[redacted]

From: Bown, Chris
Sent: 11 September 2012 13:17
To: 'david@davidamos.net'; Fisher, Jon
Subject: RE: Update on SWC - commercial in consortium

My comments:

I guess the problem is that each FOI lead wishes to do their own thing and make their own judgements rather than receive legal advice via the consortium legal advisors.

I guess the issue also is about the balance of risk in that if we try to influence individual FOI leads they might (but wrongly) see that is inappropriate and putting pressure on them unreasonably and thus think it is sinister (again wrongly) against the risk of documents that might prejudice future negotiations being released when they are subject to appropriate exclusion – a judgement for each CEO?

We are up against the 'closing date' (? Tomorrow)so some will be getting nervous.

Chris

From: David Amos [mailto:david@davidamos.net]
Sent: 11 September 2012 12:57
To: Fisher, Jon; Bown, Chris
Subject: Re: Update on SWC - commercial in consortium

Jon

Do we really want to say thay coordinating FOIs is all too problematic (without knowing what the arguments are). I assume you and Chris have discussed? If we are not coordinating why are we giving the advice contained in this email?

I assume that our decision could still be not to release - should we be indicating that this is still an option as it reads as if we're about to approve release?

Do we want the agenda in the open before next week?

Happy to discuss.

Thanks

David
Sent using BlackBerry® from Orange

From: "Fisher, Jon" <Jon.Fisher@poole.nhs.uk>
Date: Tue, 11 Sep 2012 11:28:20 +0000
To: 'david@davidamos.net'<david@davidamos.net>; Bown, Chris<Chris.Bown@poole.nhs.uk>
Subject: RE: Update on SWC - commercial in consortium

Thanks David, I've revisited in light of your comments. The email carries on quite a bit further than ;instead' unfortunately, the bits after this need close scrutiny...will send that bit to you in a minute.

Would be useful if the agenda for the 18th could be attached, I can't find this in my emails though. Will ask Angie to attach once this email text is agreed.

Jon.

Dear all,

Reponses to letters received from Unison and RCN
You will all now likely to be in receipt of letters from [redacted], Unison head of health and on behalf of the NHS staff council unions, and Dr Peter Carter, RCN chief executive and general secretary. I will be issuing a model response to each of these letters shortly that you may wish to use as the source text for your replies.

Appointment of project manager
I am pleased to announce the appointment of Kristin Crook as the new consortium project manager. Kristin has worked extensively in health, as well as in public sector finance. Kristin will work for the consortium on a part-time basis, and can be contacted via [redacted] Further information on Kristin's role will be circulated later this week.

Reminder – 18 September conference
If you have not already done so, please confirm attendance (including the detail of any nominated trust representatives you wish to attend) as soon as possible, via angela.challice@poole.nhs.uk Please see my email of 3 September for more information, or contact Angie directly.

Outstanding FOIs – advice received: please cascade this section to your FOI leads
1) 'Provide all correspondence relating to the consortium between trust X and other consortium trusts. In addition provide all internal correspondence within trust X relating to the consortium' (note: further request made in response to a request for clarification of initial request):

The applicant, in the view of the consortium's legal advisor, has not clarified but in fact extended the scope of their original request and therefore trusts should return to the applicant to state this, and that their revised request is very likely to exceed the fees limit. In the spirit of providing a response to the applicant, trusts may wish to inquire whether, in light of this, the applicant would like their original request to be dealt with instead. Trusts should begin to compile the information requested in the original FOI inquiry ('provide all correspondence relating to the consortium between trust X and other consortium trusts') prior to receiving confirmation from the applicant, and to begin to review the contents to see what information is held and whether any exemptions may apply.

2) 'Provide all correspondence relating to SWC between trust X and the Department of Health':

It is highly unlikely that many consortium trusts will hold such correspondence. Your FOI leads should be tasked with identifying any relevant correspondence that you may hold in the usual way and in the event that such correspondence exists, considers fully which exemptions may or may not apply.

Future FOI handling – not for onward dissemination
As you know, we have tried to co-ordinate FOI requests and responses from a consortium-wide perspective to date. For a variety of reasons, including logistical issues (for example FOI requests arriving with different trusts at different times, not all trusts receiving the same FOIs, difficulties in identifying common requests, each trust holding potentially different information, etc) and governance frameworks (eg each trust being ultimately responsible under the act for their own response, leading to discomfort among some about working with consortium-wide advice) it has not been possible to manage this effectively.

