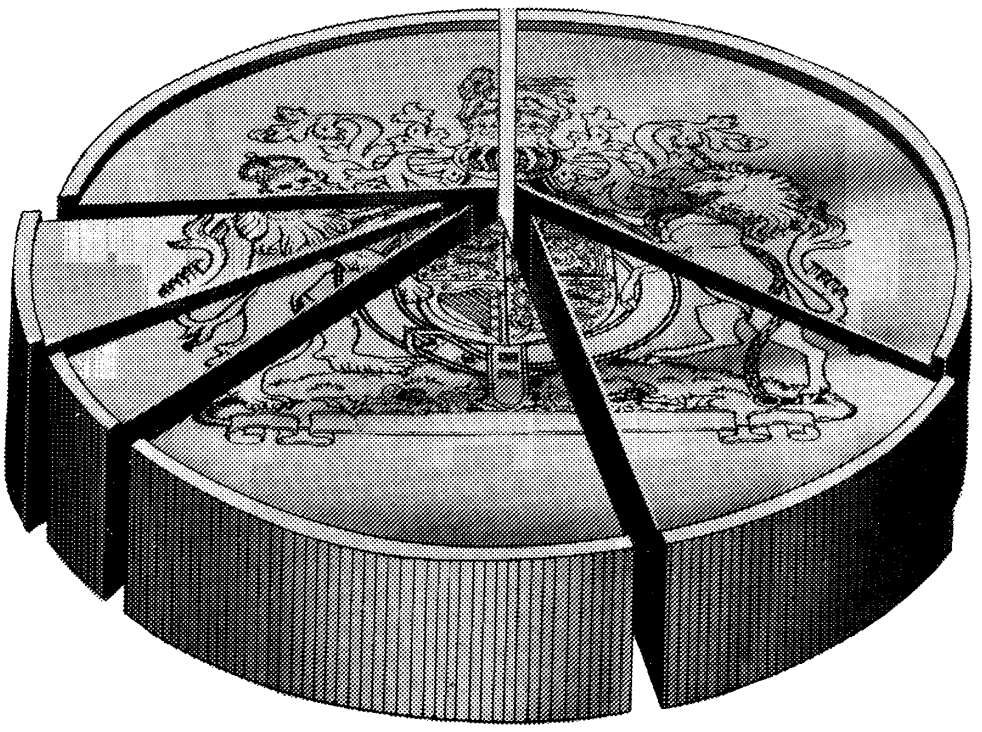
NHS PAY
A time for change

A DISCUSSION PAPER ON A NEW SYSTEM OF
PAY DETERMINATION FOR THE NHS



NAHA

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A DISCUSSION PAPER ON A NEW SYSTEM OF
PAY DETERMINATION FOR THE NHS

King Edward's Hospital Fund for London

NAHA

National Association of Health Authorities

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Foreword

During 1984 the King's Fund and NAHA agreed to set up a joint working party, under the chairmanship of Lady McCarthy, to review the present system of pay determination in the NHS and to make recommendations for reform.

The working party has now concluded its deliberations and, before reaching any decisions on its recommendations, we are publishing its report in order to gauge the reactions of the Service and of other interested bodies. We hope that the report will stimulate a wide-ranging debate on this important issue.

Robert Maxwell
Secretary
King Edward's Hospital Fund for London

Arthur Taylor
Chairman
NAHA

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INTRODUCTION

Since the King's Fund and NAHA published their proposed new systems for pay determination in the NHS in 1983[1], there have been a number of major developments: the publication and implementation of the Griffiths Report on management; the contracting out of hotel services in parts of the NHS; and the creation of the Pay Review Body for Nurses and Professions Allied to Medicine. Because these represent a potentially fundamental change in the whole system and structure of pay, the two organisations agreed in 1984 to convene a working party (its membership is listed in Annex 1) to consider what problems these developments have produced, and whether a new and more radical set of proposals should be advanced.

The 1983 Reports strongly advocated a coherent system of pay determination, based on the principle of external comparability and following closely the recommendations of the Megaw Inquiry into Civil Service Pay[2]. The King's Fund Report also recommended an elaborate structure to service the system, which relied heavily on the Regional Chairmen to act as the management voice. Certain criticisms of the Whitley system – most notably its continued isolation from the Service – were made, and the reports suggested ways in which the Whitley Councils could be strengthened, their accountability made clearer, and their briefing systems improved.

The Government has clearly demonstrated that it does not support extensive use of comparability as a suitable method for establishing rates of pay in the public sector, and prefers to use the concept of 'market forces'. So there has been no move either in the Civil Service or the NHS towards creating the apparatus needed to establish a consistent set of comparators to determine appropriate levels of pay. Both the Review Bodies – for Doctors and Dentists and for Nurses and Professions Allied to Medicine – in their 1985 Reports mention the use of comparability. 'Changing levels of remuneration in other walks of life have a part to play in our considerations. We do not think it right to determine levels of pay for NHS doctors and dentists in isolation from relevant pay developments elsewhere . . .'[3] 'We have reservations about the use of external comparisons and think that caution should be exercised in applying them, but they cannot be completely set aside . . .'[4].

There has been no significant change in the way in which wage levels are determined since the earlier reports were published. But there have been some significant changes in the composition of the management sides of Whitley, and in the way in which the views of NHS management are given to the Secretary of State and the DHSS. Some of these changes were heralded in the King's Fund Report.

These changes were introduced by the Secretary of State in January

INTRODUCTION

1984 and were intended to enable an overview of priorities in pay and a cross-council strategy to be developed. The changes were generally welcomed by the NHS at the time. However, there seems, now, to be a difference of opinion as to whether the reconstitution of the management sides has, in fact, enabled these objectives to be fulfilled.

John Leopold, reporting on research into the personnel function in the NHS, comments that he 'found an increase in confidence in better briefed members' and 'a genuine belief that members are beginning to develop forward strategies and priorities in pay'(5). This greater sense of confidence among management side members does not, however, seem to have communicated itself to all managers and chairmen. The Health and Social Service Journal, in a report of a conference on pay, commented '. . . throughout the debate the chaos and absurdity of the present pay system was underlined . . . '(6).

