All in it together?
The executive pay bill in England’s NHS
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Introduction

Nursing staff in England have seen a steady real-terms cut in their pay packets over the last four years. Since the Coalition came into power in 2010, nursing pay has lagged up to eight per cent behind inflation, an average real terms cut of over £2,600. This year, most nurses won’t be getting a pay rise at all, and those that do will get an average of less than £5 per week. As a result, staff are finding it more and more difficult to make ends meet, and morale in the profession has hit an all-time low.

Yet while they – some of the lowest paid employees in the public sector – struggle to keep pace with the rising cost of living, the RCN hears regular reports of senior NHS executives receiving generous salary increases and bonus payments. In other words, people already on the highest salaries in the health service are seeing their rewards accelerating ahead of the earnings of the staff they lead.

The Government has made it clear that NHS employers should show responsibility and restraint in setting the pay of the most senior staff, and contends that most employers are in fact doing this. But the picture seen by the RCN is very different.

We set out to investigate the extent to which NHS executive team costs are accelerating ahead of staff salaries, and whether or not the most senior managers in the health service are leading by example on pay restraint.

Using data secured under the Freedom of Information Act, this report All in it together? The executive pay bill in England’s NHS, clearly shows that over the last two years, executive team costs (pay, bonuses and other rewards) have been rising significantly faster than the salaries of nursing staff. While nurses, midwives and health visitors’ earnings have risen by an average of 1.6 per cent, executive costs in the trusts which responded to our request rose by over six per cent, with some parts of the country seeing inflation of executive rewards running at almost 15 per cent. Increases varied according to the type of trust; we found the biggest increases in executive pay bills in acute specialist trusts, where the average overall rise was 13 per cent.

From all the NHS trusts that responded to our Freedom of Information Act (FoI) request, 50 per cent had awarded salary increases of at least £5,000 to one or more executive director and a quarter had awarded increases in benefit in kind payments to at least one or more executive directors. There were also numerous examples of executives being paid substantial bonuses on top of their salaries, with two chief executives receiving bonuses of at least £40,000 – more than a senior ward sister or district nurse will earn in a year.

Frontline staff accepted that pay restraint was part of seeing the NHS through economic hard times; that they were ‘all in it together’, but it appears that many managers were exempting themselves from the same stricture. Little wonder, then, that nurses are feeling demoralised and undervalued.

There are many examples of excellent management in the NHS and those trusts and executives that have acted responsibly are to be commended.

The RCN urges all employers to lead by example and ensure that the rewards for their executive teams mirror those given to the rest of their workforce.
1. Methodology

On 11 February 2014, the RCN sent a request under the Freedom of Information Act 2000 to 235 NHS provider trusts in England, asking them to provide the total 'employee expenses for executive directors'. The NHS Manual for Accounts, Accounts Completion Guidance (Department of Health, 2013) defines this as “the cost of the Executive team members, as defined by the Trust. This includes their gross pay including employer pension and National Insurance contributions (NICs), any termination benefits paid less costs that have been capitalised and charged to capital schemes” (see explanatory notes below).

The information that we requested was closely aligned to the statutory format required for the completion of published annual accounts for each NHS trust. The request sought to minimise the burden on these NHS organisations by expressing a preference for information already held centrally as part of the preparation of each trust’s annual financial statements. In making the request we highlighted that there was a public interest in obtaining a better understanding of the remuneration of employees within NHS provider organisations.

Due to the tight timeframe for gathering the information, the trusts were asked to supply information from the first three quarters of the 2013 to 2014 financial year (April 2013 to December 2013), as well as a full year estimate. Where these trusts provided only financial year Quarter 1 to Quarter 3 data to us but not a full year estimate, an estimate has been produced based on extrapolating the nine month figure to a full 12 months.

The RCN’s analysis outlined in this report is based on a sample of 126 trusts which responded to the RCN’s FoI request, providing information in a usable format that was comparable to that presented in the statutory annual accounts for the two previous financial years.

In addition, where available, published audited remuneration reports from trust annual reports and accounts have been analysed to provide a more detailed analysis of changes to individual executive director pay.

Explanatory notes

The term employee expenses for executive directors includes salaries and wages, social security costs, employers’ contributions to the NHS Pensions Scheme, other pensions costs, other post-employment benefits, other employment benefits and termination benefits less the costs that have been capitalised. Under the NHS Manual for Accounts termination benefits will include redundancy payments, the costs of staff under the Mutually Agreed Resignation Scheme (MARS) and compensation for loss of office.

For further details on methodology please see explanatory notes for Tables 1 to 7 and also the additional notes in Appendix 1.
2. Analysis of reward levels for NHS executive directors

Table 1 provides the headline results from the RCN’s information gathering work on reward levels for NHS executive directors. This data enables us to get a more detailed picture by looking at the aggregate increases in costs for the executive director team as a whole.

