PRE-BUDGET REPORT

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THE PHONEY WAR CONTINUES

It's possible to read the chancellor's pre-Budget report from cover to cover and still have very little idea of its actual impact on the NHS.

Managers have known for some time that savings of between £15bn and £20bn over a four-year period are required. With the UK economic outlook seemingly declining rather than improving – the Treasury now estimates GDP will shrink by 4.75 per cent this year instead of the 3.5 per cent April projection – we are entering a period of gloom the like of which many in the NHS today have never experienced.

One of the few tangible spending reductions, the proposal to reduce the cost and scope of NHS IT investment, seemed to be pitched to court public support when Alistair Darling effectively leaked his own report early last week.

In it, he boasts of protecting the frontline services that comprise 95 per cent of NHS expenditure. Their funding is to rise in line with inflation. In the context of a miserable financial outlook for the public sector as a whole, this may seem like a small relief – until one stops to consider the minimum £5bn or so the UK health sector needs each year to keep pace with demographic change, a growing population and the march of science. And the 5 per cent of the budget being cut in real terms comprises more than the bloated fat-cat bureaucracy of popular caricature: training and research may well be the principal victims.

There is something missing here. Those spending plans for 2011-14 that are being so enthusiastically protected are built on heroic efficiency gain assumptions. Managers and clinicians are typically already pursuing cost improvements of at least 5 per cent, year after year, in an NHS that has rarely approached half that level.

The reality of this ceaseless grind seeps through in the parallel Department of Health report, *NHS 2010-15: from good to great*, published the day after the pre-Budget report. Highlights include:

- a maximum payment by results tariff uplift of zero per cent for the next four years, intended to "drive all providers to become as efficient as the highest performers". If combined with the widely anticipated marginal cost tariff for clinical activity beyond specified thresholds, loss-making specialties will become simply unsustainable;
- a 30 per cent reduction in management costs – or perhaps all costs – in primary care trusts and strategic health authorities over the same four-year period.

Identifying the implied cuts is, naturally, being left to local discretion. Savings on this scale could entail perhaps half a dozen general hospitals going to the wall in each SHA; delivering them by 2014 would represent a huge challenge.

'Savings on this scale could entail half a dozen general hospitals going to the wall in each SHA'

But with commissioners under threat of being shamed if they indulge in "slash and burn" tactics, don't expect any serious progress this side of May.

Yet if the report is short on detail of how savings will be made, there are plenty of commitments to bind managers' hands. A 1 per cent cap on public sector pay settlements may be presented as a tough stance, and the unions will squeal, but consider.

As Darling was presenting his report on Wednesday, the Republic of Ireland government agreed its own 2010 budget. It features material public sector pay cuts (ranging from 4 per cent for the lowest earners to 20 per cent for senior managers) and the imposition of 12 days' unpaid leave. Ouch.

NHS managers are being asked to cut costs. What remains unclear from the pre-Budget report is how much support they will receive if they pursue the task with vigour. Save £20bn, but don't cause any ripples. For the time being, the phoney war continues. ●

Noel Plumridge is a consultant and former NHS finance director, noelplumridge@aol.com

There was a collective sigh of relief from the NHS that the pre-Budget report was not worse – but groans as the announcements on management costs and the tariff began to sink in.

"I think it seems quite a challenging agenda going forward for the public sector – but I don't think what we witnessed yesterday was the worst scenario," says Jon Swift, director of finance and performance at NHS East Riding.

"We have to do it," says Michelle Spandley, deputy director of finance at Portsmouth Hospitals Trust. "It is something we have been planning for anyway – but the devil will be in the detail."

The early announcements that cuts were on the way and the maintenance of planned budgets for 2010-11 have also given organisations a chance to prepare.

"It's given the NHS a bit of time to think," says Jonathan Ratnage, financial accountant at Chesterfield Royal Hospital Foundation Trust. This may avoid some of the "slash and burn" responses that have been seen as very harmful in the past. Many finance managers say they have been planning how to deal with cuts – often using different scenarios.

"Everyone should be – and probably is – prepared for some level of cuts, whether they are prepared for 5 per cent or possibly 10 per cent in support services," says Jonathan Evans, head of finance at Imperial College Healthcare Trust.

