Department of Health

Supplementary Evidence for the NHS Pay Review Body (NHSPRB): Review for 2017

Supplementary Evidence from the Health Department for England

November 2016

DH ID box
Title: Supplementary Evidence for the NHS Pay Review Body (NHSPRB): Review for 2017
Author: Acute Care and Workforce/ Workforce/Pay, Pensions & Employment Services /13710
Document Purpose: Policy
Publication date: November 2016
Target audience: Pay Review Bodies Public NHS Organisations
Contact details: nhs_pp&e_services@dh.gsi.gov.uk

Published to gov.uk, in PDF format only.

www.gov.uk/dh

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1. Response to the NHS Pay Review Body's Supplementary Questions

Question 1: Given that the members of our remit group have to deal with costs of housing, can you explain the rationale for using CPI as a measure of the cost of living faced by the remit group instead of alternatives such as CPIH, RPIJ or RPI?

Consumer Price Inflation (CPI) is a standard measure for understanding changes in earnings in the context of inflation. It is used widely to determine a measure of the real value of earnings.

Question 2: How does the evidence provided in paragraph 4.34, 4.35 and Annex C support the statement in paragraph 4.36 that "regional targeting of the pay award would not be financially efficient"?

In the case of nurses, which represent over a third of the non-medical paybill, the trends seen appear relatively consistent across regions so could not be addressed though regional allowances. Comparing trends within regions and across staff groups shows considerable variability. Where there may be issues to address then these do not appear to form a consistent geographical pattern that could be tackled with regional allowances. Finally, the interpretation of data for infrastructure support staff is confounded by recent NHS system reform.

This combination of national rather than geographical effects for a large segment of the workforce, inconsistent geographical effects across other staff groups and a poor evidence base for others suggests any regional pay element could not be well targeted. A poorly targeting use of resource, with a strict limit to pay uplifts, would not be financially efficient.

Question 3: How is the funding system compatible with the Government's aspiration set out by the Chief Secretary to the Treasury to target future pay awards? For example, how would targeted pay awards in 2018/19 work in practice given that the shift to a two-year tariff means that prices for 2018/19 will be set in early 2017. What are the implications for the workforce of the move to a two-year tariff?

On 31 October NHS Improvement and NHS England published the statutory consultation for the 2017/18 to 2018/19 national tariff. The Impact Assessment is not yet complete.

https://improvement.nhs.uk/resources/national-tariff-1719-consultation

However, the Market Forces Factor (MFF) already aligns funding to the local labour market.

The NHS will continue to be funded for an average 1% pay award up to 2019/2020. We do not believe any decision to introduce a two-year tariff will prevent consideration of the evidence and case for targeting.

Question 4: Would high earners - including in the DDRB remit group - leaving the NHS Pension Scheme increase contribution rates for other Agenda for Change staff?

The current benefit structure is afforded on the assumption that 9.8% of pensionable pay is received into the scheme though member contributions. Employers contribute 14.3%. Where

the membership profile changes, this may mean that the scheme no longer collects the required 9.8% across all active members and an adjustment to rates/tiers may become necessary.

Question 5: What is the DH reaction to the issues raised by NHS Employers and by Joint Staff Side about the consequences of the cliff-edges in the tiered pension contribution structure and the decision to not uplift income bands in line with pay increases in causing pay rises and progression to equate to significant cuts in take-home pay for staff close to the thresholds (as e.g. happened to staff at the top point of band 8A in April 2016)?

The Department held discussions with trades unions and employer representatives on the structure of member contribution rates for the four year period 1 April 2015 to 31 March 2019 that would deliver the required average contribution of 9.8% as set out in the Proposed Final Agreement.

Following those discussions the Department finalised in June 2014 a proposed set of contribution rates, tiered according to earnings and fixed for four years. The rates and tiers remain the same as the current rates for 2014-15, save for a small adjustment to the tier 4-5 boundary. These were published ahead of consultation in the document, NHS Pension Scheme: Update on scheme reforms and contribution rates.

In their response, the trades unions reiterated their preferred option which would have added 0.1% to all contribution rates but allowed revalorisation of the earnings tiers in line with any future uplift to Agenda for Change pay scales. They felt this to be the fairest way of achieving the required contribution yield.

The Department remained of the view that on balance the proposed approach is an appropriate solution. A further rise in contribution rates for all members would have been the fourth successive year of such rises and unwelcome. Also the prevalence of pay supplements means that only a minority of staff have their pensionable pay directly linked to Agenda for Change basic pay points.

For instance there are significant areas of the workforce that are in receipt of shift work enhancements (such as around 60% of nursing staff and 97% of ambulance staff), and 20% of NHS staff are in receipt of geographical allowances. This calls into question the relevance of continuing to link contribution rate tiers to Agenda for Change basic pay points.

Question 6: The Migration Advisory Committee's Partial Review of the Shortage Occupation List: Review of Nursing (March 2016) made a number of criticisms of workforce planning to address nursing shortages in England, and concluded that DH and NHS Employers had "an unrealistic view that the role of pay in recruitment and retention is only weak" and noted that "if we were looking at almost any other occupation than nurses, we would find it easy to conclude that our sensible criteria were not met…we would suggest to the employers that they go and increase the number of training places to meet capacity and increase staff pay to reduce the numbers leaving the position". What is the Department of Health's view on this?

Health Education England (HEE) is responsible for workforce planning in the NHS. In 2016-17, the HEE commissioning and investment plan forecasts an additional supply by 2020 of 40,000 nurses as a result of undergraduate and postgraduate commissions placed with universities between 2012 and 2016. Moving new nursing students on to the student loans system from

August 2017 allows universities to offer up to 10,000 extra nursing, midwifery and allied health degree places by 2020-21.

