



NHS Pay Review Body

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Thirtieth Report 2017

Chair: Jerry Cope



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

**Presented to the National Assembly for Wales by the First Minister
and the Cabinet Secretary for Health, Well-being and Sport**

**Presented to the Northern Ireland Assembly by
the Minister for Health¹**

March 2017

Cm 9440

¹ In the absence of a Northern Ireland Executive at the time of publication, this report was presented to the Permanent Secretary of the Department of Health in Northern Ireland.



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NHS Pay Review Body

The NHS Pay Review Body (NHSPRB) is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health and Sport in Scotland, the First Minister and the Cabinet Secretary for Health, Well-being and Sport in Wales, and the First Minister, Deputy First Minister and Minister for Health in Northern Ireland, on the remuneration of all staff paid under Agenda for Change and employed in the National Health Service (NHS).²

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

- the need to recruit, retain and motivate suitably able and qualified staff;
- regional/local variations in labour markets and their effects on the recruitment and retention of staff;
- the funds available to the Health Departments, as set out in the Government's Departmental Expenditure Limits;
- the Government's inflation target;
- the principle of equal pay for work of equal value in the NHS;
- the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

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

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

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

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

Members of the Review Body are:

Jerry Cope (Chair)
Bronwen Curtis CBE
Patricia Gordon³
Joan Ingram
Shamaila Qureshi⁴
Professor David Ulph CBE
Professor Jonathan Wadsworth²
Lorraine Zuleta

The secretariat is provided by the Office of Manpower Economics.

² References to the NHS should be read as including all staff on Agenda for Change in Health and Social Care Trusts in Northern Ireland.

³ Professor Jonathan Wadsworth was appointed to the NHS Pay Review Body in April 2016. Patricia Gordon was appointed to the NHS Pay Review Body in November 2016.

⁴ Shamaila Qureshi was unable to take part in consideration of this year's report but remains a full Member of the Review Body.

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NHSPRB Thirtieth Report 2017

Executive Summary

Our 2017/18 recommendations on the pay uplift are:

- We recommend a 1 per cent increase to all Agenda for Change pay points from 1 April 2017 in England, Wales and Northern Ireland.
- We recommend a 1 per cent increase to the High Cost Area Supplement minimum and maximum payments.

In addition:

- We recommend that pay point 1 in Northern Ireland is adjusted so it is above the 2017/18 level of the National Living Wage.
- The Health Departments in England, Wales and Northern Ireland should ensure that annual pay awards do not have unintended consequences in reducing the take-home pay of staff whose pay award causes them to cross pension contribution thresholds.

A list of our additional observations is included at the end of this summary.

Our remit

1. Each of the four nations of the United Kingdom asked us to make recommendations in relation to the remuneration in 2017/18 of the 1.3 million Agenda for Change staff employed by the NHS and by Health and Social Care Trusts in Northern Ireland.
2. Our report and recommendations are produced in the context of significant affordability pressures facing the NHS across the UK, with increasing demand for healthcare being accommodated within budgets that are broadly flat in real terms. All four nations are attempting to meet demanding efficiency targets and cope with significant day-to-day service requirements at the same time as delivering transformational change through service redesign and introducing new models of care.
3. Public sector pay policy has been set out by the UK Government until 2019/20 and provides the context for our recommendations in England. The policy position for Scotland, Wales and Northern Ireland continues to be short-term, covering 2017/18 only.
4. The Scottish Government provided us with its remit and evidence very late in the process due to the postponement of their Draft Budget for 2017/18. As a result, we have been unable fully to consider pay recommendations for Scotland in this report and instead will produce a separate supplement covering Scotland. While we understand the factors that led the Scottish Government to postpone submitting evidence to us, late evidence constrains the time available for us and for other parties to consider, reflect upon and respond to the evidence. We urge all parties to submit timely evidence in future pay rounds.

Overall reflections

5. It is clear that current public sector pay policy is coming under stress. There are significant supply shortages in a number of staff groups and geographical areas. There are widespread concerns about recruitment, retention and motivation that are shared by employers and staff side alike. Inflation is set to increase during 2017 compared to what was forecast leading to bigger cuts in real pay for staff than were anticipated in 2015, when current public sector pay policy was announced by the new UK Government. Local pay flexibilities to address recruitment and retention issues are not being used to alleviate the very shortages they were designed to address. Our judgement is that we are approaching the point when the current pay policy will require some modification, and greater flexibility, within the NHS.
6. Pay matters for the attractiveness of the service. Potential future staff will be more sensitive to pay than existing staff are. The impact on supply of the changes in student funding in England is still uncertain, but there is a risk of an adverse impact and early signs of falls in application numbers. Take-home pay is important for existing NHS staff and many saw a cut in their take-home pay in cash terms in 2016/17, whilst at the same time their workloads were increasing.
7. There is no people strategy for the NHS linked to the delivery of the Five Year Forward View in England which is leading to workforce issues being neglected, with a piecemeal and short-term approach to the role of pay and inertia at local level. We set out our views on this, and in relation to the people strategy in Wales and Northern Ireland, in more detail in Chapter 6.

The Economy, Labour Market and Pay

8. The overarching economic context for this pay round is the outcome of the EU Referendum and the uncertainty this has brought. However, economic growth continued to be steady in 2016, and inflation continued to be below the UK Government's target, though was starting to increase in the second half of the year. Employment growth continued with the employment rate remaining close to historic highs. Private sector earnings growth continued to be above inflation and was significantly above public sector earnings growth.

Affordability, Efficiency and Productivity

9. There remains a big affordability challenge in each of the four nations of the UK. There is evidence of increasing strain on healthcare providers and serious difficulties in achieving the required efficiency savings and productivity improvements while delivering good quality patient care within the funding envelope. It is hoped that service transformation can fill a large part of the funding gap. We feel that it would be helpful to consider the different ways in which the gap between rapidly increasing demand pressures and plans for slow funding increases can be bridged and discuss this further in Chapter 3. We are concerned that holding down pay has become the default position for making efficiencies, as service transformation is not yet delivering. Reliance on pay to meet the affordability challenge risks putting further pressure on the real wages of NHS staff and creating a perception of unfairness, which could be counter-productive due to its impact on recruitment, retention and motivation.

Recruitment, Retention and Vacancies

10. We do not see significant short-term nationwide recruitment and retention issues that are linked to pay. There are shortfalls of professional staff in some occupations, including nursing and paramedics, with reported shortfalls concentrated in London, the Home Counties, the East of England and the East Midlands. There are similar problems in Wales and Northern Ireland. While there are issues in recruiting sufficient professional staff to cover demand in some areas, the joining rate increased in every staff group, and the NHS workforce increased in size in virtually every staff group in every country in the UK. However, home-grown recruitment remains insufficient to meet demand in some professional groups, with reliance on overseas nationals to narrow the gap.
11. The gap is also being filled by agency staff, as well as by Bank staff and a higher incidence of paid and unpaid overtime. There have been large increases in agency expenditure in recent years in all four nations of the UK and there is now a central focus, starting in England, on driving agency costs down. If the NHS wants further to reduce agency usage, trusts and health boards will need to go beyond expenditure controls and consider how they can incentivise agency staff to join the NHS as permanent staff, or to work their additional hours via staff banks. Staff see that money is being spent on agency staff, and see this as contradictory to the pay policy that is applied to them. This is demotivating and it is apparent that there needs to be a better understanding of the optimal mix between substantive staff, overtime, bank working and agency staff, with recognition that there is a total cost to employing people in the NHS that goes beyond the employed staff pay bill. We discuss this further in Chapters 3 and 4.

Motivation, Satisfaction and Staff Engagement

12. It is clear that NHS staff continue to be highly motivated. However, the picture is more complicated than this. There is also evidence that staff are under increasing pressure, have concerns about the quality of care they can give, and feel that they are not valued. There is a consensus among employers and staff side that morale is falling. This is a concern as it could translate into low engagement with the service reforms necessary to respond to the demands on the service and deliver patient care.

Workforce Planning, Future Supply and the People Strategy

13. NHS workforce planning in England has come under intense scrutiny, and there are signs of renewed emphasis on this in Wales and Northern Ireland also. There are a lot of uncertainties in both projections of service demand and workforce supply. This is inevitable to a degree given the risks associated with the impact of the EU referendum on a key source of supply and with the reforms to student funding arrangements in England, as well as the service transformation that is on the horizon. We support the improvements being made to workforce planning but note that there is no consensus amongst the parties about what the role of pay might be in future supply and workforce planning.
14. We believe there are real opportunities for apprenticeships to become a valued source of professional staff to the NHS, especially by providing clear career pathways for support staff to progress as their skills and experience increase. However, there are risks of a short-term tactical approach, focused entirely on meeting the targets and recouping Levy payments, which would mean that these opportunities are not maximised.

Pay Recommendations for 2017/18

15. We were told by the Health Departments in England and Wales that a 1 per cent pay award is funded and by the Health Department in Northern Ireland that a 1 per cent pay award was being factored into budget considerations. It is clear that a pay award higher than 1 per cent would require trade-offs in terms of service levels, investment decisions and potentially staff numbers, with associated implications for workload and pressures on staff and service delivery unless accompanying actions were taken to manage demand.
16. The evidence of very serious affordability pressures, no significant nationwide recruitment and retention issues related to pay, and suggestions that reducing workload pressures could have a positive impact on staff morale, made us give serious consideration to the case for a nil pay award. However, as we have said in previous years, and employers and staff side both made clear in their evidence to us, public sector pay policy for a 1 per cent increase has set staff expectations. There is a consensus among all evidence providers that the negative impact on staff morale of a pay award below 1 per cent is not worth the relatively small financial benefit, even if this flowed through to increases in staffing levels as opposed to reducing deficits. A pay award has the virtues of being immediate, visible, uniform and attributable.
17. With inflation having increased in recent months and forecast to rise further during 2017, and private sector wage settlements running at around 2 per cent, we are also very aware that a 1 per cent pay award implies a greater real terms cut in the value of pay than previously anticipated. We discuss this further in looking at pay policy over the medium term.
18. There was no support from evidence providers for targeting pay at a national level through Agenda for Change pay scales, within the 1 per cent pay envelope. Reasons cited included the lack of a robust evidence base, the limited positive impact that targeting within a 1 per cent award could have, the significant negative impact on morale of giving some staff a pay award lower than 1 per cent and worries among employers about how targeted recommendations would be funded at a local level.
19. There is, however, clearly a case for pay targeting given that there are recruitment and retention pressures in certain occupational groups and in some geographical areas. As we said last year, targeting at a national level through Agenda for Change is a blunt instrument. There are already appropriate mechanisms within Agenda for Change that enable trusts to target pay to address local recruitment and retention needs. However, as we discuss in Chapter 4, the fact that the use of Recruitment and Retention Premia (RRPs) is dwindling alongside an increase in the very pressures they are intended to alleviate suggests that there is a serious problem for local management, who feel unable, or unwilling, to use RRP in practice.
20. The evidence shows that recruitment and retention pressures and staff shortages are more severe in London and the surrounding areas. The High Cost Area Supplement (HCAS) does not appear to fully compensate staff for the additional costs of living and working inside London and the surrounding areas. There are also cliff edge effects around the HCAS boundaries that are a key driver of staff shortages in large parts of the Home Counties. Yet none of the parties proposed any changes to HCAS beyond uplifting it in line with the main pay award. We have taken a cautious approach as a result.
21. We considered the proposal made by Staff Side in favour of levelling pay in every UK country up to its level in Scotland. We did not hear any persuasive evidence that this would have any significant benefits in terms of recruitment, retention and motivation and there is no evidence of existing differentials causing cross-border issues. Differences in pay are an inevitable feature of devolved health policy.

Having weighed up all these factors, we recommend a uniform 1 per cent increase to all Agenda for Change pay points from 1 April 2017 in England, Wales and Northern Ireland.

We recommend a 1 per cent increase to the High Cost Area Supplement minimum and maximum payments.

22. There are still a number of unanswered questions about how each of the four nations will implement the National Living Wage. The key issue for us is how pay differentials will be maintained in order to incentivise staff to take on progressively more skilled and responsible roles. We continue to consider the National Living Wage to be a social policy with no compelling recruitment and retention reasons to support higher increases to lower paid groups in the NHS. We do not support the proposition to use the funding available for general pay awards intended to support recruitment and retention in the NHS to meet the cost of implementing the National Living Wage.
23. In the absence of clear answers to these implementation questions, we recommend that pay point 1 in Northern Ireland is increased to ensure compatibility with the National Living Wage.
24. In Wales, we note that the implementation of the Living Wage Foundation living wage has already led to significant pay compression. We are concerned about the impact this could have on staff in roles requiring more responsibility, skills and experience than entry-level roles at the bottom of the pay scale.

We recommend that pay point 1 in Northern Ireland should be adjusted so that it is above the 2017/18 level of the National Living Wage.

25. The tiered structure of pension contribution rates combined with the fixed nominal value of contribution thresholds led to the unintended and perverse consequence of the 2016/17 pay award translating into a significant reduction in take-home pay for some staff since it has led to them crossing contribution threshold boundaries. We believe that action is required to ensure that the annual pay award has the intended effect of increasing, rather than decreasing, take-home pay for all staff.

The Health Departments in England, Wales and Northern Ireland should ensure that annual pay awards do not have unintended consequences in reducing the take-home pay of staff whose pay award causes them to cross pension contribution thresholds.

Pay Policy over the Medium Term

26. The evidence we have received gives us cause for concern about the sustainability of public sector pay policy over the next few years. Inflation is already higher than previously expected. There are also pressures stemming from changes in the UK's relationship with the EU and from changes in the student funding system in England, which heighten the need for the NHS pay and employment offer to be attractive. We agree with NHS England that NHS pay will need to keep pace with private sector pay over the medium-term to recruit and retain staff.
27. We are concerned that, in too many places, the default strategy to deal with significant increases in patient demand within a slowly increasing budget is by expecting NHS staff to work more intensively, in more stressful working environments, for pay that continues to decrease in real terms. We do not consider this a sustainable position.

28. We believe greater consideration needs to be given to the medium-term supply position of the NHS. The current rigid pay policy could be storing up problems for the future. The question is how, and when, to introduce greater flexibility. Should the government wait until there is evidence of significant damage to recruitment, retention and motivation outcomes? Or is there an argument that action now will save money in the medium-term by avoiding future supply shortages becoming critical? It is conceivable also that greater flexibility in pay policy could drive bigger gains for patient outcomes by, for example, using it as an opportunity to reform Agenda for Change to incentivise productivity improvements and efficiency savings.
29. It is crucial that the parties think about these questions, rather than wait for problems to overtake them. One possibility would be if the Government allowed targeting to alleviate recruitment and retention problems from *outside* of the one per cent cap. This would require funding to be provided appropriately.

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15 February 2017

Our additional observations:

- It is important to understand and monitor trends over time in **take-home pay** as well as in gross pay as this conditions the impact of pay awards on recruitment, retention and motivation. We would welcome evidence on this matter in future submissions.
- We repeat our request from last year for the health departments to improve the **evidence on the drivers of pay bill trends** over time and agency expenditure, not only to support the pay review process but to enable the service to be well managed.
- While progress has been made, more work needs to be done to provide a robust set of **workforce data** covering fill rates, vacancies and attrition rates by staff group and geographical area, not only to allow us to develop a sophisticated picture about what is happening to inform our recommendations but also to enable effective national and local planning.
- The next phase of work on the **use of agency staff** needs to move beyond the necessary initial focus on short-term 'crisis management' measures to control rapid increases in expenditure, towards a more strategic approach. This should mean more deliberate management of the mix between different ways of hiring staff based on an improved understanding of how pay and the employment offer affect supply and overall costs.
- The agreement reached on the **Agenda for Change** banding position of paramedics could provide a template for the NHS for making changes to services to improve productivity by: ensuring that job profiles evolve to match changes to NHS roles; encouraging and incentivising staff to make the effort to support improvements in productivity by allowing them to share in some of the benefits to the NHS of doing so; and recognising additional skills, expertise and responsibilities that result from changes.
- The **National Living Wage** will begin to affect Agenda for Change pay scales from April 2017. Governments across the UK need to clarify arrangements for paying the National Living Wage in the NHS including whether they intend to incorporate it into Agenda for Change or pay it as a supplement to eligible staff and what action they will take to avoid compression of pay differentials. They also need to clarify funding arrangements – we continue to have serious doubts about any proposition to fund a social policy such as the National Living Wage from funding intended for general pay awards to support recruitment and retention.
- The Welsh Government needs to take action to address the impact of the Living Wage Foundation living wage on **pay compression** to tackle potential motivation and recruitment issues.
- **Pay policy is now coming under greater stress than for several years, especially with the likelihood of rising inflation, and we are approaching the point when greater flexibility may be needed in the NHS.** It is crucial that health departments think beyond next year, to how pay policy might drive gains for patient outcomes and enable reform of Agenda for Change. This is not to understate the financial pressures facing the NHS – they are clearly considerable – but staff in the NHS cannot, as NHS England have always made clear, be paid materially less than workers in the economy as a whole over the medium-term.
- **To help manage the transition to an exit from current pay policy,** the Government should consider making pay policy more flexible, perhaps by allowing targeting to alleviate recruitment and retention problems from *outside* of the one per cent cap which would require funding to be provided appropriately. Linked to this, as we have said in previous reports HR expertise at a local level is needed.

Chapter 1 – Introduction

Introduction

- 1.1 For 2017/18 we received remits from the UK Government, the Scottish Government, the Welsh Government and the Northern Ireland Executive.⁵ More detail on the remits is provided later in this chapter.
- 1.2 We have considered the remits in relation to our standing terms of reference and set out the evidence from the parties presented on these matters, together with our conclusions and recommendations, under each of these elements.⁶

Structure of the report

- 1.3 This report is divided into chapters, which include:
 - Introduction.
 - Economy, labour market and pay.
 - Affordability, efficiency and productivity.
 - Recruitment, retention and vacancies.
 - Motivation, morale and staff engagement.
 - Workforce planning, future supply and the people strategy.
 - Pay proposals, recommendations and observations.
- 1.4 The appendices consist of:
 - Appendix A: Remit letters.
 - Appendix B: Recommended Agenda for Change pay scales with effect from 1 April 2017 for England, Wales and Northern Ireland.
 - Appendix C: Composition of our remit group.
 - Appendix D: Links to written and supplementary evidence.
 - Appendix E: Previous reports published by the Review Body.
 - Appendix F: Abbreviations used in this report.
 - Appendix G: Workforce monitoring data.

Twenty-Ninth Report 2016

- 1.5 Our *Twenty-Ninth Report* was submitted to the Prime Minister, the Secretary of State for Health and the relevant Ministers of the devolved nations on 1 March 2016. We recommended a 1 per cent increase to all Agenda for Change pay points and to High Cost Area Supplements minima and maxima from 1 April 2016.
- 1.6 Our recommendations were accepted by the United Kingdom Government, the Welsh Government and the Northern Ireland Executive. The Scottish Government also accepted our recommendations and, in addition, topped up the pay awards of staff whose full-time equivalent basic pay was below £22,000 to ensure that all pay points were above the Scottish Living Wage and that pay points 3-16 were uplifted by at least £400, in line with Scotland's Public Sector Pay Policy. Scotland also discontinued the use of pay point 2.

⁵ Where we refer to the Scottish Government, Welsh Government and Northern Ireland Executive we are referencing the Health Departments in the respective countries.

⁶ The NHSPRB terms of reference can be found at page iii of this report.

Remits for this report

- 1.7 The remit letters from each of the four countries are included in full at Appendix A and summarised below.

HM Treasury

- 1.8 The Chief Secretary to the Treasury wrote to us on 13 July 2016 asking for pay recommendations for 2017/18. The letter emphasised that the fiscal context remains very challenging following the outcome of the EU Referendum vote and confirmed that the UK Government's Public Sector Pay Policy announced at the Summer Budget 2015 remained in place, with the UK Government funding public sector workforces for pay awards of an average of 1 per cent per year until 2019/20.
- 1.9 It also set out the Chief Secretary's expectation that the 2017/18 pay award be targeted to support service delivery and address recruitment and retention pressures. The letter was explicit that there should be no expectation that every worker will receive a 1 per cent pay award and that pay targeting could mean that some workers may receive more than 1 per cent while others receive less.

Department of Health for England

- 1.10 The Secretary of State for Health wrote to us on 22 August 2016 requesting pay recommendations for 2017/18. The letter stated that the NHS is facing unprecedented challenges. It also highlighted the importance of public sector pay restraint to the Government's management of the public finances and noted that this continued to present challenges for the NHS.
- 1.11 The letter continued by noting that the Chief Secretary to the Treasury had asked us to consider how an award might be targeted to support recruitment and retention. It stated that the Department recognised the importance of pay investment in supporting the recruitment and retention of NHS staff. It acknowledged that our previous reports had concluded better data would be required to enable the Review Body to take an evidence-based view of recruitment and retention and to allow consideration of whether there is a case for pay targeting. The letter committed to setting out the Department's progress on this in their evidence.

Scottish Government

- 1.12 The Cabinet Secretary for Finance and Constitution wrote to us on 30 September 2016 requesting pay recommendations for 2017/18. The letter stated that the Scottish Government's Draft Budget and Public Sector Pay Policy for 2017/18 would not be published until the week commencing the 12 December due to uncertainties about potential changes the UK Government could make to future public spending allocations in the Autumn Statement on 23 November. It went on to say that this would require late submission of evidence and envisaged recommendations for Scotland being made later than elsewhere in the UK as a result.
- 1.13 The Cabinet Secretary for Health and Sport wrote to us on 20 December 2016 providing further details of the remit. The letter outlined the main features of the Scottish Government's Public Sector Pay Policy for 2017/18, which formed the basis for the remit: an overall 1 per cent cap on the cost of the increase in basic pay for those earning more than £22,000; continued commitment to paying the Scottish Living Wage; a guaranteed minimum increase of £400 for staff earning £22,000 or less; and an expectation of extensions to no compulsory redundancy agreements. It also said that it would be important for the Review Body to take into account the considerable ongoing financial challenges facing NHS Scotland and noted that any pay increase had to be affordable.

Welsh Government

- 1.14 The Cabinet Secretary for Health, Well-being and Sport wrote to us on 22 August 2016 requesting pay recommendations for 2017/18. The letter said that recommendations should take into account the UK Government's Public Sector Pay Policy as well as the recruitment and retention challenges faced by all UK health departments.

Northern Ireland Executive

- 1.15 The Minister for Health wrote to us on 3 August 2016 requesting pay recommendations for the 2017/18 pay round. The letter stated that the Northern Ireland Executive has endorsed the principle of adherence to the UK Government's Public Sector Pay Policy and noted that pay proposals made by the Department would be constrained by HM Treasury's calls for continued pay restraint, as well as the continued financial challenges faced by the Department.

Our comment on the remits

- 1.16 Our remit covers the 1.3 million Agenda for Change staff in England, Scotland, Wales and Northern Ireland. The detailed composition of our remit group can be found at Appendix C.
- 1.17 The remits for 2017/18 have some similarities: each of the UK nations emphasises the importance of continued pay restraint to meet the financial challenges facing the NHS across the whole country, with all UK Governments proposing to fund pay awards of 1 per cent for all or the majority of staff. However, there are important differences.
- 1.18 First, while the Agenda for Change framework continues to operate on a UK-wide basis, there are differences in pay rates in each of the four countries, with NHS staff in Scotland getting paid the most and NHS staff in Northern Ireland getting paid the least, albeit the differences in pay are relatively small across much of the pay structure (though percentage differences are bigger for staff in Bands 1-4). England and Scotland have also removed some pay points at the bottom of the pay structure. These differences are due to a divergence in pay awards and pay policy across the UK since 2014. Staff Side proposed to us in their evidence that pay rates across the UK be harmonised, levelling pay up to Scotland. We give full consideration to this proposal, alongside our consideration of whether to make UK-wide recommendations or specific awards in each country, in Chapter 7 based on the evidence presented to us by all of the parties.
- 1.19 Second, the UK nations each have different social policy objectives that they are trying to achieve which impact on their pay proposals:
- The Scottish Government proposes that all members of staff paid less than £22,000 should receive an award of £400 – i.e. at least 1.8 per cent – with all NHS staff continuing to be paid at least the Scottish Living Wage (£16,522 for full-time NHS staff in 2017/18). This will increase the overall cost of the pay policy above 1 per cent. For comparison, pay point 3 – the lowest pay point in use in Scotland – is currently worth £16,132.
 - The Welsh Government proposes that all NHS staff in Wales will continue to receive the Living Wage set by the Living Wage Foundation (£16,522 for full-time NHS staff in 2017/18) via adjustments to local NHS pay scales.
 - All employees in the UK aged 25 and over who are not in the first year of an apprenticeship are legally entitled to the National Living Wage (which we calculate to be £14,665 for full-time NHS staff from April 2017). This will begin to affect Agenda for Change pay scales Northern Ireland from 2017/18 and those in England from 2018/19. While NHS staff in Wales will not be directly affected due to the adjustments that are made to local NHS pay scales to ensure everyone is paid at least the Living Wage Foundation living wage, the National Living Wage will also begin to affect national Agenda for Change pay scales in Wales from 2017/18.

1.20 Third, there are differing views on pay targeting. We will explore the issue of pay targeting in more detail in Chapter 7:

- The UK Government continues to have an ambition for the pay award to be targeted where this can be shown to benefit recruitment and retention. However, pay targeting is not proposed by the Department of Health for England this year based on their assessment that there is no evidence that targeting the 1 per cent award would resolve any significant recruitment and retention issues and might affect motivation adversely.
- The Scottish Government proposes to target the pay award for social reasons, with staff paid less than £22,000 receiving higher percentage increases than other staff (see above). They are neutral on pay targeting for recruitment and retention purposes, explicitly noting that there is no assumption that individual members of staff will receive an uplift of 1 per cent but making no proposals for targeting.
- The Welsh Government is explicit that targeting pay to staff groups is not an approach that they would wish to consider.
- The Northern Ireland Executive made no proposals for pay targeting this year.

Parties giving evidence

1.21 We received written evidence from the organisations listed below for this round:

Government Departments and Arm's Length Bodies

Department of Health for England
Health Education England
NHS England
NHS Improvement
Northern Ireland Executive
Scottish Government
Welsh Government

Employers' Bodies

NHS Employers
NHS Providers

Bodies representing NHS Staff

Chartered Society of Physiotherapy
Joint Staff Side
Royal College of Midwives
Royal College of Nursing
UNISON
Unite

Other Bodies

The NHS Staff Council

1.22 We also received an update letter from the Association of Ambulance Chief Executives.

- 1.23 We held oral evidence sessions over four days during November 2016, December 2016 and January 2017 with the following parties:

Government Departments and Arm's Length Bodies

Department of Health for England (with the Minister of State for Health and officials from the Department of Health and HM Treasury)

Health Education England

NHS Improvement

Northern Ireland Executive (with officials and representatives from employers in Northern Ireland)

Scottish Government (with the Cabinet Secretary for Health and Sport, officials and representatives from employers in Scotland)

Welsh Government (with officials and representatives from employers in Wales)

Employers' Bodies

NHS Employers

NHS Providers

Bodies representing NHS Staff

Joint Staff Side (with representatives from the Chartered Society of Physiotherapists, the GMB, the Royal College of Nursing, the Royal College of Midwives, UNISON and Unite)

- 1.24 Our work programme to produce this particular report included eleven Review Body meetings in which we considered the written and oral evidence, examined information on the economy and labour market and formed our conclusions, observations and recommendations.
- 1.25 We thank all of the parties for the time and effort they spent in developing their written evidence submissions and in preparing for and attending oral evidence sessions. Last year we highlighted the importance of parties meeting the deadlines we set for evidence to ensure both that we have sufficient time to consider and interrogate it, and that all parties have sufficient time to comment and respond to each other's evidence. This year we received written evidence from all parties in England by our deadline of 30 September. The Welsh Government submitted evidence on October 21 and the Northern Ireland Executive submitted evidence on the 27 October. We look to all parties to meet our deadlines in the next pay round.
- 1.26 The Scottish Government informed us at the start of the pay round that they would be unable to submit evidence to us by our deadline due to the knock-on effect of the decision to delay publishing their Draft Budget 2017/18 until after the UK Government's Autumn Statement on 23 November. We received evidence from them on 20 December. As a result, we were unable fully to consider pay recommendations for Scotland during the main UK pay round and will be producing a separate supplement to this report later in March which will cover Scotland. However, as this remains a UK-wide report, it does include coverage of factual evidence on the situation in Scotland, including workforce data.
- 1.27 While we understand the factors that led Scotland to postpone submitting evidence to us, we are aware that this, combined with the Scottish Government's desire to receive recommendations in time to make a pay award in April 2017, has had an impact in constraining the time available for us and for other parties to consider, reflect upon and respond to the evidence. We also understand that all parties continue to value the pay review process being operated across the UK and note that late evidence puts this at risk by hampering our ability to consider the UK dimension to the workforce issues in each of the four countries.

- 1.28 We note the Government's intention to extend gender pay gap reporting to the public sector in England, and look forward to receiving evidence on how this relates to our remit group next year.

Review Body visits in 2016

- 1.29 Our annual programme of visits to NHS organisations provides important context for our considerations and is a crucial addition to the parties' evidence. The visits provide an opportunity to discuss the issues we consider directly with members of our remit group and with NHS management. We visit a number of organisations across the whole United Kingdom to ensure we hear a range of perspectives from people working in different types of NHS organisations and different parts of the country. We are very grateful to the staff who worked hard to organise our visits and to those who gave up their time in order to meet us.

- 1.30 Between May and July 2016 we visited the following organisations:

Luton and Dunstable University Hospital NHS Foundation Trust
Walsall Healthcare NHS Trust
South West Yorkshire Partnership NHS Foundation Trust
NHS Dumfries and Galloway
Northumbria Healthcare NHS Foundation Trust
Abertawe Bro Morgannwg University Health Board
Northern Health and Social Care Trust, Northern Ireland

Chapter 2 – The Economy, Labour Market and Pay

Introduction

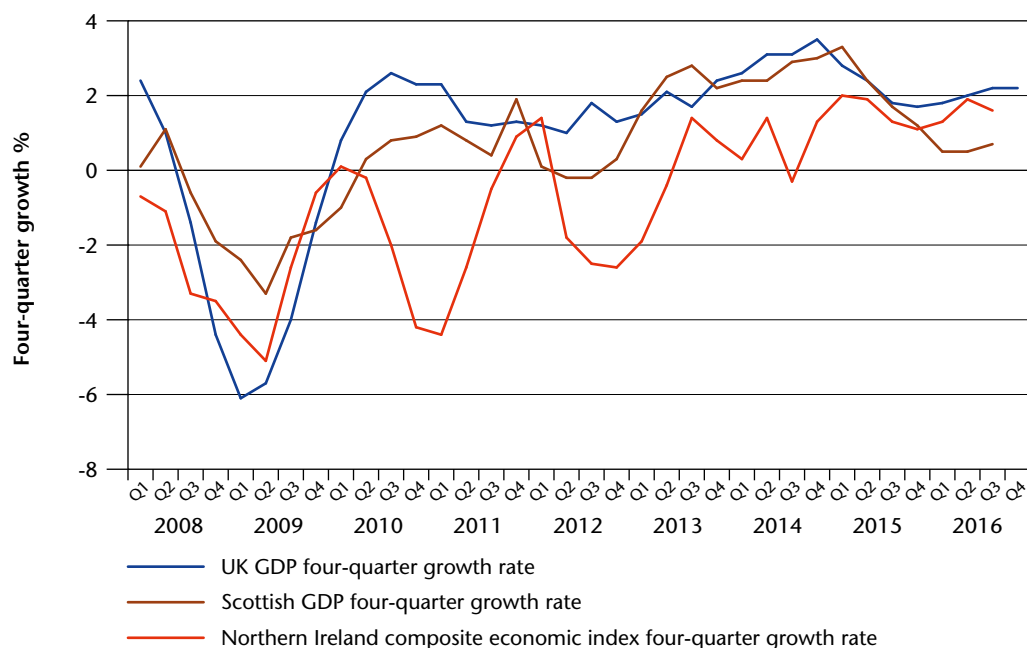
- 2.1 In this chapter we analyse the latest available data on the economy, the labour market and pay. This information provides important context to inform our consideration of pay recommendations for Agenda for Change staff. The parties' evidence was presented during autumn 2016 so reflects the position at that time. We conclude this chapter with an assessment of earnings, including take-home pay, of Agenda for Change staff, by drawing on NHS information and data from the 2016 Annual Survey of Hours and Earnings (ASHE). We also monitor data on membership of the NHS Pension Scheme.
- 2.2 In light of the outcome of the EU Referendum there is a higher degree of uncertainty about the likely performance of the economy over the next few years than in previous years. Many forecasts have been revised and all have large caveats around them.

The Economy

Economic Growth

- 2.3 We consider economic growth to be part of the broader context to our deliberations. It has implications for employment and earnings growth and for government finances via its impact on tax revenues and borrowing. These are all relevant to our consideration of pay.
- 2.4 Economic growth in the United Kingdom continues to be positive. Gross Domestic Product (GDP) grew by 2.0 per cent in 2016 as a whole compared to 2015. The Office for Budget Responsibility's forecast of economic growth for 2017 has been revised downwards to 1.4 per cent although some other forecasters are more optimistic. Some of the recent economic growth has been driven by an increasing population: GDP per head grew by 1.3 per cent in 2016 as a whole compared to 1.4 per cent in 2015. Since the pre-recession peak in the first quarter of 2008, the economy has grown by 8.7 per cent overall, while GDP per head has increased by 1.9 per cent.
- 2.5 Economic growth in Scotland fell behind the UK as a whole in 2016, having kept pace with UK-wide growth over the previous three years (see figure 2.1). Northern Ireland saw a triple-dip recession followed by positive but relatively slow growth over the last four years. The Scottish economy was 6.0 per cent bigger in the third quarter of 2016 than in the first quarter of 2008, the pre-recession peak for the UK economy. The Northern Ireland economy was 5.9 per cent smaller in the third quarter of 2008 than in the first quarter of 2008. For comparison, the UK economy grew by 8.1 per cent over the same time period. Separate GDP data is not available for Wales or England.

Figure 2.1: Annual growth in GDP, 2008 to 2016, UK, Scotland and Northern Ireland



Source: Office for National Statistics (ONS), Scottish Government, DETINI

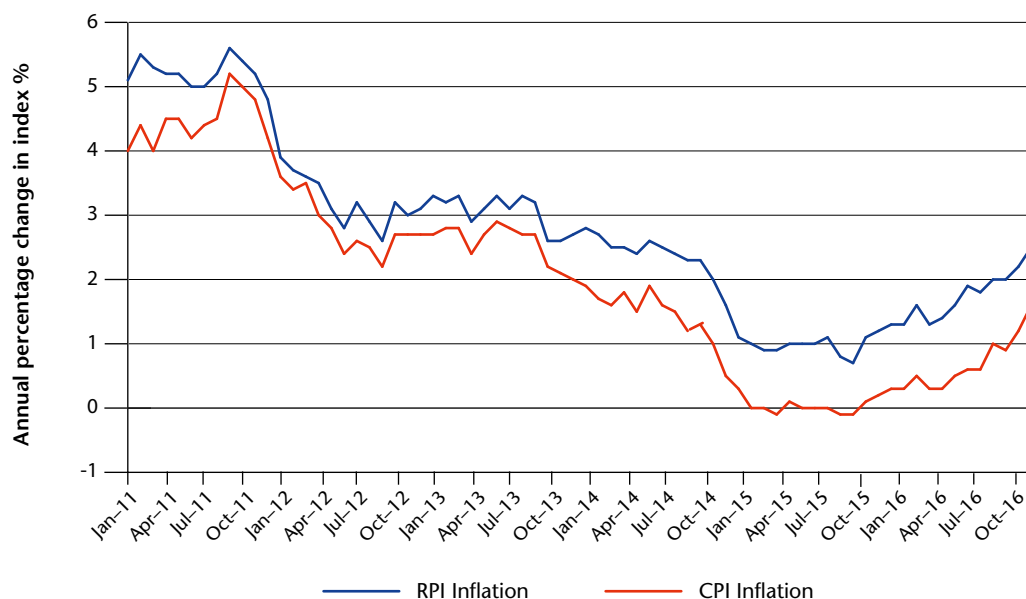
Inflation

- 2.6 We are interested in the rate of inflation as this tells us about changes in the cost of living. Our terms of reference also states that we must have regard to the UK Government’s inflation target.
- 2.7 In December 2016, Consumer Price Index (CPI) inflation was 1.6 per cent. Figure 2.2 shows that the CPI inflation rate has been steadily increasing over 2016, from 0.3 per cent at the start of the year, with the rate of increase accelerating in the second half of the year. Retail Price Index (RPI) inflation was 2.5 per cent in December 2016, an increase from 1.2 per cent in December 2015.
- 2.8 The most recent inflation forecasts (see table 2.1) suggest that inflation will continue to increase in 2017. CPI inflation is now forecast by the Office of Budget Responsibility to be about 2.5 per cent and RPI inflation 3.4 per cent in the fourth quarter of 2017, both 0.8 percentage points higher than was forecast in March 2016. The forecast increases in inflation and therefore the cost of living are largely because of rising oil prices and the depreciation of the pound over the last 12 months, leading to higher import prices.

Table 2.1: Inflation forecasts, Quarter 4

	OBR (November) %		Bank of England central projection (November) %	Treasury independent average (December) %	
	CPI	RPI	CPI	CPI	RPI
2017	2.5	3.4	2.8	2.8	3.3
2018	2.5	3.6	2.7	2.6	3.0
2019	2.0	3.1	2.5	2.0	3.1
2020	2.0	3.2	–	2.0	3.1

Figure 2.2: Inflation, 2011 to 2016



Source: ONS, CPI (D7G7), RPI (CZBH), monthly, not seasonally adjusted, UK, January 2011-December 2016

Box 1 – What is the right inflation rate to use to assess changes in the cost of living facing the remit group?

It is important for the Review Body to develop a good understanding of trends in real pay. There are several inflation indices published by the ONS which could be used for this purpose and each could lead to different conclusions about recent trends in real pay. There is no single measure of inflation; each of these indices was developed for a different purpose and they attempt to measure different things. There are differing views among the parties about which is most appropriate for measuring changes in the cost of living facing the remit group, with the Department of Health for England favouring CPI and Joint Staff Side favouring RPI.

Historically, the RPI has been used to measure changes in the cost of living. In recent years there have been concerns that issues with the technical way in which the RPI is constructed mean that it systematically overstates increases in the cost of living. These concerns led to the creation of the UK Consumer Price Statistics Review (the “Johnson Review”). This concluded that CPIH – a variant of CPI which includes housing costs – should become the main measure of inflation. This recommendation was accepted by the National Statistician, who has stated that *“RPI is not a good measure of inflation...I strongly discourage the use of RPI as a measure of inflation as there are far superior alternatives”*. Whilst the ONS do not regard CPI as a “cost of living” index, the CPI is now used by the ONS in their statistical releases to adjust nominal data on earnings and incomes for the impact of inflation.

However, the Royal Statistical Society has disputed the view that CPI is an appropriate measure of inflation to use for pay uprating purposes. They have noted that it was designed for macroeconomic purposes to, for example, provide internationally comparable rates of inflation, rather than as a measure of changes in the cost of living facing the average UK household and said that there is no real justification for using CPI or its variants for uprating purposes.

Instead, they recommend that a new Household Inflation Index be developed based on actual payments made by households and weighted to reflect spending of the average household (rather than to reflect total expenditure, as in CPIH) and that this becomes the headline recommended measure for uprating purposes to replace RPI. The ONS is in the process of developing such a measure.

We are attracted by the arguments made by the Royal Statistical Society. We are interested in changes in the cost of living faced by members of the remit group rather than internationally comparable economy-wide inflation pressures. In our view, none of the inflation indices currently published measures this adequately – with RPI exaggerating and CPI understating increases in the cost of living – and we believe that the true rate of inflation facing the remit group is likely to lie somewhere between the two.

Therefore, in this report we report real earnings figures based on both CPI and RPI. In the longer-term, we hope that the new Household Inflation Index being developed by ONS will resolve these issues and ultimately become the index we use in assessing changes in the cost of living facing the remit group.

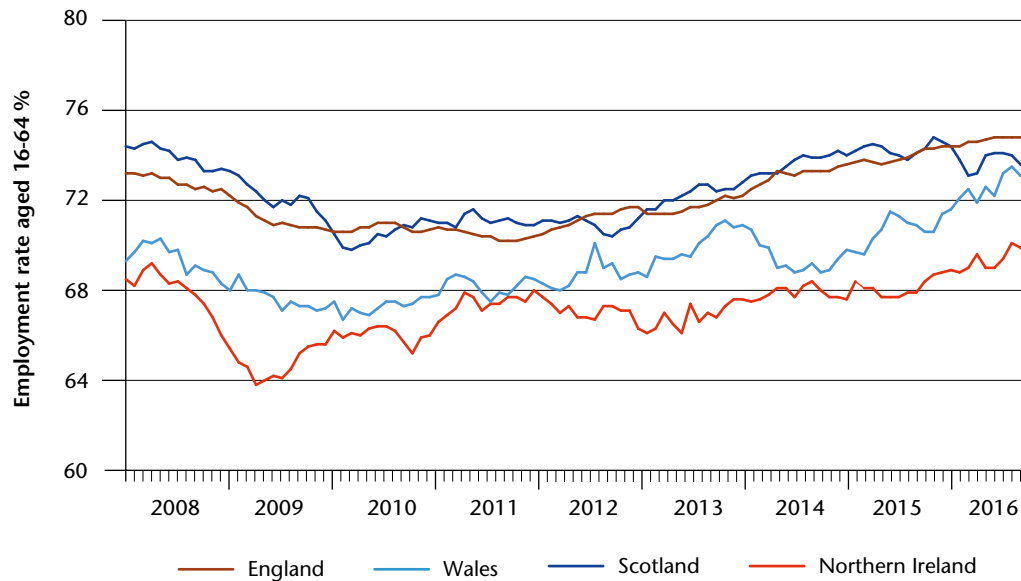
References

- UK Consumer Price Statistics: A Review, UK Statistics Authority, 2015
- Statement on Future Consumer Price Inflation Statistics in the UK, ONS, 10 November 2016
- Letter from Peter Diggle (President of the Royal Statistical Society) to John Pullinger (National Statistician) on the Review of Consumer Price Statistics, 6 February 2015, https://www.statisticsauthority.gov.uk/wp-content/uploads/2015/11/letterpeterdiggletojohnpullingerfeb1_tcm97-44434.pdf

Employment

- 2.9 We are interested in trends in employment and unemployment as these tell us about the wider labour market within which our remit group sit, including those driving pay, pay increases and labour shortages.
- 2.10 The employment level in the UK as a whole has grown by 294,000 in the year to November 2016 to reach 31.8 million people in work, with increases to both the number of people working full-time and part-time. The employment rate reached 74.5 per cent in November 2016, a record high, compared to 74.0 per cent a year earlier. The unemployment rate was 4.8 per cent in November 2016, down from 5.1 per cent a year earlier. It has not been lower since mid-2005.
- 2.11 The number of people employed in England continued to show strong growth in 2016, growing by 1.2 per cent in the year to October 2016, to reach an employment rate of 74.8 per cent, the highest on record. The employment rate in Scotland had reached a peak in October 2015, but since then the number of people employed has fallen by 0.9 per cent, to give an employment rate of 73.3 per cent in October 2016. Employment in Wales has shown particularly strong growth over the last two years, with the number of people employed growing by 2.8 per cent in the year to October 2016, to reach an employment rate of 72.9 per cent, a record high and well above pre-recession employment rates. Employment in Northern Ireland also showed strong growth of 1.9 per cent in the year to October 2016, to reach an employment rate of 69.5 per cent, also above the pre-recession employment rate.

Figure 2.3: Employment rates by country, 2008 to 2016

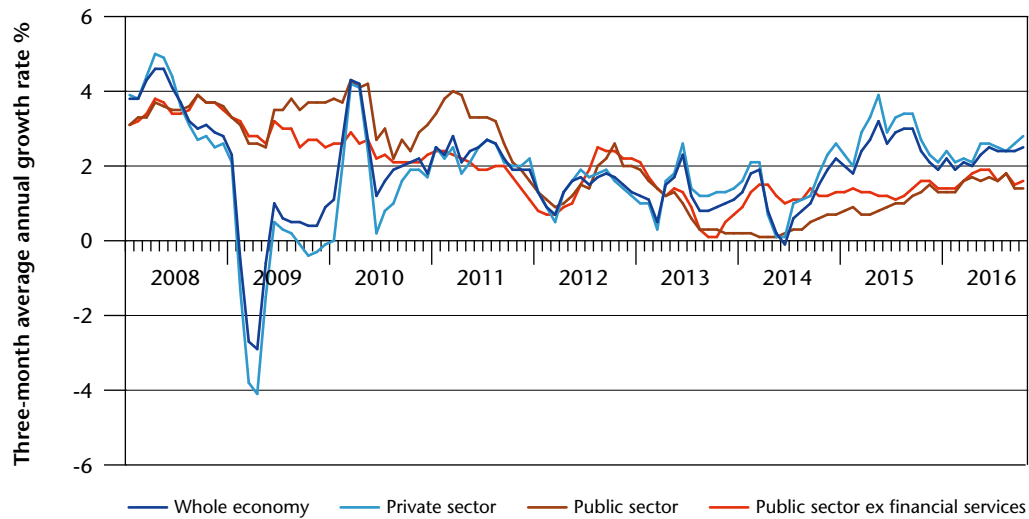


Source: ONS, Labour Force Survey (LF3Y, LF3Z, LF42, LF5Z)

Average Earnings Growth and Pay Settlements

- 2.12 We are interested in earnings growth in the economy as a whole as this can shed light on the competitiveness of pay of our remit group. It is important to note, however, the distinction between pay rates, which our remit relates to, and earnings, which capture pay in the widest sense.
- 2.13 The Average Weekly Earnings (covering Great Britain) series tracks movement in average nominal weekly earnings. Figure 2.4 presents time series data for average weekly earnings. Over the last two-and-a-half years private sector earnings growth has outstripped public sector earnings growth. In the 12 months up to November 2016 average private sector earnings growth was 3.1 per cent, whilst in the public sector average earnings growth was closer to 1.3 per cent.

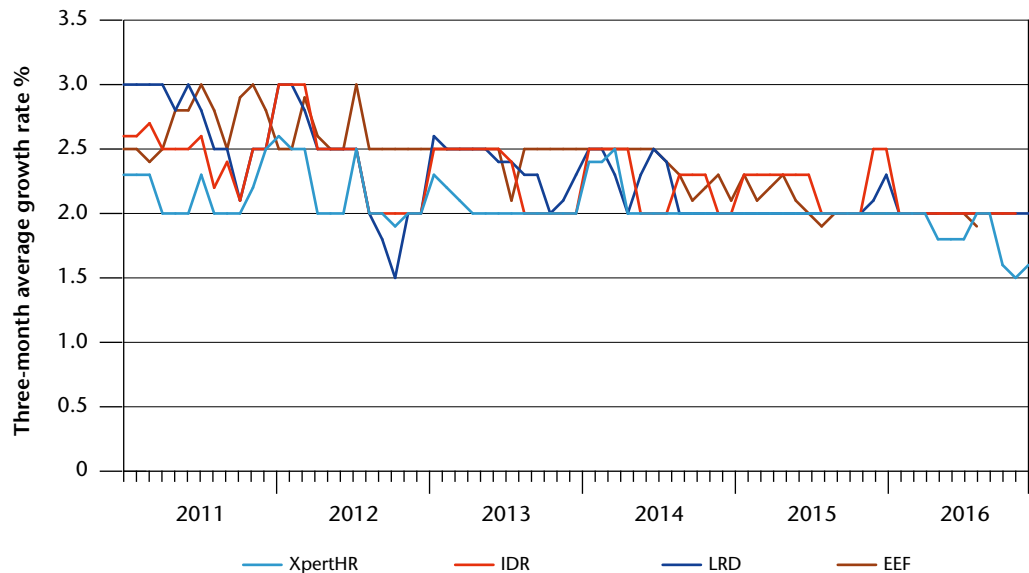
Figure 2.4: Average weekly earnings (total pay), three month average, 2008 to 2016



Source: ONS, average weekly earnings annual three-month average change in total pay for: the whole economy (KAC3); private sector (KAC6); public sector (KAC9); private sector excluding financial services (KAE2); monthly, seasonally adjusted, GB, 2008-2016

2.14 Pay settlements in the wider economy have been broadly stable, with the value of the median settlement at 2 per cent through 2016, similar to the previous three years (see Figure 2.5). The XpertHR median has dropped below 2 per cent in the most recent three month periods, partly due to a high proportion of public sector reviews being included in the most recent data, while the Engineering Employers' Federation has reported weaker pay bargaining, reflecting the poorer economic outlook in late 2016. This suggests that pressures on pay bargaining remain muted.

Figure 2.5: Pay settlements, 2011 to 2016 (three-month average)



Source: XpertHR, IDS/IDR, LRD, and EEF, pay databank records, three-month medians, UK, 2011-2016

Public-Private Sector Earnings Differential

- 2.15 Similarly to earnings growth and pay settlements in the previous section, we are interested in the public-private sector earnings differential as this tells us how competitive public sector earnings are relative to private sector earnings.
- 2.16 In 2016, the average gross annual earnings of people working full-time in the private sector in the UK were £34,810 – 2.8 per cent higher than average earnings in the public sector of £33,869. However, the private sector earnings premium is skewed by higher private sector earnings inequality: looking at median earnings – a better measure of the experience of the typical worker – public sector workers on average earned 12.3 per cent more than those in the private sector (with earnings of £30,586 compared to £27,227).⁷
- 2.17 Looking at trends over time, the Annual Survey of Hours and Earnings suggests that private sector median weekly earnings as a proportion of public sector median weekly earnings was fairly steady between 2010 and 2015 at around 85 per cent. This gap between public and private earnings narrowed in 2016, with private sector median weekly earnings 87 per cent of public sector weekly earnings, as median private sector earnings increased by 3.4 per cent while median public sector earnings increased by only 0.7 per cent. The introduction of the National Living Wage has led to a similar effect at the bottom decile of the earnings distribution as a far higher proportion of private sector workers than public sector workers were affected.
- 2.18 However, the characteristics of private and public sector workers and jobs are very different, meaning that the raw comparisons above are not like-for-like comparisons due to e.g. age, skill level, occupation and experience – the average public sector worker would, if they moved to the private sector, be expected to command higher than average earnings. After controlling for a range of individual and job-related characteristics – including region, occupation, age, gender, job tenure and organisation size – the Office of National Statistics has estimated that average hourly earnings in the public sector (excluding overtime) were 5.5 per cent lower than similar individuals doing similar jobs in the private sector in 2016,⁸ although we note that different assumptions will produce different results.

Evidence from the parties on the economy⁹

- 2.19 The **Department of Health** for England said that, following the outcome of the EU referendum, the UK economy is entering a new phase which will pose challenges to the public finances and noted that independent forecasters have cut expected growth for 2017 from 2.1 per cent to 0.7 per cent since the EU referendum. They noted that public debt stood at its highest share of GDP since the late 1960s and that the deficit remained among the highest among advanced economies. They told us that it is vital that the Government continued to reduce the budget deficit and that public sector pay restraint played a key role in the Government's plans for achieving this while protecting jobs and maintaining public services, having saved £8 billion in the last Parliament and expected to save a further £5 billion during this Parliament.

⁷ Annual Survey of Hours and Earnings 2016, Office for National Statistics, October 2016, Table 13.

⁸ Analysis of factors affecting earnings using Annual Survey of Hours and Earnings 2016, Office for National Statistics, October 2016.

⁹ Evidence was received from the parties during the autumn and winter 2016 and has since been overtaken by more recent data.

