The NHS Employers organisation's submission to the NHS pay review body 2012/2013

September 2011
Key messages to the NHS Pay Review Body

- The NHS will need to achieve unprecedented levels of efficiency savings of up to £20bn before 2014/2015 to meet growing demand. In view of the cost pressures, employers are increasingly concerned that the present national pay and conditions arrangements are not affordable. Restraining pay bill costs is essential to minimise potential job losses and protect services.

- The majority of provider organisations are facing cost reduction targets significantly in excess of the 4 per cent efficiency saving assumed in the 2011/2012 tariff. Some NHS foundation trusts are reporting targets as high as 9 per cent.

- NHS organisations share a concern to maintain quality service provision and to reduce the requirement for job losses, particularly compulsory redundancy. It was this concern which motivated the unsuccessful proposal to freeze increments in the NHS in return for no compulsory redundancies.

- Many employers are now seeking discussions with their staff representatives locally, which address reform of the pay system in light of their challenging financial context. Increasingly, employers are interested in how the Agenda for Change arrangements could be better aligned to performance and productivity.

- Employers are very concerned about the cost of the proposed minimum increase of £250 for lower paid staff. This will add around 0.4 per cent to the pay bill. The majority of staff earning under £21,000 will receive incremental pay increases during 2012/2013 worth around 3.3 per cent, ranging from £355 to £683 in addition to any increase that might be recommended by the pay review body. There are no particular labour market issues affecting this group of the workforce. NHS pay rates for this group remain competitive with other sectors.

- The Government has proposed increases to the employee contribution to the NHS Pension Scheme from 2012/2013. This is likely to affect staff earning over £15,000 per year. However, as pensions are deferred pay, this should not be used to justify any additional increase in pay rates.

- Recruitment and retention is generally improving across the country. Employers do not see any requirement for nationally set recruitment and retention premia and believe that local employers are able to respond to any issues if they should need to.
1. Introduction

1.1. The NHS Employers organisation welcomes the opportunity to submit our evidence for 2012/2013. We value the continuing 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. 2012/2013 will be the second year of the Government’s pay freeze for public sector workforces, except for those earning a full time equivalent of £21,000 or less. We note that the intention is that these lower paid staff will receive a minimum increase of £250 in 2012/2013.

1.3. In line with the revised remit, we have not submitted evidence in relation to general pay uplift. We have provided evidence to inform the NHS Pay Review Body’s consideration of the uplift for those groups of staff earning £21,000 or less. We are also providing an update on wider developments affecting the Agenda for Change staff group.

1.4. The NHS Employers organisation has been continuing a 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. We have held discussions at meetings of regional human resources directors, NHS Confederation and other employer networks. There has also been substantive discussion with the NHS Employers policy board and with employer representatives on the NHS Staff Council.

1.5. The context to this year’s pay review is set by the Government’s proposals to reform the structure of the NHS in England. The white paper Equity and excellence: Liberating the NHS, published in July 2010, sets out the most significant reorganisation of the NHS in its history with major implications for the workforce. Amid concerns about the proposals, the Government ‘paused’ the parliamentary process in April 2011 to listen to concerns about the Bill. The NHS Future Forum was established, chaired by Professor Steve Field. In June 2011, the forum made 16 overall recommendations to the Government, which accepted the recommendations and confirmed a more phased transition. On 20 June, NHS chief executive, David Nicholson published a refreshed timetable, which confirmed that all statutory changes due to occur in April 2012 would now not happen before July 2012. The Government’s revised plans continue to involve the abolition of strategic health authorities (SHAs) and primary care trusts (PCTs) and new commissioning and education and training arrangements. These changes will be introduced while the NHS strives to make efficiency savings of up to £20bn,
which includes a 45 per cent reduction in management costs by 2015. NHS organisations are expected to achieve these through the quality, innovation, productivity and prevention (QIPP) programme.

1.6. The messages contained in this submission have been endorsed by members of the NHS Employers policy board.
2. **NHS financial position**

2.1. Employers have identified finance and cost savings as one of their key priorities as the NHS will need to achieve unprecedented levels of efficiency savings of up to £20bn before 2014/2015. The focus on tackling the underlying increase in the costs and demand for healthcare, at the same time as managing one of the biggest reorganisations in its history, is a major financial challenge.

