may also discourage employers from making best use of higher and degree-level apprenticeships that would take longer to deliver, the start figures for which could only be included in one annual reporting cycle”

8.8 Currently there are few apprenticeships available in the areas of greatest clinical shortage. An employer-led ‘Trailblazer’ group is now working on developing a nursing apprenticeship but this is expected to take another couple of years. There may be similar developments for allied health professionals but again these will not be available in the short-term.

8.9 As a result, the primary focus of apprenticeship development has been in Bands 1-3 with some provision for Band 4 roles. HEE data shows that the majority of apprenticeships in the NHS are delivering at educational level 2 – equivalent to GCSE A-Cs. It is far from certain whether there will be an appetite from NHS employers to invest in degree-level apprenticeships in the NHS, even if more do become available. This reflects in part the short-term one-year target cycle for starts, and also the uncertainty over the effects of the removal of the student bursary.

8.10 The government has stated that removal of the bursary will lead to far greater numbers of students enrolling on and completing nursing and AHP degree programmes. Staff Side does not agree that this will materialise but it seems likely that many employers will wait to see whether they can fill their vacancies with people coming off degree programmes having financed themselves, before they decide whether to invest significantly in degree apprenticeships. This is because for apprenticeships they will have to pay a salary for the duration of a part-time degree, typically five years, and there are still question marks over whether levy vouchers will fund the full cost of degrees including tuition fees and placement costs.

8.11 As the levy only pays for training and assessment but not for salaries there will be further pressure to drive down wages of apprentices in order to make up for the levy outlay, and as a more general means of cutting paybills.

8.12 Staff Side is concerned that apprentice pay is being set by and large outside of the Agenda for Change agreement, creating a two-tier workforce that will only worsen as the number of apprentices in the service continues to grow. There is widespread use of the statutory minimum wage for apprentices, currently £3.30 an hour, as well as a range of interpretations of Annex U of Agenda for Change, and a number of ad hoc approaches that have sprung up at employer level, such as a £100 a week flat rate for all apprentices.

8.13 We are also concerned that, despite clear government guidance that apprentices should be on the same terms and conditions as all other employees, we are seeing employers seeking to exclude them from Agenda for Change terms and conditions, either through outsourcing their employment to Apprentice Training Agencies (ATAs) or through giving them non-AfC contracts with inferior terms.

8.14 The free-for-all on pay determination for apprentices reflects the fact that the Agenda for Change agreement contains no specific provisions on apprenticeships. Some employers have made selective use of Annex U of the agreement which covers ‘trainees’.

8.15 Para 2 (ii) covers situations where trainees undertake a period of learning on the job that is usually less than 12 months and states that this type of trainee can be evaluated using the NHS Job Evaluation (JE) Scheme. Staff Side contends that for most apprenticeships for roles in Bands 1-4, especially those at Levels 1-3, the on-the-job learning element would consist of less than 12 months and evaluation of an apprentice should be used.

8.16 However, employers are rarely applying this, and instead apply – wrongly in our view – Para 2 (iii) which allows for the application of percentage reductions to band maximums where “staff develop their knowledge and skills significantly **during a time period measured in years.**”

8.17 There are three problems with this. Firstly, the typical apprenticeships do not meet this definition in terms of knowledge acquisition over years, as the apprentices are quickly carrying out the main job duties. For example for a Band 2 job, the knowledge training and experience JE factor usually scores level 2: *“At this level the required knowledge generally takes a few weeks in the job to learn.”*

8.18 Secondly, many employers are using the percentage reductions to salaries set out in para 3 but ignoring para 4 which provides that the “main (adult) rate of the NMW” should be the absolute floor for any trainee. There is now an additional question mark over what this means – the Staff Side would contend that this should mean the statutory minimum rate for those aged 25 and over.

