Realising the Benefits?

ASSESSING THE IMPLEMENTATION OF AGENDA FOR CHANGE

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King's Fund

Agenda for Change is the most ambitious pay reform introduced into the NHS. In addition to simplifying the system of pay, its objectives were to improve the delivery of patient care as well as staff recruitment, retention and motivation. This paper examines progress in implementation based on interviews with key national informants and on case studies in 10 NHS trusts. The report highlights unrealised potential in achieving positive changes to NHS care and makes a number of recommendations for action at national, SHA and NHS trust level.

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Foreword

The government's programme of NHS workforce reform and pay modernisation introduced three major new contracts and pay system: for general practitioners, for NHS hospital consultants, and for nurses and other staff. The motivation for these deals was not just to pay staff more, but to secure changes in working patterns and productivity that would translate into benefits for patients.

The King's Fund conducted the first independent evaluation of the impact of the consultant contract in England in May 2006. The report, *Assessing the New NHS Consultant Contract – A something for something deal?* concluded that despite large increases in consultant pay and pensions, there was little evidence that consultants' working practices had changed.

In a similar vein, this report provides the first independent assessment of the impact of the new pay system for nurses and other NHS staff – Agenda for Change. Introduced to the health service in 2004, it is the largest and most ambitious attempt to introduce a new pay system in the NHS, applying to more than one million staff across the United Kingdom.

The arrangements it replaced were a mess. Agenda for Change introduced simplified national pay 'spines' covering different staff groups, a national job evaluation scheme and a competency-based career framework (later named the Knowledge and Skills Framework (KSF)).

The goals were nothing if not ambitious. Agenda for Change was designed to develop new roles and new ways of working. It was intended to improve recruitment and retention; pay fairly and equitably for work done; and create a system in which career progression was based on responsibility, competence and satisfactory performance. Agenda for Change was also created to simplify and modernise conditions of service and, if all that were not enough, its advocates also claimed that it would lead to better care for patients.

Many of those ambitions remain unfulfilled. Health service staff have certainly received significant pay increases, with most on the front line receiving rises of more than 10 per cent. The basic salary for a qualified nurse has increased by around 15 per cent in the past three years.

However, the new pay system has exceeded all cost estimates and, together with the new contracts for GPs and senior hospital doctors, contributed the equivalent of half the £900 million gross deficit recorded by the health service for 2006/7. Furthermore, the new pay spines will deliver incremental annual pay increases that will increase the pressure on NHS finances and could contribute to deficits in some areas.

Meanwhile, there are few signs as yet that it has delivered increased productivity or transformed practice and there is evidence that, despite the extra cost, many staff are far

from satisfied by the process. Managers too complain that the current version of the KSF is cumbersome and costly to implement.

There are some encouraging aspects. The paper – based on analysis of information provided by case studies of 10 acute NHS trusts in England and interviews with managers, NHS employers and unions – found that most interviewees believed that, in part at least, the new system will assist in delivering improvements in care and staff experience.

But the report concludes that a combination of rushed implementation, a serious underestimate of the costs involved, and a failure to embed personal development plans for all staff has made it difficult for the new system to bring about real improvements in care.

One of the most significant concerns raised by the report is the absence of an independent, robust evaluation of the impact of Agenda for Change – despite the fact that templates for such evaluation have been developed. Given the scale of the exercise, the millions of pounds of taxpayers' money that have been and are being spent, the failure to undertake this is indefensible. It may be too late now to undertake a full evaluation, but it would seem important to undertake some form of enquiry into Agenda for Change to address issues of accountability and to enable lessons to be learned.

This report does not purport to provide a comprehensive analysis of the impact of Agenda for Change – it is a limited study that provides some insight into its implementation and its impact so far in a small number of trusts. Nevertheless, we hope its findings will prove useful to those responsible for delivering this key reform and will encourage those who created it to consider whether there are better ways to reform pay in our national health system.
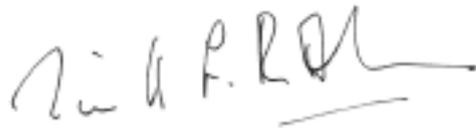
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Acknowledgements

Introduction

The need for a new NHS pay system

'Agenda for Change was not just about more pay.'
(Department of Health 2007, p 6)

This report examines progress in implementing Agenda for Change, the new pay system for NHS staff. It draws from interviews with key national informants, and case studies in 10 NHS trusts in England. Agenda for Change is the largest-ever attempt to introduce a new pay system in the NHS, covering more than 1 million staff. Its objectives were to improve the delivery of patient care as well as staff recruitment, retention and motivation. It covers a far larger and more diverse workforce, and accounts for a larger proportion of the total NHS pay bill, than the new contracts implemented for GPs and medical consultants, which have already received some evaluation (Williams and Buchan 2006; National Audit Office 2007). As such, the development and implementation of Agenda for Change merits close assessment.

In this introductory section we report on the background to the negotiation of Agenda for Change – why a new pay system was needed in the NHS, and the timetable for its negotiation and agreement. Subsequent sections report in more detail on the main features of the new system, the experiences so far in implementing the agreed system, and the evidence that the new system is delivering benefits for patients, staff and the NHS.

The case for change in NHS pay

By the mid-1990s the NHS pay system, developed nearly 50 years earlier with the creation of the NHS in 1948, was increasingly being seen as outdated and not fit for purpose. The Whitley Council-based NHS pay system was founded on national bargaining units, each involving multiple staff associations/unions covering different staff groups. Many regarded the Whitley system as complex and inflexible, constraining the development of new roles and unresponsive to the high levels of contribution being made by experienced clinical staff. It was also open to challenge on the basis of equal pay for work of equal value. Pressure to overhaul the pay system was growing.

Previous attempts to reform the NHS pay system had met with limited success. NHS nurse clinical grading, introduced in the late 1980s, was bedeviled with high numbers of appeals. The Conservative government's tentative steps towards local pay bargaining in the early 1990s failed to achieve any significant level of pay reform, as many NHS trusts either did not take it up or did not make much progress in implementing new pay structures.

With the election of a Labour government in May 1997, the prospect of a new NHS pay system was raised. Exploratory talks between the health departments and unions/professional associations on a new approach to NHS pay began in September 1997. The government's

White Paper on Health, published at the end of 1997, announced the intention to 'modernise' the NHS: 'In a national health service, the current mix of national and local contracts is divisive and costly. The Government's objective for the longer term is therefore to see staff receive national pay, if this can be matched by meaningful local flexibility, since current national terms of service for a multitude of staff groups are regarded as inequitable and inflexible' (Department of Health 1997, para 6.28).

Agenda for Change was just one element in the overall approach to modernising the NHS and introducing a new approach to workforce policy and planning. An NHS human resources strategy for workforce expansion and new ways of working was adopted (Department of Health 1998), and a blueprint for establishing a new approach to workforce planning and development was agreed (Department of Health 2000a). The new pay systems for NHS staff were regarded as critical, integral elements in this process of change.

The long haul: negotiating Agenda for Change

In February 1999, the government published its proposals for a new pay framework for NHS staff, *Agenda for Change – Modernising the NHS Pay System* (Department of Health 1999b). The proposals included simplified national pay 'spines' covering different staff groups, a national job evaluation scheme and a competency-based career framework (later named the Knowledge and Skills Framework (KSF)). The proposals emphasised that the new system was designed to: enable staff to give their best for patients, working in new ways and breaking down traditional barriers; pay fairly and equitably for work done, with career progression based on responsibility, competence and satisfactory performance; and simplify and modernise conditions of service, with national core conditions and considerable local flexibility.

The initial plan (Department of Health 1999b) was to open talks on the proposals with NHS staff and professional organisations, aiming to reach agreement on the new system by September 1999. This target date proved to be hopelessly optimistic. The negotiators from the Department of Health and unions/professional associations issued three joint statements, in October 1999 (Department of Health 1999a), November 2000 (Department of Health 2000b) and November 2001 (Department of Health 2001, p 1), which reported on progress in agreeing the principles and approach. The third joint statement highlighted the cost implications of reaching agreement: 'In view of the scale of investment required for pay reform, the Government has decided to leave final decisions of funding and implementation until after the 2002 Spending Review is announced.'

In December 2002 an 'understanding' was finally reached between the national negotiators and a framework document was published. Negotiations continued and the proposed agreement, including a three-year pay deal, was published on 28 January 2003. Implementation began with a piloting process in 12 'early implementer' sites followed by the national roll-out of Agenda for Change from 1 December 2004. The original intention was for staff to be assimilated by 30 September 2005 and the KSF to be applied to all NHS posts covered by Agenda for Change no later than October 2006. But again this proved to be optimistic and there was further slippage during this process, and achieving agreement on new unsocial hours payments was put to one side in order not to halt agreement and implementation. However, by the end of 2006, more than 99 per cent of staff in England were on Agenda for Change pay arrangements.

At the time of writing, it is unlikely that the unsocial hours payment element of Agenda for Change will be implemented before 2008 and many staff are not yet covered by the KSF. A new NHS pay system, first discussed in 1997 and formally negotiated from 1999, will have taken 10 years to achieve full implementation. The table below summarises the timetable of negotiations and implementation.

TABLE 1: SUMMARY TIMETABLE OF KEY MILESTONES

May 1997	Labour government elected
September 1997	Exploratory talks on a new NHS pay system begin
December 1997	White Paper on modernising the NHS is published
February 1999	*Agenda for Change– Modernising the NHS Pay System* is published
October 1999	First joint statement of progress
November 2000	Second joint statement of progress
November 2001	Third joint statement of progress
December 2002	Framework agreement agreed and published
January 2003	Proposed agreement and three-year pay deal announced
June 2003	'Early implementer' sites begin to implement Agenda for Change in England
December 2004	National roll-out of Agenda for Change starts in England
September 2005	Original deadline for assimilating staff on to new pay and conditions
October 2006	Original deadline for implementation of Knowledge and Skills Framework
February 2007 – April 2007	Consultation on draft proposals for unsocial hours payments
Late 2007 or 2008?	New unsocial hours payments introduced?

