NHS Pay Review Body

# NHS Pay Review Body

# Thirty-Third Report 2020

*Chair:* Philippa Hird

CP 260


# NHS Pay Review Body

## Thirty-Third Report 2020

*Chair:* Philippa Hird

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

**Presented to the Welsh Parliament by**
**the First Minister and the Minister for Health and Social Services**

**Presented to the Northern Ireland Assembly by the First Minister,**
**Deputy First Minister and Minister of Health**

**July 2020**

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## NHS Pay Review Body

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

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

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

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

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

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

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

Members of the Review Body are:

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

The secretariat is provided by the Office of Manpower Economics.

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[1] References to the NHS should be read as including all staff on Agenda for Change in personal and social care service organisations in Northern Ireland.

[2] Anne Phillimore was appointed to the Review Body on 8 March 2020.

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# NHS PAY REVIEW BODY 2020 REPORT

## Executive Summary

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

**Our overall conclusions**

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

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

*Our remits*

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

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

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

*NHS context*

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

*The parties' evidence and our analysis*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*29 May 2020*

# Chapter 1 – Introduction

## Introduction

1.1 Our report this year has been completed against the uncertain background of COVID-19[3]. The effect of the response to COVID-19 on the UK economy, labour market and the NHS began to emerge after we had received our remits from the UK Government and Devolved Administrations, and after the parties submitted their evidence to us. While COVID-19 changed the context for this report, we have continued to consider the remits in our usual way, including longer-term trends in the data and information that support our evidence-based process.

1.2 The AfC pay agreements are now in place across each country in the UK and entered their final year in 2020/21. Therefore, we were not asked to provide pay recommendations. For England and Wales, we were again asked to monitor the implementation of the 2018 AfC pay agreements. Also for England, the Minister for Health asked for our observations on the role of Recruitment and Retention Premia, including the recruitment and retention of IT staff. We were not provided with a remit by the Scottish Government. In Northern Ireland, the AfC framework agreement was reached in February 2020 and the Minister of Health asked us for our views on the impact of the re-establishment of pay parity with England and Wales, and on factors specific to the Northern Ireland health and social care labour market.

1.3 Our report seeks to set out the ground as it relates to our standing terms of reference to enable a smooth return to making pay recommendations from 2021/22 onwards as determined by our remits.

## The context for the 2020/21 pay round

1.4 Many of the effects of COVID-19 and the UK Government's response are unknown at the time of this report. The Government has announced a number of significant measures to support public services and the economy. In the March 2020 budget, the UK Government provided an emergency fund for the NHS and other public services to tackle the pressures on health and social care services. The Government subsequently put in place mechanisms to expand the health and social care workforce. More widely to help the economy, the UK Government has introduced temporary measures to support businesses, employees and the self-employed.

1.5 The data and information to understand the short and long-term effects are not available for this report and might take some time to emerge. With that in mind, we have set out some potential implications of COVID-19 in relation to those matters which influence our remit. Our main focus is on the potential impact on the labour market and pay awards, followed by the impact on the economy, Government finances and affordability, and transformation of NHS services.

[3] Throughout this report the reference COVID-19 is used to refer to the Coronavirus (COVID-19) pandemic. See Office for National Statistics guidance available at: https://style.ons.gov.uk/category/coronavirus/writing-about-the-coronavirus/

*The labour market and pay awards*

1.6 There have been immediate effects on the NHS and its staff. Managing the healthcare response to COVID-19 has increased the workload and health risks for those both in the NHS and care sector dealing with COVID-19 patients[4]. There has been some redeployment of NHS staff and, in addition, the Government has introduced some temporary measures to support NHS staff and to manage the pressures on them. The impact of COVID-19 on the future levels and patterns of demand in the NHS are unclear and there are likely to be implications of these for our future assessments of recruitment, retention and motivation for AfC staff.

1.7 The full effects on the labour market are also unclear at the time of this report. There could be different impacts on the public and private sectors. The public sector offers more security of employment than the private sector, though those working in frontline services and support roles might feel more pressurised or at risk. Some workers in the private sector might have also experienced increased work pressures and risk, and some have been given temporary pay increases. Significant numbers of private sector employees have been furloughed and some made redundant, and therefore face uncertainty about their future pay and employment prospects. There are also emerging indications of cuts in executive pay and bonuses. In addition, there could be non-pay factors influencing the labour market which could bear on future recruitment, retention, morale and motivation of AfC staff. Evidence might also cover the impact of changes to the labour market on the pool of potential entrants to the NHS. We will monitor and assess the labour market indicators and comparative positions when further data is available.

