NHS Pay Review Body

Thirty-First Report 2018

Chair: Philippa Hird



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

Presented to the Scottish Parliament by the First Minister and the Cabinet Secretary for Health and Sport

Presented to the National Assembly for Wales by the First Minister and the Cabinet Secretary for Health and Social Services

Presented to the Permanent Secretary for the Department of Health, Northern Ireland

June 2018



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NHS Pay Review Body

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

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

the need to recruit, retain and motivate suitably able and qualified staff;

regional/local variations in labour markets and their effects on the recruitment and retention of staff:

the funds available to the Health Departments, as set out in the Government's Departmental Expenditure Limits;

the Government's inflation target;

the principle of equal pay for work of equal value in the NHS;

the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

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

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

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

Reports and recommendations should be submitted jointly to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for Health and Wellbeing in Scotland, the First Minister and the Cabinet Secretary for Health, Wellbeing and Sport of the National Assembly for Wales, and the First Minister, Deputy First Minister and Minister for Health of the Northern Ireland Executive².

Members³ of the Review Body are:

Philippa Hird (Chair)
Bronwen Curtis CBE
Patricia Gordon
Joan Ingram OBE
Professor David Ulph CBE
Professor Jonathan Wadsworth
Lorraine Zuleta

The secretariat is provided by the Office of Manpower Economics.

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

² In the absence of a First Minister, Deputy First Minister and Minister for Health of the Northern Ireland Executive, the report should be submitted to the Permanent Secretary to the Department of Health, Northern Ireland.

³ Shamaila Qureshi resigned as a member of the Review Body in February 2018.

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NHS PAY REVIEW BODY 2018 REPORT

Executive Summary

1. We report this year in the context of the most significant change to the Agenda for Change (AfC) pay structure since its introduction in 2004. This major pay development covers 1.2 million staff (FTE) across the UK and affects a pay bill of over £43 billion. The UK Government intends a substantial investment in the AfC workforce who are working hard to maintain services to patients while under pressure from changing and increasing demand. Against this background, our report considers the evidence and makes observations on the implementation and operation of the three-year AfC pay agreement.

Our overall conclusions on our standing remit and our observations on the AfC pay agreement from 2018/19 to 2020/21

- We have been struck by the high levels of consensus among external commentators and the parties on the opportunities and significant challenges facing the NHS.
- It is clear that workforce issues are of the most significant concern and of the highest priority for healthcare providers.
- The evidence suggests that pay restraint has contributed to efficiency savings within the NHS, but is not contributing to the recruitment, retention and motivation of NHS staff.
- There is a workforce gap identified in the draft Health and Social Care Workforce Strategy for England which is creating an unsustainably high level of vacancies, work pressures and potential risks to patient care. There are some plans in place, which contain significant risks, to bridge that gap by 2021 but the gap will persist to 2027 if there is no action on workforce numbers, productivity or service redesign.
- The recruitment risks to the plans are chiefly domestic routes into nursing, potential impacts of Brexit, reduced advocacy among AfC staff and medium term reward.
- The retention risks to the plans are high workload, insufficient flexible working, leadership capacity and medium term reward.
- There has been considerable effort and goodwill by the NHS Staff Council in reaching a three-year agreement on AfC pay in England.
- The agreement provides a balanced package of pay reforms that aim to address the concerns of both AfC staff and employers, and to contribute to the sustainability of the workforce. It includes enhanced starting pay, protection for the lowest paid, restructuring of pay bands and improved pay progression supported by renewed performance management.
- In agreeing the design of the new pay structure the parties have taken a planned, medium term approach to manage the transitional effects and to address the affordability of pay increases.
- Overall, we conclude that the elements of the agreement, when taken together, begin to respond to our conclusions from the evidence on recruitment, retention and motivation. We look forward to monitoring the impact of the pay agreement on bridging the workforce gap, and stress the importance of delivering wider workforce developments as part of pay reform.

- The complexity of the agreement requires effective communications with AfC staff, given that the effect on pay increases for individual AfC staff, and within each band, will vary considerably.
- Effective performance management systems, which improve organisational
 performance and working lives for staff are difficult to implement and operate.
 To ensure that the proposed system does support the delivery of better patient
 care, NHS organisations should not underestimate the substantial volume of
 work required to implement and run the new system.
- The gender pay gap for AfC staff and any effects the new pay structure may have on that gap will require monitoring. We look forward to the parties' equality impact assessment to support the agreement.
- We note that the Scottish Government announced 2018/19 pay awards for AfC staff on 9 June 2018. The AfC agreement allowed the parties in Scotland, Wales and Northern Ireland to discuss whether and how the content of the agreement could be implemented. Negotiations were underway but were not completed in time for this report and we would welcome updates on the outcomes.

Introduction and our remit

- 2. The context for this 2018 pay round has shifted somewhat since we concluded our 2017 Report. The economic environment has been relatively stable although uncertainty remains. For example, inflation increased during 2017 and in early 2018 before decreasing slightly by the time we completed this report. During this period, the UK Government changed the emphasis in its public sector pay policy, with a more flexible approach for AfC staff, subject to conditions, and this opened the opportunity for negotiations on reforms to the AfC pay structure. The reforms sought better to reflect modern working practices, service needs and fairness for employees. (Paragraphs 1.1 to 1.2)
- 3. The remit for our report was set by: (i) the Chief Secretary to the Treasury's letter enabling more flexibility in public sector pay to address areas of skill shortages in return for improvements in productivity; (ii) the 2017 Autumn Budget providing additional funding for pay awards for AfC staff if agreement could be reached about reforms to boost productivity; and (iii) the specific remit letters for England, Scotland, Wales and Northern Ireland. (Paragraphs 1.15 to 1.19)

Context

4. There is much common ground and agreement among the range of external commentators and NHS organisations on the nature of the pressures on the NHS. They suggest that, while some progress has been made, there is further to go to achieve sustained transformation of services. The financial pressures within the NHS remain. These pressures will continue to be a significant long term factor in determining the affordability of AfC pay awards and the ability of trusts and health boards to recruit, retain and motivate staff. We note the widespread recognition that the NHS workforce is essential to delivering good patient care and that workforce challenges are the number one priority. (Paragraphs 2.40 to 2.41)

The parties' evidence and our analysis

- 5. The main points from the evidence and our conclusions are:
 - Economy and labour market GDP forecast growth is at 1.5% for 2018, slowing to 1.3% in 2019, and picking up slowly by 0.1% each year after 2019. CPI inflation fell to 2.5% in March 2018. The OBR forecast CPI inflation at 2.4% in 2018 (RPI inflation at 3.7%), 1.8% in 2019 (RPI 3.0%) and 1.9% in 2020 (RPI 2.9%). We recognise the differing positions of the parties on inflation measures, and will continue to report on both CPI and RPI inflation. Average weekly earnings were 2.6% in the three months to March 2018, with the OBR forecast at 2.7% for 2018, 2.4% in 2019, and 2.3% in 2020; (Paragraphs 4.3 to 4.9)
 - Productivity in the parties' evidence the interpretations of productivity vary but often make links to outcomes for patient care. We can see significant benefit in the parties reaching consensus on the drivers, definition and measures of productivity in the NHS; (Paragraphs 4.14 to 4.17)
 - Workforce the AfC workforce increased by around 2% per year between 2015 and 2017 but more slowly in Scotland than in the other countries. There are also differences in skill mix between the four countries. We conclude, however, from the draft Health and Care Workforce Strategy for England, that there is a projected workforce gap, and our assessment of the evidence is made in the knowledge that there is a shared ambition among all the parties to bridge that gap. We welcome the Scottish National Health and Social Care Workforce Plan, and the Northern Ireland Workforce Strategy; (Paragraphs 4.24 to 4.27)
 - Supply and recruitment the draft Workforce Strategy recognises the importance
 of increasing the number of qualified people available and willing to work for the
 NHS. The planned strategic response is to increase the domestic supply through
 more clinical placements, increasing nurse associates and increasing the use of
 apprenticeships; (Paragraphs 4.36 to 4.41)
 - The removal of the bursary in England has been followed by a 20% reduction in applications to AfC-related health degrees in the UK in 2017. The number of acceptances on AfC-related health degree courses increased by 0.6% but nursing acceptances fell (by 0.9%). There may be risks over the quality of entrants if the number of applications continues to diminish; (Paragraphs 4.43 to 4.50)
 - Data from the NMC register show that the number of leavers overtook joiners in 2017, and that new joiners from the EEA fell from 9,389 in 2015/16 to 805 in 2017/18; (Paragraphs 4.52 to 4.53)
 - The NHS intends to create 100,000 more apprenticeships in England by 2020; (Paragraphs 4.61 to 4.64)
 - There have been significant efforts to reduce agency costs through more effective use of bank and substantive roles; (Paragraphs 4.65 to 4.68)
 - Vacancies there is general agreement among the parties on the high and increasing levels of vacancies across the NHS, with a view that there are currently 36,000 nursing vacancies in England and a consistently high rate since 2015.
 Vacancy rates vary around the countries of the UK; (Paragraphs 4.69 to 4.77)
 - Retention given the high level of vacancies, the costly option of agency staff and the lag in supply initiatives taking hold, retaining existing AfC staff is a key element in bridging the workforce gap. The parties agree that the retention rate for some groups of clinical staff has declined in recent years. The DHSC's stability index suggested a slight worsening in retaining the workforce across most groups in the five years to 2016/17. There has been a rise in voluntary resignations as a proportion of leavers from 44.7% to 63% in the five years to 2016/17, and a gradual increase in the rate of nurses leaving to 8.7% in 2016/17. We welcome the major retention initiatives being run through NHS Improvement; (Paragraphs 4.78 to 4.87)

- Motivation and engagement there is broad consensus among the parties and external commentators that staff who are more engaged will be more effective in delivering good patient care. The 2017 NHS Staff Survey in England showed the Engagement Index for AfC staff fell slightly after a number of years of increase, job satisfaction was generally stable, and satisfaction with pay fell sharply by 5.8 percentage points to 29.4%. 63% of staff would recommend their organisation as a place to work (NHS Friends and Family Test) and there was a fall to 39% of NHS nursing staff recommending nursing as a career (RCN survey). The first year of new survey arrangements in Scotland suggested an Engagement Index of 75%; (Paragraphs 4.88 to 4.107)
- Earnings in 2017 all AfC groups, except ambulance staff, saw an increase in average total earnings ranging from 0.4% to 2.0%. When adjusted for wider changes in the economy, nurses have seen a slight reduction in their earnings relative to the economy. The DHSC concluded that mean annual earnings growth for NHS staff had been lower than comparators across the wider economy in the last five years. Our analysis showed that graduate pay for AfC-related health degrees compares well relative to other graduates on entry, but less so after the five-year point. There are risks to AfC recruitment and retention should the differential with the National Living Wage erode. (Paragraphs 4.108 to 4.130)
- 6. We draw on the parties' evidence and our analysis in framing our overall conclusions on the factors influencing AfC pay (Paragraphs 4.131 to 4.141). Pay restraint has made a significant contribution to efficiency savings within the NHS. Pay is one measure of the way in which staff are valued, and we have seen in the evidence that pay restraint is not contributing to supporting the recruitment, retention and motivation of AfC staff at a time when these are huge priorities for the NHS.
- 7. Inflation increased in 2017 before falling back slightly in early 2018. We recognise that the level of inflation is an important consideration to AfC staff. Our broad conclusion on the overall position of AfC pay relative to the UK market is that it has declined slightly in recent years and this is acknowledged by the DHSC's analysis. It is clear from the NHS Staff Survey, individual trades unions' surveys and our visits that existing levels of pay do not help AfC staff feel valued. Pay could become an increasing concern when viewed alongside the significant workforce gap, high levels of vacancies, decreasing retention rates and reducing levels of advocacy by staff. We note that the NHS as a whole and individual countries have made efforts to ensure that the lowest paid AfC staff are paid above the National Living Wage (and equivalents).
- 8. Looking forward, there are risks to the AfC workforce from developments in the wider labour market. There has been a slight upward rise in average earnings and a pick up in pay settlements early in 2018. AfC staff are paid well relative to other graduates entering the market, but less so after five years in the NHS. We observe that modern employers focus on Total Reward, which includes pay, benefits and the whole working experience, to ensure that they can recruit, retain and motivate staff. Pensions form a valuable component of the Total Reward package for AfC staff as does flexible working. NHS organisations need to promote the attractiveness of the employment offer in the NHS, particularly to remain competitive in the eyes of the next generation of entrants.

- 9. Pay will have a role to play but it is important that it is part of wider workforce developments. We have identified in this report a series of warning signs across the countries of the UK that point to a gap between the number of qualified people available and willing to work in the NHS, and the work that needs to be done. There are risks for the supply and recruitment of AfC staff, and these issues require long lead times to solve. There is a workforce gap identified in the draft Workforce Strategy for England which is creating an unsustainably high level of vacancies, work pressures and potential risks to patient care. There are some plans in place, which contain significant risks, to bridge that gap by 2021, but the gap will persist to 2027 if there is no action on workforce numbers, productivity or service redesign. The draft Workforce Strategy is welcome, but we are concerned about clear ownership and accountability to deliver the actions to address workforce challenges.
- 10. The workforce gap underpins high levels of vacancies in the NHS across the UK. These vacancies have consequences for the workload, hours and goodwill of existing AfC staff. We emphasise the importance of ensuring effective retention of existing staff. Although there does not appear to be a single cause, a consistently reported reason for leaving the NHS appears to be work-life balance which may underpin a requirement for further development of flexible working arrangements. We also conclude, as other parties do, that the effective engagement of all AfC staff in the NHS will support efficient and effective delivery of good patient care. This widespread acknowledgement needs to be acted upon by employers to ensure their workforce is well-managed and rewarded.

Framework agreement on the reform of AfC 2018/19 to 2020/2021

- 11. The Health Secretary's remit letter said that the Autumn 2017 Budget provided additional funding for pay awards for AfC staff, provided they were part of an agreement with AfC trades unions about reforms to boost productivity. The Health Secretary expected our deliberations to be informed by the outcome of negotiations. (Paragraph 5.1)
- 12. On 21 March 2018, the NHS Staff Council reached a framework agreement on the proposed reform of the AfC pay structure for England. Following consultation, on 8 June 2018 the majority of NHS trades unions announced that they had accepted the proposed pay deal for England. The Staff Side chair and Employer chair of the NHS Staff Council wrote to us on 11 June 2018 informing us that NHS staff had voted overwhelmingly in favour of the agreement and that it would then be ratified by the NHS Staff Council. The three-year agreement includes: (Paragraphs 5.16 to 5.21)
 - a 6.5% cumulative increase over the three-year period to the value of the top point of each pay band for Bands 2 to 8c;
 - variable increases for other AfC staff between 9% and 29% over the three years would be delivered through pay progression, changes to starting salaries and/or restructuring pay bands;
 - an increase to starting salaries by removing overlaps between pay bands;
 - a new minimum basic pay rate of £17,460 from April 2018;
 - pay band restructuring to reduce the number of pay points by 2021;
 - a new NHS Staff Council progression framework from April 2019;
 - improved levels of attendance through a focus on staff health and wellbeing at national and local level; and
 - consistency of terms and conditions, and adjustments to payment schemes for unsocial hours.

- 13. We note that the UK Government has adopted a more flexible approach to public sector pay. We welcome the parties' significant progress in reaching an agreement. We look forward to monitoring the impact of the pay agreement on bridging the workforce gap, and we stress the importance of delivering wider workforce developments as an integral part of pay reform. The parties have taken a planned, medium term approach to manage the transition from the existing AfC pay structure over three years and to address affordability. Overall, we conclude that the elements of the agreement begin to respond to our conclusions from the evidence on recruitment, retention and motivation. (Paragraphs 5.22 to 5.33)
- 14. Our specific observations on the agreement are as follows:
 - the additional funding should ensure that the pay costs arising from the agreement are affordable for NHS organisations. A separate funding mechanism would ensure the additional funding reaches employing organisations. We also expect to hear about the way in which the Devolved Administrations are managing the funding from the Barnett consequentials; (Paragraphs 5.34 to 5.36)
 - the complexity of the agreement requires effective communications with AfC staff, and we acknowledge the extensive material already made available by the parties. As a result of the agreement and workforce change, the DHSC estimates the AfC pay bill per FTE in England will increase by about 3% each year between 2018/19 and 2020/21. The effect on pay increases for individual AfC staff and within pay bands will vary considerably, and these effects were important considerations to the parties in designing and agreeing the reforms; (Paragraphs 5.37 to 5.39)
 - new pay arrangements will need to be monitored against the recruitment and retention factors identified in this report, including in the context of Total Reward; (Paragraphs 5.40 to 5.46)
 - the reforms to pay bands require effective implementation to avoid the risk of wide variations in their operation. We recognise the importance of ensuring that the minimum rate of AfC pay is set to stay ahead of statutory requirements and to remain competitive in the labour market. This covers a significant proportion of AfC staff, and we expect the parties to keep AfC pay rates under review. Bands 3 and 4 might require attention as they will cover new roles. In Bands 5 to 7 more emphasis will be needed on existing staff being engaged, motivated and retained. There will be differential effects for Bands 8a and above. Shorter pay bands with larger pay increases will place greater emphasis on the performance review process and on the standards required for progression. Quicker pay progression will lead to larger proportions of staff at the top of pay bands for a longer part of their career. This could require career development incentives; (Paragraphs 5.47 to 5.56)
 - implementation will require effective staff involvement. The agreement aims to increase staff engagement by putting appraisal and personal development at the heart of pay progression. There are revised performance management arrangements and the NHS Staff Council is working with NHS Improvement on implementation and monitoring. We note that implementing and operating effective performance management systems is difficult. All staff should receive well-structured appraisals which can contribute to improved organisational performance and working lives for staff. To ensure that the proposed system does support the delivery of better patient care, NHS organisations should not underestimate the substantial volume of work required to implement and run the new system. New pay rates will impact on AfC staff through their basic pay, earnings and take-home pay. The effects and unintended consequences in relation to pension, tax and National Insurance thresholds will need to be examined; (Paragraphs 5.59 to 5.67)

- On 9 June 2018, the Scottish Government announced that for 2018/19 AfC staff currently earning up to £80,000 would receive at least a 3% uplift, those earning £80,000 and over would receive a flat rate increase of £1,600, and the bottom pay points for Bands 1 and 2 would be increased to £17,110 to fulfil the obligation to pay the Scottish Living Wage. The Scottish Government also stated that this uplift was a payment on account of progress made in the negotiations so far and that the negotiations would continue towards a three-year pay deal; (Paragraph 5.74)
- The AfC agreement allowed the parties in Scotland, Wales and Northern Ireland to discuss whether and the way in which the content of the agreement could be implemented. We understand from the Devolved Administrations that negotiations are underway but would not be completed in time for this report. We support these negotiations and we draw the parties' attention to our observations. We would welcome updates on progress and outcomes when available. (Paragraph 5.76)
- 15. The agreement sets out our role during the period of the agreement including retaining our standing remit, and monitoring the progress of implementation and impact of the agreement. We look forward to working with the parties on measures for effective monitoring. In the meantime, we set out some considerations on the strategy and implementation, and the data requirements. (Paragraphs 5.77 to 5.80)

Philippa Hird (Chair)
Bronwen Curtis
Patricia Gordon
Joan Ingram
David Ulph
Jonathan Wadsworth
Lorraine Zuleta

13 June 2018

Chapter 1 – Introduction

Introduction

- 1.1 The context for this 2018 pay round has shifted somewhat since we concluded our last report in early 2017. The UK Government changed the emphasis in its public sector pay policy, with a more flexible approach for Agenda for Change (AfC) staff, subject to conditions. The economic environment has been relatively stable although uncertainty remains. For example, inflation increased during 2017 and in early 2018, before decreasing slightly by the time we completed this report.
- 1.2 The UK Government's pay policy opened the opportunity for NHS Employers and the relevant trades unions to negotiate reforms to the AfC pay structure. The pay reforms sought better to reflect modern working practices, service needs and fairness for employees. These pay reforms have been negotiated while the NHS continues to face financial pressures, and major challenges in meeting demand and achieving transformation. This is at a time when the pressurised AfC workforce has become a greater priority for NHS organisations with a clear recognition of a workforce gap.
- 1.3 All these changes will have implications for the longer term and we aim in this report to take a perspective on pay for AfC staff which properly takes them into account. Our terms of reference require us to consider the overall strategy that the NHS should place patients at the heart of all it does. We therefore seek to understand the way in which pay contributes to sustainability in the NHS and good patient care. We set out the remits for 2018/19 below, and then provide a brief overview of the context in Chapter 2 and summaries of the parties' evidence in Chapter 3, before analysing the main themes in Chapter 4 and concluding with our observations in Chapter 5 on the AfC pay agreement in England.

The context for the 2018/19 pay round

- 1.4 Our 2017 Report was submitted to the Prime Minister, the Secretary of State for Health and relevant Ministers in Wales and Northern Ireland on 16 February 2017. We also submitted the 2017 Report Scotland Supplement to the First Minister of the Scottish Government and the Cabinet Secretary for Health and Sport on 21 March 2017. Our 2017 recommendations for a 1% increase to all AfC pay points (and to High Cost Area Supplements minima and maxima) were accepted by the UK Government, the Welsh Government and, in the absence of a Northern Ireland Executive, the Permanent Secretary of the Department of Health, Northern Ireland. The Scottish Government also accepted our recommendations and, in addition, uplifted the salary of all staff earning below £22,000 by at least £400 in accordance with the Scottish Government's public sector pay policy.
- 1.5 In our 2017 Report, we emphasised that the UK Government's public sector pay policy, at that time, was coming under significant stress. We were concerned about the sustainability of the pay policy over the next few years as inflation was already higher than previously expected, and vacancy levels were causing concern. Since our 2017 Report, economic growth has been slow and productivity has been flat, and inflation has risen during 2017 and early 2018. Pay settlements and earnings growth started to pick up in early 2018. The NHS trades unions emphasised the effects of sustained pay restraint and rising inflation. We have seen gaps in the AfC workforce, with a mismatch between the numbers entering the workforce and the numbers of staff needed to deliver services to patients.

- 1.6 In early autumn 2017, the Chief Secretary to the Treasury (CST) announced more flexibility in public sector pay to address areas of skill shortages, in return for improvements in public sector productivity. The 2017 Autumn Budget provided additional funding for pay awards for AfC staff if agreement could be reached on reforms to boost productivity. In December 2017, our specific remits were covered in the letters for England, Wales and Northern Ireland. The remit letter from the Scottish Government outlined its one-year public sector pay policy for 2018/19 in February 2018. These remits are set out in more detail below.
- 1.7 Our pay round and the parties' evidence were therefore conditioned by the parties' negotiations on reaching an agreement on a reformed AfC pay structure in England. This was followed by negotiations in each of the Devolved Administrations in parallel with our considerations, which were not concluded in time for this report. The parties kept us informed of progress and the outcome for England, on which we comment in Chapter 5.
- 1.8 While there has been a focus on the AfC pay agreement, we have continued to assess the overall position for the AfC workforce against the wider context for the NHS. Despite efforts to manage demand under the NHS Five Year Forward View, there are continuing long term pressures from increasing volume and complexity of demand, which require the NHS to transform models of care while continuing to deliver increased activity. The financial challenges in the NHS remain and, as a significant proportion of NHS expenditure is on staff, there are ongoing implications for the affordability of pay awards. This supports the need for productivity gains and efficiency improvements.
- 1.9 It is clear that the NHS needs to ensure that there is a better balance between the number of qualified people available and willing to work in the NHS, and the work that needs to be done to deliver patient care. External commentators and NHS organisations now recognise that a fully recruited, trained and retained workforce is a priority and there are welcome developments, including Health Education England's draft Health and Social Care Workforce Strategy.
- 1.10 There are a series of pressures on the NHS workforce. This was the first year following the withdrawal of bursaries for students in AfC professional groups in England. It was also a year in which growth in the AfC workforce slowed and there was a high volume of vacancies, with particular concerns emerging for nursing staff and some other AfC groups. Behind these developments are the challenges of Brexit, the implications of which, particularly for the NHS workforce, have yet to be fully worked out, either nationally or for the UK's health care sector.
- 1.11 In this report, we continue to assess trends in the economy and labour market, earnings, supply and recruitment, retention, and motivation and engagement. These are the cornerstones of our independent consideration of evidence against our standing terms of reference. In the context of the AfC pay agreement, we will continue to monitor these trends in the coming years to establish a firm baseline for future pay rounds, particularly when emerging from the three-year pay agreement.

The 2018/19 remits

1.12 Our 2018 pay round was delayed by the UK Government's decision to move to an Autumn Budget. While the CST announced the UK Government's revised public sector pay policy in September 2017, the Budget in November 2017 delayed the issuing of our remit letters and submission of evidence until December 2017 and January 2018. The Scottish Government's December 2017 Budget announced its public sector pay policy, followed by a remit letter and evidence submission in February 2018. This year, we were unable to report until June 2018.

- 1.13 Our reports would usually be submitted in February each year to allow the Governments' consideration of our recommendations in time for implementation at the April pay settlement date. We would welcome clarification from the Governments of the timing for future pay rounds to ensure any pay awards can be implemented for AfC staff in a timely manner.
- 1.14 For 2018/19, we received remits from the UK Government, the Scottish Government, the Welsh Government⁴, and the Department of Health, Northern Ireland.

Chief Secretary to the Treasury's letter

1.15 The Chief Secretary to the Treasury wrote to us on 21 September 2017 setting out the overarching approach to the 2018/19 pay round. The CST reiterated that the previous Spending Review had budgeted for a 1% average increase in basic pay and progression awards for specific workforces, and that there was a continuing need for pay discipline in the coming years to ensure the affordability of public services. The CST said that the UK Government recognised that in some parts of the public sector, particularly in areas of skill shortages, more flexibility might be required to deliver world class public services including in return for productivity improvements.

Secretary of State for Health's remit letter

1.16 Following the 2017 Autumn Budget, the Secretary of State for Health wrote to us on 7 December 2017 clarifying the Chancellor's commitment to provide additional funding for AfC pay awards, provided that the awards were part of an agreement with AfC trades unions about reforms to boost productivity. These negotiations were to seek an agreement on a multi-year pay deal. The Health Secretary confirmed that the negotiations should not pre-judge our independent role in recommending on the level of pay award and expected our recommendations to be informed by the outcome of talks with the AfC trades unions.

Scottish Government

- 1.17 The Cabinet Secretary for Health and Sport wrote to us on 7 February 2018 outlining the Scottish Government's revised public sector pay policy for 2018/19, as announced in the December 2017 Budget. The Cabinet Secretary said that consideration of staff pay must be informed by this policy framework although, beyond the elements of the policy, we were invited to be as free as possible in considering issues and making recommendations for Scotland. The main features of the pay policy were:
 - lifting the pay cap by providing a guaranteed minimum increase of 3% for public sector workers who earn £36,500 or less;
 - a limit of up to 2% on the increase in baseline pay bill for those earning above £36,500 and below £80,000;
 - limiting the maximum pay increase for those earning £80,000 or more to £1,600; and
 - continuation of the policy commitment to No Compulsory Redundancy.

References to the Scottish and Welsh Government in this report should be read as references to the Health Departments in the respective countries.

Welsh Government

1.18 The Cabinet Secretary for Health and Social Services wrote to us on 21 December 2017 asking us to consider evidence and make recommendations on: (i) what would be a fair pay award for NHS Staff in Wales; and (ii) taking into account our recommendations on a fair pay award and the very challenging financial circumstances of the Welsh Government, what level of pay award could be afforded by the NHS in Wales in the absence of further funding from the UK Treasury. The Cabinet Secretary also cited the benefits in the degree of mobility in pay across the UK being underpinned by a common core of contractual arrangements.

Northern Ireland

1.19 In the absence of a Northern Ireland Executive, the Permanent Secretary to the Department of Health, Northern Ireland, wrote to us on 18 December 2017 to assist us in the task of providing recommendations for Northern Ireland for 2018/19. The Permanent Secretary confirmed that the Department of Finance had agreed that the public sector pay policy set by the previous Finance Minister would continue to apply in 2017/18. This allowed the Department of Health to implement the 1% pay award for health and social care workers.

Visits and evidence submissions

1.20 Our independent process is underpinned by visits to NHS organisations, the submission of written and oral evidence by the parties, and our own analysis of other sources of pay and workforce information. Our activity to support this report is described below.

Our visits

- 1.21 We are grateful to the following trusts and boards that hosted our visits between May and July 2017:
 - South Central Ambulance Service NHS Foundation Trust;
 - Salford Royal NHS Foundation Trust;
 - South Eastern Health and Social Care Trust, Northern Ireland;
 - Derby Teaching Hospitals NHS Foundation Trust;
 - Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust;
 - West Hertfordshire Hospitals NHS Foundation Trust;
 - Cardiff and Vale University Health Board, Wales; and
 - NHS Borders, Scotland.

Parties submitting evidence

1.22 The parties listed below submitted written evidence in December 2017 and February 2018, which was followed by oral evidence with specific organisations between February and April 2018 (copies of written evidence are on the parties' websites – see Appendix D).

Government departments and NHS organisations

- The Department of Health and Social Care for England
- Health Education England
- NHS England
- NHS Improvement
- The Scottish Government
- The Welsh Government
- The Department of Health, Northern Ireland

Employers' bodies

- NHS Employers
- NHS Providers

Bodies representing NHS Staff

- The loint Staff Side
- The Royal College of Midwives
- The Royal College of Nursing
- UNISON
- The Chartered Society of Physiotherapy
- The Society of Radiographers
- Unite
- The GMB

Our sources of evidence and information

- 1.23 Our considerations in this report have also been informed by extensive published data and other available information on healthcare and the wider pay environment. For 2018/19, these were:
 - reports, analysis and commentary on demand in the NHS, financial pressures, sustainability and transformation, and the NHS workforce, by external commentators, Parliamentary Committees and NHS organisations;
 - our analysis of trends in the AfC workforce;
 - our analysis of trends in AfC basic pay and total earnings, take-home pay, pay comparisons (including the graduate labour market and their earnings), the National Minimum Wage and the National Living Wage, and Total Reward;
 - our analysis of data from NHS and individual trades unions' surveys;
 - our regular assessments of the economic and labour market context including indicators of and forecasts for economic growth, inflation, average earnings growth, public-private sector pay differentials, and employment; and
 - independent research commissioned by the Office of Manpower Economics during 2017, for instance on the use and effectiveness of market pay supplements, valuing different workplace rewards, and wage growth in pay review body occupations.
- 1.24 We will continue to draw on all these sources of evidence in our role to monitor the implementation and impact of the AfC pay agreement from 2019 onwards.

Chapter 2 – Context

Introduction

2.1 In this chapter, we aim to assess the context across the UK by drawing on the regular reports from external commentators and NHS organisations on the pressures on the NHS from demand for services, the need for transformation of services and the financial challenge. This background information is in addition to the parties' evidence submitted to us, and includes publications by some of our usual evidence providers. It helps to inform our considerations of the parties' evidence, our analysis and the AfC pay agreement in later chapters of this report.

The NHS Five Year Forward View

- 2.2 The NHS Five Year Forward View⁵ (in England) is often referred to by external commentators in assessing pressures in the NHS. In summary it set out the following plans in 2014:
 - a radical upgrade in prevention and public health;
 - patients gaining greater control of their own care;
 - the NHS taking decisive steps to break down the barriers in how care is provided;
 - different local health communities supported by NHS national leadership to choose from a small number of radical new care delivery options;
 - options for integrated services;
 - more investment in primary care with GP-led Clinical Commissioning Groups (CCG) having the option of more control over the wider NHS budget;
 - national leadership acting coherently and providing meaningful local flexibility in payment rules, regulatory requirements and other mechanisms; and
 - action on demand, efficiency and funding to address the mismatch between resources and patient needs of £30 million a year by 2020/21.
- 2.3 We note that external commentators and NHS organisations are supportive of the aims of the Five Year Forward View but regularly comment on the difficulty in achieving progress.

Demand for NHS services

2.4 The increased demand placed on the NHS is widely acknowledged. In this section we summarise information and commentary on the demand for services and on the NHS performance data available at the time of this report.

Department of Health (October 2014), NHS Five Year Forward View. Available at: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

- 2.5 In October 2017, the Care Quality Commission (CQC) reported on the state of care⁶ drawing on its inspections of adult social care, NHS providers and GP practices. The CQC commented that demand in England continued to rise from increasing numbers of people with complex, chronic or multiple conditions (including diabetes, cancer and heart disease) and an ageing population. For hospitals in the five years to 2017, there had been substantial rises in total attendance at A&E, in emergency admissions via A&E and in elective admissions. Bed occupancy remained above the recommended practice maximum of 85%, at the highest recorded average of 91.4% in March 2017. Ambulance calls had increased by 20% between 2011/12 and 2016/17. Bed occupancy in mental health wards remained high, with detentions under the Mental Health Act rising by 20% in the previous two years. The CQC considered that delivering adult social care had become more challenging, with people aged 85 or over set to double over the next two decades, and a growing unmet care need. The CQC commented that all health and social care staff were under huge pressure through greater demand, unfilled vacancies, fewer available hospital beds, and longer waiting times for treatment. The CQC described the overall picture on the state of care as precarious, with the whole health and care system at full stretch.
- 2.6 Overall, the CQC found that the quality of care across England was "mostly good". From the CQC's inspection and ratings programme, 6% of NHS acute hospital and mental health core services were rated as "outstanding", whereas 3% were rated as "inadequate", and 37% of NHS acute core services and 24% of mental health core services rated as "requires improvement". The CQC reported that, where it had re-inspected services, common factors contributing to improvement included: strong leadership (visible and approachable); a positive culture (engaging and empowering staff); a shared vision (among stakeholders); and an outward looking approach (reaching out to local communities and partners).
- 2.7 The CQC commented that all health and care sectors were facing great challenges in recruiting and retaining staff, with different services competing in the same pool of skilled and qualified staff. The CQC cited Skills for Care estimates of 90,000 vacancies across all roles, and that vacancy rates in adult social care had stabilised but remained high. It added that NHS Jobs vacancy data showed that all NHS vacancies had increased by 16% between March 2015 and March 2017, and that in the same period nursing and midwifery vacancies rose by 22%. The CQC commented that the Brexit effect was unclear.
- 2.8 NHS Improvement provide analyses of performance in the provider sector⁷. At December 2017, it noted that, although record demand for services and variation in performance across the sector had led to a decline in the sector's finances, providers had kept A&E performance steady at a national level compared to the previous year, and appeared to have stopped the year-on-year decline in performance seen during recent years. NHS Improvement added, however, that A&E performance remained significantly below NHS Constitution standards, and that demand for emergency care and high levels of bed occupancy had impacted on providers' ability to perform elective work. It also pointed to overall bed occupancy being affected by delays in transfers of care to other settings, including social care, but that, overall, providers had made progress in reducing delayed discharges.

⁶ Care Quality Commission (October 2017), *The State of Health Care and Adult Social Care in England 2016/17*. Available at: http://www.cqc.org.uk/publications/major-report/state-care

NHS Improvement, Performance of the NHS Provider sector for the month ended 31 December 2017. Available at: https://improvement.nhs.uk/documents/2471/Performance_of_the_NHS_provider_sector_for_the_month_ended_31_December.pdf

- 2.9 In its March 2018 analysis⁸, the Kings Fund commented that emergency admissions to the NHS jumped by 6.8% in January 2018 compared to January 2017. It said that maintaining performance not far off winter 2016/17 levels in the face of this demand was testament to planning and to the hard work of NHS staff.
- 2.10 In Scotland, demand for services was assessed as part of Audit Scotland's 2016/17 annual review of the NHS⁹. It concluded that the challenges facing the NHS continued to intensify increasing costs, growing demand and continuing pressures on public finances. Audit Scotland said that more people were waiting longer to be seen a 15% increase in those waiting for a first outpatient appointment and a 99% increase in those waiting over 12 weeks. Emergency admissions had increased by 3.5% over the five years to 2015/16. It commented that NHS staff had helped maintain and improve the quality of NHS care but it was recognised that maintaining quality was becoming increasingly difficult. Audit Scotland argued that the way healthcare was planned, managed and delivered must change. It cited the major change of the integration of health and social care, with some positive signs in reducing delayed discharges.

NHS service transformation

- 2.11 The focus for service transformation in the NHS is the Sustainability and Transformation Partnerships (STP) supported by the Sustainability and Transformation Fund (STF). In its 2017 report¹⁰, the Lords Select Committee said that, at that stage, it would be premature to make a judgement about the current effectiveness of STP. It advocated integrated health and social care, with greater emphasis on primary and community services as presenting the best model for delivering patient-centred, seamless care.
- 2.12 More recently, in January 2018, the National Audit Office¹¹ (NAO) reported on sustainability and transformation in the NHS. The NAO said that progress had been made in setting up 44 new partnership arrangements which laid the foundations for a more strategic approach to meeting demand. Partnerships' effectiveness had varied, and their tight financial positions made it difficult for them to shift focus from short term day-to-day pressures to delivering transformation of services. The NAO commented that the STF had helped the NHS improve its financial position from a £1,848 million deficit in 2015/16 to a £111 million surplus in 2016/17. However, the NAO said that the overall surplus in 2016/17 was achieved by a series of measures to rebalance NHS finances, some of which had restricted the money available for longer term transformation. Investment for transformation was more focused on those partnerships that were the most advanced, which risked those that were relatively under-developed or complex being left further behind. The NAO made recommendations which included further and faster progress towards aligning nationwide incentives, regulation, and processes.

The Kings Fund (March 2018), How is the NHS Performing? Available at: https://www.kingsfund.org.uk/publications/how-nhs-performing-march-2018

⁹ Audit Scotland (October 2017), 2016/17 Annual Review of the NHS. Available at: http://www.audit-scotland.gov.uk/report/nhs-in-scotland-2017

¹⁰ Lords Select Committee (April 2017), Long-Term Sustainability of the NHS and Adult Social Care. Available at: https://publications.parliament.uk/pa/ld201617/ldselect/ldnhssus/151/151.pdf

National Audit Office (January 2018), Sustainability and Transformation in the NHS. Available at: https://www.nao.org.uk/wp-content/uploads/2018/01/Sustainability-and-transformation-in-the-NHS.pdf

- 2.13 In March 2018, the House of Commons Public Accounts Committee¹² also concluded that the Department of Health and Social Care's (DHSC) system for funding and financially supporting the NHS focused too much on short term survival, and limited the NHS's ability to transform services to achieve sustainability in the long term. The Committee said that the financial pressures facing NHS providers had led to the DHSC using money to prop up services but not to transform them to provide better care. It commented that the DHSC had focused funding on sustainability not transformation, despite its commitment to transforming care delivery models to deliver savings by integrating care.
- 2.14 In autumn 2017, the Institute for Government provided a picture of the performance of government in running public services¹³. It observed that successive governments had relied on a combination of efficiency savings and pay restraint to manage spending and, where this had proven insufficient, the scope of services had narrowed or quality had fallen. The Government's failure to make successful transformative changes had left it trapped in a reactive cycle. On health, the Institute commented that the Government had little choice but to put in more money, and that the Government would need to make good on the transformative promises of STPs if it wanted to break out of the deficit spending cycle. As with other commentators, and among other things, the Institute highlighted that spending on hospitals had increased in real terms, but the 2015 Spending Review front-loaded funding so that future growth between 2016/17 and 2020/21 would be low by historic standards. It added that spending had outpaced funding in acute settings, with the STF reducing provider deficit by a third.
- 2.15 On transformation in the NHS in Scotland, Audit Scotland's 2016/17 annual review made a series of recommendations to the Scottish Government focusing on: delivery of the 2020 Vision and changing the way healthcare services were provided; improving governance, accountability and transparency; and promoting the culture change necessary to move to new ways of providing and accessing healthcare. Specifically, Audit Scotland recommended developing a longer term approach to financial planning to allow NHS Boards and integration authorities flexibility in planning and developing more community-based services. It also recommended continuing to develop a comprehensive approach to workforce planning that reflected forecasts of future staffing and skills requirements, and provided a clear breakdown of transitional and future costs to meet projected demand through additional recruitment and training.

¹² House of Commons Committee of Public Accounts (March 2018), Sustainability and Transformation in the NHS. Available at: https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/793/793.pdf

¹³ Institute for Government (October 2017), Performance Tracker: Autumn 2017. Available at: https://www.instituteforgovernment.org.uk/publications/performance-tracker-autumn-2017

2.16 In Wales, a Parliamentary Review into the long term future of Health and Social Care has been established, and reported in January 2018¹⁴. The Review reported that the vision was to revolutionise care so that it: empowered individuals to take decisions; tailored care to the individual's expressed needs and preferences; was far more proactive and preventative; was provided as close as possible to people's homes; was seamless; and was of the highest quality. It recommended four mutually supportive goals (the Quadruple Aim) to: improve population health and wellbeing through a focus on prevention; improve the experience and quality of care for individuals and families; enrich the wellbeing, capability and engagement of the health and social care workforce; and increase the value achieved from funding of health and care through improvement, innovation, use of best practice, and eliminating waste. A specific high-level recommendation from the Review was to make Wales "a great place to work" and the urgent alignment of the workforce with new service models, with staff well trained, supported and engaged to deliver and continually improve a quality service consistent with the vision.

