The NHS Employers organisation submission to the NHS Pay Review Body on market facing pay

March 2012
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Key messages to the NHS Pay Review Body

- The NHS will need to achieve unprecedented levels of efficiency savings of up to £20bn before 2014/15 to meet growing demand. In view of the cost pressures, restraining paybill costs remains a key priority for employers. These are essential to minimise potential job losses and protect services.

- We recognise that employers do operate in different local labour markets and some pay flexibility would potentially lead to more efficient use of the paybill. However, the NHS has a wide-ranging sophisticated workforce that operates at international, national, regional and local levels. This requires careful consideration to ensure that any changes do not lead to pay escalation or labour market instability through skill seepage to higher wage areas.

- There is limited appetite from employers for full local pay bargaining and moving away from Agenda for Change, which may involve the development of a bespoke job evaluation system. Such a move would raise issues of local capacity, increase administration costs and risk pay inflation as employers compete directly for staff on pay. Getting rewards wrong could have a significant impact on the quality of patient care and safety. Employers also recognised that fundamentally changing a pay system is not a quick fix.

- There is a desire from employers for more flexibility around pay and conditions of service, which can seem generous in some places compared to other comparable employers. Most employers would like this to be delivered through a development of the national framework. Evidence suggests that private sector organisations with sites across the country tend to nationally determine pay even if there is regional or zonal differentiation.

- There is some evidence that regional and local labour markets do have influence on the NHS. Turnover rates and recruitment and retention pressures do differ across the NHS in England.

- The Agenda for Change pay system currently makes some provision for zonal pay differentiation with additional pay supplements for all staff working in London. A variation of high cost area supplements (HCAS) could be extended and amended to differentiate pay awards to other areas should there be evidence to justify this.

- Local employers currently have the option to pay recruitment and retention premia to address staff group-specific labour market issues.

- Employers would be concerned that a crude zonal or regional system will not work effectively across the range of occupations and professions which exist in the NHS.

- The NHS is subject to a complex funding formula based upon a national tariff for most services and a “market forces factor”. If there are changes to the structure of the pay system, employers would want to see the benefits available for reinvestment, or not to be disadvantaged through future differential pay increases.

- Agenda for Change is underpinned by a job evaluation system consistent with equal pay principles. Differential pay increases for staff in the same pay bands could raise equal pay risks unless justified by evidence.
1. **Introduction and discussion**

1.1 The NHS Employers organisation has been asked to submit evidence to contribute to the review on both market facing pay and on how the Agenda for Change national framework could be more locally responsive. We continue to value the role of the NHS Pay Review Body in bringing an independent and expert view on remuneration issues in relation to the NHS workforce.

1.2 We have had an ongoing programme of employer engagement, with the full range of NHS organisations on their priorities for national pay and conditions of service over the last year. Our submission is based upon discussions at meetings of regional human resources directors and other employer network meetings. We have undertaken a web-based questionnaire and had substantive discussion with the NHS Employers policy board and with employer representatives on the NHS Staff Council.

1.3 Our consultation with employers has revealed a range of different employer perspectives on the scope for introducing a greater element of market facing pay into the Agenda for Change system. Unsurprisingly, there is no common view and employers will want to consider the merits of any specific proposals which might emerge from this process. This submission aims to set out the issues and priorities raised by employers and provides evidence and contextual information that we hope will be of assistance to the pay review body.

1.4 Our evidence for your 2012/13 round stressed that “Employers are becoming concerned that the present national pay arrangements in their current form are not affordable”. In view of the need to achieve unprecedented levels of efficiency savings, restraining paybill costs remains a key priority for employers. This continues to be the case. Increases in paybill costs will create considerable financial pressure unless fully funded through the Payment by Results (PbR) tariff. For the past two years the tariff prices have decreased to ensure that unit costs fall. This in turn drives the need to make efficiencies. Any proposals to emerge in relation to market facing pay have to be considered within this context. Any changes to the pay system should support employers in delivering services to patients and/or contribute to supporting recruitment, retention, motivation or morale of their workforce.

1.5 Generally, employers have been telling us that they are still supportive of the national frameworks, subject to them being made more affordable and having greater local flexibility (see Appendix A). In relation to more market facing pay, this indicates an expectation that this would still be delivered as part of the national framework with a continuing role for the pay review body.

1.6 We understand that research has found that large private sector organisations, with sites across the country, tend to have national pay frameworks so as to avoid the time and additional costs of multiple local bargaining units. Income Data Services (IDS)¹ has found that nationally-determined zonal approaches are common in the retail sector, whilst the banks tend to use regional pay bands. This may involve splitting the country into four or five zones, which may be based upon geographical areas or categories of location linked to “hot spots” or major cities. In 2007, a similar approach was adopted into the Ministry of Justice based upon five different pay zones for the majority of staff.²

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1.7 The Chancellor announced in the Autumn Statement\(^3\) that the headline pay increases for public sector pay would be restricted to an average of one per cent in the two years following the pay freeze (2013/14 and 2014/15). This suggests there will be little scope for meaningful pay differentiation between regions or zones during these years.