Source: King's Fund, 2007

What is Agenda for Change?

Agenda for Change is the largest and most ambitious attempt ever to reform the NHS pay system. In this section we summarise the key elements, characteristics and components of the new pay system:

- wide and simplified coverage
- job evaluation
- Knowledge and Skills Framework (KSF) – a new career development framework
- measuring success.

Wide and simplified coverage

The Agenda for Change pay system applies to more than 1 million NHS staff in all parts of the United Kingdom, and it covers all staff groups apart from doctors and dentists, who have separate new pay contracts, and very senior managers, who are mainly employed on individual contracts of employment. Agenda for Change introduced two new pay spines: one for staff covered by the remit of the Review Body for Nursing and Other Health Professions; and one for other directly employed NHS staff. These two pay spines replaced the multiplicity of occupational pay grades, pay points and salary scales that had characterised the Whitley system, where each profession had multiple pay grades. Different NHS staff groups were covered by different Whitley councils, and were employed on different terms and conditions, including different working hours.

Agenda for Change also incorporated (or 'bought out') the many supplementary payments and additional allowances previously paid under the Whitley system in order to simplify ('harmonise') the new pay system (*see* Appendix 2, p 33, for details). The previous system of London weighting and fringe allowances was also replaced by a new category of 'high-cost area' pay supplement, and recruitment and retention premiums were introduced to provide an additional pay option for individual posts or specific groups of posts that were hard to fill.

Job evaluation

To ensure that 'equal pay for work of equal value' was delivered, the pay system was underpinned by a job evaluation scheme, which was based on 16 factors. Each factor (eg, 'analytical and judgement skills', 'emotional effort' and 'working conditions') had different identified levels, and a points score was derived for each job. The factors and the weighting and scoring system used in Agenda for Change were developed as a tailor-made system for NHS staff as it was agreed there was no pre-existing system capable of evaluating all of the jobs covered.

The new pay spines are divided into nine pay bands, and staff covered by Agenda for Change were assimilated on to one of these pay bands on the basis of job weight, as measured by the NHS job evaluation scheme. To assist the process of moving staff on to

the new pay system, a number of national job profiles were drawn up and these were then evaluated. Staff in jobs that matched these national profiles were assimilated on the basis of the agreed job evaluation score for the appropriate profile. This was designed to remove the need to evaluate every job in every NHS organisation. The original intention was for these national job profiles to cover about 80 per cent of all NHS staff. But delays in agreeing and publishing national job profiles and the large numbers of different roles meant that NHS organisations faced a significant task in matching their roles to the national job profiles, as well as having to evaluate many jobs at the local level. Some of those we interviewed were critical of the limited availability of national job profiles during their matching processes and also of the time and work required to evaluate each job.

KSF – a new career development framework

The KSF has been promoted as a critical element in achieving the full benefits of Agenda for Change. The framework defines and describes the knowledge and skills required for NHS staff to work effectively in their jobs and deliver quality services. It provides a framework for the review and development of each staff member and is the basis for determining individual employee pay and career progression within Agenda for Change. Each job has a KSF post outline that sets out the dimensions, levels and indicators required for the post-holder to undertake it effectively. The KSF process is based on an annual developmental review between each staff member and their line manager, which should produce a personal development plan (PDP). An e-KSF tool has been created to help NHS organisations develop, maintain and record KSF post outlines and PDPs. The e-KSF tool was originally developed as a stand-alone system but it is now capable of being linked to the Electronic Staff Record and it is hoped that this will make it easier to use.

The KSF was built on two key principles: that it should be 'simple, easy to explain and understand' and 'be operationally feasible to implement'. As discussed later in this report, some argue that the first principle has been lost, and therefore the second has not been achieved.

Measuring success

The final Agenda for Change agreement contained an annex setting out 10 positive success criteria that the new system was designed to help achieve (the intended outcomes), and a further five criteria relating to the avoidance of risk in implementation. The 10 positive success criteria identified were:
- more patients being treated more quickly
- higher-quality care
- better recruitment and retention
- better teamwork/breaking down barriers
- greater innovation in deployment of staff
- fair pay
- improving all aspects of equal opportunity and diversity
- better pay
- better career development
- better morale.

These 10 criteria are not all easy to measure or assess; in later sections we report on local assessment of progress in achieving them. The five risk avoidance issues were:

- implementation within available funding
- implementation within agreed management capacity
- implementation within agreed service constraints
- implementation with only a small minority of staff with lower pay
- implementation consistent with improved working lives.

The extent to which these criteria have been met is examined in the next two sections.

Implementing Agenda for Change: the local and national experience

This section examines the experience so far in implementing Agenda for Change. It draws from 10 detailed case studies that were conducted in NHS acute trusts in England from late March 2007 to May 2007. None of these trusts were early implementers but there was a mix of large and small trusts, foundation and non-foundation hospital trusts, and they were drawn from different parts of the country (*see* Appendix 4, p 37, for details). Interviews were also conducted with key national informants who had been involved in the national negotiations and/or have a current policy responsibility for NHS pay. These interviewees came from both management and union/professional associations, and in most cases they were interviewed twice; once before the local case studies had been conducted, and again afterwards.

Managers favour the new system

Most of the NHS trust managers interviewed are in favour of Agenda for Change, believing that, in part at least, it will assist in delivering the improvements in patient care and staff experience that were its stated objectives. This is partly also a reaction to the perceived inadequacies of the old system: 'Whitley was unwieldy and having staff on new terms and conditions is helpful – it will help teamworking and break down previous silos'; 'We strongly support the move towards harmonisation of benefits – we see this as an important way of encouraging teamwork'. The main benefits of Agenda for Change highlighted by these managers are: 'fairness', moving different staff groups on to harmonised conditions; equal pay claim 'protection'; and scope to introduce new roles and working practices. One of the case study sites, which had previously made significant progress in introducing a local pay structure, commented that Agenda for Change is very much in line with what it had been trying to achieve.

National negotiations were slow… local implementation was rushed

As highlighted earlier, Agenda for Change took many years to design, negotiate and agree at national level. National informants acknowledged that the initial timetable was ambitious, and that reaching agreement took much longer than had been initially intended. Some trust managers argued that the timescale for implementation was also optimistic and therefore the process was rushed – and in some cases accompanied by pressure from their strategic health authority (SHA) and the Department of Health to meet the very challenging timetable for full implementation.

One human resources director noted that pressure from the SHA to complete implementation was 'heavy and no help', and reported being summoned to the authority, along with the trust's chief executive, where 'we felt like being at school'. Another noted that the 'Department of Health was breathing down our necks to speed up implementation… we had a lot of threats from the centre'. Other trust managers were more positive in their view

of external support: 'We had external support from an NHS Employers best practice facilitator, which was useful'; 'The SHA was helpful in implementation… they set up a steering group that helped address anomalies emerging because of the speed of implementation'; 'We received useful advice from our local early implementer'.

Different SHAs reportedly adopted different approaches to supporting local implementation, varying from hands-off monitoring to planned support to direct intervention. There was a commonly reported view among the managers interviewed that achieving the 'tick box' of full implementation was given a higher priority by 'the centre' than ensuring consistency or completeness of the implementation process.

Similar findings have been reported in relation to the implementation of the consultant contract and the GP contract (House of Commons Health Committee 2007; Williams and Buchan 2006). The drive to secure full national implementation within the timetable, including job matching and local panel reviews, inevitably put pressure on local management; some reported that they were either under-resourced to meet the timetable or had to cut corners to keep to it. 'We underestimated the workload'; 'Some job descriptions were not properly checked by line managers before being signed off… these jobs were banded too high'; 'The process was unwieldy and there could have been more support nationally…'

Others reported satisfaction with the process of implementation within their own trust, suggesting that it had been well prepared and adequately resourced: 'We put a lot of emphasis on planning and front-end work to ensure consistent implementation'.

The overall costs of implementation

The financial situation currently facing the NHS is much tighter than was the case when Agenda for Change was being developed. The long delays in negotiation and implementation have meant that the new pay system is beginning to function just as the NHS in England has moved from a period of relative funding growth to one of fiscal constraint, and there is greater scrutiny on public sector pay awards (Incomes Data Services 2007; Parish 2007a).

There is no single cost measure for assessing the implementation of Agenda for Change; depending on the starting point, coverage and staff assessed, the cost will be different. The results of various cost assessments, including additional costs associated with the new pay system, are discussed below.

The review of the early implementers' experience (Department of Health 2004) addressed costs, including the number of staff who were likely to receive protected pay. Estimates produced for the review (*Ibid*, p 9) suggested that more than 90 per cent of staff would benefit from an immediate pay increase, and some 10 per cent of staff would see their total pay increase by at least £2,000 a year. The pay of 7.5 per cent of staff would be protected.

Cost assessment data was collected in 2005 in 28 sample sites. In the first 12 months of implementation, from October 2004 to September 2005, direct earnings costs exceeded those originally estimated by 0.5 per cent of the Agenda for Change pay bill, or around £120 million a year in cash terms. In the same period, the indirect earnings costs of replacing additional hours and leave arising from Agenda for Change exceeded those originally estimated by at least £100 million a year. An exercise was subsequently carried out by SHA

finance directors in late 2005 to validate these effects. This broadly confirmed the findings from the sample site monitoring in terms of the overall effect on costs, although there were some significant variations between SHAs (Review Body for Nursing and Other Health Professions 2006, p 57).

In April 2006, the Minister of State for Health reported that 'The funding envelope for Agenda for Change is £1.4 billion in 2006–07 and £1.8 billion in 2007–08, an increase of £440 million and £380 million respectively over 2005–06. Actual costs for 2006–07, 2007–08 and 2008–09 will depend to a significant extent on experience of the operation of the new Agenda for Change pay progression arrangements and matters are being kept under review' (Hansard 2006/7). More recent estimates from the Department of Health forecast that £2.2 billion will be spent on implementing Agenda for Change by 2008/9 (House of Commons Health Committee 2006a).

