NHS Pay Review Body

Thirtieth Report 2017

Chair: Jerry Cope

Executive Summary

Cm 9440
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, the First Minister and the Cabinet Secretary for Health and Sport in Scotland, the First Minister and the Cabinet Secretary for Health, Well-being and Sport in Wales, and the First Minister, Deputy First Minister and Minister for Health in 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, the First Minister and the Cabinet Secretary for Health and Sport in Scotland, the First Minister and the Cabinet Secretary for Health, Wellbeing and Sport in Wales, and the First Minister, Deputy First Minister and Minister for Health in Northern Ireland.

Members of the Review Body are:

- Jerry Cope (Chair)
- Bronwen Curtis CBE
- Patricia Gordon\(^2\)
- Joan Ingram
- Shamaila Qureshi\(^3\)
- Professor David Ulph CBE
- Professor Jonathan Wadsworth\(^2\)
- 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 Health and Social Care Trusts in Northern Ireland.

\(^2\) Professor Jonathan Wadsworth was appointed to the NHS Pay Review Body in April 2016. Patricia Gordon was appointed to the NHS Pay Review Body in November 2016.

\(^3\) Shamaila Qureshi was unable to take part in consideration of this year’s report but remains a full Member of the Review Body.
NHSPRB Thirtieth Report 2017

Executive Summary

Our 2017/18 recommendations on the pay uplift are:

- We recommend a 1 per cent increase to all Agenda for Change pay points from 1 April 2017 in England, Wales and Northern Ireland.
- We recommend a 1 per cent increase to the High Cost Area Supplement minimum and maximum payments.

In addition:

- We recommend that pay point 1 in Northern Ireland is adjusted so it is above the 2017/18 level of the National Living Wage.
- The Health Departments in England, Wales and Northern Ireland should ensure that annual pay awards do not have unintended consequences in reducing the take-home pay of staff whose pay award causes them to cross pension contribution thresholds.

A list of our additional observations is included at the end of this summary.

Our remit

1. Each of the four nations of the United Kingdom asked us to make recommendations in relation to the remuneration in 2017/18 of the 1.3 million Agenda for Change staff employed by the NHS and by Health and Social Care Trusts in Northern Ireland.

2. Our report and recommendations are produced in the context of significant affordability pressures facing the NHS across the UK, with increasing demand for healthcare being accommodated within budgets that are broadly flat in real terms. All four nations are attempting to meet demanding efficiency targets and cope with significant day-to-day service requirements at the same time as delivering transformational change through service redesign and introducing new models of care.

3. Public sector pay policy has been set out by the UK Government until 2019/20 and provides the context for our recommendations in England. The policy position for Scotland, Wales and Northern Ireland continues to be short-term, covering 2017/18 only.

4. The Scottish Government provided us with its remit and evidence very late in the process due to the postponement of their Draft Budget for 2017/18. As a result, we have been unable fully to consider pay recommendations for Scotland in this report and instead will produce a separate supplement covering Scotland. While we understand the factors that led the Scottish Government to postpone submitting evidence to us, late evidence constrains the time available for us and for other parties to consider, reflect upon and respond to the evidence. We urge all parties to submit timely evidence in future pay rounds.
Overall reflections

5. It is clear that current public sector pay policy is coming under stress. There are significant supply shortages in a number of staff groups and geographical areas. There are widespread concerns about recruitment, retention and motivation that are shared by employers and staff side alike. Inflation is set to increase during 2017 compared to what was forecast leading to bigger cuts in real pay for staff than were anticipated in 2015, when current public sector pay policy was announced by the new UK Government. Local pay flexibilities to address recruitment and retention issues are not being used to alleviate the very shortages they were designed to address. Our judgement is that we are approaching the point when the current pay policy will require some modification, and greater flexibility, within the NHS.

6. Pay matters for the attractiveness of the service. Potential future staff will be more sensitive to pay than existing staff are. The impact on supply of the changes in student funding in England is still uncertain, but there is a risk of an adverse impact and early signs of falls in application numbers. Take-home pay is important for existing NHS staff and many saw a cut in their take-home pay in cash terms in 2016/17, whilst at the same time their workloads were increasing.

