Health Foundation long read (PDF version)

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Where next for NHS nurses' pay?

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The Health Foundation

Contents

Key points

- The gruelling effects of the pandemic and cost-of-living crisis have accelerated the need to review the current approach to NHS nurse pay determination, to ensure it can be fit for purpose as part of an overall NHS workforce strategy.
- This analysis looks at the impact of high inflation and other factors affecting nurse pay, assessing the potential implications for the 2022 NHS Pay Review Body recommendations on nurses' earnings. Secondly, we consider the extent to which the current pay determination system could be improved to meet NHS nurse workforce priorities.
- Between 2011 and 2021, NHS nurses' average basic earnings fell by 5% in real terms (after accounting for consumer price inflation). While the trend in nurses' average earnings compared favourably with teachers and police officers, for example, the government-imposed 7-year public sector pay cap (which ended in 2017), led to a significant drop in nurses' pay compared with overall average earnings across the wider economy. Nurses' average earnings fell by 1.2% a year in real terms between 2010 and 2017, while economy wide employees' average earnings fell by 0.6% a year in real terms over the same period.
- If the NHS Pay Review Body recommendations accept government's request to cap any pay increase for 2022/23 at 3%, a further significant real-terms reduction in nurses' pay will be the likely outcome.
- There must be a fully effective and independent review body system, based on full commitment of all parties, including governments, to accept, implement and fund its recommendations in full. This has not always happened in the past.
- Three further implications need to be considered:
    1. It is necessary to break the short-term, narrow annual focus on 'how much' NHS nurses' pay increases in a year. Government should consider moving to a standardised, multiple year pay cycle – probably of 3 years – to free up space for creative, longer term thinking on pay.
    2. The gender and ethnicity pay gap review, proposed by the Department of Health and Social Care, must be actioned rapidly. Transparent pay equity for NHS nurses will underpin both retention and career progression.
    3. The coverage of the current Review Body could be adapted to create policy and fiscal space for targeting and prioritisation – for instance, to target and retain highly skilled nurses who are high risk for early retirement or reduced hours.

1. Introduction

Over the past 2 years, the NHS workforce has been at the heart of the fight against the COVID-19 pandemic. With continuing high levels of NHS staff vacancies, rapid increases in inflation and the resulting cost-of-living squeeze dominating the headlines this year, NHS staff pay is very much on the policy agenda. Against this backdrop, this analysis updates our work on long-term trends in NHS nurses' earnings and re-examines key priorities for the system underpinning NHS nurse pay determination.

The UK has a unique mechanism in place to determine the pay of nurses and other NHS staff. The NHS pay review body system independently considers evidence from UK governments, employers and trade unions. It then makes recommendations to government on pay increases for most NHS staff, usually on an annual basis. There are two review bodies covering NHS staff: the Review Body on Doctors' and Dentists' Remuneration (DDRB) and the NHS Pay Review Body (NHSPRB). The latter makes recommendations for the 1.2 million staff employed under the Agenda for Change contract, including nurses, allied health professionals, clinical support staff (such as health care assistants) and administrative staff.

Last year we considered the long-term trends in nurses' pay, and assessed the impact of the NHSPRB system since it was set up in 1983. We concluded that the process can only be judged as 'successful' if recommendations are fully implemented by government, which we highlighted has not always been the case. About 1 in 3 of the NHS nurses' pay recommendations made by the review body from 1984 to 2007 were either implemented in a staged manner or delayed by government. This was followed by a 3-year deal covering 2007 to 2010, then a 7-year public sector pay 'freeze' from 2010 to 2017, and a further 3-year arrangement up to 2021.

There are currently tentative signs of a return to a 'normal' annual Pay Review Body determination process, producing an annual report. However, NHS registered nurse shortages persist, with around 40,000 vacancies in England. Moreover, for the first time in two decades, nurses and all other workers are facing the negative impact of high inflation of above 8% a year on their earnings, which is a major feature of the broadly unfavourable NHS funding climate.

We update our analysis on NHS nurses' pay to take account of the impact of the 2021 pay award, and consider the context for this year's NHSPRB recommendations. We first analyse the impact of high inflation and other factors affecting nurses' pay, to set the context for the potential implications of the 2022 NHSPRB recommendations for nurses' earnings. Second, we consider the extent to which the current pay determination system could be improved to meet NHS nurse workforce priorities.

2. Workforce and funding context

Health care is labour intensive. The NHS nursing pay bill, as determined by the NHSPRB, represents both a major cost to the Treasury and a major investment in supporting population health, largely because of the size of the NHS-registered nurse workforce. The NHS Hospital and Community Health Service (HCHS) in England directly employs around 320,000 full-time equivalent (FTE) nurses and health visitors (as of January 2022). The vast majority of those staff – around 9 out of every 10 NHS nurses – are reported to be women. These staff account for around a quarter of all NHS staff and around 40% of NHS vacancies. In 2020/21, nurses' pay bill accounted for nearly one-third of the overall NHS Agenda for Change staff pay bill of around £47bn. (This is based on input from the Department of Health and Social Care (DHSC), which the authors gratefully acknowledge.)

Nurses' average earnings fell by 1.2% a year in real terms between 2010 and 2017, while economy-wide employees' average earnings fell by 0.6% a year in real terms over the same period. As nearly 90% of NHS nurses are women and nearly 2 in 5 (39%) of NHS HCHS contracts for female nurses and health visitors were part time in October 2019, it is worth looking at those statistics for female full-time employees only. Even so, female full-time nurses' average earnings fell by 1.1% a year in real terms between 2010 and 2017, while economy-wide female full-time employees' average earnings fell by 0.3% a year over the same period. While faring better than some other large public sector groups such as teachers and police officers, after taking account of inflation, female full-time nurses' mean gross weekly earnings in 2019 were virtually the same as in 2008.

Last year, the NHSPRB recommended a headline 3% increase, which was accepted and implemented late by the UK government in July 2021; the Scottish government made an earlier award, reported as representing a higher overall average pay uplift for Agenda for Change staff of 4%. The Scottish government has now announced that it will not seek a recommendation from the NHSPRB for a pay award in 2022/23 and will hold direct negotiations with the health trade unions instead.

The 3% increase applied in England after the 2021/22 award has turned out to be below inflation, which has increased markedly since then. It was estimated at close to 8% (as of April 2022) if we consider the Consumer Prices Index (CPI) including owner occupiers' housing costs (CPIH), which is the lead measure of inflation used by the Office for National Statistics (ONS). The nursing unions had argued for a significant and larger pay increase to make up for real earnings 'lost' during the public sector pay freeze of 2010 to 2017. In addition, and unlike the other three UK countries, nurses and other NHS staff in England did not receive any bonus payment in 2020/21 in recognition of their contributions during the pandemic.