The financial challenge in the NHS

- 2.17 The affordability of pay awards is a significant feature of our considerations under our terms of reference. The pressure on public finances has also shaped the UK Government's public sector pay policy in recent years. While the UK Government's pay policy has introduced some flexibility from 2018/19, and additional funding is to be made available for the AfC pay agreement (see Chapter 5), we continue to assess the financial challenge in the NHS.
- 2.18 NHS Improvement's performance assessment¹⁵ noted that the additional funding for the NHS over the 2017/18 winter had helped offset some of the costs already incurred by providers. Operational pressures had had a material impact on NHS finances, and NHS Improvement said that at Quarter 3 2017/18 providers reported a deficit of £1,281 million, £365 million above the ambitious plan set for this point in the year. This was attributable to a combination of factors, including overspends on employee costs (of £701 million) and non-pay costs (of £292 million). NHS Improvement said that the increase for non-pay expenditure was expected to be just 1% higher than the levels seen in 2016/17 by the end of 2017/18.
- 2.19 NHS Improvement said that at the start of 2017/18 providers planned a reduction in the pay bill (the single biggest area of expenditure) driven by a planned reduction in temporary staffing and workforce productivity measures. However, by Quarter 3 2017/18, total employee costs were overspent by 1.83% against the plan, including overspends on nursing staff costs and bank costs. NHS Improvement observed that the overspend reflected the significant pressure caused by increased demand, vacancies and staff sickness/absence. It noted that, while the use of bank staff was £664 million above plan at Quarter 3 2017/18, agency costs had continued to decrease significantly following its initiatives, and action taken by providers.

¹⁴ The Parliamentary Review of Health and Social Care in Wales (January 2018), *A Revolution for Within: Transforming Health and Care in Wales*. Available at: https://beta.gov.wales/sites/default/files/publications/2018-01/Review-health-social-care-report-final.pdf

NHS Improvement, Performance of the NHS Provider sector for the month ended 31 December 2017. Available at: https://improvement.nhs.uk/documents/2471/Performance_of_the_NHS_provider_sector_for_the_month_ended_31_December.pdf

- 2.20 On efficiency savings, NHS Improvement confirmed that providers set out plans to deliver a total of £3.7 billion savings in 2017/18 and that the sector had outperformed the wider economy by delivering an implied 1.8% productivity improvement. NHS Improvement reported cost improvements of 3.3%, equivalent to £2,139 million of improvements in the first nine months of 2017/18, £97 million higher than the same period in 2016/17. Despite the achievements of providers, NHS Improvement said that there was a shortfall of £329 million against the ambitious level of cost improvements planned to date with some of the under-performance attributed to operational issues.
- 2.21 The Nuffield Trust¹⁶ responded to NHS Improvement's performance figures. The Trust said that, as it predicted at the start of the year, reported deficits were set to be in the region of £1 billion for 2017/18. It considered that even this figure disguised a real underlying deficit of close to £4 billion which would roll on from year to year, after one-off sources of money were taken out. The Nuffield Trust said that the savings being demanded were just not realistic, and that NHS trusts had been asked to save 4% of their costs for the seventh year running.
- 2.22 The Kings Fund's assessment of March 2018¹⁷ concluded that the funding outlook for 2018/19 was a repeat of recent years low growth, insufficient to keep pace with demand, and insufficient to provide headroom for rapid transformation. Additional funding from the 2017 Budget helped offset some of the costs of winter already incurred by providers. The Kings Fund said that some of the funding was used to reduce overspends already incurred rather than to buy extra capacity. It reported a significant jump in the proportion of CCGs (more than one-third) forecasting an end-of-year deficit, and that half of NHS trust finance directors were forecasting a deficit, broadly the same proportion at the same time the previous year. The Kings Fund said that NHS provider deficits were forecast to reach £931 million which meant that the gap that the DHSC must cover was growing, and might explain HM Treasury's "late-in-the-day" top-ups. However, at least for the near future, the Kings Fund concluded that without some better news on finance and workforce, it was likely that finance directors' pessimism would continue to be well-founded.
- 2.23 NHS Providers¹⁸ reported that they were on course to realise more than £3 billion in savings. However, they said that the forecast provider sector deficit was at least £930 million, over £750 million more than planned, taking account of the 2017 Budget's extra winter funding. In contrast to NHS Improvement's view, NHS Providers commented that, far from recovering, A&E performance had dropped to the worst levels ever recorded, and waits for routine surgery had significantly increased. There were similar pressures in the community, mental health and ambulance sectors. NHS Providers concluded that, next year, patients' experience of care was likely to continue to fall below the standards that trusts and the NHS Constitution considered acceptable, and that the size of the task would add a significant extra burden onto an already hard-pressed workforce.

Nuffield Trust – Press Release 21 February 2018. Available at: https://www.nuffieldtrust.org.uk/news-item/nuffield-trust-response-to-nhsi-figures

¹⁷ The Kings Fund (March 2018), *How is the NHS Performing?* Available at: https://www.kingsfund.org.uk/publications/how-nhs-performing-march-2018

¹⁸ NHS Providers (March 2018), *Tough Task*. Available at: http://nhsproviders.org/news-blogs/news/a-tough-task-ahead-for-the-nhs-in-201819

2.24 The Secretary of State for Northern Ireland announced on 8 March 2018¹⁹ that, in the absence of local Ministers, and given the proximity of the next financial year, it would not be appropriate for the UK Government to take fundamental decisions about service delivery and transformation. However, the Secretary of State commented that the UK Government must act to secure public services and enable Northern Ireland departments to meet urgent pressures in health and education. The Secretary of State said that the settlement also delivered £410 million in financial support arising from the financial annex to the Confidence and Supply Agreement between the Conservative Party and the Democratic Unionist Party. This included: £80 million in support for immediate health and education pressures; £30 million to support programmes to address issues of mental health and severe deprivation; £100 million for ongoing work to transform the health service in line with the broad-based consensus fostered by the Bengoa Report²⁰; and a £200 million boost in capital spending for key infrastructure projects.

NHS workforce

- 2.25 In reporting on the pressures in the NHS, several external commentators and NHS organisations have cited growing concerns over the NHS workforce, including its prominence across NHS priorities. Many of these use similar data, much of which is updated in Chapters 3 and 4 of this report.
- 2.26 In 2017, the Lords Select Committee's Report on sustainability in the NHS and adult social care²¹ commented on the absence of a comprehensive national long term strategy to secure the workforce, and that this represented the biggest internal threat to the sustainability of the NHS. The Committee recommended that Health Education England should be substantially strengthened and transformed into a new single, integrated strategic workforce planning body. A transformed Health Education England should use its greater budgetary freedom to review current commissioning and funding mechanisms, to explore how initial and ongoing education and training might achieve a more multi-professional skill mix among the workforce.
- 2.27 In October 2017, the Health Foundation²² reported on NHS workforce challenges, re-iterating its 2016 findings on substantial shortages in nursing and primary care as symptoms of a more fundamental fault line, and an approach to workforce planning that was not fit for purpose. Growth in the NHS workforce was uneven, and the Foundation found that there were fewer full time equivalent nurses and health visitors, most notably in community nursing and mental health, both critical to the success of the NHS Five Year Forward View. There had been a marked change in skill mix in the NHS since 2010, with a significant fall in the ratio of nurses to consultants in hospital and community health services.

¹⁹ Written Ministerial Statements: Northern Ireland finances (8 March 2018). Available at: https://www.gov.uk/government/news/written-ministerial-statement-northern-ireland-finances

²⁰ The Department of Health, Northern Ireland (2016), *Systems not Structures: Changing Health and Social Care.* Available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-full-report.pdf

²¹ Lords Select Committee (April 2017), Long-Term Sustainability of the NHS and Adult Social Care. Available at: https://publications.parliament.uk/pa/ld201617/ldselect/ldnhssus/151/151.pdf
See also the Government's response (February 2018). Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/682614/Government_response_report_on_Long-Term_Sustainability_of_the_NHS_and_Adult_Social_Care__web_accessible_.pdf

²² Health Foundation (October 2017), *Rising Pressure: the NHS Workforce Challenge*. Available at: http://www.health.org.uk/sites/health/files/RisingPressureNHSWorkforceChallenge.pdf

- 2.28 The Health Foundation looked at two workforce pressure points. The autumn 2017 student cohort was the first not to receive the bursaries for nurses and allied health professions and early data suggested applications to universities had fallen by 23% although they still exceeded the number of places on offer. Applications to nursing were down across the UK, but the fall was sharper in England, and most notable among mature applicants aged 25 and over who tend to make up 40% of applicants. Apprenticeships and nursing associates were providing alternative routes. The Foundation commented on poor implementation of student funding reforms, the late funding of clinical placements, insufficient focus on the needs of older applicants, and a priority to halve the rate of attrition from nursing courses.
- 2.29 The Foundation's second pressure point was retention. It pointed to HEE estimates of shortages of NHS staff in England (one in ten nurses) and that the gap would narrow slightly, but the NHS would still not have enough qualified nurses by 2021. This would be compounded by HEE's estimates that over the five years to 2021 the NHS would lose 84,000 nurses before retirement age. Despite an emphasis on improving retention, the Foundation cited the percentage of staff staying at a trust in a given year falling from a median of 89% in 2010/11 to 85% in 2016/17.
- 2.30 The Health Foundation concluded that it had never been more important to manage training, recruitment and retention, but that the gap between national rhetoric and the reality for the NHS workforce was growing. It added that the situation was worsening, with demand for services growing much faster than key staff groups, and that the absence of a sustained and nationally focused workforce policy and planning prevented effective and co-ordinated policy interventions.
- 2.31 In November 2017, NHS Providers reported²³ on the way in which rapidly rising demand and constrained funding was leading to mounting pressure across health and social services, developing a workforce gap, and requiring a fresh approach to the workforce. They commented on hospital, mental health, community and ambulance services struggling to recruit and retain to deliver high quality care. In NHS Providers' view, this workforce gap was undermining performance, and risks preventing the delivery of service transformation. They reported that two-thirds of trust chairs and chief executives considered the workforce was the most pressing challenge to delivering high quality healthcare.
- 2.32 NHS Providers cited the following factors contributing to the workforce gap:
 - supply not keeping pace with rising demand and a greater focus on quality. 93% of trust chairs and chief executives considered supply shortages the biggest challenge to recruitment and retention;
 - recruitment and retention had become more difficult as the job got harder, training budgets were cut, and pay restraint bit. 60% of trust chairs and chief executives pointed to work pressure as a challenge to recruitment and retention, and 38% pointed to pay and reward; and
 - even if there were no supply shortages, and trusts had no difficulty recruiting and retaining staff, trusts might still be unable to afford to employ the staff they needed to deliver services, given low growth in funds allocated to the provider sector relative to rising demand.
- 2.33 NHS Providers summarised key areas for development including supply, making the NHS a great place to work, workforce development and improving productivity, and leadership development.

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²³ NHS Providers (November 2017), *There For Us – A Better Future For the NHS Workforce*. Available at: https://nhsproviders.org/media/3901/there-for-us-a-better-future-for-the-nhs-workforce.pdf

- 2.34 In March 2018, the Public Accounts Committee²⁴ concluded that staff shortages across the NHS were having a serious and negative impact on both the sustainability and transformation of services. The Committee was concerned that some hospitals had adopted unsustainable staffing models to meet the needs of patients over the winter period, with existing staff working more hours. It asked DHSC and NHS England to report back on actions to tackle key workforce issues.
- 2.35 The Health Committee published its Nursing Workforce Report²⁵ in January 2018. The Committee highlighted the importance of retention of nurses, that pay was a retention issue, and that any links between pay and productivity must be "realistic". In summary, the main conclusions from the Health Committee were:
 - the nursing workforce was overstretched and struggling to cope with demand, with pressures on morale, retention, and standards of care for patients;
 - too little attention had been given to retaining existing nurses, as more were leaving the register than joining it. Not enough research had been done on the reasons why nurses were leaving difficult working conditions exacerbated by staffing shortfalls were cited as major factors. Retention initiatives should focus on access to high quality continuing professional development, flexible career pathways and flexible working. It was essential that the Government did not see pay as the sole solution;
 - causes for the shortfall included workload pressures, poor access to continuing professional development, a sense of not feeling valued, ongoing pay restraint, the impact of Brexit and the introduction of language testing;
 - cuts to continuing professional development budgets should be reversed and greater attention should be given to ensuring access;
 - the nursing workforce needed to be expanded at scale and pace;
 - new routes into nursing were welcome, but it was essential to monitor the impact
 of changes to funding for degrees (and to act quickly if there were signs that
 numbers were declining), particularly the impact on mature students and shortage
 areas;
 - nurses from across the EU working in the UK needed further reassurance about their
 right to remain following the vote to leave the EU. It was essential that changes to
 language testing for overseas nurses were regularly monitored. Migration policy
 needed to extend the period that nurses were on the shortage occupation list; and
 - pay restraint was a factor in the recruitment and retention challenge.
- 2.36 NHS Improvement's performance reports²⁶ included, for the first time, data on the workforce, which it considered gave the clearest indication so far of the scale of the workforce challenge facing providers. In addition to the 1.1 million whole time equivalent staff employed by providers, there were around 100,000 vacancies. Management of vacancies via recruitment of substantive staff and effective use of temporary staffing (bank and agency) was a key priority for NHS Improvement.

²⁴ House of Commons Committee of Public Accounts (March 2018), Sustainability and Transformation in the NHS. Available at: https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/793/793.pdf

²⁵ Health Committee (January 2018), *The Nursing Workforce*. Available at: https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/353/353.pdf

NHS Improvement, Performance of the NHS Provider sector for the month ended 31 December 2017. Available at: https://improvement.nhs.uk/documents/2471/Performance_of_the_NHS_provider_sector_for_the_month_ended_31_December.pdf

- 2.37 In assessing NHS Improvement's performance reports, the Kings Fund²⁷ questioned whether the controls on the use of expensive agency staff damaged performance. Two-thirds of finance directors stated that these controls had little or no impact. However, with workforce shortages so widespread in the NHS, particularly in nursing, the Kings Fund concluded that even turning to expensive agency staff could not stop the slide in performance. It reported that 55% of finance directors said that the additional funding from the 2017 Budget had made little or no difference the inability to find more staff was an issue.
- 2.38 The Nuffield Trust²⁸ welcomed NHS Improvement's publication of figures on workforce vacancies and expressed its view that, in some ways, the lack of crucial workers in the NHS was an even bigger problem than the lack of funding.
- 2.39 In Scotland, Audit Scotland acknowledged that workforce planning had become more complex due to the integration of health and social care, and regional and national planning arrangements. In 2017, the Scottish Government published its workforce plan covering secondary care²⁹, which included the setting up of a new National Workforce Planning Group. Audit Scotland commented on this report³⁰ that: (i) workforce challenges included continuing recruitment and retention difficulties, an ageing workforce, greater use of temporary staff, and changing demands of an ageing population; (ii) the Scottish Government and health boards had not planned effectively for the long term and responsibility for workforce planning was confused; and (iii) the Scottish Government had not yet adequately estimated what impact increasing and changing demand could have on the workforce or skills required to meet this need. Audit Scotland recommended improved understanding of future demand (including scenario planning demand and workforce supply), providing clear costs of meeting projected demand, and setting out expected transitional costs/savings in implementing NHS reform.

The context for our pay considerations

- 2.40 The themes set out in this chapter provide the context for our considerations of the evidence on AfC pay. There is much common ground and agreement among the range of external commentators and NHS organisations on the nature of the pressures on the NHS. Commentators suggest that, while some progress has been made, there is much further to go to achieve sustained transformation of services. The financial pressures within the NHS remain. These pressures will continue to be a significant long term factor in determining the affordability of AfC pay awards and the ability of trusts and health boards to recruit, retain and motivate staff.
- 2.41 Given the pressures from demand, transformation and finances across the UK, we note the widespread recognition by all commentators that the NHS workforce is essential to delivering good patient care and that workforce challenges are the number one priority. The recognition of workforce challenges has led to an improved focus on developing monitoring data. In the following chapters we assess the workforce trends, and the role of the AfC pay agreement in addressing the workforce challenge.

²⁷ The Kings Fund (March 2018), *How is the NHS Performing?* Available at: https://www.kingsfund.org.uk/publications/how-nhs-performing-march-2018

²⁸ Nuffield Trust – Press Release 21 February 2018. Available at: https://www.nuffieldtrust.org.uk/news-item/nuffield-trust-response-to-nhsi-figures

²⁹ Scottish Government (June 2017), *National Health and Social Care Workforce Plan – Part 1*. Available at: http://www.gov.scot/Publications/2017/06/1354

³⁰ Audit Scotland (July 2017), NHS Workforce Planning: The Clinical Workforce in Secondary Care. Available at: http://www.audit-scotland.gov.uk/report/nhs-workforce-planning

Chapter 3 – The Parties' Evidence

Introduction

3.1 In this chapter we summarise the parties' evidence under the main themes for our considerations in this pay round, as submitted between December 2017 and February 2018. We have also included some of the parties' comments from oral evidence sessions where appropriate. We return to our analysis of these themes, including any updated information, in Chapter 4.

Economy and labour market

- 3.2 The **UK Government** stated that its more flexible approach to public sector pay made it all the more important that pay review bodies continued to consider affordability, alongside wider economic circumstances, when making their recommendations. The UK Government considered that the UK economy had demonstrated its resilience, with Gross Domestic Product (GDP) growth for 19 quarters and employment at a near record high. However, it recognised that business investment had been affected by uncertainty, and productivity growth had slowed across all advanced economies since the financial crisis, but that it had slowed more in the UK than elsewhere. The Office for Budget Responsibility (OBR) had revised down expectations for productivity growth.
- 3.3 The UK Government commented on its significant progress since 2010 in restoring public finances to health. The deficit had been reduced to 2.3% of GDP in 2016/17, its lowest level since before the financial crisis. However, the UK Government considered that borrowing needed to be reduced further to ensure economic resilience, improve fiscal sustainability, and lessen the burden on future generations.
- 3.4 Public sector pay accounted for around £1 in every £4 spent by the Government, and the public sector pay bill had increased to £179.41 billion in 2016/17. The UK Government therefore considered that public sector pay necessarily played an important role in controlling spending. Departments were facing longer term pressures, for example from demographic changes. The UK Government emphasised that discipline in public spending remained central to achieving the Government's fiscal targets. The last Spending Review budgeted for 1% average basic pay awards, in addition to progression pay for specific workforces. The UK Government added that, therefore, pay discipline would ensure the affordability of the public service and the sustainability of public sector employment. The UK Government added that pay bills should deliver maximum value for money and noted that, between 2010 and 2016, public sector productivity had increased by 3%. Further productivity improvements were vital to deliver Government objectives and meet rising demand. The UK Government would therefore consider pay awards which were agreed in return for improvements to public sector productivity.
- 3.5 The UK Government summarised the labour market with the following points, as at January 2018 when evidence was submitted (in Chapter 4 we provide an up-to-date analysis at the time of preparing this report):
 - the OBR forecast that the number of people in employment would continue to increase, and the unemployment rate would increase slightly as it returned to the OBR's equilibrium rate;
 - weak growth in labour productivity had been weighing down on wages and the OBR expected productivity to remain flat in 2017 before increasing in 2018 and 2019;

- with a lower forecast for productivity growth, the OBR expected average earnings growth of 2.3% in 2017, 2018 and 2019. The UK Government considered that a pick-up in productivity was vital for the recovery of cross-economy wage growth rates to pre-recession levels; and
- following the last recession, public sector wages did not undergo the sharp fall seen in the private sector but had since grown at a slower pace than private sector wages, according to the UK Government. It stressed that the overall remuneration of public sector employees, when taking employer pension contributions into account, remained at a significant premium.
- 3.6 The UK Government recognised that higher inflation was putting pressure on all households including hardworking public servants. In oral evidence, HM Treasury commented that the Government's main measure of inflation was the Consumer Prices Index (CPI), as it was a more relevant measure for pay awards, and that the Retail Prices Index (RPI) was not a "national statistic" as defined by the Office of National Statistics (ONS). The UK Government cited that most forecasters expected this period of above-target inflation to be temporary, pushed above the target by the boost to import prices from the past depreciation of sterling. It added that the OBR and the Bank of England expected inflation to peak at the end of 2017, and to fall again over 2018 and 2019. The UK Government considered the relationship between pay and inflation to be a weak one, in part due to the temporary nature of many inflation fluctuations. The UK Government concluded that public sector pay awards were complex and determined by a variety of factors, notably retention and recruitment, and that rates of inflation were important but not the only consideration. The UK Government asked pay review bodies to take account of the total reward package, including that public service pension schemes continued to be among the best available, and significantly above the average provision in the private sector. The UK Government also said that the introduction of the National Living Wage marked an increase in pay for over a million workers across the UK labour market, including in the public sector.
- 3.7 The UK Government concluded on the economy and labour market that much of its evidence would feed into retention and recruitment, although this would vary considerably across geographies, specialisms and grades, where public sector workers faced different labour market structures. The UK Government invited specific comment and analysis from pay review bodies on any trends and how pay systems could help address these issues.
- 3.8 The **Joint Staff Side** considered that CPI inflation consistently understated the real level of inflation, as it failed adequately to measure housing (almost two-thirds of housing in the UK being owner occupied); was less targeted on the experiences of the working population than RPI; and was calculated using a flawed statistical technique that consistently under-estimated the actual cost of living faced by employees. The Staff Side cited the Royal Statistical Society's view that CPI inflation was never intended as a measure of changes in costs facing households, but was designed for macroeconomic purposes. The ONS had now adopted the inflation measure Consumer Prices Index Housing (CPIH) and, though this represented an improvement on CPI, it measured housing costs as if all households rented their accommodation, and flaws remained. The Staff Side concluded that RPI inflation remained by far the most common reference point for pay negotiations, with an Incomes Data Research 2016 survey finding that 75% of employers regarded RPI inflation as most relevant to making decisions on the level of pay award.

- 3.9 The Staff Side's evidence highlighted the following on the economic and labour market context:
 - pay settlements across the economy stood at 2.2% in the year to December 2017 well below the long run median of between 3% and 3.5% that had prevailed for over two decades until 2008. Median pay settlements in the private sector were 2.2%, almost 1% higher than in the public sector. The Bank of England forecast pay settlements in 2018 would cluster between 2.5% and 3.5%;
 - trends in average earnings growth showed the declining competitiveness of public sector wages, which had been behind private sector earnings growth in every month, except two, since April 2013. In September 2017, average earnings growth across the economy stood at 2.2%, private sector growth at 2.4%, and public sector growth at 1.7%. The OBR forecast that growth would average 2.3% between 2017 and 2019 before escalating every year to reach 3.1% by 2022;
 - the ONS had made like-for-like comparisons taking into account region, occupation, gender and job tenure, showing the average public sector worker was paid 1% less than a private sector worker in 2016, with the gap growing to 5.5% when organisational size was taken as a factor; and
 - the unemployment rate had declined to 4.3% at November 2017, bringing it to a 42-year low, although it was forecast to rise to 4.5% in 2018 as growth slowed. Labour turnover rates were up to 19.4% across the economy (according to XpertHR), and just under half of employers were under significant pressure to raise wages for high and middle skilled roles (according to the Chartered Institute for Personnel and Development).
- 3.10 The **Scottish Government** commented that the Scottish economy had remained resilient and that the labour market had strengthened in the past year, with unemployment falling and employment increasing. It noted that nominal earnings rose over the year to April 2017 but that the acceleration in inflation had resulted in a fall in real earnings. In summary, the Scottish Government highlighted:
 - Scottish GDP growth had strengthened slightly to 0.6% in Q3 2017, driven by growth in the services and production sectors, but offset by contraction in the construction sector;
 - the employment rate had risen to 75.0% in 2017 and the unemployment rate was on a downward trend in 2017 to 4.0%;
 - median full time weekly earnings had grown by 2.4% in the year to April 2017, but this had been outpaced by the rise in inflation following the EU referendum, resulting in real wages falling 0.3% in Scotland in the year to April 2017; and
 - labour productivity in Scotland fell by 2.2% at Q2 2017, reflecting that the growth in average hours worked had outpaced the growth in output. Since 2007, labour productivity had grown by 6.6% compared to the UK average of 1.1%.
- 3.11 The Scottish Government said that independent forecasts for Scotland had suggested economic growth of between 0.7% and 1.4% for 2018, which were below Scotland's long run trend rate of 2%. It concluded that uncertainty surrounding Brexit remained a key factor affecting the economic outlook with business investment intentions fragile. Domestic pressures from weak real wage growth squeezing household finances, weaknesses in consumer sentiment, and weaker UK growth, were risks to growth over the coming year.

3.12 The Welsh Government considered that current economic conditions were broadly favourable in Wales, although the Brexit vote had already had a negative impact on economic performance. It noted that the OBR had repeatedly revised down its forecasts for a recovery in productivity, but that Gross Value Added in Wales (measuring output from an area) per head had increased by 13.7% between 2012 and 2016, although remaining lower than in any other UK country or region. The Welsh Government said that the employment rate in Wales remained below the UK average, although it had increased between 2012 and 2017 more than the rate in the UK. The unemployment rate decreased by 3.4 percentage points between 2012 and 2017, but remained slightly above the UK average. The Welsh Government observed that median weekly earnings increased by 10.1% between 2012 and 2017 in Wales, compared with an 8.8% increase in the UK, and that real earnings had decreased in three of the past six years in Wales.

Productivity

- 3.13 The **Department of Health and Social Care** (DHSC) said that the measure of productivity it used for the NHS in England was developed by the University of York. This used a range of NHS data sources to assess outputs and inputs, and also adjusted the output measures to take some account of quality change, including change in waiting times and death rates. The Department commented that, while labour productivity was an important component of efficiency, labour inputs accounted for only around half of the cost of the NHS. The Department said that a broader measure, total factor productivity, divided total output by an appropriate measure of all inputs, for example including additional costs such as drugs alongside labour costs.
- 3.14 The University of York (Centre for Health Economics) produced figures on total factor productivity. These showed that in 2014/15 the total volume of NHS inputs increased by 85%, but NHS outputs were 94% higher than in 1998/99, resulting in a moderate growth of 0.2% per annum in total factor productivity.
- 3.15 The University of York also produced figures on labour productivity. In 2014/15, the volume of NHS labour input was 45% higher, but NHS outputs were 93% higher than in 1998/99 (the base year). This suggested an average growth in labour productivity of around 2% per annum.
- 3.16 More generally, the Department acknowledged that productivity, as it formally defined in its evidence, did not take into account the cost of inputs including changes in staff pay. It added that a full measure of technical efficiency would, in addition, factor in changes in pay and the costs of inputs relative to a suitable deflator, and that, if pay were to increase more quickly than the GDP deflator, this would have a negative effect on technical efficiency.

- 3.17 **NHS Improvement** said that, although the NHS was rated as one of the most efficient healthcare systems in the world, on average across trusts there were still unwarranted variations. It observed that the average cost of an inpatient treatment was £3,500 per weighted activity unit, but that there was more than 20% variation between the most expensive and least expensive trust. The 2016 Carter Review's³¹ recommendations had helped to reduce variations across the biggest areas of spend including clinical staff. NHS Improvement commented that a significant focus of its work on improving operational productivity was the clinical workforce. NHS Improvement cited the Carter Review's findings that the most expensive trust spent around 1.3 times more on clinical staff, per weighted activity unit, than the least expensive trust. It also pointed to other productivity issues such as: Electronic Staff Records allowing trusts to compare their workforce productivity; few trusts benefitting from e-rostering; ensuring up to date medical job planning; and the use of the Model Hospital Portal. The Carter Review estimated that around £2 billion each year of efficiency gains could be achieved by reducing unwarranted variation in clinical workforce productivity.
- 3.18 NHS Employers commented that employers had already met, and were continuing to deliver, productivity above the national average. NHS Employers said it would be extremely difficult to fund any additional investment into pay without having to make difficult choices about the number of staff and services. They cited the pre-budget analysis from the King's Fund, the Health Foundation and the Nuffield Trust, which suggested that productivity in the NHS was improving by 1.7% a year, and was outperforming the wider economy, with the focus on improving productivity by tackling variations in care, improving clinical practice, and making better decisions about how money was spent.
- 3.19 NHS Employers said that the link between effective staff engagement and outcomes was well known. They said that evidence over many years showed that, where employers invested time and effort in engaging and looking after their people, patient care was improved. NHS Employers considered that a common thread linking the recruitment, retention, workforce and productivity challenges was the national pay and conditions of service framework. As they continued with their programme of change and reform, NHS Employers considered that there would be opportunities to link the programme to national and efficiency programmes such as the Carter Review, and the Getting It Right First Time project. NHS Employers felt that there would be opportunities to align further pay and performance.
- 3.20 The Joint Staff Side said that it was clear that much had been done by the workforce to sustain productive working in the NHS, particularly working extra hours which were often unpaid.
- 3.21 In response to suggestions from the Government that pay should be linked to productivity gains, the Royal College of Nursing (RCN) reflected comments from nursing staff who questioned how much more productive they were expected to be at a time when staff were under more and more pressure, and were working high levels of unpaid overtime due to staff shortages, as well as extra hours to get by financially. The RCN concluded that nursing staff were highly productive by any reasonable interpretation.

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³¹ Department of Health and Social Care (2016), *Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations*. Available at: https://www.gov.uk/government/publications/productivity-in-nhs-hospitals

- 3.22 The RCN added that the NHS was losing out on untapped potential and productivity gains. It commented further on productivity in nursing including:
 - staff were well placed to see blockages to productivity gains;
 - pressures forcing older nurses to take early retirement with a huge loss of skill and experience;
 - the lack of clinical opportunities for experienced nurses was both demotivating and could prompt staff to leave;
 - the scale and complexity of paperwork was a barrier to service quality; and
 - work pressures got in the way of staff keeping up with new developments, updating their own skills and knowledge, and working to their potential.
- 3.23 The **Society of Radiographers** (SoR) commented that the cost of meeting productivity improvements had been met in full by the additional income generated from radiographers working harder and longer.
- 3.24 The **GMB** argued that NHS workers had delivered productivity improvements, but indexing pay to productivity in a fair, timely and transparent way was extremely difficult in practice. It noted that there had been a three-year lag in the ONS assessment of public sector health productivity, but that the last analysis suggested health productivity had improved by 9.6% between 2010 and 2014, and contrasted this with increases to most AfC spine points of 2% over the same period. The GMB added that productivity improvements should be achieved by motivating and investing in NHS workers, but that recent years had seen cuts to investment in training alongside real terms pay cuts.

NHS demand and service transformation

- 3.25 The **Department of Health and Social Care** commented that the Government was providing the £10 billion of additional funding a year that the NHS said it needed to deliver its Five Year Forward View. The Department said that it was working with partners by:
 - reducing demand for NHS care by improving the public's health, introducing new models and places to care for patients, and reducing unwarranted variation in care;
 - making better use of providers' resources;
 - reducing NHS costs by improving purchasing;
 - increasing income to the NHS through charges and commercial opportunities; and
 - reducing system overheads by reducing NHS management costs.
- 3.26 The Department said that the NHS continued to face significant challenges with increasing demand for health services due to an ageing, growing population, and the requirement to recover the provider net deficit position. The Department commented that the demands on the health and social care system continued to increase, and that meeting this demand while improving quality of service in an affordable way was increasingly challenging. It added that the challenge required a focus on efficiency and transformational change.
- 3.27 The Department considered that, in recent years, the NHS had continued to manage rising demands on its services. It said that the numbers of emergency admissions per calendar day (an indicator of emergency demand) had grown continuously between 2011/12 and 2016/17, and the number of elective patients treated per working day (referral to treatment) had increased over the same period.

- 3.28 NHS Improvement commented that the NHS had maintained and improved patient care, and delivered efficiencies during a time of increasing financial pressure, caused by slowing growth in the NHS budget combined with rising demand. NHS Improvement was leading the national programme to develop safe staffing improvement resources for specific NHS care settings, including acute inpatients and children's services. The programme used evidence-based tools to ensure that staffing levels were flexible and adapted to the needs of patients. Eight sector specific improvement resources had been developed by system leaders supported by academic teams. NHS Improvement was working with Health Education England to support the broader transformation of the NHS workforce through supporting providers in developing new roles, including recognising the value of non-registered care staff, apprentices and nurse associates. For example, the roles of Advanced Clinical Practitioners and Specialist Clinical Practice gave existing nurses or allied health professionals the opportunity to develop skills, and to provide a more expert service to patients.
- 3.29 NHS Employers commented that NHS organisations had to manage growing disparities between rising demand for services and the amount of funding available, while continuing to meet public and patient expectations. They continued that the increasing demand came from a growing population consisting of older people, and from a greater prevalence of long term, often complex, patient conditions. NHS Employers' work on transformation focused on providing more services in the community, integrating health and social care, preventing illness, promoting health and wellbeing, and getting the best from their talented staff. The development of Sustainability and Transformation Partnerships (STP), and in some cases Accountable Care Systems, was expected to provide opportunities for joined-up, better coordinated care, with change led at system level. NHS Employers recommended that, if transformation plans were to improve outcomes for patients, there must be new workforce plans that reflected more collaborative working across established organisational boundaries.
- 3.30 NHS Employers noted the Care Quality Commission's (CQC) conclusions that, despite very real challenges, the quality of health and social care had been maintained, and that most patients were getting good, safe care. NHS Employers pointed out that the CQC had also warned that the combination of greater demand and unfilled vacancies meant that staff were working harder than ever to deliver the quality of care, although there was a limit to their resilience. They also noted the King's Fund quarterly monitoring report which had predicted that the NHS was set to miss targets, including for improving A&E performance, reducing delayed transfers of care, and financial targets for reducing deficits in the provider sector.
- 3.31 **Health Education England** (HEE) felt that it was responding to system changes, such as the requirement better to support STPs, and that a priority must be its transformation offer to STPs through Local Workforce Action Boards. HEE referred to the draft Health and Care Workforce Strategy's conclusion that more must be done to keep up with increased demand as the population expanded and grew older. HEE cited the draft Strategy's range of measures to improve productivity, boost training and retention, open up new routes into nursing, and to prepare the future workforce for technological advances which HEE believed were poised to transform modern medicine.
- 3.32 **NHS Providers**, in oral evidence, said that the Sustainability and Transformation agenda had changed, with an explicit move in funding away from transformation to sustainability, in order to ensure that the NHS could deliver services. They added that the Sustainability and Transformation Fund was to be renamed the Provider Stability Fund to recognise the severity of delivery pressures.

- 3.33 The **GMB** observed that the NHS was under severe strain and that some of the causes were related to, but separate from low pay, such as rising workloads, cuts to social care and dependency on agency staffing. It added that declining NHS performance could not always be linked to a single factor, but low pay had led to serious operational challenges for the NHS.
- 3.34 The **Royal College of Nursing** commented that there were not enough nursing staff to provide care, and patient safety was at risk. In its view, this crisis had been created by a failure to invest in the nursing profession and to provide sufficient funding for pay, conditions, career pathways and training. It said this failure to invest had resulted in a depleted nursing workforce facing shrinking wages, while workload pressures continued to rise. The RCN reported that in its 2017 Employment Survey, 14% of nursing staff said that there were sufficient staffing levels in their workplace to meet patient/client needs, and that 39% believed that patient care was compromised by short staffing on most or every shift. The RCN's report on *Safe and Effective Staffing: Nursing Against the Odds32* showed that safe and effective staffing was the exception not the rule. It added that existing staff were plugging the gap between missing staff and the demand for care, because of factors beyond their control.
- 3.35 The **Royal College of Midwives** (RCM) considered that, because of staff shortages, maternity units were struggling to meet the demands of the service, with Heads of Midwifery frequently redeploying staff to other areas, using bank and agency staff, withdrawing services and closing the unit.
- 3.36 The **Society of Radiographers** said that on average a radiographer undertook 215 more examinations each year than three years ago, which had generated significant extra income for NHS trusts. It added that specialist procedures, Computed Tomography and Magnetic Resonance Imaging in 2017 had seen a marked increase in usage, of around 7-8%.
- 3.37 The **Scottish Government** pointed to its 2020 Vision for the health care system to have: integrated health and social care; a focus on prevention, anticipation and supported self-management; day case hospital treatment would be the norm; care to the highest standards of quality and safety with the person at the centre of all decisions; and a focus on ensuring people get back into their home or community environment as soon as appropriate. The Scottish Government reported good progress towards the Vision, and significant progress through 2017 in taking forward the delivery plan. On the integration of health and social care, the Scottish Government said that 31 Integration Authorities had been fully operational since 2016, managing approximately £8.5 billion of resources. It also said that Audit Scotland's 2017 Report had noted that these authorities were already having a positive impact on the quality and sustainability of care, and further achievements, such as delivery of the Scottish Living Wage for all adult social care workers, and savings of £250 million in 2016/17.

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³² Royal College of Nursing (September 2017), Safe and Effective Staffing: Nursing Against the Odds. Available at: https://www.rcn.org.uk/professional-development/publications/pub-006415

- 3.38 The Welsh Government said that the demand facing the system continued to increase, despite increasing numbers in the NHS workforce. It added that the NHS in Wales faced significant demand challenges from the population as life expectancy increased, with an ageing population, a growth in the number of people with chronic conditions, and the impact of budget restraint on services. The Welsh Government pointed to the increase between 2012/13 and 2015/16 in referrals for a first outpatient appointment. The number of outpatient attendances had reduced slightly, as there had been a concerted effort in the last few years to treat patients closer to home. The Welsh Government commented that it had provided additional revenue funding of £100 million over the next two years to support transformation, including for the Integrated Care Fund, targeting primary care clusters and support for regional planning.
- 3.39 The **Department of Health, Northern Ireland** referred to its 10-year approach to transforming health and social care *Health and Wellbeing 2026: Delivering Together*³³ which responded to the Bengoa Report's conclusions on the best configurations of services in Northern Ireland. The Department commented that good progress had been made on the actions and highlighted transformation activities including: a 2017 Health and Social Care Collective Leadership Strategy; consultations on Imaging Services and Reshaping Stroke Services; engagement events to refine a draft framework for Community Development Approaches; developing a model for Multi-Disciplinary Teams in primary care; a Workforce Strategy (including recruitment and retention, new job roles and upskilling); HCS restructuring and a future operating model; and gathering evidence to determine a model for Elective Care Centres.

NHS finances, efficiency savings and affordability

3.40 The **Department of Health and Social Care** commented that in the 2015 Spending Review the Government had committed to backing the NHS, with an additional £8 billion in real terms by 2020/21. At Budget 2017, the Government committed a further £2.8 billion of revenue funding by 2019/20, and an additional £3.5 billion of new capital investment by 2022/23. The Department's evidence showed that the total departmental expenditure covering both capital and revenue spend for 2018/19 would increase by 3.4% cash growth and 1.9% in real terms growth to £113.5 million.

Table 3.1: NHS England Total Departmental Expenditure Limit

	NHS England TDEL (£bn)	Cash growth	Real terms growth
2013/14	94.7		
2014/15	97.3	2.8%	1.3%
2015/16	100.5	3.2%	2.6%
2016/17	106.0	5.4%	3.1%
2017/18	109.7	3.6%	2.0%
2018/19	113.5	3.4%	1.9%

Source: DHSC Evidence

³³ Department of Health, Northern Ireland (October 2016), *Health and Wellbeing 2026: Delivering Together.* Available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf

- 3.41 The Department noted that the pay bill continued to grow, largely as a result of rising on-costs and an expansion of the workforce. The Department observed that on average, between 2011/12 and 2016/17, increases to the Health and Community Health Services pay bill accounted for 30% of the increases in revenue expenditure. The Department concluded that, despite many competing pressures, the NHS had managed to increase its permanent staff spend and largely maintain the proportion of expenditure on permanent staff.
- 3.42 The Department said that the NHS Five Year Forward View anticipated a gap between resources and patient needs of nearly £30 billion a year by 2020/21 if the NHS received flat real terms funding increases, and if no further efficiencies were delivered. Therefore, to fill this gap, the NHS would deliver £22 billion of efficiency savings, equivalent to 2% to 3% per year, the majority of which were not cost reductions, but actions to moderate the rate of spending growth.
- 3.43 The Department also referred to NHS Improvement's substantial progress in delivering the efficiencies identified in Lord Carter's 2016 Review of operational productivity and performance in English NHS acute hospitals. This programme was supporting providers to deliver at least £5 billion efficiency savings to 2020/21. Going forward, there would be increasing focus on moderating activity growth through programmes such as new care models and right care, and delivering improved workforce productivity. The Department concluded that meeting the efficiency challenge was likely to require shifting the focus from centrally driven savings to transformational changes. In its view this would reduce the long term cost pressures on NHS services.
- 3.44 **NHS England** commented that it was clear that the coming years would continue to require very significant further financial savings and efficiency improvements. As a result, all providers in the service needed to make savings and deliver efficiency gains each year. NHS England estimated that around £3.5 billion of efficiencies between 2015/16 and 2020/21 were predicated on implementing the Government's 1% public sector pay cap until 2019/20.
- 3.45 NHS Improvement said that the aggregate financial deficit had reduced to £791 million in 2016/17. This had been achieved through the combined efforts of the sector and the introduction of £1.8 billion of Sustainability and Transformation Funding. At September 2017, providers forecasted an aggregate financial deficit of £623 million for 2017/18, despite delivering larger cost improvement plans and levels of efficiency far greater than the wider economy. NHS Improvement noted that, with additional funding from the 2017 Budget, NHS revenue growth for 2018/19 would be 1.9% and, factoring in England's growing and ageing patient population, age-weighted NHS revenue growth per person would be 0.9% in 2018/19 and -0.4% in 2019/20. While NHS Improvement welcomed the extra revenue, it said that the outlook for provider finances remained very challenging, and that any pay awards above 1% without additional funding from the Government would simply increase the deficits.

