Department of Health & Social Care

The Department of Health and Social Care's written evidence to the NHS Pay Review Body (NHSPRB) for the 2022 to 2023 pay round

Contents

1. Introduction and NHS strategy

This chapter sets out the wider context for the department's 2022 to 2023 (2022-23) evidence, including the strategic context for NHS pay and the Agenda for Change (AfC) workforce. This chapter also provides an overview of this year's written evidence to the NHS Pay Review Body (NHSPRB).

For a pay recommendation for the AfC workforce in 2021-22, the government looked to the NHSPRB, and in July, after careful consideration, accepted the 3% recommendation in full. This year, the government is again inviting the NHSPRB to make a pay recommendation for the AfC workforce within a challenging health, economic and fiscal context.

Autumn budget and spending review 2021

At the Spending Review 2021 (SR21), the Chancellor set out the government's plan for public expenditure for the next 3 years. NHS England's day-to-day budget was given an average of 3.8% real terms growth per year. Part-funded by the new Health and Social Care Levy, this equates to £23.3 billion over three years.

Since SR21, the context within which the NHS operates has been rapidly changing. COVID-19 has already had a considerable impact on the NHS and while the vaccine programme has put the UK in a strong position, there is still a large degree of uncertainty as new COVID variants emerge. HMT set out in their economic evidence that there also remains uncertainty in the economic outlook, and risks that public sector pay increases exacerbate temporary inflation pressures.

The NHS budget has now been set until 2024-25. While this gives the NHS the financial security to address challenges in a sustainable manner, the settlement is tight and there will be a need for careful prioritisation to stay within available funding and make progress towards long-term financial sustainability.

At SR21 the government was clear its priorities were to improve health outcomes for patients by ensuring the NHS can tackle the elective backlog, deliver the Long-Term Plan, and have the resources to continue its response to COVID-19 pandemic. This specifically included:

1. More than £8 billion to tackle the elective backlog, which comes on top of £2 billion funding provided for this purpose in 2021-22. This means that the NHS in England can aim to deliver around 30% more elective activity by 2024-25 than was the case before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and guidance.

2. Additional funding to grow the NHS workforce. This will be achieved by progressing existing commitments for 50,000 more nurses and 50 million more primary care appointments, as well as funding the training of some of the biggest undergraduate intakes of medical students and nurses ever.

3. £9.6 billion over the SR period for COVID-19 related health spending so that the NHS can continue to respond to and mitigate the impacts of the virus.

Chapter 2 of our evidence focuses on the impact of SR21 and how NHS finances are being specifically targeted at meeting these priorities.

NHS workforce

The increase in vital budgets through SR21 will ensure that the NHS can meet these key priorities and keep building a bigger and better trained NHS workforce. Chapter 3 of our evidence outlines the Department's current strategy to ensure that the NHS has the workforce it needs, including workforce planning and service transformation and integration. For instance, we are working with system partners to increase supply throughout the nursing workforce, participating in ethical and sustainable international recruitment and diversifying education and training pipelines. There is also significant reform taking place more widely in the health and care system to improve integration of services around the needs of patients.

Recruitment and retention are not only crucial to meeting objectives like elective recovery but for safeguarding staff health, wellbeing and morale and avoiding burnout. The government recognises that staff are also motivated by their workplace environment and culture, championing inclusion, diversity and prioritising health and wellbeing. Chapter 4 sets out how the workforce has changed in the last year, outlining the current data and analysis on joiners, leavers, vacancies, and temporary staffing in the AfC workforce. The chapter outlines that retention remains stable and overall, the workforce continues to grow, however there is more to do, and our evidence outlines the current and additional steps the government and our NHS system partners are taking to increase morale and motivation amongst the workforce.

The NHS total reward offer remains a key recruitment and retention tool and continues to play a key role in ensuring the NHS can grow the workforce it needs. The total package includes a range of benefits beyond basic pay that exceed those offered in other sectors. These benefits include a generous holiday allowance, opportunities for additional earnings and enhanced rates for unsocial hours and access to a much-valued pension scheme to name a few. Chapters 5 and 6 of our evidence provide more detail of the total reward package and describe how earnings for the AfC workforce have remained broadly competitive against the wider economy and comparable labour markets, growing in line

with expectations following the multi-year AfC deal and last year's 3% pay uplift. Whilst data for NHS earnings growth in 2021-22 is not yet available, we expect to see most staff have growth of around 3% following the 2021-22 pay award. Given the wider public sector pay pause in the 21 - 22 pay round for which NHS staff where exempt, we expect the NHS to compare favourably to the rest of the public sector.

Whilst data for earnings growth in 2021-22 is not yet available, given the wider public sector pay pause in the 2021-22 pay round for which NHS staff where exempt, we expect the NHS to compare favourably to the rest of the public sector.

In the 2022-23 financial year, the NHS is returning to its pre-pandemic financial regime following temporary arrangements in light of the pandemic. There is a need for greater financial restraint in the context of stretching efficiency requirements and making progress towards long-term financial sustainability. NHSEI's evidence provides further information on this.

The government, as ever, has a careful balance to strike between ensuring the NHS has the workforce it needs to deliver health priorities, whilst also ensuring the NHS remains on a sustainable financial footing and delivering value for money for the taxpayer.

As the NHS budget is now set, there are stark trade-offs between pay and other NHS spending. In addition, growing the workforce, however crucial, does come at a cost. There is a direct trade-off between growing the workforce, investing in public services and giving higher pay rises, and this is the careful balance the government must strike to ensure the NHS remains an affordable, value-for-money service for the taxpayer.

Pay rises above affordability could materially impact government's ability to deliver on these and other commitments. It is therefore essential that pay remains affordable to help deliver more frontline staff and expand the clinical capacity of the NHS. It is therefore crucial during this challenging fiscal and economic climate that the DDRB carefully consider the important balance between ensuring that existing funding, which has been set within the NHS budget, can be used to expand the AfC workforce, whilst also fairly rewarding staff. We ask that in reaching your recommendation you take into account the NHS' financial position detailed within chapter 2 of this evidence, and within NHS England and Improvement's (NHSEI) evidence. Further information will also be provided at oral evidence.

We look forward to receiving your report in May 2022.

2. NHS finances

This chapter describes the financial context for the NHS.

As set out in the SR21 settlement, the focus for the NHS is balancing the priorities of managing the ongoing pandemic response and addressing the elective recovery challenge. Growing the NHS workforce is essential to achieving these objectives.

In 2020-21, the government spent an estimated £45 billion of additional revenue costs across the health and social care system to mitigate the impacts of COVID-19. For 2021-22 the Government has so far approved £34 billion for frontline health services, including £15 billion of day-to-day funding for the NHS. NHS financial sustainability is key to its post-pandemic recovery with increasing productivity crucial to restoring the performance of the NHS. To achieve this, funds have been allocated to put the NHS on a sustainable footing and fund the biggest catch-up programme in NHS history. Part-funded by the new Health and Social Care Levy, SR21 delivers an average 3.8% real terms growth per year for the NHS – equating to £23.3 billion over three years. This includes more than £8 billion to tackle the elective backlog, which comes on top of £2 billion funding already provided for this purpose in 2021-22.

This is alongside a key priority of reforming and growing the NHS workforce. 2021-22 was the first year following the 3-year AfC deal (2018-19 - 2020-21) which invested 3% per annum. In addition to headline pay, DHSC has also embarked on pay and contract reform right across the NHS workforce over the last few years as part of our ambition to make the NHS the best employer in the world, providing the highest quality care.

There is an expectation that the NHS can catch up on some of the lost efficiency and make productivity savings in 2022-23 in order to return to financial balance. It is therefore important that the 2022-23 pay awards support the government's objective to deliver long-term financial sustainability in the NHS.

Economic Context

As a result of the underlying resilience of the economy, the vaccination programme and the £378 billion of the pandemic support provided to families and businesses, the UK economy has seen faster than anticipated growth after the largest quarterly decline in GDP since comparable records began in 1955. In November 2021, GDP was estimated to be above pre-pandemic levels for the first time. However, the emergence of the Omicron variant and the tightening of restrictions at the end of 2021 have increased economic uncertainty.

As set out in HMT's Economic Evidence to Review Bodies 2021, the gradual reopening of the global economy and the rapid return of economic activity has led to a substantial rise in commodity and raw material prices, as demand for inputs has outpaced production. Global supply issues, including increases in transportation and energy costs, have pushed up inflation in the UK. In the 12 months to December 2021, inflation grew to 5.4%, the highest in almost 30 years. The Bank of England now expects it to reach around 6% in April 2022. The OBR expects it to remain elevated across 2022 and 2023 before stabilising towards the target of 2% in the middle of the decade. If wages were to increase in line with the temporary spike in inflation, this increase could become more permanent. Given that price stability is part of the terms of reference for PRBs, this must be considered as part of their recommendations. The government is committed to price stability and has re-affirmed the Bank of England's 2% consumer price inflation target at the Budget.

The pandemic has highlighted the significant value of job security in both the NHS as well as the public sector more widely. Latest Labour Force Survey data for September 2021 shows that the number of people in private sector employment is 690k lower than pre-pandemic levels, whilst employment in the NHS and public sector continues to rise. As set out in SR21, PRBs must be aware that, to ensure fairness and the sustainability of public finances, public sector earnings growth over the next 3 years should retain broad parity with the private sector and continue to be affordable. Whole economy pay growth in average earnings is forecasted to be in line with the pre-pandemic period over the coming years, as the base effects of the pandemic unwind.

Funding growth

The NHS LTP published in January 2019 set out the NHS's 10-year strategy to improve the quality of patient care and health outcomes, ensuring that patients will be supported with world-class care at every stage of their life. The LTP rightly sets out that putting the NHS back onto a sustainable financial path is a key priority and is essential to delivering further improvements in care. The pandemic has understandably impacted on progress towards implementing many elements of the LTP. However, as set out in the Mandate, we are focused on minimising the further adverse impact of the pandemic and then recovering delivery against commitments made in the LTP – including supporting the further expansion of NHS programmes and services and embedding the positive changes brought about by the pandemic such as integration and technology advancements.

Since the beginning of the pandemic, the NHS has risen to the biggest challenge in its history by responding to the threat of COVID-19. In 2020-21, the government spent an estimated £45 billion of additional revenue costs across the health and social care system to mitigate the impacts of COVID-19. For 2021-22 the Government has so far approved £34 billion for frontline health services, including £15 billion of day-to-day funding for the NHS.

As described in chapter 1, SR21 took steps to place the NHS on a sustainable footing and to fund the biggest catch-up programme in NHS history. The increase in funding for elective recovery, growing the workforce and allowing the NHS to continue to respond to the pandemic will further enable the NHS to deliver better service and health outcomes for patients.

This is part-funded by the new Health and Social Care Levy introduced by government, which represents a 1.25% increase to National Insurance contributions with revenue ringfenced to support UK health and social care bodies. The NHS will see the tangible benefits resulting from the Health and Social Care Levy more than most as the additional funds are distributed throughout the system.

The SR21 settlement for Health and Social Care will also ensure that we can keep building a bigger and better trained NHS workforce. The government is committed to delivering 50,000 more nurses and 50 million more primary care appointments by funding the training of some of the biggest undergraduate intakes of medical students and nurses ever. The settlement will also continue to support a strong pipeline of new midwives and allied health professionals, who are key to delivering the full range of NHS services.

Table 1 - Opening mandate for NHS England

NHS England (NHSE)	NHSE Revenue Departmental Expenditure Limits (RDEL) excluding ringfence (RF) (cash) £ billion*	NHSE Capital Departmental Expenditure Limits (CDEL) excluding ringfence (RF) (cash) £ billion
2013-14	93.676	0.200
2014-15	97.017	0.270
2015-16	100.200	0.300
2016-17	105.702	0.260
2017-18	109.536	0.247
2018-19	114.603	0.254
2019-20	123.377	0.260
2020-21	149.473	0.365
2021-22	144.365	0.301
2022-23	151.827	0.219
2023-24	157.407	0.219
2024-25	162.678	0.219

(Source: 2021 to 2022 Financial Directions to NHS England)

Table 1 above shows the opening mandate for NHS England (NHSE) in 2021-22, and indicative amounts for future years, in line with the outcome of SR21. These figures include an increase for pensions revaluation which was provided alongside the LTP settlement. Figures exclude depreciation, AME and technical budget.

The SR21 settlement, and the LTP settlement that underpins it, gives the NHS the financial security to address challenges in a sustainable manner. There will be multiple

calls on available funding, including pay, and these will need careful prioritisation to stay within available funding. As described later in the chapter, more funding put towards pay will mean less funding for other priorities, including the size of the workforce that is affordable, as well as wider non-ringfenced investments required to deliver the NHS LTP and elective recovery.

It is essential that this money is spent wisely and in line with the NHS priorities which will have the most effective impact on delivering high-quality care for patients. Therefore, the government has set 5 financial tests alongside the LTP settlement to ensure the service is put on a more sustainable footing for the future. The 5 tests are:

- the NHS (including providers) will return to financial balance
- the NHS will achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care
- the NHS will reduce the growth in demand for care through better integration and prevention
- the NHS will reduce variation across the health system, improving providers' financial and operational performance
- the NHS will make better use of capital investment and its existing assets to drive transformation

While the 5 tests remain important to the delivery of the LTP, COVID-19 has meant reporting against the tests has rightly been temporarily put on hold to allow the system to focus on managing and responding to the pandemic.

Financial position

The government's 2021-22 Mandate to the NHS provides clarity on headline objectives for the NHS. The financial directions to NHSE published alongside the Mandate partially reflect further funding to deliver manifesto commitments agreed at Budget 2021 as well as any funding required for the 2021-22 financial year to meet pressures arising due to COVID-19. Given the nature of COVID-19, the Mandate reinforces the importance of public money being spent with care on targeted, timely and time-limited interventions.

2021-22 is the third year of the LTP period and began during the winter COVID-19 peak. Since the start of the 2020-21 financial year, the NHS's financial framework was suspended and replaced with a temporary regime to help deal with the impact of COVID-

19. The temporary regime moved to a system of nationally agreed block contracts with retrospective top-ups for reasonable COVID-19 related costs.

The NHS ended the 2020-21 financial year in an overall underspend position against its revised budget, including the additional COVID-19 related funding. Due to the revised financial framework which provided systems with fixed envelopes to operate within throughout 2020-21, in addition to a continuing focus on financial rigour and efficiency, most Trusts reported a year end position that was in surplus or financial balance.

Throughout the 2021-22 financial year, the NHS has been fully supported with the necessary funding at the right time, resulting in all spending pressures being met including those arising due to COVID-19. The NHS is now returning to its pre-pandemic financial regime, and there is a need for greater financial restraint in the context of stretching efficiency requirements. Evidence provided by NHSEI offers further information on this.

The financial impact of COVID-19 will be felt across the health and social care system for years to come.

Table 2 - NHS Providers RDEL Breakdown

NHS Providers RDEL Breakdown (£m)	2016-17	2017-18	2018-19	2019-20	2020-21
NHS providers' RDEL Outturn as per SoPS	935	1,038	826	1,008	-731
Provisions Adjustment	-43	-39	23	50	418
Other Adjustments	-101	-8	-22	-159	-342
Aggregate Net Deficit (Surplus)	791	991	827	899	-655
Unallocated Sustainability Funding	0	-25	0	-144	0
Adjust Net COVID-19 Impact	0	0	0	-85	0
Reported Net Deficit	791	966	827	669	-655

Share of resources going to pay

Table 3 shows the proportion of funding consumed by NHS provider permanent and bank staff spend over the last 8 years. Note that NHS provider permanent staff spend only covers staff working within hospital and community health settings.

Table 3 - Increases in Revenue Expenditure and the Proportion Consumed by Pay bill

Year	NHSE RDEL (£ billion)	NHS Provider Permanent and Bank Staff Spend (£ billion)	% of spend on staff	Increase in total spend	Increase in provider permanent and bank staff spend
2013-14	93.7	42.9	45.8%	n/a	n/a
2014-15	97.0	43.9	45.3%	3.57%	2.37%
2015-16	100.2	45.2	45.1%	3.28%	2.80%
2016-17	105.7	47.7	45.1%	5.49%	5.58%

2017-18	109.5	49.9	45.6%	3.63%	4.64%
2018-19	114.4	52.6	45.9%	4.46%	5.35%
2019-20	120.5	55.7	46.2%	5.35%	5.88%
2020-21	141.5	62.5	44.1%	17.37%	12.22%

Notes:

- 2019-20 and 2020-21 NHSE RDEL excludes £2.8 billion for the revaluation of the NHS pensions scheme
- 2019-20 NHS Provider Permanent and Bank Staff revised since last year's submission due to delays in finalising the accounts of one NHS provider
- 2013-14 to 2019-20 NHSE RDEL represents the budget. 2020-21 NHSE RDEL represents the outturn expenditure (the higher budget of £146.6 billion reflects the high level of uncertainty around the financial pressures arising from the pandemic)

2021-22 was the first year following the 3-year AfC deal (2018-19 – 2020-21) which invested 3% per annum. The government asked the NHS Pay Review Body for a pay recommendation in 2021-22 and the Review Body recommended a 3% pay increase which the government accepted and implemented. This was significantly above the government's affordability envelope given pressures related to COVID-19. The NHS received an additional £5.4billion in the second half of the year to support COVID-19 response and tackle the elective backlogs. This injection of funding allowed the 3% pay award to be funded.

In addition to this deal, further reforms to staff contracts have occurred elsewhere in the NHS.

Demand pressures

Activity and demand levels in the health system for elective care dropped dramatically in 2020-21, as numbers of self-presenting patients reduced and the NHS freed up capacity to manage COVID-19 demand, including the suspension of all non-urgent elective operations. As a result, there was a reduction in the number of patients seen for both elective and non-elective care compared to 2019-20.

Figure 1 - Emergency Admissions – per calendar day (Source: A&E attendances and Emergency Admission Statistics)

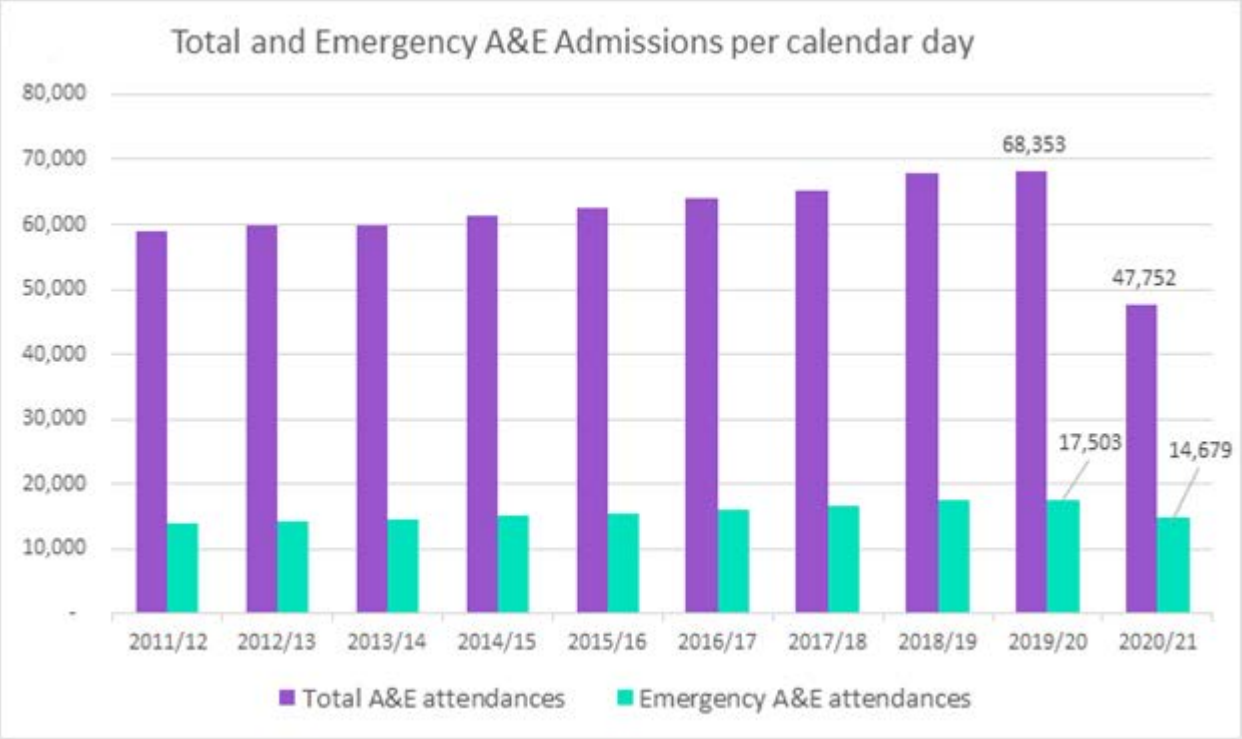
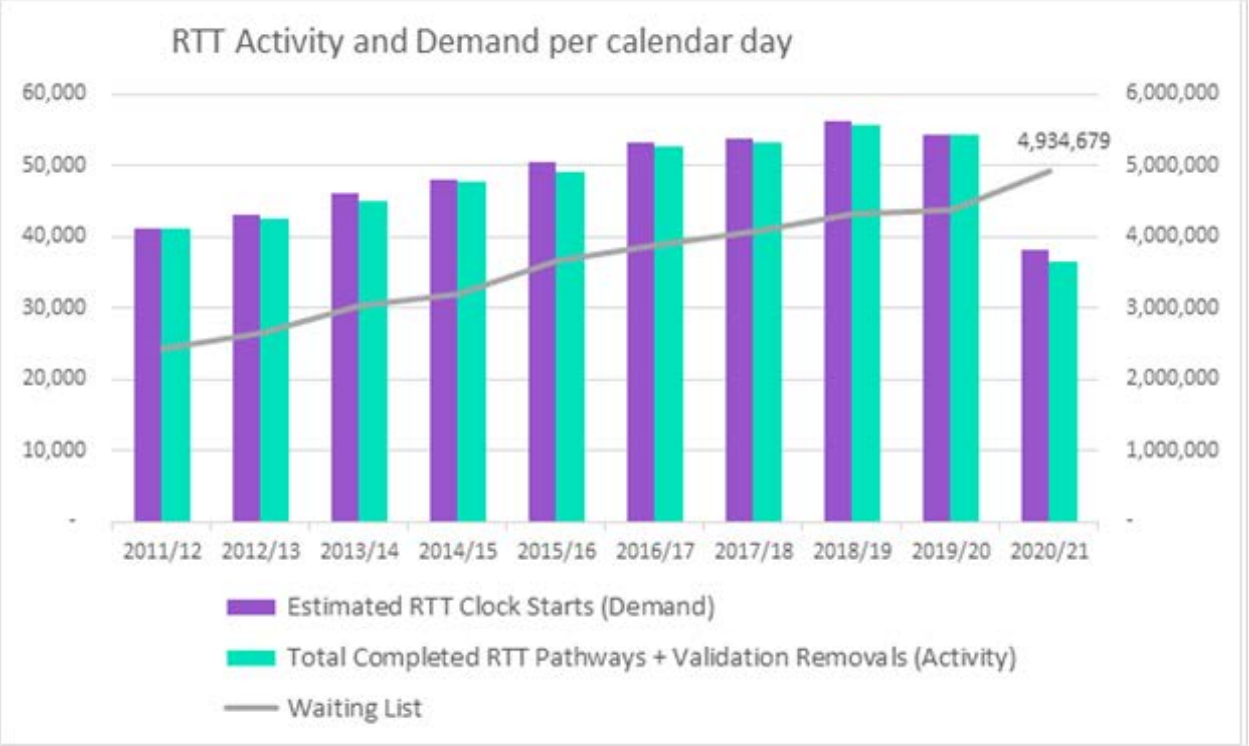


Figure 2 - Referral to Treatment Pathways Completed per Working Day (Source: NHSE Consultant Led Referral to Treatment Statistics. Data adjusted for non-submitting Trusts and exclusion of sexual health services from 2013)



Compared to the year before, in 2020-21 there was a 16.1% reduction in the number of emergency admissions. There was a 32.7% reduction in the number of completed

pathways, and the RTT waiting list reach 4.9 million by the end of the financial year as demand continued to outpace activity, as shown in Figures 1 and 2.

Despite the continuing best efforts of the NHS, many of the core waiting time and access targets were not achieved during 2020-21. These included A&E, referral to treatment, cancer treatment, diagnostic tests, and ambulance response standards.

The government is committed to tackling the elective recovery backlog as well as continuing to support the NHS in responding to COVID-19 and the increased pressures on the system during winter. This is whilst also working hard to deliver the maximum elective activity possible.

We have committed in Build Back Better: Our Plan for Health and Social Care, to reducing the elective backlog as part of improving NHS services going forwards. As a part of this we have committed £8 billion over the next 3 years to step up elective activity and transform elective services. This funding could deliver the equivalent of around 9 million more checks, scans, and procedures. It will also mean NHSEI can aim to deliver the equivalent of around 30 per cent more elective activity by 2024-25 than it was before the pandemic.

Calculating productivity in the NHS

Labour productivity is 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 measures the amount of output generated per 'unit' of labour, and as such, is an important component of efficiency.

The measure of labour productivity we use for the NHS in England is that developed by the University of York (Centre for Health Economics, CHE). Their measure uses a range of NHS data sources to assess outputs and inputs, as well as adjusting the output measure to take some account of quality change, including change in waiting times and death rates. Their figures show that between 2005-06 and 2018-19 the NHS’s average annual labour productivity was 2.0%.

Labour productivity is an important component of efficiency, but labour inputs account for only around half of the total cost of the NHS. A broader measure of productivity divides total output by an appropriate measure of all inputs, for example, including drugs as an input. This is called total factor productivity and is also measured by York University (CHE). Their figures show that between 2005-06 and 2018-19 the NHS’s average annual total factor productivity growth was 1.1%.

Productivity, as formally defined here, does not take into account the costs of inputs, including changes in staff pay. 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 increases more quickly than GDP deflator, this would have a negative effect on technical efficiency.

It is hard to identify productivity for individual staff groups as each unit of output is generated by a combination of different staff groups, from consultants and nurses, to management and support staff. It is difficult to disaggregate the productivity of these groups when they are contributing to the same unit of output.

The input factor of productivity can be more easily broken down by staff group. The labour input in York CHE's productivity measure is a weighted combination of different staff groups; the growths for each staff group is summarised in Chapter 5.

