

INNOVATIONS IN PAY AND GRADING IN NHS TRUSTS

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Table of Contents

| | |
|---|----|
| Executive Summary | i |
| Overview | 1 |
| PART ONE: THE LITERATURE | 2 |
| 1.1 INTRODUCTION | 2 |
| 1.2 PAY IN THE PUBLIC SERVICES: THE CONTEXT | 2 |
| 1.2.1 The Conservative years 1979-1997 | 2 |
| 1.2.2 New Labour 1997-2001 | 3 |
| 1.2.3 School teachers | 4 |
| 1.2.4 Civil Service | 4 |
| 1.2.5 Universities | 5 |
| 1.3 LOCAL GOVERNMENT | 6 |
| 1.3.1 Background | 6 |
| 1.3.2 The 1997 agreement | 7 |
| 1.3.3 Reasons for slow progress | 8 |
| 1.3.4 Implications for the NHS | 10 |
| 1.4 THE NATIONAL HEALTH SERVICE | 11 |
| 1.4.1 Background | 11 |
| 1.4.2 The Whitley system | 12 |
| 1.4.3 Critiques: structure | 13 |
| 1.4.4 Critiques: complexity | 14 |
| 1.4.5 Critiques: centralisation | 15 |
| 1.4.6 Equal value | 16 |
| 1.4.7 The internal market and devolved bargaining | 16 |
| 1.4.8 Agenda for Change | 17 |
| 1.5 DEBATES AND ISSUES | 18 |
| 1.5.1 Reward management and 'new pay' | 18 |
| 1.5.2 Best fit or best practice? | 18 |
| 1.5.3 Fixed or variable pay? | 18 |
| 1.5.4 New forms of pay progression | 19 |
| 1.5.5 Equity and equality | 22 |
| 1.5.6 Harmonisation | 23 |
| 1.5.7 Variable hours | 24 |
| 1.5.8 Determining pay: a wider picture | 25 |
| 1.6 SUMMARY | 26 |
| PART TWO: ANALYSIS | 28 |
| 2.1 INTRODUCTION | 28 |
| 2.2 THE RESEARCH | 28 |
| 2.2.1 The research questions | 28 |
| 2.2.2 Methods and sample | 29 |
| 2.2.2.1. The case study trusts | 29 |
| 2.2.2.2 Documents | 32 |
| 2.2.2.3 Interviews | 32 |
| 2.2.3 Summary | 35 |
| 2.3 THE FINDINGS | 35 |
| 2.3.1 Trust aims and objectives | 35 |
| 2.3.2 Pay systems | 37 |

| | |
|---|----|
| 2.3.2.1 Coverage: eligibility and take-up | 37 |
| 2.3.2.2 Grading structure | 38 |
| 2.3.2.3 Terms and conditions: incorporation | 40 |
| 2.3.2.4 Terms and conditions: harmonisation | 42 |
| 2.3.2.5 Settlements | 43 |
| 2.3.2.6 Market supplements | 43 |
| 2.3.3 Pay progression | 43 |
| 2.3.3.1 Basis | 43 |
| 2.3.3.2 Consolidation? | 45 |
| 2.3.3.3 Procedures | 46 |
| 2.3.3.4 Distribution of awards | 46 |
| 2.3.3.5 Discrimination in performance | 47 |
| 2.3.4 Process | 48 |
| 2.3.4.1 Union involvement | 49 |
| 2.3.4.2 Management consultants | 52 |
| 2.3.4.3 Staff involvement | 52 |
| 2.3.4.4 Time | 52 |
| 2.3.5 Costs | 53 |
| 2.3.5.1 Stakeholder perceptions | 53 |
| 2.3.5.2 Development costs | 53 |
| 2.3.5.3 Assimilation costs | 54 |
| 2.3.5.4 On-going paybill costs | 55 |
| 2.3.6 Evaluation | 56 |
| 2.3.7 Outcomes | 58 |
| 2.3.7.1 The stakeholders | 58 |
| 2.3.7.2 Working practices: temporal flexibility | 59 |
| 2.3.7.3 Working practices: functional flexibility | 60 |
| 2.3.7.4 Employment data | 61 |
| 2.3.7.5 Patient outcomes | 64 |
| 2.3.7.6 Staff views | 65 |
| 2.3.7.7 Union views | 67 |
| 2.3.7.7.1 General | 67 |
| 2.3.7.7.2 Performance pay | 68 |
| 2.3.7.7.3 Remuneration | 68 |
| 2.3.7.7.4 Partnership | 69 |
| 2.3.8 Summary | 69 |
| 2.4 DISCUSSION AND CONCLUSIONS | 70 |
| 2.4.1 Research question one | 70 |
| 2.4.1.1 Structure | 70 |
| 2.4.1.2 Complexity | 71 |
| 2.4.1.3 Centralisation | 71 |
| 2.4.1.4 Equal value | 72 |
| 2.4.2 Research question two | 72 |
| 2.4.3 Research question three | 73 |
| 2.4.3.1 Pay strategies | 73 |
| 2.4.3.2 Variable pay | 73 |
| 2.4.3.3 Grading structures | 74 |
| 2.4.3.4 Variable hours | 75 |
| 2.4.4 Research question four | 75 |
| 2.4.5 Final comment | 77 |
| Glossary | 78 |

| | |
|------------------|----|
| Appendix A | 80 |
| References | 81 |

Tables and Figures

| | |
|---|----|
| Table 1.1: NHS Hospital and Community Services: directly employed staff | 11 |
| Table 2.1: Trusts by NHS region, type and size | 29 |
| Table 2. 2 Documents | 33 |
| Table 2.3: Fieldwork | 34 |
| Table 2.4: Trust pay arrangements by coverage | 38 |
| Table 2.5: Harmonisation by trust | 42 |
| Table 2.6: Process by trust | 51 |
| Table 2.7: Costs of introducing new pay system by trust | 57 |
| Figure 1.1: The three 'rings' of pressures shaping change in pay practices (Grimshaw, 2000) | 25 |
| Figure 2.1: Trusts' changes to pay by staff coverage | 31 |
| Figure 2.2: Departure from Whitley banding by trust | 40 |
| Figure 2.3: Degree of union involvement by trust | 50 |

Executive Summary

A. The scope and objectives of the research

This report examines innovations in pay and grading in 10 NHS trusts in England using data collected from March 2000 to January 2001, ie prior to the implementation of *Agenda for Change*. These 10 trusts, which varied in size, function, and location, were selected primarily to illustrate a variety of different approaches to pay and grading. The research utilised a qualitative methodology, with interviews of managers on a one to one basis, group interviews with lay union representatives, focus groups with staff and the inspection of documents. This study focused on four questions:

- Did local pay resolve the problems associated with Whitley?
- What were the consequences of local pay?
- Were the trusts' pay systems introduced in line with 'new pay' ideas and current trends in reward management?
- What factors were critical to the success of developing and implementing local pay systems in NHS trusts?

B. Background

The data on pay and grading in NHS trusts was placed in context by reviewing pay arrangements in the public services. In the civil service decentralised collective bargaining is well established with pay progression essentially based on performance; but the amount and form of performance rewards were being re-examined, with team bonuses being considered. In the universities an independent review (Bett, 1999) proposed wide ranging reforms to both bargaining structures and pay systems to address long- standing gender inequality issues but at the time of writing there had been little progress on the review's recommendations. In local government a new national level 'single status' agreement was concluded in 1997. The agreement gives local authorities considerable discretion. For instance they can choose a job evaluation system and determine a range of premium payments, but there has been slow progress on implementation.

To inform further our answers to the research questions, the report also reviewed the criticisms of Whitley and the debates and issues surrounding the choice and application of pay systems, in particular the 'new pay' and reward management literature.

C. Findings

Aims and objectives

Management aims could be categorised as value driven or issue driven. The former included such objectives as fairness, simplicity, equity and enhanced patient care. The latter included recruitment and retention issues. Trusts adopted a values based, strategic approach where they were proposing to introduce pay changes for a

significant proportion of their workforce throughout the organisation. Conversely, where trusts were proposing to introduce pay changes for a discrete area only, issues driven approaches were adopted. The need to manage performance was often not an espoused aim, but interviewees suggested that it formed at least part of the rationale for pay changes.

Pay systems

The extent to which trust employees were eligible for local pay systems varied. At one trust none were eligible as the trust adhered to the national arrangements. On the other hand in three trusts all non-medical staff were eligible and in the remaining trusts discrete occupational groups only were eligible for the new arrangements. Take-up rates among eligible staff also varied, from 25% to virtually 100%.

Four out of our 10 trusts used Medequate job evaluation, one trust used Hay and another introduced 'recruitment clusters' based on a competency grading system. The remaining trusts based their new grading systems on the national grading system with changes to suit their circumstances. Three of the trusts using job evaluation adopted single pay spines, which managers saw as enhancing teamwork and providing a defence against equal value claims. Only one trust introduced a very broad banded structure with no pay maxima to grades, only pay minima. Most trusts which introduced their own pay systems ended up with grading structures which were little different from the national grading structures either in theory or in practice.

Basic pay apart, four of our trusts did not move away from the national terms and conditions. Turning to those that did, significant features were the incorporation of unsocial hours premia into basic pay and harmonisation of unsocial hours premia, overtime, working hours (37.5 per week) and on call payments. Of all the major conditions annual leave was the least likely to be harmonised, essentially for pragmatic reasons, ie the costs involved in harmonisation.

Pay progression

Performance related payments were made for at least some staff in nine of our 10 case study trusts but only in one was performance related to the organisation as a whole. In all the other trusts, performance related to the individual but there was variation as to whether the individual's performance was measured by behavioural and/or clinical attributes, with some trusts developing competencies. As to how the payments were made, the majority of trusts made payments on an incremental, consolidated basis. Two trusts employed a mixture of consolidated and non-consolidated increases and one trust gave non-consolidated bonuses only to staff at the top of their grade, with service related increments within grade.

There was a wide variation in the extent to which trusts' performance pay systems discriminated between employees' performance. For example, at one end of the spectrum nurses and midwives at one trust could receive 10 possible levels of award ranging from 0 to 6%. Within the spectrum, in three trusts a performance award was withheld from around 10% of employees. At the other end of the spectrum, in three trusts the performance award, equating to a service related increment under Whitley, was not normally withheld.

Process

The unions did not favour any departure from national pay arrangements. Given that general stance they adopted three main approaches: in five trusts there were management/union agreements on the new pay system and negotiations and agreement each year on the annual review; at three trusts there were management/union discussions prior to the introduction of a new pay system, but not agreement, though subsequently there were negotiations and agreement on the annual increase; at two trusts there was no discussion before the introduction of a new pay system, but subsequently there were negotiations and agreement on the annual increase. As to staffs' views, five trusts held focus groups of staff to elicit views about the future shape of a pay system or to help to compile competencies.

Costs

Management time in developing a pay system was hard to quantify, especially where managers incorporated pay development and implementation into their other duties. Three trusts, however, introduced a new full-time post. Assimilation costs ranged from nil to 3.5% of the paybill and depended on a number of factors, including the extent to which the new pay system differed from national arrangements and whether the trust, wishing for a high take-up rate initially, offered generous incentives to transferring staff.

Outcomes

Our data revealed that eight of the 10 case study trusts took the opportunity of changes to pay systems to introduce rotating shifts, new on-call arrangements or annual hours. Managers were of the view that such new working patterns, underpinned by revised payment systems, enabled them to meet service needs more effectively. The main area where the pay system was used to support multi-skilling was in theatres. ODPs/ODAs and theatre nurses were placed on a new and common pay system (instead of two separate sets of national arrangements) and at the same time were trained to provide functional flexibility.

There was a paucity of evaluation conducted by trusts. Where evaluation took place it was often small in scale, eg evaluation of a pilot. Moreover, although trusts collect data on labour turnover and sickness absence and now carry out an annual staff attitude survey, none compared those on the national arrangements with those on the trust's pay system. This limited the usefulness of such data for the purposes of this study.

With this important caveat, we examined labour turnover data. It did not indicate that new pay systems had had any noticeable positive or negative long-term effects. The sickness data examined, however, indicated that the introduction of a new pay system had, in a few trusts, gone hand in hand with a reduction in sickness absence, though this did not necessarily equate to a causal link.

As to patient outcomes, the link between pay systems and three NHS performance indicators (emergency re-admissions, deaths within 30 days of surgery after emergency and non-emergency admissions) were explored but no clear relationship

was found. Many management interviewees, however, and some staff, were strongly of the view that their new pay systems had led to an improvement in patient care.

D. Conclusions

Our literature review indicated that managers identified three problematic areas in Whitley: the Whitley Council structure, the complexity of the numerous collective agreements and the high degree of centralisation. Another problem, equal value, was revealed in the litigation stemming from *Enderby v Frenchay Health Authority* (1993).

Our data showed that where the case study trusts made innovations in pay and grading the bargaining structure was greatly simplified both on the management side and the union side. Also, in a number of trusts collective agreements were simplified. Other trusts, however, introduced a number of pay systems for different occupational categories and/or departments in the trust and this resulted in considerable complexity, compounded in one case by a merger. Another source of complexity was the pay progression arrangements. Eight out of the 10 trusts studied had replaced service related increments with performance based pay progression arrangements. As to centralisation, interestingly only in three trusts were the majority of employees covered by pay arrangements which materially differed from the national arrangements. This suggested that managers on the whole did not necessarily make use of the pay flexibility provided to them. Moreover, only three trusts introduced job evaluated single pay spines which could obviate equal value problems for employees in the same employment.

We also examined the consequences of local pay. On the one hand, interviewees highlighted benefits for the service, especially where new pay arrangements supported changes in working hours and/or multi-skilling. On the other hand, local pay arrangements were not unproblematic. Where the new pay system included an opaque system of performance related pay which made fine distinctions between staff there was both union hostility and staff dissatisfaction.

The 'new pay' and reward management writers recommend a strategic approach to pay, ie that there should be a link between pay and business strategy. Our data, however, indicated that only four of our 10 trusts adopted a strategic approach, while a further three trusts planned to take an organisation-wide approach but in the event did not do so. The 'new pay' writers also recommend that pay be based on the individual (for example, by performance pay), rather than a rate for the job. Nine out of our 10 case study trusts introduced at least an element of performance related pay, though the rhetoric of performance pay was not always translated into reality and only in one trust was the annual increase entirely based on performance.

As to grading structures, our data contrasted with the views of American 'new pay' writers that job evaluation is in decline and that broad banding is on the increase. Five trusts used job evaluation and there was only limited evidence of broad banding. An area where our data accorded with current trends in reward management, however, was harmonisation, with single pay spines in three trusts and harmonisation in respect of terms and conditions, apart from pay, in six out of the 10 case study trusts. We also found examples of trusts introducing variability in the weekly amount or timing of employees' hours, while keeping constant employees' pay.

Finally, factors critical to the success of developing and implementing new pay systems were considered and the following conclusions were drawn from our data:

- A close working relationship between management and the staff side at trust level eased the development and introduction of local pay regimes.
- Trust managers said that the process of introducing a new pay system was more time consuming than they had anticipated and three trusts created new full-time posts to develop and implement local pay regimes.
- Liaison with employees, for instance on assimilation arrangements and the drawing up of competencies, engendered the confidence of staff and unions who mistrusted complex and opaque performance pay systems.
- Harmonisation of terms and conditions, as well as being perceived by management, unions and staff as equitable, also contributed to improvements in functional flexibility and teamworking.
- Management considered that the subsuming of certain premium payments into basic pay served to underpin temporal flexibility and staff welcomed the ensuing stability in earnings.
- Our focus groups of staff were of the view that pay systems must be considered alongside a number of other factors, particularly career development arrangements and pay levels.

OVERVIEW

This report focuses on innovations in pay and grading in 10 NHS trusts in England prior to the implementation of *Agenda for Change*. Our approach utilised a case study methodology. The research questions (stemming from our original proposal, see Appendix A) were:

- Did local pay resolve the problems associated with Whitley?
- What were the consequences of local pay?
- Were the trusts' pay systems introduced in line with 'new pay' ideas and current trends in reward management?
- What factors were critical to the success of developing and implementing local pay systems in NHS trusts?

This report is organised in two parts. Part one reports the background literature, placing our data in context by reviewing the state of play in the public services and specifically local government and the NHS. The literature review also addresses the debates and issues surrounding the choice and application of pay structures. These served to prompt our research questions. Part two provides an account of our empirical work. Analyses are organised around several key issues, including trust aims and objectives, pay systems, pay progression arrangements, the process of developing and implementing trust pay and outcomes. We end by drawing together our findings and the current literature, presenting key conclusions and pointing to critical success factors.

PART ONE: THE LITERATURE

1.1 Introduction

Over the last two decades there have been major changes in the way in which employees' pay and grading is determined in the UK. These developments have been driven by both economic and political changes and have affected the private and public sectors. In this literature review we provide a context for our research on innovations in pay and grading in the NHS. The review is organised into sections. In section 1.2 we examine changes in public sector pay generally. In sections 1.3 and 1.4 we take a detailed look at local government and the NHS respectively. In section 1.5 we consider the theoretical debates and issues in what has become increasingly known as reward management.

1.2 Pay in the public services: the context

1.2.1 The Conservative years 1979-1997

The Conservative government elected in 1979 was in power for a substantial enough period to have had a significant effect upon employment policies in a way that few post-war governments have had. Essentially in 1979 it abandoned the use of incomes policies to control wage and price inflation in favour of a market approach. For instance, Mr Kenneth Clarke, when Minister of State for Employment, said in 1987:

We must move towards a system more clearly based on market forces, on demand and supply, on competition and on ability to pay... If we can move to a system where pay increases are primarily based on performance, merit, company profitability and demand and supply in the local labour market, we will dethrone once and for all the annual pay round and the belief that pay increases do not have to be earned (cited in Kessler and Bayliss, 1998:223).

The Conservative government, as the direct or indirect employer, was able to influence the pay arrangements for public sector workers in line with this approach. For instance, it gradually introduced performance related pay into the civil service and for senior managers in the NHS in the 1980s. Then in the 1990s performance related pay became a feature in the bespoke pay systems developed by some NHS trusts and in a significant number of local authorities, at least for senior managers. It also replaced collective bargaining for certain public sector workers with determination by pay review bodies: nurses and professions allied to medicine in the NHS and school teachers in England and Wales (White, 2000). The coverage of the Senior Salaries Review Body was also extended to cover grade 5 civil servants (Cabinet Office, 1994).

Furthermore, from 1996 the Conservative government replaced national pay determination for all civil servants (except the most senior) with department/agency pay determination in an attempt to ensure that pay rates more accurately reflected specific labour market needs rather than the many and often conflicting needs of the civil service as a whole (Cabinet Office, 1994; Corby, 1998). Similarly it encouraged local bargaining in the NHS in 1995-96 in an attempt to ensure that pay reflected local labour market conditions (Corby, 1996). In addition, especially in the tight labour market generated by the economic boom of the late 1980s, it reacted to labour market

pressures by awarding special pay additions to public sector workers in short supply, rather than increasing pay more generally (White, 1996).

The economic downturn of the early 1990s led the then Chancellor of the Exchequer, Kenneth Clarke, to impose a pay limit of 1.5 % in the public sector, followed by a freeze on pay budgets for the subsequent three years. Under this pay policy any increases for public sector workers had to be funded through efficiency or other savings (IDS, 1993).

1.2.2 New Labour 1997-2001

Initially New Labour continued with its predecessor's public sector pay policy. It sought to ensure that all pay increases in the public services were self-financing. In 1998, the first year in which the new government considered the recommendations of the pay review bodies, the awards were accepted but staged, reducing the overall cost. In the subsequent three years, however, it implemented in full the pay review body recommendations.

Over the period from January 1998 to September 2000 public sector earnings, as measured by the monthly Average Earnings Index, continued to run below the level in the private sector. A more reliable measure, the annual New Earnings Survey, indicates that average weekly earnings in the public sector stood at £394.40, compared to £412.30 in the private sector in April 2000 (ONS, 2000). Pay dispersion is much narrower in the public sector than in the private with lowest decile workers having higher pay in the public than the private sector. In contrast, highest decile workers have higher pay in the private sector than in the public sector.

The government, in its white paper *Modernising Government* (Cabinet Office, 1999a), laid down its main political objectives for the public services. In respect of public sector employees, it undertook to revise performance management arrangements and tackle the under-representation of women, ethnic minorities and people with disabilities. Also, the government, in contrast to its predecessor, said that 'we will continue to work closely with the public sector trade unions to achieve our shared goals of committed, fair, efficient and effective public services' (Cabinet Office, 1999a: 62). In addition it said: 'Public servants must be rewarded fairly for the contribution they make. We must make sure that our approach to pay encourages more of the best people to join and stay' (Cabinet Office 1999a:58). The government then listed four ways in which this objective could be achieved:

- the reform of 'outdated' systems, including challenging the 'idea that "fair pay" means that everybody should get the same increase, or that pay and conditions should all be set nationally';
- revising pay scales and grading systems to deal with recruitment and retention problems for certain key groups of staff such as teachers and nurses so that 'more skilled people can stay in the front line';
- making best use of non-pay incentives, for example better training and development opportunities, good career prospects, family friendly policies and employee recognition schemes;

- rewarding results and performance. 'A person's pay should reflect their output, results and performance... We should challenge systems which give automatic pay increases to poor or inefficient performers';

(Cabinet Office 1999a: 59).

1.2.3 School teachers

This overarching policy was translated somewhat differently in each public service, in part according to its history and political salience. An example of New Labour's objective of rewarding results and performance and its objective of revising pay scales to deal with recruitment and retention problems of key staff can be found in the proposals for individual performance-related pay for school teachers. The government proposed a new nine point scale for classroom teachers based on annual increments with a performance threshold which would trigger an immediate £2,000 increase with a further five performance-related pay points on top of the nine point scale. Teachers with management or other additional responsibilities would receive special allowances (Department for Education and Employment, 1998).

The additional increments were to be paid from September 2000 but the government's plans were temporarily thrown into disarray in July 2000, when the National Union of Teachers successfully challenged the performance scheme in the courts. This is because, unlike other UK public servants, any changes to the pay of school teachers in England and Wales must be approved by Parliament but this had not been done. Subsequently the Secretary of State asked the pay review body to consider the performance pay scheme, which then went ahead with additional government funding (Department for Education and Employment, 2000).

1.2.4 Civil Service

The Conservative government, as noted above (see sub-section 1.2.1), had made significant changes to civil service pay, introducing individual performance related pay and replacing national level bargaining with bargaining by department/executive agency. Thus Labour's espoused policies of rewarding performance, reforming 'outdated' systems and revising pay scales to deal with recruitment and retention problems would seem already to have been realised. Problems, however, remained, mainly centred on pay progression arrangements. The Cabinet Office has recognised the fact that in many departments and agencies the size of the performance-related pay increase is insufficient to motivate staff (IDS, 2000:35). It said:

Performance related pay needs to take its place in a culture of proactive management. We need to be clearer about what we actually want from performance related pay and how that can be achieved within the financial constraints which will continue to exist' (Cabinet Office 1999b:13).

As a result, departments and agencies are reviewing their performance management structures, with a view to introducing new pay and appraisal systems from April 2001.

A parallel review of civil service performance pay was undertaken by the Public Services Productivity Panel in the Treasury, led by John Makinson, Group Finance

Director of Pearson plc. It looked at four major civil service departments and proposed that:

- unconsolidated merit bonuses should replace the current consolidated performance increases,
- performance should be measured against operational targets, rather than against individual appraisal results, and
- team based bonuses, based on efficiency savings, should be used instead of individual performance pay for most civil servants,

(Makinson, 2000).

At the time of writing these proposals had yet to be accepted though one department (Customs & Excise) was conducting some pilots of team bonuses.

1.2.5 Universities

In the universities (which strictly are not part of the public sector) there are a number of pay related problems. First, since the transformation of the previously local government controlled polytechnics into 'new' universities in 1992, there has been a single system of higher education with one employers' organisation but two sets of negotiations for 'old' and 'new' universities, each with their own settlement dates. Amalgamation of the two separate negotiating machineries has been long overdue. Second, there are continuing equal value problems (Bett, 1999).

An independent review, chaired by Sir Michael Bett, recommended that higher education should retain a broad national framework for the determination of pay and conditions of service, but with freedom within the framework for individual institutions to adapt the detail (Bett, 1999). It also recommended that:

- The present 10 separate negotiating groups (six bargaining groups in 'old' universities in England and Wales, three groups in 'new' universities in England and Wales and one group in Scottish universities) should be replaced by a single National Council with an independent chairperson and secretariat.
- There should be two closely related pay spines: one for academics (teachers, research and academic related staff) and one for non-academic staff (ancillaries, administrative and technical staff), with a common settlement date for all groups.
- Pay progression for academic staff should be based on length of service (up to four years), relevant qualifications, additional responsibilities, and merit and achievement.
- Pay progression for non-academic staff should be based on merit and achievement, responsibilities and acquired competencies, as well as experience gained in the first few years of service in a grade.