The recent Health Committee Report on Workforce Planning concluded that 'the cost of pay reform has consistently exceeded Department of Health expectations. Officials told the Committee that spending on Agenda for Change had exceeded projections by £100 million in 2004–05, although subsequent information implied an overspend of £220 million' (House of Commons Health Committee 2007, p 24, para 58). Total overspends for 2004/5 for the different new NHS pay systems are shown in the table below.

TABLE 2: OVERSPENDING ON PAY REFORM RELATIVE TO PROJECTED SPENDING, 2004/5

	GP contract	Agenda for Change	Consultant contract	Total overspend
Overspend 2004/5	£250 million	£220 million	£90 million	£540 million

Source: House of Commons Health Committee, 2007, p 24. Based on information supplied to the Committee by Department of Health

During the Health Committee's other recent inquiry, on NHS deficits, the Secretary of State for Health acknowledged the need to improve accuracy of pay cost projections, although she denied that overspending on the new contracts was a major cause of deficits (House of Commons Health Committee 2006b Q817). Other witnesses disagreed, arguing that excess costs associated with the new contracts had significantly exacerbated deficits in particular NHS organisations (*Ibid* Q187).

It is difficult to assess the exact impact of Agenda for Change on NHS staff salaries and earnings. The recent Health Committee Report (House of Commons Health Committee 2007, p 21, para 49) concluded that 'it is clear that the majority of staff have received substantial pay increases'. The latest NHS data on staff earnings in England, suggest that qualified nurses' basic pay has increased by approximately 15 per cent between August 2004 and January to March 2007, while unqualified nurses' pay increased by approximately 16 per cent (The Information Centre 2007). The impact on earnings is complicated by the fact that under the new pay system basic pay includes leads and allowances that were paid separately under the Whitley system. There are also significant costs associated with many staff receiving more annual leave and some staff working fewer hours (some staff groups such as allied health professionals are to work longer hours but this is to be phased in, while the impact of reductions in hours has had a more immediate effect).

There has also been a differential cost impact across different occupations and grades as a result of Agenda for Change. Full implementation was bound to change internal pay relativities between groups and occupations within the NHS workforce, and so alter the cost balance. Application of a standardised job evaluation template across a range of occupations that had previously been unconnected, in terms of assessment of job 'worth' or 'weight', created a new pattern of relativities. This in itself was a challenge to local management, who had to work for consistent implementation while dealing with the communication requirements, as well as dealing with issues related to relative 'winners' and 'losers' that emerged as a result of the process.

There was remarkable consistency from case study managers about which groups had experienced a relative loss or gain as a result of Agenda for Change. Those who identified a group that had fared relatively less well in assimilation on to the new pay system pointed to administrative and clerical staff. 'The losers have been band 4 and 5 admin and clerical staff'; 'Admin and clerical staff feel like they have lost out – and they have – but the system was designed to do this'. This view was backed up by national informants. There was also general agreement as to who were the relative 'winners'. 'The big winners have been senior clinical nursing staff and senior therapy professionals'; 'Specialist nurses have cost more than was planned and anticipated'. Some interviewees also noted that ancillary grades had benefited by moving across to a new pay system where there was more scope for pay and career progression. Most of the managers reported some level of appeals being under way, but none reported this to be at a level that was regarded as problematic. In fact, many noted that the number of appeals was lower than anticipated.

The Department of Health, in its evidence to the 2007 Review Body for Nursing and Other Health Professions, highlighted particular concerns about the longer-term costs associated with Agenda for Change. Under the previous pay arrangements, most NHS staff had been employed by the NHS for sufficient years to be on the maximum pay point on their pay scale. When staff were transferred on to Agenda for Change, with its broader pay ranges, many were assimilated below maximum pay points. Additional new staff being employed as a result of NHS expansion were also unlikely to be appointed at the top end of the pay scales. (Data from the Electronic Staff Record, covering around 128,000 NHS staff, suggests that as many as 79 per cent of staff under Agenda for Change are below their scale maximum.) This has meant that many staff under Agenda for Change now receive both an incremental rise in their pay (as they progress within their pay band) and a cost of living uplift, leading to a higher overall percentage increase in the pay bill (Incomes Data Services 2006). This should have been anticipated and included fully in the modelling of the costs of implementation.

The local costs – and methods of costing – have been variable

Implementing a new pay system inevitably incurs costs – both one-off costs linked to the process of setting up new systems, and ongoing costs if staff are assimilated on to the new structure at a higher level. Given the need to account for and control these costs and to check actual costs against planned (and funded) pay changes, it is surprising that not all the case study trusts could provide a detailed assessment of local costs of implementation, and those that did provided different types of costing. Three trusts provided cost estimates of '3.6 per cent', 'about 2.5 per cent to 3 per cent', and 'between 4 per cent and 6 per cent' on the pay bill in the first full year of implementation. Many also reported that the additional funding provided had not been sufficient to cover the estimated cost of implementation.

One stated that actual costs of implementation were 6–8 per cent above estimate. Another indicated that 'the ballpark figure was about one-quarter above planned'. A third indicated that it had spent about £150,000 in salary costs over two years to cover the time associated with completing the implementation process. It was 'not sure' about overall costs, 'but they were more than the trust was given'. The variation in these responses highlights the lack of a standard approach to costing the implementation process.

The difficulties in providing a precise cost were partly due to implementation taking place over different financial years, against a backdrop of changing financial circumstances, and in some cases also reflected a change in senior personnel at trust board level. In some cases, however, the inability of human resources managers to provide detailed costings reinforces the general point that has been made about a lack of 'connect' between human resources and finance functions in some trusts, leading to poor costing of staffing changes (House of Commons Health Committee 2007).

It should also be noted that, while the process of transition and implementation was time-consuming and resource-intensive, some managers also highlighted that the new system, when bedded down, would be simpler to operate than the multiple Whitley systems it replaced, thereby reducing administration and payroll management costs.

Other cost issues identified by managers were the additional costs incurred by increased annual leave (including costs for cover), the potential for increased sick pay costs, and the costs of pay and career progression in the new system: 'We have modelled this for the next five years as part of our foundation trust application process and it's horrendous'. There is a sense in which the timetable for full implementation has extended beyond the timeline of relatively high funding, creating a funding gap that is an additional challenge for local managers trying to balance the books. One of their largest cost centres, the staff pay bill, has never been entirely under their control, and has recently been subject to transition costs combined with the additional cost drivers inherent in the new system.

Unfinished business

Agenda for Change represents a new approach to pay determination for NHS staff. Pay levels of individual workers are more closely linked to their job content (as set out in their agreed job description), and career development is more structured within the Knowledge and Skills Framework (KSF).

However, at the time of the case studies, from March to May 2007, none of the trusts reported that they had yet achieved 100 per cent coverage of personal development plans (PDPs) or had all relevant staff assimilated on to the KSF. They reported between 60 per cent and 'nearly all' staff on PDPs; and from 'not yet all' staff, up to '95 per cent plus' and 'virtually all' staff being on KSF job outlines. The case studies highlighted the fact that full benefits realisation is not achievable without a fully functioning KSF: 'We need to maintain focus to fully embed KSF and maintain the integrity of the system'; 'The key challenge now is getting KSF sorted'.

These findings are supported by the results of a national survey which quoted figures gathered by SHAs in December 2006 (O'Dowd 2007) suggesting that:
- 67 per cent of staff have a full KSF job outline

- 27 per cent have had a development review using KSF
- 33 per cent have a KSF personal development plan
- 16 per cent have supported development linked to KSF.

The SHAs undertake quarterly monitoring and the latest results provided to NHS Employers (for the end of March 2007) suggest some improvement, although the response rate is not as complete as for the December 2006 figures. Based on returns from five of the ten SHAs, some 78 per cent of staff have a KSF outline and 29 per cent have had a KSF-based development review.

The results of the Healthcare Commission's annual national NHS staff survey (discussed elsewhere in this report) also suggest that significant numbers of staff are not receiving the regular performance reviews or agreeing the PDPs required to operate the KSF.

The recent Health Committee Report on NHS Workforce Planning concluded that 'Effective use of the KSF has great potential to improve staff productivity. The KSF can improve access to relevant education and training, and support amended roles which will allow staff to develop the skills required to increase flexibility and efficiency. However, there is little evidence that these opportunities are yet being taken' (House of Commons Health Committee 2007, p 74, para 217). There are plans to launch a tripartite initiative involving the Department of Health, NHS Employers and staff-side organisations to embed the KSF and promote the benefits of using it.

A second area of unfinished business is to reach agreement and implement a new system for payments for unsocial hours for staff covered by Agenda for Change. The assessment of the early implementers in piloting Agenda for Change found 'evidence of significant difficulties' in operating the original proposed unsocial hours system and concluded that it should not be rolled out (Department of Health 2004).

An interim holding arrangement was introduced while the NHS Staff Council undertook a review and then consulted on draft proposals for a new system of payments for unsocial hours, to be introduced from 1 October 2007. The arrangements provide for staff to receive percentage enhancements for working unsocial hours based on their pay band. The consultation process ended on 20 April 2007 and given that staff-side organisations will want to consult their members on the final proposals, it is unlikely that any new system will be introduced until 2008. According to managers interviewed in some of the case study sites, the lack of a new unsocial hours pay system has constrained progress in achieving some of the intended benefits of Agenda for Change.

Benefits realisation: evaluating impact

Agenda for Change was intended to be a means to an end – to facilitate the development of new roles and new ways of working, and to improve staff recruitment and retention. This so-called 'benefits realisation' was highlighted as the rationale for investing in the new pay system. In this section we explore in more detail what Agenda for Change was expected to deliver, and assess the extent to which its impact has been evaluated.

