Fourteenth report on nursing staff, midwives and health visitors 1997 / Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine ; Chairman, Bryan Rigby ; presented to Parliament by the Prime Minister by Command of Her Majesty, February 1997.

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Fourteenth Report
on Nursing Staff, Midwives
and Health Visitors 1997

Chairman: Bryan Rigby

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The Review Body for Nursing Staff, Midwives, Health Visitors and the Professions Allied to Medicine was set up in July 1983 to advise the Prime Minister on the remuneration of

(i) Nursing staff, Midwives and Health Visitors employed in the National Health Service;

(ii) Physiotherapists, Radiographers, Remedial Gymnasts, Occupational Therapists, Orthoptists, Chiropodists, Dietitians, and related grades employed in the National Health Service.

The physiotherapy and remedial gymnastics professions merged in November 1985 to form a single profession of physiotherapy.

The members[1] of the Review Body are :

Mr Bryan Rigby *(Chairman)*
Mrs Anne Dean
Mrs Sheila Gleig
Mr Lyndon Haddon
Ms Ruth Lea
Miss Anne Mackie, OBE
Mr Keith Miles
Professor Gillian Raab.

The Secretariat is provided by the Office of Manpower Economics.

[1]Mr Miles was appointed to the Review Body by the Prime Minister in April 1996.

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Main findings and recommendations

- Our primary role is to ensure fair pay for nursing staff. We continue to believe that local pay determination can play a role in fulfilling that task: our support for the principle has not changed.
- However, we are disappointed with the course of local pay determination in 1996. Nursing staff appear to have been offered by way of local pay increases that which was left after other priorities had been met. The outcome for individual nurses has been uncertain and often very slow to materialise. In many cases Trust management and staff were left negotiating over small sums. This is not how we believed matters would develop when we made our recommendations.
- The parties have again referred the question of uprating to us. **We have decided that for 1996–97 there should be a total uprating of 2.8 per cent over the uprated 1995–96 salary scales**, that is, a further 0.8 per cent from April 1997, in addition to the 2 per cent increase in national scales recommended in our last report and agreed for 1996–97.
- In considering the options for the year 1997–98, we have sought to arrive at recommendations which would give further encouragement to the process of local pay determination, while at the same time safeguarding the pay levels of nursing staff. Some Trusts have been able to introduce relevant organisational change, supported by innovative approaches to local pay determination. However they are still few in number, and cover a small minority of our remit group. We are of the view that progress towards local pay determination will continue to be limited unless additional funding is made available to enable Trusts to implement change.
- **We therefore recommend that separately identified funds be made available within the Health Departments that Trusts might draw on, as and when they can demonstrate that they have a viable strategy for restructuring remuneration, to the benefit of the service offered to patients and the nursing staff who provide it.**
- We also remain convinced that scope for effective local pay determination in respect of staff on Whitley, and shadow Whitley contracts, would increase significantly if it could be agreed which aspects of national terms and conditions should remain as core for the service as a whole and which should be regarded as of operational significance and negotiated locally. We urge the Departments' and Staff Side's negotiators to meet to consider the matter.
- The development and implementation of local pay strategies take time. Our task is to ensure that nursing staff receive fair treatment while progress is made in Trusts, at differing rates appropriate to their own needs and circumstances, towards local strategies involving pay. **We therefore recommend for 1997–98 a 3.3 per cent increase in the uprated national scales, payable from April 1997.** We make no recommendations for 1997–98 in relation to leads and allowances, believing that any changes in these can best be determined locally.
- Our recommendation on national scales is not intended to preclude further locally negotiated increases in those Trusts where management and staff sides can work together to achieve them. In addition, we hope that the prospect of the additional funds we propose being available will encourage the more widespread development of local pay initiatives which contribute effectively to the continuous development of nursing care.

Chapter 1

The background to the report and our recommendations for 1997–98

Evidence received and visits made for the fourteenth review

1. In this fourteenth review we have taken evidence from the Minister for Health, the Health Departments, the National Association of Health Authorities and Trusts (NAHAT) and the NHS Trust Federation, the Association of Healthcare Human Resource Management (AHHRM), the Staff Side of the Nursing and Midwifery Staffs Negotiating Council, the Royal College of Nursing (RCN), UNISON, the Royal College of Midwives (RCM), and the Health Visitors' Association (HVA) and Scottish Health Visitors' Association (SHVA). We are most grateful to all these organisations whose evidence has materially assisted us in our task.

2. As in previous years we have been helped by surveys conducted for us by the Office of Manpower Economics (OME). These include a major study monitoring the impact of local pay determination (see Appendices E and F) and a survey of nursing manpower, the results of which are set out in Appendix D and summarised in chapter 3.

3. We have again made a number of visits to NHS Trusts to meet management and the staff on whose pay we make recommendations and to listen to their views. Once more, local pay determination was the topic on which we received most comment, but other matters were also brought to our attention. We visited Trusts covering mental health, learning disabilities, acute, and community care. We were thus able to form some first-hand impressions of the circumstances in which staff work and the attitudes of nurses, midwives and health visitors to a number of issues. We thank the many individuals in the Trusts who spent time talking to us. Such visits provide us with a fuller understanding of the context within which to interpret the formal evidence we receive.

Background to the Review Body's 1996 report and to its recommendations for 1997–98

4. We first proposed an element of local pay determination in our recommendations for 1995–96. We did so because we felt that such a recommendation stemmed logically from the NHS reforms. We also considered that local pay determination, particularly as part of a more general change strategy, had the potential both to benefit staff and to contribute to the achievement of greater flexibility and efficiency in delivering health services.

5. Despite constraints on the introduction of local pay determination in 1995, we continued to support it in our recommendations for 1996-97 for the following main reasons:

- the original reason for recommending local pay determination had not changed;
- almost all Trusts had reached pay settlements of three per cent on basic pay for their nursing staff in 1995–96. This increase compared

favourably with awards elsewhere in the public sector and was broadly in line with those in the private sector;

- we regarded the September 1995 framework agreement for local pay determination as providing significant safeguards for staff. Importantly, too, it was an agreement that the parties had reached together. Moreover, as a result of that agreement, the vast majority of nursing staff in the NHS received, as part of their 1995–96 annual pay settlement, an amount determined locally;
- we felt that many Trusts had made significant progress in developing their thinking about local pay determination and in some instances were devising attractive local pay packages.

6. The national framework agreement for local pay determination included uprating provisions to ensure that national salary scales were adjusted annually to reflect the outcome of local pay negotiations in the preceding year. Following failure by the two Sides of the Nursing and Midwifery Staffs Negotiating Council to agree on an appropriate level of uprating for 1995–96, we considered the evidence and decided that there should be a total uprating of three per cent over the 1994–95 national scales.

7. We recommended for 1996–97 a 2 per cent increase in these uprated national scales as a basis for further local pay determination. We did this because we were aware that, notwithstanding the framework agreement and the overall level of pay settlements achieved in 1995–96, the Staff Side organisations, and nursing staff themselves, remained nervous about local pay determination and that some reassurance was required in terms of the level and timing of increases being received.

8. We further recommended that individual Trusts should engage in negotiation with their staff representatives about local pay increases. We placed no upper or lower limit on such further increases. However, we took the view that in addition to our recommended increase in national salary scales, the resources available for 1996–97 should have enabled Trusts to offer reasonable local pay increases that made negotiation worthwhile.

9. We are disappointed with the course of local pay determination in 1996. Our primary role is to ensure fair pay for nursing staff. We continue to believe that local pay determination can play a role in fulfilling that task: our support for the principle has not changed. However, the process operating in 1996 has generally left the local element of pay for nursing staff as a residual to be determined after all other demands on available funds have been satisfied. The outcome for individual nursing staff has been uncertain and often very slow to materialise, and is not how we envisaged matters proceeding when we made our recommendations. Contrary to our expectations, Trust management and staff were left in many cases negotiating over small sums.

10. There are a variety of competing pressures for funds in 1997–98. In these circumstances, Trusts might yet again only feel able to offer nursing staff, by way of local pay increases, that which was left after other Trust commitments had been met. The Health Departments have recognised that there is a problem with the process and we welcome the recommendations contained in the "Flory" report on pay, finance and contracting.[1] The guidance is a useful start in encouraging Trusts to plan their local pay strategies, and to enter into a dialogue with purchasers about them. However, we are not convinced that even with this guidance, the arrangements are yet in place to deliver the types of local pay awards we would regard as being fair were we to recommend the degree of local pay flexibility the Departments and employers propose.

11. We remain convinced, despite our disappointment with the course of the 1996–97 pay round, that local pay determination makes sense in the context of

[1]The report of the working party on NHS pay, finance and contracting, chaired by David Flory, Regional Director of Finance for Northern and Yorkshire.

the current NHS structure and retains the potential to benefit both staff and patients, and contribute to improved flexibility and efficiency in service delivery. Indeed, in our visits and monitoring, we saw examples of local pay determination positively supporting organisational change and innovation. The schemes in question entailed simpler pay and grading structures which rewarded the acquisition of skills and/or the achievement of high performance and were regarded by those involved as improving job satisfaction and career progression, as well as supporting more effective organisation for the delivery of patient care. A feature of these initiatives was close involvement in their development by nursing staff and their unions; this involvement is in our view necessary if organisational change is to be introduced successfully.

Recommendations for 1997–98

12. We record in paragraphs 34 to 38 our decision that, since the parties had failed to agree an uprating figure for 1996–97, **there should be a total uprating of 2.8 per cent over the uprated 1995–96 salary scales,** that is, a further 0.8 per cent from April 1997, in addition to the 2 per cent increase in national salary scales recommended in our last report and agreed for 1996–97.

13. In considering the options for the year 1997–98 we have sought to arrive at recommendations which would give further encouragement to the process of local pay determination, while at the same time safeguarding the pay levels of nursing staff. This has been difficult, particularly given the polarised views of the parties.

14. Some Trusts have developed innovative approaches to local pay determination but they are still few in number covering a small minority of nursing staff. More evidence of widespread creativity in the application of local pay determination is needed if the whole process is not to fall into disrepute and an opportunity be lost. We are of the view that progress will continue to be limited unless funding is available to help to implement change. Significant resources are usually required to introduce new pay and grading systems, for example: for consultancy; for assimilation on to new pay spines; for consolidation of allowances, where appropriate; and for incentives to encourage staff to transfer. **We therefore recommend that separately identified funds be made available within the Health Departments that Trusts might draw on, as and when they can demonstrate that they have a viable strategy for restructuring remuneration, to the benefit of the service offered to patients and the nursing staff who provide it.** We believe that this is likely to be the best way to encourage local pay determination for our remit group. We do not recommend a specified level of funding, but experience suggests that sums in the region of some 2 to 3 per cent of a Trust's paybill for the groups affected might be required over a period to implement change of this kind. Trusts are at different stages in terms of the development of strategies for local pay determination and it is likely, in our view, that funds would need to be available over a number of years in order to enable Trusts to proceed when they are ready. The overall cost in any one year would therefore be less significant. We believe however that in the longer term, our proposal should enable further efficiencies to be achieved, thus justifying the initial investment.

15. We also remain convinced that scope for effective local pay determination in respect of staff on Whitley, and shadow Whitley contracts, would increase significantly if it could be agreed which aspects of national terms and conditions should remain as core for the service as a whole, and which should be regarded as of operational significance and negotiated locally. This would enable management and staff to work constructively together to identify ways of increasing efficiency and benefiting both patients and nursing staff. We urge the Departments' and Staff Side's negotiators to meet soon to consider the matter.

16. The development and implementation of local pay strategies take time, and even if funds were available, many Trusts would not be in a position to make significant progress in 1997–98. We believe that this is mainly because their local

pay strategies require further development but that progress is also hampered in some cases where information systems are inadequate.

17. Our task is to ensure that nursing staff receive fair treatment while progress is made in Trusts, at differing rates appropriate to their own needs and circumstances, towards local strategies involving pay. After carefully considering a range of options, **we recommend for 1997–98 a 3.3 per cent increase in the uprated national scales, payable from April 1997.** This seems to us, in the circumstances, the most appropriate way forward at this stage. It provides, in essence, a "breathing space" for those Trusts which have not yet implemented innovative approaches to local pay strategies to enable both management and staff to work constructively together to that end. We make no recommendations for 1997–98 in relation to leads and allowances, believing that any changes in these can best be determined locally between management and staff sides.

18. Our recommendation on national scales is not intended to preclude further locally negotiated increases in those Trusts where management and staff sides can work together to achieve them. In addition, we hope that, with the prospect of the additional funds we propose being made available, the opportunity will be taken, on a more widespread basis, to develop strategies for future implementation which contribute effectively to the continuous development of nursing care.

19. As emphasised in previous reports, we remain firmly of the view that:

- Trusts should apply our recommendations to their nursing staff, midwives and health visitors on shadow Whitley contracts in the same way as they apply them to staff on Whitley contracts. The application of the uprating figure should also apply similarly to both groups of staff;
- our recommendations, and the application of the uprating, should provide the wider framework within which Trusts negotiate pay and conditions for staff on distinct Trust contracts.

20. We shall continue closely to monitor developments in local pay determination and their outcome. The results of this monitoring will be one of the factors that we take into account when formulating our recommendations for 1998–99.

Chapter 2

Local pay determination in 1996

Background

21. In this chapter we consider in more detail developments in local pay determination in 1996.

22. We are disappointed with the course of local pay determination in 1996. Our primary role is to ensure fair pay for nursing staff and our support for local pay determination is based on its potential for furthering that aim. We made our recommendations in good faith. We noted that the Government was providing 3.9 per cent additional resources. As we stated in our 1996 report, we believed that these resources should have enabled "all Trusts to offer reasonable local pay increases to their staff" in addition to our recommendation for a 2 per cent increase in national salary scales. In the event, and contrary to our expectations, Trust management and staff were left in many cases negotiating over small sums.

23. Our 1996 report also described a number of further criteria against which progress would be judged. These included: the need for Trusts and purchasers to work constructively together to achieve a beneficial outcome for both nursing staff and patients; that efficiency gains arising from local pay determination should benefit nursing staff directly, as well as the Trust as a whole; that Trusts should develop attractive pay strategies; and that staff should be persuaded of the benefits of local pay determination. In our view, these criteria have not been widely met.

The process of local pay determination in 1996

24. Trusts have generally failed to take the initiative in the development of their local pay strategies and purchasers appear to have demonstrated little interest in the issue. As a result, and as the evidence from the Health Departments confirms, many purchasers took the view that pay increases for staff within Trusts would be adequately funded at the level of the gross domestic product (GDP) deflator for 1996–97 of 2.75 per cent, and that it was up to Trusts to fund any additional amounts through further efficiency savings beyond those already required (averaging 3 per cent) to support improved patient care. These further efficiency savings, dependent in turn on increased productivity, have been difficult to achieve, especially since the framework agreement has placed on a slower track national negotiations to enable local variation of Whitley conditions. Moreover, because the 2.75 per cent had to cover nationally determined increases in doctors' pay as well, many Trusts advised their employees that even this level of increased funding might not be available for nurses' pay.

25. We are not satisfied with a process in which nursing staff appear likely to be offered by way of pay increases that which is left after other priorities have been met. We therefore welcome the "Flory" report which resulted in guidance from the NHS Executive to Trusts and purchasers on how to approach pay, finance and contracting in future. The emphasis on Trusts' responsibilities for developing remuneration strategies; on providers and purchasers entering into a dialogue about them; and the encouragement of early consideration of proposed

levels of local pay increases in purchaser/provider contract negotiations, is particularly helpful. Nonetheless it is guidance only, and given continued pressure on NHS funding, and the marked change of behaviour from both Trusts and purchasers required to implement it, we are concerned about whether it will lead to significant change, at least in the short term. We would wish to avoid a repetition of this year's events.

The negotiating process

26. A further feature of the process that has operated in 1996 is that the sums involved have often been too low for meaningful local pay negotiation to take place. All parties complained to us about the fact that there was so little to negotiate about. This has meant that there has been little local creativity in the use of local pay determination – for example in the tackling of recruitment and retention problems – and that some managers, as well as many local staff sides, have questioned whether it has been worth the time and effort involved.