- A new job evaluation scheme should be introduced to remedy gender inequalities for which funding by central government would be necessary. The committee estimated that the paybill increases necessary would be about 9% for academic staff and around 8% for non-academic staff.

In February 2000, it was agreed in principle that three joint working parties should be established to deal with new national bargaining machinery, equal opportunities and casualisation (NATFHE, 2000:1). Following the ending of a dispute over the 2000 pay awards in universities and as part of those settlements, it was agreed at the beginning of 2001 that the joint working party on equal opportunities should go ahead forthwith.

The so-called Russell Group of elite universities, however, that hope to create a British 'Ivy League', have made it clear that they wish to make pay and conditions much more dependent on market principles. They want lecturers' salaries and conditions to be priced according to scarcity, performance and demand. The government, as part of an injection of money into higher education, has asked all universities to devise pay schemes, essentially in accordance with the Russell Group approach, for consideration by the Higher Education Funding Council (Kelly, 2000). Whether national level bargaining can withstand these pressures is an open question.

1.3 Local government

1.3.1 Background

While the NHS has not yet agreed a new pay structure, local government did so with effect from 1997. Local government in England and Wales employs 1.2 million people (excluding teachers) and has a paybill of £13 billion¹. There are 410 local authorities each employing from a few hundred staff to tens of thousands (White and Hutchinson, 1996). These differences in size reflect geographical size to some extent, but also the range of services provided. The largest employers are the large metropolitan city authorities and the London boroughs, followed by the county councils and unitary councils. The district councils, while most numerous, are the smallest, as they employ relatively few occupational groups.

Local government is funded both by central government grants (which provide around 80% of the total) and by its own revenue, raised through the council tax. It, therefore, has a degree of financial independence and a wide scope in employment matters compared to central government. Most local authorities, however, since the Second World War, have followed the various national agreements on pay and conditions. In the 1980s a small number of local authorities, largely small district councils, opted out of the national agreements to establish their own terms and conditions (Griffiths, 1990; Bryson et al, 1993) at least for some of their staff. In many cases these opted out councils used the opportunity to introduce performance related pay schemes and new job evaluation systems (IDS/KPMG Peat Marwick McLintock, 1988; IDS/Coopers and Lybrand, 1989).

¹ Information provided by a press officer in the Employers' Organisation, January 2001.

The 1997 agreement was not the first major new deal in local government in recent years. In 1987 the local government employers and the unions representing manual workers concluded an agreement. The job evaluation (JE) exercise, conducted by a joint management/union team, led to the creation of a new six grade structure for manual workers (IDS, 1987). Certain 'plus rates' paid for particular duties were also consolidated. The national job evaluation scheme adopted was points-based, with eight weighted factors, which allowed each job to be evaluated at local council level. A key concern was equal value and the JE scheme's factors covered all aspects of manual workers' tasks, not just the traditional factors of educational/training attainments and strength (IDS, 1987; IRS, 1987; Hastings, 2000). Accordingly, it resulted in the moving of some female jobs to higher grades.

The agreement, however, whilst it dealt with basic pay rates, did not tackle the fact that male manual workers typically receive bonuses and female manual workers, eg cooks, do not. According to a survey of manual workers' pay by the local government employers in 1996, 57% of men received bonus payments compared to only 7% of women (cited in IDS, 1999:91). The 1987 agreement also included a commitment in the longer term to harmonisation with white collar staff. The creation of the trade union, Unison, in 1993 (Certification Officer, 1994), which brought together both manual and non-manual local government employees, gave added impetus to this commitment.

1.3.2 The 1997 agreement

The 1987 agreement was superseded by the 1997 so-called single status agreement, which brought together the two largest bargaining groups, the manual workers' national joint council (NJC) and the administrative professional, technical and clerical (APT & C) NJC, establishing a single pay spine and harmonising working hours. The culmination of several years of negotiations, the agreement maintains a national framework for pay determination but in response to employer demands, allows more local flexibility than hitherto at individual council level. The agreement, however, does not cover a number of small bargaining groups such as chief executives, chief officers and various specialist education groups and maintenance crafts, who retain their own agreements.

The major objectives of the new pay system are threefold: to address a longstanding issue of fairness or 'equity' between the terms and conditions of manual and non-manual workers; to address problems of equal value, especially in bonus schemes; and to allow employers more local flexibility in grading, pay progression systems and terms and conditions (IDS, 1998). The agreement provides for:

- the creation of a single integrated 49 point pay spine for both manual and non-manual employees,
- a standard 37 hour week for all employees from 1 April 1999,
- a new national job evaluation scheme with the encouragement of local grading reviews,

- the ability to modify certain conditions of service by local negotiation, (particularly unsocial hours premia),
 - the ability to grade staff on a single point or a scale,
 - the ending of subsistence allowances,
 - the ability to average hours over a longer period than a week,
 - the handling of grading appeals locally rather than at provincial level as before, and
 - clearer provisions on the suspension of sick pay,
- (National Joint Council, 1997).

1.3.3 Reasons for slow progress

Progress with implementation of the local authority agreement has been slow for four main reasons: structure, local flexibility, cost and management/union relations. Dealing first with structure, local authorities have a degree of independence, as noted in sub-section 1.3.1. They come together voluntarily and do not have to follow the national agreements, though most do so, and were able to use the national pay spine flexibly before the 1997 agreement (IDS/KPMG Peat Marwick McLintock, 1988). There is a national employers' organisation and provincial councils but, unlike the NHS, there is no direct involvement in national negotiations by central government (White and Hutchinson, 1996). As a result, there is no hierarchical structure to ensure implementation locally.

As to local flexibility, councils have considerable choice within the national agreement. For example they are free to choose either the bespoke National Joint Council (NJC) JE scheme or some other scheme. The unions favour the use of the NJC scheme but some councils have chosen to use Hay, the Greater London Employers' scheme or some other patented scheme. In some cases councils, which had opted out of the national agreement prior to 1997, had already adopted new JE schemes. Councils are also free to design their own grading systems, although they 'must be fair and non-discriminatory, complying with equal pay legislation and associated Codes of Practice' (National Joint Council, 1997: 2.3). This allows the number of grades to differ from council to council, unlike the previous recommended national grades (IRS, 1998b).

Although by 1999 more than 110 councils had agreed to use the new NJC scheme, (out of 191 that had decided on a JE scheme), only a handful had actually begun the process of evaluation and even fewer had completed it (Employers' Organisation, 1999). A year later, progress continued to be slow. An IRS survey of 98 councils, employing 58% of the 1.2 million employees covered by the agreement, found that by July 2000 only seven respondents (six district councils and one county council) had carried out job evaluation and put a new harmonised pay structure in place. The survey also found, however, that 71% said that they had decided on which job evaluation scheme to use (IRS, 2000). At the time of writing not a single large

metropolitan authority had completed the exercise. Small district councils have made most progress, essentially because they employ few manual workers and relatively few occupational categories, so harmonisation is simpler. One large council which has completed the introduction of the NJC job evaluation scheme is West Sussex County Council, which implemented a 12-grade structure. A major impetus in that local authority was the outcome of an equal value case.

Another key area where there is flexibility relates to terms and conditions outwith pay. The national agreement provides for local negotiation over the unresolved issues of shift payments, unsocial hours payments, most standby allowances and the bonus scheme for manual workers (IDS, 1998:83). The only national conditions remaining are sick pay and car allowances, although the NJC continues to set working time premia (eg overtime and shift allowances for those who have not adopted local conditions). Local authorities, charged with resolving such important issues locally, have not been able to implement the new pay system easily or quickly.

The third reason for slow progress relates to cost. As discussed in sub-section 1.3.1 local government finance comes from both central government grants and the local authority's council tax. There is no specific allocation of central government funds for pay costs and councils set their own staffing levels and pay budgets. This means that councils have to meet any costs of the new agreement from their own budgets. The agreement provided for the harmonisation of working hours at 37 hours per week and this has involved a two hour reduction for manual workers. The IRS survey found that 85% of respondents had introduced a 37 hour week for manual workers, although this does not necessarily imply parity with non-manual workers in all cases (IRS 2000). (In some London authorities white-collar staff are already on 36 or 35 hours per week.) There are also costs connected with the consolidation of pay additions into basic salaries because employees normally expect some financial gain for accepting this change.

The IRS survey found that a number of allowances had been changed by respondents, including subsistence allowances (57%); weekend rates (47%); mileage allowances (43%); overtime rates (42%); and evening rates (40%). Annualised hours systems had been introduced by 26% of respondents. Consolidation or the reduction/abolition of allowances is one way in which employers can make savings, but there are on-going costs of protection for staff who are downgraded. There are also significant transaction costs. Some councils have established dedicated 'single status' teams employing specialist temporary contract staff (such as Birmingham and Newcastle City Councils), but elsewhere councils are trying to cope with existing HR staff. One way of containing costs might be the piecemeal approach taken by Newcastle City Council. It plans to have the NJC job evaluation scheme in place for the six existing manual grades and the three lowest APT&C grades by the end of 2001, with the higher grades joining later. The single status agreement was to be cost neutral, but at West Sussex County Council, for example, the changes totalled £5 million spread over a six year period (IRS, 2000:11). The unions are lobbying the government to provide councils with extra funding to help implement the agreement.

The fourth reason for the slow progress relates to management/union relations. Although the agreement was the result of close working and partnership between employers and unions nationally, according to anecdotal reports the same partnership

has not been in evidence in some local authorities and this has slowed negotiations down. The national agreement exacerbates this because it provides for much of the detail of the new terms and conditions (and often the most contentious items) to be determined locally and this appears to be a major stumbling block. IRS reported a number of industrial disputes in local councils resulting from the agreement (IRS, 2000:6).

Lack of progress in implementation apart, the objective of addressing equal value problems and giving local authorities greater control over pay may conflict. There has been reluctance at a local level to tackle the issue of gender discrimination in bonus schemes. Furthermore, variation in the job evaluation systems selected by local authorities may give rise to equal value problems. Under the Equal Pay Act employees can only make comparisons with others in the same employment (or in associated companies in the private sector). The Employment Appeal Tribunal (EAT), however, scrutinising the European Directive from which the national provisions stem, held in the case of *Scullard v Knowles* (1996) that in the public sector such comparisons may go wider. Scullard, employed by a government funded regional education advisory council, successfully compared herself to male managers employed by other regional advisory councils. It was held that she could make such a comparison. The units were supported and funded by the Training and Education Directorate of what is now the Department for Education and Employment and thus were in the 'same service'.

Similarly in *South Ayrshire Council v Morton* (2001) the EAT ruled that EU equal pay law allowed a teacher employed by one Scottish local authority to nominate as a comparator a teacher employed by a different authority. Even though each local authority decided how salary scales agreed by the Scottish Joint Negotiating Council were to be implemented, there was 'sufficient connection in a loose and non-technical sense'. Accordingly the applicant and the nominated comparator could be said to be in the same service even though the applicant's employer had no control over the terms and conditions of employment of the comparator employed by another local authority. Although it has not yet been tested whether or not local government is a service under the equal pay provisions in respect of employees other than teachers, the cases cited above suggest that an employee of one local authority could compare herself with employees in another local authority

1.3.4 Implications for the NHS

The 1997 single status agreement was a major achievement in terms of meeting the requirements of the employers and trade unions. By combining the twin aims of a fairer pay system and local flexibility in pay, grading and allowances, the agreement provides a useful model of pay modernisation in the public services. Its implementation, however, has been much slower than anticipated, largely because of the costs of introduction and, in some cases, the inability to reach agreement locally on matters left to local negotiation.

The 1997 agreement is primarily about the harmonisation of just two (albeit major) bargaining groups for manual and non-manual workers. It does not cover all the groups of local government staff, nor does it require the harmonisation of terms and conditions for differing professional and technical groups. The major remaining group

of local government employees, school teachers, continues to be covered separately by a pay review body and there is no pay linkage with NJC staff. Thus the local government agreement differs from the proposals in *Agenda for Change* (Department of Health, 1999), which envisage the harmonisation of the many professional and technical NHS occupations. Another difference is that local government employers come together voluntarily but in the NHS, there is a hierarchical system with a chain of command running from the Department of Health and the NHS Executive at the apex, through regional directors to NHS trusts.

1.4 The National Health Service

1.4.1 Background

The National Health Service (NHS), essentially funded by central government out of general taxation, currently receives some £54.2 billion². Of this 70% is spent on the costs of employing its nearly one million staff in England (782,000 whole time equivalents) of whom in 1999 68% were direct care staff and 32% were management and support staff.

Table 1.1: NHS Hospital and Community Services: directly employed staff³

30 September, 1999; England: Whole-time equivalent (thousands)

| Staff group | 1989 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 |
|---|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
| All directly employed staff | 797.3 | 758.5 | 755.6 | 761.3 | 758.1 | 765.9 | 782.1 |
| All direct care staff | ----- | ----- | 497.3 | 507.9 | 508.3 | 517.3 | 529.3 |
| Nursing, midwifery, health visiting staff | ----- | ----- | 330.4 | 332.7 | 330.6 | 332.2 | 338.6 |
| of which qualified staff | ----- | ----- | 246.8 | 248.1 | 246.0 | 247.2 | 250.7 |
| Medical & dental staff | 44.1 | 49.4 | 52.6 | 54.2 | 57.1 | 58.7 | 60.3 |
| Other direct care staff | ----- | ----- | 111.6 | 118.5 | 120.6 | 126.4 | 130.4 |
| All management & support staff | ----- | ----- | 260.9 | 255.9 | 249.7 | 248.6 | 252.8 |
| Admin. & estates staff | ----- | ----- | 168.7 | 167.4 | 167.0 | 167.7 | 172.8 |
| Other management & support staff | ----- | ----- | 92.2 | 88.4 | 82.8 | 80.9 | 80.0 |

The directly employed NHS workforce is predominantly female (76%), although the proportion is smaller for some staff groups, eg 34% for medical and dental staff, according to Department of Health Statistics. The numbers of non-professional groups have varied over the last two decades. In particular, the number of ancillaries has more than halved since 1983, reflecting the then government's requirement for competitive tendering for laundry, cleaning and catering services. Some contracts

² UK net NHS Expenditure Plan 2000/2001.

³ www.doh.gov.uk/HPSSS/TBL-D1.HTM accessed 5/3/01

went outside the NHS but, even where in-house tenders were successful, this was often because hours and jobs were cut (Mailly et al, 1989). Seifert (1992) estimates that 82% of tenders were won in-house.

A distinction can be made between those staff in a labour market which is external, eg building and maintenance craftsmen, secretaries and those whose labour market is internal eg doctors and qualified nurses. Even where the labour market is largely internal, however, health care staff can work in private healthcare, as well as for the NHS and/or for an agency. Hendry (1995) distinguishes further with a four-part typology: internal labour market, occupational labour market, technical and industrial labour market and external labour market. An internal labour market is where ports of entry are restricted, eg the civil service, so the majority of NHS staff according to Hendry's typology would fall within the category of an occupational labour market. This, he says, is where the 'benefits of training accrue to the individual, and their first loyalty is often said to be to the craft, occupation or profession, rather than to the organisation' (1995:232). Irrespective of the typology used, however, the different labour market contexts for the various NHS job 'families' create tensions at trust level.

1.4.2 The Whitley system

When the NHS was established in 1948 it adopted the so-called Whitley industrial relations system, which was in use in the civil service and local government (Winchester and Bach, 1995). The system stemmed from a report of a committee chaired by J. S. Whitley in 1916 which recommended the establishment of joint industrial councils with formal written constitutions and joint determination over a wide range of matters or, to use today's terminology, a partnership approach (Clegg, 1985:204-207). The NHS Whitley system was designed to:

secure the greatest possible measure of co-operation between the authorities responsible for the nation's health and the general body of persons engaged in the health services, with a view to increased efficiency in the public service, and the well-being of those engaged in the services... [and] to provide machinery for the consideration of remuneration and conditions of service (Main Constitution of the Whitley Councils for the Health Service (Great Britain) cited in Loveridge 1971: 147).

At present there is a general Whitley Council for matters affecting all NHS staff and numerous functional councils and several committees⁴ as follows:

Administrative and clerical staffs (including ambulance officers, control assistants),
Ambulance staffs,
Ancillary staffs,
Professional & Technical A (including radiographers, physiotherapists and occupational therapists),
Scientific and Professional Staffs who have committees for:

- speech therapists,
- clinical psychologists,
- clinical scientists,

⁴ Verbal communication from Department of Health, 31.1.01.

- hospital pharmacists,
 - chaplains,
- Professional and Technical ‘B’ (medical laboratory scientific officers, medical technical officers, estates officers, operating department practitioners/assistants, dental staff),
 Doctors and dentists,
 Nurses, midwives and health visitors.

For building trades and maintenance staff there is a management advisory panel (MAP). Although not legally constituted as a Whitley Council, it operates in the same way as the functional councils cited above.

This NHS Whitley system has essentially been unaltered since its inception, although there have been some changes (Seifert, 1992) as follows:

- in 1962, when a pay review body was set up to recommend the fees, allowances and pay of doctors and dentists;
- in 1974, when a new Whitley Council was created for ambulance staff (previously employed by local authorities);
- in 1983 when a pay review body for nurses, midwives, health visitors and the professions allied to medicine was established to recommend pay and certain allowances but not other terms and conditions which remained to be determined under the Whitley system;
- from 1990 when NHS trusts set up under the NHS and Community Care Act could determine the terms and conditions of their staff, subject to certain legal restrictions.

Although the NHS Whitley system has not changed in any material respect since it was established, it has been heavily criticised for many decades. These criticisms centre on structure; complexity; over centralisation/ lack of local flexibility and equal value. They are now addressed in turn.

1.4.3 Critiques: structure

Dealing first with the Whitley council structure, Lord McCarthy described the system famously as ‘employers who do not pay and paymasters who do not employ’ (McCarthy, 1976: para 2.3) and highlighted the disproportionate influence of departmental civil servants upon negotiations. McCarthy's suggestion was that the civil servants should have control over the overall cost of pay offers but that the detail of the pay structures should be left to the NHS managers.

Other recommendations for the reform of the Whitley Council structure were made by the TUC (1981), the National Association of Health Authorities (1983) and the King’s Fund (McCarthy, 1983). The last wanted the regional chairmen to appoint the chairs of the Whitley Councils to ensure accountability to the service and to be given the responsibility for formulating a strategy on NHS pay.

What resulted was the formation of a pay strategy sub-group by the RHA chairmen. The aim of the sub-group was to

.... develop objectives for pay policies which reflect the manpower requirements of the NHS; future pay policy options and their consequences in anticipation of public expenditure sub-committee discussions; [and] advise on strategy within which management sides have to operate (Leopold and Beaumont, 1986:39).

In addition, the total number of Whitley Council management side members was cut from over 200 to less than 40 and management side members were henceforward appointed by the Health Secretary on the basis of their personal qualities, rather than as representatives. Leopold and Beaumont (1986) argued that these changes were designed to reduce the impact of intra-organisational bargaining, specifically between the department and NHS representatives and to increase the influence of NHS management over pay decisions and pay strategy. Maily et al (1989) argued that the overwhelming preponderance of NHS managers on the Whitley Councils appointed by the Health Secretary may have reduced intra-organisational bargaining between government and the NHS, but at the expense of an independent, truly representative management side.

McCarthy also called for the rationalisation of representation on the staff side and for proportional representation for the unions, but this proved unpopular with the TUC unions, which could have lost seats to the professional bodies. The number of unions represented on Whitley fell, however, from 48 in 1950 to 39 by 1989 (Maily et al, 1989:127). In the 1990s this process continued, notably with the amalgamation of the National Union of Public Employees, the Confederation of Health Service Employees and the National and Local Government Officers' Association to form Unison in 1993 (Certification Officer, 1994) and the transfers of engagements of the Health Visitors' Association to MSF in 1990 (Certification Officer, 1991). Nevertheless, there are still over 20 unions represented on Whitley, over a dozen Whitley Councils/Committees and a very large management side.

The intricate Whitley machinery is compounded by the fact that the two pay review bodies (for doctors/dentists and nurses and professions allied to medicine) set the pay of over half the staff working in the NHS, though their other terms and conditions are set by Whitley. As Seifert (1992:277) says:

'If Whitley was criticised for being remote and incomprehensible to ordinary health workers, so pay review is worse. If Whitley was criticised for the muddled role of government, so pay review is worse.'

It is noteworthy that those occupations covered by pay review bodies have received larger increases than groups not covered by pay review bodies, according to Elliott and Duffus (1996) who looked at pay levels over the period 1970-1992. Although this report centres on pay structures, not pay levels, the former impacts on the latter.

1.4.4 Critiques: complexity

Some 15 years ago the King's Fund/National Association of Health Authorities (1985) criticised the complexity of Whitley. It proposed that the Whitley Councils

should be wound up and three new bodies should be created: a pay policy committee to determine policy and negotiating strategy; a pay negotiation unit to brief the policy committee; and an NHS negotiation council to negotiate new pay bands. There would be a 'spinal column' to which all NHS salaries would be attached, thus producing broad pay bands to enable the reward of merit and performance. This suggested single spine, however, was rejected by almost all the NHS staff organisations.

The Warlow report (1989:v), 'the only comprehensive review [of NHS conditions of employment] to have taken place since the inception of the NHS', also criticised the complexity of Whitley. Based on interviews with over 600 NHS managers either individually or in small groups, it said:

Other than the specialist (personnel officers), few managers are familiar with all of the provisions applying to their occupation and none appear conversant with many of the provisions applying to other occupations... They believe that most staff (again with the exception of the specialists and representatives) fare no better and often have a lesser understanding... The existence of 12 sets of agreements governing the employment conditions of NHS staff is complex – but 12 sets following no common structure, having different styles of authorship and sometimes using different terminology, compounds the managers' problems of understanding (Warlow, 1989:36).

The report called for the use of simpler wording, more uniform principles and a reduction in the scope of national regulation.

1.4.5 Critiques: centralisation

The reduction of the complexity of Whitley agreements thus interacts with another focus of criticism: the need for decentralisation. The tension between national and local pay determination has been a theme in the NHS for many a decade. On the one hand, the Department of Health and/or HM Treasury want to control public expenditure, and thus the pay of NHS employees, and to provide effective accountability through the Secretary of State to Parliament. On the other hand, local managers want flexibility to enable pay to be contingent on their service needs and to reflect local labour market conditions. Furthermore, 'many doubt whether highly detailed, prescriptive, functionally based national agreements can cater for the degree of variety of local operational requirements' (Warlow, 1989:3).

The McCarthy report (1976) proposed that the Whitley Councils should negotiate more flexible agreements, allowing for wider interpretation and adaptation at regional level and below (Cuming 1978:193). Flexible elements in pay agreements could include starting salaries and allowances for differences in job content and performance elements. Regional councils would be given the job of developing bargaining on all aspects of work arrangements and the distribution of work tasks, especially those having an impact upon pay such as overtime, shifts and leave rotas.

Warlow (1989) considered that terms and conditions could be fashioned to local circumstances in one of three ways: by national agreements which allow wide local discretion in their application; by placing the onus for determining conditions on the district health authority; or by discriminating between these approaches according to the issue.

1.4.6 Equal value

A criticism which came to the fore from the mid-1980s arises from the fact that, under the Whitley Council structure, terms and conditions are set for the different occupational groups separately. Some occupational groups are mainly female, eg speech and language therapists, and some are mainly male, eg clinical psychologists. An employer may satisfy the provisions of the Equal Pay (Amendment) Regulations 1983, by claiming that there is a material factor which gives rise to differences in pay between mainly male and mainly female groups. The European Court of Justice, however, in the leading case of *Enderby v Frenchay Health Authority* (1993) held that it would not be sufficient for an employer to rely on the absence of discrimination within each of the collective bargaining processes taken separately; nor to show that statistically significant pay differences between female dominated and male dominated jobs arose for non-discriminatory reasons. Where there is job segregation and a statistically significant difference in pay it is up to the employer to provide objective justification. A factor-based job evaluation scheme may provide such a justification, but there is none to date for the NHS as a whole, though there are in some trusts. Under the Equal Pay Act an employee can only make comparisons with others in the same employment (or with employees in associated companies in the private sector). The rulings in *Scullard* (1996) and *South Ayrshire Council* (2001), however, which are based on EU law, suggest that an employee in one trust might be able to nominate as a comparator an employee in another trust (see sub-section 1.3.3). In other words, it is strongly arguable that comparisons could be made across the service; but this point has not yet been tested in respect of the NHS.