The background to benefits realisation

The Department of Health in England published a draft benefits realisation framework in October 2004 to help NHS organisations deliver the benefits expected of Agenda for Change (*see* Appendix 1, pp 29–32), which made it clear that Agenda for Change would be 'a contributory factor to achieving the success criteria [discussed on pp 5–6] rather than the sole factor'. The framework included detailed suggestions on approaches to measurement and data sources to be used.

In October 2005 NHS Employers published *Agenda for Change and Benefits Realisation: A framework for developing thinking* (NHS Employers 2005), and this including the following 'eight rules of thumb for realising benefits from Agenda for Change':

1. Benefits accrue over time: do not expect instant results. But do identify 'quick wins' and prioritise these.
2. Connect Agenda for Change to existing change programmes.
3. Change does not have to be large or wholesale to be effective; small changes in roles and processes, and very localised change, can yield results.
4. Management of benefits should be separated from management of implementation. Project managers will be too 'heads down' overseeing and supporting the transactional to concentrate on the transformational.
5. Ensure that Agenda for Change and service improvement leads work together to share expertise and increase potential benefits.
6. Benefits realisation should be strategically led from the board.
7. Once you have targeted areas for benefit realisation, those who are capable of achieving the benefits should be empowered and resourced to lead on this.
8. Staff often have the best ideas about changes that will make a difference to patients and themselves. Staff involvement is key to the success of Agenda for Change.

NHS Employers also ran a series of workshops in 2006 to promote and network good practice in realising the benefits to be achieved by Agenda for Change. The workshops led to a report (NHS Employers 2006), which gave examples of good practice in using Agenda for Change to improve services and to increase workforce productivity. However, the report also marked the breaking up of much of the NHS Employers Agenda for Change Implementation Support Team.

NHS Employers has also set out a schedule and timeline for benefits realisation (see below). In the next section we consider progress made so far by the case study trusts in achieving these benefits at local level.

TABLE 3: NHS EMPLOYERS BENEFITS TIMELINE FOR AGENDA FOR CHANGE

Implementation benefits	Intermediate benefits	Long-term benefits
Fair pay	More teamwork	More patients treated more quickly
Better pay	Greater innovation in staff deployment	Higher-quality care
Partnership working	Better career development	
Equal opportunities and diversity	Better recruitment and retention	
Human resources systems	Better morale	
Simplified administration		

Source: NHS Employers, 2005

Local experience with benefits realisation

Agenda for Change had been implemented for about a year in the case study trusts. At this relatively early stage in the process, most of the managers interviewed could identify positive changes that had already been achieved within their trust as a result of Agenda for Change. They all said their trusts were either in the implementation or intermediate phase of benefits realisation, as described in the NHS Employers benefits timeline.

'Implementation benefits' identified as having already been achieved in most of the trusts included: human resources systems (for example, improved job descriptions), better partnership working, equal pay and simplified human resources/payroll administration.

Improved job descriptions are a means to an end; they provide a more accurate and agreed outline of job content and thus enable roles to be clearly defined, as well as changes in roles, or new roles, to be implemented. One manager characterised new job descriptions as an 'early win'; another noted that 'it's given us a greater understanding of what people do… has given a common currency and understanding across disciplines that was not there before'. Agenda for Change could not have been fully implemented without full and agreed job descriptions, so this has led to an improvement. However, it also raises a question about the absence of accurate job descriptions in the past.

The new pay system was developed at national level in partnership with NHS staff-side organisations, and there was also a partnership approach to its implementation. The local effort of assessing and assimilating jobs on to the new structure brought local management and workforce representatives together, creating a closer bond that some managers noted also improved local-level employee relations on other matters. Better partnership working

with trade unions and staff representatives was a commonly reported outcome of Agenda for Change. The benefits of this 'dividend' are hard to quantify or assess and it is unclear if this will last, particularly in current circumstances where there is national level disagreement related to the delayed implementation of the 2007 pay awards in the NHS in England.

Achieving equal pay for jobs of equal value was one of the key objectives of Agenda for Change. The trust managers were generally supportive of the move to standardised working hours and job evaluation-based pay as providing a more transparent and 'fairer' pay system. One unintended consequence of implementation was to flush out more equal pay claims before implementation was concluded. NHS Employers estimates that there are currently around 10,000 equal pay claims lodged against the NHS in England (NHS Employers, 2007). While it cannot be confirmed that Agenda for Change has guaranteed equal pay, it does appear to have been an important factor in limiting the exposure of the NHS to equal pay claims. The cost of settling these claims can be substantial, so if the new pay system has provided a better defence to such claims and prevented a wave of them, this will have been a significant cost-saving. For example, in 2005, Unison reached agreement with the North Cumbria Acute Hospitals NHS Trust covering around 1,500 female staff working in posts ranging from nurses to catering assistants and clerical officers, who compared themselves to craft operatives, labourers and maintenance assistants. They claimed back-pay for up to six years from the lodging of their claim and received compensation ranging from £35,000 to £200,000 each.

As noted earlier, the completion of implementation of Agenda for Change was set against a backdrop of a worsening financial situation for some NHS trusts, and a less optimistic labour market outlook, with posts being held vacant and recruitment activity slowing. This makes it difficult to isolate and assess the potential positive early impacts of Agenda for Change. In terms of the 'intermediate' benefits identified by NHS Employers in the table opposite, the managers in the case study NHS trusts were less certain that some of the benefits (eg, improved morale and recruitment and retention) would be attainable because of the changing financial circumstances. However, one area where several – but not all – of the trusts had already made progress to 'intermediate' level, facilitated by Agenda for Change, was in changes in staff deployment.

New roles had been introduced in some trusts; examples included band 4 therapy assistants, band 4 associate practitioners and generic care assistants. Managers in these trusts are clear that Agenda for Change is at best a 'facilitator, not a driver of this process'; 'Agenda for Change has to an extent accelerated this happening… it's given us a window of opportunity'. Others noted that one unanticipated impact of Agenda for Change was to increase staff costs in a way and at a time that focused management attention on re-profiling staffing levels and skill mix to reduce costs: 'Some jobs were banded too high… we couldn't afford this so there has been some service redesign reconfiguration as a result'; 'unit costs are up, and will go up further over the next three to four years unless we do something about skill-mix'; 'those that have done well will be hit most with productivity improvements or job cuts'.

Most of the 10 trusts reported that new roles and job redesign had already occurred as a result of Agenda for Change – either the positive direct impact of Agenda for Change facilitating the creation and 'pricing' of new roles, or the unanticipated indirect impact of Agenda for Change driving higher unit labour costs, which was in turn leading to job redesign.

Other trusts intended to redesign jobs and services, facilitated by Agenda for Change, but had not yet done so – either because of lack of capacity or different priorities: 'Introducing new roles has been slower than anticipated – there are so many priorities at the moment'.

Job redesign, the introduction of new roles and new 'ways of working', such as care pathways, have been features of the NHS since the implementation of the NHS Plan. The proliferation of new roles was noted recently by the Health Committee (House of Commons Health Committee 2007) and is not simply a direct result of Agenda for Change; but clearly in some trusts, the new pay system has helped accelerate or expand this process.

The NHS Employers timeline for achieving benefits realisation identified two long-term benefits: 'more patients treated more quickly' and 'higher-quality care'. The major question now is, can all the benefits perceived as emerging from Agenda for Change be realised given the significant changes in the NHS funding situation since 2006? Managers in the case study trusts indicated that they believed it would take another two to five years to achieve long-term benefits. Even then, several cautioned that the broader impact of financial deficits and tightening of NHS funding streams, combined with the knock-on effects of increased pay bill costs as Agenda for Change bedded down, meant that full benefits realisation would be challenging and problematic. This was echoed at national level by some of the interviewees, with one union official commenting that: 'The jury is out on benefits realisation. There are good examples of trusts using Agenda for Change to bring about improvements in care, but the mainstream NHS has so far failed to grasp the challenge… Without further central government pressure to deliver, opportunities will be lost'.

Several local managers pointed to the delayed agreement at national level on the new system of unsocial hours payments as a constraint on progress and two expressed concern about the new agreement itself (at consultation phase at the time of writing this report). 'It may be equal pay-compliant but otherwise it looks out of date'; 'it will be a sell-out and the unions will get what they want'.

Evaluation of impact

While interviewees could point to local examples and experience of benefits realisation, there has so far been only limited evaluation of the experience of implementation and the impact of Agenda for Change.

The first opportunity for evaluation came with the early implementer sites. Their experiences had the potential to inform the process of full implementation. As noted above, data from the sites had been used in assessing the overall costs of implementation (Department of Health 2004), but there was scope to assess a broader range of implementation issues. The Review Body for Nursing and Other Health Professions visited early implementer sites in England in 2003 and 2004 (Review Body for Nursing and Other Health Professions 2004, 2005) to assess the benefits of the new pay system, identify areas of best practice and highlight issues to be addressed by the parties prior to national roll-out. Its assessment of the potential to realise benefits was optimistic, but it cautioned that it would take time for the new system to be fully accepted and operational.

While the sites were supposed to give the opportunity for full testing of Agenda for Change and for networking of lessons learned, several of the national and local-level interviewees

commented that they did not feel this had been achieved. One trust manager noted: 'Commissioning a lot of pilots didn't help us at all – because there was insufficient effort to assess, and then network, the lessons to be learned'. A national-level commentator noted: 'The early implementer process really gave us insufficient feedback'.

More recent evidence of the impact of Agenda for Change can be found in the October 2006 NHS staff survey (available at: www.healthcarecommission.org.uk). Analysis of the results of the four years from 2003 to 2006 enables some assessment of impact and any evidence of benefits being delivered, at least from a staff perspective (*see* tables 4 and 5, pp 18, 19).