It had been hoped that an FOI working group would be established to support the management of such requests in the future, and a teleconference looking at practical ways this may be taken forward took place on Friday of last week. Regrettably, the general view of those on the call was that centralised support was problematic, not relevant to all trusts and in some cases, unwelcome. The group was unwilling to move forward without detailed terms of reference, which will be time consuming to create, and produce an unwieldy and potentially overly-complex new process. No trust FOI representative on the call was willing to help in the initial production of these terms of reference, it should be noted.

Therefore it is proposed that each trust should proceed to respond to FOI requests received that concern the consortium in line with best practice and under the direction of your own FOI teams. I would however encourage you to contact Kristin (see contact details above) if you have any significant questions or concerns, and provide your FOI responses where appropriate to her as well for our records.

Kind regards,

Chris.

.....

Jon Fisher
Senior communications manager

From: David Amos [mailto:david@davidamos.net]
Sent: 11 September 2012 11:48
To: Fisher, Jon; Bown, Chris
Subject: Re: Update on SWC - commercial in consortium

Jon

Looks good - good idea to include reference to KC.

1) Do you want to say when "shortly" is?
2) "...as THE new..."
2) Say she is part-time rather than 3 days per week

Does your letter end with "instead", just checking that I've seen it all?

Is it worth reminding them re: 18th?

Thanks

David
Sent using BlackBerry® from Orange

From: "Fisher, Jon" <Jon.Fisher@poole.nhs.uk>
Date: Tue, 11 Sep 2012 10:29:18 +0000
To: Bown, Chris<Chris.Bown@poole.nhs.uk>; david@davidamos.net<david@davidamos.net>
Subject: Update on SWC - commercial in consortium

Hi Chris, David, draft email to CEOs/HRDs below.

You will want to review very carefully as some bits may be contentious, ref FOIs in light of yesterday's emails on the same subject.

s42

Advice for FOI 1) is my summary of [redacted] for FOI 2) it is my common sense approach to handling.

Don't know if you want Kristin's contact details circulated? I have added them in to email for now.

Jon.

Dear all,

Reponses to letters received from Unison and RCN
You will all now likely to be in receipt of letters from Christina McNea, Unison head of health and on behalf of the NHS staff council unions, and Dr Peter Carter, RCN chief executive and general secretary. I will be issuing a model response to each of these letters shortly that you may wish to use as the source text for your replies.

[redacted]

From: Bown, Chris
Sent: 22 August 2012 10:14
To: Challice, Angela
Subject: South West Consortium Discussion Documents Publication
Attachments: 22 8 12SWC Letter to trade unions publications.doc

Importance: High

Angie this is the letter to all but the RCN and the SoR. Need to add website address in full.

Chris

Dear (RCN and SoR only)

Further to my letter to you on 10th August, I am now writing to provide you with copies of the two discussion documents which have been produced by the Steering Group of the South West Pay, Terms and conditions Consortium (SWC).

The trusts involved in the SWC have decided that they wish to undertake a comprehensive discussion around the themes in these two documents in an open and transparent way. Each trust will be providing an internal briefing to staff, staffside representatives, FT governors (where appropriate) and trust board members immediately prior to the publication of these two discussion documents (at Noon on 22nd August). The SWC is also issuing a press release and an updated set of FAQs at the same time. All of the documentation will be available on the SWC website (www.....).

I would like to emphasise that these two discussion documents do not contain any decisions and have been produced to encourage informed debate and discussion. One have been designed to set out what the service, financial and economic challenges are over the next few years – so that we can assess whether this adequately quantifies what the twenty trusts feel could be the case. The other sets out an assessment of the current position relating to pay, terms and conditions given the pay reforms of the past decade, and produces a long list of options for consideration – nothing has been excluded at this stage of the debate as no proposals or decisions have been made.

Finally I would like to thank you for your reply to my previous letter, where you have indicated that your trade union is prepared to meet Chief Executives of the SWC to examine the challenges which face the NHS. I will share your response with colleagues and we can discuss how best to make this happen practically.

I look forward to hearing from you.