7. There is no people strategy for the NHS linked to the delivery of the Five Year Forward View in England which is leading to workforce issues being neglected, with a piecemeal and short-term approach to the role of pay and inertia at local level. We set out our views on this, and in relation to the people strategy in Wales and Northern Ireland, in more detail in Chapter 6.

The Economy, Labour Market and Pay

8. The overarching economic context for this pay round is the outcome of the EU Referendum and the uncertainty this has brought. However, economic growth continued to be steady in 2016, and inflation continued to be below the UK Government’s target, though was starting to increase in the second half of the year. Employment growth continued with the employment rate remaining close to historic highs. Private sector earnings growth continued to be above inflation and was significantly above public sector earnings growth.

Affordability, Efficiency and Productivity

9. There remains a big affordability challenge in each of the four nations of the UK. There is evidence of increasing strain on healthcare providers and serious difficulties in achieving the required efficiency savings and productivity improvements while delivering good quality patient care within the funding envelope. It is hoped that service transformation can fill a large part of the funding gap. We feel that it would be helpful to consider the different ways in which the gap between rapidly increasing demand pressures and plans for slow funding increases can be bridged and discuss this further in Chapter 3. We are concerned that holding down pay has become the default position for making efficiencies, as service transformation is not yet delivering. Reliance on pay to meet the affordability challenge risks putting further pressure on the real wages of NHS staff and creating a perception of unfairness, which could be counter-productive due to its impact on recruitment, retention and motivation.
Recruitment, Retention and Vacancies

10. We do not see significant short-term nationwide recruitment and retention issues that are linked to pay. There are shortfalls of professional staff in some occupations, including nursing and paramedics, with reported shortfalls concentrated in London, the Home Counties, the East of England and the East Midlands. There are similar problems in Wales and Northern Ireland. While there are issues in recruiting sufficient professional staff to cover demand in some areas, the joining rate increased in every staff group, and the NHS workforce increased in size in virtually every staff group in every country in the UK. However, home-grown recruitment remains insufficient to meet demand in some professional groups, with reliance on overseas nationals to narrow the gap.

11. The gap is also being filled by agency staff, as well as by Bank staff and a higher incidence of paid and unpaid overtime. There have been large increases in agency expenditure in recent years in all four nations of the UK and there is now a central focus, starting in England, on driving agency costs down. If the NHS wants further to reduce agency usage, trusts and health boards will need to go beyond expenditure controls and consider how they can incentivise agency staff to join the NHS as permanent staff, or to work their additional hours via staff banks. Staff see that money is being spent on agency staff, and see this as contradictory to the pay policy that is applied to them. This is demotivating and it is apparent that there needs to be a better understanding of the optimal mix between substantive staff, overtime, bank working and agency staff, with recognition that there is a total cost to employing people in the NHS that goes beyond the employed staff pay bill. We discuss this further in Chapters 3 and 4.

Motivation, Satisfaction and Staff Engagement

12. It is clear that NHS staff continue to be highly motivated. However, the picture is more complicated than this. There is also evidence that staff are under increasing pressure, have concerns about the quality of care they can give, and feel that they are not valued. There is a consensus among employers and staff side that morale is falling. This is a concern as it could translate into low engagement with the service reforms necessary to respond to the demands on the service and deliver patient care.

Workforce Planning, Future Supply and the People Strategy

13. NHS workforce planning in England has come under intense scrutiny, and there are signs of renewed emphasis on this in Wales and Northern Ireland also. There are a lot of uncertainties in both projections of service demand and workforce supply. This is inevitable to a degree given the risks associated with the impact of the EU referendum on a key source of supply and with the reforms to student funding arrangements in England, as well as the service transformation that is on the horizon. We support the improvements being made to workforce planning but note that there is no consensus amongst the parties about what the role of pay might be in future supply and workforce planning.

14. We believe there are real opportunities for apprenticeships to become a valued source of professional staff to the NHS, especially by providing clear career pathways for support staff to progress as their skills and experience increase. However, there are risks of a short-term tactical approach, focused entirely on meeting the targets and recouping Levy payments, which would mean that these opportunities are not maximised.
Pay Recommendations for 2017/18

15. We were told by the Health Departments in England and Wales that a 1 per cent pay award is funded and by the Health Department in Northern Ireland that a 1 per cent pay award was being factored into budget considerations. It is clear that a pay award higher than 1 per cent would require trade-offs in terms of service levels, investment decisions and potentially staff numbers, with associated implications for workload and pressures on staff and service delivery unless accompanying actions were taken to manage demand.