The plan is developed using the workforce planning processes HEE have established over the past three years and as such is built upon the needs of local employers, providers, commissioners and other stakeholders who, as members of their Local Education Training Boards (LETBs), have shaped the thirteen local plans that are at the heart of the Workforce Plan for England. This plan is predominately an aggregate of the local LETB plans, but the final national plan is only agreed with the advice and input of HEE's clinical advisory groups and Patients' Advisory Forum, as well as the Royal Colleges and other stakeholders.

In 2015 the NHS saw record numbers of nurses, midwives and health visitors in post. The number of adult nurse training places commissioned has increased by 19% and overall nursing by 15% over the past three years. Currently there are 58,000 nurses (including midwives) in training as at the end of March 2016.

HEE is working closely with universities to improve attrition rates from courses which will further increase the number of nursing students who graduate. The Department of Health's mandate to HEE includes a requirement for HEE to reduce attrition rates from training programmes by 50% by 2017.

Since 2012-13 commissions for nursing places have increased year on year following a decrease in commissions in prior years.

Whilst the intake into training places is important, the key driver for future supply is the output from the programmes, which varies as student retention varies. Determination of the number of training places to commission is therefore based on the anticipated future demand in the local health economy, recent information about student retention and levels of graduate employment.

Current Workforce Shortages - Taken from HEE Workforce Plan

HEE has highlighted that the investments and commissions described in our Workforce Plans for England cannot, in the main, effect the current workforce supply position, but instead act to ensure that future shortages are avoided.

The system has over the past few years relied on each individual component of the system to discharge their own responsibilities in respect of current workforce supply and demand in order to address any problems. This approach has not been sufficient to guarantee effective solutions in problem areas and it has become apparent that more active co-ordination and management of the various current supply and demand variables, including the significant workforce productivity challenge, is required.

This was a key driver of the establishment of the Workforce Advisory Board (WAB). Membership from DH, all ALBs, plus employer representatives, ensures the bodies that hold all the relevant policy levers capable of shaping the workforce are present in one place. Addressing current shortages is one of four priority programmes that the board is overseeing, and in this report we outline some of the individual work streams being undertaken including oversight of the nursing supply programme, the Paramedic Evidence Education Project (PEEP) paramedic programme, as well as the joint HEE /Royal College of Emergency Medicine (RCEM) programme on improving emergency medicine workforce supply and the wide ranging work on the primary care workforce including General Practitioners.

Such co-ordination must however be effective at a local level as well as nationally and regionally. In light of this HEE has commenced the convening of Local Workforce Action Boards (LWABs) as a mechanism through which local partners can meet to agree and discharge their Workforce Plan for England 2016 6 collective responsibilities in a co-ordinated manner across the full range of workforce issues outlined in this report.

Question 7: The Royal College of Midwives claims there is currently a shortage of nearly 3,500 midwives in the UK and has made similar claims for at least the last five years in evidence to us. Do you recognise this figure? Why is it taking so long to fill this shortage? At what point is this shortage deemed to be a problem?

We don't recognise the numbers as there is no national vacancy survey undertaken on behalf of the department.

There are currently over 1,700 (FTE) more midwives in the NHS than in May 2010 and over 6,300 (headcount) midwives currently in training.

Question 8: How satisfied are you that there is robust evidence to support the estimate that the removal of NHS bursaries from new nursing, midwifery and allied health students will provide an extra "10,000 training places for home-grown nurses, midwives and allied health professionals by the end of this Parliament"? Do you have any further detail about how this estimate was calculated? What is the plan for ensuring that these extra training places will turn into new recruits?

The current system of financial support for nursing, midwifery and allied health professional students is not considered to be sustainable. Currently, people studying for a degree in nursing, midwifery and the Allied Health Professions receive bursaries to cover tuition and living costs. These bursaries are paid from general taxation and are not recoverable from the student after they graduate. The number of students trained is therefore constrained by the Government's finances.

The reform of the healthcare student financing system will reduce the burden on the taxpayer, and enable Higher Education Institutions to provide places on nursing, midwifery and Allied Health Professions courses to meet expressed demand from potential students. It should reduce the risks that the number of student places offered is constrained by short term financial issues for departmental budgets, rather than the longer term needs of the healthcare system. In the longer term, the reforms should improve the supply of qualified healthcare graduates and thus reduce the health system's reliance on agency and overseas staff.

These reforms will open up opportunities for the 37,000 nursing applicants turned down in 2014.

Based on the experience of the higher education system generally, when £9,000 fees were introduced in other higher education subjects in 2012, the percentage of students from the most disadvantaged backgrounds continued to increase. In 2015, record entry rates by young people from disadvantaged backgrounds increased to 18.5%.

For healthcare students, the combination of an increase of typically around 25% or more in support for living costs through student loans and bringing these students under the access agreement system will support widening participation from disadvantaged groups.

Through the consultation process, the Government received evidence of the need for supplementary funding for healthcare students because of the compulsory clinical placement element of their courses. Additional funding will be made available to cover additional costs for travel, dual accommodation and childcare allowances, and an exceptional hardship fund.

We consider that increasing the living cost support available in these ways, along with the additional allowances available, would continue to ensure that students from a range of diverse backgrounds consider applying to train as a nurse, midwife or allied health professional.

For universities the combination of tuition fees and additional teaching grant funding that the Government has allocated to the Higher Education Funding Council for England will increase the resources available for teaching. In addition universities can now increase their student numbers, making their provision more sustainable. It is now up to universities to recruit more students.

Responsibility for staffing rests with local NHS employers, with a focus on the numbers and skill mix needed to deliver quality care, patient safety and efficiency, taking into account local factors such as acuity and case mix.

Question 9: Do you agree that there should be a national workforce strategy for the NHS? If yes, what should the aims be? Who is responsible for such a strategy? Can we see any early drafts of it?