2. **Existing Agenda for Change provisions**

2.1 There is already provision in the NHS Staff Council’s conditions of service handbook for some forms of market facing pay. These are the provisions for:

- high cost areas supplements (HCAS)
- local recruitment and retention premia.

2.2 **High cost area supplements** (HCAS) were introduced with the Agenda for Change agreement in 2004 as a replacement for the old flat-rate London weighting payments. Before Agenda for Change the value of London weighting allowances was dependent on staff group. HCAS were introduced as a harmonised pay supplement that was applicable to all staff groups covered by the new pay system.

2.3 Levels of payment are dependent on specific geographical zones and are expressed as a percentage of salary subject to minimum and maximum payments. The current values\(^4\) are shown in Figure 1 below. HCAS payments recognise that employers in London and surrounding areas generally face more challenging local and regional labour market pressures and higher costs than those faced in the rest of England.

**Figure 1 Agenda for Change High Cost Area Supplements – Current values**

<table>
<thead>
<tr>
<th>Area</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inner London</td>
<td>20 per cent of basic salary, subject to a:</td>
</tr>
<tr>
<td></td>
<td>• minimum payment of £4,036 and a maximum payment of £6,217</td>
</tr>
<tr>
<td>Outer London</td>
<td>15 per cent of basic salary, subject to a:</td>
</tr>
<tr>
<td></td>
<td>• minimum payment of £3,414 and a maximum payment of £4,351</td>
</tr>
<tr>
<td>Fringe areas (see Appendix B)</td>
<td>5 per cent of basic salary, subject to a:</td>
</tr>
<tr>
<td></td>
<td>• minimum payment of £933 and a maximum payment of £1,616</td>
</tr>
</tbody>
</table>


2.4 There is some evidence to suggest that the value of HCAS for Agenda for Change staff are higher than the level of pay supplements given to those working in London for nationwide private sector employers. The graph in Figure 2 shows that NHS high cost area supplements are competitive when compared with the allowances for London and the south east used by nationwide private sector employers. Within inner London, only British Gas pays its Band 1 staff an allowance which is within the range of HCAS allowances paid under Agenda for Change in the NHS. In outer London, only Band 2 British Gas staff have allowances which exceed the rates paid under Agenda for Change in the NHS. Santander, Waterstones, First Great Western and Network Rail, all pay allowances which are substantially below those used in the NHS. In spite of the levels of pay supplements paid to NHS staff working in London, information available suggests that levels of NHS staff turnover and vacancies are still generally higher in London than those in the rest of England.

Figure 2 – Comparison of NHS Agenda for Change high cost area supplements (HCAS) with London/south east allowances at nationwide private sector employers

![Comparison of NHS Agenda for Change high cost area supplements (HCAS) with London/south east allowances at nationwide private sector employers](image)

Please note that whilst the boundaries for the NHS high cost area supplements are broadly similar to those used across the private sector, the boundaries are not coterminous.

2.5 Figure 3 shows the proportions of staff in receipt of HCAS in each of the former SHA regions. The current defined HCAS areas are all in London and the surrounding areas (fringe). The fringe HCAS area overlaps with the boundaries of three of the existing strategic health authorities – South Central, South East Coast and East of England (see Appendix B). There are no HCAS supplements paid in any other areas of the country.

The NHS Employers organisation submission to the NHS Pay Review Body on market facing pay
The use of HCAS is one of the factors that contribute to regional variation in NHS pay. The other key factor is the use of recruitment and retention premia (RRPs). In areas outside the HCAS area, or where the HCAS alone is insufficient for employers to recruit and retain staff, employers are able to use the local flexibility of paying an RRP. We believe that if there was a move to market facing pay, these elements of Agenda for Change could be adapted to accommodate the award of differential pay awards.

2.6 The agreement also provides flexibility to local employers outside of the London specified geographic area, to propose an increase in the level of high cost area supplement for staff in their area or, (in the case of areas where no supplement exists), to introduce a supplement. In practice this has not happened because the additional financial costs of such arrangements would have to be met from existing resources. The national agreement makes clear that, “It will be open to the NHSPRB to make recommendations on the future geographic coverage of high cost area supplements and on the value of such supplements”.

2.7 Current arrangements potentially provide for these pay supplements to be extended to other geographic areas or zones of the country, if evidence supported this. Extension of HCAS could be used in areas where evidence suggested that the Agenda for Change pay rates were behind the local market rates.

