Chapter One
INTRODUCTION

1.1 The Community Practitioners and Health Visitors Association (CPHVA)[1], as a member of the Staff Side of the Nursing and Midwifery Staffs Negotiating Council (NMNC) endorses the evidence submitted collectively to the Review Body (RB) by the Staff Side.

1.2 Our evidence looks at some of the specific issues for the 22,000 Community Practitioners and Community Nurses represented by the CPHVA, the Community Psychiatric Nurses Association (CPNA)[2] and Amicus MSF[3]. This year for the first time we also raise specific issues relating to 8,000 members of the National Association of Theatre Nurses (NATN)[4], a professional body for nurses and theatre staff working in a perioperative environment.

1.3 Last year, our evidence:

- commented on 2001 report of the RB;
- set the context for the 2002 review;
- outlined the new primary and community care agenda;
- addresses recruitment, retention and morale;
- raised a number of grading issues relating to Community Practitioner professions.

1.4 This year's evidence:

- comments on the 2002 report of the RB;
- outlines economic factors to be taken into account;
- raises Agenda for Change (AfC) and grading issues relating to a number of nursing disciplines;
- raises issues items of allowances, terms and conditions which can be addressed to facilitate AfC;
- addresses recruitment, retention and morale.

CPHVA proposals

- a substantial increase for all Community Practitioners which we define as being above the cost of living and that will rest comfortably in the upper quartile of the range of salary increases for second quarter of 2003 in order to continue the momentum of the Pay Review Body in restoring nurses real spending power;
- the extension of Cost of Living Supplements (COLs) to non-registered nurses;
- the consolidation of the remaining two Discretionary Points into the salary scale, with automatic progress through to the top point of the newly extended scale;
- a substantial increase in London Weighting;

[1]The CPHVA is a professionally autonomous section of the Amicus MSF trade union.
[2] The CPNA is a professionally autonomous section of the Amicus MSF trade union.
[3] Amicus MSF represents over 60,000 professional, technical and scientific staff in the NHS including 500 Community Nursery Nurses.
[4] The NATN has signed a partnership agreement with Amicus MSF.

- an increase in mileage allowances to ensure staff no longer subsidise the NHS;
- the extension of the two point grade structure for Modern Matrons to be extended to Community Practitioners and those working in Theatres;
- the broadening of access to the grade point on the top of grades A and B for those who have qualifications in healthcare recognised as equivalent to NVQ 2 and 3;
- a payment made through the salary to cover registration fees to the Nursing and Midwifery Council similar to that introduced by the STRB for teachers.

Chapter Two
THE 2002 REPORT

2.1 The key recommendations for the CPHVA members of the Review Body (RB)[5] report were:

- A 3.6 per cent uplift on the 2001-02 salary scales;
- Deletion of the lowest three increments from the consultant nurse, midwife and health visitor scale.
- An additional increment at the top of Grades A and B for staff who have attained National or Scottish Vocational Qualifications in 'care' subject at levels two and three respectively.

2.2 Other items in the report included:

- In Grade A, the deletion of the age-related point and a minimum cash uplift for staff on the first six points of the scale.
- A parallel two-grade structure for modern matrons to provide scope for further automatic progression.
- All cash based leads and allowances to be increased in line with the basic uplift.
- An increase in the psychiatric lead and regional secure unit allowance by 32 per cent and on-call and standby payments to be increased by 50 per cent. This particularly benefited our CPNA members.
- A simpler structure for London weighting (which is also increased by 3.6 per cent) based on payments applicable to all staff irrespective of their earnings. This was to the advantage of all nurses on point 5 of the C grade and below.

2.3 The CPHVA's Head of Labour Relations, Barrie Brown said: "This rise goes a fair way to recognising the aspirations of health visitors and community nurses. It paves the way for further negotiations on future pay structures that are taking place under the umbrella of Agenda for Change which should see a radical revamping of pay grades in the NHS."

2.4 Some organisations took a more trenchant view on the increase. However, the CPHVA believe that this would be a valid viewpoint if you believed that this was the year that the RB would tackle major structural problems with the level of nurse's pay. This was an optimistic scenario and once the Staff Side organisations were engaged in the Agenda for Change talks this was always going to be means by which these would be addressed.

2.5 Therefore this annual uplift was a fair increase and well above the rate of inflation for the April 2002 and within the upper quartile of pay settlements for the same period. This met one of the objectives of the CPHVA as outlined in our submission last year. Once consolidated with previous year's increases this was another, albeit small, step in restoring nurses real spending power. But as an increase to tackle structural problems in nurses pay we await the outcome of the Agenda for Change talks.

[5] **Nineteenth Report on Nursing Staff, Midwives and Health Visitors 2002.**

2.6 The RB whilst recognising 'encouraging signs' indicated that it was looking for 'solid indications in the coming year that progress (on recruitment and retention) was soundly based and sustainable (para.2.81)'. We will comment on this later on in this submission.

2.7 Unfortunately, Discretionary Points remained after the consolidation of one from 1st April 2001. This was a great disappointment particularly when scope was provided for H and I grade modern matrons for automatic progression.

2.8 The RB claimed (para.1.38) that over 90 per cent of Trusts had full implemented a scheme and during the lifetime of the scheme about a quarter of eligible nurses and midwives had received points. Our own surveys revealed a lower rate of success. This underlined the point that we were making that the criteria for the Points were very similar to the clinical grading criteria for Community Practitioners and therefore made it difficult for CPHVA to obtain the points.

