



NHS Pay Review Body

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Thirty-Fourth Report 2021

Chair: Philippa Hird



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**Presented to Parliament by
the Prime Minister and Secretary of State for Health and Social Care
by Command of Her Majesty**

**Presented to the Welsh Parliament by
the First Minister and the Minister for Health and Social Services**

**Presented to the Northern Ireland Assembly by the First Minister,
deputy First Minister and Minister of Health**

July 2021



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NHS Pay Review Body

The NHS Pay Review Body (NHSPRB) is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for Health and Social Care in Scotland, the First Minister and the Minister for Health and Social Services in Wales, and the First Minister, deputy First Minister and Minister for Health in Northern Ireland, on the remuneration of all staff paid under Agenda for Change and employed in the National Health Service (NHS)¹.

In reaching its recommendations, the Review Body is to have regard to the following considerations:

- the need to recruit, retain and motivate suitably able and qualified staff;
- regional/local variations in labour markets and their effects on the recruitment and retention of staff;
- the funds available to the Health Departments, as set out in the Government's Departmental Expenditure Limits;
- the Government's inflation target;
- the principle of equal pay for work of equal value in the NHS;
- the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

The Review Body may also be asked to consider other specific issues.

The Review Body is also required to take careful account of the economic and other evidence submitted by the Government, Trades Unions, representatives of NHS employers and others.

The Review Body should take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief, and disability.

Reports and recommendations should be submitted jointly to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for Health and Social Care in Scotland, the First Minister and the Minister for Health and Social Services in Wales, and the First Minister, deputy First Minister and Minister for Health in Northern Ireland.

Members of the Review Body are:

- Philippa Hird (Chair)
- Richard Cooper
- Patricia Gordon
- Neville Hounsome
- Stephanie Marston
- Professor Karen Mumford CBE
- Anne Phillimore
- Professor David Ulph CBE

The secretariat is provided by the Office of Manpower Economics.

¹ References to the NHS should be read as including all staff on Agenda for Change in health and social care service organisations in Northern Ireland.

Contents

Report Structure			vii
		Introduction	vii
		Our 2020 report	vii
		Remits for 2021/22	vii
		The structure of our report	viii
<i>Chapter</i>	1	Introduction	1
		Introduction	1
		The context for the 2021/22 pay round	1
		Our 2020 Report	2
		Remits for 2021/22	3
		Evidence submissions and visits	5
		Our overall approach	7
<i>Chapter</i>	2	National Health Service Context	9
		Introduction	9
		NHS finances	9
		Demand and quality of care	10
		NHS workforce	17
		Our assessment on the context for the Agenda for Change workforce	20
<i>Chapter</i>	3	The Parties' Evidence	21
		Introduction	21
		COVID-19 and the impact on the National Health Service and Agenda for Change staff	21
		Workload and additional hours	26
		Gender and ethnicity	27
		Economy and labour market	29
		NHS funding and affordability	31
		Supply and recruitment	34
		Vacancies and shortage groups	41
		Morale and motivation	42
		Retention	44
		Agenda for Change earnings	47
		Total reward and pensions	50
		2018 Agenda for Change pay agreements	51
		Pay approaches	56
		Recruitment and Retention Premia	63
		High Cost Area Supplements	64
		Workforce strategies and workforce numbers	64
		Service transformation, integration and productivity	68

<i>Chapter</i>	4	Agenda for Change Staff in the NHS – Our Analysis of the Evidence	71
		Introduction	71
		Staff experience of COVID-19 to date	71
		Forthcoming challenges for staff	74
		Gender and ethnicity	76
		Economy and labour market	85
		NHS funding and affordability	89
		Workforce numbers and recruitment	91
		Vacancies and shortage groups	105
		Morale and motivation	110
		Retention	123
		Earnings	128
		2018 Agenda for Change pay agreements assessment	143
<i>Chapter</i>	5	Pay recommendations	149
		Introduction	149
		Pay proposals	149
		Our concluding arguments	150
		Our recommendations	157
		Nurses’ pay	158
<i>Chapter</i>	6	Forward Look	161
		Introduction	161
		COVID-19	161
		Workforce strategy and planning	161
		National workforce policies	162
		Total reward	163
		Service transformation, integration and productivity	164
		High Cost Area Supplements	166
		Recruitment and Retention Premia	167
		Evidence gaps and data limitations	167
<i>Appendix</i>	A	Remit Letters	169
<i>Appendix</i>	B	Agenda for Change Pay Bands Under The Framework Agreement In England 2018/19 – 2020/21	175
<i>Appendix</i>	C	Previous Reports of the Review Body	179

NHS PAY REVIEW BODY 2021 REPORT

Report Structure

Introduction

1. The NHS Pay Review Body (NHSPRB) is an independent body that makes recommendations to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for Health and Social Care in Scotland, the First Minister and the Minister for Health and Social Services in Wales, and the First Minister, deputy First Minister and Minister for Health in Northern Ireland, on the remuneration of all staff paid under Agenda for Change and employed in the National Health Service (NHS) (in England, Wales and Scotland) and Health and Social Care (HSC) in Northern Ireland.
2. Our report provides recommendations for 2021/22 for Agenda for Change (AfC) staff as they emerge from the 2018 three-year pay agreement that was in place across the UK. We have made our pay recommendation for 2021/22 in the context of our remit letters and have assessed the evidence, data and information as they relate to our standing terms of reference.

Our 2020 report

3. We submitted our 2020 Report to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and Minister for Health and Social Services in Wales, and the First Minister, deputy First Minister and Minister of Health in Northern Ireland on 29 May 2020. The Scottish Government did not provide a remit for 2020/21.
4. On 21 July 2020, the UK Government accepted our report and noted the work and helpful observations of the Review Body. On 21 July 2020, the Welsh Government's Minister for Health and Social Services wrote to us and confirmed that he had noted our observations on Wales. On 27 July 2020, the Minister of Health for Northern Ireland wrote to us and noted our observations and conclusions going forward.

Remits for 2021/22

5. The respective three-year AfC pay agreements were in place in England, Wales and Scotland from 2018. Following the restoration of the Northern Ireland Executive in January 2020, an agreement on a pay award for 2019/20 and 2020/21 was reached, which brought Northern Ireland AfC pay structures in line with England and Wales from 1 April 2020.
6. The Secretary of State for Health and Social Care, the Minister for Health and Social Services in Wales, and the Minister of Health in Northern Ireland asked us in their corresponding remit letters to make a recommendation for a pay award for AfC for 2021/22.
7. The Cabinet Secretary for Health and Sport² in Scotland wrote to us and said that due to the industrial relations landscape, Scotland should take a collective bargaining approach to reach a settlement for the 2021/22 pay round and confirmed that the Review Body would not be required to make recommendations for the 2021/22 pay round.

² On 19 May 2021, the title of Cabinet Secretary for Health and Sport became Cabinet Secretary for Health and Social Care. Available at: <https://www.gov.scot/news/new-scottish-cabinet/>

The structure of our report

8. The structure of our report is set out below.

Chapter 1 – Introduction

9. Chapter 1 sets out the context to our consideration of this year’s remits, explains our approach to conducting the review, and outlines the structure of this report. It covers: the context for the 2021/22 pay round; our 2020 report; remits for 2021/22; evidence submissions and visits; and our overall approach.

Chapter 2 – National Health Service context

10. Chapter 2 sets out the context of NHS developments relevant to our considerations of the AfC workforce. It covers: NHS finances; demand and quality of care; and NHS workforce.

Chapter 3 – The parties’ evidence

11. Chapter 3 sets out a summary of the parties’ evidence submissions. It covers: COVID-19 and the impact on the NHS and AfC staff; workload and additional hours; gender and ethnicity; economy and labour market; NHS funding and affordability; supply and recruitment; vacancies and shortage groups; morale and motivation; retention; Agenda for Change earnings; total reward and pensions; 2018 Agenda for Change pay agreements; pay approaches; Recruitment and Retention Premia; High Cost Area Supplements; workforce strategies and workforce numbers; and service transformation, integration and productivity.

Chapter 4 – Agenda for Change staff in the NHS – Our analysis of the evidence

12. Chapter 4 sets out our analysis and assessment. It covers: staff experience of COVID-19 to date, forthcoming challenges for staff; gender and ethnicity; economy and labour market; NHS funding and affordability; workforce numbers and recruitment; vacancies and shortage groups; morale and motivation; retention; earnings; and 2018 Agenda for Change pay agreements assessment.

Chapter 5 – Pay recommendations

13. Chapter 5 provides a **comprehensive summary** of the key factors influencing our recommendation and observations this year, and our conclusions alongside those recommendations and observations. It covers: pay proposals; our concluding arguments; our recommendation; and observations.
 - Our 2021/22 pay **recommendation** is a consolidated award of 3% from 1 April 2021 for all Agenda for Change staff.
 - We urge employers to continue to develop the mechanisms they have to support the **rest and recuperation** of AfC staff.
 - We set out our particular concerns about **nurses’ pay**.

Chapter 6 – Forward look

14. Chapter 6 sets out our forward look. It covers: COVID-19; workforce strategy and planning; national workforce policies; total reward; service transformation, integration and productivity; High Cost Area Supplements; Recruitment and Retention Premia; and evidence gaps and data limitations.

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Professor Karen Mumford CBE
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23 June 2021

Chapter 1 Introduction

Introduction

- 1.1 This chapter sets out the context to our consideration of this year's remits, explains our approach to conducting the review and outlines the structure of this report. The three-year Agenda for Change (AfC) pay agreements were in place across each country in the UK between the financial years 2018/19 and 2020/21. The NHS Pay Review Body (NHSPRB) received remits from England, Northern Ireland and Wales governments for this year's pay round and this report includes our pay recommendations for 2021/22. The Scottish Government wrote to us to say that it would not be providing us with a remit this year and that they would instead take a collective bargaining approach to reach a settlement for the 2021/22 pay round.

The context for the 2021/22 pay round

- 1.2 Our report this year has, again, been completed against the ongoing background of the coronavirus (COVID-19) pandemic. The National Health Service (NHS) entered the pandemic facing existing challenges in delivering planned service changes alongside continuing financial pressures and increases in demand. NHS staff faced the risk of infection from the virus. Office of National Statistics data² show that between 9 March and 28 December 2020 there were 414 deaths involving COVID-19 registered among health care workers, aged 20 to 64 years in England and Wales. Sickness absence rates in the NHS increased in the spring of 2020 and again into the autumn. Staff experienced additional stress from fear of bringing the disease home to their families and working conditions that for many were difficult. The effort of NHS staff has been appreciated by the public. However, there is an ongoing challenge created by new variants, a significant backlog of care to tackle and an exhausted workforce that needs time to recover.
- 1.3 The evidence of disproportionate mortality and morbidity amongst some ethnic minorities who contracted COVID-19 has grown over the last year. In the NHS, a risk-assessment process for frontline NHS staff showed that those from ethnic minorities were more likely to be working in roles with increased risk and more exposure to COVID-19.
- 1.4 In previous reports, we have commented on the scale of the AfC workforce gap that has persisted for a number of years and is widely acknowledged as a continuing pressure for the NHS. Some level of vacancies is inevitable, and vacancy rates show some encouraging signs with falls over the last year. However, there is still some way to go to bring them to acceptable levels.

² ONS (25 January 2021), *Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered between 9 March and 28 December 2020*. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/death-registered-between-9-march-and-28-december-2020#deaths-involving-covid-19-among-men-and-women-health-and-social-care-workers>

- 1.5 The AfC workforce in the NHS is emerging from the three-year deal covering the period to 2020/21. This saw significant investment in the workforce as a response to substantial workforce shortages. Its implementation has created some challenges and we have commented on these in previous reports. As a result of its complexity, there were communication challenges and staff found it difficult to understand what their pay increase would be and why. The deal also remains unfinished after the three years, with the restructuring of the AfC pay structure due to be completed in 2021/22. An increase of around 0.7% on the pay bill this year will cover this overhang to allow the removal of the existing transitional pay points for Bands 5, 6 and 7 and leave each with three pay points.
- 1.6 The devolved administrations have responded to the pandemic differently from a pay perspective, making the following payments to staff:
- On 30 November 2020, the First Minister of Scotland announced a one-off gross payment of £500 to full-time staff (payable on a pro rata basis for part-time workers);
 - On 28 January 2021, the Northern Ireland Health Minister announced a one-off recognition payment for Health and Social Care (HSC) staff of £735 per person (estimated to result in a net award of £500 after tax and national insurance); and
 - On 17 March 2021, the Welsh Minister for Health and Social Services announced the one-off bonus payment for NHS and social care staff equivalent to £735 per person, to cover the basic rate of tax and national insurance contributions incurred, and that after deductions most people would receive £500.
- 1.7 The pandemic has resulted in considerable uncertainty in much of the data we typically assess to inform our recommendations. Pay review bodies make judgements based on the best available evidence. This was more challenging this year. The evidence on the potential long-term impact of COVID-19 on the economy, society, the NHS and those who work in it is only just emerging. The economic and labour market data and forecasts are more volatile than usual. We had much testimony but limited data on the way in which the pandemic had impacted on the working lives of AfC staff.
- 1.8 As the Review Body, we have been made very aware of the sensitivity of our pay recommendation this year. The public displays in the early phases of COVID-19 demonstrated to NHS staff the value attached to their services by the people they serve. Staff bodies have called for substantial pay increases as evidence that the governments also value their contribution both during and beyond the pandemic. In England, the government has set out a pay pause for the majority of the public sector, and in Northern Ireland rises have been limited to 1%. Whilst both England and Northern Ireland have exempted NHS staff from their national public sector pay policies and, with Wales, sought our recommendation, it has been clear that the fiscal position is challenging, and there are significant calls on the public purse and difficult choices for governments to make. There are considerable differences between the parties, and we recognise that views are strongly held.

Our 2020 Report

- 1.9 We submitted our 2020 Report to the Prime Minister, the Secretary of State for Health and Social Care, the Minister for Health and Social Services in Wales, and the Permanent Secretary of the Department of Health, Northern Ireland on 29 May 2020. The Scottish Government did not provide a remit for 2020/21.

- 1.10 On 21 July 2020, the UK Government accepted our report and noted the work and helpful observations of the Review Body. On 21 July 2020, the Welsh Government's Minister for Health and Social Services wrote to us and confirmed that he had noted our observations on Wales. On 27 July 2020, the Minister of Health for Northern Ireland wrote to us and noted our observations and conclusions going forward.

Remits for 2021/22

- 1.11 The respective three-year AfC pay agreements for England, Wales and Scotland were in force between the Financial Years 2018/19 to 2020/21. Following the restoration of the Northern Ireland Executive in January 2020, an agreement on a pay award for 2019/20 and 2020/21 was reached, which brought Northern Ireland AfC pay structures in line with England and Wales from 1 April 2020. We comment in Chapter 4 on the implementation and impact of the pay agreements.

Secretary of State for Health's remit letter

- 1.12 The Secretary of State for Health and Social Care wrote to us on 18 December 2020 to commence the 2021/22 pay round. The Secretary of State said that although the UK Government had paused pay awards for the majority of the public sector, the uniquely challenging impact of the COVID-19 pandemic on the NHS had meant there was a commitment to continue to provide NHS workers with a pay rise and our pay recommendations for all AfC staff employed by the NHS were therefore sought. The Secretary of State continued by stating that our recommendations should take into account the extremely challenging fiscal and economic context and consider the affordability of pay awards. The affordability of pay recommendations would have to be considered within the context of the significant financial and economic pressures that had resulted from the COVID-19 pandemic, both within the NHS and wider public finances. He requested that in our final report we describe the way in which we have taken account of affordability, the need for workforce growth and making best use of the funds available to deliver the best care for patients, and have balanced these with the importance of continuing to recruit, retain and motivate NHS staff.
- 1.13 The Secretary of State reiterated the Spending Review announcement that public sector workers earning the full-time equivalent of less than £24,000, would continue to pay uplifts at a value of £250 or the National Living Wage increase, whichever is higher. While not wanting to prejudge our recommendations, he set out that staff within the NHS with salaries below this threshold should expect to receive pay increases no lower than this level and our recommendations should be made within this context.

Northern Ireland

- 1.14 The Minister of Health, Northern Ireland wrote to us on 8 January 2021 to commence the 2021/22 pay round. He noted that following considerable engagement with employers and trade unions throughout the year, an agreement on a pay deal for 2019/20 and 2020/21 was reached. This deal restored pay parity, with England and Wales, for AfC staff in Northern Ireland with effect from 1 April 2019. He noted the UK Government's public sector pay policy, its pause of pay awards and its announcement that NHS staff would receive a pay uplift in recognition of their efforts in addressing COVID-19. The Minister continued by saying that he would welcome recommendations on pay for Northern Ireland and that these recommendations should take into account of the economic context and affordability issues.

- 1.15 The Minister said that he would be interested in the views of the Review Body on wider recruitment, retention and staff motivation factors specific to Northern Ireland. He also said he would particularly welcome views which might highlight staff migration, recruitment deficiencies and key behavioural drivers.
- 1.16 On 16 March 2021, the Northern Ireland Executive announced their public sector pay policy for 2021/22. Key aspects of the policy included:
- There would not be an across-the-board public sector pay freeze;
 - Pay awards of up to 1% would be allowed in addition to any legally entitled progression increases (which will typically result in an overall increase in the pay bill of around 2%) where reforms are agreed;
 - Given the particular impact of COVID-19 on the health service, the 1% limit on pay awards would not apply to those staff groups. Rather the recommendations of the NHS and Doctor and Dentist's Review Bodies, which have been asked to report by the Government, will be taken into account in the determination of those pay awards;
 - Continued progression of the Living Wage Foundation Living Wage;
 - Pay awards, including any higher awards proposed would have to be found from within existing departmental budgets or funded through efficiencies; and
 - There would be flexibility for higher awards in return for cash releasing efficiency savings through improvements to public sector productivity.

Welsh Government

- 1.17 The Minister for Health and Social Services wrote to us on 18 January 2021 to commence the 2021/22 pay round. The Minister said the Welsh Government would be asking the Review Body for pay recommendations specifically on what would be a fair and affordable pay rise for AfC staff, in light of the wider economic situation to help them sustain the NHS in Wales and deliver the priorities set out in *A Healthier Wales: Our Plan for Health and Social Care*³. The Minister continued by stating that the advice and recommendations of the Review Body would enable him to determine a fair pay award for AfC staff across NHS Wales.

Scottish Government

- 1.18 The Cabinet Secretary for Health and Sport⁴ wrote to us on 30 September 2020 to set out the Scottish government's position for 2021/22. The Cabinet Secretary said that due to the industrial relations landscape, Scotland should take a collective bargaining approach to reach a settlement for the 2021/22 pay round and confirmed that the Review Body would not be required to make recommendations for the 2021/22 pay round.
- 1.19 On 24 March 2021, the Scottish Government offered a pay uplift for the 154,000 NHS Scotland AfC health workers. The pay rise would ensure that staff on pay Bands 1 to 7 would receive at least a 4% pay rise compared to 2020/21, with staff who earned less than £25,000 in 2020/21 getting a guaranteed minimum increase of over £1,000 in 2021/22. This would mean that staff on the lowest AfC pay point would get a 5.4% increase. Those on the highest pay points would receive uplifts of £800. While pay increases were usually effective from 1 April, the 2021/22 pay settlement would be backdated to 1 December 2020 in recognition of an exceptional year of significant pressure for staff.

³ Welsh Government (8 June 2018), *A healthier Wales: long term plan for health and social care*. Available at: <https://gov.wales/healthier-wales-long-term-plan-health-and-social-care>

⁴ On 19 May 2021, the title of Cabinet Secretary for Health and Sport became Cabinet Secretary for Health and Social Care. Available at: <https://www.gov.scot/news/new-scottish-cabinet/>

- 1.20 Following consultative ballots of their members, a majority of health trades unions notified the Scottish Government of their acceptance of the offer. The exceptions were RCN and GMB, where members voted to reject. On 14 May 2021, the Scottish Government announced immediate implementation of the offer.

Evidence submissions and visits

- 1.21 Our considerations were informed by the parties' written and oral evidence submissions and our analysis of a range of pay and workforce information, which were supplemented by our visits to NHS organisations and education providers.

Parties submitting evidence

- 1.22 Between January and April 2021, we received written and oral evidence and the majority of the parties published their evidence on their websites. Those who submitted evidence were as follows:

Government departments and NHS organisations

- HM Treasury
- The Department of Health and Social Care for England
- NHS Staff Council
- NHS England and NHS Improvement
- Health Education England
- The Welsh Government
- The Department of Health, Northern Ireland

Employers' bodies

- NHS Employers
- NHS Providers

Staff representatives

- The Joint Staff Side
- The Royal College of Nursing
- The Royal College of Midwives
- UNISON
- Unite
- GMB
- The Chartered Society of Physiotherapy
- The Society of Radiographers
- The College of Podiatry
- Managers in Partnership

We also received submissions from other bodies, which included the campaign group, Nurses United, and from individuals.

The Review Body process

- 1.23 Following the commencement of the round and the reporting date requested in the Department of Health and Social Care (DHSC) remit letter, we set a deadline for written evidence of 18 January 2021. Northern Ireland and Wales remit letters were both received on 18 January. Whilst Northern Ireland did not give a date for report submission, Wales asked for it “as soon as possible”. We received most of the evidence around this date, including that from the trades unions and employer bodies. However, there were significant delays in the receipt of evidence from a number of government departments – DHSC submitted evidence on 4 March, Health Education England (HEE) on 9 March and NHS England and NHS Improvement (NHS E&I) on 12 March. The late submission of written evidence from some stakeholders led to delays in oral evidence sessions and, subsequently, the submission date for the report.
- 1.24 We know the importance of the Review Body process to our remit group and are concerned that late submission of evidence sends an unhelpful signal to them. We are grateful for the flexibility shown by many of the parties this year in relation to delayed written evidence and, consequently, the oral evidence process. We recognise the challenging situation brought about by the pandemic and the impact it has had on the workload of all the parties, but the lateness of some evidence made the process even more difficult this year for those who had met the deadlines. We would ask that next year all parties submit evidence in a timely manner, which would enable the Review Body process to proceed on a planned timescale.

Other pay and workforce information

- 1.25 Whilst we drew on the parties’ evidence throughout our analysis in Chapter 4 of this report, we also considered published data and information on the NHS. This included reports from external commentators providing wider analysis of issues relevant to our considerations. We supplemented these with analysis of the latest economic and labour market indicators, and research commissioned by the Office of Manpower Economics.

Our visits

- 1.26 We conducted visits to NHS trusts, a Welsh health board and a university between September and December 2020. Because of COVID-19, our programme of visits was conducted virtually this year. These visits helped us to understand how management, staff and students viewed AfC workforce issues within their working/educational environments and the experience of working, studying and managing services during the pandemic. The visits were particularly useful in hearing first-hand views on pay arrangements and the way in which they relate to recruitment, retention and motivation. We are grateful to management, staff representatives, AfC staff and students that participated in these visits, and particularly those involved in their organisation. We visited the following NHS organisations:
- Northumbria Healthcare NHS Foundation Trust;
 - South East Coast Ambulance Service NHS Foundation Trust;
 - Kettering General Hospital NHS Foundation Trust;
 - Southern Health and Social Care Trust;
 - Mid Cheshire Hospitals NHS Foundation Trust;
 - Cwm Taf Morgannwg University Health Board; and
 - London South Bank University

Our overall approach

- 1.27 Our report provides recommendations for 2021/22 for AfC staff following the three-year AfC pay agreement that was in force between the Financial Years 2018/19 to 2020/21. We have made our pay recommendation for 2021/22 in the context of our remit letters and have assessed the evidence, data and information as they relate to our standing terms of reference.
- 1.28 Our report therefore sets out the context of NHS developments relevant to our considerations of the AfC workforce (in Chapter 2), and then provides a summary of the parties' evidence submissions (in Chapter 3), followed by our analysis and conclusions (in Chapter 4), pay recommendations (in Chapter 5) and a forward look (in Chapter 6).

Chapter 2 National Health Service Context

Introduction

2.1 We set out in this chapter the ongoing developments in the National Health Service (NHS) which relate to our considerations on the Agenda for Change (AfC) workforce. It covers published data and reports by external commentators on NHS finances and performance, demand and quality of care and the AfC workforce, including the impact of COVID-19. The developments in the NHS feed into our analysis in Chapter 4 of this report.

NHS finances

NHS England and NHS Improvement finance data

2.2 NHS England and NHS Improvement (NHS E&I) financial performance data for England⁵ was available for the period April 2020 to January 2021 as follows:

- The position to the end of January 2021 showed a net expenditure of £117.8 billion. This figure included the total expenditure on the commissioning and provider sectors and represented an overspend of £12.0 billion or 11.3% against pre-COVID-19 planned expenditure;
- The financial impact of COVID-19 on the provider sector to month 10 of 2020/21 totalled £6.3 billion, including an estimated £2.1 billion of lost income, £2.1 billion of additional pay costs, and £2.0 billion of other COVID-19 costs, which had been offset by reductions in expenditure in other areas of around £1.0 billion in the first half of the year;
- The full year forecast as at the end of January 2021 was for additional expenditure against the original mandate of £19 billion before accounting for funding in relation to vaccines and testing. The additional expenditure related directly to COVID-19 pandemic including the likely full year impact of an increased level of annual leave was to be accrued by NHS employers and other one-off impacts from 2020/21.

NHS funding for 2021/22

2.3 For 2020/21, in England, in response to the pandemic, a temporary financial architecture was put in place that allowed systems in the first half of the year to claim for any retrospective costs and establish allocations in the second half of the year that included additional funding for COVID-19 costs. The financial settlement for months 7 to 12 would be agreed once there was greater certainty around the circumstances facing the NHS going into the second half of the year. The English NHS 2021/22 priorities and operational planning guidance confirmed that the financial settlement had been made for the first half of the year⁶. Department of Health and Social Care (DHSC) told us that for the financial year 2021/22, they expected the total additional investment in AfC pay growth to be 1.7%.

⁵ NHS England and NHS Improvement (25 March 2021), *Board Meeting Papers*. Available at: <https://www.england.nhs.uk/publication/nhs-england-and-nhs-improvement-board-meetings-in-common-agenda-and-papers-25-march-2021/>

⁶ NHS, *Allocations*. Available at: <https://www.england.nhs.uk/allocations/>

NHS finances in the Devolved Administrations

- 2.4 In Wales, funding is allocated through the UK Government Spending Review and other Budget announcements. The amount for Wales is derived using the Barnett formula. An adjustment to the Barnett formula to include a needs based factor has delivered nearly £600 million in additional funding for Wales over the period 2018/19 to 2021/22, around £275 million of that in relation to COVID-19 funding. As a result of the pandemic, the final budget for 2021/22 allocated an additional £380 million for the first six months of 2021/22, increasing health spending to £9.6 billion⁷. The Welsh Parliament confirmed that £766 million will be provided via Barnett consequentials relating to COVID-19 in 2021/22⁸.
- 2.5 The Northern Ireland Executive budget for 2021/22 set out that the Chancellor's Budget announcement of 3 March included a significant level of further funding for health in England, which would provide a Barnett Consequential of approximately £224.0 million Resource DEL for the Northern Ireland Executive in 2021/22.⁹ The 2021/22 budget position for health was £6.5 billion.

Demand and quality of care

NHS England and NHS Improvement performance

- 2.6 NHS operational performance data¹⁰ for England was published in March with the next set of data expected on 24 June 2021. Where data has been drawn from the NHS Combined Performance Summary, which was decommissioned in March 2020, this is indicated. These showed:
- Hospitals have cared for over 350,000 COVID-19 patients needing treatment and on the busiest day in January 2021, there were more than 34,000 patients on wards. However, there were 5,000 patients occupying beds due to COVID-19 on 18 March 2021;
 - Over 15.7 million patients have attended emergency departments across England since April 2020. There were 45,646 Accident and Emergency (A&E) attendances per day in February 2021, almost 1.3 million over the month, representing a daily increase of around 8% compared to January 2021. In comparison, A&E attendances for January 2020¹¹ were 2.11 million, 0.1% more than in January 2019. In the year to February 2020, 17.8 million people had attended NHS A&E departments¹²;

⁷ Welsh Government (March 2021), *Final Budget 2022*. Available at: <https://gov.wales/final-budget-2021-to-2022>

⁸ Welsh Parliament (23 December 2020), *The Welsh Government's spending plans for 2021-22 - what's ahead?* Available at: <https://research.senedd.wales/research-articles/the-welsh-government-s-spending-plans-for-2021-22-what-s-ahead/>

⁹ Department of Finance Northern Ireland (27 April 2021,) *Northern Ireland Budget 2021-2022*. Available at: <https://www.finance-ni.gov.uk/publications/northern-ireland-budget-2021-2022>

¹⁰ NHS E&I (March 2021), *Operational Performance update*. Available at: <https://www.england.nhs.uk/wp-content/uploads/2021/03/agenda-item-5.1-operationl-performance-update.pdf>

¹¹ NHS (13 February 2020), *Combined Performance Summary*. Available at: <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/02/Combined-Performance-Summary-February-December-January-data-2020-oi2U9.pdf>

¹² NHS (26 March 2020), *NHS England and NHS Improvement Board Meetings in Common – Operational performance report*. Available at: <https://www.england.nhs.uk/wp-content/uploads/2020/03/bm2012-operational-performance-report-draft.pdf>

- The number of emergency admissions in February 2021 was 422,000, up almost 5% per day from January 2021 compared to 559,058 emergency admissions in January 2020. In the 12 months to the end of January 2021, NHS 111 handled 3.2 million extra calls, an increase of almost a fifth on the same period the year before. For the year to March 2021, response times for ambulances had improved across all six standards¹³ from the 2019/20 position. The total waiting list for January 2021 stood at 4.59 million with 304,044 patients waiting 52 weeks or longer for treatment. At the end of January 2021, 66.2% of patients were waiting less than 18 weeks. Median waits had declined from over 19 weeks in July 2020 to 12 weeks in January 2021. The median wait for routine operations had fallen to 11 weeks, down from 11.6 weeks in March and from a high of 19.6 weeks last July. Waits for diagnostic tests also fell, with the median now standing at 2.7 weeks, down by three-quarters after the initial impact of the pandemic in May last year. 1.61 million of the 15 key diagnostic tests were performed during January 2021. This represented an increase of 996,949 compared to the first wave peak in April 2020. From the start of the pandemic in March 2020 to the end of January 2021, nearly 1.9 million people were urgently referred to cancer services. The data showed that 84% were seen within two weeks and cancer treatments were at 89% of the level seen in this period the year before. Urgent cancer referrals and cancer treatment levels were higher than before the pandemic by December 2020 and the target of 96% of patients starting treatment within 31 days of a decision to treat was met for the first time since April 2020;
- In early 2021 the disruption to cancer services was lower than at the peak in April/ May 2020 despite high COVID-19 hospitalisation rates. Over 170,000 people were referred for checks on the urgent two-week wait pathway, which was more than twice the number of monthly referrals seen in the first peak in 2020. A total of 22,942 people started a first treatment for cancer in January 2021, which was around 83% of the number in the same period the previous year, and 94% of whom did so within 31 days of a decision to treat; and
- There has been an increase in the number of patients referred for talking therapies for common disorders such as depression and anxiety. The number of people with a learning disability, autism or both in an inpatient setting had reduced by 28% from 2,895 in March 2015 to 2,059 on 31 January 2021.

2.7 The NHS¹⁴ on 10 June 2021 provided an update on the recovery of elective care and mental health services as follows:

- There have been 1.1 million people beginning treatment and 1.8 million diagnostic tests taking place in April, all against the backdrop of having cared for 400,000 seriously ill COVID-19 patients in hospital since the pandemic began. As of 28 March 2021, nearly 26 million people across England had received at least one dose of COVID-19 vaccine. More than 58 million COVID-19 vaccines have been given in just six months;
- In May 2021, the NHS also faced one of its busiest months on record in terms of emergency care in May, with staff responding to more than 800,000 incidents – an increase of over 70,000 from two years previously;
- Improving Access to Psychological Therapies referrals have increased significantly to 159,140 in March 2021, a rise from 133,365 in February and from 108,330 the year before. There has been an increase in the number of patients referred for talking therapies for common disorders such as depression and anxiety; and

¹³ NHS Providers (March 2019), *The Ambulance Service Understanding the New Standards*. Available at: <https://nhsproviders.org/the-ambulance-service-understanding-the-new-standards>

¹⁴ NHS (10 June 2021), *NHS ahead of target in recovery of elective care, and mental health services back to pre-pandemic levels*. Available at: <https://www.england.nhs.uk/2021/06/nhs-ahead-of-target-in-recovery-of-elective-care-and-mental-health-services-back-to-pre-pandemic-levels/>

- The number of people waiting over 52 weeks to begin treatment dropped by more than 50,000 in April, while by May, operations and other elective activity had climbed to 90% of pre-pandemic levels.

Performance data for the Devolved Administrations

- 2.8 In Wales, there were 82,621 emergency department attendances in April 2021 compared to 40,565 a year earlier, 74.15% of patients spent less than four hours in an emergency department in April 2021 against a target of 95% and a decrease of 4.83% compared to 78.98% in February 2020, the median waiting time for diagnostic services rose from 2.77 weeks in January 2020 to 9.17 weeks in January 2021. As of 5 January 2021, 2,772 beds were occupied with COVID-19 related patients representing 35% of all hospitalisations. There were 140 invasive ventilated beds occupied by COVID-19 related patients in comparison to 164 at the peak in April 2020.¹⁵
- 2.9 In Northern Ireland¹⁶, at 31 March 2021, there were six waiting time targets, two each for outpatients, inpatients and diagnostic tests, which target the proportion of patients that should be seen before 9, 13, 26 or 52 weeks. When compared to the previous quarter's data the targets for outpatient waiting times had not been achieved as of 31 December 2020, inpatient admissions to Health Service hospitals had increased by 3.3% compared to 30 September 2020 and 62.8% of patients had been waiting for diagnostic tests for over the nine weeks' target at the end of 2020. As of 12 January 2021, there was a peak reported on the daily dashboard¹⁷ of 1,052 confirmed COVID-19 inpatients compared to the spring 2020 peak of 357 on 8 April 2020.

Quality of care

- 2.10 The Care Quality Commission's (CQC) report¹⁸ on the *State of Health Care and Adult Social Care in England 2019/20* concluded the care that people received in 2019/20 was mostly of good quality. However, the CQC noted that while quality was largely maintained compared with the previous year, there was no improvement overall. Their report looked at the quality of care in the health and care system over the past year including the period before the COVID-19 pandemic and during February and March 2020. The CQC report's focus was on the impact COVID-19 has had on health and adult social care services, their staff and the people using them.
- 2.11 The CQC's points on the impact of the COVID-19 pandemic included:
- Health and care staff across all roles and services showed resilience under unprecedented pressures and adapted quickly to work in different ways to keep people safe;
 - In hospitals and care homes, staff worked long hours in difficult circumstances to care for people who were very sick with COVID-19 and, despite their efforts to protect people, tragically they saw many of those they cared for die. Some staff also had to deal with the loss of colleagues to COVID-19;
 - A key challenge for providers had been maintaining a safe environment through good infection prevention and control practices;

¹⁵ Welsh Government (20 May 2021), *NHS Activity and Performance Summary: March and April 2021*. Available at: <https://gov.wales/nhs-activity-and-performance-summary-march-and-april-2021>

¹⁶ Department of Health Northern Ireland (27 May 2021), *Northern Ireland waiting time statistics summary as at March 2021*. Available at: <https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-summary-march-2021>

¹⁷ Department of Health Northern Ireland (25 February 2021), *Daily Dashboard Data*. Available at: <https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-summary-december-2020>

¹⁸ Care Quality Commission (October 2020), *State of Care*. Available at: <https://www.cqc.org.uk/publications/major-report/state-care>

- The speed and enormity of scale in the pandemic challenges had required health and care providers to respond in new ways and develop new procedures and ways of working for service at very short notice. Accelerated and shared digital approaches supported providers to work together and keep connected well but technology did not always assist with efficient and timely access to care for people. The crisis had accelerated learning and improvement across the system, encouraging innovation that had previously proved difficult to mainstream. However, the CQC said that the potential of new approaches to care must be fully evaluated before they became established practice;
- The CQC said that for the first time ever, the NHS stopped the majority of its non-emergency services as the need to adapt quickly to manage demand and keep people safe became imperative. The CQC said that there was a substantial drop of 69% in the number of new referrals to treatment from 1.6 million in February 2020 to less than 500,000 in April 2020. However, new referrals had risen to 1.2 million by July 2020. It reported that more than 58% of the waiting list for a diagnostic test (more than 570,000 patients) had been waiting at least six weeks as at the end of May 2020. Cancer services were significantly affected during lockdown with a 58% fall in the number of cancer referrals to acute trusts in April 2020 compared with April 2019. There was a “huge pent-up” demand for care and treatment as a result of elective care and urgent services postponement during the pandemic;
- Emergency departments were reconfigured to separate COVID and non-COVID patients; clinical expertise at the ‘front door’ increased, with improved access to face-to-face specialists and there was closer working between departments such as emergency departments and radiology. There had been 57% fewer people attending urgent and emergency care in April 2020 than in April 2019;
- The disproportionate effect of COVID-19 had affected health and social care workers as well as people in need of care. For example, CQC heard about overcrowding on wards for people with mental health conditions, raising concerns about infection control;
- CQC had heard of a number of good infection prevention and control examples but there were some examples of where the systems and procedures in trusts to manage infection prevention and control well and mitigate risks were ineffective. Oversight of infection prevention and control training varied between trusts meaning that some could not always be assured that staff had been adequately trained in infection and control procedures. Some trusts had challenges on space that limited their ability to isolate and cohort COVID-19 patients;
- Health and social care staff worked above and beyond, with a shared drive to look after people well and keep them safe. CQC said that strategies to manage staff and resources across sectors and partnerships were inconsistently navigated, causing varied success of collaboration within systems. Initiatives to manage professional skills capacity across providers was managed well in some areas, with demonstrable impact. At times, the pace of change had felt overwhelming for health and social care providers;
- The CQC said that providers have faced many challenges including making sure services had enough employees with the right skills to cope with new and increased demands. Strategies included the redeployment of existing staff, for example staff moving from one area of a hospital to another, commonly to critical care, while minimising the risk of transmission. Some people were redeployed to another sector, such as hospital and community staff with appropriate clinical skills moving to care homes; and

- The CQC noted that the redeployment of district and community nursing teams to support the pandemic response had affected community health services, which were likely to be a key player in supporting the COVID recovery. The challenge for the workforce would be to manage the complexity of COVID rehabilitation while at the same time restarting discontinued services, dealing with a backlog of non-COVID cases, and not suffering poor health as a result of increased workload.

2.12 The CQC's forward look at the challenges and opportunities included that:

- The problems that existed before COVID-19 had not gone away;
- Services needed to be designed around people's needs;
- A new deal that reaches across health and care was needed for the adult social care workforce that developed clear career progression, secured the right skills for the sector, better recognised and valued staff, invested in their training and supported appropriate professionalisation; and
- The increased waiting lists and backlog of urgent and elective care needed to be addressed.

NHS Confederation

2.13 The NHS Confederation has issued two reports with a focus on the NHS workforce during the pandemic. A report was published in September 2020, *NHS Reset: a new directions for health and care* followed by a report in March 2021, *Putting People first: supporting NHS staff in the aftermath of COVID-19*.

2.14 The NHS Confederation report, *NHS Reset: a new direction for health and care*¹⁹, was published in September 2020 after the first wave of COVID-19 but before the second wave of the pandemic. NHS Reset is an NHS Confederation campaign to help shape what the health and care system should look like in the aftermath of the pandemic. It brought together NHS Confederation members and partners to look at rebuilding local NHS systems and resetting the way health and care was planned, commissioned and delivered set against a recognition of the sacrifices and achievements of the COVID-19 period. The report reflected on the health and care sectors' learning from the initial six months experience of dealing with COVID-19 and how this could help shape what the health and care system should look like in the aftermath of the pandemic. The NHS Confederation drew data together from its discussions with more than 2,500 senior leaders, frontline clinicians, stakeholders and parliamentarians and the findings of a September 2020 survey of more than 250 NHS leaders from across the NHS.

2.15 The report made a number of observations on the health and care workforce. Key points were:

- The disproportionate impact of the virus on ethnic minority communities was mirrored in the impact on ethnic minority staff with long-standing differences in treatment between ethnic minority staff and their White colleagues;
- Staff across the NHS had made significant changes to their way of working throughout this period;
- Employers had focused on staff wellbeing during the peak of the pandemic and delivered a range of programmes to support staff. The challenge was to sustain that work;
- Some employers had recognised the chance to think differently to improve workforce supply; and
- The wider economic impact of COVID-19 might make health and care careers more attractive in the future.

¹⁹ NHS Confederation (September 2021), *NHS Reset: a new direction for health and care*. Available at: <https://www.nhsconfed.org/publications/nhs-reset-new-direction-health-and-care>

- 2.16 The report also highlighted key workforce points from NHS leaders on; the impact of COVID-19 on the mental wellbeing of staff; ongoing staff shortages; the need for investment in infrastructure to support staff in their jobs; and improved linkages between national, regional and local providers; and ongoing concerns about EU Exit and the impact on staffing. The report noted that the scale and pace of innovation had been one of the unexpected consequences of the pandemic. It said its work with NHS leaders clearly showed their determination to seize the opportunity to sustain these positive changes and deliver services in new and better ways to the public. It noted the widespread adoption of new technology had been combined with real advances in partnership working at local level. While it noted the road to recovery for the health and care system would be long and challenging, it said the sector had learned much and, as a result, was in a better position to manage subsequent waves of the pandemic if the beneficial changes identified in the report were sustained.
- 2.17 The NHS Confederation report²⁰, *Putting People First: supporting NHS staff in the aftermath of COVID-19* was published in March 2021 and takes forward the next steps identified in the earlier report from September 2020. These steps included addressing workforce-related issues around workload pressures, vacancies and their impact on staff wellbeing.
- 2.18 It was noted that COVID-19 was likely to endure as a chronic problem for years to come and that it was now time to think about how NHS staff can be supported in the long-term to overcome the trauma they have experienced and to build capacity and space to think for the future. Addressing the stubborn workforce-related issues around workload pressures, vacancies and their impact on staff wellbeing was the immediate priority. The report said that boards and local leaders must also prioritise action to address the discrimination experienced by many staff, particularly among ethnic minority employees.
- 2.19 The NHS Confederation noted that existing support offers provided both nationally and at the level of local employing organisations had so far supported staff well in their immediate wellbeing needs. Continued investment was required, with responsibility handed down to local systems and organisations who were best placed to know what support their staff required and who can ensure that all staff working across a system could access what was needed.
- 2.20 The NHS Confederation noted that existing support offers provided both nationally and at the level of local employing organisations had so far supported staff well in their immediate wellbeing needs. Continued investment was required, with responsibility handed down to local systems and organisations who were best placed to know what support their staff required and who can ensure that all staff working across a system could access what was needed.
- 2.21 The report said there was work for local NHS leaders to take forward and this needed to be accompanied by support from national healthcare leaders and wider government in making this a sustainable reality. These included:
- Ensuring service recovery plans place people recovery at the centre and support local leaders to create the time and space for their staff to rest, reflect, de-brief and be re-charged;
 - Ensuring people recovery and reset were not an add-on and separate to how the whole service moves forward;
 - Publishing a funded workforce strategy that addresses the workforce supply and vacancy issues in all of services; and

²⁰ NHS Confederation report (March 2021), *Putting people first: supporting NHS staff in the aftermath of COVID-19*. Available at: <https://www.nhsconfed.org/resources/2021/03/putting-people-first-nhs-staff-aftermath-covid19>

- Facilitating best practice sharing and improvement to address workplace inequalities.

NHS COVID-19 recovery plans

- 2.22 NHS E&I published its recovery plan for England²¹ in March 2021, stating that there would be an acceleration of the delivery of NHS operations and other non-urgent services as part of a £8.1 billion plan to help the health service recover all patient services following the winter wave of COVID-19. The money would also fund more support for staff who may have been impacted by their experiences during COVID-19. The NHS was rolling out 40 mental health hubs to help staff recover and hospitals were being encouraged to recruit more healthcare and medical support workers to ease the burden on existing staff.
- 2.23 In Wales, the government also published its recovery plan²² in March 2021. The priority was to build more resilient health and social care services and support and develop the workforce by reframing services to provide the integrated health and care support needed. The scale of the costs of recovery would be considerable and detailed plans were in development.
- 2.24 The Department of Health, Northern Ireland published its *Rebuilding Health and Social Care Services Strategic Framework* in June 2020 and in March 2021 published its consultation analysis report of its consultation on *Temporary Amendments to the HSC Framework Document*.²³ The Strategic Framework sets out Northern Ireland's approach to restoring services as quickly as possible by building on the new ways of working and innovations developed in response to the pandemic. A new Management Board for Rebuilding HSC services was formed to provide clear direction to the HSCB, PHA, HSC trusts and BSO. Trusts and the Northern Ireland Ambulance Service rebuild planning has been guided by the Board's five key rebuild principles which were to de-escalate Intensive Care provision; ensure staff were afforded an opportunity to take annual leave before returning to deliver care in their areas of expertise; the elective care rebuild must reflect regional prioritisation; to seek to develop green pathways and schedule theatre lists two to three weeks in advance and prioritise the Nightingale facilities for de-escalation to increase regional complex surgery capacity as quickly as possible. In line with this guidance, HSC trusts and the Northern Ireland Ambulance Service have issued service rebuild plans for the period April to June 2021. A key challenge to implementing their plans was said to be the ability to staff the rebuild plans safely and appropriately as well as the vaccination programme; manage local cluster outbreak and enable the flexible working necessary to support childcare and caring commitments.

²¹ NHS (25 March 2021), *COVID-19 recovery plan for patient care and staff wellbeing*. Available at: <https://www.england.nhs.uk/2021/03/nhs-sets-out-covid-19-recovery-plan-for-patient-care-and-staff-wellbeing/>

²² Welsh Government (22 March 2021), *Improving health and social care (COVID-19 looking forward)*. Available at: <https://gov.wales/improving-health-and-social-care-covid-19-looking-forward>

²³ Department of Health (9 June 2020), *Rebuilding Health and Social Care Services*. Available at: <https://www.health-ni.gov.uk/publications/rebuilding-hsc-services> (accessed 3 June 2021)

NHS workforce

Health Foundation

2.25 The Health Foundation published its report²⁴ *Building the NHS nursing workforce in England* in December 2020 which highlighted that staff shortages had become more pronounced compared with previous years and were increasing the risk of service delivery being compromised. In particular, it highlighted the shortfall in registered nurses. Modest growth in NHS nurse numbers had not kept pace with demand and nursing vacancies had increased to almost 44,000 in the first quarter of 2019/20, equivalent to 12% of the nursing workforce.

2.26 Key points from the nursing workforce report in 2020 included:

- In December 2019, the government committed to increase the number of registered nurses working in the NHS in England by 50,000 by 2024/25. Coronavirus (COVID-19) had since underlined the urgent need to address critical nursing shortages;
- From 2010/11 to 2017/18, the number of full-time equivalent (FTE) nurses in the NHS barely changed, even as NHS hospital and community sector activity levels increased by 26%. Since 2017/18, nurse numbers had increased, with the number of FTE nurses and health visitors in the NHS rising by 4.8% in the year to June 2020;
- Disparities between service areas continued to widen. The number of FTE nurses working in adult hospital nursing grew by 5.5% in the year to June 2020, while the numbers working in community nursing and mental health grew only by 1.6%, and 3.8% respectively. Over the past 10 years, only adult nursing and children's nursing had seen increases in FTE nurse numbers, while the numbers in community nursing, mental health nursing and learning disability nursing were all lower than they were in June 2010;
- Pay is a central element in the employment contract: a highly visible sign of 'worth', a retention mechanism and an important policy lever. Sustaining a pay determination system that pays nurses equitably over the long term must be a critical element in the overall NHS strategy;
- Vacancy rates are one measure of staff shortages as they highlighted posts that the NHS is funding but cannot fill. Across all staff groups, the NHS had 83,591 FTE vacancies in June 2020. Registered nurse FTE vacancies accounted for close to 38,000 (45%) of these. A quarter of all nursing vacancies were in mental health. This was particularly concerning as COVID-19 was likely to lead to further demand for mental health services;
- The overall skill mix of the NHS nursing workforce continued to develop. The number of FTE nursing support staff increased at over twice the rate of growth in registered nurse numbers in the year to June 2020;
- The main 'supply' of new nurses to the NHS came from undergraduate university degree courses. In 2020 there was a 23% increase in the number of students accepted onto nursing degree courses in England (relative to 2019) – resulting in the highest annual number of acceptances since 2011;
- The UK ranked below the average of high-income Organisation for Economic Co-operation and Development (OECD) countries in terms of the number of practising nurses and the annual number of new nurse graduates relative to its population. On both counts, the UK reported lower ratios than comparable countries such as Germany, the USA and Australia;

²⁴ Health Foundation (December 2020), *Building the NHS nursing workforce in England*. Available at: <https://www.health.org.uk/publications/reports/building-the-nhs-nursing-workforce-in-england>

- To achieve the required increase in the number of new graduate nurses, the UK needed to address the long-term training bottleneck. Solutions here could include increasing the use of simulation-based clinical experience, or reducing the total clinical hours required to be on a par with undergraduate nursing courses in the USA and Australia;
- The UK had been highly reliant on recruiting nurses trained outside the UK. About 15% of registered nurses in the UK were trained outside the UK – more than double the OECD average;
- The analysis showed that achieving the government’s target of employing 50,000 NHS nurses by the end of the parliament would only be possible with sustained investment and policy action on domestic supply, including a marked improvement in retention of the current nurse workforce. Coordinated, ethical and effective international recruitment would also be required. To meet the 50,000 target the government would need an average of 5,000 international recruits a year up to 2024/25; and
- The 50,000 target would be insufficient to meet increased demand. There needed to be a shift in focus, away from a single top-down target to a more sustainable, long-term approach. This should start with robust, independent projections of the future demand for and potential supply of nurses.

House of Commons Health and Social Care Committee

2.27 The House of Commons Health and Social Care Committee published its *Workforce burnout and resilience in the NHS and social care* report in June 2021²⁵. This followed the launch of its inquiry into workforce burnout and resilience in July 2020. The report found that workforce burnout across the NHS and social care has reached an emergency level and poses a risk to the future functioning of both services.

2.28 The report commented that while pay and reward were not the focus of this inquiry, the committee had received evidence that suggested that pay could also contribute to stress and burnout in health and care. The report noted that low pay is a particular issue in the social care workforce, and that some 56% of NHS staff work unpaid additional hours on top of their contract. The Local Government Association (LGA) evidence to the committee suggested that pay was not the only area of reward discrepancy between the social care and NHS workforces, with less favourable sick pay and pension arrangements likely where social care workers are employed in the independent sector rather than by a local authority.

2.29 The report drew a range of conclusions relating to understanding the scale of burnout, issues of workforce culture, the specific impacts of COVID-19 on staff and workforce planning. It made the following related recommendations.

Scale and impact of workforce burnout

- The DHSC extends the NHS Staff Survey to cover the care sector;
- The NHS Staff Survey and any social care equivalent includes an overall staff wellbeing measure, so that employers and national bodies can better understand staff wellbeing and take action based on that understanding;
- Integrated Care Systems (ICSs) be required to facilitate access to wellbeing support for NHS and social care workers across their systems, and that they are accountable for the accessibility and take-up of those services; and

²⁵ House of Commons Health and Social Care Committee (June 2021), *Workforce burnout and resilience in the NHS and social care*. Available at: <https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/22/2202.htm>

- The level of resources allocated to mental health support for health and care staff be maintained as and when the NHS and social care return to 'business as usual' after the pandemic; and that the adequacy of resources allocated to that support be monitored on a regular basis.

Workplace culture

- The Department develops a strategy for the creation of Freedom to Speak Up Guardians in social care;
- NHS England undertake a review of the role of targets across the NHS which seeks to balance the operational grip they undoubtedly deliver to senior managers against the risks of inadvertently creating a culture which deprioritises care of both staff and patients;
- The DHSC work with stakeholders to develop staff wellbeing indicators, on which NHS bodies can be judged;
- Workforce Race Equality Standard (WRES) data be made part of the 'balanced basket of indicators' for ICSs, with the result that they become accountable for progress across their domains. As part of this process, organisations should set themselves ambitious yet achievable targets that include timings;
- Adult social care have its own People Plan, which includes parallel commitments to those for the NHS on diversity and inclusion; and
- The Department develops an NHS and social care national policy framework around migration to support national and local workforce planning and identify the balance between domestic and international recruitment in the short, medium and long-term.

The impact of COVID-19 on burnout

- National bodies must continue to monitor the impact of covid-19 on the NHS and adult social care workforce and ensure that workforce planning builds in time for recovery after the pandemic is over;
- The DHSC, the national bodies, and individual organisations across the NHS and social care commit to capturing and disseminating the innovations—in particular, giving greater levels of autonomy to staff and new forms of integrated working—during the pandemic so that they can be embedded in organisations as they return to 'business as usual';
- The Department set out how it plans to implement those recommendations, with a corresponding timeframe; and
- ICSs have a duty to report on progress made against those recommendations made to improve the support for their staff from ethnic minority backgrounds.

Workforce planning

- The Department publishes regular, costed updates along with delivery timelines for all of the proposals in the People Plan;
- The Department, as a priority, produces a People Plan for social care that is aligned to the ambitions set out in the NHS People Plan;
- Health Education England (HEE) publish objective, transparent and independently-audited annual reports on workforce projections that cover the next five, ten and twenty years including an assessment of whether sufficient numbers are being trained and that such workforce projections cover social care as well as the NHS given the close links between the two systems.

2.30 The committee's report also restated the following earlier recommendations to the Department on the reform and funding of social care in previous reports and called for the Government to publish a 10-year plan for the social care sector as it has done for the NHS.

NHS Workforce initiatives

- 2.31 There have been several staff related initiatives aimed at recruitment and retention introduced during COVID-19 in England. These included the suspension of car parking charges, employers granting extra leave and local flexible working and wellbeing initiatives. *We are the NHS: People Plan 2020/21*²⁶ outlined several workforce initiatives in England:
- A dedicated health and care staff support service, including confidential support via phone and text messages;
 - Free access to mental health and wellbeing apps;
 - Free car parking for staff from 1 January 2021 to 21 June 2021;
 - NHS E&I would pilot an approach to improving staff mental health by establishing resilience hubs working in partnership with occupational health programmes to undertake proactive outreach and assessment, and needs;
 - Workplaces would offer opportunities to be physically active and staff would be able to access physical activity throughout their working day;
 - Frontline healthcare workers involved in direct patient care would be encouraged to receive seasonal influenza vaccination annually to protect themselves and their patients from influenza;
 - From September 2020, every member of the NHS should have a health and wellbeing conversation and develop a personalised plan; and
 - All staff should have access to appropriate PPE and be trained in its use.

Our assessment on the context for the Agenda for Change workforce

- 2.32 We review further the developments in the NHS to provide the context to our considerations in Chapter 4 of this report.
- 2.33 The regular published data and reports from external commentators highlight the very significant impact that COVID-19 has had on the NHS and its staff. COVID-19 has delayed elective treatments, transformative programmes and workforce development and heightened the challenges of managing and maintaining services. Delays in tackling issues in these areas may also impact on the ability of the NHS to recover from the pandemic. Demand for care was high before the pandemic; the backlog of treatment is substantial and likely to rise. The prevailing economic and financial situation is also challenging. Significant sums having already been spent on the NHS and COVID-19 specifically but the uncertain funding climate for the second half of this financial year makes it more difficult for employers to plan.
- 2.34 We note the reports from external commentators such as the Health Foundation and the House of Commons Health and Social Care select committee on workforce issues. These have highlighted in particular the impact of COVID-19 on staff health and wellbeing, and disproportionately so for those from ethnic minorities. They also highlighted the workforce's willingness to adapt ways of working and the need for investment, where required to support this. Commentators also pointed to staff shortages and the link between these to both the capacity to provide a good service and to staff wellbeing.

²⁶ NHS England (July 2020), *We are the NHS: People Plan for 2020/21*. Available at: <https://www.england.nhs.uk/ournhspeople/>

Chapter 3 The Parties' Evidence

Introduction

- 3.1 In this chapter we set out a summary of the main points from the parties' evidence. The summaries follow the same structure as our analysis in Chapter 4 and broadly cover our terms of reference. The parties' evidence was submitted between January and March 2021 and where later data or information has become available we have set these out in Chapter 4. The full versions of the parties' evidence can be found on their websites.

COVID-19 and the impact on the National Health Service and Agenda for Change staff

- 3.2 The written evidence submitted by all the parties informed us of the work and care that staff had given to patients during the COVID-19 pandemic and the challenging circumstances that they had to work under. We were also informed of sacrifices made by staff during this time including not spending time with families, risking illness themselves and in some cases, loss of life.
- 3.3 The **Department of Health and Social Care (DHSC)** informed us that COVID-19 has placed greater focus on staff wellbeing issues and highlighted just how important work on staff wellbeing was. The department said that the National Health Service (NHS) People Plan for England puts health and wellbeing at its core with a new support package. Since April 2020, NHS staff had been able to access a number of benefits and services designed to improve staff wellbeing. In oral evidence, DHSC told us that phase four planning guidance on workforce recovery was published in early spring of 2021. DHSC stressed that this would not solve all the issues and there was still obvious tension between dealing with the elective backlog and looking after staff many of whom have had a difficult year.
- 3.4 DHSC told us that despite the continuing best efforts of the NHS, many of the core waiting time and access targets were not achieved during 2019/20, largely due to the increasing demand pressures placed on frontline services throughout the year, including prior to COVID-19. These included A&E, referral to treatment, cancer treatment, diagnostic tests and ambulance response standards. The government was committed to supporting NHS capacity during surges in COVID-19 cases alongside the increased pressures on the system during winter. This was whilst also working hard to deliver the maximum elective activity possible.
- 3.5 In oral evidence, DHSC told us that staff have had mixed experiences whilst working through COVID-19. Conditions during the pandemic, including the PPE challenge, had made work difficult for many frontline staff, and staff at all levels have had to adapt to new ways of working. While this was challenging, some staff had welcomed the additional flexibility and autonomy in their roles.
- 3.6 **NHS England and NHS Improvement (NHS E&I)** said that health and care staff continued to display extraordinary commitment in responding to the pandemic's unprecedented pressures and challenges.
- 3.7 NHS E&I said that it had worked across a range of system partners to continue to ensure that critical care capacity was maximised to deal with the very high influx of patients who needed this care, whilst it supported local employers, at pace, to mobilise and re-deploy existing staff and deploy new staff, including volunteers. This had included, for example:
- Local partnership working using video and online consultations;

- Faster deployment, skills and competency-based deployment (rather than just professional background);
 - Guidance to support the retention and deployment of staff and support their physical and mental wellbeing;
 - Faster clearance processes to ensure staff were legally safe to work with patients;
 - New ways of delivering education and health consultations (for example: virtual teaching, training, GP appointments);
 - Introduction of a new COVID-19 Life Assurance Scheme (introduced by DHSC for the families of staff in the event of a staff member dying due to COVID-19). This would be in addition to life assurance available through membership of the NHS Pension Scheme; and
 - New temporary guidance on the national terms and conditions of service.
- 3.8 NHS E&I said that it did not know what the long-term impact of COVID-19 would be, but there was already evidence of increasing burnout and mental health issues among nurses and other staff.
- 3.9 Health Education England (HEE) said that throughout the COVID-19 pandemic, Workforce Planning and Intelligence had played a significant role in the response to COVID-19, applying available data and analytics in 'real-time', and developing a range of tools aimed at supporting front-line services during the early stages of the pandemic. Critical care staffing models, combining clinical expertise with analytical know-how, enabled assessment of beds and staff required and consideration of working patterns and skill mix. These tools, constructed extremely rapidly, informed strategy and delivery plans. HEE also said that analysis of data from HEE's Trainee Information System (TIS) and the NHS Electronic Staff Record (ESR) enabled identification of staff with 'airways management²⁷' competences, quantification of the depth of that competence, and intelligence on how recently these skills had been deployed.
- 3.10 In oral evidence, HEE said that once the economic situation improved and employment opportunities increased, it would be more challenging to retain some staff. The impact of COVID-19 may lead to an increase in leavers in the medium to long term. It also said that the temporary register of staff that had been set up during COVID-19 would only last a short time and it was expected that most of the staff on it would leave the NHS with a small number wanting to stay. The return of staff to the NHS was welcomed. However, there were limitations to the deployment of these staff including logistical difficulties for local providers on the demand side as some staff were out of practice with processes.

²⁷ Airways management are skills required to support complex and critical care patients with respiratory or airway problems.

- 3.11 **NHS Employers** told us the pandemic was the greatest challenge the NHS had faced. The impact of the pandemic on the NHS was not likely to be known for some time. It would be critical to understand the strain on health and care staff and the impact on their health and wellbeing, alongside the effects of restoring services, reducing significant staff vacancy rates and the impact of the second wave. NHS Employers also told us that they needed ongoing financial support to continue in order to assist employers in health and social care to strengthen their workforce. Health and social care had experienced very high demands for both admission of emergency cases for treatment, including critical care, and access to primary care services. At the same time, some health and care staff and their families had been infected by the virus, creating unusually high sickness absence or caring issues. The continuing impacts of the pandemic were maintaining the pressure on staff. Assessments of the risks faced by staff in high-risk categories had been carried out and some of these staff have been removed from the care of patients with COVID-19. In some cases, this had exacerbated the staffing shortages that had existed before the pandemic. Remaining staff had made many changes to their daily work routines. These included changing in and out of personal protective equipment, administering tests and reorganising multiple site visits or ward rounds. These changes reduced the amount of work they could do in a day.
- 3.12 NHS Employers told us that in a recent survey of employers in England conducted by the NHS Confederation, nine out of 10 respondents said they were concerned about the long term impact that the pandemic would have on their frontline staff. Employers expected that the effects on staff mental health and wellbeing may take up to five years to show, and employers and national stakeholders continued to provide increased support to staff.
- 3.13 NHS Employers said that staff had shown great flexibility by adapting their working hours and practices, taking on different roles in different locations, changing job plans and pausing academic and continuing professional development (CPD) activity. It had also been a very stressful time for many staff and the full impact on health and wellbeing may not become apparent until the worst of the crisis is over. It noted that staff may wish to go back to their normal roles, or they may wish to change their normal working patterns, roles, and responsibilities.
- 3.14 In oral evidence, NHS Employers told us that the 'one team' dynamic that staff had demonstrated during COVID-19 had been impressive and needed to be recognised.
- 3.15 In oral evidence, **NHS Providers** said that during COVID-19 there had been high levels of commitment and flexibility from the NHS workforce in the work they were doing and, in relation to the risk attached to this, said a pay uplift for Agenda for Change (AfC) staff should include all staff as delivering services was seen as a team effort.
- 3.16 The Joint Staff Side said that the ability of the NHS to respond to the challenge of COVID-19 was undeniably hampered by the resilience of the system as a result of long term under-investment. There had been two main issues in particular: systemic staffing issues and the initial availability of Personal Protective Equipment.