- 2.20 However, the Department of Health noted that the strength of the economy means the UK is well-placed to deal with any short-term economic volatility and the longer-term economic adjustment to a new relationship with the EU. They said that the economy is in a far stronger position than in 2010 and noted that the budget deficit has been cut by almost two thirds from its 2009/10 post-war peak, employment is at a record high and unemployment is at its lowest level since 2005. They told us that the UK economy has grown by 13.8 per cent since the first quarter of 2010 and that it was now 7.7 per cent bigger than its pre-crisis peak, with the UK the second fastest growing major economy in 2015. The Department of Health also observed that inflation was close to zero throughout 2015, predominately due to falling fuel and food prices.
- 2.21 They told us that wage growth was fairly stable in the first half of 2016, with total pay in the year to April-June 2016 up by 2.4 per cent in nominal terms and by 2.1 per cent in real terms and said that this was the 21st consecutive month in which average earnings have outstripped inflation and the longest period of real wage growth since 2008. However, they noted that nominal private sector wage growth remains below the rates of 4-5 per cent seen before the recession.
- 2.22 On the public-private sector pay differential, the Department of Health told us that the overall level of average public sector wages remained higher than that of the private sector in the three months to June 2016. They also highlighted analysis by the Institute of Fiscal Studies and the Office for National Statistics that they said had shown that, on average, public sector workers were paid more than workers with similar characteristics in the private sector. They said that, while the public-private pay differential is narrowing, the overall remuneration of public sector employees continues to be higher than the market when taking employer pension contributions into account, citing a recent unpublished HMT analysis that found that on average public sector workers benefit from a 10.4 per cent premium compared with those working in the private sector who have similar characteristics.
- 2.23 The **Welsh Government** told us that data on the labour market and on output in the private sector suggested that economic performance in Wales had been similar to economic performance in the wider UK, noting that employment had increased by 7.4 per cent in Wales since the recession ended (compared to 9.2 per cent in the UK as a whole) and that Wales' share of UK Gross Value Added had remained fairly stable over the past 5 years (increasing by 14.5 per cent between 2010 and 2014).
- 2.24 They told us that the performance of the Welsh economy in the short-to-medium-term will be largely driven by the performance of the wider UK economy and that it is reasonable to assume that economic growth in Wales will be similar to economic growth in the wider UK over the next few years. They noted that the EU Referendum result had caused increased uncertainty about economic prospects and that this had led to the Bank of England downgrading its economic forecast for 2017 from 2.3 per cent to 0.8 per cent, with increases in inflation and unemployment now being forecast.
- 2.25 The Welsh Government also made a number of comparisons of the economic situation in Wales to that in the rest of the UK, noting that:
- Gross Value Added per head in Wales remained lower than in any other UK country or region.
 - The employment rate in Wales remained below the UK average and, while higher than in Northern Ireland, the North East and the West Midlands, is lower than the other 8 regions and countries.
 - The unemployment rate in Wales remained above the UK average, though is the sixth lowest of the 12 UK regions and countries.
 - Median full-time gross weekly earnings were lower in Wales than in the UK as a whole and fell slightly in 2015, with real wages falling in both Wales and the UK in four out of the last five years.

- 2.26 The **Northern Ireland Executive** said that recently reported economic growth had been broadly positive, with growth driven by the private sector. However, they noted that growth had been uneven, that there was still some way to go to recover lost ground and that growth was slower than in the wider UK. They told us that the Northern Ireland labour market was experiencing a “jobs rich” recovery, with business activity improving and new jobs being created, though highlighted concerns about high rates of economic inactivity, youth unemployment and long-term unemployment.
- 2.27 On employment, they noted that the unemployment rate in Northern Ireland – 5.6 per cent in May-July 2016 – was the fifth highest of the UK regions and above the UK average rate of 4.9 per cent, though the claimant count had fallen by 16 per cent in the year to August 2016. They also noted that economic inactivity among 16-64 year olds was 26.4 per cent – significantly higher than the UK average rate and the highest of the twelve UK regions.
- 2.28 The Northern Ireland Executive highlighted the impact of the EU referendum result in creating uncertainty and challenges for the Northern Ireland economy, noting that business activity initially dropped following the vote to leave and that growth reported by local firms in August 2016 was the weakest experienced in 2015 and well below the pre-downturn long-term average.
- 2.29 They told us that public expenditure in Northern Ireland would decrease in real terms in 2016/17 and over the coming years, and that efficiency and productivity improvements will continue to be essential to meet key targets. They noted that the high proportion of Government expenditure accounted for by pay means that trends in public sector pay have significant implications for the availability of resources to support staff and delivery of public services in Northern Ireland, with public expenditure tightening having a particular impact on Northern Ireland due to its relatively large public sector workforce, accounting for 27.6 per cent of all employment (compared to 16.8 per cent in the UK as a whole).
- 2.30 They also observed that, while public sector pay is below the UK average, the raw public-private pay differential in Northern Ireland is – at 19.4 per cent – the highest in the UK, driven by the fact that private sector pay in Northern Ireland is the lowest in the UK, 19.9 per cent below the UK average.
- 2.31 **Joint Staff Side** said that RPI remains the most accurate measure of inflation faced by employees. They told us that it is widely acknowledged that CPI consistently understates the real level of inflation as it fails to adequately measure housing costs by excluding the housing costs of owner occupiers. They also said that CPI does not fully match the experiences of the working population as it includes pensioners and the highest earning 4 per cent of households as well as tourists. They said that the cost of living – as measured by RPI – has increased by 19.4 per cent between the start of 2011 and the end of 2015 and is set to increase by a further 15 per cent by 2020.
- 2.32 They said that over the next four years – the lifetime of the current public sector pay cap – GDP is predicted to grow by an average of 2.1 per cent per year, the cost of living (as measured by RPI) is due to grow by an average of 2.8 per cent per year and average earnings growth is expected to be an average of 3.3 per cent per year. They noted that public sector pay policy of 1 per cent means that NHS pay will continue to fall behind the cost of living and economic growth.

Earnings of our Remit Group

2.33 In this section we look at changes in the value of the Agenda for Change pay structure and the mean and relative earnings, and take-home pay, of our remit group.

Agenda for Change pay structure

2.34 Changes in the value of the Agenda for Change pay structure between 2010/11 and 2016/17 have varied significantly across the UK, with the biggest increases in Scotland. In every country, increases in nominal terms have been most rapid at Bands 1-4, with increases highest for those at the lowest pay points (see Table 2.2). The pay increases experienced by the lowest paid staff in the NHS have been more rapid than increases in the value of the pay structure in England (due to pay point 1 no longer being in use), Scotland (due to pay points 1 and 2 no longer being in use) and Wales (due to staff in pay points 1-4 receiving a supplement to their pay so that they are paid at the Living Wage Foundation's Living Wage).

Table 2.2: Change in the nominal value of the Agenda for Change pay structure by pay point 2010/11 – 2016/17

Country	Pay at the lowest pay point in use	Bands 1-4 (increase in the value of pay points up to 16)	Bands 5-8C (increase in the value of pay points 17-42)	Band 8C and above (increase in the value of pay point 43 and above)	RPI inflation (Apr 2010 to Apr 2016)	CPI inflation (Apr 2010 to Apr 2016)
England	11.7 per cent (pay point 1 is no longer in use)	3.5 per cent to 8.9 per cent	3.0 per cent	2.0 per cent	17.3 per cent	12.3 per cent
Scotland	18.2 per cent (pay point 2 is no longer in use)	4.9 per cent to 12.3 per cent	4.1 per cent			
Wales	18.2 per cent (staff at pay points 1-4 receive the Living Wage)	3.5 per cent to 6.7 per cent	3.0 per cent			
Northern Ireland	5.7 per cent	2.4 per cent to 5.7 per cent	2.0 per cent			

Source: OME analysis of pay scales, Office for National Statistics

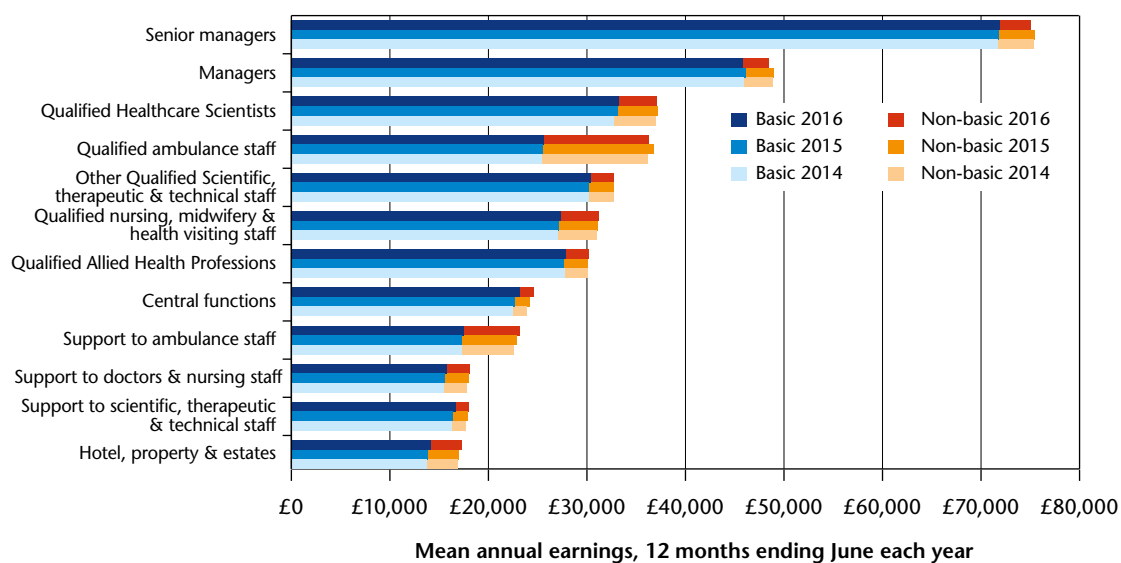
2.35 Given increases in the cost of living between April 2010 and April 2016, the real terms value of pay across most of the pay structure has noticeably fallen in each of the four nations. For example, the value of the pay structure at Band 5 and above has fallen by at least 11 per cent measured against RPI and by at least 7 per cent measured against CPI in every part of the UK.

Average earnings in the remit group

2.36 Figure 2.6 shows the mean basic salary¹⁰ per person and total earnings¹¹ by staff group in England for the last three years:

- Senior managers had the highest basic salary (£71,868) and total earnings (£75,024). Whilst their basic earnings have stayed more or less constant, non-basic earnings have continued to decline and have halved since 2013, probably due to a reduction in performance-related pay.
- Other managers have also seen a fall in their total earnings, due to lower basic and non-basic pay.
- Average total earnings also fell for qualified healthcare scientists, qualified ambulance staff and other qualified scientific, therapeutic and technical staff. For example, qualified ambulance staff saw their total earnings decrease by 1.2 per cent due to a reduction in non-basic payments for overtime and shift working.
- All staff groups saw their non-basic earnings decrease, with falls ranging from 0.4 per cent for ambulance support staff to 15.8 per cent for senior managers.
- Average basic earnings growth for the five lowest paid staff groups – hotel, property and estates, support to scientific, therapeutic and technical staff, support to doctors and nurses, support to ambulance staff and central functions – exceeded 1 per cent.

Figure 2.6: Mean basic salary and mean non-basic salary per person by main staff groups, 2014 to 2016, England



Source: OME analysis of NHS Digital data.

¹⁰ Basic salary refers to pay at an individual's Agenda for Change spine point.

¹¹ Total earnings include: basic salary (per person) and non-basic salary (per person). Non-basic salary includes hours-related pay, such as on-call, shift working and overtime; location payments such as location allowances and other local payments; recruitment and retention premia; and 'other' payments such as occupational absence and protected pay.

Weekly pay of those working in the human health and social work sector

2.37 The Annual Survey of Hours and Earnings (ASHE) has been used to compare earnings for the human health and social work activities sector¹² to employees in the public and private sector as well as to certain broad occupational groups.¹³ These sector and group earnings (median gross weekly pay)¹⁴ are shown in Table 2.3 below.

2.38 Following two years of below average growth, median gross weekly pay for full-time employees in the human health and social work activities sector increased by 2.6 per cent in 2016, a faster rate of increase than the rest of the public sector (0.7 per cent) though slower than the 3.4 per cent increase in the private sector average wage.

Table 2.3: Change in median gross weekly pay for full-time employees at adult rates, 2014 to 2016, April each year, United Kingdom

United Kingdom	Median gross weekly pay (change on previous year)		
	2014	2015	2016
Human health and social work activities sector	£494 (-0.6%)	£497 (0.5%)	£510 (2.6%)
All employees	£518 (0.2%)	£527 (1.7%)	£539 (2.2%)
Public sector	£579 (1.0%)	£590 (1.9%)	£594 (0.7%)
Private sector	£493 (0.7%)	£500 (1.4%)	£517 (3.4%)
Professional occupations [1]	£711 (1.1%)	£717 (0.8%)	£726 (1.3%)
Associate professional and technical occupations [2]	£584 (0.3%)	£592 (1.4%)	£594 (0.2%)
Administrative & secretarial occupations	£407 (1.8%)	£415 (2.0%)	£423 (2.0%)
Skilled trades occupations	£480 (0.9%)	£489 (1.8%)	£498 (1.9%)
Caring, leisure and other service occupations	£335 (-0.6%)	£341 (1.9%)	£353 (3.4%)

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

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

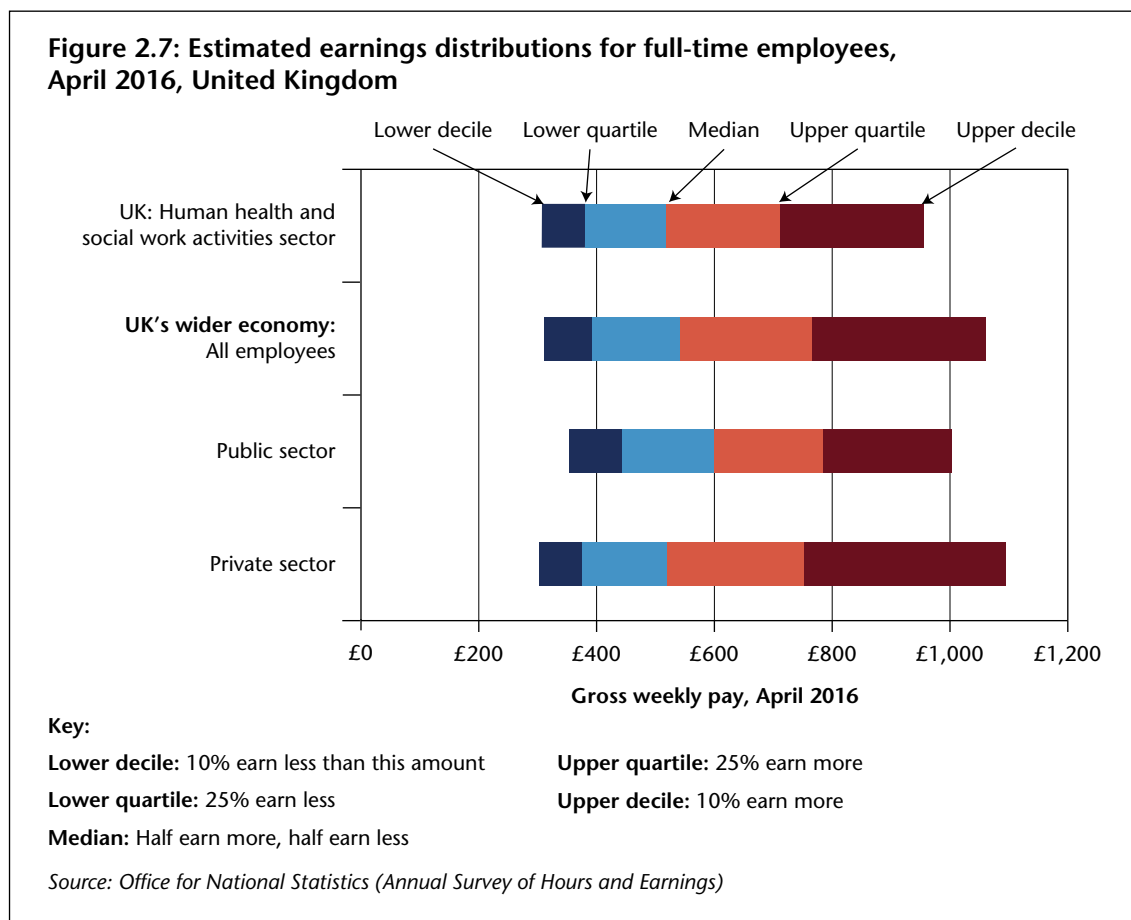
[2] Includes, for example, police officers and some AHPs and ST&Ts. Nurses and midwives were in this group until April 2010.

¹²This sector includes the provision of health and social work activities. It covers a wide range of activities, from health care provided by trained medical professionals in hospitals and other facilities, to residential care activities that still involve a degree of health care activities and to social work activities not involving the services of health care professionals.

¹³ASHE is used as the source for comparison as it is a robust survey and can also be analysed by occupations, industrial classifications and by country. Although, as noted in *Market-Facing Pay: How Agenda for Change Pay Can be Made More Appropriate to Local Labour Markets* – NHS Pay Review Body (2012), such comparisons are hard to draw definitively, because of the differing compositions of the respective workforces, and in practice changes in pay are driven by a host of factors.

¹⁴Gross weekly (as at April 2015), rather than annual (the year to March 2015) pay is used, as it represents a more up-to-date indicator.

2.39 Figure 2.7 uses data from ASHE to show how full-time earnings of the public and private sectors as a whole compared with the human health and social work activity sector in 2016. Pay was lower in the human health and social work activities sector than in either the public or the private sector at each point in the earnings distribution.



Trends over time in individual pay in the remit group

- 2.40 The changes in earnings over time experienced by individual members of the remit group can be very different to trends in average pay due to pay progression, career progression, geographical movement and changes in personal working patterns. For example, slightly more than half (54 per cent) of NHS staff in England were due to receive pay increments of around 3 to 4 per cent on average in 2016/17 in addition to the 1 per cent pay award (see paragraph 4.6).
- 2.41 To shed light on this, the Department of Health for England submitted analysis from a longitudinal study looking at the earnings of individual members of Agenda for Change staff who were employed in both March 2010 and March 2015 – 70 per cent of all staff in the remit group who were employed in March 2010.
- 2.42 This analysis concluded that there was significant variation between and within staff groups in changes in earnings over time (see Table 2.4). The median worker employed in both March 2010 and March 2015 saw their average earnings increase by an average of 1.7 per cent to 2.9 per cent per year depending on their staff group. This was substantially higher than growth in average earnings within each staff group over the five years and compares to annualised CPI inflation of 2.4 per cent and annualised RPI inflation of 3.1 per cent over the period.

Table 2.4: Average annual increase in total earnings of Agenda for Change staff employed in March 2010 and in March 2015 by staff group, adjusting for changes in contracted hours

	20th percentile	40th percentile	Median	60th percentile	80th percentile
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%

Source: Evidence submitted by the Department of Health

2.43 The increases in pay over time that are experienced by individual workers in the economy as a whole, especially those who remain continuously employed in the same job, tend to be higher than changes over time in headline earnings – pay tends to increase with age, experience and job tenure. Given this, while there is no easily available comparator of longitudinal earnings in the five years to March 2015 for individuals in the wider economy who remain with the same employer, we would expect this to be substantially higher than economy-wide earnings growth.

Take-home pay in England

2.44 Whilst total earnings have generally been increasing in cash terms over the last five years, the take-home pay of NHS staff has also been affected by a number of changes to pensions and to direct taxation, which have affected the whole economy, as well as changes to the NHS Pension Scheme. These changes have included:

- Increases to the income tax personal allowance (increases take-home pay).
- Increases to student loan repayment thresholds for those taking out loans before 2012 (increases take-home pay).
- Increases to National Insurance thresholds (increases take-home pay).
- Decreases in the higher rate income tax threshold (decreases take-home pay).
- The abolition of the state second pension meaning the end of contracting-out and higher National Insurance contributions for members of the NHS pension scheme from April 2016 (decreases take-home pay).
- Increases in contribution rates to the NHS Pension Scheme (decreases take-home pay).

2.45 Office of Manpower Economics analysis looking at trends in the basic take-home pay of the top pay point of pay bands in England suggests that take-home pay has been increasing much faster for staff in lower bands, compared to those in the middle and higher bands. Staff in the highest bands have seen a nominal reduction in their take-home pay, largely due to increased pension contributions. Many NHS employees – including those at the top of pay band 5 – saw their take-home pay fall in cash terms in 2016/17 as increases in National Insurance contributions associated with the end of contracting out were higher than the value of the 1 per cent pay award. Staff in the rest of the UK will have seen similar changes in their take-home pay.

2.46 Table 2.5 suggests that:

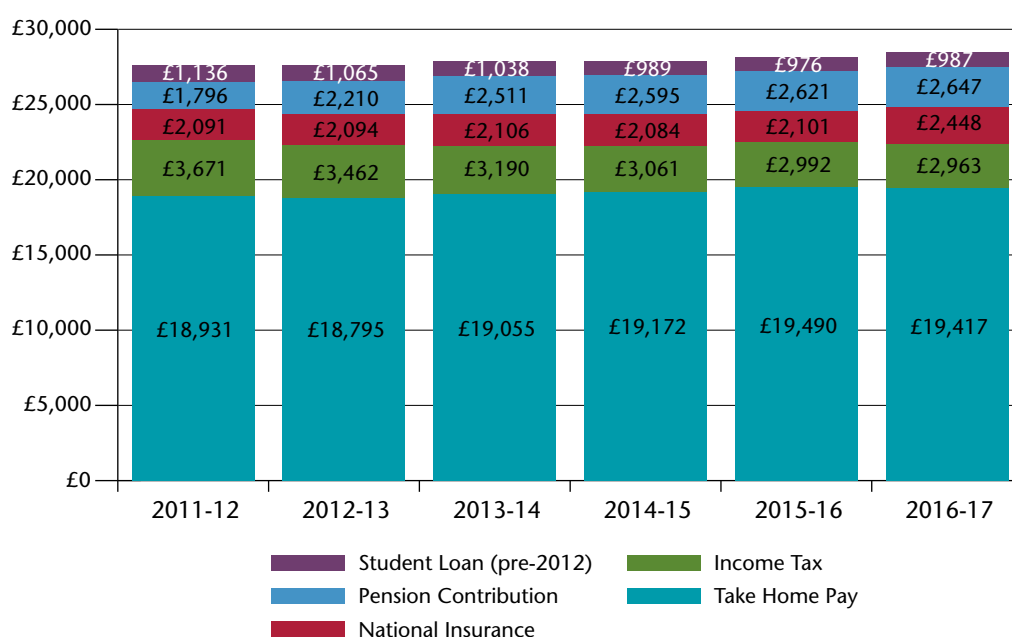
- Staff at the top of band 1 will have seen an increase in take-home pay of £1,234, more than the increase in their gross pay of £902 between 2011/12 and 2016/17. This is due to the changes to income tax outweighing the small increase in pension contributions and national insurance at this income level.
- Staff at the top of band 5 will have seen an increase in take-home pay of about £485, compared to an overall increase in gross pay of £837. The increase in pension contributions and national insurance (£851 and £357) outweighed the decrease in income tax and student loan repayments (£708 and £149). Indeed, the increase in pension contributions was higher than the combined pay uplifts (Figure 2.8).
- Although uplifts for staff at the top of band 9 have increased gross pay by £1,959, take-home pay has fallen by £2,182. This is largely due to the increase in pensions contributions, which have increased by £6,113 over the period.

Table 2.5: Estimated take-home pay for top of band pay points, England, 2011-12 to 2016-17

Top of:	Take home pay						5-year change	
	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	£	%
Band 1	£11,864	£12,177	£12,558	£12,692	£13,053	£13,097	£1,234	10.4
Band 3	£14,283	£14,637	£15,033	£15,170	£15,448	£15,458	£1,174	8.2
Band 5	£18,931	£18,795	£19,055	£19,172	£19,490	£19,417	£485	2.6
Band 7	£25,872	£25,560	£25,782	£25,868	£26,247	£26,074	£201	0.8
Band 9	£51,893	£50,659	£49,894	£49,410	£49,632	£49,711	-£2,182	-4.2

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

Figure 2.8: Estimated take home pay – top of band 5, England, 2011-12 to 2016-17



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

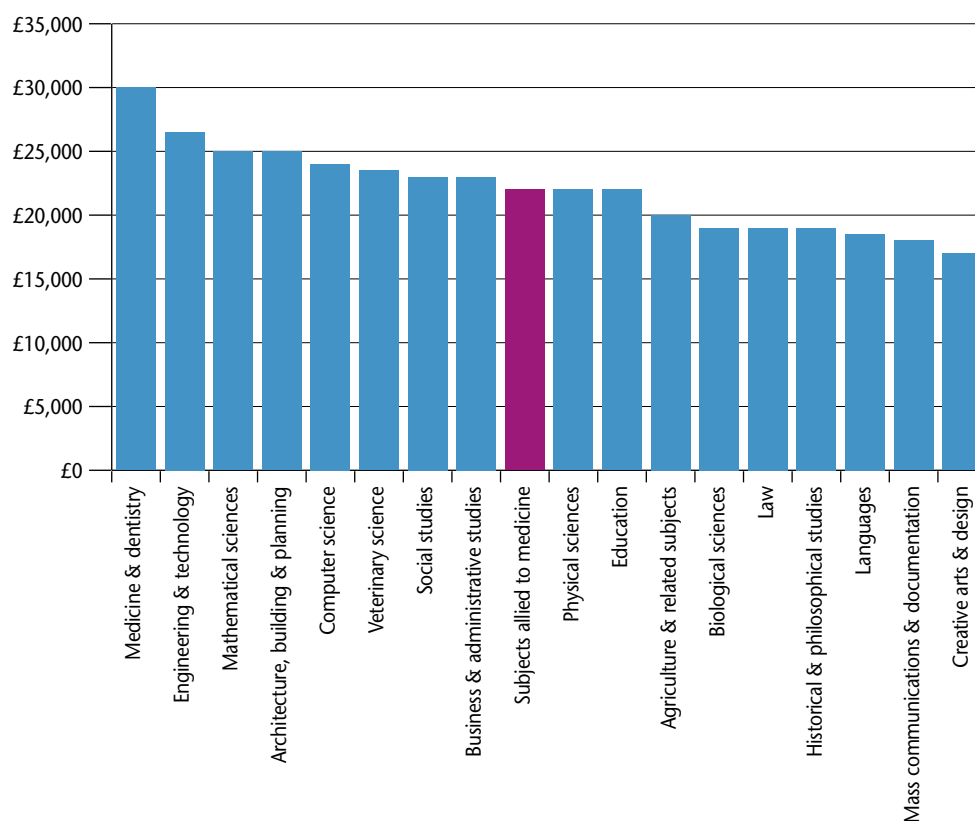
2.47 Even though take-home pay has been increasing in cash terms for much of the remit group, take-home pay has fallen in real terms over the last 5 years for staff at the top of pay bands across much of the pay structure. Adjusting for RPI, real take-home pay fell by 8 per cent for staff at the top of Band 5 and by 1 per cent for staff at the top of Band 1 between April 2011 and April 2016. Adjusting for CPI, real take-home pay fell by 5 per cent for staff at the top of Band 5 and increased by 3 per cent for staff at the top of Band 1 over the same time period.

Graduate Earnings

2.48 We have included analysis of graduate earnings for the first time this year. This is to help build up a picture of how competitive the Agenda for Change pay offer is in relation to other graduate professions, bearing in mind that clinical and managerial roles in the NHS typically require degree-level qualifications.

2.49 Data from the Destinations of Leavers from Higher Education Survey (DLHE) shows that median starting salaries for graduates from non-medical health degree courses are roughly the same as the mean of distribution (£22,000) of graduate starting salaries. Figure 2.9 shows graduates from 'medicine and dentistry' and 'engineering and technology' are at the top end of the distribution whereas graduates from creative arts and mass communication are at the bottom end. The difference in median earnings between the top (medicine and dentistry) and bottom (creative arts and design) of the distribution is £13,000.

Figure 2.9: Median starting salary by 1-digit Standard Occupational Code, UK, 2014/15



Source: OME analysis of HESA 2014/15 data

2.50 The data in Table 2.6 highlights the variation between graduate starting salaries for those doing non-medical degree courses between regions in England (with graduates working in London earning more than those in other regions) and between different courses (with those who studied complementary medicines having the highest starting salaries and those who studied ophthalmics having the lowest starting salaries).

Table 2.6: Median starting salary for non-medical health degree courses, by region in England, 2014/15

	North East	North West	Yorks & Humber	East Midlands	West Midlands	East of England	London	South East	South West
Nursing	£21,692	£21,692	£21,500	£21,700	£21,787	£22,000	£25,500	£22,000	£21,642
Anatomy, physiology & pathology	£21,685	£21,600	£21,600	£21,000	£21,682	£21,700	£25,000	£21,692	£21,500
Aural & oral sciences	£21,500	£21,378	£21,600	£21,550	£21,500	£21,692	£25,000	£21,635	£21,500
Broadly-based programmes within subjects allied to medicine	£25,023	£21,000	£20,900	£20,770	£23,000	£22,000	£30,000	£21,000	£22,000
Complementary medicines, therapies & well-being	£25,750	£32,000	£37,000	£21,500	£26,000	£30,000	£30,000	£25,000	£23,500
Medical technology	£22,000	£21,692	£22,000	£21,692	£21,692	£21,800	£26,000	£22,000	£21,750
Nutrition	£21,692	£21,600	£21,500	£21,500	£21,600	£21,900	£24,000	£21,692	£21,500
Ophthalmics	£15,000	£15,000	£13,936	£13,750	£14,400	£16,000	£14,250	£18,000	£15,500
Pharmacology, toxicology & pharmacy	£21,000	£18,512	£19,000	£18,900	£18,500	£21,000	£20,000	£20,000	£21,000
Others in subjects allied to medicine	£23,000	£25,000	£22,000	£21,800	£24,000	£23,000	£26,000	£24,000	£22,000

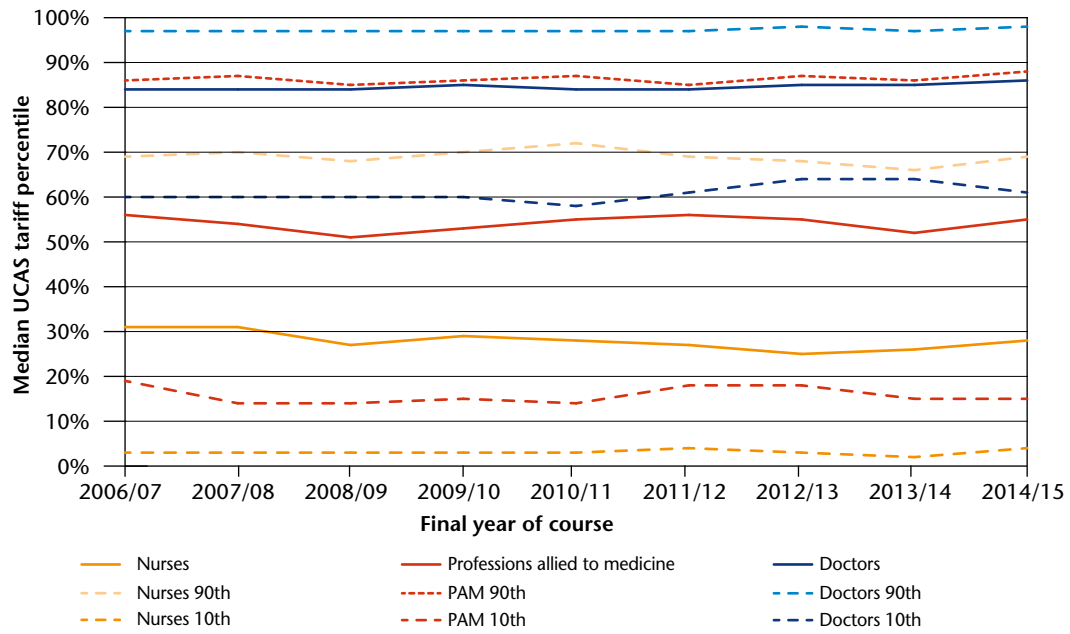
Source: OME analysis of HESA 2014/15 data

2.51 Research carried out by the Institute for Fiscal Studies¹⁵ found that young full-time graduate entrants to nursing had, on average, lower A-level attainment than the average graduate, with attainment at about the 30th percentile of university graduates, meaning 70 per cent of graduates had higher A-level attainment than young graduate entrants to nursing (see Figure 2.10). It also found that new entrants to nursing are in the top half of the earnings distribution of new graduates (see Figure 2.11). Taken together, this suggests that starting salaries for nurses remain competitive compared to the starting salaries of those in other professions with similar A-level attainment.

2.52 However, caution is required as this analysis looks at starting salaries only and so does not factor in career progression prospects in Agenda for Change roles relative to other graduate professions. The research sample also excludes 85 per cent of nursing graduates due to: being over 25 (69 per cent of the sample), young graduates not graduating from full-time courses (2 per cent of the sample) or young graduates not having UCAS data available (14 per cent).

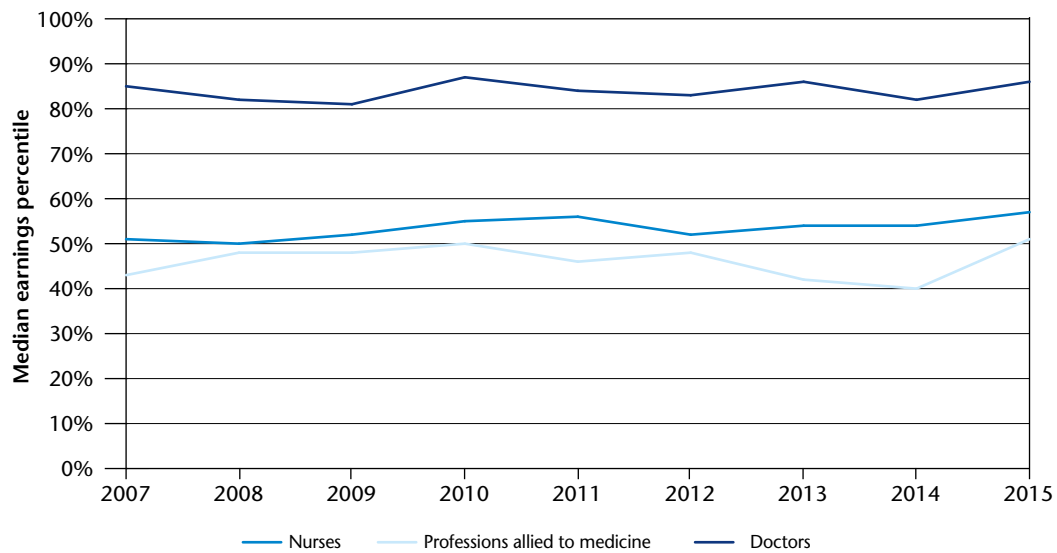
¹⁵ Institute for Fiscal Studies, *The Changing Educational Attainment of Graduate Recruits to Major Public Sector Occupations*, 2017.

Figure 2.10: Relative educational attainment of new medical workers



Source: Research by the IFS concerning the Changing Educational Attainment of Graduate Recruits to Major Public Sector Occupations

Figure 2.11: Young graduate earnings percentile, 2007 to 2015



Source: Research by the IFS concerning the Changing Educational Attainment of Graduate Recruits to Major Public Sector Occupations

Evidence from the parties on earnings of the Remit Group

- 2.53 The **Department of Health** for England told us that the average earnings growth experienced by members of the remit group has been lower than the private sector average for the last two years and that the gap is expected to continue to widen. They told us that, together with improved employment prospects in the wider economy, this represents a potential recruitment and retention risk to the NHS. They also noted that recent NHS pay awards have been below the wider public sector pay cap and that earnings growth was below inflation between 2010 and 2015. They said that overall earnings per person have increased year-on-year since 2010/11 by 4.0 per cent or by an average of 0.8 per cent per year.
- 2.54 They noted that the earnings growth experienced by individuals working in the NHS since 2010/11 is different to trends in average pay in the NHS. They highlighted their longitudinal analysis of individual pay growth since 2010/11 (presented above) and said that this showed that the total earnings of Agenda for Change employees employed in the NHS in both 2010 and 2015 increased by an average of between 1.7 per cent and 2.9 per cent per year, depending on staff group.
- 2.55 They also highlighted analysis they had carried out using the Annual Survey of Hours and Earnings looking at comparisons of NHS pay growth over the last three years to occupational groups with similar average earnings to NHSPRB remit groups. They said that this showed that NHS average earnings growth in the latest 3 years has been less than growth in the comparator group. However, they highlighted differences within this, with earnings growth for Central Functions similar to growth for the comparator group, with higher-paid NHS groups faring less well.
- 2.56 The Department of Health also reported that there has been upward Band drift for nurses in the last two years, with a drop in the representation of nurses in Band 5 and an increase at Band 6. They said that the reasons for this were not entirely clear, but that they may include local organisations responding to a shortage in supply, a greater focus on safe staffing levels following the Francis report and skills re-profiling to support service delivery across the seven day week. They also suggested that it may be the result of local action to improve pay in response to continuing national pay restraint.
- 2.57 **Joint Staff Side** told us that the value of the Agenda for Change pay framework had diminished significantly over the last five years, with NHS staff suffering real terms wage cuts of an average of 12.3 per cent. They said that median earnings had increased by 7.1 per cent between 2011 and 2016 compared to RPI growth of 19.4 per cent. They estimated that £4.3 billion has been cut from NHS staff salaries in England alone between 2010 and 2016 due to pay awards being lower than RPI inflation.
- 2.58 They said that earnings had lagged behind the cost of living for several years and will continue to fall behind inflation if the Pay Review Body abides by the cap set by the UK Government for this year's award. They also noted that the labour market is tightening and told us that NHS salaries are falling behind other professions.
- 2.59 When asked about the Department of Health for England's longitudinal analysis in supplementary evidence, Joint Staff Side told us that incremental pay progression reflects competence and experience. They said that the most important point of the Pay Review Body process was whether the value of the pay structure has kept pace with the cost of living and that it was clear that it has not. They also highlighted a couple of methodological issues with the analysis, including that it under-represented earnings of older staff, meaning more employees were eligible for pay progression in the sample than in the wider NHS workforce.

- 2.60 Joint Staff Side cited evidence from the Association of Graduate Recruiters Survey that the average graduate starting salary in 2015 was £28,000 (with a median graduate salary of £35,000 after three years) and from the High Fliers Graduate Market Report 2016 that the median graduate starting salary in 2016 was £30,000. They said that this shows that most degree-entry roles in the NHS, which are graded at Band 5, have much lower salaries than comparators elsewhere in the economy. In supplementary evidence, Staff Side told us that Agenda for Change salaries should be compared to other jobs requiring a degree and said that the sub-set of graduate salaries they cite is the most appropriate comparator available as other data sources (e.g. from the Higher Education Statistics Agency) include many graduates who are not in graduate-level jobs.
- 2.61 The **Royal College of Midwives** said that pay restraint over the past six years had resulted in a real terms decrease in pay for NHS employees and that capping pay at 1 per cent until 2020 will further decrease the value of midwives' pay. They noted that the 2010/11 pay award was below both RPI and CPI inflation, resulting in a real decrease in the value of pay, and that there has been continued devaluation in the value of NHS employees' pay in subsequent years due to the pay freeze that started in April 2011.
- 2.62 They said that, compared to pay awards in line with RPI inflation, the value of pay for a midwife at the top of band six decreased by over £6,000 between 2010 and 2016 and that the UK Government's public sector pay policy implied that this gap would increase to £9,000 by 2020. They said that this equates to a decrease in the real value of a midwife's salary of over 25 per cent in the decade to 2020. They told us that they have substantial concerns about the impact that this will have on the attractiveness of midwifery as a career and described it as a retrograde step back to a time when NHS careers, particularly female dominated professions such as midwifery, were poorly paid and poorly valued.
- 2.63 The Royal College of Midwives identified a number of pressures on take-home pay over the last few years including increases in pension contributions (from 6.5 per cent to 9.3 per cent for the majority of midwives), increases in National Insurance contributions due to changes to the state second pension by 1.4 per cent of salary above the National Insurance threshold) and increases in Nursing and Midwifery Council registration fees (over 30 per cent). They also told us that changes to tax credits are likely to affect most midwife support workers and some midwives, especially if they work part-time and are the sole earner in the household.
- 2.64 They also said that they do not agree that incremental progression can act as a substitute for an annual pay increase on basic pay. They said that incremental progression represents reward for increased skill and experience, as agreed under the Agenda for Change framework.
- 2.65 **Unison** said that they had asked staff how they felt their pay had changed relative to their cost of living and 63 per cent of respondents feel worse off than they did 12 months ago. They said that respondents identified food, transport and utility bills as the areas that have increased in price the most compared with their income. Unison also told us that a sizeable minority (40 per cent) also identified increased housing costs as having a negative impact on their spending power.
- 2.66 **Unite** told us that the real-term loss of earnings impacts hardest on lowest paid workers as they tend to spend larger proportions of their income on basic staples like food, rent and energy. Unite also highlighted findings from their staff survey which suggested that significant numbers of NHS staff have also experienced reductions in their terms and conditions of employment that have impacts on take-home pay, especially unsocial hours payments, overtime and sickness policy. They also highlighted car parking charges as an area of concern.

- 2.67 They also reiterated their view that pay increments do not represent a pay rise but rather take into account the training development rates of pay before an NHS employee reaches the rate for their job, which they consider to be the top of the band. They added that this has been recognised on several occasions by the PRB itself and that the appropriate forum for discussion of increments would be in the stalled review of the Agenda for Change pay system. Unite said that the Pay Review Body process should be considering whether the value of the pay structure has kept pace with the cost of living and that it was clear it had not.
- 2.68 Unite also told us that downbanding had been a significant theme in surveys of staff carried out by unions over several years, though it was difficult to find NHS-wide data on the issue. They said analysis carried out as part of preparations for the Staff Side evidence uncovered an interesting trend that could illustrate the issue, with a plateauing of average basic earnings per FTE since January 2013 despite the national pay awards. They said that this could be an indication of downbanding, though noted that they were not certain of this and asked the Review Body to explore the issue further.
- 2.69 The **Royal College of Nursing** told us that nursing staff in the NHS have experienced a real drop in median earnings of between 9 per cent and 14 per cent since 2011. They told us that median pay for qualified nursing, midwifery and health visiting staff increased by 5.8 per cent and median pay for support to doctors and nursing staff by 10.1 per cent between 2011 and 2016, compared to RPI increasing by 19.4 per cent.
- 2.70 They said that it was vital that nurses' pay levels compete effectively with pay in other graduate professions and that starting salaries for qualified nurses have consistently fallen behind median graduate salaries in the UK, which they said are around £8,100 or 37 per cent higher than the bottom of Agenda for Change Band 5.

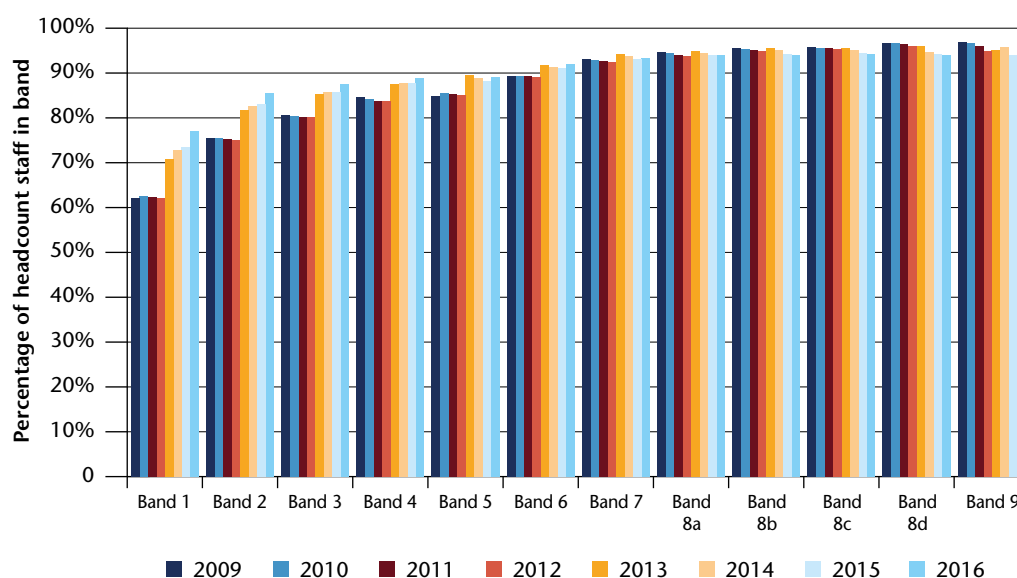
Total Reward

- 2.71 The employment package offered to staff working in the NHS extends beyond earnings, including (for example) eligibility for membership of the NHS Pension Scheme, non-pay benefits, holiday entitlement, sick pay entitlement, career progression opportunities, learning and development and the working environment, among other things. Whilst outside of our remit, the package as a whole is important context. This section summarises the evidence we received on Total Reward, including on membership of the NHS Pension Scheme.

Membership of the NHS Pension Scheme

- 2.72 Whilst the overall NHS pension membership rate has been increasing, this hides an underlying trend of small decreases in membership for those in bands 8 and 9. The major increases in scheme membership up to July 2016 were in Bands 1-4. The increases in membership between 2012 and 2013 were due to the coming into force of the provisions of the Pensions Act 2008 requiring statutory auto-enrolment into occupational pension schemes. Across most bands there is slightly higher membership for women than men, but the general trends are similar.

Figure 2.12: Estimated pension membership rate by Agenda for Change band, 2009 to 2016, July each year, England



Source: OME Analysis of NHS Employers data

Evidence from the parties on Total Reward

- 2.73 The **Department of Health** for England said the new NHS Pension Scheme 2015 continued to provide a generous pension for NHS staff and remained one of the best schemes available, and told us that the Government Actuary's Department has calculated members could generally expect to receive around £3-£6 in pension benefits value for every £1 contributed. They noted that, as the scheme is backed by the Exchequer and re-valued in line with price inflation, it provides a guaranteed retirement income. They told us that a band 5-6 nurse retiring at 68 with 35 years' service wholly in the 2015 scheme could expect a pension of around £19,000 per year.
- 2.74 They noted that the introduction of the new single tier state pension in April 2016 had led to an increase in National Insurance contributions for members of the NHS pension scheme and their employers due to the end of contracting out. However, they observed that higher contributions do not appear to have led to an increase in the number of people opting-out from the NHS pension scheme, with membership rates continuing to be high across all staff groups, though with some signs of slight decreases in membership of the scheme amongst the highest paid Agenda for Change bands.
- 2.75 In supplementary evidence the Department of Health told us that, in discussions about pension scheme contribution rates between 2015 and 2019, trade unions had asked for earnings tiers to be revalorised in line with future uplifts to Agenda for Change pay scales. They said that the prevalence of pay supplements means that only a minority of staff have their pensionable pay directly linked to Agenda for Change pay points – with around 60 per cent of nursing staff and 97 per cent of ambulance staff in receipt of shift work enhancements and 20 per cent of staff in receipt of geographical allowances – calling into question the relevance of linking pension contribution rate tiers to Agenda for Change pay points.

- 2.76 On total reward more broadly, the Department of Health said that they had commissioned NHS Employers to continue to build the business case for total reward in the NHS including through: working on the strategic context; improving understanding of it; and developing communications and benchmarking. They said that the Total Reward Engagement Network meets regularly with the aim of raising awareness of reward as a recruitment and retention tool and that they were commissioning research into the relationship between total reward and employee engagement to help build the business case.
- 2.77 At oral evidence, they said that employers had the tools and mechanisms they need to communicate with staff but were not yet utilising them effectively. They noted that some trusts were tweaking the reward package for staff, such as giving staff the opportunity to opt-out of the NHS pension scheme in return for salary increases. They told us that the Department was encouraging trusts to get the message across to staff that total reward in the NHS went beyond access to the NHS Pension Scheme. They said that they recognised that people were not accessing Total Reward statements and acknowledged that more needed to be done to get employers to promote them more, though said that 10 per cent of such a large workforce accessing the statements was positive.
- 2.78 **NHS Employers** said that, with 46 per cent of the NHS workforce aged 45 or above, there are a significant number of staff at an age where they are considering their retirement options. They suggested that the combined impact of recent changes to the NHS pension scheme, pension taxation, pension contribution increases and prolonged pay restraint may lead some staff towards some form of early retirement. They said that this would potentially have some impact on supply and demand, staff experience and agency spending.
- 2.79 They also noted that, as high earners contributed more to the NHS Pension Scheme via their higher contribution rate, significant numbers of high earners opting out of the scheme would have an impact on the average overall yield that is received and mean that employee contribution rates at all levels, including lower bands, would have to increase. They said that this had the potential to undermine the integrity of the scheme.
- 2.80 NHS Employers also said that the nature of tiered contribution rates to the NHS Pension Scheme means that a pay rise for pension scheme members can lead to a reduction in their take-home pay. As an example, they noted that the April 2016 pay award meant that staff at the top point of Band 8A moved to a higher contribution tier, with their contribution rate increasing from 9.3 per cent to 12.5 per cent and annual pension contributions increasing from £4,423 per year to £6,004 per year.
- 2.81 Regarding total reward, NHS Employers told us that employers in other sectors may seem to be more competitive in terms of the basic pay being offered, making it more important for the NHS to stress the total reward package. They said that the NHS continued to have a well-regarded package of valuable employment benefits, including a generous pension scheme, and that they were increasingly seeing employers in the NHS broadening their definition of total reward to include recognition schemes, health and wellbeing initiatives and training and development programmes.
- 2.82 They also highlighted the work of the NHS Employers Total Reward Engagement Network, which gave NHS organisations engaged in total reward work an opportunity to discuss reward-related issues and share knowledge and experience with other organisations. They also told us about an evidence review they had commissioned from the Institute of Employment Studies which had concluded that the broader the definition of total reward that is adopted, the more significant the potential impact on employee engagement. They said that the review reinforced that there is no one-size-fits-all approach to reward. They further emphasised this in supplementary evidence, stating that in order for strategic reward to be fully effective it must be aligned with the needs of the organisation and deliver what staff find valuable, meaning that employers need to understand their unique business and service requirements and use reward levers to achieve these.

- 2.83 They told us about a survey they carried out exploring how strategic total reward was being used in the NHS. This found that only 15 per cent of employers said that they had a reward strategy in place, though a further 51 per cent had one in development and others had embedded elements of strategic reward in other workforce strategies. They said that the survey also looked at how employers were using reward to meet specific workforce challenges, with 54 per cent of respondents using reward to meet recruitment and retention issues. A quarter of respondents said they were not using reward to meet specific workforce challenges. NHS Employers suggested this meant there could be more focus applied to ensuring that there was a return on the investment in reward.
- 2.84 They also identified an increase in the use of low-cost or cost neutral reward schemes such as 'refer a friend' schemes for recruitment, promotion of schemes for staff to buy and sell annual leave, negotiated travel reductions, money advice services and relocation allowances. They told us that salary sacrifice arrangements, which allow individuals to access tax-free benefits such as childcare vouchers, remain the biggest local reward initiatives, though noted that there were government policy challenges to the continued availability of these arrangements.
- 2.85 NHS Employers also noted the role of Total Reward Statements in making staff aware of the value of the whole reward package through an annual personalised summary. They said that 2015/16 was the second year of rollout of Total Reward Statements in the NHS and said that around 200,000 active NHS Pension Scheme members accessed their statement during the year, up 26 per cent on the previous year.
- 2.86 **NHS Providers** said that there was a continuing need to make known the total reward on offer for working in the NHS, for example pension and annual leave provision, so that staff can make an accurate comparison as to how the total reward they receive compares to what is on offer in other sectors.
- 2.87 The **Welsh Government** said they had noted the comments of the Review Body on the potential impact of pension and wider Total Reward strategies and that they will continue to monitor the scheme membership rates and were trying to identify the impact of the wider reward packages on recruitment and retention.
- 2.88 **Joint Staff Side** told us that the NHS pension is an important part of the overall pay and reward package for staff in the NHS. They said that they accepted the concept of total reward and acknowledged that the NHS pension a driver for retention in certain staff groups, especially staff in the final part of their career. However, they said that it is misleading to point to the NHS pension to deflect from the immediate issues that result from a failure to maintain the value of the pay framework and that, while Staff Side strongly supports younger NHS employees joining the pension scheme as soon as possible, it is salary and earnings that provide incentives at that stage of their career.
- 2.89 They noted that a number of government-led initiatives have seen employer and employee costs associated with the NHS Pension Scheme increase, highlighting the end of contracting out and the passing of the scheme administration charge from the Department of Health for England to individual employers. They also highlighted the fact that staff at the top of band 8A moved into the next contribution tier as a result of the 2016/17 pay award and so have seen an overall reduction in their taxable pay.
- 2.90 The Joint Staff Side told us in oral evidence that the process of accessing Total Reward statements is complicated. They said it is currently done via signing into the Government Gateway rather than via work intranets. They also said that it is also often not widely publicised to staff and forces staff to have to work quite hard in order to view their statements.