The Department of Health keeps under constant review the range of interacting policies which impact on the health and care workforce in England, including pay, pensions, employee relations, workforce planning, professional regulation and other relevant factors. There are currently no plans to publish a detailed overarching account of this evolving picture, but we will over time be publishing policy documents on key aspects, such as possible further legislation on professional regulation, or how best to improve the working lives of health and care staff.

Question 10: NHS Employers has estimated that the cost of statutory compliance with the National Living Wage in 2020/21 will be £180 million (0.39 per cent of pay bill). Does DH recognise this figure?

NHS Employers have been leading discussions with staff side representatives about how to respond to meeting National Living Wage requirements. Our respective analysts share data, models and methodologies in the interests of consistency and avoiding duplication. DH accept the NHS Employers estimate of National Living Wage costs though we recognise this is subject to change. The future values of the National Living Wage depends on wider economy earnings growth, which is not clear yet, and this will affect the costs for the NHS.

Question 11: NHS Employers has suggested that HCAS allowances should be flattened across London to alleviate “cliff edge effects” across the boundary. Is this a sensible suggestion?

The design of geographical pay allowances is complex and raises a number of issues, as seen in the recent consideration of market facing pay. ‘Cliff edge effects’ are an appropriate concern about zonal pay systems, particularly when transportation links are good and travel to work areas potential wide. However, any potential change would need to be considered in detail to avoid unforeseen consequences. One potential issue is that equalising the value of the three High Cost Area Supplement (HCAS) zones would increase the difference between the Fringe zone and the surrounding national rate areas, which could increase cliff edge effects here. Another is whether the most central of London employers would face recruitment and retention difficulties if their staff could earn the same amount, but face lower housing costs and/or shorter commutes by living and working further from the centre.

Question 12: NHS Employers estimate that the introduction of the Apprenticeship Levy in April 2017 will cost the NHS £200 million per year and that meeting the NHS's share of the public sector apprenticeship target will require a 65 per cent increase in the number of Apprenticeship starts in the NHS to 28,000 per year (paragraphs 124-127 of their evidence).

- What is the role of Apprentices in the NHS? Can you provide more detail about how Apprenticeships fit with wider workforce strategy in terms of addressing supply? Can you also address the challenges identified by NHS Employers (paragraphs 124-127 of their evidence) and Joint Staff Side (paragraphs 8.1-8.22 of their evidence) and how these are being tackled?
- Can you also comment on how Apprenticeships will fit with the Agenda for Change pay system? Will Apprentices be on the AfC scale? If so where?

The Department for Education publication of 25 October 2016 Apprenticeship funding: how it will work confirms how the apprentice levy will operate. The final guidance took account of views, such as those of NHS Employers, and has extended the apprentice voucher expiry period to 24 months instead of the originally proposed 18 months. This extended expiry period will provide greater flexibility for NHS providers to spend their levy vouchers - allowing time to develop more higher and degree level apprentice standards and to develop organisational infrastructure to support the increase in numbers of apprentices. Health Education England (HEE) are taking forward a programme of work to support the development of a range of new healthcare apprentice standards, including higher and degree level standards.

HEE PRB evidence shows almost 20,000 NHS apprentices in the most recent year 2015/16. If the public sector target is confirmed as 2.3% of headcount, this would see the NHS with a target of approximately 27,500 apprentices which would be an increase of 37.5% on current numbers.

We note the Joint Staff Side concerns at para 8.4 of their evidence about the unintended consequences from the drive to increase numbers of NHS apprentices. It is important to understand the apprentice levy is applied equally across the public and private sector and the public sector target applied equally across all public sector employers, employing more than 250 staff. The Apprenticeship levy and associated apprenticeship funding reforms, and the public sector target support the Government's commitment to three million apprentices by 2020, which in turn is designed to support an increase in productivity of the UK workforce and support social mobility. In response to these policies HEE continue to work with the National Skills Academy for Health to develop guidance on creating quality apprenticeships in the NHS.

The Department for Education (DfE) consulted on a proposed public sector target and will provide a response to their consultation in due course. DfE will take account of a range of views including those provided by NHS Employers, as part of their response.

The higher degree level nurse apprentice standard was submitted to DfE for approval in August. The Nurse Degree Apprentice Trailblazer group aim to have the standard approved and ready for delivery by Autumn 2017. HEE are currently prioritising work to support the development of a range of healthcare apprentice standards. These will be across a range of NHS roles, including higher and degree level apprenticeships. Once a broader menu of apprentice standards are available, we expect NHS employers will employ a mix of apprentices in Bands 1 to 4 roles and those in higher and degree level roles.

NHS trusts are free to determine the terms and conditions, including pay for the staff they employ but most prefer to use national pay frameworks like Agenda for Change.

There are very many different types of apprenticeships available in the NHS which organisations are free to develop and which are not confined to any particular age group, education, skills or experience. It would not be possible to say where on the pay scale each apprentice would sit within each organisation.

The NHS Staff Council, a partnership of NHS Employers and NHS trades unions, is working to advise and support employers by considering the scope for a set of apprentice employment principles to help guide employers about how to employ apprentices in a fair and consistent way.

The Apprentice National Minimum Wage is recommended by the Low Pay Commission and is currently set at £3.40. The National Living Wage, and the National Minimum Wage for workers aged under 25 is the minimum pay per hour almost all workers are entitled to by law. NHS employers are bound to meet national pay rates, including the national apprentice wage, in line with all other employers. The Apprentice National Minimum Wage applies to Apprentices under the age of 19 or in the first year of their Apprenticeship. All other Apprentices should be paid at least the relevant National Minimum Wage or National Living Wage rate, and most apprentices are paid more than the minimum wage. Pay levels above the statutory wage floor are for employers and workers to agree, however, government strongly encourages employers to pay more when they can afford it.