- 3.17 The **Joint Staff Side** said that the impact of the pandemic on the NHS was far from over and a new variant of the virus promised to push the entire NHS workforce to its limits. The UK needed a well-resourced, motivated and energised workforce to get to the other side of the immediate pandemic and manage its long term consequences. NHS staff had put their own lives on hold and in danger, all in the line of duty and in defence of the population. Tens of thousands had caught the virus, many had been severely ill and sadly some had died. The Joint Staff Side drew attention to the fact that ONS statistics²⁸ showed a total of 625 health and social care workers' deaths across England and Wales had been linked to COVID-19 up to 20 July 2020.
- 3.18 The Joint Staff Side said that working through the pandemic had had a profound impact on all NHS staff. Whilst some people had found redeployment to new roles hugely meaningful and fulfilling, others had reported fear and stress at being adrift in unfamiliar environments as they had been called on to backfill service gaps or cover for colleagues. Staff working on busy Intensive Care Units (ICUs) and other wards had a very different experience from those who have been isolated with some clinicians feeling particularly de-skilled and alienated without direct patient contact. This had short and long term consequences and was likely to affect their intention to stay in the NHS.
- 3.19 The **Royal College of Nursing (RCN)** told us that since the start of the COVID-19 pandemic, sickness absence rates amongst nursing staff were highest in April 2020, peaking at 7.4% for both registered nurses and health visitors, and for nursing support staff. Of those absences, over a third (36.7%) were COVID-19 related among nurses and health visitors, and just under a third (27.4%) amongst nurse support staff.
- 3.20 The RCN said that the pandemic had also severely impacted workforce numbers through sickness absence and staff members self-isolating or shielding. The RCN received regular reports on staffing pressures and one typical report from an Emergency Department in an NHS England trust in December showed that it was dealing with 4.4% of staff on sick leave due to COVID-19 related illness or self-isolation, and a further 3.5% off on non-COVID-19 related sick leave and 1.8% on maternity leave.
- 3.21 The RCN said the NHS would not be able to meet the demands of the pandemic without more staff. There was an immediate need to deal with the backlog of work, reduce waiting lists and waiting times and restore activity to previous levels. However, the pandemic had exposed the system's fragilities, and a greater investment in the NHS nursing workforce was necessary to address those fragilities and build back resilience.
- 3.22 The RCN told us the number of nurse support workers had increased over the last year by 11.1% in England, by 16.8% in Scotland and by 22.5% in Wales whilst there had been little change in Northern Ireland. This largely reflected the number of students employed on clinical placements in response to the pandemic. There had also been a growth in the registered nursing and midwifery workforce, but at a slower rate (4.5% in England, 1.7% in Scotland, 1% in Wales and 2.5% in Northern Ireland). At this point, it was not possible to ascertain how much this growth was attributable to nursing staff returning to practice.
- 3.23 The RCN told us that the pandemic had had a major impact on staff training opportunities, as many programmes had been paused. This was likely to have an impact on career progression as well as motivation and retention.

²⁸ ONS (7 August 2020), *Deaths involving the coronavirus (COVID-19) among health and social care workers in England and Wales, deaths registered between 9 March and 28 December 2020*. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/12819deathsinvolvingthecoronaviruscovid19amonghealthandsocialcareworkersinenglandandwalesdeathsregisteredbetween9marchand28december2020>

- 3.24 **Unite** said the COVID-19 pandemic had pushed the NHS to the brink, compounding already endemic concerns around staffing following years of under-investment and the impact of post EU-Exit. NHS staff had worked over and above the call of duty, putting themselves and their families at risk to support public health during the pandemic. Unite also said that these huge pressures had compounded deeper concerns around workforce and capacity. The NHS had continued to face a significant and growing staffing crisis, with resources stretched and recruitment and retention issues at all levels, with over 100,000 vacancies in the NHS reported even before the pandemic hit. Unite believed that a decent pay rise for all NHS staff would help recruit and retain the crucial workers that the health service needed.
- 3.25 **GMB** told us that NHS staff were assessed to have some of the highest occupational exposure rates to COVID-19. This exposure was reflected in the mortality rates amongst health workers. A GMB Freedom of Information Act survey of NHS ambulance trusts revealed very high rates of sickness absence during the early months of the pandemic. More recent reporting suggested that absence rates have again reached the 12% level at some sites and trusts. GMB also told us that, in common with the wider workforce, the effects of COVID-19 infections had been particularly acutely felt among Black, Asian and Minority Ethnic NHS workers and workers who share other at-risk characteristics.
- 3.26 **Managers in Partnership** said that its members had undertaken an extraordinary range of activities in response to the pandemic. All staff had worked with great flexibility and dedication to meet the emergency conditions. Managers had made their specific contribution through planning, problem-solving and supporting other staff, often working in incredibly difficult and psychologically distressing conditions.
- 3.27 The **Welsh Government** told us that activity at Emergency Departments (EDs) across Wales had reduced significantly during the first months of the COVID-19 pandemic, at times 60% below the 'normal range'. However, since June and throughout the summer period, there was a gradual return to the 'normal range' of activity at EDs. In October, daily average attendances at EDs reduced with 25% fewer attendances when compared to the 'normal range'. The Welsh Government also told us that there were 17% fewer patients admitted to EDs and 8% fewer ambulance arrivals when compared to October 2019. The latest data indicated activity had stabilised in November with ED attendances remaining around 25% below the 'normal range' and admissions, and ambulance arrivals at similar levels to October. There was a drastic drop in ED attendances, admissions and ambulance arrivals. It was believed that this was the effect of rising COVID-19 cases and government guidance that advised to only attend hospital if it was a matter of urgency.
- 3.28 The Welsh Government also said that health boards had been holding outpatient appointments virtually, making use of technology and using telephone and video consultations. Where necessary, patients were still being seen face to face.
- 3.29 The Welsh Government said that during the first wave of the pandemic a health and wellbeing sub-group was established as a sub-group of the COVID-19 Workforce Deployment and Wellbeing Planning Response Group (Workforce Cell). The sub-group was established to provide oversight and guidance to support the health and wellbeing planning being undertaken across organisations in response to the coronavirus (COVID-19) pandemic and to act as an expert forum for the identification of appropriate and informed courses of action based on workforce intelligence from several sources.
- 3.30 In oral evidence, the Welsh Government told us that nursing students who had been put into placements in the first wave of COVID-19 had mixed experiences; some were positive, but some were unhappy. No nursing students were deployed for the second wave of COVID-19.

- 3.31 The **Department of Health, Northern Ireland** told us that whilst the timing and scale were unpredictable, it was expected that there would be further COVID-19 waves, with the current wave coinciding with colder weather and winter pressures. It was important, therefore, that there were comprehensive surge plans in place for critical care, hospital beds and care homes, including the development of a Nightingale facility to help lift pressures from the system.

Workload and additional hours

- 3.32 **NHS Providers** told us that in 2019, 35% of staff worked additional unpaid hours on a weekly basis and 56% of staff worked additional unpaid hours. More than half of those working additional unpaid time were doing so for an average of five hours or more per week.
- 3.33 The **RCN** said that nursing staff had experienced stress associated with sleep deprivation, exhaustion due to heavy workloads and an inability to take breaks due to demand and staff shortages.
- 3.34 The **RCN** told us that long hours working had only been exacerbated during the pandemic. The 2019 Northern Ireland Health and Social Care (HSC) Staff Survey showed that 59% of nursing and midwifery respondents (compared to 50% of all occupations) worked unpaid overtime, of whom just 17% described this as acceptable. The 2019 England NHS Staff Survey showed that 67.5% of registered nurses and 32.6% of nursing and healthcare assistants worked unpaid overtime on a weekly basis (compared to 55.9% of all occupations).
- 3.35 The **Royal College of Midwives (RCM)** said that incredibly high workloads and work-related stress were a common feature in the lives of midwives and maternity support workers (MSWs) with many working extra unpaid hours, feeling dehydrated, skipping meals and even delaying using the toilet. Workloads and staff shortages were having a serious impact on morale and motivation. RCM informed us that 61% of Heads of Midwifery (HOMs) reported that morale and motivation in their units was ok or poor with 71% of RCM members having considered leaving the profession with over a third (38%) seriously thinking about it.
- 3.36 RCM informed us that the results of the NHS Staff Survey (conducted in 2019 and published early 2020) revealed that 34% of midwives felt they were unable to meet the conflicting demands on their time at work, 40.3% of midwives reported feeling unwell due to work-related stress in the previous 12 months, and 63.7% had continued to come to work despite not feeling well enough to perform their duties.
- 3.37 The **Chartered Society of Physiotherapy** said that when its members were asked about how their NHS workloads had changed from 12 months previously, 74% of members reported that their workloads had increased. Asked to indicate what factors had led to increased workload, 79% of impacted members cited service demands arising from the NHS's COVID-19 response. The accruing of new responsibilities – and insufficient sickness, maternity or holiday cover – were also frequently given as contributing factors, cited by 71% and 49% respectively. It also said that 81% of those respondents who at least considered leaving NHS employment over the past year stated that an early pay rise would have positively affected their decision-making.

- 3.38 **Managers in Partnership** said that like other NHS staff, its members had been going the extra mile since March last year. In a survey, its members had reported working significantly longer hours than 'normal extra hours', working from home with rising expectations to be available outside normal working hours, even when not on call, breaking annual leave to undertake urgent tasks, significant disruption to family and private life, routinely experiencing fatigue and strain, and difficulties in booking and carrying forward annual leave. Its survey showed that 24% of its members worked more than 20 to 25 hours of unpaid overtime per week during the first wave of the pandemic, with 60% working between 5 and 20 hours of unpaid overtime a week. It noted that everyone expected to work differently and under great pressure during an emergency.

Gender and ethnicity

- 3.39 **DHSC** told us that the NHS Workforce was more ethnically diverse than the wider economy. Across the non-medical workforce about 78% of the workforce was White with a further 6% Black, 8% Asian or Asian British. There were currently just over 4% of the workforce with Unknown or Not Stated Ethnicity. DHSC also told us that while BAME representation in the workforce had been relatively stable over the past 5 years, there had been some changes within staff groups. In most staff groups there have been increases in the proportion of BAME staff since 2015.
- 3.40 **DHSC** said that the latest data on the gender and ethnicity pay gaps for the period to the end of May 2020 on a basic pay per full-time equivalent (FTE) basis suggested that, on average, women had lower average pay than men and BAME staff had lower average pay than White staff. For example, the average pay for a White Female nurse was around 3% (£110 pa) lower than that of a White Male nurse. DHSC also said that gaps tended to be smaller within staff groups than across the wider AfC workforce. DHSC argued that this would suggest that gaps were largely being caused by staff group composition effects (with more White and male staff in the higher paying staff groups). Over the past five years, the gender pay gap had increased by 1 percentage point for White staff and 2 percentage points for BAME staff. The ethnicity pay gap had been relatively stable for both male and female staff but was higher for male staff. The gender pay gap tended to be higher when looking at average earnings rather than basic pay. This might suggest that male staff were more likely to receive additional earnings even after controlling for differences in working patterns.
- 3.41 **DHSC** said that analysis suggested that the 'promotion gap' between genders and ethnicities were smaller within specific staff groups. As such, the specific staff group mix of different groups may be responsible for some portion of any apparent gap. For example, a support to midwife staff member (within the support to doctors, nurses and midwives staff group) would very infrequently be promoted above Band 4. Within that role, both men and women were equally likely (or unlikely) to be promoted, but as the role was predominantly occupied by women, this produced an overall 'promotion gap'. Controlling for this effect would reduce any such gap. DHSC also noted some evidence of working patterns being important, with part-time staff being much less likely to be working at a higher band compared to full-time staff.
- 3.42 **NHS Employers** told us that Black and ethnic minority staff continue to be under represented in the upper tiers of the NHS, resulting in lower earnings in this group. In the nursing workforce, the pay gap was 8.5% in favour of White staff.
- 3.43 **NHS Employers** said that within nursing, men were over represented at senior bands compared to their level of representation in the whole profession and men reached higher grades faster than women. The quality and extent of the national dataset on these subjects was improving, which NHS Employers hoped would allow for a more robust dialogue with the Review Body on causes and solutions in the near future.

- 3.44 NHS Employers told us that although patients were returning to the NHS, there was a danger that lingering worries over contracting the virus may deter potential job applicants. The disproportionate impact the virus had had on ethnic minorities was well known and may discourage potential recruits from these communities. Urgent research into this challenge was needed so that effective ways to mitigate risks could be developed. The need to redeploy some BAME staff was creating challenges within some organisations.
- 3.45 **NHS Providers** said that whilst other elements of the People Plan²⁹ were welcomed by trust leaders – in particular, the strong focus on reducing discrimination and improving the working lives of Black, Asian and minority ethnic staff – the plan's reception on the whole was mixed.
- 3.46 NHS Providers said that issues around inclusivity in the NHS had been at the front of mind for NHS leaders in recent months. It also said that evidence continued to mount on the devastating and disproportionate impact COVID-19 was having on ethnic minority people and communities in the UK. These circumstances and events had raised awareness and highlighted growing concern within the NHS over the levels of structural racism and racial inequalities faced by Black, Asian and ethnic minority staff.
- 3.47 NHS Providers informed us that the Equality and Human Rights Commission (EHRC) has launched a statutory inquiry into the experiences of ethnic minority people working on the frontline in lower-paid health and care roles. NHS Providers welcomed this piece of work and looked forward to engaging with the EHRC over the role of trusts as employers and anchor institutions within local communities.
- 3.48 NHS Providers said that there was more trusts could and must do to improve pay, progression and the overall working lives of ethnic minority staff who are disproportionately employed within the lower bands of the AfC framework.
- 3.49 In oral evidence, NHS Providers said that risk assessments for frontline staff during COVID-19 had been a relatively positive move with 95% carried out. This had shown that BAME staff were more likely to be working in roles with increased risk and more exposure to COVID-19. However, redeployment away from the frontline was tricky to implement whilst also maintaining services because trusts did not have a large pool of people to draw from.
- 3.50 The **RCN** told us that the report, *Gender and Nursing as a Profession: Valuing nurses and paying them their worth*³⁰ highlighted the lack of opportunities for progression for nursing staff. The structural and societal barriers to progression were multi-faceted and deeply entrenched within nursing as a highly gendered profession. These included job evaluation structures which failed to accurately and fully measure the technical, productive, cognitive and emotional aspects of the role, on top of structural barriers facing women, people from ethnic minority backgrounds and others with protected characteristics in the world of work in general. All these barriers needed to be tackled in order to make nursing an attractive and sustainable career.
- 3.51 The **RCM** told us that bullying, harassment and discrimination was a particular problem for BAME midwives. In 2019, 42% of midwives reported experiencing discrimination based on their ethnic background.

²⁹ NHS England (30 July 2020), *We are the NHS: People Plan for 2020/21 – action for us all*. Available at: <https://www.england.nhs.uk/ourhspople/>

³⁰ RCN (29 January 2020), *Gender and Nursing as a Profession: Valuing nurses and paying them their worth*. Available at: www.rcn.org.uk/professional-development/publications/pub-007954

- 3.52 The **Society of Radiographers** said that a far higher proportion of women worked in the public sector than the private sector, something that was especially amplified in the allied health professions, including radiography. This trend was growing with women now making up around three in four current radiography undergraduates. Therefore, there was an additional equality dividend to taking this opportunity to give a significant pay increase to all NHS staff.
- 3.53 In oral evidence, the **Welsh Government** told us that a race equality action plan was to be developed. This plan was still in the consultation³¹ process. It was likely that the plan would include Welsh Health and Social Services.

Economy and labour market

- 3.54 **HM Treasury** said that the COVID-19 pandemic had brought significant disruption to the UK economy. The government had taken necessary action to slow the spread of the virus, placing considerable restrictions on people and businesses, and providing support to jobs and income.
- 3.55 HM Treasury said that according to the latest Office for Budget Responsibility (OBR) forecast³², output was projected to fall by 11.3% in 2020. The OBR's central forecast suggested output by March 2021 would be 10% below its pre-virus peak. The long-term outlook assumed permanent economic scarring caused by the pandemic with output at the five-year forecast horizon lying 3% below its pre-pandemic trajectory. The path of output was highly conditional on the path of COVID-19 and the possibility of a third wave. HM Treasury informed us that before the pandemic, inflationary pressure looked to be broadly consistent with the 2% target over the medium term. Consumer Price Index (CPI) fell to 0.2% in August 2020 and was expected to be 0.6% for the 2020/21 financial year, before rising to 1.4% in 2021/22 and returning to target in 2025/26.
- 3.56 HM Treasury told us that the economic impacts of COVID-19 and the unprecedented support packages announced by government had meant a significant but necessary increase in borrowing and debt. The OBR's central forecast for Public Sector Net Borrowing (PSNB) in 2020/21 was £393.5 billion (19% of Gross Domestic Product (GDP)), which was seven times higher than the £54.8 billion the OBR expected in March. HM Treasury also said PSNB was set to fall sharply in 2021/22 to a still historically high £164.2 billion (7.4% of GDP) as activity recovered and much of the temporary fiscal support expired.
- 3.57 HM Treasury told us that the unprecedented nature of the COVID-19 crisis meant that unemployment had risen. It also told us that in the OBR's central forecast the recovery in employment and fall in unemployment rate broadly followed the recovery in GDP. However, the outlook for the labour market was contingent on what happened when support schemes such as the Coronavirus Job Retention Scheme (CJRS) wound down.
- 3.58 HM Treasury argued that the economy and the private sector labour market had seen huge disruption from COVID-19 but that the public sector had been largely shielded from these effects. It also argued that while private sector employment fell by 0.2% between Q1 2020 and Q2 2020, employment in the public sector had risen by 0.7%. This was mainly because of increasing employment in the NHS in response to COVID-19.

³¹ Welsh Government (24 March 2021), *Race Equality Action Plan: An Anti-racist Wales*. Available at: <https://gov.wales/race-equality-action-plan-anti-racist-wales>

³² Office for Budget Responsibility (November 2020), *Economic and Fiscal Outlook*. Available at: <https://obr.uk/efo/economic-and-fiscal-outlook-november-2020/>

- 3.59 HM Treasury said that Average Weekly Earnings data showed the significant divergence between public and private sector wage growth in recent months. Current wage data was relatively volatile as it had been impacted by the CJRS changes to the composition of the labour market and the impact of reduced labour demand.
- 3.60 HM Treasury said that the outlook for both unemployment and wages remained uncertain, reflecting the wider position in the economy as a whole. HM Treasury stressed that this uncertainty was a key variable in its approach to public sector pay, which is why the policy would be revisited once the outlook was clearer for 2022/23.
- 3.61 The **Joint Staff Side** said that increasing pay for public sector workers was an effective way of intervening to promote an economic recovery. NHS institutions were present across the UK and giving staff a substantial pay rise would boost spending in every community in every part of the UK. By boosting the income of households, the Exchequer could also expect to benefit from increased tax revenues and reduced reliance on other forms of income support including benefits and the return of employee pension contributions, as well as the economic benefits of getting people to spend money again.
- 3.62 The Welsh Government told us that the OBR had noted that the economic outlook was highly uncertain and depended upon the future path of coronavirus, the stringency of public health restrictions, the timing and effectiveness of vaccines, and the reactions of households and businesses to all of these. As a result, there were many paths the economy could take.
- 3.63 The Welsh Government said that the OBR did not provide a separate economic forecast for Wales, but it had previously noted that there was no trend difference between Wales and the UK when developments were assessed on the basis of GDP per head. Any short-term divergences appeared essentially random. In respect of unemployment, it said that if Wales experienced a similar proportional rise to that forecast for the UK under the OBR's central scenario, the number unemployed could increase from 71,000 today to approximately 114,000, with unemployment not returning to pre-crisis levels until the end of 2024.
- 3.64 The Welsh Government said that if the transition to the post-EU Exit trading relationship was disruptive – and so far that was proving to be the case to some degree – this would cause short-term economic harm and would probably either prolong the current recession or cause a new one. Wales was likely to be more severely affected than average by the transition to the new trading relationship, as Wales was more reliant on the European Union (EU) as an export market than the UK was as a whole.
- 3.65 The **Department of Health, Northern Ireland** told us that as a small open economy, Northern Ireland was particularly vulnerable to national and international conditions outside of its control. The impact of COVID-19 on the economy had been severe and continued to impact negatively on economic growth prospects. It also told us that its Department for the Economy had estimated that the overall output within the local economy was around 25% to 30% below normal during lockdown. Furthermore, it noted the Ulster University Economic Policy Centre (UUEPC) estimated a significant contraction in economic output in 2020 of 11.6% over the year as a whole, similar to other local forecasts.

3.66 The Department of Health, Northern Ireland informed us that UUEPC had estimated that the unemployment rate in Northern Ireland could reach 13% at its peak in 2020. It also said that the unemployment rate in Northern Ireland had increased over the quarter from 2.5% to 3.7% in June to August 2020, the largest quarterly increase since 2012. Data indicated that the increase was driven by those under the age of 35 years. Within this, the youth unemployment rate (16 to 24 years) doubled to an estimated 11.8%. The Department of Health, Northern Ireland told us that the employment rate for Northern Ireland currently sat at 70.6%.

NHS funding and affordability

3.67 DHSC informed us that at the Budget 2020 DHSC had received over £5 billion to meet the Government's manifesto commitments in respect of the NHS in England of;

- 50,000 more nurses;
- 50 million additional appointments in primary care;
- More funding for hospital car parking; and
- Establishing a Learning Disability and Autism Community Discharge Grant to support discharges into the community.

3.68 DHSC told us that the Spending Review 2020 also provided a further £3 billion to support NHS recovery from the impacts of COVID-19 in 2021/22, on top of the Long Term Plan settlement. This included around £1 billion to begin tackling the elective backlog and around £500 million for mental health services and investment in the NHS workforce. The Spending Review settlement in autumn 2020 settled non-NHS revenue budgets for 2021/22. This included £260 million for HEE to continue to support the education and training of the NHS's workforce and deliver on the commitments of the Long Term Plan; this included funding for training more new nurses and doctors, delivering some of the biggest undergraduate intakes ever. The Spending Review settlement delivered a 3.5% real terms a year increase on DHSC's overall core resource budget (excluding COVID-19 funding) since 2019/20. Increasing these vital budgets would further enable the NHS to deliver a better service and health outcomes for patients. Despite the settlement, COVID-19 had placed a strain on NHS finances.

3.69 DHSC said that the long term NHS funding settlement for England was held by NHS E&I who set out the affordability constraints and financial pressures within the system. There was an interaction between pay uplifts and their ability to deliver wide-ranging priorities. Spend on pay awards was one of the biggest financial pressures on NHS funding, a pressure which was recurrent. DHSC also said that the NHS Long Term Plan commitment gave the NHS the financial security to address challenges in a sustainable manner. There would be multiple calls on funding, including pay, and these would need careful prioritisation in order to stay within the available total. More funding for pay would mean less funding for other priorities, including the size of the workforce and wider investments required to deliver the NHS Long Term Plan.

3.70 DHSC said the UK Government's 2020/21 mandate to the NHS provided clarity on headline objectives for the NHS. The financial directions to NHS E&I published alongside the mandate partially reflected further funding to deliver manifesto commitments agreed at Budget 2020 and did not fully reflect emergency COVID-19 funding. Given the nature of COVID-19, the mandate reinforced the importance of public money being spent with care on targeted, timely and time-limited interventions.

- 3.71 DHSC told us that although recovering finances in the NHS continued to be a major focus, in these exceptional circumstances funding the response to COVID-19 had been, and continued to be, a priority. In 2015/16 disciplined financial management was reintroduced to stabilise finances and secure the immediate future of the health service. NHS leaders devised a plan of action, in operation since July 2016, involving a series of controls and levers designed to exert tighter control over local organisations. DHSC told us that this approach had been broadly successful in doing what it set out to achieve – notably a stabilising of finances across NHS providers, with the majority of trusts demonstrating strong, effective and sustainable financial management. DHSC also said during the 2019/20 financial year, the NHS balanced its financial budget based on opening accounts of NHS planned spend, excluding COVID-19 spend. Through continuing focus on financial rigour and efficiency, most trusts have once again met their control totals. It also informed us that the financial rigour and efficiency would need to continue in future years to help recover from COVID-19. The impact would be felt across the health and social care system in the 2020/21 financial year and beyond.
- 3.72 DHSC told us that 2019/20 was the first year of the Long Term Plan period and represented for England a step towards these longer-term ambitions; where both commissioner and provider sectors move towards aggregate financial balance and fewer organisations ended the year in deficit. Significant progress was made pre-COVID-19, with the NHS once again delivering overall financial balance, with the number of trusts in deficit reduced by half and finances in most trusts and commissioners in a much healthier position than seen in previous years. A minority of trusts remained with significant deficit levels, but a number of those have hit their agreed financial targets and were on track to recovery.
- 3.73 DHSC said that whilst the majority of COVID-19 related spend would occur in future financial years, spending impacts had been felt in February and March of 2019/20. Those trusts affected and the NHS overall had been fully supported with funding and financing at the right time, and all spending pressures had been met.
- 3.74 DHSC said that through the five financial tests, the government had set the NHS England a stretching but realistic goal of making productivity growth of at least 1.1% per year, with all savings reinvested in frontline care. The impact of COVID-19 had caused major disruption to this goal, as the system had not had the capacity to plan for and deliver efficiencies. The additional £3 billion of funding set out in Spending Review 2020 would help the NHS to get back on track to delivering the Long Term Plan, but the government recognised that recovering previous efficiency plans in the short term will be challenging.
- 3.75 **NHS E&I** said that whilst agreement was still awaited on extra COVID-19 funding for 2021/22, the November 2020 Spending Review confirmed an initial additional £3 billion in 2021/22 to support the NHS recovery from the impacts of COVID-19. This included:
- Around £1 billion to begin to tackle the elective backlog;
 - Around £500 million to address waiting times for mental health services, improve access and invest in the NHS workforce; and
 - Around £1.5 billion to help ease existing pressures in the NHS caused by COVID-19.
- 3.76 NHS E&I said that pay awards for some NHS staff groups in 2021/22 were already committed to. Some AfC staff in Bands 5, 6 and 7 (circa 100,000 staff) would move to a higher pay step in 2021/22, as part of the remaining implementation of the 2018 AfC deal. A significant number of AfC staff were earning below £24,000 and for them the Spending Review committed to provide a £250 pay rise (worth between 1.05% and 1.4% of their salary).

- 3.77 NHS E&I told us that the NHS had continued to balance the books nationally across providers and commissioners, whilst the aggregate provider deficit almost halved. The number of individual providers in deficit had also halved. Important changes to the NHS payment system had moved funding away from activity-based payments. A blended payment approach to funding was introduced for non-elective services that included a fixed and variable element, which provided greater certainty for commissioners and providers. Staff costs were a significant proportion of the total expenditure of NHS providers which had been relatively stable over recent years. However, around a quarter of the additional COVID-19 spending in the first half of 2020/21 related to staff costs.
- 3.78 NHS E&I told us that in 2019/20, the NHS Pension Scheme³³ employer contribution rate increased from 14.3% to 20.6%. The additional costs of this change were currently being met centrally by NHS E&I for employers receiving funding from NHS E&I budgets or from other NHS budgets. Additional funding was included in the NHS funding settlement and centrally by NHS E&I for employers receiving funding and represented an investment to maintain current benefits from the scheme; it totals just under £3 billion a year. Employee contributions remained unchanged.
- 3.79 NHS E&I said the response to the COVID-19 pandemic had impacted on NHS costs in 2020/21. In March 2020, temporary financial arrangements were introduced to remove routine burdens on NHS organisations and free them up to devote maximum operational efforts to COVID-19 readiness and response. These included the suspension of usual payment and contract arrangements, with block contract payments for all NHS trusts and foundation trusts.
- 3.80 **NHS Employers** told us that employers in England had welcomed the additional funding provided to the NHS to help it to cope with the pandemic, including £13.4 billion to write off previous loans. However, whilst this was welcome action, such targeted injections of resources did not address the underlying structural issue of financial sustainability being required in the short, medium and longer term. NHS Employers also said that the Health Foundation had identified a potential funding gap in 2021/22 of around £10 billion.
- 3.81 NHS Employers said that any uplifts to pay must remain fully funded, including by association, appropriate funding provisions being made to NHS England and NHS Improvement and to public health budgets. Without additional funding support, plans for workforce growth in key areas, including some of the specialised areas of nursing such as mental health and learning disability nursing, would be jeopardised.
- 3.82 In oral evidence, NHS Employers said that the funding envelope for 2021/22 was not clear and it was difficult to ascertain what was included and what was not. It confirmed that trusts had been allocated funding for the first six months of the financial year to September 2021 only. Operational planning for services and the workforce needed to deliver them was complicated and more difficult given trusts did not know their funding settlements for the second half of the financial year.
- 3.83 In oral evidence, **NHS Providers** confirmed that NHS trusts had only been funded for the first six months of the 2021/22 financial year and this funding envelope was only agreed in late March. NHS Providers said that NHS trusts had originally planned for a pay uplift of around 2% for 2021/22. NHS Providers believed that the additional cost from the 2018 AfC pay agreement was a 0.7% overhang but it could not clarify how these extra costs would be funded. NHS Providers suggested that these would have to come from savings within trusts' budgets.

³³ The NHS pension scheme in England and Wales is the same.

- 3.84 The **Joint Staff Side** said the cost of government borrowing was now at an all-time low, meaning that even with the additional government borrowing of 2020, the cost of servicing government debt was more than sustainable.
- 3.85 The **Welsh Government** told us that in March 2019, the NHS Pension Scheme³⁴ employer contribution rate increased from 14.38% to 20.68%. All NHS Wales organisations were accounting for this cumulative cost at the end of the financial year (March 2020).
- 3.86 The **Department of Health, Northern Ireland** said given the COVID-19 position and the significant pressures facing the Resource Budget, it was anticipated that departments would face significant resource constraints for 'business as usual' activities. It also said that efficiency and productivity improvements would continue to be essential to meet key targets within current resources, given the financial position. However, realising efficiencies was becoming increasingly challenging for departments following recent years of public expenditure constraint. The high proportion of government expenditure accounted for by pay meant that trends in public sector pay costs had significant implications for the availability of resources to support staff and deliver public services in Northern Ireland.

Supply and recruitment

General

- 3.87 **NHS E&I** said that during the first wave of COVID-19, public visibility of the work of the NHS increased, with an accompanying surge in interest in NHS careers. Between March and June 2020, visitors to the NHS health careers website looking for information on training to become a nurse rose by 138%, a paramedic by 103% and a diagnostic radiographer by 152%. In March 2020, applications to jobs in the NHS reached 407,000 up by 21,400 compared to the previous month, and up by just over a quarter compared to March 2019.
- 3.88 **HEE** told us that interest in health and care careers had soared during the pandemic, with a huge surge in visitors to the NHS Health Careers website seeking information about scores of different roles. Record numbers of students had applied to begin nursing courses at English universities this year.
- 3.89 **HEE** said that following a request from the Secretary of State for Health and Social Care, the Nursing and Midwifery Council (NMC) had introduced a set of emergency standards that enabled final year nursing students (not including those in their final year of a two-year postgraduate diploma programme) to undertake up to 100% of their time in clinical practice while that standard remained in effect. The NMC had also recognised that in some regions it may not have been possible for first year students to remain in practice as normal and had therefore agreed to reinstate the emergency standard which allowed first years to complete their year in academic and online learning where their normal placements cannot be supported. **HEE** also told us that the NMC emergency and recovery standards were optional. It would be up to each Approved Education Institution (university) in consultation with the placement providers to determine if their adoption was needed.
- 3.90 **HEE** said that COVID-19 inevitably had an impact on the programme to train nursing associates. With activity curtailed due to COVID-19, all placements and activity ceased in March 2020. Since the start of the second wave, activity had again seen reductions.

³⁴ The NHS pension scheme in England and Wales is the same.

- 3.91 **NHS Employers** said that the NHS People Plan was supported by NHS HR. Directors of HR had commented that the plan did not say fully how the workforce shortage of around 100,000 staff vacancies would be addressed. It also said that recruitment of nurses from abroad was becoming more difficult due to the global effects of the pandemic, and filling vacancies with home-grown talent was at best a medium-term fix because of the time taken to train a new starter.
- 3.92 NHS Employers said they had been advised by NHS Leaders of the need to plan to recruit staff with new and different skill sets to match the requirements of new care settings, technological developments, and new integrated models of service delivery. Multi-disciplinary team working would be more important as would the need for staff to use a broader range of skills in a bigger range of settings.
- 3.93 The **Joint Staff Side** told us that the COVID-19 pandemic had highlighted the importance of workforce planning, of having a well-trained, properly equipped and motivated workforce. The toll on the workforce this year had been significant and the impact on those intending to leave and those likely to take early retirement was not yet clear.
- 3.94 The **Society of Radiographers** said that whilst demand for imaging and radiotherapy services had been rocketing, the ability to recruit and retain enough staff to meet the demand had become increasingly strained and challenging. It said that the Richards report³⁵ recognised we were "at a tipping point" before COVID-19 with provision falling behind existing targets as a direct consequence of long-term under-investment in both staff and equipment.

Pre-registration entrants

- 3.95 **DHSC** said the latest data from UCAS showed a 26% increase in the number of placed applicants on nursing and midwifery courses in England this year and when compared to 2016, the final year of NHS bursary, UK acceptances had increased by 28% in 2020. DHSC also told us that UCAS data showed that overseas applicants had more than doubled since 2019 while applicants from the EU had fallen by 49% since 2016. There had also been increases in EU applicants being accepted onto nursing and midwifery courses. In 2020, acceptances from the EU increased by 30% on the same time last year. When compared to pre-bursary reforms (2016), EU acceptances were 47% lower in 2020.
- 3.96 DHSC told us that to support the expansion of the number of university training places, HEE had announced that £15 million would be made available through their Clinical Placements Expansion Programme. This would increase the number of clinical placements in the NHS and support growth in nursing, midwifery and the allied health professions.
- 3.97 DHSC told us that for the cohorts of entrants between July 2016 and July 2017, the continuation rates were 93% for nursing and 94% for both midwifery and allied health professions. Continuation rates were defined as the proportion of students that were continuing in higher education study, not necessarily on the same course or at the same provider or had qualified one year and 14 days after starting their course. Non-continuation rates for nursing, midwifery and allied health professions were similar to the average for all courses (6%).

³⁵ NHS E&I (November 2020), *Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England*. Available at: <https://www.england.nhs.uk/publication/diagnostics-recovery-and-renewal-report-of-the-independent-review-of-diagnostic-services-for-nhs-england/>

- 3.98 **HEE** told us that the blended learning nursing degree provided a flexible way to fit study around work and life, using mainly digital technologies but still including practical, hands-on experience. This innovative approach was designed to help grow the nursing workforce, as set out in NHS Long Term Plan.
- 3.99 In oral evidence, **HEE** told us that the re-introduction of the bursary had helped to make studying for nursing degrees financially more viable and this had positively impacted on the numbers of nursing students. It also told us that blended learning degrees were an opportunity to get more mature nursing students into the system. It was estimated that around 500 to 600 staff would pass through the first cycle of the programme. However, this approach was comparatively more expensive for Higher Educational Institutes (HEIs).
- 3.100 The **Welsh Government** told us in August 2020, in comparison to August 2019, the largest staff group increase was students (918.56%), followed by additional clinical services (7.49%) and medical and dental staff (6.49%). However, the largest FTE increase was in nursing and midwifery registered (up by 573.49 FTE staff). Over the past five years training places for nurses and midwives had increased by 72% and 97% respectively. From April 2021, Wales would be training more nurses, midwives, than ever before.

International recruitment

- 3.101 **DHSC** told us it did not expect post-EU exit to have a significant short-term impact on the availability of health and care staff in the NHS. In the longer term there may be a reduction in the in-flow of staff from the European Economic Area (EEA), due to new immigration requirements and economic uncertainty. **DHSC** said it had taken a number of steps to help mitigate any supply impacts by:
- Passing legislation that allows regulators to accept qualifications unilaterally from the EU after exit day;
 - A reduction in language test requirements by both the NMC and the Home Office;
 - The introduction of a streamlined international registration process by the NMC; and
 - Development of system guidance on 'passporting' of staff between different providers.
- 3.102 **DHSC** told us it would continue to monitor and analyse overall staffing levels across the NHS and Adult Social Care in England. It was working across government to ensure there would continue to be sufficient staff to deliver the high-quality services on which patients relied on following the UK's exit from the EU.
- 3.103 **DHSC** said that the COVID-19 pandemic and resultant border closures saw a significant fall in the numbers of health and care professionals able to travel to the UK to take up NHS posts in the first half of 2020. However, as restrictions have eased, there was a steady increase in joiners. Whilst future restrictions remained a possibility, **DHSC** expected a return to pre-covid levels once the pandemic impact decreases. The number of EU non-medical staff had increased by over 10,000 between June 2016 and June 2020 and now form 5.6% of all non-medical staff on a headcount basis, an increase of 1%. **DHSC** said that despite this increase in overall EU non-medical staff, between June 2016 and June 2020 the number of EU nurses, midwives and health visitors decreased by over 2,500. Departmental analysis suggested this was most likely a consequence of the NMC introducing more rigorous language testing for EEA applicants in January 2016. Nurses and health visitors form the largest non-medical staff group for EU27 workers. As of June 2020, there were over 19,200 nurses and health visitors from the EU27.

- 3.104 In oral evidence, DHSC told us that some areas of the NHS were too reliant on international recruitment and it was concerned to ensure its overseas recruitment model was ethical. Whilst this had cost advantages to some extent there were questions over both the ethics and the viability of high levels of international recruitment.
- 3.105 **NHS E&I** told us that as of January 2020, over 67,000 of the 169,000 NHS staff with non-British nationality were nationals of EU countries. As of June 2020, 5.5% of NHS staff in England were nationals of other EU countries – a figure that has remained stable since June 2016. There were 32 trusts (mostly in London and the South East of England) where over 10% of staff were nationals of EU countries. Since 2017, the number of (primary and secondary care) nurses joining the UK workforce from the EU had been steady and the proportion leaving had remained stable.
- 3.106 **NHS Employers** said that whilst international recruitment could help meet supply gaps in the short-to-medium term, it was not a long-term solution to NHS staffing shortages. Employers were increasing domestic supply, but they were still reliant on overseas recruitment, particularly for the nursing workforce. The continuing recruitment of nurses from outside the EEA was essential to maintain and develop nurse staffing levels. For the second year running, there had been a 15% increase in the number of people from outside the EEA on the NMC register, rising from 73,308 to 84,316 in March 2020.
- 3.107 NHS Employers said restrictive immigration policy particularly in relation to salary thresholds and uncertainty around EU Exit had made it hard for employers to recruit from overseas. However, the new points-based system, which would be launched fully in January 2021, would enable the NHS to attract and recruit medium to highly skilled individuals. Social care, on the other hand, would not benefit from the new system and this posed a great threat to the sector's workforce supply and ability to maintain crucial services.
- 3.108 NHS Employers told us that since the EU referendum, nurses and health visitors were the only staff groups to report a fall in the number of recorded EU nationals, from 7.4% of the workforce in 2016 to 6% in January 2020. In stark contrast to the number of people coming from outside the EEA, there had been a large drop in new joiners coming from within the EEA, from 19% in 2015/16 to just 6.4% in 2019. In March 2020, there were a further 1,650 (5%) fewer people from within the EEA on the NMC register than in the previous year.
- 3.109 NHS Employers told us that the NHS could continue recruiting from both domestic and international markets so long as the current arrangement for a shortage occupation list remained. Problems of retention were not primarily caused by pay. There were elements of many NHS jobs, such as intensity and workload, which could not be addressed through financial reward. Local actions by employers to address nurse shortages were focusing on recruitment campaigns in local communities and international recruitment, as well as continued activities that support retention. Bank shifts were helping to meet increased demand caused by the pandemic.
- 3.110 The **Joint Staff Side** argued that it could not be right that NHS workforce planning decisions were dependent on recruiting already trained workers from abroad. Such a policy was unsustainable and contributed to the weakening of health systems in other parts of the world that had borne the cost of training these staff. The NHS should be sufficiently funded to ensure the service can be sustained by recruiting staff trained in the UK (whatever their nationality), such that our the training and reward packages met UK staffing needs.

- 3.111 The Joint Staff Side said that monthly data from the NMC suggested that the number of nurses trained outside the EEA joining the NMC's permanent register plummeted from 1,348 in March to only 35 in April. In the most recent period since 2016, which saw the vote for EU Exit and new English language test requirements for nurses, there had been a rapid decline in inflows from the EEA but a rapid increase in non-EEA international recruitment, mainly resulting from a switch back to recruitment from India and the Philippines. The inflow of registrants from non-EEA countries doubled in 2019/20 relative to the previous year (from around 6,150 to over 12,000).
- 3.112 The **RCN** told us many EEA nurses were choosing to leave the UK and many others were choosing not to come in the first place. This was both likely due to uncertainty and hostility around immigration and the impact of COVID-19. Overall, since the EU referendum, over 14,000 EEA nurses and midwives had left the UK workforce. A similar trend was reflected in the number of EEA registrants joining the register for the first time with a 91% reduction over the period between March 2016 and September 2020 (from 10,179 to 938). The number of non-EEA nurses and midwives joining the NMC register for the first time grew by 300% (from 2,389 to 9,545). The number of non-EEA nurses leaving the UK also reduced by 37% from 2,090 to 1,318 over the same period. However, this growth had not made up the shortfall in nurses from abroad since the referendum. Whilst the RCN was clear that international recruitment could not be used as a substitute for a domestic workforce, overseas recruitment was vital and must continue so that people can receive safe and effective care.
- 3.113 Data from the RCN's Labour Market Review suggested there were a further 30,895 (4.3%) nurses and midwives who trained in the EU or EEA and were registered to work in the UK. In addition, 85,873 (12%) were nurses and midwives first registered outside the EEA. The majority of those registrants first registered outside the EEA qualified either in the Philippines (39.1%) or India (29%). The number of nurses and midwives first qualified in the EEA had fallen by 20.8% since 2015, while the number qualified outside the EEA had grown by 28.1%. This coincided broadly with the UK's decision to leave the European Union, with registered nurses and midwives choosing to leave the UK or not to move to the UK for work while the UK continued to rely on international recruitment to meet staffing needs.
- 3.114 The RCN said that looking at new entrants to the NMC register, the overall number (including UK, EEA and non-EEA registrants) stood at 37,324 in 2020 – a rise of 9.0% from 2019. This was largely accounted for by a significant rise in the number of entrants from nurses first registered outside the EEA. There were 26,841 UK new entrants (71.9% of all new entrants), 938 EEA new entrants (2.5%) and 9,545 non-EEA new entrants (25.6%).
- 3.115 The **Society of Radiographers** informed us that the Richards' report highlighted a reduction in recruitment of diagnostic radiographers from the EU – down from 3,000 to 900 in 2017/18. They told us all parts of radiography remained on the Shortage Occupation List and informed us that the Health Foundation had said that "At present there is no coherent government approach to international recruitment in the NHS in England.

Recruitment of nursing associates

- 3.116 **DHSC** said that HEE continued to lead the national nursing associate expansion programme in 2020. DfE data on nursing associate apprentice starts showed 1,420 started training in the 2017/18 academic year, 4,390 in 2018/19 and 3,620 in 2019/20. There were reduced numbers of nursing associate apprentices starting training in 2020 because of the impact of the COVID-19 when many NHS employers halted recruiting new staff into training programmes.

Recruitment of apprentices

- 3.117 **DHSC** told us that the NHS Staff Council had worked hard to reach a consensus on a new Apprentice Pay Framework under the AfC pay and contract reform deal but could not agree the minimum pay rate for all apprenticeships. Although the partners were disappointed that they could not reach a national collective agreement, they remained committed to support trusts to widen participation and help grow the domestic workforce. There was existing guidance in the NHS Terms and Conditions of Service Handbook for AfC staff to ensure trainees were fairly paid, which the partners agreed trusts should continue to use. DHSC also told us that there were 18,100 new apprentices starting training in the NHS in 2019/20 academic year.
- 3.118 DHSC said that in August 2020, the Government announced additional funding was being made available to employers of registered nurse degree apprentices of £8,300 per placement per year from 2020/21 to 2024/25. This was to support employers in making an apprenticeship places available to individuals wishing to train to be a nurse via the apprenticeship route. This funding was to support with the costs of training both existing and future nurse apprentices. The funding applied to all four fields of nursing i.e. Adult, Children, Mental Health and Learning Disabilities.
- 3.119 **HEE** informed us that the standards for nursing degree apprenticeships had been approved and there was a growing number of NHS organisations advertising vacancies. Nursing degree apprenticeships offered flexible routes to becoming a nurse that did not require full-time study at university, although nursing degree apprentices would still need to undertake academic study at degree level. Employers were invited to express their interest in applying for the funding which would make £8,300 available per apprentice. It was hoped that the funding would support more than 400 new apprenticeships train to become registered nurses.
- 3.120 **HEE** said there had been over 22,000 NHS apprenticeship starts to date this academic year. It said that these apprentices made a huge contribution to the delivery of essential services across the NHS in frontline clinical and non-clinical roles, and each of them made a difference to the continuing delivery of care and clinical services during the COVID-19 pandemic.
- 3.121 The **NHS Staff Council** said that in August 2020 **HEE** had announced additional funding was to be made available to enable employers to support nursing apprenticeships. This funding had the option for being used for back-fill purposes.

Supply of bank and agency staff

- 3.122 **DHSC** told us that in England, NHS trust spending on agency staff rose by 40% between 2013/14 and 2015/16 (£2.6 billion to £3.6 billion). However, following the subsequent introduction of agency spend controls, expenditure on agency staffing had reduced to £2.4 billion in 2019/20. It also told us that since April 2017, agency costs had consistently been below 5% of overall pay costs and had now fallen to 4% down from 7.8% at its peak in 2015/16. The continued reduction in agency staff costs was a significant achievement in view of the record levels of demand and the extreme pressure on the acute sector. DHSC added that overall this year, there was a bigger reduction of agency staff, and therefore agency shifts, than of NHS bank workers and NHS substantive workers. There were fewer agency and bank shifts during the first wave of COVID-19, with agency staff seeing the biggest reduction.
- 3.123 **DHSC** said that progress had been made in reducing the reliance on the use of expensive agency staff within the NHS. The overall average price per agency shift decreased by 1.3% from 2018/19, resulting in an overall saving of £19 million (0.8%).

- 3.124 **NHS E&I** told us that the NHS had made progress in improving the value for money from its agency spend in recent years. A certain level of agency spend was healthy for flexible staffing to meet fluctuations in demand. However, the NHS People Plan set out further measures to improve the quality and value for money from temporary staffing, including action to ensure that all agency supply was via an approved procurement framework. In April 2016, 'agency rules' were introduced to support trusts to reduce agency expenditure and move towards a more sustainable level of temporary staffing spend. Since then, trusts had reduced agency spend by over £1.2 billion per year, with this reduced level of spend maintained between 2017/18 and 2019/20 despite inflationary pressures and shift volume increasing by 10%. There had been a significant reduction in agency spend as a proportion of the total NHS pay bill, from 8.2% at its peak in 2015/16 to 4% in 2019/20. The cost of a procured agency shift had also fallen from an average of £511 in 2017/18 to £459 in 2019/20. NHS E&I also told us that the proportion of agency shifts as a share of overall temporary staffing had fallen from 29% in December 2017 to 22% in August 2020, which reflected its strategy to procure more of the NHS's temporary staffing needs via staff banks. During the first five months of 2020/21, trusts spent £0.91 billion on agency staff, 10% lower than in the same period in 2019/20.
- 3.125 The **Welsh Government** said that in its previous submissions it advised the NHS about its programme of work to address the deployment of temporary staff in the NHS. However, due to the pandemic this work had been paused. The agency and locum spend continued to be high and the programme of work, which had commenced in early 2020, remained a priority. The Welsh Government added that it would continue to monitor the situation and its aim was to revisit this as soon as was practically possible during 2021.
- 3.126 The Welsh Government said the concept of the Collaborative Bank Partnership (CBP) was developed as a result of the All Wales Workforce Directors' vision to create a collaborative bank of high quality staff that could be utilised across Wales to ensure safe effective care for patients. Also, the aim was to also deliver weekly pay with the aim of reducing nursing agency spend.
- 3.127 The **Department of Health, Northern Ireland** told us that the key aim of expenditure on agency and bank nurses had been to ensure that safe and effective services were sustained and maintained. A key factor in tackling the issue of agency expenditure was transformation of HSC and the need for long-term investment in our HSC workforce. The report³⁶ made clear that rising locum and agency costs were due to the current configuration of services and that "changing the model of care" was the only solution. Officials were currently working with HSC employers and trade union colleagues on detailed proposals to reduce agency and locum spend in Northern Ireland, beginning with an examination of the root causes of agency expenditure.
- 3.128 The Department of Health, Northern Ireland informed us that:
- Agency spend in Northern Ireland had continued to rise year on year. For the 2019/20 financial year, HSC trusts' combined expenditure on AfC agency and locum staff was £159.5 million, up from £114.6 million in 2018/19, a rise of 39.2%;
 - Overall AfC expenditure on agency and locum in 2019/20 was £159.5 million a rise of £114.1 million or 251% on 2015/16 (£45.4 million);
 - In 2019/20 nursing and midwifery expenditure totalled £89.8 million, a rise of £37.7 million or 72.4% on 2018/19 and a rise of £74 million or 468.4% on 2015/16;

³⁶ The Department of Health, Northern Ireland (25 October 2016), *Systems, Not Structures - Changing Health and Social Care*. Available at: <https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report>

- Nursing and midwifery expenditure accounted for 35.3% of the overall agency spend. Of the total nursing and midwifery figure, 61% (£54.9 million) was off-contract spend;
- Total bank spend for 2019/20 was £99.2 million; and
- Nursing and midwifery bank spend totalled £70.5 million in 2019/20.

3.129 In oral evidence, the Department of Health, Northern Ireland told us that part of the plan to assess the benefits of the 2018 AfC pay agreement in Northern Ireland was a drive to decrease agency spend. It had requested health trusts to bring people in using the standard contract during COVID-19. It added that in order to bring agency spend under control, CEOs had been asked to work collaboratively to develop a plan but progress had stalled over the last year and would be picked up again later in 2021. The Department of Health, Northern Ireland also said it was not helpful to have colleagues working side by side where agency workers were earning three times more than HSC staff. This message was being driven home to the CEOs of health and social care trusts in Northern Ireland.

Vacancies and shortage groups

- 3.130 **DHSC** informed us that as a result of the pandemic, retention rates had improved as staff and NHS trusts responded to the ongoing pandemic. DHSC also informed us that vacancy rates in the NHS had dropped, as they had in the wider UK labour market, where redundancies had increased to record levels. DHSC added that as a result, opportunities for NHS staff to move jobs or leave the NHS were more limited than usual.
- 3.131 DHSC said that the overall nursing vacancy rate had showed some variation over the last year, ranging from 12.1% to 9.9%, which was equivalent to vacancies of 43,000 to 36,000.
- 3.132 **NHS E&I** told us that between December 2018 and December 2020, substantive nursing vacancies decreased by 3,500 to around 36,000 FTE (9.7% vacancy rate). This reduction was the result of substantive nursing workforce growth outstripping the increase in nursing workforce demand. However, the level of nursing vacancies still posed a significant operational challenge to NHS providers, and there was substantial variation in vacancy rates between providers across England.
- 3.133 **NHS Employers** said the overall numbers of nurses in England had increased over the last decade, but the number of learning disability nurses employed in hospital or community settings reduced by 38% over the period September 2010 to September 2019. NHS Employers stressed that whilst it welcomed the Government's commitment to deliver 50,000 more nurses, it was unclear how many of these would be recruited to work within the areas of mental health and learning disability.
- 3.134 **NHS Providers** informed us that high vacancy rates in the NHS had resulted in persistent rota gaps within trusts, filled predominantly by shifts taken by bank and agency staff. Many temporary shifts were filled by staff already on substantive contracts and, separately, findings from recent NHS staff surveys showed an unsustainable level of overtime undertaken by the workforce.
- 3.135 The **Joint Staff Side** told us that the NHS in England persistently had around 100,000 vacancies and had consistently failed to meet staffing targets. During the course of the pandemic staffing challenges had impacted on service availability, which had added to the challenges of dealing with the pandemic, impacted long-term patient outcomes and increased the backlog of work.

- 3.136 In oral evidence, the **RCN** highlighted some of its concerns around safe staffing. RCN argued that only in the NHS would this level of staffing be tolerated and stressed that the levels of staffing in the NHS would cause alarm in some other sectors. There were chronic shortages in some areas and some staff did not feel safe at work.
- 3.137 The **RCM** told us that there was currently a shortage of just over 3,000 midwives in England alone. Fair pay was critical to the recruitment and retention of midwives and MSWs. The RCM said that 83% of respondents in its members' survey did not feel that their trust/board had the right number of staff to operate a safe service.
- 3.138 **Managers in Partnership** said the shortage of staff would possibly be the most significant strategic problem faced by the NHS in the next 10 years. The vacancy rate in the NHS was set to rise on pre-pandemic trends to one in five by the end of this decade.
- 3.139 **Nurses United** told us that the vacancy rate had ballooned from 8,153 registered nurses (RNs) (a vacancy rate of 2.5%) in 2010 to 43,590 RNs (12%) in 2019. It stressed that it was important for the Review Body to consider that 254,518 (35%) members of the NMC register were aged over 51 years and therefore likely to be able to retire under their current pension arrangements.

Morale and motivation

- 3.140 **DHSC** told us that in broad terms, the English 2019 NHS Staff Survey results showed an improvement in responses regarding immediate managers, quality of appraisals and safety culture. There was a decrease in the percentage of NHS staff that were looking to leave the NHS. This was a strong and positive step, but more work needed to be done. No theme scores had worsened over the last four years of the survey. However, ambulance trust staff continued to perform poorly across a range of staff experience metrics, although improvements in most metrics had been made since 2015.
- 3.141 **DHSC** said the NHS Staff Survey national average health and wellbeing score stands at 5.9/10 for 2019 (for England). Scores for health and wellbeing had been mostly unchanged over the last five years. The ambulance staff score was 4.7, which was notably lower than other staff groups.
- 3.142 **NHS E&I** said compassionate and inclusive working environments also positively impacted staff engagement. It said a 0.12 increase in staff engagement scores in the NHS Staff Survey correlated with a 0.9% decrease in agency spending, saving on average £1.7 million for each trust.
- 3.143 **NHS Providers** said that in last year's evidence it discussed the critical importance of investment in workforce development (CPD) and this continued to hold true.
- 3.144 The **Joint Staff Side** said that staff had gone above and beyond their contractual obligations, working overtime, both paid and unpaid, and were aware of the huge responsibility and trust that the country had placed in them. All staff side unions reported large increases in stress and mental health challenges being faced by their members as the impact of COVID-19 had taken its toll on the workforce.

- 3.145 The Joint Staff Side told us the NHS Staff Survey for England (NHS England 2020) painted an alarming picture of high and increasing proportions of staff reporting feeling unwell as a result of work stress (40%), coming to work despite not feeling well enough to perform their duties (57%) as well as many reporting experiencing unrealistic time pressures (77%). The NHS Staff Survey also showed that 35% of staff work paid additional hours and 56% unpaid additional hours on top of their contracted hours. The NHS Staff Survey for Northern Ireland Health and Social Care 2019 showed similar results, with 47% reporting they had felt unwell due to work-related stress in the previous 12 months, while 61% reported they had attended work in the previous three months despite feeling unwell due to pressure from their manager, colleagues or themselves. Given that these surveys were conducted before the impact of pandemic on the workforce the Joint Staff Side expected the current position to have deteriorated significantly during 2020.
- 3.146 The **RCN** said respondents to the 2020 RCN membership survey were asked about their workplace experiences and whether their workplace had improved, worsened or stayed the same compared to before the pandemic. It was alarming to note that well over half (57.9%) reported that staff morale had worsened, while only 12.8% reported it had improved. It noted that, in addition to long standing staffing shortages which impacted on staff morale and the ability of nursing staff to undertake their role effectively, almost four in 10 stated that staffing levels had worsened over the pandemic period. It also said that that over three-quarters reported stress levels had increased since the pandemic, both among their colleagues (87.1%) and themselves (77.2%) while a high percentage (84.1%) stated they were worried about health and safety.
- 3.147 The **RCN** informed us that during the first wave of the pandemic, increased staff absence was having an impact on the ability to provide safe and effective care, as well as significantly impacting members' own health and wellbeing. Registered nurses had been under strain from increased workloads whilst nursing support workers reported lower levels of supervision and felt they were forced to work above their competency. This has only been exacerbated during the second wave, with nursing staff now displaying symptoms of Post Traumatic Stress Disorder (PTSD).
- 3.148 The **RCN** told us that respondents to the 2020 RCN Member Survey were asked how valued they felt by different constituent groups and whether this had changed since the start of the COVID-19 pandemic. The most striking findings were that whilst respondents clearly felt more valued by the public (76.4%), the media (60.6%) and patients (55%), very few (17.7%) felt more valued by the government. Whilst just over a third (36.5%) stated that the level of value was unchanged, a similar proportion (34%) stated they felt even less valued by the government, even at a time of extraordinary effort and demand on nursing staff.
- 3.149 The **RCM** told us that its all-member survey carried out in November 2020 asked a series of questions about staffing levels. The results showed that 83% of respondents did not feel that their trust/board had the right number of staff to operate a safe service. The results showed that 42% said half of shifts were understaffed, while a third said there were very significant gaps in most shifts and 63% were working unpaid beyond their contracted hours with 37% working additional paid overtime.
- 3.150 **UNISON** said that almost half (48%) of its survey respondents stated they had not coped well mentally during the pandemic for reasons including fear of getting sick, increased exposure to unwell patients and feeling isolated. **UNISON** also told us that a significant number of staff reported accessing financial support, guidance or products. Over a third of staff (34%) had asked for financial support from family or friends, and over one in 10 staff (11%) reported using a debt advice service. Of greatest concern was use of foodbanks, pawn shops and predatory financial services, with 7% of NHS staff reporting they had used payday loan providers.

- 3.151 **Unite** told us its survey reported that only 18% of respondents felt either valued or highly valued by the government, whilst in contrast 53% felt valued or highly valued by the NHS, 68% by their manager, 73% by the public, 88% by patients and 91% by their colleagues. This suggested a major disconnect between the government and the wider public mood.
- 3.152 Unite said the Review Body should consider the impact that organisational changes were having on staff and wider morale and motivation in the workforce. Organisational change added to the broad concerns NHS staff had about their work and pay.
- 3.153 **GMB** informed us that, in a mental health survey completed by 761 NHS workers between September to October 2020, 75.5% of respondents agreed that their work during COVID-19 had a serious negative impact on their mental health. It added that NHS workers had risen to the challenge of COVID-19 at great personal cost and said that the effects of bereavement, the ongoing health effects of long COVID-19, fear of infection and taking the virus home, the often traumatic nature of work during the pandemic, and additional workload and inadequate cover had all combined to undermine the health and wellbeing of NHS workers.

Retention

- 3.154 **DHSC** said that the stability index captured how successful the NHS was in retaining its staff. The index was computed by NHS Digital on data for England. There had not been much variation in the stability index³⁷ for the Hospital and Community Health Services (HCHS) non-medical workforce in each staff group, with the largest variation being 2.5% for infrastructure staff between 2014/15 and 2019/20.
- 3.155 DHSC told us that leaver rates had fallen since last year for all large staff groups in England. The leaver rate was the share of the workforce leaving their staff group in the NHS Trusts and Clinical Commissioning Groups (CCGs) in a year. Overall, leaver rates across England appeared to have fallen from peaks in 2016/17 and 2017/18. However, in oral evidence, DHSC told us that it was more cautious after considering the latest data. It also told us that pulse surveys had been carried out and results of the surveys had created some concerns on retention. DHSC hoped to share some of the results of these surveys with the Review Body later this year.
- 3.156 **NHS E&I** told us COVID-19 also played a part in reducing NHS leaver rates in 2020, because many felt committed to support the NHS and patients during this challenging period.
- 3.157 NHS E&I said staff morale and wellbeing, and retention and workforce expansion, remained key areas of focus for its work. It said it was strengthening the health and wellbeing support in response to staff needs and in line with the commitments in the NHS People Plan 2020/21. The 2019 NHS Staff Survey results (before the pandemic) showed that 40.3% of respondents had felt unwell as a result of work-related stress in the last 12 months, with a higher proportion (56.6%) reporting coming to work in the last three months despite not feeling well enough to perform their duties (58.9% of registered nurses and midwives, 61.5% of nursing and healthcare assistants (HCAs) and 65.9% of ambulance staff).

³⁷ The Stability Index is the percentage of staff there at the start of the period that do not leave the specified group during the period in question. For example, if a trust had 100 nurses in July and a year later 90 of those nurses remained in post, the trust the Stability Index would be 90/100 expressed as a percentage:

- 3.158 NHS E&I said it had surveyed the returners, who were referred to potential employers, to obtain their feedback on the process and understand their intentions to remain in employment in the NHS. The results from October 2020 indicated that around 50% of respondents were 'interested in continuing to work in the health and social care system in the medium to long term in some capacity'.
- 3.159 NHS E&I also told us that when a level 4 National Incident was declared, infrastructure was rapidly created to enable former NHS staff to return to the NHS where they could be deployed to different services to boost the emergency response. Students also stepped out of training to increase their direct support to patient care, and some staff were redeployed to areas experiencing pressure under the 'mutual aid' protocols.
- 3.160 NHS E&I said it had engaged with returners to continue to match them with opportunities to support priority work across the NHS, as well as retain them in the service on a longer term basis.
- 3.161 **NHS Employers** said the NHS Long Term Plan in England committed to extend NHS Improvements' Retention Collaborative Programme, with the aim of improving staff retention by at least 2% by 2025. The new NHS "We are the NHS People Plan"³⁸ included "Our People Promise"³⁹, which outlined behaviours and actions that staff can expect from NHS leaders and colleagues to improve the experience of everyone working in the NHS.
- 3.162 NHS Employers said it believed that retention often relied on the individual's experience in work, and employers said that the leadership culture was the most important influence on staff motivation and their desire to stay working in the NHS. In their joint report, *Closing the Gap*⁴⁰, the King's Fund, Nuffield Trust and the Health Foundation suggested that retention was directly related to the leadership and culture of the organisation. The report suggested that staff leave because they feel overworked, underpaid, poorly treated, unable to deliver good care, unable to progress, or a combination of some or all of these things.
- 3.163 NHS Employers said that the numbers of nurses leaving the NMC register were the lowest recorded for five years. It referred to the report, *The Courage of Compassion*⁴¹ and highlighted that the King's Fund said that the number of nurses and health visitors leaving their posts in hospitals and community services in England within three years of joining had risen about 50% since 2013/14 and was now around 28%. The authors suggested that this situation had been compounded by the pandemic, which had exacerbated longer term issues including high workloads, inadequate working conditions, staff burnout and inequalities which the authors noted, especially impacted staff in minority ethnic groups who had been worst affected by the pandemic.
- 3.164 NHS Employers told us that feedback from its Total Reward Engagement Network indicated that the needs of staff vary, and were influenced by factors such as age, personal circumstances, and career aspirations. Within NHS organisations, there were different groups of employees that were motivated in different ways and the needs of each group would have different implications for reward design and a line manager's behaviour.

