Department of Health & Social Care

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

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2019/20 Pay Round

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Executive Summary

We recognise that the NHS continues to face significant challenges with increasing demand for health services due to an ageing, growing population. To respond to that challenge, the NHS is shifting the focus towards transformational changes, to help reduce the long-term cost pressures on NHS services by helping staff to increase their productivity.

To support this ambition, at Autumn Budget 2017 the Chancellor of the Exchequer committed to increase pay investment for NHS staff in return for reforms to the Agenda for Change contract that help recruit and retain staff and boost productivity (and capacity).

On 27 June 2018, a multi-year pay and contract reform Agenda for Change deal was agreed between NHS trades unions and NHS Employers, supported by the majority of trades unions and their members and represents the most significant reforms since Agenda for Change was introduced in 2004.

The national collective agreement, set out in the Agenda for Change Framework Agreement, delivers pay awards and contract reforms over three years (2018/2019 to 2020/2021). The Chancellor released £800m additional funding for 2018/2019. Funding for the last two years of the pay deal (2019/2020 to 2020/2021) will be met from the Long-Term Funding Settlement.

In this context, the Department of Health and Social Care's remit letter makes clear that the NHS Pay Review Body is not being asked to make any pay or contract reform recommendations for 2019/2020. The Review Body will however, continue to receive evidence on the state of recruitment, retention and motivation of Agenda for Change staff throughout the period of the three-year pay and contract reform deal.

The remit letter also makes clear that whilst it may be too early to make any observations on how the deal is being implemented, we do expect the NHS Pay Review Body to receive information from the NHS Staff Council and its partners on their plans for monitoring the deal and supporting organisations, their leaders and their staff to implement the agreement as expected on the ground.

Patients, and their experience of care, must be at the heart of everything the system does. We want to help ensure that, the NHS can continue to deliver world-class patient care, putting patients first and keeping them safe whilst providing the high quality care we all expect. The pay review bodies for the NHS are asked, as part of their standing remits, to give regard to that.

The Government's longstanding aim remains the same. It is to ensure that we can recruit, retain, and motivate sufficient high calibre NHS staff to deliver government policy and

ensure best value for the taxpayer. It is a complex matter of judgement which includes the overall impact of the NHS employment offer, pay and non-pay terms on attracting and keeping the staff the NHS needs.

All of this means that Government must strike the right balance between pay and staff numbers through systems of reward that are affordable and fit for purpose. Staff tell us that they want to know they will have the right number of colleagues working alongside them in hospital or in the community.

The key context for considering the evidence on recruitment, retention and motivation is NHS England's Long-Term Plan for the NHS published on 7 January 2019. Although the Review Body is not being asked to make pay or contract reform recommendations, it should note the affordability assumptions and the importance of making planned workforce growth affordable.

As in recent years - and reflecting the roles of the Department, its Arms-Length Bodies and other organisations - the NHS Pay Review Body will be invited to consider, alongside evidence from the trades unions, professional bodies and other stakeholders:

- high-level evidence from the Department, including the strategic policy objectives and the economic and financial (NHS funding) context

- evidence from NHS England on its Long-Term Plan and the implications for workforce growth and affordability;

- evidence from NHS Improvement on provider issues, specifically its plans for ensuring employers implement the deal as expected on the ground and how to best realise the benefits of the deal which has at its heart improvements to productivity and capacity; and

- evidence from NHS Employers on how they are supporting employers to implement the deal and progress on negotiations on wider agreements on reforms to other terms and conditions of service and policies.

This evidence covers:

Chapter 1: Strategic Context; Government Pay Policy; and the Government's Response to the 31st NHS Pay Review Body Report

Chapter 2: Evidence on the General Economic Outlook

Chapter 3: NHS Finances

Chapter 4: HCHS Agenda for Change Staff Earnings

Chapter 5: Workforce Strategy

Chapter 6: Recruitment, Retention, Motivation and Agenda for Change Workforce Planning

Chapter 7: Agenda for Change Multi-year Pay and Contract Reform Deal

Chapter 8: Pensions and Total Reward

1. NHS Strategy and Introduction

1.1 The NHS has seen, and will continue to see, real growth in its budget. In the 2015 Spending Review, the Government committed to backing the NHS with an additional £8 billion in real terms, by 2020/21; subsequent additional funding increases included £2.8 billion of revenue funding for frontline services announced in the Autumn 2017 budget.

1.2 In June 2018 the Prime Minister set out a new multi-year funding plan for the NHS, setting the real terms growth for spending in return for the NHS agreeing NHS England's Long-Term Plan with the Government; a plan which determines the direction the NHS will take over the next decade.

1.3 The health and care system continues to face increasing demand for its services, driven by an increasingly aged and frail population, and meeting this demand and driving up quality in an affordable way is incredibly challenging. NHS England's Long-Term Funding settlement gives the NHS the financial security to implement a ten year plan that addresses these challenges in a sustainable manner.

1.4 NHS England was asked to develop its Long-Term Plan against five financial tests to ensure that the service is being put on a more sustainable footing (see Chapter 3). The Plan was published on 7 January 2019, and NHS England and NHS Improvement published full planning guidance on 10 January 2019. The Plan takes into account the multi-year pay settlement for Agenda for Change staff from 2018/2019 to 2020/2021.

Workforce

1.5 Ensuring that the NHS has access to the right mix and number of staff who have the skills, values and experience to deliver high quality, affordable care is a fundamental aspect of the Department's overarching strategic programme for the health and care system. The Department works with system partners to ensure there is a highly engaged and motivated workforce delivering NHS services to patients.

1.6 NHS England's Long-Term Plan published on 7 January 2019 sets out a number of specific workforce actions that can have a positive impact now, and that a Workforce Implementation Plan will follow later in 2019. The Department will continue to work with the Home Office to ensure that after we leave the EU, we will have in place an immigration system which works in the best interests of the whole of the UK.

Staff engagement

1.7 Staff engagement is crucial to securing and retaining the workforce that the NHS needs, as is making the most effective use of the entire NHS employment offer - pay and non-pay benefits. We strongly believe that recruitment and retention is not just about pay, it is about creating a culture and environment in the NHS where staff want to work, where staff feel safe to raise concerns and to learn from mistakes; where employers listen to and empower staff, work hard to keep them safe and ensure bullying and harassment is not tolerated. The Department continues to work in partnership with its arms-length bodies and other organisations to support trusts in their responsibility for improving staff experience.

Government Pay Policy, 2018/19 Awards and our Approach to Pay and Contract Reform

1.8 The Government's public sector pay policy aims to ensure that the overall package for public sector workers is fair to them and that we can deliver world class public services which are affordable within the public finances and fair to taxpayers as a whole.

1.9 Patients, and their experience of care, must be at the heart of everything that the system does - we want to help ensure that the NHS can continue to deliver world-class patient care, putting patients first and keeping them safe whilst providing the high quality care we all expect. The pay review bodies for the NHS are asked, as part of their standing remits, to give regard to that.

1.10 All of this requires ensuring the right balance between pay and staff numbers through systems of reward that are affordable and fit for purpose. Staff tell us that they want to know they will have the right number of colleagues working alongside them in hospital or in the community.

1.11 We continue to focus on public sector pay reform to ensure that terms and conditions are fit for purpose, affordable and sustainable. The approach taken (including the public sector pay cap that was in place until 2017/18) has been essential to ensuring continued levels of recruitment and retention. The non-medical NHS workforce increased by 69,587 FTEs (7.9%) between March 2013 and March 2018

1.12 In September 2017, the Government said that it recognised that, within the context of a continued need for pay discipline to ensure the affordability of public services and the sustainability of public sector employment, more flexibility may be required in some parts of the public sector, particularly in areas of skills shortage, to deliver

world class public services, including in return for improvements to public sector productivity.

1.13 Existing spending plans, set through the 2015 Spending Review and budgeting for a 1% average increase in basic pay and progression pay awards for specific workforces, remained in place. The Chancellor stated that to protect patient services he would commit to increase pay investment for staff employed on the Agenda for Change contract.

1.14 The Agenda for Change three-year multi-year pay and contract reform deal is a ‘something for something’ deal. In return for additional pay investment, reforms will help staff to increase their productivity and help increase the number of staff available for patient care through a range of pay and non-pay reforms (not just headline pay increases). For example, through improved local appraisal and performance systems, supported by a reformed pay structure which incentivises staff to develop the skills and behaviours they need to progress to the next pay point. There is strong evidence that where the annual appraisal experience is positive, this can lead to better staff engagement and through that better outcomes for patients. The deal also commits employers to support their staff maintain their mental and physical health and wellbeing, helping to reduce sickness absence levels to the best in the public sector, increasing capacity for patient care.

1.15 The AfC multi-year pay and contract reform deal is part of the continued focus on public sector pay reform to ensure that terms and conditions are fit for purpose, affordable and sustainable. This approach (including the public sector pay cap that was in place until 2017/18) is essential to ensure continued levels of recruitment and retention.

1.16 The AfC multi-year pay and contract reform deal takes into account the Government’s obligations under the Public Sector Equality Duty and the potential impacts on those who share a protected characteristic (age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation).

2. Evidence on the General Economic Outlook

Introduction

2.1 The economic and fiscal context in which the Pay Review Bodies make their recommendations was set out in the October 2018 Budget. However, as in previous years this chapter sets out points in the economic and fiscal context which are of particular relevance to the PRB process, notably the latest OBR projections and labour market context, both public and private. This should be considered alongside the rest of the evidence set out in this document.

2.2 In July the Government announced the biggest pay rise in almost 10 years for around one million public sector workers across Britain. This Government recognises that public sector workers deserve to be fairly rewarded for the vital work they do, and seeks to ensure the overall package remains fair and competitive.

2.3 Our flexible approach to pay allows us to recognise areas of skill shortage, and improvements to workforce productivity. The Government continues to take a balanced approach to public spending and it is important that pay awards are considered within the wider fiscal picture. With budgets for 2019-20 already set, it is crucial that Pay Review Bodies consider the more detailed information about affordability set out in this document alongside the economic and fiscal context.

UK economy

2.4 As usual, it is very important that the PRBs take into account the wider fiscal context when making their recommendations. The UK economy has solid foundations and continues to demonstrate its resilience. GDP has grown every year since 2010 and is forecast by the OBR to continue growing over the forecast period. Employment is at a near record high and real wages are rising at the fastest rate for two years.

2.5 There has been a sustained worldwide slowdown in productivity growth since the 2008 financial crisis, but the UK has been affected more than most. Whilst productivity growth has improved since 2016 it remains below pre-crisis levels. Increasing productivity is the only sustainable way to boost economic growth and prosperity, and to deliver better jobs and higher income for people across the

country. The forecast for productivity remains subdued in the medium term but is expected to rise gradually to reach 1.2% per year[i] by 2023.

2.6 With public services accounting for around 20% of UK GDP, public sector productivity plays an important role in the UK's productivity growth overall. While public sector productivity has increased by 0.8% in the last year, continued improvement is essential for meeting growing demands on our world class public services. Public sector pay awards should reward efforts to modernise workforces and delivery models.

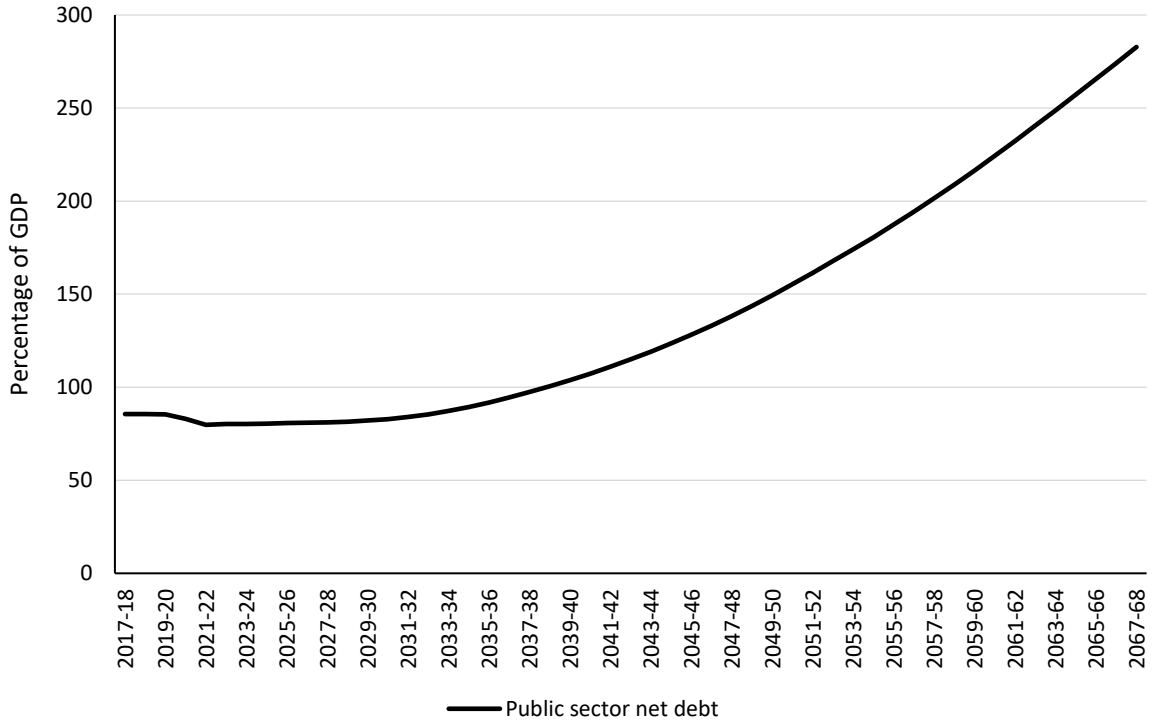
Public finances

2.7 Since 2010 the government has made significant progress in restoring the public finances to health, which have now reached a turning point. The deficit has been reduced by four-fifths from a post-war peak of 9.9% of GDP in 2009-10 to 1.9% in 2017-18. The fiscal rules approved by Parliament in January 2017 commit the government to reducing the cyclically-adjusted deficit to below 2% of GDP by 2020-21 and having debt as a share of GDP falling in 2020-21. These rules will guide the UK towards a balanced budget by the middle of the next decade. The OBR forecasts that the government has met both its near-term fiscal targets in 2017-18, three years early, and will meet them in the target year.

2.8 The need for fiscal discipline continues however as, despite the improvement, debt still remains too high at over 80% of GDP. Continuing to reduce borrowing and debt is important to enhancing the UK's economic resilience, improving fiscal sustainability, and lessening the debt interest burden on future generations.

2.9 The OBR's 2018 Fiscal Sustainability Report (FSR) was published in July and highlighted the long-term pressures and risks to the public finances, underscoring the importance of locking in this hard-won progress. The 2018 FSR projection shows that, left unaddressed, demographic change and non-demographic cost pressures on health, pensions, and social care would push the debt-to-GDP ratio far beyond sustainable levels in the long-term. This would pass an unacceptable burden on to the next generation, and the government is therefore committed to ensuring that debt remains on a sustainable trajectory.

Figure 2.1: Baseline projection public sector net debt (OBR Fiscal Sustainability Report, 2018)[ii]



2.10 Affordable pay awards will be an essential part of keeping borrowing under control: the public sector pay bill was £183.79bn in 2017. This accounts for £1 in every £4 spent by the Government. There continues to be a need to ensure increases in pay are affordable to ensure the delivery of world-class public services remains sustainable. Keeping control of public sector pay supports the Governments fiscal strategy to avoid passing an increasing burden of debt onto future generations. We spend more on debt interest than on the police and Armed Forces combined.

2.11 Existing spending plans set through the Spending Review 2015 remain in place, excepting the NHS, where the Government has announced a five-year funding settlement. The affordability position for each workforce is set out elsewhere in this evidence pack.

Labour market

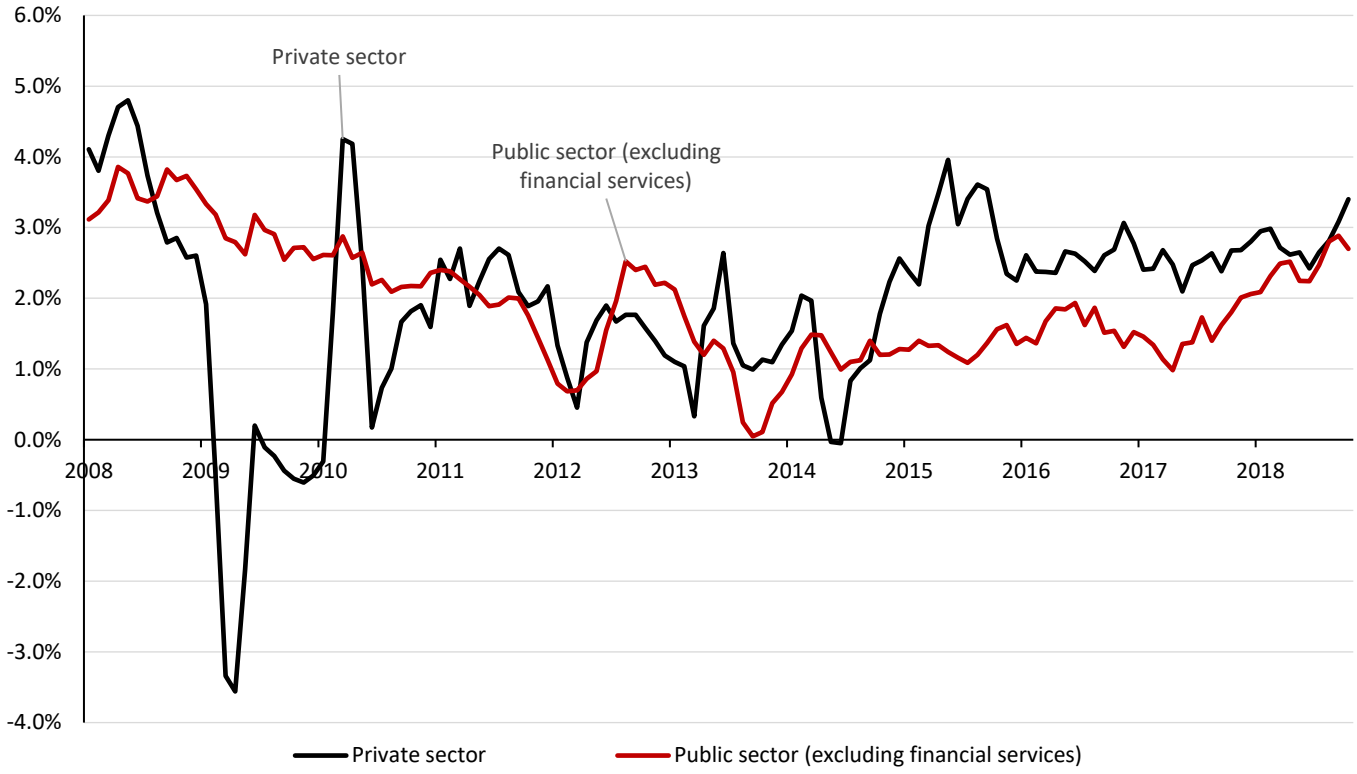
2.12 Activity in the UK labour market is an important contextual consideration. Total employment reached a new record high in the 3 months to October 2018, with 32.5 million people in work. In 2018 the unemployment rate has dropped to its lowest since the 1970's, currently at 4.1%, it remains close to its historic low.

2.13 In their most recent Economic and Fiscal Outlook, the OBR revised down their assessment of the equilibrium rate of unemployment from 4.6% to 4.0% at the end

of the forecast. The unemployment rate is forecast to reach 3.7% in 2019, before returning to 4.0% by 2023.

2.14 The downward revision to the equilibrium rate of unemployment was accompanied by an upward revision to labour market participation, meaning the number of people available to the labour market has increased. This was partially offset by a fall in average hours worked. Looking ahead, the OBR forecast employment to rise every year to reach 33.2 million by 2023.

Figure 2.2: Public sector (excluding financial services) and private sector average nominal earnings growth (ONS November 2018).



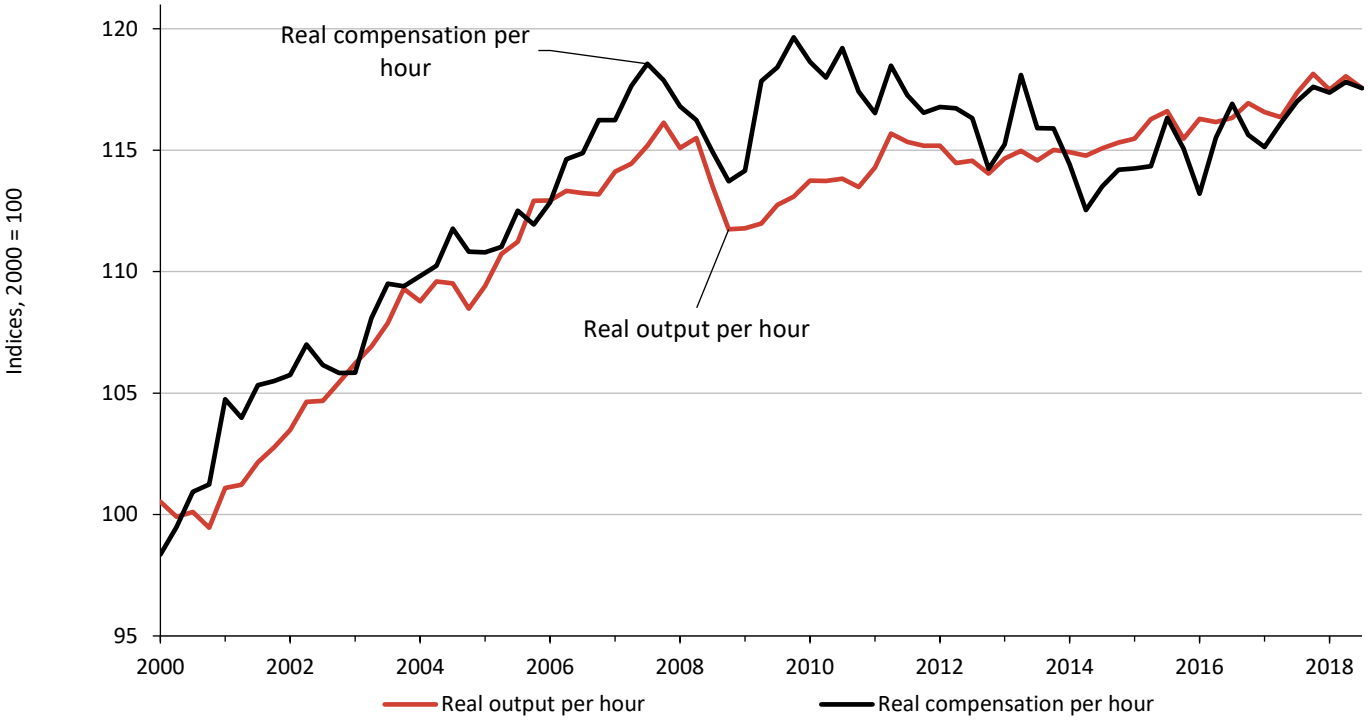
2.15 Total nominal wage growth rose to 3.3% in the 3 months to October[iii] (including bonuses), although wage growth remains lower than averages seen prior to the financial crisis, which reflects sluggish productivity growth. Public sector (excluding financial services) and private sector total wage growth are both above the current rate of inflation, at 2.7% and 3.4% respectively. Both the public sector and the private sector have seen real total pay growth in the three months to October. It should be noted that wage growth as reflected in the ONS Average Weekly

Earnings series reflects pay growth beyond annual settlements, including promotions, incremental increases and compositional changes.

2.16 The OBR forecast average earnings growth for the whole economy to be 2.6% in 2018, 2.5% in 2019, 2.8% in 2020, 3.0% in 2021, 3.1% in 2022 and 3.2% by 2023[iv]. Average earnings growth is forecast to remain below the pre-crisis average.

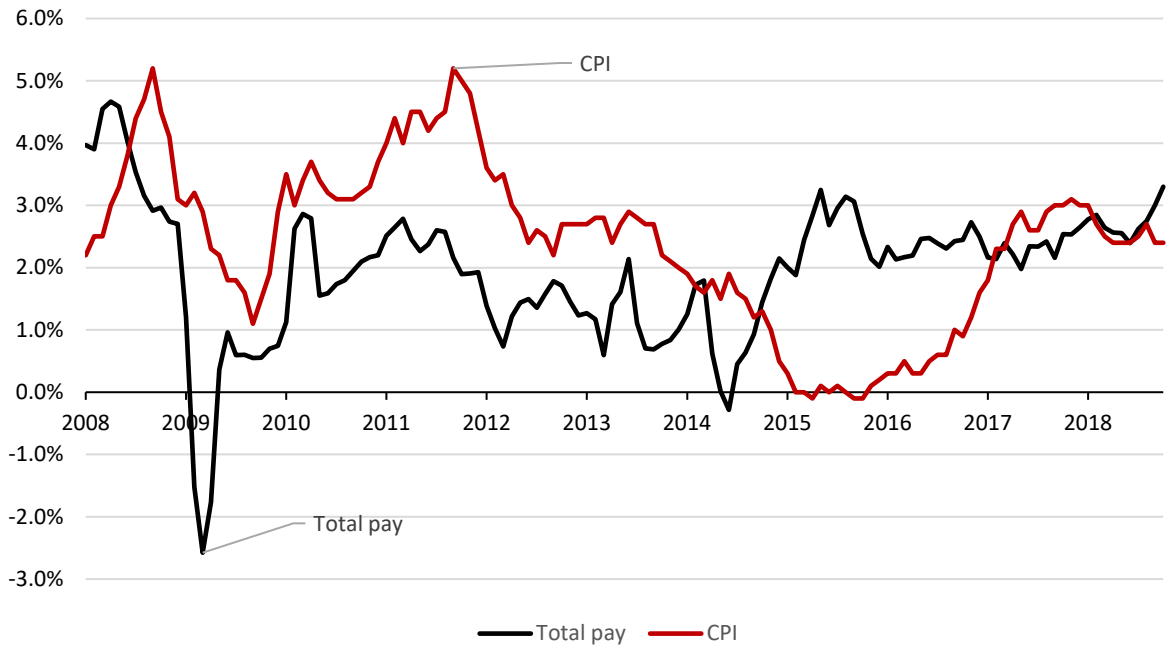
2.17 Ultimately, a pickup in productivity is vital for the recovery of cross-economy wage growth rates to pre-recession levels. Public and private sector wages tend to move in similar directions, both because of pay expectations and the implications of tax receipts on public sector budgets. Despite low unemployment, weak growth in labour productivity has been weighing down on wages and, ultimately, the public finances. The OBR forecasts productivity growth of 0.8% in 2019, 0.9% in 2020, 1.0% in 2021, 1.1% 2022 and 1.2% in 2023.

Figure 2.3: Real output per hour and real compensation per hour, year on year growth (ONS November 2018)



2.18 Inflation reached a peak of 3.1% in November 2017, following an increase in import prices after the earlier depreciation of sterling, but has since fallen back to 2.1% in the year to December 2018. The OBR forecasts CPI inflation to be 2.6% in 2018 and it is then expected to be 2.0% in 2019. It remains the view of Government that the appropriate level of public sector pay award is complex and determined by a variety of factors. Rates of price inflation are important, but not the only consideration.

Figure 2.4: Whole economy average earnings growth and inflation (ONS November 2018)



Public sector pay and pensions

2.19 Public sector pay remains competitive: the median full-time wage in the public sector is £31,414, compared to £28,802 in the private sector. Public sector workers benefit from wider Government measures to support wages and ensure that people take home more of what they earn. The introduction of the National Living Wage marked an increase in pay for approximately one million people across the UK labour market, including in the public sector. Income tax changes mean that a typical taxpayer will pay £1,205 less in tax in 2019-20, compared to 2010-11, an additional support to public sector workers.

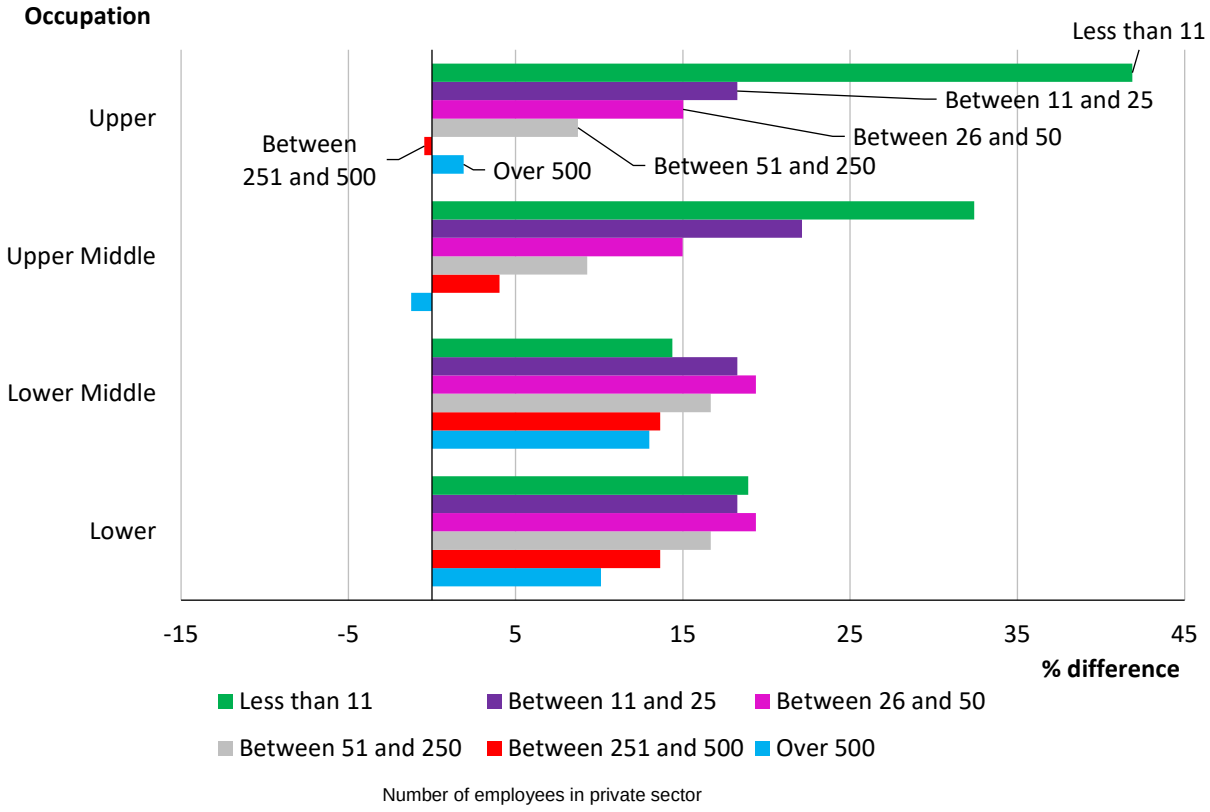
2.20 Following the 2008 financial crisis public sector workers were protected from the sharp drop in wages that was seen in the private sector, though wages subsequently grew at a slower pace. However, during Q3 2018 public and private sector wage growth was similar, and public sector remuneration when pensions are taken into account remains higher than in private sector, as shown in recent ONS analysis (see chart 5).

2.21 This analysis shows that after controlling for various individual and job characteristics, on average there is a positive earnings differential in favour of the public sector, when pensions are included. However, as shown in Chart 5 below, this premium varies considerably by occupational skill level, and by the size of private sector firm being compared to the public sector, which is treated as a single large employer in this analysis. The right-hand side shows the average

premium received by public sector workers in comparison to their private sector counterparts, and the left-hand side showing the penalty.

2.22 Key PRB workforces, including teachers, police and NHS staff such as nurses, midwives and GPs are in the upper and upper middle skill categories according to the ONS Standard Occupational Classification.

Figure 2.5: Average percentage difference in mean hourly earnings (includes pensions) of employees, by occupational group and firm size, private sector compared with public sector, UK, 2017[v]



2.23 When considering changes to remuneration, PRBs should take account of the total reward package including elements such as progression pay, allowances and pensions. Public service pension schemes continue to be amongst the best available and significantly above the average value of pension provision in the private sector. Around 13.3% of active occupational pensions scheme membership in the private sector is in defined benefit (DB) schemes, with the vast majority in defined contribution (DC) schemes. In contrast, over 92.7% of active members in the public sector are in DB arrangements.

2.24 The Budget confirmed a reduction of the discount rate for calculating employer contributions in unfunded public service pension schemes. The valuations indicate

that there will be additional costs to employers in providing public service pensions over the long-term. It is a long standing principle that the full costs of public sector pensions are recognised by employers at the point they are incurred. This is important to ensure that the schemes are affordable and sustainable in the long-term. However, HM Treasury is working with departments to ensure that recognition of these additional costs does not jeopardise the delivery of frontline public services or put undue pressure on public employers.

