DH Department of Health

THE SENIOR SALARIES REVIEW BODY (SSRB)

REVIEW FOR 2013
WRITTEN EVIDENCE FROM THE HEALTH DEPARTMENT FOR ENGLAND

31 October 2012

Prepared by:

NHS Pay, Pensions and Employment Services
Workforce Division
External Relations Directorate
Department of Health

You may re-use the text of this document (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit www.nationalarchives.gov.uk/doc/open-government-licence/

© Crown copyright 2012
First published October 2012
Published to DH website, in electronic PDF format only.
www.dh.gov.uk/publications

Contents

The Senior Salaries Review Body
Review for 2013

CONTENTS	PAGE
Executive Summary	4
Chapter 1: Very Senior Managers: The NHS Context	6
Chapter 2: The New ALB VSM Pay Framework	9
Chapter 3: VSMs: Data and Comparisons	12
Chapter 4: NHS Finances, Policy / Affordability	17

ANNEXES		PAGE
Annex A:	**Remit Letter from CST**	23
Annex B:	**ALBs and Ambulance Trusts**	25
Annex C:	**VSMs by Organisation and Framework**	26
Annex D:	**Information on ENDPBs**	28
Annex E:	**VSM Pay Rates and Comparators**	31
Annex F:	**NHS Pension Scheme**	34

EXECUTIVE SUMMARY

1. The NHS is undergoing very significant structural change. By 1 April 2013, all Strategic Health Authorities and Primary Care Trusts will have been replaced by a range of successor bodies including the NHS Commissioning Board, clinical commissioning groups, the NHS Trust Development Authority and Health Education England. As a result of these changes, the very senior managers (VSMs) falling within the SSRB's remit will be employed only by Special Health Authorities (SpHAs) and Executive Non-Departmental Public Bodies (ENDPBs), together with a small number in those ambulance trusts yet to achieve foundation trust status.

2. The driver behind these changes is the Government's vision for a fully autonomous provider sector set free from central control and for commissioning undertaken by independent clinical commissioning groups led by clinicians themselves and accountable to the autonomous NHS Commissioning Board. The background to the changes is the very serious economic situation facing the country as a whole and the severe financial pressures facing the NHS, as set out in chapter 4. In this context, continuing pay restraint in the NHS is essential. The Government has therefore restricted annual average pay increases for the public sector, including VSMs, to a maximum of 1% for each of the next two years.

3. Although the VSMs employed by the Department's arms-length bodies (ALBs) will be relatively few in number, they will have exceptionally important roles and responsibilities as the leaders of key national organisations. They deserve to be paid fairly for those responsibilities within the context of continuing pay restraint and the need to ensure that pay is affordable. The pay of most VSMs in ALBs will in future be determined by a new national pay framework. This evidence aims to inform the SSRB about the new pay framework and about the new organisations that will employ VSMs. These organisations will not be fully established and take on all their functions until 1 April 2013. Inevitably therefore some of the information included in this evidence is incomplete or based on best estimates of the position in April 2013.

4. The evidence shows that historically the Department's ALBs have been very stable organisations with very low rates of staff turn-over at VSM level and few problems with recruitment or retention. We are confident that the introduction of the new pay framework will not change this as it has been designed broadly to be cost neutral in its effect. However, it may be some time before it is possible realistically to assess the effect of its introduction on the recruitment, retention and motivation of VSMs as it would be unsafe to draw conclusions solely from the experience of the transition to the new pay framework and the new organisations. The evidence does however suggest that the new pay framework is not deterring or hindering recruitment to the new organisations although it recognises that in some cases recruitment has been

facilitated by the protection of current pay to retain key talent and reduce the costs of redundancy.

5. Chapter 3 and Annex E of the evidence provides as much relevant information as is currently available on the estimated numbers of VSMs in each ALB as at 1 April 2013 and includes a sample of spot rates of pay for a range of posts evaluated under the job evaluation scheme in the new framework. It also includes for comparison rates of pay in NHS Foundation Trusts and proposed rates in clinical commissioning groups and suggests that the rates available under the new framework will be competitive with but not ahead of the rates for equivalent responsibilities elsewhere in the NHS. It also suggests that while there is the potential for overlap between the rates in the framework and the top of Agenda for Change, in practice very few ALB VSM roles have been evaluated at spot rates below £100,000.

CHAPTER 1 – VERY SENIOR MANAGERS: THE NHS CONTEXT

Overview

- The Government has restricted public sector pay uplifts to an average of 1% per annum for 2012/13 and 2013/14
- A new national pay framework has been developed for VSMs in ALBs
- Following the abolition of SHAs and PCTs, VSMs will be employed only by SpHAs, ENDPBs and ambulance trusts until they achieve foundation trust status
- Several important new ALBs have been established, including the NHS Commissioning Board

1. The overall financial position facing the NHS is discussed in detail in chapter 4. The wider economic evidence will be provided by the Cabinet Office as part of the evidence for the senior civil service pay review. It was in this context that the Chief Secretary to the Treasury wrote to the Chair of the SSRB on 16 July 2012 (copy of letter at Annex A), advising that the Government has restricted the remit of the pay review bodies to considering how an increase of 1% might be distributed. The Government has provided sufficient funding for the NHS to support an average annual headline pay increase of up to 1% for NHS staff, including VSMs.

2. The NHS is facing the challenge, within tight financial settlements, of making administrative savings of 33% while simultaneously undergoing major structural reform. 1 April 2013 represents a highly significant milestone in this process. Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) will no longer exist. Their functions will be assumed by a range of successor bodies, including the NHS Commissioning Board (NHSCB), the NHS Trust Development Authority (NTDA), Health Education England (HEE), the Health Research Authority (HRA), Clinical Commissioning Groups (CCGs), Public Health England and Local Authorities.

3. The Government set out its vision for the new NHS in its 2010 White Paper "*Equity and Excellence: Liberating the NHS*". At the heart of this vision is a more devolved and autonomous system for both commissioners and providers, with all provider organisations becoming NHS Foundation Trusts and most commissioning becoming the responsibility of CCGs, led by those closest to patients, GPs, with close engagement from nurses and other clinicians.

4. The autonomous NHSCB will have a key role within this new system. Its responsibilities will include providing national leadership for quality improvement through commissioning; promoting and extending public and patient involvement and choice; holding CCGs to account for delivering outcomes and financial performance; commissioning primary care services and national and certain regional specialised services; and allocating and accounting for NHS resources.

5. The Government's vision for pay within the new system is determined firstly by the need for sustained pay restraint in light of the paramount need to reduce the public finance deficit and restore a stable economy with sustainable economic growth. Secondly, the Government believes that pay decisions are best left to employers who should be free to set their own pay policies to recruit, retain and motivate their staff. NHS Foundation Trusts and NHS Trusts already have freedom to set their own rates of pay for their VSMs. CCGs will also have this freedom subject to any guidance issued by the NHSCB. However, there is a national pay framework governing the pay of VSMs in SHAs, PCTs, Special Health Authorities (SpHAs) and Ambulance Trusts (until they achieve foundation trust status). The SSRB remit currently

excludes VSMs in NHS Trusts and Foundation Trusts and includes VSMs subject to the national pay framework.