Full impact

The proposed 30 per cent savings on primary care trust and strategic health authority management costs over four years had been trailed but will still be difficult. Steve Phoenix, chief executive of West Kent PCT, points out the transformation that PCTs will have to undertake over the next few years.

"We have the lowest PCT operating costs in the South – in a sense we have had to make a virtue of a necessity but it does mean we are very lean. If the approach is as crude as 'everyone needs to take 30 per cent off their budgets' then it will cause us problems," he says.

However, some form of regional envelope for cuts may be adopted rather than a rigid approach for each PCT regardless of circumstances, he believes.

The full impact on the NHS will become clear with the release of the operating framework this week, when organisations can see exactly what the figures will mean for them. Stephen Evans, assistant director of finance at Hull and East Yorkshire Hospitals Trust, says that while PCTs may get an increase, it will be important to see how that comes down to the secondary sector.

Mr Phoenix points out that whichever rate of inflation is used to calculate the increase in the NHS budget for 2011-13 will be important: will it reflect the rate the NHS is experiencing, such as the increased NI contributions for employers, or just the headline national rate?

'I think finance people are overpaid for what we do'

And with most NHS organisations operating within a percentage or two of their budgets, even a small change in the figures could have a massive impact on profitability. Mr Evans says: "We are a £800m-a-year trust. If you take 5 per cent off that it will swing the bottom line. We are planning for a £12m surplus but if you took 5 per cent off our income, that's £40m – that's close to a £30m deficit."

The trust is already expecting to deliver 7 per cent in efficiency savings. So what could be cut or improved? Mr Evans thinks there could be savings in the use of external consultants. A trust as big as Imperial could justify having internal teams to do much of their work – this would be cheaper in the long term.

Imperial is introducing service-line reporting, which is helping to identify areas where costs exceed income – and is being surprisingly successful in opening engagement with clinicians about what needs to change.

Mr Evans attributes this partly to having a lot of clinicians at very senior levels in the trust.

But no one doubts the magnitude of the task ahead. This is not like the efficiency savings of the past few years when the challenge has been to do more with a small increase in money; for the foreseeable future, the NHS will be asked to do more with, in real terms, less money.

For the first time, government policy and the financial incentives of the tariff on key areas such as where care should be provided and demand management will be pointing in the same direction.

Mr Phoenix believes there will be pressure on acute trusts to "sweat their assets" but there is a clear message they should not do so in a way that bankrupts the system. He says his own local health economy was in a better shape to face these challenges than it had been for some time, with the troubled Maidstone and Tunbridge Wells Trust hoping to break even month on month from early next year.

However, the future will be challenging for some hospitals – particularly those with high fixed costs payments, such as for private finance initiative projects.

Jeremy Black, service level agreement and payment by results accountant at the new South London Healthcare Trust, points out that they are tied into agreements and cannot reduce those costs easily.

But there was an acceptance among many people that the NHS had escaped some of the pain which employees in the private sector had experienced over the past 18 months. Several people pointed out that they knew private sector employees who had lost jobs or had pay cuts – in some cases by 10 or 15 per cent. In this respect, the NHS was simply beginning to share the pain.

One even suggested that NHS salaries for managers were quite good: "From a manager's point of view I see a [band] 8b service manager with three or four direct reports. Would I say that job is worth £50,000? Probably not. I think finance people are overpaid for what we do. I earn the same amount as my friends in other sectors but I have more job security."

The 1 per cent pay rise will help control costs, which is likely to be particularly important for acute providers who will not get an uplift in tariff.

"That 'wage control' might be quite helpful – it is where most of the money has gone over the past 10 years," points out Russell Barnes-Heath, finance director at City and Hackney PCT.

But there was concern that NHS staff would be taking a cut in their real pay and that this could affect recruitment and retention, especially if the predictions of the UK returning to growth by this time turned out to be true. This, however, could vary from region to region.

This was coupled with a concern that the NHS would need to keep good staff to deliver on productivity and quality improvements.

"We need good people on the ground to effect change and improve productivity," says one PCT chief executive, who wanted to remain anonymous.

Dangerous disinvestment

"The only way organisations will survive on the provider side is through much closer working, lining up care pathways and improving productivity."

