PO-CH/NL/0478

PART A

Part . A -

SECRET

(Circulate under cover and notify REGISTRY of movement)

Begins: 17/8/88.
Ends: 16/1/89.

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PO CH / NL / 0478.
PT. A.

Chancellor's (Lawson) Papers:
National Health Service Workers Pay.

DD's: 25 Years

21/2/96.

PO CH / NL / 0478. PT. A.

CONFIDENTIAL

cc. PS/ch/ex
PS/cst
Mr Anson
Mr Phillips
Dame A Mueller
Mr Kelly
Miss Peirson
Mr Turnbull
Mr Saunders
Mr Griffiths
Mr Call

Treasury Chambers, Parliament Street, SW1P 3AG

Mrs Edwina Currie MP
Parliamentary Under Secretary of State
Department of Health
Richmond House
79 Whitehall
LONDON SW1

17 August 1988

Dear Edwina,

NURSES' PAY

I have been following very closely the recent developments in the talks with the Staff Side concerning the implementation of the new clinical grading structure. Following yesterday's discussions the position now seems to be generally satisfactory but I am concerned that we should maintain an absolutely clear and consistent line on the question of the funding of the pay award.

Over the next weeks there will inevitably be continued allegations from the nursing unions and others that the £803m provided is not enough and calls for the government to make more money available. It is essential therefore that we should on no account say anything to fuel speculation that the funding provided is insufficient or give any impression that more money might be forthcoming. In response to questions in this area we must stick to our agreed line, most recently set out in the question and answer briefing prepared for health authority general managers, that there is no evidence that the £803m will not be enough to ensure the proper implementation of the agreement.

Yours ever
Peter

PETER BROOKE

CONFIDENTIAL

I agree. HP. 17/8.

1. MR PHILLIPS

2. PAYMASTER GENERAL

FROM: D P GRIFFITHS
DATE: 17 AUGUST 1988

cc PS/Chancellor
PS/Chief Secretary
Mr Anson
Dame A Mueller
Mr Kelly
Miss Peirson
Mr Turnbull
Mr Saunders
Mr Call

NURSES' PAY

On "News at Ten" last night some remarks by Mrs Currie were interpreted as an admission that the money allocated for the nurses' pay award might not be enough and a suggestion that there could be more money for the nurses. As far as we are aware, this has not yet been picked up elsewhere by the media but could be a source of embarrassment. In the light of this we recommend that it would be helpful for you to send a short letter to Mrs Currie to emphasise the importance of sticking to the agreed line on the funding of the award and avoiding getting drawn into speculation.

2. As explained in Mr Phillips' note of yesterday, the line we have agreed with the Department of Health is that there is no evidence that the money already provided will not be enough to ensure the proper implementation of the agreement concerning the new clinical grading structure. In the interview shown on "News at Ten" Mrs Currie said

> " At the moment we have no information whatsoever as to whether the enormous sum of money - £803m - one of the biggest pay increases anybody has ever seen in this country - as to whether that will be perhaps sufficient or not sufficient or too much..."

This unfortunately does carry the implication that the award could turn out to be underfunded (when we have been at great pains to avoid giving any such impression). But the use of this remark by "News at Ten" as a basis for the Government's suggesting that more money could be forthcoming is certainly somewhat dubious.

3. Questions about the alleged underfunding of the award and calls for more money to be provided will continue to be made over the next few weeks. And we must ensure that there are no further chinks in the Government's position which could be exploited. It would therefore be best to leave no room for doubt on the aqreed line and emphasise that this must be maintained consistently in all statements. This will be helpful for Mr Mellor when he takes up the Duty Minister's baton at the Department of Health on Monday.

4. Otherwise the position on the nurses' pay talks is developing in a reasonably satisfactory way. The unions have agreed to resume formal discussions with the Management Side without the latter's having to make any substantive concessions. References in today's press about revised guidance on the implementation of the new grading structure being issued to health authorities simply relate to clarification of certain points of detail arising from the original guidelines - which remain fully in force.

5. The Management Side will be sending a letter to the nursing unions setting out what was agreed in yesterday's talks. We will be shown this before it issues. Copies of the letter will be sent to health authority general managers under cover of a letter from Len Peach, the NHS Chief Executive, to brief them on developments and the line they should take in response to questions. Again we will have the opportunity to comment on this in draft. The letter to the unions will probably be issued to the Press.

6. The next potential flashpoint will come tomorrow afternoon when the RCN consults its members about the talks on the implementation of the clinical grading structure. The Staff Side hold their next meeting on Friday.

7. The Chief Secretary has been briefed on developments and is content that a letter along the above lines should go to Mrs Currie.

D P GRIFFITHS

CONFIDENTIAL

DRAFT LETTER FROM THE PAYMASTER GENERAL TO:-

Mrs Edwina Currie MP
Parliamentary Under Secretary
for Health
Department of Health
Richmond House
79 Whitehall
London SW1

NURSES' PAY

I have been following very closely the recent developments in the talks with the Staff Side concerning the implementation of the new clinical grading structure. Following yesterday's discussions the position now seems to be generally satisfactory but I am concerned that we should maintain an absolutely clear and consistent line on the question of the funding of the pay award.

Over the next weeks there will inevitably be continued allegations from the nursing unions and others that the £803m provided is not enough and calls for the Government to make more money available. It is essential therefore that we should on no account say anything to fuel speculation that the funding provided is insufficient or give any impression that more money might be forthcoming. In response to questions in this area we must stick to our agreed line, most recently set out in the question and answer briefing prepared for health authority general managers, that there is no evidence that the £803m will not be enough to ensure the proper implementation of the agreement.

CONFIDENTIAL

FROM: G H PHILLIPS
DATE: 18 AUGUST 1988

PAYMASTER GENERAL

cc: PS/Chancellor
PS/Chief Secretary
PS/Financial Secretary
Mr Anson
Dame A Mueller
Mr Kelly
Miss Peirson
Mr Turnbull
Ms Seammen
Mr Saunders
Mr Griffiths
Mr Call

NURSES' PAY

We spoke today about further developments on nurses' pay. This note briefly records them.

2. Today's "Times" carries a front and back page story implying that the Government will find more money for the regrading exercises if that is necessary and quoting a letter from Mrs Currie to Mr Robin Cook. A copy of that letter, and the letter to which it was a response, is attached. Had we been consulted, we would have objected to the phrasing in Mrs Currie's letter that says "It is not possible to say whether that estimate will be exceeded or not until the provisional returns which we have requested from the health authorities have been received." As you know, I had agreed a less open-ended formula with DHSS officials and your letter to Mrs Currie of 17 August confirmed that that was also your view.

3. However, an even more unsatisfactory event has come to light, namely that the Prime Minister wrote to Mr Kinnock on 12 August a letter which was not cleared with the Treasury and which also contained some very open-ended statements about whether the amount of money agreed to be made available would be sufficient. A copy of the Prime Minister's letter is also attached.

4. Given the amount of contact we have had in the last few days with Department of Health officials, I am sure

it is right that we should register a firm protest at their failure to consult us about these two key letters. You agreed that that should be done. I have therefore written to the Permanent Secretary and to the Chief Executive of the NHS Management Board registering our view, and a copy of that letter is also attached.

5. Our principal concern is to try to get the line used by the Department of Health more on track with the approach Treasury Ministers would prefer. In the light of your letter to Mrs Currie, it was put to me this morning that Department of Health Ministers might adopt the following formulation:

> "Health Ministers mean exactly what they say about funding the award. Funding has been allocated in good faith based on the best estimates available. Responsible Governments do not respond to wild and inaccurate statements, nor do they issue blank cheques at every turn."

6. I have told the Department of Health that I did not think that this would do and offered them the following alternative which they have agreed to put to their Ministers:

> "We have asked health authorities to report their provisional returns to the Department by 5 September. The Government has made clear its funding provision to meet the Review Body recommendations. This is extremely generous. The Government does not intend to respond to questions about a hypothetical situation or issue blank cheques."

(I have reinforced - mpw)

7. We have made it clear to No 10 that Treasury Ministers should have been consulted about the letter she sent to Mr Kinnock on 12 August and that we expect to be consulted in future. While neither the Prime Minister's letter nor Mrs Currie's indicate in terms that more money will need to be made available, they are major hostages to fortune which will make it more difficult than it would otherwise

X

have been to accommodate the regrading exercise within the total sum of £803 million.

HAYDEN PHILLIPS

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Parliamentary Under Secretary of State for Health

16 AUG 88

Robin Cook Esq MP

My dear Robin

I am replying to your letter of 16 August which was addressed to the Secretary of State. The exact words he used were

> "I am firmly resolved to carry out the undertaking which the Government gave to implement its Review Body recommendations and I am anxious to complete the complex re-grading process within the agreed timetable."

That is, and always has been the Government's position. So far as funding is concerned the cost was estimated at the time of the Review Body awards at £803 million and that is the amount which has been made available to the health authorities. It is not possible to say whether that estimate will be exceeded or not until the provisional returns which we have requested from the health authorities have been received.

I am sad to see that over the last week, you have repeatedly implied that the Government is somehow going back on its word. Let me make it clear once and for all that we will keep our promise to the nurses - which is more than can be said for the last Labour Government. For you to talk about broken promises when nurses' pay was cut by more than 20 per cent in real terms between 1974 and 1979 suggests you either have no memory or no shame.

I am releasing this letter to the press to try to clear up once and for all the misunderstanding that you have wilfully sought to cause. Meanwhile I hope you are enjoying your holiday.

Yours sincerely

Edwina

EDWINA CURRIE

10 AUG '88 10:51 FROM 01 210 5529 TELEX RM PAGE.002

** TOTAL PAGE.003 **

1/12

From: Robin Cook MP

HOUSE OF COMMONS
LONDON SW1A 0AA

DEPT OF HEALTH & SOCIAL SERVICES

Rt Hon Kenneth Clarke QC MP
Secretary of State for Health
Department of Health and Social Security
Richmond Terrace
79 Whitehall
LONDON SW1A 2NS

16 August 1988

Dear Ken

I read with interest your statement on nurses regrading.

I note that you gave a commitment "to carry out the undertaking the government gave on the implementation of the Pay Review body report". You will no doubt have been advised that the key undertaking given by the government at the time was a pledge to fully fund the nurses pay settlement, and that all other undertakings depend on it being honoured. I therefore should be obliged if you would confirm that your commitment includes this central undertaking and that the government will fund the full cost to health authorities of the regrading review.

Yours sincerely

Robin Cook MP

PS I should be obliged for an early reply by the duty minister.

cc. Miss Harper
by hand Mrs Kirk
Mrs Westbrook
Mr Mansell
Mr Gurney
Mr James - for advice & draft reply today please
Mrs Poole
Mrs Christopherson
Mr Hill

Flora Goodhall
106 RH 16/8.

Copy to Dilwyn Griffiths (Treasury) Rec'd 5pm 17/8

cc Miss Harper 10/6
Mrs Bagg
Mrs Mowbray
Mr Gurney
Mr J. James
Miss Poole
Miss Christopherson
Mr Price
Mr Walden
Mr Hill

10 DOWNING STREET
LONDON SW1A 2AA

THE PRIME MINISTER

12 August 1988

cc Mr Phillips
Sent to me by John James. The draft was not cleared with us and we certainly would have wanted to take out *. However, hopefully the PMG's letter will set things back on an even keel. PMG 17/8

Dear Mr Kinnock,

Thank you for your further letter of 22 July about the level of NHS expenditure.

In whatever terms expenditure is expressed the crucial measure of its worth is the level of health service activity which it will sustain. As you well know the health service is treating significantly more patients than in previous years. In other words the service is, through increased funding and improved efficiency responding to the rising real demand to which you refer. It is also supporting a larger, better paid workforce. This simple relationship between inputs and outputs is one which you continue to ignore.

You miss the same point in making comparisons with the proportions of GDP devoted to health care in other countries. The OECD average of public spending on health does not tell you anything about the range or level of services which that spending will purchase. On most accepted measures of health outputs the United Kingdom compares favourably with other countries including those who spend a higher proportion of their national income on health than we do. It is also the case that some of these countries do not spend at a higher rate from choice. Both France and West Germany for example are anxious to reduce health spending. It is now acknowledged that we get better value for our money in the health service than do many other countries: that means more health care for a similar expenditure than elsewhere.

774
184

So far as the new clinical grading structure for nurses is concerned, the cost was estimated at the time of the Review Body awards at £803 million, and that is the amount which has been made available to the health authorities. The Review Body said that the actual cost might well differ from their estimates, but contrary to your assertion, they did not offer any view as to whether the estimate would prove too high or too low. It is still not possible to say whether the estimate will be exceeded nor, if it were, by how much. The Department of Health has asked all Regions to scrutinise Districts' provisional grading assessments, and to provide Regional analyses by 5 September. These will be looked at in the Department to ensure consistency and fairness. Only then will a firm estimate of cost be possible. No purpose is served by hypothetical speculation in the absence of firm information.

Yours sincerely

Margaret Thatcher

The Rt. Hon. Neil Kinnock, MP.

AUG 12 '88 15:53 930 4433 EXT 3188 P.3

3612

CONFIDENTIAL

H M Treasury

Parliament Street London SW1P 3AG

Switchboard 01-270 3000

Direct Dialling 01-270 .....

Hayden Phillips
Deputy Secretary

C W France Esq CB
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

18 August 1988

Dear Chris

NURSES' PAY

I should let you, and Len Peach know, how strongly we feel here about your department's failure to consult the Treasury about two letters sent to the Opposition: one from the Prime Minister dated 12 August to Mr Kinnock, and one from Mrs Currie to Mr Robin Cook of 16 August. Both of them contain statements about the funding of pay following the regrading which are of direct concern to Treasury Ministers, on which they should have been consulted, and to which they would have objected.

This failure to consult seems inexplicable when such detailed consultations took place over your former Secretary of State's letter to Health Authority Chairmen of 22 July, when the Prime Minister was replying to a letter from Mr Kinnock dated 22 July, and when we were carefully agreeing this week with John James a question and answer briefing which covered hypothetical questions about future funding. The line we then agreed was reflected in the Paymaster-General's letter of 17 August to Mrs Currie to which I do not need to add.

I recognise that handling the unions and the media on this sort of issue is very fast moving but Treasury Ministers and officials are and will be available for rapid consultation and when we have been consulted I do not believe we have held up decisions.

A copy of this letter goes to Len Peach, and to John Anson.

Yours ever

Hayden

N. Griffiths.
Apology, at least.
HP.
19/8

cc PS/ChExch ←
PS/CST
PS/PMG
Mr Ansell

NHS MANAGEMENT BOARD

Department of Health & Social Security

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Chief Executive

Len Peach

Hayden Phillips Esq
HM Treasury
Parliament Street
LONDON
SW1P 3AG

19 August 1988

Dear Hayden,

Thank you for copying to me your letter of 18 August to Chris France. As he is away and I shall be on leave after today, I think it best that I should reply.

Our two Departments have of course co-operated very closely over this issue during the last ten days, and we have greatly appreciated the help you have given us. I am sorry that anything has happened to mar this, and I trust that we can quickly put the matter of the two letters behind us. Both were dealt with on the day of despatch, to tight deadlines by individuals who were heavily involved at the same time in operational aspects of the dispute. It would undoubtedly have been preferable to clear lines with Treasury officials, and I can only express regret that this was not done. There was no intention to depart from the agreed line, and we were, and are, at one with you on the need to avoid saying anything that could be construed as a commitment to additional funding should the cost of the regrading exercise ultimately prove to be more than £803 million. There was some concern here at the tone in which Mrs Currie proposed to reply to Robin Cook, and this was accordingly cleared specifically with Number Ten.

We have of course drawn from this the proper lessons from the future, and will keep in as close touch as possible. In the meantime please accept my apologies.

E.R.

I am sending copies of this letter to Chris France and John Anson.

Yours sincerely,

Len.

LEN PEACH

CONFIDENTIAL

FROM: Ms K ELLIMAN
DATE: 19 August 1988

MR G H PHILLIPS

cc PS/Chancellor
PS/Chief Secretary
PS/Financial Secretary
Mr Anson
Dame Anne Mueller
Mr Kelly
Miss Peirson
Mr Turnbull
Ms Seammen
Mr Saunders
Mr Griffiths
Mr Call

NURSES' PAY

The Paymaster General has seen your note of 18 August. He has commented:

"As crisp as the DoH lettuce was looking sad at the edges".

Kim Elliman

KIM ELLIMAN
Private Secretary

FROM: D P GRIFFITHS
DATE: 19 AUGUST 1988

FINANCIAL SECRETARY

cc PS/Chancellor
PS/Chief Secretary
PS/Paymaster General
Mr Anson
Dame A Mueller
Mr Phillips
Mr Kelly
Miss Peirson
Mr Turnbull
Ms Seammen
Mr Saunders
Mr Call

Ch/ to be aware of where matters stand. (pps behind record a bad fond from DoH)

NURSES' PAY

This is to brief you on the latest developments on nurses' pay and to provide advance warning about a possible initiative which Department of Health may seek to clear with us on Tuesday next week.

Background

2. Briefly, since the Staff Side walked out of talks last week on the implementation of the new clinical grading structure for nurses, the Department of Health have sought to defuse the situation and avoid the escalation of industrial action by some presentational measures to secure the resumption of discussions. However, no substantive concessions have been offered. We can let you have copies of earlier situation reports and papers on nurses' pay if this would be helpful. Given the problems we have had over the past week with Department of Health regarding proper consultation (outlined in Mr Phillips' note of 18 August to the Paymaster General), we have emphasised the importance of our being kept in very close touch with developments and of DoH's proposals and statements being cleared with Treasury Ministers. It is particularly important that any concessions which might be offered to the nursing unions should not have cost implications.

3. The Royal College of Nursing's national rally last night did not produce any surprises and the RCN leadership continues to take a responsible approach and has urged members to defer protest

action. There are reports in today's papers that the Royal College of Midwives (RCM) are very concerned about the implementation of the new clinical grading structure and may call a ballot to allow the union's no-strike rule to be changed. The Department of Health consider the problem is a local one and do not believe that there is a danger of national action by the Midwives. The pressure for action is coming from midwives in the North West who traditionally contain some of the most militant members of the RCM.

Outlook

4. All the nursing unions meet today to co-ordinate their position prior to further discussions with the Management Side next Wednesday. It is believed that the unions will confirm that they are prepared to continue discussions.

Possible Concession

5. The particular focus of the dispute so far has been the grading of ward sisters. The Management Side has maintained its stance that only one sister per ward can be placed in the higher of the main grades (G) on the ground of continuing responsibility for the ward. However, they have explained that it was always the intention that other sisters could qualify for this grade by reason of the specialist clinical skills.

6. The particular concession which Department of Health may wish to clear with us before the management-union talks resume relates to 2 sister psychiatric wards. The sisters in these wards are mostly all COHSE members and there is a long-standing restrictive practice that the two sisters in each ward are treated as of equal responsibility. In conformity with the instructions in the grading guidelines concerning continuing responsibility, in these psychiatric wards one sister would be graded G, the other F. If it cannot be agreed which sister should be given continuing responsibility, they will both have to be placed in the lower grade until the issue is settled.

7. The concession DoH have in mind is as follows. If it can be agreed that, from a given date (for example 1 January 1989), one sister in each psychiatric ward is given continuing responsibility and upgraded (the other sister remaining at F), in the meantime both the sisters in the ward will share the extra money which would have gone to the holder of the G post. This concession does not entail any extra paybill costs (though it would mean the loss of some potential temporary savings). DOH see the concession as having two main attractions:

i. it would smooth the way for ending the restrictive practice;

ii. it could encourage COHSE not to escalate protest action - COHSE have so far been the most intransigent of the nursing unions.

But they are considering further the extent to which this initiative would provoke increased pressure for concessions in other areas from the other nursing unions.

8. DOH Ministers have not yet been consulted on the idea.DoH officials are meeting Mr Mellor at 2 pm on Tuesday and Mr Clarke will then be consulted on the telephone. It is not certain whether he will give the proposal his blessing but, if he does, we will then be formally consulted.

9. As the proposal is cost neutral, one major concern is removed but DoH will have to convince us that it would not have adverse ramifications elsewhere for the implementation of the new grading structure.

D P GRIFFITHS

st2Aug.25

CONFIDENTIAL

FROM: D P GRIFFITHS
DATE: 23 August 1988

1. MISS PEIRSON
2. FINANCIAL SECRETARY

cc PS/Chancellor
PS/Chief Secretary
Mr Anson
Dame A Mueller
Mr Phillips
Mr Kelly
Mr Turnbull
Ms Seammen
Mr Saunders o/r
Mr Call

NURSES' PAY

1. Further to my minute of 19 August, Department of Health have informed me that Kenneth Clarke has said he does not want any concessions to be offered to the nursing unions at tomorrow's discussions. No action is therefore required on our part at present. However, DoH may come back to us at a later stage depending upon how the negotiations progress.

2. We have been giving further thought to the DoH's idea for a concession relating to two-sister psychiatric wards (a pooling of the salaries between the two sisters until the date at which it is decided which one should be transferred to the higher grade). We consider the risks of this proposal outweigh any likely gains and, if DoH do decide to run the concession again at some point, we recommend that Treasury Ministers reject the proposal.

3. Our main concerns are that this concession could not be ring-fenced and and would simply store up trouble later. Having set the precedent in the two-sister psychiatric wards, the unions representing sisters in other specialities may press for similar arrangements to be adopted in their areas while the position on grading has yet finally to be determined . DoH themselves acknowledge that they could give no guarantee that the concession could be restricted to the psychiatric wards. Moreover, although the concession would not entail any immediate additional paybill costs, it could result in problems when the regrading of the sisters was eventually brought into effect. Whichever sister was

allocated to the lower grade would face a drop in salary when the temporary pay sharing arrangements ended and this would exacerbate an already sensitive situation. To avoid potential difficulties managements could be tempted to continue to pay the lower grade sister at the enhanced rate or even find some excuse to place both sisters on the higher grade - either of which would produce adverse paybill implications. DoH argue that this problem would not arise if the extra money during the transitional period was paid to the sisters as a one-off lump sum bonus but expectations could still be created. (Pay division agree.)

4. DOH officials see one of the aims of offering the concession as dampening down the militant attitude which COHSE are currently displaying. But it is not clear why any concession should be made. A lot of the heat has already been taken out of the dispute over regrading and the signs are that support for the day of protest action called by COHSE for Thursday will be very weak. There therefore seems no need to buy off COHSE. Indeed it can be argued that protest action by COHSE members will serve to discredit their case in the eyes of public and weaken their position - especially given the responsible attitude being displayed by the Royal College of Nursing and even (surprisingly) NUPE.

5. I will keep you informed of further developments.

D P GRIFFITHS

022/3291

CONFIDENTIAL

NP

FROM: **MISS C EVANS**
DATE: **24 August 1988**

MR GRIFFITHS

cc:
PS/Chancellor
PS/Financial Secretary
PS/Paymaster General
Mr Anson
Dame Anne Mueller
Mr H Phillips
Mr Kelly
Miss Peirson
Mr Turnbull
Ms Seammen
Mr Saunders
Mr Call

NURSES' PAY

The Chief Secretary has seen your submission of 19 August to the Financial Secretary. He agrees that we should resist the possible concession to psychiatric nursing sisters which he thinks will buy very little and could open the floodgates to some very messy deals.