6. After 1 April 2013, the national pay framework will continue to apply to VSMs in SpHAs and Ambulance Trusts (until they become Foundation Trusts) and these VSMs will continue to be within the SSRB's remit. However, following the independent review of the national VSM pay framework, a new VSM pay framework has been developed and was published in May 2012. The new pay framework is based on a job evaluation scheme specially adapted for senior roles in the NHS and applies to VSMs in both SpHAs and Executive Non-Departmental Public Bodies (ENDPBs), collectively termed "Arms-Length Bodies" (ALBs). For the purposes of the framework, the ALBs have also been assessed and placed within rank order in terms of the SSRB evaluation tool and pay bands for ENDPB chief executives. For 2013/14, therefore, the SSRB's remit has been extended to include VSMs in all the DH ALBs subject to the new pay framework. These bodies are listed at Annex B.

7. It is important to note how migration to the new ALB VSM pay framework is taking place. VSMs in SHAs and PCTs will remain on the old national framework until their organisations are abolished. VSMs in Ambulance Trusts will remain on the old framework until their organisations achieve foundation trust status – all Ambulance Trusts are expected to become Foundation Trusts during 2013. VSMs in SpHAs and ENDPBs will also remain on the old framework unless they are appointed to new roles or placed on new contracts, when the new framework will apply.

8. If VSMs are appointed on the terms of the new framework in an organisation where other VSMs remain on the terms of the old framework, there is the potential for challenge on equal pay legislation grounds. ALBs have therefore been advised in these circumstances to undertake an equal pay review so that they can identify and manage any equal pay risks locally. Annex C shows for each ALB both the total number of VSMs and where possible the applicable framework.

9. The appointments process for VSM posts in the new ALBs gives priority to VSMs at risk of redundancy and seeks to avoid the loss of the talented leaders necessary to successfully establish and take forward the new organisations. In some cases, this has involved the proposed award of recruitment and retention premia (RRP) where total pay in an SHA or PCT is higher than the evaluated spot rate in the new organisations.

10. We fully appreciate that for this pay review round it is a priority for the SSRB to understand better the restructuring of the NHS and the implications for staff within its remit. In chapter 3, we provide relevant information about the organisations that from 1 April will be the main employers of VSMs within the remit with a particular focus on the NHSCB.

11. In May of this year, following the Government's request to the SSRB to consider how VSM pay could be made more market facing, we submitted evidence to the SSRB arguing that there is a national market for VSMs and that the introduction of local pay could jeopardise recruitment to the key leadership roles in exceptionally important national organisations. We are now able to update some of the data in our earlier evidence, now that the structures of the NHSCB and other new ALBs have become clearer.

12. It is also appropriate to mention in connection with the wider context on senior pay the report of the Will Hutton Fair Pay Review published in March 2011. This review was a response to concern that executive pay had accelerated far ahead of the pay of other staff and was insufficiently monitored or controlled. The review made clear that very high executive pay was overwhelmingly a private sector phenomenon. In our evidence on market facing pay, we showed that the chief executives of NHS organisations are paid very much less than counterparts in private sector companies of comparable size. Nevertheless, the review made a number of recommendations of relevance to the NHS, including the benchmarking of the pay of

ENDPB chief executives in accordance with SSRB bands. In addition, the accounts of NHS organisations, including ALBs, will need from 2011/12 to publish the figure representing the multiple of the highest earnings in the organisation to the median earnings; and to separately identify performance-related pay (bonuses) from basic pay.

CHAPTER 2 – THE NEW ALB VSM PAY FRAMEWORK

Overview

- A new national VSM pay framework was published in May 2012
- The framework is based on a job evaluation scheme specially adapted for senior NHS managers
- The rates of pay in the new framework are linked to SSRB pay bands for ENDPB chief executives
- The framework includes a performance-related pay scheme
- The framework provides flexibilities including recruitment and retention premia

1 The VSM pay framework that currently applies in SHAs and PCTs was introduced in 2006. While it provided a consistent and coherent approach to determining senior pay, it was perceived to suffer from some key problems, including the arbitrary way in which the pay of executive directors was "pegged" to a fixed percentage of the pay of chief executives rather than based on the evaluation of individual job weight. Some concerns were also expressed about the availability of quite extensive flexibilities, including up to 30% RRP, which were potentially open to manipulation and excessive use.

2 An independent review of the pay framework was therefore commissioned and led by Alan Wright, the ex-head of the OME. The review made a number of recommendations, including the central recommendation that a system of job evaluation be developed for VSMs, ensuring that reward would be closely and accurately related to job weight. The Government accepted the recommendations and commissioned PricewaterhouseCoopers (PwC) to develop the job evaluation scheme (JES).

3 It was intended that the new pay framework, based on the JES, would supersede the old framework and apply to all VSMs in SHAs, PCTs, Ambulance Trusts and SpHAs. However, after the publication of the White Paper "*Equity and Excellence: Liberating the NHS*", which announced the abolition of SHAs and PCTs, it was decided that the new VSM pay framework should be adapted to apply only to SpHAs and ENDPBs. Previously, ENDPBs had been encouraged to adopt the VSM framework or follow its principles but were free to use their own policies for determining VSM pay. However, following the publication in 2010 of the SSRB report on senior pay in the public sector and subsequent report aimed at introducing greater consistency across Government in the pay of ENDPB chief executives, it was decided that VSM pay in both SpHAs and ENDPBs should be determined on the same basis. The Secretary of State has therefore taken powers in the NHS Health and Social Care Act 2012 to require the pay policy in the NHSCB and other ENDPBs to be subject to his approval and has decided that initially the new VSM pay framework should be mandatory for both types of ALB.

4 The JES developed by PwC for the new pay framework is based on their own "Monks" JES specially adapted for senior NHS roles and with flexibility to accommodate and assess not only existing VSM roles in current ALBs but also new VSM roles in new organisations. The JES is an analytical job evaluation system which measures the responsibilities of, and the levels of skill or competency required to carry out, VSM roles under seven key areas. The areas (known as "factors") are as follows:

- Factor 1 – Knowledge
- Factor 2 – Specialist skills
- Factor 3 – People skills
- Factor 4 – External impact
- Factor 5 – Decision making

- Factor 6 – Innovation/creative thinking
- Factor 7 – Emotional demands.

5 Within each factor there is a series of defined levels and each level has a score. The primary activity in the JES process is to assess the level into which each job should be placed, based on the information that the evaluator has on the job and the detailed definitions set out in the JES. The scores for each of the seven factors are then aggregated to calculate the total size of the job. Comprehensive information about the JES has been published on the DH website at: http://www.dh.gov.uk/health/2012/05/pay-framework-albs/.

