

*In short supply: pay policy
and nurse numbers –*
NHS pay

NHS pay: time to end the freeze?

About this supplement

This supplement is produced to accompany the report *In short supply: pay policy and nurse numbers*

NHS pay: time to end the freeze?

Introduction

The NHS is a labour-intensive sector. Two-thirds of provider costs are related to staffing. The total NHS staff pay bill in England was £46bn in 2016. At aggregate level, controlling NHS costs is in large part about controlling the pay bill. But pay is also at the core of the implicit contract between the NHS and its workforce. It can be an incentive or disincentive for recruitment and retention, and to work in certain regions, specialties, working locations and working times. In part this depends not just how much the worker is paid, but also how – and how their pay compares with those they regard as comparators. The NHS cannot function effectively unless it has a pay system aligned with, and supporting the attainment of, NHS values and objectives.

This inherent tension between managing costs and sustaining effective staffing has to be resolved in any health system. However, broader labour market characteristics, political dynamics and organisational context play a part in differentiating how pay determination has evolved in different health systems. This document examines the current NHS pay system and its key pressure points. It presents a summary analysis of recent trends in NHS staff earnings and related indicators, before then looking at how other countries determine the pay of health workers. It concludes by assessing if the current NHS pay system is fit for purpose, and puts forward recommendations for improvement.

Analysis: the current NHS pay system

The pay of the vast majority of people working for the NHS is based on nationally agreed pay structures, with separate pay determination systems for doctors, for nurses and other health professions, and for other NHS staff. For NHS doctors, nurses and other health professions, national pay recommendations are made by independent pay review bodies.

The review bodies are committees of independent experts appointed by government, with a secretariat provided by the Office of Manpower Economics. They make their decisions based on evidence submitted by trade unions, employers and government, and on any additional research they have commissioned.*

The Doctors' and Dentists' Pay Review Body (DDRB) was set up in 1971 and covers more than 200,000 NHS salaried hospital medical staff, dentists and general practitioners (GPs). The NHS Pay Review Body (NHSPRB) for NHS nurses, other health professionals and staff was established initially in 1983 and now covers approximately 1.4 million people. The remit of the review body system covers the UK, but there are some differences in approach across the four UK countries. For example, the government in Scotland has emphasised living wage thresholds and has, in some recent years, fully implemented review body recommendations while England has delayed doing so fully. In 2016/17, the NHSPRB had to provide a separate supplement report on Scotland due to postponement of the 2017/18 budget in Scotland.

NHS staff pay is primarily determined at national level, but there is some scope for local supplementary payments to staff, where NHS employers have sufficient funds and can demonstrate they have recruitment and retention difficulties. Several reports, and both the DDRB and NHSPRB,¹ have noted that these flexibilities are only infrequently used by local NHS employers, and have reviewed options for increasing flexibility or 'targeted' pay. This will be discussed in more detail in the next section.

The review bodies 'price' a pay structure and system that has been negotiated and agreed at national level between government, employers and trade unions/professional associations. Usually the review body process is an annual cycle of evidence taking, followed by pay recommendations. However, as a result of public sector austerity measures there have been government-imposed public sector pay freezes in recent years – the role of the review bodies has been constrained and their influence reduced.

Last year, the secretary of state for health wrote a letter to the NHSPRB to say that it should recommend a rise of 1% to take effect on 1 April 2017, with a similar level each year until 2020. This prompted one commentator to highlight what he called the 'charade' of NHS pay determination, noting that, 'Until now the RB has – reluctantly – done the government's bidding and accepted its well-worn line that public sector pay restraint is necessary given the precarious state of the nation's finances. But my understanding is that the RB is reaching the end of its tether, in fear that it might be reaching the end of the road.'²