This year, it looks even harder to navigate the trade union demands to improve the value of nurses' earnings. The pay bill for NHS permanent and bank staff accounts for a little under half of NHS England's revenue expenditure (around 44% in 2020/21), and pay pressures account for just over

two-thirds of the 2022/23 NHS cost uplift factor for NHS trusts, which is used to calculate the efficient cost of health care provision in the coming year. During the 2021 Spending Review, the government set out its funding plans for the 3 years to 2024/25. Its desire to manage public sector pay growth and NHS funding pressures means that the health service budget has limited headroom for any significant increases in the pay bill.

The government request to the NHSPRB for the 2022/23 round is that it considers the 'challenging health, economic and fiscal context' and caps any pay increase at 3%. This reflects two linked aims: to limit increased pay bill-induced costs for government, and to contain the potential inflationary impact of a large pay increase to a large workforce, leading to wider wage price spirals. In February 2022, the Governor of the Bank of England argued the need for wage restraint to prevent an upward spiral. With inflation now more than double that 3% figure and continuing to rise, government evidence arguing for a capped 3% increase will mean a further significant real-terms reduction in nurses' pay.

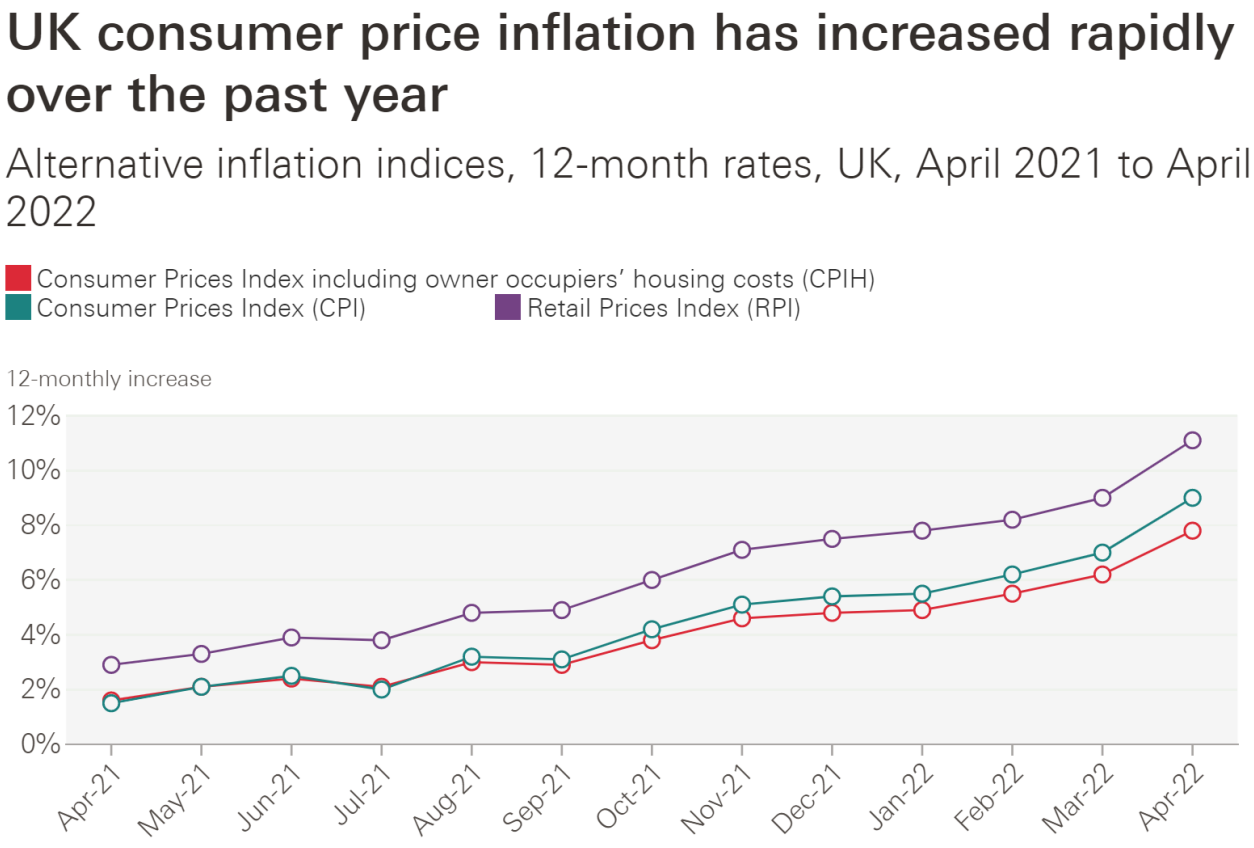
In their evidence to the NHSPRB this year, the unions have restated the need for a substantial 'catch-up' award to compensate for real earnings losses and to counter the effects of higher inflation. The Royal College of Nursing (RCN) has pitched its demand at '5% plus inflation' – totalling about 12.5% at the time it made its claim. The other unions have not stated a specific target.

3. Trends in NHS nurses' pay and earnings

As we have highlighted, overall NHS funding prospects appear very challenging, and this has led to government demands for a below-inflation NHS pay award in 2022/23.

In the year to April 2022, the CPIH increased by 7.8%, having gone up significantly month-on-month over the past year (see Figure 1). We use the CPIH in this analysis as it is the lead inflation measure used by the ONS, but annual growth rates for alternative indices over the past year are also summarised in Figure 1. The oft-quoted CPI tends to be very similar to the CPIH, although in more recent months it has pulled further ahead of the CPIH. The Retail Prices Index (RPI) is another commonly used indicator, though it has a number of shortcomings, highlighted by the ONS.

