



Department
of Health

The NHS Pay Review Body (NHSPRB) Review for 2017

Written Evidence from the Health Department for
England

October 2016

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The NHS Pay Review Body (NHSPRB) Review for 2017

Written Evidence from the Health Department for
England

Prepared by NHS Pay, Pensions & Employment Services Team

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Executive summary

This evidence is provided in the context of the strategic direction set out by the government for public sector pay over the period to 2020: a pay policy designed to ensure that the public sector workforce is affordable. Together with an average annual pay increase of 1% for the years 2016/17 to 2019/2020, to be targeted in a way that best supports recruitment and retention, the aim for the wider public sector as well as the NHS is to reform and modernise terms and conditions, developing more affordable, sustainable pay systems.

The remit letter from the Chief Secretary to the Treasury makes clear the expectation that pay awards will be targeted to support the continued delivery of public services and to address recruitment and retention pressures, noting the requirement for the review body to consider good, evidence-based propositions. As we explain at Chapters 4 and 5, we are making good progress to secure the evidence base the Pay Review Body needs, vacancy data in particular.

We recognise that the NHS continues to face significant challenge with increasing demand for health services due to an ageing, growing population and the requirement to recover the provider net deficit position. To find the efficiency savings the NHS needs to make, it is shifting the focus from centrally driven savings to transformational changes, which will reduce the long-term cost pressures on NHS services. We expect trusts to balance their books in 2017/2018. Pay restraint will help trusts by ensuring the workforce is affordable.

Contract reform

For the NHS, the aim is to ensure that contracts are not just affordable but help support the delivery of safe quality services across the seven day week, ensuring appropriate reward for those that do most for their patients, who work most intensively and at the most unsocial times. Informed by the helpful recommendations from the Review Body in July 2015, Chapter 5 sets out the progress of discussions between NHS Employers and NHS trades unions on contract reform.

NHS workforce policy

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

The Department is taking action to increase the supply of trained staff available to work in the NHS and wider health and care system ("workforce supply"). In conjunction with Health Education England (HEE) and NHS England, the Department has taken a range of actions to boost the supply of domestically trained staff and to increase the efficiency and productivity of the existing workforce through better use of technology and changing the skill mix.

There has been an increase of over 25,000 more professionally qualified staff working in the NHS since May 2010 and with over 50,000 nurses and over 50,000 doctors currently in training,¹ the government will continue to make sure there are sufficient staff available to give patients high quality, safe and sustainable care 24 hours a day, seven days a week.

¹ These figures are not directly comparable because the nurses are nursing students on university courses, whereas the doctors figure is the number of "Doctors and Dentists Training

HEE has increased the number of key professional groups being trained. For example, the numbers of nurse training places being commissioned each year has increased by 15% since 2013. Additionally, the reforms to funding of training for nurses and allied health professionals will further boost supply. By removing restrictions on the number of places, universities are free to increase nursing, midwifery and allied health professional training places by up to 10,000 by 2020.

HEE has also increased the number of commissions for paramedic training, up by 60.8% in 2016-17. There are plans to increase this further for 2017-18 to tackle historical workforce shortages.

Where workforce shortages arise, international recruitment through Tier 2 of the Points Based immigration system, or from EEA countries, has been used to fill any remaining gaps. Following the outcome of the referendum, the government will be entering negotiations with the EU on a range of issues including migration policy.

Employers are encouraged to recognise the benefits of adopting flexible working patterns such as shift or part-time working to accommodate personal commitments, thereby improving retention and making the NHS a more attractive option for a permanent career.

Pay Targeting

The Department strongly supports the principle of targeting which is integral to, for example, how contracts are reformed as evidenced under the Agenda for Change (AfC) 2013 collective agreement which removed pay enhancements from sick pay for most staff except the lowest paid. In 2014/2015, the pay settlement was targeted so that only those medical and non-medical employed staff no longer eligible to receive progression pay received a payment, and in 2015/2016 the pay settlement for AfC staff only was also targeted so that lower paid staff received a pay award of at least 2%, with most other staff receiving at least 1% made affordable by freezing the pay award and incremental pay of higher paid staff.

Case for targeting

We recognise that pay restraint is challenging for staff but also that CPI inflation remains at a very low level, currently 0.6% (which fell to 0% in 2015/2016). The evidence presented in this report confirms that overall earnings per person have increased year-on-year since 2010/11, in total by 4.0% or 0.8% a year. Average basic pay per full time equivalent has increased by more than the impact of pay awards and around half of the AfC workforce continue to receive incremental pay of around 3% on average (no eligible AfC employee will receive less than 1% in incremental pay); A longitudinal study shows that the total earnings of those AfC contracted employees who were employed in the NHS in 2010 and also in 2015 increased by an average of between 1.7% and 2.9% per year, depending on staff group, between 2010 and 2015. The average annual CPI figure over the same period was 2.4%. Turnover has been relatively flat for most AfC staff groups and that, apart from nurses, there are no significant national recruitment and retention problems. Although there are early signs that leaver rates are increasing, capacity has continued to grow. Agency costs have continued to increase, particularly in the south-east, but the figures include all staff groups, medical and non-medical. We expect costs to fall over time as supply increases. Morale, as indicated by the NHS staff survey Engagement Index has

in the NHS" (historically referred to as junior doctors), not the number of medical students on university courses.

improved and morale appears not to have changed significantly in recent years and is holding up well.

The NHS needs the right numbers of staff, with the right skills, in the right places at the right times - recruitment, retention and motivation are key to this. It is open to employers to use local payments and where recruitment and retention is a concern, to ensure they have the right people strategies in place to help improve staff engagement. At a national level, as described earlier, robust workforce planning, including for education and training will help secure the supply the NHS needs.

There are some risks to the NHS of continued pay restraint in relation to better earnings growth and improved employment in the wider economy, including recruitment and retention, agency costs and staff morale. However, pay is not the only motivator. It is important that trust boards explore how the entire NHS employment offer, a "Total Reward" approach to pay and non-pay benefits which, as described in Chapter 7, can help employers to use the increasing NHS pay bill in the best way to secure, retain and motivate the skilled workforce they need.

For the 2017/2018 pay round, the evidence suggests that there are no significant recruitment, retention or motivation problems that would be resolved through targeting the pay award on an occupational or regional basis. In the absence of strong evidence to the contrary, the proposal is that a uniform 1% increase should apply to all AfC staff groups.

Our proposal for 2017/18 is made in the light of:

- ongoing discussions on contractual reform;
- annual incremental pay increase of around 3% on average, for just over half of the AfC workforce;
- that we recognise that differential targeting can be helpful, but we do not have sufficient evidence to support this in this pay round, however we are working towards providing the evidence to support targeted pay awards for 2018/19; and
- that the rate of inflation remains very low.

In its 29th report the Review Body identified information that would aid its consideration of the evidence provided by the parties in the annual pay rounds, including workforce monitoring data and greater granularity in earnings data. The Department's analytical team is working closely with the Review Body secretariat to bring together data and information from a range of sources that will provide a reliable single source for all parties. We expect the final data set to be available for the 2018/2019 pay round. The second set of provisional and experimental Vacancy Statistics, published in February 2016, is discussed in Chapter 5.

As in recent years - and reflecting the roles of the Department, its Arms-Length Bodies and other organisations - the 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 affordability and funding and the Five Year Forward View;
- evidence from NHS Employers and NHS Providers on reformed contracts, total reward, recruitment, retention and motivation;
- evidence from HEE on education, training, workforce capacity and supply; and

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- evidence from NHS Improvement on how they support the Department and NHS organisations on a range of issues, for example to restore and maintain financial balance, delivering on the clinical standards, workforce planning and bearing down on Agency spend.

Evidence Structure

The following chapters in the Department's evidence set out:

- Chapter 1: NHS Strategy and Introduction
- Chapter 2: The general economic outlook for the UK economy which underlines the need for continued public sector pay restraint
- Chapter 3: NHS Finance
- Chapter 4: Data on HCHS AfC Staff Earnings
- Chapter 5: Workforce information including - vacancy rates, agency spend, and non-medical workforce planning including international recruitment
- Chapter 6 The aims of contract reform and progress
- Chapter 7: Pensions and Total Reward

1. NHS Strategy and Introduction

- 1.1. On the back of a strong economy, the government is investing £10 billion more in the NHS by 2020, with £6bn frontloaded in 2016/17. Whilst this is a generous settlement compared to other Government Departments, the health and social care system faces increasing demand for its services, driven by an increasingly aged and frail population. Meeting this demand and driving up quality in an affordable way is incredibly challenging. The NHS is well aware that it must do things differently, harnessing innovation and the creativity of its workforce to deliver the consistent high quality care patients and their families expect.
- 1.2. The Department's Shared Delivery Plan 2015-2021² is informed by the NHS's own improvement plan - the Five Year Forward View³ - improving access to a free and high quality health service. NHS England's report Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21⁴ makes clear that providers cannot choose to either improve care for patients or balance their books - they must do both:

"The Spending Review provided the NHS in England with a credible basis on which to accomplish three interdependent and essential tasks: first, to implement the Five Year Forward View; second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients".

Government Pay Policy

- 1.3. At Summer 2015 budget the government set a four year pay policy from 2016/17 onwards to allow workforces to plan ahead – an average annual pay increase of 1%, to be targeted in a way that best supports recruitment and retention.
- 1.4. Prolonged pay restraint is challenging and needs to be accompanied by a continued focus on public sector pay reform - in the NHS around half of the workforce receive incremental pay of around 3.4% on average, in addition to any annual pay award. We continue to pursue reform of pay systems, to ensure that terms and conditions are fit for purpose, affordable and sustainable.
- 1.5. Those who are leading NHS organisations have a key role in setting an example to other staff of the pay restraint that is an essential part of meeting the challenges that the NHS faces. The Secretary of State for Health set this out clearly in his letter of 2 June 2015, (see Annex A) to Chairs of all NHS organisations and his letter now provides the context for decisions on executive pay.

Workforce

- 1.6. The overarching aim of healthcare workforce policy is to ensure the right workforce with the right skills is available and affordable in the right place at the right time to provide the services patients need. To achieve this, the NHS needs to be able to recruit and retain high quality, highly motivated staff in sufficient numbers and enable their training and

² <https://www.gov.uk/government/publications/department-of-health-shared-delivery-plan-2015-to-2020/shared-delivery-plan-2015-to-2020>

³ <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

⁴ <https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf>

development throughout their career to reflect the way services and technology will change.

- 1.7. Affordability of the workforce requires a balance of pay and reward which is sufficiently attractive to enable the recruitment and retention of a high quality workforce and maintain good industrial relations. The NHS must improve quality and minimise costs whilst ensuring that:
- it has the engaged workforce it needs;
 - it has a workforce that feels confident to challenge the care it delivers for the benefit of patients; and
 - it is delivering transformational change for the benefit of patients.
- 1.8. Investment in the workforce has delivered an increase of over 25,000 professionally qualified staff since May 2010; there are over 50,000 nurses currently in training whilst investment in educating, training and recruiting doctors has delivered a 10% increase in the medical workforce over that period. Chapter 5 sets out the numbers currently in training, so that we can continue to ensure that the NHS has sufficient staff to deliver safe and sustainable, high quality patient services seven days a week. Health Education England's (HEE) annual workforce plan for 2016/17 sets out how current workforce challenges are being met⁵.
- 1.9. HEE's plan for 2015/16 acknowledged the staffing pressures in the NHS and highlighted the difficulties caused as a result of demand outstripping supply in four key professional groups: nursing, paramedics, general practice, and emergency medicine. To ease these immediate pressures we have:
- introduced a cap on the rates of agency pay, making agency working a less attractive alternative and increasing the overall productivity of the workforce; and
 - begun to implement productivity gains – as evidenced in Lord Carter's review – through more effective rostering of nurses, better work planning for consultants, and more efficient deployment of allied health professionals. The workforce component is expected to contribute £2 billion.
- 1.10. The NHS at a local level is assessing what workforce demands it will have until the end of the Spending Review period and is planning accordingly to ensure it has the right numbers of appropriately skilled staff in place. NHS employers, and staff and their representatives, need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support job and service redesign, and encourage recruitment and retention in parts of the country and in occupations where vacancies are high. We are working with our partner organisations to ensure that the future workforce is flexible enough to respond to the changing demands that the NHS will experience.
- 1.11. In December 2015, the NHS shared planning guidance 2016/17-2020/21⁶ outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England is producing a multi-year Sustainability and Transformation Plan (STP), showing how local services will

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https://www.hee.nhs.uk/sites/default/files/documents/HEE%20Workforce%20Plan%20for%20England%202016%20180516_0.pdf

⁶ <https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/>

evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View⁷ vision of better health, better patient care and improved NHS efficiency. As part of this, local health and care systems came together in January 2016 to form 44 STP ‘footprints’⁸. The health and care organisations within these geographic footprints are working together to develop STPs which will help drive genuine and sustainable transformation in patient experience and health outcomes of the longer-term. STPs are a key element on the NHS Shared Planning Guidance and the local implementation of the Five Year Forward View. They are supported by six of the national health and care bodies: NHS England, NHS Improvement, the Care Quality Commission (CQC), Health Education England (HEE), Public Health England (PHE) and the National Institute for Health and Care Excellence (NICE).

Contract Reform

- 1.12. Contract reform is part of our strategy for helping the NHS to balance its books whilst continuing to recruit and retain the staff it needs. Contract reform is not about reducing the pay bill, but about ensuring it can be used more effectively to support patient care. This includes making changes that support the recruitment and retention of the skilled, dedicated and compassionate staff the NHS needs, and ensuring that terms and conditions help rather than hinder productivity improvements and other measures to support patient care. For AfC staff, we agreed to focus initially on the incremental pay system, for example to remove overlaps and shorten pay scales before looking at wider terms and conditions in order to develop, as advised by the Review Body, a balanced package of reforms.

Staff engagement

- 1.13. 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, and work hard to keep them safe and ensure bullying and harassment is not tolerated.
- 1.14. The overall employment offer should help to incentivise and reward those staff who do the most for patients whenever patients need them. This includes ensuring the value of the NHS reward package in comparison to other employers is communicated effectively, as discussed in Chapter 7. We continue to commission
- 1.15. NHS Employers to support local employers in developing their employment offer and local staff engagement strategies.⁹
- 1.16. These principles, pay and non-pay, are those we believe employers and trades unions support.

⁷ <https://www.england.nhs.uk/ourwork/futurenhs/>

⁸ <https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/>

⁹ <http://www.nhsemployers.org/your-workforce/pay-and-reward/reward/total-reward-in-the-nhs> and <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/staff-engagement>

Pay restraint in the NHS

- 1.17. We know pay restraint is challenging for staff, but ensuring the NHS workforce is affordable will help protect jobs and services and ensure staff can be deployed most effectively. Paying more to the detriment of affordable staffing levels would over-stretch the workforce and also risk retention problems. It is essential that the NHS is able to attract, retain, motivate and afford the workforce required to meet patient needs.
- 1.18. There are some risks to recruitment and retention from continued pay restraint. Our analysis in Annex B covers earnings growth, recruitment and retention, agency costs and staff morale.
- 1.19. This analysis shows that the leaver rate increased in 2015/16 and that agency costs have grown. However, AfC capacity has continued to grow and morale appears to have been maintained. Robust arrangements are in place to ensure supply of the right number of staff with the right skills.
- 1.20. The government is mindful of monitoring the impact of pay restraint. Given affordability constraints and the absence of sustained recruitment and retention difficulties and after reviewing the available evidence, a uniform 1% pay award for 2017/2018 is considered an appropriate pay award across all AfC staff groups in these difficult circumstances.
- 1.21. The government will continue to: monitor the recruitment and retention situation; develop its intelligence base; and to review the application of targeting, beyond that which may underpin proposals for contract reform, to make best use of available pay resources in the future.

Summary

- 1.22. We do not underestimate the scale of the challenge which can only be achieved if the whole system works together – national bodies can create the right environment, but local delivery is essential. It is vital that the NHS is able to recruit, retain and motivate the workforce it needs. Around half of the AfC workforce receive incremental pay progression of over 3% on average in addition to annual pay awards. In the absence of sustained recruitment and retention difficulties, one percent is considered an appropriate pay award.
- 1.23. At a national level, pay restraint will help the NHS afford the workforce it needs, but pay is only one of a number of levers. To help mitigate risks to recruitment and retention that may arise from prolonged pay restraint, local organisations must utilise the entire employment offer, pay and non-pay benefits, which includes access to an occupational pension scheme. This approach together with a much stronger focus on staff engagement will help ensure the NHS remains the employer of choice for those that want to work in the NHS as part of the healthcare team.
- 1.24. Innovation and creativity is therefore needed at the national and local level, but the majority of the efficiencies needed will be driven and delivered locally, by providers through the commissioning process. This will require firm and decisive action at the local level as well as the right culture and leadership to drive improvement.

2. Evidence on the General Economic Outlook

Introduction

- 2.1. Following the outcome of the EU referendum, the UK economy is entering a new phase which will pose new challenges to the public finances. Public debt stands at its highest share of GDP since the late 1960s, and the deficit remains among the highest in advanced economies. It is vital that the Government continues with its intention to reduce the budget deficit over an appropriate timeframe.
- 2.2. Public sector pay restraint continues to play a key role in fiscal consolidation. It helped save approximately £8bn in the last Parliament and is expected to save another £5bn in this Parliament.
- 2.3. At Summer Budget 2015 the Government announced that it would fund public sector workforces for pay awards of 1 per cent for four years from 2016-17 to 2019-20. The OBR forecast estimated that this policy will protect 200,000 jobs by 2019-20. The Government made clear that it expects pay awards to be targeted to support the delivery of public services.
- 2.4. At a time when the UK faces a period of uncertainty following the vote to leave the EU, the 1 per cent public sector pay policy will continue to play an important role in delivering the Government's objective of reducing the budget deficit over an appropriate timeframe, protecting jobs and maintaining public services.
- 2.5. The vote to leave the EU has created a period of uncertainty, which will be followed by an adjustment as the shape of the UK's new relationship with the EU becomes clear and the economy responds. The strength of the economy means the UK is well-placed to deal with any short-term volatility and the longer-term adjustment.
- 2.6. The economy is in a far stronger position than in 2010, with the budget deficit cut by almost two thirds from its 2009-10 post-war peak, employment at a record high of 31.7 million, unemployment at 4.9 per cent, the lowest level since 2005, and the highest number of businesses on record, almost 1 million more than in 2010. The World Bank has ranked the UK the sixth best place for doing business, and the World Economic Forum placed it as the tenth most competitive country in the world in their latest survey.
- 2.7. The UK's economic performance has been strong in recent years. The UK economy has grown by 13.8 per cent since Q1 2010, and is 7.7 per cent bigger than at its pre-crisis peak. It was the fastest growing major advanced economy in 2014, at 3.1 per cent, and the second fastest in 2015, at 2.2 per cent, behind only the US. The UK economy grew 0.6 per cent in Q2 2016, following 0.4 per cent growth in Q1 2016.
- 2.8. Inflation was close to zero throughout 2015, predominantly as a result of falling fuel and food prices, and in recent months has begun to edge higher as past falls in fuel prices drop out of the annual comparison.
- 2.9. The Government, the Bank of England and the Financial Conduct Authority have worked together to maintain financial stability following the referendum result. The independent Monetary Policy Committee (MPC) and Financial Policy Committee (FPC) have taken steps to support the economy through this period of adjustment, with the MPC announcing a package of measures designed to provide additional support to growth and to achieve a sustainable return of inflation to the 2 per cent target. Along with the

actions the Bank of England has taken, the Government is prepared to take any necessary steps to support the UK economy and promote confidence.

Affordability and Fiscal Strategy

- 2.10. Since 2010 the Government has taken action to cut the deficit which has reduced from its 2009-10 post-war peak of 10.1 per cent of GDP to 4 per cent of GDP in 2015-16. The deficit remains high compared to advanced economies and public sector net debt as a share of GDP has more than doubled since the pre-recession period. The 2015 Charter for Budget Responsibility set out the then Chancellor's fiscal targets, including the fiscal mandate to achieve a headline surplus in 2019-20 and each subsequent year.
- 2.11. The Charter for Budget Responsibility was explicit that the surplus rule will be suspended if the economy is hit by a significant negative shock (defined as 4 quarter-on-4 quarter GDP growth below 1 per cent). This provides flexibility to allow the automatic stabilisers to operate freely when needed. Following a shock, the Government of the day will be required to review what are the appropriate fiscal targets as the public finances return to surplus. The framework does not prescribe what the targets should be, allowing the Government of the day to respond to the circumstances. However, the targets will be voted on by the House of Commons and assessed by the Office for Budget Responsibility.
- 2.12. Following the decision of the British people to leave the European Union, it is clear the UK economy is experiencing some turbulence. Neither the Treasury nor the Office for Budget Responsibility have produced revised economic forecasts since the EU referendum. However, the latest comparison of independent forecasters shows that expected growth for 2017 has been cut from 2.1 percent to 0.7 per cent in 2017 since the referendum. It is highly likely that the Office for Budget Responsibility will forecast growth of less than 1 per cent on a 4 quarter-on-4 quarter basis which will trigger the requirement for the Treasury to review the fiscal targets.
- 2.13. The Chancellor of the Exchequer has been clear that in light of the referendum result the Government will no longer pursue a surplus in 2019-20. He has also been clear that reducing the deficit remains a core priority for the Government. The Government's fiscal position will be set out at the Autumn Statement in the normal way once the Office for Budget Responsibility have produced a revised economic and fiscal forecast.

Labour market

- 2.14. The labour market has performed strongly in recent years. While there is still uncertainty about the future of the labour market, the latest data (April-June 2016) show continued strength in the headline figures, with employment up by 606,000 over the year, to a record level of 31.7m. At 74.5 per cent the employment rate is the highest on record. The quality of employment has been strong, with the majority of employment growth over the year being among full-time workers (62 per cent) and among high and medium-skilled occupations (87 per cent).
- 2.15. Unemployment fell by 207,000 over the year to a level of 1.6m, with the rate falling to an 11 year low of 4.9 per cent. Over 60 per cent of the fall in unemployment over the year came from the decrease in long-term unemployment (unemployment of 12 months or more), which was down by 130,000 over the year.
- 2.16. Youth unemployment (16-24) was down by 105,000 over the year to April-June 2016, to a level of 626,000. The youth unemployment rate stood at 13.7 per cent, down 2.1

percentage points on the year. Excluding people in full-time education, there were 418,000 unemployed 16-24 year-olds, with a corresponding unemployment rate of 12.1 per cent.

- 2.17. The claimant count in July fell by 8,600 over the month and by 27,100 over the year, with the claimant count rate at 2.2 per cent.
- 2.18. The number of vacancies in the three months to July stood at 741,000. While this reflects a fall on the quarter, this is consistent with recent trends in vacancies and remains up on the same period last year.
- 2.19. Wage growth was fairly stable in the first half of 2016. In April-June total pay was up 2.4 per cent on the year in nominal terms and by 2.1 per cent in real terms. This marks the 21st month that average earnings have outstripped inflation, continuing the longest period of real wage growth since 2008. Figure 1 summarises these statistics:

Figure 2.1: Labour market statistics summary (Levels in 000s, rates in %)*

	2011	2012	2013	2014	2015	Apr-Jun 2016
Employment level, 000s (All aged 16 and over)	29,376	29,696	30,044	30,757	31,296	31,750
Employment rate % (All aged 16-64)	70.3	71	71.5	72.9	73.7	74.5
Unemployment level, 000s (All aged 16 and over)	2,593	2,572	2,474	2,026	1,781	1,641
Unemployment rate % (All aged 16 and over)	8.1	8.0	7.6	6.2	5.4	4.9
Youth unemployment level, 000s (All aged 16-24)	996	1007	967	782	685	626
Youth unemployment rate % (All aged 16-24)	21.4	21.4	20.9	17.1	14.9	13.7
Claimant Count	1,534.4	1,585.6	1,421.8	1,037.1	798.7	763.6**

Source: UK Labour Market: August 2016, ONS

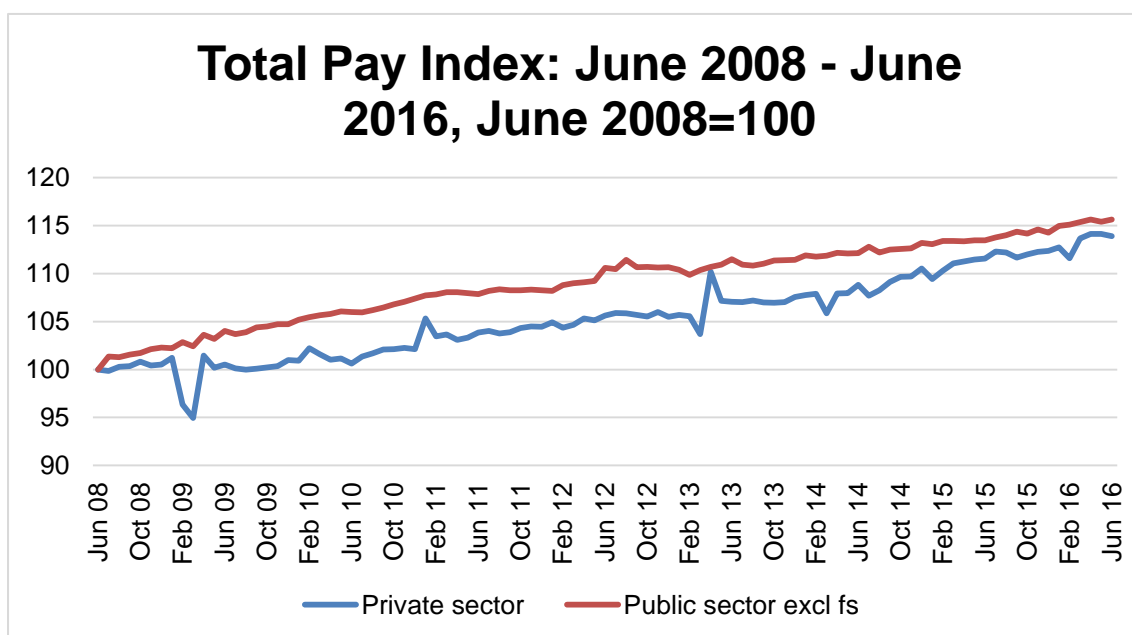
* The latest public and private sector employment figures available are for the first quarter of 2016. These show that private sector employment rose by 55,000 on the quarter and was up by 485,000 over the year. This more than offset the fall in public sector employment which was up by 1,000 on the quarter but down by 24,000 over the year. Since Q1 2010 over 6½ private sector jobs have been created for every public sector job lost. These series exclude the effects of major reclassifications where large bodies employing large number of people have moved between the public and private sectors.