1.8 The NHS has plans to fill the longstanding AfC workforce gap through initiatives to attract new entrants into AfC degree professions and to retain the existing workforce. The workforce developments in the expected NHS People Plan, and in the Devolved Administrations' workforce strategies, and the Government's target to increase the nursing workforce will need to be reviewed to reflect the short and long-term impacts of COVID-19. There could be a case to reassess demand and supply for the health and social care workforce, including the effects of temporary workforce measures. Such evidence might also cover the risks of relying on front-loaded workforce solutions, specifically the potential for a severe reduction in overseas recruitment.

1.9 The level of AfC pay increases for 2020/21 has been set under the current AfC pay agreements. For our future reports and for our expected return to making pay recommendations for 2021/22, we will consider the way in which COVID-19 has influenced prevailing labour market conditions and pay indicators across the economy. These conditions and further influences on private and public sector pay, including the direction of Governments' public sector pay policies, will feed into our future considerations alongside all the factors in our terms of reference.

*The economy, Government finances and affordability*

1.10 There is uncertainty over the length and shape of the UK Government's response to the current situation, and consequently uncertainty over the length and depth of the economic downturn and the nature of the bounce-back in the UK and the rest of the world. It is unclear whether there will be long-term scarring effects on economic conditions.

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[4] Office for National Statistics (11 May 2020), *Which Occupations have the Highest Exposure to the Coronavirus (COVID-19)*. Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/whichoccupationshavethehighestpotentialexposuretothecoronaviruscovid19/2020-05-11

1.11 The forecasts and scenarios for economic recovery are likely to be volatile for some time and we will need to assess the emerging impacts for our next round. In this regard, we look forward to receiving evidence on the way in which COVID-19 and the associated economic downturn might feed into the levels of Government expenditure on public services and into NHS budgets, which will be an important feature of our considerations on the affordability of AfC pay awards. We will also continue to review the short and long-term trends in economic indicators, which could cover the effects of changes in the level and pattern of future demand, business survival and the impact on employment levels, the viability of various international supply chains, labour market mobility and the convergent effect of the UK's exit from the EU.

1.12 The level of future health and social care budgets could also have implications for the funding available for implementing new service models under the NHS Long Term Plan and also for delivering the workforce developments expected to be set out in the NHS People Plan.

### *Transformation of NHS services*

1.13 The plans in the NHS for the transformation of services and the accompanying workforce developments are the backdrop to our considerations. COVID-19 has influenced the operation and management of the NHS. The response of the health and social care workforce has shown their flexibility in performing different roles in different ways with different processes, working in different health environments and continuing to manage high workloads. In future evidence, we would ask the parties to assess whether the response to COVID-19 has accelerated progress towards the objectives for transformation in the NHS Long Term Plan and similar transformation programmes in the Devolved Administrations. For instance, the evidence might provide insights into the tensions between a single system of demand for health and social care services, and the different sectors delivering the services, including the NHS, local authorities, the private sector and the third sector. We have identified some of the workforce and pay implications for the integration of health and social care, and across services within the NHS acute, primary and community care sectors, and we stand ready to contribute to further developments.

1.14 On a similar theme the NHS has experienced increasing levels of demand for services for many years and COVID-19 could have displaced other health and social care activity. Our future reports will look to assess the resulting effect on AfC staff of storing up demand for services from delayed treatment and, potentially, the increasing complexity in the health needs of the population, such as the impact on mental health. We comment throughout this report on the pressures on leadership capacity to deliver effective change programmes and future evidence might reflect any further pressures from the COVID-19 response.

## Our 2019 Report

1.15 We submitted our 2019 Report to the Prime Minister, the Secretary of State for Health and Social Care, the Minister for Health and Social Services in Wales, and the Permanent Secretary of the Department of Health, Northern Ireland on 22 May 2019. The Scottish Government did not provide a remit for 2019/20. We were not asked to make pay recommendations and our report therefore drew overall conclusions based on our terms of reference and initial observations on the implementation of the 2018 AfC pay agreements.

1.16 On 22 July 2019, the UK Government accepted our report and noted the observations on the 2018 AfC pay agreements. On 18 June 2019, the Permanent Secretary of the Department of Health, Northern Ireland wrote to us noting that the report would support future consideration and discussions with stakeholders over pay. On 6 September 2019, the Welsh Government confirmed that it had noted the report and its wider comments on evidence requirements for future reports.

