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Health and Adult Social Care Overview and Scrutiny Panel

Wednesday 26 September 2012

PRESENT:

Councillor Mrs Aspinall, in the Chair.
Councillor Monahan, Vice Chair.
Councillors Mrs Bowyer, Gordon, James, Mrs Nicholson, Parker, Jon Taylor and Tuffin.

Apologies for absence: Councillors Fox and Dr. Mahony.

Also in attendance: Councillor Bent (Torbay Council), Councillor Parsons (Cornwall Council) and Councillor Westlake (Devon County Council).

The meeting started at 10.00 am and finished at 3.00 pm.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

34. DECLARATIONS OF INTEREST

The following declarations of interest were made in accordance with the code of conduct -

Name	**Minute Number and Issue**	**Reason**	**Interest**
Councillor J Taylor	Minute No. 36 and 37 SW NHS South West Regional Pay	NHS Employee	Personal
Councillor Parker	Minute No. 36 and 37 SW NHS South West Regional Pay	Member of the National Public Services Committee (GMB)	Personal
Councillor Aspinall	Minute No. 36 and 37 SW NHS South West Regional Pay	Retired Member of the Royal College of Midwives	Personal

35. CHAIR'S URGENT BUSINESS

There were no items of Chair's urgent business.

36. SOUTH WEST PAY, TERMS AND CONDITIONS CONSORTIUM

The panel's lead officer advised the panel that the South West Pay, Terms and Conditions Consortium were unable to send a representative to the meeting. Members were given a short

briefing on the purpose of the consortium and referred to the discussion documents and frequently asked questions contained within the agenda papers.

37. NHS SOUTH WEST REGIONAL PAY - WITNESS SESSION

A. PLYMOUTH HOSPITALS NHS TRUST

The panel heard from Ann James, Chief Executive of Plymouth NHS Hospitals Trust. Ms James reported that –

(a) the Consortium was a group of 20 health trusts identifying opportunities to standardise practice;

(b) the Trust Board and management team were aware of the anxiety and distress caused to staff and had set up a dedicated line to Ms James where staff could raise their concerns;

(c) whatever proposals were made by the consortium, they would need to be approved by the Trust Board;

(d) no decisions would been taken without due consideration of all alternative options;

(e) 63 per cent of the Trust's income was spent on wages which equated to around £230million per year, if there were no changes made to pay, terms and conditions the wage bill would increase by a further £7million in 2013-14;

(f) every work day there was approximately 230 people absent across the Trust which cost in the region of £7million per year, there were many reasons for absence and the Trust worked with staff to address them;

(g) all alternative options to changes to pay, terms and conditions would be explored with decisions being made in an open and transparent manner;

(h) the consortium would continue to meet and would be providing feedback to the Trust on a regular basis, a business case was expected before the end of the calendar year;

(i) Ms James was committed to high quality patient care and would ensure that staff were involved and views taken into account when the Trust made decisions regarding changes to pay, terms and conditions.

In response to questions from the panel it was reported that –

(j) the Trust Board would be advised on possible opportunities for shared services and alternative service delivery in order to

make informed decisions when considering any proposals regarding pay, terms and conditions. Although the Trust experienced a large amount of sickness absence, care needed to be taken on how sickness absence was addressed, particularly in an acute hospital setting;

(k) the Trust was disappointed with staff survey results which put the Trust in the bottom 20 per cent of Trusts with regard to engagement with staff. There was work taking place to address the problem. Although current discussions on pay, terms and conditions may impact on staff morale, the financial situation could not be ignored and all options had to be explored;

(l) all areas of the public sector were dealing with issues of this nature and the Trust Board would take full responsibility for any final decisions made regarding pay, terms and conditions. The Trust was not in a position to choose efficiency savings over changes to pay, terms and conditions and had to explore both;

(m) consistency in pay, terms and conditions would allow for improved recruitment and retention;

(n) the approach would be open and transparent. The Trust was aware of the large contribution they made to the economy of the city and the sub region;

(o) staff were still providing excellent care to all patients, staff were aware of discussions regarding changes to pay , terms and conditions but their priority remained patient care;