³⁸ NHS England (30 July 2020), *We are the NHS: People Plan for 2020/21 – action for us all*. Available at: <https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/>

³⁹ NHS England and NHS Improvement (30 July 2020), *Our NHS People Promise*. Available at: <https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/>

⁴⁰ The King's Fund (21 March 2019), *Closing the gap: key areas for action on the health and care workforce*. Available at: <https://www.kingsfund.org.uk/publications/closing-gap-health-care-workforce>

⁴¹ The King's Fund (23 September 2020), *The courage of compassion: Supporting nurses and midwives to deliver high-quality care*. Available at: <https://www.kingsfund.org.uk/publications/courage-compassion-supporting-nurses-midwives>

- 3.165 NHS Employers said that during the pandemic so far, more than 13,000 former or overseas nurses and midwives had joined the NMC temporary register. NHS organisations and Integrated Care Systems (ICSs) were exploring retention opportunities for as many of these staff as possible.
- 3.166 **NHS Providers** told us that a survey of English trust leaders in August 2020, prior to the start of the second wave of the pandemic, had found that 99% were concerned about the level of burnout in their workforce. While retention rates had been encouraging over the past 12 months, there was a lack of confidence amongst trust leaders that this would hold up beyond the end of the COVID-19 emergency period.
- 3.167 NHS Providers said there were also immediate, operational pressures linked to the effect of COVID-19 on staff wellbeing. There was an obvious correlation between persistent workforce gaps leading up to the pandemic, an overstretched workforce going above and beyond to protect the public over the past 12 months, and a service that – despite incredible efforts at all levels of the workforce within trusts – was being forced to prioritise and reduce its offer to patients in some areas.
- 3.168 The **RCM** said that the HOMS survey had identified that the most common reason for leaving was retirement. The vast majority of these midwives were at the top of their pay band and it was such staff who benefited least from the three-year pay deals.
- 3.169 The RCM said it remained concerned that the lack of opportunities for career progression for both midwives and MSWs would have a damaging impact on the attractiveness of both as a career. The majority of midwives and MSWs were at the top of their pay band (the full rate for the job) meaning the lack of opportunities to progress in both career and salary was keenly felt.
- 3.170 The RCM said that it was imperative that the UK Government's commitment in 2018 to train 3,650 more midwives in England was met. It would take a number of years for any new midwives to increase the overall numbers as those joining the profession must be balanced against the number of midwives leaving, which had increased as a result of EU Exit and the number of midwives choosing to retire. RCM also said that vacancies may increase further as a result of continuing poor pay and conditions and the impact of the COVID-19 pandemic. The latest data from the NMC showed that almost one-third (29%) of registered midwives in the UK were aged over 50; fair pay along with flexible working opportunities including 'retire and return' was key to retaining these experienced midwives in the NHS. It added that historically high vacancy rates in maternity teams had been exacerbated this year due to the COVID-19 pandemic with increased sickness absence levels and self-isolation of staff.
- 3.171 **UNISON** told us that when it asked its members if they had considered leaving the NHS, 46% said they had not considered leaving whilst over a third of staff 34% reported either fairly or very seriously considering leaving.
- 3.172 In oral evidence, **Unite** told us that the duties of existing staff were being extended and many felt that the post they were performing was not the same post they were appointed into. Some professions with shoulder markets had staff that were beginning to look at these markets for alternative employment as they felt their salary did not match the duties they were performing.

- 3.173 **GMB** told us that the NHS continued to face acute recruitment and retention challenges. Whilst there may be more applicants per job in the overall economy, pre-existing difficulties had continued during the pandemic – and in some cases, these challenges had been exacerbated by the outbreak. There was an NHS vacancy rate of 6.9% in September 2020 (or 87,237 FTE positions). GMB argued that whilst this represented a fall on the pre-pandemic period, the rate was substantially higher than vacancies across the economy as a whole (at 1.7%). Overall, human health and social work activity had the highest vacancy rates of the categories tracked by the ONS. Some traditional recruitment activities have been prevented or curtailed by post EU-Exit and COVID-19 restrictions.
- 3.174 GMB said there was strong evidence that the NHS was failing to retain staff in sufficient numbers. In the second quarter of 2020 74,871 NHS workers left their jobs – this was the highest number of leavers during the second quarter on record, and a 13% increase on the second quarter of 2019. It also said that high unemployment rates in the general economy had not translated into a resolution of the longstanding recruitment problems in the NHS.
- 3.175 The **Chartered Society of Physiotherapy** told us the need to address the long-term workforce issues was also clear when looking at the number of physiotherapy staff who had left – or were considering leaving – the NHS, particularly as many of those most likely to leave were the more experienced staff at the top of their AfC band. The need to retain staff in the NHS had never been more acute, and given the low morale reported along with the low levels of job satisfaction on a number of aspects, including pay and career progression, there had to be real concern that significant numbers of physiotherapy staff could leave the NHS.

Agenda for Change earnings

Agenda for Change earnings

- 3.176 **DHSC** told us that over the last financial year (2019/20) average earnings for AfC staff had increased by 3.1% and had risen by 6.1% since the start of the multi-year agreement of 2018 and were expected to increase by around 3% in 2020/21 as a result of the final year of the agreement. Earnings growth during the first two years of the deal were similar to that in the wider economy, and above the level of inflation, before the economic impacts of the COVID-19 pandemic began to emerge. It said that assessments of longer term HCHS earnings should consider the impacts of the pandemic on the wider labour market which were not yet fully apparent. In addition to the headline pay award, individual members of staff may also have been eligible to access higher earnings growth as a result of pay progression, promotion or, in 2021/22, pay scale reform completion. The impact of higher earnings growth as a result of pay progression and promotion was dependent on an individual's band and how long they have been employed in the NHS. DHSC also told us that the highest growth in earnings over the past year was in the ambulance (11.2%) and support to ambulance (8.7%) staff groups. This was largely a result of changes to staff coding which resulted in some staff, mainly Band 4, being reclassified as being in the support grouping rather than the qualified group. This increased the average banding for both groups and thus increased average pay for both.
- 3.177 DHSC said Longitudinal Educational Outcomes (LEO) graduate data showed that in the first year following graduation, nurses and midwives had relatively high earnings compared to graduates from other subjects as well as having relatively high employment levels. Median pay for graduates as a whole 10 years after graduation was over 50% higher than in the first year after graduation, but for comparison the figure for nurses was lower at 17%. However, this did not account for the composition and working patterns of the workforce.

- 3.178 DHSC informed us that between 2017/18 and 2019/20 the combined effect of 5.2% growth in total FTE and 11.2% growth in pay bill per FTE resulted in the aggregate pay bill increasing by 17.0%. On-costs drift had a neutral effect (0%) in 2018/19, with average pay bill growth being similar to average earnings growth. On-costs drift had a large positive effect (4.7%) in 2019/20. This was due to an increase in the employer pension contribution rate from April 2019.
- 3.179 DHSC said that average earnings growth for HCHS workers had increased in 2018/19 and 2019/20, reaching a peak of 3.2%, higher than that in the wider economy (3%). However, over the past five years, earnings in the wider economy had grown at between 2.5% and 3%, while HCHS growth rates had been below 1% for five years (from 2012/13 to 2017/18).
- 3.180 DHSC said that pay over the three-year period of the AfC deal had increased beyond the level of inflation and together with the increase in staffing numbers this had meant a higher proportion of overall expenditure directed to pay. This trend was important to bear in mind when considering the affordability of pay recommendations particularly considering the challenging fiscal and economic context, along with other pre-existing pressures such as an ageing population.
- 3.181 DHSC said that between 2017 and March 2020 the proportion of the workforce at the top of band had fallen in most bands. One reason for this was the growth in the workforce meaning that newly recruited staff would not have had the time to progress to the top of band. As the reform of the pay structure was completed, there may be an increase in the proportion of people at the top of each band as the time taken to reach that position is reduced. For example, the minimum time taken to reach the top of Band 5 would reduce from seven to four years.
- 3.182 DHSC said that the Pay Review Bodies had sought evidence on how HCHS earnings compared to those for other professional groups. When assessing starting salaries in the HCHS sector it was important to account for both basic pay, as determined by the pay band, but also any additional earnings. A newly qualified nurse starting at the bottom of Band 5, would have basic pay of just under £25,000, but would also be likely to receive additional earnings due to some of the factors specific to working in the health system. Compared with workers in the wider economy, a greater proportion of NHS staff need to work unsocial hours to ensure the provision of a 24/7 service.
- 3.183 The **NHS Staff Council** said that the Staff Side had expressed a desire to agree joint NHS Staff Council guidance on the process for implementation of re-earnable pay in Bands 8c, 8d and 9. This work was paused pending the outcome of the national work on developing the Very Senior Manager (VSM) pay framework being undertaken by NHS E&I. The NHS Staff Council wanted to ensure that any jointly agreed guidance aligned with the approach being taken for those employed on VSM contracts. To date, NHS E&I were still to publish their VSM pay framework.
- 3.184 The **Joint Staff Side** told us that there had been a real impact on take home pay for public sector workers by the decade-long public sector pay freeze. A 2017 Office for Manpower Economics study⁴² estimated that this amounted to a 6% cut in pay between 2010 and 2015 alone. Although the pay freeze had since been lifted, wages still lagged behind their pre-2010 equivalent. The public sector remained the poor relation when it came to pay, with the NHS and broader public sector consistently lagging behind the private sector. Since 2010 average weekly pay in the private sector had grown 22%, compared to just 17% in the public sector.

⁴² Office of Manpower Economics (3 July 2017), *Wage growth in Pay Review Body Occupations*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/623810/Wage_Growth_in_PRB_Occupations_-_final_report__3_.pdf

- 3.185 The Joint Staff Side said that analysis of data for England showed that all staff (AfC workforce and doctors) had experienced a 13.2% real terms drop in earnings since 2010. Annual earnings growth rates for all staff had been below Retail Price Index (RPI) inflation in every year between 2010 and 2018. In addition, in most years Agenda for Change earnings had failed to track annual growth in annual weekly earnings across the UK labour market.
- 3.186 The **RCN** told us that between 2010 and 2020 earnings had fallen behind inflation as measured by both RPI and CPI, with the only real growth seen among nursing auxiliaries and assistants where earnings had grown by 2.1% between 2019 and 2020.
- 3.187 The **RCM** told us that NHS staff had faced real terms losses in pay over the past decade and that the 2018 AfC agreements had only partially begun to address those losses. They said that the value of pay for a midwife at the top of band 6 had decreased by over £7,000 in real terms since 2010.
- 3.188 **GMB** told us that against the RPI, average real earnings had fallen by 11% since 2010 and that against CPI, average earnings had fallen in real terms. It argued that NHS pay was worth significantly less than it was 10 years ago, with a serious and detrimental impact on their members' quality of life, ability to afford necessities, and family relationships.
- 3.189 **GMB** said that the levels of dissatisfaction with pay reported through the NHS Staff Survey remained at unacceptable levels. The survey reported that 36% of NHS workers as being 'very dissatisfied' or 'dissatisfied' with their pay, rising to 47% of ambulance workers.
- 3.190 **GMB** said that top of band workers had experienced sharp cuts in the real value of their pay, and top of band data remained the best means of measuring changes in the value of pay over time.
- 3.191 **GMB** told us that the NHS was no longer a Living Wage employer following the November 2020 uprating of the Foundation Living Wage rate to £9.50 outside London.
- 3.192 The **Chartered Society of Physiotherapists** said that 14% of its survey respondents reported regularly working additional paid employment outside of their main NHS role. A further 13% reported working occasionally outside of their main role. Of those that reported taking additional outside work, 72% reported this as necessary in order to save money; 54% reported doing so as their main role salary did not meet their costs of living; and a further 26% of those that undertook additional work did so to manage debt.
- 3.193 The **College of Podiatry** told us that there was a similar private sector market that could be compared to NHS workers and NHS staff had intimate knowledge of their worth in the private sector. Its survey suggested 75% of respondents believed they would earn more in the private sector. The College of Podiatry argued that results of its survey clearly showed the private sector to be an attractive option. The survey also produced evidence of the difficulties in recruitment of qualified staff in the NHS.
- 3.194 The College of Podiatry said that its evidence highlighted that 70% of its members lived in a household that had been adversely affected by the economic impact of COVID-19. Restricting public sector pay would not reduce the economic impact of the pandemic but would mean that individuals who had suffered would be hit twice if a wage earner in the household had also been economically hit by a low or below inflation pay-rise.
- 3.195 The College of Podiatry commented that its members report that filling vacancies was difficult and simple supply and demand would suggest that improved pay rates would attract and retain more staff. In podiatry terms, that would mean making employment in the NHS as attractive as working in the independent sector.

Ambulance staff

3.196 **GMB** said that unsociable hours payments were especially important for ambulance staff. On average, 27.4% of ambulance workers' earnings were made up of non-basic payments (of which shift payments were by the far the most significant component). By contrast, non-basic payments account for 13.9% of average earnings for all staff. Ambulance workers were the second most dependent group on additional payments after specialist registrars. The closure of Annex 5 to new entrants was an issue of serious concern for GMB's ambulance members. In the GMB's NHS members survey, excluding 'don't know' responses, 58% of ambulance members said that they had not pursued a promotion in order to protect their unsociable hours payments. This figure was essentially unchanged in 2019, when 57% of ambulance members said they had not pursued a promotion due to the change in terms and conditions. The changes to unsociable hours payments were having serious workforce impacts, and GMB asked that the Pay Review Body investigated this area and made recommendations.

Total reward and pensions

3.197 **DHSC** told us that Total Reward was the tangible and intangible benefits that an employer offered an employee and it remained central to recruiting and retaining staff in the NHS. The value of the NHS total reward package remained high.

3.198 **DHSC** said that the Government Actuary's Department (GAD) calculated that Scheme members can generally expect to receive around £3 to £6 in pension benefits for every £1 contributed. **DHSC** also said that the Scheme was backed by the Exchequer and was revalued in line with price inflation, providing a guaranteed income in retirement. A band 5 or 6 nurse retiring at 68 with 35 years' service wholly in the 2015 Scheme could expect an annual pension of around £19,000. **DHSC** told us that overall membership of the NHS pension scheme amongst NHS staff was high. Between October 2011 and July 2020, the percentage of NHS staff who were members of the NHS Pension Scheme had increased by 4.8%. Membership rates for the NHS Pension Scheme compared favourably with private sector pension scheme participation. The Department for Work and Pensions published a report⁴³ in June 2019 comparing the participation rates and savings trends between public and private sector pension schemes. The report studied pension scheme data between 2008 and 2018. Although private sector pension scheme participation had risen since the introduction of automatic enrolment, participation in private sector schemes (85%) was still lower than the public sector (93%).

3.199 **DHSC** said Total Reward Statements (TRS) were provided to NHS staff and gave staff a better understanding of the benefits they had or may have access to as an NHS employee. TRS provided personalised information about the value of staff employment packages, including remuneration details and benefits provided locally by their employer. Individual NHS employing organisations may also offer other forms of local reward

3.200 In oral evidence, **NHS E&I** told us that there were implications for the retention of older staff after the McCloud judgement. More trusts were looking at flexible working options such as part-time, job share and where appropriate, working from home.

3.201 In oral evidence, **NHS Providers** told us that trusts were really worried about a broadening of the numbers retiring from the NHS as a result of the McCloud judgement given the age profile of staff and the effect this would have on the service as experienced staff are lost. It would be helpful for a way to be found to encourage these staff to stay.

⁴³ Department of Work and Pensions (5 June 2016), *Workplace pension participation and saving trends: 2008 to 2018*. Available at: <https://www.gov.uk/government/statistics/workplace-pension-participation-and-saving-trends-2008-to-2018>

- 3.202 The **Joint Staff Side** said that any pay uplift, be it cost of living or pay step increase, saw a growing proportion of staff experiencing a reduction in take home pay as they moved into a higher pension contribution tier. For many of these pension scheme members, there was no equivalent increase in the value of their pension benefit as the accrual rate was the same regardless of contribution tier. They had expected a new contribution framework to have been introduced in 2021 but this would not now come into effect until April 2022 at the earliest.
- 3.203 In oral evidence, the Joint Staff Side told us that some staff might have delayed retirement whilst awaiting the outcome of the approach to the McCloud judgement. It added that it could be challenging to persuade these staff to remain within the core NHS workforce, even on a part-time basis, rather than retiring and taking up agency working.
- 3.204 In oral evidence, the **RCN** said that some staff had delayed retirement to work during COVID-19. RCN said the pension changes that would result from the McCloud judgment would also impact on the number of staff who were able to retire. It said that the NMC register currently contained 50,000 nurses above the age of 62 years and the risk of losing these staff was now very high.
- 3.205 In oral evidence, the **RCM** told us that it was not clear how the McCloud judgement would impact on retention. Some staff now had a choice to retire earlier which could impact on staff numbers. There was a risk that a pay uplift that did not meet expectations could preclude the decision of some staff to take up retirement options.
- 3.206 In oral evidence, **Unite** said that the McCloud judgement on pensions had still left some pensions issues unresolved and it was not clear what the approach to pensions would be going forward.
- 3.207 In oral evidence, **GMB** said that the McCloud judgement would give staff a choice on whether to retire at an earlier point including some ambulance workers who would be able to retire at 60 years.
- 3.208 The **Society of Radiographers** said that a worrying example of new reward frustrations being cited by members was the pension scheme – as a significant proportion of people's routine pay was excluded from the scheme which was meant to recognise all earnings as opposed to final salary. It also said that over the coming months ahead of likely pension reforms in 2022. It would be exploring emerging concerns more fully to test if existing staff's under-selling of the pension was contributing to stubbornly high pension opt-out rates amongst new professionals at Band 5.
- 3.209 **Managers in Partnership** said employers were rightly concerned that the remedy for discrimination in the transitional arrangements for the new pension scheme would make it more financially attractive for staff to leave earlier than they might have planned to.

2018 Agenda for Change pay agreements

General

- 3.210 **DHSC** told us that the 2018 AfC Pay agreement represented a significant investment in the AfC workforce. In 2021/22 there remained a small number of outstanding elements as a consequence of the multi-year deal, some of which would result in further benefit to individual members of AfC staff. DHSC also told us that the pay assumption proposed in their evidence did not include the circa 0.7% that had already been committed in 2021/22 as part of the multi-year Agenda for Change deal (2018/19 to 2020/21). This 'overhang' of the deal was agreed by all parties. DHSC expected the total investment in AfC in 2021/22 to be 1.7%.

- 3.211 DHSC said that NHS E&I was leading the work to develop a benefits realisation plan to underpin the implementation of the AfC deal. This would help to ensure the AfC deal delivered the outcomes the partners expected including providing the data necessary for them to measure the success of the deal. NHS E&I were working with NHS Employers, the NHS Staff Council and DHSC to agree the most appropriate and measurable key performance indicators and intended to share a draft with the Staff Council co-chairs for feedback
- 3.212 In oral evidence, **NHS E&I** told us that information on benefits realisation would be shared with the Review Body in September 2021.
- 3.213 **NHS Employers** told us that changes to the pay structure had been introduced in stages, with some pay points being removed and/or merged in April 2018, 2019 and 2020. However, it was not possible to complete all the pay structure changes and stay within the 9% funding envelope over the three years of the reforms to 2020/21. Consequently, it was agreed that the final reforms to Bands 5 to 7 would be completed during 2021/22. NHS Employers also said that this structural reform would cost around 0.7% of the non-medical pay bill. The exact cost would depend on the distribution of FTE staff in April 2021. The 2021/22 pay award for staff on the 2018 terms and conditions of service would be additional to this cost
- 3.214 NHS Employers said that moving to the final pay structure for pay Bands 8 to 9 in April 2020 meant that staff on some points in these pay bands would have seen a reduction in basic pay based on the reformed pay bands. The agreement therefore included a provision for affected staff to receive top-up payments during 2020/21 to ensure that no staff would be worse off because of the pay deal over the three-year implementation period. The associated cost of the top-up payments in 2020/21 was around 0.1% of the non-medical pay bill.
- 3.215 NHS Employers said it was understood at the time of the framework agreement that if the top-up payments were not extended beyond March 2021, a minority of staff would see a reduction in basic pay in 2021/22. It also said that there was now a choice about whether to allow the affected staff to see a reduction in pay in 2021/22 or to offer some form of extended pay protection. If the pay protection was allowed to expire, there would be a saving of around 0.1% of the non-medical pay bill.
- 3.216 NHS Employers said that on implementing the 2018 reforms, the NHS Staff Council had delivered on the key recommendation in the Francis Report that pay progression should be linked to the quality of care and not time served. The reforms helped to better incentivise compassionate and excellent care and the delivery of more care more appropriately. This was in line with the NHS Long Term Plan based on a new service model which placed more emphasis on prevention and health inequalities, improving the quality of care and health outcomes across all major health conditions and harnessing technology to transform services.
- 3.217 NHS Employers said that now that the transactional phases of the pay reforms had been largely completed, it was important to allow time for the system changes to be consolidated and for HR to make the most of the opportunity for a new focus on quality and, staff learning and development.
- 3.218 In oral evidence, NHS Employers told us that some good strategic thinking was being undertaken in the trusts of how to maintain the workforce in light of COVID-19 and the elective treatment backlog. However, if 75% of staff were at the top of their pay band, the strategic issue was not progression.

- 3.219 In oral evidence, NHS Employers said there was a real issue with morale and motivation for those at the top of band who would also be affected the most by the pay award decision as there was no further progression. With around 75% of staff at the top of their pay band, a pay recommendation needed to be meaningful for these staff. However, differentiating the top of band for a special reward would not feel right to people this year.
- 3.220 In oral evidence, NHS Employers told us that there would be a structural issue owing to the narrowness of the pay band gaps if more was given to the top of band. Lots of staff were at the top of band and those below this needed to wait two to five years to progress so a decent flat percentage pay increase was needed this year. Non-pay factors were also important – for example being able to take annual leave and getting professional development back on track.
- 3.221 In oral evidence, NHS Employers told us that the three-year deal had achieved some very necessary and meaningful pay reforms and future issues to look at in the short, medium and long term including the proportion of staff bunched at the top of bands and the length of time taken to move from the pay band entry point to the top of the band.
- 3.222 **NHS Providers** told us that in England there had been a specific, ongoing challenge for trusts delivering community services commissioned by local authorities, which had failed to receive funding to meet the costs of pay rises for their workforce, despite these staff being employed on AfC contracts.
- 3.223 In oral evidence, NHS Providers said that as a consequence of the AfC pay agreement, in the longer term, there would be more people at the top of the bands. This was when it would be important for pay to be keeping pace with the cost of living.
- 3.224 The **RCM** said the 2018 AfC pay agreements resolved long-standing structural issues by removing overlaps between bands to improve starting and promotion pay and shortening most pay bands to make it quicker to reach the full rate for the job. For those members of staff at the top of the band, real terms losses over the past decade were still keenly felt.
- 3.225 The RCM told us the vast majority of midwives were at the top of their pay band and it was these staff who had benefited least from the three year pay deals. A significant pay rise for all NHS staff was key to ensure midwives and MSWs felt valued enough to stay in the profession.
- 3.226 **Unite** told us that it supported the 2018 deals as a starting point on a pay journey for NHS staff but the deals did not reverse the impact of eight years of pay caps and freezes in the NHS. The COVID-19 crisis had further underlined the need for meaningful increases to NHS pay in order to restore the lost value over the last decade.
- 3.227 Unite said more than 15 years on from the implementation of Agenda for Change and particularly after years of austerity with pay freezes and thousands of NHS workers working over and above their contracted hours freely, a review of annual leave had not properly occurred.
- 3.228 Unite said that the entrenchment of the growing separation between the four UK countries into distinct NHS pay spines had led to the fragmentation of the Agenda for Change agreement. Pressures from political devolution, government under funding and the impact of outsourcing NHS staff and services were all contributing to this. Unite was concerned that this trend should be resolved to prevent cliff edges or further distortions from taking root.

- 3.229 Unite told us that trusts did not act in a uniform way across England when implementing AfC pay regulations, with good and bad practice. For this reason, Unite was calling for an organisational change policy for all trusts in England that entrenches fairness into the process and tackles members' concerns about downbanding and downgrading.
- 3.230 The **Chartered Society of Physiotherapy** said that results of its member surveys showed that those working at the top of their AfC band were significantly less satisfied with pay when compared with those still working through their bands' entry and mid pay points. This finding reflected comments raised in their qualitative research where members detailed how limited NHS career progression results in members – at all points within NHS career pathways – getting 'stuck' in grades not reflective of their workplace responsibilities. It also said that its members were asked to comment on how their take home pay had changed relative to their costs of living over the past 12 months. It was reported that 63% of respondents indicated it had deteriorated either somewhat or substantially, with only 4.5% indicating any improvement.
- 3.231 The **College of Podiatry** told us career progression was limited, resulting in grade blocking as once the top of a pay band was reached there was little room for progression. Added to the number of podiatrists, who were either at the top of their pay bands now or have been for some time, pay and career stagnation was a common theme. It also said that its members, who were at the top of their pay band in 2018, were unlikely to have seen a significant rise in pay following the 2018 Framework Agreement. The overall rise for those who were on the top of their band in 2018 was 6.5% Bands 5, 6, 7, 8a to 8c, 5.45% in Band 8 and 4.48% in Band 9 over the three years to March 2021.

Progression

- 3.232 DHSC told us that 2020/21 would see the end of the three-year deal agreed in 2018 which had made key changes to reform the contract and to support recruitment, retention and productivity by investing in all pay points, reducing the number of pay points in each band and ending automatic pay progression. The pay scale reform would be fully implemented in 2021. DHSC also told us that whilst it had invested in all parts of the contract, it understood that pay progression and promotion may mean the experiences of individual members of staff varied depending on what role they were in and where they sat within their band.
- 3.233 The NHS Staff Council said the DHSC had provided advice to NHS employing organisations so that for the duration of the pandemic, the usual arrangements that required staff to demonstrate or show they met the requirements for the role would be paused. Consequently, from 27 March 2020, some of the benefits of introducing the new pay progression framework might have been lost where staff would have automatically progressed to the next pay step point where this was due.

Transition from Band 1 to Band 2

- 3.234 **DHSC** said that in December 2018 Band 1 was closed to new entrants with existing staff given the opportunity to transfer to Band 2 by March 2021. In June 2020, there were around 7,300 staff remaining in Band 1 compared to 25,000 in December 2018. Pay values at the top of Band 1 and the bottom of Band 2 were the same. For those remaining at Band 1, NHS E&I and NHS Employers were working with trusts to better understand the reasons why staff were choosing to remain in Band 1 and providing advice on upskilling opportunities. For England, the number of AfC Band 1 staff decreased by 3.4% between July 2019 and July 2020. This was linked to the closure of the Band to new entrants as of December 2018, and the subsequent transfer of remaining staff into Band 2. The latest data from NHS Digital, for December 2020, showed that there were 6,200 FTE staff still in Band 1, of which over 5,500 were in the hotel, property and estates staff group.
- 3.235 The **NHS Staff Council** had been monitoring the numbers of staff transitioning from Band 1 to Band 2 using data from NHS Digital. The total number of Band 1s (FTE) in November 2018, when Band 1 closed to new entrants, was 24,900. As of May 2020, when the last transition data was available, the total number was 7,549, a decrease of 17,441 FTE. The Staff Council would continue to support trusts that had been identified as having a significant number of staff remaining in Band 1.

Priorities at the end of the pay agreement

- 3.236 **DHSC** informed us as part of the three-year pay and reform deal, staff on some pay points in bands 8 and 9 were given consolidated payments during the third year of the deal (2020/21). No agreement was reached on what would happen to these consolidated payments in 2021/22, the first year outside of the three-year deal. The decision on what should happen to affected staff in these bands would need to be considered as part of the 2021/22 pay round by Ministers, taking in to account any Review Body recommendations. DHSC added that, given Review Body recommendations would not be known until after 1 April 2021, there was a need to preserve current pay for affected staff so that it did not drop. These payments represented an additional commitment on top of the 0.7% overhang.
- 3.237 The **NHS Staff Council** told us that throughout 2020, a small number of staff in Bands 8 and 9 have been in receipt of a one-off consolidated payment. This consolidated payment was introduced as part of transitional arrangements to ensure that those on legacy pay points were no worse off under the new pay structure during the three years of the pay deal changes. The NHS Staff Council added that without a mandate for further structural change, the most feasible option was for the consolidated payment to be continued for an additional two years until the issue is resolved itself by 1 April 2023. The cost of continuing the consolidated payment, with or without increasing the payment in line with any pay award, would add further unfunded cost pressure to the pay bill above the estimated 0.7% 'carry over' cost pressure already identified.
- 3.238 **NHS Employers** referred to the need to align pay reform with structural reform of working patterns. Staff must feel more empowered to flex and re-shape their careers. Employers have noted the importance of development opportunities as pivotal in the new pay agreement, to motivate those at the top of the pay bands.

- 3.239 NHS Employers told us that as a result of the AfC pay agreement, in the agreed final AfC pay structure, pay bands 8 to 9 had been reduced to two pay points per band. The changes to the pay structure had been introduced in stages, with some pay points being removed and/or merged at the start of each year of the deal (April 2018, 2019, and 2020). Moving to the final pay structure for pay bands 8 to 9 in April 2020 would mean that staff on some points in these pay bands would see a reduction in basic pay based on the reformed pay bands. The agreement therefore included a provision for affected staff to receive top-up payments during 2020/21 to ensure that no staff would be worse off because of the pay deal over the three-year implementation period. The associated cost of the top-up payments in 2020/21 was around 0.1% of the non-medical pay bill.
- 3.240 NHS Employers said that if the top-up payments were not extended beyond March 2021, a minority of staff would see a reduction in basic pay in 2021/22. This was understood at the time of the framework agreement, but the decision about how to handle this was deferred to be dealt with alongside 2021/22 pay policy decisions. There was now a choice about whether to allow the affected staff to see a reduction in pay in 2021/22 or to offer some form of extended pay protection. If the pay protection was allowed to expire, there would be a saving of around 0.1% of the non-medical pay bill. There were several options for extending some form of pay protection, the pros and cons of which needed to be worked through with the DHSC and other stakeholders. These would result in at most a small net pay bill pressure in 2021/22 from spending marginally above the 0.1% currently being spent on pay protection in 2020/21
- 3.241 **NHS Providers** said that it believed that there would have been significant merit in the introduction of a new, fully funded multi-year pay deal, given the benefits this could provide to workforce and financial planning within organisations and across systems for the short and medium term. However, NHS Providers added that given the remit that the Review Body had been set for the 2021/22 pay round only, their further evidence and comments on pay were based on the likely implementation of a single-year award.
- 3.242 **Managers in Partnership** told us that in the three year deal the Government had insisted on capping awards for Bands 8c, d and 9, even though such an approach made no difference to the overall cost of the deal or to the investment in lower paid staff. Similarly, the Government decided at the last minute to exclude Bands 8 and 9 from an important element of the reform package, which was the shortening of pay bands. These decisions were arbitrary and designed largely for presentational reasons. They were not well-received by clinical and non-clinical staff in these bands.

Pay approaches

- 3.243 **HM Treasury** informed us that OBR expected wages to continue to grow across 2020/21 (0.9%) and 2021/22 (2.2%), albeit at a significantly reduced rate relative to the March 2020 forecast. The OBR expected some bounce back in wages in 2021/22 as the economy recovered, although both of these factors were highly uncertain and subject to wider developments.
- 3.244 HM Treasury told us that public sector remuneration remained generous relative to the private sector, and COVID-19 was likely to broaden this disparity, especially taking into account Government's acceptance in full of most of the recommendations for 2020/21 from the respective Pay Review Bodies. The Government had determined that a temporary pause in public sector pay growth, excluding the NHS and awards for the lowest paid, was needed until the full impact of COVID-19 on the wider economy was clearer.

- 3.245 HM Treasury said that for the majority of public sector workers, this was the third consecutive year of pay awards in excess of inflation. The inflation forecast had fallen by 0.8% and 1.3% since the March 2020 and 2019 forecasts respectively, meaning that awards for 2020/21 were substantially more generous in real terms than expected.
- 3.246 HM Treasury said that in addition to pay, it was important to consider all parts of remuneration when assessing the position of employees in the public sector relative to private sector. 'Future service' employer pension contributions in the public sector were typically around 20%. It argued that this was generous even for large private sector employers and private sector averages would be far lower once automatic enrolment was taken into account.
- 3.247 HM Treasury said that ONS's analysis of the full remuneration package of employees (including pensions, bonuses and overtime) showed that in 2019 public sector workers were paid 7% more than workers in the private sector on average. Given the substantial effects of COVID-19 on the economy and labour market, HM Treasury expected the gap between sectors to widen further. Pausing headline pay awards next year would prevent further expansion of the gap. HM Treasury asked the Review Body to note that the Government had chosen to exempt the NHS given the unique and continuing impact of COVID-19 on the health service.
- 3.248 HM Treasury also said that pay settlement data could give a better indication of underlying wage pressure. The private sector median settlements fell to 0% in the three months to the end of July, August and September, before rising again to 2% in the three months to October.
- 3.249 DHSC said that median earnings of AfC staff (£25,500) were equivalent to the wider economy (£25,780). Earnings for AfC staff at the 25th percentile were £19,000, and earnings at the 75th percentile were £36,000. Average earnings varied by staff group where some, such as those requiring professional qualifications, had median earnings above the UK average. Whilst others, such as those in support roles, were below the UK average. However, when comparing NHS staff groups to roles with equivalent levels of qualification and experience, AfC staff earnings were in line with those in the wider economy.
- 3.250 DHSC told us that the Government announced a pause in public sector pay rises for all workforces, with an exception for employees with basic full-time equivalent salaries of £24,000 or under and for the NHS. In settling the DHSC and NHS budget, the Government assumed a headline pay award of 1% for NHS staff. Anything higher would require reprioritisation.
- 3.251 DHSC told us that following on from the multi-year pay deal, the long-standing aim of the Government remained the same. Within the current challenging economic context, DHSC told us it must ensure that it could continue to recruit, retain and motivate the compassionate, skilled and dedicated workforce the NHS needed in order to deliver world-class care, whilst also guaranteeing the best value for the taxpayer. Carefully balancing these aims was a complex matter that reflected the overall NHS employment offer, including pay and non-pay terms and conditions.
- 3.252 In oral evidence, DHSC confirmed that it was Government who ultimately take responsibility for public sector pay and within agreed budgets DHSC is responsible for the NHS in England.
- 3.253 In oral evidence, DHSC informed us that the proposed pay assumption for 2021/22 included staff earning below £24,000 receiving an uplift of £250 with most other staff getting 1%. This would add up to 1.05% with then 0.7% available for overhanging AfC issues, adding up to a 1.75% pay assumption in total.

- 3.254 In oral evidence, DHSC said that the Treasury had confirmed there was an argument that a modest uplift for NHS would be appropriate as this would reflect the economic situation the UK faced. Any uplift would need to be considered against the affordability issue. DHSC also said that the 1% figure in DHSC evidence had taken account of these arguments. An uplift higher than 1% would require reprioritisation of some services. There was also a fairness point, many other public sector staff were not getting a pay rise and people in the private sector had lost their jobs and suffered financial hardship. A modest uplift would reward staff but would be fair to the taxpayer.
- 3.255 **NHS E&I** told us that NHS staff should receive a fair salary, rewarding and recognising their amazing contribution, including during the COVID-19 pandemic.
- 3.256 **NHS Employers** told us that in terms of a pay uplift from 1 April 2021, employers want to see all staff treated fairly and in the same way. NHS Employers had noted the announcement in the November 2020 Spending Review, that public sector workers earning less than £24,000 would receive a pay increase of at least £250. It would need further information on how this will be applied in the NHS. NHS Employers also told us that NHS leaders were telling them that any pay uplift in 2021/22 must reflect the enormous effort made by staff, be affordable and fully funded, and not be a detriment to closing the gap in terms of workforce shortages.
- 3.257 NHS Employers said that after several years of complex pay changes, which had been essential to complete the necessary structural reform to the pay system and which had had unique impacts on individuals, NHS leaders would prefer a pay award settlement that was straightforward and applied in the same way to all staff.
- 3.258 NHS Employers said that containing pay costs had implications for the attractiveness of working in the NHS and for the morale and motivation of the staff who are already in post. With around two-thirds of their costs attributable to the workforce, leaders in NHS trusts repeatedly tell them that pay must continue to be affordable, both in the short and longer term.
- 3.259 NHS Employers said that its pay policy must help support the delivery of the NHS Long Term Plan and recruitment and retention of staff were crucial to its successful delivery. Employers were improving staff engagement by obtaining regular feedback on the needs and aspirations of their staff. It was known that for nurses, the satisfaction of caring for people together with a long-term desire to nurse were important factors in drawing talented people into the profession. Nurses expected to work in a caring team and have a satisfying career. Yet conflicts in clinical settings, disappointment over the treatment of nurses and changes within the NHS and nursing can deter promising people from choosing nursing as a career. Employers were acting on feedback from nurses to ensure that they felt a valued part of the healthcare team.
- 3.260 In oral evidence, NHS Employers told us that that employers' views on pay had been focussed on the short term over the last 10 years. An uplift of between 2% and 2.5% was what might be felt to be fair and affordable.
- 3.261 **NHS Providers** told us that trusts had told them it was critical for staff throughout the NHS to receive a meaningful, real terms pay increase in 2021/22. It also said that a significant majority (82%) of respondents to its survey of NHS trust HR Directors this year had called for a pay uplift of at least 3%, with only 14% saying it should be 2% or less.

- 3.262 NHS Providers said that recent remit letters from the Secretary of State for Health and Social Care to the DDRB had made strong note of an apparent “direct trade-off” between levels of pay and staff numbers in the medical profession, and this year there was a similar message to the Review Body with the Secretary of State noting a “close relationship between pay and staff numbers” in the context of affordability for the Government. NHS Providers accepted that there was a plan to fund both pay increases and workforce growth from within the five-year NHS England settlement – which was notionally “set” in value for the duration – and did not believe other immediate or longer-term service priorities should be compromised by the awarding of meaningful pay rises for staff.
- 3.263 NHS Providers said it appreciated the Secretary of State’s request for the PRB to consider the impact of COVID-19 on the national economy. It agreed that the economic context was challenging. The key piece of this challenge was how the Government chose to prioritise areas for funding and/or considered new ways of increasing revenue to ensure ongoing and appropriate levels of financial support for key public services and public sector staff. It also said that it was essential that pay awards were fully funded by the Government and affordable for trusts to administer for all eligible staff. Affordability of pay rises had presented a key financial and operational challenge for trusts as employing organisations in recent years, due to imperfections in the broader design of the three-year pay settlement.
- 3.264 In oral evidence, NHS Providers said the pay uplift it requested in its written evidence of at least 3% had been derived from asking HR Directors specifically what would be appropriate with staff acceptance and affordability in mind. NHS Providers believed that a 3% uplift would recognise and reward staff for their efforts in responding to COVID-19 and that this number would help with future retention of staff.
- 3.265 The **Joint Staff Side** said a substantial pay rise for the NHS workforce was a necessary investment for the future, critical to both recruitment and retention of staff. With staff intentions to leave growing and a major recruitment drive now underway, it was important to make the NHS an attractive long term proposition for the future, to tackle the persistent understaffing and build resilience into the system with the UK economy likely to rebound quickly to strength. With labour supply limited by new immigration rules and the UK’s exit from Freedom of Movement, it was important to think now about how to ensure that we have the necessary workforce in place for the future. Pay and pay progression were critical to recruitment and retention of staff.
- 3.266 The Joint Staff Side said public sector pay constraint from 2010 had in reality served only to stifle rather than support economic growth. Estimates from the New Economics Foundation (NEF 2019), using OBR analysis, found that the cumulative effect of austerity was to shrink the economy by £100 billion compared to what it would have been without the cuts. Delivering a significant pay rise for NHS staff was a sensible fiscal intervention to support the UK economy. It would also support pay negotiations in the private sector, sending a strong message of confidence to employers to agree pay increases for staff and keep consumer spending high.
- 3.267 The Joint Staff Side had commissioned London Economics to undertake independent research on the net impact to the Exchequer of increasing pay for Agenda for Change staff. The research undertaken detailed economic modelling of the impact of a 5% and 10% increase in the total AfC pay bill (for AfC staff in England). The research concluded that of the initial outlay (corresponding to £1.70 billion and £3.40 billion associated with the 5% and 10% increases). The research also made the following points:
- HM Treasury would recoup 47% (equivalent to £0.79 billion for 5% and £1.60 billion for 10%) of the additional pay bill cost through collecting the income tax and NI insurance contributions of AfC staff and their employers alone;

- HM Treasury would recoup a further 26% (£0.44 billion for 5% and £0.89 billion for 10%) of the additional pay bill costs through direct, indirect and induced taxation receipts resulting from the impact of AfC staff spending of the additional disposable income throughout the wider economy;
- There would be a significant impact on recruitment and retention and reduced reliance on bank and agency staff over a 10 year period, resulting in overall cost savings to HM Treasury corresponding to £0.06 billion (for a 5% pay bill increase) or £0.13 billion (for a 10% pay bill increase);
- The research also modelled the impact of cost savings from a reduction in student loan write-offs (for a given cohort of English-domiciled students undertaking nursing degrees), which it calculated would generate an additional £0.07 billion (for 5%) or £0.13 billion (for 10%) in savings to HM Treasury; and
- In total, this means that increasing the AfC pay bill by 10% had a net cost of just £0.66 billion to HM Treasury.

3.268 The Joint Staff Side said that the public sector remained the poor relation when it came to pay, with the NHS and broader public sector consistently lagging behind the private sector. Since 2010 average weekly pay in the private sector pay had grown 22%, compared to just 17% in the public sector.

3.269 The Joint Staff Side told us that NHS staff had seen the Government spend billions of pounds to support the economy and witnessed huge sums of money being wasted on failed procurement, poor contracts and a test track and trace system that had struggled to deliver. The Chancellor had explicitly promised NHS staff a pay rise in recognition of their efforts, and the expectation amongst the workforce was that they deserve and have earned a substantial pay rise.

3.270 The Joint Staff Side informed us that across the world, in similar advanced economies as the UK, it saw health workers' contribution to the pandemic being recognised through their pay negotiations. The French Government had agreed to give pay rises worth €8 billion (£7.2 billion; \$9 billion) to health workers, an agreement that would see the wages of health workers rise by €183 a month on average. Germany had agreed a pay deal with public-sector unions that will cover about 2.3 million workers employed by municipalities and the federal administration. The Verdi union and public employers said they had agreed an inverse sliding scale of pay gains, from plus 4.5% for the lowest income bracket to plus 3.2% for the highest bracket. The agreement would run until the end of 2022. The effect of seeing colleagues in other countries receiving pay increases, in recognition of their contribution during the pandemic, had significantly raised the expectations of staff in the UK.

3.271 The Joint Staff Side argued that investment in pay helped staff feel valued and played an important part in boosting morale and improving job satisfaction. In the NHS Staff Survey for England in 2019 that followed the £4.2 billion investment in Agenda for Change pay, scores for staff satisfaction with pay jumped by 5.1% and continued to increase by a further 2% the following year.

3.272 The Joint Staff Side told us that public opinion strongly supported NHS workers and this had only been reinforced by the COVID-19 crisis. During the lockdown over the spring and summer of 2020, it was impossible to walk down a street in the UK without seeing a rainbow emblazoned in a window offering thanks and support for NHS workers. The public had consistently supported giving NHS workers a pay rise. In a ComRes poll for UNISON in July 2020, 69% of the public said that they supported a significant pay rise for NHS workers to be implemented before the end of the year.

- 3.273 The **RCN** said the remit letter from the Secretary of State for Health and Social Care for the 2021-22 pay round, subsequent to the November Spending review which had identified £3 billion additional funding to support the NHS recovery in England, was highly disappointing. The Spending Review committed no additional funding for pay and the remit letter pointed to a return to public sector pay restraint. The combination of these two announcements would mean NHS organisations faced difficult choices between increased pay, jobs and service delivery. The RCN said it had always been clear that decisions around funding, service delivery and workforce must not be taken in isolation.
- 3.274 The RCN argued that the Government should be doing everything it could to support the recovery of the UK's economic and social health. This included increasing the capacity and resilience of the NHS and, as a highly labour-intensive organisation, this must include investment in the workforce. All public sector workers, including the NHS, had suffered real terms pay cuts over the last 10 years and using the plight of private sector workers to justify further hardship to public sector workers was dangerous as it caused divisions and pitted one sector against another. The RCN also said that the NHS workforce knew that all public spending was a political choice. Recent spending decisions including those on contracts to supply equipment and testing capacity to deal with the pandemic would inevitably be weighed against the pay decision in assessing how NHS workers feel valued.
- 3.275 The **RCM** said that in 2020 the value of pay for a midwife at the top of band six had decreased by over £7,000 in real terms since 2010.
- 3.276 The RCM told us that increasing disparity in pay impacted on the morale and motivation of midwives and MSWs in the rest of the UK, and only 2% of RCM members felt valued by the UK Government. This was compounded by pay rises awarded to health and wider public sector workers in the rest of Europe. These pay rises were worth €8 billion (£7.2 billion; \$9 billion) to health workers in France, and in Germany there were public sector pay increases from 4.5% for the lowest income bracket to 3.2% for the highest bracket. The RCM also said that the NHS was the biggest employer in Europe and it helped to stabilise the economy. Increasing pay for NHS workers was an effective way of intervening to promote an economic recovery. The RCM argued that by boosting the income of households, the Exchequer could also expect to benefit from increased tax revenues.
- 3.277 **UNISON** said that everyone working in the NHS deserved a pay rise. That was why it was asking the Government to give all staff a rise of at least £2,000. UNISON said that NHS staff reported that this pay increase would make them more likely to remain working in the NHS, improve their morale, and that they would spend more in their local economy. Meeting this claim would add less than £3 billion to the annual operating budget for the NHS in England, a modest portion of the overall pay bill. It would also generate benefits back to HM Treasury in the form of increased tax receipts and less spending on in-work benefits. UNISON said it began working with UNISON members in the NHS on its approach to a 2021 pay settlement as far back as autumn 2018 through its national and regional structures, UNISON conferences, and other forms of engagement. In February 2020, nearing the end of the three-year agreement, it conducted a membership consultation to evaluate our approach to the 2018 reforms and to ask members how they wished it to approach the next pay round (2021/22)

- 3.278 UNISON told us that NHS staff felt strongly about pay. There were high levels of dissatisfaction and anger about how NHS staff had been treated. There were also very high levels of expectation that the Government must take positive action on pay, with a strong risk of further discontent if that did not happen. The challenge of this combination could not be over-stated. Inaction, or positions taken in bad faith, inequitable treatment or even simply poor communication would make this situation much worse. It also told us its survey reported that when staff were asked about the possibility of positive Government action on pay and reward most staff responded positively. Staff had reported that a pay increase of £2,000 would address issues of value, morale, retention, and household finances.
- 3.279 **Unite** told us it had urged the Government to support the joint health union call for pay talks to start soon so NHS workers could get a decent wage increase. Unite had welcomed the Scottish Government's commitment to early pay discussions and to backdate pay for NHS staff to December 2020 and was strongly urging the UK Government to make a similar commitment. Unite had also approached the Welsh and Northern Ireland administrations for similar discussions. It also told us that all NHS staff deserved a pay rise and that pay differentials represented the added skills, training and responsibilities of staff further up the spine. Unite believed it was clear that lower paid staff would feel the bite of loss of earnings more acutely than the higher paid. In recognition of this, Unite's pay claim called for a bottom loading of the pay offer of £3,000 or 15%, whichever was the greater.
- 3.280 Unite said it welcomed the Government's decision to give the Review Body a more open remit this year compared to previous years. Unite reiterated, however, that the Review Body should be completely independent and free from Government interference. That independence should include the ability to make recommendations on the levels of funding the Government had provided to the NHS, rather than simply within the constraints of prior budgetary decisions. Since 2010/11 there had been many years of capped 1% pay rises or pay freezes for NHS workers. This had meant that large numbers of NHS workers had seen their pay decrease by around a fifth in real terms.
- 3.281 Unite informed us that 69% of respondents to its survey said they were either dissatisfied or very dissatisfied with their level of pay, which was a marked increase on last year where that figure was 58%. This reversal suggested that any positive impact of the 2018 agreement had now been lost following the experience of the pandemic. It also informed us that dissatisfaction with pay tended to be higher the lower down the pay spine. Of the groups of staff with significant response rates in Unite's survey, health care assistants, mental health nurses, ambulance staff and estates and maintenance staff, nurses and ancillary staff expressed the highest levels of dissatisfaction with their level of pay. Unite said it would also welcome the Review Body's support for amending the definition of unsocial hours to change to 7 pm to 7 am instead of the current 8 pm to 6 am applied in section 2 of the Agenda for Change terms and conditions handbook. This would go a small way to improving compensation for staff working long hours to keep the service running.
- 3.282 **GMB** believed that NHS pay should be at least restored in real terms to its 2010 levels. In line with this principle, it called for a one-year fully funded headline increase of 15% or £2 an hour – whichever was highest.
- 3.283 The **Society of Radiographers** told us that the UK Government, under the Health Secretary and Chancellor, signed off £12 billion between March and May 2020 on establishing their Track and Trace system. The Society of Radiographers also told us that paying all NHS staff £2,000 more would cost a comparatively small £3.13 billion.

- 3.284 **Managers in Partnership** said its members were managers of services and functions across the health and care system. Managers in Partnership was convinced that a significant pay award was necessary for the NHS in order to motivate, recruit and retain staff in the next few years. It also said that it supported the cause of lower paid staff in the NHS, for example, it fully supported differentiated awards in order to make the NHS a living wage employer.
- 3.285 The **Department of Health, Northern Ireland** told us that the findings from the UUEPC report on public and private sector pay from 24th March 2020 indicated that Northern Ireland public sector wages were on par with other UK regions, with the exception of London. In contrast, Northern Ireland private sector wages were the lowest in the UK. The paper also noted analysis undertaken by the Institute for Fiscal Studies (IFS) which found that headline public sector pay remained significantly higher than private sector pay but was significantly reduced when controlled for workers' characteristics such as working time, occupational structure, qualifications and demographic factors. When taking these characteristics into account, the premium on Northern Ireland public sector pay (on an hourly basis) fell from a headline differential of approximately 30% to 10% for 2016 to 2018.
- 3.286 The Department of Health Northern Ireland said that enforcement of pay growth limits was devolved to the Northern Ireland Executive within the overarching parameters set by HM Treasury. The 2020/21 public sector pay policy for Northern Ireland was determined by the Finance Minister on 2 September 2020. It added that the Finance Minister would determine pay policy for 2021/22 next year.
- 3.287 The Department of Health, Northern Ireland said that there was scope to offer increased awards to reward staff appropriately and there was flexibility for higher awards in return for cash releasing efficiency savings through improvements to public sector productivity. In oral evidence, they noted that £52 million was allocated in relation to AfC pay in 2021/22. This would provide for around a 2% increase on the estimated pay bill for 2020/21. A pay award above 2% would require reprioritisation.

Recruitment and Retention Premia

General

- 3.288 **DHSC** said that usage of Recruitment and Retention Premia (RRPs) remained low across the NHS and had fallen in recent years. The use of RRP may reflect the legacy use of "Cost of Living" payments under the precursor to AfC.
- 3.289 **NHS Employers** said that it had not received information to suggest that employers in England were increasing their use of local RRP. Employers wished to avoid creating competition on pay amongst neighbouring trusts, which tended to drive wage inflation.
- 3.290 The **Welsh Government** told us that it does not support the use of targeted pay to specific staff groups. Although there were shortages of staff in specific specialities, evidence showed that these are UK-wide issues and relate to the numbers of staff training in these areas, rather than the financial rewards.
- 3.291 The **Department of Health, Northern Ireland** said the Northern Ireland Recruitment and Retention Framework was introduced in 2007 to address local recruitment difficulties. Under these arrangements, there were currently two long-term RRP in place for non-engineering radiotherapy medical physics and histocompatibility.

High Cost Area Supplements

3.292 **GMB** said that whilst High Cost Area Supplements (HCAS) was nominally a percentage system with minima and maxima boundings, in reality it had become a two-tier system for almost all recipients, and the value of the payments bore little resemblance to the true costs of living in London.

Workforce strategies and workforce numbers

- 3.293 **DHSC** told us that effective workforce strategy was critical to the delivery of safe, affordable, high quality care. Ensuring that the NHS had access to the right mix and number of staff who have the skills, values and experience to deliver high quality, affordable care was a fundamental aspect of the DHSC's overarching strategic programme for the health and care system.
- 3.294 **DHSC** said it worked with Arm's Length Bodies (ALBs) on the delivery and implementation of workforce policy. NHS E&I was responsible for setting the priorities and direction of the NHS, encouraging and informing the national debate to improve health and care, and delivering the NHS People Plan. DHSC told us that the NHS People Plan was a key route for setting out policy and actions to expand the NHS workforce, strengthening recruitment and retention through improving staff health and wellbeing, equality, diversity and inclusion and the NHS leadership culture. Education and training of the workforce is the core function of HEE.
- 3.295 **DHSC** told us that the Government remained committed to the historic long-term settlement for the NHS which provided a cash increase of £33.9 billion a year by 2023/24. This takes the NHS England budget from £114.6 billion in 2018/19 to £148.5 billion in 2023/24, with an increase of £6.3 billion in 2021/22. It also told us the NHS budget was set for 2019/20 to 2023/24. This budget included money for planned workforce growth and there would be trade-offs if expenditure on pay exceeded affordability assumptions. COVID-19 had created unavoidable direct and indirect financial impacts in the 2020/21 financial year and contributed to a challenging wider economic context.
- 3.296 **DHSC** told us that the Government had committed to delivering 50,000 more nurses by 2025 through a combination of increased supply, recruitment and retention with NHS Digital data showing an increase of 14,800 FTE nurses at August 2020 compared to August 2019.
- 3.297 **NHS E&I** told us that in June 2019 NHS England and NHS Improvement published the Interim People Plan, which formed part of the overall implementation plan for the NHS Long Term Plan. NHS E&I said the plan had laid the foundations for the workforce transformation it needed to bring about to deliver the new service models and ways of working set out in the NHS Long Term Plan.
- 3.298 **NHS E&I** said that the NHS People Plan also placed greater emphasis on the role of ICSs in leading and overseeing progress on the people and workforce agenda and strengthening collaboration among all health and care partners to meet the needs of their population in 2020/21 and beyond. It also said that systems were at the heart of the route map set out in the NHS Long Term Plan for health and care joined up locally around population health needs. ICSs had a leading role in bringing together all local providers of NHS services, primary and community care training hubs, local government and social care providers, local education providers and other partners to accelerate collaborative ways of working to deliver strategic workforce priorities. NHS E&I added that it would work with and through, its seven regional teams and with HEE regional teams to support systems and organisations to deliver these priorities.

- 3.299 NHS E&I said that during 2018 it introduced new standards for ambulance services to ensure that the sickest patients received the fastest response, all patients obtained the response they needed first time and in a clinically appropriate timeframe. To enable the introduction of these standards, new ways of working for newly qualified paramedics were implemented. All paramedics must acquire the skills, experience and professional development necessary to operate the new models of care confidently. Paramedics needed to work in a supportive and enabling environment, with appropriate systems and facilities to fulfil their professional role to its full potential. The 2016 re-banding agreement was implemented and embedded between March 2018 and March 2020. Progress in its implementation continued to be monitored by a sub-group of the Ambulance Improvement Programme Workforce and Leadership Workstream, reporting to the Joint Ambulance Improvement Programme Board.
- 3.300 HEE told us that whilst staff supply, through training, retention and recruitment from elsewhere, was the most immediate issue facing the NHS, skill mix and workforce transformation through CPD were also key issues for HEE to address. HEE confirmed that it was responsible for future workforce supply and it was exploring all available routes (new graduates, staff returning to practice and staff joining from elsewhere, either overseas or non-NHS sectors) to better match supply and demand.
- 3.301 NHS Employers said that in an NHS Confederation survey of 250 NHS leaders, nine out of ten respondents were not confident that they could achieve the goals of the NHS Long Term Plan within their existing revenue settlement, with workforce cited as the most common pressure.
- 3.302 NHS Employers said that it was disappointing to report, once again, that the NHS did not have a published workforce plan. The "We are the NHS People Plan" sets a challenge of being open to all clinical and non-clinical permanent roles being flexible. NHS Employers reported that the feedback they received from their staff, including through their exit surveys, suggested nurses often only receive their rotas 12 weeks in advance. This can make holidays, childcare, special occasions, and other life events difficult to plan for.
- 3.303 NHS Employers said that staff needed more opportunities to choose the hours they worked and had more control over their weekly tasks. It also said that employers informed them that many staff in the later stages of their careers, who wanted to continue to work, were put off by long shifts and undesirable work-life balance. Employers recognised that by providing more flexible working arrangements and managed reductions in participation, these experienced and talented people could continue to make an important contribution including support to new recruits.
- 3.304 NHS Employers informed us that the nursing associate role bridged the gap between healthcare support workers and registered nurses. Nursing associates delivered hands-on care in a range of settings. Employers were using this role to attract new talent into the NHS, and to develop and retain significant numbers of staff already in support worker roles. This was making it easier for more staff to become registered nurses.
- 3.305 NHS Employers believed that workforce planning in the NHS must be a continual process to align the needs and priorities of the system with those of the workforce. Only this way can the NHS meet its legislative, regulatory, and patient service objectives. NHS Employers also believed that evidence-based workforce development strategies would enable employers to factor in the long-term impacts of the pandemic on the existing workforce. The features employers wanted to see in workforce planning at both local and national level were:
- Based on health and social care strategy and business plan;
 - Focused on future need;

- Flexible enough to deal with constant change;
- Subject to constant feedback and review; and
- Planning for staff numbers and skills, staff potential and how staff will be deployed and organised.

3.306 **NHS Providers** said that the reception to the People Plan on the whole was mixed. This was partly due to the lack of answers provided by the plan in some key areas including on training numbers and on staff pay. Whilst NHS Providers recognised NHS England/ NHS Improvement, which published the document, does not hold decisions on pay awards within its remit, the absence of any mention of staff pay and reward was notable in a plan responding primarily to the effects of the pandemic.

3.307 The **RCN** said it supported the Health Foundation's assessment that the NHS should commit to anchor workforce strategies which 'involve thinking not only about how the NHS can grow local workforce supply and widen access to employment for local communities, but also how the NHS can be a better employer and place to build a career for more people'. The NHS acts as an anchor not only in the number of jobs it creates, but in how the NHS can support the health and wellbeing of its staff through good employment conditions and the working environment.

3.308 The RCN told us that at July 2020, there were 14,243 people on the temporary register made up of three main cohorts: those who had left the permanent register in the last three years (66%), those who left the permanent register in the last three to five years (16%) and eligible overseas registration candidates (18%). The NMC surveyed people on the temporary register, with 9,433 (66%) replying. Of these respondents, just over half (56%) had not started working, practising or had received an offer of employment at the point they filled out the survey. Around a quarter (28%) had started practising as a nurse or midwife and 11% had received an offer of employment but not yet started. Just over a third (36%) said it was highly likely or possible that they would want to join the permanent register. Nearly a quarter (23%) said it was possible, and 14% said they had not yet decided. Just over a quarter (27%) said it was highly unlikely.

3.309 The RCN also told us that its intelligence suggested that the rate of bank working in England had also increased considerably over the period of the pandemic. However, this data had not yet been published or shared, in order to understand whether or not it presented a clear picture of bank/agency spend and fill rates, to what extent temporary and permanent staff were different or the same workforce, and whether local decision-making on staffing was driven by safety and quality and was sustainable for delivery of safe and effective care.

3.310 The RCN argued that there were several actions which the Government needed to take to address the challenges facing the nursing workforce. This included a fully funded health and care workforce strategy, additional investment in nursing higher education supply and legislation to clarify roles, responsibilities and accountability for workforce planning and supply. Each of these required actions would take several years to have any impact.

3.311 The RCN's Labour Market Review reported that NMC data showed there were 724,516 nurses, midwives and nursing associates on the register at September 2020, representing an increase of 18,264 (2.6%) since September 2019. It was also worth noting that at the time of reporting, there were 12,756 nurses and midwives on the COVID-19 temporary register, and between April and September, almost 2,000 people left the temporary register to join the permanent one. It also told us that since 2015, there had been a 4.8% increase in the number of nurses, a 21.0% increase in the number of midwives and a fall of 29.5% in registrants with joint nursing and midwifery registration. The nursing associate part of the NMC register opened at the beginning of 2019.