Conclusion

2.25 This chapter summarises the economic and fiscal evidence which is likely to be relevant to the recommendations of the PRBs. This is intended to inform consideration of the affordability of specific pay awards, and to place these awards in economic context, on top of the workforce specific evidence presented elsewhere in this evidence pack.

2.26 Much of the evidence presented here will feed into retention and recruitment across public sector workforces. Retention and recruitment will vary considerably across geographies, specialisms and grades. As set out in our remit letter, we ask that the PRBs set out what consideration they have given to targeting in their final report, alongside affordability of awards.

3. NHS Finances

3.1 This chapter describes the financial context for the NHS.

Funding growth

3.2 The NHS Five Year Forward View (2014) set out the NHS's plan for delivering transformational changes to meet broad healthcare challenges. The Government signalled its clear support for this plan through the 2015 Spending Review settlement with a commitment to increase NHS funding by more than £8 billion per year by 2020-21 compared to 2015-16 (and £10 billion compared to 2014-15).

3.3 The Government has subsequently continued to provide additional funding increases, including £2.8 billion announced at the 2017 Autumn budget. This provided a significant increase in resource funding for day-to-day spending to support the NHS to put the service on a stronger, more sustainable footing.

3.4 In June 2018, the Prime Minister set out a new multi-year funding plan for the NHS, setting the real terms growth rate for spending in return for the NHS's new Long-Term Plan, which sets out how this money will be spent. This Long Term Plan now determines the direction the NHS will take over the next decade.

3.5 All of this means that the NHS has, and will continue to see, real growth in its budget. Over the next five years this will average real-terms increases of 3.4%.

3.6 3.6 NHS England’s RDEL and real-terms growth figures since 2013/14 will follow this evidence.

3.7 This long-term funding commitment gives the NHS the financial security to develop a 10-year plan that addresses challenges in a sustainable manner. Consequently, it is essential that this money is spent wisely, which is why the Government has set five financial tests to ensure the service is being put on a more sustainable footing:

- improving productivity and efficiency;
- eliminating provider deficits;
- reducing unwarranted variation in the system so people get the consistently high standards of care wherever they live;

- getting much better at managing demand effectively;
- making better use of capital investment.

3.8 There will be multiple calls on available funding, including pay, and these will need careful prioritisation in order to stay within available funding. More funding put towards pay will mean less funding for other priorities, including the size of the workforce that is affordable.

Financial position

3.9 The Government's Mandate to the NHS includes: a clear objective for the NHS to balance its budget; for NHS England and NHS Improvement (which has responsibility for financial control in NHS providers) to work together to stabilise finances across the system; and, to increase financial sustainability through improved efficiency and productivity in the provision of healthcare.

3.10 The NHS continues to work incredibly hard to manage its finances in a challenging environment. Since the financial re-set of July 2016, significant progress has been made and maintained into 2017-18. NHS providers continue to demonstrate that strong, effective and sustainable financial management is possible.

3.11 However, despite these successes, a small proportion of providers continue to make up the majority of the overall provider deficit. The NHS's Long-Term Plan sets out the measures intended to support the most challenged organisations in returning to balance, and commits to reducing year-on-year the number of trusts and CCGs in deficit, so that all NHS organisations are in balance by 2023/24.

Figure 3.2 Provider deficit time series

NHS Providers RDEL Breakdown	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
	£m	£m	£m	£m	£m	£m	£m	£m
Total Provider Deficit	(458)	(476)	(544)	107	842	2,448	791	991
Provisions Adjustment	(106)	(163)	(120)	53	121	74	43	39
Other Adjustments	(183)	3	68	(11)	(47)	27	101	8
Total Revenue DEL	(748)	(636)	(596)	149	916	2,548	935	1,038

3.12 The NHS has been afforded the highest priority by the Government as demonstrated by a further increase of over £20 billion a year in real terms by 2023/24. This will ensure that the NHS is properly funded to meet the growing demands on the service. The NHS's ten-year strategic plan sets out how the

money will be best spent to take forward the reforms to deliver a more sustainable NHS with improved care for patients and better health outcomes.

Share of resource going to pay

3.13 Figure 3.3 shows the proportion of funding consumed by NHS provider permanent staff spend over the last 5 years. Note that NHS provider permanent staff spend only covers staff working within hospital and community health settings, and so excludes General Practitioners, GP practice staff and General Dental Practitioners.

3.14 On average, between 2013/14 and 2017/18, increases to the HCHS paybill accounted for 44% (£7.0bn out of £15.9bn) of the increases in revenue expenditure.

3.15 Despite many competing pressures, the NHS has managed to increase its permanent staff spend while largely maintaining the proportion of expenditure spent on permanent staff.

Figure 3.3 Increases in Revenue Expenditure and the Proportion Consumed by Paybill

	NHS England RDEL (£bn)	Provider Permanent Staff Spend (£bn)	% of spend on staff	Increase in total spend	Increase in provider permanent staff spend
2013-14	93.7	42.9	45.8%		
2014-15	97.0	43.9	45.3%	3.6%	2.4%
2015-16	100.2	45.2	45.1%	3.3%	2.8%
2016-17	105.7	47.7	45.1%	5.5%	5.6%
2017-18	109.5	49.9	45.6%	3.6%	4.6%

3.16 In line with Government's wider policy, pay rises across the health service have largely stayed around 1%. However, last year the Chief Secretary to the Treasury confirmed a more flexible approach to public sector pay, in return for improvements to productivity.

3.17 Following this, and in recognition of the dedication shown by staff across the NHS, over the course of this year Government has announced a range of pay rises for doctors, dentists, and Agenda for Change staff.

3.18 These deals reflect the Government's continued support for the NHS workforce to deliver excellent care, while reinforcing public sector pay policy that pay flexibility

should be in return for reforms that improve recruitment and retention and boost productivity.

3.19 The long-term settlement sets out overall funding available to the NHS from 2019/20, including for pay. The Government has confirmed that funding for the last two years of the Agenda for Change deal will be met from the long-term settlement. This long-term funding settlement runs off a baseline for 2018/19 that includes the £800m of additional funding for the Agenda for Change deal in 2018/19.

Demand pressures

3.20 Demand for services provided in the health and care system continues to rise above what would typically be expected from population growth and demographics alone. To meet this demand the NHS continues to deliver more activity than ever before, as evidenced by the number and growth in emergency admissions and elective (i.e. non-emergency) treatments over the last 6 years.

3.21 Compared with 2016-17, the NHS managed just over half a million more A&E attendances in 2017-18, an increase of 3.8% in people seen by a specialist for suspected cancer and performed more 528,000 more diagnostic tests.

Figure 3.4: Emergency admissions per calendar day

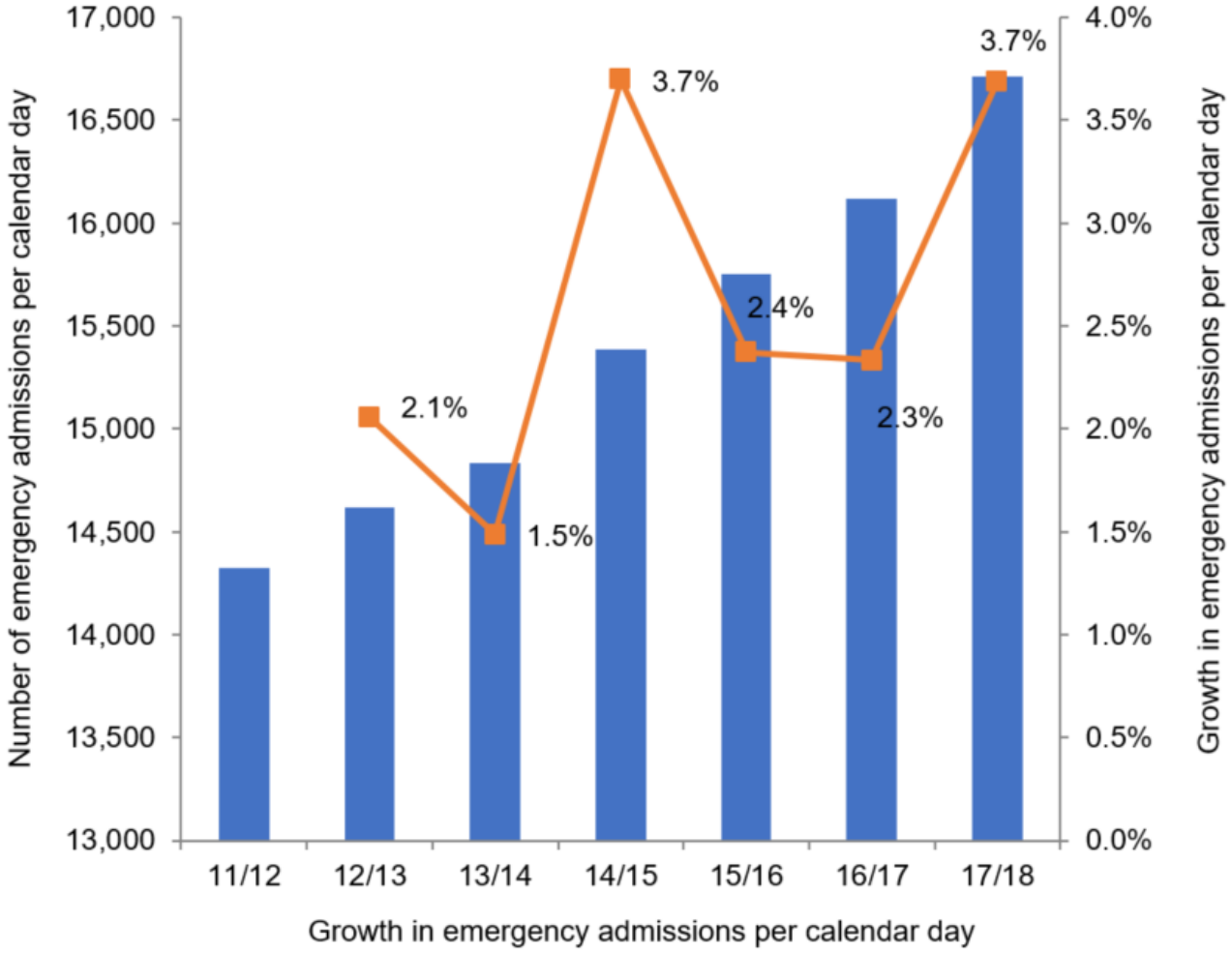
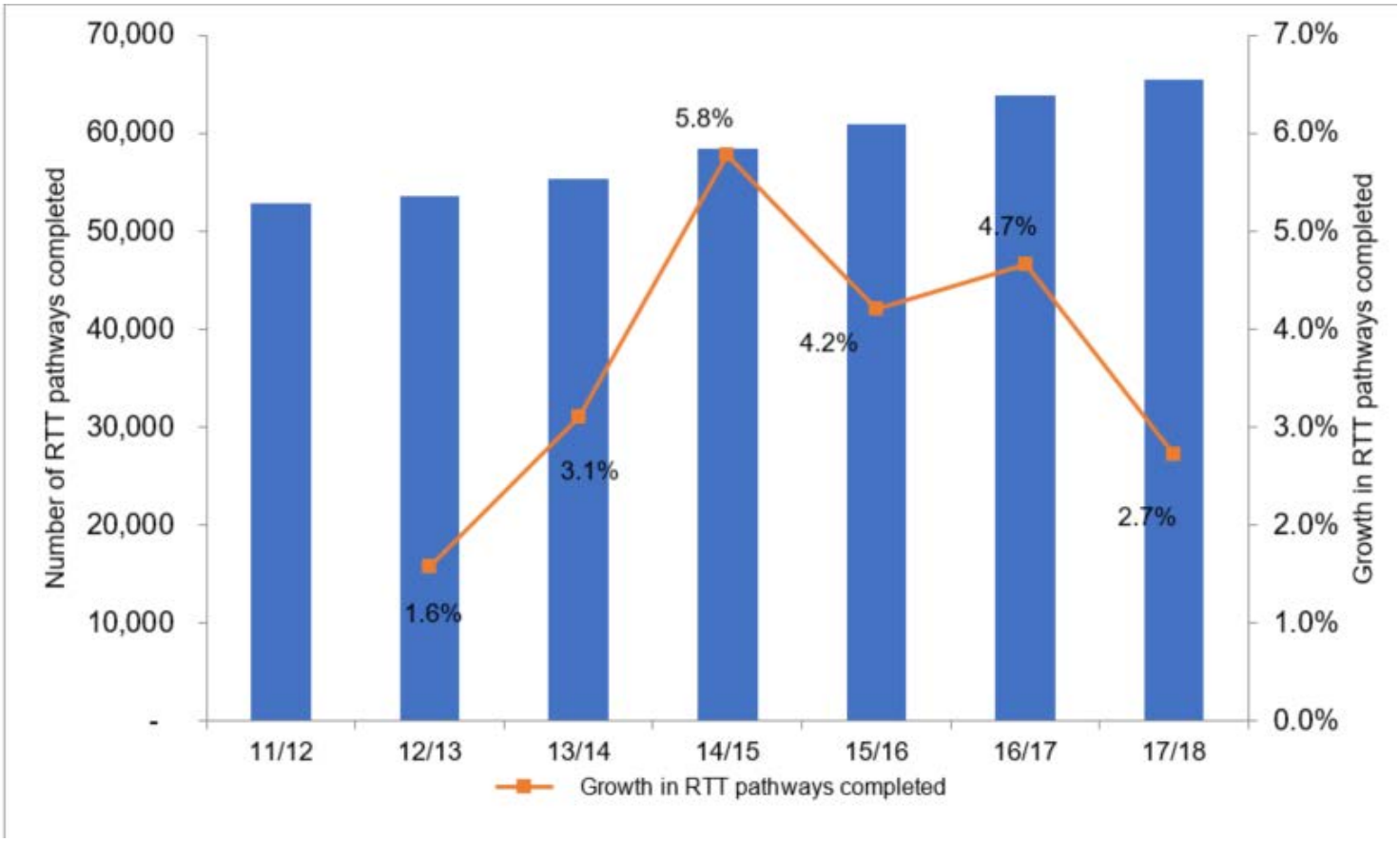


Figure 3.5: RTT pathways completed per working day



3.22 Despite the increasing activity during the year, the NHS balanced its financial budget through continuing focus on financial rigour and efficiency, with the majority of Trusts once again meeting their control totals. Managing demand effectively is one of the five financial tests that Government has set the NHS as part of the long-term funding settlement, while the NHS committed to cutting down avoidable demand in its 10 Point Efficiency Plan.

3.23 This level of rigour will need to be continued in future years, in order to ensure the long-term sustainability of the system.

Efficiency

3.24 To achieve this level of sustainability, the NHS must also continue developing into an increasingly efficient system. This efficiency will ensure that the funding received is used in the most effective manner to achieve the best value and the best possible outcomes.

3.25 The overall efficiency challenge is set out in the joint NHS' 10 Point Efficiency Plan – a single, agreed plan of action on how the NHS will deliver the necessary savings to ensure it lives within its means. This includes:

- Operational Productivity Programme: reducing variation in clinical practice and improving management of resources in NHS acute, community, mental health, and ambulance providers, following the recommendations of the 2016 Carter Review of operational productivity.

- Getting it Right First Time: driving quality and productivity improvement in over 30 clinical specialities, helping to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improving patient outcomes.

- Other cost improvement initiatives: such as RightCare which is supporting commissioners to reduce unwarranted variations in care; and NHS Improvement's Financial Improvement Programme which is providing central support combined with sharing learning and guidance to help raise levels of achievement against plans.

3.26 NHS England and NHS Improvement have joint oversight over the programme and monitor its progress. They provide expert central support and combine this with the sharing of learning and guidance to help raise levels of achievement against plans. Each NHS organisation has been set a stretching efficiency target as their contribution to this plan.

3.27 Progress is monitored through provider Cost Improvement Programmes (CIPs), and commissioner Quality, Innovation, Productivity and Prevention plans (QIPPs). In 2017/18 total savings delivered through Provider CIPS was £3.2bn while Commissioner QIPPs delivered a further £3.0bn.

3.28 The system has made progress in implementing the Operational Productivity programme; across 2017-18, this programme has delivered £1.45 billion of efficiency savings for the NHS across the service, including hospital pharmacy and medicines, the clinical workforce, procurement, back-office services and estates. This is a promising start, but the challenge going forward remains ensuring that learning and best practice is spread across the NHS so that the full benefits of this work are felt everywhere.

3.29 Alongside this, progress has been made in reducing the reliance on the use of expensive agency staff within the NHS, reducing spending on agency workers to the targeted level of £2.5 billion, and increasing the use of bank staff, who are typically more committed to their trusts. This represents a cost reduction of £1.2bn over two years.

3.30 However, whilst progress has been made, at this point in time the NHS is not yet seeing the level of sustainable efficiencies that it needs. Organisations will need to address this and deliver more recurrent efficiencies to deliver sustainability as part of the Long-Term Plan.

Productivity in the NHS

3.31 Labour productivity is calculated by dividing total NHS output by an appropriate measure of labour input (usually some form of weighted sum of staff numbers and hours worked). It measures the amount of output generated per 'unit' of labour, and as such is an important component of efficiency.

3.32 The measure of labour productivity we use for the NHS in England is the one developed by the University of York (Centre for Health Economics, CHE). The York measure uses a range of NHS data sources to assess outputs and inputs and also adjusts the output measure to take some account of quality change, including change in waiting times and death rates. Their figures show between 2005/06 and 2015/16 the NHS's average annual labour productivity was 2.5%.

Figure 3.6: Labour Productivity Data from York University (CHE)

	Total Output Growth	Labour Input Growth	Labour Productivity Growth
2005/06	7.1%	3.4%	3.6%
2006/07	6.5%	0.6%	5.9%
2007/08	3.7%	0.7%	2.9%
2008/09	5.7%	4.1%	1.5%
2009/10	4.1%	4.5%	-0.4%
2010/11	4.6%	1.4%	3.2%
2011/12	3.2%	0.1%	3.4%
2012/13	2.3%	-2.0%	4.4%
2013/14	2.6%	0.4%	2.1%
2014/15	2.5%	2.8%	-0.3%
2015/16	2.6%	1.3%	1.3%
Average Annual Growth	4.1%	1.6%	2.5%

3.33 Labour productivity is an important component of efficiency, but labour inputs account for only around half of the total cost of the NHS. A broader measure of productivity divides total output by an appropriate measure of all inputs, for example including drugs. This is called total factor productivity and York University also produce figures on this basis. Their figures show that between 2005/06 and 2015/16 the NHS's average annual labour productivity was 1.2%.

Figure 3.7: Total Factor Productivity Data from York University (CHE)

	Total Output Growth	Total Factor Input Growth	Total Factor Productivity Growth
2005/06	7.1%	7.2%	-0.1%
2006/07	6.5%	1.9%	4.5%
2007/08	3.7%	3.9%	-0.2%
2008/09	5.7%	4.2%	1.4%
2009/10	4.1%	5.4%	-1.3%
2010/11	4.6%	1.3%	3.2%
2011/12	3.2%	1.0%	2.1%
2012/13	2.3%	2.0%	0.4%
2013/14	2.6%	0.4%	2.2%
2014/15	2.5%	1.9%	0.5%
2015/16	2.6%	2.6%	0.0%
Average Annual Growth	4.1%	2.9%	1.2%

3.34 More generally, productivity, as formally defined here, does not take into account the costs of inputs, including changes in staff pay. A full measure of technical efficiency would, in addition, factor in changes in pay and the cost of inputs relative to a suitable deflator. If pay increases more quickly than GDP deflator, this would have a negative effect on technical efficiency.

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

3.36 The input factor of productivity can be more easily broken down by staff group. The labour input in York CHE's productivity measure is a weighted combination of different staff groups; the growths for each staff group is summarised in Chapter 6 of this submission.

3.37 As part of the long-term funding settlement, the NHS has committed to achieve cash-releasing productivity growth of at least 1.1% a year.

Conclusion

3.38 The Government has reiterated its commitment to the NHS through the long-term funding settlement that will deliver real terms increases in its budget of over £20 billion per year over.

3.39 Government's continued support for the NHS workforce was further underlined by recently announced pay rises, reflective of the more flexible approach to public sector pay than had previously been pursued by Government. These pay deals have rewarded staff dedication and productivity improvements, as well as encouraging recruitment and retention.

3.40 The long-term nature of the settlement will give the NHS the security to implement its Long Term Plan for the service, determining the direction of the NHS over the next decade, and putting the service on a more sustainable footing to meet the demands of the future.

3.41 Pay forms one part of a wider rewards package that includes pensions, and as a whole is intended to recognise the hard work of the NHS workforce.

4. Hospital and Community Health Services (HCHS) Agenda for Change Staff Earnings

Chapter Summary

4.1 With the introduction of a reformed Agenda for Change (AfC) contract, basic pay has grown. Staff on pay bands 1 and 2 have seen larger increases than those in the higher pay bands. As well as basic pay, shift work, geographical allowances and overtime continue to be the most common other elements of pay.

4.2 Comparing with the wider economy, earnings growth has consistently been lower for non-medical staff since 2010-11 However, this is based on the average growth across all staff and does not consider individual pay journeys or the impact of increments via Agenda for Change, for which data here has yet to reflect the AfC reforms effective from 1 April 2018. The recent growth in the private sector also follows a period in which average earnings growth was higher in the public sector during the 2000s.

HCHS Earnings, Earnings Growth & Pay Progression

4.3 Most non-medical staff are employed on the AfC contact underpinned by the national Job Evaluation Scheme (JES). This system allocates each job role to a band based on a range of factors with pay rates in 2018-19 ranging from £17,460 for roles at the bottom of Band 1 to £102,506 at the top of Band 9.

4.4 Figure 4.1 shows the current AfC pay scales in 2018-19 as well as a comparison with 2013-14. The growth in Basic Pay has been highest for Bands 1 and 2 and reflects the removal of pay point 1 in 2016 as well as the introduction of the new AfC contract. Under the AfC pay and contract reform deal, Band 1 was removed in December 2018.

4.5 As of April 2018, 43% of non-medical staff were at the top of their AfC Band – The new spine points were introduced in April 2018, but this change was largely implemented with the pay rise that came in August. As such, while the data we have supplied as at April 2018 this year is correct, it does not reflect the current AfC structure which includes higher starting pay for most pay bands with fewer pay points which, subject to staff meeting the required standards for their role, allows them to reach the top of their Band sooner.

Figure 4.1: AfC pay scales in 2018-19 and comparison with 2013-14

		Basic Pay 13/14	Basic Pay 18/19	Growth in Basic Pay	Proportion at top of Pay Band (April 2018)
Band 1	Bottom	14,294	17,460	22.1%	
	Top	15,013	17,460	16.3%	86%
Band 2	Bottom	14,294	17,460	22.1%	
	Top	17,425	18,702	7.3%	44%
Band 3	Bottom	16,271	17,787	9.3%	
	Top	19,268	20,448	6.1%	48%
Band 4	Bottom	18,838	20,150	7.0%	
	Top	22,016	23,363	6.1%	46%
Band 5	Bottom	21,388	23,023	7.6%	
	Top	27,901	29,608	6.1%	39%
Band 6	Bottom	25,783	28,050	8.8%	
	Top	34,530	36,644	6.1%	37%
Band 7	Bottom	30,764	33,222	8.0%	
	Top	40,558	43,041	6.1%	44%
Band 8a	Bottom	39,239	42,414	8.1%	
	Top	47,088	49,969	6.1%	42%
Band 8b	Bottom	45,207	49,242	8.9%	
	Top	56,504	59,964	6.1%	46%
Band 8c	Bottom	54,998	59,090	7.4%	
	Top	67,805	71,243	5.1%	44%
Band 8d	Bottom	65,922	70,206	6.5%	
	Top	81,618	85,333	4.6%	47%
Band 9	Bottom	77,850	84,507	8.6%	
	Top	98,453	102,506	4.1%	44%

Source – NHS Employers

4.6 Hourly pay rates for AfC staff can be compared to the National Living Wage, which is the compulsory legal minimum pay rate and the voluntary Foundation Living Wage which has been calculated by the Living Wage Foundation[vi].

Figure 4.2: Agenda for Change minimums vs National Living Wage and Foundation Living Wage

	Inner London	Outer London	London Fringe	Rest of England
Agenda for Change Minimum	£11.14	£10.80	£9.44	£8.93
National Living Wage	£7.83	£7.83	£7.83	£7.83
Foundation Living Wage	£10.55	£10.55	£9.00	£9.00

New Agenda for Change Contract and Pay Progression

4.7 The reformed AfC contract was introduced at the start of 2018-19 and was largely implemented in August 2018. The reformed contract introduced several changes to the banding structure including closing Band 1 to new entrants (effective from 1 December 2018) and through fewer pay points, reducing the time it takes to reach the top of a pay band for those staff in Bands 1-7.

4.8 The AfC agreement is a 3-year agreement which sets out the pay points from 2018-19 to 2020-21. The table below compares the year before the new contract (2017-18) with the position after implementation (2020-21) to show the impact that the reformed contract will have on both starting basic pay and pay progression.

4.9 The reformed contract will increase starting pay by between 13% and 23% and there will be increases to the top of each pay range. It will also introduce changes to the system of pay progression with a reduction in the number of pay points in each band meaning that by the 6th year of experience, all staff will have reached the top of the pay band.

Figure 4.3: Agenda for Change basic pay vs 6th year basic pay

	Starting Basic Pay		6th Year Basic Pay	
	Contract as of 2017/18	Reformed Contract	Contract as of 2017/18	Reformed Contract
AfC Band 1	£15,404	£18,005	£15,671 (1.7%)	£19,337 (7.4%)
AfC Band 2	£15,404	£18,005	£17,524 (13.8%)	£19,337 (7.4%)
AfC Band 3	£16,968	£19,737	£18,157 (7%)	£21,142 (7.1%)
AfC Band 4	£19,409	£21,892	£22,128 (14%)	£24,157 (10.3%)
AfC Band 5	£22,128	£24,907	£26,565 (20.1%)	£27,416 (10.1%)
AfC Band 6	£26,565	£31,365	£31,696 (19.3%)	£33,779 (7.7%)
AfC Band 7	£31,696	£38,890	£37,777 (19.2%)	£41,723 (7.3%)
AfC Band 8a	£40,428	£45,753	£48,514 (20%)	£51,668 (12.9%)
AfC Band 8b	£47,092	£53,168	£58,217 (23.6%)	£62,001 (16.6%)
AfC Band 8c	£56,665	£63,751	£69,168 (22.1%)	£73,664 (15.5%)
AfC Band 8d	£67,247	£75,914	£83,258 (23.8%)	£87,754 (15.6%)
AfC Band 9	£79,415	£91,004	£100,431 (26.5%)	£100,927 (15.3%)

Source – NHS Employers

4.10 The agreement reduces the number of pay points within each band and in Bands 1-7, reduces the length of time required for staff to reach the top of their pay band. This is shown in the figure below. For instance, it will take 4 years for an individual

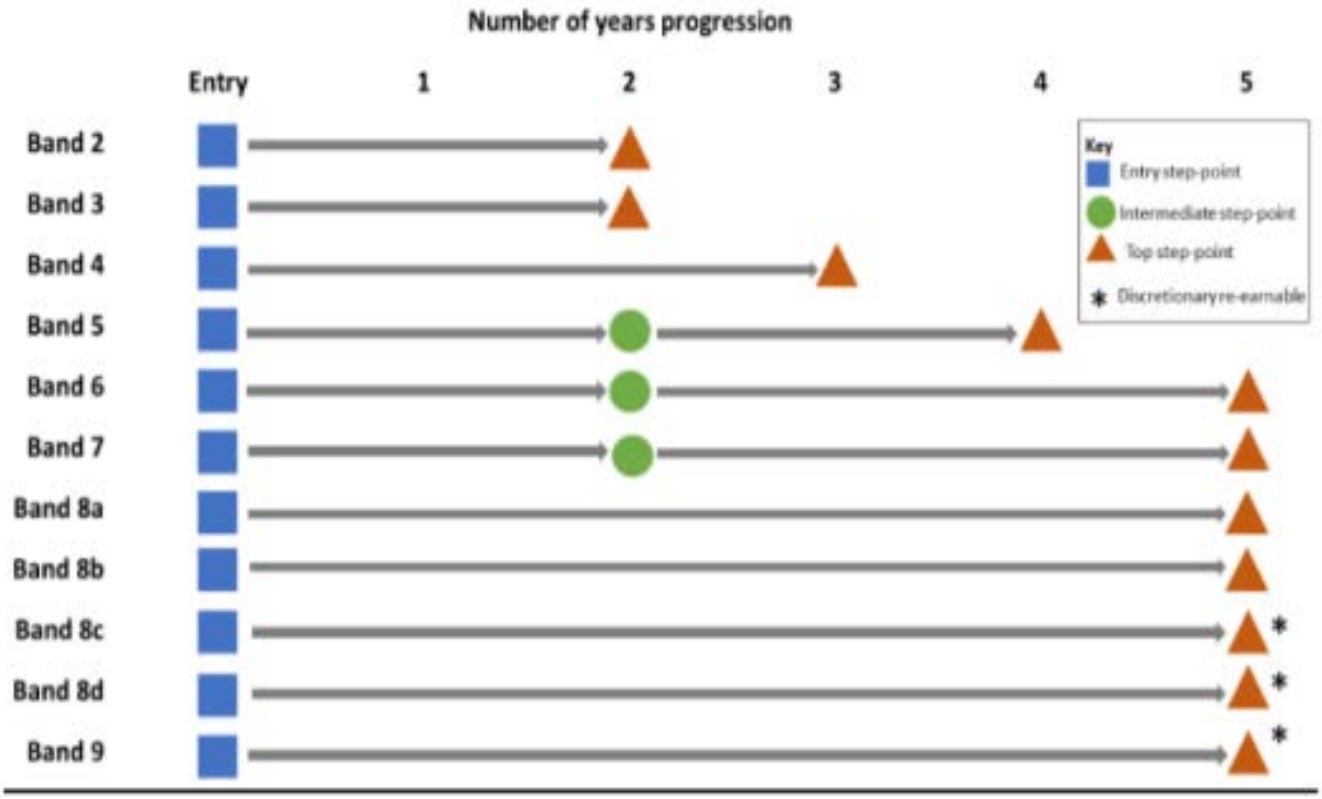
to reach the top of Band 5 compared with 7 years under the pre- 1 April 2018 pay structure.

4.11 In Bands 5, 6 and 7 there will still be intermediate pay points after 2 years of experience. These increments will be worth between 6% and 8% depending on the band.

Current Base Pay, Total Earnings and Allowances

4.12 This section provides information on earnings for non-medical staff including the difference between basic pay and additional earnings.

Figure 4.4: AfC Contract Pay Structure



Source NHS Employers

4.13 Figure 4.5 shows the three measures of earnings published by NHS Digital:

- earnings per person measures the average total earnings including any additional payments, for example, unsocial hours, geographical allowance;
- basic pay per full time equivalent (FTE) measures the basic pay received and is scaled to take account of Part Time working; and

- basic pay per person measures the basic pay received and does not make any adjustment for part time working – it will therefore be lower than the per FTE measure.

4.14 Earnings per FTE is not published by NHS Digital – this is because not all types of earnings can be scaled in the same way as basic pay (for example, it cannot be assumed that if someone increased their hours from 0.5 FTE to 1 FTE they would also double any overtime payments).

Figure 4.5: Measures of earnings per staff group 12 months to March 2018

Staff Group	Earnings per person	Basic pay per person	Basic pay per FTE
Nurses & health visitors	£31,683	£27,903	£31,519
Midwives	£31,671	£26,976	£33,160
Ambulance staff	£36,318	£25,950	£27,632
Scientific, therapeutic & technical staff	£32,556	£30,051	£35,158
Support to clinical staff	£18,686	£16,352	£19,175
Support to doctors, nurses & midwives	£18,464	£16,077	£18,927
Support to ambulance staff	£23,516	£18,089	£19,975
Support to ST&T staff	£18,323	£16,996	£20,057
NHS infrastructure support	£27,945	£25,745	£28,669
Central functions	£24,652	£23,316	£25,838
Hotel, property & estates	£17,681	£14,527	£18,014
Senior managers	£76,508	£73,370	£78,156
Managers	£47,705	£45,330	£47,789
Other staff or those with an unknown classification	£13,314	£12,404	£11,912

Source – NHS Digital Earnings Statistics for 12 Months to March 2018

4.15 Figure 4.6 shows the different additional pay allowances that are available under the AfC contract and the proportion of staff that are in receipt of them (Geographical Allowances I.e. High Cost Area Supplements, unsocial hours and recruitment and retention premia (RRPs)).