Figure 1



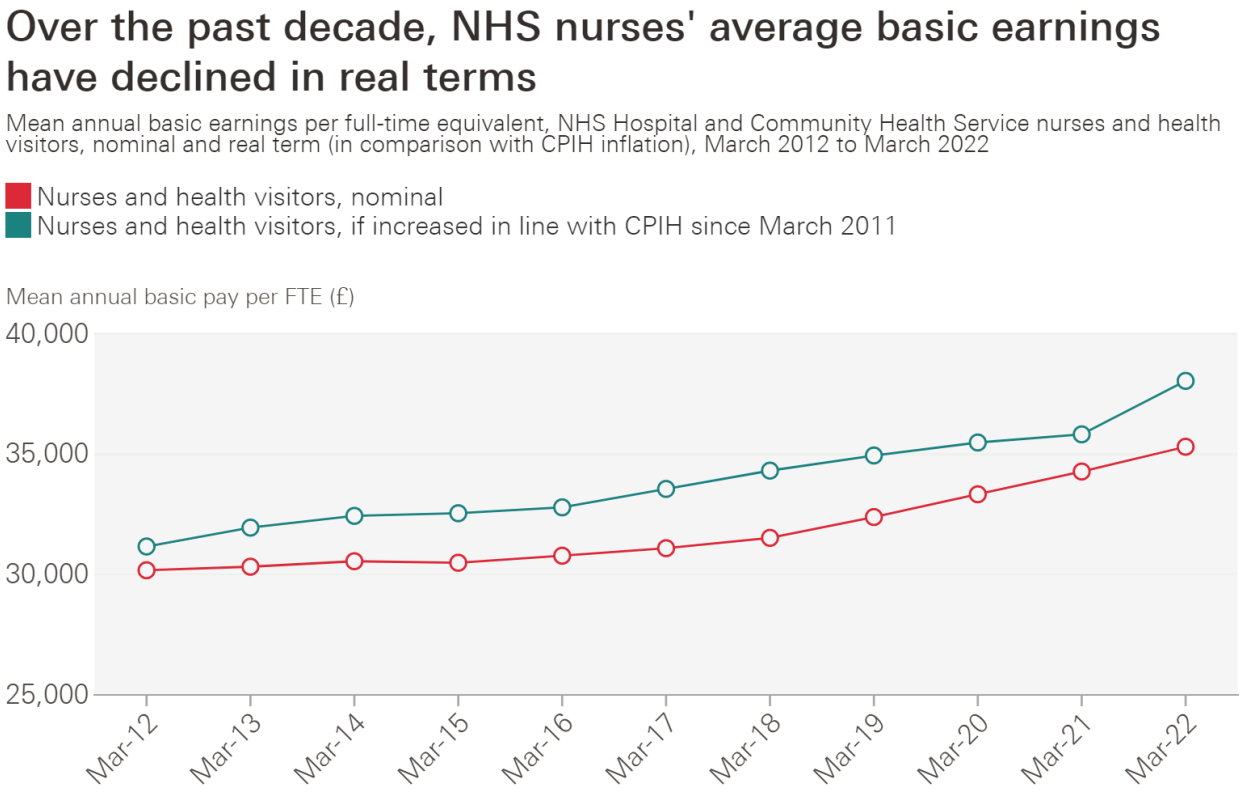
Source: Office for National Statistics

While longer term projections made by the Office for Budget Responsibility (OBR) in March 2022 suggest that inflation will drop back to 4% in 2023 and 1.5% in 2024, many working nurses will never have experienced such high inflation during their career. This has been compounded by additional employment and fiscal changes that have hit the take-home pay of some NHS staff. These

include increased National Insurance contributions (NICs) for some higher paid NHS nurses and increased pension contributions for some. (Calculations from the Institute of Fiscal Studies (IFS) suggest that employees earning less than around £35,000 will see a fall in their overall NICs bill in 2022/23 relative to 2021/22, while those earning more than £35,000 will see an increase.)

Against this background, we set out a brief analysis of recent trends in nurses' earnings. It is evident that over the past decade, NHS nurses' average basic earnings have fallen in real terms (relative to CPIH inflation, Figure 2 and Figure 3). The 3-year Agenda for Change pay award in 2018 led to a gradual increase in NHS nurses' average basic earnings, but this was not sufficient to reverse the decline from 2010/11 to 2017/1818, and the rapid increases in inflation over the past year have had a visible negative impact (Figure 3).

Figure 2



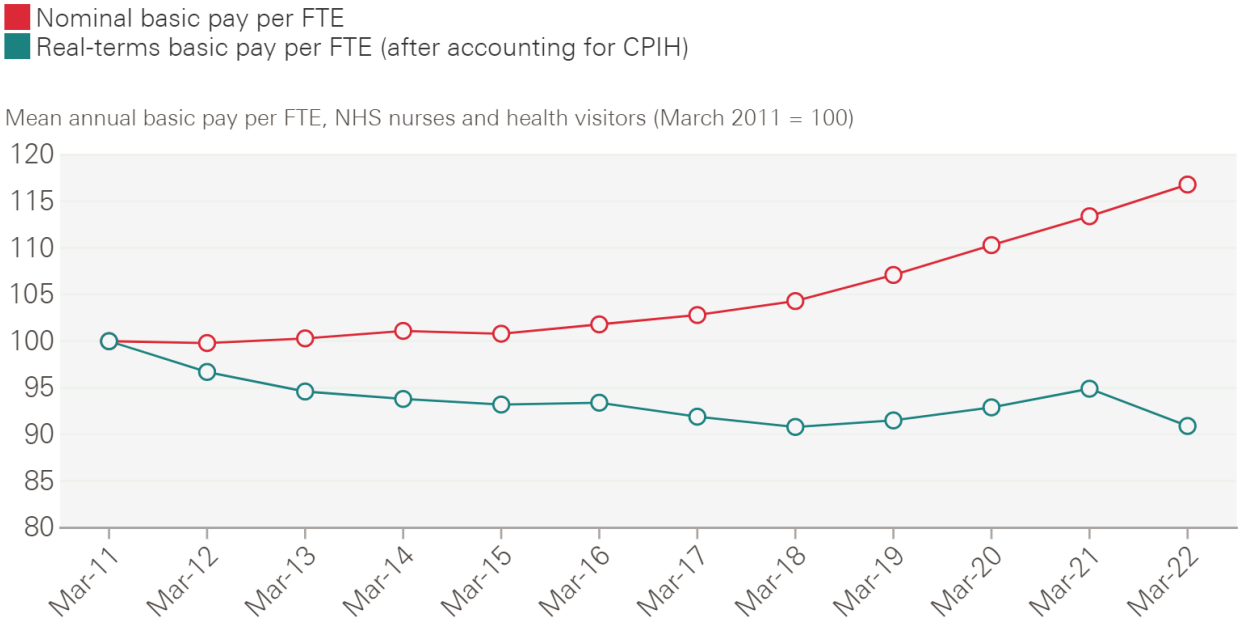
Source: NHS Digital Staff earnings data (provisional estimate for March 2022*), ONS CPIH data.