The whole Whitley system is seen, by many managers, to be restrictive and to frustrate the desire of local management to recruit suitable and properly paid people to manage the changes which are felt to be necessary. The critics point out that the principles of Whitley have been undermined by the different rates paid to regional and district general managers in the Service and are likely to be further undermined if the same system is applied to the appointment of unit general managers. This freedom to recruit at the 'right rate' is sought by some managers for all staff in their Districts. Consequently, they argue that the national framework should be dismantled, and replaced by a wholly local system of bargaining. Others, while demanding more local flexibility, would prefer to keep a national framework.

Because this demand for a purely local pay system is being vigorously canvassed as a solution to NHS pay problems, the working party examined the arguments for and against it in an attempt to see whether and how such a system might solve perceived problems.

References:

(1) Margaret McCarthy, A New System for Pay Determination for the NHS, King's Fund Project Paper 39, 1983.
Pay Determination in the NHS: A System for the Future, NAHA, 1983.
Pay Determination for the NHS: Conclusions of the Strathallan Seminar, NAHA, 1983
(2) Report of Committee of Inquiry into Civil Service Pay, 1982. Cmnd. 8590.
(3) Review Body on Doctors' and Dentists' Remuneration, 15th Report 1985. Cmnd. 9527.
(4) Review Body for Nursing Staff, Midwives and Health Visitors and Professions Allied to Medicine, 1985. Cmnd. 9528.
(5) Health and Social Service Journal, January 31 1985.
(6) Health and Social Service Journal, October 11 1984.

LOCAL BARGAINING

We began the examination by making a list of all the advantages which could be cited, and all the disadvantages which might be argued against the system. We acknowledged that both lists were *a priori.* But, during our discussions, we identified four practical problems which we thought were critical in persuading us of the undesirability of recommending a totally local system. Recognising, however, the need and desire for some changes in the present method of determining pay, we looked at a number of other pay structures to see if they could help us in suggesting some alternative. Finally, in the light of all this, we devised a system, the principles of which we think will provide the elements of change.

Advantages

A. *To General Management*

1. Greater responsiveness to local priorities;
2. Greater local control and visible accountability;
3. More power to the general management function and a requirement for managers to behave more like industrial managers;
4. More responsiveness to local labour markets, easing recruitment difficulties;
5. The possibility of reducing anomalies in the present pay structure;
6. An opportunity to introduce a system of payment for performance while eliminating bonus schemes;
7. An opportunity for easier overall planning, since any local pay system would require greater certainty in funding.

B. *For Industrial Relations*

1. More meaningful bargaining about productivity and reducing numbers;
2. A reduction in the risk of national disputes and a diminution in the power of national trade unions;
3. A change in the nature of pay bargaining.

Disadvantages

A. *To General Management*

1. A threat to the coherence, unity and concept of a national health service;
2. A loss of central control over pay levels unless freedom to bargain was constrained;
3. A heavy cost in terms of management input and skills;
4. A probable worsening of the low pay problem;
5. The undesirability and impossibility of operating such a system for staff constituting a national market;
6. Possible disadvantageous effects on staff mobility, creating either very low or very high turnover rates – producing either inflexibility or instability;

7. Wealthy or inefficient authorities 'poaching' scarce staff;
8. National skill shortages being disguised;
9. Irreversibly damaging if done badly.

B. *For Industrial Relations*

1. Very divisive among staff, exacerbating the distortions of the internal labour market already occurring because of the existence of the pay review mechanism;
2. An increase of union power at local level with the risk of local disputes being more difficult to solve;
3. Bargains struck could be used coercively to force up rates generally;
4. Local harmony between management and unions disrupted with consequent threat to local services.

When we examined our list of 'pros' we found that there were a number of factors which made the prospect of a locally determined scheme very attractive. Local management does need flexibility in order to meet differing needs and new structures. It is the lack of such flexibility and the consequent inability to shape local services to local needs and priorities which causes the most frustration, particularly among those managers who have a clear vision of the way in which their service ought to be moving. There is also a growing desire to pay for performance (PFP) in ways other than the now out-dated bonus schemes which have largely degenerated into systems of paying 'over the odds' on the national rate. PFP is very much the current mode of thinking throughout large sections of industry and enthusiasm for it has not by-passed NHS managers. It would also be extremely helpful to local management if they were able to use local discretion to buy out restrictive practices, which would enable them to achieve more genuine increases in productivity with a reduction in establishments.

Industry outside the NHS has not been able to produce such results without cost: only local NHS management has been required to go to the bargaining table without the necessary budget to buy change.

But to many NHS managers, the disadvantages seem at least as potent as the advantages. How they would respond to the arguments for and against local bargaining depends very much on individual temperament. Some would undoubtedly find the ideas challenging and exciting; others frightening and daunting. Some of the arguments which we have listed are a matter of conjecture – whether, for example, the pay structure can be made more meaningful or whether the results would be divisive. But the major difficulties which would arise from dismantling totally a national system were revealed when we attempted to answer four questions: What is 'local' bargaining? How can it be reconciled with the pay review system? What would be

the Government's view? Would local management be competent to devise and manage their own pay systems? The answers we found seemed to us to present the nub of the problem.

The nub of the problem

1) *What is Local?*

It seems that when 'local' bargaining has been discussed, many of its proponents talk as though 'local' means District. Certainly, if the spirit of devolution is to be carried through to pay, the District appears to be the natural management unit for autonomous bargaining. But is this really a practical proposition? Health Districts make little sense in pay bargaining terms – particularly if one thinks about the way in which rates might be established for a number of staff. A very few of the larger Districts – like Leicestershire and Oxfordshire – might be able to establish something like a genuine local rate for unskilled manual staff or clerical staff – but most Districts would have to establish a common rate between them. This could only be done through some sort of consortium of Districts – which would inevitably be matched with some representative system on the staff side. There would undoubtedly be different local labour markets for different groups of staff. The local market for unskilled female part-time labour for example, is very different from the local market for skilled female full-time secretarial staff. The markets are different again for laboratory technicians or ambulancemen.