Simon Crowther, assistant director of finance at Derbyshire County PCT, says the 1 per cent pay rise is not surprising, but adds: "I think there will be more of it to come. I think it's a bit shortsighted – if organisations start to disinvest in quality staff, that's the danger.

"You could lose the wrong staff and with a challenging agenda you need to keep the best people."

Vulnerable areas could be those where staff skills are most portable, such as HR, finance and IT, suggests Mr Phoenix. He expects to see substantial reductions in the total NHS wage bill, but says this should be manageable through natural wastage.

However, the picture won't be uniform – more people could be employed in the primary and community sectors, but fewer in the acute sector.

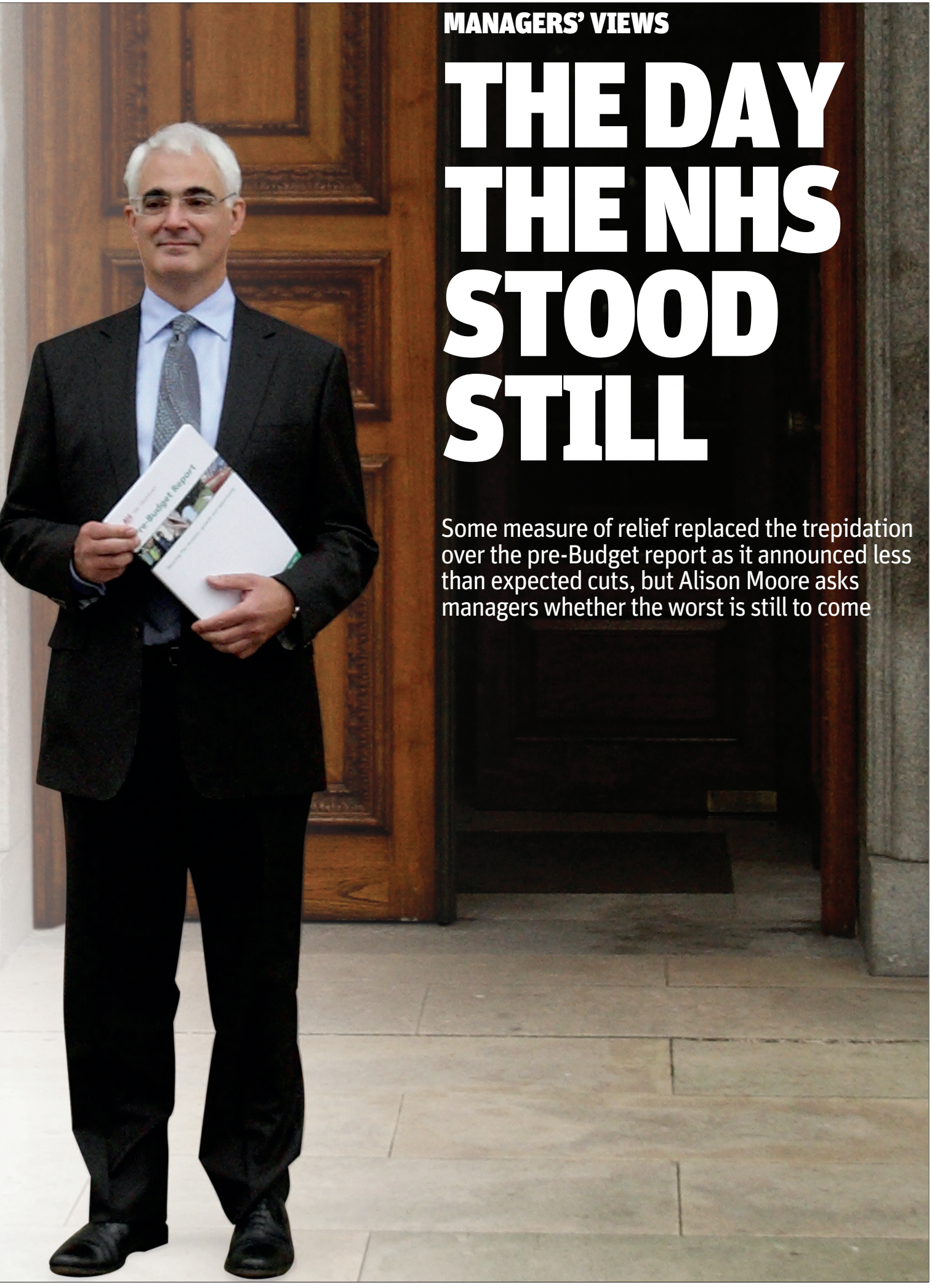
But although NHS staff will not be keeping up with inflation in 2011-13, many will still be getting automatic progression up the *Agenda for Change* pay scale, points out Jonathan Evans. Depending on what happens to job mobility, this could have a substantial impact on the overall pay bill.

