1. Introduction
The nursing policy landscape has been recently dominated by debates around staffing levels and nurse to patient ratios. While the RCN strongly supports the use of minimum staffing levels, we recognise that the NHS Pay Review Body’s (PRB) remit does not and should not cover this issue. However, the pressures and challenges that have led both the RCN, its sister unions, academics and patient groups to call for minimum staffing levels are of relevance to the PRB. In particular, increasing economic pressures on the NHS are leading to mounting concerns about how workforce cuts and reconfigurations may affect patient care and service quality, staff morale and motivation, and nursing recruitment and retention.

Calls for minimum staffing levels have been made in response to concerns about vacancy freezes, rising workloads, changes to skills mix and cuts to both existing posts and to student numbers. Meanwhile, there is a growing body of research evidence which shows that nurse staffing levels make a difference to patient outcomes, patient experience, quality of care and the efficiency of care delivery. For example, proportionally fewer patients die in hospitals with better nurse to patient ratios\(^1\) and differences in patient to nurse ratios are associated with differences in both patient and nurse outcomes.\(^2\) A review of international evidence on staffing ratios by the National Nursing Research Unit suggests mandated ratios could “improve nurse staffing and lead to better recruitment, generate a more stable workforce, and more manageable workloads for staff....The impact on patient outcomes is less clear but there is evidence that the resultant lower caseloads are related to lower levels of patient mortality” \(^3\)

While there is a strong evidence of a direct link between nursing staffing levels and patient and quality outcomes, the relationship does not rest purely on absolute numbers of nursing staff working in the NHS. The link between staffing levels and outcomes also depends on having a highly trained, motivated, supported and fairly-paid workforce who have enough time both to carry out their own duties and for their own development. The rise in demand for services continues to grow, allied to the increasing complexity of patient conditions, and requires adequate numbers of staff with the right skills. However, the supply of nursing staff is threatened by both a squeeze on nursing posts, as NHS employers attempt to achieve savings targets, and by reductions in commissioned places for pre-registration nurses. Moreover, both the retention of nursing staff and the attraction of nursing in the NHS as a career are threatened by an ongoing pay freeze, ever increasing workloads and reduced morale and motivation due to widespread restructuring and re-organisation.

This submission accompanies the evidence presented by the staff side trade unions and supports the key recommendations made in the report.

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3 [www.kcl.ac.uk/nursing/research/nrnu/policy/Policy-Plus-Issues-by-Theme/Whodeliversnursingcare(roles)/PolicyIssue34.pdf](http://www.kcl.ac.uk/nursing/research/nrnu/policy/Policy-Plus-Issues-by-Theme/Whodeliversnursingcare(roles)/PolicyIssue34.pdf)
2. **Recommendations**

We call on the PRB to:

- recognise the impact of, and potential damage caused by, shrinking nursing numbers and re-organisation on patient care and service quality and on workforce morale and motivation, recruitment and motivation
- recognise that the lack of clarity on the form and function of workforce planning risks undermining security of nurse staffing supply
- recognise that the impact of inflation consistently running well above NHS pay awards, alongside the two year pay freeze imposed on staff earning above £21,000, has taken a damaging toll on the living standards of NHS staff
- make a recommendation to raise NHS pay rates, that both protects their real value against prevailing inflation rates and makes a significant contribution toward addressing the major deterioration in NHS earnings that has seen the majority of staff suffer a 9% cut in living standards over the last two years alone
- make a recommendation for an additional pay rise for staff earning less than £21,000 in recognition of the additional pressures that inflation has placed on workers at the lower end of the pay scale. This addition should recognise £250 as the bare minimum uplift
- address the erosion of the differential between Agenda for Change points 15 and 16 by recommending additional rises above point 15 to smooth out the steps between points.

3. **The nursing workforce**

While the four UK countries have different data collection methods and timeframes, the data below indicates an overall downward trend in nursing numbers.

