AMICUS EVIDENCE TO THE PAY REVIEW BODY- 2006

Introduction

1. This is the second evidence from Amicus since the introduction of the new pay system known as Agenda for Change (AFC).

2. In last year's evidence Amicus recognised that the Pay Review Body (PRB) process was in transition and we were very keen to open a dialogue about how we would conduct our work post implementation of AFC. We outlined information and data that we believe was necessary to enter into meaningful discussions in relation to your new role in making recommendations on Recruitment and Retention Premias (R&RPs) and High Cost Area Allowances (HCA's). You gave an honest appraisal of your capacity to respond to such requests and we are now keen to determine how we can jointly work together to gather information so that this role can be carried out on an informed and methodical basis. We also note that this year the joint staff side evidence has also requested the development of data sources to be shared by parties to help inform our deliberations. We also have no objection to producing shared data sources with the NHS Employers.

3. Amicus submitted claims for Recruitment and Retention Premia for Cytology Screeners and Pharmacists in hope that this claim would form part of your recommendations but more in the expectation that discussions around these will help establish a template for the formulation of such claims in the future.

4. Amicus wishes to avoid submission of the traditional type of evidence previously submitted by staff side organisations prior to the implementation to AFC. We are signatories to the joint staff side evidence. Repetition of the general case made in this evidence does not add to the case being made. We believe that we need to start "cutting to the chase" in these deliberations. Our evidence will be submitted on the basis that it complements or addresses an argument made in the joint staff side evidence from perhaps a unique perspective. You can rightfully assume there where we do not address an issue made in the joint staff side evidence we are in full support of the case being made.

5. Amicus sought extension of the remit of the PRB to a range of professions and occupations which were similar in terms of the level of education and training required to practice as those groups already covered. This case has now been superseded by discussions which are taking place following the fiasco of last year's pay talks at the Pay Negotiating Council (PNC) about the possible extension of the PRB to all NHS staff. The Amicus National Health Sector Conference this year took the decision that there should be single status employment with all staff on a single pay spine and with changes to the pay structure and the pay uplift determined by means of the PRB.

6. Finally it would be amiss of us not to comment on last year's report[1]. Amicus warmly congratulated the PRB on its bold statement of independence as indicated by many of the recommendations made. The delay in the publication of the report created unease and suspicion amongst Amicus representatives and stewards but this was allayed by the contents of the report. In addition there was great attention to detail with the PRB making suggestions on resolving seemingly relatively trivial issues such as mileage allowances which have a disproportionate impact on groups of our members. We should also add that despite the delay the report's recommendations were implemented by the Government in full and this should also be recognised and welcomed.

Agenda for Change and equal pay for work of equal value

7. Amicus is fully committed to the process of pay modernisation in the NHS. We accept that analytical Job Evaluation is the only means by which roles in the NHS can be ranked informed by the principles of equal pay for work of equal value. The Job Evaluation Scheme (JES)[2] which was developed is a bespoke scheme, created in partnership, by people working in or for the NHS. Amicus has contributed more than most to the completion of this process.

8. Amicus is confident that if applied fairly and consistently the JES will make a significant step towards achieving equal pay for work of equal value. In an organisation the size of the NHS it would be unavoidable if there were not areas of concern for us. But this confidence has not been undermined by implementation. Where concern exists we are confident that this can be tackled in partnership the foundations for which were laid in the majority of employers during implementation.

9. Clearly, the AFC is very much a learning curve for all parties to the agreement. The next stage of the process to achieve equal value is to monitor consistency of outcomes across the NHS. The national monitoring system – Computer Assisted Job Evaluation (CAJE) – provides useful data of outcomes across job families, bands and factors. The joint staff side evidence includes comprehensive data extracted from CAJE.

[1] Review Body for Nursing and Other Professions, Twenty-First Report 2006
[2] Contained within the NHS Job Evaluation Handbook (Second Edition) November 2004

10. Amicus disagrees with the joint staff side evidence in relation to the absence of data on old Whitley grades being an impediment to assessing outcomes. Previous evidence from Amicus stated our concern about the inconsistency of the application of the Whitley grading criteria. At the best the former Whitley grade is an impure measure of consistency when used to assess AFC outcomes. Whilst we strived for a new pay system, some minds are very much prisoners of the old one. This may have prevented innovative thinking about the correct position for certain roles in the AFC pay hierarchy both in absolute terms but also relative to other roles. It is for this reason that Amicus in its job description training advised members not to insert their former Whitley grade during this process and this in turn may explain why this data is not available on the CAJE system!