Note: NHS Digital defines mean annual basic pay per FTE to be the 'mean amount of basic pay paid per 1 full-time equivalent post in a 12-month period'. *We use ONS data on the 12-month CPIH for March in each year from 2011 to 2021 to estimate real-terms earnings. As NHS staff earnings data for March 2022 were unavailable at the time of writing, we used data on the mean annual basic pay per FTE in March 2021 and increased that by 3% to reflect the Agenda for Change pay award for 2021/22. The March 2022 nominal earnings estimate is therefore provisional and is likely to vary significantly for individual nurses.

Figure 3

Over the past decade, NHS nurses' average basic earnings have declined in real terms

Index of nominal and real-terms mean annual basic earnings per full-time equivalent, NHS Hospital and Community Health Service nurses and health visitors, March 2012 to March 2022



Source: Earnings data are sourced from NHS Digital's ESR system and CPIH estimates are sourced from ONS data.

Note: NHS Digital defines mean annual basic pay per FTE to be the 'mean amount of basic pay paid per 1 full-time equivalent post in a 12 month period'. *We use ONS data on the 12-month CPIH for March in each year from 2011 to 2021 to estimate real-terms earnings. As NHS staff earnings data for March 2022 were unavailable at the time of writing, we used data on the mean annual basic pay per FTE in March 2021 and increased that by 3% to reflect the Agenda for Change pay award for 2021/22. The March 2022 nominal earnings estimate is therefore provisional and is likely to vary significantly for individual nurses.

At the time of writing, the NHS pay award for Agenda for Change staff for 2022/23 is yet to be decided. From the government's perspective, there is a trade-off between higher NHS staff pay increases and the amount of activity that can be delivered under current funding plans. A one percentage point pay award increase costs around £900m across the overall NHS HCHS workforce (equivalent to around 16,000 FTE nurses). This underlines the centrality of aligning staff pay with national workforce planning, with growth in pay and staff activity appearing to be perceived as alternatives. This is all the more relevant in the context of the government's recently stated NHS efficiency target of 2.2% a year.

Nurses' pay in 2022/23: two scenarios

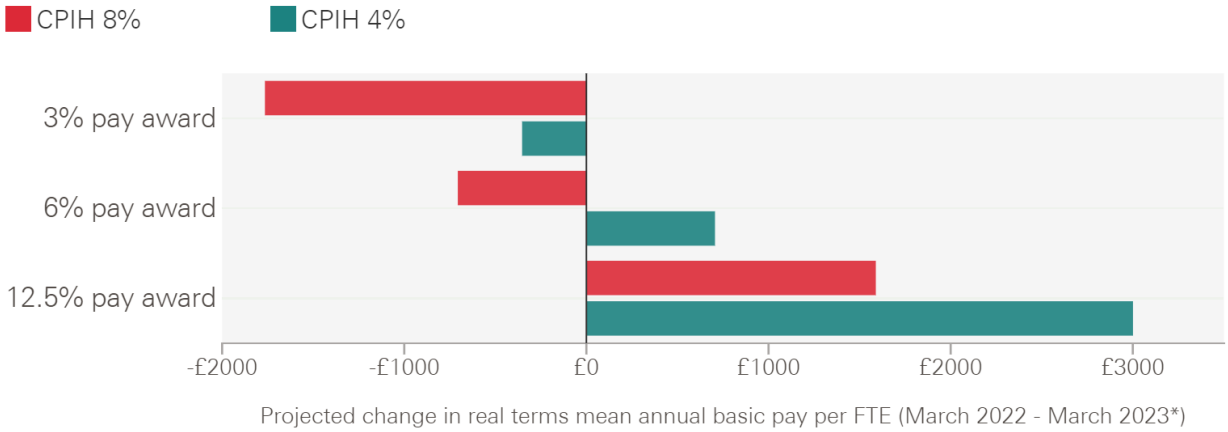
We have analysed what alternative pay awards would mean for nurses' average basic earnings in real terms, using two possible estimates for inflation over the year 2022/23: 4% (the OBR's latest estimate for 2023); and an alternative 'higher' estimate of 8% (Figure 4). A 3% pay award would lead to nurses' basic earnings falling on average in real terms in both inflation scenarios. In the higher inflation scenario, even a 6% pay award would not deliver real-terms earnings increases in 2022/23 for many nurses. A 12.5% award would lead to a real-terms increase under either inflation scenario. It is important to recognise that these are averages and that pay changes for individual nurses will vary considerably.

Then, we also consider the implications of high proportions of nurses being at the top pay point on Agenda for Change pay bands, which places primary emphasis on total pay uplift rather than individual pay progression as the main source of pay increase. The NHSPRB has, in the past, noted the need to 'de-compress' some pay bands to provide more pay headroom. The DHSC, in its evidence to the NHSPRB this year, has also reflected, 'Over the longer term however there is some evidence that earnings for nurses grow less quickly than for graduates from other subjects. For example […] median earnings for nurse graduates are around £5,800 higher than average 1 year after graduation but this gap closes over time and after 10 years median earnings for nurse graduates are below other graduates.' Recent analysis by the IFS has highlighted compression of pay distribution in the NHS and other parts of the public sector since 2010.

Figure 4

If inflation is at 4% a year in spring 2023, a pay award of 3% would mean a real-terms decrease in average basic pay for NHS nurses

Projected change in NHS Hospital and Community Health Service nurses' mean annual basic pay per full-time equivalent in alternative CPIH inflation scenarios



Source: NHS Digital data on NHS staff earnings; ONS / OBR data / forecasts of CPIH / CPI inflation

***Note:** mean annual basic pay per FTE nurse and health visitor in March 2021: £34,275, projection for March 2022: £35,304 (at the time of writing, earnings data for March 2022 were not available).

4. Aligning nurses' pay and the nursing labour market

Assessing trends in nurses' pay and earnings in isolation from nurse labour market profile and behaviour is to focus on only part of the picture. UK research evidence on the role of pay in nurses' labour markets is extremely limited. For a workforce that is so critical and so costly, in terms of overall pay bill, this lack of evidence is surprising.

It is also notable that NHS pay levels and pay determination have been largely absent from the current focus on developing a national NHS workforce strategy. At the time of writing, an upcoming Health Education England review of long-term strategic trends for the health and regulated social care workforce ('Framework 15') is awaited. The government has commissioned NHS England to develop a workforce strategy later this year, but at the time of writing, it was unclear whether NHS staff pay would be integrated into this strategy.

This evidence gap and policy disconnect between workforce pay and workforce planning needs to be urgently addressed if pay is to be used effectively as a central policy lever in recruiting, retaining and motivating NHS nurses and other NHS staff. NHS pay determination processes and pay levels must also be aligned with broader workforce strategy.