- 3.46 NHS Improvement reported that, at September 2017, providers had achieved significant agency savings and maintained the high efficiency levels seen in previous years. It added that in the first six months of 2017/18, the sector outperformed the wider economy by delivering an implied 2.0% efficiency improvement, supported by cost improvements of 2.9%. Despite efficiency and cost improvement, there was a shortfall of £169 million against the ambitious level of cost improvements planned. NHS Improvement said that providers planned for pay growth of just 0.4% which was significantly below anticipated pay inflation of 2.1%. This represented a real terms reduction in the sector's pay bill. mainly through a reduction in temporary staffing costs. It estimated that pay bill costs for the first two quarters of 2017/18 were £256 million worse than plan, driven by increased costs for medical staff and nursing staff. In contrast to previous years, the use of bank staff was £407 million above plan, reflecting the increasing use of such staff to manage workloads in the face of increased demands, a high level of vacancies, sickness absence and staff turnover. NHS Improvement added that a continued reduction in reliance on agency staff (with a forecast underspend of £249 million) had been achieved by moving agency workers and shifts into more cost-effective bank and substantive roles.
- 3.47 NHS Employers said that the financial outlook remained extremely challenging and that it restricted the ability of the NHS to invest in pay without additional funds. Although the NHS had been protected from the full impact of austerity since 2010, NHS Employers commented that the funding increase was substantially less than the increase in demand for services and the increase in other cost pressures. The overall financial deficit in trusts fell from around £2.5 billion in 2015/16 to a reported £791 million in 2016/17, but NHS Employers considered that persistent levels of structural debt had limited the financial resources available for delivering current services and for transforming them for the future. Employers were engaged on programmes to improve quality and drive up efficiency, yet these required additional resource and would take time to deliver results. NHS Employers concluded that around two-thirds of budgets were spent on staff, and that this cost would remain central to efforts to manage budgets, improve efficiency and transform services.
- 3.48 NHS Employers cited analysis by the Nuffield Trust, the Health Foundation and the King's Fund which had suggested that the funding requirement for 2018/19 would be nearer £4 billion if deterioration in the quality and availability of care were to be avoided.
- 3.49 NHS Providers said that workforce was the top concern for NHS trusts across the country, with staffing challenges now considered as pressing as the financial challenge. NHS Providers considered it essential that there was a clear and credible process for the funding for any pay award to reach provider trusts, recognising that the Government had committed to providing new funding in addition to the £1.6 billion announced in the 2017 Budget for 2018/19. NHS Providers added that improving pay and reward without additional funding could exacerbate the deep financial challenges already facing the sector.
- 3.50 The **Joint Staff Side** stated that the principle underpinning its claim was that sufficient additional funding should be provided by Government, with spending spread between real pay uplifts, restorative awards and funding a restructure. In costing the claim, the Staff Side cited analysis by the Institute for Public Policy Research which showed that the cost of increasing pay in line with CPI inflation would be £1.8 billion a year by 2019/20 compared with the pay cap, but the real cost to HM Treasury would be half of this when taking into account higher tax receipts, lower welfare payments, and the impact of additional GDP generated. The Staff Side said that the Government should allocate additional funding to the NHS pay bill, in addition to the funding needed for pay increases, in order to ensure that the pay structure remained fit for purpose.
- 3.51 **UNISON** and **Unite** repeated their support in the Joint Staff Side evidence for a fully funded, UK-wide pay settlement.

- 3.52 The Scottish Government highlighted the unprecedented challenges faced in terms of demographic change, rising demand and expectations, and financial constraints. It said that the scale of the real terms reduction in the Scottish Government budget for the period 2010/11 to 2019/20 (8.0%) had required tough decisions about expenditure across government. The Scottish Government stated that in 2018/19 an above inflation increase for Health and Sport would be delivered, with the additional funding provided to support frontline services and continued reform. NHS Health Boards would receive a cash terms uplift of 1.5% and also a share of money for investment in reform, with the latter increasing by £175 million to £303 million in 2018/19. The Scottish Government said that, overall, additional funding to NHS Health Boards would increase by 3.7%, which amounted to a real terms increase of 2.2%. It expected all Boards to take all reasonable steps to live within their means, and to make best use of the available resources as part of a balanced approach to finance and performance. It would also be essential to continue the twin approach of investment and reform, and to shift the balance of care to community health services. In oral evidence, the Scottish Government commented that Health Boards were expected to fund any pay uplift with the first 1% from their increased funding. It said the rest of the funding for any pay award would be made up from Barnett consequentials as the additional funding for pay fed into budgets in England.
- 3.53 The Welsh Government argued that, following successive rounds of cuts by the UK Government, its resource budget in 2019/20 was down by 6%, or nearly £1 billion in real terms since 2010/11. The NHS in Wales continued to be the single largest area of expenditure for the Welsh Government which, in its view, reflected its value to the Welsh public. It said that an additional £230 million was being invested in the Welsh NHS in 2018/19, bringing the total health budget for 2018/19 to £7.723 billion, and a further £220 million in 2019/20. However, it noted that the Health Foundation had identified a net gap of £150 million by the end of 2019/20. Despite financial pressure, the Welsh Government emphasised the need to maintain the quality of services to patients and to invest in the workforce, including covering the additional cost of the Living Wage Foundation recommended rates (estimated at £12.566 million in 2017/18).

Workforce

- 3.54 The **Department of Health and Social Care** said that effective workforce policy was critical to the delivery of affordable, high quality care. Securing the people with the values, skills, experience and expertise which the NHS needed was central to the future of England's Health and Care system. The Department commented that it had taken action in conjunction with Health Education England and NHS England to boost the supply of domestically trained staff, to increase the efficiency and productivity of the existing workforce, and to change the skill mix. The Department also said that it had initiated the introduction of a new group, chaired by the Minister of State for Health, to steer its strategic programme and implement the publication by Health Education England of a draft Health and Social Care Workforce Strategy.
- 3.55 The Department commented that the total workforce had continued to grow, by 6.2% since 2012, with all areas apart from infrastructure staff increasing. It said that there were 32,000 more qualified clinical staff than in 2010. However, while the workforce continued to grow, there was still a significant challenge to fill training places, with the recent fall in the number of nurse applications.
- 3.56 The Department provided data on the change in full time equivalent (FTE) AfC staff from March 2012 to March 2017 which showed growth in most staff groups. However, there had been a reduction in most infrastructure support groups (central functions, hotel, property and estates, and managers) apart from senior managers.

- 3.57 Health Education England said that it provided the NHS with a single national body for commissioning education and training places to secure the future workforce. It operated a "single system of dispersed leadership", working with providers of NHS services, Sustainability and Transformation Partnerships, Local Workforce Advisory Boards, and other organisations such as commissioners, local authorities and education providers.
- 3.58 HEE said that it had produced a draft Workforce Strategy entitled *Facing the Facts, Shaping the Future, A Health and Social Care Workforce Strategy for England to 2027*³⁴. The draft Strategy was a consultation document produced by HEE, with content from NHS England, NHS Improvement, Public Health England, the Care Quality Commission, National Institute for Clinical Excellence, and the Department of Health. HEE said that the draft Strategy looked at the challenges faced by the health and care system, charting the growth in the NHS workforce over the last five years and also setting out the critical workforce challenges that would be faced over the next decade. HEE commented that, while the NHS was employing more staff now than at any time in its history, with significant growth from 2012 in newly qualified staff across the majority of professional groups, the draft Strategy concluded that more must be done to keep up with increased demand as the population expanded and grew older. Further detail on the draft Strategy is set out in Chapter 4 of this report.
- 3.59 **NHS Improvement** commented that tackling the strategic workforce challenges required co-ordinated action across a range of national bodies with responsibilities for different aspects of planning, training and education, supply, retention and productivity to improve:
 - supply, for instance by developing new routes into nursing, through international recruitment, and by maximising existing supply through conversion of agency staff to substantive workforce;
 - retention of the current workforce;
 - leadership culture and staff engagement; and
 - productivity of the existing workforce, including by developing new innovative workforce models.
- 3.60 NHS Employers welcomed the announcement of a robust co-ordinated approach to workforce strategy. They said a workforce strategy would need to make clear how the NHS would collectively address the future supply, retention and development of its workforce. They added that this was an opportunity to set out how actions to date would help employers in the short, medium and longer term, as well as to be clear on what further actions would need to be taken at every level of the NHS and across government. NHS Employers considered that there were growing and widespread concerns about the health and social care workforce and the impact of long term austerity, Brexit, changes to the funding of education and legacy issues at Mid-Staffordshire Hospital. Getting workforce policy right in the future would, according to NHS Employers, be central to delivering sustainable and affordable high quality health and care services.
- 3.61 **NHS Providers** stated that the workforce challenge had surpassed the financial challenge facing the provider sector and that, in their recent survey of trust leaders, 66% of provider trust chairs and chief executives reported that workforce was the most pressing challenge to delivery of high quality healthcare at their trust. NHS Providers said that the recent draft Health and Social Care Workforce Strategy was a constructive start to tackling the workforce challenge.

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³⁴ Health Education England (December 2017), Facing the Facts, Shaping the Future, A Health and Social Care Workforce Strategy for England to 2027. Available at: https://www.hee.nhs.uk/sites/default/files/documents/Facing%20the%20 Facts%2C%20Shaping%20the%20Future%20%E2%80%93%20a%20draft%20health%20and%20care%20 workforce%20strategy%20for%20England%20to%202027.pdf

- 3.62 The **Joint Staff Side** commented that the draft Health and Social Care Workforce Strategy acknowledged the problems of the workforce, but that the proposed measures would take time to impact on future supply, retention, training and development. It said that the evidence showed that staffing had already reached crisis point in the NHS. The Staff Side said that it was alarmed that the Nursing and Midwifery Council (NMC) had seen a drop in the number of registrants for the first time in 2017. The Staff Side felt that two significant developments could worsen recruitment even further changes to student funding and Brexit.
- 3.63 The **Royal College of Nursing** believed that it had seen signs from governments and policy makers of a long overdue recognition of the crisis facing the nursing workforce. It said that this recognition had come after repeated warnings by the RCN of a "perfect storm" caused by a combination of pay restraint, increasing work intensity and poor workforce planning. There had been a failure to recognise the need to match the demand for with the supply of nursing staff and the inevitable impact of predictable staff shortages. The RCN argued that the solutions offered by the Government were focused almost entirely on supply, such as the creation of a degree-level apprenticeship route into nursing, and new roles including nursing associates in England. These would not fill the gaps of over 40,000 registered nurse vacancies. The Nursing and Midwifery Council had warned that, for the first time, more people were leaving than joining the register, and the shortfall was the focus of an inquiry by the Health Select Committee.
- 3.64 The **Scottish Government** said that as at September 2017 there had been an increase in whole time equivalent (WTE) nursing and midwifery staff working in NHS Scotland of 0.4% over the September 2016 figure, and an increase of 5.6% over the September 2012 level. The number of AfC staff working in NHS Scotland as at September 2017 was 125,677.8 (WTE). This represented an increase of 776.6 (0.6%) over the September 2016 figure, and an increase of 6,725.1 (5.7%) over the September 2012 level. The Scotlish Government noted that, in headcount terms, the number of AfC staff working in NHS Scotland as at September 2017 was 147,445. This was an increase of 861 (0.6%) over the September 2016 figure, and an increase of 6,445 (4.6%) over the September 2012 level.
- 3.65 The Scottish Government observed that *Everyone Matters: 2020 Workforce Vision*³⁵ (published in 2013) was its workforce policy for NHS Scotland, and its commitment to valuing the workforce. Specifically, the Vision said that the Scottish Government would respond to the needs of the people it cared for, adapt to new, improved ways of working, and work seamlessly with colleagues and partner organisations. The Vision aimed to continue to modernise the way the NHS worked, to embrace technology, and to create a great place to work and deliver a high quality healthcare service which was among the best in the world. The Scottish Government said that it had published Part 1 of the National Health and Social Care Workforce Plan³⁶ in June 2017 (covering secondary care) which would: strengthen and harmonise workforce planning practice; take full account of the future demand for safe and high quality services for Scotland's people; and work accurately to identify gaps in supply. It added that publication of the plan in three parts (social care in part 2 and primary care in part 3) reflected the need for an incremental approach.

³⁵ Scottish Government (2013), Everyone Matters: 2020 Workforce Vision. Available at: www.gov.scot/resource/0042/00424225.pdf

³⁶ Scottish Government (June 2017), National Health and Social Care Workforce Plan – Part 1. Available at: http://www.gov.scot/Publications/2017/06/1354

- 3.66 Data supplied by the **Welsh Government** for the last six years demonstrated a relatively stable nursing and midwifery workforce in NHS Wales. The Welsh Government said that the data illustrated the increase in FTE NHS Wales staff from 2007 to 2016 by staff group, during which time the total number of scientific, therapeutic and technical staff had increased from 10,654 to 12,429 a jump of 16.66%. The Welsh Government considered that, while the numbers of medical and dental, allied health professionals and additional professional, scientific and technical staff groups had steadily increased over the last six years, other staff groups such as healthcare scientists and estates and ancillary staff had noticeably declined. In Wales, around 2% of nurses were from the EU and 3% non-EU overseas.
- 3.67 The Welsh Government said that, in March 2017, the number of FTE staff in the NHS was 71,226 the highest during the last seven years. Demand for numbers had been driven by the Francis Review, the Andrews Review, the Nursing Staffing Levels (Wales) Act and labour market changes such as the rise of agency contracts.
- 3.68 The Welsh Government had continued to invest in advanced practice programmes for nursing, paramedicine and a range of other roles, in addition to programmes which enabled a range of professionals to obtain extended skills packages. It said that it had increased the level of support invested in developing the healthcare support worker section of the workforce by adopting the first phase of a career and skills framework introduced for clinical health care support workers. Extension of this framework to cover non-clinical roles would be addressed in the next phase. The Welsh Government argued that the key to sustaining the workforce was the introduction of greater flexibility in routes to education and training across the broad range of health care professional education and training programmes. The Welsh Government had asked its commissioners to identify where additional flexibility could be introduced into currently centrally-funded education and training programmes.
- 3.69 In December 2017, the Cabinet Secretary for Health and Social Services announced a £107 million investment package to support education and training programmes for healthcare professionals in Wales. This investment represented an increase of £12 million compared with the 2017/18 package, enabling more than 3,500 new students to join those already studying healthcare education programmes across Wales. The Welsh Government explained that there would be 9,490 people in training, compared to 8,573 in 2017/18. It said that there would be increases in training places of 10% for nurses, 12% for health visitors, and 10% in physiotherapy and occupational therapy, plus maintenance of the 40% increase in midwifery places.
- 3.70 The **Department of Health, Northern Ireland** noted that its draft workforce strategy was nearing completion, and had recently been considered by its Transformation Implementation Group. It said the strategy covered all aspects of the health and social care workforce, including retention and recruitment, opportunities for introducing new job roles and upskilling initiatives. The strategy has since been launched.

Supply and recruitment

3.71 The **Department of Health and Social Care** considered that the change in the funding system for undergraduates presented an opportunity to increase the future supply of registered nurses, as well as that of other clinical professionals. It said that additional clinical placement funding announced in 2017 would facilitate expansion by enabling around 5,000 more nursing students to enter training each year to 2020/21. This would represent a 25% increase over the number of nursing students in 2016/17. The Department added that HEE was working with Higher Education Institutes (HEIs) and NHS providers to increase safely the number of clinical placements and ensure their compliance with quality frameworks.

- 3.72 The Department noted that, although the 2017 application cycle had not yet closed, data available on the numbers of placed students by mid-September 2017 showed that placed applicants to nursing courses at English Higher Education Institutions, by applicants domiciled in England, had decreased by 5%. The Department said that placed applicants on nursing courses in England from all domiciles had decreased by 6%. It argued that the drop in applications to nursing courses was consistent with the performance of other higher education courses when tuition fees were introduced and was similar to the numbers of applications at the same stage in 2014 and 2015. In oral evidence, the Department said that, since the removal of bursaries, there had been 1.4 applicants to every place and therefore, in its view, recruitment to university places had remained healthy.
- 3.73 The Department said that HEE had been engaged in schemes to encourage health professionals to return to practice. HEE's work had focused on those nurses who, for a variety of reasons, had left the profession, but who would come back if the right training and support were available. The Department observed that, since the programme began, 3,596 nurses had completed their re-training, and were now available for employment on the front line to provide care and support for patients. It argued that this was positive for returning staff and patients, and was a quick and efficient way of boosting the current workforce.
- 3.74 **Health Education England** said that the elements of supply to the adult nursing workforce had changed year on year. While it had seen no particular deterioration of recruitment or retention, HEE said that the scale of the flows out of and back into the NHS from other settings was striking. This included movement between UK NHS and other employers, as well as international migration. It noted that joiners to adult nursing between 2013/14 and 2016/17 from sources other than newly qualified had increased by almost 3%, but newly qualified joiners had dropped by 17%. HEE said that the children's nursing workforce had seen a particular deterioration of recruitment from sources other than newly qualified nurses, with a fall from 8.7% in 2013/14 to 6.0% in 2016/17. HEE added that the scale of the flows out of the NHS to other settings was at around 8% to nearly 10% per year.
- 3.75 NHS Employers said they welcomed initiatives that had been introduced recently to increase the supply of healthcare professionals. They hoped that policy changes to routes into nursing were providing employers with more opportunities to increase supply in the long term, but they did not expect to see the results until 2021/22 onwards. NHS Employers felt that it would be counterproductive if the supply strategy did not complement important national initiatives, and innovative local work on recruitment, with more work on retaining, supporting and developing the highly trained, talented and committed staff already working in the NHS.
- 3.76 NHS Employers said the intake of September 2017 was the first which would not receive a bursary and that the full impact of the change in policy had yet to be seen. However, they cited indicative figures from Universities and Colleges Admissions Service (UCAS) which showed that by the January deadline for the 2017 cycle, there were 23% fewer applicants to nursing from England, and 25% fewer applicants from the EU (excluding the UK) compared to the same time the previous year. NHS Employers said that UCAS figures had shown a drop of about 6% in the number of students taking up nursing places in England. In addition, there had been a shift in the age profile the number of students aged under 20 starting nurse training was 6% higher, but there were around 10% fewer people aged 20 and over.

- 3.77 NHS Employers commented that the number of joiners to the NMC register trained within the EU had been rising steadily over the past 10 years. NMC data showed registrations had increased from 3,436 in the year 2012/13 to 9,389 in the year 2015/16. However, this declined to 6,382 in 2016/17. NHS Employers said that it was too early to make a clear-cut judgement about whether this was a direct result of the decision to leave the EU. However, any indication that the UK was becoming a less attractive place to work was a cause of concern for NHS Employers, especially as the sector would continue to depend on workers from outside the UK in the short to medium term.
- 3.78 The **Joint Staff Side** said that Brexit might have a damaging impact on the recruitment of staff to the NHS. It estimated that around 62,000 NHS staff in England were EU nationals (5.6% of all staff as at June 2017) and it was unclear whether the NHS would be able to continue to recruit staff from other EU countries post-Brexit. It said that if NHS organisations were not able to recruit from the EU, or if this were restricted, it would shut off a valuable source for recruiting qualified and registered staff. It believed that this would leave the NHS with two sources of recruitment of professional staff, recruiting new graduates, or recruiting former staff back to the NHS, and that these options had the same drawback of a time delay in recruitment.
- 3.79 The Staff Side considered that the change in UK Government funding for student midwives, nurses and allied health professionals, and the removal of the bursaries, coupled with the replacement with a student loan, would have an adverse effect on recruitment. It believed that the prospect of accumulating significant debt would deter many aspiring students, particularly older people, and that early figures had shown a significant drop in applications to nursing courses and midwifery courses at university.
- 3.80 The **Royal College of Midwives** suggested that the prospect of accumulating significant debt would deter many aspiring students from studying midwifery, particularly if it were their second degree. It noted the significant drop in applications to study midwifery at university.
- 3.81 The **GMB** noted that applications for NHS posts in England had fallen by 27% per vacancy in the last two years. It said that unfilled vacancies had increased by 30% between February 2015 and March 2017. It pointed to NHS Digital experimental data which showed that the number of applications per vacancy had fallen by 27%, and the 28% reduction in applications for estates and ancillary roles was greater than it was for some medically qualified categories.
- 3.82 The **Scottish Government** said that it controlled annual intake numbers for student nurses and midwives. The recommended intake was determined by running a supply and demand model, based in part on demand projections from NHS Boards, and analysis of current students in training, student completion rates, and the inflow and outflow from the workforce. The Scottish Government said that the numbers of nursing and midwifery pre-registration students in training were provided annually by NHS Education for Scotland and reflected the total count of students active on pre-registration programmes in Scotland. It reported that at 31 October 2016 there were 10,239 nursing and midwifery pre-registration students in training across NHS Scotland which was an increase of 303 (3%) compared with the 2015 level. In the longer term, it was a decrease of 399 (3.8%) on the number of students in training five years previously, in 2011 (10,638), and 330 (3.3%) above the number 10 years previously in 2006 (9,909).

- 3.83 The Scottish Government said that the total number of students in training continued to be relatively high, though the number had dipped, reflecting a 10% reduction in recommended intakes in 2011/12 and 2012/13. The reduction was in response to a projected reduction in demand for nursing and midwifery staff made by NHS Health Boards at that time. However, the Scottish Government said that, reflecting more recent demand for qualified staff, Ministers had recommended six years of increases in intakes since 2013/14, most recently 5.6% in 2016/17, 4.7% in 2017/18, and 10.8% in 2018/19. It reported that UCAS data published in December 2017 indicated the high number of acceptances to nursing at providers in Scotland, equating to 3,615 acceptances (all domiciles), an increase of 265 (8.0%). It added that there were 3,225 acceptances to nursing in 2017 to a UK HEI from Scottish domiciled applicants, an increase of 275 (9.3%) from the previous year and the second highest on record.
- 3.84 The Welsh Government said that Health Boards and trusts looked to overseas recruitment to fill gaps in medical staff and nursing, although it commented that this should not be seen as a quick and simple solution, and needed to be considered as part of the wider package and the renewed Wales offer. It added that Health Boards were working on improved links with education to make their organisations more attractive to potential employers for the limited number of graduates emerging from universities. In oral evidence, the Welsh Government commented that the bursary for nursing students remained in Wales, and included a two-year tie-in. It considered that this had been beneficial as most graduates stay and work in Wales after graduating.
- 3.85 In oral evidence, the **Department of Health, Northern Ireland** commented that health and social care needed to be an employer of choice. It had commissioned 901 undergraduate nursing places from April 2018. The Department had conducted some planning on Brexit scenarios, as a hard border with the Republic of Ireland could cause labour mobility issues.

Nursing associates

- 3.86 The **Department of Health and Social Care** said that there would be a further 5,000 nursing associates in 2018 and 7,500 in 2019. It considered that the nursing associate role created a bridge between senior healthcare support workers and registered nurses by delivering hands on care, allowing registered nurses to spend more time using their specialist training to focus on clinical duties, and to take more of a lead in decisions on patient care. In October 2017, the Secretary of State for Health had announced plans to train thousands of nursing associates through the apprentice route. The planned expansion was designed to support employers to grow the domestic nursing supply, and reduce reliance on overseas trained staff and expensive agency staff. The Department said it was working with HEE, the Nursing and Midwifery Council, and Higher Education Institutions to ensure a progression pathway between nursing associates and registered nurse roles.
- 3.87 NHS Employers considered that the creation of the nursing associate role could help to be a bridge between healthcare assistants and graduate registered nurses. They said that initial analysis completed by HEE suggested that the cohort of nursing associates in a pilot had demonstrated a greater diversity than the pool of applicants normally seen in university nursing degree courses, with the potential to support greater social mobility for prospective nursing associates. Employers were awaiting the outcome of the pilot for nursing associates and they required a clearer view on the scope of the role. Once agreed, employers would be able to plan more accurately how to use nursing associates across the workforce to meet the needs of their patients and service users. NHS Employers added a further consideration would be whether to include the nursing associate role within safe staffing figures.

Apprenticeships

- 3.88 The **Department of Health and Social Care** said that the apprenticeship agenda was an important part of the overall plan for the NHS workforce to become more self-sufficient. It said its policy aimed to develop career pathways through the apprentice route into the regulated healthcare professions. There were also a large number of clinical apprenticeship standards for NHS roles in development. The Department expected non-healthcare apprenticeships to be used widely across the NHS in roles such as business and administration, leadership and management, and digital roles.
- 3.89 **Health Education England** said that nursing degree apprenticeships were being developed and there would also be increasing opportunities for current healthcare support staff to apply for nursing associate apprenticeships, which could lead onto nursing degree apprenticeships.
- 3.90 The **Scottish Government** observed that in 2016/17, 50% (11) of all NHS Boards in Scotland provided new Modern Apprenticeship opportunities. A total of 85 Modern Apprentice opportunities were appointed using different frameworks (contributing to a target of 500 new Modern Apprentice opportunities between 2014 and 2017). It added that 410 new Modern Apprentices were recruited over the three-year period to July 2017.
- NHS Employers explained that the cost of the levy to the NHS was approximately £200 million in 2017/18. They said that the funds could only be used to pay for apprenticeship training and assessment and it was not permissible to use them to cover other associated costs, for example, wages, travel costs or organisational infrastructure. In oral evidence, NHS Employers felt that there were difficulties with apprenticeships, as the levy barely covered training costs. NHS Employers reported that the number of apprenticeship opportunities in the NHS had grown considerably in recent years, with 15,532 starts by the end of 2016/17. Across the NHS, the 2.3% target would equate to around 28,000 apprenticeship starts per annum, measured as an average across the reporting years 2017/18 to 2020/21. NHS Employers said that this target would need to be around 42,000 if the sector were to spend all the monies paid under the levy arrangements (based on current funding caps). They noted that the NHS Staff Council had produced quidance arrangements for pay and banding of trainees, and that there were job evaluation profiles for roles where apprenticeships were commonly used, such as healthcare support and business administration. NHS Employers also considered that the introduction of the nursing degree apprenticeship gave a new opportunity for employers to train nurses.
- 3.92 **NHS Providers** said, in oral evidence, that the draft Workforce Strategy was ambitious, with the need to develop new roles and better apprenticeships, although the latter was constrained by the levy.

Supply of bank and agency staff

3.93 The **Department of Health and Social Care** said that spending on agency staff rose by 40% from £2.6 billion to £3.7 billion between 2013/14 and 2015/16, but that NHS Improvement had introduced agency controls, reducing expenditure on agency staff to £2.9 billion in 2016/17. The Department noted that this was a fall of £800 million, around 22% across the total workforce, in 2016/17. It added that there was a significant reduction in agency expenditure in Q1 2017/18, with overall agency spend at £169 million, around 22% lower than Q1 in 2016/17, and around 32% lower than Q1 2015/16. It continued that agency expenditure was highly variable between trusts, and variation between trusts within regions was far greater than the variation across regions.

3.94 The Department commented that a national bank strategy was being developed, in order to increase bank staff utilisation across trusts and to decrease agency spending even further. It added that relatively new data published by NHS Digital on bank staff showed a year on year (June 2016 to June 2017) increase in the use of all staff groups, except for ambulance staff where there was a decrease. The Department argued that this apparent growth in bank staff use was a consequence of the policy to reduce expensive agency spending.

Table 3.2: AfC bank staff usage, FTE, England, June 2016 to June 2017

	Jun-16	Jun-17	% change
Nurses & health visitors	8,942	10,158	13.6%
Midwives	387	462	19.3%
Ambulance staff	245	219	-10.5%
Scientific, therapeutic & technical staff	1,272	1,351	6.3%
Support to doctors, nurses & midwives	17,163	18,435	7.4%
Support to ambulance staff	348	415	19.2%
Support to ST&T staff	873	896	2.6%
Central functions	4,936	5,102	3.4%
Hotel, property & estates	2,662	2,791	4.9%
Senior managers	27	53	93.2%
Managers	101	103	1.5%

Source: NHS Digital, DHSC Evidence

- 3.95 NHS Improvement said that agency costs had continued to decrease significantly, following action from NHS Improvement and providers over the last two years. This action had led to the continued reduction in the reliance on agency staff which had, in part, been achieved by moving agency workers and shifts into more cost-effective bank and substantive roles. NHS Improvement said that agency spend as a percentage of the total NHS provider pay bill had fallen from 5.0% at Q2 2017/18, and that providers anticipated a further fall to 4.4% by the end of 2017/18. Given known pressures, the more likely risk adjusted forecast outturn would be closer to the ceiling of £2.5 billion. NHS Improvement argued that controlling the level of agency spending with the rules introduced over the last two years had facilitated a greater degree of workforce planning, and had improved the value for money in this area of significant spend.
- 3.96 **NHS Employers** observed that trusts used various methods to reduce agency spend. Some trusts had reverted to weekly rather than monthly payments for bank work. One trust had successfully piloted a scheme where staff could sell back annual leave to the trust.
- 3.97 The **Royal of College of Midwives** commented that a Freedom of Information request to all UK NHS organisations with maternity units had asked them how much they had spent on agency, bank and overtime for midwives in 2016. The replies received by the RCM stated that NHS organisations spent £97 million, and the RCM concluded that this was enough to pay 2,731 full time, experienced midwives (at the top of Band 6) or 4,391 full time, newly qualified midwives.

- 3.98 The **Scottish Government** said that spending on agency nursing staff had decreased slightly from £24.68 million in 2015/16 to £24.55 million in 2016/17. It felt that agency spend had increased in general over the last few years due to the use of premium rate agencies who had seen a gap in the market and acted on it. The Scottish Government said that some contracted agencies had been unable to supply very specialist staff such as theatre and critical care nurses. It added that Health Boards had undertaken improvement work, such as new governance and local procedures on temporary staff, to reduce spending. The Scottish Government's policy was to utilise the flexibility offered by the nurse banks to secure value for money by decreasing the use of more expensive agency staff, including use of regional staff banks.
- 3.99 The Welsh Government said that the reliance on agency staff had increased consistently in recent years and that NHS Wales was taking proactive action to address the rising costs associated with agency staff and to eradicate the use of off-contract agency in nursing. It also said that Health Boards and trusts were targeting agency, locum and associated cost, while they worked together collaboratively to find all-Wales solutions. It provided examples such as: a communication campaign to encourage staff to sign up to band and on-contract agency arrangements; a stronger focus on workforce planning; proactive local recruitment campaigns; and partnerships with neighbouring Health Boards.
- 3.100 The Welsh Government had set up a Temporary Nurse Staffing Capacity Steering Group in 2015 to oversee and direct an all-Wales action plan. This incorporated the work of other groups into one integrated plan with the aim of managing nurse staffing capacity and reducing agency costs. The Group focused on four main workstreams:
 - off-contract agency supporting the implementation of actions to eradicate off-contract nursing agency throughout NHS Wales and mitigate associated patient safety risks;
 - demand and supply looking at temporary staffing demand drivers and working to increase internal supply;
 - bank and contract agency examining the variations in current bank and agency arrangements across NHS Wales organisations and monitoring the new nursing framework contract with the view to develop future models; and
 - recruitment and retention the Welsh Government was working with Nurse Directors and Workforce & OD Directors on a number of areas.
- 3.101 The **Department of Health, Northern Ireland** provided data which indicated that agency spend (including medical and dental) was £68.7 million in 2012/13 and had increased to £134.7 million in 2016/17. The Department said that trusts in Northern Ireland spent money on agency staff to ensure that safe and effective services were sustained at all times for patients, and to cover for sickness/maternity leave and increases in demand over the winter months. It said that trusts had developed internal bank systems from a pool of qualified existing staff. However, the supply of bank staff could vary, especially at holiday times and across Northern Ireland, and as a consequence staffing needs would sometimes be greater than supply. In such cases agency staff were used to meet this demand. The Department also said that trusts had a regional Agency Framework pricing structure which set hourly rates for staff at the same rates as substantive staff, including on costs.

Workload and working hours

- 3.102 The **Department of Health and Social Care** commented that, from the 2016 NHS Staff Survey, workload challenges in respect of extra hours appeared to be highest for midwives with an increase in their paid and unpaid extra hours up to five hours per week, although offset by a reduction in the number working 11 or more extra hours. Data for all staff groups showed an increase in staff reporting that they were paid overtime in 2016, with unpaid extra hours showing a slight dip, although the Department acknowledged that a high proportion of staff were continuing to work unpaid extra hours.
- 3.103 The **Joint Staff Side** observed from individual trades unions' surveys that a large proportion of respondents were working extra hours to get by financially, either by taking additional paid work in their main job, bank or agency work, or by taking a second or even third job outside the NHS. The individual trades unions' surveys included extensive comments and examples from AfC staff highlighting pressures from workload and working hours.
- 3.104 From the 2017 Labour Force Survey, the **RCN** noted that 29% of registered nurses working in the NHS worked paid overtime (a median of 7.5 hours per week), and 43% worked unpaid overtime (a median of 3 hours per week). For nursing auxiliaries and assistants, 37% worked paid overtime (a median of 10 hours per week) and 22% worked unpaid overtime (a median of 2 hours per week). The RCN reported from its Employment Survey that 73% of respondents worked extra hours at least once a week (an average of 6.3 hours per week). Of those working excess hours, 52% said these were usually unpaid, and 22% said they had received time off in lieu.

Figure 3.1: RCN 2017 Employment Survey – I feel I am under too much pressure at work

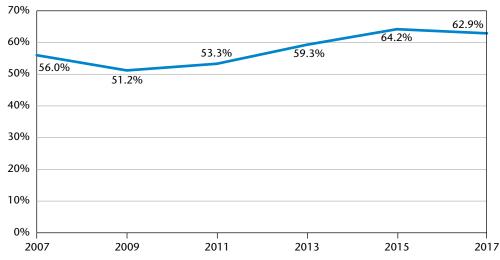
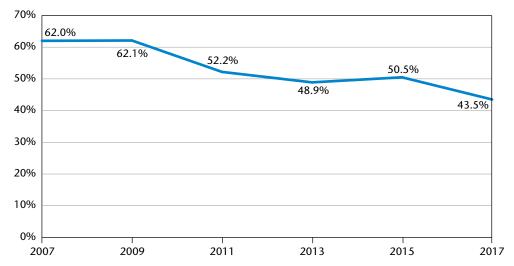
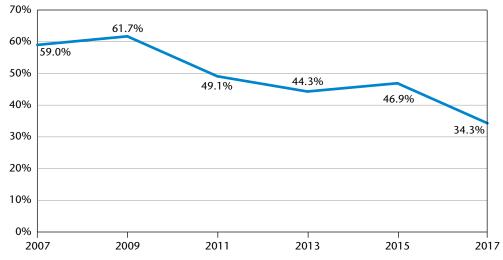


Figure 3.2: RCN 2017 Employment Survey – I am satisfied with the choice I have over the length of shifts I work



Source: IES/ERL/RCN, RCN Evidence

Figure 3.3: RCN 2017 Employment Survey – I feel able to balance my home and work lives



Source: IES/ERL/RCN, RCN Evidence

- 3.105 The individual trades unions highlighted the following findings from their surveys on workload and working hours:
 - The **Royal College of Midwives** 84% of respondents strongly disagreed/ disagreed that workload was at an appropriate level, 91% strongly disagreed/ disagreed that there were enough staff at their organisation to do their job, and 93% of responding Heads of Midwifery said that their unit relied on goodwill from midwives;
 - The **Society of Radiographers** 51% of respondents complained of increased workload and 45% expressed concern over staffing levels;
 - Chartered Society of Physiotherapy (CSoP) 72% of respondents regularly worked unpaid overtime, 11% regularly worked more than 5 hours unpaid each week, and 95% did so to deal with their workload, 68% to provide quality care and 31% to help with staff shortages;
 - **UNISON** 21% of staff did additional paid work on top of their day job, of which 55% did bank work and 36% had a second job outside the NHS; and

- Unite 67% of respondents were "always" or "frequently" working more than their contracted hours (with 44% saying that this time was unpaid), 30% were doing more than 4 hours a week extra, and 10% were doing more than 8 hours extra a week.
- 3.106 The **GMB** commented that the culture of unpaid overtime and unsociable hours in the NHS had a negative impact on staff quality of life and was a major cause of stress. It said that the percentage of NHS staff regularly working overtime was underestimated in the Labour Force Survey and was twice as high in the NHS Staff Survey. The GMB concluded that a full time worker on 37.5 hours a week would be due a 17.2% annual pay rise if 4.3 additional weekly hours were paid at overtime rates.

Vacancies and shortage groups

- 3.107 The **Department of Health and Social Care** said it had continued to develop more robust data on staff vacancies. It said vacancy information was limited to advertised vacancies and although the data was relatively new, the trend in vacancy numbers was upwards. The vast majority of vacancies were filled by bank and agency staff. The Department said that an investigation by NHS Improvement had estimated there were around 36,000 nurse vacancies, of which 33,000 were covered by bank and agency staff. The Department considered that it was making progress on reducing agency spend, and a more strategic approach to the use of bank staff was being developed. The Department continued to work with NHS England and HEE to consider how skill mix changes could help address workforce shortages.
- 3.108 It said that NHS Digital had continued to investigate other sources for vacancy information in order to build on the information extracted from NHS Jobs, potentially including data derived from the Electronic Staff Records (ESR) system, even though not all organisations used ESR to record establishment and vacancies.
- 3.109 **Health Education England** said that up to 42,000 posts in nursing, midwifery and the allied health professions were not currently filled by substantively-employed staff. It added that NHS workforce vacancies had been reduced by up to 9.8% during 2016/17 (about one percentage point). This reduction was set against substantial workforce growth, including new adult nursing posts, with the rapid expansion in new posts resulting in high vacancy levels. HEE pointed out that overall vacancies had peaked at 10.9% in 2016, and had remained high in 2017.
- 3.110 **NHS Improvement** commented that there were significant staff shortages in some sectors such as mental health, in professions such as nursing, and in some regions, such as rural and coastal areas. NHS Improvement said that to gain a greater understanding of the true demand gap, vacancy-derived demand had been calculated based on nursing vacancy rates submitted to NHS Improvement via the monthly workforce return. This further increased the current demand gap, which NHS Improvement calculated to be between 35,000 and 39,000 in 2017 (month 7), and which equated to around an 11% vacancy rate.
- 3.111 **NHS Employers** said that shortages of staff posed challenges to the implementation of new models of care, and challenges in the delivery of emergency medicine. The shortage of nursing and midwifery professions in particular presented difficulties for the delivery of services such as A&E and maternity.
- 3.112 **NHS Providers** said that London and the South East had the highest shortfalls across all staff groups except in the category of other qualified staff. NHS Providers had been told by trusts in and around London that the high cost of living, particularly housing, was a barrier to recruiting and retaining staff and that the current High Cost Area Supplements did not mitigate for this.

- 3.113 The **Joint Staff Side** believed that the NHS had a staffing crisis and that many professional groups now had shortages. It said that: the vacancy rate for nurses was over 5% in Scotland, at over 3,000; there were 1,200 nursing vacancies in Wales; and between 36,000 and 42,000 vacancies in England. The Staff Side also expressed concerns at midwifery vacancies and noted that said there was a shortage of 3,500 midwives, and that the radiotherapy radiographic workforce had a vacancy rate of 6.2% across the UK.
- 3.114 The **Royal College of Nursing** highlighted its 2017 report *Safe and Effective Staffing:* the Real Picture³⁷ which showed that the vacancy rate for registered nurses had nearly doubled in the last three years, from 20,000 to 40,000, and with nearly 28,000 vacancies at Band 5 level. The report also showed that there had been a 2% overall growth in the UK NHS nursing workforce since 2010. The RCN argued, however, that this growth was set against the increasing vacancy rates across the UK, and that the number of nursing staff was insufficient to meet demand. The RCN did not believe that sufficient steps were being taken to address the problem while the NHS was facing unprecedented nursing staff shortages.
- 3.115 The **Royal College of Midwives** said that the number of new recruits must increase, and the service must retain existing staff to prevent the downward spiral of staffing shortages.
- 3.116 The **Chartered Society of Physiotherapists** estimated that there were 3,900 European physiotherapists working in the UK and, at a time of staff shortages of a very similar amount and with services already very badly overstretched, any loss of supply would have a serious impact on patient care, as well as adding to the stress on the remaining staff.
- 3.117 The **Society of Radiographers** commented that the diagnostic service, and to a greater degree radiotherapy, had suffered from shortages for a number of years. The SoR said that this was partly down to poor recruitment planning that had not been assessed or matched against service design and increasing demand. In recent years, shortfalls in specialist areas had been met by recruitment from overseas or long term employment of locum and agency. This was costly and erratic and could be disruptive to the service, as there was little in the way of continuity. The SoR said that there were key specialist areas in diagnostics where shortages were most acute, but equally that the general diagnostics service had suffered from shortages of staff in the last seven years. The Society had seen a marked increase in the use of this service, which had not been met by an appreciable increase in recruitment.
- 3.118 Unite believed that there was a staffing crisis in the NHS brought on by the Government's funding and pay policy and asked the Review Body to consider the impact this was having on the service, and on NHS staff forced to work in understaffed conditions. It also asked the Review Body to recommend improvements to agency spend, vacancies and recruitment and retention data in order better to solve staffing problems.
- 3.119 The **Scottish Government** provided the following data on vacancies at September 2017 (compared with September 2016):
 - total nursing and midwifery vacancies were at 4.5% (as a percentage of establishment) compared with 4.3% in 2016. The majority of the recorded vacancies were for less than three months. The three-month vacancy rate was at 1.3%, the same as 2016;
 - for midwifery, total vacancies stood at 4.2%, a slight increase on 4.1% reported in 2016. The three-month vacancy rate was 1.3%, a slight decrease from 1.4% in 2016;

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³⁷ Royal College of Nursing (May 2017), Safe and Effective Staffing: The Real Picture. Available at: https://www.rcn.org.uk/professional-development/publications/pub-006195

- the vacancy rate for allied health professionals was 4.1%, an increase over the 3.7% level in 2016;
- for paramedics, the rate was 4.5%, an increase over the 2012 rate at 4.1%;
- the overall vacancy rate for qualified pharmacists (Bands 6 to 9) was 6.5%, an increase from the 6.3% level in 2016. The three-month vacancy rate of 3.3% was an increase from 1.8% in 2016; and
- vacancy rates for Band 6 and Band 7 pharmacists were 11.0% and 9.6% respectively, representing an increase from the Band 6 level in 2016 of 8.3% and a slight decrease from the Band 7 level in 2016 of 11.2%. Vacancy rates over three months for Band 6 staff had gone up from 0.0% in 2016 to 3.1% in 2017, and the rate for Band 7 had gone up from 2.9% to 5.2%.
- 3.120 The **Welsh Government** noted that advertised vacancies rose between April 2016 and March 2017 but fell for nursing and midwifery (registered) and allied health professionals.

