NHS Pay Review Body

NHS Pay Review Body

Thirty-Third Report 2020

Chair: Philippa Hird

Executive Summary

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NHS Pay Review Body

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

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

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

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

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

the Government's inflation target;

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

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

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

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

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

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

Members of the Review Body are:

Philippa Hird (Chair)
Richard Cooper
Patricia Gordon
Neville Hounsome
Stephanie Marston
Anne Phillimore[2]
Professor David Ulph CBE
Professor Jonathan Wadsworth

The secretariat is provided by the Office of Manpower Economics.

NHS PAY REVIEW BODY 2020 REPORT

Executive Summary

1. The AfC pay agreements which are now in place in each UK country and run through 2020/21 provide the context for our report. While these agreements are in place we have not been asked to make pay recommendations but to monitor their implementation. We look forward to receiving the growing evidence base, which will be used by us and others to assess the effectiveness of the agreements.

Our overall conclusions

- **Evidence for this report was gathered before COVID-19 but the report was written as the pandemic developed and takes account of its current impact to the extent that is evident and sets out ways in which the pandemic may impact on the NHS and Agenda for Change staff in future years. These will include but not be limited to workforce planning, short and medium term recruitment, retention, morale and affordability.**
- **The NHS Long Term Plan and transformation plans in the Devolved Administrations contain ambitions for service development, which are dependent on new ways of working, new systems and the development of new roles. Ahead of the significant pressures caused by the response to COVID-19, we heard consistent evidence that the capacity to deliver new programmes effectively was severely limited by operational and workforce pressures.**
- **The Review Body has been struck by the persistence of the Agenda for Change staff workforce gap, in particular for nursing staff. The gap impacts on staff and patient experience, and creates risks for patient services and outcomes. All parties acknowledge the need to front-load initiatives to bridge this gap.**
- **Some initiatives to bridge the gap are in place and are likely to have some positive impact. It is not clear that they will be sufficient and there is a delay created by the time it takes to train registered staff. Plans to bridge the gap by recruiting overseas staff are likely to be undermined by the restrictions created by COVID-19.**
- **The Review Body has heard consistently from some AfC staff that they do not feel valued. The NHS People Plan is expected to contain significant and ambitious plans for workforce, leadership and staff development and its publication and implementation, with appropriate system-wide leadership and funding, creates an opportunity to recognise the role of Agenda for Change staff in England.**
- **We also look forward to further evidence on the impact of the health and social care workforce strategies in the Devolved Administrations.**
- **The Review Body stands ready to move towards making recommendations for pay for AfC staff in 2021 at the conclusion of the AfC agreements, which covered pay and other elements and which were reached in 2018 in England, Scotland and Wales, and in 2020 in Northern Ireland.**
- **These agreements increased pay for all AfC staff in all four nations. The only Staff Survey covering pay satisfaction was for England and this showed that the proportion of staff satisfied with pay increased from 29% in 2017, before the pay agreement, to 36% in 2019. While other substantial elements of the agreements have been enacted, there are elements which have not been concluded or for which the evidence will follow.**

- **The inter-dependencies between the health and social care systems are widely acknowledged and there are ambitions for further integration. There are significant differences between the two systems in pay and reward structures, which need to be reconciled for integration to go ahead effectively.**
- **The Devolved Administrations set pay for Agenda for Change staff on the basis of their national policy and to achieve their national goals. We have heard from some AfC staff that they compare pay rates across the four nations, which may impact on both their decisions about where to work and their happiness with the pay they receive.**
- **In competing for staff with other public and private sector employers the NHS has an opportunity to create an attractive apprenticeship, which offers secure employment, fulfilling roles, and excellent training and progression opportunities.**
- **The Agenda for Change pay spine encompasses a large number of roles in a single framework. It offers limited scope for flexibility. This report sets out a number of observations on the way in which the pay spine sits alongside RRP and HCAS, and the Review Body stands ready to support any further work to be carried out.**

