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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

Date: Wednesday 26 September 2012
Time: 10 am
Venue: Council House

Members:
Councillor Mrs Aspinall, Chair
Councillor Monahan, Vice Chair
Councillors Mrs Bowyer, Fox, Gordon, James, Dr. Mahony, Mrs Nicholson, Parker, Jon Taylor and Tuffin.

Members are invited to attend the above meeting to consider the items of business overleaf.

Members and officers are requested to sign the attendance list at the meeting.

Bob Coomber
Interim Chief Executive

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

AGENDA

PART I – PUBLIC MEETING

1. APOLOGIES

To receive apologies for non-attendance by panel members.

2. DECLARATIONS OF INTEREST

Members will be asked to make any declarations of interest in respect of items on this agenda.

3. CHAIR'S URGENT BUSINESS

To receive reports on business which, in the opinion of the Chair, should be brought forward for urgent consideration.

4. SOUTH WEST PAY, TERMS AND CONDITIONS CONSORTIUM **(Pages 1 - 44)**

5. NHS SOUTH WEST REGIONAL PAY - WITNESS SESSION

5.1. PLYMOUTH HOSPITALS NHS TRUST

5.2. ROYAL COLLEGE OF NURSING **(Pages 45 - 54)**

5.3. ROYAL COLLEGE OF MIDWIVES

5.4. BRITISH MEDICAL ASSOCIATION

5.5. PLYMOUTH HOSPITALS NHS TRUST JSNC

5.6. PLYMOUTH CHAMBER OF COMMERCE

5.7. PLYMOUTH UNIVERSITY

6. EXEMPT BUSINESS

To consider passing a resolution under Section 100A (4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following item(s) of business on the grounds that it (they) involve(s) the likely disclosure of exempt information as defined in paragraph(s) of Part 1 of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000

PART II (PRIVATE MEETING)

AGENDA

MEMBERS OF THE PUBLIC TO NOTE

that under the law, the Panel is entitled to consider certain items in private. Members of the public will be asked to leave the meeting when such items are discussed.

NIL.

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South West Pay, Terms and Conditions Consortium – Frequently asked questions

Source: http://meetingthechallenge.info/

What is the south west pay, terms and conditions consortium?

The consortium comprises 20 NHS trusts and foundation trusts and has been established in response to the serious financial and clinical service challenges facing the NHS, both now and in the future.

The consortium's steering group is responsible for identifying how taxpayer funding may be more efficiently used in order to protect both employment and the continued delivery of high quality healthcare, which includes looking at the pay, terms and conditions of all staff.

Why has it been established?

The consortium believes that the NHS' largest expenditure – the workforce – must be better designed to reflect the needs of each organisation in maintaining and building on high quality health services, whilst recognising and rewarding hard working and high performing staff.

Pay, terms and conditions form a significant and growing part of the financial challenge facing NHS organisations, despite the Government's two year freeze, which ends after this financial year, and an announcement to cap annual pay increases at an average of one per cent for the next two years.

For example, an average sized trust with a turnover of £200m will see its expenditure on pay increase by more than £3m per year from 2013/14. As a result of these and other cost pressures, including reduced income, Monitor (the independent regulator of NHS foundation trusts) has estimated that organisations of this size will need to produce savings of around £9m a year for each year until 2016/17 to remain in good financial health.

The aim of the consortium is to provide greater security for health services and staff, with an affordable pay, terms and conditions system that recognises and rewards performance, promotes greater productivity, and creates a flexible workforce responsive to changing patient needs that is fit for purpose in the modern NHS.

Can these challenges be met by current cost improvement or savings plans, or by working more efficiently?

The consortium believes the challenges outlined earlier cannot be successfully met without more innovative ways of achieving efficiencies and maximising productivity being examined, whilst protecting and continually seeking to improve patient care. It is in everyone's interest – staff, patients, and employers, local health economies – to find ways to support a

financially sustainable NHS. As a result, viable organisations are in a much stronger place to protect jobs and patient services.

Therefore the consortium will be looking at how overall workforce costs could be reduced, whilst maintaining a transparent and fair system that is better able to reward high performance and support the continued delivery of high quality healthcare.

What happens if these challenges cannot be met?

NHS organisations throughout England, including consortium members in the south west, are facing enormous financial and service challenges now and over the coming years.

The consortium believes that without exploring changes to the current pay, terms and conditions frameworks, employers will have little option, in addition to other cost improvement schemes, other than to reduce workforce numbers to a level which potentially undermines the sustainability of high quality services for our patients.

What remit does the consortium have?

The consortium will develop a full business case, which will detail the challenges facing the NHS in the south west, and suggest and evaluate options which could help meet them over the medium-term.

The full business case is anticipated to be completed by the end of this calendar year which will then be presented for consideration and decision at each consortium member's trust board.

As part of its preparation of the business case, the consortium will also seek to engage with the relevant trade unions. The consortium has no authority or power to introduce any changes – it will only set out potential options and make recommendations for individual trust boards to consider consulting on with their own staff representatives.

What is the role of trust boards?

Every trust board will consider carefully and decide individually whether it wishes to consult locally on and progress any of the recommendations set out in the business case.

Why is the consortium looking at staff pay, terms and conditions?

As outlined earlier, staff pay makes up more than two thirds of total expenditure each trust spends each year. Pay, terms and conditions continue to form a significant part of the financial challenge facing NHS organisations, even allowing for the Government's two year pay freeze, which ends in this financial year, and the recently announced proposal to cap annual pay increases for the next two years at an average of one per cent.

While many cost improvement programmes at trust-level have successfully addressed the use of expensive agency or bank staff, or reduced pay bill costs by utilising the normal turnover of staff as they leave or retire, and service improvement projects have generated some very welcome efficiency and cost savings, current and future financial and operational challenges are such that these are simply not enough.

Each trust must find more innovative ways to ensure staff are rewarded and recognised, while preserving high quality services for our patients. The work of the consortium aims to support each trust to consider these innovative solutions while safeguarding employment and high quality services for the future.

I have read and heard that there are proposals in place to reduce pay by up to 15 per cent, and reduce sickness absence leave, among others. Are these true?

The consortium has not put forward any proposals at all, therefore statements of this kind are not true.

These types of headlines are based on documents which list the kinds of areas that might be looked at in any review of pay, terms and conditions, and certainly do not constitute firm plans or decisions. These documents were written in order to start a discussion at a regional level amongst interested trusts about what might be consulted upon with staff.

The consortium's business case, which is anticipated to be completed before the end of 2012, will set out potential options for consideration for change which each trust board will then consider whether they wish to consult upon or progress locally.

Can trusts dismiss and re-engage staff on to new pay, terms and conditions, as I've read and heard about?

Under employment law, this option is available to employers, including those in the NHS, but only after attempts to reach agreement on any changes have been exhausted. However consortium trusts are in agreement that it is neither desirable nor necessary, and will do all that is possible to avoid this.

Should trust boards formulate proposals for new pay, terms or conditions, each individual organisation will work hard to proactively engage and consult with staff and representatives to seek agreement.

Is the consortium advocating blanket pay cuts for staff?

No. The consortium steering group is looking at a wide range of possible options that may help to provide greater security for health services and staff, with an affordable pay, terms and conditions system that recognises and rewards performance, promotes greater productivity, and creates a flexible workforce responsive to changing patient needs that is fit for purpose in the modern NHS.

One of these possible options includes looking at a pay reduction – it should be stressed that the consortium and member organisations believe that such a measure is unnecessary and undesirable.

Is the consortium looking at Agenda for Change staff only?

No. it is important to understand that the consortium will look at the pay, terms and conditions for all staff groups, which includes medical and dental staff and senior managers (including chief executives).

My trust reported a financial surplus last year. Why should we be part of the consortium?

Some trusts in the South West did report a surplus in 2011/12. The consortium believes that the financial and service delivery challenges facing individual trusts are greater than the surpluses each organisation will be able to produce in the years ahead. Therefore there is a need for all member organisations to explore ways in which savings can be found, including looking at how pay, terms and conditions can play a part in this.

One of the possible options in the 'addressing pay, terms and conditions' discussion paper includes reducing the length of the working week. If this was introduced, does that mean fewer patients would be cared for by member trusts?

While efficiencies in how the NHS is run and operates cannot bridge the savings gap alone, they can play an important role in supporting this. By using the latest technologies, more effective medicines and procedures, working more collaboratively (including with partner organisations and community services) and removing waste as far as possible, the NHS is more productive than ever. By safeguarding employment by avoiding redundancies, it may be possible to reduce the working week whilst maintaining current and planned-for activity levels.

In common with all other potential options outlined in this document, it is included to promote debate and discussion.

Why has the consortium been established when there are already national negotiations taking place on changes to terms and conditions under Agenda for Change?

The consortium is fully supportive of the national discussions between employer representatives and unions which have been taking place for more than 18 months and are looking at modernising the current Agenda for Change system of terms and conditions.

Each Trust, and the consortium, will be monitoring progress of these talks with great interest. Each consortium member is keen to see these talks succeed and produce

amendments to current pay, terms and conditions which will support each Trust in meeting the significant financial and service challenges outlined earlier in this document.

The consortium believes that rather than watch these negotiations from a distance, it can and should work in parallel while these discussions take place to provide the best opportunity to be sustainable organisations in the years ahead.

It is also appropriate that, in response to the unprecedented challenges the NHS faces outlined earlier, the consortium explores the possibility of achieving efficiencies through changes to the terms and conditions of other staff groups beyond those working under Agenda for Change.

Why isn't the consortium talking to unions?

Regrettably, to date, key unions have indicated they are unwilling to discuss the scope of the project whilst national negotiations are ongoing.

The consortium's steering group chair was invited by the Social Partnership Forum in the south west, at which representatives from every major union meet with employers on a regular basis, to discuss the project in early July. This invitation was subsequently withdrawn.

All participating trusts are totally committed to working with staff and local unions throughout the period in which the full business case is produced, and beyond. Staff engagement is essential in all matters as this improves the quality of any decisions made and promotes understanding and knowledge.

It should be noted that each member organisation is keeping its local union representatives informed of any developments concerning the consortium.
The consortium remains willing and committed to meeting with the relevant unions as part of efforts to engage fully with staff and representatives.

Will trusts engage with staff?

Each trust welcomes, and is committed to, constructive engagement with staff and representatives. Any amendments to terms and conditions must be properly and formally consulted on, and each trust will seek to work closely with staff and representatives should this be necessary. It is important to reiterate that no proposals have been put forward or decisions made.

Prior to any consultation that may arise, each trust – recognising the anxiety some of the reporting of the work of the consortium may have created – has undertaken to provide staff with regular updates on the work of the consortium, through documents like this FAQs, staff briefings by senior managers and newsletter or bulletin updates.

If a trust is interested in any of the recommendations by the consortium to consider varying a staff group's terms and conditions, a formal consultation process will begin whilst these considerations are at a formative stage and before any decisions are made – engaging with staff is an essential part of this process.

We welcome thoughts and ideas from staff, through their employer or union representative, on any proposals they feel may support financially sustainable organisations.

Can trusts implement changes without talking to staff?

No. Each trust must consult with staff-side and staff on any proposals that involve their pay, terms and conditions.

The consortium says that by examining pay, terms and conditions, 6,000 NHS jobs in the south west can be safeguarded over the next three years. Does this mean that 6,000 jobs are currently at risk in the region?

No. This example was used to help illustrate and quantify the scale of the challenge facing member trusts in the south west. In light of these challenges, and without exploring innovative ways of reducing expenditure, for example changes to the current pay, terms and conditions frameworks, employers may have little option, in addition to other cost improvement schemes, than to consider reductions in the workforce.

By supporting sustainable organisations, member trusts will be in a much stronger place to protect jobs and patient services.

Is this review connected with the current national proposal on pension reform?

No. There is no direct relationship, and the consortium is not looking at pension changes. However, there are inevitably connections between pay, terms and conditions and pensions.

I've heard that some parts of the public sector are looking at changing pay to reflect where staff live – is the consortium looking at proposing this?

No. The Government announced in the Budget earlier in the year that it was asking the pay review body to consider how the national public sector pay systems could better take account of local and regional labour market pressures. The suggestion was that this would allow the national pay systems to pay more to staff working in those areas where the cost of living is higher and certain skills are in high demand.

The consortium's review of pay, terms and conditions is entirely separate to this national review.

What is the difference between a consortium and a 'cartel', as I have heard the south west pay terms and condition consortium referred to as?

It is inaccurate to refer to the consortium as a 'cartel'.

According to dictionaries, a consortium is a group of organisations working together towards a common aim. A cartel is a group of organisations who join together in order to manipulate a market, for example by controlling prices or limiting competition.

The consortium is solely motivated by the desire to provide the best services for patients, promote job security and offer rewarding careers, whilst living within available resources.

Each trust has paid £10,000 to join the consortium – what will this be used for?

In order to secure professional advice, for example legal support that is not readily available in the NHS, each member of the consortium has agreed to contribute £10,000 towards the project's costs. This will also cover the appointment of an external advisor and project manager, as well as administration. It is important that this programme of work is appropriately resourced and has access to expert opinion and guidance. By working together in this way, this project can be run far more efficiently and at a lower cost than by twenty organisations working separately on their own.

Who has joined the consortium?