Table 4 - York CHE Total Factor Productivity (Figures are all quality adjusted so take into account changes in quality of care (for example, waiting times)

Year	Quality Adjusted Output	Total Input	Total Factor productivity
2005-06	7.1%	7.2%	-0.1%
2006-07	6.5%	1.9%	4.5%
2007-08	3.7%	3.9%	-0.2%
2008-09	5.7%	4.2%	1.4%
2009-10	4.1%	5.4%	-1.3%
2010-11	4.6%	1.3%	3.2%
2011-12	3.2%	1.0%	2.1%
2012-13	2.3%	2.0%	0.4%
2013-14	2.6%	0.4%	2.2%
2014-15	2.5%	1.9%	0.5%
2015-16	2.6%	2.7%	-0.2%
2016-17	3.0%	1.0%	1.9%
2017-18	2.6%	0.9%	1.7%
2018-19	2.2%	3.0%	-0.8%

Table 5 - York CHE Labour Productivity (Figures are all quality adjusted so take into account changes in quality of care (for example, waiting times)

Year	Quality Adjusted Output	Labour Input	Labour Productivity
2005-06	7.1%	3.4%	3.6%
2006-07	6.5%	0.6%	5.9%
2007-08	3.7%	0.7%	2.9%
2008-09	5.7%	4.1%	1.5%
2009-10	4.1%	4.5%	-0.4%
2010-11	4.6%	1.4%	3.1%
2011-12	3.2%	0.1%	3.1%
2012-13	2.3%	-2.0%	4.4%
2013-14	2.6%	0.4%	2.3%

2014-15	2.5%	2.8%	-0.3%
2015-16	2.6%	1.3%	1.3%
2016-17	3.0%	2.4%	0.6%
2017-18	2.6%	2.4%	0.2%
2018-19	2.2%	2.4%	-0.2%

Even though the annual measures haven't captured this yet, the ONS quarterly measures have explicitly stated that reductions in health output have reduced the total public sector productivity figures (Source: UK productivity introduction - April to June 2020).

It is important to note that infection controls and lockdowns have delivered health benefits (for example, less COVID cases) that aren't captured in our usual measures of productivity.

Productivity and efficiency in the NHS

The government has set out in "Build Back Better" that recovering and increasing productivity will be crucial to restoring the performance of the NHS.

The ONS estimated public service productivity as a whole fell by 32.6% between April and June 2020 and 22.4% between July and September 2020 compared with the same quarter a year earlier, and that even as it recovered productivity was still nevertheless 9.8% lower in Q1 2021 compared with Q1 2019. It is reasonable to expect that the impact on NHS productivity would be similar. NHS productivity will have fallen significantly during 2020-21 because of the cancellation of non-urgent elective work, staff shortages and absences, and enhanced infection prevention and control. These were combined with rising costs and inputs due to increased critical care and PPE requirements.

The impact of COVID, including enhanced infection prevention and control (IPC) measures, remains a challenge for productivity. Enhanced IPC guidance, which is necessary to protect patients and staff, has reduced productivity by reducing capacity (for example, physical distancing of beds), increasing costs (for example, buying PPE), and reducing throughput (for example, longer gaps between scans for enhanced cleaning).

The vaccination programmes and reductions in cases have allowed for some relaxation of IPC rules, but productivity is yet to recover to pre-pandemic levels. NHS and UKHSA will work together to review IPC rules and determine what adjustments can be made to improve productivity without compromising patient safety.

As part of the funding announced at the spending review, the government will invest in programmes to help the NHS return to productivity growth and achieve an ambitious productivity trajectory while delivering on the elective recovery challenge. Key productivity programmes prioritised by NHSEI are:

- improving patient pathways – simplifying a patient pathway will ensure patients are seen faster at the right speciality, diagnosed earlier, and treated sooner. Improving the skills mix and enhancing digital connections between primary, secondary and community services in a pathway will reduce unnecessary referrals and encourage treatments closer to or at home

- setting up surgical hubs – increasing surgical productivity will increase efficiency for some of the costliest parts of the NHS. Surgical hubs will provide opportunity for patients to be seen and treated faster which will reduce the number of patients on the waiting list faster

- expanding Community Diagnostic Centres (CDCs) – the NHS will increase the number of CDCs to at least 100 by 2024-25. CDCs separate elective diagnostics from acute hospital settings, reducing the risk of COVID infection, and offering improved productivity by reserving facilities for elective care

- making outpatient care more personalised – the NHS will give patients greater control and convenience over their outpatient appointments by supporting them to initiate follow-up care and to self-manage their conditions. This will also reduce the number of unnecessary or low-value follow-up appointments

- digital productivity programmes – using digital tools such as single sign-on, e-rostering, digital staff passports, improved communication tools, and shared care records to save clinical staff time that can be better spent caring for patients

The productivity programmes aligned with the elective recovery will build on the achievements of the 2016 Carter Review and the Operational Productivity programmes which saw a saving of £3.57 billion by January 2020, supporting average productivity growth of 1.6% from 2010-19.

Alongside this, the Department and NHSEI have created a Flexible Staffing Strategy that aims to meet fluctuations in demand by building a flexible workforce that is sustainable, high quality and value for money for the NHS. A series of measures have been introduced to bring NHS agency spending under control. These measures and the impact they have had on spending are described in Chapter 5 of this evidence.

Affordability

In chapters 1 and 2, we have described the challenging economic and NHS financial landscape for 2022-23.

With the NHS moving away from temporary COVID-19 arrangements and returning to its pre-pandemic financial regime, there is a need for financial restraint in the context

of stretching efficiency requirements the NHS has committed to deliver as part of the 2021 Spending Review, building on the NHS Long Term Plan commitments and delivering value for money for the taxpayer.

When set in January 2019, the Long-Term Plan assumed a headline uplift of 2% for 2022/23. The outcome of SR21 has provided a tight settlement for the NHS, requiring the delivery of a range of priorities and efficiencies which will need careful prioritisation in order stay within available funding. In settling the DHSC and NHS budget, the government assumed a headline pay award of 2% for NHS staff. The department has an additional 1% "contingency" which it is choosing to make available for AfC pay, providing an overall affordable headline pay award of up to 3%. Doing so means that this contingency will not be available for other priorities, and some examples of these trade-offs are set out below. Since SR21, the emergence of Omicron has placed additional uncertainty on the economy, and could further reduce the NHS's ability to prioritise significant new pay interventions, above that which was accounted for in the SR.

As already mentioned earlier in this evidence, the NHS budget has been fixed to prioritise investments which will enable the NHS to tackle the elective backlog, grow the NHS workforce, continue the fight against COVID-19 and deliver the Long Term Plan. This includes the significant step government has already undertaken to increase National Insurance Contributions by 1.25% to fund the Health and Social Care Levy. This leaves extremely limited room for any further investment in pay and therefore to achieve these objectives, financial restraint on pay is needed.

To put this into context, each additional 1% of pay for the Hospital and Community Health Service (HCHS) non-medical workforce costs around £700 million per year allowing for the full system costs beyond the substantive workforce. This equates to around 13,000 full-time nurses or 400,000 procedures. For the HCHS workforce as a whole, an additional 1% of pay costs around £900 million which is equivalent to around 16,000 full-time nurses or 500,000 Procedures.

These examples illustrate how more funding allocated towards pay than what is affordable, will lead to reduced ability to tackle the elective care backlog and expand clinical capacity to deliver a more effective health and social care system.

Patients, and their experience of care, must be at the heart of everything that the system does - we want to help ensure that the NHS can continue to put patients first and deliver world class patient care.

Our focus is on ensuring that the overall package of reward helps to recruit and retain the staff we need whilst maintaining affordability. Growing the workforce is crucial, but there is a direct correlation between the size of the workforce and what is affordable in terms of

pay. This is the careful balance the government must strike to ensure the NHS remains an affordable, value-for-money service for the taxpayer.

It is therefore crucial during this challenging fiscal and economic climate that the NHSPRB carefully consider the important balance between ensuring that existing funding can be used to expand the AfC workforce, whilst also fairly rewarding staff.

DHSC ministers and officials will be able to provide further information on affordability at oral evidence.

3. Workforce strategy

This chapter discusses the current strategy for the NHS workforce and provides further information on the NHS People Plan. It includes updates on current manifesto commitments and key priorities including workforce culture, leadership, and workforce planning.

Effective workforce strategy is important for the delivery of safe, affordable, high quality care, both now and in the longer term. Ensuring that the NHS has access to the right mix and number of staff who have the skills, values, and experience to deliver high quality, affordable care is a fundamental aspect of the DHSC's overarching programme for the health and care system.

There are currently record numbers of doctors and nurses working in the NHS, and the Department continues to work closely with the various bodies involved in workforce planning and training to help ensure the NHS continues to recruit and retain staff. This commitment is supported by a robust programme of work including delivery of the Nurse 50k manifesto commitment, investment in international recruitment, the expansion of medical training places, and training grants for nursing, midwifery, and Allied Health Professions students.

The Department recognises that in addition to growing the workforce, work must continue to help improve ways of working to increase productivity and efficiency through advancing skills mix and service transformation. The Department is therefore developing proposals to improve the integration of health and social care services around the needs of patients.

In addition to training and recruiting additional workforce and improving ways of working, there is a significant programme of work in place to retain and look after the existing workforce. Initiatives include improving staff wellbeing, fostering an increased sense of belonging, and promoting greater equality, diversity, and inclusion.

The Department works through its ALBs on the delivery and implementation of workforce policy. In conjunction with the department, NHSEI is responsible for setting the priorities and direction of the NHS workforce and encouraging and informing the national debate to improve health and care. NHSEI is responsible for delivering the NHS People Plan.

Building on the experience of the pandemic, NHSEI will also be working with Health Education England (HEE) to explore the potential of new roles and making best use of skills through multidisciplinary teams, as well as ensuring the workforce can respond to technological change and support new service models to provide high-quality patient care, now and in the future. This work will include developing proposals for medical education reform to improve efficacy and flexibility of our medical education system, guided by the

lessons of the COVID response, as well as through HEE's advanced practice programme, expand clinical practice for nurses, allied health professionals, pharmacists and healthcare scientists to ensure people can practise to their maximum ability, not the top of their capacity.

Education and training of the workforce is the core function of HEE and, subject to parliamentary passage of the requisite powers within the Health and Care Bill, will be merged with NHSEI. The merger will help ensure that workforce is placed at the forefront of the national NHS agenda as it will integrate service, workforce, and finance planning in one place, reflecting its importance. It will also simplify the national system for leading the NHS, ensuring a common purpose and strategic direction.

NHSEI/HEE have responsibility for short term workforce planning and the deployment of workforce to meet service need, with each Integrated Care System (ICS) planning workforce requirements for its own service. ICSs are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area, including working to ensure the system is retaining, recruiting and, where required, growing its workforce to meet future need.

The Department retains strategic oversight for the NHS workforce and is delivering longer term strategic workforce planning. It also includes HEE Long Term Strategic Framework ("Framework 15"), commissioned in July 2021, which will review long term strategic trends for the health and regulated social care workforce.

The Department has also set out further reforms to improve recruitment and support for our social care workforce in the White Paper, published on 1 December 2021. This sets out the vision for a well-trained and developed workforce, a healthy and supported workforce, and a sustainable and recognised workforce. Our policies include a Knowledge and Skills Framework and a linked training offer to ensure staff feel recognised, rewarded, and equipped with the rights skills and knowledge, including to support adults with learning disabilities and complex needs.

The NHS people plan

'We are the NHS: People Plan 2020-21 – action for us all' was published in July 2020, setting out the actions which will make sure the NHS has the right measures in place to support transformation across the whole system and grow the workforce, acknowledging the impact of the pandemic. The People Plan focuses on building resilience across the NHS workforce with actions to support recruitment and retention. NHSEI is responsible for the delivery of the NHS People Plan and will go into this in more detail in the evidence that they submit to the review body.

The 2021-22 NHS operational planning guidance, which sets the priorities for the NHS, reaffirms the importance of the 4 pillars of the NHS People Plan – looking after staff and helping them to recover, belonging in the NHS and addressing inequalities, new ways of working and growing the workforce for the future.

The experience of the pandemic has shown, once more, that the NHS is nothing without its exceptional staff. NHS staff have been severely tested by the challenges of dealing with the pandemic and it is vitally important that they are kept safe, supported now and over the months ahead, and able to recover. Investing in staff health and wellbeing is very important. The NHS has strengthened the mental health and wellbeing support offer for health and social care staff in 2021-22, with £37 million invested in 40 mental health and wellbeing hubs across the country. These provide proactive outreach and clinical assessment, access to evidence-based mental health services and other support where needed. The NHS Retention Programme is working to understand why staff are leaving, resulting in targeted interventions to support staff to stay whilst keeping them well. While much is being done, we are not complacent and both the Department and NHSEI will continue to seek to understand what further action will help support staff in keeping well and feeling supported while doing the difficult jobs that they do.

NHS covenant

The Department is exploring the potential for a Covenant for NHS staff. This could provide an opportunity to ensure there is comprehensive, meaningful, and lasting support to those working in the NHS on issues such as health and wellbeing, recognition, bullying, harassment, and violence reduction. We are currently working through the best approach to developing the NHS Covenant with partners including NHSEI, NHS Employers and the Social Partnership Forum and will engage further with NHS staff and others on how we might shape the NHS Covenant and ensure it is aligned with the staff rights in the NHS Constitution and some of the good work being done through other initiatives such as the NHS People Plan and NHS People Promise.

Leadership review

The Health and Social Care Leadership Review, led by General Sir Gordon Messenger with support from Dame Linda Pollard, will look to strengthen the leadership of health and social care in England, with the aim of reducing regional disparities in efficiency and health outcomes. The Terms of Reference have now been published, which outline further detail on the scope of the review.

Research has shown that leadership plays a significant role in shaping organisational culture. Strong leadership in health and social care will ensure the best outcomes for our

key priorities and that the necessary leadership behaviours, strategies and qualities are developed to maximise these efforts - which is vital in ensuring that every pound of investment is spent well.

The move to Integrated Care Boards in April 2022 and the need for ever closer working between NHS organisations and local authorities provides an opportunity to look at what more needs to be done to foster and replicate the best leadership and management and to address underperformance. It also provides a new focus on how leaders from both health and care work together to provide efficient and integrated care for the people they serve.

The Leadership Review is working closely and extensively with stakeholders across health and social care to discuss how to ensure the right pay and incentives are in place to foster good and excellent performance.

The review should report to the Secretary of State for Health and Social Care in early 2022.

International recruitment

Internationally trained staff have been part of the NHS since its inception in 1948 and continue to play a vital role. International recruitment remains an important part of achieving our workforce commitments.

Ethical and sustainable international recruitment is central to our approach, set out in the Department's revised Code of Practice for International Recruitment which aligns with the latest advice from the World Health.

Many international staff benefit enormously from the opportunity to work in the NHS – both in terms of professional development and economically - and we have made it easier for those wanting to further their career to come to work in the NHS. Since 2016, we have seen increases in joiners of nearly all staff types from the EU and EEA. The growth in Rest of World nationalities has increased at a particularly fast pace, from 5.4% of all non-medical joiners in 2017 to 11.8% in 2021.

While some of these professionals will stay in the UK, many return to their home countries, taking with them enhanced experience in new clinical settings and new skills which can help strengthen their countries health system.

50k nurses manifesto commitment

This government is committed to growing and supporting the NHS workforce to ensure it continues to provide world class health and care. government is committed to deliver

50,000 more nurses by the end of this Parliament and put the NHS on a trajectory to a sustainable long-term supply in future. The target is ambitious, and delivery is complex, requiring cooperation and coordination on a system-wide basis.

The Department has established a comprehensive delivery programme to meet the nursing manifesto commitment. Working across a range of delivery partners to improve retention and support return to practice, invest in and diversify our training pipeline, and ethically recruit internationally.

Delivery of 50,000 more nurses in the NHS in England will support the 1.3 million full-time equivalent staff who make up the NHS workforce and address nursing shortages. There are around 307,000 full-time equivalent nurses in the NHS working in hospital and community services, making up a quarter of all NHS staff, with over 16,000 further full-time equivalent nurses employed in GP practices.

The government has already taken steps to deliver this commitment by providing a financial support package. Eligible pre-registration nursing, midwifery, and most allied health students on courses at English universities from September 2020 will benefit from grants of at least £5,000 per academic year which they will not need to pay back.

An additional £1,000 a year will be available to prioritise shortage groups that are key to delivering the NHS Long Term Plan, including new students on courses for Mental Health and Learning Disability nursing.

More than 35,000 students are expected to benefit from training grant funding every year, including those on midwifery and allied health courses. All students will receive at least £5,000 a year (in addition to maintenance and tuition fee loans provided by the Students Loan Company) with up to £3,000 further funding available for eligible students.

In August 2020, the government announced additional funding to employers of Registered Nurse Degree Apprentices of £8,300 per placement per year. This funding is available to employers to support with the costs of training both existing nurse apprentices and future ones joining the apprenticeship programme. It applies to all 4 fields of nursing : Adult, Children, Mental Health and Learning Disabilities.

We are on track to deliver this commitment with each workstream currently performing as expected.

Service transformation, integration, and productivity

The government is developing proposals to improve the integration of health and social care services around the needs of patients. These proposals will be published in 2022. The health and social care workforce are central in delivering more integrated care, and

the drive to deliver more integrated services will support the health and care workforce to deliver care in a more effective way, working across traditional boundaries. This will both benefit patients and service users and will support professionals to work more effectively.

NHSEI evidence will cover this in further detail.

Workforce planning and forward look

The Health and Care Bill builds on this work and investment. Publishing a report detailing the roles and responsibilities of the bodies involved in workforce planning and supply, as we are proposing in clause [35] of the Bill, is one part of our commitment to improve workforce planning and supply. The report will set out the role and responsibility of each of the bodies in the system responsible for workforce planning for the first time – to increase accountability and transparency and provide assurance that the system is making this issue a priority. Part of the rationale for this report is that workforce planning in the NHS necessarily requires collaboration between various bodies at different levels of the system – national, regional, and local.

This workforce accountability report will cover the whole of the NHS including primary care, secondary care, and community care. It will also cover where sections of the workforce are shared between health and social care – for example, registered nurses or for the case of public health, doctors and other regulated healthcare professions.

In July 2021, the Department commissioned HEE to work with partners and review long term strategic trends for the health and regulated social care workforce. This will review and renew the long-term strategic framework for the health workforce, to help ensure we have the right numbers, skills, values, and behaviours to deliver world leading clinical services and continued high standards of patient care. For the first time ever, the framework will also include regulated professionals working in social care, like nurses and occupational therapists.

Building on this work, the Department for Health and Social Care has recently commissioned NHS England to develop a workforce strategy and will set out the key conclusions of that work in due course.

Going forward HEE will also continue to drive innovation in how it develops the future workforce. In March 2021, the government announced funding of up to £15 million for English universities to invest in new simulated training facilities and technology, providing flexibility for healthcare students during the pandemic. This can involve the use of virtual reality (VR) technology, manikins, role play, and smart phones, tablets, or computers, allowing students to practise their clinical skills in a safe environment. Blended Learning programmes offer predominantly online remote-access study to those people who may

have the aptitude and values to join the nursing profession, but currently are unable to learn in traditional ways. HEE anticipate that around 8500 nurses will start training in BLPs over the next 5 years

Supporting all this work is our recent announcement of our intention to formally merge HEE with NHSEI.

Apprentices

As part of the 2018 Framework Agreement reached on the reform of the AfC system, the negotiating partners agreed they would attempt to reach a consensus position on Apprenticeship pay rates. The NHS Staff Council worked hard to reach consensus on a new pay framework but could not agree the minimum pay rate for all apprenticeships. Although the partners are disappointed that they could not reach a national collective agreement, they remain committed to support trusts to widen participation and help grow the domestic workforce. There is existing guidance in the NHS Terms and Conditions of Service Handbook for AfC staff to ensure trainees are fairly paid, which the partners agree trusts should continue to use.

4. Recruitment, retention, motivation and non-medical workforce planning

This chapter describes and discusses the existing size of the workforce and how it has changed with regards to patterns of recruitment, retention, and motivation. We have highlighted and discussed where there might be COVID-19 impacts below and as part of sections where notable. The remainder of the chapter reflects on and updates on aspects of workforce planning and key topics of interest as requested by the review body.

The size of the non-medical workforce is at record levels with notable increases in the nursing workforce which aligns with the "Nurse 50K" manifesto commitment. It continues to become an even more diverse workforce in terms of nationality, ethnicity, and gender. Education and training pipelines continue to diversify, bringing in new roles and staff from local areas. Trends in vacancies, temporary staffing, retention rates and the numbers of staff joining and leaving the non-medical workforce have been impacted by the pandemic. The data shows that less staff have been leaving however there are early signs that leaver rates and vacancy levels are now returning to pre-pandemic levels.

COVID-19 impacts and impacts to workforce data

There have been a broad range of workforce changes as part of responding to the COVID-19 pandemic. These have had implications and impacts to workforce data which makes interpreting 2020-21 data more challenging than normal. Therefore, data for this year should be treated with caution. This includes:

- student nurses being deployed either as healthcare assistants or nurses depending on where they were in their studies. This meant typical patterns of joiners to the NHS have changed;

- vacancy numbers and rates appear to be artificially suppressed due to NHS Trusts focusing on the COVID-19 response and therefore pausing and / or focusing less on assessing their establishment. We expect there also have been some data quality or coverage issues as also highlighted by NHS Digital;

- whilst the international workforce continues to grow, international recruitment flows were briefly impacted, reduced, or paused whilst travel restrictions were in place;

- some staff were employed via NHS Professionals and other routes, these are likely to have had an effect on workforce statistics;

- many people were and continue to work longer hours, but other professions, depending on their specialism may not have seen the same demands as part of the pandemic response. There were also a number of redeployments of staff which make it challenging to understand what care areas they did or did not provide service in at times.

Numbers in work

The overall non-medical NHS workforce as at September 2021 is 1,078,042 FTEs, this has increased by 134,081 FTEs (14.2%) between September 2017 and September 2021. Further detail is shown in Table 6. From September 2020-21 all known classifications of staff groups FTEs increased other than midwives.

Table 6 - Non-medical staff FTE September 2017 to September 2021

Staff group	Sep-17	Sep-18	Sep-19	Sep-20	Sep-21	Change since Sep-17
All non-medical staff groups	943,961	962,963	994,737	1,039,036	1,078,042	134,082 (14.2%)
Nurses and health visitors	283,853	285,674	291,533	304,490	313,836	29,983 (10.6%)
Midwives	21,206	21,323	21,497	22,169	21,842	637 (3.0%)
Ambulance staff*	20,258	20,951	16,217	17,375	17,790	-2,468 (-12.2%)
Scientific, therapeutic and technical staff	134,990	139,241	143,805	150,137	155,158	20,168 (14.9%)
Support to doctors, nurses and midwives	243,762	246,650	257,423	269,053	277,621	33,859 (13.9%)
Support to ambulance staff*	14,731	15,430	21,962	24,267	24,736	10,005 (67.9%)
Support to ST&T staff	56,099	57,660	60,318	64,287	71,157	15,059 (26.8%)
Central functions	80,739	84,066	88,822	94,541	100,960	20,220 (25.0%)
Hotel, property and estates	51,890	53,751	55,618	58,016	59,850	7,960 (15.3%)

Senior managers	10,282	10,365	10,898	11,290	12,046	1,765 (17.2%)
Managers	21,673	23,100	24,033	21,574	22,306	632 (2.9%)
Other staff / unknown classification	4,478	4,752	2,611	1,838	740	-3,738 (-83.5%)

Source: NHS Digital HCHS monthly workforce publication.

*In April 2019, around 6,000 ambulance staff were reclassified as support to ambulance staff, which has resulted in the drop in ambulance staff and increase support to ambulance staff between September 2018 and September 2019

Joiners

The overall non-medical joiner rate for the year to March 2021 for all regions and staff is 13.4% with over 159,000 headcount joining the workforce. Joiner rates vary between 7.3% for senior managers and 18.6% for support to ST&T staff.

Table 7- Joiners by Staff Group March 2020 - March 2021

Staff group	Number of Joiners	Joiner Rate
All non-medical staff groups	159,690	13.4%
Nurses and health visitors	37,472	11.0%
Midwives	3,215	12.0%
Ambulance staff	1,417	7.7%
Scientific, therapeutic and technical staff	20,374	11.9%
Support to doctors, nurses & midwives	53,255	16.9%
Support to ambulance staff	4,367	16.8%
Support to ST&T staff	14,240	18.6%
Central functions	13,367	12.8%
Hotel, property and estates	8,648	11.9%
Senior managers	875	7.3%
Managers	1,818	7.9%
Other staff or those with unknown classification	642	39.5%

Source: NHS Digital HCHS Workforce Statistics

Note: the joiner rate is calculated by dividing the number of joiners by the average headcount in that category at the beginning and end of the period, expressed as a percentage.

While joiner rates vary across staff groups and regions, joiner rates in main staff groups are generally higher in the South and East than they are in the North and Midlands.

Joiner rates for the year to March 2021 for non-medical staff groups are shown in Table 8. We see the highest joiner rates in support staff, and the lowest joiner rates in senior managers and ambulance staff. This is consistent across all regions, with the highest joiner rates for all staff in the South and East, and the lowest joiner rates in the North and Midlands.

Table 8 - Joiners by Staff Group March 2020 - March 2021

Staff Group	All Regions	East of England	London	Midlands	North East and Yorkshire	North West	South East	South West
All non-medical staff groups	13.4%	15.0%	13.7%	12.5%	12.4%	12.9%	14.8%	14.2%
Nurses and health visitors	11.0%	10.6%	10.9%	10.9%	10.6%	11.4%	11.3%	11.5%
Midwives	12.0%	12.7%	12.0%	11.4%	11.9%	11.4%	13.7%	10.8%
Ambulance staff	7.7%	7.1%	10.1%	6.2%	7.8%	3.7%	10.6%	8.5%
Scientific, therapeutic and technical staff	11.9%	13.3%	12.8%	11.2%	10.9%	10.6%	13.3%	12.0%
Support to doctors, nurses and midwives	16.9%	20.7%	16.4%	15.5%	15.0%	17.0%	18.2%	18.5%
Support to ambulance staff	16.8%	22.0%	17.2%	13.1%	15.8%	12.9%	20.1%	21.3%
Support to ST&T staff	18.6%	18.0%	20.3%	15.7%	19.7%	16.8%	22.7%	17.7%
Central functions	12.8%	16.0%	12.2%	11.9%	11.4%	11.2%	15.5%	12.9%
Hotel, property and estates	11.9%	10.1%	21.8%	10.7%	9.6%	11.4%	11.7%	13.6%
Senior managers	7.3%	7.5%	8.2%	6.3%	6.7%	6.6%	9.4%	5.4%
Managers	7.9%	9.5%	9.1%	6.6%	6.3%	7.0%	8.6%	8.8%

Leaver rates and trends

Leaver rates have fallen since last year for all staff groups in England. The leaver rate is the share of the workforce leaving their staff group in the NHS Trusts and CCGs in a

year. This includes people moving to different parts of the health and social care sector, as well as people going on parental leave. Leaver rates have been gradually falling across England in recent years, with significant drops in leaver rates for all staff groups occurring during the pandemic. In 2020-21 Ambulance staff had the lowest leaver rate in England, at 6.0%, whilst midwives had the highest leaver rate of 9.8%.

We are seeing these leaver rates rise and return to pre-pandemic levels in the most recent data but there is no evidence, as yet, for any increased rate of staff leaving the NHS as a direct impact of the pandemic, though it is likely still too early for this to be showing in data. There is no robust available data on where staff are leaving the NHS to go, or whether they are returning after breaks from employment.