Local pay determination for staff on Whitley, or shadow Whitley contracts

27. There has, in our view, been little effective use made of local pay determination during 1996 in respect of the vast majority of nursing staff who remain on Whitley, or shadow Whitley contracts. We consider that if local pay determination for these staff is to be successful it needs to provide opportunities for negotiation of changes in existing practices with the objective of producing efficiency gains leading to benefits for both patients and staff. The provision in the framework agreement that national negotiations for local variation of Whitley conditions should be on a slower track has severely limited the areas of change that Trusts have felt able to address through local pay bargaining. No Whitley conditions for nursing staff have been remitted for local negotiation during 1996. We consider that it would be desirable for agreement to be reached on which national terms and conditions should remain as core for the service as a whole, and which should be regarded as operational and for local negotiation.

Local pay determination for staff on distinct Trust contracts

28. We are aware that a significant number of Trusts would like to introduce local contracts which include new pay and reward strategies. These strategies, which are part of a much broader approach to process improvement and the re-organisation of service provision, tend, typically, to contain simpler pay and grading structures; reward the acquisition of skills, competencies and/or good performance; consolidate allowances into basic pay and harmonise hours of work. Such initiatives have the potential, we feel, to result in agreements with gains for both patients and nursing staff, funded from savings which would not otherwise have been achieved.

29. Nonetheless while many Trusts appear to have made progress in thinking through how they might use local contracts, much less progress has been made in implementing them, and encouraging take-up by existing nursing staff. The introduction of new local pay and grading arrangements has a variety of resource and cost implications, including the design of new systems; the costs of assimilating staff on to new pay scales; and incentives for staff to transfer. Trusts have in our view been hampered by the absence of funds that they might draw on to assist them in this task. The right of a large number of staff to retain their Whitley contracts means that managers have to provide tangible benefits to encourage staff to transfer. Without such incentives we feel that the movement of staff on to distinct Trust contracts is likely to be very slow indeed.

Local pay settlements for nursing staff in 1996

30. Two important measures of the success of local pay determination are the pace at which local pay settlements are reached, and their level. By December, some ten months after our recommendations were known and over eight months after the beginning of the financial year to which our recommendations applied, the Health Departments said that some forty per cent of Trusts had reached local pay settlements in respect of their nursing staff.

31. A number of reasons have been put forward by the parties to explain the slowness with which pay offers have been made, and settlements reached. These include delays in the settling of Trusts' contracts with purchasers for 1996–97;

lack of forward planning about local pay for nursing staff by Trusts and purchasers; competing financial and service pressures in a particularly difficult year; a perception that our recommendation for a 2 per cent increase in national salary scales consumed the major share of resources available; a tendency on the part of some Trusts and some staff side representatives to await a lead from elsewhere; the attitude of the national Staff Side; insufficient management resources and lack of Trust commitment to the process. Notwithstanding these problems, we are disappointed with the pace of local pay settlements for nursing staff in 1996.

32. The second measure of success is the level of local pay settlements reached. Again, nursing staff are unlikely to be personally convinced that local pay determination can benefit them unless they receive pay awards which are both broadly in line with those achieved in the public sector and in the economy more generally, and which also reflect their perceived contribution to their local Trust. While we did not explicitly indicate a range or level for the outcome of local pay negotiation in 1996–97, we did state that we expected Trusts to offer reasonable local pay increases to their nursing staff, in addition to our recommended increase in national salary scales.

33. While we do not yet know the final outcome of local pay settlements for nursing staff in 1996–97, we have been concerned at the levels of some local pay offers which have, in turn, led to delays in concluding settlements. We believe that the levels of these offers have stemmed, at least in part, from a process which has failed adequately to provide for local pay determination for nursing staff. While appreciating the difficulties referred to in previous paragraphs, we have also been concerned at the lack of creativity in the nature of the pay settlements reached.

Uprating in respect of local pay settlements in 1996–97

34. In December 1996 the two Sides of the Nursing and Midwifery Staffs Negotiating Council reported to the Review Body that they had failed to reach agreement on the extent to which national salary scales should be uprated from 1 April 1997 to reflect the outcome of local negotiations in 1996–97, and asked us to make the decision.

35. In its evidence, the **Management Side** argued that because, at the time the negotiations were taking place, there had been significantly fewer settlements than the Health Departments' target of 50 per cent by that stage, the overall position on both offers and settlements should be recognised when we reached our decision. It took the view that settlements alone were not representative of the range of offers and affordable outcomes across the NHS. It asked us to set the uprating figure at **2.5 per cent** arguing that such a figure reflected the intention of the framework agreement to underpin local pay developments. It also argued that it was necessary for the uprating figure to be settled at a level which was broadly affordable in the service and reflected the varying pressures on Trusts. It suggested that a significantly higher figure would ratchet up rates in an unacceptably large number of Trusts; undermine confidence in the framework agreement; and prejudice Trusts' ability to make reasonable local pay offers from 1 April 1997.

36. The **Staff Side**, in its evidence, argued that the vast majority of settlements were at 3 per cent or higher. Moreover the level of outstanding offers was, for the most part, slowly increasing. It stated that the only conclusion that might reasonably be drawn was that the overwhelming majority of nursing staff would receive pay increases for 1996–97 of 3 per cent. It referred to the terms of the framework agreement which said that "it will be inappropriate for national scales to reflect the extremes of local practice. Therefore in determining increases both Sides shall have regard to the range and distribution of local settlements and should agree a figure which best accords with local practice". It further suggested that arguments relating to the general economic climate or affordability had no bearing on, or relevance to, the framework agreement. It asked us to set the uprating figure at **3 per cent**.

37. Given the relatively low number of settlements at the time we were asked to make the decision, we have considered it reasonable to consider the range and distribution of both offers and settlements. However, we are also mindful of the terms of the framework agreement, in particular that it would be inappropriate for national scales to reflect the extremes of local practice. We believe that an uprating figure of 2.5 per cent would represent such an extreme: it is also not clear that the overwhelming majority of nursing staff will necessarily receive overall pay increases of 3 per cent for 1996–97. **We have therefore decided that for 1996–97 there should be a total uprating of 2.8 per cent over the uprated 1995–96 national scales,** that is, a further 0.8 per cent from April 1997, in addition to the 2 per cent increase in national scales recommended in our last report and agreed for 1996–97.

38. We are very disappointed that, for the second year running, we have been asked to make this decision. It is not a role we sought and it is a task which we have again undertaken with great reluctance. The decision was made particularly difficult by the disappointingly low number of settlements. We hope that we will not be called upon to make such a decision again.

Chapter 3

Consideration of evidence

39. In this chapter we consider information submitted to us, including:

- evidence on local pay determination: how it has worked in 1996, the extent to which we should continue to support it, and how we should recommend in 1997;
- evidence on those other factors which we take into account when making our recommendations. These include issues of productivity and workload, morale and motivation, fairness and comparability, recruitment and retention, and affordability and wider economic considerations.

40. We also report on our monitoring activities and the decision we reached in respect of the pay of senior nurses and senior midwives.

Local pay determination

41. The **Health Departments'** evidence confirmed their commitment to local pay determination. They saw it as a key step in enabling the NHS to improve and enhance patient services, while providing fair rewards to recruit, retain and motivate nursing staff. They did not see local pay determination as representing low pay.

42. Neither did they see limited progress to date as invalidating the policy. There was a limit to the progress that could be expected in one year. Trusts needed to deliver improved health care and this would to a large degree rest on their ability to motivate staff to higher performance. They argued that while pay and conditions were just one of many factors affecting staff motivation, Trusts could not develop comprehensive reward strategies if pay and conditions of service were determined nationally. The benefits of local pay determination included freedom to develop local reward strategies; the development of shared principles of fairness in pay systems; more visible links between pay and Trusts' performance; scope to negotiate productivity changes; freedom to change pay differentials and target staff in short supply; and local control over costs. They felt that local pay negotiation encouraged an open book approach and a benefit at Trust level could be the ability to choose, perhaps in negotiation with staff representatives, between a smaller pay rise for the entire workforce or a larger pay rise and reduced numbers of staff.

43. The Departments' strategy for introducing local pay and conditions had two tracks: locally determined pay and conditions for staff on distinct Trust contracts, and local pay negotiations for staff on Whitley, and shadow Whitley contracts. They considered that both tracks would continue to be appropriate in different circumstances, although the fullest benefits were only at present available through distinct Trust contracts. Progress had, in their view, been made and more Trusts were using local contracts imaginatively. The framework agreement was not ideal as a basis for local pay determination for staff on Whitley, and shadow Whitley contracts, and changes to it would be sought in 1997.

44. Notwithstanding progress, the Departments considered that there had been some particular problems with the 1996 pay round. The resource and operational pressures on Trusts in 1996 had been particularly severe. There had been insufficient planning at local level and some managers, and staff side representatives, had been waiting for others to take the lead. Our recommendation for a 2 per cent increase in national salary scales had not helped because it had taken up the major share of resources available for pay increases; removed the opportunity for creativity; and taken the urgency out of local negotiations.

45. The Departments asked us to reaffirm our support for local pay determination and increase its scope by recommending for 1997–98 a zero or minimal increase in national salary scales, leaving headroom for local negotiation on a significant proportion of the overall pay increase. They also asked us not to recommend a range or benchmark for local negotiations and to encourage both sides to work on freeing up national terms and conditions of service for local determination.

46. The Health Departments' evidence received broad support from the **National Association of Health Authorities and Trusts (NAHAT)** and the **Trust Federation**. They, too, considered local pay determination essential to improved efficiency in the NHS. They argued that it provided employers with a key lever to secure changes of direct benefit to patients; a more flexible and locally responsive workforce; and more effective control of their paybill.

47. They felt that Trusts had progressed considerably over the last two years in implementing local pay determination. A large number of Trusts had used their pay freedoms to introduce initiatives that improved services. Others had done much preparatory work behind the scenes. There had, nonetheless, been four significant obstacles to progress in 1996: our decision to make a recommendation on national salary scales; the uprating provisions of the framework agreement; national negotiations to enable local variation of Whitley conditions being on a slower track; and the nature of the pay awards for hospital doctors and dentists. In acknowledging that progress in achieving pay settlements for nursing staff had been slow, they said that there had been insufficient funding to make local pay offers that both reflected what Trusts could afford and were in turn acceptable to the staff sides.

48. The employers argued that the national pay award plus local pay determination (x + y) approach that had operated in 1995 and 1996 had failed to assist progress. They urged us to continue to support local pay determination by recommending no increase in national salary scales and to leave Trusts to determine appropriate levels of reward to match their local circumstances. They also asked us to seek an early review of the uprating mechanism, and to consider adopting an alternative advisory/monitoring role.

49. Written evidence was also received from the **Association of Healthcare Human Resource Management (AHHRM)**. The Association emphasised that it would not be in Trusts' own interests to embark on low pay strategies. It also criticised the format of our 1995 and 1996 recommendations, arguing that they had constrained attempts to use local pay bargaining to secure change. This in turn had had the effect of diminishing the interest of some Trust managers in local pay determination. The Association asked us to continue to support local pay determination by recommending no increase in national salary scales for 1997, and to adjust our role to one of monitoring. In addition it urged us to recommend that Whitley conditions became matters for local negotiation.

50. The **Staff Side's** evidence, by contrast, maintained that local pay determination did not work and was not wanted. It argued that very few Trusts had implemented local pay schemes and that most Trusts had little real enthusiasm for the process. It felt that where such schemes had been introduced they had generally led to lower pay and poorer conditions of service. Local pay determination had also led to Trusts introducing what the Staff Side believed to

be undesirable practices which it urged us to discourage. These included the linking of pay increases to performance, productivity, local labour markets and absence rates. In any case, the Staff Side argued that the effective implementation of change in Trusts did not rely upon local pay determination.

51. The Staff Side maintained that nursing staff remained opposed to local pay determination. Purchasers, for their part, were seen to be primarily concerned with what Trusts delivered by way of health care and less interested in what they paid their staff. The roles of nursing staff, midwives and health visitors had expanded and changed, but these developments had not been recognised in recent pay awards. It was argued that there was a diminishing supply of, and increasing demand for, nursing staff whose pay was lagging well behind that of comparable occupations within and outside health care.

52. The Staff Side suggested that we had subtly re-interpreted our terms of reference. It drew attention to our first report where we said that our recommendations were not bound by cash limit assumptions and that our role was to recommend the levels of pay deemed to be right after all factors had been considered. It argued that, were we not to recommend in that way, the previous cycle of worsening pay, staff shortages and disputes, which it maintained had existed before the setting up of the Review Body, was likely to recur.

53. The Staff Side asked us to re-assert our independence by recommending for 1997–98 a significant increase in the national rates of pay of nursing staff. Any amount we expected to be delivered locally should not fail to be made explicit. It said that a pay review body which made incomplete or partial recommendations in pay was a contradiction in terms.

54. The evidence from the individual Staff Side organisations endorsed that from the Staff Side as a whole although there were some differences in emphasis.

55. The **Royal College of Nursing (RCN)** stated that a return to national pay determination was necessary because nurses were a national resource educated to national level. It also argued that the NHS faced a widespread shortage of nurses and that while pay was not a complete answer to these shortages, it had a significant role to play. Linking pay to what was felt to be affordable at local level meant, in its view, that reasonable pay increases could only be achieved if numbers of jobs or the level of services were reduced: the guidance resulting from the "Flory" report issued in October 1996 by the NHS Executive on pay, finance and contracting would make no difference; morale and staff shortages would become worse. It said that we should make explicit recommendations for an overall national increase in the remuneration of nurses. Trusts who truly wanted local pay determination could still attain it through the Trust contract route allowed for within the provisions of the 1990 NHS Act.

56. **UNISON** argued that Trusts "cannot be trusted with local pay bargaining": only if we were to recommend a national pay increase would fair and appropriate pay awards be made. The attitude survey it had commissioned from Gallup showed that staff did not consider their pay levels to be an accurate reflection of their increased workloads and responsibilities. The survey also showed that more nursing staff than ever felt under valued and under rewarded for the work they did. UNISON felt that as alternative employment became easier to find, more nursing staff would leave, unless they were adequately rewarded financially.

57. The **Health Visitors' Association (HVA)** said that there was no evidence that local pay determination had benefited its members. Pay offers in 1996 had been disappointingly low because of a shortage of funds. Moreover, resources in Trusts in 1997–98 were again likely to be severely constrained. In such circumstances, unless Trusts were required to pay national awards, the HVA considered that there was a serious risk that Trusts would be tempted to offer the most minimal pay increases. This would have a demoralising effect on staff, leading to a further exodus from the service which would, in turn, exacerbate

existing recruitment difficulties. HVA members already felt undervalued and were demoralised and tired.

58. The **Royal College of Midwives (RCM)** pointed out that while it had had firm reservations about local pay determination, it had been prepared to use the opportunity it presented to reach an agreement with the NHS Executive in July 1995 on advice to Trusts on midwives' pay and grading. However, in its view, the progress that had been made in implementing this agreement had been disappointing. It considered that the NHS Executive had failed to afford the guidance sufficient priority, with the consequence that there had been a lack of commitment to its implementation by purchasers and Trusts. The RCM was not confident that the guidance issued by the NHS Executive on pay, finance and contracting would carry any more weight. Real improvements in remuneration were needed to assist in the recruitment and retention of midwives. The RCM asked us to recommend both an increase in national salary scales and that grade F should be the minimum appropriate grade for midwives. It also asked us to support its attempts to secure the implementation of the agreement it had made with the Executive.

59. From the evidence we see the key issues as follows:

- the Health Departments and the employers' organisations continued strongly to support local pay determination. The Staff Side and the individual organisations remained generally strongly opposed;

- all parties giving evidence considered that there had been problems with the course of the 1996 pay round. There was less agreement on the progress of local pay determination itself. The Health Departments and employers' organisations argued that significant progress had been made over the last two years, but indicated that, with national negotiations for local variation of Whitley conditions on a slower track, most progress had been made through the development of Trust contracts. The Staff Side and individual organisations maintained that even there progress had, in reality, been very limited;

- the Health Departments asked us to recommend a zero or minimal increase in national salary scales, leaving headroom for local negotiation on a significant proportion of the overall pay increase. They also requested that no range or benchmark be given. The organisations representing the employers wanted a similar recommendation, asking specifically for no increase in national salary scales. The Health Departments and AHHRM also asked us to encourage freeing up national terms and conditions for local negotiation;

- the Staff Side and the individual staff organisations asked us to recommend a significant increase in national pay. Recommendations on any amount to be delivered locally should be made explicit.