The consortium now comprises 20 NHS trusts from the south west:

- Poole Hospital NHS Foundation Trust
- Dorset County 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
- Northern 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

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DISCUSSION DOCUMENT

SOUTH WEST PAY, TERMS AND CONDITIONS CONSORTIUM

ADDRESSING PAY, TERMS AND CONDITIONS

BACKGROUND

The South West Pay, Terms and Conditions Consortium ["SWC"] was established in June 2012 with sixteen participating NHS employers. The SWC now has twenty participants involving NHS foundation and NHS trusts from acute, teaching, mental health and community health care sectors. The SWC has been set up to produce a full business case by the end of the calendar year in order to quantify the current and future economic, financial and service challenges, and in turn consider how best to create a "fit for purpose" set of pay, terms and conditions. This discussion paper has been produced as part of SWC's wider scoping exercise in producing a business case and to assist considerations about how best to address current and future pay, terms and conditions for all NHS staff groups. The SWC does not have the authority, responsibility nor mandate to engage in negotiations, as sovereignty rests with the individual participating trusts.

CONTENTS

1. INTRODUCTION

This discussion paper has been written for the SWC Steering Group in order to assist it in its production of a full business case. This paper does not include any recommendations and does not represent any proposals or decisions regarding pay, terms and conditions. It has been designed to be read alongside the accompanying paper which quantifies the economic, financial and service challenges facing the participating NHS employers. While this paper is wide-ranging, any mention of potential changes does not mean that decisions have been taken to pursue them or that an assumption has been made that they will be pursued by the individual member trusts. The SWC remains committed to achieving a "fit for purpose" set of terms and conditions through national negotiations.

This paper will also be considered alongside further papers on the legal issues related to potential positions which the SWC might take in the future and an assessment of the options on how best to manage any potential changes. A further paper will examine the long list of options which will be included in the full business case. No decisions will be taken until the finalisation of the full business case.

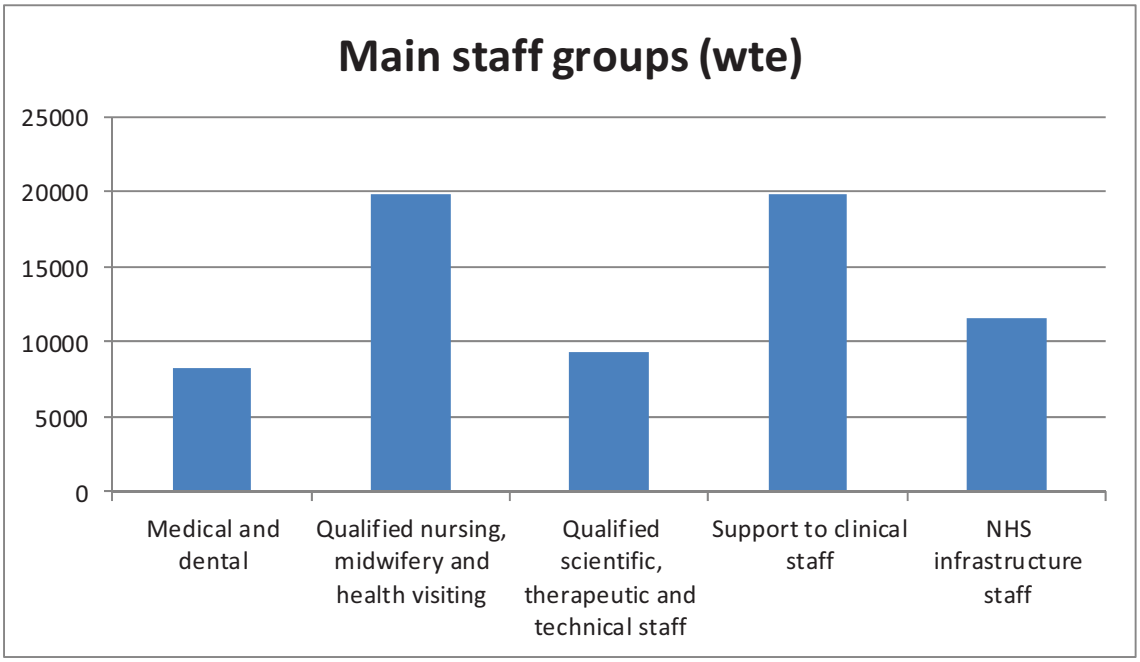
This paper addresses the context related to NHS pay and conditions, constructs the principles which will determine the SWC's approach to future pay reform, considers a long list of potential labour cost compressors, examines the potential costs and timelines related to individual compressors, poses a series of questions and compiles a list of useful references.

2. SWC WORKFORCE PROFILES

Twenty NHS employers have joined the SWC, representing the vast majority of NHS staff working in the South West region. Set out below is a summary of the principal staff groups which make up the well over 68,000 employees and a graph setting out the numbers of staff by individual participating NHS employer, split between medical and non-medical staff. Assuming an average full employer cost of £40,000 per employee, the total cost of this workforce is £2.8bn. This represents around 7% of the total NHS workforce in England.

The NHS workforce as a whole across the South West region has grown by over 20% in the period 2001-2011 (on average by 2.3% per year). During 2010/11 the total workforce was reduced by 1.1%.

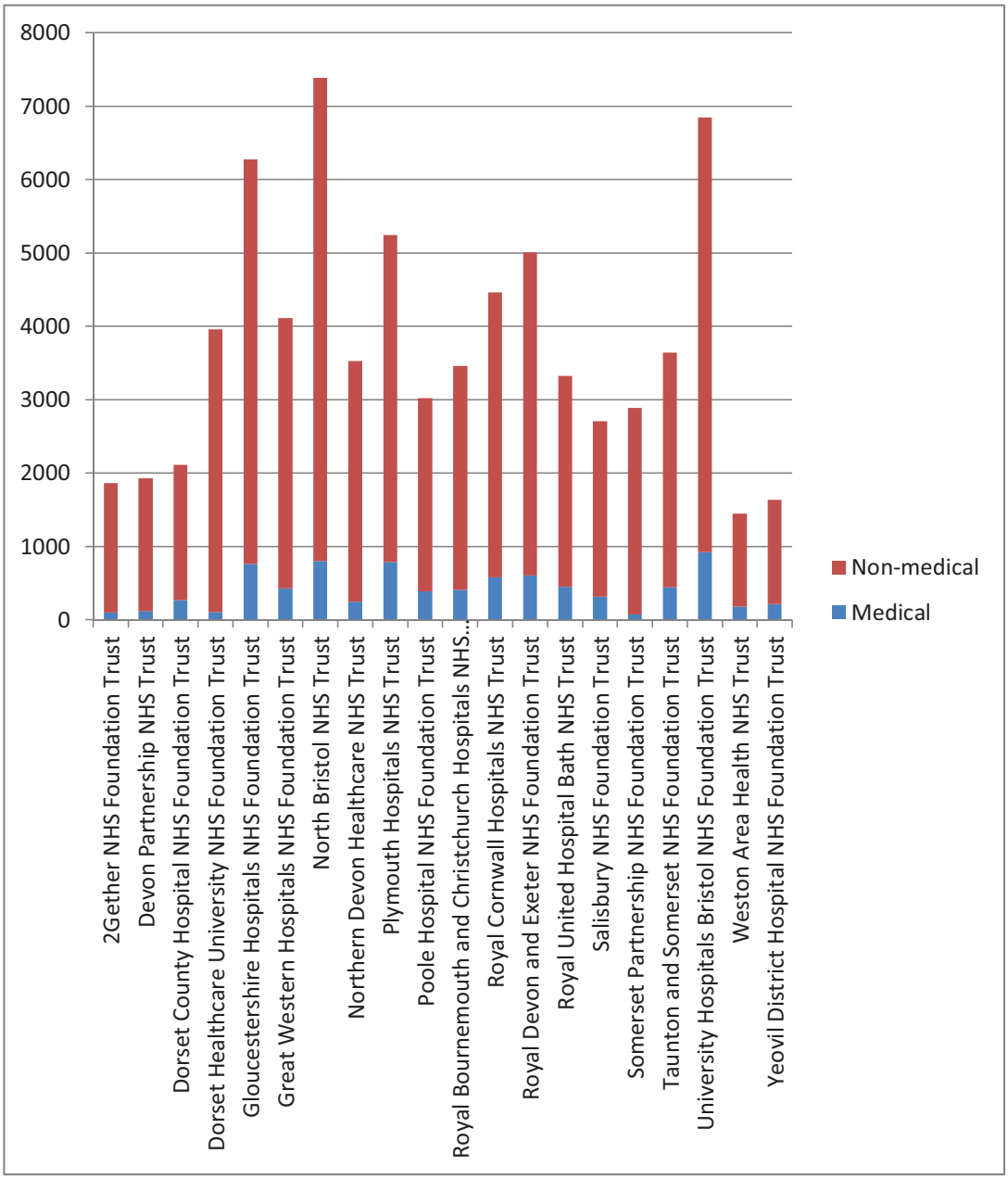
Figure 1: SWC workforce profile



Source: DH Information Centre – Medical staff: January 2012, Other staff groups: October 2011 (January 2012 not available)

Total non-medical staff = 68,719 wte.

Figure 2: SWC Participating NHS employers' workforce profiles (wte)



Staff employed by participating NHS employers represents 91% of medical, and 67% of non-medical, NHS staff working in the South West region. The lower percentage of non-medical staff is due to the fact that - together with some NHS employers which have chosen not to join the SWC - SHA and PCT staff (who predominantly employ non-medical staff) have all been excluded as they are going through substantial organisational transition.

The SWC Steering Group has agreed that all staff groups are included in the scope of the work of the SWC, which are:

- Agenda for Change
- Consultants (medical and dental)
- Associate Specialists/staff grade/specialty doctors
- Junior medical staff

- Very senior managers (VSM)
- Board directors
- Temporary staff – bank, NHS Professionals, agency
- Interims
- Locally (employer-level) contracted staff.

There may also be implications for contracted out staff for whom the NHS has funding in order to fulfil the previous commitment (NHS Employers/trade unions/DH/private sector) which make sure that these staff have similar pay and conditions to those directly employed in the NHS.

3. CONTEXT

This section provides an update on the relevant pay and conditions context within which the SWC is operating as background.

DECADE 2000+ PAY REFORMS

The two main pay and conditions systems which are relevant to those staff employed by NHS employers in the SWC have now been in place for nearly a decade. The new consultants' contract and Agenda for Change were implemented from 2003, after a significant period of consultation and negotiation. Both systems were implemented without being fully tested in advance (despite efforts to do so with Agenda for Change) and replaced previous systems designed and implemented in the 1940s and 1950s respectively. It is not the place of this discussion paper to undertake a full evaluation of the performance and practice of these two pay systems. There is considerable experience across the SWC with regard to the benefits and limitations of these systems.

It has been stated that there have been twenty-four changes to Agenda for Change since 2004, all of which have been favourable to employees. While the pay system for junior medical staff has now matured, the other two have not, which means that annual increases in payroll costs are more pronounced as staff make their way up the pay spine headroom. It is estimated that the annual cost of incremental and pay drift is on average +2%.

It was agreed when Agenda for Change was established that there would be a comprehensive review in 2011, which has not taken place. Criticisms of these two pay systems are based on the views that they have not completely fulfilled the original ambitions underpinning their design, that implementation has raised unintended consequences, and that they are not "fit for purpose" going forward, especially given the very challenging financial future.

NATIONAL PAY REFORM NEGOTIATIONS

While there are no national discussions between staff-side and NHS Employers with regard to the consultants' contract and junior medical staff, four proposals are out to consultation by the trade unions to modify Agenda for Change. Discussions have been underway over the past eighteen months, with different opinions on whether these represent the first or only stage in making changes to Agenda for Change. The consultation includes proposals to:

- Remove unsocial hours rates of sick pay

- Introduce new pay and conditions for managers (evaluated as in posts on more than 731 points)
- Remove the fast-track increments for staff under preceptorship
- Establish a closer connection between increments and performance.

Consultation on these proposals was due to end by 27th July 2012 – and the trade unions have indicated that they will take decisions on whether to accept all, some, or none of these proposals in September 2012. The trade unions have also stated, amongst other criticisms, that the SWC's actions have undermined national negotiations.

An attempt will be made later in this paper to evaluate what savings could be derived from each of these proposals. Criticisms of the nature of these proposals are based on the uncertainty about the subsequent prospects for the consideration of further reforms and that they are enabling agreements which mean that each NHS employer would still need to consult and reach agreement at a local level, on the practical arrangements to deliver them. The recent experience regarding the local establishment of on-call arrangements has frustrated both employers and trade unions with regard to the time and effort involved in such endeavours.

NHS WORKFORCE AND PAY DYNAMICS

The NHS workforce and remuneration are neither static nor simple. After a long period of NHS workforce growth, especially during the 2000s decade, it is now shrinking, albeit not by a high level at this point. In the period March 2011 to March 2012, the whole time equivalent number of NHS staff in England reduced by 1.5%. The number of staff providing NHS services is growing with the increasing introduction of commercial, social enterprise and voluntary service providers. Foundation trusts forecast in 2011 that their workforces would reduce by 6% during 2012-14.

While the national sets of terms and conditions dominate the means by which NHS staff are remunerated and the terms of their contracts, there are a number of actual and potential developments, which include:

- Pensions reform – immediate increase in employee contributions and other changes from 2015
- Review of Clinical Excellence (local employer) Awards – due for implementation after the Government has announced (and negotiated) its position in 2013/14
- Pay Review Bodies have been asked by the Treasury (and relevant Government departments) to consider market facing pay (regional pay)
- Job re-evaluations/re-grading at a local level
- Consultant job planning being more rigorously implemented by some trusts
- Extensive discussions (although incomplete) regarding on-call arrangements
- Ending of the Cabinet Office "Two Tier Workforce" code in December 2010
- VAT added onto temporary staffing
- Improved pay and conditions for agency/temporary staff (EU Agency Directive)
- Ten thousand community NHS staff transferred to social enterprises
- Staff being employed by new organisations responsible for clinical commissioning.