2.9 Amicus MSF has almost been alone in seeking to defend the clinical grading criteria. Other organisations have often agreed with management that it is out of date. This has inadvertently led to members being 'under-graded'. Now even other organisation are catching on that their members are under-graded. The drive for appropriate grading is being supported by the Nursing Times.

2.10 The RB stated the view that 'our view has not changed' regarding employers obligations in respect of the clinical grading structure and added 'that where staff meet the criteria for Grade C they should so graded' (para.3.62). This is in direct response to our campaign on behalf of Community Nursery Nurses.

2.11 Our grading campaign is making steady progress. We have urged members to step up their efforts as we are seeking for members to be on the proper point on the present grading structure before Agenda for Change comes to be implemented. However, we like the RB would prefer that Trusts recognise their obligations regarding the clinical grading criteria and instead work with our members in improving clinical practice.

2.12 Even with Agenda for Change at last becoming imminent we are hoping to further develop pay and conditions for our members in the Twentieth Report. Contrary to the probable assertions of the Health Departments and the employers seeking no major changes ahead of Agenda for Change we will outline how our proposals are compatible with pay modernisation.

Chapter Three
ECONOMIC FACTORS

NHS funding

£bn	2002/3	2003/4	2004/5	2005/6	2006/7	2007/8	Average real growth
Previous plan	**65.4**	**69.7**					
New provision		**72.1**	**79.3**	**87.2**	**95.9**	**105.6**	**7.4%**

Note: Figures are subject to the decisions of the devolved administrations.

3.1 The 2002 Budget announced the largest ever-sustained increase in NHS resources. A 3.4 per cent average annual terms real growth in UK NHS spending for five years, putting the NHS on a sustainable long-term financial footing with spending to grow by 10 per cent in cash terms or by 43 per cent over the period.

3.2 Over the same period the Government has set for increasing the numbers of nurses, midwives and health visitors by 35,000. However, whilst this target is welcome, it appears to the CPHVA more for propagandist purposes than practical application. No workforce planning has been done on how this figure should be distributed throughout the nursing disciplines. Maybe this is a indeterminable objective. The CPHVA has met huge obstacles in trying to develop a robust model for the community. However, we are convinced of need to boost capacity in the primary care sector in order to meet Government health targets and improve healthcare in the long term.

3.3 This argument is reinforced by the fact that some tier 2 services are moving into primary care to reduce acute pressures and to meet secondary care targets. Unless resources are increased to meet these new commitments our members will be placed under a great deal of strain. Something has to give here and we are certain that it will be the balance of resources between acute and primary care not our members.

3.4 At the same time there is a drive for nurses to take on enhanced roles to enable the NHS to become compliant with the Working Time Directive for doctors. Once again we are confident that this is an opportunity and challenge that nurses will meet as they have done in the past.

3.5 But what are the target figures for an increased number of healthcare assistants and support staff who will take on work in order to ensure that nurses take on these enhanced roles? How will the Government ensure that evolving nursing disciplines like Community Nursery Nurses get due recognition from regulatory bodies in order that more skilled nursing staff can confidently delegate work in line with professional codes of practice? And at what point does a nurse transcend the profession and take on a totally new role and therefore does not count for the Government's targets for expanded numbers?

3.6 For example Genetic Counsellors and Sexual Health Advisors are mainly drawn from nursing and whose pay is based in the main on the Nursing and Midwifery scale but are professions seeking separate registration from nursing with the Health Professions Council. The increasing interaction between nursing, and scientific and technical staff in the theatres does point towards the creation of a new practitioner role but would regulation necessarily reside with the Nursing and Midwifery Council as the scientific and technical staff are not registered nurses?

3.7 We need national work to be undertaken by the Department of Health on targets in the National Service Frameworks looking at workloads and the skills mix required to meet these targets and whether this can be achieved within the available resources. Instead the approach is to initiate pilots through the Workforce Confederations which whilst being an interesting area of endeavour often throw up questions relating to appropriate professional boundaries and skills depletion and is no substitute for the planning outlined above.

3.8 We also fear that pressure will come to direct these extra resources to service provision at the expense of continuing the process of the last reports of the Review Body (RB) to addressing the historic decline in the spending power of nursing staff. Firstly, this view ignores that in a people centred service such as the NHS, the contribution of staff cannot be ignored. The attempt by the Health Departments to juxtapose salary costs versus service provision has been effectively addressed by the RB in the past. Secondly, in an era of relatively low inflation the NHS can use these greatly expanded resources to both improve the salaries of nursing staff and invest directly in other aspects of service provision.

3.9 There is also an increasing penchant for funding and resourcing short-term special projects as opposed to the mainstream service that continues to face cost and other financial pressures. Despite protestations to the contrary from the Department this is an attempt to micro manage the service through using these special projects as an indicative tool for the rest of the service.

3.10 There is a great deal of expectation being built up amongst nurses that we are approaching a new pay settlement. During the period of the talks the RB has within its remit made a difference and must continue its good work this year to help ensure that the Government follows the logic of its own conclusions on the problems facing the NHS as outlined in the NHS Plan. The objectives for Government for the extra resources should be threefold: boost capacity; boost the basic pay of nurses and set up a reward structure for those that take on enhanced roles or greater responsibilities.