2.8 The levels of existing HCAS rates may require ongoing review and maintenance to ensure they continue to be set at an appropriate rate.
2.9 If it were to be judged that NHS rates in some areas were in excess of local or regional market rates, this would be best addressed by resources available for pay to be used to introduce the extension of HCAS targeted to specified areas, rather than be used for general increases to the pay scales. This over a period of time would introduce greater pay differentiation across England.

2.10 Although in October 2011 the ten strategic health authorities in England merged to form four clusters, the analysis throughout this evidence is based on the ten strategic health authority (SHA) boundaries that existed prior to 1 October 2011. This provides further detail of the extent of national variation in recruitment and retention experience, and a consistent geographic unit to compare and contrast the various metrics. This is not to suggest that existing SHA regions would be the most appropriate geographical units to differentiate pay. The regional presentation of the data is likely to hide significant variation within the regions. IDS Pay confirms that “the greatest income gaps in the UK are not those between regions, but are found within regions”.5

2.11 There is also provision for local employers to decide to pay recruitment and retention premia (RRP) which can be targeted at specific groups of staff with the aim of addressing significant labour market challenges, some organisations have struggled to recruit into specific specialities or roles. The handbook6 says:

“A recruitment and retention premia is an addition to the pay of an individual post or specific group of posts where market pressures would otherwise prevent the employer from being able to recruit staff to and retain staff in, sufficient numbers for the posts concerned, at the normal salary for a job of that weight.”

2.12 Local employers are able to apply a recruitment and retention premia to posts of a specific class or type. Premia may also be applied to individual posts where the post is unique within the organisation concerned.

2.13 The use of local RRP is intended to address market problems where there was evidence that the reason for the difficulty in recruiting or retaining staff was directly related to levels of pay – that pay supplements would help a local employer to compete in the local labour market. Use of local RRP is not an appropriate response where the reason for failing to recruit is due to a lack of supply of health-related specialists.

2.14 It is recognised that recruitment and retention issues are not always totally reliant on pay levels. Other issues including good employment practices, scope for career development, working conditions, flexibility, employer reputation and quality of local transport can all have an impact.

2.15 The Agenda for Change pay system is underpinned by an equality proofed job evaluation system. To ensure compliance with equal pay principles individuals (irrespective of job role) undertaking work assessed as being of equivalent job weight should be in the same pay bands. Any additional pay supplements in the form of an RRP have to be justified by evidence that this is needed to support recruitment or retention. This requirement was re-affirmed in the employment tribunal judgment in the Hartley equal pay test case.7

5 IDS, Regional earnings data shows little variation, IDS Pay Report 1092, March 2012.
6 The Staff Council, NHS terms and conditions of service handbook, 2012
2.16 Evidence suggests that the flexibility to use local RRPs is not being widely used, mainly due to the prevailing depressed labour market climate. Although some employers report difficulties in a limited number of specialties, generally employers are not finding the need to pay additional pay to recruit and retain staff. In most parts of the country employers report no particular recruitment problems. Some have reported getting large numbers of applicants for vacancies they advertise, which may suggest that in certain posts pay is higher than the market rate.

2.17 The national agreement also makes provision for national recruitment and retention premia (NRRPs) where the labour market problem affects a particular job role across the country. NRRPs were paid to some maintenance craft workers as a transitional measure when the new pay system was introduced. Their payments are now being withdrawn on a phased basis. Employers generally take the view that the need for NRRPs will be rare because recruitment or retention issues tend to vary across the country and most staff groups covered by Agenda for Change will not operate in national labour markets.

2.18 Figure 4 details the usage of RRPs across the NHS. RRPs are used in all ten regions. RRPs are most frequently used in the South East (15.5 per cent of staff receive an RRP). RRP usage decreases towards the north of the country. Fewest RRPs are used in the North East (0.7 per cent). The London area uses fewer RRPs than its immediate neighbours (South East Coast, East of England, South Central). This is likely to be because the almost universal use of the high cost area supplement in London reduces the need to pay separate additional RRPs.