1.4.7 The internal market and devolved bargaining

The National Health Service and Community Care Act 1990, which created self governing NHS trusts from hospitals run by the district health authorities, provided the opportunity to resolve some of the problems which had been identified with Whitley (Department of Health, 1990). Empowered to set the terms and conditions of employees, trust management would no longer be bound by the Whitley Council structure, could simplify agreements and mould their arrangements to suit their situation. To foster devolved pay determination, the NHS Executive 'pump-primed' certain trust pay initiatives.

The development of trust pay, though, was slow and in 1994 the government, losing patience with the slow pace of change, sought to impose local bargaining on trusts by requiring them to negotiate top-ups to the basic national awards. Thus there were national level enabling agreements concluded in 1994 for non-pay review body staff which allowed trusts to make local payments 'based on the performance of the organisation', although 'agreement with staff and their trade unions and extensive communication with those affected are essential' (Corby, 1996). Similarly the pay review body reports of 1995 for nurses, midwives and health visitors and the professions allied to medicine awarded 1% nationally with a further 0.5% to 2% to be awarded locally. This, however, sparked off an industrial dispute only resolved through a complex agreement. The agreement provided for local bargaining to top up the national pay awards but with an uprating mechanism through which the national pay rates would be adjusted annually to reflect the outcome of the previous year's

local negotiations. In fact these complex provisions for local pay were only used in 1995 and 1996.

Moreover, a survey of 137 trusts in 1997 found that although more than three-quarters of the sample had developed local terms and conditions for trust staff, only 35 trusts had made extensive use of their freedom to set terms and conditions which differed in a majority of respects from Whitley (IRS, 1997). The reward components most likely to vary from national terms and conditions were annual leave; premium payments and enhancements; pay progression methods and sick pay. Bryson et al (1995:130) point out that, 'in the long term the removal of complex premia and conditions diminishes the union role of joint regulation of the system as there is less opportunity for the unions to get involved'.

In short, the government's push to make trusts determine their own terms and conditions, thus breaking away from Whitley and reflecting their own needs and circumstances, including the local labour market, was only partially successful. A number of reasons have been suggested for this. First the law: a contract can only be varied by agreement, so under common law NHS employees can remain on the national arrangements provided they stay in the same job. Furthermore, there is statutory protection of an employee's contractual rights under the Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE) where an employee, who was employed by a health authority, has a new employer, the trust, provided the employee stays in the same job. Second, the continuance of the national pay arrangements (the Whitley system and the pay review bodies) had a countervailing effect to government policy (Carter and Fairbrother, 1999). Third, pragmatic HR directors had more immediate priorities than introducing local pay (Corby and Higham, 1996). Fourth, HR directors who sought to reduce the cost of the paybill could more easily obtain such reductions by changes in working practices and skill mix changes rather than by devolved collective bargaining (Bach and Winchester, 1994; Lloyd and Seifert, 1995; Bach, 1998). Fifth, there were institutional obstacles arising from the tension between the centre and the field (Locock and Dopson, 1999) and union opposition (Lloyd, 1997; Thornley, 1998; Thornley et al, 2000), which restricted the development of local pay.

1.4.8 Agenda for Change

When there was a change of government in 1997, a full-blown local pay system had been developed in only a minority of NHS trusts and/or for small groups of staff. In February 1999 the Health Secretary announced new proposals in *Agenda for Change* (Department of Health, 1999). To provide a defence against equal value claims a new job evaluation scheme was proposed. To provide simplicity, there would be just three NHS bargaining groups with a national pay spine for each, with a considerable degree of harmonisation. To provide flexibility there would be some delegation to trusts on some matters. At the time of writing, the relevant parties are in the throes of negotiating a new pay system for the NHS.

1.5 Debates and issues

1.5.1 Reward management and 'new pay'

The changes outlined above were accompanied by the development of a new paradigm in the UK, 'reward management'. The term 'reward management' was first used by Armstrong and Murlis who define it as 'the development, implementation, maintenance, communication and evaluation of reward processes' (Armstrong and Murlis 1998:1), although Child had talked of 'reward policies' four years earlier (Child, 1984). While subtly different, there are close similarities between the British 'reward management' paradigm and the American 'new pay' paradigm. For instance, both adopt a holistic approach to reward.

1.5.2 Best fit or best practice?

A major strand in both US 'new pay' and British reward management literature is the emphasis upon reward systems being contingent upon business strategy and explicitly linked to business performance, (Lawler, 1990, 1995; Mahoney, 1989; Schuster and Zingheim 1992). For example, Lawler said:

The new pay argues in favour of a pay-design process that starts with business strategy and organisational design. It argues against an assumption that certain best practices must be incorporated into a company's approach to pay (Lawler, 1995:14).

Similarly, Gomez-Mejia and Balkin state:

The emerging paradigm of the field is based on a strategic orientation where issues of internal equity and external equity are viewed as secondary to the firm's need to use pay as an essential integrating and signalling mechanism to achieve overarching business objectives (Gomez-Mejia and Balkin, 1992:4).

This contingency approach can be contrasted with those who advocate a 'best practice' approach (Taylor, 2000). A number of writers argue that certain reward practices and 'high commitment management' can lead to improved performance, irrespective of business circumstances (Huselid, 1995; Fernie and Metcalf, 1996; Wood, 1996; Pfeffer, 1994 and 1998). Also, there is considerable scepticism as to whether reward systems have become more linked to business strategy in practice (Smith, 1993; Poole and Jenkins, 1998). A recent survey of senior managers' views on new approaches to pay and reward found considerable support for the ideas expressed in the 'new pay' paradigm. There was considerably less evidence, however, of changes in practice (Poole and Jenkins, 1998), although there was a marked difference between the larger private sector companies and the rest. Whatever the practice, however, a contingency approach is scarcely new, as Kessler (2000:272) points out. It echoes the earlier, contingency based approach to pay design advocated by Lupton and Gowler (1969) or White (1981).

1.5.3 Fixed or variable pay?

Schuster and Zingheim (1992) argue that the traditional pay concepts of job evaluated grading structures, payment by time, seniority based pay progression and service-related benefits are the product of Taylorist, manufacturing industries operating in

stable and predictable product market conditions. In the more volatile business environment of today, however, pay levels and composition need to fluctuate according to business circumstances; hence the emphasis upon variable pay as opposed to fixed pay and the individualisation of reward systems. In the words of a CBI report, the great attraction of variable pay is that pay 'can go up and, crucially, down in line with individual, group and company performance' (CBI/Wyatt 1994:5).

According to the 'new pay' writers, employers must abandon concepts of 'rate for the job' in favour of those based on an individual employee's value as measured in the external market. Lawler (1990:153) argues: 'Paying people according to their value in the market pays. After all, it is people who move from job to job and from company to company'. The use of internal comparisons for setting wages should be avoided, as it runs 'the great risk of producing pay rates that are not competitive' (Lawler 1990:192).

Also the proportion of fixed to variable pay should be increased to allow for more incentive pay based upon individual, group and/or organisational performance. As Heery (1996) indicates, this pay philosophy suggests a transfer of the organisation's business risks from the employer to the employee.

1.5.4 New forms of pay progression

An important corollary of moves towards more person and incentive based remuneration systems has been the development of new criteria by which employees progress up a pay structure. While payment by output, performance or productivity was common among manual workers in the past, there has been a substantial decline in payment by results (PBR) among this group in recent years (Druker, 2000). In contrast, there has been a sharp increase in the numbers of non-manual workers who have all or part of their annual pay increase related to their performance. The third Workplace Industrial Relations Survey (WIRS) (Millward et al, 1992) found that between 30% and 40% of workplaces had merit pay for white-collar staff at various levels, compared to under 20% of workplaces with schemes for manual workers. A survey for the Chartered Institute of Personnel and Development (Cannell and Wood, 1992) of 360 organisations found that a quarter of employers had introduced performance-related pay for non-manual workers over the previous five years, but only 6% had introduced such schemes for manual workers.

There has been a substantial academic debate about the value of performance related or merit pay systems. This debate has largely been ignored by HR practitioners, who have continued to extol the benefits of such systems in the face of widespread evidence to the contrary (see for example Brown and Armstrong, 1999). The underpinning theory for all performance related pay systems is expectancy theory (Vroom, 1964; Porter and Lawler, 1968), the belief that employees will adjust their behaviour in line with the expected reward. Critics of individual performance related pay have focused on several aspects, not least the concept that pay is a motivator. The American critique of performance related pay goes back to the 1950s (Sayles, 1952; Whyte, 1955) but more recent critics have included Pearce (1985; 1987) and Kohn (1993). The latter lists a number of problems with performance related pay systems: pay is not a motivator; rewards punish non-recipients; differential rewards rupture teamwork; rewards ignore reasons; rewards discourage risk-taking; and rewards

undermine interest. Kohn quotes Deci's and Ryan's research in the early 1970s which showed that 'any contingent payment system tends to undermine intrinsic motivation' (Kohn, 1993:512).

UK critiques of performance related pay can be found in various studies including those by Bowey, Thorpe and Hellier (1986); Kinnie and Lowe (1990); Marsden and Richardson (1991); Cannell and Wood (1992); Kessler and Purcell (1992); Thompson (1993); Marsden and Richardson (1994); and Marsden and French (1998). Without exception, all these studies found major problems in operationalising merit pay and considerable evidence of negative effects upon employee motivation. The studies based upon surveys of employees' views were particularly critical but the Chartered Institute of Personnel and Development (IPD, 1999) found that managers, especially those in the public sector, were also critical. Public sector managers were 'much less likely [than their private sector counterparts] to feel that their schemes are generating beneficial outcomes for their organisation on every indicator' (IPD, 1998:6). Nevertheless, the same survey found little evidence of a lack of interest: 40% of organisations had individual performance related pay (IPRP) for managers and 25% for non-management grades, although the incidence was higher in the private sector than in the public sector.

There are a number of ways in which pay can be related to performance. In the simplest form, employees receive a merit bonus, usually unconsolidated into basic pay, on top of their normal pay. In some schemes, pay progression is consolidated and linked to an incremental scale. In other schemes, progression is a percentage increase applied within a broad pay band. In many so called 'all merit' schemes, there is no annual cost of living underpinning increase (although, in reality, the average increase is usually close to the cost of living increase).

Alternatives to linking pay to individual performance include both skills and competence based pay, whereby progression is linked to the acquisition of new skills or qualifications or the demonstration of key behavioural characteristics or competencies. Pritchard and Murlis (1992) distinguish between skills, which are concerned with practical abilities and expertise and may also include mastery of a certain body of knowledge, and competencies, which are related to underlying behavioural and attitudinal characteristics or traits needed to carry out the job effectively. Competencies can be used for a range of HR purposes, including recruitment, career development and reward systems both for grading jobs and as criteria for pay progression.

The attraction of skills or competency based progression over traditional output or target related performance pay is that it provides a longer term approach. As Kessler (2000:274) suggests: 'One of the many concerns raised with such (output related) schemes is that, by focusing upon output achievements, they encourage a narrow and blinkered concentration on specific tasks to the neglect of daily, behavioural requirements needed to perform the job in an all-round sense'. In contrast, competency based systems reward employees for development within the job and link to the organisation's core competencies. Kessler (2000) points to a number of different circumstances and rationales for introducing competency based pay; in some cases it has been used to create a new organisational culture or to introduce new quality and customer service objectives.

Research evidence, however, indicates that there is limited use of both skills based and competency based schemes (Industrial Society, 1998). In a critique by Sparrow (1996), a number of deficiencies and problems with competence based systems were identified. First, he argued that the identification of the key competencies may rely on existing appraisal techniques which are not sufficient or robust enough for the purpose. Second, he argued that separating out in-built behaviour from that which can be developed is a complex and uncertain business. Third, he argued that managers have to make accurate judgements about revealed competency, a task to which most will not be equal.

Empirical evidence suggests that competency based schemes may be problematic in certain areas. A small scale survey of competency based approaches to human resource management in the British civil service indicated widespread support among HR managers, who nevertheless identified problems, including the difficulty in applying competency criteria and the complexity of competency frameworks (Farnham and Horton, 2000).

A further problem with competency based systems, as with performance related pay, is the potential for gender or racial bias in the decisions of managers. There is evidence that women and ethnic minorities are likely to be under-rated as performance or competence is equated with white, male behavioural characteristics (Bevan and Thompson, 1992; Civil Service College, 1995). Of course, traditional seniority based pay progression systems are not free of bias, particularly for women who take career breaks.

Another alternative to performance related pay is the use of team based pay. (See, for instance, sub-section 1.2.4 on the use of team based pay instead of individual performance related pay (IPRP) for certain civil servants.) There are a number of ways in which the behaviour associated with teamworking can be rewarded. Teamwork can be assessed as part of an employee's performance appraisal and thus feed into IPRP. Teamwork can be included as a criterion in a competency based grading scheme and thus feed into basic pay. Finally teamwork can be rewarded by a team bonus (Harrington, 2000). It is largely this last aspect that interests reward management writers. Again, however, team bonuses are fairly limited in practice (Thompson, 1995) and most common among manual workers, as surveys by the Industrial Society (1996) and the IPD (1994) have confirmed. Problems identified with team bonuses include the selection of viable criteria to judge team performance, especially if there is no tangible output; the transient nature of many teams; and the problem of equity in paying a collective bonus when levels of input to the team may be uneven (Armstrong, 2000).

Organisation-wide reward systems are more common than team bonuses (IPD, 1994), largely because they have been encouraged by government. These include periodic bonuses based upon some measure of organisational performance (eg profits, turnover, share performance); profit-sharing schemes, profit related pay (PRP) and share ownership schemes.

According to Hyman (2000) the link between financial participation and organisational performance is by no means well established and it is difficult to

separate out the effects of employee financial participation from wider forms of participation. In contrast, the Brookings Institution (Blinder, 1990) in the USA found that profit sharing raised productivity but employee share ownership plans (ESOPs) did not. Blinder (1990), however, concluded that changing the way workers were treated may boost productivity more than changing the way they were paid.

In conclusion, there have been various attempts to link pay progression to some measure of individual worth, be it performance, skills or competence. Brown and Armstrong (1999) have brought all of these various methods together under the rubric of 'pay for contribution'.

1.5.5 Equity and equality

Another major debate over recent years has been the increasing divide over whether pay policies should be based on the concept of equity/equality. According to equity theory, largely associated with Adams (1963), the major determinant of employee satisfaction at work is the extent to which the employee feels that he/she is fairly rewarded in comparison to colleagues. Employees are less interested in actual levels of pay than in the fair distribution of rewards within the workforce. Research projects established to test Adams's equity theory have produced positive findings (Mowday, 1996).

There are, however, two schools of thought as to how equity is defined (Runciman, 1995). On the one hand, there is a basic egalitarian approach. On the other hand, there is a libertarian view that the market should determine the distribution of rewards. The 'rate for the job' relates to the egalitarian approach, while external pay referencing systems relate to the market approach.

The introduction of sex discrimination and equal pay legislation, including the 'equal value' provisions which stem from the European Union's Council Directive 75/117/EEC, have resulted in increased attention being paid to concepts of equality between men and women and the creation of gender neutral grading systems based on job evaluation. In contrast to the views expressed by the American 'new pay' writers that job evaluation is old fashioned and in decline, there is considerable evidence in the UK that the reverse is the case. Kessler reports that the use of job evaluation is found in around a half to three-quarters of organisations and a survey in the mid-1990s found that a significant number of organisations were introducing job evaluation for the first time (Industrial Society, 1996). This is mainly because organisations are seeking to create grading structures which are resistant to equal value claims by employees (Hastings, 2000). Also, job evaluation remains popular because 'job size remains a key support to grading structures and crucial to more general notions of career development within the organisation' (Kessler, 2000:278).

Nevertheless, while job evaluation remains important, there have been attempts to create less rigid and bureaucratic systems (IRS, 1996; Industrial Society, 1996). In particular there have been moves towards simplified structures, including integrated systems for all staff and the use of competencies as the basis for grade classification, rather than the traditional job description. This has allowed organisations to create a more 'person' centred form of grade classification, rather than the traditional

concentration on the content of the job. (See Armstrong and Baron, 1995; Pritchard and Murlis, 1992).

Another development has been the use of so-called 'broad banding' structures to grade employees. These structures have been devised to strike some sort of balance between the need for task flexibility on the one hand and role demarcation on the other. They involve the replacement of numerous grades, each with its own salary scale, with a smaller number of wider pay bands, often based on just a simple minimum and maximum with no intermediate incremental points. This allows a larger number of jobs to be subsumed into the wide band and is seen as particularly useful where organisational structures have become flatter and thus where the opportunities for career progression are limited. Employers have much more discretion with such broad band systems, than with narrower grades, to place and progress individual employees. The evidence again, however, suggests that there has been limited take-up of broad banding among organisations (Industrial Society, 1997).

1.5.6 Harmonisation

Other current trends in reward systems, apart from those proposed by 'new pay' writers, include harmonisation and variable hours. According to the latest 1998 Workplace Employee Relations Survey (WERS, formerly WIRS), there has been a shift towards 'single table' arrangements whereby all the unions in a workplace negotiate together as a single unit. This development has been most common in the public sector: 23% of public sector workplaces in 1990 had single table bargaining rising to 70% of such workplaces in 1998 (Millward et al, 2000). Moreover, single table bargaining has led to increasing harmonisation of terms and conditions. The trend towards single table bargaining is driven by the effects of decentralisation, deregulation and privatisation; the changing structure of employment; the blurring of job boundaries through technological change; and in the private sector only the increased presence of both US and Japanese owned firms, both of which tend to favour single status (and single union) arrangements within the UK (Price and Price, 1994; Russell, 1998; Druker, 2000)

The impetus for harmonisation of manual and non-manual workers' terms and conditions often comes from union demands for equity, but its introduction usually stems from a management initiative (Farnham and Pimlott, 1995:326; Russell, 1998:14). The gains identified for management include improved efficiency and productivity, such as improved time keeping, lower labour turnover and reduced absence rates, but less tangible benefits include improvements in worker morale, attitude to work, loyalty and commitment (Russell, 1998:15). The ending of restrictive work practices, rigid job and skill demarcation, job rights and trade boundaries are also identified by Russell as key objectives for employers in negotiating harmonised terms. These changes allow for the development of multi-skilling and team working and a more flexible approach to job design. In some cases, the shift to salaried status for manual workers has entailed agreements to consolidate allowances and premium payments into basic pay, thereby additionally cutting labour costs.

For manual employees harmonisation often provides benefits in improved pay levels; greater stability in weekly earnings; and enhanced career potential. Non-manual

workers, however, may resent their loss of status and seek to defend their privileges. Farnham and Pimlott (1995:326) argue: 'Effective harmonisation ultimately requires fundamental changes in employee attitudes and in managerial attitudes to the two groups, with sometimes radical changes in working methods'.

There are a number of different approaches to harmonisation. The pay of different groups of employees may be brought together on to a single integrated pay system, but a divide may still exist in respect of other terms and conditions (eg lower paid staff may receive fewer or lower levels of benefits than higher paid staff).

Alternatively, staff may move on to a single pay spine with common terms and conditions, including working hours (often called single status), usually with harmonisation upwards, not downwards. Of course, in reality no organisation has completely single status conditions as managers will usually have access to 'perks' (eg company cars) which are not available to other workers.

1.5.7 Variable hours

Variability does not only relate to pay. It also relates to hours. Traditionally, employees work a set number of hours per week and meet any further fluctuations in the demand for the provision of goods and services by working overtime and/or working weekends/nights when premia are paid. Under such arrangements the employee's pay may vary from pay period to pay period according to the overtime/unsocial hours worked.

An alternative is to allow for variation in hours while keeping constant employees' pay. This can take the form of what is commonly called flexitime where employees work certain core hours, but outside the core can vary the hours within a defined range and carry over credit or debit hours from one period, for instance a month, to another. Such a system gives a significant amount of discretion to the employee over the hours worked, though not varying the pay the employee receives and is useful to the employer who wishes to attract workers.

Another form of hours variability is flexible rostering, where the employee does not work a set shift, eg permanent nights, and the employer decides the pattern of shift working which varies from period to period, for instance a week or a month. In return for this flexibility the employee is rewarded by a percentage addition to the annual salary. A variation is self-rostering, where again the pattern of shift working varies, but pay is constant and the employee has choice of shift, within certain parameters.

Annual hours, whose basic principle is that working time is defined in terms of the year rather than the week, also provides for variability in hours, but constancy in pay. There are two main types: in one type the emphasis is on the variability of weekly hours with work periods longer in busy times and shorter during slack times. In the second type rostered hours are less than the agreed annual hours: workers are effectively on-call for the non-rostered time and can be required to come into work to cover unforeseen circumstances (Arrowsmith and Sisson, 2000). According to IDS (1991) employers have introduced annual hours or flexible rostering not only to match hours to business needs but also to eliminate the costs of overtime. Connected with this is the employer's enhanced ability to predict labour costs more accurately. The main benefit to the employee is the predictability of earnings over the year, but the

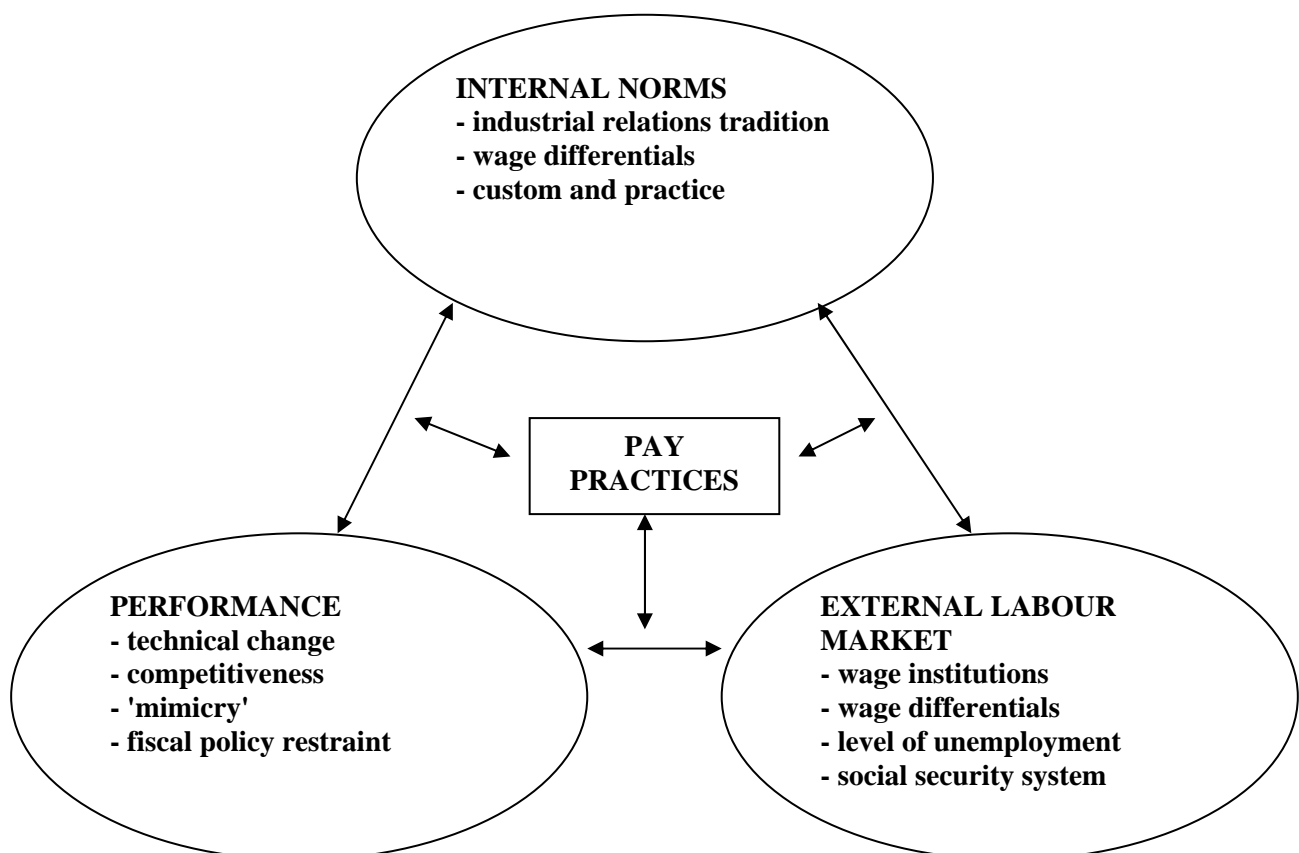
main disadvantage stems from the employee's inability to plan personal commitments such as child-care arrangements.