8.19 Thirdly, Annex U produces some anomalous looking outcomes depending on band, length of band, and duration of apprenticeship. In England in 2016/17 for apprenticeships lasting 12-24 months, an apprentice in a Band 1 job would start on £5.55 per hour (70% of the band maximum) which is just 71% of the Band 1 minimum. If it was Band 2 or Band 3 apprenticeship, the starting rate of 70% of the Band maximum is worth 83% of the Band minimum. However in a Band 5 apprenticeship the 70% Band maximum starting rate is worth 91% of the Band minimum. In other words, Annex U para 3 delivers a proportionately greater pay penalty in relation to lower banded roles than for the higher banded.

8.20 In Scotland it has now been agreed that all modern apprentices will be paid at least the Living Wage, and Annex U has been amended to reflect this.²⁹

8.21 We call on the PRB to recognise the potentially destabilising impact of the levy, the targets and apprenticeships as a growing form of employment within the NHS. We ask the PRB to recommend:

- The development of a national framework for determining apprentice pay should form part of the AFC refresh talks
- All apprenticeships undertaken within the NHS should be on full AfC terms and conditions
- Apprentices should also be covered by the Living Wage Foundation Living Wage
- Apprenticeship levy money should be pooled and ring-fenced to the NHS so that any unused funding can be offered out around the NHS rather than lost to other sectors.

Examples of NHS apprentice vacancies

²⁹ [www.sehd.scot.nhs.uk/pcs/PCS2016\(AFC\)04.pdf](http://www.sehd.scot.nhs.uk/pcs/PCS2016(AFC)04.pdf)

8.22 Below is a selection of apprentice vacancies in the NHS found on the government's apprenticeship search website on 1 August 2016³⁰. Very few of the vacancies on that day were for advanced level apprenticeships and none were for higher or degree level. The examples below show the preponderance of low pay rates clustering around the NMW statutory apprenticeship minimum. Where an apprenticeship goes beyond 12 months it is not clear what these employers will pay in the second year for people aged 19 and over. There are however some employers paying at the NMW rate for those aged 25 and over, or even higher. There is no obvious correlation between pay rates and role or level of apprenticeship.

Role	Level*	Employer	£ph	Duration
NHS Informatics	Intermediate	Various in North West region	£3.30 Yr 1 (£3.58 Yr 2)	24 mths
Healthcare Assistant	Intermediate	Kent & Medway NHS Trust	£3.30	12-15 mths
Administrator	Intermediate	NHS Bedfordshire CCG	£7.73	12 mths
Administrative Assistant	Intermediate	Hinchingbrooke Health Care NHS Trust	£3.60	12 mths
Corporate Services	Advanced	NHS High Weald Lewes Havens Clinical Commissioning Group	£3.93	12-18 mths
Housekeeper	Intermediate	North Hampshire Hospitals NHS Trust	£3.30	Not specified
Admissions Co-ordinator	Intermediate	Whittington Hospital	£7.20	12-15 mths
Pharmacy Assistant	Intermediate	Good Hope Hospital NHS Trust	£3.30	12-18 mths
Mechanical Maintenance	Intermediate	University Hospitals of Leicester	£3.40	18 mths
IT Learner Management Systems	Advanced	Pennine Acute Hospitals NHS Trust	£6.41	12-14 mths

***Levels**

Intermediate apprenticeship:
Advanced apprenticeship:
Higher apprenticeship:
Degree apprenticeship:

Level 2 = 5 GCSE passes at grades A* to C
Level 3 = 2 A level passes
Level 4, 5, 6 and 7 = Foundation degree and above
Level 6 and 7 = Bachelor's or master's degree

³⁰ <https://www.gov.uk/apply-apprenticeship>

9. The need for a workforce strategy

9.1 In the Joint Staff Side evidence for last year's pay round, we highlighted the need for a comprehensive workforce strategy to tackle the many and inter-connected challenges facing the NHS workforce, including increasing use of agency staff, stagnating wage levels, declining morale and motivation and increased staff shortages across the UK.