If people stay in their NHS jobs because the economy outside is harsh, this could push wage costs up. ●

MANAGERS' VIEWS

THE DAY THE NHS STOOD STILL

Some measure of relief replaced the trepidation over the pre-Budget report as it announced less than expected cuts, but Alison Moore asks managers whether the worst is still to come



PA

EFFICIENCY

TOUGHER THAN IT HAS EVER BEEN

The pre-Budget report aims to protect spending on the NHS front line, leaving some £5bn open to cuts. David Nicholson tells Sally Gainsbury where he expects the pain to be felt

NHS chief executive David Nicholson believes the NHS has done remarkably well, considering the circumstances, out of the pre-Budget report.

Although chancellor Alistair Darling pledged in his speech to the Commons last week a "real terms increase" in spending on the "frontline NHS" from 2011, the text of his report referred more modestly to such spending rising "in line with inflation" in 2011-12 and 2012-13 – the equivalent to a real terms freeze.

Still, that is better than the average 6.4 per cent annual real terms cuts the Institute for Fiscal Studies has calculated many other government departments will experience in 2011-12 and 2012-13.

Mr Nicholson told *HSJ*: "Comparatively, across government, it's a fantastic deal [for the NHS], but historically it's a very low position. We've grown by almost a third over the past few years, so we can't really complain."

Mr Nicholson has also warned NHS finance chiefs to be alert to the nuances of Mr Darling's words. The promise to increase spending "in line with inflation" only applies to "frontline" NHS spending, which the chancellor defined as the "95 per cent of spending that supports patient care".

The department says it is safe to assume that means the remaining 5 per cent of the budget – some £5bn – will not rise with inflation and could even be cut. Taken as a whole then, the Department of Health's total budget is likely to be cut in real terms at least.

Mr Nicholson says: "Let's not kid ourselves. This is tougher than the NHS has ever had, through its history. And it's for a sustained period. I do not wish to underestimate all of that."

But, for next year at least, NHS spending will remain broadly the same, at £104bn in revenue for the department as a whole. That means next year's primary care trust allocations will remain as they were announced last year – giving an average 5.5 per cent increase on this year's allocations.

However, the centrepiece of the NHS operating framework for 2010-11 is the DH's plan to "import" the financial challenge and pain of 2011-12 into 2010-11, to ensure the NHS starts making the savings and cuts well in advance – "to force us to make those tough decisions then," Mr Nicholson says.

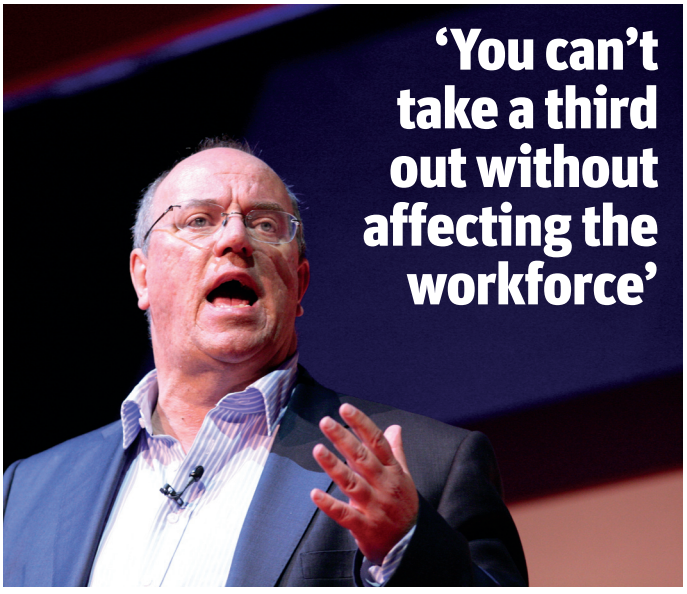
Although PCTs will be asked to spend a further £400m of their accumulated surpluses, they will be expected to do so non-recurrently, ie on one-off projects or costs. The aim there is to guard against PCTs becoming dependent on an unsustainable level of spending.

