

3.8 Workforce and pay

A key element of health and social service delivery is the recruitment, retention and motivation of sufficient numbers of appropriately skilled staff. Health and social services are labour intensive sectors, with direct staff costs accounting for around two-thirds of total spending. Therefore, whilst the workforce is critical to delivery, it is also important to make every effort that the significant costs associated with this input are minimised as far as possible, while balancing the demands of the system, patients, taxpayers and staff.

The importance of workforce issues is reflected in the focus of a number of major reports and reviews recently. The **Wanless Review**⁸⁸, for example, indicated that a significant increase in health care staff will be required over the next 20 years to deliver a new 'vision' of care envisaged by the review. In addition, workforce issues were considered as part of the 2002 **Needs and Effectiveness Evaluation**⁸⁹. More recently, the DHSSPS has published results from a series of uni-professional workforce reviews, whilst the Department of Finance and Personnel has produced a **Pay and Workforce Strategy** for the Northern Ireland Executive Departments with a major focus on health⁹⁰.

Here we consider the current availability and future requirements of staffing resource for health and social services in Northern Ireland and whether these resources could be used more effectively and efficiently. It is important to note at the outset that unlike other aspects of health and social care services where distinct Northern Irish policies are developed, in terms of the pay and conditions of staff, Northern Ireland tends to mirror the position in Great Britain.

3.8.1 Historic staffing trends and comparisons

Currently, there are around 110,000 people employed in health and social care in Northern Ireland, equivalent to nearly 6.4% of the entire population and around 28% more than in the UK as a whole⁹¹. In turn there are approximately 68,000 people employed directly as public servants in NHS Trusts in Northern Ireland⁹². In addition, of course, there are thousands of people providing care and support in the form of charities, friends and relations, without whom the formal health care system would be under unsustainable pressure.

⁸⁸ Securing our Future Health: Taking a Long-Term View, Final Report of the Wanless Review, April 2002

⁸⁹ Effectiveness Evaluation: Health and Social Care, DHSSPS

⁹⁰ Northern Ireland Pay and Workforce Strategy 2004, DFP

⁹¹ There are 3 million employee jobs in SIC N (Health & Social Work) in the UK as a whole equivalent to 5.0% of the population.

⁹² The main difference between the two figures are those employed in the provision of social services but not by the public sector, including those working in independent nursing and residential homes- however, to the extent that the public sector funds such services, these workers can be considered to be indirectly employed by the public sector. The latter figure also does not include GPs, Pharmacists, Dentists and Opticians working in Family Practitioner Services. .

Figure 3.75: Trends in health service employment in Northern Ireland are similar to those in other countries

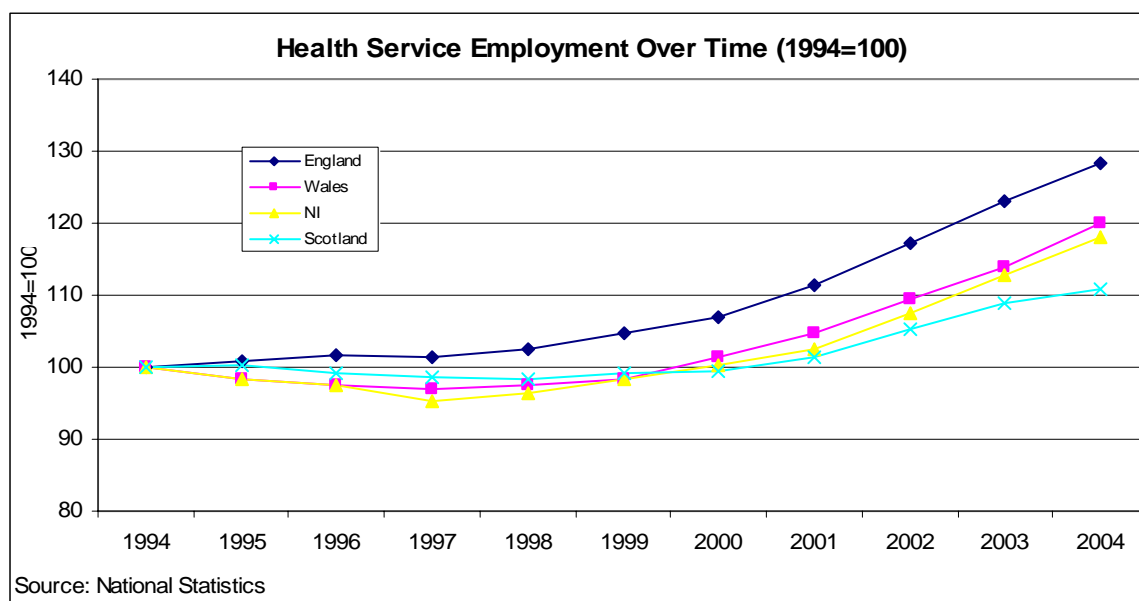


Figure 3.75 shows that in common with Wales and Scotland, Northern Ireland experienced a decline in NHS employment in the mid 1990's - possibly linked to the contracting out of services. More recently, all UK countries have experienced growth in numbers of health care staff, with England experiencing the fastest growth - although the base for England was, and remains lower.

Whilst differences in the coverage of workforce statistics for the UK countries makes overall comparisons of staffing levels difficult, Figure 3.76 compares the number of hospital and community health service (HCHS) staff, qualified nurses and medical & dental staff per head of population.