- **England:** 348,972 qualified nursing staff, midwives and health visitors by headcount as at June 2012; a drop of 2,333 or 0.7% over the year.
- **Scotland:** 65,324 nursing and midwifery staff by headcount at June 2012; a drop of 532 or 0.8% over the year.
- **Wales:** 25,344 qualified nursing staff, midwives and health visitors by headcount at September 2011; a drop of 92 or 0.4% over the year.
- **Northern Ireland:** 16,168 qualified nursing and midwifery staff by headcount at March 2012; a rise of 156 or 1% over the year.

The annual Labour Market Review (LMR), undertaken for the RCN since 2001, has tracked NHS nursing workforce data, changes in supply and demand and developments in workforce planning. For the first time in the series’ history, the LMR reports an actual decline in nurse staffing numbers. It also suggests that, based on key indicators, the decline is likely to become a deepening trend.

This emerging trend is of obvious concern and warnings have been raised by many organisations, including the RCN, its sister unions and patient groups. The RCN’s Frontline First campaign, for one, has been monitoring the effect of the economic downturn on the NHS since 2010 and provides updated figures on posts at risk.
The Nursing and Care Quality Forum, set up by the current Prime Minister, also highlighted concerns about understaffing and the skill mix balance between nurses and support workers. The forum stated that: “Delivering high quality care with compassion dignity and respect with good health outcomes is extremely challenging if there are not enough skilled and suitably competent staff.”

The report went on to state: “There is increasing national and international evidence that links staffing levels and skill mix to outcomes for people receiving care, and some high profile care failures point to inadequate staffing as a key factor.” It recommended that the Care Quality Commission “seek assurance that organisations are reviewing their staffing levels and skill mix and that they are taking appropriate action where staffing levels expose concerns over quality and safety.”

Further research by National Nursing Research Unit (NNRU) at King’s College London and the University of Southampton underlines the impact of nursing staffing levels of patient quality and safety. This research, based on a survey of 3,000 nurses across England, is part of an international research programme looking at links between nursing workforce issues and patient outcomes across 15 countries. The research demonstrates that nurse staffing and workforce issues have a significant impact on both staff satisfaction levels and patient care.

The research provides evidence of the links between nurse staffing and the quality of care patients receive. For example, on wards with poorer registered nurse staffing levels, nurses were more likely to indicate that care had been left undone due to lack of time. Their research also found that nearly half of the nurses surveyed would leave their current job if they could. The researchers conclude that at a time when the number of nurses being trained is being cut, the service can ill-afford to lose this valuable expertise.

The LMR highlights the use of temporary nurses in the NHS which it is suggested could either be an “indicator of system inefficiency” or a source of productivity improvement. In any case, the LMR concludes that it is difficult to establish the size of the temporary workforce in the NHS and the cost. While NHS Scotland publishes detailed data on the number of hours and costs of bank and agency nursing staff used, this is not the case for the other UK countries.

The LMR shows that the trend in Scotland is a reduction in the use of temporary nursing staff and a switch from agency to bank staff, through efforts to reduce costs. Available data for England is partial, based on just a sample of NHS organisations and across nursing bands 2-6. However, this suggests that shift demand for temporary staff has increased over the last year. The report concludes that “without more complete data on temporary nursing staff usage, workforce planning assumptions will continue to be based on an underestimation of the workforce supply required to meet current demands.”

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4 www.kcl.ac.uk/nursing/research/nnru/publications/Reports/RN4Cast-Nurse-survey-report-27-6-12-FINAL.pdf
3.1 Nursing workforce supply
The supply of ‘new’ nurses to the UK comes mainly from pre-registration nurse education in the UK and in some periods, international sources. The LMR 2012 shows that supply from UK pre-registration education has been the major source in recent years, while international recruitment made a major contribution in the earlier part of the last decade.

The LMR shows that commissioned places for pre-registration nursing has fallen from 24,800 in 2010/11 to 22,640 in 2011/12 – a drop of 8.7%. This number will reduce by a further 5.6% to 21,380 in 2012/13.

The drop in number of available places prompted David Green, vice-chancellor of the University of Worcester and former chair of the West Midlands group of Universities to state that: “We are heading straight for a national disaster in two to three years’ time.”