Table 9 - Leaver rates by Staff Group

Staff Group	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
All non-medical staff	10.9%	11.2%	11.2%	10.4%	10.1%	8.8%
Nurses and health visitors	10.3%	10.7%	10.7%	10.2%	9.9%	8.8%
Midwives	10.0%	10.6%	10.5%	10.4%	10.6%	9.8%
Ambulance staff	7.5%	7.2%	7.9%	7.6%	7.9%	6.0%
Scientific, therapeutic and technical staff	11.2%	11.0%	10.8%	10.5%	10.2%	9.0%
Support to doctors, nurses and midwives	10.9%	11.9%	11.6%	10.7%	10.4%	9.1%
Support to ambulance staff	11.9%	11.4%	11.9%	10.2%	8.1%	6.9%
Support to ST&T staff	11.9%	12.1%	11.9%	11.9%	11.0%	9.5%
Central functions	12.1%	11.5%	11.9%	10.9%	10.2%	8.2%
Hotel, property and estates	10.4%	11.4%	11.3%	8.7%	8.6%	7.7%
Senior managers	11.6%	10.8%	11.6%	10.7%	10.2%	8.2%
Managers	11.4%	10.1%	10.5%	9.4%	9.4%	7.6%
Other staff or those with unknown classification	20.8%	25.1%	24.9%	20.6%	25.7%	17.2%

Retention

Reasons for leaving

Reasons for leaving data are published by NHSD and are based on set categories within ESR, without organisations explaining further detail such as the cause of an employee

voluntarily resigning. In the 2020-21, voluntary resignation accounted for almost 40% of all reasons for leaving. Of all recorded reasons, retirement was the next biggest reason for leaving at 17% of the leaver workforce.

This reason increased significantly in 2020-21, likely due to the number of short-term positions created in response to the pandemic. Voluntary resignations had been increasing steadily in the years to 2018-19, with a large increase seen in the most recent year likely due to the pandemic. There have been year-on-year decreases in the number of redundancies of staff since 2015-16.

Table 10 - Reasons for Leaving Numbers (Absolute and Percentage)

Reason for leaving	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Dismissal	4,464	4,282	4,006	3,816	3,545	2,736	3.9%	3.6%	3.3%	3.3%	3.2%	2.6%
Employee Transfer	5,234	6,480	6,134	3,105	3,041	1,544	4.6%	5.4%	5.1%	2.7%	2.7%	1.5%
End of Fixed Term Contract	2,317	2,227	2,223	2,060	2,069	2,220	2.0%	1.9%	1.8%	1.8%	1.8%	2.1%
End of Fixed Term Contract - Completion of Training Scheme	575	529	470	495	440	409	0.5%	0.4%	0.4%	0.4%	0.4%	0.4%
End of Fixed Term Contract - End of Work Requirement	271	322	299	269	351	328	0.2%	0.3%	0.2%	0.2%	0.3%	0.3%
End of Fixed Term Contract - External Rotation	475	390	448	375	361	8	0.4%	0.3%	0.4%	0.3%	0.3%	0.0%
End of Fixed Term Contract - Other						365						0.4%
Mutually Agreed Resignation	740	789	507	342	251	160	0.7%	0.7%	0.4%	0.3%	0.2%	0.2%
Others	790	821	878	1,238	1,561	1,286	0.7%	0.7%	0.7%	1.1%	1.4%	1.2%
Redundancy	1,639	1,324	1,258	920	751	492	1.4%	1.1%	1.0%	0.8%	0.7%	0.5%
Retirement	18,119	17,690	17,051	15,522	16,023	17,703	15.9%	14.8%	14.1%	13.5%	14.3%	17.0%
Voluntary Resignation	49,429	51,365	53,148	52,341	50,529	41,602	26.1%	27.9%	28.5%	29.9%	29.8%	39.9%
Unknown	29,663	33,318	34,480	34,311	33,432	35,403	43.5%	43.0%	44.0%	45.6%	45.0%	34.0%
All Reasons for Leaving	113,716	119,537	120,902	114,794	112,220	104,099						

Source: NHS Digital HCHS monthly workforce publication.

Note: Totals may not equal sum of the component par

Vacancies

NHSEI undertake monthly workforce data collection from NHS trusts, which includes data on staff in post (including bank and agency) and vacancies (defined as the difference between the reported whole-time equivalent substantive staff in post and planned workforce levels). Vacancies typically show seasonal variation with peaks occurring at the start of the financial year, and troughs occurring at the end. The overall nursing vacancy rate has showed some variation over the last 3 years, ranging from 12.3% to 9.2%, which is equivalent to vacancies of over 44,000 to over 34,000. Further figures are published by NHS Digital.

NHSEI define a vacancy as the gap between staff in post and funded establishment at a trust. Vacancies should reflect the planned headroom for sickness absence, maternity leave, and the temporary staffing which a trust is expecting to require. Though we do not have good information on this, many of the vacancies will be covered by bank and agency staff, and the figures may not represent 'gaps' in the workforce, or that work is not being carried out. This means that although the vacancy figures are a measure of shortfall, they are not measure shifts which are untilled.

NHS Digital also highlight that these experimental statistics should be treated with caution especially considering ongoing disruption from the COVID-19 pandemic. NHS Digital highlight:

"Due to the COVID-19 pandemic, there has been a significant disruption to recruitment activity within the NHS. This is apparent from the significantly lower reported advertised vacancies between March and June 2020 as the NHS was fully focused on dealing with the pandemic and the typical seasonal pattern not shown.

"Whilst some critical recruitment increased in response to the situation, other elements were significantly reduced – this is particularly the case for certain Staff Groups. However, we believe that the headline figures included in the bulletin remain of immediate use, as they represent the situation as it was at the time, but year on year comparisons should be avoided."

Table 11 – Nursing and other Non- Medical Vacancies and Vacancy Rates from Q2 2018-19 – Q2 2021-22

	Nursing Staff		Other Non-Medical staff	
	Vacancy Rate	WTE Vacancies	Vacancy Rate	WTE Vacancies
18-19 Q2	12.1%	42,679	7.5%	53,416
18-19 Q3	11.1%	39,686	7.4%	52,311
18-19 Q4	11.1%	39,524	6.7%	47,656

19-20 Q1	12.3%	44,195	7.7%	56,039
19-20 Q2	12.1%	43,452	7.3%	53,067
19-20 Q3	10.7%	38,736	7.1%	52,312
19-20 Q4	9.9%	36,083	6.0%	43,926
20-21 Q1	10.3%	37,760	4.9%	37,368
20-21 Q2	10.1%	37,144	5.6%	42,835
20-21 Q3	9.7%	36,277	6.0%	45,913
20-21 Q4	9.2%	34,678	4.5%	34,770
21-22 Q1	10.3%	38,956	5.9%	46,430
21-22 Q2	10.5%	39,813	6.5%	51,314

Source: NHS Digital Vacancy Statistics

The international workforce

The government wants to attract the brightest and the best internationally trained health and care staff and has taken steps to support those who choose to come and further their careers in the UK. Despite the ongoing uncertainty due to the COVID-19 pandemic and travel restrictions in place for some of the year, the internationally trained workforce continues to grow.

Since 2016, we have seen increases in joiners of nearly all staff types from the EU and EEA, and the rest of the world. The exceptions to this trend are EU and EEA nurses and health visitors, which have shown a decline from 6.8% to 5.9%, and midwives from the EEA and EU (5.4% to 5.2%) and rest of the world (2.0% to 1.4%). In the case of nurses and health visitors, the fall in EEA and EU joiners has been offset by increases in joiners from the rest of the world – 8.2% to 18.5% (Table 12).

Table 12 - Proportions of all Non-medical Joiners by Staff Group and nationality, June 2021

Staff Group	United Kingdom	EU/EEA	Rest of World
All non-medical staff 2017	82.9%	4.8%	5.4%
All non-medical staff 2021	78.8%	6.2%	11.8%
Nurses and health visitors 2017	78.6%	6.8%	8.2%
Nurses and health visitors 2021	73.3%	5.9%	18.5%
Midwives 2017	85.9%	5.4%	2.0%
Midwives 2021	92.1%	5.2%	1.4%
Ambulance staff 2017	79.3%	1.9%	2.9%
Ambulance staff 2021	83.2%	2.4%	5.9%
Scientific, therapeutic and technical staff 2017	85.3%	5.0%	3.6%
Scientific, therapeutic and technical staff 2021	82.9%	7.5%	7.6%
Support Staff 2017	84.4%	3.6%	5.1%
Support Staff 2021	78.5%	5.9%	11.5%

Admin Staff 2017	85.7%	3.8%	3.6%
Admin Staff 2021	84.3%	6.7%	5.7%

Source: NHS Digital Workforce Statistics, these figures show joiners to the NHS workforce, they may include non-UK nationals who had previously worked in health and social care for non-NHS-providers.

The number of overseas staff with EU/EEA and Rest of World nationalities has increased over the past 5 years, however, growth in Rest of World nationalities has increased at a faster pace than from both UK and EU nationalities. The recent increase in Rest of World non-medical staff numbers is likely due to a combination of factors, including the removal of the cap on Tier 2 visas.

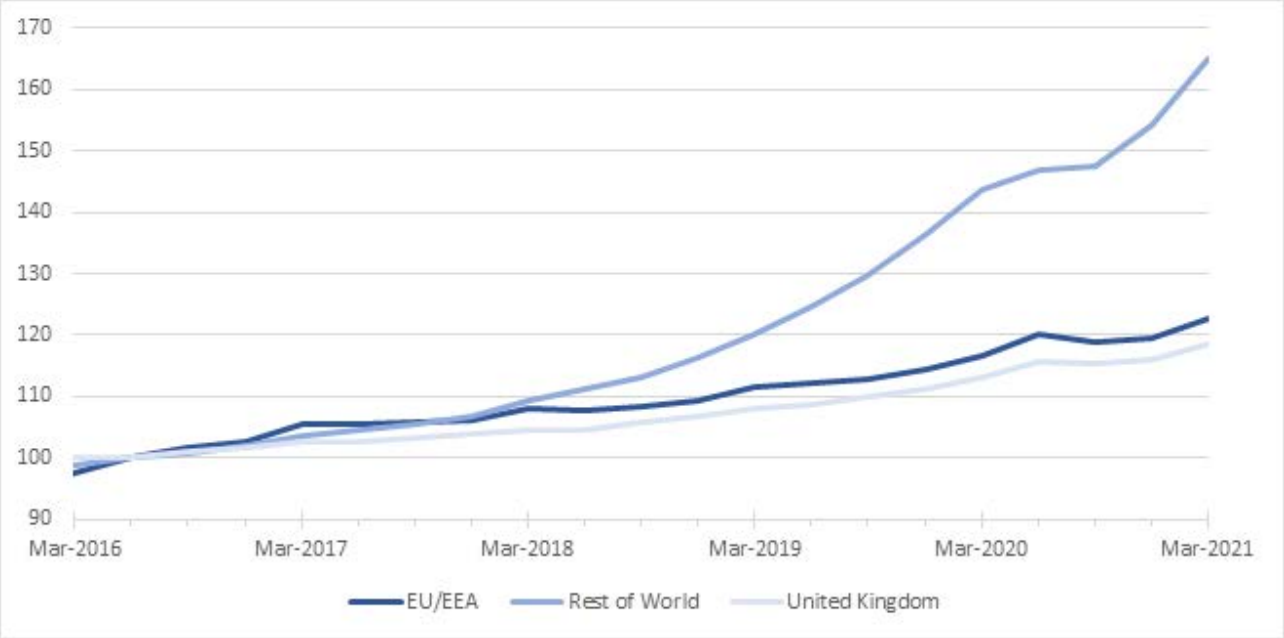
Around 12% of non-medical staff have a non-UK nationality. Of these, 4.9% are from the EU27. Table 13 shows the percentage of HCHS EU and EEA and Rest of World (excluding UK) workers for each staff group.

Table 13 – Non-medical Workforce by Nationality Group (March 2021)

Staff Group	EU/EEA	Rest of World	United Kingdom	Unknown
All non-medical staff	4.9%	7.5%	84.5%	3.1%
Nurses and health visitors	5.5%	13.4%	78.6%	2.5%
Midwives	4.8%	1.7%	91.0%	2.6%
Ambulance staff	2.6%	4.1%	83.9%	9.5%
Scientific, therapeutic and technical staff	5.8%	4.4%	87.5%	2.4%
Support Staff	4.4%	6.2%	86.0%	3.4%
Admin Staff	4.6%	4.0%	88.0%	3.4%

Source: NHS Digital Workforce Statistics

Figure 3 – Growth of Non-medical Workforce by Nationality



Source: NHS Digital Workforce Statistics

Table 14 – Growth of Non- Medical Workforce by Nationality

Date	All Nationalities	EU/EEA	Rest of World	United Kingdom	Unknown
2015-16	1,053,739	47,715	54,851	866,974	84,543
2016-17	1,073,617	51,559	57,423	889,760	75,191
2017-18	1,088,641	52,790	60,705	907,770	67,673
2018-19	1,118,464	54,545	66,566	938,463	59,158
2019-20	1,160,742	57,056	79,621	981,523	42,774
2020-21	1,216,386	59,879	91,447	1,027,890	37,414

Source: NHS Digital Workforce Statistics

Internationally trained staff in eligible health and care roles (including doctors, nurses, allied health professionals and social workers) can migrate to the UK on the Health and Care Visa, introduced in August 2020. Applicants for this visa are guaranteed a decision within 3 weeks and pay reduced visa fees (£232). From August 2020 all health and social care staff are exempt from paying the Immigration Health Surcharge (£624 per year).

From January 2021 the UK introduced a new points-based immigration system to replace free movement from the EU. This system is global, meaning overseas recruits face the same immigration control whether they come from the EU or further afield.

Diversity analysis

The NHS Workforce is more ethnically diverse than the wider economy. Across the Non-Medical workforce about 76% of the workforce is White with a further 7% Black or Black British and 9% Asian or Asian British. There are currently just under 4% of the workforce

with Unknown or Not Stated Ethnicity. BAME representation in the workforce has been increasing slightly over the past 5 years.

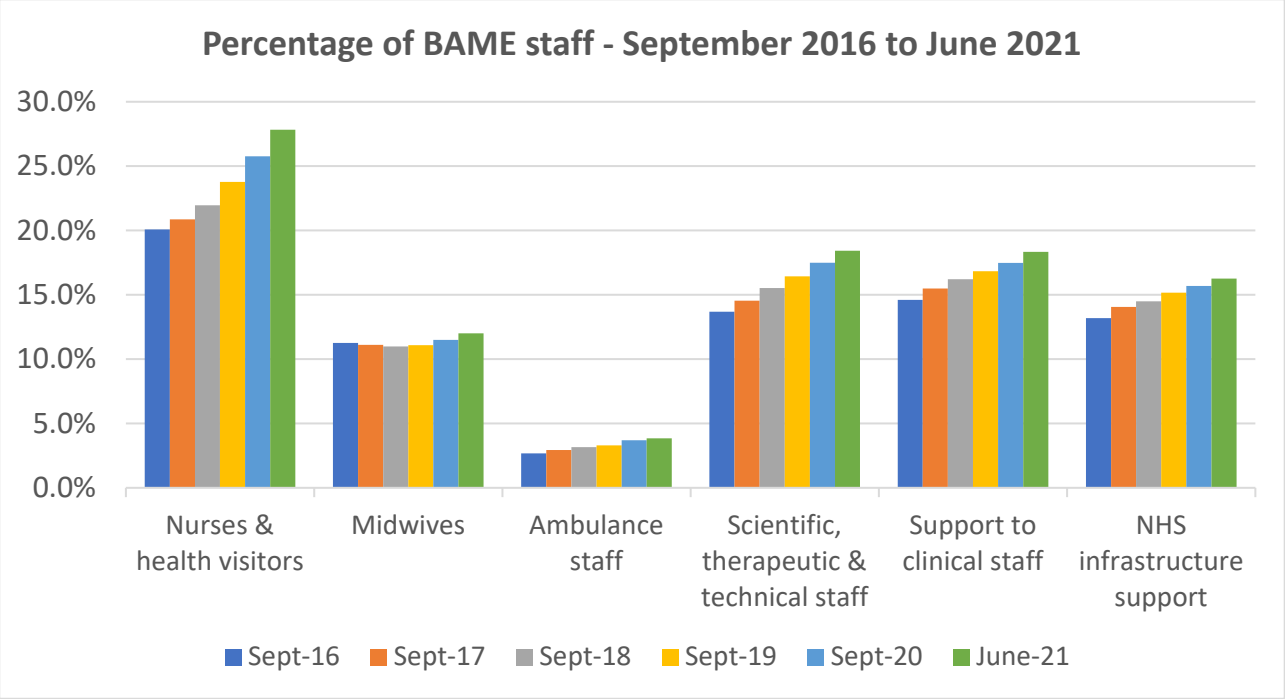
Table 15 - Ethnicity makeup of Non-Medical NHS roles

June 2021 (%age of Headcount)	Asian or Asian British	Black or Black British	Chinese	Mixed	White	Any Other Ethnic Group	Not Stated	Unknown and Discont. codes
All non-medical staff	9.0%	6.8%	0.4%	1.8%	75.8%	2.5%	3.0%	0.8%
Nurses and health visitors	11.9%	9.2%	0.3%	1.5%	68.2%	4.8%	3.1%	0.9%
Midwives	2.2%	7.2%	0.2%	1.9%	84.9%	0.6%	2.4%	0.7%
Ambulance staff	1.3%	0.6%	0.2%	1.4%	93.7%	0.3%	2.3%	0.2%
Scientific, therapeutic and technical staff	9.6%	4.6%	0.8%	1.9%	78.3%	1.4%	2.6%	0.7%
Support to doctors, nurses and midwives	8.0%	7.5%	0.2%	1.9%	76.7%	2.1%	2.8%	0.8%
Support to ambulance staff	3.7%	2.3%	0.1%	1.7%	88.3%	0.2%	3.6%	0.3%
Support to ST&T staff	7.9%	4.9%	0.4%	2.2%	79.7%	1.5%	2.7%	0.9%
Central functions	8.4%	5.2%	0.4%	1.9%	79.5%	0.8%	3.0%	0.8%
Hotel, property and estates	7.6%	6.2%	0.2%	1.6%	76.1%	2.0%	5.2%	1.3%
Senior managers	5.1%	3.0%	0.2%	1.1%	85.7%	0.5%	3.3%	1.1%
Managers	6.7%	4.1%	0.4%	1.7%	82.4%	0.7%	3.1%	1.0%
Other staff or unknown classification	26.3%	7.6%	0.3%	2.0%	36.7%	23.7%	2.1%	1.3%

Source: NHS Digital HCHS monthly workforce publication – June 2021

While the overall BAME representation in the workforce has been stable since 2016, there have been some changes within staff groups as shown in Figure 4. In all staff groups there have been increases in the proportion of BAME staff since 2016.

Figure 4 - Change in BAME Representation by Staff Group (2016-21)



Source: NHS Digital Workforce Statistics

Gender balance in the non-medical workforce

Data from June 2021 shows that just under 80% of the Non-Medical workforce are female. The proportion of female staff varies by staff group with higher proportions of female staff in the Nursing (88%), Midwifery (99%) and Support to Doctors and Nurses (85%). Compared to the rest of the NHS workforce, Males have higher representation in Staff Groups including Ambulance Staff (57%), Support to Ambulance (46%) and Senior Managers (42%). The proportion of female staff is broadly unchanged over time.

Table 16 – Workforce Gender Representation by Staff Group (June 2021)

Staff Group	Female	Male
Nurses and health visitors	88.41%	11.59%
Midwives	99.68%	0.32%
Ambulance staff	43.01%	56.99%
Scientific, therapeutic and technical staff	77.37%	22.63%
Support to doctors, nurses and midwives	84.97%	15.03%
Support to ambulance staff	53.35%	46.65%
Support to ST&T staff	78.95%	21.05%
Central functions	71.30%	28.70%
Hotel, property and estates	57.90%	42.10%
Senior managers	57.77%	42.23%
Managers	61.76%	38.24%
Other staff or those with unknown classification	79.80%	20.20%
All Non-Medical staff	79.82%	20.18%

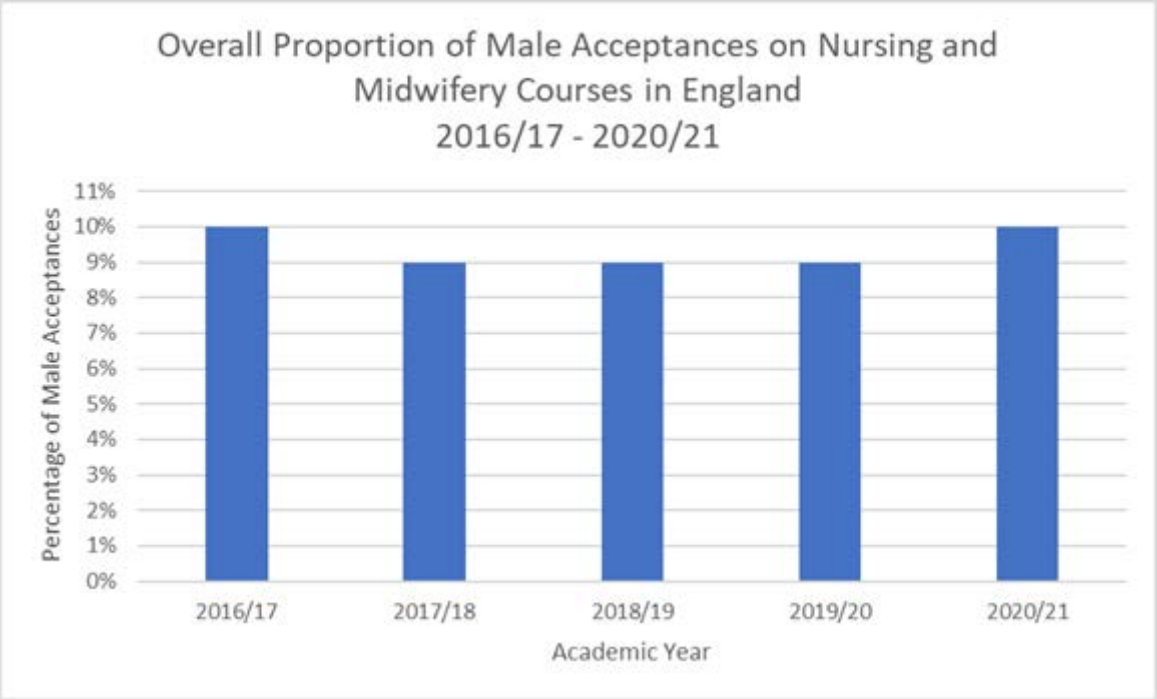
Source: NHS Digital Workforce Statistics

Gender balance in healthcare education

Given the balance of men and women in AfC roles and the importance of appealing to the widest possible range of talent to work in the NHS at all levels, the Pay Review Body asked for information on gender and degree choices for nursing, midwifery, and allied health professionals.

UCAS data shows that men made up around 10% of overall acceptances on nursing and midwifery courses in 2020. Over the period 2016-17 – 2020-21 academic years, this has remained broadly the same as shown in Figure 5.

Figure 5 - Overall Proportion of Male Acceptances on Nursing and Midwifery Courses in the UK



Source: Universities and Colleges Admissions Service (UCAS) data - end of cycle 2020
Entrants to nursing, midwifery and Allied Health Professionals by POLAR3 - a participation measure

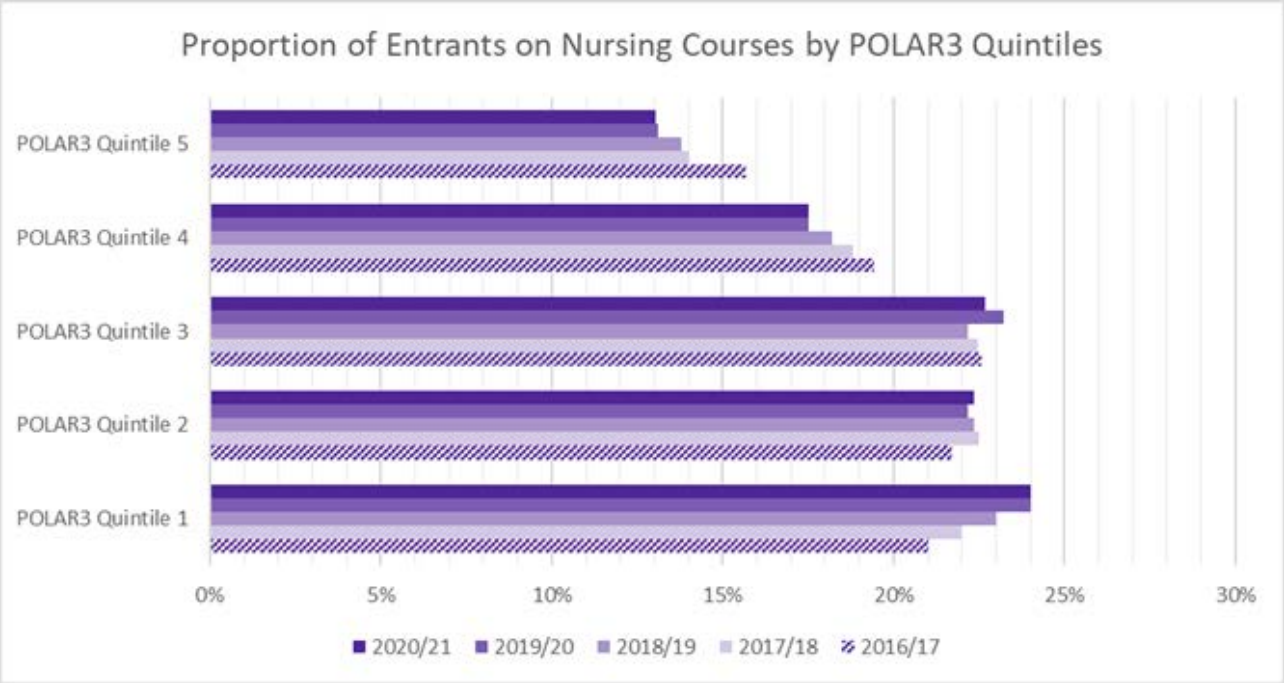
The Pay Review Body have also asked for information on socio-economic background and degree choices for entrants to nursing, midwifery and allied health professions.

The Participation of Local Areas (POLAR) is a participation measure which classifies local areas into 5 groups, based on the proportion of 18-year olds who enter higher education aged 18 or 19. Group 1 (quintile 1) represents the most disadvantaged fifth of backgrounds, and group 5 (quintile 5) represents the least disadvantaged fifth.

Data, in Figure 6 shows that the proportion of students entering nursing degree courses from POLAR3 quintile 1, the most disadvantaged fifth of backgrounds, increased from 21% in 2016 to 24% in 2020.