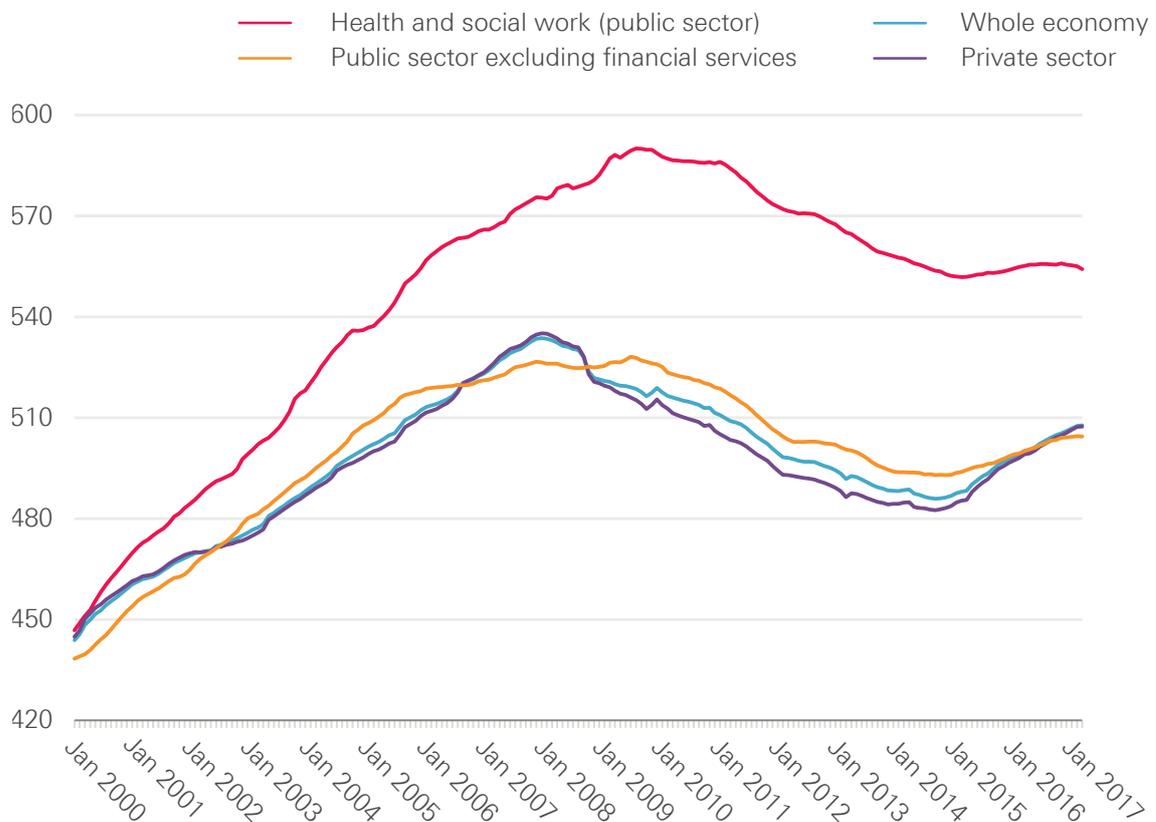
* For details, see: www.gov.uk/government/organisations/nhs-pay-review-body/about

This year, the NHSPRB itself noted that ‘Our judgement is that we are approaching the point when the current pay policy will require some modification, and greater flexibility, within the NHS’.³ The *Next steps on the five year forward view* for NHS England also noted the ‘challenge’ arising from ‘ongoing pay restraint’, but otherwise did not address the issue specifically.⁴

The NHS pay system is clearly under stress. This was highlighted in the recent report from the House of Lords Select Committee on the long-term sustainability of the NHS.⁵ Even so, it continues to have support from leading trade unions.⁶

On the back of commitments to workforce pay in *The NHS Plan*, pay in the NHS rose in real terms between 2000 and 2010, with growth outpacing the rest of the economy (see Figure 1). Since then the picture has been quite different, with the 1% pay cap meaning that NHS pay has consistently risen by less than inflation (at consumer price index (CPI)).