** Monthly data used (July 2016)

Public sector pay and pensions

- 2.20. IFS and ONS analysis has shown, on average, higher pay growth in the public sector when compared to workers with similar characteristics in the private sector. While the public-private pay differential is narrowing, the overall remuneration of public sector employees when taking employer pension provision into account continues to be above that of the market.
- 2.21. In the three months to June 2016, private sector total pay growth (including bonuses) stood at 2.5 per cent, while private sector regular pay growth (excluding bonuses) stood at 2.4 per cent. Although low inflation has helped boost real wages, nominal private sector wage growth remains below rates seen before the recession (about 4-5 per cent per annum).
- 2.22. Public sector total pay growth (including bonuses) was 1.9 per cent in the three months to June 2016. Regular earnings (excluding bonuses) grew by 1.7 per cent over the same period. These rates stood above the rate of inflation in this period (0.5 per cent) but still below the pre-recession average growth rate, as in the private sector.
- 2.23. Historically, public sector wages tend to fall and recover at a slower pace during economic cycles than private sector wages – there can be a delay between a recession occurring and public sector wage adjustment. Since July 2014, private sector earnings growth has been faster than growth in public sector wages, but this follows on from sustained public sector wage growth in the years immediately following the recession. From the three months to June 2008 to the three months to June 2016, total average public sector earnings increased by 15.6 per cent, while those in the private sector have increased by 13.8 per cent. The overall level of public sector average weekly wage remains above that of the private sector, as shown in Figure 2 which compares the growth in average public and private sector weekly earnings since 2008.

Figure 2.2: Total pay comparison



Source: Average Weekly Earnings, ONS Labour Market Statistics, June 2016

- 2.24. When considering changes to remuneration, it is important to consider other elements of the total reward package. Including employer pension contributions to pay and bonus,

recent HMT analysis finds that on average public sector workers benefit from a 10.4 per cent premium compared with their private sector counterparts as can be seen in Figure 3. This is supported by the IFS (October 2014 paper), who found that a 4.6 per cent pay premium continues to exist in favour of public sector workers and that the premium increases significantly if one incorporates pension payments in the analysis. This premium is driven by a number of factors including higher pay for women, and protection for the low paid in the public sector. Figure 3 shows the comparison of average hourly earnings for public and private sector workers with similar characteristics across time.

Figure 2.3: Estimated public-private hourly pay differential



- 2.25. This Government wants to build an economy that works for everyone, and wants to do this in a fair way by ensuring that low wage workers take a greater share of the gains from growth. An essential part of this is the introduction of a new National Living Wage (NLW).
- 2.26. In April 2016, the NLW was introduced at £7.20 for workers aged 25 and over, marking an increase in pay for over a million workers across the UK. Estimates indicate that approximately 200,000 public sector workers have directly benefitted from the policy.

Pension reforms

- 2.27. One major factor in the overall reward package is pension provision. The design and scope of private sector occupational schemes has changed significantly in the last 25 years. Participation in private sector schemes fell from 6.5m active members in 1991 to 2.8m in 2013, whereas participation in the public sector increased over the same period. Private sector participation rates are now increasing, following the phased introduction of mandatory workplace pension savings, but this growth is in defined contribution schemes where the employee rather than the employer bears the investment risk. The average employer contribution to private sector pensions was around 7 per cent of pay in 2014, compared to average employer costs of around 14 per cent of pay in the reformed public service pension schemes.
- 2.28. Where private sector defined benefit provision exists, the employer contribution towards the costs is broadly similar to the cost of providing the reformed public sector schemes,

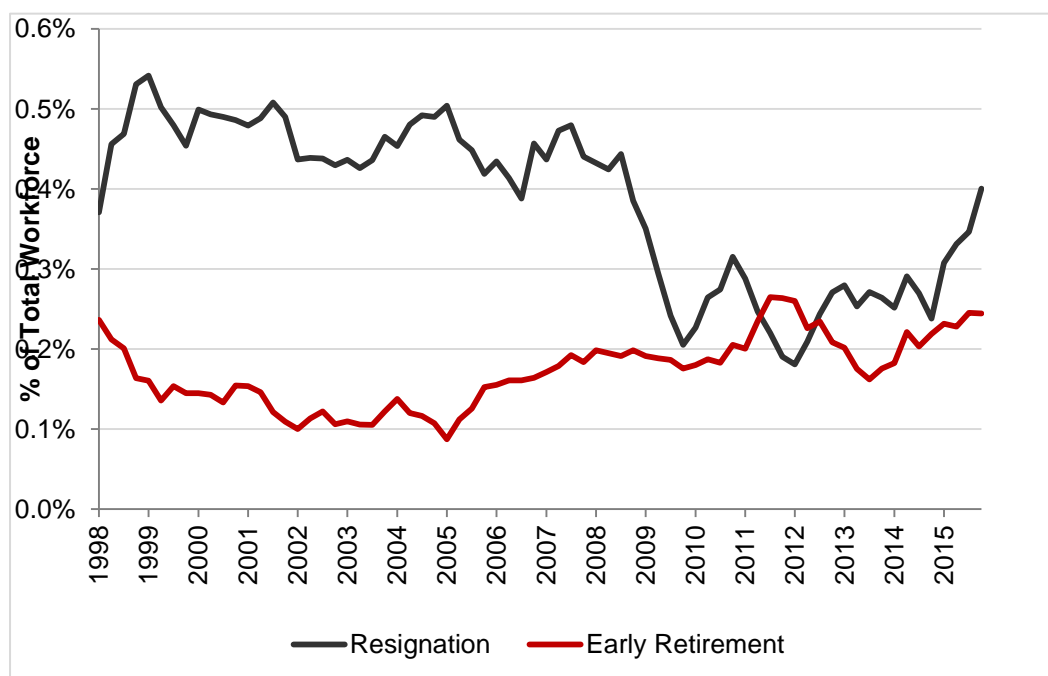
however fewer private sector employees have access to such arrangements. The average employer contribution to private sector career average schemes was 12.7 per cent of pay in 2014. There were 1.6m active members of defined benefit schemes in the private sector in 2014.

- 2.29. Public service pension schemes continue to be amongst the best available and significantly above the average value of pension provision in the private sector.

Recruitment and Retention

- 2.30. Across the whole economy there is evidence that the labour market is performing strongly with strong growth in employment. However, there is limited evidence of widespread recruitment and retention issues within the public sector. Figure 4 shows recent resignation and early retirement rates in the public sector.

Figure 2.4: Resignation and Early Retirement Rates (up to Q4 2015)



Source: Labour Force Survey Microdata, ONS and HM Treasury analysis

- 2.31. The rate at which people are resigning from the public sector remains substantially below pre-recession levels. Within the public sector, the resignation rate was relatively constant prior to the recession, in the region of 0.4 – 0.5 per cent. From the middle of 2008 this rate fell sharply to 0.2 – 0.3 per cent, potentially relating to opportunities outside the public sector becoming scarcer. Since then it has made little sustained recovery. Resignation rates over the last year have increased but remain below pre-recession levels. The early retirement rate figures have fluctuated since 2010.
- 2.32. The CIPD Labour Monthly Outlook, Spring 2016, indicates that amongst all private sector firms, where pay has increased by 2 per cent or more, only 28 per cent of those cases were set at that level to address recruitment and retention issues.

3. NHS Finances

Funding Growth

- 3.1. This chapter sets out the financial context for the NHS.
- 3.2. Between 1999/2000 and 2010/11 NHS revenue expenditure increased by an average of 5.7% in real terms. In the following five years, 2011/12 to 2015/16, NHS revenue expenditure increased by an average of 1.9% per year in real terms. Table 3.1 shows
- outturn NHS revenue expenditure figures from 1999/2000 to 2015/16
 - Revenue Departmental Expenditure Limits (RDEL)

Table 3.1 NHS Revenue Expenditure: England - outturn 1999/2000 to 2015/16 and plan 2016/17 & 2017/18

Year		Revenue Net NHS Expenditure, £bn (4)(5)(6)	% Increase	% Real Terms Increase (7)
Resource Budgeting Stage 1 (1)				
1999/00	Outturn	39.3	-	-
2000/01	Outturn	42.7	8.6	6.5
2001/02	Outturn	47.3	10.8	9.4
2002/03	Outturn	51.9	9.8	7.4
Resource Budgeting Stage 2 (2)				
2002/03	Outturn	56.9	-	-
2003/04	Outturn	61.9	8.7	6.3
2004/05	Outturn	66.9	8.1	5.3
2005/06	Outturn	74.2	10.9	8.0
2006/07	Outturn	78.5	5.8	2.7
2007/08	Outturn	86.4	10.1	7.5
2008/09	Outturn	90.7	5.0	2.3
2009/10	Outturn	97.8	7.8	6.4
Resource Budgeting - Aligned (3)				
2009/10	Outturn	94.4	-	-
2010/11	Outturn	97.5	3.2	1.4
2011/12	Outturn	100.3	2.9	1.5
2012/13	Outturn	102.6	2.3	0.2
2013/14	Outturn	106.5	3.8	2.1
2014/15	Outturn	110.6	3.8	2.2
2015/16	Outturn	114.7	3.8	3.7
2016/17	Plan	117.3	2.2	0.7
2017/18	Plan	120.4	2.6	0.8

(1) Expenditure figures from 1999/2000 to 2002/03 are on a Stage 1 resource budgeting basis.

(2) Expenditure figures from 2003/04 to 2009/10 are on a Stage 2 resource budgeting basis.

(3) Expenditure figures from 2010/11 are on an aligned basis following the government's Clear Line of Sight programme. Expenditure in 2009/10 has been restated.

(4) Expenditure figures over time are not consistent due to changes in government accounting and this should be noted when making comparisons between years.

(5) Revenue is quoted gross of non-trust depreciation and impairments; prior to September 2007 revenue was quoted net of non-trust depreciation and impairments. This brings DH in line with HMT presentation of the statistics.

- (6) Expenditure excludes NHS (AME).
 (7) GDP as at 30th June 2016.

Share of Resource Going to Pay

3.3. Table 3.2 shows the proportion of the increased funding that has been consumed by the HCHS paybill over time. Note that the HCHS workforce comprises staff working within hospital and community health settings, and so excludes General Practitioners, GP practice staff and General Dental Practitioners.

Table 3.2 Increases in Revenue Expenditure and the Proportion Consumed by Paybill

Year	Increase in Revenue Expenditure	Increase in HCHS Provider Paybill	Proportion of Revenue Increase on Paybill	Increase in HCHS Paybill due to Prices		Increase in HCHS Paybill due to Volume	
	(£bn)	(£bn)	(%)	(%)	(£bn)	(%)	(£bn)
2001/02	4.6	2.4	51	7.3	1.6	4.5	0.9
2002/03	4.6	2.4	51	5.2	1.3	5.4	1.2
2003/04	6.5	2.6	41	5.4	1.4	5.2	1.3
2004/05	5.0	4.5	91	11.9	3.8	4.4	1.2
2005/06	7.3	2.5	34	4.7	1.6	3.2	1.0
2006/07	4.3	1.3	30	5.3	1.9	-1.4	-0.5
2007/08	7.9	1.3	16	4.1	1.5	-0.5	-0.2
2008/09	4.4	2.6	60	3.2	1.3	3.8	1.4
2009/10	7.1	2.7	39	1.9	0.8	5.0	2.0
2010/11	3.3	1.6	49	2.9	1.3	0.9	0.4
Average	5.5	2.4	44	5.3	1.6	2.8	0.9
2011/12	2.8	-0.5	-17	-0.1	-0.1	-1.0	-0.4
2012/13	2.3	0.7	31	1.5	0.6	0.2	0.1
2013/14	3.9	1.1	28	0.7	0.3	1.9	0.8
2014/15	4.1	1.0	25	0.2	0.1	2.2	1.0
2015/16	4.2	1.2	29	0.7	0.3	2.1	0.9
Average	3.5	0.7	21	0.6	0.2	1.1	0.5

(1) Revised 2010/11 to 2012/13 following accounts restatements and exclude inter-company eliminations.

(2) Excludes ALB and DH core staff expenditure.

(3) Excludes GPs.

(4) Volume & Price estimates changed method in 2010/11 to make use of a more detailed staff group breakdown from ESR.

(5) Figures may not sum due to rounding.

3.4. On average, between 2011/12 and 2015/16, increases to the HCHS paybill have consumed 20.6% (£0.7bn out of £3.5bn) of the increases in revenue expenditure. Of these 20.6 percentage points, pay effects have consumed around 7.1 percentage points and volume effects around 13.5 percentage points.

3.5. HCHS pay is the largest cost pressure, on average it has accounted for around 38% of the increases in revenue expenditure since 2001/02. As pay represents such a large proportion of NHS resources, managing the paybill is key to ensuring the NHS lives within the funding growth it has been assigned in the next year.

Pressures on NHS Funding Growth

- 3.6. Different priorities compete for limited funding growth given to the NHS. They are grouped into three categories
- baseline pressures
 - underlying demand
 - service developments
- 3.7. Baseline pressures cover the cost of meeting existing commitments that are essential for delivery of NHS services. They do not cover underlying demand or increased levels of activity, which may arise due to demographic pressures or medical advances. Service developments are new areas of activity which arise due to new policies or ministerial commitments.
- 3.8. HCHS paybill pressures are the largest component of the baseline pressures and usually form the first call on NHS resources. Managing baseline pressures effectively allows the NHS to treat a growing, ageing population whilst making best use of the funding available.

Financial Balance

- 3.9. In recent years the NHS budget has represented an unprecedented challenge to the service to deliver quality care with limited resources. Although the Department, in comparison to other Government Departments, received a generous settlement, the position in 2017/18 is tight because of the requirement to recover the provider net deficit position.

Provider Deficits

- 3.10. The NHS faces a significant financial challenge in 2016/17. This is why we are investing the additional £10 billion the NHS has said it needs to implement its own plan for the future, with £6 billion frontloaded by the end of this year. Whilst NHS providers delivered an overall net deficit in 2015/16, offsetting savings throughout the rest of the system were achieved and financial balance against all spending controls was delivered. With the financial controls package and help from system leads, we expect to deliver financial balance against the overall spending controls in 2016/17.
- 3.11. In 2017/18 we expect trusts to balance their books, but it will still be challenging due to increasing demand for health services as a consequence of the ageing and growing population, and new drugs and treatments.

Productivity in the NHS

- 3.12. 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.
- 3.13. 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 that in 2013/14 NHS outputs were 89% higher than in their base year of 1998/99, while volume of labour input was 41% higher. This suggests an average growth in labour productivity of 2.0% per annum

Table 3.3 Labour Productivity Data from York University (CHE)

	Total Output Growth	Labour Input Growth	Labour Productivity Growth	Output Index	Labour Index	Productivity Index
				100.0	100.0	100.0
1999/00	2.2%	1.6%	0.6%	102.2	101.6	100.6
2000/01	2.3%	1.1%	1.2%	104.5	102.7	101.8
2001/02	3.7%	5.4%	-1.6%	108.4	108.3	100.2
2002/03	5.8%	4.7%	1.0%	114.7	113.4	101.3
2003/04	4.9%	4.5%	0.4%	120.4	118.5	101.7
2004/05	6.4%	4.8%	1.6%	128.1	124.1	103.3
2005/06	7.1%	3.4%	3.6%	137.2	128.4	107.0
2006/07	6.5%	0.6%	5.8%	146.1	129.2	113.2
2007/08	3.7%	0.6%	3.0%	151.5	130.1	116.6
2008/09	5.7%	4.2%	1.5%	160.2	135.5	118.3
2009/10	4.1%	4.6%	-0.4%	166.8	141.7	117.8
2010/11	4.6%	1.3%	3.2%	174.4	143.5	121.6
2011/12	3.2%	-0.2%	3.4%	179.9	143.2	125.8
2012/13	2.3%	-2.0%	4.4%	184.1	140.4	131.3
2013/14	2.6%	0.4%	2.1%	188.9	140.9	134.1
Average Annual Growth	4.3%	2.3%	2.0%			

- 3.14. 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, as before, that in 2013/14 NHS outputs were 89% higher than in the base year of 1998/99. However, the total volume of factor inputs increased by 82% over the same period, resulting in a moderate growth of 0.2% per annum in total factor productivity.
- 3.15. 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 the GDP deflator, this would have a negative effect on technical efficiency.

Table 3.4 Total Factor Productivity Data from York University (CHE)

	Total Output Growth	Total Factor Input Growth	Total Factor Productivity Growth	Output Index	Total Input Index	TFP Productivity Index
				100.0	100.0	100.0
1999/00	2.2%	5.1%	-2.7%	102.2	105.1	97.3
2000/01	2.3%	1.6%	0.7%	104.5	106.7	98.0
2001/02	3.7%	6.1%	-2.2%	108.4	113.2	95.8
2002/03	5.8%	7.1%	-1.2%	114.7	121.2	94.6
2003/04	4.9%	7.6%	-2.5%	120.4	130.4	92.3
2004/05	6.4%	6.5%	-0.4%	128.1	138.9	91.9
2005/06	7.1%	7.2%	-0.1%	137.2	148.9	91.8
2006/07	6.5%	1.9%	4.5%	146.1	151.8	96.0
2007/08	3.7%	3.9%	-0.2%	151.5	157.6	95.7
2008/09	5.7%	4.2%	1.4%	160.2	164.3	97.1
2009/10	4.1%	5.4%	-1.3%	166.8	173.2	95.9
2010/11	4.6%	1.3%	3.2%	174.4	175.5	99.0
2011/12	3.2%	1.0%	2.1%	179.9	177.3	101.1
2012/13	2.3%	2.0%	0.4%	184.1	180.8	101.5
2013/14	2.6%	0.4%	2.2%	188.9	181.6	103.7
Average Annual Growth	4.3%	4.1%	0.2%			

Efficiency Savings

3.16. The NHS Five Year Forward View anticipated a gap between resources and patient needs of nearly £30 billion a year by 2020/21, if there were no further efficiencies. To fill this gap we are investing the additional £10 billion the NHS has said it needs to implement its own plan for the future, with £6 billion frontloaded by the end of this year, along with £22 billion of efficiency savings (equivalent to 2% - 3% efficiency per annum). This is challenging but as the above shows is in line with average growth in labour productivity of 2.0% per annum in recent years.

3.17. The Department of Health is working with the health service, partners and patients to develop key elements of the programme required to achieve the efficiency savings. The five main areas of focus are:

- reducing demand for NHS care by improving the public’s overall health, introducing new models and places to care for patients that mean they don’t always need to go to hospital and reducing unwarranted variation in care;
- making better use of NHS providers’ resources – money, technology, estates and people;
- reducing some NHS costs by limiting pay increases and improving purchasing;
- increasing income to the NHS through charges and commercial opportunities; and
- reducing system overheads by reducing NHS management costs.

3.18. Lord Carter’s recent review into productivity and how hospitals buy goods and services found that the NHS could save up to £5 billion a year, by making better use of staff, medicines and deploying its vast buying power more effectively, so every penny possible can be spent on patient care. Lord Carter’s review says that increasing staff efficiency by

just one per cent, through better planned rotas and shifts could save hospitals £400 million a year.

Conclusion

- 3.19. The NHS faces a significant financial challenge over the next five years. The NHS Five Year Forward View anticipated a gap between resources and patient needs of nearly £30 billion a year by 2020/21, if there were no further efficiencies. To fill this gap we are investing the additional £10 billion the NHS has said it needs to implement its own plan for the future, with £6 billion frontloaded by the end of this year.
- 3.20. This will require the NHS to meet the challenge of finding £22 billion of efficiency savings by 2020/21. Meeting this challenge is likely to require shifting the focus from centrally driven savings to transformational changes, which will reduce the long-term cost pressures on NHS services.

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

Summary

- 4.1. As described in Chapter 2, there are signs of wider labour market recovery. Unemployment is down, employment is up, and private sector pay growth has accelerated after a period of low growth. NHS recruitment and retention prospects need to be considered in the context of this wider recovery.
- 4.2. Chapter 2 suggests a pay premium remains for the public sector as a whole, and that public sector pay has grown faster than that of the private sector in the period since the financial crisis though not since July 2014. However, at occupation group level, comparison of recent earnings growth with economy-wide comparator groups shows that NHS earnings have grown less than comparators, though the gap varies between NHS occupation groups.
- 4.3. Economy-wide earnings growth has varied regionally; highest in the North East and lowest in London. The Agenda for Change minimum pay rate is higher than the National Living Wage and above the Foundation Living Wage in London.
- 4.4. The leaver rates show some signs of increase in 2015/16, but capacity has continued to grow, and there are robust workforce planning arrangements in place.
- 4.5. The use of recruitment and retention premia (RRP) appears to have fallen. However, this may reflect the historical Cost of Living geographical allowance that was phased out in favour of High Cost Area Supplements (HCAS). There is therefore no evidence of increased use of RRPs to address recruitment and retention problems..
- 4.6. Agency costs have continued to increase in most regions, particularly in the south-east. The figures are not however broken down between medical and NHS PRB remit staff.
- 4.7. Morale, as indicated by the NHS Staff Survey Engagement Index and sickness absence, appears not to have changed significantly in recent years.
- 4.8. Overall, the evidence does not point to widespread recruitment and retention difficulties or justify higher pay awards. Linking back to Chapter 2, one explanation could be the pensions benefit not captured in simple earnings growth comparisons. However, we recognise the recruitment and retention risks and will continue to monitor.

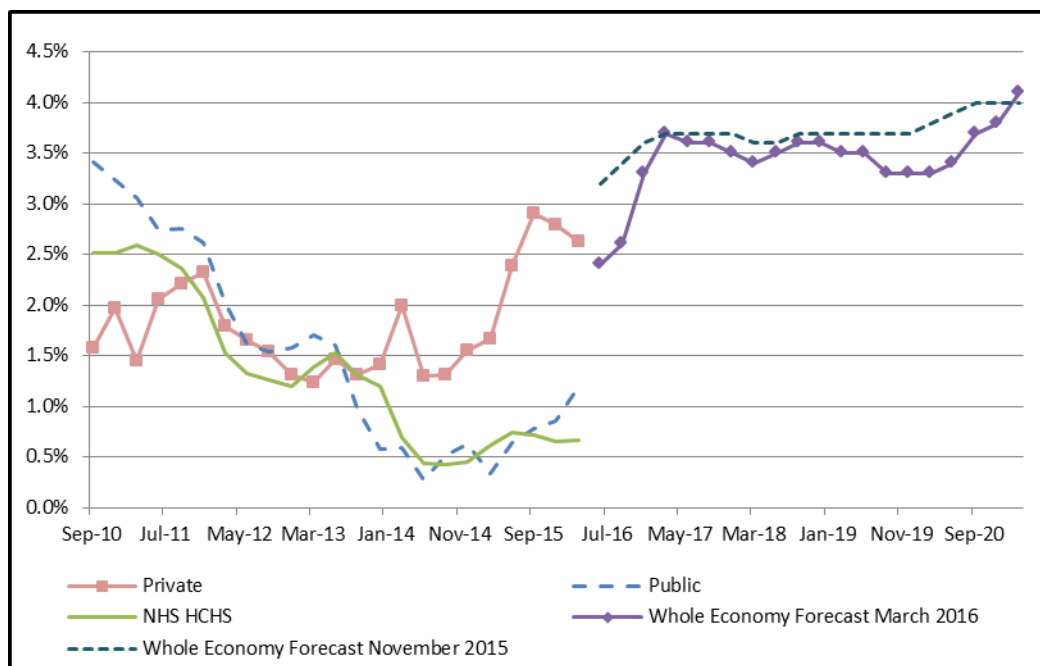
Economic Context

- 4.9. Chapter 2 suggests a pay premium remains for the public sector as a whole, particularly when pension benefits are included, and that public sector pay has grown faster than private sector over the period since the financial crisis. However HCHS average earnings growth has been lower than the private sector average for the last two years, and the gap is expected to continue to widen, although uncertainty about the wider economic impact of the UK decision to leave the EU may alter this. Viewed together with improved employment prospects in the wider economy, this represents a potential recruitment and retention risk to the NHS.