Economic Factors

3.11 Inflation is comfortably low with the underlying index having remained below the Government's target figure for the whole of the previous financial year. The all items index for June 2002 is 1.0 per cent. The Treasury's inflation target for RPIX remains at 2.5 per cent. Independent forecasts are predicting that inflation is set to increase throughout the last quarter of 2002 and to be at, or just above, the 2.5 per cent target throughout 2003[6] with a figure of 3.2 per cent being forecast for the whole year.

3.12 Although growth in average earnings has fallen to historically low levels, commentators are expecting an upturn as the economy recovers and headline inflation creeps up. Earnings growth of 4.7 per cent is being forecast the second quarter of 2003[7]. Public sector settlements having been running ahead of those in the private sector as the Government tries to tackle recruitment and retention problems in key areas. Whilst public sector pay may be outstripping those in the private sector one good course does not give us a feast.

3.13 The Budget deficit this year is forecast to be £11bn lower than the £12bn forecast in November's 2001 pre-Budget report and will rise to £13bn next year. This is within the Chancellor's self-imposed "golden" rule that current government spending should be matched by current receipts over the economic cycle. Public sector national debt as a proportion of gross domestic product will amount to 31 per cent of GDP by 2006/7. The Department of Health continues to under-spend both in public investment and current budget.

[6] IRS Pay Intelligence.
[7] Ibid.

Chapter Four
PAY AND GRADING

Agenda for Change

4.1 The technical work in the four working parties under Agenda for Change (AfC) is all but complete. At the time of submission we hope to be in intense negotiations with the Department of Health.

4.2 We agree with the 'scenarios' on AfC and the work of the Review Body (RB) as detailed in the Staff Side evidence.

4.3 The delay in AfC caused by awaiting the results of Comprehensive Spending Review was worth the wait. The Secretary of State for Health has won a major victory and he should rightly be congratulated.

4.4 However, there are two key issues for Amicus. Firstly, the balance, between the professions, of the distribution of any immediate extra money put into salaries. Secondly, the balance between immediate money and that tied to reform or modernisation through changes in roles. Much of this extra money is clearly going to be tied to reform and modernisation. However, it is also clear that the Government needs to seek a new settlement for NHS staff and as a result the 'pay cake' should be larger post AfC than before.

Clinical Grading

4.5 Staff Side organisations are expending a lot of time and energy defending the Nursing and Midwifery Staffs Grading Structure[8]. This would be better devoted to helping to improve clinical practice and introducing a modernised pay system. Clinical Grading should ensure that nurses practising at the same level should be on same grade irrespective of which part of the country they reside.

4.6 As a result of evidence from Staff Side organisations on Clinical Grading the Review Body (RB) has made recommendations to the Health Departments in its seventeenth (2000) and eighteenth (2001) reports to *"remind Trusts of their existing obligation in respect of the nationally agreed grading criteria"*. A paragraph to this effect was included in the Advance Letters for those years. Last year the RB stated the view that *"our view has not changed"* regarding employers obligations in respect of the clinical grading structure

4.7 Employers have seeking to undermine salary rates payable to nurses. In doing so they have claimed that in someway the Clinical Grading Structure is out of date and redundant. We are not against updating any pay structure. After we have been engaged in the AfC talks for three years. However, we insist this is undertaken through proper negotiation under partnership. This should reflect changing roles and clinical priorities.

[8] Nursing and Midwifery Staffs Negotiating Council Staff Side: A Guide to the Clinical Grading Structure - April 1988.

4.8 Instead a process of stealth with cost cutting being the main objective in mind has taken place. As a result the national pay system has been undermined with people getting paid different amounts for doing the same job in different parts of the country. At the same time the system is unresponsive to changing roles and nurses are not regraded when moving to higher levels of practice. This is a poor precedent for proposals to introduce a competency-based approach to pay progression, the Knowledge and Skills Framework, under Agenda for Change.

4.9 Rather cheekily, employers have either denied that such grade drift has taken place or it is the direction of the employee. Staff Side surveys of nursing disciplines have indicated that this is largely not the case and on most occasions grade drift is to the detriment of Staff.

4.10 We have warned that this approach will backfire and prevent Trusts recruiting sufficient numbers of nurses to meet expanding recruitment targets. More important it also means that the RB is making recommendations on the level of uplift need to meet these very same targets on the incorrect premise that nurses are being paid the correct rate in the first place.

4.11 We are hopeful that the AfC talks on Modernising the NHS Pay System will address all these issues. However we are not resting on our laurels. We are going to ensure that our members are on the correct position on the present scale before they assimilate to the AfC scales.

4.12 This year we will once again identify inappropriate or unfair application of the Clinical Grading criteria, backing up this up with data to justify our claims and outlining steps we are taking to remedy the situation.

Community Nursery Nurses

4.13 Community Nursery Nurses are employed alongside Community Practitioners as part of skill mix in the community. Our last survey[9] showed that the grading of these staff appears to be purely arbitrary, varying from trust to trust and the grades given do not reflect there level of qualification attainment or the value of their work as part of a community based team.

4.14 The Clinical Grading structure for Scale C applies to posts in which the post-holder provides nursing care under the direction of a registered nurse, midwife or health visitor. We are now winning grading claims on a regular basis.