60. In his evidence to the Review Body in 1994, the Minister for Health invited us to monitor developments in local pay determination. We accordingly again commissioned the OME to conduct a monitoring exercise in order to provide information for our consideration in the autumn of 1996. A telephone enquiry was undertaken between mid-September and mid-October of all Trusts in Great Britain employing nursing staff. Details of the statistical findings are given in Appendix E. In parallel with this enquiry, 25 case study visits were undertaken by P-E International to establish in greater depth the reasons behind the behaviour of Trusts during the second year of local pay determination, and their preparedness and strategies for the future. A fuller description of the case studies and their findings is in Appendix F. A paper containing the main findings from the telephone enquiry was circulated to the parties in January 1997.

61. In April 1996 the Nursing and Midwifery Staff Side asked us to make a recommendation on the pay of senior nurses and senior midwives with effect from 1 September 1995. It argued that there had been a narrowing of differentials between the clinical salary scales and those for senior nurses and senior midwives; that there was considerable overlap between the two scales; and that the pay for this group of staff had deteriorated against external comparators. After considering the evidence available to us we decided that there were insufficiently strong grounds for us to intervene at that point but that we would ask the OME to keep the position under review by monitoring the pay settlements for this group in future.

Comments

62. Our own visits and monitoring have tended to confirm the existence of entrenched opinions about local pay determination reported in the Staff Side's evidence. Many staff were opposed to local pay determination in principle; others were against it because they thought it would penalise them.

63. The course of the 1996 pay round had reinforced nursing staff's view that local pay determination was likely to be to their disadvantage. The award to doctors, in terms of both its size and the fact that it was national in nature, was compared unfavourably with the award to nursing staff and was also seen as taking away some of the resources available for their own pay settlements. They felt that their own pay offers and settlements had been slow to materialise and in many instances the local pay increases on offer were regarded as too low.

64. By contrast, we found that while many Trust managers had reservations about how local pay determination had worked in 1996, they generally continued to favour it at least in principle. Many had devised strategies for its use, particularly through the development of Trust contracts, although implementation was recognised as a difficulty. Nonetheless, we also found some evidence of weariness at the obstacles in the way of using local pay determination to secure change and further improve efficiency. These obstacles included lack of resources; the terms of the framework agreement; little scope for further efficiency savings to release funds to supplement local pay offers; entrenched attitudes against local pay determination by the local staff sides and by nursing staff themselves; and the nature of our 1996–97 recommendations.

65. We have already said that we do not consider that local pay determination in 1996 has fulfilled the criteria for success outlined in our 1996 report. The process has shown itself to be severely constrained and against this background we understand why nursing staff feel disappointed. Nor are we surprised that the enthusiasm of some Trust managers for local pay determination appears to have diminished. There are a number of hurdles to overcome if local pay determination is to work effectively; Trusts have limited time and resources, and are confronted with a variety of other operational challenges.

66. The RCM has asked us specifically to support its attempts to secure the implementation of the agreement it made with the Executive in July 1995 on midwives' pay and grading. This agreement gave guidance on the pay and grading of midwives within the framework of both local and Whitley structures. The thrust of the agreement is that the remuneration of midwives needs to take into account developments in their working practices and responsibilities following the introduction of the Government policy: "Changing Childbirth". Our continued support for local pay determination is based on its potential to assist change which benefits both staff and patients, and we consequently endorse the RCM's wish to secure the agreement's implementation.

Productivity and workload

67. The evidence from the **Staff Side** first concentrated on the changing roles of nursing staff, midwives and health visitors. Registered nurses were undertaking a range of procedures formerly undertaken by junior doctors and were taking the initiative in identifying and responding to need through, for example, nurse-led units, and the development of nurse practitioners. Midwives were taking on extra responsibilities as a result of "Changing Childbirth", while

the role of health visitors was also changing following the shift in recent years to primary health care. Non-registered nursing staff were becoming responsible for an increasing amount of direct nursing care. The Staff Side argued that these changes had not been recognised in recent pay awards and urged us to take account of them now.

68. The Staff Side also argued that nursing staff were working harder. It stated that workloads had increased, the number of hours of unrewarded overtime had gone up, and at the same time, staff numbers had fallen. It cited data from the NHS Executive which showed that in the year to March 1996, episodes of care for hospital inpatients had increased by 5 per cent, and patient contacts in the community by 2.5 per cent. It pointed out as well that progress had been made on most of the key Patient's Charter standards and that waiting list targets had been met. Finally the Staff Side argued that the current increase in workloads was part of a long-term trend. NHS efficiency targets had been set and met since 1992.

69. The evidence from the individual Staff Side organisations concentrated particularly on increases in workload. The **RCN** argued that nurses were under more pressure than ever before, through pressure on resources and inadequate staffing levels. The **RCM** maintained that a national shortage of midwives was placing increasing pressure on its members, 80 per cent of whom were working some form of overtime. **UNISON** reported that the survey it had commissioned from Gallup showed that nearly nine in ten respondents felt that workload and pressure had risen. Two thirds of respondents reported a decrease in the number of staff working in their ward or unit, three in five reported an increase in the number of patients treated, while some nine out of ten felt that stress levels had increased over the last twelve months. The **HVA** also maintained that at a time of increasing health visitor shortages, when demand for health visitors was rising, both workloads and stress levels were increasing.

70. **NAHAT** and the **Trust Federation** argued that issues of productivity and workload were best addressed at local level where staff were able to discuss problems with local managers and agree the means to resolve them. Local pay negotiation provided an opportunity to discuss "service benefits" (including productivity) alongside pay at the negotiating table. In many Trusts nursing staff were already leading changes in the way in which services were delivered. The **Health Departments'** evidence did not comment directly on productivity and workload; they did however argue that some of the advantages of local pay determination were to enhance patient services and provide scope to negotiate productivity changes.

Comments

71. Our impression from visits, confirmed by the evidence presented to us by the Staff Side, was that nursing staff believe that productivity was being raised by increasing their workloads, rather than by devising new and improved work methods, with consequent effect on the quality of care. As we have said before, productivity is difficult to assess but the achievement year-on-year of efficiency savings, together with measurable productivity improvements, suggest that the productivity of nursing staff has indeed continued to rise and that workloads remain heavy. There were many complaints by individual nursing staff about increased pressure of work which was attributed to factors such as inadequate staffing levels; increasing recruitment problems; higher expectations and dependency of patients; the time needed to supervise students and newly qualified nursing staff; and taking on extra responsibilities as a result of changing roles. We were also struck by the number of complaints from staff at the increasing amount of paperwork they were required to complete, resulting in part from poor information systems.

72. While we accept that issues of productivity and workload are best addressed at local level, complaints about heavy workloads by nursing staff were a constant feature of our visits. We agree with the employers' organisations and Health Departments that local pay determination can provide opportunities to negotiate productivity changes. However, in order for this to take place, staff

need to have confidence in the process and to consider that it provides the scope for them personally to benefit.

Morale and motivation

73. A number of the Staff Side organisations referred in their evidence to low morale. The **RCN** looked at the connection between morale and recruitment and retention, arguing that if the NHS wanted to attract and retain staff to overcome shortages, the problem of morale had to be addressed. It referred to the attitude survey it had commissioned from the Institute of Employment Studies (IES) as confirming an established trend of growing dissatisfaction with NHS employment. It concluded that nurse morale was low; that retention difficulties were likely to increase unless the issue was addressed; and that pay in the form of a fair, national pay award had a significant part to play in restoring morale.

74. **UNISON** also referred, when commenting on morale, to the results of the survey it had commissioned from Gallup. This survey had indicated that eighty per cent of respondents felt that morale in their ward or unit had worsened over the last year with health visitors, midwives and staff nurses most likely to report a fall. Levels of pay in general, and local pay determination in particular, were cited as contributing factors. UNISON also considered that as alternative employment became easier to find, more nursing staff would leave the NHS unless they received substantial pay awards.

75. The evidence from the **HVA** echoed these themes. It said that its surveys showed workloads increasing; stress levels rising; and morale deteriorating. It argued that pay was not the only – or, indeed, the most important – element affecting staff morale. However, pay levels relative to others, and what was perceived to be the waste of resources and unfairness of local pay bargaining, were, in its view, major contributors to low morale.

76. By contrast, **NAHAT** and the **Trust Federation** argued that it was the obstacles to local pay determination, rather than local pay determination itself, that were affecting staff morale. More flexibility was needed to enable Trusts to address staff concerns and build a healthy dialogue as part of local pay negotiation. More generally, staff concerns were best addressed at local level where human resource strategies including initiatives such as staff charters, health at work schemes, and counselling services had an important role to pay. Some 44 NHS organisations had now obtained certification as "Investors in People" and many others had expressed a commitment to do so.

77. The **Health Departments** stated that pay levels should be sufficient to recruit, retain and motivate staff within that which was affordable. In oral evidence they argued that pay itself was not the main issue in retaining and motivating staff. They also suggested that Trust conditions and practices based on local need could contribute to a contented workforce.

Comments

78. Our visits tend to support the contention that while motivation and commitment remained high, morale among nursing staff was often low. The reasons varied, but included heavy workloads, exacerbated in some instances by staff shortages, and the amount of change taking place. A frequent complaint made by staff was about a lack of promotion opportunities, or doing work out of grade because Trusts were reducing the number of higher-graded posts. Pay was seen as an issue: some felt that local pay determination, because it related to what a Trust could afford, could only adversely affect how much they received by way of a pay increase and how long they had to wait to get it.

79. We have noted the extent to which the attitude of local Trust managers can have an impact on morale, and we agree that local human resource strategies can significantly influence the state of morale of staff in individual Trusts. In this context we are disappointed that communications by Trusts about their pay strategies often appear to be so poor. We accept that 1996 has been a difficult year for local pay determination. We consider, nonetheless, that Trusts could usefully have done more to explain to staff the reasoning behind the concept and its potential benefits, in order to dispute the charge that its only rationale is to

enable Trusts to contain costs and, as a result, pay less than they would have had to pay, had there been a national pay award only.

Fairness and comparability

80. The **Health Departments** said that figures for pay settlements in any one year should be set in context. They went on to say that since the Review Body was established in 1983, nursing staff had received higher cumulative pay awards than had doctors and dentists. Over the longer term, they argued that the increase in average earnings of nursing staff since 1970 had been greater than that for any other significant group in the public sector and that their real earnings had risen by over 67 per cent between 1979 and 1995 compared with 38 per cent for the whole economy. The Departments also drew attention to the potential for earnings growth over the course of a nursing career through annual increments and promotions and the fact that earnings could be higher than basic pay because of additions such as special duty payments (for working unsocial hours or week-ends), overtime and the various leads and allowances. Their evidence gave examples of how earnings might progress for a range of hypothetical individuals taking these factors into account. The estimated nursing staff's paybill is shown in Appendix C.

81. **NAHAT** and the **Trust Federation** said that for two years staff had been offered pay rises that reflected Trusts' ability to pay and that given financial constraints, low inflation and the offers made to other non-medical staff, the offers to nurses had been fair in the circumstances. They recognised, however, that staff might take a different view when the increases were seen alongside the awards to hospital doctors and dentists. Their evidence also pointed out that Trusts were seeking to secure greater harmonisation and simplification of pay and conditions with increased parity across staff groups, and that there had been initiatives to address low pay. They said that local pay and reward schemes were about securing the right approach locally to match local need. Finally, they said that while they supported the view that pay levels should be sufficient to recruit, retain and motivate staff and that levels should be "felt fair", the term "felt fair" did not necessarily mean "the same for all".

82. The **Staff Side** said that the NHS needed the trust and confidence of its staff if it were to function effectively. In order to do this it had to ensure that staff were fairly paid and did not feel exploited. It then went on to quote our first report where we said, "we have an obligation to consider what is fair to nursing staff themselves," and had identified our task as being to "establish a stable system of pay determination which will ensure fair levels of remuneration for the nursing profession". The Staff Side said that in recent years a much more limited definition of fairness had prevailed which equated it with what was necessary for recruitment and retention – that is what the market required as a minimum. It said that nursing staff continued to believe that their pay should be based, at least in part, on the value of their work compared with jobs of a similar nature and comparable worth. The written evidence set out a range of such comparators including local authority day centre officers, nursery nurses, and social workers, as well as junior doctors, teachers and police officers. It concluded that not only were nursing staff paid at a lower level than these staff, but also that they had fallen further behind in the last year. Finally, the Staff Side said that we had a responsibility to ensure that nursing pay was seen as fair and that this would be essential in ensuring that the profession was able to recruit and retain sufficient staff, especially as the labour market tightened.

83. **UNISON** provided a paper it had commissioned from Dr Carole Thornley of the Centre for Industrial Relations at Keele University entitled "Dispelling the Myth – Nursing pay trends 1979–96". The paper's main conclusions were that: three out of four nurses earned less than the national average wage; the basic pay of one third of nurses was below the Council of Europe's decency threshold (68 per cent of average full-time earnings); registered nurses had not improved their position relative to male non-manual employees and non-registered nurses had lost ground relative to male non-manual comparators. The paper called for parity to be achieved with comparator

professions; a commitment to end low pay; a commitment to achieve equal pay; and for a unified national framework for nurses' pay determination.

Comments

84. We have considered very carefully the evidence put to us on fairness and comparability, both in terms of the changes in pay that have taken place over time and in terms of the levels of pay. In examining levels of pay, we have taken account not only of average earnings but also of the range and composition of earnings at different levels of seniority. Moreover we have recognised that when making comparisons over time, the choice of the base year and any intervening one-off events such as clinical grading can have a significant effect on the outcome of comparisons.

85. In examining pay levels, we have taken account of the pay of nursing staff relative to that of other occupational groups with which members of the nursing profession could compare themselves. The choice of comparator occupations and what view to take on the comparisons are, however, matters of judgement, and comparisons are made difficult by differences in job content, skill requirements and terms and conditions of employment. It is, in our opinion, inappropriate to base such comparisons on any formal link with specific comparator groups. We have, therefore, taken account not only of the evidence provided by the parties but also other pay data sources, including economy-wide average earnings information, in formulating our recommendations. It should also be remembered that comparability is only one of a range of factors that we take into account.

Recruitment and retention

86. The **Health Departments** told us that there was no general recruitment and retention problem for nursing staff in the NHS, although there were pockets of difficulty in some areas in some specialties. They also said that discussion with Human Resource Directors showed a general view that higher pay was not an appropriate way of dealing with recruitment and retention problems and that managers were often nervous of starting a pay spiral in the local labour market.

87. According to the Health Departments' annual Non-Medical Manpower Census, the overall nursing workforce, excluding learners, employed directly by the NHS fell by 0.3 per cent from 415,270 whole-time equivalents (WTE) in September 1994 to 414,070 WTE in September 1995, following a fall of 0.8 per cent between 1993 and 1994. A summary of staff numbers at September 1995 is shown in Appendix B. The change from classifying staff by clinical grade to using the new occupational codes means that detailed comparisons of the figures for 1994 and 1995 are not possible, but it is clear that the overall numbers of registered and unregistered nursing staff are roughly stable, and that the decline in the number of learners (student and pupil nurses) is continuing as Project 2000 courses replace traditional nurse education.

88. The Departments said that the new education and training consortia were now established in England, as were the Regional Education and Development Groups (REDGs) that supported the consortia and co-ordinated their education commissioning activity. The NHS Executive itself had commissioned a national workforce modelling project to provide consortia and REDGs with a more complete picture of overall demand and to inform local decisions about investment in training. The Departments also cited examples of local initiatives, which they said were likely to improve co-ordination and recruitment and retention practice among Trusts. In oral evidence they said that the increased numbers of training commissions announced for 1995–96 and subsequent years were designed to address the forecast increase in retirements expected towards the turn of the century.