There are also changes to employment regulations already implemented or proposed by the current Government. Actual changes include the qualifying period to claim unfair dismissal extension of employment rights from one to two years and financially-controlled access to employment tribunals.

The trend in pay levels across the UK workforce in recent years will be examined in further analysis to be undertaken at a later stage of the SWC's work. This trend will be analysed as part of an examination of labour market issues. Since 2008, private sector pay levels have fallen behind the public sector – although it appears that this gap is closing as the private sector recovers and public sector pay restraint occurs. There needs to be caution about generalised comparisons between the two sectors given the different characteristics of these two workforces. It is worth noting that NHS pay continues to rise, despite a freeze on pay due to the immaturity of the relatively new pay systems (creating additional headroom) and the nature of the annual increments.

LOCAL PAY ARRANGEMENTS AND FREEDOMS

There is one NHS foundation trust which is frequently cited as having moved away from Agenda for Change, using the freedoms available within the pay system. It is worth highlighting what the position actually has been. Southend Hospital NHS FT had a long history of local pay prior to 2004, driven by its location being outside London weighting. In 2004 Employees were originally given the option to choose new local terms or Agenda for Change – 95% chose the former. While the Trust now has a lower cost pay system, having not paid national uplifts and shorter pay spines up until a few years ago it was more expensive than Agenda for Change. Their local terms do not apply to medical staff, and broadly mirror the arrangements for job evaluation and pay spines in Agenda for Change. One particularly interesting feature of these arrangements is the introduction of a trust-wide bonus scheme where the over-achievement of the planned annual surplus has been shared between employees and the Trust (40:60) on a non-pensionable, unconsolidated basis.

Annex K in Agenda for Change is widely cited as giving freedoms to FTs to set their own local terms and conditions. In fact, the Annex only allows changes which are the same (in cost) or more expensive than Agenda for Change and in agreement with staff-side. Since the pay reforms of the early-2000s, no trust has moved completely away from the national pay and terms system.

Many trusts have local pay arrangements – and did so before the pay reforms of the past decade. In the main, these have been used for remuneration for extra clinical activity (waiting list initiatives) and for posts which do not fit Agenda for Change and require (often) higher remuneration in order to compete in the labour market. The use of interims and temporary staff has produced a very wide (if not in volume) range of variations from national terms and conditions.

It appears that some trusts (working outside of a coordinated regional network) are considering or have launched local consultation to change terms and conditions (on a limited basis). There is some indication that trusts across England are following very closely what the SWC is doing and have made similar assessments regarding the financial gap facing them as those trusts which have set up the SWC.

GOVERNMENT POSITION

The Government's White Paper ("Excellence and Equity: Liberating the NHS") made references to the future for pay negotiations. These key references (section 4.35-4.36) are:

- "The need for fiscal consolidation is paramount and this will require sustained pay restraint across the public sector"
- "Pay decisions should be led by healthcare employers rather than imposed by the Government. In future, all individual employers will have the right, as foundation trusts have now, to determine pay for their own staff"
- "It is likely that many providers will want to continue to use national contracts as a basis for their local terms and conditions"
- "In the longer term, we will work with NHS employers and trade unions to explore appropriate arrangements for setting pay"
- "While ministers will retain responsibility for determining overall resources and affordability, we would expect employers to take the lead in providing advice on staffing and cost pressures"
- "Employers would also be responsible for leading negotiations on new employment contracts"
- In line with our aim of a decentralised system, the main incentives for financial management and efficiency will in future come from tariff-setting and a transparent regulatory framework – not from central government controls on providers' pay and internal processes".

Since the creation of the SWC, the Government has had the opportunity to state its position in an Opposition allotted debate (16th July 2012) and health questions (17th July 2012) in the House of Commons, with regard to what the twenty trusts are doing. In summary, the Government's headline statements include:

- It is for employers, not the Government, to lead negotiations on terms and conditions of their staff
- The Health Act 2006 gives trusts powers to set their own terms and conditions
- Pay systems must evolve
- Trusts must work with trade unions to agree changes
- Government should do everything possible to support NHS employers to have flexibility in pay, terms and conditions to motivation, recruitment and retention
- Secretary of State is not overruling the South West Consortium – the Consortium is clear it wants the national A4C framework to offer flexibilities
- The flexibility the consortium needs can be delivered by the national negotiations
- Proposals to reduce base pay or dismiss and re-engage staff are neither necessary nor desirable.

It should be noted that both Opposition and Liberal Democrat politicians have expressed concerns about what the remit and role of SWC made commitments to maintain the current system of national pay and conditions.

UK LABOUR MARKET ISSUES

Since 2008, there is considerable commentary about the recent, current and future state of the UK labour market. While it is necessary to be cautious about generalisations they provide a useful way to sum up what has, is and could be happening in the context of the world-wide economic crisis.

The CIPD produces a quarterly summary of the labour market outlook across the principal sectors – private, public and voluntary. In its summary in Spring 2012, it noted the trends set out in the table below. In headline terms, with regard to intentions to make redundancies the public and voluntary sectors are forecasting a downturn and the private sector an increase. With regard to recruitment intentions, both the public and voluntary sectors are intending to increase activity compared with the previous quarter, and the private sector is expecting to continue to reduce recruitment.

Figure 3: Redundancy intentions

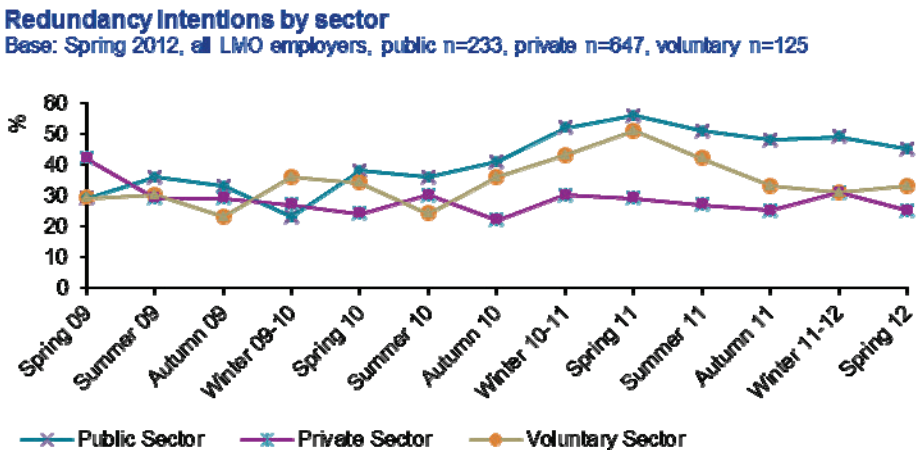
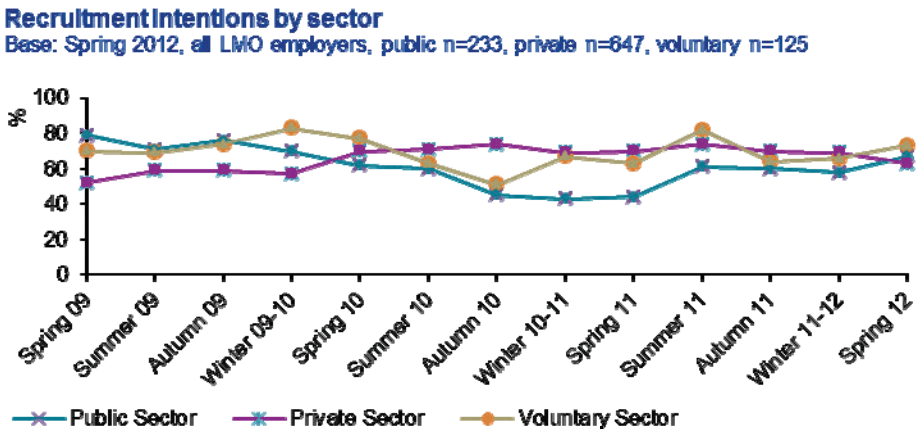


Figure 1: Recruitment intentions



Source: CIPD labour market outlook, Spring 2012

Pay levels across the UK labour force have remained static since a reduction in the private sector after the 2008 economic crash. Unemployment is at its highest levels since the mid-1990s – with

some indication that it is not growing in line with expectations, given the lack of growth in the UK economy over the past year. The most recent reported level of unemployment shows a decrease on the previous quarter. Increasingly, the gap is growing between those workers with skills and those without (or less) in terms of gaining employment.

To some extent the impact of the economically constrained times have only just started to affect the NHS in 2012/13, after a sustained period of financial growth since the early 2000s. The private sector and other parts of the public sector have had to take actions with regard to their workforce costs prior to this current period. Those companies which were able to survive the initial shock of the economic crisis were able to do so by reducing the value of terms and conditions in order to save jobs (and the organisation as a whole). This was also pursued as part of a deliberate strategy to "hoard jobs" (e.g. BT) whereby high and disruptive redundancy costs and the loss of talent were avoided on the basis that future growth would enable the reengagement of temporarily displaced staff. Local government has had its financial reductions front-loaded since 2010, and some have taken (controversial) steps to reduce the value of pay and conditions.

The Chartered Institute of Personnel and Development (CIPD) has reported (13th August 2012) that a number of private sector companies have deliberately kept on more staff than they can immediately afford in order to retain valuable skills and capability, on the basis that future improved economic performance will make this affordable. This report indicated that should economic circumstances not improve then some of these staff will need to be made redundant.

4. GOVERNING PRINCIPLES

The SWC will need to establish what principles will govern the proposals and recommendations which it will take in the full business case. The principles which underpinned the production of Agenda for Change stand the test of time. Set out below are these principles – which it seems do not need modification for today's challenges, although they have not been fulfilled and their application needs to be reassessed in the light of experience and the challenges ahead.

Agenda for Change principles

- Pay system which leads to more patients being treated, more quickly and higher quality
- Assist new ways of working – promoting efficiency and effectiveness, meeting needs of patients
- Achieving a quality workforce with the right numbers, right skills and diversity, organised in the right way
- Improve recruitment, retention and morale
- Improve all aspects of equal opportunities and diversity
- Meet equal pay for equal value
- Implement new pay system within the management, financial and service constraints

March 2003

The SWC will want to consider whether it wishes to recommend a fresh start to pay and conditions with a brand new pay system – or to make modifications to the current system. The SWC has

declared that it is totally committed to working with the trade unions and staff in this endeavour – and wishes to support any changes (at a national or local level) through extensive consultation and voluntary agreement.

5. CHANGE IN EXCHANGE

There is evidence that employers who have managed to secure voluntary agreement to a reduced value of terms and conditions (on a temporary or permanent basis) which have reduced the overall cost of the pay bill, have done so by offering a genuine exchange. Exchanges are where employees can receive tangible benefits in return for reductions in the value of their remuneration packages. Such a position is of course in the mutual benefit of both the organisation and employees – especially where it means that the organisation can afford to survive and continue to deliver on its service offerings. Examples of exchanges that may be offered in these circumstances include:

a) **Job security through organisational viability** – where the organisation is capable of remaining viable, in turn it can give a greater degree of job security which is significantly reduced if it cannot afford its existing workforce costs.

b) **Overall commitment to the structure and maintenance of national terms and conditions** – relatively minor modifications can be compatible with maintaining a commitment to the overall structure, principles and processes of the existing structure of pay and conditions, making it less likely that there will be a complete move away and creation of a brand new system.

c) **Opportunity to repay lost value through a bonus scheme at the end of the financial year once service and financial targets have been achieved** – where changes to pay levels (in whatever form) are made at the start of the financial year, it could be possible to create a scheme whereby some or all of its value is given at the end of the year once financial and service objectives have been met (and the cost is affordable).

d) **Guaranteed no redundancy deals (compulsory and/or voluntary)** - in some cases real job security can be in the form of a guarantee that there will be no compulsory redundancies given the confidence that the organisation has to plan and forecast. This has been done in both the private sector and the NHS.

e) **Avoidance of arbitrary job freezes based on which posts become available** – a more stable approach to managing workforce costs can mean that immediate, less-planned actions to reduce and control costs (such as job freezes) can be avoided. Job freezes are inevitably fairly arbitrary, driven by when vacancies occur, not which posts are most appropriate for removal. Job freezes make it more difficult to manage service developments and change – and can leave teams depleted.

f) **Reduced remuneration for temporary staff (especially agency) which is often comparatively favourable** – where there are changes to the pay and conditions to permanent staff it is possible to reduce the cost of temporary staffing (as this tends to mirror them). This enables the organisation to release resources for investing in permanent staff.

g) **Investment in the skills and capability of staff to enable them to make progress up the career structure (and therefore financial gain)** – with greater financial and service certainty, the organisation is in a better position (and will wish) to invest in specific training and education programmes to enhance skills and promote career-development.

h) **Reduced need to outsource (and therefore TUPE staff)** – alternatives to addressing pay, terms and conditions include the procurement and sub-contracting of services from the private and voluntary sectors where they can deliver the right quality of services at a reduced cost. Avoiding these options makes it less likely that staff will be transferred to new employers, which is frequently not preferred by employees (even though there is a degree of short-term protection).

i) **Less likely that other providers will win tenders on the basis that they are more competitive on financial grounds** – inevitably where costs are reduced (through whatever means) this helps the organisation to be more competitive enabling it to maintain its current provision of (and secure new) services.