Community Psychiatric Nurses

4.15 Research has shown that a greater percentage of the community mental health nursing workforce is graded at more junior grades than ever before. The 4th quinquennial national community mental health nursing survey of England and Wales, demonstrated that the grade mix of the workforce has changed markedly from that of a previous survey in 1990.

[9] **Bought In –Sold Out? Community Nursery Nurses grading: MSF 1999.**

4.16 The provisional results of a survey of CPNA members which has yet to be released reveals that 59 per cent of respondents are on G grade and above, 17.2 per cent are on F grade and 23.7 per cent are on E grade.

4.17 A recent successful claim for G grade in Scotland for Community Psychiatric Nurses will herald a major drive for proper grading.

Consultant nurses, midwives and health visitors

4.18 Last year the Review Body acted on our assertion that this post was being introduced on the 'cheap' by deleting the lowest three points on the scale.

4.19 According to the Health Service Report the most current information of starting rates for Consultant Nurse posts as advertised during 2001[10] revealed the following information:

- Average minimum advertised salary is £33,176.
- Average maximum advertised salary is £38,929.
- Median minimum advertised salary is £33,555.
- Median maximum advertised salary is £37,630.

4.20 Some employers are offering additional benefits in order to lure consultant nurses.

4.21 However, we accept that this information is pre-the implementation of the RB's recommendation. Therefore, it is too early to determine the affect that this has had on salary rates both immediately for existing Nurse Consultants and indicatively for newly created posts.

4.22 The CPHVA has residual fears over the proportion of posts based in Primary Care and that the development of the post was driven by the medical model of health care, rather than the social model.

District Nurses

4.23 District Nurses who are qualified to an equivalent level as Health Visitors have seen their grading change dramatically. There have been many proposals to change the grading of District Nurses that have been cost driven grade mix, not health driven skill mix and this is why the number of G grade District Nurses has dropped dramatically in recent years[11]. These moves have left the profession feeling particularly demoralised.

[10] Health Service Report Nurse Consultants Database.

[11] See First Assessment p.75 - a review of district nursing services in England and Wales: Audit Commission - 1999.

4.24 The CPHVA will be launching a major campaign in district nursing in the Autumn.

Practice Mentors

4.25 The Clinical Grading criteria makes it clear that H Grade is the appropriate grade for staff who are Practice Mentors. The central role of the Practice Mentor is to facilitate the post graduate students to attain professional competence through experience in practice. Our last survey of Practice Mentors revealed that only 50 per cent were on substantive H grade.

4.26 Amicus MSF recently applied to go to an Employment Tribunal on behalf of a member who was not paid the H grade. The Trust settled our claim before proceedings started.

Practice Nurses

4.27 Practice Nurses remain employed by GP practices. Therefore, for many, their pay does not follow the recommendations of the RB. They are not always given increments, nor are they always graded appropriately.

4.28 The Department has sent a letter to all Health Authorities and PCT/Gs. This letter stresses the importance placed on the commitment to give Practice Nurses the increases awarded by the RB, including that in order to increase practice nurses' pay, GP practices should be adequately reimbursed for the employment of practice staff. The letter also states that the Healthy Authority or PCT/G must consult with the Local Medical Committees (LMCs) with the aim of reaching an agreement on the level of GP reimbursement.

School Nurses

4.29 The training and competencies of school nurses are comparable to other Community Practitioners, yet School Nurses are employed principally on E (24%) or F (52%) grades with only 12% on a G Grade[12]. Taking into account the 'term time factor' of their work, this equates to remuneration on the level of grade D or E.

4.30 These regional fluctuations in grading levels that cannot be rationally explained by the Clinical Grading criteria.

4.31 Amicus MSF recently won a major success on School Nurses regrading in North Tyneside and will result in us redoubling our efforts. Claims are being tabled the length and breadth of the country.

4.32 In Scotland, many Trusts have reneged on the commitment by the Scottish Executive to give common training and grading to all Community Practitioners by denying School Nurses G grade positions. This is despite statements from the Scottish Executive that "record sums are available to fund these posts".

[12] **Ibid.**

Theatre Nurses

4.33 The rates of pay for Theatre Nurses are simply too low. There is increasing demand for the work of Theatre Nurses, however, no information is collected nationally by the Department of Health on vacancy rates for this group and this is 'lumped' alongside other nursing staff in acute and elderly care. Because of shortages many staff work on the bank or through an agency from which the agencies greatly profit. The first experiences of NHS Professionals are not entirely favourable. Shortages are exacerbated by the fact that only two institutions provide courses for the extended role of Surgical Assistant.

4.34 The National Association of Theatre Nurses is working with the Royal College of Surgeons and others on developing competencies for more extended roles. However, unless investment is forthcoming in training and the reward system for this group who are at the cutting edge of new ways of working shortages will continue.

Chapter Five
ALLOWANCES, TERMS AND CONDITIONS

5.1 We raise comments in a range of areas in the full knowledge that the system may be greatly simplified post Agenda for Change (AfC). Many allowances may also be affected due to the commitment in AfC to introduce recruitment and retention supplements in hard to recruit areas, although their exact nature and relationship to present cost based allowances has not yet been determined, let alone agreed by Staff Side organisations. No doubt management will advise against restructuring these payments ahead of agreement on AfC but there is nothing to prevent the Review Body (RB) making recommendations in this area to address its remit in the short term and particularly where this is compatible with pay modernisation.