Figure 1: Pay since the turn of the century

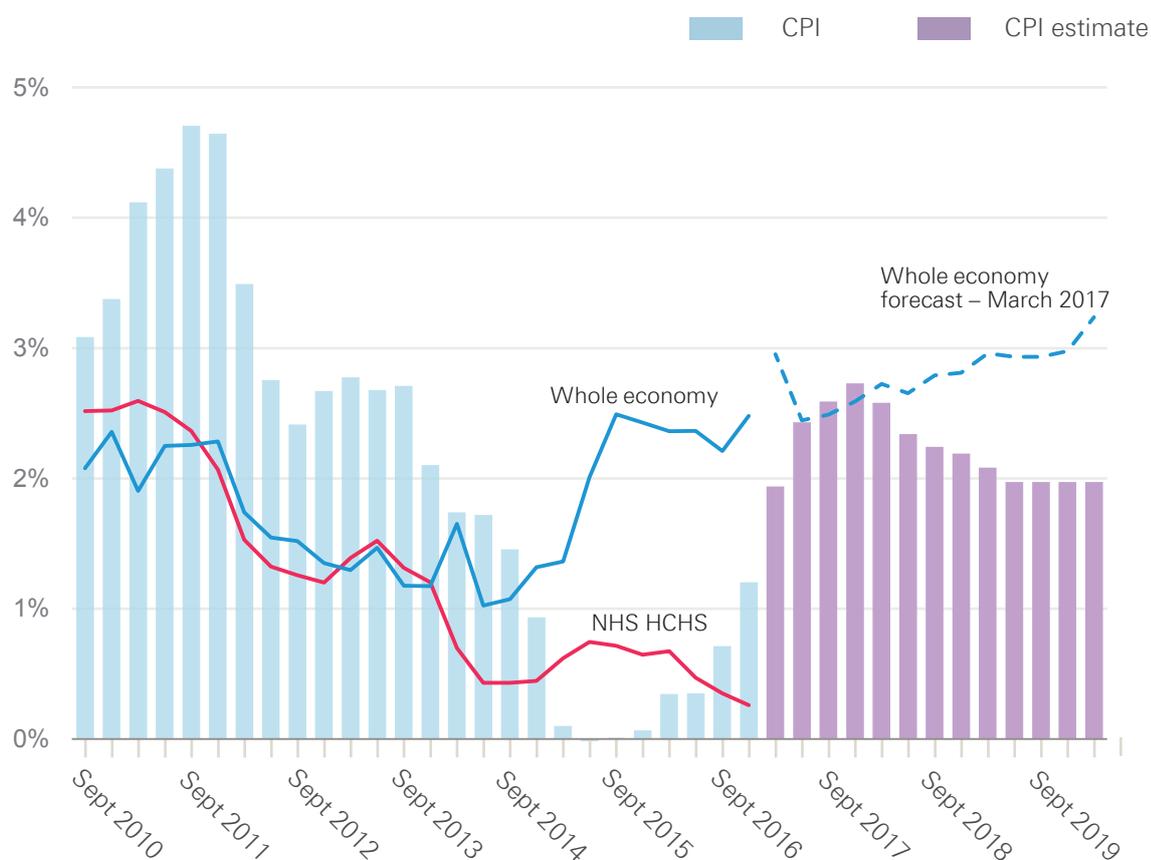


However, Figure 2 highlights recent trends in NHS staff earnings and puts this in the context of broader trends and projections in inflation and earnings in the UK economy since 2010. Different start dates will present a different picture, but over the period since 2010 changes in NHS staff earnings have mirrored those in the broader public sector, but have showed a relative decline in comparison to private sector and whole economy earnings since 2013. Between 2010 and 2017, the real value of health and social care staff’s pay has fallen by 6% (while in the economy as a whole it has fallen by only 2%). Within the NHS the size of the real (inflation-adjusted) pay cut varies: it is 6% across the board for earnings per person, 6% for midwives, 8% for doctors and 12% for health visitors

(although some of this may be a result of changing skill mix and staff numbers). This reflects the impact of government policy on pay constraint. Inflation has also increased from a low in 2015 to more than 2% per annum.

Current projections on whole economy forecast and on inflation (CPI) through to 2021 highlight the likelihood of inflation remaining in the 2–3% per year range, and about 3% per year growth in the economy. This means that NHS pay is likely to continue to reduce relative to both inflation and the wider economy over the period. The NHSPRB calculated that NHS pay at Agenda for Change band 5 and above will have been cut by 12% (CPI) to 20% (RPI) in real terms over the decade from 2010/11 to 2020/21.

Figure 2: change in HCHS, public and private earnings and whole economy forecast and inflation



Source: Department of Health Annual report and accounts 2015/16, Office for National Statistics population estimates, NHS England Annual accounts 2015/16.