2 The Chief Secretary has also seen the letter on nurses' pay sent by the Prime Minister to Mr Kinnock, as well as Mrs Currie's letter to Robin Cook. In his view these are not at all in line with policy and he is pleased that Len Peach has apologised. But he fears that the horse may have bolted on the £803 million ceiling. He recognises that these letters could have simply been maladroit but he doubts it and believes that we have been bounced unacceptably. We must now watch very carefully to make sure that DOH do not offer grading concessions that will increase the cost since they may now feel that they can extract further funds from us on the basis of the Prime Minister's letter and the earlier "fully funding" remarks. Mr Wanless has already spoken to you about clearance of the Prime Minister's reply to the latest letter from Mr Kinnock seeking a further assurance on the funding of the restructuring.

CEvans

MISS C EVANS
Private Secretary

MG0424t

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01 210 3000

From the Secretary of State for ~~Social Services~~ Health

BF 2819

→M.

27/9/88.

The Rt Hon John Major MP
Chief Secretary to the Treasury
HM Treasury
Parliament Street
LONDON
SW1P 3AG

Mr de Bertodano (with enclosure)
Ca Sir P Middleton
Mr Anson, David A Mueller, Mr Phillips
Miss Peirson, Mr Saunders, Mr C W Kelly
Ms Seammen, Mr Tomlinson, Mr Call

GOVERNMENT EVIDENCE TO THE NURSES AND PAMs PAY REVIEW BODY

I enclose a draft of the Government's evidence on nurses' pay for this year's Review Body round. (We intend to submit separate evidence on the professions allied to medicine in view of the continuing negotiations on restructuring.) I should be grateful for your agreement that this can go forward to the Review Body. It is necessary to have this by 29 September so that we can meet the Review Body's request for written evidence by the end of this month. However I would like your agreement as quickly as possible so that I can try to begin to win the presentational battle. We have been keeping your officials in close touch with its preparation.

This year, for the first time, we intend to publish the evidence. In the past, Health Departments have not done so and have maintained that these submissions to the Review Body are confidential. In practice, however, it is not possible to keep our evidence out of the public domain. The convention is that, once written evidence has been submitted to the Review Body by Health Departments and the Staff Side, the two parties exchange evidence. The Review Body set great store by this because they question each Side on the other's points at oral evidence stage. But the result is that the Staff Side leak selectively from our evidence anything which they think suits their cause. They also launch their own evidence publicly with a great blaze of publicity.

This means that we have always lost the opening round of the public debate on nurses pay every year. I have decided that we will publish the evidence in its entirety shortly after we have sent it to the Review Body. I am very anxious to get in first if at all possible and produce our evidence before the Unions produce theirs. For this reason, I would welcome your quick agreement.

E.R.

Although we have drafted the evidence with an eye to publication, its tone is tough. In particular, it emphasises that real-terms pay increases of the kind which nurses have received in recent years are no longer needed since they are a costly and ineffective response to the recruitment and retention problems we anticipate. In their place the evidence signals our intention to move further towards geographical pay as soon as possible. I want to take the initiative on this and I hope to open up a debate that is not solely obsessed with the percentage increase awarded and the funding of it. The trades unions will, of course, react unfavourably. Our arguments will, however, stand scrutiny and they will have difficulty. Nevertheless, it will be important not to provide them with material on the amount of the award which is so clumsy that they can use it against us and distract the public's attention from our arguments. It is for this reason that I am anxious to avoid the kind of bad press which you will no doubt recall we received last year for recommending a "modest" pay increase in line with the cost of living. We can minimise the quotable value of our recommendation without making any real or practical concession by saying that there is no case for further substantial increases in real-terms pay, without specifying precisely what level of increase we would like to see emerge. We shall, of course, make our position quite clear at oral evidence stage. But, in doing so in that forum, we shall avoid the risk of wilful misrepresentation. I feel very strongly that this is the best way of handling the matter and I do not want to shoot myself in the foot by using a tougher phrase which will be latched on by the press and then prove to be of no practical use to us before the Review Body. I hope you will agree that this is the best way to handle this point.

A copy of this letter and of the draft evidence goes to the Prime Minister, Norman Fowler, Wyn Roberts, Michael Forsyth, Richard Needham and to Sir Robin Butler.

KENNETH CLARKE

CHANCELLOR OF THE EXCHEQUER

HONI SOIT QUI MAL Y PENSE

It is intolerable that Ministers should be presented with such a sudden submission on such an important matter on 28/9, or less than agreement is req. by 29/9.

2. On the [illegible], I have initialled some deletions. But the Governor also needs [illegible] to make weightier [illegible] to the recommendations: the further fact that doctors in Ireland [illegible] have not [illegible] that [illegible].

CHANCELLOR OF THE EXCHEQUER

REVIEW BODIES

Chi/

both wadges of draft Evidence behind. These are Pay division's copies so not all scribbles are mine.

I notice that the general passages on Economy / Earnings eh are not same in both. I prefer the Nurses version which is the shorter.

[CST will also be looking at this – when he gets time!]

NJ.

pay1.bw/de Berker/07-28.9

CONFIDENTIAL

FROM: J de BERKER
DATE: 28 September 1988

1. MS SEAMMEN
2. CHIEF SECRETARY

cc Chancellor
Sir Peter Middleton
Dame Anne Mueller
Mr Anson
Mr Phillips
Mr C W Kelly
Miss Peirson
Ms Seammen
Mr Saunders
Mr Griffiths
Mr Call

GOVERNMENT EVIDENCE TO THE DOCTORS' AND DENTISTS' REVIEW BODY

Mr Mellor's letter of 27 September asks you to accept the draft evidence to the Doctors' and Dentists' review body (DDRB). It has been agreed at Official level and we advise you to accept, but you will wish to ask that, as in previous years, official discuss the briefing for the oral evidence beforehand.

Background

2. Last year the DDRB recommended increases averaging 7.9 per cent. These were implemented in full. The next report is due in mid-January and the DDRB asked for evidence by mid-September, which is why Mr Mellor has asked you to clear it so quickly. Department of Health Ministers are due to give oral evidence on 3 November.

3. Like the nurses review body the DDRB also gets the official and staff sides to comment on each others' evidence, but there have been no problems in keeping the evidence confidential so Mr Mellor does not propose to publish until after the DDRB has reported.

The Evidence

4. This consists of 9 sections running from A to H. The main thrust of the evidence is in section A which makes it clear, that in the Government's view there is no need for any further increase in real terms remuneration levels for groups covered by the DDRB. The line in funding is also satisfactory: there can be no presumption of additional funding at a later date and no such presumption should underlie any recommendations.

5. Sections B to H are primarily descriptive. Section B deals with general NHS developments, C with hospital doctors and dentists, D with general medical practitioners, E with general dental practitioners, F with opthalmic medical practitioners, G with community doctors, and H with community dental services.

Line to Take

6. We advise you to accept the evidence and endorse the line that there should not be any real terms increase in the remuneration of the groups covered by the DDRB. You will also wish to ask that officials discuss the briefing for oral evidence beforehand. A draft letter is attached.

7. ST are content.

Jonathan de Berker

JONATHAN de BERKER

ENC

DRAFT LETTER

From: Chief Secretary
To: Minister for Health

Copied to: Prime Minister, Norman Fowler, Wyn Roberts, Michael Forsyth, Richard Needham, Sir Robin Butler

GOVERNMENT EVIDENCE TO THE DOCTORS' AND DENTISTS' REVIEW BODY

Thank you for your letter of 27 September and the Draft Evidence to the Doctors' and Dentists' Review Body (DDRB) attached to it.

I welcome the evidence and I am content that it should be forwarded to the DDRB. The line that there should be no real increase in remuneration levels must be right. I would be grateful if, as in previous years, our officials could discuss the briefing for the oral evidence beforehand.

I am copying this to the Prime Minister, Norman Fowler, Wyn Roberts, Michael Forsyth, Richard Needham and to Sir Robin Butler.


CHANCELLOR OF THE EXCHEQUER

pay1/bw/de Berker/05-28.9

CONFIDENTIAL

FROM: J de BERKER
DATE: 28 September 1988

1. **MS SEAMMEN**
2. **CHIEF SECRETARY**

cc Chancellor
Sir Peter Middleton
Dame Anne Mueller
Mr Anson
Mr Phillips
Mr C W Kelly
Miss Peirson
Mr Turnbull
Ms Seammen
Mr Saunders
Mr White
Mr Griffiths
Mr Call

NURSES' REVIEW BODY EVIDENCE

Mr Clarke's letter of 27 September covers a draft of the Government's evidence to the Nurses and PAMs Review Body (NPRB) on nurses' pay. The evidence is excellent apart from one important flaw. In paragraph 1.6, and again in paragraph 7.2, it is said that the Health Departments conclude that the 1989 review is not the occasion for major changes in the overall level of nurses' pay and that there is no necessity for any further substantial increase in real-terms remuneration levels.

I wonder about this wording - does it imply that our main argument is awkwardness of timing, and also that we are merely deferring consideration of further major changes

2. In our view the word "substantial" must be deleted, otherwise the NPRB and the Staff Side could argue that the Government evidence had sanctioned an increase 2 or 3 per cent above the RPI, which would give them a pay increase of between 8 and 10 per cent - depending on the level of inflation at the end of this year.

3. Mr Clarke argues that any misunderstandings about what is acceptable for the 1989 nurses' pay increase can be cleared up in oral evidence. We understand that Mr Mellor is due to give evidence on 4 November. But by then it will be too late, as the Government evidence is due to be published early next week and there will be a month for misunderstandings to take hold.

4. We advise you to welcome the evidence with the proviso that the reference to "substantial" is deleted. You will also want to ask that, as in previous years, officials discuss the briefing for oral evidence beforehand.

Background

5. The Government accepted the NPRB recommendations on the clinical grading view and on the London Supplements payable on top of London Weighting. The increases averaged 15.3 per cent but so far Nurses have only received the immediate 4 per cent increase recommended by the Review Body. The new scale should be in payment, with back pay to 1 April, by Christmas.

6. Nurses in London have also benefited from partial implementation of the new London Supplements. These are related to basic pay and the full effect will be felt when the clinical grading scales are in place.

7. The NPRB is due to report in mid-Janaury and they have asked for written evidence by the end of this month, with oral evidence in November. The NPRB also deals with the pay of PAMs, but the written evidence for them has been delayed by continuing negotiations on restructuring. This will be subject to a separate submission when it appears.

8. This year, for the first time, Mr Clarke is proposing to publish the Government's evidence to deny the Staff Side the opportunity to leak from it selectively to the Government's disadvantage. We understand that Mr Clarke may well hold a press conference to launch the evidence.

The Evidence

9. This consists of 7 short sections and six appendices. With the exception of paragraphs 1.6 and 7.2 it has been agreed at official level. The main thrust is that 1989 is not the year for major changes in nurses' pay. The clinical grading review and the

introduction of the new London supplements are not yet complete, so it is too soon to assess the affect on recruitment and retention, although the Department of Health anticipate that this will be favourable.

10. The evidence puts considerable emphasis on the scope for further geographical variation in pay once the grading review and London supplements have bedded down (paragraph 1.5), and envisages an approach which would deal with the geographical and skill shortages by the use of additional points on a pay spine (paragraph 3.6).

11. On funding, the evidence says (paragraph 2.6) that the Autumn Statement will set out the resources to be made available to Health Authorities in 1989/90 that there should be no presumption of additional funding at a later date, and that no such presumption should underly any recommendations.

Conclusion

12. The evidence is sound on geographical pay variation, and it says the right things on funding. The general thrust on the nurses' 1989 pay increase is also correct - there should be no further changes - but this expressed in a way which could be interpreted as giving Government sanction to increases of anything up to 10 per cent. This would be unacceptable coming on top of the 1988 increases.

13. We advise you to accept the evidence provided the reference to "substantial" in paragraphs 1.6 and 7.2 is deleted. You will also want to ask, that as in previous years, your officials are kept in touch on the briefing for the oral evidence. A draft letter is attached.

14. ST are content.

Jonathan de Berker

JONATHAN De BERKER

CONFIDENTIAL

DRAFT LETTER

From: Chief Secretary
To: Secretary of State for Health

Copied to: Prime Minister, Norman Fowler, Wyn Roberts, Michael Forsyth, Richard Needham and to Sir Robin Butler.

GOVERNMENT EVIDENCE TO THE NURSES AND PAMs PAY REVIEW BODY

Thank you for your letter of 27 September and the draft evidence on nurses' pay attached to it.

The evidence is in general excellent, but I am afraid I must take issue with you on an important point in your letter. I am, like you, very keen that we should win the propaganda battle and agree that we should publish our evidence in its entirety so that you can take the initiative. But in so doing, we must be careful not to prejudice the substance of our case. I am sure we are agreed that our message to the Review Body must be that there is no case for any further increase in real terms in nurses' pay this year, but in paragraphs 1.6 and 7.2 your draft evidence says that there is no necessity for any further substantial increases in nurses' real-terms remuneration levels. This reference to "substantial" should be deleted. Otherwise the widespread impression will be that the Government itself has accepted that nurses should have an increase of, say, 2 or 3 per cent above the RPI. Given the temporary increase in the RPI in the rest of this year and early next year, this could result in a further large increase in 1989 on top of the 15.3 per cent in 1988. I share your view on the importance of getting the presentation right, but I am concerned that by the time it comes to given oral evidence in November it

will be too late to correct a misunderstanding of this nature. Indeed, if you were to argue in oral evidence that by no substantial increase you had meant no increase at all, it would be difficult to avoid accusations of bad faith.

I would also be grateful if, as in previous years, our officials could discuss the briefing for the oral evidence beforehand.

I am copying this to the Prime Minister, Norman Fowler, Wyn Roberts, Michael Forsyth, Richard Needham, and to Sir Robin Butler.

chex.nh/mw/64 **CONFIDENTIAL**

FROM: MISS M P WALLACE
DATE: 29 September 1988

PS/CHIEF SECRETARY

cc Sir P Middleton
Dame Anne Mueller
Mr Anson
Mr Phillips
Mr C W Kelly
Miss Peirson
Mr Turnbull
Ms Seammen
Mr Saunders
Mr White
Mr Griffiths
Mr de Berker
Mr Call

HEALTH REVIEW BODY EVIDENCE

The Chancellor has seen Mr de Berker's two minutes of 28 September. He has now also seen copies of the draft evidence. He had the following comments, which I understand Ray division will be reflecting in a revised draft letter for the Chief Secretary to see later today.

<u>Doctors and Dentists review body</u>

2. (i) The Chancellor would like the following general paragraphs about the economy deleted: A5, A6, A10, A11 ~~and A16~~.

(ii) In paragraph A27, he would like to delete the words "to reflect their responsibilities and career expectations" - he takes the view that this is a green light for a massive recommendation, and wholly anti-market.

(iii) More generally, he has commented that the evidence needs to put more weight on the recruitment and retention considerations - the fact that we have more doctors than we need.

Nurses review body

3. (i) The Chancellor's comment on this is that he does not like paragraph 1.6 (and 7.2) at all. The point is that last year's award was the result of a once-and-for-all fundamental restructuring. There should henceforth be no "major changes" in the overall level of nurses' pay - not just in 1989 but also thereafter. The only special factor this year is that we do not even have the evidence on which to base any fine tuning of the details.

MOIRA WALLACE

CHIEF SECRETARY TO THE TREASURY

[passed on] APS/CST says KC accepted pmp

FROM : Cathy Evans
DATE : 30 September

MS SEAMMEN

cc Chancellor
Sir P Middleton
Dame A Mueller
Mr Anson
Mr Phillips
Mr C W Kelly
Miss Peirson
Mr Turnbull
Mr de Berker
Mr Saunders
Mr White
Mr Griffiths
Mr Call

Ch/ I'm not sure I like the DoH alternative. If it means anything it means that present structure is right but still room for discussion about level relative to other groups. [illegible]

OK provided that ~~[illegible] [illegible] [illegible]~~ "pattern of" is deleted. Otherwise we are giving no guidance at all about the overall [illegible].

NURSES REVIEW BODY : GOVERNMENT EVIDENCE

Mr Clarke telephoned the Chief Secretary at 1 o'clock today. In response to the Chief Secretary's letter he proposes to redraft para 1.6 and 7.2 of the evidence as attached. The Chief Secretary thinks this sounds acceptable.

2. The Chief Secretary promised to respond asap this afternoon. Could you let me know by <u>3.30</u> if the new formulation is acceptable ps.

CEvans.

1.4 The new structure will also help authorities to make the most effective use of the staff at their disposal. It will complement the work which is already in hand to secure the patterns of management and staffing which are needed for cost-effective patient care. Once the immediate task of assimilation is completed, therefore, changes from the grading patterns resulting from the initial exercise can be expected over time as health authorities use the new structure in this way.

1.5 The Health Departments' general approach to pay remains as in previous years, namely that, within the limit of what can be afforded, pay should be set according to what is needed to recruit, retain and motivate staff. The very wide range of pay increases which the 1988/89 award provides was brought about through the introduction both of the new clinical grading structure and of London supplements. Taken together they represent a substantial move towards a more flexible system of pay which is more closely attuned to the needs of NHS management. In particular, these developments will help in dealing more effectively with problems of recruitment and retention on a selective basis which best targets available resources. The Health Departments believe that this process should be extended by further moves towards more flexible remuneration arrangements which enable pay levels to reflect differences in labour markets. They are particularly keen to see greater scope for geographical variation in pay. They accept that it may not be possible to make further major changes towards geographical pay arrangements in the current review. But they regard such changes as a priority and will be presenting recommendations to the Review Body as soon as possible.

1.6 The Health Departments conclude ~~that the current round is not the occasion for major changes in the overall level of nurses' pay and that there is no need this year for any further substantial increase in real-terms remuneration levels.~~ that the existing [pattern of] remuneration levels should be maintained.

There is no need to do more than maintain current level of remun

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CONFIDENTIAL

MP

DRAFT LETTER

From: Chief Secretary
To: Secretary of State for Health

Copied to: Prime Minister, Norman Fowler, Wyn Roberts, Michael Forsyth, Richard Needham and to Sir Robin Butler.

GOVERNMENT EVIDENCE TO THE NURSES AND PAMs PAY REVIEW BODY

Thank you for your letter of 27 September and the draft evidence on nurses' pay attached to it.

In general I am content with the evidence, but I must take issue with you on an important point in your letter. I am, like you, very keen that we should win the propaganda battle and agree that we should publish our evidence in its entirety so that you can take the initiative. But in so doing we must be careful not to prejudice the substance of our case.

I am sure we are agreed that our message to the Review Body must be that there is no case for any further increase in real terms in nurses' pay. But in paragraphs 1.6 and 7.2 your draft evidence says that "the Health Departments conclude that the 1989 review is not the occasion for major changes on the overall level of nurses' pay and that there is no necessity for any further substantial increases in remuneration levels." The clear implication is that there could be major changes in later years notwithstanding the increases for the once-for-all nurses' fundamental restructuring, and that even this year the Government has accepted that nurses should have an increase of say, 2 or 3 per cent above the RPI. Given the temporary increase in the RPI in the rest of this year

and early next year this could result in a further large increase in 1989 on top of the 15.3 per cent in 1988. I share your view on the importance of getting the presentation right, but I am concerned that by the time it comes to given oral evidence in November it will be too late to correct a misunderstanding of this nature. Indeed, if you were to argue in oral evidence that by no substantial increase you had meant no increase at all, it would be difficult to avoid accusations of bad faith.

To avoid these damaging implications the evidence should be amended to read "the Health Departments conclude that there is no necessity for any further increases in nurses' remuneration in real terms".

I would also be grateful if, as in previous years, our officials could discuss the briefing for the oral evidence beforehand.

I am copying this to the Prime Minister, Norman Fowler, Wyn Roberts, Michael Forsyth, Richard Needham, and to Sir Robin Butler.

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CONFIDENTIAL

DRAFT LETTER

From: Chief Secretary
To: Minister for Health

Copied to: Prime Minister, Norman Fowler, Wyn Roberts, Michael Forsyth, Richard Needham, Sir Robin Butler

GOVERNMENT EVIDENCE TO THE DOCTORS AND DENTISTS REVIEW BODY

Thank you for your letter of 27 September and the Draft Evidence to the Doctors and Dentists Review Body attached to it.

I am of course content with the line that there should be no real increase in remuneration levels. This must be right. But in the conclusion in paragraph A27 it is undermined by saying that the profession's rewards should reflect their responsibilities and career expectations. This could be used to justify hefty increases despite the absence of any recruitment and retention problems - indeed, arguably we already have too many doctors. The last sentence of the paragraph should therefore be amended to read "The Government recognises the importance of rewarding the professions adequately but in the light of the evidence we have submitted, particularly on the very satisfactory state of recruitment and retention, we believe that there is no need for any increase in remuneration levels in real terms". I also consider that given the brevity of Section A

the general economic evidence has too much prominence. It would be appropriate to delete paragraphs A5, A6, A10, and A11 in order to highlight our main message. Finally, I would be grateful if, as in previous years, our officials could discuss the briefing for the oral evidence beforehand.

I am copying this to the Prime Minister, Norman Fowler, Wyn Roberts, Michael Forsyth, Richard Needham and to Sir robin Butler.

pay1.sb/de Berker/14.10.001

CONFIDENTIAL

FROM: J DE BERKER

DATE: 14 October 1988

1. MS D J SEAMMEN
2. CHIEF SECRETARY

cc Chancellor
Sir P Middleton
Dame Anne Mueller
Mr Anson
Mr Phillips
Mr C W Kelly
Miss Peirson
Mr Turnbull
Mr Saunders
Mr White
Mr Griffiths
Mr Call

REVIEW BODY EVIDENCE FOR PROFESSIONS ALLIED TO MEDICINE

1. A draft of the Review Body Evidence for PAMs is attached. Mr Mellor will be looking at it over the week-end, and we understand he is planning to write to you on Monday asking for rapid clearance. The Department of Health have already missed the review body's end September deadline for written evidence. We would therefore be grateful for any comments you may have.

2. The evidence has been discussed with us at official level and sticks closely to the general line agreed by Ministers for the evidence on nurses ie existing remuneration levels should be maintained, but that is all. Unless there are any significant changes in the copy attached to Mr Mellor's forthcoming letter we will advise you to accept.

Background

3. This year the review body recommended increases averaging 8.8 per cent. These included London supplements payable on top of London Weighting. The cost was £45 million. The recommendations were accepted in full and backdated to 1 April 1988. Unlike the nurses, the PAM's are not waiting for any money from their 1988 settlement.

4. The review body is due to report in mid-January and they asked for written evidence by the end of September. This was delayed by continuing negotiations on grading. Negotiations for a regrading exercise this year have now broken down, although the Department of Health hope to resume negotiations in time for 1990. The sticking point was that the staff side were unable to agree to a sufficiently flexible grading structure for the senior management. There was a final meeting between Mr Mellor and the unions on Tuesday. It was not possible to complete the evidence until the outcome of the meeting was known. Mr Mellor will be giving oral evidence in November.

5. This year the Government published the nurses' evidence for the first time. The Department of Health are also proposing to publish the evidence on PAMs for the same reasons. They do not anticipate it will attract so much public interest so there will not be a formal press conference.