89. **NAHAT** and the **Trust Federation** said that evidence from a survey by Pay and Workforce Research and anecdotal evidence from Trusts continued to suggest that there were limited localised shortages in elderly care, mental health, children's health, theatre, orthopaedic and ITU nursing and that some inner cities had particular problems. They said that these problems were mostly caused

by supply constraints which were best addressed through improved workforce planning and that analysis of pay settlements by the Pay Clubs showed that local pay was not being used to overcome recruitment problems. Employers realised that problems were caused by supply constraints and that pay increases might start unnecessary pay spirals.

90. The **Staff Side** said demand for nursing staff both inside and outside the NHS had grown strongly in recent years and that this growth could be expected to continue. Moreover the large number of part-time staff being recruited meant that the number of people being employed was rising faster than the number of whole-time equivalents. It also said that last year's OME survey of nursing vacancies confirmed that there were increasing shortages. While acknowledging that the Department of Health had increased the number of training commissions in 1995–96 compared with 1994–95 and was forecasting that further rises would occur in each of the two following years, the Staff Side said that this would not be enough to meet demand and that in any case these increases would not result in more trained nurses becoming available for three more years. It went on to say that since the participation rate of qualified nurses in the labour force was already well above that of the general population, the Departments' hopes of drawing on this pool to cover shortages were misplaced. It said that the increase in the number of those on the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) register of qualified nursing staff was too small to meet the increased demand and that, besides, the number of initial registrations had continued to fall as had the number of those registered but not currently practising. Looking ahead, the Staff Side said that the new requirement for nursing staff to re-register every three years would begin to take effect in the near future, which might in turn reduce the numbers available to practice.

91. The Staff Side also drew attention to the evidence from the **RCM** and the **HVA** which showed increasing problems with the supply of midwives and health visitors respectively. The RCM's survey of heads of midwifery and senior midwives showed that 75 per cent of midwifery units were experiencing some level of staffing shortage and that the total vacancy rate was 4.8 per cent. The increase in the number of health visitors to be trained, the increasing number of advertisements for health visitors, and the appearance of health visitors as a shortage group for the first time in the Income Data Services Survey of NHS staffing all pointed to an increasing shortage of this group.

92. The **RCN** said that, based on enquiries it had received from employers, shortages were no longer confined to specialties in which recruitment difficulties had been recognised for some time, but were also among GP practice nurses and Registered Mental Nurses. It also reported that according to the annual IES survey of RCN members, there was an increase in turnover in 1995–96 compared with 1994–95. The survey also showed that the wastage rate had risen from 5 to 6 per cent of staff in post and that the proportion of leavers who were retiring had risen from 7 to 11 per cent. The College said that the survey confirmed an established trend of growing dissatisfaction with NHS employment, and that those nurses who would have left the profession but for the recession might leave now.

93. The results of the OME's latest manpower survey as they relate to nursing staff are set out in Appendix D. Comparisons with the survey of nursing vacancies conducted in 1995 using matched samples (that is, those units which completed the survey in both years) show that between March 1995 and March 1996 the three-month vacancy rate for registered staff rose from 1.1 per cent to 1.6 per cent; and the one-month vacancy rate for Grades A and B fell from 2.0 per cent to 1.7 per cent, the lowest since the survey began. By area of work, the three-month vacancy rate for all grades of staff rose in all occupational groups. The vacancy rate for registered staff rose in Wales, Scotland and all the NHS regions in England, though it fell slightly in the Inner London and London Fringe zones.

94. Following the discontinuation by the Department of Health of its survey of the numbers of nursing staff joining and leaving NHS Trusts, the "KM48", the OME, on our behalf, undertook to collect similar data in conjunction with its annual survey of nursing vacancies. This part of the survey showed that turnover rates (that is, leavers plus transfers between NHS units, as a proportion of staff in post) in England had fallen slightly from 15 per cent in 1994–95 to 14 per cent in 1995–96 and gave a rate for Great Britain (not previously available) of 13 per cent. The wastage rate (that is, leavers excluding transfers between NHS units, as a proportion of staff in post) in England was at around 10 per cent in 1995–96 having risen slowly since 1991–92; wastage rates in England were highest in the former Special Health Authorities (21 per cent) and the North Thames region (14 per cent) and lowest in the Northern and Yorkshire region (7 per cent). These wastage rates may be over-estimates because a number of units did not know the destination of their leavers and classified them as "don't know/other reasons", when some of them may have transferred to other NHS units. The OME also said that the number of nursing practitioners on the UKCC register rose by 2,060 between March 1995 and March 1996 to 645,011.

Comments

95. We said in our last report that although we were not persuaded that there was a general shortage of nursing staff, we believed however that there were some signs that more general shortages might emerge in the future. We are still of this view and the evidence of the OME's survey of nursing vacancies is that signs of shortages among registered staff are becoming clearer. The Health Departments are probably right in stating that there are not large, general shortages, but it is our impression that, given current workloads, even a low level of vacancies or vacancies in a few specialties can have a significant effect on the ability of Trusts to function effectively, and we believe that the situation has tightened over the last year.

96. We also said in our last report that we believed that local pay determination could be part of the solution to local recruitment problems and problems with particular specialties. The evidence from both this year's and last year's local pay negotiations is that there has been no significant attempt to use local pay in this way. Furthermore, the Health Departments and the employers in their evidence to us this year said that local pay determination was not felt to be suitable for this purpose because of the dangers of developing local pay spirals and that shortages mainly result from supply problems. This contradicts evidence from the Health Departments on this point in previous years.

97. It seems to us that Trusts could do more to deal with their recruitment and retention problems. Evidence from follow-up enquiries to the OME's surveys, confirmed by the case studies we commissioned into recruitment and retention, strongly suggests that in some Trusts the information systems supporting the Trusts' human resource function are inadequate. Paper-based systems for logging and tracking vacancies, and especially leavers, are often too slow or unreliable to provide a Trust-wide view in time for action to be taken. Integrated information technology systems that bring together payroll and personnel information so that vacancies and staffing changes can be tracked in "real time" can significantly enhance management's ability to anticipate and respond to staffing problems.

98. There is also evidence of a lack of a strategic approach in some Trusts to issues of recruitment and especially retention. In some cases this is apparent from the shortage of basic data on vacancies or on the reasons staff have left, but also from the failure to follow through Trust Board policies on flexible working and family-friendly employment practices to ensure that they are implemented.

99. We were very disappointed that the Department of Health decided to discontinue its survey of nursing joiners and leavers, and that the replacement survey undertaken by the OME, despite intensive follow-up work, achieved a response rate of only 52 per cent. We also note that the Departments have taken no action in response to our request for statistics on the composition of earnings and we are most concerned that the annual non-medical manpower census may

be discontinued, a development which would further reduce the Health Departments' statistical evidence to us. We have commented on the inadequate manpower information systems in some Trusts and for the Departments to place their faith entirely in them seems to us to be an extremely risky strategy.

100. We are left wondering too how some Trusts can recruit, retain and motivate staff without adequate manpower data at Trust level. It seems to us that it would be difficult to address retention problems, for example, if it is not known why staff have left. Furthermore, with reliance being placed on the local training and education consortia for manpower planning, which will in turn be informed by data from individual Trusts, the need for reliable Trust-level data is greater rather than less than before. We are concerned that the Working Paper 10 statistics (an annual mandatory return, administered in 1996 by the regional offices of the NHS Executive in England) on staff in post, joiners and leavers by broad staff groups may be discontinued on a national basis. We have asked that, if the Working Paper 10 surveys are continued, the OME should try to integrate its enquiries on our behalf with them in order to try to increase the response rate above that achieved in 1996.

101. While we recognise the need to minimise burdens on Trusts, they and the Departments in their turn must recognise our and others' legitimate need for statistics at a national level. We cannot simply accept uncritically the assurances in some of the evidence we have received that all is well. Given the persistent and widespread anecdotal evidence of shortages we might have felt compelled to take the view that shortages were worsening more seriously than we believe is the case. The need for statistics must be recognised not only by individual Trust Human Resource managers but also by those at all levels of the service who are responsible for providing adequate management resources.

102. In our last report we said that we would welcome detailed evidence from the Departments and other parties on how the new education and training planning systems were working. We welcome the detailed statistical evidence on this topic prepared by the IES and submitted by the RCN, which has provided helpful background information to our discussions; by contrast, we were disappointed by the lack of quantitative information on this topic in the Health Departments' evidence.

Affordability and wider economic considerations

103. Both the **Health Departments**, and **NAHAT** and the **Trust Federation**, repeatedly emphasised the importance of affordability in their evidence. The Departments said that we should make our recommendations on the understanding that there would be no additional money from the Reserve to fund pay increases in the coming year. The Government's economic evidence to all the Review Bodies made it clear that the cost of running public services should not increase as the result of pay settlements and that any increases in pay should be offset by improvements in efficiency or productivity.

104. The employers commented that 1996–97 had been one of the most difficult contracting rounds that their members had experienced and were continuing to experience. They also said that affordability could really only be judged at local level and would be affected by such factors as general inflation funding (the percentage increase in the GDP deflator); capitation-based adjustments; adjustments to GP fundholders' resources; changes in national and local health priorities, for example, mental health developments, emergencies, and paediatric intensive care developments; and efficiency savings. In conclusion and looking ahead they said that they reluctantly believed there were unlikely to be any grounds for repeating the Review Body's optimism about the availability of funds.

105. The **Staff Side** said in its written evidence that, in its view, the Review Body was not bound, either by legislation or its terms of reference, to follow Government policy on public sector pay. Its practice had been to make recommendations it believed were appropriate in the circumstances and to leave the Government to deal with issues of affordability.

106. At the end of November, the Departments gave us evidence on the Government's plans for expenditure on the National Health Service in 1997–98. Expenditure on the Hospital and Community Health Services (HCHS) in England was planned to rise by 5.1 per cent in cash terms, compared with the budget for 1996–97 – equivalent to a rise of 3 per cent in real terms. They also said they would require purchasers to deliver efficiency gains of 2.7 per cent on average. The Departments informed us that allocations to individual Health Authorities would rise by between 3.38 per cent and 4.96 per cent in cash terms and average 3.93 per cent. They also said that it was essential for decisions on pay awards to take full account of affordability considerations.

107. In a press notice issued after the Budget, NAHAT and the Trust Federation welcomed the increase in resources but cautioned that costs, including pay, would have to be kept on a tight rein given the low allowance for inflation of 2 per cent; NAHAT went on to say in a later press notice that some of the increase in budgets was already committed. In subsequent written evidence, NAHAT said that a major concern among employers was that inflation had been underestimated and that cash-releasing efficiency gains would be no more achievable in 1997–98 than in 1996–97. In the circumstances, NAHAT anticipated that the total available for pay would not exceed 2 per cent on the total paybill in most cases.

108. In oral evidence after the Budget, the Staff Side said that the figures appeared to suggest that there was room for reasonable pay increases in 1997–98, but that, in any case, affordability was a matter for the Government, not the Review Body. It warned, however, that, judging by the experience of the 1996–97 pay round, if a national award were not made, in practice little would be allocated for pay increases by Trusts faced with a variety of pressures. Finally, it drew attention to the deficits incurred by some Trusts in 1996–97 which would absorb some of the funds allocated for 1997–98.

Comments

109. We note that the Government is providing 5.1 per cent additional resources to the HCHS in England in 1997–98, and an average increase in allocations to Health Authorities of 3.9 per cent. We also note the range of initiatives and priorities announced at the time of the Budget, and the employers' concerns. The Government has set a target of 2.7 per cent average efficiency gains in the coming year and we would expect nursing staff, as they have in past years, to make a significant contribution to the achievement of these gains. We believe that the further development of local strategies involving pay could yield greater gains in the longer term to the benefit of both staff and patients. While we have, as in previous years, taken account of affordability, we have not seen it as the main determining factor in formulating our recommendations, nor do we see it as overriding other considerations.

BRYAN RIGBY *(Chairman)*
ANNE DEAN
SHEILA GLEIG
LYNDON HADDON
RUTH LEA
ANNE M MACKIE
KEITH MILES
GILLIAN RAAB

OFFICE OF MANPOWER ECONOMICS
14 January 1997

Appendix A

Recommended national salary scales

Pay grade title	*Recommended salary scale 1 April 1996* £ pa	*Recommended salary scale 1 April 1997* £ pa
Student and pupil nurses		
Student Nurse/Student Midwife	7,485	7,795
without nursing qualification	7,910	8,235
	8,680	9,035
Pupil Nurse	7,485	7,795
	7,910	8,235
RGN/RSCN 4-year integrated course	7,485	7,795
	7,910	8,235
	8,680	9,035
	9,040	9,410
RGN/RMN 4-year integrated course	7,910	8,220
	8,335	8,660
	9,105	9,460
	9,465	9,835
Clinical grades		
Grade A under age 18	7,030	7,320
age 18 or over	7,695	8,010
	7,970	8,300
	8,245	8,590
	8,520	8,880
	8,815	9,175
	9,115	9,485
	9,415	9,800
Grade B	9,115	9,485
	9,415	9,800
	9,715	10,115
	10,040	10,455
	10,375	10,800
Grade C	10,375	10,800
	10,725	11,165
	11,095	11,550
	11,495	11,965
	11,895	12,385
	12,295	12,805
Grade D	11,895	12,385
	12,295	12,805
	12,725	13,250
	13,165	13,705
	13,605	14,165
Grade E	13,605	14,165
	14,055	14,635
	14,550	15,150
	15,095	15,715
	15,760	16,410
Grade F	15,095	15,715
	15,760	16,410
	16,430	17,105
	17,115	17,820
	17,800	18,535
	18,490	19,250

Pay grade title	*Recommended salary scale 1 April 1996* £ pa	*Recommended salary scale 1 April 1997* £ pa
Grade G	17,800	18,535
	18,490	19,250
	19,185	19,975
	19,890	20,710
	20,595	21,440
Grade H	19,890	20,710
	20,595	21,440
	21,305	22,180
	22,020	22,925
	22,745	23,680
Grade I	22,020	22,925
	22,745	23,680
	23,480	24,445
	24,215	25,210
	24,950	25,975
Education grades		
Grade 1	19,960	20,780
	20,645	21,495
	21,330	22,210
	22,030	22,935
	22,745	23,680
Grade 2	22,030	22,935
	22,745	23,680
	23,460	24,425
	24,175	25,170
	25,005	26,035
Grade 3	24,175	25,170
	25,005	26,035
	25,885	26,950
	26,810	27,910
	27,740	28,880
Grade 4	26,810	27,910
	27,740	28,880
	28,740	29,920
	29,740	30,960
	30,790	32,055
Grade 5	29,740	30,960
	30,790	32,055
	31,840	33,150
	32,890	34,245
	33,990	35,385
Grade 6	32,890	34,245
	33,990	35,385
	35,090	36,530
	36,240	37,730
	37,390	38,930
Grade 7	36,240	37,730
	37,390	38,930
	38,550	40,135
	39,710	41,340
	40,870	42,550

Pay grade title		*Recommended salary scale 1 April 1996* £ pa	*Recommended salary scale 1 April 1997* £ pa
Day nursery grades			
Day Nursery Assistant	under age 19	7,030	7,320
	age 19 or over	7,695	8,010
		7,970	8,300
		8,245	8,590
		8,520	8,880
		8,815	9,175
		9,115	9,485
		9,415	9,800
Staff Nursery Nurse, NNEB		8,745	9,105
		8,995	9,365
		9,250	9,630
		9,505	9,895
		9,760	10,160
		10,015	10,425
Day Nursery Deputy Matron ('grade' b)		10,280	10,705
		10,625	11,060
		10,975	11,425
		11,330	11,795
		11,685	12,165
		12,040	12,535
		12,395	12,905
		12,755	13,280
Day Nursery Deputy Matron ('grade' a)		10,400	10,825
		10,755	11,195
		11,110	11,565
		11,465	11,935
		11,820	12,305
		12,180	12,680
		12,540	13,055
		12,905	13,435
Day Nursery Matron ('grade' c)		10,975	11,425
		11,330	11,795
		11,685	12,165
		12,040	12,535
		12,395	12,905
		12,755	13,280
		13,115	13,655
		13,475	14,030
		13,840	14,410
Day Nursery Matron ('grade' b)		11,110	11,565
		11,465	11,935
		11,820	12,305
		12,180	12,680
		12,540	13,055
		12,905	13,435
		13,270	13,815
		13,635	14,195
		14,000	14,575
Day Nursery Matron ('grade' a)		11,330	11,795
		11,685	12,165
		12,040	12,535
		12,395	12,905
		12,755	13,280
		13,115	13,655
		13,475	14,030
		13,840	14,410
		14,205	14,790