Table 1: Mean annual executive team costs against UK inflation

<table>
<thead>
<tr>
<th>Measure</th>
<th>2011-12</th>
<th>2012-13</th>
<th>Annual increase (%)</th>
<th>2013-2014</th>
<th>Annual increase (%)</th>
<th>Two year increase (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean annual executive team costs per trust</td>
<td>£936,992</td>
<td>£949,437</td>
<td>1.3</td>
<td>£994,545</td>
<td>4.8</td>
<td>6.1</td>
</tr>
<tr>
<td>Inflation (CPI all items index)</td>
<td>-</td>
<td>-</td>
<td>2.8</td>
<td>-</td>
<td>1.7</td>
<td>4.5</td>
</tr>
<tr>
<td>Inflation (RPI all items index)</td>
<td>-</td>
<td>-</td>
<td>3.3</td>
<td>-</td>
<td>2.5</td>
<td>5.8</td>
</tr>
</tbody>
</table>

Explanatory notes for Table 1

a) The RCN has used the mean average as the basis for calculating the total costs attributed to executive director remuneration.

b) Annual pay for NHS executive directors is not centrally controlled and therefore the RCN has used the total aggregated costs for each NHS trust that are associated with executive director remuneration as shown annually in the statutory accounts. NHS trusts must follow the reporting requirements as published in the annual NHS Manual for Accounts, which is based on current financial reporting standards, adapted for the NHS.

c) To avoid confusion this report refers to the term ‘costs’ to collectively describe all the expenses incurred by the trust for rewarding executive directors for their services. These costs are shown in the ‘operating expenses’ section in the notes to the annual accounts.

Table 2 provides details on reward levels for the nursing workforce.

Table 2: Nursing workforce earnings against UK inflation

<table>
<thead>
<tr>
<th>Measure</th>
<th>2011-12</th>
<th>2012-13</th>
<th>Annual increase (%)</th>
<th>2013-2014</th>
<th>Annual increase (%)</th>
<th>Two year increase (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nurses, midwives and health visitors</td>
<td>£30,439</td>
<td>£30,657</td>
<td>0.7</td>
<td>£30,938</td>
<td>0.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Mean annual earnings per person</td>
<td>-</td>
<td>-</td>
<td>2.8</td>
<td>-</td>
<td>1.7</td>
<td>4.5</td>
</tr>
<tr>
<td>Qualified nurses, midwives and health visitors</td>
<td>£30,390</td>
<td>£30,544</td>
<td>0.5</td>
<td>£30,794</td>
<td>0.8</td>
<td>1.3</td>
</tr>
<tr>
<td>Mean annual basic pay per FTE</td>
<td>-</td>
<td>-</td>
<td>2.8</td>
<td>-</td>
<td>1.7</td>
<td>4.5</td>
</tr>
<tr>
<td>AfC Band 5 top increment (Point 23) FTE basic pay</td>
<td>£27,625</td>
<td>£27,625</td>
<td>0.0</td>
<td>£27,901</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Inflation (CPI all items index)</td>
<td>-</td>
<td>-</td>
<td>3.3</td>
<td>-</td>
<td>2.5</td>
<td>5.8</td>
</tr>
</tbody>
</table>

Inflation (RPI all items index)                       | -       | -       | 3.3                 | -         | 2.5                 | 5.8                   |
**Explanatory notes for Table 2**

Mean annual earnings per person and mean annual basic pay per FTE are provided for the qualified nursing, midwifery and health visiting workforce, working in NHS hospital and community services in England. These figures are sourced from monthly Health and Social Care Information Centre (HSCIC) earnings data (HSCIC, 2014). Figures for the full 2013 to 2014 financial year are estimated based on linear projection from available data April 2013 to February 2014.

- **Mean annual earnings per person** refers to the ‘mean amount paid to an individual in a 12 month period, regardless of the contracted FTE’, and is made up of basic pay for contracted hours and non-basic pay. Non-basic pay includes payments such as:
  - payments for additional activity, including time in lieu and redundancy payments
  - geographic allowances
  - local payments
  - on-call and stand-by payments
  - overtime payments
  - recruitment and retention premia
  - shift working and unsocial hours payments
  - other payments, including bonus/performance-related pay, non-statutory occupational absence payments, protected pay.

- **Mean annual basic pay per FTE** refers to annual pay for contracted hours, adjusted to a full time equivalent of 37.5 hours per week.

- **AfC Band 5 (Point 23)** – This illustrates the annual Agenda for Change pay settlements, and represents the change in annual full time basic pay for Band 5 NHS staff that have reached the top of the scale for their incremental progression.

Please see Appendix 1 for additional notes on the methodology used in Table 1 and Table 2.