According to IRS (1998a) annual hours were more common among manual than non-manual employees, while Arrowsmith and Sisson (2000) said that 'annual hours remain very much a minority practice' but its incidence is increasing. This is reflected in the findings of Arrowsmith and Mossé, (2000) in respect of NHS trusts. In 1996 and 1997 one in 10 trusts reported the adoption of annual hours for some employees. This increased to one in five in 1998.

1.5.8 Determining pay: a wider picture

The preceding sections have discussed a number of discrete areas that affect pay determination. Grimshaw (2000), taking a wider stance, argues that various factors interrelate to determine pay and often conflict with each other. For instance, internal norms, such as custom and practice, may conflict with wage differentials in the external labour market and the importation of a performance related pay system may conflict with the industrial relations traditions of the organisation. Grimshaw (2000) provides a model of the interrelationship between these factors and pay practices; see figure 1.1 below.

Figure 1.1: The three 'rings' of pressures shaping change in pay practices (Grimshaw, 2000)



Returning specifically to the public services, while the impact of current trends in reward management and 'new pay' ideas can be detected, this has happened in a refracted manner (see White, 1999). According to Kessler and Purcell (1996), there has been some imbibing of the contingency view, ie that pay systems should be contingent on business strategy, and the concept that pay should become more individualised. These ideas, however, have been moderated by the traditions of British public sector industrial relations. In the public services, there remains a concern to incorporate certain aspects of 'best practice', including transparency and equity. Furthermore, the continuing presence of strong trade unions, not least among powerful groups of professional staff, mediates the more radical ideas of the 'new pay' literature.

1.6 Summary

Part one of this report places in context our research on innovations in NHS pay and grading. It first reviewed both the changes and continuity in policy between the Conservative governments 1979-1997 and the Labour administration 1997-2001. Second, it looked at pay for school teachers and the civil service, where there is a continuing concern with performance related pay, and at the universities. The last have been examining issues related to the simplification of pay determination systems and the equality proofing of the grading structure. Third, the report examined local government, particularly the 1997 single status agreement, where implementation has been slow, largely for cost reasons and the need for agreement locally on a wide range of matters. Fourth, the report looked at the NHS. The Whitley system has been criticised on four main grounds connected with its structure, complexity, lack of flexibility and equal value problems. These criticisms could be addressed at least in part when NHS trusts were established from 1991, as they had the freedom to introduce their own pay systems. In fact, however, trusts' use of this freedom has been limited: few have introduced new systems for most of their staff. There are a number of reasons for this including the legal position, the continuance of national pay arrangements and institutional obstacles.

Finally, part one of this report turns to the 'new pay' ideas and current trends in reward management. The 'new pay' literature stresses the need for a strategic approach to pay to be adopted, for pay to be related to the individual's contribution, (despite much evidence from surveys of the disbenefits of such an approach) and broad banded grading structures. Other current trends in reward management include harmonisation and a number of approaches whereby employees' pay is kept constant, despite variations in the amount and timing of the weekly hours worked. These ideas and trends, however, have been moderated by the traditions of British industrial relations.

PART TWO: ANALYSIS

2.1 Introduction

Part two of this volume is divided into three sections. The first section outlines our research questions and describes our research methodology. The second section reports our research findings. These are presented under the following thematic headings:

- Trust aims and objectives
- Pay systems
- Pay progression
- Process
- Costs
- Evaluation
- Outcomes

These thematic headings are not exclusive categories, rather they are used to organise the data. In our final section, discussion and conclusions, we revisit our research questions, pulling together the literature and our findings.

Our report intentionally draws selectively from our data to illustrate points being discussed. Tables and figures summarise the position in each trust. We emphasise that all figures in this report are designed to provide an immediate graphical impression and are not intended as statistical representations.

2.2 The research

2.2.1 The research questions

This part of our report addresses the research questions and outlines our methodology. Our original research questions as outlined in our proposal (December 1999) (see Appendix A) were reformulated to take account of our literature review, absorbing our earlier questions. Our revised research questions were as follows:

- Did local pay resolve the problems associated with Whitley?
- What were the consequences of local pay?
- Were the trusts' pay systems introduced in line with 'new pay' ideas and current trends in reward management?
- What factors were critical to the success of developing and implementing new pay systems in NHS trusts?

2.2.2 Methods and sample

We discuss here both the 10 case study trusts selected and the methods of data collection.

2.2.2.1. The case study trusts

Our work focused on the experience of 10 NHS trusts in England (see table 2.1). These 10 trusts were selected after discussion with the Department of Health as case studies to illustrate a variety of different approaches to pay and grading and highlight the themes and issues that arose in making innovations. This sample provided relatively fine grained data and captured the rationales, possibilities and constraints in some detail. The sample was not, however, statistically representative of all trusts in England, nor was it statistically representative of all trusts which introduced changes in pay and grading. So it was not possible to gross up the findings to the country as a whole.

Table 2.1: Trusts by NHS region, type and size

| Trust | NHS region | No. non-medical employees ^a (at Sep. 1999) | |
|--------------------|----------------------|--|-------|
| | | Headcount | WTE |
| Acute Teaching 1 | Trent | 4,286 | 3,447 |
| Acute Teaching 2 | Trent | 4,534 | 3,667 |
| Acute Teaching 3 | London | 3,744 | 3,423 |
| Community | South East | 1,805 | 1,040 |
| Large Acute | Eastern | 2,151 | 1,799 |
| Multiservice 1 | South East | 2,687 | 2,287 |
| Multiservice 2 | Eastern | 2,361 | 1,809 |
| Multiservice 3: | North West | 4,557 | 3,618 |
| Very Large Acute 1 | Trent | 4,409 | 3,605 |
| Very Large Acute 2 | Northern & Yorkshire | 4,419 | 3,513 |

Source: ^a NHS Executive, 1999b.

Very Large Acute 1 was the result of a merger in 1998 between two hospitals (Urban 1 and Urban 2) which had, and still had at the time of writing, different pay systems. Therefore, we refer to Urban 1, Urban 2 or Very Large Acute 1 as appropriate. Acute Teaching 1 merged with two other trusts in April 2000. As this post-dated the commencement of this research, our report deals only with the pre-merged trust.

The 10 trusts in this study, which were geographically located across England, were situated in seven out of the eight NHS regions (table 2.1). (South West region was the

only region without a trust in our sample.) Three of the case study trusts were in the Trent region, two in Eastern region, two in the South-East, with other trusts from the London, Northern and Yorkshire and North West regions. Three of the trusts have paid cost of living supplements under a national scheme for qualified nurses and professions allied to medicine (PAMs) as from 1 April 2001, which attests to their labour market problems. We sought to include another London NHS trust in our sample, but unfortunately though initially we were promised co-operation, we were then not given access.

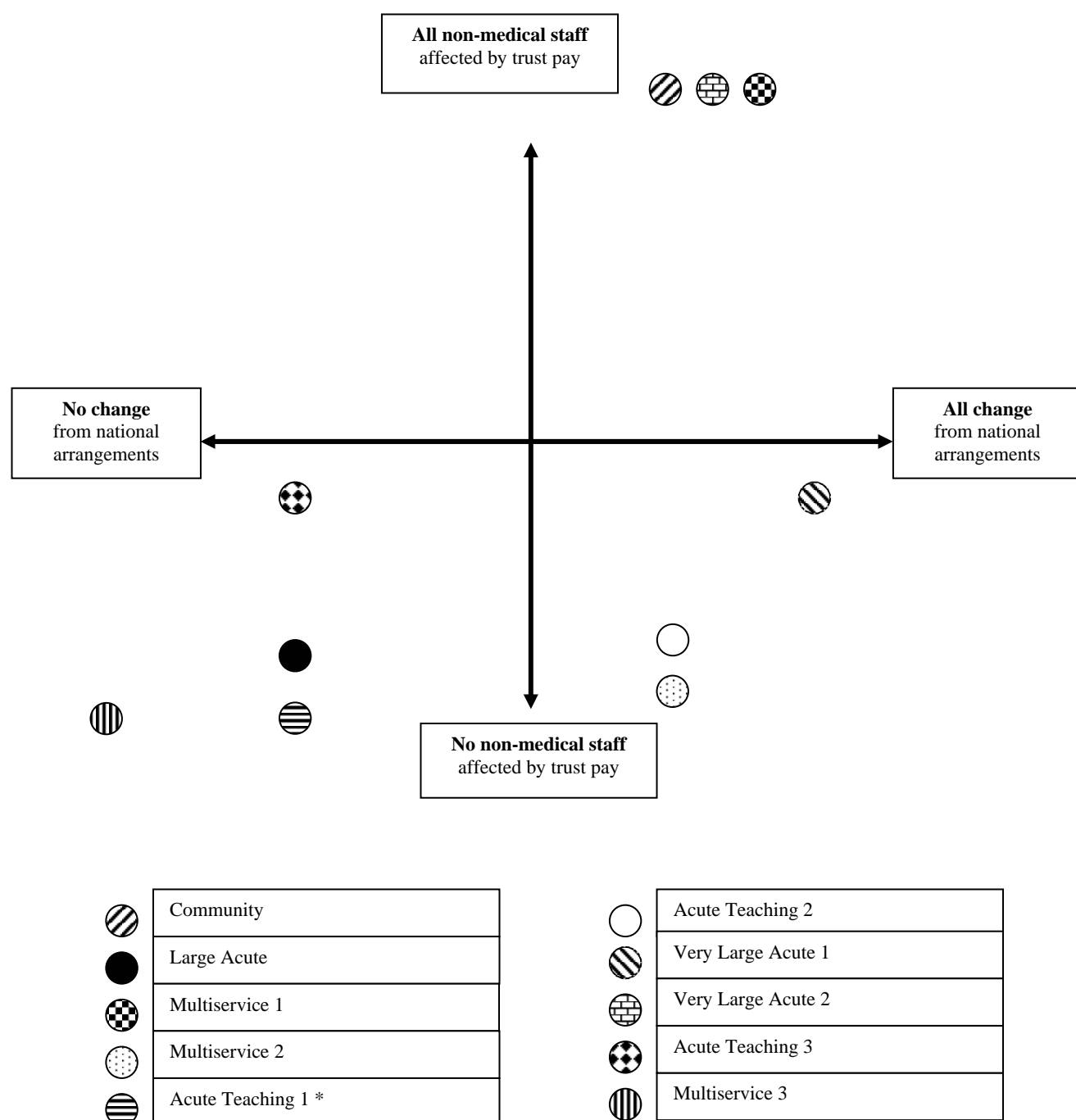
Our 10 trusts provided a range of differing services, reflecting the diverse nature of NHS trusts in England. Three were acute teaching trusts, three were acute trusts, three were multiservice trusts and one was a specialised community trust (table 2.1). We intentionally did not include any ambulance NHS trusts as the type of service provided, and the main occupational groups employed, are not found elsewhere in the NHS. Moreover, ambulance trusts unlike other NHS trusts, only employ a few occupational groups. Therefore, their industrial relations structures are less complex.

The 10 trusts varied in size both in income and in number of employees. Department of Health figures on trust income for 1999/00 were still provisional and subject to continuing audit at the time of writing (at January 2001). Accordingly, 1998/99 figures were used (NHS Executive, 1999a). Annual income for the year 1998/99 ranged from £32,529 million to £185,927 million (median £127,770 million) in our case study trusts. Income of the 402 NHS trusts in England for this period spanned £2,592 to £432,071 million, the average being £68,276 million (mean figure; median £59,169 million). These figures suggest that, as a group, the 10 trusts in this study received larger incomes than the national average. Since becoming trusts, all study sites have met their three financial duties: to balance income against expenditure (taking one year with another), to operate within externally set financing limits and to achieve a capital cost absorption rate of 6%.

As to employees, at September 1999 the total number of non-medical employees, based on headcount, in our 10 trusts ranged from 1,805 to 4,557 (median 4,015) (table 2.2). Comparative figures for all NHS trusts in England, using September 1999 data (NHS Executive, 1999b), spanned from 202 to 10,800 employees (median 2,060). These figures suggest that, as a group, the 10 trusts in this study had a greater number of non-medical employees than the national average.

As mentioned above (this sub-section) the trusts were selected because they had made some pay innovations. Some trusts had introduced changes to pay systems as early as 1994 (Urban 1), with others introducing changes up to the time of our fieldwork (eg Acute Teaching 2, and Acute Teaching 3). Thus we were able to examine both the immediate and longer term effects of changes in payment systems.

Figure 2.1: Trusts' changes to pay by staff coverage: a comparison



- Nearly all non-medical staff eligible, but only a minority transferred.

The trusts studied adopted a range of different approaches to terms and conditions. Some made radical changes to the national arrangements whereas others made minimal changes. Some introduced changes for most non-medical staff whereas others introduced changes for only a few non-medical staff. Figure 2.1 depicts the extent to which the trust's pay system departed from Whitley and the proportion of the trust's non-medical staff affected by revised pay arrangements.

2.2.2.2 Documents

Having selected the case study trusts, we then began to collect relevant documents. We perused secondary sources, such as reports from Incomes Data Services and Industrial Relations Services. We also asked for a range of trust documents as set out in table 2.2. Unfortunately we were not always able to obtain these documents because they had been mislaid eg because of office moves. Accordingly, the table notes whether the documents were provided.

In some instances although documents were provided, they were inadequate for our purposes. For instance one trust only supplied labour turnover data for one year. For a fuller discussion see sub section 2.3.7.4. Also the monitoring and evaluation varied greatly in its depth and nature. In some trusts the HR director reported to the board only the numbers of employees on trust pay. In other trusts, evaluation encompassed a survey of employee attitudes to a new performance system. See section 2.6.

In many trusts, however, we were provided with documents which are not listed in the table. For instance one trust provided us with the management consultant's report drawn up before any pay changes were made. In two trusts the staff side secretaries lent us their entire files. These documents provided us with important background, although we were not always at liberty to quote from them.

2.2.2.3 Interviews

The research was carried out between March 2000 and January 2001. As well as being based on an inspection of documents, 73 tape-recorded interview sessions were conducted incorporating management, union and staff perspectives (table 2.3). Managerial staff were interviewed on a one to one basis and interviews typically lasted forty five minutes to one and a half hours. The director of human resources/head of personnel (or equivalent title), or in one case the deputy HR director, was interviewed in all 10 trusts. In addition, other personnel managers were seen in four trusts. The director of finance was interviewed in eight of the 10 trusts. Additional management interviewees typically included the director of nursing and managers of clinical directorates. We were able to interview two 'line managers', ie heads of clinical directorates, in eight trusts. Where trusts applied new pay systems to some occupational groups only, we interviewed one manager whose staff were eligible for a new pay system and another line manager whose staff were not. The questions varied according to the pay system in place and the HR manager interviewed was asked about the features of the pay innovations that had been introduced, how the changes had been put in place, the nature of the unions' role and the costs incurred.

Table 2.2: Documents

| Trust | Annual report 98-99 | Occupational breakdown | Staff attitude survey 1999-2000 | Sickness data | Labour turnover data | Exit interview data | Paper(s) on aims of any pay systems | Monitoring or evaluation reports | Information on the performance pay system |
|---------------------------------|------------------------|---------------------------|------------------------------------|---------------|----------------------|---------------------|--|--|---|
| Acute Teaching 1 | √ | √ | √ | √ | √ | x | √ | √ | √ |
| Acute Teaching 2 | √ | √ | x | √ | √ | x | √ | √ | √ |
| Acute Teaching 3 | √ | √ | √ | x | √ | √ | √ | √ | √ |
| Community | √ | √ | x | √ | √ | √ | x | √ | x |
| Large Acute | √ | √ | x | x | x | √ | √ | x | √ |
| Multiservice 1 | √ | √ | x | √ | √ | √ | x | √ | √ |
| Multiservice 2 | √ | √ | √ | √ | √ | √ | x | √ | x |
| Multiservice 3 | √ | √ | √ | √ | √ | x | x | x | N/A |
| Very Large Acute 1 (Urban 1) | √ | √ | x | √ | √ | x | √ | √ | √ |
| Very Large Acute 2 | √ | √ | √ | √ | √ | x | √ | √ | √ |

Other questions to the HR managers, the nursing director and the line managers covered:

- the original aims and objectives of pay innovations and whether they varied over time,
- the impact of the pay system on recruitment, retention, workloads, career progression, working practices, teamworking, morale,
- the resources in management time needed to introduce new pay systems,
- the evaluation undertaken.

The questions to the finance director centred on the pay bill costs.

Union representatives, who were seen in all 10 trusts, were mostly interviewed using group techniques with sessions lasting approximately one and a half to two hours. Our primary aim was that these group sessions would include either the chair and/or the secretary of the staff side. On occasion, however, largely due to work commitments, a substitution was necessary. We also aimed to ensure that the major unions in the trust, generally Unison and the RCN, were represented in our fieldwork. The union representatives were asked about what they thought were management's aims in introducing new pay arrangements, the nature of the staff side involvement and the impact of pay innovations on recruitment, retention, workloads, career progression, working practices, teamworking and morale.

Table 2.3: Fieldwork

| Trust: NHS region | No. interviews conducted | | | |
|----------------------|--|------------------------------|--------------------------|-----------|
| | Management One to one interviews | Union Group interviews | Staff Focus groups | Total |
| Acute Teaching 1 | 3 | 1 | 0 | 4 |
| Acute Teaching 2 | 5 | 1† | 3 | 9 |
| Acute Teaching 3 | 5* | 1 | 2 | 8 |
| Community | 5 | 2‡ | 2 | 9 |
| Large Acute | 5 | 1 | 1 | 7 |
| Multiservice 1 | 6 | 1 | 3 | 10 |
| Multiservice 2 | 5* | 1** | 3 | 9 |
| Multiservice 3: | 4 | 1† | 2 | 7 |
| Very Large Acute 1 | 3** | 1 | 0 | 4 |
| Very Large Acute 2 | 5* | 1 | 0 | 6 |
| Totals | 46 | 11 | 16 | 73 |

* In one of these interviews two respondents were present.

** In addition, a sole union representative was separately interviewed.

† Interview with single staff side representative only.

‡ Interviews were held with two staff side representatives individually.

Employee interviews utilised focus group techniques. In contrast to group interviews, focus groups were characterised by an emphasis on staff interaction to investigate and explore common and/or different perceptions relating to pay arrangements and each focus group typically comprised eight employees. Employee focus groups typically lasted one to one and a half hours and included employees from a range of divisions, including theatres and oncology. Where pay systems affected some occupational groups only, one focus group was selected from staff eligible for the trust's pay system and who came from a clinical directorate where we had interviewed the line manager and one focus group was selected from staff who were only eligible for the national arrangements and who came from a clinical directorate where we had interviewed the line manager. Focus groups discussed the impact of the pay system upon recruitment, retention, workloads, morale, career progression, teamworking and working practices.

2.2.3 Summary

This section describes the data on which this report is based. In summary, we conducted case studies of 10 trusts which were primarily selected to show a range of approaches to pay and which varied in function, size and geographical location. Our data were based on documents and 73 interview sessions comprising either one-to-one interviews, group interviews or staff focus groups. Our data addressed four research questions: whether trust pay systems resolved the problems associated with Whitley, the consequences of trust pay, the extent to which trust pay systems incorporated 'new pay' ideas and current trends in reward management and the factors critical to success in developing and implementing new pay systems.

2.3 The findings

2.3.1 Trust aims and objectives

This part of our report presents our findings under the following headings: trust aims and objectives, pay systems, pay progression, process, costs, evaluation and outcomes. These headings do not represent exclusive categories, rather they are used to organise our data. We begin by looking at trust aims and objectives.

Our data revealed that the aims and objectives of introducing new pay arrangements varied according to several factors, particularly the aims and objectives of stakeholders, eg management and/or unions. Focusing on management aims and objectives, our data was largely based on management interviewees' recollections, as we were often not provided with the original documentation proposing pay changes. Broadly, management aims could be categorised as value driven or issue driven. Whilst we emphasise that these approaches do not necessarily represent discrete categories, the former espoused concerns such as fairness, simplicity, equity, performance management and enhanced patient care. The latter related to more practical concerns such as recruitment and retention and temporal and functional flexibility. For instance, Very Large Acute 2 described its aims and objectives in an annual report in values terms: 'a flexible, equitable and simple approach to pay and conditions of service'. In contrast, interviewees at Multiservice 2 informed us that the main objective of their new pay system in theatres was the removal of 'artificial

barriers between surgical skills and anaesthetic skills of the theatre practitioners'. Interestingly, our data revealed that theatres were regarded as a priority area. In all but two of our trusts which had theatre changes were made to the pay and conditions of theatre staff. (The exceptions were Large Acute and Multiservice 3) In particular management wanted to align the work of ODAs/ODPs and theatre nurses.

Notably, scrutiny of our data revealed that trusts adopted a values based approach where they were proposing to introduce pay changes for a significant proportion of their workforce throughout their organisation. Conversely, where trusts were proposing to introduce pay changes for a discrete area only, eg a department or occupational category, issues driven approaches were adopted.

Costs were also an influential factor. On the one hand some trusts were of the view that pay changes would not lead to an increase in the paybill. Higher basic pay would be offset by the consolidation of unsocial hours payments into basic pay, as occurred at Community. On the other hand, an expectation that a new pay system might be costly deterred some trusts from developing and/or introducing more extensive changes to pay arrangements, for instance at Acute Teaching 3 and Large Acute.

Managerial perspectives were not necessarily static over time. In some trusts, whilst initial concerns centred on value driven aspects, issues related concerns came to the fore in later years. Our data revealed two examples of this situation and in both cases there was a considerable delay between development and implementation of the new pay arrangements. At Acute Teaching 3, whilst initial aims related essentially to flexibility and performance management, by the time the scheme had got underway recruitment and retention were becoming issues. At Acute Teaching 2, where initial concerns were value driven, a 1998 report to the board stated: 'The pressure to develop harmonised terms and conditions, although commencing at a corporate level are now primarily bottom up'. Interestingly however, there was no evidence of issue related concerns evolving into value related concerns.

In many trusts, the need to manage performance was not stated overtly as an aim. Nevertheless, some interviewees suggested that this was an implicit consideration which could fall under the rubric of enhanced patient care or flexibility. For instance at Urban 1 a management interviewee suggested that at least part of the rationale for changes in pay regimes for nurses and midwives and other occupational groups was the link of pay determination to performance management. Realisation of the aims and objectives was contingent upon the party/parties who championed the new arrangements. In addition to the human resources director, in some trusts influential roles were played by others, eg the trust board members at Multiservice 1, the director of nursing services at Acute Teaching 3.

The unions did not favour any departure from national pay arrangements. Given that principled stance, they adopted pragmatic approaches. Some became involved to seek to influence the direction of changes. For example, at Community the aims and objectives of unions were to limit any potential adverse impact. At other trusts, the unions considered local pay arrangements as a means of increasing salaries for some staff (Acute Teaching 2) or enhancing staff development (Large Acute). At Acute Teaching 1 the unions refused to enter into discussions as they did not want to be seen to endorse, in any respect, the introduction of local pay. Unions, on the whole, were

particularly opposed to performance pay and the abolition of service based increments. Nevertheless, at Large Acute the introduction of new competency based pay progression criteria for clinical support workers were developed from a union proposal and the full time union official was an important champion (see sub-section 2.3.4.1).

2.3.2 Pay systems

We deal here with the proportion of employees covered by trust pay systems, grading structures, the incorporation of premia and allowances into basic pay, the harmonisation of terms and conditions, annual settlements and market supplements.

2.3.2.1 Coverage: eligibility and take-up

The extent to which trust employees were eligible for local pay systems varied considerably. On the one hand, at Multiservice 3 none were eligible: the trust used the flexibility provided under Whitley to introduce new on-call arrangements for certain staff. On the other hand, in three trusts, there were local arrangements for which all non-medical staff were eligible, while in the remaining trusts only discrete occupational groups were eligible for the new arrangements. This ranged from less than 100 to some 4,000. Details of eligibility appear in table 2.4.

Eligibility and take-up, although related, are not the same and a number of factors appear to have influenced take-up rates: first, the length of time since the trust pay system was introduced allied to labour turnover rates. Under the common law a contract can only be varied by agreement and under statute the Transfer of Undertaking (Protection of Employment) Regulations provide that existing employees who stay in the same job can opt to remain to be covered by the national arrangements, even though their employer is the trust, not the health authority as before. Thus, whereas Multiservice 1 and Very Large Acute 2 introduced new pay systems for all non-medical staff except directors in 1994, actual take-up was some 10 percentage points higher in the latter than the former trust at the time of our fieldwork (summer 2000). This may be partly because Multiservice 1, which was near London, had higher labour turnover rates than Very Large Acute 2, which was in the north east. Details of take-up appear in table 2.4.