4.16 The most common allowances received were for people working unsocial hours (Shift Work) and for those working in areas with geographical allowances. The ‘Support to Ambulance staff’ group were most likely to receive additional payments for overtime.

Figure 4.6: Pay allowances available under Agenda for Change contract and proportion of staff in receipt of them

Staff Group / Medical Grade	Additional Activity	Geographical Allowances	Local Payments	On-Call	Overtime	RRP	Shift Work	Other
Nurses & health visitors	4.9%	21.0%	3.5%	4.2%	7.2%	0.8%	59.2%	2.1%
Midwives	7.2%	24.3%	6.1%	19.3%	3.2%	0.7%	78.4%	2.2%
Ambulance staff	23.5%	19.9%	27.9%	4.6%	56.9%	0.1%	96.7%	2.6%
Scientific, therapeutic & technical staff	5.3%	21.7%	6.4%	12.2%	9.2%	1.0%	24.7%	2.2%
Support to clinical staff	6.6%	17.7%	3.3%	1.0%	7.8%	0.3%	42.1%	2.9%
Support to doctors, nurses & midwives	5.8%	18.1%	2.6%	0.7%	5.9%	0.3%	44.2%	3.1%
Support to ambulance staff	18.2%	10.8%	15.7%	2.7%	39.6%	0.1%	77.2%	2.5%
Support to ST&T staff	7.3%	17.6%	3.0%	1.8%	8.4%	0.2%	24.6%	1.9%
NHS infrastructure support	8.2%	17.6%	4.7%	4.5%	8.3%	1.1%	22.8%	2.0%
Central functions	2.8%	20.8%	3.0%	2.5%	4.3%	0.6%	5.3%	1.6%
Hotel, property & estates	19.1%	10.8%	5.9%	4.1%	17.3%	1.8%	56.2%	2.6%
Senior managers	0.8%	17.2%	9.2%	13.7%	0.1%	1.1%	2.8%	1.9%
Managers	1.2%	25.0%	5.4%	9.2%	1.9%	0.9%	4.4%	1.8%
Other staff	3.3%	11.0%	4.7%	0.6%	3.4%	0.2%	18.1%	1.9%

Source – NHS Digital Earnings Publication

4.17 Figure 4.7 shows the average value of allowances for those who received them based on data from the Electronic Staff Record and published by NHS Digital. Figures may include negative payments to recover previous overpayments or large, one-off, payments.

Figure 4.7: Average value of allowances

Staff Group / Medical Grade	Additional Activity	Geographical Allowances	Local Payments	On-Call	Overtime	RRP	Shift Work	Other
Nurses & health visitors	£3,117	£4,010	£1,959	£1,992	£3,877	£1,252	£3,869	£2,414
Midwives	£2,710	£3,728	£1,122	£1,206	£3,545	£1,813	£3,966	£2,426
Ambulance staff	£1,967	£3,481	£1,523	£1,965	£4,899	£3,902	£6,178	-£2,027
Scientific, therapeutic & technical staff	£3,680	£4,046	£3,063	£3,264	£3,403	£3,146	£1,678	£3,463
Support to clinical staff	£1,993	£2,952	£1,125	£1,924	£2,771	£1,479	£3,239	£1,250
Support to doctors, nurses & midwives	£2,071	£2,931	£1,088	£1,557	£2,701	£1,371	£3,383	£1,242
Support to ambulance staff	£1,555	£2,947	£1,528	£1,942	£3,444	£4,110	£4,056	£1,301
Support to ST&T staff	£1,988	£3,034	£716	£2,560	£2,207	£1,715	£1,485	£1,285
NHS infrastructure support	£3,606	£3,725	£2,358	£2,945	£3,348	£3,771	£2,739	£2,866
Central functions	£4,736	£3,674	£1,641	£2,849	£3,250	£3,592	£2,038	£2,833
Hotel, property & estates	£1,922	£2,880	£1,263	£3,497	£3,255	£3,012	£2,851	£1,390
Senior managers	£130,449	£4,077	£6,835	£2,371	£6,487	£8,743	£1,028	£10,529
Managers	£29,158	£4,824	£3,780	£2,730	£6,499	£5,576	£2,405	£5,219
Other staff	£2,316	£2,618	£1,901	£1,600	£2,023	£2,067	£1,960	£918

Source – NHS Digital Earnings Publication for the 12 months to March 2018

4.18 Just under 1% of all non-medical staff received a RRP There is some variation across staff groups, regions and bands:

- professionally qualified staff were more likely to receive RRP payments than Support to Clinical Staff;
- staff in the South of England were more likely to receive RRP payments; and
- more senior staff were more likely to receive RRP payments.

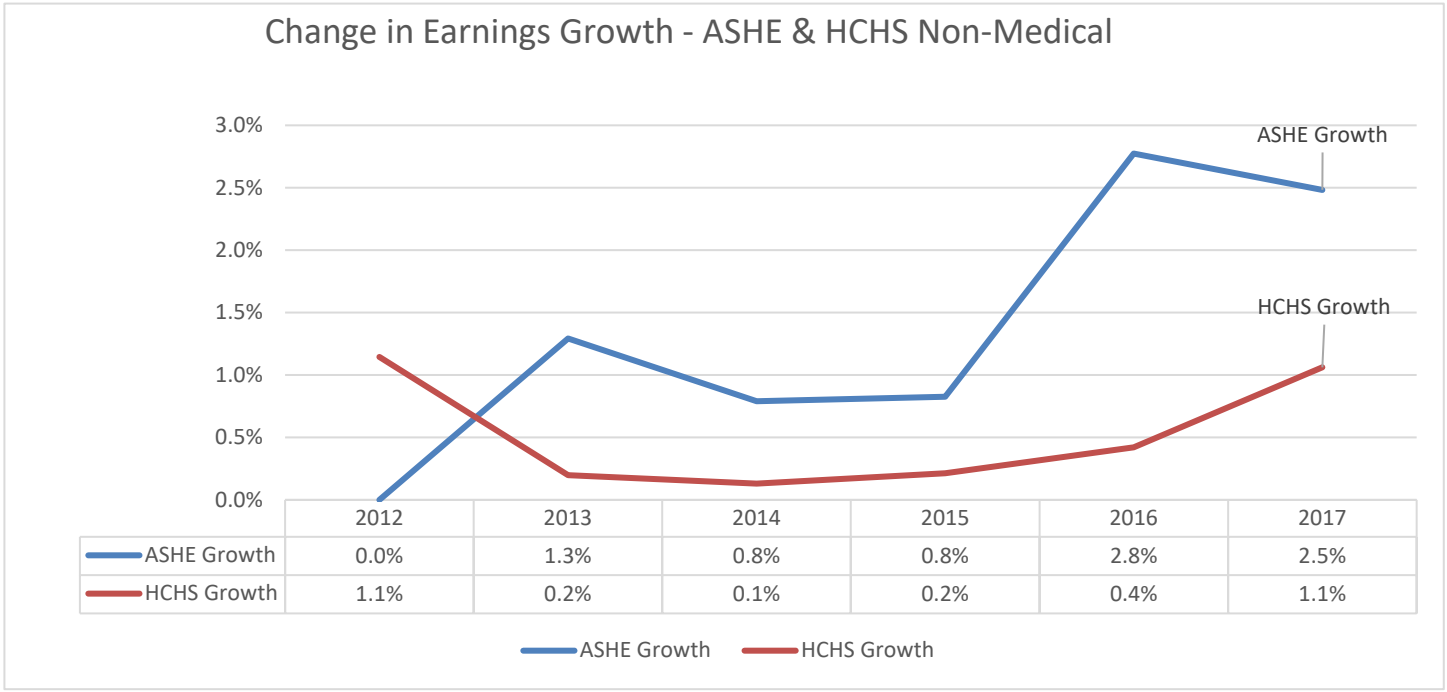
4.19 Historically, the percentage of staff receiving an RRP has remained the same over the last several years.

Changes in Earnings

4.20 Figure 4.8 compares the annual change in earnings since 2011 for non-medical staff and the wider economy. Earnings growth has consistently been lower for non-medical staff than in the wider economy over this period – however this is based on the average growth across all staff and does not consider individual pay journeys or the impact of annual increments for staff that have not reached the top of their pay band.

4.21 Figure 4.8 begins in 2012 because 2010 was the first full year that earnings data is available for the HCHS sector.

Figure 4.8: Change in earnings growth - non-medical staff and wider economy 2012-2017

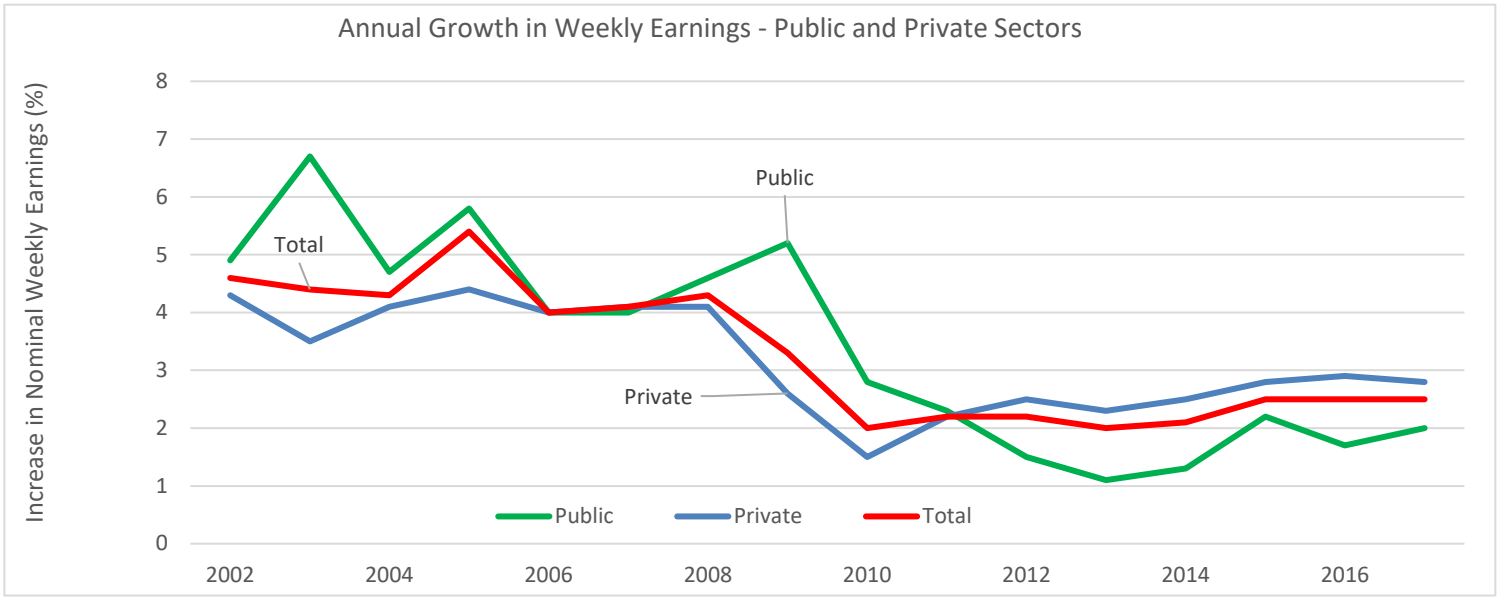


	2012	2013	2014	2015	2016	2017
ASHE Growth	0.0%	1.3%	0.8%	0.8%	2.8%	2.5%
HCHS Growth	1.1%	0.2%	0.1%	0.2%	0.4%	1.1%

4.22 Over a longer time period there have been differences in the average earnings of people in the Public and Private sectors. Figure 4.9 shows average growth in gross weekly earnings for the Public and Private sectors between 2002 and 2017. It shows that throughout the period 2002 – 2011 earnings growth was higher in the Public sector before Private earnings growth increased following the financial crisis.

Figure 4.9: Average growth in gross weekly earnings

Source – Office for National Statistics



4.23 For the 12 months to March 2018 average earnings per person ranged from £18,300 for Support to Scientific, Therapeutic & Technical Staff (STT) to £76,500 for Senior Managers.

4.24 These figures are based on average earnings across a staff group at a given point in time. Changes over time can be influenced by changes to the composition of a staff group over that time. For example, in the case of ambulance staff, the 0% increase in earnings may be caused by an increase in staff numbers and may mean a higher proportion of staff are in less senior positions. Individual members of staff will have been eligible for pay increases including annual increments for those not at the top of their AfC Pay Band.

Figure 4.10: Changes in earnings by quartile and mean - non-medical staff and wider economy, 13/14 to 17/18

	Lower Quartile – 25% earn less than			Median 50% earn more than			Upper Quartile 25% earn more than			Mean		
	13/14	17/18	Growth	13/14	17/18	Growth	13/14	17/18	Growth	13/14	17/18	Growth
UK Economy via ASHE	£13,191	£14,458	9.6%	£22,069	£23,474	6.4%	£34,000	£35,870	5.5%	£27,316	£29,009	6.2%
Nurses, Midwives & Health Visitors	£26,000	£26,500	1.9%	£31,500	£32,000	1.6%	£37,000	£38,000	2.7%	£30,917	£31,683	2.5%
Ambulance staff	£31,500	£30,500	-3.2%	£36,500	£37,500	2.7%	£42,500	£43,000	1.2%	£36,300	£36,318	0.0%
Scientific, therapeutic & technical staff	£24,500	£25,000	2.0%	£31,500	£32,500	3.2%	£40,000	£41,000	2.5%	£32,225	£32,556	1.0%
Support to clinical staff	£14,500	£15,500	6.9%	£18,500	£19,000	2.7%	£22,500	£23,000	2.2%	£18,003	£18,686	3.8%
Central Functions, Hotel, Property & Estates	£14,500	£15,500	6.9%	£19,500	£20,000	2.6%	£26,500	£27,000	1.9%	£20,989	£21,687	3.3%
Managers & Senior Managers	£42,000	£42,000	0.0%	£52,500	£51,500	-1.9%	£68,000	£68,500	0.7%	£56,926	£56,925	0.0%

4.25 Due to the range of jobs in the NHS figures for the whole service can mask what is happening within individual staff groups. Figure 4.5 shows average earnings per person for different staff groups. It shows that pay growth has been generally lower in the NHS when compared to the wider economy as measured through ASHE data.

4.26 These figures will not consider the impact of the AfC pay deal which was effective from 2018-19. This will increase earnings most for those in the less senior AfC grades.

4.27 Earnings growth has tended to be lower for non-medical staff than has been seen in the wider economy. Across all sectors, income growth has been just over 6% compared to growth of between 0% and 4% for the non-medical sector.

4.28 There is variation in the levels of earnings growth across non-medical staff groups. Mean earnings growth has been highest for those in support to clinical and infrastructure support roles and lowest for Managers, Senior Managers and Ambulance staff.

4.29 Growth has tended to be higher for those in the lower portion of the income distribution. For Support to Clinical Staff the lower quartile increased by almost 7% compared to 2.2% for the upper quartile – this may be linked to the removal of the lowest spine point over the period.

Current pay levels versus comparator groups in the wider economy

4.30 An alternative comparison would be to compare earnings in the NHS to those in the wider economy using data from the Annual Survey of Hours and Earnings (ASHE). Comparison groups have been chosen to compare roles that are broadly similar in terms of:

- qualifications, training and experience;
- responsibilities and risk;
- skills and competencies;
- seniority; and
- leadership and management.

4.31 The table below shows the mapping that has been used to compare ASHE data with the NHS Pay Review Body remit group. For example, Support to Clinical staff are compared against the Caring, Leisure and other Service occupations from ASHE.

Figure 4.11: Mapping used to compare ASHE data with NHSPRB remit group

ASHE Group	NHS Comparison
Managers, directors and senior officials	Managers
Professional occupations	Qualified Clinical Staff
Associate professional and technical occupations	Qualified Clinical Staff
Administrative and secretarial occupations	Central Functions
Skilled trades occupations	Hotel, Property & Estates
Caring, leisure and other service occupations	Support to Clinical Staff
Elementary occupations	Hotel, Property & Estates
Skilled trades occupations	Hotel, Property & Estates

4.32 The table below shows that the mean annual earnings growth for NHS staff has been lower than comparators across the wider economy in the last five years.

Figure 4.12: Mean annual earnings growth for NHS staff vs comparators

	HCHS Earnings				Percentage Change	
	Earnings per Headcount		Whole Economy Earnings of Comparator Group Means		HCHS Group 2013/14 to 2017/18	Comparator Group 2013 to 2017
NHSPRB Remit Group	2013/14	2017/18	2013	2017	Mean	Mean
Hotel, Property & Estates	£16,959	£17,679	£18,158	£19,615	4.2%	8.0%
Support to Clinical Staff	£17,984	£18,696	£13,673	£14,443	4.0%	5.6%
Central Functions	£23,285	£24,670	£18,630	£19,808	6.0%	6.3%
Qualified Health Professionals	£31,481	£32,134	£35,097	£36,151	2.1%	3.0%
Managers	£47,366	£47,690	£52,282	£54,774	0.7%	4.8%

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

Longitudinal Pay Analysis

4.33 Analysis of data from the Electronic Staff Record shows there were around 600,000 non-medical staff employed in both March 2010 and March 2018. The median average increase in Basic Pay per FTE for these staff was 21.5%.

4.34 In the period 2010-2018 median average increases ranged from 18.9% for Support to Clinical Staff to 24.9% for STT staff. Increases were higher where staff received a promotion and moved to a higher AfC Band.

4.35 This measure considers individual pay journeys, including the impact of annual incremental pay increases and so presents a picture of the increase in pay experienced by actual staff. This is not captured by earnings statistics which look at averages over whole workforces.

4.36 This is important because the incremental pay system means that annual incremental pay increases can be higher than the annual increase to pay scales.

4.37 Figure 4.13 considers those staff who were employed in both March 2010 and March 2018. The figures show the difference in Basic Pay per FTE for people employed at both time points.

- There were just over 200,000 nurses & midwives employed in both March 2010 and March 2018. For these staff the median increase in Basic Pay was 22% and 25% of staff received an increase of over 36.5%.

- Staff in the Support to Clinical staff group had lower increases than professionally qualified staff.

- The staff with the largest increases were those who received a promotion over the period.

Figure 4.13: Difference in basic pay per FTE for people employed in both March 2010 and March 2018

Change in Basic Pay per FTE between March 2010 & March 2018 Percentage Increase in Basic Pay per FTE	25% received growth of less than 25%	Median	25% received growth of more than 25%	Headcount	Annualised Rate (Median)
Headline Staff Group					
NHS Infrastructure Support	12.4	23.1	39.1	117,063	3.0%
Qualified Ambulance Staff	10.7	24.6	39	12,068	3.2%
Qualified Scientific, Therapeutic & Technical Staff	10	24.9	42.7	90,313	3.2%
Qualified nursing, midwifery & health visiting staff	8.6	22	36.5	207,222	2.9%
Support to Clinical Staff	11.2	18.9	27.9	175,574	2.5%
Total	11.2	21.5	35.2	602,240	2.8%

Source – DHSC Analysis of Electronic Staff Record Data Warehouse

4.38 A similar analysis can be conducted for people who were employed in both March 2017 and March 2018. Those eligible for incremental pay will have received an increase of around 3.5% while those at the top of their pay band (and no longer eligible for incremental pay increases) will have received an increase of 1% in line with changes to headline pay scales.

Figure 4.14: Difference in basic pay per FTE for people employed in both March 2017 and March 2018

Change in Basic Pay per FTE between March 2017 & March 2018 Percentage Increase in Basic Pay per FTE	25% received growth of less than	Median	25% received growth of more than	Headcount
Headline Staff Group				
NHS Infrastructure Support	1	2	4.6	186,905
Qualified Ambulance Staff	1	4.1	5.1	18,305
Qualified Scientific, Therapeutic & Technical Staff	1	3.5	5.1	136,340
Qualified nursing, midwifery & health visiting staff	1	3.5	5.1	298,552
Support to Clinical Staff	1	1	3.8	301,515
Total	1	2	4.5	941,617

Source – DHSC Analysis from Electronic Staff Record Data Warehouse

4.39 Figure 4.14 highlights the impact of progression under the previous AfC contract. In all staff groups there were some individuals who received an increase of 1%, in line with the headline pay award. The median increase was generally in line with people moving to the next pay increment (increases of around 3.5%) and the upper quartile receiving higher increases – perhaps due to being promoted to the next pay band.

Regional Variation

4.40 Data from the Annual Survey of Hours and Earnings shows that over the past four years earnings growth has been highest in the South West and North East (7%) and lowest in the East Midlands (4%)

Figure 4.15: Whole economy median earnings per person growth by region, 2013 to 2017. Indices: 2013=100

Source: ONS annual survey of hours and earnings data 2017

5. Workforce Strategy

Workforce Strategy

5.1 Effective workforce policy is critical to the delivery of affordable, high quality care. Ensuring that the NHS has access to the right mix and number of staff who have the skills, values and experience to deliver high quality, affordable care is a fundamental aspect of the Department of Health and Social Care's overarching strategic programme for the health and care system.

5.2 The Department of Health and Social Care is responsible for leading, shaping and funding healthcare in England. The Department works with system partners to ensure there is a highly engaged and motivated workforce delivering NHS services to patients.

5.3 The Department works through its Arms-Length Bodies (ALBs) on the delivery and implementation of workforce policy. NHS England is the ALB responsible for setting the priorities and direction of the NHS and encouraging and informing the national debate to improve health and care. NHS England will be chiefly responsible for delivering a credible workforce plan, with education and training of the workforce being the core functions of Health Education England.

5.4 This year, NHS England and NHS Improvement agreed new joint working arrangements; including the creation of a People directorate led by a new Chief People Officer. The Chief People Officer, working closely with Health Education England, NHS Employers and other national partners, will have responsibility for providing a cohesive approach to improving leadership and management of the NHS workforce.

5.5 Additionally, Health Education England and NHS Improvement have agreed to a number of measures to improve how both organisations work together. These include new governance procedures for the Health Education England mandate. These new arrangements supersede the Workforce Strategy Board, which we established last year and which no longer meets.

5.6 The NHS Long-Term Plan published in January 2019 sets out a vital strategic framework to ensure that over the next ten years the NHS will have the staff it needs so that nurses and doctors have the time they need to care, working in a supportive culture that allows them to provide the expert compassionate care they are committed to providing.

5.7 It highlights the following objectives as most important for the workforce:

- ensuring we have enough people, with the right skills and experience, so that staff have the time they need to care for patients well;

- ensuring our people have rewarding jobs, work in a positive culture, with opportunities to develop their skills and use state of the art equipment, and have support to manage the complex and often stressful nature of delivering healthcare;

- strengthen and support good, compassionate and diverse leadership at all levels – managerial and clinical – to meet the complex practical, financial and cultural challenges a successful workforce plan and Long Term Plan will demand.

5.8 Critically, the plan is not just about numbers. It focusses on ensuring that our dedicated staff are supported, valued and empowered to do their best, with clear commitments to tackle bullying, discrimination and violence and a programme of work to sustain the physical and mental health of staff who work under pressure every day and every night.

5.9 To ensure a detailed plan that everyone in the NHS can get behind, the Secretary of State has commissioned Baroness Harding, Chair of NHS Improvement, to lead a rapid and inclusive programme of work to set out a detailed workforce implementation plan to be published in the Spring. The plan will be concise and delivery focussed, detailing what progress can be made on the commitments in the Long-Term Plan, identifying a series of actions to deliver on these commitments.

6. Recruitment, Retention, Motivation and Non-Medical Workforce Planning

Chapter Summary

6.1 The overall non-medical NHS workforce has increased by 69,587 FTEs (7.9%) between March 2013 and March 2018.

6.2 The number of EU27 non-medical staff have also increased by over 5,000 between March 2016 and March 2018 and now form 4.8% of all non-medical staff on a headcount basis.

6.3 The non-medical workforce is predominately female (approximately 77%) and more ethnically diverse when compared to statistics for all employees across all industries.

6.4 New data published by NHS Improvement shows that the vacancy rate has remained stable over the last five quarters – ranging from between 9.4% and 8.9%, which is equivalent to between 88,000 FTE and 96,000.

6.5 Data shows that the overall stability index (proportion who stay in the workforce over the year) and sickness absence rates have remained broadly the same.

Background

6.6 Effective workforce policy is critical to the delivery of affordable, high quality care. Securing the people with the right values, skills, experience and expertise which the NHS needs is central to the future of England's health and care system.

6.7 The Department is responsible for leading, shaping and funding healthcare in England. The Department works with system partners to ensure there is a highly engaged and motivated medical and non-medical workforce delivering NHS services to patients. The Department works through its Arms-Length Bodies (ALBs) on the delivery and implementation of workforce policy. Building on recent, constructive joint work to develop workforce priorities for NHS England's NHS Long-Term Plan, HEE, NHS Improvement, and DHSC have agreed new, joint working arrangements, for example working together to develop HEE's mandate. These will help ensure that our organisations work much more closely together to

support local health systems to recruit, train, develop and retain the staff the NHS depends upon, while enhancing leadership across the service.

6.8 Effective workforce planning requires reliable and accurate workforce information at both national and local level. HEE's national workforce planning for England is underpinned by national data collected by NHS Digital and a comprehensive local workforce planning process. This process includes working with Sustainable Transformation Plans and Local Workforce Advisory Boards, to ensure delivery plans reflect the needs of local service users.

6.9 A sustainable approach to long-term nursing supply is essential to workforce planning, therefore we will continue to work with the Home Office to ensure that after we leave the EU we will have in place an immigration system which works in the best interests of the whole of the UK. We deeply value the contribution of all EU nurses working in the NHS and social care, and our first priority has always been to provide certainty to these EU citizens.

6.10 We are aware, however, that we cannot rely on overseas recruitment alone and have in place longer term plans to ensure we have the right skills domestically. In view of this, the Department has oversight of a package of measures currently being implemented by a number of ALBs to ensure the required workforce is in place to deliver safe and effective services. These measures look to broaden routes into nursing, work with trusts on a range of recruitment, retention, sickness absence and return to practice programmes, and grow the undergraduate nursing degree supply route.

6.11 Recent changes to the nurse education funding system mean that we have moved away from centrally imposed number controls and have enabled universities to invest sustainably for the long term and increase student places to meet market demand. We are working with HEE and the university sector to ensure students continue to apply for the additional 5,000 nurse training places that have been made available each year, up to the end of clearing in October 2018 and in future years.

6.12 The Department is in the process of consulting with key stakeholders on the outcomes of these changes to student funding, alongside work being done to ensure a sustainable approach to long-term nursing supply.

6.13 The NHS Long Term Plan sets out that the national workforce group will agree action to improve supply over the course of the Long Term Plan. This will centre on increasing the number of undergraduate nursing degrees, reducing attrition

from training and improving retention, with the aim of improving the nursing vacancy rate to 5% by 2028.

6.14 HEE is best placed to address any questions that the Review Body may have about the quality of workforce planning or the evidence base that underpins its decisions on future workforce investment.

Numbers in work

6.15 The overall non-medical NHS workforce has increased by 69,587 FTEs (7.9%) between March 2013 and March 2018. All areas apart from Central functions and Hotel, property and estates have seen increases. Increases vary from 4% growth in nurses and health visitors to 21.1% increase in support for ambulance staff.

Figure 6.1: Non-medical staff FTE March 2013 to March 2018

Staff groups	Mar-13	Mar-18	Change (FTE)	% Change
Nurses and health visitors	274,803	285,745	10,942	4.0%
Midwives	20,741	21,790	1,049	5.1%
Ambulance staff	17,647	20,552	2,905	16.5%
Scientific, therapeutic and technical staff	122,630	136,549	13,919	11.4%
Support to doctors, nurses and midwives	215,562	245,602	30,040	13.9%
Support to ambulance staff	12,565	15,219	2,654	21.1%
Support to ST&T staff	48,596	57,312	8,716	17.9%
Senior managers	9,710	10,233	523	5.4%
Managers	21,331	22,355	1,024	4.8%
Central functions	83,441	82,649	-792	-0.9%
Hotel, property and estates	53,773	52,380	-1,393	-2.6%
Total	880,799	950,386	69,587	7.9%

Source: NHS Digital HCHS monthly workforce publication

6.16 As context and as shared within chapter 4, most non-medical staff in the NHS hold roles that are covered by the Agenda for Change (AfC) contract with pay rates in 2018-19 ranging from £17,460 for roles at the bottom of Band 1 to £102,506 at the top of Band 9.

6.17 Growth in Basic Pay has been highest for Bands 1 and 2 and reflects the removal of pay point 1 in 2016 as well as the introduction of the new Agenda for Change contract from April 2018.

6.18 As of April 2018, 43% of Non-Medical staff were at the top of their AfC Pay Band – The new spine points were introduced in April 2018, but this change was largely implemented with the pay rise that came in August. As such, while the data we have supplied as at April 2018 this year is correct, it does not reflect the current AfC structure which has reduced the number of pay points in some bands allowing individuals to reach the top of the band sooner.

Diversity Analysis

6.19 The non-medical workforce is more ethnically diverse when comparing statistics for all employees and their declared ethnicity, where 88% identify as white[vii].The chart below shows a snapshot of the ethnic diversity of the non-medical workforce as at September 2017. The data shows that the majority of each staff group are predominately white at 77.1%. Compared to other staff groups, the ambulance staff group has the highest percentage of white people (94%). Nurses and health visitors are the most ethnically diverse of all the staff groups, 25% of nurses and health visitors are not white. Of those, 8.5% are Asian or Asian British and 7.6% are Black or Black British. This may be due to international recruitment to drive up nursing numbers.

6.20 Looking at the available data (2015 onwards) for diversity, there appears to be some small percentage increases in ethnic diversity over time which is further analysed in figure 6.6 and 6.7. Our understanding of this data will likely increase with time and as more data becomes available.