- 2.91 The **Royal College of Nursing** reported that some NHS Trusts were offering new staff in some occupational groups higher rates of pay to compete with employment agencies by giving new staff the option of opting-out of the NHS Pension Scheme and using the employer contribution that would have otherwise been made to increase their basic pay. They highlighted such a scheme, eventually withdrawn, for new nurses in Oxleas Foundation Trust and one for band 5 and 6 nurses, midwives and operating department practitioners in East and North Hertfordshire NHS Trust.
- 2.92 They said that these schemes, which were likely to be copied by other NHS organisations, demonstrated that higher rates were being offered where there were staff shortages instead of Recruitment and Retention Premia. They also said that these schemes risked putting future pension and deferred income at risk, leading to poverty for retired staff and – if significant numbers of employers chose to follow – undermining the NHS Pension Scheme.
- 2.93 The **Royal College of Midwives** said that they are fundamentally opposed to incentive schemes offering an additional sum of money to new recruits in exchange for opting out of the NHS Pension Scheme. They said that they believed it to be an attempt to undermine the NHS Pension Scheme and that they were very concerned about the long-term financial impact that this could have on their members who choose not to contribute to a pension and suggested that it would increase the gender pensions gap. They said that it is clear that organisations operating such schemes have identified that the starting salary is too low to recruit midwives and nurses and that if trusts are struggling to recruit midwives and nurses they should offer to pay a local RRP. They told us that it is not acceptable to pay a sum of money in exchange for forgoing membership of the NHS Pension Scheme.
- 2.94 **UNISON** reported that a survey of their members revealed that 37 per cent said the NHS Pension Scheme was a key reason they had remained in the NHS compared to only 14 per cent who cited NHS pay and conditions.

Our comment on the Economy, Labour Market and Pay

- 2.95 There is a lot of economic uncertainty as the UK begins to negotiate its new relationship with the European Union. Despite this increased uncertainty, the UK economy continued to perform strongly during 2016, with economic growth around trend levels, employment continuing at close to record levels, recovering private sector earnings and continued low inflation.
- 2.96 However, economic growth is forecast by the Office for Budget Responsibility to slow in 2017. The latest OBR forecasts for 2017¹⁶ are for:
- GDP growth to decrease to 1.4 per cent.
 - CPI inflation to increase to 2.3 per cent.
 - RPI inflation to increase to 3.2 per cent.
 - Unemployment to increase to 5.5 per cent.
 - Average nominal earnings growth to increase to 2.4 per cent (though this is slower than the OBR's previous forecast for 3.6 per cent earnings growth in 2017).
 - Average real earnings growth against CPI to decrease to 0.1 per cent.
 - An additional £122 billion of government borrowing between 2016/17 and 2020/21 than was previously expected.

¹⁶ Office for Budget Responsibility, *Economic and Fiscal Outlook*, November 2016.

- 2.97 These changes would have a number of implications for public sector pay. First, an increase in inflation compared to previous forecasts would mean that the cut in real pay implied by current public sector pay policy would be *higher* than was previously expected. Second, a decrease in private sector earnings growth compared to previous forecasts would mean that the cut in relative pay implied by current public sector pay policy would be *lower* than was previously expected. Third, an increase in government borrowing would increase the pressure on the public finances and on public spending, including on the NHS.
- 2.98 Private sector earnings continued to rise more rapidly than public sector earnings during 2016. The ONS has concluded that the public sector earnings premium that emerged during the recession has now been eroded, with a substantial private sector earnings premium in the top half of the earnings distribution, though the Department of Health for England told us that, after taking into account employer contributions to public sector pension schemes, a public sector earnings premium of around 10 per cent remains.
- 2.99 We believe that the argument for further reductions in the relative value of public sector pay, on the basis that public sector workers get paid more than their peers with similar characteristics doing similar jobs in the private sector, is weakening. This increases the risks that a continuation of current public sector pay policy – not least for highly-skilled workers and those in London and the South East – leads to public sector pay becoming uncompetitive with implications for recruitment and retention. NHS England stated in the Five Year Forward View that NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain staff. We share that view. Therefore if current trends continue, simple arithmetic would point to a catch-up in public sector pay at some point, as happened at the exit from previous public sector pay policies.
- 2.100 Overall, at the moment pay in the remit group remains competitive. The current recruitment and retention picture is covered later in the report. However, since 2010/11, relative to average hourly earnings there has been a cut in the value of the Agenda for Change pay structure in England at Band 5 and above of 6 per cent and public sector pay policy implies a further cut of 8 per cent by 2020/21. In other words, the UK Government is anticipating that over the decade 2010/11 to 2020/21, the value of the pay structure will fall by 14 per cent relative to average earnings. This is in addition to increases in workload and reductions in job security seen by some staff groups.
- 2.101 Real pay in the NHS has also decreased significantly over the last few years. Since 2010/11, there has been an 8 (CPI) to 12 per cent (RPI) cut in the value of the Agenda for Change pay structure in England at Band 5 and above (decreases have been lower for staff in Bands 1-4 and higher for staff above pay point 43) and public sector pay policy implies a further 5 to 9 per cent cut by 2020/21. This would equate to a 12 to 20 per cent cut in the real terms value over the decade 2010/11 to 2020/21. As noted above, the decrease in real NHS pay over the next few years implied by the UK Government's public sector pay policy is bigger than previously expected, meaning a bigger cut in the living standards of NHS staff not eligible for pay progression increments. This may have adverse implications for motivation and morale, as well as for recruitment and retention.
- 2.102 Ultimately, it is take-home pay rather than gross pay that matters to recruitment, retention and motivation – the impact of changes in pension contributions and wider government policy decisions on tax and in-work benefits are important as well as the rate of pay. While changes to the income tax personal allowance have mitigated the impact of pay restraint on the take-home pay of the lowest-paid staff in the NHS, increasing pension contributions and the end of contracting out have exacerbated the impact of pay restraint for staff at middle and higher pay bands. Our analysis also shows that take-home pay actually fell in cash terms in 2016/17 for many staff at band 5 and above due to increases in National Insurance contributions associated with the end of contracting out outweighing the impact on net pay of the 1 per cent pay award.

Observation

It is important to understand and monitor trends over time in take-home pay as well as in gross pay as this conditions the impact of pay awards on recruitment, retention and motivation. We would welcome evidence on this matter in future submissions.

- 2.103 We were given differing views about the use of Agenda for Change pay bands and how these may relate to trends in earnings. We do not consider it part of our remit to explore what is happening to the banding position of NHS staff, although we would like to understand the reasoning behind any changes, as part of our consideration of average earnings.
- 2.104 We heard that the tiered structure of pension contribution rates combined with the fixed nominal value of contribution thresholds led to the unintended and perverse consequence of the 2016/17 pay award translating into a significant reduction in take-home pay for some staff in England as it led to them crossing contribution threshold boundaries. NHS Employers noted that staff at pay point 38 – whose gross pay increased by £475 in 2016/17 – saw their pension contributions increase by £1,581 and a decrease in their take-home pay as a result of the 1 per cent pay award. While we accept the point made by the Department of Health for England that the situation is complicated by the fact that many staff are in receipt of pensionable supplements to their pay, we believe that action is required to ensure that the annual pay award has the intended effect of increasing, rather than decreasing, take-home pay for all staff.

Recommendation

The Health Departments in England, Wales and Northern Ireland should ensure that annual pay awards do not have unintended consequences in reducing the take-home pay of staff whose pay pre-award is just below pension contribution thresholds.

- 2.105 The Department of Health for England noted in their evidence that the continuation of pay progression in the NHS – in contrast to much of the rest of the public sector – has softened the impact of pay restraint on individual members of staff, with many NHS staff who were employed in both 2010 and 2015 seeing their real pay increase over the period. While we accept that pay progression has served to mitigate the impact of the falling real value of the pay structure on the living standards of many individual staff, this ignores the effect on experienced staff at the top of their pay band – around half of NHS staff in England and around six out of ten NHS staff in Northern Ireland and Wales – who the service needs to retain and motivate to underpin good quality patient care.

Chapter 3 – Affordability, Efficiency and Productivity

Introduction

- 3.1 In this chapter we review the evidence on the funds available to the Health Departments in each of the four nations of the UK and the affordability of any pay uplift. This is a key consideration within our terms of reference.

Employed Staff Pay Bill

- 3.2 This section of the report outlines the evidence that we received about the employed staff pay bill and its drivers, including expenditure on agency staff.

Non-medical pay bill

- 3.3 We received data on the non-medical paybill in England, Wales and Scotland. We did not receive any data from Northern Ireland.

England

- 3.4 In 2015/16, the total pay bill for Hospital and Community Health Service (HCHS) non-medical staff was £35.7 billion, which was about three quarters of total expenditure on all HCHS staff (see Table 3.1).
- 3.5 In cash terms, the non-medical HCHS pay bill increased by 2.3 per cent in 2015/16 and is 4.8 per cent higher than in 2010/11. Qualified nursing and midwifery staff and health visitors are the largest non-medical paybill cost, with expenditure of £13.5 billion or 38 per cent of the total paybill in 2015/16. However, the biggest recent growth in paybill has been in the support to clinical staff group, with 4.2 per cent growth in 2015/16 and 13.0 per cent growth since 2010/11. Since 2010/11 the percentage of total health expenditure spent on the HCHS paybill has declined from 43 per cent to 39 per cent.
- 3.6 In real terms,¹⁷ the non-medical HCHS pay bill increased by 1.5 per cent in 2015/16, the second consecutive year of real terms growth following falls in 2011/12, 2012/13 and 2013/14. However, it remains 2.6 per cent lower than in 2010/11. Looking at individual staff groups, the real paybill in 2015/16 was below the level in 2010/11 for all staff groups except support to clinical staff, where the paybill was 3.6 per cent higher.

¹⁷Using the GDP deflator to adjust nominal expenditure figures for the impact of inflation, as is the convention in analyses of public expenditure.

Table 3.1: Employed Hospital and Community Health Service staff paybill and DH total health expenditure

£ million	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Department of Health total health expenditure			100,418	102,844	105,221	109,774	113,345	117,248
Total HCHS Paybill	39,159	41,918	43,354	43,284	43,663	44,140	45,085	46,112
Total HCHS non-medical staff	30,476	32,784	34,046	33,816	33,964	34,224	34,872	35,674
Qualified nursing, midwifery & health visiting staff	11,762	12,425	12,829	12,850	12,883	13,077	13,293	13,508
Total Qualified scientific, therapeutic & technical staff	5,168	5,560	5,849	5,923	5,981	6,012	6,048	6,139
Qualified ambulance staff	745	780	798	809	820	821	823	844
Support to clinical staff	6,349	6,866	7,188	7,159	7,227	7,413	7,689	8,012
NHS infrastructure support	6,452	7,153	7,382	7,074	7,053	6,901	7,017	7,170

Source: Department of Health's Headline Hospital and Community Health Services pay bill metrics (experimental)

Wales

- 3.7 In 2015/16, the total non-medical pay bill in Wales was £2.1 billion (Table 3.2). In cash terms, it increased by 1.8 per cent in 2015/16 and is 5.9 per cent higher than in 2011/12. Registered nursing and midwifery staff are the largest non-medical paybill cost, with expenditure of £790 million or 38 per cent of the total non-medical paybill in 2015/16. The paybill for additional clinical staff saw the largest percentage increase having increased by 14.5% since 2011/12.
- 3.8 In real terms,¹⁸ the non-medical pay bill increased by 1.1 per cent in 2015/16. This represented a return to real growth following several years of falls. However, it remains 0.2 per cent below its level in 2011/12.

Table 3.2: Non-Medical paybill in Wales

£ million	2011/12	2012/13	2013/14	2014/15	2015/16
Non-Medical Pay Bill	£1,941	£1,969	£1,997	£2,019	£2,055
Add Prof Scientific and Technic	£92	£97	£102	£90	£94
Additional Clinical Services	£299	£309	£316	£328	£343
Administrative and Clerical	£389	£391	£397	£403	£415
Allied Health Professionals	£178	£181	£184	£185	£189
Estates and Ancillary	£151	£152	£151	£152	£152
Healthcare Scientists	£70	£68	£65	£73	£73
Nursing and Midwifery Registered	£760	£768	£780	£786	£788
Students	£2	£2	£2	£2	£2

Source: Welsh Government

¹⁸ Using the GDP deflator to adjust nominal expenditure figures for the impact of inflation, as is the convention in analyses of public expenditure.

Scotland

- 3.9 In 2015/16, the total paybill for Hospitals and Community Services Non-Medical Staff was £4.0 billion (see Table 3.3), which was three quarters of the total Hospital and Community Services pay bill in Scotland.
- 3.10 In cash terms, the non-medical HCHS pay bill increased by 3.5 per cent in 2015/16 and is 11.0 per cent higher than in 2011/12. In real terms,¹⁹ the non-medical HCHS pay bill increased by 2.7 per cent, the third consecutive year of increase, and was 4.6 per cent above its level in 2011/12.

Table 3.3: Hospitals and Community Services paybill in Scotland (£ millions)

Staff Group	Financial Year				
	2011/12	2012/13	2013/14	2014/15	2015/16
Total	4,765	4,815	5,000	5,161	5,374
Total Non-Medical	3,635	3,673	3,793	3,899	4,035
Nursing and Midwifery	2,087	2,113	2,194	2,263	2,347
AHPs and Others	364	366	380	381	399
Other	1,184	1,193	1,218	1,254	1,289

Source: Scottish Government

Drivers of changes in the pay bill in England

- 3.11 Analysis of the drivers of changes in the pay bill was provided by the Department of Health for England. The Scottish Government, Welsh Government and the Northern Ireland Executive were unable to provide any information, which we find surprising given its importance.
- 3.12 Changes over time in the non-medical pay bill can be broken down into three categories to analyse the contribution made by different drivers:
- Changes in the number of full-time equivalent (FTE) non-medical staff employed by the NHS.
 - The impact of the basic pay settlement.
 - Pay drift – changes in the average cost per FTE of the workforce due to, for example, changes to staff composition by seniority or group, incremental pay progression and employment costs.
- 3.13 These three categories are described in Table 3.2 below as average FTE growth, headline pay award and paybill per FTE drift.
- 3.14 Table 3.2 presents the analysis provided by the **Department of Health** for England on the drivers of changes in the pay bill. It shows that in 2015/16 the non-medical staff paybill grew by 2.3 per cent. This was largely due to an expansion in the workforce of 2 per cent. The headline pay award increased the pay bill by a further 0.5 per cent, whilst pay drift was negative for the third year in a row, an important consideration when evaluating the impact of increments.

¹⁹Using the GDP deflator to adjust nominal expenditure figures for the impact of inflation, as is the convention in analyses of public expenditure.

Table 3.4: Change in costs of Hospital and Community Health Services non-medical staff pay bill, 2009/10 to 2015/16, England

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Aggregate Nominal Paybill Growth	7.6%	3.8%	-0.7%	0.4%	0.8%	1.9%	2.3%
<i>Elements of Paybill Growth</i>							
Average FTE Growth	4.6%	0.8%	-1.9%	-0.4%	0.6%	2.0%	2.0%
Headline Pay Award	2.4%	2.2%	0.3%	0.3%	1.0%	0.4%	0.5%
Paybill per FTE Drift	0.5%	0.7%	0.9%	0.6%	-0.8%	-0.6%	-0.2%

Source: Department of Health's Headline Hospital and Community Health Services pay bill metrics (experimental)

Notes:

- All totals are derived from unrounded figures.
- In 2014/15 a non-consolidated pay award of 1 per cent was given to those on the top pay point of their pay band, with 0 per cent to others.
- In 2015/16 various increases were given to pay points ranging from 3.1 per cent for those on pay point 2 to 0 per cent for those on pay points 43 to 54.
- Last year's award of 1 per cent (in 2016/17) is not included in this table as the data is not yet available.
- Agency staff costs are not included in these pay bill calculations.

Agency expenditure

- 3.15 Agency expenditure continued to rise across the United Kingdom in 2015/16.
- 3.16 In England, data provided by **NHS Improvement** showed that total expenditure on Agency staff in the NHS increased from £3.3 billion in 2014/15 to £3.6 billion in 2015/16 and expenditure as a proportion of staff expenditure increased from 4.1 per cent in October 2011 to 8.2 per cent in mid-2015. Expenditure could not be disaggregated between medical and non-medical staff. More evidence on the changes in agency usage in England is set out in Chapter 4 of this report.
- 3.17 In Scotland, total expenditure on Agency nurses and midwives increased by 47 per cent from £16.0 million in 2014/15 to £23.5 million in 2015/16. This is nearly six times higher than expenditure of £3.9 million in 2011/12 though is still below nominal 2005/06 expenditure of £26.5 million. Continued increases on this scale would become problematic and will need to be closely monitored. Agency nurses and midwives accounted for 0.4 per cent of total nursing and midwifery capacity. We do not have any data on agency expenditure in Scotland for other staff groups.

3.18 In Northern Ireland, data provided by the **Northern Ireland Executive** (see Table 3.5) showed that total expenditure on Agency staff by Health and Social Care Trusts increased from £79 million in 2014/15 to £92 million in 2015/16. £45 million of agency expenditure in 2015/16 was on non-medical staff, a 19 per cent increase on the previous year.

Table 3.5: Agency and Locum spend in Northern Ireland from 2010/11 to 2015/16 (£ million)

Agency Spend	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2015/16 % increase
Medical & Dental	£23.6	£23.1	£32.4	£32.6	£38.5	£46.4	20.5%
Nursing & Midwifery	£6.9	£8.6	£9.9	£11.1	£12.1	£15.8	30.7%
Prof & Tech	£1.2	£2.4	£4.9	£4.0	£3.0	£3.6	19.2%
Admin & Clerical	£5.0	£6.6	£10.9	£10.8	£10.6	£10.6	-0.1%
Support Services	£2.0	£2.8	£4.7	£5.3	£6.3	£7.8	24.0%
Social Services	£4.1	£4.6	£5.5	£5.8	£5.8	£7.5	28.8%
Other	£0.1	£0.1	£0.3	£0.1	£0.2	£0.1	-48.6%
Total	£43.0	£48.4	£68.7	£69.7	£76.5	£91.8	20.0%
Total Non-Medical	£19.4	£25.3	£36.2	£37.1	£38.1	£45.4	19.4%

Source: Northern Ireland Executive evidence submission

3.19 In Wales, data provided by the **Welsh Government** (see Table 3.6) showed that total expenditure on Agency and locum staff increased by 54 per cent from £88 million (2.8 per cent of total pay) in 2014/15 to £135 million (4.1 per cent of total pay) in 2015/16.

Table 3.6: Agency and Locum spend in Wales from 2012/13 to 2015/16

	Agency / Locum (premium) Expenditure	Total pay	Percentage of total pay
	£000s	£000s	%
2012/13	40,203	3,007,721	1.3%
2013/14	49,287	3,073,769	1.6%
2014/15	87,786	3,161,525	2.8%
2015/16	135,257	3,302,673	4.1%

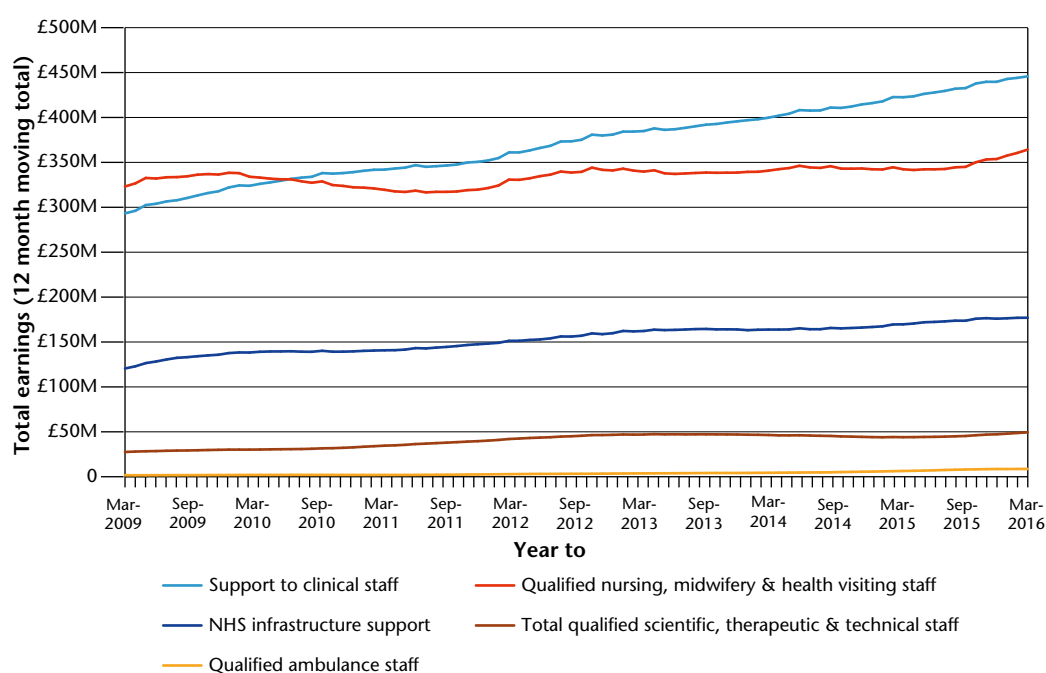
Source: Welsh Government evidence submission

Earnings of Bank Staff

England

- 3.20 The total earnings of non-medical bank staff in England increased from £776 million in 2008/09 to £976 million in 2014/15 and £1,041 million in 2015/16. However, the extent to which this is due to increases in the number of hours of work being done through NHS staff banks or an increase in hourly wages is unclear.
- 3.21 There has been wide variation in trends in Bank earnings over time for different staff groups. Increases in Bank earnings have been particularly rapid for the support to clinical staff group, which have increased by 50 per cent since 2008/09. Increases for nursing and midwifery staff have been relatively slow, with Bank earnings increasing by only 9 per cent since 2008/09.

Figure 3.1: Bank staff – total earnings by staff group (non-medical), 12 month moving total, England 2009-2016



Source: OME Analysis of NHS Digital Data

Northern Ireland

- 3.22 Expenditure on Bank staff in Northern Ireland was £65.6 million in 2015/16, an 84 per cent increase on expenditure of £35.7 million in 2010/11.
- 3.23 Table 3.7 below shows the breakdown of expenditure on Bank staff in Northern Ireland by HSC trust and by staff group. Key points include:
- Almost three quarters – 71 per cent – of expenditure on Bank staff is on nursing and midwifery staff. Most of the rest is on social services staff.
 - Expenditure on non-medical Bank staff in Northern Ireland is 44 per cent higher than expenditure on agency staff.

Table 3.7: Bank Expenditure in Northern Ireland by Staff Group (£ million)

Staff Group	2015-16
Medical & Dental	£0.1
Nursing & Midwifery	£46.5
Prof & Tech	£1.0
Admin & Clerical	£0.6
Support Services	£5.0
Estates & Maintenance	£0.0
Social Services	£12.4
Ambulance	£0.0
Prison Services	£0.0
Other	£0.0
Total	£65.6

Source: Northern Ireland Executive evidence submission

Scotland

3.24 Expenditure on Bank nursing and midwifery staff in Scotland in 2015/16 was £134.6 million, a 56 per cent increase of expenditure of £86.2 million in 2010/11. The number of hours worked by Bank nursing and midwifery staff increased by 40 per cent, from 6.0 million to 8.4 million, over the same period. In 2015/16, Bank staff made up 6.5 per cent of total nursing and midwifery capacity in Scotland.²⁰

Wales

3.25 Expenditure on Bank staff in Wales decreased by 6 per cent in 2015/16, from the previous financial year, to £55.5 million. However, this was still substantially higher than 2010/11 expenditure.

3.26 Table 3.8 below shows the breakdown of expenditure on Bank staff in Wales by staff group for 2014/15 and 2015/16. Key points include:

- Almost half of the bank expenditure in 2015/16 was spent on “additional clinical services”.
- The second largest expenditure was the nursing and midwifery staff group at 22 per cent of total bank expenditure. There was a 14 per cent (£1.9 million) fall in Bank expenditure on nursing and midwifery staff in 2015/16.

²⁰ NHS Scotland Workforce Statistics, accessed from <https://isdscotland.scot.nhs.uk/Health-Topics/Workforce/Publications/data-tables.asp>

Table 3.8: Bank Expenditure in Wales by Staff Group, financial year

	2014-15	2015-16
Add Prof Scientific and Technic	£428,730	£480,516
Additional Clinical Services	£26,415,352	£27,400,139
Administrative and Clerical	£3,967,957	£3,395,549
Allied Health Professionals	£690,931	£677,045
Estates and Ancillary	£5,741,212	£5,035,747
Healthcare Scientists	£157,823	£112,441
Medical and Dental	£7,502,559	£6,398,574
Nursing and Midwifery Registered	£13,920,805	£12,020,921
Students	£1,000	£5,561
Total	£58,826,368	£55,526,494

Source: Welsh Government evidence submission

Productivity and Efficiency

3.27 There are three related concepts that are useful in thinking about increasing productivity and efficiency in the NHS:²¹

- **Input costs:** Reducing the costs paid for the staff, goods and services used in the NHS by e.g. pay restraint, increasing unpaid overtime, using generic drugs, procurement savings or estates rationalisation.
- **Productivity:** Using inputs more effectively to produce higher output e.g. using operating theatres more intensively to produce more operations for a given capital cost.
- **Effectiveness:** Changing the mix of outputs that are produced to maximise health outcomes e.g. service reconfiguration to shift care from acute to primary care settings.

3.28 The Five Year Forward View in England sets out plans to deliver £22 billion of financial savings between 2015/16 and 2020/21, while maintaining service quality, through a combination of action to reduce input costs, improve productivity and improve effectiveness as well as action to manage demand. The terms ‘productivity improvements’ and ‘efficiency savings’ tend to be used interchangeably to mean any activities – be they reducing input costs, improving productivity, improving effectiveness or managing demand – that generate financial savings to the NHS compared to the counter-factual in which these actions are not taken.

3.29 Productivity in the NHS is measured by comparing changes over time in quality-adjusted output (cost-weighted activity for all publicly funded health services adjusted for quality using e.g. survival rates, waiting times, primary care outcomes and patient surveys) to changes over time in inputs (full-time equivalent staff weighted by cost, goods and capital). There are a number of different specific methodologies used for measuring productivity which each give different estimates of productivity growth.

²¹ See Health Foundation, *Briefing: Acute Hospital Productivity*, February 2016.

Table 3.9: Estimates of productivity increases in the NHS in 2013/14

Source	Notes	Input growth in 2013/14	Output growth in 2013/14	Productivity growth in 2013/14
Office for National Statistics	All publicly funded healthcare, 2013 calendar year, UK-wide	1.7 per cent	4.6 per cent	2.9 per cent
Centre for Health Economics	All publicly funded healthcare, England only	0.4 per cent	2.6 per cent	2.2 per cent
Health Foundation	Acute sector only, no quality adjustment, England only	3.2 per cent	2.2 per cent	-1.0 per cent

Sources: Office for National Statistics (*Public services productivity estimates: Healthcare, quality adjusted, January 2017*).

Centre for Health Economics (*Productivity of the English NHS: 2013/14 update, January 2016*); Health Foundation (*Analysis of acute hospital productivity from 2009/10 – 2014/15, February 2016*).

Evidence from the parties on affordability, efficiency and productivity

3.30 In this section of our report we consider the evidence from the parties on their funding position, the affordability context and the productivity and efficiency programme.

3.31 The **Department of Health** for England said that the NHS Five Year Forward View anticipated that £22 billion of efficiency savings would need to be made between 2015/16 and 2020/21 – equivalent to 2-3 per cent savings every year – to fill the gap between resources and patient needs. They told us that, while this efficiency savings target was challenging, it was in line with the average annual growth in labour productivity of 2 per cent seen in recent years.

3.32 The Department of Health identified five main areas they were focusing on to achieve these efficiency savings. These included:

- Reducing demand for NHS care via improving public health, introducing new models of care to divert patients from acute settings and reducing variations in care.
- Using NHS resources more efficiently – money, technology, estates and people. It was noted that the Carter Review found that the NHS could save up to £5 billion a year by making better use of staff, medicines and the NHS’s purchasing power.
- Reducing NHS costs by limiting pay increases and improving purchasing.
- Increasing NHS income via charges and commercial opportunities.
- Reducing system overheads via reducing NHS management costs.

3.33 On the contribution of pay to efficiency savings, the Department of Health noted that historically pay had been the largest cost pressure facing the NHS, with increases in the Hospital and Community Health Services (HCHS) pay bill accounting for around 38 per cent of increases in NHS revenue expenditure since 2001/02. They argued that this meant that managing the pay bill through continued pay restraint was key to ensuring affordability and told us that the NHS in England would continue to be funded for an average one per cent pay award in 2017/18, 2018/19 and 2019/20.

- 3.34 The Department of Health told us in oral evidence that the Autumn Statement saw the Department of Health receive a favourable settlement from the Treasury. The NHS budget was increased significantly with real terms increases in the budget in every year, with much of the additional funding front-loaded. Putting this increased funding into context, the budget for NHS England in 2014/15 was £98.1 billion and by 2020/21 its budget would be £119.9 billion. They also said that it was also important to stress that the budgets for the Department of Health and the NHS are different – the DH budget is not increasing in real terms – and, for example, some of the savings from nursing bursaries, have been recycled into the NHS, which might explain the difference with Health Select Committee figures that some organisations have cited.
- 3.35 The Department of Health also confirmed in oral evidence that the NHS is under pressure to raise productivity to accommodate increases in demand. They highlighted Professor Tim Briggs' work on "Getting It Right First Time", which has highlighted significant variation in patient outcomes across different trusts and is informing actions to reduce this variability by, for example, stopping patients from repeatedly seeking treatment. They also highlighted other measures that have been taken to improve efficiency, including on procurement and managing demand. As an example of the latter they told us how one trust had introduced a streaming system in Accident and Emergency departments which is estimated to have redirected 30 per cent of patients out of the hospital to more appropriate care settings.
- 3.36 **NHS England** also highlighted that a £22 billion efficiency challenge between 2016/17 and 2020/21 compared to the "do nothing" baseline remained despite real terms funding growth over the next 5 years. NHS England noted that the efficiency improvements required are similar in scale to those that were needed from 2010 to 2015. They pointed us towards their May 2016 evidence to the Health Select Committee for further details about their programme to deliver these efficiencies and the baseline against which savings are assessed.²²
- 3.37 NHS England said that current plans required £3.5 billion of these efficiency savings to be delivered through implementing the Government's 1 per cent public sector pay cap until 2019/20. They told us that, if these savings were not delivered through pay restraint, additional savings would be needed from elsewhere, potentially reducing the resources available for delivering and improving services to patients.
- 3.38 **NHS Improvement** told us that the NHS provider sector in England had been facing significant and sustained financial strain, with the sector ending the 2015/16 financial year with a deficit of £2.5 billion, substantially bigger than the £0.8 billion deficit in the previous year and about £0.5 billion worse than planned. They noted that around two thirds (66.1 per cent) of provider expenditure in 2015/16 was accounted for by workforce costs. They also provided data showing agency expenditure in 2015/16 was £3.6 billion – or 7.5 per cent of total pay costs – which was 62 per cent higher than planned agency expenditure of £2.2 billion.
- 3.39 NHS Improvement explained how they had introduced controls on agency expenditure with the aim of reducing agency spend, including by encouraging staff to return to permanent or bank working and by encouraging greater managerial focus on the issue. These rules included expenditure ceilings on individual trusts, price caps on agencies, wage caps on agency staff and mandatory use of framework agreements, with "break-glass" provisions to allow for the controls to be over-ridden where needed to maintain patient safety. NHS Improvement said these controls had reduced expenditure in the early part of 2016 by around 20 per cent compared to 2015, with most trusts reporting some net savings and average agency rates for nurses falling 18 per cent since controls were introduced.

²² NHS England, *NHS Five Year Forward View: Recap Briefing for the Health Select Committee on Technical Modelling and Scenarios*, May 2016.

- 3.40 On operational productivity, NHS Improvement highlighted the Carter Review findings that there were unwarranted variations in efficiency across trusts, giving the example that there is more than 20 per cent variation between the most and least expensive trust in terms of the cost of inpatient treatment. They noted that Lord Carter had estimated that the NHS in England could achieve total efficiency gains of at least £5 billion per year by 2020/21 if all trusts were as efficient as the current average performers in all areas. NHS Improvement identified a number of actions they were taking to reduce this variation to help trusts unlock these efficiency savings, including development of the Model Hospital portal to help providers benchmark key performance and productivity metrics against their peers and best practice.
- 3.41 **NHS Employers** said that the financial position of the NHS set the key context for this year's pay round and that continuing to contain pay costs remained an integral part of addressing the financial challenge. They noted that the NHS continues to face unprecedented financial and service challenges, observing that two thirds of trusts were in deficit in 2015/16 and the overall shortfall, at £2.5 billion, was at record levels. They also highlighted that the financial settlement for the NHS up to 2020 was extremely challenging, with ambitious targets to deliver efficiency savings alongside continued rises in demand for services of 2.5 per cent per year for acute services. They told us that changes in staff costs above those already planned for would have a significant impact on the financial viability and sustainability of NHS financial plans.
- 3.42 NHS Employers said that demand for NHS services continues to outstrip increases in NHS funding. They told us that acute activity grows by around 2.5 per cent per year and pressure on prices by up to 3.7 per cent, while NHS funding is set to grow at a little under 1 per cent per year over this Parliament. They noted that the £8.6 billion per year of hospital savings required by 2020 as part of the efficiency programme implied 2 per cent per annum productivity improvements and told us that this would require a significant step-up from the long-run average of 1 per cent per year productivity improvements as well as a reversal of recent hospital productivity, which they said had been reducing for the last three years. They flagged up findings from the latest NHS Confederation member survey that 96 per cent of NHS leaders had little or no confidence that the efficiency savings set out in the Five Year Forward View would be possible.
- 3.43 **NHS Providers** said that provider trusts have had to cope with increasing demand and rising costs within funding increases that have averaged 0.9 per cent per year since 2010, which is well below the historical average of about 4 per cent. They told us that this had led to providers' financial positions worsening, with a £2.5 billion deficit in 2015/16. They also noted that achieving the target set by central government to limit the total deficit to £250 million in 2016/17 would be extremely challenging, especially as large amounts of the savings needed to rely on measures such as back office rationalisation that were unlikely to be able to deliver savings within the financial year. However, NHS Providers did suggest that additional resources that were being provided through the tariff and the £1.8 billion sustainability fund, together with other one-off measures, would help. NHS Providers observed that an annual pay award would be affordable provided that it was fully funded through the national tariff.
- 3.44 The **Welsh Government** identified a number of affordability challenges facing NHS Wales, including rising costs, increasing demand, an ageing population and a growth in the number of people experiencing chronic conditions. A number of increases in employment costs arising from increases in employer pension contributions, pension auto-enrolment and the April 2017 introduction of the Apprenticeship Levy were also identified. In addition, they observed that the financial settlement for the wider public sector was challenging, noting that the Welsh Government's revenue budget in 2019/20 would be around 8 per cent lower in real terms than in 2010/11. However, they said that the health budget was being protected to some degree from this pressure, highlighting recent increases in health budget allocations.

- 3.45 On long-term sustainability, the Welsh Government cited a recent Health Foundation report²³ which they said confirmed that the NHS in Wales would be financially sustainable and affordable provided it continued to deliver efficiency in line with long-term trends and NHS funding increases in line with expected GDP growth. However, the Welsh Government noted that, in the short-term, a funding gap of £150 million per year by the end of 2019/20 had been identified (assuming that the UK Government's public sector pay policy was followed in Wales), though they said that this was being addressed in part through additional funding allocations.
- 3.46 The **Northern Ireland Executive** said that real public expenditure in Northern Ireland would decrease over the next few years with efficiency and productivity improvements essential to meeting key targets within current resources. They noted that the high proportion of expenditure accounted for by pay meant that trends in public sector pay costs would have significant implications for the availability of resources to support staff and deliver public services. The Northern Ireland Executive observed that a 1 per cent pay award may cost a further £21 million in 2017/18.

Funding Pay Awards through the tariff

- 3.47 In this section of our report, we consider the evidence from the parties in England on available resources for pay awards being provided through the tariff.

Evidence from the parties on funding pay awards through the tariff

- 3.48 **NHS Employers** said that a two-year national tariff was being introduced for the 2017/18 and 2018/19 financial years. They noted that there were no plans to set an efficiency factor within the tariff of greater than 2 per cent – in line with the efficiency factor set in 2016/17 and half the level set in previous years. NHS Employers said that the multi-year tariff would help support the implementation of Sustainability and Transformation Plans, though noted that this would depend on the extent to which the deficit in the provider sector had been eliminated by the end of the current financial year.
- 3.49 NHS Employers also said that feedback from employers showed that the majority said they would prefer multi-year pay settlements to provide greater stability and certainty about pay costs. However, they also noted that a number of employers disagreed given current economic uncertainties and the belief that a longer-term pay settlement would work best in the context of supporting a transition to a reformed pay structure.
- 3.50 On pay targeting, NHS Employers noted during oral evidence that funding targeted awards through the tariff would require adjustment of the Market Forces Factor and allocations to CCGs and that there was no easy way of doing this, especially given that the two-year national tariff will fix these until April 2019.
- 3.51 **NHS Providers** told us that the annual pay award was funded via the cost uplift within the national tariff whereby changes in costs that all providers had to bear were factored into tariff prices. They noted that the proposed cost uplift in 2017/18 of 2.1 per cent was significantly less than the 3.0 per cent uplift in 2016/17 and suggested that it would seem less likely than in previous years that the tariff had addressed issues of pay affordability.
- 3.52 On pay targeting, NHS Providers said that the Market Forces Factor within the tariff was supposed to adjust prices in line with pay variation across different geographic regions but that it had not been updated for several years and its accuracy in adjusting for local pay circumstances had been questioned by some NHS providers.
- 3.53 **The Department of Health** for England told us that the NHS would be funded for an average one per cent pay award up to 2019/20.

²³ Health Foundation, *The Path to Sustainability: Funding Projections for the NHS in Wales*, October 2016.

- 3.54 On pay targeting, they said that the Market Forces Factor already aligned funding to the local labour market and that they did not believe the decision to introduce a two-year tariff would prevent consideration of the evidence and case for targeting. However, at oral evidence the Department acknowledged that it would be difficult for the existing NHS funding system to respond with extra money to ensure any targeted recommendations were funded at a local level.
- 3.55 **NHS England** said that the two-year National Tariff Payment System for 2017/18 and 2018/19 included an assumption of 1 per cent headline growth in pay, with adjustments to take account of other factors affecting overall pay expenditure such as pay drift. They said that the two-year tariff would provide greater stability and certainty to support long-term planning and investment. They told us that this would support service redesign and the recruitment of appropriately qualified staff, improving patient experience and outcomes and also reducing pay pressures on providers.
- 3.56 **NHS Improvement** told us that the pay assumptions being made within the Tariff were published in *National Tariff Payment System 2017/18 to 2018/19: A Consultation Notice*.²⁴ This identified four key elements of pay inflation: pay settlements, pay drift, staff group mix and extra overhead labour costs. It projected labour cost inflation of 2.1 per cent in 2017/18 and 2.0 per cent in 2018/19 based on:
- A 1 per cent pay award in 2017/18 and in 2018/19 in line with public sector pay policy.
 - Pay drift and group mix effects of 0.7 per cent in 2017/18 and 1.0 per cent in 2018/19, adjusting DH projections by -0.3 per cent to exclude elements of pay inflation that would lead to additional output and be remunerated through activity rather than price.
 - The apprenticeship levy and the immigration skills charge, which together were expected to add a net 0.4 per cent to the pay bill in 2017/18 only.

Service Transformation, including Sustainability and Transformation Plans

- 3.57 This section will cover the evidence that we have received on Sustainability and Transformation Plans (STPs).

Evidence from the parties on service transformation

- 3.58 The **Department of Health** for England said that every health and care system in England is producing a multi-year STP, showing how local services will evolve and become more sustainable over the next five years to deliver the Five Year Forward View vision of better health, better patient care and improved NHS efficiency. They told us that there were 44 STP 'footprints' and that health and care organisations within each area were working together to develop STPs which will help drive genuine and sustainable transformation in patient experience and health outcomes over the long-term.
- 3.59 **Health Education England** told us in oral evidence that (at the time they were giving evidence) there was little granular detail available regarding the development of STPs to inform understanding of their workforce implications. They said that there was some early aggregation of figures at the national level but that this was only indicative and subject to change as final plans were developed.

²⁴ NHS Improvement, *National Tariff Payment System 2017/18 to 2018/19: A Consultation Notice*, October 2016.

- 3.60 **NHS England** highlighted NHS shared planning guidance issued in December 2015 that set out a new approach to help ensure that health and care services are planned by place rather than solely around individual institutions, and over a period of five years rather than a single year. They said that the design and delivery of STPs was central to this, and that these must show clearly how each area will pursue the 'triple aim' set out in the NHS Five Year Forward View – improved health and wellbeing, transformed quality of care and sustainable finances. They noted that, while there was clear scope for STPs to facilitate collaboration and integration of service which will have staff implications, it was too early to draw national conclusions on workforce requirements before consensus on future service models was finalised.
- 3.61 They said that the STP process had shown that systems were committed to delivering transformation in the interests of patients and that the STP process would yield significant efficiency savings against the target of £15 billion by 2020/21.
- 3.62 **NHS Employers** said that a different approach is required to deliver a health and social care system that is capable of meeting the scale of the financial and sustainability challenge by: shifting care from hospitals to the community; introducing new models of care that support the integration of health and social care; and supporting a focus on preventing illness and promoting health and wellbeing.
- 3.63 They highlighted the role that STPs will play in bridging the gap between health and social care, improving outcomes for people accessing services, supporting greater efficiency and effectiveness in service delivery, and delivering cost savings. They said that £1.8 billion of additional funding has been agreed for providers as part of a Sustainability and Transformation Fund to support these changes.
- 3.64 In oral evidence, we were told that some employers have already established STP clusters with significant cross-site working including across different HCAS zones. They noted that differentials in pay between staff employed by different organisations can cause problems if staff are working closely with someone doing a similar job on a different pay scale with noticeably more pay.
- 3.65 **NHS Improvement** said that they are working directly with three STP footprints on productivity and transformation, including working with Health Education England, NHS Employers and NHS England to identify and remove any system-level barriers and engaging with local workforce advisory boards to provide practical support in areas such as retention, recruitment and staff mobility.
- 3.66 They also highlighted their work with Health Education England to support NHS providers in developing new roles, including recognising the value of non-registered care staff in bands 2-4 and apprentice and nurse associate roles through sharing best practice and facilitating buddy arrangements between trusts. They said that this programme will also support the development of advanced practice roles for nurses and learning opportunities for other staff groups to support the medical workforce.
- 3.67 NHS Improvement told us in oral evidence that the development of STPs is in its early stages meaning that it is too early to judge the overall progress being made or the deliverability of the plans. They noted that it is the first time that this approach to service delivery had been applied and so will take time. They said that some STPs had already achieved some of what they had set out to do and are collaborating closely with each other, especially where there is a history of previous collaboration, but that some were lagging behind. They added that it has been challenging to develop good collaboration in a short space of time, especially where the STP footprint areas were less reflective of the local healthcare economy. They stressed that it is important to remember that not all STPs will reach their destination at the same time.

3.68 **NHS Providers** told us in oral evidence that service transformation takes time and that savings from STPs will only be available after significant time lags, making it challenging to restrain demand and achieve short-term savings targets.

Our comment on affordability, efficiency and productivity

3.69 There is a big affordability challenge over the next few years in each of the four nations of the UK. The underlying driver of this affordability challenge is the combination of slowly increasing real terms NHS budgets with significant increases in patient demand driven by demographic pressure, increasing patient expectations and pressures on the social care system.

3.70 The Spending Review in England provided for an increase in nominal NHS expenditure of 18 per cent between 2015/16 and 2020/21. This is broadly in line with anticipated NHS cost inflation – with, for example, the unit cost of acute services anticipated by NHS England to increase by 16 per cent over the period in the absence of pay restraint. However, demand for healthcare is also expected to increase significantly over the period with, for example, NHS England anticipating a 13 per cent increase in demand for acute services over the period.²⁵

3.71 Scotland, Wales and Northern Ireland are facing similar demand and funding pressures. All four countries of the UK have taken the view that some degree of pay restraint is required, as part of broader action to reduce the cost of healthcare, in order to accommodate rising patient demand within broadly flat real terms budgets.

3.72 This is especially the case given the challenges faced by trusts and health boards in living within their budgets. There is evidence of increasing strain on health providers and difficulties in achieving the required efficiency savings while delivering good quality patient care within the funding envelope:

- Financial results for 2015/16 show that the majority of trusts in England were in deficit and that the overall deficit is at record levels. The recent National Audit Office report on financial sustainability of the NHS in England concluded that “financial problems are endemic and this is not sustainable” and questioned whether plans to move the system back to financial stability in 2016/17 will be effective, noting that government has “a way to go to demonstrate that they have balanced resources and achieved stability as a result of this effort”.²⁶
- Audit Scotland said that NHS funding in Scotland is not keeping pace with increasing demand. They noted that health boards are facing an extremely challenging financial position and will need to make unprecedented levels of savings in 2016/17 to break even. They also note that NHS Scotland failed to meet seven out of its eight key performance targets.²⁷
- A recent report published by the Health Foundation²⁸ concluded that the NHS in Wales faces a funding gap of £700 million by 2020/21 – equivalent to 10 per cent of current NHS spending – and that filling this would require adherence to the UK Government’s public sector pay policy combined with efficiency savings of 1.5 per cent per year and the resisting of demand pressures due to social care funding constraints, technological change and patient demand.
- There is a lot of scepticism among senior NHS leaders in England about the realism of the efficiency savings set out in the Five Year Forward View – the finding that 96 per cent had little or no confidence the required savings would be possible highlighted by NHS Employers is particularly concerning.

²⁵ NHS England, *NHS Five Year Forward View: Recap Briefing for the Health Select Committee on Technical Modelling and Scenarios*, May 2016.

²⁶ National Audit Office, *Financial Stability of the NHS*, November 2016.

²⁷ Audit Scotland, *NHS in Scotland 2016*, October 2016.

²⁸ Health Foundation, *The Path to Sustainability: Funding Projections for the NHS in Wales*, October 2016.

- Patient demand continues to increase rapidly, with A&E attendances in England up 5 per cent and emergency hospital admissions from A&E up 4 per cent year-on-year in the second quarter of 2016/17.²⁹
- Access to healthcare in England – as measured by performance targets for urgent care and waiting times – continues to worsen.³⁰
- Pressures on frontline staff in England continue to increase despite increasing staff numbers, discussed at greater length in Chapter 4.
- In May 2016, NHS England said that, without an upgrade in prevention measures, support for wider public health measures and action to address the widening gap between social care need and social care funding, the demand projections in the Five Year Forward View will be too optimistic meaning that the funding gap will be bigger than anticipated.³¹

3.73 In thinking about the affordability challenge, it is helpful to consider the different ways in which the gap between rapidly increasing demand pressures and plans for slow funding increases can, in principle, be bridged:

- Manage the growth in demand for particular types of service (e.g. improved public health, improved social care or increased rationing).
- Generate additional revenue streams (e.g. increased user charging or shifting the costs of training onto students).
- Get genuine productivity improvements by obtaining given levels of activity or outcomes with fewer staff and resources (e.g. through service re-configuration).
- Use labour and resources more intensively (e.g. encouraging better utilisation of NHS staff).
- Reduce service quality (e.g. allowing waiting times to increase, increasing patient/nurse ratios, using less experienced/qualified staff, reducing maintenance and investment or accepting worse health outcomes).
- Try to moderate the costs of inputs (e.g. reducing the cost of drugs or holding down NHS pay).

3.74 It is not helpful to bundle all these different potential responses to affordability challenges together under the headline of “efficiency savings” because it makes it hard to assess how achievable they are in comparison with cost and efficiency savings in other organisations and because some types of savings are more desirable than others. In particular, the final item involves a comparison between actual pay rates and a counter-factual alternative that is difficult to estimate with any degree of precision.

3.75 Along with other commentators we are concerned that there are limits to how far the NHS can balance broadly flat real funding with rapidly increasing demand. We are also concerned that holding down pay has become the default position, as service transformation is not yet delivering sufficient efficiencies. Unlike in many parts of the public sector, there are limits to how far the NHS can moderate demand as it is unable fully to control the level of activity e.g. the NHS is unable to turn away patients arriving at A&E and it can be politically difficult to reconfigure services to improve efficiency. There are also limits to the types of efficiency savings that can be made due to e.g. regulatory requirements on service quality such as safe staffing levels or education requirements for staff. In the face of all of these pressures, attempts to control costs in certain ways can have unintended consequences:

- Unplanned deterioration in the quality of care leading to e.g. elective operations being postponed reducing asset utilisation as well as waiting time targets being missed.

²⁹The King’s Fund, *Quarterly Monitoring Report*, November 2016.

³⁰The King’s Fund, *Quarterly Monitoring Report*, November 2016.

³¹NHS England, *NHS Five Year Forward View: Recap Briefing for the Health Select Committee on Technical Modelling and Scenarios*, May 2016.

- Unintended increases in cost pressures elsewhere e.g. an increase in the use of paid overtime and agency due to staff shortages if pay becomes uncompetitive.
- Significant levels of unpaid overtime and an intensification of work effort, with a consequent impact on staff morale.
- Perceptions of unfairness, with potential impact on recruitment, retention and motivation, from staff being expected to absorb additional cuts in their real pay at the same time as their workload increases in order to mitigate the cost pressures created by unfunded increases in the demand for healthcare.

3.76 It is hoped that Sustainability and Transformation Plans (STPs) in England will deliver significant savings against the £22 billion efficiency challenge identified in the Five Year Forward View both in terms of moderating demand growth e.g. through care redesign (which accounts for £4.3 billion of the savings target) and in terms of supporting the target to improve secondary care productivity by 2 per cent per year e.g. through service reconfiguration (which accounts for £8.6 billion of the savings target). However, we note the concern expressed by NHS Providers that transformation takes time, that realising the benefits and improvements from new care models will be a 10-15 year process and not a 3-5 year process, and that the evidence for integration achieving efficiencies is weak.³² We share this concern and worry that the savings anticipated over the next few years as a result of STPs will not materialise quickly, worsening affordability pressures.

3.77 While the Health Departments in England and Wales said that they would provide funding for a 1 per cent pay award, and the Health Department in Northern Ireland said that they were factoring a potential 1 per cent pay uplift into budget considerations for 2017/18, the difficulties faced in restraining demand and the severe challenges in achieving the assumed efficiency savings suggest that this may not be truly affordable at current funding levels.

3.78 The Five Year Forward View baseline for pay costs assumed that average NHS pay would increase in line with the Office for Budget Responsibility's March 2014 projections of whole economy average earnings growth³³ – an average of 3.7 per cent per year.³⁴ NHS England's estimate of the contribution to efficiency savings being made by pay restraint over the next few years – £3.5 billion – is based on an assumption that average NHS pay will increase in line with the UK Government's public sector pay policy – 1 per cent per year.

3.79 In last year's report we noted that it was impossible to provide an accurate interpretation of the comparative position across the UK on pay bill drivers – including agency spend – as the four countries do not provide consistent data. We asked each of the four countries to replicate the approach taken by the Department of Health in England on the drivers of pay bill increases and to replicate the approach taken by the Northern Ireland Executive in breaking down agency spend by staff group. We are disappointed that this has not happened as it means that we do not have a full understanding of the pay bill drivers and context in each country and this makes accurate comparisons across the UK impossible.