In addition there is the problem of the number of staff employed in each district in different occupations. Although there are sufficient numbers in the external labour market in some groups – unskilled staff in domestic work or nursing auxiliary grades for example – to make the notion of a local labour market tenable, in other occupations – such as MLSOs or phlebotomists – there is not a large enough external market to establish a meaningful local rate. The only sensible unit for establishing these rates would be the Region.

2) *Staff Covered by Pay Review*

Even if a complex system of mixed bargaining at different levels were thought possible, the fact that 50% of NHS staff have been taken out of any bargaining system must make the problem of creating a coherent pay system well-nigh impossible for local managers. It is not merely that the determination of the rates for 50% of the staff is outside any one District's (or Region's) control – that is difficult enough. But these 50% are in many ways 'rate-setters', and what they are awarded by their Review Bodies is bound to be regarded as the 'going rate' for other groups of staff throughout the NHS. This is, of

course, true whether rates are determined locally or nationally, but it is easier for NHS management, nationally, to minimise the potential damage to the pay of other groups of staff which could occur as a result of Review Body awards.

The whole problem of what to do about Review Body awards which are outside the control of management is just beginning to affect the NHS. There are a number of other pay systems which have 'mixed' forms of settlement. The Civil Service bargains, in principle at least, for all grades up to under-secretary whereas the salaries of top civil servants are settled by the Top Salaries Review Body. A number of large firms bargain up to higher management level. But the common feature of these systems is that the cut-off point is horizontal – that is to say the top is sliced off. Only the NHS has a system of pay in which the system is vertically mixed, with groups of staff at all levels of skill and pay having their awards arrived at in different ways. This system offends against one of the most important characteristics necessary for an acceptable pay system. Labour economists have shown, through numbers of field studies that internal comparisons – 'felt fair' comparisons – are crucially important in gaining acceptance of a pay structure. The breaching of this principle, although difficult enough to handle nationally, is bound to be even more difficult to deal with at a local level, where staff can relate their rates personally to those of people working alongside them whose rewards are different and granted on other criteria.

3) *The Government View*

This seems contradictory. On the one hand, some ministerial statements lead one to suppose that the Government might favour a local system. Health ministers have been reported as being 'critical of the NHS practice of paying the same rate for a particular job in any part of the country. They look to wide national variations in the labour market and the going pay rates in other sectors'[1].

It is not difficult to understand why ministers find the idea attractive. It seems to offer further opportunities for more savings for the Service as a whole. It removes the DHSS from the direct responsibility of denying wage increases and places the onus of resistance directly on NHS management. It seems to carry further the idea of local devolution of responsibility to which the Government still claims to subscribe. The reality of the cost of wage increases beyond what the Government sets in its annual targets would be more clearly brought home to health authorities, NHS workers and the public if these awards were made locally and the costs were negotiated openly.

On the other hand, if the future resembles the past, the Treasury would be very resistant to giving up one of the instruments – i.e. the wage bill for the major public service sector – for regulating public expenditure. Even the Review Bodies can only *recommend* rises in rates, and the Government has reserved the right to accept, reject or vary their recommendations. If pay were to be determined locally it is likely that the Government would not exercise such rights, unless it was prepared to continue to exercise the same rigid controls nationally over the level of funding.

There would also certainly have to be changes in the way the RAWP formula is applied if local wages were to be genuinely discretionary. Although studies have shown that the operation of the labour market is more complex than believers in the free market argue, there is quite clearly a marked difference in the level of rates between the South East and the rest of the country. Health authorities in the South East would undoubtedly have to pay more to recruit most levels of staff than the rest of the country. But these are precisely the Regions which are RAWP losers. Would the Government be prepared to see an accelerated run-down of services in this part of the country? Or would it feel it necessary, for political if for no other reason, to intervene and provide extra funding for these Regions? Since the total size of the NHS budget is unlikely to be increased, if the South East were to receive extra funding in order to pay enhanced local rates, the money would have to be directed from other Regions who find their local labour markets cheaper. This would, of course, produce a 'reverse' RAWP.

4) *NHS Management*

We regarded the first three objections which we have listed as very substantial drawbacks to the idea of locally determined pay. But at least as, if not the most substantial objection is the question of whether NHS management has the competence to handle such a radically changed system.

This is not a criticism of the NHS. Managers develop skills to match the requirements of their industry. Such requirements breed their own sort of management or attract recruits to match their own requirements. The whole culture of the NHS has never been towards detailed, technical knowledge and understanding of suitable and acceptable payments systems and of how these systems are organised to match the purpose of the enterprise. Such skills are not easy to acquire and take a considerable time to produce satisfactory results. Not only have NHS managers not been required to develop such skills – they have been positively discouraged by the present system

from acquiring them. One may speculate about why this is so. One probable reason is that, as we have already mentioned, the Treasury has a close interest in the size and distribution of pay in this area, and the system has been seen as being important to control for reasons of public policy.

Not only would it be very costly in terms of management input to develop a separate local pay system; it would also be a slow and painful set of skills for managers to acquire with a high risk of costly mistakes. It would mean that the Government would have radically to change its attitude towards the recruitment of 'administrators' in the NHS, since many more would be required in each District or 'bargaining unit' in order to create and maintain a pay system.

Having considered these problems we feel that total local discretion to fix pay would be unworkable for the NHS.

Reference:

(1) Health and Social Service Journal, October 11 1984.