6 Great care, informed by many years of experience working with a wide variety of organisations by PwC, has gone into the design of the JES and the processes associated with it. The purpose is to enable decisions on pay to be made on an objective basis that is free from discrimination and ensures that differences in pay between different management roles can be objectively justified. To facilitate this and to ensure consistency, all job evaluations under the framework are being undertaken by trained evaluators in the NHS Business Services Authority (NHS BSA) on behalf of the Department. However, in accordance with the principles set out in the Will Hutton Fair Review, that executive pay should be determined by an independent remuneration committee and that no individual executive should be involved in deciding his or her own remuneration, the new pay framework provides that the JES process should be led by the ALB's remuneration committee, with the NHS BSA's trained evaluators providing expert input. This, together with new rules from HM Treasury about the disclosure of senior salaries in the public sector, ensures the whole process is independent, robust, consistent, objective, fair and transparent.

7 Another of the recommendations of the Wright Review that has been accepted for the new pay framework is that there should continue to be spot rates of pay rather than any form of incremental progression. The spot rates within the framework associated with the JES scores have been linked to the SSRB pay bands for ENDPB chief executives so that the highest basic pay available is £225,000 p.a. Each ALB has also been ranked and placed within the appropriate SSRB pay band. We provided information about how the pay available through the framework compared with that in other parts of the NHS in our evidence on market facing pay and we return to this in chapter 3.

8 The new pay framework was published only at the end of May 2012 so there is only limited evidence so far about any issues concerned with implementation or recruitment and retention. Any such evidence must reflect the fact that the NHS is currently in a state of transition from the old structures to the new so that e.g. an exceptionally large number of posts are having to be evaluated over a short period of time and appointments made. It may also be affected by the fact that the NHS is reducing the number of VSM posts and that some VSM staff are being appointed on their existing salaries to retain key talent and avoid redundancy costs. As far as we can tell, however, the new framework seems to be providing pay at levels sufficient to attract the talented leaders essential to the success of the new system, but in some cases flexibilities are being used to retain this talent.

9 The new pay framework has been designed to deliver an appropriate reward for VSMs through the JES based on the weight and responsibilities of the job. However, it is essential that all pay systems should have a sufficient degree of flexibility to accommodate the unusual and the exceptional. The new framework provides this flexibility in a number of ways:

- the local remuneration committee has the flexibility to select the most appropriate spot rate from a range of 90% to 100% of the maximum JES score for the post;

- an RRP may be awarded of up to 10% above the spot rate subject to the agreement of the DH ALB remuneration committee (and in some cases the agreement of the Secretary of State and Chief Secretary to the Treasury also);

- a higher RRP may exceptionally be awarded subject to DH/HMT approval;

- an additional responsibilities allowance of up to 10% may be awarded to VSMs who take on additional responsibilities for more than 3 months but less than 12 months. Additional responsibilities that extend beyond 12 months should be subject to JE review;

- VSMs new to their roles may receive development pay of no less than 90% of the maximum spot rate for a limited period.

10 The new pay framework includes a performance-related pay (PRP) scheme based on three categories of performance:

- category A: eligibility for an annual uplift, consolidated into salary plus eligibility for a non-consolidated bonus;

- category B: eligibility for an annual uplift, consolidated into salary but no bonus;

- category C: no annual uplift and no bonus.

11 Bonuses are currently restricted to the top 25% of performers and a maximum of 5% of reckonable pay. The 25% quota will remain in place for 2012/13 and we recommend that the 5% maximum should also continue to apply. The restriction in the “old” pay framework, that no VSM is eligible for a bonus in an organisation that fails to meet its annual financial control target, does not apply in the new pay framework.

12 The ALB Remuneration Committee in the DH is responsible for the overall supervision of the VSM pay framework. The Remuneration Committee comprises the Permanent Secretary, the Director General of Policy, Strategy and Finance, the HR Director and a DH non-executive director. Certain decisions under the framework require the approval of the Remuneration Committee (and in some circumstances, e.g. some salaries over £142,500 per annum, that of the Secretary of State and the Chief Secretary to the Treasury), including ratification of the pay of all chief executives and executive directors and all RRP awards.

CHAPTER 3 – VSMs: DATA & COMPARISONS

Overview

- **VSMs are leaders of vitally important national organisations**
- **No evidence of recruitment and retention problems for VSMs**
- **VSM pay and total reward packages are competitive with other parts of NHS**
- **Too soon to draw firm conclusions about effect of introducing the new pay framework but early signs are encouraging**

1. As mentioned above, from 1 April 2013 VSMs within the SSRB's remit will be employed only by SpHAs, ENDPBs and (until they become foundation trusts) Ambulance Trusts. These bodies are listed at Annex B in rank order (in the case of ALBs) of SSRB chief executive pay bands. VSMs employed by Ambulance Trusts will be on the terms of the old pay framework. VSMs employed by ALBs may be on the terms of either the old or new pay frameworks. The new pay framework is being introduced on a mandatory basis for new appointments in both SpHAs and ENDPBs. However, the old pay framework was mandatory only in SpHAs – ENDPBs were encouraged to follow its principles but were able to use their own VSM pay systems. This means that in CQC, Monitor, the Human Fertilisation and Embryology Authority, The Human Tissue Authority and the Council for Regulatory Healthcare Excellence there will be a process of migration from local VSM pay frameworks to the new framework. Annex C includes the latest information available on the numbers and pay of VSMs employed by each body, including the relevant pay framework.

2. The SSRB will be aware that the DH has three main types of ALB: Executive Agencies; ENDPBs and SpHAs. Staff in Executive Agencies are normally on civil service terms and conditions, so VSM equivalents (members of the senior civil service) in the DH's Executive Agencies, including Public Health England, are included in the SSRB's remit as part of Cabinet Office evidence. The configuration of ALBs set out at Annex B reflects the results, as at 1 April 2013, of the DH's review of its ALBs which was designed to simplify the national landscape, remove duplication and better align the ALB sector with the rest of the health and social care system. In line with the principle set out in *Equity and Excellence: Liberating the NHS* of maximising devolution and autonomy, it is intended that where consistent with their future roles the DH ALBs should have the status of ENDPBs rather than SpHAs. This permits a greater degree of independence.

Pay Remit

3. Executive Non Departmental Public Bodies (ENDPBs) are funded by the same Pay Remit process as Government Departments. In most instances, HM Treasury has delegated the authority to approve ENDPB pay remits to individual Departments. HMT issues annually the Pay Remit Guidance, which sets out the process and pay setting parameters for the bodies covered by the pay remit. VSMs in ENDPBs are either included in the general organisational pay remit or are covered separately by the government response to SSRB recommendations.

NHSCB

4. The ALB review has resulted in a significant rationalisation and streamlining of the DH ALBs. However, the structural reforms of the NHS have included the creation of some new and extremely important ALBs. Of these, the NHSCB will be by far the biggest employer of VSMs. It is also a major employer of other staff on medical and Agenda for Change terms and conditions. It will directly employ some 4,000 staff. It is a major national organisation with a central role in the new architecture of the NHS. Below a Board of nine national directors, it will incorporate 4 regional offices and 27 local offices. The 212 CCGs will be accountable to it and it will itself be responsible directly for the commissioning of some £20bn of primary care and specialised national services. The NHSCB will hold some 35,000 contracts for primary care services. Two thirds of the staff employed by the NHSCB will be based in the local offices.