## Remits for 2020/21

1.17 In England, Scotland and Wales the relevant AfC pay agreements were in place covering 2020/21. Following the restoration of the Northern Ireland Executive in January 2020, the Minister of Health made a statement on resolving the AfC staff dispute, which was followed by publication of the AfC draft framework agreement. This provided AfC pay offers for 2019/20 and 2020/21, which would bring Northern Ireland pay structures in line with England from 1 April 2020. The AfC framework agreement was accepted by the trades unions on 24 February, although it was rejected by the Northern Ireland Public Service Alliance. We comment in Chapter 4 on the progress implementing these agreements.

### *Minister of State for Health's remit letter*

1.18 The Minister for Health wrote to us on 5 November 2019 to commence the 2020/21 pay round. The Minister reiterated that over the period of the AfC pay agreement for England (2018/19 to 2020/21) we would not be asked to make any pay recommendations. The Minister asked us to monitor the implementation of the agreement and invited our observations on the evidence from the NHS Staff Council, NHS England and Improvement, and other parties on implementation. The Minister invited our observations on the role of Recruitment and Retention Premia (RRPs) and how they might support the recruitment and retention of staff. The Minister also asked for our observations on the potential for the greater use of RRPs on, but not limited to, the recruitment and retention of IT staff.

### *Scottish Government*

1.19 The Cabinet Secretary for Health and Sport wrote to us on 5 December 2019 to set out the Scottish Government's position for 2020/21. The Cabinet Secretary continued to be of the view that Scotland should focus on the implementation of the current pay agreement and the agreed reforms. The Cabinet Secretary therefore confirmed that Scotland would not be supplying a remit for the 2020/21 pay year.

### *Welsh Government*

1.20 The Minister for Health and Social Services wrote to us on 6 January 2020 to commence the 2020/21 pay round. The Minister confirmed that during the life of the 2018 AfC pay agreement the Welsh Government would not ask us to make any specific recommendations on pay. However, the Minister asked that we continued to monitor the implementation of the agreement and its impact.

### *Northern Ireland*

1.21 The Minister of Health wrote to us on 24 February 2020 to commence the 2020/21 pay round. The Minister noted that the Department of Finance had set out Northern Ireland's public sector pay policy for 2019/20 and, at the time of writing, an AfC draft framework agreement was out for consultation with trades unions. The Minister confirmed that Northern Ireland did not require any specific recommendations on pay, but would be most interested to have the Review Body's views on wider recruitment, retention and staff motivation factors specific to the Northern Ireland health labour market, which might highlight staff migration, recruitment deficiencies and key behavioural drivers. The Minister also welcomed views that the impact of re-establishment of pay parity, with England and Wales, might have in making Northern Ireland a more attractive destination in which to pursue a career in health and social care.

## Evidence submissions and visits

1.22 Our considerations are informed by the parties' written and oral evidence submissions and our analysis of a range of pay and workforce information. These are supplemented by our visits to NHS organisations and education providers.

### *Parties submitting evidence*

1.23 Between January and March 2020, the parties listed below submitted written evidence. Copies of written evidence are on the parties' websites[5]. We also held oral evidence sessions with specific organisations in February and March 2020. The parties from which evidence was taken are set out below.

*Government departments and NHS organisations*

- The Department of Health and Social Care for England
- NHS England and Improvement
- Health Education England
- The Welsh Government
- The Department of Health, Northern Ireland

*Employers' bodies*

- NHS Employers
- NHS Providers

*Bodies representing NHS Staff*

- The Joint Staff Side
- The Royal College of Midwives
- The Royal College of Nursing
- UNISON
- Unite
- GMB

### *Other pay and workforce information*

1.24 While we draw on the parties' evidence throughout our analysis in Chapter 4 of this report, we also collate published data and information on the NHS. This includes reports from external commentators providing wider analysis of issues relevant to our considerations. We supplement these with analysis of the latest economic and labour market indicators, and research commissioned by the Office of Manpower Economics.

[5] Links to the parties' websites are on the OME webpages at: https://www.gov.uk/government/publications/remit-letters-links-to-evidence-and-timetable-for-nhsprbs-2020-pay-round

*Our visits*

1.25 We conducted visits to NHS trusts and a university between June 2019 and November 2019. These visits help us to understand how management, staff and students view AfC workforce issues within their working environments. The visits are particularly useful in hearing first-hand views on pay arrangements and the way in which they relate to recruitment, retention and motivation. We are grateful to management, staff representatives, AfC staff and students that participated in these visits, and particularly those involved in their organisation. We visited the following NHS organisations and education providers:

- Mersey Care NHS Foundation Trust;
- Hywel Dda University Health Board;
- Royal Berkshire NHS Foundation Trust;
- Sherwood Forest Hospitals NHS Foundation Trust;
- Western Health and Social Care Trust, Northern Ireland;
- City University of London; and
- South Western Ambulance Service NHS Foundation Trust.