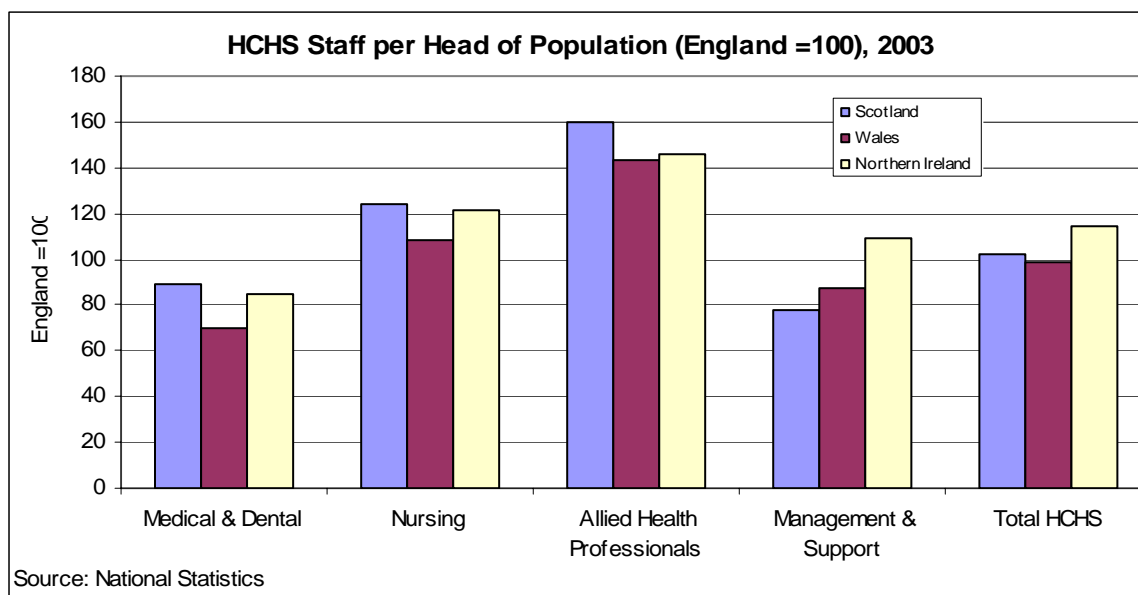
It can be seen that Northern Ireland has significantly higher levels of total HCHS staff per head of population than the rest of the UK. However, as the Interim Wanless Report highlighted, the UK as a whole has substantially fewer doctors and nurses than many other western industrialised countries⁹³. Although it may be the case that England has too few health care staff rather than Northern Ireland having too many, the public sector funding parameters currently applying in the UK mean that it is the position in England that is most relevant when considering Northern Ireland's relative level of provision.

A particular issue in the Needs and Effectiveness Evaluation was the level of administrative & clerical staff in the Health & Personal Social Services (HPSS) sector. It was shown that this staff group accounted for broadly the same share of overall HPSS staff in Northern Ireland as England in 1999. However, between 1999 and 2003 the number of administrative & clerical staff increased by 20% in Northern Ireland compared to just under 3% in England - which meant that there were 43% *more* administrative & clerical staff per head of population employed in the HPSS sector in Northern Ireland than in England (although at least part of this difference may be due

⁹³ Paragraph 11.17, Wanless Interim Report, HM Treasury

to definitional differences in the way staff are categorised between the two countries)⁹⁴.

Figure 3.76: Northern Ireland has over 10% more HCHS staff per head of population than England

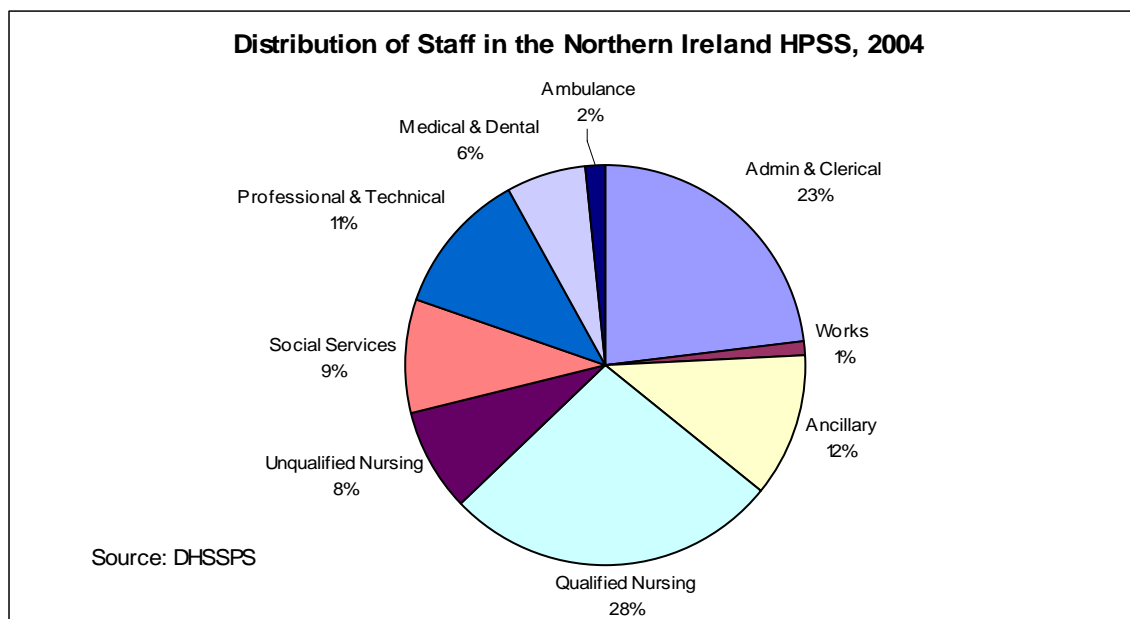


In terms of the major staff groups employed outside of the HCHS, there are 6% more GPs per head of population in Northern Ireland than England and 4% more personal social services staff. However, Northern Ireland's staffing compliment for both these groups per head of population is lower than in Wales and Scotland.

Figure 3.77 shows that the largest grouping in the health and social care workforce is qualified nursing & midwifery staff (28%), followed by administration & clerical staff (23%). However, since 1994, the fastest growth in staff numbers has occurred in the professional & technical staff grouping - which includes physiotherapists, radiographers and dieticians.

⁹⁴ In 2003 Administrative & Clerical staff accounted for 22.8% of Health and Personal Social Services staff in Northern Ireland compared to 14.5% in England.

Figure 3.77: Nurses and administration and clerical staff made up over half of the entire health and social care workforce in 2004.



