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

cc PS
cc BP

CONFIDENTIAL

Paul Gray Esq
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12 December 1988

Dear Paul

NHS REVIEW - GP BUDGETS AND PRIVATE PRACTICE

At the Prime Minister's meeting on 23 November the Secretary of State agreed to circulate a note about the effects of rates of private insurance on GP budgets.

The two points raised in discussion were:

firstly, that if patients knew that the GP would refer them to a private hospital as NHS treatment this would act as a disincentive to taking out private insurance; and

secondly, that a simple capitation approach to budget setting would lead to overfunding practices with existing high rates of usage of the private sector.

On the first, the Secretary of State believes that in practice the incentives will be quite the other way. Any NHS patients referred to the private sector will be a charge on the practice budget in just the same way as patients referred to NHS hospitals. The GP will wish to protect his budget and this may well provide the GP with an incentive to be more assiduous in enquiring whether the patient has private insurance cover before making his referral. This could lead to greater usage of private sector facilities, though not at NHS expense, than previously. This incentive to make sure that existing insurance cover is fully used will be particularly effective where the budget already takes account of the propensity of patients to use the private sector.

E.R.

This in turn suggests that the budgets should not be based on an unvarying capitation system. Rather budgets need to take account not just of expected levels of referrals but also actual or historical levels. When the RHA agrees with the GP practice the level of the budget it needs to have information about referral practices, at least to NHS hospitals, in the previous year. Where the "expected" referral level - based on weighted capitation - is higher than actual rates, the RHA would rely mainly on the latter. They would have no interest in unnecessarily overfunding a practice at the expense of other participating practices or DHAs. The GP practices need to be able to feel that they can "beat the budget" - that after all is their incentive to participate - but that should arise from more careful referral practices rather than overfunding. This use of both expected and actual referral rates in setting the budget, in the Secretary of State's view, meets the second point above.

I am sending copies of this letter to the Private Secretaries to the Chancellor, Chief Secretary, the Secretaries of State for Scotland, Wales and Northern Ireland, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr Wilson (Cabinet Office) and Mr Whitehead (Policy Unit).

Yours

Andy

A J McKEON
Private Secretary

cc B/P

HC 64

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.

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 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 and 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 national pay bargaining processes will be contentious politically and will create pressure for a commitment not to pay less than Review Body or Whitley Council rates.

15. Third, it will be important to ensure that the new arrangements do not 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. If self-governing hospitals attract these staff away from other hospitals, there will be 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. In addition it will be necessary to rely upon the 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. Existing managers will have little or no experience of, or capacity for, driving hard pay bargains and 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. This 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 could 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.

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.