Cost of Living Supplements (COLs)

5.2 Our concerns about this supplement have been detailed in previous evidence. In an announcement by the Secretary of State for Health which coincided with the release of the Nineteenth Review Body Report, Alan Milburn MP, announced that Cost of Living Supplements (COLs) had be extended to cover East and West Kent, North and South Essex, Northamptonshire and East Sussex, Brighton and Hove. This is very welcome but does not preclude more objective criteria for COLs and their extension to non-registered and non-PRB groups in the geographical areas presently covered.

5.3 Amicus MSF will shortly be launching a campaign on COLs in our London, Southern and Eastern Regions with the goal of obtaining the supplement for non-registered and non-PRB groups. As part of AfC we expect the remit of the RB to be greatly expanded. This opens up the possibility for these groups to receive COLs on the same terms as those presently covered.

Discretionary Points

5.4 Our arguments on Discretionary Points have been well rehearsed.

- A CPHVA survey[13] highlighted the possible discriminatory impact of Discretionary Points. This survey also confirms evidence produced on similar types of payment systems in the NHS i.e. amongst Doctors[14] or as applied in the private sector or other parts of the public sector.
- Other nursing grades have been subject to grade re-structuring without a discretionary element.
- Trusts that implemented Discretionary Points based on national agreements often took the view that the difference between the six national criteria and the interpretation of existing G and H grade criteria was so slim that although it is evident that staff are working at this higher level no extra points were awarded.

13 What's the Point? Discretionary or Discriminatory Points. CPHVA/MSF - June 2000.
14 Is there discrimination against women and ethnic minority consultants in the allocation of discretionary awards? BMJ Journal May 2002

- Others believed that the phrase ‘discretionary’ meant that they could choose whether to implement the agreement, whilst in reality the discretion was based on whether the criteria was met.
- Perhaps most importantly, the perceived need to limit their award due to cash limits in some employers, some applicants were ‘failed’ even though they met the criteria.

5.5 The RB also made a very apposite comparison between the lack of central funding for discretionary points and that for the cost of living supplements.

5.6 The Office of Manpower Economics earnings data collection exercise indicated at the time that Discretionary Points were proposed that 49 per cent of Grade F nursing staff, and 75 per cent or more of Grades G, H and I were at the top of their Whitley pay scales. As a result they were dependent on the PRB recommendations for their annual pay increases. The RB considered this an *“unhelpful constraint”* on the scope for career progression. We estimate based on extrapolating returns from our annual Ominbus survey that 80 per cent of the health visiting workforce are at the top of the scale.

5.7 We simply ask have Discretionary Points helped experienced staff over this 'unhelpful' constraint? We believe that this question was partly answered with the recommendation in the 2001 report that consolidated one discretionary point into the salary scale. Now is the time to put this scheme to rest and consolidate the remaining two points.

5.8 The new pay system will introduce a competency framework, the Knowledge and Skills Framework, which will replace Discretionary Points. However, the KSF will be less acceptable to members if Discretionary Points remain as this will shape their attitude to such frameworks. Therefore, consolidation is not only compatible with AfC but must proceed its implementation in order to facilitate acceptance of the KSF.

London Weighting

5.9 In July 2002 a Greater London Authority (GLA) Advisory Panel produced a report looking at the issue of London Weighting and recommended a new approach to calculating payments. The GLA had set up the panel following discussions about public sector recruitment difficulties in the capital and the need to respond to pressures such as the soaring cost of housing.

5.10 The London Weighting Index devised by the Pay Board in the 1970s attempted to compare the additional costs faced by employees working in London. The GLA panel rejected this direct comparison approach. The panel instead proposed that it was better to rely on what the private sector labour market delivers. It commissioned the Institute of Employment Research to look at pay levels in London and compare them with pay levels outside the capital to produce what it calls standardised spatial wage differentials (SSWDs). For inner London it found that average SSWD for public sector workers is 25 per cent while in the private sector it is 37 per cent.

5.11 However, we accept that such a comparison is difficult in nursing because the vast majority of nurses work in the public sector and many in the private sector have a Whitley 'link' so any difference is minimised.

5.12 The panel itself recommended that on average, public sector employees in Inner London should be paid 33 per cent more than workers outside London and 11-15 per cent for those in Outer London.

5.13 Research undertaken by Unite[15] revealed that the dislocation between NHS pay and private sector housing costs manifests itself in London where one-in-four nurses own their own home, compared to two-thirds outside of London.

5.14 The fact of the matter is that recruitment and retention difficulties are exacerbated in London because the real spending power of staff is less than outside. The vacancy rate for Health Visitors in London is 7.0 per cent.

Mileage Allowances

5.15 The use of a car for work purposes is the number one quality of working life issue for our members. This causes immense frustration and saps staff morale. The sums of money involved in addressing these would easily be outweighed by the consequential boost to motivation.