**RCN commentary**

- The data indicates that over the last two years, NHS provider trusts have, on average, increased the amount they spend on their executive teams by 6.1 per cent, a far higher rate than the increase in average earnings of the nursing, midwifery and health visiting workforce, at 1.6 per cent.

- The data also illustrates that over the last two years, the costs of executive directors has tracked, and even outpaced measures of inflation. In contrast, earnings for nurses, midwives and health visitors have increased at rates far below inflation, resulting in a significant real terms erosion of earnings.

Tables 3 to 7 provide details of the average costs of executive teams for the financial years 2011/12 and 2013/14, showing the percentage increase or decrease between the two years. The information is provided at regional level, by trust size according to income and staff numbers, and finally by trust type and foundation trust status.

**Table 3: Executive director team costs 2011/12 to 2013/14 by region in England**

<table>
<thead>
<tr>
<th>Region</th>
<th>No. in category</th>
<th>2011-12 Average executive team costs £</th>
<th>2013-14 Average executive team costs £</th>
<th>Two year increase %</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Midlands</td>
<td>7</td>
<td>965,714</td>
<td>1,095,952</td>
<td>13.49</td>
</tr>
<tr>
<td>Eastern</td>
<td>17</td>
<td>977,235</td>
<td>1,121,941</td>
<td>14.81</td>
</tr>
<tr>
<td>London</td>
<td>16</td>
<td>871,625</td>
<td>931,375</td>
<td>6.86</td>
</tr>
<tr>
<td>North West</td>
<td>21</td>
<td>791,810</td>
<td>868,508</td>
<td>9.69</td>
</tr>
<tr>
<td>Northern</td>
<td>6</td>
<td>1,177,000</td>
<td>1,012,333</td>
<td>-13.99</td>
</tr>
<tr>
<td>South East</td>
<td>24</td>
<td>999,833</td>
<td>1,017,375</td>
<td>1.75</td>
</tr>
<tr>
<td>South West</td>
<td>9</td>
<td>861,444</td>
<td>907,704</td>
<td>5.37</td>
</tr>
<tr>
<td>West Midlands</td>
<td>14</td>
<td>960,643</td>
<td>1,058,357</td>
<td>10.17</td>
</tr>
<tr>
<td>Yorkshire &amp; The Humber</td>
<td>12</td>
<td>987,833</td>
<td>995,833</td>
<td>0.81</td>
</tr>
</tbody>
</table>

**Explanatory notes for Table 3**

- Regional analysis is based on RCN regions, which are largely contiguous with previous NHS strategic health authorities (SHA) areas, except RCN South East which comprises NHS South East Coast and NHS South Central, and RCN Northern which comprises NHS North East and the Cumbria region of NHS North West.

**RCN commentary**

- The figures show that the highest increase was in the Eastern area with an average increase of 14.81 per cent.

- There was variation between regions in terms of increasing expenditure on executive directors. All regions, with the exception of the Northern region, saw average increases in expenditure. However, the Northern region saw significantly higher expenditure than other regions in 2011/12, a discrepancy that was brought down to lower levels more consistent with other regions in 2013/14. Despite the small sample size for the Northern region, all six trusts analysed saw decreases in executive expenditure over the last two years.
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Table 4: Executive director team costs 2011/12 to 2013/14 by trust income in England

<table>
<thead>
<tr>
<th>Trust income</th>
<th>No. in category</th>
<th>2011-12 Average executive team costs £</th>
<th>2013-14 Average executive team costs £</th>
<th>Two year increase %</th>
</tr>
</thead>
<tbody>
<tr>
<td>£0 - £150 million</td>
<td>23</td>
<td>697,130</td>
<td>745,696</td>
<td>6.97</td>
</tr>
<tr>
<td>£150 - £200 million</td>
<td>30</td>
<td>888,133</td>
<td>998,078</td>
<td>12.38</td>
</tr>
<tr>
<td>£200 - £300 million</td>
<td>35</td>
<td>1,018,086</td>
<td>1,026,981</td>
<td>0.87</td>
</tr>
<tr>
<td>£300 - £500 million</td>
<td>23</td>
<td>1,011,826</td>
<td>1,055,783</td>
<td>4.34</td>
</tr>
<tr>
<td>£500 million +</td>
<td>15</td>
<td>1,098,533</td>
<td>1,199,467</td>
<td>9.19</td>
</tr>
</tbody>
</table>

Explanatory note for Table 4
a) Trust income is based on operating income declared in trust annual accounts 2012/13.