The Evidence

6. This consists of 5 short sections and 5 annexes. It has been agreed at official level subject to the views of Treasury Ministers and any alterations Mr Mellor may make. The general thrust of the evidence is that:

- recruitment and retention are broadly satisfactory;

- in the absence of agreement on a grading review the relativities between the grades should be left unchanged;

- further large across the board increases will not solve emerging demographic problems;

- a more accurately targeted response is needed to direct resources towards particular skills and geographical shortages;

- in particular the Health Departments believe that there is greater scope for geographical variation in pay; and

- the existing remuneration levels should be maintained (the line agreed for nurses).

7. On funding, the evidence says that the Autumn Statement will set out the resources to be made available to Health Authorities in 1989-90 and the next two years, that there should be no presumption of additional funding at a later date, and that no such presumption should underline any recommendation.

Conclusion

8. The evidence is sound on geographical pay and funding, and the line that existing remuneration levels should be maintained must be right. If you are content, we will put up a draft letter accepting the evidence when Mr Mellor writes - provided of course there are no significant changes in the copy attached to his letter.

9. ST are content.

Jonathan de Berker

JONATHAN DE BERKER

1.ORP

REVIEW BODY FOR NURSING STAFF, MIDWIVES, HEALTH VISITORS AND PROFESSIONS ALLIED TO MEDICINE

1989 REVIEW

WRITTEN EVIDENCE ON PROFESSIONS ALLIED TO MEDICINE FROM THE HEALTH DEPARTMENTS

CONTENTS

CONFIDENTIAL

DRAFT

REVIEW BODY FOR NURSING STAFF, MIDWIVES, HEALTH VISITORS AND PROFESSIONS ALLIED TO MEDICINE

1989 REVIEW

WRITTEN EVIDENCE ON PROFESSIONS ALLIED TO MEDICINE FROM THE HEALTH DEPARTMENTS

1. INTRODUCTION

1.1 The Government accepted the recommendations contained in the Review Body's Fifth Report in full and with effect from 1 April 1988. As a result the rates of pay for the professions allied to medicine and related groups of staff, which were already at their highest ever real-terms level, have now risen on average by nearly 40% in real-terms since 1979.

1.2 In their report the Review Body recommended basic pay increases ranging from 7.9% to 9.1% for professional staff and 7.6% to 9.5% for helpers. It also recommended special pay supplements for staff working in London, in the form of percentage additions to basic pay. The Review Body estimated that their recommendations would, in total, add some 8.8% to the paybill. In consequence, members of this group have received average pay increases in 1988 which are much in excess both of the increase in the cost of living and of increases received by many other groups of workers.

1.3 The increases were designed (paragraph 55 of the Report) to reinforce what the Review Body saw as both Management Side's and Staff Side's initiatives to deal with recruitment and retention problems. They did not however make any changes in relativities between the grades within the current structure for these professions as recommended last year by the Staff Side. This was because a grading review was due to take place for this group during 1988. As noted elsewhere in this Evidence (Chapter 3) intensive discussions have taken place over the year on this review, but despite these, the Health Departments regret that it was not possible to reach final agreement on the total package in time for the 1989 evidence. The Health Departments hope

however, that negotiations can be concluded on a total package in time for joint evidence to be submitted for the 1990 Review.

1.4 The Health Departments' general approach to the pay of the professions allied to medicine, remains as in previous years, that within the level of what can be afforded, they should be set according to what is required to recruit, retain and motivate the staff needed. The numbers of staff in this group continue to increase, and recruitment and retention remains broadly satisfactory although there are problems related to individual professions primarily radiographers.

1.5 The Health Departments believe that the introduction in due course of a new grading structure (provided a satisfactory agreement can be concluded with the Staff Side), together with the London supplements introduced this year, will together represent a substantial move towards a more flexible system of pay which is more closely attuned to the needs of NHS management. In particular, these developments will help the NHS to deal more effectively with problems of recruitment and retention on a selective basis which best targets available resources. The Health Departments believe that this process should be extended by further moves towards more flexible remuneration arrangements which enable pay levels to reflect differences in labour markets. They are particularly keen to see greater scope for geographical variation in pay. They accept that it may not be possible to make further major changes towards geographical pay arrangements in the current review, but they regard such changes as a priority and will be presenting recommendations to the Review Body as soon as possible.

1.6 The Health Departments conclude that the existing remuneration levels should be maintained.

2. THE GENERAL ECONOMIC SITUATION

The Cost of Living

2.1 The Government's plans for public spending form a central part of its economic policy. Within the framework of the Medium Term Financial Strategy, the Government's objective is to hold the rate of growth of public spending

below the growth of the economy as a whole and thus to reduce public spending as a proportion of national income. This will enable a prudent fiscal stance to be combined with reductions in the burden of taxation, so encouraging enterprise and efficiency, and thus the growth of output and employment.

2.2 Inflation as measured by the RPI has averaged below 5% for the last two years, but in September it rose to 5.9%. With increases in mortgage interest rates it is likely to edge up further in the next few months before coming down again in 1989. But the Government will take whatever action is required to keep inflation under control.

2.3 The Tax and Price Index - which measures the pay rise required by the average employee to compensate for price increases after taking account of tax changes - only rose 3.9% in the year to September.

2.4 Given the background outlined in paragraphs 2.2 and 2.3, modest pay increases are all that are required to take account of changes in the cost of living.

NHS Resources and Affordability

2.5 The Government's decisions on levels of spending in the NHS in 1989-90 and the subsequent two years will form part of the Chancellor's Autumn Statement and will subsequently be described in greater detail by the Secretary of State for Health. A summary of these announcements will be provided by the Health Departments in the form of supplementary evidence. Details of the contributions the continuing programme of cost improvements and the income generation initiative will make to the pool of resources available to health will similarly be given later.

2.6 In 1988/89 the Government made available additional funds specifically to provide for the costs over and above baseline funding of the 1988/89 award for the professions allied to medicine. This will not however constitute a precedent for the future. The Autumn Statement will set out the resources to be made available to health authorities in 1989-90 and there are also again expected to be cash savings as a result of improved efficiency. There can therefore be no presumption of additional funding at a later date, and no such presumption should underlie any recommendation.

Movements in Pay and Earnings

2.7 The Health Departments agree with the statement of the Review Body in their Fifth Report (paragraph 44) that external comparisons are not the only factor, or even the major factor to be considered in formulating their recommendations. Indeed, they do not regard such comparisons as particularly relevant in themselves to the interests of the National Health Service. The right approach is to take account of all aspects of employment to arrive at pay levels in the public sector which ensure that sufficient employees of the right standard are recruited and retained. Data on pay settlements and earnings movements in the economy should only inform pay determination to the extent that they are relevant.

2.8 External comparisons would not, in any event, offer strong support for significant increases in pay. Since 1984, the average pay increases for the professions allied to medicine and related grades of staff have been higher than those of all other NHS staff groups save nurses, and higher than the average in either the public or private sectors of the economy as a whole. Their pay has also increased far faster than prices. Average levels of the pay of the professions allied to medicine are now higher in real terms than those set either by the Halsbury Report (1974) or Clegg Report (1979). The professions now enjoy their highest ever levels of real terms pay which has increased by nearly 40% since 1979 (see Table A1).

2.9 The Confederation of British Industry data on settlements in private sector manufacturing and private sector services, show that since August 1987 manufacturing settlements averaged 5.9% (with just under half being under 5.5%) and settlements in private sector services have averaged 6.8%. For the economy as a whole, the Office of Manpower Economics conducted a survey of settlements on behalf of the Police Negotiating Board. This showed that in the year to June half the settlements for basic pay were below 6%, and the average was 6.8%.

2.10 The increase in earnings is greater than settlements because of "drift". Drift reflects changes in overtime, bonus payments (including performance pay), and in some cases movement up incremental scales. In the past year this has added about 1.75% to earnings, which is in line with

experience in earlier years. Every occupation benefits from earnings drift to a greater or lesser extent, and the Government does not consider that any settlement for a Review Body group should reflect earnings drift elsewhere in the economy; otherwise they would benefit from drift twice over, their own, and that of other groups as well.

2.11 It is important that pay increases for review body groups should not be excessive. Although they should be looked at on their own merits, it is unreal to ignore the extent to which they can influence others in the public sector and elsewhere. In recent years pay settlements for review body groups have had a significant influence on average pay and earnings data, further fuelling expectations.

2.12 A more detailed examination of movements in settlements and earnings is at Annex A.

2.13 The economic evidence will be updated when the Autumn Statement becomes available.

3. RECRUITMENT AND RETENTION

The Current Position

3.1 The results of the survey of vacancies of 31 March 1988 that the Office of Manpower Economics has conducted on behalf of the Review Body will not of course give any indication of the impact of the 1988 award on the retention position in the professions. It is reasonable to assume that the picture which emerges will improve over the coming months as the full impact of the 1988 award takes effect. For the moment the manpower tables at Annex B comprise the most up to date information available to the Health Departments, all of which pre-date the Review Body's 1988 award. These however show that the numbers of staff employed in the professions allied to medicine in the NHS continued to increase.

3.2 The table below gives the total whole time equivalent number employed at 30 September 1987 and the proportion of the workforce who were qualified. The total of 40,400 was 3.0% greater than at 30 September 1986. Over the

same period the number of professionally qualified staff rose to 78.7% of the workforce. Details of the position for each of the professions are given in Annex B.

PAMs Employed by the NHS in Great Britain at 30 September each year

	1983	1984	1985	1986	1987
Total WTE Staff	34,980	36,190	37,990	39,210	40,400
Qualified as % of total	77.8	77.7	78.0	78.3	78.7

3.3 The manpower trends for individual professions vary. Between September 1986 and September 1987 the number of State Registered chiropodists increased by 8%, occupational therapists by over 6% and dietitians by just under 6%. The number of technical instructors rose by nearly 6%. There were smaller percentage increases in the number of physiotherapists, orthoptists and radiographers. There was a proportionately larger increase in the smaller professions of art and music therapy.

3.4 Data on entrants to the professions are important in assessing the manpower position of PAMs. Comparative figures by profession for students entering training and qualifying for each year from 1982 to 1987, together with wastage rates from training for certain professions and numbers registering with the Council for the Professions Supplementary to Medicine are shown in Tables B4-6 of Annex B.

3.5 The evidence from Table B4 is that student intakes for the academic year 1987/88 in chiropody, occupational therapy and physiotherapy have maintained the level of previous years and indeed have increased. The figures for occupational therapy include for the first time an intake at Christ Church College, Canterbury, and for chiropody a new school at Southampton. As noted in Table B4 of Annex B the figures for entrance to occupational therapy training do not include the intake to the four-year part-time conversion courses for occupational therapy helpers, which amounted to 68 in the 1987/88 academic year.

3.6 A slight decline continues in dietetics, and in orthoptics where the wastage rate is still running at a comparatively high level. There has been a more marked decline in numbers entering radiography training.

3.7 It is too early to comment in detail on the experience of schools in filling student vacancies for the 1988/89 academic year, although difficulties have been reported in Schools of Chiropody and Radiography. The Health Departments will however be monitoring the situation further.

3.8 Regional short and long term plans have become an increasingly important source of information for showing future demand for staff. To date we have received only 70% of Regional programmes for 1988/89 and are in the process of analysing the returns. However, from those received, we can see that the reliance placed on helper grades varies between staff groups and Regions. Within overall staff groups there are wide variations in projected staffing levels and again within these figures are even greater Regional variations. Through Short Term Programmes we are able to get a feel for Regions' current plans to the end of the strategic period (1994). However Regional programmes show varying patterns for demand requirements for all staff groups, not only PAMs. This is why the Chief Executive, in the letter to the Service reproduced as Annex C calls for surveys of individual professional groups in order to refine demand and is a forerunner to the preparation of supply and training strategies. At present, the Health Departments are by no means convinced that the quality of manpower planning for the Professions Allied to Medicine, is sufficiently good to place total reliance on Regions' existing long-term demand projections.

3.9 The demographic trends, particularly the decline in the number of suitably qualified school leavers, referred to in the Departments' evidence last year, point to increasing difficulty for the NHS in satisfying rising demand from the sources on which it has traditionally relied. The Health Departments' evidence last year touched on a number of strategies required to cope with these trends and further developments are discussed below.

Pay

3.10 One element in any manpower strategy is clearly the level of pay which is set. The Health Departments' view is that, following increases amounting

over the last 4 years to 24.1% in real terms, further large across-the-board increases are not a cost-effective means of maintaining an adequate workforce in the professions allied to medicine. A more accurately targetted response is needed to direct resources towards particular skills and geographical shortages. This calls for the introduction of geographical pay variations as a means of responding to different recruitment and retention needs in different parts of the country.

3.11 The Review Body's decision to introduce pay supplements for staff working in London represents a significant step in this direction. These supplements have been implemented from 1 April on the basis of the pay award recommended by the Review Body. As for nursing staff, the Health Departments will be monitoring the effect of the new supplements closely and the outcome of this monitoring will be reflected in evidence to the Review Body for their subsequent reviews.

3.12 The Health Departments believe that there is greater scope for geographical variation in pay. They believe that the right approach would be to consider a more flexible system of supplements (perhaps in the form of additional points on a pay spine) linked to geographical or skill shortages. The Health Departments intend to pursue this matter urgently in the light of developments including the progress of the grading review (para 3.14) for the professions. They will wish to raise these issues with the Staff Side with a view to early discussions in the Negotiating Council, and will wish to put further evidence to the Review Body at the appropriate time.

3.13 Pay, however, is not the only element in an effective recruitment and retention strategy. Indeed, pay-related solutions based wholly or principally on successive real-terms increases in remuneration levels are likely to prove both costly and ineffective. They will result in unproductive leapfrogging in settlement levels between competing employers for what, in the case of the professions allied to medicine, is, and is likely to remain, essentially a limited pool of potential recruits. This will be damaging not only to the NHS but to the economy more generally because comparable shortages of staff, drawn from similarly qualified recruits, exist in other organisations. Big increases in pay will not cure such shortages.

Grading

3.14 Clearly, a key element in any recruitment and retention strategy is the establishment of an appropriate career structure and relativities between jobs. These issue have been under intensive consideration over the past year by the Professions Allied to Medicine (PTA) Council. The jointly agreed Terms of Reference for this review are set out at Annex D.

3.15 Although no formal offer was made by the Management Side, they made it clear that their objective was a comprehensive grading structure which, they suggested, might have 3 main structural elements:

3.15.1 a basic structure of 7 grades to cover all state registered staff apart from the small number in teaching grades (who would have a separate 7 grade structure); and three grades for non-state registered staff (helpers and Technical Instructors). These would be coupled with grading definitions designed to give employing authorities maximum flexibility and in particular to enable them to recognise clinical as well as managerial requirements in particular posts;

3.15.2 a common pay spine for all the above grades; and

3.15.3 discretion for management to award up to two additional incremental points within or above the pay range for each grade in recognition of exceptionally heavy additional responsibilities.

3.16 A package on these lines would have the following advantages to the NHS:-

3.16.1 improving recruitment and retention by a career structure which enabled clinical excellence as well as management responsibilities to be adequately rewarded;

3.16.2 the ability to recognise fully the position of unqualified helper staff and other non-State registered groups, thus providing management with opportunities to employ such staff as a way of developing more cost-effective skill-mixes and ensuring that State

registered and other qualified staff are employed on work appropriate to their training and experience; and

3.16.3 enabling management to establish sensible and cost-effective grading relativities and managerial levels in particular by getting away from rigid and over prescriptive definitions in the senior management grades.

3.17 During the year, a great deal of effort has been put into the review by both Sides. The Joint Grading Review Working Party whose establishment was reported in last year's evidence increased the frequency of its meetings. Monthly meetings were followed by a two-day residential meeting in Edinburgh in July and subsequent weekly meetings, with meetings of smaller working groups looking at detailed specific issues being held between these main meetings. Considerable progress was made on a number of issues. The Health Departments much regret however that unfortunately despite this intensive effort it has not proved possible to reach final agreement in time for the 1989 Review. The Sides appeared to be close to agreement on a number of the substantive issues, but the Staff Side were unable to agree to the Management Side's proposals on the important issue of a flexible structure for the senior management grades. The Health Departments very much hope that after a pause for reflection, discussions can be continued in an effort to resolve the outstanding issues in time for the Review Body's next report.

3.18 As a consequence of this work the full PTA Council has only met twice since the beginning of 1988, and it has not therefore taken forward a number of claims noted in the Health Departments' evidence for the 1988 Review.

Allowances

3.19 Against this background, there will be no change this year in the pattern of allowances at present in place for these professions. The Health Departments' view remains however that expressed in the evidence for the 1987 and 1988 Reviews that there are no grounds for any further increases.

Action on Manpower, Education and Training Initiatives (see also Annex E)

a. The NAO Report

3.20 The Health Departments' evidence for the 1988 Review touched in some detail on the Report of the Committee of Public Accounts commenting on one by the National Audit Office on Control of Professional and Technical Manpower in the NHS and its consequences. Since that evidence, the Chief Executive of the NHS Management Board has met the Chairman and Registrar of the Council for the Professions Supplementary to Medicine. With them he has reached a useful understanding for the future on the need for the Council and its Boards to take account of the resource implications for the NHS of their decisions.

3.21 Meetings have also been held with representatives of the main professional bodies representing the professions allied to medicine. They have without exception welcomed the opportunity to open up a better dialogue with the Management Board and the Manpower Planning Advisory Group and have willingly agreed to share important manpower information with the Group.

b. Safeguarding immediate supply

3.22 The Chief Executive has also written to health authorities (in the letter reproduced at Annex C) drawing their attention to the Committee of Public Accounts and National Audit Office reports and reiterating in strong terms the need for local health authorities not to take precipitate local action to close training schools or reduce training places, bursaries or clinical placements, any of which actions might adversely affect the national supply position of the professions allied to medicine, until analysis by individual professional groups of supply and demand issues is better advanced and decisions can be taken on a more informed basis.

3.23 Separate action has been taken to tackle urgently the problem of recruitment to the radiography profession - this is noted in paragraph 1.3 and the Appendix of Annex E.

c. Ongoing Work of the Manpower Planning Advisory Group

3.24 Current action on investigating the balance of supply and demand and establishing future skill-mix requirements has been the focus of the work of the Manpower Planning Advisory Group (as described in last year's Evidence).

Manpower studies have been mounted in occupational therapy, physiotherapy and radiography and a report received on the current roles and functions of orthoptists, developments foreshadowed in the Health Departments' evidence for the 1988 Review. All these studies have been mounted with the full co-operation of the professional bodies concerned and in occupational therapy in conjunction with a Commission set up by the College of Occupational Therapists. A detailed note of the present position on the initiatives taken by the Manpower Planning Advisory Group is at Section 1 of Annex E.

3.25 As the results of these studies become known, the Health Departments together with the Manpower Planning Advisory Group will be considering what further action is necessary to give advice to NHS authorities on optimum student intakes for future years. Short-term advice on the maintenance of supply of radiography students has already been issued (see 3.23 above). As these studies continue it becomes even clearer that in addition to the creation of more places on conventional three-year diploma training courses, increasing reliance will have to be placed on alternative recruitment strategies such as those discussed in the Health Department' evidence for the 1988 Review. (These are touched on in more detail in the following section.) Annex E also discusses the present position on various reviews of training provision and structures being carried out within the NHS for these professions.

3.26 The Manpower Steering Group established by the Welsh Office is closely associated with and involved in the work of the Manpower Planning Advisory Group. The Manpower Steering Group has also initiated a manpower resource planning exercise at the All-Wales level which will identify projected requirements within individual staff groups over the next decade and enable action to be taken to forestall potential difficulties. The first round of the exercise, which is nearing completion, has examined in detail a number of the professions allied to medicine: occupational therapy, physiotherapy and chiropody.

d. Other Recruitment Strategies

3.27 The Health Departments acknowledge that in the light of demographic change and the continually rising demands for particular professions allied to medicine greater reliance must be placed in future on alternative recruitment strategies to supplement traditional methods. These include.-

i. development of alternative styles of training (for example conversion courses for helpers and possibly shortened courses for mature graduates in other disciplines): so far these have been confined to occupational therapy (see Section 3 of Annex E) but may have applicability for other professions;

ii. detailed investigations of skill-mix and manpower requirements (as already set in hand by the MPAG and the Commission set up by the College of Occupational Therapists);

iii. Recruitment publicity: "return to work" campaigns and more effective management of the career break, and the provision of refresher courses;

iv. experimentation with the use of Training Agency (YTS and related) programmes for the NHS;

v. widening the entry gate to training eg by recognition of vocational qualifications.

3.28 On 3.27(iii) a new range of recruitment publicity leaflets is being published by the Department - one for each of the professions. All are expected to be available by the middle of next year.

3.29 As far as the Youth Training Scheme is concerned, the Health Departments drew the attention of the Review Body last year to the joint MSC, DHSS, UKCC and NHS Training Authority feasibility study of the Scheme as an entry route for nurses and support workers. A series of pilot schemes is due to start in the autumn of 1988. The Care Sector Consortium set up last year by the (then) Manpower Services Commission with the National Council for Vocational Qualifications to provide an overview of training in both the health and social services in the public, private and voluntary sectors will continue to discuss the type of training to be provided through the scheme, and the possible progression of YTS trainees into professional nurse training. The Health Departments will be considering carefully the applicability of such schemes to the professions allied to medicine. The Training Agency has replaced the Job Training Scheme with a new adult training scheme which

started this autumn. There are special provisions covering lone parents and women returning to the workforce after a career break which may be particularly appropriate to the need of nurses, but the feasibility of using the scheme as an entry route to the professions has not yet been explored.

e. Equality of Opportunity

3.30 In November 1986 the Secretary of State for Social Services established a working group to consider personnel policies and procedures necessary to provide equal opportunity for women in NHS employment and in particular to make recommendations for management of the career break. The group issued practical guidance to authorities on recruitment and selection procedures in October 1987, and monitoring and evaluation in 1988. Further guidance is likely to be issued later this year.

3.31 A taskforce set up by the King's Fund published a "model policy" for applying the Commission on Racial Equality's Code of Practice on racial discrimination effectively in July 1987. In March of this year the taskforce published guidance on equal opportunity advisers for ethnic minority employers in the NHS.

4. LONDON SUPPLEMENTS

4.1 As Health Departments have said earlier in this Evidence (para 3.11 above) they will be monitoring the effects of London supplements. Whilst this is being done, they wish to see the supplements continue.

4.2 In considering its recommendations for 1989 the Review Body will wish to take account of the outcome of negotiations within the London Weighting Consortium on London weighting rates for 1987/88. Agreement has been reached on an increase of 5.5% which took effect from 1 July 1987 which takes the inner London rate for the professions allied to medicine to £1,267 and the outer London rate to £757. The rates for fringe staff and those in extra territorially managed units remain at £149 and £527 respectively. Negotiations have yet to start on rates for 1988/89.

4.3 Apart from any increase in London weighting, if the value of the London supplements expressed as a percentage of basic pay remains unchanged, members of the professions working in the London area will earn progressively higher

salaries than their counterparts working elsewhere. Until the effects of the new supplements on the recruitment and retention position in London have been assessed, therefore, the Health Departments see no case for changing the pattern of the supplements or for increasing their real terms value.