Earnings Growth

- 4.10. Chapter 2 shows that public sector pay has grown faster than private sector over the period since the financial crisis. Recent NHS pay awards have been below the wider public sector pay awards cap. Furthermore, absolute comparisons of pay across industries and sectors are notoriously difficult. Capturing differences in pressures and working patterns is particularly complicated. The material below shows that recent NHS pay growth has fallen behind that of the private sector, and the risk is that this will continue.
- 4.11. The Office for National Statistics (ONS) publishes earnings statistics for the economy based on their Weekly Earnings Survey. These statistics show that private sector earnings growth has been higher than all public sector earnings growth since 2013.
- 4.12. HCHS earnings statistics published by NHS Digital (formerly HSCIC), based on staff pay records in the NHS Electronic Staff Record, also show lower growth than the ONS private sector figures. The private-public earnings differential has returned to around the pre-crisis level. Latest Office for Budget Responsibility (OBR) forecasts, published in March, expected economy-wide earnings to continue to grow significantly in 2016-17. Note that the next set of forecasts may be affected by the vote for the UK to leave the EU.

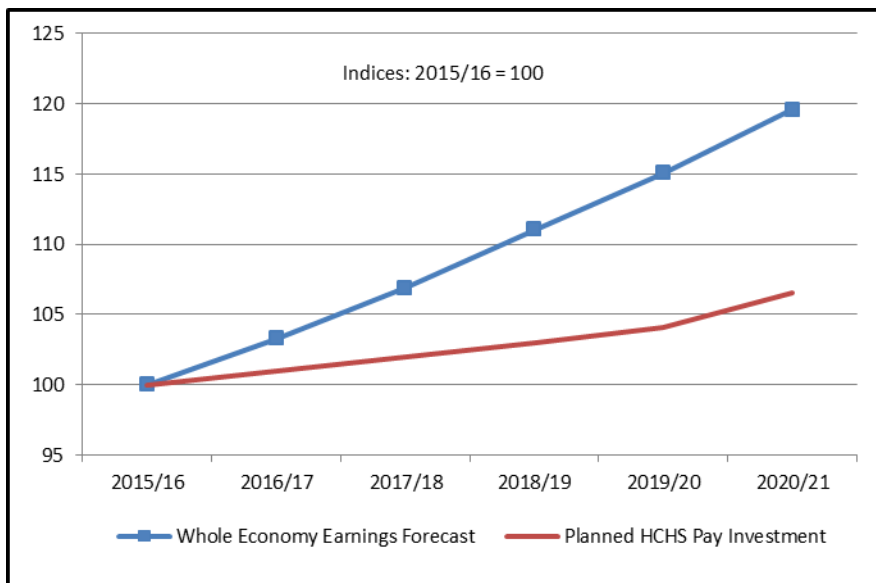
Table 4.1: Average Earnings Growth by Sector and HCHS: Time Series and Forecasts



Sources: Collated Summary Outputs: HCHS Headline Paybill Metrics (see Annex); ONS AWE Table; OBR Table

- 4.13. Planned investment in HCHS pay is 1% per year for the next three years. This is significantly lower than the latest OBR forecasts of whole economy earnings growth. Note that the next set of forecasts may be affected by the vote for the UK to leave the EU.

Table 4.2: Planned Investment in NHS Pay and Forecast Whole Economy Earnings Growth

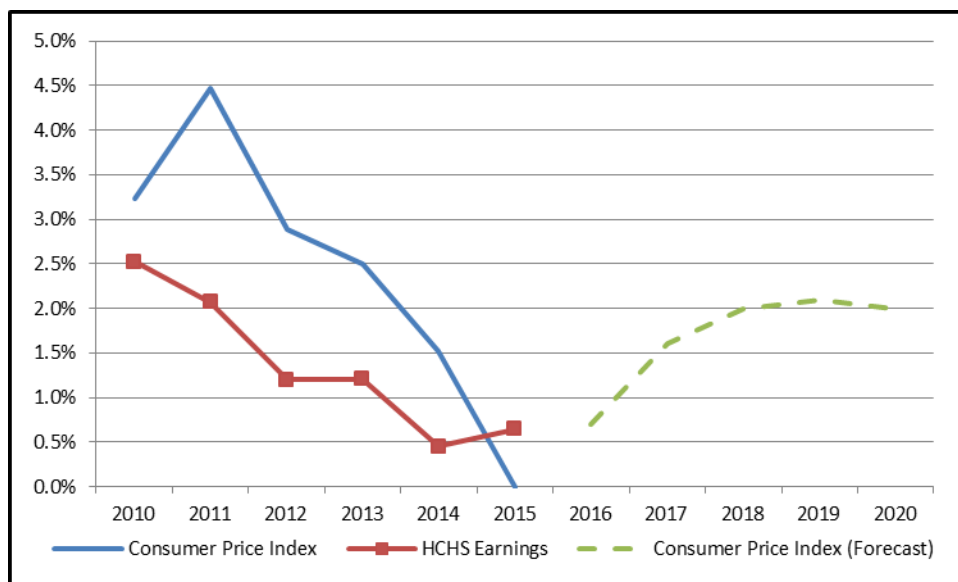


Source: Office for Budget Responsibility

Inflation

4.14. HCHS average earnings growth was below inflation between 2010 and 2015, and slightly above inflation in 2015-16, when inflation fell to 0%. The latest OBR forecast (March) anticipated inflation rising over the next two years to 2%. Again, note that UK exit from the EU may alter these forecasts.

Table 4.3: Average HCHS Earnings Growth and Inflation: Times Series and Forecasts



Sources: Collated Summary Outputs: HCHS Headline Paybill Metrics (see Annex); ONS CPI Table; OBR Table

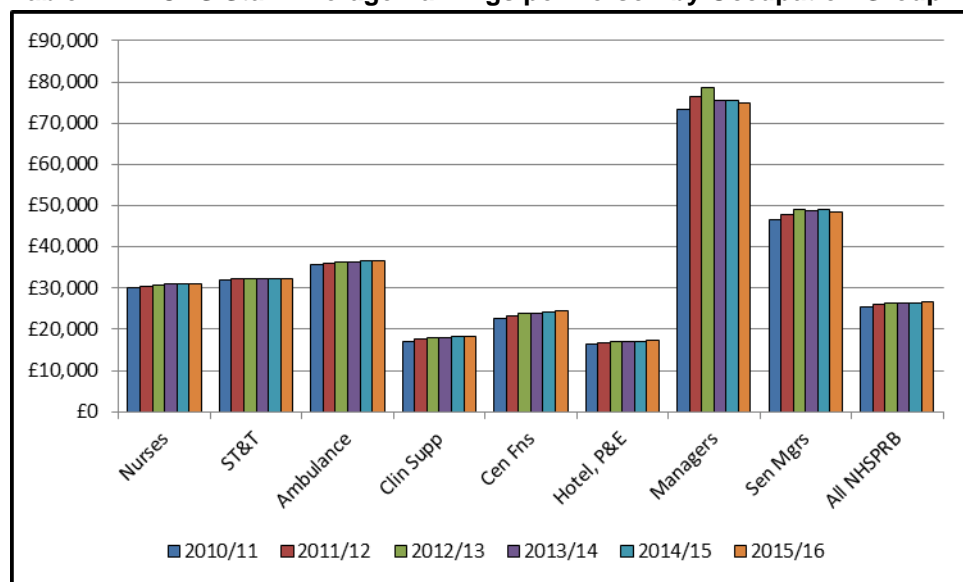
Employment

4.15. As described in Chapter 2 Figure 1, unemployment has fallen and employment has grown.

Agenda for Change Staff Earnings Growth

- 4.16. Overall earnings per person have increased year-on-year since 2010/11, in total by 4.0% or 0.8% per annum. The average basic pay per FTE has increased by more than the impact of pay awards. There has been upward Band drift for nurses in the last two years. The reasons for this are not entirely clear, but may be due to local organisations responding to a shortage in supply, a greater focus on safe staffing levels following recommendations accepted by government following the Francis report on Mid Staffordshire NHS Foundation Trust and skills re-profiling to support service delivery across the seven day week.
- 4.17. Comparison with whole economy comparator occupations shows that average earnings for NHSPRB remit group have grown less than comparator groups, though the gap varies between NHS occupation groups. Minimum Agenda for Change pay rates are above the National Living Wage, and are above the Foundation Living Wage in London. The National Living Wage is not expected to have implications for Agenda for Change rates in 2017/18. Economy-wide earnings growth between 2010 and 2015 varied between regions, from 4% in London to 10% in the North East. The latest figures show a continuation of the downward trend in the proportion of staff receiving an RRP payment.
- 4.18. NHS Digital publishes NHS Earnings Statistics based on information about payments to staff in the NHS Electronic Staff Record. Average earnings per person have grown year-on-year since 2010/11 for most of the main occupation groups, by an overall total of 0.7% to £31,152. Growth has been flat for the Scientific, Technical & Therapeutic staff group. In the last four years growth has been broadly flat for the Senior Managers group and there have been decreases for the Managers group.

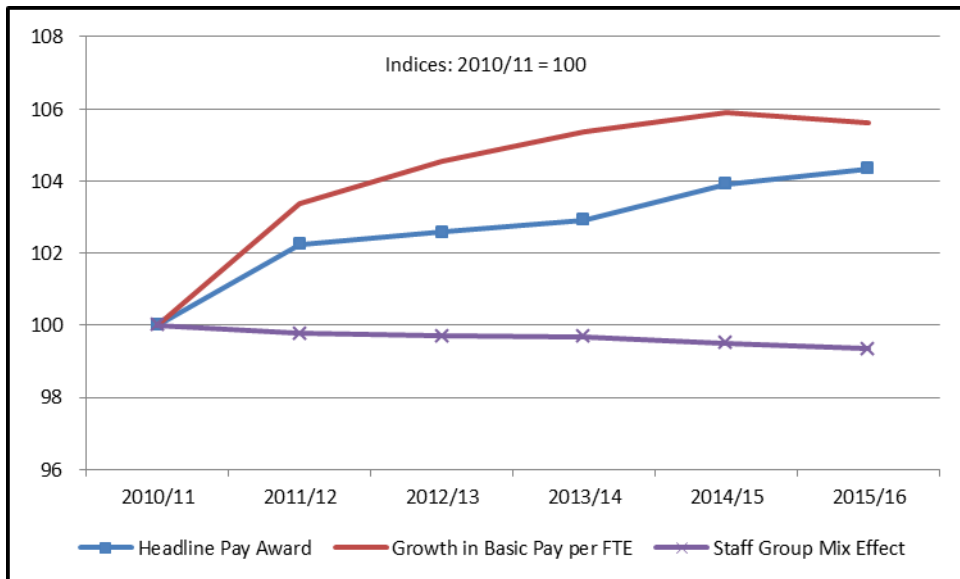
Table 4.4: HCHS Staff Average Earnings per Person by Occupation Group: Time Series



Source: NHS Digital – NHS Earnings Statistics

- 4.19. The effect of headline pay awards was about 2.6%, and average Basic Pay per FTE increased by 3.0%. This included a downward effect of -0.6% from change in staff group mix, which reflects the fact that FTE capacity for lower-paid staff groups grew faster than the number of staff in higher-paid groups, reducing the overall average pay.

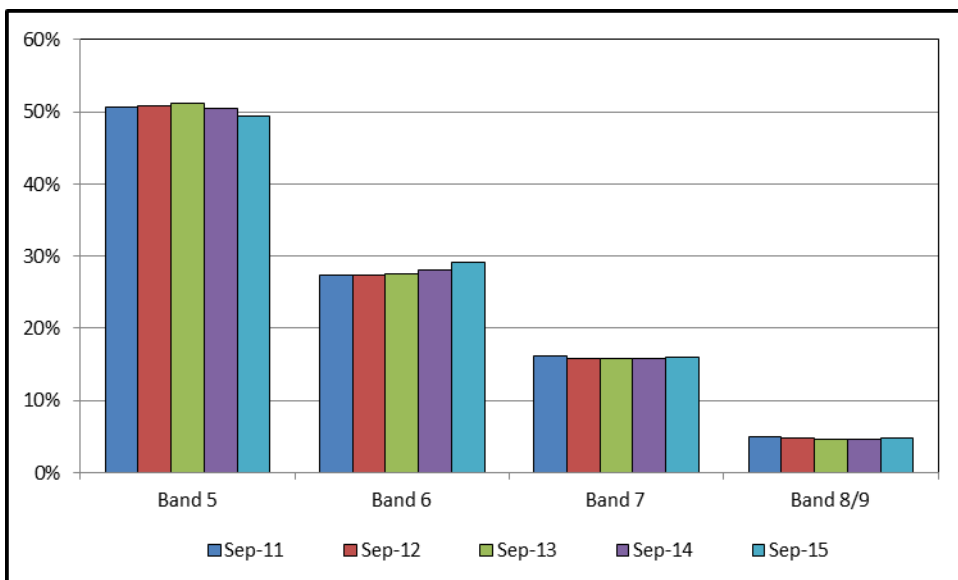
Table 4.5: Pay Awards and Average Earnings Growth for NHSPRB Remit Staff: Time Series Indices



Source: Collated Summary Outputs: HCHS Headline Paybill Metrics (see Annex)

4.20. There has been upward pay band drift for nurses since September 2013, with a drop in the representation of nurses in Band 5 and an increase at Band 6. This may reflect local decisions to change skill mix. There is a risk that it could be the result of local action to improve pay in response to continuing national pay restraint, but equally it might be a response to the staff shortage arising when recruitment levels rose much more than Trusts had previously planned.

Table 4.6: Distribution of HCHS Nurses FTE Between Agenda for Change Pay Bands: 2011 to 2015



Source: NHS Digital Workforce Statistics

Longitudinal Analysis of earnings growth experienced by individuals

4.21. The figures above do not represent the earnings growth experienced by staff employed within one group throughout the five-year period. We have undertaken separate analysis on this which is included at Annex B, and which shows the total earnings of AfC staff increased by an average of 1.7% and 2.9% per year, depending on staff group between 2010 and 2015. They also include people who joined or left as well as those

promoted from one group to another. Many people will have received pay progression increments and some will have had a pay rise on promotion; around half were on the top point of their pay scale in 2015/16.

Comparison of Earnings Growth between NHS and Wider Economy

- 4.22. Statistics from the Office for National Statistics (ONS) Annual Survey of Hours and Earnings (ASHE) have been analysed to assess movements in pay of occupation groups comparable with NHSPRB remit groups. NHS Digital publishes percentile earnings distribution statistics for each staff group, based on information about payments to staff in the NHS Electronic Staff Record. The approach taken has been to identify for 2015 occupation groups in the ASHE statistics with mean average earnings within the inter-quartile range for each NHSPRB remit group, using gross annual earnings figures, and to assess how these figures have changed since 2012. The results can then be compared broadly with growth in the NHS mean average earnings figures published by NHS Digital for 2012/13 and 2015/16.
- 4.23. The ASHE table includes estimates of the number of jobs in each occupation, so it's possible to calculate both a weighted and an unweighted mean. The table below shows that average NHS average earnings growth in the latest 3 years has been less than growth in the comparator groups, though the relative difference has varied between NHS staff groups. Central Functions staff earnings growth was similar to growth for the comparator group, but the higher-paid NHS groups in particular fared less well in comparison with comparator groups. Increased NHS workforce growth in the last two years will have depressed average pay through increasing the percentage of staff at the lower end of pay bands (new recruits).

Table 4.7: Earnings per Person Growth for Wider Economy Comparator Groups and NHSPRB Remit Staff: 2012 to 2015

NHSPRB Remit Group	HCHS Earnings					Whole Economy Earnings of Comparator Group		Percentage Increase Over 3 Years		
	2012 Distributions			Mean Averages		Mean Average 2012		Comparator Group 2012 to 2015		HCHS Group 2012/13 to 2015/16
	Lower Quartile	Median	Upper Quartile	2012/13	2015/16	Unweighted	Weighted	Unweighted Mean	Weighted Mean	Weighted Mean
Hotel, Property & Estates	£11,000	£16,000	£21,000	£16,882	£17,232	£16,085	£15,707	2.8%	3.0%	2.1%
Support to Clinical Staff	£14,000	£18,000	£21,500	£17,819	£18,343	£18,407	£18,030	4.2%	3.6%	2.9%
Central Functions	£17,000	£21,500	£29,000	£23,764	£24,510	£22,952	£25,664	4.0%	3.2%	3.1%
Qualified Health Professionals	£25,000	£31,000	£37,500	£31,328	£31,667	£29,786	£27,355	2.9%	3.0%	1.1%
Managers & Senior Managers	£41,000	£51,500	£67,000	£57,837	£56,510	£48,753	£48,102	0.7%	-0.3%	-2.3%

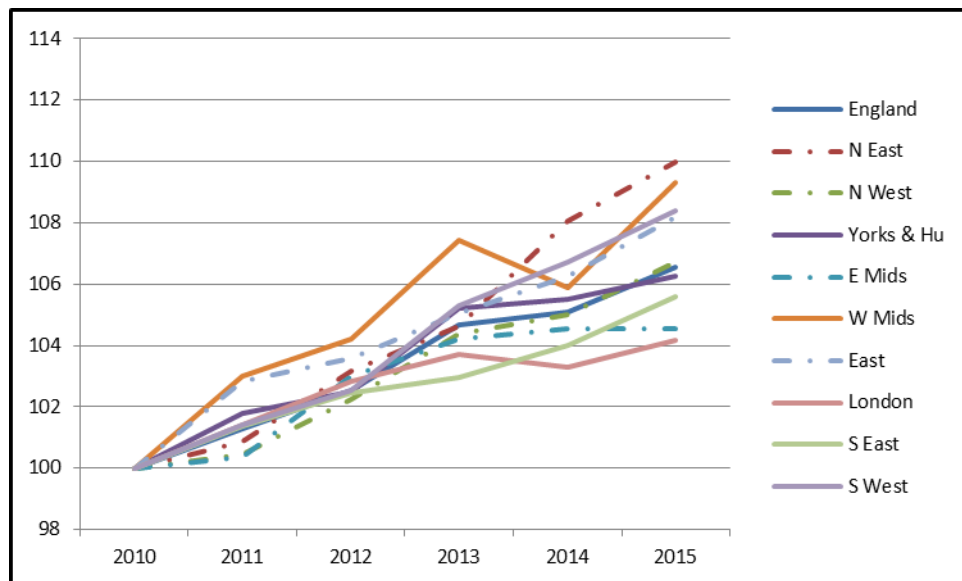
Sources: Office for National Statistics: Annual Survey of Hours and Earnings. NHS Digital: NHS Earnings Statistics

Regional Variation

- 4.24. The regional time series of average earnings per person published by the Office for National statistics from its Annual Survey of Hours and Earnings shows that the largest percentage increases over the last 5 years have been in the North East (10%) and West

Midlands, and the lowest were in London (just over 4%) and East Midlands.

Table 4.8: Whole Economy Earnings per Person Growth, by Region, 2010 to 2015: Indices 2010 = 100



4.25. The Living Wage Foundation publishes estimates of hourly pay rates necessary to cover essential living costs in the UK. These are calculated by the Centre for Research in Social Policy at Loughborough University, with funding from the Joseph Rowntree Foundation. The latest figures published in 2016 are £9.40 per hour for London and £8.25 per hour for the rest of the UK. Current minimum Agenda for Change pay rates, including high-cost area supplements (HCAS) where applicable, exceed £9.40 per hour in both inner and outer London, and exceed £8.25 per hour in the London fringe area.

Table 4.9: Minimum Pay Rates: Agenda for Change, National Living Wage and Foundation Living Wage

	Inner London	Outer London	London Fringe	Rest of England
Agenda for Change Minimum	£9.93	£9.60	£8.29	£7.80
National Living Wage	£7.20	£7.20	£7.20	£7.20
Foundation Living Wage	£9.40	£9.40	£8.25	£8.25

Recruitment & Retention Premia

4.26. This analysis is performed by NHS Employers and included in their evidence to avoid duplication. Consistency with the Headline Pay Bill Metrics figures is ensured by sharing data. The latest figures show a continuation of the downward trend in the proportion of staff receiving an RRP payment. This decrease was expected, given earlier NHSPRB findings that many of the payments made are pay protection for staff who received the Cost of Living Supplement (COLS) but do not receive HCAS, because their employing organisation is in a location which received COLS but does not qualify for HCAS. There is no evidence of an increase in the use of RRPs to address R&R problems. Although employers are free to use the local pay flexibilities available to them such as RRPs to address short or long term issues, anecdotally we understand that they may be reluctant

to do so because of the risk that use of RRP by, for example, neighbouring trusts could lead to pay escalation as they compete for staff. We recognise that this may be due to lack of or limited HR capacity to develop the business case for making additional RRP payments in a way that ensures any equal pay risks are properly managed. NHS Employers will provide more information in their evidence on the use of RRPs.

National Living Wage

4.27. The current National Living Wage is £7.20 per hour, for workers aged 25 and over. This compares with the minimum NHS basic pay of £7.80 per hour. The National Living Wage is expected to increase in April 2017, though not to a level above the current NHS minimum. Analysis of likely future costs is performed by NHS Employers and included in their evidence to avoid duplication.

Recruitment and Retention

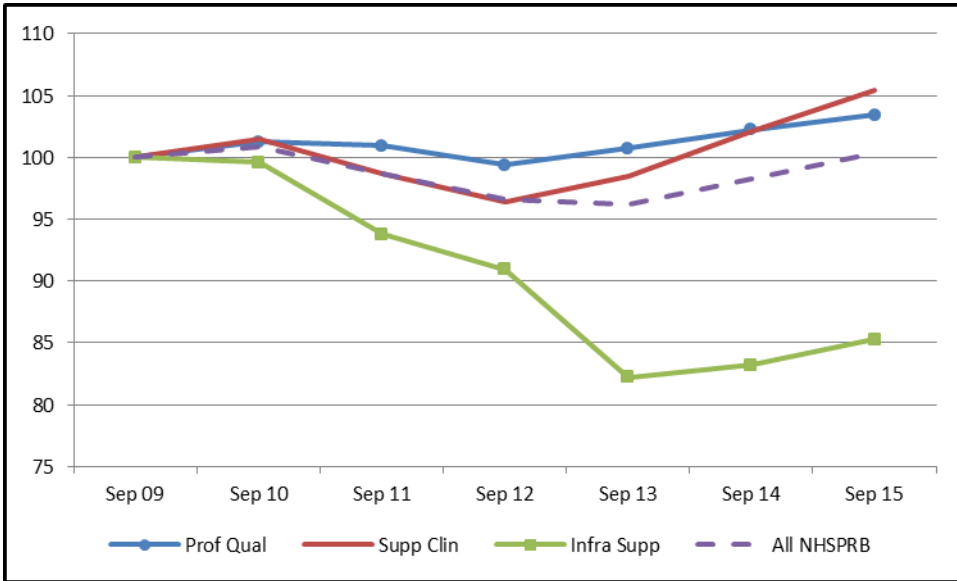
4.28. Undoubtedly the NHS position is bolstered by the value of the NHS pension scheme, but the question of how staff will react to a relative deterioration in pay must be considered. It is therefore prudent to look at recruitment and retention indicators to ensure an appropriate pay strategy, and to look below the high-level aggregate picture to consider the need for targeting.

Capacity

4.29. Overall, capacity has increased in the last three years back to its 2009 level, with higher increases for professionally qualified clinical and clinical support staff, offset by fewer infrastructure support staff. DH and HEE work together to ensure robust workforce planning arrangements ensure supply of the right number of staff with the right skills.

4.30. Workforce Statistics published by NHS Digital show that the NHSPRB remit group workforce in Trusts and Clinical Commissioning Groups was the same FTE size in 2015 as in 2009. At staff group level, there was a decrease of 15% for infrastructure support staff and increases for professionally qualified clinical staff (+3.4%) and support to clinical staff (+5.4%). Within the six-year period there were decreases between 2010 and 2012, followed by growth in the last three years except for the infrastructure support group, which was reduced in size as a result of the health system transformation in 2013 and has increased in the last two years.