3.8.2 Future staffing needs

For England, the Wanless Review projected a need for an additional 62,000 doctors, 108,000 nurses and 74,000 health care assistants over the next 20 years. If these large increases are translated to Northern Ireland, then even allowing for greater staffing now, Northern Ireland will also require a significant increase in staff to provide the same level of service (although given its higher starting point, the increases will not need to be as great). Northern Ireland's share (based on 7% higher level of need) of the Wanless projections would suggest an additional 2,200 doctors, 3,900 nurses and 2,700 health care assistants by 2022. However, taking into account Northern Ireland's higher starting point would suggest an increase of only 2,170 nurses for example⁹⁵.

A consistent theme raised by staff representatives in this Review's consultations was the need for better workforce planning. Given that around half of the staff employed in the health and social care sector in Northern Ireland are in regulated professions which require lengthy periods of training, it is essential that there is adequate workforce planning in place to ensure that supply meets demand. It is the role of the department - in conjunction with the local universities - to ensure that sufficient training places are made available in order to meet future staff requirements.

The Needs and Effectiveness Evaluation indicated that health and social care workforce planning in Northern Ireland had been somewhat underdeveloped in the past. In particular, during the 1980s poor planning meant that too many staff were

⁹⁵ The Wanless Projections would suggest that there will be approximately 413,000 nurses in England in 2022, or 7.62 per 1,000 population. Given that there are currently 7.42 nurses per head of population in NI, and adjusting for population change and need, this would suggest an additional 2,170 nurses.

being trained relative to the demand from the health and social care services (which are, in essence, a monopsonist for such labour). In response, during the 1990's there were reductions in the number of training places - with the result that there were perceived to be labour shortages. Whilst there is waste in funding training when there may not be the opportunity to use the skills developed, it is not clear why demand should exactly meet supply for certain public sector professions when it is not the case for most other professions. The additional cost of training is likely to be lower than the premium paid to health care professionals resulting from the tight labour market that has been a feature of the current system.

To improve the standard of workforce planning, in 2001 the DHSSPS commenced a series of uni-professional workforce reviews covering the main groups employed in health and social care - including the main clinical professions.

The main purpose of these workforce reviews was to provide medium term projections of the demand and supply for each profession. The need for staff was expected to increase if increasing health and social care demand were to be met (as a result of an ageing population, changing roles as well as service developments). Supply was expected to fall - due in general to the numbers entering the workforce not being sufficient to balance those leaving. Overall, the workforce reviews projected significant shortfalls in the supply of professional staff by 2006. However, the subsequent *Pay and Workforce Strategy* suggested that the former projections exaggerated the scale of shortfall and that there would be merit in considering the approach to workforce planning in England where there was greater emphasis on policies to ensure that supply met demand (for example, through changes in skill mix, retention policies etc). Whilst the recently produced revised workforce review for nursing has taken on board a number of these criticisms, the approach remains less pro-active than in England⁹⁶. For example, it is assumed when modelling future supply that no progress will be made in reducing the attrition rate from degree courses whilst the anticipated productivity growth is less than in England.

Although there is likely to be a requirement for additional health & social care staff in the coming years, the increase needed may not be as great as that suggested by DHSSPS. Further, it is important to ensure that the existing staff resources are used effectively and efficiently before significantly increasing these inputs.

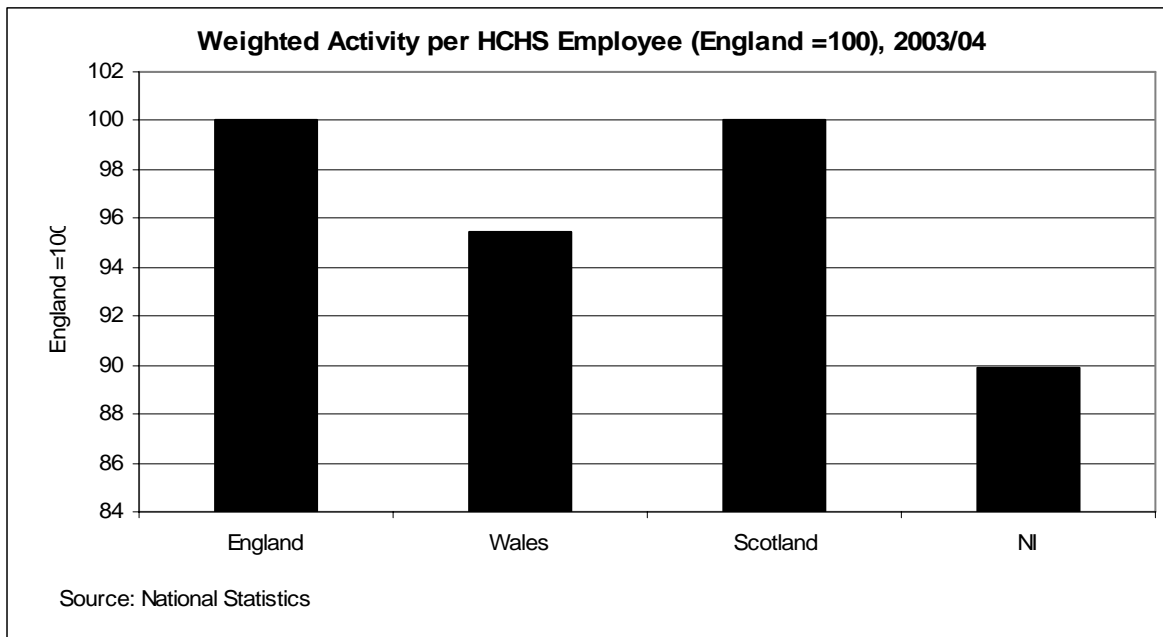
3.8.3 Effectiveness, efficiency and productivity

It is beyond the scope of this study to consider in great detail the extent to which staff are used effectively and efficiently in Northern Ireland as this would require detailed micro analysis of working patterns. However, as figures 3.60-3.63 in section 3.71 on Efficiency indicated, given that staffing levels are significantly higher than in England, whilst activity levels are slightly lower, this would suggest that productivity could be improved. Figure 3.78 below shows that weighted activity per HCHS employee is 10% lower in Northern Ireland than England. Whilst there are many arguments that could be employed to explain the lower level of productivity in Northern Ireland - such as policy decisions to reduce access times associated with the geography of Northern Ireland, increased health and social care demand arising from high levels

⁹⁶ Review of Workforce Planning for Nursing Midwifery and Health Visiting Final Report February 2005, DHSSPS

of deprivation, and poor development of ICT – it is not clear how significant each is in explaining the variation.

