NHS Pay Review Body

NHS Pay Review Body

Thirty-First Report 2018

Chair: Philippa Hird

Executive Summary

Cm 9641

NHS Pay Review Body

The NHS Pay Review Body (NHSPRB) is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for Health and Wellbeing in Scotland, the First Minister and the Cabinet Secretary for Health, Wellbeing and Sport in the National Assembly for Wales, and the First Minister, Deputy First Minister and Permanent Secretary of the Department of Health, Northern Ireland, on the remuneration of all staff paid under Agenda for Change and employed in the National Health Service (NHS)[1].

In reaching its recommendations, the Review Body is to have regard to the following considerations:

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.

The Review Body may also be asked to consider other specific issues.

The Review Body is also required to take careful account of the economic and other evidence submitted by the Government, Trades Unions, representatives of NHS employers and others.

The Review Body should take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief, and disability.

Reports and recommendations should be submitted jointly to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for Health and Wellbeing in Scotland, the First Minister and the Cabinet Secretary for Health, Wellbeing and Sport of the National Assembly for Wales, and the First Minister, Deputy First Minister and Minister for Health of the Northern Ireland Executive[2].

Members[3] of the Review Body are:

Philippa Hird (Chair)
Bronwen Curtis CBE
Patricia Gordon
Joan Ingram OBE
Professor David Ulph CBE
Professor Jonathan Wadsworth
Lorraine Zuleta

The secretariat is provided by the Office of Manpower Economics.

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[1] References to the NHS should be read as including all staff on Agenda for Change in personal and social care service organisations in Northern Ireland.

[2] In the absence of a First Minister, Deputy First Minister and Minister for Health of the Northern Ireland Executive, the report should be submitted to the Permanent Secretary to the Department of Health, Northern Ireland.

[3] Shamaila Qureshi resigned as a member of the Review Body in February 2018.

Executive Summary

1. We report this year in the context of the most significant change to the Agenda for Change (AfC) pay structure since its introduction in 2004. This major pay development covers 1.2 million staff (FTE) across the UK and affects a pay bill of over £43 billion. The UK Government intends a substantial investment in the AfC workforce who are working hard to maintain services to patients while under pressure from changing and increasing demand. Against this background, our report considers the evidence and makes observations on the implementation and operation of the three-year AfC pay agreement.

Our overall conclusions on our standing remit and our observations on the AfC pay agreement from 2018/19 to 2020/21

- **We have been struck by the high levels of consensus among external commentators and the parties on the opportunities and significant challenges facing the NHS.**
- **It is clear that workforce issues are of the most significant concern and of the highest priority for healthcare providers.**
- **The evidence suggests that pay restraint has contributed to efficiency savings within the NHS, but is not contributing to the recruitment, retention and motivation of NHS staff.**
- **There is a workforce gap identified in the draft Health and Social Care Workforce Strategy for England which is creating an unsustainably high level of vacancies, work pressures and potential risks to patient care. There are some plans in place, which contain significant risks, to bridge that gap by 2021 but the gap will persist to 2027 if there is no action on workforce numbers, productivity or service redesign.**
- **The recruitment risks to the plans are chiefly domestic routes into nursing, potential impacts of Brexit, reduced advocacy among AfC staff and medium term reward.**
- **The retention risks to the plans are high workload, insufficient flexible working, leadership capacity and medium term reward.**
- **There has been considerable effort and goodwill by the NHS Staff Council in reaching a three-year agreement on AfC pay in England.**
- **The agreement provides a balanced package of pay reforms that aim to address the concerns of both AfC staff and employers, and to contribute to the sustainability of the workforce. It includes enhanced starting pay, protection for the lowest paid, restructuring of pay bands and improved pay progression supported by renewed performance management.**
- **In agreeing the design of the new pay structure the parties have taken a planned, medium term approach to manage the transitional effects and to address the affordability of pay increases.**
- **Overall, we conclude that the elements of the agreement, when taken together, begin to respond to our conclusions from the evidence on recruitment, retention and motivation. We look forward to monitoring the impact of the pay agreement on bridging the workforce gap, and stress the importance of delivering wider workforce developments as part of pay reform.**