Table 5: Executive director team costs 2011/12 to 2013/14 by FTE staff numbers in England

<table>
<thead>
<tr>
<th>FTE staff numbers</th>
<th>No. in category</th>
<th>2011-12 Average executive team costs £</th>
<th>2013-14 Average executive team costs £</th>
<th>Two year increase %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 1,500</td>
<td>9</td>
<td>571,778</td>
<td>647,185</td>
<td>13.19</td>
</tr>
<tr>
<td>1,500 - 2,500</td>
<td>19</td>
<td>806,947</td>
<td>887,772</td>
<td>10.02</td>
</tr>
<tr>
<td>2,500 - 3,500</td>
<td>34</td>
<td>918,265</td>
<td>983,265</td>
<td>7.08</td>
</tr>
<tr>
<td>3,500 - 5,000</td>
<td>29</td>
<td>1,010,517</td>
<td>1,018,322</td>
<td>0.77</td>
</tr>
<tr>
<td>5,000 - 7,000</td>
<td>21</td>
<td>1,010,571</td>
<td>1,019,190</td>
<td>0.85</td>
</tr>
<tr>
<td>7,000 +</td>
<td>14</td>
<td>1,131,071</td>
<td>1,303,929</td>
<td>15.28</td>
</tr>
</tbody>
</table>

Explanatory notes for Table 5
a) FTE staff numbers are based on information from the HSCIC, provided for the middle financial year of this study, correct at March 2013.

RCN commentary

- Tables 4 and 5 show that there is a clear link between trust size, in income and staff numbers, and trust costs on executive directors. However, there is no clear positive link between trust size and increases in level of executive director reward over the last two years.

- The figures appear to show that the largest increases in executive director costs were among the smallest and the largest NHS trusts by both income and staff numbers.

- The largest trusts, with over 7,000 full time staff, saw the biggest increases, with a mean 15.28 per cent increase. Trusts with the fewest staff, with between 0 to 1,500 full time staff, also saw large increases, with a mean 13.19 per cent increase.

- Smaller trusts with lower incomes saw large increases, with 6.97 per cent increases for those under £150 million, and 12.38 per cent increases for those on between £150 and £200 million. The largest trusts, with income over £500 million, also saw large increases, with a mean 9.19 per cent increase over the two years.

- It is also apparent that the NHS is undergoing considerable changes with some trusts changing their entire senior management team over the review period, which clearly has an impact on the overall effectiveness of the team.

- In some areas, particularly at chief executive level and in finance, there have been skill shortages which led to trusts relying on very expensive interim staff, which clearly takes funding away from the frontline.
Table 6: Executive director team costs 2011/12 to 2013/14 by trust type in England

<table>
<thead>
<tr>
<th>Trust type</th>
<th>No. in category</th>
<th>2011-12 Average executive team costs £</th>
<th>2013-14 Average executive team costs £</th>
<th>Two year increase %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute specialist</td>
<td>13</td>
<td>734,000</td>
<td>829,436</td>
<td>13.00</td>
</tr>
<tr>
<td>Acute</td>
<td>74</td>
<td>979,000</td>
<td>1,042,982</td>
<td>6.54</td>
</tr>
<tr>
<td>Community/mental health/learning disability</td>
<td>39</td>
<td>924,949</td>
<td>957,675</td>
<td>2.54</td>
</tr>
</tbody>
</table>

RCN commentary
- The figures show that the highest increase was in acute specialist trusts with an average overall increase of 13 per cent.
- In contrast, increases in costs for community/mental health/learning disability care trusts were 2.54 per cent, although these organisations will sometimes be responsible for a wide range of services.
- There were again increases in costs for executive directors at levels above the nationally set award for those staff under Agenda for Change pay arrangements.

Table 7 below divides the same group of NHS provider trusts but looks at whether there is a difference between increases in foundation NHS trusts and non-foundation NHS trusts.

- The figures show that the increases were nearly 0.64 per cent higher for non-foundation trust organisations.
- The variation may reflect that non-foundation trusts feel under pressure to attract senior leaders to help them achieve foundation trust status.

Table 7: Executive director team costs 2011/12 to 2013/14 by foundation trust status in England

<table>
<thead>
<tr>
<th>Trust type</th>
<th>No. in category</th>
<th>2011-12 Average executive team costs £</th>
<th>2013-14 Average executive team costs £</th>
<th>Two year increase %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation trust</td>
<td>91</td>
<td>940,187</td>
<td>996,275</td>
<td>5.97</td>
</tr>
<tr>
<td>Non-foundation trust</td>
<td>35</td>
<td>928,686</td>
<td>990,048</td>
<td>6.61</td>
</tr>
</tbody>
</table>

Explanatory notes for Tables 6 and 7
a) Acute trusts are responsible for making sure that hospitals in England provide high quality health care.
b) Acute specialist care organisations focus on specific groups of the population or areas of treatment.
c) Community/mental health/learning disability trusts are organisations responsible for managing a wide range of care services in England, including community care, mental health and learning disability (LD) services.
d) Some NHS trusts may be one of the above but also have foundation trust status. This means that they have different governance arrangements and have more freedoms to determine their own future.