A second factor influencing take-up was whether the new pay system radically departed from the national arrangements. Employees may feel that the closer the trust pay system is to the national arrangements, the less they are at risk. For instance at Acute Teaching 3 in respect of nurses, midwives and support workers and at Large Acute in respect of clinical support workers and midwives, the trust arrangements complied with the national pay points (though the pay progression system differed) and in both these trusts the overwhelming majority of eligible staff had accepted the new system. Indeed, at Acute Teaching 3, two of the new D grade nurses in one of our focus groups were unaware that they were on a trust pay system. Perhaps, however, this was not surprising given that a recent advertisement in the *Nursing Times* (2000) for nurses in the cardiothoracic unit did not refer to the trust's competency based pay system.

Table 2.4: Trust pay arrangements by coverage

| Trust | Staff groups eligible | Take-up ^a (%) |
|---|---|--------------------------|
| Acute Teaching 1 | All non-medical staff except scientists, pharmacists, estates officers. | 25 |
| Acute Teaching 2 | All theatre staff | 90 |
| Acute Teaching 3 | Nurses, midwives, health visitors, support workers | 90 |
| Community | All non-medical staff except grade B clinical psychologists | 65 |
| Large Acute | Maintenance craftsmen | 100 |
| | Clinical sterile support department | 100 |
| | Nearly all CSWs | 90 |
| | Midwives | >65 |
| Multiservice 1 | All non-medical staff | 75-80 |
| Multiservice 2 | Qualified theatre staff only | 92 |
| Multiservice 3 | Some pathology laboratory staff | N/A ^c |
| Very Large Acute 1: Urban 1 Urban 2 | Nurses, midwives ^b | 95 |
| | A & E, Trauma & Orthopaedics | >90 |
| Very Large Acute 2 | All non-medical staff | 67 |

^a Take-up at time of fieldwork: April to September 2000.

^b Urban 1 also developed pay systems for admin. & clerical, hotel services, 'professional' staff, ODPs/ODAs.

^c Not applicable as changes centred on variation to Whitley terms.

A third factor influencing take-up rates was the immediate financial incentive provided. For instance when the new pay arrangements for nurses, midwives and support workers were introduced at Urban 1 in 1994, staff moving on to the new structure were assimilated on to the next highest point *plus* an additional increment *plus* a further increment if the transfer took place in the first month, ie three increments worth 2% each. In fact the take-up rate amongst this occupational group was 95% by the time of the fieldwork. At Community, where a new pay system was also introduced in 1996, the take-up rate was 65% at the time of our fieldwork: staff transferring moved on to the next highest point, worth up to 4%. Interestingly at Multiservice 1 the financial incentive was not immediate. Staff transferring moved across without any change to their pay, but all 'excellent' staff could continue to receive increases, whatever their position in the pay band, without hitting a ceiling and the take-up rate at the time of our fieldwork was 75%-80%.

2.3.2.2 Grading structure

Four of our nine trusts which introduced local pay arrangements, used the Medequate job evaluation system, while Multiservice 1 introduced 'recruitment clusters' based on a competency grading system. At Urban 1 the Hay job evaluation system was used for so called professional staff, ie staff whose role was substantially managerial or

where an individual was a professional head of a service or department. The Hay job evaluation system was also used at Urban 2 in Accident & Emergency and Trauma & Orthopaedics to support a new patient focused care system.

Large Acute and Acute Teaching 3 both eschewed job evaluation and closely based their grading structures on the Whitley grading structures. Acute Teaching 2 apart, the unions in the trusts which used Medequate had profound reservations. A comment by a staff representative at Community was not untypical:

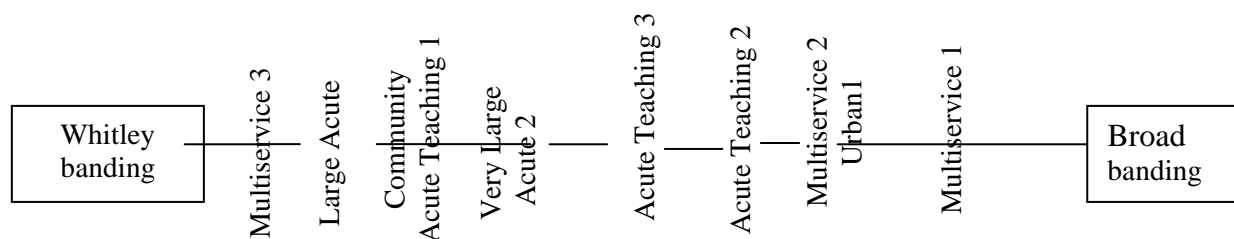
[Medequate] wasn't initially designed for the health service... It was very obviously biased in certain areas... budget holders and people who controlled a lot of staff... against therefore clinical staff who maybe don't have a lot of budgetary control or don't control a lot of staff, but actually... do a very complex and difficult job.

Three of the 10 trusts which we studied created single pay spines, (Acute Teaching 1, Community and Very Large Acute 2). Interestingly, although the unions rejected the concept of a single spine when it was proposed by the King's Fund/National Association of Health Authorities (1985) (see sub-section 1.4.4), some 10 years later this was not a stumbling block. Indeed, managers at Community cited the single pay spine as a major strength and expressed concern about the proposal under *Agenda for Change* to introduce three pay spines. The unions, too, approved of the single pay spine which covered all employees whether they were 'a nurse or a painter'. At Very Large Acute 2 the single spine was seen by management as a means of deterring equal value claims and was acceptable, in principle, to the unions. The unions' main concern related to the performance element of the pay system. At Acute Teaching 1 (where the unions were not involved in the development of the pay system) the HR director saw the single pay spine as an enabler for teamworking.

Three trusts (Acute Teaching 2, Acute Teaching 3, Multiservice 2,) had originally intended to cover all the non-medical staff in the trust but for a number of pragmatic reasons, including cost pressures, had not done so. Indeed, Acute Teaching 2 had 'Medequated' jobs throughout the trust.

Another significant feature of the grading structure was whether the trusts essentially continued to follow the spans determined nationally or introduced broader bands. Multiservice 1, which had no pay ceilings on its bands, just minima, was at one end of the spectrum having broad bands. Multiservice 2 introduced a three grade structure covering four nurse clinical grades and three medical technical officer grades, while Acute Teaching 2's 10 grades were mostly broader than the Whitley grades. Others (Acute Teaching 1, Community and Very Large Acute 2), while introducing their own grading structures, in fact ended up with structures which were little different from the Whitley grading systems, while Large Acute only tinkered with the national grading systems and Multiservice 3 observed them completely. Figure 2.2 illustrates the position.

Figure 2.2: Departure from Whitley banding by trust



The pay structure at Acute Teaching 3 at first sight seemed to be a broad banded one. The trust replaced the nine nursing and midwifery grades A to I with four bands:

- Band 1: Support worker (corresponds to grades A and B),
- Band 2: Qualified nurse/midwife (corresponds to grades D and E),
- Band 3: Senior qualified nurse/midwife (corresponds to grades F and G),
- Band 4: Manager/specialist (corresponds to grades H and I).

These broad bands, however, were subdivided to correspond with the clinical grades and staff could only move between the sub-bands if they had the competencies, the finance was available and the service required those competencies. Moreover, even if those conditions were satisfied, a formal interview was required if there was more than one suitable person in the area. As a union representative commented:

The philosophy was to open up the barriers basically... but if you were working as a D grade and you'd met all the competencies and perhaps could go to an E grade, you'd still have to wait for a job to apply.

This comment was consonant with that of a personnel director at another trust, who eschewed broad banding. He commented:

It's very difficult to control costs on a broad banding system... unless you build in lots of quotas and performance bars and artificial constraints which then defeat the whole object of the exercise.

2.3.2.3 Terms and conditions: incorporation

Leaving basic pay aside, we found that four out of our 10 trusts (Acute Teaching 3, Large Acute, Multiservice 1⁵, Multiservice 3) did not move away from the national terms and conditions, which vary by occupational group, even though in one case, Multiservice 1, the trust made extensive changes to basic pay.

Turning to the other trusts, we found that a key management aim in changing terms and conditions was to incorporate premia and allowances into basic pay to ensure simplicity. As the HR director of Community said:

⁵ Multiservice1 incorporated on-call payments into annual salaries for pathology staff

We rationalised the allowances... we wanted to get rid of allowances because there were a whole range that were meaningless and small amounts and when you advertise a post, why take it into account. You give the basic pay and don't say plus laundry, plus psychiatric lead, plus this, plus all the rest.

Connected with this was the aim of ensuring that although the timing at which work took place could vary, eg from week to week, the salary received would remain constant from one pay period to another. This has advantages for management in that it can predict the paybill and, perhaps reduce the costs of overtime/unsocial hours work. The advantage for staff is that earnings can be predicted and do not vary, for instance on account of annual leave or sickness. Thus, three trusts developed inclusive rates for the job based on the extent of the unsocial hours in the work pattern as follows:

- Acute Teaching 2 (theatres): basic; basic + 3%; basic + 5%; basic + 8%.
- Community: basic; basic + 8%; basic + 15%.
- Very Large Acute 2: basic; basic + 2%; basic + 5%; basic + 12½%.

Acute Teaching 2 introduced the basic + 3% rate in 2000. Hitherto it had only two plus rates in addition to the basic rate. Very Large Acute 2 introduced a basic + 2% rate (for weekend working, but not shifts) in 1999. Before then it only had two plus rates in addition to the basic rate. Also in 1999/2000 it raised the highest rate in stages from 10% to 12½%. An interviewee commented that before the third lower rate was introduced, some staff who were doing quite a lot of unsocial hours were receiving the 5% enhancement, even though strictly speaking they did not meet the criteria for 5%, but it was not equitable that they should only receive the basic salary.

Very Large Acute 2 claimed that inclusive rates served to obviate the perverse incentives that operate under the Whitley system of premia. The acting personnel director commented that the ward sister, who draws up the off duties, would be tempted under Whitley 'to put herself on duty at times when she was paid most, when it was least useful to the organisation in terms of her doing her management role'.

Another example of an inclusive rate of pay despite variations in hours worked was the annual hours scheme for maintenance craftsmen at Large Acute. The agreement, effective from 1.9.97, was based on an annual hours agreement of 2,300 hours per year with provision of a full 24 hours service with overtime and call-out payments absorbed and new shift patterns designed to meet the needs of the service.

At Multiservice 3, where external auditors found that the budget was uncontrollable as on-call payments were based on the timing of tests, not the workload, a continuous process pattern (CPP) agreement in respect of the haematology and clinical biochemistry departments was introduced from September 1998. The agreement provided for a 24-hour rota system with an agreed sum divided equally between rota members. At Multiservice 2 unsocial hours payments for work during the week were incorporated into basic pay, but not for weekend work.

As the NHS operates throughout the year on a seven-day a week, 24 hour basis, the relationship between pay and hours is a singular feature of this organisation. This relationship was addressed in varying ways as our data revealed and any configuration gave rise to both problems and solutions. See sub-section 2.3.7.2.

2.3.2.4 Terms and conditions: harmonisation

Details of harmonisation are set out in table 2.6. Working hours and on-call were harmonised in five trusts. The standard 37.5 hours per week was adopted in place of the national arrangements under which working hours vary by occupational group. Nurses, midwives and health visitors have a working week of 37.5 hours and are the largest occupational group; thus the weighted average is 37.5 hours.

At Acute Teaching 2, Community, Multiservice 2, and Very Large Acute 2 unsocial hours payments were not only incorporated into basic pay, they were also harmonised in respect of the different occupational groups. In contrast, Acute Teaching 1 and Urban 1 harmonised but did not incorporate. Also, whereas the former applied the rates payable to nurses and midwives to other occupational groups, the latter introduced a new, lower rate for most occupational groups (nurses, midwives, administrative and clerical staff, hotel services staff and ODAs/ODPs).

Table 2.5: Harmonisation by trust

| Trust | Working hours | Unsocial hours | Overtime | On-call | Annual leave |
|------------------------|---------------|----------------|----------|---------|--------------|
| Acute Teaching 1 | x | √ | √ | √ | (√) |
| Acute Teaching 2* | √ | √ | √ | √ | x |
| Acute Teaching 3 | x | x | x | x | x |
| Community | √ | √ | √ | √ | x |
| Large Acute | x | x | x | x | x |
| Multiservice 1 | x | x | x | x | x |
| Multiservice 2 ** | √ | √ | √ | √ | √ |
| Multiservice 3 | x | x | x | x | x |
| Very Large Acute 1 *** | √ | √ | √ | x | x |
| Very Large Acute 2 | √ | √ | √ | √ | x |
| Multiservice 3 | x | x | x | x | x |

* Local pay applicable to theatre staff only and based on three separate rates/work patterns

**Local pay applicable to theatre staff only

*** Relates to Urban 1: nurses, midwives, admin. & clerical, hotel services, ODAs/ODPs.

In six trusts overtime was also harmonised, but there was variation as to whether or not there was a reduction compared to the national arrangements (time + a half Monday to Saturday for nurses and double time on Sunday). Two trusts: Community and Very Large Acute 2 extended the nurses and midwives overtime rates to other occupational groups. Four trusts paid lower rates. Thus Multiservice 2 did not make any overtime payments to its theatre staff Monday to Friday and provided time plus one third on Saturday and time plus two thirds on Sunday and bank holiday. Urban 1 paid time and a third Monday to Saturday and time and a half on Sunday. Acute

Teaching 2 paid overtime at time and a third for its theatre staff and Acute Teaching 1 only paid overtime premia after 42 hours had been worked, ie the first 4 ½ hours above the contracted hours were only paid at the basic rate, with time off in lieu.

Four trusts did not carry out any harmonisation. The finance director at Multiservice 1 said that they wanted the new pay system, introduced in 1994, 'to bed in properly'. Then the trust started to look at harmonising terms and conditions, but a change of government took place.

Of all the major conditions annual leave was the least likely to be harmonised and continued to be related to grade and length of service, except for qualified theatre staff in Multiservice 2 and for all above level 1 at Acute Teaching 1. This was a pragmatic assessment of the costs entailed, not a principled stance. Nevertheless, even where harmonisation was not achieved, there was some standardisation. Data relating to the impact of harmonisation on teamworking are discussed in sub-section 2.3.7.5 below.

2.3.2.5 Settlements

As noted before, three trusts did not depart from the national pay points (Acute Teaching 3, Large Acute, Multiservice 3) and thus automatically applied the annual national settlements. The other seven trusts, whatever their freedom in theory, tailored their settlement to the national ones. At Acute Teaching 1, Community and Very Large Acute 2, where there were single spines, there were special considerations. First, the differential increases to the tops of certain grades by the nurses' and PAMs' pay review body in 1999 and 2000 necessitated some tinkering with trust scales to maintain equity between those on Whitley and those on trust contracts. Second, the pay review body award for nurses and PAMs was the benchmark, not the lower settlements applying to the non-pay review body groups and essentially all employees received the same percentage increase.

2.3.2.6 Market supplements

We were told that market supplements for certain groups of staff were applied at Community, (information technology (IT) staff, finance staff and clinical psychologists); Very Large Acute 1 (administrative and clerical staff and hotel services staff where necessary); and at Very Large Acute 2 (medical electronics staff, pharmacists and radiographers). Only at Community were we aware that this caused tensions with those staff who did not receive such supplements and this tension arose only in respect of clinical psychologists and not in respect of IT and finance staff.

2.3.3 Pay progression

We focus first on the basis of pay progression, particularly progression based on performance and whether or not performance payments were consolidated. We then consider how performance pay was awarded and distributed.

2.3.3.1 Basis

In eight of our case study trusts the link between pay progression and service was replaced with a link between pay progression and performance. The main exception was Multiservice 3. At Acute Teaching 1, however, there were service-related

increments until employees reached the top of their grade, where they were eligible for a non-consolidated performance bonus.

Only in Very Large Acute 2 was the performance related pay contingent upon the performance of the trust, not the individual. The non-executive directors decided the amount based on the trust's achievement of:

- quality targets, as for example set out in the *Patient's Charter*,
- number of patients dealt with, as stipulated in the trust's contracts with purchasers,
- financial targets,
- service developments, as set out in the trust's business plan.

To date (2000) the trust never achieved 100% of its targets and the actual performance award paid varied between 4.8% in 1994 to 7.2% in 1999. The researchers were informed that comprehensive information from each directorate was sent to the non-executive directors prior to their decision on the annual performance award, but how they decided the extent to which targets were achieved and thus the performance award was not at all clear.

Team bonuses were very rarely used in our case study trusts, only for some 10 pharmacists at Acute Teaching 1 and for theatre staff at Acute Teaching 3 (where the pay arrangements were under review at the time of writing). Individual performance related or competency based pay was much more common than team or organisation based pay and was found in eight of our trusts. Competencies were either based on skills, or behaviours, or clinical care, or a combination. Moreover, the competencies often varied significantly by occupational group. At Large Acute, for instance, the competencies of clinical support workers were equated to the achievement and demonstration of skills, but the competencies for midwives were behavioural and professional/clinical. The mix of the behavioural and professional/clinical was also to be found for nurses, midwives and their support workers at Acute Teaching 2, Acute Teaching 3 and Multiservice. For instance at Multiservice 1 assessment was based on:

- occupational skills,
- client care,
- decision making and problem solving,
- interpersonal skills,
- leadership skills,
- planning and administration.

At Urban 1 the criteria used to assess the performance of nurses and midwives under their performance pay scheme covered a range of behavioural attributes as clinical competence was assumed. The criteria used were weighted and there were eight headings:

- *process*: assessment, planning implementation and evaluation of care needs,
- *professional responsibility*: staff and ward/department development,
- *research*,
- *human relations*: communications, relationship building, interpersonal understanding, personal awareness,

- *teamwork,*
- *adaptability,*
- *attendance,*
- *commitment to patient care.*

At Urban 2 performance assessment was based on a mixture of behavioural attributes and skills, using the English National Board's 10 key characteristics and three additional characteristics as follows:

- | | |
|----------------------|------------------------|
| • accountability, | • resource management, |
| • clinical skills, | • quality of care, |
| • research, | • change, |
| • teamwork, | • care planning, |
| • innovation, | • communication, |
| • health promotion, | • teaching skills. |
| • staff development, | |

In fact a new performance assessment scheme was being developed to merge the two different systems of staff appraisal at Urban 1 and Urban 2 in the wake of the merger of those two hospitals. The main aim was to introduce an assessment procedure which was more transparent, had a stronger evidence base and was less subjective.

Our data suggested that trusts found it more straight forward to develop competencies based on skills than on more abstract clinical and behavioural attributes. The latter were often evaluated by means of employee portfolios or profiles which staff may not have found easy to compile. Acute Teaching 2 theatres' pay progression competency scheme, grade 6 said: '...profile construction is organised in your own time and there is no definitive method of producing one', according to an internal document.

At Acute Teaching 1 and Multiservice 2 the researchers did not obtain any criteria for performance assessment, whilst at Community the researchers were told that the trust's competency profiles were primarily designed for recruitment purposes and, according to a management interviewee they were:

... an additional tool at the performance development review to help the manager to decide whether to award the progression point. They are not used on their own to make that decision.

2.3.3.2 Consolidation?

Having considered the basis on which performance was assessed, we now consider how performance pay was applied in the nine trusts where there was performance/competency pay. In six of our trusts performance pay was consolidated and by incremental step. At Acute Teaching 1 a non-consolidated performance bonus was paid only to those at the top of their grade.

Multiservice 1 and Very Large Acute 2 employed a mixture of both consolidated and non-consolidated payments. At the latter, half of the performance element (which as noted above was based on trust, not individual performance) was awarded as a consolidated increase and half as a non-consolidated lump sum, though those at the

top of the grade received only the unconsolidated half. At Multiservice 1, where there were no grade maxima, only minima,

- staff rated 'poor' did not receive an increase,
- staff rated 'satisfactory' received a consolidated percentage increase which in practice was in line with the national award,
- staff rated 'good' received a consolidated percentage increase which in practice was some two percentage points above their colleagues rated satisfactory (ie broadly equivalent to half an increment under Whitley),
- staff rated superior received the same consolidated percentage increase as those rated good, plus a non-consolidated bonus of 2%,
- staff rated 'excellent' received the same consolidated percentage increase as those rated good, plus a non-consolidated bonus of 4%.

2.3.3.3 Procedures

Multiservice 3 had service related, not performance related, pay progression, as did Acute Teaching 1 which, however, provided a non-consolidated bonus for those at the top of the grade as noted above. The remaining eight trusts had performance related pay progression but only at Multiservice 1 was there a single annual performance award and no separate annual settlement based, for instance, on the cost of living and/or the national pay awards. All the other trusts distinguished between the annual settlement and the performance award. Of these trusts, three (Acute Teaching 2, Community and Very Large Acute 2) applied their annual performance award on a single date, while Urban 1 applied its annual performance award either on 1 April or 1 October. The remainders applied a performance award according to the employee's anniversary.

It is debatable from the management viewpoint whether one approach is preferable to another but from the employee's viewpoint there is a disadvantage in a once a year date as some time may elapse between appointment and pay progression. For instance at Acute Teaching 2, where there was pay progression for theatre staff on 1 April, only staff who had completed six months' service in post, irrespective of whether this had been achieved by appointment, promotion or regrading could progress. Thus staff who joined after 1 October had to wait up to almost 18 months before they were eligible for a performance related increment.

2.3.3.4 Distribution of awards

Only at Urban 1 was there a forced distribution (where management prescribe the allocation of awards in advance) and a complex system to ensure paybill control. The appraisal resulted in the top 10% receiving a rating of 3; the next 20% receiving a rating of 2, the remainder receiving a rating of 1 unless they had a score of below 100, when they received a nil rating. The ratings determined the *potential maximum* salary increase, as each pay band had performance bars as follows:

- Staff below bar 3 could receive a potential maximum salary increase of 6% if rated 3 and a potential maximum salary of 4% and 2% if rated 2 or 1 respectively.

- Staff between bars 3 and 2 could receive a potential maximum salary increase of 4% if rated 3 and 2% if rated 2. Those rated 1 did not get a performance increase.
- Staff above bar 2 who were rated 3 could receive a potential maximum salary increase of 2%. Those rated 2 and 1 did not get a performance increase.

The bars limited the rate of progression and only high performers could progress to the maximum of the band. The next stage was for salary increases to be awarded. These were awarded in 0.5% bandings according to the number of points scored by the individual. Staff whose scores were in the bottom 45% of staff scores in each sub-occupational group received a 2% salary increase (except that staff scoring below 100 received no percentage increase). Staff scoring above the 45% trigger received a salary increase of between 2.5% and 6% split into eight bandings in 0.5% steps. Thus there was a forced distribution. The last stage was for the salary increase indicated by the score to be mediated by the employee's position on the pay spine relative to the performance bars and the employee's rating.

At Multiservice 1 performance awards followed a bell curve: 20% of employees were expected to be assessed as poor or satisfactory; 60% of employees were expected to be assessed as good; 20% as superior or excellent. Departmental managers were able to deviate from this distribution but were required to meet additional costs from their budget.

2.3.3.5 Discrimination in performance

We now consider to what extent the performance related pay system discriminated between employees. At Multiservice 1 there was a five point rating scale and Urban 1's professional contribution rating system for nurses and midwives provided for 10 possible levels of award: 0 and then nine bandings between 2% and 6%. In other words, the performance awards at these trusts were based on fine distinctions.

At Community, 80% of staff received one performance based increment, while 10% received two increments and 10% received nothing. At Acute Teaching 2 theatre staff could only receive one competency based increment a year and different figures were mentioned in interviews as to the number of eligible staff who had not been given a competency increment in 1999, ranging from 10% to 25%.

At Very Large Acute 2, all employees on trust terms received the same percentage performance increase (unless they were at the top of the grade when they received half the increase), but those who had a disciplinary warning extant or had been absent from work, whether or not on account of sickness, did not receive the award. Individuals absent for more than fifteen days, or on four separate occasions in a year lost 50% of their performance award. If this level of absence occurred in the following year then the individual lost 100%, ie all the performance award. Different figures were mentioned in interviews as to the number of eligible staff who had not been given a performance award ranging from 3% to 10%. The unions were critical of the use of the absence based criterion, pointing to inequities between different parts of the trust. One interviewee remarked:

Yes in the early days I am led to believe that some divisions, some divisional leaders didn't believe in stopping the bonus for any reason, so there were certain divisions that never lost their bonus. There were other divisions where, particularly facilities and staff within the facilities division, lost their bonus at the drop of a spoon.