11. Amicus believes that there is no short cut but for staff organisations to consistency check or benchmark AFC outcomes through their own members. They are in the best position to determine whether colleagues at the same level of practice and/or responsibility are on the same pay band irrespective of what part of the country they work in. That is why we are seeking to supplement CAJE data with our own surveys so that a qualitative assessment can be made on whether equal value has been achieved. No doubt many employers will disagree with the conclusions that will arise from this survey work. However AFC provides for an evidenced based process to resolve such differences.

12. However we remain of the view that AFC should be independently audited by an organisation with expertise in this area.

Amicus therefore proposes that the OME commissions an equal pay audit of Agenda for Change outcomes informed by Equal Opportunities Commission guidelines and supported by technical experts in this area.

13. In recognising the great progress which has been made on the implementation of AFC we once again wish to raise areas of concern on practice in a minority of employers.

14. Amicus is now receiving numerous reports expressing concern about abuses of consistency checking. The procedure for consistency checking is detailed on pages 66-68 of the printed version of the Job Evaluation Handbook (2nd Edition). This has been supplemented by a Consistency Checking Checklist produced by the Job Evaluation Group (JEG) which is attached with this Reps Direct.

"The aim is to achieve consistency of local matching and evaluations:

- Internally, against one other local matching and evaluations, in order to avoid local grading anomalies and consequent review requests.
- Externally, against national benchmark evaluations, in order to avoid locally matched or evaluated jobs getting 'out of line' with similar jobs elsewhere".

In addition, "the failure to carry out rigorous consistency checking …. is likely to increase the number of requests for review in the medium term and grievances and possible equal pay claims in the longer term".

15. Reading of the procedure for consistency checking reveals that it is an analytical and methodical process which relies on this to be undertaken based on the application of common sense on testing whether outcomes across factors, and between and within professions are consistent, fair and robust. As we have come to appreciate this common sense is sometimes in short supply in a worrying number of NHS organisations.

16. Alleged abuses are taking place for a number of reasons:

- Outcomes have come out higher than the subjective assessments of the senior managerial team.
- Service managers seeking to maintain previous Whitley based pay hierarchies when AFC has highlighted that these were not robust or equality proofed.
- General managers seeking to insert a pay hierarchy based on managerial skills despite moves to create clinical career pathways which are supported by AFC.
- Subjective assessment of inter-occupational relativities not sustained by AFC.
- Simple managerial interference outside agreed national procedures and processes.

17. Apart from bad practice this often has poor methodology associated. The team undertaking the consistency checking often works solely from data generated from the national CAJE system. Therefore this is not an informed process. Job information which informed the original outcome and may justify the apparent inconsistency is noticeable by its absence from some employers undertaking consistency checking in this manner.

18. Amicus has received more recent reports from stewards that some employers believe that AFC was for the assimilation of current staff and we are now in a "post AFC period". This confusion is partly informed by the extent of the pay flexibilities that Foundation Trusts[3] believe they possess and underpins our concern that further fragmentation of the NHS could seriously compromise a national pay system and reintroduce inequalities.

19. This attitude is taking root at a time when deficits in some employers are resulting in turn around teams proposing the reduction of banding levels under the guise of service reconfiguration or skill mix, when in actual fact postholders are required to carry out the same role on a lower band than previously paid and a crude band mix is introduced optimised at the level of frozen or reduced budgets with bandings determined by management rather than by AFC processes. This is informed by the needs to cut costs rather than by the principles of equal pay for work of equal value. This will greatly impact on morale and open up the NHS to equal pay challenges.

20. Amicus is tackling many abuses in process. For example, one Early Implementer Trust with a significant number of reviews has made great strides to resolving these and this should be recognised.

[3] The final AFC agreement (readily available on the NHS Employers website) page 29 details the actual pay flexibilities of Foundation Trusts

Amicus therefore seeks endorsement by the PRB of AFC and associated best practice and procedures.

21. The joint staff side evidence presents for the first time comprehensive data on outcomes for NHS staff. The vast majority of registered and other degree level professions currently covered by the PRB are entering at Pay Band 5. This is obviously right and consistent.