One of the key messages from analysis of the staff survey results is that NHS staff views on some of the issues associated with the success criteria for Agenda for Change (such as quality of job design, staff job satisfaction and staff intention to leave their jobs) have changed very little between 2003 and 2006. Indeed, responses indicate that there are some key measures directly linked to Agenda for Change (such as the numbers of staff reporting having received appraisals and personal development plans (PDPs)) where the performance of the NHS appears to have deteriorated in recent years. Staff also now appear to have more negative views on the extent to which their work is valued, the quality of patient care and the fairness of promotion and career progression arrangements.

Some of the interviewees at national and local level commented on the high level of expectations among staff with regard to Agenda for Change and the difficulty of meeting these expectations. It may be that the staff survey results reflect this sense of disillusionment. By 2006, reductions in the number of posts and redundancies were having an impact on the NHS and this is also likely to have affected staff views and morale.

The percentage of staff reporting having an appraisal and PDP in the past year increased between 2003 and 2004, but has since fallen. Some organisations have linked this to the implementation of Agenda for Change and in particular the work associated with implementing the NHS Knowledge and Skills Framework (KSF), which requires a KSF outline to be agreed with staff.

The staff survey questions do not mention KSF and the KSF documentation does not mention the term 'appraisal', and it is possible that the use of different terms may have affected the responses given by some staff. At least one case study commented on the significant differences between the results of its own monitoring of appraisals/performance reviews and PDPs (which showed nearly all staff having these on a regular basis) and the results of its staff survey (which suggested much lower levels of occurrence).

The 2006 survey also included, for the first time, some questions directly concerning the implementation of Agenda for Change. Almost 69,500 staff from 171 acute trusts (including 20 specialist trusts) took part in this survey. While the results for acute trusts are generally in line with results from all types of trusts, there are some significant differences between individual trusts. This suggests that staff in different trusts have very different views as to the experience of the implementation of Agenda for Change within their organisations. It is not clear whether these differences reflect differences of approach in local implementation or just varying perceptions of staff in different organisations. This is an area worthy of further investigation to highlight possible lessons to be learned. A full and systematic evaluation of the implementation of Agenda for Change would allow this to happen.

TABLE 4: SELECTED STAFF RESULTS FOR ALL ACUTE TRUSTS FROM THE 2003 TO 2006 NHS NATIONAL STAFF SURVEYS

	2003	2004	2005	2006
Staff with an appraisal/performance development review in last 12 months	60%	62%	59%	57%
Staff with a personal development plan (PDP) agreed in the last 12 months	46%	50%	47%	47%
Staff receiving training and development in last 12 months	87%	93%	94%	95%
Quality of job design (on a scale of 1 to 5 where higher score is better)	3.4	3.3	3.32	3.29
Extent of positive feeling within the organisation (on a scale of 1 to 5 where higher score is better)	3.0	3.1	2.98	3.39
Staff job satisfaction (on a scale of 1 to 5 where higher score is better)	3.5	3.5	3.40	3.39
Staff intention to leave (on a scale of 1 to 5 where **lower** score is better)	2.7	2.6	2.67	2.72
Staff feeling their work is valued by their employer/trust	42%	43%	28%	26%
Staff with positive view on standard of patient care	54%	58%	44%	42%
Staff with positive view that trust acts fairly on career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age (new question from 2004)	n/a	60%	54%	51%

Source: Healthcare Commission, 2007

Nearly three-quarters of staff in acute trusts reported receiving a new job outline or job description and some 35 per cent agreed or strongly agreed that they were satisfied with the information they received from their trust about Agenda for Change; 29 per cent disagreed or strongly disagreed. Table 5, opposite, shows the responses of staff in different types of acute trust in relation to Agenda for Change.

The results for individual acute trusts varied significantly:
■ Fifty-five per cent of staff at the Airedale NHS Trust and Royal West Sussex NHS Trust thought their banding was fair while only 23 per cent of staff at North Middlesex University Hospital NHS Trust thought this was the case.
■ Fifty-six per cent of staff at the Queen Victoria Hospital NHS Foundation Trust agreed implementation was successful, compared to 2 per cent of staff at Sheffield Teaching Hospitals NHS Foundation Trust and 6 per cent at the Royal Wolverhampton Hospitals NHS Trust.

TABLE 5: RESPONSES OF STAFF IN ACUTE TRUSTS IN RELATION TO AGENDA FOR CHANGE

Agenda for Change	Yes or agree/ strongly agree	No or disagree/ strongly disagree	Do not know or neither agree/disagree
Pay banding is fair	41%	35%	15%
Implemented successfully	25%	33%	36%
Has resulted in taking on increased responsibilities in job	21%	35%	32%

Source: Healthcare Commission, 2007

■ Thirty-four per cent of staff at Barts and the London NHS Trust say they have increased their responsibilities, compared to just 6 per cent at Sheffield Teaching Hospitals NHS Foundation Trust.

Further analysis of the survey data highlights that staff in smaller trusts are more likely to report positive experiences with Agenda for Change, and that there is regional variation (staff in the trusts in the North East and North West strategic heath authority (SHA) regions, for example, have a more positive view of Agenda for Change implementation than their counterparts in, say, Yorkshire & Humberside). There is also some indication of variation in response from different occupations, and variation in response by gender and ethnic background: significantly more non-white staff responded that they did not know whether their banding was fair (30 per cent compared to 13 per cent of white staff) (*see* Appendix 3, pp 34–6).

The Royal College of Nursing (RCN) surveyed its members to collect their views on the impact of Agenda for Change (Ball and Pike 2006) and the results broadly echo the results of the national NHS staff survey.

Managers in the case study sites were asked how they were evaluating the impact of Agenda for Change. Most pointed to a limited range of indicators drawn from the 'standard' measures of turnover, absence, recruitment and retention; annual staff surveys; assessing numbers of appeals; and benchmarking with similar trusts.

The NHS Employers report on the implementation of Agenda for Change (NHS Employers 2006, p 41) noted that 'NHS organisations were advised to devise their own success criteria during the preparation phase of the Agenda for Change project' and referred to the 'draft framework' on benefits realisation prepared by the Department of Health in 2004 (*see* Appendix 1, pp 29–32). The same report noted that many of these suggested success criteria were 'quite broad and consequently it will not be straightforward to demonstrate or attribute any of the desirable changes to Agenda for Change as a distinct cause'.

While the success criteria are broad and difficult to measure, the draft framework suggested detailed approaches to measurement and data sources that might be used. It also highlighted the need to collect baseline data to allow subsequent comparisons to be made. There is little evidence that this baseline data is being collected to allow benchmarking.

There has been little systematic SHA or national-level monitoring or evaluation of the effects, so far, of what is the most expensive overhaul of the NHS pay system. One manager noted he was 'surprised that there is no detailed monitoring of progress in getting return on investment in pay reform'. Another, when asked about SHA/national monitoring, replied: 'Everyone seems to have forgotten about benefits realisation. No one is asking me about it'. A third commented: 'The next time we redevelop the NHS pay system will be sooner than 40 years... We need to learn what has happened this time'.

Constraints on evaluation

The staff survey results provide some context. There is currently little additional information available on which to base a more systematic evaluation of the success or otherwise of Agenda for Change in meeting its objectives. This would not be an easy exercise, but it is necessary, even if some of the objectives are not easy to measure and attributing causality is difficult.

For example, sickness absence rates were included as a measure of staff morale in the success criteria and benefits realisation framework of Agenda for Change, but it is not possible to attribute causality in assessing the contribution of the new pay system towards the fall in NHS sickness rates. Other factors such as improved management of absence may be the key influence on the national sickness absence rate for NHS staff in England falling from 4.7 per cent in 2003 to 4.6 per cent in 2004 and 4.5 per cent in 2005. The results for 2006 have yet to be published at the time of producing this report.

Vacancy rates for NHS staff have fallen significantly with, for example, the three-month vacancy rate for qualified nursing staff falling from 2.6 per cent in 2004 to 1.9 per cent in 2005 and 0.9 per cent in 2006; the rate for qualified allied health professionals has fallen from 4.3 per cent in 2004 to 3.4 per cent in 2005 and again to 1.6 per cent in 2006. Again, it would be difficult to attribute these falls to Agenda for Change, particularly given the reductions in posts and the recruitment freezes that have been evident in the NHS in 2006 and 2007. A recent study for the Nursing and Other Health Professions Review Body (NHS Partners 2007) found that NHS trusts had scaled back their recruitment activities, and generally felt that recruitment and retention problems had eased or were non-existent. However, they were unsure whether this was due to higher salaries under Agenda for Change, an increase in the numbers of staff being trained, or a reduction in the demand for staff because of NHS financial constraints.

One initiative, introduced from 2005, has added to the difficulty in isolating and attributing measurable changes to Agenda for Change. In response to concerns about the number of reforms within the NHS and that service improvements were likely to have many drivers, the Integrated Service Improvement Programme (ISIP) was developed (available at: www.isip.nhs.uk). All local health communities had to submit benefits realisation plans for integrated change programmes by the end of March 2006. The aim was to remove the need to produce separate benefits plans for every initiative. Workforce reforms, including Agenda for Change, are covered by the programme.

ISIP appears to have had only limited impact on workforce change issues, including Agenda for Change. A review of around 120 ISIP local health community plans at September 2006 showed that only 10 per cent selected workforce as a priority objective and even fewer

featured Agenda for Change or pay modernisation (Nash 2007). An assessment of the outturn for ISIP for 2006/7 at April 2007 concluded that there was 'little systematic focus' on benefits being realised from workforce 'enablers' (ISIP 2007).

Our interviews with local managers suggested only a limited awareness of ISIP among the human resources community and our interviews with some of the key personnel at national level appeared to confirm the impression that implementation of Agenda for Change was largely owned by human resources, with little involvement from those leading service improvements. The emphasis on the transactional activities required to implement Agenda for Change, rather than the transformational possibilities it offers, may be understandable given the pressure put on organisations to implement, but it calls into question the extent to which all the anticipated benefits are likely to be realised. So far, monitoring by SHAs and the Department of Health has focused on the progress made in implementation, rather than on how the new pay system is being used and measuring the benefits that may have resulted.