RCN commentary
- The figures show that the highest increase was in acute specialist trusts with an average overall increase of 13 per cent.
- In contrast, increases in costs for community/mental health/learning disability care trusts were 2.54 per cent, although these organisations will sometimes be responsible for a wide range of services.
- There were again increases in costs for executive directors at levels above the nationally set award for those staff under Agenda for Change pay arrangements.
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**Trusts claiming exemption under the Freedom of Information Act**

The following trusts claimed exemption under sections 21 and 22 of the Freedom of Information Act 2000 and did not provide the information requested by the RCN:

- 5 Boroughs Partnership NHS Foundation Trust
- Barnet and Chase Farm Hospitals NHS Trust
- Barts Health NHS Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Cornwall Partnership NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- Epsom and St Helier University Hospitals NHS Trust
- Gloucestershire Care Services NHS Trust
- Harrogate and District NHS Foundation Trust
- Kingston Hospital NHS Trust
- Leeds Community Healthcare NHS Trust
- Northampton General Hospital NHS Trust
- Northumbria Healthcare NHS Foundation Trust
- Royal Wolverhampton Hospitals NHS Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- Solent NHS Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Southport and Ormskirk Hospital NHS Trust
- Stockport NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- University Hospitals Bristol NHS Foundation Trust
- University Hospitals Coventry and Warwickshire NHS Trust
- West London Mental Health NHS Trust
- Wrightington, Wigan and Leigh NHS Foundation Trust
- York Teaching Hospital NHS Foundation Trust.

Where these trusts have published their annual report and accounts for 2012/13, the RCN has included this data to calculate reward levels for individual NHS executive directors in the following chapter of this publication.
3. Examples of reward levels for individual NHS executive directors

Our information on pay for individual NHS executive directors is based on published data from both the annual reports and the annual accounts from individual NHS trust organisations. The key results are derived from a comparison of the published annual report and accounts between 2011/12 and 2012/13. This information is generally published in a standard format according to the NHS Manual for Accounts and will have been subject to audit by each trust’s external auditors.

There is a requirement to publish a remuneration report for all senior managers within the trust. This includes executive, non-executive and locally defined senior managers. For each individual identified this shows:

- bonus payments in bands of £5K
- the salary within bands of £5K for NHS trust chief executives.

In most cases, NHS trusts followed this standard format. Comparative figures were also provided for the previous year, therefore it is possible to track changes over financial years.

Despite its publication being a requirement for annual reports, this table was often omitted from the documents index. There were also some formatting issues that reduced the usefulness of the available information. These issues were a little surprising in that the information should be subject to audit by the external auditors.

Some examples of the changes found are listed below.

1) Bonuses

Despite the pay restraint bonuses continued to be paid.

<table>
<thead>
<tr>
<th>Trust</th>
<th>Information on bonus payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxford University Hospital NHS Trust</td>
<td>One member of the executive team received a bonus of between £5 - 10k. Six others received payments that fell within the £10 - 15k band. The chief executive received a payment falling within the £40 - 45k band.</td>
</tr>
<tr>
<td>West Hertfordshire Hospitals NHS Trust</td>
<td>Three team members received bonuses in the £15 - 20k band, one in the £20 - 25k band, one in the £20 - 25k band with their 2012/13 chief executive receiving a bonus also in the £40 - 45k band.</td>
</tr>
<tr>
<td>Cambridgeshire &amp; Peterborough NHSFT</td>
<td>The contracted director of finance received a payment classified as a bonus of between £15 - 20k in 2012/13.</td>
</tr>
<tr>
<td>Whittington Hospital NHS Trust</td>
<td>Three members of the executive team received bonus payments falling in the £0 - 5k band with a further two receiving payments falling in the £5 - 10k band.</td>
</tr>
<tr>
<td>Western Sussex Hospitals NHSFT</td>
<td>Four members of the executive team received bonus payments that fell within the £5 - 10k band, and another one received a payment that fell within the £0 - 5k band.</td>
</tr>
<tr>
<td>Frimley Park Hospital NHSFT</td>
<td>Five members of the executive team received bonuses falling within the £0 - 5k band and the chief executive was paid a bonus of between £5 - 10k.</td>
</tr>
<tr>
<td>Kent Community Health NHS Trust</td>
<td>Four members of the executive team received bonuses of between £1 - 5k in 2012/13.</td>
</tr>
</tbody>
</table>

All information has been sourced from the relevant trust’s annual report and accounts for 2012/13.