Our remits

2. The remit letters for England, Wales and Northern Ireland did not seek our pay recommendations, and Scotland did not provide a remit. For England and Wales, the relevant Ministers asked us to monitor the implementation of the AfC pay agreements. The Minister for Health in England asked for our observations on the role of Recruitment and Retention Premia (RRP) and on their potential use for IT staff. The Minister of Health in Northern Ireland asked for our views on factors specific to the Northern Ireland health and social care labour market and the impact of re-establishing AfC pay parity with England and Wales. With the AfC pay agreements in place in each of the four countries of the UK through 2020/21, our approach remains assessing the evidence against our standing terms of reference, which ensures an evidence base to return to making pay recommendations from 2021/22.

3. While COVID-19 has changed the context for this report, we have continued to consider the remits in the usual way, including longer term trends. Many effects of COVID-19 and the Government's response are unknown, and data and information are not available for this report.

4. Future evidence will help us understand the impacts of COVID-19. Managing the healthcare response has increased the workload and health risks for those in the NHS and care sector dealing with COVID-19 patients. The full effects on the labour market are unclear and there could be different impacts on the public and private sectors. The NHS workforce developments in the expected NHS People Plan and Devolved Administrations' workforce strategies will need review. There is uncertainty over the length and shape of the response to COVID-19 and the length and depth of the economic downturn. We look forward to evidence on the way in which these might feed into levels of Government expenditure on public services and spending decisions on the NHS. The response of the health and social care workforce has shown their flexibility in performing in different ways and future evidence might assess whether there has been accelerated progress in the transformation programmes for NHS services.

NHS context

5. The regular published data and reports from external commentators continue to show that the NHS faces challenges in delivering planned service changes while demand levels and financial pressures continue to increase. Many trusts are focused on the immediate resources needed for services, which limits the capacity and resource to introduce longer-term service and workforce developments. Integrated Care Systems need funding and incentives to support collaborative working, and workforce configurations and pay arrangements are a particular challenge. The scale of the AfC workforce gap has now persisted over a number of years and is widely acknowledged as a continuing pressure for the NHS, and reports comment on the impact of staff shortages on existing staff and trust performance. The measures in the expected NHS People Plan will need to address these if the NHS is to close the workforce gap.

The parties' evidence and our analysis

6. The parties' evidence (summarised in Chapter 3) was submitted before COVID-19. Our analysis and conclusions (Chapter 4) are also informed by subsequent data on the economy, labour market, AfC earnings and the workforce.

7. Economy and labour market (paragraphs 4.2 to 4.13). At the beginning of 2020, employment growth continued to be strong and unemployment had increased slightly but had been low throughout 2019. By March 2020, average earnings in both the public and private sector had fallen back after reaching the highest rates in 2019 since the 2008 recession. Median pay settlements remained at around 2.5% in 2019. Economic growth throughout 2019 remained subdued at 1.4% reflecting in part global economic uncertainties and those uncertainties from the trade deals which might be reached with the EU and the rest of the world following the UK's exit from the EU. Inflation had been on a broad downward path in 2018 and 2019. The longer-term trends in the economy and labour market and the short-term effects of COVID-19 will provide the backdrop to our considerations of AfC recruitment, retention and motivation in later reports.

8. AfC earnings and total reward (paragraphs 4.14 to 4.44). The 2018 AfC pay agreements are increasing AfC basic pay and total earnings, and improving the position of AfC groups against pay in the wider economy. In 2019 in England, AfC basic pay increased by between 2.2% and 9.5%, total earnings increased between 2.4% and 8.2%, and all groups received an increase in additional earnings. The rate of growth of earnings was greater in the human health and social work activities sector than across the economy as a whole. Relative AfC earnings vary across an NHS career and we would welcome the parties' evidence on the influencing factors, including the effects of the 2018 AfC pay agreement such as increasing starting pay and faster progression to the top of pay bands.