**Figure 4 – Use of recruitment and retention premia for Agenda for Change staff by SHA region (2011 boundaries) – Percentage of staff receiving RRP payments**

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>0.7%</td>
</tr>
<tr>
<td>North West</td>
<td>0.8%</td>
</tr>
<tr>
<td>Yorkshire and Humber</td>
<td>0.6%</td>
</tr>
<tr>
<td>East Midlands</td>
<td>3.1%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>1.1%</td>
</tr>
<tr>
<td>East of England</td>
<td>5.4%</td>
</tr>
<tr>
<td>London</td>
<td>2.4%</td>
</tr>
<tr>
<td>South East Coast</td>
<td>15.4%</td>
</tr>
<tr>
<td>South Central</td>
<td>10.8%</td>
</tr>
<tr>
<td>South West</td>
<td>8.0%</td>
</tr>
</tbody>
</table>

*Data Source: NHS Employers analysis of data from ESR Data Warehouse as at November 2011. Indicative proportions of staff (FTE) in receipt of either general or long-term RRPs. Actual proportions may vary slightly due to local variation in how the payments are categorised and recorded in ESR.*
2.19 Figure 5 details how RRP usage varies across Agenda for Change staff groups. There is significantly more variation in RRP usage within staff groups than when looking at Agenda for Change as a whole. RRPs are most frequently used in nursing and midwifery (8 per cent of staff in this group receive an RRP). However, usage varies for the staff group between strategic health authorities, ranging from 0 per cent in the North East to 36 per cent in the South East Coast. The relatively high usage of RRPs for qualified nursing and health professional staff is likely to be reflective of pre-Agenda for Change “cost of living supplements”, which were converted into local recruitment and retention premia on implementation. Some employers are currently seeking to withdraw such payments. In contrast, only 1 per cent of administrative and clerical staff receive RRPs, and this varies between 0 per cent in the North East to 1.4 per cent in London.

**Figure 5 – Use of RRPs for Agenda for Change staff by staff group and SHA region**

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>East Midlands</th>
<th>East of England</th>
<th>London</th>
<th>North East</th>
<th>North West</th>
<th>South Central</th>
<th>South East</th>
<th>South West</th>
<th>West Midlands</th>
<th>Yorkshire and the Humber</th>
<th>NHS in England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add prof scientific and technic</td>
<td>3.2%</td>
<td>3.3%</td>
<td>2.6%</td>
<td>2.2%</td>
<td>2.2%</td>
<td>5.0%</td>
<td>10.2%</td>
<td>5.0%</td>
<td>2.1%</td>
<td>2.1%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>0.4%</td>
<td>1.2%</td>
<td>3.3%</td>
<td>0.4%</td>
<td>0.5%</td>
<td>2.7%</td>
<td>3.0%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>0.2%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>0.6%</td>
<td>1.3%</td>
<td>1.4%</td>
<td>0.3%</td>
<td>0.3%</td>
<td>1.3%</td>
<td>0.9%</td>
<td>0.8%</td>
<td>0.6%</td>
<td>0.3%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>5.2%</td>
<td>7.5%</td>
<td>1.5%</td>
<td>0.1%</td>
<td>0.2%</td>
<td>17.0%</td>
<td>25.4%</td>
<td>12.6%</td>
<td>0.3%</td>
<td>0.1%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>3.7%</td>
<td>5.7%</td>
<td>9.8%</td>
<td>4.5%</td>
<td>4.1%</td>
<td>6.4%</td>
<td>6.0%</td>
<td>4.2%</td>
<td>4.4%</td>
<td>3.4%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>0.1%</td>
<td>0.9%</td>
<td>1.8%</td>
<td>0.6%</td>
<td>0.6%</td>
<td>3.5%</td>
<td>1.4%</td>
<td>0.4%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>6.1%</td>
<td>11.4%</td>
<td>2.3%</td>
<td>0.3%</td>
<td>0.6%</td>
<td>23.3%</td>
<td>36.3%</td>
<td>19.1%</td>
<td>0.9%</td>
<td>0.2%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Students</td>
<td>0.0%</td>
<td>0.5%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.3%</td>
<td>0.8%</td>
<td>5.4%</td>
<td>4.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.9%</td>
</tr>
<tr>
<td>All staff groups</td>
<td><strong>3.1%</strong></td>
<td><strong>5.4%</strong></td>
<td><strong>2.4%</strong></td>
<td><strong>0.7%</strong></td>
<td><strong>0.8%</strong></td>
<td><strong>10.8%</strong></td>
<td><strong>15.4%</strong></td>
<td><strong>8.0%</strong></td>
<td><strong>1.1%</strong></td>
<td><strong>0.6%</strong></td>
<td><strong>4.1%</strong></td>
</tr>
</tbody>
</table>

**Data Sources:** NHS Employers analysis of data from ESR Data Warehouse as at November 2011. Indicative proportions of staff (FTE) in receipt of either general or long-term RRPs. Actual proportions may vary slightly due to local variation in how the payments are categorised and recorded in ESR.

2.20 The Agenda for Change pay system covers a wide range of staff groups on nine harmonised pay bands. The 2011/12 pay range is between £13,903 and £97,478. This makes direct comparison with particular local labour markets difficult and complex. The NHS employs the majority of registered nurses\(^8\) and most health professional groups. In effect, the NHS sets the market rate for these groups.