(p) there were some services for which the Trust struggled to recruit. A long term plan for recruitment would be developed. There were not any definitive proposals for outsourcing; the current situation was unsettling for staff and the Trust would ensure that staff were being engaged. The Trust did not want to prolong the uncertainty about pay and the future direction of the hospital;

(q) that many clinicians believed that that model of a large acute Trust providing a wide range of services was out dated and needed to change rapidly with more services delivered in the community and the need for hospitals to shrink. The Trust needed to be engaged in that debate. The Health community needed to provide the right service at the right size in the right place and the Hospital would need to carefully consider its future place in the new health system;

(r) the Trust recognised its role in health care in Devon and

Cornwall and would ensure fairness across the 'bigger patch'. No proposals had been put forward by the consortium and when proposals were made the Trust Board would consider the impact on services and staff morale;

(s) all staff across the Trust were included in the consortium's discussions, including managers;

(t) the Trust would be required to make approximate savings of £40 million over two years. The Trust would be reviewing plans in place and arrangements with commissioners;

(u) with regard to national 'Agenda for Change' negotiations the board would need to discuss and express a view on those negotiations. Pay, terms and conditions needed to be sustainable for staff and services.

The panel thanked Ms James for her attendance and contribution.

B. PLYMOUTH UNIVERSITY

Dr Sue Kinsey, Associate Professor in HR Management, reported to the panel that –

(a) the rationale on which regional and local pay systems were seen as a positive change rested on private / public pay comparisons and the crowding out hypothesis. There was very little evidence to support the crowding out hypothesis and a lack of research evidence from private employers;

(b) regional / local pay systems should not be considered when systems were in financial crisis;

(c) private / public sector pay comparisons did not take account of the different occupational markets and the public sector work force profile. Private sector best practice had been advocated without understanding public sector contexts;

(d) there was a wealth of research on performance related pay in the public sector which had shown there had been adverse and unintended consequences;

(e) evidence suggested that where pay bargaining became more fragmented greater inequalities developed across genders, ethnic minorities and between the top and bottom of organisations;

(f) pay changes were deemed a blunt instrument for increasing productivity, sustainable performance required positive working climate and effective and supportive management.

In response to questions from members of the panel, it was reported that –

(g) there was a wealth of research on the 'public sector ethos' and how it had been eroded over a number of years;

(h) consultation did not equal engagement. Top down consultation was often an information giving exercise rather than effective engagement;

(i) pay inequality was at its lowest when national pay and conditions existed;

(j) it was notoriously difficult to put a financial value on an effective, sustainable workforce. It had been difficult to prove that Human Resources interventions resulted in measurable outcomes;

(k) key to the morale of the workforce was a positive psychological contract. Key threats to morale included risks to job security and changes to terms and conditions. Change management theory suggested that effective consultation was key, although this could be seen as 'sugar coating' what was unpalatable;

(l) there was a need to enhance the employees ability to contribute to any organisation. Workers should be engaged in discussions on job descriptions, service redesign and management of absence. Staff should feel to contribute to the best of their ability and enable them to give their best efforts.

The panel thanked Dr Kinsey for her attendance.

C. ROYAL COLLEGE OF MIDWIVES

The panel welcomed John Skewes, Director of Employment Relations and Development at the Royal College of Midwives (RCM). Mr Skewes reported that –

(a) the RCM was involved in the inception of the Agenda for Change (AFC), the NHS pay system. It had replaced a myriad of terms and conditions;

(b) the AFC was based on job evaluation, increasing fairness and removing discrimination. The system was based on a knowledge and skills framework monitored through an appraisal system, however eight years after the instigation only 66 per cent of staff received an appraisal;

(c) efficiency gains would not be achieved, unless system redesign was implemented. The Consortium's approach was 'salami slicing';

(d) pay clearly had a role in the Nicholson challenge of £20bn productivity and efficiency savings across the NHS, however the cost of pay in the South West relatively lower than in the rest of the country;

(e) the Chancellor had asked the pay review bodies to look at the concept of regional pay and the issue of crowding out. 99 per cent of midwives worked in the NHS and were not likely to crowd anyone out;

(f) the Consortium proposals would result in a 15 per cent cut in take home pay, there were already pay cuts in real terms with pension contributions increasing;

(g) the RCM were engaging in a review of the 'Agenda for Change'. NHS employers had engaged with proposals and consultation had shown that members wished to continue to negotiate the 'Agenda for Change'. There were savings which could be made to sickness and unsocial hours payments. the RCM would not negotiate with the Consortium as it was felt that they could not be engaged fully in simultaneous negotiations.