These payments would have been approved by the local remuneration committee which is made up of non-executive directors using their discretion to make such payments despite frontline staff suffering under the national pay restraint guidelines.
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2) Salary levels
As NHS chief executives and chief operating officers are in a pre-eminent and critical leadership position the RCN looked at individuals who have had increased salaries of more than three Bands and are therefore receiving increases of at least £15k. The examples we have identified are:

<table>
<thead>
<tr>
<th>Trust</th>
<th>Post holder</th>
<th>2011/12</th>
<th>2012/13</th>
<th>Increase in Bands</th>
</tr>
</thead>
<tbody>
<tr>
<td>York Teaching Hospital NHSFT</td>
<td>Chief executive</td>
<td>£160 – 165k</td>
<td>£190 – 195k</td>
<td>6</td>
</tr>
<tr>
<td>Tees, Esk and Wear Valleys NHSFT</td>
<td>Chief executive</td>
<td>£150 – 155k</td>
<td>£180 – 185k</td>
<td>6</td>
</tr>
<tr>
<td>Northern Lincolnshire and Goole Hospitals NHSFT</td>
<td>Chief executive</td>
<td>£140 – 145k</td>
<td>£165 – 170k</td>
<td>5</td>
</tr>
<tr>
<td>Gateshead Health NHSFT</td>
<td>Chief executive</td>
<td>£185 – 190k</td>
<td>£205 – 210k</td>
<td>4</td>
</tr>
<tr>
<td>Royal Bournemouth and Christchurch Hospitals NHSFT</td>
<td>Chief executive</td>
<td>£170 – 175k</td>
<td>£190 – 195k</td>
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</tr>
<tr>
<td>Luton and Dunstable NHSFT</td>
<td>Chief executive (1)</td>
<td>£180 – 185k</td>
<td>£200 – 205k</td>
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<tr>
<td>Royal National Orthopaedic Hospital NHS Trust</td>
<td>Chief executive</td>
<td>£125 – 130k</td>
<td>£140 – 145k</td>
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<tr>
<td></td>
<td>Chief operating officer and deputy CE</td>
<td>£100 – 105k</td>
<td>£115 – 120k</td>
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<tr>
<td>Northumbria Healthcare NHSFT</td>
<td>Chief executive (1)</td>
<td>£225 – 230k</td>
<td>£240 – 245k</td>
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<tr>
<td>North Tees and Hartlepool NHSFT</td>
<td>Chief operating officer and deputy CE</td>
<td>£115 – 120k</td>
<td>£130 – 135k</td>
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<tr>
<td>Maidstone and Tunbridge Wells NHST</td>
<td>Chief executive (2)</td>
<td>£185 – 190k</td>
<td>£200 – 205k</td>
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<tr>
<td>Southern Health NHSFT</td>
<td>Chief executive</td>
<td>£160 – 165k</td>
<td>£175 – 180k</td>
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</tr>
</tbody>
</table>

All information has been sourced from the relevant trust’s annual report and accounts for 2012/13.

Explanatory notes
(1) Salary increases were due to the individuals leaving the NHS Pension Scheme and receiving the employers’ pension contributions as a salary increase. This does not increase the trusts’ overall costs, but generates increases for the individual.
(2) Post holder ceased contributing to NHS Pension in 2012/13, there was no mention of a transfer of costs to basic salary.

3) Benefits in kind
The RCN has also identified a number of examples of benefits in kind payments to NHS executive directors. Most common is the provision of a leased car. Such provision is a direct cost to the NHS and recognised in the remuneration reports published as part of the cost of employing its senior team. These are separately identifiable as costs within an NHS trust’s annual report and accounts. The value of the benefits in kind payments ranges from £100 per year up to nearly £10k per year.

In some trusts, benefits in kind payments might be made to one executive director and in other trusts they may be made to a number of executive directors. We are aware that the majority of payments relate to car lease costs or other travel-related expenses. The leased car packages tend to be three year contracts, so will remain consistent over that period. Other items may vary from year to year, but relate to much smaller sums. Significant benefit in kind payments should be reviewed and approved by the Trust Remuneration Committee when looking at the total individual remuneration package of each executive director.
All in it together? The executive pay bill in England’s NHS

4. Pay levels for NHS senior managers

As part of the process of comparing levels of reward for frontline nursing staff with senior management within NHS trusts, the RCN has also analysed official earnings and pay data for senior NHS managers.

Figures from the Health and Social Care Information Centre (HSCIC) published show that as of February 2014, senior managers in NHS hospital and community services have seen annual basic pay grow by 12.7 per cent since May 2010, and annual earnings (including non-basic pay) grow by 13.3 per cent (HSCIC, 2014).

In contrast, nurses, midwives and health visitors have experienced only a 5.1 per cent rise in basic pay, and a 4.7 per cent rise in annual earnings. As figure 1 shows, when pay and earnings are considered against inflation (running at between 11.4 per cent (CPI) and 13.7 per cent (RPI) since May 2010) senior managers have largely been protected from the impact of inflation, whereas nursing staff have seen year-on-year erosion of their income in real terms. According to RPI, nurses have seen their earnings fall by £2,667 in real terms since May 2010, and £1,982 according to CPI. Nurses are struggling to keep their heads above the water financially, as their pay levels fail to keep pace with the cost of living and inflation.