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2.21 Around a third of non-medical NHS roles are comparable with similar roles in the private sector. For those roles that are comparable, evidence suggests that NHS average pay is at least as high as that of the private sector. As a matter of policy, the pay of the lowest paid NHS groups has been targeted in pay settlements in recent years, largely due to the importance attached to maintaining good quality staff involved in hospital cleaning to support the reductions in hospital-acquired infection. This has made NHS pay at lower levels competitive in labour market terms. For instance, Figure 6 shows, the minimum basic salary paid to an NHS cleaner is higher than that paid to three-quarters of cleaners employed in local government. Figure 7 shows support workers in AfC Bands 1 and 2 receive a basic salary that is higher than the median basic salary paid to their equivalents (recorded as care assistants) in not-for-profit and services sectors in all English regions.

2.22 There is very limited information available that would allow for occupation-specific comparison between the NHS and employers from other sectors. Information on earnings from the Office for National Statistics may be less robust when broken down by occupation, sector and geographical area. Direct comparisons cannot always be made with other employment sectors as geographical boundaries (such as those of local authorities and primary care trusts) may differ. We are not aware of any analysis which takes into account “total reward”. Some form of central monitoring and up-to-date labour market information for the appropriate level of geographic detail would need to be established were the pay rounds to require such analysis.

Figure 6 – Comparisons of median basic pay plus high cost area supplements between the NHS and local government for cleaners – AfC Bands 1 and 2


Note: NHS minimum/maximum salaries shown include minimum/maximum high cost area supplements as per the handbook, where appropriate. Error bars show the upper and lower quartiles.

11 Incomes Data Services, IDS Pay Online; Pay Levels Of Care Assistants In Job Levels 1 and 2, http://idspay.co.uk/pay-online/, IDS Pay Levels set 1 July 2010 to 30 June 2011.
3. Allocation of funding in the NHS

3.1 The allocation of funding in the NHS does recognise that it is more expensive to provide services in some parts of the country than in others. Staffing costs, geography, land values and private provider prices all affect the cost of provision of healthcare. The market forces factor (MFF) is the mechanism which takes all these factors into account in the allocation of funding to NHS commissioners and the prices they pay to providers of care.

3.2 National pay arrangements mean that rates of basic pay do not vary across the NHS. However, due to the use of high cost area supplements (HCAS), and to a lesser extent recruitment and retention premia (RRP), there is geographical variation in overall staffing costs. Overall staffing costs are also indirectly affected by how difficult it is to recruit and retain staff. Where rates of pay are higher in the private sector, it often leads to increased indirect expense due to increased turnover, vacancies and use of agency staff.

3.3 To take into account this variation in staffing costs, the staff MFF adjusts financial allocations to NHS organisations, by using variation in wages in the private sector within the direct geographic area as a proxy for the variations in NHS staffing costs. Statistical analysis of the Annual Survey of Hours and Earnings (ASHE) data identifies these geographic variations in private sector pay while taking into account other factors such as age, gender, industry and occupation.


Note: ROSEland is an abbreviation for “Rest of South East land” and is broadly equivalent to the area that receives Fringe High Cost Area Supplements. NHS minimum/maximum salaries shown include the minimum/maximum high cost area supplements as per the handbook, where appropriate. Error bars show the upper and lower quartiles.
3.4 The staff MFF calculations inform primary care trust (PCT) allocations, payment by results (PbR) – the mechanism that reimburses provider organisations for the quantity and types of care it provides – and payments for those services that fall outside of PbR.

3.5 Any move towards greater regional or local pay differentiation for Agenda for Change staff would have to be of benefit to local employers and patients. In view of financial challenges, any changes would need to be reflected in the NHS financial arrangements. There would need to be a clear mechanism which would see a meaningful link between funding and paybill costs.

3.6 In theory, if funding consistently falls short of staffing costs, it is ultimately likely to be reflected in reduced provision of patient services. Conversely, if any employer savings on staff costs derived from more market facing pay are reflected in reduced funding, the employer will receive no relative benefit, yet it may be detrimentally affected by the consequences such as increased turnover and difficulty recruiting. One method of achieving a strong relationship between staffing costs and financial allocations might be to take account of the staff MFF to determine the extent of geographical variation that might be needed outside of London and the fringe.

3.7 It is the balance, interplay and relationship between the funding arrangements, pay administration costs and the potential to destabilise labour movement at the borders of any regional or zonal pay system, that is most likely to concern employers who will be mindful of the impact getting this balance wrong will have on patient care.

3.8 Employers who are currently least aligned with their local labour markets are those that are likely to suffer most disruption in a move to more market facing pay. If an NHS organisation is required to increase its pay to meet market pressures it might ultimately make long-term savings through lower vacancies and turnover leading to increased productivity. However, any new savings would take time to materialise due to the expense of any new pay supplement.