In response to questions from the panel it was reported that –

(h) the impact of NHS regionalised pay on the local economy would be huge;

(i) there was a view that the RCM would not be flexible which was inaccurate as some of Consortium proposals were sound;

(j) a consistent approach to a comprehensive appraisal system was required across the NHS system. Managers needed to be aware of the importance of the appraisal system. Down banding of some posts had already started to take place and savings should be realised over the next few years;

(k) negotiators were close to agreement with regard to the AFC.

The panel thanked Mr Skewes for his attendance.

D. ROYAL COLLEGE OF NURSING

The panel welcomed Helen Hancox, Project Lead for the Campaign Against SW Pay Cartel, Royal College of Nursing (RCN). It was reported that –

(a) South Devon Healthcare had not joined the Consortium. The Trust was highly rated and won a number of awards. The Trust had not joined as it is was not deemed right for patients and not right for staff;

(b) the RCN did not believe that changing the terms and conditions was the answer to the financial challenge. Although it was accepted that services needed to be delivered differently this could be done by addressing procurement and other related activities;

(c) the RCN believed that their members were the easy target. In general Nursing was not a militant profession. Ms Hancox reported never having heard so many members talk about a specific subject;

(d) there were demotivated and demoralised staff throughout the NHS. RCN members on average gave 7 hours a week extra, if forced to work 40 hours a week staff would work to rule;

(e) the Consortium's discussion documents were ill conceived and do not have costing against them;

(f) with regard to levels of sickness it needed to be recognised that nurses typically had higher rates of sickness because of the hours they worked and the type of work they carried out. Shift workers were more unlikely to be unwell and suffer obesity. Women that worked regular night shifts have more prevalent rates of breast cancer;

(g) PHNT did not have a good staff survey results. Although Ms Hancox was reassured by the statements provided by Ms

James, it was requested that the panel note that the trust had 11 of the 38 staff survey indicators in the "worst 20 per cent" category and that attacking terms and conditions would not improve these scores.

In response to questions from the panel, it was reported that –

(h) not all sickness was stress related but working shifts made people ill, clinicians inevitably got unwell because of the environments in which they work;

(i) staff told the RCN that they were demotivated and demoralised. Many staff said if changes to pay and conditions resulted in a staff contracts being terminated before implementation staff would not re-apply;

(j) staff retention and recruitment would be severely hampered by proposals for regional pay. Currently 25 per cent of nurses on the Peninsula were over 55. The recent intake of student nurses at Royal Cornwall Hospital Treliske was only 80 students. Trusts were required to recruit from abroad from countries such as Portugal and the Philippines;

(k) many organisations were seeing a downward shift in the available skill mix;

(l) for some staff the change to pay, terms and conditions would result in work not paying. Many staff would choose to work with agencies as terms were often better. Some Trusts were already spending four times as much on agency staff then previously;

(m) Services provided by Specialist Nurses were being eroded. The RCN believed that specialist nurses would go elsewhere to acheive better remuneration;

(n) there was already a huge reliance on agency staff at the Royal Devon and Exeter Hospital. Temporary agency staff were employed for weeks with accommodation and travel expenses paid. If regionalised pay had the anticipated impact on recruitment and retention this situation would worsen.

The panel thanked Ms Hancox for her attendance.