Figure 6.2: Diversity snapshot at 2017

September 2017 (Headcount)	White	Black or Black British	Asian or Asian British	Mixed	Chinese	Any Other Ethnic Group	Not Stated	Unknown
Nurses and health visitors	75.2%	7.6%	8.5%	1.3%	0.4%	3.2%	3.3%	0.6%
Midwives	85.4%	7.0%	1.8%	1.4%	0.3%	0.6%	3.0%	0.5%
Ambulance staff	93.5%	0.6%	1.0%	0.9%	0.1%	0.2%	3.5%	0.1%
Scientific, therapeutic and technical staff	81.9%	3.3%	7.9%	1.5%	0.7%	1.1%	3.0%	0.6%
Support to doctors, nurses and midwives	79.7%	6.4%	6.6%	1.5%	0.2%	1.6%	3.2%	0.6%
Support to ambulance staff	89.8%	1.5%	2.4%	1.2%	0.1%	0.1%	3.6%	1.4%
Support to ST&T staff	82.4%	4.2%	6.6%	1.6%	0.3%	1.2%	3.2%	0.6%
Central functions	81.2%	4.7%	7.4%	1.5%	0.4%	0.7%	3.4%	0.7%
Hotel, property and estates	79.7%	5.5%	6.7%	1.3%	0.2%	1.7%	4.1%	0.9%
Senior managers	86.9%	1.9%	3.8%	0.9%	0.3%	0.3%	4.5%	1.4%
Managers	84.5%	3.6%	5.5%	1.2%	0.3%	0.6%	3.5%	0.8%
Other staff or those with unknown classification	74.0%	5.1%	10.2%	2.2%	0.2%	1.3%	5.0%	1.9%
Grand total	77.1%	5.5%	8.9%	1.5%	0.5%	2.0%	3.6%	0.8%

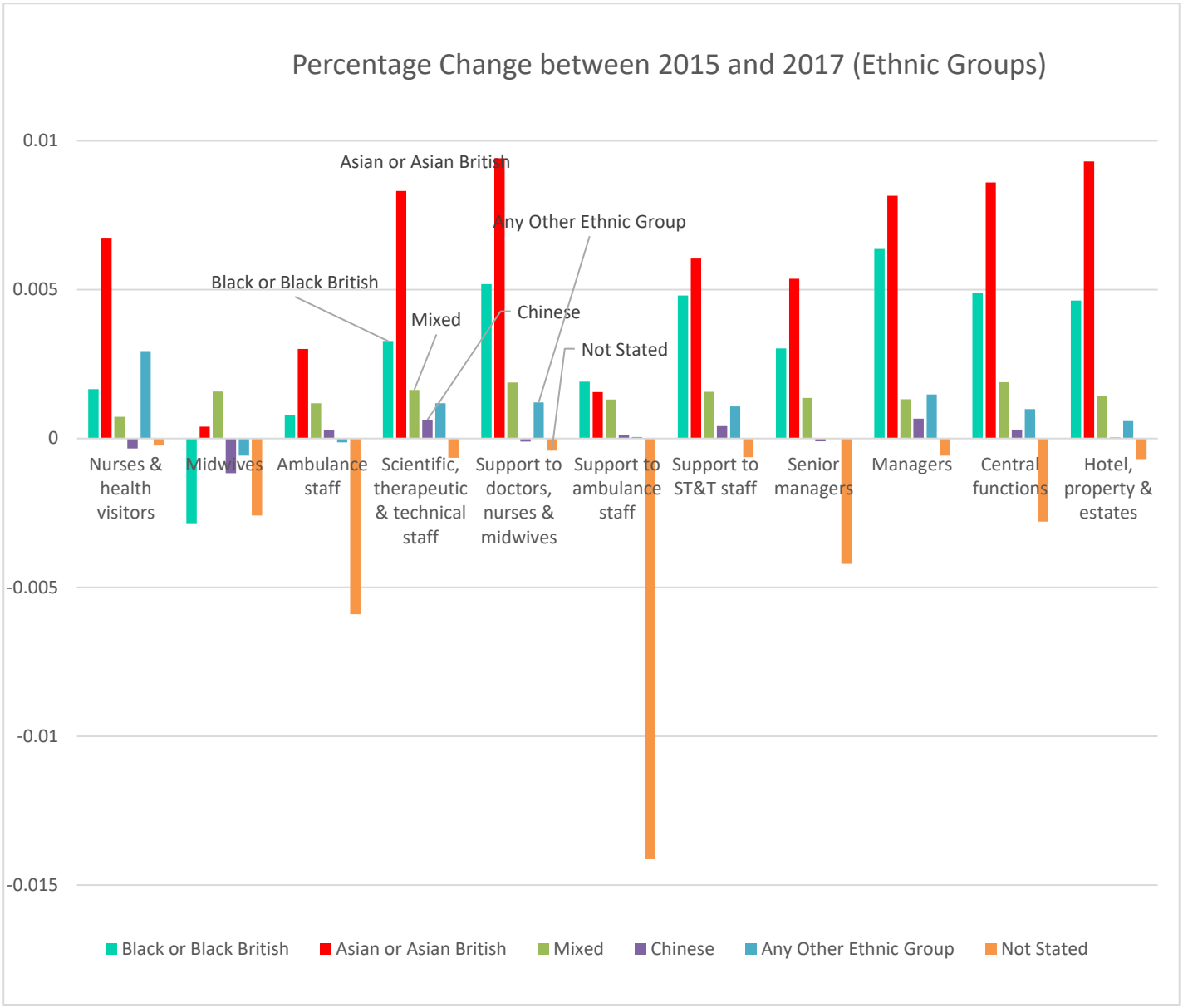
Figure 6.3: Diversity snapshot at 2015

September 2015 (Headcount)	White	Black or Black British	Asian or Asian British	Mixed	Chinese	Any Other Ethnic Group	Not Stated	Unknown
Nurses and health visitors	76.4%	7.4%	7.8%	1.2%	0.4%	2.9%	3.4%	0.6%
Midwives	84.9%	7.3%	1.8%	1.2%	0.4%	0.7%	3.3%	0.5%
Ambulance staff	93.5%	0.5%	0.7%	0.8%	0.1%	0.3%	4.1%	0.0%
Scientific, therapeutic and technical staff	83.5%	2.9%	7.1%	1.4%	0.6%	1.0%	3.1%	0.5%
Support to doctors, nurses and midwives	81.5%	5.9%	5.7%	1.3%	0.2%	1.5%	3.3%	0.5%
Support to ambulance staff	90.0%	1.3%	2.2%	1.1%	0.1%	0.1%	5.0%	0.2%
Support to ST&T staff	83.8%	3.7%	6.0%	1.4%	0.3%	1.1%	3.3%	0.5%
Senior managers	87.5%	1.6%	3.3%	0.8%	0.3%	0.3%	4.9%	1.4%
Managers	85.8%	2.9%	4.7%	1.1%	0.3%	0.4%	3.5%	1.3%
Central functions	82.4%	4.2%	6.5%	1.3%	0.4%	0.6%	3.7%	0.9%
Hotel, property and estates	81.3%	5.0%	5.8%	1.1%	0.2%	1.6%	4.1%	0.9%
Unknown	78.3%	4.3%	7.1%	1.8%	0.3%	1.0%	5.0%	2.3%
Grand total	78.5%	5.2%	8.2%	1.4%	0.5%	1.8%	3.6%	0.7%

Source: NHS Digital HCHS workforce publication

6.21 There has been a slight decrease in the proportion of staff who are white in all staff groups apart from in the midwives staff group. The largest decrease has been in the Support to doctors, nurses and midwives, where there has been a 1.8% decrease between 2015 and 2017.

Figure 6.4: Percentage change in ethnic groups since 2015



6.22 Looking at Figure 6.4, there have been some percentage point increases in the numbers of staff from other ethnic groups since 2015. In all staff groups apart from midwives, the “Asian or Asian British” staff group has shown the largest increases compared to other ethnic groups since 2015. Within the Midwives staff group, the Mixed ethnic group has showed the largest increase since 2015.

Gender

6.23 The proportion of men and women in the NHS workforce has remained broadly the same over the period 2015 to 2017.

6.24 Midwives show the largest disparity between men and women, with men representing only 0.4% of the workforce. Nurses and health visitors also fare poorly in terms of gender balance - around 11% of nurses and health visitors are men.

6.25 Support to ambulance staff are the most equally balanced staff group in terms of gender, with almost a 50/50 split between the genders.

Figure 6.5: Gender mix within staff groups from 2015 to 2017

	2015		2016		2017	
Staff group	Men	Women	Men	Women	Men	Women
Nurses & Health visitors	11.2%	88.8%	11.4%	88.6%	11.3%	88.7%
Midwives	0.4%	99.6%	0.4%	99.6%	0.4%	99.6%
Ambulance staff	62.4%	37.6%	62.0%	38.0%	61.6%	38.4%
Scientific, therapeutic & technical staff	22.2%	77.8%	22.2%	77.8%	22.2%	77.8%
Support to doctors, nurses & midwives	14.2%	85.8%	14.2%	85.8%	14.2%	85.8%
Support to ambulance staff	51.4%	48.6%	50.6%	49.4%	49.5%	50.5%
Support to ST&T staff	19.6%	80.4%	19.9%	80.1%	20.1%	79.9%
Central functions	25.4%	74.6%	26.5%	73.5%	27.0%	73.0%
Hotel, property & estates	41.7%	58.3%	41.4%	58.6%	41.6%	58.4%
Senior managers	43.3%	56.7%	42.8%	57.2%	42.6%	57.4%
Managers	37.4%	62.6%	37.4%	62.6%	37.4%	62.6%
Unknown	23.1%	76.9%	25.5%	74.5%	26.4%	73.6%
Grand total	22.7%	77.3%	22.9%	77.1%	22.9%	77.1%

Exiting the European Union

6.26 The Department of Health and Social Care is clear that our priority is to ensure that EU staff currently working in the NHS are not only able to stay, but feel welcomed and encouraged to stay.

6.27 The Home Office has launched the EU Settlement Scheme – a simple registration process for EU nationals who arrive in the UK to live before the end of 2020 (or by 29 March 2019 in the event of 'no deal') to enable them to remain living in the UK, with broadly the same rights as they currently enjoy.

6.28 The Home Office tested this scheme with all health and social care staff from 26 November 2018, giving them earlier access than the rest of the population.

6.29 There are over 4,300 more EU27 nationals since the referendum now employed in NHS Trusts and CCGs. This includes almost 600 more EU27 doctors since June 2016.

6.30 The data so far provides little evidence of an adverse Brexit impact on the employment of EU27 nationals in the NHS, particularly given other factors such as the additional language controls.

6.31 We continue to monitor and analyse overall staffing levels across the NHS and adult social care, and we're working across Government to ensure there will continue to be sufficient staff to deliver the high-quality services on which patients rely following the UK's exit from the EU.

6.32 On 18 September 2018 the Migration Advisory Committee (MAC) published its important review on the patterns of EEA migration on the UK and recommendations for a future migration system.

6.33 In its report, the MAC concludes that they believe the UK should focus on enabling higher skilled migration coupled with a more restrictive policy on lower-skilled migration in the design of its post-Brexit system.

6.34 The Department will continue to work with the Home Office to ensure that after we leave the EU, we will have in place an immigration system which works in the best interests of the whole of the UK.

Non-Medical Staff from EU

6.35 The number of EU27 non-medical staff have increased by over 5,000 between March 2016 and March 2018 and now form 4.8% of all non-medical staff on a headcount basis.

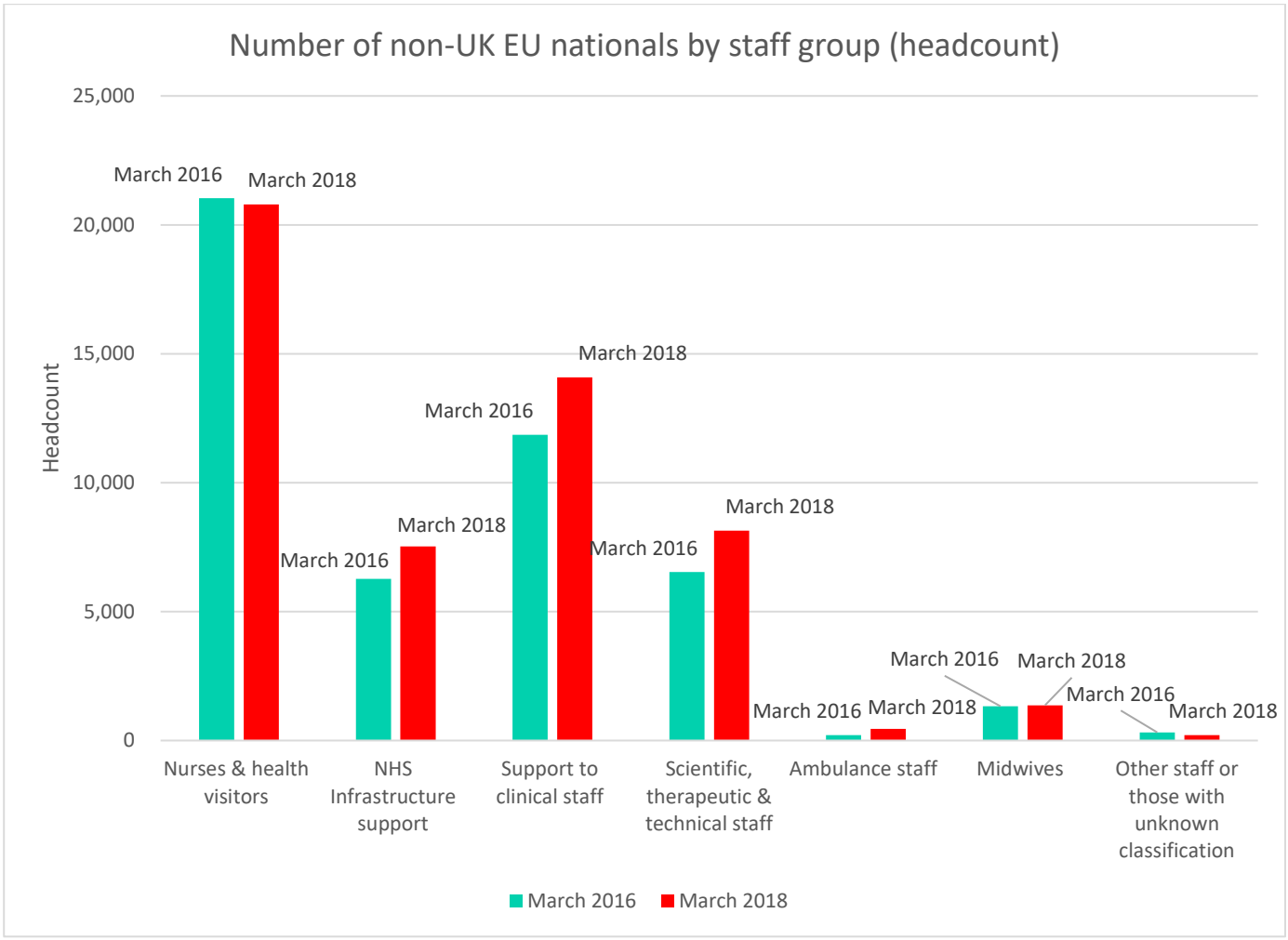
Figure 6.6: Non-medical staff from EU27

Staff group	March 2016	March 2018	Change
All non-medical staff from EU27	47,454	52,471	5,017
As a percentage of all non-medical staff	4.5%	4.8%	0.3%

6.36 Nurses and health visitors form the largest non-medical staff group for EU27 workers. As at March 2018 there are 20,787 nurses and health visitors from the EU27. Between March 2016 and March 2018, the number of EU27 nurses and health visitors decreased while all other staff groups had increases in their EU27 workforces, apart from the staff group "other staff or those with unknown classification".

6.37 Departmental analysis suggests that the reduction in Nurses and Health visitors is more likely to be a consequence of the Nursing and Midwifery Council (NMC) introducing more rigorous language testing for EEA applicants, than the decision to leave the European Union. The number of EU27 nurses and health visitors fell by 243 between March 2016 and March 2018.

Figure 6.7: Non-UK EU nationals by staff group



Education & Training Funding Reforms

6.38 At Spending Review 2015, it was agreed that new pre-registration undergraduate and postgraduate nursing, midwifery and allied health professional students would receive their tuition funding and financial support through the standard student support system, rather than NHS bursaries. These changes came into effect in 2017, and most new undergraduate and postgraduate pre-registration healthcare students now receive student loans from the Student Loans Company (SLC).

6.39 The move from the NHS Bursary to the standard student loans system means that most students will typically receive an increase of up to 25% in the up-front financial resources provided whilst they study, compared to previous arrangements.

Figure 6.8: Breakdown of maintenance support figures
(These figures are applicable to a 42-week course, with figures differing on courses of different lengths).

Student location		NHS bursary scheme (16-17)	DFE funding scheme (18-19)	Difference (%)	Difference (£)
London	Maximum grant	£4,191	£0		
	Maximum loan	£3,263	£11,345		
	Long course loan	£0	£1,440		
	Extra weeks allowance	£1,296	£0		
	Maximum Total	£8,750	£12,785	46%	£4,035
Outside London	Maximum grant	£3,643	£0		
	Maximum loan	£2,324	£8,700		
	Long course loan	£0	£1,116		
	Extra weeks allowance	£1,008	£0		
	Maximum Total	£6,975	£9,816	41%	£2,841
Living at home	Maximum grant	£3,207	£0		
	Maximum loan	£1,744	£7,324		
	Long course loan	£0	£732		
	Extra weeks allowance	£672	£0		
	Maximum Total	£5,623	£8,056	43%	£2,433

6.40 With the increase in the student loan re-payment threshold introduced by the Department for Education, from April 2018 a newly qualified nurse will not pay back their loan on earnings up to £25,000.

6.41 The move to bring the funding of pre-registration nursing degrees and Allied Health courses into line with other undergraduate courses through the student support system removed the "cap" of centrally imposed number controls and financial limitations, which a fixed envelope of Government funding for fees and bursaries represented. This change has allowed us to increase nurse training places by 25% - that is 5,000 additional nurse training places every year from September 2018 and an increase of 3,000 midwifery places over the next four years, with 650 available this year.

6.42 In support of this reform, we have also announced additional clinical placement funding to provide up to 10,000 placements. This presents an opportunity to

further increase the future supply of registered nurses, as well as that of other clinical professionals. The Department, HEE and the wider system are continuing to work closely with Higher Education Institutions (HEIs) and partners, to continue to attract high calibre applicants to take up these additional places, and to ensure the provision of high quality clinical placements to support expansion.

6.43 Having a nursing degree increases the probability of being employed compared to the average graduate[viii] and once qualified, healthcare provides a wide range of career and development possibilities. There is still strong demand for nursing courses, as UCAS data from 2018 shows that there are still more applicants than places available. However, there are a range of complex issues as to why applicant numbers have fallen slightly further than university applicants overall. The Department is working with relevant bodies across health and education to monitor the effects of the healthcare funding reforms, including the impact on application numbers on all the professions affected.

6.44 The most recent UCAS figures show there has been a 1.7 percent decrease in acceptances to nursing and midwifery courses in 2018 when compared to last year (2017). UCAS figures on acceptances to nursing and midwifery courses show there have been 22,200 acceptances for 2018 entry, compared with 22,575 at this point in 2017.

6.45 The overall number of placed applicants at 28 days after A-Level results day over the last five years is shown in Figure 6.9 below.

Figure 6.9: Placed applicants for nursing and midwifery courses at 28 days after A-level results day.

Entry year	2014	2015	2016	2017	2018
Acceptances	21,815	22,130	23,280	22,575	22,200

Source: Published UCAS clearing analysis data 2018

6.46 The number of applicants to nursing and midwifery courses in England has decreased by 12% in 2018 when compared to 2017; the first intake of students affected by bursary reform.

Figure 6.10: UCAS June deadline applicant numbers

Entry year	2014	2015	2016	2017	2018
Applicants	57,420	56,101	56,790	44,160	38,970

Source: UCAS June deadline publication 2018.

6.47 The Department is working closely with the higher education sector, ALBs and other key stakeholders to monitor the impact of the funding reform on application numbers and uptake of university placements.

6.48 Regulations laid on 28 March 2018 complete the healthcare reforms started last year by enabling postgraduate pre-registration nursing, midwifery, allied health professional, and most new dental hygiene and dental therapy students to receive student loans from the SLC. As an acknowledgement of the additional student debt postgraduate students are likely to incur, the Secretary of State announced a 'golden hello' payment incentive applicable to students who commence loan funded postgraduate pre-registration nursing courses in the 2018/19 academic year. Eligible students will receive a £10k 'golden hello'' payment once they have graduated and go on to work in learning disability, mental health or district nursing. Payments will be made to these graduates once they take up in employment in the health and care sector in England. Working with the NHS and the university sector, the Government is finalising the most effective way to administer and introduce the scheme and will set out details in due course.

6.49 In acknowledgement of the unique position of nursing students undertaking clinical placements, both undergraduate and postgraduate nursing, midwifery and allied health profession students can access additional financial support whilst undertaking the mandatory clinical placement aspects of their courses. The Department has made provisions for these students to apply for financial support from the Learning Support Fund (LSF) through the NHS Business Services Authority (NHSBSA). This offers specific and targeted support for students; £1,000 per student per year non-means tested child dependents allowance, travel and dual accommodation expenses for clinical placements, and students experiencing extreme financial hardship can also apply for additional support of up to £3,000 through the Exceptional Support Fund.

Skill Mix

6.50 Health and Care employers say they need a more flexible workforce to keep pace with developments in treatments and interventions[ix]. There are a range of new roles designed to provide employers with a wider skill mix within multidisciplinary teams.

6.51 The Nursing Associate role is one of many new roles emerging across the healthcare professions; Physicians' Associates, Physicians' Assistant (anaesthesia), Surgical Care Practitioner, Advanced Clinical Practitioner and

Nursing Associates are all designed to improve patient care and form a valuable part of a contemporary multidisciplinary workforce.

6.52 The Nursing Associate role is designed to bridge the gap between Healthcare Assistants and Registered Nurses in England. Nursing Associates will deliver care, freeing up Registered Nurses to spend more time using their skills and knowledge to focus on complex clinical duties and take a lead in decisions on the management of patient care.

6.53 Following their training, Nursing Associates will work within teams with direct or indirect supervision to deliver aspects of nursing care, complementing the work of registered nurses.

6.54 Health Education England originally piloted the Nursing Associate role across 35 test sites, training 2,000 Nursing Associates. A further expansion of trainees was announced in October 2017, with Health Education England leading a national expansion programme to train up to 5,000 Nursing Associate apprentices in 2018 and 7,500 in 2019. HEE report almost 3,000 Nursing Associate apprentices are enrolled on a programme as at November 2018.

6.55 Professional regulation is now confirmed for Nursing Associates. The NMC was confirmed as the regulator in law in July, allowing the first successful Nursing Associates from HEE's pilot to join the NMC's register in January.

6.56 The NHS Five Year Forward View, provided an increased focus on the value of embedding and increasing the use of new professional roles within multi-disciplinary teams as part of a continuing drive to provide safe, accessible and high quality care for patients. Four of these professional roles can be grouped under the Medical Associate Professionals (MAPs) heading as they share some similarities in their career framework and education and training. The four roles are:

- Physicians' associates (PAs)
- Physicians' assistants (anaesthesia) (PA(A))
- Surgical care practitioner (SCP)
- Advanced critical care practitioner (ACCP)

6.57 The increased use of MAP roles could contribute to this improved skills mix and facilitate high quality patient care in both primary and secondary care settings. The Secretary of State announced his intention to regulate Physicians' Associates and Physicians Assistants Anaesthesia in October 2018.

6.58 The further growth of the Physicians' Associate role is supported by HEE who have developed the role through a defined career framework, professional identity, and targeted investment in training. This is a key part of the Government's policy to develop a more effective, strong and expanding general practice to meet future need. HEE

6.59 HEE and NHS Improvement are also working to embed the national framework for training Advanced Clinical Practitioner (ACP) roles. In common with other new roles, ACPs can add valuable skills into wider skill mix and often complement work of doctors in Emergency and Cancer Care.

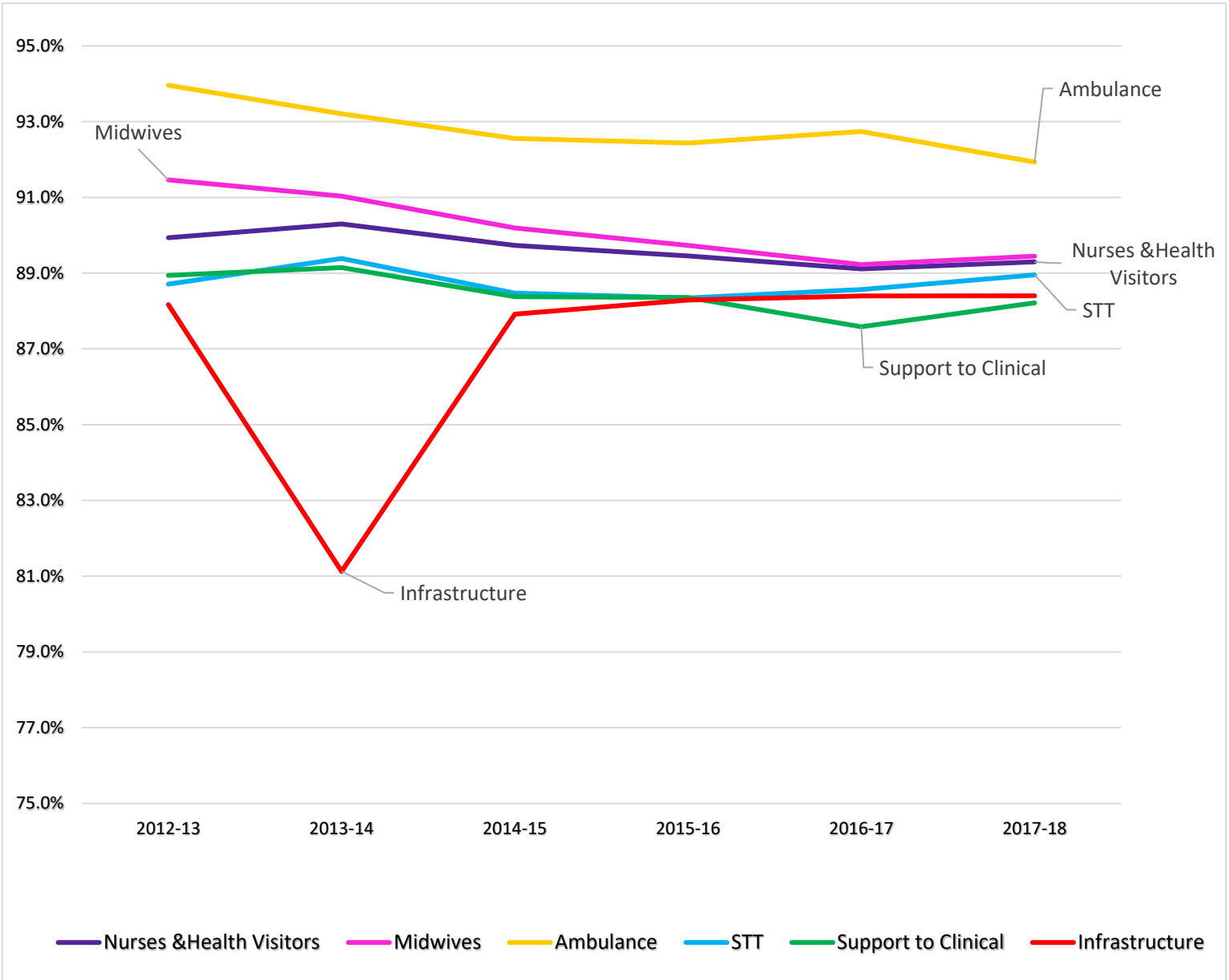
Recruitment & Retention

6.60 The Stability Index[x] is the percentage of staff there are at the start of the period that do not leave the specified group (for example, organisation, staff group or the NHS in England) during the period in question. This is a useful indicator of how well the NHS is doing in retaining the workforce it has.

6.61 The chart below shows that within each staff group there has not been much variation in the stability index for the HCHS non-medical workforce. NHS Digital data shows retention has fallen slightly for most NHS Pay Review Body staff groups in recent years. There was a one-off temporary decrease for infrastructure in 2013/14 during transformation of the health system as PCTs closed and some jobs moved out of the HCHS to, for example, new social enterprises.

Figure 6.11: Stability Index for the Non-Medical Workforce

Staff groups	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Nurses &Health Visitors	89.9%	90.3%	89.7%	89.5%	89.1%	89.3%
Midwives	91.5%	91.0%	90.2%	89.7%	89.2%	89.4%
Ambulance	94.0%	93.2%	92.6%	92.4%	92.7%	91.9%
STT	88.7%	89.4%	88.5%	88.3%	88.6%	89.0%
Support to Clinical	88.9%	89.1%	88.4%	88.4%	87.6%	88.2%
Infrastructure	88.2%	81.1%	87.9%	88.3%	88.4%	88.4%



Source: NHS Digital

Non-Medical Reasons for Leaving

6.62 In the 2017/18 financial year, most non-medical staff left because they voluntarily resigned (44%). The trend in reasons for leaving has been broadly the same for the past four years. However, the 2017/18 figure for Voluntary resignation is 11.6 percentage points higher than it was in the 2013/14. There have been year-on-year decreases in the number of redundancies of non-medical staff between 2013 and 2018.

Figure 6.12: Reasons for leaving since 2013/14

Reason for leaving	2013/ 14	2014/ 15	2015/ 16	2016/ 17	2017/ 18	2013/ 14	2014/ 15	2015/ 16	2016/ 17	2017/ 18
Dismissal	4,123	4,272	4,464	4,282	4,006	3.5%	3.9%	3.9%	3.6%	3.3%
Employee Transfer	24,417	6,950	5,234	6,480	6,134	20.5%	6.3%	4.6%	5.4%	5.1%
End of Fixed Term Contract	2,490	2,298	2,317	2,227	2,223	2.1%	2.1%	2.0%	1.9%	1.8%
End of Fixed Term Contract – Completion of Training Scheme	599	626	575	529	470	0.5%	0.6%	0.5%	0.4%	0.4%
End of Fixed Term Contract – End of Work Requirement	415	301	271	322	299	0.3%	0.3%	0.2%	0.3%	0.2%
End of Fixed Term Contract – External Rotation	12	7	9	6	8	0.0%	0.0%	0.0%	0.0%	0.0%
End of Fixed Term Contract – Other	532	452	475	390	448	0.4%	0.4%	0.4%	0.3%	0.4%
Mutually Agreed Resignation	1,538	1,143	740	789	507	1.3%	1.0%	0.7%	0.7%	0.4%
Others	773	838	781	815	870	0.6%	0.8%	0.7%	0.7%	0.7%
Redundancy	3,994	1,819	1,639	1,324	1,258	3.3%	1.7%	1.4%	1.1%	1.0%
Retirement	16,440	18,241	18,119	17,690	17,051	13.8%	16.6%	15.9%	14.8%	14.1%
Unknown	25,362	26,574	29,663	33,318	34,480	21.3%	24.1%	26.1%	27.9%	28.5%
Voluntary Resignation	38,594	46,640	49,429	51,365	53,148	32.4%	42.3%	43.5%	43.0%	44.0%
All Reasons for Leaving	119,289	110,161	113,716	119,537	120,902	100%	100%	100%	100%	100%

Staff Group Leaver rates by region

6.63 Examination of leaver rates for staff groups across the regions show the following:

- the leaver rate for Nurses and health visitors, midwives; and scientific, therapeutic and technical staff has increased since 2010 in all regions;

- Ambulance staff, support to clinical staff – Leaver rates across all regions have increased since 2010, apart from ambulance staff in Wessex who have seen a 1 percentage point decrease and support to clinical staff in the East Midlands who have also seen a decrease of 1 percentage point; and

- infrastructure Support Staff – The leaver rate peak in 2013-14 coincided with transformation of the health system, when Primary Care Trusts and Strategic Health Authorities closed, and Social Enterprises were created. Some staff left the NHS, and some moved with their jobs into Social Enterprises. This makes it difficult to identify possible trends. Across most regions the leaver rate has decreased since 2010, apart from the North East and South West where the leaver rate has increased by 9.8 percentage points and 1.8 percentage points respectively.

6.64 Ambulance staff have the lowest leaver rate at 7.9% in England at 2017/18. All other staff groups have a leaver rate of between 10% and 11%.

6.65 Leaver rates by region over time show some patterns. For example, the leaver rates increased quite significantly in London, Thames Valley and Kent, Surrey and Sussex for midwives, ambulance staff and ST&T staff.

6.66 For midwives, the highest leaver rate was seen in the Thames Valley region, 13.6% in 2017/18, up by 4.35 percentage points since 2010/11. For ambulance staff, the highest rate was also seen in the Thames Valley region, 11.14% in 2017/18, up by 6 percentage points since 2010/11. For ST&T staff the highest leaver rate was also in the Thames Valley region, 13.6% in 2017/18. More detailed analysis of staff group leaver rates by region are provided in Annex 4.

Vacancies

6.67 NHS Improvement perform monthly workforce data collections from NHS trusts and foundation trusts, which contains data on staff in post (including bank and agency), and vacancies. The data has shown the vacancy rate to remain stable over the last five quarters – ranging from between 9.4% and 8.9%, which is

equivalent to between 88k FTE and 96k. This is a new collection with 5 quarters of data so changes in figures should be treated with caution and it is too early to assess any seasonal impacts.

6.68 Bank and agency staff are typically used to fill these vacancies, in addition to covering sickness absence and long-term leave. Approximately 90% of the 96k vacancies in 18/19 Q1 were filled by a combination of bank (75%) and agency (25%) staff.