5. The NHSCB was inaugurated as a SpHA in October 2011 and became an ENDPB on 1 October 2012 prior to assuming its full functions in April 2013.

6. It is inevitable that such a large and complex national organisation will require a far larger cohort of senior managers than the traditional Board of directors. Under the new pay framework therefore, the definition of VSM has been expanded to include all those whose posts, as assessed under the JES, that in the judgement of the local ALB remuneration committee are of sufficient weight that AfC or alternative local pay arrangements are not appropriate.

7. As the new VSM pay range starts at £69,750 - £77,500, potentially there is scope for overlap between this range and the AfC pay range. However, when PwC undertook preliminary evaluations of ALB VSM posts as part of their work on developing the JES, it was clear that the vast majority of VSM posts in the ALBs in existence at the time were weighted at above £100,000 p.a. under the new pay framework. This tendency for VSM roles in ALBs to be consistently evaluated above the upper limit of AfC is confirmed by the evaluations that have so far been undertaken in the new ALBs. Annex E provides information on the spot rates of a sample of VSM posts evaluated under the new framework. It should be noted that following the assessment of ALBs under the SSRB's evaluation tool for determining the appropriate salary band for their chief executives, none of the DH ALBs fell within the bottom two bands.

8. It is currently estimated that the NHSCB will employ 223 VSMs. However, that figure may be subject to change subject to final organisation design discussions. The process of appointing VSMs to the NHSCB is ongoing and it is not yet possible to definitely say whether any VSMs will transfer to the NHSCB on their existing pay and terms and conditions or which VSMs, if appointed on the terms of the new pay framework, will be awarded RRP.

NHS Trust Development Authority

9. The NHS TDA was established as a SpHA in June 2012 and will assume its full functions in April 2013. Although the NHS TDA will be a relatively small organisation initially employing a total of only 228 staff, the nature of its functions will require a significant number of staff to work at VSM level. The NHS TDA will take over functions from DH, SHAs and the Appointments Commission and will be responsible for helping some 103 NHS Trusts to deliver sustainable, high quality services and to achieve foundation trust status, thus realising the Government's vision of a fully autonomous provider landscape. It will also take over from the Appointments Commission responsibility for appointing Chairs and non-executive directors in NHS Trusts.

10. The NHS TDA will have a Board including a chief executive and 8 national executive directors. It is expected to employ some 33 VSMs in total.

Health Education England

11. HEE was established as a SpHA in June 2012 and will take on its full responsibilities in April 2013. Subject to legislation, it will become an ENDPB. HEE's role will be to provide national leadership for education, training and workforce development. It will be led by a chief executive and 5 national executive directors and be responsible for allocating the £5bn multi-professional education and training budget to 10 local education and training boards (LETBs) and holding them to account. It is likely to employ some 40 VSMs and 1650 staff across the country to support this work.

Health Research Authority

12. The HRA was established as a SpHA in December 2011 with the core purpose of protecting and promoting the interests of patients and the public in health research. The HRA will become an ENDP subject to legislation. The HRA incorporates the National Research Ethics Service. The HRA will employ only two VSMs.

Other ENDPBs

13. There is further information about the roles and responsibilities of other ENDPBs new to the SSRB at Annex D.

Recruitment and retention

14. There is no evidence of any recruitment or retention problems in the ALBs existing prior to the NHS transition programme (i.e. excluding the newly formed NHSCB, NHS TDA, HEE and HRA). These are bodies where historically, turn-over of VSMs has been very low. Table 1 below shows the number of VSMs who have left in the last 5 years, excluding those who have retired or not been replaced.

Table 1

ALB	VSMs who have left in last 5 years
Care Quality Commission	3
Council for Regulatory Healthcare Excellence	3
Information Centre	0
Human Fertilisation and Embryology Authority	4
Human Tissue Authority	7
Monitor	2
National Institute for Health and Clinical Excellence	1
NHS Business Services Authority	0
NHS Blood and Transplant Authority	2
NHS Litigation Authority	0

15. VSMs in these organisations will in most cases be on the terms of the "old" pay framework except in those ENDPBs where a different pay system for VSMs has been operated. We suggest, however, that while the SSRB will wish to be aware of the numbers of VSMs on each

framework (and we have indicated this where the information is available at Annex C), for pay review purposes the difference is not important. This is because the new pay framework for VSMs has been specifically designed to be broadly cost neutral in comparison with the old pay framework. When PwC undertook preliminary evaluations in developing the new framework, the "gainers" were broadly balanced by the "losers".

16. In the ALBs that will exist at April 2013 (excluding the new ones), RRP awards have been made only to two VSMs in the NHS Business Services Authority and two in the NHS Litigation Authority. Three of these awards were put into payment on transition to the then new pay framework in 2006 – only one award has been made because of recruitment difficulties. Of the small number of VSMs who have left their jobs in the last few years, most have retired. The existing ALB VSM workforce is a remarkably stable one.

17. It is essential that the new ALB VSM pay framework should provide pay at the right level to recruit, retain and motivate the leaders of the new organisations at the centre of the NHS reforms. This means that the reward package needs to be competitive with that available in NHS Trusts, Foundation Trusts and CCGs which have freedom to set their own rates of pay for VSMs and is the main labour market from which DH ALBs tend to recruit. At the same time, as bodies with pay subject to Ministerial control, it is important that ALBs set an example to the rest of the NHS of pay restraint. This is a difficult balance to maintain, requiring the new VSM pay framework to be kept carefully under review. However, it is clear from the accounts of NHS Trusts and Foundation Trusts for the year ending March 2011 (the latest available) that for the moment at least, increases in pay for VSMs have virtually come to a halt.

18. Average pay increases for executive directors in 2010/11 were 1% in PCTs, 1.6% in non-PCTs and 1.7% in Foundation Trusts. Median pay increases in a matched group of non-medical executive directors came in at zero. The figures also show the gap between VSM pay in Foundation Trusts and non-Foundation Trusts to have drastically diminished – in both FTs and non-FTs, median total earnings for chief executives came to £157,500. This compares with a differential of nearly 8% in the previous year. However, executive pay in FTs still tends to be higher for most board positions, the greatest differential being for finance directors where the median was 4.4% higher in FTs. (Figures from IDS NHS Boardroom Pay Report 2012.)

19. It should be noted that 2010/11 was the year before the start of the pay freeze for NHS staff earning more than £21,000 p.a. However, VSMs in SHAs, PCTs, SpHAs and Ambulance Trusts had their pay frozen at April 2009 levels in 2010/11 and so (together with consultants) entered the pay freeze a year before other NHS staff.

20. Annex E compares a representative sample of spot rates for roles in ALBs evaluated under the new pay framework with corresponding rates in NHS Foundation Trusts and CCGs. (Until April 2013, CCGs formally remain part of PCTs. When fully established, they will have freedom to set their own pay rates for their senior managers and office holders. The information in the Annex is derived from guidance issued by the NHSCB which is advisory rather than mandatory for CCGs.) It should be noted that the process of evaluating VSM roles and making appointments in the new ALBs is still not complete. In other ALBs, spot rates are shown only for those roles where an appointment has been made on the terms of the new framework. The Annex also includes the current rates under the "old" pay framework for VSMs in SpHAs and Ambulance Trusts.