## Our overall approach

1.26 Our report for 2020/21 covers the final year of the current AfC pay agreements now in place across each of the four countries of the UK. These agreements, once fully implemented by the end of 2020/21, deliver the same AfC pay rates in England, Wales and Northern Ireland. The AfC agreement in Scotland mirrored the changes to the pay structure in other UK countries but AfC pay rates are higher than these other countries as a result of higher pay awards under the Scottish Government's public sector pay policy, including differential pay awards in 2018/19 and paying the Scottish Living Wage.

1.27 While we have not been asked to provide pay recommendations for AfC staff, we have continued to take the approach of assessing the evidence, data and information as they relate to our standing terms of reference. This approach ensures an evidence base, which prepares the ground for us to return to making pay recommendations from 2021/22 when the AfC pay agreements come to an end.

1.28 Our report therefore sets out the context of NHS developments relevant to our considerations of the AfC workforce (in Chapter 2), and then provides a summary of the parties' evidence submissions (in Chapter 3), before our analysis and conclusions (in Chapter 4). The latter includes the matters referred to us for consideration, namely (i) monitoring the implementation of the 2018 AfC pay agreements (specifically for England and Wales), (ii) our observations on the use of RRP and recruitment and retention of IT staff, and (iii) an assessment of the Northern Ireland health and social care labour market, and the impact of re-establishing pay parity with England and Wales.

# Chapter 2 – NHS Context

## Introduction

2.1 We aim to set out in this chapter the ongoing developments in the NHS which relate to our considerations on the AfC workforce. It covers published data and reports by external commentators on NHS finances and performance, service transformation, demand and quality of care, and the NHS workforce. We also set out the Government's announcements on finance and workforce measures in response to COVID-19. The developments in the NHS also feed into our analysis in Chapter 4 of this report.

## NHS finances

### *NHS E&I finance data*

2.2 Financial performance data for England[6] was available for the second quarter of 2019/20. NHS England and NHS Improvement (NHS E&I) reported the following:

- The total provider sector deficit was £1,067.7 million (with technical adjustments), which was £70.2 million or 0.2% above plan for this period;
- Total commissioning sector deficit was £239.1 million, which was £59.4 million or 0.1% above plan;
- The total combined position against the plan was a deficit of 0.2% by the second quarter of 2019/20. The outturn forecast for 2019/20 was a deficit of 0.1%;
- Total provider pay costs were £28,895.3 million, overspent by 1.0% which included a 2.4% overspend on medical staff, 0.4% on nursing staff and 0.7% on other staff. The outturn forecast for 2019/20 was an overspend of 0.8% in total employee costs; and
- Expenditure on agency staff was £1,194 million or 7.2% over the level planned, with expenditure on bank staff £1,832 million or 13.5% over the level planned. The outturn forecast for 2019/20 was for bank expenditure to be overspent by 8.9% but agency expenditure to be underspent by 1.0%.

2.3 In March and April 2020 extra funding measures were announced to assist the NHS in managing the response to COVID-19. The March 2020 UK Budget[7] provided an additional £34 billion per year by 2023/24 in addition to the NHS funding settlement, confirmed in the 2019 spending round which allocated £139 billion for health budgets in 2020/21. Following the budget, further financial measures were announced for the NHS, including the write-off of £13.4 billion of debt as part of a major financial reset for NHS providers[8]. In response to COVID-19, the NHS also announced £300 million for community pharmacies[9], including increasing workforce capacity.

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6 NHS E&I (December 2019), *Financial Performance Report Second Quarter 2019/20*. Available at: https://www.england.nhs.uk/publication/financial-performance-reports/

7 UK Government (March 2020), *Budget 2020.* Available at: https://www.gov.uk/government/publications/budget-2020-documents/budget-2020

8 UK Government (April 2020), *NHS to Benefit from £13.4 billion Write-Off.* Available at: https://www.gov.uk/government/news/nhs-to-benefit-from-13-4-billion-debt-write-off

9 UK Government (April 2020), *£300 million Announced for Community Pharmacies to Support them During Coronavirus Outbreak*. Available at: https://www.gov.uk/government/news/300-million-announced-for-community-pharmacies-to-support-them-during-coronavirus-outbreak

*NHS finances in the Devolved Administrations*

2.4 The total Scottish Government Budget[10] for 2020/21 was £50 billion within which the Scottish Government increased investment in health and care services by over £1 billion, taking the portfolio investment to over £15 billion. The Scottish Government said that this additional funding saw health resource and capital Barnett consequentials passed on in full, plus the allocation of more than £100 million over and above consequentials to support frontline spending. The Scottish Government commented that frontline health spending in Scotland was £136 per person (6.3%) higher than in England.