Pay grade title	*Recommended salary scale 1 April 1996* £ pa	*Recommended salary scale 1 April 1997* £ pa
Special school grades		
Enrolled Nurse, Group A or B Establishment	10,055	10,470
	10,435	10,865
	10,820	11,265
	11,205	11,665
	11,590	12,065
	11,975	12,465
	12,360	12,870
Staff Nurse, Group A Establishment	11,645	12,130
	12,060	12,560
	12,475	12,990
	12,890	13,420
	13,305	13,850
	13,720	14,285
Special School Nurse, Group B Establishment	12,905	13,440
	13,555	14,115
	14,205	14,790
	14,855	15,465
	15,505	16,140
	16,160	16,825
Senior Special School Nurse, Group B Establishment	14,330	14,920
	15,140	15,760
	15,950	16,605
	16,760	17,450
	17,570	18,295
	18,380	19,140
	19,190	19,985
Sister, Group A Establishment	14,330	14,920
	15,140	15,760
	15,950	16,605
	16,760	17,450
	17,570	18,295
	18,380	19,140
	19,190	19,985
Assistant Matron, Group A Establishment	15,705	16,350
	16,410	17,085
	17,115	17,820
	17,820	18,555
	18,525	19,290
	19,230	20,025
Matron, Group A Establishment ('grade' b)	15,970	16,625
	16,675	17,360
	17,380	18,095
	18,085	18,830
	18,790	19,565
	19,495	20,300
Matron, Group A Establishment ('grade' a)	16,135	16,800
	16,840	17,530
	17,545	18,265
	18,250	19,000
	18,955	19,735
	19,660	20,470

Appendix B

Staff numbers

Whole-time equivalent numbers of staff in Great Britain at 30 September 1995 (*a*)

Pay grade	Whole-time equivalents	
	Number	Percentage (*b*)
	(000)	%
Registered staff (*c*)	292.3	69.3
Unregistered staff (*d*)	116.1	27.5
Student and Pupil nurses	7.6	1.8
Other nursing staff (*e*)	5.8	1.4
Total (*b*)	421.7	100.0

Source: Health Departments' estimates.

(*a*) Excludes agency staff and permanent staff contracted to work for less than 2 hours per week.
(*b*) Totals may not equal the sum of components because of rounding, and percentages have been calculated from unrounded figures.
(*c*) Clinical grades C to I, nurse education grades, qualified nursery nurses, senior nurses and senior midwives and those on Trust grades with first or second level registration with the UKCC. Figures are no longer available by grade.
(*d*) Clinical grades A and B. Figures are no longer available by grade.
(*e*) May include some Project 2000 students and some health care assistants, who are not within the Review Body's remit, and staff on local payscales not identified elsewhere.

Appendix C

Paybill

Breakdown of estimated (*a*) 1996–97 paybill (*b*) for Great Britain

	Cost	
	Cash	As percentage of paybill (*c*)(*d*)
	£ million	%
Pay (*e*)	6,803	98.2
London allowance	123	1.8
Sub-total (*c*)(*d*)	6,926	100.0
Employers' costs (*f*)	776	—
Agency staff costs	154	—
Total (*c*)	7,857	—

Source: Health Departments.

(*a*) Estimates are based on the 1996 FIS10 exercise and estimated staff numbers at 1 April 1997.
(*b*) Excludes students on Project 2000 courses, and senior nurses and senior midwives.
(*c*) Totals may not equal the sum of components because of rounding, and percentages have been calculated from unrounded figures.
(*d*) Excluding employers' national insurance contributions and superannuation, agency staff, students on Project 2000 courses and senior nurses and senior midwives.
(*e*) Includes basic pay, overtime, special duty payments, pay-related and non-pay related allowances, none of which is separately identifiable.
(*f*) Employers' national insurance contributions and superannuation.

Appendix D

Manpower survey, 1996

Conduct of the survey

1. For our fourteenth review, our Secretariat in the Office of Manpower Economics approached all directly managed units (DMUs) and Trusts in Great Britain that were known to employ nursing staff, for details of staff in post, vacancies, joiners and leavers among those staff. The range of data collected was greater than in previous years because the NHS Executive had discontinued its survey of nursing joiners and leavers in England (the "KM48").

Coverage

2. Questionnaires were sent to all units in Great Britain in March and April 1996 for return before 17 May 1996. The survey covered all those staff within our remit except learners of any type, and requested information in respect of 31 March 1996 about staff in post; posts held permanently open; total vacancies; and whether those vacancies had, at that date, lasted up to one month, two or three months, or over three months. Information was also collected in respect of joiners and leavers between 1 April 1995 and 31 March 1996. Since the new occupational coding system was introduced by the NHS Executive from 1 April 1995, comprehensive data by clinical grade have not been available and as a consequence the groupings used in collecting and analysing the data were different from those used in previous years.

3. The object of the survey was to establish the level of effective demand that the NHS was making on the labour market for nursing and midwifery staff, and to this end respondents were asked to supply details of vacancies they were actively seeking to fill, rather than simply of posts that were unfilled. The information on posts held permanently open was requested to help check and interpret the vacancy data. The information on joiners and leavers also helped to identify possible causes of changes in the vacancy data.

Response

4. Information in respect of 308 units (52 per cent) was both of sufficient quality and received in time to be included in the analysis - details are in Table 1. In 1995, returns from 68 per cent of units were achieved. The decline in the response rate is disappointing and efforts will be made to improve it; however, the response was sufficient for valid analyses to be conducted.

5. The usable response covered over 212,000 whole-time equivalent (WTE) staff in post (some 51 per cent of WTE staff, excluding students and pupils, in Great Britain) and an establishment of over 221,000 WTE.

Technical points

6. The usable responses overall from the Northern and Yorkshire and South Thames regions were disappointing, averaging only 36 per cent and 39 per cent respectively compared with 56 per cent in the rest of Great Britain. Because of the relatively poor response from areas where vacancy rates tend to be higher, the vacancy rates quoted for Great Britain, for England, and for individual areas of work, are probably lower than the true figures. When comparing results for 1995 and 1996, greater attention should be paid to the results for the matched samples because these will be less affected by changes in the composition of the samples between years.

7. The number of units, and thus the proportion of the full 1996 survey establishment, which could be included in the matched sample comparison (paragraphs 17 to 8, 24 and Tables 5A to 7) was relatively high overall, but not distributed evenly across regions (Table 1).

8. The figures for "establishment" used as the denominator for the vacancy rates was not collected separately in the 1996 survey but has been calculated as the sum of WTE staff in post, posts held permanently open and total vacancies. We believe that this is a more robust figure than the sometimes notional and out-of-date establishment figures that have occasionally been recorded in the past.

Results: vacancies

Overall

9. Percentages of posts which were vacant or held permanently open at 31 March 1996 are shown in the table below.

Vacancies and posts held permanently open at 31 March 1996

	Percentage of posts which, at 31 March 1996			
	Had been vacant			Were held permanently open
	For over 3 months	For over 1 month	For any period (*a*)	
	%	%	%	%
Total	1.8	2.7	3.7	0.3
Registered staff (*b*)	2.0	3.0	4.1	0.3
Nursing auxiliaries and assistants (*c*)	1.2	1.8	2.8	0.4

(*a*) Including posts which had been vacant for one month or less.
(*b*) All nursing staff except nursing auxiliaries and assistants.
(*c*) All unregistered nursing staff, excluding Healthcare Assistants.

10. As we have said in previous reports, we do not consider the totality of vacancies on any given date to be the most appropriate measure of shortage. To advertise a post, interview applicants and appoint the new postholder - who may have to serve a period of notice - will in many cases take a considerable period of time. Accordingly, we initially took vacancies which had existed for three months or more ("three-month vacancies") as the most appropriate measure for all staff. The OME has recently reviewed this assumption in conjunction with independent consultants and we are of the view that this remains the most appropriate measure in respect of registered staff. For nursing auxiliaries and assistants we consider that vacancies which have existed for over one month ("one-month vacancies") are more appropriate. The analysis below reflects these views as far as possible.

By registration status

11. The overall three-month vacancy rate among registered staff was 2.0 per cent (Table 2A); for nursing auxiliaries and assistants the one-month vacancy rate was 1.8 per cent (Table 2B).

12. Just under 500 WTE posts (0.3 per cent) for registered staff and 260 WTE posts (0.4 per cent) for nursing auxiliaries and assistants were held permanently open at 31 March 1996 (Tables 2A and 2B).

By country, region and London Weighting zone

13. Table 2A also summarises the data received for registered staff by country, region, and London Weighting zone. The three-month vacancy rate was higher in England (2.3 per cent) than Scotland (0.8 per cent) or Wales (0.7 per cent). Within the English regions, the two Thames regions and the former SHAs had the three highest three-month vacancy rates. The lowest three-month vacancy rates were in the Northern and Yorkshire (0.9 per cent) and South and West regions (0.8 per cent).

14. The three-month vacancy rates for registered staff in the Inner and Outer London Weighting zones were considerably higher than for the rest of Great Britain outside London, with Outer London being the highest. For nursing auxiliaries and assistants (Table 2B) there were above average one-month vacancy rates in the two Thames regions, the former SHAs and the Anglia and Oxford and West Midlands regions.

By occupational group

15. Results by occupational group are summarised in Table 3. The highest three-month vacancy rate was among first level registered staff[1] in paediatrics

[1] Registered nursing staff with first-level registration. They will have either a degree or a diploma in nursing and they include Project 2000 graduates. Those on Whitley employment contracts will be on clinical grade D or above. Second level registered staff include those previously described as enrolled nurses and will typically be on clinical grades C or D. Entry to training for second level registration has now ceased.

(4.4 per cent), with education (3.2 per cent), theatre (3.1 per cent), and mental illness (3.0) also well above average.

16. Table 4 shows, for the largest occupational groups, the three-month vacancy rates by country, region, and London Weighting zone.

Comparison with results of 1995 survey

17. A matched sample comparison with the results of the 1995 survey is in Tables 5A to 7. The analyses are based on the units which supplied comparable data in both 1995 and 1996. (A number of technical points affecting the comparison are discussed in paragraphs 6 to 8 above.)

By registration status

18. For all registered staff (Table 5A) the three-month vacancy rate rose from 1.1 per cent to 1.6 per cent; for nursing auxiliaries and assistants (Table 5B), the one-month vacancy rate fell from 2.0 per cent to 1.7 per cent.

19. Between March 1995 and March 1996 the establishment for registered staff (Table 5A) rose by about 2,900 WTE, whilst staff in post rose by about 3,400 WTE. Total vacancies rose by 270, but three-month vacancies rose by over 600. The number of WTE posts held permanently open fell by nearly 800 WTE to 330.

20. For nursing auxiliaries and assistants (Table 5B) over the year to March 1996, the establishment fell by over 400 and staff in post was almost unchanged; total vacancies fell by 240 WTE and one-month vacancies fell by around 120 WTE. The number of WTE posts held permanently open fell by about 150 to 240.

21. The proportion of posts held permanently open (Table 7) fell sharply following the large increases recorded in 1995. These posts represent management decisions not to fill certain posts with permanent or near-permanent staff, but to retain flexibility and their decline may reflect increasingly tight financial constraints. The sharp rise in the proportion of vacancies that had been vacant for three months or more (Table 6) may reflect the increasing difficulty, attested to in anecdotal evidence, in filling nursing vacancies.

By country, region and London Weighting zone

22. Wales, Scotland and all the English regions recorded an increase in the three-month vacancy rate for registered staff (Table 5A); there was a strong rise in the Outer London zone, but the fall in the London Fringe zone may be a consequence of the low response rate for that area.

23. For nursing auxiliaries and assistants (Table 5B), four out of the nine English regions showed an increase in the one-month vacancy rate, with the West Midlands and North Thames having remained the same and the rest of Great Britain, including Wales and Scotland, showing reductions. All the London Weighting zones showed a fall in 1996 compared with 1995, although the vacancy rate in Inner London remained by far the highest.

By area of work

24. By area of work (Table 6) three-month vacancy rates for registered staff and nursing auxiliaries and assistants together increased in all areas except education (–0.4 percentage points) and the numerically small general administration group (–0.1 percentage points). The greatest increases were in paediatrics (+0.9) and mental illness (+0. 7).

Results: joiners and leavers

Summary

25. The number of staff joining Trusts in the year to 31 March 1996 was recorded as equivalent to 13 per cent of staff in post at 31 March 1996 (Table 8) and the number of leavers was also 13 per cent of staff in post (Table 10). Although direct comparisons with previous years are not possible because of changes in coverage (joiners and leavers in Wales, for example, have not been surveyed for some years), these overall figures are not very different from those recorded for England in previous KM48 surveys.

Joiners

26. Overall, 16 per cent of joiners were recorded as newly qualified staff, with 39 per cent being recorded as transfers from other NHS units and 5 per cent as re-entrants (Table 8). Over 40 per cent of joiners had no reason recorded or joined for reasons other than those given above. The high rate of non-response

to the reason for joining question should be borne in mind in interpreting these results.

Leavers - by country, region and London Weighting zone and by occupational group

27. Similar problems of incomplete response were found in the recording of leavers as of joiners and we refer to this in the main body of our report. The total leaving rate (or turnover rate) was highest in the former Special Health Authorities (30 per cent), and the North Thames region (22 per cent) and lowest in Wales (8 per cent) (Table 10). By London Weighting zone, turnover was very high in Inner London at 33 per cent. By occupational group (Table 11) turnover was highest in other first level general nursing (17 per cent) and among Registered Sick Children's Nurses (RSCNs) (16 per cent) and lowest among health visitors and District nurses (both 9 per cent).

28. The wastage rate (that is, leavers excluding transfers to other NHS units, as a proportion of staff in post) was recorded as around 9 per cent in Great Britain with particularly high rates in North Thames (14 per cent) and the former Special Health Authorities (21 per cent) with the lowest rates being in Wales (5 per cent) and the Northern and Yorkshire region (7 per cent) (Table 10). Wastage was also high in Inner London (21 per cent), and among auxiliaries and assistants generally (11 per cent).

Table 1 **Response by country/region and London Weighting zone**

	Forms sent out	Usable forms returned	Usable forms as a percentage of forms sent out	Establishment in matched sample as a percentage of establishment in full sample
	No.	No.	%	%
Total	591	308	52.1	76.3
By country/region				
Wales	31	17	54.8	71.5
Scotland	77	48	62.3	71.5
England	483	243	50.3	77.8
Northern and Yorkshire	63	23	36.5	82.2
Trent	45	25	55.6	75.0
Anglia and Oxford	51	28	54.9	80.0
North Thames	62	29	46.8	61.1
South Thames	66	26	39.4	72.9
South and West	57	31	54.4	77.3
West Midlands	59	32	54.2	82.6
North West	69	43	62.3	89.8
(former) Special Health Authorities	11	6	54.5	52.9
By London Weighting zone				
Inner London	38	17	44.7	55.9
Outer London	30	18	60.0	68.9
London Fringe zone	27	6	22.2	63.8
Rest of Great Britain	496	267	53.8	78.3

Table 2A **Summary of data (*a*) for registered staff (*b*) by region and London Weighting zone**

	At 31 March 1996						Vacancies which had lasted for over 3 months as a percentage establishment
	Establishment	Staff in post	Posts held permanently open	Total vacancies	Vacancies which had lasted for		
					2 or 3 months	over 3 months	
	WTE	WTE	WTE	WTE	WTE	WTE	%
All registered	162,710	155,578	498	6,634	1,629	3,185	2.0
By country/region							
Wales	9,288	9,122	22	144	32	61	0.7
Scotland	28,257	27,274	182	801	261	238	0.8
England	125,164	119,182	293	5,689	1,336	2,886	2.3
Northern and Yorkshire	12,726	12,347	15	364	134	120	0.9
Trent	10,934	10,669	15	251	58	134	1.2
Anglia and Oxford	13,611	12,961	21	630	144	273	2.0
North Thames	16,586	15,224	21	1,341	349	732	4.4
South Thames	12,070	10,988	89	994	135	706	5.8
South and West	18,171	17,733	59	379	116	136	0.8
West Midlands	12,362	11,872	1	489	139	227	1.8
North West	25,020	24,035	68	918	193	429	1.7
(former) Special Health Authorities	3,684	3,355	5	324	69	128	3.5
By London Weighting zone							
Inner London	10,955	9,903	5	1,047	239	589	5.4
Outer London	9,586	8,399	90	1,097	115	807	8.4
London Fringe zone	2,697	2,590	0	107	54	15	0.6
Rest of Great Britain	139,472	134,686	402	4,384	1,221	1,773	1.3

(*a*) All figures have been rounded independently, and percentages have been calculated from unrounded figures.