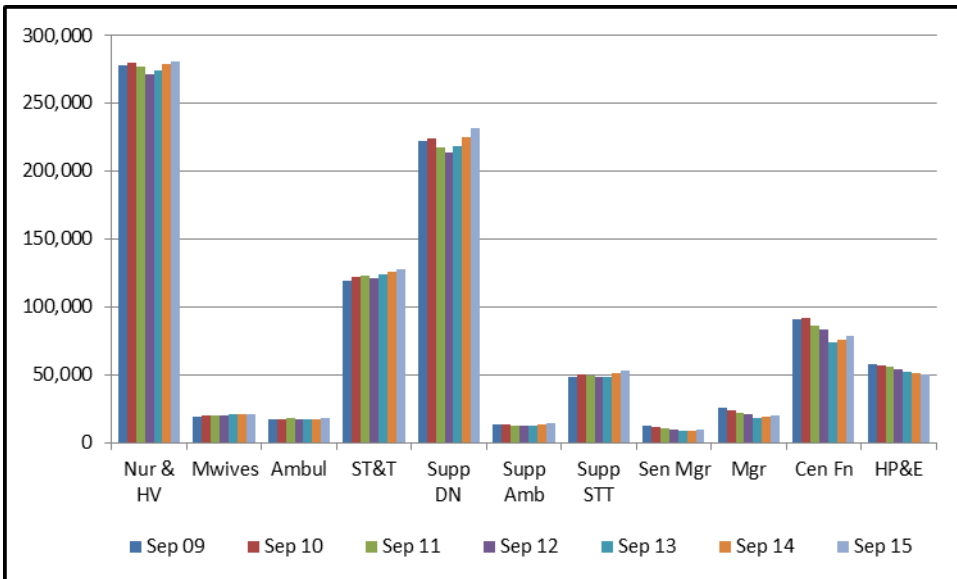
Table 4.10: NHSPRB Remit Workforce FTE Growth: Time Series Indices



Source: NHS Digital Workforce Statistics

4.31. Within these broad groups, there has been some variation between the professions/areas of work. Notably the FTE number of midwives has grown year on year; the hotel, property and estates group has become smaller every year; and there has been strong growth in support to doctors and nurses in the last three years.

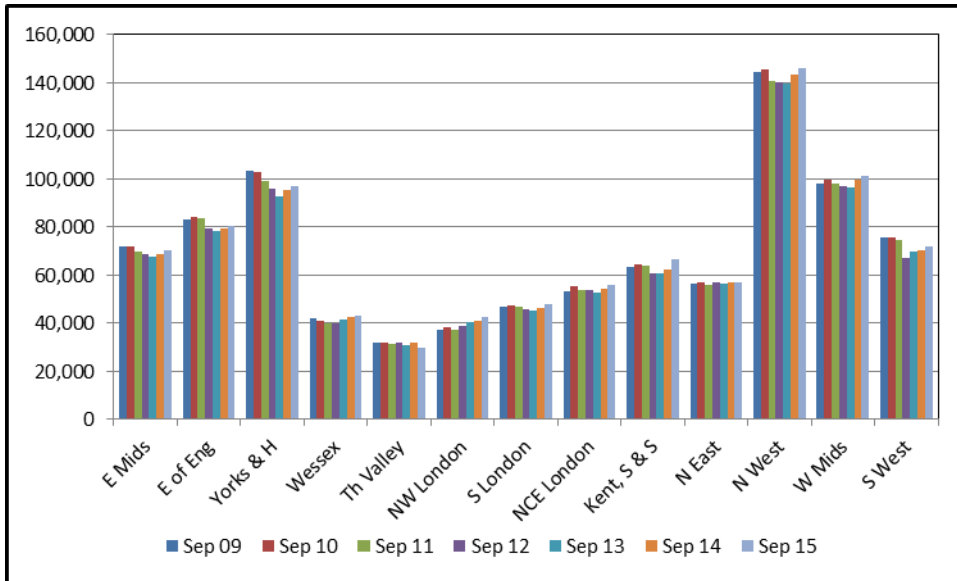
Table 4.11: NHSPRB Remit FTE, by Staff Group: Time Series



Source: NHS Digital Workforce Statistics

4.32. The North West is the largest region in terms of the workforce and Thames Valley is the smallest. In most regions there has been a similar pattern, with decrease between 2010 and 2012 followed by increase in the last three years. Three regions have had increases in both periods – North West London, North Central and East London, North East and Thames Valley has experienced an overall decrease since 2010.

Table 4.12: NHSPRB Remit Group Workforce FTE by Region: Time Series

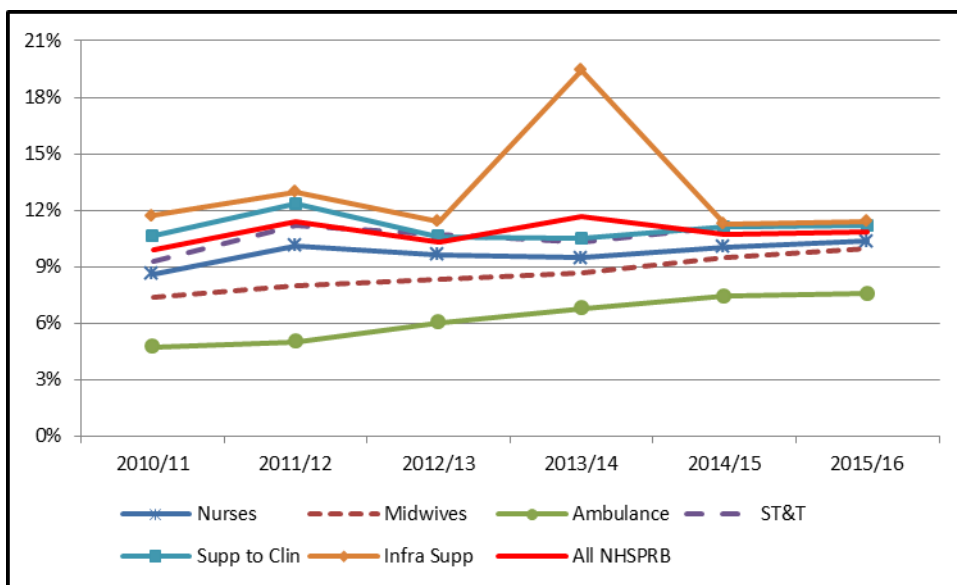


Source: NHS Digital Workforce Statistics

Turnover

4.33. NHS Digital produces turnover statistics based on information in the NHS Electronic Staff Record. The leaver rate is the percentage of the workforce leaving their staff group in the HCHS in a year. It excludes staff moving between Trusts. The leaver rate for NHSPRB remit staff overall has remained fairly flat at a level between 10% and 12% though there are signs of slight increase in the last 2 years. There was a one-off temporary increase in 2013/14 during transformation of the health system, particularly for infrastructure support staff, as PCTs closed and some jobs moved out of the HCHS to eg NHS England. There has been an increasing trend for some staff groups, including qualified ambulance staff and midwives, though these two groups still have lower than average leaver rates.

Table 4.13: HCHS Staff Leaver Rates, by Staff Group: Time Series



Source: NHS Digital (ad hoc request)

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

- 4.34. The regional figures in the charts at Annex C, show employees who left the HCHS, and do not include people who moved between Trusts. They include people whose jobs moved into new Social Enterprises.
- 4.35. The regional pictures show:
- Nurses and health visitors; Midwives; and Ambulance Staff – signs of possible increase in most regions.
 - Scientific, Therapeutic and Technical Staff; and Support to Clinical Staff – signs of increase in some regions, but these are not clustered in one part of England.
 - 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.
- 4.36. This evidence suggests that regional targeting of the pay award would not be financially efficient.

Vacancies

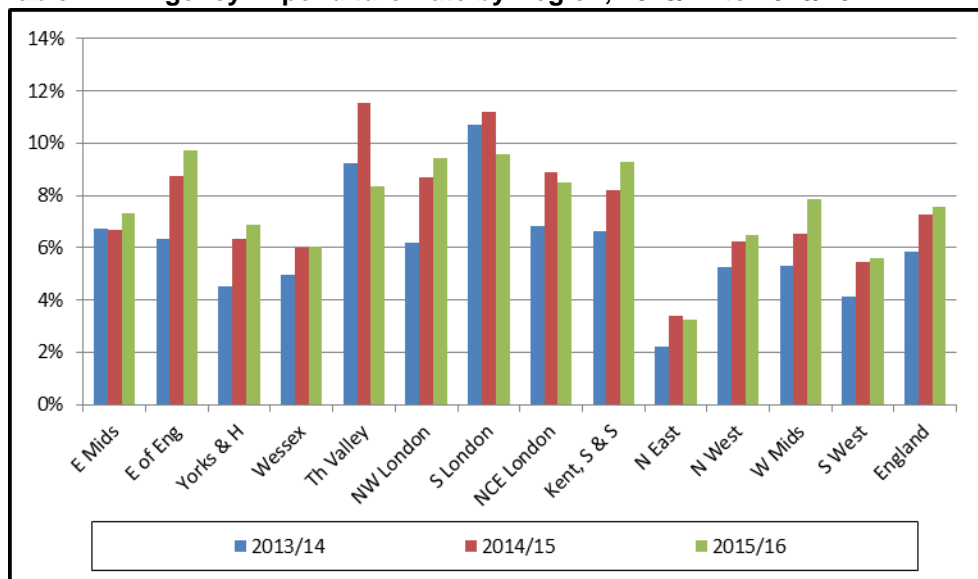
- 4.37. NHS Digital has published a second set of vacancy statistics based on NHS Jobs advertisements. The methodology has been refined, so the statistics are not comparable with those published in 2015. DH supports the HSCIC stated view on the statistics published: “This publication provides figures which are an insight to recruitment in the NHS but which should be treated with caution, and users are discouraged from attempting to draw any conclusions from this data at this time.”

Agency Use

Analysis

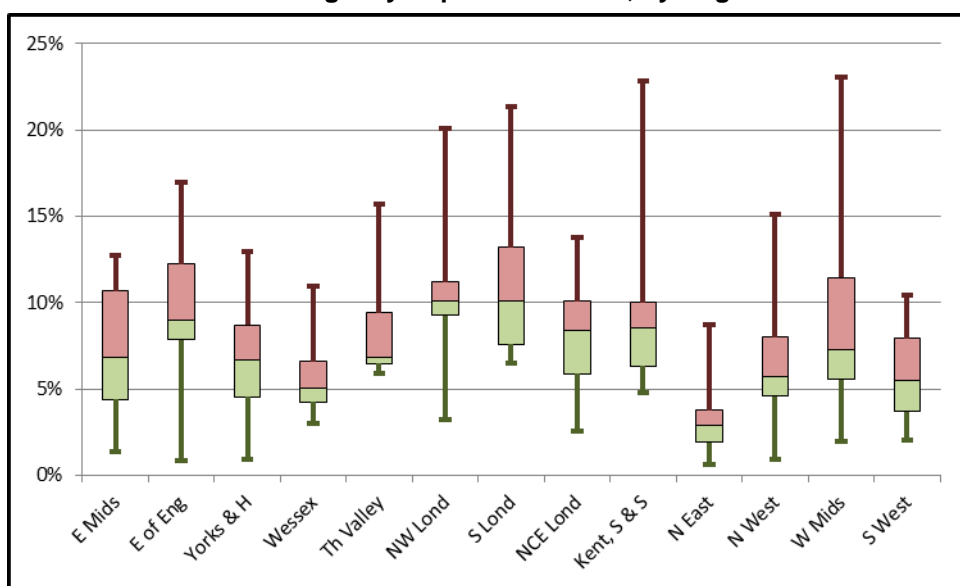
- 4.38. The available national expenditure figures do not separate NHSPRB Remit from medical and dental staff. They include all expenditure on off-payroll staffing, including agency, self-employed contractors and externally-managed banks.
- 4.39. Total expenditure on off-payroll staffing has increased significantly, from £2.6bn in 2013-14 to £3.7bn in 2015-16. At region level, the expenditure rate (agency as a percentage of total staff costs) is generally higher than average in London and the South-East and relatively low in the North and South West. The level of change in the last two years has not followed a clear geographical pattern. There have been decreases in Thames Valley and South London; and the largest increases were in East of England, North West London, and Kent, Surrey and Sussex.

Table 4.14: Agency Expenditure Rate by Region, 2013/14 to 2015/16



Source: NHS Improvement

Table 4.15: Variation in Agency Expenditure Rate, by Region: 2015/16



Source: NHS Improvement – Trust Financial Accounts

Note: The chart shows the 5 quartile Trust agency values for each region. For example, in East Midlands, the lowest agency expenditure by a Trust was 1.4% of staff costs, the highest was 12.7%, and the median average was 6.8%. The upper and lower limits of the box are the 25% and 75% points: 25% of Trusts had agency expenditure more than 10.7%, and 75% spent more than 4.4% of staffing expenditure on agency.

4.40. Agency expenditure is highly variable between Trusts. Variation between Trusts within regions is far greater than variation in the average between regions. In 2015-16 the regional median average varied between 2.9% and 10.1%, and the Trust rate ranged from less than 1% to 23% of staff costs. This suggests that agency expenditure is driven principally by individual Trust-specific factors.

Summary

- 4.41. Agency expenditure for HCHS staff overall has increased significantly in most regions, though the figures cover all HCHS staff, not just the NHSPRB remit group.
- 4.42. The increase is widely believed to have resulted from unexpected increase in recruitment beyond planned levels, primarily to achieve safer staffing levels. This level of demand could not be met in the short term by the supply of newly qualified graduates. Aggregate regional rates are generally higher in London and the south-east than in the north and south-west, but variation between Trusts within regions is much greater than variation between regions, suggesting that costs are driven by individual Trust-specific factors.

Controlling Agency spend

- 4.43. A range of financial controls to limit spending on high cost agency staff have been introduced since summer 2015 as part of the wider effort to stem unaffordable growth in total workforce costs. These controls comprise caps on the prices paid to agencies, ceilings on agency spend and use of approved frameworks for the procurement of agency workers. The controls are intended to reduce the cost of agency staffing to the NHS from £3.7bn in 2015/16 to around £2.5bn in 2016/17 which is needed to control costs and ensure our workforce is sustainable.
- 4.44. The number of hours of agency and bank staff in acute trusts increased from c1.2m in December 2012 through to over 1.9m in December 2014, as hospitals increased their staffing following the publication of the Francis Report in February 2013. Spending on agency has risen by £2.5bn (from £1.7bn in 2010/11 to £3.7bn in 2015/16). On 13 October 2015, the Government announced a series of radical measures to address the cost of agency staff employed in the NHS with the intention of significantly reducing spending. The financial controls introduced by NHS Improvement¹⁰ which are now in place include:
- A requirement for all trusts to stay within annual expenditure ceilings
 - mandatory use of approved frameworks for procurement
 - hourly price caps limiting the amount a trust can pay to an agency.

Annual Expenditure Ceilings

- 4.45. NHS Improvement set ceilings on the total amount individual NHS Trusts and Foundation Trusts can spend on agency staff in 2016/17. The ceilings were calculated based on a Trust's Q1 to Q3 (April to December) 2015/16 spend on agency as a percentage of total staff spend (Table 4.16).

¹⁰ <https://improvement.nhs.uk/resources/reducing-expenditure-on-nhs-agency-staff-rules-and-price-caps/>

Table 4.16 Agency Spend Ceilings for NHS Trusts and NHS Foundation Trusts

Current Agency Spend as a Percentage of Total Staff Spend	Required Reduction in Agency Spend
Above 4.6%	35%
3% - 4.6%	0 - 35%
At or below 3%	0%

Mandatory Use of Approved Frameworks

4.46. As of 1 April 2016 all NHS Trusts and NHS Foundation Trusts are required to use frameworks approved by NHS Improvement when procuring agency staff. Price caps are being embedded into framework agreements and will be fully embedded by late October 2016. As such, agencies will be incentivised to comply on price so that their staff can be procured through mandatory frameworks.

Hourly Price Cap

4.47. In November 2015, price caps were introduced limiting the amount a trust can pay to an agency for temporary staff.

4.48. The price caps were introduced gradually and in a phased approach, having initially been set at a higher level to enable NHS Trusts and Foundation Trusts time to adapt. Table 4.17 shows the phasing of the price caps.

Table 4.17 Phasing of Hourly Price Caps for Temporary Staff

	Junior Doctors	Nurses & Other Clinical Staff	Other Staff
23 Nov 2015	150%	100%	55%
1 Feb 2016	100%	75%	55%
1 April 2016	55%	55%	55%

4.49. Price caps for all staff from 1 April 2016 are calculated at 55% above basic pay rates. This takes into account holiday pay (annual leave and bank holidays), employer National Insurance contributions, a nominal employer pension contribution and a modest agency fee. Further information and reference tables are available on the NHS Improvement website¹¹.

4.50. The controls are having an impact on spending. From April 2016 to July 2016 the NHS has spent £188m less than in the same period in 2015. (Spending is £555m less than projected spending before controls were introduced). We recognise there is more to do

¹¹ <https://improvement.nhs.uk/resources/reducing-expenditure-on-nhs-agency-staff-rules-and-price-caps/>

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

and as such we are working in partnership with NHSI to deliver a number of measures to strengthen controls and drive further spending reductions.

5. Recruitment, Retention, Motivation and Non Medical Workforce Planning

Background

- 5.1. Effective workforce policy is critical to the delivery of affordable, high quality care. Securing the people with the values, skills, experience and expertise which the NHS needs is central to the future of England's health and care system.
- 5.2. The Department is taking action to increase the supply of trained staff available to work in the NHS and wider health and care system ("workforce supply") and supporting a world class health education and training system. In conjunction with HEE and NHS England, the Department has taken a range of actions to boost the supply of domestically trained staff through recruiting and training new staff and retaining productive and experienced existing staff, and by increasing the efficiency and productivity of the workforce through better use of technology and changing the skill mix.
- 5.3. HEE has a clear remit to lead workforce planning and education commissioning across the health system to secure the future supply of workforce, based on local plans which are affordable and take full account of national policy requirements including integration and 7-day services.
- 5.4. Effective workforce planning requires reliable and accurate workforce information at both national and local level. HEE's National Workforce Plan for England is underpinned by national data collected by NHS Digital and a comprehensive local workforce planning process. This process involves local health communities across the country working in partnership to ensure that plans for the future workforce reflect the needs of local service users, providers and commissioners of healthcare in both acute and community settings within the available resources.
- 5.5. 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.

Workforce Information

- 5.6. Reliable and accurate workforce information is required to support national policy making and public and parliamentary accountability as well as to underpin workforce planning. The Department works closely with NHS Digital to support the improvement of the quality and coverage of published workforce information. Last year the DDRB and the NHSPRB asked for more consistent evidence and data covering vacancies, attrition/turnover by staff group and geography. The Department's analytical team is working closely with the Review Body secretariat to bring together data and information from a range of sources that will provide a reliable single source for all parties and address some of these issues.

Published Workforce Information

- 5.7. NHS Digital publishes workforce statistics monthly, bi-annually and annually. The annual publication provides the best means of viewing medium and long-term trends in workforce numbers and provides detailed information on staff working in the NHS in England at 30 September each year, including information on doctors working in general

Recruitment, Retention, Motivation and Non Medical Workforce Planning

practice and primary care staff. This annual publication provides a more detailed breakdown of the HCHS information already published in the monthly workforce statistics and is the only source of long term time series covering the entire NHS workforce.

- 5.8. The monthly statistics provide a time series back to September 2009 for the HCHS trusts and CCGs. The time series provides the opportunity to see the effects of seasonal variation such as the impact of the training cycle. Medical students graduate in the summer and take up employment between July and August. Normal turnover results in a gradual decline in numbers over the rest of the year.
- 5.9. The monthly data provides headcount and fte staff in post statistics, includes turnover and is drawn from the HR and Payroll system for the NHS - Electronic Staff Record (ESR). It does not include staff working in general practice or those providing NHS funded services that do not use ESR, such as the independent sector, local authorities and some social enterprises, as well as two NHS organisations that do not use ESR.

Improvements to published workforce information

- 5.10. Following substantial consultation in 2015, NHS Digital implemented changes to the methodology for collecting and reporting workforce statistics. This resulted in a more accurate count of staff numbers and changes to the publication of workforce information to include separate publications covering independent sector staff and those working in NHS Central Bodies and Support Organisations. These changes came into place in the published statistics on 30 March 2016 covering HCHS and independent sector staff providing NHS funded services. The revised time series takes into account the main structural changes from the Health and Social Care Act 2012 to enable a historical comparison with previously published statistics.

Impact

HCHS – trusts and CCGs

- 5.11. The new methodology showed a difference of 69,317 fte at September 2015 between the old and new methodology for HCHS NHS staff. Of this number:
 - 26,798 are now included in the HCHS support organisations and central bodies statistics;
 - 17,854 previously included in the HCHS monthly statistics but reflect staff working in community interest companies and social enterprises are now included in the independent sector organisations publication;
 - 25,095 are not receiving pay for activity and therefore have not been included;
 - 189 are now included in the GP workforce statistics; and
 - 212 have a non-service contract (the following contract types - Honorary; Non-Exec Director/Chair; Prof Exec Committee; Retainer Scheme and Widow/Widower) and therefore have been removed from the statistics.
- 5.12. NHS Digital also publishes additional quarterly data on HCHS staff in trusts and CCGs, including reasons for leaving, staff movements and redundancy data, as well as data on earnings and sickness absence. On a quarterly basis, NHS Digital publishes data on HCHS Central Bodies and Support Organisations which includes for example NHS England, HEE, NHS Digital, Public Health England.

- 5.13. As part of the consultation, NHS Digital sought users' views on the introduction of a publication of bank staff numbers to provide additional information on the flexible workforce. As a result of feedback, NHS Digital has undertaken some initial work to investigate the NHS staff earnings data to identify bank staff, with the intention of developing a new publication to show these new analyses and provide a time series by staff group.
- 5.14. The Department has worked with NHS England, HEE and NHS Digital on the design of the workforce information architecture for the new education and training system, developed, piloted, and has now rolled out a workforce Minimum Data Set (wMDS) to be collected from all providers of NHS funded care, to support the workforce planning process.
- 5.15. The wMDS is an expanded data collection that now covers all HCHS and general practice staff, and is collected bi-annually. The wMDS also includes information on absences and vacancies.
- 5.16. The second collection of data will be published by NHS Digital in September 2016 and will reflect the staff in post numbers as at 31 March 2016. For general practice, the data will also include more detail on joiners and leavers (including if available, the source of recruitment, reason for leaving and destination). Also general practice absence and vacancy data which will be included for the first time and will cover the 6 month period from September 2015 to March 2016.
- 5.17. All wMDS data items will assist planners in understanding workforce demographics and in developing strategies and plans to ensure the appropriate education commissioning, education and learning strategies and whole system changes to provide a future workforce with the required skills and competencies.

Vacancy data

- 5.18. Vacancy rates are an important element of workforce planning at local and national levels. NHS Digital consulted on the publication of administrative data taken from NHS Jobs to provide some vacancy data. The feedback generated continues to inform the development of the publication with the third and most detailed in the series published on the 25 August 2016. This publication follows a similar but enhanced methodology and format, which will continue to develop and provide more meaningful information and trends of advertised vacancy per fte by staff group, area of work, occupational group, region and organisation cluster group.
- 5.19. The data derived from NHS Jobs reflects the fte that is advertised for each vacancy, taking into account adverts that offer more than one post. However, an advert might cover multiple vacancies or an ongoing recruitment programme. Whilst the processing of the data has been improved, in particular with regards to ensuring only jobs in the NHS are included, adverts can be placed by NHS sub-contractors and local authorities so not all adverts will be for jobs in the NHS.
- 5.20. The publication on 25 August covered the period 1 February 2015 to 31 March 2016 (inclusive) and breaks down the fte advertised vacancies each quarter by staff group and area of work. This publication of "experimental" data differs again in that the timescales have changed. This is the first time the data has been displayed in four quarters. Due to these methodological changes it is not possible to directly compare the figures covered by the three publications and NHS Digital are discouraging users from attempting to draw any conclusions from this data at this time.