9. The gender pay gap across all AfC groups is at 6% for basic pay in England. Data indicated a basic pay gap of up to 8% in favour of white staff compared with other ethnic groups (based on NHS Digital definitions). We are keeping these differences under review and ask for evidence on the reasons behind the different rates of progression through the AfC pay bands for men and women, and for ethnic groups.

10. The parties place great emphasis on the value of the AfC total reward package in their evidence. The NHS People Plan is expected to develop the NHS employment offer and we also note the challenge of designing reward for Integrated Care Systems. The reward package needs to be able to respond to the various influences during an NHS career and communications could better set out the benefits of new pension arrangements.

11. 2018 AfC pay agreements (paragraphs 4.45 to 4.86). Our approach to monitoring the implementation of the AfC pay agreements in England, Wales and Northern Ireland is based on the core issues in our standing terms of reference, specifically affordability, recruitment, retention and motivation. We expect the parties to specify the value of and to evidence the return on the investment in pay reform, and we look forward to NHS E&I's further work on benefits realisation. Our report sets out the data we would expect to assess the effectiveness of the agreement.

12. The NHS Staff Council has implemented many of the key actions in the agreements and initial measures point to increases in AfC starting pay, total earnings, the value of the top of pay bands and the minimum level of AfC basic pay. Other actions implemented are restructured pay bands, a new progression framework with effect from 2021/22 and revised unsocial hours payments. The closure of pay Band 1 has been partially implemented. Following negotiations in the NHS Staff Council, no national agreement was reached on apprenticeship pay.

13. Affordability and productivity considerations will need to be informed by the pay bill effects, the increased contribution of staff through the new progression framework and the upskilling of Band 1 posts. As yet, there is no direct evidence on the way in which the reformed pay structure supports different channels of recruitment or on the effect on retention, including the specific need to incentivise the higher proportions of staff reaching the top of their pay bands. On motivation, the proportion of staff satisfied with pay has increased from 29% in 2017 to 36% in 2019. There has yet to be any impact on other measures of motivation and engagement which have remained stable, such as the engagement index in the Staff Survey, the Friends and Family Test, and sickness absence rates.

14. Northern Ireland economy, labour market and AfC pay parity (paragraphs 4.87 to 4.105). There are some differences in the economy and labour market between Northern Ireland and the rest of the UK. The public sector plays a larger role in the Northern Ireland labour market and Health and Social Care (HSC) is a significant employer. With public sector earnings ahead of those in the private sector, the HSC should be well-placed in the Northern Ireland labour market. However, the levels of vacancies and agency spending suggests that the HSC workforce is under staffing pressure. Although some aggregate data does not suggest there is a major flow of commuters to the Republic of Ireland, we were not presented with any evidence from the parties on the number of AfC staff that migrated from Northern Ireland to other parts of the UK and it would be helpful to see further detailed work from potential sources better to understand patterns of migration. We note that the HSC Workforce Strategy aims to resolve many workforce issues by 2026 and that many of the workforce issues we have identified are planned to be reviewed as part of the safe staffing discussions between the Department, employers and unions under the 2020 AfC framework agreement.

15. Staff place great value on the AfC pay structure and we have heard from some staff that they compare their pay with other parts of the UK. Economic, labour market and pay indicators suggest that the HSC is a relatively attractive place to work in Northern Ireland. At this stage, we can draw no firm conclusions about the impact of re-establishing AfC pay parity, although the parties said that pay parity was seen as a positive move. We look forward to monitoring the effects of the AfC framework agreement in Northern Ireland, as for other UK countries.

16. Service transformation, integration and productivity (paragraphs 4.106 to 4.117). Demand for services continues to rise and places pressures on the existing AfC workforce, with NHS Employers suggesting that high levels of demand pressures on services were becoming the new norm throughout the year and that employers were spending much of their time resolving immediate resourcing problems, which prevented them from implementing longer-term workforce strategies and changes in cultures.