2.5 In Wales, the budget for Health and Social Care was £8.74 billion for 2020/21. This equated to a health and social services spend per person of more than £3,000, almost £300 more than in England. Three local health boards (of seven across Wales) failed to submit balanced financial plans for the current year and were expected to report a deficit at the end of 2019/20[11].

2.6 On 31 March 2020, the Northern Ireland Finance Minister made a budget statement for 2020/21, influenced by the response to COVID-19. The statement included that the Health and Social Care budget was £6.16 billion, an increase of 6.9% from the baseline, compared with an overall increase in departmental allocations of 8.1%.

*National Audit Office*

2.7 The National Audit Office's *NHS Financial Management and Sustainability Report*[12] covered the 2018/19 financial year (in England). Of particular interest to our considerations was the NAO's conclusion that there continued to be a risk that the NHS would be unable to use the extra funding from the long-term settlement optimally because of staffing shortages. We also note the NAO's view that NHS E&I continued to adopt a more joined-up approach to oversight but was still in a period of transition.

2.8 The NAO's main findings were that:

- NHS commissioners and trusts reported a combined surplus of £89 million, with financial balance only achieved with significant underspends by NHS England. Trusts reported a combined deficit of £827 million and Clinical Commissioning Groups an overspend of £150 million, which was offset by an underspend of £1,066 million by NHS England;
- Clinical Commissioning Groups failed to achieve financial balance and trusts were unable to contain their combined deficit to NHS E&I's ambition;
- Trusts were becoming increasingly dependent on short-term measures to meet financial targets – 31% of savings were one-off compared with 26% in 2017/18. The variation in the financial performance of trusts grew, with the percentage of trusts in deficit increasing from 43% to 46% in 2018/19. Some trusts continued to rely on short-term loans from the Department of Health and Social Care (DHSC) with little or no prospect of paying them back. The underlying reasons for the most financially challenged trusts were complex and not fully understood – the 10 worst-performing trusts had a combined deficit of £844 million representing 31% of the combined deficit of all trusts reporting a deficit;
- Trusts continued to struggle to make the capital investments needed to maintain the estate and support transformation; and

[10] Scottish Government (February 2020), *Scottish Budget 2020/21*. Available at: https://www.gov.scot/publications/scottish-budget-2020-21/pages/1/

[11] Welsh Government (March 2020), *NHS Activity and Performance Summary: January and February 2020.* Available at: https://gov.wales/nhs-activity-and-performance-summary

[12] National Audit Office (February 2020), *NHS Financial Management and Sustainability Report*. Available at: https://www.nao.org.uk/report/nhs-financial-management-and-sustainability/?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=

- The NHS had not yet fully achieved the vision in the Five Year Forward View and, while the NHS Long Term Plan had built on lessons learnt, the NHS might struggle to deliver all its commitments with the additional money available. (The Plan contained more than 500 general ambitions and more than 100 commitments.) Local partnerships continued to develop system working but still faced significant challenges to become sustainable and deliver the Plan. A lack of clarity persisted on key areas of health and care spending that were likely to affect the NHS's ability to deliver the Plan.

2.9 The NAO concluded that the NHS was treating more patients but had not yet achieved the fundamental transformation in services and finance regime needed to meet rising demand. The NAO said that the short-term fixes in place to manage resources in a constrained financial environment were not sustainable. The NAO added that that years of short-term funding decisions for the health sector meant that resources had moved away from areas of investment in the future, such as the workforce, public health and capital. The NAO said that this would need to be rebalanced to ensure that the ambitions set out in the NHS Long Term Plan were realised. To bring about lasting stability, the NAO considered that the NHS needed a financial restructuring programme not just a recovery programme. Finally, the NAO commented that if Integrated Care Systems (ICSs) were to be successful, funding mechanisms and incentives needed to support collaborative behaviours.

### *Audit Scotland*

2.10 Audit Scotland published its report on the *NHS in Scotland 2019*[13] in October 2019. Audit Scotland drew the following main conclusions:

- In 2018/19, the NHS Budget in Scotland increased in real terms by 1% to £13.4 billion and represented 42% of the Scottish Government's budget. The NHS was starting to address some of its financial pressures but risks remained with a number of NHS Boards predicting year end deficits;
- The healthcare system faced increasing pressure from rising demand and costs;
- The NHS faced significant workforce pressures and it was challenging to recruit enough people with the right skills, particularly in rural areas; and
- Progress had been slow on the integration of health and social care. Audit Scotland criticised the NHS workforce planning processes and workplace culture, and commented that not all Integrated Authorities had produced a workforce plan as these were intended to provide future information on supply and demand.