16. The evidence of very serious affordability pressures, no significant nationwide recruitment and retention issues related to pay, and suggestions that reducing workload pressures could have a positive impact on staff morale, made us give serious consideration to the case for a nil pay award. However, as we have said in previous years, and employers and staff side both made clear in their evidence to us, public sector pay policy for a 1 per cent increase has set staff expectations. There is a consensus among all evidence providers that the negative impact on staff morale of a pay award below 1 per cent is not worth the relatively small financial benefit, even if this flowed through to increases in staffing levels as opposed to reducing deficits. A pay award has the virtues of being immediate, visible, uniform and attributable.

17. With inflation having increased in recent months and forecast to rise further during 2017, and private sector wage settlements running at around 2 per cent, we are also very aware that a 1 per cent pay award implies a greater real terms cut in the value of pay than previously anticipated. We discuss this further in looking at pay policy over the medium term.

18. There was no support from evidence providers for targeting pay at a national level through Agenda for Change pay scales, within the 1 per cent pay envelope. Reasons cited included the lack of a robust evidence base, the limited positive impact that targeting within a 1 per cent award could have, the significant negative impact on morale of giving some staff a pay award lower than 1 per cent and worries among employers about how targeted recommendations would be funded at a local level.

19. 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. As we said last year, targeting at a national level through Agenda for Change is a blunt instrument. There are already appropriate mechanisms within Agenda for Change that enable trusts to target pay to address local recruitment and retention needs. However, as we discuss in Chapter 4, 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 RRPs in practice.

20. The evidence shows that recruitment and retention pressures and staff shortages are more severe in London and the surrounding areas. The High Cost Area Supplement (HCAS) does not appear to fully compensate staff for the additional costs of living and working inside London and the surrounding areas. There are also cliff edge effects around the HCAS boundaries that are a key driver of staff shortages in large parts of the Home Counties. Yet none of the parties proposed any changes to HCAS beyond uplifting it in line with the main pay award. We have taken a cautious approach as a result.

21. We considered the proposal made by Staff Side in favour of levelling pay in every UK country up to its level in Scotland. We did not hear any persuasive evidence that this would have any significant benefits in terms of recruitment, retention and motivation and there is no evidence of existing differentials causing cross-border issues. Differences in pay are an inevitable feature of devolved health policy.
Having weighed up all these factors, we recommend a uniform 1 per cent increase to all Agenda for Change pay points from 1 April 2017 in England, Wales and Northern Ireland.

We recommend a 1 per cent increase to the High Cost Area Supplement minimum and maximum payments.

22. There are still a number of unanswered questions about how each of the four nations will implement the National Living Wage. The key issue for us is how pay differentials will be maintained in order to incentivise staff to take on progressively more skilled and responsible roles. We continue to consider the National Living Wage to be a social policy with no compelling recruitment and retention reasons to support higher increases to lower paid groups in the NHS. We do not support the proposition to use the funding available for general pay awards intended to support recruitment and retention in the NHS to meet the cost of implementing the National Living Wage.

23. In the absence of clear answers to these implementation questions, we recommend that pay point 1 in Northern Ireland is increased to ensure compatibility with the National Living Wage.

24. In Wales, we note that the implementation of the Living Wage Foundation living wage has already led to significant pay compression. We are concerned about the impact this could have on staff in roles requiring more responsibility, skills and experience than entry-level roles at the bottom of the pay scale.

We recommend that pay point 1 in Northern Ireland should be adjusted so that it is above the 2017/18 level of the National Living Wage.

25. The tiered structure of pension contribution rates combined with the fixed nominal value of contribution thresholds led to the unintended and perverse consequence of the 2016/17 pay award translating into a significant reduction in take-home pay for some staff since it has led to them crossing contribution threshold boundaries. We believe that action is required to ensure that the annual pay award has the intended effect of increasing, rather than decreasing, take-home pay for all staff.

The Health Departments in England, Wales and Northern Ireland should ensure that annual pay awards do not have unintended consequences in reducing the take-home pay of staff whose pay award causes them to cross pension contribution thresholds.