On the Staff Side proposal that apprentice levy money should be pooled and ring-fenced to the NHS. The recently published DfE levy guidance *Apprenticeship funding: how it will work clearly explains the rules around pooling levy vouchers….. If you are in a group of companies connected for the purposes of paying the levy, your group will be able to collect their funds together into one digital account. Your group will do this by registering to have PAYE schemes attached to a single digital account. Since you can only use funds in your digital account to pay for apprenticeship training for your own employees, employers that are not connected will not be able to pool funds in a digital account.*

Within the apprenticeship funding system the Government is only allowing employers to aggregate their funding to single account where they are group of companies connected for the purposes of paying the levy. NHS employers are not connected for the purpose of paying the levy and therefore cannot aggregate their funds into a single account. Introducing a system whereby employers, who are not connected for the purposes of paying the levy, to “pool” their funds would introduce significant administrative complexity when employers have told us above all they want a system that is simple to understand and operate. As NHS employers are not connected for the purpose of paying the levy they can each make use of the £15,000 allowance, rather than there only being once allowance for the NHS as a whole.

Apprenticeship funding is provided to individual employers based on their apprenticeship levy contribution. Individual employers are in control of their individual apprenticeship funding and have 24 months to spend their levy contribution before the funds expire. The NHS cannot ring-fence as the Government is not permitting any group of employers in any sector to do this. However the Government is committed to bring forward a facility that enables employers to direct funds to other employers on the digital system.

The main aim of the apprenticeship levy is to support employers in growing the quality and number of apprenticeships in their own workforce, but we know there are employers who will want to support their supply chain or other employers in their sector by transferring funds from their digital account. Government has committed to introducing the ability to do this in 2018, and

to initially allowing levy-paying employers to transfer up to 10% of the annual value of funds entering their digital accounts to other employers.

While a transfer value of 10% of the annual value of funds entering an employer's digital accounts is lower than the 20% suggested by NHS employers in their feedback to the proposed funding reforms, DfE recognise it is important to understand employer views in transferring levy vouchers. DfE have created a new employer working group to help it develop proposals for a transfers system that works for all employers, including those in the NHS. This group, which will have NHS representation, will help government design how transfers should work, the level of funds that could be transferred longer term and what controls are needed to protect the integrity of the apprenticeship system.

Question 13: NHS Employers noted in their evidence that "the development of joint working with local authorities may mean that, in future, pay and conditions changes in both the NHS and local government may need to be considered together" and that "responding to the need to work differently across organisations will present a major training and development challenge. One outcome might be generically skilled staff across health and social care". Does DH have any comments on this?

We recognise that there are significant challenges as well as opportunities and that our growing and changing population will require a different response from the health and care system. We believe that a strategic approach to the health and care workforce will inform how we best train and develop health and care staff to meet the future needs of patients and service users and make the very best use of tax payer funding.

DH is working with Health Education England (HEE) and Skills for Care (SfC) on the development of generic skills/roles across health and care, but it is too early to say how terms and conditions might need to change. We can say that these are of course important considerations in developing a system that better responds to health and care needs.

Our primary aim is to ensure health and care staff have the right skills, values and behaviours to help deliver the very best outcomes for patients or service users.

Question 14: The NHS Staff Survey has a response rate of 41 per cent, meaning well over half of staff do not respond to it. Has DH done any analysis of how representative those who respond to the staff survey are of the entire remit group? What actions are being taken to increase the response rate?

DH has not done any analysis of how representative those who respond to the staff survey are of the entire remit group. The NHS Staff Survey is owned and managed by NHS England who commission Picker Institute Europe, which is vastly experienced in running surveys, to co-ordinate it on their behalf.

The NHS Staff Survey is the largest of its kind anywhere in the world. Because of the expert leadership provided by Picker and NHS England in preparing for it each year, the response rate, when compared to other similar types of survey, is very high. In the 2015 NHS Staff Survey, we heard from more staff than ever before. Last year, 153 of the 241 participating trusts chose to undertake a census approach (asking all their staff to respond to the staff survey rather than a sample) and overall we heard from 299,000 staff compared to 203,000 in 2013.

A pilot study by NHS England and Picker which aimed to increase response rates to the survey, was run alongside the 2015 NHS Staff Survey and found that increasing the number of

reminder emails sent and using a more concise message led to an increased response rate, particularly from black and minority ethnic groups. The learning from this successful pilot has been implemented in the standard survey processes for the 2016 NHS Staff Survey.

For the 2016 NHS Staff Survey, NHS England has increased the minimum sample size to 1,250 staff (from 850) where a census is not possible and has increased the number of online reminders that can be issued to staff. NHS England are also working to ensure that we are learning from those already conducting an online census about steps to support others in adopting this approach and that we are also speaking with organisations with high response rates to develop case studies and good practice suggestions for maximising response rates (more information is available at http://www.nhsstaffsurveys.com/Page/1058/Survey-Documents/Survey-Documents/).

In July, NHS England wrote to Trust Chief Executives, HR directors and Staff Survey leads to encourage them to consider adopting a census approach for their annual NHS Staff Survey.

For those organisations who undertake a sample approach, the sampling process is overseen and checked by Picker who provide advice to participating organisations on how to correctly select a random sample in line with the survey's eligibility criteria. Results used to compare organisations and produce national figures are weighted to allow appropriate comparisons to be made. When organisation results are compared they are weighted to account for the differing proportions of staff groups at each organisation. This is done to ensure that comparisons between organisations are fair. National results are weighted to account for the number of staff that work at each organisation and also the staff group proportions, to ensure that the national results are accurate and that year on year comparisons are appropriate.

Question 15: Paragraph 3.14 notes that growth in total factor productivity between 1998/99 and 2013/14 was 0.2 per cent per year compared to labour productivity growth of 2.0 per cent per year. What explains the very slow growth of TFP compared to the growth in labour productivity?