The proportion of entrants to nursing from the least disadvantaged fifth of backgrounds decreased from 16% in 2016 to 13% in 2020.

Figure 6 - Proportion of Entrants on Nursing Courses by POLAR3 Quintiles 2016-20



Source: Universities and Colleges Admissions Service (UCAS) data - end of cycle 2020

Attrition from healthcare related degrees

Table 17 shows continuation rates of full-time entrants to first degree level study at English providers (continuation rate is defined as the proportion of students that were continuing in HE study, not necessarily on the same course or at the same provider or had qualified one year and 14 days after starting their course). For the cohorts of entrants between July 2016 and July 2017, the continuation rates were 93 percent for nursing, 94 percent for midwifery, and 94 percent for allied health professions.

Table 17 - Continuation rates of full-time entrants to first degree level study in England between July 2016 and July 2017

Subject	Continuation Rate
Nursing	93%
Midwifery	94%
Allied health professions	94%

Source: Office for Students (OfS) analysis of Higher Education Statistics Agency (HESA) data – October 2019

Temporary staffing

NHS Trusts use flexible staffing arrangements to efficiently manage the fluctuating demands of healthcare, which is regularly subject to unavoidable increases in demand. A temporary workforce market allows the NHS to meet demand fluctuations without the need to increase capacity above that which would be required on a sustained basis. Trusts use their own banks (managed in-house or via management companies) and external agencies to resource extra temporary staff.

In response to an escalation in agency spend (NHS trust spending on agency staff rose by 40% between 2013-14 and 2015-16 from £2.6 billion to £3.6 billion) measures were introduced in 2015 to bring NHS agency spending under control. Price caps limiting the amount a trust can pay to an agency for temporary staff of 55% above basic substantive pay rates were introduced, as were the mandatory use of approved frameworks for procurement, and the requirement for all trusts to stay within the specified Annual Expenditure Ceilings for agency staff.

In 2019, NHSEI updated the agency rules to include 2 new policy initiatives requiring trusts to use only substantive or bank workers to fill admin and estates shifts (with exemptions for special projects, shortage projects, shortage specialties and IT staff) and requiring the use of on-framework agency workers to fill non-clinical and unregistered clinical shifts. These changes came into effect on 16 September 2019. For trusts, this will reduce cost and give greater assurance of quality. All the above measures are regularly monitored for compliance and effectiveness.

Ongoing workstreams

The Department and NHSEI have created a flexible staffing strategy that aims to meet fluctuations in demand by building a flexible workforce that is sustainable, high quality and value for money for the NHS. We aim to support NHS providers to reduce their agency staff bills and encourage workers back into substantive and bank roles. This will help ease financial pressure by developing and improving the trust's strategy, procurement, and commercial negotiation in their approach to temporary staffing. There are 3 workstreams:

- off-framework: Work in partnership with trusts, systems, and our approved framework operators to reduce/eliminate off-framework supply into the NHS to give assurance on quality and value for money standards of the staff working via agencies

- price cap compliance: Continue to implement and monitor the Agency Rules with ongoing collection and analysis of data and working with ICSs and trusts to support intervention where necessary

- bank acceleration programme: Develop and deliver the Bank Programme and measure and report key programme outcomes. Increase transparency and collaborative working within the NHS to reduce competitive behaviours. Increase the number of collaborative banks in England to reduce the reliance on agency by offering increased flexibility to bank staff

Trends in agency use

The ‘Agency Rules’ have contributed to a reduction in spending on agency workers to £2.38 billion in 2019-20 compared to £3.6 billion in 2015-16. Agency spend in 2019-20 accounted for 4.0% of the overall NHS pay bill, down from 7.8% at its peak in 2015-16. The overall average price per agency shift decreased by 1.3% from 2018-19, resulting in an overall saving of £19 million (0.8%). The continued reduction in the proportion of agency staff costs to total pay bill is a significant achievement in view of the record levels of demand and the pressure on the acute sector.

In 2020-21, total spend on agency and bank increased, but the number of agency shifts decreased. 2021-22 data (up until September 2021) shows that bank and agency spend is continuing to rise as is agency spend as a percentage of total pay bill. Due to COVID-19, the first 5 months of 2020 saw a significant decrease in agency shifts, with a shift towards more bank work (see 'Covid-19 impact on Agency and Bank’ section). However, the current upturn in demand for temporary staffing reflects the move into the elective recovery phase. Data update for 2020-21 expected in NHSEI submission to the PRB.

NHS Professionals, who manage temporary staffing for over 20% of the secondary care market, report that agency rates of pay are increasing faster than bank for the Nursing and Midwifery staff group reflecting the more challenging market conditions in nursing and difficulty in recruiting more nurses to the bank - demand is increasing at a greater rate than increases in supply.

The spend by staff group data update for 2020-21 is expected in NHSEI submission.

Price cap compliance

Trusts are required to procure agency staff via approved frameworks and within price caps unless there are exceptional circumstances (known as ‘break glass’). The national average price cap compliance has remained consistent at 60% since April 2018. There is however wide regional variation.

There is also variation across staff groups. Price cap compliance in recent years is highest for Admin and Estates (over 90%), whilst Medical and Dental shifts have been 14% compliant. The national shortages of medics in certain specialities (such as orthopaedics, geriatrics, cardiothoracic oncology, and radiology) may contribute to poorer compliance rates amongst this group. Generally speaking, challenges with price cap adherence fall into 4 main categories: staff shortages; preferences with geographical location; use of workforce planning tools (such as e-rostering) and sourcing delays; COVID-19 factors affecting availability.

COVID-19 impact on agency and bank

During the COVID-19 pandemic there has been significant disruption to the health system, a lot of which has manifested in the cancellation of elective work. Therefore, the supply and demand for bank and agency workers has shown less predictability than under normal, 'business as usual' conditions. However, programmes aimed at addressing the backlog in elective care, combined with winter pressures, means we are seeing a significant rise in the demand for flexible workers.

Under normal circumstances, it is up to each individual trust to manage their recruitment locally. During the pandemic, a number of programmes were set up to identify and deploy more flexible resources into the NHS. This included NHSEI's Bring Back Staff (BBS) and NHS Professional's (NHSP) COVID-19 National Rapid Response Programmes. As the Test and Trace programme has contracted, NHSP have been less able to offer workers that are deemed Clinically Vulnerable/Extremely Clinically Vulnerable a workforce alternative to 'front-line' employment.

During the first wave of COVID-19 there was a significant decrease in agency shifts, with a shift towards more bank work. This was more notable in the nursing and midwifery workforce (see figures 7 and 8). The volume of shifts decreased by 15% in the first 5 months of 2020-21 and during this period trusts spent £0.91 billion on agency staff, which was 10% lower than the same period in 2019-20.

Overall, temporary staffing costs increased in 2020-21, mainly driven by increases in bank spend. Higher temporary staffing costs are being driven by both volume effects (more shifts) and price pressures (inflation on price per shift). These are related because higher demand for staff generates a supply shortfall and will result in some price inflation.

Figure 7 - Total hours worked bank vs agency: Doctors (NHSP)

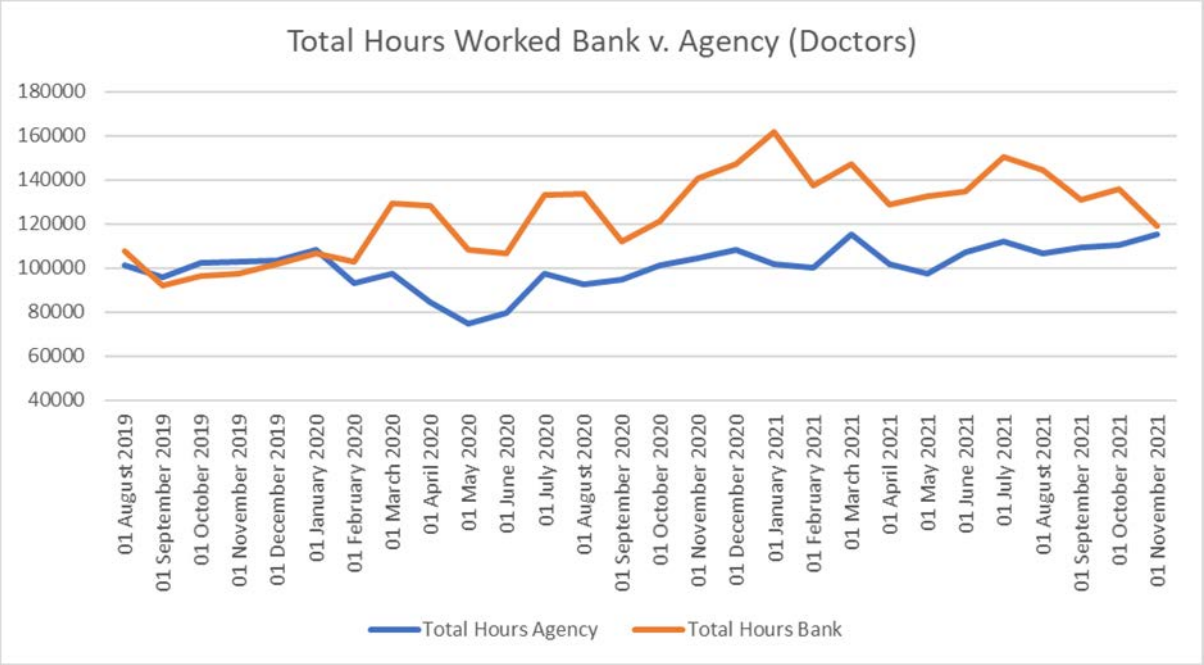
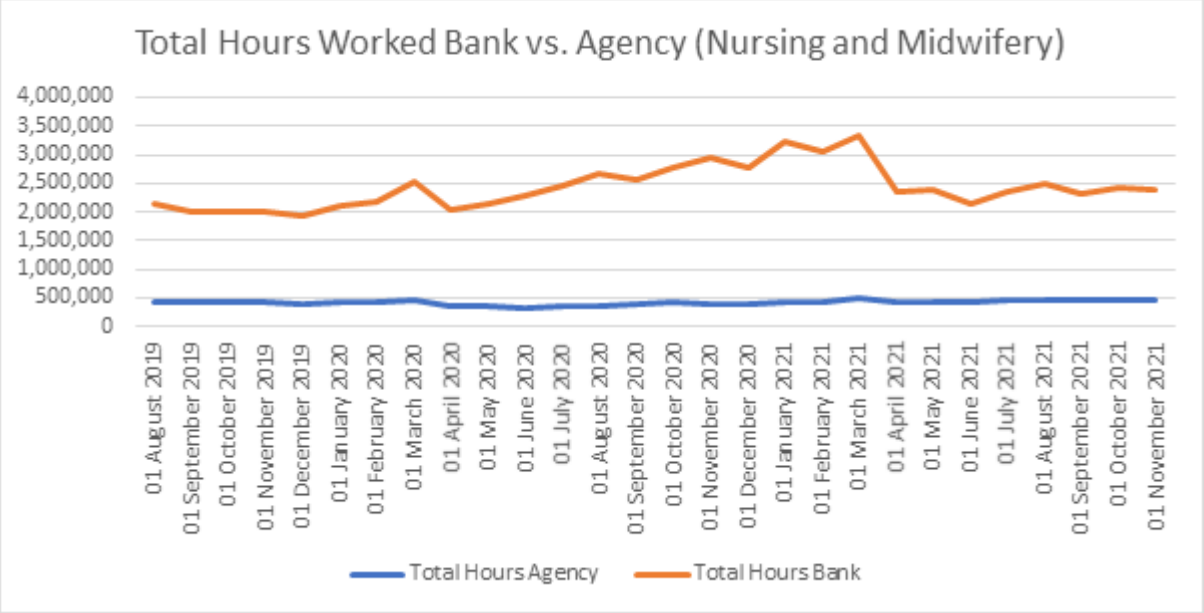


Figure 8 - Total hours worked bank vs agency: Nursing and Midwifery (NHSP)



Future predictions on agency and bank staff

There will be continued pressures on temporary staffing over 2021-22 and 2022-23 due to COVID-19 pressures and clearing the elective backlog.

We estimate that spend on temporary staffing will rise further in the short term as we prioritise workforce and elective recovery. This is likely to be driven by both price and volume affects, with overall demand for staff increasing with corresponding implications for overall price. We are working to ensure that agency staff are used in a fiscally responsible

way that continues to put in the building blocks for sustainably reducing agency spend in the future.

Staff engagement and wellbeing

The NHS Staff Survey gives useful information about many aspects of staff experience at work. The published NHS staff survey results for 2015 to 2020 is available at: http://www.nhsstaffsurveyresults.com/. National and local reports are available with summary briefing on specific themes such as health and wellbeing, staff morale and bullying and harassment. NHSEI manages the NHS staff survey and will discuss the latest findings in their evidence to the review body.

Engagement

The "Staff Engagement" score in the Staff Survey is based on responses to 3 sections of the survey covering staff motivation and satisfaction, involvement, and willingness to be an advocate for the service. This score can then be used for comparison purposes between different organisations.

Staff engagement scores have generally remained consistent over the last 5 years, with ambulance staff continuing to score below average. The percentage of staff who would recommend their organisation as a place to work has increased year on year from 59.6% in 2017 to 66.8% in 2020. While Ambulance Trusts have improved markedly on this measure since 2016 and continued to improve in 2020, they remain the only benchmarking group to be performing substantially below the national average.

Over the last 5 years, staff with frequent face-to face contact with patients or service users have reported more enthusiasm for their job (75.1% say they are enthusiastic about their job) than staff in non-patient facing roles (67.6%). However, in 2020 the proportion of staff in patient-facing roles describing themselves as enthusiastic about their job declined, while enthusiasm increased amongst those with no patient contact.

Satisfaction with pay

Satisfaction has varied over time with an improvement since the beginning of the AfC multi-year pay and contract reform deal however across all respondents there was a modest reduction (1.3 percentage points) in 2020.

Across all respondents to the survey, the percentage of staff satisfied with their level of pay is 36.7% however there is variation across some of the key staff groups. Typically, staff in higher paying roles (managers for example) were more satisfied than those in lower paying roles.

There is some variation across gender with satisfaction in pay, with 36.9% of female staff being satisfied with their pay compared to 38.9% of male staff. Staff aged 21 to 30 have lower satisfaction with pay which may reflect the tendency for staff to progress into higher pay bands over time.

Flexible working and additional hours

Staff satisfaction with flexible working has shown some improvement over the last 4 years, particularly so for ambulance staff.

The proportion of staff who work any additional paid hours has remained mostly consistent over the last 4 years, falling by 1.3 percentage points since last year. There is a significant amount of variability in this question based on the staff group. Those working in more direct care roles are more likely to work additional hours. More information on plans to increase flexibility in the NHS can be found in Chapter 6.

Sickness absence

Table 18 shows sickness absence rates for NHS Trusts and CCGs since 2010-11. It shows that there has been no major change over the long term with rates always between 4.37% and 4.58% until 2018-19. COVID-19's impact on sickness absence is reflected in the figures for 2019-20 and 2020-21 and is covered in more detail in later sections.

Table 18 - Sickness Absence in NHS Trusts and CCGs between 2010-11 and 2020-21 – Total HCHS Non-Medical staff

Year	Sickness Absence Rate (%)
2010-11	4.46%
2011-12	4.42%
2012-13	4.56%
2013-14	4.37%
2014-15	4.58%
2015-16	4.47%
2016-17	4.50%
2017-18	4.52%
2018-19	4.55%
2019-20	4.83%
2020-21	5.02%

Source: NHS Digital Sickness Absence Statistics

Sickness absence rates for all staff vary by region. Rates tend to be higher in the north of England compared to London and South East.

Table 19 - All Staff Sickness Absence by Health Education Region 2016-17 to 2020-21

Region	2016-17	2017-18	2018-19	2019-20	2020-21
England	4.16%	4.19%	4.21%	4.48%	4.66%
London	3.39%	3.44%	3.54%	3.87%	4.20%
South West of England	4.16%	4.17%	4.18%	4.41%	4.15%
South East of England	3.85%	3.91%	3.87%	4.16%	4.40%
Midlands	4.33%	4.48%	4.52%	4.80%	4.89%
East of England	4.09%	4.04%	4.11%	4.27%	4.57%
North West	4.82%	4.83%	4.87%	5.20%	5.53%
North East and Yorkshire	4.62%	4.57%	4.51%	4.76%	5.01%
SHAs and other statutory bodies	3.11%	2.79%	2.77%	2.95%	2.27%

Source: NHS Digital Sickness Absence Statistics

Table 20 - Non-Medical Staff Sickness Absence by NHS England Region 2020-21

Region	2020-21
England	5.00%
London	4.62%
South West of England	4.46%
South East of England	4.71%
Midlands	5.21%
East of England	4.90%
North West	6.00%
North East and Yorkshire	5.30%
SHAs and other statutory bodies	2.37%

Source: NHS Digital Sickness Absence Statistics

Sickness absence also varies by staff group with ‘frontline staff’, nurses, midwives, ambulance staff and clinical support staff having some of the highest rates of absence while non-frontline groups have lower reported absence rates. Some of this will be related to the nature of the work undertaken. These trends show no signs of change over the last 5 years, with COVID-19 having increased the distinction between the 2 groups recently.

Table 21 - Sickness Absence Rates by Non-Medical Staff Group 2016-17 to 2020-21

Staff Group	2016-17	2017-18	2018-19	2019-20	2020-21
Nurses and health visitors	4.44%	4.47%	4.48%	4.73%	5.28%
Midwives	4.75%	4.93%	4.80%	5.11%	5.02%
Ambulance staff	5.49%	5.31%	5.31%	5.38%	5.83%
Scientific, therapeutic and technical staff	2.98%	2.97%	3.02%	3.24%	3.21%
Support to clinical staff	5.57%	5.63%	5.67%	6.04%	6.32%
NHS infrastructure support	3.73%	3.74%	3.79%	4.04%	3.62%
Other staff or unknown classification	1.66%	1.18%	1.20%	1.41%	1.08%

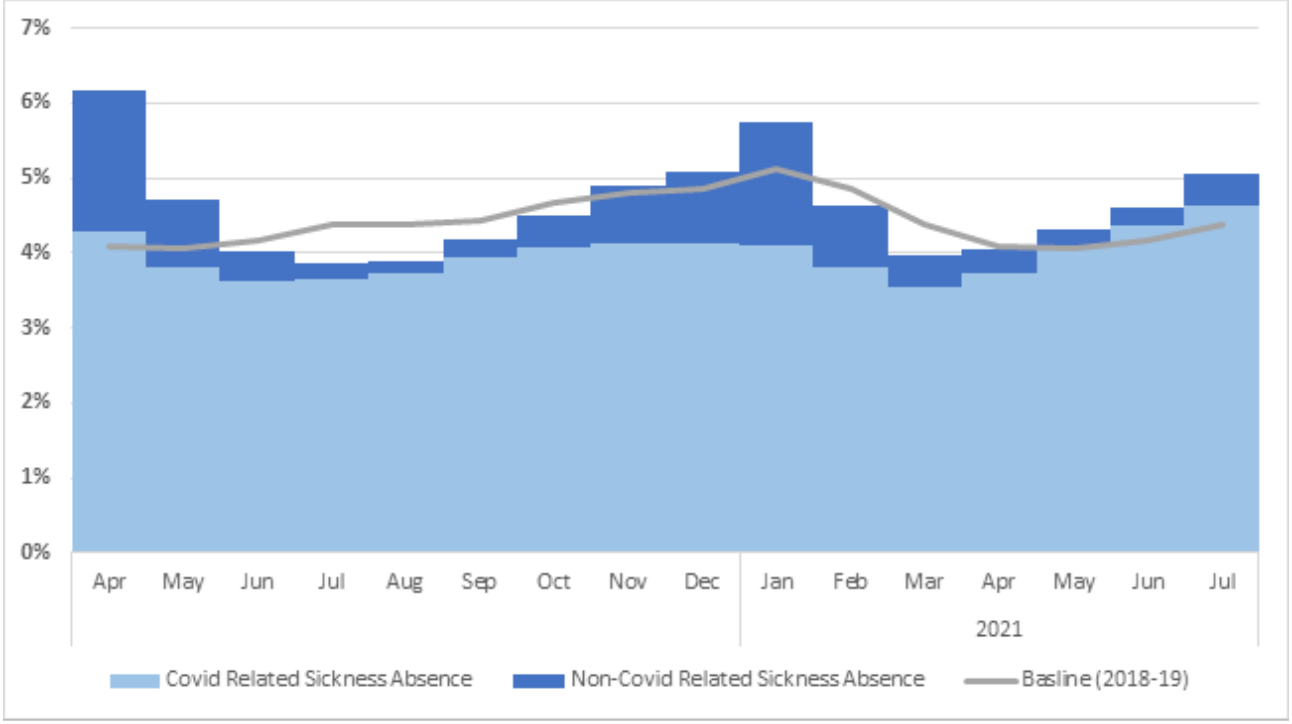
Source: NHS Digital Sickness Absence Statistics

COVID-19 related sickness absence

NHS Digital data is available to describe trends in sickness absence during the on-going response to the pandemic. Additional coding has been made available on the Electronic Staff Record (ESR) for organisations to record against.

Figure 9 shows the ESR reported rates of absence for non-medical staff split by those coded as COVID related or not. Peaks matching waves one and 2 of the pandemic can be seen but the underlying rate of non-covid absence is below that seen in the baseline year of 2018-19.

Figure 9 – Monthly Non-Medical Sickness Absence Rates split by Covid and Non-Covid Coding March 2020 to July 2021



Disruption of study

The pandemic severely disrupted the studies of students during the pandemic. This was caused by (a) students being deployed to the front line to help support the COVID-19 effort and (b) a reduction in clinical placements as the healthcare system shifted its focus to immediate priorities.

Led by HEE, the system has worked hard to ensure the education and training system continues to operate effectively:

- we have allowed students affected by delays caused by COVID-19 to apply for extended funding from the NHS Learning Support Fund until the 31 August 2022

- through their Clinical Placement Expansion Programme (CPEP), HEE have released over £50 million over recent years to support growth in clinical placements

- HEE, education providers and placement providers have invested in new ways of delivering placements (for example, simulation) which meet requirements of professional bodies and regulators

- HEE have supported growth in infrastructure and academic capacity. They have invested over £6 million in Blended Learning programmes to increase capacity and widen participation

This effort has supported further expansion of training. UCAS data showed 30,185 acceptances to nursing and midwifery courses in England for the 2021 academic year. This is the highest figure since these statistics were first recorded.

For existing staff, in September 2019 the government announced a £210 million funding boost for frontline NHS staff which included a £1,000 personal development budget for every nurse, midwife and allied health professional working in the NHS to support their continuing professional development over 3 years.

Apprenticeships

Apprenticeships play a key role in ensuring the NHS has a future workforce which is representative of the local population it serves. New or existing employees can begin or continue to develop their careers via an apprenticeship pathway. It shifts the emphasis from training for an NHS career via the university route, allowing people to 'earn as they learn'. The NHS apprentice agenda is designed to support entry into careers in the NHS for people from all backgrounds.

The apprentice agenda is at the heart of an aspiration to provide careers, not just jobs for people working in the NHS. There is a range of healthcare apprenticeships available in the NHS, including nurse degree apprenticeship, nursing associate, associate ambulance practitioner, podiatrist, healthcare assistant practitioner, healthcare support worker, healthcare science assistant and pharmacy services assistant. These pathways allow people to start at entry level apprenticeship roles and progress to becoming a registered healthcare professional.

There is also a range of non-clinical apprentice standards that may be used in the healthcare sector in areas such as facilities, digital and business administration.

There is a complete apprenticeship pathway available into the nursing profession from Healthcare Assistant, to Nursing Associate, to Nurse Degree Apprentice and onto Advanced Clinical Practitioner. Apprenticeship pathways are also available for Allied Health Professionals. New T Level qualifications in Health and Science will be ready for delivery in 2021 offering an alternative route into health and care professions.

As at January 2022, there were 63 apprenticeship standards approved for delivery in the health and science category and 12 in development for use in the health and science sectors. Recently approved apprentice standards include District Nurse and Clinical Associate in Psychology.

There were around 24,500 apprentices starting training in the NHS in the 20/21 academic year. (Source: Department of Education)

As described in chapter 3, the NHS Staff Council worked hard to reach consensus on a new pay framework but could not agree the minimum pay rate for all apprenticeships. They remain committed to support trusts to widen participation and help grow the domestic workforce.

DHSC continues to work closely with key stakeholders; HEE, The Department for Education, Education and Skills Funding Agency, and the Institute for Apprenticeships and Technical Education to implement an NHS-wide strategy for apprenticeships. NHS apprenticeship numbers and levy spend continue to increase as employers work to embed apprenticeships within their future workforce planning.

Nursing associates

The Nursing Associate role is designed to provide the NHS with a new profession, allowing employers to make the most of current and emerging talent and help them to address some of their supply challenges. Following their training, Nursing Associates will undertake some of the duties that registered nurses currently undertake, enabling registered nurses to spend more time on the assessment and care associated with both complex needs and advances in treatment.

The NMC was confirmed as the professional regulator for Nursing Associates in July 2018.The first successful Nursing Associates from HEE’s pilot began to join the NMC’s register in January 2019.

HEE continue to lead the national Nursing Associate expansion programme in 2021 with an annual delivery target of 5,000 new Nursing Associates per annum. DfE data on Nursing Associate apprentice starts shows around 4,370 in 2018-19, around 3,620 in 2019-20 and around 4,300 in 20-21. Reduced numbers of Nursing Associate apprentices

starting training in 2020 because of the impact of the pandemic where many NHS employers halted recruiting new staff into training programmes.

DHSC commissioned a robust programme of research to evaluate the impact of the Nursing Associate role within the workforce. An interim research report, ‘Evaluating the Introduction of the Nursing Associate role Health and Social Care’, and accompanying case studies, was published in 2020, explaining the value of the role as well as areas for improvement. Since then, Kings College London have published a number of other reports on the introduction and development of the Nursing Associate role from policymaker perspectives and from postholder perspectives. Examining the introduction of the Nursing Associate role in health and social care (kcl.ac.uk)

High cost area supplement

In last year’s report, the Review Body commented on the High Cost Area Supplement (HCAS) contained within the NHS Terms and Conditions of Service, applicable to staff working in defined locations in and around London. HCAS supports staff on AfC terms and conditions with higher costs of living by adding a percentage supplement to pay based on whether a place of work is based in inner, outer, or the “Fringe” area of London, subject to a minimum and maximum cap. As HCAS is based on a percentage of salary, its value increases as basic salaries increase, and the minimum and maximum cap on the value of HCAS payments are increased by the annual pay uplift.

The Department notes the observations made by the Review Body, with regards to reviewing the purpose of HCAS allowing a clearer view for all parties in determining whether any revisions may be required to the policy itself. The Review Body noted that the purpose should focus on compensating for cost of living supporting what is needed for recruitment and retention in high cost areas – looking at drivers of costs such as housing and transport.