21. The Department does not hold information on the wider reward package for VSMs in NHS Trusts and Foundation Trusts, including pension entitlements and non-pay elements. However, most VSMs in these organisations are believed to be members of the NHS Pension Scheme and to enjoy other benefits comparable to those available in ALBs. As noted above, from 2011/12, organisations will have to identify separately in their remuneration reports awards of performance-related pay (bonuses) from basic pay for executive directors, so the next IDS

Boardroom Pay Report should provide better data on this element of pay in NHS Trusts and Foundation Trusts.

22. It should be noted that the VSM pay frameworks (old and new) do not specify entitlements to pensions, redundancy, sickness pay or annual leave which are matters for individual contracts of employment. However, for ALBs in which NHS terms and conditions apply (and it is believed for NHS Trusts and Foundation Trusts), these elements are broadly in line with the provisions in Agenda for Change, including:

- high quality defined benefit pension (details at Annex F);
- annual leave entitlement of 27 days rising to 33 days after 10 years;
- sickness pay entitlement of six months full pay and six months half pay after 5 years;
- 39 weeks paid maternity leave; eight weeks at full pay, 18 weeks at half pay and 13 weeks at statutory levels;
- two weeks paid paternity leave;
- flexible working;
- redundancy entitlement generally up to two times annual salary.

23. The NHSCB and the other new ALBs have not yet completed their recruitment to all their VSM posts but the evidence suggests that so far they have not had difficulty in doing so. In most cases, staff have been recruited from SHAs and PCTs – the chief executives and other VSMs in these organisations have valuable skills that the NHS needs to retain and it has also been important to minimise potential redundancy costs.

CHAPTER 4 – NHS FINANCES POLICY / AFFORDABILITY

1. This chapter sets out the financial position for the NHS in 2013/14. To explain the pressures on the NHS from pay increases and the financial constraints within which the NHS is working, it focuses on the effects of increases in pay for Agenda for Change staff. As the total paybill for VSMs is likely to be no more than some 0.15% of that for AfC staff, clearly different issues of affordability arise. Nevertheless, the cost of VSMs represents a significant element within the management costs budgets of individual ALBs on top of the pressures from the paybill for other staff.

Public sector pay freeze

2. During the early part of the recession, many private sector workers accepted reduced pay in order to support jobs, while public sector pay continued to rise. The Government has taken the difficult decision following the two-year pay freeze to cap public sector pay increases at 1% to help put the UK's public finances back on track. Restraint now will help to protect jobs in the public sector and support the quality of public services.

3. There is no evidence of staff shortages for AfC staff or need for higher pay to improve retention.

Funding growth

4. The NHS saw large increases in funding between 2000/01 and 2010/11, with an average real terms growth in revenue expenditure of 5.3% per year. Table 4.1 shows:

    - the NHS revenue figures from 2000/01 to 2010/11;
    - forecasted revenue outturn for 2011/12; and
    - the Revenue Departmental Expenditure Limits (RDEL) as agreed in the 2010 Spending Review for the years 2012/13 to 2014/15 (SR 2010):

Table 4.1: NHS Revenue Since 2000/01

NHS Revenue Expend-iture (£bn)	Cash Growth	NHS Revenue Expenditure (£bn)	Cash growth	Real growth
2000/01	Outturn	42.7		
2001/02	Outturn	47.3	10.8%	8.7%
2002/03	Outturn	51.9	9.8%	7.1%
2002/03	Outturn (rebased)	55.4		
2003/04	Outturn	61.9	11.7%	8.8%
2004/05	Outturn	66.9	8.1%	5.0%
2005/06	Outturn	74.2	10.9%	8.4%
2006/07	Outturn	78.5	5.8%	3.0%
2007/08	Outturn	86.4	10.1%	7.4%
2008/09	Outturn	90.7	5.0%	2.3%
2009/10	Outturn	97.8	7.8%	6.2%
2009/10	Outturn (aligned)	95.6		
2010/11	Outturn	98.9	3.4%	0.6%
2011/12	Estimated Outturn	101.5	2.7%	0.3%
2012/13	RDEL	105.5	3.9%	1.1%
2013/14	RDEL	108.2	2.5%	0.0%
2014/15	RDEL	111.1	2.7%	0.2%

(1) Expenditure figures from 2000/01 to 2002/03 are on a Stage 1 resource budgeting basis.
(2) Expenditure figures from 2003/04 to 2008/09 are on a Stage 2 resource budgeting basis, this means cost of capital and cost of new provisions are included in the RDEL.
(3) Expenditure figures from 2010/11 are on an aligned basis. Aligned means that cost of capital is no longer included in RDEL and new provisions are included in Annually Managed Expenditure rather than RDEL.
(4) This includes the budget exchange that moved £250m of the SR settlement from 2011/12 to 2012/13

Share of resource going to pay

5. Table 4.2 below shows the cash increases in the NHS revenue expenditure over the last eight years, and the proportion of the revenue expenditure increases consumed by paybill. This proportion is broken down into:

- the proportion that went on price increases (that is, on wage increases); and
- the proportion that went on volume increases (that is, on employing extra staff).

Table 4.2: Increase In Revenue Expenditure And Proportion Consumed by Paybill

	Revenue increase (cash) (£bn)	Paybill increase (cash) (£bn)	% of revenue increase on paybill	% of revenue increase on paybill prices	% of revenue increase on paybill volume
2001/02	4.6	2.4	51.4%	31.6%	19.8%
2002/03	4.6	2.4	51.1%	25.1%	26.0%
2003/04	6.5	2.6	40.9%	20.7%	20.1%
2004/05	5.0	4.5	90.6%	65.1%	25.4%
2005/06	7.3	2.5	34.4%	20.4%	14.1%
2006/07	4.3	1.3	30.2%	42.1%	-11.9%
2007/08	7.9	1.3	16.3%	18.5%	-2.1%
2008/09	4.4	2.5	57.3%	38.3%	19.0%
2009/10	7.1	2.8	39.5%	14.7%	24.8%
2010/11	3.3	1.5	45.4%	32.9%	12.5%
2011/12	2.7	-0.2	-6.7%	18.3%	-24.9%
Average	5.5	2.4	45.7%	29.8%	11.1%

The NHS Paybill

6. Between 2000/01 and 2011/12, increases in paybill prices have on average accounted for 29.8% of the cash increases in NHS revenue expenditure. In 2011/12, despite the pay freeze and a reduction in paybill volume increases of 24.9% (due primarily to reductions in non-clinical staff numbers), increases in paybill prices still accounted for a revenue increase of 18.3%.

7. Pay is the most significant cost pressure, accounting for more than 40% of NHS revenue expenditure and from 2001/02 to 2011/12 accounted for 45% of the increases in revenue. As pay represents such a large proportion of the NHS budget, managing the paybill is key to ensuring that the NHS is able to cope with the future slow-down in funding growth.