Agenda for Change: where next?

The previous sections have set out progress to date with the national agreement and local implementation of Agenda for Change. But there has been no systematic attempt to evaluate the progress made in realising the benefits expected from Agenda for Change. This is despite the fact that templates for such evaluation were developed – the draft Benefits Realisation Framework, and the indicators outlined in more general terms within the Partnership Agreement Success Criteria. Given the scale of the exercise, its costs and assumed benefits, the absence of any continued commitment to such systematic evaluation undermines the overall potential for Agenda for Change to deliver improvements to the NHS. This section considers other key factors that will impact on the sustainability of Agenda for Change over the next two to five years – the time period managers identified to reach 'long-term benefits'. These factors are:

- the endurance of the NHS Knowledge and Skills Framework (KSF)
- foundation trust status
- pressure for local/regional pay
- the role of the new strategic health authorities (SHAs)
- NHS funding
- management capacity.

The endurance of the Knowledge and Skills Framework

There are questions, nationally and locally, about the likely longevity of the KSF as a standard system throughout the NHS. As noted earlier, national surveys have highlighted that not all staff are yet assimilated on to the KSF. While most of the respondents interviewed for this report at national and trust level were supportive of KSF, some were concerned about its future.

Recent evidence confirms that not all NHS staff have a KSF job outline; some sources have suggested that the proportion of staff with a KSF job outline may actually be falling (Staines 2007) and support for implementation of the KSF by some SHAs is being 'wound down'. In February 2007, a national survey highlighted that 67 per cent of NHS staff had a job outline and 27 per cent had a KSF-based development review. It quoted the KSF project manager at NHS Employers: 'It's very frustrating for us and SHAs because we want to know what is going on. At this stage we should be looking for every NHS organisation to have over 90 per cent of staff using KSF fully, but no, it's disappointing' (O'Dowd 2007). At local level, one NHS trust – Chesterfield – has announced it will not use the KSF 'because of the additional cost and the need to achieve financial balance' (Chesterfield Royal Hospital NHS Foundation Trust 2006). The head of the non-medical pay team at NHS Employers recently commented that 'benefits will not be fully realised until the KSF is fully implemented... Much valuable work has been done towards implementing the KSF, but many organisations have lost KSF expertise over recent months, largely due to reorganisation' (Winnard 2007). One manager at a case study trust commented that 'we need a "lighter touch" KSF'.

The Department of Health, NHS Employers and NHS staff-side organisations are currently engaged in a tripartite initiative to ensure that implementation of the KSF continues, so that it is firmly embedded. There is a planned 'relaunch' of the KSF in the autumn of 2007 (Parish 2007b). There have been suggestions that some NHS organisations over-complicate the framework by, for example, using too many dimensions for posts or requiring portfolios of written evidence where this was not appropriate. Despite the current limitations on full implementation of KSF, the review of future regulation of non-medical staff in the NHS suggested that in the longer term, one option would be to use the KSF to support the revalidation process for NHS staff (Department of Health 2006).

Foundation trust status

Four of the case study trusts already had foundation trust status. Others were at an advanced stage of preparing to apply for foundation trust status. Foundation trusts have greater potential freedom in relation to local human resources policy. Some foundation trusts have already exercised a degree of this freedom by implementing Agenda for Change at their own pace rather than in line with the national timetable. One (Southend) has already announced that it has moved away from Agenda for Change to its own local pay system, 'because one of the inherent problems with Agenda for Change is built-in increments for staff who may not have received them before, they might have been on a spot point' (House of Commons Health Committee 2006c).

The long-term policy objective in the NHS in England is for all trusts to have foundation status. This raises questions about the sustainability of Agenda for Change as a national pay system. Southend may be an exceptional case, but foundation status does provide trust management with greater freedom in terms of human resources policies, and preparing for foundation status has in itself been a major driver for management to focus on controlling pay costs and on staff mix and deployment. 'There has been a greater awareness of the cost of staff... but this is linked to the process of becoming a foundation trust'.

Pressure for local/regional pay

In recent months there has been a resurgence in speculation about the possibility of introducing some type of local or regional pay to the NHS. The Conservative opposition has trailed such an idea (Snow 2007), and regionalised pay in the public sector has also been a recurring theme emerging from the Department of Health and the Treasury (Mooney 2007). A leaked Department of Health document in January 2007 identified future pay options, including 'greater use of local and regional pay to bring down nurses' pay' (Mooney and Donnelly 2007). In June 2007 the devolved administration in Scotland announced that it would fully implement the 2007 Review Body pay recommendations ahead of its counterparts – the first time that one of the four UK countries has 'broken ranks' on a major aspect of the timing of NHS pay implementation.

Agenda for Change does include scope for locally determined pay supplements for 'shortage' posts but the question remains about its long-term viability as a national pay framework if political pressure for local pay were to become pronounced.

Most of the case study managers who expressed an opinion about local pay did not welcome it as a possibility – they saw it as costly, resource-intensive and unnecessary: 'A huge task would be involved in moving away from Agenda for Change... there is enough flexibility in

Agenda for Change'; 'I would not want to move to local pay… you would end up paying more than the national agreements'.

As noted earlier, when NHS local pay was last a major feature, in the early 1990s, it failed to gain widespread acceptance by many local managers because it was regarded as being complicated and high-cost, and was opposed by the trade unions. The next few years will test the local adaptability of Agenda for Change; it may be that a more localised form of NHS pay determination could emerge once again as a proposed policy tool, should Agenda for Change come to be regarded as insufficiently flexible for changing local circumstances.

The role of the new strategic health authorities

The recent restructuring of the NHS in England, from 28 smaller SHAs to 10 larger ones, has major implications for workforce planning and human resources practice. It was noted earlier that there were varying levels of support from the 'old' SHAs during implementation of Agenda for Change – varying from a laissez-faire, monitoring approach to a direct (and sometimes unwelcome) intervention.

The new SHAs have recently completed the process of appointing director-level posts for workforce policy. It is too early to judge how the new SHAs will function in relation to workforce issues, both individually and collectively (the latter being a key recommendation from the Health Committee) (House of Commons Health Committee 2007). How they take forward policy in relation to Agenda for Change will be a critical issue in determining the degree to which the NHS pay strategy is applied consistently, and will also be a factor in the process of benefits realisation. Feedback from interviewees at trust and SHA level suggested that most thought SHAs would not play a central role in sustaining the use of Agenda for Change in delivering benefits.

NHS funding

As noted earlier, the NHS in England is coming to the end of a period of increased and historically high levels of funding (Appleby 2007a). Funding projections for future years suggest that the rate of annual funding increases will reduce towards average 'historic' levels.

Much of the recent funding growth has supported increases in staffing numbers and in staff pay (Appleby 2007b). The Health Committee has said that 'the Department of Health has acknowledged that workforce reform has played a minor but significant role in recent years' in improving health service staffing: 'the last five years has been 80% about growth and 20% about transformation and new ways of working' (House of Commons Health Committee 2007 Ev 12). Agenda for Change is being fully implemented just as funding levels fall – not the most supportive fiscal environment to achieve effective and sustained implementation. Several of the case study NHS trusts reported a cost over-run on implementation and, in this harsher financial climate, were focusing on achieving cost containment through skill-mix changes.

The intention was that Agenda for Change would facilitate more effective working practices and teamwork; this is happening in some trusts, but Agenda for Change is also a source of cost inflation, which has created financial challenges that were not all anticipated or planned. Initial underestimates of the costs of implementation may be a factor in the difficulties

experienced at trust level in funding pay bill increases, and the end result has been to contribute to increased pay costs, just as the growth in NHS funding is projected to tail off. One factor in determining the long-term viability and sustainability of Agenda for Change is the extent to which future pay bill costs are better determined, and future staffing changes costed more accurately. This will be an increasing challenge to local management in the NHS as they are tasked with improving productivity.

Management capacity

Agenda for Change has placed significant additional demands on human resources management and local staff representatives of NHS trusts. Implementation has required a major local effort; this has helped to improve management-union partnership in some trusts but has also stretched capacity and resources. In some of the case study trusts there was a sense that implementation was an end in itself, and that other human resources priorities have now to be dealt with. One trust reported that it had closed down Agenda for Change as a project; the human resources director in another referred to 'other pressures', meaning that introducing new roles had been much slower than anticipated. In contrast, other managers reported that using Agenda for Change to achieve workforce and organisational change remained a priority: 'we need to integrate Agenda for Change, process review and design and workforce planning as the way forward'; 'Agenda for Change provides local drivers for change… it puts what we do with 80 per cent of our costs under the microscope'.

A three-way tension is developing. First, national NHS funding is tightening, constraining further pay bill increases, and making productivity improvement demands on the workforce. Second, although Agenda for Change is now largely implemented in the NHS in England, it will require continued effort for a number of years to deliver the range of possible benefits envisaged when the new system was designed and agreed. Third, local management now have other pressing priorities, such as implementing the new Electronic Staff Record, developing effective working relationships with the new SHAs and dealing with deficit-linked staffing changes.

The world is moving on. It is a very different NHS from that which existed when Agenda for Change was first outlined in 1999. In this scenario, some local managers may not press on to take full advantage of what Agenda for Change can deliver. Other important issues will take priority, and Agenda for Change could come to be regarded as just a one-off exercise in moving to a new 'fairer' pay system, and its full potential to support benefits realisation will not be harnessed. As one manager noted, 'The focus now is on improved efficiency… It's down to you to use what's in the Agenda for Change framework to use staff more efficiently'.