Total factor productivity compares the growth in the activity of all NHS services (Total Output) with the growth in all inputs, both labour and non-labour, used to deliver those services (Total Input). Thus, the difference between total factor productivity and labour productivity is non-labour productivity (the growth in total output compared with the growth in all non-labour inputs). The measures of productivity used by the Department are commissioned from the Centre for Health Economics (CHE) at the University of York. In their most recent measure, for 2013/14, CHE consider the split of inputs to be about 55% labour to 45% non-labour. The non-labour inputs considered by CHE are given in the table below (categorised as either intermediates or capital).

Table 40 Intermediate and capital items	Intermediates	Capital
NHS Trusts Source: Financial Monitoring & Accounts	Services from Other NHS Trusts Services from PCTs Services from Other NHS Bodies Services from Foundation Trusts Purchase of Healthcare from Non-NHS Bodies Supplies & Services - Clinical Supplies & Services - General Consultancy Services Transport Audit fees Other Auditors Remuneration Clinical Negligence Research & Development (excluding staff costs) Education & Training Establishment Other	Premises Impairments & Reversals of Receivables Inventories write downs Depreciation Amortisation Impairments & Reversals of Property, Plant & Equipment Impairments & Reversals of Intangible Assets Impairments & Reversals of Financial Assets Impairments & Reversals for non-current Assets held for sale Impairments & Reversals for Investment Properties
PCTs/SHAs/CCGs/ NHS England Group Source: DH Annual Report & Accounts	Consultancy Services Transport Clinical Negligence Costs Establishment Education, Training & Conferences Supplies & Services - Clinical Supplies & Services - General Inventories consumed Research & Development Expenditure Other	Premises Impairment of Receivables Rentals under operating leases Depreciation Amortisation Impairments & reversals

Question 16: Job advertisement data from NHS Jobs (below) indicates that, while there are a large number of applicants for each advertised vacancy, only about 1 in 5 posts being advertised for end up being filled. Does DH have any comments on what infer from this?

	Applications per advertised vacancy	Shortlisted per advertised vacancy	Appointed per advertised vacancy
All National Workforce Data Set (NWD) Staff Groups	12.5	2.9	0.19
Additional Clinical Services	29.5	6.5	0.34
Additional Professional Scientific and Technical	10.4	2.7	0.20
Administrative and Clerical	23.7	4.2	0.24
Allied Health Professionals	7.2	2.0	0.18
Estates and Ancillary	20.4	5.0	0.30
Healthcare Scientists	11.0	1.8	0.17
Medical and Dental	5.1	1.2	0.06
Nursing and Midwifery Registered	4.1	1.7	0.14
Students	17.1	3.8	0.32

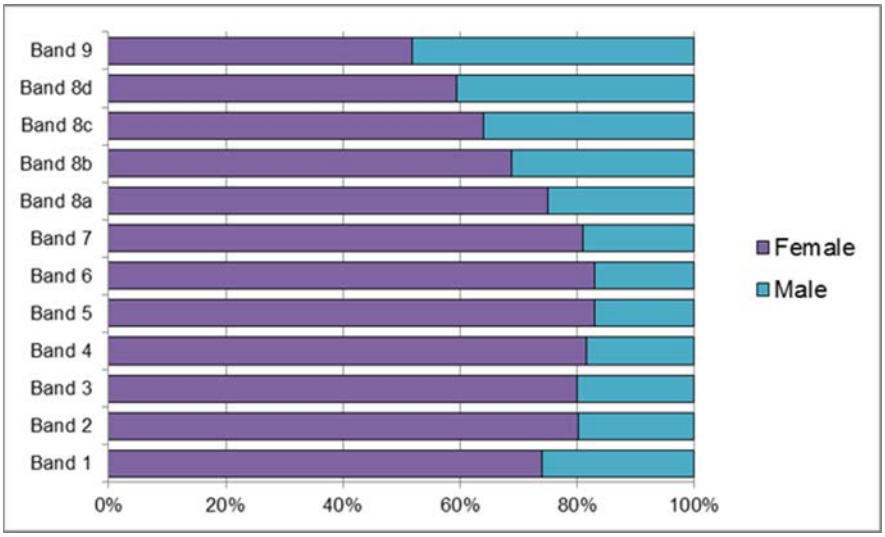
This is the third provisional experimental publication of NHS vacancy statistics created from administrative data related to published vacancy adverts obtained from NHS Jobs, the main recruitment website for the NHS. The statistics and the accompanying tables are exploratory and provide information on the administrative data available from NHS Jobs as much as on the recruitment of staff. The publication provides figures which are an insight to recruitment in the NHS but which should be treated with caution, though the expanded time series may now begin to allow users to consider relative changes over time.

As one advert can be used to fill multiple posts it is not possible to accurately state the number of vacancies within a specified period. (An advert might cover multiple vacancies, a new post i.e. not a vacancy, or an ongoing recruitment programme and adverts can also be placed by NHS sub-contractors and local authorities so not all adverts will be for jobs in the NHS.) Therefore the only accurate statement remains that the number of advertised full-time equivalent posts shows the minimum number of posts employers wish to fill. It is not possible to state the precise level of undercounting, but it is possible to say that it will vary for different staff groups. For example the undercount for nurses is likely to be greater than for other staff groups because of a number of issues including the high level of rolling adverts used for that staff group.

Whilst at first glance it is tempting to infer from job advertisement data from NHS Jobs that though there are a large number of applicants for each advertised vacancy, only about 1 in 5 posts being advertised for end up being filled. It is important to understand that it is not possible from the data to reach this conclusion due to the nature of the different ways organisations use NHS Jobs and the way that NHS Digital compile the data.

Organisations may use NHS Jobs to publish a vacancy advert in which case the data will show that and the system will record the number of web hits on the advert and the number of applications submitted. If, however, organisations do not use NHS Jobs to shortlist applicants then the system will not record the number of applicants shortlisted, and if they do not update the site with the details of applicants appointed (which they are not required to do) then the system will not capture this information either. Therefore, the coverage of the data reduces along the recruitment process and it is not possible to infer advert/appointment conversion ratios.