Pressures on NHS funding growth

8. Different priorities compete for shares of the Department's cash limited funding. These spending pressures are analysed in three broad areas:

   - baseline pressures;
   - underlying demand and service developments; and
   - service developments.

9. Baseline pressures cover the costs of meeting existing commitments that are essential for the NHS: they do not cover additional and new activity. Baseline pressures are the first call on NHS resources. The HCHS paybill (including pay settlement) forms a significant part of these baseline pressures, along with prescribing (primary care and hospital) and primary care services.

10. Underlying demand is pressure due to general growth in activity levels. Demand has grown on average by 2.7% p.a. in the last 10 years.

11. Service developments cover policy and manifesto commitments to improve quality. Service developments over the current SR period include:

    - the cancer drugs fund (£600m total over the course of the SR);
    - 4,200 sure start health visitors (£577m total over the course of the SR and £172m annual recurrent cost post SR); and
    - expanding access to talking therapies (£433m total cost over the course of the SR and £141m annual recurrent cost post SR).

Allocation of resources in past spending reviews

12. Table 4.3 shows how increases in revenue (RDEL) in past spending reviews have been deposited across different components. Approximately 35% has been deployed to higher pay (rows 4 & 10) and 48% to activity growth and service developments (rows 2, 3 & 12). In the past, non-pay baseline pressures have consumed less than 20% of available resources.

13. Table 4.3 also shows (row 1) that the level of resource available in 2013/14 is 60% less than in years covered by previous spending reviews. In the last 3 spending reviews there were annual increases in resource of £6-8bn, in 2013/14 there is only an extra £3bn of resources available.

14. The final column shows how the SR2010 settlement for 2013/14 might be distributed if we assume:

    - pay drift is 1.6% (the historic average); and
    - an average 1% pay settlement.

Table 4.3: Disposition or Revenue Increase Across Expenditure Components

Row	Component of Expenditure	SR2002 £bn	SR2004 £bn	CSR2007 £bn	Indicative disposition in 13-14 £bn
1	Average annual increase in revenue (£bn)[1]	7.9	7.2	5.7	2.7
2	Activity Growth[2]	0.8	2.9	1.1	0.6
3	Service Developments	1.5	1.6	1.7	0.5
4	Hospital and Community Services Pay (Price only Component)	2.3	1.7	2.0	1.1
5	Secondary Care Drugs	0.3	0.3	0.4	0.5
6	EEA Medical Costs, Welfare Food & NHS Litigation	0.2	0.3	0.1	0.2
7	Primary Care Drugs	0.4	0.3	0.3	0.4
8	General Dentistry, Ophthalmic and Pharmaceutical Services	0.2	0.2	0.2	0.2
9	Prices	0.1	0.1	0.1	0.03
10	General Medical Services	1.3	0.1	0.2	0.2
11	Funding for Social Care[3]				0.2
12	Productivity	0.7	-0.3	-0.3	-1.2

(1) Average growth over each SR period in 2013/14 prices.
(2) The productivity figures represent the money that was saved/spent as a result of changes in productivity. A negative figure represents an increase in productivity.
(3) The NHS will make funding available to be spent on measures to support social care which also benefit health. This funding is £176m in 2013/14 including reablement, designed to help people stay independent as long as possible

15. The indicative disposition for 2013/14 shows the difficulties that arise with lower levels of resources available in 2013/14. The forecast growth in non-discretionary, baseline pressures at rows 6, 7, 8, 9 & 10 and increased support to social care consume the majority of extra resources available. Unless there are increases in productivity, this leaves just £1bn (37%) of the extra resources available for pay increases, activity growth and service developments.

16. Even with 1% settlement and 1.6% drift[1] (the long run historic average),pay increases consume approximately £1.1bn of extra resources. So to deliver even moderate increases in activity of £0.7bn (compared to a previous average of £1bn) and £0.5bn spend on service development (compared to a previous average of £1.6bn) the NHS would need to deliver £1.2bn of productivity savings (much higher than that delivered in the recent SRs).

[1] Even with drift at 1% the productivity required will be £0.9bn.

17. Any extra increases in pay over the 1% level will increase this already considerable productivity challenge. A 1% increase for all NHS HCHS staff itself represents a cost pressure of around £430m.

18. The DH has introduced the QIPP agenda to deliver higher productivity, procurement savings and reduce management costs to release resources for activity growth and service improvements. However, the higher the level of pay growth the more difficult the balance between staff numbers, productivity and service delivery becomes. In a nutshell, the higher the levels of pay the fewer staff will be employed and more productivity improvement is required to meet patient demand.

Conclusion

19. The funding available to the NHS is fixed and extremely tight compared with the recent past (as shown above in Table 4.1). In such circumstances, increases in pay will reduce the funds available for service developments and activity growth and reduce the demand for staff.

20. Although the Department of Health plans unprecedented savings in non-pay costs through QIPP, the level of non-discretionary demand-led pressures such as drugs bill, EEA medical costs and litigation means the continuation of pay drift and pay growth of 1% is likely to put considerable pressure on staffing levels. The Department of Health has delivered ambitious reductions in the number of managers and administration staff, primarily in SHAs and PCTs to protect front-line services but reductions in clinical posts cannot be ruled out.

21. The cost of VSM pay in ALBs cannot be divorced from the wider context of pressures on the NHS as a whole. While a small proportion of the total NHS paybill, VSM pay levels send an important message about the need for pay restraint. It is clear that this message is being heeded not just in the organisations where VSM pay is centrally controlled but also in NHS Trusts and Foundation Trusts which are exercising prudence and responsibility in their decisions on senior pay,

SSRB Remit Letter from CST ANNEX - A

HM Treasury, 1 Horse Guards Road, London, SW1A 2HQ

Bill Cockburn CBE TD, Chair
Senior Salaries Review Body
Office of Manpower Economics
6th Floor
Victoria House
Southampton Row
London
WC1B 4AD

16 July 2012

Dear Bill,

PUBLIC SECTOR PAY 2013-14

The Government greatly values the contribution of the Senior Salaries Review Body in delivering robust, evidence-based pay outcomes for public sector workers.

2. At the 2011 Autumn Statement, the Government announced that public sector pay awards will average 1% for the two years following the pay freeze. The Government has also asked certain Review Bodies to consider how to make public sector pay more responsive to local labour markets in their remit groups- who will be reporting from July 2012. I am now writing to set out how the Government proposes that the Senior Salaries Review Body approach the 2013-14 round.

2. The Government believes that the case for continued pay restraint across the public sector remains strong. Detailed evidence will be set out in the round, but at the highest level, reasons for this include:

- Recruitment and retention: While recognising some variation between remit groups, the evidence so far is that, given the current labour market

position, there are unlikely to be significant recruitment and retention issues for the majority of public sector workforces over the next year.

- Affordability: Pay restraint remains a crucial part of the consolidation plans that will help to put the UK back onto the path of fiscal sustainability – and continued restraint in relation to public sector pay will help to protect jobs in the public sector and support the quality of public services.