3.9 The introduction of market facing pay may lead to unexpected consequences for some employers. This suggests the need for a gradual transition between the current pay mechanism and a more market facing pay approach to minimise these risks. The Chancellor announced in the Autumn Statement\textsuperscript{13} that the headline pay increases for public sector pay would be restricted to an average of one per cent in the two years following the pay freeze (2013/14 and 2014/15). This suggests there will be little scope for meaningful pay differentiation during these years.

3.10 Whether the approach to pay differentiation is regional or zonal, there are likely to be issues along the boundaries where there is a significant contrast between higher and lower paying areas or ‘cliff edges’. Staff who are within commuting distance of employers on both sides of the boundary, might be expected to opt for the employer offering the highest reward, making recruitment and retention very difficult for the employer on the lower paying side of the boundary. Any financial incentives offered in order to improve recruitment and retention could lead to ‘pay spirals’, where employers compete to retain staff in limited supply. Due to good transport links, proximity of employers and staff shortages, some employers outside of the inner London zone have already experienced this difficulty.

4. **Evidence of regional variations**

4.1 Figure 8 illustrates the extent of regional variation in employers’ experience of recruitment and retention. This variation goes some way to explaining the significant regional variations in HCAS and RRP usage. The regions in the north clearly experience lower turnover and vacancies than London and the surrounding regions.

**Figure 8 – NHS vacancies and turnover rates**

<table>
<thead>
<tr>
<th>Region/SHA</th>
<th>2011 NHS vacancies as a proportion of non-medical staff</th>
<th>Turnover October 2010 - October 2011 (non-medical staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>9.7%</td>
<td>7.3%</td>
</tr>
<tr>
<td>North West</td>
<td>9.0%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Yorkshire and Humber</td>
<td>8.9%</td>
<td>7.4%</td>
</tr>
<tr>
<td>East Midlands</td>
<td>8.6%</td>
<td>8.6%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>10.2%</td>
<td>8.0%</td>
</tr>
<tr>
<td>East of England</td>
<td>11.9%</td>
<td>8.8%</td>
</tr>
<tr>
<td>London</td>
<td>14.3%</td>
<td>9.7%</td>
</tr>
<tr>
<td>South East Coast</td>
<td>14.5%</td>
<td>8.9%</td>
</tr>
<tr>
<td>South Central</td>
<td>13.9%</td>
<td>9.6%</td>
</tr>
<tr>
<td>South West</td>
<td>13.0%</td>
<td>8.9%</td>
</tr>
</tbody>
</table>


**Note:** ASHE data is split by Government Office Region (GOR). Vacancy, Turnover and RRP Information is split by former Strategic Health Authority (SHA) boundaries. The South East GOR region is equivalent to the South East and South Central SHAs.
4.2 There is evidence that general levels of pay vary by region in the private sector. The Institute for Fiscal Studies (IFS)\textsuperscript{14} recently concluded that the public sector pays about 8.3 per cent more to comparable workers in the private sector. With the exception of the south east (where men earn 1.4 per cent less on average in the public sector than the private sector) there is a premium for working in the public sector across all regions (up to 18.3 per cent for women working in the north). Figure 9 illustrates the variation in private sector pay by government office region. IDS Pay analysis of the ASHE data concludes “that there continues to be little variation in pay outside of London and the south east”. This is clearly illustrated in Figure 9.

**Figure 9 – Private sector hourly gross earnings by government office region**

![Image of map showing hourly gross earnings by government office region]

**Data source:** Annual Survey of Hours and Earnings – 2011.

4.3 The IFS concluded that there were higher levels of NHS vacancies in the areas where there were higher levels of private sector pay. They commented that “this would be expected to affect the quality of public services”. This conclusion is supported by the vacancy and turnover data shown in Figure 8. NHS turnover and vacancy rates are highest in London and the south east, which broadly corresponds to the areas where private sector pay is highest.

4.4 Making generic comparisons between the pay of public and private sector employers is difficult due to differences in the skill mix, qualifications and roles of the two sectors. In the NHS, for example, some of the lower paid roles have been contracted out whilst the rest of the workforce is skewed to high skill graduate level roles.

4.5 It is of note that IFS’s primary explanation for this gap is that the public sector has been slower to respond to the recession starting in 2008 than the private sector. They predict that this gap will be eliminated by 2015 due to the pay freeze/restraint. Therefore going forward, the finding that the public sector apparently pays more than the private sector is likely to be of less significance than the regional differences.