17. Integrated Care Systems are planned to be in place in all areas by 2021 but progress appears to be variable. The parties stressed that managing demand in the NHS depended on capacity in social care. Integrated Care Systems will require new organisation and employment structures, and moves to harmonise terms and conditions would require a consistent approach to reward packages and to be supported by appropriate financial investment.

18. The NHS Long Term Plan has set a target of making re-investable productivity gains of at least 1.1% a year over the next five years. There are difficulties in measuring productivity and its rate of growth in a complex organisation such as the NHS. Productivity gains in recent years have been driven by pay restraint. There will need to be renewed emphasis on the productivity gains from new models of service, new ways of working, process improvements, changing the workforce skill mix, and the development of technology and digital services.

19. NHS affordability and efficiency savings (paragraphs 4.118 to 4.122). COVID-19 has had a major impact on Government finances and those of the NHS. External commentators and performance data continues to point to the NHS under financial pressure, although the Government has written off some debts for providers. Assessments against the NHS Long Term Plan's five financial tests will help considerations of the affordability of pay awards. There remains a requirement for investment in the workforce developments expected in the NHS People Plan. Trusts continue to make efficiency savings but these tend to focus on cost control rather than transformational savings through new ways of working.

20. Workforce strategies and staffing numbers (paragraphs 4.123 to 4.138). Following the launch of the Interim NHS People Plan in June 2019, we look forward to the publication of the NHS People Plan in England, expected later in 2020, and to hearing more about the implementation of the workforce strategies in the Devolved Administrations. The AfC workforce continues to increase year-on-year, both overall and in each UK country, with variations among AfC groups. Our analysis of gender and ethnicity in the workforce requires further information to understand the interactions between many characteristics that affect pay and employment opportunities.

21. Nursing workforce (paragraphs 4.139 to 4.147). Trends over the last decade point to a steady increase in the overall numbers of nurses and health visitors, driven by rising numbers in adult and children's nursing and midwifery. In contrast, there has been a significant decline in numbers of nurses in learning disability and mental health, and falls in health visitors in community health. NMC data at September 2019 showed a 1.8% increase in nurses and midwives on the Register resulting from an increase in joiners for the first time since 2016 and a fall in the number of leavers for the second consecutive year. The interim NHS People Plan set out the range of measures to improve the supply and retention of nurses, and the Government has a target for 50,000 more nurses by 2025.

22. Vacancies and shortage groups (paragraphs 4.148 to 4.161). There is a consensus on the scale of the AfC workforce gap and a clear picture of the impact of staff shortages. The level of vacancies across the NHS workforce as a whole has remained persistently high with the implications for staff seen in evidence through: additional working hours; increased use of bank and agency cover; increasing work-related stress leading to sickness absence; concerns over work/life balance, and poor staff health and wellbeing risking retention; recruitment difficulties if entrants perceive work in the NHS as stressful; and staff feeling that they were not able to deliver quality of care they want to patients. Staff shortages also impact on trust performance, managing patient services and waiting lists while maintaining patient safety, delayed discharges, increased agency costs, and shortages limit time for organisational and culture change, improving leadership and delivering workforce developments.

23. Once vacancies reach a certain level and persist, they are potentially very difficult to address. The failure to treat patients quickly adds to future demand for services, and the pressure on existing staff leads to sickness absences and to recruitment, retention and motivation difficulties. There is a consensus among the parties on the required action and the need to front-load the response, as expected in the NHS People Plan.