- 3.312 The RCN said that data for the NHS England workforce showed that by July 2020, there were 147 registered nurses who had returned to practice working in the NHS (out of a headcount of 328,242) plus 10,036 students in employment within the nursing support workforce (making up 3.1% of a workforce of 328,242). It also said that these numbers, however, were likely to be higher in reality as the data did not record all staff that have returned to the NHS as part of the returners scheme. Many were likely to be recorded on contract types, for example fixed term, honorary or bank contracts, that were not fully accessible through ESR data. Many were also likely to have been employed via NHS Professionals. RCN continued by saying that data for the NHS Scotland workforce showed that by June 2020, 2,423 nursing students were in employment within the nursing support workforce (making up 3.8% of a workforce of 63,178). This data was an underestimate, however, as some NHS employers added student details only to the NHS payroll system and not also to the NHS HR system, in order to progress induction at pace.
- 3.313 The **RCM** told us that a member survey carried out by the RCM in November 2020 asked a series of questions about staffing levels. The results showed that 83% of respondents did not feel that their trust/board had the right number of staff to operate a safe service. However, 42% said half of shifts were understaffed, while a third said there were very significant gaps in most shifts; 63% were working beyond their contracted hours, unpaid, and 37% working additional paid overtime.
- 3.314 The RCM said that it supported maternity transformation programmes across the UK but that there must be adequate investment and safe staffing levels. In order that maternity continuity of care (MCOC) could be implemented safely and successfully it was imperative that the right staffing levels were in place. Fair pay, with flexible working opportunities and control on working hours, was absolutely crucial to the ability of the NHS to recruit and retain enough midwives and MSWs to be able to successfully implement MCOC.
- 3.315 **Unite** told us that 81% of members reported staff shortages in their workplace over the last year and 69% reported experiencing staff shortages frequently and a further 20% reported them sometimes. Unite maintained that the staffing issues faced by the NHS had been caused by the Government's funding, workforce planning and pay policy, as well as the impact of EU Exit. Unite argued that as in previous years the Review Body should continue to consider the impact this was having on the service and NHS staff forced to work in understaffed conditions.
- 3.316 The **Welsh Government** said the NHS in Wales, as of August 2020, directly employed 97,470 staff. Of this figure 58,458 were employed full time with 39,012 employed part time. The FTE for NHS Wales staff was 80,702 in August 2019 and was 85,204.49 in August 2020. The latest official statistics, published by Stats Wales for September 2020, showed 77,934 FTE staff (excluding medical and dental staff), a 4.8% increase from 74,352 in September 2019.
- 3.317 The **Department of Health, Northern Ireland** informed us that international recruitment for nursing commenced in January 2016 as one approach to address the escalating registered nurse (Adult) vacancies across the five Health and Social Care trusts. On 23 March 2020, all international nurse recruitment was suspended in order that HSC resources could be directed towards managing COVID-19. It also informed us that at the point when the temporary suspension was imposed, the HSC had 504 international nurse arrivals, against a target of 622 by March 2020. 458 nurses currently remained in post. Department of Health, Northern Ireland added that on 3 September 2020 the suspension on international recruitment was lifted and HSC trusts were able to resume their recruitment plans. Plans were in place to secure a potential additional 320 nurses by March 2021.

3.318 The **Department of Health, Northern Ireland** said the key objectives of the of the Health and Social Care Workforce Strategy 2026⁴⁴ were: education and training; strategic workforce planning and the health and wellbeing of the workforce. Going forward, sustainable funding would be key to implementing workforce recommendations.

Service transformation, integration and productivity

Service transformation

- 3.319 **HEE** told us that by the end of 2020/21, HEE would support the expansion of multidisciplinary teams in primary care in England, through the full roll out of primary care training hubs, to make sure there were enough people and leaders to create multidisciplinary teams that could respond to local population needs.
- 3.320 **NHS Employers** said that the HR community told them that an affordable national pay settlement for 2021/22 would support the refocus on the urgent transformational activity that was necessary to develop the workforce in line with the growing and complex demands being placed on it. This was notwithstanding the continuing impacts of the pandemic,
- 3.321 NHS Employers told us that that the NHS Confederation's NHS Reset campaign reflected the widely held view, including amongst NHS leaders, that restoring the NHS to a pre-pandemic status quo would be to waste the huge amount of energy, ingenuity and creativity generated by clinicians and managers in response to the pandemic. The pandemic, and the NHS response to it, should inspire new and innovative ways of working to secure lasting and sustainable changes to the planning and delivery of care.
- 3.322 The **Welsh Government** told us that the decision to establish an NHS Executive was announced in *A Healthier Wales*⁴⁵. The aim was to create an organisation that provided the strong leadership and strategic direction which any complex system required if it was to be capable of change. It would ensure a consistent approach to planning, priority setting based on outcomes, performance management and accountability. It would both support and challenge health organisations in Wales and facilitate the development of capacity and capability across the systems. It also told us that due to the COVID-19 pandemic, work on establishing a programme that would deliver the new organisation had now been paused.
- 3.323 The **Department of Health, Northern Ireland** said that COVID-19 had had a profound impact on the delivery of HSC services. The pace, scale and direction of transformation activity, and therefore the associated costs going forward, would be informed by the ongoing work to manage the current wave of the virus, and subsequent rebuilding of HSC services, whilst managing the potential impact of future waves.
- 3.324 The Department of Health, Northern Ireland said legislative drafting was nearing completion and it was the intention to bring forward a Bill in early 2021 to give effect to the Health and Social Care Board's closure in March 2022.

⁴⁴ Department of Health, Northern Ireland (2 May 2018), *Health and Social Care Workforce Strategy 2026*. Available at: <https://www.health-ni.gov.uk/publications/health-and-social-care-workforce-strategy-2026>

⁴⁵ Welsh Government (June 2018), *A healthier Wales: long term plan for health and social care*. Available at: <https://gov.wales/healthier-wales-long-term-plan-health-and-social-care>

Integration in England

- 3.325 **DHSC** said that the recent Health and Care White Paper⁴⁶ was about improving the integration of health and social care between local councils and the NHS to deliver better joined up care. Better integration would remove the barriers stopping people accessing care. These reforms would put in place a system to help people access care and contribute to preventing people being passed from pillar to post when having their care needs assessed. This process should be seamless. Within this ambition, important consideration needed to be given to the workforce experience and how staff move within it. It was important that the health and social care system could recruit and retain the staff it needed and that staff were enabled to work across boundaries and operate seamlessly across the two areas.
- 3.326 **DHSC** said that the NHS Long Term Plan was clear that ICSs should be the main organising unit for local health services. HEE and NHS E&I were supporting local health systems (STPs/ICSs) to develop workforce plans, as an integral part of service and financial plans, enabling it to understand better the number and mix of roles required to deliver the NHS Long Term Plan and inform national workforce planning.
- 3.327 **NHS Employers** noted that the NHS Reset report⁴⁷ said that any reset must create a model for the NHS that supported integration, partnership working and co-operation between health and care services. However, there was still some uncertainty about how systems should operate and how they should be underpinned by legislation. To date, the role of systems had been limited by uncertainty about their form and function and they had developed within a policy framework that focused on competition rather than collaboration.
- 3.328 **NHS Employers** told us that the Government must urgently follow through on its commitment to social care reform, and a modern social care system supported by a new sustainable funding model remained a priority. The NHS was concerned about any widening of the gap around pay given the scale of vacancies in social care.
- 3.329 **NHS Employers** said the NHS Long Term Plan placed a stronger emphasis on the role of ICSs in workforce planning locally. It was likely that in future, systems would increasingly look to resolve workforce challenges collaboratively with partners within their system and across other systems. **NHS Employers** also said its discussions to date had largely been centred around the needs and capacity of individual employers. **NHS Employers** added that in future, they would have to consider the role of systems in ensuring that the right staff, with the right skills, were in the right place to meet the evolving needs of their patients.
- 3.330 **NHS Employers** said that pay differentials between health and social care were a barrier to the integration of health and care services and to the objectives in the NHS Long Term Plan. **NHS Employers** said it was disappointing that there was not a workforce plan for social care, where the impacts of the pandemic have been so severe on both care users and staff. **NHS Employers** stressed that more than ever, there needed to be a comprehensive workforce plan for health and social care and the innovative response to COVID-19 would inform the restoration and improvement of services. For example, its ambitions for embedding ICSs right across England would provide and improve the 'joined up' services the public rightly deserved.

⁴⁶ Department of Health and Social Care (11 February 2021), *Working together to improve health and social care for all*. Available at: <https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all>

⁴⁷ NHS Confederation (September 2020), *NHS Reset: a new direction for health and care*. Available at: <https://www.nhsconfed.org/resources/2020/09/nhs-reset-a-new-direction-for-health-and-care>

Productivity

- 3.331 DHSC said labour productivity was calculated by dividing total NHS output by an appropriate measure of labour input (usually some form of a weighted sum of staff numbers and hours worked). It measured the amount of output generated per 'unit' of labour, and as such, was an important component of efficiency. The measure of labour productivity used for the NHS in England was that developed by the University of York (Centre for Health Economics, CHE). These figures showed between 2005/06 and 2015/16 the NHS's average annual labour productivity was 2.5% and the NHS's average annual total factor productivity growth was 1.2%.
- 3.332 DHSC said that labour productivity was an important component of efficiency. The average total factor productivity growth between 2005/06 and 2015/16 reflected the progress made by the NHS workforce's committed efforts to improving productivity where possible. However, there still remained areas for improvement which must be targeted if the objectives set out in the Long Term Plan were to be achieved that productivity, as formally defined in its evidence did not take into account the costs of inputs, including changes in staff pay.
- 3.333 DHSC told us that a full measure of technical efficiency would, in addition, factor in changes in pay and the cost of inputs relative to a suitable deflator. If pay increased more quickly than GDP deflator, this would have a negative effect on technical efficiency. If the NHS was 1% more productive than last year it would produce 1% more output (for example treatments) per input (for example, per doctor/nurse). Hence, with fixed inputs it would deliver 1% more output (for example, treatments). This meant that within a fixed funding envelope the NHS could increase treatments by 1% (to meet increased demand) or increase input prices by 1% (for example, increase wages) or a mixture of the two.
- 3.334 In oral evidence, DHSC said that the NHS Long Term Plan did include an assumption for a pay envelope of 2.1% including pay drift, with a productivity assumption of 1.1%. Circumstances had now changed due to COVID-19 and those productivity gains were unlikely to be achieved. DHSC also said that it hoped that future improvements in morale across the NHS would generate productivity increases and help in attracting new entrants. The overarching aim was to turn the NHS into a model employer and a safe space to work with a secure job for staff. DHSC added that there was a need for more people to be enabled to work flexibly and for more productivity from the workforce, for example, through a review of the skill mix and changes to reflect what would be needed in the future.

Chapter 4 Agenda for Change Staff in the NHS – Our Analysis of the Evidence

Introduction

4.1 Our analysis in this chapter is based on the written and oral evidence available, data from the Office of Manpower Economics and other sources as they relate to our terms of reference and matters remitted to us this year. In addition, over the last three years the 2018 Agenda for Change (AfC) pay agreement for England and Wales and the 2019 agreement for Northern Ireland have been in force and we were asked to monitor their progress. Our analysis covers:

- The impact of the coronavirus (COVID-19) pandemic on the National Health Service (NHS) and its workforce;
- The economy, labour market and NHS funding;
- The AfC workforce, including specific issues in relation to female and ethnic minority staff, vacancies and shortage groups;
- AfC earnings and the three year pay agreements; and
- Trends in recruitment, morale and motivation and retention.

Staff experience of COVID-19 to date

4.2 Our assessment here is based on written and oral evidence from the parties, some published studies, evidence from our visits which took place in September and October 2020 and the staff opinion survey which was carried out in England in October and November 2020. This is a large scale survey with significant participation. The timing however was between the two waves of the pandemic.

4.3 Since our last report⁴⁸, NHS staff continued to work through the first wave of the pandemic and then through a second wave whilst also starting to tackle the backlog of previously interrupted elective care. The NHS and its staff are now rolling out the vaccine programme and there is still much uncertainty ahead with the risk of future waves of the disease, the need for future vaccine rollouts to tackle new variants, the implications of long COVID and a mental health impact on society beginning to emerge. Alongside this, there is consensus on the likelihood of a significant backlog of care from postponed treatment and late presentation.

4.4 For many AfC staff, there was increased risk of infection from the virus as the majority were unable to work from home. In England and Wales, between 9 March and 28 December 2020 there were 414 deaths involving COVID-19 registered among health care workers, aged 20 to 64 years as referenced by the Office for National Statistics (ONS)⁴⁹. By the time of the 2020 NHS Staff Survey in November 2020 one third of non-medical staff in England said that they had worked on a COVID-19 specific ward or area at some time during the pandemic. At the beginning of the pandemic there were challenges with the supply of personal protective equipment (PPE). The Joint Staff Side said that there had been two main issues in particular: systemic staffing issues and initially the availability of PPE. Staff have lived with the risk of catching COVID-19 and alongside this additional stress from the fear of bringing the disease home to their families. Some staff have lived away from family for this reason.

⁴⁸ NHSPRB (July 2020), *National Health Service Pay Review Body 33rd Report: 2020*. Available at: <https://www.gov.uk/government/publications/national-health-service-pay-review-body-33rd-report-2020>

⁴⁹ ONS (25 January 2021), *Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered between 9 March and 28 December 2020*. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathregisteredbetween9marchand28december2020#deaths-involving-covid-19-among-men-and-women-health-and-social-care-workers>

- 4.5 Working conditions for many were difficult. COVID-19 exposed staff to a level of patient death higher than would ever have been anticipated. At times, staff were only able to deliver patient care in ways they would previously have considered unacceptable, and we heard evidence of this on our visits.
- 4.6 A University College Hospital London (UCLH) and King’s College London study⁵⁰ showed that staff in intensive care units (ICUs) had faced a particularly challenging time, frequently working while wearing PPE for long periods in areas where the perceived risk of COVID-19 exposure was high, with the challenges of managing staff and equipment shortages on a daily basis. The high rate of mortality amongst COVID-19 patients admitted to ICUs, coupled with difficulty in communication and providing adequate end-of-life support to patients in the absence of their next of kin because of visiting restrictions, was a specific stressor for all staff working in ICUs.
- 4.7 In addition to the increased pressure and intensity of work many staff also showed significant flexibility in the work they undertook. This included the reworking and reorganising of services undertaken by staff at the beginning of the pandemic. A number of staff were redeployed from their usual jobs to support frontline work. In the 2020 NHS Staff Survey, 18% of non-medical staff in England said they had been redeployed at some point during the pandemic. On our visits AfC staff described the stress of not being able to carry out their normal role, anxiety for existing patients they were unable to see and concern over the reduced numbers of those presenting.
- 4.8 Students and others returning to the service also stepped up to support the NHS through the pandemic following the setting up of a COVID-19 emergency register. This allowed the temporary registration of nurses and midwives who had left the register in recent years, the registration of students nearing the end of their programme and the lifting of restrictions on the number of hours student nurses could work in the NHS, and flexibility in the processes for registering overseas nurses and midwives who were nearing the end of their registration process. By June 2020 at least 174 registered nurses, health visitors and midwives who had returned to practice were working in the NHS, and over 10,000 students were employed to support doctors, nurses and midwives.
- 4.9 The 2020 NHS Staff Survey showed that 36% of non-medical staff in England were required to change their practices and work remotely or from home at some point during the pandemic. NHS staff quickly adapted some roles to homeworking to protect staff and patients and support the response to COVID-19.

⁵⁰ UCLH and King’s College London study (January 2021), *Mental health of staff working in intensive care during COVID-19*. Available at: <https://academic.oup.com/ocmed/article/71/2/62/6072139>

- 4.10 A variety of measures were put in place to support NHS staff and to manage the pressures on them at national and local levels. For example, staff were given free parking in England and across the UK, many organisations gave hospital staff free meals. The Department of Health and Social Care (DHSC) noted the March 2020 NHS People Plan had put health and wellbeing at its core for NHS England staff with a new support package and had published phase four planning guidance in spring 2021, which would help workforce recovery. NHS England and NHS Improvement (NHS E&I) said that it had worked with system partners to ensure that critical care capacity was maximised, whilst it supported local employers, at pace, to mobilise and re-deploy staff. This had included local partnership working; guidance to support the staff physical and mental wellbeing; introduction of a new COVID-19 Life Assurance Scheme⁵¹; and new temporary guidance on national terms and conditions of service. The Northern Ireland HSC Public Health Agency's health and wellbeing resources⁵² noted that 20 minute Care and Support Space sessions were available to all Health and Social Care (HSC) staff across the system to support staff during the pandemic. The Welsh Government's health circular⁵³ noted a multi-layered health and wellbeing support offer for the NHS Wales workforce during the pandemic that included a dedicated confidential Samaritans helpline, SilverCloud and an expanded Health for Health Professionals service. The health boards in Wales had introduced new ways of working during the pandemic such as holding outpatient appointments virtually, making use of technology and using telephone and video consultations.

Our assessment of the staff experience of COVID-19 to date

- 4.11 It is clear that COVID-19 was an unprecedented shock for the NHS at a point at which the NHS was already struggling to meet its targets. The effort of AfC staff and the flexibility they have shown has been significant. The experience of staff varied widely across job role and the different stages of the pandemic, some were able to work from home, and new, innovative and positive ways of working were found. However, what was striking in the evidence we received from all the parties and the conversations we had in our visits was the strength of feeling that staff across many different roles operated as one team through all the stages of the pandemic, relying on each other and showing enormous flexibility in the way they did this.
- 4.12 NHS AfC staff reasonably expect that their jobs will contain a degree of stress and personal risk. Indeed, this is built into job specifications. However, the understanding of the risks created by COVID-19, the effective management of it in a frontline NHS setting and the confidence of staff in risk mitigation took time to develop. It was widely acknowledged by most of the parties that a substantial proportion of AfC staff worked with consistent levels of stress and risk, and for extended periods of time significantly beyond the levels that had been previously expected within their roles.
- 4.13 Our evidence on the AfC staff experience over the last year has come from employee surveys, from evidence from trades unions and employers and from our visits to NHS Trusts. This data is limited in its scope and, in particular, does not allow us to track the differing experiences of staff over the course of the pandemic. We understand from NHS E&I that there are plans to publish more pulse surveys and we look forward to receiving the results of that important work.

⁵¹ This scheme was introduced by DHSC for the families of staff who die in service due to COVID-19.

⁵² HSC Public Health Agency, *Staff health and wellbeing resources*. Available at: <https://www.publichealth.hscni.net/covid-19-coronavirus/guidance-hsc-staff-healthcare-workers-and-care-providers/staff-health-and-0>

⁵³ Welsh Government (30 October 2020), *Welsh Health Circular Expectation for NHS Health Boards and Trusts to ensure the health and wellbeing of the workforce during the Covid-19 pandemic*. Available at: https://gov.wales/sites/default/files/publications/2020-11/expectations-for-nhs-health-boards-and-trusts-to-ensure-the-health-and-wellbeing-of-the-workforce-during-the-covid-19-pandemic_0.pdf

Forthcoming challenges for staff

- 4.14 As the UK comes out of the second wave of COVID-19, there is a clear challenge ahead in the backlog of treatment built up during the pandemic. This will need to be tackled by AfC staff in the context of potential future waves of the disease, long COVID, and the mental health impact on society. The pandemic has had a significant impact on AfC staff. Early evidence from the parties and independent studies show the presence of mental health issues such as post-traumatic shock and stress, and symptoms of long COVID amongst NHS staff.
- 4.15 The UCLH and King's College London study on the mental health of staff working in intensive care during the pandemic found that poor mental health was common in many ICU clinicians with higher levels of distress most pronounced in nurses. The findings showed that 45% met the threshold for probable clinical significance on at least one of the following measures: severe depression (6%), Post Traumatic Stress Disorder (40%), severe anxiety (11%) or problem drinking (7%). The proportion of respondents who reported frequent thoughts of being better off dead or of hurting themselves in the two weeks before completing the survey was 13%. COVID-19 was described as being like nothing that had ever been seen before and having stretched people to the very limits of what can be done.
- 4.16 Sickness absence rates in the NHS in England and Wales spiked between March and May 2020, fell back during the summer but then increased again through the autumn. This would need to be tackled by staff alongside dealing with future waves of the disease, long COVID, the mental health implications on society and future vaccinations programmes. In England, between March 2020 and January 2021, approaching 3 million working days had been lost for reasons related to COVID-19. ONS data⁵⁴ showed that prevalence of self-reported long COVID was greatest in people aged 35 to 69 year, females, those living in the most deprived areas, those working in health or social care and those with a pre-existing activity-limiting health condition or disability. The ONS said that the raised prevalence rate could largely be explained by the risk of initial infection and other socio-demographic characteristics such as age, sex and location for health and social workers in particular. High prevalence rates of self-reported long COVID among health and social care workers may also partly reflect increased awareness of long COVID among workers in these sectors. On our visits we heard staff express concern over the symptoms of long COVID that they were experiencing.
- 4.17 The NHS Confederation said in its March 2021 report Putting People First: supporting NHS staff in the aftermath of COVID-19, that the experience of caring for patients and service users during the pandemic over the last 12 months had taken an enormous toll on NHS staff. They raised concerns about the impact on staff health and wellbeing of a gruelling year and said that measures to address the wellbeing of staff effectively would include addressing long-standing vacancies and dealing with underlying cause of staff distress (including systemic workplace discrimination), which were prevalent pre-COVID-19.

⁵⁴ ONS (4 June 2021), *Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 4 June 2021*. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/4june2021>

- 4.18 There is a significant backlog of care from postponed treatment and late presentation of patients. DHSC said that around £1 billion from the Long Term Plan settlement would help to begin tackling the elective backlog. NHS E&I also reference this amount of funding to tackle the elective backlog. In oral evidence, DHSC noted that phase four planning guidance was published in early spring of 2021 and focused substantively on workforce recovery. DHSC stressed that this would not solve all the issues and there was still obvious tension between dealing with the elective backlog and looking after staff, many of whom have had a traumatic and difficult year. In oral evidence, NHS Employers told us that some good strategic thinking was being undertaken in the trusts on how to maintain the workforce in light of COVID-19 and an elective treatment backlog. The Joint Staff Side told us that during the course of the pandemic staffing challenges had impacted on service availability, which added to the challenges of dealing with the pandemic, impacted long-term patient outcomes and increased the backlog of work. The Royal College of Nursing (RCN) said the NHS would not be able to meet the demands of the pandemic without more staff; there was an immediate need to deal with the backlog of work and reduce waiting lists and waiting times and restore activity to previous levels. The House of Commons Health and Social Care Committee published its *Workforce burnout and resilience in the NHS and social care* report in June 2021⁵⁵. The report found that workforce burnout across the NHS and social care had reached an emergency level and posed a risk to the future functioning of both services.
- 4.19 Alongside this, NHS staff would underpin the continued roll out the COVID-19 vaccination programme. And, as new variants of the virus circulate, the NHS would need to extend its effort to administer booster jabs.
- 4.20 The Care Quality Commission (CQC) noted for England that the speed and enormity of the pandemic challenges had required health and care providers to respond in new ways and develop new procedures and ways of working at pace. Accelerated and shared digital approaches supported providers to work together and remain well connected. Learning and improvement had been accelerated across the system encouraging innovation that had previously proved difficult to mainstream. New strategies to manage staff, resources and professional skills capacity were also put in place though with varied success. In evidence, parties have told us that new and innovative ways of working were developed in response to the pandemic. NHS Employers told us that restoring the NHS to a pre-pandemic status quo would be to waste the huge amount of energy, ingenuity and creativity put into new and innovative ways of working and miss securing lasting and sustainable changes to the planning and delivery of care. The CQC said that the potential of new approaches to care must, however, be fully evaluated before they became established practice.
- 4.21 As the NHS Confederation report noted, throughout the pandemic, there has been a significant focus on placing staff experience and wellbeing at the centre of decision making and the need for this to continue with the challenges ahead. It will be important to ensure that a continuing focus on staff sits at the heart of recovery and reset planning. We note that there may be productivity gains to be made going forwards if positive changes to the planning and delivery of care can be harnessed and further developed successfully. Staff involvement in this process will be key.
- 4.22 We understand from parties that many training programmes were paused during the pandemic and staff training opportunities were reduced. AfC staff will need to catch up on lost training time and this may have short-term productivity impacts whilst staff undertake training.

⁵⁵ House of Commons Health and Social Care Committee (8 June 2021), *Workforce burnout and resilience in the NHS and social care*. Available at: <https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/22/2202.htm>

Our assessment of the forthcoming challenges

- 4.23 There is consensus that the NHS is likely to face high levels of demand over the period of this review. This is a result of the backlog of care from postponed treatment and delayed presentation by patients; the treatment of long COVID; increased demand for mental health services; and the ongoing need to care for COVID-19 patients in any subsequent waves and to administer booster vaccines as the virus mutates.
- 4.24 There could be productivity gains to be made in the medium term by identifying and harnessing best practice from service delivery adaptations made by the NHS during the pandemic. Effectively involving the staff who deliver these services in their development and implementation will be crucial.
- 4.25 There will be a sustained requirement for discretionary effort and commitment from an exhausted and overwhelmed NHS workforce.
- 4.26 The NHS system will need to ensure staff are supported in maintaining their wellbeing and work-life balance, as well as in catching up with training and development missed due to the demands of the pandemic.

Gender and ethnicity⁵⁶

- 4.27 The NHS Long Term Plan affirms that the NHS's greatest strength is its people. The NHS and UK taxpayers invest significantly in the AfC workforce and it is therefore essential that the NHS does not waste this investment. The NHS needs to use and develop the skills and experience of all those who work in AfC roles to best effect and to attract, retain and promote the broadest range of talent to deliver a health service providing the best care to the public that it can.
- 4.28 In our 2020 report, we raised a number of issues in relation to gender and ethnicity and staff experience in the NHS. We said that we were keeping differences in pay across an NHS career and the pay gap by gender and ethnicity under review, but needed better data to understand this issue. We asked parties to provide any data and insights into the dynamics influencing pay and progression over an NHS career. We said that evidence would be welcomed on the reasons behind the different rates of progression through the AfC pay bands by gender and ethnicity, including any differences between those moving through the pay bands and those directly entering the higher pay bands. This would enable us to understand the drivers of the underlying causes of the pay gaps by gender or ethnicity including the interactions between the many characteristics that affect pay and employment opportunities.
- 4.29 In our report last year, we also noted concerns raised in relation to the new pay progression system. The Staff Side pointed to data from the WRES that indicated that ethnic minority staff were more likely to be subject to disciplinary procedures. The Staff Side were therefore concerned at the potential for some AfC staff not to receive pay progression. We agreed the situation needed to be closely monitored at individual and trust level and through the NHS Staff Council. We have since received a copy of the Equality Impact Assessment for the 2018 AfC pay agreement that assesses the impact of the reforms on diversity and staff with protected characteristics. It is crucial the assessment is accurate and that mitigating actions have been identified to ensure the pay progression system does not inadvertently create disadvantage. The Equality Impact Assessment is an important element of the pay progression policy and procedures in monitoring the impact of the changes going forward and the benefits realised.

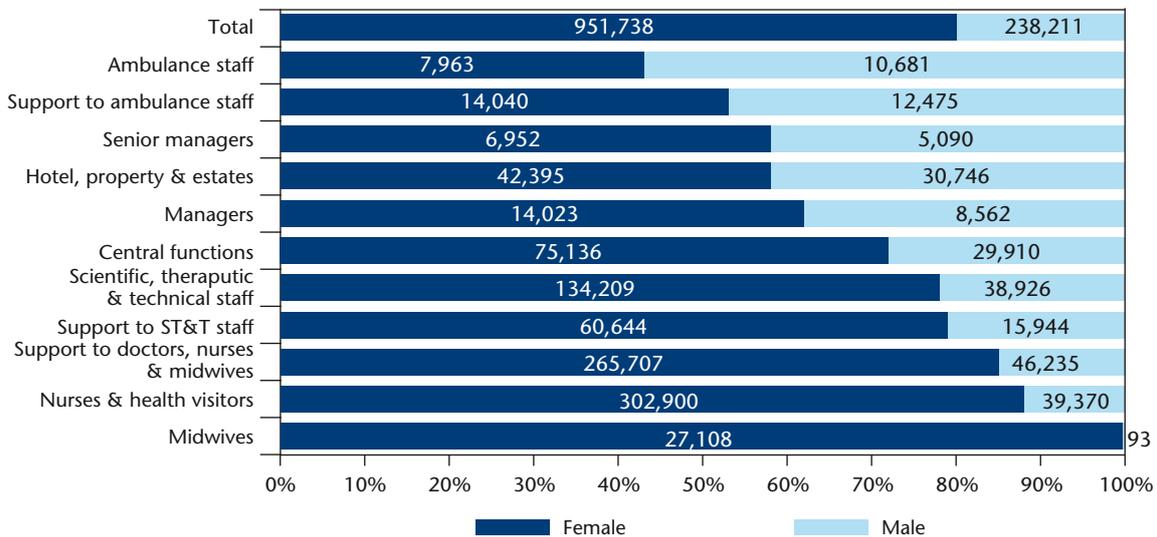
⁵⁶ In this report we follow the guidance of the Race Disparity Unit (RDU) approach to writing about ethnicity and use 'ethnic minorities' to refer to all ethnic groups except the White British group. For comparisons with the White group as a whole, we use 'all other ethnic groups combined' or 'ethnic minorities (excluding White minorities)'. We also refer to 'White' and 'Other than White' if space is limited. We use BAME only when quoting from sources that use this term.

4.30 In this year’s report we have looked at evidence we have received relating to female and ethnic minority AfC staff to try to understand differences in their experience of working within the NHS compared to other groups of staff. We set out here the evidence on workforce numbers, COVID-19 impacts, motivation and morale and earnings.

Agenda for Change workforce by gender and ethnicity

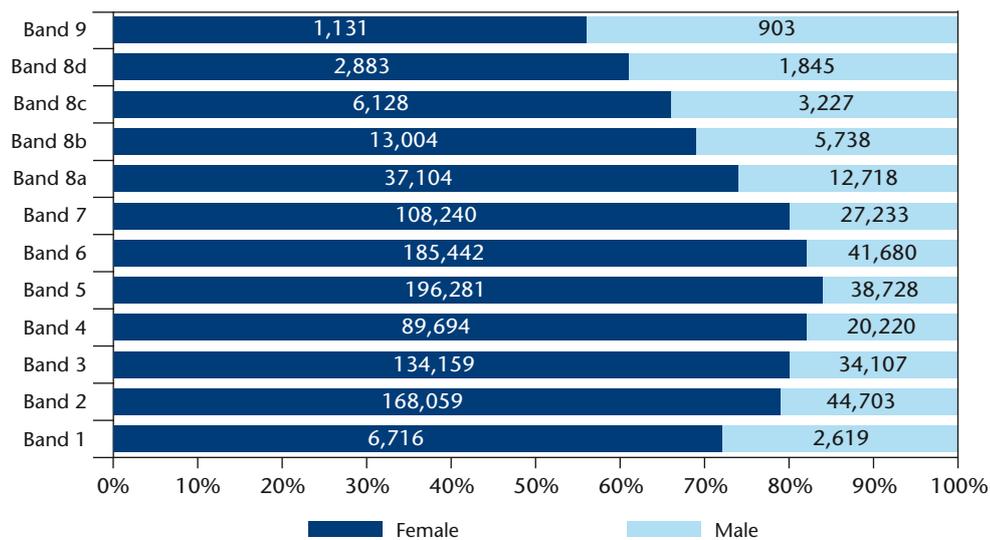
4.31 We consider the data on the gender breakdown of AfC staff to monitor any changes in workforce trends, given that the AfC workforce is predominantly female. The analysis in Figures 4.1 and 4.2 show a breakdown of AfC staff by gender, by broad staff group and by band, in England in December 2020. Overall, we note that men make up 20% of AfC staff, and that in all staff groups other than ambulance staff (57%), women make up a majority of the workforce. We also see from the data that the only other staff groups where men make up more than 40% of the workforce are support to ambulance staff (47%), senior managers (42%) and hotel, property and estates staff (42%). The analysis by AfC pay band also shows that women make up a majority of staff in every pay band, and over 70% of staff in every band except Bands 8b to 8d and Band 9.

Figure 4.1: Staff in Agenda for Change roles by gender, by staff group, in England, December 2020, headcount



Source: NHS Digital

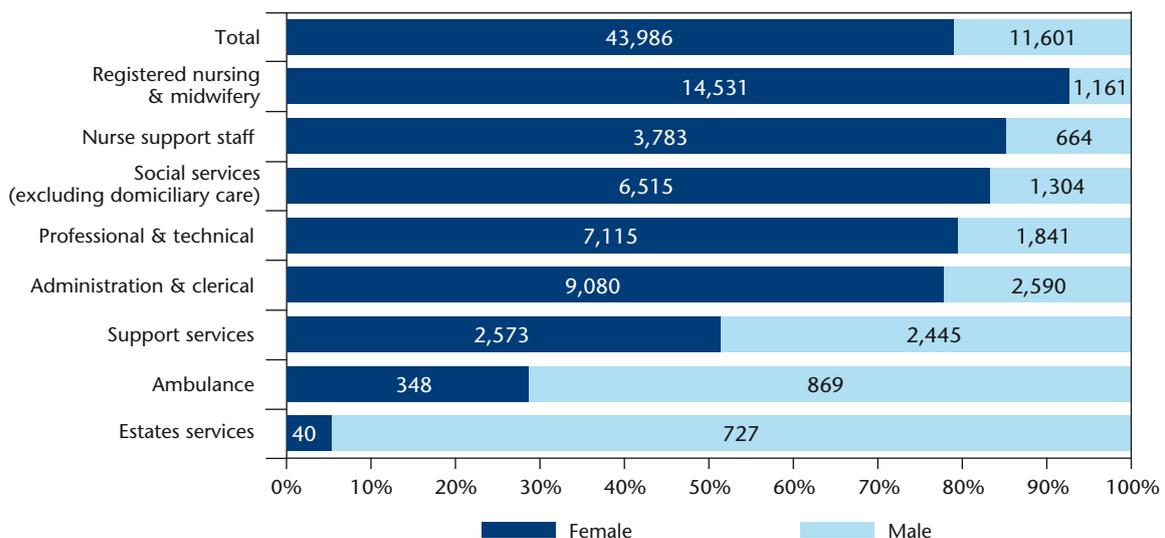
Figure 4.2: Staff in AfC roles by gender, by band, in England, December 2020, headcount



Source: NHS Digital

4.32 Figure 4.3 shows a breakdown of AfC staff by broad staff group by gender in Northern Ireland in March 2020. In all staff groups other than estates services (95%), ambulance staff (71%) and support services (49%), men make up less than 25% of the workforce.

Figure 4.3: Staff in AfC roles by gender in Northern Ireland, March 2020, FTE

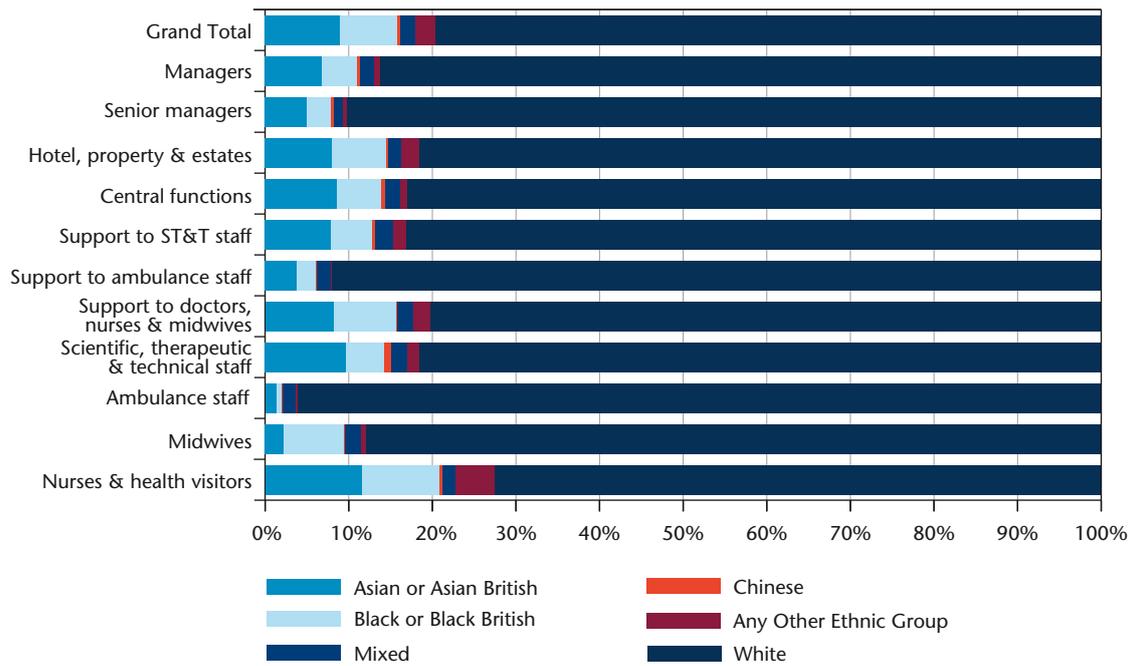


Source: Department of Health, Northern Ireland

4.33 Our workforce analysis for this report also included the representation of different ethnic minorities among AfC staff (based on NHS Digital definitions). Figure 4.4 shows a breakdown of AfC staff by ethnicity and by broad staff group, in England, in December 2020. Overall, we note that, excluding those staff whose ethnicity was unknown or not stated, 20% were from ethnic minorities: 9% of staff were Asian or Asian British; 7% Black or Black British; 2% mixed ethnicity; fewer than 1% Chinese; 2% from other ethnic minorities; and 80% White. The data suggests that by staff group, the least ethnically diverse were ambulance staff, with just 4% from ethnic minorities: 1% Asian or Asian British; 1% Black or Black British; 1% mixed ethnicity, and 96% White. We can see that, in contrast, 27% of nurses and health visitors were from ethnic minorities: 12% were Asian or Asian British staff, 9% Black or Black British staff; 2% mixed ethnicity; 5% from other ethnic minorities; and 73% were White.

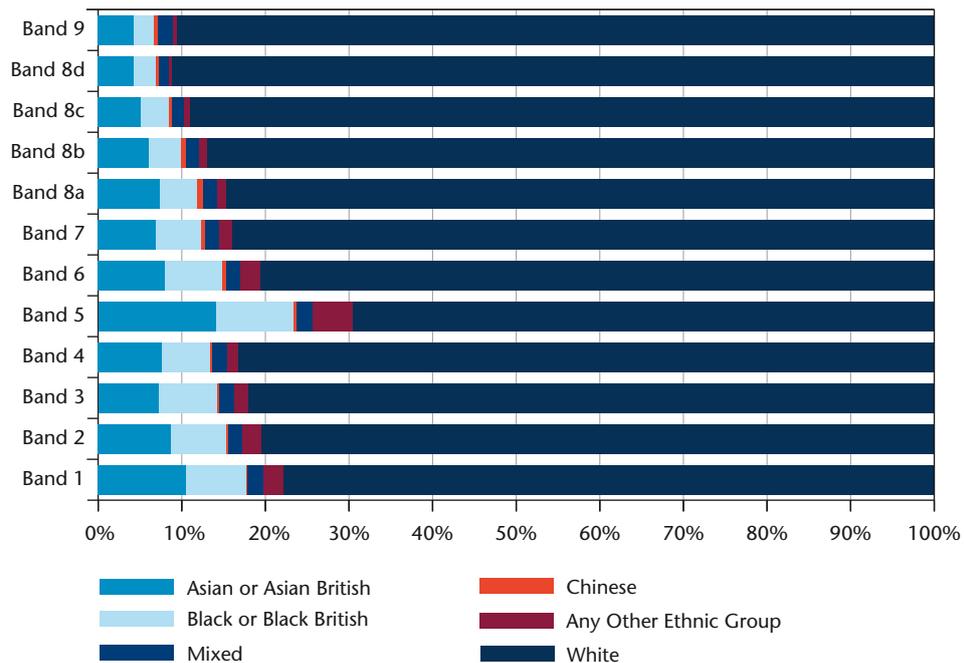
4.34 Figure 4.5 shows a breakdown of AfC staff by ethnicity and by band, in England in December 2020. It is notable that the percentage of staff from ethnic minorities declines in the higher bands and that in Bands 8d and 9 just 9% of staff were from ethnic minorities. There were 30% of staff in Band 5 from an ethnic minority group, with 14% Asian or Asian British staff, 9% Black or Black British staff, 2% of mixed ethnicity, 5% from other ethnic minorities, and 70% White staff. The only other pay band to have more than 20% of staff from ethnic minorities was Band 1, with 11% Asian or Asian British staff, 7% Black or Black British staff, 2% of mixed ethnicity, 2% from other ethnic minorities, and 78% White staff.

Figure 4.4: Staff in AfC roles by ethnic group, by staff group, in England, December 2020, headcount



Source: NHS Digital

Figure 4.5: Staff in AfC roles by ethnic group, by band, in England, December 2020, headcount



Source: NHS Digital

COVID-19

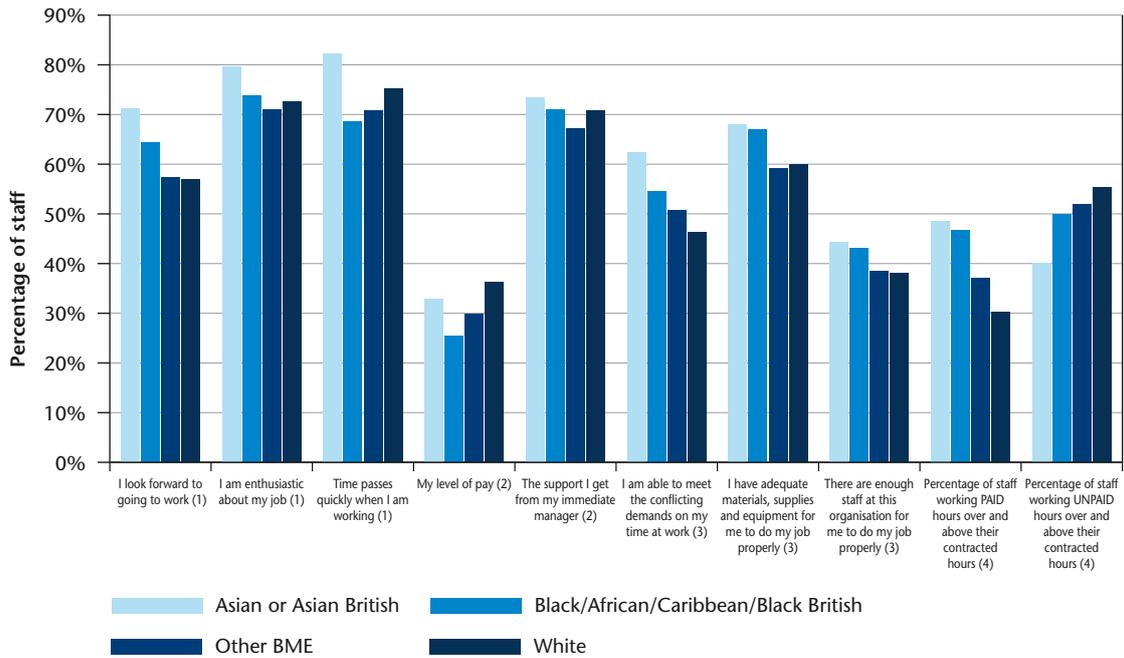
- 4.35 The importance of understanding the way in which protected characteristics such as gender and ethnicity affect staff experience across the NHS has been very evident over the last year in the disproportionate impact of COVID-19 on staff from some ethnic minorities.
- 4.36 Within the NHS, there is evidence⁵⁷ of a disproportionate mortality and morbidity amongst ethnic minorities who contracted COVID-19, including NHS staff. NHS E&I told us that they had taken comprehensive action to support vulnerable staff through a dedicated programme of work including to understand and address the impact of COVID-19 on Black, Asian and minority ethnic (BAME) communities and staff. This included the publication of a risk reduction framework by NHS Employers in May 2020 and employers were encouraged to conduct individual risk assessments and workplace assessment of their staff. In oral evidence, NHS Providers said that risk assessments for 95% of frontline staff during COVID-19 had been completed by early October 2020. They said that the process showed that those from ethnic minorities were more likely to be working in roles with increased risk and more exposure to COVID-19. However, we note that they also said that redeployment away from the frontline was difficult to implement because trusts do not have a large pool of people on which to draw.

⁵⁷ NHS England and NHS Improvement, *Addressing impact of COVID-19 on BAME staff in the NHS*. Available at: <https://www.england.nhs.uk/coronavirus/workforce/addressing-impact-of-covid-19-on-bame-staff-in-the-nhs/>

Morale and motivation

4.37 Figure 4.6 shows satisfaction of AfC staff in England with aspects of the job and work pressures, by ethnic group. For most of the variables, staff from minority ethnic groups were more satisfied than their White colleagues. However, staff from ethnic minorities were less satisfied with their pay than White colleagues. A greater percentage of staff from ethnic minorities said that they worked paid hours in addition to their contracted hours than White colleagues, while White AfC staff were more likely to say that they worked unpaid hours in addition to their contracted hours.

Figure 4.6: AfC staff satisfaction with aspects of the job and work pressures by ethnic group, England, 2020



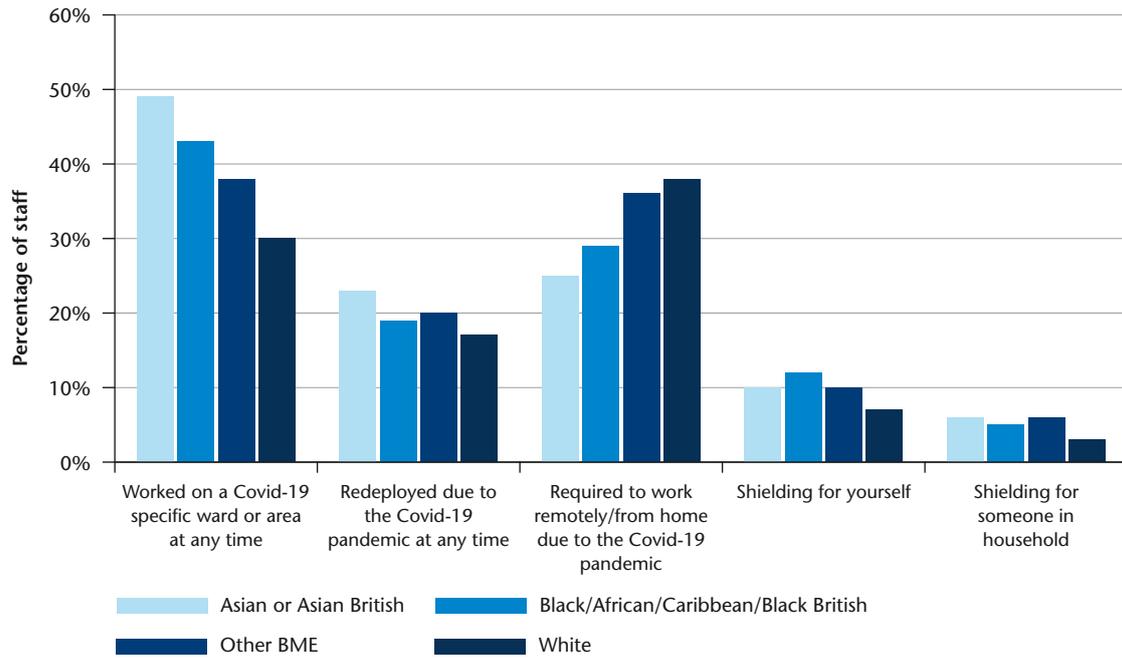
Source: NHS Staff Survey data, Picker Institute Europe

Notes:

- (1) Staff responding “often” or “always”
- (2) Staff responding “satisfied” or “very satisfied”
- (3) Staff responding “agree” or “strongly agree”
- (4) Staff indicating one or more additional hours

4.38 Figure 4.7 shows AfC staff in England responses to questions about their experiences during the COVID-19 pandemic, by ethnic group. Staff from ethnic minorities were more likely to have been redeployed, or to have shielded, and were more likely to have worked on a COVID-19 ward or area, than White staff. Staff from ethnic minorities were also less likely to say that they had worked from home/remotely than White staff.

Figure 4.7: AfC staff experiences during the COVID-19 pandemic by ethnic group, England, 2020



Source: NHS Staff Survey data, Picker Institute Europe

Pay and earnings by gender and ethnic group

4.39 NHS Digital have published data for England showing the differences in mean basic pay and total earnings (for full-time staff only), between male and female staff and White and all other ethnic minorities combined, in May 2020 (Table 4.1).

Table 4.1 Differences in mean monthly basic pay and average earnings (full-time staff only), by gender and ethnicity, England, May 2020

Staff Group	Basic pay per FTE				Total earnings – Full time staff only			
	Gender pay gap		Ethnicity pay gap		Gender pay gap		Ethnicity pay gap	
	White	BME	Male	Female	White	BME	Male	Female
	Female/ Male	Female/ Male	BME/ White	BME/ White	Female/ Male	Female/ Male	BME/ White	BME/ White
Nurses & health visitors	-3%	-2%	-11%	-10%	-4%	-3%	-10%	-9%
Midwives	-4%	-11%	9%	1%	-7%	no data	no data	2%
Ambulance staff	-6%	-6%	-7%	-7%	-8%	-8%	-6%	-6%
Scientific, therapeutic & technical staff	-4%	-1%	-8%	-5%	-8%	-6%	-4%	-3%
Support to doctors, nurses & midwives	-1%	0%	-2%	-1%	-4%	-3%	-1%	0%
Support to ambulance staff	-2%	-2%	-2%	-2%	-2%	-1%	-4%	-3%
Support to ST&T staff	-1%	1%	-3%	-1%	-2%	-3%	-2%	-2%
Central functions	-12%	-7%	-3%	2%	-11%	-8%	-4%	-0%
Hotel, property & estates	-12%	-6%	-9%	-2%	-14%	-11%	-7%	-5%
Senior managers	-10%	-10%	-7%	-6%	-8%	-4%	-13%	-9%
Managers	-5%	-3%	-5%	-3%	-4%	-3%	-6%	-5%

Source – NHS Digital Earnings Statistics – May 2020

Basic Pay per FTE is available for all staff and is based on Basic Pay only

For staff who work Part-Time Basic Pay is scaled as if the person was working Full Time (For example Basic Pay is doubled if someone works 0.5 FTE)

Data covers working in the HCHS Sector in England and is based on data from the Electronic Staff Record

For basic pay:

- White female staff were paid less than White males, for all staff groups, with the difference ranging between 12% for central functions and hotel, property and estates staff, and 1% for staff supporting doctors, nurses and midwives, and staff supporting scientific, therapeutic and technical staff;
- Female staff from ethnic minorities were paid less than male staff from ethnic minorities, for most staff groups. The largest differences were for midwives (11%) and senior managers (10%). For staff supporting scientific, therapeutic and technical staff, female staff from ethnic minorities were paid 1% more than male staff from ethnic minorities;
- Male staff from ethnic minorities were paid less than White male staff. The largest differences were for nurses and health visitors (11%) and hotel, property and estates staff (9%). For midwives, male staff from ethnic minorities were paid 9% more than white male colleagues, but this is based on a small number of staff (fewer than 100 midwives are male); and
- Female staff from ethnic minorities were paid less than White female staff. The largest differences were for nurses and health visitors (10%) and ambulance staff (7%). For central functions staff (2%) and midwives (1%), female staff from ethnic minorities were paid more than White female colleagues.

For total earnings:

- White female staff were paid less than White males, for all staff groups, with the difference ranging between 14% for hotel, property and estates staff, and 2% for staff supporting ambulance staff, and staff supporting scientific, therapeutic and technical staff;
- Female staff from ethnic minorities were paid less than male staff from ethnic minorities, for all staff groups, with the difference ranging between 11% for hotel, property and estates staff, and 1% for ambulance support staff;
- Male staff from ethnic minority group staff were paid less than White male staff, for all staff groups. The differences ranged between 13% for senior managers and 10% for nurses and health visitors to 1% for staff supporting doctors, nurses and midwives;
- Female staff from ethnic minorities were paid less than White female staff, for most staff groups. The largest differences, of 9%, were for senior managers and nurses and health visitors. Female midwives from ethnic minorities were paid 2% more than White female colleagues; and
- Pay and earnings data show that, for England, on average, male NHS staff were paid more than female staff and White staff were paid more than staff from all other ethnic groups combined. The differences vary across staff groups, although the largest differences are between White males and White females in the central functions and hotel, property and estates staff groups and White nurses and midwives and nurses and midwives from all other ethnic groups combined.

Our assessment of data on pay and earnings and workforce by gender and ethnicity

- 4.40 The data for England in Figures 4.1, 4.2, 4.4 and 4.5 revealed higher relative numbers of women and ethnic minorities in lower paid occupational groups, and also at lower pay bands within those occupations. This is highlighted by the small numbers of women and ethnic minorities above Band 8c. This occupational segregation of staff and the distribution of staff across the bands underpins the gender and ethnicity pay gaps evident in the AfC workforce in Table 4.1.
- 4.41 We recognise that these outcomes, relating to the distribution of staff across bands and occupational groups are likely to be the result of multiple factors, some of which may be associated with recruitment, retention and promotion practices within the NHS.
- 4.42 Further work is clearly required better to understand the size and cause of these differences in pay. Following the publication of the Independent Review into Gender Pay Gaps in Medicine in England in 2020, and again in oral evidence, DHSC would look to bring together stakeholders and commission research to look at ethnicity pay gaps across all NHS staff, including those on AfC terms and conditions. We welcome this and encourage the parties to take this forward. We expect to receive evidence in future years, showing a greater understanding of the situation and plans of action to address these gaps.
- 4.43 We are aware of the work already being undertaken by trusts to increase the number of ethnic minority board members better to represent the level of ethnic minority staff in the workforce. The NHS WRES 2020 report⁵⁸ notes a 22% increase in ethnic minority trust board members between 2019 and 2020. In NHS England, there were 22 trusts with four or more ethnic minority board members in 2020 compared to eight trusts in 2019 and overall, 10% of board members were from ethnic minority backgrounds.

⁵⁸ NHS Workforce Race Equality Standard (February 2021), *2020 Data Analysis Report for NHS Trusts and Clinical Commissioning Groups*. Available at: <https://www.england.nhs.uk/publication/workforce-race-equality-standard-2020-supporting-data/>

- 4.44 It is important that NHS performance management processes are monitored carefully following completion of the structural changes to the AfC pay bands on 1 April 2021. The effect of implementing these changes and the impact on different groups of staff should be monitored over time. This will identify any process changes needed to prevent discrimination and help check the benefits have been delivered. DHSC told us that 31 March 2021 saw the end of the three-year deal agreed in 2018 including ending automatic pay progression but the implementation had been delayed due to COVID-19. We observe that trusts reported one of the benefits to linking pay progression with performance was fewer staff on formal disciplinary measures. However, the WRES 2020 report⁵⁹ found that ethnic minority staff were 16% more likely to enter the formal disciplinary process compared to White staff. The NHS People Plan⁶⁰ said that the NHS needed to close the ethnicity gap in entry to formal disciplinary processes. In the Plan, it said there was an expectation that the percentage of organisations that had eliminated such gaps would increase from 31% in 2019 to 51% in 2020. For our reports, evidence would be welcome on the progress organisations have made against this target.
- 4.45 The data showed differences in experiences between those of different ethnic groups. For example, White staff were less likely to say that they worked in a COVID-19 ward or area, or to have redeployed as a result of COVID-19, but were more likely to have been required to work remotely/from home. As we said earlier in chapter 4 (paragraph 4.35), staff from ethnic minorities were more likely to work in staff groups, such as nursing and midwifery and nursing and healthcare assistants, that were more likely to have worked in COVID-19 wards or areas or to have been redeployed.
- 4.46 We emphasise that effective equality impact assessments are critical for major projects, such as the AfC three-year deal, and the new performance management framework, and are a key step in the benefits realisation process.

Economy and labour market

Economy

- 4.47 In chapter 1, we commented on the effects of COVID-19 on the economy, the labour market, the NHS and its workforce in the context of remits for 2021/21 pay recommendations for AfC staff in England, Northern Ireland and Wales. We also noted the background to our considerations which have been supported by the evidence submitted by the parties and the emerging economic and labour market forecasts for 2021 from external commentators. In this chapter, we set out the Government's response to COVID-19 and the latest available data at the time of this report including the most recent economic growth and inflation forecasts.

⁵⁹ NHS Workforce Race Equality Standard (February 2021), *2020 Data Analysis Report for NHS Trusts and Clinical Commissioning Groups*. Available at: <https://www.england.nhs.uk/publication/workforce-race-equality-standard-2020-supporting-data/>

⁶⁰ NHS (30 July 2020), *We are the NHS: People Plan for 2020.21 – action for us all*. Available at: <https://www.england.nhs.uk/ournhspople/>

- 4.48 Measures taken to deal with the pandemic, both directly through extra spending on the NHS, and to mitigate the effects of the selective lockdown measures introduced to reduce its spread, have pushed government borrowing up to a post-war high and debt, as a proportion of Gross Domestic Product (GDP), to its highest level in 60 years. In March 2021, the Office for Budget Responsibility (OBR)⁶¹ estimated public sector net borrowing to be £355 billion (16.9% of GDP) in 2020-21, its highest level since 1944/45, and public sector net debt to have risen to 100% of GDP, its highest level since 1958/59. Planned public borrowing for 2021-22 is £234 billion (10.3% of GDP). We note the volatility of GDP over the last year, the predicted recovery during 2021, and the impact of the crisis on public expenditure. We note that there will be a delay before the full impact of the pandemic on NHS finances and workforces is known. Predictions for 2021/22 are different from the situation at the time of the Spending Review in autumn 2020 and it is against this economic backdrop that we are making our recommendations.
- 4.49 In its January 2021 evidence, HM Treasury said that the COVID-19 impact on the wider economy had been significant, with GDP in October 2020 23.4% higher than its April low, but 7.9% below the February level. It expected labour market slack to be created as a result of unemployment rising to 7.5% in Quarter 2 2021 and to weigh down on wages in 2021/22. The whole economy earnings were forecast to be 1.2% lower in 2021/22 compared to the March 2020 forecast and the rate of inflation was forecasted to rise to 1.4% in 2021/22. HM Treasury said that private sector settlements had been subdued between March to September 2020 and the median settlements had fallen to 0% in the three months to the ends of July, August and September 2020 before rising again to 2% in the three months to October 2020.
- 4.50 The economic and labour market forecasts have developed since parties wrote their evidence to support their views on the affordability of a pay increase. We use the latest data to inform our pay recommendations.
- 4.51 We summarise below the economic and labour market indicators at the time of our considerations for this report:
- The economy experienced a sharp contraction of 19% in the second quarter of 2020, as the spread of COVID-19 led the Government to introduce selective lockdowns on various sectors of the economy. This was followed by growth of 18.5% in the second half of 2020, but a further contraction of 1.5% in the first quarter of 2021. By April 2021 GDP was 4% below the pre-pandemic peak. Both the Bank of England and the OBR forecast strong growth through the rest of 2021;
 - In its May Monetary Policy Report the Bank of England revised up its path for economic growth in 2021, as COVID-19 cases continued to fall, the vaccine programme proceeded apace, and restrictions on economic activity were eased. It expected GDP growth of 7.25% overall in 2021, with a recovery to pre-pandemic levels by the end of the year⁶². This projection has a high level of uncertainty, and assumes that restrictions on economic activity ease in line with the plans set out by the UK Government and devolved administrations;
 - As of April 2021, Consumer Prices Index (CPI) inflation was 1.5%, Consumer Prices Index Including Owner Occupiers' Housing Costs (CPIH) inflation was 1.6% and Retail Price Index (RPI) inflation was 2.9%;

⁶¹ OBR (3 March 2021), *Economic and fiscal outlook – March 2021*. Available at: <https://obr.uk/efo/economic-and-fiscal-outlook-march-2021/>

⁶² Bank of England (6 May 2021), *Monetary Policy Report – May 2021*. Available at: <https://www.bankofengland.co.uk/monetary-policy-report/2021/may-2021>

- In its May Monetary Policy Report, the Bank of England said it expected CPI inflation to rise to its 2% target later in 2021. The OBR also expected a sharp rise in CPI inflation, to 1.9% in the second quarter of 2021, before falling back to 1.6% in the second half of 2021. The OBR forecasted RPI to be 2.4% by the final quarter of 2021;
- Labour market. Pay As You Earn Real Time Information (RTI) data indicated that the number of employees on payrolls fell by over 960,000 between February 2020 and November 2020. However, payroll numbers have increased each month between November 2020 and April 2021, by 190,000 in total over the period;
- Labour Force Survey data showed a fall in total employment of 529,000 over the year to March 2021, but with all of this concentrated among the self-employed. This puts the total numbers on UK payrolls 770,000 lower than before the pandemic;
- The total amount paid through PAYE in the UK fell from £73.2 billion in January 2020, to £70.0 billion in May 2020, a fall of 4.5%. However, by March 2021, the PAYE data had recovered to £74.7 billion, up 2.2% from a year earlier. Around half of this total pay bill growth came from health and social care, which saw pay bill growth of 8.5% over the year;
- According to the average weekly earnings series, the level of private sector average earnings fell between February and April 2020, remained stable for three months, and has grown since June 2020. In the three months to March 2021 whole economy annual average earnings growth was 4.0%, with growth of 3.7% in the private sector and 5.7% in the public sector (excluding financial services). However, the ONS said that the earnings growth figures had been affected by changes to the composition of employee jobs, which meant that underlying earnings growth was around 3%;
- Pay settlement data for 2021 indicated that 28% of reviews this year have been pay freezes, compared to 20% in 2020. There had also been a notable increase in the proportion of pay reviews in the 1% to 1.9% range. The latest XpertHR data gave a median of 1.9% for pay reviews in the three months to April 2021, while both Incomes Data Research (IDR) and the Labour Research Department (LRD) had medians of 2.0% for the three months to April 2021; and
- The Government increased the National Living Wage (NLW) from 1 April 2021, by 2.2% from £8.72 to £8.91. The Low Pay Commission (LPC) has been asked by Government to make increases to the NLW towards a target of two-thirds of median earnings by 2024, taking economic conditions into account. The LPC has said that its best estimate of the increases required to meet this target would be for an NLW of £9.42 from April 2022 (an increase of 5.7% from the 2021 rate) and £10.33 from 2024 (an increase of 15.9% from the 2021 rate). The NLW is now covering those aged 23 years and above, this may also change by 2024.

4.52 We summarise below the Northern Ireland economic and labour market indicators at the time of our considerations for this report:

- In the three months to March 2021, Northern Ireland's employment rate was 69.1%, lower than the UK-wide equivalent of 75.2%. Over the same period, the unemployment rate in Northern Ireland was 3.6%, which was also lower than the UK-wide equivalent of 4.8%. The inactivity rate in Northern Ireland was 28.3%, higher than the UK-wide equivalent of 21.0%; and
- Median weekly earnings in Northern Ireland for all workers stood at £431.30, compared to £479.10 for the UK as a whole in April 2020. Gross weekly median earnings grew by 0.6% in the year to April 2020 in Northern Ireland, while across the wider UK there was no change on the year.