The NHSPRB assesses several key dimensions of evidence when making its recommendations on nurses' pay. These include 'affordability', recruitment and retention, and nurses' morale and motivation. As noted earlier, government is arguing strongly that affordability considerations must be a major constraint on NHS pay growth. When looking at the other key dimensions that the NHSPRB must consider, a mixed and incomplete picture emerges.

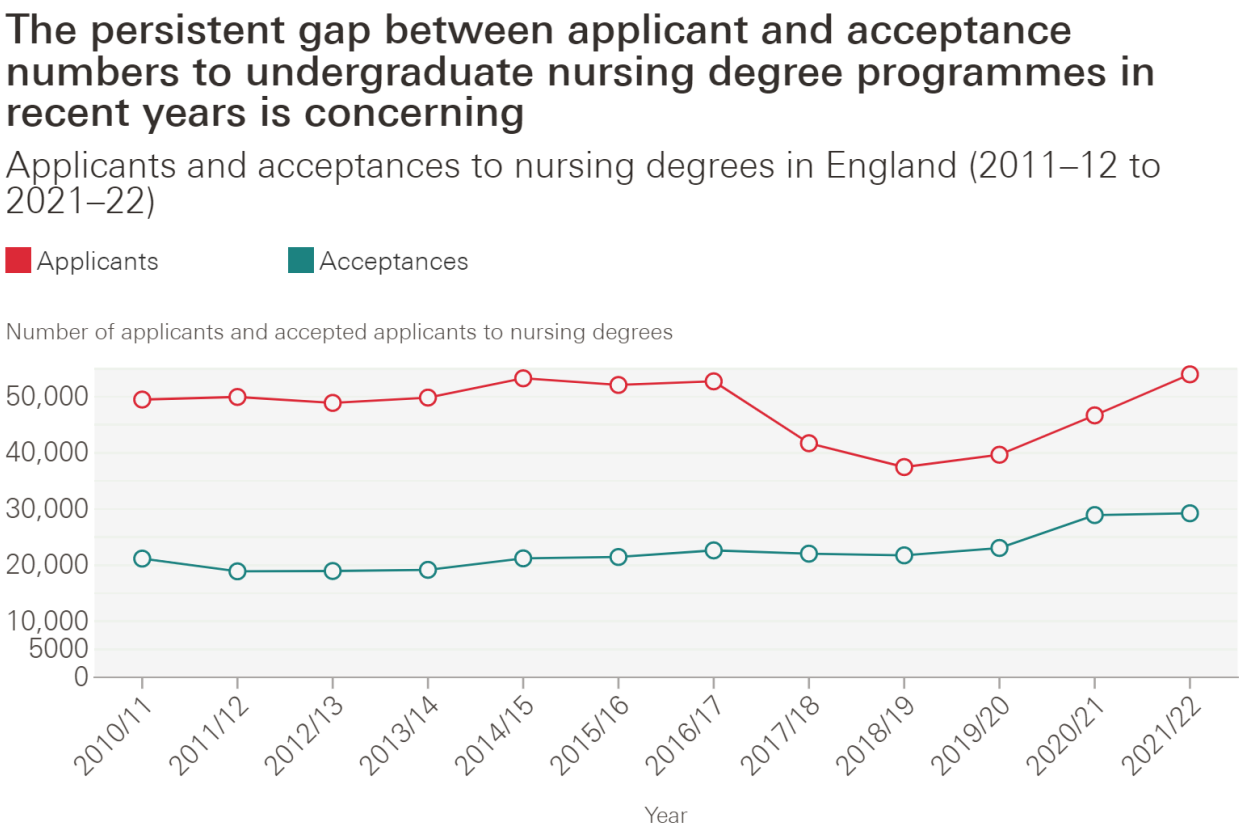
Challenges to recruitment

In terms of initial recruitment into the nursing profession, the potential for increasing the number of students entering UK nurse education has improved markedly in the past couple of years, with increases in applications to nurse education (Figure 4). This is reportedly partly due to the high-profile, positive coverage of the profession at the front line of the response to COVID-19, and partly because a nursing career offers relative job stability in times of economic uncertainty.

Currently, the primary recruitment challenge is to enable these applicants to go on and become student nurses. There is a significant long-term gap between the number of applicants and the number of accepted students (Figure 5). The current gap is reportedly due to limited capacity in universities to expand the numbers of student nurses being trained and placed effectively in clinical supervision. Headline numbers of applicants suggest recent significant growth, after a decline from 2016 to 2019, but 2021–22 'acceptances' did not keep pace with the growth in applicants that year.

The figures also conceal differences in levels of attractiveness of different branches of nursing, with mental health and learning disabilities struggling to fill available training places (see also Table 1).