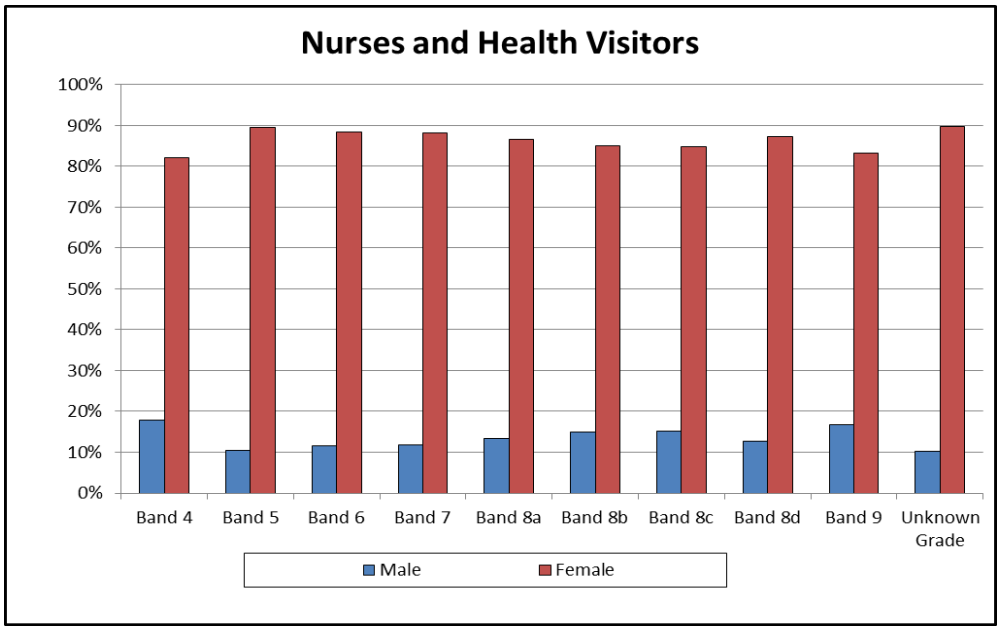
Question 17: The chart below illustrates the gender mix of staff in each Agenda for Change band. There is a clear drop off in the proportion of female staff in bands 8 and 9. Does DH have any further analysis or comment on this?

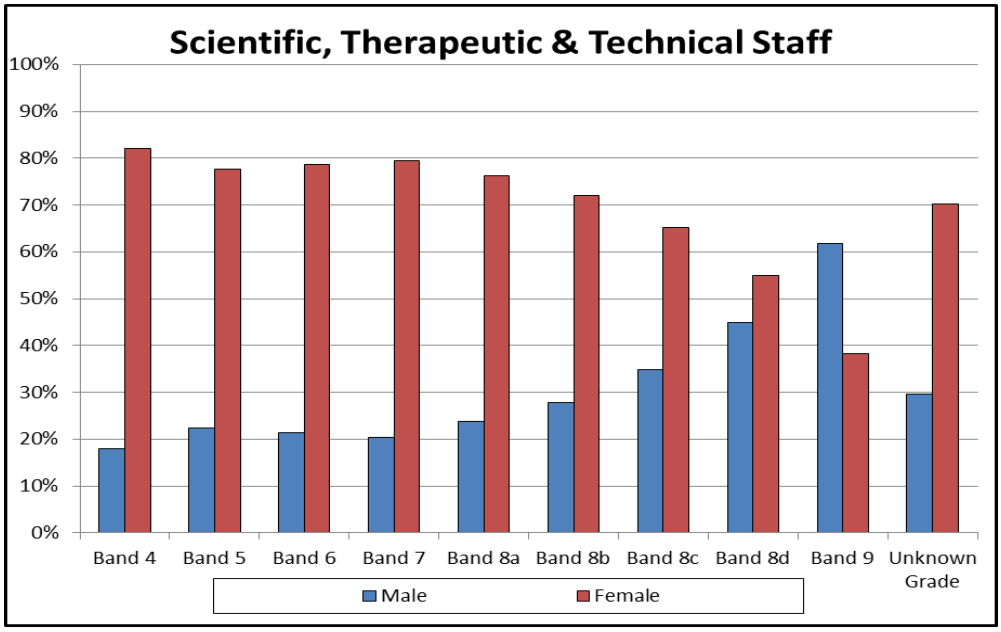


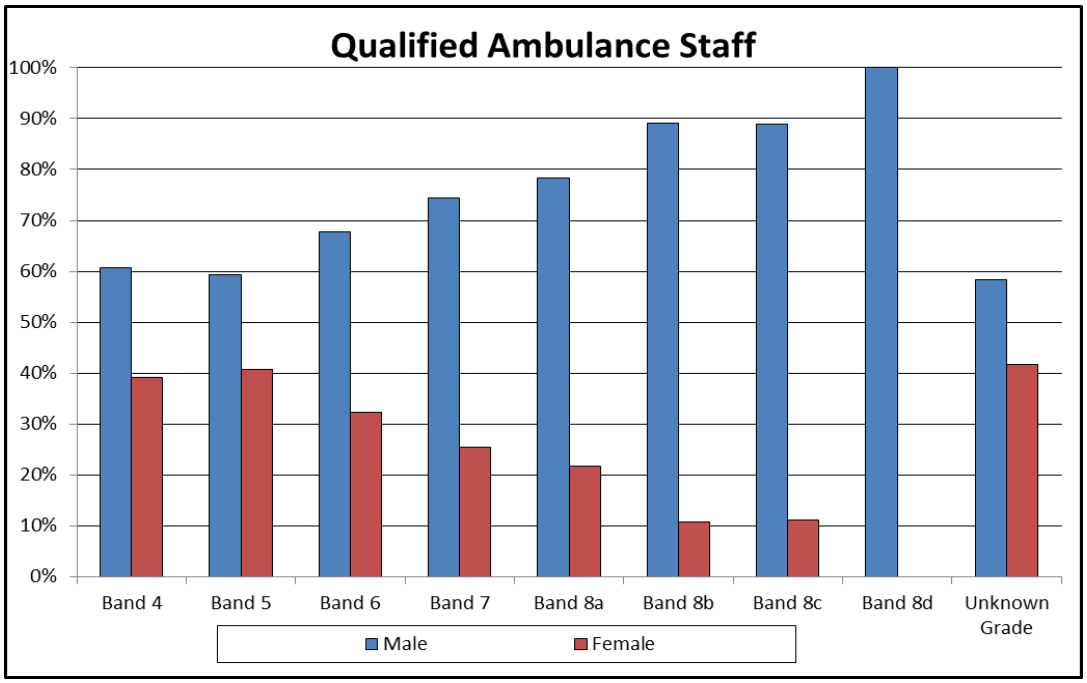
NHS Digital publishes these statistics by occupation group, though not by region. The latest tables are in the attached Excel file, and are also summarised below.