- **The complexity of the agreement requires effective communications with AfC staff, given that the effect on pay increases for individual AfC staff, and within each band, will vary considerably.**
- **Effective performance management systems, which improve organisational performance and working lives for staff are difficult to implement and operate. To ensure that the proposed system does support the delivery of better patient care, NHS organisations should not underestimate the substantial volume of work required to implement and run the new system.**
- **The gender pay gap for AfC staff and any effects the new pay structure may have on that gap will require monitoring. We look forward to the parties' equality impact assessment to support the agreement.**
- **We note that the Scottish Government announced 2018/19 pay awards for AfC staff on 9 June 2018. The AfC agreement allowed the parties in Scotland, Wales and Northern Ireland to discuss whether and how the content of the agreement could be implemented. Negotiations were underway but were not completed in time for this report and we would welcome updates on the outcomes.**

Introduction and our remit

2. The context for this 2018 pay round has shifted somewhat since we concluded our 2017 Report. The economic environment has been relatively stable although uncertainty remains. For example, inflation increased during 2017 and in early 2018 before decreasing slightly by the time we completed this report. During this period, the UK Government changed the emphasis in its public sector pay policy, with a more flexible approach for AfC staff, subject to conditions, and this opened the opportunity for negotiations on reforms to the AfC pay structure. The reforms sought better to reflect modern working practices, service needs and fairness for employees. (Paragraphs 1.1 to 1.2)

3. The remit for our report was set by: (i) the Chief Secretary to the Treasury's letter enabling more flexibility in public sector pay to address areas of skill shortages in return for improvements in productivity; (ii) the 2017 Autumn Budget providing additional funding for pay awards for AfC staff if agreement could be reached about reforms to boost productivity; and (iii) the specific remit letters for England, Scotland, Wales and Northern Ireland. (Paragraphs 1.15 to 1.19)

Context

4. There is much common ground and agreement among the range of external commentators and NHS organisations on the nature of the pressures on the NHS. They suggest that, while some progress has been made, there is further to go to achieve sustained transformation of services. The financial pressures within the NHS remain. These pressures will continue to be a significant long term factor in determining the affordability of AfC pay awards and the ability of trusts and health boards to recruit, retain and motivate staff. We note the widespread recognition that the NHS workforce is essential to delivering good patient care and that workforce challenges are the number one priority. (Paragraphs 2.40 to 2.41)