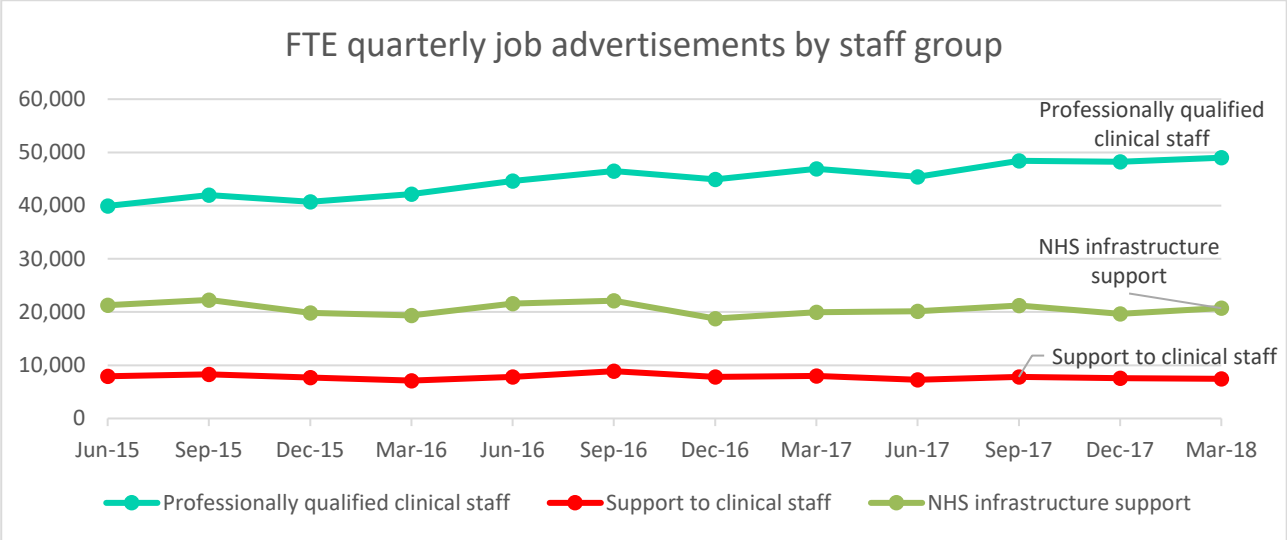
Figure 6.13: Vacancies

Staff Group		17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Nursing	Vacancy rate	10.9%	11.2%	10.2%	10.2%	11.8%
	WTE Vacancies	38,328	39,154	35,934	35,794	41,722
Other staff	Vacancy rate	8.4%	8.0%	8.0%	7.6%	7.8%
	WTE Vacancies	57,946	54,987	55,677	52,699	54,446
Total	Vacancy rate	9.4%	9.1%	8.9%	8.4%	9.2%
	WTE Vacancies	96,274	94,141	91,611	88,493	96,168

Source: NHS Improvement quarter 1 18/19 data collection

6.69 NHS Digital publish data on the number of job advertisements on the NHS jobs website. This is a proxy for vacancies. It shows that job adverts for professionally qualified non-medical staff have risen over the last three years, while they have remained stable for support and infrastructure staff.

Figure 6. 14: Quarterly job adverts by staff group



Source: NHS Digital bi-annual job advert statistics

Agency and Bank Staff

6.70 The use of Agency and Bank staffing provides some insights and an indication of how the NHS labour market is operating. They include all expenditure on off-payroll staffing, including agency, self-employed contractors and externally-managed banks.

6.71 NHS Improvement and DHSC have signalled an intent to make greater use of Bank staff as an alternative to using agency staff for temporary staffing. An early focus of this work includes a programme aimed at improving trusts' bank offers by providing bank staff with the ability to self-book shifts; allowing them to see those shifts alongside their normal rota using integrated technology; and providing prompter payment and pension flexibility for those shifts.

6.72 Trusts also recognise the importance of attracting staff to work on cost effective banks and have introduced many other initiatives including:

- Being clear about the benefits of NHS employment (i.e. NHS Pension Scheme, paid training, indemnity cover);
- Making improvements to NHS staff Banks including making it easier for substantive staff to choose and be paid promptly for additional shifts; and
- Making substantive contracts more flexible (for example if a nurse can only work 2 days in a week the trust should consider providing a contract for 2 days per week).

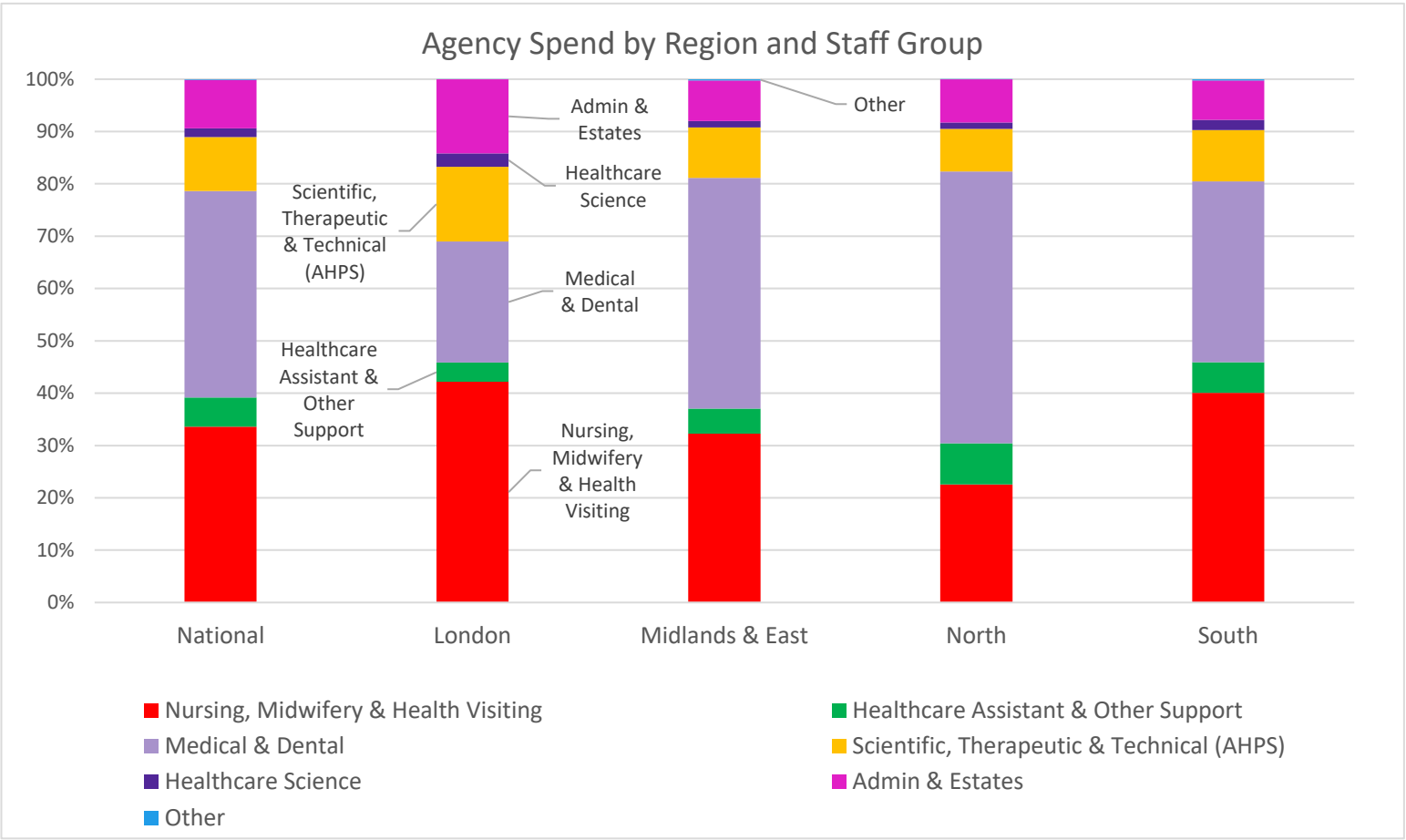
6.73 NHS Trust spending on agency staff rose by 40% between 2013/14 and 2015/16 (£2.6bn to £3.7bn). Following the introduction of agency spend controls, expenditure on agency staffing reduced to £2.9bn in 2016/17 and £2.5bn in 2017/18 (a fall of 18% or £550 million across the total workforce in 2017/18 from the previous year).

6.74 NHS Improvement have provided detailed data on agency spend by staff group and region. In 2017/18 the agency spend on Non-Medical staff was £1,450mn which represents 61% of total agency spend.

6.75 A greater proportion of agency spend was on Non-Medical staff in London and the South compared to the North. In London over 75% of agency spend was on Non-Medical staff compared to under 50% in the North of England.

6.76 London and the South of England had the highest rates of agency spend on nursing, midwifery and health visitors.

Figure 6.15: Agency Expenditure By Staff Group and Region



Source – NHS Improvement

6.77 Introducing measures to reduce agency spend can only have maximum impact where trusts have a viable alternative temporary staffing solution. Staff banks ensure better quality and continuity of care, while allowing the reduction of unnecessary agency spending.

6.78 NHS Digital produce experimental statistics on the number of Bank staff working in Trusts and Clinical Commissioning Groups (CCGs). This covers people who are paid through the Electronic Staff Record system who hold an assignment with a contracted FTE of zero. This is a relatively new data source and so there is only a limited time series available.

6.79 Figure 6.16 shows the number of people, on a headcount basis, who are recorded as working in a bank role. It shows that the number of bank staff has increased by 23% over the last two years. Over the same period the size of the substantive workforce in NHS Trusts and CCGs increased by 3%.

6.80 The increase in Bank staff is also related to the movement away from agency staff in favour of more cost-effective Bank employment as well as using bank staff to handle increased demand, vacancies and staff turnover.

Figure 6.16: Headcount of people working in a bank role

Staff Group	Jun-16	Jun-17	Jun-18
Nurses & health visitors	49,153	55,362	60,004
Midwives	2,578	3,198	3,598
Ambulance staff	805	859	969
Scientific, therapeutic & technical staff	6,640	7,519	9,158
Support to clinical staff	60,330	66,472	71,407
Support to doctors, nurses & midwives	56,489	62,067	66,864
Support to ambulance staff	955	1,061	951
Support to ST&T staff	3,019	3,485	3,770
NHS infrastructure support	22,190	23,616	24,378
Central functions	13,794	14,583	14,340
Hotel, property & estates	8,141	8,660	9,541
Senior managers	70	163	188
Managers	219	259	356
Other staff or those with unknown classification	114	145	163

Source – NHS Digital Workforce Statistics

6.81 These totals will only include records where payment for Bank work is recorded through a separate assignment on ESR. It will not include any cases where Bank work is not recorded through ESR or if someone is paid through their regular, substantive, assignment.

6.82 In many cases staff work on the bank in addition to holding another, substantive, contract in the NHS. DHSC analysis from ESR suggests that up to 75% of nurses and midwives who worked a Bank assignment also held a substantive contract.

Apprenticeships

6.83 The NHS apprentice agenda is designed to support entry into careers in the NHS for people from all backgrounds. The apprentice agenda is at the heart of an aspiration to provide careers, not just jobs for people working in the NHS. Apprentice career pathways are now open in nursing, healthcare science and to become a paramedic. These pathways allow people to start at entry level apprenticeship roles and progress to becoming a registered healthcare professional. There are many occupations to train for via the apprentice route in the NHS, including business administration, digital, accountancy, podiatry, operating department practitioner and Advanced Clinical Practitioner.

6.84 Much of the focus of the NHS programme in 2018 and 2019 is the expansion of the Nursing Associate role through the apprentice route. Health Education England are leading a national expansion programme to train 5,000 Nursing Associate apprentices in 2018 and a further 7,500 in 2019. The Nursing Associate role is designed to provide the NHS with a new profession, allowing employers to make the most of current and emerging talent and help them to address some of their supply challenges. Following their training, Nursing Associates will undertake some of the duties that registered nurses currently undertake enabling the registered nurses to spend more time on the assessment and care associated with both complex needs and advances in treatment.

6.85 As part of the Agenda for Change pay and contract reform deal, there is a commitment to seek agreement on a new apprentice pay framework. Discussions between NHS trades unions and NHS Employers, under the auspices of the NHS Staff Council continue.

Staff Experience

6.86 The NHS Staff Survey provides useful insight into staff experience of working in the NHS including, for example, their motivation, engagement, satisfaction with flexible working and pay. In future, results from the survey will take the form of a new set of indicators, or themes rather than the 32 key findings. This will provide organisations with a concise summary of how they are performing across different

areas of staff experience relative to their peers and there will be a clearer indicator of staff morale.

6.87 Although staff experience in the NHS has remained relatively stable, there has been a slight decline in a large proportion of Key Findings from the 2017 NHS Staff Survey. In particular, the overall engagement score has decreased for most staff groups, the largest being for Ambulance Staff. The staff groups where engagement improved were Social Care staff and Public Health/Health Improvement.

6.88 DHSC and their partners recognise there is no room for complacency and are working in partnership with Arm's Length Bodies and other colleague organisations to support trusts in their responsibility for improving staff experience as follows:

- #TalkHealthandCare, recently launched by Secretary of State, gives staff the opportunity to share their views and contribute ideas to improve the experience of people working across health and care. Being immediate and interactive, it supplements more traditional routes such as consultations and staff surveys.

- NHS Improvement has:

    - Its "Staff Experience and Outcomes Explorer" which provides a link between the NHS Staff Survey's website on-line tool and research that has been undertaken to establish the links between staff experience and the impact on outcomes for patients;

    - a staff retention collaborative which, in its second year, has been looking at how to help staff at different stages of their career e.g. mentoring when they first join the service, flexible working options mid-career and then flexible retirement choices towards the end of careers. They share good practice on their 'Retention Hub - a collection of resources developed with support from HR, Nursing and Medical Directors from across the NHS. Trusts involved in this programme are experiencing their lowest staff turnover for a number of years;

    - a staff health and wellbeing collaborative which is working with 73 trusts to develop 10 high impact actions for rolling out across the NHS including options for quicker access to accredited occupational health services. The Collaborative will support the NHS commitment to reduce NHS sickness absence by 1% by April 2020 and to the public services average by 2022;

- The collaborative and NHS England's staff health and wellbeing framework (see below) embed "Thriving at Work" principles aimed at improving workplace mental health and developing positive and supportive workplace cultures;

- a Culture and Leadership Programme with a revised toolkit and guides and continues to share with and gather from trusts working on their culture and exploring use of the toolkit with trusts in special measures; and

- established a partnership group to oversee implementation of the new pay, terms and conditions deal negotiated between the Government and health unions representing the PRB remit groups.

6.89 NHS Digital publishes NHS sickness absence rates which provide more information on length and number of episodes. The Staff Friends and Family Test which assesses the extent to which an employee would advocate their trust as a place to work or receive treatment. For quarter one 2018/19, the Test shows 66% of staff say they would recommend their organisation as a place to work (up 2% from the previous year) and 81% would recommend their trust as a place to receive treatment (the highest it has been since Q1 2017/18).

6.90 Comparisons with the NHS staff survey should be resisted, but in response to its question, "I would recommend my organisation as a place to work", 44% for ambulance technicians, 63% for paramedics and 71% for Emergency Care Assistants (the highest for all staff groups).

- The Care Quality Commission provides inspection reports and publications:

  - "Driving Improvement: Case Studies from eight NHS trusts" which highlights that "Engaging and empowering staff is key to driving improvement in hospital care";

  - 2017/18 State of Care which shows resilience in the workforce has been maintained despite the pressures organisations are facing in their struggles to recruit and retain staff.

  - A revised Well Led Framework which through reviews of leadership and governance identify areas that would benefit from further targeted development to secure and sustain future performance. NHSI is encouraging organisations to carry out, every three to five years, externally facilitated, developmental reviews of their leadership and governance using the well led framework.

- Sustainability and Transformation Partnerships use staff engagement to improve local services. New Care Models and Staff Engagement: All Aboard aimed to help spread learning from the vanguard programme across the health and care sector including:
    - enabling staff across organisations to 'break down the barriers' so people can break out of old working patterns and think differently;
    - recognising that those on the front line of care have the best ideas about how to improve it – but need to feel empowered to do so; and
    - recognising that if staff feel their contribution is valued, they will want to do all they can to make new care models a success;
    - The NHS Constitution remains the framework for what employers and staff should expect of each other and patients.
- NHS England has developed the:
    - staff health and wellbeing framework which sets out standards for what organisations in the NHS need to do to help support staff in feeling well, healthy and happy at work. The framework includes organisational enablers of essential leadership, structural, cultural building blocks for improving staff health and wellbeing and interventions for mental health, musculoskeletal injuries and encouraging healthier lifestyles; and
    - 2017/19 Commissioning for Quality and Innovation (CQUIN) incentive scheme which encourages trusts to invest in innovative local solutions for improving staff physical and mental health. To qualify for incentive payments, trusts must show a 5% improvement in two of the three health and wellbeing questions in the NHS Staff Survey or achieve a 75% positive response rate;
- NHS Employers provides advice, guidance and good practice
- Our response to the Government's NHS workforce manifesto commitments:
    - "We will take vigorous and immediate action against those who abuse or attack the people who work for and make our NHS": via the new NHS Violence Reduction Strategy commissioned by ministers, developed by NHS Improvement and NHS England with the NHS and launched by Secretary of State in October. The Strategy will aim to make appropriate use of the new Assaults against Emergency Workers (Offences) Act.

- "We will strengthen the entitlement for NHS employees to flexible working to help those with caring responsibilities for young children or older relatives": better use of technology (another priority for the Secretary of State) including apps and electronic rostering are being piloted and rolled out aimed at helping organisations make optimum use of their permanent and temporary workforces which should help them offer flexible working to more staff who want that. In respect of e-rostering, the Department is working across Government, with health leaders and trusts, on improving procurement arrangements including better evidence to support its use, easier access to the market for providers, better interaction with other systems, for example, the Electronic Staff Record/payroll, more user training, better access to data.

- "We will introduce new services for employees to give them the support they need including quicker access to mental health and musculoskeletal services": this is being delivered via the health and wellbeing programmes described above following Secretary of State's July announcement about quicker access to services for staff who need help.

- We will act to reduce bullying rates in the NHS, which are far too high: this is being led by the national Social Partnership Forum's "Collective Call to Action" which, during its second year has focussed on: support and training for line managers, the impact of bullying on patient care and encouraging sharing of good practice across the health and care system. The SPF is due to review the progress it has made as part of its consideration for third year priorities. DHSC along with the other UK health departments are working with the royal colleges and unions, including the BMA, to reflect the need for kindness, compassion and respect in staff recruitment as well as in subsequent training and development throughout careers.

Key Outcomes from the 2017 Staff Survey

6.91 The 32 key findings of the 2017 NHS Staff Survey showed improvements in 11 and reductions in 21.

6.92 Figure 6.17 shows the questions which recorded the largest changes in 2017 compared to 2016, in all cases they deteriorated in 2017.

6.93 The largest single change was a 5.6 percentage point reduction in satisfaction with pay. The decrease for Nurses and Midwives was 8%.

Figure 6.17: Survey questions with the biggest decrease in score between 2016 to 2017

No.	Question	% Score (2017)	Percentage Point change (+/-)	Survey theme
5g	My level of pay (% agreeing/strongly agreeing)	31.3%	-5.6	Staff job satisfaction
9c*	% saying they have felt unwell in the last 12 months as a result of work related stress	38.4%	+1.6*	Health and wellbeing
6a	I am satisfied with the quality of care I give to patients/service users (% agreeing/strongly agreeing)	81.2%	-1.5	Contribution to patient care
6c	I am able to deliver the care that I aspire to (% agreeing/strongly agreeing)	66.8%	-1.4	Contribution to patient care
2a	I look forward to going to work (% often/always)	57.6%	-1.2	Staff motivation at work
16	% saying the organisation acts fairly with regard to career progression/promotion, regardless of…	84.2%	-1.2	Equal opportunities
3c	I am able to do my job to a standard I am personally pleased with (% agreeing/strongly agreeing)	80.0%	-1.2	Job design

*For this question a lower score indicates a better score

6.94 There were increases in the number reporting feeling unwell due to work related stress and a reduction in those satisfied with the quality of care being provided.

6.95 There were some improvements including a reduction in staff working additional hours and improvements in appraisals and line management.

Staff Engagement

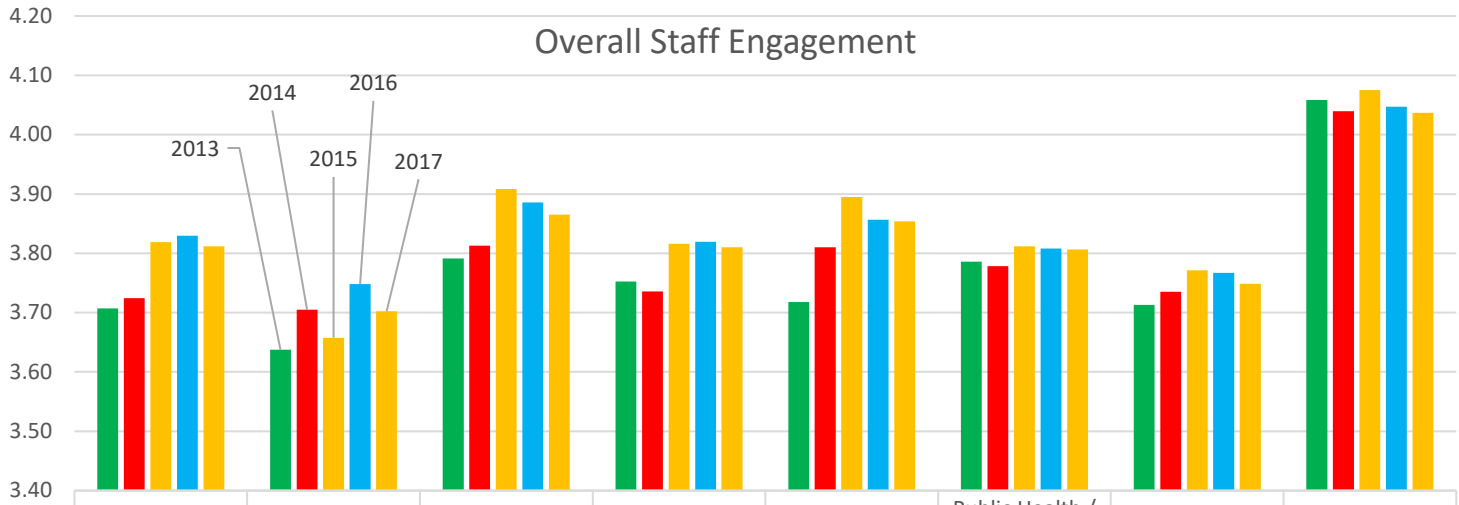
6.96 The NHS Staff Survey "Staff Engagement" score is derived from:

- Recommendation of employer as a place to work or receive treatment
- Staff Motivation at work
- Staff ability to contribute to improvements at work.

6.97 Figure 6.18 shows the overall staff engagement score over the past 5 years for NHS Pay Review Body remit groups. It shows most have improved since 2013 but there were small reductions in 2017. Since 2015, Nurses and Midwives have seen the largest reduction of 0.04 points.

6.98 General Managers have the highest engagement – they are the only group who have a score of more than 4 (out of 5) in each year.

Figure 6.18: Overall staff engagement scores for past 5 years for NHSPRB remit groups



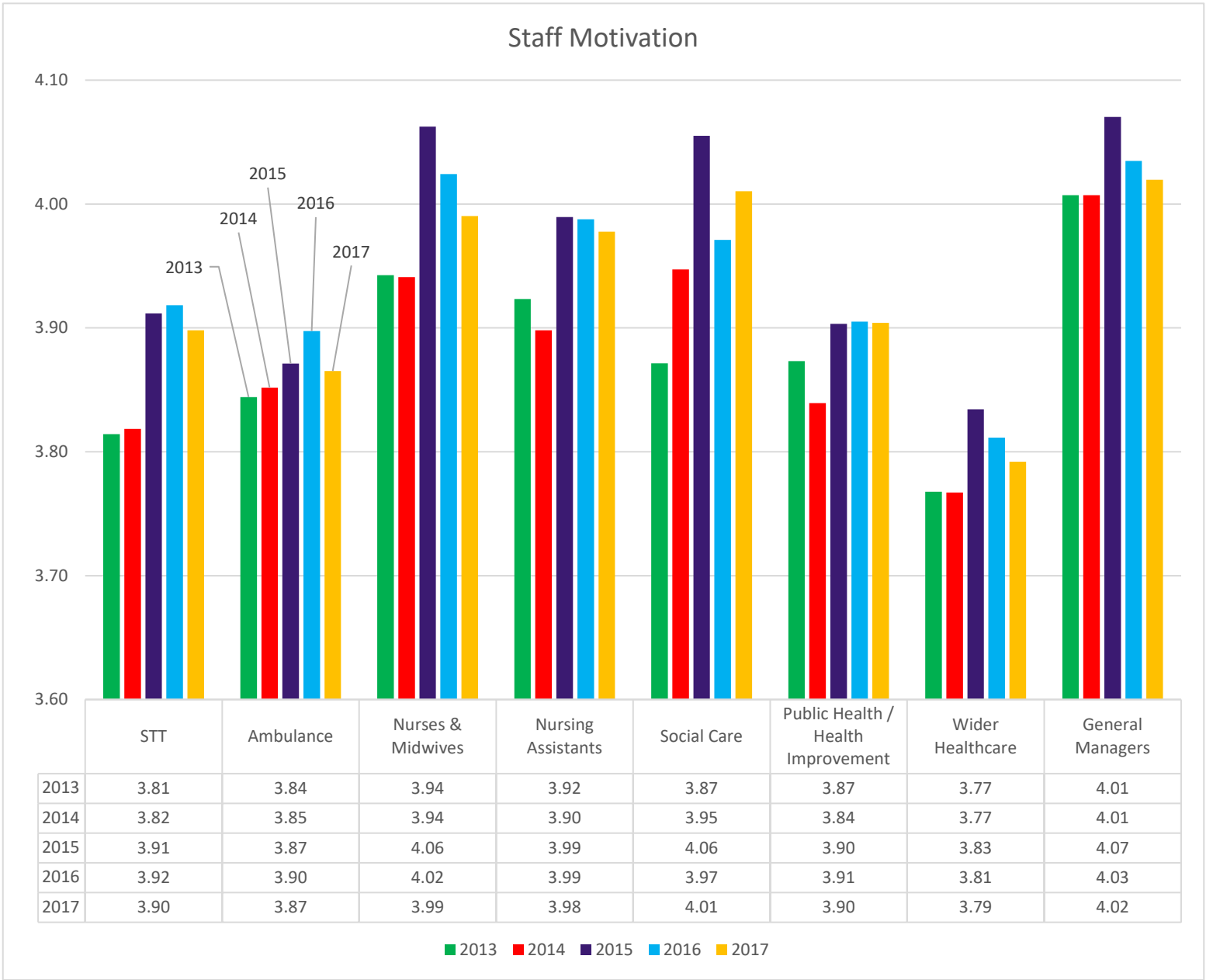
	STT	Ambulance	Nurses & Midwives	Nursing Assistants	Social Care	Public Health / Health Improvement	Wider Healthcare	General Managers
2013	3.71	3.64	3.79	3.75	3.72	3.79	3.71	4.06
2014	3.72	3.71	3.81	3.74	3.81	3.78	3.74	4.04
2015	3.82	3.66	3.91	3.82	3.90	3.81	3.77	4.08
2016	3.83	3.75	3.89	3.82	3.86	3.81	3.77	4.05
2017	3.81	3.70	3.87	3.81	3.85	3.81	3.75	4.04

Staff Motivation

6.99 Definition: “the intrinsic motivation of NHS staff and the underlying reasons why people do the job that they do and want to put effort into their work such as the desire to provide care, to earn money or to achieve promotion. Measures of this might include whether staff look forward to going to work and if they are enthusiastic about their job”

6.100 Figure 6.19 shows staff Motivation scores over the past 5 years with small declines for all bar one remit group over the past year.

Figure 6.19: Overall staff motivation scores for past 5 years for NHSPRB remit groups

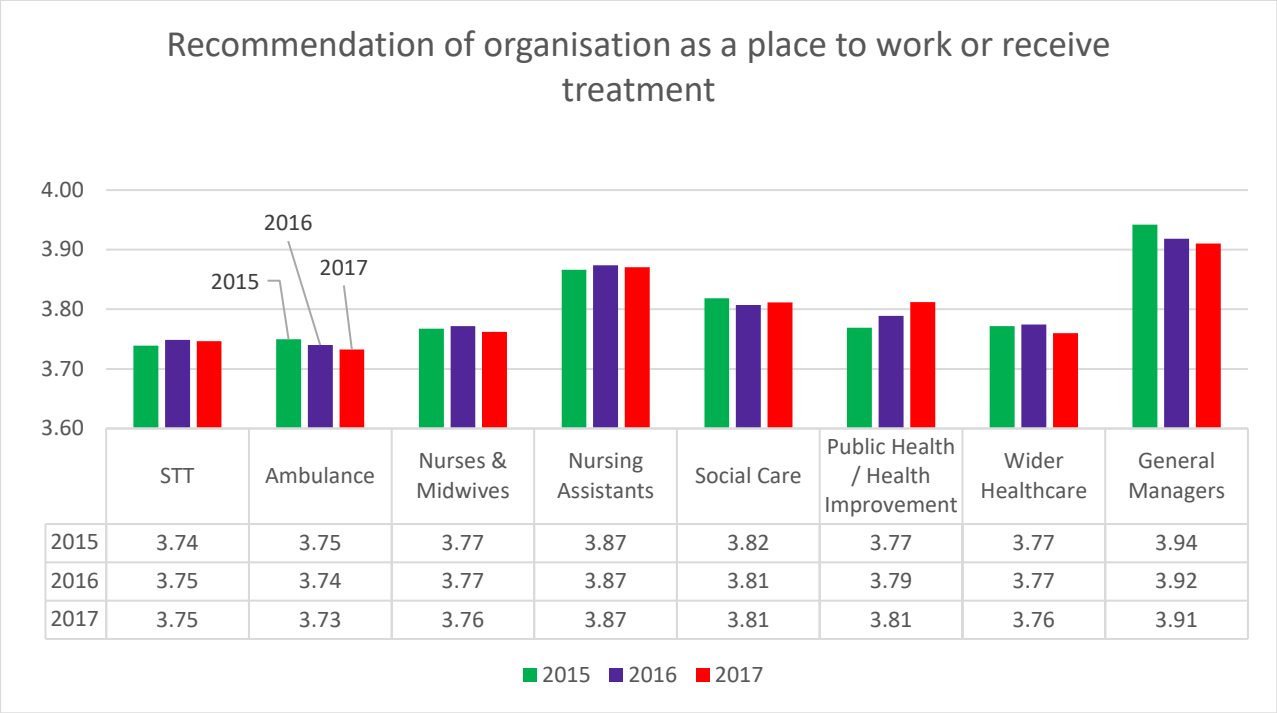


	STT	Ambulance	Nurses & Midwives	Nursing Assistants	Social Care	Public Health / Health Improvement	Wider Healthcare	General Managers
2013	3.81	3.84	3.94	3.92	3.87	3.87	3.77	4.01
2014	3.82	3.85	3.94	3.90	3.95	3.84	3.77	4.01
2015	3.91	3.87	4.06	3.99	4.06	3.90	3.83	4.07
2016	3.92	3.90	4.02	3.99	3.97	3.91	3.81	4.03
2017	3.90	3.87	3.99	3.98	4.01	3.90	3.79	4.02

Staff Satisfaction

6.101 Figure 6.20 shows the results for staff satisfaction with the organisation they work for and if they would recommend it as a place to work or receive treatment. It indicates small changes over the past 3 surveys with scores for most remit groups changing by 0.02 points or less.

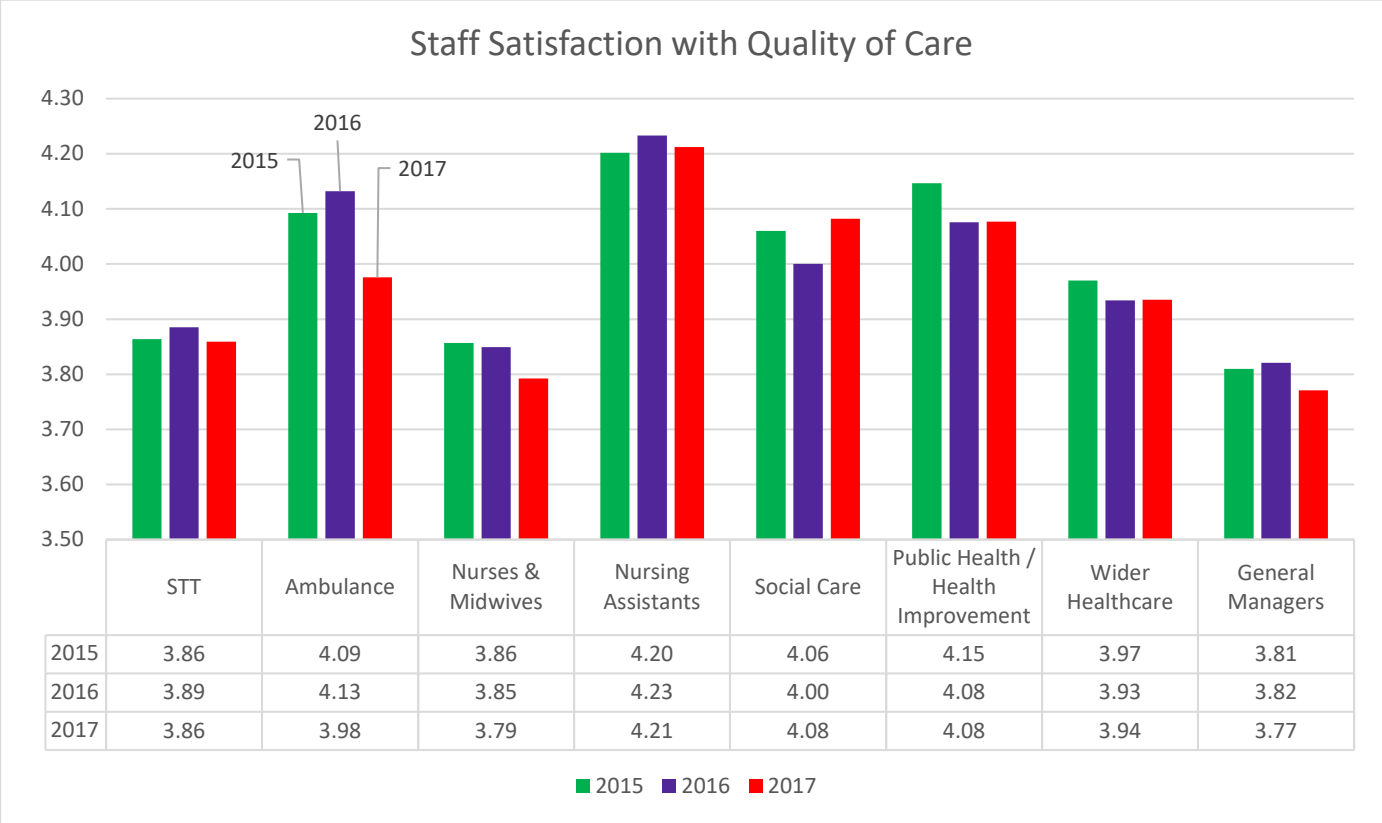
Figure 6.20: Staff recommending their organisation as a place to work or receive treatment



	STT	Ambulance	Nurses & Midwives	Nursing Assistants	Social Care	Public Health / Health Improvement	Wider Healthcare	General Managers
2015	3.74	3.75	3.77	3.87	3.82	3.77	3.77	3.94
2016	3.75	3.74	3.77	3.87	3.81	3.79	3.77	3.92
2017	3.75	3.73	3.76	3.87	3.81	3.81	3.76	3.91

6.102 Figure 6.21 shows the results for staff satisfaction about the quality of care they are able to deliver. In the past year there appears to have been a small decline, most pronounced for Nursing, Midwifery and Ambulance staff. Nursing assistants are consistently the most satisfied.