Accordingly changes were introduced in 2000. Absence for reasons of pregnancy and bereavement and occupationally induced sickness were no longer counted and, in the interests of consistency across the trust, a panel was set up to make a final decision on whether the award should be withheld.

Whereas in most trusts the performance award discriminated between poor and better performers at least to some extent, in three trusts (Acute Teaching 3, Large Acute, Multiservice 2) the performance award was not normally withheld and a performance based increment was awarded. Accordingly, the pay progression system in practice was only a little different from the Whitley system of so-called automatic increments, where in theory an increment can be withheld from a poor performer. Management interviewees at Acute Teaching 3, however, maintained that the competency based pay progression system ensured that managers focused on performance in the job. As a result, the *process* of awarding increments differed and managers made a positive decision in respect of each job-holder.

At Multiservice 2, according to an internal document in 1998, 'the general approach is that staff are deemed entitled to their routine annual increment unless a major negative issue had been highlighted but not yet resolved following appropriate counselling'. A theatre practitioner II, however, who left on 15 April 1998, was recorded in her exit interview as never having had a management staff review in her six years of employment in the trust, including over one year on the new theatre pay system.

Interestingly, our data revealed that trusts' performance pay systems made fine distinctions where they had been introduced in the first half of the 1990s. The two trusts which introduced performance pay systems earliest, ie in 1994, (Multiservice 1 and Urban 1 in respect of nurses) introduced fine distinctions in their performance pay systems. In contrast, we found no examples of trusts which introduced their performance pay systems after 1996 making fine distinctions.

2.3.4 Process

In reporting on innovations in pay and grading we refer to 'process' as incorporating two aspects; development and implementation. Essentially three parties have the potential to influence the development and implementation of trust pay and conditions: management, unions and employees. The complex ways in which these parties interrelate were important variables in pay modernisation programmes, whether or not trusts departed from national arrangements, minimally or radically. Our data revealed a number of managerial approaches which could be adopted. These approaches highlighted how unions may or may not have been involved and where they were involved, such involvement varied. Management may:

- adopt a unilateral approach whereby there is no union involvement,
- liaise with employees directly both as individuals and through the use of focus groups,

- liaise with employees indirectly through the use of external consultancy firms,
- hold discussions with the unions,
- negotiate with the unions, and/or
- adopt one, some, or all of these approaches.

The complexity of the situation was further confounded as management could adopt one, some, or all of these approaches in both the development and/or the implementation of trust pay systems. Moreover, our data suggested that an array of associated aspects, for example the use of management consultants, the degree of staff involvement and/or duration of time between initiation and implementation of trust pay, also had the potential to influence process. Although this sub-section predominantly focuses on management approaches, it is important to remember that unions may decline to liaise with management. Each case study differed. We now use a selection of these case studies to illustrate pertinent points.

2.3.4.1 Union involvement

Figure 2.3 illustrates the degree of union involvement in each trust. Essentially, there were three categories:

- i) where there was negotiation and agreement on the new pay system and also on subsequent pay increases;
- ii) where the unions were involved in discussions on the development of the pay scheme, but there was no agreement. Once the scheme was introduced, however, there was joint negotiation and agreement on subsequent pay increases;
- iii) where the unions were not involved in developing the scheme but negotiated and agreed pay increases once the scheme was introduced.

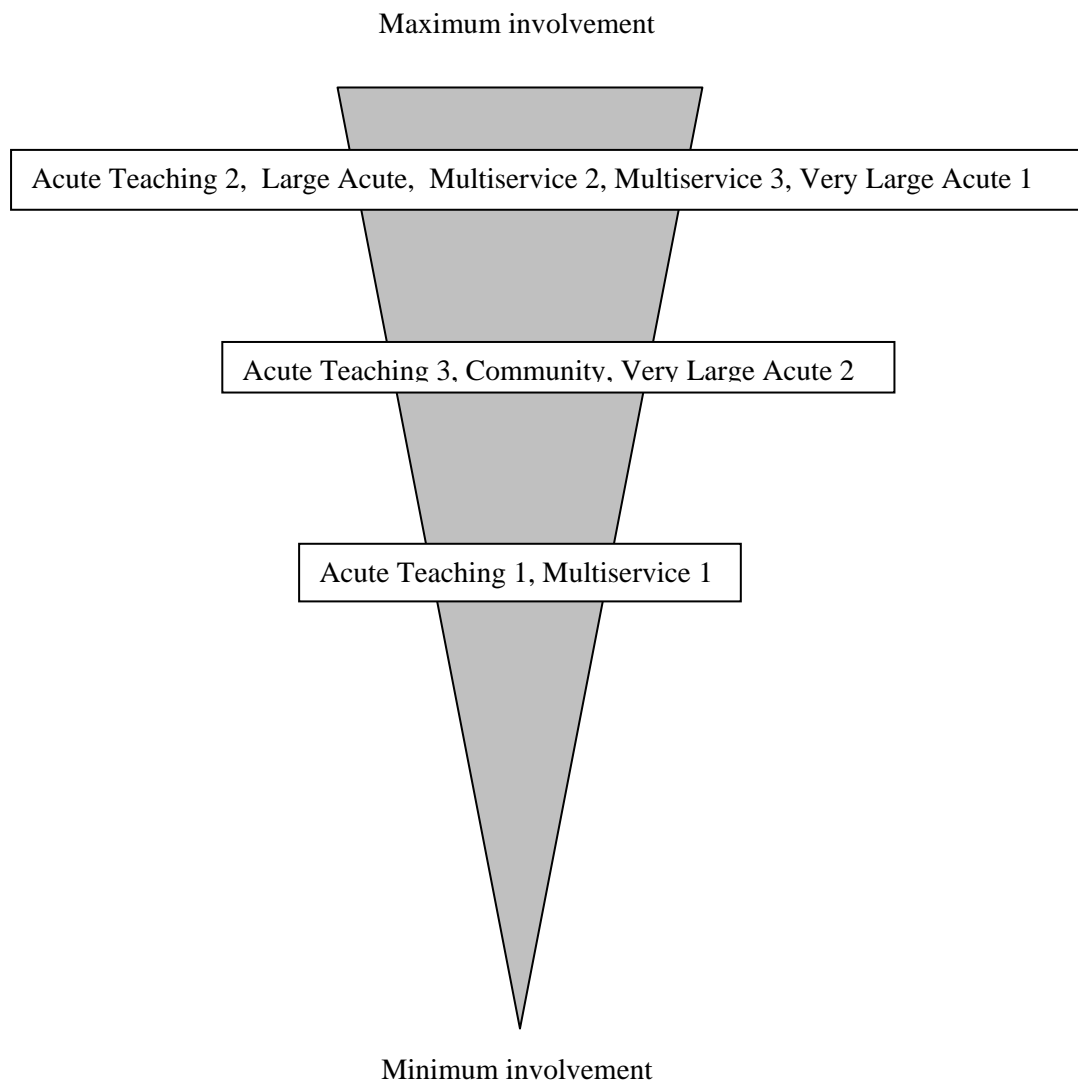
It is notable that the degree of union involvement had no apparent influence on whether radical or minimal changes were introduced. For example, at both Multiservice 1 and Urban 1 radical changes were introduced but at the former there was little union involvement and at the latter there was union agreement, (see figure 2.3).

Focusing on the range of managerial approaches that could be adopted, table 2.6 reveals that in all but two trusts (Acute Teaching 1 and Multiservice 1), there was at least discussion between management and unions prior to a new pay system being introduced. At Acute Teaching 1, according to management, the unions declined to take part in discussions, even on a 'need to know' basis so that they could advise their members.

At Multiservice 1, which had a competency based grading system, the unions were not invited to take part in the development of the system. This was undertaken by a consultancy firm (Lloyd Masters). The unions, however, signed a recognition agreement and subsequently negotiated the pay increase for staff on trust terms. At Very Large Acute 2, the unions' rationale for engaging in discussion was to influence the final model. At Community an interesting situation occurred. The unions did not support the development of the new pay arrangements mainly because they were of the view that the job evaluation system used, Medequate, did not adequately value the

role of clinicians. Nevertheless, they later reached a compromise with management whereby employees on trust contracts prior to the new pay system being launched, could opt to remain on Whitley terms, rather than automatically receiving the new trust terms.

Figure 2.3: Degree of union involvement by trust



In contrast to the approaches of the trusts mentioned above, at four trusts the unions were fully involved from initiation. Thus at Multiservice 3 a new agreement on a continuous process pattern (CPP) was negotiated between management and the relevant union, MSF, with the full involvement of both the full-time official and the staff representative.

Table 2.6: Process by trust

| Trust | Focus groups | Management consultants | Discussion with unions | Agreement with unions |
|--------------------|----------------|------------------------|------------------------|-----------------------|
| Acute Teaching 1 | x | x | x | x |
| Acute Teaching 2 | √ | x | √ | √ |
| Acute Teaching 3 | √ | √ | √ | x |
| Community | √ | √ | √ | x |
| Large Acute | x | √ | √ | √ |
| Multiservice 1 | x | √ | x | x |
| Multiservice 2 | √ | x | √ | √ |
| Multiservice 3 | x | x | √ | √ |
| Very Large Acute 1 | √ ^a | √ ^a | √ | √ |
| Very Large Acute 2 | x | x | √ | x |

^a With nurses, midwives and HCAs (Urban 1)

At Acute Teaching 2, in respect of the theatres agreement, the trade unions were involved at two main levels. First, discussions took place within the forum of the general bargaining group and through the staff side chair. Second, at departmental level, the Unison representative liaised closely with both the staff and the staff side chair. Indeed, both union representatives and management considered trade union involvement at Acute Teaching 2 critical to success. One management interviewee, commenting on the union representative in theatres, remarked:

He went to every meeting there was about pay. He was taken seriously. His concerns were taken seriously. I think that is reflected in the amount of people who actually came over on to the pay scale.

Notably, implementation at Acute Teaching 2 also included a one-year pilot project in theatres.

Interestingly, at Large Acute a union representative was instrumental in developing the pay scheme for clinical support workers (CSWs). Against a backdrop of recruitment and retention difficulties in nursing, CSWs (previously called auxiliaries) were undertaking a range of additional duties. This led to Unison supporting an appeal for a number of staff to be regraded from grade A to grade B. Immediately prior to the hearing, the union official suggested that a working party be set up to obviate the need for appeals and properly reward CSWs for additional duties undertaken. The then assistant director of nursing, who accepted that CSWs were taking on new responsibilities, subsequently accepted this suggestion. Thus, the move to new arrangements stemmed directly from a union proposal.

2.3.4.2 Management consultants

Turning to the use of management consultants, these were commissioned in five of our ten case study trusts (see 2.6). Our data revealed that the role of the management consultants differed from trust to trust. It could range from investigating staff views about pay and their jobs and making recommendations, as KPMG did at Acute Teaching 3, Hay did at Urban 1 and Towers Perrin did at Community, to developing a competency system, as Lloyd Masters did at Large Acute and Multiservice 1.

2.3.4.3 Staff involvement

Staff involvement primarily occurred through the use of focus groups, which may or may not have been facilitated by management consultants. Focus groups were held with or without management consultants in five trusts (see 2.6). Staff involvement took a number of forms:

- suggestions about the future shape of the pay agreement,
- helping to formulate and compile competencies,
- communications with management individually about their pay if they were to move over to a new system.

For example, at Acute Teaching 3 staff, through focus groups, suggested changes to the pay system. At Acute Teaching 2, groups of theatre staff met with management to draw up competencies. At Urban 1, a manager and a union representative conducted interviews jointly with each member of staff individually to explain how their position would change under a new pay system.

2.3.4.4 Time

Our data revealed that the duration of time between initiation to implementation of trust pay varied between our case studies, as mentioned in sub-section 2.2.2. At Acute Teaching 3 the trust wanted to proceed slowly. As one interviewee remarked:

You know if it's limited to one or two service centres and it all goes pear shaped, it's much easier to control the damage; but if it's rolled out and if it affects every nurse, midwife and health visitor employed by the trust then it's quite difficult to control that damage and actually to bring that back in and it would have a negative effect on confidence in the employer.

Roll-out, however, took much longer than anticipated due to a protracted period of staff training in competency based appraisal and the initial project leader leaving. At Acute Teaching 2 too, there was some time between initiation and implementation. In 1995 there was a trust wide job evaluation exercise. For a number of reasons, including cost and change of government, it was decided to roll out gradually and the first staffing department to receive trust terms was theatres, in January 1998. In other trusts, implementation occurred much more rapidly. For example Multiservice 1 gained trust status in 1993 and launched a new pay system in 1994.

2.3.5 Costs

This sub-section initially focuses on stakeholder perceptions and then goes on to discuss developmental costs, assimilation costs and on-going costs. It must be noted, however, that costs were affected by the extent of the changes made to the national arrangements, for example whether the development of the trust system involved radical or minimal changes. Costs were also affected by the extent of staff covered by the new system, for example whether applicable to one, some or all non-medical occupational groups. In addition, our data revealed that other factors had a bearing on costs, such as whether additional funds were available to support the development and implementation of trust pay arrangements, the extent of the incentive payments offered to induce staff to transfer to trust terms and whether trusts obtained offsetting cost savings.

It is important to bear in mind that fear of incurring costs could be an impediment to change. Two trusts eschewed major changes to pay (Large Acute and Multiservice 3) because of an unwillingness to risk an increase in costs. Also three trusts which originally intended to apply a new pay system to all non-medical staff decided to restrict it to discrete groups only, largely because of cost pressures.

2.3.5.1 Stakeholder perceptions

In many trusts, the unions were of the view that a new pay system had been introduced to obtain paybill savings. For instance at Urban 1 a union representative interviewed suggested that pay reform was 'very much linked to money... a long term objective to save money'. Similarly at Multiservice 1 the unions were firmly of the view that the new pay system saved the trust money. (Management in neither trust, however, stated that as one of their aims; see sub-section 2.2.2). Reduced costs may have flowed from reductions in overtime pay or unsocial hours payments but these reductions were offset by higher basic pay. Indeed a management interviewee's comments at Acute Teaching 2 were not untypical. He said: 'It's been generally accepted... that it wasn't about saving money. It was about bringing more modern practices into the pay system.'

2.3.5.2 Development costs

It was difficult to establish exact resource and/or financial costs in respect of the management time involved in development of new pay systems as none of the trusts we studied quantified this information precisely, but all relevant interviewees made general remarks. For example, one commented:

Over the time, we have had two or three people working on the project at different times and each of them at different levels and working different hours.

Another interviewee remarked:

You need the time of trade union reps. You need the expertise of union reps, you need motivated knowledgeable trade union reps and they need to put a hell of a lot of time in and that can have quite an impact. You can virtually lose a whole time equivalent for a protracted period in the trade union role and if they are not knowledgeable and motivated, you have a real problem. In management time again what you need is somebody who has the understanding

and motivation to do this and also has the capacity in their working day to commit to this because of course they still have their day job.

What was revealed by our data was that the management time incurred in developing a bespoke trust pay system could be extensive. The pay system for nurses and midwives at Urban 1 entailed 'an investment of more than 500 person hours', according to a report by the then HR director. At Acute Teaching 2 a report to the trust board remarked that resources for the development and introduction of the theatres pay scheme included '... project meetings lasting 32 hours in total, plus management, personnel and management accountant's time outside of these meetings'. This same report also suggested that whilst no extra staff were taken on, the project manager's time equated to, on average, one day a week over a year. In contrast, other organisations employed additional staff to assist with the development and implementation of the trust pay system: three trusts introduced a full-time post.

In respect of sums dispersed in development, again our data was incomplete, perhaps because of commercial confidentiality. Where trusts employed management consultants, they did not reveal the payments involved. 'Pump priming' money was given by the NHS Executive to Acute Teaching 3 and Urban 1 who received around £70,000 and £80,000 respectively, according to interviewees. At Acute Teaching 2 the trust centrally provided £30,000 to 'pump prime' the theatre pilot project; equating to 1.1% of the theatres' paybill.

Development costs were broken down into four areas: the development of the pay system, the briefing of staff, the development of the competencies or attributes determining pay progression and the training of managers in competency/performance appraisal. Trusts, when providing some albeit limited information about development costs, were normally unable to provide further breakdowns. Where trusts introduced pay systems, however, HR and/or line managers saw each member of staff individually to explain their personal pay position both under Whitley and the trust pay system. Such an interview lasted generally half an hour. Unusually in respect of nurses and midwives at Urban 1 a HR manager and a union representative jointly carried out the interview with the member of staff. Such interview costs were absorbed by management. Also management absorbed training costs in the general training budget. As to the development of competencies, sometimes a consultant was used, as at Multiservice 1 and Large Acute and sometimes the cost of development was absorbed by the line manager as for theatres at Acute Teaching 2.

2.3.5.3 Assimilation costs

Assimilation costs varied. There were no assimilation costs at Acute Teaching 3, where national pay points were followed and at Multiservice 1, where the new pay system did not have pay points. An interviewee told us that assimilation costs for Acute Teaching 1 were calculated at £540,000 in 1994/95 in respect of all eligible staff. At Urban 1, nursing and midwifery staff received two increments, (worth 2% each) on transfer, with a further increment if the transfer took place in the first month of the new pay system. It was suggested that the new arrangements resulted in a very slight increase in the nursing paybill, in part due to the costs of assimilation. At Multiservice 2, where the assimilation costs equated to 3.5% of the paybill, some theatre staff received increases of around £1,000 per year. An interviewee who

remarked, 'My memory is that people were pretty happy as their wages went up' corroborated this.

Very Large Acute 2 informed the researchers that overall there were no assimilation costs because starters who commenced at lower salaries were balanced by staff transferring to the new system. Two trusts (Acute Teaching 1, Large Acute) said that assimilation costs had to be absorbed into the departmental budget, through efficiency savings which could involve changes in skill mix and reductions in premium payments. For instance, at Large Acute the cost of introducing the CSW pay deal was equivalent to the loss of 15 whole time equivalent D grades. Because D grade vacancies exceeded that number, this was notional. Indeed, a management interviewee remarked:

I couldn't recruit Ds [qualified nurses] because the students just weren't coming through...So when we actually changed, I had quite a lot of vacancies and could move the money quite easily. What we said is we've got 10 As who need to go up to B. Finance looked at the money and agreed that we had got D grade money in there and changed that down. It means you recruit less Ds, but I couldn't recruit in the first place.

2.3.5.4 On-going paybill costs

On-going paybill costs were difficult to quantify as trusts conducted little or no evaluation (see sub-section 2.3.6). Scrutiny of the limited data available to us revealed that on-going paybill costs ranged widely. Savings of £60,000 were reported at Multiservice 3, where the introduction of a 'continuous process pattern' (CPP) agreement changed working patterns for laboratory staff. Minimal savings were reported at Very Large Acute 2 and no savings were made at Acute Teaching 3, where changes to the pay structure were minimal.

At Multiservice 1, where there were no grade maxima only grade minima, an interviewee was of the view that the pay bill was 'probably slightly higher' under the trust's pay system: an estimated 20% of the workforce had gone 'off scale' ie were receiving higher pay than the equivalent Whitley maximum. There was a 'healthy turnover' of staff, however, and part of the performance pay award was in the form of a non-consolidated bonus and thus recyclable money. A further interviewee, however, remarked that if it had not been for the *Agenda for Change* proposals, the trust might have considered renegotiating its pay system because 'I don't think very long term it would be viable'.

Managers at Acute Teaching 1 and Acute Teaching 2 said that increases in basic salaries for staff were offset by savings from overtime and unsocial hours payments. Also three trusts specifically reported savings from management/payroll administration. For instance the finance director at Very Large Acute 2, said that since the introduction of their single pay spine in 1994, the number of staff employed by the trust had increased by 30-40% but the number of payroll staff had remained constant. The finance director at Multiservice 1 said that the new pay system had resulted in 'far less' payroll costs, though she was not sure how much was attributable to the new pay system and how much to new working practices in payroll. At Large Acute the new pay arrangements for maintenance craftsmen and staff in Central Sterile Services Department resulted not only in savings on overtime and unsocial hours payments,

but also in the saving of management time through the removal of clocking on and the transfer of staff from weekly pay to monthly pay. At Community, where overall the paybill increased by 1%, the new, simpler pay system had led to administrative savings. The finance director said:

Rather than having this complex system of people claiming different premium rates whether they are working Saturday or Sunday or late during the week they are assimilated to just one scale which compensates them for that regardless... So it's much simpler for managers. It's much easier to administer.

On the other hand, the new pay systems all of which included an element of performance pay led to an increase in management time in appraising staff, at least one hour per employee. A manager at Multiservice 1 commented that appraisal 'would slip in a busy environment, but because it's related to pay you're all very careful to get them done for everybody'. No trust, however, had either calculated on a financial basis the costs in management time or the savings in management time mentioned above.

Table 2.7 pulls together our data but it should be noted that the data provided to us were neither comprehensive, nor in the same format from trust to trust.

2.3.6 Evaluation

It is not our intention here to provide comprehensive results of every evaluation to which we refer. This is dealt with in sub-section 2.3.7 on outcomes. Rather, this sub-section outlines the different ways in which evaluation was conducted, reports on the different parties, internal and external, that took part in evaluation and outlines the diverse foci of trusts' evaluation.

We were surprised at the paucity of evaluation. For example, at Acute Teaching 1 in the original briefing to the board the HR director said:

It is essential that the introduction of new pay and conditions be closely monitored to ensure they are operationally appropriate and viable. Applying them in a piece-meal fashion to coincide with the re-engineering "roll out" provides the opportunity to closely monitor small and manageable segments of the organisation enabling swift corrective action to be taken when seen to be necessary (HR director, 1994).

Nevertheless, in the event Acute Teaching 1 did not undertake any formal evaluation, apart from monitoring the numbers who were on the trust pay system. Furthermore, trust figures on sickness absence and labour turnover were sometimes inadequate; see sub-section 2.3.7.4. This was somewhat surprising given that in some trusts, the resources necessary to develop and implement trust pay systems were extensive; (see sub-sections 2.3.5.2 and 2.3.5.4). Also, whilst the NHS Executive now requires trusts to conduct annual staff attitude surveys, the detail is determined at trust level. Our data revealed that these surveys tended to focus on a variety of issues, including pay levels but did not examine employee attitudes to pay systems and, as with other trust statistics, did not distinguish between those on trust terms and those on Whitley.

Table 2.7: Costs of introducing new pay system by trust

| Trust | Staff group | Development costs | Assimilation costs | On-going paybill costs ie after offsetting savings |
|--------------------|---|---|---|--|
| Community | | | | |
| Acute Teaching 1 | Non-medical staff except scientists, estates officers pharmacists | Absorbed by existing HR staff and line managers | £540,000 | Costs absorbed by departments |
| Acute Teaching 2 | All theatre staff | Absorbed by existing HR staff and line managers | 1.1% of paybill | Not known but savings on overtime pay & sickness absence |
| Acute Teaching 3 | Nurses | Consultants + full time post and other costs absorbed by HR staff and line managers | National pay points observed | Less than 2% |
| Community | All non-medical staff except certain clinical psychologists | Consultants + full-time post | One increment (4% basic pay) | 1% costs |
| Large Acute | CSWs | Absorbed by existing HR staff and by line managers. | National pay points observed | Costs absorbed by departments with loss of posts. |
| | Maintenance craftsmen | | Not known | Costs offset by savings from abolishing clocking, overtime, call-out payments & weekly pay. |
| Multiservice 1 | All non-medical staff | Consultant + full-time post with other costs absorbed by HR and line managers | None | 'Probably slightly higher': an estimated 20% of population above equivalent Whitley scale maximum. |
| Multiservice 2 | Qualified theatre staff | Absorbed by existing HR staff and line manager | Up to 3.5% of paybill | Not known but some offsetting savings |
| Multiservice 3 | Certain laboratory staff | N/A | N/A | N/A |
| Urban 1 | Nurses | Consultant + 500 person hours absorbed by existing HR staff and line managers | 4% of basic pay + 2% incentive to change immediately | A very slight increase |
| Very Large Acute 2 | All non-medical staff | Absorbed by existing HR staff and line managers. | None: those moving across balanced by starters recruited on less attractive packages. | Minimal savings |

Only one of our case study trusts, Multiservice 3, went beyond an in-house survey. It was part of a consortium of 38 trusts in the north of England that commissioned Electoral Reform Ballot Services to carry out a staff opinion survey. Thus it was able to benchmark its findings against those of other trusts in the area (Electoral Reform Ballot Services, 2000). In short then, evaluation was limited. Where evaluation took place, however, it could be divided into internal and external evaluation. Dealing first with internal evaluation, ie evaluation conducted by the trust, at Community there was an audit of the performance development review system among community nurses in 1999. At Acute Teaching 3 a formal review of the pilot of the competency based pay system was undertaken (Stern, 1997) but it focused mainly on the effects of the pay system on recruitment. According to the HR director 'we were not evaluating in the sense of setting it against costed alternatives'. At Multiservice 2, where an interim audit of the theatres' pay system was conducted, the primary focus was the changes which had occurred in working practices.