4.4 In paragraph 60 of its 1988 report, the Review Body commented that "it would clearly be more sensible if the London problem, in so far as it affects the pay of those within our remit, could be dealt with wholly in one forum, whether the General Whitley Council or the Review Body". The Health Departments are considering this issue which has important implications for all the staff groups in the NHS. Any changes would need to be negotiated with the Staff Side. It is unlikely that any new arrangements will be in place in time to affect the outcome of the Review Body's 1989 report. The Health Departments suggest that the Review Body base their recommendations on London supplements for 1989 on the assumption that the present arrangements will continue. They will submit supplementary evidence if the position changes.

5. CONCLUSION

5.1 Existing evidence of the continued increase in numbers in the professions indicates that pay levels are not unattractive, and the Health Departments' view remains that further substantial increases in pay levels will not solve increasing demographic problems. Other strategies are necessary to tackle specific recruitment and retention problems in individual professions and these are being actively pursued.

5.2 The Health Departments continue to hope that a comprehensive agreement can be reached with the Staff Side on a new grading structure for the professions which will also assist in promoting recruitment and retention.

5.3 Against this background the Health Departments conclude that the existing remuneration levels should be maintained.

ANNEX A

NURSES AND PAMS REVIEW BODY: 1989 REVIEW

PAY AND EARNINGS COMPARISONS FOR PAMS

1. Table A1 shows the movement in PAMs pay since 1976: it demonstrates that the present level of real terms pay is higher than at any time during that period.

PAY SETTLEMENTS

2. Comparisons of pay movements within the NHS and in the wider public sector are shown at Table A2. In recent years not only have average pay settlements for PAMs consistently exceeded those for non-review body staff within the NHS but they have been greater than those received by almost any other group in the public sector.

3. The cumulative percentage increase in settlements for PAMs during the period 1983/84 to 1987/88 has been 55.2%. During the same period the equivalent figure for the CBI manufacturing sector was 33.1%. During the period 1984/85 to 1987/88 the cumulative increase for PAMs was 44% whereas that for all sectors under Industrial Relations Services data was 25.4%. Thus PAMs settlements have been better than average in whichever survey is used. The overall cost of pay settlements for PAMs from 1985/86 to 1987/88 have averaged 8.29%, 9.1% and 8.8%. Over the same period average settlements in the public sector were 6%, 7% and 6.0%, settlements covering whole industries in the private sector were even lower at 5.6%, 5.0% and 5.8% and settlements for private sector companies averaged 6.0%, 5.8% and 6.4% respectively (see Table A3).

EARNINGS

4. Figures for average pay settlements do not give a complete picture of movements in relative earnings of different groups within the economy as they do not include the effect on earnings of revised work patterns, pay systems, bonus arrangements, overtime and allowances. It is therefore relevant, as a further indicator, to compare trends in earnings for different groups. But there are dangers in taking movements in average earnings as a sole guide, rather than as one indicator amongst many. It is clearly not right to increase the pay of the professions allied to medicine and related grades in the NHS simply because workers in other parts of the economy are working more overtime or earning higher bonuses through productivity or through wage drift.

5. Changes in the relative earnings of the professions allied to medicine over time can be assessed by reference to the average earnings information from the New Earnings Survey and from the Earnings Related Base of Data (ERBOD) which covers NHS staff, and are illustrated in Table A4. The 1987 ERBOD data (the latest available) reflect the level of earnings following the 1 April 1987 award and do not, therefore, include the 8.8% settlement from 1 April 1988. The April 1988 average pay award to the professions allied to medicine was higher than the underlying annual increase in average earnings which stood at 8.5%, so that, over that period the average of the professions allied to medicine's pay will have risen as a percentage of average earnings.

PAY MOVEMENTS WITHIN THE NHS

5. Table A2 shows that between 1978/79 and 1987/88, NHS staff whose pay is recommended by a Review Body have received higher overall pay increases than other NHS staff. Since the full implementation of the staged Clegg Awards on 1 April 1980, PAMs, nurses and doctors have benefited from average pay increases worth 84.8%, 89.17% and 75.5% respectively. The average yearly pay award for PAMs has consistently been higher than awards for NHS ancillary, dministrative and clerical, ambulance, professional and technical scientific and maintenance staff over the period 1983/84 and 1987/88 and this has significantly altered pay relativities in the NHS.

ANNEX A

TABLE A1

PROFESSIONS ALLIED TO MEDICINE (a)
MOVEMENTS IN PAY RATES 1976-1988 (b)

PAY ROUND YEAR 1 August to 31 July	PERCENTAGE PAY INCREASE (c)	PERCENTAGE CHANGE RPI JULY-JULY %	PERCENTAGE INCREASE real pay (d) %	CUMULATIVE POSITION 1974/75=10 %
1976-1977	5	17.6	-10.7	89.3
1977-1978	10	7.8	2	91.1
1978-1979	9	15.6	-5.7	85.6
CUMULATIVE 1976-1979	25.9	46.5	-12.8	
1979-1980	37.9 (e)	16.9	18	101
1980-1981	6	10.9	-4.4	96.8
1981-1982	7.5	8.7	-1.1	95.8
1982-1983	4.5	4.2	0.3	96
1983-1984	7.8	4.5	3.2	99
1984-1985	12.1 (f)	6.9	4.9	103.9
1985-1986	8.2	2.4	5.7	109.7
1986-1987	9.1	4.4	4.5	114.7
1987-1988	8.8	4.8	3.8	119.1
CUMULATIVE 1979-1988	154.9	83.7	39.2	
CUMULATIVE 1983-1988	55.2	25.1	24.5	

NOTES

a) Professions allied to medicine were defined as a group at the inception of the review body: pay data for radiographers has been used prior to 1983

b) Figures reflect the full cost of appropriate award ,not changes in average earnings.

c) Percentage pay increase reflects full year effect of increases agreed within pay round year (1 August to 31 July)

d) Percentage real increase reflects the percentage cash increases for the pay round year deflated by the increase in the RPI throughout the pay round year, that is in the 12 months to July

e) Staged award, final part paid with effect from 1 April 1980.

f) Staged award final part paid with effect from 1 February

TABLE A2

PAY SETTLEMENTS FOR SELECTED GROUPS AND RPI, AEI and TPI MOVEMENTS WITHIN PAY-ROUND YEARS
(Percentages with Backdated cumulative percentages)

Pay Round Year 1 August - 31 July	RPI (July - July)		AEI (July - July)		TPI (July - July)		NHS: Doctors and Dentists		NHS: Nurses and Midwives		NHS: PAR's		NHS: ASC		NHS: A & C		NHS: AHB		OTHER PUBLIC SECTOR: Police (Federated Ranks)		OTHER PUBLIC SECTOR: Civil Service (Admin)		OTHER PUBLIC SECTOR: Teachers (England & Wales)		OTHER PUBLIC SECTOR: Local Government (Manual)		OTHER PUBLIC SECTOR: Local Government (Admin)		Firemen	
1978/79	15.8	112.5	16.5	168.7	13.2	101.8	25.7	189.8	10.0	193.4	9.0	177.8	9.0	108.8	25.8	116.3	9.0	138.0	20.0+ 15.5	238.1	25.0	125.5	9.3	157.6	26.0	140.3	26.0	117.9	22.0	192.8
1979/80	16.9	83.1	19.0	130.8	18.5	78.2	18.7 10.7	130.6	21.0++ 14.0	166.7	21.0++ 14.0	154.9	10.6++ 13.0	91.5	14.0	72.0	23.0++ 13.0	118.3	13.5	143.9	16.8	80.4	20.95	135.7	13.0	90.7	15.0	73.0	20.0	140.0
1980/81	10.9	57.1	12.0	94.4	14.3	50.3	6.0	75.5	6.0	93.4	6.0	84.8	7.8	53.3	6.0	50.8	7.3	57.1	21.3	114.9	7.5	51.8	19.7	94.9	7.5	68.7	7.5	50.4	18.8	100.0
1981/82	8.7	41.7	10.9	73.6	9.6	31.5	6.2	65.5	-	82.5	7.5	74.4	6.0	42.2	6.0	42.3	6.0	46.4	13.2	77.2	5.9	41.2	6.0	62.8	6.9	57.0	5.7	39.9	10.1	68.3
1982/83	4.2	30.3	7.8	56.6	3.1	20.0	9.7	55.9	12.3‡	82.5	4.5	62.2	4.5	34.1	4.5	34.3	4.5	38.1	10.3	56.5	4.9	33.4	4.98	53.6	4.9	46.8	4.9	32.4	7.5	52.9
1983/84	4.5	25.1	5.2	45.2	3.3	16.4	6.9	42.1	7.5	62.5	7.8	55.2	4.5	28.4	4.5	28.5	4.5	32.2	8.4	41.9	4.6	27.1	5.1	46.3	4.5	40.0	4.9	26.2	7.8	42.2
1984/85	6.9	19.7	8.8	38.0	6.3	12.7	6.3	32.9	8.6	51.1	12.1	44.0	4.7	22.8	4.7	22.9	7.8‡‡	26.5	5.13	30.9	4.9	21.5	8.5	39.2	5.1	34.0	5.6	20.3	7.2	31.9
1985/86	2.4	12.0	8.2	26.8	0.4	6.0	7.6	25.0	7.8	39.2	8.2	28.4	6.0	17.3	6.0	17.4	6.0	17.3	7.5	24.5	6.0	15.9	5.73	28.3	8.0	27.5	5.96	13.9	7.2	23.1
1986/87	4.4	9.4	8.1	17.2	2.8	5.6	7.7	16.2	9.5	29.1	9.1	18.7	5.0	10.7	5.0	10.8	5.0	10.7	7.5	15.8	4.6$	9.3	16.4$$	21.3	6.7	18.0	7.5	7.5	7.0	14.8
1987/88	4.8	4.8	8.5	8.5	2.7	2.7	7.9	7.9	17.9	17.9	8.8	8.8	5.4‡‡	5.4	5.5	5.5	5.4‡‡	5.4	7.75	7.75	4.5	4.5	4.25	4.25	10.6#	10.6			7.3	7.3

Notes: 0 The % change in the RPI, AEI and TPI is that from July of the base year to July of the latest year - not the yearly cumulative increase.

\+ 1st and 2nd part of Edmund-Davies award paid 1/9/78 and 1/5/79.

++ Staged Clegg award paid 1/8/79 and 1/4/80.

‡ Two-year award paid wholly in 1982-83 pay round.

‡‡ Assumes all projected efficiency savings are achieved.

$ Plus additional increases from 1/9/87 & 1/1/88 for certain Admin. grades.

$$ Staged award, 8.2% paid 1/1/87 and balance from 1/10/87.

\# 14 month settlement paid two months earlier than usual - from 1/7/87.

‡‡ In addition the standard working week was reduced by 1 hour.

RPI Retail Price Index AEI Average Earnings Index

TPI Tax and Price Index; a measure of the increase in gross taxable income needed to compensate tax payers for increases in retail prices after allowing for changes in direct taxes, including employees NI contributions.

ANNEX A

PAY INFORMATION UNIT
October 1988

ANNEX A
TABLE A3

PAY SETTLEMENT INFORMATION
(percentage increases)

Pay-Round (1 Aug - 31 July)	Professions Allied to Medicine average RB settlemennt	INFLATION Annual increase to July	INDUSTRIAL RELATIONS SERVICES (1)				C.B.I (2)	
			All	Public Sector	Private Industries	Private Companies	Manufact-uring	Non-Gov' services
1983-84	7.8	4.5	------ not available ------				6.0	6.5
1984-85	12.1 (3)	6.9	5.6	5.6	5.6	6.4	6.3	6.9
1985-86	8.2	2.4	5.9	6.0	5.6	6.0	6.1	6.8
1986-87	9.1	4.4	6.0	7.0	5.0	5.8	5.1	6.1
1987-88	8.8	4.8	5.8	6.0	5.8	6.4	5.9	6.8

Notes:
1. Median basic pay settlements based on the 12 months ending July, weighted by the number of employees.
2. Average pay settlements.
3. Staged award; final part paid with effect from 1.2.86.

Sources: IRS and CBI pay databa

ANNEX A

TABLE A4

AVERAGE GROSS WEEKLY EARNINGS : Full time staff

	1984	1985	1986	1987
SENIOR I (£) : (1)	172.3	180.5	212.8	229.3
NON - MANUAL EMPLOYEES :- (2)				
PUBLIC SECTOR -				
Earnings (£)	172.0	181.4	196.5	208.8
Average Senior I pay as a percentage...	100.2	99.5	108.3	109.8
PRIVATE SECTOR -				
Earnings (£)	172.3	187.0	203.9	222.8
Average Senior I pay as a percentage...	100.0	96.5	104.3	102.9
ALL SECTORS -				
Earnings (£)	172.2	184.6	200.9	217.4
Average Senior I pay as a percentage...	100.0	97.8	105.9	105.5

Notes:

(1) Estimated earnings of staff in post on 30 September, based on returns from Regional Health Authorities and SHAs (Source: DHSS Earnings Related Base of Data).

(2) Earnings are for employees on adult rates of pay and whose pay was not affected by absence. (Source : DE New Earnings Survey)

ANNEX B: PROFESSIONS ALLIED TO MEDICINE
MANPOWER TABLES

ANNEX B

TABLE B1

TABLE

PROFESSIONS ALLIED TO MEDICINE BY GRADE AS AT 30 SEPTEMBER 1987 : GREAT BRITAIN WHOLE-TIME EQUIVALENTS (a)

	TOTAL	BASIC GRADE	SENIOR II	SENIOR I	CHIEF IV	CHIEF III	CHIEF II	CHIEF I	DISTRICT POSTS	TUTORIAL STAFF	OTHER QUALIFIED
Art & Music Therapist (b)	290	30	140	80	10	10	-	-	-	-	20
Chiropodist (c)	3,330	*	1,650	890	160	200	10	-	190	30	200
Dietitian	1,400	340	330	420	60	60	-	-	170	-	20
Occupational Therapist	5,360	1,200	1,250	1,650	330	490	140	100	140	50	20
Orthoptist	570	30	220	200	20	30	10	10	-	30	*
Physiotherapist (d,e,f)	11,030	2,720	3,160	3,220	500	780	150	120	170	150	50
Radiographer (d,g)	9,810	4,100	2,290	1,610	460	670	160	140	90	240	50
TOTAL QUALIFIED PAMS	31,790	8,420	9,040	8,070	1,540	2,240	480	370	760	510	370
Technical Instructors (h)	2,550										
Helpers (i)(j)	5,990										
Total of above groups	40,330										
PAM Others (k)	70										
TOTAL PAMS	40,400										

SOURCE: Department of Health (SR7) Annual Census of NHS Non-Medical Manpower; Welsh Office and Scottish Health Service Common Services Agency

NOTES:

(a) Figures independently rounded to nearest ten (10) whole time equivalents.
* denotes less than 5.0 WTEs.

(b) Includes "Other" staff on Art/Music Therapist payscales.

(c) Sessional Basic/Senior Chiropodists are included under "Basic/Senior Chiropodists". Sessional staff in other grades shown under "Others".

(d) Superintendent Physiotherapists and Radiographers are shown under "Chief".

(e) Includes Remedial Gymnasts (merged to form a single profession in April 1986).

(f) Remedial Gymnast trainees are shown under "Others".

(g) District Radiographers cannot be separately identified, and are included with "Chief" posts

(h) Includes Art and Music Instructors, and other staff (e.g. Single-Handed Occupational Therapy helpers) on Technical Instructor payscales.

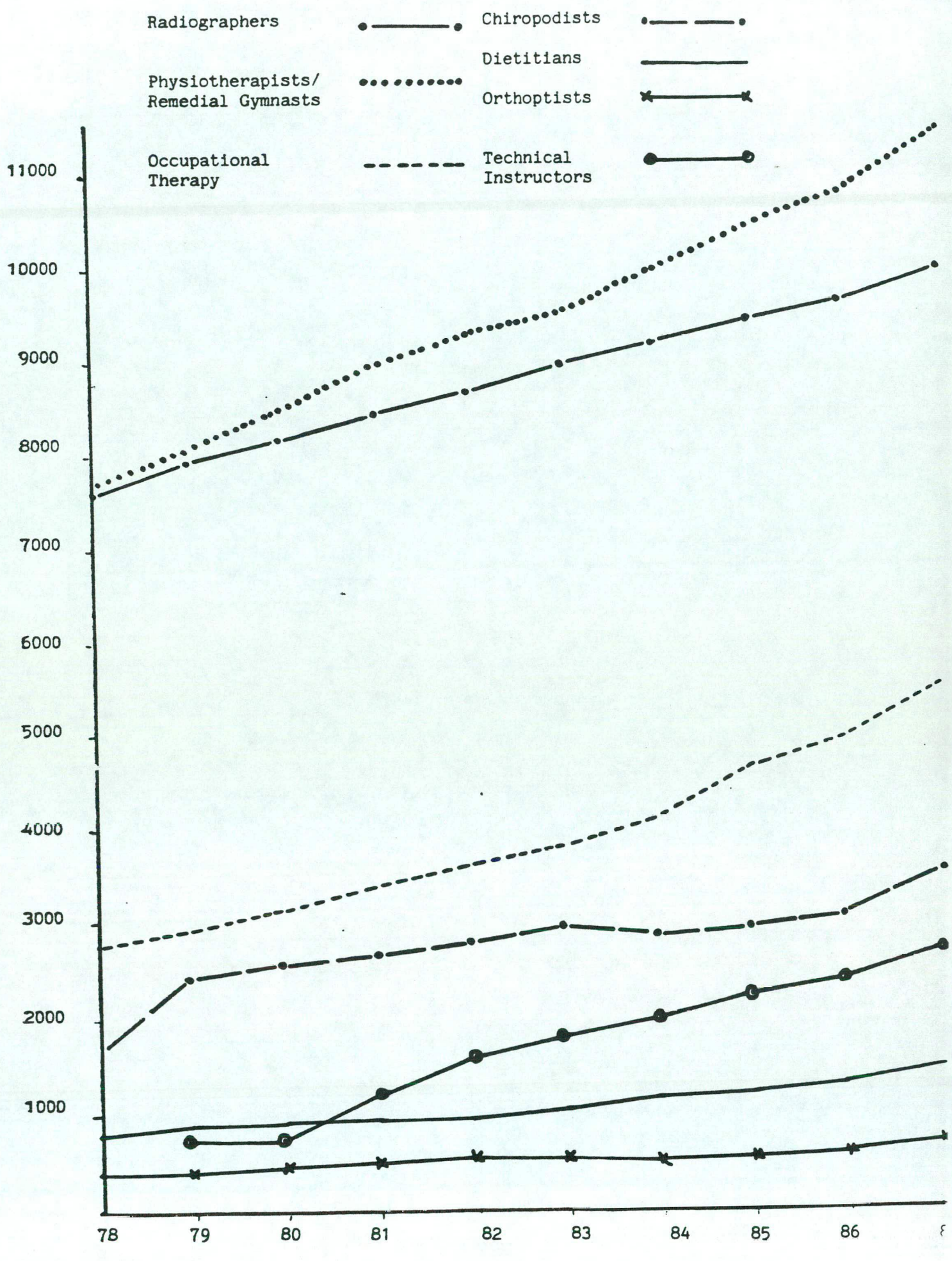
(i) Includes helpers on payscales PP01 and PQ00 (5,600 WTEs) and Footcare Assistants (390 WTEs).

(j) Excludes 290 WTE Radiography Helpers whose terms and conditions of service are formally negotiated by the PT'A' (PAM) Council. Their pay is determined on an ad-hoc basis, although it is linked to that of other helper staff covered by the Review Body.

(k) Includes staff on ad-hoc or unspecified payscales and occupation codes.

ANNEX B
TABLE B2

TABLE B2 : PAMS (WTE) EMPLOYED IN THE NHS IN GREAT BRITAIN



ANNEX B

TABLE B3

PROFESSIONS ALLIED TO MEDICINE - GREAT BRITAIN
COMPARISON BETWEEN SEPTEMBER 1986 and SEPTEMBER 1987

	WHOLE TIME EQUIVALENTS		CHANGE 1986 TO 1987	
Profession	1986	1987	WTE	%
Art and Music therapist	260	290	30	11.2%
Chiropodist	3,090	3,330	250	8.0%
Dietitian	1,320	1,400	80	5.7%
Occupational Therapist	5,030	5,360	330	6.5%
Orthoptist	540	570	30	4.7%
Physiotherapist	10,800	11,030	230	2.1%
Radiographer	9,650	9,810	160	1.7%
TOTAL QUALIFIED PAMS	30,700	31,790	1,090	3.6%
Technical Instructors	2,420	2,550	130	5.5%
Helpers	5,950	5,990	40	0.6%
Total excluding PAM others	39,060	40,330	1,260	3.2%
PAM others	150	70	-80	-51.2%
TOTAL ALL PAMS	39,210	40,400	1,190	3.0%

SOURCE: Department of Health (SR7) Annual Census of NHS Non-Medical Manpower; Welsh Office; Scottish Health Service Common Services Agency.

NOTE: All figures independently rounded to the nearest ten (10) whole time equivalents. Changes calculated on unrounded figures.

ANNEX B
TABLE B4

PROFESSIONS ALLIED TO MEDICINE: TRAINING AND WASTAGE: GREAT BRITAIN

YEAR OF INTAKE YEAR QUALIFIED	1980/ 1983	1981/ 1984	1982/ 1985	1983/ 1986	1984/ 1987	1985/ 1988	1986/ 1989	1987/ 1990
RADIOGRAPHY*								
Intake	802	967	1001	980	859	794	679	579
Qualifying	862	768	920	868	580			
PHYSIOTHERAPY								
Intake	996	991	977	954	960	967	962	978
Qualifying	856	844	891	886	858			
Wastage Rate %	14.1	14.8	8.8	7.1	10.6			
OCCUPATIONAL THERAPY**								
Intake	695	714	766	751	747	760	704	814
Qualifying	593	592	673	667	660			
Wastage Rate %	14.7	17.1	12.1	11.1	11.6			
CHIROPODY								
Intake	326	324	353	374	389	442	439	454
Qualifying	295	297	334	345	369			
Wastage Rate %	9.5	8.3	5.4	7.7	5.1			
DIETETICSó								
Intake	212	217	235	261	252	274	240	233
Qualifying	161	159	198	212	219			
ORTHOPTICS								
Intake	56	76	71	61	55	56	46	40
Qualifying	53	59	49	41	43			
Wastage Rate %	5.4	22.4	31.0	32.7	21.8			

* In radiography the length of course was changed in 1982 from $2\frac{1}{2}$ to $2\frac{3}{4}$ years: we also understand that in some cases, course lengths and the date and frequency of annual intakes may also vary between schools. For this reason wastage rates are uncertain and are not given.

** This figure reflects only the intake to conventional 3-year diploma courses in this discipline; it does not reflect the intake on 4-years' conversion courses for occupational therapy helpers.

ó No wastage rate is given for dietetics because of the varying length of courses.

ANNEX B

TABLE B5

PROFESSIONS ALLIED TO MEDICINE: STATE REGISTRATION: UK

	1980	1981	1982	1983	1984	1985	1986	1987
RADIOGRAPHY Registrations	854	810	874	887	801	925	922	843
PHYSIOTHERAPY Registrations	1274	1068	1201	1248	2063	1180	2370	1349
OCCUPATIONAL THERAPY Registrations	664	605	697	792	749	897	884	992
CHIROPODY Registrations	251	242	280	325	160	479	375	370
DIETETICS Registrations	206	192	209	175	169	219	253	236
ORTHOPTICS Registrations	69	45	49	44	66	40	46	39

State Registration is open to any qualified persons in the United Kingdom and to other persons whose qualifications are regarded as equivalent by the appropriate Board of the Council for Professions Supplementary to Medicine.