6. STAFF COST REDUCTION POTENTIAL OPPORTUNITIES

While absolutely no proposals have been put forward regarding any proposed changes to pay, terms and conditions, this section addresses the full set of options in order to inform the production of the full business case.

The table below sets out the range of elements from which a selection could be chosen in line with the SWC's commitment to produce a "fit for purpose" set of terms and conditions which meets the principles identified above. This table summarises the financial implications of an example of each opportunity. This assessment does not address the period of consultation which would be required and desired.

The financial assessment is based on a sample typical trust which employs 3,500 staff with an annual turnover of £220m. It would be misleading for the reader to take this list and add up each of the savings to produce a total.

LABOUR COST COMPRESSOR	SAMPLE SAVINGS
1. Additional Programmed Activities (APAs)	Reduce APA rates – or focus their usage on a frequent renewable basis – PA rate valued at £10k plus employer costs
2. Annual leave	Per day of reduced annual leave = £150 per day employment cost plus cover for 50% of staff 2 days of annual leave where capacity can be reduced in 50% of jobs and cover avoided in 50% of jobs = £750k
3. Bonus scheme (all staff)	Self-funding has paid for on an unconsolidated basis from over-achieved surplus
4. Clinical Excellence (Local Employer Based) Awards	CEA points valued at c£3k which could be more connected to desired service activities

5. Consultant on-call supplements	Reduce paid time allocated to on-and off-site on-call thereby reducing PA and supplementary rates – PA rate valued at £10k plus employer costs
6. Extra hours	I hour on top of 37.5 hours (AfC) would create a 2.66% efficiency gain worth £2.6m (also increasing plain rate time therefore reducing overtime rate working)
7. Flexible benefits	Best to set a target to achieve given complexity – say £100k – where staff exchange salary for increased annual leave
8. Flex-release (voluntary hours reduction)	25 staff give up 25% of working hours (and income) and 50% capacity is not replaced = £125k
9. Increments	Each increment valued at 3% of pay 10% of total increments withheld = £420k on a prospective basis
10. Junior medical staff (juniors)	Limited working employment contract which is mostly education without access to the current % enhancements Up to 50% saving on 1000 staff in SWC
11. Locum and retired consultants	End offer of guaranteed SPA time – unknown number in this position, likely to be c10 consultants therefore savings or capacity creation = £140k. Sufficient SPA time still required for revalidation.
12. Knowledge and Skills Framework (KSF) reform into KS Performance Framework	See increments savings profile (opportunity number 9)
13. New consultant roles – direct clinical care	Establishment of initially static consultant roles where output is predominantly DCC PAs (90%) 15% saving or capacity creation on the typical consultant role. For 15 new posts = £250k
14. New employer models – a two-tier workforce	This requires special analysis to come up with new terms and conditions – which could be up to 20-25% less than current costs for posts where there is sufficient labour supply
15. Pay inflation (uplift)	Pay cash limit = 0% except very low paid until 2013 – 1% for 2013-14
16. Pay levels	0.5% = £700k 1% = £1.4m
17. Pay protection policy	The typical level of pay protection is between 2 and 3 years. One trust has established 9 months for relatively new staff

18. Preceptorship incremental fast-track	For 50 new band 5 appointments = £60k (deferred benefit as pay progression will ultimately be reached unless promotion occurs)
19. Premium sick pay	Sickness absence paid a plain rate = £100k
20. Recruitment and retention premia (RRP)	Removal of RRPs after protection = £50k
21. Reduction in working week (and income)	10% reduction in working week - equivalent to 250 staff = 3.75 hours for non-medical staff; notional 4 hours per consultant Total pay cost value = £14m
22. Redundancy payments	Current position where redundancy costs average between 1 to 2 years of salary costs given typical length of service plus early-retirement financial commitments
23. Remuneration for extra clinical work	Charges for undertaking extra clinical work (eg Waiting List Initiative)
24. Sickness absence (short term)	2 days of sickness benefit unpaid where average 8 days per person per year @ £150 per day = £750k Assumes no change in sickness rate – where it reduces, savings made on reduced cover
25. Sickness absence (new staff and long term)	Reduce sick pay for new staff and long term benefits from 6 months full and 6 months half pay after 5 years' service to 50% of the value On the basis of 10% turnover – 250 new staff who currently take 10 days sick pay (£0.5m) and 30 staff on very long term sick (£400k)
26. Supporting Professional Activities (SPAs)	Reduce time spent on SPA activity – PA rate valued at £10k plus employer costs SPA average = 2.5 PAs therefore savings or capacity creation of 0.5 PAs x 150 consultants = £1.8m
27. Temporary staffing rates	10% reduction in £10m total spend = £1m
28. Unsocial hours allowances	Estimated total unsocial hours payments = £4m 10% reduction in unsocial hours payments - £400k

Notes:

- The currency has been modelled on a sample typical trust employing c3.5k staff with average levels of HR KPIs (10% vacancy and turnover, 4% sickness absence, 10% of workforce spend on temporary staff rates)
- Extended hours, reduced annual and sick leave, and increased attendance all reduce the need for cover for a proportion of staff (mostly clinical).

With regard to the national negotiations on Agenda for Change (and assuming that it is possible to negotiate local arrangements to deliver them) the sample typical trust employing 3,500 staff could make the following savings (optimistic evaluation and requires verification) on an annual recurring basis:

PROPOSAL	SAVINGS
Unsocial hours sick pay	£100k
Managers' terms and conditions	Unquantifiable at this stage – savings to be made
Preceptorship	£50k (cash flow benefit)
Increments and performance	£200k
TOTAL	£350k (including cash flow benefit)

The SWC has indicated that it could save over 6,000 jobs through a more "fit for purpose" system of pay and conditions and thereby deliver on trusts' service obligations. Inevitably some changes which involve increasing workforce productivity through reducing unit labour costs would also involve reducing the need for posts (not recruited). Any changes could also be on a temporary basis, while time is taken to develop and implement strategic interventions – such as service rationalisations and M&A – which deliver financial as well as service benefits.

7. THE POTENTIAL CASE FOR CHANGE

This discussion paper does not in itself advocate any specific changes – and the accompanying paper will help quantify whether and/or to what extent changes to pay, terms and conditions are necessary. Set out below is the overall proposition to outline what case could be made at national or any other level to change terms and conditions:

a) Provides an opportunity to create the right flexible pay system which can reward those that perform and promote recruitment and retention
b) Recognises that the classic approach of reducing payroll costs through marginal activity is a diminishing return
c) Allows an open and transparent discussion with staff about the financial and service challenges ahead
d) Provides an opportunity to establish a system for whole organisation bonuses
e) Gives greater job security and enhanced investment in professional development and skills
f) Makes NHS employers more competitive – and therefore more viable and successful in the interests of staff and patients
g) Supports the NHS in continuing to offer comprehensive healthcare, free at the point of use
h) Means that "fit for purpose" NHS employee benefits which do not jeopardise recruitment and retention
i) Provides an opportunity to accommodate trade unions' concerns about the current pay systems in line with the governing principles
j) Recognises that the current system has not fulfilled the ambitions and governing principles originally intended
k) Provides an opportunity to rectify the unplanned and unintended consequences from the originally designed pay reforms – lessons learnt from implementation.

8. QUESTIONS FOR DISCUSSION

A. Do the Agenda for Change principles still stand as those governing the SWC's approach?
B. Does the SWC want to propose a model for a brand new set of pay and conditions or make specific proposals to change the existing national terms and conditions whilst maintaining its broad structure and value?
C. Does the SWC want to consider recommending making changes on a temporary basis?
D. What could NHS employers offer in exchange for changes to terms and conditions?
E. Are there any other labour cost compressors which could be considered in the long list?
F. How can the SWC's commitment to undertake an equality impact assessment be fulfilled?
G. Could the SWC address other workforce issues, such as the allocation of education and training funding or the procurement of staffing supply (e.g. agency staffing) where possible in partnership with the trade unions and professional associations?
H. What criteria (over and above the principles) should be used to select what to recommend if the economic, financial and service case states that it is necessary?

9. REFERENCES

These references have been collated in support of both this paper and the accompanying one which addresses the economic, financial and service challenges.

PUBLICATION	SOURCE	DATE	LINK
Forecasts for the UK economy	HM Treasury	July 2012	http://www.hm-treasury.gov.uk/d/201207forcomp.pdf
NHS Staff engagement guidance and on-line toolkit	NHS Employers	2012	http://www.nhsemployers.org/EmploymentPolicyAndPractice/staff-engagement/Pages/Staff-Engagement-And-Involvement.aspx
NHS and social care funding – the outlook to 2021/22	Nuffield Trust	July 2012	http://www.ifs.org.uk/publications/6228
NHS foundation trusts: consolidated accounts 2011/12	Monitor	July 2012	http://www.monitor-nhsft.gov.uk/home/browse-category/reports-nhs-foundation-trusts/nhs-foundation-trusts-review-and-consolidated-acc
Securing the financial sustainability of the NHS	National Audit Office	July 2012	http://www.nao.org.uk/publications/1213/nhs_financial_sustainability.aspx
The economic impact of local and regional pay in the public sector	TUC/NEF	July 2012	http://www.tuc.org.uk/tucfiles/345.pdf

Fiscal sustainability report	Office for Budget Responsibility	July 2012	http://budgetresponsibility.independent.gov.uk/fiscal-sustainability-report-july-2012/
The austerity debates	Reform	July 2012	http://www.reform.co.uk/resources/0000/0435/120718_The_Austerity_Debates.pdf
Pay circular (medical and dental) 1/2012	NHS Employers	June 2012	http://www.nhsemployers.org/Aboutus/Publications/Documents/Pay-Circular-MD-1-2012.pdf
NHS staff earnings estimates – Jan to March 2012	NHS Information Centre	June 2012	http://www.ic.nhs.uk/webfiles/publications/010_Workforce/nhsstaffearningsjanmar2012/Earnings_Bulletin_Jun_12.pdf
Monthly NHS hospital and community health service – workforce statistics March 2012 (provisional)	NHS Information Centre	June 2012	http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/monthly-nhs-hospital-and-community-health-service-hchs-workforce-statistics-in-england-march-2012-provisional-statistics
Proposals to change Agenda for Change	NHS Staff Council	June 2012	http://www.nhsemployers.org/PayAndContracts/AgendaForChange/Pages/NHSTradesUnionsConsultonProposalsonAgendaforChange.aspx
Rising to the Nicholson challenge	Reform	June 2012	http://www.reform.co.uk/resources/0000/0405/120616_Slides.pdf
Thinking about rationing	King's Fund	May 2012	http://www.kingsfund.org.uk/publications/rationing.html
Labour market outlook – Spring 2012	CIPD	May 2012	http://www.cipd.co.uk/hr-resources/survey-reports/labour-market-outlook-spring-2012.aspx
Education, training and workforce planning report	Health Select Committee	May 2012	http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/6/602.htm
Healthy efficiency: the NHS and public service reform	Reform	May 2012	http://www.reform.co.uk/content/13769/research/health/healthy_efficiency_the_nhs_and_public_service_reform
Leadership and engagement for improvement in the NHS	King's Fund	May 2012	http://www.kingsfund.org.uk/publications/leadership_review_12.html

Budget 2012	Treasury	March 2012	http://www.hm-treasury.gov.uk/budget2012_documents.htm
Chancellor's letter to Pay Review Bodies and Government economic evidence	Treasury	March 2012	http://www.ome.uk.com/Article/Detail.aspx?ArticleUid=a782b32d-b08b-423b-8061-361211188711
Budget 2012 and the NHS workforce	NHS Employers	March 2012	http://www.nhsemployers.org/PayAndContracts/Pages/Budget2012AndTheNHSWorkforce.aspx
Submission to the Pay Review Body on market facing pay	NHS Employers	March 2012	http://www.nhsemployers.org/Aboutus/Publications/Documents/Submission-to-the-NHS-Pay-Review-Body-on-market-facing-pay.pdf
Pay circular (Agenda for Change) 2/2012	NHS Employers	March 2012	http://www.nhsemployers.org/Aboutus/Publications/PayCirculars/Documents/Pay_Circular_AfC_2-2012.pdf
NHS terms and conditions of service handbook (Agenda for Change)	NHS Staff Council	Feb 2012	http://www.nhsemployers.org/SiteCollectionDocuments/AfC_tc_of_service_handbook_fb.pdf
Delivering sustainable cost improvement programmes	Monitor/Audit Commission	Jan 2012	http://www.monitor-nhsft.gov.uk/cips
Public expenditure	Health Select Committee	Jan 2012	http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1499/149902.htm
Total reward in the NHS	NHS Employers	Nov 2011	http://www.nhsemployers.org/Aboutus/Publications/Documents/Total_reward_101111.pdf
Location based pay differentiation	Unison/IDS	Sept 2011	http://www.unison.org.uk/file/IDS%20research%20paper%20for%20UNISON%20FINAL%2016%2009%2011%20(2).pdf
A decisive decade – mapping the future NHS workforce	RCN	July 2011	http://www.rcn.org.uk/__data/assets/pdf_file/0004/394780/004158.pdf
Equity and excellence: liberating the NHS White Paper ("Valuing Staff" pages 40-41)	Department of Health	July 2010	http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
Terms and conditions:	Department of	Sept	http://www.nhsemployers.org/PayA

Consultants (England)	Health	2009	ndContracts/MedicalandDentalContracts/ConsultantsAndDentalConsultants/Pages/Consultants-Homepage.aspx
Effect of Agenda for Change on career progression of the radiographic workforce	Society of radiographers	July 2009	http://www.sor.org/learning/document-library/effect-agenda-change-career-progression-radiographic-workforce-2009
NHS pay modernisation in England: Agenda for Change	Audit Commission	Jan 2009	http://www.nao.org.uk/publications/0809/nhs_pay_modernisation.aspx
NHS workforce planning – limitations and possibilities	King's Fund	2009	http://www.nhshistory.net/NHS_Workforce_Planning[1].pdf
Pay Modernisation: A new contract for NHS consultants in England	National Audit Office	April 2007	http://www.nao.org.uk/publications/0607/pay_modernisation_a_new_contr.aspx
Assessing the New NHS Consultant Contract - A something for something deal?	King's Fund	May 2006	http://www.kingsfund.org.uk/publications/assessing_the.html

SWC 22nd August 2012

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DISCUSSION DOCUMENT

SOUTH WEST PAY, TERMS AND CONDITIONS CONSORTIUM

THE ECONOMIC, FINANCIAL AND SERVICE CHALLENGES

BACKGROUND

The South West Pay, Terms and Conditions Consortium ["SWC"] was established in June 2012 with sixteen participating NHS employers. The SWC now has twenty participants involving NHS foundation and NHS trusts from acute, teaching, mental health and community health care sectors. The SWC has been set up to produce a full business case by the end of the calendar year in order to quantify the current and future economic, financial and service challenges, and in turn consider how best to create a "fit for purpose" set of pay, terms and conditions. This discussion paper has been produced as part of SWC's wider scoping exercise in producing a business case and in order to quantify these challenges to assist considerations about how best to address current and future pay, terms and conditions for all NHS staff groups. The SWC does not have the authority, responsibility or mandate to engage in negotiations, as sovereignty rests with the individual participating trusts.