The LMR 2012 highlights the impact of previous ‘boom and bust’ approaches to workforce planning, with reduced intakes to training creating staff shortages, with a subsequent need to “scale up training and rely on high levels of active international recruitment to make good domestic training capacity shortfalls.” It concludes that the reality of a staff decline over the last two years is likely to be a continuing trend “unless policy makers accept the major contribution that reduced intakes to pre-registration will make to reduced overall supply.”

Over the last ten years there has been a marked decline in the international inflow of nurses to the UK. In the early part of this decade, between 10,000 and 16,000 international nurses were added annually to the UK register. This figure had fallen to fewer than 3,000 per year by 2010, but since then the international contribution has grown reaching about 4,000 new registrants in 2011/12. The LMR states that it is too early to be clear whether this represents the beginning of an upsurge in international inflow, but the decline up to 2010 appears to have been reversed.

4. Workforce planning
This year’s submission repeats warnings made in last year’s evidence about uncertainty and risk surrounding NHS workforce planning in England. The 2012 LMR commissioned for the RCN describes the new system as “not yet fully defined or implemented.” The LMR highlights the risks engendered by the delays in implementation and lack of clarity about the shape and structure of the system as insufficient attention is paid to workforce planning. It also highlights the risks of the ‘employer led’ approach which is to be used in workforce planning. This approach, which was last attempted in the 1990s, created an undersupply in the nursing workforce. The report warns that cost containment pressures all too often lead to local employers taking a narrow, local view of their future requirements, without taking sufficient account of changed demand and of labour market dynamics and staff flows. As these narrow views are aggregated up to regional and national level, the end result can be a significant underestimate of future requirements for nursing staff.

5. Joint survey of NHS trade union members
The RCN submission draws extensively from the 2012 joint staff side survey of NHS trade union members. The survey, undertaken by Incomes Data Services (IDS), was administered...
in the summer of 2012 and published in September. In total, the survey received 34,691 responses. This evidence reports on the findings from the 8,701 respondents who defined their occupation as ‘nurse’. In section nine, we look at the smaller number of health care assistant respondents. Where possible, we compare findings with those from the 2010 survey, which is based on the same methodology and contains many of the same questions as the 2012 survey.

This submission, in common with the joint staff side evidence, highlights main findings from the survey. The IDS report is submitted separately for fuller consideration.

6. Recruitment and retention

Chart 1 shows that a worryingly high number of nursing staff report that they have considered leaving their job, with almost two-thirds (64%) stating they have thought about it very or at least fairly seriously (compared to 60% in 2010). Chart 2 shows that of these respondents, just 9% would do so in order to take up a new position with their own organisation and a further fifth (19%) to work for a different NHS organisation. A third (34%) would leave for a post in the private sector either in health care (20%) or outside health care (14%). A significant number would leave their post (20%) for something completely different, such as retirement or looking after children or a relative. The RCN has made repeated warnings about the ageing workforce in nursing. With 12% of the nursing workforce aged 55 or over and a quarter aged 50 or over, larger cohorts of nurses moving toward retirement age mean there are growing implications for replacement strategies.

Chart 1: Over the last 12 months how seriously have you considered leaving your current position?

Source: IDS joint staff side NHS trade union membership survey 2012
Chart 2: Alternative career options for those considering leaving the NHS

The key reasons* for considering leaving the NHS are:

- stress/workload (80%)
- staff shortages (67%)
- proposed changes to the NHS pension scheme (64%)
- the changing nature of the NHS e.g. restructuring (64%)
- having to compromise on standards of care (62%)
- feeling undervalued due to levels of pay (58%)
- managers’ treatment of staff (55%).

*Respondents were able to select more than one reason.

The report by the National Nursing Research Unit (NNRU) at King’s College also looked at the link between pressures on staff and retention. The researchers concluded that working with inadequate staffing not only puts patients at risk, but places immense pressure on staff, and this has a knock effect on morale. Their research found that nearly half of the nurses surveyed would leave their current job if they could.