TABLE B.6 :– COMPARISON OF NUMBERS ENTERING TRAINING IN PHYSIOTHERAPY, OCCUPATIONAL THERAPY AND CHIROPODY WITH COMPLETIONS – GREAT BRITAIN.

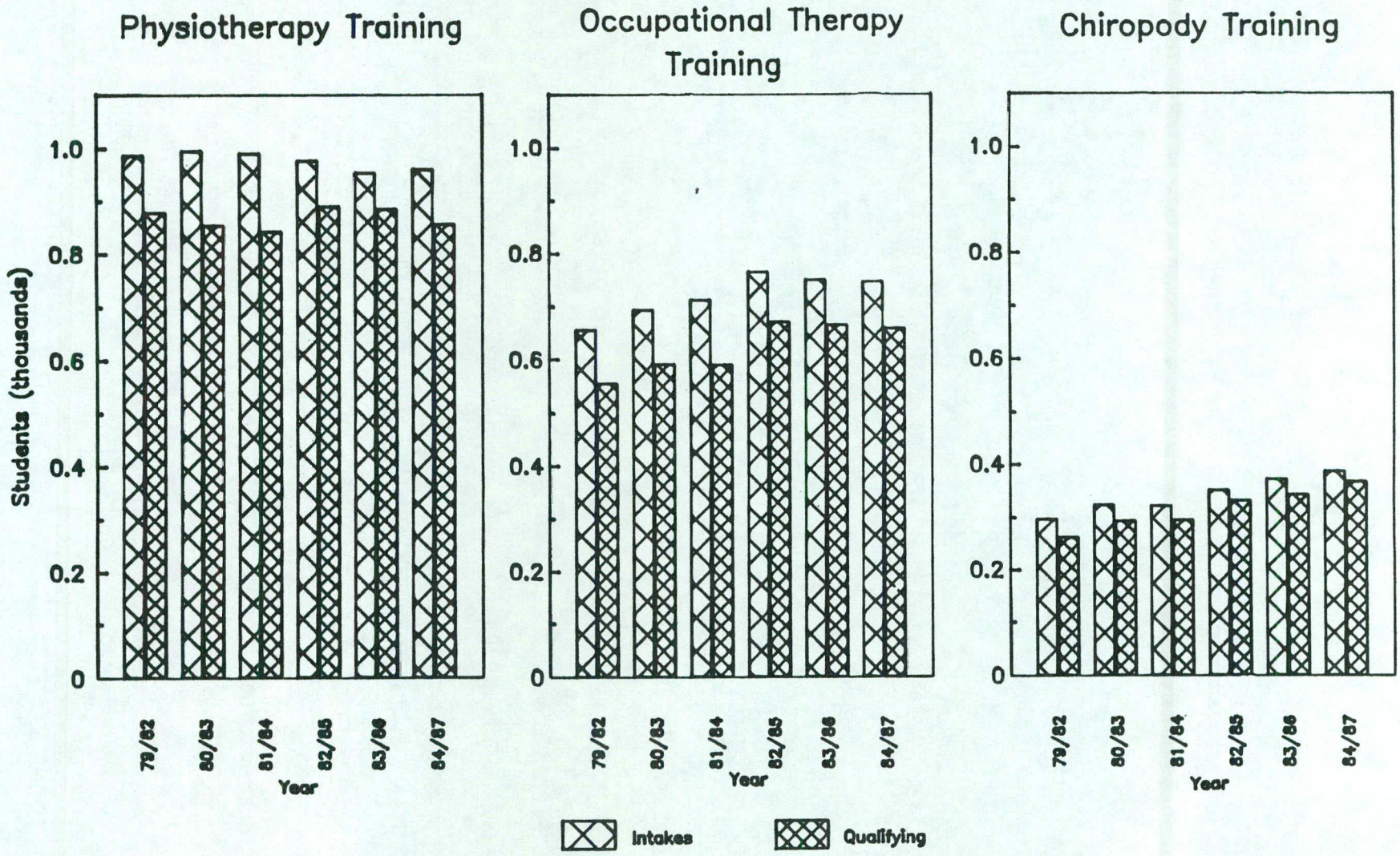


TABLE B7
PROFESSIONS ALLIED TO MEDICINE - TUTORIAL STAFF BY GRADE AND PROFESSION (a)
AT 30 SEPTEMBER 1987 GREAT BRITAIN WHOLE-TIME EQUIVALENTS (b)

	TOTAL TUTORIAL STAFF	STUDENT TEACHER	TEACHER	SENIOR TEACHER	PRINCIPAL 11	(c) PRINCIPAL 1	OTHER TUTORIAL
Art & Music Therapist	-	-	-	-	-	-	-
Chiropodist	33	-	14	17	1	2	-
Dietitian	-	-	-	-	-	-	-
Occupational Therapist	47	3	27	9	2	6	-
Orthoptist	32	-	18	5	8	1	-
Physiotherapist	153	1	65	66	-	21	1
Radiographer	240	2	47	67	39	42	22
TOTAL TUTORIAL PARS	506	28	170	163	50	72	23

SOURCE: Department of Health (SR7) Annual Census of NHS Non-Medical Manpower; Welsh Office ; Scottish Health Service Common Services Agency

NOTES: (a) Includes only staff employed in NHS schools. Does not include any tutorial staff employed in the Further Education sector.
(b) Figures are shown independently rounded to the nearest whole-time equivalent
(c) Includes Principal 24 +

ANNEX C

JW4478p

NHS MANAGEMENT BOARD
Department of Health & Social Security
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000
From the Chief Executive
Len Peach

EL(88)MB/113

7 July 1988

Dear Regional General Manager

1. Last year, the Committee of Public Accounts (CPA) reported on the control of National Health Service Manpower(1). The report was based on an earlier report by the Comptroller and Auditor General on control over professional and technical manpower(2). A summary of the CPA's main conclusions and recommendations is attached at Appendix 1. The CPA report concentrates on the larger of the professions supplementary to medicine, although it also picks up a number of the nursing manpower issues covered in my letter of 13 June 1986. This letter, however, deals with action in respect of a number of other professions as well.

2. The professional and technical staff groups have had the largest percentage growth of all staff groups in recent years, a growth which is planned to continue throughout the strategic planning period. For these groups, as for nurses, there will be difficulties in maintaining intakes to training in the face of declining numbers of suitably qualified 18 year olds. In view of the importance of these staff to the achievement of service objectives, I should be grateful if you will ensure that the issues covered in this letter are considered at both regional and district levels, and that action is taken where necessary. Appendix 2 summarises the action in hand nationally. This letter concentrates on the action required at regional and district levels.

3. The CPA's conclusions in respect of nursing cover staff shortages, skill mix and nurse education and training. Action is in hand at all levels of the Service in respect of these issues. A number of measures in respect of recruitment, retention and re-entry have been introduced; local skill mix studies are underway in many places (and nationally the Department is continuing to sponsor academic research in this field); and action in respect of Project 2000 will be the subject of a separate communication. As an aid to action in this area, I attach as Appendix 3, a guide commissioned from

NOTES

(1) Eleventh Report from the Committee of Public Accounts: Control of National Health Service Manpower (HMSO: April 1987)
(2) National Health Service: Control over Professional and Technical Manpower (HMSO: December 1986)

E.R.

the Department's Operational Research Service by the Manpower Planning Advisory Group (MPAG) on supply modelling. This is based on nurse supply modelling, but the principles are applicable to other staff groups and may be helpful with the tasks outlined in paragraph 5. The guide is written in clear, non-technical language and is intended for a wider audience than manpower planners. It could be read with profit by anyone involved in the demand for and provision of qualified staff. The guide is the first in a series of MPAG manpower monographs which will deal with methodological issues.

4. Turning to other professional and technical staff, the CPA endorsed the view that 'the determination of staffing requirements is a local matter. In that context, I reiterate the advice contained in the MPAG's letter of April 1986 to Regional General Managers following its analysis of Regional Strategic Plans from which it identified weaknesses in Regions' long-term demand forecasts. The Group then said:-

> 'clearly it would not be appropriate at this stage to take irrevocable decisions on training and supply on the basis of the information available, and further work should be put in hand to test the robustness of the data and to examine the factors influencing demand/supply recruitment and training decision.'

This advice still stands. To be blunt, the truth is that, both at national and regional levels, analysis by individual professional staff group of supply and demand issues is still not satisfactory. I recognise the constraints of time and expertise which have led to this situation. But while it persists, I must say in very clear terms that authorities should not take any precipitate local action to close training schools or reduce training places, bursaries or clinical placements, any of which might adversely affect the national supply position. Any such action in the immediate future would be irresponsible, given the lack of overall knowledge at both national and local levels. Advice on action to be taken follows in the subsequent paragraphs.

5. Since the MPAG's 1986 analysis a number of Regions have undertaken surveys of individual professional staff groups in order to refine their demand forecasting as a precursor to the preparation of supply and training strategies. Regions which have not already undertaken such surveys should do so; those which have not ensured complete coverage should also do so. This work is important if authorities are to ensure the integration of their manpower planning with service and financial planning, both in the short term and long terms. Regions should also assist their districts to develop profiles of the existing workforce and to introduce more objective demand determination methodologies.

6. Regions should also ensure that Districts take action to improve short term supply by the introduction of innovative employment practices, retention and return policies; the re-examination of staffing structures in the light of thinking of service provision; the identification of areas of skill shortages and reviewing the possibilities for using helpers and other support staff to supplement scarce professional skills. Regions should also take explicit steps to review the professional and other skills available to them to judge the adequacy of District manpower plans in respect of professional and technical staff. The mere transmission of targets set by professions themselves, or targets generated separately by manpower planners and

E.R.

treasurers, cannot be regarded as acceptable. The issues involved in demand determination, substitution and skill mix are complex. None of this work can be successfully achieved without the commitment and involvement of the professional service heads in planning. Equally, it is necessary for Regions to have and to demonstrate an independent and objective source of analytic advice on plans for these staff groups.

7. For many of these staff groups the Department expects that regions will work towards self-sufficiency in terms of supply, either independently or in collaboration with neighbouring regions. I accept that the variety of training provision, which varies from NHS school to private schools to training provided in higher education makes it difficult to be precise about this, but in general terms we expect that Regions should be able to plan, within a national framework for their own supply of occupational therapists, physiotherapists, radiographers, clinical psychologists, medical laboratory scientific officers, and chiropodists. Orthoptists present particular problems because of their very small numbers; and for speech therapists and dieticians, where training is in the higher education sector with little direct NHS input the position is different again.

8. In most of these professions, MPAG has work in hand to clarify supply and training needs. The net effect of all this work is, we hope, that MPAG will be able by the end of the year to issue the results of an overall analysis of the national supply situation for PAM groups speech therapy and clinical psychology.

9. However, we recognise that one of the problems with the supply of these staff groups is the different funding mechanisms for training that are in exsistance. Discussions are under way with the Department of Education and Science on some of these aspects, but, in the meantime, we would welcome the views of regional health authorities on the objectives for self-sufficiency in the preceding paragraph and on any central mechanisms required to equalise the funding contribution of different health service agencies. Views should cover at least the following aspects:-

(a) each profession should be treated separately, in view of the differences in the organisation and funding of training;

(b) the potential local effects of the Education Reform Bill and the changes to funding mechanisms for universities and polytechnics should be taken into account;

(c) explicitly, the question of introducing and equalising mechanisms between authorities who 'export' and 'import' trained staff (either by authorities themselves forming consortia to achieve self-sufficiency, or by some sort of pricing arrangement or centralised allocations/adjustment with accompanying mechanisms to determine collective NHS view on demand).

10. We accept the CPA's argument that greater emphasis should be placed on manpower planning, skill mix and training for professional and technical staff groups in the review process. We shall therefore, be paying particular attention in regional reviews and will be looking to regions to follow that through to district reviews.

11. To summarise, we look for the following action:-

E.R.

(a) as a preparation for the next round of strategic plans, and in any event within the next calendar year, demand and supply plans for each profession staff group to be drawn up;

(b) in view of the critical importance of a number of these staff groups to the delivery of regional stretegic plans, a rigorous assessment of supply, demand and skill mix for each group;

(c) views on the planning and funding issues as set out in paragraph 9 to reach the Department (Mrs Fox Room 208 Hannibal House, Elephant and Castle, London SE1 6TE) by 30th September.

12. This letter will be cancelled and deleted from the communications index on 31 December 1989.

Yours sincerely

Len Peach

LEN PEACH

9RP

ANNEX D

PAM GRADING REVIEW: OBJECTIVES

The objectives jointly agreed with the Staff Side for the Review are as follows:-

1. to produce appropriate relationships within the professions allied to medicine and related grades of staff;

2. to respond flexibly to varying circumstances and recognise appropriately the responsibilities carried by staff;

3. to be simple to administer, as far as practicable allow for sensible career progression and provide appropriate rewards of clinical excellence;

4. to cope now and for the future with the very wide variety of tasks undertaken by members of the professions allied to medicine and related grades of staff; and

5. to cope with specific problems related to the particular professions and the technical instructor and helper grades.

ANNEX E

MANPOWER EDUCATION AND TRAINING INITIATIVES

1. MPAG WORK WITH THE PROFESSIONS ALLIED TO MEDICINE

1.1 NATIONAL PROFESSIONAL MANPOWER INFORMATION INITIATIVE

Following the Chief Executive's meeting with representatives of 6 of the Professions Allied to Medicine (referred to in paragraph 3.20 of the main evidence) and agreement on sharing of information, the MPAG has asked individual Regional Health Authorities to take the lead in supplying information on the individual staff groups whilst at the same time tapping into the information already held by the professional associations. The aim of the initiative is to improve the quality and the flow of data between the service, professions and the Department of Health.

1.2 OCCUPATIONAL THERAPY

The MPAG has commissioned a King's Fund consortium to undertake a review of skill-mix and manpower requirements for occupational therapy within the NHS and local authorities. Their report is expected by Autumn 1989. This work will form part of a longer-term project which will continue with a review of competences and training requirements.

1.3 RADIOGRAPHY

The MPAG has commissioned the South West Thames Regional Health Authority's Manpower Division to undertake an examination of the short term demand and supply in radiography. Their report, which highlights the likely supply and demand difficulties, has been published under cover of a letter setting out in clear terms the immediate short term action that needs to be taken both nationally and locally and the future medium/long term action that MPAG is considering. This letter is attached as Appendix I to this Annex.

1.4 PHYSIOTHERAPY

A joint Chartered Society of Physiotherapy/MPAG Consultative Group has been established to provide a national overview of manpower and training issues. An interim presentation of the current manpower situation has been received

and further work on demands and determination, workload analysis and the development of a supply model is continuing. This work is expected to lead on to an examination of skill-mix.

1.5 ORTHOPTICS

The Department's Research Management Division commissioned the National Foundation for Educational Research to undertake a research project into the current roles and functions of orthoptists. The report highlights a number of issues relating to the future of the profession and the future level at which orthoptics should be taught on which the Department is consulting Regional Health Authorities and the College of Ophthalmologists.

1.6 CHIROPODY

The Association of Chief Chiropody Officers has conducted a UK-based manpower survey of all State Registered practitioners and foot care assistants. This will form a data-base for analysis by manpower planners in the Oxford RHA and the results will be available to the MPAG early in 1989. This will enable the Group to assess future supply, demand and skill-mix requirements for the chiropody service.

2. DISCUSSIONS WITH THE DEPARTMENT OF EDUCATION AND SCIENCE

2.1 The discussions referred to in the Health Department's 1988 evidence are still continuing. The two main issues were:

i. whether there should be any fundamental change in the allocation of responsibilities between the Health and Education Departments for funding pre-registration training of particular groups, either by the addition of further groups to those whose training might be funded by the Department of Education, or by renegotiating the split of funding on a different basis (eg between responsibility for formal "educational" elements, as opposed to clinical training); or

ii. whether, if existing arrangements are maintained, there should be a renegotiation of the formula by which local education authorities calculate the cost to the NHS of providing certain facilities.

No agreement has yet been reached on these.

2.2 The discussions have also covered two other issues. One, touched on in last year's evidence, relates to the impact on NHS training arrangements of the proposals embodied in the Education Reform Act, following Command 114 "Higher Education; Meeting the Challenge". In particular, the Health Departments are studying the implications for NHS training arrangements of the decision by Department of Education Ministers that following the inception of the Polytechnics and Colleges Funding Council (PCFC) under the proposed legislation, the only controls on degree level courses in institutions under its aegis will be those presented by the requirement for academic validation and by the limits to institutions' total resources. The views of NHS authorities on the impact of the changes to be brought about by the PCFC are also being sought in the letter from the Chief Executive reproduced at Annex C.

2.3 The other related issue, is a proposal by the Chartered Society of Physiotherapy that provision for pre-registration training now made in NHS establishments would be transferred to institutions of further and higher education ie within the funding responsibilities of the PCFC. This is obviously a proposal which has important implications for the NHS and any final response would have to have regard of the views of NHS management, service needs and the resource implications for the NHS. For the moment the issue is being carefully considered and no firm final decisions have been made.

3. TRAINING DEVELOPMENTS

3.1 The interest of Regional Health Authorities in transferring NHS-based schools of occupational therapy and physiotherapy to the PSHE sector, reported in the Health Department's evidence last year continues. The Wolverhampton School of Occupational Therapy transferred to the Coventry (Lanchester) Polytechnic at the beginning of the 1988/89 academic year. In addition, one Region is discussing the practicality of concentrating its future training provision in physiotherapy on two schools, one in a PHSE institution, the other associated with London University. Only 8 PAMs schools remain within the NHS in Scotland. Of these 3 are in Glasgow where

the Radiography school is to transfer to Queen's College, Glasgow by the end of this calendar year and the school of Occupational Therapy and Chiropody are to follow from the beginning of the 1989/90 academic year. A further 3 are in Aberdeen where it is hoped to transfer the Occupational Therapy school to Robert Gordon's Institute of Technology within the next year with the Physiotherapy school shortly afterwards, with Radiography following. The remaining 2 schools are of Radiography and Radiotherapy in Edinburgh where the Health and Education interests are working up transfer proposals to put to the Scottish Office.

3.2 Conversion courses for mature helpers in occupational therapy continue to be developed. That at Brent has now been approved by the Occupational Therapists' Board of the Council for Professions Supplementary to Medicine and other are being planned in various parts of the country. In addition, shortened two-year courses for graduates in disciplines related to occupational therapy leading to State Registration are now being developed on at least two sites. One of these is being funded in part directly by the Department. The Health Departments are also talking to representatives of local authority associations about ways in which they might contribute towards the cost of pre-registration training of occupational therapists. Plans are on course for an addition of 100 to the annual intake of occupational therapy students by 1990/91 as discussed in the Health Departments' evidence for the 1988 Review and there are plans in at least three Regional Health Authorities for establishing further schools of occupational therapy if funding can be agreed.

3.3 Final decisions on the future pattern of pre-registration training and numbers of schools for orthoptics will be taken when the Health Departments have considered the results of the research project conducted by the National Foundation for Educational Research mentioned above. They will also need to take account of comments from Regional Health Authorities following the Chief Executive's letter to them on manpower issues (Annex C) and the consultations with the British Orthoptic Society and the College of Ophthalmologists. Plans continue to be considered in a number of regions for further rationalisation of pre-registration training provision in radiography, bearing in mind also the need to maintain levels of training provision as advised by the Department. No further progress has been made in transferring the one

remaining NHS-based School of Chiropody in England to the PSHE sector. The remaining chiropody school in Scotland is to transfer to the Education Sector in 1989 (see 3.1 above).

A:DM48A

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From: P J WORMALD - Director of Operations (Personnel)
N H S Management Board

To Regional General Managers 12 September 1988

Copies to: : General Managers of Special Health Authorities

Dear Regional General Manager

RADIOGRAPHY MANPOWER AND TRAINING

1. EL(88)MB/113 of 7th July 1988 sought action by Authorities on a number of manpower planning issues relating particularly to professional and technical staff. The present letter addresses some issues specific to radiography. A summary of main points and action required is in paragraph 12.

2. The Manpower Planning Advisory Group (MPAG) commissioned from South West Thames RHA a review of supply and demand for radiographers in the short term. Its terms of reference were:

> "To present recommendations on the numbers of training places required in each of the five years commencing 1988/89, so as to balance demand and supply in the profession".

3. Six copies of the Report and of an executive summary are enclosed. RHAs are asked to disseminate this letter and its enclosures as appropriate. Additional copies may be obtained from Mr Jarvis Room 207 Hannibal House.

4. The Report has not yet been considered in detail by MPAG or the Department. It contains a number of points which need national consideration and action. The main ones are listed in Annex A. The Department proposes to discuss these with Regional Personnel Directors at an early opportunity, in particular to agree which of them are appropriate to simultaneous work by the Department and RHAs and which would best be left exclusively for national action for the time being. RHAs will be kept in touch with progress at national level.

E.R.

5. RHAs will wish to take the findings and recommendations of the Report into account in undertaking the tasks required by EL(88)MB/113 as they relate to radiography. Attention is drawn particularly to the recommendations relating to rationalisation of schools. The Department agrees with the general thrust of these recommendations, but recognises that, for diagnostic radiography at least, a reduction to one school per region may not be universally practicable. I should make it clear that the reference to closing training schools in paragraph 4 of EL(88)MB/113 does not apply to rationalisation without reduction in the total number of places.

6. RHAs are asked to give urgent attention to intakes to training for the forthcoming year. It is clear from the Report that a serious shortage of radiographers is in prospect. MPAG takes the view that, whatever changes there may be in skill mix and however successful the service is in improving retention and re-entry, there is no risk that the level of intakes which the report proposes in the short term will result in over-supply of qualified staff.

7. Actual intakes in 1987 totalled 504, a 40% drop since 1983. Our information is that the national total of places for which funding is available this year is 886 (Chapter 4, page 23). The Report suggests (Chapter 6 page 38) that this intake is higher than needed, and recommends intakes of 581 in 1988 and 587 in 1989. The national intake of 595 in 1986 (for Regional breakdown see Appendix 4.4) comes very close to this recommendation and the Department hopes that regions will get as close as possible to these figures, even if they are above the numbers required for regional self-sufficiency in the long term - see paragraph 4 of EL(88)MB/113.

8. If you are not able to utilise all the places which the report recommends as needed, you may wish to consider transferring the unused monies to recruitment publicity, retention initiatives, refresher training and supernumerary training posts for returners, as some regions are already doing successfully.

9. RHAs should monitor the entry qualifications being demanded by individual schools, and should follow-up any evidence that competent candidates are being excluded by unnecessarily high requirements.

10. RHAs are also asked to monitor the immediate job destinations of qualifying students and to ensure that such students are helped to find first posts where necessary.

11. South West Thames RHA, as the agreed centre of responsibility for radiography manpower planning, will continue to monitor the national situation on behalf of MPAG.

E.R.

Action required

12. RHAs are asked to

(i) disseminate this letter and its enclosures as necessary (paragraph 3)

(ii) take the findings of the radiography report into account when responding to EL(88)MB/113 (pararagraph 5).

(iii) give urgent attention to student intakes for the current year (paragraph 7).

(iv) monitor the post-qualification destinations of radiography students and ensure that they are given any necessary help in obtaining initial posts (paragraph 10).