22. However we repeat the point we made last year that the salary range for this Band has been set by collective bargaining. The PRB in time will have to determine whether the salary range for pay Band 5 is set at sufficiently high enough levels to recruit and retain skilled and professional staff.

23. Despite the Government's ambitious targets for expanding higher education planned recruitment targets are still exacting to recruit from the graduate pool. The salary range for Band 5 compares unfavourably with starting salaries for graduates in other parts of the economy. For example Income Data Services[4] produces a reputable survey on graduate starting salaries across a range of sectors of the economy.

24. There are apparently conflicting visions of professional development based on the interpretation of Annexe T[5] of the agreement which impacts on pay and will ultimately determine whether the NHS becomes a more attractive employer for newly qualified graduates.

25. It is apparent that many NHS Employers vision that in any given profession the majority of practitioners will be placed on Band 5 with the numbers tapering as we progress up the Bands. They have outlined this vision with the development of occupational "Christmas trees" which are derived from the picture that arises from the distribution of postholders across AFC bands in any particular occupational grouping or service area. We have no problem with conceptualising career structures in this way. What matters to us is the ultimate shape of the "tree".

26. Our understanding of the factor plan and Annexe T leads us to believe that in the majority of professions, the practitioners period on Band 5 will be a great deal shorter than progression to the top of that salary scale i.e. 8 years. In effect we believe that Band 6 will become the career grade for most professions entering at Band 5 and other professions may have a higher career grade depending on the starting Band (e.g. pharmacists start at Band 6 and clinical psychologists Band 7). The resulting salary ranges will make the NHS a competitive employer of graduate professionals.

[4] IDS Executive Compensation Review: Pay and progression for graduates 2006, Research File 73, February 2006

[5] Agenda for Change – NHS Terms and Conditions of Service Handbook November 2004 p.167

27. Last year Amicus expressed confidence that our officers and representatives will win this difference of view in most employers. We are content with the progress that has been made so far. We have entered into agreements with employers which effectively codifies band progression from the entry Band to the next Band. However we are alarmed that some employers are now seeking to revisit real advances made in this way as a result of financial pressures. They should be reminded that AFC constitutes a new negotiated contract of employment for NHS employees. We note that the similar attempts to undermine agreed salary rates are not being made for other groups of NHS staff covered by a different PRB who likewise have negotiated their own new contract.

Amicus therefore proposes that the PRB next year invites evidence on the distribution of staff across the Pay Bands and seek to determine whether any differential spread in outcomes can be objectively justified with a view to making recommendations on salary progression for negatively affected groups. The reason for this is that recruitment and retention problems which may have resulted in claims for R&RPs from staff side organisations may in actual fact arise from relatively poor access to salary progression through the AFC Bands.

Staff morale

28. The joint staff side evidence gives detailed quantitative data on staff's current attitude to working in the NHS.

29. Amicus has undertaken no detailed survey work of this kind in the past year. However we have had to deal with the consequences of representing members facing changes in Government policy or decisions made by employers locally. Amicus officers and representatives report a general bewilderment about the stated Government intent on a particular issue and how they experience the effects of implementation (or lack of) of this as health service employees. They are concerned about the lack of an evidence based approach to decision making. They are angry that there is a move from "what matters is what works" to an ideological commitment to certain policy mechanisms. They believe that the Government pays lip service to partnership and consultation. We illustrate:

- The government stated intent is to move towards a public health agenda. The government has targets for a range of public health indicators. So why on earth are health visiting and school nursing posts being cut and GUM clinics being shut down?
- The Carter Review of Pathology Services[6] advocated a redistributive model for pathology services and advised that contestability through the involvement of the independent sector has led to fragmentation in other countries and may undermine core service provision in the NHS. So why on earth did the Press Release from the Health Minister on publication of the review propose that in future routine tests may move to the independent sector?

[6] Lord Carter of Coles' Report of the Review of NHS Pathology Services in Englan*d*

- The same Health Minister announced in the House of Lords that the NHS will commission 300,000 patient episodes per year in audiology from the independent sector without consultation with the main professional body representing scientists, technicians and therapists. So why on earth is the NHS commissioning a number of patient episodes in excess of total activity[7] which will ultimately lead to the transfer of all NHS work in this work moving to the independent sector without receiving professional advice from those in the best position to give this – the practitioners?

30. No survey is needed as the strength of feeling on such matters is indicated by the number of health workers and their families joining local demonstrations currently taking place the length and breadth of the country.