5.16 Our members work in the community that means in the main meeting clients or patients at their home, place of work, clinics or drop-in centres. Therefore the use of a car is essential to delivering an effective and efficient service to clients and patients. A survey by the CPHVA[16] revealed that 97 per cent of respondents used their car to carry out their duties as a Community Practitioner. The same survey revealed that on average respondents drove their car for 268 miles per month during the course of their work as Community Practitioners[17]. A study done by Lambeth NHS Trust found that community staff who relied on public transport to reach patients spent significantly more time travelling and less time treating patients, they were also more stressed than car drivers doing similar work.

5.17 Mileage costs incurred for mileage on Staffs own cars is fixed nationally by the General Whitley Council. The CPHVA has consistently sought to raise mileage rates ever since the AA rate overtook the NHS rates. After two years of seeking to get an increased offer, management finally put forward an 'interim' offer with effect from July 2000.

5.18 The increase was for 4p an mile from 29p for Regular User Allowance and 39.8p for Standard User Allowance, well below what the Staff Side said which is necessary. Attempts to clarify what 'interim' means at the Whitely Council have been stalled.

[15] The Key Worker Conundrum – Unite May 2002
[16] Health Visitors and their cars 2000
[17] Ibid.

5.19 We want to ensure the mileage rates payable cover the true cost of running a car so that staff are not subsidising the NHS for the use of an essential tool of the trade. Motor Organisations produce details of running costs of driving a car.

5.20 Other public sector employees receive better mileage rates. Often these public sector workers are working alongside NHS staff such as social workers. In the case of Northern Ireland they have the same employer. Members of Parliament get 53.1p per mile.

5.21 A national agreement on mileage allowances will be part of the new Agenda for Change Staff Handbook.

Modern Matrons

5.22 Last year the Review Body agreed with proposals from the Health Departments to introduce additional increments for Modern Matrons. Many Community Practitioners and Specialist Nurses are now working out how they have given offence. We have Consultant Nurses that are disproportionately based in the acute sector, Discretionary Points where the 'success rate' for Community Practitioners is lower than that of other nursing disciplines and now Modern Matrons who are solely based in a ward setting.

5.23 At the same time the Health Departments policies place greater emphasis on the work of our members and public health in general. In the Theatres nursing staff are in the forefront of developing new enhanced roles.

5.24 There is a move towards self-managed teams in line with the NHS Plan and Shifting the Balance of Power. The team co-ordinators will be responsible for a group of Community Nurses or Theatre Staff. In the community this means more than one caseload in the ward without walls. The idea is that they have sufficient authority to make decisions that will effect care close to the patient.

5.25 There are a number of Points in the Modern Matrons guidance[18] that can be interpreted for the Community:

- Patient Advocacy and Liaison Service (PALS) – still in practice in the community.
- Ward Environment Budgets – community budgets with a public health focus.
- Benchmarking – this is already the responsibility of co-ordinators and linked to clinical governance.
- Whole patient journey – with single assessment in the community, this takes place especially as the majority of the patients come back home.

5.26 Likewise team leaders provide "a visible, accessible and authoritative presence in ward *(one without walls, our addition)* settings to whom patients and their families can turn for assistance, advice and support"[19].

[18] Implementing the NHS Plan – Modern Matrons: HSC 2001/010.
[19] Ibid: Paragraph 13.

5.27 The whole concept of the team is for them to make decisions that relate to team function, skill mix, recruitment, budgets, etc and this appears to be more than is required from Modern Matrons.

5.28 The role of Modern Matron has a parallel in the Community and the Theatres. Whether this is a 'new' initiative like Modern Matrons or a part of continuing development of team leader and specialist roles is open to debate. We could claim to call them Modern Health Visiting/School Nurse Team Leaders or Modern Clinical Specialists or Modern Surgical Assistants but we would rather be more honest. However, our members carrying out these roles are no less deserving of a two-grade structure in Grades H and I to provide scope for further automatic progression.

5.29 This would also be compatible with the 'skills escalator' concept that is being discussed under AfC and will be manifested in the Knowledge and Skills framework.

National Vocational Qualification (NVQ) linked increment

5.30 The Advanced Letter (NM) 1/2002 failed to take on board some of the concerns raised by Amicus MSF regarding the implementation of the NVQ linked extra increment for Grade A and Grade B nurses that may discriminate against Community Nursery Nurses (CNNs). For Grade B nurses this makes a difference of £445 to the annual salary.

5.31 A literal implementation of this recommendation will in effect deny those who possess other qualifications at that level like the CACHE Diploma in Childcare and Education (more commonly known as the NNEB) or the BTEC Diploma in Childhood Studies from receiving the extra increment.

5.32 According to the Council for Awards in Children's Care and Education and Edexcel these two qualifications are recognised as being equivalent to NVQ Level 3.

5.33 The Chair of the CPHVA Labour Relations Committee was on the body that created the NVQ in Early Years Studies and she clearly recalls that this was never envisaged as a replacement for the CACHE Diploma or the BTEC. Also CNNs at our recent series of training days also expressed the view that the NVQ was not as relevant to their role in the community as the CACHE Diploma or the BTEC. Therefore a literal interpretation will force CNNs to take a less relevant qualification in order to gain the extra increment and this will not improve standards of practice.

5.34 This is also simply a case of equity of treatment. Where NVQ3 equivalent qualified CNNs are denied the extra increment Amicus MSF will investigate whether this recommendation has a discriminatory effect on our members.