OTHER PAY SYSTEMS

But although we reject the idea of totally local bargaining, we do agree that the present national pay system is unduly rigid and does prevent local management from initiating change. So we looked at other systems to see if they could help us in formulating a new structure. We looked again at the Megaw Inquiry into Civil Service Pay, since we had found in our 1983 paper, that the Report had shown similarities between the two systems. Megaw says:

> We were attracted to the concept of decentralisation, because we believe that the transfer of responsibility for pay to the centre has tended to undermine the ability of managers in the Civil Service to respond to management needs, and . . . has led them to take less interest in important management issues than they should . . . they have tended to become spectators in the face of pressing problems . . . To give departments a larger measure of responsibility for the determination and structure of the pay of their staff might well effect a positive and valuable change in civil service management style. para 281

In spite of this analysis, however, Megaw rejected the idea of wholesale local bargaining for the Civil Service for much the same reasons as we have for the NHS.

i. We do not think it possible for widespread authority over pay to be delegated to departments without widespread delegation of financial authority to match. para 283

ii. A high proportion of the Civil Service is to be found in grades which exist service-wide, and flexible movement of staff between departments and between different areas of staff within departments is made easier by common pay-scales for the grades. Giving departments the possibility of raising pay to meet shortages might result in 'bidding-up' between departments who are often competitors for very similar labour in the same area. This would be costly and cause a general rise in pay for the occupations in question with very little management gain . . . para 284

iii. Relaxation of central control . . . would be very difficult to reconcile with the political sensitivity of the overall result of negotiations and would be very hard to keep within bounds; para 284

iv. . . . decentralisation would spread the seeds for friction between departments and for sectional disputes between unions and groups of staff. para 284

v. It could be more costly to administer a fragmented bargaining system. para 284

OTHER PAY SYSTEMS

vi. Neither departments nor unions are at present organised to provide quickly a sufficient pool of expertise for pay negotiations at departmental level. para 284

vii. There are good arguments for concentrating negotiations in the hands of those with a high degree of knowledge and experience in industrial relations and pay bargaining. para 284

But Megaw does concede that it might be worth trying experiments in some government departments.

We were, however, very conscious that the NHS is being required to behave in a more business-orientated way since the publication and implementation of the Griffiths Inquiry. We looked therefore at some pay structures of industries in the private sector, to see if their pay systems were of help.

The current desire for freedom to bargain locally in the NHS seems to arise partly from a belief – particularly among managers – that they are unduly constrained as against their competitors in the labour market by the national pay system. There appears to be a myth that managers in private industry have considerably more discretion locally, to pay according to local labour market rates and to adjust terms and conditions according to similar principles. It may very well be true that small businesses, locally-based, with low turnover and few employees do have freedom to employ at strictly 'what the market will bear' rates, but the workforce employed by those sorts of business are likely to be casual, with a high rate of turnover and with very little skill or training.

Even the most cursory glance at the pay structures of the large national employers shows that there is a very high degree of centralised control over rates, grading and conditions, and, moreover, that within each industry, there is a clear internal labour market, in which rates and conditions of each company – although they may vary to some degree – quite closely reflect competitors'.

We have looked in more detail at some representative industries – selected because we thought that their characteristics were closest to those of the NHS. They are nationwide, covering all regions and districts of the country and are service rather than manufacturing industries. We chose to look at retailing, insurance and banking.

Retailing has a very simple pay structure which is common to all the large firms. The country is split into four bands: the West End; the rest of London; Provincial A; and Provincial B. There may be some variation in the banding to reflect local labour demand – e.g. a store may be placed in a higher band than the size of the town would merit. Inside

each band, the jobs are simply structured into five grades. The only discretion given to local managers is to promote 'assistants' to 'leading assistants' or 'sale staff'. There is slightly more flexibility for branch managers and above, but this variation is based on performance and level of responsibility and on elements such as turnover, and numbers of staff. There are yearly increments for junior staff up to the age of 19. The rates of pay vary slightly between each company. But with the exception of one firm – which pays consistently about £10 a week more in each band than the others – the variations are small. In the words of one major company 'the system works because all our major competitors follow a similar policy'.

Insurance Companies have a more complex structure, with a larger number of grades, but the principles seem to be very much like those of retailing. The country is divided into Inner London, Outer London and/or major towns, and the rest. Some companies have a larger scale than others, but the majority seem to range over 11-15 points. There are marginal variations between the rates of each company. Higher management grades and rates are dependent upon turnover, number of staff, complexity of work etc.

The pay structures of the *banking industry* are the most interesting for the purposes of this study. Until 1968 each of the major banks had conducted its own negotiations. Then the major clearing banks agreed to set up a Federation of Employers in order to stabilise the pay system for the banking industry. A Joint Negotiating Council was established with representatives of the major banks on the employers' side and representatives of the National Union of Banking Employees and the Council of Bank Staff Associates forming the staff side. The first major task of the JNC was to agree a job evaluation exercise from which the present pay structure covering all the major clearing banks was evolved. Employers and staff agreed that the most important element in their negotiations was the need for a stable and ordered clerical pay structure. The banks felt that this was important because this group was vulnerable to the external market. There were other principles which both sides agreed should be built into the job evaluation exercise. Not only should it be sensitive to the external market, it should also allow for career development and reward responsibility and initiative. The structure was age-based. In order to ensure better co-ordination between the different banks, a post of director of the Federation was created.

This centralised system has produced difficulties, particularly where one or two banks have different priorities. Autonomy has been preserved for wholly-owned subsidiaries. But this autonomy has, on the whole, been more apparent than real, since the JNC has established the rates,

by and large, for the banking industry. But it seems that both employers' and staff sides acknowledge that the establishment of centralised bargaining has brought a considerable degree of stability to the industry.

Banking may not be the most radical industry in the country, but it is one of the most profitable. If such an industry moves from fragmented to centralised bargaining because it perceives this to be a more stable and satisfactory system, the lessons for the NHS must be obvious.

A REFORMED SYSTEM

As we said earlier we reject the idea of a wholly locally determined pay system. We were reinforced in this view by an examination of other pay structures. We did, however, observe that although they were strongly centralised, they all contained some degree of banding. We thought some adaptation of this 'banding notion' might be helpful in trying to devise a system which reconciles a broad national framework with the opportunity for some local flexibility.

We believe that any such system should fulfil certain criteria. It should allow managers to tackle the problems of internal relativities, which have become distorted through the application of different terms and conditions of employment to different occupations. A typical example of this distortion is the relationship of take-home pay of craftsmen to the salaries of works officers. Another is the take-home pay of senior porters and junior managers in units.

Managers, having set objectives in the light of service needs, should be able to use payments systems to attract sufficient numbers of staff of the necessary quality in order to achieve these objectives. Because some of these needs and objectives will be set nationally, while others will be local, the system will need to be sufficiently flexible to allow for local discretion.

A new pay system must be much more simple and readily understood. Managers must also be given opportunities to reward merit and performance.