Recruitment and Retention – the dimensions of this problem

31. No doubt some evidence will trumpet a major advance in the Department of Health (DOH) vacancy rate[8]. Amicus shares the joint staff side's view that we cannot rely on this one indicator to indicate whether the PRB has met one of its key objectives of establishing salary levels needed to recruit skilled and professional staff to meet the Government's health targets. We have previously submitted evidence how the real vacancy rate can be disguised and this is part of the joint staff side's evidence this year. We have concerns that quite significant recruitment and retention problems amongst small specialities vital to patient care may be hidden by this data by being subsumed into that of broader occupational groupings or the overall vacancy rate based on headcount may not reveal inappropriate skill mix in certain service areas. These facts were recognised this year by the PRB in responding to evidence by the Chartered Society of Physiotherapy.

32. Amicus hopes that a broader perspective is taken on this issue because those who emphasise this data to the exclusion of other indicators may be accused to a certain extent of complacency. Just like low inflation in an economy may actually lead to stagflation, a low vacancy rate may reveal a stagnating health labour market with damaging consequences in the future.

33. Besides Amicus believe that salary levels should not just be set at the level of the minimum necessary to recruit and retain skilled and professional staff but also at a level to reward and motivate. We go into further detail on this point later on in this evidence.

34. Amicus believes that it would be churlish to dismiss the improvement of the vacancy rate out of hand. But this was an indicator with which we have consistently expressed scepticism about its value, particularly when considered in isolation, and regardless of whether the rate was relatively good or relatively bad. However, where the improvement in the vacancy rate is as a result of the NHS becoming a more attractive employer to work for this is welcomed by us.

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[7] The British Academy of Audiology estimates current total annual activity of 250,000 patient episodes.

[8] Available on: www.ic.nhs.uk/pubs/vacsurveyresmar2006

35. Alternatively employers have been cutting vacant posts to reduce the salary bill for 2006-7. Organisations may also have been filling posts to cut the use of agency/locums which are more expensive. One of our Speech and Language Therapy representatives told us:

"In speech and language therapy we don't have vacancies as such. When a person leaves the money immediately disappears off the budget sheet. Our managers have to put in a really strong case to get the money back so can advertise. This is a slow process and there are a number of panels where request get looked at and I gather it is like jumping through hoops. For some types of job you can make stronger cases, for example, if you do not replace a SLT that does swallow assessments the patients may die but for posts in the children's team it is a little harder to convince people of the necessity. If you just look at vacancies then it will be a bit misleading as there aren't any!"

36. Amicus seeks a more considered approach. Our members contrast positive developments with this indicator and their current experiences of vacancy freezes and job cuts. It just does not add up in their minds. This considered approach should be based on employers properly determining the complement of staff required to deliver the service and meet the Government's health priorities and targets. A real vacancy rate would be based on the level of short fall in this complement. Just before the three year deal the NHS Employers were seeking to submit joint statistical evidence to the PRB as it was claimed that some data supplied was either contentious or anecdotal or less than scientific or even all three. We are aware that the PRB is looking for a more rigorous approach to the submitting of such data.

37. Let Amicus illustrate our point using data put together by associated professional bodies. Speech and Language Therapists (SLTs) are specialists in communication disorders. In the UK, approximately 2.5 million people have communication difficulties which can result in their failure to access education and social, economic and career opportunities. SLTs assess, diagnose and develop a programme of care to maximize communication potential. They also work to support people with swallowing, eating and drinking difficulties. SLTs are often supported by SLT assistants and co-workers.

38. The 2005 NHS census reported a headcount of 6,759 SLTs. Demand modelling performed by the Workforce Review Team utilising the workforce alignment tool (WALT) data collection (March 2005) indicates that supply/demand parity should be achieved by 2013. However, it needs to be noted that the data collection was undertaken prior to the current financial recovery plans and recent policy initiatives, and any planned expansion may now be significantly different.

39. The three month DOH vacancy survey reported a vacancy rate of 1.1% (2005: 2.5 %.). The Royal College of Speech and Language Therapists (RCSLT) from surveying their manager members report that this is severely understated due to the timing of collection and definition of a qualifying vacancy and estimate the level of vacancies to be between 20-30%. This is not even in the same ball park as the DOH figure and this alone must give the PRB cause for concern.