Retention

- 3.121 The **Department of Health and Social Care** said that, although the total workforce continued to grow, the rate of retention for some groups of clinical staff had declined over the past decade. It noted that staff engagement had increased slightly over the same time period. However, it expressed concern that fewer members of staff were choosing to remain in the NHS. The Department said that there was no single solution to retention issues, but that improving retention was a vital part of the Government's workforce supply strategy both at a national and local level to ensure more of the trained workforce were kept for longer. It argued that retention required a multi-dimensional approach to retain staff. The Department said that there was a need to ensure that staff were empowered to do their job and engaged in their work, and that there was flexibility around the work "offer", including creating open and supportive environments to work in and investing in Continuing Professional Development (CPD) alongside clear and achievable career development pathways. The Department acknowledged that a better work-life balance was the largest growing reason for voluntary resignations, however, there were no particularly strong, clear regional patterns in leaver rates.
- 3.122 The Department said that it used the stability index³⁸ to measure how well the NHS was doing in retaining the workforce. It considered that data from NHS Digital showed retention continuing to fall slightly for most AfC groups in recent years, and that retention of ambulance staff was better than other staff groups.

³⁸ The stability index is the percentage of staff at the start of the period that do not leave the specified group during the period in question. For example, if a trust had 100 nurses in July and a year later 90 of those nurses remained in post in the trust, the stability index would be 90/100 expressed as a percentage: 90%.

Table 3.3: Stability index for AfC staff, England, 2012/13 to 2016/17

Staff groups	2012/13	2013/14	2014/15	2015/16	2016/17
Nurses & Health Visitors	89.9%	90.3%	89.7%	89.5%	89.1%
Midwives	91.5%	91.0%	90.2%	89.7%	89.2%
Ambulance	94.0%	93.2%	92.6%	92.4%	92.7%
Scientific, Therapeutic & Technical Staff	88.7%	89.4%	88.5%	88.3%	88.6%
Support to Clinical	88.9%	89.1%	88.4%	88.4%	87.6%
Infrastructure	88.2%	81.1%	87.9%	88.3%	88.4%

Source: NHS Digital, DHSC Evidence

3.123 The Department had used ESR data to undertake some analysis on leavers. It said the stated reasons for leaving must be treated with caution as these returns were clerically completed and there were many cases in which no reason for leaving had been given. It said the picture over the last five years (2012/13 to 2016/17) suggested that over half had left as a result of voluntary resignations (the proportion had risen from 44.7% to 63.0%). Its analysis of voluntary resignations, excluding those resigning for reasons unknown, showed that the proportion leaving for work-life balance had increased from 11% to around 16%, and that the percentage of those leaving for better reward package had remained broadly stable at around 5% over this period.

Table 3.4: DHSC analysis of top 3 reasons for leaving – AfC staff, England, 2012/13 to 2016/17

	Absolute figures					Percentage of all leavers				
Reason for leaving	2012/13	2013/14	2014/15	2015/16	2016/17	2012/13	2013/14	2014/15	2015/16	2016/17
Voluntary resignation	74,598	84,678	98,418	104,804	108,722	44.7%	58.0%	60.6%	62.1%	63.0%
Retirement	21,814	22,394	26,007	25,732	25,875	13.1%	15.3%	16.0%	15.2%	15.0%
Dismissal	5,422	5,374	5,464	5,986	5,860	3.2%	3.7%	3.4%	3.5%	3.4%

Source: NHS Electronic Staff Records, DHSC Evidence

3.124 The Department said that NHS Improvement was directly supporting 53 mental health providers and over 50 acute and community providers in the development of improvement measures to support nurse retention and participation rates. NHS Improvement had applied guidance and good practice and had launched a national programme on retention to strengthen the support available to trusts. The Department said that initially this work focussed on a nursing-led Direct Support Programme. However, NHS Improvement were also focussing on a mental health retention programme, in which all mental health trusts would be set targets to achieve the 6,000 FTE savings target based on their current clinical leaver rates. NHS Improvement had committed to this target by 2020.

- 3.125 **NHS Improvement** said that data from the ESR indicated that that nurse leavers from the NHS had gradually gone up, from 7.3% in 2012/13 to 8.7% in 2016/17 an increase of 1.4 percentage points over the last five years. It noted that the rate at which registered nurses were leaving trusts (including to move to other trusts) had increased from 12.3% to 15.0%, suggesting that insufficient growth, more retirements and increased demand for staff might be impacting on trusts competing with each other for the same nursing supply. NHS Improvement argued that this had cost the NHS significant amounts of money collectively, and in individual organisations, as well as potentially impacting on the quality and availability of services as staff moved between trusts.
- 3.126 NHS Improvement had undertaken analysis on retention in provider organisations and had developed a work programme to support improvements in retention. This work programme included:
 - a series of Retention Masterclasses aimed at Directors of Nursing and HR Directors drawing upon best practice case studies focussing on evidence based interventions such as the staff offer, CPD, careers advice and planning, retirement and organisational culture;
 - a National Retention Improvement Programme with NHS Employers, which covered all staff groups and built on the existing NHS Employers' programme currently working with 92 trusts. All remaining trusts would be expected to complete the programme to help maximise the return on investment by increasing retention rates;
 - a NHS Improvement Retention Direct Support Programme on nursing which
 provided targeted, clinically-led support to trusts in the top quartile of nursing
 leaver rates. It had begun with the top 20 trusts in July 2017, followed by a further
 cohort of trusts in October 2017, and a final cohort in January 2018 to complete
 action in the worst quartile; and
 - a bespoke programme of support for mental health trusts covering nursing and medics. Providers with above average leaver rates received targeted support and would be required to achieve larger, proportional WTE savings. All mental health trusts were required to produce detailed improvement plans on how they planned to address their high leaver rates and improve retention over the next 12 months, with the sector working to achieve 6,000 WTE savings by 2020.
- 3.127 **Health Education England** commented that that its draft Workforce Strategy included targeted retention schemes to encourage staff to continue working in healthcare, including support for local NHS organisations on how to improve retention rates, an expansion of the nursing Return to Practice scheme, and efforts to encourage European nationals to stay. HEE's analysis of retention for specific groups found that for adult nursing retention had deteriorated between 2013/14 and 2016/17, with non-retirement leavers increasing by 11%, non-retirement leavers in children's nursing increasing by 14% between 2015/16 and 2016/17, and deteriorating retention in mental health nursing in 2016/17.

- 3.128 NHS Employers said that there was no single action which would resolve staff retention issues. They recognised that some turnover of staff was healthy and was to be expected. However, they argued that high volume turnover, combined with difficulties in recruitment, led to rota gaps which in turn added to pressure on the remaining staff, and could lead to an over-reliance on expensive agency and locum staff. NHS Employers pointed to a range of actions that employers could take to help retain and develop existing staff, including their toolkit³⁹. These actions included: improving staff engagement; supporting and promoting health and wellbeing; providing a safe and open environment in which concerns could be raised and acted upon; offering flexible working and e-rostering; developing a culture which recognised and valued difference; tackling bullying and harassment; providing education and training activities; and offering flexible retirement options. In addition, NHS Employers commented that pay and reward was an equally influential factor in staff retention, and that employers had promoted the full range of reward and benefits that the NHS offered. They argued that where employees understood these benefits they could make better informed decisions on whether to leave or remain.
- 3.129 **NHS Providers** said that national data on retention showed that across staff groups there was a common trend from 2010/11 to 2015/16 of leaver rates rising.
- 3.130 The **Royal College of Nursing** said that data from NHS Digital showed that turnover rates in England and Scotland had been increasing in recent months. For Band 5 nursing staff in England the 2016 leaving rate (2.3%) overtook the joining rate (2.1%). This showed, in the RCN's view, the instability and vulnerability in the workforce. The turnover rate for all nursing staff in Scotland had risen from 5.4% in 2011/12 to 7.2% in 2016/17. The RCN said that the number of leavers in the nursing and midwifery workforce in Northern Ireland had grown from 4.2% in 2014 to 5.9% in 2017. NMC data for Northern Ireland showed that in 2016/17 the number of leavers was higher than joiners which indicated, in the view of the RCN, a recruitment and retention problem across the health and social care economy.
- 3.131 The **Scottish Government** said that the way in which Information Services Division calculated and presented turnover changed two years ago to make the data simpler and easier to interpret. The 2017 figures were therefore no longer directly comparable to the longer term figures. The Scottish Government reported that whole time equivalent turnover had decreased slightly from 6.4% in 2015/16 to 6.3% in 2016/17, with headcount turnover remaining at 6.8%. It also noted that, in view of the previous recruitment and retention issues among ambulance staff, the long term trend in paramedic and technician numbers was up.
- 3.132 The Scottish Government reported that there were a small number of Recruitment and Retention Premia (RRP) in place in NHS Scotland to help attract staff to specific locations. Since the removal of National RRPs in 2013, a number of north of Scotland NHS Boards had applied for and been granted a local RRP to allow them to compete with the oil and renewables industry, for trades such as electricians and plumbers. The Scottish Government reported that NHS Shetland, NHS Orkney, NHS Western Isles, NHS Highland, NHS Grampian and the Scottish Ambulance Service based in Aberdeen all had RRPs in place for qualified maintenance personnel. NHS Lothian had also applied for and been granted an RRP for maintenance staff in the region. The other RRP in place was for NHS Western Isles to assist recruiting Band 7 pharmacy staff.

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³⁹ NHS Employers, *Improving Staff Retention – A Guide for Employers*. Available at: http://www.nhsemployers.org/news/2017/09/improving-staff-retention-a-quide-for-employers

3.133 Data supplied by the **Welsh Government** stated that the leaver rate across the NHS in Wales was 6.24% in the year to March 2017 – nursing and midwifery was at 6.91%, and allied health professionals at 6.25%, but rates were much higher for professional, scientific and technical staff at 9.40% and additional clinical services staff at 9.53%. The data also showed the vast majority of leavers resigned voluntarily.

Motivation and engagement

- 3.134 The **Department of Health and Social Care** commented that staff engagement was crucial to securing and the retaining the workforce that the NHS needed. It said that recruitment and retention was not just about pay, but about creating a culture and environment in the NHS where staff wanted to work, felt safe to raise concerns, and to learn from mistakes. The Department said that the evidence suggested that the staff experience in the NHS had remained broadly stable since last year and engagement scores had improved, although with some variation across the NHS and challenges for some staff groups. The Department was working in partnership with Arm's Length Bodies and NHS trades unions to improve staff retention by:
 - exploring how trusts could be supported and progress measured through the Care Quality Commission's inspection programme;
 - working with NHS Digital to improve sickness absence data;
 - promoting NHS Improvement's "Staff Experience and Outcomes Explorer" for trusts to assess their progress; and
 - commissioning NHS Employers to bring together engagement, wellbeing, organisational development and tackling bullying into one advice programme.
- 3.135 The Department cited the CQC's view that engaging and empowering staff was key to driving improvement in hospital care, STPs using staff engagement to refresh local services for patients, and supporting staff engagement in NHS Improvement's Culture and Leadership Programme. The Department also highlighted the main findings from the 2016 NHS Staff Survey (which have been updated with the 2017 results in Chapter 4).
- 3.136 The Department's analysis of NHS Digital's sickness absence statistics pointed to no material change to rates since 2010, with the latest 12 month average at 4.16% to March 2017.
- 3.137 The Department also referred to the Friends and Family Test which, for the last quarter of 2016/17, showed that 64% of staff would recommend their organisation as a place to work, and that 79% would recommend their trust as a place to receive treatment.
- 3.138 **NHS Employers** said that embedding and realising the benefits of any strategic workforce plan would require leadership, and a commitment by organisations to ensure that all staff were valued, supported and developed throughout their careers. They observed that the link between effective staff engagement and outcomes was well known. They felt that the more NHS organisations valued their staff, and wished to make their working lives a positive experience, the better placed they would be to meet difficult recruitment and retention challenges and, most importantly of all, the more they would be able to provide consistently safe, high quality care to their patients.
- 3.139 NHS Employers believed that evidence over many years had shown that, where time and effort was invested in engaging and looking after staff, patient care had improved. Employers welcomed the emphasis on staff health and wellbeing in the NHS Five Year Forward View. This had stressed the importance of the physical and mental wellbeing of the NHS workforce. They argued that changes to working conditions, and a stronger workplace culture of trust and engagement, would help boost morale and staff retention in struggling areas. NHS Employers noted the key findings from the 2016 NHS Staff Survey (see Chapter 4 for the 2017 results).

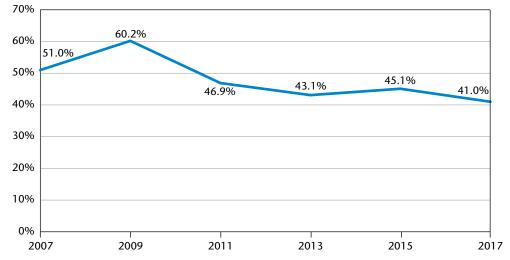
- 3.140 NHS Employers commented that NHS sickness rates varied significantly between organisations and staff groups, with mental health and musculoskeletal conditions the highest reasons. In addition to the costs of agency cover, Public Health England estimated staff absence costs at £2.4 billion.
- 3.141 **NHS Providers** said that staff must be appropriately and fairly rewarded to support recruitment and retention, and to help create a motivated workforce. They commented that there were critical factors affecting the staff experience which were largely outside provider trusts' control, notably the work pressure created by the fundamental mismatch between what the NHS was asked to do and the resources made available, cuts to workforce development budgets, and pay restraint.
- 3.142 NHS Improvement commented on improved morale having a direct impact on the quality of care, and that its National Leadership Development and Improvement Strategy sought to set the direction for capacity and capability building.
- 3.143 The **Joint Staff Side** commented that there were strong indications that pay restraint was damaging morale and motivation among NHS staff. The Staff Side pointed to the 2016 NHS Staff Survey for England (updated results are in Chapter 4). The individual trades unions commented as follows on motivation and morale (including their own survey results):
 - the **Royal College of Nursing** while intrinsic job satisfaction remained high for nursing staff, nursing had suffered a continued erosion of esteem, and a decreasing proportion of NHS nursing staff believed that the profession would continue to offer a secure job in the future, down to 41% (43% of all nursing staff), or would recommend nursing as a career, down to 39% (41% of all nursing staff);
 - the Royal College of Midwives 54% of Heads of Midwifery rated morale and motivation in their organisation as "OK" or "poor" and only 2% as "very good".
 47% of respondents strongly disagreed/disagreed that they looked forward going to work. The RCM concluded from its survey that satisfaction with their work was very low among midwifery staff and that maternity units were reliant on goodwill;
 - the Chartered Society of Physiotherapy 82% of respondents would feel better about/more satisfied with their job if they received an above inflation pay rise;
 - the **Society of Chiropodists and Podiatrists** only 26% would recommend a career in the NHS to a newly qualified podiatrist;
 - UNISON as rising costs cut into the relative value of NHS pay, morale and motivation were falling across the NHS. Nearly 6 in 10 staff said morale was low or very low with 70% saying morale had fallen over the last year and nearly 9 out of 10 saying morale was having an impact on their productivity. UNISON added that this was having a serious effect on retention; and
 - Unite Government pay and funding policy had had a devastating impact on staff morale and had caused a serious staffing crisis across the NHS. 85% of survey respondents reported that morale and motivation in their workplaces was worse or a lot worse, increased from 80% in 2016. Respondents cited the causes of worsening morale as increased workplace stress (84%), falling value of take home pay (67%), and restructuring and reorganisation (60%). Also 36% of respondents would probably not and 24% would definitely not recommend their own occupation or profession as a career in the NHS.

100% 80.8% 79.0% 80% 73.6% 71.6% 69.5% 73.3% 60% 40% 20% 0% 2009 2011 2015 2013 2017 2007

Figure 3.4: RCN 2017 Employment Survey – I think nursing is a rewarding career

Source: IES/ERL/RCN, RCN Evidence

Figure 3.5: RCN 2017 Employment Survey – I would recommend nursing as a career



Source: IES/ERL/RCN, RCN Evidence

- 3.144 The **Scottish Government** recognised that delivering high quality, safe and effective services required a workforce which was empowered, committed and understood the diverse needs of the population. It cited the NHS Scotland Staff Governance Standard and its Monitoring Framework. The Scottish Government had discontinued the national annual staff survey, with the staff experience to be measured in the future using the iMatter Continuous Improvement Model aimed at transforming staff engagement. This model was supplemented by the 2017 Dignity at Work Survey.
- 3.145 The Welsh Government pointed to national and local approaches to staff engagement, including through strong social partnership and the Wales Partnership Forum, a Common Principles Project to manage difficult workplace employment issues, and local and national staff wellbeing approaches. The Welsh Government reiterated the results of the 2016 NHS Wales Staff Survey (ahead of the 2018 survey results) and commented on the workshops run across all Health Boards and trusts to consult on the results and plan actions. Individual Health Boards had embedded their action planning within their organisational development programmes. The Welsh Government commented that sickness absence, as one proxy of the effectiveness of wellbeing initiatives, showed stable rates since 2010/11, and a 12-month sickness absence rate of 5.1% in 2016/17.

Earnings, pay progression and pay comparisons

- 3.146 The **Department of Health and Social Care** said that the pay bill continued to grow, largely as a result of rising on-costs and an expansion of the workforce. There had been very limited growth as a result of additional earnings, pay drift or the use of Recruitment and Retention Premia. The Department commented that average earnings per FTE AfC staff had not grown as swiftly over the last five years as in the private sector. The total earnings of those AfC staff who were employed in the NHS in 2010 and also in 2015 had increased by an average of between 1.7% and 2.9% per year depending on staff group. The Department reaffirmed that public sector pay remained, on average, comparable to private sector pay, and that public sector defined benefit pensions were among the best available.
- 3.147 The Department compared year on year earnings growth between 2012/13 and 2016/17, and concluded that growth in the private sector (yearly average of 1.6%) had been consistently higher than that experienced by AfC staff (yearly average of 0.4%). The Department continued that overall averages could obscure differences in certain professions and pay ranges, but that average growth for most NHS staffs groups tended to be lower than across the economy. From comparisons using the Annual Survey of Hours and Earnings between 2012/13 and 2016/17, the Department showed that all employees saw median earnings increase by 7.4% (mean 5.8%) whereas AfC groups saw median earnings increase by between 1.4% and 6.2% (mean between -0.9% and 3.9%). The Department added that earnings growth across the overall distribution had been higher for those with lower earnings, had increased at a slower rate at the median, and had increased at a much lower rate at the upper quartile.
- 3.148 The Department compared earnings growth for similar workers based on: qualifications, training and experience; responsibilities and risks; skill and competencies; professional standing and status; and leadership and management. The Department concluded that mean annual earnings growth for NHS staff had been lower than comparators across the wider economy in the last five years. Between 2012/13 and 2016/17, the mean increase in earnings for the comparator group ranged from 1.4% to 5.5%, and the mean earnings increase for the HCHS group ranged from -2.0% to 3.8%. For qualified health professionals, comparator group earnings increased by 5.2% whereas HCHS group earnings increased by 3.1%.

Table 3.5: DHSC analysis of HCHS staff groups and comparator groups, England, 2012/13 to 2016/17

		arnings		conomy	Percentage Change		
	(Earnings per Headcount)		Comparat	ngs of tor Group ans)	HCHS Group 2012/13 to 2016/17	Comparator Group 2012 to 2016	
NHSPRB Remit Group	2012/13	2016/17	2012 2016		Mean	Mean	
Hotel, Property & Estates	£23,552	£24,241	£15,707	£16,538	2.9%	5.3%	
Support to Clinical Staff	£17,798	£18,473	£18,030	£18,982	3.8%	5.3%	
Central Functions	£16,950	£17,513	£25,664	£27,073	3.3%	5.5%	
Qualified Health Professionals	£38,768	£39,976	£27,355	£28,775	3.1%	5.2%	
Managers	£47,974	£47,038	£48,102	£48,788	-2.0%	1.4%	

Source: NHS Digital Mean annual earnings per person by Staff Group, in NHS Trusts and CCGs in England and ONS Gross Annual Pay Data, DHSC Evidence

3.149 The Department commented that the drivers influencing the change in pay bill per FTE were headline pay awards, changes in band mix, changes in pay point mix, changes in staff group mix, additional earnings effects, and on-cost effects (such as changes in the rules that govern employer pension contributions or employer national insurance contribution). The Department said that on average the pay bill per FTE increased by 0.94% every year between 2011/12 and 2016/17 (see Table 3.6 below). This increased by 2.4% in 2016/17, with 1.95 percentage points of the increase driven by the impact of the single tier state pension introduction. The Department also highlighted the movements in AfC staff pay bill components.

Table 3.6: AfC staff pay bill per FTE, year on year changes, England, 2011/12 to 2016/17

AfC staff	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Paybill per FTE growth	1.4%	1.1%	0.4%	0.0%	0.4%	2.4%
Headline pay award and pay reform	0.3%	0.3%	1.0%	0.4%	0.5%	1.0%
Basic pay per FTE	1.1%	0.6%	-0.1%	-0.5%	0.4%	-0.1%
Additional earnings per FTE	-0.1%	0.2%	-0.6%	0.4%	-0.6%	-0.3%
Staff group mix	0.0%	0.0%	-0.1%	-0.1%	-0.2%	-0.2%
Total on-costs per FTE	0.0%	0.0%	0.2%	-0.1%	0.2%	2.0%

Source: Department of Health Headline HCHS Pay bill Metric Estimates, DHSC Evidence

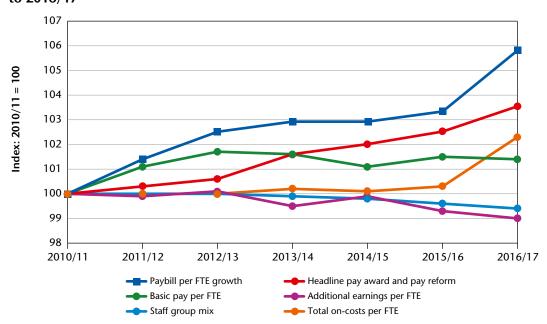


Figure 3.6: Movements in AfC staff pay bill components, England, 2010/11 to 2016/17

Source: Department of Health Headline HCHS Pay Bill Metric Estimates, DHSC Evidence

- 3.150 The Department's analysis showed that individuals not at the top of their pay band would progress by gaining an increment each year, typically valued at around 3% to 4% of salary. The proportion of AfC staff at the top of their pay band at March 2017 was between 85.4% (Band 1) and 37.8% (Band 6).
- 3.151 NHS Providers said that NHS pay had not kept pace with the wider economy and inflation. They cited the Health Foundation report that between 2008/09 and 2015/16 the basic pay of NHS staff had fallen by 6% in real terms. They added that the OBR's inflation estimates for 2017 were 2.7% for CPI inflation and 3.6% for RPI inflation, whereas NHS staff received a pay award for 2017/18 of 1% in line with the Government's public sector pay policy.
- 3.152 The **Joint Staff Side** emphasised that the value of the AfC pay framework had diminished significantly over the last seven years, with NHS staff suffering a real terms fall in earnings of between 10% and 20%. The Staff Side commented that there had been real terms losses for each AfC pay band due to pay restraint and, while the size of the loss varied across the four UK countries, all pay points had fallen behind costs. The Staff Side provided examples of how pay would have increased if RPI inflation had been applied since 2011/12, including a nurse at the top of Band 5 where the salary would have increased by between £4,705 and £5,566.
- 3.153 The Staff Side said that in nominal terms earnings had grown between 2010 and 2017, but CPI inflation had grown by 13.2% and RPI inflation by 20.4% over the same period, meaning a real terms drop in earnings against RPI inflation for the following groups:

•	Nurses and health visitors	-14.7%
•	Midwives	-17.1%
•	Ambulance staff	-20.0%
•	Scientific, therapeutic and technical staff	-17.6%
•	Support to clinical staff	-10.4%
•	NHS infrastructure staff	-10.8%

- 3.154 The Staff Side added that union surveys of members demonstrated the personal impact of pay restraint on NHS staff, with the majority of respondents stating that they were financially worse off, and that this had led to changes in behaviour such as cutting back on holidays and the amount put away for savings. The individual trades unions provided summaries of narrative comments from individual AfC staff in their surveys which included examples of where they felt financially worse off and undervalued in terms of pay. In oral evidence, the Staff Side said that it was difficult to find comparator groups for AfC staff, but that for nurses, comparators were considered to be public sector employees such as teachers, social workers and police officers.
- 3.155 The RCN said that seven years of pay restraint had eroded the real terms value of pay for all nursing staff. It calculated that the real terms annual change in earnings for Bands 4 to 7 adjusted for RPI inflation since 2010 showed cumulative losses of between 11% and 13.9%.

125 120 115 110 105 100 95 2011 2012 2013 2014 2016 2017 2010 2015 ■ Band 4 — Band 5 — Band 6 — Band 7

Figure 3.7: RCN analysis of annual earnings Bands 4-7 against the Retail Prices Index and Consumer Prices Index, England, 2010-2017 (2010=100)

Source: NHS Digital, annual earnings April to March. Annual RPI and CPI 2010-2016, first two quarters 2017, RCN Evidence

- 3.156 The RCN also found that 64% of respondents to its 2017 survey described their pay band as inappropriate (compared with 42% in 2015, 40% in 2013 and 38% in 2011) comparative figures were at 75.9% in Northern Ireland, 67% in Scotland and 64% in Wales. The survey also showed that:
 - 73.5% of respondents said that they were worse off financially than five years ago, and that the main way to cope with everyday expenses was to take on extra work, either additional hours (51%) or a second job (23%);
 - 63% of respondents had had to make adjustments or get financial help;
 - 59% had cut back on food and travel costs;
 - 22% had struggled to pay utility bills;
 - 11% had been late with rent or mortgage payments; and
 - 2.4% had used charities or food banks.
- 3.157 The RCN added that the workforce was predominantly female and around half were the main or primary breadwinner in their household, indicating the dependence on their wages and a high level of vulnerability among many UK households to depreciating pay. The RCN concluded that most nursing staff were in a fragile financial position when it came to their employment.

- 3.158 The **RCM** calculated that the pay for a midwife at the top of Band 6 from 2010 to 2017, against RPI inflation, had decreased by over £6,600. Its 2017 member survey found that:
 - 86% of respondents felt worse off financially than five years ago;
 - 78% worried about paying bills;
 - 35% worried so much about money that it affected their work; and
 - 61% were considering leaving the service but 80% who were considering leaving would stay if they had a pay increase.
- 3.159 The **Chartered Society of Physiotherapy** said that half the respondents to their survey were dissatisfied with their level of pay and a further 25% very dissatisfied. It added that 29% of respondents sometimes or regularly took on other paid employment to earn extra money to save and pay off debts.
- 3.160 The **Society of Radiographers** calculated that AfC Bands 5 to 8 had lost, on average, 14% of their purchasing power since 2010 with the added effect of some radiographers moving to higher tier pension contributions. It cited an OME study⁴⁰ which concluded that AfC radiographers had experienced a big decline in median real gross hourly earnings. This was statistically significantly larger than the decline in non-pay review body comparators and accounted for by changes in occupational workforce composition. From its survey, the SoR found that respondents had to service debt, use food banks, fall back on savings, and supplement income through a second job (the latter at 14% of respondents and increasing from 9.5% in 2015).
- 3.161 **UNISON** commented on the results of its 2017 NHS Pay Survey, which found that almost all NHS staff reported rising cost of utilities, transport and food as driving up living costs, plus a sizeable minority reporting increases in housing and childcare costs. It said that, in response to these costs, NHS staff had had to make changes to their lifestyle and cut back on family holidays, visits to restaurants and meals out, and savings. Further analysis suggested that 37% of respondents asked family or friends for financial support, 58% relied on unsocial hours payments and 21% did additional paid work (56% did bank work and 36% had a second job outside the NHS) of which 73% did so because their basic salary did not cover basic living costs.
- 3.162 The **GMB** stated that after seven years of real terms pay cuts NHS staff had suffered a significant loss to their quality of living. It said that measuring changes to the top of pay bands was the best method of examining change over time, as currently around half of NHS staff were at the top of their band and did not benefit from pay progression. The GMB said that its modelling of cumulative real terms losses demonstrated that Bands 4 and above had endured the greatest percentage reductions and that, against RPI inflation, a top of Band 4 worker would have cumulatively lost 88% of their pre-deductions annual salary between 2011/12 and 2019/20 (unless the pay cap was lifted).
- 3.163 **Unite** estimated that the majority of NHS staff had lost between 10% to 20% of their real terms pay over the last seven years, made worse by increases to pension contributions and national insurance rates. In Unite's 2017 survey 59% of respondents reported that the pay cap had had a negative or very negative impact on the services offered to patients, 4% claimed in-work benefits or tax credits to maintain their standard of living, and 19% reported doing additional work to supplement their income (up from 15% in 2016) with 9% working outside the NHS and 6% through the NHS bank.

⁴⁰ Office of Manpower Economics (2017), *Wage Growth in Pay Review Body Occupations*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/623810/Wage_Growth_in_PRB_Occupations_-_final_report__3_.pdf

3.164 At the time of their December 2017 submission, the **Joint Staff Side** concluded from its analysis of earnings and inflation that a fully funded UK-wide pay settlement was required which would match RPI inflation, start to restore pay lost during the years of austerity (a consolidated sum of £800 to all) and invest in improving the NHS pay structure. The Staff Side commissioned Incomes Data Research to cost these proposals at approximately £2.2 billion or an increase of 6.3% to the AfC pay bill in 2018/19.

National Living Wage

- 3.165 The **Department of Health and Social Care** calculated that the annual AfC wage at the lowest band, based on a 37.5 hour week, exceeded the National Living Wage (NLW) across England for people 25 years of age and over. With the National Living Wage at £7.50, the Department provided AfC minimum hourly wages for Inner London at £10.03, Outer London at £9.69, London Fringe at £8.37, and Rest of England at £7.88.
- 3.166 NHS Employers said that they were working in partnership with trades unions to explore what changes might be needed to accommodate the impact of the NLW. They did not necessarily want the bottom AfC pay point to be the NLW rate, as this would erode the NHS's competitive labour market position relative to other employers. At the time of the evidence submission, NHS Employers reported that investing resources in the bottom end of the pay structure in the current tight financial climate was not a priority for most employers. Depending on changes to the NLW and national pay uplifts, NHS Employers forecast that the NLW would have implications for AfC pay scales by 2019/20, potentially staff in Bands 1, 2 and the beginning of Band 3 could have the same basic salary. NHS Employers considered differentiation between pay bands remained important.
- 3.167 The **Joint Staff Side** said that the introduction of National Minimum Wage rates from April 2018 might have a knock-on effect for wages further up the pay scale, in order to maintain differentials reflecting job evaluation ranking of role. The Staff Side commented that recent studies had shown that Living Wage employers reported an increase in productivity, a reduction in staff turnover/absenteeism rates, and improvements in their public reputation.
- 3.168 At the time of the December 2017 submission, **UNISON** sought to ensure that, through a combination of the elements of the Staff Side's pay claim, all NHS staff received a pay increase of at least £1 an hour, moving toward a pay structure with £10 an hour as the lowest wage in the NHS. UNISON said that it had very clear priorities for reforming the pay structure, including ending low pay and making sure there was a genuine Living Wage. **Unite** also argued that more should be done to improve the wages of the lowest paid staff and that differentials had been stretched and distorted. Unite considered that the real terms loss of earnings impacted hardest on lowest paid workers, who tend to spend larger proportions of their income on basic staples like food, rent and energy. Unite said that there was still a substantial number of NHS staff not being paid the Living Wage as defined by the Living Wage Foundation (in England and Northern Ireland), and that this issue needed to be tackled to end poverty pay, and to bring the NHS pay structure in line across all four UK countries.
- 3.169 The **Scottish Government** highlighted that its pay policy included the continuing requirement for employers to pay staff the real Living Wage.
- 3.170 In oral evidence, the **Department of Health**, **Northern Ireland** recognised that the implementation of the National Living Wage had compressed AfC pay scales in the lower pay bands. The Department added that Bands 1 and 2 would be affected in 2018/19 although the Department would not carry out a major restructure in advance of the AfC negotiations for England being concluded.

Total Reward

- 3.171 The **Department of Health and Social Care** considered Total Reward as central to the ability of NHS employers to recruit and retain staff. It said that there was some evidence that employers were developing a strategic approach to reward. The Department also pointed to trend analysis by the Government Actuary's Department, which showed that between 2011/12 and 2017/18 Band 6 nurses had seen a large increase (about 20%) in total rewards, largely driven by an increase to pay bands and, in contrast, midwives and Band 5 nurses had stable total rewards, with an increase of about 2% for midwives and about 3% for Band 5 nurses. The Department added that Total Reward Statements provided staff with a better understanding of their benefits, and that further stakeholder engagement events had been held, and access to statements had increased in 2017.
- 3.172 The **Welsh Government** said that Total Reward approaches varied across NHS Wales organisations, with Total Reward Statements available to all staff, and it provided examples of "benefit in kind" schemes.
- 3.173 **NHS Employers** commented that the NHS provided a comprehensive and attractive employment offer and it had a well-regarded package of valuable benefits, including a generous pension scheme. They said that the Total Reward Engagement Network and their 2017 survey of employers had demonstrated a broader definition of reward including:
 - health and wellbeing, including financial wellbeing, as a focus which was not always communicated as part of the employment package;
 - less traditionally perceived benefits such as training and development, recognition schemes, the local surroundings and organisational values were increasingly included as part of the employment offer which was consistent with models of strategic reward e.g. Hay Group's public sector total reward model;
 - Recruitment and Retention Premia and relocation packages, although limited to difficult to recruit posts;
 - "Recommend a friend" schemes, web sections on reward and recruitment, more
 creative ways of retaining staff focusing on non-monetary reward initiatives (e.g.
 extended holidays and selling back annual leave), and local schemes such as
 reducing travel costs; and
 - other central initiatives covering salary sacrifice schemes, tax-free childcare and increasing numbers accessing Total Reward Statements.

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

Introduction

4.1 This chapter adds additional data and evidence from our own analysis, recent updates, and other sources that help inform our evidence-base. Drawing on this and the evidence in previous chapters, we provide our assessment of the emerging picture regarding Agenda for Change staffing and pay.

Economy and labour market

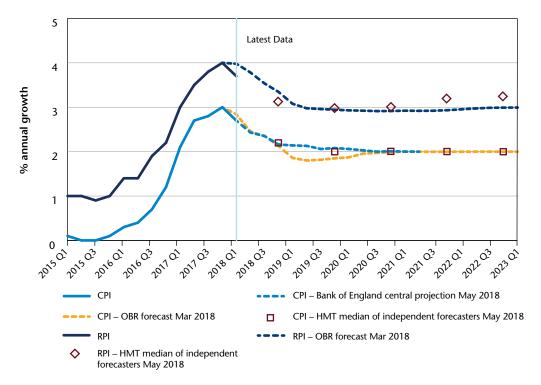
- 4.2 Our considerations on pay are framed by the overall current and forecast position on the economy and labour market. The key indicators, as at the time of preparing this report, are set out below. We look also at the forecasts for the medium term in the light of the three-year AfC pay agreement.
- 4.3 On the general economic picture, GDP grew at 1.8% in 2017. At March 2018, the Office for Budget Responsibility⁴¹ (OBR) reported GDP growth forecast at 1.5% in 2018, slowing to 1.3% in 2019. It forecast GDP growth picking up slowly by an additional 0.1% each year after 2019. On the labour market, the OBR expected employment growth to slow between 2018 and 2022 from the strong rates seen in much of the post-crisis period. The OBR forecast that the unemployment rate would be at 4.3% in 2018 and would be 4.6% by 2022. We note that the unemployment rate continues to be at a low level.
- 4.4 Against this background, we note the differing emphasis in the parties' evidence. The UK Government's evidence focused on resilience in the economy, with moderate GDP growth and with employment at a near record high, and significant progress on restoring public finances to health. It did, however, recognise the uncertainty in the economy in 2017; that productivity growth had slowed, and that weak growth in labour productivity had weighed down on wages. The UK Government also recognised that higher inflation was putting pressure on household budgets, but added its view that there was a weak relationship between inflation and pay. It stressed that public sector pay played an important part in controlling public spending and that pay discipline would ensure the affordability of public services and the sustainability of public sector employment.
- 4.5 Similar overall economic circumstances prevailed in Scotland and Wales. The Scottish Government pointed to economic resilience, with modest GDP growth, rising employment, and a downward trend in unemployment. However, it acknowledged that labour productivity (as measured by output per hour) had fallen, reflecting faster growth in average hours worked to output. The Welsh Government also cited economic conditions as broadly favourable, with increasing employment and falling unemployment.

⁴¹ Office for Budget Responsibility (March 2018), Economic and Fiscal Outlook. Available at: http://obr.uk/efo/economic-fiscal-outlook-march-2018/

- 4.6 We note the Joint Staff Side's focus on the effects of rising inflation (as measured by RPI) relative to pay awards during the period of pay restraint. They pointed to the value of current and forecast pay settlements, trends in average earnings growth showing the declining competitiveness of public sector wages against private sector earnings, and ONS comparisons⁴² showing the average public sector worker was paid 1% less than a private sector worker in 2016.
- 4.7 The parties' evidence provided differing views on the appropriate measure of inflation for pay determination, with HM Treasury favouring CPI inflation while the Staff Side favour RPI inflation. In our view, these choices reflect the different concerns of the two groups. HM Treasury looks at the pressures that NHS pay (and public sector pay more widely) put on public spending in relation to tax revenue, and so wishes to deflate nominal pay by a measure of inflation that reflects the Government's concerns. In contrast, the Staff Side look at the way in which pay affects the living standards of their members and so want a measure of inflation that reflects what is happening to the prices of the typical bundle of goods and services they consume, including housing. We recognise the differing positions of the two parties. Indeed, in our 2017 Report we concluded that we should report on what is happening to both CPI and RPI, and we will continue to do so.
- 4.8 We will also continue to assess the position of AfC pay against a range of indicators across the labour market and economy. In the context of inflation, earnings and affordability, pay restraint in recent years has made a significant contribution to efficiency savings within the NHS.
- 4.9 At the time of this report, we note the prevailing and forecast economic indicators relating to pay determination (as in the following charts). CPI inflation fell to 2.5% at March 2018 with the OBR forecasting it at 2.4% in 2018 (RPI inflation 3.7%), 1.8% in 2019 (RPI 3.0%), and 1.9% in 2020 (RPI 2.9%). Total pay growth averaged 2.6% in the three months to March 2018, while regular pay growth was 2.9%, its highest since 2015. The OBR forecast average earnings growth of 2.7% in 2018, 2.4% in 2019 and 2.3% in 2020. Pay settlements picked up in the first quarter of 2018 to between 2.5% and 3.0%.

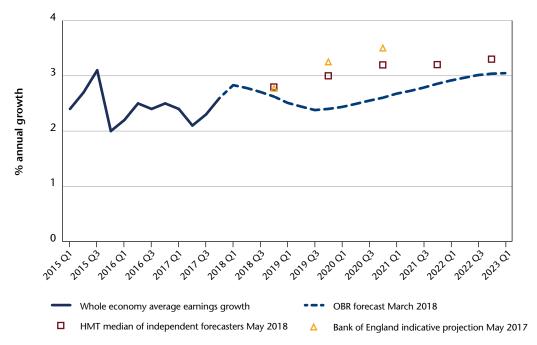
⁴² Office for National Statistics (2016). *Analysis of Factors Affecting Earnings Using Annual Survey of Hours and Earnings:* 2016. Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/articles/analysisoffactorsaffectingearningsusingannualsurveyofhoursandearnings/2016

Figure 4.1: CPI and RPI forecasts, 2015 to 2022



Source: ONS, CPI (D7G7), RPI (CZBH), quarterly, not seasonally adjusted, UK, Q1 2015-Q4 2017; Bank of England Inflation Report, February 2018; OBR, March 2018; HM Treasury February/March 2018

Figure 4.2: Average earnings growth and forecasts, 2015 to 2022



Source: ONS, average weekly earnings annual three-month average change in total pay for the whole economy (KAC3), quarterly Q1 2015-Q4 2017, GB; Bank of England Inflation Report, February 2018; OBR March 2018; HM Treasury February/March 2018

- 4.10 We conclude that there are a number of issues for NHS pay and its workforce arising from the prevailing and forecast economic indicators as follows:
 - there are ongoing risks to AfC recruitment and retention should average earnings growth and pay settlements elsewhere in the public and private sector make average AfC pay less competitive;
 - in evidence, the Staff Side stressed the importance of pay to staff, and NHS Employers emphasised that the competitiveness of pay does matter to employers who need to recruit: and
 - there are many uncertainties within the economy which could influence inflation and, in turn, future pay settlements, such as shocks to the economy, e.g. Brexit or oil prices. The healthcare workforce could be at significant risk given the extent of recruitment from the EU and the need to retain existing EU staff.