Observation

We repeat our request from last year for the health departments to improve the evidence on the drivers of pay bill trends over time and agency expenditure, not only to support the pay review process but to help understanding of cost drivers facing the service.

³² NHS Providers, *The State of the NHS Provider Sector*, November 2016.

³³ NHS England, *NHS Five Year Forward View: Recap Briefing for the Health Select Committee on Technical Modelling and Scenarios*, May 2016. There was also some adjustment for known employer cost changes.

³⁴ Office for Budget Responsibility, *Economic and Fiscal Outlook March 2014: Table 1.6*, March 2014.

3.80 As noted in Chapter 1, our remit set by the UK Government this year included an expectation that pay awards would be targeted. Our report last year highlighted our concerns that the mechanics of the pay and tariff system were unable to cope with targeting pay by geography or by staff group and that, as a result, targeted awards would impact negatively on some providers finances. We asked that health departments consider how funding mechanisms need to be adapted to allow proposals for pay targeting to be funded and for assurances that this issue had been resolved. These assurances have not been forthcoming. While, in England, the Market Forces Factor aligns the funding of NHS organisations to average private sector pay in the local area, this has been fixed for several years now, is not directly related to recruitment and retention pressures within the NHS, and would not adjust to provide additional (or fewer) resources in response to pay targeting recommendations. We therefore have no confidence that national pay targeting would be funded at a local level, especially within the context of a national tariff that will shortly be fixed until April 2019. This constrains our ability seriously to consider national pay targeting. We return to this in Chapter 7.

Chapter 4 – Recruitment, Retention and Vacancies

Introduction

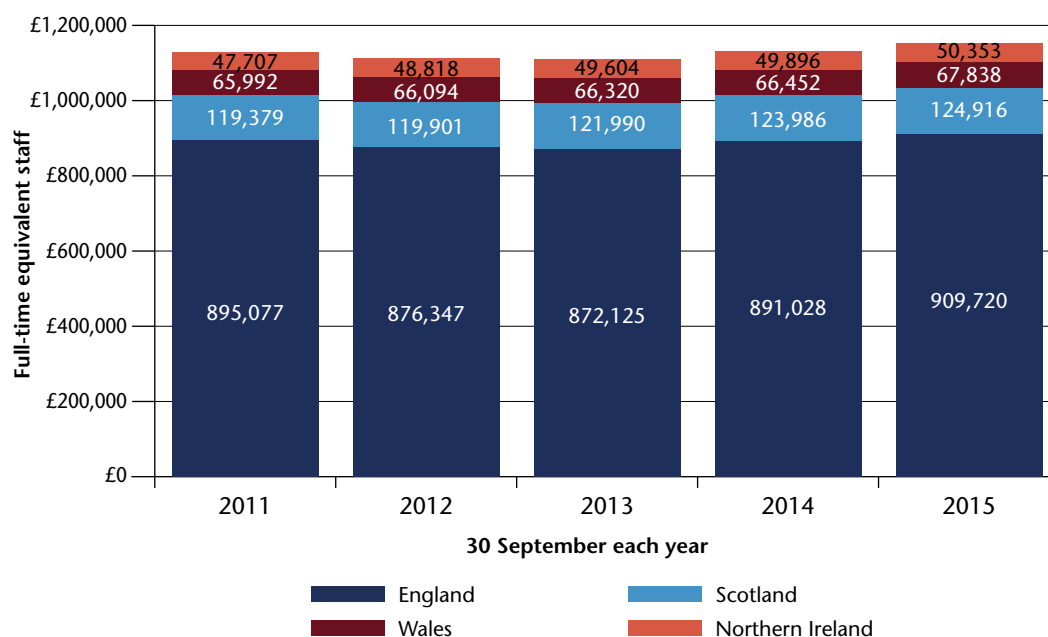
- 4.1 We are required by our terms of reference to have regard to the need to recruit and retain suitably able and qualified staff, and to the effects of regional and local variations in labour markets on the recruitment and retention of staff in reaching our recommendations.
- 4.2 This chapter therefore presents the evidence presented to us, as well as our own analysis, of the current recruitment and retention position of our remit group, including: the NHS workforce, vacancies and turnover; High Cost Area Supplements; and Recruitment and Retention Premia (RRPs).
- 4.3 The focus of this chapter is on the current picture. Chapter 6 looks ahead to prospects for the longer-term and how future supply is managed, including workforce planning, training provision and the NHS's People Strategy.

NHS Workforce, Turnover and Vacancies

Changes in staffing levels

- 4.4 Figure 4.1 shows recent changes in the non-medical NHS workforce for the United Kingdom as a whole and for each of the four United Kingdom countries:
 - The United Kingdom FTE non-medical NHS workforce increased by 1.9 per cent (~21,500 FTE) between September 2014 and September 2015, to a total of 1.153 million FTE or 1.328 million in headcount.
 - Of the United Kingdom non-medical FTE workforce in 2015, England accounted for 80 per cent, Scotland for 10 per cent, Wales for 6 per cent and Northern Ireland for 4 per cent. These proportions were unchanged from 2014.
 - Each country of the United Kingdom experienced an increase to their non-medical NHS workforce between September 2014 and September 2015, with growth faster in England and Wales than elsewhere:
 - England: 2.1 per cent increase in FTE (~18,700) equal to a 1.8 per cent increase in headcount (~18,300);
 - Scotland: 0.8 per cent increase in FTE (~950) equal to a 0.7 per cent increase in headcount (~970);
 - Wales: 2.1 per cent increase in FTE (~1,400) equal to a 1.9 per cent increase in headcount (~1,500);
 - Northern Ireland: 1.0 per cent increase in FTE (~500), equal to a 0.9 per cent increase in headcount (~500).

Figure 4.1: NHS non-medical workforce in the United Kingdom, September 2011 to September 2015¹



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

4.5 Table 4.1 looks in more detail at the change in the number of FTE non-medical NHS staff in the year to September 2015. Every staff group in England, Scotland, Wales and Northern Ireland, with the exception of administration, estates and management in Northern Ireland, saw an increase in staff numbers. Ambulance was the fastest growing staff group in each of the four nations of the United Kingdom, with a 4.8 per cent increase in staff numbers across the whole country.

³⁵ NHS Digital has changed its workforce data collection methodology in England, meaning comparisons cannot be made with previously published data. This report presents updated data which may conflict with previously published results. These methodology changes have resulted in a fall in the estimated number of staff working for the NHS in England. Further detail on the impact of the changes is available from NHS Digital <http://content.digital.nhs.uk/search/catalogue?productid=20576&q=method&topics=0%2fWorkforce&pubdate=MAR%2c2016&sort=Relevance&size=10&page=1#top>

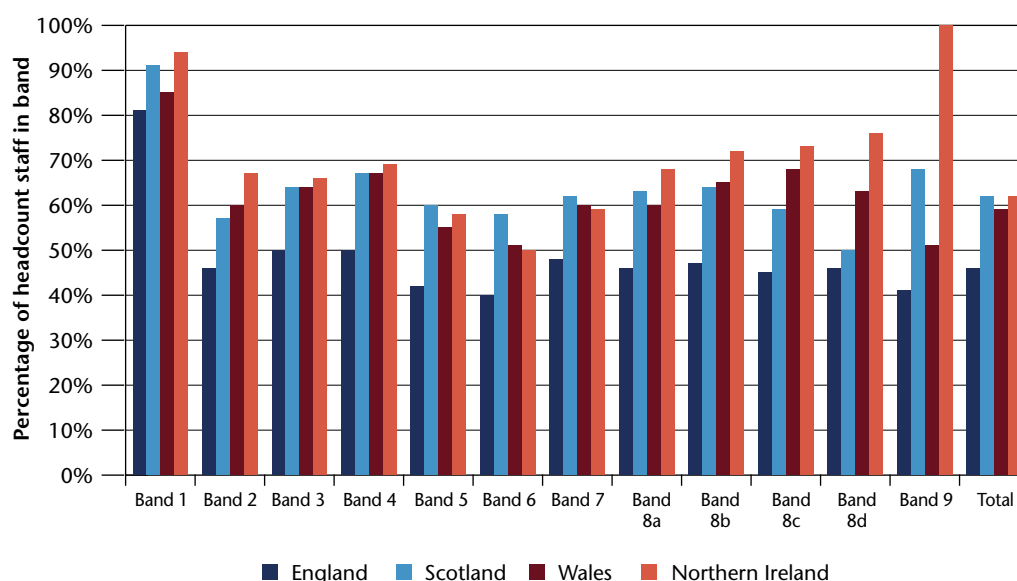
Table 4.1: Full-time equivalent non-medical staff in NHS by United Kingdom country and broad staff group, September 2014 to September 2015

Broad staff group		England	Scotland	Wales	Northern Ireland	United Kingdom
Qualified nursing and midwifery	FTE	302,408	43,085	22,146	14,725	382,365
	% change	0.9%	1.1%	0.7%	1.7%	0.9%
	FTE change	2,589	469	159	253	3,470
Unqualified nursing and healthcare assistants and support	FTE	232,270	15,838	16,290	4,044	268,442
	% change	3.1%	0.3%	2.0%	1.4%	2.9%
	FTE change	7,050	47	327	54	7,479
Professional, technical and social care	FTE	180,479	22,148	11,971	14,201	228,800
	% change	2.0%	0.7%	2.6%	1.8%	1.9%
	FTE change	3,505	160	301	254	4,219
Ambulance	FTE	32,492	3,811	1,598	1,070	38,970
	% change	5.3%	1.6%	3.5%	2.4%	4.8%
	FTE change	1,649	60	54	25	1,788
Administration, Estates and Managers	FTE	158,101	39,019	15,724	16,313	229,158
	% change	2.5%	0.7%	3.6%	-0.8%	2.0%
	FTE change	3,816	264	552	-129	4,502
Total	FTE	909,720	124,916	67,838	50,353	1,152,826
	% change	2.1%	0.8%	2.1%	0.9%	1.9%
	FTE change	18,692	930	1,385	457	21,464

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

4.6 Figure 4.2 shows the percentage of staff at the top of each Agenda for Change pay band by United Kingdom country. For England, Scotland and Northern Ireland, the latest available data relates to 2016. The figures for individual countries ranged from 46 per cent of staff at the top of pay bands in England to 62 per cent in Scotland and Northern Ireland. For Wales, the data used relate to 2015 and show that 59 per cent of staff were at the top of pay bands in 2015. This means that more than half of the remit group in the UK as a whole – and around six out of ten staff in Northern Ireland, Scotland and Wales – are not eligible for incremental pay increases.

Figure 4.2: Percentage of staff at the top of pay bands by UK country, latest available data



Source: NHS Employers, and Wales, Scotland and Northern Ireland Health Departments.

Note: Data for England relate to April 2016; Scotland, 2015/16 average; Wales, Sept 2015; Northern Ireland, March 2016

Turnover

4.7 Table 4.2 and Table 4.3 show the latest available joining and leaving rates in England, Scotland, Wales and Northern Ireland by staff group. Data is not directly comparable between the different countries. For example, in England the data includes staff moving between different NHS trusts as well as moves into and out of the NHS.

4.8 Looking at leaving rates:

- Overall leaving rates have been broadly static in each of the countries, though trends within individual staff groups have varied. For example, in England leaving rates for midwives and ambulance staff have been increasing over the last few years while leaving rates for support staff have been flat.

Table 4.2: Leaving rates from the NHS by staff group and country, 2010 to 2016

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
England						
All NHS non-medical	9.9%	11.4%	10.3%	11.7%	10.7%	10.9%
Nurses & health visitors	8.6%	10.1%	9.7%	9.5%	10.1%	10.4%
Midwives	7.4%	8.0%	8.3%	8.7%	9.5%	10.0%
Ambulance staff	4.8%	5.0%	6.0%	6.8%	7.4%	7.6%
Scientific, therapeutic & technical staff	9.3%	11.2%	10.7%	10.3%	11.1%	11.2%
Support to clinical staff	10.6%	12.3%	10.6%	10.5%	11.1%	11.2%
NHS infrastructure support	11.7%	13.0%	11.4%	19.5%	11.3%	11.4%
Scotland						
All NHS (incl. medical and dental)	7.1%	6.5%	5.7%	5.8%	6.2%	6.5%
Nursing and midwifery	6.0%	5.9%	6.0%	6.2%	6.8%	7.2%
Allied health professions	6.2%	6.5%	6.3%	5.7%	6.6%	7.0%
Other therapeutic services	9.0%	6.7%	6.2%	6.9%	6.5%	7.1%
Personal and social care	7.8%	18.1%	13.3%	14.2%	13.4%	10.5%
Healthcare science	5.8%	8.5%	7.1%	6.5%	7.1%	7.2%
Ambulance services	3.5%	4.7%	4.8%	N/A	7.5%	10.0%
Administrative services	7.4%	9.0%	7.3%	7.5%	7.3%	8.0%
Support services	12.3%	11.3%	9.1%	9.2%	9.3%	9.0%
Wales						
All NHS (incl. medical and dental)	N/A	N/A	N/A	N/A	N/A	6.1%
Nursing and midwifery (registered)	N/A	N/A	N/A	N/A	N/A	6.9%
Allied health professionals	N/A	N/A	N/A	N/A	N/A	6.8%
Estates and ancillary	N/A	N/A	N/A	N/A	N/A	7.4%
Healthcare scientists	N/A	N/A	N/A	N/A	N/A	6.7%
Additional professional, scientific and technical	N/A	N/A	N/A	N/A	N/A	9.3%
Additional clinical services	N/A	N/A	N/A	N/A	N/A	9.3%
Administrative and clerical	N/A	N/A	N/A	N/A	N/A	7.9%
Northern Ireland						
All NHS (incl. medical and dental)	5.2%	4.2%	5.2%	4.6%	4.8%	4.6%
Administration & Clerical	5.8%	3.6%	4.8%	5.6%	4.6%	4.4%
Estates Services	6.5%	5.3%	11.5%	6.5%	5.8%	8.6%
Support Services	7.3%	6.0%	5.2%	5.4%	7.5%	5.3%
Nursing & Midwifery	4.4%	3.9%	4.5%	4.2%	5.0%	5.1%
Social Services (excl. Home Helps)	10.4%	9.0%	7.1%	5.6%	4.3%	4.7%
Professional & Technical	4.6%	3.5%	4.3%	3.6%	4.2%	3.9%
Ambulance	1.6%	2.3%	2.5%	2.6%	3.8%	3.3%

Source: NHS Digital; Information Services Division Scotland; Department of Health Northern Ireland (HSC); and Welsh Government evidence

4.9 Looking at joining rates:

- Since 2012/13 joining rates have been increasing in England in all staff groups but have been broadly flat in Scotland and Northern Ireland. No time series data is available for Wales.
- Joining rates are higher than leaving rates in every part of the United Kingdom, meaning that the number of NHS staff is increasing, as shown in Figure 4.1.

- This is the case for every staff group in England, Scotland and Wales and for staff groups in Northern Ireland with the exception of administration and clerical, estate services and support services.
- Overall, taking leaving and joining rates together, turnover has increased.

Table 4.3: Joining rates to the NHS by staff group and country, 2010 to 2016

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
England						
All NHS non-medical	8.8%	8.3%	9.7%	11.7%	12.0%	12.7%
Nurses & health visitors	8.2%	7.8%	9.0%	10.9%	10.2%	10.6%
Midwives	9.2%	9.2%	9.5%	10.1%	10.1%	10.6%
Ambulance staff	3.0%	3.4%	3.8%	5.0%	5.6%	8.2%
Scientific, therapeutic & technical staff	9.3%	8.3%	9.5%	11.2%	11.0%	11.6%
Support to clinical staff	9.8%	9.1%	11.2%	13.9%	14.5%	15.3%
NHS infrastructure support	8.0%	7.9%	9.0%	10.7%	12.0%	12.9%
Scotland						
All NHS (incl. medical and dental)	4.7%	4.6%	7.1%	7.2%	7.4%	7.2%
Nursing and midwifery	3.4%	4.7%	6.6%	7.7%	8.1%	7.4%
Allied health professions	4.7%	5.7%	8.0%	18.2%	7.4%	8.3%
Other therapeutic services	9.8%	9.6%	10.5%	10.1%	10.8%	9.3%
Personal and social care	7.6%	14.0%	12.3%	13.1%	21.3%	21.0%
Healthcare science	3.8%	4.3%	5.6%	8.0%	7.9%	7.6%
Ambulance services	3.1%	1.8%	6.4%	N/A	9.6%	11.7%
Administrative services	4.3%	4.0%	7.3%	8.6%	8.8%	8.2%
Support services	7.8%	8.2%	9.3%	9.5%	8.6%	9.3%
Wales						
All NHS (incl. medical and dental)	N/A	N/A	N/A	N/A	N/A	8.4%
Nursing and midwifery (registered)	N/A	N/A	N/A	N/A	N/A	7.5%
Allied health professionals	N/A	N/A	N/A	N/A	N/A	9.1%
Estates and ancillary	N/A	N/A	N/A	N/A	N/A	8.2%
Healthcare scientists	N/A	N/A	N/A	N/A	N/A	7.5%
Additional professional, scientific and technical	N/A	N/A	N/A	N/A	N/A	14.2%
Additional clinical services	N/A	N/A	N/A	N/A	N/A	14.4%
Administrative and clerical	N/A	N/A	N/A	N/A	N/A	10.7%
Northern Ireland						
All NHS (incl. medical and dental)	3.4%	4.6%	6.0%	5.4%	5.1%	5.6%
Administration & Clerical	4.3%	6.5%	5.7%	4.7%	5.1%	4.3%
Estates Services	3.8%	6.9%	10.9%	7.2%	6.2%	7.2%
Support Services	5.2%	2.6%	7.1%	5.8%	3.4%	4.2%
Nursing & Midwifery	2.3%	4.4%	6.2%	5.9%	5.7%	6.7%
Social Services (excl. Home Helps)	5.2%	5.2%	4.0%	5.5%	5.5%	5.9%
Professional & Technical	4.1%	7.1%	7.5%	6.5%	5.0%	6.6%
Ambulance	4.6%	0.7%	7.3%	0.4%	1.0%	8.8%

Source: NHS Digital; Information Services Division Scotland; Department of Health Northern Ireland (HSC); and Welsh Government evidence

Shortfall and Vacancy rates

4.10 The four nations of the UK report vacancy rates in different ways. This makes it difficult for us to make comparisons across the UK. This section of the report looks at the best evidence available on vacancies and shortfall rates in each of the four nations of the UK.

England

- 4.11 The health service in England suspended their vacancy survey in 2010. Since then NHS Digital has been developing experimental data based on advertisements on the NHS Jobs website. We have decided to not present these data here due to ongoing issues of data quality. They are summarised in the Department of Health for England's evidence, presented at paragraph 4.24. The lack of reliable vacancy data in England continues to be a serious barrier to the Review Body fulfilling its remit.
- 4.12 This year Health Education England provided us with data on the "shortfall rate" for professionally-qualified permanent staff based on data collected from providers in the course of their demand forecasting work, which feeds into the annual workforce plan. This is not comparable to the vacancy data provided by the other three nations of the UK as employers will, in many cases, not be actively recruiting to fill the entire gap between expressed demand and supply due to, for example, financial constraints or a conscious choice to use temporary staffing arrangements to meet the shortfall. This data is presented in Table 4.4, which shows an England-wide shortfall of between 5.9 and 9 per cent for different professionally qualified occupational groups. We return to this in paragraph 4.34.
- 4.13 The data implies that there was a total shortfall of professionally qualified non-medical staff of 8.1 per cent or 41,000 in England as a whole in March 2015, including a shortfall of nurses and midwifery staff of 9.0 per cent or 30,500. There are significant differences in shortfall rates at regional level: for example, the Health Education Thames Valley region reported shortfalls of registered nursing, midwifery and health visiting staff of 31 per cent and shortfalls of paramedics of 26 per cent.

Table 4.4: Current provider expressed shortfall from demand for staff at March 2015

Staff group	England	North	Midlands and East	London and South East	South
Nursing and Midwifery	9.0%	6.7%	8.3%	12.4%	9.9%
Allied Health Professions	6.8%	6.0%	6.0%	9.3%	6.3%
<i>Of which Qualified Ambulance Staff</i>	7.3%	6.3%	8.3%	9.2%	4.7%
Healthcare scientists	6.1%	5.7%	3.7%	8.6%	6.9%
Other qualified staff	5.9%	5.7%	9.1%	5.4%	2.1%

Source: Health Education England

Scotland

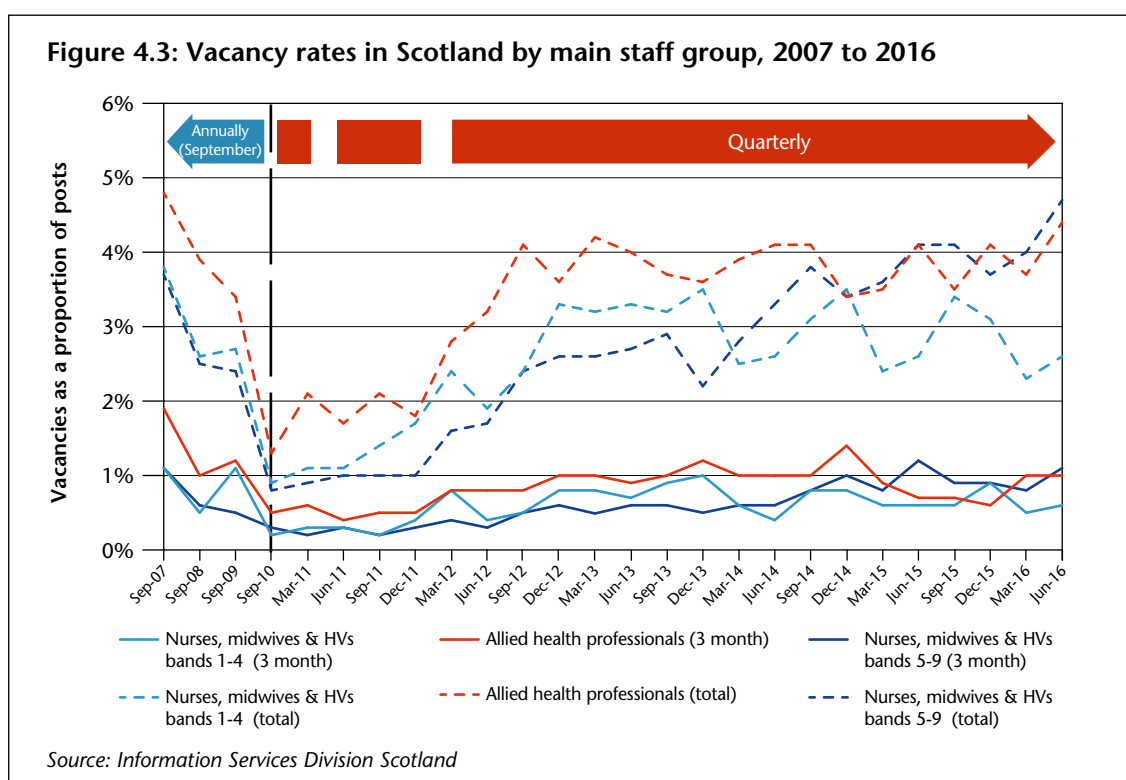
4.14 Published vacancy data in Scotland gives the total number of vacancies which NHS organisations were actively trying to fill. Three month vacancy rates look at the sub-set of these that have been vacant for three months or more. These vacancy rates express the number of vacancies as a percentage of the total posts, both filled and vacant.

4.15 Table 4.5 presents the latest vacancy rates for nurses, midwives and health visitors and for allied health professionals, and Figure 4.3 illustrates the trend over time. This shows that vacancy rates for nurses, midwives and health visitor at bands 5-9 and allied health professionals have been broadly stable over time, with vacancy rates for nurses, midwives and health visitors at bands 1-4 increasing over time and now, at 4.7 per cent in June 2016, exceeding pre-recession levels.

Table 4.5: Latest vacancy rates by main staff group, Scotland

	Three-month vacancies		Total vacancies	
	Vacancy rate (%)	Annual percentage point change	Vacancy rate (%)	Annual percentage point change
Scotland (June 2016)				
Nurses, midwives & HVs bands 5-9	1.1	-0.1	4.7	0.6
Nurses, midwives & HVs bands 1-4	0.6	0.0	2.6	0.0
Allied health professionals	1.0	0.3	4.4	0.3

Source: Information Services Division Scotland



Wales

- 4.16 Wales discontinued publication of vacancy data in 2011. The Welsh Government has provided data on the number of vacancies advertised in each month in the 2015/16 financial year. This data will under-represent the true level of vacancies as not all jobs will be recorded through this process and vacancies may be held open for financial reasons or be filled by temporary staff and hence not advertised.

Table 4.6: Vacancies advertised in Wales (Full-Time Equivalent) during the 2015-16 financial year

	Advertised Vacancies											
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Add Prof Scientific and Technic	2.2	9.0	7.6	10.7	3.6	11.0	38.4	7.3	8.2	14.0	12.4	10.0
Additional Clinical Services	26.3	32.5	73.9	117.2	243.5	148.4	60.7	51.6	104.9	47.9	66.1	34.1
Administrative and Clerical	38.4	47.3	44.7	55.9	30.4	72.3	106.9	101.2	25.4	38.3	32.3	21.3
Allied Health Professionals	14.6	17.5	13.1	14.8	13.6	17.8	19.0	21.8	17.4	20.3	13.8	9.8
Estates and Ancillary	6.2	21.7	7.5	0.0	9.2	15.6	8.9	11.2	2.0	11.7	4.3	16.3
Healthcare Scientists	4.0	6.1	8.0	7.8	2.0	6.0	4.0	6.0	4.0	3.0	2.8	9.0
Medical and Dental	32.5	20.0	33.0	20.0	14.0	13.0	11.0	15.0	10.0	6.0	3.0	9.0
Nursing and Midwifery Registered	44.2	173.6	252.2	262.1	134.3	115.3	207.2	191.7	113.3	214.2	121.9	81.3
All Staff Groups	168.5	327.8	440.0	488.6	450.5	399.4	456.1	405.7	285.1	355.3	256.5	190.8

Source: Welsh Government Evidence

Northern Ireland

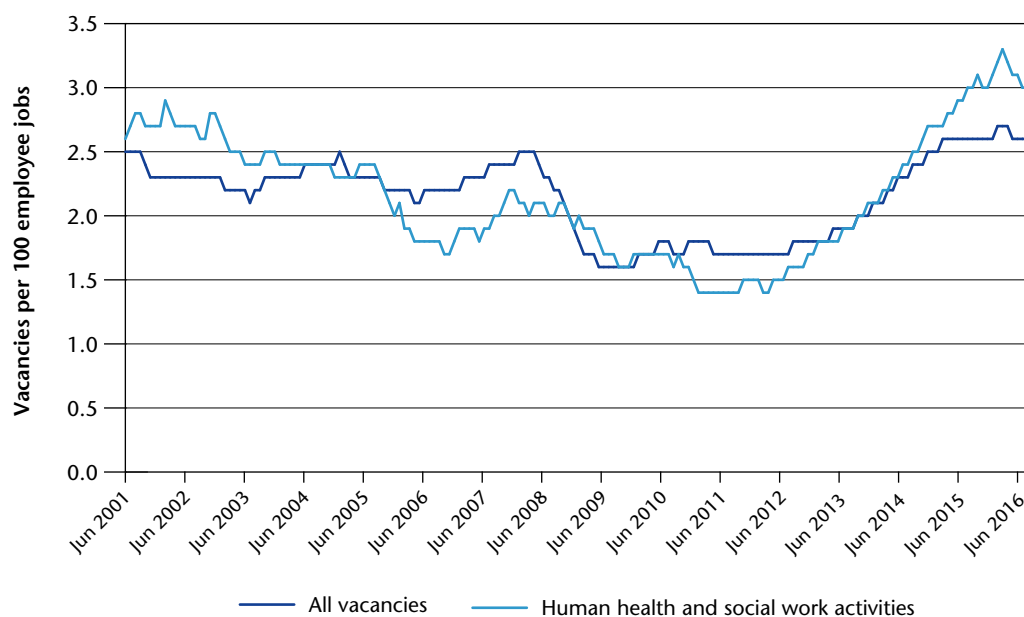
- 4.17 The Northern Ireland Executive did not provide any vacancy data for the 2015/16 financial year.

The Office for National Statistics (ONS) Vacancy survey

- 4.18 We are interested in Office for National Statistics data on vacancies to get a sense of how the vacancy rate in the health sector compares to the vacancy rate in the wider economy.
- 4.19 The ONS conducts a monthly survey of businesses,³⁶ collecting data on the number of vacancies for which employers are actively seeking recruits from outside their organisations. Data are presented as a ratio of vacancies per 100 employee jobs, on a three-month rolling average basis.
- 4.20 Over the last three years, the vacancy ratio in the human health and social work sector – which includes social work and private sector health activities as well as the NHS – has been increasing at a faster rate than the vacancy ratio in the economy as a whole and stood at 3 per cent in August 2016 – the highest it has been since at least June 2001 and twice as high than in June 2012. This compares to a vacancy rate of 2.6 per cent in the economy as a whole (see Figure 4.4).

³⁶The ONS Vacancy Survey is a monthly survey of businesses in Great Britain which samples around 6,000 businesses. The survey covers the whole economy apart from agriculture, forestry and fishing. Figures were correct as at 16 September 2015.

Figure 4.4: Ratio of vacancies per 100 employee jobs, Great Britain, 2001 to 2016



Source: Office for National Statistics

Evidence from the parties on NHS workforce, turnover and vacancies

- 4.21 The **Department of Health** for England told us that the size of the remit group had increased over the last three years and had now returned to its 2009 level. They noted that increases in professionally qualified clinical staff (up 3.4 per cent) and clinical support staff (up 5.4 per cent) had offset decreases in the number of infrastructure support staff (down 15 per cent).
- 4.22 They said that turnover had been relatively flat for most staff groups at 10-12 per cent, though there were signs of some increases over the last two years, especially for qualified ambulance staff and midwives. However, it was noted that overall capacity had continued to grow despite this and that – apart from for nurses – there were no significant national recruitment and retention problems.
- 4.23 On workforce data quality, the Department of Health said that they were working closely with NHS Digital to improve the quality and coverage of published workforce information to improve the evidence base on recruitment, retention and vacancies and that good progress was being made. They told us that, following a consultation in 2015, NHS Digital implemented changes in their methodology for collecting and reporting workforce statistics which took effect in 30 March 2016 which had resulted in a number of changes to the published time series data, including an overall reduction of over 69,000 in the number of Agenda for Change FTE staff. They also noted that, working together with NHS England, Health Education England and NHS Digital, they had rolled out the workforce Minimum Data Set (wMDS), increasing the amount of workforce data that is collected to support the workforce planning process.

- 4.24 On vacancy data, the Department of Health highlighted the publication by NHS Digital of the third set of experimental advertised vacancy data in August 2016 and noted a number of methodological improvements since last year. However, they noted a number of continuing issues with the data. One issue identified was that the data undercounts the true number of vacancies as one advert can be used to fill multiple posts and the Department of Health were unable to estimate the level of undercounting, though did note that undercounting was likely to be higher for nurses than other groups. Another issue identified was that it is not compulsory to update the NHS Jobs website when applicants are appointed and many organisations do not, meaning that the data cannot be used to make conclusions about how easy the NHS is finding it to recruit staff. Because of these issues, the Department of Health told us that they agree with the view of NHS Digital that the figures should be treated with caution and noted that NHS Digital have cautioned against drawing conclusions from the data at this time. We were told that NHS Digital will continue to make improvements to the quality of this data and also investigate other potential sources of vacancy data using NHS Jobs, including data derived from the Electronic Staff Record (ESR) system.
- 4.25 **NHS Improvement** said that hospitals estimated that they had 15,000 fewer nurses than they needed. They identified two key drivers of this shortage. First, the Francis Report had led to a rapid increase in demand for nurses with, for example, demand for nurses caring for adult acute patients in 2014 of 189,000 being 24,000 higher than forecast in 2012. Second, the number of nurses being recruited each year from outside of the European Economic Area had decreased by over 95 per cent since its peak in the early 2000s.
- 4.26 On turnover, NHS Improvement noted that they were exploring the key drivers of nursing turnover and how staff retention could be improved following a Public Accounts Committee recommendation and highlighted two emerging findings. First, they observed that some trusts in areas facing difficult recruitment and retention challenges – such as Frimley Park Hospital NHS Foundation Trust in the ‘fringe’ area around London – were “beating the odds” and had low turnover rates. Second, they said that pay does not appear to be a key driver of recruitment and retention issues across the NHS though noted it may be a concern for particular roles in particular areas. Third, they noted the value of offering flexible working options, particularly around rotas, to help staff meet caring responsibilities and to support the retention of older and more experienced staff who struggled to sustain night work and other patterns of shift working.
- 4.27 The **Welsh Government** told us that, overall, staff retention had changed little in recent years though there are areas where there are concerns relating to the retention of new recruits and general turnover. They said that retention was one of the thirteen priorities identified by the NHS Wales Executive Board and commissioned as workstreams to be led by a Director of Workforce and OD. This work would review the broader aspects of engagement, appraisal and development to ensure staff were nurtured and supported throughout their careers; ensure strategies, policies and practices were in place to enable staff to continue in active employment; and use the outputs of the NHS Staff Survey to identify areas where changes could be made to improve retention. They also told us that work is underway to ensure more accurate data is available about why individuals leave the NHS to enable more targeted interventions for critical staff groups.
- 4.28 The **Northern Ireland Executive** told us that Trusts were reporting that it was increasingly difficult to attract staff from elsewhere in the UK into the north of Ireland due to the location and the differential in the Agenda for Change pay scales as a result of differing pay awards, with the Western Trust regularly experiencing the most difficulty.

- 4.29 The **Joint Staff Side** said the UK's vote to leave the EU could have major implications for the NHS in the future. Freedom of movement and mutual recognition of professional qualifications within the EU meant that many health professionals currently working in the UK had come from other EU countries. The Joint Staff Side also said the introduction of new restrictions may directly prevent EU-born NHS staff from working in the UK, or have an indirect impact as EU-born staff may choose to leave the UK due to uncertainty created before new rules are put in place on migration restriction. It was possible that this may lead to further specific occupations being placed on the Migration Advisory Committee's shortage occupation list, which currently enabled employers to recruit nurses and midwives from outside the European Economic Area in order to deal with staffing shortages.
- 4.30 The **Royal College of Nursing** told us that, between November 2014 and November 2015, the joining rate for the nursing, midwifery and health visitor workforce was 8.9 per cent compared to a leaving rate of 10.4 per cent.
- 4.31 The **Royal College of Midwives** said Heads of Midwifery (HOMs) were frequently redeploying staff to other areas; using bank and agency staff; withdrawing services and closing maternity units due to staff shortages. Fundamentally, organisations were relying on the goodwill of midwives and maternity support workers to staff the units and this was leading to high levels of stress and burn out and was causing midwives to leave midwifery. The Royal College of Midwives also said the most common reasons that midwives gave for leaving was staffing levels and workload. They said that maternity services were in a catch-22 situation, with many midwives leaving midwifery because of understaffing which further exacerbated staffing levels. However, they told us that 80 per cent of the midwives who were intending to leave midwifery in the next two years said that increased pay would encourage them to stay in midwifery.
- 4.32 The Royal College of Midwives said their survey found that the most common reasons that midwives gave for wanting to leave midwifery were because of staffing, workload and not having enough time to spend giving women and their families high quality care. They said that, if more midwives are retained, staffing levels will improve, which will in turn cause fewer midwives to leave. They also said that something must be done initially to retain midwives in order to break the cycle of staffing shortages and told us that in effect we have a 'chicken and egg' scenario. The Royal College of Midwives stressed that there must be a concerted effort to retain existing midwives so that there is a firm foundation to build upon so that, in the future, midwives will be retained because there are appropriate staffing levels.
- 4.33 **UNISON** told us that their 2015 survey found 83 per cent of staff had considered leaving with 55% of staff having done so fairly or very seriously. This was similar to their 2016 survey. UNISON also told us that, as their survey is of members, they had no way of contacting the majority of people who have left the NHS such as those likely to have left the NHS through outsourcing, privatisation and sub-contracting. They said that they did not expect all staff who had said that they have fairly or seriously considered leaving to actually leave. UNISON said to tell us that none of the main factors (Increased workload – 67 per cent, Stress at work – 67 per cent, Feeling undervalued by management – 59 per cent, Feeling undervalued due to low levels of pay – 58 per cent) cited as reasons to leave were likely to change over the next year. UNISON believed a point of stasis had been reached and these were now essentially standing issues in the NHS. UNISON believed this would only compound the morale challenges facing the NHS so that while the number considering leaving may remain at similar levels, the number actually doing so was likely to rise.

Our comment on NHS workforce, turnover and vacancies

- 4.34 There is a difference between vacancies and shortfall. At present the shortfall data given to us by Health Education England is more robust than the experimental data on vacancies being developed by NHS Digital. We are grateful to Health Education England for sharing these data and note that they were originally collected for a different purpose.
- 4.35 There are significant shortfalls of professional staff in some occupations, especially nursing, including midwifery, and paramedics. Reported shortfalls are concentrated in certain geographical areas – London and (especially) the Home Counties, the East of England and the East Midlands. While shortfalls in other parts of England and vacancies in other parts of the UK look manageable, there are localised issues for certain specialisms. We are not aware of any modelling of whether these shortfalls or vacancy rates are a problem. These may be potential areas where the case for pay targeting should be considered.
- 4.36 At present, these shortfalls are being managed through a combination of international recruitment, agency and Bank staff and paid overtime. There may be drawbacks from operating with significant shortfalls, including the additional costs of temporary staffing, motivation issues arising from increasing staff workloads and relying on unpaid overtime. There are also potential service quality issues from having insufficient staff and difficulties in implementing service reform if staff are operating beyond capacity on a day-to-day basis.
- 4.37 While there were small increases in the leaving rate in every staff group in England, turnover remains at a manageable level and the overall NHS workforce is growing in virtually every staff group in every country. Nonetheless there are clearly risks if turnover continues to increase which will need to be monitored and mitigated, especially as the competitiveness of NHS pay relative to the private sector worsens in the current period of pay restraint, and as the NHS pay premium in lower bands is eaten away by increases in the National Living Wage.
- 4.38 Whilst shortages are serious, they do appear to be confined to some occupations and some locations. However, there would be bigger recruitment issues were it not for significant recruitment from abroad as home-grown recruitment is insufficient to meet demand in many professional groups. While the inclusion of a number of occupations – including nurses, paramedics, sonographers, radiographers, orthotists and prosthetists – on the Shortage Occupation List is helping to ease issues, it is only a short-term solution and there are risks to overseas recruitment from the decision to leave the European Union. These future risks are discussed in Chapter 6.
- 4.39 The clinical staff shortages that exist in many local areas appear still to be largely driven by recent unforecast increases in demand over the past few years for some professional groups, coupled with the time lags involved in training sufficient numbers of qualified staff to meet this demand, rather than by adverse trends in recruitment and retention. While we note the conclusion of the Migration Advisory Committee, in the context of nurses, that there is “an unrealistic view that the role of pay in recruitment and retention is only weak”, we have not seen any persuasive evidence that recruitment or retention nationally will be significantly improved in the very short-run through a higher general pay award. We look in more detail about the role of pay in supply in the medium-to-long term in Chapter 6.

- 4.40 While there have been some improvements since last year – especially in England, with data on shortfall from demand being made available to us by Health Education England – data on recruitment, retention and vacancies is still not good enough. The constituent nations of the UK define vacancies and present data in different ways, making it difficult to compare the situation across the entire UK. There continues to be insufficient workforce data to allow us to develop effective recommendations on pay targeting as, like we said in our last report, the limited data constrains our ability to accurately assess where the issues are and where pay solutions may or may not help. Appendix G summarises the data requirement.

Observation

While progress has been made, more work needs to be done to provide a robust set of workforce data covering fill rates, vacancies and attrition rates by staff group and geographical area, not only to allow us to develop a sophisticated picture about what is happening to inform our recommendations but also to enable effective national and local planning.

Agency Spending

- 4.41 As noted in Chapter 3, spending on Agency staff increased in 2015/16 in each of the countries of the UK. This section of the report considers the evidence we received from the parties on agency spending and what this tells us about recruitment, retention and staff shortages within the remit group.

Evidence from the parties on agency spending

- 4.42 The **Department of Health** for England said that total expenditure by the NHS on agency and other off-payroll staff increased significantly from £2.6 billion in 2013/14 to £3.7 billion in 2015/16. This covered both medical and non-medical staff – we were told that it was not possible to break down spending by staff group within the national total. They told us that the increase in agency expenditure was widely believed to have resulted from unexpected increases in recruitment to meet safer staffing levels following publication of the Francis Report in February 2013 which could not be met in the short-term by the supply of newly qualified graduates.
- 4.43 They observed that there was significant variation in agency spending by region as a proportion of staff costs, with relatively high spending in London and the South East and relatively low spending in the North and South West. They also noted that changes over time had not followed a clear pattern, with decreases in agency usage in the Thames Valley and South London and big increases in the East of England, North West London and Kent, Surrey and Sussex. They also highlighted the fact that variation in agency expenditure within regions was greater than variation between different regions and told us that this suggested that agency expenditure was driven principally by individual Trust-specific factors.
- 4.44 The Department of Health outlined a range of financial controls that had been imposed centrally intended to reduce the cost of agency staffing to around £2.5 billion in 2016/17. These included caps on the prices paid to agencies (now 55 per cent above basic hourly pay rates), mandatory limits on agency spending within every Trust and mandatory use of approved frameworks for the procurement of Agency staff. They told us that this had reduced spending in the first quarter of 2016/17 by £188 million compared to the same period in 2015/16.

- 4.45 **NHS Employers** told us that NHS expenditure on agency staffing in 2014/15 was £3.3 billion, representing 7.6 per cent of total staffing costs. They noted that reports by the Health Foundation and the National Audit Office had identified a negative correlation between an organisation's expenditure on agency staff and their financial performance, with higher expenditure on agency staff associated with worse financial performance.
- 4.46 They said that the rules introduced by NHS Improvement to control the amount of money being spent on temporary staffing were designed to encourage staff currently working for agencies to work for the NHS on a permanent basis or on NHS staff banks. They said that wage caps ensured that agency staff were paid on the same hourly basis as permanent staff, reducing the financial attraction of working for an agency.
- 4.47 They noted that less than a third of respondents believed that the agency cap had encouraged staff to work for them on a permanent basis. They also told us that anecdotal evidence suggested that the agency cap had a positive impact on the numbers working on internal staff banks.
- 4.48 **NHS Improvement** told us that both the number of agency staff used by the NHS and the price of agency staff had increased over recent years leading to an 80 per cent increase in total agency spend between the first quarter of 2011/12 and the second quarter of 2013/14. They said that by mid-2015 agency spending – at 8.2 per cent of total pay – was at record levels. They told us that Trusts spend £3.3 billion in agency staff in 2014/15 and £3.6 billion in 2015/16 and that increasing agency spending was a key driver of growing deficits.
- 4.49 They identified a number of drivers of this increase. They told us that there was a fundamental mismatch between demand for doctors and nurses and supply, with activity growth outstripping demographic trends and unplanned growth in staffing in response to the Francis Report. They said that these demand increases were exacerbated by a collapse in nurse migration from outside the EEA and previous reductions in the numbers of funded nurse training places. They said that as supply was largely fixed in the short-run and the increase in overseas recruitment only partially met that increase in demand, this led to higher prices and volumes in the agency market, which serves as the 'overflow' market for the NHS workforce. They also noted that around half of agency staff were permanent NHS staff reselling part of their time to employers.
- 4.50 NHS Improvement told us that they introduced agency rules in November 2015 with the aims of encouraging staff to return to permanent and bank working, increasing managerial focus on agency spending, greater quality assurance on agency supply and reducing agency spending. They outlined the rules and, in response to supplementary questions about the maximum wage caps for agency staff, said that these were based on top of band wages with an upwards adjustment for employee benefits such as holiday pay. We were told that agency rules could be overridden in exceptional circumstances for patient safety reasons.
- 4.51 On the impact of the agency rules to date, NHS Improvement told us that recent expenditure was around 20 per cent below 2015 levels, with around two thirds of trusts reporting some net savings. We were told that sample data suggested prices for nursing staff had decreased by some 18 per cent since the introduction of agency rules, though average rates paid were still substantially above the caps – with 29 per cent of shifts overriding the caps – which we were told implied that agency nurse pay was on average 15 per cent above substantive pay. They said that this suggested that the mismatch between supply and demand for nurses remained and was an issue that could not be resolved solely through the new agency rules.

- 4.52 NHS Improvement also noted that the volume of agency use did not appear to have reduced significantly – though no national data on this was collected – with reductions in some trusts balanced by increases in others. NHS Improvement also told us that they did not collect any national data on the number of bank shifts nor the wages paid to bank staff, though cited analysis carried out by NHS Professions suggesting a 6.2 per cent increase in bank hours worked and a 1.8 per cent increase in hourly bank charges in the year to April 2016.
- 4.53 The **Welsh Government** told us that the reliance on agency staff had increased consistently in recent years. They said that NHS Wales were taking action to address rising agency costs by eradicating the use of off-contract agencies and that Health Boards were working both individually and collaboratively to address rising costs. Highlighted measures included communication campaigns to encourage staff to sign up to internal staff banks and on-contract agencies, stronger focus on workforce planning and recruitment campaigns for permanent staff. They also highlighted the work of the Temporary Nurse Staffing Capacity Steering Group in developing an all-Wales action plan to manage nurse staffing capacity and reduce agency costs.
- 4.54 The **Northern Ireland Executive** told us that expenditure on agency staff had increased significantly over the past few years, from £44 million in 2010/11 to £79 million in 2014/15 and £92 million in 2015/16. Expenditure on bank staff had also increased significantly over the same time period.
- 4.55 They told us that the position on agency spending was no longer financially sustainable in the short-to-medium term. They said they were currently considering the case for introducing a cap on agency costs and are monitoring the impact of the agency cap in England as part of this.
- 4.56 The **Joint Staff Side** noted that the cost of agency staffing in the NHS had increased substantially over the last few years and cited reports by the Royal College of Midwives and the Royal College of Nurses that they said suggested organisations were reliant on agency staff to form their established workforces and not just to cover temporary gaps in the rota.
- 4.57 They told us that initial findings showed that the agency cap has not been very successful due to the large number of breaches – 60,000 shifts in the first three months of 2016 – and told us that a number of trusts were seeing continued increases in agency expenditure. They also noted that there did not seem to have been an impact on the agency rules on the level of bank and overtime working. They told us that publication of bank, agency and overtime spend against total workforce spend by trust and occupational group would be very helpful in understanding workforce dynamics in the NHS.
- 4.58 Staff Side said that they agreed that the use of agency staff in the NHS had reached inappropriate levels and should be controlled but said that they did not believe that NHS Improvement’s rules would do this in a safe and sustainable way, noting that the underlying issue was a shortage of supply and that agency rules do not address this.
- 4.59 They said that a whole workforce strategy needed to be developed to reduce agency spending and increase the number of permanently employed staff. In the short-term, they suggested that agency spending could be reduced by increasing the use of overtime or increasing use of internal staff banks and by increasing the value of the Agenda for Change pay structure.

- 4.60 The Joint Staff Side told us in oral evidence that agency usage was a proxy for vacancies and was still running at around £3 billion. In their view Agency spend was money lost to the service and was the economic cost of pay restraint. They also said that staff perceived the discretionary spend on agency to be wasteful and that this added to the sense of injustice among staff due to work intensification, stress and not feeling valued.
- 4.61 The **Royal College of Midwives** cited findings from a recent Freedom of Information request that NHS organisations spent £72.7 million on agency, overtime and bank midwives in 2015 and suggested that, based on the average hourly spend estimates in the request, this spending would have funded the equivalent of around 1,400 full-time midwives, substantially lower than the number of midwives that could be employed permanently with the same amount of money.
- 4.62 The **Royal College of Nursing** cited analysis they had carried out using the Labour Force Survey that suggested that at least 2 per cent of nurses in the NHS work in a nursing role through an employment agency either as their main or second job every week. They also cited evidence from a survey of agency nurses suggesting reasons for working as agency nurses included greater levels of more control over the shift worked (80 per cent), more control over number of hours worked (67 per cent), better rates of pay (67 per cent), better work-life balance (49 per cent) and ability to gain experience in a new area (40 per cent).
- 4.63 They noted that the National Audit Office had estimated that total hours of agency and bank nurse time in England equate to 30,000 full-time equivalent nurses and noted that the agency cap was unlikely to reduce reliance on agency staff. They highlighted the Migration Advisory Committee conclusions that over-reliance on agency staffing was a reflection of a nursing shortage and a direct consequence of wage levels in the NHS and that employers were preferring to pay agency costs rather than recruitment and retention premia to help recruit permanent staff.

Our comment on agency spending

- 4.64 The evidence on agency spending is indicative of significant staff shortages for some staff groups in England and growing, though still relatively low, staff shortages elsewhere in the UK. While data has improved this year, there are still gaps where it would be useful to have more detailed data on agency expenditure in order to allow us to develop a more sophisticated picture about these shortages and their impact on affordability pressures, especially in England and in Wales.
- 4.65 The data in England suggests that the agency cap is achieving its main objective of driving a significant decrease in the cost to the NHS of agency nursing staff, with data provided by NHS Improvement suggesting that overall expenditure on agency staff has fallen by around 20 per cent, though we note that NHS Providers have said that savings have not been as high as was anticipated.³⁷
- 4.66 There is a lack of hard data about the wider impact of the agency cap including its success in achieving its secondary objective of encouraging agency staff to join NHS staff banks or join the NHS as permanent staff and the overall level of net financial savings that are being achieved. However, the evidence we have received, while imperfect, suggests that agency volumes remain largely unchanged and that there has been little change in the supply and use of bank staff and overtime working. We were surprised by this apparent lack of impact despite NHS Improvement's stated objectives for agency controls and the significant reduction in the wage premium enjoyed by agency nurses over substantive and bank staff.

³⁷Public Accounts Committee, Financial Stability of the NHS: Written Evidence from NHS Providers, 11 January 2017.

- 4.67 Higher wage rates are not the only factor motivating people to work for agencies in addition to, or instead of, being direct employees of the NHS. Research from the National Institute of Economic and Social Research suggests that many decisions to enter agency working are due to deteriorating job quality and a desire to escape permanent employment, with concerns over increased bureaucracy, target setting, insufficient resources, unmanageable workloads, a lack of work-life balance and unmet demands for flexible working within the NHS.³⁸ Similar messages were given in the evidence we received from the Royal College of Nursing and from employers. If the NHS wants to reduce agency usage further, trusts will need to go beyond controls on agency spend and consider how they can incentivise agency staff to join the NHS as permanent staff and/or work additional hours via staff banks and overtime rather than via employment agencies. The evidence suggests that, while ensuring there are sufficient financial incentives for staff to work beyond their contracted hours will need to play a role, offering appropriate employment packages that appeal to those who currently prefer the flexibilities and lifestyle provided by agency working will be as important.
- 4.68 As discussed in Chapter 3 there is an overarching question about what the cost of employing people to provide good quality patient care actually is. It seems to us that focusing only on the paybill for employed staff restricts understanding of the mix between substantive staff, overtime, bank working and agency staff. We have some sympathy with the views put to us by Joint Staff Side: staff see that money is being spent on agency staff and see this as contradictory to the pay policy that is applied to them. There is arguably little evidence that conscious decisions are being made about this mix and little sense that employers or the NHS management have a view about what the optimal level of each element is, nor recognise that there is a total cost to employing people that goes beyond the pay bill.

Observation

The next phase of work on the use of agency staff needs to move beyond the necessary initial focus on short-term 'crisis management' measures to control rapid increases in expenditure, towards a more strategic approach. This should mean more deliberate management of the mix between different ways of hiring staff based on an improved understanding of how pay and the employment offer affect supply and overall costs.