Figure 2 highlights the main challenge for the NHS pay system. Having contained NHS staff earnings growth in recent years, UK governments now face a situation where recent trends and future projections highlight that earnings in the broader economy are growing more rapidly, and inflation is at a level that will erode the purchasing power of NHS staff. This year the NHSPRB noted that ‘The evidence we have received gives us cause for concern about the sustainability of public sector pay policy over the next few years’, pointing to growing inflation and the need for NHS pay to keep pace with private sector pay over the medium term to recruit and retain staff.⁷

The case for NHS pay reform

Given evidence that the growth in NHS staff earnings is now falling behind other employees, as well as statements about the pay system itself being under pressure and requiring change, is there a case for NHS pay reform? And if so, what type of reform?

The need for pay reform has been a recurring theme since the NHS was established in 1948, with pay determination being based on national bargaining units ('Whitley councils'), each involving multiple staff associations/trade unions representing different staff groups. Almost from inception, the national Whitley system was regarded by some commentators as: being too complex and inflexible; being unresponsive to labour market variation and change; constraining the development of new roles; unable to reflect adequately the high levels of contribution being made by experienced clinical staff; and having a shadowy but dominant role played by Treasury.⁸

In the 1950s and 1960s there was frequent recourse to arbitration to settle Whitley council disputes; for example, there were four reviews of NHS nurses' pay in the 1960s, and two further independent reviews in the 1970s. These were essentially 'catch up' exercises, with NHS pay having fallen behind that of other workers in between these reviews.⁹

In more recent decades, broader plans for NHS reform and restructuring have repeatedly included discussions that NHS pay determination should be shifted to a more localised approach, to enable local NHS management autonomy and control and reflect more closely varying labour market conditions. Individualised (sometimes performance-related) pay¹⁰ and localised or 'regional' pay determination was a theme of the NHS reforms of the 1980s. It was flagged again last decade, with NHS employers being given the option to withdraw from NHS pay determination and establish their own tailor-made approaches.^{11,12,13}

The last significant reforms of the pay structures for NHS staff were implemented more than 10 years ago, when new national contracts and pay structures were negotiated for GPs, for hospital-based salaried medical consultants, and for other NHS staff. The main stated objectives of these reforms were to improve recruitment and retention, increase pay flexibility within a national framework and improve productivity, as well as to ensure compliance with equal pay legislation. 'Agenda for Change', the largest new pay system covering about 1.3 million nurses and other non-medical staff, took seven years to negotiate and implement, from 1999 to 2006.¹⁴

Research published at the time of implementation of these new contracts, and reviews by the National Audit Office, all highlighted that despite the significant overall costs of implementation, there was no systematic assessment of costs, benefits and impact conducted nationally. Therefore there was no way of assessing in any detail if the new pay systems delivered on claimed benefits.^{15,16,17,18,19}

The current national system does make some provision for local pay flexibility. There are additional high cost area supplements (HCAS) for staff working in London and the south east, and individual NHS employers also have the flexibility to vary the pay they offer through the application of local recruitment and retention premia (RRPs), within the national pay framework. In addition, NHS foundation trusts have the authority to

renegotiate their own terms and conditions outside of national frameworks. In practice few foundation trusts choose to do so,²⁰ and a regional pay consortium (‘cartel’) established by NHS trusts in south-west England did not become operational.²¹ In this year’s report, the NHSPRB noted the fact that ‘the use of Recruitment and Retention Premia (RRPs) is dwindling alongside an increase in the very pressures they are intended to alleviate suggests that there is a serious problem for local management, who feel unable, or unwilling, to use RRP in practice.’²² This year the DDRB highlighted that ‘In principle, the pay system already offers potential for local flexibilities of this sort. In practice, trusts and health boards have found it challenging to develop and use these. Local expertise in devising and managing new pay initiatives is in short supply, and management attention focuses on maintaining day-to-day services to patients. The apparent lack of willingness to use local pay flexibilities needs to be challenged, and their use tested in practice.’²³

Despite the scope for additional local pay flexibility, the reality is that only a very small number of NHS employers have ever withdrawn from the national pay system,²⁴ and some of those that did have subsequently returned.²⁵ The main reasons for this repeatedly stalled shift away have included lack of funds, limited local management capacity (or disinterest) and opposition from trade unions.^{26,27,28} More recently, the national policy focus has shifted from a direct focus on pay rates to an indirect one that seeks to reduce additional payments for unsocial working hours.²⁹