Yours sincerely,

Chris Bown

Chair SWC

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

		2013/14	2014/15	2015/16	2016/17	2017/18
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

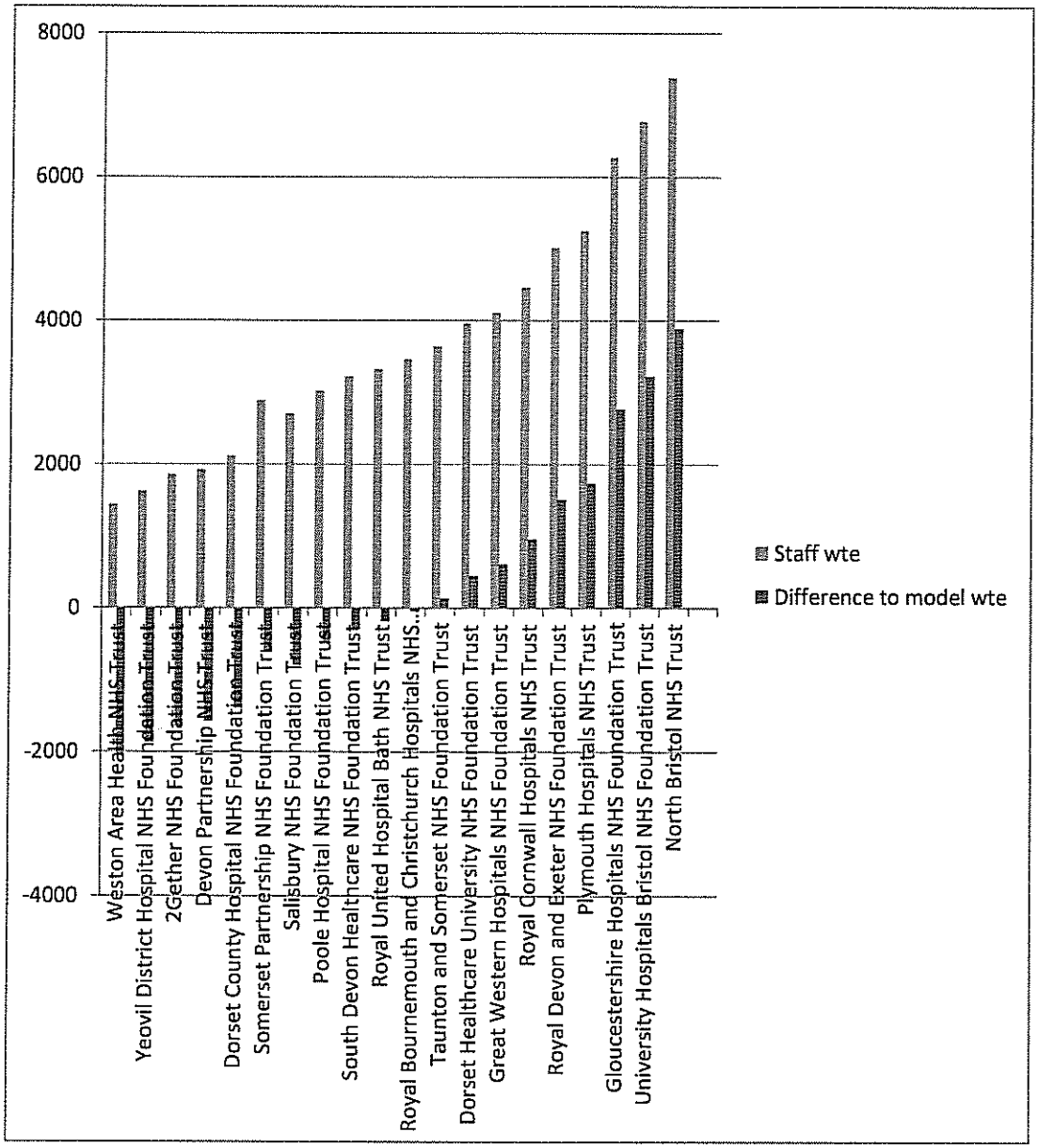
to proposing changes to pay, terms and conditions. Considerable efforts will be required to maintain this level of contribution through productivity improvements, such as reducing length of stay and changes to care settings. The alternative to addressing pay, terms and conditions is a wholesale reduction 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