High Cost Area Supplements (HCAS)

- 4.69 In this section we consider the evidence from the parties on High Cost Area Supplements (HCAS).
- 4.70 The total cost of Geographical Allowances (including HCAS) for non-medical HCHS staff has increased by 19 per cent since 2008/09, increasing from £639 million to £759 million in 2015/16. The proportion of staff receiving geographic allowances has remained largely stable at 19.5 per cent in March 2013 and 19.2 per cent in March 2015.

Table 4.7: Aggregate cost of Geographical Allowance Payments, England, 2008/09 to 2015/16

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
HCHS non-medical staff	£639m	£688m	£723m	£716m	£713m	£720m	£735m	£759m

Source: Department of Health, *Headline HCHS Paybill Metrics (Experimental)*

³⁸ National Institute of Economic and Social Research, *Use of Agency Workers in the Public Sector – Report to the Office of Manpower Economics* (2017).

Evidence from the parties on High Cost Area Supplements

- 4.71 **NHS Employers** said that there were recruitment and retention challenges facing employers in the London area which went beyond the level of High Cost Area Supplement (HCAS) payments. They told us that transport costs had increased by 25 per cent and average house prices by 37 per cent over the last five years, which was leaving London NHS Trusts struggling to attract and retain staff, with jobs requiring a car being particularly difficult to fill. They also highlighted analysis they had done which suggested that more NHS staff were choosing to live outside of London and commute in.
- 4.72 However, they proposed that HCAS was left unchanged in relative terms, with increases to the minima and maxima rates in line with the headline pay award. They told us that a small adjustment to HCAS would not alleviate the issues faced by employers in London and that they believe targeted action on cost of living pressures like housing and travel costs would be more effective than trying to address them through pay and also noted that employers in London would be concerned about having to implement higher pay awards without additional funding being provided. As well as this, they highlighted the impact of increasing HCAS on employers outside of London – within a 1 per cent envelope, a higher pay award in London would mean a lower award elsewhere in England – and also told us that increases in HCAS would exacerbate cliff edge effects around the boundaries of HCAS zones.
- 4.73 On the structure of HCAS, NHS Employers highlighted challenges for employers on the boundaries of HCAS zones who had services covering both inner and outer London. They noted that service relocation could cause recruitment and retention difficulties as existing members of staff saw increased travel costs at the same time as a reduction in their earnings due to moving to a lower HCAS allowance zone. They told us that some employers had suggested that supplements should be flattened out across London, though also noted that there would be winners and losers from this approach and that there would still be a cliff-edge effect at the boundary of the new harmonised zone.
- 4.74 NHS Employers told us in oral evidence that a small adjustment in HCAS would not alleviate the issues that employers face in London. They said that Trusts are having issues recruiting and retaining staff in London though noted that this is not unique to the NHS and is fairly common across the public sector. They said that staff are moving further and further away from work and consequently are more concerned about issues such as accommodation and transport. Employers think solving the cost of living issues directly will be far more effective and feasible than addressing cost of living issues through pay.
- 4.75 The **Department of Health** for England explained that the design of geographical pay allowances was complex and raised a number of issues. They noted that the concerns about cliff edges identified by NHS Employers were valid – especially where transportation links were good and travel to work areas wide – but said that action intended to reduce them could have unforeseen consequences. They identified two examples of this: first, that action to tackle the cliff-edge between London and the Fringe could have a negative impact on the surrounding national rate areas; second, they noted that flattening the differential between inner and outer London could cause recruitment issues for central London employers.
- 4.76 The **Joint Staff Side** said that it was clear that the value of HCAS had not kept pace with the cost of living, as was the case for the value of the pay structure across the whole United Kingdom. However, they told us that HCAS could not be a replacement for fair, annual pay awards to maintain value of the entire framework and protect NHS staff from cost of living increases and told us that they would support an uplift of HCAS threshold in line with the overall pay award.

4.77 They told us that adjustments to HCAS to tackle the cliff edge issues identified by NHS Employers were likely to produce more unintended consequences than benefits, giving the example of the impact that flattening HCAS would have in reducing incentives for staff to work in inner zones. They also noted that the London Social Partnership Forum had done a lot of work on this issue and that they should be involved in any discussion on the future of HCAS.

Our comment on High Cost Area Supplements

4.78 The evidence we have received shows that recruitment and retention pressures and staff shortages are more severe in London and the surrounding areas than elsewhere and that HCAS does not sufficiently compensate staff for the additional costs of working around London (though there may be other career attractions to working in some London hospitals). It also suggests that cliff edge issues around the HCAS boundaries are significant and a driver of staff shortages around the HCAS region boundaries within commuting distance of London, with employers in these areas competing with employers within the HCAS region for staff. While some of the parties suggested wider concerted action to alleviate the high costs of living facing public sector staff in London, such as housing and transport costs, it remains the case that someone has to bear the costs of providing such support and it is hard to see how employers could avoid these or would wish to relinquish control of a key tool with which to attract staff.

4.79 We believe that, given the evidence that there are bigger pressures on supply in London and the surrounding areas than in the rest of the country, it is clear that HCAS is not fulfilling its purpose of allowing employers in high-cost areas to recruit and retain high quality staff in all staff groups and across the whole pay structure. However, given the potential for unforeseen consequences of changes to HCAS in worsening cliff edge issues and the lack of enthusiasm for change among employers and staff side, we do not feel we have the evidence base to make recommendations on relative changes to HCAS during this pay round. Related to our points about the need for a much better understanding of the full costs of employing staff to provide good quality care that we made above, we also suggest that employers and the Department of Health for England takes a serious look at the costs of HCAS in light of the use of expensive agency staff that are filling gaps and consider where money is better spent.

Recruitment and Retention Premia (RRP)

4.80 In this section we consider the trend for Recruitment and Retention Premia (RRP) across the countries of the United Kingdom and examine how well these pay flexibilities are working.

4.81 The total cost of RRP for non-medical HCHS staff has reduced by 74 per cent since 2008/09, falling from £57 million to £15 million in 2015/16. The proportion of staff receiving RRP payments has also declined from 3.4 per cent in March 2013 to 0.9 per cent in March 2015.

Table 4.8: Aggregate cost of Recruitment and Retention Premia Payments, England, 2008/09 to 2015/16

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
HCHS non-medical staff	£57m	£62m	£61m	£51m	£36m	£22m	£18m	£15m

Source: Department of Health, Headline HCHS Paybill Metrics (Experimental)

Evidence from the parties on Recruitment and Retention Premia

- 4.82 The **Department of Health** for England noted that the long-term downward trend in the use of RRPs had carried on as the number of NHS staff in receipt of pay protection due to loss of the Cost of Living Supplement when Agenda for Change was introduced continued to fall. They told us that there was no evidence of an increase in the use of RRPs to address recruitment and retention problems. It was suggested that employers were reluctant to use local pay flexibilities due to the risk that their use could lead to pay escalation as local areas compete for staff and due to a lack of HR capacity to develop the business case for making RRP payments in a way that ensures equal pay risks are properly managed.
- 4.83 **NHS Employers** said that only 0.8 per cent of non-medical staff were in receipt of RRPs during April 2016 compared to 5.8 per cent in September 2010. They also noted that the percentage of qualified nursing, midwifery and health visiting staff receiving RRPs fell from 3.1 per cent in April 2014 to 1.0 per cent in April 2016 and suggested that this indicated that employers had not found the use of pay premia to be effective in resolving issues with nursing supply.
- 4.84 **NHS Providers** told us in oral evidence that the supply of professionally qualified staff was fixed in the short-term and that paying local RRPs would often simply involve poaching staff from other areas, who may in turn be forced to pay more to compete for staff, leaving higher pay bill costs but no overall changes in supply.
- 4.85 The **Welsh Government** noted that there were currently no national RRPs and only one local RRP in place in Wales. They told us that the use of RRPs had been discussed at a local level but that Health Boards had indicated that they were not convinced they would be cost effective as they thought they were unlikely to make much difference to the key shortage areas.
- 4.86 The **Joint Staff Side** told us in oral evidence that if more money was available in the short-term then RRPs should be used to address shortages in those occupations which need more staff e.g. nursing and midwifery. However, they said trusts have the problem of finding the money to do this. A clear strategic workforce plan and strategy would help to alleviate these issues.
- 4.87 The **Royal College of Nursing** said that despite the evidence that nursing staff choose to work for agencies for higher salaries, employers have not drawn on the facility in Agenda for Change to pay local retention and recruitment premia. The Royal College of Nursing added that they would prefer a long-term approach to deal with staffing issues though asked the Review Body to support their call for employers to look in the short-term to RRPs, bank and overtime provisions to reduce the reliance on agency staffing.

Our comment on Recruitment and Retention Premia

- 4.88 NHS Trusts currently have the flexibility to target pay in response to local recruitment and retention concerns through Recruitment and Retention Premia. These may have different effects in different areas. However, despite evidence of significant localised supply pressures, employers are, in the main, choosing not to use these flexibilities.

4.89 We have heard a number of possible explanations for this, including:

- Short-term demands for cost savings.
- The additional costs of new RRP not being funded through the tariff.
- A reluctance to introduce new payments that may be difficult to remove.
- A belief that RRP will ultimately be self-defeating with pay being bid up and no overall impact on supply.
- The fact that the NHS, as a monopsony for many of its occupational groups, is able to use its market power to hold down pay of existing staff, many of whom have few outside options, below market rates, with trusts having a financial incentive to cooperate in this endeavour.
- A preference for using other mechanisms to increase the price paid for new recruits while leaving pay for existing staff untouched e.g. via use of agency staff or “over-grading” new staff.
- A lack of organisational capacity and capability within individual employers to make best use of local flexibilities.
- The availability of staff from outside of the UK has led employers to see this as a more cost effective way of filling shortages than increasing pay.

4.90 We continue to believe that RRP are an important flexibility and that local targeting of pay is, in general, a better approach than targeting through national pay scales. However, the fact that their use is dwindling alongside an increase in the very pressures they are intended to alleviate suggests that there is a problem. It seems to us that the costs and benefits of using RRP need to be better understood by trusts and health boards, linked to a fuller assessment of the total costs of staffing the service, which links back to the observation we make in relation to agency spending earlier in this chapter.

4.91 We note also that there is a difference between the likely effectiveness of RRP in situations where the pool of potential new recruits is limited, as is currently the case for trained clinical staff, and where the pool is not fixed, which applies to those staff whose skills are widely used in other sectors. Trusts and Health Boards should be able to differentiate between these. Finally we suggest that there might be ways to use RRP or higher bank rates to incentivise a different skill-mix in service areas suffering most from shortfalls in trained clinical staff. We return to this issue alongside our discussion of pay targeting in Chapter 7.

Chapter 5 – Motivation, Morale and Staff Engagement

Introduction

- 5.1 Our terms of reference require us to have regard to the motivation of our remit group. Staff motivation is not explicitly defined in our terms of reference. We see motivation as encapsulating the motivation of staff to care for patients, their satisfaction with their working experience and their degree of engagement in what needs to be done to improve the service they offer.
- 5.2 Due to the timing of the pay round, one of the issues we face in assessing trends in motivation, morale and staff engagement is that much of the evidence we have is out-of-date: the most recent Staff Surveys in England, Scotland and Northern Ireland were carried out in the second half of 2015, well over 12 months ago (the most recent Staff Survey data for Wales is from August-October 2016).
- 5.3 In this chapter we consider a range of indicators of staff motivation and staff engagement, including rates of sickness absence, appraisal rates and the results of the centralised staff surveys carried out in each of the four nations. We also review the evidence from the parties.

NHS Staff Surveys

England

- 5.4 Table 5.1 provides an overview of trends over time in responses to some of the key questions in the staff survey for non-medical staff in England between 2010 and 2015. Overall, the staff survey results suggest that engagement and staff job satisfaction for non-medical staff has generally been increasing. However, workload has also generally been increasing. In particular the number of staff working unpaid hours has increased year-on-year since 2011, increasing by almost 1 percentage point this year. There has been an increase, of 1.4 percentage points, in the percentage of staff saying they are satisfied with the support they get from their colleagues.
- 5.5 Staff satisfaction with pay has increased for the first time since 2010, however it is still below 2013 levels. General managers had the largest percentage of staff giving positive views about their level of pay (at just under 60 per cent). Nursing or healthcare assistants have the lowest satisfaction with pay, followed by ambulance staff.
- 5.6 Table 5.2 breaks down the results by staff group and shows that there was wide variation across the NHS. There is a clear divide between registered nurses and midwives and the wider healthcare team (administrative and clerical, central functions and maintenance). In general nurses and midwives are more satisfied with the nature of the job they do, but are less satisfied with their workload. Conversely, the wider healthcare team do not appear to have the same workload pressures but are less satisfied with their worklife. General managers score well in almost all measures, but they were the most likely to work extra unpaid hours. Ambulance staff were one of the least likely to work unpaid hours, but the most likely to do extra paid hours.
- 5.7 Table 5.3 looks at satisfaction with pay and with the quality of care that can be delivered by staff group. Across the remit group as a whole, more staff were dissatisfied with their pay than were satisfied, with nursing and healthcare assistants, ambulance staff, administrative and clerical and maintenance and ancillary staff being most negative about their pay. However, fewer than half of every staff group are dissatisfied with their pay. Satisfaction with the quality of patient care was generally high among frontline healthcare staff, though midwives were less satisfied than other groups.

Table 5.1: Summary results from the National NHS Staff Survey, 2010 to 2015, England, excluding medical and dental staff

Measure	2010	2011	2012	2013	2014	2015	Trend ¹
Engagement and job satisfaction							
I look forward to going to work	51.7	49.9	51.7	52.1	51.6	57.1	
I am enthusiastic about my job	66.1	65.1	67.3	68.1	67.7	73.3	
Time passes quickly when I am working	73.9	73.3	74.2	74.3	73.8	76.8	
The recognition I get for good work	47.3	45.8	48.7	49.4	49.9	51.8	
The support I get from my immediate manager	64.6	63.5	65.4	66.0	66.1	67.2	
The support I get from my work colleagues	77.0	76.4	78.4	78.3	78.4	80.8	
The amount of responsibility I am given	71.7	70.5	73.4	73.1	72.8	73.3	
The opportunities I have to use my skills	66.6	65.5	69.9	69.6	69.6	69.9	
The extent to which my organisation values my work	35.1	33.3	40.0	40.4	40.8	41.1	
My level of pay	41.0	38.7	37.4	35.8	30.9	34.6	
Percentage of staff appraised in the last 12 months	77.1	79.0	83.2	83.8	83.5	85.4	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months ²			29.5	28.9	28.2	28.0	
Workload							
I am unable to meet all the conflicting demands on my time at work ^{2,3}		41.9	43.2	44.3	44.7		
I have adequate materials, supplies and equipment to do my work		58.9	56.5	55.8	55.7	54.6	
There are enough staff at this organisation for me to do my job properly		30.2	30.1	29.2	28.6	29.9	
During the last 12 months have you felt unwell as a result of work related stress? ²		30.5	38.6	39.6	40.0	37.8	
Percentage of staff working PAID hours over and above their contracted hours? ²		25.4	30.0	30.2	30.2	31.1	
Percentage of staff working UNPAID hours over and above their contracted hours? ²		53.1	56.1	57.0	58.1	59.0	

Source: England NHS Staff Survey. Results are unweighted

Table 5.1 notes:

¹ Trend lines do not have a common scale; they each show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed both in the context of the data in the preceding columns and the full range of possible scores for each measure.

² Lower scores are better in these cases, however, in all other cases, higher scores are better.

³ For 2015, this question was reversed to "I am able to meet..." so direct comparisons are not possible.

Table 5.2: Staff group summary results from the National NHS Staff Survey 2015, England

	Registered Nurses & Midwives	Midwives	Health visitors	Nursing or healthcare assistants	Allied Health Professionals, Healthcare Scientists and Scientific & Technical staff	General managers	Admin & clerical staff	Central functions/ corporate services	Maintenance/ ancillary	Ambulance staff
I look forward to going to work	63.7	58.9	65.2	64.3	58.3	63.4	54.0	54.1	56.3	60.5
I am enthusiastic about my job	80.4	80.1	82.2	77.7	75.4	79.0	67.3	69.0	67.8	74.7
Time passes quickly when I am working	84.0	83.1	90.6	71.6	78.0	86.5	73.9	77.2	73.7	67.5
I have adequate materials, supplies and equipment to do my work	57.4	42.8	47.2	60.1	55.9	65.4	64.8	66.1	58.0	59.9
There are enough staff at this organisation for me to do my job properly	28.7	20.4	28.4	30.2	29.0	38.8	39.0	40.8	36.5	37.1
During the last 12 months have you felt unwell as a result of work related stress? *	38.9	45.6	35.8	35.1	36.0	33.8	32.8	30.9	27.4	36.1
Percentage of staff working UNPAID hours over and above their contracted hours? *	73.8	84.0	83.6	39.4	64.1	88.0	47.0	68.5	37.3	39.4
I am able to meet all the conflicting demands on my time at work	39.5	27.8	31.2	51.7	38.2	43.3	53.7	46.9	51.5	49.6

Source: England NHS Staff Survey. Results are unweighted.

* Lower scores are better in these cases.

Table 5.3: Pay and service delivery results, 2015, England

	All non-medical staff (2015)	Registered Nurses & Midwives	Midwives	Health visitors	Nursing or healthcare assistants	Allied Health Professionals, Healthcare Scientists and Scientific & Technical staff	General managers	Admin & clerical staff	Central functions/ corporate services	Maintenance/ ancillary	Ambulance staff
Satisfaction with pay	34.6	41.6	36.9	36.0	29.4	42.3	58.2	30.4	46.1	33.9	33.7
Dissatisfaction with pay*	39.3	32.6	35.9	30.0	45.8	33.0	21.0	40.4	27.0	41.6	42.5
I am satisfied with the quality of care I give to patients/service users	69.3	75.8	69.4	76.5	87.8	75.6	40.7	50.9	25.3	53.4	80.4
I feel that my role makes a difference to patients/service users	82.3	91.7	92.2	90.4	92.9	89.1	73.4	60.1	51.8	71.9	87.3
I am able to deliver the care I aspire to	56.2	62.1	49.7	57.8	77.2	60.4	29.7	40.2	17.1	44.2	73.6

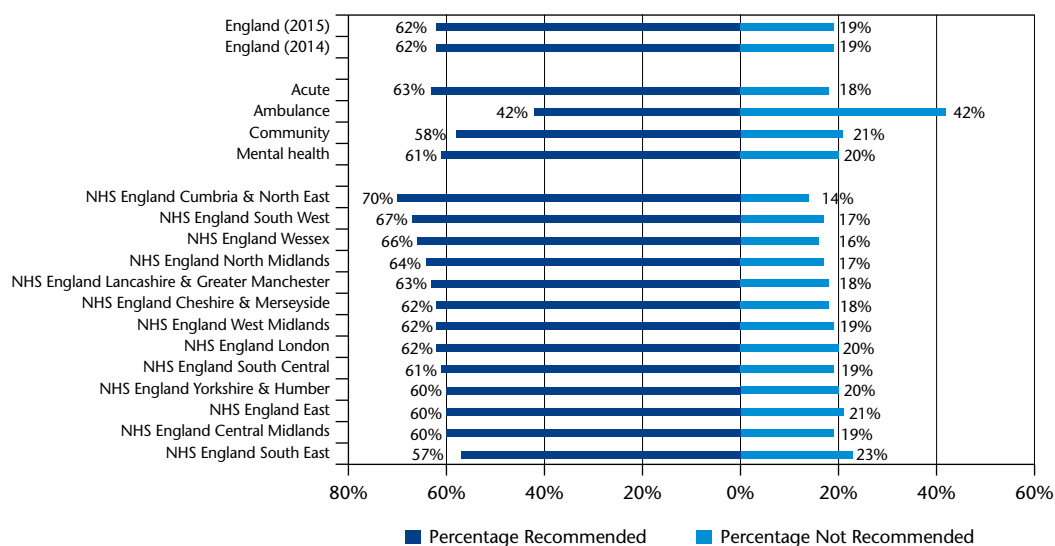
Source: England NHS Staff Survey. Results are unweighted.

Note: Figures for the wider healthcare team are lower because many staff chose to answer the question as not being applicable to them.

* Lower scores are better in this case.

- 5.8 Another source of information is the Friends and Family test. 62 per cent of staff (both medical and non-medical) would recommend their organisation to friends and family as a place to work, similar to last year (Figure 5.1). However, only 42 per cent of ambulance staff recommended their organisation to friends and family as a place to work, with an equal percentage saying they would not recommend it. There is some variation by region, with NHS England Cumbria & North East being the most recommended (70 per cent) and NHS England South East the least recommended (57 per cent), but most other geographies are within 1 or 2 percentage points of the average.
- 5.9 A higher proportion of staff recommended their organisation as a place to receive care than recommended it as an employer. In 2015, 79 per cent of staff recommended their organisation as a place to receive care, which is an increase of 2 percentage points from 2014. Across the two questions those areas that scored highly for care recommendations tended to also score highly for work recommendations.

Figure 5.1: Friends and Family Test (Staff) by Work Area and Geography, Q4 2015, England



Source: NHS England, Friends and Family Test.

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

Scotland

- 5.10 There was no NHS Scotland Staff Survey in 2016 and the Scottish Government has now decided to discontinue the annual staff survey and replace it with the iMatter Continuous Improvement Model. The first data from this will be publicly available in early 2018.
- 5.11 The 2015 NHS Scotland Staff Survey results were published in December 2015. Almost 60,700 staff completed the survey. This is a 38 per cent response rate, a 3 percentage point increase on the participation rate in 2014. Negative perceptions appeared to centre on the issues of change management and staff shortages. Positive themes were around line management, team working and commitment to the job.

Wales

5.12 The 2016 staff survey for the NHS in Wales built upon the previous survey in 2013 and the questionnaire remained largely the same. The response rate in 2016 was 38 per cent. Table 5.4 highlights the compositional questions that determined the headline staff engagement index score. There were improvements in all themes, especially the staff advocacy and recommendation' theme.

Table 5.4: Wales Staff Survey summary

Theme	Question	2013	2016
Intrinsic psychological engagement	I look forward to going to work	49%	55%
	I'm enthusiastic about my job	60%	66%
	I am happy to go the extra mile at work when required	86%	89%
	THEME SCORE:	65%	70%
Ability to contribute towards improvement at work	I am able to make improvements in my area of work	54%	60%
	I am involved in deciding on the changes that affect my work/area/team/department	37%	44%
	THEME SCORE:	46%	52%
Staff advocacy and recommendation	I would recommend my organisation as a place to work	48%	57%
	I am proud to tell people I work for my organisation	51%	62%
	THEME SCORE:	49%	59%
OVERALL ENGAGEMENT INDEX SCORE:		55%	62%

Source: NHS Wales Staff Survey 2016

5.13 Other improvements in staff engagement were seen in response to questions about the satisfaction with the standard of care if a relative were to need treatment at their organisation (68 per cent in 2016, up from 53 per cent in 2013). However, responses to questions regarding resources and demand highlighted continued staff dissatisfaction. 57 per cent of staff said they didn't have adequate materials and supplies to carry out their work, up from 43 per cent in 2013. Likewise, 48 per cent of staff expressed difficulty in meeting all the conflicting demands on their time, unchanged since 2013.

Northern Ireland

5.14 The last staff survey in Northern Ireland was carried out in 2015 and published in May 2016. The response rate continued to be the lowest of the UK countries at 26 per cent. Table 5.5 shows the overall engagement score by staff group and highlights a fairly positive score for nursing & midwifery staff and social services staff. Meanwhile the score for ambulance staff is the lowest; particularly in response to the question about ability to contribute towards improvements at work, for which they scored 1.12 compared to the average of 3.17 (out of 5). Ambulance staff tended to have the lowest engagement scores of any staff group in most questions.

Table 5.5: Northern Ireland Staff Survey summary

Theme	HSCNI15	Nursing & Midwifery	Admin & Clerical	Ambulance	Estates	Prof. & Tech	Social Services	Support Services
KF22: Staff ability to contribute towards improvements at work	3.17	3.28	3.16	1.12	3.33	3.41	3.26	2.25
KF24: Staff recommendation of the trust as a place to work or receive treatment	3.71	3.78	3.68	2.93	3.61	3.65	3.87	3.71
KF25: Staff motivation at work	3.90	4.01	3.75	3.53	3.89	3.86	4.14	3.88
Overall Staff Engagement	3.72	3.80	3.66	3.02	3.69	3.71	3.87	3.60

Source: HSCNI Staff Survey 2015

5.15 Scores for questions about job roles, managers and the organisation are improving but still remain low. 67 per cent said they worked more than their contracted hours, down from 73 per cent in 2012. 61 per cent of staff said they have adequate materials and equipment to do their work and only 35 per cent said there were enough staff to do their jobs properly.

Sickness Absence

5.16 Sickness absence rates are calculated as the percentage of working hours lost through sickness absence. Table 5.6 shows the latest figures for each of the four nations of the UK (though Northern Ireland stopped collecting data in 2013). The figures are not seasonally adjusted so – as one would expect – sickness absence is higher in the autumn and winter (Q4 and Q1) than they are in spring and summer (Q2 and Q3). The table shows absence rates for Scotland have been steadily increasing since 2010/11. Absence rates in England were largely consistent with the rates in the previous two years. Absence rates in Wales have fallen compared to the previous three years, but are still higher than rates in England.

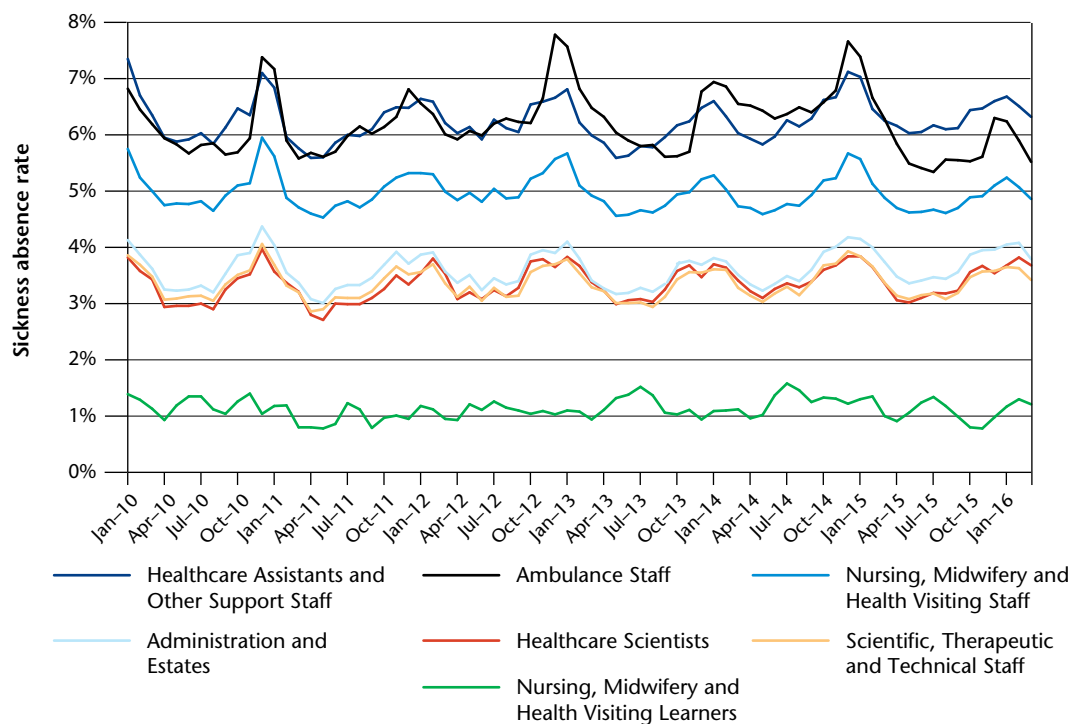
5.17 Figure 5.2 shows sickness absence rates by staff group in England between 2010 and 2016. It shows that ambulance staff, healthcare assistants and other support staff, and nursing, midwifery and health visiting staff, had higher than average sickness rates. Sickness rates for the ambulance staff group have noticeably fallen in 2016, but are still amongst the highest sickness rates of any staff group.

Table 5.6: Sickness absence rates within the NHS by country (FTE)

	England	Wales	Scotland		Northern Ireland	
Q1 2010	4.5%	5.3%	full year 2009/10	4.8%	6 months to Mar 2010	5.9%
Q2 2010	3.9%	4.7%				
Q3 2010	4.0%	4.9%			6 months to Sep 2010	5.3%
Q4 2010	4.5%	5.4%				
Q1 2011	4.2%	5.1%	full year 2010/11	4.7%	6 months to Mar 2011	5.6%
Q2 2011	3.8%	4.7%				
Q3 2011	4.0%	4.9%			6 months to Sep 2011	5.0%
Q4 2011	4.4%	5.4%				
Q1 2012	4.4%	5.4%	full year 2011/12	4.6%	6 months to Mar 2012	5.5%
Q2 2012	4.0%	5.1%				
Q3 2012	4.1%	5.3%			6 months to Sep 2012	5.3%
Q4 2012	4.5%	5.8%				
Q1 2013	4.4%	5.5%	full year 2012/13	4.8%	6 months to Mar 2013	5.7%
Q2 2013	3.9%	5.1%				
Q3 2013	3.9%	5.2%			6 months to Sep 2013	Not available
Q4 2013	4.3%	5.7%				
Q1 2014	4.3%	5.7%	full year 2013/14	4.8%	6 months to Mar 2014	Not available
Q2 2014	3.9%	5.2%				
Q3 2014	4.1%	5.5%			6 months to Sep 2014	Not available
Q4 2014	4.6%	5.9%				
Q1 2015	4.4%	5.6%	full year 2014/15	5.0%	6 months to Mar 2015	Not available
Q2 2015	3.9%	5.0%				
Q3 2015	4.0%	5.2%			6 months to Sep 2015	Not available
Q4 2015	4.3%	5.4%				
Q1 2016	4.4%	5.3%	full year 2015/16	5.2%	6 months to Mar 2016	Not available

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

Figure 5.2: Sickness absence rates in England by main staff group, 2010 to 2016



Source: NHS Digital

Appraisal and the Knowledge and Skills Framework

England

5.18 Table 5.1 shows that staff appraisal rates in England – based on the recent staff survey – increased in 2015, with 85 per cent of respondents stating that they had an appraisal or review in the previous 12 months. Around three quarters of staff members who had had an appraisal agreed, at least to some extent, that it had helped improve how they did their job (70 per cent) and left them feeling their work was valued by their organisation (74 per cent).

5.19 However, there were significant variations across the NHS. For example:

- There were big differences by staff group: for example, while 90 per cent of midwives and 87 per cent of nurses reported having an appraisal, only 76 per cent of paramedics and 66 per cent of ambulance technicians did.
- There were big differences by employer: appraisal rates were significantly lower in Ambulance Trusts, where only two thirds (67 per cent) reported having an appraisal and, of those who had, 42 per cent said it had not improved how they did their job and 41 per cent said it did not leave them feeling their work was valued by their organisation.

Wales

5.20 74 per cent of staff survey respondents in Wales said that they had had a Performance Appraisal and Development Review in the last 12 months, an increase of 19 percentage points since 2013. Of those having reviews, about half (53 per cent) said that the review had helped them to improve how they did their job and three quarters (78 per cent) said it had helped agree clear objectives for their work. 62 per cent of staff responded that the review left them feeling that their work was valued by their organisation.

Northern Ireland

- 5.21 65 per cent of staff in Northern Ireland had an appraisal in 2015, up from 52 per cent in 2012, though only 31 per cent said they had a well-structured appraisal. There was significant variation across different employers, with only 25 per cent of Northern Ireland Ambulance Service staff reporting that they had an appraisal and only 6 per cent saying they had a well-structured appraisal.

Scotland

- 5.22 In the latest survey, nearly three out of four staff who responded to the Scottish NHS staff survey (74 per cent) had undertaken any kind of development or performance review. This was a decrease of one percentage point on 2014. Two thirds of respondents (66 per cent) felt that their review had helped them to agree clear objectives for their work. A lower proportion (43 per cent) felt their review had helped them improve how they do their job.
- 5.23 Across Health Boards in Scotland, the percentage of respondents who had taken part in a review in the last 12 months ranged from 50 to 97 per cent. Ambulance Staff who responded to the survey were the least likely to have taken part in a review (51 per cent).

Evidence from the parties on Motivation, Morale and Staff Engagement

- 5.24 The **Department of Health** for England said that 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. They told us 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, feel safe raising concerns and are able to learn from mistakes, and where employers listen to and empower staff, working hard to keep them safe and ensuring bullying and harassment is not tolerated.
- 5.25 They told us that morale, as indicated by the NHS Staff Survey Engagement Index and sickness absence, appeared not to have changed significantly in recent years. They said that the overall Engagement Index score – which they used to measure morale – had increased from 3.71 in 2014 to 3.78 (out of 5) in the 2015 Staff Survey, noting that this was the fourth successive year of increase. They also said that staff engagement had increased for all staff groups in 2015 with the exception of operational ambulance staff. However, they identified some areas of concern, including work pressures, bullying and harassment.
- 5.26 They also highlighted the NHS Staff Survey motivation measure, which was defined as “the extent to which staff look forward to going to work and are enthusiastic about and absorbed in their jobs”, and noted that this had been fairly stable over time, increasing from 3.82 in 2011 to 3.92 in 2015 (out of 5) in the 2015 Staff Survey.
- 5.27 A further measure of staff motivation cited by the Department of Health was the extent to which an employee would advocate their trust as a place to receive care and as a place to work, reflected in the Friends and Family Test (FFT), introduced in April 2014 and carried out quarterly. In the fourth quarter of 2015/16, 79 per cent of staff said they would recommend their trust as a place to receive treatment and 62 per cent said they would recommend their trust as a place to work.
- 5.28 In terms of staff well-being, the Department of Health told us that there were only small changes in the 2015 staff survey compared with 2014, with a slight rise in the proportion of staff working additional hours (+1 percentage point and a slight reduction in the proportion suffering from work-related stress (-2 percentage point).

- 5.29 The Department of Health noted that research had shown that good staff support and engagement was directly related to patient experience, safety and quality of care. They also told us that there was a complex relationship between overall pay and levels of staff engagement, morale and motivation.
- 5.30 They said that staff engagement was crucial to creating the right culture and developing an environment where staff want to work. They said that, at a national level, they encouraged local organisations to develop their own local initiatives as they are best placed to identify the local engagement strategy for their own workforce. They told us that 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. They said that trends over time in staff engagement and morale suggests that the various initiatives in place, both locally and nationally, are having a positive impact.
- 5.31 The Department of Health identified a number of ways in which they were highlighting the importance of staff engagement. One of the examples they gave was the support they were giving to events with NHS Employers to raise the profile of staff engagement and its importance in the service, including support for the government's "Engaging for Success Taskforce". They said that they had commissioned NHS Employers to develop staff engagement resources and collate and share examples of good practice to support trusts and help line managers foster staff engagement and better understand what it means to be an engaging manager in the NHS.
- 5.32 The Department of Health told us that the importance of staff engagement is also being promoted by the NHS Leadership Academy in their refreshed version of 'the Healthy NHS Board'. They said that this sets out what Trust 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. They also said that the Academy is also developing and implementing a leadership development offer that places strong emphasis on shaping positive cultures and engaging staff.
- 5.33 The Department of Health also told us that 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 Vanguards (sites for the new models of care programme) and gave a number of case study examples.
- 5.34 **NHS Employers** informed us that staff engagement, as measured by the NHS Staff Survey, improved in 2015 with increases against both the overall indicator of staff engagement and the motivation measure, the latter driven by an improvement in the level of enthusiasm staff feel for their job which rose from 69 per cent to 74 per cent. Improvements were also noted in the proportion of staff who were willing to recommend the NHS as an employer and the percentage of staff feeling able to contribute to improvements at work. We were told that over twenty five trusts increased their staff engagement levels significantly in 2015, including many which had had historical challenges.
- 5.35 They also noted a number of areas where staff remained less satisfied, highlighting the measures for recognition and value of staff by managers and the organisation (3.43 out of 5) and the quality of communication within the organisation (only 31 per cent reported good communication in their organisation). They also said that there remains considerable variation between trusts in their staff engagement levels which needs to be reduced.

- 5.36 They said that current pressures on the NHS were a major challenge to sustaining engagement and that it was possible that staff opinion on issues such as pay and staffing levels could adversely impact on staff engagement over time. They told us that employers will need to develop their efforts, including by sharing ideas and experiences.
- 5.37 NHS Employers also reported that the NHS has a national framework of Staff Pledges which aim to encourage NHS organisations to develop local engagement approaches. NHS Employers is commissioned by the Department of Health for England to assist employers in this field. They said the NHS Employers website shares case studies and other resources with over 25 trusts highlighted as examples of good practice. In 2015 NHS Employers identified:
- An increase in employers focussing on staff engagement. They said that most employers had adopted new approaches to staff involvement and communication, with many implementing new methods of seeking staff feedback in addition to the national staff survey. They also noted a growth in 'back-to-the-floor' and open door exercises, when senior leaders have direct communication with staff on wards.
 - A renewed focus on increasing the capacity of line managers to foster engagement, with at least a dozen trusts having developed specific programmes in this area. NHS Employers said that they had developed resources to support employers to foster line managers' role in engagement.
 - A growth in schemes which seek to recognise and reward the contribution of staff. NHS Employers said they had identified over seventy such schemes and said that they are mostly in the form of non-monetary awards and are well received by staff. They also said that a small number of organisations have linked contribution and reward via their performance progression arrangements.
- 5.38 **NHS Improvement** said that 'culture and engagement' is one of the four themes in the programme they have developed to support NHS providers in responding to national workforce challenges.
- 5.39 They told us that they recognise that staff engagement is pivotal to performance and that this is reflected in their work on culture and leadership. They said that their culture and leadership diagnostic tools for providers use a range of evidence, including staff engagement scores, as measures for boards to help them understand how their organisational culture and leadership behaviours are supporting staff engagement, motivation and therefore performance.
- 5.40 They also said that they jointly led work on "*Developing People – Improving Care: A National Framework for Action on Improvement and Leadership Development in NHS Funded Services*" with Health Education England, which aimed to equip and encourage people in NHS-funded roles to continually improve local health and care systems and gain pride and joy from their work. They also highlighted the well-led framework, which they said was used to support providers in assessing leadership and governance arrangements and included guidance for providers to consider how they use their staff engagement findings to understand if staff feel valued, supported and developed and how to address areas where further work is required.
- 5.41 **Joint Staff Side** told us that financial and capacity challenges were putting more and more pressure on staff. They said that the combined impact of long-term growth in workload, staff shortages and higher intensity of work were leading to dangerously declining levels of morale. They highlighted findings from the NHS Staff Survey that show high levels of work-related stress in the workforce, with 37 per cent of staff in England and 36 per cent of staff in Northern Ireland saying that they had felt unwell as a result of work-related stress.

- 5.42 They also cited results from surveys of union members suggesting low levels of morale, with 80 per cent of respondents to a Unite survey saying morale was worse than a year ago and 56 per cent of respondents to a UNISON survey saying morale was low or very low in their workplace compared to only 7 per cent who said it was high or very high, with a majority of respondents in both surveys saying that they had considered leaving the NHS.
- 5.43 In explaining the difference between surveys of union members and the NHS Staff Survey, Joint Staff Side told us that the 'Staff Motivation at Work' measure cited by the Department of Health for England was a composite score made up of three items: 'I look forward to going to work'; 'I am enthusiastic about my job'; and 'Time passes quickly when I am working'. They said that these items relate to intrinsic job satisfaction and that the motivation measure does not take the evidence of workload pressures shown in other parts of the survey into account.
- 5.44 The **Royal College of Nursing** highlighted experimental analysis of the Labour Force Survey which they had carried out suggesting that 3.1 per cent of nurses in the NHS were actively looking for a new job in the first quarter of 2016.
- 5.45 They said that the results of the most recent NHS Staff Surveys undertaken in England, Scotland and Northern Ireland indicated high levels of workload, with many nurses reporting there were insufficient staffing levels for them to carry out their job properly, having to work additional hours, experiencing work-related stress and turning up for work despite not feeling well enough to do so. They also noted findings from the Royal College of Nursing's 2015 Employment Survey showing that 35 per cent of respondents worked in excess of their contracted hours several times a week and a further 16 per cent worked in excess of their contracted hours on every shift. They told us that nurses' duty of care was all too often being undermined by pressures caused by inadequate staffing levels and skill mix leading to excessive working hours, stress and burnout.
- 5.46 **UNISON** reported findings from their pay survey in which over half of respondents described morale in their organisation as 'low' or 'very low' and only 7 per cent described it as 'high' or 'very high', with almost two thirds (65 per cent) of respondents saying morale had fallen over the last 12 months. They said that only 32 per cent of respondents would positively recommend their occupation or profession to someone looking for a career and only 37 per cent would positively recommend their employer to someone looking for a job. They told us that over half of respondents had fairly or very seriously considered leaving their current position.
- 5.47 In explaining the differences between the findings from the NHS Staff Survey and the UNISON pay survey, UNISON told us that morale (measured by the pay survey) and motivation (measured by the NHS Staff Survey) were different things. They said that their members in general remain highly motivated due to, for example, a strongly held public service ethos or the pressure of seeing patients with unmet needs. They said that morale encompasses how valued staff feel, how easy or difficult working conditions are and how well-rewarded people feel for the motivation they demonstrate and that they were alarmed by the frequent reports of declining morale that they hear.
- 5.48 UNISON told us that it was difficult to improve motivation through small pay awards but that not maintaining the value of NHS pay and reward damaged morale and may eventually impact on motivation. They said the impact of falling morale would put attempts at organisational change at risk and lead to higher sickness absence, increased stress, lower productivity and increasing staff turnover.

- 5.49 **Unite** told us that low morale and stress continued to be an issue, with 80 per cent of respondents to the Unite survey saying that morale and motivation in their workplaces had fallen compared to the previous year, with increased workplace stress (79 per cent), restructuring and reorganisation (57 per cent) and falling take-home pay (47 per cent) identified by respondents as drivers of this. They also told us that over a quarter of respondents (27 per cent) had reported bullying, discrimination or other negative behaviours from their manager. They said that over half – 56 per cent – of respondents to the Unite survey said they had considered taking a job outside of the NHS in the past 12 months.
- 5.50 Unite also told us that workload continued to be a major concern for Unite members, with over two thirds (68 per cent) of respondents to the Unite survey saying they “always” or “frequently” worked more than their contracted hours, with most of these saying that this time was all unpaid (though with significant differences by occupation and seniority). Half of respondents to the Unite survey said that their workloads had increased a lot and over two thirds (68 per cent) reported staff shortages.
- 5.51 The **Welsh Government** said that it engages NHS staff representatives in numerous forums. These forums include the relevant trade unions, NHS Employers and Welsh Government officials. It told us it had initiated the ‘Common Principles Project’ to help to improve staff engagement which started in late 2014 and was focused on developing a different approach to managing difficult workplace employment issues and so improving engagement of the workforce.
- 5.52 The Welsh Government continued by saying that the ‘Common Principles Project’ group is taking the dissemination of these values forward and said that the core principles were distributed via payslips to NHS staff in Wales in September 2016. They added that this method is the start of further communications to ensure the principles are fully embedded through local intranets, staff newsletters and other methods. They said that a workshop was held in May 2016 with employers and staff side from all NHS organisations to understand the relationship between the local values and behaviours and the overarching NHS Core Principles. They emphasised that work will be continued to further embed the Core Principles in all NHS organisations.

Evidence from the parties on specific staff groups

- 5.53 This section looks at the evidence we received from the parties regarding two specific staff groups where concerns were raised regarding motivation, morale and engagement: ambulance staff and midwives.

Ambulance

- 5.54 **NHS Employers** said that the most recent staff survey results showed a continuing pattern of worse staff experience on health and well-being in the ambulance service, with the Staff Engagement Index for Ambulance Staff in the 2015 staff survey – 3.38 – increasing over time but still significantly below the engagement score of 3.78 in the service as a whole. They told us that ambulance staff reported a higher level of work pressure, work-related stress, pressure to work when unwell and bullying and harassment by colleagues than other staff. For example, 48 per cent of ambulance staff reported taking time off as a result of work-related stress compared to 37 per cent of staff in the service as a whole. They told us that this points to a situation where changes within the workplace which directly affect staff experience could have a significant impact on the retention of ambulance staff.

- 5.55 They identified a number of areas where action could be taken to improve staff engagement, including focusing on activities to support the health and well-being of ambulance staff, using integrated services to look for different roles which ambulance staff could move into if they were unable to continue in the ambulance service, using cross-organisation work and rotational roles to reduce the amount of time staff are exposed to the pressures of front-line service delivery and improved support for line management and leadership to address the issues around staff experience and staff engagement. On this latter point, they said that work carried out by Professor Michael West could be used to assess the extent to which the ambulance service is implementing actions to ensure effective staff engagement and experience.
- 5.56 They also told us that sickness absence levels in the ambulance service are higher than those in the wider NHS, with the average sickness rate in 2015 of 4.7 per cent higher than the national average of 4.2 per cent. They also said that the sickness rate had increased to 5.9 per cent in February 2016 and noted that there was significant variation between trusts, with the sickness absence rate in February 2016 varying from 3.8 per cent to 6.9 per cent.
- 5.57 They said that the evidence suggests that greater attention to the factors which affect staff experience could have a much more positive effect than an intervention based on pay alone e.g. through the paramedic banding review and other ongoing work looking at pay structures in the ambulance service.
- 5.58 The **Northern Ireland Executive** acknowledged in oral evidence that the Staff Survey showed that there were issues with the ambulance service in Northern Ireland, which included:
- Health and wellbeing of staff;
 - Contentment with the job; and
 - Levels of staff engagement.
- 5.59 They told us that the Northern Ireland Ambulance Service was looking at the culture of the service and was trying to engage more with staff to tackle them, including through looking at how similar issues were being tackled in the rest of the UK. They noted that the term “staff engagement” in the ambulance service had, in recent years, often meant management engaging with Trade Unions rather than talking directly to staff but that a real effort was now being made to engage with staff and involve them more directly in change. They also highlighted a number of issues in the ambulance service that were revealed by the staff survey, including violent attacks by patients and managers on staff and high sickness levels. They said that there were plans at director level to tackle these issues and increase the focus on the health and wellbeing of staff.

Midwives

- 5.60 The **Royal College of Midwives** said that there is a shortage of nearly 3,500 midwives in the UK and that this was leading to maternity units struggling to meet the demands of the service, with Heads of Midwifery frequently redeploying staff to other areas, using bank and agency staff, withdrawing services and closing maternity units. They told us that organisations were relying on the goodwill of midwives and maternity support workers to staff maternity units and that this was leading to high levels of stress and burn-out and causing midwives to leave midwifery, with the most common reasons that midwives gave for leaving being staffing levels and workload. They said that maternity services are in a catch-22 situation with many midwives leaving midwifery due to understaffing which further exacerbates staffing levels.

- 5.61 They told us that maternity units were facing unprecedented challenges and were overworked and understaffed and that this had resulted in low levels of staff engagement. They said that improving staff engagement would improve organisational financial performance via reduced litigation costs and sickness absence and would also improve patient outcomes. They also highlighted findings from their Head of Midwifery Survey that only 1 per cent said morale and motivation in their organisation was 'very good', with 60 per cent saying morale was 'ok' or 'poor'.
- 5.62 The Royal College of Midwives also cited findings from a survey of their members about their health, safety and well-being at work which they said showed increased pressure and demands were having a significant effect on the health, safety and wellbeing of midwives and maternity support workers, with respondents reporting that they were feeling stressed, burned out and unable to give high quality care to women and their families.
- 5.63 They also said that the Government needed to stop considering their pay policy in isolation; they needed a total strategy for the whole workforce. They said they were concerned that the Government's zeal for cutting pay, terms and conditions for NHS staff would actually result in far higher costs to the NHS in terms of low staff engagement and patient outcomes. They said that investment in staff was an investment in high quality care.
- 5.64 **Health Education England** told us in oral evidence that their data suggested that shortfalls of midwives were not as large as implied by the Royal College of Midwives and were decreasing over time. They suggested that the difference between their data and the estimates of shortages produced by the Royal College of Midwives was that RCM were claiming the number of funded posts was insufficient rather than there being difficulties in filling the number of funded posts, which is how a shortfall was defined in official estimates.

Our comment on motivation, morale and staff engagement

Overview of the evidence base

- 5.65 We believe, as Unison has pointed out, that it would be helpful for future evidence from the parties to have a shared language when talking about the 'motivation' element of our remit. We do not wish to be restricted in our assessment because there are differing interpretations of the words used. It is therefore useful for us to define more precisely what we mean by each:
- By *staff motivation*, we mean the intrinsic motivation of NHS staff and the underlying reasons why people do the job that they do and want to put effort into their work such as the desire to provide care, to earn money or to achieve promotion. Measures of this might include whether staff look forward to going to work and if they are enthusiastic about their job.
 - By *staff satisfaction* (which is often described as morale in the evidence), we mean whether NHS staff are happy with their experience of work and achieve what they set out to. Measures of this might include whether staff feel their work is valued, their satisfaction with the work environment and issues such as workload, and whether they feel able to give the care they aspire to.
 - By *staff engagement*, we mean how committed staff are to their organisation (affiliation) and whether they will put extra work in to e.g. engage with initiatives aimed at reforming healthcare delivery to improve efficiency (effort).

- 5.66 The levels of and directions in each of these elements can differ, both within a staff group, as well as between staff groups. For example, midwives may feel that their job is very important and worthwhile and have high levels of motivation while at the same time feel that the pressures of work are such that they cannot deliver the care they aspire to and so have low levels of job satisfaction. Many of the evidence submissions by the parties ignored this complexity and simply cherry picked the components that supported the story that they wanted to tell.
- 5.67 We are therefore concerned about the quality of the evidence-base for this aspect of our remit. We have tried to piece together the data from historic Staff Surveys with reducing response rates, from staff-side submissions and other sources like the Friends and Family test, as well as what we hear on our visits. We urge the parties to conduct more sophisticated analysis in the future as well as face up to the complexity of the situation. The acknowledgement that the NHS depends not only on skills, knowledge and expertise but also staff goodwill is shared by all parties. We comment in more detail on the various aspects of this part of our remit below.

Staff motivation, satisfaction and engagement

- 5.68 Looking at the evidence we do have available, there are two key sources of official data regarding motivation collected by the NHS: the Staff Survey and, in England, the Family and Friends Test.
- 5.69 While a valuable source of information for monitoring trends in motivation, morale and staff engagement at the national level, the former is limited in its usefulness as a planning tool for local employers as it is largely out of date by the time the current process of publishing, analysing and action planning has taken place. There are also concerns about the level of participation, with at least 59 per cent of staff in each UK country not engaging with official staff surveys, and it is plausible that staff with low motivation, morale and engagement do not engage with the surveys. There are also limitations in how existing staff surveys measure some aspects of motivation morale and staff engagement, especially in high-level summaries of 'engagement scores', which can risk complacency about significant staff morale and engagement issues facing the NHS. The better use of the staff survey would be to use it as a measure to support targeted local improvement plans which are based on discussions with staff and their representatives in Trusts and as a measure of progress against national priorities.
- 5.70 The Family and Friends Test in England is potentially more useful as it is undertaken quarterly, data is available at regular intervals and it focuses on two fundamental questions which have the potential to unlock some meaningful data on staff motivation, satisfaction and engagement. However, the real added value, as in many surveys, is the narrative where Trusts can start to understand why staff are saying what they are saying.
- 5.71 Both surveys are supplementary to the core task in Trusts and Health Boards of listening and responding to staff. Taken together they could be very useful in identifying issues which could be tackled at the national or regional level and those which are far better dealt with locally. Bringing some clarity in this area may enable a wider evidence base which helps to produce a shared agreement on the key issues and a clear action plan for tackling them. The national issues would potentially form part of the strategic people framework. We would like to have an integrated, ideally shared, position which incorporates national and local surveys, and the views of staff, which goes beyond anecdotal evidence. We talk more about a strategic people framework in Chapter 6.