24. Pre-registration entrants (paragraphs 4.164 to 4.175). Acceptances to undergraduate nursing and AfC-related degree courses increased in 2019 across the UK. Acceptances to undergraduate nursing degrees increased by 6.4% in England, 8.5% in Scotland, 3.1% in Wales and 6.4% in Northern Ireland. Recent recruitment campaigns have raised the profile of NHS careers and we welcome the introduction of annual maintenance grants in England. The extent to which graduate entrants will contribute towards the Government's nursing target and to closing the workforce gap, meeting increasing demand for services and delivering on new service models is not clear. Further evidence is required on the way in which additional funding support for clinical placements in trusts allows universities to offer places to appropriately qualified applicants. Support during training might also be targeted at increasing and retaining entrants in shortages areas. Women represent 91% of those accepted onto nursing degrees suggesting that men remained an untapped source of recruitment. Recent recruitment campaigns sought to break from stereotypes of entrants and we await information on their effect.

25. EU and non-EU recruitment (paragraphs 4.176 to 4.179). Front-loaded solutions that rely on overseas recruitment might be at risk from the impact of COVID-19 and the UK's exit from the EU. Future data from the NMC Register will provide insights into the longer-term trends on the recruitment and retention of EU and non-EU staff, and the impact of the Government's measures to allow temporary registrations of returners and students, and extending visas for overseas staff.

26. Recruitment of nursing associates in England (paragraphs 4.180 to 4.188). In January 2020, there were 1,093 FTE nursing associates working in the NHS in England and 4,300 trainees. NHS organisations, employers and unions all support the development of nursing associates and we continue to see an opportunity for them to make a significant contribution to the envisaged transformation of services and the development of new NHS careers.

27. Recruitment of apprentices (paragraphs 4.189 to 4.196). Trusts are using apprenticeships to build supply and capacity but there are continuing problems using the levy, such as covering backfill costs, resources for supervisory capacity, and access to and use of training providers. Employers in the NHS are beginning to collaborate at a regional level and there are further opportunities to alleviate the barriers through Integrated Care Systems. Effective apprenticeship programmes could help the NHS to compete with both the public and private sectors in attracting joiners, delivering high quality training, providing a clear route into NHS careers and offering long term employment. The failure to agree national apprenticeship pay rates is a missed opportunity for the NHS Staff Council.

28. Supply of bank and agency staff (paragraphs 4.197 to 4.203). Bank and agency staff remain an important source of temporary staffing, which allows trusts to respond to fluctuations in resourcing requirements. In addition, some AfC staff view bank and agency work as offering a degree of flexible working. However, bank and agency resources have also come to be one way of enabling trusts to meet growing levels of demand for services in recent years. The 2015 cap on agency spending in England appears to have been effective in reducing expenditure and in a shift to bank working, which trusts see as more cost-effective and offering continuity of care. More collaborative approaches to bank working are emerging through pilot programmes and Integrated Care Systems could be in a strong position to develop these approaches. Further information would be welcome on the impact of agency cover in NHS Wales being provided by the All Wales Framework Contract and the use of agency staff in Northern Ireland, including actions to control spending.

29. Retention (paragraphs 4.204 to 4.210). Data at March 2019 suggest a continuing trend of joiners just exceeding leavers for most AfC groups in England, Scotland and Northern Ireland. Leaving rates have stabilised in recent years but remain high for some AfC groups. Improving retention rates across the NHS workforce is expected to be a feature in the NHS People Plan. NHS E&I's retention programmes should provide further information on the effectiveness of specific retention measures and the lessons learned from the programme. Clear targets are needed for retention rates across the AfC workforce and for specific shortage groups. From the limited data available achieving a good work/life balance remains a significant influence on retention. The absence of leaving data is a significant weakness in current workforce planning arrangements and we request, and stand ready to contribute to, an examination of the way in which data could be improved.