3. The Government recognises the Review Bodies role in providing independent advice on pay uplifts. In 2013-14, the Government will limit uplifts to an average of 1% in each workforce. The Review Body should therefore focus on considering how the 1% will be divided within their remit group. When considering their recommendations, Review Bodies may additionally want to consider the level of progression pay provided to the workforce and the potential for payments to be more generous for certain groups of staff.

4. The 1% average uplift should be applied to the basic salary based on the normal interpretation of basic salary in each workforce. This definition does not include overtime or any regular payments such as London weighting, recruitment or retention premia or other allowances.

5. I would like to express my gratitude to the Senior Salaries Review Body once again and look forward to continued dialogue with you in the future.

Best wishes

DANNY ALEXANDER

2

ANNEX – B

ALBs and Ambulance Trusts at 1 April 2013

ALB	SSRB Band	Status (subject to legislation)
NHS Commissioning Board	F	ENDPB
Care Quality Commission	F	ENDPB
Monitor	F	ENDPB
NHS Blood and Transplant Authority	E	SpHA
NHS Trust Development Authority	E	SpHA
Health Education England	E	ENDPB
National Institute for Health and Clinical Excellence	E	ENDPB
NHS Business Services Authority	E	SpHA
NHS Litigation Authority	E	SpHA
Human Fertilisation and Embryology Authority	D	ENDPB
NHS Health and Social Care Information Centre	D	ENDPB
Health Research Authority	C	ENDPB
Human Tissue Authority	C	ENDPB
Council for Regulatory Healthcare Excellence	C	ENDPB

Ambulance Trusts (not Foundation Trusts at September 2012)

East Midlands
East of England
Great Western
London
North West
West Midlands
Yorkshire

ANNEX – C

VSMs at 1 April 2013

ALB	VSMs on new frame-work	VSMs on old frame-work	VSMs on other frame-work	% receiving RRP	% average RRP award	Total VSM Paybill £
NHS Commissioning Board	223[1]	n/a[2]	n/a	RRP may be awarded to match current pay of staff at risk of redundancy	n/a	35,011,950 (inc. on costs)
Care Quality Commission	2	0	6	0	0	1,072,125
Monitor	9	0	0	0	0	1,600,000
NHS Blood and Transplant Authority	2	7	0	0	0	1,133,000
NHS Trust Development Authority	33	0	0	RRP may be awarded to match current pay of staff at risk of redundancy	n/a	5,300,000 (inc. on costs)
Health Education England	40	1	0	RRP may be awarded to match current pay of staff at risk of redundancy	n/a	n/a
National Institute for Health and Clinical Excellence	2	5	0	0	0	937,000
NHS Business Services Authority	1	4	0	40	8.85	702,031
NHS Litigation Authority	1	3	0	50	25.2	600,000
Human Fertilisation and Embryology Authority	3	0	0	0	0	315,000
NHS Health and Social Care Information Centre	0	7	0	0	0	860,000
Health Research Authority	2	0	0	0	0	210,000
Human Tissue Authority	0	0	5 (4.6 FTE)	5	0	376,000
Council for Healthcare Regulatory Excellence	0	0	4	0	0	380,076

[1]Excludes VSMs to be appointed to the national improvement body and leadership academy
[2]Until appointments are confirmed it is not possible to say whether any VSMs may be appointed on the terms of the old pay framework

Ambulance Trusts

Ambulance Trust	VSMs
East Midlands	8
East of England	6
Great Western	one
London	3
North West	6
West Midlands	5
Yorkshire	5

ANNEX – D

Information on ENDPBs

Information on the NHS Commissioning Board, NHS Trust Development Authority, Health Education England and the Health Research Authority was provided in Chapter 3. This annex provides brief information about the other ENDPBs (excepting those that were previously SpHAs and included in the SSRB's remit) employing VSMs within the SSRB's new remit.

Care Quality Commission

The Care Quality Commission (CQC) was fully established on 1 April 2009 as the independent regulator of all health and social care services in England. It is responsible for the registration and inspection of some 22,000 providers of more than 40,000 services to ensure they meet national standards of quality and safety. It is also responsible for protecting the interests of patients detained under the Mental Health Act. These responsibilities will require it to work closely with the NHSCB and Monitor.

CQC is led by a chief executive and Board including 6 executive directors. In 2011/12, it employed more than 1,800 staff and had net expenditure of £60.9m. From 1 April 2012, CQC has been organised on the basis of 4 regions, aligned with the corresponding regional offices of the NHSCB. From 1 April 2013, CQC will become responsible for the registration of all general medical practices.

In 2011/12, CQC decided in view of the pay freeze not to award its VSMs any bonuses, although they were contractually entitled to awards of up to 10%.

The figure representing the ratio between the highest CQC earnings and the median (which following the Will Hutton Fair Pay Review all public sector organisations must publish from 2011/12 onwards) was 5.3 (unchanged from the previous year).

Monitor

Monitor was established in 2004. Its current role is to authorise and regulate NHS Foundation Trusts to ensure that they are well led, financially robust and able to deliver excellent health care and value for money. Monitor also supports the development of applicants for foundation trust status which are legally constituted, financially robust and well governed.

Monitor is currently led by an interim chief executive who is also the Chair and Board including 5 executive directors. In 2011/12 it employed an average of 119 WTEs and 30 agency or other temporary staff. It had net expenditure of £15,538,000. The figure representing the ratio between the highest earnings in Monitor and the median was 4.1 (4.7 in the previous year). Monitor's employees are members of the Principal Civil Service Pension Scheme.

The Health and Social Care Act 2012 made provisions for significant changes in Monitor's role. In 2013, Monitor will become the sector regulator for health care providers in England. All providers will need to be registered by CQC and licensed by Monitor. The core of the

new role will be to "protect and promote the interests of people who use health care services by promoting the provision of services which are economic, efficient and effective and to maintain or improve the quality of the services."

Monitor will start to introduce its licence for providers of NHS-funded care in 2013. The licence will set out the conditions providers must meet and will be the key tool for the majority of Monitor's functions. As sector regulator, Monitor's functions will include:

- regulating prices;
- enabling services to be provided in an integrated way;
- safeguarding choice and competition;
- supporting commissioners so that they can ensure essential health services continue to be provided if a provider gets into financial difficulties.

This role will require Monitor to work closely with the NHSCB, CQC and the National Institute for Clinical Excellence (NICE). In particular, from 2014/15, pricing for NHS services will be the joint responsibility of Monitor and the NHSCB.

Monitor will also have a continuing role in assessing the remaining NHS Trusts when they apply for foundation trust status.

Human Fertilisation and Embryology Authority (HFEA)

The HFEA is the UK independent regulator overseeing the use of gametes and human embryos in fertility treatment and research. It is responsible for licensing UK fertility clinics and research involving human embryos and for providing impartial and authoritative information to the public.

HFEA is led by a chief executive and Board including 2 executive directors. In 2011/12, it employed an average of 73 permanent staff and had total net expenditure of £5,927,616. The ratio of highest to median earnings was 4.5 (unchanged from previous year). Staff are members of the Principal Civil Service Pension Scheme.