Recommendations

Agenda for Change is the largest-ever attempt to develop a new ('modern') pay system in the NHS. It affects the livelihood of more than 1 million workers, has a major impact on NHS finances, and by introducing links to the knowledge and skills of the workforce, it also affects patient care. This report is the first independent assessment of the progress and impact of the new pay system. It could be argued that it is early days for Agenda for Change – it took several years to design and is only just implemented. But its very scale and central importance to NHS costs and delivery of care argues for a full assessment at an early stage so that lessons can be learned and any necessary changes made. As noted earlier, it is surprising that there is no NHS-led systematic full-scale evaluation under way.

This report has noted some progress in implementation, and the impact of recent financial constraints, but has also highlighted unrealised potential to achieve positive changes to NHS care through effective implementation and management of the new pay system and the associated NHS Knowledge and Skills Framework (KSF). To realise fully the potential of Agenda for Change, a number of critical issues require action.

National level

SYSTEMATIC ASSESSMENT OF COST AND IMPACT

There is a critical need for evaluation of the cost and impact in order to identify limitations and scope for further improvement. Given the scale of the exercise, the level of funding involved, and the stated objectives of changing working patterns and improving patient care, the absence of any independent national and regional impact assessment is of concern. There is a need for the various national stakeholders to agree to commission an independent and systematic policy-level assessment of the impact, lessons learned, costs and benefits, and issues that need improvement.

FULL REVIEW OF THE KSF

The KSF is an important part of the new pay and career structure for NHS staff, but it has not been fully implemented, and concerns have been raised about its robustness, partly linked to the resources required to sustain it. Recent work has identified the need for NHS organisations to keep the operation of the KSF as simple as possible and not to over-complicate it. Currently any attempt to use the KSF to support the revalidation process for staff would be undermined, as the lack of full support and implementation for KSF prevents it from being used as a universal tool for revalidation.

This highlights the importance of reviewing progress with implementation and learning the lessons from experience. It is likely that further modification is needed to ensure the KSF can achieve its intended role as an integral element within Agenda for Change. This may be the outcome of the proposed 'relaunch' of the KSF, intended for the autumn. The relaunch

must take account of the challenges of achieving full implementation, it cannot just be a rebranding exercise.

ACHIEVING BENEFITS REALISATION

Benefits realisation has been a rationale for Agenda for Change, and for the other new NHS pay systems. The failure of the consultant contract and the GP contract to deliver full benefits – so far at least – has been highlighted in other reports. Can Agenda for Change fare better? The financial and organisational context in which it now has to function is more challenging, and there is a sense that managers in some trusts do not have the motivation or inclination to take forward Agenda for Change to maximise benefits realisation.

The danger is that Agenda for Change will not be used as a means to an end of improving patient care, but has become an end in itself – an implementation box ticked, with management focus moving on to the next big challenge. There is a real need for the centre – the Department of Health and NHS Employers – to ensure that this does not happen, by continuing to drive the process and support improved local efforts. NHS Employers has published some good practice examples, but there is still a need for a more systematic audit of practice in achieving benefits realisation, either as part of an overall evaluation of Agenda for Change, or as a focused effort of knowledge transfer.

While a list of benefits to be realised in the short, medium and long term was developed at an early stage of implementation of Agenda for Change, there is no evidence that this has been used systematically to assess progress at NHS trust level, or applied regionally or nationally to track success or failure in achieving the intended benefits. These benefits are more likely to be achieved if there is a consistent assessment of progress made (and any variations) at trust level, together with networking of experiences. This can be achieved by more systematic monitoring and networking, building on the template already developed when the original Agenda for Change agreement was reached. This is an area where NHS Employers could take the lead, in collaboration with strategic health authorities (SHAs) and trusts.

FUTURE PAY DETERMINATION

The implementation of Agenda for Change has created a new centre of balance for NHS pay determination, and altered the relationship between the major stakeholders – the Department of Health, the Treasury, NHS Employers, trade unions and professional associations, and the pay review bodies. Given these changes, and the centrality of Agenda for Change, there is a need for all involved to review how best they can maintain their effectiveness, both individually and collectively, in this new pay determination process. The proposed extension of the Review Body to cover other Agenda for Change staff may be one method of simplifying some processes.

SHA level

SUPPORTING LOCAL CAPACITY AND REGIONAL CONSISTENCY

The 'new' SHAs have come into being well after Agenda for Change was formulated, but they inherit a stake in some of the remaining challenges of full implementation, as well as a role in maintaining effective workforce policies. Trusts and foundation trusts within their region

will have demonstrated a varied level of capacity to realise the benefits of Agenda for Change; this in turn may be a reflection of varied levels of management capacity. SHAs can support systematic networking of good practice in using Agenda for Change within their region, in particular, in realising benefits, and could play a role in any national evaluation. This process should be led by SHA chief executives and their workforce directors.

NHS trusts

KEEPING AGENDA FOR CHANGE ON THE AGENDA

NHS trust managers have many demands on their time and effort. As noted in this report, there has been a tendency for some to 'tick' the Agenda for Change box and move on to other priorities. This betrays a lack of full understanding of the timeline for achieving the potential benefits, an absence of appropriate management capacity, or an overall weariness with their lot. However, there are some positive signs. Many of the managers interviewed for this report have shown an appetite and desire to make Agenda for Change a central component in securing benefits, not just for the workforce but for patient care and NHS productivity.

Management at trust level must maintain or re-energise their use of Agenda for Change to secure benefits. This can best be done by making the monitoring of progress in using Agenda for Change an item for board-level scrutiny, with a senior manager having named responsibility for leading on continued implementation and benefits realisation, to an agreed timetable.

So far, the costs of Agenda for Change are more obvious than the benefits. Some benefits that have been realised at local level, such as improved working relationships with staff-side organisations, are hidden or difficult to quantify. Other, longer-term benefits will not be realised unless more systematic efforts are made to use the new pay system in the way it was intended – to facilitate and reinforce improvements in staff skills, roles and motivation, leading to improved patient care. If the recommendations set out above are not followed, it is unlikely we will ever be certain that Agenda for Change was worth its cost.

Appendix 1:
Agenda for Change – Benefits Realisation Framework

The table below is a re-ordered (in terms of time frame) and slightly edited version of the draft Benefits Realisation Framework issued by the Department of Health in August 2004.

Time frame	Success criteria	General approach to measurement	Assessment of criteria	Data source	Good practice
Short term	**Fair pay** – pay consistent with principle of equal pay for work of equal value, conditions of service the same for staff in the same grades & the same length of service	Data on pay distribution by gender, ethnicity and pay band Exception reports relating to job matching and evaluation Data on reviews/appeals	**Direct measure** Human resources (HR) system data, equal opportunities monitoring and staff perception as measured by survey; ie, before and after surveys	**Local data** Various HR/payroll systems data Healthcare Commission: staff attitude survey	Need baseline and post-assimilation
Short term	**Better pay** – higher NHS minimum wage, majority of staff with access to higher max pay rates under the new system	Review of impact on staff earnings and prospective earnings compared with previous national and local systems	**Direct measure** Implicit within the construction of the new pay system	**National data** National earnings data	To be tested nationally
Short term	**Better career development** – appraisal and personal development plans (PDPs) for all staff, wider access to training opportunities, and more staff progressing to new and more demanding roles	Data on use of Knowledge and Skills Framework (KSF) and development reviews, and support for training and development	**Direct measure** Following KSF implementation it may be possible in longer term to track monitoring of Gateways, eg, number through or not/attrition rates Staff survey baseline of extent of appraisal systems in place	**Local data** HR systems Healthcare Commission: staff attitude survey	Baseline required Examples and narrative

Time frame	Success criteria	General approach to measurement	Assessment of criteria	Data source	Good practice
Medium term	**Better recruitment & retention** – reduced turnover and vacancy rates and reduced attrition from training	Data provided to boards on turnover, starters and leavers, and vacancy rates	**Direct measure** Direct comparable data available Baseline of turnover /vacancy data Higher Education Institution attrition data	**National data** Workforce census and vacancy survey Strategic health authority (SHA) level	Organisation to have a workforce strategy that feeds into local delivery plans Use Sept 2004 as baseline
Medium term	**Improve all aspects of equal opportunity and diversity** including access to NHS careers, training and working patterns	Data on equality and diversity policies, eg, IWL in England, implementation of Disability Standard, development of childcare strategies and Race Equality Scheme, staff attitude surveys	**Direct measure** Staff attitude pre- and post-assimilation Baselines of current training and working patterns and monitoring of exceptions under new system	**National data** Healthcare Commission: staff attitude survey	February 2005 September 2004 results
Medium term	**Better morale** – higher staff satisfaction with remuneration and careers, reduction in sickness and absence, more staff actively involved in continuous service improvement in partnership with employers	Data on: improved recruitment and retention rates (*see* above); sickness absence trends; staff survey outcomes; service improvement activities/trends	**Direct measure** Surveys pre- and post-implementation	**Local data** Healthcare Commission: staff attitude survey	Baseline required Examples and narrative
Medium term	**Better teamwork / breaking down barriers** – the creation of additional posts involving new roles, leading to shorter care pathways and fewer adverse incidents due to poor teamwork (such as appointment cancellation)	Organisational data relating to: numbers of new roles and existing staff doing things differently facilitated by Agenda for Change system Impact on care pathways	**Indirect and direct measures** Data available through project teams/local reports/strategies, etc Counts of newly created posts/new roles that are related to patient	**Local data** New Ways of Working and role redesign teams: opportunistic and planned Agenda for Change enabler projects Examples of new posts, etc	Include patients, patient representatives and carers in all redesign projects Use the Modernisation Agency 10 key change principles as a guide to focus service redesign