5.35 Amicus MSF raised this issue with John Hutton, Minister of Health. In a written reply he said:

"Finally, you raised an issue concerning nursery nurses and the extra increment available to nursing support staff who obtain NVQ qualifications. The Nurses & Midwives Advance Letter precisely reflected the recommendation of the Pay Review Body. There are however a number of qualifications that may be equivalent to Care NVQs and local employers are free to take these into account if they think it appropriate".

5.36 We are happy to report that many Trusts have followed this advice and awarded the increment to CNNs.

5.37 The above issue would be academic if CNNs were appropriately graded in the first place (see relevant section in Chapter Four).

5.38 The present approach of not recognising NVQ equivalents is outwit the approach being developed through the Knowledge and Skills Framework as part of AfC.

Registration Fees

5.39 There is an increasing tendency to improve the quality and amount of regulation of Health Professions. This results from public concern arising from a number of recent scandals.

5.40 Whilst this is an appropriate and welcome response on another level this can increase cost pressures for the main regulatory bodies the Nursing and Midwifery Council (NMC) and the Health Professions Council (HPC). At present there is no other means of raising this income except through charging fees to practitioners. The NMC and the HPC do not believe that it is desirable for the Government to fund the increased level of regulation that itself requires because this may threaten their independence. However, it is interesting to note that central funding for the Parliamentary Standards Committee is not considered to threaten the independence of that body and MPs are not required to pay a registration fee.

5.41 Many practitioners consider that these fees are now becoming a tax on work and this has sharply come into focus by the proposals of the HPC to hike up registration fees from £22 at present to between £65 and £85 from 1st April 2003. The NMC is reportedly facing financial problems and could propose a fee hike. Already, Health Visitors are also required to pay to record their additional qualification and there are proposals to charge nurse prescribers to record their qualification even though many nurses were forced to undertake this role under the threat of downgrading.

5.42 On the formation of the General Teaching Council (GTC) with which all teachers are required to register, the teaching unions raised with the School Teachers' Review Body (STRB) the issue of the £30 (£24 in Wales) registration fee who after deliberation added £33 (to cover fee and National Insurance) on top of the basic uplift[20]. This amount is now consolidated into the basic rate and will be revised automatically in line with STRB recommendations.

5.43 Amicus MSF will be seeking to include registration fees as part of the new Agenda for Change Staff Handbook. The RB can pre-empt these discussions by taking an approach consistent with that taken by the STRB.

[20] School Teachers' Review Body Eleventh Report 2002.

Chapter Six
RECRUITMENT AND RETENTION

6.1 The CPHVA supports the broad thrust of the evidence submitted by the Staff Side. However, the problems facing the recruitment and retention of Community Practitioners as you are aware somewhat different in nature. The CPHVA is concerned that the Community Practitioner professions have markedly older age profiles than other nursing professions. According to one of our Omnibus surveys the average age of Community Practitioners was 47.82 years in 2001[21].

6.2 The age profile of Community Practitioners in England is backed up by data from the Department of Health. As you can see Health Visitors and District Nurses have a more aged profile than nursing staff in general.

Age distribution of nursing, midwifery and health visiting staff[22]

	<30	<40	<50	50+
All nursing staff (Qualified)	15.7	34.0	31.2	18.6
Health Visitors	2.2	23.6	40.7	33.0
District Nurses	4.5	26.6	39.3	29.4

6.3 Fifteen per cent (+1 % on last year) of Health Visitors and 12 per cent (= to last year) of District Nurses are over fifty-five according to Department of Health NHS Hospital and Community Health Services Non-Medical Workforce Census (England: 30 September 2001) and therefore could retire at any time. This is further evidence of an ageing Health Visiting workforce.

6.4 There is some doubt whether the number of training commissions will produce sufficient numbers to replace those who may choose to leave the service. These numbers are rising but much too slowly.

6.5 There has been a welcome increase in the trend of numbers eligible for Registration.

[21] The Health Visitor Omnibus: A Telephone Survey of 500 Health Visitors, Durdle Davies Business Research 2000.

[22] Department of Health NHS Hospital and Community Health Services Non-Medical Workforce Census (England: 30 September 2000)

Specialist Practice and Traditional Community Programmes 1996-2001[23]
Numbers eligible for registration

	1996/97	1997/98	1998/99	1999/00	2000/01
Health Visiting	516	577	599	578	611
District Nursing	468	505	572	542	567
School Nursing	75	90	114	87	118

6.6 According to most recent figures only 709 Community Practitioners joined the UKCC's professional register (part eleven) in the year to 31st March 2000[24]. The figures for the most recent recorded year are not know because the NMC has not produced a more recent statistical analysis of the professional register. No doubt this has proven difficult to produce when you have difficulty registering and re-registering people in the first place! However, if registrations are at this rate it is not sufficient to replace those who are leaving practice.

6.7 The CPHVA welcomes the strong emphasis now being placed on recruitment and retention. You will note our comments on targets for recruiting Community Practitioners under the section on NHS Funding. How many of 35,000 extra nurses to be recruited will be Community Practitioners? It appears that the Department of Health does not know. We can only re-state that to meet the Government's health targets and expanded role capacity in Primary Care needs to be greatly increased.

6.8 The RB whilst recognising 'encouraging signs' indicated that it was looking for 'solid indications in the coming year that progress (on recruitment and retention) was soundly based and sustainable (para.2.81)'.