Pay Bands

We think that these criteria would best be met by establishing a system of pay bands. Agreement as to which posts should be in each band should be determined nationally. Health authorities would be given some discretion within the determined band to negotiate either individual or group rates. The yearly increases in rates would be negotiated nationally. For example: the band in which computer programmers are placed would be a question for national negotiation. Individual health authorities, locally, would decide where in the band they would place their programmers according to such principles as recruitment and retention, and internal differentials. Equally, individual performance could be rewarded by moving a particular programmer up the pay band.

The working party therefore recommends that there should be three broad pay bands, which initially would group together all occupations that are at present on comparable rates. Although we are not proposing in detail who should be in each band we see them broadly covering:

A REFORMED SYSTEM

Band 1 (£21,000 and over): A small number of people in 'top posts' whose professional responsibilities are different, but whose posts are clearly comparable. Examples of posts in this band are general managers, senior professional advisors, senior scientific advisors, and consultants. There would be a small number of posts in this band and little local flexibility in the determination of individual rates. National criteria such as size of population managed and size of budget would determine the pay of individuals within the band.

Band 2 (£9,000 – £21,500): This is the major band in which local flexibility can be exercised. It would be possible to give total local discretion to authorities to negotiate their own structures within these limits, but since we have argued against unfettered local discretion, we recommend that within the broad parameters three overlapping spines should be introduced. Spine A would run in three series of four increments from £9,000 – £14,000; Spine B in three series of four increments from £12,000 – £18,500; and Spine C in three series of three increments from £15,500 – £21,500. Each spine would overlap and Spine C, the top spine, would overlap Band 1 by £500. Initially posts should be allocated centrally to one of the spines, but local discretion would be given as to where on the spine individuals were placed.

Band 3 (up to £9,000): This is a mixed band of basic and training grades which goes up to £9,000. National negotiations would set a minimum level for each group, but authorities would be free to negotiate rates within this band. However, there would be a number of professional training grades whose pay would be determined nationally.

We have set out the system diagrammatically in Figures 1 and 2. Figure 1 superimposes the proposed banding system upon the present pay relationship of various groups. Figure 2 illustrates our proposals for Band 2 with three spines.

We acknowledge that if such a system were introduced, the position of each occupational group within it would be decided initially by the present rates of pay. There are, of course, disagreements about present internal differentials between groups. Some of these present differentials could be altered by DHAs' own decisions about the position of each group where discretion is given. However, there will be those who say that such a system cannot be established before there is a complete job evaluation of all groups. We do not accept this argument for three reasons.

First, such an evaluation would take a considerable time to complete. We believe that the Service cannot continue with the present

unchanged system, because its rigidity is preventing necessary change.

The second reason why we think that a complete job evaluation should be resisted is because the changing nature of many jobs in the Health Service would make such an evaluation out-of-date almost before its completion.

We acknowledge, however, that such a rationalisation based on a job evaluation exercise is necessary. But we believe that this would be better achieved by national negotiations over a period of time. In fact, keeping some rationality in any pay system requires constant re-evaluation of the relative position of each group within the system to take account of changing job content.

Our third reason for wanting to see a gradual re-evaluation of internal relativities is that the process of adjustment will undoubtedly carry with it some costs, which it is important to identify. It is worth reiterating that every major industry, apart from the NHS, recognises and budgets for the cost of change before it embarks on making changes. It is to the credit of the NHS – and particularly to health authorities – that they have achieved a great deal of change without being given the budgets to effect them. But to achieve wholesale change is not possible without some cost.

Staff Covered by Pay Review

We cannot escape the fact that the pay of almost 50% of NHS staff is outside the control of their employers. We have, nevertheless, included these occupations in Figure 1 because this is important for the purposes of internal relativities. We also believe that all the groups of staff covered by pay review should be allocated to the appropriate band because it should help the various Pay Review Bodies to determine future levels of pay.

Machinery

Management Arrangements

One of the continuing weaknesses in the pay system is the difficulty of creating a management side which has the visible authority to speak for the Health Service as a whole. The system which we have proposed still necessitates a management side to carry out the negotiations which we have identified as needing to be done at a national level, since we remain firmly committed to the principle that pay questions should be settled through collective bargaining. We would see national negotiations as being principally concerned about three areas: devising and controlling the banding system; the distribution of money among the bands; rationalising conditions of service.

A REFORMED SYSTEM

Any management side must consist of three elements: the DHSS, the NHS Management Board and representatives of the NHS. The first two are easy to identify: the Minister would continue to be represented by a departmental civil servant, whose responsibilities would be to report to the Minister the views of management and staff, and *vice versa.* The Personnel Director would represent the Management Board. It is, as always, who represents the NHS which presents the difficulty.

The 1983 King's Fund Working Party Report recommended that Regional Chairmen were the only group who could fulfil this role, although the Strathallan Paper dissented from this view. However, the Regional Chairmen have come to be seen as representing NHS management during the last two years. This system has not, however, entirely satisfied the rest of NHS management, who are still unhappy about whether their views on pay are being fully taken into account. If this is the case, the blame does not rest entirely with the Regional Chairmen, but rather with the nature of the present pay system which, because of its remote nature, produces frustration and lack of interest on the part of NHS managers from District Chairmen down. It is a natural reaction not to take any view on or to make decisions about a problem if people feel that they have no power to influence its resolution. One of the important features of the system we are recommending is that, because it has scope for local determination, DHAs and their managers will be able to form views and make decisions about pay. Regional Chairmen will then be able to get a much clearer idea of what the Service actually wants from its pay system and how much it is prepared to pay for it. We believe, therefore, that in national pay negotiations, Regional Chairmen are the most suitable representatives of NHS management in England.

When we consider the structure of the machinery to support the management side of the NHS, it becomes clear that the present vertically-based functional Whitley Councils would not be appropriate for the pay system we are recommending.

In devising new structures, there is also a need to distinguish between machinery for gathering information, for making policy and for negotiating on such policy. We therefore recommend the creation of three sorts of machinery to ensure that policy decisions are reached and implemented in the light of full inputs of information from the Service.