The NNRU report shows that there is significant correlation between where nurses would like to move to and their level of dissatisfaction. The more dissatisfied nurses are, the more
likely are they to leave nursing altogether. For example, of those who would like to carry on
nursing in a different hospital, just over half (57%) are dissatisfied with their current job
compared to two-thirds (65%) of those who want to carry on nursing but not in a hospital
and three-quarters (75%) of those who do not want to carry on nursing at all. There is a
similar difference in how they rate their working environment between those wanting to
carry on nursing (in hospital and elsewhere) and stop nursing altogether.

The telephone interviews conducted for the IDS survey drew out the finding that while job
satisfaction may currently be waning in NHS, a key factor promoting retention is job
security. For example, one Band 6 nurse told interviewers that apart from pay, job security
motivates them to stay working in the NHS, particularly in relation to a job outside the NHS
where they feel they would be much more vulnerable to a ‘first in first out’ redundancy
situation.

Perceived job security in the NHS may at this point be acting as an important factor in
retention, alongside the retention of Agenda for Change terms and conditions for most staff
working in the NHS. However, any further erosion of the terms and conditions package, on
top of ongoing pay restraint can only be expected to have a damaging impact on staff
commitment.

7. Morale and motivation in the NHS workforce
Respondents were asked about workplace morale and whether it had improved or
deteriorated over the last 12 months. Two thirds stated that morale had worsened, with a
fifth (22%) stating it was a ‘lot worse’ and double that number stating it was ‘worse’ (44%).
In 2010, just over half (55%) told us that morale and motivation had got worse over the
previous year.

A high proportion of nursing staff (63%) attribute falling morale and motivation to a feeling
of dissatisfaction with the quality of care they feel able to provide, compared to just under
half (46%) of the general group. This is reinforced in further findings, as set out in Table 1,
showing that two-fifths (40%) of all nursing respondents state they are dissatisfied with
their ability to carry out their job to a high standard.

The main reason (83%) given for declining morale is increased levels of stress. This is echoed
in the National Nursing Research Unit report which found that two-fifths (42%) of nurses
surveyed are suffering from emotional exhaustion and are ‘burnt out’. It also found that
nurses with higher levels of emotional exhaustion are more likely to be dissatisfied with
their jobs

Other key issues linked to worsening levels of morale are changes to terms and conditions,
including pension entitlements (57%), and the falling value of pay (55%)

Another key theme of the findings is the level of apprehension around NHS
restructuring and reorganisation. This was cited by 58% of respondents as a key reason for
considering leaving the NHS. This was reinforced in the telephone interviews with nursing
staff, in common with other members of the NHS workforce, expressing their anxiety about
the impact of restructuring, both on the service they provide and their employment
situation.

“I am anxious about my job. The senior management in my unit was restructured (down-banded) last year and now they’re restructuring administration and clerical. Are they going to come back and restructure band 7s?”

“Waiting times have gone up [as a result of restructuring]. They’ve created two senior roles but we need people on the ‘shop floor’.”

Nurse, band 7

Table 1: Levels of satisfaction with aspects of work

<table>
<thead>
<tr>
<th></th>
<th>Very satisfied</th>
<th>Fairly satisfied</th>
<th>Neither satisfied nor dissatisfied</th>
<th>Fairly dissatisfied</th>
<th>Very dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nurse %</td>
<td>All %</td>
<td>Nurse %</td>
<td>All %</td>
<td>Nurse %</td>
</tr>
<tr>
<td>Pay</td>
<td>1.6</td>
<td>2.3</td>
<td>21.7</td>
<td>24.3</td>
<td>21.9</td>
</tr>
<tr>
<td>Job security</td>
<td>4.0</td>
<td>4.6</td>
<td>35.1</td>
<td>33.5</td>
<td>25.3</td>
</tr>
<tr>
<td>Ability to carry out job to high standard</td>
<td>6.0</td>
<td>9.6</td>
<td>27.5</td>
<td>31.5</td>
<td>16.2</td>
</tr>
<tr>
<td>Hours of work</td>
<td>6.0</td>
<td>8.9</td>
<td>34.3</td>
<td>38.7</td>
<td>21.1</td>
</tr>
</tbody>
</table>