The financial allocations to trusts already take in to account the unavoidable cost differences between providers by adjusting allocations for different parts of the country, but any changes to the HCAS system would inevitably have financial impacts. If a greater number of HCAS areas were created, it would put pressure on financial allocations which are currently optimised for elective recovery. Any changes on a cost neutral basis would by definition lead to winners and losers.

The Review Body noted in last year’s report “house prices may be rising in rural areas as home working potentially increases following COVID-19”. We do not know if this is the case and if so, what impact it may be having on recruitment and retention. House prices could be one of a number of variables that impact upon recruitment, and may have a knock on impact in to rental costs.

However, the uncertainty and change caused by COVID-19 creates a problem in attempting to robustly reform, in the midst of a global shock which may permanently alter ways of working in the wider economy, with potential wider impact on the locations that people need to be based in for work. We have yet to see if the pandemic will have wider long-term effects, for example on private sector wages or the cost of living in different areas of the country, which may also impact upon recruitment and retention in the NHS.

With this in mind, the Department would argue that now is not the right time to try and determine what a future HCAS system may look like.

5. Pay and earnings

This chapter presents information on pay and earnings for Non-Medical staff working in the Hospital and Community Health (HCHS) sector in England covered by the PRB remit and working under the AfC contract - predominantly this covers staff working for NHS Trusts, NHS Foundation Trusts and Clinical Commissioning Groups.

The chapter starts by introducing the key messages that are explored in more detail in earlier chapters. It then outlines the baseline position and includes an introduction to the AfC contract and how it has changed over time. It considers trends in pay and earnings over the past 12-months, explaining some of the reasons behind those changes. It closes by comparing earnings in the NHS to the wider labour market and investigates how earnings for NHS staff changes over time as well as the latest data on the Gender and Ethnicity Pay Gaps.

Introduction

This chapter contains information on pay and earnings for HCHS staff in England, how they have changed over time and comparisons with connected labour markets. Information on earnings does not take into account the benefits of the wider reward package that are detailed in Chapter 6.

The reforms to the AfC contract that were agreed as part of the 2018 agreement were fully implemented from April 2021 with a reduction in the number of pay points and an end to the system of automatic incremental progression.

Average earnings in the HCHS sector increased by 3.7% in the 12-months to the end of March 2021 which was slightly higher than the 3.5% growth in basic pay per person. Earnings growth varied between bands with staff in clinical support tending to see higher growth compared to those in professionally qualified roles. This partly reflects the changes to the structure of AfC in April 2020 which benefitted staff in Bands 2 to 4 when the number of Pay Steps in these bands was reduced and more staff moved to top of band. Some staff will have had higher earnings in 2020-21 due to an increase in workload during the pandemic but this will not impact all staff equally.

While data for earnings growth in 2021-22 is not yet available we expect to see most staff have growth of around 3% following the 2021-22 pay award. This is likely to be favourable compared to the rest of the public sector as the NHS was exempt from the public sector pay pause. Some staff in Bands 5 to 7 will also benefit from the completion of reforms to the AfC structure.

Earnings remain broadly competitive to both the wider economy and selected connected labour markets. In 2020-21 Average earnings in the HCHS sector increased by 3.7% (NHS Digital Earnings) compared to a reduction of 0.6% in the wider economy (Annual Survey of Hours and Earnings, 2021 provisional) however this is likely to be impacted by the pandemic and there is some evidence of recovery in more recent data.

There remains uncertainty about how labour markets will recover from the pandemic and its impacts on current labour market data. This should be borne in mind when interpreting the current evidence.

National living wage

In 2021-22, the minimum rate of pay in the NHS is £9.49 per hour (increasing to up to £11.84 per hour for those working in Inner London). The statutory minimum, payable to most employees aged 23 and over, is currently £8.91.

Following the Spending Review announcement, the National Living Wage will increase to £9.50 per hour from 1st April 2022 with a commitment to increase the National Living Wage to 2/3 of median earnings by 2024-25.

Pay recommendations for the 22-23 pay round will be announced after April 2022, meaning the National Living Wage will temporarily be higher than the current NHS minimum wage. The government therefore is required to act prior to April to ensure the NHS remains legally compliant and will work with necessary systems to ensure NHS staff are paid at least the National Living Wage in the interim until the 22-23 pay uplifts are agreed.

Baseline pay and recent growth

This section presents information that can be used to establish the baseline that should be used as a starting point for the 2022-23 pay round. It includes a background to the AfC pay system and how it operates, latest data on levels of pay and earnings for staff in the remit group and some of the factors that can be used to explain why pay has increased over time in both 2020-21 and during the course of the 3-year AfC Pay Agreement that concluded at the end of 2020-21. It will then compare NHS pay to its comparators in the wider economy and consider how NHS staff experience the pay system.

Background to the NHS pay system and the 2018 pay agreement

Almost all non-medical staff working in the HCHS in England are employed under the AfC framework that was first introduced in 2004 and amended as part of the multi-year pay agreement reached in 2018. A small number of Non-Medical staff do not work under AfC

including people employed on "local" terms or Very Senior Managers where a different framework applies.

Under AfC each role is evaluated and placed into a pay band based on the skills required. The job evaluation process means that very different roles can be compared and that all staff who work in the sector are paid fairly.

In AfC, staff can increase their pay through either pay progression or promotion:

- Progression occurs when staff move to a higher pay step point within their current pay band. This generally occurs over time subject to satisfactory performance and development. Following the 2018 AfC agreement staff will spend at least 2 years in each pay step before being eligible for progression. After reaching the top pay step staff would need to be promoted to access further pay progression more than annual headline pay awards.

- Promotion occurs when somebody progresses into a higher pay band because of taking a new role with increased responsibility. On promotion staff would usually start at the bottom pay step point in the new band meaning that, in time, they would also be eligible for progression in the new band.

An example of the difference between pay progression and promotion is shown in Table 22.

Table 22 - Progression and Promotion in Agenda for Change System

Years of Experience	Band 4	Band 5	Band 6
0 - 1 Year	Pay Step Point 1	Pay Step Point 1	Pay Step Point 1
1 - 2 Years			Promotion
2 - 3 Years		Pay Step Point 2	Pay Step Point 2
3 - 4 Years	Progression		
4 -5 Years		Pay Step Point 3	
5 - 6 Years	Pay Step Point 2		Pay Step Point 3
6 - 7 Years			
7 - 8 Years			

Source - NHS Employers Pay Circular

As part of the 2018 agreement the AfC System was reformed to reduce the number of pay step points in each band and enable staff to reach the top of the band sooner. The new system was fully implemented in April 2021 when the final transition points were removed from Bands 5 to 7.

The rates of pay in 2021-22, by Pay Band and Step Point, are shown in Table 23.

Table 23 - NHS Agenda for Change Pay by Band and Step-Point in 2021-22

Pay Band	Step Point 1 (Starting)	Step Point 2 (Intermediate)	Step Point 3 (Top of Band)	Minimum Time to Top of Band	Pay Differential Between Top and Bottom of Band (%)
Band 1*	£18,546	N/A	N/A	N/A	N/A
Band 2	£18,546	N/A	£19,918	2 Years	7%
Band 3	£20,330	N/A	£21,777	2 Years	7%
Band 4	£22,549	N/A	£24,882	3 Years	10%
Band 5	£25,655	£27,780	£31,534	4 Years	23%
Band 6	£32,306	£34,172	£39,027	5 Years	21%
Band 7	£40,057	£42,121	£45,839	5 Years	14%
Band 8a	£47,126	N/A	£53,219	5 Years	13%
Band 8b	£54,764	N/A	£63,862	5 Years	17%
Band 8c	£65,664	N/A	£75,874	5 Years	16%
Band 8d	£78,192	N/A	£90,387	5 Years	16%
Band 9	£93,735	N/A	£108,075	5 Years	15%

Source - NHS Employers Pay Circular *Band 1 contains only one pay point and was closed to new entrants in December 2018.

A small number of staff in bands 8a and above will continue to receive temporary non-consolidated payments in 2021-22 to ensure their base salary is not below what it was prior to the 2018 agreement. A maximum of around 1% (11,000 FTE) of the AfC workforce are eligible for these payments that are worth between £800 and £8,000 in 2021-22 and this number will decrease over time as staff progress to top of band and no longer require this protection.

More information on these payments is available at NHS Employers Release on Band 8 / 9 Consolidated Payments.

Proportion of staff eligible for incremental pay progression in 2021-22

Staff can be split into different groups depending on where they sit within the pay band. Staff who are "top of band" have reached the top pay step of their current pay band and are not eligible for progression within their current pay band but can seek promotion to a higher pay band.

"Progressors" are staff who are not currently at the top of their current pay band and are eligible for future pay progression however this may not be in the next 12 months as staff are expected to spend at least 2 years in each pay step. This group can be further sub-dived as follows:

- "Transition Point Progressors" - Staff in Bands 5 to 7 who were in pay points that were merged to the top of band on 1st April 2021 when the changes to the structure of the AfC contract were completed

- "In Year Progressors" are staff who will be eligible to receive pay progression over the next 12 months based on their current pay step. For example, those who currently have 2 to 3 years of experience in Band 4 who once they reach 3 years of experience will be eligible for progression

- "Staff Between Increments" are those who are not yet at the top of band but not eligible for pay progression in the next 12 months as under the reformed pay structure staff can expect to spend at least 2 years in each pay step. For example, Band 4 staff with 1 to 2 years of experience will not receive progression until at least the end of their third year

Table 24 shows the distribution of staff between AfC band and potential for progression at the 31st March 2021. Those in the "Transition Point" group will have transferred to the top of band on 1st April when reform of the AfC structure was completed.

Table 24 - Staff by Band and Eligibility for Pay Step Progression at 31st March 2021

Band	FTE	Top of Band	Progressors	Transition Point Progressors	In-Year Progressors	Staff Between Increments
Band 1*	5,596	100%	0%	N/A	0%	0%
Band 2	180,896	64%	36%	N/A	17%	19%
Band 3	149,933	67%	33%	N/A	13%	20%
Band 4	105,882	55%	45%	N/A	7%	37%
Band 5**	213,214	37%	63%	10%	22%	31%
Band 6**	202,878	41%	59%	12%	18%	29%
Band 7**	122,515	45%	55%	11%	17%	27%
Band 8a	46,166	44%	56%	N/A	9%	47%
Band 8b	17,741	46%	54%	N/A	10%	44%
Band 8c	9,026	47%	53%	N/A	10%	43%
Band 8d	4,616	48%	52%	N/A	10%	42%
Band 9	2,040	49%	51%	N/A	9%	42%
All AfC	1,073,669	50%	50%	5%	16%	28%

Source - NHS Digital Workforce Statistics.

Note - * Band 1 was closed to new entrants in December 2018 and contains a single pay-point. ** Bands 5 to 7 contains "transition points" which were automatically transferred to the top of band on 1st April 2021.

Around 50% of staff were at top of band at the end of March 2021 with a further 5%, in Bands 5 to 7, moving to the top of band following the removal of transition points.

Around 16% of the workforce are currently at pay steps that would be eligible for pay progression over the next 12 months subject to satisfactory performance. Based on the 2021-22 pay values the average value of progression, for those eligible, is around 8.5%. As the transition to the new structure has been completed it is reasonable to assume the proportions will remain relatively stable each year with around 55% at top of band, 15% "In Year Progressors" and 30% "Between Progression Points"

Average pay and earnings

NHS Digital publish information on pay and earnings for the HCHS workforce in England and covers substantive staff who are directly employed by an NHS organisation. This data does not include other earnings including any agency, bank, or independent employment.

There are 3 principal measures of earnings which can be used dependent on the context.

- Total Earnings Per Person - This calculates the average earnings received per member of staff over the period. It does not adjust for part-time working and so is effectively the total paid to staff divided by the total headcount.

- Total Basic Pay Per Person - This calculates the average basic pay received per person over the period and does not adjust for part-time working. It is the total amount of basic pay paid to staff divided by the total headcount.

- Total Basic Pay Per FTE - The level of basic pay received is directly proportional to the number of hours worked. As such this measure calculates the average amount of basic pay if it is assumed that all staff were to work on a full-time basis.

NHS Digital do not produce information on earnings per FTE because total earnings cannot be assumed to grow in direct proportion with time in the same way as basic pay.

Table 25 presents average basic pay and total earnings by staff group, for the 12-month period to the end of March 2021 and growth compared to the previous 12-month period to the end of March 2020.

Table 25 - Average Pay and Earnings for AfC staff working in NHS Trusts and CCGs in 12-months to end of March 2021 and growth over previous 12-months

Staff Group	Earnings per Person	Basic Pay per Person	Basic Pay per FTE	Growth in Earnings	Growth in Basic Pay
All Agenda for Change	£29,543	£26,175	£29,876	3.7%	3.5%
Nurses and Health Visitors	£34,671	£30,431	£34,275	3.4%	3.1%
Midwives	£34,473	£29,440	£36,059	2.9%	3.1%
Ambulance Staff	£43,384	£31,282	£33,487	6.4%	4.8%
Scientific, Therapeutic and Technical Staff	£35,883	£32,974	£38,316	3.5%	3.3%
Support to Doctors, Nurses and Midwives	£20,532	£18,033	£21,037	4.5%	4.9%
Support to Ambulance	£27,623	£20,669	£22,752	5.6%	3.9%
Support to STT	£20,668	£19,169	£22,319	5.3%	5.4%
Central Functions	£27,807	£26,189	£28,785	5.5%	5.1%
Hotel, Property and Estates	£19,779	£16,431	£20,348	4.0%	4.7%
Senior Managers	£82,284	£78,131	£82,648	2.4%	1.5%
Managers	£54,284	£50,987	£53,381	6.6%	5.4%

Source - NHS Digital Earnings Statistics

Average earnings growth across all staff was around 3.7% in 2020-21 and ranges from 2.4% (Senior Managers) to 6.4% (Ambulance Staff).

Differences in the growth in pay and earnings between staff groups will reflect several factors including:

- some staff groups will have seen larger increases in basic pay as part of AfC reform agreed in 2018. From 1st April 2020 transition points in Bands 2 ,3 and 4 were removed resulting in more staff transferring to the band maximum. This helps to explain larger increases in the staff groups that have a greater proportion of staff in these bands (for example, Support to Clinical Staff)

- some staff groups, including Ambulance and Support to Ambulance, saw increases in earnings higher than increases in basic pay - it is possible that this reflects increased additional earnings caused by an increase in activity during the pandemic

This data is based on the period to the end of March 2021 and will not include the impact of changes to the pay system that came into effect from 1st April 2021 including:

- all AfC points were increased by 3% in line with the recommendations of the 2021 PRB report;

- transition points in Bands 5 to 7 were removed, with staff on those points transferring to the top of band from 1st April 2021 - this completed the transition to the new pay structure agreed in 2018; and

- some staff in Bands 8a and above will continue to receive non-consolidated payments to offset reductions in basic pay resulting from a reduction of pay points in these bands.

The impacts of these changes will be seen in future earnings data, but we would expect most staff to have earnings growth of around 3% in 2021-22.

Additional earnings

In addition to basic pay, staff can access additional earnings depending on time, location or if it was paid at overtime rates.

The structure of the AfC contract means that some staff groups are more likely to receive additional earnings. For example, clinical staff are more likely to work unsocial hours to maintain a 24/7 service whilst ambulance staff have relatively high levels of overtime.

Table 26 shows the proportion of additional earnings by staff group and change between the 12-months to March 2020 and March 2021. Across all staff the ratio of basic pay to Additional Earnings has increased slightly from 10.8% to 11.0% with more substantial increases for some staff groups including Ambulance and Support to Ambulance which may be connected to increased requirements during the pandemic. The "paybill drivers" section explains how this can contribute to positive "additional earnings" drift as additional earnings grew faster than basic pay - This may reflect the staff groups who are most likely to receive additional earnings or changes to the staff group mix during the pandemic.

It is also the case that individual members of staff may have seen more substantial changes dependent on their role and individual circumstances - some staff may have been required, or elected, to work many additional hours while others may not.

Table 26 - Additional Earnings as Proportion of Total Earnings by Staff Group - Mar 2020 and Mar 2021

Staff Group	Mar-20	Mar-21
All Agenda for Change	10.8%	11.0%
Nurses and health visitors	12.0%	12.2%
Midwives	14.8%	14.6%
Ambulance staff	26.8%	27.9%
Scientific, therapeutic and technical staff	7.9%	8.1%
Support to doctors, nurses and midwives	12.6%	12.2%
Support to ambulance staff	24.0%	25.2%
Support to ST&T staff	7.4%	7.3%
Central functions	5.5%	5.8%
Hotel, property and estates	17.5%	16.9%
Senior managers	4.2%	5.0%

Managers	5.0%	6.1%

Source - NHS Digital Earnings Statistics

Total earnings by band

Average earnings will vary by band which reflects both the difference in basic pay between different bands but also the likelihood of receiving additional earnings as shown in Table 27. Earnings growth tended to be higher in the less senior bands which will, in part, reflect the changes to the AfC pay structure which most impacted these bands while growth was lower in the more senior bands.

Band 1 has been closed to new entrants since December 2018 and most staff have since transferred to Band 2 with under 6,000 FTE remaining in Band 1 as of March 2021. Basic pay rates in Band 1 increased in 2020-21 and so it is likely the apparent reduction in earnings reflects the characteristics and working patterns of staff who have chosen to remain in Band 1 - for example if more part-time staff remained in Band 1 or if they were less likely to receive additional earnings.

Table 27 - Agenda for Change Earnings by Band - 2016-17 to 2020-21

Total Earnings per person	2016-17	2017-18	2018-19	2019-20	2020-21	1 Year Increase
All Agenda for Change	£26,571	£26,821	£27,600	£28,494	£29,543	3.7%
Band 1	£13,331	£13,570	£15,003	£15,160	£15,118	-0.3%
Band 2	£16,293	£16,472	£17,391	£17,459	£18,053	3.4%
Band 3	£18,141	£18,265	£18,692	£19,191	£20,138	4.9%
Band 4	£20,728	£20,858	£21,273	£21,760	£22,609	3.9%
Band 5	£26,588	£26,455	£26,956	£27,725	£28,693	3.5%
Band 6	£31,041	£31,468	£32,113	£33,319	£34,446	3.4%
Band 7	£36,683	£36,848	£37,560	£39,041	£40,639	4.1%
Band 8a	£43,244	£43,616	£44,560	£45,671	£46,665	2.2%
Band 8b	£52,516	£53,091	£54,245	£55,430	£56,456	1.9%
Band 8c	£62,816	£63,428	£64,978	£66,520	£68,221	2.6%
Band 8d	£76,898	£77,881	£79,622	£81,368	£83,404	2.5%
Band 9	£94,162	£95,275	£96,998	£98,787	£101,135	2.4%

Source - NHS Digital Earnings Statistics Source

Drivers of growth in earnings

Average earnings change for many reasons. Some relate to changes in the composition of the workforce (for example, more senior staff or more staff in higher earning occupations), some relate more specifically to pay rates. Table 28 presents trends in earnings growth and its component drivers over recent years.

Analysis is based on the DHSC Headline Paybill Metrics. The paybill metrics use data on workforce earnings and size published by NHS Digital to calculate the cost of employing

different types of staff, including pension and National Insurance contributions, and how it changes over time. This can then be compared with the value of the pay award to determine if growth is higher or lower than can be explained via the pay award.

Table 28 - Breakdown of Average Earnings Growth for Non-Medical Staff

Pay Growth Element	15-16	16-17	17-18	18-19	19-20	20-21	18-21 Avg
Basic Pay per FTE Growth	0.7%	0.7%	1.3%	3.2%	2.9%	3.1%	**3.1%**
Additional Earnings per FTE Growth	-3.8%	-2.0%	-0.8%	0.2%	5.4%	5.5%	**3.7%**
Total Earnings per FTE Growth	0.2%	0.4%	1.1%	2.9%	3.1%	3.4%	**3.2%**
Of which	-	-	-	-	-	-	**-**
(a) Headline Pay Awards	0.4%	1.0%	1.0%	3.0%	3.3%	2.9%	**3.1%**
(b) Total Earnings Drift	-0.2%	-0.6%	0.1%	-0.1%	-0.1%	0.5%	**0.1%**
Of which	-	-	-	-	-	-	
(b1) Basic Pay Drift	0.0%	-0.1%	0.2%	0.1%	0.3%	0.4%	**0.3%**
(b2) Additional Earnings Drift Impact	0.0%	-0.3%	-0.2%	-0.3%	-0.1%	0.5%	**0.0%**
(b3) Staff Group Mix Effect	-0.2%	-0.1%	0.1%	0.1%	-0.3%	-0.4%	**-0.2%**

Source: DHSC Headline Paybill Metrics

Note: Total Earnings Drift includes staff group mix effects; Basic Pay Drift and Additional Earnings Drift Impact are excluding staff group mix effects

Average total earnings per FTE grew by 3.4% in 2020-21, reflecting the combined impact of the 2020-21 headline pay award of 2.9% and positive total earnings drift of 0.5%. The headline pay award includes the impact of the expiry of the one-off non-consolidated payment to staff at the top of their band paid in 2019-20 (so is lower than the pay award impact on average basic pay) but excludes the impact of the completion of final pay scale reforms in April 2021. Growth in earnings per FTE (3.4%) is slightly lower than growth in earnings per person (3.7%, Table 28). This indicates that FTE growth was higher than headcount growth and there has been a small increase in the participation rate, defined as average FTE per person, over the period.

Total earnings drift, the difference between earnings growth and headline pay awards, reflects the combined effect of:

- a positive "basic pay drift" (excluding staff group mix effects) of 0.4% in 2020-21 (meaning that average basic pay increased by more than the change to headline basic pay rates). This indicates the mix of staff across pay points and bands has become

more expensive. This has been the trend since 2017-18 with positive basic pay drift of 0.9% over the course of the AfC agreement

- a positive “additional earnings drift impact” (excluding staff group mix effects) of 0.5%, which indicates an increased use of additional earnings payments in 2020-21. Additional earnings per FTE increased by 5.5% in 2020-21 and this includes the dampening effect of the expiry of the one-off non-consolidated payment in 2019-20 to those already at top of band. Increases in average additional earnings per FTE for overtime and shift working in 2020-21 were major contributors to the positive additional earnings drift impact, which is consistent with additional hours being worked by some staff due to the pandemic. This reverses the pattern seen in recent years, prior to 2019-20, when the additional earnings drift impact was negative

- a negative "staff group mix" effect of -0.4% reflecting a shift toward lower earning staff groups in 2020-21. The highest FTE growth in 2020-21 was in support to clinical staff groups and will include health care students who entered the workforce early as part of the response to the Pandemic. Over the past 3 years the overall staff group mix effect was -0.6% but follows a period in which this effect was neutral

Labour market analysis

This section provides comparisons between earnings for those working on AfC, the wider economy in general and specific comparator occupations which may attract candidates with similar skills or qualifications. This section only looks at earnings and does not take into account the wider reward package which for NHS staff is explored in Chapter 6.

There is evidence that earnings for HCHS staff remain broadly comparable with those in connected labour markets and have grown more quickly than the wider economy since the 2018 pay agreement although to some extent this will reflect the impact of the pandemic on the private sector.

While there remains considerable uncertainty, in particular since the emergence of the Omicron variant, the wider economy has shown signs of recovery in recent months.

In addition to earnings data published by NHS Digital for those working for the NHS in England, the Office for National Statistics (ONS) produces information on earnings in the wider economy:

- the Annual Survey of Hours and Earnings (ASHE) provides information about the levels, distribution and make-up of earnings and hours paid for employees in all industries and occupations across the UK and has been collected since 1970. It is

based on a survey of around 1% of the PAYE register and typically covers around 180,000 jobs from 60,000 employers

- Average Weekly Earnings (AWE) is an indicator of short-term changes in earnings. It is based on returns to the "Monthly Wages and Salaries Survey" and covers around 9,000 businesses with 13.8 million employees. Average weekly earnings are based on total wage bill divided by total number of employees.

- PAYE "Real Time Information" (RTI) is based on data on pay collected through the "Real Time Information" tax system and covers all staff rather than a sample but is still classified as experimental.

Some caution is required when interpreting this data due to the impact of the pandemic on the composition of the workforce or the earnings of people on furlough. The Office for National Statistics explains these "base effects" in more detail here - https://blog.ons.gov.uk/2021/05/19/beware-base-effects/

As a result, it may be necessary to look at longer term trends and consider other data sources that may provide more insight into current labour market conditions.

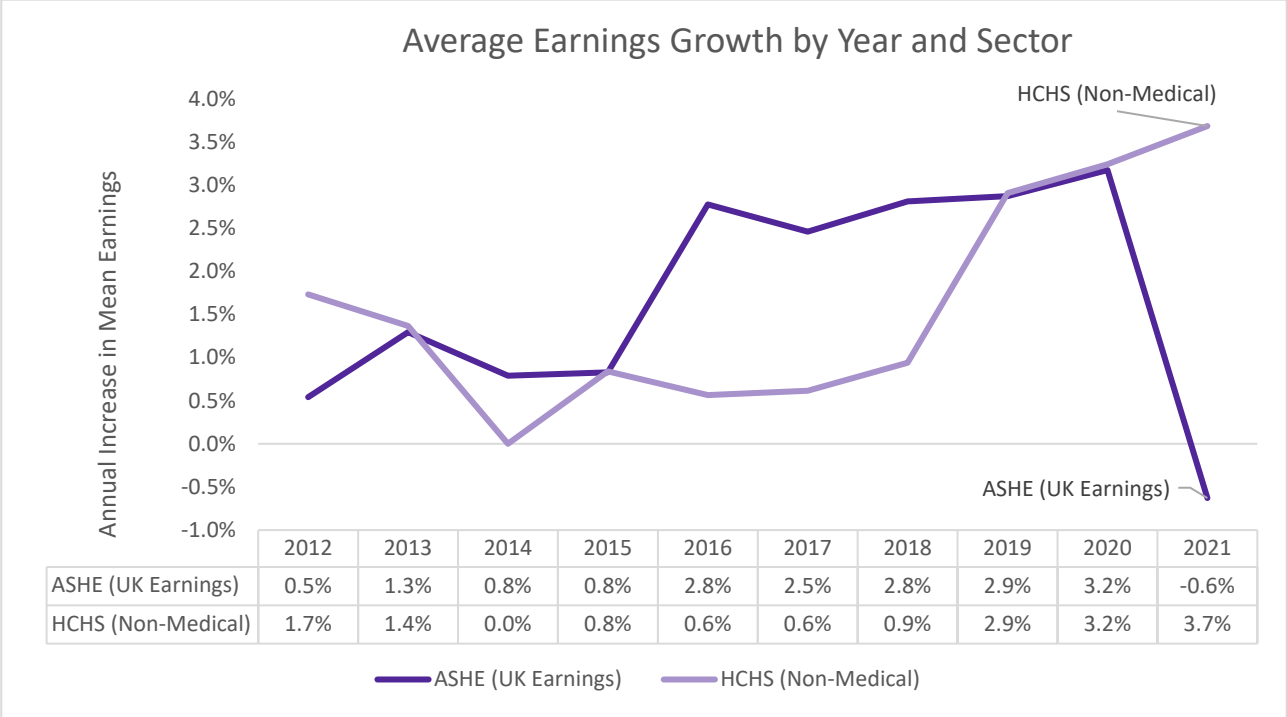
Comparisons with the wider economy

Figure 10 compares the growth in mean average earnings in the HCHS sector against the UK average from ASHE since the introduction of ESR.