Yours sincerely

P J WORMALD

Cancellation

This letter will be cancelled and deleted from the communications index on 31 December 1989.

RADIOGRAPHY MANPOWER - NATIONAL ACTION

A number of the report's recommendations relate to issues on which action at national level is required. This annex outlines the planned direction of national action.

The action proposed falls into five main areas:-

a) a Steering Group has been established between the MPAG, the College of Radiographers and the Royal College of Radiologists to oversee research work on developing accceptable workload and demand determination methodologies;

b) MPAG is also represented on a Steering Group to oversee work by South West Thames RHA which aims to put into practice locally some of the report's recommendations on flexible working practices and experiments with skill mix, with a view to national dissemination of the results;

c) there will be early discussions between the Department of Health, the Radiographers Board of the Council for the Professions Supplementary to Medicine and the College of Radiographers about a review of entry requirements to training;

d) the recommendation relating to the requirement that all staff, including part-timers, have an on-call commitment is being referred to the *PAM (PTA) Negotiating Council*;

e) South West Thames RHA will continue to update the statistical material contained in the report and will co-ordinate further work on using OPCS census data to establish workforce participation rates for radiographers.

passed on

FROM: J DE BERKER
DATE: 19 OCTOBER 2988

1. MISS PEIRSON
2. **CHIEF SECRETARY**

cc: Chancellor
Sir Peter Middleton
Dame Anne Mueller
Mr Anson
Mr Phillips
Mr C W Kelly
Miss Peirson
Mr Turnbull
Mr Saunders
Mr White
Ms Seammen (or)
Mr Griffiths
Mr Call

[noted]

GOVERNMENT EVIDENCE TO THE NURSES AND PAMs REVIEW BODY

The Government Review Body evidence on PAMs is attached to Mr Mellor's letter of 19 October. In view of the very tight timetable he asks for your agreement by tomorrow evening, Thursday 20 October, if that is possible.

2. The penultimate version of the evidence was discussed in my submission of 14 October. The present version is identical apart from a substantive point of funding which is unacceptable, and a few minor changes listed in the Annex which we advise you to accept.

3. On funding, the last sentence of paragraph 2.6 has been amended to read: "There can be no presumption of full funding at a later date, and no such presumption should underlie any recommendation". This leaves open the possibility of partial funding at a later date which was ruled out in the previous version which referred to: "...no presumption of additional funding at a later date ....". This was the form of words agreed for nurses and for doctors. You will want the original form of words reinstated. (We have tried at official level but DH say Mr Clarke wanted the change.)

4. A draft letter is attached.

5. ST are content.

JONANTHAN DE BERKER

ANNEX: MINOR CHANGES IN THE EVIDENCE

Para 1.5. The last sentence of the version attached to my submission of 14 October read: "They accept that it may not be possible to make further major changes towards geographical pay arrangements in the current review, but they regard such changes as a priority and will be presenting recommendations to the Review Body as soon as possible. The words "further", and "as soon as possible", have been deleted.

Para 3.16. This has been deleted. This outlined the benefits that a PAMs regrading exercise would have had for the NHS, we do not think anything is lost by removing it.

Para 4.4. In the previous version the third sentence read: "Any changes would need to be negotiated with the Staff Side." "discussed" has now been substituted for "negotiated".

There were also some corrections to the annexes.

DRAFT LETTER FROM THE CHIEF SECRETARY TO MR MELLOR

cc: Prime Minister
Norman Fowler
Wynn Roberts
Michael Forsyth
Richard Needham
Sir Robin Butler

GOVERNMENT EVIDENCE TO THE NURSES AND PAMs REVIEW BODY

Thank you for your letter of 19 October covering the Review Body evidence on PAMs.

I am content with the evidence apart from one point on the funding of pay awards. For nurses and doctors we said there could be no presumption of <u>additional</u> funding at a later date. In paragraph 2.6 of the evidence on PAMs it is said that there can be no presumption of <u>full</u> funding at a later date. This leaves open the possibility of partial / additional funding at a later date. This is not acceptable, and I would be grateful if you could revert to the form of words we agreed for nurses and for doctors.

I am copying this to the Prime Minister, Norman Fowler, Wynn Roberts, Michael Forsyth, Richard Needham, and to Sir Robin Butler.

pay1.sb/de Berker/11.11.001

CONFIDENTIAL

FROM: J DE BERKER

DATE: 11 November 1988

1. MS SEAMMEN
2. CHIEF SECRETRY

cc Chancellor
Sir P Middleton
Dame Anne Mueller
Mr Anson
Mr Phillips
Mr C W Kelly
Miss Peirson
Mr Turnbull
Mr Saunders
Mr White
Mr Griffiths
Mr Call

EVIDENCE TO THE REVIEW BODY ON LOCAL PAY FLEXIBILITY FOR NURSES AND MIDWIVES

1. We have agreed with Department of Health officials that proposals for an experimental regional pay scheme costing £5 million may be put to the Nurses and PAMs Review Body (NPRB) for consideration within the review body's overall recommendations. This is not, of course, additional funding. Whether the scheme should go ahead will need to be considered in the light of the review body's recommendations when these are available. DoH plan to send evidence to the NPRB in the middle of next week.

2. The draft evidence is attached. It has been modified in the light of our comments and we think it is now satisfactory. Department of Health Ministers will be seeing it over the week-end. We would be grateful for your views. If you are content, we will clear it at official level provided there are no significant changes.

Key Issues

3. **The NPRB should feel able to endorse the proposals and include them in their recommendations.** (Paragraphs 1 and 16). The Department of Health believe that without the NPRB's endorsement they will be unable to get the staff side to negotiate on the

proposals. We are keen that the NPRB should endorse the proposals because it will make it harder for them to wash their hands of geographical pay variation. On past form this is an issue which they would prefer to avoid. But if nurses' pay is to be properly based on what is needed for recruitment and retention geographical variation should play an integral part in their deliberations.

4. **Targeting.** The payments would be used solely to tackle recruitment and retention difficulties (paragraph 2). In principle, the scheme should cover the whole country but pending the evaluation of the London supplements introduced this year the scheme would not be available in the inner or outer London pay areas (paragraph 5). The money would be allocated centrally by the Department of Health (paragraph 10) against bids from districts according to criteria (paragraph 7) based substantially on ones put forward by us in earlier official correspondence. Bids from the districts would be vetted by the Regional Health Authorities before going forward to the Department of Health.

5. **The nature of the Supplement.** We would prefer to see the payments made as an additional point/points on the nurses' pay spine. This would have the advantage of tying flexible payments to the NPRB's main recommendations on the pay spine rather than divorcing them as a separate issue of interest to the Department of Health but peripheral to the review body's concerns. The disadvantages of this approach are, firstly, that it will be difficult to resist claims that the extra spine points should be taken into account for calculating overtime etc - a proposal that Department of Health want to resist (paragraph 3); and secondly, the NPRB might refuse to endorse a scheme based on extra spine points.

6. Since getting acceptance of the principle of flexible pay is more important than the precise form in which it is made, we have agreed that the review body should be also given alternatives to spine points, in particular, percentage additions to basic pay or flat rate allowances. When making recommendations for London supplements last year the review body chose not to use spine points but instead specified the supplements as percentage

additions to pay subject to a limit on the maximum amounts payable. It is possible they might want to repeat this approach for flexible pay.

7. **Evaluation.** Clearly it is important that the scheme should be evaluated as rapidly as possible. If it is successful we will wish to expand it and if it is disappointing we will need to know the defects so that they can be remedied. As part of their applications districts will be expected to provide proposals for monitoring the effectiveness of the supplements and the need for their continuation (paragraph 7(ix)). It is also suggested (paragraph 15) that health authorities where supplements are in payment should make returns every six months on the numbers and amounts of supplements actually in payment rather than authorised and indicating their effects. We will ask the Department of Health to evaluate this scheme before the end of its first year of operation.

Conclusion

8. If we can get this scheme introduced, especially with the NPRB's blessing, it would undoubtedly be helpful. If recruitment and retention black spots can be eliminated it will be harder for the review body to justify substantial across the board increases. The pilot scheme costing £5 million is unlikely to eliminate anything but the worst black spots, but it is clearly a step in the right direction.

9. ST are content.

JONATHAN DE BERKER

MANAGEMENT – IN CONFIDENCE

PAY FLEXIBILITY FOR NURSES AND MIDWIVES: DEPARTMENT OF HEALTH PROPOSALS FOR AN EXPERIMENTAL SCHEME

Introduction

1. At the oral evidence session on 4 November, the Department asked the Review Body whether they would consider recommending, within their overall recommendations, that a sum of £5 million should be set aside in 1989/90 for a pilot exercise in supplementing national rates of basic pay for nurses and midwives where this was deemed appropriate on recruitment and retention grounds. The purpose of this note is to indicate how such a scheme might operate. Its aims are to help meet a small number of particularly difficult recruitment/retention cases, and to pilot the criteria and help us develop them.

The general approach

2. The supplements would be used solely to tackle recruitment and retention difficulties. They would not be used to reward individual performance.

3. The payments would not be taken into account in calculating rates for overtime, special duty payments, or other enhanced payments. For the time being, these would continue to be paid according to the existing criteria, and would not be replaced by, or absorbed into, the supplements.

4. The supplement would not count as basic salary for the purpose of determining incremental points on promotion.

5. In prinicple the scheme should cover the whole country but pending evaluation of the effects of the London supplements on recruitment and retention, we do not envisage at this stage that ~~the scheme~~ it would be available in the Inner or Outer London pay areas, although bids from the London Fringe zone would be considered.

6. The scheme is designed to operate on an experimental basis. It will be important to keep all options open and to learn as we go through careful monitoring and evaluation.

Criteria for application

7. At least for the period of the initial experiment, in view of the limited sum available, the allocation of funds would be controlled centrally, so that it can be carefully targeted on genuine problems. It would be for Districts to submit cases for payment of the supplements, through Regions, to the Department. The submission might be expected to cover the following areas:

i. vacancy rates, including details of any posts which have been unfilled for periods in excess of three months, despite advertisements; and also details of any posts which, for reasons of expediency, have been covered by inappropriately qualified staff;

ii. labour turnover, if possible distinguishing between voluntary quits, retirements, career breaks, etc;

iii. action taken to tackle recruitment and retention problems by way of non-pay initiatives and their degree of success;

iv. the number, grade(s) and location(s) by clinical area of the posts which the bid covers. Blanket District coverage would be discouraged to ensure the targeting of the supplements on the most acute areas (by grade, speciality and/or location) of difficulty;

v. the level of the proposed supplement (see paragraph 12 below);

vi. the estimated cost of the proposals, including savings from the replacement of agency staff;

vii. a statement as to why payment of the supplement might be expected to solve the problem (by reference, where appropriate, to the local labour market, high housing costs, etc);

viii. planned sources of recruitment;

ix. the District's proposals for monitoring the effectiveness of the supplements and the need for their continuation.

N.B. The data at (i) and (ii) should, so far as possible, relate specifically to (iv) and include historical information, to show trends over time and whether the situation is improving or deteriorating.

The Regional role

8. It would be for Regions to scrutinise Districts bids. Those that they support would be forwarded to the Department with an accompanying statement:

i. confirming that, in their view, the case for payment of supplements is justified and likely to be effective, and would not result in merely poaching staff from neighbouring Districts;

ii. indicating their level of support for the bid and their assessment of its priority in relation to any other District bids from that Region.

9. In preparing their statements, Regions would be expected to relate the District data to equivalent regional data to put the former into perspective.

The Departmental role

10. All bids, with the accompanying Regional Statement, would be submitted to the Department. They would then be assessed by a small panel of Departmental and NHS officials, including professional advisers, against similar criteria to those set out in paragraph 7. Money would then be allocated against approved bids.

The nature of the supplement

11. The criteria do not, of themselves, tell us anything about the appropriate size of any supplement. The system is untried and untested. Trial and error will be necessary to get the supplements at the appropriate level. Initially at least, given the sum available and the experimental nature of the scheme, the levels of payment would need to be relatively modest.

12. The supplement could be either a percentage of basic pay, or a flat-rate addition to annual salary, or an additional point/points on the Whitley pay spine. It might be appropriate to limit the payments to, say, two levels which might be:

i. 2½%/5% of basic pay; or

ii. £250/£500 which, in cash terms represents roughly, 2½%/5% of the maximum of Scale E (the higher Staff Nurse grade). This would cover 20,000 or 10,000 posts respectively (about 4% or 2% of the WTE GB nursing/midwifery workforce); or

iii. one or two additional points on the pay spine. (The value of one spine point for qualified staff ranges from £250 for enrolled nurses to £500 for senior nurses.)

Withdrawing the supplements

13. The supplements would relate to posts and not to individuals and would, therefore, not be portable. If, on annual review of the continuing need for payment, it was determined that the post should no longer attract a supplement or should attract a supplement at a lower level, the cash value of the supplement would be protected on a mark-time basis for existing postholders. Similar protection arrangements would also apply where staff were transferred from a supplemented to an un-supplemented or lower-supplemented post at the request of the employing authority. In all other cases, eg voluntary, promotional or disciplinary moves, entitlement to supplementation would, where appropriate, cease from the effective date of the move.

Appealability

14. Decisions on whether or not a supplement would be payable would not be challengeable under the appeals procedure set out in Section 32 of the General Whitley Council Handbook and there would be no right of appeal.

Monitoring and evaluation

15. Health Authorities where supplements were in payment would be required to monitor their effects on the recruitment and retention position. They would be asked to submit returns after, say, six and twelve months identifying the numbers and amounts of the supplements in payment; indicating the changes to the vacancy/turnover situation for the grades/locations in receipt of the supplement; assessing the extent to which these were due to the supplements or other factors; proposing any changes in the scheme; and commenting generally on its effectiveness. Regions would be asked to report similarly.

Consultation with the Staff Side

16. It is envisaged that we should want to consult the Staff Side at national level on the way in which the scheme should be operated – for example, on the criteria for payment and control mechanisms, etc – but not upon the principle of the scheme itself. Such consultation might best take place immediately after the Review Body has reported (assuming that the Review Body endorses the scheme). No progress with the Staff Side can be expected before then.

HAP

11 November 1988

chex.md/mw/116 **CONFIDENTIAL**

FROM: MISS M P WALLACE
DATE: 14 November 1988

PS/CHIEF SECRETARY

cc Sir P Middleton
Dame Anne Mueller
Mr Anson
Mr Phillips
Mr C W Kelly
Miss Peirson
Mr Turnbull
Ms Seammen
Mr Saunders
Mr de Berker
Mr White
Mr Griffiths
Mr Call

EVIDENCE TO THE REVIEW BODY ON LOCAL PAY FLEXIBILITY FOR NURSES AND MIDWIVES

The Chancellor has seen Mr de Berker's minute of 11 November. He comments that it is very important that this is not seen as a concession to industrial action.

MOIRA WALLACE

FROM: D P GRIFFITHS
DATE: 18 November 1988

1. MR PHILLIPS

2. CHIEF SECRETARY

cc Chancellor
Sir P Middleton
Mr Anson
Sir T Burns
Dame A Mueller
Miss Peirson
Mr Turnbull
Mr C W Kelly
Mr Gieve
Mr Parsonage
Mr Saunders
Ms Seammen
Mr Sussex
Mr Call

NHS REVIEW: PAY AND CONDITIONS OF NHS STAFF

At the Ministerial Group meeting on 21 October it was agreed that there should be discussions between the Treasury and the Department of Health about the pay aspects of the review. The objective would be an agreed Treasury/DH paper. DH have now sent us the attached draft paper (which has been approved by Mr Clarke) setting out their proposals for determining the pay and conditions of staff both in self-governing and health authority managed hospitals. (The specific issue of consultants' merit awards will be dealt with either in correspondence or in a separate paper.) In view of the very short time we have had to consider the draft, the very radical nature of the proposals it makes and the serious reservations we have about them, there was no prospect of reaching agreement on a joint paper in time for it to be taken at next week's Ministerial Group meeting. We have therefore agreed with the Department and the Cabinet Office that it should be deferred until the following meeting.

2. The proposals are for a significantly more devolved and flexible system. But self-governing and health authority managed hospitals would be subject to very different arrangements. For the latter the proposals entail building on initiatives already in train or under consideration and giving these a further push. The pay of doctors, nurses and paramedical professions would continue to be set by Review Bodies and there would be centralised bargaining for non-Review Body groups. But there would be discretion for managers to make local pay additions where there are recruitment and retention difficulties. There would also be

more scope for productivity and performance-related pay. The proposals need to be worked up in more detail and we will want to ensure the additional expenditure on management manpower and training involved can be expected to result in worthwhile benefits. We have no difficulties with the thrust of the proposed arrangements but there may be differences between us and DH about the speed of change, the magnitude of the discretion given to local managers and the arrangements for control and monitoring.

3. The proposals relating to self-governing hospitals are much more radical. If the DH have their way, these hospitals would from the outset be untied from both the Review Body and Whitley systems and given complete freedom to negotiate the pay and conditions of all their staff. Competition between hospitals for contracts and the cash limits on health authorities as buyers would be the mechanisms relied on to impose the necessary discipline to keep pay costs down. DH acknowledge that again there would need to be substantial (but as yet unquantified) investment in the personnel function for self-governing hospitals, as well as further improvements in its general management.

4. We have already raised a number of our concerns about these proposals with DH. The principal ones are: -

(i) We are sceptical whether in practice competition between hospitals can be expected to maintain cost discipline, especially at a time when demographic trends will be leading to a much tighter labour market. What controls will there be where a self-governing hospital is a local monopoly supplier ? And how real will competition be even where it is not ? We suspect that competition is more likely to show itself in competition for staff.

(ii) Nor are we sanguine that the strict control of buyers' cash budgets will prevent bidding up of pay. There may be no breach of the cash limits as such but we could find ourselves facing ever higher Survey bids in order to maintain what DH consider an acceptable volume of service provision, or face considerable political difficulty if we refused to validate actual pay costs.

(iii) Will the managers of self-governing hospitals have the capability to negotiate pay and conditions, or will they be soft targets for pressure from staff interests ? What are the resource implications of providing the necessary capability ? Can this be achieved on the timescale envisaged for the introduction of self-governing hospitals - especially if there are a large number of these hospitals from the start ? If they were given the flexibilities proposed, the incentive for hospitals to move to self-governing status as quickly as they could would be a very strong one indeed.

(iv) If pay in self-governing hospitals is significantly higher, they will attract the best staff. Health authority hospitals would be forced to follow suit or accept that they will be offering a poorer service. This would be a particular problem in some of the disciplines such as IT and finance where there are already shortages of good staff. Moreover, Review Bodies would be unlikely to allow a significant differential to open up between the pay of the professions in the two categories of hospital. This would be a recipe for a pay spiral.

(v) The proposals for pay flexibility for self-governing hospitals go far beyond anything which has been suqqested for Next Steps agencies. There are potential implications for large parts of the public sector.

(vi) We are not sure that DH have properly thought through the implications of changing the contracts of self-governing hospital staff the proposals entail.

(vii) There are also consequences for the new funding system. If funding allocations are to reflect input costs, the the greater the extent to which pay is locally determined the further away we move from the ideal of a simple weighted capitation system.

5. there are obvious attractions in the idea of giving self-governing hospitals the flexibility they need to achieve the maximum gains in efficiency and clear analogies with the Next

Steps initiative. But, as with Next Steps, we must be satisfied that the implications of the proposals are properly addressed. At the extreme they could call into question the wisdom of going down this path at all. At the very least they require a very careful assessment of what degree of devolution is feasible and desirable; on what timescale; and what controls (transitional or permanent) will be necessary.

6. While there is a measure of agreement about desirable objectives, we anticipate that there may be considerable difficulty in reaching an agreed position with DH about whether the difficulties inherent in the idea are in practice soluble and, if they are, the extent of the controls necessary, the pace of change and the scale of the resource implications. At present our view is that the risks of an escalation in NHS pay costs entailed by the DH proposals are very substantial indeed, too great to accept Mr Clarke's leap of faith - attractive though that may be in some respects. There will almost certainly need to be some interim controls and a much more gradual transition to devolved pay bargaining.

7. There is one other point worth mentioning. When discussing pay, the Ministerial Group particularly mentioned the problem of the overlap between the Nurses pay review Body and the Whitley Council for nurses.The DH draft does not make any specific proposals in this area but the problem is under review. DH acknowledge the debacle which took place over the nurses' regrading exercise but attribute this to the way in which the issue was handled rather than a fundamental flaw in the system. Mr Clarke's inclination is to leave as little as possible to be determined by the Review Body.

8. It would be helpful to have your reactions to the DH proposals about self-governing hospitals before we take things further. You may wish to speak to Mr Clarke to see how the public expenditure concerns might be reconciled with the aim of much greater devolution.

9. This submission has been agreed with the Pay Group.

D P GRIFFITHS

CONFIDENTIAL

NHS REVIEW

PAY AND CONDITIONS OF NHS STAFF

Introduction

1. The present system of negotiation and control of NHS pay and conditions is highly centralised. National pay scales are negotiated centrally, or determined on Review Body recommendation. Conditions of employment are negotiated centrally. The relationship between the Review Bodies and Whitley negotiating bodies is set out in the annex. Health Authorities have very little freedom to vary pay and conditions without central approval. On the whole this system has proved effective in keeping down pay rates in the NHS.

2. Health Authorities are responsible for grading staff within the centrally agreed grading structures. These structures afford some flexibility, varying between staff groups. Authorities, particularly in London and the south east have been exceeding the proper limits of flexibility in order to overcome recruitment and retention difficulties.

3. Variation in pay is available only in the form of:

- London weighting
- London supplements for nurses and professions allied to medicine, recommended by the Review Body in 1988
- discretionary basic rates and performance related pay for a small number of top managers
- regional variations for IT staff
- bonus schemes for manual staff.

Aim of flexibility

4. The overall thrust of the NHS Review is to devolve responsibility to the lowest practicable level throughout the NHS. This should in principle apply to the determination of pay and conditions. The aim should be to give management the tools to:

- overcome geographical variations in labour markets
- increase productivity through new working conditions
- encourage and reward high performance by individuals.

5. In a fully devolved system, all three approaches would be used at the complete discretion of local management. It is unlikely that the NHS as a whole would ever be in this position, but such devolution should be given to self governing hospitals.

Flexibility in the mainstream of the NHS

6. While tight central pay control has held down pay levels, especially for non-Review Body staff, recruitment and retention problems have become apparent for some groups in most areas, and for all groups in London and the south east. A radical review of conditions of service is nearing completion. Greater devolution is a key objective here also, giving managers the freedom to devise total employment packages suited to local needs. Since the NHS has no experience of pay determination, devolution needs to be managed to prevent a general escalation of pay levels. A scheme is therefore being prepared which will:

- retain central negotiation of rates which will apply to most non-Review Body staff

- allow local managers to increase these rates by a maximum percentage, varying in different parts of the country, to meet proven market difficulties

- retain Review Bodies for doctors and nurses

- provide scope for productivity bargaining

- extend performance related pay (changes to the doctors' distinction award system are being dealt with separately).

7. Local management currently have few responsibilities in these areas. But it will be possible to give them progressively greater freedom as they gain experience and recruit the support staff necessary to run a more highly devolved system.