Productivity

- 4.11 Improving productivity is generally seen as a contributor to economic growth but the debate on productivity is evolving. The UK Government has placed an emphasis on improvements in productivity across the economy, including the way in which productivity improvements can be supported in the public sector and, specifically, in the health sector. Against this background, the letter from the Chief Secretary to the Treasury and the Secretary of State's remit letter focused on the public sector pay policy, and their desire to see any additional flexibility balanced by improvements to public sector productivity. We also noted the Chancellor's Autumn Budget statement that additional funding could be available as part of an agreement about reforms to boost productivity. As part of our work this year we therefore reviewed the parties' evidence to find common ground on the factors influencing productivity as they related to the NHS and AfC staff.
- 4.12 In 2017, the Health Foundation⁴³ commented that the NHS had become more productive in recent years. The Foundation cited research from the University of York which calculated that productivity had increased across the NHS by an average of 1.75% a year between 2009/10 and 2014/15, above the long-run average for the NHS at 0.9% since 1995. The Foundation added that this was higher than the growth in productivity for the whole economy since 2009, which had averaged 0.4% a year. The Department of Health and Social Care's evidence for this report included the University of York assessment which put NHS labour productivity of around 2% per annum (and moderate total factor productivity at 0.2% per annum) between the base year of 1998/99 and 2014/15.
- 4.13 Also in evidence, NHS Improvement and the Department of Health and Social Care cited Lord Carter's 2016 review of acute hospital productivity, which found large variations in efficiency across the NHS, e.g. for in-patient care. NHS Improvement said that it was focusing its work on operational productivity, but pointed to the "unwarranted" variations, as identified by Carter, in the cost of treatment across trusts. NHS Employers stated that trusts had already met and were continuing to deliver productivity above the national average, and that there were links between productivity and AfC recruitment, retention and engagement. The Staff Side pointed to work done by the workforce to sustain productive working in the NHS, particularly the unremunerated productivity bonus which is derived from staff working unpaid extra hours.

⁴³ Health Foundation (May 2017), *Election Briefing: NHS and Social Care Funding*. Available at: http://www.health.org.uk/sites/health/files/Election%20briefing%20NHS%20and%20social%20care%20funding.pdf

- 4.14 We note these interpretations in evidence which often make some potentially significant links between productivity and outcomes for patient care. In the oral evidence sessions with the various parties we pursued this question of productivity, with the aim of identifying how satisfied those parties were with existing measures, and what alternatives they might be able to offer if they felt there was room for improvement. In general, we did not identify any significant fresh thinking on the way in which productivity might be better measured in the NHS, or on linking the contribution of AfC staff to improvements, or on linking any improvements to pay increases. We noted in our 2017 Report that the terms "productivity savings" and "efficiency savings" appeared to be used interchangeably, and we observe that that holding pay down can be a default position for efficiency/productivity in a period when service transformation has yet to deliver efficiencies. We note that a significant part of the productivity gains in the NHS have come from pay restraint and, in the light of the UK Government's revised approach to public sector pay, providers will not have the same recourse to this option.
- 4.15 We recognise that the negotiations to reach the AfC pay agreement placed emphasis on pay arrangements to support changing working practices and improving capacity, underpinned by a more effective performance management system.
- 4.16 It is not part of the Review Body's role to come up with a better definition on measurement of productivity in the NHS. However, consensus on relevant drivers, and appropriate measures and interpretation of productivity, will be important in terms of future sustainability, transformation and improving patient outcomes. Some of the factors within our remit and relevant to this debate include:
 - the changing skills mix within the AfC workforce, specifically the contribution of emerging new roles;
 - the effectiveness of recruitment and retention of AfC staff, and the management of vacancies;
 - the efficient deployment of the workforce, in particular the use of flexible working and bank arrangements;
 - the use made of the benefits of staff engagement and staff development, as recognised among NHS organisations;
 - the contribution of staff to delivering services through additional worked hours and goodwill; and
 - the improvements sought through the AfC pay agreement, specifically in performance management, staff wellbeing and absence rates.
- 4.17 In recognition of the importance attached to this issue by the Government, we can see significant benefit in the parties reaching common ground on the drivers for, definition of and measures for productivity in the NHS.

Workforce

Draft Health and Social Care Workforce Strategy (England)

4.18 In December 2017 Health Education England, with support from a range of other NHS organisations, produced a draft Health and Care Workforce Strategy for England. The draft Strategy reviewed the growth in the NHS workforce in the last five years and set out the challenges for the next decade. At the time of this report, HEE had received consultation responses and was expected to publish a final report by July 2018.

- 4.19 We note that the draft Strategy, as it stood when published in 2017, had suggested that more needed to be done to keep up with increased demand as the population expanded and grew older. It had proposed a set of six shared principles designed to underpin future workforce decisions, with a focus on a range of measures to improve productivity, boost training and retention, open up new routes into nursing, and prepare the future workforce for advances in technology. The draft Strategy focused on clinical staff but recognised that the wider workforce was critical to the running of the NHS.
- 4.20 In summary, the draft Strategy included the following actions as they relate to our remit:
 - targeted retention schemes, including support for local NHS organisations on improving retention, an expansion of the nursing Return to Practice scheme, and efforts to encourage European nationals to stay by ensuring a streamlined, userfriendly service for obtaining settled status;
 - a far-reaching technology review looking at how advances in genomics, pharmaceuticals, artificial intelligence and robotics would change roles, functions and skills/training needs of clinical staff; and
 - making the NHS a more inclusive, "family-friendly" employer acknowledging the changing shape and expectations of the workforce, demands for flexible working practices and developing an attractive employment offer.
- 4.21 The draft Strategy seeks to make the NHS an employer of choice, seeing pay as a significant factor in recruitment and retention, and noting a potential agreement on Agenda for Change pay. We noted, however, that the draft Strategy had also commented on the need for a good employment package to flex to the needs of employees at different stages of a career, and that HEE was said to have been doing further work to understand better the differing needs of different generations.
- 4.22 The draft Strategy highlighted the pressures on NHS staff, with up to 42,000 posts in nursing, midwifery and the allied health professions not currently filled by substantively employed staff.
- 4.23 The draft Strategy concluded that the current gap between workforce demand and supply had occurred partly due to a historic disconnect between service, financial and workforce planning. Drawing on the NHS Five Year Forward View, the draft Strategy had included service specific workforce plans for priority areas in cancer, mental health, urgent and emergency care, maternity and primary care and the impacts for specific professional groups. It also emphasised the particular challenges facing the adult social care workforce. The draft Strategy included analyses of specific AfC groups, and it highlighted particular concerns over the supply into nursing (adult and children) and mental health nursing. Increasing domestic supply will take time to impact on workforce numbers and, in this respect, we acknowledge the NHS Employers' comment that the changes to routes into nursing would not increase supply until 2021/22 onwards. Looking forward to workforce requirements beyond 2021/22 it outlined that, with no action on productivity or service redesign, the NHS would need 190,000 additional posts by 2027, when supply trends indicated that only 72,000 were expected to join the NHS by then.
- 4.24 We see it as an important and welcome development that NHS organisations and a range of external commentators are now all recognising the importance of a fully recruited and retained AfC workforce, which is able to meet the changing demand from a growing and ageing population with increasingly complex needs. In this context, we noted a potentially significant development that, as reported by NHS Providers, for trusts, workforce issues have for the first time overtaken financial considerations as a priority.

4.25 We conclude from the draft Strategy that there is a workforce gap which is creating an unsustainably high level of vacancies, work pressures and potential risks to patient care. There are some plans in place, which contain significant risks, to bridge that gap by 2021 but the gap will persist to 2027 if there is no action on workforce numbers, productivity or service redesign. Our assessment of the evidence is made in the knowledge that there is a shared ambition among all the parties to bridge the gap. Given the model of dispersed leadership across the NHS however, we are not clear where ownership and accountability sits for the delivery of the actions required to address the workforce challenges. The draft Strategy represents a significant amount of collaborative work across the NHS but the forecasting of the demand projections, the supply to meet these, and the relationship with the NHS Five Year Forward View are not clear. As yet, we have not seen evidence of plans that, taken together, would enable NHS organisations to meet these challenges, and we look forward to these being set out in the final Strategy (due in July 2018).

Northern Ireland Health and Social Care Workforce Strategy

- 4.26 In May 2018, the Department of Health, Northern Ireland launched its *Health and Social Care Workforce Strategy 2026*⁴⁴ which stemmed from the Bengoa Report *Systems, Not Structures Changing Health and Social Care* ⁴⁵. The Workforce Strategy had three key objectives:
 - by 2026, the reconfigured health and social care system would have the optimum number of people in place to deliver treatment and care, and would promote health and wellbeing to everyone in Northern Ireland, with the best possible combination of skills and expertise;
 - by 2021, health and social care would be a fulfilling and rewarding place to work and train, and people would feel valued and supported; and
 - by 2019, the Department of Health, Northern Ireland and health and social care providers would be able to monitor workforce trends and issues effectively, and would be able to take proactive action to address these before problems become acute.
- 4.27 The Strategy was developed by the Department of Health, Northern Ireland, health and social care providers/bodies, and in close co-operation with trade unions. We welcome the publication of the Strategy and look forward to hearing in future evidence submissions the way in which the detailed measures are implemented.

Staffing numbers

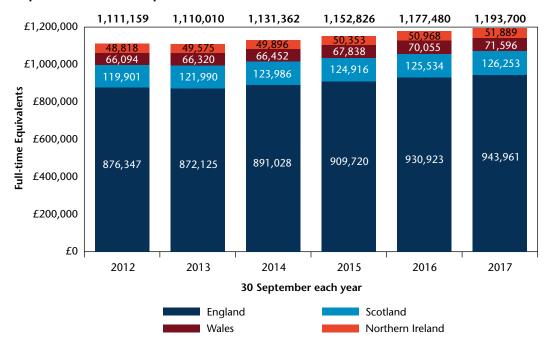
4.28 In this section we set out the overall AfC staff numbers across the UK and in the individual countries. The UK AfC workforce is large and increasing, with 1.4 million staff, equivalent to almost 1.2 million full time equivalent staff including an extra 40,000 FTE staff joining since 2015. There has been a shift in the skill mix of AfC staff across the UK, with comparatively higher growth in nursing assistants and support staff than for nursing and midwifery. There are also new roles such as apprentices, nurse practitioners and nurse associates. These changes in workforce will need to be managed alongside service redesigns to ensure service levels are maintained and productivity improved. Ambulance staffing numbers have increased proportionally more quickly than other staff groups, growing at twice the rate of the average for AfC staff.

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

⁴⁵ Department of Health, Northern Ireland (October 2016), *Systems, Not Structures – Changing Health and Social Care.*Available at: https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report

4.29 Total staff numbers across all four countries are increasing. However, staffing levels are increasing more slowly in Scotland than in the other countries. There are also clear differences in skill mix between the four countries; in both Scotland and Northern Ireland the proportion of staff in administration, estates and management is noticeably higher than in the UK as a whole. Conversely, the proportion of nursing assistants and health care assistants were higher in England and Wales than Scotland and Northern Ireland.

Figure 4.3: NHS AfC full-time equivalent workforce by United Kingdom country,⁴⁶ September 2012 to September 2017

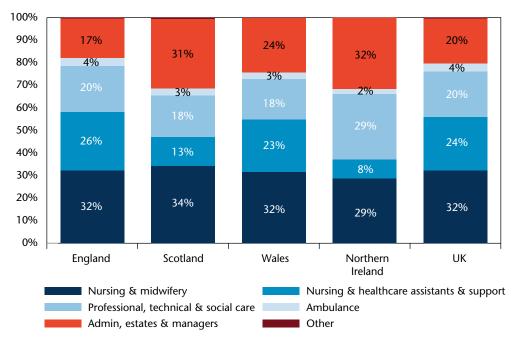


Source: NHS Digital workforce statistics; Welsh Government (StatsWales); Information Services Division Scotland; and Department of Health, Northern Ireland

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⁴⁶ From 2014 in Northern Ireland, the data on home-helps are no longer collected and therefore for comparisons purposes, these home-help numbers have been excluded from previous years.

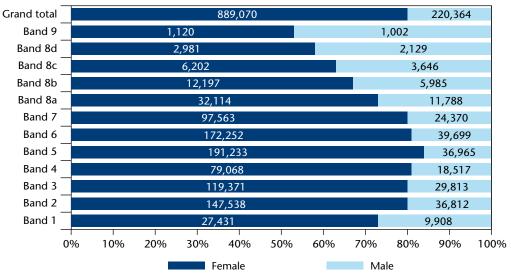
Figure 4.4: NHS AfC full-time equivalent workforce by broad staff group⁴⁷ and by United Kingdom country, September 2017



Source: NHS Digital workforce statistics; Welsh Government (StatsWales); Information Services Division Scotland; and Department of Health, Northern Ireland

4.30 The AfC workforce is predominantly a female workforce, with women making up over 80% and ambulance staff being the only broad staff group to consist of more men than women. However, in the senior positions (Bands 8 and 9) there are a smaller proportion of women than in the other pay bands. As we discuss later, this would be likely to have an impact on the overall gender pay gap.

Figure 4.5: Staff in Agenda for Change pay bands by gender in England, headcount, November 2017

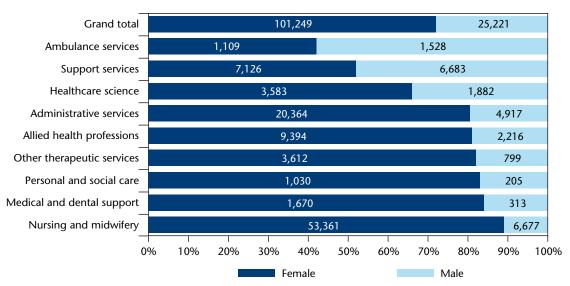


Source: NHS Digital workforce statistics

Note: The horizontal axis displays the percentage of females within each pay band.

⁴⁷ Appendix C provides information on which categories of staff in each country have been allocated to each broad staff group.

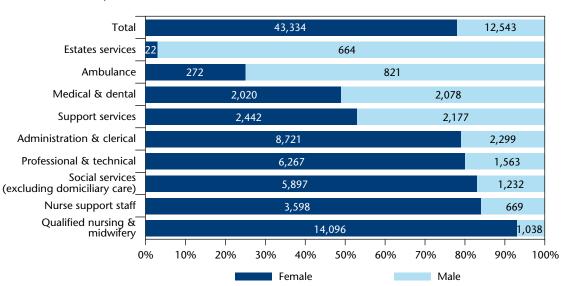
Figure 4.6: Staff in Agenda for Change roles by gender in Scotland, December 2017, WTE



Source: IDS statistics

Note: This chart uses IDS workforce divisions. Paramedics are included in Allied health professions in this classification. Unallocated/not known is excluded from these figures.

Figure 4.7: Staff in Agenda for Change roles by gender in Northern Ireland, March 2017, WTE



Source: Department of Health, Northern Ireland

Nationality

4.31 The NHS employs people from across the world. Some AfC staff groups, including nursing and midwifery, appear to be more reliant on overseas staff than others and are therefore more susceptible to changes such as Brexit. In particular, EU nationality staff are generally younger than staff from the rest of the world who are more evenly spread across the age groups.

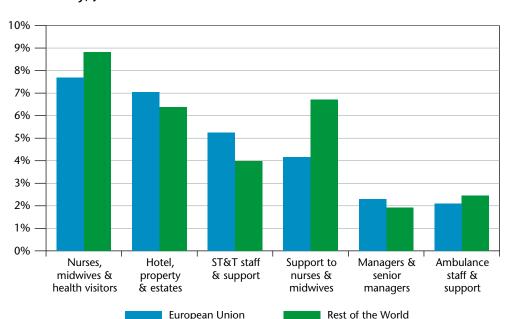


Figure 4.8: Percentage of FTE AfC workforce for broad staff groups in England by stated nationality, June 2017

Source: NHS Digital workforce statistics

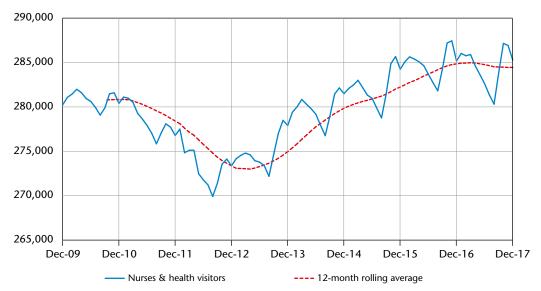
Notes: (1) Rest of the world excludes EU (26) and British workforce.

- (2) Those whose nationality were unknown were excluded from this analysis.
- (3) The remaining percentage that is not included in the graph is British.

Nursing workforce

- 4.32 The nursing workforce makes up a significant part of the AfC workforce as a whole, and is often the staff group thought of by the public, alongside doctors, when thinking about the NHS as a whole. There has been a particular focus on the nursing workforce due to the removal of the training bursary, Brexit and changes to language tests.
- 4.33 In England, the nursing workforce had been increasing. Data suggests that following changes to the language testing and Brexit, there has been a reduction in the number of nurses joining the NHS from EU countries. It is not clear where this shortfall in staffing will be made up from in the long term. In 2015, nursing was added to the Migration Advisory Committee's shortage list, which makes it possible to recruit from outside the EU. We are concerned that, against a background of an overall shortage and an increasing demand, the number of nurses in the NHS has remained largely unchanged over the previous year.
- 4.34 In Scotland, the nursing workforce has on average been slowly increasing, despite a fall between 2015 and 2016. The latest figures available suggest there were 44,120 nurses and midwives, an increase of 1.5% over a two-year period. Wales has seen the strongest growth in nursing numbers of the four countries over the last two years. In Northern Ireland, nursing numbers fell between 2016 and 2017.
- 4.35 While skill mix changes and upskilling of nursing associates and support staff may reduce the demand on nursing, the simultaneous expectations for upskilling of nurses to support the medical professions will mean that demand for nursing staff is unlikely to decrease.

Figure 4.9: Number of nurses and health visitor staff, FTE, England, December 2009 to December 2017



Source: NHS Digital workforce statistics

Note: The full time equivalent axis has been cropped to allow small differences between periods to be seen more clearly.

Supply and recruitment

General

- 4.36 The latest data reinforces our overall concerns in our 2017 Report that supply plans were insufficient to tackle current staff shortages, and that assumptions on demand and supply forecasts were opaque. The draft Health and Care Workforce Strategy acknowledges that gaps in the workforce will continue for the next few years and recognises the importance of increasing the number of qualified people available and willing to work in the NHS. Despite describing Ministerial responsibility and HEE's strategic role, we could not see in the draft Strategy a clear ownership of the way in which supply of AfC staff was to be managed. This is a particular concern given the move away from bursaries, and the risks for universities in attracting sufficient numbers into student training.
- 4.37 The UK Government's planned and strategic response to gaps in the AfC workforce is to increase domestic supply. Additional funding has been announced for more clinical placements, expected to enable 5,000 more nursing students per year in England by 2020/21. When the funding reforms were announced in 2017 and bursaries were removed, the Department of Health⁴⁸ considered that this would enable universities to offer up to 10,000 extra training places on pre-registration healthcare programmes. We comment later in the Chapter on the reduced numbers of applications, although we note that acceptances onto courses remain stable.
- 4.38 The positions vary in other UK countries as Scotland, Wales and Northern Ireland have retained the bursaries. The Scottish Government commented that nursing student numbers remained relatively high and, although currently lower than 10 years ago, had grown steadily in the last five years. The Welsh Government pointed to the effectiveness of its bursary tie-in, although acknowledging the importance of overseas recruitment.

⁴⁸ Department of Health and Social Care (2017), *Policy Paper: NHS Bursary Reform.* Available at: https://www.gov.uk/government/publications/nhs-bursary-reform/nhs-bursary-reform

- 4.39 The UK Government also sees opportunities to increase domestic supply through increasing the number of nurse associates and the use of apprenticeships. Expanding supply through these routes, including clinical placements, will require additional training and supervisory resource at a time of rising pressure on the AfC workforce.
- 4.40 On a general point relating to recruitment, NHS organisations will need to take into account the expectations of the next generation entering the labour market. The NHS will continue to attract a diverse workforce in the future and the AfC employment proposition (including the national framework and local practices) needs to be designed to respond to and engage with all staff. According to research commissioned by the OME into Modern Pay Systems⁴⁹, people now entering the labour market have a different approach to their careers from their predecessors, valuing aspects such as worklife balance, flexibility and variety in the workplace. These entrants also expect rapid progression, and attach value to learning and development over financial benefit once basic pay and conditions are met. If this analysis is correct, the NHS will need to ensure that future career pathways recognise these changing attitudes towards employment.
- 4.41 The NHS attracts people from a range of sources into a wide variety of roles within the AfC workforce. Therefore, for this report, we have examined evidence on these sources which cover the supply of graduates, the numbers on the Nursing and Midwifery Council register, apprentices and the supply of additional labour through bank and agency arrangements. We assess the latest trends in supply and recruitment, and the risks to achieving the required number of entrants. From our overall assessment we conclude that: there are concerns over the management and leadership of supply; accurate data is needed to monitor the impact of the change to bursaries; sources of EU and international recruitment are changing; and a full range of supply mechanisms will need to be deployed to ensure the attractiveness of NHS careers.

Entrants to AfC-related health degrees

- 4.42 We have assessed the data from UCAS on the numbers of applications, applicants and acceptances for AfC-related health degree courses in England, Scotland⁵⁰, Northern Ireland and Wales. While this provides a useful indication of the numbers who might enter the NHS workforce in about three years' time, to obtain a complete picture we consider that a more in-depth analysis is required of (i) the proportion of acceptances who graduate with suitable grades, and (ii) of these, the proportion who choose to join the NHS.
- 4.43 The removal of the bursary in England has been followed by a 20% reduction in applications to AfC-related health degree courses in the UK in 2017. However, our analysis continues to suggest that nursing is still one of the most sought after degree courses, with 6.6 applications per acceptance compared with an average across all subjects of 5.2 applications per acceptance. Table 4.1 below presents a comparison in 2017 of the ratio of applications to acceptances in nursing compared with other courses in high demand (listing the top 8 subjects by this ratio with at least 100 acceptances). Only 2 of these courses are not healthcare degrees.

⁴⁹ Office of Manpower Economics (November 2016), Research into Modern Pay Systems. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/567543/PWC_ Research_into_modern_pay_systems_Nov_2016..pdf

⁵⁰ In Scotland, there is a substantial number of students in Scotland (about a third of young undergraduates across all subjects) who are not reflected in the data due to the provision of higher education in further education colleges.

Table 4.1: Subjects with the highest ratio of applications to acceptances, UK, 2017

Subject	2017	2016	2015
Others in Medicine and Dentistry	9.74	8.15	9.50
Pre-clinical Medicine	8.85	9.56	9.88
Artificial Intelligence	8.20	7.24	5.71
Pre-clinical Dentistry	8.14	8.24	9.02
Anatomy, Physiology and Pathology	7.15	8.32	8.07
Biotechnology	6.71	6.25	6.31
Nursing	6.57	8.13	8.44
Medical Technology	6.48	7.90	7.93

Source: OME analysis of UCAS data

4.44 We note from the data in 2017 that a total of 55,750 students accepted places on AfC-related health degree courses an increase of 325 students. Of these, 28,625 students accepted a place at university to study nursing a reduction of 260 from 2016. However, there was an increase of 585 students accepting a place to study other AfC-related health courses, to a total of 27,125 students.

Table 4.2: Numbers of entrants (acceptances) for each AfC-related health degree, UK, 2015-2017⁵¹

Year of entry	2015	2016	2017	% change 2016-2017
B1 – Anatomy, Physiology and Pathology	4,415	4,540	4,635	2.1%
B2 – Pharmacology, Toxicology and Pharmacy	4,215	4,320	4,315	-0.1%
B3 – Complementary Medicine	1,160	1,115	1,220	9.4%
B4 – Nutrition	1,285	1,425	1,410	-1.1%
B5 – Ophthalmics	1,090	1,140	1,130	-0.9%
B6 – Aural and Oral Sciences	750	705	655	-7.1%
B7 – Nursing	27,530	28,885	28,625	-0.9%
B8 – Medical Technology	1,935	2,085	2,105	1.0%
B9 – Others in Subjects allied to Medicine	10,695	10,890	11,405	4.7%
BB – Combinations within Subjects allied to Medicine	450	320	250	-21.9%
Grand Total	53,525	55,425	55,750	0.6%

Source: OME analysis of UCAS data

 $^{^{51}}$ There is a +/- 5 difference between some of these numbers and other published UCAS data. This is likely due to differing rounding calculations on different categories.

- 4.45 Table 4.2 shows that the overall number of acceptances on AfC-related health degrees has increased by 0.6%, although there were some variations across degree subjects. The number of nursing degree acceptances has fallen by 0.9%. We note that following the removal of the bursary the proportion of people accepted who were in the 21 and over age group has fallen by 3 percentage points, from 62% to 59% of acceptances. Overall, the numbers of nurses being trained has fallen since 2016.
- 4.46 We reiterate from our 2017 Report that many students who enter nursing and other AfC-related health degree courses do not enter full time work for the NHS. From HEE's figures, out of 100 adult nursing degree places commissioned, only 58 FTEs enter the NHS. For this report, we examined data from the Higher Education Statistics Agency which showed that, for those of a known destination, the majority of nursing graduates who responded work in the hospital or other health related sectors (Table 4.3). We note that in Wales the AfC bursary requires a two-year tie-in.

Table 4.3: Destination⁵² of graduates from AfC-related health degree courses, by proportions, 2015/16⁵³ (row percentages)

Hospital Sector	GMP Sector	Specialist Medical Activity	Dental Sector	Residential Care	Other Health Activity	Total Non- Health Activities	Number with known destination (% known of total)
81%	4%	0%	0%	2%	8%	5%	21,216 (94%)
34%	4%	1%	0%	2%	22%	38%	7,537 (80%)
30%	2%	0%	0%	0%	2%	66%	3,409 (85%)
53%	1%	7%	0%	1%	7%	31%	2,935 (74%)
85%	0%	1%	2%	0%	2%	10%	1,676 (93%)
34%	1%	0%	0%	0%	5%	59%	863 (77%)
42%	3%	2%	0%	1%	18%	34%	848 (90%)
13%	0%	0%	0%	0%	1%	86%	732 (93%)
7%	2%	33%	0%	1%	19%	38%	402 (54%)
3%	0%	0%	0%	0%	2%	95%	71 (47%)
	Sector 81% 34% 30% 53% 85% 42% 13%	Sector Sector 81% 4% 34% 4% 30% 2% 53% 1% 85% 0% 34% 1% 42% 3% 13% 0% 7% 2%	Hospital Sector GMP Sector Medical Activity 81% 4% 0% 34% 4% 1% 30% 2% 0% 53% 1% 7% 85% 0% 1% 34% 1% 0% 42% 3% 2% 13% 0% 0% 7% 2% 33%	Hospital Sector GMP Sector Medical Activity Dental Sector 81% 4% 0% 0% 34% 4% 1% 0% 30% 2% 0% 0% 53% 1% 7% 0% 85% 0% 1% 2% 34% 1% 0% 0% 42% 3% 2% 0% 13% 0% 0% 0% 7% 2% 33% 0%	Hospital Sector GMP Sector Medical Activity Dental Sector Residential Sector 81% 4% 0% 0% 2% 34% 4% 1% 0% 2% 30% 2% 0% 0% 0% 53% 1% 7% 0% 1% 85% 0% 1% 2% 0% 34% 1% 0% 0% 0% 42% 3% 2% 0% 1% 13% 0% 0% 0% 0% 7% 2% 33% 0% 1%	Hospital Sector GMP Sector Medical Activity Dental Sector Residential Care Health Activity 81% 4% 0% 0% 2% 8% 34% 4% 1% 0% 2% 22% 30% 2% 0% 0% 0% 2% 53% 1% 7% 0% 1% 7% 85% 0% 1% 2% 0% 2% 34% 1% 0% 0% 0% 5% 42% 3% 2% 0% 1% 18% 13% 0% 0% 0% 1% 19% 7% 2% 33% 0% 1% 19%	Hospital Sector GMP Sector Specialist Medical Activity Dental Sector Residential Care Care Other Health Activity Non-Health Activities 81% 4% 0% 0% 2% 8% 5% 34% 4% 1% 0% 2% 22% 38% 30% 2% 0% 0% 0% 2% 66% 53% 1% 7% 0% 1% 7% 31% 85% 0% 1% 2% 0% 2% 10% 34% 1% 0% 0% 0% 5% 59% 42% 3% 2% 0% 1% 18% 34% 13% 0% 0% 0% 1% 86% 7% 2% 33% 0% 1% 19% 38%

Source: OME analysis of HESA 2015/16 data

⁵² Many graduates have an unknown destination and have therefore been excluded from this analysis.

⁵³ Higher Education Statistics Authority data relate to the cohort of graduates from the year before publication.

- 4.47 We have yet to see whether the Government's initiatives will increase the domestic supply and reverse recent trends. We remain concerned over the impact on the numbers starting degree courses once the cap associated with the bursary system came off. A likely fall in the numbers applying to these degree courses could still be consistent with an increase or decrease in the numbers accepted onto them, depending on the ratio of good applicants to places. We have seen that, although there has been a fall in applications in England, the number of acceptances has remained stable. However, we consider that, should applications continue to diminish, there are potential risks in the longer term over the quality of entrants, and we will wish to continue to monitor this.
- 4.48 We also note that there could be an impact on the proportion of graduates who might choose to work in the NHS, given that they could now be carrying a debt following training. It is too early to assess the magnitude of this second effect but we wish to continue monitoring any impact on employment choices after graduation.
- 4.49 Having noted the potential of these effects and although the number of applications has fallen, the number of acceptances remains stable and university places are continuing to be filled. We conclude from the data that nursing graduates can find employment in the NHS after graduation as there is demand for their skills. We remain concerned about the significant wastage rates during training, the low conversion rate from university places to entrants to the NHS, and the difficulties for older entrants.
- 4.50 In our view, these risks to supply could be considerable given the Government's emphasis on increasing numbers from domestic sources and the length of time before measures impact on numbers in the NHS. In the meantime, we will continue to make regular assessments of the leading indicators of supply, including the numbers and quality of applicants (e.g. tariff points of students entering measured against other relevant degrees), applications, acceptances, university places, clinical placements, wastage during training, and entrants to the NHS. From a pay perspective, we will also continue to assess the supply of graduates to the NHS against the wider graduate pay and labour market. We will also continue to assess the specific recruitment and supply issues for Scotland, Wales and Northern Ireland.

Nursing and Midwifery Council register

- 4.51 The Nursing and Midwifery Council's (NMC), which is the regulator for these professions and requires a registration fee, provides data on nurses and midwives who are registered to practice in the UK, and which we consider gives a useful snapshot of the available nursing and midwifery workforce. The NMC publish data on joiners and leavers from its register, and some analysis regarding age of leavers and reasons for leaving. We recognise, however, that not all registrants are currently working, and that the numbers include workers from independent sectors or other settings.
- 4.52 From the NMC data at July 2017, we see the overall pattern of initial⁵⁴ joiners and leavers between 2012 and 2017, we note that up until 2015/16 there were more people joining the register than leaving it. However, in 2016/17 the number of leavers overtook the number of initial joiners.

⁵⁴ Only includes new joiners – excludes those who have been previously registered and are returning.

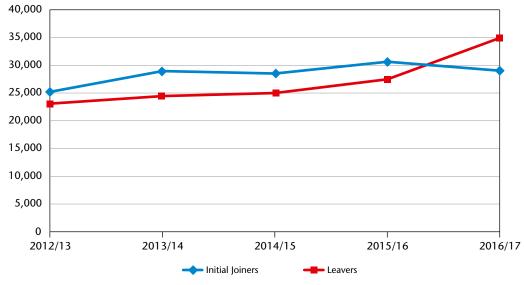
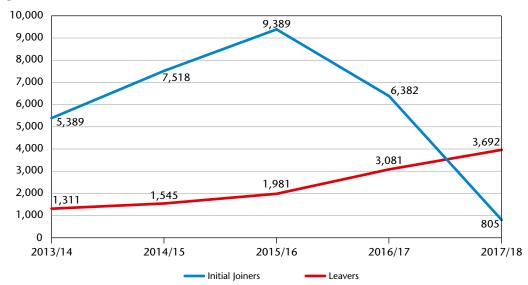


Figure 4.10: Overall numbers joining and leaving the NMC register, UK, 2012-2017

Source: The NMC register 2012/13 – 2016/17

4.53 More recent data published in March 2018, shows the clear impact that Brexit and the more stringent language requirements are having on EU nurses and midwives wanting to work in the UK. The number of new joiners from the EEA fell from 9,389 in 2015/16 to only 805 in 2017/18, meanwhile over the same period the number of leavers from the EU has doubled from 1,981 to 3,962. There are implications for supply into these professions, as those leaving the register are qualified and trained, whereas the shortfall has to be made up from new entrants requiring training.

Figure 4.11: Nurses and midwives from the EEA joining and leaving the NMC register, UK, 2013-2018



Source: The NMC Register, March 2018

- 4.54 We have also drawn upon the NMC's survey of people who left the register between June 2017 and November 2017. Of the 3,496 respondents, the top reasons for leaving, aside from retirement, were staffing levels at 26% and a change in personal circumstances at 25% (e.g. ill health, childcare).
- 4.55 Out of the small number of responses (227) from former registrants from the EEA, 59% planned to leave the UK, 47% said that Brexit had encouraged them to consider working outside the UK, and 22% cited change in personal circumstances.

4.56 The NMC register provides a helpful overall measure of existing supply. The sharp increase in leavers from the NMC register in 2016/17, and the dramatic decline in the number of nurses joining the register from EU countries, are concerns to NHS supply. These trends appear to be changing and therefore require close monitoring given previous significant intakes to the NHS workforce from EU and international recruitment.

International

- 4.57 Data from NHS Digital provides the nationality (EU or Rest of the World) of new joiners to the AfC workforce in England (Table 4.4 below). There was a fall in the percentage of EU joiners between 2015/16 and 2016/17 in all AfC groups, except for scientific, therapeutic and technical and ambulance staff.
- 4.58 Most staff groups saw little change in the percentage of staff from the rest of the world. In contrast, ambulance staff saw a large intake of recruits from non-EU countries between 2014/15 and 2016/17 to meet the growing demand faced by the emergency services.

Table 4.4: Percentage of joiners from abroad to the NHS AfC workforce in England by nationality and broad staff group (headcount) – 2012-13 to 2016-17

	Joiners of EU nationality							
	2012/13	2013/14	2014/15	2015/16	2016/17			
Nurses & health visitors	7.4%	12.7%	17.0%	18.0%	11.9%			
Midwives	5.3%	7.6%	8.9%	9.3%	8.7%			
Ambulance staff	1.8%	2.6%	2.6%	4.1%	7.1%			
Scientific, therapeutic & technical staff	6.9%	7.0%	8.1%	8.3%	8.9%			
Support to clinical staff	4.0%	4.5%	5.9%	7.0%	6.6%			
NHS infrastructure support	4.7%	4.4%	4.8%	6.5%	6.0%			
		Joiners o	f non-EU na	tionality				
Nurses & health visitors	7.8%	7.3%	6.6%	7.2%	8.7%			
Midwives	2.1%	1.6%	1.3%	1.1%	1.3%			
Ambulance staff	0.6%	0.9%	10.5%	20.0%	11.4%			
Scientific, therapeutic & technical staff	5.1%	4.5%	4.8%	5.2%	5.5%			
Support to clinical staff	7.2%	6.8%	8.3%	8.4%	8.1%			
NHS infrastructure support	5.7%	5.2%	4.9%	4.9%	4.9%			

Source: NHS Digital

- 4.59 The number of Tier 2 visas issued for the Human Health and Social Work Activities industry had increased by about 5,000 between 2011 and 2017, from around 1,500 to 6,500. The increase over the last two years might in part be due to the addition of nurses to the shortage occupation list in November 2015.
- 4.60 The NMC data show a decline in the numbers from the EU who wish to work in the NHS. It is currently not clear where this shortfall will be made up from, as we have been told that trusts are finding overseas recruitment, from both EU and non-EU countries, increasingly difficult.

Apprentices

4.61 For the health and social care sector in England, the key increase in apprenticeship participants followed the introduction of apprenticeships for workers aged 25 and over in 2006/07. There was rapid growth between 2009/10 and 2012/13, and by 2016/17 there were nearly 90,000 apprenticeship programme starts in health and social care, with about 70% of the apprentices aged over 25. The starts on apprenticeship programmes included around 1,000 higher level apprenticeships for assistant practitioners. As of September 2017, there were 577 advanced nurse practitioners in Scotland.

100,000
90,000
80,000
70,000
60,000
40,000
30,000
20,000
10,000
10,000
20,000
10,000
25+
19-24
16-18

Figure 4.12: Volume of Health and Social Care apprenticeships started in England, by age band, 2002/03 to 2016/17

Source: OME analysis of Department for Education – Further Education data: Apprenticeships

- 4.62 The introduction of the apprenticeship levy in spring 2017 required all employers with a pay bill over £3 million in the UK to contribute towards the cost of apprenticeships. The NHS aims to create 100,000 more apprenticeships in England by 2020 in roles covering nursing and healthcare assistants, IT, estates and facilities, domestic and housekeeping services, and business administration and accounting.
- 4.63 The development of apprentices in healthcare roles could have an important influence on the skill mix across AfC groups, with the potential to expand the capacity and deployment of staff and therefore contribute to improved NHS productivity. Apprenticeships cover a range of AfC occupational groups, including the first steps to professional groups, therefore NHS organisations will want to take a strategic approach to their management. We recognise the contribution that apprenticeships could potentially make to the supply of the NHS workforce. We consider that such an approach might include more consistency in identifying apprenticeship routes, career pathways and supporting pay arrangements.

4.64 The apprenticeship programme in the NHS is ambitious and we have yet to see firm evidence of the way in which it will help bridge the workforce gap. We note that NHS Employers and NHS Providers point to the cost pressures associated with the use of apprentices and the limitations of using the apprenticeship levy for AfC occupational groups. We have also heard on our visits that different trusts are taking different approaches to apprentice pay. Until these arrangements are fully grounded in the NHS, rather than emerging piecemeal at local level, NHS organisations may not be able to maximise the return on investment through the levy. In respect of pay, we welcome the AfC pay agreement which allows the NHS Staff Council to negotiate pay arrangements for apprentices as a matter of priority.

Supply of bank and agency staff

- 4.65 We note from the evidence that the use of agency and bank staff are an essential source of labour supply to trusts in managing the workforce gap. These sources provide much needed flexibility in meeting demands to keep services running. Given the continuing workforce pressures and vacancies, the high levels of agency and bank usage will need to remain part of trusts' strategy in the medium term. The trusts' dependency on these arrangements poses risks for the future. We note the potential risk from individual staff no longer willing to make themselves available for additional hours or shifts.
- 4.66 There are variations in agency and bank costs between trusts and between different countries in the UK. In Scotland, spending on agency nursing staff has decreased with a policy to use nurse banks to secure value for money. In Wales, the reliance on agency staff has increased consistently in recent years with action being taken to address rising costs. In Northern Ireland, agency spend has increased significantly. We note from the evidence that there have been significant efforts in England to reduce agency costs through greater emphasis on more cost-effective use of bank and substantive roles. Bank usage and costs have increased as a result. We note that there can be significant resources involved in organising bank work. This not only adds to the demand pressures on staff that bank and agency work are trying to address, but means that cost savings arising from the policy could be much smaller than the headline figures suggest. We would welcome further evidence on these costs.
- 4.67 These arrangements provide flexibility to AfC staff should they seek additional shifts but also offer staff the opportunity to earn additional income. On our visits, however, we heard that staff were coming under pressure to work bank shifts, which could adversely affect work-life balance and pose a risk to retention. We suggest throughout this report that the development of more effective flexible working arrangements will go a long way to supporting better recruitment and retention of AfC staff.
- 4.68 We have heard on our visits that pay rates on offer for bank working vary across different trusts. We will continue to monitor the position but, in the meantime, we endorse the AfC pay agreement's invitation to the NHS Staff Council to explore the scope for a framework on bank and agency working.