In recent years the review bodies have also commissioned independent analysis to examine the scope for various types of flexibility. A 2012 study examined how large multi-site employers in other service industries determined pay, in order to assess if other sectors had devolved or local pay determination. The study concluded that ‘Decisions are mostly made either centrally – by senior managers, central HR or the reward team – or are market driven, with little local discretion. Where there is discretion, awards are controlled firmly by budgets’.³⁰

More recently, a report for the NHSPRB on ‘targeted pay’ (distinguishing between employees in order to target pay rises) identified several dimensions for targeting: skills, experience and occupation; location; and employee performance. It concluded that effective targeting requires good evidence and that there needs to be a workforce strategy and an understanding of how pay is linked to output, at both individual and organisational level.³¹ In its 2017 report, the NHSPRB noted that ‘there was no support from evidence providers’ for targeting pay at a national level, but that ‘There is, however, clearly a case for pay targeting given that there are recruitment and retention pressures in certain occupational groups and in some geographical areas.’³² The DDRB in its 2017 reported noted similarly that ‘we think it highly desirable that different types of targeted pay and reward incentives should be explored, including some that might be radically new.’³³

While current national negotiations have focused on aspects of shift pay and working patterns and hours for some NHS staff (notably NHS consultants) against a backdrop of government-imposed pay restraint, there has been little change in the approach to NHS pay determination at local, organisational level. The lack of local change reflects, in part at least, the limited flexibilities that exist in the system, which have in turn been further constrained by national pay restraint. Local flexibility within a national system is

particularly difficult to sustain when there is limited room for individual organisations to be innovative, and when the external labour market is challenging – many NHS trusts in England are reporting increasing difficulties in recruiting staff.

The next section examines recent experience with pay determination for people working in health care in other Organisation for Economic Co-operation and Development (OECD) countries.

How do other countries determine the pay of health staff?

The structure and processes of pay determination in any health system reflect the evolution of broader cultural and political developments, as well as different employment models, labour market dynamics, and health sector structures, organisation and funding.^{34,35,36} A recent study by the OECD³⁷ gives some insight into how the pay of health sector staff is determined in the UK and seven other high income countries (Canada, Germany, France, Netherlands, Norway, New Zealand and Portugal).

Most of the countries in the study reported a core national/sector-wide pay determination model. In France, the Netherlands, New Zealand, Norway, Portugal and the UK, the primary focus was at the national level, either across the whole health sector, or at the subsector level. France, Norway and the UK provided some scope for 'top-up' wage setting at a local level. New Zealand also has some separate regional or local collective agreements, which in part were a legacy of a previous decentralised wage setting model. In Canada the main focus was at the province level, while Germany exhibited a mixed pattern of pay contracts at federal and hospital owner level.

Most of the countries also reported direct or indirect government involvement in health sector pay determination. In Portugal and the UK this reflected a situation where the government was both the main funder of health services and employer of the health workforce. In normal times, an annual cycle of wage setting was reported in France, Portugal and the UK; in Norway, a biannual process was reported. For the remaining countries, the reported cycle of wage setting varied between 18 months and 3 years.

Some of the main conclusions of the OECD review are of direct relevance to the current situation in the UK. The review noted that fiscal pressures after the economic crises of 2008 had led to some 're-centralisation' of health sector pay determination, particularly in France, Portugal and the UK, and that centralised pay determination could be an important tool for government at times of fiscal constraint.

More generally, the OECD report noted that there had been debate about the pros and cons of different models of local, regional and national-level pay determination in the public sector in many OECD countries.^{38,39,40} Proponents of localised wage setting argue that this can hold the prospect of more local managerial input into pay bill control, and the development of overall reward strategies more tailored to local needs, priorities and purposes. However, the OECD report concluded by noting that, while the limitations and potential weaknesses of centralised/national pay determination have been identified, the recent experience in the countries examined in the report suggested that, at a time of fiscal restraint, 'the benefits of centralised and/or co-ordinated wage setting – simplicity, scope for co-ordination and centralised control, limited need for local management capacity, scope for transparency and pay equity – generally appear to have been given more attention by national policy makers'.