2.11 Audit Scotland's recommendations included: developing a new national health and social care strategy to run from 2020; developing and publishing the national, integrated health and social care workforce plan and guidance; improving the quality and availability of information, particularly in primary and community care; finalising and publishing, as a matter of urgency, the national capital investment strategy; reporting publicly on progress against the health and social care delivery plan; developing a single annual staff survey; and ensuring all NHS Boards actively promoted positive workplace behaviours and had action plans in place to improve culture.

[13] Audit Scotland (October 2019), *NHS in Scotland 2019*. Available at: https://www.audit-scotland.gov.uk/news/nhs-is-running-hot-and-needs-to-refocus-priorities

## Service transformation, demand and quality of care

### *NHS E&I performance data*

2.12 NHS combined performance data[14] for England was last published in February 2020 and showed:

- 2.11 million A&E attendances in January 2020, 0.1% more than in January 2019. Attendances in the 12 months to January 2020 were 4.3% higher than the preceding 12-month period. 81.7% of attendees were admitted, transferred or discharged within four hours – a 3.0% decrease on the equivalent figure for January 2019;
- 0.9% fewer emergency admissions in January 2020 than in January 2019. Admissions in the 12 months to January 2020 were up 3.4% on the preceding 12-month period;
- The mean average ambulance response times in December 2019 were 7 minutes 8 seconds for Category 1 and 21 minutes 5 seconds for Category 2. Both of these averages missed their respective standards of 7 and 18 minutes;
- A 15.0% increase in delayed days of transfer of care to 148,101 in December 2019, compared with December 2018. The proportion of delays attributable to the NHS in December 2019 was 60.6% (down from 61.5% in December 2018) and 30.3% attributed to social care (up from 29.9% in December 2018);
- The total number of completed Referral to Treatment pathways in the 12 months to December 2019 was estimated at 17.1 million, an increase of 2.7% over the previous year. 83.7% of patients on the waiting list at December 2019 had been waiting less than 18 weeks, therefore not meeting the 92% standard and compared to 86.6% at the end of December 2018. The total waiting list at the end of December 2019 was estimated at 4.6 million, an increase of 6.6% over the equivalent figure for December 2018;
- The number of diagnostic tests conducted at December 2019 increased by 4.4% on the preceding 12-month period. 4.2% of the patients waiting for one of the 15 key diagnostic tests at the end of December 2019 had been waiting six weeks or longer from referral, compared with the operational standard of less than 1%; and
- People seen following an urgent referral for suspected cancer in December 2019 increased by 9.6% or 207,422 more patients on the previous 12-month period. 91.8% of people in December 2019 were seen by a specialist within two weeks of an urgent GP referral for suspected cancer, compared to 93.7% at the end of December 2018. The operational standard specifies that 93% of patients should be seen within this time.

### *Performance data for the Devolved Administrations*

2.13 NHS Scotland met two of the eight national waiting times standards in 2018/19. The number of people seen on time increased for seven of the eight targets between 2017/18 and 2018/19. On the headline target of 95% of A&E patients seen within four hours, the number seen grew by 1.8%, but A&E attendances grew by 2.8%. The overall percentage seen within four hours was 91.2%. Inpatient experience of care suggested 86% had a positive experience in 2018, up from 84% in 2016. 30% of patients reported being delayed on the day of leaving hospital, down nine percentage points on 2016.

[14] NHS E&I (February 2020), *Combined Performance Summary*. Available at: https://www.england.nhs.uk/statistics/statistical-work-areas/combined-performance-summary/

2.14 In Wales[15], emergency admissions rose by 3% and total A&E attendances rose by 2.7% in the year to January 2020. Over the same period, 74.6% of A&E patients were seen within four hours against the target of 95%, a decrease of 2.6 percentage points on January 2019.

2.15 In Northern Ireland, there were six waiting time targets[16], two each for outpatients, inpatients and diagnostic tests, which target the proportion of patients that should be seen after 9, 26 or 52 weeks. None of the six were achieved as of December 2019. For example, the target was for 0% of outpatients waiting longer than 52 weeks for a first appointment and 36.7% of outpatients waited this long. On the target that 100% of urgent diagnostic tests were reported on within two days, 84.6% met the target at December 2019.