Vacancies

- 4.69 From our perspective we see trends in vacancies as a leading indicator of the level of demand for services and where potential shortages against staffing levels might exist. In evidence for this report, there has been a renewed emphasis on the impact for the NHS of carrying a high volume of vacancies. This is a growing concern to NHS organisations, as seen by the emphasis on improved data in this area, and there are implications for trusts in ensuring safe staffing levels, patient safety and clinical governance. Vacancies have a direct impact on the number of staff available for each shift and on the workload of individual staff. We have seen from Staff Side surveys, and have been told by staff on our visits, that covering for vacancies adds to the workload of both existing staff and those undertaking additional hours.
- 4.70 We note that in 2017/18, for the first time and in response to significant concerns in this area, NHS Improvement published vacancy figures for England in its third quarter performance report. NHS Improvement's data suggested that there were about 100,000 vacancies across the NHS, at a vacancy rate of about 8.4%. Table 4.5 shows that, of these, about a third were nursing vacancies, with about 36,000 nursing vacancies at a rate of over 10%. The vacancy rate for medical and other staff was lower at 7.9% and 7.5% respectively, but we note that there were still over 50,000 vacancies for non-nursing AfC staff.

Table 4.5: NHS Provider vacancies, England, 2017/18

		2017/18 Q1	2017/18 Q2	2017/18 Q3
Nursing	Vacancy Rate	10.9%	11.2%	10.3%
Nursing	WTE Vacancies	38,180	39,004	35,835
Modical	Vacancy Rate	9.1%	8.3%	7.9%
Medical	WTE Vacancies	10,848	10,097	9,676
Other Staff	Vacancy Rate	7.9%	7.5%	7.5%
Other Stall	WTE Vacancies	53,535	51,058	51,942
Total Workforce	Vacancy Rate	9.0%	8.7%	8.4%
Total Workforce	WTE Vacancies	102,563	100,159	97,453

Source: NHS Improvement

4.71 Health Education England also provided detailed vacancy data (Table 4.6) which largely agreed with that from NHS Improvement. For example, the vacancy rate for adult nursing (the largest category) was over 10%, with 25,000 vacancies. The vacancy rate for mental health nursing was higher, with over 15% of posts vacant, about 6,650 vacancies.

Table 4.6: Health Education England vacancy rates, 2014 to 2017

Vacancy rate	2014	2015	2016	2017
Adult Nursing	4.2%	10.0%	10.9%	10.2%
Children's Nursing	4.3%	7.3%	10.0%	10.6%
Learning Disability Nursing	11.7%	17.0%	13.7%	15.7%
Mental Health Nursing	22.4%	11.7%	14.0%	15.3%
Midwives	4.5%	5.3%	5.0%	4.4%
Clinical Psychology	9.2%	10.8%	14.4%	11.5%
Diagnostic Radiography	4.5%	5.9%	6.9%	9.7%
Dietetics	4.0%	4.4%	3.5%	1.3%
Occupational Therapy	5.6%	6.3%	7.8%	
Operating Department Practice	4.1%	4.8%	3.3%	0.9%
Paramedics	3.9%	5.4%	7.4%	
Physiotherapy	5.2%	6.7%	7.5%	
Podiatry	4.1%	7.9%	4.8%	
Speech and Language Therapy	5.0%	6.3%	4.0%	1.7%
Therapeutic Radiography	4.7%	5.0%	1.8%	
Total	6.6%	9.0%	10.0%	

Source: HEE analysis of NHS Electronic Staff Record data and provider expressed demand

- 4.72 NHS Digital's vacancy statistics measure the numbers of advertisements on the *NHS Jobs* website for Hospital and Community Health Services vacancies. The proportion of adverts to headcount has increased in every health education area, suggesting that vacancy rates were increasing. NHS Digital's data suggest that, on average, advertised vacancies covered about 2.6% of the workforce in each month of 2016/17.
- 4.73 Vacancy rates have varied among the countries of the UK. In Wales, advertised vacancies rose in 2017 but fell for nursing, midwifery and allied health professionals. In Scotland, while there has been considerable seasonal variation between quarters, the trend in the three-month vacancy rate for both Bands 1-4 and allied health professionals has been fairly stable since 2012 to 2013. However, the three-month vacancy rate for Bands 5-9 has continued to increase with the total vacancy⁵⁵ rate for this group rising from 1% in 2011 to 5.7% in June 2017 (Figure 4.13).

Total vacancies means the total number of vacancies which NHS organisations were actively trying to fill, and three-month vacancies mean those vacancies which NHS organisations were actively trying to fill, which had been vacant for three months or more. Three-month vacancies are therefore a subset of total vacancies. Vacancy rates, expressed as a percentage, are calculated as the number of vacancies, divided by the sum of staff in post plus vacancies.

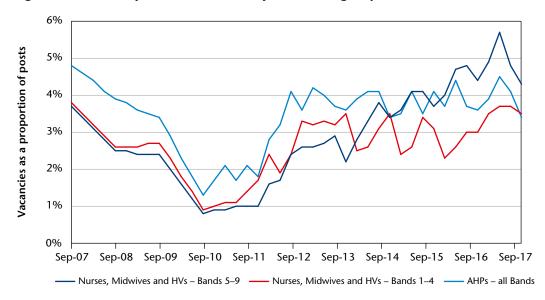


Figure 4.13: Vacancy rates in Scotland by main staff group, 2007-2017

Source: Information Services Division Scotland. Notes: Data prior to March 2011 was released annually for September. After March 2011, data is released quarterly.

- 4.74 The parties in evidence and those staff on our visits told us that there were high levels of vacancies, but that service provision was continuing to be maintained through goodwill, unpaid overtime, additional hours, and the use of bank and agency staff. However, there are consequences of running with this level of vacancies. If these shifts are not being covered by permanent staff, then there can be a loss of productivity and continuity, and a potential impact on patient care and outcomes. Staff may feel uncomfortable and unable to work to their full potential in new work areas where they may not know local procedures, or where and how to access equipment, and so forth. Such staff can be reliant on colleagues who have to take time to support them. This can impact on staff workload, stress, working hours and motivation.
- 4.75 In our previous reports, we have asked for improvements to vacancy data. We welcome NHS Improvement starting to publish vacancy figures and we note that, as part of its evidence, HEE has published more detailed data. We would also like to acknowledge the continued work done by the Workforce Information Review Group and the wider NHS Digital teams to improve the data sources. We look forward to more accurate and consistent data on vacancies in the longer term.
- 4.76 We understand the difficulties of having a clear picture on vacancy levels. The position can be clouded by many factors including temporary cover of posts, whether posts are being advertised, the duration of adverts, and trusts keeping vacancies open as a method of holding down staff costs, as we have heard on our visits. While there has been an improvement in information for this report, we continue to encourage all organisations to work on the quality of these data, as trends in vacancy rates are an important area in our assessment of the AfC workforce.
- 4.77 From the available data, it is clear that nursing vacancies have been at a consistently high rate since 2015, with increasing levels among specific groups such as children's nursing and mental health nursing. We note the general agreement among the parties that there are high and increasing levels of vacancies across the NHS, with a prevailing view that there are currently at least 36,000 nursing vacancies in England.

Retention

- 4.78 In this section we set out our overall conclusions on retention for AfC staff groups drawing on the parties' evidence from Chapter 3. Given the high level of vacancies, the costly option of agency staff and the lag in supply initiatives taking hold, retaining existing AfC staff is a key element of bridging the workforce gap.
- 4.79 We start by examining the latest available data⁵⁶ on joining and leaving rates in England⁵⁷, Scotland, Northern Ireland and Wales⁵⁸ (Table 4.7).
- 4.80 In England, looking at the trends since 2010/11 the leaving rates for all staff groups have increased overall, except for NHS infrastructure staff⁵⁹. For 2016/17, the joining rates were higher than the leaving rates for all staff groups except for nurses and health visitors. In Scotland⁶⁰, the joining rates for all staff groups have increased overall from 2011/12 to 2016/17, but the leaving rates varied among staff groups over the same period. In 2016/17, the joining rates were higher than leaving rates for all staff groups, except for administrative services and support services. In Northern Ireland, while the joining rate was higher than the leaving rate overall, it was not consistent across all staff groups. The joining rates were lower than leaving rates for around half of the staff groups in 2016/17. In Wales, data were available only for 2016, when joining rates were higher than leaving rates for all groups.

⁵⁶ Due to varying classifications of joiners and leavers used in each country, comparisons should only be made within each country's own staff groups.

⁵⁷ Joiners and leavers data for England exclude internal transfers, so are net flows into and out of NHS England. However, they exclude Chesterfield or Moorfields hospitals as these are not on the Electronic Staff Record system.

⁵⁸ Data is available for the year April 2016-March 2017 for England, Scotland and Northern Ireland. For Wales the latest available data is April 2015-March 2016.

⁵⁹ For England and Northern Ireland, the leaving rate is calculated by dividing the number of leavers by the average of the headcount of staff at the beginning of the period and headcount of staff at the end of the period and similarly for the joining rate.

⁶⁰ For Scotland, leavers are defined as employees who were in post as at 31 March in the previous year but not in post in the current year as at 31 March. Joiners are defined in the opposite scenario. The rate is calculated is the same way as for England and Northern Ireland.

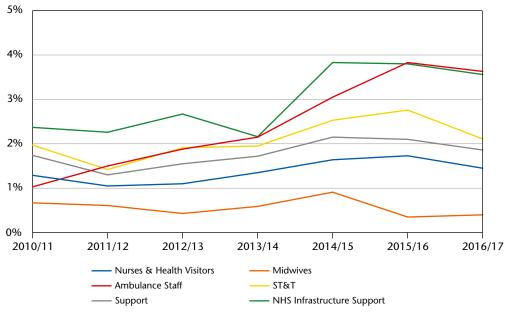
Table 4.7: Leaving and joining rates to the NHS by staff group headcount and country, April 2016 to March 2017

	Year to March 201			
England	Leaving rate	Joining rate		
AfC staff (exc bank and locums)	11.2%	12.9%		
Nurses & health visitors	10.7%	10.3%		
Midwives	10.6%	11.1%		
Ambulance staff	7.3%	7.8%		
Scientific, therapeutic & technical staff	11.0%	12.4%		
Support to clinical staff	11.9%	15.6%		
NHS infrastructure support	11.3%	13.5%		
	Year to Mai	ch 2017		
Scotland	Leaving rate	Joining rate		
AfC staff	6.7%	7.2%		
Nursing & midwifery	7.6%	8.1%		
Allied health professions	6.6%	8.2%		
Other therapeutic services	7.1%	12.7%		
Personal & social care	12.9%	21.3%		
Healthcare science	7.6%	8.2%		
Ambulance services	9.2%	12.4%		
Administrative services	7.7%	7.6%		
Support services	8.9%	8.2%		
	Year to Mai	rch 2017		
Northern Ireland	Leaving rate	Joining rate		
AfC staff	5.4%	6.8%		
Administration & clerical	5.3%	5.1%		
Estates services	9.2%	7.5%		
Support services	5.5%	6.3%		
Nursing & midwifery	5.9%	7.3%		
Social services (exc home helps)	5.1%	7.6%		
Professional & technical	4.3%	8.0%		
Ambulance	4.1%	3.9%		
	Year to Mai	ch 2016		
Wales	Leaving rate	Joining rate		
NHS Wales (inc medical and dental)	6.1%	8.4%		
Nursing & midwifery registered	6.9%	7.5%		
Allied health professionals	6.8%	9.1%		
Estates & ancillary	7.4%	8.2%		
Healthcare scientists	6.7%	7.5%		
Additional professional scientific & technical	9.3%	14.2%		
Additional clinical services	9.3%	14.4%		
Administrative & clerical	7.9%	10.7%		

Source: NHS Digital; Information Services Division Scotland; and Department of Health, Northern Ireland, StatsWales and NHS Digital iView

4.81 We note that for all staff groups the most common reason for leaving (excluding unknown reasons) was retirement – this was highest for midwives, but lowest among ambulance staff. The second highest reason for all staff groups was voluntary resignation. Redundancies were the least likely reason for leaving across all staff groups. Figure 4.14 below shows the percentage of leavers citing "voluntary resignation for better rewards package" as a reason for leaving by staff group over time. While these levels were low, there was a noticeable rise in the percentage for ambulance staff and NHS infrastructure staff leaving for this reason since 2013/14. We also note that the trend for most other staff groups between 2010/11 and 2016/17 was relatively constant or a slight rise.

Figure 4.14: Percentage of leavers citing "voluntary resignation for better rewards package" as a reason for leaving by staff group, England, 2010/11 to 2016/17



Source: NHS Digital

- 4.82 The data comparing joiners and leavers provide a picture of the dynamics of the workforce. However, the trend in leaver rates is a key concern for us. In our 2017 Report, we noted the widespread concerns on retention that were shared by the parties. The evidence and our assessments for this report suggest that these concerns have not diminished.
- 4.83 We acknowledge that the degree and level of turnover are important features of labour markets, allowing employers to refresh their workforce and people to develop their careers. Turnover can be inefficiently low for organisations as well as inefficiently high. There appears to be general agreement among the parties that the retention rate for some groups of clinical staff has declined in recent years. The DHSC's stability index suggested a slight worsening in retaining the workforce across most groups in the five years to 2016/17. Overall, there has been a rise in voluntary resignations as a proportion of leavers from 44.7% to 63% in the five years to 2016/17. Over the same period, there has been a gradual increase in the rate of nurses leaving to 8.7% in 2016/17. There are variations in leaver rates across AfC groups and across the countries of the UK. The Health Foundation⁶¹ commented on the estimation that the NHS would lose 84,000 nurses before retirement age between 2016 and 2021. In this respect, employers will need to consider whether further retention measures are needed to encourage extended service. Against this background in recent trends for AfC groups, there is a renewed emphasis among NHS organisations on addressing retention.

⁶¹ Health Foundation (2017), *Rising Pressure: the NHS Workforce Challenge*. Available at: https://health.org.uk/sites/health/files/RisingPressureNHSWorkforceChallenge.pdf

- 4.84 Although these trends show a clear pattern, there was a general view among the parties that there was no single cause of the decline in retention. The Department of Health and Social Care's evidence showed an increasing proportion of leavers citing work-life balance issues as the reason why they left increasing from 11% to 16% between 2012/13 and 2016/17. Staff Side surveys showed a range of dissatisfaction over pay restraint and its effects on pay, but the Department's data showed that the proportion of staff leaving for a better reward package was stable at around 5% over the five years to 2016/17. In our view, a combination of factors is likely to influence individual's decisions to leave. This combination, therefore, requires a range of initiatives to find retention solutions. As we have said in previous reports, there is a continuing need to improve the data on the reasons for voluntary resignations.
- 4.85 Given the complexity of factors influencing retention, we welcome the major initiatives being run through NHS Improvement. These initiatives include an overall programme covering generic retention issues, plus specific programmes for nursing and mental health. NHS Employers have also developed a retention toolkit. We consider that much can be achieved locally on retention, within national initiatives, as trusts are best placed to understand their business needs, workforce requirements, local markets and local working environment. We look forward to these initiatives providing a better insight into influences on retention and best practice solutions. We would welcome an assessment in future evidence submissions from the parties of the retention initiatives underway.
- 4.86 We consider that the Total Reward package can have a significant influence on retention. The financial and other elements of the package can impact on specific aspects of the employee experience for individuals. In assessing the role of pay we have commented in previous reports on understanding the influence of a range of non-pay measures to address retention. We are encouraged by the recognition of non-pay factors among NHS organisations. We have heard a consistent message from AfC staff that to achieve a reasonable work-life balance the development of flexible working arrangements was a priority. We would also highlight the influence of different retention factors at different stages of a career. In this respect and as we comment earlier on recruitment, we look forward to seeing further work under the draft Workforce Strategy, which included research on the attitudes of the next generation and what they expect from an employment offer.
- 4.87 Finally on retention, we commented in our 2017 Report that Recruitment and Retention Premia were an important flexibility which allowed local targeting of pay. The parties and AfC staff on our visits suggest that the use of RRPs had declined because of lack of specific funding and the desire to avoid bidding wars with neighbouring organisations. We would welcome evidence from the parties on the use and effectiveness of RRPs to recruit and retain staff and more information on why they are not widely used.

Motivation and engagement

- 4.88 We welcome the parties' evidence, which is set out in Chapter 3, that continues to place an emphasis on effective staff engagement. The link between engaged staff in the NHS and outcomes for patients has been accepted by the parties, and we would add that such engagement is the mark of successful organisations. It is clear from the evidence that there are important links between staff engagement, contribution and retention. Engaged staff are more likely to be advocates for work within the NHS and may therefore support recruitment.
- 4.89 We consider that AfC staff are engaged when they feel that they are well-managed, their work is valued and rewarded, they contribute to good patient care, and they have opportunities for learning and development. To that end, we review the evidence below from the NHS Staff Surveys (and the equivalent in Scotland), sickness absence and the Friends and Family Test.

- 4.90 Since our 2017 Report, the fourteenth and fifteenth annual surveys of NHS Staff in England have been published. They were conducted in autumn 2016 and 2017, with a response rate of 45% and almost 500,000 respondents in 2017. There have been no further staff survey results from Wales or Northern Ireland, which run surveys every three to five years and which last ran them in 2015. Scotland has moved to a new survey system (iMatter) in 2017/18. We highlight the importance to our deliberations of timely data from staff surveys.
- 4.91 In England, AfC staff satisfaction⁶² with pay had been broadly stable in recent staff surveys but fell sharply in 2017 by 5.8 percentage points to 29.4%. For specific groups the 2017 results showed:
 - registered nurses' and midwives' satisfaction fell by 6.9 percentage points to 35.2%;
 - general managers remained the most satisfied group (57.2%) and also the least dissatisfied⁶³ with their levels of pay (general managers had held this position since 2007) although they were not as satisfied as in 2016;
 - nursing and healthcare assistants continued to have the lowest satisfaction with pay, which had fallen by an additional 3.0 percentage points from 2016; and
 - ambulance staff satisfaction with pay fell by 9.2 percentage points to 26.0%.

AfC staff (2017) -5.8 +7.6 AfC staff (2016) 0.4 +0.6 AfC staff (2015) Registered nurses & midwives -6.9 +8.9 - midwives -8.6 +10.5 - health visitors -9.1 +5.0 Nursing or healthcare assistants Allied health professionals, healthcare -6.2 +6.8 scientists, scientific & technical staff General managers -1.0 +1.4 Administrative & clerical staff -2.9 +4.4Central functions / corporate services +1.9 Maintenance / ancillary -4.3 +5.1 Ambulance staff -9.2 +4.7 30 10 60 50 40 10 20 30 40 50 60 Percentage of staff Very satisfied Satisfied Dissatisfied Very dissatisfied

Figure 4.15: Satisfaction with level of pay by staff group, England, 2017

Source: National NHS Staff Survey (England)

⁽¹⁾ Those who answered "neither satisfied nor dissatisfied" are not included in this chart.

⁽²⁾ Labels indicate change in percentage points from previous year.

⁶² In each case, satisfied refers to participants answering that they were 'satisfied' or 'very satisfied' with their level of pay.

⁶³ In each case, dissatisfied refers to participants answering that they were 'dissatisfied' or 'very dissatisfied' with their level of pay.

- 4.92 Table 4.8 below provides a selection of staff survey results on engagement and satisfaction. We note that these showed that engagement and job satisfaction among AfC staff decreased in 2017:
 - the Engagement Index for AfC staff fell slightly after a number of years of steady increase;
 - the largest decrease in 2017 (apart from on the level of satisfaction with pay) came from staff saying that they looked forward to going to work, which decreased by 1.0 percentage points;
 - over a quarter of staff experienced harassment or bullying, unchanged from 2016;
 - of these selected measures, the only positive from the previous year was from a larger proportion of staff agreeing that they get support from their immediate manager, which increased by 0.5 percentage points; and
 - 86.4% of staff had had an appraisal in the last 12 months, similar to the previous year. Of these
 - only about two-thirds of the appraisals identified training, learning or development needs
 - about 70% said it helped them improve how they did their job
 - about three quarters felt their work is valued
 - about 85% agreed clear objectives for their work.
- 4.93 Looking at trends since 2011, we saw that job satisfaction had generally been increasing across all staff groups. However, between 2015 and 2016 changes had been more mixed, and in 2017 were generally slightly negative. We note in particular:
 - among clinical staff, health visitors tend to have had the highest levels of satisfaction, whereas ambulance staff had some of the lowest;
 - there was a large increase in satisfaction of ambulance staff with the support they get from colleagues, increasing by almost 6 percentage points. However, feelings about the extent to which the organisation valued them, which had increased by about 10 percentage points in 2016, had since fallen by a similar amount;
 - midwives and ambulance staff felt the least valued by their organisation; and
 - among non-clinical staff, general managers persistently had the highest satisfaction, with administrative and clerical usually the lowest.

Table 4.8: Selected job satisfaction results from the national NHS Staff Survey, AfC staff, England, 2011 to 2017

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

Source: National NHS Staff Survey (England)

Notes:

- (1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and full range of possible scores for each measure.
- (2) Lower scores are better in this case.
- 4.94 Table 4.9 provides a selection of staff survey results on working pressures. These results show generally that work pressures had increased compared to 2016, specifically:
 - fewer AfC staff felt they had adequate supplies, a decline of about 0.8 percentage points to 55%;
 - an increase of 1.5 percentage points in staff reporting they had felt unwell as a result of work related stress to 39%;
 - the percentage of staff working paid overtime had increased by 0.7 percentage points to nearly a third, while the percentage working unpaid hours had decreased by a similar amount (0.7 percentage points) to 57%; and
 - across all staff groups, there was an increase in the percentage of staff reporting that they had felt unwell as a result of work related stress, with health visitors expressing the highest increase of 5.5 percentage points.

- 4.95 Among clinical staff, there has been a mixed picture from the staff survey results on workforce pressures, with some groups showing improvements in 2017 and others showing declines. In particular:
 - differences in the proportion of staff working additional unpaid hours
 - among clinical staff, 50.5% of ambulance staff worked additional unpaid hours compared with over 82% of health visitors and midwives
 - for non-clinical staff, 37.3% of maintenance/ancillary staff worked additional unpaid hours, compared with 86.0% of general managers;
 - an increase in the percentage of staff agreeing that there were enough staff at their organisation, although at a low level at around 30%
 - registered nurses and midwives had seen an increase each year
 - midwives reported the lowest satisfaction with around 20% agreeing
 - ambulance staff had the largest fall between 2016 and 2017 of 5 percentage points;
 - health visitors agreeing that they were able to meet all the conflicting demands on their time at work decreased by 8.4 percentage points from 39% to 32% in 2017.

Table 4.9: Selected working pressures results from the national NHS Staff Survey, AfC staff, England, 2011 to 2017

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

Source: National NHS Staff Survey (England)

Notes:

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

- 4.96 In November 2017, all staff across NHS Scotland and 23 Health and Social Care Partnerships were asked to participate in iMatter and the Dignity at Work survey⁶⁴. These replaced the Scottish Staff Survey last run in 2015. iMatter achieved a 63% response rate, with over 100,000 responses. As this is the first year of these new results it is not possible to compare these results with previous staff survey results in Scotland, or results in other countries.
- 4.97 The Scottish Engagement Index stood at 75%, which took into account responses to 28 questions⁶⁵. In general, staff were satisfied that they had sufficient support to do their job well (77%), that their work gave them a sense of achievement (81%) and felt appreciated for the work they do (73%). In terms of their organisation, 70% agreed that their organisation cared about their health and wellbeing, and 71% that they get the help and support they need from other teams and services within the organisation. However, staff were less confident that performance was managed well within their organisation at 64%. The Scottish staff survey has similar questions to the Friends and Family Test, which showed that 74% would recommend their organisation as a good place to work, whilst 78% would be happy for a friend or relative to access services within their organisation.
- 4.98 We review sickness absence as an indicator of staff demotivation and dissatisfaction. Sickness absence rates are calculated as the percentage of working hours lost through sickness absence. While rates between England and Wales can be compared (as they use the same Electronic Staff Record), Scotland and Northern Ireland calculated these rates slightly differently so therefore the data should only be used to monitor trends within a country. Higher rates could be a reflection of better recording rather than more sickness, both between groups and across time.
- 4.99 The overall trends suggest that sickness absence rates for Scotland had slowly increased since 2010/11 to 5.2% by 2017. Sickness absence rates in England fluctuated and were 4.3% in 2017. Absence rates in Wales had fallen since 2014 reaching 5.2%, but were still higher than those in England.
- 4.100 Figure 4.16 shows sickness absence rates by staff group in England between 2010 and 2017. Between January and March 2017, the average NHS sickness absence rate was 4.3% (similar to 2016) but low reported rates of sickness absence for medical and dental staff (not shown in Figure 4.16) served to bring down the overall average. Ambulance staff, healthcare assistants and other support staff, and nursing, midwifery and health visiting staff groups had higher than NHS average sickness absence rates. Sickness rates for the ambulance staff group had fallen since 2015. These sickness rates had remained below those of healthcare assistants and other support staff. We note the variances between AfC groups and, in particular, the high sickness absence rates for front line staff which have implications for the workload of others and high agency costs.

⁶⁴ The Scottish Government (March 2018), *Health and Social Care Staff Experience Report 2017*. Available at http://www.gov.scot/Resource/0053/00532256.pdf

Each question had six possible responses; 'Strongly Agree', 'Agree', 'Slightly Agree', 'Slightly Disagree', 'Disagree' and 'Strongly Disagree'

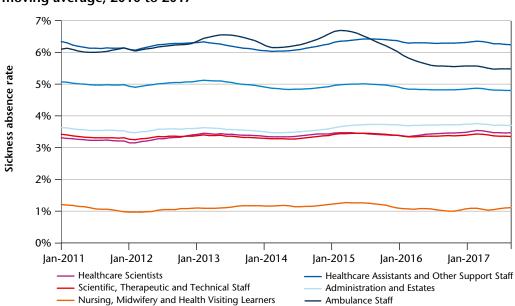


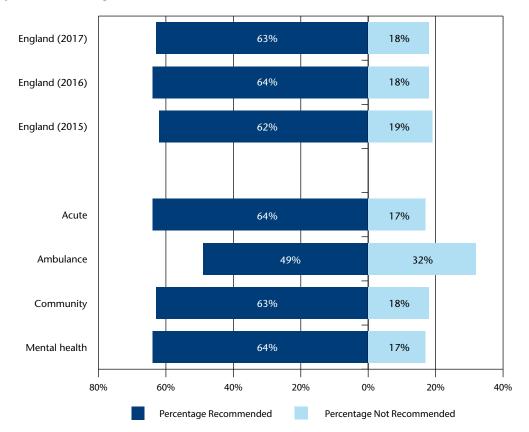
Figure 4.16: Sickness absence rates in England by main staff group, 12 month moving average, 2010 to 2017

Source: NHS Digital

4.101 With the identified workforce gap and resulting pressures on the workforce, we consider the way in which staff view their organisation (as an employer and a provider of care) as an important indicator of motivation and advocacy. We note from the NHS Friends and Family Test in 2017 that, as a place to work, 63% of staff (both medical and AfC) would recommend their organisation to friends and family. This was a slight decrease on 2016 (Figure 4.17). Ambulance staff remained the least likely group to recommend their organisation as a place to work in (49%), although this had increased by 7 percentage points compared to 2015. Similarly, the percentage not recommending had fallen by 10 percentage points.

Nursing, Midwifery and Health Visiting Staff

Figure 4.17: Recommendation as a place to work, Friends and Family Test (staff), by work area, England, Q4, 2015 to 2017



Source: NHS England, Friends and Family Test

Note: The question asked was "We would like you to think about your recent experience of working in <the organisation>. How likely are you to recommend <this organisation> to friends and family as a place to work?"

4.102 When asked to recommend their organisation as a place to receive care, a higher proportion of staff would recommend their organisation to family and friends than those recommending it as an employer. In the fourth quarter of 2017, 80% of staff would recommend their organisation as a place to receive care, a slight increase from 2016 (Figure 4.18), although those in mental health were considerably lower at 76% than other service areas.

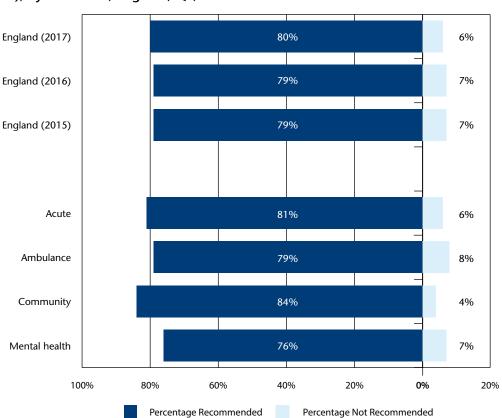


Figure 4.18: Recommendation as a place to receive care, Friends and Family Test (staff), by work area, England, Q4, 2015 to 2017

Source: NHS England, Friends and Family Test

Note: The question asked was "We would like you to think about your recent experience of working in <the organisation>. How likely are you to recommend <this organisation> to friends and family if they needed care or treatment?"

- 4.103 There is broad consensus among the parties and external commentators that staff who are more engaged will be more effective in delivering good patient care. We understand that AfC staff expect the NHS to be a challenging, demanding and busy working environment. There are, however, consistent messages from staff on the way in which staffing levels, shortages, vacancies and workload, which are symptomatic of wider demand, put pressures on staff motivation and satisfaction. These present potential risks to recruitment, retention and attendance.
- 4.104 There is a widespread recognition, by all the parties, that AfC staff morale and motivation is a significant concern. The NHS Staff Survey, Staff Side surveys and our visits provide substantial evidence of the factors affecting staff motivation. These factors centre on staff not feeling valued, because of continued pay restraint, workload pressures, and concerns with quality of care that they are able to provide. Even if the pay measures in the AfC agreement begin to impact on the significant drop in satisfaction with pay in the NHS Staff Survey 2017 (down to 29.4% after being broadly stable in recent surveys), any recovery is likely to be muted, unless there is an accompanying focus on wider workforce developments.
- 4.105 It is likely that workforce pressures have impacted on work-life balance factors influencing leavers, the number of staff recommending their organisation as a place to work (63% in the Friends and Family Test), and the numbers of NHS nursing staff that would recommend nursing as a career (falling to 39% in 2017). We see these advocacy indicators as important measures of recruitment and retention in the light of workforce gaps and pressures on staff.

- 4.106 The draft Health and Social Care Workforce Strategy points to an ambition to make the NHS a more family-friendly workplace, and one which recognises the importance of staff engagement. We welcome the progress made by NHS Employers in response to our observations in previous reports on the importance of staff engagement. It is helpful that the benefits of staff engagement are now being recognised in relation to the potential impact on productivity and the quality of patient care. In the context of motivation, we would add that improving flexible working arrangements and access to, and funding for, training and development (as found by the Health Committee's Report on the nursing workforce) are seen by AfC staff significant motivating factors.
- 4.107 We comment in Chapter 5 on the parties' emphasis that the AfC pay agreement provides a renewed focus on staff engagement by "putting appraisal and personal development at the heart of pay progression", with staff supported to develop their skills and competencies. We note the 2017 NHS Staff Survey results on staff appraisals provide a firm base to introduce revised arrangements. We look forward to further evidence on the impact and outcomes from the revised process.

Earnings, pay progression and pay comparisons

AfC staff earnings

4.108 Earnings growth for AfC groups has been low since 2010 during the period of pay restraint under the UK Government's public sector pay policy. From our analysis of earnings data for 2017, all AfC staff groups, except ambulance staff, saw an increase in average total earnings ranging from 0.4% to 2.0% (Figure 4.19). While basic pay increased for all staff groups, non-basic pay fell for all except two (senior managers and hotel, property and estates). Total earnings per person for ambulance staff fell by 1.1%, driven by a fall in non-basic earnings of almost 4%.

Senior managers

Managers

Ambulance staff

Scientific, therapeutic & technical staff

Midwives

Nurses & health visitors

Central functions

Support to ambulance staff

Support to doctors, nurses & midwives

Figure 4.19: Mean basic and non-basic salary⁶⁶ per person⁶⁷ by main staff groups⁶⁸, 2015 to 2017, England

Mean annual earnings, 12 months ending June each year

£10,000 £20,000 £30,000 £40,000 £50,000 £60,000 £70,000 £80,000

Source: NHS Digital

Pay progression and promotion

Support to ST&T staff

£0

Hotel, property & estates

4.109 Agenda for Change is designed with a range of pay points within each band: as staff gain experience and skills, they move through these pay points and are rewarded with higher pay each year (although increment values vary). However, once staff have reached the top pay point in each band, they only receive pay increases based on uplifts to the pay scales. Table 4.10 shows that in England, over 40% of staff are at the top of their band and that this is broadly consistent across most bands. Ambulance staff have the lowest proportion of staff at the top of the band, although we note that this is likely to be due to the re-banding of paramedic posts in December 2016.

⁶⁶ Total earnings include: basic salary and additional earnings. Additional earnings includes hours-related pay, such as on-call, shift working and overtime; location payments such as location allowances and other local payments; recruitment and retention premia; and 'other' payments such as occupational absence and protected pay.

⁶⁷ Measuring salaries on a per person basis tends to deflate the estimate of earnings, the severity of which will vary depending on the numbers of staff working part-time.

⁶⁸ In all staff groups there may be some staff who are not on Agenda for Change terms and conditions.

Table 4.10: Estimated share of staff (FTE) on top of band by staff group and band, April 2017

	i i		
Hotel, property & estates	66%	Band 1	85%
Support to doctors & nursing staff	47%	Band 2	44%
Qualified nursing & health visiting staff	44%	Band 3	50%
Qualified midwives	43%	Band 4	48%
Support to ambulance staff	43%	Band 5	40%
Support to scientific, therapeutic & technical staff	41%	Band 6	37%
Qualified scientific, therapeutic & technical staff	40%	Band 7	46%
Managers	36%	Band 8a	44%
Central functions	36%	Band 8b	46%
Senior managers	29%	Band 8c	44%
Qualified ambulance staff	17%	Band 8d	48%
		Band 9	43%
Total HCHS non-medical staff	43%		

Source: NHS Digital Provisional NHS Staff Earnings Estimates

- 4.110 In recent years, we note that Government policies in each of the four countries have emphasised the pay of lower paid staff, particularly since the pay freeze and subsequent pay restraint was introduced. Given the different pay awards across the countries, there are now some significant cross-country differences in AfC pay rates:
 - at all points on the pay scale Scotland is higher than any other country, with the percentage differences being larger at the top and bottom of AfC; and
 - pay points in Northern Ireland are generally below those of the other countries, particularly at the lowest pay points.
- 4.111 In addition, we have seen that the different awards by pay point in each country have, in some cases, led to compression of the pay scales, particularly:
 - in England, pay point 9 is only 1% above pay point 8, which means that an individual at the top of Band 2 and considering promotion would get only a 1% pay rise for taking on many extra responsibilities;
 - in Scotland, pay points 14, 15 and 16 are compressed, meaning an individual moving through these pay points would see progression increases of only 1% followed by 0.6%, smaller than any other single year's progression;
 - in Wales, due to the commitment to the Living Wage Foundation Living Wage, pay points 1 to 5 are all paid effectively the same rate. This means that there is no progression for those years; and
 - in Northern Ireland there are currently no major compression issues. However, in the near term the National Living Wage is likely to continue to increase at a faster rate than the AfC uplifts. This will cause similar compression at the bottom of the pay scales to what is already being seen in Wales.
- 4.112 As we identified in our 2017 Report, the variable uplifts given to pay points, particularly in the lower bands, have caused pay scale compression in some areas. This is a problem because staff might be reluctant to apply for promotions where the increase in responsibility is too large compared to the small increase in pay.

Income compared to the wider economy

4.113 We have been told on our visits, and by the Staff Side, that AfC staff feel that over the last few years their purchasing power has declined. Our analysis suggests that while the starting salary of nurses may have seen a decrease in purchasing power since 2010, this same effect has been seen across the rest of the economy. Nurses have, however, seen a slight reduction in their earnings each year relative to the whole economy.

130 Agenda for Change 125 120 ndexed: 1999 = 100 115 110 105 100 95 90 85 80 Deflated by CPI Deflated by RPI Deflated by median annual full-time employee earnings growth (ASHE)

Figure 4.20: Nurse starting pay point⁶⁹ deflated by average earnings and inflation, England, 1999-2017

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

Pay comparisons

- 4.114 We comment earlier in this report that monitoring the graduate and wider employment market and pay levels will be essential in maintaining an acceptable supply of graduates to the NHS. Graduate starting salaries are widely published and could help or hinder recruitment into the NHS. Also relative pay movements in the wider economy could encourage or discourage existing staff from looking to work elsewhere. Our comparisons focus on basic pay and earnings and do not include the value of other benefits, such as the NHS pension which we consider is a valuable component of the Total Reward package.
- 4.115 The AfC pay scales cover a wide variety of roles and pay, and therefore we examine a wide variety of comparators. Our analysis of the *Annual Survey of Hours and Earnings* (ASHE) suggests that pay in the human health and social work activities⁷⁰ sector has been increasing at a slower rate than in the private sector between 2015 and 2017, and at a slower rate than the whole economy in 2015 and 2017 (although at a faster rate in 2016).

⁶⁹ 1999-2003, Whitley D grade, 2004-2017, Band 5.

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

Table 4.11: Change in median gross weekly pay for full-time employees at adult rates, 2015 to 2017, April each year, United Kingdom

United Kingdom	Median gross weekly pay (change on previous year)					
	2015		20	16	20	17
Human health and social work activities sector	£497 (0).5%)	£510	(2.6%)	£509	(-0.2%)
All employees	£527 (1	.7%)	£539	(2.2%)	£550	(2.2%)
Public sector	£590 (1	.9%)	£594	(0.7%)	£599	(0.9%)
Private sector	£500 (1	.4%)	£517	(3.4%)	£532	(2.8%)
Professional occupations[1]	£717 (0).8%)	£726	(1.3%)	£733	(1.0%)
Associate professional and technical occupations[2]	£592 (1	.4%)	£591	(-0.2%)	£606	(2.4%)
Administrative and secretarial occupations	£415 (2	2.0%)	£423	(2.0%)	£432	(2.0%)
Skilled trades occupations	£489 (1	.8%)	£497	(1.6%)	£510	(2.6%)
Caring, leisure and other service occupations	£341 (1	.9%)	£353	(3.4%)	£361	(2.5%)

Source: Office for National Statistics (Annual Survey of Hours and Earnings)

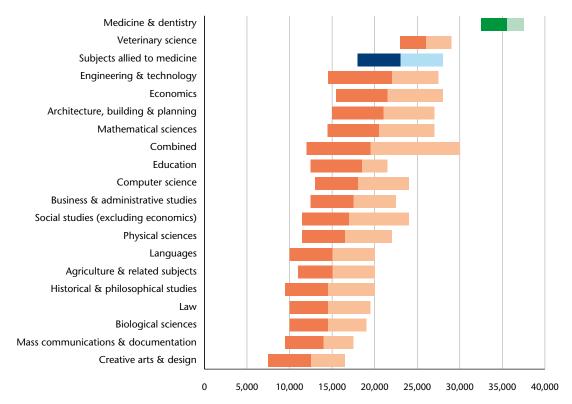
Notes:

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

[2] Includes, for example, police officers and some AHPs and ST&Ts. Nurses and midwives were in this group until April 2010.

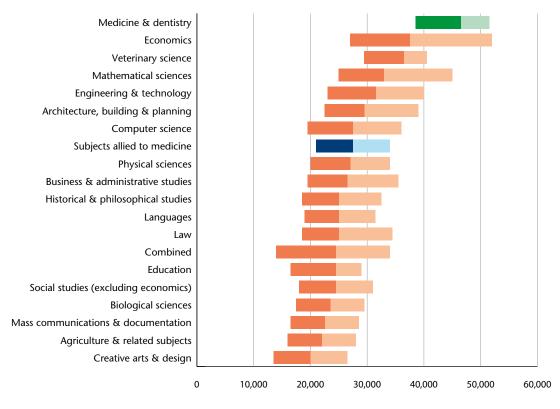
- 4.116 We have also seen new data from the Longitudinal Education Outcomes (LEO) dataset published by the Department for Education, which allow more accurate tracking of graduate salaries using matched HMRC data. The data are based on the degree subject studied, irrespective of the job done after graduation. We conclude from the data (Figures 4.21 and 4.22) that graduate pay for AfC-related health degrees compares well relative to other graduates on entry, but less so at the five-year point in the NHS, which includes the 40% of Band 5 staff at the top of the band. The high ranking on entry is partly due to the near-guaranteed career in their chosen profession immediately after graduation for AfC-related health degrees, compared to many other subjects.
- 4.117 We can see that, despite most staff receiving pay progression during the first five years, earnings for graduates with AfC-related health degrees slip down the rankings as graduates with other degrees overtake them. Looking beyond five years, we see that many AfC staff will start to be at the top of their pay scale, so could see their relative pay continue to slip further down the rankings.

Figure 4.21: Earnings 1 year after graduation (2008/09 cohort), lower quartile, median and upper quartile, $\bf f$



Source: OME analysis of LEO data set

Figure 4.22: Earnings 5 years after graduation (2008/09 cohort), lower quartile, median and upper quartile, \pounds



Source: OME analysis of LEO data set

Gender pay

4.118 By April 2018, all NHS trusts were required to have published information on gender pay⁷¹. NHS Digital data show similar figures across the whole NHS in England broken down by staff group. While we note the headline gender pay gap figure is 23%, within the AfC staff group the gender pay gap is much lower at 4%, as it removes much of the differences in gender composition between AfC and medical staff groups, notwithstanding that the AfC is a female dominated group. The proportion of women is smaller in Bands 8 and 9 than other pay bands but we note that the pay gap for AfC senior managers is 12%. In general, there is a large gender pay gap for infrastructure support staff, a negative gender pay gap for support staff, and a small gender pay gap for other AfC staff (Table 4.12). This analysis reinforces the workforce data, where there are lower proportions of women in the higher bands.