Time to end the freeze?

Pay and pay systems are a critical element in any health sector human resource strategy. Pay rates are a factor in determining how the organisation connects with external labour markets through staff recruitment and retention. In addition, the type of pay system selected by an organisation can be a major factor in creating organisational culture and supporting specific types of staff behaviour and performance. Changing a pay system can be one strategy to achieve or sustain organisational change.

In attempting to answer if the current NHS pay system is fit for purpose, the first question must be: for what purpose(s)? NHSPRB summarises its remit as ‘to have regard’ to:

- the need to recruit, retain and motivate suitably able and qualified staff
- regional/local variations in labour markets and their effects on the recruitment and retention of staff
- the funds available to the health departments, as set out in the government’s departmental expenditure limits
- the government’s inflation target
- the principle of equal pay for work of equal value in the NHS
- the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.⁴¹

At various times the arguments in favour of NHS pay reform have been predicated on a varying range of factors, some organisational and some with a political edge. These factors include: dealing with staff shortages; better addressing varying local labour market challenges; improving performance and productivity; giving local management more autonomy; enabling career development and improving staff motivation; controlling the pay bill; and challenging the national power base of the trade unions.

Different stakeholders have prioritised different factors over time, and not all factors can easily be accommodated in a consistent annual cycle of pay determination. One of the problems with previous attempts to reform NHS pay determination has been a lack of clarity of purpose – some reform objectives have been articulated (but may not have been achievable), while in other cases the objectives were either not stated, were not attainable only by pay reform, or have been in conflict with each other.

It is impossible to disconnect NHS pay from NHS funding. At a time of NHS funding constraints, NHS pay is inevitably a target for control. As noted in the previous section, the UK is not the only OECD country in which governments have taken advantage of existing national pay determination systems to limit pay increases in recent years. If pay restraint is the objective, a centralised approach can make ‘sense’, but if sustained over a period of time, this is likely to lead to pent-up demand from staff as they see their pay rates fall behind others and their earnings eroded by inflation. This will lead to increasing pressure for ‘catch up’ awards. This is exactly what happened repeatedly in the NHS in the 1950s, 1960s and 1970s – and was one of the reasons for establishing the NHSPRB in the early 1980s.

If the policy priority is to use pay as a lever to enable and implement local change and additional workforce flexibilities, then it should first be noted that:

- the current flexibilities in the NHS pay system are not being used to full effect
- local management capacity does not currently exist in all NHS trusts to handle local pay determination effectively (this was a factor in the failure of NHS ‘local pay’ reforms in the 1990s)
- there is currently little scope for introducing new pay flexibilities given tight national fiscal constraints, unless these can be cost-neutral, productivity enhancing, or, as the NHSPRB noted in its 2017 report, if additional funding was made available⁴²
- pay strategy should be integrated in an overall workforce development strategy, rather than determined in isolation.

The longer ‘top-down’ NHS pay restraint continues, the more pressure will increase on the current system. This year the NHSPRB highlighted that greater consideration needed to be given to the medium-term staff supply position of the NHS, and that ‘the current rigid pay policy could be storing up problems for the future’.⁴³ Meanwhile, the DDRB highlighted that ‘consideration therefore needs to be given to planning an exit strategy at the end of the pay policy period’.⁴⁴ This same point was reinforced by the recent House of Lords Select Committee report on long-term sustainability of the NHS.⁴⁵

The current phase of national NHS pay bill control began at a time of economic recession, with low inflation and high unemployment. However, this is increasingly being replaced by greater numbers of staff shortages and the likelihood of higher inflation. In addition, the need for staffing growth (as noted in the recent *Next steps on the NHS five year forward view*⁴⁶), internal skills shortages, the search for productivity improvements, the ageing of the NHS workforce, and external labour market changes and unknowns (eg the impact of Brexit on NHS staffing) all point to the need to better align the total reward package of NHS staff with organisational priorities.

NHS policymakers and UK governments cannot just focus on national pay bill control or on local flexibility and productivity improvement; they must address both. The current approach to NHS pay determination, notably the review bodies, is under stress. This stress is mainly created by top-down funding constraint rather than internal dissonance or lack of relevance, but it does raise questions about the continued effectiveness of the current system.