- 4.53 The UK Government introduced a range of measures to support employees, the self-employed and businesses during the pandemic when specific sectors of the economy were closed during lockdown. In the months following the start of the pandemic, there was a large fall in employment levels for the under 25s as employers restricted recruitment.
- 4.54 The CIPD's quarterly Labour Market Outlook for spring 2021 indicated that employment intentions for the second quarter of 2021 had risen sharply in the winter quarter and were at their strongest since those in the three months of winter 2012/13. Employers' optimism was evident across all three major sectors of the UK economy, pointing to a strong and broad-based employment recovery in the short term.
- 4.55 The proportion of organisations planning to recruit in the three months to June 2021 had risen to 64%, from 40% a year earlier, and positive recruitment intentions of 73% within the healthcare sector were amongst the highest across all sectors. Redundancy intentions had fallen to below pre-pandemic levels with far fewer organisations (12%) planning to make any redundancies compared with the previous 12 months. Over three-quarters (77%) of employers surveyed intended to review their wages over the next 12 months, around three in 10 (29%) intended to review wages between April and June 2021. Employers said that the median basic pay increases in their organisations (excluding bonuses) would be 2%, up from 1% in the winter 2020/21 quarter. The CIPD report noted that the pay outlook for private sector workers, with a median basic pay award of 2% in the period to March 2022, was brighter than that for public sector workers, where a median basic pay award of 0.9% was expected. CIPD said pay settlements looked set to return to pre-pandemic levels.
- 4.56 On 24 December 2020, a new trade and co-operation deal between the European Union (EU) and the UK was agreed. The King's Fund article, *Brexit and the end of the transition period: what does it mean for the health and care system*⁶³ said that the numbers of nurses arriving from the European Economic Area (EEA) had decreased rapidly since the referendum and significant numbers were leaving the UK health and care workforce. We noted their comment that this decline had been offset by a greater rate of increase in numbers of non-EEA nurses arriving. The King's Fund thought that the NHS and social care sector would not be able to function without their international workforce, noting that the current workforce shortfall in the NHS was so severe that at least 5,000 more nurses a year will need to be recruited from overseas while measures to increase domestic training capacity take effect. The DHSC told us that they did not expect EU Exit to have a significant short-term impact on the availability of health and care staff in the NHS but in the longer term there may be a reduction in the in-flow of staff from the EEA due to new immigration requirements and economic uncertainty. In addition to the negative effects from the pandemic, the Department of Health, Northern Ireland said they were uncertain about the level of impact that the EU Exit would have on its persisting and long-standing labour market challenges. The longer-term trends of EU Exit on the economy and labour market would provide the backdrop to our considerations of AfC supply and recruitment.

Our assessment of the economy and labour market

- 4.57 The government is carrying high levels of debt and is still faced with significant claims for further public spending. The CPI rate is expected to be around 2% for the period that our pay recommendation will cover and RPI is forecast by the OBR to be at 2.4% by the end of 2021.

⁶³ The King's Fund (11 January 2021), *Brexit and the end of the transition period: what does it mean for the health and care system?* Available at: <https://www.kingsfund.org.uk/publications/articles/brexit-end-of-transition-period-impact-health-care-system>

- 4.58 Forecasts are for a relatively rapid economic recovery, although this is dependent on there being no further significant lockdowns. Data shows that the number of employees on payrolls in April 2021 was almost 800,000 lower than in January 2020, but there were signs of some recovery, as employee numbers were almost 100,000 higher than in March 2021. Again, future levels of employment are dependent on the strength of any economic recovery and the impact of the withdrawal of the Coronavirus Job Retention Scheme.
- 4.59 We note the CIPD forecast of employment intentions and optimism expressed by employers across all three major sectors of the UK economy pointed to a strong and broad-based employment recovery in the short term.
- 4.60 The latest headline estimates show strong growth in average earnings in the quarter to March 2021, but the ONS have pointed out that this is partly driven by changes to the composition of employee jobs which means that the underlying growth in earnings is lower than the published data suggest. The NHS employs staff in all areas of the UK. For some professions, such as nursing and midwifery, the NHS will be the largest employer, at local and national level. For other staff groups, the NHS will be competing for staff with a wide range of other employers. Demand for staff, and the potential for earnings growth, is likely to vary greatly by sector. However, we need to ensure that pay rates in the NHS are set at levels that allow the service to compete across a wide range of markets.

NHS funding and affordability

NHS funding

- 4.61 A five-year funding plan for the NHS from 2019/20 was set out in June 2018 and, for England, enshrined in law in the NHS Funding Act 2020. Funding was allocated to clinical commissioning groups (CCGs) in England via allocations that included a growth assumption for pay awards. The funding allocations for the devolved administrations for Northern Ireland and Wales are determined using the Barnett formula. Barnett consequentials are calculated on the increase in NHS England spending over the assumed baseline.
- 4.62 Money for pay awards for the HSC in Northern Ireland is allocated annually by the Department of Health. Given that AfC staff in Northern Ireland work in both health and social care, the impact of a pay award will be greater in Northern Ireland than the rest of the UK. The public sector pay policy for Northern Ireland in 2021/22 set out that pay awards of up to 1% would be allowed where reforms were agreed and there would be flexibility for higher awards in return for cash releasing efficiency savings through improvements to public sector productivity. However, the 1% limit would not apply to staff in the health and care service. In oral evidence, the Department of Health, Northern Ireland noted that the budget announced in April had £52 million set aside for AfC pay in 2021/22. This was around a 2% increase on the pay bill and a pay award above 2% would require reprioritisation. The Welsh Government told us in oral evidence that the expectation was there would be a real terms award above 1% and provision had been made for this in the health budget.

4.63 Prior to the pandemic, a growth assumption for pay awards alongside a productivity assumption would have been included in funding allocations for England. In 2020/21, in response to the pandemic, a temporary financial architecture was put in place that allowed systems in the first half of the year to claim for any retrospective costs and establish allocations in the second half of the year that included additional funding for COVID-19 costs. For 2021/22, it was decided to roll these allocations over for the first half of the year to minimise the planning burden on the NHS during the most recent wave of COVID-19. In terms of pay growth, these envelopes included 0.7% of the pay bill for the three-year deal AfC overhang. The funding allocation for the second half of the year had not been set at the time we finalised our report. The pay award for the whole year would be reflected in the funding arrangements for the second half of the year once our recommendations had been considered. In terms of funding pay growth for the financial year 2021/22, DHSC expected the total investment in AfC to be 1.7%.

Affordability

- 4.64 HM Treasury told us that the economic impacts of COVID-19 and the unprecedented packages put in place had meant a significant but necessary increase in government borrowing and debt. It said that the process for government spending decisions would ensure sustainable levels of borrowing and debt. Their view was that medium-term public sector pay growth should retain parity with the private sector, and the government said it must exercise restraint in future public sector pay awards.
- 4.65 The Joint Staff Side argued that a significant pay increase would provide a macroeconomic boost and was affordable, given historically low costs of borrowing. Their evidence included a report from London Economics, *The net Exchequer impact of increasing pay for Agenda for Change staff report*⁶⁴ which argued that the net cost to the Treasury of a 10% increase in AfC pay would be only £0.66 billion. This arose in part through additional tax receipts generated both as a direct result of increased AfC pay and through the multiplier impacts on the incomes of individuals and businesses that a pay increase to such a large and geographically dispersed group of workers would generate. In addition, the increased pay of AfC staff would lead to a larger fraction of student loans being repaid. Finally, London Economics calculated that such a pay increase would have a significant impact on recruitment and retention, leading to a saving in staff costs as the NHS would be less reliant on more expensive agency and bank staff to fill shortages.
- 4.66 The Government had assumed a headline pay award of 1% for AfC staff in England and said that anything higher would require re-prioritisation of some services. DHSC said that more funding towards pay would mean less funding for other priorities, including the size of the workforce that is affordable, as well as wider investments required to deliver the NHS Long Term plan. The Department of Health Northern Ireland said pay awards, including any higher awards, would have to be found from existing departmental budgets or funded through efficiencies. In oral evidence, the Welsh Government told us that the higher the pay award the more difficult the choices would be on how to fund it and other priority ambitions for the Welsh NHS. There were shortages in the domestic supply of nurses, midwives and Allied Health Professionals (AHPs) pre-COVID and closing the AfC workforce gaps would take time. A pay uplift for AfC staff could improve the retention rates, decrease the cost of Agency staff to the NHS and positively influence and encourage experienced and newly qualified nurses to continue working in the NHS over the short to medium term.

⁶⁴ London Economics (January 2021), *The net Exchequer impact of increasing pay for Agenda for Change staff*. Available at: <https://londonconomics.co.uk/blog/publication/the-net-exchequer-impact-of-increasing-pay-for-agenda-for-change-staff/>

- 4.67 The NHS England 2021/22 priorities and operational planning guidance⁶⁵ set out the priorities for the full year including restoring services and reducing backlogs and asked for full plans to be developed for the first half of the year across activity, workforce and money. The challenge for the NHS would be to rebuild services, meet demands for new services and reduce elective treatments backlogs, as well as supporting staff recovery against a backdrop of uncertainty about the future pattern of COVID-19 transmission. The guidance recognised that delivery against the Long Term Plan strategic goals would need to be accelerated in order to achieve the priority areas for tackling health inequalities.
- 4.68 NHS Employers said NHS leaders were telling them that any pay uplift in 2021/22 must reflect the enormous effort made by staff, be fully funded and not be a detriment to closing the gap in terms of workforce shortages. NHS Providers said that it was essential that pay awards were fully funded by the Government and affordable for trusts to administer for all eligible staff. The NHS Long Term Plan set a target of making re-investable productivity gains of at least 1.1% a year over the next five years. In oral evidence, DHSC confirmed that the NHS Long Term Plan did include a pay envelope of 2.1% but with a productivity assumption of 1.1%. Circumstances have now changed due to COVID-19 and those productivity gains were unlikely to be achieved.

Our assessment of NHS funding and affordability

- 4.69 The NHS funding settlement for the first six months of 2021/22 included funding for the 0.7% overhang from the three-year deal. We note that the funding for the second half of 2021/22 has not been set. The cost of an award is such that, including on-costs such as NHS Employers National Insurance Contributions and Employers Pension Contributions, each 1% increase in pay would add £466 million to the AfC pay bill in England in 2021/22, £38 million in Wales and £24 million in Northern Ireland
- 4.70 We are very clear that the fiscal position is challenging and mindful of the many competing claims on public spending. We note the historically low costs of government borrowing and the impact of rising inflation on the cost of that borrowing.
- 4.71 We acknowledge that some fraction of a pay increase would come back to HM Treasury via higher increased tax revenue, but note that this would be true of many other types of public spending.
- 4.72 We also acknowledge that, given the need to maintain and grow the AfC workforce, filling shortages with substantive staff rather than relying on bank and agency would reduce the staff costs of delivering good levels of patient care.

Workforce numbers and recruitment

Introduction

- 4.73 We heard a consensus among the parties on the scale of the overall AfC workforce gap, the required action, and the need to front-load the response to close the gap, which included international recruitment. The data on the impact of COVID-19 on the numbers from overseas joining the NHS is provided in our analysis below. We are concerned that workforce planning reassessments for the medium to long term take account of the time lag for growing the domestic supply of new entrants into AfC professions.

⁶⁵ NHS (25 March 2021), *2021/22 priorities and operational planning guidance*. Available at: <https://www.england.nhs.uk/publication/2021-22-priorities-and-operational-planning-guidance/>

4.74 To support the recovery of services it will be important for NHS workforce planning to be transparent and that strategic priorities are communicated effectively to the workforce at national, regional and local levels. We have been told employers want to see workforce planning at both local and national levels that are:

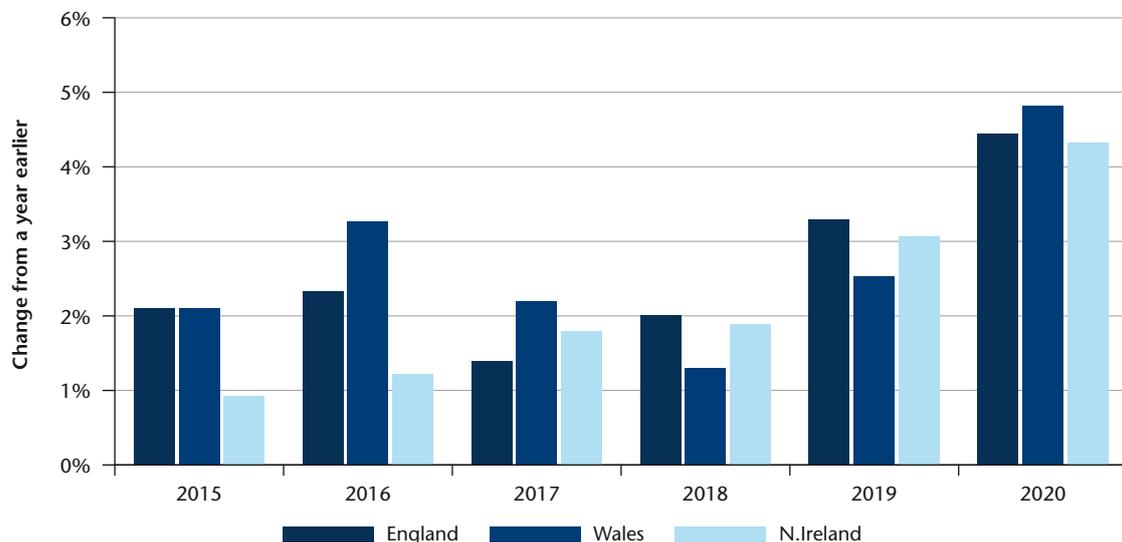
- Based on health and social care strategy and business plans;
- Focused on future need;
- Flexible enough to deal with constant change;
- Subject to constant feedback and review; and
- Planning for staff numbers and skills, staff potential and how staff will be deployed and organised.

Staffing numbers

4.75 We review below the numbers and composition of staff in in England, Wales and Northern Ireland, where data is available.

4.76 The AfC workforce continues to increase year-on-year, both overall and in each UK country. We note that in September 2020 there were 1.2 million full-time equivalent (FTE) AfC staff in England, Wales and Northern Ireland, of which, approximately 1.04 million were working in England, 80,000 in Wales and 55,000 in Northern Ireland. We also track the trends in the workforce and Figure 4.8 shows the change in staffing numbers each year since 2015. We note that in the year to September 2020, compared with a year earlier, the number of FTE staff rose in by 4.8% in Wales, 4.5% in England, and 4.3% in Northern Ireland. We also see that on a headcount basis there were 1.3 million AfC staff as of September 2020. Of these, approximately 1.18 million were in England, 90,000 in Wales, and 70,000 in Northern Ireland.

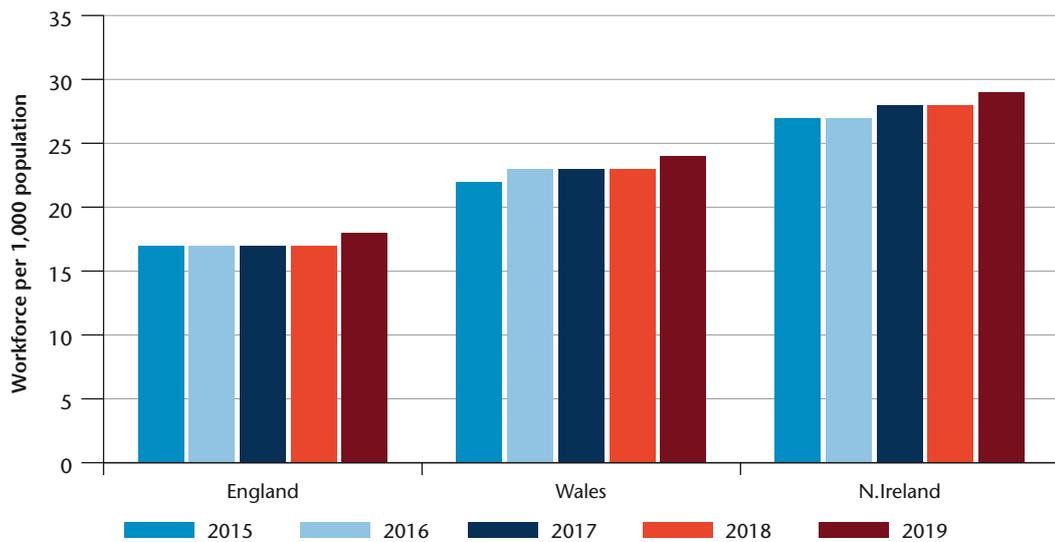
Figure 4.8: Change in AfC full-time equivalent workforce, England, Wales and Northern Ireland, 2015 to 2020



Source: NHS Digital, Stats Wales, Department of Health, Northern Ireland

4.77 We have seen in our previous assessments, and continue to be told by the parties in evidence, that while the number of FTE AfC staff has increased year on year, the population and demands on the service have also grown. Against this background, we have examined the number of AfC staff per head of population. Our analysis in Figure 4.9 shows the number of FTE AfC staff per 1,000 of the population in England, Wales and Northern Ireland. We note that the increase in the height of the bars for each country, shows that the number of FTE staff is growing more quickly than the population. We can also see that England has the fewest FTE AfC staff per 1,000 population, whereas Northern Ireland has the largest number of AfC staff relative to the population, as the Northern Ireland workforce includes those working in social care.

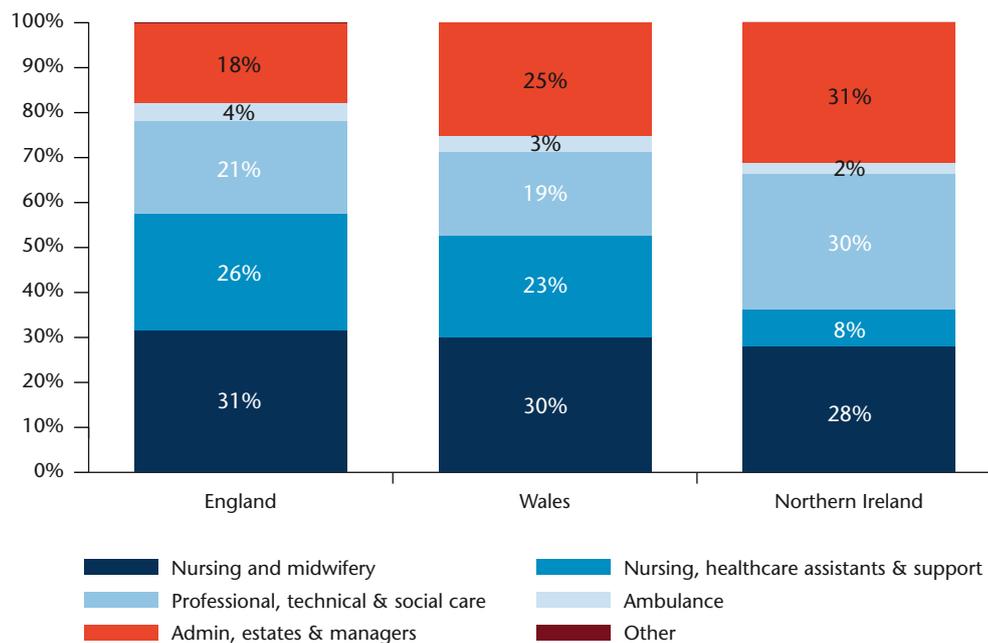
Figure 4.9: NHS AfC full-time equivalent workforce per 1,000 population, England, Wales, Northern Ireland, 2015 to 2019



Source: OME calculations based on data from NHS Digital, Stats Wales, Department of Health, Northern Ireland, ONS

4.78 Our analysis in Figure 4.10 shows a breakdown of AfC staff by broad staff group in England, Wales and Northern Ireland. We observe that in Northern Ireland there is a relatively high share of administration, estates and management staff, and professional, technical and social care staff, compared with England and Wales, which reflects the inclusion of social care staff in the Northern Ireland workforce. We note that other variations by AfC staff group include that England and Wales have a relatively high proportion of nursing and healthcare assistants.

Figure 4.10: NHS AfC full-time equivalent workforce by broad staff group, England, Wales, Northern Ireland, September 2020



Source: NHS Digital, Stats Wales, Department of Health, Northern Ireland

Nursing workforce

4.79 Figure 4.11 shows the FTE number of nurses, health visitors and midwives in England, between December 2009 and December 2020. Overall, the number of nurses and health visitors fell between 2010 and 2012, then grew between 2012 and 2016 and levelled out between 2016 and the first half of 2018. However, between the three months to August 2018 and the three months to December 2020, the number of nurses and health visitors increased by 8.5%.

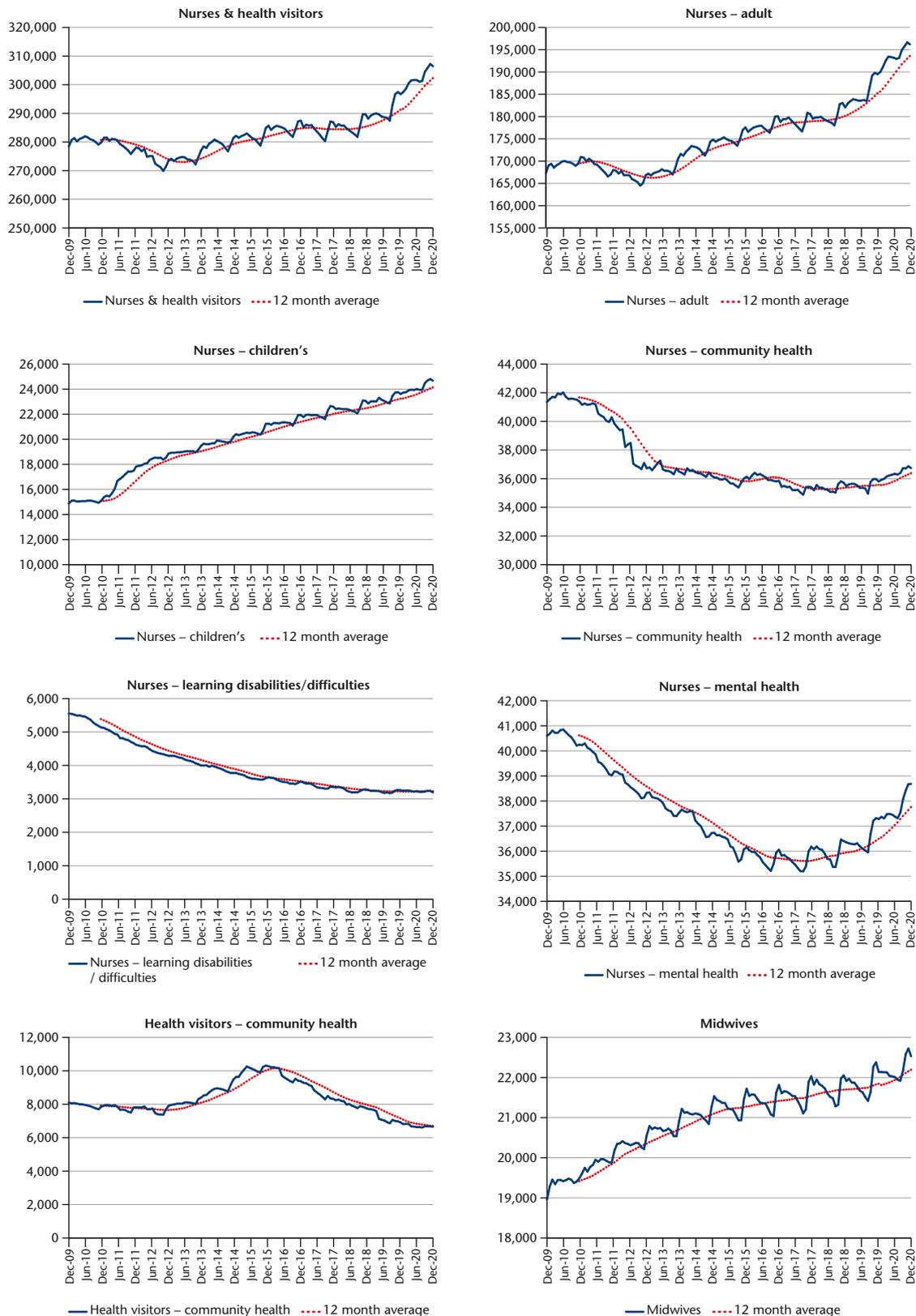
4.80 Groups within the nursing and health visitor and midwifery populations experienced different rates of growth between 2010 and 2020. Over the period there was growth in the number of children’s nurses (59%), midwives (14%) and adult nurses (14%). However, over the same period there were falls in the number of learning difficulties/disabilities nurses (39%), health visitors (15%), community health nurses (12%), and mental health nurses (7%).

4.81 The data, for the three months to December 2020, compared with the three months to August 2018, the point at which nursing numbers started to grow, also show different rates of growth for different groups. There was relatively strong growth in the number of children’s nurses (11.5%), adult nurses (9.9%) and mental health nurses (8.8%). There was more modest growth in the number of community health nurses (4.9%), very little growth in the number of learning difficulties/disabilities nurses (0.9%), and a fall in the number of health visitors (15.0%). Over the same period there was an increase in the number of midwives of 5.5%.

4.82 The data, for the three months to December 2020, compared with the same period one year earlier (pre-COVID-19), show an increase in the number of nurses and health visitors of 3.6%. Within that overall total, there were increases in the number of children’s nurses (4.9%), adult nurses (3.9%), mental health nurses (3.8%), and community health nurses (2.8%), but falls in the number of health visitors (3.9%), and learning difficulties/disabilities nurses (0.7%). Over the same period there was an increase in the number of midwives of 2.2%.

4.83 The Government has set a target for 50,000 more nurses in England by 2025. The latest data to December 2020, compared with December 2019, shows an increase of 11,000 FTE nurses working in NHS Hospital and Community Health Services over that period.

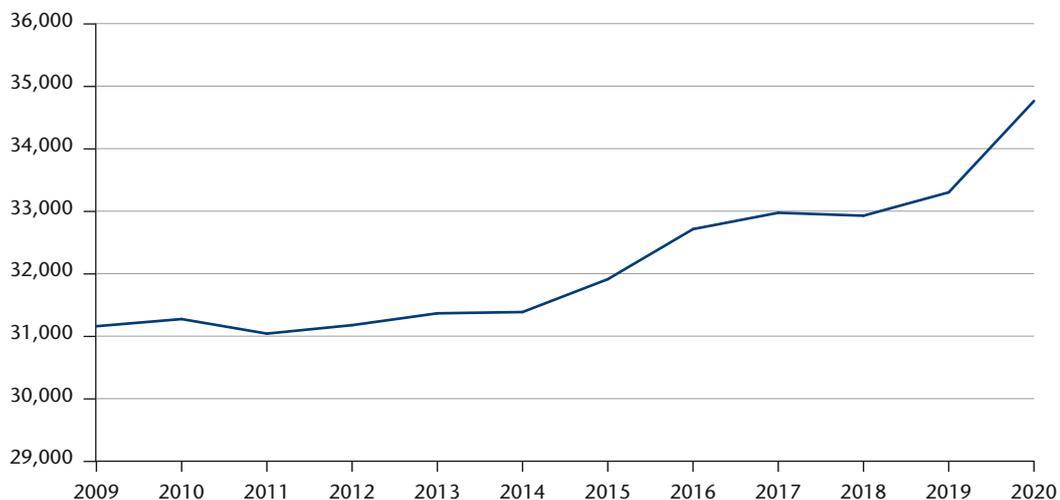
Figure 4.11: Number of nurses, health visitor staff and midwives, FTE, by nursing category, England, December 2009 to December 2020



Source: NHS Digital

4.84 Figure 4.12 shows that in Wales the number of qualified nursing, midwifery and health visiting staff rose each year between 2012 and 2017, before falling by 0.1% in 2018. However, numbers increased in 2019, by 1.1% and by a further 4.4% between September 2019 and September 2020.

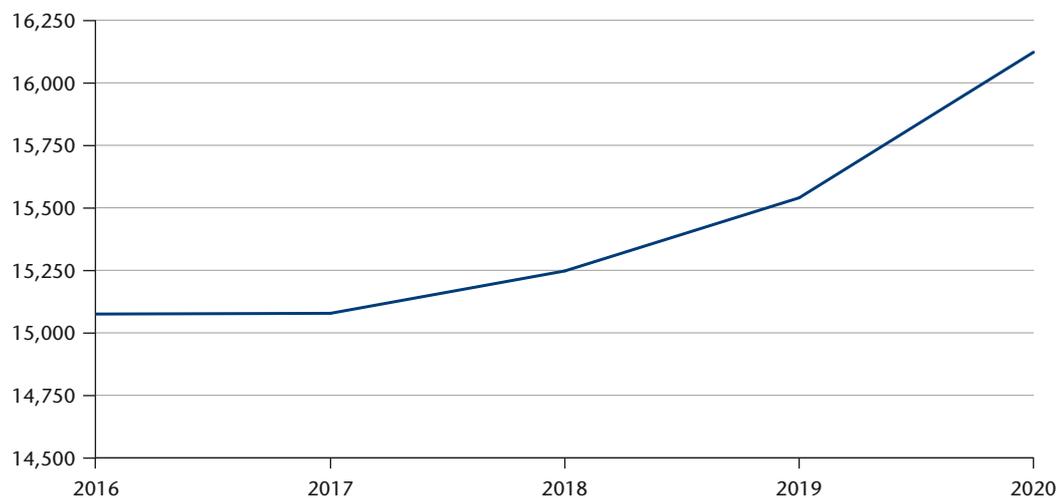
Figure 4.12: Number of nursing, midwifery and health visiting staff, FTE, Wales, September 2009 to September 2020



Source: Stats Wales

4.85 Figure 4.13 shows that in Northern Ireland, the number of qualified nurses and midwifery staff grew each year between 2017 and 2020, with particularly strong growth of 3.7% between December 2019 and December 2020.

Figure 4.13: Number of registered nursing and midwifery staff, FTE, Northern Ireland, December 2016 to December 2020

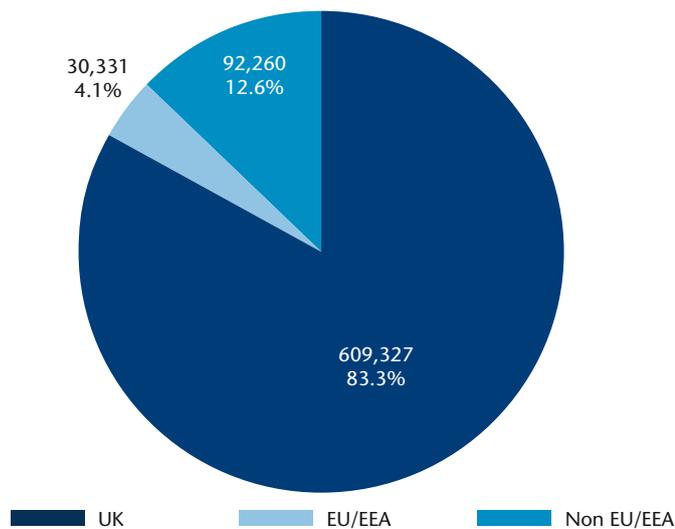


Source: Department of Health, Northern Ireland

Nursing and Midwifery Council Register

4.86 Data on the Nursing and Midwifery Council (NMC) Register helps us understand the total available workforce for nurses, midwives and nursing associates. It shows the numbers able to practice in the United Kingdom (UK), although this will cover those working in the NHS, private and independent sectors or the third sector, and not all of those on the register will be working in their registered roles or working at all. The latest data for March 2021, showed that there were 731,918 nurses and midwives registered to work in the UK. Of the total number 609,327 were initially registered in the UK, 30,331 were initially registered in the EU/EEA and 92,260 initially registered outside the EU/EEA (Figure 4.14).

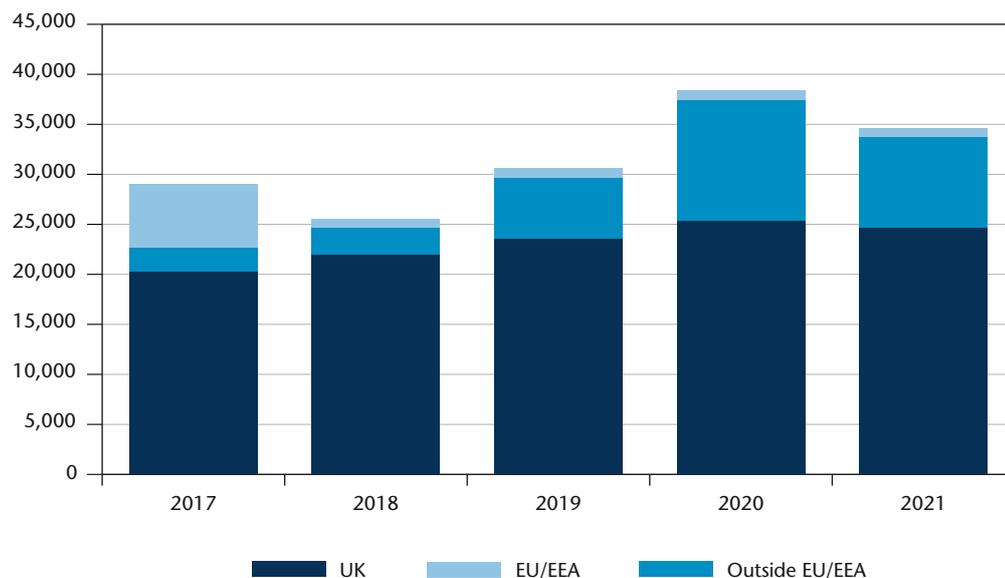
Figure 4.14: Overall numbers of nurses and midwives on the NMC register by country of qualification, UK, March 2021



Source: Nursing and Midwifery Council (NMC) Register, March 2021

4.87 In the year to March 2021, there was an increase of 15,311 (2.1%) nurses and midwives on the register, as 34,577 joined the register for the first time and 23,936 left the register (Figures 4.15 and 4.16).

Figure 4.15: Joiners to the NMC register, between year to March 2017 and year to March 2021, from the UK, EU/EEA and outside the EU/EEA

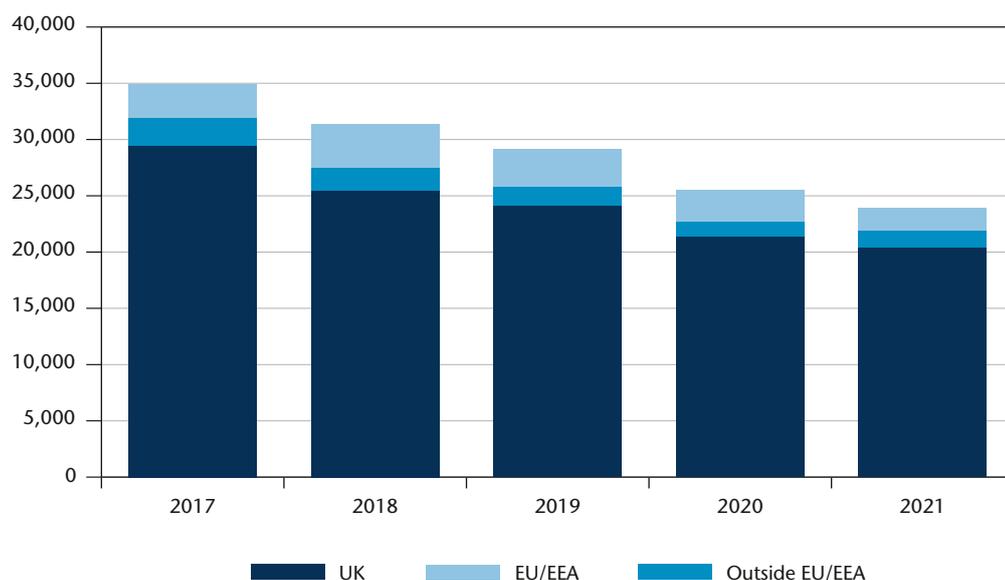


Source: Nursing and Midwifery Council (NMC) Register, March 2021

4.88 Figure 4.15 shows the numbers joining the register for the first time between the year to March 2017 and the year to March 2021. Overall, the numbers joining the register increased in each of the two years to March 2020, with much of the growth in joiners accounted for by those who trained outside the EU/EEA, especially those who trained in India and the Philippines.

4.89 Figure 4.16 shows the numbers leaving the register between the year to March 2017 and the year to March 2021. Overall, the numbers leaving the register have fallen in each of the last four years. In the year to March 2021, the number of leavers from outside the EU/EEA were higher than in the previous 12 months, but were more than offset by falls in the number of nurses and midwives from both the UK and from the EU/EEA leaving the register.

Figure 4.16: Leavers from the NMC register, between year to March 2017 and year to March 2021, from the UK, EU/EEA and outside the EU/EEA



Source: Nursing and Midwifery Council (NMC) Register, March 2021

- 4.90 In addition to its main register, the NMC established a temporary register in March 2020, in response to COVID-19, which allowed people in the following three categories to register and practice⁶⁶:
- Those who left the permanent register within the previous three years;
 - Those who left the permanent register between three and five years ago; and
 - Eligible overseas candidates.
- 4.91 In September 2020 the NMC published a report summarising the characteristics and activity of those on its temporary register at 2 July 2020. Headlines included:
- Of the 14,243 people on the temporary register, 66% had left the permanent register in the previous three years, 16% had left between three and five years ago, and 18% were from overseas;
 - Fewer than 50% had either started to practice or received an employment offer. However, experience varied, between overseas applicants, of whom 92% were practising, compared with 14% who left the register in the previous three years, and 6% of those who left between three and five years ago;
 - The NMC said that they expected that a majority of overseas applicants were already working in a pre-registration capacity, while waiting to take their final Objective Structured Clinical Examination (OSCE);
 - Compared to the permanent register, those on the temporary register were:
 - More likely to be aged 50 and above;
 - More likely to be male; and
 - Less likely to identify as White or Black but more likely to identify as Asian; and
 - Of those on the temporary register, 36% said that it was highly likely that they would want to join the permanent register. There were 97% of overseas applicants, who said they were highly likely to want to join, compared with 20% of those who left within three years and 27% of those who left between three and five years ago.
- 4.92 In January 2021, the NMC further extended those able to join the temporary register, to a further group of overseas trained nurses in the final stages of their application to join the permanent register, and those who had left the permanent register more recently. The NMC reported that at 31 March 2021 there were 15,457 nurses and midwives on the temporary register. This is an increase from 14,243 at 2 July 2020, but the NMC also reported that 3,880 people had left the temporary register, to join the permanent register. The NMC said that the majority of those who left the temporary register to join the permanent register were international professionals who had joined the temporary register ahead of passing their OSCE. The NMC also said that 520 had previously been on their permanent register and were therefore returning to it.
- 4.93 NHS Digital published data, for England, showing the numbers of staff returning to the NHS, and the number of students added to the payroll, as part of the response to COVID-19. This data showed that the numbers recorded as returning to the service as nurses and midwives peaked at 174, in June 2020, while in July 2020, over 10,000 students were recorded as being employed as staff supporting doctors, nurses and midwives. NHS Digital did say that local organisations had not been mandated to record information about these groups in specific ways, so the data may underestimate the actual numbers returning to the service.

⁶⁶ The NMC took the decision not to open up the temporary register to students.

Data on pre-registration entrants

4.94 Table 4.2 shows the number of unique applicants⁶⁷ and acceptances⁶⁸ to study for a nursing degree between 2011 and 2020.

Table 4.2: Numbers of applicants and acceptances for nursing degrees, UK, 2011 to 2020

	Number of Applicants	Number of Acceptances	Applicants per Acceptance
2011	63,275	23,995	2.64
2012	61,770	23,835	2.59
2013	63,675	24,700	2.58
2014	67,415	26,965	2.50
2015	66,190	27,535	2.40
2016	66,730	28,890	2.31
2017	54,985	28,620	1.92
2018	50,805	28,540	1.78
2019	54,225	30,390	1.78
2020	62,920	37,630	1.67

Source: OME estimates using UCAS data

4.95 In 2020, there were 62,920 applicants to study a nursing degree in the UK with 37,630 acceptances. Compared with 2019, the number of applicants and acceptances both increased, by 16% and 24% respectively. Growth in the number of applicants aged 25 years and above, was particularly strong, increasing by 28% from 2019.

4.96 Table 4.3 shows the number of unique applicants and acceptances to study for a degree in health-related subjects between 2011 and 2020.

Table 4.3: Numbers of applicants and acceptances for health-related⁶⁹ degrees (excluding nursing), UK, 2011 to 2020

	Number of Applicants	Number of Acceptances	Applicants per Acceptance
2011	67,555	23,960	2.82
2012	63,710	22,785	2.80
2013	66,105	24,775	2.67
2014	70,155	25,440	2.76
2015	69,730	26,000	2.68
2016	71,825	26,565	2.70
2017	66,885	27,135	2.46
2018	67,515	27,715	2.44
2019	74,680	29,580	2.52
2020	79,725	32,450	2.46

Source: OME estimates using UCAS data

⁶⁷ Number of unique applicants: defined as the number of applicants making at least one choice through the UCAS main scheme.

⁶⁸ Acceptance: defined as an applicant who has been placed for entry into higher education.

⁶⁹ Includes: Subjects allied to Medicine (B0); Anatomy, Physiology and Pathology (B1); Pharmacology, Toxicology and Pharmacy (B2); Complementary Medicine (B3); Nutrition (B4); Ophthalmic (B5); Aural and Oral Sciences (B6); Medical Technology (B8); Others in Subjects allied to Medicine (B9); and Combinations within Subjects allied to Medicine (BB).

- 4.97 In 2020, there were 79,725 applicants to study for a degree in health-related subjects, excluding nursing, with 32,450 acceptances. Compared with 2019, the number of applicants and acceptances both increased, by 7% and 10% respectively.
- 4.98 Health Education England (HEE) conducted a survey of existing students to understand the impact of COVID-19 on students. HEE said that the first wave of COVID-19 had changed student experiences in several profound ways. HEE found that many students on extended placements were largely positive about their experience, with 90% saying that clinical placements were of a high quality and a good learning environment, but almost 60% said that they were concerned about catching up with their academic studies. Student experiences of online learning were less positive, with over 70% saying that they struggled to complete the learning outcomes from online learning. HEE said that most students were concerned about the impact of COVID-19 on their career, with ethnic minority students being most concerned. Nursing and midwifery students were identified as being particularly concerned about catching up with their clinical skills.
- 4.99 Many students had considered leaving their course. HEE said that 41% of student midwives, 37% of student nurses and 27% of student AHPs had considered leaving their course. HEE highlighted a difference between students in the early part of their studies and those who had almost completed their studies. Year 1, year 2 students and year 3 students on the first six months of their course, were more likely to consider leaving than postgraduate pre-registration students and students on the final six months of their programme. Amongst the reasons given for considering leaving were academic concerns and being overwhelmed and stressed by the situation.

International recruitment

- 4.100 In the year to March 2020, 10,500 AfC staff joining the NHS in England came from outside the UK, accounting for 7% of all new staff. Overseas recruitment for nurses and health visitors was particularly important, with 18% of those joining coming from outside the UK. Compared with the year to March 2018, overseas recruitment accounted for a greater share of new recruits in 2020, increasing from 3% for all AfC staff and 5% for nurses and health visitors. Growth was particularly strong from countries outside the EU, with 9,800 staff joining in the year to March 2020, up from 2,900 two years earlier.
- 4.101 Data from the NMC shows the total number of nurses and midwives registered in the UK, whether working in the NHS or not. Table 4.4 shows that in March 2021 there were 731,918 nurses and midwives on the NMC Register, 30,331 of whom were initially registered in the EU/EEA and 92,260 of whom were initially registered outside the EU/EEA. Between March 2018 and March 2021, the total number on the register increased by 41,640, of which 22,602 were first registered in the UK, and 23,822 outside the EU/EEA. The numbers first registered in the EU/EEA fell by 4,784.

Table 4.4: Number of NMC registered nurses and midwives by place of initial registration, March 2018 to March 2021.

	Mar 2018	Sep 2018	Mar 2019	Sep 2019	Mar 2020	Sep 2020	Mar 2021
TOTAL	690,278	693,618	698,237	706,252	716,607	724,516	731,918
UK	586,725	589,253	591,894	596,906	600,906	607,748	609,327
EU/EEA	35,115	33,874	33,035	31,973	31,385	30,895	30,331
non EU/EEA	68,438	70,491	73,308	77,373	84,316	85,873	92,260

Source: Nursing and Midwifery Council (NMC) Register, March 2021

4.102 Table 4.5 shows that between March 2018 and March 2021 the numbers on the register first registered in the EU/EEA fell steadily, by 14% in total. Over the same period the numbers on the register first registered outside the EU/EEA, increased by 35%. Growth in numbers on the register from outside the EU/EEA fell back between March and September 2020, which the NMC said was “primarily due to protective measures arising from the coronavirus pandemic having a significant effect on the movement of people from outside the UK as well as temporarily restricting the ability to run overseas nursing and midwifery tests”. However, growth in numbers registered outside the EU/EEA recovered in the six months to March 2021.

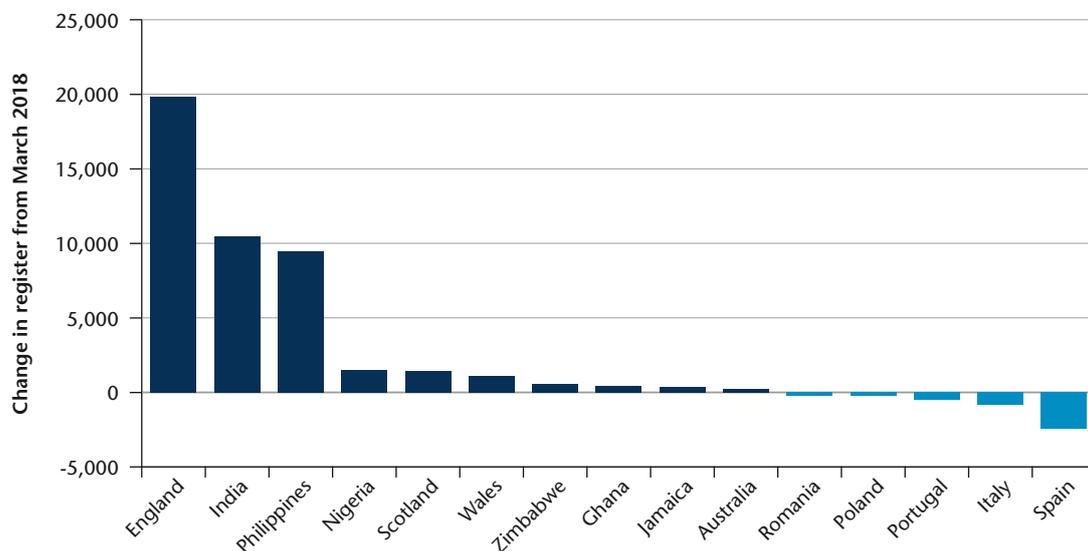
Table 4.5: Change in number of NMC registered nurses and midwives by place of initial registration, March 2018 to March 2021, compared with previous period, %.

	Sep 2018	Mar 2019	Sep 2019	Mar 2020	Sep 2020	Mar 2021
TOTAL	0.5%	0.7%	1.1%	1.5%	1.1%	1.0%
UK	0.4%	0.4%	0.8%	0.7%	1.1%	0.3%
EU/EEA	-3.5%	-2.5%	-3.2%	-1.8%	-1.6%	-1.8%
non EU/EEA	3.0%	4.0%	5.5%	9.0%	1.8%	7.4%

Source: Nursing and Midwifery Council (NMC) Register, March 2021

4.103 Figure 4.17 shows the change in numbers on the NMC register, between March 2018 and March 2021, by country of initial registration. This shows that much of the growth in those registered outside the EEA was driven by nurses and midwives from the Philippines and India. The numbers on the register from each of those countries was more than 9,000 higher in March 2021 than in March 2018.

Figure 4.17: Changes in the numbers on the NMC register, by country of training, March 2018 to March 2021

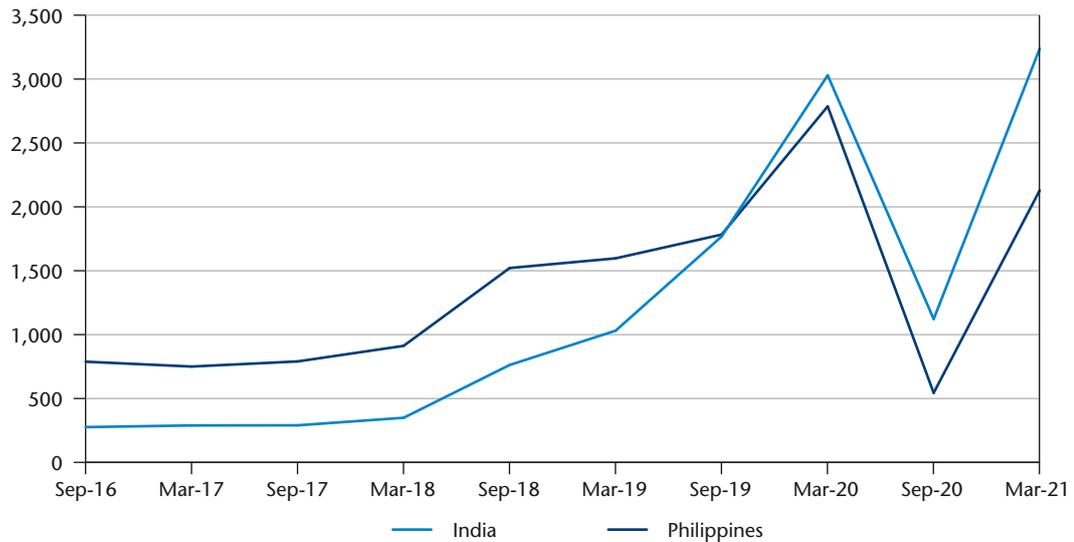


Source: Nursing and Midwifery Council (NMC) Register, March 2021

Note: Only includes those countries where the net change was greater than +/- 200

4.104 Figure 4.18 highlights the volatile growth in the numbers joining the NMC register who were originally registered in India and the Philippines since March 2018.

Figure 4.18: New joiners to the NMC register, from India and the Philippines, September 2016 to March 2021

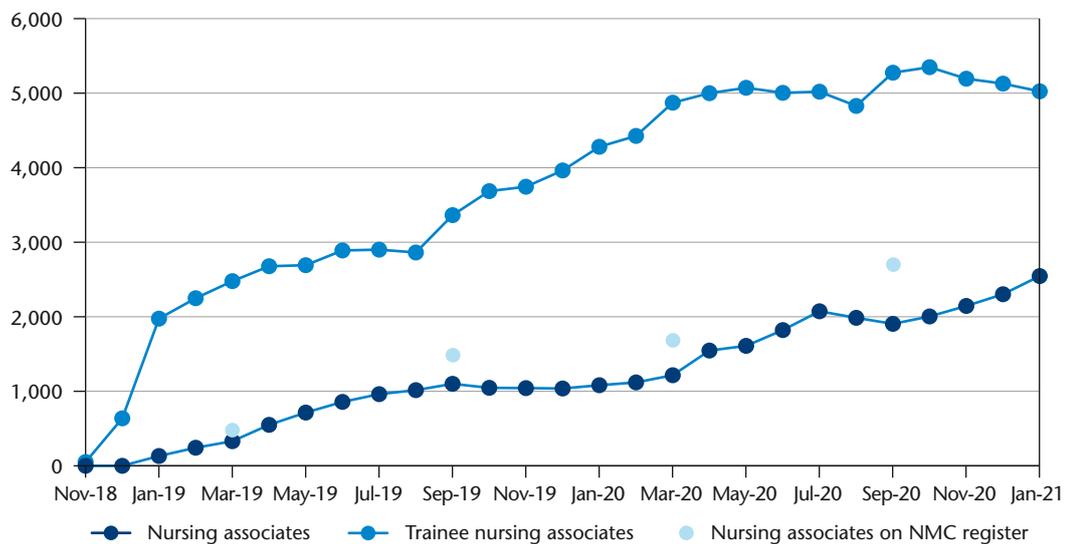


Source: Nursing and Midwifery Council (NMC) Register, March 2021

Recruitment of nursing associates in England

4.105 Since March 2019, the NMC has registered nursing associates and its latest data, for March 2021, showed that there were 4,353 nursing associates registered. Data from NHS Digital showed that in January 2021 there were 2,546 FTE nursing associates working in the NHS in England (Figure 4.19), the highest number recorded to date. NHS Digital data also shows that there were 5,024 FTE trainee nursing associates working in the NHS in England, a fall of 6% from the peak recorded in October 2020.

Figure 4.19: Nursing associates and trainee nursing associates, FTE, England, November 2018 to January 2021



Source: NHS Digital and Nursing and Midwifery Council

Recruitment of apprentices

4.106 Following the introduction of the apprenticeship levy in 2017, the number of all apprenticeship starts in 2017/18 fell 24% to 375,800, from 494,900 in 2016/17. Although some of this decline was reversed in 2018/19, with apprenticeship starts rising by 5% to 393,400, this was followed in 2019/20, with a sharp fall in starts, of 18%, to 322,500.

- 4.107 The number of Health, Public Services and Care apprenticeship starts broadly exhibited the same pattern as that of all apprenticeship starts. Starts dropped dramatically after the introduction of the apprenticeship levy, then recovered slightly in 2018/19, but fell sharply in 2019/20. In 2019/20 there were 82,200 starts, a fall of 16% from 97,700 in 2018/19.
- 4.108 Data for the public sector as a whole showed that between 2017/18 and 2019/20 the number of apprenticeship starts in England was 1.7% of the workforce (on a headcount basis)⁷⁰. The equivalent figure for the NHS in England was 1.5%. With the exception of the Armed Forces, where apprenticeship starts were 7.9% of the workforce, the NHS was in line with that of most other public sector employers, where new apprenticeships were the equivalent of between 0.7% and 1.8% of the workforce.

Our assessment of workforce numbers and recruitment

- 4.109 Increasing staffing numbers and closing workforce gaps in the medium term is dependent on being able to encourage greater numbers to train and qualify for careers in the NHS, better retain existing members of staff, and, where gaps still exist, look to recruit staff from outside the UK.
- 4.110 The number of applicants to nursing and other health related degrees fell in 2017 following the removal of financial support for students in England. There was a further fall in the number of applicants to nursing degrees in 2018. The number of applicants increased from 2019, following a marketing campaign and the 2018 AfC pay agreement, which increased the starting pay of nurses. The number of acceptances also rose following the provision of additional support provided by HEE to expand the capacity for student placements. There was a further sharp increase in the number of applicants and acceptances to study for nursing and other health related degrees in 2020 following the introduction of new annual maintenance grants for nursing, midwifery and the majority of allied health profession students from September 2020. There was a particularly large increase in the number of applicants aged 25 and above for nursing and midwifery courses, which may reflect the relative importance of financial support for more mature students. We will look to see if this strong growth in the number of mature applicants continues.
- 4.111 Another factor behind the increase in applicants may be a result of the NHS, and those working in it, having a higher profile because of the impact of COVID-19. Potential applicants may have seen the impact that those working in healthcare could have, and the value placed on that by the wider public.
- 4.112 Some of the increase in acceptances may have been impacted by the increase in A Level grades created by centre assessed grades assessment in 2020. It will be important to track the progression rates for this cohort.
- 4.113 Many existing students on NHS placements during 2020 will have had very different experiences than students in previous years. Some will have had their motivation to follow a career in healthcare and the NHS reinforced, while others may be looking to pursue other careers. HEE highlighted the concerns that some students have about online learning, their ability to catch up with their academic studies and being overwhelmed and stressed by their experiences. HEE also said that many students had considered leaving their course, which may feed through into increased drop-out rates during undergraduate courses.

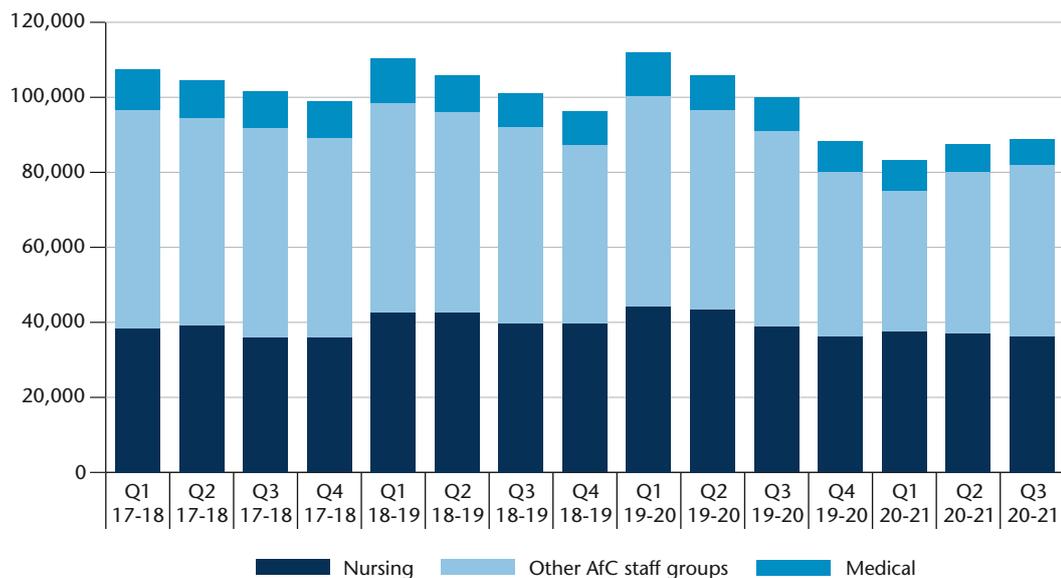
⁷⁰ GOV.UK (26 November 2020), *Apprenticeships and traineeships*. Available at: <https://explore-education-statistics.service.gov.uk/find-statistics/apprenticeships-and-traineeships/2019-20#dataBlock-bac86dd0-4fc8-451e-8aa5-8a9bcffdd6c2-charts>

- 4.114 We note significant extra funding for placements provided, and recognise that to cope with increased student numbers, the NHS will continue to need to be able to find the financial and human resources to make more placement opportunities available, with sufficient experienced staff available to provide training and mentoring support.
- 4.115 As a short-term response to COVID-19, the NMC opened a temporary register to encourage UK qualified personnel who had previously left the register to return, and for eligible overseas candidates. By July 2020, over 14,000 people had joined this temporary register, but the NMC said that fewer than 50% of those had started to practice or received an offer, and most of those who had done so were overseas applicants who were already working in a pre-registration capacity. The NMC said that by the end of March 2021, almost 3,900 people who had joined their temporary register left it to join their permanent register, with the majority being international professionals who joined the temporary register ahead of passing their OSCE. NHS Digital estimated that by June 2020, in England, over 10,000 students were working in roles supporting doctors, nurses and midwives, while fewer than 200 staff had returned to the NHS as a registered nurse or midwife.
- 4.116 While the increase in student numbers is welcome it will be between three and four years before this increase begins to feed through into increased numbers of substantive staff in the NHS. This means that there will still be a need to recruit staff from overseas in the short-term. Data from the NMC has shown that a reduction in the number of nurses and midwives from the EU/EEA has been more than matched by an increase in nurses from outside the EU/EEA, especially from the Philippines and India. However, the NMC data also showed a sharp fall in the numbers coming to the UK from the Philippines and India as a result of COVID-19. The incidence of COVID-19 in other parts of the world, as well as the UK, is likely to have an impact, in the short term at least, on the ability of the NHS to recruit the numbers of nurses and midwives from outside the UK that it had planned. This places a greater premium on being able to retain those staff already employed by the NHS.
- 4.117 Much of this section has focused on the numbers joining the NHS after completing a traditional university degree. However, the service continues to develop new, less traditional ways of expanding the workforce. This includes pathways such as nursing associates, whose number continue to grow. The NHS also makes use of apprentices, to a similar extent as to other public sector employers, although the number of new apprentice starts in health, public services and care fell sharply in 2020. HEE told us about the introduction of a new blended nursing degree which started early in 2021, which it said was aimed at those who have the skills and aptitude to nurse but whose circumstances don't allow them to study in the traditional way. We look forward to receiving evidence in future rounds setting out the impact of these approaches.

Vacancies and shortage groups

- 4.118 NHS E&I publishes quarterly estimates of vacancies across the NHS in England. The latest data, for the third quarter of 2020/21, to December 2020, showed that overall, there were just under 89,000 total NHS vacancies, of which 36,214 were nursing vacancies, and 45,555 were in other, non-nursing, AfC staff groups (Figure 4.20).

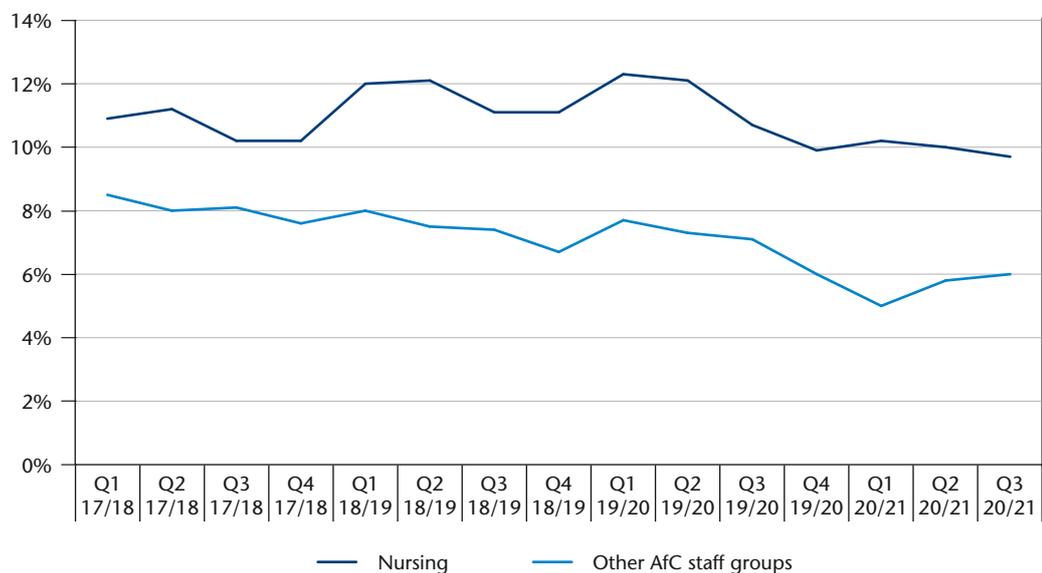
Figure 4.20: NHS Provider vacancies, England, 2017-18 quarter 3 to 2020-21 quarter 3



Source: OME calculations based on NHS E&I data

4.119 Figure 4.21 shows that in the third quarter of 2020/21 the nursing vacancy rate was 9.7%, down from 10.7% in the same quarter a year earlier, and from a peak of 12.3% in the first quarter of 2019/20. The vacancy rate for non-nursing AfC staff groups was 6.0% in the third quarter of 2020/21, down from 7.1% in the same quarter a year earlier, and from around 8% throughout 2017/18.