Table 4.12: Mean annual basic pay per FTE by gender, England, 2017

	Mean Annual Basic Pay £ per FTE ^[1]		
	Male	Female	Gap
All staff	37,470	28,702	23%
Medical staff	67,788	57,569	15%
AfC staff	28,156	26,941	4%
Clinical staff			
Nurses & health visitors	31,582	31,387	1%
Midwives	33,613	33,085	2%
Ambulance staff	27,886	26,807	4%
Scientific, therapeutic & technical staff	36,027	34,811	3%
Support to clinical staff:			
Support to doctors, nurses & midwives	18,645	18,913	-1%
Support to ambulance staff	19,644	20,200	-3%
Support to ST&T staff	19,963	19,996	0%
NHS infrastructure support:			
Central functions	28,004	24,889	11%
Hotel, property & estates	19,436	16,949	13%
Senior managers	83,354	73,717	12%
Managers	49,337	46,620	6%

Source: NHS Digital, Provisional NHS Staff Earnings Estimates

Note:

[1] Mean annual basic pay per FTE is the mean amount of basic pay paid per 1 Full-Time Equivalent post in a 12 month period.

⁷¹ The gender pay gap is the difference in the average hourly wage of all men and women across the workforce. If women do more of the less well paid jobs within an organisation than men, the gender pay gap is usually bigger. The gender pay gap is not the same as unequal pay which is paying men and women differently for performing the same (or similar) work.

Take-home pay

- 4.119 Over the six years between 2011/12 and 2017/18 basic pay for NHS staff at the top of their pay band in England has increased by between 7.2% for Band 1, and 3% for Band 9 (Table 4.13). However, our analysis suggests that, due to changes in pension contribution rates, national insurance and income tax, take-home pay has changed more significantly. According to our calculations, the change in take-home pay was much higher for lower bands than higher bands, ranging from an increase of 11.4% for Band 1 to a fall of 2.4% for Band 9. The uplift of 1% to basic pay and other tax changes at April 2017, led to an increase in take-home pay of between 0.9% (Band 1)⁷² and 1.4% (Band 3).
- 4.120 In general, we conclude that the changes to take-home pay due to combinations of annual pay uplifts, tax, national insurance and pensions changes have impacted more positively for the lower paid staff than for the higher paid staff, to the point where some staff in the higher bands have seen their nominal take-home pay fall between 2011/12 and 2017/18.

Table 4.13: Basic pay and take-home pay, England, 2011/12 to 2017/18

	Basic pay					1-yea chang		5-yea chang		6-yea chang			
Top of:	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	£	%	£	%	£	%
Band 1	£14,614	£14,864	£15,013	£15,013	£15,363	£15,516	£15,671	£155	1.0	£807	5.4	£1,057	7.2
Band 3	£18,827	£19,077	£19,268	£19,268	£19,461	£19,655	£19,852	£197	1.0	£775	4.1	£1,025	5.4
Band 5	£27,625	£27,625	£27,901	£27,901	£28,180	£28,462	£28,746	£284	1.0	£1,121	4.1	£1,121	4.1
Band 7	£40,157	£40,157	£40,558	£40,558	£40,964	£41,373	£41,787	£414	1.0	£1,630	4.1	£1,630	4.1
Band 9	£97,478	£97,478	£98,453	£98,453	£98,453	£99,437	£100,431	£994	1.0	£2,953	3.0	£2,953	3.0

	Take home pay				1-yea		5-yea		6-yea				
Top of:	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	£	%	£	%	£	%
Band 1	£11,864	£12,177	£12,558	£12,692	£13,053	£13,097	£13,221	£124	0.9	£1,045	8.6	£1,357	11.4
Band 3	£14,628	£14,932	£15,294	£15,383	£15,640	£15,652	£15,877	£225	1.4	£945	6.3	£1,250	8.5
Band 5	£20,068	£19,859	£20,094	£20,161	£20,466	£20,404	£20,676	£272	1.3	£816	4.1	£608	3.0
Band 7	£28,136	£27,753	£27,959	£27,996	£28,374	£28,223	£28,573	£351	1.2	£820	3.0	£437	1.6
Band 9	£59,316	£58,011	£57,282	£56,749	£56,933	£57,086	£57,882	£796	1.4	-£129	-0.2	-£1,434	-2.4

Source: OME Analysis of HMRC, NHS Employers and NHS Business Services data

The National Living Wage and Living Wage Foundation Living Wage

- 4.121 We have noted in recent reports that the lowest pay point in Agenda for Change has historically been well above the level of the National Minimum Wage. However, with the introduction of the National Living Wage, together with several years of pay restraint, this differential has decreased or disappeared for the lowest pay bands. There are risks to AfC recruitment and retention as the differential erodes, and staff may increasingly choose to work elsewhere.
- 4.122 We note that, in 2017/18, the National Living Wage was higher than AfC pay point 1 in Northern Ireland. In the absence of the Northern Ireland Executive, the initial decision was made that only staff aged over 25 should be paid the higher rate (in line with the legislation), rather than the pay scale itself being uplifted. As set out in the Northern Ireland remit letter (Annex A) the pay point has since been uplifted above the National Living Wage level. A similar initial decision has been taken for 2018/19 with only the pay of staff aged 25 or over being uplifted in line with the National Living Wage rate (calculated by Northern Ireland to be £15,310).

⁷² The percentage increase for Band 1 was lower than other groups as they moved into a higher pension contribution bracket due to the uplift.

- 4.123 From 1 April 2018, workers aged 25 and over are legally entitled to at least £7.83 per hour, and the OBR forecast it to rise to £8.56 by 2020^{73} (£16,738 per year). The Living Wage Foundation Living Wage⁷⁴ is a voluntary rate which is "independently-calculated based on what people need to get by". The rate from April 2018 is £8.75 across the UK (£17,109 per year) and £10.20 in London (£19,944 per year). These rates are announced each November and are currently higher than the National Living Wage. The NHS in Scotland and Wales are Living Wage Foundation Living Wage employers.
- 4.124 From our assessment, the National Living Wage would start to affect pay points in Wales in April 2018, due to the Welsh Government commitment to paying the Living Wage Foundation Living Wage. This should have no real consequences for pay. On the other hand, the Foundation Living Wage will increase to £8.75 per hour, meaning that staff on the bottom of Band 1 will be paid the same as staff on the bottom of Band 3, as the Foundation Living Wage level creeps up the pay scales.
- 4.125 The Scottish Government's public sector pay policy has focused on the lowest paid and the removal of AfC pay points 1 and 2, therefore, the remaining pay points are all above the levels of the National Minimum Wage, and will only be marginally affected by the increase to the Foundation Living Wage.

Table 4.14: National Minimum Wage, National Living Wage and the Living Wage Foundation Living Wage rates per hour

Age Group	National Minimum Wage	National Living Wage ⁷⁵	Living Wage Foundation Living Wage	
		(from 1 April 2018)	(from 1 April 2018)	
			National ⁷⁶	London
25+	NLW from 1 April 2017	£7.83		
21-24	£7.38		60.75	610.20
18-20	£5.90		£8.75	£10.20
Under 18	£4.20			
Apprentice	£3.70			

Recruitment and Retention Premia

4.126 We note that there has been a decline in the proportion of AfC staff receiving Recruitment and Retention Premia (RRP) and the total payments made in recent years. At April 2017, less than 1% of AfC staff received RRPs. However, this varied by staff groups, with non-clinical staff (managers, senior managers, and hotel, property and estates) more likely to receive an RRP as there were more comparable to jobs outside the NHS. There was also regional variation, with areas in and around London more likely to pay RRPs.

⁷³ November 2017 forecast. The Government has asked the Low Pay Commission to recommend the level of the path of the National Living Wage going forward, with the target of the total wage reaching 60% of median earnings by 2020.

⁷⁴ Available at: https://www.livingwage.org.uk/what-real-living-wage

⁷⁵ The new National Living Wage is effectively a new National Minimum Wage for those aged 25+.

⁷⁶ Scotland and Wales currently pay rates based on the Living Wage Foundation Living Wage (but this is not legally binding). The NLW will likely impact nominally on the lowest pay points in Wales this coming year (2018/19), whilst it will only impact in Scotland after 2020/21.

- 4.127 We considered research by IES on the use and effectiveness of market pay supplements⁷⁷. This found that pay supplements (including RRPs) were neither universally successful nor unsuccessful, and neither good value for money nor a poor return on their cost. It also found that the situations and settings and the aims and nature of these payments varied enormously across the populations studied. IES concluded that a positive impact from using supplements was more likely to be enhanced with very clear criteria, tight targeting on specific groups, good external market and internal HR data, and cooperation with other employers locally.
- 4.128 We would welcome evidence in future rounds on the effective use of RRPs, both by geography and by specialism. Views on our visits suggested that the use of RRPs has declined because of the lack of specific funding, and to avoid starting a bidding war between neighbouring trusts or between staff groups within the trust.

Pensions

- 4.129 Pensions form a valuable component of the Total Reward package for AfC staff. However, we note that the overall pension membership rate had fallen in 2017. The large increases in pension membership in the lower pay bands seen between 2012 and 2013 were due to the change to auto enrolment. Across most pay bands there was slightly higher membership for women than men, but the general trends were similar.
- 4.130 In our 2017 Report, we highlighted that the tiered approach to pension contributions led to the perverse consequence of some pay uplifts leading to reductions in take home pay. Responding to our recommendation, the Department of Health and Social Care confirmed in evidence that there will be a review of the approach to member contributions with a view to reaching agreement on new rates for implementation from 1 April 2019.

Office of Manpower Economics (November 2017), Review of the Use and Effectiveness of Market Pay Supplements. Available at: https://www.gov.uk/government/publications/review-of-the-use-and-effectiveness-of-market-pay-supplements-november-2017

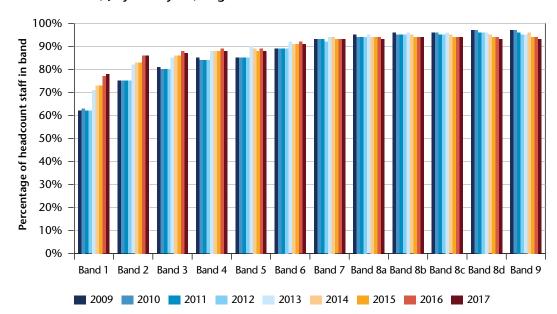


Figure 4.23: Estimated pension membership rate by Agenda for Change band, 2009 to 2017, July each year, England

Source: Department of Health extract from Electronic Staff Record

Our overall conclusions on AfC pay

- 4.131 We draw on the parties' evidence in Chapter 3 and our analysis in this chapter in framing our overall conclusions on the factors influencing AfC pay. Staff motivation has been impacted by the UK Government's policies of pay restraint in recent years. Pay restraint has made a significant contribution to efficiency savings within the NHS. Pay is one measure of the way in which staff are valued, and we have seen in the evidence that pay restraint is not contributing to supporting the recruitment, retention and motivation of AfC staff at a time when these are huge priorities in the NHS. This overall picture is broadly mirrored in all the countries of the UK within our remit. There are specific issues for individual countries as identified earlier in this chapter.
- 4.132 Overall, the general economic environment in the UK has remained relatively stable, although uncertainties remain. For example, inflation has increased in 2017 before falling back slightly into 2018. We recognise that the level of inflation is an important consideration to AfC staff. Our broad conclusion on the overall position of AfC pay relative to the UK market is that it has declined slightly in recent years. We note the DHSC's conclusion that mean annual earnings growth for NHS staff had been lower than comparators across the wider economy in the last five years. It is clear from the NHS Staff Survey, individual trades unions' surveys, and our visits that existing levels of pay do not help AfC staff feel valued. Pay could become an increasing concern when viewed alongside the significant workforce gap, high levels of vacancies, decreasing retention rates and reducing levels of advocacy by staff.
- 4.133 We note that the NHS as a whole and individual countries have made efforts to ensure that the lowest paid AfC staff are paid above the National Living Wage (and equivalents) and there is no evidence of recruitment and retention concerns at this level. We would welcome further clarification of the position in Northern Ireland for the pay of staff aged under 25 for 2018/19 and in future years.

- 4.134 Looking forward, there are risks to the AfC workforce from developments in the wider labour market. We have yet to see significant pay movements across the economy but there has been a slight upward rise in average earnings and a pick up in pay settlements early in 2018. Employers in the NHS have recognised that they need to stay competitive, particularly to recruit the staff needed to deliver services to patients. The evidence on pay for AfC professions shows that they are paid well relative to other graduates entering the market, but less so after the five-year point in the NHS, which could particularly affect the 40% of staff on the top of Band 5.
- 4.135 We observe that modern employers focus on Total Reward to ensure that they can recruit, retain and motivate staff. Total Reward includes pay, pensions (a valuable component of the AfC package), other benefits, learning and development opportunities, and the overall work experience. NHS organisations have, generally, recognised that to become an employer of choice, as emphasised in the draft Workforce Strategy, they need to promote the attractiveness of the employment offer in the NHS. The NHS is a stable employer with significant pensions and benefits, and with intrinsically rewarding work. We also note that extensive national and local work (being led by NHS Employers) is providing a focus on wider issues such as health and wellbeing, and training and development. Within Total Reward we observe that different elements of the available package affect staff in different ways and at different stages of a career. It is important to have an effective pay structure which offers appropriate progression, in conjunction with the capability to bring other non-pay elements into play as needed over a career in the NHS. We comment earlier in this chapter on the evidence that the next generation of entrants will be looking at the Total Reward package rather than specifically at pay. We will continue to assess the Total Reward package as part of our future considerations.
- 4.136 In the context of the AfC pay agreement, pay will have a role to play but it is important that it is part of wider workforce developments. We have identified in this report a series of warning signs across the countries of the UK that point to a gap between the number of qualified people available and willing to work in the NHS, and the work that needs to be done. There are risks to the supply of AfC staff, particularly for professional groups. Applications to university courses have declined following the removal of bursaries in England, and we have yet to see whether there will be an impact on the quality of students, and those actually entering the NHS professions. The NMC registrations data highlight the significant loss of EU nationals from nursing and midwifery, and there will be further implications of Brexit for a workforce dependent on EU and overseas recruitment. Solutions to increasing the supply will have varying lead times. Reliance on domestic recruitment, as the UK Government recognises, will need to ensure that the NHS package remains competitive in the eyes of the next generation of entrants.
- 4.137 We conclude from the draft Workforce Strategy that there is a workforce gap which is creating an unsustainably high level of vacancies, work pressures and potential risks to patient care. There are some plans in place, which contain significant risks, to bridge that gap by 2021 but the gap will persist to 2027 if there is no action on workforce numbers, productivity or service redesign. While the draft Workforce Strategy for England is welcome, we remain concerned about clear ownership and accountability to deliver the actions required to address workforce challenges.

- 4.138 The continuing workforce gap underpins high levels of vacancies in the NHS across UK countries, and across a range of occupational groups. This issue is recognised as a priority among the parties and external commentators, and has led to improved data. The causes of vacancies and the way they are handled by trusts needs to be carefully assessed, as there are many factors influencing this picture. However, the consequences of vacancies for AfC staff are identified by all parties as a growing concern. The solution often involves temporary measures, such as costly agency cover, but the impact on existing staff is marked. The evidence from the parties and individual trades unions' surveys is clear that workforce gaps and vacancies result in higher workloads and greater pressure on existing staff, leading to a greater reliance on staff providing additional hours and goodwill to ensure effective services to patients. These drive dissatisfaction among staff, affect motivation and lead to frustration over the ability to do a good job for patients.
- 4.139 Given the workforce gap and the risks to the current strategies to bridge the gap, we emphasise the importance of ensuring effective retention of existing staff. The proportion of leavers through voluntary resignations is increasing. There is widespread acknowledgement among the parties of a rise in attrition in some clinical groups, notably in nursing. The reasons why this is happening are less clear. There does not appear to be a single cause, and we consider that, for individuals, a combination of influencing factors might be at work, which could include pay arrangements. That said, a consistently reported reason for leaving appears to relate to work-life balance which, in our view, may underpin a requirement for further development of flexible working arrangements. Retaining staff will also be an issue for the workforce as significant numbers of nurses are predicted to leave the NHS before retirement age by 2021.
- 4.140 Throughout this chapter we have also set out the significance of effective staff engagement. We consider, as other parties do, that effective engagement of all AfC staff in the NHS supports the efficient and effective delivery of good patient care, enhanced staff contribution and staff retention. This widespread acknowledgement needs to be acted upon by employers to ensure their workforce is well-managed and rewarded. In this respect, we specifically highlight the way in which learning and development (over a career) can be an effective motivator, as staff wish to be fully equipped to deliver the best care possible to patients.
- 4.141 In the next chapter we review the AfC pay agreement, drawing on our overall conclusions on AfC pay and other workforce developments. We will have a continuing role to monitor the implementation and impact of the AfC agreement and therefore our overall conclusions here will help frame that future role.

Chapter 5 – Framework Agreement on the Reform of Agenda for Change

Introduction

- 5.1 This chapter reviews the outputs of the parties' negotiations on the Agenda for Change pay structure in response to the Chancellor's commitment in the Autumn Budget 2017 to provide additional funding for pay awards for staff employed under AfC contracts in England (as set out in the Health Secretary's remit letter). The resulting proposed framework agreement on AfC was submitted to us in joint evidence from the NHS Staff Council in March 2018. This AfC agreement outlined the parties' expectations of our continuing role to retain our standing remit, and to monitor the implementation and impact of the agreement.
- 5.2 The AfC pay structure has been subject to reform at various stages since its implementation in 2004. We therefore start this chapter with some background, including short summaries of previous reforms and the parties' initial evidence ahead of negotiations. We then examine the features of the agreement, review the position of the Devolved Administrations and provide our observations (including aspects to monitor in future pay rounds). Finally, we note a request from the Joint Staff Side for a review of High Cost Area Supplements.

Background to the AfC negotiations

Previous AfC reforms

- 5.3 The AfC pay structure was implemented in 2004 and previous Review Body reports have noted and commented on several reforms since 2009. The first major reforms were part of a three-year pay agreement for 2008/09 to 2010/11, including overall pay awards and structural changes to Bands 1 and 5. Review Body reports at that time also highlighted the importance of correctly applying the Knowledge and Skills Framework, which was considered crucial to the efficient delivery of current and future services.
- 5.4 In 2013, the NHS Staff Council agreed a series of AfC changes (in England) covering: (i) incremental pay progression linked to performance standards determined locally and national principles underpinning locally developed performance systems; (ii) sick leave, unsocial hours payments and injury allowances; and (iii) national principles on workforce re-profiling. These changes were also adopted in Wales as part of the 2015 pay deal, initially on a three-year basis with ongoing negotiations on whether they would be rolled forward. There was no agreement in Scotland and Northern Ireland. The Review Body at the time welcomed these changes, but commented that AfC needed to be reviewed regularly to respond to changes in the labour market. In 2015, the parties reached an agreement for England, Wales and Northern Ireland which included structural changes to the bottom of the AfC pay scales.
- 5.5 Reforms to the AfC pay structure since 2004 demonstrate the parties' willingness to engage and modify the system. The revisions negotiated from 2018/19 onwards represent the most significant structural change since AfC's inception, prompted by the UK Government's provision of additional funding.

Parties' initial evidence

- 5.6 Ahead of reaching the agreement, the parties submitted evidence in December 2017 and January 2018 setting out their initial positions on the negotiations on the AfC framework. We have not rehearsed this material in detail here, as the key element going forward is the outcome of the negotiations rather than the positions the parties took at the outset. However, for context, we summarise that initial evidence below.
- 5.7 The **Department of Health and Social Care** believed that after nearly 10 years the time was now right to review the AfC agreement to ensure it could continue to deliver flexibility, capacity, fairness and value. The Department considered that the negotiations would support NHS organisations to maximise the contribution of staff, reduce the reliance on agency staffing, strengthen the agreement on progression, and provide an opportunity to review the need for wider reform of the pay scales to maximise value for patients and fairness for all staff.
- 5.8 NHS Employers considered that the relaxation of pay restraint could help support existing employer initiatives to address recruitment, retention and continued improvements in workforce productivity. Employers understood that they needed to move out of prolonged pay restraint in a sensible, managed way, with any investment in pay fully funded from HM Treasury. NHS Employers believed that the pay system needed to change to support the NHS to deliver the priorities set out in NHS England's *Next Steps on the Five Year Forward View*. They said that employers were less confident that the system reflected the needs of a modern health and care system, and that they were looking for a balanced package of changes to terms and conditions which would support system-wide initiatives, increase available capacity at an affordable level, and further reduce the costs of agency staffing.
- 5.9 NHS Providers welcomed the Government's commitment to fund an end to pay restraint for AfC staff, subject to successful negotiations on reform. From their survey of HR Directors, 44% suggested a 3% pay award would be required to support recruitment and retention of staff, and 30% considered 2% would be required. NHS Providers therefore considered that the range of 2% to 3% appeared to be a useful starting point for discussions.
- 5.10 The **Joint Staff Side** commented that the Government should allocate additional funding to the NHS pay bill, in addition to that needed for pay increases, to ensure the pay structure remained fit for purpose. The Staff Side emphasised that NHS staff would not foot the bill for their own pay rise, and that much had been done by the workforce to sustain productive working in the NHS, particularly working extra hours which were often unpaid. The Staff Side also argued that NHS pay rates should return to UK-wide levels as there had been no strategic decision to vary pay in differing countries. **Unite** remained extremely concerned by the fragmentation of the AfC structure as a result of political devolution, Government under-funding, and the impact of outsourcing of NHS staff and services.
- 5.11 During our oral evidence sessions in February and March 2018, the parties were able to update us on progress with negotiations between the Joint Staff Side and NHS Employers and to clarify their individual positions. On 26 February 2018, the NHS Staff Council wrote to us with an update on the progress of exploratory discussions.

Devolved Administrations

5.12 The NHS Staff Council confirmed that the agreement currently applies to England only. However, the agreement made clear that the parties in Scotland, Wales and Northern Ireland would be able to hold discussions about whether and how it could be implemented in the light of funding available through the Barnett formula.

- 5.13 In oral evidence with the Scottish Government, the Cabinet Secretary for Health and Sport noted the AfC pay agreement in England, and said that negotiations had been set up in Scotland with a view to reaching a three-year agreement. The Cabinet Secretary said that the Scottish Terms and Conditions group would use the proposals for England as a framework to determine how they might apply in Scotland. The focus of negotiations would be on a 2018/19 pay award, in the light of the Scottish Government's pay policy, and setting the parameters for negotiations in the second and third years, which the Cabinet Secretary indicated could vary from those proposed in England. The Cabinet Secretary was confident that agreement would be reached.
- 5.14 The Welsh Government, in oral evidence, commented that implementation of the agreement was under discussion in the NHS Wales Partnership, although further evidence submissions and different pay recommendations would not be required in the context of the Review Body process.
- 5.15 In oral evidence, the Department of Health, Northern Ireland said that Northern Ireland should be kept up to date on any AfC agreement for England. However, it noted that, in the absence of a Northern Ireland public sector pay policy, the Department of Health NI would not be in a position to implement any pay awards. The Department of Health NI considered that any outcome on the AfC agreement should be fully funded for all countries, and should include a link to performance appraisal, and that it would require a restructure to avoid pay compression in implementing the National Living Wage.

Framework agreement on Agenda for Change 2018/19 to 2020/21

- 5.16 On 21 March 2018, the NHS Staff Council reached a framework agreement on the proposed reform of the NHS pay structure for AfC staff in England⁷⁸. On 29 March 2018, the NHS Staff Council submitted further joint information about the proposed framework agreement. In doing so, the Council highlighted that the agreement set out an expectation of a continuing Review Body role during the period of the agreement as follows:
 - retaining the Review Body's standing remit, and monitoring the progress of implementation and the impact of the agreement;
 - remaining open to the parties to submit evidence on specific areas of concern through the course of the agreement; and
 - an expectation of further consideration of the role of Recruitment and Retention Premia and High Cost Area Supplements.

Features of the agreement

5.17 The parties' discussions on the framework agreement were guided by key objectives, including to: support the attraction and recruitment of staff; support the retention of staff; increase staff engagement by putting appraisal and personal development at the heart of progression; support the growing use of apprenticeships, including into healthcare careers; support new training pathways focussing on careers not jobs; map out future work to encourage consistency of approach to bank working; and improve the health and wellbeing of staff to improve attendance levels.

⁷⁸ NHS Staff Council (21 March 2018), Framework Agreement on the Proposed Reform of NHS Pay Structure for Agenda for Change Staff. Available at:

http://www.nhsemployers.org/your-workforce/2018-contract-refresh/framework-agreement

- 5.18 The intention of the reforms to the pay structure was that by the end of the three-year agreement individuals would have basic pay that was of greater value than under expectations at that time (which were defined as a 1% pay award per annum plus contractual increments). The parties recognised that an equality impact assessment would need to be commissioned to support the agreement. The NHS Staff Council would agree a work programme to monitor implementation and to ensure all aspects of the agreement were implemented as intended.
- 5.19 The agreement specifies that it is intended to cover all NHS employers in England listed in Annex A of the NHS Terms and Conditions of Service Handbook. It will be important to clarify the application and handling of the agreement to ensure that it captures all appropriate AfC staff, and to manage the expectations of those who will not be covered by the agreement.
- 5.20 The main elements of the three-year agreement in England, as set out by the NHS Staff Council in March 2018, were:
 - a 6.5% cumulative increase over the three-year period to the value of the top point of each pay band for Bands 2 to 8c 3% in 2018/19, 1.7% in 2019/20 (plus a cash lump sum to deliver an additional 1.1%), and 1.67% in 2020/21. The value of the increase to the top pay points in Bands 8d and 9 would be capped at the level of the increase in value at the top of Band 8c;
 - variable increases for other AfC staff between 9% and 29% over the three years would be delivered through pay progression, changes to starting salaries and/or restructuring pay bands;
 - an increase to starting salaries by removing overlaps between pay bands the bottom point of bands would be removed in 2018/19 and further points removed in 2019/20;
 - a new minimum basic pay rate of £17,460 from April 2018 (an increase of around 13% in Band 1) to future proof the pay structure, stay ahead of statutory requirements and ensure the NHS retained a competitive market advantage. Band 1 would be closed from December 2018 and provider organisations would be encouraged to upskill roles to Band 2 by March 2021;
 - pay band restructuring to reduce the number of pay points by 2021
 - reducing Bands 2, 3 and 4 to two points with staff reaching the top in two to three years (rather than the current six years)
 - reducing Bands 5, 6 and 7 to three points, with staff reaching the top in four to five years (rather than the current seven to eight years)
 - reducing Bands 8 and 9 to two points (reaching the top in five years as at present). Bands 8c and above would retain up to 10% of re-earnable pay subject to performance after reaching the top point;
 - a new NHS Staff Council progression framework from April 2019 to help ensure that all staff have the appropriate knowledge and skills to carry out their roles, and to make the greatest possible contribution to patient care;
 - The framework would
 - enable staff in Bands 2 to 7 to reach the top of their pay band more quickly
 - describe minimum periods of time before progression to the next pay point
 - not be automatic
 - give staff the opportunity to demonstrate they meet the required standards
 - require line managers and staff to follow the process in order to access the next pay point, and
 - require employers to provide information to the NHS Staff Council to enable monitoring in relation to employees with protected characteristics;
 - improved levels of attendance through a focus on staff health and wellbeing at national and local level. The ambition was that positive management of sickness absence would match the best in the public sector; and

- consistency of terms and conditions, specifically guaranteeing access to annual leave and time off in lieu, access to leave for child bereavement and parental care, and a national framework for buying and selling leave. There would also be adjustments to payment schemes for unsocial hours.
- 5.21 The NHS Staff Council confirmed that provisional agreement on the framework formed the basis on which NHS trades unions would consult their memberships. On 8 June 2018, the majority of the NHS trades unions announced that they had accepted the pay deal for England. The Staff Side chair and the Employer chair of the NHS Staff Council wrote to us on 11 June 2018 informing us that NHS staff had voted overwhelmingly in favour of the agreement, and that it would then be ratified by the NHS Staff Council.

Our observations on the AfC agreement

Overview

- 5.22 We note that the UK Government has adopted a more flexible approach to public sector pay and has recognised that the pay arrangements for the Agenda for Change workforce required reform. The Secretary of State for Health's remit letter also recognised the need for a fair pay rise, alongside improving recruitment and retention, and developing reforms which better reflected modern working practices, service needs and fairness for employees.
- 5.23 We welcome the parties' significant progress in reaching an agreement that provides a balanced package of pay reforms that aim to address the concerns of both AfC staff and employers. There is a shared ambition across NHS organisations to bridge the workforce gap, identified in the draft Health and Social Care Workforce Strategy, which is creating an unsustainably high level of vacancies, work pressures and potential risks to patient care. We look forward to monitoring the impact of the pay agreement on bridging that gap, and we stress the importance of delivering wider workforce developments as an integral part of much-needed pay reform.
- 5.24 In our 2017 Report, we concluded that the public sector pay policy, at that time, was coming under stress, and that the policy would require some modification and greater flexibility with in the NHS. Since then, we have seen evidence that demonstrates the importance of pay to AfC staff. We have heard frequently from AfC staff on our visits to NHS trusts that they did not feel valued because of continued pay restraint. Respondents to the individual trades unions' surveys felt they were worse off than five years ago. This strength of feeling was compounded by the working pressures they faced. There have also been falls in levels of staff satisfaction with pay in the NHS Staff Survey and sharp falls in the number of staff recommending their profession as a career in the NHS, significantly among nursing staff. Our data show a long term workforce gap, emerging concerns on the number of joiners to the NMC register, pressures from substantial levels of vacancies and increasing numbers of leavers from the NHS.
- 5.25 These strands of evidence are clearly recognised by the UK Government, HM Treasury, the Department of Health and Social Care, NHS Employers, other NHS organisations, external commentators, the Joint Staff Side and AfC staff themselves. This recognition provided a platform for the negotiations on reforming AfC pay.
- 5.26 In agreeing the design of the new pay arrangements, the parties have taken a planned, medium term approach to manage the transition from the existing AfC structure over three years. In our view, this approach allows the parties to manage the transitional effects and to address the affordability of pay increases in an appropriate timeframe.

- 5.27 The three-year agreement allows time for planned workforce developments to be implemented and to bed down. All NHS organisations and external commentators agree that a fully recruited, retained and motivated workforce is essential to the sustainability and transformation of the NHS. Concerns over a robust AfC workforce across NHS organisations are acknowledged by all parties to be a risk to delivering patient services. As we said earlier, workforce developments must be seen as an integral part of pay reform, such as a range of recruitment and retention initiatives, particularly: increasing student numbers, new entrants and re-entrants to the NHS; the development of new roles; enhancing flexible working arrangements; developing career progression; and supporting emerging best practice on retaining staff.
- 5.28 The pay agreement provides a range of reforms that could contribute to the sustainability of the workforce in the longer term, as it includes enhanced starting pay, protection for the lowest paid, restructuring to meet the needs of different AfC groups, and improved pay progression supported by renewed performance management.
- 5.29 We identified earlier in our report the significance to AfC staff of access to flexible working arrangements, and that achieving work-life balance was a major factor influencing retention. Against this background, we welcome the agreement's reference to scoping further work in the NHS Staff Council to encourage consistency of approach to bank working. This includes cost-effective incentives to encourage staff to offer their time to staff banks to increase capacity, which might also usefully examine consistency on bank pay rates. We welcome this approach, and emphasise that it be developed in the wider context of enhancing flexible working arrangements, including learning from pilots underway, reducing agency costs, and converting more agency staff to permanent employees.
- 5.30 These workforce developments, taken together and supported by effective pay arrangements, could support AfC staff to make a significant contribution to the transformation of services and the productivity improvements signposted in our remit letters. The parties and other NHS organisations have a range of views on productivity and, as we comment in Chapter 4, there could be significant benefit in the parties reaching consensus on the drivers, definition and measures of productivity. The agreement highlights the parties' emphasis on staff being supported to develop their skills and competences to carry out their role, so making the greatest possible contribution to patient care. A central feature of the agreement is a revised system for performance management, and we look forward to seeing evidence on its effectiveness against the planned outputs for patients and services. Other workforce developments should help productivity, such as delivering on the measures in the draft Health and Social Care Workforce Strategy which include changing the skill mix of the AfC workforce.
- 5.31 We have yet to see the parties' equality impact assessment to support the agreement. Specifically, we expect the parties to identify any issues and actions required relating to: the way in which pay supports attracting and retaining a diverse AfC workforce; new arrangements addressing any gender pay issues across all AfC pay bands (we comment on the current position in Chapter 4); and monitoring information on the position of AfC staff with protected characteristics under the new pay progression system (as identified in the agreement).
- 5.32 We provide further analysis below of the agreement and how it might be monitored to ensure its effective implementation and required impact.

5.33 Overall, we conclude that the elements of the agreement, when taken together, begin to respond to our conclusions from the evidence on recruitment, retention and motivation as set out in Chapter 4 of this report. More widely, the agreement, in particular, may address some immediate concerns in helping AfC staff feel valued, acknowledging the pressures on cost of living, and influencing recruitment, retention and motivation.

Affordability, levels of pay increases and pay bill effects

- 5.34 The agreement sets out the investment in pay agreed by NHS Employers, the NHS trades unions, and the Department of Health and Social Care. The UK Government, including HM Treasury, has agreed the parameters of the agreement, its affordability and the additional funding required. We understand that the pay bill cost⁷⁹ is £4.2 billion over the three years, with a cost of £800 million additional funding available for 2018/19. This additional funding should ensure that the pay costs arising from the agreement are affordable for NHS organisations, which is a key consideration for us against other factors in our terms of reference. However, given the substantial funding levels to be invested, and the sensitivity of the pay bill to other workforce changes, there will need to be robust data for the parties to monitor the in-year and cumulative pay bill effect over the course of the agreement. We will continue to monitor pay bill costs in order to establish the appropriate baseline for our future pay considerations from 2021 onwards.
- 5.35 We also noted during our discussions with the parties in oral evidence a degree of concern over the mechanism to deliver additional funding to individual employing organisations. For our part, we wished to understand how, within the complex NHS funding system, additional resource could reach those organisations incurring the significant additional pay costs. We were concerned that funding for pay could be diverted into other funding streams, given the financial pressures within the NHS. However, we were reassured by all parties that the current tariff system would not be appropriate, and that a separate funding mechanism would ensure the additional funding reaches employing organisations. We expect to hear more on the nature of this funding mechanism and that it is operating effectively on implementation, and in each of the years covered by the agreement, as the reformed pay structure delivers variations in pay costs across the AfC workforce. We would also expect to hear about the way in which the Devolved Administrations are managing the funding of Health Boards and trusts given the funding from the Barnett consequentials.
- 5.36 The agreement is designed to make a transition from current arrangements to a reformed pay structure by 2020/21. We acknowledge that these reforms are to be staged across the three years in order to remain affordable and to manage the effects on the workforce. We also note that the agreement intends that, by the end of the three-year period (and on 1 April of each of the years), individuals will have basic pay that is of greater value than under expectations at that time (defined as a 1% pay award per annum plus contractual increments). As a result, the pay increases, according to the material published by NHS Employers and the Staff Side, are variable for different AfC groups in the first and subsequent years. For example, pay increases range from 9% to 29% over the three years from pay progression, changes to starting pay and restructuring, whereas those on the top of pay bands would receive a cumulative increase of 6.5% (plus an additional non-consolidated increase in 2019/20).

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⁷⁹ Department of Health and Social Care (21 March 2018), NHS Workforce: Written Statement – HCWS574. Available at: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/ Commons/2018-03-21/HCWS574/

- 5.37 The complexity of the agreement requires effective communications with AfC staff. We acknowledge the extensive material already made available by NHS Employers and the Staff Side to explain the agreement, including pay journeys for individual staff to show the variable effects. Given that, in the past, AfC staff have been accustomed to pay reforms which have been more uniform in their application, further communications will need to be managed in an effective and efficient way to ensure staff have clear sight of the individual impacts in subsequent years of the agreement.
- 5.38 As an example of the variable effects of the agreement, we note that for 2018/19 alone, there are four major components influencing the pay bill, and individual pay increases in the first year:
 - increases to the top pay points in each pay band;
 - increases to other pay points within pay bands;
 - the removal of the bottom pay point in each band; and
 - the increase to the minimum pay rate in Bands 1 and 2.
- 5.39 The Department of Health and Social Care estimates that, as a result of the agreement and workforce change, the AfC pay bill per FTE in England will increase by about 3% each year between 2018/19 and 2020/21. It is very important to recognise that these figures represent the overall pay bill impact of the agreement. The effect on pay increases for individual AfC staff, and within each pay band, will vary considerably. The variable effects on the pay bill and for individuals were important considerations to the parties in designing and agreeing the reforms, including affordability and way in which the transition was made from the existing pay structure over the three-year period. Should the Devolved Administrations negotiate and implement differing arrangements, the outcomes for individual staff in each country could also vary.

Recruitment and retention

- 5.40 As we conclude above, the pay arrangements in the agreement have the potential to support the recruitment, retention and motivation of AfC staff. It is widely recognised that bridging the workforce gap in the NHS is a significant issue and will take time to address. Staff shortages and vacancies persist across AfC groups. In the meantime, there is a renewed emphasis on retaining AfC staff to limit the effects of existing and continuing workforce gaps. Close monitoring will be required to track the way in which the pay reforms support and influence new entrants, career progression and retaining staff.
- 5.41 On recruitment, the draft Health and Social Care Workforce Strategy for England recognises the challenges of increasing supply. While we see the importance of improved AfC starting pay at various entry points, pay is only one factor influencing decisions to join the NHS. We therefore re-iterate the need to monitor pay rates against other recruitment activity including:
 - the planned increase in student clinical placements;
 - the impact of the removal of bursaries and any impacts of student debt;
 - improving progression through, and on completion of, training;
 - changes in the graduate labour market including pay comparisons;
 - the impact of Brexit and international recruitment, and whether pay is an influence;
 - pay arrangements and progression for new routes into professions, including nurse associates, upskilling healthcare and nursing assistants, and developing effective apprenticeships; and
 - ensuring pay and the wider employment offer meets the differing career and working aspirations of coming generations, including improved flexible working arrangements, addressing work-life balance and opportunities for training.

- 5.42 The parties recognise that apprenticeships can provide opportunities to develop the workforce. Apprentices will cover a range of AfC groups, including new routes into professional groups, and will therefore require effective career pathways. There is a clear need to develop consistent pay arrangements for apprentices across trusts and we welcome, under the agreement, the NHS Staff Council's priority to negotiate a new provision. We look forward to the outcome and stand ready to contribute as required.
- 5.43 The evidence points to continuing shortages and vacancies among specific groups, notably in nursing and midwifery, and which could persist for a number of years. The AfC agreement might not alter this position until the full structure beds down in the medium term, alongside the supply and retention measures taking effect. The evidence also indicates that staff shortages give rise to work pressures, which in turn lead to difficulties for staff over the quality of patient care they are able to provide. From the individual trades unions' surveys, these factors appear to be important drivers of the decision of staff to leave the NHS.
- 5.44 We have concerns that a potentially unstable dynamic could exist whereby the decisions of some staff to leave the NHS intensify the work pressures on remaining staff, causing yet further staff to leave. On a similar note, evidence from unions' surveys points to significant rises in the additional hours worked by AfC staff, and that staff have been working extra hours to maximise their income during pay restraint. We have also heard this from AfC staff on our visits. We observe that there is potential for improved pay rates and earnings under the AfC agreement to reduce this imperative for staff, and thereby limit the supply of hours available to trusts. Additional hours and unsocial hours working also have implications for the level of goodwill among staff. These issues will all need to be kept under review as new pay arrangements are implemented.
- 5.45 We have noted in previous reports that there are a range of factors influencing retention. Pay is part of the equation for staff but combinations of factors are likely to be at work for individuals, notably staffing levels, workload and work-life balance. Trades unions' surveys suggest falling numbers of staff willing to advocate their profession as a career in the NHS. The AfC agreement offers improved pay progression to many staff which should help retention. However, there are risks to retention, as quicker progression to the top of bands could lead to large proportions of staff spending longer without pay progression over their careers, and having to depend on the incentives of promotion and career development. Given the existing and continuing workforce gap, turnover needs to be kept at a minimum in the NHS. We therefore reinforce the need to monitor trends in retention and the need for more detailed information on reasons for leaving as the pay agreement is implemented. Against this background, we acknowledge the progress made and actions emerging from the retention programmes underway through NHS Improvement. We will be interested to see how the measures from these programmes are being implemented and their interaction with new pay progression and performance management under the agreement. We also stand ready to consider the role of Recruitment and Retention Premia, as the agreement sets out, should the parties present evidence.
- 5.46 We commented in our overall observations that we intend to maintain a focus on Total Reward. The agreement covers a range of pay reforms which aim to offer a balanced package to AfC staff over a career. We welcome the strategic work on Total Reward being undertaken in the NHS which is promoting the content and value of the package on offer. We will continue to monitor the effect and any enhancements from the agreement.