In contrast to these relatively limited evaluations, Urban 1 carried out an extensive evaluation of its performance pay system two years after its introduction. The data were obtained from a range of sources including a questionnaire survey, individual interviews and focus groups. In addition there was an analysis of the performance payments made to ascertain if there was any bias on grounds of gender and ethnicity. As a result Urban 1 made some changes.

Other trusts combined internal and external evaluation. This was exemplified at Acute Teaching 2 where an MBA student examined staff attitudes towards the theatres' pay system and the HR director examined the managerial benefits of the system. The latter included the effects of the trust system on recruitment and retention of staff, rostering and expenditure. Similarly, evaluation at Very Large Acute 2 also incorporated internal and external reviews, the former consisting of an in-house evaluation of the impact of its pay system 18 months after it had been introduced. The external evaluation consisted of an examination of the effects of performance pay on employee motivation, conducted by a university. Another trust to combine internal and external evaluation was Multiservice 1. In 1995 the trust conducted an evaluation of their performance pay system based on responses from 42 employees which indicated a number of concerns (see section 3.4.7) and in 1996 a university investigated the effects of performance pay on employee motivation.

2.3.7 Outcomes

We now turn to the outcomes of trust pay systems. We first discuss the parties who have a stake in the outcomes. Then we look at working practices, employment data and the outcomes for patients. Finally we consider the views of staff and unions.

2.3.7.1 The stakeholders

There are four main stakeholders in the outcomes of changes to NHS pay and grading systems: management, unions, employees and patients. The different stakeholders have different priorities. For instance a management priority is likely to be the extent to which a pay system is cost effective and supports functional or temporal flexibility, whereas a union priority is likely to centre on the level of pay and the transparency and equity of a pay system. This is a priority shared by employees, who may also

favour stability in earnings. The link between pay systems and patients is the most problematic. Whilst patient care is influenced by the dynamics between management, unions and employees, there is no obvious and direct causal relationship between these variables. As one HR director said, patient care is probably 'one step removed' and another HR director said that changes to pay systems 'facilitate, but do not deliver' changes to the provision of health services. Given the differing approaches of stakeholders, we look in turn at working practices, patient outcomes and then staff and union attitudes on the fairness of the system. We deal first with working practices.

2.3.7.2 Working practices: temporal flexibility

Trusts have been concerned to reduce the number of staff on permanent nights and introduce rotating shifts for a number of reasons. First permanent nights attract expensive unsocial hours premia under the national arrangements but many interviewees expressed a view that those on day shifts work harder and had more complex jobs than those on permanent nights but were paid less. (Trusts only deal with emergency procedures at night and in the main night staff 'baby-sit', an interviewee claimed.) Second, those on permanent nights miss out on developmental and training opportunities and third they are often divorced from the main management chain.

Reductions in permanent night work can be secured under Whitley, for instance putting new staff on rotating shift contracts or obtaining agreement to variation in contract. As detailed in sub-section 2.3.2.3, however, a number of trusts took the opportunity of changes to pay to introduce rotating shifts. For instance, our research showed that three of our 10 trusts (Acute Teaching 2 in respect of staff in theatres only, Community and Very Large Acute 2) paid inclusive rates dependant on the flexibility provided, with the highest inclusive rate for those on rotating shifts.

We were informed that the new roster system at Acute Teaching 2, underpinned by an inclusive rate payment system, provided a better match than hitherto with service needs. It led to fewer operations being cancelled, a significant reduction in the waiting list and emergency work after midnight limited to critical operations only. Nevertheless, there were disadvantages with an inclusive rate system. For instance, a focus group of nurses at Community suggested that a degree of inflexibility had been introduced into staff deployment. As a ward manager said:

If you have someone on flexi 1 [basic + 8%] ... if you want them to do say a week on nights, it's impossible really to get any night money because they're on a flexi 1 contract.

Another disadvantage of inclusive rates was identified by a management interviewee at Community who was of the view that they tempted some individuals to take longer off sick. She said:

Before if you were off for a month you missed out all your allowances, whereas now you get the same amounts, so instead of taking one week and thinking well I'm losing money, people maybe take two or three.

Her view, however, was not borne out by an analysis of sickness statistics; (see sub-section 2.3.7.4).

We noted above (this sub-section) that changes to shift systems can be made irrespective of changes to pay and we came across experiments in self-rostering where pay changes had not been made, eg oncology at Acute Teaching 2. Brooks (2000:26) argues that self-rostering lessens the detrimental effects of shiftwork for employees, while service needs can be met provided that 'there are sufficient checks in place'. Also we found that changes to hours of work for PAMs had been made with and without changes to pay systems. For instance at Community the new inclusive rates supported evening working by occupational therapists (though a focus group of PAMs were not aware of that provision). At Acute Teaching 3, the opening hours of certain physiotherapy out-patient clinics had been extended and physiotherapists, who remained on Whitley, worked longer hours on some days and in return had a half day off a week.

A second important way that trusts can obtain temporal flexibility and at the same time control paybill costs is by rationalising the on-call arrangements. For instance Multiservice 3 changed the on-call system for certain pathology departments through a continuous process pattern (CPP) agreement (see 2.3.2.3), albeit within the flexibility provided under Whitley. The departmental manager was of the view that CPP worked well, while employees said that although 'CPP is not perfect, it's the best we've got'.

In theatres at Multiservice 2, a new shift system was introduced during the day, with unsocial hours premia for weekday work incorporated into basic pay and on-call was substituted for night duty. According to the theatre manager:

The absence of the 'convenience factor' of having night duty staff has reduced the incidence of inappropriate surgery during the night. The downside of the on-call service is that occasionally an elective list has to be cancelled because the emergency team has worked through the previous night, thereby reducing staffing levels on the following day (Shannon, 1999:571).

In short, eight of our 10 trusts introduced rotating shifts and/or new on-call arrangements or annual hours underpinned by new pay systems and managers were of the view that this enabled them to meet service needs more efficiently and effectively.

2.3.7.3 Working practices: functional flexibility

The main area where the pay system was used to support functional flexibility was in theatres, whether or not as part of trust wide pay changes. Leaving aside Community which did not have theatres, six out of the remaining nine trusts specifically changed terms and conditions in theatres. The main aim was to support the multi-skilling of ODAs/ODPs and theatre nurses against a background of a national shortage of the latter and to reward the skills of the former so that their pay would equate with that of theatre nurses with whom, with training, they were to a large extent interchangeable. (Under Whitley ODAs/ODPs fall within the Professional and Technical B Council, not the Nursing and Midwifery Staff Council.) Pay apart, management interviewees regarded the harmonisation of working hours and overtime/unsocial hours premia as particularly important in underpinning functional flexibility.

The changes in terms and conditions so that ODAs/ODPs and theatre nurses were placed on a common footing, however, could only support functional flexibility, not

deliver it. Delivery can only be secured by the necessary training: eg nurse training in anaesthetics and ODAs/ODPs in scrubbing up and recovery. Training is dependent on staff release, which had led to problems at Multiservice 2, hampering the achievement of multi-skilling. Nevertheless there and at Acute Teaching 2, the changes to the pay system were considered by management to have been essential catalysts. For instance a management interviewee at Acute Teaching 2 said:

I don't think we could have taken it quite as far as we did without equal reward for equal contribution.... Before the change basically ODPs had one coffee room and nurses had another. That's going. It's not completely gone.

A union interviewee also thought that the new pay system had led to the breaking down of demarcations. After the pay changes, she said:

One wasn't getting more pay for being on-call. One wasn't getting more overtime payment. They were all getting annual leave at the same rate and basically it meant that they could work alongside not looking to say, you have got more than I have got.

Theatres apart, another area of multi-skilling in our case studies was in respect of support workers at Large Acute where clinical support workers (CSWs) who acquired and demonstrated certain skills moved from grade A to grade B automatically.

A number of trusts had created new posts, eg 'ward hostesses' at Very Large Acute 2 (whose responsibilities include making beds, serving meals, basic patient administration and simple maintenance work such as changing light bulbs) and 'discharge co-ordinators' at Large Acute. At Very Large Acute 2, the new post was 'Medequated' and slotted into the pay spine relatively easily and quickly, whereas under Whitley personnel 'would have scratched [their] heads' as to whether it was an administrative or ancillary post. At Large Acute, however, where there was no trust-wide job evaluation system, the grading of the post was more problematic. At the time of the fieldwork, a post-holder complained that she had already been waiting many months for her grade to be allocated.

2.3.7.4 Employment data

This sub-section is based on data collected from the trusts in this study. We endeavoured to see how and, if so, in what way changes in pay systems had affected certain employment data. We found that exit interview data were not always kept centrally for the whole organisation. In some trusts it was collected and held by department/directorate heads, while in other trusts it was only collected for those departments/directorates where a problem had been identified.

In short, there were only a few trusts where we were able to locate useful exit interview data. At Community, the percentage of staff citing pay as a major factor in their decision to leave the trust almost halved in 1998/99 compared to 1996/97 (from approximately 25% to 12%). According to a report to the board in 1999, that 'could be a reflection of the satisfaction with trust pay'. At Multiservice 1, where a new pay structure was launched in 1994, exit interview data were examined for three periods (April-September 1996; October-March 1996/97; April-September 1999). There appeared to have been a slight increase in respondents claiming that trust pay was poor between 1996 and 1999. No data prior to 1996 was available and no distinction

was made between staff on Whitley and staff on trust pay, so it was difficult to establish the effect of the introduction of the new pay system.

Bearing in mind that there are many factors, apart from pay, which contribute to recruitment and retention and bearing in mind that labour turnover data reflects pay levels, rather than pay systems, we then looked at the effect of new pay systems on labour turnover. We could not draw any conclusions on a cross case basis. This was because data was not comparable between trusts due to the varying range of local initiatives that had been introduced by trusts; the different staff groups focused upon by trusts and the different methods of data collection adopted by trusts.

We then sought to see if we could draw conclusions from the labour turnover data in respect of a trust individually. We found that we were unable to do so. In none of the trusts studied did labour turnover data distinguish between those on Whitley and those on the trust pay system. Moreover, the data were often deficient in at least one other respect:

- Data did not longitudinally examine labour-force aspects by staff group before and after the introduction of trust pay systems.
- Data did not distinguish by staff group, even where pay changes had been introduced for selective groups of employees only, eg theatre staff.
- Data was incomplete/sporadic, covering intermittent time periods that were not comparable with each other.
- Data related to very short time periods post the introduction of a new pay system, because a trust had only recently introduced new pay arrangements.

For instance, at Large Acute new pay arrangements for clinical support workers and midwives were only introduced in 1999, so a clear pattern had not yet emerged. At Acute Teaching 3 too, because of the slow roll-out which had only just been completed for qualified nursing and midwifery staff by the time of the fieldwork (June/July 2000), labour turnover data were of limited use. At Very Large Acute 1 it was not possible to separate out labour turnover and sickness absence figures for its two components (Urban 1 and Urban 2) post merger, ie 1998, though terms and conditions at the two hospitals remained distinct.

Given these important caveats, particularly the lack of distinction between Whitley staff and trust paid staff, we looked at labour turnover data where trusts provided fairly comprehensive statistics. We found that the new pay systems did not seem to have had any noticeable positive or negative long-term effects on turnover rates. At Community the new pay system was introduced from 1 July 1996 and had no apparent effect on labour turnover: from 1997-99 the average rate was 14 % compared to an average of 15% between 1993-95. At Very Large Acute 2 labour turnover also remained fairly static and varied by under four percentage points from 1993 to 2000. At March 1993, ie a year before the trust pay system was introduced, labour turnover stood at 10.9%. By March 2000 it was 13.3%. Between those dates there were fluctuations with the highest point being reached in March 1995 (14.5%).

Labour turnover data for nurses and midwives at Urban 1 was examined from 1993/4, ie the year before the new pay system was introduced, until 1996/97, ie just before the merger with Urban 2. The data show that labour turnover for Urban 1 nurses and midwives in 1993/94 was 12.3%, rising to 16.7% in 1995/96 and then falling back to 12.8% in 1996/97. In short, labour turnover data showed fluctuations and thus no evidence of positive or negative changes being associated with the introduction of the new pay system in 1994.

As to theatres at Multiservice 2, two years before the new pay system was introduced for clinically qualified staff, labour turnover was 13.2% (1995/96) and 6.1% (1996/97). In the year immediately following the introduction of the new pay regime (1997/98) labour turnover reduced to nil. The following year it rose to 6.1% and the year after to 13.6%. In Acute Teaching 2, where a new pay system was implemented in January 1998, we were told that labour turnover in theatres in 1998/99 was about 5% but had increased to 9.9% in 1999/2000. A management interviewee, however, was of the view that this was 'not because of pay. I think that it is connected to the way we have reorganised theatres'. At Multiservice 1 some data relating to the period from April 1996 (ie two years after the introduction of the pay system) was available. This showed a span of just over three percentage points between 1996/97 and 1999/2000 (22.4% to 19.1%).

Although Acute Teaching 3 labour turnover data were not useful for our purposes, we obtained some information on the results of a pilot of the pay system. A review found that three out of 13 respondents in the Children and Women's Services and five out of 27 respondents in Cardiothoracic Services said that the trust's competency based nurses' pay system would positively influence their decision to apply for a post (Stern, 1997).

We were not provided with sickness absence data for all our 10 trusts. Moreover, the extent to which and how pay and grading and sickness absence are related is debatable. For instance sickness absence varies seasonally, although the pay system does not, and is influenced by the policies and procedures for handling sickness absence. Leaving that debate aside, where the necessary data were provided, we found that in some trusts the introduction of the new pay system had gone hand in hand with a reduction in sickness absence. For instance at Acute Teaching 2 sickness absence was 5.3% in theatres in 1999-2000, compared with 7% before the new agreement was introduced in January 1998. At Community sickness absence was 3.1% in 1998/99 compared to 3.5% in 1992/93. (Community's new pay system was introduced in 1996.) At Multiservice 2 sickness absence in theatres was 7.3% (1995/96) and 6.0% (1996/97). The year after the new theatres' pay system was introduced (1997/98) it fell to 3.7%. At Urban 2 we were given sickness absence data for Accident & Emergency and Trauma & Orthopaedics, where new pay systems were introduced in 1996. In the year before the new pay arrangements were introduced sickness absence was 2.6% and 3.6% respectively. The comparable figures for 1997/1998 were 2.6% and 2.4% respectively, ie a downward trend in Trauma & Orthopaedics but not Accident & Emergency. These reductions, however, may be attributed to new approaches to sickness management as noted above (this sub-section), rather than new pay systems and, in any event, do not equate to a causal link between these two variables.

2.3.7.5 Patient outcomes

Patient outcomes are affected indirectly by pay systems, for instance where they underpin temporal and functional flexibility (see sub-sections 2.3.7.2 and 2.3.7.3) and lead to improved service delivery and/or where they lead to improved staff performance. Accordingly, we first examined NHS performance indicator data (1998/99) in respect of our case study trusts. We then examined interview data from our management respondents.

In short, the quantitative data did not allow us to find any positive or negative causal relationship between NHS performance indicators and innovations in pay and grading, because the performance indicators themselves were deficient for the purposes of this study. Although the indicators compared like with like, eg multiservice trusts with multiservice trusts and acute teaching trusts with acute teaching trusts, their development is only in its infancy. Also, 'differences may occur between hospitals due to the differing mix of specialities' and 'death rates may vary between trusts due to the variation in the complexity of procedures carried out. For example, the major cardiac centres may have high death rates due to the complexity of the operations carried out' (NHS Executive, 2000: 65-67). Furthermore, none of the trusts in this study made changes to the pay of medical staff, yet their work was a major influence on these indicators. With these important caveats in mind, we looked at the league tables of both emergency re-admissions and deaths following surgery. These indicators applied to all our case study trusts, except Community where there were no theatres and, unsurprisingly, we were unable to establish any relationship between the performance indicators and pay systems.

Next we turned to our qualitative data and asked management interviewees about the inter-relationship between pay systems and patient care. In some trusts, interviewees were of the view that the inter-relationship was both tenuous and hard to identify. In other trusts, however, management was of the view that new pay systems had led to an improvement in patient care. For instance at Acute Teaching 1, the business process re-engineering (BPR) exercise, which in turn had led to the development of Acute Teaching 1's pay system, had resulted in improved patient experiences, eg 'one-stop shops' for a range of diagnostic tests.

Moreover, managers in the trusts which had carried out some harmonisation were strongly of the view that harmonised pay systems supported teamwork across occupational boundaries. For instance, an interviewee at Acute Teaching 1 said that the change in pay and grading had been an aid to changing the culture of the hospital by stressing teamwork and breaking down professional boundaries. She contrasted Acute Teaching 1's pay system with the Whitley grading systems, which reinforced professional boundaries between the many occupational groups in the NHS. Such a comment was not untypical. At Large Acute an interviewee said:

It's the old chestnut about having everyone in boxes... If we're talking about teamworking, about being all in this together, it's got to be more harmony for conditions of service.

As table 2.5 above indicates, however, trusts either did not harmonise any terms or conditions or harmonised more than one. Accordingly managers were unable to link the harmonisation of a particular term with teamworking. Their comments were made

in respect of a package. Moreover, managers in four out of our 10 trusts which did not carry out harmonisation did not consider that the pay system effected teamworking either positively or negatively.

Most managers were also of the view that a pay progression system based on performance/competence had beneficial outcomes for patient care. Thus, at Acute Teaching 2 the theatre manager considered that the competency based pay progression system had led to improvements in standards of dress and behaviour to patients, 'just little things that are probably quite unquantifiable really'. At Large Acute a manager was of the view that the competency based pay scheme for clinical support workers (CSWs) had contributed to an improvement in standards of health care. Nevertheless, she added a rider, remarking that the competency based pay system 'will only be as good as the kind of appraisal that sits within it... You'll find a lot of managers not wanting to rock the boat unless they've got a particularly poor performer'. This interviewee was not the only manager who harboured doubts about the operation of performance pay. A manager at Multiservice 1 said that although she thought that 'the ethos behind performance related pay is good... how people are judged on their performance and then money is attached to it, there are issues there'.

At Acute Teaching 3, a manager felt that the new pay progression system had resulted in staff becoming more focused on their roles and his conversations with patients and students indicated that this was positive. On the other hand a PAMs manager at Acute Teaching 3, whose staff did not have a competency based system, was more sceptical. She said: 'if there'd been a lot of positive vibes [from the nursing competency system] then I'm sure we'd have looked more strongly to see whether we could do it... We'd need to see very clear benefits from it to spend time away from doing the clinical work.'

2.3.7.6 Staff views

Our data on staff views is drawn from focus groups which were not conducted in every trust (see table 2.3) and, where relevant, staff surveys. Staff experiences varied depending on their occupational group and the trust's pay system. Accordingly, it was not possible to provide a blanket assessment of their views.

Staff views fell into two main categories: their views about the relationship between the pay system and patient care and their views about the fairness of the pay system *per se*. These two areas, although analytically distinct, in practice are not divorced from each other. For instance, morale and motivation relate, whether directly or indirectly, both to patient care and to views about the fairness of the system.

We deal first with staffs' views about patient care. On the positive side, at Large Acute qualified nurses said that the new competency based pay system for CSWs helped to ensure that they had trained support and enabled them to get teams together 'because we each know what we can do'. Another nurse said:

A competency based pay system is a good thing. It should replace annual increments. You shouldn't just sit back on your heels and just expect to get more pay for not performing or achieving.

At Acute Teaching 3 a nursing staff focus group was also generally positive. Comments included 'brilliant, a framework to work towards', 'better than a job description... it tells you the qualities you need'. One thought it had motivated D grade nurses in her area; 'people were a bit lazy before'.

On the negative side competencies may impact negatively on mobility within the internal labour market. As a management interviewee at Acute Teaching 2 pointed out, an E grade nurse who wanted to transfer from a ward into theatres might not have the competencies required for theatres and, if so, could not immediately be offered pay at the level previously enjoyed.

Urban 1's survey of its nurses, midwives and support staff in 1997 found that 44% were of the view that the new pay system had had a positive impact on patient care as opposed to 30% who disagreed and 26% who were either unsure or did not respond to that question. Moreover 45% were of the view that the new pay system had had a positive impact on staff motivation compared to 40% who did not. On the other hand, only 29% of respondents were of the view that it encouraged more flexible working. The survey, which presented rather contradictory findings, only had a 20% response rate, so the results should be treated with caution.

A staff survey conducted by a university in 1996 at Multiservice 1 also had contradictory findings. For instance a bare majority (52%) thought that the individual performance and development review (IPDR) system had undermined staff morale but a similar majority (55%) thought that their performance rating was a fair reflection of their work. In the three focus groups at Multiservice 1 which we carried out in June 2000 we found that staff were virtually unanimously of the view that the IPDR system did not enhance employee morale. Focus group respondents wanted a guaranteed rise, not a performance related one. A typical comment was:

If the nurse's performance is poor, then it is up to the superior to pick it up and address that long before any performance appraisal at the end of the year or something.

The difference between the university's findings and our findings may reflect the difference in time or may be a product of methodological design. The university's findings were based on 693 responses to structured questionnaires, whereas our findings were based on responses derived from focus groups comprising some 20 people in all, where participants were able to talk openly at some length.

A study of staff views on the theatres' pay system by an MBA student at Acute Teaching 2 also revealed some contradictory findings. For instance the study found that staff thought that working relationships were improving but morale remained variable. Our focus groups corroborated these findings.

Turning to staff views about the fairness of their pay, in every trust where we conducted focus groups, staff voiced dissatisfaction with their pay levels (rather than the pay system *per se*) and compared their position with professions inside and outside the NHS. For instance at Acute Teaching 3 nursing staff compared their pay unfavourably with teachers and the police as well as those in private sector industries. Theatre staff at Multiservice 3 made comments such as 'You shouldn't have to be a manager to earn a reasonable salary' whilst laboratory staff, in particular were of the view that they were inequitably rewarded both absolutely and compared to colleagues

in nursing, radiography and physiotherapy. Indeed one MLSO said that although she had worked for many years in the NHS, her daughter, a nurse, was earning more than her.

Staff, however, did not suggest that differences in terms and conditions between occupational groups affected their commitment. Moreover, a union representative in another trust which had not harmonised commented that she did not believe that her members were aware of the terms and conditions of colleagues in other occupational groups and that such differences did not hinder staff from working together. As a nurse at Multiservice 1 said:

Every day you get on with your multi-disciplinary team. You have to get on with them and communicate with them, regardless of whether you're getting paid a penny or a pound because you are all there because of the patient and you are there to work together at the end of the day. That's why I think most nurses are in the nursing profession. The money's not great but it's the profession you choose that you love and enjoy.

As mentioned, trusts have been required to conduct annual staff attitude surveys from 1999 (see sub-section 2.3.6). We were provided with such surveys for five out of our 10 trusts. They all indicated that pay and benefits attracted adverse ratings. It is important to bear in mind, however, that dissatisfaction with pay may reflect more general concerns about pay levels rather than pay systems as such and the latter, not the former, is the focus of this study. Furthermore, the results were from all staff, not solely from those on trust pay.

Finally, our focus groups at Acute Teaching 2 and Community, where the pay rates were inclusive of unsocial hours premia, revealed that staff valued the stability in earnings. Moreover, we were told by a manager at Very Large Acute 2, where there were inclusive rates also, that staff there welcomed the stability in earnings which the system provided. They also liked the lump sum bonus.

2.3.7.7 Union views

We now concentrate on outcome from the unions' point of view. The unions had a strong belief in the principle of equity. In all our case study trusts, the unions considered that their members were inequitably rewarded compared to their responsibilities and the pay enjoyed by those not in the NHS. This view was held regardless of whether their members were on a trust pay system or on the national arrangements.