2.2. In October 2010, the Government’s spending review for the period 2011/2012 to 2014/2015 confirmed that the NHS budget would increase to £10.6bn over four years. This assumes reductions in management costs and productivity gains will release up to £20bn, which can be reinvested in front line services over the four year period. The Centre for Workforce Intelligence’s (CfWI) research into workforce and productivity asserts that “large cuts to administrative and managerial staffing costs can make a modest contribution to savings, but the most significant savings can be achieved by increasing the productivity and efficiency of existing resources. For example, savings can be made by adjusting skill mix.”

2.3. The NHS will need to achieve unprecedented levels of efficiency savings to achieve the £20bn before 2014/2015. The King’s Fund has estimated this to be a productivity gain of between 4 and 5 per cent per year. The payment by results tariff (PBR) assumes a 4 per cent efficiency saving over 2011/2012. A Health Service Journal survey of 131 acute trusts conducted in April found an average 6 per cent target. Monitor estimates that NHS foundation trusts are aiming to attain a 4.4 per cent reduction in operating costs through cost improvement plans in 2011/2012, as well as similar reductions in the ensuing two years. Some NHS foundation trusts have told us that they have to achieve cost improvement plans significantly higher than this of up to 9 per cent over the coming year. The cost of meeting automatic incremental pay progression is a factor which makes it more difficult for NHS trusts to achieve these challenging targets.

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2.4. To investigate efficiency savings in more detail, a sample of ten NHS foundation trusts was selected (see the Annex). The sample shows all have year-on-year plans to reduce operating expenses for the next three years by an average of 4.7 per cent. Examples include:

- An acute FT in the North West is seeking to save a total of 479 full-time equivalent posts by reducing patients’ length of stay.
- An acute FT in the South East is intending to reduce its full-time equivalent posts by an average of 73 per year using several measures such as minimising bank expenditure, and removing both vacancies and excess capacity.
- An acute FT in the South West is planning to remove the equivalent of about 250 posts using cost reductions such as sickness rather than post reductions.

2.5. Monitor also states that the percentage of planned savings for 2011/2012 that relate to staff costs (61 per cent) is slightly less than the average proportion of trusts’ staffing costs (67 per cent). It surmises that foundation trusts should maintain high standards of patient care as before, but that they are aiming to achieve the savings by improving productivity on the front line and by decreasing administrative or clerical costs.5

2.6. The most recent NHS Confederation members’ survey6 gathered responses from 287 chief executives and chairs from 243 organisations. Key messages from the survey were:

- 42 per cent of members said that the financial position facing their organisation was the “worst they had ever experienced” while an additional 47 per cent said it was “very serious, but not the worst experienced”.
- 70 per cent of members thought that the current financial challenges would get worse in the short term (the next 12 months), while 67 per cent thought it would get worse in the medium term (over the next three years).
- 13 per cent of members expected an overspend in 2011/2012 (although 62 per cent of these are expecting it to be no more than 2 per cent). In comparison, the Audit Commission found that only 9 out of 276 organisations (3.3 per cent) failed to achieve financial balance7.

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2.7. By 2014/2015 the overall costs of the “NHS superstructure” is required to reduce by a third. This includes the existing primary care trusts and strategic health authorities to save on average 45 per cent of management costs.

2.8. There are high levels of unavoidable pressure on NHS finances from increasing demands for new technology, structural reforms and productivity. So within this settlement, the NHS faces a difficult mix of pressures and will have to work very hard to minimise the impact on services. Achieving more will be immensely difficult while delivering a major programme of structural reform.

2.9. The Department of Health impact assessment puts the total cost of the changes to the “system architecture” required by the Health and Social Care Bill to be between £1,001m and £1,478m. These costs are assumed to be incurred predominantly in 2011/2012 and 2012/2013 when SHAs and PCTs are due to be abolished. This includes an estimated £195m already spent on redundancies.