Other sources have confirmed that senior NHS managers have been receiving pay rises in line with or above inflation levels, while nurses see their earnings eroded. An investigation in late 2013 by The Daily Telegraph found 24 NHS managers were paid rates of more than £1,000 a day during 2012 to 2013 (Donnelly, 2013). Margaret Hodge, Chair of the Commons Public Accounts Committee commented that it was, “appalling and immensely depressing. We know the NHS is struggling to cope with its financial constraints. Ministers have repeatedly said they will clamp down on this, but these figures show it is worse than ever – the gravy train rolls on and on.”

Figure 1: Mean annual basic pay and earnings for qualified nursing, midwifery and health visiting staff, and senior managers against inflation, NHS hospital and community services, May 2010 to February 2014

Explanatory notes

According to the HSCIC NHS Occupation Code Manual (HSCIC, 2013), senior managers are “those who have overall responsibility for budgets, staff or assets or who are held accountable for a significant area of work”. The senior manager workforce group includes:

- Chief executives, finance directors and other executive directors who are voting members of the organisation, excepting those who need to be clinically qualified in order to perform their role, for example, medical director, nursing director. These staff are generally rewarded above the Agenda for Change pay scale, with some on the very senior manager (VSM) pay scale.
- Senior managers who directly report to the executive, for example, assistant director of finance, who may deputise for more senior colleagues, and do not need to be clinically qualified to perform their role.
5. Recommendations

This report shows that however you cut the figures, NHS executive director teams and NHS senior managers have managed broadly to keep pace with inflation whereas individual remuneration for nurses, midwives and health visitors clearly have not. Urgent action needs to be taken to ensure the nation has sufficient staff available to meet the demands of tomorrow’s patients. The RCN has therefore made the following recommendations.

1. Levels of reward for NHS executive directors and senior managers must reflect the similar pay restraint being experienced by other NHS staff. In playing their part, nursing staff have experienced severe pay restraint, with pay freezes in 2011/12 and 2012/13. As a result nursing staff have seen a significant fall in their earnings as inflation has far outstripped pay.

2. There is an urgent need for greater fairness between the levels of reward for frontline staff, senior managers and executive directors. The Government must implement in full the recommendations of the Pay Review Body (see note below). The impact of awards above the rate of inflation for executive directors and senior managers on the morale of frontline staff should be a key consideration for the Government and the Department of Health.

3. There is an urgent need for greater transparency in the process for setting levels of reward for executive director teams in the NHS. The Hutton Report (Hutton, 2011) said that, “a framework for senior pay is required that is understood by both citizens and public servants to be fair, and to guarantee that public servants’ pay is duly deserved for contributions that citizens value”. The RCN experience in gathering the information for this report indicates that the framework is not widely understood and transparency is limited.

4. NHS remuneration committees should be required to follow the Government’s wider pay policies for NHS staff as a whole when setting reward levels for the executive director team. At present the committees are currently only ‘encouraged’ to follow pay guidelines set by Government in England which the RCN believes is unacceptable. There needs to be much greater clarity on the use of the terms ‘reasonable’ remuneration and scrutiny of ‘local market forces’ that are used by many remuneration committees to justify the approval of above inflation increases in reward levels for executive directors. Also discretionary bonuses should not be awarded if a trust is not performing to acceptable standards. Executive directors need to show restraint and lead by example for staff in the trust.

5. The Government must recognise that the impact of inflation has damaged the living standards of nurses and that continued stagnation of wages risk further damaging future recruitment and retention.

Explanatory notes

The NHS Pay Review Body (PRB) published its report and recommendations on pay for 2014/15 on 13 March 2014 (NHS Pay Review Body, 2014). In summary, the PRB recommended a one per cent increase on all pay points and a one per cent increase on high cost area supplements. However, this year the Westminster Government decided to reject the recommendations from the independent Pay Review Body and announced the following: staff at the top of pay bands would receive a one per cent non-consolidated (one off) rise for 2014 to 2015 and a two per cent non-consolidated rise 2015 to 2016. So, a nurse at the top of Band 5 currently receiving £27,901 would see pay rise to £28,180 for 2014 to 2015 and £28,459 in 2015 to 2016. After this, pay would revert back to £27,901. Staff not at the top point (around 60 per cent of the workforce) will continue to benefit from pay progression, if performance is satisfactory, but will not have a cost of living increase.
Conclusion

This report paints a clear picture of a growing gap between the pay of the NHS staff working with patients at the frontline of care, and the salaries of the senior executives running the hospitals that employ them. In some cases, this may be partly because departing managers have been awarded redundancy payments – an issue which the Government is now, belatedly, tackling. The reorganisation of the NHS in England has resulted in large numbers of senior managers being dismissed, only to be re-employed elsewhere in the NHS, months or even weeks later. But the individual examples detailed in this report demonstrate that remuneration committees are awarding pay rises and bonuses which are running significantly ahead of inflation.