Figure 4.21: NHS Provider vacancy rates, nursing and non-nursing AfC staff groups, England, 2017/18 quarter 1 to 2020/21 quarter 3



Source: OME calculations based on NHS E&I data

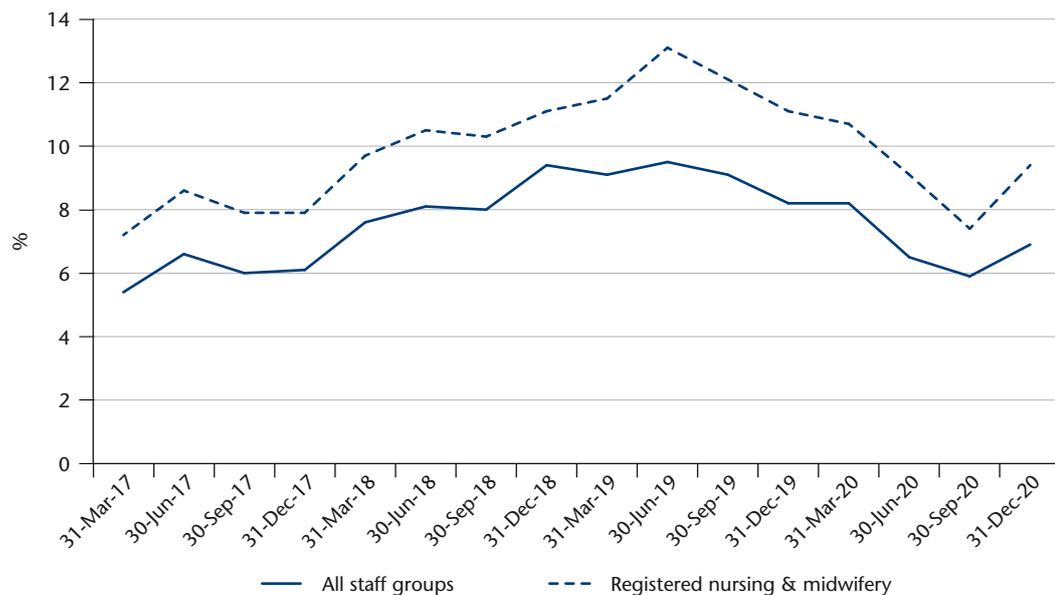
4.120 The NHS in Wales had 1,837 FTE advertised vacancies for non-medical staff in July 2020 (Table 4.6), down from 1,985 in July 2019, a fall of 7.5%.

Table 4.6 NHS Wales, advertised vacancies, by staff group, July 2019 and July 2020

	July 2019	July 2020
	Vacancies	
All Staff Groups (exc medical and dental)	1,985	1,837
Add Prof Scientific and Technic	121	66
Additional Clinical Services	258	359
Administrative and Clerical	404	376
Allied Health Professionals	203	155
Estates and Ancillary	48	83
Healthcare Scientists	39	39
Nursing and Midwifery Registered	912	759

Source: Welsh Government

4.121 For Northern Ireland the most recent data shows that at the end of December 2020 there was an overall vacancy rate of 6.9%, a reduction from 8.2% a year earlier (Figure 4.22). Over the same period, registered nursing and midwifery vacancies fell from 11.1% to 9.4%, nursing and midwifery support staff vacancies fell from 9.8% to 7.8%, and social workers' vacancies fell from 7.9% to 7.5%.

Figure 4.22: HSC, Northern Ireland, vacancy rate, March 2017 to December 2020

Source: Department of Health, Northern Ireland

Supply of bank and agency staff

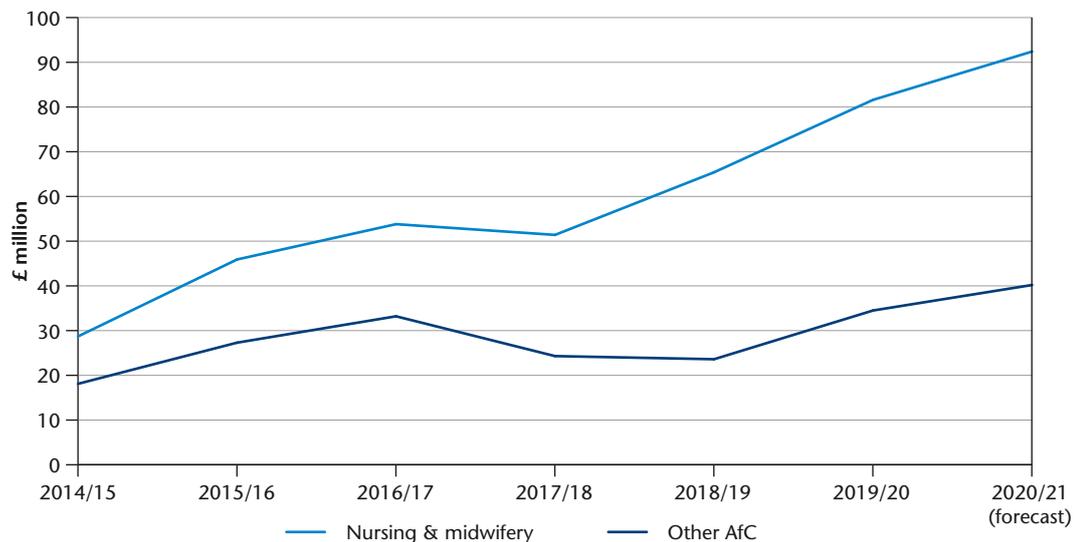
4.122 Bank and agency staff are an important source of temporary staffing, which allows trusts to respond to fluctuations in demand. While both bank and agency are used to fill gaps in the short term, employers generally see banks as more cost-effective and offering greater continuity of care, compared with the use of agency staff.

4.123 Following the introduction of agency spend controls in England in 2015, expenditure on agency staffing reduced to £2.4 billion in 2019/20 (from £3.6 billion in 2015/16). In the same period, agency costs had also now fallen to just above 4% of overall pay costs. The DHSC provided us with data on the proportion of agency spend that can be attributed to different staff groups in 2019/20:

- A total of £879 million (37% of total agency spend) was for nursing, midwifery and health visiting staff. Compared with 2018/19, this represents a fall of £35 million (4%); and
- A total of £583 million (24% of total agency spend) was for AfC staff, excluding nursing, midwifery and health visiting staff. Compared with 2018/19, this represents a fall of £35 million (6%).

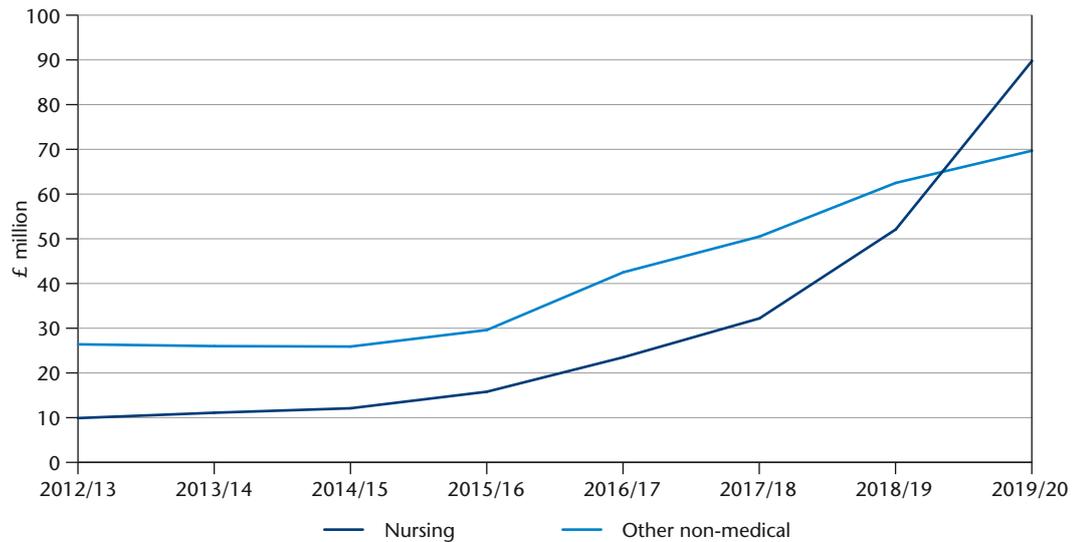
4.124 The Welsh Government’s evidence points to expenditure on nursing and midwifery increasing significantly, from £51.4 million in 2017/18 to £81.6 million in 2019/20, with a further increase to £92.4 million (13%) forecast for 2020/21 (Figure 4.23). The Welsh Government said that its programme of work to address the deployment of temporary staff had been paused as it recognised the need to take a pragmatic approach to ensure that the service was sufficiently staffed to meet the demands of COVID-19.

Figure 4.23: Agency spend, for AfC staff groups, Wales, 2014/15 to 2020/21



Source: Welsh Government

4.125 Figure 4.24 shows agency spend in Northern Ireland for nursing and other non-medical staff, increasing sharply since 2014/15, from £38 million, to £159 million in 2019/20. The increase in expenditure on nursing staff over that period was particularly large, from £12 million to £90 million.

Figure 4.24: Agency spend, for AfC staff groups, Northern Ireland, 2012/13 to 2019/20

Source: Department of Health, Northern Ireland

Our assessment of vacancies and shortage groups

- 4.126 Some level of vacancies is inevitable, as staff move into and out of roles in the NHS and HSC. However, vacancy rates at persistently high levels have the potential to impact on service delivery and the patient experience, as well as adding to the pressures on staff in place. This is reflected in the 2020 NHS Staff Survey results for England, where fewer than a half of AfC staff said that they were able to meet all the demands on their time at work, over 40% said that they had felt unwell as a result of work-related stress, a third said that they worked paid overtime and over half said that they worked unpaid extra hours. There is also a financial cost to carrying vacancies on a persistent basis, as gaps need to be filled through the use of banks or agencies.
- 4.127 Although vacancy rates remain persistently high, in particular for nursing, the data for each of the three countries does show some encouraging signs. The data for both England and Northern Ireland shows a welcome decline in vacancy rates since the middle of 2019, although the most recent data does show an increase in vacancies in the three months to December 2020. However, it is unclear what impact COVID-19 has had on vacancy rates and whether any longer-term decline will be maintained through 2021 and beyond.
- 4.128 Although the vacancy rate for nurses in England has fallen from over 12% at its peak, to just under 10%, this remains almost double the 5% target expressed in the NHS Long Term Plan for England. We note that a single vacancy figure for nursing as a whole can be misleading, with variations between trusts and areas of specialism. As the Health Foundation point out, a quarter of all nursing vacancies are in mental health, despite accounting for 12% of overall nursing numbers.

- 4.129 We heard from many of those giving evidence about the impact of carrying vacancies on existing staff and on the quality of care that patients receive. Failure to fill shifts places an increased burden on staff in post, which in turn can impact on their motivation, their wellbeing and their desire to continue working in the service. The NHS Staff Survey for England for 2020 showed a welcome increase in the percentage of staff saying that they thought there were enough staff at their organisation for them to do their job properly, and a reduction in the percentage saying that they were working unpaid hours over and above their contracted hours. However, there were still fewer than a third saying that there were sufficient staff at their organisation, and over a half of those responding said that they were extra unpaid hours. In addition, 40% of survey respondents said that they had felt unwell as a result of work-related stress. We have also heard that using bank, and particularly agency staff, to fill gaps can impact on the continuity, and quality of care provided to patients. We heard on our visits the way in which morale can be impacted by being asked regularly to work alongside staff members paid significantly higher rates for doing a similar job.
- 4.130 We recognise that many vacancies, while left unfilled in the medium and long term, are filled in the short-term by either bank or agency staff. Given the extra costs involved and the impact on continuity of care, we believe the use of agencies to fill gaps should be a last resort. We note the welcome progress that has been made in England, reducing agency spend from £3.6 billion in 2015/16 to £2.4 billion in 2019/20.
- 4.131 Agency spend, however, has increased sharply in Wales between 2017/18 and 2019/20, and is forecast to increase further in 2020/21. The Welsh Government said that its programme of work to address the deployment of temporary staff in the NHS has been paused due to the pandemic. We encourage the Welsh Government to resume this work as soon as practicable and we look forward to hearing in evidence about the All Wales Collaborative Bank that has been developed, and how effective it is in reducing agency spend. Agency spend in Northern Ireland has risen sharply since 2015/16 and despite a recent fall in vacancy rates, shows no sign of levelling out or falling. The Department of Health, Northern Ireland said that senior managers had been asked work together collaboratively to develop a plan to reduce agency expenditure but progress had stalled over the last year and would be picked up again later in 2021. Again, we encourage the parties in Northern Ireland to resume this work as soon as practicable.

Morale and motivation

- 4.132 A key element of our terms of reference is the motivation of AfC staff and in this section, we comment on the latest employee opinion data from staff surveys held across England, Northern Ireland and Wales. The surveys in England and Wales took place at similar times, between the first and second waves of COVID-19. The impact of COVID-19 on the morale and motivation of the HSC workforce in Northern Ireland will be assessed in our future reports once staff survey data is available.

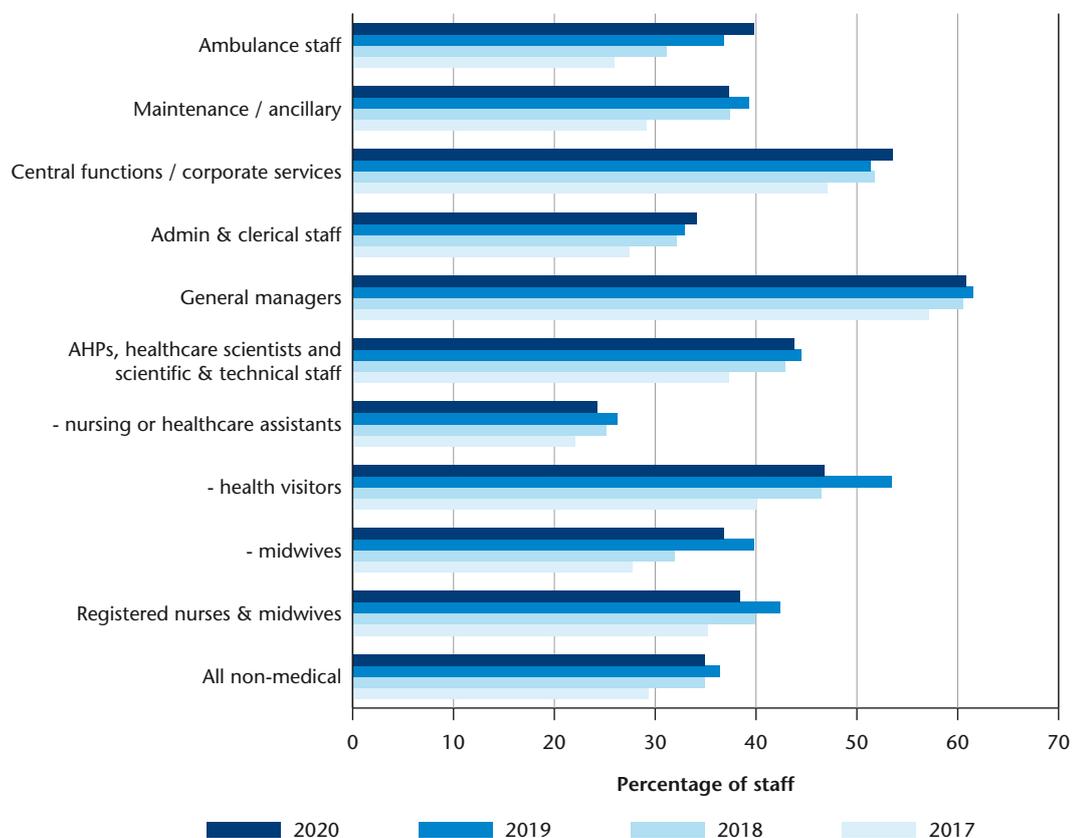
NHS Staff Survey (England)

- 4.133 Since our report in 2020, the survey of NHS staff in England was published. It was conducted in October and November 2020, between the first and second waves of COVID-19. There were 595,000 responses, a response rate of 47%, down slightly from 48% in 2019.

4.134 Figure 4.25 shows AfC staff satisfaction⁷¹ with pay between 2017 and 2020. Satisfaction with pay declined in 2020, compared with 2019, by 1.5 percentage points. In 2020, 34.9% of staff responded positively to the survey, saying they were satisfied with pay, compared with 39.6% who said they were dissatisfied⁷². For specific groups, the 2020 results, compared with 2019, showed:

- A decrease in satisfaction with pay for most staff groups. Registered nurses and midwives satisfaction with pay decreased by 4.0 percentage points, including a particularly sharp fall in satisfaction with pay for health visitors, of 6.7 percentage points;
- The only groups to show an increase in satisfaction with pay were ambulance staff, staff in central functions/corporate services and administration and clerical staff;
- General managers remained the group most satisfied with pay (60.8%); and
- Nursing and healthcare assistants continued to have the lowest satisfaction with pay, at 24.3%, following a fall of 2.0 percentage points from 2019.

Figure 4.25: Satisfaction with level of pay by staff group, England, 2017 to 2020



Source: National NHS Staff Survey (England)

⁷¹ In each case, satisfied refers to participants answering that they were “satisfied” or “very satisfied” with their level of pay.

⁷² In each case, dissatisfied refers to participants answering that they were “dissatisfied” or “very dissatisfied” with their level of pay.

- 4.135 Although satisfaction with pay fell between 2019 and 2020, this followed two years where satisfaction with pay had increased. Comparing the results for 2020 with 2017, the last survey conducted before the 2018 AfC pay deal was agreed, satisfaction with pay was 5.5 percentage points higher, while dissatisfaction with pay declined by 7.0 percentage points over the same period. All major staff groups showed an increase in satisfaction with pay over the period, with the largest increases in satisfaction for ambulance staff (up 13.8 percentage points), midwives (9 percentage points), and maintenance and ancillary staff (8.1 percentage points). Those with the smallest increase in satisfaction were nursing and healthcare assistants (2.3 percentage points) and registered nurses and midwives (3.1 percentage points).
- 4.136 Table 4.7 below provides a selection of NHS Staff Survey results on engagement and satisfaction. Generally, the results are less positive than in 2019. The largest falls in positive responses were for enthusiasm about the job (1.6 percentage points), satisfaction with pay (1.5 percentage points), and time passing quickly when working (1.1 percentage points). However, there was a reduction in the percentage of staff saying that they had experienced harassment, bullying or abuse from patients, relatives or the public in the previous 12 months.
- 4.137 Table 4.8 provides a selection of NHS Staff Survey results on working pressures. Compared with 2019, the results were generally more positive, with increases in the percentage who said that they were able to meet all the conflicting demands on their time at work, that they had adequate materials, supplies and equipment to do their work and that there were enough staff at their organisation to do their job properly. However, there was also an increase, for the fourth consecutive year, to 44%, in the percentage of staff who said that they felt unwell as a result of work-related stress. Registered nurses and midwives (46%), and ambulance staff (45%) were the staff groups most likely to report feeling unwell as a result of work-related stress.

Table 4.7: Selected job satisfaction results from the national NHS staff survey, AfC staff, England, 2011 to 2020

Measure	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Trend ¹
Engagement and job satisfaction											
I look forward to going to work	49.9	51.7	52.1	51.6	57.1	57.9	56.9	58.2	58.8	58.3	
I am enthusiastic about my job	65.1	67.3	68.1	67.7	73.3	73.8	73.1	74.1	74.5	72.9	
Time passes quickly when I am working	73.3	74.2	74.3	73.8	76.8	76.6	75.8	75.8	76.2	75.1	
The recognition I get for good work	45.8	48.7	49.4	49.9	51.8	53.0	52.8	56.5	57.9	57.2	
The support I get from my immediate manager	63.5	65.4	66.0	66.1	67.2	68.3	68.8	70.2	71.2	70.5	
The support I get from my work colleagues	76.4	78.4	78.3	78.4	80.8	81.5	81.3	81.6	81.7	81.1	
The amount of responsibility I am given	70.5	73.4	73.1	72.8	73.3	73.8	73.1	74.1	74.5	74.0	
The opportunities I have to use my skills	65.5	69.9	69.6	69.6	69.9	70.6	69.9	71.0	71.5	71.1	
The extent to which my organisation values my work	33.3	40.0	40.4	40.8	41.1	43.1	42.9	46.3	48.0	48.0	
My level of pay	38.7	37.4	35.8	30.9	34.6	35.2	29.4	34.9	36.4	34.9	
Percentage of staff appraised in the last 12 months	80.6	83.2	83.8	83.5	85.4	86.5	86.4	88.1	87.9		
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months ²		29.5	28.9	28.2	28.0	27.5	27.5	27.8	28.1	26.4	

Source: NHS Staff Survey (England)

Notes:

(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and full range of possible scores for each measure.

(2) Lower scores are better in this case.

Table 4.8: Selected working pressures results from the national NHS Staff Survey, AfC staff, England, 2011 to 2020

Measure	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Trend ¹
Workload											
I am unable to meet all the conflicting demands on my time at work ^{2,3}	41.9	43.2	44.3	44.7							
I am able to meet all the conflicting demands on my time at work ⁴					42.9	45.1	45.0	45.6	46.7	48.2	
I have adequate materials, supplies and equipment to do my work	58.9	56.5	55.8	55.7	54.6	55.5	54.7	55.4	56.6	60.8	
There are enough staff at this organisation for me to do my job properly	30.2	30.1	29.2	28.6	29.9	31.4	31.2	32.3	32.6	38.6	
During the last 12 months have you felt unwell as a result of work related stress ²		38.6	39.6	40.0	37.8	37.2	38.7	40.0	40.6	44.2	
Percentage of staff working PAID hours over and above their contracted hours ²	25.4	30.0	30.2	30.2	31.1	31.5	32.2	33.2	34.4	33.2	
Percentage of staff working UNPAID hours over and above their contracted hours ²	53.1	56.1	57.0	58.1	59.0	57.1	56.4	55.7	53.9	53.5	

Source: NHS Staff Survey (England)

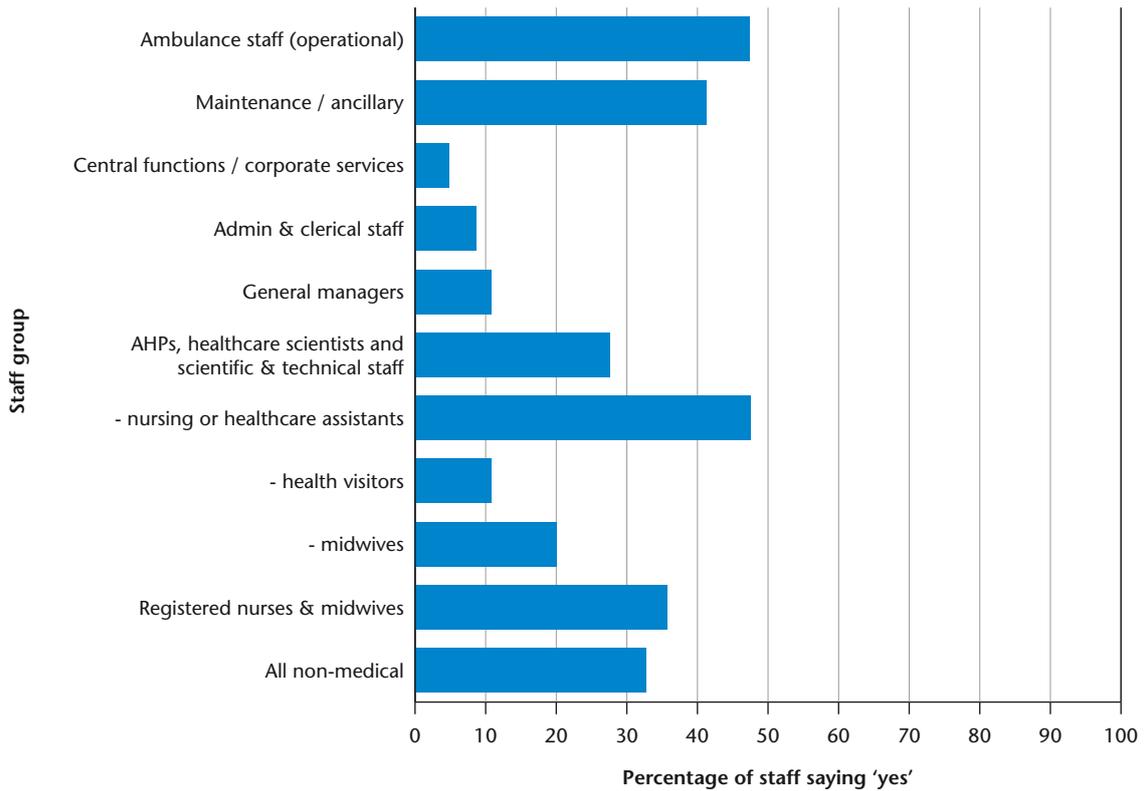
Notes:

- (1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and full range of possible scores for each measure.
- (2) Lower scores are better in this case.
- (3) For 2015 this question was reversed to "I am able to meet ..."
- (4) This question was introduced in 2015.

4.138 In addition to the usual range of questions, staff were asked, as part of the 2020 survey, about their experiences during the COVID-19 pandemic. Key points include:

- 33% of AfC staff said that they had worked on a COVID-19 ward or area at any time. Nursing and healthcare assistants and operational ambulance staff were the staff groups most likely to have done so (47%) (Figure 4.26);

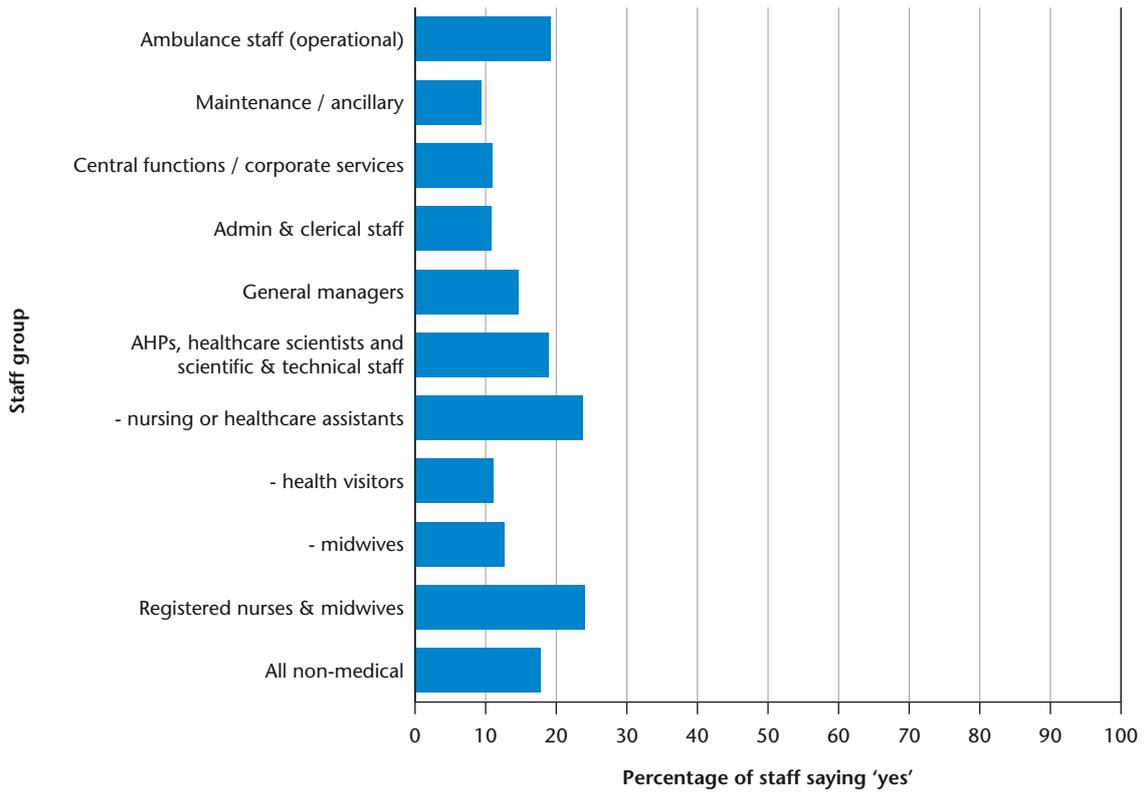
Figure 4.26: Staff saying they had worked on a COVID-19 specific ward or area, from the national NHS staff survey, AfC staff, England, 2020



Source: NHS Staff Survey (England)

- 18% of AfC staff said that they had been redeployed due to the COVID-19 pandemic at any time. Registered nurses and midwives and nursing and healthcare assistants were the staff groups most likely to have done so (24%) (Figure 4.27); and

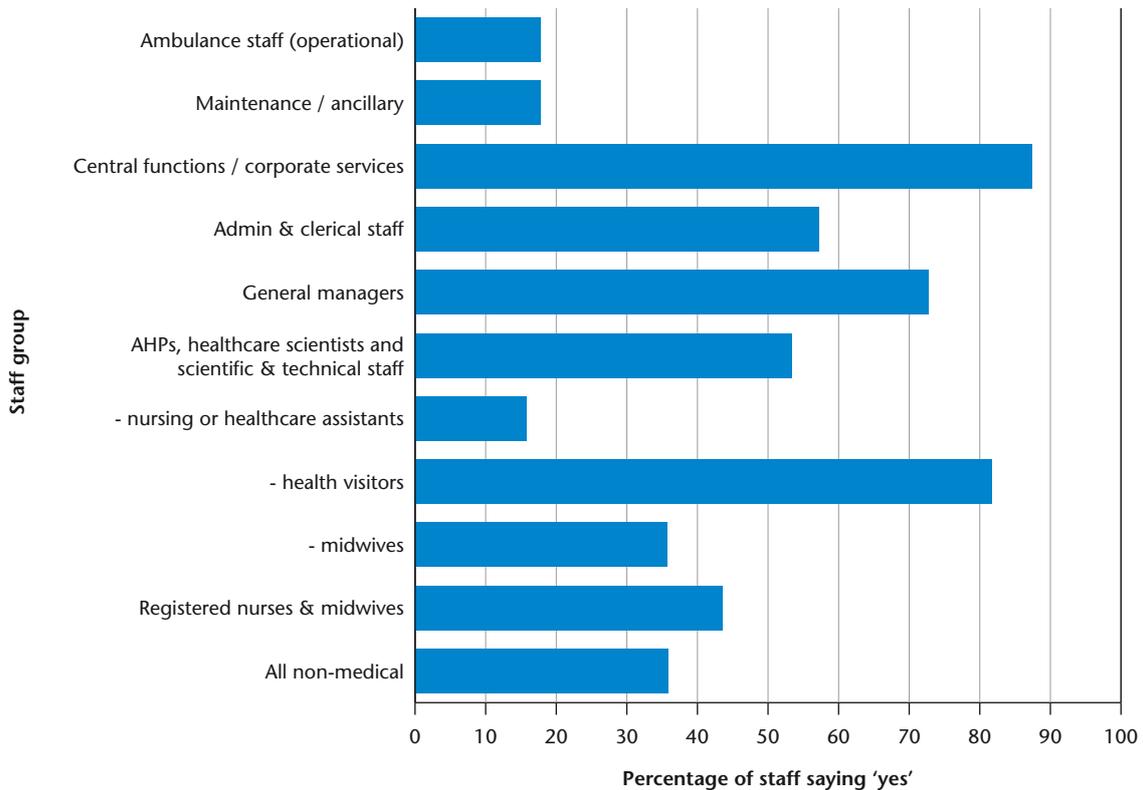
Figure 4.27: Staff saying they had been redeployed due to the COVID-19 pandemic at any time, from the national NHS staff survey, AfC staff, England, 2020



Source: NHS Staff Survey (England)

- 36% of AfC staff said that they had been required to work remotely/from home due to the COVID-19 pandemic. More than 80% of health visitors and staff in central functions and corporate services said that they had done so (Figure 4.28).

Figure 4.28: Staff saying they had been required to work remotely/from home due to the COVID-19 pandemic, from the national NHS staff survey, AfC staff, England, 2020



Source: NHS Staff Survey (England)

HSC Northern Ireland Staff Survey

4.139 In 2019 the Northern Ireland Statistics and Research Agency conducted a survey of Health and Social Care staff in Northern Ireland, which we reported on in our 2020 Report. The Department of Health, Northern Ireland, said that each HSC organisation was responsible for taking forward work in response to the survey, but that this work had been paused as a result of COVID-19 pressures.

NHS Wales Staff Survey

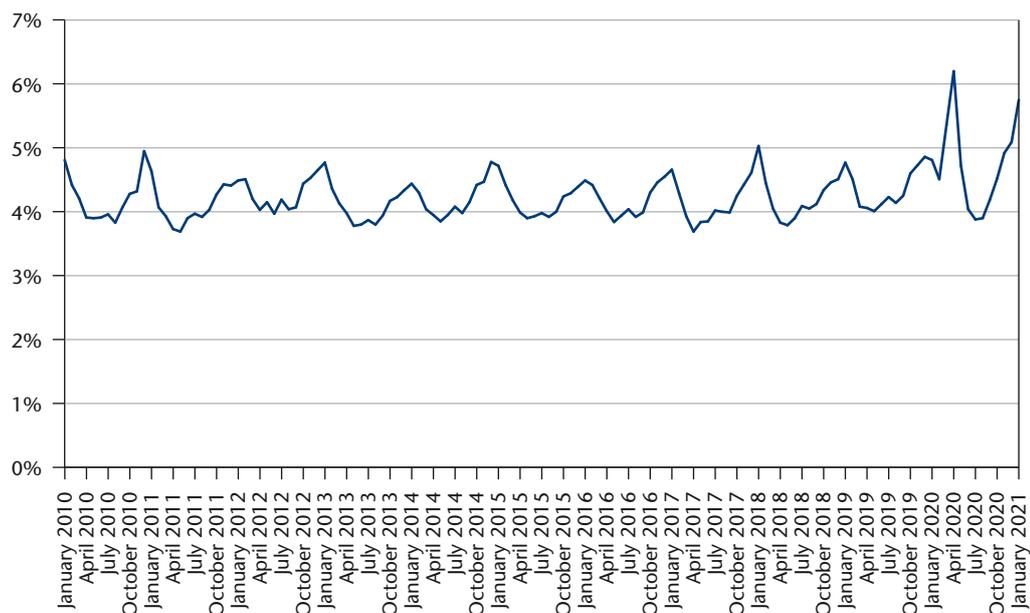
4.140 The Welsh Government said that it had run a shorter staff survey in November 2020 than in previous years, following concerns that a longer survey would adversely affect response rates. The 2020 survey achieved a response rate of 20%, down from 29% in 2018. The Welsh Government said that considering the current circumstances, a lower response rate was to be expected. It went on to say that between 2018 and 2020 there had been:

- A reduction in bullying, harassment and abuse from managers (from 18% to 10%), members of the public (21% to 15%), and other colleagues (18% to 17%);
- An increase in the percentage of staff feeling enthusiastic about their work (68% to 77%);
- An increase in people saying that they would tell others that they were proud to work for the NHS (from 72% to 73%); and
- A reduction in people saying that they had confidence that action would be taken to address issues raised by the survey (from 50% to 24%).

Sickness absence

4.141 Figure 4.29 shows sickness absence rates in England for staff as a whole between January 2010 and January 2021. Between January 2010 and February 2020, monthly sickness absence rates fluctuated within a narrow range of 3.7% to 5.0%. However, in March and April 2020, as a result of COVID-19, sickness absence rates increased to 5.4% and 6.2% respectively. Absence rates then fell back below 4% during the summer of 2020, below levels seen during the summer of 2019. Sickness absence rates increased again, through the autumn of 2020, and by January 2021 had reached 5.7%.

Figure 4.29: Sickness absence rates in England, all staff, January 2010 to January 2021



Source: NHS Digital

4.142 Since March 2020, NHS Digital have been publishing estimates of NHS sickness related to COVID-19. Table 4.9 shows that absence related to COVID-19 was relatively high between March and May 2020, peaking at 1.9% in April 2020. Absence related to COVID-19 has increased again in December 2020 and January 2021, to a level only exceeded in April 2020. Between March 2020 and January 2021 approaching 3 million working days have been lost for reasons related to COVID-19.

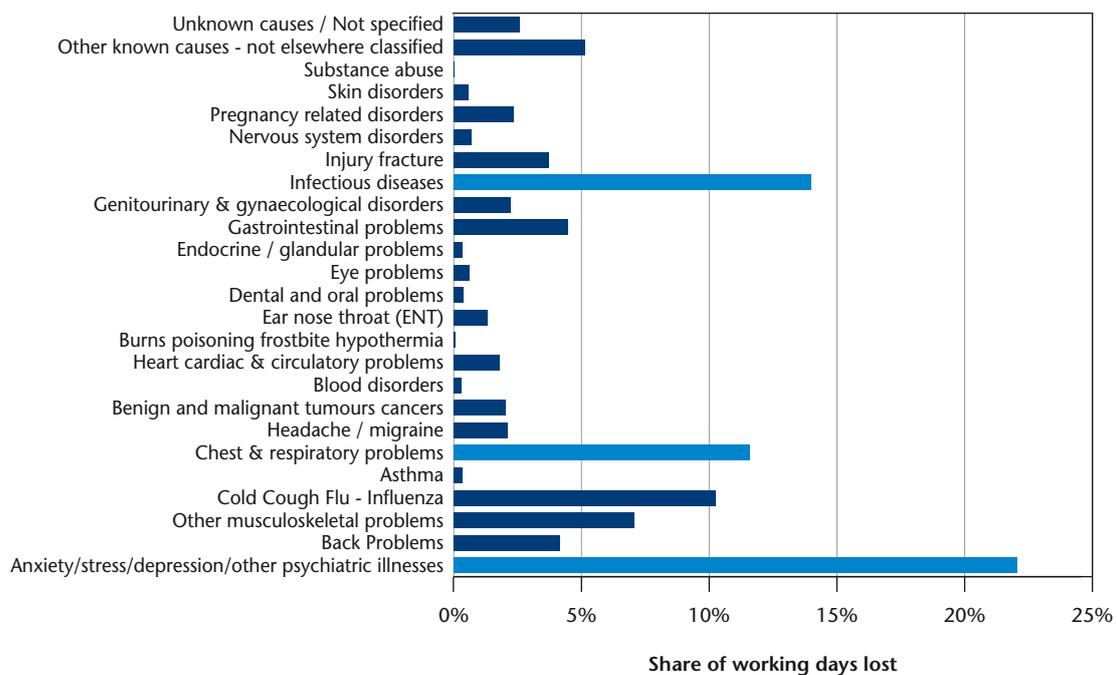
Table 4.9: Sickness absence rates, NHS England, March 2020 to January 2021, non-COVID-19 and COVID-19 related

	Overall sickness rate	Non-COVID-19 related absence	COVID-19 related absence	Days absence related to COVID-19 (AfC staff)
Mar-20	5.4%	4.5%	0.8%	281,867
Apr-20	6.2%	4.3%	1.9%	635,089
May-20	4.7%	3.8%	0.9%	320,815
Jun-20	4.0%	3.6%	0.4%	138,203
Jul-20	3.9%	3.7%	0.2%	79,963
Aug-20	3.9%	3.7%	0.2%	57,086
Sep-20	4.2%	3.9%	0.2%	83,592
Oct-20	4.5%	4.1%	0.4%	154,987
Nov-20	4.9%	4.2%	0.8%	268,809
Dec-20	5.1%	4.2%	0.9%	338,536
Jan-21	5.7%	4.1%	1.6%	606,654
	Total Days absence related to COVID-19 (AfC staff)			2,965,598

Source: NHS Digital

4.143 Figure 4.30 shows the percentage of sickness absence days in January 2021, the most recent month for which data is available, by cause (COVID-19 and non-COVID-19 related). Despite COVID-19 leading to an increase in sickness absence, anxiety/stress/depression/other psychiatric illnesses still accounted for 22% of all absence in that month. The impact of COVID-19 was reflected in the data by infectious diseases accounting for 14% of all absence and chest and respiratory problems accounting for a further 12%.

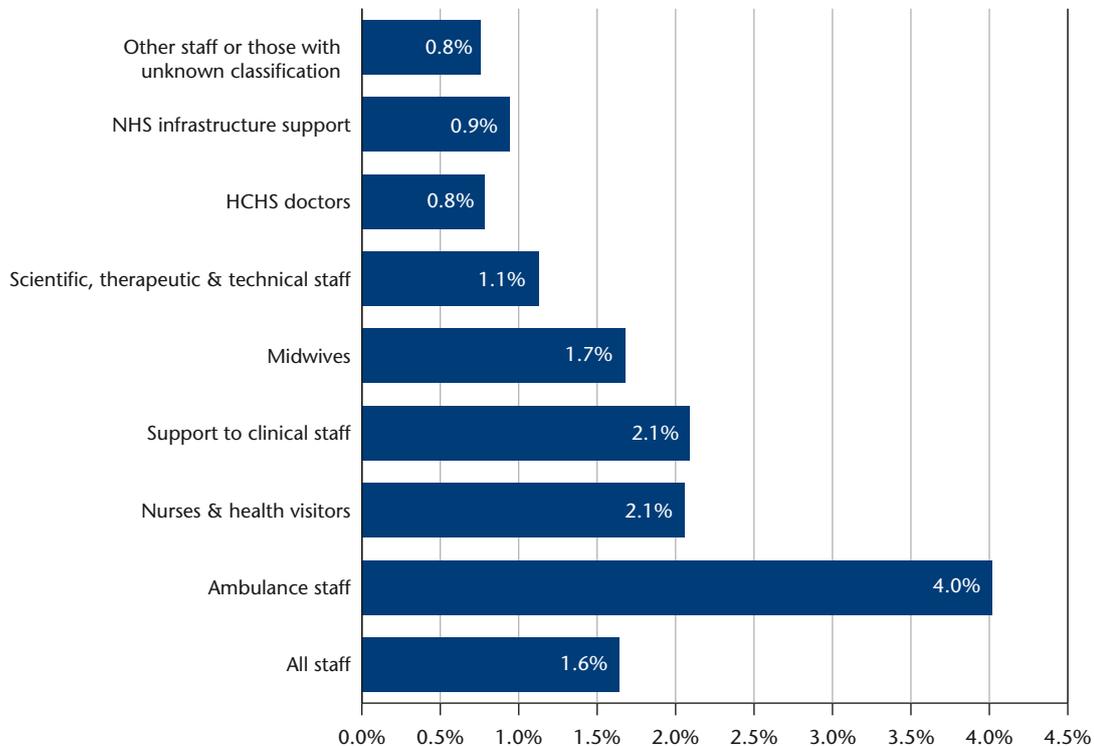
Figure 4.30: Reasons for sickness absence, England, all staff (excluding medical and dental), January 2021



Source: NHS Digital

4.144 COVID-19 has impacted on sickness absence rates for staff groups in different ways. Figure 4.31 shows that in January 2021, that ambulance staff, nurses and health visitors, support to clinical staff and midwives saw the largest amount of absence related to COVID-19.

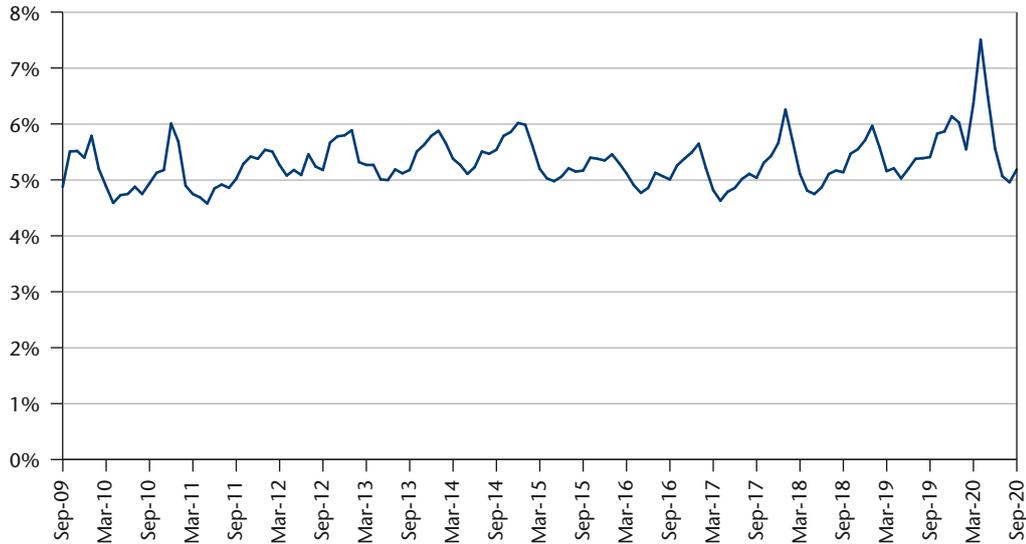
Figure 4.31: Rates of sickness absence attributable to COVID-19, England, January 2021, by staff group



Source: NHS Digital

4.145 Figure 4.32 shows sickness absence rates in the NHS in Wales between September 2009 and September 2020. Between July 2009 and February 2020, the overall sickness absence rate fluctuated in a range between 4.6% and 6.3%, but sickness absence rates spiked between March and May 2020, peaking at 7.5% in April 2020. During the summer of 2020 sickness absence rates eased and were lower than they had been a year earlier. However, September 2020 saw the first increase in sickness absence since April 2020.

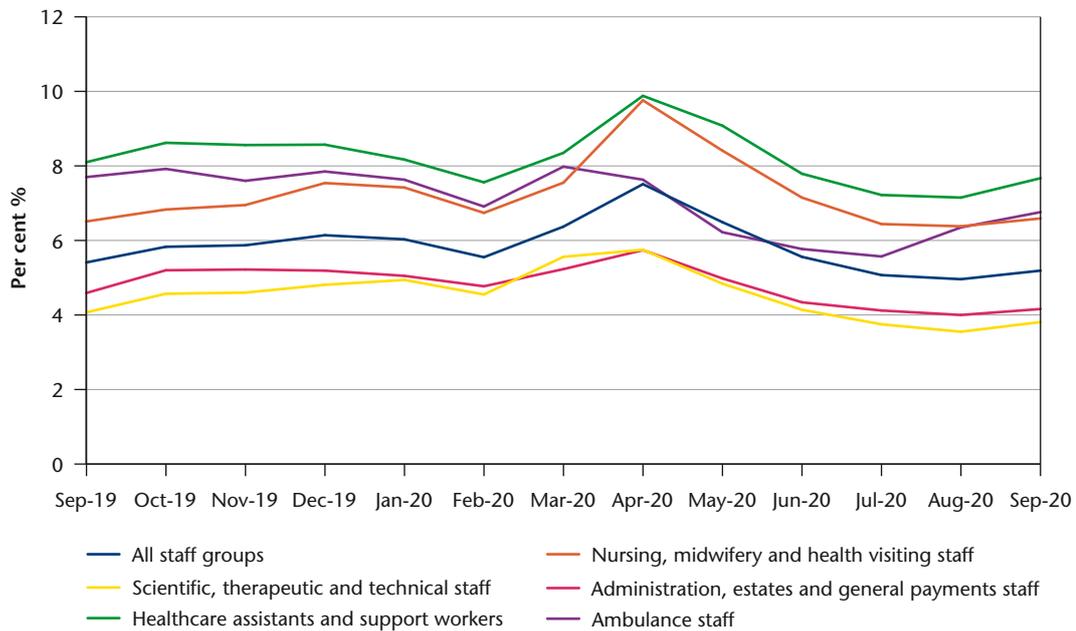
Figure 4.32: Sickness absence rates, Wales, 2009 to 2020, %



Source: Stats Wales

4.146 Figure 4.33 shows rates of sickness absence in Wales, by staff group, between September 2019 and September 2020. In April 2020, the month in which sickness was at its highest during the first wave of COVID-19, absence rates were highest for healthcare assistants and support workers (9.9%) and nurses, midwives and health visitors (9.8%).

Figure 4.33: Sickness absence rates, Wales, by staff group, September 2019 to September 2020, %



Source: Stats Wales

Our overall assessments on morale and motivation

- 4.147 The 2020 NHS Staff Survey in England is particularly informative this year. The survey, which attracted almost 600,000 responses, is the only service wide survey conducted since the COVID-19 pandemic began, that is in a form that allows comparisons with previous years, and also asks about satisfaction with pay. The 2020 survey in England was conducted in October and November 2020, after the first wave of COVID-19 had abated, but before the second wave. We note that the views of participants may have been affected by the timing in relation to COVID-19, and that if the survey had been conducted either in the spring of 2020, or early in 2021, the results may have been different.
- 4.148 As we come to the end of the 2018 AfC pay agreement, the results from this survey give us an opportunity to see if staff feel differently about their pay now, than they did in 2017. The results show that, despite a small fall in satisfaction with pay in 2020, compared with 2019, since 2017 there has been an increase in the percentage of staffing saying that are satisfied with their pay, from 29% in 2017, to 35% in 2020. All staff groups saw an increase in satisfaction with pay over the period, although those groups recording the smallest improvements in satisfaction were nurses and midwives, and nursing and healthcare assistants, two groups who saw some of the smallest increases in average earnings over the period of the deal.
- 4.149 Many of the indicators of job satisfaction showed a decline between 2019 and 2020. Staff were less likely to say that they looked forward to going to work or were enthusiastic about their job, were less satisfied with the support they received from their managers and colleagues, and the recognition they got for their work. There was a welcome decline in the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the past year, although it is unclear what impact changes in working practices resulting from COVID-19 had on interactions between staff and relatives and the public.
- 4.150 In addition to the usual suite of questions the survey this year asked staff about their experiences of COVID-19. The results showed that staff will have had a wide variety of experiences. Around a third of staff said that they had worked in a COVID-19 ward or area at any time, with almost 50% of ambulance staff and nursing and healthcare assistants saying that they had done so. Over a third of staff reported having to work remotely/from home during the pandemic, with over 80% of health visitors and staff in central functions and corporate services having done so. The results showed that 18% of staff said that they had been redeployed due to COVID-19, with almost a quarter of registered nurses and midwives and nursing and healthcare assistants saying that they had done so.
- 4.151 One aspect of the AfC pay agreement in England had been the emphasis on progression. The survey usually asks if staff have had an appraisal, and results for recent years have been on an upward trend. However, this year, as the survey was being developed, training and appraisals were put on hold because of the COVID-19 pandemic, so the section on personal development (including appraisals) was removed for the 2020 survey. We hope that this section of the survey is reintroduced for 2021, as the effectiveness of the system of progression is dependent on staff receiving effective appraisals.

- 4.152 In the years prior to 2020, sickness absence rates in both England and Wales fluctuated within narrow ranges. However, data for both countries showed a sharp increase in sickness absence in the spring of 2020, coinciding with the first wave of COVID-19. Sickness absence rates recorded in the summer of 2020, had fallen back from the spring peaks and were at levels seen in previous years. However, the data for England, to January 2021, show a further increase in sickness absence as the second wave of COVID-19 started to build. We expect that as the data becomes available, sickness absence rates will increase further still in the early part of 2021, as the incidence of COVID-19 increased again.
- 4.153 Not surprisingly, the data for England showed an increase in the amount of sickness absence attributed to ‘infectious diseases’ and ‘chest and respiratory problems’ through 2020. Nevertheless, even at the times when sickness rates had increased as a result of COVID-19, over a fifth of all recorded sickness absence was attributed to anxiety, stress, depression, and other psychiatric illnesses, decreasing slightly as a proportion to 22% in January 2021, from 24% in January 2020.
- 4.154 The NHS Staff Survey for 2020 showed that a significant percentage of staff were away from work because they were shielding, for themselves, or for another member of their household. It is likely that trusts will have recorded such absence in different ways, for example, one approach could be to record absence as special leave. This means that the sickness absence figures may underestimate the overall extent of staff absence.
- 4.155 Having a well-motivated workforce is key if the NHS is to expand services to recover the ground lost in 2020. There is clear evidence that the 2018 AfC pay deal has had a positive impact on satisfaction with pay, with those whose pay increased more showing higher levels of satisfaction than those who had lower increases. However, other aspects related to wider job satisfaction are less positive, and it may be possible that the results from the 2020 NHS Staff Survey, undertaken when the incidence of COVID-19 was some way below its peak, may portray a more positive picture than the situation through the winter of 2020/21 or at the time of writing. The increase in the numbers saying that their organisation had sufficient staff was encouraging and may reflect the increase in staffing numbers since the middle of 2018. Nevertheless, pressures on staff remain high, and trusts will find it challenging to expand services, at the same time as enhancing the wellbeing of their staff.

Retention

- 4.156 Table 4.10 shows joining and leaving rates in England⁷³, and Northern Ireland, by staff group. For both England and Northern Ireland, in 2019/20, the joining rates were greater than the leaving rates for each staff group. Although the response to COVID-19 would have seen an increase in staff joining the NHS and HCS, much of this would have taken place after March 2020, and so will not show up in these figures.
- 4.157 In England, in 2019/20, the leaving rate was 9.9% across all staff groups. With the exception of ambulance staff (7.9%), the leaving rates for all groups were within a relatively narrow range of 9.5% to 10.2%. The largest gap between joining and leaving rates was for support to clinical staff (16.5% joining rate, 10.2% leaving rate).
- 4.158 In Northern Ireland, in 2019/20, the leaving rate was 5.4% across all staff groups. Leaving rates ranged between 4.0% for professional and technical staff and 6.7% for estates services staff. Despite having the highest leaving rate, a joining rate of 12.3% meant that the largest gap between joining and leaving rates was for estates services staff.

⁷³ Joiners and leavers data for England exclude internal transfers, so are net flows into and out of the NHS in England.

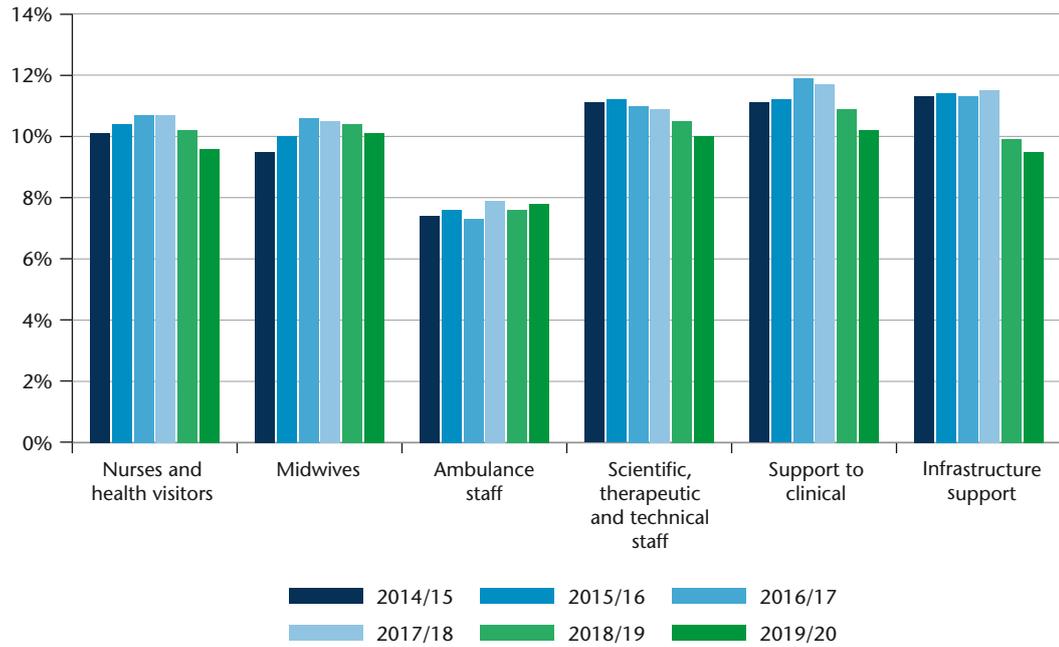
Table 4.10: Leaving and joining rates to the NHS by staff group headcount and country, year to March 2020

England	Leaving rate	Joining rate	Percentage point diff
AfC Staff (exc bank and locums)	9.9%	13.8%	4.0
Nurses & health visitors	9.6%	12.4%	2.9
Midwives	10.1%	12.0%	1.9
Ambulance staff	7.9%	8.3%	0.5
Scientific, therapeutic & technical staff	10.0%	12.4%	2.4
Support to clinical staff	10.2%	16.5%	6.3
NHS infrastructure support	9.5%	12.8%	3.3
Northern Ireland	Leaving rate	Joining rate	Percentage point diff
AfC Staff	5.4%	8.3%	2.9
Administration & clerical	5.0%	7.7%	2.7
Estates services	6.7%	12.3%	5.6
Support services	5.2%	8.0%	2.8
Nursing & midwifery	6.2%	8.4%	2.2
Social services (excl. dom.care)	5.5%	8.7%	3.2
Professional & technical	4.0%	8.7%	4.7
Ambulance	4.3%	5.7%	1.4

Sources: NHS Digital, and the Department of Health, Northern Ireland.

4.159 Figure 4.34 looks at leaving rates for different staff groups in England, between 2014/15 to 2019/20. The figure shows that, except for ambulance staff, leaving rates fell in both 2018/19 and 2019/20. The leaving rate for nurses and health visitors, fell from 10.7% in 2017/18, to 10.2% in 2018/19 and 9.6% in 2019/20. Although the leaving rate for ambulance staff rose slightly in 2019/20, compared with 2018/19, the leaving rate for this group remains relatively low compared with other groups.

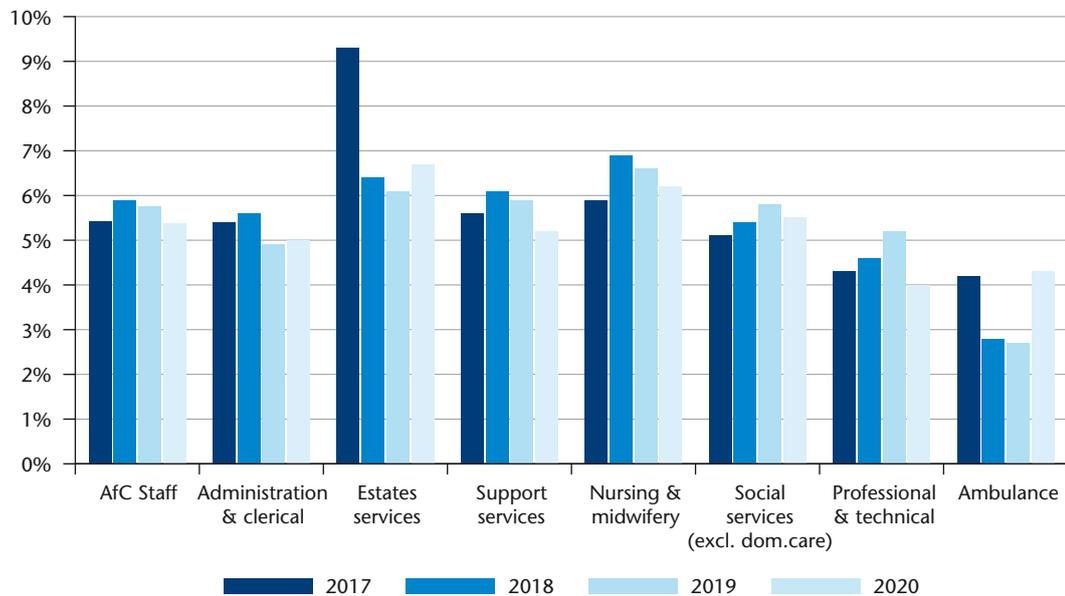
Figure 4.34: Annual leaving rates, England 2014/15 to 2019/20, by staff group



Source: NHS Digital

4.160 Figure 4.35 looks at leaving rates for different staff groups in Northern Ireland, between 2016/17 to 2019/20. In Northern Ireland, the leaving rate for AfC staff as a whole, fell from 5.9% in 2017/18, to 5.8% in 2018/19 and 5.4% for 2019/20. The leaving rate for nursing and midwifery staff fell from 6.9% in 2017/18, to 6.6% in 2018/19, and 6.2% in 2019/20.

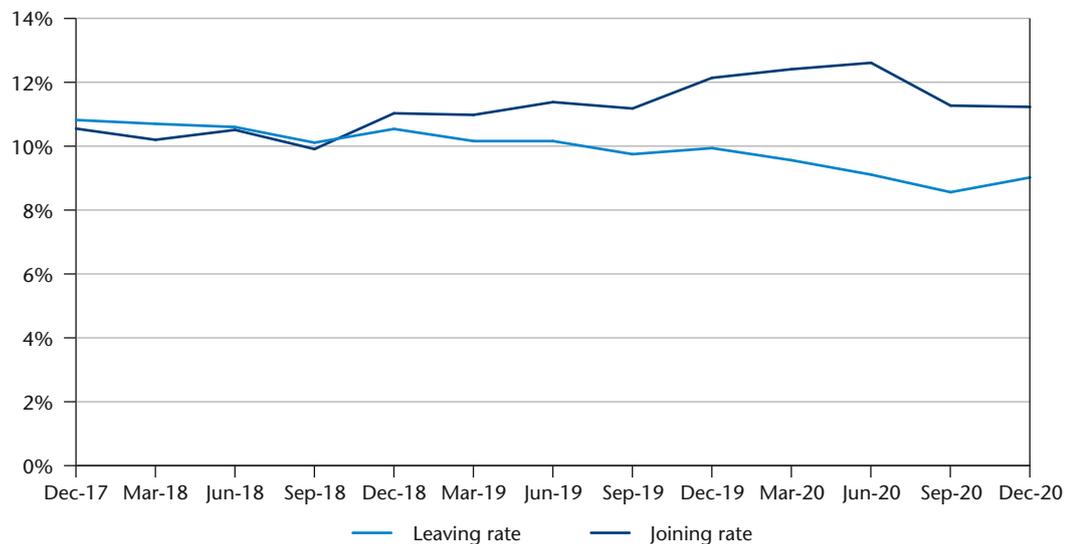
Figure 4.35: Annual leaving rates, Northern Ireland 2016/17 to 2019/20, by staff group



Source: Department of Health, Northern Ireland

4.161 NHS Digital produce leavers and joiners data on a quarterly basis, for England, with the latest data covering the period to December 2020. Figure 4.36 shows that the joining rate for nurses and health visitors fell back in the second half of 2020, following a period of growth from September 2018 onwards. The leaving rate fell from the end of December 2018 onwards, to 8.6% in the year to September 2020. However, the latest data, for the year to December 2020 showed an increase in the leaving rate, to 9.0%.

Figure 4.36: Leaving and joining rates, nurses and health visitors, England, December 2017 to December 2020



Source: NHS Digital

4.162 NHS Digital publish data for England, showing reasons why staff left the NHS. The most common reasons given for leaving were: voluntary resignation (45%) and retirement (14%). For a further 30% of staff leaving the NHS, reasons for leaving were unknown. Amongst those leaving voluntarily, 9% of all leavers said that they did so for reasons related to work-life balance and a further 2% said that they left for a better reward package. However, given the large percentage of leavers for whom no information is available, this data is of limited value.

Our assessment of retention

4.163 Most of the data we have received covers the period to the end of March 2020, and so was little affected by COVID-19. Staffing numbers have been increasing and the outflow data for both England and Northern Ireland show a fall in leaving rates in both 2018/19 and 2019/20. Although we cannot be sure that the falls in outflow are a result of the increases in pay associated with the three-year AfC deal, there is a correlation between falling outflow rates and increased pay.