CONTENTS

1. INTRODUCTION

This discussion paper has been written for the SWC Steering Group in order to assist it in its production of a full business case. This paper does not include any recommendations and does not represent any proposals or decisions regarding pay, terms and conditions. It has been designed to be read alongside the accompanying paper which addresses pay, terms and conditions. While this paper is wide-ranging, any mention of potential changes does not mean that decisions have been taken to pursue them or that an assumption has been made that they will be pursued by individual member trusts. The SWC remains committed to achieving a "fit for purpose" set of terms and conditions through national negotiations and providing high quality, value for money patient services.

This paper will also be considered alongside further papers that may be produced if required on the legal issues related to potential positions which the SWC might take in the future, some labour market analysis, and an assessment of the options on how best to manage any potential changes. A further paper may be produced which will examine the long list of potential options which will be included in the full business case. No proposals or decisions will be made until the finalisation of the full business case.

This discussion paper seeks to quantify the economic, financial and service challenges – and to produce analysis of what this means for a sample trust against which each participating NHS employer can compare themselves. While these three challenges have been addressed in separate sections, it is acknowledged that they are in fact highly inter-linked and interdependent. There are many views, both within and outside the NHS, about the long term economic, financial and service challenges, especially beyond the current three-year planning cycle. This paper does not intend to provide original economic analysis but to draw on the information which is available, so that the SWC can make professional, responsible and realistic judgements.

2. THE SOUTH WEST CONTEXT

The total financial allocation to Primary Care Trusts in the South West region in 2010-11 was £8,364,858,000, which represented 9.4% of total expenditure in the English NHS.

Twenty NHS employers have joined the SWC, representing the vast majority of NHS staff working in the South West region, which comes to a total of more than 68,000 employees. Assuming an average full employer cost of £40,000 per employee, the total cost of this workforce is £2.8bn. This represents around 7% of the total NHS workforce in England.

The NHS workforce, as a whole, across the South West region has grown by over 20% in the period 2001-2011 (on average by 2.3% per year). During 2010/11 the total workforce was reduced by 1.1%.

Staff employed by participating NHS employers represents 91% of medical, and 67% of non-medical, NHS staff working in the South West region. The lower percentage of non-medical staff is due to the fact that - together with some NHS employers who have chosen not to join the SWC - SHA and PCT staff, who are mostly non-medical staff, have all been excluded due to their different circumstances as they are going through substantial organisational transition.

The SWC Steering Group has agreed that the following staff groups are in the scope of the work of the SWC:

- Agenda for Change
- Consultants (medical and dental)
- Associate Specialists/staff grade/specialty doctors
- Junior medical staff
- Very senior managers (VSM)
- Board directors
- Temporary staff – bank, NHS Professionals, agency
- Interims
- Locally (employer level) contracted staff.

3. THE ECONOMIC CHALLENGE

Recent figures (25th July 2012) released by the Office for National Statistics has shown that the UK economy is still in recession – with its provisional estimate that the economy shrunk by -0.7%, higher than the forecasted -0.2%. While NHS employers can depend upon the advice and forecasts produced by HM Treasury and the Department of Health, they do have the responsibility to interpret this guidance when setting out their financial and service challenges over the immediate three year period, and beyond.

The UK Budget in 2012 included analysis produced by the Office for Budgetary responsibility (OBR) forecast that the world economy is expected to grow by around 4% (between 3.3% in 2012 and 4.9% in 2016). This drops to around 1.5% in the Euro Area (between -0.3% in 2012 and 1.7% in 2016). The current fiscal consolidation of £123bn is planned to take place over the next seven years.

Total public sector current expenditure has been forecasted by HM Treasury to increase from £647.3bn in 2011 to £708.6bn in 2016/17 – with average annual real growth between 2015/16 and 2016/17 to be -0.9%. The OBR has forecast that public sector current expenditure will reduce as a percentage of GDP from 42.6% in 2010/11 to 36.5% in2016/17. The Chancellor stated in March 2012 that spending on public services in the UK would still need to be reduced in real terms by an average of 1.7% per year over 2015/16 and 2016/17 to keep the current spending plans.

The comparison of independent forecasts for the UK economy undertaken by the HM Treasury in July 2012 recorded that the average predictions for growth in July 2013 peak at 2.5% and are as low as 0.5% - with an average of 1.4%. The indications are that economic conditions, certainly in the Euro Area have deteriorated since the Budget 2012. More details set out in the Budget can be found via the links in the references in section 8.

The trend in pay levels across the UK workforce in recent years will be examined in further analysis to be undertaken at a later stage of the SWC's work. This trend will be analysed as part of an examination of labour market issues in both the public and private sectors. Since 2008, private sector pay levels have fallen behind the public sector – although it appears that this gap is closing as the private sector recovers and public sector pay restraint occurs. There needs to be caution about generalised comparisons between the two sectors given the different characteristics of these two

workforces. It is worth noting that NHS pay continues to rise despite a freeze on pay due to the relatively new pay systems still undergoing development and the nature of annual increments.

4. THE NHS FINANCIAL CHALLENGE

The Institute of Fiscal Studies (IFS) and Nuffield Trust report in July 2012, noted that public spending on the NHS increased faster than economy-wide inflation since the 1950s, with an average growth rate of 4.0% per year between 1949/50 and 2010/11. The percentage of spend on the NHS as a share of national income has grown from 3.5% to 7.9% over this period. The current Coalition Government has committed to growth (above inflation) NHS funding each year – which is 0.1% above inflation during 2012/13.

This report noted that the four year spending round, starting 2011/12 represents the tightest four-year period of funding for the NHS in the last 50 years. Spending increased particularly rapidly under the last Labour Government, with an average real growth rate of 6.4% a year between 1996/7 and 2009/10.

Monitor reported in April 2012 what it expected in terms of efficiency savings over the 2012-2017 period (see table below). Monitor based its estimates on income pressures consistent with the Operating Framework regarding the tariff for 2012/13 and beyond. It also made assumptions about cost pressures by considering the likely pay and non-pay pressures in the NHS, including the latest economic forecasts published by the OBR, historic trends in NHS pay and prices, and stated government policy on public sector pay. These estimates are set out in the table below, using two scenarios – "assessor" (central estimate of the expected pressures and risks' to provider income and costs) and "downside" (building on "assessor" case but reflects a more pessimistic view of the expected pressures and risks).

Figure 1: Monitor estimates of sector-wide efficiency requirements

		2012/3	2013/4	2014/5	2015/6	2016/7
Acute	Assessor	4.5%	5%	5%	4.2%	4.2%
Acute	Downside	5.25%	5.5%	5.5%	5%	5%
Non-acute	Assessor	4.5%	5%	5%	4.2%	4.2%
Non-acute	Downside	5%	5.5%	5.5%	4.7%	4.7%

Monitor has also indicated that for acute trusts the impact of tariff income levers as described in the Operating Framework and Payment by Results Guidance for 2012/13 could be significant. Monitor stated that this could be so significant that these pressures could increase the efficiency challenge by 2% (non-recurrently). Monitor has recently released the 2011/12 consolidated accounts of foundation trusts which has revealed that over half did not meet their cost improvement targets. Pay accounts for approximately 70 per cent of these trusts' costs – a total of £22.6bn in 2011-12, £576m above plan. Meanwhile, unpublished results of a separate Health Service Journal survey (12th July 2012) revealed that acute foundation trusts aimed to reduce more than £500m off their pay bill in 2012-13.

The SWC has indicated that it could save over 6,000 jobs through a more "fit for purpose" system of pay and conditions and thereby deliver on trusts' service obligations. Inevitably some changes

which involve increasing workforce productivity through reducing unit labour costs would also involve reducing the need for posts (not recruited). Any changes could also be on a temporary basis, while time is taken to develop and implement strategic interventions – such as service rationalisations and M&A (mergers and acquisitions) – which deliver financial as well as service benefits.

With regard to the current national negotiations on Agenda for Change (and assuming that it is possible to negotiate local arrangements to deliver them) the sample typical trust employing 3,500 staff could make the following savings (optimistic evaluation and requires verification) on an annual recurring basis:

PROPOSAL	SAVINGS
Unsocial hours sick pay	£100k
Managers terms and conditions	Unquantifiable at this stage – savings to be made
Preceptorship	£50k (cash flow benefit)
Increments and performance	£200k (to occur a year after implementation)
TOTAL	£350k (including cash flow benefit)

Note: This assessment is based on an NHS employer with 3,500 staff (pay bill of £140m/turnover of £220m) with average sickness levels (3.5%) and staff performance.

5. THE SERVICE CHALLENGE

The principal challenge facing the NHS is summed up as the 'Nicholson Challenge' whereby it needs to save £20bn by 2015, an average of 5% per year. The SWC participating NHS employers are all used to planning and delivering cost improvement programmes throughout the recent period of financial growth over the past decade and more recently the 'Nicholson Challenge'.

The National Audit Office and Monitor in their report on "Delivering Sustainable Cost Improvement Programmes" in January 2012 noted that CIP success varied amongst trusts and that several factors were common in organisations performing well in CIP planning, delivery and sustainability. The report stated that successful CIPs were not simply schemes that saved money – and "that the most successful organisations have developed long-term plans to transform clinical and non-clinical services that not only result in permanent cost savings, but also improve patient care, satisfaction and safety". The SWC is fully committed to these objectives.

The IFS/Nuffield Trust report's (mentioned in the section above) headline statement was that public funding for health "is set to be tight until at least the end of the decade" and that "if NHS productivity does not increase sufficiently fast to bridge the gap between funding and demand pressures, then access to and quality of care is likely to deteriorate".

NHS employers' capability to compete successfully for procured clinical activity will depend upon their financial competitiveness, as well as the quality of the clinical services on offer. The ability to continue to provide existing patient services by public sector organisations depends upon their determination to reduce costs, while other commercial and voluntary organisations have already been able to do so.

The underlying service demand assumptions by the SWC participating NHS employers are that:

- They wish to maintain and improve the quality of existing patient services
- Demand will increase due to demographic changes and advances in medical innovation and technology
- National targets relating to access will remain in place
- Public (taxpayer and patient) expectations regarding the provision of excellent services will continue to increase
- Healthcare inflation to deliver adequate service quality will be higher than tariff-designed component
- Need to cope with a range of significant service-related cost pressures (such as IT, Francis Report on Mid-Staffordshire NHS FT)
- Regulatory standards and requirements will continue to increase
- Commissioners will continue to specify new standards in clinical practice.

6. MODELLING THE FINANCIAL AND SERVICE CHALLENGES

This section is designed to model the consequences of the factors set out above. This analysis does not represent a full business case discipline but is an attempt to promote discussion by the SWC with regard to the development of its overall approach.

CHARACTERISTICS OF THE SAMPLE TRUST MODEL

In order to assist the analysis in this paper, a sample trust has been modelled, with the characteristics listed below. These will be checked and confirmed during the next phase of work being undertaken by the SWC.