E. BRITISH MEDICAL ASSOCIATION

The panel welcomed Richard Griffiths, Industrial Relations Manager, British Medical Association (BMA). Mr Griffiths reported that –

(a) the BMA was well aware of the challenges facing the NHS, nationally, regionally and in Trusts locally. It remained the policy of the BMA to resist any erosion of terms and conditions of service. Any proposal which sought to undermine the application of national terms and conditions for doctors in the NHS was rejected as an inappropriate way of attempting to save costs and would not gain support at local or regional level;

(b) any attempt to diminish the terms and conditions currently applicable to medically qualified staff in the SW region would be counter-productive and a dangerous and unnecessary diversion for Trust Managers at a time when the cooperation and commitment of medical staff was an absolute necessity to the success and survival of many Trusts;

(c) whilst Trusts may wish to consider all the options available to them, the BMA strongly recommended that trusts concentrated on identifying operational savings through better management of existing resources rather than make attacks on the terms and conditions of members. It was not the terms and conditions which were the problem, but how they were managed;

(d) the BMA was not prepared to enter into any discussions with Trusts, either individually or collectively, by region or sub region, if proposals were detrimental to nationally agreed terms and conditions;

(e) the BMA would strenuously resist any attempts to undermine nationally negotiated terms and conditions at both local and regional levels;

(f) the BMA was prepared to be and had been actively involved in assisting Trusts to better manage the terms and conditions of medical staff at a local level;

(g) the BMA had seen the "Local Pay Compressor" suggestions of the Consortium in relation to Medical Staff and was struck by the poverty of thought with many of the suggestions amounting to unworkable proposals that had previously been rejected by both the Employers and BMA at national level;

(h) the dangers associated with all of the proposals far outweighed the benefits and the Trusts in the south west

should engage with Medical Staff through the established local negotiating committees to facilitate improved management of existing resources rather than attacking the terms and conditions in an attempt to get changes that simply will not be delivered but may end up being extremely destructive.

In response to question from members of the panel it was reported that –

(i) there would undoubtedly be a negative impact on patients;
(j) the proposals for medical staff would not deliver significant savings. Medical staff needed to be engaged in how to move organisations moved forward and deliver a 'best practice' organisations, those discussing possible proposals clearly had little experience in clinical management;

(k) the process that the consortium had embarked on was tactically inept. All trusts needed to consider the challenges that faced them. The terms and conditions debate had diverted attention away from the important work of service redesign.

The panel thanked Mr Griffiths for his contribution.

F. PLYMOUTH HOSPITALS NHS TRUST JSNC

Suzy Franklin representing the Derriford Hospital Joint Staff Negotiating Committee was welcomed to the meeting. Ms Franklin reported that unions had seen a significant rise in staff approaching them for advice and that it was felt that management were unable or unwilling to engage staff in the issue of regional pay.

In response to questions from the panel Ms Franklin reported that Union members had become aware of the Consortium and developing regional proposals following a Consortium press release. The work of the Consortium had damaged relations between staff and management but the Unions felt reassured that Ms James as the incoming Chief Executive would be working to address this.

The panel thanks Ms Franklin for her contribution to the meeting.

G. PLYMOUTH CHAMBER OF COMMERCE

The panel welcomed Carolyn Giles, representing the Plymouth Chamber of commerce. Carolyn reported that –

(a) there was a need to recognise that the Consortium were not just working on pay changes but that a number of options

were being considered;

(b) the AFC was not affordable and probably never had been. The pay system was out of step locally and the Local Economic Partnership had shown that NHS pay was 8-13 per cent higher than in the private sector;

(c) the NHS had to make changes and one of those options could result in a high level number of redundancies, less pay could be seen as a palatable alternative to no pay;

(d) should there changes to pay, terms and conditions there could be a significant impact on the money spent in the local economy;

(e) there was an excellent calibre of clinical staff working at Derriford. The result of regional pay could mean that more mobile members may not be retained by the Trust;

(f) issues around employee relations were a significant factor. If staff were to engage in industrial action it would have a significant impact on the private sector;

(g) AFC required urgent review and the management of existing term and conditions properly implemented;

(h) if regional pay was implemented it could lead to the loss of approximately £1.2bn from the regional economy.

In response to questions from members of the panel it was reported that –

(i) the implications of the implementation of regional pay in the South West would be felt across all sectors;

(j) it was not necessarily the case that the private sector would be able to fill the gap of job losses. There would be an element of competition through the 'Any Qualified Providers';

(k) any changes would have an impact, whether they are serious or significant depends on what proposals are accepted and implemented. A reduction in pay would undoubtedly have an impact;

(l) any drop in income of public sector workers would damage the income of small business and services. Tough decisions needed to be made.

The panel thanked Carolyn for her contribution to the meeting.