4.164 More recent data for England only, shows that the leaving rate for nurses and health visitors has continued to fall through much of 2020, although data for the final quarter did show an upturn in outflow. Although we cannot be certain why outflow rates have fallen through 2020, some parties have suggested that the fall may have been due to some staff choosing to remain in the NHS to help the response to COVID-19, while others may have found reduced employment opportunities outside the NHS as the wider economy was affected by COVID-19.

- 4.165 While increases in the numbers applying to study for degrees in subjects related to the provision of healthcare are welcome, these will not feed through to qualified staff working in the NHS for three to four years. In addition, threats to the ability to recruit from overseas, as a result of COVID-19, highlight the importance of retaining existing staff. Data show that over the period of the 2018 AfC agreement, staffing numbers have increased, as outflow has fallen and has been exceeded by joining rates. While this is encouraging there are a number of significant risks to the retention of staff.
- 4.166 We heard from the parties that the effects of coping with COVID-19, professionally and personally, was having a detrimental effect on the wellbeing of staff. Many had worked directly on COVID-19 wards or areas at some point during the pandemic, with a significant number reporting exhaustion or burnout, and in the 2020 NHS Staff Survey for England, over 40% of staff reported having felt unwell as a result of work-related stress in the last 12 months. This poses a particular challenge, at a time when the service looks to clear the backlog of work and treatments that have built up since the spring of 2020. To be able to do this effectively, the service will need to make sure it retains enough staff, to ease workload pressures on staff, and to provide services for patients. The concerns we heard from the parties were largely echoed in the House of Commons Health and Social Care Committee *Workforce burnout and resilience in the NHS and social care* report. The committee heard that COVID-19 had exacerbated existing challenges around workforce, burnout and resilience. The report concluded that workforce burnout across the NHS and social care had ‘reached an emergency level’.
- 4.167 Many parties, including DHSC and NHS E&I, have expressed concern that resignations may rebound if more external opportunities become available as the economy recovers. The timing and strength of any economic upturn and the impact it might have on the ability of the NHS to retain its staff is unclear at present. The impact on different staff groups is also likely to vary, depending on how widespread external opportunities are for particular trades and skills. The NHS needs to be well placed to meet external challenges from other potential employers, through offering competitive pay and reward, and being recognised as a good employer.
- 4.168 A further retention risk relates to the numbers of more experienced staff choosing to retire. A consequence of the McCloud Court of Appeal Judgement relating to the reform of public sector pensions will provide new options for staff about whether to remain in the service or to retire and take their pension.
- 4.169 Although the results of the 2020 NHS Staff Survey for England were more positive than might have been expected, we are open to the possibility that this is a result of the survey being conducted in October and November 2020, between the first two waves of COVID-19. It is important, therefore, that we take this into account when considering the survey results.
- 4.170 In our 2020 report we highlighted the weaknesses of the data looking at the reasons for leaving, with there being no specific information on why many of those leaving chose to do so. There was no improvement in the quality of the data we saw this year, and again we encourage the parties to provide us with more comprehensive data for us to consider next year.

Earnings

4.171 The 2018 AfC pay agreement spans the period between April 2018 and March 2021. The latest data, for England, covers the period up to and including December 2020. An analysis of basic pay⁷⁴ and overall earnings⁷⁵ growth between the year to December 2017 and the year to December 2020, can be used as a proxy for basic pay and earnings growth across the span of the agreement so far (Table 4.11). The further removal of pay points on Bands 5 to 7 included in the 2018 agreement are scheduled to take effect from April 2021.

Table 4.11: Average basic pay and annual earnings per person, England, between 12-month periods ending December 2017 and December 2020

Staff group	Basic pay per head		Earnings per head		Basic pay per head (% change)	Earnings per head (% change)
	Year to Dec 2017	Year to Dec 2020	Year to Dec 2017	Year to Dec 2020		
Nurses & health visitors	£27,811	£30,184	£31,592	£34,310	8.5%	8.6%
Midwives	£26,929	£29,205	£31,644	£34,161	8.5%	8.0%
Scientific, therapeutic & technical staff	£29,993	£32,685	£32,507	£35,495	9.0%	9.2%
Support to doctors, nurses & midwives	£16,021	£17,815	£18,411	£20,277	11.2%	10.1%
Support to ST&T staff	£16,925	£18,913	£18,247	£20,378	11.7%	11.7%
Central functions	£23,225	£25,868	£24,556	£27,404	11.4%	11.6%
Hotel, property & estates	£14,505	£16,247	£17,661	£19,543	12.0%	10.7%
Senior managers	£73,120	£77,866	£76,161	£81,825	6.5%	7.4%
Managers	£45,190	£50,472	£47,570	£53,545	11.7%	12.6%
Ambulance staff/support to ambulance staff	£22,030	£24,859	£30,613	£33,605	12.8%	9.8%
All AfC staff	£23,774	£25,996	£26,753	£29,217	9.3%	9.2%

Source: NHS Digital.

4.172 Key points from the data are, between the year to December 2017 and the year to December 2020:

- For all AfC staff, on average, basic pay and overall earnings each grew by just over 9%;
- Against both basic pay and average earnings: senior managers; nurses and health visitors; midwives; and scientific, therapeutic and technical staff, saw smaller average increases than other groups;
- The staff groups with the largest proportion of staff in Bands 1 to 4 saw larger increases than for other groups. This is likely to be driven by the closure of Band 1 and the completion of scale shortening in the lower bands within the three years of the deal; and
- Ambulance staff and support to ambulance staff saw a relatively large increase in basic pay but a less pronounced increase in overall earnings.

⁷⁴ Measuring salaries on a per person basis tends to deflate the estimate of earnings, the severity of which will vary depending on the numbers of staff working part time.

⁷⁵ Total earnings include: basic salary (per person) and non-basic salary (per person). Non-basic salary includes hours-related pay, such as on-call, shift working and overtime; location payments such as location allowances and other local payments; recruitment and retention premia; and 'other' payments such as occupational absence and protected pay.

4.173 Table 4.12 shows the breakdown of average total earnings for the main staff groups for the 12 months ending December 2017 and December 2020. Overall, non-basic pay made up 11% of all earnings in both 2017 and 2020. The groups where non-basic pay made up the greatest share of total earnings were ambulance/support to ambulance staff (26% in December 2020) and hotel, property and estates staff (17%). For both these groups non-basic earnings made up a smaller share of total earnings in 2020 than in 2017. For ambulance/support to ambulance staff 15% of earnings are made up of shift work payments and overtime a further 7%. For hotel, property and estates staff 9% of earnings were for shift work and overtime a further 3%.

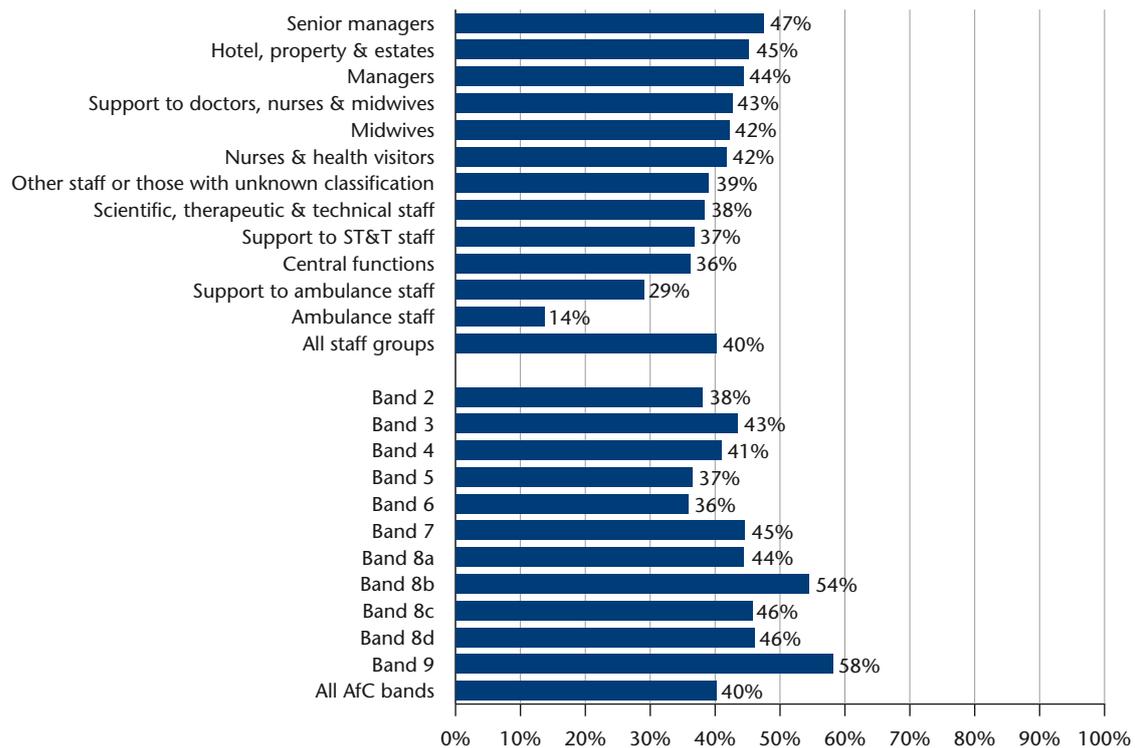
Table 4.12: Non-basic pay per person, as a share of total earnings, by staff group, 12 month periods ending December 2017 and December 2020, England

Staff group	Non-basic pay as share of earnings	
	Year to Dec 2017	Year to Dec 2020
Nurses & health visitors	12%	12%
Midwives	15%	15%
Scientific, therapeutic & technical staff	8%	8%
Support to doctors, nurses & midwives	13%	12%
Support to ST&T staff	7%	7%
Central functions	5%	6%
Hotel, property & estates	18%	17%
Senior managers	4%	5%
Managers	5%	6%
Ambulance staff/Support to ambulance staff	28%	26%
All AfC staff	11%	11%

Source: NHS Digital.

4.174 Figure 4.37 shows that in England, at the end of March 2020, 40% of AfC staff were at the top of their pay band. The proportion varied across staff groups with most having between 36% and 47%, the exceptions being ambulance staff (14%) and support to ambulance staff (29%). Other than Band 1, which is now a single pay point, 58% of Band 9 staff and 54% of Band 8b staff were on top of their band while between 36% and 46% of staff on all other bands were on the top of their band. Compared with March 2019, this represents a fall in the percentage of staff at the top of their band, from 44%. The DHSC said that the non-medical workforce had grown more quickly in 2019/20 than in previous years, with newer staff likely to be below the top of their band.

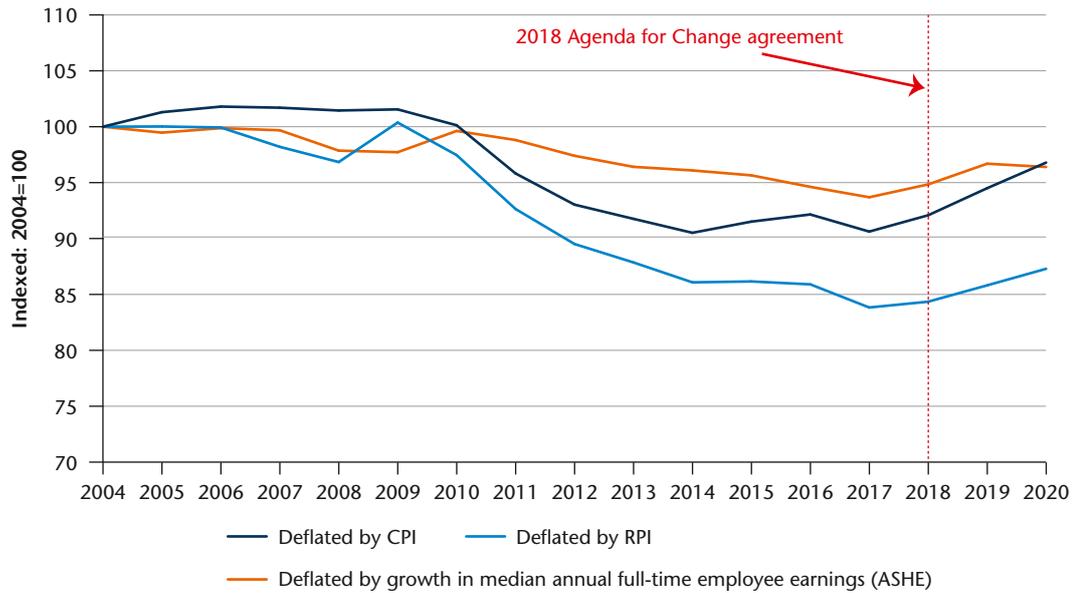
Figure 4.37: Estimated share of staff (FTE) on top of band by staff group and band, 31 March 2020, England



Source: NHS Digital

4.175 Figure 4.38 shows changes to the nurse starting pay point in England since the introduction of AfC in 2004, adjusted either for inflation, or earnings growth in the wider economy. Following the introduction of AfC the nurse starting pay point in England maintained its value against both inflation and average earnings growth until 2009, shortly after the financial crash. Between 2009 and 2017, the first point on the scale lost value, particularly compared with inflation as measured by RPI, and to a slightly lesser extent relative to full-time employee earnings growth. The increase in value of the starting pay point for nurses contained in the 2018 AfC pay agreement meant that in each year between 2018 and 2020 starting pay for nurses grew more quickly than both CPI and RPI price inflation. In both 2018 and 2019 starting pay grew more quickly than median average earnings, but fell back slightly against this comparator in 2020. Nurses starting pay in 2020 was at its highest value since 2013 relative to RPI and since 2010 relative to CPI. However, nurses starting pay still remains below its value when AfC was introduced in 2004.

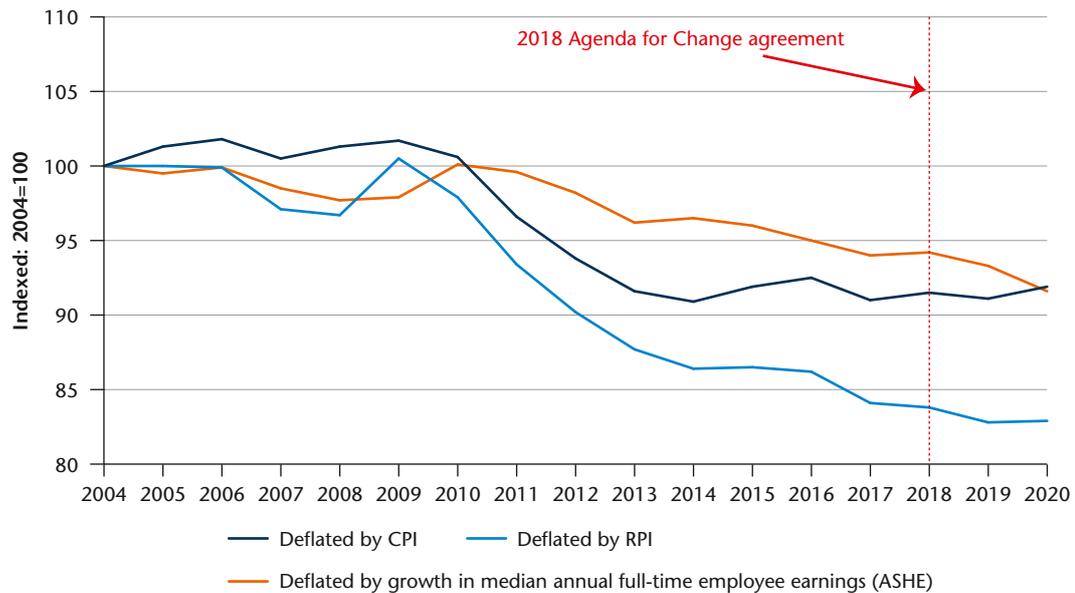
Figure 4.38: Nurse starting pay point deflated by the growth in median average earnings and inflation, England, 2004 to 2020



Source: OME analysis of ONS data (Annual Survey of Hours and Earnings (ASHE), CPI (D7G7) April each year, RPI (CZBH) April each year)

4.176 The bottom point on Band 5 will be the pay point on which most nurses join the service, but there are also more nurses and health visitors paid on Band 5 than any other band and 42% of those are on the top of the pay band. Figure 4.39 shows changes to the value of the pay point at the top of Band 5 since the introduction of AfC in 2004, adjusted either for inflation, or earnings growth in the wider economy. Following the introduction of AfC the pay point at the top of Band 5 maintained its value against inflation until 2009 and average earnings growth until 2010. However, between 2011 and 2017 the value of the top point of Band 5 increased by just 4%, meaning that this point lost value compared with both inflation and earnings growth. The 2018 AfC pay agreement saw the Band 5 maximum increase by 3.0% in the first year of the deal and 1.7% in each of the second and third years. These increases meant that although the Band 5 maximum continued to lose ground against RPI and average earnings growth, it did maintain its value against CPI over the course of the agreement.

Figure 4.39: Top of Band 5, deflated by the growth in median average earnings and inflation, England, 2004 to 2020



Source: OME analysis of ONS data (Annual Survey of Hours and Earnings (ASHE), CPI (D7G7) April each year, RPI (CZBH) April each year)

Pay comparisons

4.177 The *Annual Survey of Hours and Earnings (ASHE)* has been used for a number of years to compare earnings for the human health and social work activities sector⁷⁶ with employees in the public and private sector as well as to certain broad occupational groups. These sector and group earnings (median gross weekly pay) are shown in Table 4.13. In 2020 median gross weekly pay for full-time employees in the human health and social work activities sector increased by 2.0%, compared with 0.1% across the economy as a whole and 2.4% across the public sector. Median gross weekly pay in the private sector fell by 0.6%. The reference period for the weekly ASHE calculations is April 2020, which means that some of the data is likely to be affected by the lockdown of the economy from March 2020 onwards.

⁷⁶ This section includes the provision of health and social work activities. It covers a wide range of activities, from health care provided by trained medical professionals in hospitals and other facilities, to residential care activities that still involve a degree of health care activities and to social work activities not involving the services of health care professionals

Table 4.13: Change in median gross weekly pay for full-time employees at adult rates, 2017 to 2020, April each year, United Kingdom

United Kingdom	Median gross weekly pay (change on previous year)								Change 2018- 2020
	2017		2018		2019		2020		
Human health and social work activities sector	£510	(0.0%)	£530	(3.9%)	£552	(4.3%)	£563	(2.0%)	6.4%
All employees	£550	(2.1%)	£568	(3.3%)	£585	(3.0%)	£586	(0.1%)	3.0%
Public sector	£600	(1.0%)	£613	(2.2%)	£632	(3.2%)	£647	(2.4%)	5.7%
Private sector	£531	(2.7%)	£548	(3.3%)	£571	(4.1%)	£567	(-0.6%)	3.5%
Professional occupations ¹	£733	(1.0%)	£745	(1.6%)	£769	(3.2%)	£777	(1.1%)	4.3%
Associate professional and technical occupations ²	£605	(2.3%)	£619	(2.4%)	£624	(0.8%)	£610	(-2.4%)	-1.6%
Administrative & secretarial occupations	£431	(2.0%)	£445	(3.2%)	£457	(2.7%)	£463	(1.2%)	3.9%
Skilled trades occupations	£510	(2.6%)	£524	(2.7%)	£541	(3.3%)	£507	(-6.3%)	-3.2%
Caring, leisure and other service occupations	£361	(2.4%)	£374	(3.4%)	£392	(5.0%)	£402	(2.5%)	7.6%

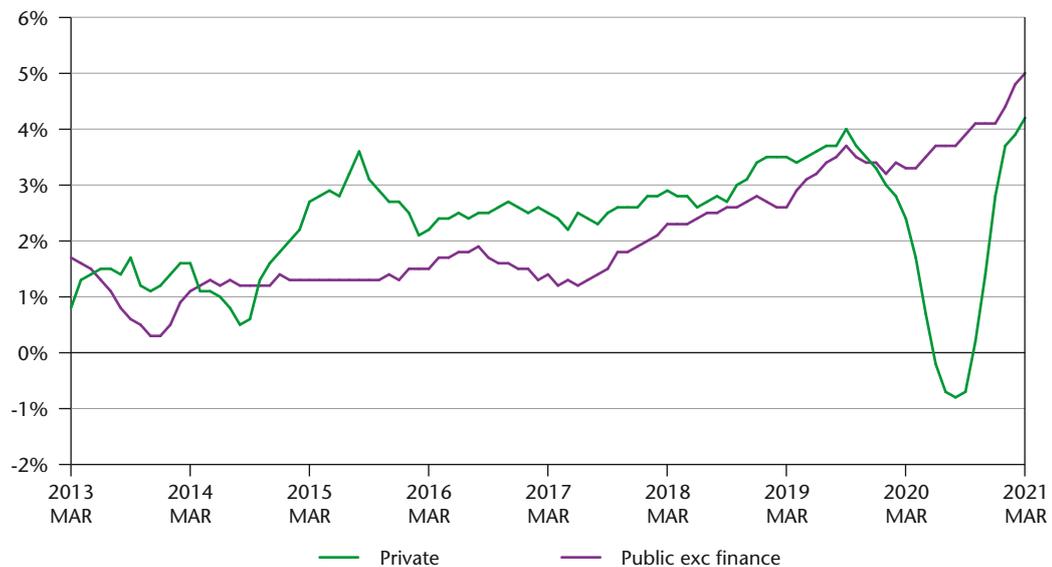
Source: ONS (Annual Survey of Hours and Earnings)

1 Includes, for example, teachers, solicitors, accountants, doctors and some AHPs and ST&Ts. Nurses and midwives are in this group from April 2011.

2 Includes, for example, police officers and some AHPs and ST&Ts.

4.178 In the remit letter to the Review Body, and those to the other pay review bodies, the Government said that according to the ONS Average Weekly Earnings (AWE) data, in the six months to September 2020, the private sector had seen a pay cut of nearly 1% compared to last year, yet public sector earnings were up by almost 4%. This statement was based on the AWE for the six months to September 2020 compared with the same six months in 2019. Figure 4.40 shows AWE growth using that method, from 2013 onwards, but run forward to March 2021 (the latest month for which data is available). The difference between private and public sector earnings growth was at its widest in September 2020, the point which the Government used as the basis of its comparison.

Figure 4.40: Average weekly earnings, six months compared with same period a year earlier, public sector (excluding finance) and private sector, March 2013 to March 2021, Great Britain

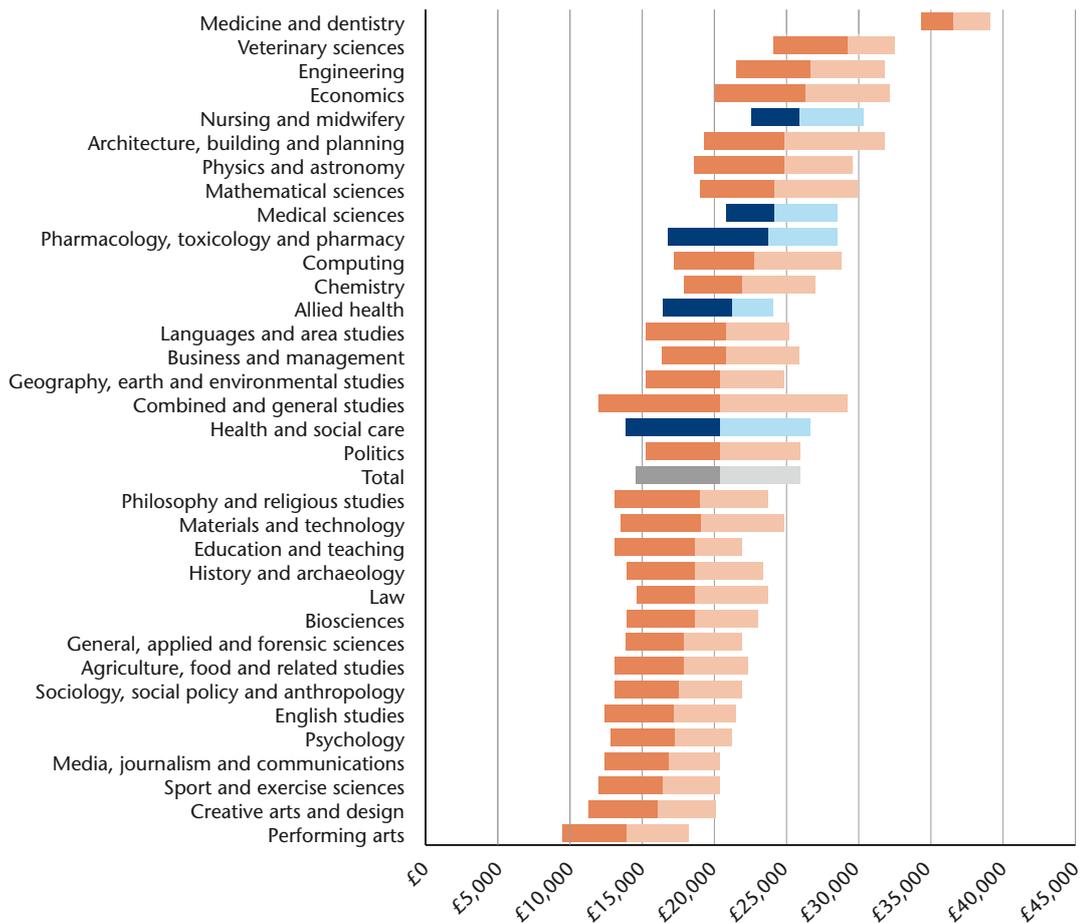


Source: ONS

- 4.179 The latest data shows that in the six months to March 2021, compared with a year earlier, the gap had narrowed considerably, as public sector earnings grew by 5% and private sector earnings grew by 4%. This follows a period between 2014 and 2019 where private sector earnings growth exceeded that in the public sector. Nevertheless, care needs to be taken when looking at this data. The ONS said that changes in pay growth had been affected by the changing composition of employee jobs, where there had been a fall in the number and proportion of lower-paid employee jobs. The ONS said that changes in the profile of employee jobs in the economy will affect average pay growth; a decrease in employee numbers in jobs that have lower pay can have an upward effect on average pay, and the other way around. The Labour Force Survey had recorded a decrease in the number of part-time jobs (which have lower average pay), and jobs in some lower-paying occupations. This changing composition increases average pay. The ONS concluded, that despite published estimates showing an increase of almost 5% across the economy as a whole, underlying earnings growth was around 3%.
- 4.180 Data from the Longitudinal Education Outcomes (LEO) data set, published by the Department for Education, tracks the nominal earnings⁷⁷ of UK-domiciled first-degree graduates from English Higher Education Institutions and Further Education Colleges, using HMRC data. The data show median earnings in 2017/18, by subject studied, for those one, five and ten years after graduation. The LEO data covers annual earnings, for both full and part time workers, and is not adjusted for geography, age or other factors. It also includes the earnings of those working in areas unrelated to their degree subject, for example someone with a nursing degree working outside the health sector.
- 4.181 Figure 4.41 shows median earnings (the centre line of the bars), and the inter-quartile range of earnings (the end points of the bars), one year after graduation. Only those who studied: medicine and dentistry; veterinary sciences; engineering; and economics, had higher median earnings than those who studied nursing or midwifery. Median earnings of those who studied medical sciences, pharmacology, toxicology and pharmacy and allied health subjects were also above the median for graduates as a whole and those who studied subjects related to health and social care had median earnings broadly in line with those of graduates as a whole. Within the allied health subjects grouping, those who studied paramedical science had median earnings behind median earnings of just those who studied medicine and dentistry.

⁷⁷ Nominal earnings defined as the cash amount an individual was paid, not adjusted for inflation.

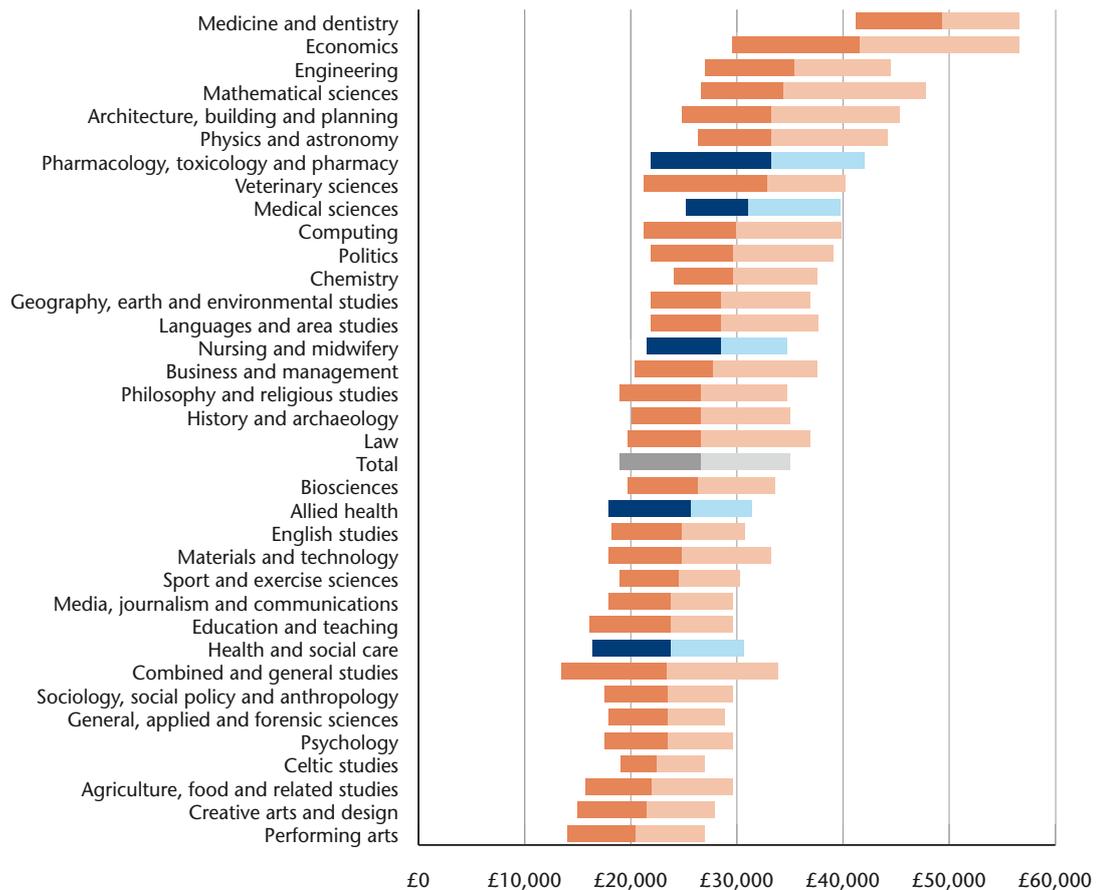
Figure 4.41: Annual gross earnings one year after graduation (2015/16 cohort), lower quartile, median and upper quartile, £



Source: OME analysis of LEO data set

4.182 Figure 4.42 shows that median earnings, five years after graduation, for those who studied pharmacology, toxicology and pharmacy and medical sciences were still considerably above median earnings for graduates as a whole. For those who studied nursing or midwifery, median earnings were still above the median for graduates as a whole, but by less than they had been one year after graduation. Median earnings for those who had studied allied health subjects, and subjects related to health and social care had fallen below the median for graduates as a whole, although within the allied health subjects grouping, those who studied paramedical science still had median earnings above the overall graduate median.

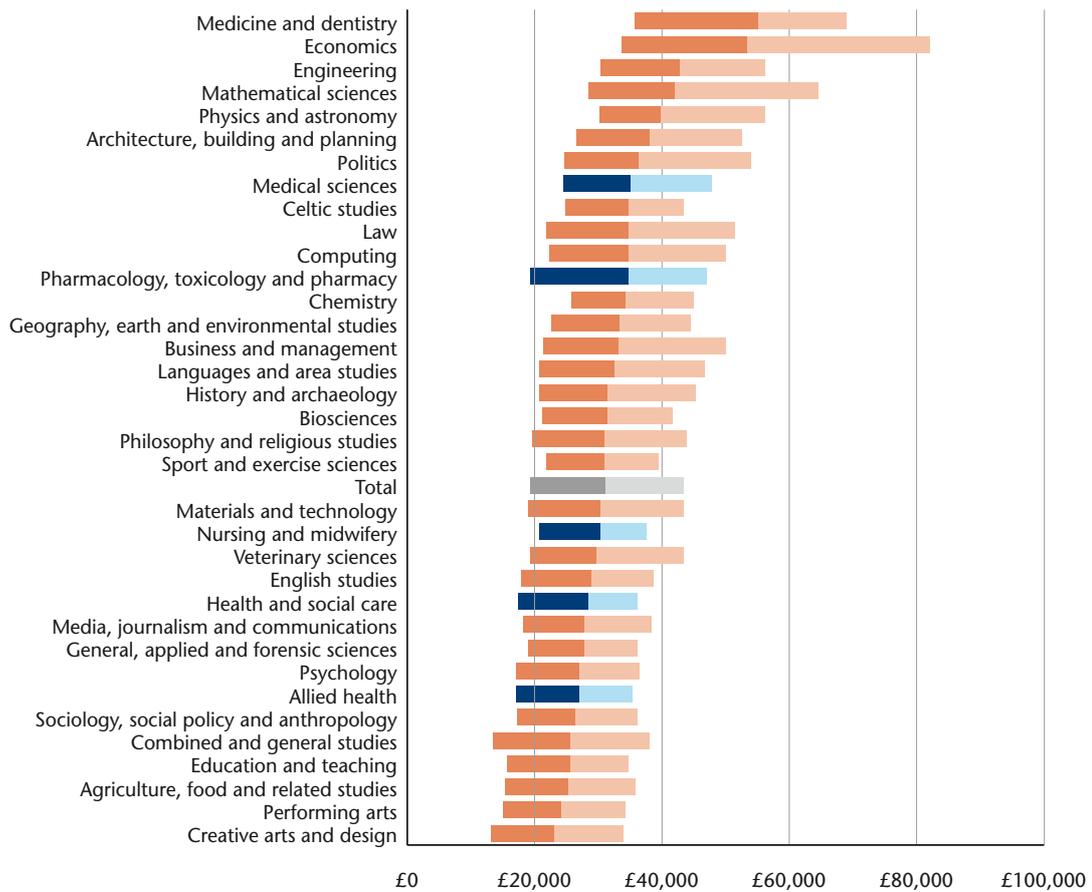
Figure 4.42: Annual gross earnings, five years after graduation (2011/12 cohort), lower quartile, median and upper quartile, £



Source: OME analysis of LEO data set

4.183 Figure 4.43 shows that median earnings, ten years after graduation, for those who studied medical sciences, and pharmacology, toxicology and pharmacy, were still above the median for graduates as a whole. However, median earnings for those who studied nursing or midwifery, had fallen below the overall graduate median, as were median earnings of those who studied subjects related to health and social care and for those who studied allied health subjects. Within the allied health subjects grouping, those who studied paramedical science still had median earnings in excess of the overall graduate median.

Figure 4.43: Annual gross earnings ten years after graduation (2006/07 cohort), lower quartile, median and upper quartile, £



Source: OME analysis of LEO data set

Take-home pay

4.184 In the three years covered by the 2018 AfC pay agreements, basic pay for NHS staff at the top of their band in England increased by between 14.9% for Band 1 and 4.5% for Band 9. After taking account of changes to income tax, national insurance and pension contributions, take-home pay increased by between 13.9% for Band 1, the highest increase, and 5.4% for Band 9, the lowest increase, over the same period.

Table 4.14: Basic full-time pay and take-home pay, at the top of pay bands, England, 2017/18 to 2020/21

Top of:	Basic pay			Change 19/20 to 20/21		Change 17/18 to 20/21	
	2017/18	2019/20	2020/21	£	%	£	%
Band 1	£15,671	£17,652	£18,005	£353	2.0	£2,334	14.9
Band 2	£18,157	£19,020	£19,337	£317	1.7	£1,180	6.5
Band 3	£19,852	£20,795	£21,142	£347	1.7	£1,290	6.5
Band 4	£22,683	£23,761	£24,157	£396	1.7	£1,474	6.5
Band 5	£28,746	£30,112	£30,615	£503	1.7	£1,869	6.5
Band 6	£35,577	£37,267	£37,890	£623	1.7	£2,313	6.5
Band 7	£41,787	£43,772	£44,503	£731	1.7	£2,716	6.5
Band 8a	£48,514	£50,819	£51,668	£849	1.7	£3,154	6.5
Band 8b	£58,217	£60,983	£62,001	£1,018	1.7	£3,784	6.5
Band 8c	£69,168	£72,597	£73,664	£1,067	1.5	£4,496	6.5
Band 8d	£83,258	£86,687	£87,754	£1,067	1.2	£4,496	5.4
Band 9	£100,431	£103,860	£104,927	£1,067	1.0	£4,496	4.5

Top of:	Take-home pay			Change 19/20 to 20/21		Change 17/18 to 20/21	
	2017/18	2019/20	2020/21	£	%	£	%
Band 1	£13,234	£14,748	£15,077	£328	2.2	£1,843	13.9
Band 2	£14,813	£15,617	£15,923	£306	2.0	£1,110	7.5
Band 3	£15,890	£16,745	£17,069	£325	1.9	£1,180	7.4
Band 4	£17,416	£18,344	£18,695	£351	1.9	£1,279	7.3
Band 5	£20,688	£21,772	£22,180	£409	1.9	£1,492	7.2
Band 6	£24,825	£26,105	£26,586	£481	1.8	£1,761	7.1
Band 7	£28,586	£30,044	£30,591	£547	1.8	£2,005	7.0
Band 8a	£31,769	£33,093	£33,774	£681	2.1	£2,005	6.3
Band 8b	£37,179	£39,332	£39,951	£618	1.6	£2,771	7.5
Band 8c	£42,710	£44,762	£45,398	£637	1.4	£2,689	6.3
Band 8d	£49,325	£51,793	£52,429	£637	1.2	£3,104	6.3
Band 9	£57,895	£60,362	£60,999	£637	1.1	£3,104	5.4

Source: OME analysis of NHS Employers data

National Living Wage and National Minimum Wage

4.185 The 2018 AfC agreement in England increased the minimum level of basic pay from £15,404 in 2017, to £18,005 from April 2020, an increase of 17%. However, increases to the NLW, of 16% over the same period, from £7.50 per hour to £8.72 per hour, mean that minimum AfC rates were little changed in relation to the NLW. In November 2020, the Government announced a further increase in the NLW, from April 2021, of 2.2%, to £8.91 per hour.

4.186 In April 2017, the AfC pay minimum, converted to an hourly rate of £7.88, was 7% below the Living Wage Foundation Living Wage (LWFLW) of £8.45 per hour. After the first year of the three-year AfC deal the AfC minimum converted to an hourly rate was 2% above the LWFLW in place in April 2018. In April 2020, after the award for the final year of the three-year deal was applied, the AfC minimum was 1% below the LWFLW in place at the time. Similarly to the NLW, the LWFLW in place on 1 April 2021 was 2.2% higher than a year earlier. The rates for the NLW and the LWFLW between 2017 and 2021 are in Table 4.15 below.

Table 4.15: National Minimum Wage, National Living Wage and the Living Wage Foundation Living Wage rates per hour, in place at April 2021

Year	National Living Wage (NLW)		Living Wage Foundation National Living Wage (LWFNLW)		Living Wage Foundation Living Wage (London)		Agenda for Change pay minimum			
	£ per hour	change from previous year	£ per hour	change from previous year	£ per hour	change from previous year	£	£ per hour	relative to NLW	relative to LWFNLW
2017	7.50		8.45		9.75		15,404	7.88	5%	-7%
2018	7.83	4.4%	8.75	3.6%	10.20	4.6%	17,460	8.93	14%	2%
2019	8.21	4.9%	9.00	2.9%	10.55	3.4%	17,652	9.03	10%	0%
2020	8.72	6.2%	9.30	3.3%	10.75	1.9%	18,005	9.21	6%	-1%
2021	8.91	2.2%	9.50	2.2%	10.85	0.9%				
Change from 2017 to 2020	16%		10%		10%		17%			

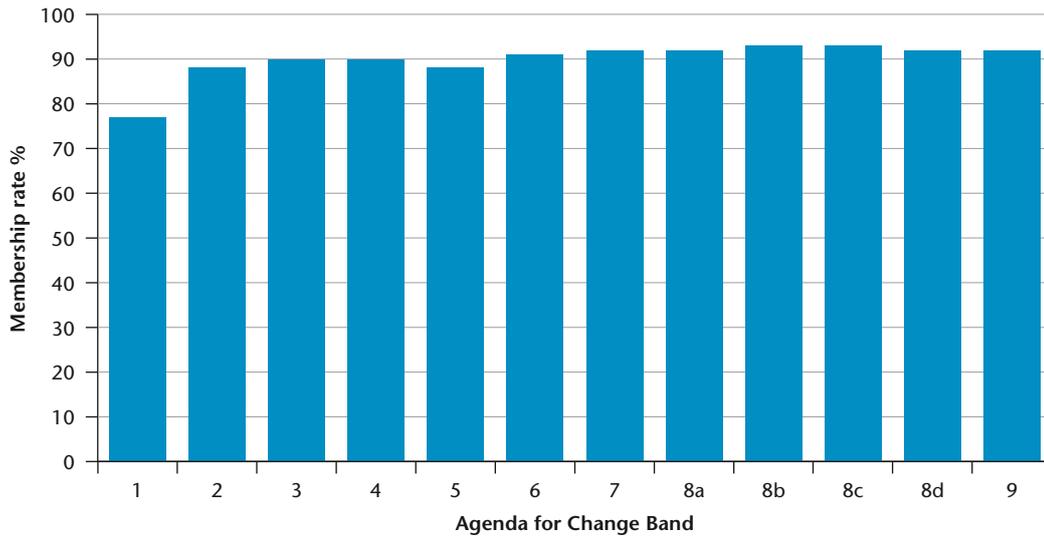
Source: Low Pay Commission, Living Wage Foundation

4.187 The LPC has been asked by Government to increase the NLW towards a target of two-thirds of median earnings, by 2024, taking economic conditions into account. The LPC estimate that to meet that target would require increasing the NLW to £9.42 in 2022 (5.7% above the 2021 level) and £10.33 in 2024 (15.9% above the 2021 level).

Pensions

4.188 In July 2020 approximately 90% of AfC staff were members of the NHS Pension Scheme (Figure 4.44). Staff in Bands 6 to 9 (91-93%) were most likely to be scheme members while those in Band 1 were least likely (77%).

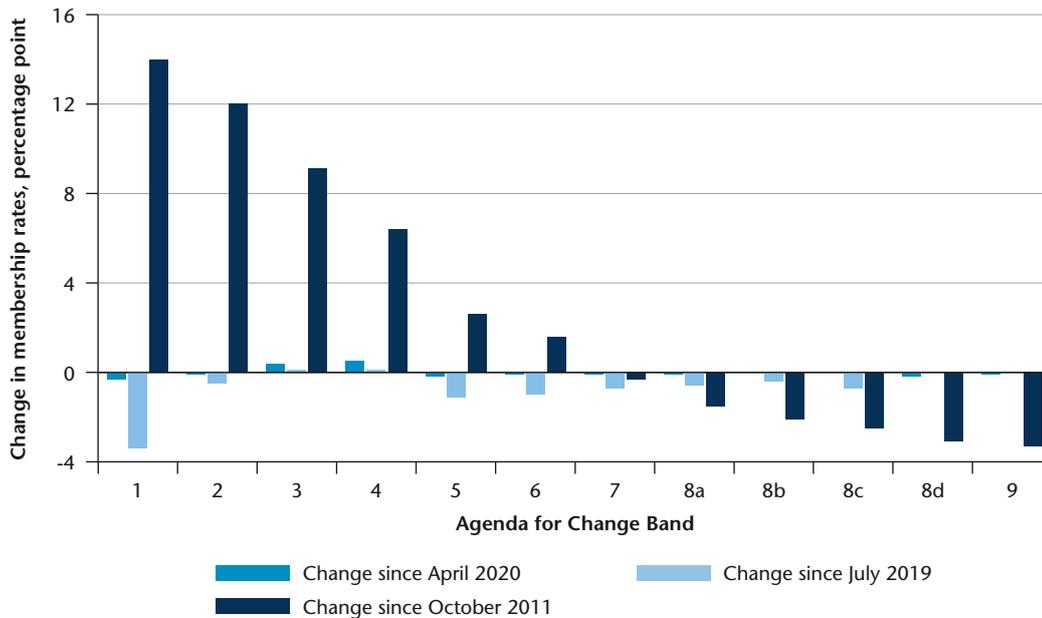
Figure 4.44: Estimated pension membership rate by AfC band, July 2020, England



Source: Department of Health and Social Care

4.189 Figure 4.45 shows changes in the membership rate of the NHS Pension Scheme in July 2020, by AfC band, compared with April 2020 (three months earlier), July 2019 (a year earlier) and October 2011. Between October 2011 and July 2020 membership rates increased for those in Bands 1 to 6 but decreased for those in Bands 7 to 9. Over that period, the largest percentage point increase in membership rate, was for those in Band 1, but, at 77%, the membership rate in that band remains below that for all other bands. However, there is now evidence that membership rates are also declining below Band 7. Except for Bands 3 and 4, membership rates in July 2020 were lower than those in July 2019 and April 2020 for each band. There was a particularly sharp fall in the membership rate of Band 1 staff, between July 2020 and July 2019 of 3.4 percentage points.

Figure 4.45: Changes in pension membership rate by AfC band, between July 2020 and April 2020, July 2019 and October 2011, England



Source: Department of Health and Social Care

Our assessment of Agenda for Change earnings

- 4.190 For this report, NHS earnings data for England was available for the calendar year 2020, which allows us to look at almost the entire period of the 2018 AfC pay agreement.
- 4.191 One of the objectives of the 2018 AfC pay agreement was to address workforce shortages, by delivering significant increases in pay and earnings for AfC staff. Our assessment of AfC earnings indicate that there were significant pay and earnings increases across all AfC groups, between the year to December 2017 and the year to December 2020. In England, AfC basic pay increased by 9.3% on average and total earnings by 9.2%. There was variation in pay and earnings growth between staff groups. The groups with the largest increases in basic pay over the period were ambulance staff and support to ambulance staff (12.8%), hotel, property and estates staff (12.0%), managers and support to scientific, therapeutic and technical (ST&T) staff (both 11.7%). The staff groups where average basic pay increased by less than the overall average were senior managers (6.5%), midwives and nurses and health visitors (both 8.5%). The data for total earnings shows similar differences between staff groups, although managers saw the largest increase in average earnings over the period (12.6%), and senior managers the lowest (7.4%). Ambulance staff, for whom shift-work and overtime payments make up a larger share of average earnings than for other groups, saw the value of these payments decline as a share of total earnings as they failed to keep pace with growth in basic pay.
- 4.192 How the 2018 pay agreement is viewed by staff may depend on where they were positioned in the pay bands at the start of the agreement. Those already on the top of their pay band at the start of the agreement will have seen an increase in basic pay of between 4.5% and 6.5% over three years, while some others who were able to move through the pay points more quickly will have seen increases in basic pay of over 20% over the same period.
- 4.193 While the restructuring of the pay bands up to Band 4 has been completed, there still remains further scale shortening in Bands 5 to 7, to take place in 2021. It was estimated that this further scale shortening would cost approximately 0.7% of the pay bill. In addition, some staff on Bands 8 and 9 have been in receipt of payments under the Bands 8 and 9 consolidated payment temporary arrangements⁷⁸ that allows for those staff receiving such payments at 31 March 2021, to continue to do so.
- 4.194 Some of these differences in earnings growth between staff groups may be influenced by the distribution of staff between pay bands, and the percentage of staff already on the top of their pay band. Nurses, midwives and health visitors were amongst the staff groups recording the smallest average increases in pay and earnings since December 2017. They were also amongst the groups with higher than average numbers of staff on the highest pay point on their Band, and no staff in Bands 1 to 4, where all the scale shortening agreed as part of the three-year agreement has already taken place. A relatively high percentage of nurses, midwives and health visitors are in Bands 5 to 7, those bands where further scale shortening will take place in 2021. As such, we may expect to see these staff groups show higher pay growth than other groups in 2021 as that scale shortening takes effect.

⁷⁸ NHS Employers (January 2021), *NHS Terms and Conditions of Service Handbook Annex 2 Table 10*. Available at: <https://www.nhsemployers.org/tchandbook/annex-1-to-3/annex-2-pay-bands-and-pay-points-on-the-second-pay-spine-in-england>

- 4.195 In previous reports we have tracked the starting salary of nurses. Previous analyses had shown that the starting salary of nurses had seen a decrease in purchasing power between 2010 and 2017. However, since the increases in the 2018 AfC pay agreement, the value of the starting pay point for nurses has grown more quickly than price inflation and average earnings. However, because the agreement focused on shortening the amount of time it took to reach the maximum pay point, the value of the points at the top of bands were increased by less than other points. Therefore, for Band 5, the band in which many nurses and health visitors are graded, the maximum pay point continued to lose value against RPI and average earnings, but held its value against CPI, across the period of the agreement.
- 4.196 The data shows that graduates who had studied health-related subjects have higher median earnings than graduates as a whole, one year after graduation. This may partly be a result of recent graduates in these vocational subjects being able to take a full-time job in the NHS related to their field of study, while graduates of other subjects may not immediately be able to find well paid jobs related to the subject they had studied. However, the earnings of those who studied nursing and midwifery, fall back towards the median as the earnings of graduates in other subjects grow more quickly, and, by a point between five and ten years after graduation, median earnings of nursing and midwifery graduates fall below those of other graduates.
- 4.197 One feature of the 2018 AfC pay agreement was the removal of Band 1, meaning that the value of the lowest AfC pay point increased by 17% over the period of the deal, from £15,404 in 2017 to £18,005 in 2020. However, over the same period, the National Living Wage increased by 16%, meaning that pay at the bottom of the AfC bands remained little changed in relation to the NLW. The NLW has already been increased by a further 2.2% from 1 April 2021, and further increases in the NLW of 5.7% in 2022 and up to 15.9% by 2024 may be required if the LPC is to deliver its current target of a NLW that is two-thirds of median earnings. Any consideration of pay in the lower AfC bands will need to take account of changes to the NLW and thought will need to be given as to where pay for these bands should sit in relation to the NLW.
- 4.198 Although Band 1 is closed to new entrants there are still over 6,000 staff on Band 1 in England. Over 5,500 of these are in the hotel, property and estates group.
- 4.199 One valuable aspect of the overall reward package is the NHS pension. Membership rates, at around 90% for most staff, remain high, albeit membership rates are lowest amongst the lowest paid. Some AfC staff on the lowest bands may feel that they cannot afford the immediate cost of contributions. Changes to the scheme in recent years mean that the pension is less valuable now than a decade ago. Changes included: a move to pension benefits being calculated on career average salaries rather than final salaries; a higher retirement age; uprating of accrued benefits by CPI rather than RPI; but also a higher accrual rate. We have heard staff compare the current scheme unfavourably with the previous scheme, but also with many other schemes available in the private sector. While pensions can be complex and difficult to understand, it is important that organisations make sure that their staff have information available, in an accessible form, that sets out the benefits they can expect from the NHS scheme.

- 4.200 The Court of Appeal ruled (McCloud judgement) that when new public sector pensions were introduced in 2015, the transitional protection available to some pension scheme members, gave rise to unlawful discrimination on the grounds of age. As a result of this judgement, members of the NHS pension schemes now have the opportunity to choose whether pension benefits accrued between 2015 and 2022 are counted against the pre-2015 scheme or the new 2015 scheme. One difference between the two schemes is the age at which pension benefits can be taken, with the pre 2015 scheme allowing members to retire and take a pension at an earlier age. In evidence, a number of the parties said that this is a risk to retention, as some staff may decide to bring forward their date of retirement. Although it is unclear how many people will choose to retire as a result of this judgement, it is important that organisations offer flexible and attractive packages to help retain those staff at or close to an age where retirement is an option. During this round we heard evidence from parties showing a willingness and desire to introduce more flexible working arrangements, but in practice little seemed to have changed to this point. We look forward to hearing from the parties next year about any changes that are introduced and the impact that they have on retention. Pay is important to staff this year following the three-year deal and their perception of an uplift may well influence the decisions that they take about their futures.
- 4.201 The 2018 AfC agreement has increased earnings for staff, as intended, with a view to addressing significant workforce shortages. There are still some outstanding issues to be addressed, such as further scale shortening at Bands 5 and above and continuing to manage the significant number of staff still on Band 1. A number of staff already on the maximum point of their band saw smaller increases in earnings as a result of the 2018 AfC agreement, and reducing the time it takes to move to the top of the pay band will see increasing numbers of staff at the band maximum. These staff will only see their pay increase in line with any annual award, and care will need to be taken to ensure those awards are sufficient to motivate and retain those staff.

2018 Agenda for Change pay agreements assessment

Introduction

- 4.202 The three-year AfC pay agreements in England, Scotland and Wales were in force for the financial years 2018/19 to 2020/21. A separate Northern Ireland AfC framework agreement was in force over these periods and restored pay parity with health workers in England and Wales with effect from 1 April 2019. We note that DHSC commented on the 2018 AfC multi-year deal having provided a new pay structure that reinforced the public sector pay policy of increased pay flexibility in return for reforms that improve recruitment and retention while boosting productivity. The NHS Staff Council said that the COVID-19 pandemic had severely affected the implementation of the planned pay progression arrangements and from 27 March 2020, some of the benefits of the new pay progression framework might have been lost and staff had automatically progressed to the next pay step point where this was due.
- 4.203 We have been told that good progress has been made implementing the benefits of the deal and that some of the outstanding elements of the multi-year deal will result in further benefit to individual members of AfC staff. We understand from the NHS Staff Council that the wider benefits realisation work is being led by NHS E&I who were continuing to track the key performance indicators.
- 4.204 In last year's report, we set out that the work on benefits realisation should include an assessment of progress for each of the elements of the agreement to show what had been achieved and what required more impetus or resource. Given the significant level of investment in pay reform, we would expect the parties to be in a position to demonstrate a return on that investment. We look forward to NHS E&I's further work on benefits realisation.

Aims of the 2018 Agenda for Change pay agreements

4.205 The key objectives from the three-year deal for England, Scotland and Wales were as follows:

- Support the attraction and recruitment of staff by increasing starting pay in every pay band;
- Support the retention of staff by increasing basic pay for the 50% of staff who are at the top of pay bands and speeding up progression to the top of the pay band;
- Increase staff engagement by putting appraisal and personal development at the heart of pay progression, so that staff are supported to develop their skills and competences in each pay band and are rewarded for this. This will help ensure that all staff have the appropriate knowledge and skills they need to carry out their roles, so make the greatest possible contribution to patient care. It will be underpinned by a commitment from employers to enhance the relationship line managers have with their staff and to fully utilise an effective appraisal process;
- Ensure that the pay system can support the growing use of apprenticeships in the NHS;
- Ensure that the pay system is supportive of new training pathways and that the health service can deliver on the aspiration to focus on “careers, not jobs”;
- Map out future work that the NHS Staff Council will undertake to encourage consistency of approach to bank working (including how the service can better incentivise staff to offer their own time to the bank) and to the development of apprenticeship routes to healthcare careers; and
- Improve the health and wellbeing of NHS staff to improve levels of attendance in the NHS with the ambition of matching the best in the public sector.

4.206 The table below sets out the specific key actions from the AfC 2018 pay agreements and our assessment:

Specific key action	Our analysis	Our assessment
Increases to starting salaries by removing pay points from the bottom of each pay band which overlap with a lower band, with one point removed in 2018/19 and further points being removed in 2019/20.	The NHS terms and conditions of service handbook on 1 April 2019 included a new pay system with faster progression to the top of bands through fewer pay step points.	Completed
The intention of the reforms was for individuals to have basic pay of greater value at the end of the three-year period than under expectations at the time of the agreement (which were defined as a 1% pay award per annum plus contractual agreements). This included increases to the top of pay bands and faster progression to the top of pay bands.	The average earnings for AfC staff had increased by 3.1% in 2019/20 and had risen by 6.1% since the start of the multi-year deal, and were expected to increase by around 3% in 2020/21 in the final year of the agreement.	Completed
Introducing a minimum basic rate from April 2018 to future proof the pay structure, stay ahead of statutory requirements and to ensure that the NHS retained a competitive market advantage.	A minimum rate of pay in the NHS was implemented from 1 April 2018 which was ahead of the Living Wage Foundation rates.	Completed

Specific key action	Our analysis	Our assessment
Also upskilling of roles from band 1 to band 2 .	DHSC told us that in June 2020 that there were around 7,300 staff remaining in band 1 compared to 25,000 in December 2018.	Incomplete
The NHS Staff Council to negotiate a new provision detailing pay for apprentices .	Following negotiations in the NHS Staff Council, no national agreement was reached on apprenticeship pay. The Staff Council have told us that this specific key action will be part of their future work programme.	Pending
A new pay progression framework to help ensure that all staff have the appropriate knowledge and skills they needed to carry out their roles and so make the greatest contribution to patient care.	DHSC told us that the new system of pay progression for new starters and promotees began on 1 April 2019 and this system came into force for all AfC staff from 1 April 2021. However, the Staff Council noted that COVID-19 had severely affected implementation of the planned pay progression arrangements.	Incomplete
NHS Staff Council work to improve levels of attendance through a focus on staff health and wellbeing at a national and local level. The ambition was that through the positive management of sickness absence the NHS will match the best in the public sector.	<p>Since April 2020, NHS staff have been able to access:</p> <ul style="list-style-type: none"> • A dedicated and confidential staff support line, operated by Samaritans and a 24/7 text support line operated by Frontline. • Specialist bereavement support through a helpline provided by Hospice UK, manned by a team of fully qualified and trained bereavement specialists. • Free access to mental health and wellbeing apps. • Virtual staff common rooms, in partnership with NHS Practitioner Health which have given staff the opportunity to reflect, share experiences and find ways to cope with how COVID-19 is affecting their life at home and at work. <p>The sickness absence rates for staff in England have fluctuated as a result of COVID-19. There have been approaching 3 million working days lost for reasons related to COVID-19 between March 2020 and January 2021. The Staff Council have told us that this specific key action will be part of their future work programme.</p>	Incomplete

Specific key action	Our analysis	Our assessment
Also the NHS Staff Council would explore the scope for a collective agreement on bank and agency working	The Staff Council have told us that this specific key action will be part of their future work programme.	Pending
Work on guaranteed access to annual leave and Time Off In Lieu	The Staff Council have told us that in year three of the deal the work to ensure access to annual leave and TOIL was outstanding.	Pending
child bereavement leave	The NHS terms and conditions of service handbook section 23 contains the provisions for child bereavement leave.	Completed
shared parental leave	The NHS terms and conditions of service handbook section 15 sets out the provisions for shared parental leave.	Completed
buying and selling annual leave	NHS Staff Council joint statement from 21 November 2019 said it was not possible to reach a joint national agreement due to a lack of consensus over what constituted an appropriate rate of pay as which leave would be sold. However, local organisations were encouraged to develop their own local buying and selling annual leave policies in partnership with local staff sides.	Incomplete
and reducing the variation in approach to payment schemes for unsocial hours payments.	DHSC told us that variation in additional earnings reflected differences including working patterns and responsibilities between staff groups. In the 12 months to March 2020, the additional earnings proportion of total earnings per person rose 11.2% for ambulance staff due to higher than average levels of unsocial hours and overtime pay. The multi-year deal changes to pay Section 2 terms for new ambulance staff rather than Annex 5 does not appear to have impacted the proportion of earnings that come through unsocial hours for ambulance staff. This has been constant at around 15% for qualified staff and 12% for those in support roles. We recognise there is an impact from the changes on sick pay levels to not include unsocial hours elements.	Incomplete

Our assessment

- 4.207 The COVID-19 pandemic impacted on the final year of changes needed to complete the multi-year agreements and delivering some of the deals' elements was paused. However, the Staff Council have told us that when there is the capacity to implement the outstanding workstreams, these areas of work will be resumed. We look forward to the evidence on the benefits realisation of the outputs delivered by the multi-year agreements.
- 4.208 The 2018 pay agreement in England included the upskilling of Band 1 roles to Band 2 roles and in December 2018 Band 1 was closed to new entrants with existing staff given the opportunity to transfer to Band 2 by March 2021. We heard on our visits that some trusts had encountered difficulties persuading staff of the merits of the move from Band 1 to Band 2. The NHS Employers' evidence confirmed that the opportunity to move to a Band 2 role would remain open to staff who had decided not to transfer as part of the choice exercise. The challenge to understand the reasons for staff choosing to remain in Band 1 does not appear to be straightforward and a new strategy may create the necessary momentum to close Band 1.
- 4.209 We will continue to monitor the transition arrangements and look forward to any emerging impact of upskilling to Band 2 roles, in particular on the staff contribution towards patient services. We note that from 1 April 2018 the multi-year AfC agreement in England set the minimum level of basic pay ahead of the Living Wage Foundation rates. In November 2020, the Government announced a further increase in the NLW of 2.2% from April 2021. The transition of staff from Band 1 to Band 2 would ensure the AfC minimum rate of basic pay would keep ahead of the various wage floors.
- 4.210 We are aware that the new pay progression system is still in its infancy but when the framework is fully in place we would expect to see:
- Data on the number of staff moving through the pay steps, and the number of staff and reasons for not moving through the pay steps. Data on staff with protected characteristics should be included;
 - An increase in the proportion of staff receiving appraisals and in the quality of appraisals as captured in the NHS Staff Survey and in trades unions' surveys. Also, any variations in indicators from surveys on the views of those staff who were between progression pay steps;
 - Improvements in the staff engagement index and in staff views on line management in the NHS Staff Survey; and
 - Appropriate access to and expenditure on CPD, including any data on training and development to enable staff to pass through the pay steps.
- 4.211 We note that the pay progression system requires staff to receive effective appraisals and that this year the personal development section was put on hold because of the COVID-19 pandemic. We would hope to receive evidence of staff opinions of their training and appraisals as this will be an important part of our considerations in future reports.

Chapter 5 Pay recommendations

Introduction

- 5.1 The Secretary of State for Health and Social Care, the Minister for Health and Social Services in Wales, and the Minister of Health in Northern Ireland asked us in their respective remit letters to make a recommendation for a pay award for Agenda for Change staff (AfC) for 2021/22. In this chapter, we set out our recommendations on AfC pay for 2021/22 in England, Northern Ireland and Wales. We make these recommendations having regard to our standing terms of reference, which include affordability, recruitment, retention and motivation and morale.