Reforms to pay bands

- 5.47 A major focus of the agreement is the restructuring of AfC pay bands. We understand that these have been carefully constructed to enable the transition to the revised pay structure over three years and to remain affordable to the NHS as a whole. As a result, the progressive removal of, and adjustments to, pay points involves significant variation in impact across the pay bands. This will need careful management and communication to ensure that AfC staff groups are fully sighted on the rationale for the change. The operation of the current AfC pay system can lead to variations in the way in which it is managed in individual trusts.
- 5.48 We emphasise that the NHS is dispersed across many providers and organisations, requiring effective action on implementation of the agreement, with adequate resources to avoid the risk of wide variations emerging on the operation of revised pay bands.
- 5.49 The intention that individuals would have basic pay of greater value than under current expectations provides a degree of protection for staff over the three years. However, there could be AfC staff in particular circumstances (such as those moving between bands or under any previous protected arrangements) or some unintended consequences which require mechanisms to ensure they are addressed. The variation of impact across pay bands and across the three-year period could also be compounded by the effects on individuals' take-home pay, for instance, when crossing tax, National Insurance and pension thresholds.
- 5.50 We recognise the importance of ensuring that the minimum rate of AfC pay in the NHS at Band 1 is set in relation to the National Living Wage. This is a priority for the NHS trades unions, but employers also recognise the need for pay rates to stay ahead of statutory requirements and to remain competitive in the labour market. Bands 1 and 2 cover 101,672 FTE staff and therefore the 2018/19 pay increase to £17,460 will apply to a significant proportion of AfC staff. These staff could also benefit from future pay increases if posts are upskilled and moved to Band 2. We expect the parties to keep AfC pay rates under review against the National Living Wage (currently £15,311 per annum) and the Living Wage Foundation Living Wage (£17,109 per annum), and to bring any concerns in evidence. On a broader note, we will continue to assess the position of rates in Band 2, particularly as fewer pay points will cover a wide range of occupational groups, some with market pressures.
- 5.51 We note that the agreement makes little reference to pay arrangements for Bands 3 and 4. These pay bands will accommodate roles of nursing associates, nursing and healthcare assistants, and, potentially, apprentices. There will be an increasing focus on these groups, as the Department of Health and Social Care and other NHS organisations have significant ambitions on these roles helping to increase supply into the professions and changing the workforce skill mix. We consider that the pay arrangements of these groups, including the compression within these pay bands, could require attention to match their career aspirations and to ensure progression into higher pay bands.
- 5.52 A major part of the restructuring has focussed on Bands 5 to 7 which cover the main AfC professional groups. We support the revised arrangements which, over the course of the three-year agreement and beyond, will provide new entrants with higher starting salaries and increased career earnings. Our assessment of earnings against the graduate market suggests that nurses' starting pay is competitive in the first five years in the NHS. However, while nurses move up the AfC pay band, the position is less competitive with other graduate occupations after the five-year point. The new pay points in the agreement will provide earlier pay progression, and potentially support recruitment into shortage groups, but the position of these professional groups will need to be kept under review after entry.

- 5.53 In analysing initial pay awards and the way in which individuals will progress though pay bands, there is a clear focus on designing the revised pay structure to support the recruitment of new entrants. For existing staff, there will be some effects of improved pay progression for some staff during transition but more emphasis will be needed on existing staff being engaged, motivated and retained. One part could be close monitoring of the effectiveness of non-pay arrangements within Bands 5 to 7, particularly opportunities for job and career development.
- 5.54 The proposed pay structures for Bands 8a and above in the agreement could produce different effects for individuals over the three-year implementation. These effects will require attention, particularly the impact for some staff at the top of bands receiving lower pay increases than in other pay bands and the use of one-off consolidated payments. We will continue to monitor the gender pay gap for AfC staff and any effects the new pay structure may have on that gap, particularly given the 12% pay gap for AfC senior managers (as we note in Chapter 4).
- 5.55 We see potential risks in relation to staff progression through pay bands. Shorter pay bands with larger pay increases will place greater onus on the performance review and on the standards required for progression. These arrangements will be different from current incremental pay progression. New performance management processes and the supporting evidence will therefore need to be transparent and effective to avoid denying appropriate progression, or creating disagreements which would have a more significant financial impact on individual staff and, potentially, influence their retention.
- 5.56 The AfC pay structure already includes a high proportion of staff reaching and remaining at the top of bands. The impact on retention of relatively lower pay increases for staff on the top of pay bands will require monitoring, particularly during Years 2 and 3 given the level of pay increases at the top of bands when the full pay effect of reformed progression is implemented for other staff. Shorter pay bands and quicker pay progression could lead to larger proportions at the top of all pay bands for a longer part of their career. This could have implications for the pace of promotion to higher bands, the initial pay effect on promotion and limited progression thereafter. The lack of headroom at the top of bands could also have retention implications where career development incentives might be required for individuals not promoted. We consider that this builds in retention risks for these experienced staff who are essential to implementing service transformation and to developing or overseeing new roles.

Unsocial hours payments

- 5.57 We note that the agreement includes revised payment schemes for unsocial hours. First, there will be a new provision, under maintaining round the clock services, to open unsocial hours payments to all ambulance staff which will apply to new entrants from 1 September 2018 and all changes of roles including promotion. Existing ambulance staff can remain on their current supplements, but will be offered a voluntary move to new rates with arrangements to be agreed in the NHS Staff Council. Second, the eligibility for payment of unsocial hours during occupational sick leave (currently available to all AfC staff on spine points 2-8) will be adjusted to a cash value (basic salary) of £18,160 with new entrants from 1 July 2018 having no access to payment during occupational sick leave. Third, percentage rates for unsocial hours payments will be adjusted for Bands 1, 2 and 3 over the three years to 2020/21.
- 5.58 These could have an impact on AfC staff, including the specific arrangements for ambulance staff, and will require monitoring and earnings data to establish if there are any recruitment, progression, retention or motivation effects.

Implementation of the agreement

- 5.59 The initial success of the agreement will depend upon implementation. An effective implementation strategy is required and will need to be supported by clear communications (to employers and staff).
- 5.60 A cornerstone of the agreement is to increase staff engagement by putting appraisal and personal development at the heart of pay progression. This is underpinned by a commitment from employers to enhance the relationship line managers have with their staff and by using an effective appraisal process. It will require significant commitment within trusts to deliver the system from HR departments, line managers and individual staff. This commitment will include additional resource and cost which will have implications for staff workloads. We comment on performance management below. The agreement emphasises staff engagement and therefore specific measures will be needed to monitor its impact on staff engagement and its contribution to improved patient care.
- 5.61 The structural reforms under the pay agreement continue to require effective job evaluation of roles. We have heard on our visits and from unions' surveys that staff perceive the job evaluation system as producing different pay banding outcomes. We comment earlier on avoiding the risks of variations in the operation of pay bands. As the revised pay structure is implemented and as new roles emerge, we also ask the parties to keep the banding of roles under review.
- 5.62 The implementation of new pay rates will impact on AfC staff through their basic pay, earnings and take-home pay. We comment in Chapter 4 on our 2017 recommendation to review pension thresholds to avoid unintended consequences for take-home pay. The effects in relation to pension, tax and National Insurance thresholds will need to be examined as the three-year agreement is implemented. We also expect the parties to monitor these effects.

Performance management

- 5.63 Our analysis earlier in this chapter acknowledges the parties' emphasis in the agreement on a new progression framework from April 2019. The agreement cites the NHS Management and Health Service Quality Report⁸⁰ which found that good management of NHS staff led to higher quality of care and that the more engaged staff were, the better the outcomes for patients and the organisation generally. The report noted the particular importance of having well-structured appraisals. The agreement also stresses the Care Quality Commission's guidance that in well-led organisations the leadership, management and governance of the organisation assures the delivery of high quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.
- 5.64 We reaffirm the importance of effective performance management in improving staff engagement and contributing to patient care. The revised arrangements should support this area, and we look forward to further details on standards and requirements in the NHS Staff Council Guidance. In the meantime, we welcome the agreement outlining the responsibilities of organisations, line managers and employees, and in recognising the importance of team working to health care. The agreement also places a responsibility on the NHS Staff Council to work with NHS Improvement on the required mechanism to track implementation and ongoing monitoring. In our view, the starting point for testing effectiveness should be to set baselines against the aims in the agreement (set out in Annex B to the agreement, paragraph 8). We expect to see regular management information and robust data on progress.

⁸⁰ Department of Health and Social Care (2011), NHS Management and Health Service Quality Report. Available at: https://www.gov.uk/government/publications/nhs-staff-management-and-health-service-quality

- 5.65 There could be important lessons to learn from previous performance management systems. Agenda for Change was underpinned by the Knowledge and Skills Framework and, in 2013, gave trusts the option to determine performance standards locally. We have regularly commented in our reports that unless fully implemented these arrangements would not reap the benefits that AfC was designed to deliver. Given the dispersed nature of NHS organisations, effective management is needed to avoid wide variations in operation of the revised system.
- 5.66 The 2017 NHS Staff Survey data showed that 86.4% of staff in England said that they had had an appraisal within the last 12 months, which was an increase from 80.6% in 2011. The increasing proportion of staff receiving appraisals since 2011 is encouraging, and should provide a platform to take forward revised performance management arrangements. Appraisals will also require care in addressing the concerns raised in the 2017 NHS Staff Survey, for instance discrimination and bullying.
- 5.67 We note that implementing and operating effective performance management systems is difficult. All staff should receive well-structured appraisals which can contribute to improved organisational performance and working lives for staff. To ensure that the proposed system does support the delivery of better patient care, NHS organisations should not underestimate the substantial volume of work required to implement and run the new system for individual trusts and staff, including the additional resource and costs involved. The agreement places great emphasis on performance management producing skilled and competent staff. This will require significant support from all the parties. To aid the success of the revised system, we emphasise the need for a visible commitment from NHS leaders, effective training for line managers and employees, and making time for regular appraisals to take place.

Our overall conclusions and monitoring arrangements

- 5.68 The UK Government has adopted a more flexible approach to public sector pay which opened the opportunity for the reform of AfC pay arrangements. All the parties have recognised the need for pay reform and have moved quickly to arrive at a balanced package under the AfC pay agreement for England. We comment below on the position for the Devolved Administrations.
- 5.69 The AfC pay reforms reflect the urgent need to address staff concerns that they feel undervalued. This was recognised as a priority by the UK Government, NHS parties and external commentators. The pay reforms also seek to address longstanding concerns around the pay structure shared by NHS Employers and the trades unions. We note that the reforms aim to make a transition to a revised pay structure over a three-year period with a pragmatic approach to manage the transition and affordability.
- 5.70 We consider that the agreement provides a range of elements to support the AfC workforce. We acknowledge the restructuring of pay arrangements to support the overall motivation of staff, to help recruitment through improved starting pay and to aid retention through better progression. The agreement also offers an opportunity to embed performance management to enable staff to fulfil their career and development aspirations, and to enhance their contribution to patient care. The pressures from demand, transformation and finances within the NHS will require an extensive contribution from an effective workforce. We note that the AfC agreement provides a welcome renewed emphasis on further work to improve levels of attendance through a focus on staff health and wellbeing at a national and local level.

5.71 We identify many other aspects of recruitment, retention and motivation throughout this report which will require monitoring so that the revised pay structure can take full effect. We see pay reform as one part of a wider strategy to address workforce developments over the longer term. When finalised, the Health and Social Care Workforce Strategy will need to set out the steps needed to bridge the workforce gap. This strategic approach is not yet in place, and we know that the parties' ambition is that the AfC pay agreement will underpin recruitment, retention and motivation in the interim period, and support the required workforce developments in the longer term. All parties and organisations involved will require continued diligence to ensure revised pay arrangements are implemented effectively, assessed and evaluated, and that continuous adjustments are made. We set out our contribution to monitoring the implementation and impact of the agreement below.

Approach of the Devolved Administrations

- 5.72 The Devolved Administrations have been discussing their positions on the AfC pay agreement since it was announced in March 2018. The agreement was for England only, but it was clear that if endorsed and implemented in England, the parties in Scotland, Wales and Northern Ireland would be able to hold discussions about whether and the way in which the content of the agreement could be implemented. We understand that the Devolved Administrations are confirming with HM Treasury that the Barnett funding formula will deliver additional funding as a result of the new funding in England. We note that, when the NHS Staff Council reached the agreement, the respective Cabinet Secretaries in Scotland and Wales both announced that any additional funding would be spent on pay.
- 5.73 From our discussions with the Scottish and Welsh Governments in oral evidence, we understand that there is a general willingness to consider the AfC pay agreement during negotiations. The Joint Staff Side and individual trades unions have advocated the importance of a UK-wide approach to the AfC pay structure.
- 5.74 In Scotland, at the time of this report negotiations were underway through the Scottish Terms and Conditions group although we note that there could be variations from the agreement in England. These centred around considering the Scottish Government's one-year public sector pay policy, an appropriate pay award for 2018/19, the parameters for 2019/20 and 2020/21, and areas already in hand (such as the Scottish Living Wage in relation to Bands 1 and 2, and new performance management arrangements). On 9 June 2018, the Scottish Government announced that for 2018/19 AfC staff currently earning up to £80,000 would receive at least a 3% uplift, those earning £80,000 and over would receive a flat rate increase of £1,600, and the bottom pay points for Bands 1 and 2 would be increased to £17,110 to fulfil the obligation to pay the Scottish Living Wage. The Scottish Government also stated that this uplift was a payment on account of progress made in the negotiations so far and that the negotiations would continue towards a three-year pay deal.
- 5.75 In Wales, initial proposals were awaited from the negotiations within the NHS Partnership. The position of the agreement in Northern Ireland remains subject to consideration in the absence of Northern Ireland Executive Ministers and an Executive pay policy for 2018/19.

5.76 We support the negotiations on the AfC pay agreement in the Devolved Administrations. It is essential that the package of AfC pay reforms are considered carefully as to their content and how it might apply within individual countries. At the time of this report, the Devolved Administrations had yet to conclude their negotiations. We would welcome updates on progress and outcomes immediately they are available. In the meantime, we draw the Devolved Administrations' and other parties' attention to our observations on the AfC agreement in this report. For the period of the agreement, we expect the Devolved Administrations to require our continuing role in assessing the position against our terms of reference, and in monitoring the implementation and impact of the agreement, as requested in England.

Monitoring arrangements

- 5.77 The agreement sets out a number of monitoring arrangements for the parties to be overseen by the NHS Staff Council. We also welcome the agreement setting out our role in retaining our standing remit and monitoring the progress of implementation and impact during the period of the agreement. It also left open the opportunity for the parties to submit evidence on specific areas of concern. Our observations in this report are designed to frame that monitoring role, and to enable the parties to have clear sight of the evidence requirements to support our considerations. We would remind the parties that robust data are required to monitor implementation and impact, and any submissions to us would require evidence-based arguments with supporting data and analysis.
- 5.78 At this stage, we consider it appropriate to draw a distinction between our monitoring role in the agreement and our standing terms of reference. We expect over the three-year period of the agreement to continue to assess the position of AfC pay against the economy and labour market, recruitment, retention and motivation. This will enable us to establish a baseline for evidence and pay considerations following the three-year agreement in 2021.
- 5.79 We look forward to working with the parties on the range of measures that will contribute to the effective monitoring of the agreement. At this stage, we summarise below the main areas that we consider require monitoring.
- 5.80 For ease of reference, we start with the strategic and implementation considerations, before looking at data requirements to support monitoring.

Strategy and implementation

- **Key objectives in the agreement** (page 5 of the agreement) in summary these are supporting recruitment, supporting retention, increasing staff engagement, supporting apprenticeships, supporting new training pathways, mapping out future work on bank working, and improving staff health and wellbeing.
- Delivering outcomes for patients and transforming services.
- Maintaining a **clarity of vision of the purpose of pay reforms**, including consensus across the parties and other NHS organisations, and the role of effective NHS leadership in implementation.
- An effective implementation strategy including communications and leadership, clarifying roles of NHS organisations (particularly NHS Improvement), and distinguishing between what is driven and managed nationally and locally.

Data requirements

 Recruitment and retention – measuring trends in joiners and leavers, numbers and quality of trainees starting and completing degree courses, the proportion taking up posts in NHS, numbers of EU/international staff in professional groups joining/ leaving the NMC register, numbers in new roles and apprenticeships, the pay impact on retention and the influence of improved pension values.

- Motivation and engagement measuring the number of staff reporting that they do not feel valued (given that AfC staff have been offered a funded pay award that might not be available to other public sector workers), trends in staff satisfaction with pay, and the numbers recommending their profession as a career in the NHS.
- **Performance management** baselines and effectiveness measures against the aims of the new system in the agreement.
- Workforce data general information on numbers, skill mix, diversity and gender (including the parties' equality impact assessment), use and costs of agency and bank staff by AfC group, and a fall in the extent to which staff take on additional hours to alleviate pay shortfalls.
- Prevailing and forecast economic and labour market conditions specifically measures and forecasts of inflation, pay settlements, average earnings, competitiveness against national, regional and local labour markets, and comparisons against the graduate labour market.
- Affordability and pay bill changes information on pay bill costs in each of the years covered by the agreement and data to establish a baseline from 2021 for our further pay considerations.
- **Funding mechanism** information to ensure that the DHSC's separate funding mechanism allows additional funding to reach employing organisations.

High Cost Area Supplements (HCAS)

5.81 In initial evidence, the **Joint Staff Side** said that the detriment and neglect that the overall pay scale had suffered had had a serious impact on staff in high cost areas. The Staff Side therefore asked us to recommend a separate review of the adequacy of HCAS and that the outcome should be funded by the Government. The Staff Side emphasised that this was not intended to preclude an adjustment to HCAS for 2018/19, as increasing the floor and ceiling rates in line with the overall pay award was a helpful way of maintaining the rates in the short term before a review. We note that the AfC pay agreement allowed scope for us to consider the role of High Cost Area Supplements. We commented in previous reports on the option for a review of HCAS and therefore invite the parties to submit further evidence in future pay rounds on the structure, operation, and minima and maxima applying to HCAS.

Appendix A - Remit Letters

Letter from the Chief Secretary of the Treasury to NHSPRB Chair



HM Treasury, 1 Horse Guards Road, London, SW1A 2HQ

Philippa Hird Chair of NHSPRB c/o Office of Manpower Economics Fleetbank House 2-6 Salisbury House EC4Y 8JX

21 September 2017

Dear Philippa,

PUBLIC SECTOR PAY 2018 -19

- Thank you for your work on the 2017/18 pay round. The Pay Review Bodies continue to
 play an invaluable role in making independent, evidence-based recommendations on
 public sector pay awards. I am extremely grateful to you and your colleagues for your
 considered work. This letter sets out the Treasury's overarching approach for the
 2018/19 pay round.
- Our public-sector workers are among the most extraordinarily talented and hardworking people in our society. They, like everyone else, deserve to have fulfilling jobs that are fairly rewarded. The Government takes a balanced approach to public spending, dealing with our debts to keep our economy strong, while also making sure we invest in our public services.
- The Government will continue to ensure that the overall package for public sector workers is fair to them and ensures that we can deliver world class public services while also being affordable within the public finances and fair to taxpayers as a whole.
- 4. The last Spending Review budgeted for a 1% average increase in basic pay and progression pay awards for specific work forces, and there will still be a need for pay discipline over the coming years, to ensure the affordability of the public services and the sustainability of public sector employment. However, the Government recognises that in some parts of the public sector, particularly in areas of skill shortage, more flexibility may be required to deliver world class public services including in return for improvements to public sector productivity.
- As the Office for Budget Responsibility's Fiscal risks report published on 13 July reminds us, at nearly 90 per cent of GDP, our public debt is still too high. So, while continuing



to invest in and improve our public services, we must also maintain our ambition to reduce debt at a pace which is sensitive to the needs of the economy.

- 6. With a more flexible policy it is of even greater importance that recommendations on annual pay awards are based on independent advice and underpinned by robust evidence, submitted by departments, that takes into account the context of wider economic circumstances, private sector comparators, and overall remuneration of public sector workers (including progression pay and pension entitlements). The role of the Pay Review Bodies is therefore more important than ever.
- 7. The Government values hugely the role of the Pay Review Bodies and appreciates the length of time it takes to complete a thorough process. As you know, the forthcoming 2018/19 annual pay round also marks the shift to a Single Fiscal Event in the autumn which will delay your receipt of departmental evidence. The process will therefore run to a later timeline this year: a letter will follow this in due course from relevant Secretaries of State and written evidence will likely be received in December rather than September as is usual for most PRB workforces.
- 8. I realise that the change in timing will impact on when the Government can expect to receive your report and, as a consequence, on when individuals will receive their pay award. I recognise that this is far from ideal as our hard-working public servants are entitled to receive their awards promptly. However, on balance given the importance of the process and the change in timing that has already occurred, I feel it is important we work to a later timeline rather than condensing the process. I hope that by making the timing clear at the beginning of the process workforces can be made aware, with plans put in place to work to a later timeline, and for you and your PRB members to manage your own time. The Office for Manpower Economics will be able to support you in this but, do get in touch if you have concerns in this regard.
- I appreciate that you may have further questions about this change in approach and I
 would be pleased to discuss this further when we meet soon. I look forward to
 working with you over the coming years.

Best wishes,

RT HON ELIZABETH TRUSS MP

Myslet Gunz

Letter from the Secretary of State for Health to NHSPRB Chair



From the Rt Hon Jeremy Hunt MP Secretary of State for Health

> 39 Victoria Street London SW1h 0EU Mb-sofs@dh.gsi.gov.uk

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

7 December 2017

Dear Ms Hird,

I am writing firstly to express my thanks for the NHS PRB's valuable work on the 2017-18 pay round and secondly, to formally commence the 2018-19 pay round.

The Chief Secretary to the Treasury wrote to you in September setting out the Government's overall approach to pay. That letter confirmed that the Government has adopted a more flexible approach to public sector pay, to address areas of skills shortages and in return for improvements to public sector productivity. Review bodies should continue to consider affordability when making their recommendations.

The Chancellor committed at Autumn Budget to provide additional funding for pay awards for staff employed under the national Agenda for Change contract provided the awards are part of an agreement with Agenda for Change trades unions about reforms to boost productivity. In considering future remuneration of these staff, I am therefore asking NHS Employers to continue exploratory talks with the Agenda for Change trades unions, with a view to the latter obtaining mandates to negotiate a multi-year agreement. Any agreed deal would need to be one that gives valued staff a fair pay rise alongside improving recruitment and retention and developing reforms which better reflect modern working practices, service needs and fairness for employees.

This does not prejudge the role of the independent NHS Pay Review Body in recommending the level of pay award that these staff should receive. We would



expect your recommendations to be informed by the outcome of talks with the Agenda for Change trade unions.

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

JEREMY HUNT

Yen Jey

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

Cabinet Secretary for Health and Sport Shona Robison MSP

T: 0300 244 4000 E: scottish.ministers@scotland.gsi.gov.uk



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

February 2018

Year Ms Hird.

Further to my letter of 8 January, I am now pleased to present you with our remit and evidence for NHS Scoltand staff covered by the NHS Pay Review Body for the 2018 pay round, which we would like you to consider.

As previously advised, the Cabinet Secretary for Finance and the Constitution announced the Scottish Government's Public Sector Pay Policy for 2018-19 on 14 December 2017 as part of his draft budget announcements. Stage 1 of the draft budget took place in Parliament on 31 January and there was a change to the Scottish Public Sector Pay Policy which will impact on the information we included in our previous letter to you. The revised pay policy summarised below provides the basis for the remit we would now like you to consider. It is a single year policy and sets out the parameters for pay increases for staff.

With regard to Pay Review Body interests, the main features of this policy are:

- lifting the pay cap by providing a guaranteed minimum increase of 3 per cent for public sector workers who earn £36,500 or less;
- a limit of up to 2 per cent on the increase in baseline paybill for those earning above £36,500 and below £80,000;
- limiting the maximum pay increase for those earning £80,000 or more to £1,600;
- continuation of the policy commitment to No Compulsory Redundancy.

You will appreciate that all consideration of staff pay by Scottish Ministers must be informed by this policy framework. However, beyond the elements set out above, we would wish the Pay Review Body to be as free as possible in considering the issues and making recommendations for Scotland for 2018-19.

I would again like to take this opportunity to thank the members of the Review Body for their work, and assure you that the Scottish Government continues to value the independent voice which the Review Body offers on Agenda for Change pay.

Copies of this letter will be sent to the Secretary of State for Health and the respective Ministers in the devolved administrations as well as representatives of the Staff Side and NHS employers.

SHONA ROBISON

Letter from the Welsh Government Cabinet Secretary for Health and Social Services to NHSPRB Chair

Vaughan Gething AC/AM Ysgrifennydd y Cabinet dros lechyd a Gwasanaethau Cymdeithasol Cabinet Secretary for Health & Social Services



Ein cyt/Our ref: MA-P/VG/4168/17

Phillipa Hird
Chair NHS Pay Review Body
Office of Manpower Economics
Fleetbank House
2-6 Galisbury Square
London
FC4Y 8JXTo Email: Craig Marcha

EC4Y 8JXTo Email: Craig.Marchant@beis.gov.uk

21 December 2017

Dear Phillipa

NHS Pay Review Body remit for Wales 2018-19

Thank you for the NHS PRB work on the 2017-18 pay round. I am writing to formally commence the 2018-19 pay found for Agenda for Change staff in Wales.

In this pay round, I would like you to consider evidence and make recommendations on two questions:

- · What would be a fair pay award for NHS staff in Wales?; and
- Taking into account your recommendations on a fair pay award, and the very challenging financial circumstances of the Welsh Government, what level of pay award could be afforded by the NHS in Wales in the absence of further funding from the UK Treasury?

Your advice and recommendations on these two questions will enable me to determine a fair pay award for Agenda for Change staff in Wales, and to seek a sufficient transfer of funding from the UK Government to Wales to enable us to fund that award and protect patient services.

In order to support your work, I intend to provide evidence to the Pay Review Bodies in the New Year and for my officials to attend the planned oral evidence sessions.

I would like to receive your advice and recommendations before the end of March 2018 to ensure that payment of any award to hard pressed NHS staff is not unduly delayed.

I have seen the remit letters issued by the Secretary of State for Health in England which conflate Issues about fair pay for the NHS workforce with discussions about contractual reforms. I am not convinced that linking these issues is either helpful nor is it clear how the sequencing of this will work without compromising the process and timetable of the pay review bodies. I have asked

Bar Carrdydd • Cardiff Bay Caerdydd • Cardiff Canolfan Cyswlit Cyntaf / First Point of Contact Centre: USUU 9604400 Goheblaeth, Vaughan, Gethingsiflyw, cymru Correspondence, Vaughan, bethingsigov, wates

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gwmraeg yn arwain at oedi.

We welcome receiving correspondence in Webh. Any correspondence received in Webh will be asswered in Webh and corresponding in Webh will not lead to a delay in responding.

officials to discuss these letters with the Department of Health so that we can understand how any contractual reform discussions will align with the Pay Review process in England.

The NHS across the four UK nations benefits from a degree of mobility within the workforce, which supports flexibility in recruitment, ease of movement for career development and training and to ensure equity for professional staff working across the UK. This mobility is underpinned by a common core of contractual arrangements across the UK. This means it is essential that employers and staff side representatives from Wales are party to any contractual negotiations and are able to represent the views and interests of Wales during the discussions. We will also be seeking early discussions with the Department of Health on this matter.

I look forward to receiving your advice and recommendations in March.

Vaughan Gething AC/AM

Ysgrifennydd y Cabinet dros lechyd a Gwasanaethau Cymdeithasol Cabinet Secretary for Health & Social Service

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Letter from the Permanent Secretary to Department of Health, Northern Ireland to NHSPRB Chair

From the Permanent Secretary and HSC Chief Executive



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

By email Charles Jordan@beis.gov.uk

Casile Buildings Upper Newtonniants Road BELFAST, 6T4 3SO

Tel 02890520559 Fax 02890520573

Error richard pengelly@health ni.gov.uk

Outrel RP1785

Date 18 Gecember 2017

Ocar Ms Had

I am writing to submit my Department's evidence to the Pay Review Body, to assist you in the task of providing recommendations for Northern Ireland in relation to the 2018/19 pay round.

I wish to advise that the Department of Finance has agreed that the 2016/17 Public Sector Pay Policy that was set by the provious Finance Manister, will continue to apply in 2017/18. This, in keeping with the everarching HM Treasury policy on UK public sector pay this year, will limit pay increases to 1 per cert. This determination, althoughout 13 December, together with the recent allocation of 226million flow allows the Department of Health to implement the 1% pay award for limith and social care workers.

I would also like to take this opportunity to thank all members of the Pay Review Sody for the important work that you continue to carry out in making independent, evidencebased recommendations on Agenda for Change pay awards

I am copying the letter to the Secretary of State for Health in England, the Cabinet Secretary for Health, Wellbeing and Sport in Scotland, the Minister for Health, Social Services in Wales, and Staff Side representatives.

Yours sincerely

RICHARD PENGELLY

Working for a Healthier People



Appendix B – Agenda for Change Pay Scales for Existing Staff Under the Framework Agreement in England 2018/19 – 2020/21

Band 1

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

Band 2

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

Band 3

	1	1	1
2017/18	2018/19	2019/20	2020/21
16,968			
17,524	17,787		
18,157	18,429		
18,333	18,608	18,813	19,737
18,839	19,122	19,332	
19,409	19,700	19,917	
19,852	20,448	20,795	21,142

Band 4

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

Band 5

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

Band 6

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

Band 7

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

Band 8a

2017/18	2018/19	2019/20	2020/21
40,428			
41,787	42,414		
43,469	44,121	44,606	45,753
45,150	45,827	46,331	46,518
47,092	47,798	48,324	48,519
48,514	49,969	50,819	51,668

Band 8d

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

Band 8b

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

Band 9

2017/18	2018/19	2019/20	2020/21
79,415			
83,258	84,507		
87,254	88,563	89,537	91,004
91,442	92,814	93,835	94,213
95,832	97,269	98,339	98,736
100,431	102,506	103,860	104,927

Band 8c

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

High Cost Area Supplement (HCAS)

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

Appendix C – Composition of our Remit Group

The following tables show the composition of our remit group in each country and in the United Kingdom as a whole as at September 2016 (C1 to C7) and September 2017 (C8 to C14). Detailed categories of staff in each country have been aggregated into broad staff groups, to enable cross-United Kingdom comparisons to be made.

Staff categories used in each administrations annual workforce census have been grouped together by our secretariat. We have had to be mindful of the differences between the four datasets, and even these broad staff groups contain inconsistencies.

NHS full time equivalent AfC workforce as at 30 September 2016

Table C1: Qualified nurses and midwives

Table CI: Kamiled Halses alla Illiamives		50100						
England	H	FTE Scotland	FTE	FTE Wales	Ħ	FTE Northern Ireland	FTE	FTE UK FTE
Qualified nurses, HVs and midwives	305,326	305,326 Nurses & midwives bands 5-9	43,025	43,025 Qualified nurses, HVs and midwives	22,436	22,436 Qualified nursing & midwifery	14,918 385,705	385,705
Table C2: Nursing, healthcare assistants and support staff	hcare assist	ants and support staff						
England	FTE	FTE Scotland	FTE	FTE Wales	ΞĦ	FTE Northern Ireland	FTE	FTE UK FTE
Support to doctors and nurses	239,540	239,540 Nurses & midwives bands 1-4	16,136	16,136 Unqualified nurses	6,952	6,952 Nurse support staff	4,202	
				Healthcare assistants and support staff	9,534			
	239,540		16,136		16,485		4,202	4,202 276,363

235,546 FTE UK FTE FTE UK FTE 14,622 7,590 7,033 Northern Ireland **Northern Ireland** Professional & Social services technical Ħ 12,429 12,429 FTE Wales FTE Wales 1,930 AHPs 1,119 10,077 4,060 5,451 22,637 Personal & social care Healthcare science Other therapeutic Medical & dental Table C3: Professional, technical and social care Scotland FTE Scotland support services AHPs Ⅱ 54,590 131,268 185,859 Scientific, therapeutic Support to ST&T staff Table C4: Ambulance & technical staff England England

41,209

1,081

2,045

3,955

1,081

977 Ambulance

1,068

Unqualified ambulance

3,955 Qualified ambulance

19,114 Emergency services

15,014

Support to ambulance

Ambulance staff

34,127

50,968 1,177,480 233,443 **UK FTE** FTE UK FTE 5,214 ž Ħ Northern Ireland 0 16,144 889 4,549 10,907 Northern Ireland Northern Ireland 13,560 Admin & clerical 1,463 Support services **Estates services** Generic FE 981 999 90 Wales 70,055 16,570 Maintenance & works Senior managers administration Clerical and Managers Wales 788 Others Wales H 13,768 분 25,225 38,992 Scotland 125,534 Administrative services Unallocated / not known Support services Table C5: Administration, estates and management Scotland Scotland Table C7: Total NHS non-medical workforce FTE 4,336 52,036 79,108 Ħ England 909'6 20,986 930,923 161,737 Hotel, property & Central functions Senior managers Table C6: Other Managers England England estates Others Η

NHS full time equivalent AfC workforce as at 30 September 2017

Table C8: Qualified nurses and midwives

England	FTE	FTE Scotland	FTE	FTE Wales	FTE	FTE Northern Ireland	H	FTE UK FTE
Qualified nurses, HVs and midwives	305,059	305,059 Nurses & midwives bands 5-9	43,238	43,238 Qualified nurses, HVs and midwives	22,582	22,582 Qualified nursing & midwifery	14,899 385,777	385,777
Table C9: Nursing, healthcare assistants and support staff	hcare assist	ants and support staff						
England	FTE	FTE Scotland	FTE	FTE Wales	FTE	FTE Northern Ireland	FIE	FTE UK FTE
Support to doctors and nurses	243,762	243,762 Nurses & midwives bands 1-4	16,175	16,175 Unqualified nurses	6,942	6,942 Nurse support staff	4,303	
				Healthcare assistants and support staff	9,704			
	243,762		16,175		16,646		4,303	4,303 280,886

242,078 **UK FTE** FTE UK FTE 42,182 H 1,103 7,210 15,172 1,103 7,962 Northern Ireland **Northern Ireland** Professional & Social services 989 Ambulance technical Ħ H 12,799 12,799 2,084 1,095 Unqualified ambulance Qualified ambulance Wales FTE Wales 1,931 AHPs 5,480 23,018 10,127 1,179 4,301 4,006 4,006 Η Personal & social care 20,258 Emergency services Healthcare science Other therapeutic Medical & dental FTE Scotland Scotland support services AHPs FIE 26,099 134,990 34,989 191,089 14,731 Support to ambulance Table C11: Ambulance Scientific, therapeutic Support to ST&T staff & technical staff Ambulance staff England England

Table C10: Professional, technical and social care

Table C12: Administration, estates and management

England	FTE	Scotland	Ħ	Wales	FTE	Northern Ireland	FIE	UK FTE
Central functions	80,739	Administrative services	25,277	Clerical and administration	14,190	Admin & clerical	10,981	
Hotel, property & estates	51,890	Support services	13,843	Maintenance & works	995	Estates services	682	
Senior managers	10,282			Managers	1,611	Support services	4,749	
Managers	21,673			Senior managers	589			
	164,584		39,119		17,384		16,412	237,499
Table C13: Other								
England	FTE	FTE Scotland	FTE	FTE Wales	FTE	FTE Northern Ireland	FIE	UK FTE
Others	4,478	Unallocated/not known	269	Others	101	Generic	0	5,276
Table C14: Total NHS non-medical workforce	งท-medical ง	workforce						
	England	5.	Scotland		Wales	Nort	Northern Ireland	UK
FTE	943,961		126,253		71,596		21,889	51,889 1,193,700

Annex C Sources: NHS Digital, Welsh Government (StatsWales), Information Services Division Scotland, the Department of Health (Northern Ireland)

Appendix D – The Parties' Website Addresses

The parties' written evidence should be available through the following links (correct as of June 2018):

Department of Health and Social

Care

https://www.gov.uk/government/publications/evidence-

for-the-nhsprb-pay-round-2018-to-2019

NHS Providers https://nhsproviders.org/resource-library/submissions/

written-evidence-to-the-pay-review-body

Health Education England https://www.hee.nhs.uk/our-work/review-bodies

Joint Staff Side https://www.unison.org.uk/content/

uploads/2018/02/24755_Joint-Staff-Side-Evidence-to-the-

NHSPRB-2018-19.pdf

NHS Employers http://www.nhsemployers.org/news/2018/01/nhs-

employers-evidence-to-the-pay-review-bodies-published

NHS England https://www.england.nhs.uk/publication/the-nhs-

pay-review-body-written-evidence-from-nhs-england-

december-2017/

Department of Health, Northern

Ireland

https://www.health-ni.gov.uk/publications/workforce-

policy-guidance-2017

Chartered Society of Physiotherapy http://www.csp.org.uk/professional-union/

union-support/pay-conditions/pay-review-body-

evidence-2018-19

GMB http://www.gmb.org.uk/GMB-evidence-NHSPRB-18-19.

pdf

Society of Radiographers https://www.sor.org/news/sor-evidence-prb-highlights-7-

years-pay-suppression

Royal College of Midwives https://www.rcm.org.uk/sites/default/files/Evidence%20

to %20 the %20 NHS%20 Pay%20 Review%20 Body%20

2017%20A4%2056pp_2FINAL.pdf

Royal College of Nursing https://www.rcn.org.uk/professional-development/

publications/pdf-006821

Unison https://www.unison.org.uk/content/uploads/2018/02/

UNISON Evidence Pay Review Body 2018-19.pdf

Unite the Union http://www.unitetheunion.org/uploaded/documents/

Unite%20evidence%20to%20the%20National%20 Health%20Service%20Pay%20Review%20Body%20

2018-1911-33614.pdf

Scottish Government http://www.gov.scot/Topics/Health/NHS-Workforce/

Policy/Pay-Conditions/SGtoNHSPRB2018-19

Welsh Government http://gov.wales/topics/health/publications/health/

reports/pay-review/?lang=en

Appendix E – Previous Reports of the Review Body

Nursing Staff, Midwives and Health Visitors

First Report on Nursing Staff, Midwives and Health Visitors Second Report on Nursing Staff, Midwives and Health Visitors Third Report on Nursing Staff, Midwives and Health Visitors Fourth Report on Nursing Staff, Midwives and Health Visitors Fifth Report on Nursing Staff, Midwives and Health Visitors Sixth Report on Nursing Staff, Midwives and Health Visitors Supplement to Sixth Report on Nursing Staff, Midwives and Health Visitors: Nursing and Midwifery Educational Staff Seventh Report on Nursing Staff, Midwives and Health Visitors First Supplement to Seventh Report on Nursing Staff, Midwives Midwives and Health Visitors: Senior Nurses and Midwives Second Supplement to Seventh Report on Nursing Staff, Midwives and Health Visitors: Senior Nurses and Midwives Eighth Report on Nursing Staff, Midwives and Health Visitors Ninth Report on Nursing Staff, Midwives and Health Visitors Report on Senior Nurses and Midwives Tenth Report on Nursing Staff, Midwives and Health Visitors Eleventh Report on Nursing Staff, Midwives and Health Visitors Twelfth Report on Nursing Staff, Midwives and Health Visitors Thirteenth Report on Nursing Staff, Midwives and Health Visitors Fourteenth Report on Nursing Staff, Midwives and Health Visitors Fifteenth Report on Nursing Staff, Midwives and Health Visitors Sixteenth Report on Nursing Staff, Midwives and Health Visitors Seventeenth Report on Nursing Staff, Midwives and Health Visitors Eighteenth Report on Nursing Staff, Midwives and Health Visitors Nineteenth Report on Nursing Staff, Midwives and Health Visitors

Cmnd. 9258, June 1984 Cmnd. 9529, June 1985 Cmnd. 9782, May 1986 Cm 129, April 1987 Cm 360, April 1988 Cm 577, February 1989

Cm 737, July 1989 Cm 934, February 1990 Cm 1165, August 1990

Cm 1386, December 1990
Cm 1410, January 1991
Cm 1811, February 1992
Cm 1862, March 1992
Cm, 2148, February 1993
Cm 2462, February 1994
Cm 2762, February 1995
Cm 3092, February 1996
Cm 3538, February 1997
Cm 3832, January 1998
Cm 4240, February 1999
Cm 4563, January 2000
Cm 4991, December 2000
Cm 5345, December 2001

Professions Allied to Medicine

First Report on Professions Allied to Medicine
Second Report on Professions Allied to Medicine
Third Report on Professions Allied to Medicine
Fourth Report on Professions Allied to Medicine
Fifth Report on Professions Allied to Medicine
Sixth Report on Professions Allied to Medicine
Seventh Report on Professions Allied to Medicine
Eighth Report on Professions Allied to Medicine
Ninth Report on Professions Allied to Medicine
Tenth Report on Professions Allied to Medicine
Eleventh Report on Professions Allied to Medicine
Twelfth Report on Professions Allied to Medicine
Twelfth Report on Professions Allied to Medicine
Thirteenth Report on Professions Allied to Medicine

Cmnd. 9257, June 1984
Cmnd. 9528, June 1985
Cmnd. 9783, May 1986
Cm 130, April 1987
Cm 361, April 1988
Cm 578, February 1989
Cm 935, February 1990
Cm 1411, January 1991
Cm 1812, February 1992
Cm 2149, February 1993
Cm 2463, February 1994
Cm 2763, February 1995
Cm 3093, February 1996

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

Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine

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

NHS Pay Review Body

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