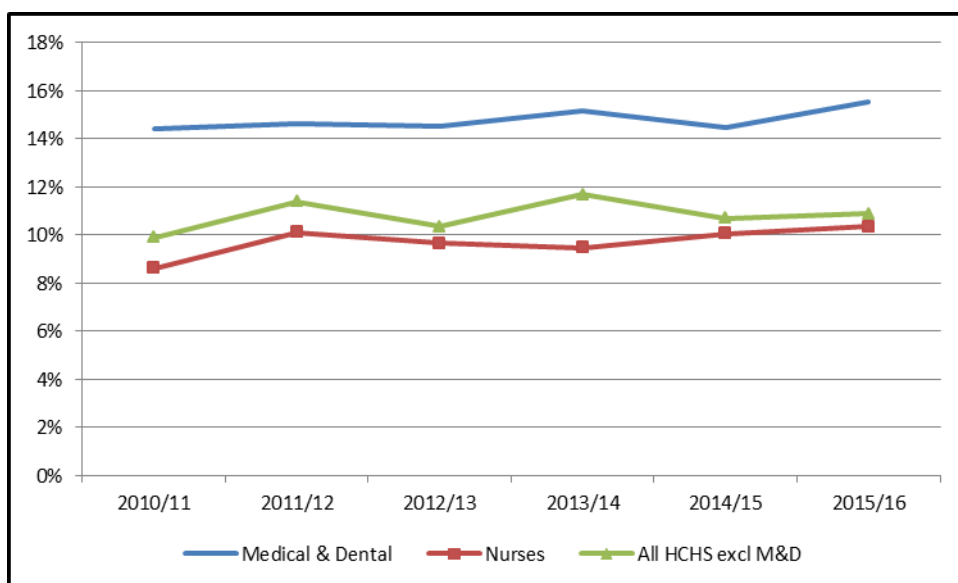
Recruitment, Retention, Motivation and Non Medical Workforce Planning

- 5.21. The data shows that the fte number of advertised vacancies in England in each month between February 2015 and March 2016 varied between around 23,000 and 29,500.
- 5.22. There are other definitional and data quality issues relating to the NHS Jobs information and NHS Digital continues to drive forward improvements in data quality. Over time, the time series will allow comparison to be made relating to the advertised vacancy fte, which may provide a more useful indicator or proxy measure related to recruitment within the NHS.
- 5.23. NHS Digital continues to investigate other sources for vacancy information to build on the information extracted from NHS Jobs, potentially including data derived from the ESR system even though not all organisations use ESR to record establishment and vacancies. The intention being to both help define what more meaningful data may be possible to extract from different systems, and improve the quality and completeness of data in those systems, including both in ESR and in NHS Jobs.
- 5.24. Information on vacancies is also gathered by HEE and NHS Improvement and used to inform workforce planning and monitoring of the health and care system.

Turnover

- 5.25. NHS Digital produces turnover statistics based on information in the NHS Electronic Staff Record. The leaver rate is the percentage of the workforce leaving their staff group in the HCHS in a year. It excludes staff moving between Trusts, but includes people moving from the HCHS to e.g. general practice. The leaver rate for HCHS non-medical & dental staff was around 10% per year during 2011/12 to 2014/15.
- 5.26. There was a one-off temporary increase in 2013/14 during transformation of the health system, including the transfer of some jobs out of the HCHS into Public Health England. The rate increased between 2014/15 and 2015/16. Note: the figures include doctors in training, some of whom leave the HCHS as part of their training, for example into primary care as part of their rotation.

Table 5.1: HCHS Staff Leaver Rates: Time Series



Source: NHS Digital (ad hoc request)

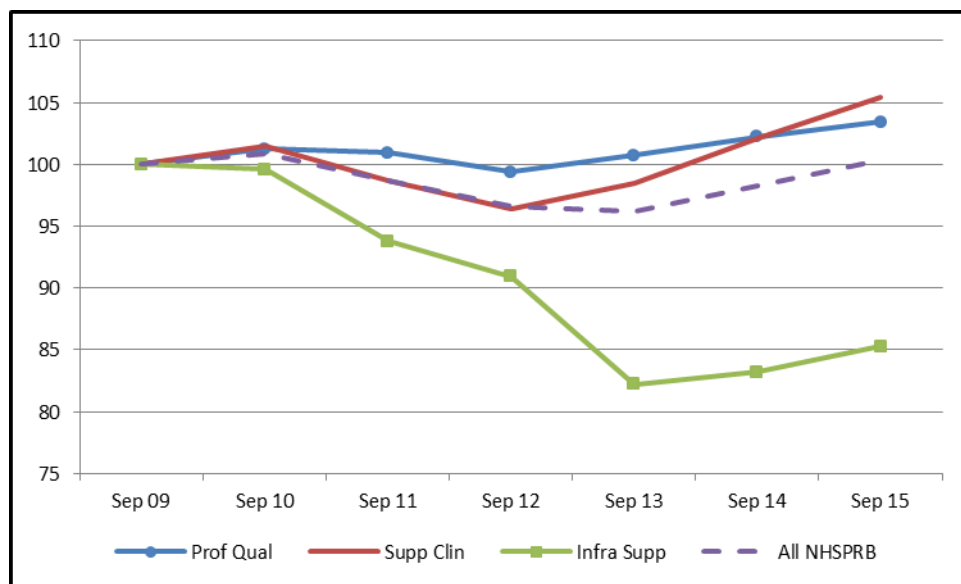
Workforce Planning

- 5.27. Effective workforce planning is critical to the delivery of affordable, high quality care. Workforce planning requires an understanding of the external and internal environment; business vision and strategy and current workforce. It also requires forecasted information taking into account the impact of turnover, retirements, recruitment and continuing professional development on workforce demand and supply. The recent National Audit Office report¹² and the Migration Advisory Committee report¹³ into nursing shortages has highlighted concerns about workforce planning in the NHS in the context of continuing shortages of key staff groups.
- 5.28. The Department is taking action to increase the supply of trained staff available to work in the NHS and wider health and care system (“workforce supply”). In conjunction with HEE and NHS England, the Department has taken a range of actions to boost the supply of domestically trained staff and to increase the efficiency and productivity of the existing workforce through better use of technology and changing the skill mix.
- 5.29. There has been an increase of over 24,000 more professionally qualified staff working in the NHS since May 2010 and with over 50,000 nurses in undergraduate training programmes the government will continue to make sure there are sufficient staff available to give patients high quality, safe and sustainable care 24 hours a day, seven days a week.
- 5.30. Workforce Statistics published by NHS Digital show that the NHSPRB remit group workforce in Trusts and Clinical Commissioning Groups was the same FTE size in 2015 as in 2009. At staff group level, there was a decrease of 15% for infrastructure support staff and increases for professionally qualified clinical staff (+3.4%) and support to clinical staff (+5.4%). Within the six-year period there were decreases between 2010 and 2012, followed by growth in the last three years except for the infrastructure support group, which was reduced in size as a result of the health system transformation in 2013 and has increased in the last two years.

¹² <https://www.nao.org.uk/report/managing-the-supply-of-nhs-clinical-staff-in-england/>

¹³ <https://www.gov.uk/government/news/migration-advisory-committee-mac-report-on-nursing-shortage>

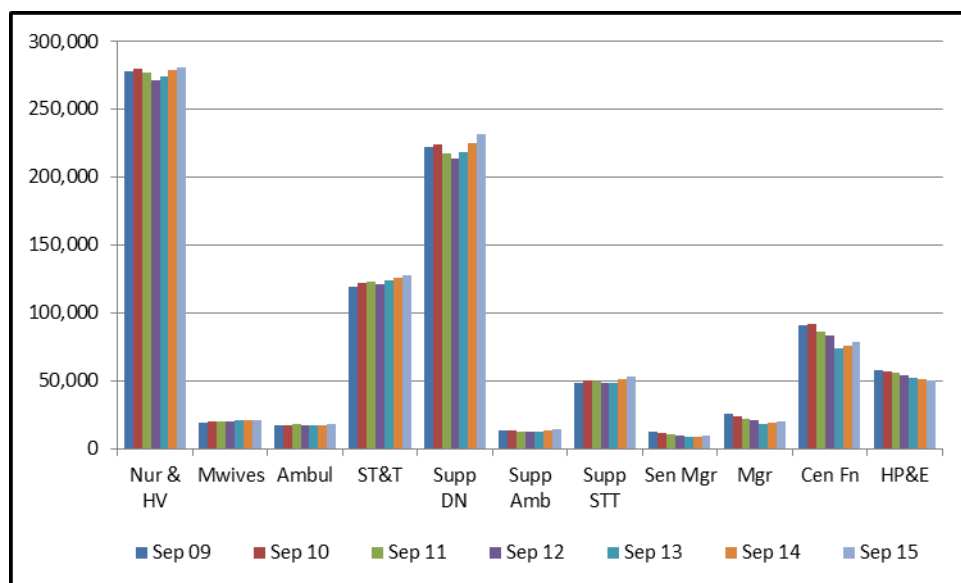
Table 5.2: NHSPRB Remit Workforce fte Growth: Time Series Indices



Source: NHS Digital Workforce Statistics

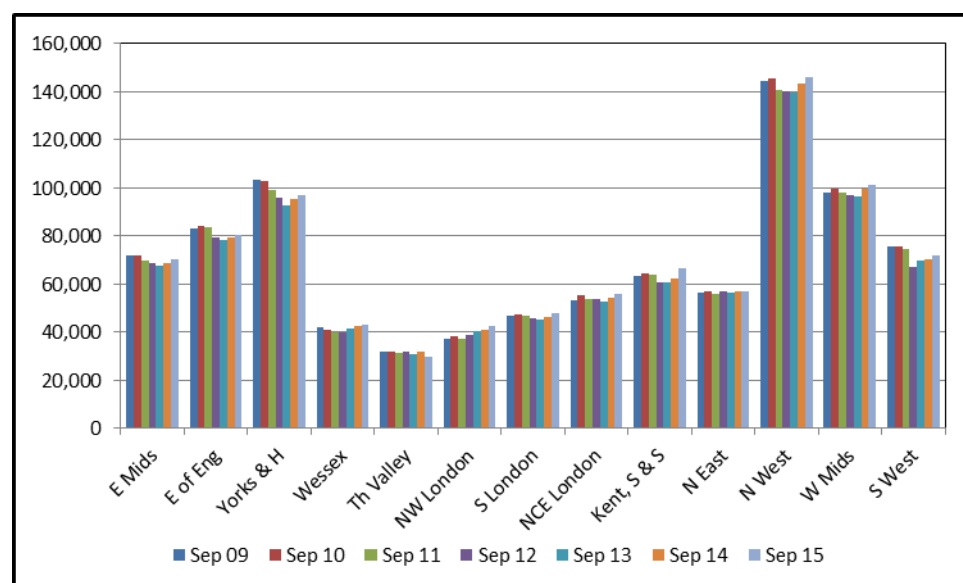
5.31. Within these broad groups, there has been some variation between the professions/ areas of work. Notably the FTE number of midwives has grown year on year; the hotel, property & estates group has become smaller every year; and there has been strong growth in support to doctors and nurses in the last three years.

Table 5.3: NHSPRB Remit fte, by Staff Group: Time Series



5.32. The North West is the largest region in terms of the non-medical and dental workforce and Thames Valley is the smallest. In most regions there has been a similar pattern, with decrease between 2010 and 2012 followed by increase in the last three years. Three regions have had increases in both periods – North West London, North Central and East London, and North East; and Thames Valley has experienced an overall decrease since 2010.

Table 5.4: NHSPRB Remit Group Workforce fte by Region: Time Series



Source: NHS Digital Workforce Statistics

- 5.33. The NHS is already recruiting more home-grown nurses by significantly increasing training places, promoting return to practice programmes and improving retention of existing staff. For example, an additional £5 million has been provided to support the Return to Practice scheme, aimed at encouraging and supporting experienced nurses who have left the profession to return. This scheme has already seen more than 2,300 returners on the programme with over 700 now back in employment.
- 5.34. HEE has also increased the number of key professional groups being trained. For example, the numbers of nurse training places being commissioned each year has increased by 15% since 2013.
- 5.35. Employers are encouraged to recognise the benefits of adopting flexible working patterns such as shift or part time working to accommodate personal commitments, thereby improving retention and making the NHS an attractive option for a permanent career.
- 5.36. HEE has also increased the number of commissions for paramedic training, up by 60.8% in 2016-17. There are plans to increase this further for 2017-18 to tackle historical workforce shortages.

Funding Reform

- 5.37. In the Spending Review 2015, the Chancellor announced that, from 1 August 2017, new nursing, midwifery and allied health students will no longer receive NHS bursaries. Instead, they will have access to the same student loans system as other students. Nursing is one of the most popular courses on University Central Administration Service (UCAS) with 57,000 applicants for around 20,000 nursing places in 2014. Funding reform will open up opportunities for those students currently unable to access training places.
- 5.38. Over time, this will increase workforce supply, by removing restrictions on the number of training places, and reduce reliance on expensive agency workers or international recruits. This is estimated to create up to 10,000 training places for home-grown nurses, midwives and allied health professionals by the end of this parliament.

- 5.39. The new system will provide:
- more nurses, midwives and allied health professionals for the NHS;
 - a better funding system for health students in England; and
 - a sustainable model for universities.
- 5.40. The government launched a 12-week public consultation on 7 April 2016 and an official response to that consultation on 21 July 2016. The government response sets out a number of policies the government will enact in order to provide extra funding to help cover additional expenses. These include travel and more support for students with children, as well as funding for dual accommodation associated with clinical placements and a fund for students who fall into exceptional hardship while studying. Ministers and officials will work with external experts and delivery partners to take this forward.
- 5.41. As set out in the Department of Health's reply to the Public Accounts Committee (July 2016)¹⁴, the effects of bursary reform will continue to be monitored and evaluated. The Department of Health will work with delivery partners such as HEE, Higher Education Funding Council for England, Student Loans Company and the Universities and Colleges Admissions Service to assess the effects of bursary reform, particularly on mature students and other protected characteristics

Skill Mix

- 5.42. The Department is working with HEE to consider how skill mix changes can help address workforce shortages.
- 5.43. The new Nursing Associate role¹⁵ will be a valuable contribution to the health and care workforce, providing a new professional group to support employers meet workforce challenges. They will work alongside healthcare support workers and fully qualified nurses focusing on patient care. Once established the Nursing Associate will make a significant contribution to the health and care workforce, allowing health and care providers to grow their own workforce and reducing reliance on expensive agency staff. HEE has committed to recruit 1,000 Nursing Associates into training by the end of 2016.
- 5.44. Physician associates (PAs) increase the medical workforce by acting in an enabling role, helping to reduce the healthcare team's workload. A PA is a graduate who has undertaken post-graduate training and who works under the supervision of a doctor. They bring new talent to the NHS and add to the skill-mix within the teams. PAs offer continuity of care for patients, as well as institutional memory for the team in which they work.
- 5.45. Secretary of State announced in June 2015 that there will be 1,000 more PAs available in primary care by 2020 as part of the wider commitment to make available 10,000 health care professionals in primary care within this timeframe. HEE has committed to recruit 205 PAs into training during the academic year 2015-16. Their current projections forecast an over recruitment into training of 75% (358). HEE's current national workforce

¹⁴ <https://www.gov.uk/government/consultations/changing-how-healthcare-education-is-funded>

¹⁵ <https://www.gov.uk/government/news/nursing-associate-role-offers-new-route-into-nursing>

plan for England sets out the proposal to commission 657 training places during 2016-17 in support of the 1,000 target.¹⁶

International Recruitment

- 5.46. The government is committed to moving towards self-sufficiency and, as set out above, has increased training numbers and significantly increased the workforce. However, the size and diversity of the workforce and the time taken to train qualified healthcare professionals means that there are always likely to be shortages caused by unexpected fluctuations in demand.
- 5.47. International recruitment can help to address workforce shortages. Whilst the measures outlined above should reduce the need to recruit from overseas it will take time to grow domestic supply. Overseas staff have always played a vital role in the NHS. Where there are particular pressures for example on nurses, the migration advisory committee has recommended they remain on the occupation shortage list until 2019 to make overseas recruitment easier.
- 5.48. Overall, the proportion of non-British staff has remained fairly stable. However, over the past six years, the number of non-EU nationals has decreased and they have been replaced by EU nationals. This reflects changes in the immigration rules to reduce migration and the increased mobility of EU citizens compared to those from outside the EU.
- 5.49. Following the outcome of the referendum the government will be entering negotiations with the EU on a range of issues including migration policy.

Health Visitors

- 5.50. The coalition Government committed to growing, by April 2015, the health visitor workforce by 4,200 and developing health visiting services to improve health outcomes and reduce inequalities. A national Health Visitor Programme facilitated delivery and led a four year transformation that was driven by significant investment in recruitment, together with a focus on retention, professional development and improved commissioning linked to public health improvement.
- 5.51. The Programme closed in April 2015. At that point the increase in (full time equivalent) health visitors in the workplace since May 2010, stood at around 4,000, this level of growth at just under 50% makes the expansion of the health visitor workforce one of the most rapid and successful in NHS history.
- 5.52. The latest published data shows the current number of health visitors (May 2016) is 9,592. The decrease since the programme ended is in part down to a different reporting method. The current NHS workforce statistics now collect only those staff employed by the NHS, at the last point the data was collected, September 2015, there were an additional 1,469 FTE health visitors working for non-NHS/ESR employers delivering NHS services.
- 5.53. The transfer of commissioning responsibilities for public health services from NHS England to local authorities for children in the 0-5 age range took place on 1 October

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https://www.hee.nhs.uk/sites/default/files/documents/HEE%20Workforce%20Plan%20for%20England%202016%20180516_0.pdf

2015. At this point, time limited Regulations came into force mandating provision of 5 key health visitor led assessments from pregnancy to age 2.5. PHE are currently leading a review of the new arrangements, based on their findings ministers will decide whether the Regulations should cease or be continued.

- 5.54. The main challenge going forward will be the sustainability of health visiting services in the new commissioning landscape, as local authority commissioners manage significant financial pressures.
- 5.55. Public Health England (PHE) is now the system leader for children's and young people's public health – including delivery of the sustainability agenda. The new Best Start in Life Board¹⁷, jointly chaired by PHE and local government, will be taking particular interest in sustaining the momentum of what has already been achieved.

Role of Pharmacists

- 5.56. In October 2015, NHS England announced an increase in the budget for a three year pilot to test the role of clinical pharmacists working in general practice. This will part-fund 403 new clinical pharmacist posts across 73 sites, covering 698 practices in England, supporting over 7 million patients.¹⁸
- 5.57. We are working to implement the Carter Review. The Rebalancing Medicines legislation programme is examining the scope of legislation and regulation, and the interface between them. It aims to ensure the legislation provides a systematic approach to quality in pharmacy and enables responsible development of practice and innovation. It also aims to reduce the burden of unnecessary and inflexible regulations. A key purpose of the programme is to optimise skill mix and maximise utilisation of the whole pharmacy workforce while safeguarding users of pharmacy through mitigation of risks that might arise from proposed changes.
- 5.58. Recognising the bigger contribution that we want pharmacists to make towards delivery of safe and effective use of medicines and the public health strategy means we have been working towards developing the current training programmes for pharmacists. Developing the degree programmes model to increase clinical teaching in universities and to increase the involvement of universities in the work place based learning in placements would produce a scientifically based, but clinically focussed programme of training. This is important for future sustainability of workforce supply.
- 5.59. These reform proposals are being considered in light of the wider reforms being made to the funding of healthcare education and training from August 2017 and the impact on resources across Government is being assessed in that context. In the meantime, HEE are working with stakeholders to develop the current arrangements for recruitment and selection to the pre-registration year; the learning and assessment in placements and the quality of placements. In developing the recruitment and selection processes, HEE is looking in the first instance to implement the principles of values based recruitment and to recruit trainees who will deliver the highest quality care and services for NHS patients. These developments together with work to develop tutors and placement quality are designed to support an integrated degree as well as improve current arrangements.

¹⁷ <https://www.gov.uk/government/publications/health-matters-giving-every-child-the-best-start-in-life/health-matters-giving-every-child-the-best-start-in-life>

¹⁸ <https://www.england.nhs.uk/commissioning/primary-care-comm/gp-action-plan/cp-gp-pilot/>

Pharmacy Student numbers

5.60. There has been considerable growth in pharmacy student numbers over the last decade or so. To date the provision of pre-registration training posts in hospitals and community pharmacies has kept pace with graduate numbers. There is no firm evidence that graduates are not securing pre-registration places but there are growing anecdotal reports of graduates taking unfunded placements. HEE is also working with NHS Trust chief pharmacists to review planning for hospital pre-registration places. Numbers increased last year by 50 but these are currently being reviewed to take account of NHS England’s clinical pharmacist initiative and the Carter Review.

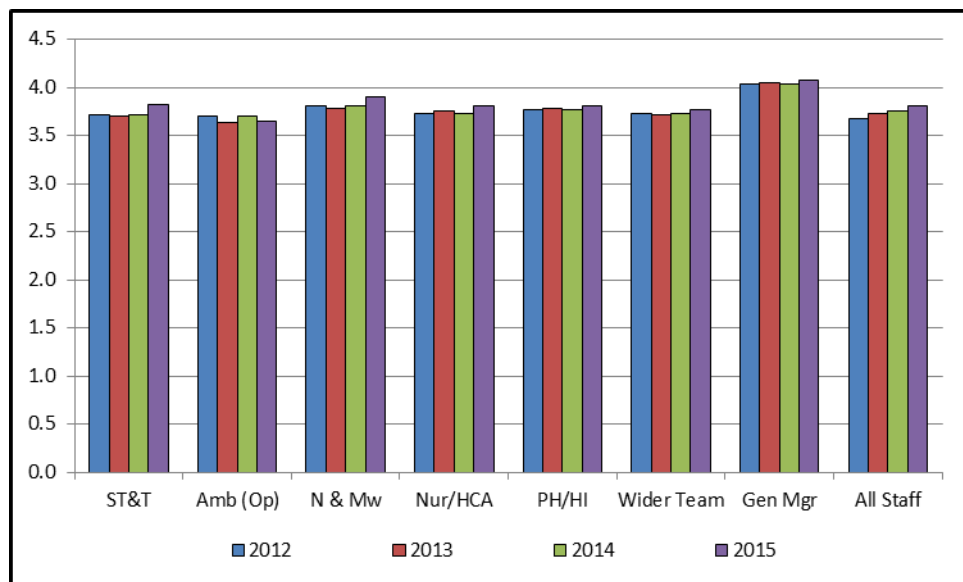
Staff experience

5.61. The Department is committed to developing and improving the data available to employers that will help them improve their staff experience. This includes the annual NHS Staff Survey, the Staff Friends and Family Test, sickness absence statistics and network groups, which complement local information. Staff engagement is improving with an overall increase across the NHS from 3.71/5 in 2014 to 3.78/5 in the 2015 Staff Survey results.

Staff Engagement

5.62. NHS England commissions the annual NHS Staff Survey. The published results include an overall Engagement Index. The Index results from the last four surveys show that for NHS staff overall the Engagement score has improved each year. In 2015 there was improvement for all groups except operational ambulance staff.

Table 5.5: Engagement Score by Staff Group: 2011 to 2015



5.63. There is a complex relationship between overall pay and levels of staff engagement, morale and motivation. Staff engagement is crucial to create the right culture and to develop an environment where staff want to work. At a national level we encourage local organisations, through the commissioning process we have with NHS Employers to develop their own local initiatives as they are best placed to identify the local engagement strategy for their workforce. NHS Employers continues to raise the importance of staff engagement highlighting other factors that impact on staff

engagement such as interaction with line managers, employee voice and the handling of organisational change.

- 5.64. The 2015 NHS Staff Survey¹⁹ score for overall staff engagement remains reasonably high despite the pressures on NHS staff. We measure morale through the NHS Staff Survey using staff engagement scores. The overall engagement score for nurses saw a rise in 2015 from 3.79/5 to 3.91/5. There has also been an increase in the engagement score for healthcare assistants from 3.74 in 2014 to 3.82 in 2015. This suggests that the various initiatives in place, both locally and nationally, are having a positive impact. However, there do remain areas of concerns such as work pressures, bullying and harassment that have to be tackled to ensure the progress being made on staff engagement is maintained, and improved.
- 5.65. A NHS Staff Survey measure for motivation was introduced in 2009. Staff Motivation as it is used within the NHS Staff Survey is defined as “the extent to which staff look forward to going to work, and are enthusiastic about and absorbed in their jobs.” The trend for motivation as measured by “staff motivation at work” has been fairly stable with overall NHS scores of 3.82/5 (2011), 3.82 (2012), 3.84 (2013), 3.83 (2014) and 3.92 (2015). Unweighted data for 2015 showed an improvement from 2014 for:
- registered nurses and midwives m 3.94 to 4.06;
 - Allied Health Professionals (AHPs) 3.82 to 3.91; and
 - nursing/healthcare assistants - 3.90 to 3.99
- 5.66. Ambulance staff also had a reasonably high score for motivation at 3.87 in 2015 up from 3.85 in 2014.
- 5.67. Published research²⁰ has shown that good staff support and engagement is directly related to patient experience, safety and quality of care.
- 5.68. A further test of “staff engagement” is the extent to which an employee would advocate their trust as a place to receive care and a place to work, and that their trust has care of patients as its top priority (advocacy). This is reflected via the FFT for staff and patients and given greater impetus as NHS England has introduced a Commissioning for Quality and Innovation (CQUIN) payment²¹ for NHS organisations to support implementation of the staff FFT.
- 5.69. The Staff FFT was introduced in April 2014 and is carried out quarterly by NHS England. It allows staff to give their feedback on NHS services helping trusts locally understand quickly what is working well and what areas need attention. The Staff FFT asks whether staff would recommend their organisation as a place to work and whether they would recommend their organisation as a place to receive treatment²². Although there is wide variation across the service, the overall trend is positive with Q4 2015/16 indicating that 62% of staff say they would recommend their organisation as a place to work, the same as Q1 2014/15 when the staff FFT was introduced. 79% of staff said that they would recommend their trust as a place to receive treatment (up from 76% in Q1 2014/15).