In 2020-21 there was growth in the HCHS sector of 3.7% while there was a reduction of 0.6% in the wider economy however this is likely due to the exceptional impact of the pandemic on the wider economy.

As shown in figure 10 over the longer term we see periods where HCHS earnings grow more quicky and also more slowly than those in the wider economy reflecting a wide range of economic and other factors. As such the selection of time period is important and this context should be considered when interpreting change. Since 2010-11, the first full year after the roll out of ESR, average mean earnings have grown by 17% for non-medical staff and 18.2% across the whole economy.

Figure 10 - Comparison of Mean Earnings Growth between HCHS AfC Staff (NHSD Earnings) and UK Economy (ASHE)



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
ASHE (UK Earnings)	0.5%	1.3%	0.8%	0.8%	2.8%	2.5%	2.8%	2.9%	3.2%	-0.6%
HCHS (Non-Medical)	1.7%	1.4%	0.0%	0.8%	0.6%	0.6%	0.9%	2.9%	3.2%	3.7%

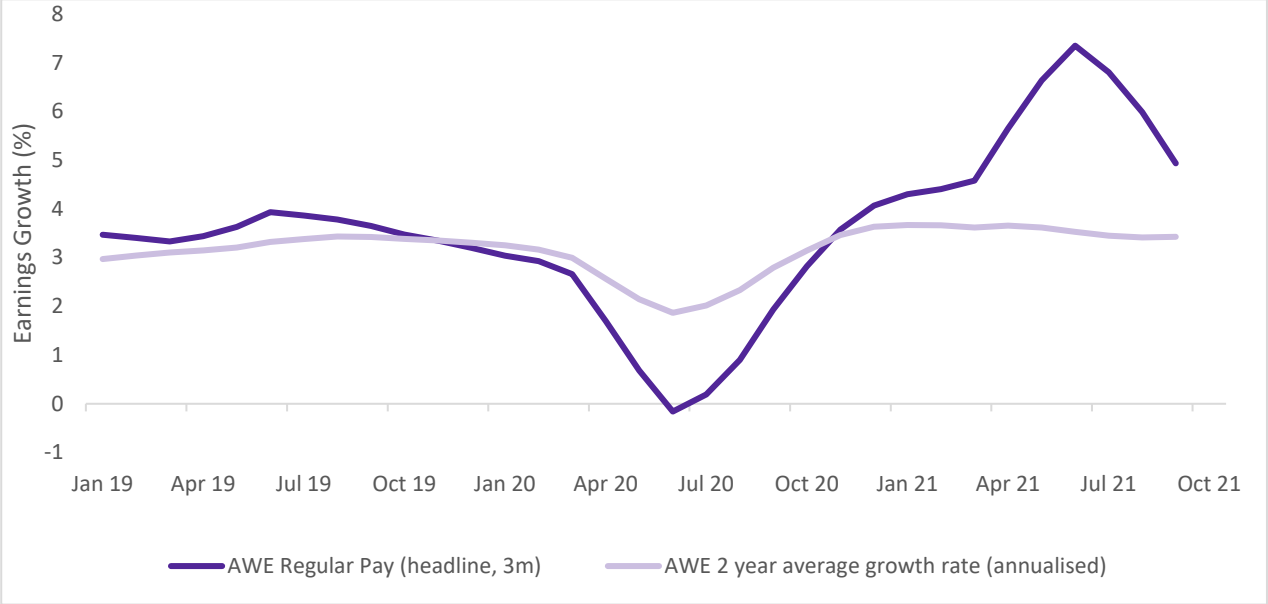
Source: NHS Digital Earnings Statistics, Annual Survey of Hours and Earnings

One of the limitations of ASHE is that there is a long lag between data collection and publication and so it may be worth considering other, timelier, data sources to provide insight on how wider labour markets have recovered.

Figure 11 shows how growth in average weekly earnings has varied since January 2019 and highlight including the impact on earnings at the start of the pandemic. Average weekly earnings (regular pay) growth was 4.9% for the three months to September 2021 although the ONS emphasize that headline earnings data is inflated by a base effect from annual comparisons to a period in 2020 when wages were deflated by furlough.

Latest forecasts for whole economy pay growth suggest that growth in average earnings will be in line with the pre-pandemic period over the coming years

HMT note that average earnings can be impacted by other factors including workforce composition and pay drift which may mean increases in average earnings are above pay settlements.



Source - ONS

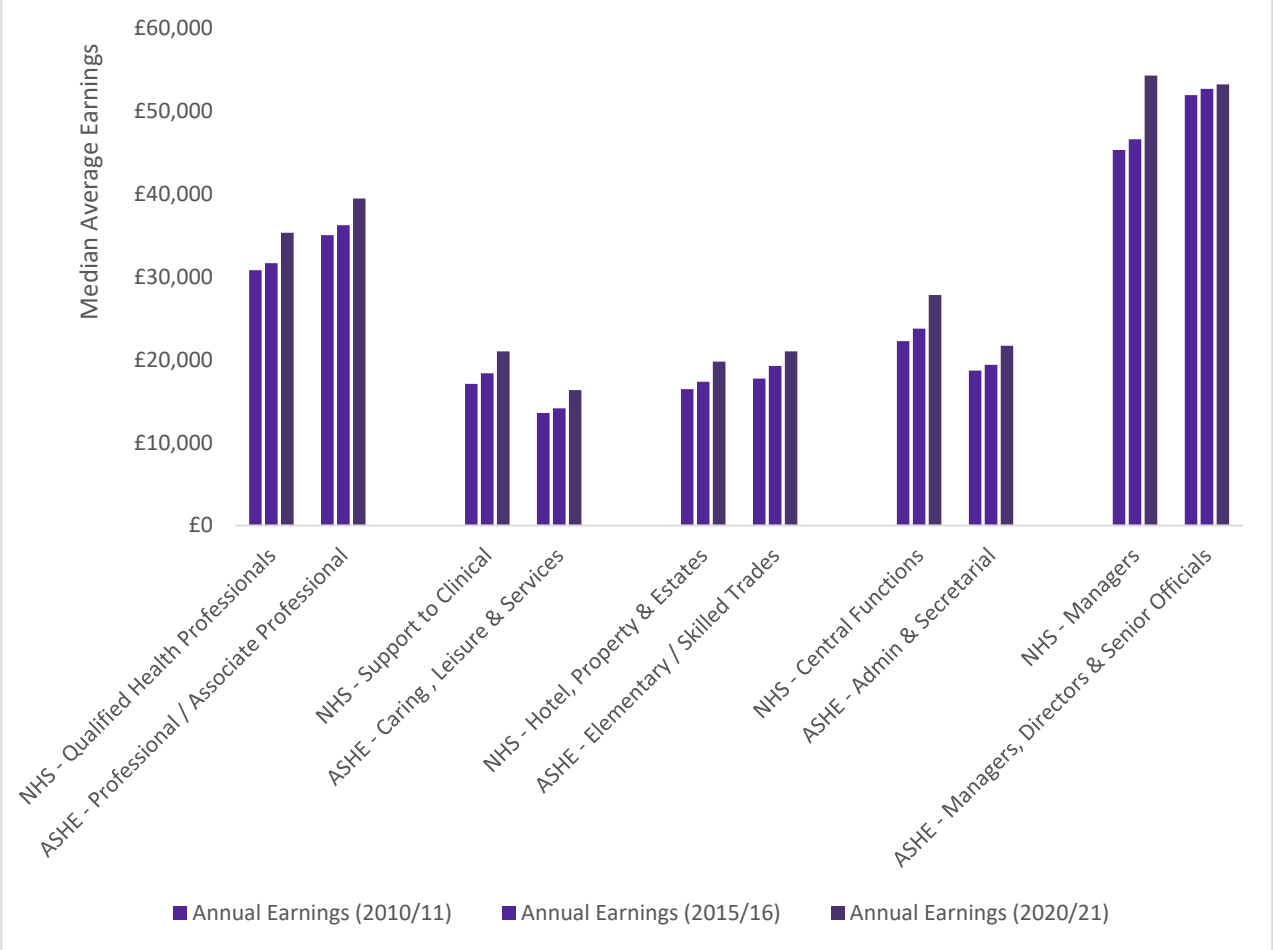
Comparisons of HCHS with connected labour markets

As well as comparisons with the wider economy in general we can make comparisons between the HCHS sector and its comparator industries. This is important in assessing how pay in the HCHS sector compares to other connected labour markets which may have staff with similar levels of skills or responsibilities.

As with the figure for the whole economy these should be treated with caution due to the differential impact of the pandemic on different sectors. It is possible that data for some sectors, including retail and hospitality at the lower end of the income distribution, have been more impacted by government restrictions - for example having a higher proportion of staff on furlough.

Figure 12 compares earnings for NHS Staff Groups against selected comparators from the wider economy with different "families" of staff grouped together. In absolute cash terms the overall earning levels are relatively similar which may suggest that they are suitable comparators - on this basis we see that earnings for support functions may be slightly higher than in the wider economy, but professional roles may be slightly lower although this does not consider wider total reward and there may be other factors such as differences in participation rate influencing the comparison.

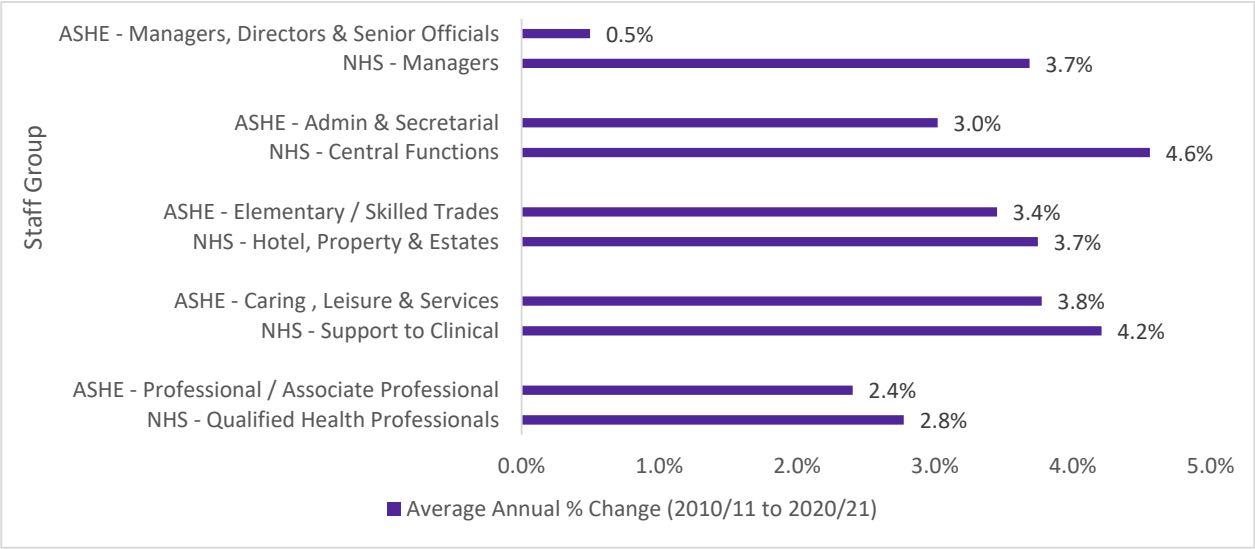
Figure 12 - Average Annual Earnings for HCHS and Comparator Sectors - 2011-12 to 2020-21



Source - NHS Digital Earnings Statistics, Annual Survey of Hours and Earnings

We can also look at changes over time for these groups to see if there are changes in the relative competitiveness of NHS wages relative to the wider economy over the past 10 years (annualised growth). For most occupation sectors NHS growth has been similar to its comparators over the period which included the 2018 AfC agreement, and in some instances, notably ahead.

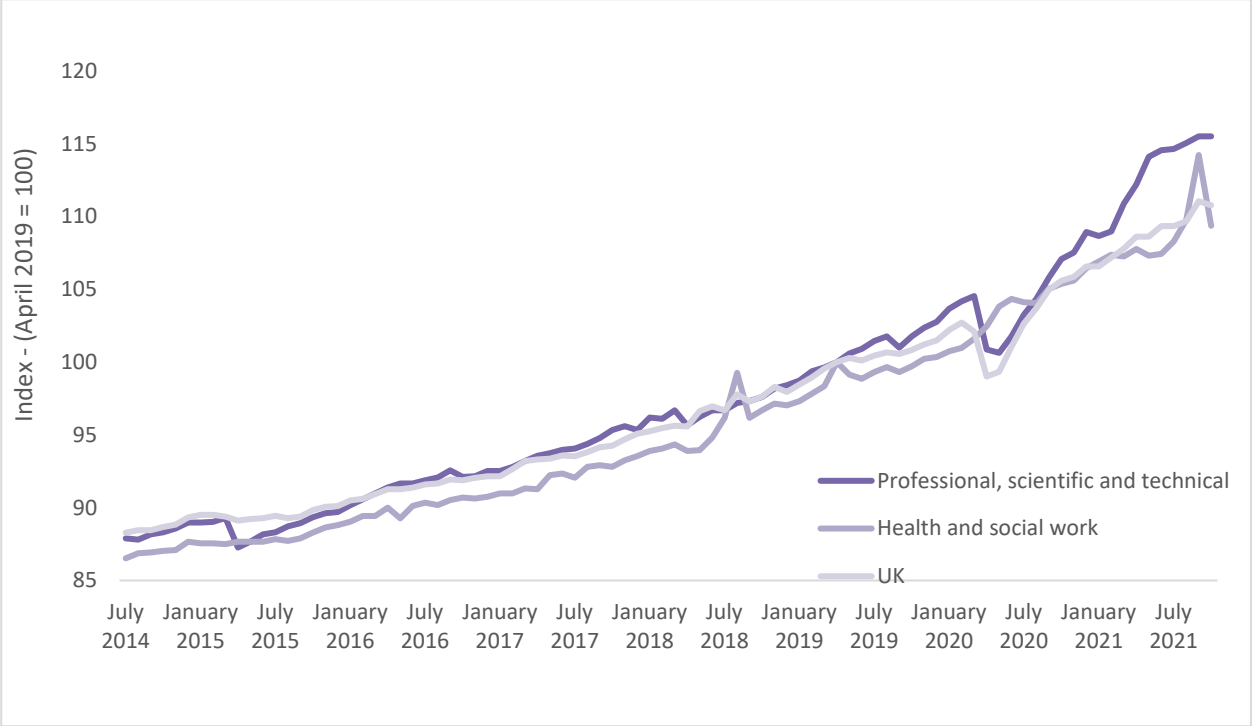
Figure 13 - Average Annual Growth in Earnings in HCHS and Comparator Sectors - 20110-11 to 2020-21



Source - NHS Digital Earnings Statistics, Annual Survey of Hours and Earnings

Figure 14 is taken from "Real Time Earnings Data" published by ONS and gives a more up to date estimate of earnings in different sectors and how different sectors have recovered since 2014. While earnings in some sectors reduced at the beginning of the Pandemic they have since returned to growth and since 2019 have seen similar growth rates to that of Health and Social Care.

Figure 14 - Office for National Statistics "Real Time Earnings Information" by selected sectors (July 2018 = 100)



Source - ONS Real Time Earnings Information (ONS)

There remains uncertainty about how labour markets will recover from the pandemic and its impacts on current labour market data. This should be borne in mind when interpreting the current evidence.

Earnings distribution and comparison with wider economy

Table 29 compares the earnings distribution in the HCHS sector to that in the wider economy. Median earnings for all HCHS staff are (comparison with UK average) with roles that require professional registration (including nurses) tending to earn slightly more than average while support roles may earn slightly less than the average which to a large extent reflects the AfC banding structure.

When interpreting differences, it is important to recognise the differences between different jobs and workforces. For example, the 24/7 nature of the health service means that health staff are more likely to receive "unsocial hours" premia than those in the wider economy which increases earnings. However, NHS staff are more likely to work part time than in the wider economy more generally. Over 35% of non-medical staff work part-time compared to around 25%[1] in the wider economy.

Table 29 - Earnings Distribution and Comparison with UK Economy

[1] https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/employment/full-time-and-part-time-employment/latest

Staff group	25% Earn Less Than	Median Earnings	25% Earn More Than	Mean Earnings
UK Average (ASHE Data)	£16,669	£25,971	£38,900	£31,447
Agenda for Change	£20,000	£26,500	£37,500	£29,506
Nurses and Health Visitors	£27,500	£34,000	£41,000	£34,671
Midwives	£27,000	£35,000	£41,500	£34,473
Ambulance Staff	£38,000	£44,500	£50,500	£43,384
Scientific, Therapeutic and Technical	£26,500	£34,500	£44,000	£35,883
Support to Doctors, Nurses and Midwives	£16,500	£21,000	£24,500	£20,532
Support to Ambulance Staff	£23,000	£28,000	£33,000	£27,623
Support to STT	£16,000	£20,500	£24,500	£20,668
Central Functions	£20,000	£25,000	£34,000	£27,807
Hotel, Property and Estates	£14,000	£19,500	£24,500	£19,779
Senior Managers	£58,000	£76,000	£101,000	£82,284
Managers	£46,000	£52,500	£62,500	£54,284

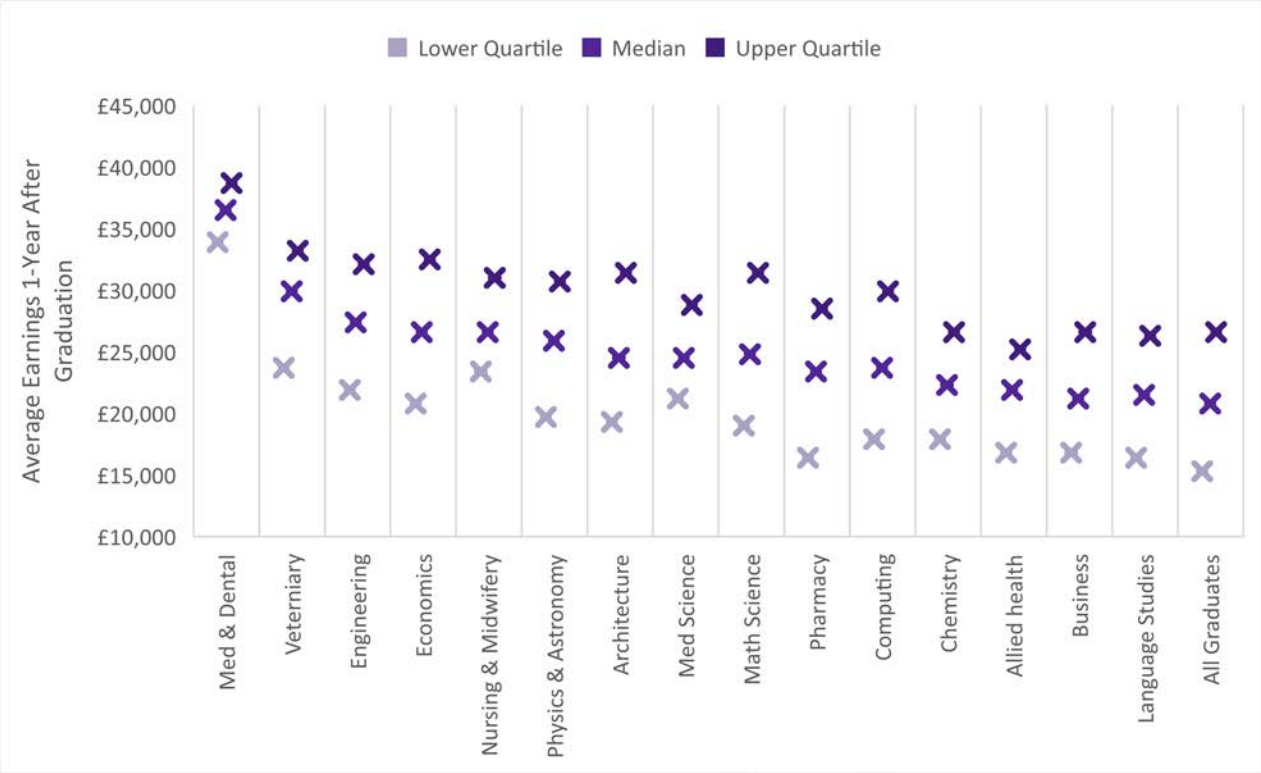
Source: NHS Digital Earnings Statistics, Annual Survey of Hours and Earnings

Graduate level outcomes

The Pay Review Bodies have sought evidence on how the HCHS sector compares to its comparators in both the short and long term to assess longer term career prospects which may link to the ability of the NHS to retain staff in future.

Figure 15 presents data from the Longitudinal Educational Outcomes (LEO) study produced by the Department of Education. This shows the distribution of earnings one year after graduation for different courses. Graduates from Nursing and Midwifery courses have higher than median earnings on graduation and are behind only Medicine, Veterinary Services, Engineering and Economics.

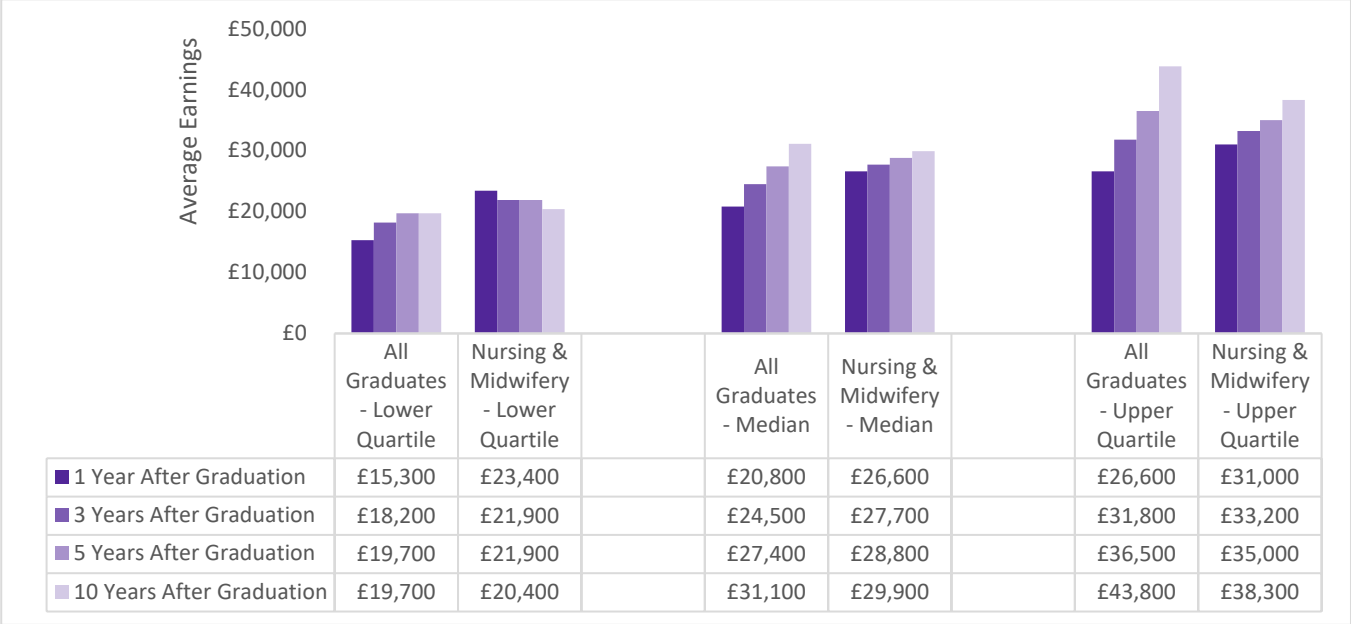
Figure 15- Average Earnings 1 Year After Graduation - LEO Education Outcomes - 2019



Source - LEO Education Outcomes - Department for Education

Over the longer term however there is some evidence that earnings for nurses grow less quickly than for graduates from other subjects. For example, Figure 16 shows that median earnings for nurse graduates are around £5,800 higher than average 1 year after graduation but this gap closes over time and after 10 years median earnings for nurse graduates are below other graduates which may reflect the relatively high number of part time nurses or the disproportionate number of women in nursing who may be more likely to take time out of the workforce in the first 10 years after graduation.

Figure 16 - Average pay "x" years after graduation for UK graduates



	All Graduates - Lower Quartile	Nursing & Midwifery - Lower Quartile	All Graduates - Median	Nursing & Midwifery - Median	All Graduates - Upper Quartile	Nursing & Midwifery - Upper Quartile
1 Year After Graduation	£15,300	£23,400	£20,800	£26,600	£26,600	£31,000
3 Years After Graduation	£18,200	£21,900	£24,500	£27,700	£31,800	£33,200
5 Years After Graduation	£19,700	£21,900	£27,400	£28,800	£36,500	£35,000
10 Years After Graduation	£19,700	£20,400	£31,100	£29,900	£43,800	£38,300

Source: Department for Education Graduate Outcomes (LEO) - 2018-19

Individual pay journeys and analysis of pay disparities

This section provides information on how individual staff experience the pay system including data on how pay for individual members of staff over time. It then provides information on pay disparities which can be caused by, amongst other factors, differences in progression including the Ethnicity and Gender Pay Gaps.

Longitudinal analysis

Data from the NHS ESR can be used to perform longitudinal analysis which looks at how pay / earnings for individual members of staff changes over time including the impact of progression, promotion, and reform.

Table 30 shows information for around 500,000 people who were employed in the HCHS sector in both March 2011 and March 2021 and is based on basic pay per FTE. It shows that 50% of staff saw an increase of at least 28.6% with 25% of staff experiencing increases of at least 45%.

Variation between staff groups is often caused by movement between staff groups - for example the higher averages for "managers" and "senior managers" may be due to people being promoted into those grades from other staff groups including central functions.