9.2 A review of publications made over the last year by prominent health care and economic bodies and parliamentary groups, which agree with the need identified by Staff Side for a comprehensive workforce strategy, reveals a coalescence of views around the damage exacted by poor workforce planning structures and strategies, the way in which targets negatively impact on the workforce and the need for a system-wide workforce strategy. This section reviews these statements, in order to draw out the key areas of analysis and recommendation. While most of these statements relate to England, there are inevitably wider lessons for the UK as a whole.

Workforce Planning Structures

9.3 The National Audit Office's report into the supply of NHS clinical staff in England assessed that the arrangements for managing the supply of clinical staff numbers are fragmented, increasing the risk of duplication and incoherence³¹. It warns that the system involves many different national and local bodies with different priorities and incentives.

9.4 The Migration Advisory Committee (MAC) agrees with this judgment on the number of bodies involved with no single, authoritative voice to speak for them, and describes a 'very confusing architecture.'³² The Health Foundation repeats this analysis and says that different NHS trusts have varying levels of capacity to understand and analyse their current and future staffing requirements, their business plans and likely funding levels. Localised funding-staffing disconnects can then become magnified at national level, where the national assessment may also be impacted by national funding-staffing disconnects.³³

9.5 Audit Scotland acknowledges the work undertaken for local workforce planning, but warns that these do not give a sufficient overview of national workforce issues or trends and do not provide solutions across boards, or nationally, to problems such as recruitment and retention difficulties in NHS Scotland³⁴.

9.6 Other bodies point to the issues around data collection and availability. For example, the Public Accounts Committee states that limitations in the data make it difficult to make well-informed decisions about workforce planning. It says there is poor information on vacancy rates, leaver rates and course completion rates. There is no systemic information on

³¹ National Audit Office (2016) *Managing the supply of NHS clinical staff in England*. www.nao.org.uk/wp-content/uploads/2016/02/Managing-the-supply-of-NHS-clinical-staff-in-England.pdf

³² Migration Advisory Committee (2016) *Partial review of the shortage occupation lists*. www.gov.uk/government/publications/partial-review-of-the-shortage-occupation-lists

³³ The Health Foundation (2016) *Staffing matters; funding counts*. www.health.org.uk/sites/health/files/StaffingMattersFundingCounts.pdf

³⁴ Audit Scotland (2015) *NHS in Scotland 2015*. www.audit-scotland.gov.uk/report/nhs-in-scotland-2015

why staff leave the NHS, where they go when they leave or why they transfer between providers.³⁵

Workforce Planning Targets

9.7 Many commentators point to the way in which centrally managed targets have a knock-on, detrimental impact on workforce outcomes. For example, the NAO judges that trusts' workforce plans appear to be influenced as much by meeting efficiency targets as by staffing need. It states that by focusing on efficiency targets when balancing financial sustainability and service requirements, trusts risk understating their true staff needs. The Health Foundation which points to mismatches between funding and staffing levels, along with repeated reorganisation, which have led to a 'boom and bust' approach to the NHS front line.

9.8 The Public Accounts Committee also highlights the impact of efficiency targets and describe them as both unrealistic and having caused the development of overly optimistic and aggressive staffing profiles which have subsequently led to staffing shortfalls. These in turn have had to be met by increased use of agency staff. Meanwhile, NHS Professionals report that many English trusts have resorted to allowing their own substantive staff to work additional hours through agencies in the effort to fill their rosters³⁶. They state that this has 'destabilised the workforce and added to Trust deficits.'

9.9 The Health Foundation draws attention to the impact of pay restraint as a key policy target. They say that this has essentially marginalised the use of pay as a policy lever to support changes in productivity and service delivery. It states that the longer the centralised 'freeze' goes on, the less pay and associated reward can be a policy lever to achieve these objectives, locally or nationally.

9.10 The Nuffield Trust looks at the targets set during workforce planning itself and makes the criticism that national workforce plans are judged against current and forecast vacancy levels, not current and future population needs. Assessing those needs, and the workforce needed to support them, should be a national research priority.