¹⁹ <http://www.nhsstaffsurveys.com/Page/1010/Home/NHS-Staff-Survey-2015/>

²⁰ West, M. Culture and Behaviour in the English NHS (2013)

²¹ <https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/>

²² <https://www.england.nhs.uk/ourwork/pe/fft/staff-fft/>

- 5.70. The annual NHS Staff Survey records advocacy (how an employee supports/promotes their organisation) through the key indicators “staff recommendation of the(ir) trust as a place to work or receive treatment”. Scores for NHSPRB’s remit group suggest continued strong scores with, for example, AHPs at 3.74 up from 3.65 in 2014, registered nurses and midwives 3.77 up from 3.67 and nursing/healthcare assistants 3.87 up from 3.81. Operational ambulance staff remain broadly stable at 3.75 down from 3.76 in 2014.
- 5.71. In terms of the Pay Review Body’s comments about how regulatory frameworks can address the issues of staff engagement, we would like to cite the CQC’s regulatory regime²³ which also uses measures of staff engagement as part of the Chief Inspector’s assessment of the organisational health of providers. Changes to the way CQC regulates, inspects and monitors care include a vision of a “well-led” service, with effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation, and an open, fair and transparent culture that listens and learns from other people’s views and experiences to make improvements. Inspections encompass an assessment of aspects of governance, leadership and culture to assess whether a service is “well-led”. The CQC reports provide information on the range of staff engagement activity across the NHS to enable benchmarking and monitoring of progress.
- 5.72. The NHS has access to a comprehensive range of data as well as good practice advice and guidance to help trusts plan how they can improve staff engagement locally. Employers are responsible for engaging with their staff on issues which affect them and the way they work. The Department supports this through the NHS Constitution Staff Pledges²⁴ which state that “the NHS is committed to engage staff in decisions that affect them and the services they provide, individually through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families”. Employers are best placed to decide how they can most effectively improve engagement locally, whilst making the most of the partnership arrangements and good practice that is in place.
- 5.73. There is clear evidence that staff engagement is being encouraged through the new models of care being developed across the NHS in England as a result of the Five Year Forward View and the development of Vanguard (sites for the new models of care programme)²⁵ and includes:
- Northumberland Primary and Acute Care System (PACS) where staff engagement has been embedded from the start. Trades unions are engaged in the work of the Vanguard via a local partnership forum. Effective staff engagement means there is a collective will to work together to ensure the best results for their patients. This organisation also has an engagement platform in place around service improvement which enables the identification of more effective ways of delivering care. The involvement of staff in the development of these new ways of working have been key in obtaining support.

²³ <http://www.cqc.org.uk/content/how-we-inspect-and-regulate-guide-providers>

²⁴ <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>

²⁵ <https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/>

- Following a move out of special measures in 2015, Bolton NHS Foundation Trust launched a scheme reassessing its values to boost the staff morale and engagement amongst its 5,000 employees. It was an opportunity to see how the organisation might move forward in the context of the Greater Manchester devolution. Four key values were identified by the staff: compassion; excellence; openness and integrity, all key elements of an engaged workforce. A further survey will be undertaken in September 2016 to enable the staff engagement team to identify whether there are any gaps to bridge and whether more work needs to be undertaken to strengthen workplace culture.
 - The Northern Devon Healthcare NHS Trust was rated fourth in the country for staff satisfaction in 2014. However, the organisation required reconfiguration as care moved closer to the patient-home and the trust needed to be sure that all staff, especially those geographically difficult to reach, were kept up to date on developments. An electronic solution was identified to ensure more frequent staff engagement opportunities and an on-line platform produced with the agreement of staff. The platform enables staff to run polls; extract health and wellbeing information; share good practice, encourage innovations through the sharing of ideas. There are plans to develop the platform further towards the end of the year enabling staff to raise areas of concern anonymously and there are plans to introduce live chat forums with the senior management team.
- 5.74. Other examples of good practice examples are available on the NHS Confederation website.²⁶
- 5.75. The Department has been highlighting the importance of staff engagement including, for example, most recently, supporting events with NHS Employers to raise the profile and its importance in the service, including support for the government's "Engaging for Success Taskforce"²⁷. The Department has commissioned NHS Employers to develop staff engagement resources and collate and share examples of good practice at the can be found below²⁸ to support trusts and, following the Francis report²⁹ to help line managers foster staff engagement and better understand what it means to be an engaging manager in the NHS.
- 5.76. The Department commissioned NHS Employers to work with the NHS Leadership Academy to develop "Do-OD" – the first national Organisational Development (OD) resource for the NHS which supports the service to be more effective in leading organisational and culture change enabling system transformation³⁰.
- 5.77. The focus of this work links with the Leadership Academy's programmes' aims. It , and supports trusts in delivering culture change, improving staff engagement, and helping the development of a more open, supportive and inclusive culture in which, for example, reporting incidents can be done with confidence, and in which the risk of bullying can be reduced. As the NHS undergoes changes on numerous levels and as the needs of

²⁶ <http://www.nhsconfed.org/resources/2016/06/new-care-models-and-staff-engagement>

²⁷ <http://engageforsuccess.org/>

²⁸ <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/staff-engagement/staff-engagement-resources>

²⁹ <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/>

³⁰ <http://www.nhsemployers.org/campaigns/organisational-development>

patients change, new approaches to delivering care are also needed. T and the work of Do-OD acknowledges the complexities and helps equip OD practitioners with knowledge and skills to enhance their practice. Do-OD will support practitioners to think differently and to make changes which take a more transformational rather than transactional approach make changes to their practice. more transformational.

- 5.78. NHS Improvement are working with the King's Fund on a 2-year programme to help NHS providers develop cultures that enable and sustain continuously improving, safe, high quality compassionate care.³¹ The programme provides practical support to help trusts diagnose their cultural issues, develop collective leadership strategies to enable them to address these issues and make the necessary changes.
- 5.79. NHS Improvement are looking at existing resources and programmes of work, such as the Carter review and where they add value, build them into the programme of work. In order to ensure that the programme is relevant and has a lasting benefit for providers, three pilot sites have been identified to help, develop and tests all aspects of the support.
- 5.80. The importance of staff engagement is also being promoted by the NHS Leadership Academy³² in their refreshed version of 'the Healthy NHS Board'³³. This sets out what boards need to put in place to help them develop a responsive insightful approach to issues in their organisations, including advice on effective staff engagement. The Academy is also developing and implementing a leadership development offer that places strong emphasis on shaping positive cultures and engaging staff.
- 5.81. The Academy provides a suite of leadership development programmes that represent the first national approach to leadership development in the NHS, designed to develop outstanding leaders for every tier across the healthcare system, 'from frontline to board'.
- 5.82. The evidence of West et al found a significant reduction in patient standardised mortality rates in organisations with high staff engagement, (in turn associated with high levels of effective and engaging leadership) so the Academy's leadership development programme contain components of the values and behaviours required in a new integrated health care system. These are focused around the needs of the patients, carers and service users in ways which liberate, engage and motivate staff to provide compassionate and personal health care. These behaviours are congruent with NHS values and uphold the NHS Constitution, which states; "Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported".
- 5.83. The Pay Review Bodies imply that a more centrally directed approach to staff engagement may be more appropriate. However, evidence from the NHS Staff Survey does shows an improvement in the overall staff engagement scores. Of course, there is no room for complacency given wide variation across NHS organisations and staff groups and the continuing pressures facing the NHS, which is why we continue to

³¹ <https://improvement.nhs.uk/resources/culture/>

³² <http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/nine-leadership-dimensions/engaging-the-team/>

³³ <http://www.leadershipacademy.nhs.uk/resources/healthy-nhs-board/>

commission NHS Employers to support local organisations to develop their own bespoke staff engagement strategies.

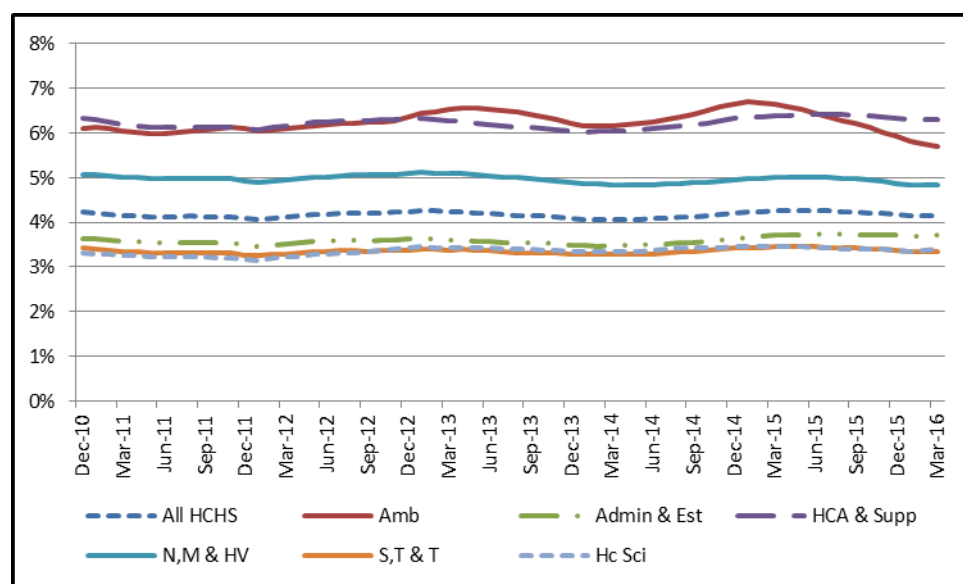
Staff Health and Wellbeing

- 5.84. The Department continues to commission NHS Employers to support trusts in their responsibility for improving the health and wellbeing of their staff in line with the NHS Constitution pledge “provide support and opportunities for staff to maintain their health, wellbeing and safety.”
- 5.85. Improving staff health and wellbeing can help NHS organisations increase productivity and make efficiency savings, as well as improve the experience of patients and staff.
- 5.86. In terms of wellbeing, key staff survey indicators show small changes compared with results from 2014. Staff working extra hours has risen in 2015 to 73% up from 72% in 2014. In respect of examples from the NHSPRB remit group, 74% of Allied Health Professionals say they are working extra hours up from 72% in 2014; the figures for operational ambulance staff are 70% (2015) down from 72% (2014) and registered nurses and midwives, 83% (2015) up from 82%. However we do not know if this is paid or unpaid or whether it is a choice to boost income.
- 5.87. 37.0% of staff in 2015 reported suffering work related stress in the last 12 months compared to the 2014 score of 38.9%. For AHPs, the figure was 36% (2015) down from 38% (2014), operational ambulance staff 36% (2015) down from 38% in 2014 and registered nurses and midwives, 39% down from 41%. However, staff feeling pressure in last 3 months to attend work when feeling unwell has decreased in 2015 to 59% whereas 2014 figures reported 61% (the 2015 figures for PRB remit staff examples were: AHPs: 56%, operational ambulance staff: 63%, registered nurses and midwives: 60%)

Sickness Absence

- 5.88. NHS Digital publishes sickness absence statistics based on information recorded locally in the NHS Electronic Staff Record. The absence rate is calculated as the number of recorded days of absence as a proportion of the total number of calendar days. Sickness absence is subject to month-to-month variation, and some of this is seasonal. The chart shows the 12-month average, which removes seasonal variation. There is variation in rates between occupation groups. These rates have mostly remained constant since 2010, though the historically high rate for ambulance staff appears to have improved in the latest period. Note that the staff groupings in this publication are based on the first character of the occupation code. The nursing, STandT and ambulance groups include clinical support staff. Also note that the All HCHS figures include medical and dental staff.

Table 5.6: Sickness Absence Rates for HCHS Staff: 12-month moving average



Source: NHS Digital – NHS Sickness Absence Rates

- 5.89. Overall sickness levels have dropped slightly for 2015/16, now at 4.15%, a decrease of 0.10% from 2014/15, which stood at 4.25%. In respect of the NHSPRB remit group, the sickness absence rate for all hospital and community services non-medical staff is 4.47% down from 4.58% (2014/15); for qualified nurses, midwives and health visitors, it is 4.49% down from 4.64%; ambulance staff sickness absence is 5.86% down from 6.85% (2014/15) and qualified scientific, therapeutic and technical staff, it is 2.92% down from 3.01%.³⁴ The overall trend remains fairly stable and lower than the 2009 estimate of 4.48% when work began on addressing sickness absence in the NHS following the Boorman Report.³⁵
- 5.90. In response to the NHS Staff Survey and following the Francis Inquiry, the Department placed stronger emphasis on Mental Health and Wellbeing, commissioning NHS Employers to develop a behaviour change toolkit to support individuals and teams to make changes which will influence their emotional wellbeing³⁶ and the quality of care they deliver. Their toolkit “How are you feeling NHS?” was launched in early 2015 and in April 2016 NHS Employers report that it had had over 3,000 hits on its website.
- 5.91. In 2014 the Department commissioned NHS Employers to develop “Healthier Staff, higher quality care”- a pledge to work to improve the health and wellbeing of staff who work in the NHS which was signed by ministers, senior DH officials and NHS Leaders³⁷.
- 5.92. The Staff Experience Summit followed, hosted by NHS Employers, which brought together senior NHS leaders to sign a pledge to continue to improve the health and wellbeing of staff who work in healthcare. The summit and pledge focussed on staff

³⁴ <http://digital.nhs.uk/searchcatalogue?productid=21177&returnid=1907>

³⁵ <http://www.nhshealthatwork.co.uk/health-work-wellbeing.asp>

³⁶ <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing/protecting-staff-and-preventing-ill-health/taking-a-targeted-approach/emotional-wellbeing>

³⁷ <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing>

experiences in their own organisations and plans to improve staff experience internally and across the system.

- 5.93. The Department has updated the 2015/16 commission of NHS Employers to support NHS England's initiative in improving staff health offer, engaging the NHS health and Wellbeing networks and supporting the 12 pilot organisations. This complements the support NHS Employers continue to provide organisations in improving their staff health and wellbeing which includes:
- Informing: keep employers up to date on the latest developments regarding health and wellbeing of the current NHS workforce;
 - Engaging: engage with employers on issues relating to the health and wellbeing of the existing workforce;
 - Influencing: Represent the views of employers to the Department of Health and key stakeholders. Influence national policy and national initiatives and exert influence on the future of health and wellbeing work; and
 - Supporting improvement and leading the way: Supporting employers across the NHS to improve the health and wellbeing of their staff by helping leaders to develop robust wellbeing programmes that deliver measureable outcomes, with a particular focus on emotional wellbeing (mental health) across the NHS. This includes encouraging trusts to use the "How are you feeling NHS?" with individuals, teams and professionals to encourage open, and supportive conversations about emotional wellbeing.
- 5.94. NHS Employers are working with NHS England and Public Health England on the £5 million initiative announced in September 2015 to improve the health and well-being of health service staff. NHS organisations will be supported to help their staff stay well, including serving healthier food, promoting physical activity, reducing stress and providing health checks covering mental health and musculoskeletal problems.³⁸
- 5.95. Other initiatives introduced by NHS Employers include the development of an interactive on-line tool that enables organisations to track their progress against the Boorman Review recommendations. The tool enables organisations to reflect on their local strategies by developing work and initiatives against progress being made on a national level³⁹.

³⁸ <https://www.england.nhs.uk/2015/09/improving-staff-health/>

³⁹ <http://www.nhsemployers.org/news/2016/06/what-progress-has-been-made-since-boorman>

6. Contract Reform

Agenda for Change contract reform

- 6.1. We reported in our evidence for the 2016/2017 pay round that we wanted to work with NHS trades unions and NHS Employers on contract reform. The partners, under the auspices of the NHS Staff Council, agreed to discuss proposals for reform, within a cost neutral envelope, and to make proposals to government.
- 6.2. Many NHS employers we understand are keen to review AfC terms and conditions to increase local flexibility through collective bargaining whilst retaining a national pay framework. Areas employers have previously identified for reform include for example, reducing the length of the pay scales, incremental pay and removing overlaps between pay bands, sick pay, annual leave and enhanced pay for working unsocial hours.
- 6.3. Discussions with NHS trades unions have been constructive. However, the partners agreed to focus initially on the incremental pay system, for example, to remove overlaps, shorten pay scales and to consider how to better support local organisations to develop local performance criteria. Cost modelling of alternative pay systems will inform the review of wider terms and conditions in order, as the Pay Review Body advised in previous reports, to develop a balanced package of reforms.
- 6.4. The Department has embarked on contract reform across the medical and non-medical workforce. Analytical support for AfC reform from both the Department and NHS Employers has been focused primarily on work to reform the juniors' and consultants' contracts which has slowed progress on modelling work to support proposals for reforming the AfC incremental pay system.
- 6.5. It has not been possible therefore for the partners to complete all the necessary modelling work to inform joint proposals for reform which means, taking into account the need for the partners to consult their respective constituents, an April 2017 implementation date is not now possible. The partners are developing a detailed AfC reform plan and will advise the Department in due course of the analytical support they need over the next financial year, with the expectation that any joint proposals may be agreed for implementation from April 2018. This should allow them to report progress on contract reform as part of the 2018/2019 annual pay round.

Incremental Progression

- 6.6. In the NHS, around half of employed staff continue to receive pay progression of around 3.4% on average, which is paid in addition to any annual pay award. For Agenda for Change staff, just under 50% are at the top of their payscale. Those below the payscale maximum are eligible for incremental pay increase of just over 3% on average. The NHS workforce is one of very few in the public sector that have pay progression systems. Conditional progression for AfC staff was introduced in 2013, effective from the 2014 performance round following collective agreement between NHS trades unions and NHS Employers. We understand that implementation across the service has been patchy and that few if any Ambulance trusts have adopted the new performance flexibilities. It will be important for the partners to continue to monitor the introduction of the 2013 agreement alongside ongoing negotiations on contract reform to inform any final proposals they agree to put to ministers.

Affording the workforce the NHS needs

- 6.7. Employers face a stark choice for staff on national pay contracts. This is to either pay staff more, accepting that this may do little to improve the quality of care for patients and is likely to restrict the number of staff employers can afford to employ, or to reform contracts to enable employers to use their pay bill, as part of their overall employment offer, to maintain safe staffing levels, with stronger links to performance, quality and productivity.
- 6.8. NHS Employers and NHS trades unions under the auspices of the NHS Staff Council recognise the need to secure feedback on progress in implementing the 2013 AfC agreement, which gave local organisations the flexibility to develop their own local performance standards for linking incremental pay more closely to performance. NHS Employers provide more detail on their findings which we understand suggests that there may be local capability and or capacity issues for some employers in developing local performance standards (which can be measured in an objective and consistent manner across their workforce). It is clear that after more than three years since the national agreement was reached, realising the benefits of collective agreements designed to help employers make a stronger link between incremental pay and performance may be challenging for some employers.
- 6.9. Through the Departments commissioning arrangements, NHS Employers continue to support local organisations through the development of, for example, best practice toolkits around performance management and we are actively discussing how we might best secure the benefits of the 2013 national collective agreement.
- 6.10. NHS employers say they want ‘something for something’. They want to make better use of their pay bill in return for better performance and productivity. The challenge for the NHS is to continue to improve the quality and responsiveness of services, whilst delivering safe, effective and compassionate care.

Agenda for Change – 2015/2016 Pay Deal

- 6.11. At the end of January 2015, to avert further industrial action, the government and NHS trades unions agreed a pay deal which remained within the one percent pay envelope but which also committed both sides to contract reform, see Annex D. It included, at the Annex to the pay deal, agreement to review how to best support the recruitment and retention of front line Ambulance staff.

Front line Ambulance staff

- 6.12. In your 29th NHS Pay Review Body report you asked that the parties work together to quickly identify solutions and best practice for trusts to address wider recruitment, retention and engagement issues for paramedics. Also, with regard to the banding position of paramedics you asked that a clear and tight timetable is agreed between the parties to reach a final decision to minimise the negative effects of the uncertainty on recruitment, retention and motivation.
- 6.13. Trades unions are concerned about the length of time it has taken the partners and the National Ambulance Strategic Partnership Forum (NASPF) to complete this work.
- 6.14. In response to these concerns and informed by your observations that “NHS England should provide central ownership and capacity to support the evolution of the future paramedic role, the identification of costs and benefits for health systems, and support

the business case for any pay band changes to assist local level decision making”, the NHS Staff Council Executive (partnership of NHS Employers and NHS trades unions) agreed to lead the work as part of its extant responsibilities for staff employed under Agenda for Change in collaboration with the NASPF, employers, commissioners and NHS England. NHS Employers hosted a number of stakeholder events to explore the challenges facing the ambulance service and potential solutions. Of particular concern to trades unions is the pay banding review for paramedics carried out over the summer by the NHS Staff Council Job Evaluation Group (a partnership of NHS Employers and NHS trades unions).

- 6.15. The Job Evaluation Group (JEG) was asked by the NASPF to undertake a technical review of existing band 5 paramedic role profiles. In particular, the NASPF asked the JEG to look at whether paramedic profiles reflected current local roles.
- 6.16. The consultation was launched via the NHS Staff Council Executive on 15 June 2016 and closed on 20 July. The partners continue to discuss the outcome of the consultation and next steps.
- 6.17. NHS Employers provide more detail in their evidence on the pay banding review and related commitments under the 2015/2016 pay deal.

Employment Freedoms

- 6.18. Some Ambulance trusts have exercised their employment freedoms to introduce modified pay structures under AfC, with some trusts adopting ‘linked’ band 5 and band 6 pay scales in order to create a career profile which they say is designed to attract and retain paramedics.
- 6.19. Most organisations employ paramedics at band 5 but some have already introduced band 6 though the rationale and arrangements (including job descriptions) for band 5 and band 6 paramedics differ across the ambulance service. The financial impact of each trust increasing the proportion of band 6 paramedics depends on their current skills mix. Trusts that already employ most of their paramedic workforce at band 6 will face lower cost pressures than trusts which employ most paramedics at band 5.
- 6.20. The partners and stakeholders are aware that the financial implications of any revised national paramedic role profile may be significant. Government will want to understand if there are any repercussive effects for other staff groups, implications for the delivery of NHS England’s Urgent and Emergency Review⁴⁰ and ongoing work under the Paramedic Evidence Based Education Project (PEEP)⁴¹
- 6.21. The NHS Staff Council Executive will produce a joint report later this year.

⁴⁰ <http://www.nhs.uk/NHSEngland/keogh-review/Pages/urgent-and-emergency-care-review.aspx>

⁴¹

https://www.uea.ac.uk/documents/10880004/11994152/PEEP_Executive_Summary.pdf/4bf94f2a-adf7-4f30-80ed-13098edb3f3f

Targeting the annual pay award

- 6.22. In Chapters 4 and 5 we set out the work we are doing to secure the evidence base the Pay Review Body needs in order to properly consider how targeted recommendations could support the recruitment, retention and motivation of particular staff groups.
- 6.23. In 2014/2015 government made the decision on affordability grounds to replace the recommended one percent consolidated pay award with a targeted two year pay settlement for 2014/2015 and 2015/2016 of one percent non-consolidated payments for those employed medical and non-medical staff no longer eligible to receive incremental pay. This decision was also informed by the fact that those eligible to receive incremental pay would, on average receive around 3% even if they did not receive an annual pay award.
- 6.24. Following industrial action, agreement was reached to review and negotiate on the 2015/2016 payment for the AfC workforce only (the 2014/2015 payment remained unchanged for medical and non-medical staff). Agreement was reached to target the 2015/2016 pay award towards lower paid staff who subsequently received at least a 2% consolidated pay award, with most other staff receiving at least a 1% consolidated pay award made affordable by freezing the incremental pay and annual pay award of higher paid staff.
- 6.25. Targeting is not however just about the annual pay award, but underpins how contract reform is designed. For example, in 2013 as part of the collective AfC agreement on sick pay, enhancements were removed from sick pay for most staff except the lowest paid. For wider contract reform, the ambition, amongst a number of reform proposals is to consider how pay could be redistributed towards those working most onerously and the most unsocial hours.
- 6.26. The Department therefore strongly supports the principle of targeting pay awards not just to address recruitment and retention issues, but as a fundamental outcome from contract reform particularly where change must be achieved within a cost neutral envelope.
- 6.27. The analysis at Chapter 5 shows that capacity has grown strongly, that the NHS Staff Survey Index shows improvement and that there has been no sustained recruitment and retention difficulty. We understand that feedback NHS Employers received from trusts suggests that organisations do not believe a differential pay award would make a material difference to the recruitment, retention or motivation of AfC staff and could be divisive.
- 6.28. The NHS Pay Review Body has been clear that accurate vacancy data, along with other key recruitment, retention and motivation data is crucial to enable it to make robust recommendations for differential pay awards. We recognise that differential targeting can be helpful, but we do not have sufficient evidence to support this in this pay round, however we are working towards providing the evidence to support targeted pay awards for 2018/19.
- 6.29. For these reasons we believe all AfC staff should receive a uniform one percent pay award. In Chapter 5 we provide an update on progress to help inform the evidence base for the 2018/2019 pay round which would enable the NHS Pay Review Body to identify those staff groups, nationally or regionally for whom pay would make a material difference to recruitment, retention and motivation.