### *Quality of care*

2.16 The Care Quality Commission's (CQC) report on the *State of Health Care and Adult Social Care in England 2018/19*[17] concluded that most of the care across England was good and, overall, the quality was improving slightly. However, the CQC added that: people did not always have good experiences of care and faced difficulties trying to get care and support; sometimes people did not get the care and support they needed until too late and things had seriously worsened for them; and the struggle to access care was especially worrying when it affected people less able to speak up for themselves, such as children and young people with mental health problems or people with a learning disability. The CQC said that too often people chased around different services even to access basic support and, in the worst cases, ended up in crisis or with the wrong kind of care. The CQC viewed "the care given to people with a learning disability or autism not being acceptable".

2.17 The CQC's report drew on quantitative analysis of its inspection ratings of almost 32,000 services and providers[18], and a programme of primary qualitative data collection. As at 31 July 2019, CQC inspections showed that the proportions of NHS services rated as "good" were 90% of GP practices, 65% of NHS acute core services, 80% for adult social care services, and 71% for NHS mental health core services.

2.18 On "other types of care being under pressure", the CQC cited the continued increase in hospital waiting times, and the growing demand for elective and cancer treatments. In hospital emergency departments, performance had continued to get worse while attendances and admissions continued to rise. The CQC commented that what used to be a winter problem was happening in summer as well. It proposed "more and better community care services being needed" to help avoid crisis situations. The CQC said that there was a lack of prevention services, early stage or low-level support, community-based NHS services and social care.

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[15] Welsh Government (March 2020), *NHS Activity and Performance Summary: January and February 2020.* Available at: https://gov.wales/nhs-activity-and-performance-summary

[16] Department of Health, Northern Ireland (December 2019), *Northern Ireland Waiting Time Statistics: Summary as at December 2019.* Available at: https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-summary-december-2019

[17] Care Quality Commission (October 2019), *The State of Health Care and Adult Social Care in England 2018/19.* Available at: https://www.cqc.org.uk/publications/major-report/state-care?banner=

[18] CQC inspections covered: 22,949 adult social care services; 146 acute NHS hospital trusts; 244 independent acute hospitals; 71 independent and NHS community health providers or locations; 10 NHS ambulance trusts; 33 independent ambulance locations; 200 hospices; 55 NHS mental health trusts; 234 independent mental health locations; 6,706 GP practices; 1,033 dental practices; and 1,444 urgent care and out-of-hours GP services.

2.19 The CQC noted that to help "care services and organisations to work more closely together" leaders needed to have a more urgent focus on delivering care in innovative, collaborative ways. It reported having seen more evidence of joint commissioning approaches but these were not yet widespread. It said that where providers worked well together people's experience of care could be improved. The CQC called for "more room and support to be given for innovations in care" reporting that innovation was at the heart of some of the high-quality care seen, including technological or smarter workforce planning. Where innovation was happening, it was more likely to be driven and supported by individual leaders or the determined efforts of local services. The CQC had not yet found enough examples of joined-up thinking between commissioners and providers where new technology was central to improving the quality of care.

2.20 The CQC concluded that workforce challenges continued to affect the delivery of health and social care in all sectors. Issues included staff turnover, getting the right skill mix, and competition for staff when recruiting across the health and care community and with other industries. The CQC added that staff shortages could further increase the strain on the workforce.

2.21 Specific workforce issues raised in CQC inspections were:

- Hospitals and mental health care in and around London faced higher costs of living and pay disparities caused by the London weighting;
- Workforce issues were linked to funding constraints;
- Disparities in pay affected staff turnover, with competition between independent, agency, NHS services, care services and other industries affecting staffing levels;
- In adult social care, staff were affected by the lack of value given to social care by society and disproportionately low levels of pay considering skill and responsibility levels. To retain staff, providers were working with other providers to create career progression opportunities;
- Providers and system partners were adopting new approaches to tackle workforce issues, with more emphasis on retaining staff by investing in wellbeing and improving morale;
- Hospital providers had been working together to address staffing issues, including joint workforce plans, matching pay across services and introducing rotation posts;
- In mental health, providers were working with local universities to encourage young professionals into the sector;
- Responses to increased demand included developing new roles (including the potential offered by nursing associates) and an emphasis on upskilling existing staff;
- Providers in hospitals and mental health services were enabling staff to progress within services rather than leaving to develop their careers elsewhere, for example, training for nurses and healthcare assistants to take on additional duties, and sponsoring healthcare assistants to train as registered nurses;
- Services had been redesigned to make the best use of the range of skills and disciplines available – the CQC produced case studies[19] in June 2019; and
- There were examples of healthcare professionals from different sectors coming together to maximise capacity, and services adapting their existing staffing model to prevent unnecessary hospital admission and better to support timely discharge.