30. Motivation and engagement (paragraphs 4.211 to 4.242). The Staff Surveys conducted in England, Wales, Scotland and Northern Ireland allow us to analyse a range of indicators and showed similar broad patterns in the results. From the survey in England we note that: since the 2018 AfC pay agreement satisfaction with pay had increased and was at a similar level to that recorded in the civil service; the percentage of staff receiving an appraisal remained high; and most staff said that they looked forward to going to work and that they were enthusiastic about their job. However, we also note that: fewer than one-third of staff said that there were enough staff at their organisation; fewer than half of staff said that they were satisfied with the extent to which their organisation values their work and that they were able to meet all the conflicting demands on their time; just over a half said that they were satisfied with the recognition they got for good work; approaching one-third of staff said they had experienced harassment, bullying or abuse from patients, relatives or the public; and the percentage of staff saying they had felt unwell as a result of work-related stress had remained high at 40.6%.

31. On other measures, there has been little change in overall sickness rates in recent years. However, in England the Interim NHS People Plan recognised that sickness absence rates in the NHS were higher than in the rest of the economy and that supporting providers to help reduce sickness will contribute towards making the NHS a better place to work. The Friends and Family Test results showed little change over time in the overall proportions of staff recommending their organisation as a place to work or to receive care.

32. Overall, the evidence on motivation and engagement suggests a mixed picture for AfC staff and reflects the nature of the work in the NHS, the challenging work environment and the increasing levels of demand placed upon staff.

33. The parties' evidence, our visits to NHS ambulance trusts, and pay and workforce data point to varied issues for ambulance staff in England. These included that ambulance staff had the highest incidence of harassment, bullying and abuse, were the least satisfied with aspects of their work, and, of those staff leaving the service, had a higher rate of dismissals than for most other staff groups. In the ambulance service, men made up the majority of the workforce and staff were the least ethnically diverse. We set these issues out in the report and would welcome further analysis by the parties of the impacts on the ambulance workforce.

34. Recruitment and Retention Premia (paragraphs 4.243 to 4.276). There was no specific support among the parties for any review of national RRP arrangements in England. Trusts were reluctant to fund local RRP or create local competition for staff. Trusts also argue that there is no additional funding available for local RRP and we saw no information on the way in which current funding through the Market Forces Factor is being used by trusts. The parties support an in-depth review of RRP but did not seek any changes to existing arrangements or suggest alternatives that might be considered. While the Interim NHS People Plan placed great emphasis on improving retention, there appears little direct link between the proposed recruitment and retention actions, and existing or new pay measures, such as RRP.

35. We observe that, despite the RRP mechanism, there is no established practice in England of differentiating pay other than by job weighting or, to a limited extent, geography. We consider that there might be merit in the NHS Staff Council examining the basis on which RRP might be applied, including whether there are factors other than that of job weighting and HCAS, such as scarcity of skills, on which the social partners would agree pay levels should be differentiated. In this context, we set out our observations on the evidence requirements to support the approach to national and local RRP.

36. DHSC suggested that the recruitment and retention of nurses was of particular concern and, while the parties made no specific case for the use of RRP for nurses beyond the availability of local RRP, it is clear that a range of measures are required to support the nursing workforce. As these are developed, consideration will need to be given to whether targeted pay solutions are required.

37. We note that NHSX might have new approaches to defining IT roles, which might have an impact on the AfC pay banding for these roles. However, the evidence from the parties on the greater use of RRP for IT staff was again limited and the use of local RRP was not evident. IT staff remain important to the technological change emphasised in the NHS Long Term Plan. There are indications of some issues in IT recruitment and retention but the parties did not feel that these represented a widespread national problem requiring an immediate pay response. Our 2019 Report set out a comprehensive list of requirements to underpin future assessments for IT staff.

38. High Cost Area Supplements (paragraphs 4.277 to 4.288). Our report sets out some considerations on the purpose, funding, structure, zones and rates of HCAS and the interaction with other parts of the pay package, which are intended to help DHSC decide whether a review is required.

Philippa Hird (*Chair*)
Richard Cooper
Patricia Gordon
Neville Hounsome
Steph Marston
Anne Phillimore
David Ulph
Jonathan Wadsworth

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