Figure 3.78: The level of weighted activity per HCHS Employee is 10% lower than in England, 2003/04.



Interestingly, figure 3.79 shows that the productivity of the health & social care sector in Northern Ireland has followed a similar trend to the rest of the UK in recent years. Productivity rose up until 1997/98, since when it has declined as activity has increased at a slower rate than the resources available. Overall, productivity in the health & social care sector has fallen at a faster rate in Northern Ireland than England and Scotland since 1994/95.

The productivity of consultants, as measured by the number of inpatient and day case finished consultant episode per consultant, follows a slightly different pattern. Figure 3.80 shows that the productivity of consultants was falling before 1997/98. Northern Ireland has experienced the smallest fall throughout the UK in productivity over this period so that the productivity of consultants is higher than in Scotland & Wales but remains (around 7.4%) lower than in England.

Figure 3.79: Northern Ireland has followed a similar trend over time to the rest of the UK in terms of HCHS labour productivity.⁹⁷

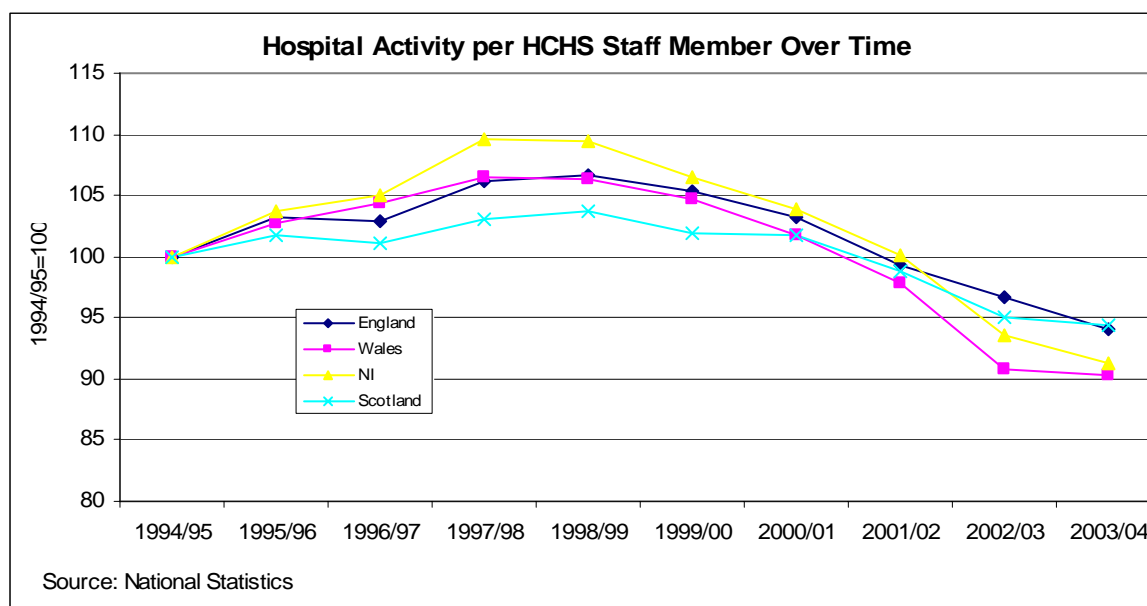
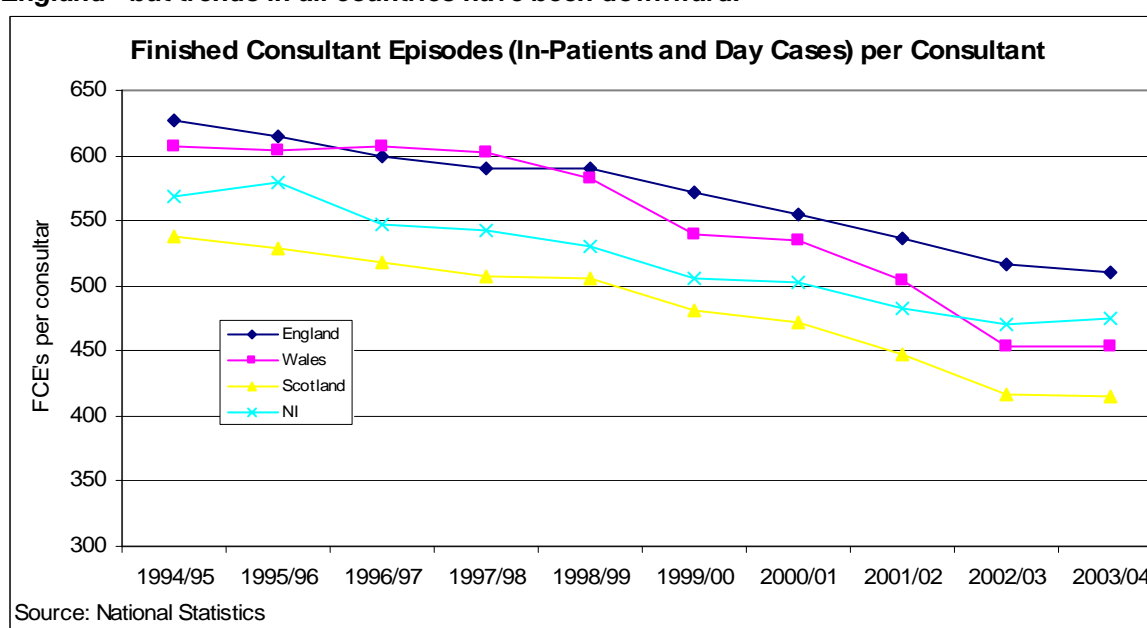


Figure 3.80: The number Finished Consultant Episode (In-patients and Day Cases) per consultant is currently higher in Northern Ireland than Scotland & Wales but lower than in England - but trends in all countries have been downward.