Time frame	Success criteria	General approach to measurement	Assessment of criteria	Data source	Good practice
		Impact on cancellation rates	pathways (before and after) Counts of adverse incidents related to poor teamwork	Measure composition of teams and level of teamworking across organisation Changes in % staff in each of nine pay bands over a number of years. Needs baseline assessment of % in each pay band at the completion of Agenda for Change	Examples and narrative (eg, increasing the role of medical secretaries has released x amount of consultant time)
Medium term	**Greater innovation in deployment of staff** – extended availability of services for patients, more sharing of tasks between team members and more staff in wider roles	Organisational data relating to: number of extended services, increased focus on new/extended roles; improved teamworking; appropriate skill-mix	**Indirect measure** More likely to be available in longer term and counted at local levels. No formal measuring systems exist Counts of extended availability of services Counts of 'changes' introduced by team changes/staff role expansion	**Local data** Service modernisation and role redesign teams	Build capacity and capability in organisational development and change management Use Organisational Development compendium by incorporating change management tools into work of project groups and workshops for people leading Agenda for Change project strands Local evaluation of new ways of working
Long term	**Higher quality care** – reforms should lead to higher average knowledge and skill levels and a reduction in both adverse incidents and patient complaints due to poor standards of service	Data provided to boards on complaints and adverse incidents Data on progress on KSF outlines supplied to SHAs in England Expenditure on training and development	**Indirect measure** Degree of attribution difficult to assess. Benefit likely to be quantifiable in medium term, eg, six months post-implementation of Agenda for Change	**Local data** Clinical governance systems, eg, data broken down into staff groups of number of adverse incidents and number of complaints	Ensure board and in particular directors of human resources, directors of modernisation/ commissioning have a joint strategic plan for benefit realisation

Time frame	Success criteria	General approach to measurement	Assessment of criteria	Data source	Good practice
		Clinical governance information systems, eg, number of development schemes initiated Tracking progress of patient complaints and adverse incidents via clinical governance systems; baselines can be obtained now		Expenditure on training and development % of time spent on learning and development	
Long term	**More patients treated more quickly** with pay reform contributing directly to delivery of shorter waiting times for patients in all aspects of NHS care	Data provided to boards on waiting times and trends	**Indirect measure** Agenda for Change will contribute to this through redesigned care pathways Can measure existing working hours and working hours under Agenda for Change and calculate additional activity within that Can measure availability of professionals measuring against retention rates Possible to measure investment in trainees – test the link between demand forecast and cost of training/ratios trained/worked hours and productivity Productivity improvement through employee empowerment	**National data** Hospital Episode Statistics data for, eg, average length of stay **Local data** Workforce statistics for participation data Agreement comparison to current workforce hours Some organisational productivity data available through NHS Information Authority 'Performance Investigator' see www.nhsia.nhs.uk	Provide regular reports to the trust board on outcomes of Agenda for Change for the service. Carry out a stock-take of modernisation projects. Understand drivers and benefits. Ensure that 'work-force designers' are trained in the modernisation agency new ways of working tool kits Check with local 'Collaborative' programmes or Changing Workforce Programme pilots Opportunistic modernisation initiatives and modernisation facilitated by Agenda for Change Baselines of 'hard' quantifiable evidence on organisational productivity data could be obtained now

Source: Department of Health , 2004

Appendix 2:
Summary of key elements of Agenda for Change

PAY BANDS

Pay band	Job weight	Pay range at 1 April 2006
1	0–160	£11,782 to £12,853
2	161–215	£12,177 to £15,107
3	216–270	£14,037 to £16,799
4	271–325	£16,405 to £19,730
5	326–395	£19,166 to £24,803
6	396–465	£22,886 to £31,004
7	466–539	£27,622 to £36,416
8a	540–584	£35,232 to £42,278
8b	585–629	£41,038 to £50,733
8c	630–674	£49,381 to £60,880
8d	675–720	£59,189 to £73,281
9	721–765	£69,899 to £88,397

Source: NHS Employers 2005b

Each pay band consists of a number of pay points, and staff progress from point to point on an annual basis to the top point of their pay range or pay band, provided their performance is satisfactory and they can demonstrate the agreed knowledge and skills appropriate to that part of the pay range or band. There are special arrangements for new entrants to band 5.

Terms and conditions
Agenda for Change also harmonised terms and conditions of employment:
- Standard working hours for full-time staff of 37.5 hours a week, excluding meal breaks, although protection and assimilation arrangements mean that this will not be fully achieved until December 2011.
- Single harmonised rate of time-and-a-half for all staff in pay bands 1 to 7 eligible for overtime payments, and double time for overtime on general public holidays.
- Annual leave entitlement (excluding 8 public holidays) of 27 days on appointment, rising to 29 days after 5 years' service and to 33 days after 10 years.

Appendix 3: Summary analysis of the NHS national staff results 2003 to 2006

The results of our analysis of the staff survey results are summarised in the main part of the report. This appendix includes details of our other analysis and discusses the influence of trust size and variations in staff survey results by region, by staff group and by gender and ethnic background. All data is taken from the Healthcare Commission website.

New job outlines/descriptions
Overall, 73 per cent of staff in acute trusts reported receiving a new job outline or description (compared to 74 per cent in all trusts) and 15 per cent had not received this, while 6 per cent did not know and a further 7 per cent said that Agenda for Change did not apply to them (because, for example, they were medical and dental staff or senior managers). The results for individual acute trusts varied significantly – in the East Lancashire Hospitals NHS Trust, 88 per cent of staff reported receiving a job outline or description while only 56 per cent of the University Hospital Birmingham NHS Foundation Trust's staff said they had received this.

Satisfaction with information received
Staff were generally divided as to whether they were satisfied with the information they had received from their trust about Agenda for Change. Some 35 per cent agreed (or strongly agreed) they were satisfied but 29 per cent disagreed (or strongly disagreed), and 29 per cent neither agreed nor disagreed. A further 7 per cent said Agenda for Change did not apply to them.

At least half of the staff were satisfied with the information received at the Royal National Hospital for Rheumatic Diseases NHS Trust (53 per cent) and Aintree University Hospitals NHS Foundation Trust (50 per cent), but only 12 per cent of staff at Sheffield Teaching Hospitals NHS Foundation Trust were satisfied.

Influence of size of trust on implementation process
The staff survey results suggest that there may be a relationship between the size of the organisation and staff views on the success of the implementation (and outcomes) of Agenda for Change in that staff tend to have more positive views in smaller acute trusts. This may reflect the increased difficulty in implementing Agenda for Change in larger organisations.

The table at the top of p 35 shows the positive views of staff on Agenda for Change in the survey by type of acute trust.

Type of acute trust	New job outline	Fair banding	Successful implementation	Satisfied with information	Increased responsibility
All acute	**73%**	**41%**	**25%**	**35%**	**21%**
Acute teaching	68%	37%	20%	31%	22%
Large acute	74%	41%	21%	33%	21%
Medium acute	73%	40%	25%	35%	21%
Small acute	75%	44%	28%	38%	21%
Specialist	70%	43%	32%	40%	23%

Regional variations

The staff survey results also suggest that there may be some regional variations in the results on implementation.

Data suggest that staff in the trusts in the North East and North West strategic health authority (SHA) regions, for example, have a more positive view of Agenda for Change implementation than their counterparts in, say, Yorkshire & Humberside.

Region	New job outline	Fair banding	Successful implementation	Satisfied with information	Increased responsibility
E Midlands	73%	42%	22%	34%	21%
East	71%	41%	25%	35%	19%
London	71%	37%	28%	36%	25%
North East	77%	43%	22%	37%	22%
North West	75%	43%	24%	37%	23%
South Cent	71%	42%	25%	33%	20%
SE Coast	75%	42%	27%	35%	20%
S West	74%	41%	24%	36%	19%
W Midlands	73%	44%	25%	35%	21%
Y & H	69%	38%	18%	30%	18%

Variations by staff group

The results also suggest some differences in staff views according to their staff groups. Some staff groups in acute trusts were less likely to say they believed their new Agenda for Change pay banding was fair, and these included groups such as nursing assistants or

health care assistants (32 per cent – although 28 per cent did not know), administrative and clerical staff (40 per cent) and infrastructure staff (42 per cent).

Overall, 48 per cent of registered nurses and midwives and 52 per cent of allied health professionals, health care scientists and scientific and technical staff in acute trusts thought their banding fair.

Variations by gender and ethnic background

Agenda for Change is designed to deliver equal pay, and the staff results are also analysed by the gender and ethnic background of respondents in acute trusts. However, these are more difficult to interpret, and there are some problems in using the results as evidence of staff views of success in achieving this.

Some 44 per cent of women in acute trusts thought their Agenda for Change banding was fair (compared to only 31 per cent of men in acute trusts) but women were also more likely to believe their banding was not fair (36 per cent compared to 32 per cent for men). Overall, 25 per cent of women agreed (or strongly agreed) that Agenda for Change was implemented successfully in their acute trust, compared to 22 per cent of men.

Black and minority ethnic staff were less likely to believe their Agenda for Change banding was fair (only 26 per cent thought this, compared to 43 per cent of white staff) but they were also less likely to believe their banding was not fair (29 per cent compared to 35 per cent for white staff). The most important difference was that significantly more non-white staff responded that they did not know whether their banding was fair (30 per cent gave this response compared to 13 per cent of white staff).

Appendix 4: Case study NHS trusts in England, conducted March 2007 – May 2007

- Case study 1: teaching hospital in the South East
- Case study 2: acute specialist trust in the North West
- Case study 3: acute trust in the South East
- Case study 4: acute trust in Yorkshire & Humberside
- Case study 5: acute trust in the North West
- Case study 6: acute hospital in the South East
- Case study 7: acute teaching trust in London
- Case study 8: teaching trust in London
- Case study 9: acute trust in the South West
- Case study 10: acute trust in the South West

Note: 4 trusts had foundation status at the time of case study

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Agenda for Change is the most ambitious pay reform introduced into the NHS. In addition to simplifying the system of pay, its objectives were to improve the delivery of patient care as well as staff recruitment, retention and motivation. This paper examines progress in implementation based on interviews with key national informants and on case studies in 10 NHS trusts. The report highlights unrealised potential in achieving positive changes to NHS care and makes a number of recommendations for action at national, SHA and NHS trust level.