40. This highlights the dangers of using the vacancy rate as currently formulated. How can it be that the vacancy rate has improved significantly when supply/demand parity has not been reached and in actual far we are beginning to hear reports from the RCSLT and our SLT representatives that posts are being lost through vacancy freezes and that some posts are in danger of redundancy?

41. The Division of Clinical Psychology of the British Psychological Society have undertaken a survey[9] which has attempted to measure the true vacancy rate for Applied Psychologists. Respondents were asked to indicate the number of Whole Time Equivalent (WTE) psychology posts that were currently occupied, vacant, frozen or filled by short-term temps. In addition, respondents were asked to record their position 12 months ago, and to predict how their service may look in 12 months time. Out of the 64 services that provided responses to this section, only 19 services were able to complete all sections. The figures shown in brackets in Table 2 indicate the number of services completing that column.

Summary of Vacancy Factor data (n=64)

		Sum	Mean	Range
Total WTE Psychology	*Last Year (68)*	732.21	10.8	0.7 - 78.0
	Present (71)	870.78	12.3	0.5 – 77.0
	Next Year (60)	733.6	12.2	1.5 – 80
Posts WTE Vacant	*Last Year (47)*	46.43	1.0	0.0 – 5.0
	Present (53)	53.43	1.0	0.0 – 4.6
	Next Year (35)	8.0	0.2	0.0 – 3.0
Posts WTE Frozen	*Last Year (39)*	6.2	0.2	0.0 - 3.2
	Present (45)	22.4	0.50	0.0 – 4.0
	Next Year (29)	4	0.1	0.0 – 2.0
Posts Filled by ST Assistants	*Last Year (38)*	15.8	0.4	0.0 – 4.2
	Present (44)	14.6	0.3	0.0 – 4.0
	Next Year (30)	5	0.2	0.0 – 2.0
Total WTE Posts Needed	*Last Year (44)*	27.74	0.6	0.0 – 10.4
	Present (34)	31.4	0.9	0.0 – 7.0
	Next Year (27)	57	2.1	0.0 – 19.0

42. The figures in the Table indicate that the number of WTE psychology staff for the services surveyed has increased since 12 months ago, by an average of 1.5 WTE (10.8 to 12.3). It is predicted that, on average, this will be maintained in the next 12 months (12.2). The number of WTE posts vacant has remained stable at an average of 1 WTE, however the forecast for the coming year is that this will drop, with a predicted vacancy factor of 0.2 WTE on average. The number of WTE posts frozen has increased slightly on average from the picture the previous year; however, this is expected to decrease again over the next 12 months. The number of posts filled by short-term assistants has remained stable. The total number of WTE posts needed has increased slightly over the last 12 months, with a large increase expected over the next year. When compared to previous years' data, a consistent pattern is found despite different services responding, which demonstrates the reliability of the questionnaire.

[9] Manager's Faculty Annual Survey (2005) Walker, S.L. & Cate, T.

43. To summarise there is a 10% increase in posts this year. There is a vacancy rate of 10% for both years (DOH survey claims 2.2%). Frozen posts (including assistants in qualified posts) 6% last year and 8% this year. By our estimation the real vacancy rate is 16% last year and 18 % this year.

Amicus therefore proposes that the PRB encourages discussions between the NHS Employers and Staff Side with a view to developing a formula for determining the real vacancy rate.

44. The current requirement for SHAs to balance off trust finances by the end of the financial year is now having a real impact on NHS services. The joint staff side evidence goes into great detail about the reasons for the deficit crisis and the government's approach to managing this. We are in full accord with this analysis. However we wish to highlight the impact on particular service areas.

45. Amicus/CPHVA has identified four factors, that taken together, paint a picture of the century old profession of health visiting in crisis and possibly in terminal decline. The 'quadruple whammy', based on the DOH's own figures, is:

- 18% of health visitors – total headcount in England was 12,818 in September 2005 – are over the retiring age of 55 and could leave their jobs tomorrow.

- However, the number of health visitors under 35 – the next generation – suffered a nine per cent drop from 1,140 in September 2004 to 1,037 in September 2005. This has not been helped by the reduction in the number of training places for new health visitors at colleges and universities in recent years.

- The number of whole time equivalent (WTE) health visitor jobs has slumped to a 12-year low of 9,809 for England in 2005. In 1988, there were 10,680 (WTE) jobs.