Human Tissue Authority (HTA)

The HTA was established by the Human Tissue Act 2004 to regulate activities concerning the removal, storage, use and disposal of human tissue. It acts as a watchdog that supports public confidence by licensing organisations that store and use human tissue for purposes such as research, patient treatment, post-mortem examinations, teaching and public exhibitions. It also gives approval for organ and bone marrow donations from living people and oversees the consent requirements of the Human Tissue Act for deceased organ donation. It licenses some 800 establishments and publishes standards licensed establishments must meet.

HTA is led by a chief executive and Board including 4 executive directors. In 2011/12 it employed an average of 38 permanent staff and had total net expenditure of £4.4m.

Permanent staff are members of the NHS Pension Scheme. The ratio of highest to median earnings was 2.3 (2.8 in 2010/11).

Council for Healthcare Regulatory Excellence (CHRE)

CHRE was established in 2003. Its role is to promote the health and well-being of patients and the public in the regulation of healthcare professionals. CHRE scrutinises and oversees the work of the nine regulatory bodies that set standards for the training and conduct of healthcare professionals. It also works closely with, and advises, the four UK government health departments on issues relating to the regulation of healthcare professionals, and monitor policy in the UK and Europe.

CHRE is led by the CEO and 3 directors. In 2011/12 it employed an average of 18.83 WTE and had a net expenditure of £ 2,441,000. The ratio of the highest to median earnings was 3.2 (unchanged from previous year).

CHRE is scheduled to leave the ALB sector in April 2013 to become an independent body called the Professional Standards Authority. However, discussions are taking place with HMT about this transition and it is possible that CHRE will remain a DH ALB for some time during 2013.

ANNEX – E

VSM Pay Rates and Comparators

Table 1: New pay framework

ALB	Post	Spot rate £
NHSCB	Chief Executive	220,000
	National Director of Finance	170,000
	Director of Strategic Finance	140,000
	Director of Financial Control	122,500
	National Director of Performance and Operations	170,000
	Chief Nursing Officer	165,000
	National HR Director	155,000
	Director of HR	117,500
	Director of Organisation Development	117,500
	Regional Director	160,000
	Regional Finance Director	130,000
	Regional Chief Nurse	125,000
	Regional HR Director	115,000
	Local Area Director	140,000
	Area Finance Director	115,000
	Area Director of Commissioning	110,000
	Area Director of Nursing and Quality	110,000
NTDA	Chief Executive	180,000
	Director of Finance	145,000
	Chief Operating Officer/Deputy CEO	145,000
	Director of Nursing	125,000
Health Education England	Chief Executive	175,000
	Director of Finance	132,500
	Director of Education and Quality	132,500

	Director of Nursing	97,500
	Director of People and Corporate Development	125,000
	Managing Director of Local Education and Training Board	115,000
CQC	Chief Executive	200,000
Monitor	Chief Executive	205,000
NICE	Chief Executive	160,000
	Director of the Centre for Clinical Practice	122,500
	Director of Evidence Resource	120,000

Table 2: "Old" Pay Framework: Pay Rates in SpHAs

		Group 1 **From £162,874 to £183,894**	**Group 2** **From £141,861 to £162,878**	**Group 3** **From £99,829 to £141,861**
SpHA Chief Executive		Mid Point £173,386	Mid Point £152,370	Mid Point £120,845
VSM Benchmark Spot Rates	% of Chief Executive			
Finance	75%	£130,040	£114,277	£90,634
HR and Workforce Development	70%	£121,370	£106,659	£84,592
IM&T	60%	£104,032	91,422	72,507

SpHAs should have robust arrangements in place for determining the percentage appropriate for VSM roles in their organisations within the range from 55% to 75% with an overall average of 65% of the mid point of the chief executive pay range.

VSMs may in addition be awarded up to 30% recruitment and retention premia and 10% additional responsibilities allowance.

Table 3: "Old" Pay Framework: Pay Rates in Ambulance Trusts

		AT Band 1	AT Band 2	AT Band 3	AT Band 4
AT Chief Executive Spot Rate		£112,764	£121,355	£128,873	£150,351
VSMs	% of Chief Executive				
Finance	75%	£84,573	£91,016	£96,655	£112,763
Operations	70%	£78,935	£84,949	£90,211	£105,246
Human Resources	60%	£67,658	£72,813	£77,324	£90,211

Table 4: Comparator Pay Rates in NHS Trusts and Foundation Trusts

	NHS Foundation Trusts		NHS Trusts	
	Average Total Pay £p.a.	Maximum Total Pay £p.a.	Average Total Pay £p.a.	Maximum Total Pay £p.a.
Chief Executive	166,532	262,500	159,709	282,700
Finance Director	121,815	182,500	115,204	172,500
Chief Operating Officer	112,047	172,500	106,322	162,500
HR Director	101,594	152,500	97,013	142,500

Figures from IDS NHS Boardroom Report 2012 – relate to year ending March 2011.

Table 5: Comparator Pay Rates in Clinical Commissioning Groups

CCG Level	Population Size	Pay Range for Chief Officer £	Pay Range for Chief Finance Officer £
Level 3	Population at or over 500k	120,000 – 130,000	95,000 – 110,000
Level 2	Population between 150k and 499k	105,000 – 120,000	85,000 – 95,000
Level 1	Population at 149k or below	90,000 – 105,000	75,000 – 85,000

Figures from guidance issued by the NHS Commissioning Board Authority and advisory only. Different rates apply where the chief officer role is undertaken by a clinician. RRP and payments for additional responsibilities may also be awarded. Actual rates may not be known until CCGs are formally established in April 2012.

ANNEX – F

NHS Pension Scheme

The Government confirmed in July that it will proceed to implement the proposed new scheme design that was published in March 2012. The new scheme retains many of the benefits of the 2008 scheme with ill-health retirement benefits, partner, spouses and dependent children's pensions on the death of the member and death in service benefits remaining unchanged. There will also be retirement flexibilities enabling staff to take their pension and continue working and being members of the scheme allowing, for a flexible approach to mixing work and other commitments in the run up to retirement.

The main features of the new scheme are as follows:

- it is a defined benefit career average scheme;
- it has an accrual rate of 1/54th of pensionable earnings each year;
- benefits earned whilst in service will be increased annually in line with a measure of price inflation, (currently the consumer price index) plus 1.5% per annum to make some allowance for the fact that NHS pays in the long run increases by more than inflation;
- when a member retires or leaves the scheme, benefits will be revalued in line with the price index (currently CPI) only;
- when a member retires, benefits will be increased in payment in line with the price index (currently CPI);
- member's normal pension age will be the same as their State Pension Age;
- if State Pension Age changes in the future, a member's Normal Pension Age will also change. All member benefits in the new scheme will become payable from the new age;
- members will be able to opt to give up some of their pension for a tax free lump sum at the rate of £12 of tax free cash for every £1 per annum of pension given up.

It should also be noted that these changes will not be introduced until 2015; existing staff within 10 years of their normal pension age will be protected and all accrued rights will be protected. These features will also apply across all members of the NHS Pension Scheme including VSMs and senior managers in NHS Trusts and Foundation Trusts.