The parties' evidence and our analysis

5. The main points from the evidence and our conclusions are:

    - Economy and labour market – GDP forecast growth is at 1.5% for 2018, slowing to 1.3% in 2019, and picking up slowly by 0.1% each year after 2019. CPI inflation fell to 2.5% in March 2018. The OBR forecast CPI inflation at 2.4% in 2018 (RPI inflation at 3.7%), 1.8% in 2019 (RPI 3.0%) and 1.9% in 2020 (RPI 2.9%). We recognise the differing positions of the parties on inflation measures, and will continue to report on both CPI and RPI inflation. Average weekly earnings were 2.6% in the three months to March 2018, with the OBR forecast at 2.7% for 2018, 2.4% in 2019, and 2.3% in 2020; (Paragraphs 4.3 to 4.9)
    - Productivity – in the parties' evidence the interpretations of productivity vary but often make links to outcomes for patient care. We can see significant benefit in the parties reaching consensus on the drivers, definition and measures of productivity in the NHS; (Paragraphs 4.14 to 4.17)
    - Workforce – the AfC workforce increased by around 2% per year between 2015 and 2017 but more slowly in Scotland than in the other countries. There are also differences in skill mix between the four countries. We conclude, however, from the draft Health and Care Workforce Strategy for England, that there is a projected workforce gap, and our assessment of the evidence is made in the knowledge that there is a shared ambition among all the parties to bridge that gap. We welcome the Scottish National Health and Social Care Workforce Plan, and the Northern Ireland Workforce Strategy; (Paragraphs 4.24 to 4.27)
    - Supply and recruitment – the draft Workforce Strategy recognises the importance of increasing the number of qualified people available and willing to work for the NHS. The planned strategic response is to increase the domestic supply through more clinical placements, increasing nurse associates and increasing the use of apprenticeships; (Paragraphs 4.36 to 4.41)
    - The removal of the bursary in England has been followed by a 20% reduction in applications to AfC-related health degrees in the UK in 2017. The number of acceptances on AfC-related health degree courses increased by 0.6% but nursing acceptances fell (by 0.9%). There may be risks over the quality of entrants if the number of applications continues to diminish; (Paragraphs 4.43 to 4.50)
    - Data from the NMC register show that the number of leavers overtook joiners in 2017, and that new joiners from the EEA fell from 9,389 in 2015/16 to 805 in 2017/18; (Paragraphs 4.52 to 4.53)
    - The NHS intends to create 100,000 more apprenticeships in England by 2020; (Paragraphs 4.61 to 4.64)
    - There have been significant efforts to reduce agency costs through more effective use of bank and substantive roles; (Paragraphs 4.65 to 4.68)
    - Vacancies – there is general agreement among the parties on the high and increasing levels of vacancies across the NHS, with a view that there are currently 36,000 nursing vacancies in England and a consistently high rate since 2015. Vacancy rates vary around the countries of the UK; (Paragraphs 4.69 to 4.77)
    - Retention – given the high level of vacancies, the costly option of agency staff and the lag in supply initiatives taking hold, retaining existing AfC staff is a key element in bridging the workforce gap. The parties agree that the retention rate for some groups of clinical staff has declined in recent years. The DHSC's stability index suggested a slight worsening in retaining the workforce across most groups in the five years to 2016/17. There has been a rise in voluntary resignations as a proportion of leavers from 44.7% to 63% in the five years to 2016/17, and a gradual increase in the rate of nurses leaving to 8.7% in 2016/17. We welcome the major retention initiatives being run through NHS Improvement; (Paragraphs 4.78 to 4.87)

- Motivation and engagement – there is broad consensus among the parties and external commentators that staff who are more engaged will be more effective in delivering good patient care. The 2017 NHS Staff Survey in England showed the Engagement Index for AfC staff fell slightly after a number of years of increase, job satisfaction was generally stable, and satisfaction with pay fell sharply by 5.8 percentage points to 29.4%. 63% of staff would recommend their organisation as a place to work (NHS Friends and Family Test) and there was a fall to 39% of NHS nursing staff recommending nursing as a career (RCN survey). The first year of new survey arrangements in Scotland suggested an Engagement Index of 75%; (Paragraphs 4.88 to 4.107)
- Earnings – in 2017 all AfC groups, except ambulance staff, saw an increase in average total earnings ranging from 0.4% to 2.0%. When adjusted for wider changes in the economy, nurses have seen a slight reduction in their earnings relative to the economy. The DHSC concluded that mean annual earnings growth for NHS staff had been lower than comparators across the wider economy in the last five years. Our analysis showed that graduate pay for AfC-related health degrees compares well relative to other graduates on entry, but less so after the five-year point. There are risks to AfC recruitment and retention should the differential with the National Living Wage erode. (Paragraphs 4.108 to 4.130)

6. We draw on the parties' evidence and our analysis in framing our overall conclusions on the factors influencing AfC pay (Paragraphs 4.131 to 4.141). Pay restraint has made a significant contribution to efficiency savings within the NHS. Pay is one measure of the way in which staff are valued, and we have seen in the evidence that pay restraint is not contributing to supporting the recruitment, retention and motivation of AfC staff at a time when these are huge priorities for the NHS.

7. Inflation increased in 2017 before falling back slightly in early 2018. We recognise that the level of inflation is an important consideration to AfC staff. Our broad conclusion on the overall position of AfC pay relative to the UK market is that it has declined slightly in recent years and this is acknowledged by the DHSC's analysis. It is clear from the NHS Staff Survey, individual trades unions' surveys and our visits that existing levels of pay do not help AfC staff feel valued. Pay could become an increasing concern when viewed alongside the significant workforce gap, high levels of vacancies, decreasing retention rates and reducing levels of advocacy by staff. We note that the NHS as a whole and individual countries have made efforts to ensure that the lowest paid AfC staff are paid above the National Living Wage (and equivalents).