- 5.72 Despite the gaps in the evidence, it is clear that frontline staff in the NHS are under increasing pressure, with increasing workloads, concerns about the quality of care and a feeling among many staff that they are not valued. There is consensus among staff side and employers that morale is falling due to a combination of increased pressures on staff and pay restraint. For example, NHS Providers recently said that Trust Chairs and Chief Executives now see the workforce challenge as just as difficult as the financial challenge, noting that *“Growing demand and staff shortages mean NHS roles are becoming more pressured and difficult, with staff increasingly overworked and under stress. A prolonged period of pay restraint and the junior doctors dispute have also had an adverse impact”*.³⁹
- 5.73 This was also a key message from our 2016 visits programme, with common themes including:
- Staff continued to enjoy working in their local teams and were proud of the jobs that they did but organisations ran on goodwill, which staff felt was running out.
 - Organisations were carrying a number of vacancies which was increasing pressure on existing staff.
 - Many non-clinical staff felt undervalued and taken for granted.
 - The 2016/17 pay award was negated by increases in pension and national insurance contributions and pay was not keeping up with the cost of living.
 - Pay differentials were being eroded due to the imminent introduction of the National Living Wage and recent bottom-weighted awards, which some staff felt made it less attractive to take on additional responsibilities.
 - Recent changes to service design in some areas were challenging for some staff, particularly around changing job roles, a perceived lack of flexibility around family responsibilities and issues around health and social care integration, with staff on different terms and conditions working alongside each other in identical jobs.
 - Health and Social care is often being integrated without staff pay and terms and conditions integration. This created tension in some organisations as identical or very similar jobs were being carried out, in co-located teams, with varying remuneration packages.
- 5.74 Despite all this, the evidence suggests that staff motivation is – in general – still reasonable and there is no evidence (yet) that falling morale is translating into poorer services, lower productivity, higher sickness rates and worse patient outcomes. But the overall feeling that *“goodwill is running out”* is a big concern and may, for example, translate into a lack of staff engagement with the service reforms necessary to deliver the challenging efficiency targets and productivity improvements set out in the Five Year Forward View.
- 5.75 One issue – as we highlighted in Chapter 3 – is that the NHS is attempting to deal with significant increases in patient demand within a budget that is only increasing slowly in real terms. It seems to us that staff satisfaction, as we define it above, is being negatively affected by the lack of progress so far in achieving efficiencies beyond those delivered by pay restraint. We are concerned that this could spill over into lack of engagement in the changes being sought. We return to this in Chapter 7.
- 5.76 While we believe pay impacts upon all three aspects of motivation, satisfaction and engagement, the key concerns highlighted by both the NHS Staff Survey and the evidence from staff side concern workload pressure. We therefore note that alleviating workload pressures *could* in the very short-term do more to address this part of our remit than pay. We also return to this in Chapter 7.

³⁹NHS Providers, *State of the Provider Sector*, November 2016.

Sickness absence

- 5.77 Sickness absence rates were broadly flat in England and Wales between the first quarter of 2015 and the first quarter of 2016 and there has been very little change over time in sickness absence in either country since 2010 (there is no data for Northern Ireland after March 2013). One noticeable change is that the sickness absence rate among ambulance staff in England appear to have been reduced in the last 12 months, though it is still higher than among other staff groups. It would be useful to have more detailed information on sickness rates in future years about the number of episodes of sickness absence and their average length, as the headline trends could be masking changes in these.
- 5.78 The lack of adverse trends in sickness absence rates is further supportive evidence for our conclusion that, overall, staff motivation is broadly the same as last year.

Appraisal and Knowledge and Skills Framework

- 5.79 We continue to support meaningful appraisal as well as training and development. The Knowledge and Skills Framework is a key part of Agenda for Change. It is therefore encouraging to see that the proportion of staff receiving an appraisal continued to increase in England, Wales and Northern Ireland. It is also encouraging that the majority of staff in England and Wales reported that their appraisal helped to improve how they did their job and increase their perception of how they were valued by their employer, though staff feedback on this in Northern Ireland was not as positive. There is also significant variation across the NHS, with fewer staff in the ambulance service reporting having had a review in both England and Northern Ireland and ambulance staff being less positive about how effective their review was.

Ambulance staff

- 5.80 One specific issue that causes us great concern is the evidence from the Northern Ireland Staff Survey about the low motivation, engagement and morale of staff working in the Northern Ireland Ambulance Service. There appear to be serious issues in the management of ambulance staff – including a quarter of staff reporting harassment, bullying and abuse from their manager and 6 per cent reporting physical violence from colleagues – and relatively low job satisfaction, with ambulance staff also feeling under more workload pressure than their colleagues elsewhere in HSC. While it was clear in oral evidence that these issues had been recognised by employers, it was not apparent that a fully-rounded plan for addressing them is in place as yet. We are also concerned by evidence that staff engagement for ambulance staff in England is noticeably weaker than for other staff groups.

Midwives

- 5.81 Another issue we are concerned about is the findings from the staff survey that midwives are reporting bigger work pressures than other occupational groups: midwives are the most likely staff group to report suffering work-related stress, working unpaid overtime and having inadequate materials, supplies, equipment and staff to do their job properly and are the least likely to report being able to meet all the conflicting demands on their time at work. The evidence from Health Education England is that there is not a serious shortfall of midwives. The findings from the staff survey and the evidence from trade unions point in a different direction. This divergence needs to be addressed.

Chapter 6 – Workforce Planning, Future Supply and the People Strategy

Introduction

- 6.1 This chapter explores the evidence on workforce supply including workforce planning, drivers of future supply (including the impact of the EU Referendum result and the impact of student funding reform), forecast trends in future supply and the impact of pay on supply. It also presents the views we heard in relation to the people strategy of the NHS.
- 6.2 It deals with the longer-term activity that links to, and builds from, the current picture on recruitment, retention and vacancies examined in Chapter 4.

Workforce Planning and Future Supply

Future Demand and Supply in England

- 6.3 Chapter 4 summarised the available data on current staff shortages within the NHS based on shortfall data for professionally qualified staff provided by Health Education England and on vacancy data provided by the health departments of Northern Ireland, Scotland and Wales.
- 6.4 This section looks at the latest Health Education England projections of supply and demand for professionally qualified staff in England contained in their most recent workforce plan.⁴⁰ Projections of future workforce supply and demand were unavailable for Northern Ireland, Scotland and Wales.
- 6.5 The most recent hospital activity data from NHS Digital shows that the demand for healthcare in England is increasing. For example:
- The number of A&E attendances increased by 4.6 per cent in 2015/16, from 19.5 million to 20.4 million. This was driven by a large increase in attendances during the winter months (January to March), which was 12.2 per cent higher than the same period in 2014/15.
 - The number of arrivals by ambulance increased by 2.2 per cent in 2015/16, from 4.5 million to 4.6 million, though has fallen as a share of total arrivals.
 - There were 648,000 babies delivered in NHS hospitals during 2015/16, an increase of 1.8 per cent.
 - The number of outpatient appointments has risen significantly, from 50.0 million in 2005/06 to 89.4 million in 2015/16.
- 6.6 This increase in activity – alongside policy changes affecting staffing such as the response to the Francis report – is increasing the demand for staff. Health Education England collated NHS provider forecasts of future demand for staff to produce an estimate of the demand for staff in each professional group in 2020, showing an overall 5.3 per cent (22,800) increase in demand for nursing, midwifery and allied health staff between 2015 and 2020.⁴¹ Health Education England caveat these forecasts by noting that the aggregate of the forecasts is inconsistent with the expectations of the Five Year Forward View and the financial settlement for the NHS set out in the Spending Review. These projections are set out in Table 6.1.

⁴⁰ Health Education England, *Workforce Plan for England: Proposed Education and Training Commissions for 2016/17*, 2016.

⁴¹ Health Education England, *Workforce Plan for England: Proposed Education and Training Commissions for 2016/17*, 2016.

Table 6.1: NHS Provider forecast changes in workforce demand 2015-2020

Workforce	2015 Demand (FTE)	2020 Forecast Demand (FTE)	Increase (FTE)	% Increase
Adult Nurse	238,141	251,198	13,057	5.5%
Children's Nurse	39,670	41,952	2,282	5.8%
Mental Health Nurse	41,669	41,896	227	0.5%
Learning Disability Nurse	4,297	4,292	-5	-0.1%
Midwifery	23,329	24,628	1,299	5.6%
Total Nursing and Midwifery	347,105	363,965	16,860	4.9%
Dietetics	4,264	4,524	260	6.1%
Occupational Therapy	18,335	18,902	566	3.1%
Physiotherapy	21,192	22,082	890	4.2%
Podiatry	3,267	3,315	49	1.5%
Speech and Language Therapy	6,860	7,004	144	2.1%
Diagnostic Radiography	14,508	15,655	1,147	7.9%
Therapeutic Radiography	2,640	3,037	396	15.0%
Paramedics	12,993	15,486	2,494	19.2%
Total Allied Health	84,059	90,005	5,946	7.1%
Total Workforces	431,164	453,970	22,806	5.3%

Source: Health Education England

6.7 Health Education England also produce forecasts for supply of NHS staff in each professional group by 2020, with high and low supply scenarios depending on the assumptions that are made about recruitment and retention e.g. international recruitment, conversion rates of student commissions into NHS staff and turnover. Based on these forecasts, there will be an increase in the supply of nursing, midwifery and allied health staff between 2015 and 2020 of between 3.4 per cent and 18.0 per cent, depending on the assumptions made. There is wide variation between forecast supply trends for different occupational groups with, for example, the supply of adult nurses and paramedics decreasing in the lower supply scenario. These projections are set out in Table 6.2.

Table 6.2: Forecast changes in NHS staff supply 2015-2020

Workforce	2015 Staff	2020 (Higher)	Increase (Higher)	2020 (Lower)	Increase (Lower)
Adult Nurse	216,282	237,416	21,133 (9.8%)	213,428	-2,854 (-1.3%)
Children's Nurse	36,027	44,945	8,918 (24.8%)	38,427	2,400 (6.7%)
Mental Health Nurse	37,880	46,387	8,506 (22.5%)	40,184	2,304 (6.1%)
Learning Disability Nurse	3,904	5,682	1,778 (45.5%)	5,030	1,126 (28.8%)
Midwifery	22,198	28,814	6,616 (29.8%)	25,505	3,307 (14.9%)
Total Nursing and Midwifery	316,292	363,243	46,952 (14.8%)	322,574	6,282 (2.0%)
Dietetics	4,042	5,556	1,514 (37.5%)	4,515	473 (11.7%)
Occupational Therapy	15,503	21,756	6,253 (40.3%)	17,740	2,237 (14.4%)
Physiotherapy	19,561	24,733	5,172 (26.4%)	19,863	302 (1.5%)
Podiatry	2,973	4,057	1,084 (36.4%)	3,645	672 (22.6%)
Speech and Language Therapy	6,347	9,816	3,469 (54.6%)	8,167	1,820 (28.7%)
Diagnostic Radiography	13,358	17,005	3,647 (27.3%)	14,653	1,295 (9.7%)
Therapeutic Radiography	2,505	3,682	1,177 (47.0%)	3,133	628 (25.0%)
Paramedics	12,272	13,671	1,398 (11.4%)	11,811	-461 (-3.8%)
Total Allied Health	76,562	100,275	23,713 (31.0%)	83,527	6,965 (9.1%)
Total Workforces	392,854	463,518	70,665 (18.0%)	406,101	13,217 (3.4%)

Source: Health Education England

6.8 These supply and demand projections can be brought together to produce forecasts of staff shortfalls by occupational group in 2020. This shows that the 'high supply' scenario is sufficient to eradicate current shortfalls in all occupational groups except adult nurses and paramedics. However, significant shortfalls would remain in the 'low supply' scenario in many occupational groups, even against current demand. These projections are set out in Table 6.3.

Table 6.3: Current and forecast shortfalls in NHS staff supply 2015-2020

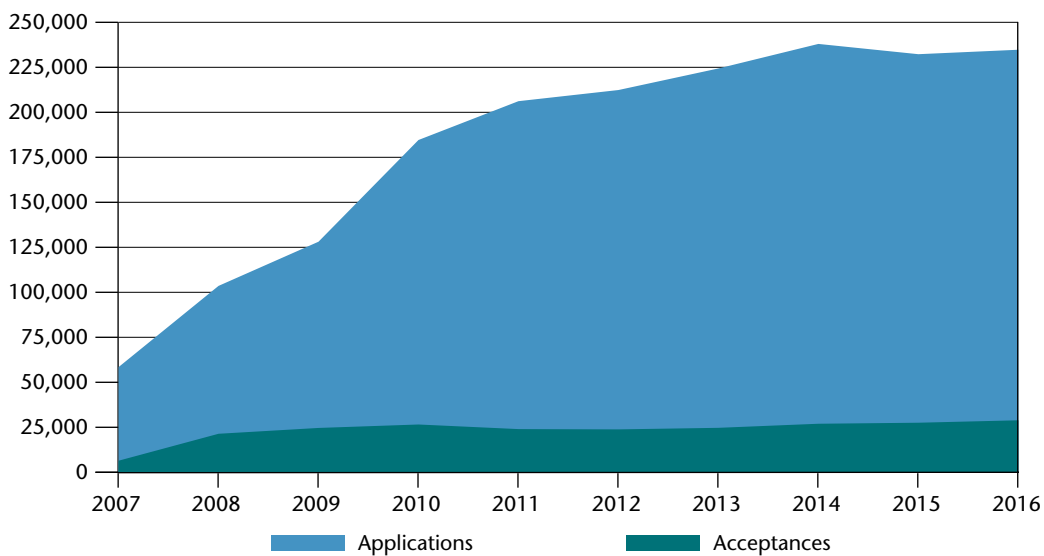
Workforce	2015 shortfall	2020 – high supply	2020 – low supply
Adult Nurse	21,859 (9.2%)	13,782 (5.5%)	37,770 (15.0%)
Children's Nurse	3,643 (9.2%)	-2,993 (-7.1%)	3,525 (8.4%)
Mental Health Nurse	3,789 (9.1%)	-4,491 (-10.7%)	1,712 (4.1%)
Learning Disability Nurse	393 (9.1%)	-1,390 (-32.4%)	-738 (-17.4%)
Midwifery	1,131 (4.8%)	-4,186 (-17.0%)	-877 (-3.6%)
Total Nursing and Midwifery	30,813 (8.9%)	722 (0.2%)	41,391 (11.4%)
Dietetics	222 (5.2%)	-1,032 (-22.8%)	9 (0.2%)
Occupational Therapy	2,832 (15.4%)	-2,854 (-15.1%)	1,162 (6.4%)
Physiotherapy	1,631 (7.7%)	-2,651 (-12.0%)	2,219 (10.0%)
Podiatry	294 (9.0%)	-742 (-22.4%)	-330 (-10.0%)
Speech and Language Therapy	513 (7.5%)	-2,812 (-40.1%)	-1,163 (-16.6%)
Diagnostic Radiography	1,150 (7.9%)	-1,350 (-8.6%)	1,002 (6.4%)
Therapeutic Radiography	135 (5.1%)	-645 (-21.1%)	-96 (-3.2%)
Paramedics	721 (5.5%)	1,815 (11.7%)	3,675 (23.7%)
Total Allied Health	7,497 (8.9%)	-10,270 (-11.4%)	6,478 (7.2%)
Total Workforces	38,310 (8.9%)	-9,548 (-2.1%)	47,869 (10.5%)

Source: OME analysis of Health Education England data (2016). Negative numbers indicate forecast surpluses

Graduate Supply

6.9 UCAS data shows that the number of applications to nursing degree courses has continued to grow since 2007 while the number of acceptances has remained broadly constant (see Figure 6.1).

Figure 6.1: Volume of total applications and acceptances for Nursing degree courses, UK, 2007 to 2016



Source: OME analysis of UCAS data

6.10 After accounting for the fact that many applicants make multiple applications, in England in 2015 there were around 57,000 unique applicants to nursing degree courses compared to 21,450 available places, meaning that there were 2.6 applicants for every place and unmet demand of 35,500: nursing degree courses are significantly over-subscribed.⁴²

6.11 Many students who enter nursing and other health-related degree courses do not enter full-time work for the NHS. For example, based on their historical experience, Health Education England expect for every 100 adult nursing degree places they commission:

- 4 people to not take up their place.
- 19 people to not complete their courses.
- 12 people to work outside of the NHS.
- The working time of 7 people to be lost due to some people working part-time.
- 58 FTE new staff working in the NHS.

6.12 The student funding system for nursing, midwifery and allied health degree courses is changing from August 2017 in England. While there are a lot of uncertainties about the impact of this on student numbers, the Department of Health's impact assessment estimates that it will create a cumulative total of 10,000 additional places on nursing, midwifery and allied health courses in 2017/18, 2018/19 and 2019/20 (equivalent to around a 10 per cent increase in the number of places over the three years) because the new system effectively removes the annual cost cap on the number of student places. The Health Foundation has calculated that there would need to be a 60 per cent fall in the number of people applying to do nursing degree courses for the proposed funding changes to result in a fall in filled training places and that such a fall would require nursing students to be ten times more sensitive to the cost of studying than the rest of the student population, based on the previous experience of the higher education funding reforms in 2012/13 (though they note that the impact will ultimately depend on the rate of return to a nursing career compared to the other options open to potential students).⁴³

⁴²Health Foundation, *Department of Health Consultation on Reforming Healthcare Education Funding: Creating a Sustainable Future Workforce – A response from the Health Foundation*, June 2016.

⁴³Health Foundation, *Department of Health Consultation on Reforming Healthcare Education Funding: Creating a Sustainable Future Workforce – A response from the Health Foundation*, June 2016.

- 6.13 The Department for Education's recent equality analysis of the changes⁴⁴ concluded that the proposed change from bursaries to loans presents a risk to the participation of students on nursing courses, particularly those from low income backgrounds, including those from protected groups. The available evidence suggests that mature students, Women, BME and Muslim students are more at risk due to their increased sensitivity to debt. The report noted that this can affect students' decisions to participate in higher education as well as other decisions (e.g. whether to take on part-time work alongside study) and said that there is a link between non-repayable grants, the prospect of debt and participation for students with protected characteristics. However, the report said that the progressive repayment system with built in protection for the lowest earners, should provide some mitigation to this.
- 6.14 The report also highlighted the demographic differences between nursing, midwifery and allied health students and the rest of the student population. It noted that 41 per cent are over 25 (compared to 18 per cent generally), that 85 per cent are female, and that healthcare students are also more likely to be poorer and more likely to have children than students generally. It noted that this was likely to make them more sensitive to cost and more debt averse than students more generally.
- 6.15 Early indications are that the number of applicants for nursing and allied health courses in England starting in the 2017/18 academic year has fallen substantially compared to the previous year. For example, UCAS data shows that the number of applicants to nursing courses starting in 2017/18 by the January deadline fell by 22.5 per cent on the previous year, with particularly large falls among mature students and those domiciled in the EU.⁴⁵ However, there appears to continue to be considerable overall excess demand, and there are also likely to be further applications made over the rest of the applications cycle. We will continue to monitor the impact of the changes to student funding in future pay rounds, including on the quality of applicants.

Evidence from the parties on workforce planning and future supply

- 6.16 The **Department of Health** told us that effective workforce planning was critical to the delivery of affordable, high quality care and noted that recent reports from the National Audit Office and the Migration Advisory Committee had highlighted concerns about workforce planning in the NHS in the context of continuing shortages of key staff groups. They said, that they were taking action to increase the supply of trained staff available to work in the NHS and the wider health and care system, together with Health Education England and NHS England, aimed at boosting the supply of domestically trained staff and increasing the efficiency and productivity of the existing workforce through better use of technology and changing the skill mix.
- 6.17 They told us that the Workforce Plan for England was developed from the 13 local plans developed by Local Education Training Boards with additional input and advice at the national level from Health Education England's clinical advisory groups, the Patients' Advisory Forum, the Royal Colleges and other stakeholders.

⁴⁴ Department of Education, *Equality Analysis: Higher Education Student Finance for the 2017 to 2018 Academic Year*, 2016.

⁴⁵ UCAS, *2017 Cycle Applicant Figures – January Deadline*, February 2017.

- 6.18 They noted that the NHS was recruiting more home-grown nurses by significantly increasing training places (with, for example, over 50,000 undergraduate nurses in training already and the numbers of nurse training places being commissioned each year increasing by 15 per cent since 2013), promoting return to practice programmes (with an additional £5 million provided to support the Return to Practice scheme) and to improve the retention of existing staff (by, for example, encouraging employers to recognise the benefits that flexible working can have in retaining staff). They also noted that the Department of Health's Mandate to Health Education England included a requirement to reduce avoidable attrition rates from training programmes by 50 per cent by 2017 as student retention was an important driver of future supply. The Department of Health told us that the Health Education England commissioning and investment plan anticipated an additional supply of 40,000 nurses as a result of undergraduate and postgraduate commissions placed with universities since 2012.
- 6.19 The Department of Health said that student funding reform – with new nursing, midwifery and allied health students no longer receiving NHS bursaries from August 2017 – would open up opportunities for those students currently unable to access training places, noting that there were 57,000 applicants for nursing courses and only 20,000 nursing places in 2014. They told us that the reforms would increase supply by removing restrictions on the number of training places, with the reforms anticipated to create up to 10,000 training places for home-grown nurses, midwives and allied health professions by the end of this Parliament.
- 6.20 They also highlighted the role that would be played by new occupational roles in addressing workforce shortages. They said that the new Nursing Associate role – which would fill the gap between healthcare support workers and registered nurses, as well as providing a non-university pathway to becoming a qualified nurse – would make a significant contribution to the health and care workforce, with 1,000 Nursing Associates in training by the end of 2016.
- 6.21 **Health Education England** highlighted the publication of the third Workforce Plan for England which set out the £5 billion of investments that were being made in the future NHS workforce during 2016/17. They noted that they had increased the overall volume of education and training, with 38,000 new training opportunities for nurses, scientists and therapists. They told us that they had targeted increases on critical areas such as adult and mental health nursing and paramedics. They told us that they forecast that the number of staff available to the NHS (including doctors) could increase by between 24,000 and 82,000 by 2020, depending on assumptions about recruitment and retention of staff in the NHS.
- 6.22 They also noted that the process by which Health Education England would seek to influence the labour market and individual students' decisions, following the change in student funding arrangements, was still in development, and the potential impact of other developments that will impact on workforce supply such as new roles (e.g. the new Nursing Associate role) and the Apprenticeship Levy were still being assessed, which made it difficult to provide a detailed assessment of long-term demand and supply.
- 6.23 At oral evidence, Health Education England told us that it is difficult for employers to quantify the impact of system shocks on the demand for healthcare staff. They said that they were moving towards more sophisticated modelling of demand using population-based demand projections alongside employers' own forecasts, with productivity and efficiency overlaid on top.

- 6.24 **NHS Improvement** told us that they were working with other bodies, including the Department of Health and Health Education England, to identify ways of improving the overall system of workforce planning and ensure it reflects the needs of NHS providers. They told us the ultimate aim of this was to have one workforce planning data collection mechanism and assurance process that would provide a single source of provider workforce planning information across the NHS and consistency across Arm's Length Bodies in workforce information, methodologies and future projections of supply and demand.
- 6.25 **NHS Employers** told us that effective workforce planning and recruitment had never been more important in the health sector. They said that the results of getting workforce planning wrong were potentially very significant and would create further system instability in an already pressurised environment, meaning that financial pressures would not be effectively and efficiently managed, noting that staff shortages had historically translated to higher costs through increases in agency spend. They told us that it was widely recognised that being able to forecast and plan for the NHS workforce was very complicated and difficult to predict and get right.
- 6.26 They said that all of the respondents to their employer survey said that they had issues with the recruitment and retention of staff, with respondents highlighting a national skills shortage, competition from other NHS organisations, local skill shortages and the age profile of the workforce as the most significant recruitment and retention challenges. They noted that pay and reward featured less prominently in employers' recruitment and retention concerns.
- 6.27 They identified a range of local initiatives aimed at addressing these difficulties, including: local and international recruitment campaigns; social media marketing; making use of local RFPs in hard to fill posts; establishing links with local education providers; redesigning roles; promoting the total reward package; using career development to aid retention; and working in partnership with other employers to promote local areas.
- 6.28 On reform of student support, NHS Employers noted that, if successful, reforms had the potential to increase substantially the supply of non-medical staff in the NHS workforce. However, they noted feedback they had received from employers which suggested that there was anxiety in the system around the reforms and concerns that the reforms could negatively impact on the overall number of applications, affect the geographical spread of courses around the country, and risk issues with ensuring there was a pipeline of trained professionals in smaller and more specialised occupations. NHS Employers told us that to mitigate these risks, employers believed the reforms should be piloted or phased in so the impact can be evaluated.
- 6.29 **NHS Providers** told us that there were several important supply side developments in respect of Agenda for Change staff, highlighting student funding reforms, the introduction of the Apprenticeship Levy and associated targets, and uncertainty about trusts' ability to recruit from the European Economic Area in future.
- 6.30 They said that too often NHS workforce policy was fragmented across different bodies and marginalised as an afterthought in national policy decisions. They told us that there was a need for a more strategic and coherent approach to workforce policy, including workforce planning.
- 6.31 At oral evidence, NHS Providers noted that the role of pay and pay restraint did not appear to have been considered strategically in workforce planning, with a disconnect between those who set the policy and those who had to implement it, meaning pay was not being considered strategically and that trade-offs could not be made between competing objectives on pay in a deliberate way.

- 6.32 The **Welsh Government** told us that Health Boards were responsible for planning their workforce, with all organisations required to provide Integrated Medium Term Plans, which were subject to scrutiny by the Welsh Government and report monthly to the Welsh Government on vacancies.
- 6.33 They also told us that they were committed to developing a national Ten Year Workforce Plan, which would consider the impact of wider changes to the NHS in Wales on the workforce and set out plans to develop and support the workforce through these changes. They said that this would be aligned to the Parliamentary Review of Health and Social Care, announced in 'Taking Wales Forward', and be shaped by its outcomes.
- 6.34 The **Northern Ireland Executive** told us that the Department's Workforce Plan advocated the necessity of a strategic approach with annual review to the future supply and demand of nursing and midwifery to make the HSC an employer of choice. They told us that a regional nurse recruitment group had been established to oversee international and local recruitment initiatives and that part of this work was streamlining recruitment processes locally and engaging more effectively with university students regarding local job opportunities. They also highlighted that the Department commissions Return to Nursing Practice places every year and increased funding to provide a further 100 places in 2016/17. Finally, they said that the Department was supporting alternative routes into nursing via Open University programmes for Health Care Assistants wishing to become registered nurses.
- 6.35 **Joint Staff Side** highlighted a number of reports over the last 12 months which they said revealed a coalescence of views around the damage exacted by poor workforce planning structures and strategies, including:
- The National Audit Office concluded that the arrangements for managing the supply of clinical staff were fragmented, increasing the risk of duplication and incoherence.
 - The Migration Advisory Committee said that there was 'a very confusing architecture' on workforce planning, with a number of bodies involved and no single, authoritative voice to speak for them.
 - The Health Foundation said that there was significant variation across different NHS trusts in the capacity to understand and analyse their current and future staffing requirements, their business plans and their likely funding levels.
 - Audit Scotland said that local workforce planning processes did not give a sufficient overview of national workforce issues or trends and did not provide solutions to national workforce issues.
 - The Public Accounts Committee said that limitations in the data made it difficult to make well-informed decisions about workforce planning, with poor information on vacancy rates, leaver rates and course completion rates and no systematic information on why staff leave the NHS or where they go when they leave.

- 6.36 They also noted that many commentators had identified negative impacts of centrally managed targets on workforce outcomes, including:
- The National Audit Office said that Trusts' workforce plans appeared to be influenced as much by meeting efficiency targets as by staffing need, with associated risks of understating required staffing levels.
 - The Health Foundation said that mismatches between funding and staffing levels combined with reorganisations had led to a 'boom and bust' approach to staffing levels in the frontline of the NHS. They also said that the use of pay restraint as a key policy target had marginalised the use of pay as a policy lever.
 - The Public Accounts Committee said that unrealistic efficiency targets had caused the development of overly optimistic and aggressive staffing profiles which had subsequently led to staffing shortfalls which had to be met by increased use of agency staff.
 - NHS Professionals reported that many English Trusts had resorted to hiring their own staff through agencies to tackle shortages.
 - The Nuffield Trust said that national workforce plans were judged against current and forecast vacancy levels rather than current and future population needs for healthcare and highlighted a lack of understanding of the latter.
- 6.37 Joint Staff Side also told us that several bodies had criticised current strategy on workforce planning:
- The National Audit Office had stated that Trusts' workforce plans were unlikely to provide a reliable forecast of long-term staffing needs because they did not take full account of changes in how services are delivered and the Public Accounts Committee had criticised the lack of assessment of the headcount implications of major policies such as seven day services.
 - The NHS Wales Workforce Review had said that there was no strategic vision for what the NHS in Wales should look like in ten years' time and that this inhibited the planning of new workforce models, skill mixes and roles.
 - The Public Accounts Committee said that efforts to retain existing clinical staff were not well managed and that this may increase shortfalls, highlighting the lack of clear accountability nationally for controlling departure rates.
- 6.38 In summary, Joint Staff Side told us that workforce planning was a major gap, describing the approaches taken in England, Wales and Northern Ireland as 'hit and miss'.
- 6.39 Joint Staff Side identified the uncertainties caused by the loss of student bursaries and plans for the UK to exit the EU as key areas of concern and called on the Review Body to acknowledge these issues and monitor their impact.
- 6.40 On the changes to the student funding system, they told us that the impact of changes on recruitment and retention were unknown and highlighted an open letter sent to the Prime Minister by a coalition of staff side organisations describing the changes as "an untested gamble with the future of the workforce that have not been properly risk assessed" and highlighting risks to supply, based on an impact assessment commissioned by UNISON and the NUS which estimated that the changes would reduce student numbers by 2,000 per year.
- 6.41 On the impact of the EU referendum, they noted that freedom of movement and mutual recognition of professional qualifications meant many health professionals in the UK come from other EU countries. They noted that leaving the EU may lead to the introduction of new restrictions on EU-born staff working in the UK or encourage EU-born staff to leave the UK due to uncertainty about their future situation.

- 6.42 The **Royal College of Nursing** said that shortages of nurses, and the decision by the Migration Advisory Committee to recommend putting nursing on the Shortage Occupation List, were the consequence of years of poor workforce planning, pay restraint and weak decision making on staffing issues, citing a report by the Institute of Employment Studies on the labour market for nurses in the UK that said poor workforce planning was one of the key drivers of shortages. They also noted conclusions of the Public Accounts Committee that ‘the NHS will not solve the problem of the reliance on agency staff until it solves its wider workforce planning issues’.
- 6.43 On student funding reforms, they said that the impact on future supply was unknown and that there appeared to have been little or no modelling work undertaken to explore the impact on the labour market to support the Government’s claims that the new system will lead to an increase in the number of nurses. They noted that, in the long-term, the impact would depend on whether nursing is seen as a comparatively attractive career. They highlighted risks to overall student numbers, risks of an uneven distribution across nursing specialisms and geographic locations and the potential impact that removing the bursary could have in severing the links between students and the NHS and so on future loyalty to the NHS as an employer. They also highlighted a survey of their members in which over two thirds said they would not have studied nursing if they had to take out student loans and pay tuition fees.
- 6.44 The **Royal College of Midwives** told us that minimum staffing levels for maternity units should be determined using Birthrate Plus and reflect, amongst other things, the complexity of case mix and the number of births. They said that, assessed against this benchmark, there is a shortage of nearly 3,500 midwives in England.
- 6.45 On changes to the student bursary, they said that the prospect of accumulating significant debt would deter many aspiring students from studying midwifery, particularly as midwifery is the second degree for many student midwives, citing a survey of current student midwives in which almost two thirds said they would not have applied to study midwifery if the proposed system of finance was in place when they started. They told us that the Government should rethink its plans to abolish the bursary for midwifery students and not introduce tuition fees given the consequences for student numbers.

Our comment on workforce planning and future supply

- 6.46 We are concerned that current demand and supply plans will be insufficient to tackle current staff shortages and that the assumptions underpinning both demand and supply forecasts are opaque. Some of the supply assumptions also seem optimistic, not least given the potential impact of the EU referendum on inward EU migration and retention of EU staff. Health Education England’s most recent Workforce Plan suggests that even if their most optimistic supply forecasts – developed prior to the EU Referendum and assuming that there is no impact on supply of student funding reforms – are achieved, there would still be significant shortages of adult nurses and paramedics in 2020. However, we acknowledge Health Education England’s own caveat to the demand forecasts, which is that they are out of line with the Five Year Forward View and so inconsistent with current financial plans. The forecasts appear to us to show that there may be a demand problem, as well as a supply problem.

- 6.47 There are a lot of uncertainties in these projections and the risks are mainly on the downside. Workforce planning arrangements need to ensure that system managers develop a good understanding of these issues to inform effective action aimed at mitigating them. For example:
- While it is difficult to forecast the impact on student numbers of changes to student funding, early indications of significant reductions in applications, especially from mature students, are concerning and there are a number of other risks which employers and others have highlighted which need to be carefully monitored and mitigated.
 - Changes to funding arrangements for nursing courses and increased use of flexible working could have an effect on the conversion rate of training places to NHS FTE workers.
 - There are also uncertainties about the medium-term impact on staffing of the decision to leave the EU – and the decrease in the £/€ exchange rate over the last 12 months – on recruitment and retention of staff from the EU. Given that 32 per cent of new nurse registrations in 2013/14 were by people from the EU,⁴⁶ any significant impact will mean that the supply assumptions in HEE’s workforce plan are incorrect.
 - Forecasts assume that continued real and relative cuts in NHS pay and increases in workload pressures on staff will not have any impact on recruitment and retention. As the Migration Advisory Committee has noted, the focus of the workforce planning process on the short-run is likely to underplay the role of pay on supply.⁴⁷ The impact of this will increase as inflation increases.
 - Demand projections are determined from the bottom-up based on local Trusts’ own returns, which have historically under-estimated demand. There are also a lot of uncertainties about future trends in demand depending on the success or otherwise of policies aimed at restraining demand for acute care and the knock-on impacts on healthcare demand of social care pressures and public health policies.
- 6.48 We were pleased to hear from Health Education England that they, in conjunction with NHS Improvement and the Department of Health, are moving ahead with a number of improvements to workforce planning processes in order to deal with some of these issues, including developing more sophisticated population-based demand projections, exploring ways of factoring in the impact of pay on supply into workforce projections and sensitivity testing plans for changes in key assumptions e.g. if the decision to leave the EU leads to changes in the recruitment and retention of EU staff. This is crucial to ensuring that the necessary mitigating actions are taken in time to avoid future workforce shortages.
- 6.49 However, service transformation is on the horizon. The implementation of Sustainability and Transformation Plans in England and on-going service reforms in other parts of the UK will have a significant impact on the workforce and is likely to mean that workforce planning assumptions will need to change. It is unclear if current plans will develop the workforce required to deliver care in the reformed NHS.
- 6.50 There is also a number of continuing data issues that make effective workforce planning difficult, which we cover in more detail in Chapter 4.

⁴⁶Royal College of Nursing, *Unheeded Warnings: Healthcare in Crisis – The UK Nursing Labour Market Review 2016*, 2016.

⁴⁷Migration Advisory Committee, *Partial Review of the Shortage Occupation List: Review of Nursing*, March 2016.

Paramedics

6.51 This section considers the evidence we received on progress in resolving the Agenda for Change banding position of paramedics. We recommended this in our last report and we are glad that this has been taken forwards.

Evidence received from the parties on paramedics

- 6.52 The **Department of Health** said that the NHS Staff Council Executive had been leading work to support the evolution of the future paramedic role and that NHS Employers had hosted a number of stakeholder events to explore the challenges facing the ambulance service and potential solutions. They noted that the pay banding review for paramedics being carried out by the NHS Staff Council Job Evaluation Group was of particular concern to trade unions.
- 6.53 They also noted that some ambulance trusts had exercised their employment freedoms to introduce modified pay structures under Agenda for Change, with some trusts adopting linked band 5 and band 6 pay scales to create a career profile to attract and retain paramedics. They said that arrangements for band 5 and band 6 paramedics differed across the ambulance service given the different roles and responsibilities performed by paramedics in different parts of the service. They also said that some trusts were already employing most of their paramedic workforce at band 6.
- 6.54 The Department of Health also said that their partners and stakeholders were aware that the financial implications of a revised national paramedic role profile may be significant and that the Government will want to understand the repercussions for other staff groups, implications for the delivery of NHS England's Urgent and Emergency Review and implications for ongoing work under the Paramedic Evidence Based Education Project (PEEP).
- 6.55 At oral evidence, the Department of Health said that the changes to the paramedic role were linked to delivery of the changes to services set out in the NHS Emergency Care Review. They told us that the intention was that the changes in the paramedic role would deliver productivity gains through more highly skilled paramedics being able to treat more patients at the scene, diverting them from Accident and Emergency units. They said that there would be a job matching process to safeguard against equal pay issues and that trade unions had accepted that they would not seek to backdate the agreement.
- 6.56 **NHS Employers** said that the 2015 pay settlement included a commitment that ambulance employers would work with trade unions to address recruitment and retention issues affecting ambulance paramedics, including consideration of job evaluations and appropriate pay bandings for paramedics and whether the evidence supported the application of a recruitment and retention premium. They noted that the Review Body concluded in its 2016 report that the case to warrant the introduction of an RRP for paramedics had not been made.
- 6.57 They said that it was acknowledged that there is a shortage in the supply of qualified paramedics and that this was reflected by the inclusion of paramedics on the Home Office's Shortage Occupation List. They told us that the opportunities for using and employing paramedics in a wider range of settings and organisations were contributing to workforce gaps faced by ambulance employers. They said this was being addressed through a number of initiatives, including an increase in the number of training places.

- 6.58 NHS Employers also said that representatives of ambulance employers, trades unions, commissioners of ambulance services and other national stakeholders met in June 2016 to consider how to make more rapid progress on various ambulance workforce issues and agreed to continue the national dialogue started by the National Ambulance Partnership Forum to:
- Review national job profiles for paramedics via the Job Evaluation Working Group.
 - Identify ways to improve the employee experience and their health and well-being. The said that this strand of work would consider the operational pressures that affect staff experience, issues around violence, aggression and perceived bullying and harassment.
 - Find workable solutions to the challenges facing ambulance staff of changes to the retirement age and to conduct a review of the impact, take-up and scope of the Early Retirement Reduction Buy Out scheme before April 2017.
- 6.59 They told us that the parties are giving priority to concluding work on ambulance job evaluation profiles, with the aim of reaching a conclusion as quickly as possible, provide guidance to employers at the local level through the job matching process, understand how any recommendations would impact on paramedic deployment and ensure that ambulance commissioners understand the financial impact of any changes. They noted that around 65 per cent of the 12,200 FTE ambulance paramedics employed by the ambulance service were on band 5, with some Trusts having more paramedics at Band 6 as a result of using local variations on the Agenda for Change national agreement.
- 6.60 They noted that the NHS Staff Council technical review of paramedic roles had found evidence of an increase in the levels of patient diagnosis and treatment by paramedics driven by the requirements of commissioners, partly aimed at reducing transfers to hospital. They said that the initial assessment indicated more paramedic posts will fall into Band 6 and noted that this left ambulance employers with the challenge of coping with a significant increase in workforce costs which will not deliver efficiency gains with a concern that commissioners will not be able to find additional funding if the level of service is the same.
- 6.61 They said that a new Band 6 Paramedic profile was released on 14 September 2016 with an intention to publish this alongside technical guidance on how existing job roles should be reviewed against it and an agreed timetable for this work.
- 6.62 At oral evidence, NHS Employers told us that part of the agreement reached with Staff Side on implementation of the band 6 profile was that a new band 5 Paramedic role would be created, with newly qualified paramedics required to serve in this role for two years before being moved up to a band 6 role. They noted that there would be financial challenges for employers in implementing new roles if the changes were not centrally funded. They also highlighted the fact that, while negotiations have been challenging and have required intense work to try and resolve the issues, the solution that has been reached is workable, right for the service and right for the workforce.
- 6.63 The **Welsh Government** said at oral evidence that they were aware of the rebanding of paramedic roles in England and that they were considering the case for adopting a similar measure in Wales. They said that there would be knock-on consequences for Wales from the implementation of the band 6 paramedic profile in England both in terms of pressure from staff and in terms of recruitment and retention issues if experienced paramedics in Wales are paid significantly less than their peers in England.
- 6.64 The **Northern Ireland Executive** said at oral evidence that they were aware of the agreement reached in England around paramedics and that a similar agreement is being considered in Northern Ireland.

Our comment on paramedics

- 6.65 In our report last year, we noted that the paramedic role had evolved in recent years. We concluded that the Agenda for Change banding position of paramedics was causing a problem for the NHS and called on the parties to agree a clear timetable towards reaching a final decision quickly to minimise the effects of uncertainty about the role on recruitment, retention and motivation. We also called on NHS England to provide central ownership and capacity to support the evolution of the future paramedic role, including identifying the costs and benefits of the changes for the health systems to support the business case for making pay band changes. We also noted that there was a wider issue around the affordability of changes to paramedic banding at the individual trust level.
- 6.66 We are pleased that the issue has been resolved in England, with the final agreement published on 9 December 2016. This included arrangements for a job matching process to take place for existing paramedics to move over time to the new profile if their role matched the new Band 6 profile, the development of a new Band 5 role for new entrant paramedics in the first two years of their career and funding for the changes to be agreed by the Department of Health, NHS England and NHS Improvement to support delivery of the agreement, with funding for future years linked to agreements between Ambulance Trusts and commissioners. We hope that this will help to improve the issues with staff engagement of ambulance staff that were discussed in Chapter 5.
- 6.67 Though this issue took far too long to resolve – and future service reforms that change the role of NHS staff need to work through similar consequential workforce issues in a far more timely fashion – the agreement shows that it is possible for the parties to work together constructively towards a negotiated solution to support productivity improvements and service reform within a tight financial envelope.

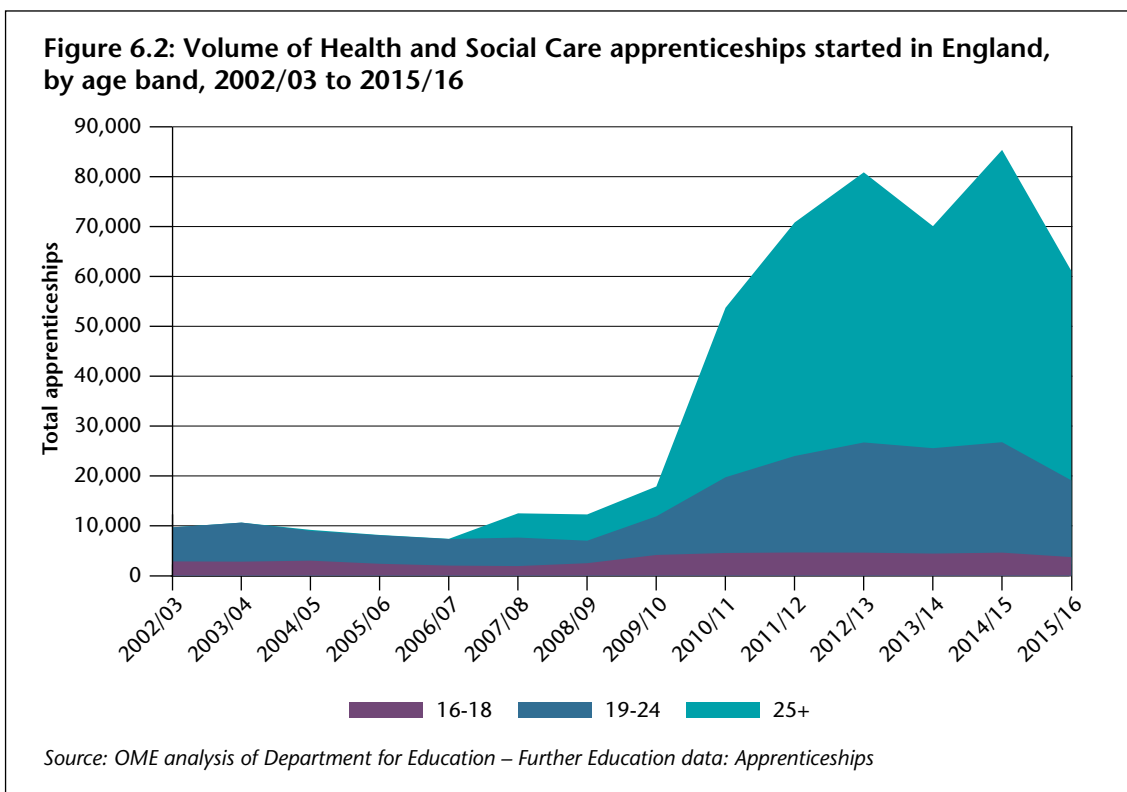
Observation

The agreement reached on the Agenda for Change banding position of paramedics could provide a template for the NHS for making changes to services to improve productivity by: ensuring that job profiles evolve to match changes to NHS roles; encouraging and incentivising staff to make the effort to support improvements in productivity by allowing them to share in some of the benefits to the NHS of doing so; and recognising additional skills, expertise and responsibilities that result from changes.

- 6.68 While the Band 6 paramedic role is available across the UK, arrangements have only been made for its implementation in England. The other nations of the UK will need to decide quickly if, and how, they will want to utilise the new Band 6 paramedic role to support reforms to urgent care services – and the required changes to the skills, expertise and productivity of paramedics along the lines of the reforms implemented in England. In order for any changes to be affordable, there will need to be a “something for something” deal, with any changes to paramedic banding linked to improvements in productivity.

Apprenticeships

- 6.69 This section considers the evidence on the impact of the changes in national policy on apprentices will have on the NHS workforce.
- 6.70 From April 2017, all employers with a pay bill in excess of £3 million – 2 per cent of employers – will have to pay a levy of 0.5 per cent of their pay bill above this to fund new apprenticeships. This is forecast to raise £3 billion per year by 2020/21. The Apprenticeship Levy will apply to all employers across the UK, though apprenticeships are a devolved policy, meaning arrangements for how the funding is spent are determined by the UK Government in England and the devolved administrations elsewhere.
- 6.71 Every employer in England subject to the levy is expected to open a digital apprenticeship service account which will enable them to access their levy payments to fund and purchase training and assessment for members of staff who are on approved apprenticeship frameworks from training providers approved by the Skills Funding Agency.
- 6.72 Public sector employers in England – including NHS organisations – are also subject to statutory targets for apprenticeship numbers through section 24 of the Enterprise Act 2016. The UK Government’s intention is for all public sector employers with a headcount in excess of 250 to deliver apprenticeships starts of at least 2.3 per cent of their headcount every year. This is based on the public sector meeting its fair share of the UK Government’s national target for 3 million apprentices to be created by 2020 based on its current share of total employment (16 per cent).
- 6.73 The total number of apprentices in the Health and Social Care sector in England has grown considerably since 2009/10, with increases in all age groups but especially among for those aged 25 and over. Of Health and Social Care apprenticeships started in 2014/15, 55 per cent were at level 2 (GCSE equivalent) and 45 per cent were at level 3 (A-level equivalent). There were no higher-level apprenticeships in this sector.



6.74 Looking specifically at the NHS, data from Health Education England shows that there were approximately 19,800 Apprenticeship starts in the NHS in England in 2015/16 (see Table 6.4).

Table 6.4: Regional breakdown of NHS apprentices in 2015/16 and targets for 2016/17

	England	North	Midlands and East	London and South East	South	CCG's/Special Health Authorities
Apprenticeship starts in 2015/16	19,818	6,109	6,678	3,555	3,476	Included in HEE regional figures
Apprenticeships target for 2016/17	19,009	6,094	5,151	4,053	3,126	583

Source: Health Education England

Evidence from the parties on apprenticeships

- 6.75 **NHS Employers** said that modelling based on the NHS organisations in scope of the Apprenticeship Levy has indicated that the cost of the Levy to the NHS in 2017/18 to be approximately £200 million and that levy contributions for a large city-based teaching hospital employing 14,000 staff would be in the region of £3.3 million per year. They said that this would place an additional financial strain on employers.
- 6.76 They also noted that the UK Government's proposals to set statutory apprenticeship targets at 2.3 per cent of headcount implied an annual target for NHS Apprenticeships of 28,000, which demonstrated a need to grow the delivery of apprenticeships.
- 6.77 They highlighted a number of challenges associated with this, including the lack of apprenticeship standards suitable for delivery in health, the lack of organisational infrastructure to support a large increase in the delivery of apprenticeships and the outsourcing of NHS services employing support staff suitable for entry-level apprenticeships.
- 6.78 In supplementary evidence, they told us that there is the potential for apprenticeships to support the development of existing staff and that this is probably the only way the NHS organisations will be able to benefit fully from their levy payments. To give examples of what this would mean in practice, they said that staff newly promoted into leadership roles could undertake leadership apprenticeships and that advanced practice apprenticeships could be developed to enable further career development of professionally qualified staff. They also noted the need to ensure that employers respond to the Levy in a strategic and responsive rather than a reactive way and said that they had established an employer apprenticeship network to help achieve this.
- 6.79 **Joint Staff Side** asked that the Review Body recognise the potentially destabilising impact of the Apprenticeship Levy, targets and apprenticeships as a growing form of employment in the NHS and to recommend the development of a national framework for determining apprentice pay, that all apprenticeships are on full Agenda for Change terms and conditions and are covered by the Living Wage Foundation Living Wage, and that apprenticeship levy money is pooled and ring-fenced to the NHS.

- 6.80 They expressed concern that, due to the current mismatch between skills shortages and availability of apprenticeships, the NHS will not be able to recoup all of the expected total £200 million annual levy payments made by the NHS each year. They suggested that the imperative for employers to recoup the maximum they can from their levy contribution would have distorting effects on recruitment and retention. They told us that some employers were converting all vacancies in Bands 1-4 into apprenticeships with no strategic approach and no assessment of suitability, the capacity of other staff to support apprentices or the retention of staff recruited as apprentices. They said that employers were looking to divert learning and development budgets to meet levy payments which would leave a shortfall in funds for development of other staff and would lead to existing staff not receiving training unless they can be shoe-horned onto an apprenticeship programme.
- 6.81 They told us that a crude approach to meet targets for starts per year would provide a disincentive for employers to invest in higher-value apprenticeships which last longer than 12 months and noted that this concern had also been raised by NHS Employers. They said that, as a result, the primary focus of apprenticeship development has been at Bands 1-3, with Health Education England data showing that the majority of apprenticeships in the NHS are at educational level 2, equivalent to GCSE-level. They also suggested that there may not be appetite among employers to invest in degree-level apprenticeships due to the fact that apprenticeships could cost more to employers than self-funding students who take the university route.
- 6.82 Staff Side also expressed concern about the way that apprentice pay was being set, noting that many apprentices were paid outside of the Agenda for Change agreement, with widespread use of the statutory minimum wage for apprentices and ad hoc approaches at employer level, saying that this was creating a two-tier workforce. They said that many employers were incorrectly applying the Annex U provisions in the Agenda for Change agreement around trainees.
- 6.83 **Unison** said that they supported the use of high-quality apprenticeships as a means of widening participation and enabling candidates from disadvantaged groups to gain a start in the NHS but that they believe they should receive fair pay and the same terms and conditions as other NHS staff.
- 6.84 They highlighted responses to a freedom of information request they made on the pay of staff hired as apprentices across the NHS in the UK. They noted that there was wide divergence in pay rates for the same roles and considerable variation in the methodology for determining pay rates, reflecting the absence of an accepted pay framework for apprentices within the NHS. They said that the most prevalent approach to starting pay was to use the statutory minimum wage for apprenticeships, with some employers hiring apprentices at the bottom of the relevant Agenda for Change band and others applying percentage reductions to the salary band maximum, paying the Living Wage Foundation living wage or using other ad hoc arrangements.
- 6.85 They told us that there was a risk that employers will seek to replace large numbers of substantive posts with apprenticeships in order to meet targets and to access a supply of cheap labour and that previously these posts would have attracted the pay band minimum. They said that they accept a salary adjustment is justifiable where an apprentice would take a substantial period of time to attain normal job entry requirements but said that, as apprenticeships are concentrated at the lower levels, candidates are quickly fulfilling the basic requirements of the job and that apprentices are getting a raw deal.