The need to improve labour productivity has been recognised. For example, **Budget 2005-2008** indicated that £225m out of the £474.2m efficiency savings over the next three years will come from the more productive use of health and social care professionals' time. These savings would fund increases in front line capacity (costing £135m) and the quality of services (costing £90m). However, this Review would note that it is not clear from the information set out in the accompanying **Efficiency Technical Notes** how the improved service will be achieved. Indeed, the

⁹⁷ Labour Productivity Index is derived by index of total weighted activity (as set out in Figure 3.9) divided by index of NHS employment. Whilst differences in methodology mean that it would not be appropriate to compare levels of productivity the chart is intended to be indicative of general trends.

main activity appears to be the collection of data on performance which, although valuable, in itself will not directly lead to significant improvements.

The **Northern Ireland Regional Strategy**⁹⁸ indicates that productivity improvements in the health & social care sector are expected to come from reduced demarcation; nurses and allied health professionals taking on some of the roles and activity of doctors, and health care assistants taking on some of the roles of nurses. The main focus on implementation revolves around joint aspects of training for medical and nursing staff with the intention of changing behaviours and attitudes towards multi professional working.

The **Needs and Effectiveness Evaluation** indicated that the level of absenteeism in Northern Ireland Trusts ranged from 3% to 7%, with an estimated overall average of 6% compared to 5% in England. Despite a requirement in Priorities for Action there appears to have been little success in reducing absenteeism rates (which currently range from 4% to 8% for Northern Ireland Trusts compared to an average of 5% for England⁹⁹). This issue was raised as part of the recent nursing workforce review, where the view was expressed that sickness policies need more rigorous enforcement, particularly after maternity leave.

Recommendation 21: Further investigation is required of possible reasons for relatively low labour productivity

3.8.4 Staffing costs

Although movement towards (lower) English staffing levels would result in higher productivity, this could be at the expense of quality of service. An alternative way to improve labour productivity and efficiency is to focus on the costs of staffing.

Health and social care staff in Northern Ireland generally enjoy the same terms and conditions as in the rest of the UK. It was argued in the **Needs and Effectiveness Evaluation** that this was necessary in order to recruit, retain and motivate staff. In addition, reducing the level of pay relative to the rest of the UK was expected to result in an increase in the number of staff leaving the system- no evidence has been produced to support these arguments.

Pay parity has become more critical in recent years due to the pay reforms initiated in England - such as Agenda for Change for non-medical staff and the new contracts for hospital consultants and general practitioners. These reforms have resulted in substantial increases in salaries, but with the prospect of changes in working practices, higher productivity and improved recruitment and retention of staff. A weakness of these reforms is that the costs are upfront and definitively set whilst the benefits in terms of service delivery tend to be more nebulous and longer term. Given the health and social care funding mechanism for Northern Ireland and a higher level of per capita staffing, implementing equivalent pay reform has placed significant resource pressures on spending in Northern Ireland - as noted earlier in section 2.2.3. Although Northern Ireland has, to date, managed to maintain pay

⁹⁸ *A Healthier Future- A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025*, DHSSPS

⁹⁹ NI figures are for October 03-March 04 whilst England figures are for 2003

parity whilst also maintaining higher staffing levels, recent pay reforms increasingly highlight the opportunity costs of maintaining such a policy.

Pay parity with the rest of the UK has been guaranteed for the past thirty years as a result of provisions in the 1971 Northern Ireland Finance Act, which indicates that the remuneration of persons employed in the health services in Northern Ireland correspond as close as possible with the rates for such services obtaining in Great Britain. In practical terms this has meant that whilst Northern Ireland was not covered under the remit of the relevant national Pay Review Bodies, the recommendations of terms and conditions from these bodies was taken up in Northern Ireland. This policy has continued, with the application of Agenda for Change reforms and changes to doctors' contracts applying equally in Northern Ireland as the rest of the UK. It needs to be recognised, however, that these particular reforms were designed and introduced in response to specific problems in England, problems which may not have occurred to the same extent in Northern Ireland.

Local pay flexibility

In 2003 the Government issued guidance¹⁰⁰ indicating that, within existing national bargaining frameworks, public sector pay should be based on local labour market conditions. In taking this forward, the terms of reference for the national Pay Review Bodies were amended to take into account local factors in their deliberations. Such local labour market conditions include vacancy rates, regional price indices and the pay gap between public and private sectors. Given that Northern Ireland is not covered under the remit of the Pay Review Bodies it is not clear how the Government's policy will be applied with respect to Northern Ireland. However to date there has been little progress in Great Britain, with local pay variations arising mainly in the form of additional payments for high cost areas, whilst the logic of the policy would be to have lower pay levels in low cost areas.

There has been considerable debate as to whether the 1971 Finance Act still implies a statutory requirement to retain pay parity. In particular, it has been argued that the change in policy means that in effect there is no longer a GB-wide settlement for Northern Ireland to retain parity with. However, the local pay policy guidance clearly indicates that national bargaining frameworks will remain. Until there is a break from parity for other regions of the UK, it is likely to be highly controversial to implement such a policy in Northern Ireland. Nevertheless, it is worth reviewing some of the evidence that bears on this issue:

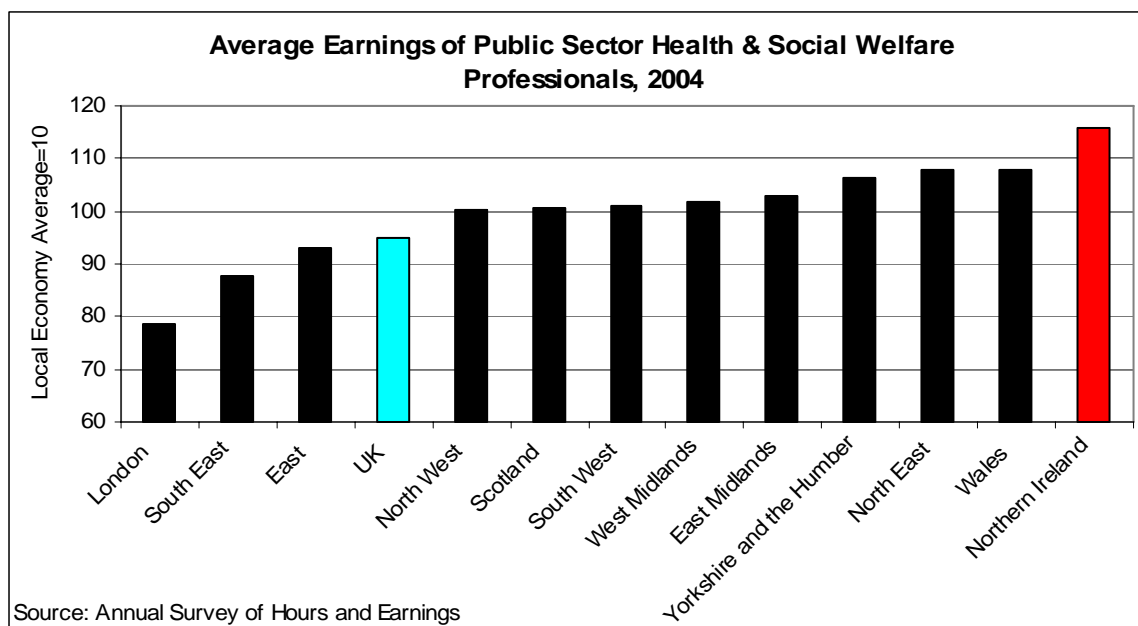
1. Public and private sector earnings gaps

The 2004 **Pay and Workforce Strategy** for the Northern Ireland departments set out analysis illustrating that the gap in earnings between the public and private sectors in Northern Ireland was higher than the rest of the UK. Whilst part of the gap could be explained in terms of the security situation in Northern Ireland and occupational structure, a significant differential remained. Figure 3.81, for example, compares the average earnings of Associated Health Professionals

¹⁰⁰ Government Guidance Note on Progressing Local Pay (October 2003), HM Treasury

with the economy average level of earnings for the UK regions¹⁰¹. It can be seen that for most UK regions the level of earnings for Associated Health Professionals working in the public sector is higher than the economy wide average. However, the differential is greatest for Northern Ireland, where average earnings are 16% higher than the economy average.

Figure 3.81: Average earnings of Health and Social Welfare Associate Professionals working in the public sector are 16% higher than for the economy as a whole in Northern Ireland.¹⁰²



In terms of specific professions, the 2004 **Annual Survey of Hours and Earnings** (National Statistics) shows that the average weekly gross pay of female nurses is 23% higher than the average for full-time females as a whole in Northern Ireland whilst the earnings of medical practitioners are almost three times higher than the Northern Ireland average. Although not all people have the appropriate skills to become doctors or nurses it would appear that the health care sector is a relatively attractive career option in the Northern Ireland labour market.

2. Labour migration

One of the main arguments against the break from pay parity is that it would result in significant numbers of staff migrating from Northern Ireland. In particular, most health care staff have transferable skills and might be considered more mobile than the rest of the population. Although it has been suggested that the increase in public sector salaries in the Republic of Ireland in recent years has led to migration of public sector workers from Northern Ireland, there is little evidence to indicate the such transfers have been significant.

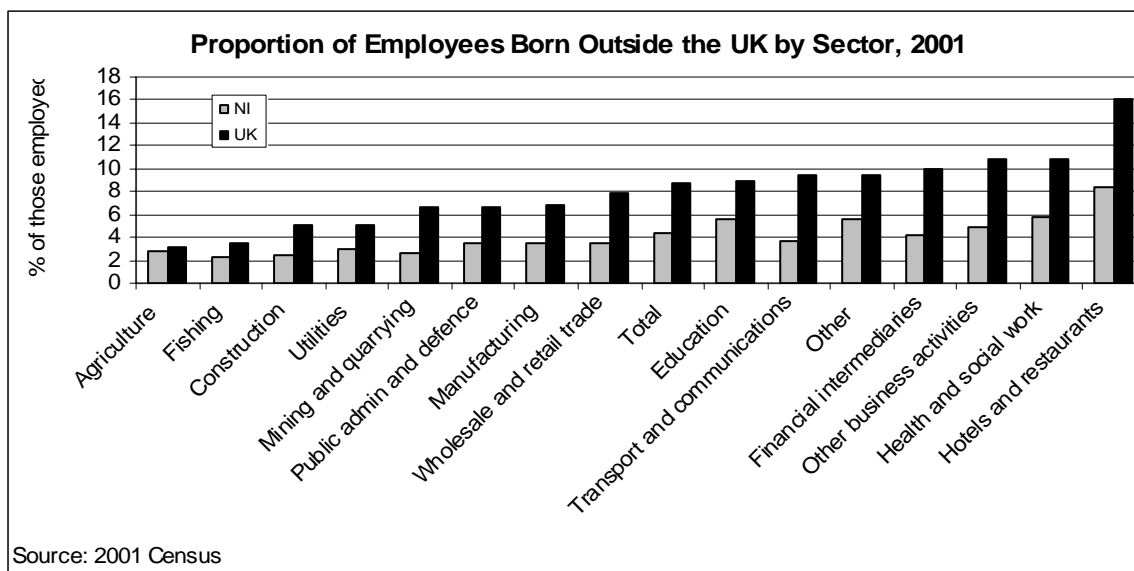
The main movement of staff in the health & social care sector has been from other countries into Northern Ireland. In 2002, approximately 3% of nurses registered in Northern Ireland were from overseas compared to 8% for

¹⁰¹ Health and social welfare associated professionals include Nurses, Midwives, Paramedics and Radiographers but exclude Doctors

¹⁰² Average (Mean) gross weekly earnings of full-time employees

England¹⁰³. There are currently 812 nurses from overseas employed by Northern Ireland Health Trusts, equivalent to 5% of nurses compared to over 10% for the UK as a whole¹⁰⁴. However, there is significant variation between Northern Ireland Trusts with overseas nurses accounting for a higher proportion of the total for the Mater, Royal and Ulster Hospitals.