8. Looking forward, there are risks to the AfC workforce from developments in the wider labour market. There has been a slight upward rise in average earnings and a pick up in pay settlements early in 2018. AfC staff are paid well relative to other graduates entering the market, but less so after five years in the NHS. We observe that modern employers focus on Total Reward, which includes pay, benefits and the whole working experience, to ensure that they can recruit, retain and motivate staff. Pensions form a valuable component of the Total Reward package for AfC staff as does flexible working. NHS organisations need to promote the attractiveness of the employment offer in the NHS, particularly to remain competitive in the eyes of the next generation of entrants.

9. Pay will have a role to play but it is important that it is part of wider workforce developments. We have identified in this report a series of warning signs across the countries of the UK that point to a gap between the number of qualified people available and willing to work in the NHS, and the work that needs to be done. There are risks for the supply and recruitment of AfC staff, and these issues require long lead times to solve. There is a workforce gap identified in the draft Workforce Strategy for England which is creating an unsustainably high level of vacancies, work pressures and potential risks to patient care. There are some plans in place, which contain significant risks, to bridge that gap by 2021, but the gap will persist to 2027 if there is no action on workforce numbers, productivity or service redesign. The draft Workforce Strategy is welcome, but we are concerned about clear ownership and accountability to deliver the actions to address workforce challenges.

10. The workforce gap underpins high levels of vacancies in the NHS across the UK. These vacancies have consequences for the workload, hours and goodwill of existing AfC staff. We emphasise the importance of ensuring effective retention of existing staff. Although there does not appear to be a single cause, a consistently reported reason for leaving the NHS appears to be work-life balance which may underpin a requirement for further development of flexible working arrangements. We also conclude, as other parties do, that the effective engagement of all AfC staff in the NHS will support efficient and effective delivery of good patient care. This widespread acknowledgement needs to be acted upon by employers to ensure their workforce is well-managed and rewarded.

Framework agreement on the reform of AfC 2018/19 to 2020/2021

11. The Health Secretary's remit letter said that the Autumn 2017 Budget provided additional funding for pay awards for AfC staff, provided they were part of an agreement with AfC trades unions about reforms to boost productivity. The Health Secretary expected our deliberations to be informed by the outcome of negotiations. (Paragraph 5.1)

12. On 21 March 2018, the NHS Staff Council reached a framework agreement on the proposed reform of the AfC pay structure for England. Following consultation, on 8 June 2018 the majority of NHS trades unions announced that they had accepted the proposed pay deal for England. The Staff Side chair and Employer chair of the NHS Staff Council wrote to us on 11 June 2018 informing us that NHS staff had voted overwhelmingly in favour of the agreement and that it would then be ratified by the NHS Staff Council. The three-year agreement includes: (Paragraphs 5.16 to 5.21)

    - a 6.5% cumulative increase over the three-year period to the value of the top point of each pay band for Bands 2 to 8c;
    - variable increases for other AfC staff between 9% and 29% over the three years would be delivered through pay progression, changes to starting salaries and/or restructuring pay bands;
    - an increase to starting salaries by removing overlaps between pay bands;
    - a new minimum basic pay rate of £17,460 from April 2018;
    - pay band restructuring to reduce the number of pay points by 2021;
    - a new NHS Staff Council progression framework from April 2019;
    - improved levels of attendance through a focus on staff health and wellbeing at national and local level; and
    - consistency of terms and conditions, and adjustments to payment schemes for unsocial hours.