Source: IDS joint staff side NHS trade union membership survey 2012

Chart 3: Reasons for deterioration in workplace morale

Source: IDS joint staff side NHS trade union membership survey 2012

The result of this decline in morale and motivation is clear damage to advocacy of NHS nursing. Just 7% of nursing respondents would definitely recommend nursing as a career,
compared to 11% in 2010, and a fifth (22%) would probably recommend their own occupation (29% in 2010). By contrast, almost two-thirds (63%) would probably or definitely not recommend nursing to someone else compared to 46% of all respondents.

Chart 4: Would you recommend your own occupation as a career in the NHS?

7.1 Workload
Chart 5 demonstrates that nursing staff – in common with other staff working in the NHS – continue to feel the pressure of heavy workloads, with a similar number reporting increased workloads in the latest survey as in 2010. In both surveys, well over half reported that their individual workload had increased a lot (56% in 2010 and 58% in 2012). Overwhelmingly, as set out in Chart 6, the reason for increased workloads is staff having to deal with additional duties and responsibilities (77% in 2012 and 79% in 2010). Slightly more nursing staff report that they have more work due to insufficient cover this year than in the previous survey (52% in 2012 and 48% in 2010) and due to vacancy freezes (39% in 2012 and 34% in 2010).
Chart 5: Changes to individual workload compared with previous 12 months

Source: IDS joint staff side NHS trade union membership survey 2012

Chart 6: Reasons for increased workload

Source: IDS joint staff side NHS trade union membership survey 2012

Chart 7 shows that three-quarters (77%) of all nursing staff report that increased workload is having a negative impact on workforce morale (70% in 2010), while half (53%) state that the stress caused by high levels of workload has a detrimental effect on relationships both within and outside work (47% in 2010). A higher proportion of nursing respondents than the
whole group stated that high workloads negatively impact on patient care, with half stating that patient care is damaged compared to a third of all respondents.

### Chart 7: Impact of increased workload

<table>
<thead>
<tr>
<th>Impact Description</th>
<th>All</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>2.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Little or no effect</td>
<td>5.9</td>
<td>3.6</td>
</tr>
<tr>
<td>Job is more interesting and stimulating</td>
<td>8.5</td>
<td>7.1</td>
</tr>
<tr>
<td>Fewer opportunities to work flexibly/fewer hours</td>
<td>21.3</td>
<td>23.4</td>
</tr>
<tr>
<td>Increased intention to leave the NHS</td>
<td>36.1</td>
<td>38.8</td>
</tr>
<tr>
<td>Detrimental effect on health</td>
<td>43.7</td>
<td>46.6</td>
</tr>
<tr>
<td>Negative impact on patient care</td>
<td>34.1</td>
<td>49.7</td>
</tr>
<tr>
<td>Detrimental effect on relationships within/outside work</td>
<td>48.9</td>
<td>52.8</td>
</tr>
<tr>
<td>Negative impact on morale</td>
<td>71.4</td>
<td>76.9</td>
</tr>
</tbody>
</table>

**Source:** IDS joint staff side NHS trade union membership survey 2012

#### 7.2 Workload and staffing

The IDS staff survey shows that a high number of nursing staff report that staff shortages have frequently occurred in their workplace over the previous year (71% compared to 66% of all respondents). A further quarter (26%) report that staff shortages occur sometimes or occasionally.