H. RECOMMENDATIONS

Following deliberations based on agenda papers and the testimony of the witnesses who attended the meeting, the panel agreed to recommend –

1. to Plymouth Hospitals NHS Trust (PHNT) that all staff are fully engaged in the consultation of any changes that affect them and their views demonstrably taken into account;

2. that PHNT formally considers the impact of any local pay scheme on the recruitment and retention of staff, particularly those with specialist skills;

3. that PHNT formally considers the impact of any local scheme on the city and sub-regional economy;

4. that the South West Pay, Terms and Conditions Consortium formally seeks the views of other key public sector employers in Plymouth and the sub-region as part of the wider consultation process;

5. that the South West Pay, Terms and Conditions Consortium and PHNT formally considers improved productivity, management and service redesign as an alternative to altering pay and conditions;

6. that PHNT ensures the existing appraisal and supervision arrangements are carried out with 100% of staff;

7. the panel notes the expenditure of seven million pounds on sickness absence within PHNT and requests the trust to produce an effective sickness/absence management strategy;

8. that PHNT formulates and publishes a response to the challenges raised in the staff survey;

9. that PHNT return to a future meeting of the panel to discuss progress against the above recommendations.

38. EXEMPT BUSINESS

There were no items of exempt business.

APPENDIX (Pages 1 - 4)

The case against a local and regional approach to pay, terms and conditions in the NHS

The BMA is opposed to any moves way from national terms and conditions of service for NHS staff. Such moves would have a significant negative impact on the NHS, staff and patients.

A national approach to contract negotiations for NHS staff is both efficient and fair. Any move to local and regional bargaining on pay and other terms and conditions of service (T and Cs) will lead to:

- the shared values and culture of the NHS being undermined
- additional costs through inefficient use of resources
- a demoralised workforce
- recruitment and retention problems
- over-complexity and inefficiency in the NHS labour market
- a reduction in service to patients

Furthermore, this issue is a costly and time consuming distraction from serious attempts to address the huge financial challenges facing the NHS. Rather than focusing resources on short-term measures that will incur additional costs and demoralise the NHS workforce, the emphasis should be on allowing staff and managers to work together on initiatives to improve quality and efficiency of service to patients.

Background

National pay, T and Cs in the NHS
Historically, the NHS' approach to determining pay and other T and Cs has been through regular national negotiations between Government, NHS management and the trade unions. Most recently, national contracts have been negotiated for the various components of the medical and dental workforce, whilst Agenda for Change is the national contract for most non-medical and dental NHS staff. Agenda for Change is the current NHS grading and pay system for all NHS staff, with the exception of doctors, dentists and very senior managers.

The benefits of a national system are clearly outlined in the Handbook to the NHS Constitution for England:

National pay policy for the NHS is designed to provide fair, affordable pay in order to recruit, retain and motivate staff for the benefit of patients and to provide value for money for taxpayers. It also provides a range of flexibilities, such as the opportunity for recruitment and retention premia, to ensure that individual employers have the ability to respond effectively to local circumstances, while retaining a consistent national pay framework that is transparent and ensures equal pay for work of equal value.

However, in the Chancellor's Autumn Statement in November 2011, it was announced that the independent Pay Review Bodies would be asked to consider how public sector pay can be made more responsive to local labour markets. In the health sector this included Agenda for Change staff but not doctors and dentists.

Developments in south west England

In summer 2012, 20 NHS trusts in south west England established themselves as the South West Pay, Terms and Conditions Consortium.

The trusts involved in the consortium are:

- Dorset County Hospital NHS Foundation Trust
- Poole Hospital NHS Foundation Trust
- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
- Gloucester Hospitals NHS Foundation Trust
- Great Western Hospitals NHS Foundation Trust
- North Bristol NHS Trust
- North Devon Healthcare NHS Trust
- Plymouth Hospitals NHS Trust
- Royal Cornwall Hospitals Trust
- Royal Devon and Exeter NHS Foundation Trust
- Royal United Hospital Bath NHS Trust
- Salisbury NHS Foundation Trust
- Taunton and Somerset NHS Foundation Trust
- University Hospitals Bristol NHS Foundation Trust
- Weston Area Health NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust
- 2gether NHS Foundation Trust
- Devon Partnership NHS Trust
- Somerset Partnership NHS Foundation Trust
- Dorset HealthCare NHS Foundation Trust

The consortium is looking to break away from national pay, T and Cs with a view to making substantial savings in order to meet the 'Nicholson Challenge'' of saving the NHS £20 billion by 2015.