In addition, the operating framework will instruct all PCTs to earmark a further 2 per cent of their baseline allocations for similarly one-off, non recurrent spending, every year. That is the equivalent to £1.7bn nationally.

Mr Nicholson told *HSJ* there would be plenty of calls on that one-off spending pot, including "funding the costs of change".

That will include the cost of making a proportion of the PCT workforce redundant. The DH has set PCTs and strategic health authorities a target to reduce their management costs by 30 per cent over the next four years. It wants to see the bulk of those cuts made next year and is open-minded about "bottom-up" reconfiguration and mergers, including with local authority social services departments.

Although Mr Nicholson said the DH would do everything it could to avoid redundancies, he admitted: "It's a substantial amount of money being taken out and there are consequences of that for the people who work in them, absolutely. I don't want to hide it; it's true. You can't take a third out without affecting the workforce."



But PCTs will not be the only part of the NHS to feel the pain. The tariff for acute hospitals will be frozen next year – implying a real terms cut as inflation and pay increases will only be met by the hospitals making efficiency savings.

On top of that, in a bid to limit the growth in admissions, hospitals will only be paid 30 per cent of the tariff price for emergency procedures they perform over their 2008-09 volumes. For most hospitals that will mean an immediate cut in their income, as any increase in patient volumes since April this year will now only be funded at the 30 per cent, so-called "marginal cost".

But, in partial compensation for that, the DH is promising more support and flexibility for foundation trusts interested in investing in and running community services – not least because those are seen as critical to reducing emergency admissions.

Such "vertical integration" has previously been frowned upon by some PCTs and SHAs who say it will lead to hospitals driving up demand for their own acute services. But the department hopes to see PCTs and trusts working together to develop "year of life" tariffs where commissioners contract with a vertically integrated provider to care for patients at the most efficient cost and setting. ●

OPINION

NEIL GRIFFITHS ON THE PUSH FOR PRODUCTIVITY

The 2008 pre-Budget report was a story of record government borrowing and VAT cuts and although it tightened the squeeze on Department of Health spending by adding £2.3bn to its efficiency targets, it left NHS spending growth pretty well untouched, at least until 2011.

You could be excused for thinking that health has got away with little negative impact again in this year's report, published this week. However, the post-2011 increases for the NHS do represent a real-terms reduction, crystallised as the "£15bn-£20bn savings that the NHS chief executive has challenged the NHS to achieve".

This year's headline is the promise to halve the £175bn budget deficit within four years while investing in infrastructure and in establishing a sustainable economic recovery. Finding the money to achieve this makes the future story one of fiscal discipline.

The apparent fall in NHS productivity over the past 10-15 years opens it to accusations of fiscal indiscipline, which is not entirely fair when starting from the past levels of chronic NHS underfunding. However, health spending in the UK is now on a par with our economic peers, and ahead of most if private spend on health is excluded.

Nevertheless, basic productivity (units of production per pound spent) has fallen in the NHS every year since 1995, on an accelerating curve. By including a factor to allow for increased quality this figure is mitigated, and by further adding a factor to allow for theoretical impact on the UK's economic performance it can be levelled out.

There is no doubt that, in simple terms, we are producing less for more than we did five, 10 or 15 years ago. This contrasts with production environments in most sectors over this same period, which have increased basic productivity and quality.

Similarly, service provision in other sectors routinely delivers increases in productivity and quality (ie both basic and quality-adjusted productivity measures). For example, since a drive for improvement took hold in the life and pensions sector in 2002, suppliers have typically been able to make savings of 30-40 per cent in back office and customer services while also achieving significant increases across all performance quality measures (process times, process accuracy, customer satisfaction, complaints resolution etc).

In the public sector, Birmingham City Council has a programme that has so far realised benefits of £84m, with total projected cost savings of £1bn over 10 years, and is aiming to perform among the top 10 per cent of councils. At the Department of Energy and Climate Change the introduction of compensation calculators on the coal health scheme has saved 200 man years and £60m in related costs.

