NHS Trade Union response to HMT consultation on reforms to public sector exit payments.

Introduction & general comments

We are unclear from the consultation the extent to which Government wishes to impose new arrangements (whether that be through an enabling agreement or with specific centrally set terms) or would prefer each public service to negotiate new arrangements through their own collective bargaining structures. Our view is that this matter is best left, for the reasons seen below, to the NHS Staff Council and the collective bargaining process.

Agenda for Change (AFC) terms and conditions of employment apply to all NHS staff with the exception of Drs and Dentists and very senior managers (vSMs). AFC Section 16 (redundancy arrangements and payments) also applies to Drs and Dentists, board executives and other senior managers.

It appears to us that the driver for the proposed changes is not ‘harmonisation’ across public sector employers but rather a reduction in redundancy benefits (and other associated benefits) in order to make the dismissal of staff more affordable. It is a pre-cursor to another round of dismissals and reorganisation.

There also appears to be a continued desire to assuage the indignation in some parts of the media at the inaccurate perception of excessive public sector exit payments from a few unrepresentative or distorted reported examples. Union members view that the Governments approach tends to demonise public sector workers either for their pay, terms and conditions or pension benefits. There is little attempt by Government to recognise the full value of the output of workers such as NHS staff. The down banding of staff onto lower rates of pay while still expecting them to ‘work as normal’ to their previous job description is but one example of the level of disregard many employers have for their staff. This consultation, along with many previous ones, coming as it does in the wake of both specific changes to NHS Agenda for Change exit terms (see below) and legislation currently in process to cap exit payments and claw back of payments made when redundant staff secure for themselves alternative employment elsewhere in the public sector, will be seen as another vindictive approach and another confirmation that public sector workers are to remain demonised.

We would also point out that, in the face of opposition, the Government seems intent on including the cost of employer-funded pension top up payments within the £95k imposed by the Enterprise Bill. Depending on an individual’s circumstances, and secondary legislation, it could therefore be the case that what an individual receives will be reduced even under existing powers. We do not therefore feel that there is any rational case for seeking further changes or reductions in this area.

The approach from Government appears solely based on post exit costs rather than attempting to stop the costs arising in the first instance. Cheaper public sector exit payments are no alternative to good workforce and succession planning obviating the need to make exit payments at all. The issue for discussion should be how the service can maximise and retain the skills of its workforce (often themselves trained and educated at considerable public expense) for the benefit of patients and
clients. It should be about how can organisations that do have to release staff help them (and other employers) by ensuring that they remain in the NHS or the wider public sector and not have their employment terminated.

Compensatory payments for dismissal on the ground of redundancy should only occur if there are no NHS jobs for someone to move to. In our response on the exit payments consultation we reminded HMT that there is an obligation on employers to look widely to find alternative employment for staff at risk. We are not convinced that such a thorough search always happens. It may be the case that such alternative posts are in reality not there but it might be more the case that there is insufficient interest in individual employers (who are in effect competitors with each other) working together to reduce the impact of redundancies on the service and on their staff.

As in other consultations (see the capping of exit payments) there is no recognition that for many staff in healthcare the NHS it is their only conceivable employer. For many staff it is a monopsony employer and the reality is that dismissal from the service on the grounds of redundancy, particularly at more senior levels, is in effect the end of their professional career. Even if such staff gain some other post-NHS employment it is likely to be of lesser status/pay and with lesser future opportunities for clinical or professional advancement. In some ways this is reflected in the comments in the consultation that many staff have long service and certainly the number of ‘graduate level’ roles in the NHS is much larger than in the UK workforce as a whole.

The impact on the effective management of resources and particularly the management of change also needs to be considered. The NHS intends to use new models of care and place-based transformation plans to save money, meet rapidly rising demand and improve quality. These plans required high levels of staff engagement and re-organisation of services if they are to succeed. Fears about job security are major barriers to successful change. A stable redundancy framework is a key element in maintaining both staff engagement and staff retention at times of organisational change and instability.

**Scope of this consultation**

This consultation deliberately conflates three very different issues; redundancy payments, voluntary redundancy payments and payments linked to mutually agreed resignation schemes (AFC S 22).