The research undertaken by the National Nursing Research Unit showed that three-quarters (76%) of all respondents to their survey say there are not sufficient staff to get the work done. A similar number (73%) stated there are not sufficient registered staff to provide quality patient care. An even higher number (86%) report that at least one aspect of care was left undone on their last shift due to lack of time. The research shows that nurses who consider the quality of care where they work to be excellent, report better staffing levels where they work than those with poorer standards of care.
Chart 8: Frequency of staff shortages in the last 12 months

<table>
<thead>
<tr>
<th></th>
<th>Nurse</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently</td>
<td>71.2</td>
<td>66.3</td>
</tr>
<tr>
<td>Sometimes</td>
<td>18.4</td>
<td>19.7</td>
</tr>
<tr>
<td>Occasionally</td>
<td>7.9</td>
<td>9.7</td>
</tr>
<tr>
<td>Never</td>
<td>1.7</td>
<td>2.6</td>
</tr>
<tr>
<td>Not sure</td>
<td>0.8</td>
<td>1.7</td>
</tr>
</tbody>
</table>

Source: IDS joint staff side NHS trade union membership survey 2012

Chart 9 suggests that a higher proportion of nursing staff than the whole group report that they regularly work more than their contracted hours, with two-fifths (42%) reporting they do so frequently (compared to 36% of all respondents) and a further third (29%) that they always work extra hours (24% of all respondents).

Further analysis shows that two-fifths (40%) of nursing staff report that additional hours are usually unpaid and just 5% state that they are paid. A further third (35%) state that they are usually offered time off in lieu (TOIL). Chart 11 shows that the majority of additional hours worked fall under four hours per week (74%) suggesting that nursing staff regularly stay after their shift or working day to finish their duties. Meanwhile, Chart 12 shows responses to the question whether working hours conflict with domestic commitment. This shows that just a minority of nurses (5%) report that working hours never conflict with their domestic commitments and that almost three-quarters (71%) report that they frequently or always conflict.
Chart 9: Working more than contracted hours

Source: IDS joint staff side NHS trade union membership survey 2012

Chart 10: How are additional hours remunerated?

Source: IDS joint staff side NHS trade union membership survey 2012
Chart 11: Number of additional hours worked each week

Source: IDS joint staff side NHS trade union membership survey 2012

Chart 12: Extent to which hours of work conflict with domestic commitments

Source: IDS joint staff side NHS trade union membership survey 2012

8. Pay and NHS terms and conditions

“Disappointed, angry and demotivated. We’re being asked to do more for less.”

Nurse, Band 7

At least 30% of the nursing workforce are at the top of their pay band and have not had a pay increase since 2009. Nursing staff also face increased pension contributions and a proposed increase in NMC fees from £76 to £120 per year. An RCN survey conducted in August this year on members’ views about the NMC fee increase received 85,000 responses, of which 99.3% were opposed to the rise.5

5 www.rcn.org.uk/newsevents/news/article/uk/rcn_rejects_nmc_fee_hike
The majority of all nursing respondents to the IDS survey told us both that the current policy of pay restraint in the NHS is unfair (90%) and that the planned policy for 2013-15 is unfair (92%). This dissatisfaction with the government’s pay policy is underlined in other survey findings, with just over half (55%) citing falling values in take-home pay as a key reason for declining workplace morale (Chart 13). In addition, more than eight in 10 respondents told us that they are financially worse off than 12 months ago (Chart 15). This is compared to just over half in 2010 (57%), when a higher proportion said that their financial situation was the same (13% in 2012 and 40% in 2010). Table 1 goes on to demonstrate that well over half (55%) of nursing staff are dissatisfied with the level of their pay, with just over a quarter (27%) expressing they are very or fairly satisfied.

The 2011 RCN report *Views from the Frontline* highlighted findings from a survey of almost 8,000 RCN members. This found that for almost six in 10 (57%) respondents, their earnings represent at least half of their total household income, suggesting that a large proportion of nursing staff are the main breadwinners. Anxiety about personal finances must only be intensified by the heavy reliance on nursing incomes within many UK households.

**Chart 13: Do you think the current NHS pay policy for 2011/13 is fair?**

<table>
<thead>
<tr>
<th></th>
<th>Nurse</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes</strong></td>
<td>4.1</td>
<td>11.3</td>
</tr>
<tr>
<td><strong>No</strong></td>
<td>90.0</td>
<td>78.3</td>
</tr>
<tr>
<td><strong>Not sure</strong></td>
<td>5.9</td>
<td>10.3</td>
</tr>
</tbody>
</table>

*Source: IDS joint staff side NHS trade union membership survey 2012*
A high proportion of nursing staff are dependent on payments in addition to their basic pay to sustain their standard of living. Over two-thirds (68%) of respondents depend on some form of payments, including unsocial hours payments, special duty or shift premia, overtime and on-call payments. Comparisons with the 2010 survey suggest a higher level of reliance on additional payments than two years ago, when we found that 58% were reliant on extra forms of pay to maintain their living standards.
Chart 16: Are you dependent on any of the following payments to sustain your standard of living?