9.11 Audit Scotland has identified several issues to be resolved through the integration of health and social care in Scotland. It points out the risk of Integrated Authorities inheriting workforces that have been organised in response to budget pressures rather than strategic needs.

Workforce Planning Strategy

9.12 Several bodies criticise the current state of strategy on workforce planning. For example, the NAO has stated that trusts' workforce plans are unlikely to provide a reliable forecast of long-term staffing needs because they do not take full account of possible changes in how services are delivered. Their report on the supply of NHS clinical staff in England states that all key health policies and guidance should explicitly consider workforce implications such as seven day services. In common with the NAO, the Public Accounts Committee also criticises the 'critical of lack of assessment of headcount implications of a

³⁵ Public Accounts Committee (2016) *Managing the supply of NHS clinical staff in England*
www.publications.parliament.uk/pa/cm201516/cmselect/cmpubacc/731/73102.htm

³⁶ NHS Professionals (2016) *Special Edition of National Trends*
www.nhsp.co.uk/index.php/download_file/375/

number of major policy initiatives such as seven day services'. Meanwhile, the NHS Wales Workforce Review has said that there is no strategic vision for what the NHS should look like in Wales in ten years' time, and that this inhibits the planning of new workforce models, skill mixes and roles.

9.13 The Public Accounts Committee also point to difficulties with staff retention and state that efforts to retain existing clinical staff are not well managed, which may further increase shortfalls. They say that it is not clear who is accountable nationally for controlling departure rates and there is not enough data on why staff leave the NHS and where they go when they leave. The Nuffield Trust also points to gaps in evidence, pointing to a 'worrying lack of evidence about the impact of skill mix changes and new and extended roles'. There is no systematic evaluation of new and extended roles at a national or local level.

The Need for a National Workforce Strategy

9.13 The NAO has stated that a more coordinated and proactive approach to managing the supply of staff could result in efficiencies for the NHS as a whole while the Public Accounts Committee has called for greater national leadership and coordinated support to help trusts reconcile financial, workforce and quality expectations. The Chief Executive of NHS England, Simon Stevens, is quoted as saying that: "*our future lies in networks and health systems; not individual go-it-alone institutions. On too many procurement and workforce issues it has felt the opposite of that.*" He stated that a 'complete strategy' for the NHS workforce is needed.³⁷

9.14 Audit Scotland have also called for a national, coordinated approach to help resolve current and future workforce issues³⁸. It should 'assess longer-term changes to skills, job roles and responsibilities within the sector as well as aligning predictions of demand and supply with recruitment and training plans. This is necessary to help ensure the NHS workforce adapts to changes in the population's needs and how services are delivered in the future.'

9.15 The Health Foundation has called for a collaborative approach to policymaking built on a sophisticated understanding of the daily lives of health professionals, their motivations, the cultures they work in, and the pressures they face. The organisation has recommended the formation of a National Workforce Strategy Board to introduce better strategic coordination. It also recommends the reconstitution of the Social Partnership Forum as a meaningful forum for shaping policy from the initiation stage, so that ministers, employers, officials and trade unions are in a continual conversation about policy as it develops and as it is implemented.

Staff Side Proposal for a Workforce Strategy

9.16 For 2017/18 we are asking the PRB to recommend a pay rise that is more than the 1% limit set by Government public sector pay policy and which starts to bridge the gap with the cost living that started to open up in 2010 and continues to grow as consecutive pay awards fail to keep pace with inflation and pay levels fall behind those for comparable professions. This is important for morale and motivation in the short-term and for recruitment

³⁷ Health Policy Insight www.healthpolicyinsight.com/?q=node/1604

³⁸ Audit Scotland (2015) *NHS in Scotland 2015* www.audit-scotland.gov.uk/report/nhs-in-scotland-2015

and retention in the longer term. Improved pay needs to go hand in hand with attention paid to other parts of NHS employment – particularly the psychological contract – to aid retention.