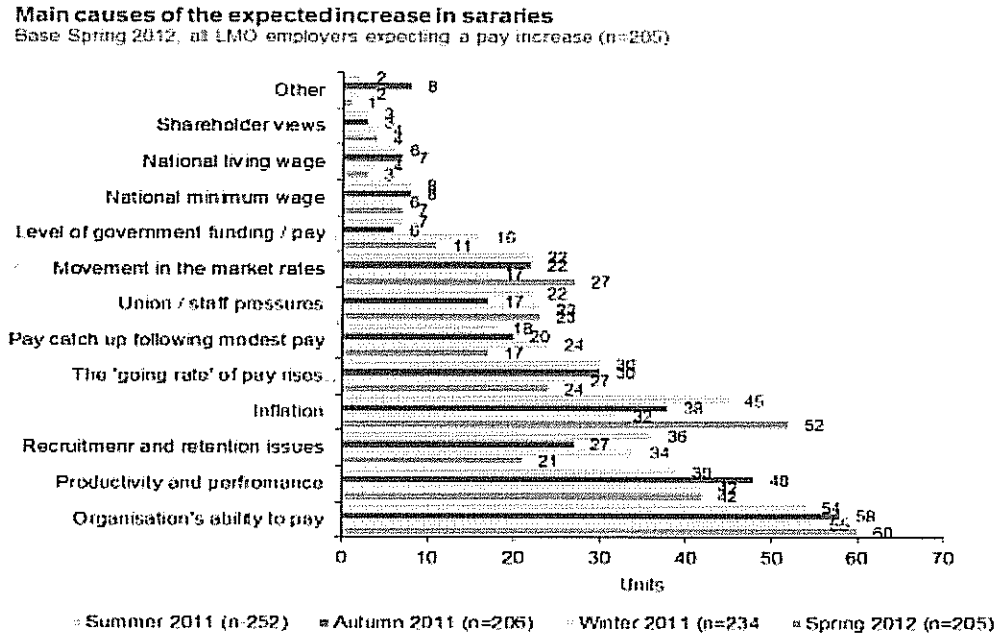
Notes:

- 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

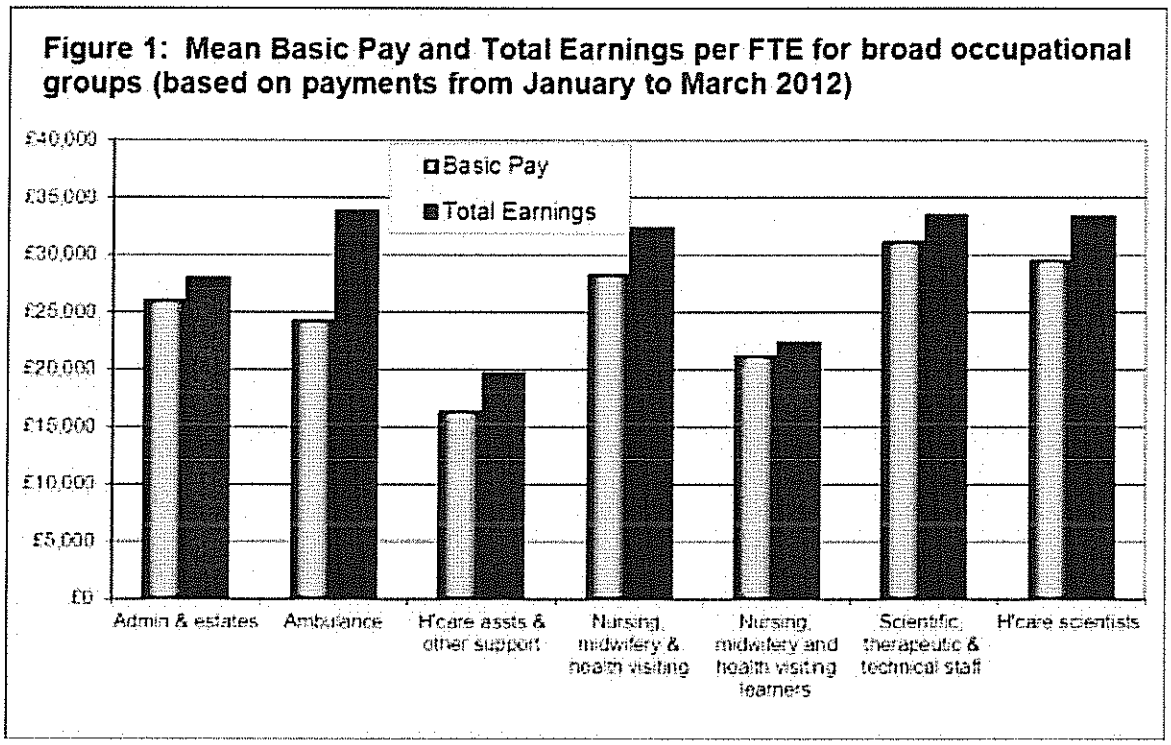
This section collates some background workforce-related data.

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.

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