There is increasing acceptance that these examples are transferable, and can assist the NHS to deliver savings that also improve quality. Equally important, these are savings that can be sustained so costs do not creep back in over time.

The report continues to highlight "driving down back-office and procurement costs" as being necessary in the NHS, but another lesson is that we sometimes look in the wrong places for these "back-office" administrative savings. There are many administrative functions in NHS trusts that are not covered by finance, HR, IT, procurement and property. Document management, bookings, reception and bed management are just four of very many. And then there are the 20-plus DH arm's length bodies, many of which undertake largely administrative functions.

> **Basic productivity has fallen in the NHS every year since 1995**

Other ideas can be triggered by a quick "benchmark" of approaches with other sectors. Organisations that sustain high performance and productivity over time seem to do so often with few strict rules and procedures, the common thread being culture and a clarity of purpose. Put simply, staff feel able to "do the right thing" and they know what "the right thing" is. The sheer density of meetings in many NHS managers' diaries may be sufficient alone to stifle this.

Another factor is the highly focused use of information, with the board taking responsibility for ensuring it gets access to the up-to-date and accurate information it needs.

Another area is technology; quite topical given the plans for reducing the cost and scope of the national programme. The right technology for the job is critical, and for most NHS trusts technology that removes paper and embeds best practice patient pathways as workflows (neither of which were ever in-scope for the national programme) are now two of the highest priorities in helping deliver transformed services.

Finally, the report is clearly pushing "channel shift" to deliver a better customer service (aka patient experience) at lower cost – another area where sectors such as local government have considerable experience. There are plenty of ideas on offer, but the NHS will need to decide quickly which will work and which won't.

It's a report characterised by what it doesn't spell out more than what it does. Those who wait for the details to be filled in are taking a huge gamble. Those who welcome the lack of specific direction to allow them to drive productivity in a way that makes most sense for them locally will be well placed. Now is the time to act. ●

Neil Griffiths is business development director for health at Capita Group.

TOTAL PLACE

POOLING POWER

One solution to the cost-cutting era looming over the NHS could be the Total Place programme, in which local public sector budgets are co-ordinated for greatest impact. By Mark Smulian

Demands for more efficient spending are easy for ministers to make but less easy for staff on the ground to achieve – governments usually assume there is a bottomless pit of money called "waste" – but the parlous state of public finances has moved the issue from aspiration to necessity.

Total Place is one exercise that might provide an answer. Its 13 pilots involve pulling together the budgets, powers and expertise of some or all of the public sector in these areas to tackle agreed problems. Initial findings have been sent to the Treasury and will inform next year's Budget.

Most pilots have some health element to them, and all require those involved to think beyond their traditional organisations and budgets. It's uncertain how far Total Place will go but, for the moment at least, the government has a lot of hopes riding on it.

Prime minister Gordon Brown last week launched the Putting the Frontline First programme as part of a drive to find £47bn of savings in the next four years.

He said: "Our task now is to develop government to work in partnership with individuals and communities to deliver the services people want in the way they want them and to preserve them in the face of all the challenges this new era presents."

That is largely what those in the Total Place pilots believe they are doing, finding not only the promise of savings but also the chance to redesign services around users, rather than around the somewhat arbitrary boundaries between public sector budgets.

Phil Swann is programme director for the Dorset pilot, which includes health, local government and the fire and police services in the county and adjacent Bournemouth and Poole. Its theme is older people's services, chosen because of the high number of unplanned hospital admissions of elderly people at an annual cost of £122m.

"Admissions to hospitals have shot up. Hospital acute services are a bit like the M25 – if they are there they will get used to capacity – so we need to look across budgets," he says. "Hospitals are open 24 hours a day and the alternative preventative services generally are not, and people have confidence in hospitals and so do their GPs, so people are pushed to them.

"It's a bit like the argument that people trust their cars but they don't trust public transport so they don't use it. Preventative services have to become trusted and build confidence in themselves."

Potential savings

Mr Swann illustrates this with the tale of Betty, an 86-year-old who lives alone, becomes nervous at night, dials 999 and gets admitted to hospital for a few days at an annual cost to the NHS of some £19,000.

There are plenty of "Bettys" in an area favoured for retirement. But under Total Place, using part of the budget to support a local group to provide a contact service has meant Betty has not been admitted to hospital since it was formed.