(*b*) All nursing staff except nursing auxiliaries and assistants.

Table 2B **Summary of data (*a*) for nursing auxiliaries and assistants by region and London Weighting zone**

	At 31 March 1996						Vacancies which had lasted for over 1 month as a percentage of establishment
	Establishment	Staff in post	Posts held permanently open	Total vacancies	Vacancies which had lasted for		
					2 or 3 months	over 3 months	
	WTE	WTE	WTE	WTE	WTE	WTE	%
All auxiliaries and assistants	58,751	56,854	260	1,637	364	695	1.8
By country/region							
Wales	3,869	3,802	17	49	8	20	0.7
Scotland	11,555	11,132	179	245	63	67	1.1
England	43,327	41,920	64	1,343	293	609	2.1
Northern and Yorkshire	4,560	4,444	4	112	18	60	1.7
Trent	4,219	4,149	4	66	23	33	1.3
Anglia and Oxford	4,819	4,541	7	271	46	100	3.0
North Thames	3,727	3,514	0	212	46	135	4.8
South Thames	4,285	4,042	10	234	42	119	3.8
South and West	7,396	7,312	21	63	24	11	0.5
West Midlands	4,428	4,285	1	141	23	61	1.9
North West	8,743	8,541	17	184	65	69	1.5
(former) Special Health Authorities	1,152	1,092	0	60	6	21	2.3
By London Weighting zone							
Inner London	1,232	1,090	0	142	17	91	8.7
Outer London	2,328	2,100	0	228	49	126	7.5
London Fringe zone	1,644	1,610	0	35	4	4	0.5
Rest of Great Britain	53,546	52,054	260	1,232	294	475	1.4

(*a*) All figures have been rounded independently, and percentages have been calculated from unrounded figures.

Table 3 **Summary of data (*a*) by occupational group**

	At 31 March 1996						Vacancies which had lasted for over 3 months as a percentage of establishment
	Establishment	Staff in post	Posts held permanently open	Total vacancies	Vacancies which had lasted for		
					2 or 3 months	over 3 months	
	WTE	WTE	WTE	WTE	WTE	WTE	%
Total	221,461	212,432	758	8,271	1,993	3,880	1.8
First level registered staff (*b*)							
Nurse Managers (*c*)	2,917	2,863	7	48	9	22	0.8
Education (*d*)	656	627	6	23	2	21	3.2
ITU/ICU (*e*)	4,622	4,392	6	223	43	102	2.2
Accident and Emergency	4,593	4,375	11	206	60	96	2.1
Theatre	6,759	6,337	24	398	101	209	3.1
Care of the elderly	10,336	9,668	77	591	152	273	2.6
Other general nursing (*f*)	45,710	43,596	76	2,038	514	895	2.0
Paediatrics	5,976	5,517	23	435	79	260	4.4
Midwifery	12,782	12,405	13	364	124	179	1.4
Health visiting	6,021	5,818	42	161	50	55	0.9
District nursing	6,131	5,999	12	120	48	33	0.5
Maternity (nursing)	2,243	2,166	7	70	9	43	1.9
Mental illness	21,102	19,863	85	1,153	264	625	3.0
Learning disabilities	5,755	5,440	20	295	63	154	2.7
Community	4,597	4,458	12	127	30	40	0.9
Second level registered staff (*g*)							
General nursing (*h*)	12,657	12,383	53	221	51	96	0.8
Paediatrics	692	687	2	3	1	2	0.3
Maternity (nursing)	577	565	0	12	7	5	0.9
Mental illness	3,433	3,368	10	56	9	29	0.8
Learning disabilities	1,365	1,319	10	36	5	15	1.1
District nursing	1,223	1,211	0	12	0	11	0.9
Community	1,347	1,328	2	17	1	9	0.6
Auxiliaries and assistants (*i*)	58,715	56,818	260	1,637	364	695	1.2
Nursery nurses	1,253	1,228	1	24	6	9	0.7

(*a*) All figures have been rounded independently, and percentages have been calculated from unrounded figures.

(*b*) Registered nursing staff with first-level registration. They will have either a degree or a diploma in nursing and they include Project 2000 graduates. Those on Whitley employment contracts will be on clinical grade D or above.

(*c*) Including senior nurses and senior midwives in management positions and whose posts required continuing clinical registration.

(*d*) Staff and posts in education grades in the NHS at 31 March 1996. Almost all of these will have transferred to the education sector during 1996–97.

(*e*) Nursing staff and posts in Intensive Therapy Units and Intensive Care Units.

(*f*) Including accident and emergency, ITU/ICU, Theatre, and care of the elderly where these could not be separately identified, and first level registered nursing staff and posts not recorded elsewhere.

(*g*) Second level registered staff include those previously described as enrolled nurses and will typically be on clinical grades C or D. Entry to training for second level registration has now ceased.

(*h*) Including accident and emergency, ITU/ICU, Theatre, and care of the elderly and other general nursing and second level registered nursing staff and posts not recorded elsewhere.

(*i*) Unregistered nursing staff and posts, excluding Health Care Assistants.

Table 4 **Three-month vacancy rates (*a*) for selected occupational groups, by region and London Weighting zone**

	First level registered nursing staff (*b*)					Second level general nursing (*d*)	Auxiliaries and assistants (*e*)
	Theatre	Care of the elderly	General nursing (*c*)	Mid-wifery	Mental illness		
	%	%	%	%	%	%	%
Total	3.1	2.6	2.0	1.4	3.0	0.8	1.2
By country/region							
Wales	1.8	0.4	1.4	0.4	0.4	0.4	0.5
Scotland	1.1	1.5	0.4	0.5	1.9	0.9	0.6
England	3.7	3.3	2.3	1.7	3.4	0.7	1.4
Northern and Yorkshire	0.3	1.6	0.2	0.5	1.9	0.2	1.3
Trent	2.7	0.4	0.3	–	6.0	–	0.8
Anglia and Oxford	4.2	3.1	2.4	1.0	3.2	0.4	2.1
North Thames	9.7	9.0	3.7	2.9	7.4	1.2	3.6
South Thames	6.2	6.9	10.6	9.5	4.1	6.6	2.8
South and West	0.7	1.1	0.7	0.1	0.0	0.2	0.2
West Midlands	1.3	1.9	1.3	1.0	1.1	0.3	1.4
North West	3.4	2.0	1.7	1.1	3.1	0.4	0.8
(former) Special Health Authorities	1.9	6.9	2.6	2.2	5.1	–	1.8
By London Weighting zone							
Inner London	12.7	9.4	4.3	6.1	2.4	5.7	7.3
Outer London	9.1	18.2	9.0	8.5	9.4	4.1	5.4
London Fringe zone	–	1.2	1.2	–	–	0.5	0.2
Rest of Great Britain	1.9	1.5	1.0	0.6	2.6	0.4	0.9

(*a*) "–" indicates no establishment or nil.

(*b*) Registered nursing staff with first-level registration. They will have either a degree or a diploma in nursing and they include Project 2000 graduates. Those on Whitley employment contracts will be on clinical grade D or above.

(*c*) Including accident and emergency, ITU/ICU, Theatre, and care of the elderly where these could not be separately identified, and first level registered nursing staff and posts not recorded elsewhere.

(*d*) Including accident and emergency, ITU/ICU, Theatre, and care of the elderly and other general nursing and second level registered nursing staff and posts not recorded elsewhere.

(*e*) Unregistered nursing staff and posts excluding Health Care Assistants.

Table 5A **Summary of data (*a*) for registered staff (*b*) by region and London Weighting zone**

MATCHED SAMPLES

	Establishment		Total vacancies		Staff in post		Vacancies which had lasted for over 3 months as a percentage of establishment	
	1995	1996	1995	1996	1995	1996	1995	1996
	WTE	WTE	WTE	WTE	WTE	WTE	%	%
All registered	122,431	125,322	4,436	4,709	116,898	120,279	1.1	1.6
By country/region								
Wales and Scotland (*c*)	25,393	27,054	615	723	24,571	26,160	0.6	0.8
England	97,038	98,268	3,821	3,986	92,327	94,118	1.3	1.8
Northern and Yorkshire	9,549	10,600	130	238	9,401	10,348	0.3	0.6
Trent	8,632	8,274	231	224	8,379	8,035	1.0	1.6
Anglia and Oxford	10,939	11,356	467	539	10,386	10,802	1.3	1.7
North Thames	9,305	10,634	585	720	8,606	9,912	2.2	2.4
South Thames	8,524	8,518	386	700	8,032	7,797	1.8	5.2
South and West	15,385	14,199	576	295	14,636	13,847	0.8	0.9
West Midlands	10,322	10,214	420	325	9,870	9,888	0.7	1.0
North West	22,126	22,458	774	852	21,037	21,567	1.1	1.9
(former) Special Health Authorities	2,255	2,016	252	93	1,980	1,922	7.4	2.8
By London Weighting zone								
Inner London	6,211	6,160	480	465	5,707	5,695	3.6	3.5
Outer London	5,594	6,707	406	752	5,100	5,949	3.6	7.2
London Fringe zone	1,673	1,847	43	50	1,591	1,798	1.2	0.8
Rest of Great Britain	108,953	110,607	3,506	3,442	104,500	106,837	0.9	1.2

(*a*) All figures have been rounded independently, and percentages have been calculated from unrounded figures.

(*b*) All staff except nursing auxiliaries and assistants.

(*c*) Separate data for Wales and Scotland are not available for the matched samples.

Table 5B **Summary of data (*a*) for Nursing auxiliaries and assistants by region and London Weighting zone**

MATCHED SAMPLES

	Establishment		Total vacancies		Staff in post		Vacancies which had lasted for over 1 month as a percentage of establishment	
	1995	1996	1995	1996	1995	1996	1995	1996
	WTE	WTE	WTE	WTE	WTE	WTE	%	%
All auxiliaries and assistants	44,115	43,693	1,381	1,143	42,342	42,313	2.0	1.7
By country/region								
Wales and Scotland (*b*)	10,718	10,803	277	225	10,331	10,402	1.6	1.1
England	33,397	32,890	1,104	919	32,011	31,911	2.1	1.9
Northern and Yorkshire	3,078	3,617	24	50	3,050	3,563	0.4	0.7
Trent	3,234	3,093	60	58	3,164	3,031	1.4	1.6
Anglia and Oxford	3,132	3,391	179	184	2,916	3,204	3.9	4.0
North Thames	1,929	1,779	121	101	1,782	1,678	5.2	5.2
South Thames	3,016	3,403	203	187	2,786	3,207	4.0	3.4
South and West	7,172	5,575	180	42	6,893	5,512	1.3	0.4
West Midlands	3,735	3,647	104	114	3,620	3,533	1.7	1.7
North West	7,536	7,844	193	171	7,279	7,656	1.5	1.6
(former) Special Health Authorities	565	541	40	14	522	527	6.8	2.3
By London Weighting zone								
Inner London	748	656	86	71	659	585	10.8	10.7
Outer London	1,674	1,503	204	154	1,455	1,349	7.6	7.1
London Fringe zone	656	924	9	12	643	912	0.9	0.3
Rest of Great Britain	41,037	40,611	1,083	906	39,585	39,468	1.6	1.4

(*a*) All figures have been rounded independently, and percentages have been calculated from unrounded figures.

(*b*) Separate data for Wales and Scotland are not available for the matched samples.

Table 6 **Summary of data (*a*) by area of work**
MATCHED SAMPLES

	Establishment		Total vacancies		Staff in post		Vacancies which had lasted for over 3 months as a percentage of establishment	
	1995	1996	1995	1996	1995	1996	1995	1996
	WTE	WTE	WTE	WTE	WTE	WTE	%	%
Total	168,237	164,543	5,939	5,870	160,786	158,115	1.2	1.6
General administration (*b*)	1,582	1,634	47	24	1,515	1,610	0.8	0.7
General nursing/care of elderly (*c*)	91,830	92,501	3,583	3,482	87,328	88,672	1.3	1.6
Paediatrics	5,391	4,973	180	194	5,174	4,776	1.1	2.0
Mental illness	26,963	26,257	998	991	25,784	25,154	1.3	2.0
Learning disabilities	11,475	10,429	379	438	11,033	9,956	1.2	1.7
Midwifery	11,295	9,937	288	296	10,904	9,628	0.8	1.3
Maternity (nursing)	3,501	3,402	110	86	3,353	3,301	1.4	1.7
Community	15,725	15,329	328	359	15,251	14,937	0.5	0.7
Education	475	82	26	1	443	81	1.6	1.2

(*a*) All figures have been rounded independently, and percentages have been calculated from unrounded figures. Nursing auxiliaries and assistants and registered staff together.
(*b*) Including central services.
(*c*) Including staff not elsewhere specified.

Table 7 **Posts held permanently open (*a*) by region and London Weighting zone**

MATCHED SAMPLES

	Registered staff (*b*)				Nursing auxiliaries and assistants			
	Posts (WTE)		As a percentage of establishment		Posts (WTE)		As a percentage of establishment	
	1995	1996	1995	1996	1995	1996	1995	1996
	WTE	WTE	%	%	WTE	WTE	%	%
Great Britain	1,097	334	0.9	0.3	391	237	0.9	0.5
By country/region								
Wales and Scotland (*c*)	207	170	0.8	0.6	109	177	1.0	1.6
England	890	164	0.9	0.2	282	61	0.8	0.2
Northern and Yorkshire	18	15	0.2	0.1	4	4	0.1	0.1
Trent	22	15	0.2	0.2	10	4	0.3	0.1
Anglia and Oxford	86	14	0.8	0.1	37	4	1.2	0.1
North Thames	115	2	1.2	0.0	25	0	1.3	0.0
South Thames	106	21	1.2	0.2	28	10	0.9	0.3
South and West	173	57	1.1	0.4	99	21	1.4	0.4
West Midlands	32	1	0.3	0.0	11	1	0.3	0.0
North West	315	38	1.4	0.2	65	17	0.9	0.2
(former) Special Health Authorities	23	0	1.0	0.0	3	0	0.5	0.0
By London Weighting zone								
Inner London	23	0	0.4	0.0	3	0	0.4	0.0
Outer London	87	6	1.6	0.1	15	0	0.9	0.0
London Fringe zone	39	0	2.3	0.0	4	0	0.6	0.0
Rest of Great Britain	948	328	0.9	0.3	368	237	0.9	0.6

(*a*) All figures have been rounded independently, and percentages have been calculated from unrounded figures.
(*b*) All staff except nursing auxiliaries and assistants.
(*c*) Separate data for Wales and Scotland are not available for the matched samples.