Figure 3.82: Only 6% of those employed in the Northern Ireland health & social care sector were born outside of the UK compared to 11% for the UK as a whole



In terms of the overall number of health and social care staff, data from the 2001 Census indicates that 89% were born in Northern Ireland, 4% in England, 3% in the Republic of Ireland and 3% outside the British Isles. Figure 3.82 shows that whilst a higher proportion of Northern Ireland health & social care staff were born outside of the UK than the economy average, the share is significantly lower than for the UK as a whole. In addition, the differential is even greater with respect to those born outside of the EU who account for over four times the share of staff in the UK as they do in the Northern Ireland health and social care sector.

Therefore, whilst Northern Ireland has an increasing reliance on overseas staff, this remains to a lesser extent than in the rest of the UK.

3. Pay and cost of living differences

A further argument is that it would be unfair for someone doing the same job in Northern Ireland to be paid less than in England. However, the cost of living is generally lower in Northern Ireland than the rest of the UK with the result that real wages are currently higher in Northern Ireland.

Whilst the 2004 **Pay and Workforce Strategy** indicated that the cost of living was nearly 10% lower than the UK average, more recent figures for 2004 indicate that prices are only 5% lower in Northern Ireland. Figure 3.83 below shows that the earnings of Associated Health Professionals working in the

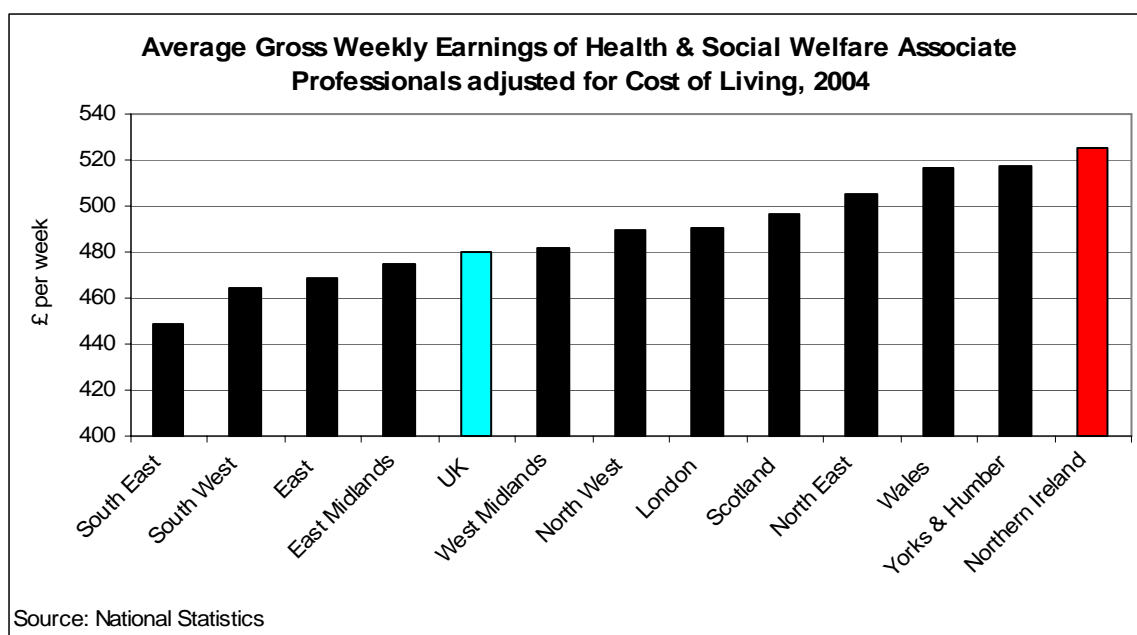
¹⁰³ Here to Stay? International Nurses in the UK, RCN

¹⁰⁴ The February 2005 Review of Nursing Workforce Planning indicated that there were 42,000 overseas nurses currently working in the UK.

public sector in Northern Ireland are the highest of UK regions after adjusting for the lower cost of living.

However, these cost of living figures are an average across the whole economy; there are significant variations between income standards due to housing costs. For example, the required income for the lowest income standard is estimated to be 9% lower than the UK average in Northern Ireland, whilst that for the highest is 28% lower¹⁰⁵. Therefore, for the more mobile health care staff there is likely to be a significant cost advantage from living and working in Northern Ireland relative to the rest of the UK.

Figure 3.83: The Average Gross Weekly Earnings of Health and Social Welfare Associate Professionals Adjusted for Cost of Living is highest of all UK regions



4. Vacancy rates

Whilst there are a number of complications in comparing vacancy rates for health care staff across UK countries, Table 3.5 provides a broad comparison.

Overall vacancy rates in Northern Ireland are lower than England and Wales - in particular, for nursing and medical & dental staff¹⁰⁶. Significant progress has been made in reducing vacancies in recent years in part due to significant recruitment of overseas doctors and nurses.

¹⁰⁵ Figures from Croner Reward Cost of Living Regional Comparisons March 2004

¹⁰⁶ More recent figures from the Nursing Workforce Review suggest that the 3 month vacancy rate for nurses rose to 1.5% in Northern Ireland in 2004.

Table 3.5: 3-month vacancy rates in Health Service for England, Wales and NI

Category	NI (Jun 04)	Wales (Mar. 04)	England (Mar. 04)
Medical and Dental of which consultant ¹⁰⁷	1.9 3.2	7.9 8.8	4.3 4.4
Nursing, Midwifery and Health Visiting	1.4	2.1	2.6
Social Services	0.9	N/a	N/a
Admin and Clerical	0.6	N/a	N/a
Professional and Technical	1.8	2.4	3.4
Other	0.9	1.4	1.3
All Staff excluding Social Services	1.3	2.1	2.2

Source: DHSSPS, NHS, NAW

5. Labour supply and training

The picture in terms of recruitment is slightly more confusing, as the recruitment procedure begins when the choice is made for degree course. Figure 3.84 shows that the number of applicants per acceptance for degree courses for Professions Allied to Medicine was higher than that for the rest of the UK¹⁰⁸. However, the ratio for medicine & dentistry courses at Northern Irish institutions was significantly lower than the rest of the UK¹⁰⁹. This latter ratio of around 3:1 is not viewed by DHSSPS as being particularly low and the view from the consultation process was that recruitment was not a significant problem.