2.10. While employers tell us that they will make every effort to protect front line services, the changes that will be required are so significant that there is likely to be an impact on front line services, even if it is possible to restrain earnings. Employers are concerned about containing pay costs within the tariff, particularly in light of the in-built incremental cost of the NHS system, which is accentuated by current low turnover.

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3. Affordability of Agenda for Change pay and conditions

3.1. Employers are becoming concerned that the present national pay arrangements in their current form are not affordable, at least in the short term. The incremental pay provisions in the Agenda for Change agreement added around 2 per cent to the pay bill of NHS organisations during 2011/2012, with a similar increase in incremental provision intended for 2012/2013. In addition to this, the uplift of £250 for the lowest paid staff resulted in a further 0.4 per cent to the pay bill for non-medical staff. Despite the Government’s two year pay freeze, the aggregate effect of the £250 uplift and Agenda for Change increments for those earning under £21,000 approximately equates to 2.4 per cent of the pay bill in each year of the pay freeze. This cost pressure seriously risks the achievement of cost improvement plans and makes it more difficult to minimise redundancies.

3.2. The affordability of any increases in earnings continues to dominate the thinking of employers in the NHS in England. Employers have told us that the pay freeze will not be sufficient to restrain the growth of the pay bill and employment costs and that further cost reductions in national pay and conditions are required to protect jobs. Employers have consistently told us that any increases in pay bill costs will be unaffordable unless fully funded through the Payment by Results (PBR) tariff. Cost pressures from increased earnings from whatever source will not be affordable and savings will need to be found elsewhere from efficiencies or reductions in service or both.

3.3. Many provider organisations have told us that there needs to be more local flexibility in the national agreements. In addition to concerns about the cost of incremental pay progression, a number of employers have said that existing national conditions of service in relation to sick pay and enhancements for unsocial hours are in need of review. Others have argued for a clearer performance/productivity link to incremental pay progression. The current situation, where staff receive an incremental pay uplift for no extra productivity increases unit costs and will make it more difficult for NHS provider organisations to compete in the light of the “any qualified provider” policy. As a result of this many employers are now seeking local discussions with staff and staff representatives about pay and conditions of service in the context of the

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9 It appears that the proportional cost of the £250 uplift for Bands 1–4 (0.4 per cent of the Agenda for Change pay bill) is the same as the cost of giving increments to Bands 1–4 (also 0.4 per cent of the Agenda for Change pay bill). In reality, the cost of increments for Bands 1–4 is actually higher than the cost of the £250 uplift, but due to rounding they appear to be the same. Using a higher level of precision for the estimates would not be appropriate given the number of variables in the calculation.
challenging financial situation.

3.4. In parallel with these local discussions, employer representatives are continuing discussions with unions on the NHS Staff Council about the scope for changes to national agreements to make them more affordable and flexible. Employer representatives have been putting the case for changes to terms and conditions, these include issues around incremental progression, extension of the working day, rate of sickness pay and annual leave provision.
4. **Staff earning under £21,000**

4.1. The NHS Pay Review Body has been given a remit to make a recommendation on the pay uplift for employees earning £21,000 or less. This relates to the basic salary of a full time equivalent employee and does not include overtime, recruitment and retention payments or high cost area supplements.

**Affordability**

4.2. Employers have told us that they are very concerned about the cost pressure that is likely to arise if the pay increase is not funded through the PBR tariff and other funding mechanisms. Under the national pay scales, employees on points 1–15 earn under £21,000. The minimum increase of a flat rate £250 to the relevant pay points will add circa 0.4 per cent to the Agenda for Change pay bill for each of the two years of the pay freeze.