Table 8 **Joiners in the year to 31 March 1996: WTE and as a percentage of staff in post (*a*) by region and London Weighting zone**

	Joiners in year to 31 March 1996									
	Newly qualified (*b*)		Transfers from within NHS		Re-entrants		Other/don't know		Total joining	
	WTE	%	WTE	%	WTE	%	WTE	%	WTE	%
All nursing staff	4,637	2.1	10,663	5.2	1,447	0.7	11,084	5.4	27,560	13.4
By country/region										
Wales	176	1.4	390	3.2	59	0.5	569	4.6	1,194	9.6
Scotland	12	0.0	2,514	6.1	16	0.0	2,372	5.8	4,914	11.9
England	4,179	2.8	7,759	5.1	1,372	0.9	8,144	5.4	21,453	14.2
Northern and Yorkshire	238	1.4	443	2.7	137	0.8	556	3.4	1,373	8.3
Trent	299	2.1	570	4.0	101	0.7	601	4.3	1,571	11.1
Anglia and Oxford	549	3.2	917	5.3	113	0.6	983	5.7	2,563	14.8
North Thames	889	5.6	1,468	9.2	162	1.0	1,267	8.0	3,787	23.8
South Thames	404	3.0	864	6.4	154	1.1	755	5.6	2,175	16.1
South and West	371	1.6	858	3.6	237	1.0	1,248	5.3	2,715	11.5
West Midlands	396	2.5	682	4.4	128	0.8	960	6.1	2,165	13.8
North West	962	3.1	1,252	4.0	294	0.9	1,450	4.6	3,958	12.7
(former) Special Health Authorities	71	2.0	705	20.0	46	1.3	324	9.2	1,146	32.4
By London Weighting zone										
Inner London	705	6.9	1,859	18.3	224	2.2	678	6.7	3,465	34.1
Outer London	309	3.8	427	5.2	65	0.8	702	8.5	1,503	18.2
London Fringe zone	151	4.4	258	7.6	18	0.5	222	6.5	648	19.1
Rest of Great Britain	3,202	1.8	8,119	4.4	1,140	0.6	9,483	5.2	21,944	12.0

(*a*) All figures have been rounded independently, and percentages have been calculated from unrounded figures.

(*b*) For nursing auxiliaries and assistants, an entrant direct from full-time or part-time education.

Table 9 **Joiners in the year to 31 March 1996: WTE and as a percentage of staff in post (*a*) by occupational group**

	Joiners in year to 31 March 1996									
	Newly qualified (*b*)		Transfers from within NHS		Re-entrants		Other/don't know		Total joining	
	WTE	%	WTE	%	WTE	%	WTE	%	WTE	%
All nursing staff	4,367	2.1	10,663	5.2	1,447	0.7	11,084	5.4	27,560	13.4
By occupational group										
RSCNs (*c*)	235	6.9	317	9.3	22	0.6	122	3.6	694	20.4
Midwives	273	2.8	446	4.5	40	0.4	225	2.3	984	9.9
Health Visitors	59	1.3	227	4.9	21	0.4	121	2.6	427	9.2
District Nurses (*d*)	41	0.8	261	4.8	25	0.5	187	3.4	513	9.5
Other general first level registered (*e*)	2,913	5.3	4,184	7.7	681	1.2	2,421	4.4	10,199	18.7
Other first level registered (*f*)	677	2.1	1,463	4.6	196	0.6	1,205	3.8	3,544	11.2
Second level registered (*g*)	75	0.1	2,874	5.3	85	0.2	2,687	5.0	5,721	10.6
Auxiliaries and assistants	94	0.2	891	2.2	377	0.9	4,116	10.0	5,478	13.3

(*a*) All figures have been rounded independently, and percentages have been calculated from unrounded figures.

(*b*) For nursing auxiliaries and assistants, an entrant direct from full-time or part-time education.

(*c*) Registered Sick Children's Nurses, whether working in paediatrics or not.

(*d*) First and second level registered District Nurses.

(*e*) First level registered general nursing staff not included elsewhere.

(*f*) Nurse managers, first level registered nurses in paediatrics, maternity, community, psychiatric and learning disabilities nursing, nursery nurses, and nurse tutors.

(*g*) Excluding second level registered District Nurses.

Table 10 **Leavers in the year to 31 March 1996: WTE and as a percentage of staff in post (*a*) by country/region and London Weighting zone**

	Leavers in year to 31 March 1996											
	Involuntary termination (*b*)		Transfers to other units within NHS		To non-NHS employment				Other/don't know		Total leaving	
					health-care (*c*)		other					
	WTE	%	WTE	%	WTE	%	WTE	%	WTE	%	WTE	%
All nursing staff	3,172	1.6	7,080	3.4	953	0.5	1,076	0.5	14,146	6.9	26,426	12.9
By country/region												
Wales	152	1.2	309	2.5	20	0.2	25	0.2	450	3.6	957	7.7
Scotland	47	0.1	1,109	2.7	7	0.0	7	0.0	3,394	8.2	4,563	11.1
England	2,973	2.0	5,662	3.7	926	0.6	1,044	0.7	10,302	6.8	20,906	13.8
Northern and Yorkshire	230	1.4	286	1.7	90	0.6	67	0.4	751	4.6	1,424	8.6
Trent	322	2.3	360	2.6	69	0.5	97	0.7	683	4.8	1,531	10.8
Anglia and Oxford	265	1.5	722	4.2	78	0.4	115	0.7	1,361	7.8	2,540	14.6
North Thames	341	2.1	1,252	7.9	64	0.4	36	0.2	1,851	11.6	3,545	22.2
South Thames	300	2.2	451	3.3	68	0.5	74	0.6	1,095	8.1	1,988	14.8
South and West	306	1.3	573	2.4	113	0.5	230	1.0	1,556	6.6	2,779	11.8
West Midlands	326	2.1	505	3.2	87	0.6	100	0.6	1,094	7.0	2,111	13.5
North West	793	2.5	1,205	3.9	188	0.6	290	0.9	1,465	4.7	3,941	12.6
(former) Special Health Authorities	90	2.5	308	8.7	168	4.8	34	0.1	445	12.6	1,045	29.6
By London Weighting zone												
Inner London	220	2.2	1,273	12.5	198	2.0	70	0.7	1,621	15.9	3,384	33.3
Outer London	202	2.4	325	3.9	38	0.5	21	0.3	689	8.4	1,275	15.4
London Fringe Zone	61	1.8	55	1.6	19	0.6	9	0.3	374	11.0	518	15.3
Rest of Great Britain	2,689	1.5	5,426	3.0	697	0.4	975	0.5	11,462	6.3	21,249	11.6

(*a*) All figures have been rounded independently, and percentages have been calculated from unrounded figures.
(*b*) For nursing auxiliaries and assistants, an entrant direct from full-time or part-time education.
(*c*) Leavers who take up appointments in the non-NHS healthcare sector, including private hospitals and clinics, residential and nursing homes, health-related education, *etc*.

Table 11 **Leavers in the year to 31 March 1996: WTE and as a percentage of staff in post (*a*) by occupational group**

	Leavers in year to 31 March 1996											
	Involuntary termination (*b*)		Transfers to other units within NHS		To non-NHS employment				Other/don't know		Total leaving	
					health-care (*c*)		other					
	WTE	%	WTE	%	WTE	%	WTE	%	WTE	%	WTE	%
All nursing staff	3,172	1.6	7,080	3.4	953	0.5	1,076	0.5	14,146	6.9	26,426	12.9
By occupational group												
RSCNs (*d*)	28	0.8	234	6.9	11	0.3	12	0.4	263	7.8	548	16.2
Midwives	169	1.7	314	3.2	29	0.3	52	0.5	428	4.3	991	10.0
Health Visitors	105	2.3	107	2.3	12	0.2	9	0.2	181	3.9	414	8.9
District Nurses (*e*)	90	1.7	101	1.9	22	0.4	12	0.2	238	4.4	464	8.6
Other general first level registered (*f*)	755	1.4	3,430	6.3	454	0.8	293	0.5	4,421	8.1	9,354	17.2
Other first level registered (*g*)	591	1.9	842	2.7	171	0.5	186	0.6	1,427	4.5	3,214	10.2
Second level registered (*h*)	334	0.6	1,573	2.9	49	0.1	54	0.1	4,289	7.9	6,299	11.6
Auxiliaries and assistants	1,100	2.7	479	1.2	205	0.5	458	1.1	2,899	7.0	5,142	12.5

(*a*) All figures have been rounded independently, and percentages have been calculated from unrounded figures.
(*b*) Including retirement, redundancy, end of short-term contract, dismissal and death.
(*c*) Leavers who take up appointments in the non-NHS healthcare sector, including private hospitals and clinics, residential and nursing homes, health-related education, *etc.*
(*d*) Registered Sick Children's Nurses, whether working in paediatrics or not.
(*e*) First and second level registered District Nurses.
(*f*) First level registered general nursing staff not included elsewhere.
(*g*) Nurse managers, first level registered nurses in paediatrics, maternity, community, psychiatric and learning disabilities nursing, nursery nurses, and nurse tutors.
(*h*) Excluding second level registered District Nurses.

Appendix E

Monitoring of locally determined pay in 1996–97

Introduction

1. In a similar exercise to that conducted in 1995, the OME, in conjunction with consultants P-E International, contacted all the Trusts in Great Britain to ask about their pay offers or settlements for 1996–97 in respect of nursing staff. Data were collected by telephone during September and October 1996.

2. In parallel with the telephone enquiry, a series of 25 case study visits was undertaken by P-E International in order to establish in greater depth the reason behind the behaviour of Trusts during the second year of local pay determination, and their preparedness and strategies for the future. A fuller description of the case studies and their findings is in Appendix F. The following results relate to the date that the survey was completed in mid-October 1996.

Summary of findings: pay offers

3. The responding Trusts made a total of 447 offers or indications of offers to nursing staff that were current at the time of the survey. A few made different offers to staff on Trust and Whitley contracts, but in the great majority of cases the same offer was made to all staff. Of the 447 offers recorded, only 59 (13 per cent) had been implemented by mid-October and might be regarded as settlements. In the analyses that follow, "offers" includes settlements unless otherwise stated.

4. The average of offers on basic pay for nursing staff was 2.78 per cent. The range of offers is summarised in the following table:

Offer ranges	Number of offers	% of total	Cumulative % of total
4.00% and over	8	1.8	1.8
3.01%–3.99%	24	5.4	7.2
3.00%	141	31.5	38.7
2.80%–2.99%	28	6.3	45.0
2.70%–2.79%	119	26.6	71.6
2.51%–2.69%	26	5.8	77.4
2.50%	65	14.5	91.9
2.01%–2.49%	20	4.5	96.4
2.00%	16	3.6	100.0
TOTAL	447	100.0	

5. Of the 447 offers to nursing staff, 141 (31.5 per cent) were for 3.0 per cent, 119 (26.6 per cent) were for between 2.70 and 2.79 per cent and nearly 92 per cent were for 2.5 per cent or more. The lowest offers were at 2.0 per cent[1] and the highest offer was 4.75 per cent. Chart 1 shows the numbers of offers on basic pay at different levels.

6. There was no significant difference between the averages for nursing staff on Trust contracts and those on Whitley contracts. Most of the Trusts making differential offers offered more to staff on Trust contracts, but two offered less (one of which had conditions attached to the Whitley offer but not the Trust contract offer).

7. The averages of offers on basic pay, analysed by region and type of unit, for nursing staff are shown in Table 1. This showed that there was little systematic variation in the average of pay offers by type of unit, though there was some by region. The range of offers by region was from 2.57 per cent in Wales and 2.61 per cent in the South and West, to 3.01 per cent in the former Special Health Authorities.

8. Within the table, the highest averages of offers were in Trusts providing a full range of services in the North Thames region (3.65 per cent), and the lowest

[1]All the "offers" of 2 per cent shown have not actually been made as such, but the reasons given by the Trusts concerned why no further offers have been made, make it clear that further increases seemed very unlikely.

in combined Community plus one of Care of Elderly, Mental Illness, or Learning disabilities in the South and West (2.00 per cent).

9. An analysis of average offers on basic pay analysed by type of unit and London Weighting zone is shown in Table 2. This shows that the London Fringe zone had the highest average (2.99 per cent) and Outer London the lowest (2.75 per cent).

Structure of offers

10. Only 45 per cent of offers were for the same percentage increase to basic pay, overtime, special duty payments, and leads and allowances; most offers were for less (in some cases zero) for one or more of these types of enhancement than for basic pay. The effect on the earnings of staff will depend on the extent to which they benefit from the enhancements, but enhancements tend to be more important for lower grades of staff. Taking overall proportions of enhancements in earnings for nursing staff and applying these to the weighted offers on basic pay, overtime, SDPs, leads and allowances reduced the average increase for nursing staff from 2.78 per cent to 2.70 per cent. This is a similar difference to that in 1995 when the average of basic pay offers for nursing staff was 2.94 per cent and the estimated value taking account of enhancements was 2.82 per cent. Further detail is given in Table 3.

Changes to conditions

11. Out of a total of 447 current offers made to nursing staff, 328 (73 per cent) had no conditions attached, 77 (17 per cent) had one condition attached, 31 (7 per cent) had two conditions attached, 9 (2 per cent) had three conditions attached, 1 (0.2 per cent) had four conditions attached and 1 (0.2 per cent) had five conditions attached. The most popular single condition, whether alone or in combination with other conditions, was the conversion of the extra-statutory holidays into annual leave (54 offers). Also popular were commitment to future discussions (19 offers), reducing sickness and/or other absenteeism (15 offers), and the meeting of financial targets (14 offers), see Table 4. The proportion of offers without conditions attached was similar to that in 1995–96 but the average number of conditions was lower.

12. Thirty current offers were marked as "staged", where the increase in basic pay was to be paid in two or more stages during 1996–97. This reduced the in-year value of the settlement and was a new development compared with 1995–96, though its effect on the overall average value of offers was negligible .

Current offers compared with previous offers

13. Of the total 447 offers to nursing staff, 85 were different from what was first offered earlier in the year. Of the revised offers, 31 per cent involved the addition or removal of conditions, 89 per cent involved a change (usually, but not always, an increase) to the offer on basic pay, 86 per cent involved revised increases to overtime or special duty payments, and 48 per cent involved revised increases to leads and allowances. Further detail is given in Table 5.

Conclusions

14. The picture was more varied in 1996–97 than in 1995–96; in particular:

(a) the single most popular figure for current offers was 3 per cent on basic pay, as in 1995–96, but with another large group clustered between 2.70 and 2.79 per cent. There was also a small group (8 per cent of offers) at under 2.5 per cent;

(b) the practice of increasing overtime, SDPs, leads or allowances by less than the increase to basic rates, which reduced the value of the offers, was more widespread than in 1995–96;

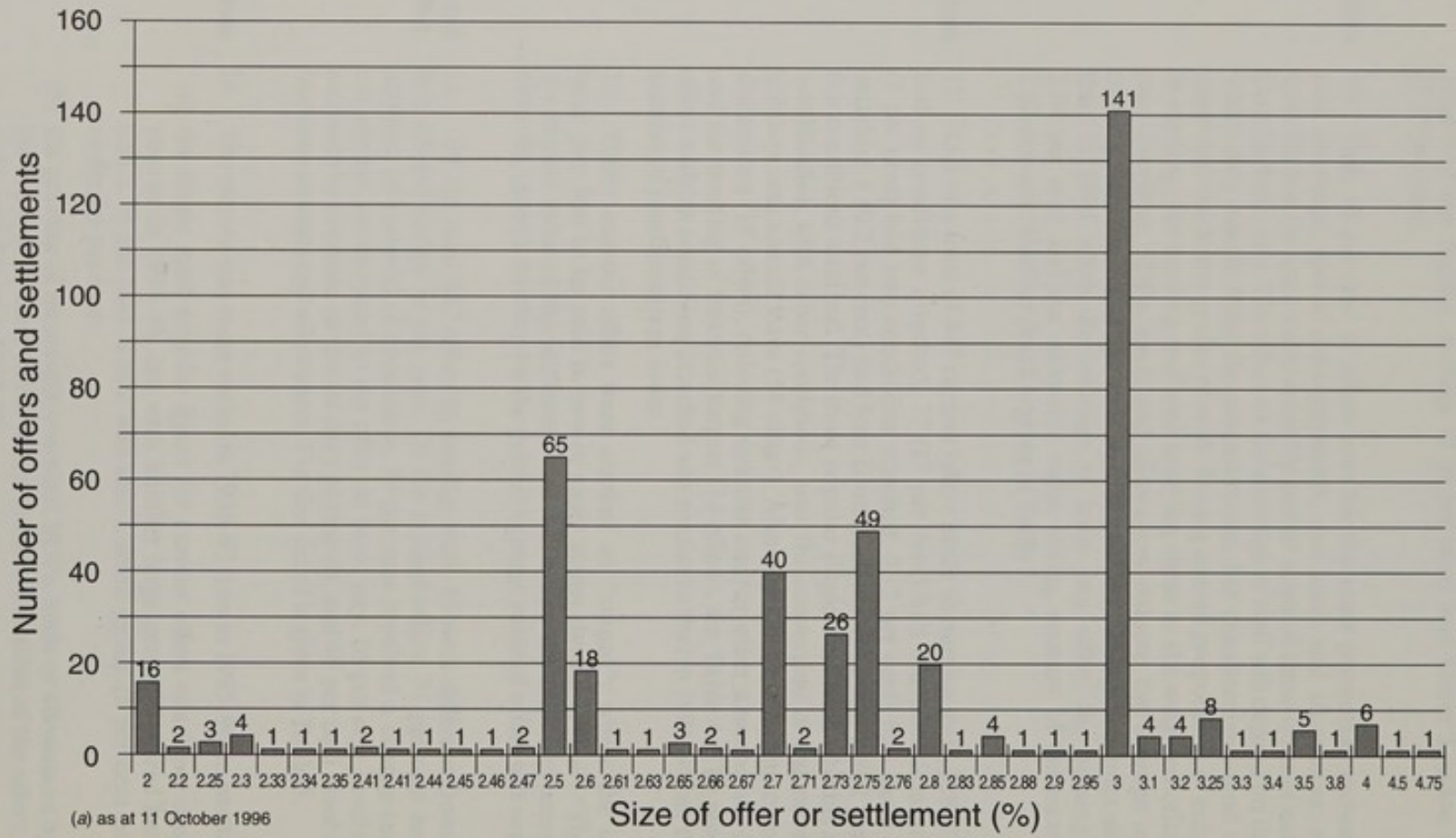
(c) there was some evidence of staging which reduced the in-year value of some offers, whereas this was not evident in 1995–96;

(d) the average number of conditions on offers in 1996–97 was lower than in 1995–96 with the conversion of extra-statutory holidays into annual leave and other unspecified conditions accounting for the majority.