5. Points for consideration

For greater regional or local pay differentiation in Agenda for Change we suggest that the following issues need consideration:

- A continued role for a national framework. Though some local NHS organisations can and may want to agree local arrangements. A central approach continues to be followed by large private sector national organisations.
- There would be need for a transparent methodology to rank each geographical area based on a range of economic and labour measures.
- There is a need for better information and data sources for future pay rounds.
- It is essential that any further pay differentiation should be balanced to NHS funding allocations.
- Any changes should avoid adding too much complexity to the national framework.
- Equal pay requirements limit the scope for much pay differentiation for staff within the same Agenda for Change pay band at employer level.
- Defining boundaries will be difficult. There are NHS organisations of all sizes, many of which are multi-site spread over large geographical boundaries. Regional and PCT boundaries are likely to end. NHS organisations near boundaries may find themselves at a competitive disadvantage for healthcare professional staff.

Our general conclusion is that the HCAS paid in London and parts of the south east, or a variation of it, could potentially be applied to other geographic parts of England where evidence justifies it. This would provide the scope for more market facing pay in Agenda for Change and would not require any change to the structure of the pay system.
Appendix A – NHS Employers market facing pay web survey

A survey was undertaken to collate employer opinions on market facing pay. The survey had 31 responses from employers, in addition to this survey we also gathered evidence from network meetings, group and one-to-one meetings and telephone calls. Responses primarily came from senior members of the HR, workforce, and payroll teams at acute, foundation, ambulance, SHA, and primary care trust organisations. Employer responses are summarised below.

Where narrative answers were provided, a number of quotes have been included to illustrate the range of employer views.

The survey revealed a range of diverse employer perspectives. We will be happy to seek further employer views when a specific proposal emerges.

1. How would you describe the labour market in which your organisation operates?

There was no common view from employers on the factors influencing their local labour market, which is reflective of regional variation in labour market conditions. Employers felt the desirability of the local area strongly affected the labour market, illustrating that labour markets are not only influenced by economic factors.

Other factors influencing the local labour markets included: ageing populations, car parking, mobility and travel, insufficient skills and proximity to higher paying or more desirable areas.

2. Which occupations are particularly influenced by local labour market pressures?

Nursing was the profession most frequently mentioned as being influenced by local labour market pressures. A wide range of other groups were mentioned in the free text response, but there were no other groups mentioned more than twice. Other groups include, ultra sonographers; pharmacists; midwives; admin and clerical; ancillary and support functions; allied health professionals; health visitors; the low paid; non-professional posts; senior management posts; locum medics in A&E; and doctors (non-Agenda for Change).

3. How do you respond to recruitment and retention difficulties?

Employers respond to recruitment and retention difficulties using a range of measures. Use of bank staff, agency staff and flexible working are widespread. Other measures included European/international recruitment, and investing in leadership development to make the organisation a desirable place to work.

4. Does Agenda for Change currently provide enough levers to allow you to address these issues?

There was no common view from employers on whether Agenda for Change offers sufficient flexibility to address recruitment and retention issues. The commentary included calls for increased local flexibility, as current rates were in some areas above the market rate, and in others insufficient to compete.
The example quotes below illustrate the range of employer views:

“It is a perfectly acceptable national framework. What is happening with local pay is that London & south east-centric model is being imposed on the rest of the country.”

“The AFC T&Cs do allow for sufficient factors in aiding R&R, although some aspects are not used in all applicable situations, such as LRRP.”

“Pays more than we need to in a number of areas.”

“As there is no local flexibility we have to find alternative strategies to attract applicants”

“More flexibility needed to ensure health can compete with social care market. Also to reward staff for achieving their objectives. Make it easier to move away from nationally agreed minimums where money saved could be invested in higher performers.”

“Agenda for Change can be too inflexible and not based upon ability as much as ‘time served.’”

“It is particularly inflexible around out-of-hours payments and performance based incentives.”

“The high cost supplement is not sufficient to compete with the disparity and inequity of wages in the local zone 1 central London labour market and we lose good staff to other sectors as a consequence of this shortfall.”

5. What national changes to Agenda for Change are needed to take account of local labour market factors?

“More comparable research could be done with local area to ensure that we are pitching ourselves at the right level.”

“The emphasis on labour market factors isn’t particularly relevant in this financial climate – it is the current paybill cost that A4C brings that is the issue.”

“None – it is working fine for us. The problems, costs and overheads are driven when such serviceable national frameworks are changed or abolished. It may not be perfect but the onus is on local organisations to use the tools already at its disposal.”

“HCAS needs to be re-assessed in some areas. The large pay gap from the inner London HCAS to regions where HCAS is not apparent creates a very large barrier to exiting the capital.”

“Issue locally is about competing in wider markets where the incremental pay scale approach makes the service expensive and reduces the ability to compete.”