1) A *Pay Policy Committee* should be formed, which should be a sub-committee of the Health Services Supervisory Board. It should be chaired either by the Chairman of the NHS Management Board or the Personnel Director, who in any case would be a member; and its members should comprise one or more representatives of the Government; four or five Regional Chairmen; and representatives of

Chairmen in Scotland and Wales. Although this Committee would be formally accountable to the Secretary of State (in his role as Chairman of the Supervisory Board), in order for the system to work we would regard it as essential for the Secretary of State to stand back from direct intervention in pay issues and for the Committee (or the Personnel Director) to deal with, for example, deputations from national trade union leaders or intervention from ACAS. The function of this Committee would be to determine both policy for the national pay framework and strategy for the negotiation of such policies with the staff side. The Committee would also be responsible for giving management evidence to the Review Bodies and for providing information and policy to influence the DHSS' negotiations with the Treasury on cash limits.

2) A *Pay Information Unit* should be formed, which would be accountable to the new Personnel Director. We would expect to see such a unit staffed by a mixture of present Whitley management side officers (who should cease to be civil servants and would become NHS officers) and NHS personnel and finance officers, seconded for a term from the Service. The function of the Unit would be to brief the Pay Policy Committee on issues of pay and manpower and to provide information to be used in negotiation and in evidence to the Review Bodies.

3) *NHS Negotiating Council.* The Negotiating Council should be chaired by the Personnel Director. Other members of the Council should probably be full-time negotiators, since this would be a heavy commitment. The Council should decide its own organisation, but we think that sub-committees would probably be needed for details of negotiations on each of the three pay bands. The Council would be accountable to the Supervisory Board's Pay Policy Committee.

Sub-National Bargaining

We outlined earlier in this Report the difficulty of establishing what is the 'local' market for workers, and consequently where the bargaining unit should best be established (p 5). We pointed out that rates for some groups of workers could best be established by the District (provided it is of a certain size), while other groups are best dealt with on a Regional basis. We are not, therefore, recommending any machinery for sub-national negotiations, believing that this will vary from Region to Region depending on the size of Districts and of homogeneous markets. Such questions are for discussion and agreement between RHAs and DHAs. However, it must be recognised that any machinery which is created will necessitate a strengthening of the personnel function at Regional and District level, both for gathering relevant information and conducting negotiations.

CONCLUSION

We recognise that the system which we are suggesting contains some radical ideas. Although we have described in some detail a possible new system, we are not necessarily committed to every last comma. We are, however, committed to a system which gives discretion to local managers, while retaining a national framework, and we do believe that the elements of our system – particularly the principle of broad bandings – is the best way to achieve these objectives.

We hope that our proposals will provoke debate. We would welcome such debate because we believe that this will stimulate change. And change in the system for determining NHS pay is long overdue.

Annex 1

MEMBERSHIP OF KING'S FUND/NAHA WORKING PARTY ON PAY DETERMINATION

Lady McCarthy, Fellow in Employee Relations, King's Fund College (Chairman)
Mrs R W Kelly, Member, Trent RHA
Mr C Roberts, Chairman, Powys HA
Mr G D Hitchcock, Chairman, North Bedfordshire HA
Miss K M Armstrong, District Nursing Officer, Newham HA
Mr E Booth, District Treasurer, Wolverhampton HA
Mr J George, Regional Personnel Officer, Trent RHA
Mr R M Nicholls, District General Manager, Southmead HA
Mr M Schofield, District General Manager, Rochdale HA
Mr D Warlow, Regional Personnel Officer, South East Thames RHA
Mr P A Hunt, Director, NAHA
Dr D R Steel, Assistant Director, NAHA

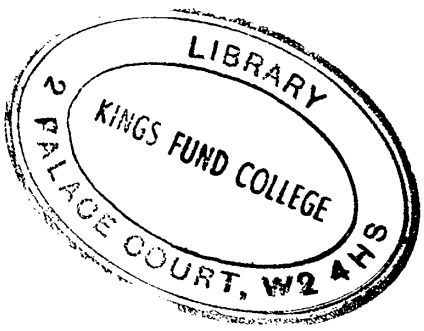
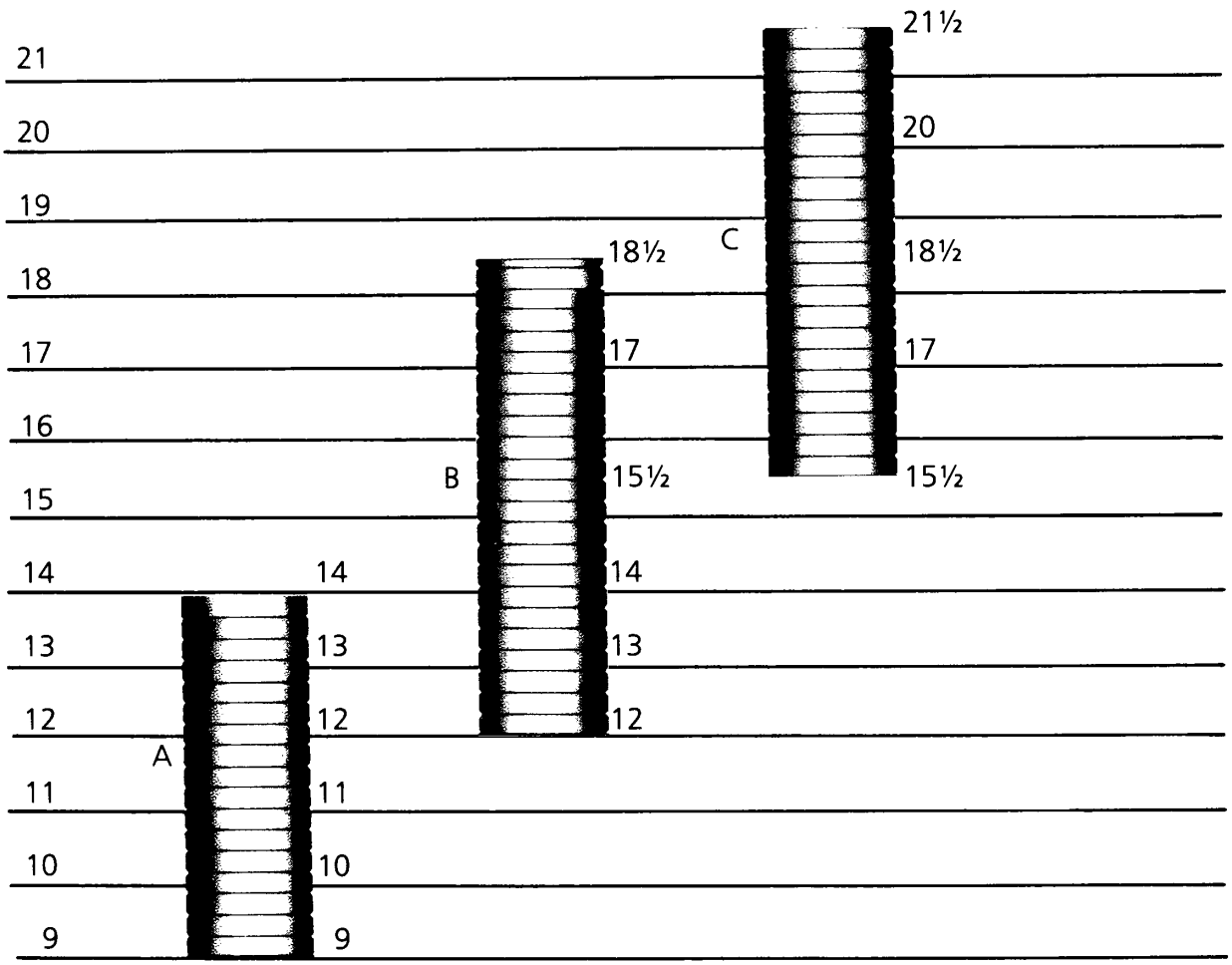