Figure 2: Characteristics of sample trust

CHARACTERISTICS	DETAILS
Income	£220m
Staff numbers	3,500 (wte)
Temporary staffing	10% = £14m
Turnover	10%
Workforce spend	£140m (65% of total income)
Vacancy level	10%

An assumption for modelling purposes has been made that this sample trust will need to make 5% savings each year (cash-releasing) over the three years 2012-15, and then the same again over the following three years 2015-18. This means the following savings on a reducing cash baseline:

- 2012-13: £11m
- 2013-14: £10.45m
- 2014-15: £9.9m

A reasonable assumption is that 65% of these savings targets would come from payroll cost – and that it is highly unlikely that more than a third could come from traditional measures, including skill mix, service staff rationalisations and "back office" reductions. The approach being taken by the SWC will mean that every effort can be considered and exhausted to find ways of reducing cost prior

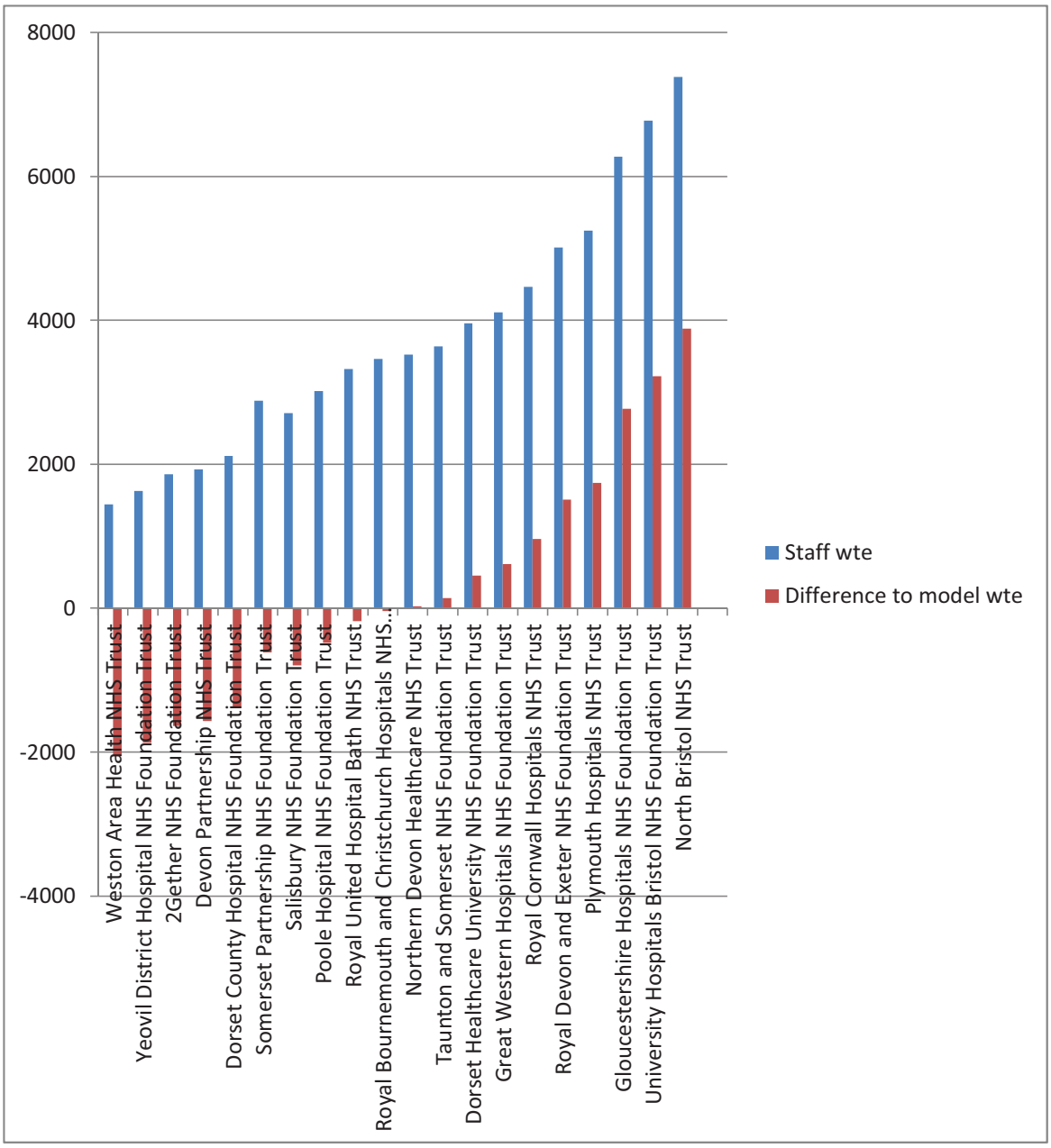
to proposing changes to pay, terms and conditions. Considerable efforts will be required to maintain this level of contribution through productivity improvements, such as reducing length of stay and changes to care settings. The alternative to addressing pay, terms and conditions is a wholesale reduction in headcount which, in potentially compromising minimum staffing levels and therefore patient safety, is extremely undesirable and costly.

Therefore, this means that there remains a need to find cost efficiencies of around £4m where addressing pay, terms and conditions could be considered. Therefore for modelling purposes this equates to around £12m over three years. It is worth stressing that no proposals have been put forward. The likelihood that NHS finances will follow the same pattern during 2015-18 means that the urgency and robustness of tackling the 2012-15 gap is even more necessary.

ANALYSIS OF SWC PARTICIPATING NHS EMPLOYERS COMPARED WITH THE SAMPLE TRUST

While the full business case will examine the actual position of each NHS employer in the SWC, in order to produce robust cost benefit analysis, at this stage, assumptions have been made about the different financial challenges of each trust using the staff numbers. Set out below is a graph which lists the participating NHS employers in the order of size (numbers of staff) – and identifies the degree to which each one is larger, the same, or smaller than the sample trust.

Figure 3: SWC Participating NHS employers' workforce numbers (wte) compared with sample model trust (3,500 wte)



MODELLING HOW BEST TO FIND SAVINGS

The table below sets out the range of staff cost reduction opportunities from which a selection could be chosen in line with the SWC's commitment to identify a "fit for purpose" set of terms and conditions which meet the principles identified above. This table summarises the potential financial implications of each option, which will be subject to review and analysis as part of the preparation of the business case, and does not constitute recommendations or proposals.

The financial assessment is based on a sample typical trust which employs 3,500 staff with an annual turnover of £220m. It would be misleading for the reader to take this list and add up each of the savings to produce a total

LABOUR COST COMPRESSOR	SAMPLE SAVINGS
1. Additional Programmed Activities (APAs)	Reduce APA rates – or focus their usage on a frequent renewable basis – PA rate valued at £10k plus employer costs
2. Annual leave	Per day of reduced annual leave = £150 per day employment cost plus cover for 50% of staff 2 days of annual leave where capacity can be reduced in 50% of jobs and cover avoided in 50% of jobs = £750k
3. Bonus scheme (all staff)	Self-funding has paid for on an unconsolidated basis from over-achieved surplus
4. Clinical Excellence (Local Employer Based) Awards	CEA points valued at c£3k which could be more connected to desired service activities
5. Consultant on-call supplements	Reduce paid time allocated to on-and off-site on-call thereby reducing PA and supplementary rates – PA rate valued at £10k plus employer costs
6. Extra hours	I hour on top of 37.5 hours (AfC) would create a 2.66% efficiency gain worth £2.6m (also increasing plain rate time therefore reducing overtime rate working)
7. Flexible benefits	Best to set a target to achieve given complexity – say £100k – where staff exchange salary for increased annual leave
8. Flex-release (voluntary hours reduction)	25 staff give up 25% of working hours (and income) and 50% capacity is not replaced = £125k
9. Increments	Each increment valued at 3% of pay 10% of total increments withheld = £420k on a prospective basis
10. Junior medical staff (juniors)	Limited working employment contract which is mostly education without access to the current % enhancements Up to 50% saving on 1000 staff in SWC
11. Locum and retired consultants	End offer of guaranteed SPA time – unknown number in this position, likely to be c10 consultants therefore savings or capacity creation = £140k. Sufficient SPA time required for revalidation.
12. Knowledge and Skills Framework (KSF) reform into KS Performance Framework	See increments savings profile (Compressor 9)
13. New consultant roles – direct clinical care	Establishment of initially static consultant roles where output is predominantly DCC PAs (90%) 15% saving or capacity creation on the typical consultant role. For 15 new posts = £250k

14. New employer models – a two-tier workforce	This requires special analysis to come up with new terms and conditions – which could be up to 20-25% less than current costs for posts where there is sufficient labour supply
15. Pay inflation (uplift)	Pay cash limit = 0% except very low paid until 2013 – 1% for 2013-14
16. Pay levels	0.5% = £700k 1% = £1.4m
17. Pay protection policy	The typical level of pay protection is between 2 and 3 years. One trust has established 9 months for relatively new staff
18. Preceptorship incremental fast-track	For 50 new band 5 appointments = £60k (deferred benefit as pay progression will ultimately be reached unless promotion occurs)
19. Premium sick pay	Sickness absence paid a plain rate = £100k
20. Recruitment and retention premia (RRP)	Removal of RRPs after protection = £50k
21. Reduction in working week (and income)	10% reduction in working week - equivalent to 250 staff = 3.75 hours for non-medical staff; notional 4 hours per consultant Total pay cost value = £14m
22. Redundancy payments	Current position where redundancy costs average between 1 to 2 years of salary costs given typical length of service plus early-retirement financial commitments
23. Remuneration for extra clinical work	Charges for undertaking extra clinical work (eg Waiting List Initiative)
24. Sickness absence (short term)	2 days of sickness benefit unpaid where average 8 days per person per year @ £150 per day = £750k Assumes no change in sickness rate – where it reduces, savings made on reduced cover
25. Sickness absence (new staff and long term)	Reduce sick pay for new staff and long term benefits from 6 months full and 6 months half pay after 5 years' service to 50% of the value On the basis of 10% turnover – 250 new staff who currently take 10 days sick pay (£0.5m) and 30 staff on very long term sick (£400k)
26. Supporting Professional Activities (SPAs)	Reduce time spent on SPA activity – PA rate valued at £10k plus employer costs SPA average = 2.5 PAs therefore savings or capacity creation of 0.5 PAs x 150 consultants = £1.8m

27. Temporary staffing rates	10% reduction in £10m total spend = £1m
28. Unsocial hours allowances	Estimated total unsocial hours payments = £4m 10% reduction in unsocial hours payments - £400k

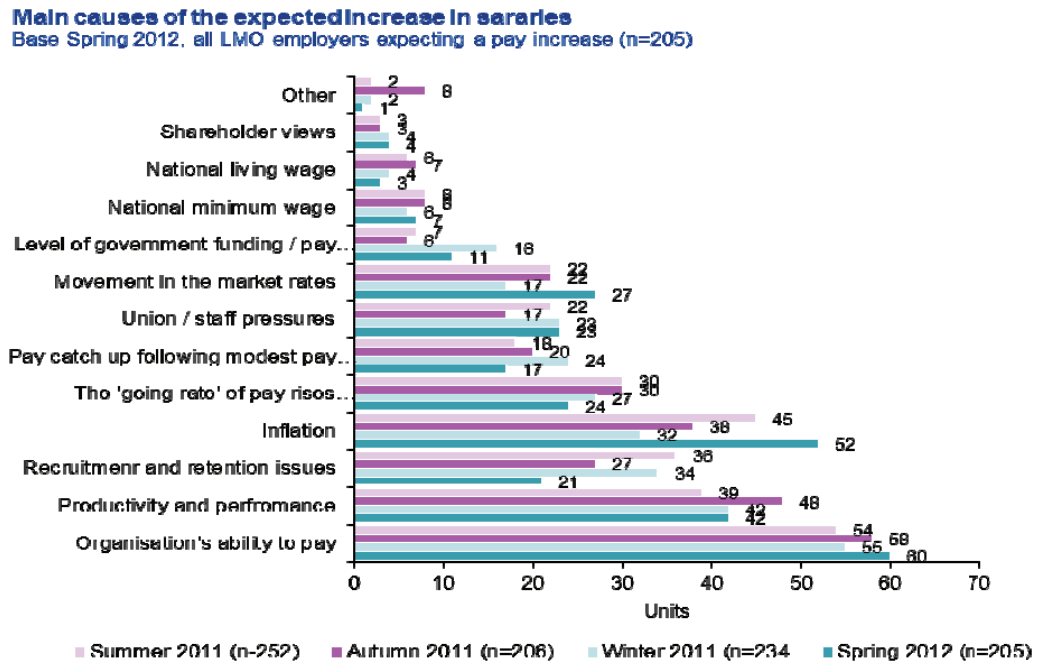
Notes:

- The currency has been modelled on a sample typical trust employing c3.5k staff with average levels of HR KPIs (10% vacancy and turnover, 4% sickness absence, 10% of workforce spend on temporary staff rates)
- Extended hours, reduced annual and sick leave, increased attendance all reduce the need for cover for a proportion of staff (mostly clinical).