- The vast increase in NHS expenditure has not been mirrored by a proportionate increase in the number of health visitors, thus undermining the government's public health agenda.

46. According to an Amicus survey[10] of representatives and members, nearly three quarters of Mental Health Trusts and Services in England (71%) are in deficit. As a result, 56% are planning cuts to services and more than two in five (43%) are proposing job cuts. The survey reported frozen posts in 49% of Trusts with financial pressures being cited as the reason in 90% of these cases. Amicus believes these cuts are evidence that mental health services are being targeted by the financial pressures on the NHS. We believe that mental health services are being treated as 'soft targets' for cuts by cash-strapped Trusts because of the stigma attached to mental health. This runs counter to all the government's stated aims to focus on mental well-being and it cannot continue to ignore the fact that we are seeing a decline in the provision of mental health services.

[10] Amicus survey of Mental Health Services – 2006.

47. The Royal College of Speech and Language Therapists (RCSLT) is saying[11] vulnerable patients are suffering because the NHS is failing to provide the therapy they need.

A national survey of speech and language therapy managers showed that:

- Six out of 10 (62%) believe they will not be able to plan for and meet future patient needs
- Half say the standard of care they now provide is significantly lower, or even that their service is no longer viable.
- More than three-quarters (78%) say their budget has been frozen or cut for the coming year.
- Nearly two-thirds (59%) say they do not anticipate taking on newly qualified speech and language therapists this year. As a result 8 out of 10 new graduates cannot find jobs, despite Government predications that it will take over 10 years until there are enough speech and language therapists to meet needs of local communities.

48. According to the RCSLT, primary care trusts and strategic health authorities are seeking short-term financial savings at the expense of delivering the service children and adults desperately need.

49. In the Vale of Aylesbury, for example, the speech and language therapy department has been forced to turn children away. No more children with speech and language difficulties can get the vital treatment they need.

Affordability

50. The joint staff side evidence includes data from the DOH on the projected budget for next year which we do not need to repeat in this evidence.

51. The joint staff side evidence includes a range of economic data which we do not need to repeat in this evidence.

52. The joint staff side evidence includes an analysis of the deficit crisis with which we are in full accord.

53. According to the analysis in the previous paragraph we believe that the deficit has been caused as a result of changes in the Government's approach to dealing with over spending Trusts. There is no reason why these Trusts should not have been afforded greater time to bring their finances into balance over a longer period of time with the money effectively "advanced" from the next years allocations. There is no reason why Trusts in balance should themselves be forced into crisis through the "top slicing" of their funds to offset the Trusts in deficit in that region or through other Trusts disinvesting from the services they previously planned to commission.

[11] RCSLT press release: Local NHS cut-backs threaten vital services – 5th. September 2006

54. Commentators have alleged that the deficit crisis has been caused by lucrative pay deals for health service employees. As you recognised in last year's report the costs of AFC have been exaggerated and besides the new pay system was introduced to bring about equal pay for work of equal value.

55. The Department of Health further claimed that "pay drift" through incremental progression should be recognised in the size of the recommended uplift for 2006/7. This was skilfully dealt with by the PRB's response. This claim was also exaggerated. For example all community practitioners formerly on the top of Whitley grade G who matched Band 6 would have assimilated at the top of that Band from October 2004 with no further incremental progression unless they move to Band 7 through acquiring additional skills, competencies or responsibilities as envisaged by this pay system.

56. The deficits crisis is a handy backdrop to the attempts by the Treasury to depress the size of awards by the PRB[12] which seeks settlements compatible with an inflation level of 2%. Media commentators have interpreted this as a 2% per cent overall ceiling on pay increases in the public sector. The Treasury has not taken the trouble of disabusing editors of this viewpoint.

57. Amicus gets a warm glow of nostalgia over such arguments as more informed participants will advise you that in a growing economy the rate of salary increases compatible with stable inflation is over and above the target rate for inflation set by the Government even if you accept the case that wages cause inflation. Moreover the premise of this argument is that public sector workers may be unfairly treated if their salary increases are the Government's main instrument to control inflation in the absence of a broader policy covering those in the private sector of which there is little prospect.

58. Amicus believes that there is an even more subtle attempt to link the PRB's recommendation with inflation rather than earnings. As you are probably aware earnings traditionally rise at about 0.5-1% above the rate of inflation. By linking any recommendation to inflation health workers will be able to afford the same "basket of goods" as this time last year. However other workers are filling their "basket" with more goods.