Pay Policy over the Medium Term

26. The evidence we have received gives us cause for concern about the sustainability of public sector pay policy over the next few years. Inflation is already higher than previously expected. There are also pressures stemming from changes in the UK’s relationship with the EU and from changes in the student funding system in England, which heighten the need for the NHS pay and employment offer to be attractive. We agree with NHS England that NHS pay will need to keep pace with private sector pay over the medium-term to recruit and retain staff.

27. We are concerned that, in too many places, the default strategy to deal with significant increases in patient demand within a slowly increasing budget is by expecting NHS staff to work more intensively, in more stressful working environments, for pay that continues to decrease in real terms. We do not consider this a sustainable position.
28. We believe greater consideration needs to be given to the medium-term supply position of the NHS. The current rigid pay policy could be storing up problems for the future. The question is how, and when, to introduce greater flexibility. Should the government wait until there is evidence of significant damage to recruitment, retention and motivation outcomes? Or is there an argument that action now will save money in the medium-term by avoiding future supply shortages becoming critical? It is conceivable also that greater flexibility in pay policy could drive bigger gains for patient outcomes by, for example, using it as an opportunity to reform Agenda for Change to incentivise productivity improvements and efficiency savings.

29. It is crucial that the parties think about these questions, rather than wait for problems to overtake them. One possibility would be if the Government allowed targeting to alleviate recruitment and retention problems from outside of the one per cent cap. This would require funding to be provided appropriately.

JERRY COPE (Chair)  
BRONWEN CURTIS  
PATRICIA GORDON  
JOAN INGRAM  
DAVID ULPH  
JONATHAN WADSWORTH  
LORRAINE ZULETA

15 February 2017
Our additional observations:

- It is important to understand and monitor trends over time in **take-home pay** as well as in gross pay as this conditions the impact of pay awards on recruitment, retention and motivation. We would welcome evidence on this matter in future submissions.

- We repeat our request from last year for the health departments to improve the **evidence on the drivers of pay bill trends** over time and agency expenditure, not only to support the pay review process but to enable the service to be well managed.

- While progress has been made, more work needs to be done to provide a robust set of **workforce data** covering fill rates, vacancies and attrition rates by staff group and geographical area, not only to allow us to develop a sophisticated picture about what is happening to inform our recommendations but also to enable effective national and local planning.

- The next phase of work on the **use of agency staff** needs to move beyond the necessary initial focus on short-term ‘crisis management’ measures to control rapid increases in expenditure, towards a more strategic approach. This should mean more deliberate management of the mix between different ways of hiring staff based on an improved understanding of how pay and the employment offer affect supply and overall costs.

- The agreement reached on the **Agenda for Change** banding position of paramedics could provide a template for the NHS for making changes to services to improve productivity by: ensuring that job profiles evolve to match changes to NHS roles; encouraging and incentivising staff to make the effort to support improvements in productivity by allowing them to share in some of the benefits to the NHS of doing so; and recognising additional skills, expertise and responsibilities that result from changes.

- The **National Living Wage** will begin to affect Agenda for Change pay scales from April 2017. Governments across the UK need to clarify arrangements for paying the National Living Wage in the NHS including whether they intend to incorporate it into Agenda for Change or pay it as a supplement to eligible staff and what action they will take to avoid compression of pay differentials. They also need to clarify funding arrangements – we continue to have serious doubts about any proposition to fund a social policy such as the National Living Wage from funding intended for general pay awards to support recruitment and retention.

- The Welsh Government needs to take action to address the impact of the Living Wage Foundation living wage on **pay compression** to tackle potential motivation and recruitment issues.

- **Pay policy is now coming under greater stress than for several years, especially with the likelihood of rising inflation, and we are approaching the point when greater flexibility may be needed in the NHS.** It is crucial that health departments think beyond next year, to how pay policy might drive gains for patient outcomes and enable reform of Agenda for Change. This is not to understate the financial pressures facing the NHS – they are clearly considerable – but staff in the NHS cannot, as NHS England have always made clear, be paid materially less than workers in the economy as a whole over the medium-term.

- **To help manage the transition to an exit from current pay policy,** the Government should consider making pay policy more flexible, perhaps by allowing targeting to alleviate recruitment and retention problems from **outside** of the one per cent cap which would require funding to be provided appropriately. Linked to this, as we have said in previous reports HR expertise at a local level is needed.