Devolution to self governing hospitals

8. Self governing hospitals should have complete freedom to determine the pay and conditions of all their staff. They will start with the pay and conditions that currently apply, but from there on, management should be free to negotiate packages which they judge will best deliver the services for which they have won contracts.

9. This freedom should apply to both Review Body and non-Review Body groups. The Review Bodies will continue, in relation to staff in health authority managed hospitals, subject to rationalisation of the arrangements for determining London supplements and to review of the relationship between the Review Bodies and the bodies which negotiate grading arrangements and conditions of service (set out in the annex). However doctors, nurses etc working in self-governing hospitals should, like other staff, be outside the central pay etc mechanisms, ie they should be withdrawn from the Review Bodies and (for doctors) from the distinction award system. Management will otherwise lack essential freedoms in relation to over half its labour force - a half which is key both to service delivery and to the potential for major efficiency savings.

10. Total devolution has three important implications. First, self governing hospitals will need to acquire sufficient management expertise to handle their

freedom effectively. Self governing hospitals are likely to be those with strong and effective general management already, but the personnel discipline in the NHS is sparse and neither NHS general management nor personnel staff have experience or expertise in pay determination. As self governing hospitals are established, particular attention will need to be paid to securing this capacity.

11. Secondly, where there is limited competition in services, higher pay costs must not simply be passed on to the health authority as customer. The new funding system, which will finance health authorities on a capitation basis, will need to enforce robust cash limits, and the corresponding prices agreed for contracts, so as to constrain pay inflation in self governing hospitals. Funding will need to take account of differing levels of geographical pay but not lead it. Levels of performance pay and productivity pay would not be relevant to funding levels; they would be determined by management because they yielded financial benefits, not costs.

12. Thirdly, for demographic reasons there will increasingly be shortages of skilled NHS staff in the 1990s. There will inevitably be a tendency for the self-governing hospitals to acquire more than their share of the best staff. In general this will not matter provided that competitive and contract disciplines lead to increased efficiency, and so restrict their overall demand. Nevertheless such competition could have a significant effect on general NHS pay levels for staff in shortage categories.

Conclusion

13. In summary, the proposed approach is:

- Keep doctors and nurses in non-self governing hospitals within the Review Body system
- Introduce greater flexibility as in paragraph 6 for these hospitals
- Untie self governing hospitals from doctors' and nurses' Review Bodies (and doctors' distinction award system)
- Untie self governing hospitals from Whitley pay and conditions for all other staff
- Ensure that adequate investment in management skills is made over the period of devolution of responsibility
- Ensure that the new funding and contract system provides sufficient pay discipline on managers of self governing hospitals.

ANNEX

DETERMINATION OF PAY AND CONDITIONS OF SERVICE FOR REVIEW BODY GROUPS

1. There are two Review Bodies, one for doctors and dentists (DDRB) and one for nursing staff, health visitors, midwives and professions allied to medicine (NPRB). (The professions allied to medicine - PAMs - are physiotherapists, radiographers, occupational therapists, chiropodists, dietitians and orthoptists.)

2. The Review Bodies are independent bodies appointed by the Prime Minister. Their terms of reference are to advise the Prime Minister on the remuneration of the staff groups concerned. (But London weighting is at present dealt with separately - see 4 below.)

3. Conditions of service and grading questions are determined separately from pay. In the case of doctors and dentists they are negotiated between the professions and the Health Departments. For the NPRB groups there are two negotiating Councils, one for nursing staff, health visitors and midwives and one for the PAMs. Changes in the structure of allowances (as well as of grades) would normally be negotiated in the Councils and then submitted to the Review Body for pricing (although the new London pay supplements recommended this year by the Review Body for nurses and PAMs - see below - had not been so negotiated).

4. The Review Body groups are also represented on the General Whitley Council, which deals with conditions of service which are of general application to all NHS staff. It also deals (via a sub-committee, the London Weighting Consortium) with London weighting allowances for all NHS staff. The respective roles of the London Weighting Consortium on the one hand and the Review Bodies and Negotiating Councils on the other in determining special arrangements for pay in London are currently under review, against the background of the 1988 Review Body award of London supplements (payable on top of London weighting) to nurses and PAMs.

week.14.11/m.15

SECRET

FROM: H PHILLIPS
DATE: 18 November 1988

CHIEF SECRETARY

cc Chancellor
Sir P Middleton
Mr Anson
Sir T Burns
Dame A Mueller
Miss Peirson
Mr Turnbull
Mr C W Kelly
Mr Gieve
Mr Parsonage
Mr Saunders
Ms Seammen
Mr Sussex
Mr Call

Ch/ all this is, indeed, as Mr Griffiths says, a leap of faith.

mpw.

NHS REVIEW: PAY AND CONDITIONS OF NHS STAFF

Mr Griffiths's note of 18 November reports on the first stage in trying to produce a joint paper on future policy for pay and conditions of NHS staff. The main difficulties we shall have with this are in the arrangements for self-governing hospitals. His note records the key points we put to the DoH in a meeting I chaired yesterday.

2. I would add only two points at this stage.

3. First, we must avoid, again, some very generalised decisions being taken which then begin to fall apart in our heads once they have been announced - a longer-running and therefore more expensive saga than the nurses' regrading exercise. The presumption in the Ministerial group is that self-governing status would not require more money or more staff, and would lead to a reduction, not an increase, in any such hospital's costs. The controls on pay-rates and pay-costs for self-governing hospitals mentioned in the DoH paper (cash limits on health authorities as buyers and competition between providing hospitals) are necessary but probably not sufficient conditions for adequate overall control.

a quote from minutes

4. Second, this control problem for us is likely to be exacerbated by the importance being given in the review to the

central role of self-governing hospitals in freeing up the supply-side of health care. The quicker the rate of growth of self-government, the argument runs, the sooner we get the efficiency gains from competition. But DoH will argue that hospitals will need carrots (in terms of maximum pay freedoms) as well as sticks (efficiency targets, and track records of financial and management competence) at the outset to get the process going. The analogy with the handling of Next steps is therefore apt. Even if we agree with Mr Clarke that we want to end up with as much freedom as he proposes, I think we will want to argue for a progressive transition.

4. Subject to your views on the approach we should take I suggest we have a further round at official level on a revised draft, and then isolate the key points for a talk between you and Mr Clarke. He touched on this at the end of your meeting with him yesterday.

HP.

HAYDEN PHILLIPS

week.28.11/m.6

SECRET

FROM: H PHILLIPS
DATE: 29 November 1988

CHIEF SECRETARY

cc Chancellor
Sir P Middleton
Mr Anson
Sir T Burns
Dame A Mueller
Miss Peirson
Mr Turnbull
Mr C W Kelly
Mr Gieve
Mr Parsonage
Mr Saunders
Ms Seammen
Mr Griffiths
Mr Sussex

NHS REVIEW: PAY AND CONDITIONS OF NHS STAFF

In the light of my minute to you of 18 November, covering Mr Griffiths's note of the same date and a DoH paper on pay, I attach a short draft letter to Mr Clarke setting out the essential points which an agreed paper between you and he must cover. You will wish to consider our approach at your meeting today.

2. Following my initial meeting with DoH Mr Clarke's officials are preparing a revised paper. The latest draft, on which Mr Wormald (DoH) and I can base a discussion, moves in our direction by indicating that

(a) self-governing hospitals will start with the pay and conditions that currently apply - as opposed to starting with complete freedom - but from there on management should be free to negotiate packages which they judge will best deliver the services for which they have won contracts;

(b) self-governing hospital managers will be sacked if they fail to meet the performance targets which contracts with the Health Authorities require them to fulfil; and

(c) the amount of freedom self-governing hospitals should have over pay and conditions should be limited, initially, because of managerial incapacity.

All this is helpful, but it is still a long way from a planned and agreed programme. We might make one more useful push at official level but that would be helped enormously if you underlined the issues of vital importance to us, along the lines of the attached draft.

HP.

HAYDEN PHILLIPS

SECRET

DRAFT LETTER FROM CHIEF SECRETARY TO SECRETARY OF STATE FOR HEALTH

NHS REVIEW: PAY AND CONDITIONS OF NHS STAFF

I have now been able to consider, and discuss with my officials, your first draft of the paper on pay which we have been asked to prepare for the next meeting of the Review Group. I know your officials are working up a further draft but I thought I should write to let you know of the points which I believe we must cover before we can put proposals to colleagues. As far as the mainstream of the NHS is concerned I am sympathetic to the approach you want to take but it will need to be worked up in more detail before we can be satisfied it is viable. I shall also need a considered assessment of the cost of providing more management training and support staff.

As far as self-governing hospitals are concerned the paper does no more than set out the objective you would like to achieve, of offering these hospitals the maximum flexibility to achieve gains in efficiency, and the single means you envisage to get there ie untying them from both the Review Body and Whitley systems. I agree that we are looking to give flexibilities in return for demonstrable improvements in efficiency, but what the paper does not say is how this will be achieved, when, and at what cost. We shall therefore need to discuss, and agree on a paper which will show colleagues how we propose to answer the following key questions:

(i) How do we avoid an expensive pay spiral? If pay in self-governing hospitals is significantly higher than

in the mainstream, they will attract the better staff. Health authority hospitals will have to follow suit or offer an increasingly poorer service. And the Review Bodies, their focus narrowed, will be unlikely to allow a significant differential to open up between the pay of the professions in the two categories of hospitals.

(ii) How are we going to deal with staff interests, and the legal and industrial relations issues of taking them out of the Review Body/Whitley system? What will be the consequences and costs of changing employment contracts?

(iii) We are to allow hospitals self-governing status where they demonstrate the managerial capacity, and track record, to exploit it efficiently. How will this test of capability be applied to the negotiation of pay and conditions?

Our starting point has to be the presumption in the Group that self-governing status will not require more money or more staff and will lead to a reduction, not an increase, in any such hospital's costs. How are cash limits on health authority buyers and competition between hospitals going to be sufficient, as well as necessary conditions to prevent pay spiralling, especially in the early years as competition develops? And what are we to do where a self-governing hospital is a local monopoly supplier?

The route we take to match pay flexibility with efficiency gains for self-governing hospitals needs to be spelt out in this paper, as we did for that on the funding of hospitals generally. I look forward to a revised paper which deals with the points I have mentioned (on which our officials can work together) and on the basis of which we can have a meeting [as soon as possible next week].

st2.ar/docs/30.11.88.2

CONFIDENTIAL

FROM: R B SAUNDERS
DATE: 30 November 1988

CHIEF SECRETARY

cc Chancellor
Sir P Middleton
Mr Anson
Sir T Burns
Dame A Mueller
Mr Phillips
Mr Kelly
Miss Peirson
Mr Turnbull
Mr Gieve
Mr Parsonage
Ms Seammen
Mr Griffiths
Mr Sussex
Mr Call

NHS REVIEW: PAY AND CONDITIONS OF NHS STAFF

Following your meeting yesterday, I attach a revised draft letter to Mr Clarke, agreed with Pay.

R B SUANDERS

SAUNDERS → CST 30/11

CONFIDENTIAL

DRAFT LETTER FROM THE CHIEF SECRETARY TO THE SECRETARY OF STATE FOR HEALTH

NHS REVIEW: PAY AND CONDITIONS OF NHS STAFF

I have now been able to consider, and discuss with my officials, your first draft of the paper on pay which we have been asked to prepare for the next meeting of the Review Group. I know your officials are already working on a further draft, but I thought I should write to let you know of my main points.

2. As you know, I have considerable sympathy with the idea of getting greater flexibility into the NHS pay system with the objective of improving the cost-effectiveness of the service. But I do not regard flexibility as an end in itself, only as a means of serving that objective. I think it is important therefore that we should present colleagues with proposals which set out in clear and practical terms how we propose to achieve it without leading to unacceptable pressures on the pay bill.

3. My main general comment on the paper is therefore that it needs to give a much franker exposition of the risks and a much clearer sense of how we are going to get from where we now are to a more flexible system without triggering a pay explosion. We need to set out the practical measures which we can take to allow managers the freedom to deploy their resources to best effect and we need to show how flexibility about pay is related to this. We must also be careful not to set unrealistic objectives for self-governing hospitals which may increase rather than reduce the

difficulties for any hospital seeking that status. There follow some more specific comments on the main sections in your paper.

The aim of flexibility

4. I think it would be better to say that the general aim of a more flexible pay system is to improve the way the NHS uses resources by enabling it to meet its staffing needs in ways which take better account of local circumstances and of varying labour markets in different skills and different parts of the country. Devolving more responsibility to local managers is simply one way of achieving this. (I think, incidentally, it is a bit exaggerated to describe devolution of responsibility as "the overall thrust" of the Review.) I should prefer the next section to describe with rather more precision how we propose to set about achieving the cost-effectiveness objectives. The existing paragraph 5 could be dropped.

5. This section could then go on to discuss the impediments imposed by the present system. It is clear that over many years the Whitley system has led to excessive bureaucratic centralisation of conditions of service. Too many decisions have to be referred upwards or agreed with the unions. I understand that many useful potential reforms have been identified in the present review of NHS conditions of employment. On face of it, some of this could be introduced quickly and at nil or little cost. We should make more of this in the paper, quoting examples of some of the more obvious absurdities.

Flexibility in the mainstream of the NHS

6. As they stand, paragraphs 6 and 7 beg rather a large number of questions - whether the proposed new flexibilities will apply to review body groups, how great the flexibility will be, how "proven market difficulties" will be identified and so on. I understand that detailed proposals have yet to be discussed between our officials. I would prefer this section to concentrate more on what the present problems are - which groups are suffering shortages, and where - and the extent to which we believe flexibility on geographical or performance pay will help those specific problems. The paper could go on to sketch in general terms the proposals you are working up to enable local management to have sufficient flexibility to meet the problems. It would have to indicate that a key constraint is the capacity of management to handle such a devolved system.

7. It is in my view important to distinguish Review Body and non-Review Body groups. The general statement in paragraphs 1 and 6 that central pay control has succeeded in holding down pay levels may hold good for Whitley groups. But it is palpably not true for Review Body groups, where nurses have had very generous increases in recent years. Giving further flexibilities in respect of Review Body groups is likely to result in yet higher pay.

Devolution to self-governing hospitals

8. I wonder if it wise to prescribe that the staff of self-governing hospitals should be taken out of the Whitley and Review

Body systems. It may be attractive to hospital management. But it is likely to arouse intense opposition from the staff. They will argue that their terms and conditions are being worsened unilaterally with all that that implies for their contractual relationship. Some might welcome the more flexible terms and conditions of service. But they would certainly expect to be paid more for them. Laying this down as a condition of self-governing status from the start may simply increase the difficulties faced by any hospital seeking this. Would it not be better to leave it to the management of the self-governing hospital to come forward with their own proposals once they are established? We should not rule out stepping out completely outside the national arrangements, if that is what the parties want, but we should not impose it.

9. Paragraph 10 notes that self-governing hospitals will need to develop management capacity and expertise to operate the new system, but contains no specific proposals for how this is to be done. If we are not be justly criticised by our colleagues, we need to be more specific here.

10. The next stage will be for our officials to work up a fresh draft of the paper, in the light of these and other more detailed comments. We shall probably then need to meet to agree the final version. But I would hope most of the ground could be cleared by officials first.

11. We shall also need to meet to discuss the question of private capital, on which I understand your officials have now sent mine a

set of examples. Although I have not had a chance to study them, it sounds as though we are making good progress with this. Here too, I hope our officials will be able to reach agreement in large measure before we meet.

JOHN MAJOR

cst.ps/5jml.12

CONFIDENTIAL

cc:
Chancellor
Sir Peter Middleton
Mr Anson
Sir T Burns
Dame A Mueller
Mr H Phillips
Mr Kelly
Miss Peirson
Mr Saunders
Mr Turnbull
Mr Gieve
Mr Parsonage
Ms Seammen
Mr Griffiths
Mr Sussex
Mr Call

Treasury Chambers, Parliament Street, SW1P

The Rt Hon Kenneth Clarke QC MP
Secretary of State of Health
Department of health
Richmond House
79 Whitehall
London
SW1A 2NS

1st December 1988

Dear Ken,

NHS REVIEW: PAY AND CONDITIONS OF NHS STAFF

I have now been able to consider your first draft of the paper on pay which we have been asked to prepare for the next meeting of the Review Group. I know your officials are already working on a further draft, but I thought I should write to let you know of my main points.

As you know, I have considerable sympathy with the idea of getting greater flexibility into the NHS pay system in order to improve the cost-effectiveness of the service. But I do not regard flexibility as an end in itself, only as a means of serving that objective. I think it is important therefore that we should present colleagues with proposals which set out in clear and practical terms how we propose to achieve it without leading to unacceptable pressures on the pay bill.

My main general comment on the paper is therefore that it needs to give a much franker exposition of the risks and a much clearer sense of how we are going to get from where we now are to a more flexible system without triggering a pay explosion. We need to set out the practical measures which we can take to allow managers the freedom to deploy their resources to best effect and we need to show how flexibility about pay is related to this. We must also be careful not to set unrealistic objectives for self-governing hospitals which may increase rather than reduce the difficulties for any hospital seeking that status. There follow some more specific comments on the main sections in your paper.

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Paragraph 10 notes that self-governing hospitals will need to develop management capacity and expertise to operate the new system, but contains no specific proposals for how this is to be done. If we are not to be justly criticised by our colleagues, we need to be more specific here. Our earlier agreements on self-governing hospitals envisage the status being conditional on an effective management track record (and other things) but handling pay flexibility will not be a part of that experience.

The next stage will be for our officials to work up a fresh draft of the paper, in the light of these and other more detailed comments. We shall probably then need to meet to agree the final version. But I would hope most of the ground could be cleared by officials first.

We shall also need to meet to discuss the question of private capital, on which I understand your officials have now sent mine a set of examples. Although I have not had a chance to study them, it sounds as though we are making good progress with this. Here too, I hope our officials will be able to reach agreement in large measure before we meet.

Yours Ever,
John

JOHN MAJOR

st2.ar/docs/2.12.12.88

CONFIDENTIAL

FROM: R B SAUNDERS

DATE: 12 December 1988

CHIEF SECRETARY

cc Chancellor
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Mrs Lomax
Miss Peirson
Mr Gieve
Mr MacAuslan
Mr Parsonage
Mr Richardson
Mr Griffiths
Mr Sussex
Mr Call

NHS REVIEW: ACCESS TO PRIVATE CAPITAL

I attach for approval a draft paper for you and Mr Clarke to put to the next meeting of the Review.

2. It is based largely on the draft attached to my minute of Friday. Paragraphs 8-13 on Bromley and the like have been revised in order to reflect the discussion with Mr Clarke this morning. It has been agreed with DOH officials. In brief, it now says that:

- we are in favour of these cost-savings schemes
- there are three possible ways of financing them
- we will consider the options in the case of Bromley
- and will aim to reach a decision in time for an announcement at the same time as the White Paper.

CONFIDENTIAL

3. Thus we take the pragmatic view that, rather than seek to change the rules to accommodate a range of hypothetical circumstances, we consider worthwhile schemes on their merits. It leaves open the option of making extra money available to finance the Bromley redevelopment, whether or not in the form of a capital loans fund. But we can consider what seems the best solution when we have seen the proposals in detail.

R B SAUNDERS

vj1.9.12

CONFIDENTIAL

DRAFT

ACCESS TO PRIVATE CAPITAL

Note by the Secretary of State for Health and the Chief Secretary to the Treasury

Our paper HC56 said that we would report back to the Group when we completed our further work on this question.

2. We have examined a range of projects which individual health authorities would like to undertake. In so doing, we have applied two general principles: that value for money must be secured on behalf of the taxpayer; and that, where the capital costs of a project ultimately devolve onto the taxpayer, there is a presumption that it should not be additional to the agreed public expenditure programme.

3. For the most part, the application of these principles to particular cases is clear, and we have found no reason why they should impede the projects from going ahead. The following are among the examples we have considered, and which we see every reason to encourage:

a. a joint venture between the NHS and the private sector, who share the construction of hospital facilities, with costs apportioned according to the use they plan to make of them. There would be opportunities for trading between the two sectors, with the private sector selling capacity to the NHS and the NHS selling diagnostic services, etc to the private sector. The NHS would receive rent from the private health care provider in respect of the land;

b. leasing NHS land, buildings or other facilities to private sector health care providers. The private sector would run facilities on an NHS hospital site. The lease might be on conventional repayment terms, or might enable the NHS as landlord to share some of the profits generated by the lessee;

c. as b., but with the lessee providing a non-health facility. This might be a hotel, shops, or a sports centre. It could sell its services to the hospital, to patients and to visitors. Again, the lease could either be conventional or involve an element of profit-sharing. This would be an alternative to the sale of the freehold, if the health authority considered that it offered a better deal;

d. leasing part of a hospital site to a housing association which would provide low-cost accommodation for NHS staff. The NHS might subsidise the lease, and possibly share in the profits. The housing association could either build afresh or refurbish existing accommodation.

4. In all these cases, there are no complications resulting from the private finance principles. The health authority needs to assess the commercial risks it faces from the venture (eg if its partner went out of business) and to ensure that it has the right management capacity and skills to deal with this as appropriate.

Contracting out

5. Contracting out is an issue, however, which raises slightly more difficult questions. In principle, if a service is contracted out to the private sector, the need for capital in the NHS is reduced. But since the contractor's fees will involve an element for the cost of financing its capital expenditure, the health authority's current costs rise. In principle, therefore, health authority capital allocations should be reduced, and current allocations increased. Where services have been contracted out so far, however - mainly, catering, cleaning and laundry services - the capital element in the contractor's fee has been so small as not to warrant any adjustment. But, at the other end of the spectrum, there are

cases where adjustments between capital and current allocations are clearly appropriate - for example, in the hypothetical case of a health authority which decided to contract out all its hospital services.

6. There is a grey area in the middle. It has already been explored for contract energy management schemes, under which a contractor takes over the energy management of a hospital, including perhaps the installation of a new boiler incorporating modern technology, with the aim of substantially reducing energy costs. Guidelines for taking account of the contractor's capital expenditure have been agreed across government. Rather similar issues will be raised by the need to upgrade or replace NHS incineration plant to comply with new statutory controls on emissions. Again, this is an area where the expertise resides in the private sector, and where significant capital expenditure by the contractor may be involved. Another case is that of a health authority which is seeking to contract out the care of some geriatric patients, rather than to replace itself an outdated and crumbling hospital.

7. Our two Departments are in touch bilaterally on these issues. We propose that officials should continue their work to clarify the ground rules in such cases.

Cost-saving projects

8. we have however identified one more difficult case. This is the financing of cost-saving projects of the sort now proposed for Bromley District Health Authority. In this case, outdated town centre facilities would be moved to a greenfield site just outside the town with the capital costs largely financed from the proceeds of selling the present sites. There would be recurrent savings from rationalisation. There is however a timing problem in that the land sales receipts are not available until after the new hospital has been constructed and the patients moved into it.

9. We are agreed about the desirability of such projects going ahead. In principle, there are three ways in which they could be financed:

a. by making room in the region's capital programme to finance the expenditure, taking credit for the associated receipts in later years;

b. by expenditure from a separate "fund" which is held back for allocation centrally rather than by regions, to which the eventual receipts are also scored. Such a "capital loans fund", which could be expected to be self-financing after about three years, was proposed by Department of Health in this year's public expenditure survey;

c. to enter into an arrangement with a contractor under which he builds the new hospital in return for vacant possession of the land so released. In effect he provides bridging finance between the construction costs and the land sales receipts. But such finance would carry a higher rate of interest than if the project were financed conventionally, as in options a. or b.