"You have to think on the level of Betty about how older people can be helped in their homes," he says.

Mr Swann says the scale of potential savings is still being explored "but if you take the £122m cost, and that we think 30 per cent of older people in hospital should not be there, you can see the sort of savings possible from providing better services outside hospitals".

Leicestershire County Council's Conservative leader David Parsons is an enthusiast for Total Place but does not think the government has followed its own logic by removing budget "ring fences". The county is working with Leicester City Council, health

TOTAL PLACE PILOTS

- Birmingham
- Bradford
- Coventry, Solihull and Warwickshire
- Croydon
- Dorset, Poole and Bournemouth
- Durham
- Kent
- Leicester and Leicestershire
- Lewisham
- Luton and Central Bedfordshire
- Manchester and Warrington
- South Tyneside, Gateshead and Sunderland
- Worcestershire

DORSET COUNTY COUNCIL

Far left and above: activities by Dorset Partnership for Older People, which has influenced the pilot, and, below, project board representative Jane Gould at a meeting involving older people

and police partners on alcohol and drug use. Mr Parsons says: "Total Place has already given us some knowledge. It has shown that ringfencing does not work, for example we are trying to fight alcohol abuse but a lot of the money is only for drug addiction, yet 60 per cent of arrests in the area are for alcohol.

"We have also come up against multiple performance management regimes for the police, health and local authorities and are trying to harmonise those. If we succeed and there is less abuse of alcohol, and so fewer people admitted to hospital or arrested, there will be savings, potentially huge ones.

"Total Place is potentially a very powerful tool but the big thing is the intellectual leap that will be needed from 13 pilots doing something to the whole of the public sector doing it."

Alcohol and drugs were chosen because the PCTs and councils had good relationships and wanted to tackle something together of immediate concern.

This harmony is not reproduced at national level, says Mr Parsons, who also chairs the Local Government Association's improvement board and represents it in Whitehall meetings.

"I'm quite clear that government departments have got to come out of their silos and the biggest challenge in that is health," he argues. "Most government departments are up for it, but the Department of Health talks about its latest internal management change as though that were the answer. It still seems to be rather top-down."

Drugs and alcohol are also the focus of the South Tyneside, Gateshead and Sunderland pilot, which will seek to co-locate police, probation and health services to minimise duplication of efforts to prevent relapses; place health teams in misuse "hotspots"; and jointly procure services or products required to support this work.

In Croydon, NHS Croydon interim director of strategic commissioning Jessica Brittin has found that "although Total Place came about for financial reasons it allows us to do something different with our services because you can look at what you are getting from different budgets".

Ms Brittin said its focus on children aged zero to five has allowed "a chance to involve the community in services so that you are looking at families as a whole and providing what they need, rather than what we think they need. Too often we can decide what the problem is when the user knows better."

Frequent flyers

She gives the example of a teenager who gave birth, after which the baby and teenager were both cared for by the girl's mother, who was also caring for elderly parents.

"This woman was caring for three generations but she had no official source of assistance because it was looked at as a teenage pregnancy, not as the needs of the whole family. Once we could bring all our budgets to bear we could help her."

In this way, Ms Brittin says involvement in Total Place has changed the way she thinks about problems.

In Birmingham, three PCTs are working with the city council and other partners on better ways to use the £7.5bn invested annually by the public sector. Among the fields being explored are learning disabilities and mental health, drugs and alcohol work, where it is hoped to cut the numbers of so-called "frequent flyers" into accident and emergency departments, and work on supporting children at risk of entering gang culture.

Richard Kenny, the city council's head of strategic development, says: "We think that central government could help us by starting to think in terms of a Birmingham budget, a simplified public sector performance management framework, and simplified accounting officer arrangements to enable greater flexibility over investment choices within the city – the issue is how far are they prepared to go?"

Bradford's public sector has focused Total Place on keeping elderly people with mental health needs from hospital, offenders from prison and young people from care.

Alison Milner, the city council's assistant director for communications, explains: "Older people with mental health needs leaving a general hospital can feel lost or overwhelmed because of the complexity of their needs and the silo delivery of support from multiple agencies.

"A lack of co-ordinated health and social care support services often means they experience longer stays in hospital and have a greater likelihood of admission into long-term care."