Figure 6.21: Staff satisfaction with quality of care

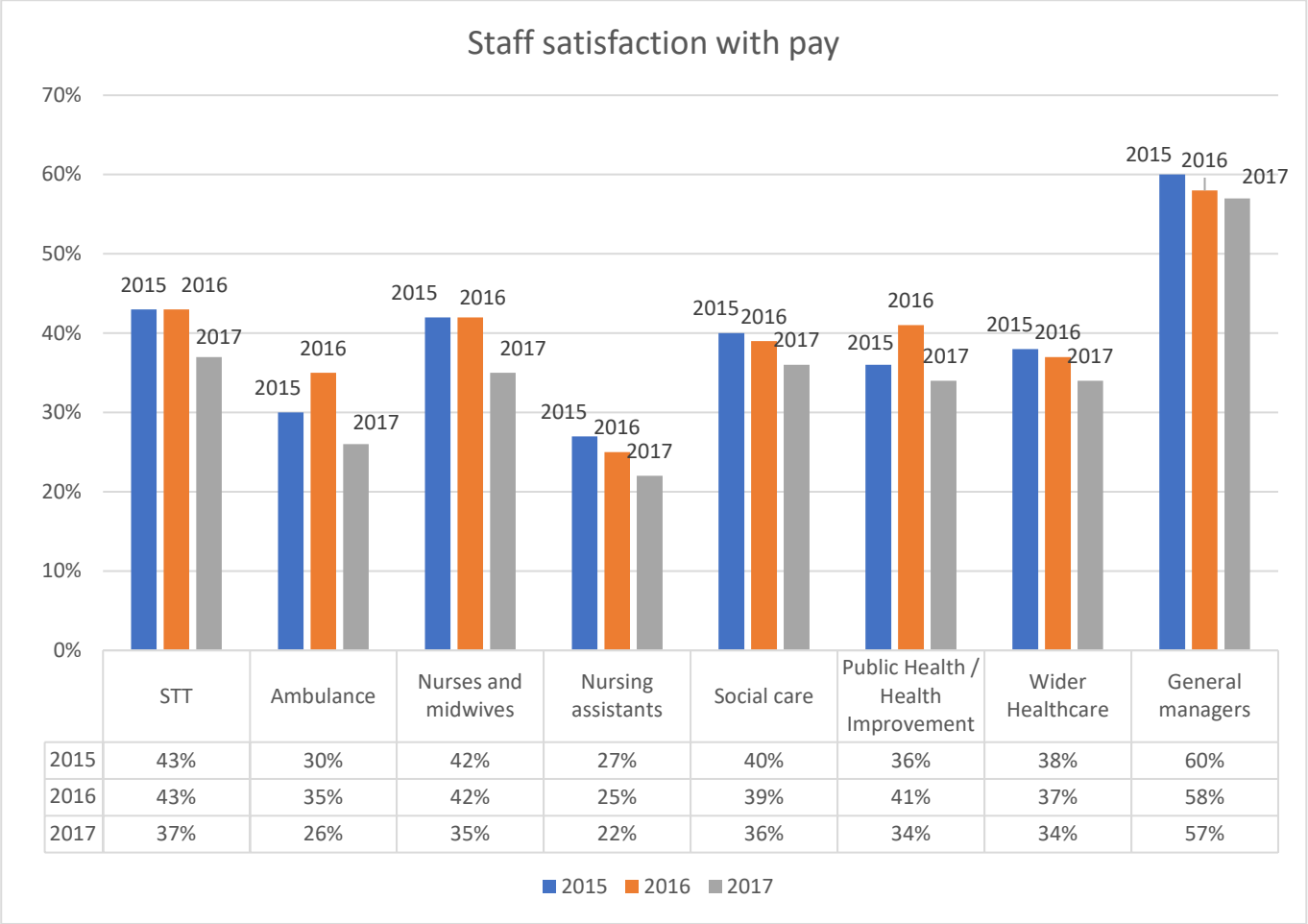


	STT	Ambulance	Nurses & Midwives	Nursing Assistants	Social Care	Public Health / Health Improvement	Wider Healthcare	General Managers
2015	3.86	4.09	3.86	4.20	4.06	4.15	3.97	3.81
2016	3.89	4.13	3.85	4.23	4.00	4.08	3.93	3.82
2017	3.86	3.98	3.79	4.21	4.08	4.08	3.94	3.77

6.103 As with other measures, there is variation in scores for underpinning questions. For example, in respect of those who agree/strongly agree with "I am able to do my job to a standard I am personally pleased with" varies from 75% of Registered Nurses and Midwives in acute trusts to 86% of Ambulance Staff working in mental health/learning disability trusts. There was variance in the same staff groups at different trust types – for example, Ambulance Staff in community trusts had 62% agreeing/strongly agreeing rising to 94% in acute specialist trusts.

6.104 Staff who were either satisfied or very satisfied with their pay has fallen slightly across all staff groups over the last two years. Over half of managers were satisfied with their pay, while under a quarter of nursing assistants were satisfied with theirs.

Figure 6.22: Staff satisfaction with pay

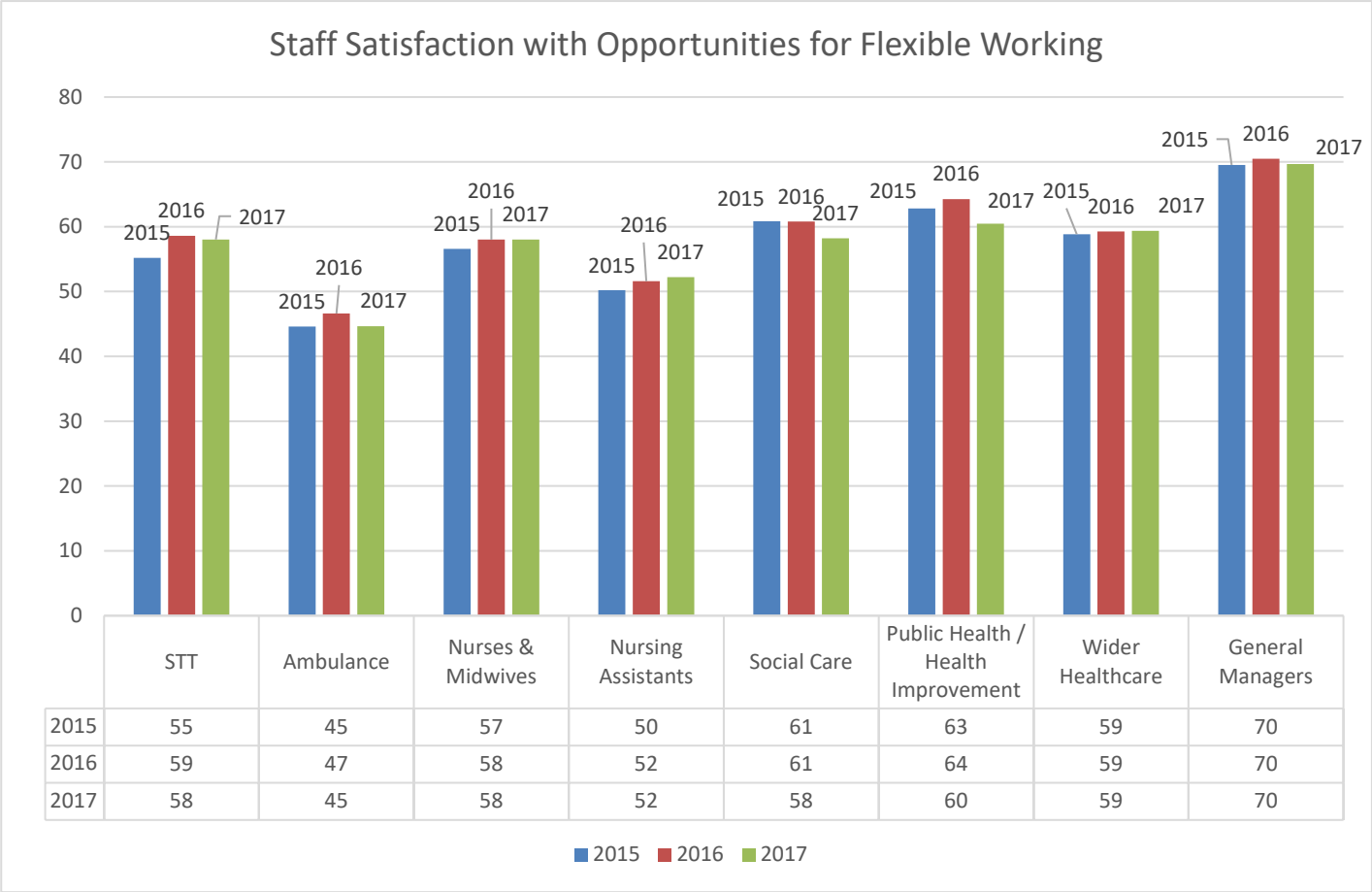


	STT	Ambulance	Nurses and midwives	Nursing assistants	Social care	Public Health / Health Improvement	Wider Healthcare	General managers
2015	43%	30%	42%	27%	40%	36%	38%	60%
2016	43%	35%	42%	25%	39%	41%	37%	58%
2017	37%	26%	35%	22%	36%	34%	34%	57%

Flexible Working and Working Additional Hours

6.105 There have been small changes in satisfaction with opportunities for flexible working over the past 3 surveys. Ambulance staff have lower satisfaction than other staff groups.

Figure 6.23: Staff satisfaction with opportunities for flexible working



	STT	Ambulance	Nurses & Midwives	Nursing Assistants	Social Care	Public Health / Health Improvement	Wider Healthcare	General Managers
2015	55	45	57	50	61	63	59	70
2016	59	47	58	52	61	64	59	70
2017	58	45	58	52	58	60	59	70

6.106 Over the last three years, the proportion of staff working additional paid hours remains around the same, while we have seen a small decline in the proportion of staff working unpaid hours. Ambulance staff work the most additional paid hours with general managers towards the fewest, while almost 90% of general managers work additional unpaid hours.

Figure 6.24: Proportion of staff working additional paid hours

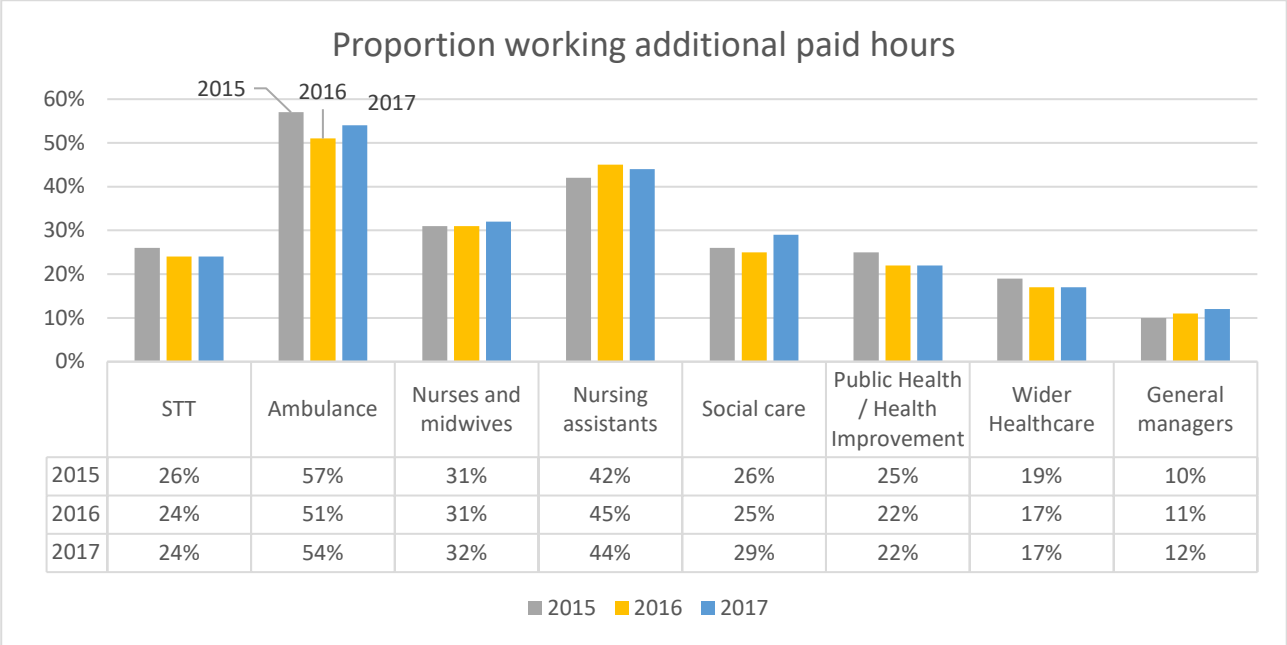
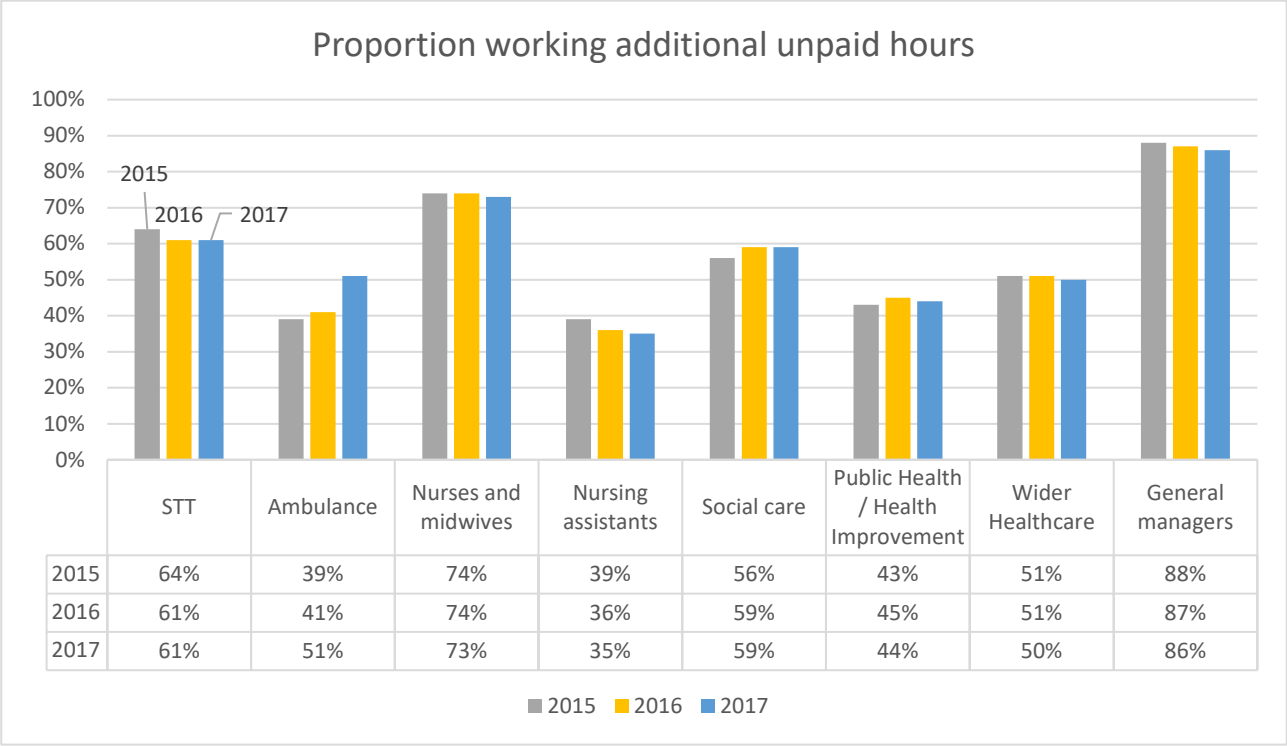


Figure 6.25: Proportion of staff working additional unpaid hours



Health and Wellbeing at Work

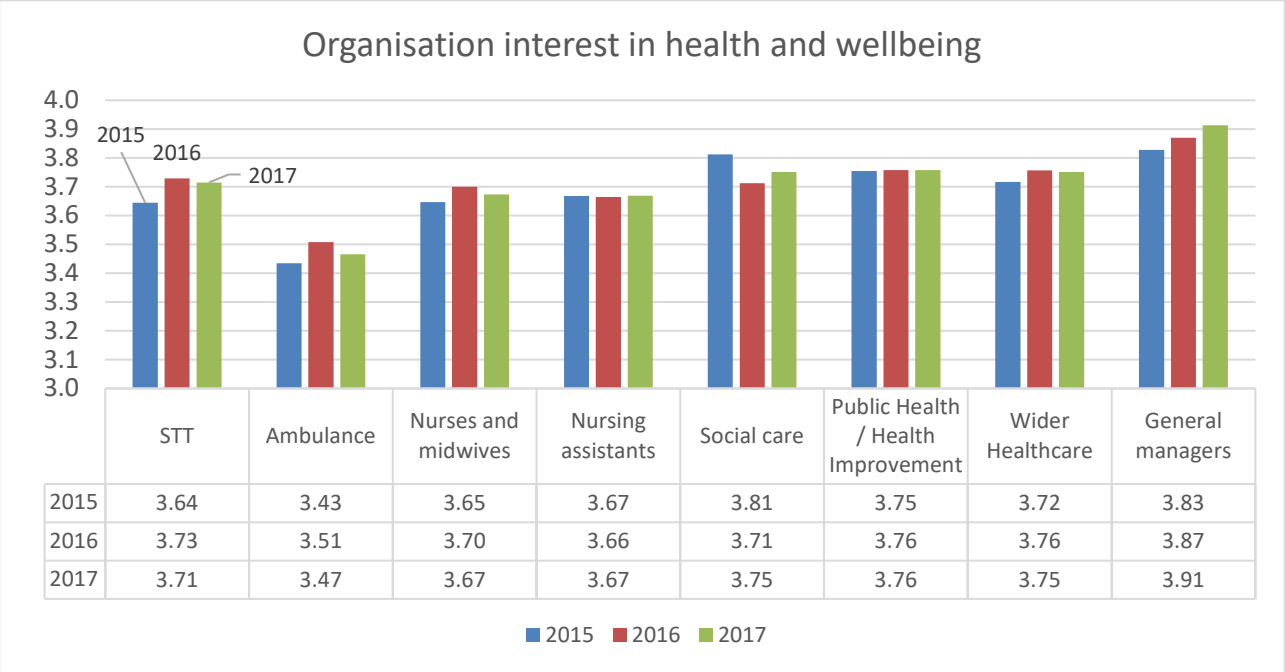
6.107 The NHS Staff survey 2017 showed mixed results in questions relating to health and wellbeing including the prevalence of work related stress, people going to work when unwell and the organisational interest in health and wellbeing. Changes may indicate, to an extent, the impact of NHS England's programme and the CQUIN incentive payments.

6.108 In respect of the percentage of staff feeling unwell due to work related stress over the previous 12 months, there is quite a wide range of results – ambulance technicians were the highest at 51%, up 7% from 2016 whilst ambulance control staff saw a decrease of 11% to 36% in the same period.

6.109 The percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves has varied depending on the group. Ambulance control staff saw significant change in 2017, with a 16% decrease to 57%, 63% for Midwives, a 1% improvement from 2016.

6.110 Organisational and management interest in and action on health and wellbeing also improved for some groups, including midwives, up to 3.47 in 2017 from 3.39. Although ambulance technicians still hold the lowest score on this question, at 3.23, it is a significant increase from the 3.00 in 2016. However, there were some significant decreases, ambulance control staff by 0.15 to 3.33.

Figure 6.26: Organisation interest in health and wellbeing

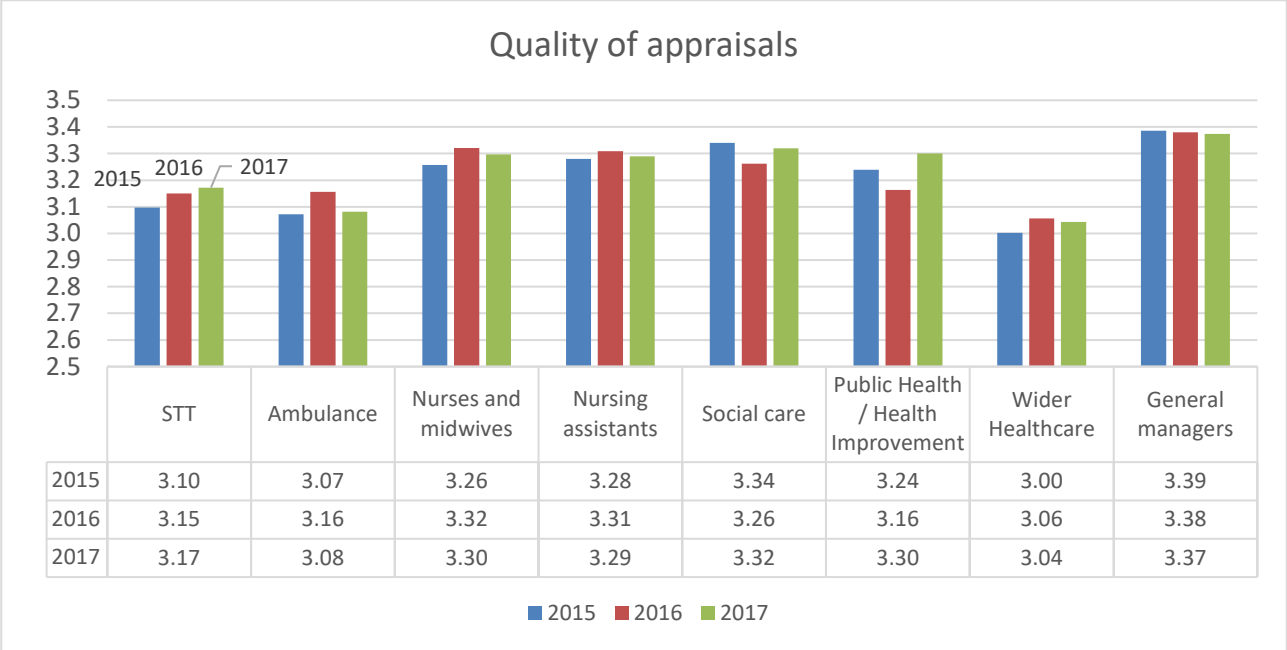


	STT	Ambulance	Nurses and midwives	Nursing assistants	Social care	Public Health / Health Improvement	Wider Healthcare	General managers
2015	3.64	3.43	3.65	3.67	3.81	3.75	3.72	3.83
2016	3.73	3.51	3.70	3.66	3.71	3.76	3.76	3.87
2017	3.71	3.47	3.67	3.67	3.75	3.76	3.75	3.91

Other measures

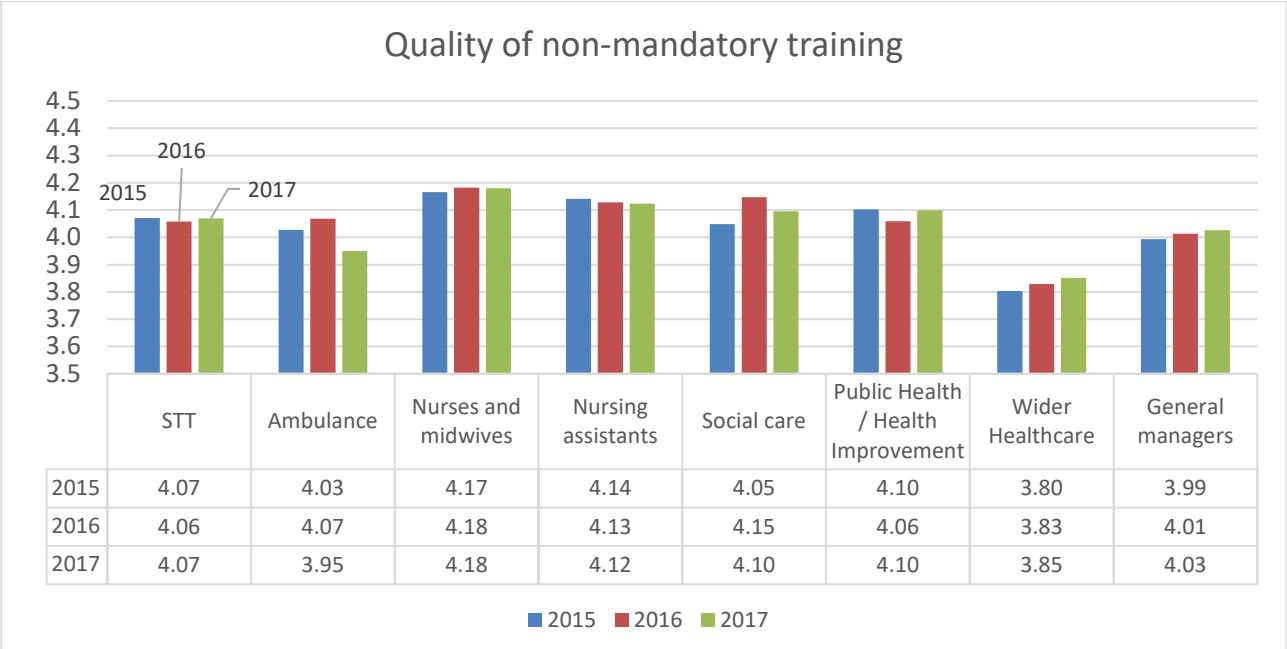
6.111 The staff survey has shown that there have been small changes in other areas covered by the staff survey such as the quality of appraisals and the quality of training and development opportunities. Between 2015 and 2017 there have been small improvements in satisfaction with the quality of appraisals and the majority of staff are satisfied with opportunities for non-mandatory training.

Figure 6.27: Staff survey scores on quality of appraisals



	STT	Ambulance	Nurses and midwives	Nursing assistants	Social care	Public Health / Health Improvement	Wider Healthcare	General managers
2015	3.10	3.07	3.26	3.28	3.34	3.24	3.00	3.39
2016	3.15	3.16	3.32	3.31	3.26	3.16	3.06	3.38
2017	3.17	3.08	3.30	3.29	3.32	3.30	3.04	3.37

Figure 6.28: Staff survey scores on quality of non-mandatory training



	STT	Ambulance	Nurses and midwives	Nursing assistants	Social care	Public Health / Health Improvement	Wider Healthcare	General managers
2015	4.07	4.03	4.17	4.14	4.05	4.10	3.80	3.99
2016	4.06	4.07	4.18	4.13	4.15	4.06	3.83	4.01
2017	4.07	3.95	4.18	4.12	4.10	4.10	3.85	4.03

Sickness Absence

6.112 Sickness absence rates have not changed materially in the period since 2010. NHS Digital publish information on Sickness Absence in the NHS using data sourced from the Electronic Staff Record which is the Human Resource and Payroll system used by all but 2 NHS Trusts, Foundation Trusts and Clinical Commissioning Groups in England.