- 6.86 In summary they told us that unless a fair pay system for apprentices is introduced there will be reputational damage to the NHS as an employment sector and to the apprenticeship brand, a divisive and demoralising two-tier workforce in large parts of the NHS, damage to the ability to recruit and retain staff with implications for patients subject to high staff turnover and employers left without a defence against equal pay challenges.
- 6.87 The **Department of Health** said that Health Education England were taking forward a programme of work to support the development of a range of new healthcare apprentice standards, including higher and degree-level standards. They said that the higher degree-level nurse apprentice standard has been submitted for approval with an aim of having it ready for delivery by Autumn 2017.
- 6.88 On pay, they noted that NHS Trusts are free to determine the pay and conditions of apprentices but that most preferred to use national pay frameworks and that, due to the wide range of different apprentices available in the NHS, it would not be possible to say where on the pay scale each should sit. They also noted that the NHS Staff Council is working to advise and support employers by considering the scope for a set of apprentice employment principles to help guide employers about how to employ apprentices in a fair and consistent way.
- 6.89 **Health Education England** told us that there are a number of funding models currently in operation for apprentices, with some Health Education England local offices paying for all or some training costs and others not paying for any training costs but funding initiatives to support the take-up of apprenticeships. They said that the introduction of the apprenticeship level and standardisation of processes across Health Education England will reduce this variation.
- 6.90 They acknowledged that there were challenges for NHS organisations in fully utilising the Levy and meet the proposed public sector targets and said that they were working with partners to develop a comprehensive range of new apprenticeship standards from Level 2 to degree and masters level and across clinical and non-clinical job roles. They said that apprenticeships will help employers attract people from diverse backgrounds and they also highlighted research that they said shows apprentices stay with an organisation for longer than employees who joined as graduates.
- 6.91 The **Welsh Government** told us that initial indications, based upon the NHS budget of £3 billion, are that the cost of the apprenticeship levy to the NHS in Wales will be around £15 million. They said that, in Wales as a whole, £111 million had been provided for apprenticeships and traineeships in 2017/18 with the Welsh Government committed to delivering a minimum of 100,000 new high-quality all-age apprenticeships over the current Welsh Assembly term. They also noted that 57 per cent of Health and Social Care apprentices in 2014/15 were at level 2, 43 per cent were at level 3 and 0.2 per cent were at level 4 or above.

Our comment on apprenticeships

- 6.92 The Apprenticeship Levy and the associated statutory targets will have a significant impact on the NHS. For example, we estimate that a statutory target of 28,000 apprenticeship starts in England would imply a 41 per cent increase in the 19,800 apprenticeship starts Health Education England says were delivered in 2015/16. This compares to annual recruitment across the entire Agenda for Change remit group – including trust-to-trust moves – of around 150,000 per year. It is also worth noting that most NHS Apprenticeships are currently delivered at Bands 1-4. Given this, as NHS Employers said in their evidence, meeting the target will require many existing staff to become apprentices which will require the development of new apprenticeship frameworks suitable for supporting professionally qualified staff in developing their skills.

- 6.93 Employers and Staff Side raised a number of challenges associated with the significant increases in NHS apprentice numbers that will be required over the next few years. These are real and appropriate concerns but, overall, we believe that there are opportunities for apprentices to become a valuable source of home-grown supply to the NHS and provide clearer career pathways for support staff to progress in the NHS and gain professional qualifications as their skills and experience improve. In order for these opportunities to be taken, continued focus is needed at a national level on ensuring apprentices are used in this strategic way to ensure that the risks identified in the evidence of employers simply taking a short-term approach focused on meeting targets identified in the evidence are not realised.
- 6.94 We note the issues raised by Staff Side regarding the pay and use of apprentices. We believe that, in the first instance, this is most appropriately dealt with through the NHS Staff Council and we note the work going on mentioned by the Department of Health in their evidence. We look forward to receiving evidence on this next year. On the issue of ring-fencing levy funds to the NHS, this is a matter of government policy that goes far wider than the NHS and so is not a matter for the Review Body, beyond noting that it demonstrates the importance of the NHS in developing effective apprenticeship standards and infrastructure to ensure that levy funds remain within the NHS.

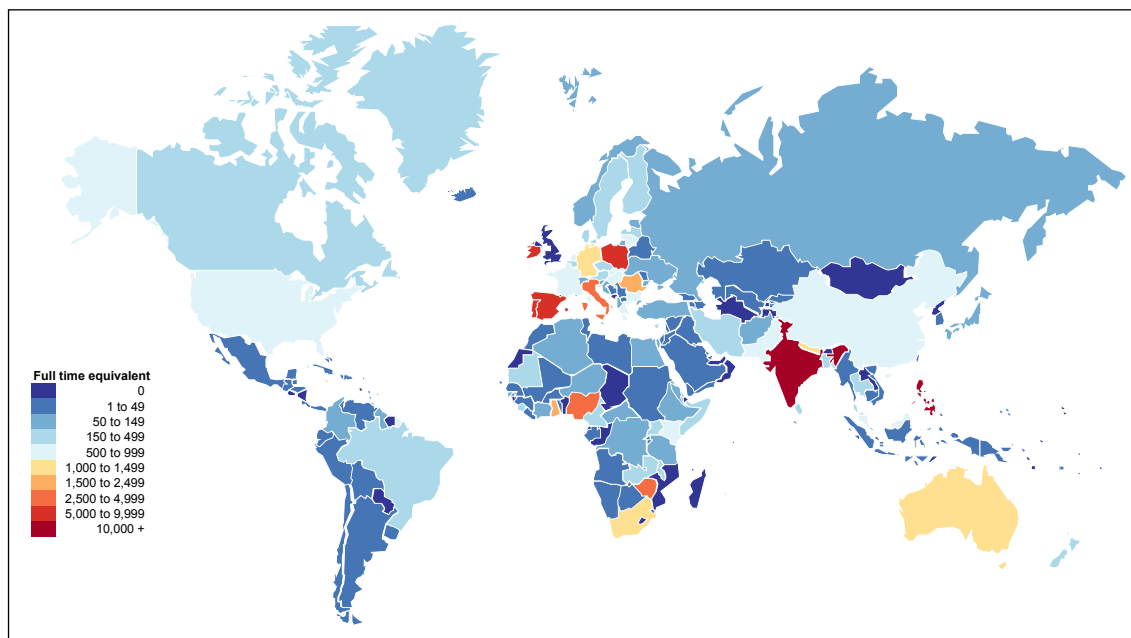
International Recruitment

- 6.95 A further source of possible recruitment is from overseas. This section looks at the data on the role played by international recruitment in the NHS.
- 6.96 The UK Government decided to add nursing to the Shortage Occupation List in November 2015 due to increased concern from employers about nursing supply. Prior to this, employers were only able to recruit nurses from inside the European Economic Area (EEA). A further review, specific to nursing, was carried out in March 2016 which resulted in the government announcing that nursing would remain on the shortage occupation list following substantial evidence pointing towards shortages across the UK, particularly in England.⁴⁸
- 6.97 Following the outcome of the EU Referendum, there is some uncertainty about the future supply of foreign workers to the NHS. Most EU member states, including the UK, have faced healthcare shortages for several years already. The European Commission estimated in its 2012 Health Workforce Action Plan that the EU could have a potential deficit of one million healthcare workers by 2020. The NHS remains reliant on foreign healthcare workers to meet the growing demands for healthcare in the UK. Moreover, if the supply of healthcare workers from abroad is already diminishing due to increased demand worldwide, the UK faces the risk that its supply of labour from abroad will further diminish as foreign workers may choose to work outside of the UK if the offer of employment is more attractive elsewhere.

⁴⁸ Migration Advisory Committee, *Partial Review of the Shortage Occupation List: Review of Nursing*, March 2016.

6.98 Figure 6.3 shows the composition of the NHS non-medical workforce by nationality. Excluding British nationals, NHS non-medical staff are most commonly from the Philippines, India, Ireland, Poland and Spain, which collectively account for around 43,600 FTE staff.

Figure 6.3: HCHS non-medical workforce in England, by nationality (excluding the UK), FTE, September 2015



Source: OME Analysis of NHS Digital data

6.99 Overall, according to data from NHS Digital, 11 per cent of the non-medical workforce in the NHS in 2015 was non-British: 5 per cent were EU nationals and 6 per cent were from outside of the EU. The nursing staff group had the highest proportion of non-British workers at 16 per cent.

6.100 Recruitment of overseas nationals continues to be important, with 22 per cent of new joiners to the non-medical workforce in England in 2015/16 being 'non-British' (10 per cent from the EU and 12 per cent from outside the EU). This includes many people who have already been in the UK for several years as well as more recent arrivals to the UK. Statistics on joiners to the NHS in England also include staff who move between NHS Trusts. Joiners to the non-medical workforce from overseas were most commonly from Spain, Italy, India, the Philippines and Portugal, providing a total of almost 10,000 FTE staff between them.

6.101 For nurses, the proportion of 'non-British' joiners is higher, with 30 per cent of nurses being 'non-British' (18 per cent from the EU, 12 per cent from outside of the EU). Looking at the UK health and social care system as a whole, 40 per cent of new registrations on the Nursing and Midwifery Council register in 2015/16 were by overseas nationals (32 per cent EU, 8 per cent non-EU), though many of these will not be employed as permanent NHS staff.⁴⁹

⁴⁹ Royal College of Nursing, *Unheeded Warnings: Healthcare in Crisis – The UK Nursing Labour Market Review 2016*, 2016.

Evidence received from the parties on international recruitment

- 6.102 The **Department of Health** for England said that international recruitment can help to address workforce shortages while the measures it is taking to grow domestic supply take effect. They noted that overseas staff have always played a vital role in the NHS and that a number of occupations where there are particular pressures, such as nursing, were on the Shortage Occupation List to help make overseas recruitment easier. They also told us that, overall, the proportion of non-British staff among joiners to the NHS has remained fairly stable over time though the composition of overseas staff has changed over the past six years, with the number of non-EU nationals decreasing and the number of EU nationals increasing, reflecting changes in immigration rules and the increased mobility of EU citizens compared to those from outside of the EU.
- 6.103 **Health Education England** told us in oral evidence that the decision to leave the European Union meant that there was a lot of uncertainty about future EEA recruitment and retention. Modelling this was difficult, with significant time lags before there would be any data on the impact of the referendum result. They said that they were scenario planning to understand better the potential impacts on supply.
- 6.104 **NHS Employers** said that, given that there was no available supply of qualified nurses in the UK beyond those already employed, the only way for employers to increase the overall supply of nurses in the short-term was to use overseas recruitment. They said that the inclusion of nurses on the Shortage Occupation List recognised that a supply problem existed and was helping to alleviate some of the previous challenges trying to recruit nurses from overseas.
- 6.105 NHS Employers reported in oral evidence that the decision to leave the EU had already had some impact, with employers who were in the middle of EU recruitment processes at the time of the referendum having reported that some candidates had rejected offers and that there had been a drop-off in interest. However, they said that there had been no discernible effect on leaver rates of overseas staff. They noted that the proportion of all staff in post who were from the EU was relatively small in most areas of England but that the proportion of EU nurses among new recruits was significant, and as high as 25 per cent in some trusts.
- 6.106 The **Joint Staff Side** said that the UK's vote to leave the EU could have major implications for the NHS in the future. They said that freedom of movement and mutual recognition of professional qualifications within the EU had meant that many health professionals currently working in the UK came from other EU countries. They said that the introduction of new restrictions may directly prevent EU-born NHS staff from working in the UK, or have an indirect impact as EU-born staff may choose to leave the UK due to uncertainty created before new immigration controls are put in place. The Joint Staff Side also said that it was possible that this may lead to specific occupations being placed on the Migration Advisory Committee's shortage occupation list, which currently enables employers to recruit nurses and midwives from outside the European Economic Area in order to deal with staffing shortages.

6.107 The **Welsh Government** said that it was developing a national and international recruitment campaign to market Wales and NHS Wales. It said that while the initial focus of the campaign was on doctors, it would soon be expanded to include other healthcare professionals. They also told us that, while there was variation in the approaches taken by different NHS organisations, employers looked to overseas recruitment to fill gaps in medical staff and nursing, with most actively recruiting from the EEA and the Philippines. However, they said that this should not be seen as a quick and simple solution and needed to be considered as part of the wider package and the renewed NHS Wales offer. They identified issues with recent changes to immigration rules which may result in increased difficulty in recruiting through this channel. In oral evidence, the Welsh Government said that the impact of the EU Referendum result on the supply of overseas staff was unclear and would depend on the settlement negotiated by the UK Government with the EU.

6.108 The **Northern Ireland Executive** told us that a regional nurse recruitment group had been established to oversee international and local recruitment initiatives. At oral evidence, they said that the shortfall in staff in Northern Ireland had led several trusts to recruit staff from overseas, with trusts in Northern Ireland having run recruitment exercises for nurses in Romania, Italy, the Philippines and Spain. They said that they were trying to fill part of the shortfall of nurses via international recruitment.

Our comment on international recruitment

6.109 A sizeable proportion of NHS staff are from overseas and new recruits from overseas are currently essential for filling staff shortages in some occupational groups and some parts of the UK due to long-standing domestic supply shortages. This means that changes in immigration policy and in the attractiveness of the UK as a destination for foreign healthcare staff could both have the potential to adversely impact staffing in the NHS.

6.110 One area of immediate concern is the impact that the decision to leave the EU will have both on existing NHS staff from the EU and the willingness of healthcare professionals in the EU to settle in the UK given uncertainty about their ability to remain in the UK over the long-term. While it is too early to estimate the potential effect with any degree of precision, the fact that 5 per cent of existing non-medical staff and 10 per cent of new recruits are from the EU means even relatively small changes in the willingness and ability of non-medical staff from the EU to settle in the UK could have an impact. The impact would be particularly significant in London and the South East, exacerbating current shortages that are bigger than elsewhere in the country.

6.111 A second area of concern is the potential impact of the Immigration Skills Charge, which is being introduced in April 2019 on both the ease of hiring staff from outside of the EU and on affordability pressures facing the NHS. This will charge employers, including NHS employers, £1,000 for each non-EU migrant entering the UK under the Tier 2 immigration route for each year of their visa. This will need to be factored into supply forecasts.

6.112 If the Government's intention is to reduce significantly the reliance of the NHS on overseas nurses in the medium-term, it will need to take action to both increase the number of domestic nursing students and ensure that the overall NHS employment proposition is attractive enough to attract sufficient UK-born students to train as nurses, to join the NHS once qualified and to stay working in the NHS over their careers. We note the Migration Advisory Committee's comments on this point.⁵⁰

⁵⁰ Migration Advisory Committee, *Partial Review of the Shortage Occupation List: Review of Nursing*, March 2016.

The Impact of Pay on Supply

6.113 This section summarises the evidence that we received about the impact of pay on supply.

Evidence from the parties on the impact of pay on supply

6.114 The **Department of Health** observed that there were some risks of continued pay restraint to recruitment and retention, agency costs and staff morale, though noted that pay was not the only motivator and that there was little evidence of these risks materialising as yet.

6.115 **NHS Employers** said that few employers responding to their provider survey identified pay and reward as a serious recruitment and retention challenge. They said that, while NHS organisations face shortages in relation to some of the health professional staff groups, this was essentially a supply issue that is not related to – and so cannot be resolved by – levels of pay as there is not another available supply of these professionals in the UK in relation to those who have already trained.

6.116 In relation to nurses, they told us they had found no evidence to suggest that the shortage of qualified nurses was directly linked to levels of pay or that using additional pay would help resolve the recruitment or retention problems. They cited the lack of use of recruitment and retention premia – which fell from 3.1 per cent in April 2014 to 1.0 per cent in April 2016 – and said that this indicates that employers have not found the use of pay premia to be effective in resolving the supply problem.

6.117 **Health Education England** told us that they had no intelligence about the extent to which pay played a role in driving the numbers of applications to clinical professional educational programmes and the quality of applicants. At oral evidence, they noted that the role of pay had not been factored into their strategies to date but told us that there was no reason why it shouldn't be in the future.

6.118 **NHS Improvement** said that, although pay clearly influenced recruitment into the NHS and retention of qualified NHS staff, it was not necessarily the most important factor and wasn't a key driver of recruitment and retention issues. They highlighted findings from the academic literature on nurse turnover and retention that pointed to working environment and job satisfaction being more important factors and suggested that this may imply that providing staff with greater flexibility over hours or work and measures to reduce workload pressures may be more cost-effective in improving recruitment and retention. However, they said that pay may be a concern for particular roles and/or in specific health economies.

6.119 On the role of relative pay in the NHS, NHS Improvement cited a recent report looking at the short-run responsiveness of NHS nurses' labour supply to relative wages that, in estimating the impact of boosting nurse pay on NHS recruitment, concluded "across most of Great Britain this effect, at least in the short-run, would be extremely small", though with higher supply responsiveness found in London (however, NHS Improvement told us that the authors argued that other measures might be more cost effective than pay). They also highlighted a report by Frontier Economics that found no evidence that Trusts in areas where NHS pay was lower relative to the private sector experience higher staff turnover, had more vacancies or were hiring more agency staff.

- 6.120 **NHS Providers** told us that they considered the main reason for nursing shortages was that the system has not trained a sufficient number of nurses to meet the increased demands following the Francis report. While they said pay was a factor in recruitment and retention, they noted that other factors such as flexibility and the working environment were important and that there was a continuing need for employers to make known the total reward on offer for working in the NHS – such as pension and annual leave provision – so that staff could make an accurate comparison with what was available in other sectors.
- 6.121 **NHS England** told us that pay, as part of a total reward package which included the NHS pension, would – alongside other factors such as job satisfaction – have a role to play in the recruitment, retention and motivation of staff. They said that the statement in the Five Year Forward View that *“As the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain frontline staff”* remained their view in the long-term.
- 6.122 **Joint Staff Side** told us that pay restraint alongside increased workload pressures on staff had increased recruitment and retention issues in the NHS. They stated that over the past six years, the NHS workforce had seen changes to their pension and terms and conditions, increased work intensification with staff frequently working beyond their hours and pay restraint leading to a significant reduction in the real terms value of pay in the NHS. They said that this had caused recruitment and retention problems and led to shortages in every professional group in the NHS. They said that current policies were creating a downward spiral where more staff leave and fewer new staff want to work in the NHS, leading to money being spent on agency staff to plug the gap.

Our comment on the impact of pay on supply

- 6.123 We have drawn a distinction between current recruitment and retention problems and future supply as we believe that the role of pay may differ in each case. It is evident that there is no consensus amongst the parties about this distinction and therefore what the role of pay might be in future supply and workforce planning.
- 6.124 There is a consensus that – in the words of NHS Improvement – “pay clearly influences recruitment into the NHS and retention of qualified NHS staff (though it is) not necessarily the most important factor”. However, the evidence we received from government and employers is that they do not consider the general level of NHS pay to be a significant issue for recruitment, retention and motivation (or at least not yet), foresee few issues from reducing real and relative NHS pay in 2017/18 and do not consider current supply shortages to be amenable to pay solutions. This to us misses the distinction between current recruitment and retention problems due to current supply shortages and future supply.
- 6.125 Some bodies – including the Migration Advisory Committee – contest the view that pay is not part of the explanation for current shortages and the view that increasing pay will do little for supply, especially in the longer-run. The large number of nurses who are on the Nursing and Midwifery Council (NMC) register suggests that there is a pool of trained nursing supply outside of the NHS who may be responsive to pay. In order to remain on the NMC register, nurses and midwives must complete 450 practice hours across a three year period – equivalent to 56 working days or 19 working days per year – as well as 35 hours of continuous professional development. The latest Labour Market Review by the Royal College of Nursing states that around a third of their members work outside the NHS in independent sector providers, which reflects the difference in the number on the NMC register and the number in the NHS workforce in England. There will also be many trained nurses in the UK who are no longer on the NMC register.

6.126 Employers' evidence highlighted their belief that the role of pay is likely to become more important over the next few years due to a number of factors including:

- Continued deterioration in real and relative NHS pay.
- The impact of student funding changes on the "psychological contract" between staff and employers and the role of pay in shaping career choices.
- The impact that well-designed pay levers could have in incentivising productivity gains.
- The impact that the National Living Wage is having in eroding the NHS pay premium at bands 1-4.
- The impact of an increasingly uncompetitive NHS offer for staff groups subject to private sector competition.

6.127 We agree that pay – and the broader employment offer – will become increasingly important as the NHS in England has to compete in the open market for undergraduates in clinical occupations in a way it has never had to do so before. It is crucial that the role of pay in decisions to embark on nursing and other degree courses; take up employment in the NHS; and to stay in and/or return to the service in the long-term is understood, monitored closely and taken into account in workforce planning processes. In thinking about this it is important to recognise that while taken in isolation the pay award in any year may have little effect, what matters are the signals that current pay awards send about likely future pay awards. The evidence we presented in Chapter 2 suggested that starting salaries of professional non-medical staff remain competitive, though there are questions about whether this remains the case when considering the relative prospects for pay progression, especially as the cost of nursing, midwifery and allied health degrees increases. Finally, the role of pay in influencing decisions regarding the demand for different types and grades of workers needs to be recognised and better taken into account in future workforce planning.

6.128 Overall, we think that greater consideration needs to be given to pay when thinking about the long-run supply and demand position of the NHS and the general attractiveness of the NHS as an employer. The responsiveness of recruitment to pay is limited but not eliminated in the short-run, especially for professionally qualified clinical staff in occupations where the NHS has a monopoly given the lack of options for using their skills outside of the service. However, pay will have a bigger impact on supply in the longer-term as existing staff are more able to retrain and more likely to re-evaluate their career decisions, and those considering investing their time and resources in obtaining a healthcare qualification to enable a career in the NHS may think again if expected career earnings, net of tax and student loan repayments, fall in relation to their other options or the perception of job quality and the working environment worsens. While the current supply issues caused by pay restraint are limited, it may be storing up serious problems for the future. It is possible that delaying action on pay may continue to save money in the very short-term but ultimately be more expensive if a bigger pay response and/or unexpected agency working is required to tackle future shortages.

People Strategy

6.129 Following the observation we made in our last report, we took a particular interest during this round in the parties' evidence and views on workforce strategy. Our preferred terminology is people strategy, as this makes clear the distinction from workforce planning and recognises the fact that, fundamentally, good patient care relies on good people. This section summarises the evidence we have received on the People Strategy in the NHS.

Evidence from the parties on the people strategy in the NHS

6.130 **NHS Providers** said that NHS workforce policy was fragmented across different bodies and marginalised as an afterthought in national policy decisions and that a more strategic and coherent approach to workforce policy is required.

6.131 When asked how this could be achieved, NHS Providers told us that they saw merit in the proposal made by the Health Foundation for the creation of a National Workforce Strategy Board, sitting within the Department of Health, to provide strategic leadership on workforce policy in England and ensure coherence across national bodies, subject to Trust autonomy not being compromised.

6.132 They identified four key areas of focus for such a National Workforce Strategy Board:

- Ensuring the NHS could recruit and maintain a motivated, healthy, flexible and productive workforce (e.g. leadership, culture, staff engagement, well-being, annual pay awards, reform of terms and conditions, domestic workforce supply, overseas recruitment and agency rules).
- Developing the NHS workforce to support the realisation of the Five Year Forward View (e.g. Sustainability and Transformation Plans, Local Workforce Action Boards, new care models, development of new roles).
- Ensuring that there was sufficient workforce information at local and national levels to allow for an effective workforce strategy.
- Ensuring that the workforce implications of national policies, such as seven day services, were fully considered and funded.

6.133 **Joint Staff Side** asked the Review Body to support their proposals for a comprehensive workforce strategy for the NHS. They noted that the need for such a strategy had been identified by a number of bodies: the National Audit Office had said that a more coordinated approach to managing the supply of staff could result in efficiencies; the Public Accounts Committee had called for greater national leadership to help trusts reconcile financial, workforce and quality expectations; the Chief Executive of the NHS had said that greater collaboration was required and said that a “complete strategy” for the NHS workforce was needed; Audit Scotland had said that a national, coordinated approach was required to help resolve current and future workforce issues; the Health Foundation had called for a collaborative approach to policymaking via the formation of a National Workforce Strategy Board and the reconstitution of the Social Partnership Forum.

6.134 They noted a number of issues that should be covered by the strategy: including pay, the psychological contract in the NHS; working conditions; instability caused by structural and leadership changes; reluctance of employers to offer flexible working; increasing workload; an aging workforce; a female workforce who need to balance work with caring responsibilities; younger generations who want a better work-life balance than previous ones had demanded; increasing work-related stress; plans for service transformation; the impact of the EU Referendum result; and divergence between the four nations of the UK in relation to pay and conditions. They said that a robust, comprehensive and co-ordinated response to these challenges would help alleviate insecurities and uncertainty, increase trade union and staff engagement, resolve recruitment and retention problems and release capacity to improve services to patients.

6.135 They identified three key areas of work that needed to be aligned to develop a coherent workforce strategy:

- The work of the NHS Staff Council in providing a pay system and terms and conditions for NHS staff that was fit for purpose, sustainable and attractive, including through steering the current review of Agenda for Change.
- Work in national partnership forums on culture, leadership, staff engagement and staff well-being.
- National, regional and sub-regional systems and processes for planning the shape of the future workforce.

6.136 They also identified ten strategic aims for an NHS workforce strategy:

1. Changes to the Agenda for Change pay structure that make it simpler to explain, understand and operate – shorter pay bands, fewer points and no overlaps between bands – achieved via the ongoing NHS Staff Council review.
2. Maintaining the current NHS Job Evaluation system as the underpinning basis of the pay structure, delivering equal work for equal pay.
3. A healthy and safe workplace, with high-quality employment practices that promote a good work-life balance; dignity at work; protecting employees' health and safety at work; job design providing employees with autonomy and control; and equitable access to learning and development opportunities.
4. Safe staffing levels, with the right number of skilled staff in the right settings, achieved via evidence-based workforce planning with engagement of the trade unions and professional bodies.
5. Making the NHS an attractive place to work and an employer of choice, with terms and conditions that support good recruitment and retention of staff, motivating staff and supporting staff development and career progression underpinned by well-structured appraisals.
6. Engagement with trade unions locally and nationally.
7. Effective management of change.
8. Equality, diversity and inclusion.
9. A learning organisation, with the NHS facilitating the learning of all its members.
10. A focus on leadership at all levels.

6.137 The **Department of Health** told us that they kept the range of interacting policies which impact on the health and care workforce in England – including pay, pensions, employee relations, workforce planning, professional regulation and other relevant factors – under constant review. They told us that there were currently no plans to publish a detailed overarching account of this evolving picture but that they would over time publish policy documents on key aspects.

6.138 At oral evidence, the Department of Health told us that, while some workforce issues had to be addressed at the centre, in most areas of policy the role of the centre was to give Trusts the right tools and encourage and support them in using them. Officials highlighted the risk that a national People Strategy would be a bland lowest common denominator document that sat on the shelf and made no difference to issues on the ground. They also suggested it could be counter-productive, with a national People Strategy taken as an excuse for inaction, discouraging local trusts from taking leadership on workforce issues locally.

6.139 The Department of Health told us that they had established a Workforce Strategy Group, chaired by the Minister of State and involving senior representatives from Arm's Length Bodies, which would pick up and resolve the various workforce issues others have identified in a more dynamic way than a strategy document would do.

6.140 **NHS England** said that the Department of Health had ultimate oversight for the workforce strategy in the NHS, with close involvement of NHS England, NHS Improvement, Health Education England and individual employers. They said that the division of responsibilities between the Department of Health and the various arm's length bodies were set out by the Department of Health in *Shared Delivery Plan 2015-20*.

6.141 **NHS Employers** told us that they welcomed the development of a national workforce strategy against the Five Year Forward View and the creation of clear plans for service delivery. They said that they would be looking for national actions which enabled greater innovation in ways of working and enhanced the broader reward and employment package for NHS staff.

6.142 At oral evidence, employers told us that a national People Strategy would only be worthwhile if it changed things on the ground and suggested that the risk would be that a command-and-control national strategy was developed that was not compatible with devolution and added an additional layer of bureaucracy without delivering much.

6.143 The **Welsh Government** said that it was committed to developing a 10 year plan for the NHS workforce. This would put in place a clear vision and set out priority areas of work that needed to be covered by Government and NHS Wales and its partners. Specific areas that would be covered include:

- Shape and size of the workforce.
- Assumptions, opportunities and risks.
- Response to current and projected challenges and difficulties.
- Role redesign, creation of new roles and ways of working.
- Education and training.
- Organisational development and workforce support.
- Defining the "Wales offer".

Our comment on the people strategy in the NHS

6.144 As we said last year, there is a gap in the strategic workforce framework. Filling this gap will be critical to managing recruitment and retention challenges over the longer-term. The evidence we received shows consensus on this point across the parties and other commentators on the health system. We are encouraged that this issue is climbing up the agenda.

6.145 There are a number of different options for filling this gap. We heard evidence relating to England from employers and from the Department of Health that creating a lengthy overarching strategy document risks having limited practical impact on the ground and may even be counter-productive by preventing local leadership and allowing local trusts to justify continued inaction by allowing the suggestion that resolving workforce issues is a responsibility of central government to take root.

6.146 However, we believe that a short forward-looking statement of strategic intent would be valuable and, by being short and focused, avoid the issues identified by employers and the Department of Health. The purpose of such a statement would be to enable the delivery of the Five Year Forward View and its next iteration, and to respond to the issues highlighted in this report. It would set out the importance of local trusts taking a more strategic view of people issues and provide a menu of options for what local employers can do using the flexibilities that exist, together with support for using them.

- 6.147 It could specify two main areas of focus. Firstly, those things that can best be done at a national level and where a central approach adds value. This could encompass measures to enable increases in workforce supply over the longer-run. Secondly, what is better done at trust level, or by working together locally, to support and drive better patient care. This could encompass short-term recruitment issues, retention and staff motivation, engagement and satisfaction. For both areas, it should then identify the priorities based on understanding and analysis of those factors which will best enable service delivery. Doing this in a strategic, coherent way may also help to foster a more sophisticated understanding of the costs and benefits of pay, both locally and nationally, which we discussed at paragraphs 4.68 and 3.75.
- 6.148 This would complement the work going on at the centre in England through the creation of the new National Workforce Strategy Board to drive more strategic thinking about workforce issues by the Department and its arm's length bodies, including thinking through more carefully the people implications of national policy initiatives and resolving other issues that the parties raised with us.
- 6.149 Strategic approaches will inevitably differ in both the Wales and Northern Ireland contexts. We are supportive of the intention in both countries to grip the issues in collaborative ways and urge all of the nations of the UK to convert statements of intent in this area into practical solutions.
- 6.150 In Wales, the NHS Wales Workforce Review (the Jenkins Review) report in March 2016⁵¹ observed that there was a lack of a long-term strategic vision for the NHS in Wales and that day-to-day performance targets often made it difficult to plan for the workforce of the future. It also made a number of recommendations around health and social care integration, the operation of the NHS Staff Council and around workforce development. The Welsh Government is due to respond to the Jenkins Review in the next few months.
- 6.151 In Northern Ireland, *Systems not Structures: Changing Health and Social Care* (the Bengoa Review) was published in October 2016,⁵² setting out a set of principles to underpin reconfiguration of health and social care in Northern Ireland. This informed the Northern Ireland Executive's 10 year plan for reconfiguration,⁵³ which set out the Executive's ambition for the 2026 health and social care system in Northern Ireland and initiated a series of work programmes to do the detailed thinking about how to achieve the ambition. This included a commitment to develop a Workforce Strategy by May 2017.

⁵¹ Welsh Government, *NHS Wales Workforce Review*, 2016.

⁵² Northern Ireland Executive, *Systems not Structures: Changing Health and Social Care – Expert Panel Report*, 2016.

⁵³ Northern Ireland Executive, *Health and Well-Being 2026: Delivering Together*, 2016.

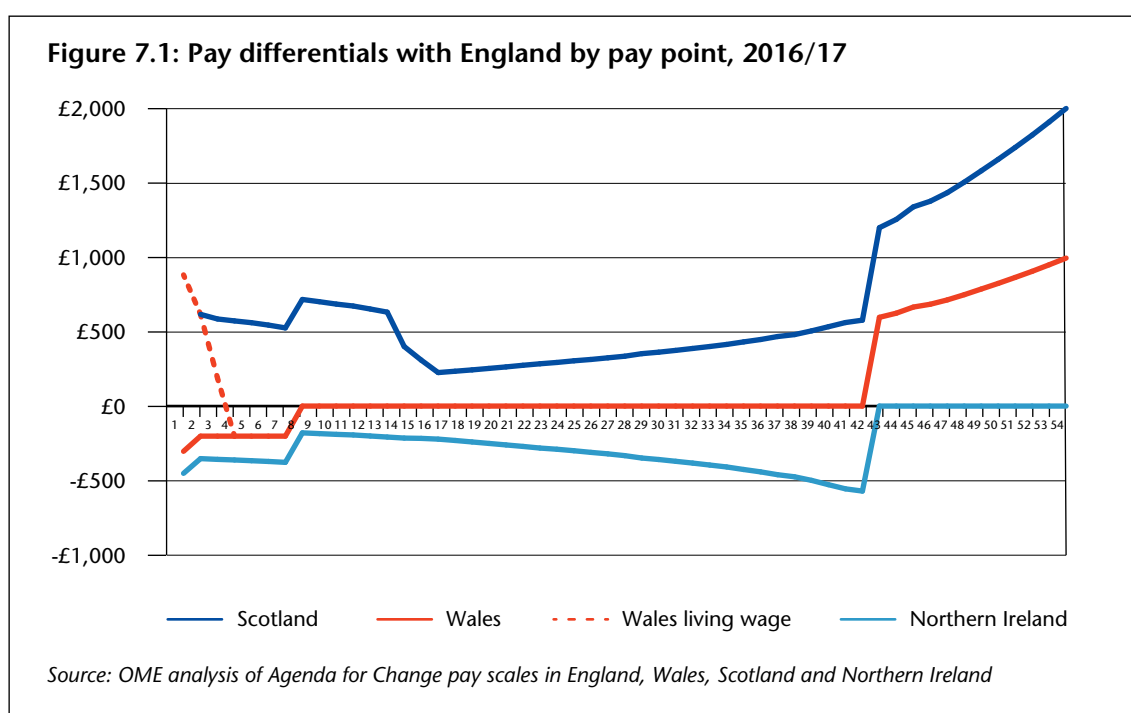
Chapter 7 – Pay Proposals, Recommendations and Observations

Introduction

7.1 This chapter brings together the main strands of the evidence relating to the remits for this pay round and our standing terms of reference, including our consideration of the pay proposals presented by the parties. We then proceed to set out our pay recommendations and observations.

Differences in pay across the four nations of the UK

7.2 Since 2014, differences between the four nations of the UK in the pay for Agenda for Change staff have emerged due to differences in pay awards, the implementation of voluntary living wages in Scotland and Wales and decisions in England and Scotland to suspend some lower pay points. Pay in Scotland is higher than elsewhere in the UK and pay in Northern Ireland is lower. This is illustrated by Figure 7.1.



The Pay Award

7.3 In this section we consider the evidence from the parties in regard to their pay proposals for 2017/18.

Evidence from the parties on the pay award

7.4 The **Department of Health** told us that public sector pay restraint continued to play a key role in fiscal consolidation. They said that the UK Government's public sector pay policy to 2020 – an average annual pay increase of 1 per cent for the years 2016/17 to 2019/20 targeted in a way that best supports recruitment and retention – was designed to ensure that the public sector workforce was affordable. They also noted that the aim for the wider public sector as well as for the NHS was to reform and modernise terms and conditions to develop more affordable and sustainable pay systems.

- 7.5 They acknowledged that pay restraint was challenging for staff, with some risks to recruitment and retention, but told us that ensuring that the NHS workforce was affordable would help protect jobs and services and ensure that staff could be deployed most effectively. They said that paying more to the detriment of affordable staffing levels would over-stretch the workforce and also risked retention problems.
- 7.6 They said that the challenges of pay restraint for staff were mitigated by the very low level of CPI inflation. They also noted that around half of the Agenda for Change workforce received incremental pay of 3 per cent on average in addition to pay awards. They told us that a longitudinal study of Agenda for Change showed that the pay for employees who were employed in the NHS in 2010 and also in 2015 increased by an average of between 1.7 per cent and 2.9 per cent per year depending on staff group, compared to average CPI inflation of 2.4 per cent. They also said that their analysis showed that there no significant national recruitment and retention problems – while there were early signs that the leaver rate was increasing and agency costs had grown, Agenda for Change capacity had continued to grow and morale appeared to have been maintained.
- 7.7 They told us that to help mitigate risks to recruitment and retention that may arise from prolonged pay restraint – especially in relation to better earnings growth and improved employment in the wider economy – local organisations must utilise the entire employment offer of pay and non-pay benefits, including access to an occupational pension scheme. They said that this Total Reward approach, together with a much stronger focus on staff engagement, would help ensure that the NHS remained the employer of choice for those that want to work in the NHS as part of the healthcare team.
- 7.8 The Minister told us in oral evidence that the Department is focused on the 2017/18 pay round. They were comfortable that the system could live with 1 per cent pay award this year without imposing too much strain, given the incremental pay structure.
- 7.9 In conclusion, the Department of Health told us that, given affordability constraints and the absence of sustained recruitment and retention difficulties, a uniform 1 per cent pay award for 2017/18 was considered appropriate across all Agenda for Change staff groups.
- 7.10 **NHS England** said that the NHS continued to face a challenging financial position and that the next five years would continue to require very significant financial savings and efficiency improvements, including through restraining growth in pay, similar in scale to those needed from 2010 to 2015. They noted that £3.5 billion of the £22 billion savings required were predicated on implementing the Government’s 1 per cent public sector pay cap to 2019/20. They told us that if savings were not delivered through pay restraint, additional unidentified savings would be needed from elsewhere, potentially reducing the resources available for delivering and improving services to patients. On the basis of this, they urged us to consider very carefully what, if any, uplift is appropriate for 2017/18.
- 7.11 In supplementary evidence, NHS England said that the position set out in the Five Year Forward View, that *“As the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain frontline staff”*, remained their view over the long-term, but the last Spending Review settlement was predicated on a public sector pay cap of 1 per cent.

- 7.12 **NHS Providers** said that they recognised the need appropriately and fairly to reward staff to support recruitment and retention and a motivated workforce. They said that, if a 1 per cent pay award was fully funded through the national tariff, then it could be affordable for providers to implement in that it would not lead to them having to take money from other budget areas and would avoid further deterioration of their finances. As such, they told us that they did not oppose a 1 per cent pay award for 2017/18 on the understanding that it was fully funded through local and national contracts.
- 7.13 At oral evidence, NHS Providers told us that it was difficult to see how public sector pay policy could be sustainable over the whole of the Parliament given the expected rise in inflation, an increasingly uncompetitive pay offer for some staff, increased competition for non-clinical staff at band 1-4 due to the National Living Wage and increased pressure on staff.
- 7.14 **NHS Employers** told us that pay made up more than two thirds of the budgets for most hospitals and that changes in staff costs, above those already planned for, would have a significant impact on the financial viability and sustainability of NHS financial plans. They said that continuing to contain pay costs remained an integral part of addressing this financial challenge. They noted that the pay review was subject to the UK Government's public sector pay policy that increases across the public sector would be constrained to an average of 1 per cent until 2020/21.
- 7.15 They said that their programme of employer engagement told them that employers supported the same percentage increase being made to all Agenda for Change staff within the average 1 per cent pay cap. They noted that employers continued to stress the importance of further pay and contract reform and that the priority for available resources should be improving the delivery of patient services and retaining key staff. While they acknowledged that NHS organisations continue to face workforce supply issues in relation to some of the health professional staff groups, they said that this was essentially a supply issue and not related to pay levels.
- 7.16 The **Welsh Government** said that NHS Wales continued to face significant challenges, including rising costs, increasing demand, an aging population, a growth in the number of people experiencing chronic conditions, increases in NHS employer pay costs and a challenging financial settlement, with the Welsh Government revenue budget around 8 per cent lower in real terms in 2019/20 than it was in 2010/11. They emphasised that the affordability of any pay award had to be managed within the context of a reducing real-terms budget. They noted that a recent Health Foundation report had identified a net funding gap of £150 million by the end of 2019/20, though some of this gap had been reduced by increases in health funding in 2016/17 and 2017/18 above that assumed in the report.
- 7.17 The **Northern Ireland Executive** highlighted that control of public sector pay in Northern Ireland was based on the principle that the public sector should offer a pay and reward package that allowed it to recruit, retain and motivate suitable staff and that public sector pay should also reflect the circumstances specific to the local labour market. They noted that resource budgets would experience a real terms decline in the coming years and that the high proportion of public expenditure accounted for by pay meant that trends in public sector pay costs had significant implications for the availability of resources to support staff and deliver public services. They also noted that relative public sector pay in Northern Ireland was higher in Northern Ireland than elsewhere, with a headline public-private earnings differential of 19.4 per cent compared to 5.6 per cent in the UK as a whole.

- 7.18 They told us that public sector pay policy for the current year was still under consideration, though said that the Northern Ireland Executive had endorsed the principle of adhering to the UK Government's public sector pay policy. They also told us that the Department of Health in Northern Ireland had identified a material and widening gap between the resources available and those required to maintain existing services. They told us that a 1 per cent pay award would cost £21 million in 2017/18 and that this would have to be considered in the context of the overall budget made available to Health and other significant pressures across the Health and Social Care system.
- 7.19 At oral evidence, Northern Ireland employers told us that pay scales are already about 2 per cent behind the rest of the UK and suggested that any further increase in this differential would make it difficult for Northern Ireland employers to be competitive with other parts of the UK when recruiting staff or encouraging students from Northern Ireland studying in the rest of the UK to return to work in Northern Ireland. They also noted that a significant difference in pay would cut across the principles of Agenda for Change and that Northern Ireland was still committed to a UK-wide pay structure.
- 7.20 The **Joint Staff Side** told us that the value of the Agenda for Change pay framework had diminished significantly over the past six years, with NHS staff suffering real terms wage cuts of an average of 12.3 per cent. They said that the Government had made significant savings by artificially restricting the ability of NHS pay to keep pace with the cost of living and that there was great strength of feeling among both staff and managers that the current pay policy was unsustainable and that a change in direction was long overdue. They also noted that the different approaches to pay awards had resulted in significant differences in pay across the four UK countries and that this meant the pay system was not felt to be fair by the workforce as NHS staff doing the same jobs were not being paid at the same rate.
- 7.21 They made three key pay proposals:
- Realigning pay scales across the UK to harmonise all Agenda for Change pay points using Scotland as a reference point.
 - Restructure Bands 1-3 to pay the Living Wage and to maintain pay differentials.
 - Make a pay award in line with RPI, applied equally to all staff in Agenda for Change.
- 7.22 The **Chartered Society of Physiotherapy** told us that falling real pay levels, constant reorganisation, increasing workloads, staffing shortages, stress and frustration with the level of care physiotherapy staff feel able to provide were undermining morale and were major contributing factors to problems in recruiting and retaining NHS physiotherapy staff. They told us that they believed the public sector pay cap was inconsistent with the full independence of the pay review body. They also said that they rejected the Government's contention that pay restraint was necessary to ensure adequate staffing levels. In conclusion, they said they supported the Joint Staff Side's pay proposals.
- 7.23 **Unite** told us that Government pay and funding policy was having a devastating impact on staff morale and causing a serious staffing crisis across the NHS and noted that they continued to oppose what they called an "ideological pay cap". They said that the Review Body should support moves to make the whole NHS a Living Wage employer, return to a single UK-wide NHS pay system and recommend that all NHS staff should receive a pay rise in line with increases in the cost of living, as measured by the RPI.
- 7.24 They told us that they supported the Joint Staff Side asks, with the addition that they proposed that the Review Body should also consider making a recommendation of an equal monetary increase to each pay point subject to all NHS staff receiving a pay increase in line with RPI inflation.

- 7.25 **UNISON** said that they wanted to see the NHS return to being an employer of choice, with fair annual pay awards and a fair deal for the lowest paid in the health service and said that going further than the Living Wage and moving to a pay structure with a minimum pay point equivalent to £10 an hour would send a clear signal that the NHS valued all staff.
- 7.26 They told us that they supported the Joint Staff Side asks, with the addition that every member of staff should receive an increase of at least £1 per hour (which is equivalent to £1,955 for full-time NHS staff).
- 7.27 The **Royal College of Nursing** told us that the success of NHS reorganisation would depend on the involvement and engagement of a committed and motivated workforce and that another year of pay restraint would send a clear message that the nursing workforce is undervalued and their contribution to the NHS underappreciated. They noted that nursing staff in the NHS have experienced a real terms drop in median earnings of between 9 per cent and 14 per cent and told us that the Migration Advisory Committee had said that pay is a key driver of poor retention of nurses in permanent roles. They said that while a meaningful pay rise would not, on its own, alleviate the challenges to recruitment, retention and morale, it would provide a strong and welcome signal to the workforce.
- 7.28 They also noted that nursing staff were choosing to work for agencies for higher salaries and proposed that the Review Body looked in the short-term to RRP's and increases in bank and overtime rates to reduce the reliance on agency staffing, in addition to supporting the Joint Staff Side asks.
- 7.29 The **Royal College of Midwives** said that the announcement by the UK Government that they would continue with pay restraint until 2020 undermined the integrity of the pay review system and would cause lasting damage to the morale and motivation of staff, worsening the staffing crisis in the NHS. They said that the Government needed to stop considering pay policy in isolation to a strategy for the whole workforce and that they were concerned that cutting pay, terms and conditions for NHS staff would actually result in higher costs to the NHS in terms of low staff engagement and worse patient outcomes.
- 7.30 They told us that the UK Government's pay policy implied that the real terms value of a midwife's salary – as measured by RPI – would have decreased by 25 per cent between 2010 and 2020 and that they had substantial concerns about the impact that this would have on the attractiveness of midwifery as a career.
- 7.31 In addition to the Joint Staff Side asks, the Royal College of Midwives asked that the Review Body make observations on how organisations could make best use of RRP's to tackle staffing shortages for midwives and to confirm our position on whether incremental progression was a separate issue to basic pay.

Pay targeting

- 7.32 Our remit for England included an expectation that pay awards would be targeted in order to support the continued delivery of public services and to address recruitment and retention pressures. This section presents the evidence we received from the parties on this issue.

Evidence received from the parties on pay targeting

- 7.33 The **Department of Health** told us that it strongly supported the principle of pay targeting and noted that previous pay awards had been targeted by, for example, excluding staff in receipt of progression increments from the 2014/15 pay award and funding a higher pay award for low paid staff in 2015/16 by freezing the pay of higher paid staff.
- 7.34 However, they told us that for the 2017/18 pay round, the evidence suggested that there were no significant recruitment, retention or motivation problems that would be resolved through targeting the pay award on an occupational or regional basis. They also cited feedback NHS Employers had received from trusts that organisations did not believe a differential pay award would make a material difference to the recruitment, retention or motivation of Agenda for Change staff and could be divisive.
- 7.35 The Department of Health told us in oral evidence that pay targeting in a tight pay envelope was very difficult as more money for one group of staff would mean less money for others. They said that there were targeting measures that local employers were using although they noted that trusts were reluctant to use RRP as they are not centrally funded.
- 7.36 The Department of Health also noted previous observations by the Review Body that robust recommendations for differential pay awards required accurate vacancy, recruitment, retention and motivation data. They said that they did not have sufficient evidence yet but were working towards having this data available to support targeted pay awards in 2018/19, enabling the Review Body to identify those staff groups, nationally or regionally, for whom pay would make a material difference to recruitment, retention or motivation.
- 7.37 In conclusion, the Department of Health told us that all Agenda for Change staff should receive a uniform 1 per cent pay award in 2017/18.
- 7.38 **NHS Employers** told us that they had clear feedback from employers that they had no evidence to justify differential pay awards to Agenda for Change staff. They said that targeting within a 1 per cent award would not make any differentiation worthwhile and could have a negative impact on the morale of the workforce.
- 7.39 They said that over half of employers responding to the joint NHS Employer/NHS Provider survey ranked giving all staff 1 per cent as their preferred option for a number of reasons, including that:
- 1 per cent was insufficient to make any changes that would have a significant impact on recruitment, retention and motivation.
 - The effort to work out alternative local pay options (e.g. robust performance pay arrangements) would be disproportionate to any gain.
 - There was a perceived risk of pay spiral and unnecessary competition between trusts if employers were encouraged to adjust pay locally.
 - There would be a negative impact on staff motivation and morale for those staff receiving a pay uplift lower than 1 per cent, putting at risk their willingness to engage with service redesign work.
 - The annual uplift was a cost of living increase which should be awarded to all staff.
- 7.40 However, NHS Employers did note that a substantial minority (a little under half) of employers responding to their survey did suggest that the pay award was targeted, with targeting the award to address recruitment and retention issues the most popular targeting option (suggested by almost a quarter of employers), with giving more to the lowest paid staff or the highest performers also suggested by some.

- 7.41 **NHS Providers** told us that the 1 per cent pay award should not be targeted at the national level as they said it may be divisive in the current industrial relations climate and may not take account of differing local recruitment challenges. They highlighted the findings from the joint NHS Employers/NHS Providers survey cited in the discussion above.
- 7.42 At oral evidence, they also suggested that pay targeting would be ineffective in resolving staff shortages as there is a fixed quantum of qualified staff in shortage occupations. They said that paying local RRP's risked being a "beggar my neighbour" policy involving poaching staff from other areas who may be forced to pay more in retaliation, leaving high pay bill costs but no change in supply or shortages.
- 7.43 The **Welsh Government** said that targeting pay awards was not an approach they wished to consider during this pay round. They told us that, although there were shortages of staff in specific specialities, the evidence showed that these were UK-wide issues and related to the numbers of staff training in these areas rather than the financial rewards. They said that these issues needed to be resolved through workforce planning, recruitment initiatives and changing the way in which roles were designed and that they did not wish to consider the use of targeted pay until wider initiatives designed to address the underlying cause of recruitment challenges had been evaluated.
- 7.44 The **Joint Staff Side** said that they continued to reject proposals to target the pay award, identifying five reasons for this:
- The lack of high quality data on vacancies and on recruitment and retention patterns made it difficult to construct an evidence base to support differential pay awards.
 - Recruitment and retention difficulties were highly complex and subject to considerable variation at local levels meaning that targeting national pay awards was at best a blunt instrument.
 - The scope for differential awards within a 1 per cent pay envelope was limited as the impact of a higher award would be negligible while the negative impact on morale of a lower award could be considerable.
 - There was a danger of unintended consequences where a pay measure intended to boost recruitment and retention for one group had a negative impact on recruitment and retention for other groups.
 - Previous attempts at targeting had caused confusion and bitterness for other staff by removing progression points, making non-consolidated awards and pay and increment freezes.
- 7.45 **Unite** told us that the Review Body should take into account the stretching effect of percentage pay rises on the pay spine and consider fairer recommendations based on their monetary value i.e. an equal monetary increase to each spine point. However, Unite also stressed that all NHS staff should receive a pay increase that at least compensated for the rate of inflation as measured by RPI.
- 7.46 The **Royal College of Midwives** said that they did not agree that there should be an unequal pay increase across the bands. They told us that they were concerned about the unintended consequences of a targeted award, in particular the consequences for equal pay, the impact on recruitment and retention and the impact on creating anomalies in the pay structure.

The National Living Wage and the Living Wage Foundation Wages

The National Living Wage

7.47 As we highlighted in our last report, the introduction of the statutory National Living Wage for over 25s will begin to impact on Agenda for Change pay scales over the next few years. Table 7.1 shows the differences between the wage levels for the various living wages.

Table 7.1: National Minimum Wage, National Living Wage and the Living Wage Foundation Living Wage rates

Age Group	National Minimum Wage (UK-wide)	National Living Wage (from 1 April 2017, UK-wide)	Living Wage Foundation Living Wage (voluntary) Scottish Living Wage	
			National	London
25+	N/A	£7.50	£8.45	£9.75
21+	£7.05	N/A		
18 – 20	£5.60			
Under 18	£4.05			
Apprentice	£3.50			

Sources: Government website on National Minimum Wage and National Living Wage, Living Wage Foundation

Notes:

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

The National Living Wage is the legal minimum an employer can pay per hour for staff aged 25 and over who are not in the first year of an apprenticeship.