10. The Secretary of State considers that the Region's capital programme is fully committed for several years ahead, and health authorities have no objective basis for comparing cost-saving projects with those that meet service objectives. So service development inevitably tends to take priority in regional capital programmes. In the Secretary of State's view, the practical choice facing health authorities in this situation is between mounting the cost-saving project now using private finance or mounting it considerably later using public finance. In these circumstances, the Secretary of State believes that the extra costs would be outweighed by the benefit of bringing the project forward.

11. On the other hand, the Chief Secretary would argue that projects promising such a good return should be accommodated within the level of capital expenditure agreed for the NHS, even if regions do not give them high priority. This could be ensured by an arrangement on the lines of option b. Option c. would also mean giving greater freedom to health authorities than to local authorities, where we have recently been tightening up.

12. The position of the Accounting Officer also needs to be considered. This issue is being addressed at present in the Bromley case, and will need also to be considered in any other such projects which are put forward.

13. We will be considering these options carefully in the Bromley case, with a view to agreeing how to proceed, with if possible an announcement around the time of the White Paper.

Conclusions

14. In conclusion, we invite colleagues:

a. to note that private finance considerations are fully compatible with a wide range of co-operative adventures which health authorities wish to enter with the private sector;

b. to agree that our two Departments should do further work on the detailed application of the general principles to the different types of contracting out which are possible;

c. to note that we shall be considering further the options for cost-saving schemes in the light of the specific Bromley case, with a view to reaching a conclusion next month.

5.12.12 CONFIDENTIAL

KELLY CST 12/12

FROM: C W KELLY

DATE: 12 December 1988

CHIEF SECRETARY

cc: Chancellor
Paymaster General
Sir Peter Middleton
Dame Anne Mueller
Mr Phillips
Mr Saunders
Ms Seammen

Ch/Ok to circulate this and capital paper behind?

NHS REVIEW : PAY

I attach a further revised version of the paper on pay amended in the light of the discussion this morning in a way which I have agreed with Mr Wormald.

2. The main change is, of course, to the concluding paragraphs 20 and 21. But you may also want to confirm that you are content with amended versions of paragraph 13 and 14.

3. The paper is being submitted simultaneously to Mr Clarke. If you and he are both content, Mr Saunders will take the necessary steps to have it circulated to the Ministerial group tomorrow.

C W KELLY

enc

NHS REVIEW

PAY AND CONDITIONS OF NHS STAFF

Joint paper by the Secretary of State for Health and the Chief Secretary to the Treasury

This paper sets out the scope for devolving responsibility for pay and conditions to management in the main-stream of the NHS, and in self-governing hospitals.

Background

2. The present system of negotiation and control of NHS pay and conditions is highly centralised. National pay scales are negotiated centrally, or determined on Review Body recommendation. Conditions of employment are also negotiated centrally. A brief description of the arrangements is set out in Annex 1. On the whole this system has proved effective in recent years in keeping down pay rates in the NHS for non-review body staff, to the benefit of public expenditure. (Pay accounts for three-quarters of NHS costs). But one consequence has been the emergence in some areas of increasing recruitment, retention and motivation problems, particularly for skilled staff.

3. The Government can never stand entirely aside from such an important part of public expenditure as NHS pay, particularly since it is indirectly almost the NHS' only customer: and recent experience has shown this to be an area which can politically be highly sensitive. But Ministerial involvement in the detailed determination of pay and conditions is in principle undesirable. The ideal situation would be one in which managers were given an overall financial envelope within which to operate and then left to get on with achieving set objectives within it. The aim would be to do that in ways which did not lead to escalating pay costs and continuous increases in the size of the financial envelope itself.

Flexible pay systems

4. The general thrust of Government policy towards pay in the public sector, and indeed in the economy more widely, is towards introducing a greater degree of flexibility. Greater flexibility can help to achieve better cost-effectiveness in expenditure on pay by relating pay rates more closer to local labour market and other conditions, by making it easier to encourage and reward high performance by individuals, and generally by providing managers with greater opportunities to use pay as an instrument of management. Where greater flexibility is accompanied by greater devolution or delegation of responsibility for pay and personnel issues - which in principle is also desirable if the necessary conditions of management capability and tight financial controls can be satisfied - that can also help to lower the political profile of such issues.

5. These considerations apply in the NHS as in other areas, particularly to non-Review Body staff.

Flexibility in the main-stream of the NHS

6. Some progress has been made in this direction in the NHS in recent years. But the extent to which individual health authorities have freedom to vary pay and conditions without central approval is still relatively limited. Apart from London Weighting and the London supplements for Nurses and Professions Allied to Medicine recommended by the Review Body in 1988, about neither of which they have discretion, the flexibilities available to individual authorities are confined to:

- performance-related pay for about 2,000 top managers together with some discretion to vary basic rates according to job weight. These arrangements are being extended to cover a further 7,000 staff with provision for market flexibility elements for hard to fill posts.

- regional variations for IT staff.

- bonus schemes for manual staff and.

- greater flexibility for some professional, technical and scientific staff allowing the possibility of eg moving pay scales up the spine to reflect increased responsibilities or expertise.

7. Health authorities also have responsibility for grading staff within centrally agreed grading structures, which affords some flexibility of a kind which varies between different groups of staff. There is some evidence that some authorities, particularly in London and the South East, have been exceeding the proper limits of this flexibility in order to overcome recruitment and retention difficulties.

8. Officials are already looking at the feasibility of introducing further flexibilities into the pay determination arrangements for the main-stream of the NHS. In the immediate future it seems unrealistic politically to do anything other than to retain the Review Bodies for doctors and nurses. But the DH have been working on proposals for an important group of the non-review body staff - the administrative and clerical grades - which, while retaining central negotiation of basic rates, would allow local managers to vary these rates by up to a given percentage, which could vary in different parts of the country, to meet proven market difficulties. The new arrangements would also provide scope for productivity bargaining and extend performance-related pay.

9. More detail on these proposals is given in Annex 2. They have not yet been discussed in detail with other departments. The changes will need to be carefully managed to avoid the risk that local variation in pay could lead to a general escalation of pay levels rather than a more finely targeted, and hence more cost-effective, outcome than across the board increases, particularly since few NHS managers have direct experience of pay bargaining and they will be dealing with trade union officials who are likely to have much more.

10. A radical internal review by DH of conditions of service is also nearing completion. Greater devolution is a key objective, giving managers greater freedom to devise employment packages more suited to local needs. The review has highlighted a number of central controls which should be abolished. It ought to be

possible to give local management progressively greater freedom as they gain experience and develop the expertise to run a more highly devolved system.

Self-governing hospitals

11. Self-governing hospitals will be , or ought to be, those with the strongest management. They will also be expected to win their business by virtue of their greater efficiency. In order to behave entirely commercially and make full use of the potential advantages of their status, they ought to be given complete freedom over the pay and conditions of their staff.

12. There are, however, a number of considerations bearing on this.

13. First, self-governing hospitals will not be starting from scratch. They will be taking on their existing staff who, even in the non-review body groups, will have existing contracts of employment which explicitly or implicitly relate to pay and conditions determined under the existing mechanisms. These cannot be altered unilaterally without risking a variety of untoward circumstances. Changes can realistically only be brought about by negotiation at hospital level of new contracts of employment.

14. Second, any proposal to take the staff of self-governing hospitals out of the remit of Review Bodies could be contentious politically, unless, of course, it is underwritten by some form of commitment not to pay less than Review Body rates.

15. Third, it will be important to ensure that the new arrangements do not for this and other reasons simply generate higher pay costs which are passed on to the health authority as customer, and touch off a pay spiral which affects not only the hospital in question but also main-stream hospitals in competition with it for staff. There are particular risks in relation to the Review Body groups. The more self-governing hospitals are successful in attracting these staff away from other hospitals, the greater will be the pressure on review bodies to match the pay rates which self-governing hospitals agree.

16. In principle, genuine competition for the provision of services ought to be an effective constraint on hospital management against letting pay get out of control. They would simply lose business if they did. But in some parts of the country, and in some specialities, the competition would be limited, particularly in the immediate future. It would therefore be necessary to rely upon some combination of:

i. Cash limited funding to the DHAs, which are the buyers in the market place; and

ii. The fact that hospital managers will be under performance-related contracts which will provide pay incentives to maintain and increase their volume of sales and the sack if they fail, for example because pay rises restrict the volume of service the DHA can buy.

17. Finally, even in self-governing hospitals management capacity will constrain the pace of change which can be managed. They will have little or no experience of, or capacity for, driving hard pay bargains. It will almost certainly be necessary for them to buy this in initially.

Conclusion

18. There is general acceptance of a need to introduce greater flexibility into the pay determination system of the NHS, irrespective of the creation of self-governing hospitals. Proposals are in the course of being worked up which ought to help to achieve this, though there are important constraints related to the capability of NHS management to exercise discretion of this kind without creating unacceptable upward pressures on the pay bill. These proposals will be brought forward in due course. The DH review of conditions of service also seems likely to lead to a number of proposals which could increase local management discretion and improve the cost-effectiveness of the NHS salary bill.

19. If they are to achieve their full potential, and because this is consistent with their underlying philosophy, there is a strong argument for giving self-governing hospitals much greater flexibility in the pay and personnel management area, not

excluding breaking away entirely from existing mechanisms for determining pay and conditions, if that is what they want. Going down this road does, however, depend upon having sufficient confidence both in the ability of the managements concerned to manage pay negotiations with trade unions and in the effectiveness of competition and other mechanisms to prevent it leading to pay leap-frogging and increases in the NHS salary bill which it would in practice be difficult not to fund.

20. Against this background we propose that self-governing hospitals should have removed from them any obligation to observe centrally determined pay and conditions. They would leave them free, by agreement with their staff, to continue to follow central arrangements, to introduce entirely different arrangements, or to adopt some intermediate position. Satisfying the Secretary of State that the hospital had the managerial and personnel capacity to handle this degree of freedom would be one of the conditions of self-governing status. The Secretary of State would also retain reserve powers to reintroduce controls if necessary.

21. Colleagues are invited:

i. To note the Secretary of State's intention to bring forward proposals to increase the extent of flexibility in the main-stream of the NHS affecting both pay and other conditions of service.

ii. To agree that self-governing hospitals should be dealt with as in paragraph 20 above.

12 December 1988

ANNEX 1

DETERMINATION OF PAY AND CONDITIONS OF SERVICE FOR REVIEW BODY GROUPS

1. There are two Review Bodies, one for doctors and dentists (DDRB) and one for nursing staff, health visitors, midwives and professions allied to medicine (NPRB). (The professions allied to medicine - PAMs - are physiotherapists, radiographers, occupational therapists, chiropodists, dietitians and orthoptists.)

2. The Review Bodies are independent bodies appointed by the Prime Minister. Their terms of reference are to advise the Prime Minister on the remuneration of the staff groups concerned. (But London weighting is at present dealt with separately - see 4 below.)

3. Conditions of service and grading questions are determined separately from pay. In the case of doctors and dentists they are negotiated between the professions and the Health Departments. For the NPRB groups there are two negotiating Councils, one for nursing staff, health visitors and midwives and one for the PAMs. Changes in the structure of allowances (as well as of grades) would normally be negotiated in the Councils and then submitted to the Review Body for pricing (although the new London pay supplements recommended this year by the Review Body for nurses and PAMs - see below - had not been so negotiated).

4. The Review Body groups are also represented on the General Whitley Council, which deals with conditions of service which are of general application to all NHS staff. It also deals (via a sub-committee, the London Weighting Consortium) with London weighting allowances for all NHS staff. The respective roles of the London Weighting Consortium on the one hand and the Review Bodies and Negotiating Councils on the other in determining special arrangements for pay in London are currently under review, against the background of the 1988 Review Body award of London supplements (payable on top of London weighting) to nurses and PAMs.

ANNEX 2

PROPOSALS FOR INTRODUCTION OF GREATER LOCAL FLEXIBILITY

The problem

1. Central bargaining with tight negotiating limits has led to increasing problems of recruitment and retention in most staff groups not covered by Review Bodies. Administrative and clerical staff are the major non-Review Body group. They include managers below general managers and board-level senior managers in regions and districts and below general managers in units. Many authorities are facing acute problems in recruiting and retaining suitable staff across the whole range from senior finance, computing and personnel to secretarial and other clinical support staff. Because of the importance of administrative and clerical staff in implementing change and securing better management of resources they have been selected as the flagship for the introduction of greater local flexibility in pay. Their occupations are particularly sensitive to labour market influences.

Senior managers

2. The current senior manager's pay arrangements are to be extended to two further levels of management including managers in units. The change is to be achieved without negotiation but individual managers will have the right to retain their existing pay and conditions of service. Key elements of the new arrangements are:-

- general managers will decide which posts they consider have responsibilities for corporate management and therefore come within the scope of the new arrangements;

- a 12-point pay range, based on a 30-point pay spine with 4% steps, will be set for each management level;

- general managers will be required to assess the relative weight of posts and propose the appropriate pay point;

- spot salaries will be authorised by the next managerial level (ie by the RHA for posts at DHA level and by the Department of Health for posts in RHAs);

- there will be local flexibility to increase basic salaries by up to the value of 2 spine points above the maximum of the range for vacant management posts which cannot otherwise be filled;

- performance-related pay based on an annual process of individual performance review can add up to 4% of salary annually and up to 20% over a minimum of 5 years.

Administrative and clerical staff

3. Proposals are being considered by Ministers which would need to be negotiated in the Whitley Council for administrative and clerical staff who are not covered by the senior managers' option outlined in paragraph 2 above. The key elements of the proposed arrangements are:-

- new tighter definitions for 10 grades on a 44-point pay spine with 4% steps (to replace over 500 pay points);

- shorter incremental scales (4 or 5 points) with elimination of age-related points from age 18;

- assimilation to the new stucture to be prescribed by reference to existing grades with personal protection where necessary;

- a facility for local management to supplement pay points where this would assist in redressing proven problems in recruitment or retention;

- flexibility to be limited initially by amount payable to individuals (up to 30% in Thames Regions and 20% elsewhere for posts up to middle management level and 10% at higher levels);

- overall use of flexibility to be controlled initially (5% of A&C paybill in Thames regions and 3% elsewhere);

- local proposals to be included in short-term plans and cleared at next management level (RHA for Districts and Department of Health for RHAs);

- use of flexibility to be monitored by separate identification of payment of supplements in annual accounts;

- system designed to permit the easy introduction of individual performance-related pay when appraisal systems fully effective.

Nursing and midwifery staff

4. Proposals have been put to the Review Body for a sum of £5m to be set aside in 1989/90 for a pilot exercise in supplementing national rates of basic pay where deemed appropriate on recruitment and retention grounds. Key elements of the proposal are:-

- aim to help to meet a small number of particularly difficult cases and to pilot the criteria and help in development;

- allocation of funds to be controlled centrally; and likely in practice to be targeted on Southern Regions (including East Anglian) but to exclude inner and outer London pay areas where universal supplements recommended by Review Body in 1988 are already payable;

- supplement to be either a percentage of basic pay or a flat-rate addition to annual salary or an additional point or points on pay spine (eg 2½%/5% of basic pay or £250/£500).

Other staff groups

5. For professional, technical and scientific staff local flexibility has been encouraged by recent settlements for certain staff groups (eg speech therapists and MLSOs) and negotiations continue for pharmacists. The concept of pay spines has been introduced and local mangers provided with flexibility in moving pay scales up the spine to reflect increased responsibilities or expertise. There is also much less prescription in the grading criteria to facilitate more flexible working arrangements. The new structures have been designed to permit easy translation to the A&C model described in paragraph 3 above.

16/1/89.

Ch

Review Bodies

Figures attached.

There are some problems over timing: D+D report will arrive this week, Nurses, AAMs & AFPRB next week, but TSRB not till 27th, following another meeting on 24th (Plowden is v cross about handling of Andrews' report). This makes it very tight (though just possible) to publish on 22nd Feb. PM is in principle attracted to linking closely with Health White Paper, though Clark is not.

A separate complication concerns Teachers. Chilver seems to be playing a waiting game, hoping to delay his report until after Review Bodies Reports published & using them as justification for exceeding his remit. He is talking of delivering his report 'mid Feb'. One option — to which the PM is provisionally attracted (ie in spite of Health WP) — is to demand Chilver's by 9 Feb or thereabouts and publish that and Review Bodies on 16 Feb. (This has [redacted] disadvantage of meaning Cabinet has to consider that & Budget @ same meeting, but probably not too serious).

AA

REVIEW BODIES.

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PAY REVIEW BODY REPORTS

Report	Main recommendations	Estimated increase in paybill for 1989-90	
		£ million	percentage
Doctors and Dentists		240	8.8
+ some increases to distribution awards	(i) Across the board 8% — both GPs and hospitals (ii) £1,000 to be added to top of consultant scale = total 10.8% at top of scale		
Nurses		348	6.9
	(i) Across the board 6.75% (ii) £5 million, subject to conditions, for experimental "flexible pay" scheme on lines requested by Government.		
Professions allied to medicine	(i) Across the board 7.7%	37.4	7.7
Top salaries		5.7	6.3
	(i) Basic 5% (underpinning all 3 groups) (ii) Judiciary: minor restructuring: pay bill increase 5.3% (iii) Military: 2 star officers to be linked to Grade 3 first performance point: paybill increase 8.6% ← means some increase of 10.3%. (iv) Civil Service: structural changes to performance pay deferred but interim increase in quota from 25% to 35% (not costed): London Allowance of £2,000 for Grade 3s: paybill increase 7.5%. ← means 10% total increase for Grade 3s.		
Armed Forces		247	6.8
No change in Falklands Islands Additional Pay	(i) Increases for trained personnel range as follows: (a) officers: 6.0% (Lt Col and above) to 8.0% (Captains) (b) Other ranks: 6.1% (WOIs) to 7.1% (Corporals) (ii) Flying pay for non-Commissioned aircrew restructured		

N.B NHS estimates are necessarily approximate as, inter alia, manpower figures are not up to date, and no allowance has been made for changed staffing levels in 1989-90.

11 January 1989

SECRET AND PERSONAL

PWP-

FROM: MISS M E PEIRSON
DATE: 16 JANUARY 1989

CHIEF SECRETARY

cc Chancellor
Sir Peter Middleton
Mr Phillips
Mr Kelly

1989 PAY REVIEW BODY REPORTS: HEALTH

Mr Clarke may raise the question of the Pay Review Body Reports at tomorrow's Health Review meeting. In particular he may mention funding, and timing. That meeting is probably not the appropriate forum to take decisions about either. But some preliminary discussion could be helpful.

Timing

2. I understand that the preliminary view is that the choice of publication date (with, of course, the Government's responses) lies between 2 and 16 February, with the latter finding greater favour. You have committed the Government to publishing the Government's responses to the Review Body Reports "by the end of January or mid-February at the latest". 16 February is on the outside edge of that commitment, which was made primarily in order that the Health Authorities should have certainty about their pay bills for the coming year when settling their budgets, so that they would have no excuse for unnecessary ward closures.

Cost

3. The figures for total cost which the Review Bodies are proposing to quote in their reports seem to be approximations to England only figures. The ready reckoners which DH have given us suggest the following costs:

UK: doctors £275 million, nurses £420 million, PAMs £45 million.

4. However, DH will be looking at the figures much more carefully in the light of the exact recommendations in the Reports. There will also be the cost to DES of the clinical academics, who get whatever awards their health service colleagues get (at a cost of the order of £5-10m).

Funding

5. The GDP deflator assumed for 1989-90 in the 1988 Survey settlement was 5 percent. Therefore, of the Review Body recommendations, the first 5 percentage points are already provided for. DH do not question that: you gave some extra money in the Survey settlement to reflect the last minute revision in the deflator. That reduces the amounts at issue to something like the following (plus a bit for clinical academics):

England: doctors £100 million, nurses £100 million, PAMs £10 million, total rather over £200 million.

UK: doctors £120 million, nurses £120 million, PAMs £15 million, total about £250 million.

6. However, around £55m of the above UK figure for doctors (and therefore of the total) is for the FPS and hence would anyway be fully funded, unless we sought offsetting policy changes. Health authorities account for the remainder of the doctors and all of the nurses and PAMs, and that is what is at issue, ie around £200m (UK).

7. It is of course highly desirable in principle that something above the first 5 percent should also be absorbed. The reason is to maintain pressure on the Review Bodies, particularly in future years, to restrain their recommendations. The alternative weapon in the Government's hands is abatement (see below). In the Government evidence to the Review Bodies this year, the Government said that the Review Bodies should not assume full funding. We

shall want to do so again, in order to put pressure on the Review Bodies to moderate their recommendations.

8. However, full funding was agreed last year, the Government using the regrading of nurses pay as the reason for special treatment. In addition, in the 1988 Survey it was eventually agreed that the only contribution to pay in 1989/90 from cost improvement savings would be for Whitley pay alone (it was put at £65 million). In your letter to Mr Clarke of 17 October recording the outcome of the Survey, you said:

> "No explicit provision has been made for the 1989 Review Body awards above the GDP deflator, but you will be maintaining the line with the Review Body and elsewhere that there will be no automatic full funding of any excess. The extent to which any excess would be met from within the agreed provision would be a matter for later decision."

Mr Clarke made no comment about Review Body pay in his reply beyond noting that your letter accurately reflected the agreement reached.

9 So, as was made very clear in the final bilaterals, there is no provision in the settlement (whereas in previous years there has been an understanding that part of the cost improvement programme proceeds should be available for Review Body pay). But the decision remains to be taken, whether or not to make the Health Authorities contribute something.

10 Since in particular you may wish to abate the doctors' pay award (see below), it would be better not to reach any early decisions on funding. Mr Clarke has repeated that he does not want to see full funding year after year, but also (I understand) that it would be unreasonable to expect health authorities to absorb the whole of the increase. Tomorrow he may argue that it would be inconsistent with the health review, where it will be important to say that the costs of the changes will be met without reducing provision for patient care, not to fully fund pay as well; OR that you can be mean about pay provided you are very

generous about the health review (ie trying to get more for the latter), though that would be reneging on the agreement on expenditure on the review which I understand you reached today.

11 We recommend that you take the line that funding will have to be considered alongside the pay awards themselves, so that Ministers can reach decisions on how far to accept the recommendations, and how far to fund them, at the same time. But you may wish to have a bilateral discussion with Mr Clarke on funding at some stage, when you have the first report by officials (scheduled for 24 January).

12 If in the end full funding is conceded, you will wish to minimise the damage to the Government's stance. The pressure on the Review Bodies to restrain their awards will be reduced if in each successive year full funding is conceded. Therefore you may wish to say that full funding is agreed because of the "exceptional circumstances" of the Health Review..

Abatement

13. Abating the awards to the nurses or PAMs is unlikely to be attractive, though you may not wish to concede that to Mr Clarke tomorrow. But I understand that the Prime Minister and Chancellor have strong feelings about the doctors' and dentists' award.

14. Officials will be examining the options for abating the doctors' award, and making recommendations to Ministers. The options will include: holding the basic percentage increase to the same as the nurses, temporarily or permanently, or rejecting or altering other elements of the award. Officials will also show what partial deferment of all the awards might save.

MEP

MISS M E PEIRSON