6.113 Figures include Medical & Dental staff who have the lowest recorded levels of sickness absence.

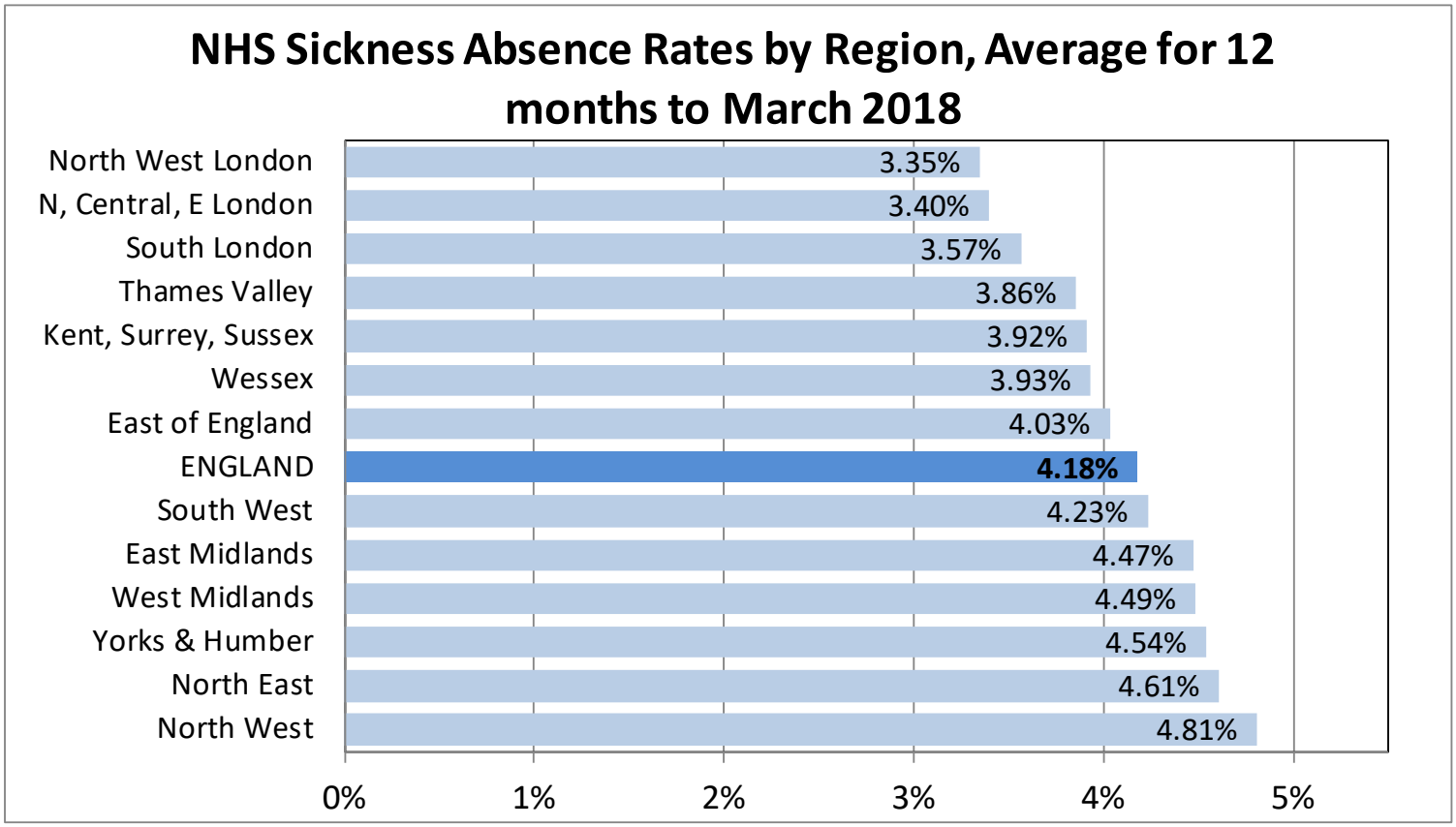
Figure 6.29: Sickness absence rates since 2009-10

Year	Sickness Absence Rate %
2009-10	4.40%
2010-11	4.16%
2011-12	4.12%
2012-13	4.24%
2013-14	4.06%
2014-15	4.25%
2015-16	4.15%
2016-17	4.16%
2017-18	4.19%

Source: NHS Digital

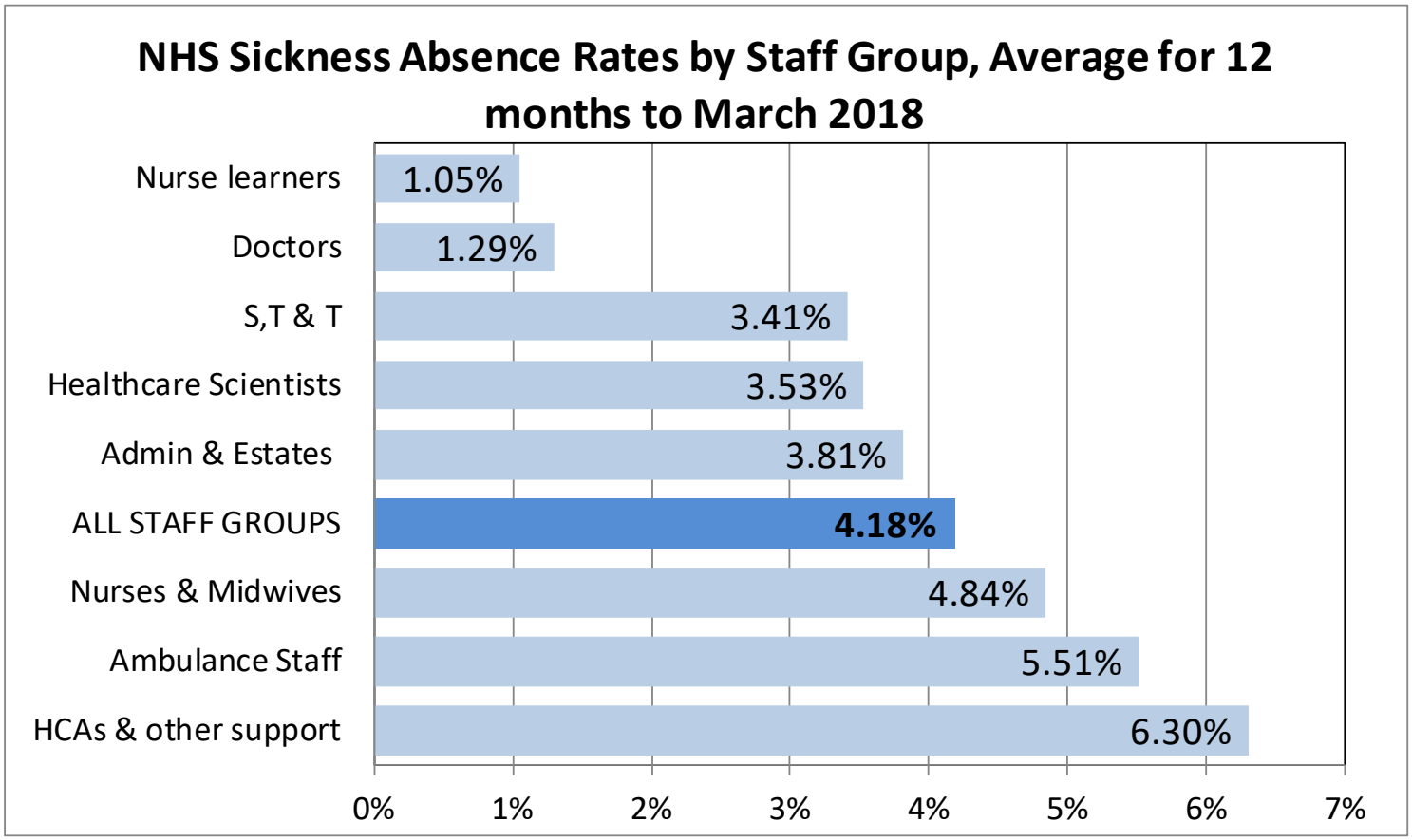
6.114 The North West Health Education England (HEE) region had the highest average sickness rate for 2017-18 at 4.81% with the lowest rate recorded by North West London region at 3.35%.

Figure 6:30: Sickness absence rates by region 12 months to March 2018



6.115 Sickness Absence rates vary by Staff Group. Ambulance staff have some of the highest rates while Doctors and the tiny group of Nurse learners have the lowest rates. There have been no significant changes in absence rates by staff group over the past few years.

Figure 6:31: Sickness absence rates by staff group 12 months to March 2018



6.116 NHS Improvement committed to a target of reducing NHS staff sickness absence by 1% by 2020 and to the public services average by 2022. They are working with 73 trusts as part of their health and wellbeing collaborative which, through identifying and spreading of good practice, is encouraging the NHS to use 10 evidence based high impact actions. These were developed as part of NHS England's NHS staff health and wellbeing framework (published in May 2018). Twelve of the trusts are also testing different models of fast access to accredited occupational health services. Participation in the collaborative is voluntary and no targets have been set for these trusts although NHS Improvement encourages them to assess what they think might be possible.

6.117 Much of the work to improve the health and wellbeing of the workforce centres around long-term cultural and leadership change, developing skills and modifying behaviours so improvement is expected to take time although participating organisations are showing improved sickness absence rates.

IT Staff National RRP – Evidence to PRB

6.118 The Department has been made aware of challenges NHS trusts are increasingly facing, in trying to recruit and retain IT staff. We are still working to establish a greater evidence base in this area, but the initial data suggests the issue is prevalent across the NHS. We have little qualitative or quantitative evidence beyond that which has been sourced in recent weeks. NHS Employers asked trust a list of questions and received responses from 69 trusts. The survey shows that 61 (88.4%) have problems recruiting and retaining IT staff across all AfC pay bands.

Evidence secured to date

6.119 The evidence we currently have is limited. We would welcome views on the evidence we have established so far. It would also be helpful to understand if the current evidence base is sufficient on which to make firm observations or recommendations. The evidence we have sourced to date is at Annex 2. It is difficult to group IT roles in the NHS as this is a free text field on the Electronic Staff Register. NHS Digital's recent search for IT roles returned over 1,700 unique results.

Comparability data on the wider market

6.120 Our work is in the initial phase of development. Work with Civil Service Pay and Reward (CSPR), who perform pay benchmarking across the Civil Service, highlighted the limitations of comparing the salaries of IT staff in the NHS to those in the private sector. Currently, benchmarking against the private sector may produce spurious results. Work continues with CSPR, NHS Employers and NHS Digital to establish comparability between IT roles in the NHS and the private sector, which we expect will allow a more accurate comparison of salary data.

Why jobs are different and a demand for a premium

6.121 We expect NHS Employers and NHS Improvement to provide evidence but we understand they too will need to build a stronger evidence base. We understand from the qualitative evidence provided by NHS Employers that NHS trusts and Foundation Trusts struggle to recruit and retain IT; the IT profession appears very different from clinical careers in the NHS. For example, clinical staff typically have long careers in their chosen clinical profession, with a nursing career typically lasting around 36 years[xi]. By contrast IT staff may be more project focused which

tends to be relatively short term; moving between employers following the completion of projects lasting around 3 or 4 years.

6.122 This is supported by vacancy data provided by NHS Digital, which shows that for the period June 2017 – June 2018 all NHS staff had a stability index (the percentage of staff who are with an organisation at the start of the measured period and who are still there at the end) of 88.4%, whilst senior IT staff had a stability index of 78%. Senior IT staff are defined by NHS Digital as those at AfC band 7 or above; we are yet to source a stability index for roles at band 6 or below.

6.123 Clinical Staff make up the bulk of jobs in the NHS, IT staff far fewer. It is reasonable to assume that, given the different working patterns of IT staff, consideration may need to be given to a bespoke reward package which better aligns to the experience of IT staff and the needs of NHS employers.

Trend Evidence

6.124 We are working with NHS Digital and CSPR to consider if any trend date can be identified for IT staff. This will include data of historic vacancy and turnover rates compared to the private sector, including historical pay development rates compared to the private sector.

The impact of vacancies (where the impacts are felt)

6.125 We understand IT roles in the NHS to have higher turnover rates compared to clinical roles, as shown in figure 6.32.

Figure 6.32: NHS turnover rates

	Joiner headcount	Joiner rate	Leaver headcount	Leaver rate	Stability index
All NHS staff	154,125	13.0%	136,520	11.5%	88.4%
Senior IT staff	651	28.0%	495	21.3%	78.0%
Managers	6,532	28.5%	5,212	22.8%	76.6%
Nurse and Health Visitors	38,112	12.1%	37,045	11.7%	88.3%

Source: NHS Digital, NHS Hospital & Community Health Service (HCHS) workforce statistics.

6.126 We do not currently have data on those IT roles which have the highest vacancy and turnover rates, but will continue work to establish this. From the data secured by NHS Employers, it appears that high vacancy rates occur at all AfC pay bands. However, 38 out of 69 trusts said they had recruitment and retention challenges for IT staff at AfC pay band 6 and above. Of those 38, a further 22 trusts said recruitment and retention challenges occur most acutely at AfC pay band 7 and above.

Geographic data (Is it a consistent picture nationally?)

6.127 NHS Employers' survey shows that 14 of the 69 who responded, believe geographical location is a barrier to recruiting and retaining IT staff. Many trusts are located in rural regions or the absence of Universities they believe appears to be a further barrier to their efforts to attract talent. Trusts near London, such as Kent Community Health NHSFT and Luton and Dunstable University NHS Trust also believe they struggle due to the ‘pull’ of better paid private sector work in inner city London. It is possible that some trusts who do not qualify for the high cost area supplement (HCAS) may lose staff to those who do. However, it also appears the HCAS may be insufficient in terms of helping the NHS compete for IT talent in these areas.

6.128 Evidence we have been able to secure so far suggests that the recruitment and retention challenges are nationwide. However, it is clear from our initial work that the impact differs across regions. NHS Employers' data suggests that there may be inconsistent benchmarking of IT roles, meaning some trusts lose IT staff to nearby trusts who have benchmarked the same role at a higher AfC pay band.

6.129 To better understand the repercussive effects of trusts using the AfC pay banding system to compete for scarce skills, we are working with CSPR to investigate the possibility of creating an NHS version of the Digital, Data and Technology framework used to evaluate IT roles across the Civil Service. This is at a very early stage but could help establish a more accurate and consistent system for benchmarking IT roles in the NHS.

What are the flexibilities available to employers?

6.130 Trusts currently have the freedom to use local recruitment and retention premia (RRPs). However, we understand trusts may be reluctant to use local RRPs due to the cost pressure and because it needs to be kept under review to ensure staff

continue to receive equal pay for work of equal value. If one trust adopts a local RRP there is the potential that others in the local area would be pressured to follow suit. This could lead to inflated pay in the region without solving the problem. It is worth noting that higher pay provided by a national or local RRP may still fall short of the salaries offered by the private sector. We would welcome the Pay Review Body's observations on how trusts can make better use of the pay flexibilities already available to them.

Total Reward

6.131 The total NHS reward offer applies to all staff including IT staff. However, given the nature of IT career progression we expect staff will want to maintain and update their IT skills regularly and may value opportunities to enhance their skills above other aspects of the total reward package. We are exploring options to secure more direct information on how IT staff view the total reward package in the NHS, and which aspects of the package they value most.

7. Agenda for Change Multi-Year Pay and Contract Reform Deal

7.1 Following constructive negotiations between NHS trades unions and NHS Employers, on 27 June 2018 agreement was reached on a new AfC national collective agreement for pay awards and contract reform over three years (2018/2019 to 2020/2021).

7.2 This agreement covers around one million AfC staff and is a good example of where public-sector employers and Unions can work together to agree a pay rise in return for wider reform.

7.3 The 3-year deal aims to ensure that every pound of the £36bn pay bill delivers value for money and is fair to patients, staff and the taxpayer. It targets recruitment, retention and capacity issues to support staff and help them meet demand within the NHS.

7.4 The NHS Staff Council, a partnership of NHS Employers and NHS trades unions will provide joint evidence on the work programme for implementing the deal; NHS Improvement will lead work to ensure the deal is implementing on the ground as the partners intend. Parallel negotiations on wider reforms agreed as part of the pay and contract reform deal continue.

7.5 The deal will help ensure the NHS can continue to recruit the skilled compassionate workforce it needs by, for example:

- targeting the greatest pay uplifts at the lowest paid in the NHS, affecting over 100,000 full time equivalent staff, so that the lowest starting salary increases from £15,404 this year to £18,005 in 20/21, through reform; and
- investing in higher starting salaries for staff in every pay band by removing overlapping pay points: a newly qualified nurse will receive starting pay 12.6% (£2,779) higher in 2020/2021 than 2018/2019 and starting pay for a midwife on moving to Band 6 will increase by 18.1%(£4,800) in 2020/2021.

7.6 The reforms will help keep the staff the NHS needs by:

- guaranteeing fair basic pay awards over three years to the 50% of staff at the top of their pay band – a cumulative 6.5%; and

- faster pay progression pay for staff not yet on the top of their pay band: due to reforms to the pay structure (higher starting pay and fewer pay points for most staff), staff will receive between 9% and 29% over three years.

7.7 Improving productivity by improving the annual appraisal process; putting learning and development at its heart:

- ending virtually automatic incremental pay replaced by larger, less frequent pay increases subject to staff meeting the required standards for their role;

- staff will be supported to develop their skills and competencies and must show/demonstrate that they meet the required standards for their role before moving to the next pay point; and

- reforming the national pay roll system (the Electronic Staff Record) so that progression pay is no longer paid automatically: pay points will be 'closed', and opened only when staff show/demonstrate they meet the required standards through a formal submission process, led and actioned by the line manager.

7.8 Increasing capacity by:

- employer commitment to support staff to maintain their health and wellbeing by reducing sickness absence levels to the best in the public sector. NHS Digital data suggests that the latest sickness absence rate for the NHS is 4.2%. For AfC staff, the average is around 4.5%.

7.9 Support retention and facilitate greater consistency across the NHS:

- New provisions will be agreed to give staff access to consistent Child Bereavement Leave, Enhanced Shared Parental Leave (extension of statutory rights), and a national framework for buying and selling annual leave;

- Over time, the calculation for sickness absence pay will be the same for all staff; and

- Very modest changes to the value of the higher rates of unsocial hours pay for staff in pay bands 1 to 3, over the period of the multi-year deal to ensure the difference between these staff and all other AfC staff is narrowed over time.

Wider contract reform

7.10 NHS Employers is leading several partnership sub groups exploring contract and policy reforms included in the AfC framework agreement. The Department, NHS England and NHS Improvement are working with NHS Employers to support ongoing talks which aim to seek agreement on:

- new guidance to support the introduction of a new pay progression system: ensuring effective support for employers on the ground with system changes to the Electronic Staff Record to ensure pay step points are closed and opened only when staff meet the required standards for their role;

- a new Apprentice pay framework: affordable offer to help increase the domestic supply of staff from different backgrounds across a range of roles, helping to increase capacity;

- new guidance to support the closing of pay band one to new entrants from 1 December 2018: ensuring staff have the skills to operate at band 2 level (whilst retaining flexibility to retain Band 1 level roles) contributing to greater productivity/efficiency;

- new policies for buying and selling annual leave: a voluntary approach to create greater consistency and flexibility for staff that want to buy more annual leave to support their work life balance and to help incentivise staff that want to sell annual leave, helping to increase capacity;

- new policies to help improve the experience of Bank working: to encourage staff to choose Banks over Agencies; we know staff are more committed to their own trust Banks;

- improving bereavement policies on the death of a child (under age 18); to help create greater consistency on how the policy operates across the NHS;

- improving shared parental leave policies: for example, to mirror arrangements available in the Civil Service; and

- improving policies for Time Off In Lieu (TOIL): greater consistency on how the policy operates locally across the NHS.

Non-statutory non-NHS organisations providing NHS services

7.11 The Written Ministerial Statement published in June 2018 makes clear that, as part of the AfC pay and contract reform deal, those non-statutory non-NHS organisations that receive NHS or Public Health Grant funding for the delivery of NHS services will be eligible to receive additional funding for 2018/2019 if those services are delivered by staff employed dynamically (existing and new staff) on the AfC contract, as set out in the NHS terms and conditions of service handbook.

7.12 In July 2018 the Department published the eligibility criteria. The aim is to compensate those organisations that must implement the entire pay deal - pay and non-pay reforms, not just headline pay - and should be compensated for the costs of doing so. Organisations that employ staff on the AfC contract are obliged to introduce the reforms. By contrast, organisations that do not employ staff on the AfC contract have no such obligation.

7.13 The Department is leading work to identify, from the applications it has received for additional funding for 2018/2019, those non-statutory non-NHS organisations that are eligible for additional funding.

7.14 Additional funding for 2018/2019 will be met directly by the Department. This is because organisations had already received 1% for 2018/2019 (under the then public sector pay cap) through the tariff, and attempts to unpick funding proved problematic. It was agreed that, exceptionally, the Department would make additional payments to eligible organisations for 2018/2019 only.

7.15 Some non-statutory non-NHS organisations mirror the annual pay award announced for NHS staff but may only employ existing staff on the AfC contract or may not use the AfC contract at all. In these circumstances organisations may incur an indirect rather than a direct cost because of the AfC deal and would not be eligible for additional funding for 2018/2019 as set out in the Written Ministerial Statement.

7.16 We expect NHS England to return to the normal funding mechanism (the national tariff system) from 2019/2020. Most NHS services that non-statutory non-NHS organisations are commissioned to provide are subject to local pricing negotiations. Commissioners must have regard for national prices (which will include pay uplifts); however, there is flexibility at a local level.

7.17 Any decision about additional funding is for the commissioners to make. However, we expect that commissioners and their non-NHS providers will want to discuss how the AfC pay and contract reform deal (particularly where staff are employed dynamically on the AfC contract) affect their local agreement to provide NHS services.

7.18 The commissioner may want to consider how a similar 'something for something' deal, which applies to directly employed NHS staff (additional pay investment in return for improvements in productivity/capacity) might apply to local commissioning agreements, for example, in return for quality improvements.

Implementing the Agenda for Change pay and contract reform deal

7.19 NHS Improvement developed and is leading the AfC Implementation Board. The aim is to ensure the governance structures and development of key performance indicators help organisations to prepare their own local implementation plans. Through those plans, NHS Improvement will advise the Department on progress and identify any areas of concern so that remedial action can be taken as quickly as possible.

7.20 NHS Improvement is working closely with the NHS Staff Council and NHS Employers to develop supporting material to help ensure organisations understand the agreement and the commitments it makes on behalf of their leadership teams and staff which aim to improve staff productivity through improved local appraisal systems and increase capacity by helping staff maintain their physical and mental health and wellbeing. It is recognised by all stakeholders that clear timely communications for both leadership teams and staff is crucial.

7.21 The design of the new pay structure moves away from the previous system of virtually automatic annual incremental pay increases, to a system which links significant pay rises at each pay step point to staff demonstrating/showing that they meet the required standards for their role. The new pay system retains the principle of re-earnable pay for staff at pay bands 8c to 9: that senior staff should be held to a higher standard than less senior staff.

7.22 For all AfC staff, the expectation is that they will meet the required standards for their role. In each case, business/personal objectives, values and behaviours will be developed locally and should be achievable. The expectation is that staff and line managers will work together, in partnership, to ensure any

training/development needs are addressed throughout the year, not just at the pay step point.

8. Pensions and Total Reward

Introduction

8.1 The NHS Pension Scheme ('the Scheme') remains a valuable part of the total reward package available to the NHS workforce. The employer continues to pay more towards the costs of the scheme than most of the workforce: currently contributing 14.3% of pensionable pay, plus an administration charge of 0.08%. Employee contributions are tiered according to income, with the rate paid by the lowest earners being 5% and the highest 14.5% (for those earning £111,377 or above).

8.2 Eligible members of the NHS workforce will now belong to one of the two existing Schemes. The finals salary defined benefit Scheme consisting of the 1995 and 2008 sections is now closed, other than for a limited group who are eligible for age-related protection. The new NHS Pension Scheme introduced in 2015 is a career average revalued earnings (CARE) Scheme. The key differences between the two Schemes, other than the way benefits are calculated, are different normal pension ages (1995 section – 60, 2008 section – 65, and 2015 Scheme – state pension age) and accrual rates (1995 section – 1/80th, 2008 section – 1/60th, 2015 Scheme – 1/54th). Under the new Care Scheme, most low and middle earners working a full career will continue to receive pension benefits that are at least as good, if not better than those under the former final salary Schemes.

8.3 The new NHS Pension Scheme 2015 continues to provide a generous pension for NHS staff and remains one of the best schemes available. The Government Actuary's Department (GAD) calculates that Scheme members can generally expect to receive around £3 to £6 in pension benefits for every £1 contributed. The Scheme is backed by the Exchequer and is revalued in line with price inflation; providing a guaranteed retirement income. A band 5-6 nurse[xii] (retiring at 68, with service wholly in the 2015 Scheme), with 35 years' service, can expect a pension of around £19,000 a year.

NHS Pension Scheme Contributions

8.4 Contributions are tiered according to earnings, with higher earners contributing proportionately more, factoring the beneficial effect of higher tax relief.

Figure 8.1: Employee contribution rates

Whole-time Equivalent Pensionable Earnings/Pay	Contribution Rate (gross)
≤ £15,431	5.0%
£15,432 - £21,477	5.6%
£21,478 - £26,823	7.1%
£26,824 - £47,845	9.3%
£47,846 - £70,630	12.5%
£70,631 - £111,376	13.5%
≥ £111,377	14.5%

8.5 Employee contribution rates remained the same in 2018-19 as they were in the previous two years, and remain set until 31 March 2019. It is expected that around 10% of members will see their contribution rate increase (by between 0.6% and 3.2% of pensionable pay, depending on where they are in the pay range) at some point in the four years 2015-2019. A proportion of members are expected to progress to higher contribution tiers year to year through pay progression.

8.6 The NHS Pay Review Body has previously recommended that annual pay awards should not have the unintended consequence of reducing the take-home pay of staff whose pay award causes them to cross pension contribution thresholds. As noted in our evidence submitted for the 2018-19 pay round, the Department asked the NHS Pension Scheme's Scheme Advisory Board (SAB – partnership of Department, NHS Employers and NHS trades unions) to review the approach to member contributions. The review explored several design elements, including whether the rate payable should be determined using whole-time equivalent or actual earnings, the range and number of tiers, and whether tier boundaries should be revalorised to avoid pay awards placing individuals in higher contribution tiers.

8.7 The SAB submitted their review conclusions in July 2018, and reached full agreement that:

- the principles underpinning the current contribution structure should be retained, include protection for the low paid, minimise the risk of opt-outs, and ensure the scheme remains a sustainable and valuable part of staff reward;
- 'cliff edges' in the contribution structure should be resolved;
- there is a pressing need to explore ways to minimise scheme opt-outs and mitigate other issues caused by the impact of pension taxation; and

- a move to use actual pay, rather than whole-time equivalent pay, to determine

  contribution rates would be appropriate.

8.8 The SAB reached a majority recommendation that the existing contribution structure be retained for a further two years until 31 March 2021. There was a recognition that further discussion was required on a number of areas, including the approach to avoiding 'cliff edges', and a desire by most trade union representatives to seek a formal mandate from their membership before recommending any move to actual pay as the basis for determining contribution rates. NHS Pension Scheme savings is deferred pay. However, the SAB also expressed concern that contribution rate rises are seen to offset part of the recently agreed AfC pay deal and could undermine member confidence in both the pay agreement and pension scheme.

8.9 The Department has accepted this recommendation. During this transitional period, the SAB will continue developing a recommended contribution structure based on the agreed elements outlined above. The SAB recommendation is made and accepted subject to the outcome of the quadrennial actuarial valuation of the scheme.

NHS Pension Scheme Membership Levels

8.10 The Department has continued to monitor changes in scheme membership using data from the Electronic Staff Register (ESR). Annex 5 presents membership rates by AfC band, as an update to the evidence provided by the Department last year. It shows the position at August 2018 and the percentage point change over the previous month, the last 12 months and October 2011.

8.11 Scheme membership remains high across all staff groups and AfC bands, with typically around 9 in 10 participating. Between October 2011 and August 2018, the proportion of NHS staff who were members of the Scheme increased by 5.1% points. Membership rates increased by 0.9% in the 12 months to August 2018 and continue to grow within the lowest paid bands; as participation rates for AfC band 1 increased 3.4% between August 2017 and 2018.

8.12 There was a decreased participation of 2.1% over the last year for doctors. Membership rates increased for each AfC band up to and including band 7, but fell by 1.7% for non-AfC staff.

8.13 Amongst the highest paid AfC bands, particularly management roles, the opt-out trend observed in previous years appears to have continued. We are reviewing recruitment and retention of high earners, of which pension tax changes will be a factor. Will explore what, if any mitigation might be appropriate in the context of total reward.

8.14 For individuals with an annual allowance tax charge, HMRC offers an alternative payment facility. The 'Scheme Pays' facility allows the individual to elect for the pension scheme to pay the tax charge on their behalf. The scheme then recoups the cost by reducing the value of the individual's pension by an amount equivalent to the tax charge plus interest. It means members can settle their tax charges without needing to pay up front.

8.15 The Department has closed a gap in the 'Scheme Pays' coverage operated by the NHS Pension Scheme, which prevented those with charges arising from the tapered annual allowance or charges under £2,000 from utilising it. The scheme administrator has confirmed that the scope of 'Scheme Pays' has been extended so that from tax year 2017-18 it can be used to meet any pension tax charge of any amount.

Total Reward

8.16 Total reward, the tangible and intangible benefits that an employer offers an employee, remains central to recruiting and retaining staff in the NHS. There is some evidence that more employers across the NHS are developing a strategic approach to reward which may be due to:

- staff demand arising from total reward statements;
- trusts recognising they need to do more to recruit and retain staff in an increasingly competitive employment market;
- employers working to reduce staff sickness and other absences by ensuring they are offering the support staff need for their physical, mental and financial wellbeing.

8.17 The Department's ambition for the NHS reward strategy remains that employers should develop their capacity and capability to;

- utilise the NHS employment package to recruit, retain and motivate the staff they need to deliver excellent services to patients;

- develop and implement local reward strategies that meet organisational objectives and workforce needs;

- improve staff understanding of their reward package and what options they have to change aspects of it;

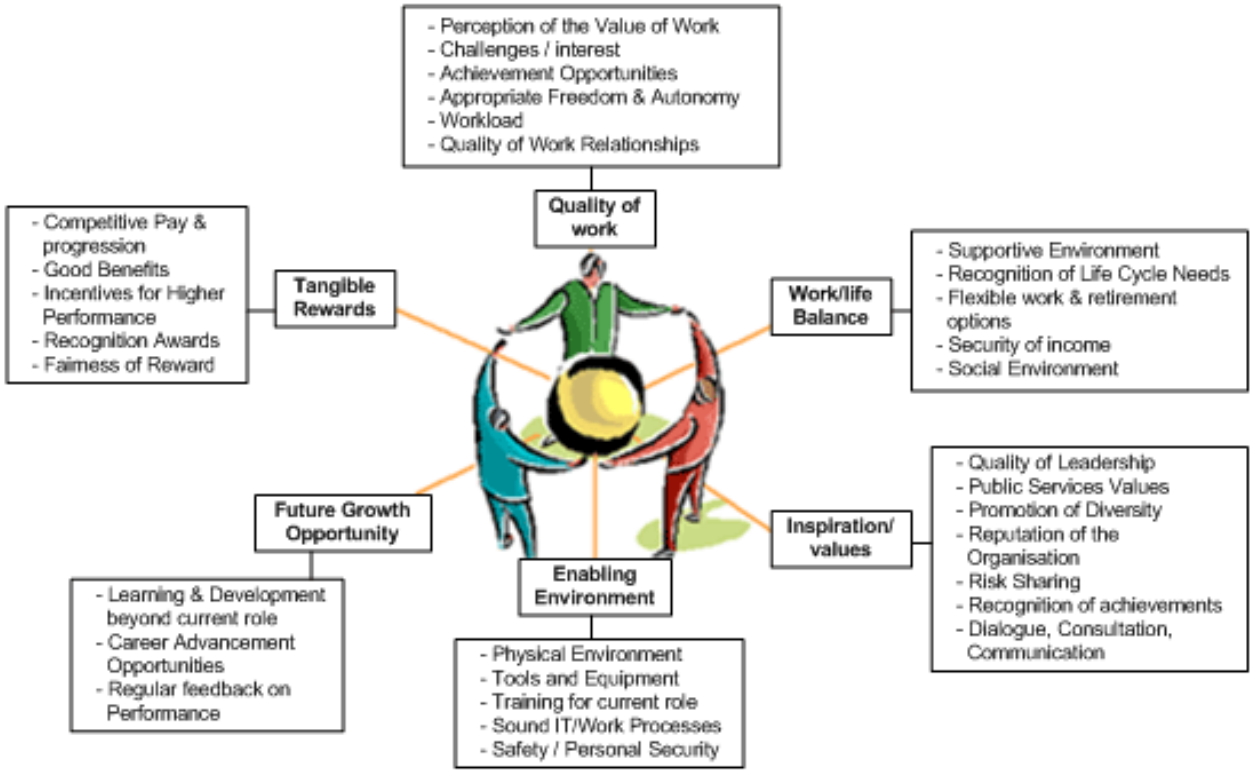
- strengthen staff experience of working for the NHS;

- contribute to improvements in workforce productivity and efficiencies in use of the NHS workforce pay bill;

- continue to be at the leading edge of innovation in public sector reward, and improve NHS staff satisfaction with pay.

8.18 The Department commissions NHS Employers to provide advice, guidance and good practice to the NHS on developing a strategic approach to reward based on the Hay Model (below).

Figure 8.2: Hay Model



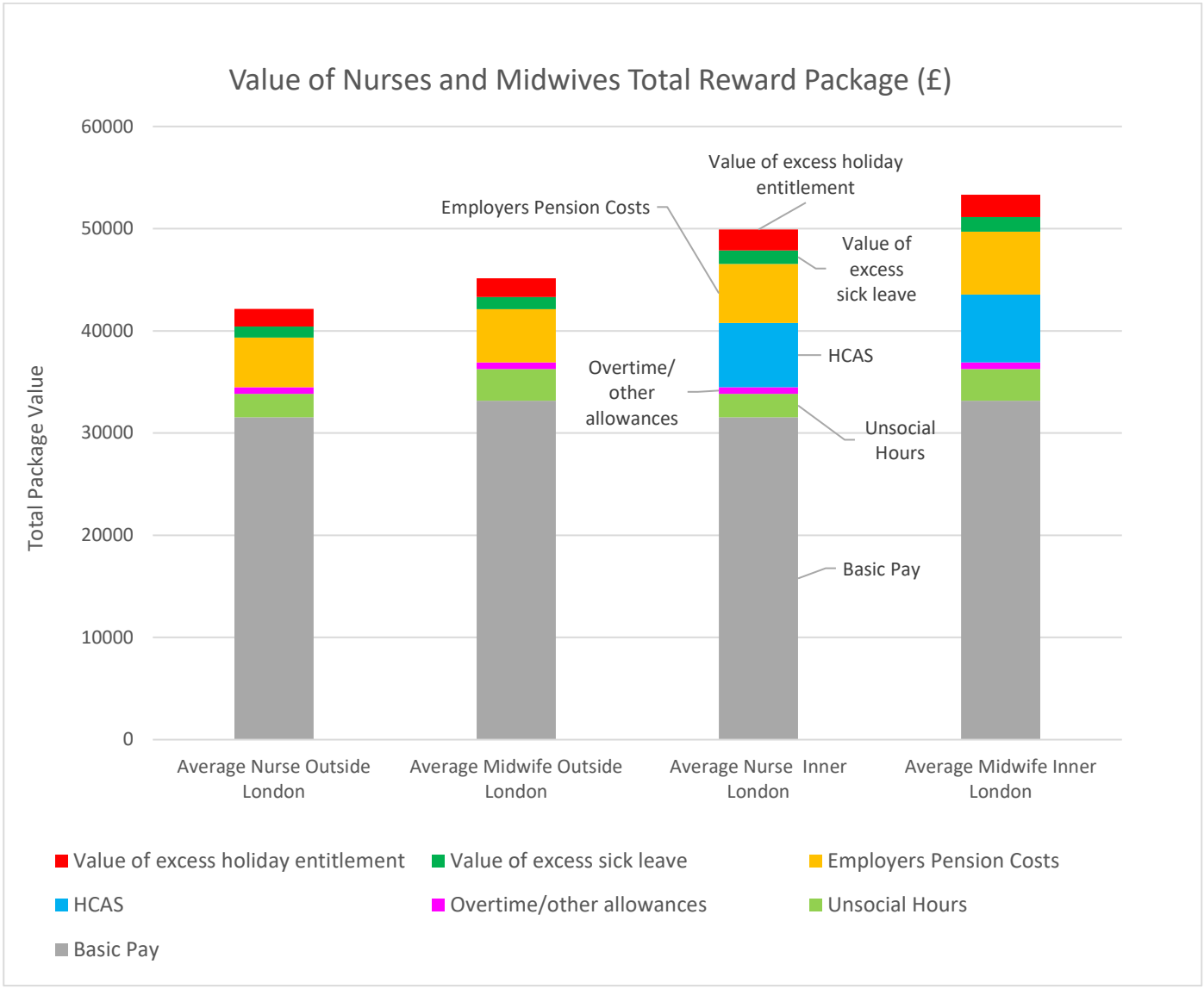
8.19 NHS Employers will provide updates on:

- their work to ensure the strategic context for total reward in the NHS remains 'fit for purpose' and aligned with their other work programmes;
- how their engagement with employers is improving NHS understanding of total reward and why they should be developing their own local reward strategies;
- their promotion of existing and new tools to support trusts in using strategic reward to deliver local workforce priorities;
- the continuing development of their total reward engagement to gain and share intelligence about total reward in the NHS; and
- their promotion of better uptake and understanding of total reward statements.