**Level of pay – progression available**

4.3. We estimate that 350,000 full time equivalent (FTE) (36 per cent of the non-medical workforce) have a basic salary of under £21,000. Employees who are not at the top of their pay band will benefit from the incremental pay progression that is part of the Agenda for Change pay system. Around 64 per cent of employees in the affected pay bands will receive pay increases as a result of pay progression during 2011/2012, equating to a total of 0.4 per cent of the Agenda for Change pay bill, and are set to do the same in 2012/2013. Increases as a percentage of basic salary at the start of the year range between 1.8 per cent (Band 4 – point 15) and 3.7 per cent (Bands 2 and 3 - point 7). Table 1 details the amount an individual’s salary will increase through one year of incremental pay progression.
Table 1. Value of annual incremental pay progression by pay point

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<tr>
<th>Pay Point</th>
<th>Increment Value 2011/12</th>
<th>Value of incremental pay progression by point</th>
<th>Value of incremental pay progression by point as % of basic salary</th>
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Table 2. Value of annual pay progression by pay point including incremental progression and £250 uplift

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<tr>
<th>Pay Point</th>
<th>Increment Value 2011/12</th>
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<th>Value of incremental pay progression by point as % of basic salary</th>
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4.4. Table 2 details the amount an individual’s salary would increase through one year of incremental pay progression and the minimum uplift of £250. Of those pay
points that receive the uplift, increases would range between 3 per cent (Band 4 point 15) and 5.2 per cent (Bands 2 and 3 – point 7). Those at the top of their pay band would receive a 1.7 per cent, 1.5 per cent, and 1.3 per cent increases on their salary respectively.

Recruitment and retention/labour market for those earning under £21,000

4.5. Employers report that turnover levels have shown reductions in each year since 2007. The shortage of alternative jobs (both inside and outside the NHS) following the recession is likely to be the key reason that turnover has decreased. Where there are job vacancies, fewer of these are “long-term”, i.e., they remain unfilled for three months or more. In the wider job market, Jobcentre Plus live unfilled vacancies have fallen from April 2010 to April 2011 for occupations equivalent to those in bands 1 to 4, such as secretaries, receptionists, public sector administrative and officers, housekeepers and caretakers.

4.6. NHS pay rates continue to be competitive with other sectors. The graph below based on data from Income Data Services (IDS) shows the average salaries for the largest Band 1–4 occupations in the NHS compared to other organisations (where equivalent occupations exist). Although the average NHS salary is lower than the median salary for administrative officer staff, it is greater than the median salary for both clerical workers and support workers, and is in the top 25 per cent of salaries for healthcare assistants.
4.7. The minimum NHS pay rate is currently £7.11, well ahead of the statutory national minimum wage of £6.08, which is effective from 1 October 2011. Taking these factors into account, employers do not think that on labour market grounds there is a need to make adjustments to the lower levels of the national pay structures.

**Need to avoid ‘leapfrogging’**

4.8. We would ask the NHS Pay Review Body to ensure that any changes they recommend do not result in “leapfrogging” of those earning just under £21,000 with those earning just over. This can happen where there are differential increases across the pay structure. As a result of your last review, pay points were increased by £250 for 2011/2012.

4.9. If the NHS pay review body was minded to recommend an increase for those staff earning under £21,000, employers would again favour a simple flat rate payment of £250 for 2012/2013 rather than any additional restructuring. We would not be supportive of any form of taper with a higher uplift at the bottom as this would add unnecessary additional cost. It is acknowledged that increasing the relevant pay points by the flat £250 would mean that the gap between point 15 and point 16 would be only £122. This compression of pay points would erode differentials in the pay structure and would have to be considered by the parties following the period of the pay freeze.

**Employer conclusions**

4.10. Employers are very concerned about the affordability of any growth in the pay bill but understand that the Government is seeking a minimum pay uplift of £250 for this group. There are no particular labour market problems affecting this group and NHS pay rates remain competitive. Most of this group of staff may benefit from incremental pay progression. We are not aware of any evidence to support a recommendation above the minimum rate for any of the relevant employees. If a uplift is to be made, this should be the minimum as a flat rate on relevant pay points. An increase of £250 on relevant pay points would add circa 0.4 per cent to the pay bill.

4.11. The Government has proposed increases to the employee contribution to the NHS Pension Scheme from 2012/2013. This is likely to affect staff earning over £15,000 per year. Pension contributions are deferred pay so it would not be appropriate that this be used to justify any additional increase in pay rates for this group.
5. Developments in the NHS Staff Council

Discussions on pay increments

5.1. NHS organisations are committed to maintaining quality service provision and to reducing the need for job losses, particularly compulsory redundancies. It was this concern which prompted the employer proposal for a national enabling agreement that would have allowed local partnerships to freeze pay increments for all staff, in exchange for certain commitments on compulsory redundancies. Trade unions rejected this proposal in January 2011.