Figure 5



Source: UCAS End of Cycle Data Report, 2021

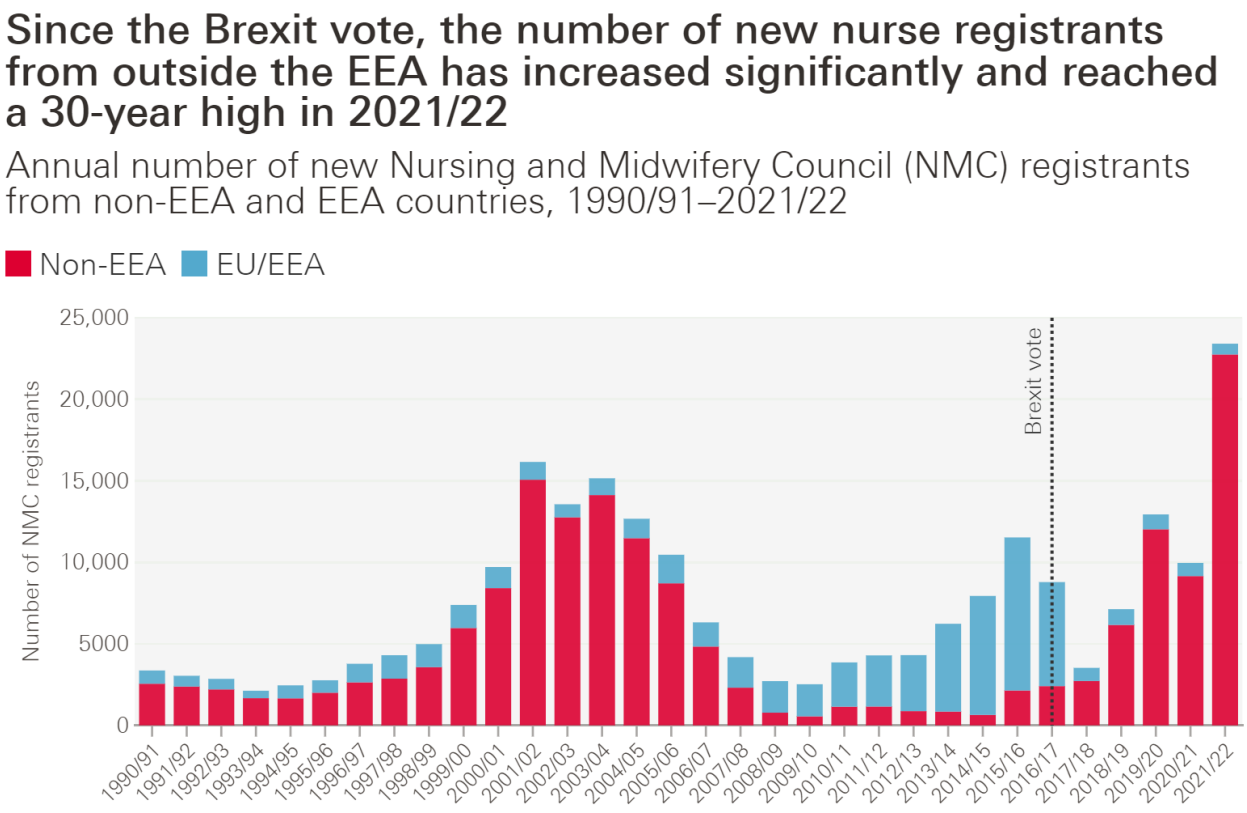
Though nursing graduates may initially experience higher median earnings than the overall median earnings of graduates of other subjects in the 5-year period after graduation, their earnings then fall below the overall median 10 years after graduation. Also, in the longer run, increased student nurse loan repayments and longer repayment periods could have a negative effect on both future recruitment levels and retention.

Growth in international recruitment

The second 'new' recruitment inflow – international recruitment – has also grown rapidly. Data from the Nursing and Midwifery Council (NMC) published in May 2022 pointed to a record annual high in the number of international nurses newly registering to practice in the UK (around 23,400). This largely reflects rapid sustained increases in the number of nurses from non-European Economic Area (EEA) countries newly registering with the NMC between 2014/15 (around 650) and 2021/22 (around 22,700, see Figure 6). Data from the Organisation for Economic Co-operation and

Development (OECD) on international comparisons align with these numbers, showing that the proportion of nurses trained outside the UK is higher than in many comparable OECD countries.

Figure 6



Source: NMC/UKCC data (including annual reports), authors' analysis.
EEA = European Economic Area

Given this increase in international inflow, and some growth in applicants to pre-registration education, nurse retention rather than recruitment is currently looming as the more immediate problem for NHS employers. It is likely to become even more challenging if the anticipated growth in outflow of nurses experiencing burnout and those nearing retirement materialises in the next couple of years.

Nurse retention and burnout

The NMC's recent register report highlighted that the number of nurses leaving its permanent register increased by nearly 3,000 in 2021/22, after having declined steadily between 2017/18 and 2020/21. NHS Digital data indicate that nurse and health visitor leaver rates declined from 9.8% in the year to December 2019 to 8.6% in the year to December 2020 (which includes the first phase of the impact of the pandemic), but then increased to around 10.1% in the year to December 2021.

A membership survey conducted by the RCN in October 2021 indicated that almost 6 in 10 of over 9,500 respondents (56.8%) were considering or planning leaving their current post (including planning for retirement). The main reasons given for thinking about leaving were feeling undervalued and feeling under too much pressure. Around 6 in 10 (62.7%) reported that their pay band or level was inappropriate. The main reasons for dissatisfaction were that pay levels had failed to keep up with increases in the cost of living; dissatisfaction with organisational pay structures; and perceived failure to reward nursing staff fully for their effort and contribution. The much larger NHS Staff Survey, conducted in 2021, reported that 40.5% of surveyed registered nurses and midwives felt burned out because of their work. Along with nursing and health care assistants, they were more likely to have worked in COVID-19 wards or areas than all other staff.

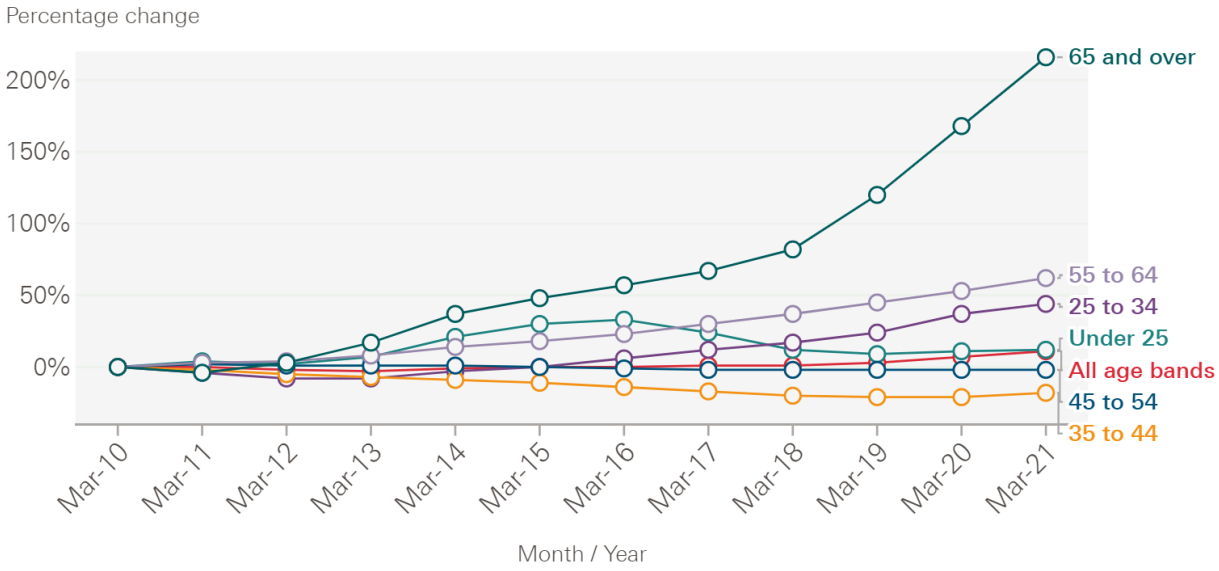
These data highlight the increasing difficulties in recent years of holding onto NHS nursing staff. This aspect of the overall pattern of nurse labour market behaviour may be more open to influence by pay increases and other policy adjustments, including fine-tuning pension contribution requirements.