8.20 The value of reward packages for this remit group is shown in the graph below and includes: basic pay, employer's pension contributions, other pay such as unsocial hours, overtime, other allowances, higher cost area supplements (for London based staff), difference between NHS sick pay and statutory sick pay, difference

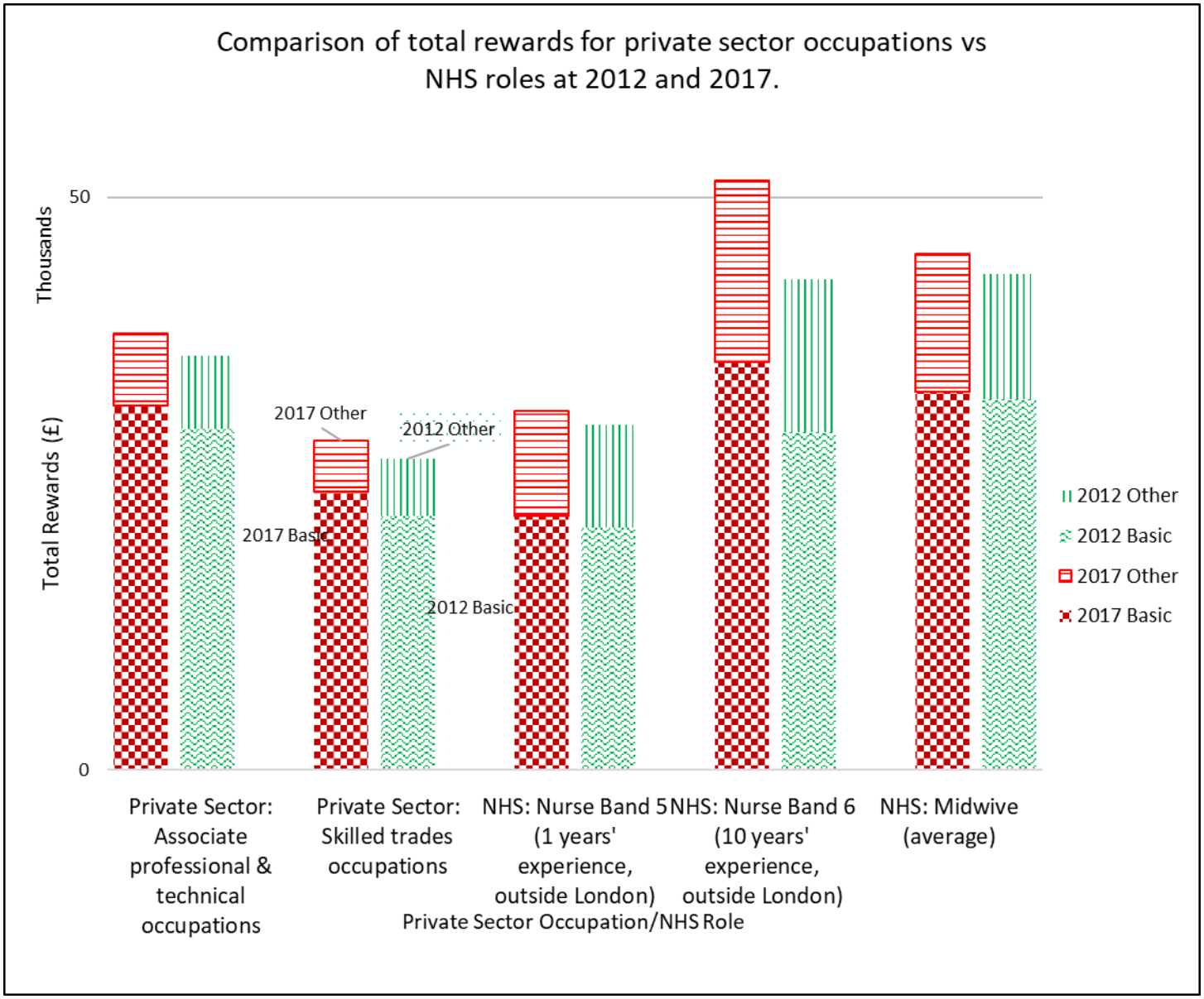
between NHS paid holiday and statutory paid holiday, difference between NHS maternity leave and statutory maternity leave, difference between NHS redundancy pay and statutory redundancy pay.

Figure 8.3: Value of Nurses and Midwives total reward package



8.21 The Department commissioned the Government Actuary's Department (GAD) to analyse total reward across various private sector occupations, based on Office for National Statistics (ONS) data for salary and pension benefits, and compared them against pay rewards for various NHS staff based on previous GAD analysis for 2012 and 2017. This analysis is intended to give an approximate indication on how the total pay rewards compare with other occupations and change over time, it is not intended to provide a direct comparison between NHS roles and other occupations.

Figure 8.4: Comparison of total rewards for private sector vs NHS roles at 2012 and 2017



8.22 All roles considered as part of this analysis from the NHS and private sector occupations experienced an increase in total rewards over the period 2012 and 2017. Nurse Band 6 with 10 years' experience, working outside London experienced the largest increase at around 20% over the period 2012-2017. Nurse Band 5 with 1 years' experience, working outside London and average midwives showed broadly similar increases in reward over this period at around 4% between 2012 and 2017. Non-basic pay makes up a larger proportion of NHS reward relative to private sector occupations as evidenced by the above graph. One driver for this might be the higher employer pension contributions available to NHS staff

relative to the private sector occupations, as well as additional pay elements and awards available to NHS staff, relative to the private sector.

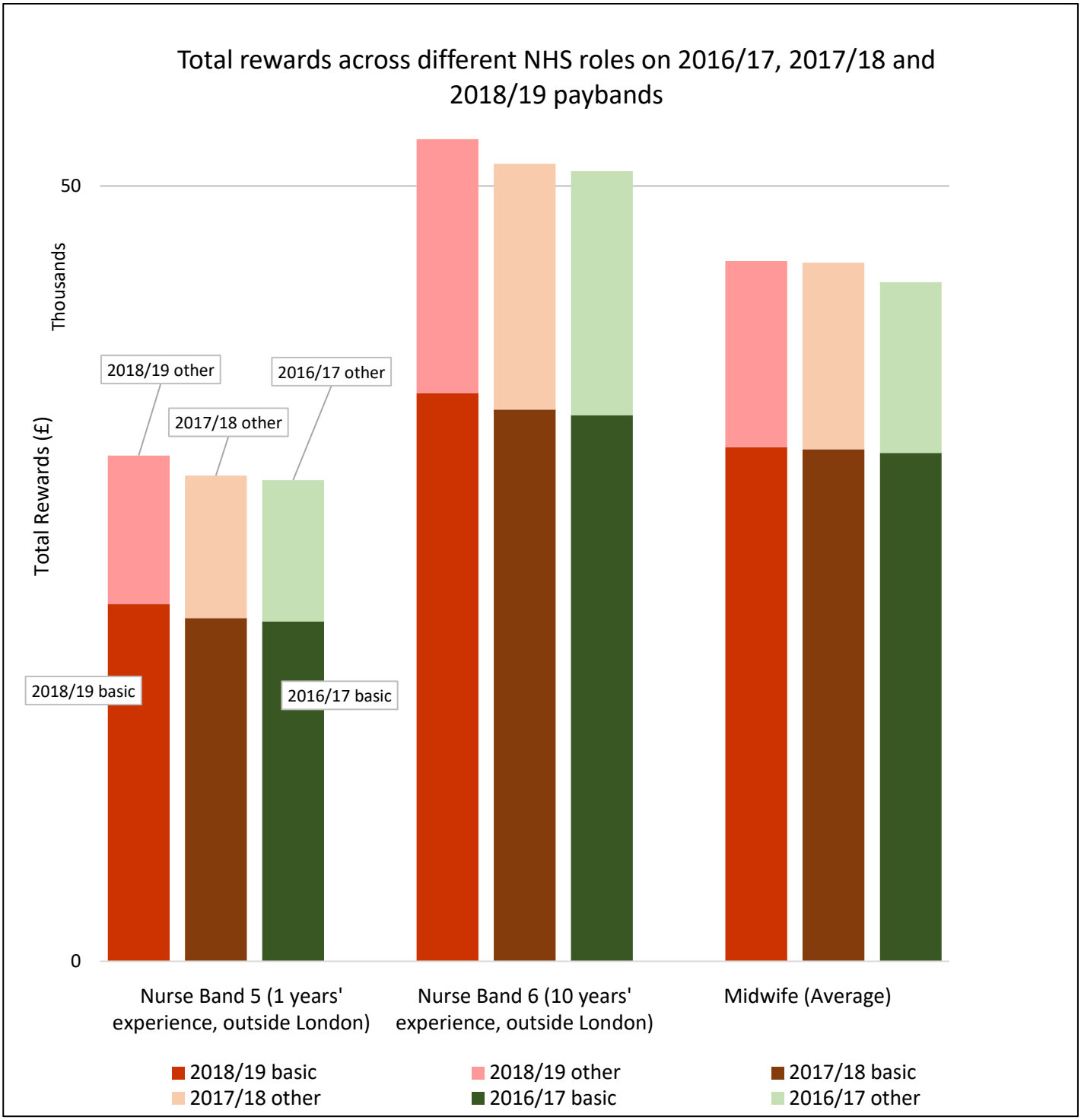
8.23 Although they are not included in the above graph, the additional non-basic pay elements of the total reward package available to NHS staff must be considered as they exceed that available in the private sector. NHS staff are entitled to redundancy up to a maximum of £160,000, whereas statutory redundancy has a maximum cap of £15,240. NHS staff receive one month's pay for every year of service up to a maximum of 24 months, whilst statutory redundancy provides 0.5 weeks for service below age 22, 1 week for service up to age 41 and 1.5 weeks for service beyond age 41.

8.24 It is difficult to quantify the value of redundancy benefits, as this only applies when an individual is made redundant and would therefore need assumptions about the rate at which members leave under redundancy terms. Eversheds Sutherland conducted a survey of employers in 2016, which found that 1/3 of respondents offer statutory benefits only. 60% of respondents consider enhanced redundancy to be discretionary, unlike the NHS, suggesting that their offer is less generous.

8.25 NHS staff are entitled to sick pay, being able to receive up to 6 months full pay and 6 months half pay subject to length of service. Statutory sick pay provides £92.05 per week for 28 weeks.

NHS Trend Analysis

8.26 GAD also carried out trend analysis for different NHS staff groups, based on the previous total reward analysis from 2011/12 by DHSC and 2015/16, 2017/18 by GAD. Figure 8.5: Total reward across different NHS roles



8.27 All roles considered as part of this analysis have experienced an increase in total rewards over the period 2016/17 to 2018/19. Nurse band 5 experienced the highest increase in reward over this period at 5%. However, Nurse band 6 and average midwives also experienced increases of 4% and 3% respectively over the

period shown. Over the year between 2017/18 and 2018/19, reward increased for Nurse Band 5 and Nurse Band 6 by 4% and 5% respectively. However, the reward for an average midwife remained broadly similar over the year. All roles considered have over 25% of total rewards made up of non-basic pay. Nurse Band 6 have the highest proportion of non-basic pay at around 31%.

Total Reward Statements

8.28 Total reward statements (TRS) provide NHS staff with a better understanding of the benefits they have or may have access to as an employee of the NHS. TRS provide personalised information about the value of staff employment packages, including remuneration details and benefits provided locally by their employer. Local reward offers from NHS organisations might include;

- Recommend a friend scheme
- Affordable accommodation
- Childcare and carer support
- Counselling and support
- Various salary sacrifice schemes
- Discounts
- Education and learning support
- Financial wellbeing
- Physical and mental health and wellbeing
- Members of the NHS Pension Scheme are also provided with an annual benefit statement (ABS), which shows the current value of their NHS Pension benefit.

8.29 Since 2016, the NHS Business Services Authority (NHSBSA), which is responsible for ABSs, has held stakeholder engagement events across the country which cater for different types of employers with a workshop on TRS so employers can understand the role they plan in promoting TRS in their organisations. The workshop also explains the difference between a TRS and an ABS, as local employers are responsible for issuing a TRS whilst the BSA creates ABSs.

8.30 The latest access total for this year's TRS is 366,527, compared to 227,930 at the same point last year. Currently there are 2,414,352 TRSs available. Refreshed statements were published in August 2018.

8.31 TRS Improvements include changes to the embedded links following the introduction of BSA's new website and an update to branding in line with the rest of the NHS. Work continues to put in place alternative arrangements for those who access their TRS via the Government Gateway which ends in 2018.

Annex 1 - Remit Letter

Philippa Hird

Chair NHS Pay Review Body

Office of Manpower Economics

Fleetbank House

2-6 Salisbury Square

London

EC4Y 8JX

21 November 2018

Dear Ms Hird,

I am writing firstly to express my thanks for the NHSPRB's invaluable work which informed its report and observations for the 2018-19 pay round and secondly, to formally commence the 2019-20 pay round. In particular, I would like to thank you and your members for your support as the partners completed the Agenda for Change negotiations. It was important that the Review Body had an opportunity to see the final agreement as part of your report to government.

You are aware that the reforms were agreed by all parties. I am pleased that the final agreement takes on board recommendations and observations the Review Body has made in a number of its reports over recent years for achieving a balanced package of reforms.

The NHS Staff Council is at the early stages of an extensive work programme and will work with its partners to develop the new terms, conditions and guidance to support implementation of some of the most significant reforms since Agenda for Change was first introduced in 2004.

You are aware that over the period of the multi-year pay deal (2018-2019 to 2020-2021) we will not ask the NHSPRB to make any pay recommendations. We will however, as agreed, ask your members to monitor the implementation of the deal and its impact over the duration of the agreement. We will also ensure that your members continue to receive data on the state of recruitment, retention and motivation as part of the public sector annual pay rounds.

This year, the NHSPRB is invited to make observations on evidence you receive from the NHS Staff Council and other parties on implementing the Agenda for Change pay agreement.

I am also asking the NHSPRB to consider issues that have been raised regarding the difficulties of recruiting and retaining IT staff. I would welcome your observations on the labour market issues and your recommendations, including any case for a national recruitment and retention premium.

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

We would welcome your report by week commencing 6 May 2019.

Yours ever,

MATT HANCOCK

Annex 2 - Evidence provided by NHS Employers

NHS Employers put the following questions to HR Directors of NHS Trusts, they received 69 responses:

- Does your organisation have a problem recruiting and retaining IT staff?

  If so:

- Which specific roles does this apply to?
- Do you know if this is an issue within your region?
- Why do you think you struggle to recruit/retain these roles?

If your organisation does struggle with recruiting and retaining IT roles:

- What Agenda for Change pay band are these roles typically paid at?
- Do you offer additional RRPs on top of basic salary?
- If you do offer additional RRPs, what is the typical percentage rate?
- If High Cost Area Supplements apply, is this paid on top of RRPs?
- Do you offer any other pay or non-pay incentives?

The questions were answered in free text fields, and the responses can be summarised as follows. 69 Trusts were asked if they struggle to recruit and retain IT staff, 61 agreed that this was an issue.

51 trusts cited the availability of higher pay and benefits in the private sector as a reason why they struggle to recruit and retain IT staff. Some said AfC is too inflexible and does not provide for IT roles, which are classified as ‘admin’ or ‘clerical’ roles. Similarly, 14 respondents feel there is a lack of clear career progression available to IT staff working in the NHS, which offers IT jobs but not necessarily IT careers. HR Directors believe IT staff leave the NHS for the private sector as they can progress more rapidly there.

14 respondents believe geographical location is a mitigating factor in their recruitment and retention of IT staff, as many rural regions without a strong university presence struggle to attract talent. Trusts near London also believe they struggle due to the pull of private sector work in inner city London.

9 trusts feel there is a lack of skills available in the current talent pool, with one respondent believing GDPR has created a demand for IT staff, and the demand is outstripping the supply. A further 9 respondents believe the technology available in the NHS is not sufficient to attract leading IT staff, they also believe the NHS does not have a strong reputation for IT. 5 trusts said there is competition between different NHS trusts to attract IT staff, and trusts will band jobs at a higher point of AfC to ensure they secure staff.

Annex 3 - Evidence provided by NHS Digital

NHSD provided turnover data for joiners and leavers from the English NHS between June 2017 and June 2018. This is set out in figure 6.32 and repeated below.

Turnover data for joiners and leavers in English NHS between June 2017 and June 2018

	Joiner headcount	Joiner rate	Leaver headcount	Leaver rate	Stability index
All NHS staff	154,125	13.0%	136,520	11.5%	88.4%
Senior IT staff	651	28.0%	495	21.3%	78.0%
Managers	6,532	28.5%	5,212	22.8%	76.6%
Nurse and Health Visitors	38,112	12.1%	37,045	11.7%	88.3%

Source: NHS Digital, NHS Hospital & Community Health Service (HCHS) workforce statistics.

As IT staff cannot be identified by occupation code, these staff were selected by searching for terms NHSD associate with the IT workforce. NHSD used the Job Title field for this, which is a free text field. Using these search terms resulted in over 1,700 different job titles being selected for this analysis.

As this group is a non-standard group created using a free text field, it may exclude some IT staff who did not fall within the search criteria. It also may include some non-IT staff who met the criteria.

Senior IT staff were defined as being on AfC pay band 7 or higher, including Very Senior Managers. Non-AfC staff were also included.

All figures show staff on ESR that have joined from outside of left to outside of each of the groups in the table.

Turnover data is based on headcount, and shows people leaving or returning to active service. This would include those going on or returning from maternity leave or career break.

Joining or leaving rates are calculated by dividing the number of joiners or leavers for a category of staff by the average of the number of staff in that category at the beginning and end of the period.

The Stability Index is the percentage of staff there at the start of the period that do not leave the specified group during the period in question.

Annex 4 – Leaver rates by Region

Leaver rates by region - Nurses and Health Visitors

Nurses and Health Visitors				12 month leaver rate				
Region	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
E Mids	8.3%	8.5%	10.1%	8.9%	9.5%	9.7%	10.3%	10.8%
E of Eng	9.0%	12.2%	11.7%	10.0%	11.0%	11.1%	10.7%	11.1%
Yorks and H	7.5%	9.8%	8.2%	10.1%	9.2%	9.7%	10.4%	10.6%
Wessex	9.7%	9.6%	9.1%	9.6%	10.5%	10.3%	10.9%	11.1%
Thames V	9.8%	10.7%	11.1%	10.2%	12.4%	11.7%	12.4%	12.3%
NW Lon	10.3%	9.8%	11.1%	10.5%	11.6%	12.2%	12.1%	11.3%
S Lon	10.2%	9.5%	11.4%	10.7%	11.4%	11.8%	12.1%	11.3%
NCE Lon	10.3%	10.1%	10.7%	10.6%	11.7%	11.8%	12.0%	11.5%
Kent, S&S	8.7%	10.0%	14.0%	9.6%	10.5%	10.7%	11.6%	11.4%
N East	7.2%	7.7%	6.7%	7.6%	7.7%	8.4%	8.5%	9.7%
N West	7.9%	7.8%	7.7%	8.0%	8.7%	9.1%	9.4%	9.7%
W Mids	8.0%	7.6%	8.0%	8.9%	9.3%	10.1%	10.3%	10.2%
S West	8.9%	20.9%	11.0%	11.3%	11.7%	11.6%	12.3%	11.5%
England	8.6%	10.1%	9.7%	9.5%	10.1%	10.4%	10.7%	10.7%

Leaver rates by region – Midwives

Midwives				12 month leaver rate				
Region	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
E Mids	6.8%	7.6%	7.9%	7.6%	9.1%	9.1%	8.7%	9.2%
E of Eng	8.4%	8.0%	9.1%	9.5%	10.7%	10.7%	12.0%	10.8%
Yorks and H	5.3%	7.2%	8.3%	8.9%	8.5%	8.8%	9.4%	10.0%
Wessex	7.8%	8.4%	7.7%	8.7%	9.9%	10.3%	10.7%	9.3%
Thames V	9.3%	11.4%	9.5%	10.7%	12.5%	13.5%	12.7%	13.6%
NW Lon	10.5%	10.8%	10.2%	10.2%	13.4%	11.6%	11.8%	11.7%
S Lon	9.4%	10.1%	9.8%	11.9%	10.7%	13.4%	11.8%	12.5%
NCE Lon	8.7%	9.8%	8.9%	8.7%	9.6%	11.2%	11.8%	12.2%
Kent, S&S	7.0%	9.2%	9.3%	7.9%	10.8%	10.0%	12.3%	12.3%
N East	6.3%	5.9%	7.1%	8.2%	7.5%	8.1%	8.2%	11.4%
N West	6.5%	6.5%	7.0%	6.5%	7.5%	9.1%	9.6%	8.6%
W Mids	6.3%	6.8%	7.2%	8.3%	8.4%	8.6%	9.2%	9.5%
S West	8.1%	7.3%	8.9%	9.4%	9.8%	9.8%	11.2%	10.9%
England	7.4%	8.0%	8.3%	8.7%	9.5%	10.0%	10.6%	10.5%

Leaver rates by region - Ambulance Staff

Ambulance Staff				12 month leaver rate				
Region	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
E Mids	4.9%	5.2%	7.0%	6.5%	6.0%	7.9%	7.1%	7.9%
E of Eng	4.9%	5.9%	7.0%	7.0%	8.5%	8.7%	6.7%	6.9%
Yorks and H	4.1%	4.8%	5.0%	7.1%	6.6%	7.6%	6.6%	6.8%
Wessex	7.2%	6.0%	6.1%	4.5%	11.9%	11.9%	9.8%	6.3%
Thames V	5.1%	5.8%	5.3%	8.8%	8.9%	9.4%	8.1%	11.1%
NW Lon	5.7%	4.6%	7.3%	8.0%	9.8%	7.9%	6.6%	8.3%
Kent, S&S	4.6%	4.3%	6.3%	7.7%	8.5%	7.3%	11.1%	9.5%
N East	4.5%	6.4%	6.9%	6.9%	7.7%	6.1%	4.8%	6.1%
N West	4.6%	4.7%	4.7%	6.4%	5.1%	6.2%	6.2%	7.8%
W Mids	3.1%	4.5%	5.0%	4.8%	5.7%	6.5%	6.6%	5.8%
S West	5.3%	5.7%	6.1%	5.8%	8.5%	8.8%	9.0%	10.1%
England	4.8%	5.0%	6.0%	6.8%	7.4%	7.6%	7.3%	7.9%

Leaver rates by region - Scientific, Therapeutic & Technical

Scientific, Therapeutic & Technical				12 month leaver rate				
Region	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
E Mids	8.5%	9.0%	9.3%	9.3%	9.5%	9.3%	9.9%	9.5%
E of Eng	9.7%	11.9%	12.8%	11.8%	13.8%	11.6%	11.7%	11.2%
Yorks and H	8.4%	9.9%	8.9%	9.8%	9.7%	10.1%	9.2%	10.0%
Wessex	10.1%	10.6%	9.7%	10.7%	12.0%	11.6%	10.7%	10.4%
Thames V	11.0%	11.2%	13.2%	11.9%	12.7%	12.1%	12.0%	13.6%
NW Lon	11.9%	11.8%	13.7%	12.4%	12.9%	13.7%	13.9%	13.2%
S Lon	11.6%	12.7%	13.4%	12.1%	16.1%	13.5%	14.3%	13.3%
NCE Lon	11.1%	12.4%	11.6%	11.9%	12.6%	15.4%	13.4%	12.9%
Kent, S&S	9.6%	11.3%	15.1%	10.4%	11.3%	11.3%	11.5%	11.9%
N East	8.6%	7.9%	8.1%	8.5%	9.2%	9.4%	9.4%	10.1%
N West	8.4%	8.5%	8.3%	9.0%	9.4%	9.8%	9.5%	9.6%
W Mids	7.4%	9.5%	8.5%	9.2%	9.2%	10.0%	10.2%	9.9%
S West	8.8%	20.9%	12.6%	10.7%	11.2%	12.3%	12.0%	11.2%
England	9.3%	11.2%	10.7%	10.3%	11.1%	11.2%	11.0%	10.9%

Leaver rates by region - Support to Clinical Staff

Support to Clinical				12 month leaver rate				
Region	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
E Mids	11.5%	10.0%	12.6%	9.9%	10.3%	10.6%	11.0%	10.5%
E of Eng	11.7%	15.1%	12.7%	11.7%	13.4%	12.9%	12.1%	12.8%
Yorks and H	9.7%	13.4%	9.1%	10.5%	9.1%	9.9%	10.3%	11.2%
Wessex	12.2%	12.2%	11.0%	11.0%	14.1%	12.6%	16.4%	12.7%
Thames V	12.6%	12.9%	12.1%	13.3%	15.0%	14.3%	16.3%	15.0%
NW Lon	11.0%	10.9%	11.4%	10.0%	11.2%	12.6%	12.7%	12.5%
S Lon	13.1%	11.7%	11.6%	11.4%	12.3%	12.4%	13.1%	13.5%
NCE Lon	11.3%	11.9%	11.2%	11.3%	12.1%	12.8%	11.9%	13.0%
Kent, S&S	11.5%	13.9%	14.4%	12.1%	12.2%	11.9%	13.7%	13.3%
N East	7.9%	8.8%	7.1%	8.5%	9.3%	8.3%	8.8%	11.0%
N West	9.2%	9.0%	8.0%	8.9%	9.3%	9.3%	10.2%	9.9%
W Mids	10.1%	11.1%	8.9%	9.0%	9.7%	10.4%	11.3%	10.8%
S West	11.2%	20.0%	12.9%	12.6%	13.1%	13.2%	13.9%	13.1%
England	10.6%	12.3%	10.6%	10.5%	11.1%	11.2%	11.9%	11.7%

Leaver rates by region - Infrastructure Support

Infrastructure support				12 month leaver rate				
Region	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
E Mids	11.6%	12.2%	15.4%	19.9%	19.7%	10.6%	10.4%	9.3%
E of Eng	12.3%	14.3%	15.6%	19.1%	12.7%	13.9%	11.5%	12.2%
Yorks and H	10.3%	12.2%	9.7%	18.5%	9.0%	10.3%	9.6%	10.7%
Wessex	18.5%	11.4%	11.6%	20.0%	12.0%	13.5%	11.9%	11.0%
Thames V	12.8%	15.1%	11.3%	19.3%	13.3%	12.6%	12.0%	12.3%
NW Lon	12.8%	13.4%	10.8%	21.1%	11.6%	14.5%	12.5%	12.2%
S Lon	12.7%	14.5%	11.4%	21.5%	11.3%	12.7%	12.9%	12.7%
NCE Lon	13.2%	17.5%	12.4%	24.6%	12.3%	12.7%	11.2%	12.0%
Kent, S&S	11.0%	13.5%	13.1%	22.7%	11.2%	11.9%	12.5%	12.6%
N East	11.9%	8.9%	6.9%	17.2%	8.7%	10.5%	14.6%	21.7%
N West	10.5%	10.8%	8.8%	18.9%	8.5%	9.9%	9.6%	9.1%
W Mids	11.5%	11.7%	11.8%	17.6%	10.0%	10.1%	11.5%	10.8%
S West	10.7%	18.7%	12.0%	18.4%	13.4%	11.8%	11.7%	12.5%
England	11.7%	13.0%	11.4%	19.5%	11.3%	11.4%	11.3%	11.5%

Source: NHS Digital HCHS workforce publication

Annex 5 - Pension Scheme membership and trends

Changes in scheme membership as at August 2018, showing percentage point change over the previous month, the last 12 months and from October 2011.

Pension scheme membership changes

		% with pension contributions	% change	% change	% change
	FTE Jul 2018	Headcount Aug 2018	Jul 2018 and Aug 2018	Aug 2017 and Aug 2018	Oct 2011 and Aug 2018
All	1,065,395	90%	0.7%	0.9%	5.1%
Staff Groups					
Doctor	110,622	89%	-0.5%	-2.1%	-1.9%
Qualified nursing, midwifery & health visiting staff	304,143	91%	0.9%	0.9%	3.2%
Qualified Scientific, therapeutic and technical staff	133,701	93%	0.8%	0.5%	2.3%
Qualified Ambulance Staff	20,676	94%	0.8%	0.1%	-1.5%
Support to Clinical Staff	319,209	89%	0.9%	1.7%	9.7%
Central Functions & Hotel, Property & Estates	136,330	86%	0.9%	1.5%	8.7%
Managers	31,773	90%	0.4%	-0.2%	-2.7%
All Non-Medical	954,773	90%	0.9%	1.2%	5.8%
AfC Band					
1	24,439	81%	1.1%	3.4%	18.8%
2	151,875	88%	1.1%	2.1%	12.2%
3	125,342	89%	0.9%	1.7%	8.7%
4	84,175	90%	0.7%	1.2%	5.6%
5	197,367	89%	1.3%	1.3%	3.6%
6	180,409	91%	0.7%	0.4%	2.1%
7	102,500	93%	0.5%	0.2%	0.2%
8a	35,751	93%	0.5%	0.0%	-0.9%
8b	14,342	93%	0.5%	-0.2%	-1.8%
8c	7,527	94%	0.4%	-0.3%	-1.7%
8d	3,703	93%	0.4%	-0.1%	-4.0%
9	1,419	93%	0.4%	-0.3%	-2.9%
Non AfC	136,546	88%	-0.5%	-1.7%	0.5%

References

[i] OBR Economic and Fiscal Outlook, October 2018.

[ii] OBR Fiscal Sustainability Report, July 2018.

[iii] Looking at annual growth rates for total pay (including bonuses), between July to September 2017 and July to September 2018.

[iv] The OBR use Wages and Salaries divided by employees to estimate wage growth, and so this will not exactly correspond to the ONS headline AWE measure.

[v] ONS, Public and private earnings in the UK, November 2018.

[vi] https://www.livingwage.org.uk/ - Hourly rates are based on the Foundation Living Wage announced in November 2018.

[vii] Office for National Statistics A09: Labour market status by ethnic group, Jul-Sep 2017 figures.

[viii] Institute for Fiscal Studies - The relative labour market returns to different degrees, June 2018

[ix] NHS England - https://www.england.nhs.uk/leadingchange/staff-leadership/nursing-associate/

[x] The definition of the stability index is provided by NHS Digital at https://digital.nhs.uk/services/iview-and-iviewplus/workforce-monthly-supporting-info-and-documents/iviewplus-workforce-nhs-staff-turnover-definitions

[xi] The figure of 36 years for a typical nursing career was constructed using NHS Pension Scheme membership data, as follows; data at 31st March 2017 shows the average past pensionable service at 2017 for nurses is c24.8 years, excluding service in CARE service from April 2015. It is therefore reasonable to increase past service by between 1.5 and 2 years to consider service since April 2015. The average age of nurses at the same period in 2017 is c52.2 years old. The average retirement age for nursing staff is 62, meaning the average staff member build a further 9.8 years' service. Over 90% of nursing staff are NHS Pension Scheme members.

[xii] Nurse joins in band 5 at 24, works full time to age 31, takes 2 short career breaks then part time 50%, full time again from age 47 onwards. Promoted to band 6 at age 33.

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