Bradford's Total Place group found that a single assessment process for both practical and psychological support needs is required and would give more emphasis to "spend for the benefit of the service user, rather than the individual organisation".

Total Place raises complex questions about who is in charge of spending what in each area, and will involve new ways of working, but the chance for better savings and comparatively painless pending cuts could be great. ●

'Although Total Place came about for financial reasons, it allows us to do something different with our services'

PAY

UNKIND CUTS

The shock news of the chancellor's 1 per cent cap on pay uplift in the public sector was heightened by the projected rise in inflation, as Helen Mooney reports

NHS managers and staff are facing pay freezes and real terms cuts

NHS staff will face real-terms pay cuts from 2011-12 and senior NHS staff will be expected to "show leadership in exercising pay restraint", the government has said.

Alistair Darling used his pre-Budget report last week to announce a 1 per cent cap on pay uplifts across the public sector for 2011-12 and 2012-13, saying that will save £3.4bn a year from 2012-13 onwards. It follows a similar cap for senior public sector managers announced earlier this year.

However, the report forecasts that inflation will be up to 3.5 per cent from 2011 onwards when measured on the retail price index. Measured on the consumer price index it will be lower at 1.5 per cent in 2011, rising to 2 per cent in 2012, but that will still leave public sector workers taking a real-terms cut.

For 2010-11, senior managers' pay in the NHS will be frozen and the government has outlined a set of "fundamental reforms" to for senior staff pay is set (see box). The government hopes such reforms will help increase the "robustness, transparency and accountability of decision making across the public sector".

'The effect on morale will depend on how staff are engaged'

However, Jon Restell, chief executive of Managers in Partnership, says it is still unclear whether a 1 per cent cap will be reflected in staff take-home pay or in the overall pay bill. "The effect on morale will depend on how staff are engaged with this – is there a way the government can cut pay but in return guarantee and save jobs?"

Mr Restell warns that the reaction in the NHS to the announcement on pay cuts and pay freezes will depend on whether the government can come up with a viable job protection programme. He says it will be important to see how the government treats NHS managers and whether they will be given the same sort of consideration as frontline clinical staff in any such proposals.

Mike Jackson, senior national officer for health and lead pay negotiator at Unison, agrees that further clarification is needed on how the 1 per cent rise will be passed to staff.

"It also remains to be seen what the role of the pay review body will be in all of this. Will the government stand them down for the next couple of years? As it is we are set to go back to the pay review body next summer to discuss pay levels."

Gill Bellord, director for core membership services at NHS Employers, also says there is an "important role" for independent bodies in setting pay. "Pay must continue to be carefully managed to avoid creating shortages of trained staffed or disruption of services," she says. ●

PRE-BUDGET REPORT PROPOSALS

NHS pay

The government will be seeking a 1 per cent cap on basic pay uplifts across the public sector for 2011-12 and 2012-13 to generate £3.4bn worth of savings by 2012-13. This builds on an announcement in October that the government will seek awards of up to 1 per cent in 2010-11 for key public sector workforces not in multi-year deals.

The government has proposed "fundamental reforms" to pay setting for senior staff, including:

- new scrutiny of pay levels above £150,000 and bonuses above £50,000;
- new requirements to publish salaries to increase transparency and accountability;
- a review of senior pay across the public sector.

This is in addition to the government's proposals in October for a pay freeze in 2010-11 for senior public sector staff.

NHS pensions

As pensions become more valuable due to people living longer, cap and share reforms mean that the government aims to cap pensions across the public sector.

NHS employers will have caps placed on the contribution they make to employee pensions, thereby limiting taxpayer liability.

However, this is not new for the NHS, which since April 2008 has had an agreement with the government to cap employer contributions at 14.2 per cent until 2016 and 14 per cent thereafter.

A cost-sharing arrangement is also in place so that where extra cost pressures are placed on the scheme, such as changed life expectancy, they will be paid for by scheme members through higher contributions, lower benefits or retiring later.

A tiered arrangement for contribution rates also means that higher paid staff pay more for their pensions.

The NHS pension scheme is subject to four-yearly revaluations which can lead to changes to the benefit and contribution structures. The next revaluation has just begun; any changes will take effect from April 2012 and will adhere to the cap on employer contributions.

SPL