5.2. The proposed enabling agreement allowed for employers to decide whether to seek agreement locally on an increment freeze. In exchange for a two-year freeze on pay increments for all staff, the deal offered a guarantee of no compulsory redundancies for NHS staff on Agenda for Change pay bands 1–6. This would have guaranteed job security for 82 per cent of all NHS staff and, given the savings that a freeze would have generated, offered considerably improved job security for all other staff. The NHS Employers organisation continues to believe that the proposal represented a balanced and realistic way of helping maximise employment and avoid costly redundancies.

5.3. The cost of employing people can be up to 70 per cent of all local employer expenditure. Without savings being made on pay and/or conditions of service, the reality is that there will be compulsory redundancies and some employers will have no choice but to consider the scope to make changes to terms and conditions locally, to minimise job losses and protect patient services.

Knowledge and Skills Framework

5.4. Since our last review in 2010, the new simplified guidance *Appraisals and KSF made simple – a practical guide* has been published. It gives employers and staff a flexible, adaptable tool to support the appraisal process. Its key features include a simple process for carrying out performance appraisal and development reviews using a simplified KSF with sample forms and templates to use and adapt locally. The new material has been broadly welcomed by employers across the service.

5.5. We were therefore encouraged by the latest NHS Staff Survey results, which show a continuing improvement in the percentage of staff who had an appraisal in the last 12 months: 77 per cent of staff in 2010 (an increase of 8 per cent). We also welcomed the increase in the percentage of staff who had a well-structured
appraisal (from 31 per cent in 2009 to 34 per cent in 2010)\textsuperscript{10}.

5.6. We hope that the new guidance, with its focus on appraisals and development, will continue to drive up appraisal rates in 2011 and position the benefits of appraisal and KSF in context – as a key driver for helping to deliver organisational objectives, the NHS Constitution pledges and QIPP.

**Review of on-call**

5.7. NHS employing organisations have been reviewing their on-call payment arrangements in line with the framework of enabling principles, which was agreed by the NHS Staff Council. The Council issued further guidance to assist organisations that were not able to complete their reviews before the protection of on-call arrangements ended on 31 March 2011. From that date all action on on-call payments has been for local determination.

**Independent review of Agenda for Change National Recruitment and Retention Premia**

5.8. The NHS Staff Council’s independent review of the Agenda for Change National Recruitment and Retention Premia (NRRP) was undertaken by the Institute for Employment Studies (IES). The IES report to the NHS Staff Council recommended that all NRRP should cease after 31 March 2011, or be converted to locally agreed pay supplements where appropriate. The parties on the NHS Staff Council subsequently negotiated a two-year transition where existing payments to individuals would be phased out by March 2013. This meant that new starters would not be entitled to the NRRPs from April 2011.

**Contribution for clinical registration fees**

5.9. Following a review by the NHS Staff Council, the £38 contribution to the cost of clinical registration fees that had been payable to individuals in Band 5-8a in England was ended. The cost of these payments had been circa £16m per annum. There was a clear employer view that this allowance could not be justified on grounds of cost as well as concerns about equity.

\textsuperscript{10} Care Quality Commission, *Briefing Note: issues highlighted by the 2010 NHS staff survey in England*, www.cqc.org.uk/ db/ documents/NHS_staff_survey_nationalbriefing_final_for_DH.pdf
Equality and diversity toolkit