2.3.7.7.1 General

Turning to pay systems, rather than pay levels, however, where a trust had its own pay regime, unions favoured systems based on the national pay points, albeit with pay progression arrangements altered, rather than pay rates based on new grading structures. They also favoured pay arrangements which resulted in greater equity between different occupational groups, as they did in respect of theatre staff at Acute Teaching 2 and Multiservice 2, or where staff were on a single pay spine as at Community and Very Large Acute 2.

2.3.7.7.2 Performance pay

The unions' main concern on the grounds of equity and their bone of contention with management was performance related pay, especially where fine distinctions between employees were made and/or a significant proportion of employees did not get a performance related increase. For instance a union representative at Very Large Acute 2 said categorically some six years after the introduction of a new pay system: 'we don't agree with the performance pay bonus'. A union representative at Urban 1 said: that the original performance related pay scheme 'was very much behavioural...very subjective' and was working with management to replace it with a new, less subjective, rating system. A union representative at Multiservice 1 said: 'the way I see it, the pay system is that it's human nature. If your face fits you do well.' Indeed, the unions were pleased where they had managed to 'water down' performance related pay. A union representative at Community said:

It's a performance review in a way but we've taken the sting out of that... We've turned it round and said you know, it's only in exceptional circumstances, if somebody's really so awful that they're not going to get it, so we've actually sort of changed the focus.

The unions were also more inclined to favour a system where only one performance increment a year could be awarded, as at Acute Teaching 2, or as in practice occurred at Acute Teaching 3 and Multiservice 2. In addition, the unions preferred the term 'competency based pay system' rather than 'performance based pay system'. A union representative remarked, 'performance related pay has got connotations ...the bells start to ring'.

Whether or not a competency or performance based pay system was used, however, the unions voiced concern over managers' assessment capabilities. The comment by a union representative at Acute Teaching 3 was not untypical:

Competencies, when they work, work well, having a set of standards for all grades irrespective if they're in a clinical area... the equity of the measure, the opportunity to measure candidates against what is fundamental, that is good but the negative aspect of that is that if the appraisal system isn't working effectively, then those competencies aren't benchmarked effectively and they can be used in a negative manner.

2.3.7.7.3 Remuneration

The unions were more likely to favour a new pay system where it led to increased remuneration for their members without distinctions made between them by management. More money had resulted from new pay arrangements for theatre staff at Multiservice 2. At Urban 1 the unions pointed out that although members obtained more money initially when they transferred to the new pay system for nurses and midwives, the bars and forced distribution of the performance pay system meant that in later years only a few reaped significant monetary rewards. Similarly at Acute Teaching 3 a union representative commented that the bars in the pay bands limited members' monetary reward.

2.3.7.7.4 Partnership

In no trust did we receive the impression that management/union relationships were deteriorating. On the contrary a new partnership forum had been set up at Multiservice 3 and was in the throes of being set up at Acute Teaching 3. At Very Large Acute 1 management and unions were working closely together to revise the performance pay system. At Large Acute closer management/union relationships had emerged when, according to the unions, a manager left. At Very Large Acute 2 the unions suggested that they now had more of a partnership with management. These developments boded well for the future.

2.3.8 Summary

This section has reported our findings. Management aims could be categorised as value driven or issues driven. A values based approach was found where trusts were proposing to introduce pay changes for a significant proportion of the workforce throughout the organisation, while an issues based approach was found where trusts were proposing to introduce pay changes for a discrete area only.

The extent to which employees were eligible for trust pay systems varied considerably as did take-up rates. As to new grading systems, half of our trusts used some form of job evaluation, with Medequate being the most common and three trusts adopted single pay spines. Only one trust introduced a very broad banded structure, with no pay maxima to grades and most trusts which introduced their own pay systems ended up with grading structures very little different from the national grading structures. Basic pay apart, there was harmonisation of conditions, particularly working hours at 37.5 hours a week, unsocial hours, overtime premia and on-call payments. Annual leave was the least likely of all the major terms and conditions to be harmonised.

Where trusts introduced new pay systems they all introduced some form of performance/competency payment and, in all except one trust, this was based on the individual, not the organisation. There was, however, a wide variation in the extent that trusts made distinctions between employees' performance. In one trust there were 10 levels of performance payment, while in contrast in two others, where employees received an annual increment if performance was satisfactory, we found no evidence that such an increment had ever been withheld.

The unions did not favour any departure from the national pay arrangements. Given that principled stance there were essentially three pragmatic approaches: management/union agreement; discussions between management and unions prior to the introduction of a new pay system, but not agreement and then subsequently negotiations and agreement on the annual increase; no discussions prior to the implementation of the pay system but subsequently negotiations and agreement on the annual increase.

Management time in developing a pay system was hard to quantify, especially where staff incorporated pay development and implementation into their other duties. Assimilation costs varied between nil and 3.5% of the paybill and in some trusts were absorbed by departments. Evaluation was limited and where it took place it was often small in scale, eg a pilot, and the data collected by trusts, for instance on labour

turnover, sickness, exit interviews, did not distinguish between those on Whitley contracts and those on trust contracts and was often insufficiently comprehensive longitudinally.

As to outcomes, these are summarised in respect of our second research question on the consequences of local pay; (see sub-section 2.4.2 below).

2.4 Discussion and conclusions

We now return to our four research questions which we address in turn.

2.4.1 Research question one

Did local pay resolve the problems associated with Whitley?

Our literature review indicated that the Whitley system was criticised on four main grounds connected with its structure, complexity, lack of local flexibility and equal value problems (see section 1.4).

2.4.1.1 Structure

The current (January 2001) Whitley Council structure is set out in sub-section 1.4.2. In summary there is a General Whitley Council with numerous functional councils and committees. There are over 20 recognised unions, many employer representatives, plus civil servants. Our data based on 10 case study trusts showed that where there were innovations in pay and grading, the structure was greatly simplified. On the management side, there was only one employer, ie the trust. On the union side the number of unions active in the trust varied, but was considerably less than the number recognised nationally. For instance, Very Large Acute 2 recognised nine unions, ie all unions with more than 30 members in the trust and Large Acute recognised seven unions. Acute Teaching 3 recognised 13 unions but had a smaller negotiating group with only six staff side representatives.

Over 25 years ago, McCarthy (1976) recommended that civil servants should have control over the overall cost of pay offers but that the detail of NHS pay structures should be left to NHS managers (see sub-section 1.4.3). From 1991, some trusts introduced their own pay systems, with managers designing their pay structures but civil servants continued to control the overall cost of the paybill in two ways. First, virtually all the income obtained by trusts comes from the Department of Health, albeit often indirectly. Second, because the law provides that some NHS staff can choose to remain under Whitley, settlements were in practice in line with the settlements agreed nationally and, in particular, the awards stemming from the pay review body for nurses and PAMs which are dependant on acceptance by the Secretary of State. In short, some trusts achieved simplification, whilst remaining under a national umbrella of cost control.

2.4.1.2 Complexity

Another problem identified by managers (Warlow, 1989) was the complexity of the numerous, diverse agreements under Whitley (see sub-section 1.4.4). In fact collective agreements were made simpler in a number of trusts. Community and Very Large Acute 2 introduced single pay spines for all except those at board level and non-medical staff and terms and conditions, except for annual leave, were harmonised. Acute Teaching 1 also introduced a single pay spine though the number of occupational categories excluded (eg pharmacists, estates offices and scientists) was greater than in the other two trusts. At Acute Teaching 2, Acute Teaching 3, Multiservice 2, Very Large Acute 1, there was simplification in theatres where ODAs/ODPs and theatre nurses were put on common terms and conditions, instead of being governed by two different Whitley Councils.

In contrast to the move by some trusts towards simplicity, there was greater complexity in other trusts. The prime example was Very Large Acute 1 where there were a variety of trust terms and conditions for many different groups of staff: at Urban 1 for nurses, midwives, nursery nurses and support workers; administrative and clerical staff; hotel services staff; professional staff and theatre staff and at Urban 2 for medical secretaries and staff in Trauma & Orthopaedics and Accident & Emergency. The merger between Urban 1 and Urban 2 in April 1998 further complicated this with new staff being put on the merged trust's contract which essentially mirrored Whitley. At the time of our research, work was being undertaken to reduce the complexities of different pay systems within the trust.

Another example of an increase in complexity was Large Acute. That trust, eschewing an organisation-wide strategic approach, introduced new terms and conditions for maintenance craftsmen, ancillary staff in the central sterile services department, clinical support workers and midwives, each group having different arrangements aimed at resolving particular problems. Even where the trust adopted an organisation-wide approach, however, the resulting pay system did not always lead to simplification. For instance, at Multiservice 1 the new pay system, which introduced eight separate recruitment clusters, abolished increments and had no set pay points above the minima, was not simple.

Pay structures apart, another source of complexity was the pay progression arrangements. Under Whitley pay progression is based on increments dependant on length of service. Such arrangements are simple and easy for staff to understand (and for finance directors to predict paybill costs). All the trusts which had replaced national pay structures, however, had introduced at least an element of performance based pay. Probably the most complex performance based pay progression system was in Urban 1 in respect of nurses and midwives, see sub-section 2.3.3.4, but in every trust union representatives found the performance/competency based arrangements opaque, even though some in theory favoured competency based pay.

2.4.1.3 Centralisation

The third critique by managers centred round what they saw as too much centralisation (Warlow, 1989). This militated against the flexibility which managers said they wanted. From 1991 trusts, by introducing their own pay systems, could

obviate this; but we have seen that one of our case study trusts did not depart from Whitley at all and in only three trusts were the majority of employees covered by pay arrangements which materially differed from the national arrangements; see figure 2.1. A number of reasons why so few trusts seized the opportunity to decentralise have been identified in the literature, including the continuance of national pay arrangements (Carter and Fairbrother, 1999), institutional obstacles (Locock and Dopson, 1999) and the more immediate priorities of pragmatic HR directors (Corby and Higham, 1996); see sub-section 1.4.8 for details.

2.4.1.4 Equal value

Problems relating to equal pay for work of equal value have come to the fore as a result of the Enderby v Frenchay Health Authority (1993) litigation. The European Court of Justice held that NHS employers are required by law objectively to justify differences in pay between male dominated occupational groups and female dominated occupational groups (see sub-section 1.4.6). A factor based job evaluation scheme can provide objective justification and our data show that four of our 10 trusts used a factor based job evaluation scheme (Medequate) for most non-medical occupational groups and one trust used a competency based factor scheme. It has not yet been tested, however, whether or not the ruling in Scullard v Knowles (1996) and South Ayrshire Council v Morton (2001) apply to employees in the NHS, ie whether an employee can compare herself for the purposes of an equal value claim with a colleague employed in another NHS trust.

2.4.2 Research question two

What were the consequences of local pay?

Sub-section 2.3.7 on outcomes gives full details of our findings which were subsumed in this research question. In summary, we found no positive or negative relationship between new pay systems and labour turnover, though given the deficiencies in the data for the purposes of this study, such findings were not surprising. Similarly, we did not find any positive or negative relationship between pay systems and NHS performance indicators. Our qualitative data, however, revealed that many management interviewees and some staff, were of the view that their new pay systems, all of which emphasised performance/competency, had led to an improvement in patient care, though it was generally admitted that this was hard to quantify. Also, our case study data revealed many examples of new pay systems indirectly affecting patient care where they underpinned temporal flexibility: new on-call arrangements, rotating shifts and annual hours (see sub-section 2.3.7). Interestingly, however, while most managers were strongly of the view that harmonisation supported teamworking across occupational boundaries, a minority of managers and most staff were of the view that teamworking took place irrespective of whether terms and conditions were harmonised.

We also found that new pay systems indirectly affected patient care where they underpinned functional flexibility. The most common example of multi-skilling was in theatres between ODAs/ODPs and theatre nurses. Of the nine trusts which had theatres, six were carrying out such multi-skilling and, in managers' views, the consequence was that they were better able to tailor their work to service needs.

There were also some negative consequences. Foremost among these was union hostility. As discussed in sub-section 2.3.7.7, the unions were opposed in principle to local pay and, for instance, at one trust the unions refused to enter into discussions with management even on a 'need to know' basis. Second, the proliferation of diverse pay systems reinforced labour market competition at a time of growing scarcity in many NHS occupations. Third, our focus group data indicated that at least some staff were dissatisfied with the trust's new pay arrangements, particularly where a comprehensive but opaque system of performance related pay had been introduced. Fourth, the development of a trust pay system was less resource efficient than national pay determination as there was a need to 'reinvent the wheel'. To take an example: in five of our case study trusts there was harmonisation of working hours at 37.5 per week, at least among some occupational groups, but in each of these trusts there were discussions with the unions. Harmonisation at national level would perhaps have been more time efficient.

2.4.3 Research question three

Our third research question was as follows:

Were the trusts' pay systems introduced in line with 'new pay' ideas and current trends in reward management?

We address this question using the areas outlined in section 1.5 of our literature review: pay strategies, variable pay, grading structures, harmonisation and variable hours.

2.4.3.1 Pay strategies

We begin by considering whether trusts adopted a strategic approach, as recommended by Lawler (1990; 1995), Mahoney (1989) and Schuster and Zingheim (1992). Our data revealed that only in four trusts was a strategic, organisation-wide approach taken. Three trusts initially planned to take an organisation-wide approach but in the event did not do so. We also considered whether those trusts which adopted a strategic approach, formulated their strategy on a contingency or best practice basis. Given that there was a coincidence in the aims espoused, eg simplicity, flexibility and performance management, our data suggested that a best practice approach was taken. Accordingly, our findings contrast with those of Kessler and Purcell (1996). As all the trusts were in the same 'business', healthcare in England, however, there was perhaps little scope for contingent differentiation.

2.4.3.2 Variable pay

The 'new pay' and reward management writers recommend the individualisation of pay, for instance by performance related pay in place of the rate for the job, and we found that our case study trusts were no exception to the finding of a growth in the use of performance related pay by British employers (Cannell and Wood, 1992): nine out of our 10 trusts introduced at least an element of performance pay. Notably, the rhetoric of performance pay was not always translated into reality. In two trusts, where performance pay was based on annual increments, there was no evidence of

such an increment ever being withheld from an employee. Only in one trust was the entire annual pay award determined by performance and there were no incremental points. In all the other trusts, there was a separate annual review and no indication that trusts had adopted the views of the Conservative government that the annual pay round be 'dethroned'; see sub-section 1.2.1.

Interestingly, our data revealed that trusts' performance pay systems made fine distinctions between employees where they had been introduced in the first half of the 1990s. (For instance one trust distinguished the performance of employees in 10 bandings.) In contrast, we found no examples of trusts which introduced their performance pay systems after 1996 making such fine distinctions.

Our literature review indicated that studies in the UK and USA, in both the public and private sectors, without exception revealed major problems in operationalising merit pay and considerable evidence of negative effects upon employee motivation, see sub-section 1.5.4. Our data from the focus groups, which we held with staff, essentially supported these findings, especially where there was a performance pay system which made fine distinctions between staff. (For further details see sub-section 2.3.7.6).

Only in one trust in respect of nurses and midwives was a specific analysis undertaken in respect of the effect of performance pay on equal opportunities. This analysis revealed no bias in respect of gender or ethnicity. This contrasted with the study of Bevan and Thompson (1992) who looked at four organisations in the public and private sectors and found gender bias. It also contrasted with a study of performance pay in the civil service (Civil Service College, 1995), which found bias on grounds of ethnicity.

Although Kessler (2000) outlines the perceived advantages of skills or competency based progression over traditional output or target related performance pay, the Industrial Society (1998) found little evidence of its use. In contrast, we found what was termed competency based pay in four trusts. Staff in our focus groups were generally positive about the principle of competency based pay, but some of their comments echoed the critiques identified by Sparrow (1996), ie developing competencies is complex and uncertain and existing appraisal techniques may not be sufficiently robust. Also, our data suggested that trusts found it more straightforward to develop competencies based on skills, than on more abstract behavioural attributes. The latter were often evaluated by means of employee portfolios or profiles which could be problematic. We also found, as did Thompson (1995), virtually no evidence of team based performance pay.

2.4.3.3 Grading structures

Our data relating to the use of job evaluation to underpin grading structures contrasted with the views of American 'new pay' writers that job evaluation is in decline. Rather our data accorded with considerable evidence in the UK that the reverse was the case; (see sub-section 1.5.5). Five of our nine trusts which introduced their own pay systems used job evaluation for some or all of their staff. This potentially provides an equal value defence and it can, if the job evaluation system is perceived as fair, (which it was not by a number of staff sides in our case studies), help to ensure that

employees perceive that they are rewarded fairly in comparison with others. In respect of banding within grading structures, we found only limited evidence of broad banding, see figure 2.2. Again this was consonant with a British study (Industrial Society, 1997).

An area where our data accorded with current trends in reward management was the use of harmonisation. The latest WERS survey (Millward et al, 2000) indicated that there has been a shift to single table arrangements and a reduction in bargaining units; (see sub-section 1.5.6). Our data revealed single spines in three trusts. We also found harmonisation of terms and conditions apart from pay; (see table 2.5).

2.4.3.4 Variable hours

Another area where our findings accorded with current trends in reward management was in respect of pay which was kept constant for the employee, although there was variability in the timing, or amount of, the weekly hours worked. The relationship between pay and hours is particularly salient in NHS trusts as they are open seven days a week, 24 hours a day. There were essentially three new main ways in which trusts related pay to hours: first, three trusts had introduced an annual salary calculated inclusive of unsocial hours premia, with three or four rates depending on the unsocial hours worked; second, in one trust on-call payments were consolidated and an annual sum divided equally among rota members; and third, in another trust an annual hours system was introduced for maintenance staff. We found that employers introduced such schemes to control costs and to match hours to service needs, ie akin to the reasons found by Russell (1998), who looked at a range of industries and services.

2.4.4 Research question four

Our fourth research question is:

What factors were critical to the success of developing and implementing 'new pay' systems in NHS trusts?

Essentially, as outlined by Grimshaw (2000), pay and grading systems are the product of a complex interplay of tensions. These include notions of equity, custom and practice, industrial relations traditions, the external labour market, the technology involved and perceived performance management needs. Bearing in mind these complexities, our data revealed a number of critical success factors. First, a close working relationship between management and the staff side was identified by both management and union interviewees to be important in ensuring that arrangements were introduced relatively smoothly. Allied to this, the unions were of the view that union confidence in the trust's project manager was essential if there was to be a smooth introduction of new pay arrangements. One of the union representatives whom we interviewed suggested that a trust-level project manager post should be job shared by a manager and a staff representative. As noted in sub-section 1.3.3, one of the reasons for the slow progress in implementing the 1997 local government agreement was the number of industrial disputes in local councils (IRS, 2000:6).

Second, communication with staff and staff involvement were seen by interviewees to be critical to success. This took a number of forms: for instance at one trust a manager and a union representative jointly saw each member of staff individually to explain how the new pay system would affect the individual and at another trust staff were involved, through focus groups, in determining the competencies required.

Third, we became aware that the introduction of new pay arrangements were exceedingly time consuming and more time consuming than managers in many trusts had anticipated, especially if the introduction of the new pay system went hand in hand with the development of competencies. Indeed, in one trust the development and roll-out of a pay system took six years. It almost goes without saying that HR managers and line managers have other demands on their time. As noted above in sub-section 1.3.3, two city councils had established units dedicated to the implementation of the 1997 local government agreement and our data revealed that three trusts created new project manager posts. Interestingly, in trusts where new pay arrangements were introduced relatively speedily, there was strong board level commitment.

Fourth, staff and union representatives were more likely to have confidence in pay systems if they were transparent. The way decisions on the performance award at some trusts were reached was not clear to staff (or to the researchers) and was criticised by staff representatives.

Fifth, we became aware that harmonisation between occupational groups could provide a catalyst for teamwork. The prime example were theatres where the different Whitley terms and conditions for ODAs/ODPs and nurses were seen as counter-productive to efficient working, with the result that theatres became a priority for new pay arrangements. Moreover, three trusts took harmonisation much further with the establishment of single pay spines. Such single status was largely welcomed by management, unions and staff on grounds of equity. Indeed, the HR director at a trust which had a single spine, expressed concern about the proposal under *Agenda for Change* to introduce three pay spines. We would add, however, that in areas where terms and conditions were not harmonised managers and staff were nevertheless of the view that various occupational groups worked together and we concluded that there were differences of degree in the level of teamwork, rather than of kind.

Sixth, we found that trusts had often subsumed unsocial hours premia into basic pay in exchange for flexible rostering. We found that employees liked the stability of earnings which this produced and there were advantages for management, for instance in being able to predict paybill costs, though it could lead to inflexibilities (see sub-section 2.3.7.2).

Perhaps the most important message of all, however, was that pay systems could not be seen in isolation and were only a part of the HR agenda. Other factors were important, particularly career progression arrangements and pay levels. Virtually all the staff in the focus groups which we held in seven trusts (see table 2.3) voiced their appreciation of any training and development opportunities open to them and voiced dissatisfaction with their pay, comparing their position with professions inside and/or outside the NHS.

2.4.5 Final comment

This report covers the pay and grading innovations introduced by trusts from the early 1990s to 2000. It has shed light on the development and implementation of trust pay structures, looking in particular at approaches to grading and pay progression, and also examining process, costs and outcomes. At the time of writing management and unions are negotiating a new pay and grading system, stemming from the proposals outlined in *Agenda for Change* (Department of Health, 1999), which will result in an agreement to apply to NHS employees nationally. The next phase of our research, which again will result in a report, will evaluate the implementation of this agreement.

GLOSSARY

| | |
|--------|--|
| A & C | Administrative and clerical staff |
| A & E | Accident and Emergency |
| APT&C | Administrative, professional, technical and clerical staff |
| ATO | Assistant technical officer |
| BPR | Business process re-engineering |
| CPP | Continuous process pattern |
| CSSD | Central Sterile Services Department |
| CSW | Clinical support worker |
| DfEE | Department for Education and Employment |
| DOH | Department of Health |
| EAT | Employment Appeal Tribunal |
| ENB | English National Board for Nursing, Midwifery and Health Visiting |
| ESOP | Employee share ownership plan |
| GNVQ | General National Vocational Qualification |
| HCA | Health care assistant |
| HR | Human resources |
| IDS | Incomes Data Services |
| IiP | Investors in People |
| IPD | Institute for Personnel Development; now Chartered Institute for Personnel and Development |
| IPDR | Individual performance and development review |
| IPR | Individual performance review |
| IPRP | Individual performance related pay |
| IRS | Industrial Relations Services |
| JE | Job evaluation |
| LSE | London School of Economics |
| MBA | Master of Business Administration |
| MLSA | Medical laboratory scientific assistant |
| MLSO | Medical laboratory scientific officer |
| MSF | Manufacturing, Science and Finance Union |
| MSR | Management staff review |
| MTO | Medical technical officer |
| N/A | Not applicable |
| NATFHE | National Association of Teachers in Further and Higher Education |
| NHS | National Health Service |
| NJC | National Joint Council |
| NVQ | National Vocational Qualification |
| ODA | Operating department assistant |
| ODP | Operating department practitioner |
| ONS | Office for National Statistics |
| PAM | Professions allied to medicine |
| PDR | Performance development review |
| PFC | Patient focused care |
| PRB | Pay review body |
| PRP | Performance related pay |
| PTA | Professional and technical A (Whitley Council) |
| PTB | Professional and technical B (Whitley Council) |
| RCM | Royal College of Midwives |
| RCN | Royal College of Nursing |
| SALT | Speech and language therapist |
| SoR | Society of Radiographers |
| T & O | Trauma and Orthopaedics |
| TUPE | Transfer of Undertakings (Protection of Employment) Regulations 1981 |

| | |
|------|---------------------------------------|
| UK | United Kingdom |
| USA | United States of America |
| WERS | Workplace employee relations survey |
| WIRS | Workplace industrial relations survey |

APPENDIX A

Our original research questions, as outlined in our proposal (December 1999) were reformulated to take account of our literature review and absorb our earlier questions. Our revised research questions were as follows:

- Did local pay resolve the problems associated with Whitley?
- What were the consequences of local pay?
- Were the trusts' pay systems introduced in line with 'new pay' ideas and current trends in reward management?
- What factors were critical to the success of developing and implementing new pay systems in NHS trusts?

Our original proposal listed the following research questions:

1. What, if any, changes in working practices have taken place since the trust was established, in particular in respect of task flexibility and temporal flexibility?
2. Are these changes in working practices related to changes in pay and, if so, how?
3. When harmonising conditions of service what are the optimum arrangements?
4. Where changes in pay and grading have taken place, what management and union resources were needed?
5. How have trusts evaluated the costs/benefits of their pay and grading arrangements?
6. Is the pay regime felt to be fair by staff?
7. Has a partnership approach by management/unions been adopted in decisions on pay, grading and working practices?

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