Developments since the completion of the OME's monitoring exercise

15. The Health Departments told us that by 12 December 1996 188 Trusts had reached settlements with their staff and that all Trusts had made an offer, including those who told us in October that they had not yet done so.

Chart 1: **Number of offers and settlements of basic pay**
Nurses, midwives and health visitors[(a)]



(*a*) as at 11 October 1996

TABLE 1 **Summary of offers or settlements on basic pay by NHS region and type of unit**

Type of Unit Region/ Country	Acute	Care of Elderly	Mental Illness	Learning disabilities	Community	Combined – all types	Community+1 of: Care of Elderly/ Mental Illness/ Learning disabilities	Two or more of: Care of Elderly/Mental Illness/ Learning disabilities	Other	**ALL Units**
	%	%	%	%	%	%	%	%	%	%
Wales	2.57	–	–	–	–	2.25	–	2.63	2.50	**2.57**
Scotland	2.93	–	–	–	3.00	3.02	–	2.86	3.00	**2.91**
Northern & Yorkshire	2.72	–	3.00	3.00	2.73	2.25	2.86	2.86	–	**2.75**
Trent	2.70	2.75	3.00	3.00	3.10	–	2.83	2.76	–	**2.73**
Anglia & Oxford	3.05	2.91	2.70	2.78	2.94	–	3.00	2.84	3.00	**2.99**
North Thames	2.71	2.50	2.86	3.06	2.92	3.65	2.65	2.71	3.00	**2.75**
South Thames	2.90	–	3.01	2.86	3.24	2.69	3.10	2.79	3.00	**2.89**
South & West	2.62	–	2.50	2.73	–	2.48	2.00	2.64	–	**2.61**
West Midlands	2.76	–	2.60	–	2.86	2.50	2.88	2.77	–	**2.74**
North West	2.71	–	2.80	2.70	2.94	–	2.87	2.80	2.80	**2.74**
(former) Special Health Authorities	3.02	–	–	–	–	–	2.75	–	3.00	**3.01**
Great Britain	**2.77**	**2.79**	**2.80**	**2.84**	**2.99**	**2.73**	**2.83**	**2.77**	**2.94**	**2.78**
No. of units	*255*	*5*	*21*	*10*	*22*	*11*	*28*	*68*	*10*	*430*

"–" indicates no units in this category.

TABLE 2 **Summary of offers or settlements on basic pay by London Weighting zone and type of unit**

Type of Unit London Weighting zone	Acute	Care of Elderly	Mental Illness	Learning disabilities	Community	Combined – all types	Community+1 of: Care of Elderly/ Mental Illness/ Learning disabilities	Two or more of: Care of Elderly/Mental Illness/ Learning disabilities	Other	**ALL Units**
	%	%	%	%	%	%	%	%	%	%
Inner	2.93	2.50	2.77	–	2.70	–	2.92	2.74	3.00	**2.88**
Outer	2.75	–	2.91	–	3.00	2.69	2.60	2.65	3.00	**2.75**
Fringe	2.95	–	3.00	2.87	3.43	–	–	2.90	–	**2.99**
Rest of Great Britain	2.75	2.86	2.76	2.82	2.94	2.75	2.85	2.77	2.87	**2.77**
Great Britain	**2.77**	**2.79**	**2.80**	**2.84**	**2.99**	**2.73**	**2.83**	**2.77**	**2.94**	**2.78**
No. of units	*255*	*5*	*21*	*10*	*22*	*11*	*28*	*68*	*10*	*430*

"–" indicates no units in this category.

Table 3 Numbers of offers or settlements where increase to basic pay is different from increase to overtime, special duty payments, leads or allowances

A. SUMMARY

Type of offer or settlement	Number of offers or settlements
Basic increase = overtime and SDP increase = leads and allowances increase	138
Basic increase = overtime or SDP increase but leads or allowances increase is different	273
Basic increase = leads or allowances increase but overtime or SDP increase is different	3
Basic increase different from overtime, SDP, leads and allowances increases	35

B. DETAIL
(where basic pay increase unequal to overtime/SDP increase and/or leads/allowances increase)

Basic pay increase	Overtime increase	SDP increase	Leads increase	Allowances increase	Number of offers
%	%	%	%	%	
2.00	–	–	–	–	8
2.00	2.00	2.00	–	–	5
2.00	2.00	2.00	–	2.00	1
2.20	–	–	–	–	1
2.20	2.20	2.20	–	–	1
2.25	2.25	2.25	–	–	3
2.30	–	2.30	2.30	–	1
2.30	2.30	2.30	–	–	3
2.33	2.33	2.33	–	–	1
2.34	2.34	2.34	–	–	1
2.35	–	–	–	–	1
2.44	2.44	2.44	–	–	1
2.45	2.45	2.45	–	–	1
2.46	2.46	2.46	–	–	1
2.47	2.47	2.47	–	–	2
2.50	–	–	–	–	4
2.50	2.50	–	–	–	4
2.50	2.50	–	–	2.50	1
2.50	2.50	2.50	–	–	39
2.50	2.50	2.50	–	2.50	2
2.60	2.60	2.60	–	–	8
2.60	2.60	2.60	–	2.60	4
2.61	2.61	2.61	–	–	1
2.63	2.63	2.63	–	–	1
2.65	2.65	2.65	–	–	1
2.66	2.66	2.66	–	–	2
2.67	2.67	2.67	–	–	1
2.70	–	–	–	–	4
2.70	2.70	–	–	–	4
2.70	2.70	2.70	–	–	21
2.70	2.70	2.70	–	2.70	1
2.71	2.71	2.71	–	–	1
2.73	–	–	–	–	1
2.73	2.73	–	–	–	3
2.73	2.73	2.73	–	–	9
2.73	2.73	2.73	–	2.73	2
2.75	–	–	–	–	2
2.75	2.75	2.75	–	–	26
2.75	2.75	2.75	–	2.75	2
2.75	2.75	2.75	2.00	2.00	1
2.75	2.75	2.75	2.75	–	1

B. DETAIL
(where basic pay increase unequal to overtime/SDP increase and/or leads/allowances increase)

Basic pay increase	Overtime increase	SDP increase	Leads increase	Allowances increase	Number of offers
%	%	%	%	%	
2.76	2.76	2.76	–	–	1
2.80	–	–	–	–	1
2.80	2.80	2.80	–	–	13
2.80	2.80	2.80	–	2.80	1
2.80	2.80	2.80	2.80	–	1
2.83	2.83	2.83	–	–	1
2.85	2.85	2.85	–	–	4
2.88	2.88	2.88	–	–	1
2.95	2.95	2.95	–	–	1
3.00	–	–	–	–	8
3.00	–	3.00	–	–	1
3.00	2.00	2.00	–	–	2
3.00	2.75	2.75	–	–	1
3.00	2.80	2.80	–	2.80	1
3.00	3.00	–	–	–	1
3.00	3.00	3.00	–	–	69
3.00	3.00	3.00	–	3.00	6
3.00	3.00	3.00	2.00	2.00	1
3.00	3.00	3.00	3.00	–	2
3.10	3.10	3.10	–	–	3
3.20	2.50	2.50	–	–	1
3.20	3.20	3.20	–	–	3
3.25	3.25	3.25	–	–	1
3.30	3.30	3.30	–	–	1
3.50	3.50	3.50	–	–	4
4.00	4.00	–	4.00	4.00	1
4.00	4.00	4.00	–	–	1
4.75	4.75	4.75	–	–	1
Total number of offers or settlements where increase to basic pay was not equal to increases in overtime, SDPs, leads, or allowances					309

"–" indicates zero increase

Table 4 **Summary of conditions attached to current pay offers or settlements**

A. NUMBERS OF OFFERS OR SETTLEMENTS CONTINGENT ON THE ACCEPTANCE OF CONDITIONS

Condition	Number of offers or settlements to which condition attached
Conversion of extra-statutory leave days into annual leave	54
Meeting financial targets	14
Meeting activity targets	3
Reducing sickness and/or other absenteeism	15
Meeting Patient's Charter standards	1
Salaries to be paid exclusively by BACS	1
Commitment to hold future discussions	19
Changes to working practices (unspecified)	2
Consolidation of allowances	7
Consolidation of unsocial hours payments	1
Consolidation of leads	4
Join new grading structure	1
Other changes	53
Offers or settlements without any conditions attached	*328*

B. NUMBERS OF CONDITIONS ATTACHED TO OFFERS OR SETTLEMENTS

Number of conditions on each offer or settlement	Number of offers or settlements with this number of conditions
None	328
1	77
2	31
3	9
4	1
5	1

Table 5 **Comparison of first and current offers where both were made**

Change between first and current offer	Number of offers changed in this way
Number of conditions changed (only)	6
Increase to basic pay changed (only)	3
Increase to leads and allowances changed (only)	1
Increase to basic pay and overtime changed	1
Increases to basic pay, overtime and SDPs changed	23
Increases to leads and allowances and number of conditions changed	2
Increases to basic pay, overtime, SDPs and allowances changed	3
Increases to basic pay, overtime, SDPs and leads changed	2
Increases to basic pay, overtime, SDPs, leads and allowances changed	26
Increases to basic pay, overtime, SDPs, and number of conditions changed	11
Increases to basic pay, overtime, leads and allowances and number of conditions changed	1
Increases to basic pay, overtime, SDPs, leads and allowances and number of conditions changed	6

Number of conditions changed at all	25
Increase to basic pay changed at all	76
Increase to overtime or SDPs changed at all	72
Increase to leads or allowances changed at all	40

Appendix F

Findings from the case studies

Introduction

1. The case studies sought information about Trusts' approaches towards implementing local pay arrangements subsequent to the Review Body's recommendations. In particular they examined: how Trusts had reacted to the 1995 and 1996 pay awards for nursing and PAM staff; the purchaser/provider interface; progress in local pay determination; and views on how the Review Body might recommend for 1997-98.

2. The twenty-five visits were made between July and September 1996 by a consultant from P-E International, accompanied, in most instances, by a member of OME. The Trusts were spread throughout England, Scotland and Wales and varied in both the size and the type of services they provided. The visits comprised structured interviews with human resource directors/managers and other members of the senior management team. Meetings were also held, in all but two cases, with representatives from the local staff sides.

The 1995 and 1996 pay awards

3. The visits found resentment by Trust managers at the amount of time spent trying to negotiate in 1995 to what they perceived as being to no avail. In addition, managers considered the Review Body's 1996 recommendations to be unhelpful in advancing the cause of local pay determination, because Trusts had so little money left over which to negotiate. They were also disappointed at local negotiation of Whitley conditions being on a slower track. The consequence was that a number of Trusts had abandoned attempts to use local pay bargaining as a means of attempting to secure change. The local staff sides were, without exception, opposed to local pay determination and disliked both the Review Body's 1995 and 1996 recommendations.

The purchaser/provider interface

4. The attitude of most purchasers towards local pay determination was characterised by Trust managers as being neutral. Trusts did not see a role for purchasers in furthering local pay determination; lack of both funds and professional human resource expertise were the main reasons given.

Progress in local pay determination

5. Local pay determination in respect of staff on Whitley contracts was seen by managers as being constrained by both lack of funds and the terms of the framework agreement: in particular, the uprating mechanism and local negotiation of national terms and conditions being on a slower track. Managers' experiences in 1995 had also affected their attitude to local pay determination in 1996 for staff on Whitley contracts. The result was that, in some cases, there was less enthusiasm than there had been previously.

6. On the other hand, the majority of managers said that they had initiatives in mind for developing Trust contracts. These included introducing new pay and grading structures and/or simplifying terms and conditions. However, these managers generally expressed concern at the extent to which employees would elect to take up such contracts. It was argued that the right of employees to retain their Whitley conditions meant that Trusts had to provide tangible benefits for staff to choose to transfer. The absence of funds to help Trusts to implement change was felt to make it difficult for Trusts to introduce new pay and grading structures.

The nature of the Review Body's 1997-98 recommendations

7. The universal preference of the local staff sides was for a national pay award. The main reason given was to enable staff to maintain their pay relativity against similar groups in the public sector. The inference was that they felt the pay of nursing and PAM staff would fall behind that of comparable groups if it was left to local pay determination.

8. Trust managers held two views. The majority wanted the Review Body to recommend no national award, leaving any increases in pay to be negotiated locally. A minority wanted the Review Body to recommend a national pay award, leaving scope for local pay determination if local Trust managers and staff sides could work together to achieve it.

Appendix G

Previous reports of the Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine

NURSING STAFF, MIDWIVES AND HEALTH VISITORS

First Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9258, June 1984
Second Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9529, June 1985
Third Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9782, May 1986
Fourth Report on Nursing Staff, Midwives and Health Visitors	Cm 129, April 1987
Fifth Report on Nursing Staff, Midwives and Health Visitors	Cm 360, April 1988
Sixth Report on Nursing Staff, Midwives and Health Visitors	Cm 577, February 1989
Supplement to Sixth Report on Nursing Staff, Midwives and Health Visitors: Nursing and Midwifery Educational Staff	Cm 737, July 1989
Seventh Report on Nursing Staff, Midwives and Health Visitors	Cm 934, February 1990
First Supplement to Seventh Report on Nursing Staff, Midwives and Health Visitors: Senior Nurses and Midwives ...	Cm 1165, August 1990
Second Supplement to Seventh Report on Nursing Staff, Midwives and Health Visitors: Senior Nurses and Midwives ...	Cm 1386, December 1990
Eighth Report on Nursing Staff, Midwives and Health Visitors	Cm 1410, January 1991
Ninth Report on Nursing Staff, Midwives and Health Visitors	Cm 1811, February 1992
Report on Senior Nurses and Midwives ...	Cm 1862, March 1992
Tenth Report on Nursing Staff, Midwives and Health Visitors	Cm 2148, February 1993
Eleventh Report on Nursing Staff, Midwives and Health Visitors	Cm 2462, February 1994
Twelfth Report on Nursing Staff, Midwives and Health Visitors	Cm 2762, February 1995
Thirteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 3092, February 1996

Previous reports on the Professions Allied to Medicine are listed in Appendix G of the Thirteenth Report on Professions Allied to Medicine: Cm 3093: February 1996.

Printed in the United Kingdom by The Stationery Office Limited
Dd 5065626 2/97 48003 3401/9 Ord.365279 106649

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ISBN 0-10-135382-0

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