Table 30 - Cumulative Change in Basic Pay per FTE for individual staff employed in both March 2011 and March 2021

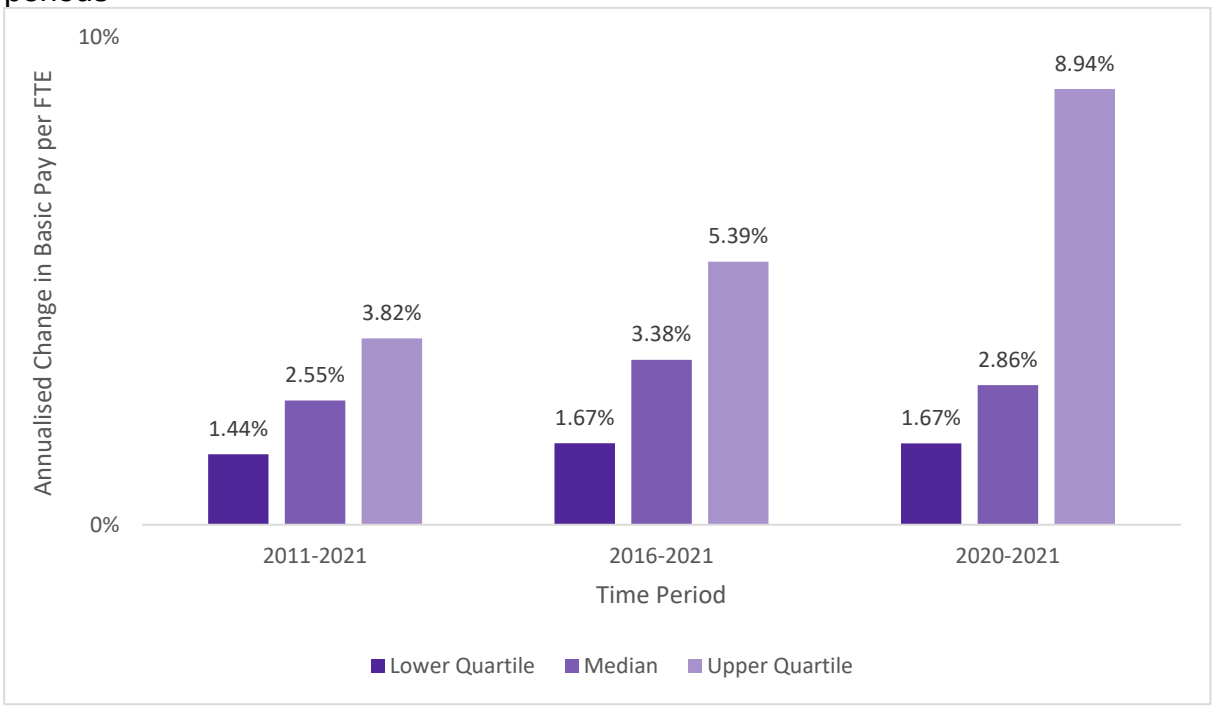
Staff Group	Count	Mean	25th Percentile	Median	75th Percentile

All Agenda for Change	508,900	34.6%	15.4%	28.6%	45.5%
Nurses and health visitors	167,000	34.7%	13.9%	29.9%	48.8%
Midwives	11,800	32.1%	10.8%	26.5%	43.1%
Ambulance staff	7,800	49.1%	28.6%	43.1%	60.8%
Scientific, Therapeutic and Technical staff	79,300	39.3%	14.2%	31.0%	56.3%
Support to doctors, nurses and midwives	114,900	25.7%	15.4%	23.5%	34.6%
Support to ambulance staff	7,000	28.7%	13.8%	25.5%	40.4%
Support to STandT staff	25,800	27.8%	15.4%	23.9%	35.4%
Central functions	48,400	40.9%	16.5%	33.1%	55.0%
Hotel, property and estates	24,700	28.9%	23.5%	25.3%	34.6%
Senior managers	6,200	65.0%	31.7%	55.0%	86.5%
Managers	15,900	59.3%	28.7%	48.7%	79.6%

Source: DHSC Analysis of Electronic Staff Record. For people who have changed staff groups between 2011 and 2021 the 2021 staff group is shown.

Figure 17 presents similar analysis over alternative time periods (on an annualised basis). Over the past 5 years median annual growth is an equivalent of around 3.4% per year which to total growth of around 18%. Over 10 years the median is around 2.5% per year or a total increase of over 28%

Figure 17 - Annual Increase in Basic Pay per FTE for individual staff over alternative time periods



Source: DHSC Analysis of Electronic Staff Record

An individual's experience of the pay system will depend on factors including the band / pay step they were in at the start of the period. Staff who are already at the top of band will experience smaller annual growth than those eligible for progression or those who achieve promotion.

Gender and ethnicity pay gaps

The government is committed to eliminating pay gaps which occur when men are paid more than women (Gender Pay Gap), or White staff are paid more than BME colleagues (Ethnicity Pay Gaps).

In 2020, the Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England ("GPG Review") was published which highlighted the extent of the issue in the medical workforce and some of the reasons why it exists.

While this review was conducted using data for medics most of the results can be generalised to the wider workforce - including staff on AfC. A similar piece of work is planned to better understand the Ethnicity Pay Gap which will cover all NHS staff.

These gaps can develop when certain conditions are met including:

- difference in Staff Group Mix - A gap will develop if Male or White staff are more likely to be in more senior staff groups compared to Female / BME staff
- differences in Grade Mix - A gap will develop if Male / White staff are more likely to be in higher bands compared to Female / BME staff
- differences in Point Mix - A gap will develop if Male / White staff are more likely to be on more senior pay points than White / BME staff
- differences in Earnings - Male / White staff may have higher earnings than Female / BME staff if they are more likely to work full-time.

Table 31 shows the extent of the Gender and Ethnicity Pay Gaps as of May 2021 using the basic pay per FTE measure. Gender and Ethnicity gaps are shown separately to isolate the impact of either characteristic.

Table 31 - Gender and Ethnicity Pay Gaps - May 2021 - Basic Pay per FTE

Staff Group	GPG - White	GPG - BME	EPG - Female	EPG - Male
Description	Comparison of White Female to White Male	Comparison of BME Male to BME Female	Comparison of BME Female to White	Comparison of BME Male to White Male

			Female	
All Agenda for Change	-8% (White Females have pay 8% lower than White Males)	-1%	-4%	-11%
Nurses and health Visitors	-4%	-2%	-11%	-12%
Professionally Qualified Staff	-4%	-3%	-10%	-11%
Support to Clinical Staff	-3%	0%	-1%	-4%
Infrastructure Support	-12%	-5%	-5%	-13%

Source - NHS Digital Earnings Statistics.

Across all AfC staff there is some evidence of both a Gender and Ethnicity Pay Gap. For example, average basic pay per FTE for White Females is 8% lower than for White Males and BME Males have basic pay per FTE 11% lower than White Males.

Pay gaps tend to be smaller within individual staff groups than across the whole workforce - this might be that the staff group effect is more significant than grade or point mix effect.

Promotions and new joiners by gender and ethnicity

One of the factors that can help to explain the continuing presence of a pay gap is to consider the bands at which new starters enter the workforce and the rates at which staff from different demographics attain promotion.

Table 32 shows the distribution of new joiners (those employed in March 2021 but not March 2020) to the HCHS sector split by band, gender and ethnicity group. By gender females were more likely to be employed at Band 5 which may reflect the increase in the Nursing workforce while males were slightly more likely to be recruited at Band 7 or above. It is similar for BME staff who have larger numbers recruited at Band 5 but less at the more senior bands.

Table 32 - Band Profile of New Joiners - Staff Employed in March 2021 but not March 2020

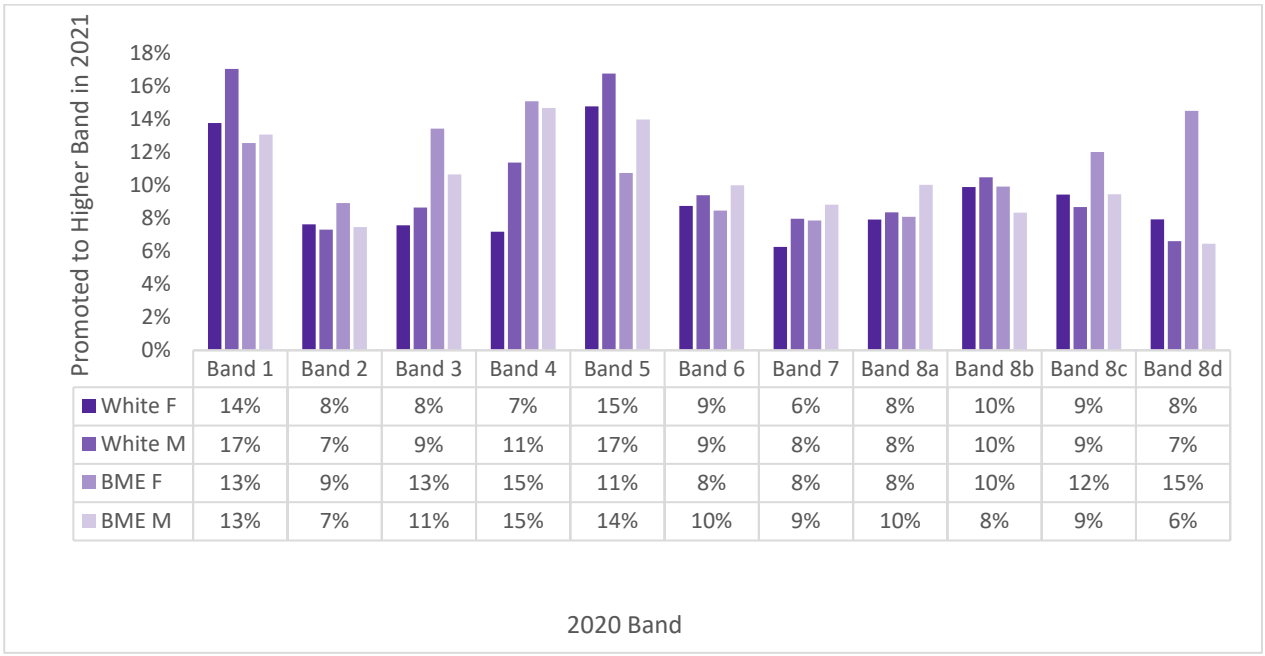
Band	All Staff	Female	Male	White	BME
Band 1	0%	0%	0%	0%	0%
Band 2	25%	25%	26%	27%	21%
Band 3	17%	16%	19%	17%	16%
Band 4	12%	12%	11%	11%	12%
Band 5	27%	29%	21%	24%	36%
Band 6	10%	10%	9%	10%	8%
Band 7	5%	5%	6%	6%	4%

Band 8a	2%	2%	3%	2%	1%
Band 8b	1%	1%	1%	1%	1%
Band 8c	0%	0%	1%	1%	0%
Band 8d	0%	0%	0%	0%	0%
Band 9	0%	0%	0%	0%	0%

Source - DHSC Analysis of Electronic Staff Record

Figure 18 shows the proportion of individuals who obtained a promotion (being in a higher band in March 2021 than March 2020) and how it differs by demographics. Across most bands' females were slightly less likely to achieve a promotion than males but there is less evidence of a difference for BME staff.

Figure 18 - Promotion by Gender, Ethnicity and Band before promotion - March 2020 to March 2021



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d
White F	14%	8%	8%	7%	15%	9%	6%	8%	10%	9%	8%
White M	17%	7%	9%	11%	17%	9%	8%	8%	10%	9%	7%
BME F	13%	9%	13%	15%	11%	8%	8%	8%	10%	12%	15%
BME M	13%	7%	11%	15%	14%	10%	9%	10%	8%	9%	6%

Source - DHSC Analysis of Electronic Staff Record

Differences between groups may be explained by other factors including differences in working patters and the band distribution for different staff groups.

We have also conducted analysis by disability status and do not find significant differences between those who declare a disability and those who do not.

Career choices and earnings

The PRB has asked for information on "how career choices can impact earnings".

Some decisions will have an immediate impact on earnings due to the provisions of the AfC contract - for example staff who work part time will naturally earn less as they work

fewer hours, and some staff groups will have higher / lower earnings due to where they sit in the job evaluation framework or the likelihood of working hours at premium time.

The analysis concentrates on career decisions which may impact earnings over a longer period due to the potential impact on an individual's progression which go beyond the basic operation of the Contract.

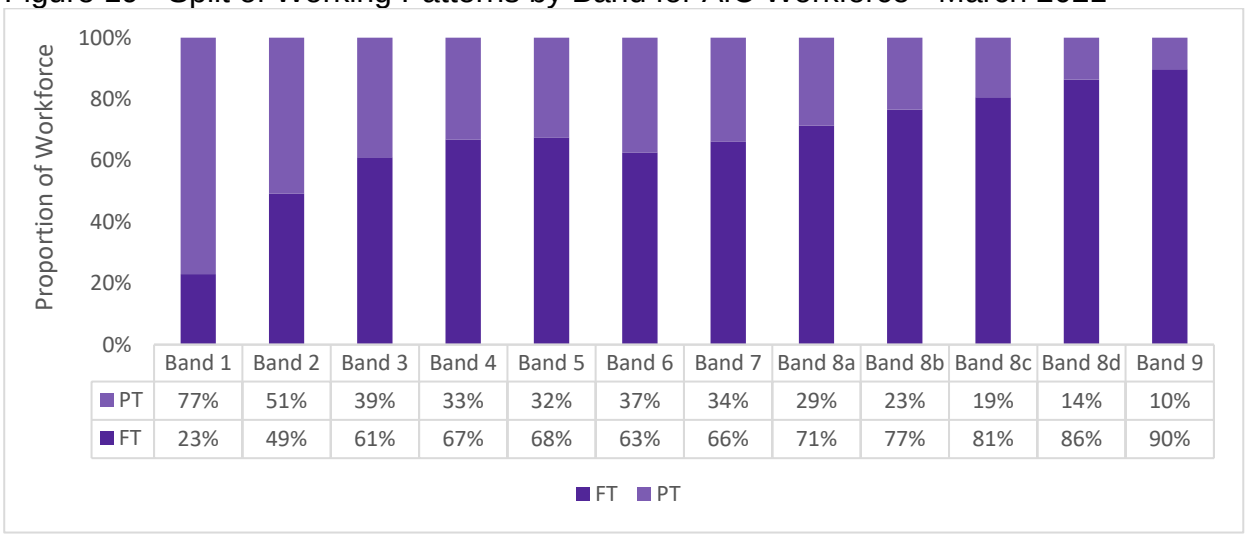
- Working Patterns - The NHS offers a variety of flexible working patterns which may mean that staff progress at different rates".

- Career Breaks - Staff who take time out of the workforce may have different progression profiles to those without breaks of service as they will have spent some time out of the workforce.

- Occupation / Organisation - Some roles may be more likely to access high levels of additional earnings due to the requirements of the role. For example, some branches of Nursing may be more likely to work unsocial hours however this simply reflects the terms of the contract.

One group to consider are part time staff. Fig 5.21 shows that, in general, there are fewer part-time staff in more senior bands with the proportion of part-time staff falling from 37% in Band 6 to only 14% in Band 8d and 10% in Band 9.

Figure 19 - Split of Working Patterns by Band for AfC Workforce - March 2021



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9
PT	77%	51%	39%	33%	32%	37%	34%	29%	23%	19%	14%	10%
FT	23%	49%	61%	67%	68%	63%	66%	71%	77%	81%	86%	90%

Source - NHS Digital Workforce Statistics - March 2021

There is some evidence that part time staff are less likely to obtain promotion than those who work full time. For example, around 16% of full time staff at Band 5 obtained promotion between March 2020 and March 2021 compared with only 5% of part time staff but there is no information on whether this is because they are less likely to apply for

promotion (for example, for work-life balance reasons) or if they are less likely to be successful in applications.

It is probable that people who take time out of the workforce, for example if they take a career break or maternity leave, progress more slowly than their contemporaries as they do not have as much experience as others. Some research on the Gender Pay Gap (see: Wage progression and the gender wage gap: the causal impact of hours of work - Institute For Fiscal Studies - IFS) suggests that working part-time can slow pay progression and lead to larger pay gaps. This is because women may take time out of the workforce, or work part-time, and thus do not have as much labour market experience as their male counterparts.

6. Total reward

Introduction to total reward

Total reward is the tangible and intangible benefits that an employer offers an employee, and it remains central to recruiting and retaining staff in the NHS. The value of the NHS total reward package remains high, as has been noted in previous rounds of PRB evidence.

The NHS total reward package includes a range of benefits that are above the statutory minimum and exceed those offered in other sectors. These benefits include a holiday allowance of up to 33 days (plus 8 public holidays), sickness absence arrangements well beyond the statutory minimum, enhanced rates for nights and weekend work, access to a much-valued pension scheme, enhanced parental leave, and support for learning, development, and career progression.

As part of the total reward package and to improve the experience of working in the NHS NHSEI have developed the NHS People Promise, which accompanied the July 2020 People Plan publication. The intention is to make the promise's principles a reality by 2024. It is structured around 7 principles aimed to make the NHS "the best place to work". The 7 principles are: We are compassionate and inclusive; We are recognised and rewarded; We each have a voice that counts; We are safe and healthy; We are always learning; We work flexibly; We are a team. More detail on the People Promise will be provided in NHSEI's written evidence.

The Department commissions NHS Employers to provide advice, guidance, and good practice to the NHS on developing a strategic approach to reward based on the Hay Model, shown in Figure 20. Further information on how individual employing organisations approach reward for their staff will be provided in the written evidence submitted by NHSEI and NHS Employers.

Figure 20 - Hay Model

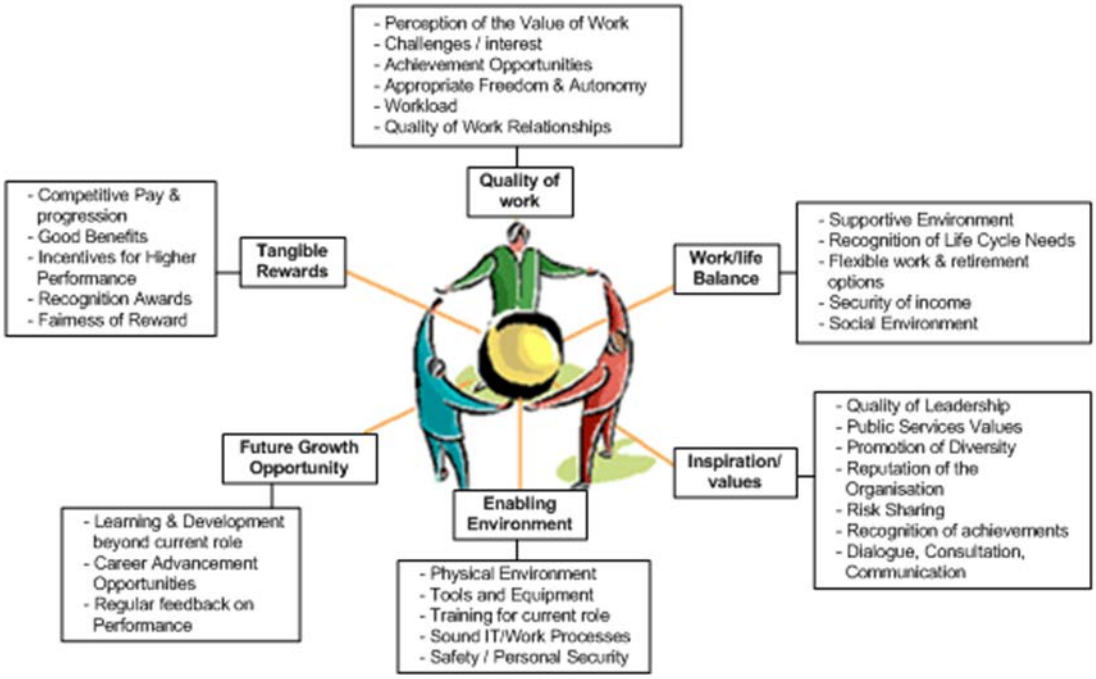
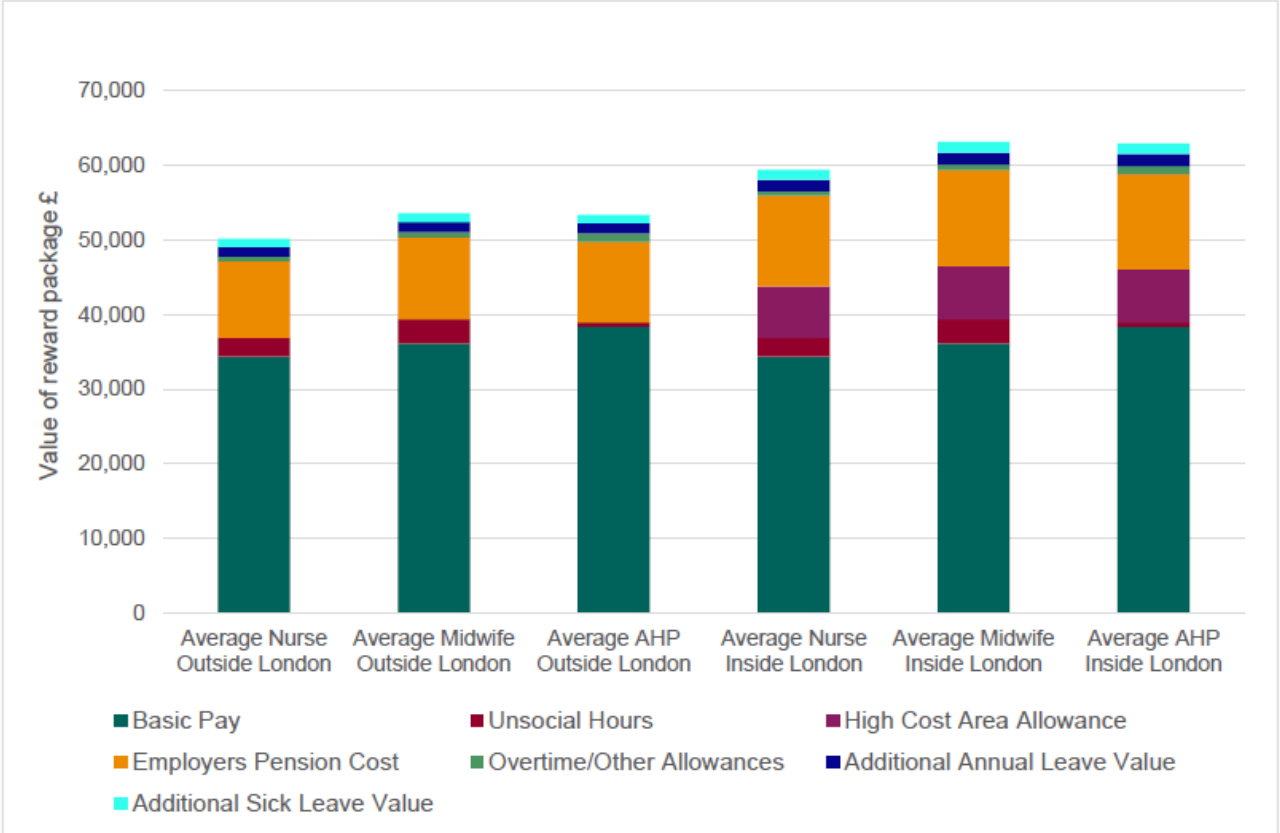


Figure 21 - Total Value of Wider Reward Packages 2021-22 (£)



The value of the reward package for a range of NHS staff roles is shown in Figure 21, which has been produced for the Department by the Government Actuary's Department (GAD). It includes basic pay, other pay such as unsocial hours payments, High Cost Area Allowances (HCEAs) for staff inside London, employer pension costs, and overtime/other allowances. It also includes additional leave over the statutory minimum and additional sick leave over statutory sick pay.

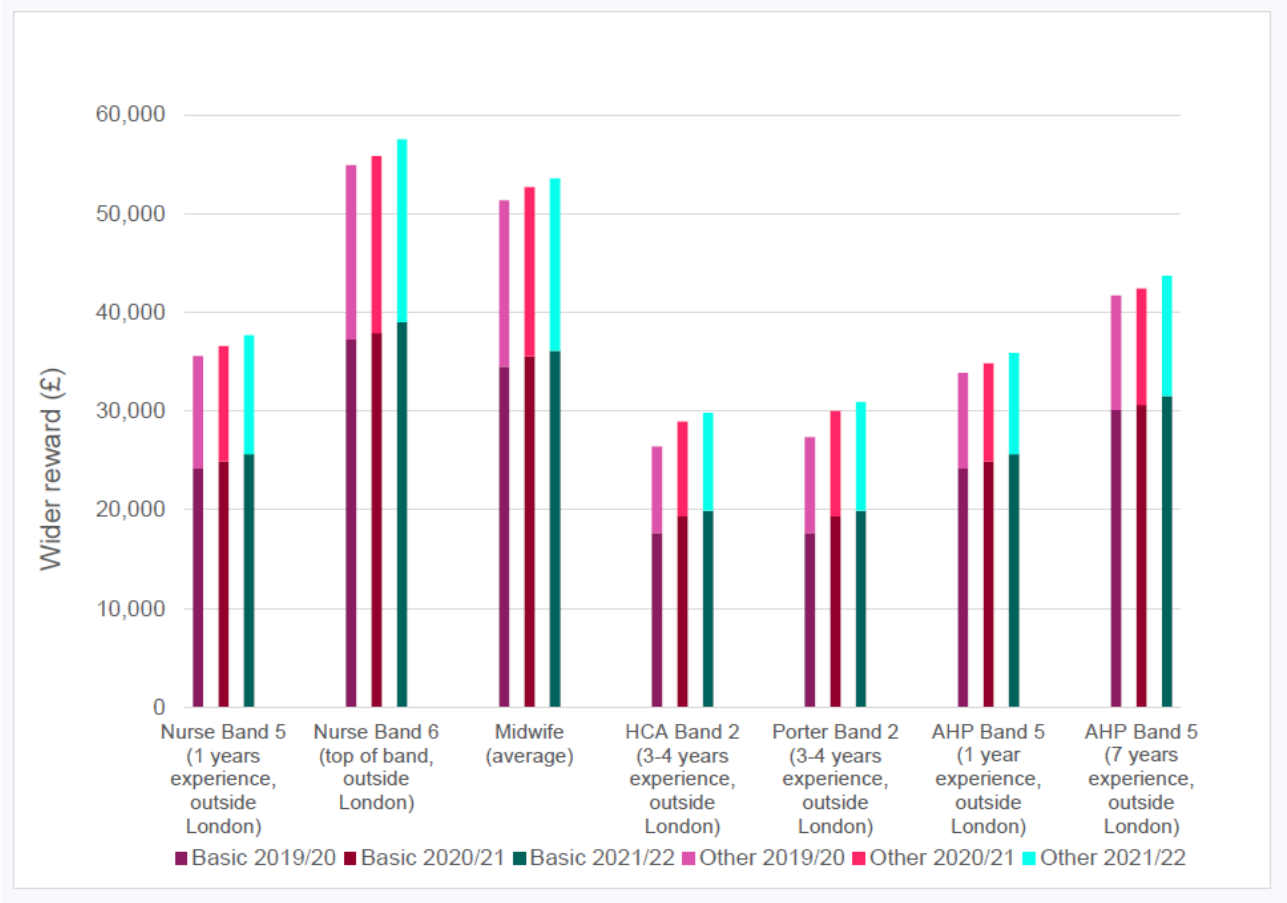
NHS trend analysis

The Department also commissioned GAD to carry out trend analysis for different NHS staff, based on the previous total reward analysis at 2018-19, 2019-20, and 2020-21. This trend analysis for NHS roles shows the split of total rewards between basic and other pay over the years 2019-20, 2020-21 and 2021-22.