13. We note that the UK Government has adopted a more flexible approach to public sector pay. We welcome the parties' significant progress in reaching an agreement. We look forward to monitoring the impact of the pay agreement on bridging the workforce gap, and we stress the importance of delivering wider workforce developments as an integral part of pay reform. The parties have taken a planned, medium term approach to manage the transition from the existing AfC pay structure over three years and to address affordability. Overall, we conclude that the elements of the agreement begin to respond to our conclusions from the evidence on recruitment, retention and motivation. (Paragraphs 5.22 to 5.33)

14. Our specific observations on the agreement are as follows:

- the additional funding should ensure that the pay costs arising from the agreement are affordable for NHS organisations. A separate funding mechanism would ensure the additional funding reaches employing organisations. We also expect to hear about the way in which the Devolved Administrations are managing the funding from the Barnett consequentials; (Paragraphs 5.34 to 5.36)
- the complexity of the agreement requires effective communications with AfC staff, and we acknowledge the extensive material already made available by the parties. As a result of the agreement and workforce change, the DHSC estimates the AfC pay bill per FTE in England will increase by about 3% each year between 2018/19 and 2020/21. The effect on pay increases for individual AfC staff and within pay bands will vary considerably, and these effects were important considerations to the parties in designing and agreeing the reforms; (Paragraphs 5.37 to 5.39)
- new pay arrangements will need to be monitored against the recruitment and retention factors identified in this report, including in the context of Total Reward; (Paragraphs 5.40 to 5.46)
- the reforms to pay bands require effective implementation to avoid the risk of wide variations in their operation. We recognise the importance of ensuring that the minimum rate of AfC pay is set to stay ahead of statutory requirements and to remain competitive in the labour market. This covers a significant proportion of AfC staff, and we expect the parties to keep AfC pay rates under review. Bands 3 and 4 might require attention as they will cover new roles. In Bands 5 to 7 more emphasis will be needed on existing staff being engaged, motivated and retained. There will be differential effects for Bands 8a and above. Shorter pay bands with larger pay increases will place greater emphasis on the performance review process and on the standards required for progression. Quicker pay progression will lead to larger proportions of staff at the top of pay bands for a longer part of their career. This could require career development incentives; (Paragraphs 5.47 to 5.56)
- implementation will require effective staff involvement. The agreement aims to increase staff engagement by putting appraisal and personal development at the heart of pay progression. There are revised performance management arrangements and the NHS Staff Council is working with NHS Improvement on implementation and monitoring. We note that implementing and operating effective performance management systems is difficult. All staff should receive well-structured appraisals which can contribute to improved organisational performance and working lives for staff. To ensure that the proposed system does support the delivery of better patient care, NHS organisations should not underestimate the substantial volume of work required to implement and run the new system. New pay rates will impact on AfC staff through their basic pay, earnings and take-home pay. The effects and unintended consequences in relation to pension, tax and National Insurance thresholds will need to be examined; (Paragraphs 5.59 to 5.67)

- On 9 June 2018, the Scottish Government announced that for 2018/19 AfC staff currently earning up to £80,000 would receive at least a 3% uplift, those earning £80,000 and over would receive a flat rate increase of £1,600, and the bottom pay points for Bands 1 and 2 would be increased to £17,110 to fulfil the obligation to pay the Scottish Living Wage. The Scottish Government also stated that this uplift was a payment on account of progress made in the negotiations so far and that the negotiations would continue towards a three-year pay deal; (Paragraph 5.74)
- The AfC agreement allowed the parties in Scotland, Wales and Northern Ireland to discuss whether and the way in which the content of the agreement could be implemented. We understand from the Devolved Administrations that negotiations are underway but would not be completed in time for this report. We support these negotiations and we draw the parties' attention to our observations. We would welcome updates on progress and outcomes when available. (Paragraph 5.76)

15. The agreement sets out our role during the period of the agreement including retaining our standing remit, and monitoring the progress of implementation and impact of the agreement. We look forward to working with the parties on measures for effective monitoring. In the meantime, we set out some considerations on the strategy and implementation, and the data requirements. (Paragraphs 5.77 to 5.80)

Philippa Hird *(Chair)*
Bronwen Curtis
Patricia Gordon
Joan Ingram
David Ulph
Jonathan Wadsworth
Lorraine Zuleta

13 June 2018