Amicus therefore seeks a one year pay award of a substantial increase across the salary ranges (Bands) which we define as being above the cost of living and that will rest comfortably in the upper quartile of salary increases for the second quarter of 2007.

59. The pay claim for the PNC will include an item for a 35 hour week. Once again this highlights the problem of having different mechanisms for determining pay for NHS staff on two pay spines which are exactly equivalent to each other in their construction.

[12] Letter from the Chancellor to Pay Review Body Chairs 13th July 2006.

60. If the claim is successful it will also have to be implemented for groups covered by the PRB as roles on separate spines but effectively on the same Band need to have same contractual working week otherwise the hourly rate of pay will differ and pay inequalities will be introduced.

61. Besides it is Amicus policy to seek a 35 hour working week across all sectors of the economy and we agree with the arguments contained within the PNC claim and further believe they can equally be made for groups covered by the PRB.

Amicus therefore seeks the introduction of a 35 hour working week for health service staff.

Recruitment and Retention Premia and High Cost Area Allowances

62. Amicus repeats what we said last year that we believe that this is a key area for the future work of the PRB. This is necessarily an area that will be developed through greater understanding by the parties to this process. We certainly believe that we made good and steady progress last year in this understanding. We were disappointed but understood your response to our claims for R&RPs for two groups.

63. The joint staff side evidence puts forward a case for a High Cost Area Supplement for South Cambridgeshire. Amicus supports this case. We further hope that consideration of this case will hope form a template for future cases of this kind.

64. For R&RPs last year we expressed the view that there was difficulty in establishing these in the absence of comprehensive data about the Agenda for Change outcomes for the occupation being considered. We now have more comprehensive data. However as we are sure you are aware this data needs interpretation in order to determine whether the outcomes are the source of any R&RP problem and whether this if agreed needs to be applied across all Bands.

65. Some of the groups listed as appropriate for long term R&RP in the agreement, will probably no longer require this as our understanding has developed, leaving us confident that few if any in that occupation will suffer pay loss. The resulting salary levels may still result in a recruitment and retention problem but this will leave them in no different position from those occupations not included in that list and their case for R&RP then should stand or fall on the same consistent criteria. However we have some fears on outcomes for some small but clinically significant groups particularly in the clinical technical area. Data must now exist on levels of pay protection for some of these groups and we could now move to establish national R&RPs if appropriate for these groups. The nationally agreed R&RP for maintenance crafts persons is now under review following negotiations last year in the PNC.

66. As we stated before we very much appreciate the deliberative approach to setting salary levels for the NHS staff within your remit.

67. Amicus repeats our view that we need a second round of evidence to look at the need for R&RP for particular occupations. The PRB was going to consult with other organisations on this proposal and we appreciate feedbacks as we believe this will lead to a more evidenced and considered approach and avoid rival organisations becoming engaged in a "bidding" war.

68. In the absence of a second round we attach as a separate item a claim for R&RP pharmacists produced by the Guild of Healthcare Pharmacists Section of Amicus which we hope could act as a template for similar claims of this nature.

69. We hope that our evidence continues to set an agenda for the PRB which can assist it define a new role for itself post AFC. We have very much appreciated the work of the PRB in previous years but we are committed to putting tried and trusted approaches behind us and help the PRB meet its objectives for the period ahead. We would very much appreciate exploring the issues that we have raised in giving oral evidence.

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29th September 2006

Summary of proposals and recommendations

Amicus therefore seeks endorsement by the PRB of AFC and associated best practice and procedures.

Amicus therefore proposes that the PRB next year invites evidence on the distribution of staff across the Pay Bands and seek to determine whether any differential spread in outcomes can be objectively justified with a view to making recommendations on salary progression for negatively affected groups. The reason for this is that recruitment and retention problems which may have resulted in claims for R&RPs from staff side organisations may in actual fact arise from relatively poor access to salary progression through the AFC Bands.

Amicus therefore proposes that the PRB encourages discussions between the NHS Employers and Staff Side with a view to developing a formula for determining the real vacancy rate.

Amicus therefore seeks a one year pay award of a substantial increase across the salary ranges (Bands) which we define as being above the cost of living and that will rest comfortably in the upper quartile of salary increases for the second quarter of 2007.

Amicus therefore seeks the introduction of a 35 hour working week for health service staff.