5.10. The NHS Staff Council’s equality and diversity subgroup developed a web-based toolkit to help employers meet their obligations under equality legislation. It is designed to support employers by providing key information by pay bands and allows organisations to analyse their workforces in a number of different ways. It includes detailed guides on procedure, best practice examples and links to breakdowns of workforces within NHS organisations by age, disability, ethnicity, religion or belief, and sex or sexual orientation within pay bands. Identifying and addressing any discrimination or bias which may occur in pay and terms and conditions is a legal obligation laid down by the public sector Equality Duty. This requirement is already met by Agenda for Change, but these new tools will help managers continue to ensure that equality is supported robustly and efficiently. The toolkit was developed with the support of the Equality and Human Rights Commission and the NHS Information Centre. The toolkit was launched on 8 August 2011 and can be accessed through the NHS Employers organisation website.
6. Recruitment and retention: general

6.1. In general the recruitment and retention position across the NHS has improved with turnover rates reducing. According to the 2011 XpertHR staff turnover rates and costs survey\textsuperscript{11}, public sector turnover (12.6 per cent) in 2010 was still considerably lower than that of the private sector (17.4 per cent), even taking redundancies into account. The voluntary redundancy rate was also lower in the public sector (8.2 per cent) compared to private sector services (10.6 per cent). More recent information from the NHS Information Centre showed that the leaving rate for all NHS staff, excluding bank, locums and trainee doctors, was 8.3 per cent (based on headcount of leavers between May 2010 and May 2011)\textsuperscript{12}. Employers do not consider any targeted action on pay at national level is necessary to address recruitment and retention issues. Local employers are best placed to understand local labour markets.

6.2. Non-medical full-time equivalent staff numbers fell from 958,923 in May 2010 to 943,398 in May 2011, a difference of 15,525 (1.6 per cent). There were reductions in full-time equivalent staff numbers between May 2010 and May 2011 for the majority of staff groups, with the exceptions of qualified midwives (up 493 to 20,625, a difference of 2.5 per cent); qualified ambulance staff (up 86 to 17,814 in, a difference of 0.5 per cent); and most scientific, therapeutic and technical staff groups (up 1,939 in total to 131,641, a difference of 1.5 per cent).\textsuperscript{13}

6.3. We have told you in the past that employers have not been persuaded of the need for a national recruitment and retention payment for junior pharmacists. Employers have told us that a “one size fits all” solution would be unlikely to resolve pharmacy recruitment problems and would not represent good value for money. This remains our view. Any new national payment would place additional financial pressure on NHS organisations at a time when resources available to the NHS and the wider economy are tightened and efficiency requirements increased and would have a direct impact on local pharmacy budgets. We understand the recruitment and retention position of pharmacy staff has improved. According to the most recent NHS Pharmacy Staffing Establishment and Vacancy Survey, Band

\textsuperscript{11}www.personneltoday.com/articles/2011/07/18/57795/public-sector-turnover-rates-indicate-restraint-from.html 247 employers were surveyed


6 pharmacist posts in England that remained vacant for three months or more decreased from 19.7 per cent in May 2009 to 11.2 per cent in May 2010. All but two SHAs (South Central and South West) saw their three-month vacancies for Band 6 pharmacists decrease between May 2009 and May 2010.\textsuperscript{14} In addition, an analysis of applications and vacancies data for Band 6 pharmacists from NHS Jobs showed that the average number of applications for each Band 6 pharmacy and pharmacologist post increased from approximately 24.5 in 2010 to approximately 31.5 to 2011.\textsuperscript{15}


\textsuperscript{15} NHS Jobs applications and vacancies data, Jobsite. 2010 data based on vacancies created between 1 January 2010 and 31 August 2010. 2011 data based on vacancies created between 1 January 2011 and 31 August 2011
7. NHS pensions and total reward in the NHS

NHS Pension Scheme

7.1 The value of the NHS Pension Scheme is an important element of the total reward package. It compares well to pensions offered to comparable occupations outside the NHS. The employer contribution of 14 per cent is a significant part of earnings for NHS Pension Scheme members.

7.2 The contributions made by employees reflect the benefits structure and the cost of providing benefits. The contribution rates reflect a balance between current pay and deferred pay. The current NHS Pension Scheme (NHSPS) is a defined benefit occupational scheme linked to salary.

7.3 Benefits for most staff in the 1995 Section of the NHSPS are based on 1/80th of pay for each year of service it includes: a separate lump sum, life assurance, ill health, partner and dependent benefits. Unreduced pensions are payable at the normal pension age of 60, based on the best of the last three-years’ service. Since April 2008, most staff can increase their separate lump sum payment by commuting some of their pension.