This disparity is having a corrosive effect on the morale of nursing staff. RCN members are increasingly disillusioned at the inequity of a system which rewards the most senior managers, while demanding that other staff accept pay erosion. We are already seeing the consequences: nurses are leaving the profession, either for better salaries elsewhere in the world, or for alternative careers. The implications for the NHS are serious. There are already nearly 20,000 unfilled nursing vacancies in the NHS in England (RCN, 2013).

NHS Employers’ most recent study on this issue highlighted an average vacancy rate of 10 per cent (NHS Employers, 2014). How many more frontline staff have to leave before action is taken?

Some managers are bucking the trend we have identified and are setting an example by acting with moderation over executive costs. The RCN calls on all NHS senior managers to follow their lead and to demonstrate the kind of pay restraint that nursing staff have been forced to accept over the last four years.
References


Appendix 1 : Additional notes on methodology

Additional notes on methodology for Table 1
a) NHS executive directors are board-level senior management employees of the NHS trust who are accountable for the work of the organisation.

b) The term capitalised is used where salary costs are viewed as part of the cost of major capital/development costs, for example, project management costs. Normally, the individual should be employed almost exclusively on that capital project, otherwise these costs should be normal revenue costs and included in this analysis. The RCN understands that it would be extremely rare for executive director expenses to be capitalised.

c) Note 10.1 from the NHS Manual for Accounts (Accounts Completion guidance) states that the figures for expenditure on NHS executive director remuneration, “exclude non-executive directors but include executive board members and staff recharged by other NHS bodies.”

d) The pay of NHS executive directors is determined by the remuneration committee within each NHS trust. The committee is made up of non-executive directors of the trust board. They have the freedom to set their own levels of remuneration for executive directors although they are ‘encouraged’ to follow national pay guidelines.

e) The annual increase in 2013/14 executive director costs and the two-year 2011/12 to 2013/14 increase in costs are projected calculations based on estimates from trusts or on data provided by trusts for the nine months April to December 2013, grossed up to a full year.

f) Inflation rates are actual calculations for each financial year based on data from the Office for National Statistics (ONS): the CPI All Items Index (www.ons.gov.uk/ons/datasets-and-tables/data-selector.html?cdid=D7BT&dataset=mm23&table-id=1.1) and RPI All Items Index (www.ons.gov.uk/ons/datasets-and-tables/data-selector.html?cdid=CHAW&dataset=mm23&table-id=2.1).

Additional notes on methodology for Table 2
a) Annual pay for NHS staff under Agenda for Change: Most posts in the NHS are covered by the Agenda for Change (AfC) pay scales. This pay system covers all staff except doctors, dentists and the most senior managers. In AfC the NHS job evaluation system determines a points score which is used to match jobs to one of the nine pay bands and determine levels of basic salary.

b) Estimates for the annual increase in 2013/14 nursing, midwifery and health visitor earnings and the two-year 2011/12 to 2013/14 increase in earnings are based on linear projected calculations from data produced by the Health and Social Care Information Centre (HSCIC) for the eleven months April 2013 to February 2014 (www.hscic.gov.uk/catalogue/PUB14157/nhs-staf-earn-est-to-feb-14-tab.xlsx.xlsx).

c) Inflation rates are actual calculations for each financial year based on data from the Office for National Statistics (ONS): the CPI All Items Index (www.ons.gov.uk/ons/datasets-and-tables/data-selector.html?cdid=D7BT&dataset=mm23&table-id=1.1) and RPI All Items Index (www.ons.gov.uk/ons/datasets-and-tables/data-selector.html?cdid=CHAW&dataset=mm23&table-id=2.1).

Additional notes on methodology for Tables 1 and 2
The RCN is aware that the increase shown for executive directors in Table 1 is an aggregate of the costs to the trust for rewarding the executive director team as a whole. This is opposed to the individual data that we are showing in Table 2 for nursing, midwifery and health visitors which is the mean annual increase in individual earnings. All efforts have been made to ensure that both methodologies used cover similar areas of expenditure and the RCN has tried to ensure that we are, as far as possible, presenting ‘like for like’ data. Employer pension and national insurance contributions (NICS) are included in Table 1 for executive directors but are not reflected in Table 2 for individual nurses, midwives and health visitors as these amounts are not included in the HSCIC published figures. However, proportional costs for employer contributions to pensions and NICS have not changed significantly over the last five years, therefore these factors are considered to be negligible. For the purposes of clarity, we have felt it important to highlight this information.
Appendix 2: Map showing the RCN England regions

Along with the three countries of Northern Ireland, Scotland and Wales there are nine geographical regions in England, which are: Eastern, East Midlands, London, Northern, North West, South East, South West, West Midlands, Yorkshire & the Humber.