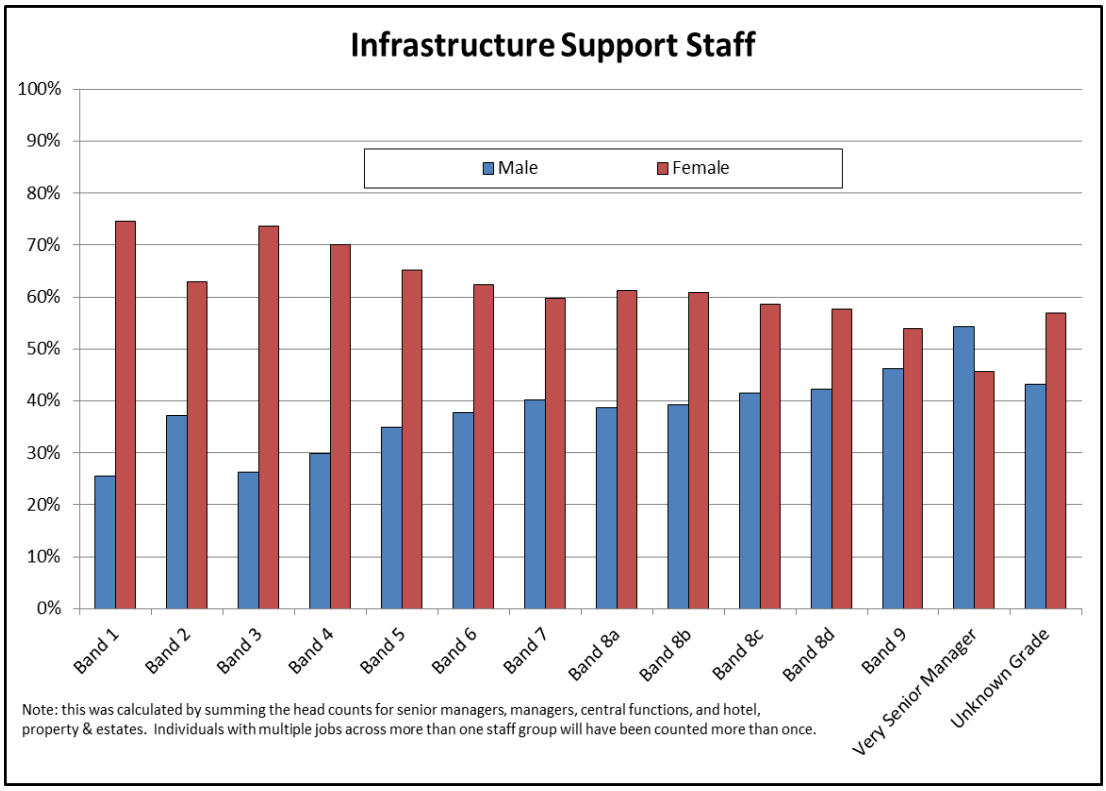
The pattern varies between occupation groups:

- For nurses and health visitors, representation of males is generally lower than average, and is at a similar level across all of the pay bands
- For scientific, therapeutic and technical staff, males have a higher representation, and there is a pattern of this representation increasing towards the higher bands
- For ambulance staff, the majority are male, and this pattern becomes more marked in the higher bands
- For infrastructure support staff, there is a more equal representation of males and females, though with a pattern of higher representation of males on the higher bands.

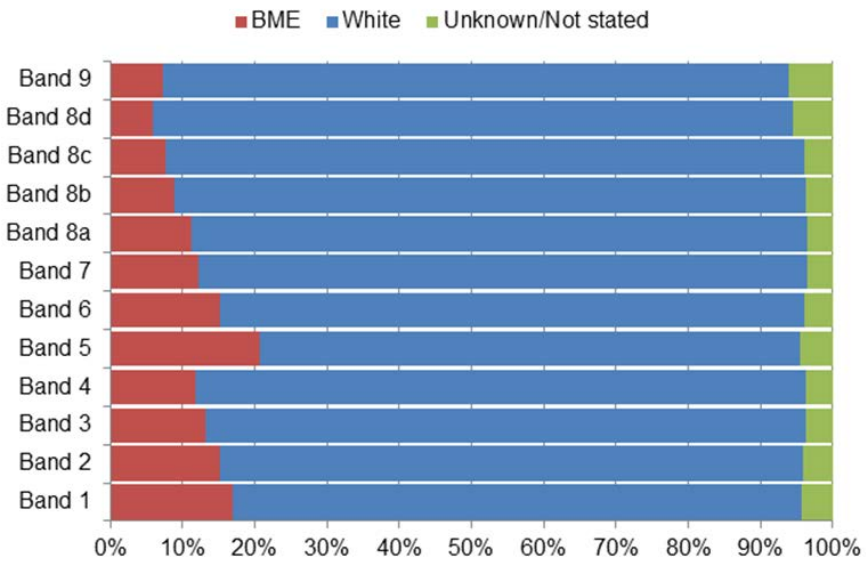



Scientific, Therapeutic & Technical Staff
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Band 4
Band 5
Band 6
Band 7
Band 8a
Band 8b
Band 8c
Band 8d
Band 9
Unknown Grade
Male
Female