7.4 Regulations came into effect from 1 October 2009 to allow all contributing members of the 1995 Section of the Scheme a choice to either remain in the 1995 Section or to transfer their accrued service to the 2008 Section of the Scheme (described as the NHS Pension Choice Exercise, which will end March 2012). The 2008 Section, open to new entrants since April 2008, has a normal pension age of 65, a 1/60th pension (1.87 per cent accrual for self-employed practitioners) no automatic lump sum, but members are able to commute part of their pension in order to secure a lump sum payment. Pensions in the 2008 Section are based on an average of the best three consecutive years’ service in the last ten years.

Reform of public sector pension schemes

7.5 From April 2011, the Consumer Price Index (CPI) rather than the Retail Price Index (RPI) is used for the price indexation of public service pensions.

7.6 For the future, the Government announced in June 2011 proposals to implement many of the recommendations of the Hutton review of public sector pensions. These include linking the public sector retirement age to the state pension age, increasing contributions from employees and moving from a final salary pension...
scheme to one based on career average. The Government also outlined its commitment to:

- protect the accrued rights of current pension scheme members
- retain a defined benefit scheme for public sector employees
- phase in any increase to employee contributions over three years
- protect the lowest paid, with no increase to those earning below £15,000 and no more that a 1.5 per cent increase for those earning below £18,000.

7.7 In July, the Government announced how it intends to proceed with plans to increase public service employee pension contribution in 2012/2013 and launched a consultation for changes to the NHS Pension Scheme. The consultation will cover increased employee contributions for 2012/2013, approximately 40 per cent of the 3.2 per cent the Government has decided is necessary to meet the Spending Review commitments. The consultation ends on the 21 October 2011.

7.8 This consultation is being undertaken separately to the Government’s response to the Hutton Review, which is expected in the autumn.

**Total reward**

7.9 The NHS Employers organisation recognises that the need to maximise the value of the NHS’s employment proposition has never been greater. The introduction of a two-year pay freeze, coupled with the reform of public sector pensions, reinforces the requirement to ensure that employees are fully aware of the total value of their pay and benefit packages.

7.10 The requirement to consider an employee’s total package rather than just their salary is reflected in the NHS Operating Framework for 2011/2012. In light of this the Department of Health is progressing:

- the introduction of annual benefit statements (ABS) for all staff during 2012, which will show the value of personal and family related pension benefits
- the introduction of a total reward statement during 2012 for those staff on the NHS’s Electronic Staff Records system (ESR), which will detail the overall reward package including pay, pension and other financial benefits, (for example, additional earnings such as overtime payments, annual leave, redundancy benefits and so on) and non-financial benefits (for example, learning and development opportunities, occupational health support services and so on).
7.11 The NHS Employers organisation believes that there is a compelling narrative for employers to develop a more coherent approach to total reward across the NHS. This includes linking basic pay and additional earnings, pensions, voluntary benefits, work-life benefits and employers’ commitment to learning and development into the total reward concept and welcomes the work of the Department of Health in this area.

7.12 The NHS Employers organisation strongly believes that the general NHS reward package remains highly competitive and is a valuable retention and recruitment tool. The current package includes:

- pay rates which compare favourably with rates on offer in related labour markets for similar jobs
- competitive overtime payments
- a generous final salary pension (with accrued rights protected as part of the Government’s pension reform agenda)
- maximum annual leave entitlement of 41 days’ holiday (compared with 28 days statutory entitlement)
- sick pay entitlement for most staff based on six months half and six months full pay
- occupational maternity pay
- service-related entitlement to redundancy pay of up to two years’ salary.
### Annex