“Weighting for high cost living areas outside of London.”

“Need to be able to offer more flexibility (reward) aligned to personal performance.”

“To consider economic factors e.g., expenses and cost of living.”

“Make it more flexible for new starters and less focused upon ‘years served’ and more focused upon ability.”

“Ability to flex standard pay points plus or minus 5 per cent.”

“The difference between regions, smaller cities and the high cost of living in London.”
6. What are the issues for employers associated with moving towards market facing pay: e.g. equity; lack of labour market information, insufficient/unsuitable financial levers?

“Equity; lack of labour market information, insufficient/unsuitable financial levers, so all of the above really. The information would need to be regularly reassessed (which would be a costly endeavour) and it may mean a ‘post code lottery’ that causes further poverty in some areas.”

“Equal pay claims, lack of labour market info on particular groups of staff.”

“Equality is a big issue in terms of what similar jobs are banded at in different NHS organisations regionally and nationally.”

“To fully attain the required information for pay bargaining is a time costly exercise, and to multiply this by the number of NHS organisations to aid local negotiations is ludicrous. We need to maintain national bargaining system, and uphold the original intentions of AFC to eliminate pay inequality.”

“Pay equity. Pay escalation. Robust criteria required to implement.”

“As an integrated health and care system the local organisations have to compete with organisations which operate outside of Agenda for Change and are finding it difficult to compete for contracts. Particular issues are the breadth of incremental scales, in some case the rates of pay but also the use of unsocial pay allowances.”

“Equal pay claims key risk given the history locally. Skill sets within the HR workforce having been subject to national arrangements for so long if the intention is to move to pay being set locally.”

“It could create a pay spiral with local trusts having to out-bid each other.”

“Poor IT systems to support market analysis.”

“Market intelligence particularly for non-clinical roles.”

“Insufficient/unsuitable financial levers.”

“Competition for labour with trusts on the borders of regions where pay may be different.”

“Insufficient financial levers; lack of local (and national) labour market information.”

“Inequity, make it more difficult in hard to employ areas, little perceived relationship between pay and local markets.”

“Lack of negotiating skills, lack of market knowledge, lack of employee relations skills, possibly lack of credible reps to negotiate with.”
### Appendix B – Areas receiving fringe high cost area supplements

The zones for high cost area payments are defined as inner London, outer London and fringe areas. These zones are based on the strategic health authority (SHA) and primary care trust (PCT) geographical boundaries that existed between 2004 and 2006, as set out below.\(^\text{15}\)

<table>
<thead>
<tr>
<th>SHAs</th>
<th>PCTs within SHAs</th>
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<tbody>
<tr>
<td>Kent &amp; Medway SHA</td>
<td>Dartford, Gravesham &amp; Swanley PCT</td>
</tr>
<tr>
<td>Essex SHA</td>
<td>Basildon PCT&lt;br&gt;Billericay, Brentwood &amp; Wickford PCT&lt;br&gt;Epping Forest PCT&lt;br&gt;Harlow PCT&lt;br&gt;Thurrock PCT</td>
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<tr>
<td>Bedfordshire &amp; Hertfordshire SHA</td>
<td>Dacorum PCT&lt;br&gt;Hertsmere PCT&lt;br&gt;Royston, Buntingford &amp; Bishop Stortford PCT&lt;br&gt;South East Hertfordshire PCT&lt;br&gt;St Albans &amp; Harpendon PCT&lt;br&gt;Watford &amp; Three Rivers PCT&lt;br&gt;Welwyn, Hatfield PCT</td>
</tr>
<tr>
<td>Thames Valley SHA</td>
<td>Bracknell Forrest PCT&lt;br&gt;Slough PCT&lt;br&gt;Windsor, Ascot &amp; Maidenhead PCT&lt;br&gt;Wokingham PCT</td>
</tr>
<tr>
<td>Surrey &amp; Sussex SHA</td>
<td>East Elmbridge &amp; Mid Surrey PCT&lt;br&gt;East Surrey PCT&lt;br&gt;Guildford &amp; Waverley PCT&lt;br&gt;North Surrey PCT&lt;br&gt;Surrey Heath and Woking PCT</td>
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NHS Employers

The NHS Employers organisation is the voice of employers in the NHS, supporting them to put patients first. Our vision is to be the authoritative voice of workforce leaders, experts in HR, negotiating fairly to get the best deal for patients.

We work with employers in the NHS to reflect their views and act on their behalf in four priority areas:

- pay and negotiations
- recruitment and planning the workforce
- healthy and productive workplaces
- employment policy and practice.

The NHS Employers organisation is part of the NHS Confederation.

Contact us

For more information on how to become involved in our work, email getinvolved@nhsemployers.org

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