The retention challenge is partly a function of the ageing workforce, with a higher proportion of registered nurses reaching potential retirement age, notably in NHS community nursing (Figure 7). It also partly reflects the impact of COVID-19. Over the past decade, the age profile of the nursing workforce has aged considerably. There are almost 20,000 more nurses aged 55 and older now than in 2010 – an increase of almost 70%. There are also far fewer nurses aged between 34 and 44, falling from almost a third of the nursing workforce to just a quarter over the decade. In the short term, the impact of the pandemic suppressed NHS nurse leaver and retirement rates, and increased 'return', as more nurses came back to the NHS or moved to work at the front line. However, in the longer term, the pandemic is likely to negatively impact on retention because of staff burnout, reduced hours and early retirement.

Figure 7

Over the past decade, the age profile of the NHS registered nurse workforce in England has aged considerably

Percentage change in NHS registered nurse and health visitor full-time equivalent numbers by age band relative to March 2011



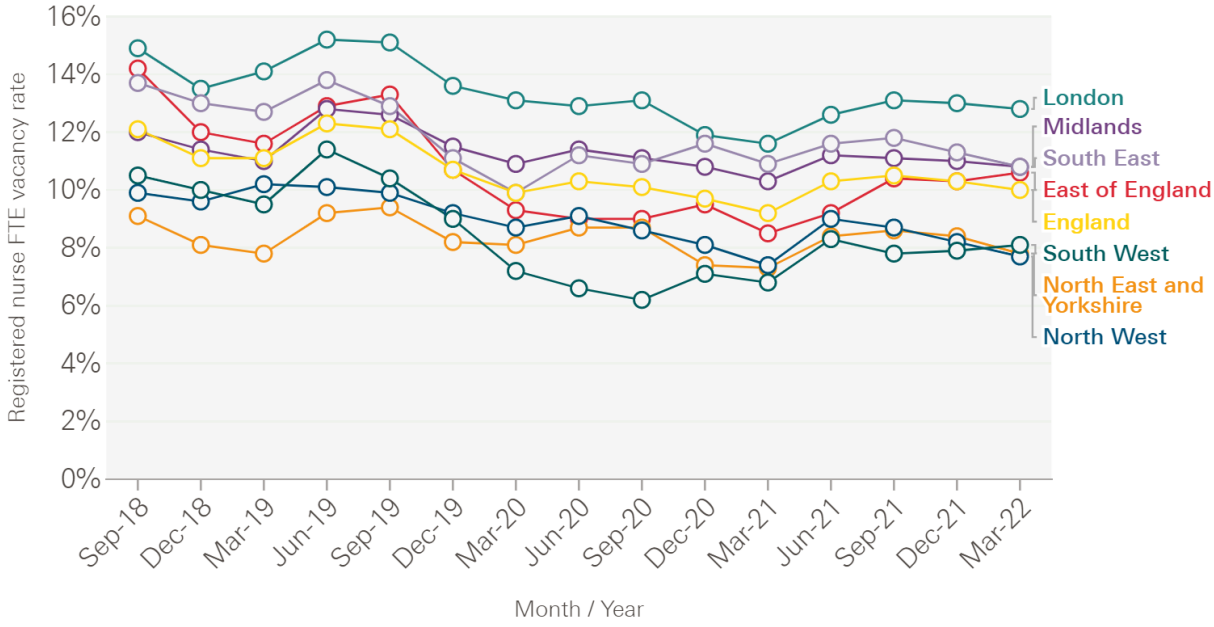
Source: NHS Digital, 2021

NHS registered nurse shortages pre-dated the pandemic, and have not changed markedly in the past 2 years, as measured by overall vacancies of around 10% (although the analysis shows variable impact across the NHS). There are marked regional variations in vacancy rates, with London and the South East reporting higher rates, of 12.8% and 10.8% respectively (Figure 8).

Figure 8

NHS nursing vacancy rates in England vary considerably across regions

Registered nurse full-time equivalent vacancy rates in the NHS in England by region (July–September 2018 to January–March 2022)



Source: NHS Digital, 2022

There has also been considerable change in FTE registered nurse vacancies by service area as a proportion of the total, which stood at 38,972 in the quarter to March 2022. (Table 1). There has been a particularly marked reduction in the proportion of overall vacancies accounted for within acute services, from 73% (28,981) in the quarter to March 2019 to 64% in the quarter to March 2022 (24,911). Relative to April–June 2018 levels, the percentage of NHS registered nurse vacancies in mental health services has increased by over 25%, accounting for 29% (11,239) of the total of FTE registered nurse vacancies in the quarter to March 2022.

Table 1: Registered FTE nurse vacancies by service area in England, percentages* and overall total (January–March 2019 to January–March 2022)

Service area	January–March 2019	January–March 2020	January–March 2021	January–March 2022
Overall total*	**39,524**	**36,083**	**34,678**	**38,972**
Acute	73%	68%	69%	64%
Ambulance**	-	-	-	-
Community	3%	4%	4%	5%
Mental health	21%	26%	24%	29%
Specialist	2%	3%	2%	2%

*The first row provides the absolute total number of FTE nurse vacancies.

** These numbers are less than 0.5% after rounding.

5. Valuing highly skilled contributions

Targeted pay for mid-to-late career NHS nurses?

In this section we move from examining pay and labour market trends to considering the options for making additional linkages between NHS nurses' pay and labour market priorities. Within tight overall national NHS pay bill control, is there scope to use pay in a more targeted approach, to address these variable but pronounced retention challenges? Can or should there be a focus on elements of the NHS pay approach being used to target regional variation in labour market characteristics, specialty variation, or other NHS nurse workforce characteristics?

Pay flexibilities can encompass additional incentives to work in a specific specialty, location, or even at a certain time of the day. The NHSPRB has previously called for unions and government to examine scope for extended use of targeted pay, albeit so far with limited success. It has also highlighted that some of the existing pay flexibilities – notably potential pay additions for 'hard to fill' posts covered by High-Cost Area Supplements (HCAS) – are not fully used because of funding constraints or lack of local management interest. There are also questions about which criteria to use to define 'high-cost areas', how to manage the labour market impact at geographical fault lines between designated and non-designated 'high-cost' areas, and possible unintended consequences when examined through the prism of the government's 'levelling up' regional agenda. There is also limited published evidence about the impact and effectiveness of supplements.