Someone who is made redundant from the NHS is deemed to be dismissed from the service by reason of redundancy. They have no choice in the matter and their NHS employer will have been unable to find them suitable alternative employment either in their own Trust or with another NHS employer. On termination their post is lost to the service. These circumstances are different, in many cases, to someone who volunteers to leave in a ‘redundancy situation’ or others who mutually agree to leave in return for a lump cash sum (in these cases a post is not lost and someone else can be redeployed into it). Whilst the consultation suggests that payments in voluntary redundancy or mutual resignation could be larger (within an agreed set tariff) we would argue that in cases where employment is compulsorily terminated the largest compensatory payment should follow.
Agenda for Change

AFC commenced in 2004 and is part of an overall employment package that includes a bespoke job evaluation scheme and knowledge and skills framework. It covers over 1 million employees. AFC was introduced with minimal service disruption and with minimal or no industrial conflict. This partnership approach was extended to the work on the 2008 and 2015 NHS pension schemes introduced to ensure long-term sustainability.

AFC is a joint agreement between trade unions and employers and managed, developed and renegotiated within the NHS Staff Council. The AFC system is a dynamic partnership process and there is clear evidence over the last 12 years that it has been responsive to the need for change in the service. The Job Evaluation Scheme embodied in AFC supports equal pay for equal work principles and facilitates the creation of new healthcare roles and ways of working.

If we look first at S16 (redundancy arrangements) we will see that this was originally transferred across intact from the previous Whitley arrangements. However after 2004 S16 was revised in the context of, then, new age discrimination legislation significant changes were made. Redundancy payments based on different age thresholds were replaced by uniform arrangements based on overall length of service. The significant advantage that those aged over 50 received in added years compared to those under that age was removed and new transitional arrangements were put in place so that those at risk of redundancy within five years continued to receive some additional (but reducing) service enhancement.

After this, NHS trade unions became aware of employers offering staff cash incentives to give up their employment outside of formal redundancy situations to support re-organisation. The trade unions saw that this was happening on an ad hoc, potentially challengeable, unfair basis across the service. It was the trade unions that brought employers and the Health Department (DH) around the table to set in place a formal structure whereby this process could be managed safely and at no risk to the service, employers and individuals. The outcome of this was the introduction of AFC S 20 Mutually Agreed Resignation Schemes – essentially an ‘enabling provision’ within AFC upon which local employers can manage the process. MARS schemes are at cost to the employer and hence trust boards require them to be supported by a local business case assuring any particular example is in the best (financial) interests of the organisation and hence indirectly the public purse.

In England and Wales recent changes to AFC (S16 (a)) have introduced a cap and floor on earnings levels for staff. All of the changes from 2004 have been secured through the Staff Council process and with a commitment from all towards ongoing partnership working. The lesson to be learned is that AFC works, has delivered significant changes in this area of terms and conditions and that leaving such discussions to the parties involved is the best way to get a satisfactory and enduring outcome for the service in its specific contexts.

Employers and unions have therefore made clear trade-offs in collective bargaining in favour of tariff (e.g. retaining four weeks pay but introducing a cap and floor on earnings) against other elements of the redundancy package (such as employer top up for early retirement). These trade-offs have been made carefully in consideration of both the priorities of our members and the needs of the employer. The proposed framework would ride roughshod over these arrangements.
Setting a maximum tariff

Redundancy payments have a number of purposes. The easiest way to understand them is as a form of compensation for the involuntary loss of employment to mitigate hardship until alternative employment or formal retirement, is secured. A more subtle function is as a facilitator of ‘organisational change’. The more a redundancy payment is seen to reflect a degree of fairness and reasonable compensation the greater chance an employer has of its workforce seeing reorganisation as a non-threatening experience.

The NHS in England and Wales has already set a maximum level of pay for redundancy purposes at £80,000. This should be reviewed regularly and should keep pace with NHS pay rises. This is not an acceptance of a ‘cap’. The NHS (England and Wales) has also set in place a minimum earnings level of £23,000 to recognise that impact of dismissal is as much to bear for lower earners as it is for higher earners. These levels should remain open to further discussion in the Staff Council. The NHS levels were set in particular circumstances and apply only to part of the NHS. They were never seen as being a prescription for Scotland and Northern Ireland and even less the wider public sector. We do not agree with the introduction of tariffs underpinned by statutory provisions.

The proposal suggests that the tariff would be three weeks’ pay for each year of service. There appears to be no logical reason for this other than that of ‘harmonisation’. The suggestion that employers might ‘apply’ a lower limit in reality means that the tariff is a maximum amount and that employers can go (and may well be encouraged to go) as far below that level as they can get away with. We note that ‘apply’ is chosen to describe this process as opposed to ‘negotiate’ and/or ‘agree’.

It is also suggested that a 15 month cap be introduced to cap the length of service that can be used.