WORKFORCE-RELATED DATA

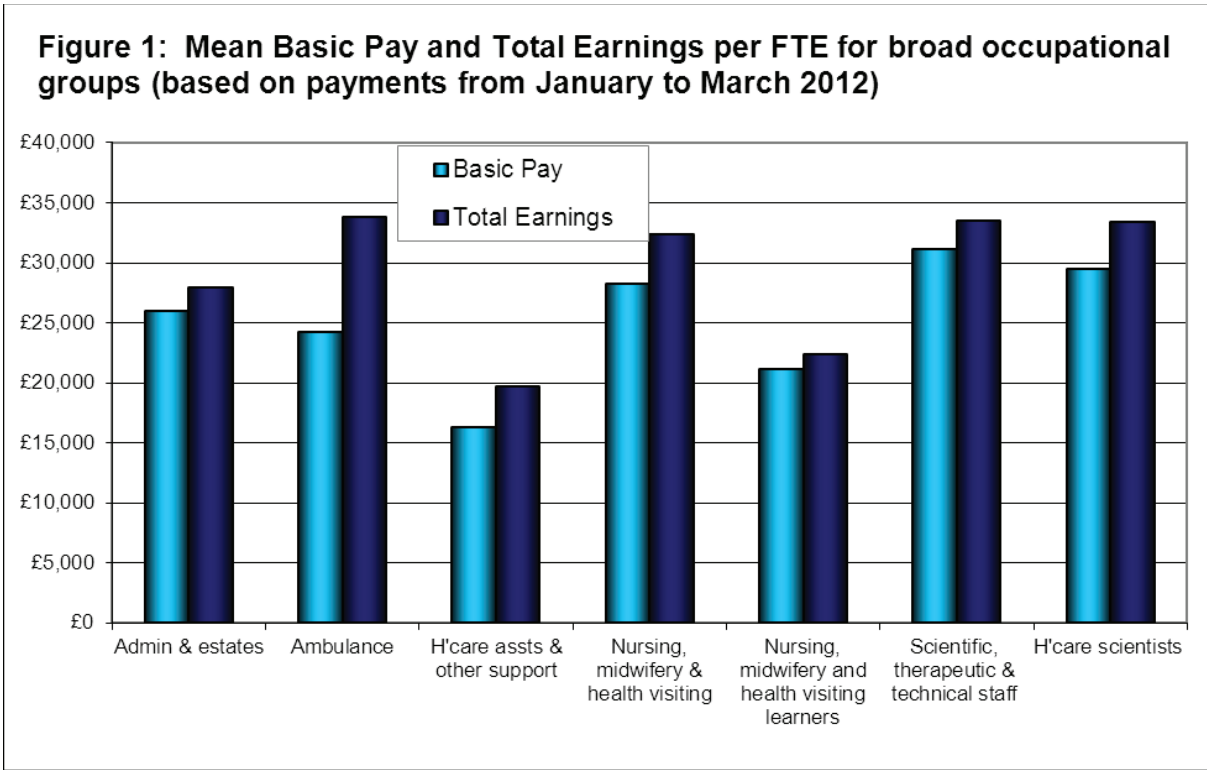
This section collates some background workforce-related data.

Figure 4: Employer views on main reasons for pay increases



Source: CIPD labur market outlook – Spring 2012

Figure 5: NHS employee basic salary and total earnings



Source: Department of Health Information Centre

Figure 6: Medical staff group – basic pay and earnings

	Mean Basic Pay per Full Time Equivalent [1]	Mean Total Earnings per Full Time Equivalent [2]	Median Full Time Equivalent Basic Pay [3]	Median Full Time Equivalent Total Earnings	Average Worked FTE in sample [4]
Foundation Yr 1 / House Officer	£22,600	£32,200	£22,400	£31,400	6,112
Foundation Yr 2 / Sen House Officer	£29,000	£40,700	£27,800	£41,700	7,436
Registrar Group	£37,700	£55,300	£37,400	£53,400	33,842
Consultants (Old Contract)	£84,900	£102,300	£80,200	£92,200	978
Consultants (New Contract)	£89,400	£116,900	£89,400	£108,200	35,191
Associate Specialists (Old Contract)	£82,700	£90,100	£74,400	£80,600	568
Associate Specialists (New Contract)	£79,000	£90,700	£77,200	£82,100	2,610
Staff Grade	£64,000	£70,400	£58,500	£61,800	490
Specialty Doctors	£57,700	£68,800	£55,800	£62,400	4,935

Source: Department of Health Information Centre (June 2012)

DELIVERY TIMESCALES

This paper does not directly address the processes available in terms of the handling and/or implementing of potential changes. However, it should be assumed that there would need to be substantial consultation to secure voluntary agreement to proposed changes, which could mean a period of several months and after submission of the business case and decisions made by each trust board.

7. QUESTIONS FOR DISCUSSION

- Is it reasonable to assume that NHS expenditure will follow the same profile over the three years 2015-18 as is forecast over 2012-2015?
- Is it reasonable and appropriate, helpful and accurate to model the sample trust as employing 3,500 staff with the suggested key performance indicators?
- How can the proportion of workforce savings which need to come from addressing pay, terms and conditions or wholesale redundancies be reasonably quantified?
- Does the description of the economic and financial forecasts reflect what judgements participating NHS employers are considering?
- Have the staff cost reduction opportunities been accurately costed?

8. REFERENCES

These references have been collated in support of both this paper and the accompanying one which addresses the economic, financial and service challenges.

PUBLICATION	SOURCE	DATE	LINK
Forecasts for the UK economy	HM Treasury	July 2012	http://www.hm-treasury.gov.uk/d/201207forcomp.pdf
NHS Staff engagement guidance and on-line toolkit	NHS Employers	2012	http://www.nhsemployers.org/EmploymentPolicyAndPractice/staff-engagement/Pages/Staff-Engagement-And-Involvement.aspx
NHS and social care funding – the outlook to 2021/22	Nuffield Trust	July 2012	http://www.ifs.org.uk/publications/6228
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Securing the financial sustainability of the NHS	National Audit Office	July 2012	http://www.nao.org.uk/publications/1213/nhs_financial_sustainability.aspx

The economic impact of local and regional pay in the public sector	TUC/NEF	July 2012	http://www.tuc.org.uk/tucfiles/345.pdf
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Pay circular (medical and dental) 1/2012	NHS Employers	June 2012	http://www.nhsemployers.org/Aboutus/Publications/Documents/Pay-Circular-MD-1-2012.pdf
NHS staff earnings estimates – Jan to March 2012	NHS Information Centre	June 2012	http://www.ic.nhs.uk/webfiles/publications/010_Workforce/nhsstaffearningsjanmar2012/Earnings_Bulletin_Jun_12.pdf
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Proposals to change Agenda for Change	NHS Staff Council	June 2012	http://www.nhsemployers.org/PayAndContracts/AgendaForChange/Pages/NHSTradesUnionsConsultonProposalsonAgendaforChange.aspx
Rising to the Nicholson challenge	Reform	June 2012	http://www.reform.co.uk/resources/0000/0405/120616_Slides.pdf
Thinking about rationing	King's Fund	May 2012	http://www.kingsfund.org.uk/publications/rationing.html
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Education, training and workforce planning report	Health Select Committee	May 2012	http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/6/602.htm
Healthy efficiency: the NHS and public service reform	Reform	May 2012	http://www.reform.co.uk/content/13769/research/health/healthy_efficiency_the_nhs_and_public_service_refo

			rm
Leadership and engagement for improvement in the NHS	King's Fund	May 2012	http://www.kingsfund.org.uk/publications/leadership_review_12.html
Budget 2012	Treasury	March 2012	http://www.hm-treasury.gov.uk/budget2012_documents.htm
Chancellor's letter to Pay Review Bodies and Government economic evidence	Treasury	March 2012	http://www.ome.uk.com/Article/Detail.aspx?ArticleUid=a782b32d-b08b-423b-8061-361211188711
Budget 2012 and the NHS workforce	NHS Employers	March 2012	http://www.nhsemployers.org/PayAndContracts/Pages/Budget2012AndTheNHSWorkforce.aspx
Submission to the Pay Review Body on market facing pay	NHS Employers	March 2012	http://www.nhsemployers.org/Aboutus/Publications/Documents/Submission-to-the-NHS-Pay-Review-Body-on-market-facing-pay.pdf
Pay circular (Agenda for Change) 2/2012	NHS Employers	March 2012	http://www.nhsemployers.org/Aboutus/Publications/PayCirculars/Documents/Pay_Circular_AfC_2-2012.pdf
NHS terms and conditions of service handbook (Agenda for Change)	NHS Staff Council	Feb 2012	http://www.nhsemployers.org/SiteCollectionDocuments/AfC_tc_of_service_handbook_fb.pdf
Delivering sustainable cost improvement programmes	Monitor/Audit Commission	Jan 2012	http://www.monitor-nhsft.gov.uk/cips
Public expenditure	Health Select Committee	Jan 2012	http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1499/149902.htm
Total reward in the NHS	NHS Employers	Nov 2011	http://www.nhsemployers.org/Aboutus/Publications/Documents/Total_reward_101111.pdf
Location based pay differentiation	Unison/IDS	Sept 2011	http://www.unison.org.uk/file/IDS%20research%20paper%20for%20UNISON%20FINAL%2016%2009%2011%20(2).pdf
A decisive decade – mapping the future NHS workforce	RCN	July 2011	http://www.rcn.org.uk/__data/assets/pdf_file/0004/394780/004158.pdf
Equity and excellence:	Department of	July	http://www.dh.gov.uk/en/Publicatio

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SWC 22nd August 2012

South West Pay Cartel
Letter to 20 Trust Chief Executives

I am writing to you to provide you with a copy of the Royal College of Nursing's report on the workforce profile in the South West which we have made public today.

This document, published by the RCN's Frontline First campaign, includes information from government sources, the NHS Staff survey and the RCN Frontline First database. It demonstrates the grave reality of the current health situation in the South West.

The enclosed report outlines the fact that the number of nursing staff in the South West region is falling, with a reduction of 2.16% between May 2010 and May 2012. Staff numbers are below the national average, but of serious concern is that the number of registered nurses in the South West fell by 3.54% in comparison to the national average of 1.16%. **The South West has had the highest drop of registered nurses of all SHAs.**

This situation runs in parallel to the fact that the region has the highest population of older people of all SHAs in England and older people have the greatest health needs.

Our report outlines the significant cuts that have already been made to services in the region. A move to localised pay would make it more difficult for Trusts to recruit to nursing posts in the South West, and there will be a further loss of nurses as they move to other areas that do offer NHS terms and conditions. This will create a skills deficit in the region that will impact on the ability of Trusts to provide high quality care.

Furthermore, the report highlights information gathered by the NHS staff survey that illustrates the already low morale of nursing staff in the South West. A move to localised pay, and a reduction in income, will have a further impact on morale. Staff who feel that they are not valued by their organisation will lose further trust and confidence in their employers. If they also feel unable to provide good quality care they will leave.

Any organisation operating with the belief that a move to localised pay will reduce staffing costs and lead to efficiency is, quite frankly, labouring under an illusion. The increased bureaucracy and need for constant negotiation will, in reality, increase costs and related expense, not decrease them.

Reducing pay, terms and conditions for South West staff is not the only choice you have. We appreciate these are difficult, uncertain times but there are other service solutions that should be considered that would not impact negatively on patient care. I urge your Trust to withdraw from the South West pay, terms and conditions consortium which is a distraction from the very real issues facing the South West.

Yours sincerely

Dr Peter Carter

Royal College of Nursing

The South West Pay Cartel – the health economy and workforce context

The South West Pay Cartel – the health economy and workforce context

Royal College of Nursing

Introduction

A group of 20 NHS trusts in the South West of England have formed a cartel (known as the "South West Pay, Terms and Conditions Consortium") to move away from the national Agenda for Change (AfC) framework and towards a regional system for pay and conditions. In response to these proposals, the RCN has looked at official workforce statistics, key indicators of health needs and our own data from the *Frontline First* campaign to analyse the current state of affairs in the South West.

Within this context, the RCN believes that breaking away from the national AfC framework is the wrong solution to the problems seen in the South West. In fact, it is likely to exacerbate them, encouraging experienced staff to leave and compromising the care of patients.

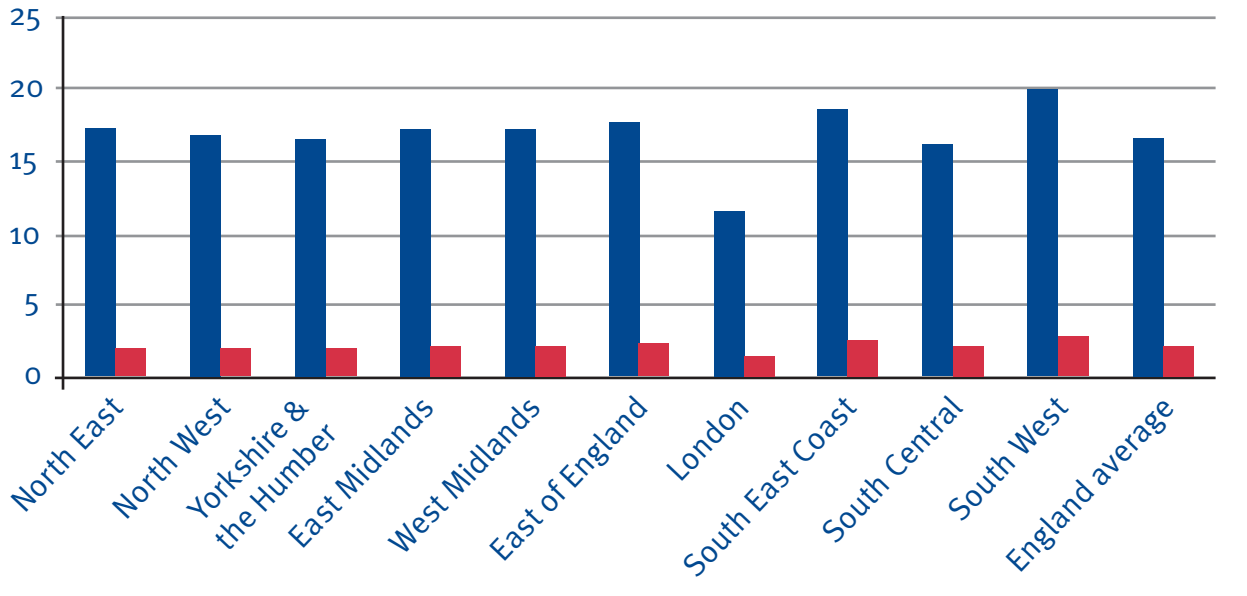
1. Population and workforce

Current situation

The South West SHA area has the oldest population out of all the SHAs in England – 19.78per cent of the population are over 65 and 2.97 per cent are over 85, compared to the England averages of 16.54 per cent and 2.3 per cent respectively (see Figure 1). Older people tend to have greater health needs than average, putting extra demands on the health care staff working in the South West.