<table>
<thead>
<tr>
<th>Payment Type</th>
<th>All</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsocial hours payments/special</td>
<td>35.6</td>
<td>55.2</td>
</tr>
<tr>
<td>duty/shift premia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overtime</td>
<td>19.5</td>
<td>20.0</td>
</tr>
<tr>
<td>On-call payments</td>
<td>7.9</td>
<td>4.2</td>
</tr>
<tr>
<td>Other</td>
<td>11.2</td>
<td>13.2</td>
</tr>
<tr>
<td>None</td>
<td>31.5</td>
<td>46.4</td>
</tr>
</tbody>
</table>

Source: IDS joint staff side NHS trade union membership survey 2012

Figures from the NHS Information Centre for England, June 2012 show that mean basic earnings for a whole-time equivalent nurse, midwife or health visitor were £30,435. Mean annual earnings per person were £30,488, and of this £3,894 (13%) were additional payments. Chart 18 presents the breakdown of these additional payments, showing that well over half (60%) come from shift payments (£2,324). This shows the level of reliance on shift payments, accounting for almost 8% of total mean annual earnings.

Almost 30% of qualified nursing staff on Band 5 and almost 40% of nursing staff on Band 6 are at the top of their scale and have not received a pay rise since 2009.
9. **Nursing staff earning less than £21,000 per annum**

NHS staff wages have been devalued due to high levels of inflation during the period pay restraint. While the £250 increase for staff earning £21,000 or less has made a small contribution to cushion the impact on low paid staff, the evidence set out in the joint staff side submission shows that inflation for the lower paid is running at an even higher level than inflation.

Chart 18 presents data from the staff side submission using the salary of a Band 3 worker at the top of their scale between April 2007 and April 2012. This chart tracks their salary if it had increased in line with the yearly Retail Price Index and shows that the gap between the two initially grew steadily before closing to approximate parity in 2010. However since then, the gap has risen to £1,495 or 8% of basic salary.
Out of the total respondents to the IDS survey, there are 112 RCN members working as health care assistants. These workers are primarily employed on Agenda for Change Bands 2 and 3 and of these, a third (33%) are at the top of their pay band and therefore will receive no incremental pay lift this year.

The survey shows that three-quarters (72%) of these respondents stated that they are financially worse off than 12 months ago, with the rest stating their situation is about the same. The survey also shows that two-thirds (65%) rely on unsocial hours payments to maintain their standard of living and a quarter (26%) rely on overtime, revealing the high level of dependence on additional payments among health care assistants.

Around a third (34%) stated they have very seriously considered leaving their job, and a similar number (33%) stated that would not recommend their occupation to someone else. The main reasons cited for considering leaving the NHS are levels of pay (67%) and high levels of stress/workload (71%).

This data, allied to the evidence presented in the joint staff side evidence demonstrates the disproportionate impact of rising inflation and pay restraint on lower paid workers in the NHS. It is for this reason that we call for protections to be made for lower paid members of the NHS workforce.

We also call for adjustments to be made in order to address the erosion of the gap between points 15 and 16. Due to the pay freeze for those earning over £21,000 and the nominal increase of £250 for those earning less than this amount, the gap has been eroded to just £122. While the average gap between pay points is 3.6%, the increase between points 15 and 16 is worth 0.6%. In the staff side evidence, we state that a minimum way of addressing the issue, would be the award of £250 for staff at point 16 and £125 for staff at point 17 (in addition to the general recommended uplift) in order to smooth out this differential, leaving the gap between 15 and 16 at 1.8% and the gap between 16 and 17 at 2.3%.