The National Living Wage will be set by the Low Pay Commission.

Employers choose to pay the Living Wage Foundation Living Wage voluntarily.

Living Wage Foundation rates are revised annual in line with cost of living increases and changes in the tax and benefit system. Increases are announced every November and apply from the following April.

7.48 The UK Government announced in November 2016 that the statutory National Living Wage rate will increase to £7.50 per hour in April 2017, which we calculate to be equivalent to £14,665 for full-time Agenda for Change staff.⁵⁴ This is above the current value of pay point 1 in Northern Ireland (currently £14,437). It is also above the value of pay point 1 in Wales (currently £14,581), though NHS staff receive a supplement to ensure that they are paid at least the Living Wage Foundation living wage.

7.49 While changes in economic forecasts mean that the National Living Wage is increasing more slowly than previously expected, Office for Budget Responsibility forecasts still imply an April 2020 National Living Wage rate of £8.80 per hour, equivalent to £17,207 for full-time Agenda for Change staff. This is above the Agenda for Change pay rate implied by the UK Government's current public sector pay policy for pay points 2-5 in England, 1-5 in Wales and 1-6 in Northern Ireland.

⁵⁴ Calculated as the National Living Wage hourly rate, multiplied by weekly hours, multiplied by the number of weeks in the year. This value is then rounded upwards to the next pound. $£7.50 \times 37.5 \times 52.14 = £14,664.38$, rounded upwards to £14,665.

The voluntary Living Wage Foundation wages

- 7.50 The Scottish Government has committed to paying all staff at least the Scottish Living Wage set by the Living Wage Foundation and the Welsh Government has committed to paying all staff at least the UK Living Wage set by the Living Wage Foundation. This is based on a weighted average of the hourly wages that the Living Wage Foundation estimates is required for families with all adults in full-time work to achieve a basic minimum standard of living.⁵⁵
- 7.51 The Scottish Living Wage and the UK Living Wage in April 2017 will both be set at £8.45, equivalent to £16,522 for full-time Agenda for Change staff. This is above the current level of pay for Agenda for Change staff at pay point 2 in Scotland (currently £16,132) and at pay point 5 in Wales (currently £16,170).
- 7.52 There have recently been changes in the methodology used by the Living Wage Foundation to calculate the voluntary living wage which will have a significant impact on the expected cost of paying the living wage over the next few years:
- Until October 2016, the living wage rate (£8.25 in October 2015) was capped below the “reference” rate based on living costs (£9.35 in October 2015), with the living wage set to increase by Average Weekly Earnings plus 2 per cent – around 5 per cent per year – until the “reference” rate was reached.⁵⁶
 - In October 2016, methodological changes reduced the value of the “reference” living wage to £8.45 per hour – the same as the headline rate of the voluntary living wage.⁵⁷ As a result the previously anticipated ‘catch-up’ growth is no longer required, meaning future increases in the value of the voluntary living wage are likely to be slower than previously expected.

Evidence from the parties on living wages

- 7.53 The **Department of Health** told us that the National Living Wage was not expected to impact on Agenda for Change staff in England in 2017/18. They also noted that the minimum Agenda for Change pay rates, including High Cost Area Supplements, currently exceeded the applicable Living Wage Foundation rate in inner London (£9.93 compared to £9.40), outer London (£9.60 compared to £9.40) and the London fringe (£8.29 compared to £8.25).
- 7.54 **NHS Employers** said that the National Living Wage would not have a direct impact on the NHS in England in 2017/18 but would have longer-term implications: based on an assumption that pay increases were in line with public sector pay policy, they estimated that it would start to have an impact from 2018/19.
- 7.55 They told us that they understand that the additional costs of the National Living Wage would have to be met within the constraints of public sector pay policy and that they estimated that statutory compliance would add £10 million to the pay bill in 2018/19, rising to £180 million in 2020/21. They noted that, as Agenda for Change did not have age-related points, it was unlikely that the NHS would be able to benefit from using the under 25 rates.

⁵⁵ See <http://www.livingwage.org.uk/what-is-the-living-wage> for more details about how the Living Wage Foundation living wage is calculated.

⁵⁶ Loughborough University Centre for Research in Social Policy, *Uprating the UK Living Wage in 2015*, 2015. Available from <http://www.lboro.ac.uk/research/crsp/mis/thelivingwage/>

⁵⁷ Resolution Foundation, *Calculating a Living Wage for London and the Rest of the UK*, October 2016.

- 7.56 NHS Employers said that they had asked employers about the challenges and opportunities of implementing the National Living Wage in their employer survey. They told us that some employers were already paying the (higher) Living Wage Foundation rate and that other employers highlighted opportunities from the National Living Wage, including opportunities to increase apprenticeships and to demonstrate to lower paid staff that the NHS was a fair and equitable employer. Challenges identified by employers included:
- An additional financial burden on already tight budgets if no additional funding was made available.
 - The potential negative impact on morale if pay awards for other staff were reduced to pay for the National Living Wage within the 1 per cent pay envelope.
 - The impact of compression of pay scales at bands 1-3 in undermining the pay structure at the bottom of the pay scale.
 - The need to re-engineer roles to improve productivity in line with higher levels of pay.
 - Funding future increases in the National Living Wage that may be higher than the general pay settlement.
 - Potential labour market issues as the current differential between basic pay at the bottom of Agenda for Change and the wider economy is eroded.
- 7.57 **NHS Providers** noted that the implication of the UK Government's policy to fund the National Living Wage out of the 1 per cent pay award was that other staff would need to be awarded less than 1 per cent to pay for higher pay increases for low paid staff. They told us this would be a challenging message for trusts to manage. They said that if the 1 per cent average pay award was to be targeted to support the introduction of the National Living Wage then it could not be used for other aims, such as addressing recruitment and retention challenges or supporting contract reform.
- 7.58 They also highlighted that their members had told them that the National Living Wage would intensify the issue of overlapping pay bands within Agenda for Change, told us that incorporating the National Living Wage would be the most pressing pay issue for Agenda for Change over the next few years and noted that it was important that a plan for this was set out.
- 7.59 The **NHS Staff Council Secretariat** said that the priority for the Agenda for Change review over the next 6 months would be looking at options for restructuring the lowest pay points in Bands 1-3 to accommodate the National Living Wage and for managing the cost impact. They noted that the trade unions had made proposals to 'hang' a revised bands 1-3 from the top of the current Band 3, keeping the lowest pay point above the Living Wage set by the Living Wage Foundation, whereas employers had made it clear that their preference was to minimise additional investment in bands 1-3 to fund reform of the middle pay bands. They also noted that trade unions believed that the National Living Wage was a social policy that should be funded outside of the 1 per cent pay envelope.
- 7.60 The **Welsh Government** said that it had been social policy in Wales to help the lowest paid members of staff and that NHS employers implemented the Living Wage from 1 January 2015 in line with the rate set by the Living Wage Foundation. They said that NHS Wales had created local pay-scales so that pay points reflected the Living Wage and that additional funding was provided by the Welsh Government in 2015/16 and 2016/17 to cover the cost of the Living Wage, with £5.6 million provided for the 2016/17 increase in the Living Wage. They told us no major issues associated with the compression of pay differentials at the bottom of the pay scales had been raised with the Welsh Government to date.

- 7.61 The **Northern Ireland Executive** told us that the National Living Wage would begin to impact on pay point 1 from 1 April 2017, affecting around 700 staff. They said that the projected minimum costs of this, excluding the impact on bank expenditure, would be additional costs of £340,000. They said that they would work with trade union and management colleagues across the whole of the UK to respond to the issue of pay compression at the bottom of the pay structure.
- 7.62 **Joint Staff Side** told us that they would object to a pay award that achieved compliance with the National Living Wage at the expense of those in higher pay bands. They said that the National Living Wage was a social policy and a government priority which must be fully funded by the UK Government. They also said that any restructuring needed to achieve compliance with the living wage must be centrally funded separately to the 1 per cent pay envelope and factored into the UK Government's budgeting for the English NHS so that the uplift also applied to devolved governments.
- 7.63 Joint Staff Side also proposed that bands 1-3 were restructured to pay the Living Wage set by the Living Wage Foundation and told us that there was evidence that this would improve recruitment and retention, improve productivity, reduce sickness absence and enhance the competitiveness of public sector pay.

Our comment and recommendations

Pay recommendations and observations for 2017/18

- 7.64 In line with the remit for this pay round, we have considered both the level of the pay award and whether it should be targeted at particular staff groups or local areas. We have considered the evidence on the situation in each of the four nations of the UK in determining our recommendations about the appropriate pay award.
- 7.65 As required by our terms of reference, in developing our recommendations we have had regard to the affordability pressures facing the NHS. There is overwhelming evidence that the NHS is under severe financial pressure in every part of the UK with, for example, the £22 billion savings target for the NHS in England looking unrealistic in the eyes of many NHS managers as well as the National Audit Office. Demand growth is also turning out to be significantly higher than was anticipated in the Five Year Forward View, meaning that savings will need to be significantly higher than £22 billion unless demand growth is restrained or additional funding provided.
- 7.66 While we have been told by the Health Departments in England and Wales that there is funding earmarked for a 1 per cent pay award, and the Health Department in Northern Ireland said that they were factoring a potential 1 per cent pay uplift into budget considerations for 2017/18, it is debatable whether this is truly affordable given NHS funding and rising patient demand, and there is a short-term affordability argument for a nil pay award that could be made. It would also seem clear that, unless there was additional funding, an award higher than 1 per cent would require trade-offs in terms of service levels, investment decisions and staff numbers, with associated implications for workload and pressures on staff unless accompanying actions were taken to restrain demand.
- 7.67 There continues to be little evidence that pay restraint in and of itself has, so far, caused serious widespread recruitment and retention issues. The overall recruitment picture is strong and the Agenda for Change workforce is growing in every occupational group, with significant shortfalls limited to some occupational groups in some geographical areas. The current level of turnover also appears manageable in every staff group: while there are signs of emerging issues in some occupations it is not clear that a higher pay award would have a noticeable immediate impact on retention.

- 7.68 While the NHS Staff Survey suggests that the motivation of NHS staff remained high in autumn 2015, NHS staff are clearly under increasing amounts of pressure with high and increasing workloads. The fact that both employers and staff side identify falling morale as a serious issue is persuasive and is consistent with what we found on our visits programme. This could, if left unchecked, ultimately lead to difficulties in engaging staff in implementing service reform. However, the question remains about the extent to which increases in pay could help address the situation in the very short-term, especially if the premise that fixed budgets mean there is a trade-off between more pay and more people is accepted.
- 7.69 This evidence – serious affordability pressures, no nationwide recruitment and retention issues related to pay, and evidence suggesting that reducing workload pressures could have a positive impact on staff morale – made us give serious consideration to the case for a nil pay award. However, as we have said in previous years, and employers and Staff Side both made clear in their evidence to us, public sector pay policy for a 1 per cent increase has set staff expectations. There is a consensus among all evidence providers that the negative impact on staff morale of a pay award below 1 per cent is not worth the relatively small financial benefit even if this flowed through to increases in staffing levels as opposed to reducing deficits. There are also issues with the visibility and uniformity of changes in staffing levels made in lieu of a pay award – individual members of staff cannot be sure that they will see any reduction in their workload as a result of changes in staffing levels and so may not find such an approach credible. A pay award has the virtues of being immediate, visible, uniform and attributable.
- 7.70 We also recognise the importance of take-home pay for NHS staff. Many saw a cut in their take-home pay in cash terms in 2016/17 due to increased National Insurance contributions resulting from the end of contracting out, and we heard on visits that it was demotivating to be told they had a one per cent award when in practice this was wiped out. With inflation now forecast to rise during 2017, and private sector wage settlements running at around 2 per cent, we are also very aware that a 1 per cent pay award implies a further real terms cut in the value of take-home pay. This opens up for us a pressing question about the sustainability of current pay policy.

Targeting

- 7.71 For us pay targeting means giving different pay increases to different workers based on a systematic pattern designed to address specific recruitment, and retention issues. This does not include targeting to achieve wider social objectives.
- 7.72 We have carefully considered the advantages and disadvantages of a targeted national pay award on the basis of occupation, region and pay band given the expectation set out by the Chief Secretary to the Treasury in our remit for England.⁵⁸ However, the Department of Health, employers and Staff Side all came out against targeting within the 1 per cent award this year giving a number of reasons, including the continued lack of a robust evidence base, the limited positive impact that targeting a 1 per cent pay award could have and the significant negative impact on morale of giving some staff a pay award lower than 1 per cent.
- 7.73 Given the emphasis placed by the Department of Health in England on the distinction between what is happening to earnings and what is happening to Agenda for Change pay rates – with earnings rising on average faster than pay rates because of pay progression – we note that the absence of targeting of *pay rates* still results in *quasi-targeting of earnings* because workers at the top of pay bands get lower increases in earnings than their peers. However, it is not clear whether this serves any clear recruitment and retention purpose.

⁵⁸ See Office of Manpower Economics, *Targeted Pay Increases in the Public Sector: Theory and Practice*, 2016 for a good summary of the types of issues we took into account in the course of our considerations of pay targeting.

- 7.74 We note that there was rather more support for targeting *additional resources* outside of the 1 per cent pay envelope, though proposals were not always defined as pay targeting by those making them. For example:
- Staff Side’s proposals on pay implied additional resources on top of a 1.9 per cent award to fund higher awards in Northern Ireland, England and Wales to bring pay into line with Scotland and to fund higher awards for those in lower bands as part of their proposed restructure of Bands 1-4.
 - Unite’s proposals for a flat-cash pay award implied additional resources on top of a 1.9 per cent award to fund higher percentage awards for those in lower bands.
 - The Royal College of Nursing and the Royal College of Midwives both suggested that the Review Body look at making recommendations around the use of RRP, which are a form of pay targeting.
- 7.75 There is, however, a case for pay targeting given the evidence that recruitment and retention pressures are currently limited to certain occupational groups in some geographical areas. As we said last year, targeting at a national level through Agenda for Change is a blunt instrument. There are already appropriate mechanisms within Agenda for Change that enable trusts to target pay to address local recruitment and retention needs. As we discuss in Chapter 4, the fact that the use of RRP is dwindling alongside an increase in the very pressures they are intended to alleviate suggests that there is a problem. There needs to be greater focus on encouraging employers to use their existing pay flexibilities in this way. This also links to making full use of total reward, as we discuss in Chapter 2.
- 7.76 As we noted in Chapter 4, the evidence we have received shows that recruitment and retention pressures and staff shortages are more severe in London and the surrounding area and also suggests that HCAS does not fully compensate staff for the additional costs of living and working in and around London. The evidence also suggests that cliff-edge issues around the HCAS boundaries are significant and are a key driver of staff shortages in large parts of the Home Counties, who compete with London employers for staff. However, none of the parties are proposing any changes to HCAS beyond uplifting it in line with the main pay award, and the potential for unintended consequences of significant change to HCAS means a lot of caution will be required.
- 7.77 We also continue to be concerned about the ability of the funding system to respond to recommendations for national pay targeting. As we said in Chapter 3, we are not confident that the mechanisms exist for the financial impact of national pay targeting recommendations on individual providers to be funded, especially in the context of a tariff that will shortly be fixed until April 2019. This continues to be a constraint on our ability seriously to consider national pay targeting during both this and next year’s pay round.
- 7.78 We considered the evidence on the appropriate level of pay uplift in each nation of the UK separately. There is a strong argument from a recruitment and retention perspective in Wales and Northern Ireland – and also from an affordability perspective in Northern Ireland – for a lower pay award than in England. However, all parties were in agreement that the negative morale and motivation implications of a pay award below 1 per cent were not worth the relatively small financial gains. The Welsh Government also highlighted their desire to keep Agenda for Change pay in line with the rest of the UK and the Northern Ireland Executive made the argument that, whilst the current pay differential with the rest of the UK is tolerable, a bigger differential would begin to risk recruitment difficulties.

7.79 We also carefully considered the proposal made by staff side in favour of levelling pay up to Scotland. We did not hear any persuasive evidence that this would have any significant benefits in terms of recruitment, retention and motivation and there is no evidence of existing differentials causing cross-border issues. Differences in pay are an inevitable feature of devolved health policy.

Recommendation 1

We recommend a uniform 1 per cent increase to all Agenda for Change pay points from 1 April 2017 in England, Wales and Northern Ireland.

Recommendation 2

We recommend a 1 per cent increase to the High Cost Area Supplement minimum and maximum payments.

The Living Wage

7.80 There are still several unanswered questions about how each of the four nations will implement the National Living Wage. For example:

- Will the National Living Wage be paid to all staff or only those who are legally entitled to it i.e. excluding under 25s and Apprentices aged over 25 who are in the first year of their apprenticeship?
- Will the National Living Wage be implemented by changing the Agenda for Change pay scale or by paying a supplement (as happens in Wales for the voluntary Living Wage Foundation wage)?
- Will Agenda for Change pay scales be altered to maintain differentials by adjusting the value of pay points that are not directly affected or by rationalising pay points at the bottom of the pay scale i.e. will the actual cost of the National Living Wage be more than the compliance cost?

7.81 These decisions will have significant implications for the impact that the National Living Wage will have on pay compression. For example, without action on the pay structure, current forecasts suggest that by 2020/21 the National Living Wage will exceed the value of pay point 6 in Northern Ireland and pay point 5 in England, eroding the differential between staff at the bottom of band 3 and staff at band 1.

7.82 These questions need to be resolved soon – assuming that each of the four nations follows current public sector pay policy, Northern Ireland will be affected by the National Living Wage from April 2017, Wales by April 2018 and England by April 2019. We note the approach taken in Scotland to rationalise the lower bands by eliminating band 1.

7.83 As we said in last year's report, we consider the National Living Wage to be a social policy with no compelling recruitment and retention reasons to support higher pay increases for lower paid groups in the NHS. Furthermore, we continue to have serious doubts about the proposition to fund the National Living Wage via lower pay increases for other staff.

7.84 In the absence of clear answers to the questions above, this year we have decided to recommend that – in addition to the headline pay award – pay point 1 in Northern Ireland is increased to ensure compatibility with the National Living Wage, funded outside of the 1 per cent.

Recommendation 3

We recommend that pay point 1 in Northern Ireland should be adjusted so that it is above the 2017/18 level of the National Living Wage.

Observation

The National Living Wage will begin to affect Agenda for Change pay scales from April 2017. Governments across the UK need to clarify arrangements for paying the National Living Wage in the NHS including whether they intend to incorporate it into Agenda for Change or pay it as a supplement to eligible staff and what action they will take to avoid compression of pay differentials. They also need to clarify funding arrangements – we continue to have serious doubts about any proposition to fund a social policy such as the National Living Wage from funding intended for general pay awards to support recruitment and retention.

- 7.85 In terms of the voluntary living wages set by the Living Wage Foundation in Scotland and Wales, we note that it has already led to significant pay compression in Wales, with staff at pay points 1-4 all paid at the living wage floor of £16,132. While we have not received any evidence from any party suggesting that this is causing significant problems as yet, pay compression is set to move further up the pay scale over the next few years and we are concerned about the impact that this pay compression could have in respect of recruitment into roles requiring more training and responsibility, integrity of the job evaluation system and risks of equal pay claims. Scotland has made adjustments to the pay structure to maintain differentials but further action is likely to be required in the future if the value of the living wage exceeds trends in public sector pay.

Observation

The Welsh Government needs to take action to address the impact of the Living Wage Foundation living wage on pay compression to tackle potential motivation and recruitment issues.

Pay policy over the medium term

- 7.86 The evidence we have received gives us cause for concern about the sustainability of public sector pay policy over the next few years. While employers told us that, given serious affordability pressures, they can live with any recruitment, retention and motivation issues caused by the 1 per cent pay policy in 2017/18, they said that they are beginning to see real signs that this will not be sustainable for much longer. Importantly inflation is forecast to be higher than was expected when the current pay policy was developed, meaning that public sector pay policy implies a bigger cut in the real value of NHS pay than was previously expected. There are also other pressures – changes in the UK's relationship with the EU may reduce the ability to fill shortfalls in staff numbers from overseas and there are risks to recruitment and retention from changes in the student funding system.

- 7.87 Pay restraint since 2010 appears not to have had a significant impact on supply over the past few years, given sluggish private sector pay growth in the early part of the decade. However, the evidence suggests that the public sector pay premium – in terms of the whole package – has now been largely eroded meaning that it is likely that continuation of current pay policy will become more impactful on supply given also that pay settlements are higher in the private sector. We agree with NHS England that NHS pay will need to keep pace with private sector pay over the medium-term to recruit and retain staff.
- 7.88 As we noted in Chapter 5, we are concerned that the attempt to deal with significant increases in patient demand within a slowly increasing budget by expecting NHS staff to work more intensively in more stressful working environments for pay that continues to decrease in real terms may become unsustainable. This is beginning to have serious implications for morale which will eventually feed through into deteriorating supply shortages if retention worsens.
- 7.89 As we noted in Chapter 6, greater consideration needs to be given to the long-run supply position of the NHS in thinking about pay. People’s behaviour will be more responsive to pay in the medium-to-long-term than in the short-term. This means that current public sector pay policy could be storing up problems for the future and, ultimately, there is an increasing risk that short-term savings from continuing with current pay policy will be exceeded by the costs of tackling future shortages and increased difficulties in making the service reforms to unlock productivity and efficiency improvements. This uncertainty, and the possible link to Agenda for Change reform, has also led us to reject the possibility this year of a two-year or longer pay award.
- 7.90 The question is how to judge when the point at which current public sector pay policy is no longer sustainable in the NHS has been reached. Should the government wait until there is evidence of significant damage to recruitment, retention and motivation outcomes? Or is there an argument that action now will save money in the medium-term by avoiding future supply shortages becoming critical? It is conceivable also that allowing the pay policy in the NHS to change could drive bigger gains for patient outcomes by, for example, using it as an opportunity to reform Agenda for Change to incentivise productivity improvements and efficiency savings.
- 7.91 Our judgement is that we are approaching the point when current public sector pay policy is no longer sustainable for the NHS. Inflation is set to increase, meaning that real pay is expected to fall faster and further over the next few years than was anticipated in 2015 when the UK Government’s public sector pay policy for this Parliament was developed. There are significant supply shortages in a number of staff groups and geographical areas, with projections of demand and supply increasingly looking too optimistic given the potential impact of the EU Referendum result on the recruitment and retention of EU staff and current trends in healthcare demand. The impact on supply of changes in student funding for nursing, midwifery and allied health courses is still uncertain and, while the excess demand for nursing courses in the previous system provides a cushion, there is a risk of an adverse impact and early signs of significant falls in application numbers. Of course there are also non-pay aspects that can make the job more or less attractive such as changes in workload, pressure on staff and the availability of flexible working arrangements.

Observation

Pay policy is now coming under greater stress than for several years, especially with the likelihood of rising inflation, and we are approaching the point when greater flexibility may be needed in the NHS. It is crucial that health departments think beyond next year to how pay policy might drive gains for patient outcomes and enable reform of Agenda for Change. This is not to understate the financial pressures facing the NHS – they are clearly considerable – but staff in the NHS cannot, as NHS England have always made clear, be paid materially less than workers in the economy as a whole over the medium-term.

Observation

To help manage the transition to an exit from current pay policy, the Government should consider making pay policy more flexible. One possibility would be if the Government allowed targeting to alleviate recruitment and retention problems from outside of the one per cent pay cap. This would require funding to be provided appropriately.

Agenda for Change reform

- 7.92 We also heard from the parties regarding the progress being made on the discussions to review and consider the scope for reforms to Agenda for Change that were started in 2015 as part of the agreement to resolve the 2014/15 pay dispute in England.
- 7.93 We were told that the focus of discussions to date has been on options for reform of the pay structure and progression. A number of shared principles for reform have been agreed, including that the new system:
- is simpler to explain, understand and operate;
 - has shorter pay bands, with fewer points and no overlaps between bands;
 - is fair and affordable for now and the future;
 - is underpinned by the current NHS Job Evaluation system that delivers equal pay for work of equal value;
 - supports and rewards the improvement of staff productivity;
 - supports staff development and career progression;
 - supports good recruitment and retention of staff, motivating staff at all levels;
 - is supportive of the longer term Health and Social Care agenda and the corresponding workforce needs;
 - links logically to the wider reward package contained within the NHS terms and conditions of service handbook;
 - supports equal opportunity and diversity.
- 7.94 Progress has been slow. A key reason for this that the NHS Staff Council identified in their evidence to us is that the 1 per cent pay envelope – together with pressures such as the need to fund the National Living Wage – limits the resources available to fund any transition costs to support a jointly agreed solution. As a result of this and other blockages, the NHS Staff Council advised us that the focus of discussions is now on restructuring Bands 1-3 to accommodate the statutory National Living Wage.
- 7.95 As we said last year, each of the four countries involved in the Agenda for Change discussions needs to be clear about what their strategic priorities are for reform, including how changes in the pay structure and in terms and conditions can support the delivery of improved patient care. As we note earlier, a key issue is resolving the incorporation of the Living Wage and differentials at lower bands. Our view remains that the parties need to work towards a balanced package of reforms, supported by transition funding.

- 7.96 The big challenge facing the health services in each country is restructuring services to improve productivity, efficiency and improve patient outcomes and the future pay structure will need to support such changes. One possibility that should be explored is whether changes to Agenda for Change could build-in “gainsharing” arrangements whereby staff are incentivised to engage in service redesign efforts by sharing the financial gains from higher productivity.
- 7.97 Progress on reform crucially depends on funding being found – unless a reformed pay structure benefits both employers and staff, no progress will be made. A managed exit from the current pay policy could potentially provide an opportunity to link increased investment in pay to reform of Agenda for Change.
- 7.98 We put forward some ideas above. However, our most important conclusion is that all of the parties need to urgently and strategically address the issues around both pay policy and the Agenda for Change pay system, and take seriously the relationship between pay and the retention and supply of staff, in order to avoid negative impacts on both patient outcomes and costs.

Appendix A – Remit letters

Letter from the Chief Secretary of the Treasury to NHSPRB Chair

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

Jerry Cope
Chair of the NHSPRB
c/o Office of Manpower Economics
Fleetbank House
2-6 Salisbury House
EC4Y 8JX

Dear Mr. Cope,

13th July 2016

PUBLIC SECTOR PAY 2017-18

1. Thank you for your work on the 2016-17 pay round. The Pay Review Bodies continue to play an invaluable role in making independent, evidence-based recommendations on public sector pay awards, as well as continuing to provide high-quality advice on wider reforms to pay and allowances policy. I am extremely grateful to you and your colleagues for your considered work. Over the remainder of the Parliament I look forward to the Pay Review Bodies continuing to advise the Government on how best to achieve pay reforms and deliver fair and sustainable pay awards for public sector workforces.

2. As you know the fiscal context remains very challenging following the outcome of the EU referendum vote. However, the Government's public sector pay policy, announced at Summer Budget 2015 and reaffirmed in the Autumn Statement and Spending Review 2015, was intended to enable prudent long-term planning while protecting jobs, and I can confirm that this policy remains in place. We will fund public sector workforces for pay awards of an average of 1 per cent a year, up to 2019/20.

3. As I set out in my letter to you last year, I expect to see targeted pay awards, in order to support the continued delivery of public services, and to address

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recruitment and retention pressures. This may mean that some workers could receive more than 1 per cent whilst others receive less, and there should be no expectation that every worker will receive a 1 per cent pay award. I am aware that this requires you to receive good, evidence-based propositions to consider.

4. Relevant Secretaries of State will write to you shortly with their remit letters, as and where needed. Relevant departments will submit their proposals covering the specific needs of their workforces in their evidence to you in the early autumn. I look forward to your 2017-18 recommendations.

Yours ever,

A handwritten signature in blue ink, appearing to read "G Hands".

GREG HANDS

OFFICIAL

2

Letter from Secretary of State for Health to NHSPRB Chair



Department
of Health

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

*Richmond House
79 Whitehall
London
SW1A 2NS*

Mr Jerry Cope
NHS Pay Review Body
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

22 August 2016

Dear Mr Cope,

I am writing as a follow up to the letter you received from the Chief Secretary to the Treasury, Greg Hands, on 13 July confirming the Government's approach to pay awards in the public sector for 2017-18.

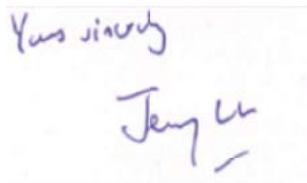
I am grateful for the invaluable work you and your members carry out on behalf of all those that participate in the pay review process. The government has made it clear that pay restraint in the public sector continues to be a crucial part of its plans for the continued prudent management of public finances to help support long term planning and to help protect jobs. I appreciate that this continues to present challenges, but your expertise, and impartial and independent judgement are vital as employers and staff respond to the unprecedented challenges facing the NHS.

In his letter to you, the Chief Secretary to the Treasury asked that you consider how an award might be targeted to support recruitment and retention.

We recognise the importance of pay investment supporting recruitment and retention of staff within the NHS. You have previously highlighted to us the importance of developing better measures that would enable you to take an evidence-based view of recruitment and retention issues and assess whether there is a case for targeting pay investment. My department will set out the progress we are making towards giving you that evidence in the autumn.

We welcome the NHS Pay Review Body's recommendations.

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

A handwritten signature in blue ink that reads "Yours sincerely" followed by "Jeremy Hunt" with a flourish underneath.

JEREMY HUNT

Letter from Scottish Government Cabinet Secretary for Finance and the Constitution to the NHSPRB Chair

Cabinet Secretary for Finance and the Constitution
Derek Mackay MSP



Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0300 244 4000

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

30 September 2016

Dear Mr Cope

NHS Pay Review Body – Remit

On behalf of the Scottish Government, I would like to record our continuing appreciation of the work your review body undertakes to advise on pay and related matters each year. I am writing to confirm that we are again requesting that you consider the position of NHS Scotland staff covered by your review body and provide recommendations concerning their remuneration in 2017-18.

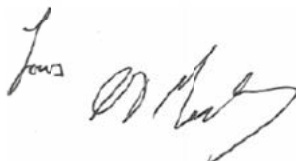
I would like to make you aware that details of our 2017-18 draft budget and accompanying Scottish public sector pay policy will not be published until after the UK Autumn Statement, and that this will impact on your deliberations. It is not yet clear what adjustments the UK Government might make to future public spending allocations, including to the Scottish Block settlement, and this will only become clear following the Autumn Statement on 23rd November. Given this uncertainty, that is why we intend publishing our draft budget for 2017-18 after the Chancellor's Autumn Statement. Following consultation with the Scottish Parliament's Finance Committee, the draft budget proposals and pay policy for 2017-18 will now be published in the week commencing the 12th of December. This means we will only be able to furnish you with our pay policy and the other evidence you consider as soon as we can after this date.

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot



I recognise that such a late submission of evidence may pose particular challenges for you. I hope this does not stop you from starting your deliberations and possibly providing recommendations for the other 3 countries in advance of a later supplement for Scotland. I know staff working to my colleague, the Cabinet Secretary for Health and Sport, have been discussing arrangements with OME staff who support you and I hope these discussions can be continued to establish the best way forward in the circumstances.

I am copying this letter to my colleague, the Cabinet Secretary for Health and Sport, together with the Ministers covering the same portfolio in the other 3 countries, for their information.



DEREK MACKAY

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

Cabinet Secretary for Health and Sport
Shona Robison MSP

T: 0300 244 4000



Mr Jerry Cope
Chair
NHS Pay Review Body
Office of Marpower Economics
8th Floor, Fleetbank House
2-6 Salisbury Square
LONDON
EC4Y 8JX

20 December 2016

Dear Mr Cope,

Further to the letter my colleague, Derek Mackay MSP, Cabinet Secretary for Finance, sent you on 30 September, I am now pleased to present you with further details of our remit and the evidence we would like you to consider. I apologise that, for the reasons outlined in Mr Mackay's letter, we are later than we would have liked in sending you this information.

Mr Mackay released the Scottish Government's Public Sector Pay Policy for 2017-18 on 15 December 2016 as part of his draft budget announcements. This pay policy provides the basis for the remit we would like you to consider. It is a single year policy and sets out the parameters for pay increases for staff. (In electronic versions of this letter, a link to the policy should be available [here](#).)

With regard to NHSPRB interests, the main features of this policy are:

- An overall 1 per cent cap on the cost of the increase in basic pay for those earning more than £22,000.
- Maintaining measures to support the lower paid, specifically a continued commitment to paying the Scottish Living Wage and guaranteeing a minimum increase of £400 for staff earning £22,000 or less.
- Continuing the expectation to negotiate extensions to no compulsory redundancy agreements as part of constructive, collaborative discussions.

You will appreciate that all consideration of staff pay by Scottish Ministers must be informed by this policy framework. However, beyond the elements set out above, we would wish the Pay Review Body to be as free as possible in considering the issues and making recommendations for Scotland in 2017-18. It is important to take into account the considerable on-going financial challenges facing NHSScotland at the present time and that any pay increase has to be affordable.

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot



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

I recognise that you are considering our remit and evidence later than the other countries this year. I also know and expect that our evidence will be subject to your normal scrutiny before you are able to provide us with recommendations in the new year. But I also hope you are able to expedite your deliberations as much as possible to assist us in getting uplifts into staff salaries at the earliest opportunity.

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

Yours sincerely,



SHONA ROBISON

Letter from Welsh Government Cabinet Secretary for Health, Well-being and Sport to NHSPRB Chair

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Cabinet Secretary for Health, Well-being and Sport



Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA-PVG/6288/16

Jerry Cope
Chair, NHS Pay Review Body
Office of Manpower Economics
8th Floor, Fleetbank House
2-6 Salisbury Square
London
WC1B 4AD

22 August 2016

Dear Jerry,

NHS Pay Review Body – Remit 2017-18

I am writing to confirm that I would appreciate the Review Body providing me with pay remit recommendations for 2017-18 in relation to all staff in Wales engaged on Agenda for Change terms and conditions.

Any recommendations should take into account the UK Government's public sector pay policy as well as the recruitment and retention challenges faced by all UK health departments. My officials will be happy to work with your secretariat to ensure all relevant supporting information is made available to meet the Review Body's timelines.

I am copying this letter to the Secretary of State for Wales, the Secretary of State for Health in England, the Cabinet Secretary for Health, Wellbeing and Sport in Scotland and the Minister for Health, Social Services and Public Safety in Northern Ireland.

Yours sincerely,

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon
Cabinet Secretary for Health, Well-being and Sport

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400
Goheblaeth.Vaughan.Gething@llyw.cymru
Correspondence.Vaughan.Gething@gov.wales

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

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

Letter from Northern Ireland Executive Minister for Health to NHSPRB Chair

FROM THE MINISTER OF HEALTH



Mr Jerry Cope
Chair, NHS Pay Review Body
Office of Manpower Economics
8th Floor
Fleetbank House
2-6 Salisbury Square
LONDON
EC4Y 8JX
By email:

Castle Buildings
Stormont Estate
Belfast BT4 3SQ
Telephone: 028 9052 0638

Our Ref: SUB/1182/2016

Date: 3 August 2016

NHS PAY REVIEW BODY (NHSPRB) REMIT 2017/18

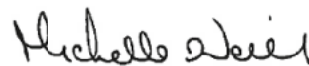
I wish to begin by conveying my thanks to the NHS Pay Review Body (NHSPRB) for its work on the 2016/17 pay round and to offer my apologies for the delay in submitting last year's remit and evidence. My Department values the work of the pay review body and its important role in making recommendations on the remuneration of Agenda for Change staff.

I write to confirm the approach of my Department in respect of the NHSPRB 2017/18 remit and would advise that it is our intention to submit evidence for the pay round before the end of September 2016 and to seek recommendations by mid February 2017 on pay for Agenda for Change staff employed in Health and Social Care (HSC).

The NI Executive has endorsed the principle of adherence to the UK Government's public sector pay policy and, therefore, any proposals will be constrained by HM Treasury's calls for continued pay restraint and indeed the continuing financial challenges within HSC.

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

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MICHELLE O'NEILL MLA
Minister of Health



Working for a Healthier People

Appendix B – Recommended Agenda for Change pay scales with effect from 1 April 2017

Recommended Agenda for Change pay scales with effect from 1 April 2017 – England

Point	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8				Band 9
								Range A	Range B	Range C	Range D	
1*												
2	15,404	15,404										
3	15,671	15,671										
4		16,104										
5		16,536										
6		16,968	16,968									
7		17,524	17,524									
8		18,157	18,157									
9			18,333									
10			18,839									
11			19,409	19,409								
12			19,852	19,852								
13				20,551								
14				21,263								
15				21,909								
16				22,128	22,128							
17				22,683	22,683							
18					23,597							
19					24,547							
20					25,551							
21					26,565	26,565						
22					27,635	27,635						
23					28,746	28,746						
24						29,626						
25						30,661						
26						31,696	31,696					
27						32,731	32,731					
28						33,895	33,895					
29						35,577	35,577					
30							36,612					
31							37,777					
32							39,070					
33							40,428	40,428				
34							41,787	41,787				
35								43,469				
36								45,150				
37								47,092	47,092			
38								48,514	48,514			
39									50,972			
40									53,818			
41									56,665	56,665		
42									58,217	58,217		
43										60,202		
44										63,021		
45										67,247	67,247	
46										69,168	69,168	
47											72,051	
48											75,573	
49											79,415	79,415
50											83,258	83,258
51												87,254
52												91,442
53												95,832
54												100,431

* Pay point not used in England (since April 2015).

Recommended Agenda for Change pay scales with effect from 1 April 2017 – Wales

Point	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8				Band 9
								Range A	Range B	Range C	Range D	
1	14,727#	14,727#										
2	15,097#	15,097#										
3	15,467#	15,467#										
4		15,900#										
5		16,332#										
6		16,764	16,764									
7		17,320	17,320									
8		17,953	17,953									
9			18,333									
10			18,839									
11			19,409	19,409								
12			19,852	19,852								
13				20,551								
14				21,263								
15				21,909								
16				22,128	22,128							
17				22,683	22,683							
18					23,597							
19					24,547							
20					25,551							
21					26,565	26,565						
22					27,635	27,635						
23					28,746	28,746						
24						29,626						
25						30,661						
26						31,696	31,696					
27						32,731	32,731					
28						33,895	33,895					
29						35,577	35,577					
30							36,612					
31							37,777					
32							39,070					
33							40,428	40,428				
34							41,787	41,787				
35							43,469					
36							45,150					
37							47,092	47,092				
38							48,514	48,514				
39								50,972				
40								53,818				
41								56,665	56,665			
42								58,217	58,217			
43									60,804			
44									63,651			
45									67,920	67,920		
46									69,860	69,860		
47										72,771		
48										76,329		
49										80,209	80,209	
50										84,091	84,091	
51											88,127	
52											92,357	
53											96,791	
54											101,436	

Pay point below 2017 Living Wage Foundation Living Wage.

Recommended Agenda for Change pay scales with effect from 1 April 2017 – Northern Ireland

Point	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8				Band 9
								Range A	Range B	Range C	Range D	
1	14,665*	14,665*										
2	14,947	14,947										
3	15,314	15,314										
4		15,742										
5		16,170										
6		16,598	16,598									
7		17,149	17,149									
8		17,776	17,776									
9			18,152									
10			18,653									
11			19,217	19,217								
12			19,655	19,655								
13				20,348								
14				21,052								
15				21,692								
16				21,909	21,909							
17				22,458	22,458							
18					23,363							
19					24,304							
20					25,298							
21					26,302	26,302						
22					27,361	27,361						
23					28,462	28,462						
24						29,333						
25						30,357						
26						31,383	31,383					
27						32,407	32,407					
28						33,560	33,560					
29						35,225	35,225					
30							36,250					
31							37,403					
32							38,683					
33							40,028	40,028				
34							41,373	41,373				
35							43,038					
36							44,703					
37							46,625	46,625				
38							48,034	48,034				
39								50,467				
40								53,285				
41								56,104	56,104			
42								57,640	57,640			
43									60,202			
44									63,021			
45									67,247	67,247		
46									69,168	69,168		
47										72,051		
48										75,573		
49										79,415	79,415	
50										83,258	83,258	
51											87,254	
52											91,442	
53											95,832	
54											100,431	

* Pay point adjusted to what we estimate to be the annual 2017 National Living Wage level. The Northern Ireland Executive should assure themselves that the value of the pay point will be compliant with the National Living Wage.

Appendix C – Composition of our Remit Group

- C1 Tables C1 to C7 show the composition of our remit group in each country and in the United Kingdom as a whole as at September 2015. Detailed categories of staff in each country have been aggregated into broad staff groups, to enable cross-United Kingdom comparisons to be made.
- C2 Staff categories used in each administrations annual workforce census have been grouped together by our secretariat. We have had to be mindful of the differences between the four datasets, and even these broad staff groups contain inconsistencies.

NHS full time equivalent non-medical workforce as at 30 September 2015

Table C1: Qualified nurses and midwives

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Qualified nurses, HVs and midwives	302,408	Nurses & midwives bands 5-9	43,085	Qualified nurses, HVs and midwives	22,146	Qualified nursing & midwifery	14,725	382,365

Table C2: Nursing, healthcare assistants and support staff

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Support to doctors, nurses and midwives	232,270	Nurses & midwives bands 1-4	15,838	Unqualified nurses	6,537	Nurse support staff	4,044	
				Healthcare assistants and support staff	9,753			
	232,270		15,838		16,290		4,044	268,422

Table C3: Professional, technical and social care

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Scientific, therapeutic and technical staff	127,921	Medical & dental support	1,836	Qualified AHPs	4,759	Professional & technical	7,345	
Support to ST&T staff	52,558	AHPs	9,972	Qualified healthcare scientists	1,866	Social services	6,855	
		Other therapeutic services	3,914	Other qualified ST&Ts	2,811			
		Personal & social care	1,001	Unqualified ST&Ts	2,535			
		Healthcare science	5,425					
	180,479		22,148		11,971		14,201	228,800

Table C4: Ambulance

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Ambulance staff	17,880	Emergency services	3,811	Qualified ambulance	1,428	Ambulance	1,070	
Support to ambulance staff	14,611			Unqualified ambulance	170			
	32,492		3,811		1,598		1,070	38,970

Table C5: Administration, estates and management

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Central functions	78,309	Administrative services	25,192	Clerical and administration	12,867	Admin & clerical	10,980	
Hotel, property and estates	50,244	Support services	13,828	Maintenance & works	959	Estates services	695	
Manager	20,290			Managers	1,339	Support services	4,638	
Senior Manager	9,259			Senior managers	559			
	158,101		39,019		15,724		16,313	229,158

Table C6: Other

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Others	3,970	Unallocated / not known	1,014	Others	108	Generic	0	5,092

Table C7: Total NHS non-medical workforce

	England	Scotland	Wales	Northern Ireland	United Kingdom
FTE	909,720	124,916	67,838	50,353	1,152,826
Headcount	1,042,948	146,644	79,926	58,658	1,328,176

Sources: NHS Digital, Welsh Government (StatsWales), Information Services Division Scotland, the Department of Health, Social Services and Public Safety Northern Ireland (HSC)

Appendix D – The parties’ website addresses

The parties’ written evidence should be available through the following links (correct as of 1 March 2017):

Department of Health	https://www.gov.uk/government/publications/information-for-the-nhsprb-pay-round-2017-to-2018
NHS Providers	https://www.nhsproviders.org/resource-library/submissions/nhs-pay-review-body-201718-pay-round-written-evidence-from-nhs-providers
Health Education England	https://hee.nhs.uk/sites/default/files/documents/NHSPRB%20Written%20Evidence%202017-18%20(Final).pdf
Joint Staff Side	http://www.csp.org.uk/documents/evidence-pay-review-body-2017-2018
NHS Employers	http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/NHSPRB%20%20FINAL%20sent%20to%20PRB%20201718.pdf
NHS England	https://www.england.nhs.uk/wp-content/uploads/2016/10/nhse-initial-evidnc-nhs-prb-2016.pdf
NHS Improvement	https://improvement.nhs.uk/resources/submission-nhs-pay-review-body-and-review-body-doctors-and-dentists-remuneration/
Northern Ireland Executive	https://www.health-ni.gov.uk/publications/workforce-policy-guidance-2016
Royal College of Midwives	https://www.rcm.org.uk/sites/default/files/Royal%20College%20of%20Midwives%20Evidence%20to%20the%20NHS%20Pay%20Review%20Body%20-%20September%202016.pdf
Royal College of Nursing	https://www.rcn.org.uk/professional-development/publications/pub-005803
Unison	https://www.unison.org.uk/content/uploads/2016/10/UNISON-NHS-PRB-Submission-2017-18.pdf
Unite the Union	http://www.unitetheunion.org/uploaded/documents/Unite%20evidence%20to%20the%20National%20Health%20Service%20Pay%20Review%20Body%202017-1811-28586.pdf
Welsh Government	http://gov.wales/topics/health/publications/health/reports/pay-review/?lang=en

Appendix E – Previous reports of the Review Body

Nursing Staff, Midwives and Health Visitors

First Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9258, June 1984
Second Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9529, June 1985
Third Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9782, May 1986
Fourth Report on Nursing Staff, Midwives and Health Visitors	Cm 129, April 1987
Fifth Report on Nursing Staff, Midwives and Health Visitors	Cm 360, April 1988
Sixth Report on Nursing Staff, Midwives and Health Visitors	Cm 577, February 1989
Supplement to Sixth Report on Nursing Staff, Midwives and Health Visitors: Nursing and Midwifery Educational Staff	Cm 737, July 1989
Seventh Report on Nursing Staff, Midwives and Health Visitors	Cm 934, February 1990
First Supplement to Seventh Report on Nursing Staff, Midwives and Health Visitors: Senior Nurses and Midwives	Cm 1165, August 1990
Second Supplement to Seventh Report on Nursing Staff, Midwives and Health Visitors: Senior Nurses and Midwives	Cm 1386, December 1990
Eighth Report on Nursing Staff, Midwives and Health Visitors	Cm 1410, January 1991
Ninth Report on Nursing Staff, Midwives and Health Visitors	Cm 1811, February 1992
Report on Senior Nurses and Midwives	Cm 1862, March 1992
Tenth Report on Nursing Staff, Midwives and Health Visitors	Cm, 2148, February 1993
Eleventh Report on Nursing Staff, Midwives and Health Visitors	Cm 2462, February 1994
Twelfth Report on Nursing Staff, Midwives and Health Visitors	Cm 2762, February 1995
Thirteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 3092, February 1996
Fourteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 3538, February 1997
Fifteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 3832, January 1998
Sixteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 4240, February 1999
Seventeenth Report on Nursing Staff, Midwives and Health Visitors	Cm 4563, January 2000
Eighteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 4991, December 2000
Nineteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 5345, December 2001

Professions Allied to Medicine

First Report on Professions Allied to Medicine	Cmnd. 9257, June 1984
Second Report on Professions Allied to Medicine	Cmnd. 9528, June 1985
Third Report on Professions Allied to Medicine	Cmnd. 9783, May 1986
Fourth Report on Professions Allied to Medicine	Cm 130, April 1987
Fifth Report on Professions Allied to Medicine	Cm 361, April 1988
Sixth Report on Professions Allied to Medicine	Cm 578, February 1989
Seventh Report on Professions Allied to Medicine	Cm 935, February 1990
Eighth Report on Professions Allied to Medicine	Cm 1411, January 1991
Ninth Report on Professions Allied to Medicine	Cm 1812, February 1992
Tenth Report on Professions Allied to Medicine	Cm 2149, February 1993
Eleventh Report on Professions Allied to Medicine	Cm 2463, February 1994

Twelfth Report on Professions Allied to Medicine	Cm 2763, February 1995
Thirteenth Report on Professions Allied to Medicine	Cm 3093, February 1996
Fourteenth Report on Professions Allied to Medicine	Cm 3539, February 1997
Fifteenth Report on Professions Allied to Medicine	Cm 3833, January 1998
Sixteenth Report on Professions Allied to Medicine	Cm 4241, February 1999
Seventeenth Report on Professions Allied to Medicine	Cm 4564, January 2000
Eighteenth Report on Professions Allied to Medicine 2000	Cm 4992, December
Nineteenth Report on Professions Allied to Medicine 2001	Cm 5346, December

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

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

NHS Pay Review Body

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

Appendix F – Abbreviations used in the report

A&E	Accident and Emergency
ALBs	Arm’s Length Bodies
AHPs	Allied Health Professionals
ASHE	Annual Survey of Hours and Earnings
BME	Black or Minority Ethnic
CCG	Clinical Commissioning Groups
CPI	Consumer Prices Index
CPIH	Consumer Price Index Housing
DETINI	Department of Enterprise, Trade and Investment in Northern Ireland
DH	Department of Health
DLHE	Destinations of Leavers from Higher Education Survey
EEA	European Economic Area
EEF	Engineering Employers Federation
ESR	Electronic Staff Record
EU	European Union
FFT	Family and Friends Test
FTE	Full-time Equivalent
GCSE	General Certificate of Secondary Education
GDP	Gross Domestic Product
HCAS	High Cost Area Supplements
HCHS	Hospital and Community Health Services
Health Departments	Department of Health; Northern Ireland Executive, Department of Health Scottish Government, Health and Social Care Directorates; and Welsh Government, Department of Health and Social Services
HEE	Health Education England
HMT	Her Majesty’s Treasury
HOMs	Heads of Midwifery
HSC	Health and Social Care
HSCIC	Health and Social Care Information Centre
HSCNI	Health and Social Care Information Centre Northern Ireland
IDR	Incomes Data Research
KSF	Knowledge and Skills Framework
LRD	Labour Research Department
LWAB	Local Workforce Action Boards
MAC	Migration Advisory Committee
NAO	National Audit Office
NHS	National Health Service
NMC	National Midwifery Council
OBR	Office for Budget Responsibility
OD	Organisational Development
ONS	Office for National Statistics
PEEP	Paramedic Evidence Based Education Project
RPI	Retail Prices Index

RRP	Recruitment and Retention Premia
STPs	Sustainability and Transformation Plans
ST&T	Scientific Technical and Therapeutic
UCAS	Universities and Colleges Admissions Service
wMDS	Workforce Minimum Data Set
WTE	Whole Time Equivalent

Appendix G – Workforce monitoring data

Last year, the NHSPRB set out the types of data needed to inform their pay deliberations, including consideration of targeting pay to address recruitment and retention pressures. We very much welcome the progress being made on the provision of better workforce data. This is critical to good decision-making in the health system, as well as to our consideration of pay recommendations and the merits of targeting. A large number of organisations collect and provide us with such information, for which we are grateful.

Several additional data needs have emerged during this round and Table G.1 summarises these. This is not an exhaustive list and we are increasingly interested in having these broken down by staff group, region, gender and age across all four nations.

Table G.1 – Data needs

Earnings of the Remit Group (Chapter 2)	Basic and total earnings. Trends in take home pay. Assessment of total reward.
Pensions (Chapter 2)	Pension membership rates by band.
Expenditure and Paybill data (Chapter 3)	Total health expenditure. Total non-medical paybill. Elements of paybill growth; including FTE growth, headline pay award and paybill per FTE drift. Source of efficiency savings and productivity improvements.
Agency and Bank (Chapter 3)	Agency spend. Bank spend. Information about the number of hours worked, type of work, pay rates and demographics. Comparative costs per head of employing permanent staff, bank staff and agency staff (including additional costs such as employer pension contributions and managing the bank).
Workforce (Chapter 4, 5, 6)	Evidence of workforce planning, including the detailed assumptions used to forecast supply and demand for staff. Potential impact of the decision to leave the EU and measures to mitigate the impact. Return to practice initiatives.
Shortfall and Vacancies (Chapter 4)	Vacancy and shortfall rates. Joining and leaving rates. Sickness rates.
Recruitment and Retention Premia (Chapter 4)	Evidence on the use of Recruitment and Retention Premia (RRP) payments.
Staff motivation (Chapter 5)	Regular staff surveys; including motivation, morale and engagement. Other relevant evidence on staff motivation (e.g. Friends and Family test).
Apprentices (Chapter 6)	Information about the use of apprentices, their pay, roles, use of the apprentice levy.
Living Wages (Chapter 7)	Calculations of the financial cost of implementing the National Living Wage or Living Wage Foundation living wage.

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