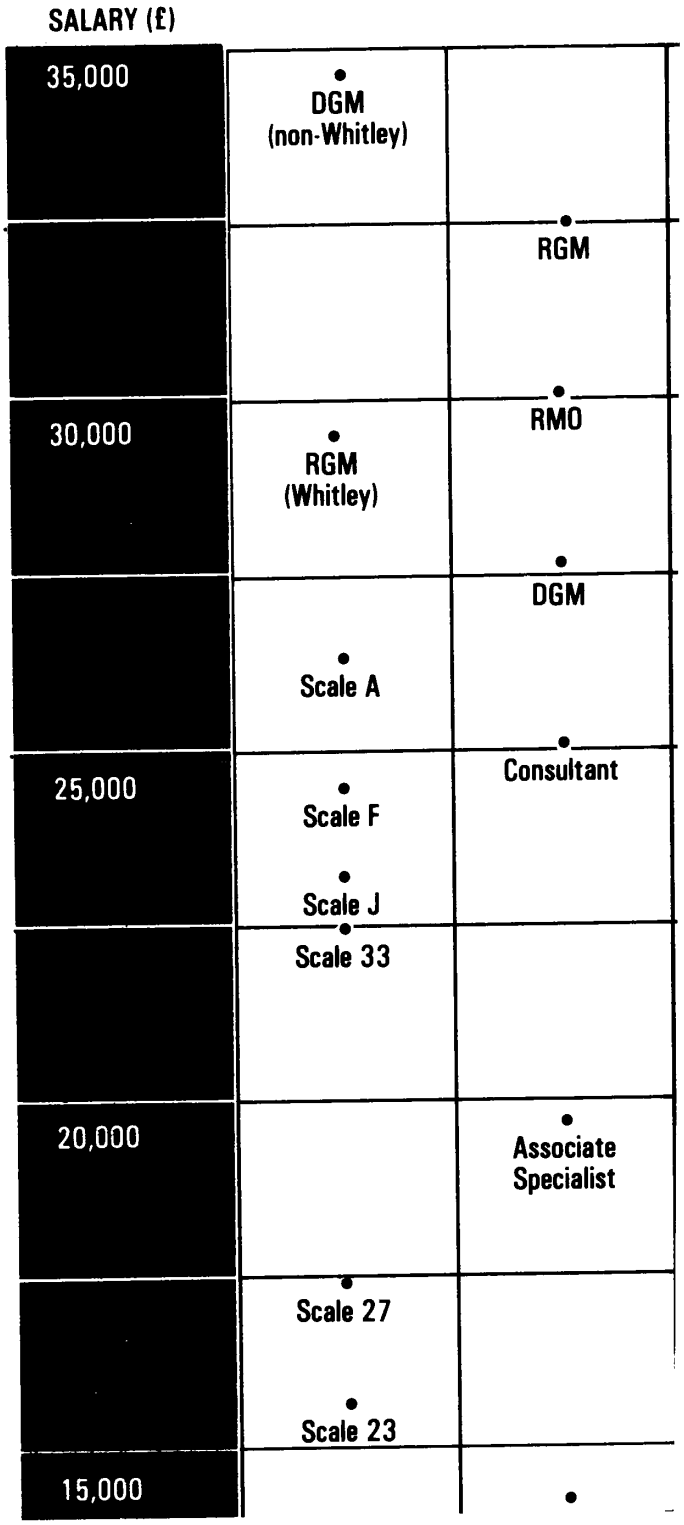
Figure 2

Band 2 with three spines



A1 £9, £10, £11, £12	B1 £12, £13, £14, £15½	C1 £15½, £17, £18½
A2 £10, £11, £12, £13	B2 £13, £14, £15½, £17	C2 £17, £18½, £20
A3 £11, £12, £13, £14	B3 £14, £15½, £17, £18½	C3 £18½, £20, £21½
4 INCREMENTS	4 INCREMENTS	3 INCREMENTS