A possible reason for the lower ratio might be that Northern Irish students are selecting not to go into medicine because of the higher qualifications requirements. As a broad indication of this, 94% of successful Northern Irish applicants to medicine & dentistry degree courses had the equivalent of three 'A' Level passes at A grade or better, compared with 84% for the UK as a whole¹¹⁰.

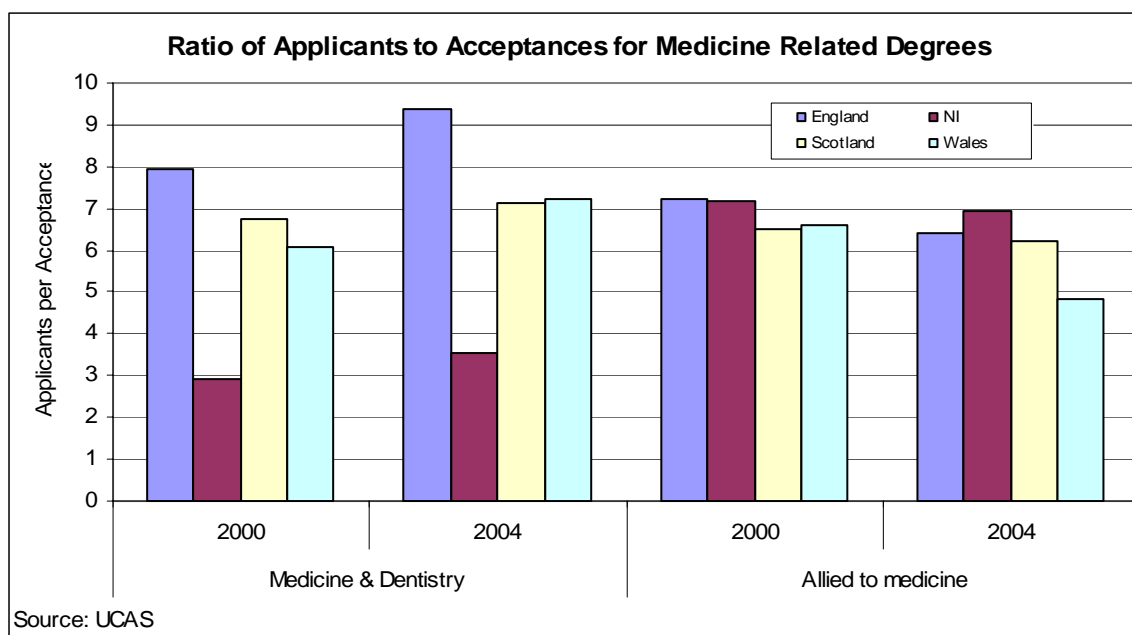
¹⁰⁷ Consultant data is for September 2003. DHSSPS have indicated that the rate is now in the region of 7%.

¹⁰⁸ There was some variation between the professions allied to medicine with Nursing (2.85) having a lower ratio than Physiotherapy (7.89), Dietetics (6.11), Occupational Therapy (7.10), Podiatry (7.07), Radiography (7.23) and Speech & Language Therapy (12.87)

¹⁰⁹ For Medicine alone the ratio was 3.73:1

¹¹⁰ In terms of Allied to Medicine Degree Course which includes Nursing, Ophthalmics and Pharmacology the percentages were 35.2% for NI and 23.7% for the UK.

Figure 3.84: The Ratio of Applicants to Acceptances for Medicine Related Degree Courses is lower in Northern Ireland than the rest of the UK



6. General Labour Market Conditions

In terms of more general indicators of the public sector labour market, whilst there is a paucity of comparable data for the UK regions, the available evidence would tend to suggest that there is greater availability of labour for the Northern Ireland health and social care sector than the rest of the UK. Although unemployment has fallen towards the UK average, the employment rate remains the lowest in the UK, whilst Northern Irish schools are producing significant numbers of highly educated young people, suggesting that there is a greater potential supply of labour in Northern Ireland than the rest of the UK. Recruitment and retention issues are not likely to be more problematic in Northern Ireland than elsewhere, therefore.

Conclusion

Relative to England, the health & social care sector in Northern Ireland currently has a reasonable level of staffing capacity. Whilst Northern Ireland will require greater numbers of health care staff in the coming years, there is scope for using existing resources more effectively.

In looking to the future, an important issue, however, is whether Northern Ireland should continue to bear the opportunity costs of maintaining pay parity with the rest of the UK - particularly as the current system of public sector funding will make it increasingly difficult to both maintain parity and, for example, continue with higher staffing levels than elsewhere.

Whilst there is scope for work patterns to be more efficient, there is also potential to more closely align the levels of pay for health & social care staff with local labour.

market conditions (within existing national frameworks) without damaging the ability of the services to recruit and retain appropriate staff. Clearly, the issue of pay parity is sensitive, and it will be the case that any policy designed to tackle this will in turn need to be sensitive to staff morale and motivation; it may well be the case that for many professions in the services that it would be better to retain pay parity and that further, where, in the best interests of the system as a whole, parity is not retained, that alternative, non-financial benefits could be considered. However, from our consultations and consideration of the available evidence, there is a strong case that the main reason for past and predicted labour shortages has been an insufficient number of training places rather than the level of pay per se.

Recommendation 22: Health and social care workers in Northern Ireland should formally come under the remit of the relevant GB Pay Review Bodies: this will enable the Government's local pay policy to be implemented on an equal basis in Northern Ireland to the rest of the UK.