6.9 The Staff Side evidence once again makes some valid points about the ambitious targets in the NHS Plan for recruiting additional nurses to the NHS. This is relevant to Community Nursing because this is the pool of staff from which most Health Visitors, District Nurses and School Nurses are drawn. The latest Department of Health Vacancy Survey[25] reveals that there has been a deterioration in the health visiting vacancy rate in England for the second year running year (from 2.2 to 2.7%). Whilst rates remain below many other nursing specialisms it should be remembered that these cannot be readily addressed by the Department of Health's current international recruitment strategy or there is no strong tradition of agency or bank working in the Community (we estimate at less than 5%). In Scotland the health visiting vacancy rate at 4.6 per cent[26] is the highest of any nursing discipline.

[23] English National Board for Nursing, Midwifery and Health Visiting Annual Report 2000-2001.
[24] Statistical analysis of the UKCC's professional register November 2000.
[25] Department of Health Vacancy Survey March 2002.
[26] Employing Nurses and Midwives June 2002.

6.10 We were questioned during the oral evidence last year about raising the vacancy rate when it remained below other disciplines. Firmly, believing that 'prevention is better than the cure' we do not want the rate to deteriorate to the levels of other disciplines before action is taken. Community Practitioners are facing a time of great change and have very little in the way of new resources to be able to deal with that change. Indeed because of the perilous state of the finances of some PCTs and their dominance by the interests of GPs some Trusts are seeking to disinvest from health visiting, school nursing and district nursing. As you may expect these are meeting a robust response from the CPHVA.

6.11 The whole thrust many of the new Government initiatives, whilst being welcome, place a great onus on the commitment and professionalism of Community Practitioners who are a small section of the overall nursing workforce.

6.12 However:

- Conspicuous from its absence from this process is any form of workforce planning on the number of Community Practitioners needed to deliver the Government's new health agenda.
- Unless proper workforce planning takes place, there is a danger that a community form of the postcode lottery will be created.
- We question whether the old measures for determining the staffing levels (if such things exist) for Community Practitioners are any longer valid in view of the new additional roles that have been given.
- The expansion of resources for the NHS means that both primary care and the acute sector can be expanded but at the same time we need to shift the balance of resources in favour of the former rather than the latter in line with the Government's healthcare strategy.

6.13 The CPHVA has responded to the RB's challenge and sought to commission research into the number of Community Practitioners necessary to carry out the new public health agenda. However, we did not receive viable proposals within the available envelope of money available for the research. We are going back to the drawing board to work out how to progress this vital area of work. Although one would think that the Health Department may have some interest in undertaking work of this kind.

6.14 Our most recent Omnibus [27] revealed increased stress and workloads pressures. 65 per cent of respondents reported an increase in stress (same as before 29%, decrease 6%). 82 per cent of respondents reported that there was some level of stress associated with being a Health Visitor.

[27] The Health Visitor Omnibus: A Telephone Survey of 500 Health Visitors, Durdle Davies Business Research 2001.

6.15 In addition:

- Roughly a quarter of the sample have over the years consistently worked between 7-12 hours per month over their contracted hours
- Roughly a fifth of the sample say that they have worked over 18 hours on top of their contracted hours, compared too only 3 per cent in 1995.
- 57 per cent believe that staffing levels have decreased.
- Three quarters of Health Visitors say their workloads have increased over the past two years.
- One in five Health Visitors admit to neglecting developmental assessments.

6.16 However there remains a strong professional commitment to health visiting:

- Job satisfaction has increased from 16 per cent in 1994 to nearly one third.

- Those unhappy with health visiting has dropped from over a half in 1994 to under a third in 2001.
- Those who would definitely leave health visiting if they had a chance remains at around one third whilst those who would definitely stay has increased to over a half.
- Those who would recommend health visiting as a career to another person has increased to over a half whilst those who would definitely not do so has dropped from 40 per cent to 27 per cent.

6.17 Our members are saying give us the resources and further staff and we will deliver on the Government's public health agenda.

6.18 In the Theatres there is no means of separating out the figures for nursing staff from other Operating Department Staff or other nursing staff working in Acute/Elderly care based on the figures supplied by the Department of Health Non Medical Workforce Census.

6.19 The North and East, West Yorkshire Development Confederations commissioned a study of current and future workforce requirements for all operating departments in this region[28].

6.20 The vacancy rates in February 2001 were 8.89 per cent for Operating Department Practitioners, 6.1 per cent for Registered Nurses and 3.1 per cent for support staff.

[28] Modernisation and Strengthening the Operating Department Workforce: Sally Moore, ODP project manager September 2001.

6.21 The report highlighted that:

- 67 per cent of NHS Trust were experiencing problems with recruiting Perioperative staff.
- The age profile has identified that the Perioperative workforce is mainly middle aged. In ten years time 50 per cent of the workforce will be retiring.
- Project service managers estimated that they would require a 13 per cent increase on current levels and a 19 per cent increase by 2006 to meet the requirements of the National Plan and the National Service Frameworks or 355 staff.

6.22 The report also recommended that:

- The profile of the Perioperative workforce needed to be raised.
- Workforce planners nationally need to collate workforce information in this area.
- Active recruitment and retention strategies.
- Carer pathways and access to CPD.
- Consider new ways of working.