Qualified Ambulance Staff
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Band 4
Band 5
Band 6
Band 7
Band 8a
Band 8b
Band 8c
Band 8d
Unknown Grade
Male
Female


Infrastructure Support Staff
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Male
Female
Band 1
Band 2
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8a
Band 8b
Band 8c
Band 8d
Band 9
Very Senior Manager
Unknown Grade
Note: this was calculated by summing the head counts for senior managers, managers, central functions, and hotel, property & estates. Individuals with multiple jobs across more than one staff group will have been counted more than once.

Question 18: The chart below illustrates the ethnic mix of staff in each Agenda for Change band. There is a clear drop off in the proportion of staff from ethnic minorities at higher levels. Does DH have any further analysis or comment on this?



NHS Digital publishes these statistics by occupation group, though not by region. The latest tables are in the attached Excel file.

The pattern is broadly similar across all staff groups.

The NHS Workforce Race Equality Standard (WRES) developed by NHS England has been included in the NHS standard contract since April 2015. The WRES helps NHS organisations, and independent providers of NHS services, to close the gaps in the experience and opportunities of Black and Minority Ethnic (BME) and White staff where these gaps exist.

The WRES does this by requiring all organisations to publish their data against the nine WRES Indicators and to develop action plans to continuously improve on their data and performance over time.

Following consultation on the nine WRES Indicators, NHS England revised them in April 2016:

1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

Note: Organisations should undertake this calculation separately for non-clinical and for clinical staff

2. Relative likelihood of staff being appointed from shortlisting across all posts
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Note: This indicator will be based on data from a two year rolling average of the current year and the previous year

4. Relative likelihood of staff accessing non-mandatory training and CPD

National NHS Staff Survey indicators (or equivalent). For each of the following four staff survey indicators, compare the outcomes of the responses for White and BME staff

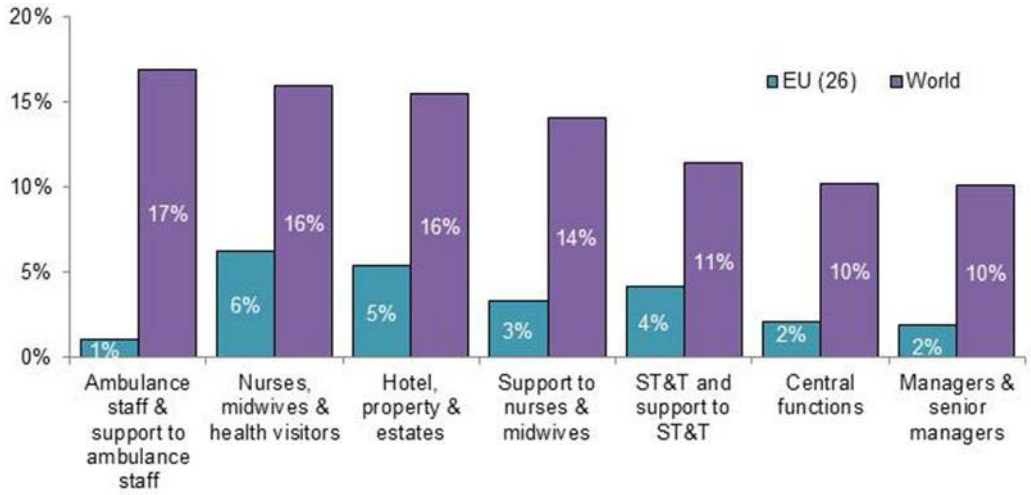
5. KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7. KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8. Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Board representation indicator. For this indicator, compare the difference for White and BME staff.

9. Percentage difference between the organisations' Board voting membership and its overall workforce

Note: Only voting members of the Board should be included when considering this indicator

Question 19: The chart below illustrates the nationality mix of Agenda for Change staff in each professional grouping. Does DH have any further analysis of this by region, particularly for London?



The Table shows the nationality mix of Agenda for Change staff in each professional grouping by Health Education England (HEE) Region in April 2015.

The Table and map below show the representation of non-UK EU nationals in each professional group, by region, in March 2016. The statistics have been sourced from the NHS Digital website.

EU nationals in the NHS workforce are most highly concentrated in the London HEE regions, with a lesser concentration in the regions surrounding London, and the least concentration in the North, Midlands and South West regions. With few exceptions, this is the case across all staff groups. Doctors have the highest proportion of EU nationals at 9%.

In the table and map, the darker shades identify higher concentrations of EU nationals in the workforce.

	North, Midlands & South West	South and East	London	England	Total EU staff
All staff	**2% - 3%**	**6% - 7%**	**10% - 11%**	**5%**	**57,604**
Doctors	7% - 8%	9% - 11%	12% - 14%	9%	10,175
of which:					
Consultants	6% - 8%	6% - 9%	11% - 13%	8%	3,873
Doctors in training	6% - 8%	9% - 12%	13% - 14%	10%	4,925
Nurses and midwives	1% - 4%	8% - 11%	13% - 14%	6%	22,361
Scientific, therapeutic & technical staff	2% - 3%	4% - 5%	9% - 10%	4%	6,536
Ambulance staff	0% - 1%	1% - 3%	0% - 2%	1%	212
Support to doctors, nurses & midwives	1% - 2%	4% - 6%	6% - 8%	3%	9,446
Managers and senior managers	0.5% - 1%	2% - 3%	4% - 5%	2%	646