**Summary of cost improvement plans for ten foundation trusts**

<table>
<thead>
<tr>
<th>Type of Trust</th>
<th>Strategic Health Authority</th>
<th>Operating Expenses (£m) less PFI Expenditure (£m)</th>
<th>CI% of Operating Expenses less PFI Expenditure</th>
<th>Planned Reduction in WTE posts</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>East Midlands</td>
<td>Actuals 2010-11: 101.3 2011-12: 149.6 2012-13: 161.5 2013-14: 159.2</td>
<td>3.5% 5.4% 4.3% 4.4%</td>
<td>Planned review of Agenda for Change T&amp;Cs to develop options to reduce cost base to minimise reductions in workforce numbers, incentives and awards (including salary sacrifice schemes and incentive schemes) to be developed.</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>East of England</td>
<td>Actuals 2010-11: 185.0 2011-12: 235.5 2012-13: 275.4 2013-14: 269.2</td>
<td>4.9% 4.9% 4.8% 4.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>London</td>
<td>Actuals 2010-11: 340.2 2011-12: 339.9 2012-13: 327.1 2013-14: 317.6</td>
<td>4.0% 3.0% 3.6% 2.8%</td>
<td>Potential for redundancy costs. Proposals for structures are to be developed, consulted upon and implemented.</td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>North East</td>
<td>Actuals 2010-11: 717.5 2011-12: 776.3 2012-13: 754.6 2013-14: 745.8</td>
<td>4.5% 4.0% 4.1% 4.1%</td>
<td>Cost improvement plan to be achieved mainly through: deletion in posts; non-pay savings; and improved productivity and changes to tariff. Details as to how many posts are to be deleted are not available.</td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>North West</td>
<td>Actuals 2010-11: 214.8 2011-12: 212.0 2012-13: 209.8 2013-14: 206.2</td>
<td>5.6% 6.1% 5.4% 4.7%</td>
<td>Cost improvement plan to be achieved mainly through: savings generated from productivity and operational efficiency; directorate/department-led schemes and central-led schemes.</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>South Central</td>
<td>Actuals 2010-11: 160.6 2011-12: 253.1 2012-13: 239.4 2013-14: 233.7</td>
<td>3.2% 4.5% 4.2% 4.1%</td>
<td>The efficiencies obtained through length of stay reduction will enable a reduction in the bed base whilst maintaining the safety and quality of services. This will enable the Trust to achieve a head count reduction as well as a reduced non-pay budget and reduced overheads.</td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>South East</td>
<td>Actuals 2010-11: 206.7 2011-12: 261.2 2012-13: 197.1 2013-14: 193.7</td>
<td>4.4% 5.6% 4.0% 4.1%</td>
<td>Cost improvement plan to be achieved mainly through service redesign in several departments and back office reviews in procurement, corporate efficiency, facilities and estate rationalisation.</td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>South West</td>
<td>Actuals 2010-11: 325.4 2011-12: 216.8 2012-13: 305.3 2013-14: 299.2</td>
<td>5.2% 5.1% 5.9% 5.6%</td>
<td>Approximately 220 in total (averaging approximately 78 per year) Posts are to be reduced by decreasing bank and agency expenditure; reorganising departments and restructuring of departments; vacancy removal and removing excess capacity.</td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>West Midlands</td>
<td>Actuals 2010-11: 214.8 2011-12: 233.2 2012-13: 280.1 2013-14: 227.9</td>
<td>2.4% 4.7% 2.5% 2.8%</td>
<td>Deliver pay savings equivalent to £250 (wte) per annum (maybe cost rather than post reduction e.g. sickness reduction).</td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>Yorkshire and the Humber</td>
<td>Actuals 2010-11: 303.2 2011-12: 311.0 2012-13: 303.5 2013-14: 296.7</td>
<td>5.1% 5.0% 4.7% 4.5%</td>
<td>Budgeted WTE of 3,980 WTE in April 2011 will reduce through the transformation programme to 3,745 WTE by the end of 2013/14. Reduction in staffing costs by 5% across the Trust, year-on-year.</td>
<td></td>
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</tbody>
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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 manage employer negotiations with the NHS trade unions on pay, pensions and terms and conditions. On behalf of primary care trusts, we lead on specific contract negotiations for GPs and dentists and are involved in contract discussions on community pharmacy.

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

1. pay and negotiations
2. recruitment and planning the workforce
3. healthy and productive workplaces
4. 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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