However, given the scale of the vacancy and retention problems in the NHS nurse workforce, there is a need for a more focused audit on the current pay structure for nurses, in order to examine the case for effective targeting. Such an audit should not be framed around trying to define 'geographical' regions or 'deserving' specialties, which are not easily delineated in a meaningful way, and which already have underused pay flexibilities in the current system.

Instead, the challenge is to retain highly skilled mid and late career registered nurses working in patient care, irrespective of geographical location or specialty. In its evidence to the NHSPRB this year (pp 56–58), the DHSC highlighted that around half of all staff are at the top of their Agenda for Change pay band – meaning they have run out of scope for incremental progression and are reliant on the annual pay uplift for any pay increase.

Many nurses are in this group and are in the high-risk category for early retirement or reduced hours, even though the NHS can ill afford to lose them. Higher potential earnings would also signal to early career nurses and potential recruits that there is more potential earnings growth than is currently the case.

Options for improving retention

One option could be to assess the potential (and cost) of 'stretching' the current pay bands in the Agenda for Change pay structure, where experienced clinical nurses are located – notably, bands 6, 7 and 8. Around 40% of NHS nurses are at the top of the main Agenda for Change pay bands. In the context of using pay as a retention lever, the starting salary for an NHS nurse is somewhat less of an issue than pay progression stalling after a few years. Nurses can reach the top of their pay bands within a few years, and the expectation of increased future earnings then tails off quickly.

Nurses' main scope for a pay increase, if they remain in post, is then the overall annual NHS pay uplift as recommended by the NHSPRB. To support retention, one option would be to apply a 'career retention enhancement' and broaden the number of individual nurses who can anticipate a longer period of progressive actual increases in their pay.

Gender and ethnicity pay gap concerns

There is another overlapping factor that needs to be urgently addressed. The DHSC in England has also highlighted concerns that 'Across all [Agenda for Change] staff there is some evidence of both a Gender and Ethnicity Pay Gap' (pp 76–77), with reports that a study is planned to better understand the ethnicity pay gap.

With more than 9 out of 10 NHS registered nurses being women, and with 28% reported to be of minority ethnic origin (pp 39–40) – the highest of any NHS staff group – there is clearly a need to assess and address any evidence of gender and racial discrimination in NHS nurses' pay. If the current pay system is found to be inherently discriminatory, action must be taken so that it is equitably structured and applied. Only then can pay be fully effective as part of a reward, retention and career development strategy.

6. Towards a more progressive pay system

In the short term, when assessing the scope for NHS nurses' pay to respond to labour market challenges, the obvious priority is to improve retention of experienced nurses. While pay is not the only solution to retention, the system should not shy away from assessing how increases in pay could be used to improve retention, and take any necessary action to deliver those changes.

There is clearly little appetite now among the main stakeholders for a substantive or radical overhaul of the NHS Agenda for Change pay system. And there are few funds available even if there were such interest in changing the system. However, there must be a better alignment of NHS staff pay and national NHS workforce policy and planning. The current disconnect serves none of the parties involved in the pay determination and workforce policy processes.

A prerequisite for change and three key implications

To support and enable progress in the longer term, and for a more progressive NHS pay system, there is a need to meet one prerequisite, and then to consider three main implications.

The prerequisite is for a fully effective and independent review body system, based on full commitment of all parties, including governments, to accept, implement and fund its recommendations in full. This has not always happened in the past, and as such risks marginalising and undermining the process, leaving a workforce policy vacuum.

Beyond this, the first element to consider for progressive change is that there should be an assessment of the scope to move to a standardised, multiple year pay determination cycle. This would probably cover 3 years, but with a clause to allow interim automatic inflation-related adjustment if a high inflation threshold was triggered. This would reduce the repeated short-term focus and free up space for more creative longer term thinking on NHS nurses' pay determination.

The second element is to ensure that the DHSC's proposed gender and ethnicity pay gap review is actioned rapidly. It should give full consideration to any inequities in the existing pay system for NHS nurses, and recommend any necessary changes to that system. Transparent pay equity is a vital part of any fully 'fair' approach to determining NHS nurses' pay that can support retention and career progression.

The third element is to give consideration to the current review body coverage across different occupations and professions. In essence, this is about creating policy and fiscal space for targeting and prioritisation (as we argued earlier with regard to experienced nurses), while maintaining fair national thresholds. The NHS Agenda for Change pay system covers more than 1 million FTE staff, many of whom have professional skills and qualifications that are specific to the health sector, while others have skills and qualifications that can transfer readily to other sectors. These staff work in a

variety of workplaces and regions with different costs of living and different levels of apparent 'attractiveness' to staff, as indicated by differing vacancy rates.

There are advantages to such a single system-wide pay structure: it is relatively easy to maintain; it offers scope for overall pay bill control; it provides a national career structure; and it hugely reduces the need for local management to devote time and effort to pay negotiations. Crucially, as stressed earlier, it can be underpinned by an 'independent' process focused on the NHSPRB. The potential disadvantage is that any pay increase that is targeted – that is, anything other than a simple 'across the board' increase for all staff – risks creating internal problems. It could also have implications for internal pay differentials, and have unintended external labour market and cost consequences.

In the introduction, we noted that the NHSPRB is a unique pay determination model. Nurses' pay determination in other comparable high-income countries, with the exception of the United States, tends to be based on municipal, regional or national collective bargaining that sets pay baselines, in many cases with scope for regional adjustment and top-up (as in Australia and Canada, for example). Previous attempts to 'regionalise' or localise NHS pay determination faltered, partly because the focus was on replacing the national system with localised approaches that would require local funding mechanisms and increased local pay determination capacity. As we have argued, the alternative approach – to optimise the use of high cost-of-living supplements and other pay flexibilities within a maintained national framework – may be more achievable.

Moves to support an approach that fully enables the current under-utilised pay flexibilities should be prioritised. This would focus on greater flexibility within a national framework that had been 'priced' by the NHSPRB.

Where to start?

The starting point for longer term improvements in NHS pay processes should be for the NHSPRB to commission an impact assessment by main staff group. This would form part of the overall focus on agreeing how best to maximise pay flexibility, target enhanced pay rates for experienced staff, and function within a fully funded system that has a 3-year default cycle.

There is a need to break the short-term narrow annual focus on 'how much' NHS nurses' pay should increase each year. We need to take a longer term perspective that reflects both external trends in the labour market and internal career structure priorities. This would enable pay to be used as an effective policy tool for years to come, linked to the overall NHS workforce strategy.

7. Supporting information

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