Pay proposals

- 5.2 The Department of Health and Social Care (DHSC) said that the economic outlook for 2021/22 remained uncertain and pay awards must be both fair and affordable. They told us that in setting the National Health Service (NHS) budget, the Government had assumed a headline pay award of 1% for NHS staff. In oral evidence, DHSC said they had budgeted for the additional cost of a £250 uplift for AfC staff earning less than £24,000 full-time equivalent (FTE) – in line with the exception to the public sector pay pause they had announced for this workforce. The Government had also set aside the 0.7% increase in the pay bill to cover the hangover from the three-year deal. This was a total pay envelope of 1.75% for 2021/22.
- 5.3 In England, pay awards for the majority of the public sector were paused in 2021/22 except for those earning the full-time equivalent of less than £24,000 and NHS workers.
- 5.4 NHS England and NHS Improvement (NHS E&I) said that NHS staff should receive a fair salary, rewarding and recognising their amazing contribution, including during the COVID-19 pandemic. A significant number of AfC staff were earning below £24,000 FTE. The Spending Review commitment of a pay uplift to their salaries of £250 would be worth between 1.05% and 1.4%.
- 5.5 NHS Providers said that, from the viewpoint of trusts, a meaningful, real-terms pay increase for staff throughout the NHS was critical. When responding to its November/December 2020 survey, 82% of HR directors had called for a pay uplift of at least 3%. They also said that it is essential that pay awards are fully funded by the Government and affordable for trusts to administer for all eligible staff.
- 5.6 NHS Employers said that employers share the desire to recognise and reward the contribution of all NHS employees during the pandemic and across their careers. Any uplifts to pay must be fully funded. In oral evidence, they said that an uplift of between 2% and 2.5% was what might be felt to be fair and affordable by employers.
- 5.7 The Department of Health, Northern Ireland set out their 2020/21 pay policy and noted that the Finance Minister would determine pay policy for 2021/22. In oral evidence, they noted that the budget announced in April had £52 million set aside for AfC pay in 2021/22. This was around a 2% increase on the pay bill. A pay award above 2% would require reprioritisation.
- 5.8 Northern Ireland announced a one-off payment to include AfC staff, in relation to work during the pandemic. This was £735 so that those qualifying for the full award would receive around £500 after basic rate tax and national insurance contributions.

- 5.9 The Northern Ireland public sector pay policy for 2021/22 set out that there would not be an across-the-board public sector pay freeze and pay awards of up to 1% would be allowed where reforms were agreed. The policy said there would be flexibility for higher awards in return for cash releasing efficiency savings through improvements to public sector productivity. The 1% limit would not apply to staff in the Health and Social Care (HSC) service.
- 5.10 The Welsh Government said that it wanted a fair and affordable pay rise for AfC staff. It had made some provision for the pay award. It was not looking for an arbitrary cap on pay and was not wedded to either a flat rate or percentage increase, although pay of the lowest paid was a priority. It did not want the integrity of the AfC pay scales affected and what it described as a return to the previous problems of differential pay.
- 5.11 Wales announced a one-off payment to include AfC staff, in relation to work during the pandemic. This was £735 so that those qualifying for the full award would receive around £500 pounds after basic rate tax and national insurance contributions.
- 5.12 The Joint Staff Side asked for an early and substantial pay rise to build on the progress made in the 2018 pay agreement. They were clear that the pay award and funding for 2021/22 should be considered separately from bonuses awarded by the devolved administrations to recognise the work of NHS staff during the pandemic. They emphasised the number of staff at the top of their pay bands and noted the importance in retaining these staff for their experience and to achieve the right skill mix.
- 5.13 The individual Trade Unions made pay award proposals:
- the Royal College of Nurses (RCN) asked for at least 12.5% for all AfC staff;
 - the Royal College of Midwives (RCM) asked for a single consolidated increase for all;
 - UNISON asked for at least £2,000 to every pay point;
 - Unite asked for the higher of £3,000 or 15%;
 - the GMB asked for the higher of 15% or £2 per hour;
 - the Chartered Society of Physiotherapists supported the joint evidence submitted by the NHS Trade Unions;
 - the Society of Radiographers asked for the higher of £2,000 or a minimum 3.5% uplift;
 - the College of Podiatry asked for the higher of a 7% rise in all AfC pay points or £2,000; and
 - Managers in Partnership asked for a meaningful pay rise that was equitable across all pay bands.
- 5.14 We also received a pay award proposal from the Nurses United campaign, who proposed a 15% uplift across all sections of the AfC workforce.

Our concluding arguments

- 5.15 A five-year funding plan for the NHS from 2019/20 was set out in June 2018 and, for England, enshrined in law in the NHS Funding Act 2020. Funding was allocated to clinical commissioning groups (CCGs) in England via allocations that included a growth assumption for pay awards. The funding allocations for Northern Ireland and Wales are determined using the Barnett formula. Barnett consequentials are calculated on the increase in NHS England spending over the assumed baseline.

- 5.16 In 2020/21, in England, in response to the pandemic, a temporary financial architecture was put in place. This allowed systems in the first half of the year to claim for any retrospective costs and establish allocations in the second half of the year that included additional funding for COVID-19 costs. For 2021/22, it was decided to roll these allocations over for the first half of the year to minimise the planning burden on the NHS during the most recent wave of COVID-19. In terms of pay growth, these envelopes included 0.7% of the pay bill for the three-year deal AfC overhang. The funding allocation for the second half of the year had not been set at the time we finalised our report. The pay award for the whole year would be reflected in the funding arrangements for the second half of the year once our recommendations had been considered.
- 5.17 As set out above, the DHSC assumed a headline pay award of 1% for NHS staff in England for 2021/22 and budgeted for the additional cost of a £250 uplift for AfC staff earning less than £24,000 FTE. In addition, it had budgeted the 0.7% already committed for the overhang of the three-year deal. In oral evidence, DHSC confirmed that the NHS Long Term Plan had included a pay envelope of 2.1% but with a target of making re-investable productivity gains of at least 1.1% a year over the five years. The DHSC said that due to COVID-19, productivity gains were unlikely to be achieved, and any award higher than 1% would, therefore, require re-prioritisation. (One per cent of the AfC pay bill for England is £466m.) The DHSC said that spending more on pay would mean less funding for other priorities, including the size of the workforce that is affordable, as well as wider investments required to deliver the NHS Long Term Plan. NHS Employers and NHS Providers told us that the pay uplift in 2021/22 must be fully funded by the Government.
- 5.18 The Department of Health, Northern Ireland, said pay awards including any higher awards would have to be found from existing departmental budgets or funded through efficiencies. In oral evidence they said they had built in AfC pay growth of 2%, and any scope to offer increased awards to reward staff would depend largely on affordability, balancing other competing demands for resources in the current budget, particularly in the COVID-19 context, that enabled essential public services to be sustainably funded going forward.
- 5.19 The Welsh Government said that it had made some provision for a pay award and would make a decision as to whether or not any additional money required would come from existing budgets in due course. In oral evidence, the Welsh Government told us that the higher the pay award the more difficult the choices would be on how to fund it and other priority ambitions for the Welsh NHS.
- 5.20 We recognise that the experience of NHS staff varied over the course of the pandemic and according to their roles and responsibilities. We heard consistently from staff and employers, and on our visits, that AfC staff were affected since March 2020 by the extraordinary pressures and additional workload with which the NHS was faced and that they contributed in different ways. While we recognise that not all NHS staff had exactly the same experience of working through the COVID-19 pandemic, we find the evidence we received from most of the parties that NHS staff pulled together as one team, compelling. We accept that AfC staff join the NHS anticipating that they will face difficult and challenging circumstances, but both the intensity and sustained nature of these challenges was undoubtedly abnormal. While this might remind some existing staff and potential recruits of the value of a career in NHS, it will also have highlighted potential risks both to themselves and their families.

- 5.21 Looking forward, there will continue to be an abnormally high level of demand facing the NHS during 2021/22, which is the period covered by this review: there is a significant backlog of care from postponed treatment and late presentation of patients; the implications of long COVID are only just beginning to emerge; there will be an increased demand for mental health services; patients will need to be cared for through any future waves of the virus; and the roll out of the vaccination programme will continue and as new variants of the virus circulate the NHS will need to extend its effort to administer booster jabs. This will require sustained effort and commitment from the NHS workforce, many of whom are severely fatigued.
- 5.22 This demand also will need to be set in the context of the vacancies and shortages of staff with which the NHS entered the pandemic. This required significant bank expenditure and agency and paid and unpaid overtime, while also coping with some reductions in sources of supply as a result of the pandemic. Much of the additional effort and commitment will therefore be discretionary.
- 5.23 The latest data show significant vacancy rates across the NHS in England, Wales and Northern Ireland. Total vacancies across the NHS in England in the third quarter of 2020/21 were just under 89,000, of which 36,214 were nursing vacancies, and 45,555 were in non-nursing AfC staff groups. This represents a nursing vacancy rate of 9.7% and 6.0% for non-nursing AfC staff groups. The NHS in Wales had 1,837 FTE advertised vacancies for non-medical staff in July 2020. For Northern Ireland, at the end of December 2020 there was an overall vacancy rate of 6.9% including a vacancy rate for registered nursing and midwifery of 9.4%. A number of commentators have noted the need for better workforce planning in the NHS, in order accurately to forecast the number of staff needed, and the Health Foundation have argued that the target for an additional 50,000 nurses in England may be insufficient in the long term to meet demand.
- 5.24 Some level of vacancies is inevitable, as staff move into and out of roles in the NHS in England and Wales and HSC in Northern Ireland. In all cases the vacancy rates show some encouraging signs with falls from levels at the same point the previous year. However, vacancy rates at persistently high levels have the potential to impact on: service delivery; the patient experience and patient safety; and cost through additional bank and agency charges. They will also add to the pressures on staff already in place. The implications for staff include: additional working hours; increasing work-related stress leading to sickness absence; concerns over work-life balance; and poor staff health and wellbeing. This leads to retention, recruitment and motivation difficulties. Although the vacancy rate for nurses in England has fallen from over 12% at its peak to just under 10%, this remains double the 5% target expressed in the NHS Long Term Plan for England.
- 5.25 It is unclear what impact COVID-19 will have on vacancy rates. However, in the shorter term, there will be reductions in supply and workforce availability arising from: an exhausted workforce needing time to recover who will need to take holiday and may have less appetite for working additional hours; potentially higher-than-usual levels of sickness due to long COVID and ongoing mental health consequences; and a temporary reduction in the supply of new NHS staff from abroad.

- 5.26 In terms of recruitment, there has been an encouraging increase in the number of applicants to and acceptances onto nursing and other healthcare-related degrees. In 2020, compared with 2019, the numbers applying to study nursing increased by 16% and the numbers applying to study other health-related subjects increased by 6%. The numbers accepted by UK universities to study nursing increased by 24%, while there was a 10% increase in numbers accepted to study other health-related subjects. This is likely to have been driven by a combination of: the reinstatement of some financial support for students studying these subjects; the increased profile of the NHS and careers in the NHS as a result of COVID-19 including secure employment prospects; increased pay in the NHS through the 2018 AfC agreement; and the way that A level grades were determined in 2020. While the ongoing increase in both applicant and acceptance rates is very positive, it will be 2023/24 before this year's cohort of students translates into increased workforce supply.
- 5.27 In the meantime, as noted, overseas recruitment may be problematic in, at least, the short term. This is particularly important in the context of England's target to recruit 50,000 more nurses and the focus that both Wales and Northern Ireland have on overseas recruitment in reducing their vacancy rates. The Health Foundation assessed that, to meet this, the NHS will need to recruit at least 5,000 nurses a year from overseas until 2023/24. The Review Body is concerned that the recent progress in recruitment from India and the Philippines may not be sustained in the short term given the current challenges of COVID-19 in those countries. Other sources of recruitment are still providing relatively few numbers of people and need to be further developed, including apprenticeships, nursing associates, and new flexible routes into training such as the blended learning nursing degree.
- 5.28 While existing staff can leave with no more than a few months' notice, it takes a number of years to train someone for a degree-level occupation. Given this gap before new trainees enter the workforce, alongside the likely dip in some elements of supply and the demand pressures that will prevail, we are of the view that it is essential to maximise retention of AfC staff.
- 5.29 For both England and Northern Ireland, in 2019/20, joining rates were greater than leaving rates for each broad staff group and, in England, leaving rates fell in both 2018/19 and 2019/20. More recent data for England only, shows that the leaving rate for nurses and health visitors has continued to fall through much of 2020, although data for the final quarter did show an upturn in outflow. Though we cannot be certain why outflow rates fell through 2020, some parties have suggested it may have been due to some staff choosing to remain in the NHS, for example, delaying retirement – to help the response to COVID-19 or reduced employment opportunities outside the NHS. We heard repeatedly in evidence and on our visits that AfC staff postponed decisions about their futures during COVID-19. We also heard in evidence, staff describe the exhaustion they felt from their work in the last year and that they were daunted at the prospect of continuing to work under this level of pressure. It seems to us that there is a clear risk both that staff that have postponed leaving decisions and those that had not previously considered leaving, having committed significantly to the NHS over the last 18 months and seeing the substantial challenges ahead, will feel that the sustained contribution they have given is enough and that they do not have the energy and resilience that will be required going forwards. In our view, there is a significant retention risk.

- 5.30 Burnout of staff was something noted by all the parties, and a workforce that has already been operating under a great deal of pressure, with little sign of this abating, creates significant threats to retention. We know that one driver of staff leaving is the sense of having an insufficient number of colleagues to provide the right quality of care. A focus on retention is therefore needed both to provide safe patient care but also to prevent a vicious circle in which a reduced number of staff pushes more staff into a decision to leave, thereby creating even more risk.
- 5.31 We note the weaknesses of data looking at reasons for leaving the NHS and the ongoing challenges in understanding and interpreting data that is available. Some risks to retention may be specific to a certain workforce group. In relation to nurses, NHS Employers and the Health Foundation identify three key groups for whom retention is of potential concern: young recent graduates who do not go on to work in the NHS (attrition); mid-career staff (who may wish to leave the NHS to pursue careers in private healthcare sectors and elsewhere); and those close to retirement. For those close to retirement across the AfC workforce, the recent McCloud judgement will provide new options for them to retire. Those staff closest to retirement are also most likely to be at the top of their pay band. Under the three-year deal, staff have seen base pay increases averaging around 9%. However, those already on the band maximum saw base pay increases of 6.5% or less. The significant number at the top of their pay band, therefore, gained least in pay over the term of the 2018 deal.
- 5.32 Many factors drive retention, and we note work to support retention across the system, including employers' detailed work on key retention risk areas such as support for retire and return. Nevertheless, pay is one driver. We have seen the outflow data for both England and Northern Ireland show a fall in leaving rates in 2018/19 and 2019/20. Although we cannot be sure that the falls in outflow are a result of the increases in pay associated with the three-year AfC deal, there is a correlation between increased pay and reduced leaver rates and with depressed pay and increased leaver rates in the NHS. We also know that the number of nurses choosing to work in the NHS is sensitive to pay in the NHS relative to both inflation and to pay in relevant alternative occupations.⁷⁹ In addition, there are specific opportunities for NHS staff in sectors where economic deterioration has not occurred at the same level as the economy as a whole – for example, there are opportunities in the private health and social care sector for a range of occupations including nursing, physiotherapists and podiatry that may well increase as both patients and the NHS look to the private sector to help tackle the backlog of care created by the pandemic.

⁷⁹ Crawford, R., Disney, R. and Emmerson, C. (2015), "*The short run elasticity of National Health Service nurses' labour supply in Great Britain*". IFS Working Paper W15/04. Available at: <https://www.ifs.org.uk/uploads/publications/wps/WP201504.pdf>

- 5.33 In order to maintain and grow the AfC workforce, it is our view that it is important this year that pay does not become a factor encouraging staff to leave. Pay matters to staff and may well influence decisions they make about their future. Pay influences the engagement staff have with and discretionary effort they give to their job and on which the NHS relies. The 2020 survey of NHS staff in England⁸⁰ was conducted in October and November 2020, between the first and second waves of COVID-19. In England AfC staff satisfaction with pay declined in 2020, compared with 2019, by 1.5 percentage points. In 2020, 34.9% of staff responded positively to the survey, compared with 39.6% who said they were dissatisfied. Although satisfaction with pay fell between 2019 and 2020, this followed two years where satisfaction with pay had increased. There is, therefore, clear evidence that the 2018 AfC pay deal had a positive impact on satisfaction with pay. We note also that those groups recording the smallest improvements in satisfaction were nurses and midwives, and nursing and healthcare assistants, two groups who saw some of the smallest increases in average earnings over the period of the deal.
- 5.34 Many of the indicators related to wider job satisfaction showed a decline between 2019 and 2020, in particular job-related stress. It may be possible that the results from the 2020 NHS Staff Survey, undertaken when the incidence of COVID-19 was some way below its peak, may portray a more positive picture than the situation through the winter of 2020/21.
- 5.35 Having a well-motivated workforce is key if the NHS is to deal with the challenges ahead. This year, the pay award and what it is seen to say about the value of AfC staff will have a significant impact on morale and motivation.
- 5.36 We have noted in Chapter 4, the uncertainty of current forecasts of the performance of the economy and labour market. We recognise that the fiscal position is challenging – that there are significant calls on the public purse, and difficult choices for government to make. There are high levels of UK debt.
- 5.37 Noting the volatility of some of the economic and labour market data we have considered the latest available data at the time of this report:
- Inflation, measured by Consumer Price Index (CPI), in April 2021 was 1.5% (with Consumer Price Index Including Housing (CPIH) inflation at 1.6%). The Bank of England expected CPI inflation to rise to its 2% target later in 2021. The Office for Budget Responsibility (OBR) also expected a sharp rise in CPI inflation, to 1.9% in the second quarter of 2021, before falling back to 1.6% in the second half of 2021;
 - Gross Domestic Product (GDP), in April 2021, was 4% below the pre-pandemic peak but both the Bank of England and the OBR forecast strong growth through the rest of 2021. The Bank of England, in the May Monetary Policy Report, revised up its path for economic growth in 2021. It expected GDP growth of 7.25% overall in 2021, with a recovery to pre-pandemic levels by the end of 2021. We note that this projection has a high level of uncertainty;
 - There were other indicators of and predictions for relatively rapid recovery of the economy and labour market. The number of employees on payrolls have increased each month between November 2020 and April 2021, by 190,000 in total over the period. Labour Force Survey data showed a fall in total employment of 529,000 over the year to March 2021, but an increase of 84,000 compared with the three months to December 2020;

⁸⁰ The 2020 NHS Staff Survey in England is particularly valuable this year. It is the only service wide survey conducted since the COVID-19 pandemic began that allows comparisons with previous years and asks participants their view on their pay.

- The Chartered Institute of Personnel and Development (CIPD) spring 2021 Labour Market Outlook indicated that employment intentions had risen sharply and were at their strongest since the winter of 2012/13. Employers' optimism was evident across the private, public and voluntary sectors, pointing to a strong and broad-based employment recovery in the short term. Pay settlements looked set to return to pre-pandemic levels, with a greater range of outcomes than previously. Redundancy intentions had fallen to below pre-pandemic levels;
- The same is true for earnings growth. The total amount paid through PAYE in the UK fell by 4.5% from January to May 2020. By March 2021, the PAYE data had recovered and was up 2.2% from a year earlier. In the three months to March 2021 whole economy annual average earnings growth was 4.0%, with growth of 3.7% in the private sector and 5.7% in the public sector (excluding financial services). However, the ONS said that the earnings growth figures had been affected by changes to the composition of employee jobs, which meant that underlying earnings growth was around 3%; and
- Pay settlement data for the first four months of 2021 indicated that 28% of reviews this year have been pay freezes, compared to 20% in 2020. There had also been a notable increase in the proportion of pay reviews in the 1.0% to 1.9% range. The latest XpertHR data gave a median of 1.9% for pay reviews in the three months to April 2021, while both Incomes Data Research (IDR) and Labour Research Department (LRD) had medians of 2.0% for the three months to April 2021.

- 5.38 The recent economic downturn and partial recovery is not a typical recession. They are the consequence of a deliberate government policy to prioritise public health and selectively to shut down and reopen specific sectors of the economy. This, coupled with differential opportunities to use modern communications technologies, means that the economic crisis has impacted in enormously different ways for different individuals and businesses. Some individuals have lost their jobs. Many of those who have not lost their jobs – in part because of the Coronavirus Job Retention Scheme – have nevertheless suffered a drop in income, and anxiety about their future. But others have been able to carry on working, albeit some remotely or from home, and maintain or even increase their earnings.
- 5.39 In assessing the retention challenge for AfC staff this year, our focus has been on the relevant alternative employment options for AfC staff rather than on the gap between what has been happening on average across the public sector and private sector, as recorded at particular points in time.
- 5.40 We know that the majority of nurses who could potentially work in NHS but who chose not to, work either as nurses in the private sector or in some other capacity in the health and care sector in either the public or private sector.⁸¹ We would expect that the same applies for other staff as there are also markets in the public, private and third sector for occupations including pharmacy, podiatry, physiotherapy, clinical science, and medical and pharmaceutical research. Given the backlog of cases and the significant savings that some have been able to build up over the last year, there is a risk that spending on private health will increase suggesting that pay and conditions in these sectors are likely to improve. The NHS also commissions the private sector to provide services. Annual Survey of Hours and Earnings (ASHE) data show that, in 2020, median gross weekly pay for full-time employees in the human health and social work activities sector increased by 2.0%, compared with 0.1% across the economy as a whole.

⁸¹ Crawford, R., Disney R, and Emmerson, C (2015), "*The short run elasticity of National Health Service nurses' labour supply in Great Britain*". IFS Working Paper W15/04. Available at: <https://www.ifs.org.uk/uploads/publications/wps/WP201504.pdf>

- 5.41 On the basis of currently available data, we consider that AfC staff may be less likely to be constrained in finding alternative sources of income outside the NHS than may have been anticipated in the autumn of 2020. To ensure that the pay award does not worsen retention, it is necessary that the award is seen to be above likely price growth and earnings in relevant alternative employment – alternative employment that may be seen to provide more straightforward and less pressurised work, with better flexible working opportunities.
- 5.42 The three-year deal was a significant investment in pay and increased earnings for the AfC remit group, as intended, in response to significant workforce shortages. In England, the investment was £4.2 billion over the three years to deliver a 3% annual increase in the AfC pay bill. Over the three years of the AfC pay agreements there were different pay and earnings effects for individual AfC staff depending on whether they were at the start of a career, progressing through the system or reaching the top of pay bands. For all AfC staff, on average, basic pay and overall earnings each grew by just over 9% over the three years to December 2020.
- 5.43 The complexity of the deal meant that staff found it difficult to understand. The way in which the agreement was structured also meant that some key groups were, unintentionally, less advantaged than others. For example, against both basic pay and average earnings nurses and health visitors, and midwives were amongst the occupational groups that saw smaller average increases than other groups.
- 5.44 Nurses were less advantaged in part because of the high proportion of them at the top of their band where pay gains were lower. As seen, those already on the band maximum saw base pay increases of 6.5% over the three years. In England, at the end of March 2020, 40% of AfC staff were at the top of their pay band but for nurses and health visitors, and midwives, this was 42%. Staff groups with the largest proportion of staff in Bands 1 to 4 saw larger increases, likely driven by the closure of Band 1 and the completion of scale shortening in the lower bands within the three years of the deal.
- 5.45 Over 150,000 nurses and health visitors are on Band 5⁸² (45% of all nurses and health visitors and 66% of all AfC staff on Band 5) and will be impacted by the agreed overhang from the three-year deal, which will only be implemented in 2021/22. This 0.7% on the pay bill will enable completion of the restructuring of the AfC pay structure by removing the existing transitional pay points for Bands 5, 6 and 7, leaving each with three pay points. This will move affected staff directly to the top of the pay band, resulting in pay increases of 11.7% for the affected point in Band 5, 12.2% for the affected point in Band 6, and 6.7% for the affected point in Band 7. These rises will not apply to those at the top of those bands. The impact of this on the earnings of different occupational groups will be visible in the data next year.
- 5.46 The range of pay award proposals, public sector pay policies and funding envelopes given to us in evidence show the significant differences that there are between the parties this year, and we recognise that views are strongly held.

Our recommendations

- 5.47 In light of the above, we considered both the amount that our recommendation should be and the structure of the award. We considered a number of possibilities. These included a flat rate rather than a percentage uplift; whether there should be a cap on the award or a floor; and whether any portion of the award should be non-consolidated.

⁸² The ESR category for this staff group is 'nurses and health visitors'. However, it should be noted that health visitors do not operate at a Band 5 level.

- 5.48 We rejected these. Following the complexity of the three-year deal and its different impacts on different sections of the AfC workforce, we heard from all the parties that what was needed this year was an award that was simple to administer and to understand, underpinned the existing structure of the AfC framework, and recognised the importance of the teamwork that operated during the pandemic by treating staff at all levels and across AfC equally. None of the parties supported a non-consolidated award.
- 5.49 Therefore, we recommend a consolidated award of 3% with effect from 1 April 2021 for all AfC staff. Such an award would add £1,398 million to the pay bill in England, £111 million in Wales and £73 million in Northern Ireland.

Recommendation: we recommend a consolidated award of 3% from 1 April 2021 for all AfC staff.

- 5.50 We note that measures that improve the wellbeing and working lives of AfC staff will ultimately also support retention. In the evidence we received and from our visits, we heard consistently about the need for the rest and recuperation of staff. There have been a number of initiatives from some employers to support wellbeing and improve the working lives of staff during the pandemic. These have included additional leave, bonuses, mental health support, expanded childcare, improved access to nutritious food, and the overhauling of rest areas. We also heard about the value placed on the suspension of car parking charges for staff in England from those that benefitted, and we therefore note the Government's intention to reintroduce charges.
- 5.51 We would therefore urge all employers, who will have a good understanding of the needs of their own staff, to continue to develop the mechanisms they have to support the rest and recuperation of staff. While recognising that the suspension of car parking charges in England benefitted some staff and not others, we would also welcome both Government and trusts considering carefully the way in which car parking charges are reintroduced and to be sensitive to these as a point of friction that can sour good employee relations.
- 5.52 We are also aware of the importance that staff place on training and learning and development opportunities and heard about some of the constraints on this during the pandemic. We look forward to evidence on the way in which training, learning and development can recover.

Nurses' pay

- 5.53 We have particular concerns about nursing pay.
- 5.54 The position in the wider market of nursing pay changes significantly over the course of a career. Nursing pay at the start of a career, one year after graduation, is near the top of graduate earnings with LEO data showing that only those who studied medicine and dentistry, veterinary sciences, engineering, and economics, had higher median earnings than those who studied nursing⁸³. At five years after graduation, earnings level off so that those who studied nursing or midwifery had median earnings still above the median for graduates as a whole, but by less than they had been one year after graduation. At 10 years, this falls back further so that median earnings for those who studied nursing or midwifery, had fallen below the overall graduate median. Nurse pay is likely to be high after graduation because those with a nursing degree move straight into a graduate job

⁸³ The LEO data category for this staff group is 'nursing and midwifery'.

in the NHS. However, earnings in nursing do not keep pace with other graduate earnings over the course of a career, and this raises the question of whether the AfC system fully reflects the professional demands on nurses and their contribution to the NHS.

- 5.55 The nursing profession has evolved and continues to do so and the breadth and depth of the knowledge, training, experience, skills, responsibilities, effort, and working conditions required to fulfil a nursing role have changed. It has become an all-degree profession, in recognition of the increased autonomy and enhanced clinical capabilities of contemporary nursing roles. Nurses are part of a modern medical workforce. To undertake the responsibilities expected of them in today's NHS, they operate in a more analytical and independent manner, must be confident in the decision-making skills required to make high-level judgements, need extensive knowledge and experience, and carry out work that demands increasingly advanced levels of practice and clinical knowledge.
- 5.56 We would therefore encourage the parties to consider whether the AfC system accurately reflects the relative job weight of the realities, complexities and development trajectories of nursing as a modern graduate profession, best to enable the recruitment, retention and motivation of nurses in the short and medium term.

Chapter 6 Forward Look

Introduction

- 6.1 In this chapter we aim to give the parties who provide evidence, and the remit group more generally, some indication of areas that are likely to be of continuing interest to us in future pay rounds.

COVID-19

- 6.2 The coronavirus (COVID-19) pandemic was a significant focus of the evidence we received from all the parties this year. As the pandemic and work needed to tackle the backlog progresses, we will look for further data next year on the evolving impact of COVID-19 and the backlog of care it has created, on the National Health Service (NHS) and staff working within it, to enable us to monitor its impact on the recruitment, retention, and morale and motivation of the Agenda for Change (AfC) workforce.

Workforce strategy and planning

- 6.3 A number of commentators have noted the need for robust and transparent workforce planning in the NHS. There is concern that current forecasts are not based on a thorough strategic workforce planning process, based on demand and the capacity required to meet that, and instead come from planning assumptions made against available funds. A transparent NHS workforce strategy, covering all AfC staff, that aims accurately to forecast appropriate and safe staffing levels for patient care would allow the whole system to understand the needs of the service and, in the context of current shortages, would build confidence in the workforce planning process.
- 6.4 We note that, in Wales, medium-term integrated plans from health boards have three-year workforce plans, which contain safer staffing numbers for nurses. Wales also has the Nurse Staffing Levels (Wales) Act 2016, which requires NHS Wales organisations to calculate the nurse staffing levels required in adult acute medical and surgical inpatient areas. We look forward to hearing about the national plan and the way in which this workforce strategy will impact on AfC staff.
- 6.5 We note the increasingly divergent pay policies of the different nations to our remit group and the need for workforce strategies in all countries to be accompanied by a comprehensive medium-term pay strategy.
- 6.6 In England, the Government has made commitments to significant developments in staffing for new service models under the NHS Long Term Plan. We highlighted in our report last year that we were yet to see evidence of the workforce planning mechanisms to support new models of care.
- 6.7 We note that the Department of Health, Northern Ireland is committed to addressing the issue of safe nurse staffing legislation. A working group has been established to take this work forward.

- 6.8 We commented last year in our report on apprentices. The NHS has an opportunity to create attractive apprenticeships, which offer secure employment, fulfilling roles, and excellent training and progression opportunities. Apprenticeships are growing in popularity and are increasingly a focus for talented young people from a diverse range of backgrounds. An apprentice route into the NHS diversifies and so helps secure the future supply of staff to the NHS. It also, given the scale and geographical spread of AfC staffing, provides valuable openings to rewarding careers with high-quality training, and offers long-term employment for groups for whom these may be less accessible. The NHS will be competing for staff with other public and private sector employers and its apprenticeship offer risks having less impact than it should do. The failure to agree national apprenticeship pay rates is a missed opportunity for the NHS Staff Council.

National workforce policies

- 6.9 In England, *We are the NHS: People Plan for England 2020/21 – action for us all* was published in July 2020⁸⁴ along with the *People Promise*. Together, they set out what NHS staff can expect from their leaders and from each other. The People Plan 2020/21 built on the interim NHS People Plan, published in 2019⁸⁵. The 2020/21 plan set out practical actions for employers and systems, as well as the actions that NHS England and NHS Improvement (NHS E&I) and Health Education England (HEE) would take, over the year. The Plan noted that the arrival of COVID-19 acted as a springboard, bringing about an incredible scale and pace of transformation, and highlighting the enormous contribution of all NHS staff. It said that the NHS must build on this momentum and continue to transform – keeping people at the heart of everything it does.
- 6.10 Last year we looked forward to the publication of the NHS People Plan. We were encouraged by the collaborative and inclusive approach among NHS organisations, employers and unions in developing the Plan. However, we noted that we commented in our 2019 Report on the continuing lack of clarity on responsibility for enacting and delivering the Plan, and that it was a priority for us that there is system-wide action on workforce priorities. We continued to consider that further clarity was required on delivery through the Department of Health and Social Care (DHSC), NHS lead organisations, Integrated Care Systems (ICSs) and individual NHS trusts. We are pleased to see publication of the 2020/21 People Plan and look forward to the seeing the actions for 2021/22.
- 6.11 We appreciate that COVID-19 will have slowed down the development and implementation of some parts of the People Plan but it will have also created opportunities to speed up some elements. For example, we comment in our report on the new and innovative ways of working that we were told had been brought about by the pandemic and the importance of involving staff in further development of these. We look forward to seeing the next iteration of the People Plan and to receiving evidence on the impact of the implementation of the Plan on the NHS and the AfC workforce.

⁸⁴ NHS England and NHS Improvement (30 July 2020), *We are the NHS: People Plan for 2020/2021*. Available at <https://www.england.nhs.uk/ournhspeople/>

⁸⁵ NHS (June 2019), *Interim NHS People Plan*. Available at: <https://www.longtermplan.nhs.uk/publication/interim-nhs-people-plan/>

- 6.12 Wales launched *A Healthier Wales: Our Workforce Strategy for Health and Social Care*^{86 87} in October 2020. The strategy signals the long-term vision for the health and care workforce as a key driver to realise the national strategic plan for health and social care, *A Healthier Wales (AHW)*⁸⁸. AHW was published in 2018 along with forty actions to focus activity on the transformation required to achieve its vision of an integrated whole system approach to health and social care. In September 2020, a Cabinet Paper, *A Healthier Wales Two Years On*⁸⁹, provided a progress update. It reflected on AHW to ensure it was relevant in the current climate and as the stabilisation and recovery of services moved forward.
- 6.13 The progress update acknowledged that the foundation of AHW had strengthened partnerships and collaboration across both organisational and geographical boundaries. COVID-19 had accelerated transformational change in how health and social care services were being delivered and the response to the pandemic had brought forward the implementation of several long-term plans. It confirmed that AHW would continue to be the strategic framework for developing and implementing new ways of working.
- 6.14 We welcome the further development of AHW. We look forward to receiving evidence next year: on its implementation and impact on AfC staff; information on how it will be measured and monitored; on the delivery plans for the workforce strategy; and the relationship with the Nurse Staffing Levels (Wales) Act 2016 and the findings from the first triennial reports from the health boards under this legislation.
- 6.15 The Department of Health, Northern Ireland launched its *Health and Social Care Workforce Strategy 2026* in 2018⁹⁰. The strategy had three key objectives: of a reconfigured health and social care system with the best possible combination of skills and expertise; that health and social care will be a fulfilling place to work and train, and that the Department of Health, Northern Ireland and health and social care providers would be able to monitor workforce trends and issues effectively.
- 6.16 We look forward to hearing more about the implementation of the strategy in further evidence submissions and the impact of its policies on the retention, recruitment, morale and motivation of AfC staff in Northern Ireland.

Total reward

- 6.17 Forward thinking employers focus on total reward to ensure that they can recruit, retain and motivate their staff and total reward for AfC staff remains an important part of our considerations. We noted last year the significant emphasis that parties placed on the value of the AfC total reward package in their evidence. The reward package also needs to be able to respond to different influences during an NHS career.

⁸⁶ Welsh Government (20 October 2020), *Written Statement: Launch of 'A Healthier Wales: Our Workforce Strategy for Health and Social Care'*. Available at: <https://gov.wales/written-statement-launch-healthier-wales-our-workforce-strategy-health-and-social-care>

⁸⁷ Health Education and Improvement Wales (HEIW) (22 October 2020), *A Healthier Wales: Our Workforce Strategy for Health and Social Care*. Available at: <https://heiw.nhs.wales/programmes/health-and-social-care-workforce-strategy>

⁸⁸ Welsh Government (8 June 2018), *A healthier Wales: long term plan for health and social care*. Available at: [A healthier Wales: long term plan for health and social care | GOV.WALES](https://gov.wales/a-healthier-wales-long-term-plan-for-health-and-social-care)

⁸⁹ Welsh Government (24 March 2021), *Written Statement: A Healthier Wales Action Review*. Available at: <https://gov.wales/written-statement-healthier-wales-action-review>

⁹⁰ Department of Health, Northern Ireland (2 May 2018), *Health and Social Care Workforce Strategy 2026*. Available at: <https://www.health-ni.gov.uk/publications/health-and-social-care-workforce-strategy-2026#:~:text=%E2%80%99Health%20>

- 6.18 One important aspect of the total reward package is flexible working arrangements. For example, recent research⁹¹ argues that working from home for two days a week can be efficient for companies and that those who prefer this pattern considered it to be equivalent in value to 6% of their wages. Flexible working comes in many forms and we were told by parties in evidence that there had been significant progress in policy development to support flexible working for AfC staff across the NHS. However, we do not underestimate the challenges of implementing such policies across a complex system of atomised employers currently dependent on fixed and long shifts, overtime both paid and unpaid and using less than cutting-edge technology to manage work patterns. Parties were unable to give us examples of the successful application of flexible working in a clinical setting and we would welcome, therefore, evidence and specific examples of the successful application of flexible working.
- 6.19 We also note the welcome focus on staff training, learning and development in national workforce plans, which is another important part of total reward and was also a focus of the three-year deal. We note that there has been an understandable but significant pause in training, learning and development activity for students and staff during the pandemic. We heard that HEE were providing financial support in the context of COVID-19, including extra funding for simulated learning. We look forward to hearing how training, learning and development will be brought back on track.

Service transformation, integration and productivity

- 6.20 Three areas of planned service changes relate to our remit as they impact on the way in which the AfC workforce is configured and deployed: new service models focused on primary care and community services and therefore the associated workforce requirements; the integration of health and social care; and staff contribution to new ways of working and therefore productivity improvements.
- 6.21 In previous years, the evidence from all parties continued to emphasise the rising demand for services and the pressures this placed on the existing AfC workforce, and last year we noted the risk that pressures on providers from finances and demand for services could also be squeezing out time and resources required to transform services as envisioned in the NHS Long Term Plan. This year, the evidence we received showed how the existing pressures on the NHS have been exacerbated by COVID-19 and the significant challenges ahead.

⁹¹ VOXEU (15 March 2021), *Working from home is revolutionising the UK labour market*. Available at: <https://voxeu.org/article/working-home-revolutionising-uk-labour-market>

Service transformation

- 6.22 In the last 12 months there has been development in the plans to restructure the NHS in England. In February 2021, the DHSC published its White Paper, *Integration and innovation: working together to improve health and social care for all*⁹², which sets out legislative proposals for a Health and Care Bill, which was subsequently set out in the Queen's Speech in May. The Paper brings together proposals that build on recommendations from NHS E&I in *Integrating care: next steps to building strong and effective integrated care systems across England*⁹³, published in November 2020, with additional proposals to support social care, public health and quality and safety in the NHS. Many of the proposals build on recommendations in the NHS Long Term Plan. The White Paper sets out its proposals under the themes: working together to integrate care; reducing bureaucracy; improving accountability and enhancing public confidence; and additional measures. At the heart of the changes being taken forward is joined up care. There are two forms of integration which will be underpinned by the legislation – integration within the NHS, and greater collaboration between the NHS and local government and wider delivery partners. We note that the Interim NHS People Plan also pointed to a substantive role for ICSs in workforce planning and deployment, and the White Paper commits to bringing forward measures for statutory ICSs. We look forward to hearing about the way in which service transformation will impact on the recruitment, retention, morale and motivation of the AfC workforce.
- 6.23 Last year, we also heard concerns that the expected growth in the primary care workforce under multi-disciplinary teams would put pressure on overall healthcare shortages for, among others, nursing, diagnostics and paramedicine. There were also some emerging indications that AfC staff from the acute sector could be attracted by primary care offering more flexible or stable working arrangements and different local pay structures. The effect could be significant for shortage staff groups who could be in demand from different health sectors. We look forward to receiving further evidence on this.

Integration of health and social care in England

- 6.24 The NHS Long Term Plan aims for ICSs to bring together local organisations to deliver the triple integration of health and social care, primary and specialist care, and physical and mental health services. Last year, we noted the evidence that, while there were examples of trusts, other providers and local authorities working well together, the funding, administrative and cultural barriers remained considerable.
- 6.25 We noted that the DHSC told us that the vast majority of the adult social care workforce was paid less than the equivalent of the bottom of AfC Band 2 and that, if the wages of these workers were raised to at least the bottom of AfC Band 2, the government estimated it would cost around £1.2 billion. The Health Foundation provided some initial comments on the effects of COVID-19 on the capacity and resilience in the NHS and social care. It cited both sectors having significant staff shortages and that assessing the cumulative impact on the NHS, social care and wider society would include, among other things, the relationships between disrupted and changed services, and public awareness strengthening the impetus for social care reform. The parties' evidence for our report stressed that managing demand in the NHS depended on capacity in social care, where much care is supplied by the private sector. We noted that the government has promised consultation on a plan for social care where workforce pressures are significant.

⁹² DHSC (11 February 2021), *Working together to improve health and social care for all*. Available at: <https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all>

⁹³ NHS England and NHS Improvement (15 January 2021), *Integrating care: Next steps to building strong and effective integrated care systems across England*. Available at: <https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/>

- 6.26 We have commented in recent reports on the ways in which the integration of health and social care is likely to require new organisation and employment structures, and consideration of staff terms and conditions. The parties have previously highlighted that overcoming the barriers to common employment and pay arrangements would need significant work, including pay levels, grading, pensions and career pathways. There are considerable differences between reward packages in social care and the NHS, including different pay structures, pension schemes, and terms and conditions.
- 6.27 As we noted last year, we consider that integrating health and social care needs to be backed up by a reward strategy across both workforces. We stress that any move to harmonise terms and conditions would require a consistent approach to reward packages and to be supported by appropriate financial investment. As integration in England progresses, we will continue to assess the impacts on the AfC workforce.

Productivity

- 6.28 In our report last year, we noted that all NHS organisations pointed to the continuing need for improved productivity. In England, the NHS Long Term Plan has set a target of making re-investable productivity gains of at least 1.1% a year over the next five years. This year, the DHSC told us that 1.1% productivity gain was unlikely to be achieved due to COVID-19 and that this was one reason for the previously budgeted 2.1% pay envelope to be reduced to 1% for 2021/22 for those earning over £24,000 full-time equivalent.
- 6.29 Last year, the DHSC's evidence pointed to the productivity gains from its efficiency plan and presented its measures of labour productivity from the Centre for Health Economics showing the NHS's average annual growth was 2.5% between 2005/06 and 2015/16. We said that, while we recognised the difficulties in measuring productivity and its rate of growth in a complex organisation such as the NHS, the way these measures are constructed depends on data relating to the cost of labour and that this carries two risks. The first is that it fails to take account of unpaid overtime that has been a feature of work in the NHS for many years. Second, it conflates cost saving through wage restraint with productivity increases. We noted that this may partly explain why these figures for productivity growth in the NHS were so much higher than in the rest of the economy.
- 6.30 We think that it is important that staff are viewed not as a cost but as an investment and that the ways in which productivity is measured and in which funding flows within the NHS provide good incentives to invest in the employment and development of staff. We consider that productivity measures may need to be reconsidered in light of COVID-19 and the changed context of demand, output and ways of working this brings, and this may provide a good opportunity to achieve a common understanding of productivity measures.

High Cost Area Supplements

- 6.31 In our report last year, we noted that the AfC pay agreement reached in 2018 included reference to our continuing role with an expectation of further consideration of High Cost Area Supplements (HCAS). In determining our remit for that report there had been some discussion in readiness for a review and we understood from the parties that there was a general consensus in favour of a review. We had, therefore, explored some broad considerations and data requirements, that might inform such a review of HCAS. We were not asked to consider HCAS this year but summarise here the broad considerations and data requirements set out in our 2020 report.

6.32 A starting point for any review might be the purpose of HCAS. The Staff Side's evidence suggested that the HCAS system owed more to evolution than design. They added that although the history of London Weighting in the NHS provided some explanation of the quirks of the system it did not provide a justification for them. While the NHS Terms and Conditions of Service Handbook sets out the operation of HCAS it does not specifically define its purpose beyond the name itself in compensating for working in high-cost areas. Reviewing the purpose of HCAS would allow a clearer view for all parties, AfC staff and trust management in determining how it might be revised to meet changed requirements. The purpose should focus on the drivers for HCAS, including compensating for cost of living and additional costs, what is needed to support recruitment and retention in high-cost areas, and what other support mechanisms might be needed (including significant drivers of costs such as housing and transport). We also note that house prices may be rising in rural areas as home working potentially increases following COVID-19.

Recruitment and Retention Premia

6.33 In our report last year, we were asked us to consider the role of Recruitment and Retention Premia (RRP) for England and how they might help support the recruitment and retention of staff. In our 2020 report we therefore set out: (i) the current arrangements for implementing national and local RRP; (ii) how national and local RRP had been used; (iii) our observations on how RRP might better support recruitment and retention; and (iv) the evidence required to support RRP. In doing so, our observations were intended to help inform any future in-depth review of RRP.

6.34 This year we were not asked to look at RRP and if parties would like us to do so in the future we could update our observations from our 2020 report.

Evidence gaps and data limitations

6.35 We appreciate parties' efforts to improve the evidence base and the information that was provided to us for this pay round. There are a number of areas we would highlight where we would welcome improved data. These include the following:

- **Equalities and pay gaps** – we would welcome the DHSC building on their Gender Pay Gap in Medicine Review and would hope to see work examining gender and ethnicity pay gaps for all AfC staff in England. We would also welcome data on gender and ethnicity and pay in the devolved administrations as well as more information on how ethnicity, gender and other protected characteristics affect the pay and experience of AfC staff working in the NHS across the UK;
- **Leavers' data** – we would welcome more complete data on where people go when they leave the NHS and on rates of movement between NHS organisations, and the reasons for these;
- **Earnings data** – we would welcome data on earnings for AfC staff from the devolved administrations;
- **2018 three-year pay agreement** – we look forward to receiving the benefits realisation work from NHS E&I in September 2021, which we understand will show what has been achieved for each element of the agreement and what may require more impetus or resource;
- **Staff surveys** – we would welcome information from pulse surveys planned for the NHS in England and staff surveys in the devolved administrations asking about satisfaction with levels of pay;
- **Students** – we would welcome data on the attrition rate of those entering university to study healthcare-related degrees and on how many go on to work in the NHS, particularly in the context of the expansion in student numbers and the experience of students during the pandemic; and

- **Flexible working** – we would welcome evidence on the patterns of flexible working and take up rates that currently exist in both clinical and non-clinical settings, which would include flexible working within NHS banks.

Appendix A – Remit Letters

Letter from Secretary of State for Health and Social Care to NHSPRB Chair

*Department of Health and Social Care
From the Rt Hon Matt Hancock
MP Secretary of State for Health and
Social Care*

POC_1282866

*39 Victoria Street
London
SW1H 0EU*

Philippa Hird
Chair NHS Pay Review Body
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

18 December 2020

Dear Ms Hird,

I should first of all like to offer my thanks for the NHS Pay Review Body's (NHSPRB) work over the past year on the 2020 report. The Government continues to appreciate and value the independent expert advice and contribution that the NHSPRB makes.

The timing of the SR announcement has unfortunately delayed the commencement of Pay Round 2021/22. I am writing now to set out how the Government proposes working with the NHSPRB in relation to the 2021/22 pay round and to formally begin the Review Body process.

You will have seen that the Chancellor of the Exchequer announced that pay rises in the public sector will be restrained and targeted in 2021/22 at the Spending Review. As the Chancellor set out, Covid-19 is having a very significant impact on the economy, labour market and the fiscal position and has suppressed earnings growth and increased redundancies in the private sector and this is reflected across departmental spending settlements. Taken from the latest ONS data, public sector total remuneration in 2019 was already 7% ahead of the private sector, adjusting for characteristics, and it has since been shielded from the pandemic's economic effects¹. According to ONS Average Weekly Earnings data, in the six months to September, the private sector has seen a pay cut of nearly 1% compared to last year, yet public sector earnings were up by almost 4%². Since March, the number of people in employment in the UK fell by 782,000, whilst over a similar period of time public sector employment increased.

Whilst we have announced a pause of pay awards for the majority of the public sector, we recognise the uniquely challenging impact coronavirus is having on the NHS and so have made a commitment to continue to provide NHS workers with a pay rise. This means that for your remit group, all Agenda for Change staff employed by the NHS, we would welcome your pay recommendations. We expect these recommendations to take account of the extremely challenging fiscal and economic context, and consider the affordability of

¹ Public and private sector earnings: 2019, ONS

² Average Weekly Earnings: 2020, ONS

pay awards. HMT will set out the fiscal and economic context in more detail as the round progresses and my Department will provide you with evidence on the affordability of pay awards.

It is vitally important planned workforce growth is affordable, particularly given the NHS budget is set until 2023/24 and there is a close relationship between pay and staff numbers. The affordability of pay recommendations will have to be considered within the context of the significant financial and economic pressures that have resulted from the Covid-19 pandemic, both within the NHS and wider public finances. The evidence that I will provide in the coming months will support you in your consideration of affordability and I request that you describe in your final report what steps you have taken to take account of affordability, the need for workforce growth and making best use of the funds available to deliver the best care for patients. These considerations must also be balanced with the importance of continuing to recruit, retain and motivate NHS staff.

We announced at Spending Review that for those public sector workers earning the full time equivalent of less than £24,000 we would continue to pay uplifts at a value of £250 or the National Living Wage increase, whichever is higher. Whilst we do not want to prejudge your recommendations for the NHS I want to set out that staff within the NHS with salaries below this threshold should expect to receive pay increases no lower than this level and we would expect your recommendations to be made within this context. More detail on the government's public sector pay policy can be seen in the SR document.

As always, whilst your remit covers the whole of the United Kingdom, it is for each administration to make its own decisions on its approach to this year's pay round and to communicate this to you directly.

We are hoping to expediate the process as much as possible this year and would welcome your report in early May 2021, subject to further discussion with the OME.

Finally, I would like to thank you again for your invaluable contribution, and I look forward to continuing our dialogue in future.

Yours ever,

MATT HANCOCK

Letter from Scottish Government Cabinet Secretary for Health and Sport to NHSPRB Chair

Riaghaltas na h-Alba/Scottish Government

Cabinet Secretary for Health and Sport

Jeane Freeman MSP

Philippa Hird
Chair
NHS Pay Review Body

By Email.

30 September 2020

Dear Philippa,

In the wake of the COVID-19 crisis, the pay settlement which will be put in place for Agenda for Change staff in 2021-22 will come under particular scrutiny. I am aware that the Westminster Government has already indicated that it intends to provide a remit to the NHS Pay Review Body and seek recommendations in relation to 2021-22. Given the industrial relations landscape in Scotland, and having listened to all sides and given the matter careful consideration, I have decided that Scotland should take a collective bargaining approach in arriving at an Agenda for Change settlement in 2021-22. I am therefore writing to confirm that the Scottish Government will not provide a remit to the NHS Pay Review Body for next year.

This is no reflection on the very helpful advice which the Review Body has provided for Scotland in the past and for which we remain grateful. Rather, it is an indication of the particular set of circumstances Scotland finds itself in as we come out of the current three year pay deal.

Should the Review Body have any questions or points of clarification, my officials would be happy to discuss these with you at your convenience.

Kind regards,

JEANE FREEMAN

Letter from Welsh Government Minister for Health and Social Services to NHSPRB Chair

Llywodraeth Cymru/Welsh Government

Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Ein cyf/Our ref: MA/VG/3730/20

Philippa Hird
Chair NHS Pay Review Body
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

18 January 2021

Dear Philippa,

Thank you for the NHSPRB's hard work and independent report and observations which have been invaluable during the life of the multi-year agreement agreed in 2018.

I would like to take this opportunity to say I truly value the hard work and commitment of all of our dedicated healthcare workers in Wales, at all times but particularly during this challenging time.

I am now writing to formally commence the 2021-22 pay round for AfC staff in Wales. As you will be aware, for the previous three years (2018-19 to 2020-21) we did not ask the NHSPRB to make any specific recommendations on pay. However, as this three year pay deal comes to end we will be asking you for pay recommendations, specifically on what would be a fair and affordable pay rise for this staff group, in light of the wider economic situation to help us sustain the NHS in Wales and deliver the priorities set out in A Healthier Wales: Our Plan for Health and Social Care.

Your advice and recommendations will enable me to determine a fair pay award for Agenda for Change staff across NHS Wales.

In order to support your work, I will provide written evidence to the Pay Review Body and my officials have committed to attend the planned oral evidence session in early March.

I would like to receive your advice and recommendations as soon as possible to ensure that payment of any award to our dedicated NHS workforce is not unduly delayed as the current three year deal comes to an end in March 2021.

I look forward to receiving your advice and recommendations.

Yours sincerely,

Vaughan Gething AC/AM

Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Letter from Minister of Health, Northern Ireland to NHSPRB Chair

FROM THE MINISTER OF HEALTH

An Roinn Sláinte/ Department of Health
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Our ref - SUB-0055-2021

Date: 18 January 2021

Philippa Hird
Chair, NHS Pay Review Body
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

Dear Philippa,

NHSPRB 2020/21 PAY ROUND

I am writing to formally commence the 2021/22 pay round for Agenda for Change (AfC) staff in Northern Ireland and to submit my Department's evidence. I wish to begin by thanking the NHS Pay Review Body for its invaluable work on the 2020/21 pay round and, in particular, for its observations on the AfC pay agreement.

On 02 September 2020, the Department of Finance (DoF) set out Northern Ireland's Public Sector Pay Policy for 2020/21. Following considerable engagement with employers and trade unions throughout the year, an agreement on a pay deal for 2019/20 and 2020/21 was reached. This proposed deal restored pay parity, with England, for Agenda for Change staff in Northern Ireland.

As has been noted by the Secretary of State for Health and Social Care in England, Rt Hon Matt Hancock MP, COVID-19 is having a very significant impact on the economy, labour market and the fiscal position and has suppressed earnings growth and increased redundancies in the private sector and this is reflected across departmental spending settlements. While more generally, a pause of pay awards has been announced for the majority of the public sector, the UK Government has also committed to provide a pay rise to NHS staff in recognition of their efforts in addressing coronavirus. I would therefore welcome your pay recommendations for health and social care staff in Northern Ireland. These recommendations should take account of the challenging fiscal and economic context and the affordability of pay awards, particularly in the Northern Ireland context, where our integrated system of health and social care brings proportionately more staff into Agenda for Change terms and conditions.

Further, I would be most interested to have the views of the NHSPRB into wider recruitment, retention and staff motivation factors specific to the Northern Ireland health labour market. I would particularly welcome views which might highlight staff migration, recruitment deficiencies and key behavioural drivers.

Robin Swann MLA

Minister of Health

Appendix B – Agenda for Change Pay Bands Under The Framework Agreement In England 2018/19 – 2020/21

Band 1

2017/18	2018/19	2019/20	2020/21
15,404			
15,671	17,460	17,652	18,005

Band 2

2017/18	2018/19	2019/20	2020/21
15,404			
15,671			
16,104			
16,536	17,460		
16,968	17,460	17,652	18,005
17,524	17,787	17,983	
18,157	18,702	19,020	19,337

Band 3

2017/18	2018/19	2019/20	2020/21
16,968			
17,524	17,787		
18,157	18,429		
18,333	18,608	18,813	19,737
18,839	19,122	19,332	
19,409	19,700	19,917	
19,852	20,448	20,795	21,142

Band 4

2017/18	2018/19	2019/20	2020/21
19,409			
19,852	20,150		
20,551	20,859	21,089	21,892
21,263	21,582	21,819	
21,909	22,238	22,482	
22,128	22,460	22,707	
22,683	23,363	23,761	24,157

Band 5

2017/18	2018/19	2019/20	2020/21
22,128			
22,683	23,023		
23,597	23,951	24,214	24,907
24,547	24,915		
25,551	25,934	26,220	26,970
26,565	26,963	27,260	27,416
27,635	28,050	28,358	
28,746	29,608	30,112	30,615

Band 6

2017/18	2018/19	2019/20	2020/21
26,565			
27,635	28,050		
28,746	29,177	30,401	31,365
29,626	30,070	32,525	
30,661	31,121		
31,696	32,171	32,525	33,176
32,731	33,222	33,587	33,779
33,895	34,403	34,782	
35,577	36,644	37,267	37,890

Band 7

2017/18	2018/19	2019/20	2020/21
31,696			
32,731	33,222		
33,895	34,403		
35,577	36,111	37,570	38,890
36,612	37,161		
37,777	38,344	38,765	40,894
39,070	39,656	40,092	41,723
40,428	41,034	41,486	
41,787	43,041	43,772	44,503

Band 8a

2017/18	2018/19	2019/20	2020/21
40,428			

2017/18	2018/19	2019/20	2020/21
41,787	42,414		
43,469	44,121	44,606	45,753
45,150	45,827	46,331	46,518
47,092	47,798	48,324	48,519
48,514	49,969	50,819	51,668

2017/18	2018/19	2019/20	2020/21
87,254	88,563	89,537	91,004
91,442	92,814	93,835	94,213
95,832	97,269	98,339	98,736
100,431	102,506	103,860	104,927

Band 8b

2017/18	2018/19	2019/20	2020/21
47,092			
48,514	49,242		
50,972	51,737	52,306	53,168
53,818	54,625	55,226	55,450
56,665	57,515	58,148	58,383
58,217	59,964	60,983	62,001

Band 8c

2017/18	2018/19	2019/20	2020/21
56,665			
58,217	59,090		
60,202	61,105	61,777	63,751
63,021	63,966	64,670	64,931
67,247	68,256	69,007	69,285
69,168	71,243	72,597	73,664

Band 8d

2017/18	2018/19	2019/20	2020/21
67,247			
69,168	70,206		
72,051	73,132	73,936	75,914
75,573	76,707	77,550	77,863
79,415	80,606	81,493	81,821
83,258	85,333	86,687	87,754

Band 9

2017/18	2018/19	2019/20	2020/21
79,415			
83,258	84,507		

High Cost Area Supplement (HCAS)

		2017/18	2018/19	2019/20	2020/21
Inner London	Minimum	4,200	4,326	4,400	4,474
	Maximum	6,469	6,664	6,778	6,892
Outer London	Minimum	3,553	3,660	3,723	3,786
	Maximum	4,528	4,664	4,744	4,824
Fringe	Minimum	971	1,001	1,019	1,037
	Maximum	1,682	1,733	1,763	1,793

Appendix C – Previous Reports of the Review Body

NURSING STAFF, MIDWIVES AND HEALTH VISITORS

First Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9258, June 1984
Second Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9529, June 1985
Third Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9782, May 1986
Fourth Report on Nursing Staff, Midwives and Health Visitors	Cm 129, April 1987
Fifth Report on Nursing Staff, Midwives and Health Visitors	Cm 360, April 1988
Sixth Report on Nursing Staff, Midwives and Health Visitors	Cm 577, February 1989
Supplement to Sixth Report on Nursing Staff, Midwives and Health Visitors: Nursing and Midwifery Educational Staff	Cm 737, July 1989
Seventh Report on Nursing Staff, Midwives and Health Visitors	Cm 934, February 1990
First Supplement to Seventh Report on Nursing Staff, Midwives and Health Visitors: Senior Nurses and Midwives	Cm 1165, August 1990
Second Supplement to Seventh Report on Nursing Staff, Midwives and Health Visitors: Senior Nurses and Midwives	Cm 1386, December 1990
Eighth Report on Nursing Staff, Midwives and Health Visitors	Cm 1410, January 1991
Ninth Report on Nursing Staff, Midwives and Health Visitors	Cm 1811, February 1992
Report on Senior Nurses and Midwives	Cm 1862, March 1992
Tenth Report on Nursing Staff, Midwives and Health Visitors	Cm, 2148, February 1993
Eleventh Report on Nursing Staff, Midwives and Health Visitors	Cm 2462, February 1994
Twelfth Report on Nursing Staff, Midwives and Health Visitors	Cm 2762, February 1995
Thirteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 3092, February 1996
Fourteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 3538, February 1997
Fifteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 3832, January 1998
Sixteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 4240, February 1999
Seventeenth Report on Nursing Staff, Midwives and Health Visitors	Cm 4563, January 2000
Eighteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 4991, December 2000
Nineteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 5345, December 2001

PROFESSIONS ALLIED TO MEDICINE

First Report on Professions Allied to Medicine	Cmnd. 9257, June 1984
Second Report on Professions Allied to Medicine	Cmnd. 9528, June 1985
Third Report on Professions Allied to Medicine	Cmnd. 9783, May 1986
Fourth Report on Professions Allied to Medicine	Cm 130, April 1987
Fifth Report on Professions Allied to Medicine	Cm 361, April 1988
Sixth Report on Professions Allied to Medicine	Cm 578, February 1989
Seventh Report on Professions Allied to Medicine	Cm 935, February 1990
Eighth Report on Professions Allied to Medicine	Cm 1411, January 1991
Ninth Report on Professions Allied to Medicine	Cm 1812, February 1992
Tenth Report on Professions Allied to Medicine	Cm 2149, February 1993
Eleventh Report on Professions Allied to Medicine	Cm 2463, February 1994
Twelfth Report on Professions Allied to Medicine	Cm 2763, February 1995
Thirteenth Report on Professions Allied to Medicine	Cm 3093, February 1996

Fourteenth Report on Professions Allied to Medicine	Cm 3539, February 1997
Fifteenth Report on Professions Allied to Medicine	Cm 3833, January 1998
Sixteenth Report on Professions Allied to Medicine	Cm 4241, February 1999
Seventeenth Report on Professions Allied to Medicine	Cm 4564, January 2000
Eighteenth Report on Professions Allied to Medicine 2000	Cm 4992, December
Nineteenth Report on Professions Allied to Medicine 2001	Cm 5346, December

NURSING STAFF, MIDWIVES, HEALTH VISITORS AND PROFESSIONS ALLIED TO MEDICINE

Twentieth Report on Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine	Cm 5716, August 2003
Twenty-First Report on Nursing and Other Health Professionals	Cm 6752, March 2006
Twenty-Second Report on Nursing and Other Health Professionals	Cm 7029, March 2007

NHS PAY REVIEW BODY

Twenty-Third Report, NHS Pay Review Body 2008	Cm 7337, April 2008
Twenty-Fourth Report, NHS Pay Review Body 2009	Cm 7646, July 2009
Decision on whether to seek a remit to review pay increases in The three year agreement – unpublished	December 2009
Twenty-Fifth Report, NHS Pay Review Body 2011	Cm 8029, March 2011
Twenty-Sixth Report, NHS Pay Review Body 2012	Cm 8298, March 2012
Market-Facing Pay, NHS Pay Review Body 2012	Cm 8501, December 2012
Twenty-Seventh Report, NHS Pay Review Body 2013	Cm 8555, March 2013
Twenty-Eighth Report, NHS Pay Review Body 2014	Cm 8831, March 2014
Scotland Report, NHS Pay Review Body 2015	SG/2015/21
Enabling the delivery of healthcare services every day of the week – the implications for Agenda for Change	Cm 9107, July 2015
Twenty-Ninth Report, NHS Pay Review Body 2016	Cm 9210, March 2016
Thirtieth Report, NHS Pay Review Body 2017	Cm 9440, March 2017
Thirty-First Report, NHS Pay Review Body 2018	Cm 9641, June 2018
Thirty-Second Report, NHS Pay Review Body 2019	CP 147, July 2019
Thirty-Third Report, NHS Pay Review Body	CP 260, July 2020