7. Pensions and Total Reward

Introduction

- 7.1. 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 cost of the Scheme than the majority of the workforce, currently contributing 14.3% of pensionable pay. 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).
- 7.2. Eligible members of the NHS workforce will now belong to one of the two existing Schemes. The final 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 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, 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.
- 7.3. 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 calculates that Scheme members can generally expect to receive around £3 to £6 in pension benefits value 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 nurse⁴² (retiring at 68, with service wholly in the 2015 scheme), with 35 years' service, can expect a pension of around £19,000 p/a.

Review of Scheme access

- 7.4. HM Treasury's non-statutory policy "The Fair Deal for Staff Pensions"⁴³ sets out how pension issues are to be dealt with when staff are compulsorily transferred from the public sector to independent providers delivering public services. The guidance applies to tenders involving compulsory transfers of staff who were transferred out under the previous Fair Deal policy - which required the provision of "broadly comparable" pension schemes. Under the guidance there will continue to be protection where staff are subsequently transferred to a new employer.
- 7.5. Changes to the Scheme from 1 April 2014 allowed independent providers (IPs) of NHS clinical services with an Alternative Provider Medical Services (APMS) contract, an NHS Standard Contract or local authority public health contract, to enrol eligible employees in the Scheme. This builds upon HM Treasury's reformed Fair Deal policy and has

⁴² 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.

⁴³ Fair Deal for staff pensions: staff transfer from central government, HM Treasury (October 2013)

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extended access to the Scheme for approximately 20,000 staff delivering NHS clinical services since 2012.

- 7.6. The provisions allowing eligible employees of IPs access to the Scheme were reviewed during 2015, after their first year in force, to ensure they were delivering the policy aim of a fair playing field (in relation to pensions) for providers competing for NHS contracts. The Department consulted with IPs, their staff, as well as those who unsuccessfully applied for access to the Scheme and reported to HM Treasury in late 2015. The review found that the policy aims are largely being met, but that clearer guidance and a shorter application process would improve the operation of the provisions. The review found that changes to the way contracts are awarded and service delivery structured, with an increasing use of sub-contractors, meant that some changes to the regulations may be desirable to recognise this.
- 7.7. The Department is working with HM Treasury on the review's recommendations.

Early Retirement Reduction Buy Out (ERRBO) scheme for frontline ambulance staff

- 7.8. The ERBBO facility, which only exists within the new 2015 Scheme, allows members of that Scheme with a normal pension age (NPA) higher than 65 to pay additional contributions to reduce or remove any early retirement reduction that would apply to their 2015 Scheme benefits if they retire before their NPA. An agreement was reached as part of the 2015-16 pay deal to provide a specific scheme for frontline ambulance staff to recognise the particular nature of their roles and the requirement to work to state pension age before being able to retire from the 2015 Scheme with unreduced benefits.
- 7.9. The facility allows the member's employer to either pay the full cost of the additional contributions required, or to share the cost with the member. The agreement negotiated by the national ambulance unions means that, for a certain cohort of staff, a 50% employer contribution towards the ERRBO will be available. The ambulance sector ERRBO agreement came into effect on 1 April 2016. ERRBO agreements (for all staff, not just ambulance staff) must commence within the first 3 months of each scheme year, so by the end of June each year.
- 7.10. The staff categories that the ambulance service has deemed - for the purposes of ERRBO only - as "front line" and who would be eligible for submitting an application for a 50% employer contribution towards their ERRBO costs are:
- all front line operational ambulance staff, with direct patient contact (which includes all variations of the following roles);
 - emergency Care Assistants;
 - emergency Medical Technicians;
 - paramedics;
 - staff based in the Emergency and Urgent Emergency Operations Centre and Patient Transport Services; and
 - additionally, any clinically qualified manager who is rostered for at least 60% of their time delivering direct patient care.

Contracting Out and New State Pension

- 7.11. The introduction of the new 'single tier' state pension from 6 April 2016 has led to an increase in national insurance contributions for members of the NHS pension scheme and their employers. This is due to the withdrawal of the 'contracting-out' rebate. Contracting out is where an individual contributes to an occupational pension scheme (e.g. the NHS pension scheme) instead of building up second state pension rights. A lower national insurance rate is paid as a result. The new state pension abolished the second state pension (and therefore contracting-out) meaning that employers and employees pay 'full rate' NI contributions from April 2016.
- 7.12. This additional cost relates to the accrual of new state pension rights, and not the NHS pension scheme. It is effectively an increase in the cost of employment and a small reduction in take home pay for individuals who were contracted-out:
- 3.4% increase in employer NI on individual's earnings between £8,000 and £40,000; and
 - 1.4% increase in employee NI for earnings between £8,000 and £40,000.
- 7.13. In terms of effect, the higher NI contributions do not appear to have led to an increase in individuals opting out from the NHS pension scheme (see Annex E).

NHS Pension Scheme Contributions

- 7.14. Employee contribution rates remained the same in 2015-16 as they were in 2014-2015, and have been 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 where they are in the pay range) at some point during the four years 2015-2019. A proportion of members are expected to progress to higher contribution tiers year to year through pay progression.
- 7.15. Even with the increases in employee contribution rates, implemented across three years from 2012/2013, the NHS Pension Scheme remains an excellent investment for retirement. The Government Actuary's Department calculate that members can generally expect to receive around £3 to £6 in pension benefits value for every £1 contributed.
- 7.16. High earners are likely to benefit from higher rate tax relief on their pension contributions. This meant that before contributions were raised in April 2012, members with full-time earnings over £60,000 actually paid a contribution rate that was lower than colleagues who earned half that amount, once tax relief had been taken into account.

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Table 7.1: Employee contribution rates

WTE Pensionable Earnings/Pay	Contribution Rate
≤ £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%

NHS Pension Scheme membership levels

- 7.17. The Department has continued to monitor changes in Scheme membership using data from ESR. Annex E presents the position as of May 2016, and shows the percentage point change over the previous month, the last 12 months and from October 2011.
- 7.18. Between October 2011 and May 2016 the proportion of NHS staff who were members of the pension scheme increased by 4.5 percentage points.
- 7.19. Within the different non-medical staff groups some variation was apparent, with membership for four of the six groups increasing over the past 12 months. Membership among qualified ambulance staff decreased by 0.2% points across May and June 2016 which is consistent with an overall decrease of 0.8% points observed in this group over the last 12 months. Membership rates for managers did not change across May and June 2016, but decreased by 0.4% points over the last 12 months.
- 7.20. Compared to the previous month (April 2016), membership rates have generally increased across the Agenda for Change pay bands, particularly amongst band 1 staff for whom rates increased by 1.3 percentage points. All other bands increased by 0.1-0.4 percentage points in the preceding month, apart from bands 8b and 8d for which rates did not change.
- 7.21. In summary, membership rates are high across all staff groups and generally growing, particularly within lower paid bands. Increases to member contributions in recent years, and the increase to employee National Insurance resulting from the abolition of contracting out, do not appear to have led to significant numbers leaving the scheme. Amongst the highest paid AfC bands, particularly management roles, there appears however to be a growing opt-out trend, albeit a fraction of a percent.
- 7.22. This may be due to the effect of new lifetime and annual allowances tax limits which potentially affect some high earners in the NHS Pension Scheme. Placing these tax measures in the context of the 1995 section of the NHS Pension Scheme, individuals who use up the full £40,000 annual allowance would see their annual pension increase by around £2,500. Those who reach the £1m lifetime allowance limit will have built up a pension of around £44,000 a year plus a tax free lump sum of £132,000.

- 7.23. Where individuals have breached either the annual or lifetime allowance, but not both, it is likely to still be a sound financial decision to continue building up pension, but may need to address the tax liability by using HMRC's 'scheme pays' facility. Over the course of an average 25 year retirement, an individual can expect the benefit from receiving more pension to outstrip the tax cost of that extra pension.
- 7.24. We are reviewing the impact of pension tax on the recruitment and retention of key staff roles, of which pension tax changes will be a factor. We will explore, what if any mitigation might be appropriate in the context of total reward.

Total Reward

- 7.25. As a concept, 'total reward' is both the tangible and intangible benefits that an employer offers an employee. In addition to financial benefits, it includes training, career development opportunities, culture and working environment. It is a means of explaining to employees the total value of their employment package. The Department considers the total reward concept central to the ability of NHS employers to recruit and retain staff.
- 7.26. The context of continued pay restraint means that NHS employers should look to be creative and willing to explore more flexible approaches to employee reward packages. To this end, the Department's approach to reward policy is to create the right environment in which NHS organisations can develop the appropriate capability and capacity to:
- fully utilise the NHS employment package to attract, motivate and retain the staff they need;
 - implement local reward strategies that are aligned with their organisational objectives and meet the needs of their workforce; and
 - ensure employees understand the full value of their reward package (the tangible and intangible benefits) and the flexibilities within it.
- 7.27. Our objective is to develop a coherent approach to reward that will help the NHS deliver workforce productivity improvements by supporting employers in ways that will:
- help NHS organisations recruit, retain and motivate the staff they need to deliver excellent services to patients;
 - enable staff to understand the value of their reward package and have access to opportunities to maximise its value for them at different stages in their career;
 - contribute to improved patient and staff experience (engagement, health and wellbeing);
 - improve local management of the NHS paybill and support wider NHS productivity gains;
 - support and empower employers across the NHS to adopt and develop innovative pay and reward solutions that meet local need and enable them to attract the best staff;
 - be in the vanguard of public sector approaches to reward; and
 - focus on reversing the dissatisfaction with pay as evidenced by NHS Staff survey results. In 2015 satisfaction with pay increased 4 percentage points to 37% compared to 2014 results, though this is still below the 38% level reported in 2013.

Since last year, we have continued to develop the NHS total reward policy by commissioning NHS Employers to continue building the business case for the NHS. NHS Employers are

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working on the strategic context, improving understanding of TR and developing communications and benchmarking through:

- the Total Reward Engagement Network (TREN) which meets regularly in London and Leeds and through which awareness of reward as a retention and recruitment tool is being raised and staff encouraged to engage more with strategic reward in their organisation;
- commissioning of research into the relationship between total reward and employee engagement, and analysis of the results;
- identify reward and workforce priorities - helping NHS employers to use reward to recruit and retain particular groups of staff;
- ensuring the NHS has access to reward expertise and is kept up to date with latest developments and leading edge practice supported by a range of products, such as checklists for job advertisements, info-graphics on multi-generational workforces and guidance for line managers on reward as a recruitment and retention tool;
- influencing a change in employer behaviour to embrace reward approaches and share learning, for example, through encouraging wider use of NHS Employers' Reward Strategy toolkit⁴⁴ - designed to lead trusts through planning, developing and implementing their reward strategies; and
- ensuring that our reward approach influences and is influenced by ongoing pay and contractual changes. For example, incorporating the ERRBO facility as part of the pay approach for frontline ambulance staff as described earlier.

There are indications that more organisations are working with their staff on alternative reward offers to address recruitment challenges and we plan to continue developing good practice and encourage innovative use of pay and pensions flexibilities.

Features of Total Reward Packages for NHSPRB Staff

7.28. Components of the reward package for NHSPRB staff, updated where appropriate from last year, include:

- annual incremental progression of between 1% and 6.7% of basic salary;
- an NHS minimum wage of £7.80 per hour which is 8% more than the national living wage of £7.20 (for aged 25 and over), and 16% more than the national minimum wage of £6.70;
- a defined benefit pension scheme with a 14.3% employer contribution and flexible early retirement options from 55 years old;
- immediate life assurance of twice an employee's annual pay and generous death benefits for spouses and dependent children;
- maximum 41 days holiday compared with the 28 days statutory minimum;
- sick pay of up to six months full pay and six months half pay compared with statutory sick pay of £88.45 per week for up to 28 weeks;
- redundancy pay of up to two year's salary with a minimum of 24 years reckonable service (using a notional £23,000 minimum and £80,000 maximum earnings for the purpose of calculating benefits) compared with the statutory half to one and a

⁴⁴ <http://www.nhsbsa.nhs.uk/3798.aspx>

half week's pay for each full year of service depending on age⁴⁵. The Enterprise Act 2016 provides that a cap of £95,000 on the value of exit payments for public sector workers will be introduced following secondary legislation⁴⁶;

- HM Treasury has consulted on further reforms to public sector exit payments to ensure greater consistency between public sector redundancy compensation schemes⁴⁷. Its response was published on 26 September 2016. The Government's expectation is that individual workforces will negotiate these changes with trade unions over the coming 9 months. We will work with NHS trade unions in the coming months to determine how the proposals will apply to the NHS, taking into consideration the savings already made from changes made to agenda for change redundancy terms in April 2015
- maternity pay of eight weeks full pay, 18 weeks half pay, 13 weeks statutory maternity pay (SMP) and an optional extra 13 weeks unpaid leave compared with the statutory entitlement of six weeks at 90% of average gross weekly earnings and 33 weeks at the lower of either £139.58 or 90% of average gross weekly earnings;
- paternity leave of two weeks starting twenty weeks after the child is born as well as an additional two to 26 weeks if the mother has returned to work. Fathers are also entitled to receive additional paternity pay if the mother has not exhausted her SMP when she returns to work; and
- the nationally recognised values, diversity and reputation of the NHS including, for example, excellent opportunities for flexible working, career breaks and other local initiatives.

Total Reward Statements

- 7.29. Total Reward Statements ("TRS") were first introduced in the NHS during 2014 and are made available annually to most NHS employees. TRS are designed to help employees understand their complete benefits package and highlight the value of their employment and NHS pension benefits in one place.
- 7.30. A TRS is a personalised summary that shows employees their reward package, including:
- basic pay;
 - allowances; and
 - pension benefits (for NHS Pension Scheme members).
- 7.31. Organisations using the NHS Electronic Staff Record ("ESR") can also add information about local benefits allowing employers to showcase the positive benefits of working for their trust. Local benefits could include:
- health and wellbeing programmes;
 - learning and development;

⁴⁵ <http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook/nhs-redundancy-arrangements>

⁴⁶ <http://www.legislation.gov.uk/ukpga/2016/12/section/41/enacted>

⁴⁷ <https://www.gov.uk/government/consultations/further-consultation-on-limiting-public-sector-exit-payments>

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- flexible working opportunities;
 - childcare vouchers; and
 - cycle to work scheme.
- 7.32. Evidence, for example, from NHS workshops suggests that employees do not understand the full value of their reward package with many unaware that they receive a 14.3% employer contribution towards their pension package. TRS should help resolve this and feedback from pilots confirmed that:
- the concept appears to be understood by staff and well supported;
 - the quality of statements is regarded as good; and
 - there is further work to be undertaken with NHS employers to support the local customisation of statements thus ensuring that the project's benefits are fully realised.
- 7.33. TRS are accessed by employees via the TRS portal and ESR employee self-service for organisations that use the facility. TRS have been developed and delivered by the NHS Business Services Authority ("NHSBSA") in partnership with the NHS Electronic Staff Record programme to support staff retention and motivation by giving NHS staff details on the overall value of their employment package. Staff in organisations not using ESR instead receive an annual benefit statement (ABS).
- 7.34. TRS content is refreshed annually for each eligible employee. NHSBSA carried out a Year One Evaluation in April 2015. Their findings show that TRS/ABS has been welcomed by NHS staff and viewed as a tool that provides valuable information. A national roll out of TRS started in 31 August 2015, with 2,197,616 statements now available.

Annex A: 2 June 2015 Letter from Secretary of State to Chairs of Trusts in All Organisations

Chairs:

NHS Trusts

NHS Foundation Trusts

Clinical Commissioning Groups

Cc' ALB Chairs (for info)

Dear Colleague,

Keeping control of the paybill while ensuring we can recruit and retain high quality staff is a crucial part of meeting the efficiency challenge. Reforming the way we pay for NHS staff is a very high priority and must include a review of the pay of the most senior staff in the NHS (Very Senior Managers – VSMs) – chief executives and executive directors. Although these staff do important jobs and deserve to be fairly rewarded, it is vital that we do not lose sight of the need to ensure that executive pay remains proportionate and justifiable. More junior staff subject to tight restraint over their pay have the right to expect this as do the public more widely.

Although we have reduced the number of senior managers across the NHS by over 1,800 the latest figures still suggest that more than half of all directors in provider trusts are paid between £100,000 and £142,500 with more than one fifth paid amounts over £142,500. At a time of financial pressure, it is right to question the need to pay so many NHS staff more than the Prime Minister. The overall reward package is not just about pay, but also includes deferred pay in the form of NHS pensions. It cannot be right to treat pension benefits as though they are entirely separate from the employment offer.

I am therefore writing today to outline the following:

Firstly, to urge you all to urgently review your policies on executive remuneration and consider whether the amounts paid are necessary and publicly justifiable.

To advise you that I shall extend to NHS Trusts the current requirement for ambulance and community NHS Trusts, to first seek the approval of the Chief Secretary to the Treasury for appointments above the Prime Minister's salary of £142,500.

I am also requesting that all FTs and CCGs seek the views of ministers via Monitor and NHS England respectively before making appointments to Boards/ Executive Boards with a salary higher than the Prime Minister's. In addition, that you advise me of those current salaries which are higher than the Prime Ministers and your justification.

To highlight particular attention to the pay of interim Board members and ensure that you follow the relevant HMT guidance on interim appointees paid on an "off-payroll" basis. Treasury guidance on such appointments states very clearly that Board members should be on the payroll of the organisations they lead unless in exceptional, short-term cases. The same rules

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apply to senior officials filling roles with significant financial responsibility. Can you please ensure that HMT's guidance on "off payroll" appointments is rigorously followed.

In addition, I believe the daily rates paid for such appointments amount, on an annual basis, to pay which is excessive and indefensible. Can you please ensure that where there are exceptions, the daily rates involved do not normally exceed what would be paid to substantive appointments.

Clamping down on "retire and return" to ensure that very senior staff cannot gain financially, from this at a cost to the taxpayer. I have concerns that very senior staff use the retire and return provisions of the NHS pension scheme to access their full pension and lump sum and then continue in full-time work. The provisions were not designed for senior staff to gain financially. I will look to extend existing rules so employees' new salaries plus their pension on returning to employment cannot be more than the original salary prior to retirement. It is unacceptable, particularly for VSMs leading organisations receiving additional tax payer support, to be better off by taking their pension and returning almost immediately to the NHS.

To set out my expectation that the new redundancy terms for NHS staff in England apply to all newly appointed VSMs (unless staff are on statutory redundancy terms) and existing VSMs where section 16 is referenced in their contracts. The new redundancy terms for NHS staff in England are now more effective than before and it would be wholly unacceptable to have very senior staff leaving on significantly better compensation packages than more junior colleagues.

The last Government legislated for the "claw back" of contractual redundancy benefits on return to public sector employment for staff earning £100k or more. The new law will be in place in April 2016. This Government will introduce an overall contractual redundancy cap of £95k. Alternative employment where ever possible must be the priority so we retain valuable skills. Redundancy should be the very last resort.

I have also considered options for better control of VSM pay across the system, and will be taking these forward in the coming weeks. These include the following:

- introducing a national VSM pay framework with benchmarked rates for executive roles, and a more effective approach to transparency and disclosure (e.g. central publication of VSM pay rates for each organisation alongside the benchmarked rate). If these measures cannot be implemented effectively on a voluntary, "comply or explain" basis, I will strongly consider taking additional legal powers. In addition, it is important that the new pay framework is informed by any relevant recommendations following publication of The Rose Review.

I recognise that effective leadership is crucial if we are to improve outcomes for patients. Getting this right is a team effort, and my expectation is that there should be no significant difference in the terms and conditions of senior leadership teams and those working on the front line. I do not believe it is acceptable that some senior managers experience the high levels of pay, with year on year increases, as a matter of course.

By the end of June I would very much welcome your plans and thoughts on:

- reviewing your policies on executive remuneration and whether the amounts paid are necessary and publicly justifiable;
- to note that NHS trusts will be required to seek the approval of the Chief Secretary to the Treasury on VSM pay which is more than the PM's - £142,500 - before making any appointments;
- via Monitor and NHS England, that FTs and CCGs should mirror the process in the rest of the NHS for appointing VSMs paid more than the PM;

- providing me with details of your current VSM salaries that are higher than the PM's and your justification;
- the introduction of a national pay framework for executive roles and how appropriate rates can best be benchmarked;
- assuring me that Board members and those filling roles with significant financial responsibility paid "off payroll" all meet the Treasury guidance and where they do not, the action you plan to take to rectify the situation.

In addition, I ask that you confirm to me in writing that you will personally scrutinise and approve any new VSM appointments in your organisation.

My officials will make contact with you as quickly as possible to provide further guidance about the information I have requested and will provide standard templates for your colleagues to complete.

I look forward to receiving your conclusions in June and continuing to work with you on this crucial aspect of the financial challenges we have to address.

JEREMY HUNT

Annex B: Earnings change for Agenda for Change contracted employees 2010-2015 – a longitudinal study.

Summary

A longitudinal study shows that the total earnings of those Agenda for Change contracted employees who were employed in the NHS in 2010 and also in 2015 increased by an average of between 1.7% and 2.9% per year, depending on staff group. This is the annualised median increase in the earnings of employees with a record of payment on the NHS Electronic Staff Record system at both March 2010 and March 2015, i.e. those who were employed over the full five year period. The average increase of these employees was greater than the increase in average earnings of all staff over the same period. Depending on staff group, those employed over the five year period had an annual average increase between 0.7 and 2.1 percentage points higher than the group's increase in average earnings. The average annual CPI figure over the same period was 2.4%.

The Analysis

Analysis has been undertaken of the total earnings of AfC contracted employees as reflected on their Electronic Staff Record. Specifically, the analysis looks at the total earnings of those employees with a record of payments made in both the months of March 2010 and March 2015. The analysis is based on the records of 718,000 employees which represent around 70% of all AfC contracted employees at March 2010. There is no presumption of continual service between the two points in time – so, in the interim, some employees may have left and re-joined. The age and gender profiles of this analysis group and how they compare with those of all AfC contracted employees are discussed later in the paper.

This analysis only includes payments to employees on permanent contracts and excludes bank.

Changes in earnings are associated with career progression, pay uplift, geographical movement and changes in personal working patterns. The analysis controls for changes in earnings due to changes in working patterns by adjusting each employee's earnings to a full time equivalent based on their recorded contracted hours. This adjustment has little impact on the median increase (as indicated at Table 3), but has a more significant effect towards the extremes of the distribution.

Key Findings

For most staff groups, half of employees benefitted from double figure increases in earnings over the five year period, equating to at least 2.2% to 2.9% annually, depending on staff group. Qualified ambulance staff benefitted slightly less, but even so, half saw an increase of at least 8.6% over the period, or 1.7% annually. There is significant variation in the extent of changes in earnings of employees over the period. For each staff group, the one fifth of employees seeing the greatest increase benefitted from at least a 26% to 29% rise, equivalent to around 5% per year. However, the one fifth of employees benefiting least had increases of no more than 4.1% over the five years, equivalent to no more than 0.8% per year. One fifth of qualified ambulance staff and nurses and midwives sustained a decrease in earnings of at least 7% (equivalent to 1.5% annually) and 1.1% (0.2% annually) respectively. Reductions in earnings reflect that staff may change jobs over the period, reduce levels of overtime, changes to on call/stand by arrangements and other changes in circumstances such as moving to areas that do not attract

geographic allowances. Table 1 expands on the distribution of the changes in total earnings over the five years, with Table 2 showing the annualised equivalents.

Table 1: Range of total earnings change, adjusting for changes in contracted hours, March 2010 to March 2015.

	20th centile	40th centile	Median	60th centile	80th centile
Qualified ambulance staff	-7.0%	4.6%	8.6%	14%	29%
Nurses and midwives	-1.1%	6.8%	11.3%	16%	26%
Scientific, therapeutic & technical	3.3%	9.4%	14.5%	19%	28%
Support to clinical staff	2.3%	8.7%	13.3%	18%	28%
NHS infrastructure support	4.1%	10.3%	15.1%	19%	29%

Table 2: Range of total earnings change, adjusting for changes in contracted hours, March 2010 to March 2015 – Annual equivalent.

	20th centile	40th centile	Median	60th centile	80th centile
Qualified ambulance staff	-1.5%	0.9%	1.7%	2.7%	5.2%
Nurses and midwives	-0.2%	1.3%	2.2%	3.0%	4.7%
Scientific, therapeutic & technical	0.6%	1.8%	2.7%	3.6%	5.1%
Support to clinical staff	0.5%	1.7%	2.5%	3.4%	5.1%
NHS infrastructure support	0.8%	2.0%	2.9%	3.6%	5.2%

The average (median) increase compares favourably with both the Consumer Price Index (CPI) and the increase in average earnings of employees as a whole over the same period. The latter is drawn from comparisons over the same time period of the mean earnings of all employees – not just those who were employed at the start and the end of the period – published by NHS Digital. Table 3 puts the findings of this study in the context of other changes over the same period, including figures for the longitudinal analysis without adjustment for part time contracted hours, which are more comparable with the increase seen in mean earnings of employees published by NHS Digital.