The consortium's discussion document Addressing Pay, Terms and Conditions makes it clear that all staff, including medical and dental, are included in the scope of its work.

Proposals include:

- A 5% pay cut for staff earning over £55,000
- Increasing working hours and reducing annual leave
- A 'last resort' of terminating existing contracts and re-employing staff under new terms
- For senior hospital doctors, a reduction in Supporting Professional Activities - protected time to work on non-clinical activities that deliver improvements to quality and efficiency.

The consortium acknowledges that national negotiations are taking place for Agenda for Change staff but claims that progress is too slow, and there is no option but to look at making changes locally or regionally. The consortium will not be producing its business case for its proposals until the beginning of October and it is proposed that discussions in individual trusts will continue until end of 2012 and beyond.

The implications of these developments are considerable, as other regions across England could follow a similar path if definite moves are made to adopt local and regional pay and other T and Cs in the south west.

In August 2012, the BMA and other health unions, including the Royal College of Nursing and UNISON, refused to recognise the consortium, making clear that any talks on the pay and T and Cs for their members should continue under the recognised and well established national machinery.

Why a local and regional approach to pay and T and Cs in the NHS would waste resources

It would be inefficient

- The well-established machinery for national bargaining in the NHS ensures an efficient and cost-effective approach to negotiations on pay and T and Cs
- A model where different parts of the NHS negotiated separately would be wasteful, with duplication of effort, more bureaucracy and greater inefficiency

It would undermine the shared ethos of the NHS

- Staff on different pay and T and Cs in different geographical areas would no longer have the same sense of working for the a singe, integrated service
- It would be unfair and inequitable that staff doing the same job as colleagues elsewhere in the country should be paid less or have different terms of service
- It would be another step towards the fragmentation of the shared values and culture of the NHS, which is already under attack from wider changes to the NHS which seeks to increase the use of 'market forces'

It is short-sighted and undermines the benefits of clinical leadership

- What the consortium is proposing is very short-sighted. For example – one possibility that has been raised is a cut to consultants' Supporting Professional Activities –specially funded time they can devote to initiatives to improve quality. The projects that consultants work on in this time frequently improve productivity and save the NHS money

It could create local recruitment and retention problems

- Regional pay differences could result in migration of doctors to other areas with better pay offers
- Demoralised staff may also choose to leave the NHS or retire early, which would compound local retention difficulties and impact on patient services
- Regional pay will cause additional problems for juniors doctors who during the start of their career rotate regularly between different posts across geographical boundaries – if pay, terms and conditions vary greatly, it will cause unnecessary uncertainty and confusion, and potentially undermine their training
- Hospitals everywhere should be able to recruit and retain high-calibre staff. In a model where pay varies between regions, there is a risk that employers in

some areas would not be able to compete for staff on a level playing field with centres of excellence in big cities because these centres could offer more attractive remuneration. There could well be an impact on patient services if high-calibre staff could not be recruited or retained.

It would demoralise staff and lead to more industrial unrest

- Staff detrimentally affected by any imposed changes to national pay and T and Cs will be angered and demoralised, particularly after recent changes to the NHS pension scheme
- This could lead to a prolonged period of poor industrial relations, which would be a further distraction from the challenges of improving the delivery of care in a context of increasing restrictions on resources

It is unevidenced

- There is no clear evidence that introducing regional pay and T and Cs in the public sector would deliver greater efficiency or long-term savings. Indeed, the £200,000 already spent by the 20 Trusts on setting up the consortium could have been better spent on improving patient services

It could increase regional variations in clinical quality

- Many elements of national contracts for doctors were put in place with clinical quality in mind. Moving away from national contracts could risk greater variations in clinical quality for patients

There could be an impact on local economies beyond the NHS

- Worsening terms and conditions for healthcare staff could have an impact not just on the NHS, but on local economies more widely.