The introduction of tariff caps based on weeks’ pay and service considered impacts mathematically equally on all affected staff irrespective of pay. In practice we would maintain that the lower paid are more immediately and dramatically affected by serious hardship.

It will be helpful to look at how these tariffs, if imposed, will affect an average earner in the NHS.

Let’s look at someone earning £27,000pa (AFC Band 5) with 20 years’ service. Currently if made redundant (i.e. dismissed through no fault of their own) they would receive £41,000 (subject to tax).

If a 3 week/15 month tariff were introduced their compensation for dismissal would be reduced to £23,300, a reduction of £17,700 or 30%. If looked at as compensation measured in months’ pay we can see that it reduces from 20 months’ pay to 8.5 months. It is difficult to see how the introduction of this into the NHS can be seen as anything other than a punitive sanction.

The information provided by the Government in box 4.A shows that the average redundancy payment in the public sector is a little higher than in the private sector. Much of this gap might be explained by the factors mentioned in box 4.A, namely the longer average service in the public sector. However we would also point out that, while individual settlements inevitably vary depending on a range of circumstances, the average redundancy payment is less than 60% of the annual average salary of £27k in the economy. This hardly smacks of over-generous treatment of those public sector workers who have lost their jobs.
Setting a taper for repayment

If nothing else in this consultation this element identifies the confusion in Government thinking and policy. The proposals suggest that someone nearing their normal pension age in a public sector pension scheme should have their compensation reduced to take account of the fact that they will be accessing a pension. We would remind Government that there are many ‘normal pension ages’ (NPA) in the NHS scheme; 55, 60, 65 and state pension age. It does not follow that all employees will be in the NHS scheme or that, if in it, they will have service sufficient enough to get a ‘good pension’ on retirement. (We would however note that the average NHS pension is less than £5000 pa.) Neither is it the case that someone intends to retire at their NPA. Indeed elsewhere it is government policy to encourage the (skilled) workforce to work longer and considerable work has been undertaken to facilitate this. Their circumstances may be such that they have no intention at all of retiring at NPA and the older someone is it is often the case that their proposed retirement date moves back in recognition that they realise they will have to work longer in order to pay off mortgages, see the children through college, pay for the care of elderly family members or that their pension will just not be sufficient to retire on. It may also be the case that for lower earners they will continue in work until such time as they can take their NHS and state pensions together. The Government proposal chooses to ignore all these possibilities and impose a hard and fast age at which their compensation will reduce.

Responses to specific questions

1) Are there alternative options and approaches to compensation provision reform you think the government should be considering? What alternative approaches would you suggest and why?

We support the continuation of collective sector-specific bargaining within the remit of the NHS Staff Council and oppose any imposition of tariff’s or tapers. We believe the history of AFC has shown that it is a dynamic and mature process that should be retained and supported by Government. We see these proposals (and earlier ones) as essentially undermining the confidence that Government should have in public sector employers negotiating what is best for the service.

2) Do you agree with the proposed approach of limiting early retirement benefits with reference to the cost for the employer? What alternative approaches would you suggest and why?

This has already been applied in the NHS, as part of a negotiated package of redundancy terms. This does not mean that it is appropriate for other public sector groups.

3) Do you agree with the proposed options around capping tariff terms? What alternative approaches would you suggest and why?

No.
In particular capping devices based on weeks of pay and duration of service disproportionately disadvantage the lower paid and possibly involve indirect discrimination because of the demographics of workers in those roles.

4) *Do you agree that the Government has established the correct scope for the implementation of this policy? Are there other factors the government should take into account with regard to scope?*

The policy cannot be implemented in isolation of the taxation regimes for exit payments. We note that HMRC already claws back a significant proportion of higher exit payments in terms of higher rate tax paid on payments in excess of £30,000.

5) *Are there other impacts not covered in the above which you would highlight in relation to the proposals in this consultation document?*

The consultation should focus much more on good workforce management and planning across the whole public sector to avoid waste and maximise the utilisation of dedication to public service and rare sector-specific skills. Two areas could be prioritised: minimising the number of structural re-organisations contemplated in the NHS by central government and maximising the redeployment of ‘at risk’ staff in the NHS and related services.

6) *Are you able to provide any further information and data in relation to the impacts which may be relevant to the government in setting out the above?*

7) *Are you able to provide information and data in relation to redundancy provisions in the wider economy which could be used to inform government’s response to this consultation?*

G O’Dwyer

On Behalf of NHS Trade Unions

Gerry.odwyer@rcn.org.uk

0207 647 3661

May 3 2016