9.17 The psychological contract in the NHS, ie how the employee is treated by the employer, and what the employee puts into the job in return is increasingly an issue. For example, the 2015 NHS Staff Survey for England found that 74% of staff felt enthusiastic about their job. However, only 38% of staff agreed that communication between senior management and staff was effective and even fewer (32%) felt that senior management tried to involve staff in important decisions.

9.18 Many organisations are becoming unstable places to work as a consequence of either or both financial uncertainty and system changes. Structural and leadership changes are leading to worsening working conditions. Employers are increasingly reluctant to agree flexible work requests including to staff returning from maternity leave. Workload is increasing as a consequence of rising demands on healthcare while at the same time there are shortages in key areas of the NHS workforce, leading staff to look at moving to different roles, reducing hours or leaving. Other issues contributing to instability are demographic, including the different needs of an ageing workforce, a predominantly female workforce needing more flexibility for caring responsibilities and younger generations also wanting more balance between their work and home life. The Government Office for Science has published a report bringing together evidence about today's older population, with future trends and projections and identifying the implications for the UK.³⁹ This highlights the need to take account of an ageing workforce in developing policies and strategy for the future.

9.19 Staff Side believes that the current review and refresh of the Agenda for Change structure also provides the opportunity to connect the vision of 'how rewarding staff fairly is good for patients', which is central to this review, with work in national partnership forums on workplace culture and staff engagement as well as workforce transformation plans. We believe that if this connection and alignment could be achieved, the effect would be to release workforce capacity and improve productivity.

Background

9.20 The current working environment for staff across the four countries is uncertain and difficult. The financial situation for the NHS in all four countries continues to be challenging. At the same time workforce supply issues mean that staffing levels are under pressure and workload demands are increasing. There is an inevitable impact on staff who are unable to deliver the quality of care they would wish to and their professional code requires. This has been identified as a major factor in the increase of work related stress among NHS staff. Each of the four countries have ambitious plans to transform services to improve delivery which involve changes to structures, jobs and ways of working. We welcome plans for improvement but provided the changes are adequately resourced, that there is clinical evidence to support the change and staff are engaged from the start. The Brexit decision is generating an additional level of uncertainty about the future financial stability of the NHS and the impact on jobs and pay as well as raising the question of increasing divergence between the four countries in relation to arrangements for pay and conditions. There are also questions about the possibility of divergence in pay and conditions in England as Trusts seek more local solutions to financial and workforce challenges. We believe that a robust, comprehensive and co-ordinated response to these challenges is needed in order to alleviate

³⁹ Government Office for Science (2016) *Future of an ageing population*
www.gov.uk/government/publications/future-of-an-ageing-population

insecurities and uncertainty; increase trade union and staff engagement; resolve recruitment and retention problems and release capacity to improve services to patients.

9.21 In our view, there are three key areas of work that need to be aligned in order to ensure the development of a coherent workforce strategy (in each of the four countries). These are:

- the work of the NHS Staff Council - in providing a pay system and terms and conditions for NHS staff that are fit for purpose, sustainable and continue to be attractive;
- work in national partnership forums on culture, leadership, staff engagement and staff wellbeing and;
- national, regional and sub-regional systems and processes for planning the shape of the workforce for the future – workforce transformation.

9.22 The NHS Staff Council is steering the current review of Agenda for Change. The review stems from the resolution of the 2014/15 pay dispute in England when trade unions made a commitment to a review of the Agenda for Change agreement as part of the settlement of the dispute. The initial focus of discussions has been looking at the pay structure and progression arrangements, before considering other aspects of the national terms and conditions handbook.

9.23 Another important aspect of ensuring that the NHS system adapts to and incorporates new roles and new ways of working is the NHS Staff Council's responsibility for job evaluation: providing an agile response to emerging roles such as the associate nurse and apprentices, ensuring the coherence of movement through pay bands and career progression and promoting ways to improve skill mix exercises for example.