Present P



The proposed banding system

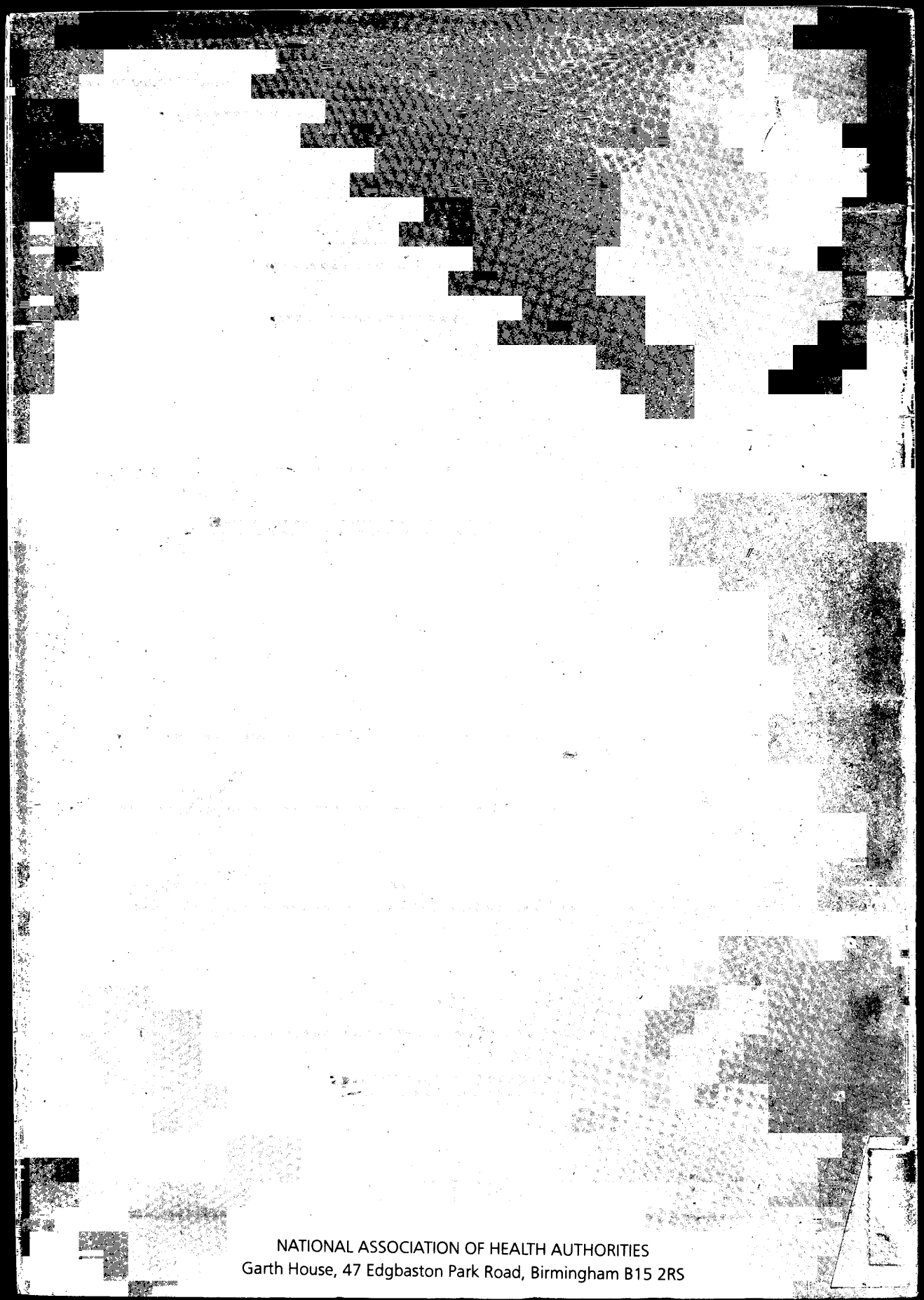
£

Band 1 21,500	GENERAL MANAGERS, SENIOR PROFESSIONAL ADVISORS, SENIOR SCIENTIFIC ADVISORS, CONSULTANTS
21,000	
Band 2 9,000	MIDDLE MANAGERS, PROFESSIONAL/SENIOR PROFESSIONAL OFFICERS
Band 3	BASIC AND TRAINING GRADES, SUPERVISORY OFFICERS, FIRST LINE MANAGERS

WHITLEY COUNCILS	ADMIN & CLERICAL	MEDICAL & DENTAL	NURSES & MIDWIVES	P.T.A. & PROFESSIONS ALLIED TO MEDICINE	ANCILLARY STAFFS	P.T.B.	MAINTENANCE CRAFTSMEN	AMBULANCE	PHARMACIS & OPTICIAN
5,000	DGM (non-Whitley)								
		RGM							
0,000	RGM (Whitley)	RMO	RGM (Whitley) DGM						
	Scale A	DGM	RNO R1						
		Consultant	DNO DHA 1+			Regional Works Officer			
5,000	Scale F Scale J			Regional Scientific Officer		Regional Architect 1			
	Scale 33			Top Grade		District Works Officer		Regional Ambulance Officer	Regional Pharmaceuti Officer
0,000		Associate Specialist	Regional Nurse						
	Scale 27 Scale 23		DNS DHA 1 Snr Nurse 1	Principal Grade		Asst Regional Architect		Chief Ambulance Officer	Principal Opth Optici & Principal Pharmacist
5,000	Scale 18	Snr Registrar		District II (Dist Snr Chief Chiropodist) Teacher (Principal)		Works Officer 5 Prn Asst Architect			
	Scale 14 Scale 9	Registrar	Snr Nurse 5	Superintendent 2		Snr Asst Architect Tech Officer Main Grade Eng MPT 1		Rank 2	Snr Opth Optician & St Pharmacist
,000		Snr House Officer	Nursing Sister 1	Supt. Physiotherapist Snr 1 Physiotherapist		Works Officer 1 District Engineer			Basic Grade Pharmacist
	Scale 1 (GAA)	House Officer	Staff Nurse Enrolled Nurse	Technical Instructor Physiotherapist	Group 18	Asst Dist Eng Tech Asst 3 MPT IV		Rank 7	
000	Clerical Officer		Nursing Auxiliary	OT Helper	Group 11 Baker Supervisor Group 1	Junior Asst Basic Grade ODA Trainee ODA	Grade 5+PR Grade 3+PR Grade 1+PR Grade 1	Leading Ambulanceman Driver/Attdnt Control Asst Trainee Ambulanceman	Graduate Stud Pharmacist Trainee Opth Optici

SARY

- — District General Manager
- — Regional General Manager
- — General Administrative Assistant
- — Performance Related Bonus
- — Regional Nursing Officer
- — District Nursing Officer
- — Director of Nursing Services



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