The roles and relevant AfC bands considered are band 5 nurse (1 year experience), band 6 nurse (10 years' seniority, earning at top point of band), midwife (average), band 2 healthcare assistant (HCA) (3 to 4 years' experience), band 2 porter (3 to 4 years' experience), band 5 AHP (1 year experience), and band 5 AHP (7+ years' experience). Please note, for an average midwife GAD has compared average rewards at 30 September 2019, 30 September 2020, and 30 June 2021 with pay bands at 2019-20, 2020-21 and 2021-22 for all other roles, however GAD believes this will only cause a negligible difference for the purpose of comparison. This is consistent with the approach used in previous years and reflects the availability of the relevant data.

Figure 22 below shows that increases are largely driven by increases to basic pay over the period 2019-20 to 2021-22. Both HCAs and porters at band 2 received the highest increase in reward over the total period, of around 13%. Nurses at band 5 (1 years' experience) and AHPs at band 5 (1 years' experience) experienced an increase of around 6% over the total period 2019-20 to 2021-22. Nurses at the top of band 6 and AHPs at band 5 (7 years' experience) experienced an increase of just under 5% over the period, with an increase of just under 2% between 2019-20 and 2020-21 and 3% between 2020-21 and 2021-22. Average midwives experienced an increase of around 4% over the period 2019-20 to 2021-22. All roles considered have at least 27% of total rewards made up of non-basic pay.

Figure 22 - Analysis of the trend in wider reward over the period 2019-20 to 2021-22



GAD also analysed total reward across various private sector occupations, based on Office for National Statistics (ONS) data for salary and pension benefits, and compared them against pay rewards for NHS staff based on their previous analysis from 2012 to 2020.

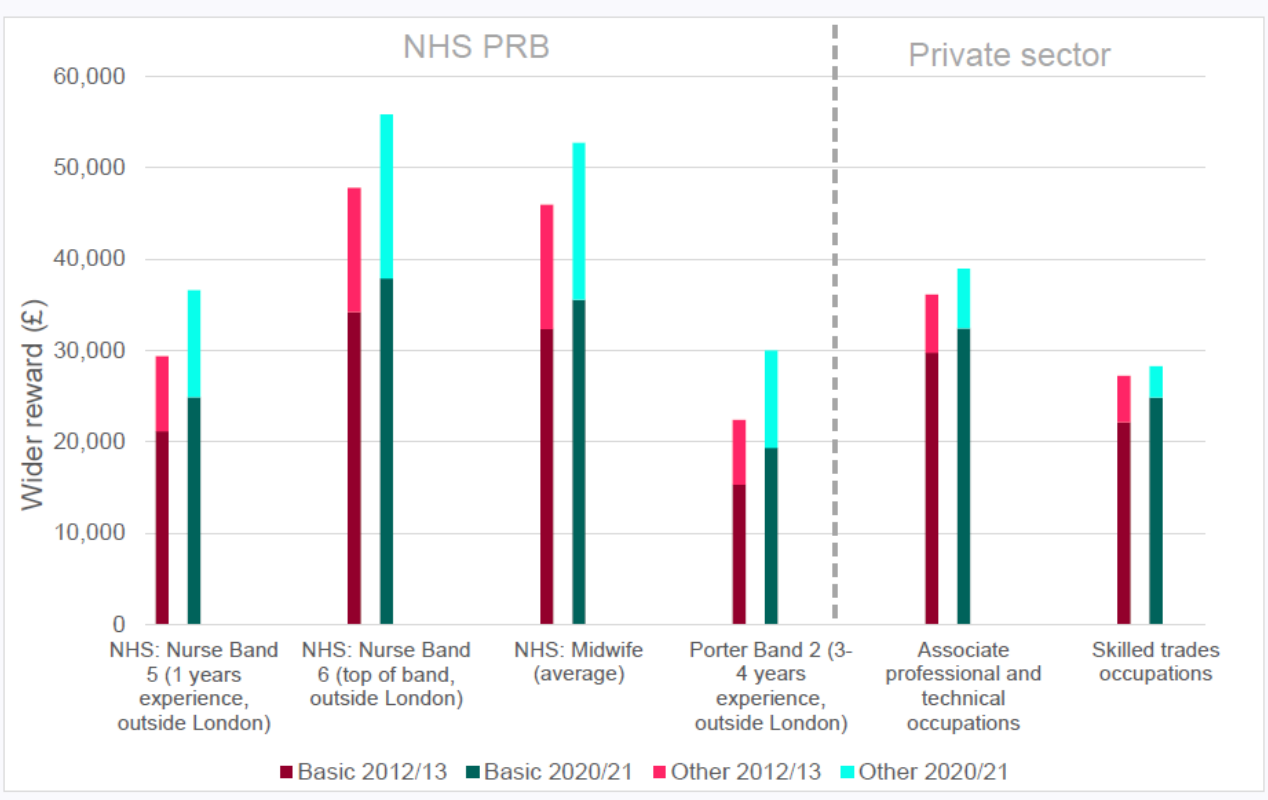
This analysis is intended to give an approximate indication on how wider reward between roles and occupations change over time; it is not intended to provide a direct comparison between any direct NHS role and other occupation. The NHS roles included in this analysis are band 5 nurse (1 year experience), band 6 nurse (10 years' seniority, earning at top point of band), midwife (average) and band 2 porter, (3 to 4 years' experience). The private sector occupations considered are associate professional and technical occupations and skilled trades occupations.

Figure 23 shows that all roles considered as part of this analysis across both NHS roles and private sector occupations experienced an increase in total wider reward packages over the period 2012 to 2020. Overall, increases are largely driven by increases to basic pay over the period. Nurses at band 5 (1 years' experience) experienced an increase of 25% over the period, whereas nurses at the top of band 6 experienced a 17% increase in total reward. The average midwife role received a 15% increase, whereas porters in band 2 have received a 34% increase over the period.

Skilled trades occupations in the private sector experienced increases of 4% over 2012 to 2020. Whereas private sector Associates experienced an increase in total reward of 8% over the period.

Non-basic pay makes up a larger proportion of NHS reward relative to private sector occupations, with ‘other’ pay making up at least 31% of total wider reward in 2020-21 for roles considered. Across the private sector occupations considered, non-basic pay makes up around 17% of total wider reward for private sector Associates and around 12% of total wider reward for Skilled Trades occupations. One driver for this might be the value of public sector pension benefits available to NHS staff and the additional pay elements and awards available, relative to the private sector.

Figure 23 - Comparison of trend of increase of NHS roles relative to private sector over the period 2012 to 2020



Introduction to the NHS Pension Scheme

Staff working in the NHS have access to the NHS Pension Scheme ("the Scheme"), which remains a valuable part of the total reward package available to the NHS workforce and one of the best pension schemes available. Membership of the Scheme is high, with around 9 in 10 NHS staff actively participating.

Eligible members of the NHS workforce will now belong to one of the 2 existing schemes, both of which are defined benefit schemes. The final salary scheme, or legacy scheme, is made up of the 1995 and 2008 Sections and is now closed to new members. All new NHS

staff join the 2015 Scheme, a career average revalued earnings (CARE) scheme which provides benefits based on average earnings over a member's career. The key differences between the 2 schemes, other than the way benefits are calculated, are different normal pension ages and accrual rates, as shown in Table 33 below.

Table 33 - Comparison of scheme, retirement age and accrual rate

Scheme or Section	Retirement Age	Accrual rate
1995 Section	60	1/80th
2008 Section	65	1/60th
2015 Scheme	State Pension Age	1/54th

GAD calculates that members can generally expect to receive around £3 to £6 in pension benefits for every £1 contributed. A band 5 or 6 nurse retiring at 68 with 35 years' service wholly in the 2015 Scheme can expect an annual pension of around £19,000.

The 2015 Scheme was introduced as part of wider reforms implemented by regulations made under the Public Service Pensions Act 2013. As part of these reforms, public service pension scheme members within 10 years of retirement were given transitional protection, and so remained in their legacy pension schemes. In December 2018, a judgement by the Court of Appeal in the cases of McCloud and Sargeant ("the McCloud judgment") found that these transitional protection arrangements gave rise to unlawful discrimination.

The Department set out the Government's proposed response to the McCloud judgment its 2021 evidence. Since then, the Government has laid proposed primary legislation, the Public Service Pensions and Judicial Offices Bill, before Parliament to implement changes in public service pension schemes to remedy the discrimination identified by the McCloud judgment. The bill was introduced into the House of Lords on 19 July 2021. Subject to Parliamentary approval, this puts in place a legal framework which requires departments to make amendments to pension scheme regulations to facilitate implementation of the remedy as directed by the bill.

The remedy has 2 parts:

- to ensure equal treatment for all members within each of the main public service pension schemes by moving all members into the new schemes on 1 April 2022 irrespective of age

- to remove the effect of transitional protection by offering eligible members a choice over the set of benefits (legacy scheme or new scheme) they wish to receive for any pensionable service during the period 1 April 2015 to 31 March 2022

On 9 December 2021, the Department launched a consultation on a draft Statutory Instrument (SI), which will make changes to the NHS Pension Scheme regulations as part of the first part of the McCloud remedy.

NHS Pension Scheme membership

The Department continues to monitor Scheme membership rates through ESR. Table 34 shows the total number of Scheme members by staff group and AfC band at July 2021. It also compares the change in membership rates from July 2020 to July 2021, July 2016 to July 2021 and July 2011 to July 2021.

Table 34 - Membership in the NHS Pension Scheme

Staff Group	FTE July 2021	NHS Digital Headcount July 2021	Membership (Headcount) July 2021	1 Year Change 2020 - 2021	5 Year Change 2016 - 2021	10 Year Change 2011 - 2021
All Non-Medical	1,070,268	1,215,603	89%	-0.6%	0.0%	5.4%
Nurses and Health Visitors	310,629	347,129	88%	-1.1%	-2.0%	1.5%
Midwives	21,942	26,556	90%	-0.6%	-2.2%	0.0%
Ambulance Staff	17,695	18,849	92%	-0.1%	-3.2%	-4.1%
Scientific, therapeutic and technical staff	152,559	173,852	92%	-0.2%	-1.0%	1.3%
Support to doctors, nurses and midwives	278,502	321,605	88%	-0.9%	1.6%	10.2%
Support to ambulance staff	24,752	26,950	92%	-0.4%	-0.7%	2.5%
Support to ST&T staff	70,546	80,971	90%	0.2%	2.6%	10.1%
Central Functions	99,762	109,381	88%	0.0%	0.9%	6.3%
Hotel, property and estates	59,848	74,816	86%	0.5%	4.3%	14.6%
Senior Managers	11,886	12,452	91%	-0.3%	-2.5%	-4.0%
Managers	22,147	23,042	90%	-0.6%	-1.3%	-1.9%

AfC Band 1	3,781	N/A	74%	-2.1%	-3.0%	11.4%
AfC Band 2	182,316	N/A	88%	0.2%	2.7%	13.0%
AfC Band 3	149,578	N/A	89%	-0.9%	1.4%	8.9%
AfC Band 4	103,409	N/A	89%	-1.5%	0.1%	5.3%
AfC Band 5	210,375	N/A	87%	-1.0%	-2.0%	2.0%
AfC Band 6	203,077	N/A	90%	-0.5%	-1.8%	1.0%
AfC Band 7	123,926	N/A	92%	-0.5%	-1.5%	-0.8%
AfC Band 8a	47,017	N/A	92%	-0.5%	-1.8%	-1.8%
AfC Band 8b	18,108	N/A	92%	-1.0%	-1.6%	-2.5%
AfC Band 8c	9,163	N/A	93%	-0.5%	-1.4%	-2.0%
AfC Band 8d	4,701	N/A	92%	-0.6%	-1.4%	-3.6%
AfC Band 9	2,089	N/A	91%	-0.9%	-2.9%	-4.6%

Note: NHS Digital Does Not Publish Headcount by AfC Band

Overall membership of the Scheme amongst NHS staff is high. Between July 2011 and July 2021, the percentage of all non-medical NHS staff who are members of the Scheme increased by 5.4%.

Membership rates for the NHS Pension Scheme compare favourably with private sector pension scheme participation. The Department for Work and Pensions published a report 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 has risen since the introduction of auto-enrolment, participation in private sector schemes (85%) is still lower than the public sector (93%). The report also shows that scheme participation for lower earners in public sector schemes is higher than that of lower earners in private sector schemes.

NHS Pension Scheme contributions

The Scheme collects contributions from both employers and members, with employers contributing 20.6% (plus a 0.08% administration charge) of a member's earnings. Members are required collectively to contribute 9.8% across the whole scheme

membership. This is the average member contribution rate and is known as the member contribution “yield”.

Tiered contribution rates were introduced in 2008, to reflect that higher earners were likely to receive proportionally more benefits than lower earners over the course of their retirement, due in part to their final salary link. To ensure the cost of the Scheme is affordable for all members, these tiered contribution rates ask higher earners to pay proportionally more than lower earners to access the valuable benefits of the Scheme. The Department keeps member contribution rates under review, in dialogue with NHS trade unions and employers through the NHS Pension Scheme Advisory Board (SAB).

The Department launched its consultation on changes to member contributions on 19 October 2021. The consultation set out that whilst the generous cross-subsidy provided by the current tier structure was intended to reduce potential financial barriers and encourage all staff to participate in the Scheme, the Department could no longer justify keeping the cross-subsidy at the same level. In the old final salary scheme, higher earners tended to derive more value from their ultimate pension benefits relative to the amount they contributed over their career, and so they were charged higher contribution rates. However, under a CARE scheme this advantage no longer exists for higher earners, as all members receive the same proportional benefit for their contributions.

Given that all members will be moved to the 2015 Scheme, a CARE scheme, for future accrual from 1 April 2022, the consultation set out a new structure (Table 35), which narrows the range between the lowest and highest contribution rates and ensures that the costs and benefits of the scheme are more evenly shared. Other changes set out in the consultation document include a move to base members’ contribution rates on their actual pensionable pay rather than their whole-time equivalent (WTE) earnings, and annual increases to each tier in line with uplifts to AfC pay bands. This will to some extent mitigate the "cliff edge" issue, previously highlighted by the NHS Pay Review Body, that sees some members charged a higher contribution rate because a pay uplift has put them into a different tier.

Adjustments to contribution tiers will be phased in over 2 years, to dampen the impact on take-home pay for staff and mitigate the risk of staff leaving the scheme on grounds of affordability. For the purpose of determining a member’s contribution tier, their pensionable earnings are rounded down to the nearest whole pound. In practice, as the tier thresholds will be increased annually in line with AfC pay awards the figures will be slightly different for future scheme years.

Table 35 - New member contribution structure, as proposed in the consultation document

Current tiers	Pensionable earnings (rounded down to nearest pound)	Current rate	Rate from 1 April 2022	Rate from 1 April 2023	Proposed tiers

-	-	(WTE pay)	(Actual pay)	(Actual pay)	-
Tier 1	Up to £13,231	5.0%	5.1%	5.2%	Tier 1
Tier 1	£13,232 to £15,431	5.0%	5.7%	6.5%	Tier 2
Tier 2	£15,432 to £21,478	5.6%	6.1%	6.5%	Tier 2
Tier 3	£21,479 to £22,548	7.1%	6.8%	6.5%	Tier 2
Tier 3	£22,549 to £26,823	7.1%	7.7%	8.3%	Tier 3
Tier 4	£26,824 to £27,779	9.3%	8.8%	8.3%	Tier 3
Tier 4	£27,780 to £42,120	9.3%	9.8%	9.8%	Tier 4
Tier 4	£42,121 to £47,845	9.3%	10.0%	10.7%	Tier 5
Tier 5	£47,846 to £54,763	12.5%	11.6%	10.7%	Tier 5
Tier 5	£54,764 to £70,630	12.5%	12.5%	12.5%	Tier 6
Tier 6	£70,631 to £111,376	13.5%	13.5%	12.5%	Tier 6
Tier 7	£111,377 and above	14.5%	13.5%	12.5%	Tier 6
-	Expected yield	9.8%	9.8%	9.8%	-

In order to balance clarity for members and a timely move to the new structure with minimising the impact of the new member contribution structure on take-home pay, the Department decided to delay the implementation of the new member contribution structure until 1 October 2022. As set out in the consultation document, the new member contribution structure will be phased in slowly to protect scheme affordability and minimise the risks to take-home pay of increases to member contribution rates.

In October 2022, approximately 40% of members are expected to receive a reduction in their contribution rates compared to the previous contribution rate structure. Whilst some members will be paying higher contribution rates, the new rates will be phased in over 2 years so that the largest increase in either year will be 0.8 percentage points. Further to this, the new structure will feature a substantial cross-subsidy that benefits lower earning NHS staff: all those earning under £27,780 will pay less than the required 9.8% rate. This means that over half of members will pay a rate that has been subsidised by contributions from their higher earning colleagues. The move to calculating contribution tiers based on members' actual pay is also likely to benefit many of the part-time NHS workforce. For example, a nurse at the top of AfC band 5 working 60% of full-time hours will pay £32 a month less under the new contribution structure, and £43 per month less than if they were on the average 9.8% rate.

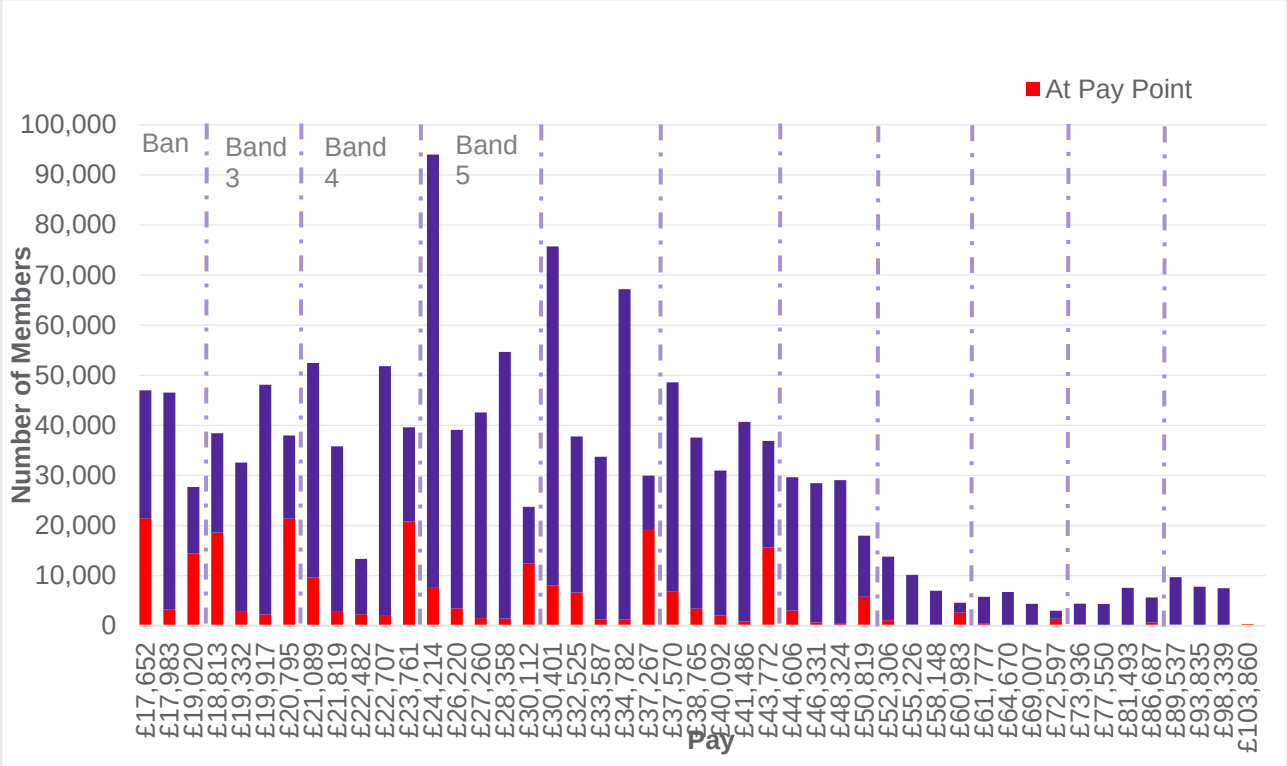
The SAB have previously considered that it is important for any tier structure to avoid 'cliff edges', whereby members are placed in a higher tier as the result of moving up an AfC pay band, and so see a decrease in their take-home pay. Whilst the new contribution structure seeks to mitigate the effect of cliff edges by linking the tier thresholds to the progression points within the AfC pay bands, in a tiered contribution structure some cliff edges will always exist.

It is also common for NHS staff to earn supplementary payments for on-call or out-of-hours work, which increase their pensionable pay. This means that a relatively small proportion of officer members of the Scheme have pensionable pay which match the AfC pay scales. This also contributes to difficulties in designing a tier structure that avoids cliff edges and makes it hard to predict the impact of any particular change in structure on individual members or groups of members.

Figure 36 is based on the officer membership data at 31 March 2020 and 2019/20 AfC pay scales and uses a threshold of plus/minus £20 WTE annual salary to determine whether a member is on each pay point. No adjustments have been made for part-time proportion since a number of records have missing part-time proportion. The chart shows that only 16% of the officer membership have WTE pensionable pay equal to one of the AfC pay points (+/- £20 margin), a very small increase from last year (15%).

It is important to note that the data underlying the chart reflects all officers in the data. This should therefore be the entire membership other than practitioners, and so the chart will also include non-AfC groups of officers, since AfC staff cannot separately be identified. To avoid a spike coming through at the final pay point in the chart, GAD have removed members who earn above the top of AfC band 9 (£103,860), as it is likely that this group would also include high earners in non-AfC groups (for example VSMs and non-GP doctors) who are included in the officer data. The final bar at this pay point in the chart is now very small since this reflects just approximately 200 members earning exactly £103,860.

Figure 36: Number of members at each AfC salary point, 2019-2020 (WTE pay)



Source: GAD analysis of NHSEI data

Flexibility around retirement

The Department is aware that staff value the ability work flexibly, and that employers' ability to make more flexible employment offers is key to retaining experienced staff in the workforce for longer. The Department has therefore been working with NHSEI on a retention initiative focused on employers making flexible employment offers to staff and engaging their higher earners on pension tax issues. These plans include:

- developing pension communications designed specifically for staff, and personal illustrations demonstrating the value of delaying retirement
- staff seminars to explain the value of the scheme and the benefits of delaying retirement, including seminars designed for those affected by pensions tax

The Department is also working with NHS Employers, who are supporting this work by providing guidance and practical examples on actions employers can take. NHS Employers have published a range of communication, guidance, and training materials to support organisations to have impactful conversations with their staff to help them make informed decisions about how the Scheme can help them to retire gradually supported by flexible working options or retire and return.

NHS Pension Scheme benefits

Beyond the pension which is payable for life following retirement, the wider scheme benefits for a member of the 2015 Scheme at 1 April 2022 include:

- tax relief on member contributions
- employer contributions, currently 20.6% of members' pay
- death in service lump sum equivalent to 2x salary
- spouse and family benefits, including benefits paid to a spouse following a death in retirement, and children's pensions in some cases
- ill health benefits, including full retirement benefits accrued without reduction under ill health Tier 1, and enhanced benefits for prospective service up to normal retirement age under ill health Tier 2
- options to exchange pension for a tax-free cash lump sum (subject to limits); early and late retirement options (subject to limits) and the option to purchase additional pension

Flexible working

As well as the specific pension flexibilities noted above, NHSEI is also working with the NHS Staff Council, a partnership of NHS trade unions and NHS Employers, to create a range of tools and support for organisations to embed flexible working. This includes toolkits aimed at line managers and individuals to support managing flexible working requests. In addition, there is a national collective agreement to include the right to flexible working from day one within the NHS Terms and Conditions of Service Handbook.

The NHS Staff Council has jointly agreed revisions to Section 33 of the NHS terms and conditions of service handbook, which will include a new day one right to request flexible working. There will be no limit on the number of applications and regardless of the reasons for a request. There are also new requirements for better centralised oversight of processes to ensure greater consistency of access to flexible working. This includes an escalation stage for circumstances where a line manager is not initially able to agree a request.

Employers will be expected to promote flexibility options at the point of recruitment and through regular staff engagement through one-to-ones, appraisals, and team discussions. The improvements are designed to support and facilitate a cultural change to ensure flexible working is available to all NHS staff. The contractual changes came into force on 13 September 2021. A programme is also underway to support organisations understand the benefits for staff and patients of flexible working.

Enhanced parental leave

Employees with 12 months continuous service with one or more NHS employers are entitled to maternity, paternity, adoption, or shared parental leave benefits above the statutory entitlement. An NHS employee earning £33,000 would be entitled to earn enhanced parental pay of around £7,000 more than that they would be entitled to under the statutory maternity leave allowance. Please note that GAD have refined their approach to calculate maternity pay after revisiting the contract terms and the figures now represent the additional value of NHS staff entitlements in excess of statutory maternity pay (previously, they looked at the value of NHS benefits only, excluding any SMP).

This calculation is provided for illustrative purposes only and represents the additional value of NHS staff entitlement in excess of SMP. Paternal pay depends on the member's contractual entitlements and is calculated relative to the current statutory maternity pay entitlements. Details on current statutory maternity pay can be found here: https://www.gov.uk/maternity-pay-leave/pay

Flexible benefits

Other than the reward elements included in our analysis, many employers also offer a range of flexible benefits, discounts and support offered to staff that may support recruitment and retention of staff and improve employee engagement. Although the range of flexible benefits offered varies across employers, some popular flexible benefits can include salary sacrifice schemes, options to buy and sell leave and a range of discount vouchers. Employers may offer travel benefits such as season ticket loan and cycle to work scheme, as well as health and wellbeing benefits including discounted gym memberships.

Many trusts have also partnered with third party providers offering staff up to 20% discount on shopping, insurance, and travel. Staff may also be entitled to cashback on purchases at specified retailers of up to 12% using prepaid cards. Therefore, employees spending around £3,000 per year at a participating supermarket could offset spending by up to £360 (around 1% of basic pay on average). The overall value to staff can vary depending on the specific benefits options offered across employers and the level of benefits taken up but we estimate these additional flexible benefits could be valued up to 1% - 3% of basic pay on average across NHS employees.

Total reward statements

Total reward statements (TRS) are provided to NHS staff and give staff a better understanding of the benefits they have or may have access to as an NHS employee. TRS provide personalised information about the value of staff employment packages, including remuneration details and benefits provided locally by their employer.

Examples of local reward individual NHS employers may offer include recommend a friend schemes, affordable accommodation, childcare and carer support, counselling and support, various salary sacrifice schemes, retail discounts, education and learning support, financial wellbeing support, physical and mental health and wellbeing support, and signposting to pensions advice services.

Annual benefit statements

NHS Pension Scheme members also receive an annual benefit statement (ABS), which shows the current value of their Scheme benefits. On 7 December 2021, the number of statements viewed by staff was 349,349, a slight decrease from 375,457 that had been viewed at around the same point in 2020.

Since 2016, the BSA have held stakeholder engagement events across the country for a range of different NHS organisations to help employers better understand their role in promoting TRS. The workshops also explain the difference between a TRS and an ABS.

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