Pensions and Total Reward

Table 3: Comparisons of increases of earnings and prices – annual equivalent

	Amb	Nurses	ST&T	Support	Infra
Median change adjusted for FTE hrs	1.7%	2.2%	2.7%	2.5%	2.9%
Median change: no FTE adjustment 1	1.4%	2.1%	2.3%	2.5%	2.9%
Change in mean earnings 2	0.3%	1.1%	0.6%	1.8%	1.9%
CPI 3	2.4%	2.4%	2.4%	2.4%	2.4%

Notes:

1. Longitudinal analysis without adjustment for changes to contracted hours. This adds context for the comparison with the change in mean earnings of all employees published by NHS Digital.
2. Change in mean earnings of all employees in 12 months to March 2015 compared with 12 months to March 2010. Source: NHS Digital.
3. See Annexe A for CPI calculation

Methodology

This analysis looks at the total earnings change for all permanent employees with records on ESR in both March 2010 and March 2015. It only compares payments made in these two months and does not take into consideration what has happened to employees between these two months, e.g. an employee could have left the NHS and returned. Total earnings is the sum of all payments made in the month, including basic pay, overtime payments, geographic allowance, etc.

Data is taken from the Electronic Staff Record (ESR) Data Warehouse. The ESR Data Warehouse is a monthly snapshot of the live ESR system, which is the HR and Payroll system used by all but two Hospital and Community Service (HCHS) organisations. The robustness of this data is subject to local coding practices and is not centrally validated. However, for this analysis, a number of constraints have been introduced, and records have been excluded where any of the following criteria were met:

- The employee's contract is non-permanent, such as bank or honorary contracts
- The level of recorded basic pay is not consistent with the recorded job role.
- Total earnings are less than £100.
- Employment was not for the full month.

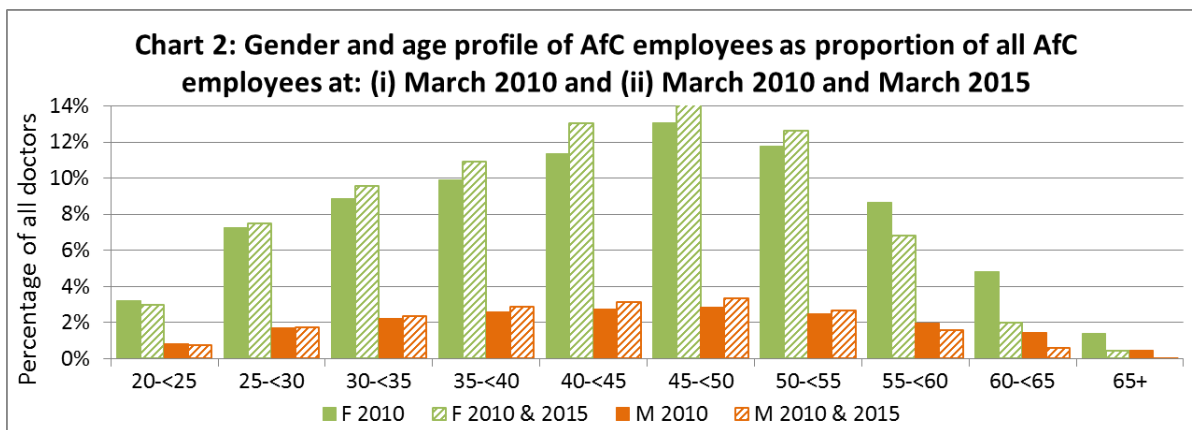
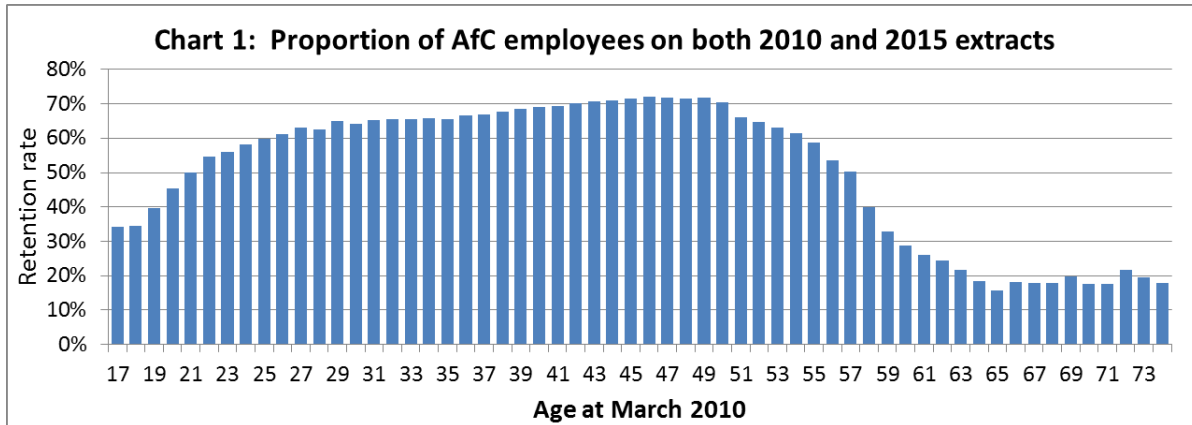
Where an employee holds more than one contract, earnings for each contract are summed.

Limitations of the analysis

Earnings of individuals are likely to fluctuate across any given period, due to changes in working patterns (such as overtime), timing of progression pay or external circumstances. For certain individuals, the two months chosen may not be representative of their long term earnings change.

The cohort of staff with a record on the March 2010 and a record on the March 2015 extracts only makes up around 70% of all those employed in 2010, and so cannot be considered to be representative of the entire workforce; they will have different characteristics to the full cohort of AfC contracted employees with a record on either of the extracts. This is highlighted at Chart 1

which shows that the proportion of those on the 2010 extract who also appear at 2015 starts to reduce markedly for those aged over 50 in 2010, which means the analysis underrepresents the earnings patterns of older staff. Chart 2 shows in more detail the age and gender profile of the analysis group with that of all employees in 2010, showing that the analysis particularly over-represents females between 30 and 55, and under-represents females over 55.



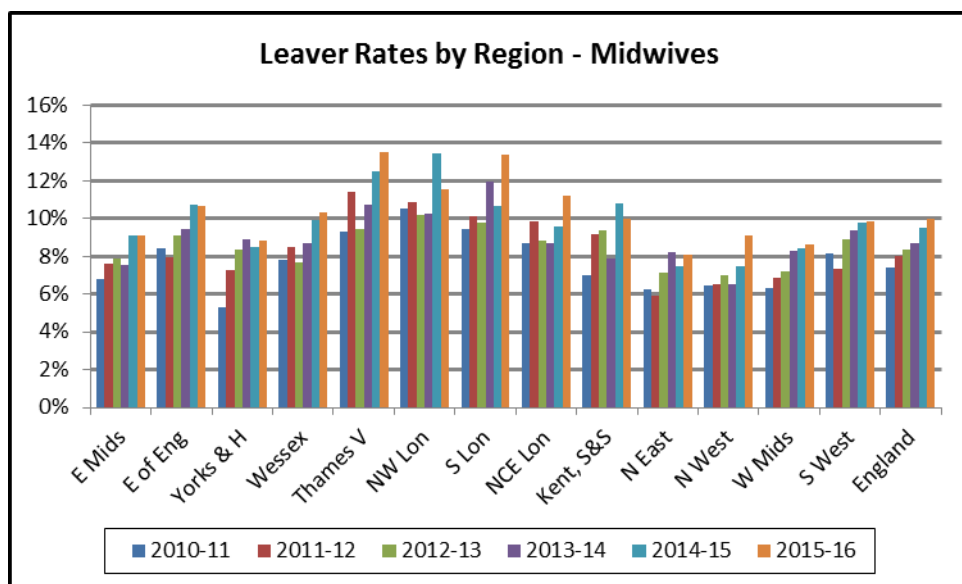
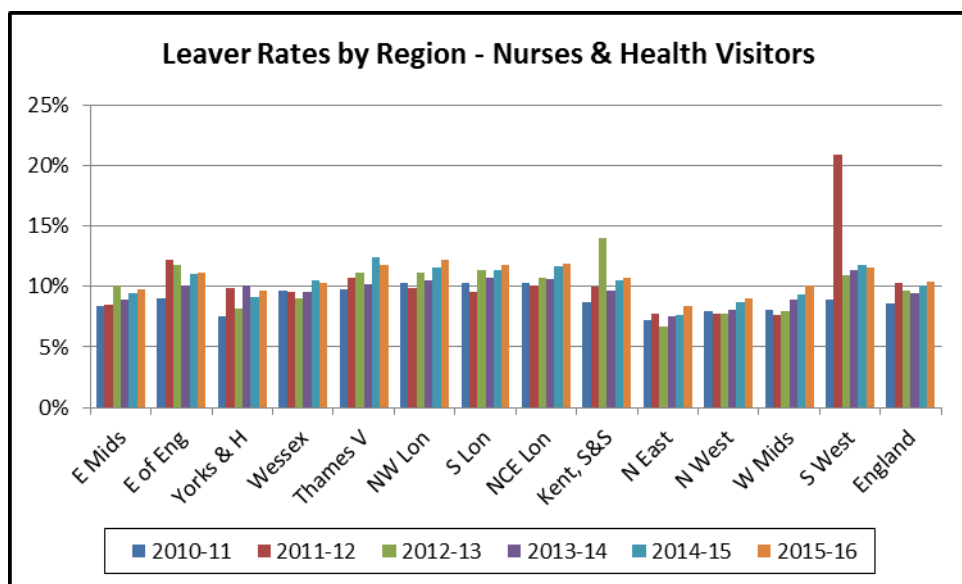
CPI 12-month inflation rate

	Per cent
12 months to Mar 2011	4.0%
12 months to Mar 2012	3.5%
12 months to Mar 2013	2.8%
12 months to Mar 2014	1.6%
12 months to Mar 2015	0.0%
Cumulative: 60 months to March 2015	12.4%
Annual average: 5 years to March 2015	2.4%

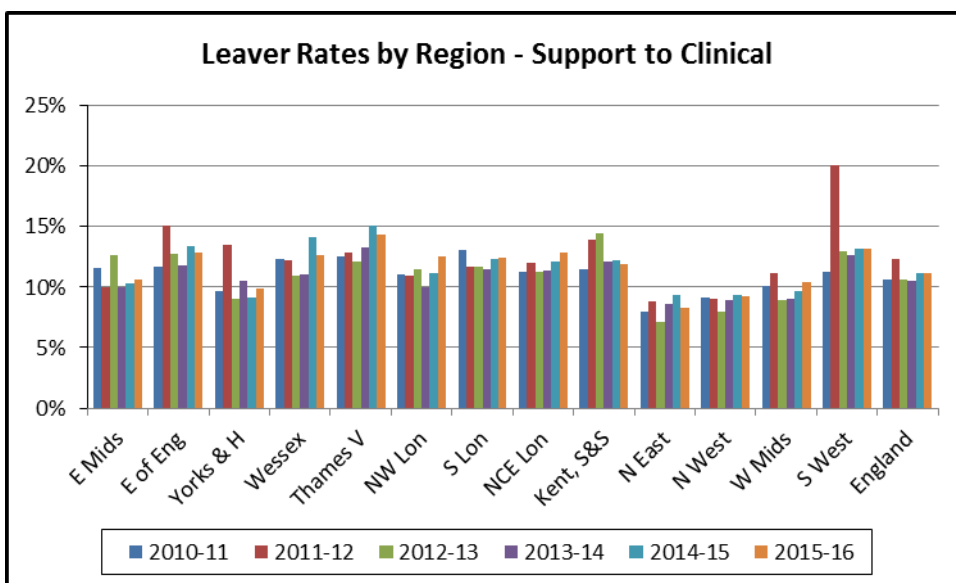
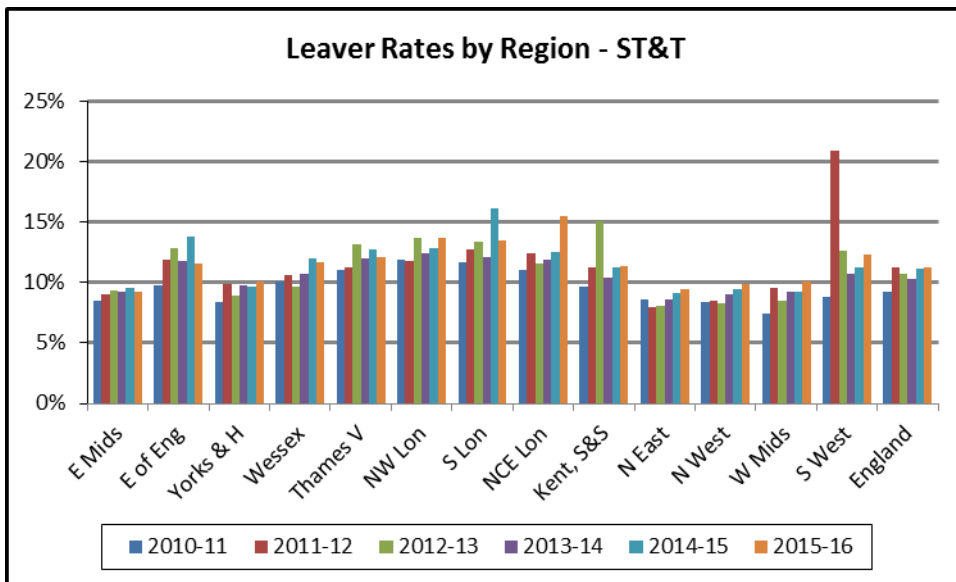
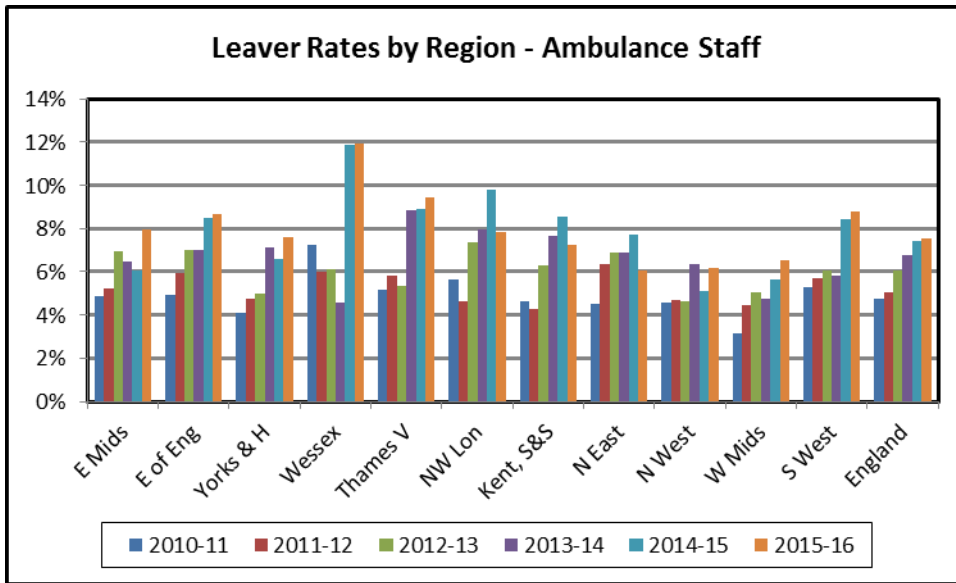
Source: <https://www.ons.gov.uk/economy/inflationandpriceindices/bulletins/consumerpriceinflation/apr2016#consumer-prices-index-cpi>

Annex C: NHSPRB Remit Group Leaver Rates

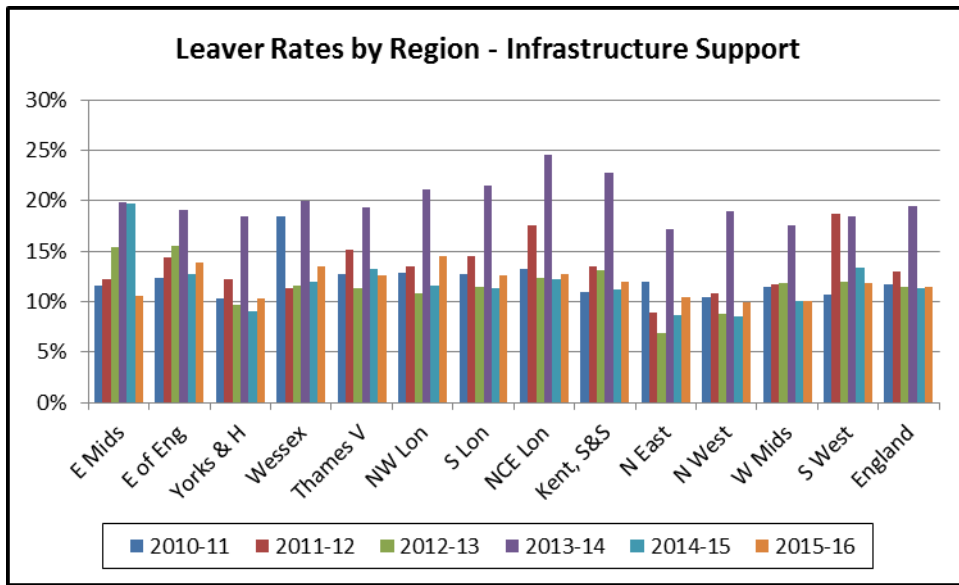
The regional figures show employees in each region who left the HCHS in England, and do not include people who moved within the HCHS between regions.



The NHS Pay Review Body (NHSPRB) Review for 2017



Pensions and Total Reward



Annex D: 27 January 2015 Agenda for Change Pay Proposal Letter from Secretary of State to the Staff Side Chair



Department
of Health

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

Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

Tel 020 7210 5320
healthsofs@dh.gsi.gov.uk

www.dh.gov.uk

Christina McAnea
Staff Side Chair of NHS Staff Council
UNISON
130 Euston Road
London
NW1 2AY

Dear Christina,

27.1.2015

Agenda for Change Pay Proposal

I am writing to you to make a pay offer for 2015/16 in respect of staff employed under Agenda for Change Terms and Conditions in England, following discussions between my officials and representatives of the staff side of the NHS Staff Council.

As we have discussed before the priority for the Government has always been to ensure a fair pay award for hard working NHS staff whilst also doing what is best for patients, and those staff, which is protecting front line staff numbers.

The pay offer is intended to provide nearly 1.1m NHS staff under Agenda for Change (AfC) terms and conditions with a pay rise next year in line with the Government's pay policy. It also provides additional support for the lowest paid staff in the NHS. This offer does not increase the cost of employing NHS staff next year and therefore does not affect the affordable NHS workforce. I would ask as part of an agreement that the Trade Unions commit to work together with NHS employers to ensure this remains affordable and that the £34bn plus spent on paying Agenda for Change staff achieves the best value going forward.

The elements of the pay proposal from the Department are as follows:

- Abolition of the bottom point of AfC and increasing pay point 2 to £15,100. This means an increase of 5.6% for staff on point 1 and 3.1% for staff on pay point 2;
- 1% consolidated pay rise for all staff up to point 42 from April 2015;
- A further consolidated pay rise of an additional £200 for staff on pay points 3-8. This means staff on these pay points will receive an increase between 2.1% and 2.3%;

- An increment freeze in 2015/16 for staff on pay point 34 and above for one year only; and
- Urgent talks to take place with a view to the proposed redundancy changes being implemented from 1 April 2015, including a floor for calculation of redundancy payments of £23,000 and a ceiling for calculation of £80,000 with an end to employer top up for early retirement on grounds of redundancy.

The Government is also taking this opportunity to reaffirm its commitment to the NHS Pay Review Body. The Pay Review Body system has generally served the NHS well and will continue to have an important role in making future recommendations on pay uplift for NHS staff in relation to 2016/17 and thereafter.

As part of the offer the Government asks the Trade Unions to commit to talks on further reforming Agenda for Change. The Government recognises that the Agenda for Change pay system has successfully created a framework for equal pay in the NHS and a framework for rewarding staff fairly. However we believe that after 10 years the time is now right to review the agreement to ensure it can continue to deliver flexibility, capacity, fairness and value.

The talks would support NHS organisations to maximise the contribution of NHS employed staff and reduce reliance on agency staffing, strengthen the AfC agreement on progression and review more generally the need for further reform of the pay system with the aims of maximising value for patients and fairness for all staff including those in Bands 8 and 9. These talks would aim to produce an agreement for implementation from April 2016 and will be part of a more general review of terms and conditions for all NHS staff.

As part of the broader negotiations, unions representing ambulance staff have had discussions with the Department and ambulance employers about related issues concerning ambulance staff terms and conditions. The annex to this letter sets out proposals for taking these forward. I would be grateful if Trade Unions representing ambulance staff would include this element of the offer in consultations with their membership on the overall proposals.

I believe that this offer strikes a fair balance between the need to protect the NHS frontline and giving staff an affordable pay rise. We hope that this offer will enable Trade Unions in dispute to suspend planned industrial action pending consultation with your members.

I am copying this letter to David Wherrett, Chair of the Staff Council Management Side.

Yes and
Jeremy

JEREMY HUNT

Annex

Proposal from Ambulance Service Employers to the Ambulance Unions

Ambulance employers recognise that the current industrial action has a wider context for ambulance staff of other concerns about terms and conditions. The Ambulance Employers commit to work in partnership with the Ambulance Trade Unions (UNISON, GMB and UNITE) to seek to resolve these wider issues.

In particular:

- In relation to Sickness / Unsocial hours allowance payment; to curtail discussions for the move away from Annex E unsocial hours enhancements. To curtail discussions around a move towards section 2a unsocial hours under A4C. To suspend immediately any further work to test, in the High Court, the national agreement on sick pay which relates to the NHS Employers and the Ambulance Service Employers view that the original agreements included the Ambulance Service Sector. This issue would instead be remitted to the wider talks on further AfC reform.
- Ambulance Employers to introduce a scheme whereby they will match the value of additional pension contributions made by front line ambulance staff to enable them to take their 2015 pension unreduced at 65. For instance if the cost of this was 4%, the employer would pay 2%.
- Ambulance employers to work with the ambulance unions to address current recruitment and retention issues, either through changes to use of job profiles and bandings or through application of recruitment and retention premia to job roles meeting agreed criteria.
- Ambulance Employers will take forward with Ambulance Unions work a specific work stream under the NHS Staff Council Working Longer Review identifying the specific challenges for front line ambulance staff of the increase in pension age and how they can be addressed.

Annex E: NHS Pension Scheme membership rate and trends

	FTE	% with pension contributions	% point change		
			May 2016	Apr 2016 and May 2016	May 2015 and May 2016
All	1,027,100	89%	0.3%	0.9%	4.5%
Staff Groups					
Doctor	104,048	92%	0.4%	0.1%	0.6%
Qualified nursing, midwifery & health visiting staff	306,851	91%	0.4%	0.6%	3.2%
Qualified Scientific, therapeutic and technical staff	129,085	93%	0.3%	0.3%	2.3%
Qualified Ambulance Staff	18,395	95%	-0.2%	-0.8%	-0.3%
Support to Clinical Staff	305,280	87%	0.4%	1.6%	7.7%
Central Functions & Hotel, Property & Estates	129,320	84%	0.3%	1.6%	6.9%
Managers	30,103	91%	0.0%	-0.4%	-2.0%
All Non-Medical	923,052	89%	0.3%	1.0%	4.9%
AfC Band					
1	24,512	77%	1.3%	3.4%	14.0%
2	151,065	85%	0.4%	2.3%	9.8%
3	120,487	87%	0.2%	1.3%	6.7%
4	80,532	89%	0.3%	1.1%	4.7%
5	209,006	89%	0.4%	0.6%	3.7%
6	166,330	92%	0.3%	0.5%	2.4%
7	98,934	93%	0.2%	0.0%	0.5%

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8a	33,343	94%	0.1%	-0.3%	-0.4%
8b	13,571	94%	0.0%	-0.3%	-1.1%
8c	7,212	94%	0.2%	-0.2%	-1.1%
8d	3,489	94%	0.0%	-0.3%	-2.4%
9	1,243	94%	0.2%	-0.2%	-2.5%
Non AfC	117,378	90%	0.3%	0.0%	2.3%

Notes

Please be aware that these figures are based on data from the Electronic Staff Record (ESR) Data Warehouse. This is the HR and payroll system that covers all NHS employees other than those working in General Practice, two NHS Foundation Trusts that have chosen not to use the system, and organisations to which functions have been transferred, such as local authorities. ESR data is not centrally validated and its reliability is subject to local coding practice

The measure of pension membership rates is based on the proportion of records where the employer made a pension contribution.

The percentage rates are based on headcount data.