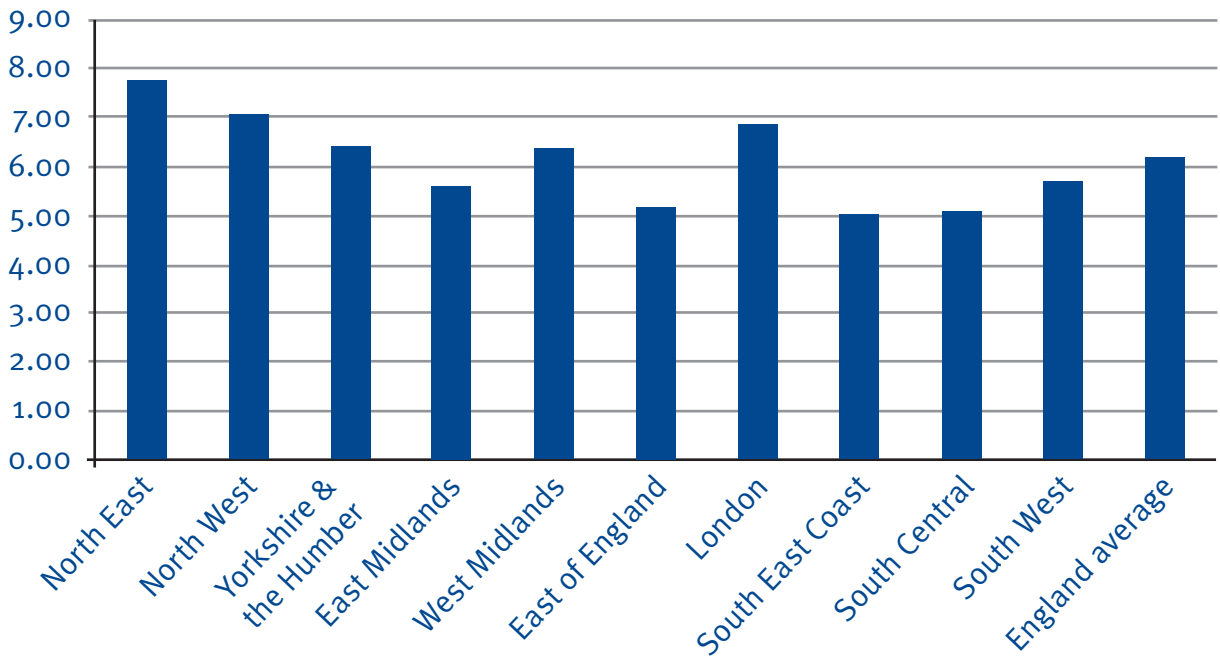
Despite having the oldest population, the number of qualified nurses, midwives and health visitors per 1,000 of the population in the South West is below the national average (5.7 compared to 6.12) (see Figure 2).

Figure 1: Percentage of the population over 65 and over 85 in each SHA area in England



Source data: NHS Information Centre, 2012a

Figure 2: Number of qualified nursing staff per 1,000 people in each SHA area



Source data: NHS Information Centre, 2012a and 2012b

Change over time

Between May 2010, when the Coalition Government came into power, and May 2012 (the latest figures available), the total NHS workforce in the South West decreased by 2.16 per cent. This compares to an average drop of 2.14 per cent across England.

However, if we look at the qualified nursing workforce on its own, this declined in the South West by 3.54 per cent, compared to an average of only 1.16 per cent across England. This was the highest drop of all SHAs (see Table 1).

So overall the workforce in the South West fell by 2.16 per cent, but nurses were hit harder than average and numbers decreased by 3.54 per cent. This is the only SHA region where this was the case. For all the others, nurse numbers either decreased by a lower percentage than the total workforce, or in two cases (London and the South East Coast) slightly increased in number.

Table 1: The percentage change in the NHS workforce between May 2010 and May 2012

	Total NHS workforce % change	Total qualified nursing % change
North East	-0.51%	-0.12%
North West	-3.72%	-3.49%
Yorkshire & The Humber	-3.89%	-3.14%
East Midlands	-2.77%	-0.64%
West Midlands	-2.02%	-0.01%
East of England	-2.94%	-1.95%
London	-0.67%	1.28%
South East Coast	0.63%	2.65%
South Central	-1.71%	-1.43%
South West	-2.16%	-3.54%
England average	**-2.14%**	**-1.16%**

Source data: NHS Information Centre, 2012c

2. NHS staff survey 2011 results

The NHS staff survey asks NHS employees how they feel about their place of work. The 2011 survey (National NHS Staff Survey Co-ordination Centre, 2012) found that:

- 11 out of the 20 trusts in the cartel were in the worst 20 per cent nationally for feeling satisfied with the **quality of work** and patient care they are able to deliver
- 8 out of the 20 trusts in the cartel were in the worst 20 per cent for staff agreeing that their role **makes a difference to patients**
- 7 out of the 20 trusts in the cartel were in the worst 20 per cent for **work pressure felt by staff**
- 7 out of the 20 trusts in the cartel were in the worst 20 per cent for staff feeling there are **good opportunities to develop** their potential at work
- 7 out of the 20 trusts in the cartel were in the worst 20 per cent for staff experiencing **physical violence** from patients, relatives or the public in last 12 months.

Although there is a mixed picture for the South West region as a whole (which is to be expected), in relation to patient focused indicators it is clear that a large proportion of the workforce already feel challenged in their ability to deliver high-quality patient care.

There are variations in relation to how engaged staff feel (both in the South West and other parts of the country). However, of the trusts in the cartel the following were in the worst 20 per cent for **overall staff engagement**:

- Royal Cornwall Hospitals NHS Trust
- Plymouth Hospitals NHS Trust
- Dorset County Hospital NHS FT
- Poole Hospital NHS FT
- Gloucestershire Hospitals NHS FT.

Out of all 38 indicators measured in the survey:

- Royal Cornwall Hospitals has **26 out of 38** indicators in the "worst 20 per cent" category
- Poole Hospital NHS FT has **19 out of 38** indicators in the "worst 20 per cent" category
- Gloucestershire Hospitals NHS FT has **18 out of 38** indicators in the "worst 20 per cent" category
- Dorset County Hospital NHS Foundation Trust has **14 out of 38** indicators in the "worst 20 per cent" category
- Weston Area Health NHS Trust has **12 out of 38** indicators in the "worst 20 per cent" category
- Plymouth Hospitals NHS Trust has **11 out of 38** indicators in the "worst 20 per cent" category.

The staff survey data suggests that staff morale is already low in many of the hospitals in the cartel, with many staff feeling that they are unable to give the quality of care they would like to patients.

3. South West cuts identified by the Frontline First campaign

The RCN acknowledges that trusts in the South West have financial challenges and that savings need to be made. However, we believe that the workforce is the wrong place to start. The RCN *Frontline First* campaign has identified many large workforce cuts that have already taken place in the South West, and these are listed below. Cutting pay or jobs will put even more pressure on an already weakened workforce. Other areas of potential savings such as procurement, drug waste, innovation and expensive PFI contracts need to be looked at first, and any changes must be clinically led.

Royal Devon and Exeter NHS Foundation Trust

The trust published plans to cut 250 WTE posts in 2011-12.

Taunton and Somerset NHS Foundation Trust

The trust has published plans to decrease its workforce by 504 WTE from 2010 to 2013. 60 per cent of the posts are clinical.

Dorset County Hospital NHS Foundation Trust

The trust reduced its bed numbers by 39 and closed its child and adolescent learning disabilities service, which was transferred to another provider. The trust already closed its spinal services in June 2011.

Plymouth Hospitals NHS Trust

The trust published plans to cut 281 posts in the financial year 2011/12, of which 145 were nursing posts. The trust stated that redundancies would be minimised. The extensive review of services and posts saw a significant number of downbanded jobs for nurses and the loss of specialist roles, notably in cardiac rehabilitation and learning and development.

In 2010 Plymouth Hospitals NHS Trust placed 159 staff at risk of redundancy. Approximately 20 Bands 5-7 nurses were affected.

Royal Cornwall Hospitals NHS Trust

In April 2011, the trust announced that it aimed to reduce its workforce by 400 staff by March 2012, mostly through "natural wastage". The trust issued an HR1 placing 38 staff at risk of redundancy.

A review of nursing and midwifery resulted in the loss of half of the trust's matron posts (a loss of eight posts) – five left the organisation during the period of the review or shortly afterwards. More recent difficulties with patient flow have resulted in a review of the medical division and reintroduction of additional matron posts.

North Bristol NHS Trust

North Bristol NHS Trust is closing the Frenchay Hospital and opening a new site with a significant reduction in bed and staff numbers.

Weston Area Health NHS Trust

Hutton Ward closed losing 24 beds. Staff were redeployed to vacant posts.

4. Voices from the frontline

The *Frontline First* campaign allows members to report cuts to services and staff they see in their workplace through a dedicated website. The South West SHA area contains 10 per cent of the population and 10.6 per cent of RCN members in England. However, 14.55 per cent of the reports we have received from members have been from the South West. This means that we are seeing approximately 50 per cent more than we would expect.

The following quotes are taken from these reports. They come from members working at trusts that form part of the South West pay cartel.

"Nursing establishments have been reduced across most clinical areas. Nursing posts have been replaced with non-registered staff. Support staff such as housekeepers, domestic staff have been reduced. Every replacement post has to be approved by the trust executive team. I am aware the trust is exploring options to amend terms and conditions of employment."

"Working overtime but only being paid bank rate (normal pay). Shift patterns and start/finish times changed with a week or less notice and [we were] told if we do not like it there are other places we can work. Vacancies not being filled when people leave, meaning remaining staff have to cover the hours.

"Lots of bullying management styles, no consultations on changes just told at the last minute that something is changing/ happening and get on with it."

"Staffing levels being cut, unpaid overtime being worked by most staff. Specialist nurses being asked to work on wards to fill staffing shortfall over bank holidays. Reduction in extra duty payment to average."

"The trust has recently removed ward administrators with the result that matrons and ward sisters are now having to undertake a greatly increased administrative workload, which is impacting upon time spent undertaking clinical duties. This is negatively impacting upon quality of supervision and clinical leadership with potential for negative impact upon patient care. Shifts which would have previously been covered by the Band 6 and 7 are now having to be covered by agency staff which appears sheer folly since the agency staff are more expensive than regular staff, and ironically the ward administrators were only paid Band 4.

"If you listen to students and Bank Staff they had repeatedly stated they had never before worked with such clinically active matrons, a statement shared by the medical staff. It is a tragedy that these highly experienced clinical staff are now busy in ward offices rather than out in the clinical area. Why standardise to poor practice when the medical areas had got it right? This change is not saving money and is impacting negatively on clinical standards."

"There is a staff shortage as they are not replacing staff who are leaving, retiring, going on maternity leave etc. As I work in theatres it is crucial we have sufficient staff to manage the patient load and lists and we do not have the numbers of staff necessary to cope. When things start to build up or go slow, managers, anaesthetists or surgeons will often come in and shout or demand to know what the holdup is but nothing gets done about the serious staff shortage which in turn makes our job stressful and upsetting on a daily basis. I often feel bullied or rushed into doing things I'm not comfortable with or feel I'm not able to give my patients the care I want to give them. Staff are off late (some days as much as two hours after their 12 hour shift ended) on almost a weekly basis because of lack of staff."

"The hospital has and continues to plan further closure of beds. This has resulted in reducing the establishment of nursing staff to the wards affected. The hospital frequently has no beds. Patients are being nursed in areas where their privacy and dignity is compromised, e.g. observation wards, and these are mixed sex without set visiting hours so privacy for patients is further compromised.

"In addition to this clinical nursing staff on the wards are spending much of their time preparing and packing up patients' belongings in order to transfer from one ward to another and also welcoming transferred patients to their ward getting to know new patients all over again and unpacking their belongings. It is not unusual for some patients to be transferred four or five times."

"The reduction of nursing staff on wards by changing shift patterns and natural wastage. This has resulted in nurses having more patients each shift to care for. Several members of staff have left recently, and their jobs are not being advertised. Shifts also not being covered by the bank, leaving the ward often short staffed. As a consequence workload has increased and job satisfaction decreased, which may be affecting patient care."

Conclusion

Reducing the pay, terms and conditions of staff in the South West is not the only choice that employers have, and this course of action is highly likely to negatively impact on patient care. There is widespread consensus in support of shifting services into the community. It is this sort of whole system reorganisation which will produce savings but is also in the best interests of patients.

We acknowledge that this change will create challenges for the workforce, but simply reducing pay or making short-sighted workforce cuts is not the answer at a time when the health care needs of the population are set to increase. Not only is there a real risk that staff will be forced to leave the NHS, but it will also be difficult to recruit, and the morale of remaining staff will be damaged further.

Rather than working together to cut staff pay, terms and conditions, employers should be collaborating to transform services and bring care closer to home.

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