9.24 This year staff wellbeing and bullying have been major work-streams for the Social Partnership Forum (England). While the wider NHS system appears to share these priorities, with activity at national and employer level around the workforce race equality standard (WRES), the NHS England/NHS Employer's wellbeing project and the Department of Health's initiative on bullying for example, engagement with the trade unions is variable. Furthermore, many of the wellbeing initiatives tend to focus on improving individual health rather than addressing the organisational level factors which have the potential to impact on health and wellbeing.

9.25 Workforce planning is a major gap. Apart from in Scotland where the workforce planning system is centralised and mandatory, the approaches in the other three countries are 'hit and miss'. Service transformation projects related to the Five Year Forward plan for England are varied and diverse. Trade unions are not routinely involved or engaged and it is difficult to assess the implications for the workforce or potential impact. In Wales, there are workforce planning structures and a system but the focus is on maintenance rather than forward thinking and innovation. There is no joined up workforce planning across the UK.

9.26 As set out above, a wide range of commentators agree with our analysis and with our view that a workforce strategy is now critical.

Strategic vision

9.27 We believe that there is a need for a workforce strategy that harnesses the NHS Staff Council refresh of the Agenda for Change pay structure; which is aligned with the initiatives in the national and regional partnership forums on culture, wellbeing and leadership and

which engages trade unions in service and workforce transformation. We believe this strategy would help create a healthy and safe working environment for staff and improve their working lives and that this would ultimately improve the quality of patient care.

Strategic aims

- 1) Changes to the Agenda for Change pay structure that make it simpler to explain, understand and operate; with shorter pay bands, fewer points and no overlaps between bands; that make it fair and affordable for now and the future.

Achieved through the ongoing NHS Staff Council review of Agenda for Change.

- 2) Maintaining the current NHS Job Evaluation system which delivers equal pay for work of equal value as the basis of Agenda for Change underpinning the pay structure.

Achieved by NHS Staff Council Leadership, dynamic and interactive training for local evaluation and healthy engagement with the process by local employers and staff sides.

- 3) A healthy and safe workplace: one with high quality employment practices and procedures which promote a good work-life balance; dignity at work; protect and promote employees' health and safety at work; job design which provides employees with autonomy and control; provides equitable access to training and learning and development opportunities for all employees. Physical, emotional and mental wellbeing, as well as job satisfaction, are key predictors of organisational outcomes, including effectiveness, productivity and innovation and this link applies even more so to the health and social care sector, where the behaviours and attitudes of staff are likely to affect the patient experience.

Achieved by coordinated and consistent national and local activity in the NHS Staff Council, national partnership forums and employing organisations.

- 4) Safe staffing levels – the right number of skilled staff in the right settings.

Achieved by evidence based workforce planning at all levels, national and local and the engagement of the trade unions and professional bodies.

- 5) The NHS is an attractive place to work and an employer of choice. Terms and conditions that support good recruitment and retention of staff, motivating staff at all levels and support staff development and career progression underpinned by well-structured appraisals;

Achieved through the ongoing NHS Staff Council review of Agenda for Change.

- 6) Engagement with trade unions locally and nationally

Achieved through positive participation on the part of employers, trade unions and the respective departments of health

- 7) Effective Management of change

Achieved through sound policies agreed jointly by employers and trade unions.

8) Equality, diversity and inclusion

Achieved by commitment to equality and diversity from the top; through promoting a working environment where difference is respected and valued; by working to ensure policies, systems and processes do not unlawfully indirectly or directly discriminate against individuals or harass or victimise them and by regularly monitoring and reporting on performance.

9) A learning organisation – the NHS facilitates the learning of all its members and continuously transforms itself.

Achieved by support for staff development and career progression underpinned by well-structured appraisals at all levels in all employers, good line management and well trained managers.

10) A focus on leadership at all levels

We believe these ten points support and reward the improvement of staff productivity and are supportive of the longer term Health and Social Care agenda and the corresponding workforce needs (in each of the four countries) and that this will help achieve ongoing improvement in the quality of patient care.