Recommendations

It is now 15 years since the last major overall reforms of the NHS pay system were initiated. By the current earliest planned end date of 2020, there will have been almost 10 years of pay restraint.⁴⁷ This year the NHSPRB itself has highlighted that it is time to take stock of the current NHS pay system. The dominant current discourse is about when pay constraint should end, and not about what to do when it does, in terms of assessing if there should be new pay reforms to meet changed organisational priorities. The risk in focusing on a return to pre-recession pay ‘normality’ is that it ignores the fact that internal and external economic and labour market conditions have changed out of all recognition since 2008.

This means that at national level there is a need to prepare the pay determination system for the ‘end of the freeze’ of national pay constraint, currently timed by government as 2020. The risk otherwise is that pent-up demand from staff will understandably lead only to another cycle of ‘catch up’, followed again by relative decline. The time is right to assess the options on how best to determine the total reward package for NHS staff, and decide if the current system continues to be fit for purpose, if it requires some alteration, or if it is time for substantial change. NHS pay is funded by UK governments, review body recommendations are implemented (or not implemented) by UK governments, and the current national pay constraint has been imposed by UK governments. It is UK governments that must take the lead on ensuring that the NHS pay system will be fit for purpose ‘after the freeze’, by initiating a review with full engagement from other national stakeholders.

Three main recommendations are set out below. The first has a longer term and strategic focus. It argues the case for an overall review of the NHS pay system to ensure that it can function effectively when pay constraint is ended. The second highlights that more can be done in the short term to maximise flexibility options in the current systems. The third makes the case to test out innovation in supporting team work.

Sustain a long-term strategic approach to pay determination, but assess the options for reform

It is important not to take a narrow or short-term view of the NHS pay determination system. As stressed in this brief, its outcome is a major and highly visible element of the contract between the organisation and the health worker, and it can be a powerful policy lever. It should also be aligned with an overall agreed approach to NHS workforce development. If 2020 is to be the end of pay constraint, then now is the time to begin a national review about what system should be in place afterwards. This is in order to either reach a decision that the current approach, with or without some modification, continues to be fit for purpose, or if a new approach is required to sustain staffing levels, motivation and productivity as well as address regional labour market variations. A starting point would be a structured national policy dialogue of key stakeholders and independent experts to analyse trends and assess options. To give impetus to this review, it should be aligned with a clear statement by UK governments about when the ‘freeze’ on public sector pay will end.

Assess how to increase uptake of ‘in-system’ pay flexibilities

As stressed in this document, there have been repeated reports that the current flexibilities within the NHS pay system are underused. The NHSPRB has this year noted that the use of recruitment and retention premia is actually in decline. Various reasons for this have been suggested. However, a rapid review of the currently available pay flexibilities, the extent of their use and evidence of their impact would be useful. This could inform policymakers about constraints on take-up that can be addressed immediately, if there is a need for changes in funding and/or local capacity, or if there are flexibilities that are not relevant or useful. Findings of the review could then be used to reform and recalibrate the available pay flexibilities and address identified constraints.

Evaluate team-based incentives

Weaknesses in previous attempts to link pay and productivity/performance of health workers have been the focus on individual performance, often of doctors,^{48,49} and the emphasis on only financial incentives rather than total reward. This ignores the team-based system of delivery and multidisciplinary team ethos that permeate the NHS. It also discounts the other factors that motivate people to work effectively in the NHS, such as participative decision making, the ability to deliver quality care, and access to training, development and career advancement.⁵⁰

Irrespective of decisions on longer-term NHS pay strategy, there is scope in the short term to:

- give greater emphasis to securing the maximum flexibilities from the current system
- provide some ‘pump-priming’ support for local pilots focusing on improved productivity and performance through incentives for effective team working.

What is needed are NHS trust-level, or STP-level, test sites that examine the potential for team-based incentive approaches. This would require ‘bundles’ of complementary local incentive policies to be developed with staff input, informed by the limited but growing international evidence base,^{51,52,53,54,55} and implemented with the specific intention of supporting sustained ‘high performance’ team working.^{56,57} Evaluation would focus on cost and output/outcome measures, in order to identify which approaches have greatest promise of sustained cost–benefit and productivity improvement.

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