[19] Care Quality Commission (June 2019), *Effective Staffing Case Studies*. Available at: https://www.cqc.org.uk/publications/themed-work/effective-staffing-case-studies

2.22 In acute services, the CQC reported that staffing levels and pressures on staff time could impact on the quality of care. Service users suggested that limited capacity could mean that staff were not always able to identify and meet people's specific needs. Staff also had limited time and space to engage in quality improvement initiatives or to attend relevant training. The CQC reported that while some services were taking steps to mitigate staffing shortages, including using technology, difficulties recruiting and retaining staff continued to be a key issue. Shortages exacerbated other staffing challenges leading to more pressurised work environments and staff leaving the service, further contributing to staff shortages. The ability to recruit varied across the country, recruiting in and around London was particularly challenging. The reputation of hospitals, their CQC rating, and the culture and working environment could be barriers to recruitment. With the emphasis on retaining staff, there were examples of a greater focus on staff wellbeing, training, career development, and empowering staff, which supported staff morale and retention.

2.23 In mental health services, the CQC noted the fall in the total number of nurses over the last five years and that its inspections frequently identified problems relating to staffing. In community mental health, there had been a rise in the number of nurses but staff shortages had become more pronounced in the last year, affecting patients' access to care and creating longer waiting times. Staffing issues were a common concern in wards providing longer-term and highly specialised treatment and care for people with the most severe and complex problems. These concerns centred on: the staff skill mix not reflecting patient needs; a lack of registered learning disability nursing time with high numbers of healthcare assistants or other non-registered roles; staff not having adequate training; and difficulties recruiting and retaining staff. The increased use of agency staff could increase the workload of permanent staff (for example, in administrative duties) and leave less time to deliver patient-centred care.

## NHS workforce

### *Health Foundation*

2.24 The Health Foundation published its fourth annual NHS workforce trends report *Falling Short: The NHS Workforce Challenge*[20] in November 2019. The Foundation's analysis further highlighted the deeply embedded challenge of skills shortages in key areas of the NHS in nursing, GP services, and community and mental health services. It said that the effect of these shortages was increasingly felt through problems with access and quality, and that this was rippling out to other sectors, notably social care and the nursing home sector.

2.25 The Foundation said that its analysis of the nursing workforce reinforced that: the UK had relatively few new nurses graduating from higher education compared to other OECD countries[21]; in England, NHS nursing numbers had not changed markedly over the last few years; attrition during undergraduate nurse education continued to be persistently high; and there was a reliance on international recruitment. The Foundation commented that the continuing concerns about relatively low increases in student nurse numbers in England had become even more pronounced. The Foundation concluded that, without radical and concerted action in the forthcoming NHS People Plan, there was a very real risk that the additional funding committed to the NHS would not deliver tangible improvements in care.

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[20] Health Foundation (November 2019), *Falling Short: The NHS Workforce Challenge*. Available at: https://www.health.org.uk/publications/reports/falling-short-the-nhs-workforce-challenge

[21] The Health Foundation cautioned on the interpretation of international comparisons. In 2018, the UK was towards the bottom of the table with approximately 30 new nurse graduates per 100,000 population graduating each year (Section 3.2 of the Health Foundation report).

2.26 In analysing staff working in NHS hospitals, mental health and community services the Health Foundation observed that:

- 2018/19 saw the fastest rate of increase in the NHS workforce this decade, but there were marked variations for different groups. Over the past decade the proportion of the clinical workforce who were registered nurses fell. Over the past five years the number of FTE doctors had increased by 10% while the number of FTE nurses increased by just 3%;
- The skill mix change continued in 2018/19. The number of clinical support staff per FTE nurse had risen by 10% and clinical support staff to doctors, nurses and midwives increased by 2.6% compared to an increase in FTE nurses of just 1.5%;
- Changes in skill mix reflected changing patient needs, technological developments and legislative changes. However, skill mix changes were being introduced in an unplanned way in response to negative factors, such as cost pressures or recruitment difficulties, rather than positive drivers of improvement; and
- While the NHS was experiencing significant staffing pressures, the issues in social care were even greater and the outlook was concerning, with registered nurse jobs in adult social care decreasing by 20% since 2012. Skills for Care noted that this decline could be related to recruitment and retention issues, but also might be a result of some organisations creating nursing assistant roles to take on some tasks previously carried out by nurses.

*National Audit Office*

2.27 The National Audit Office published its report on *the NHS Nursing Workforce*[22] on 5 March 2020. The NAO had been awaiting the NHS People Plan but it decided not to delay its own report any longer. The NAO cited the key facts as: a 5% increase in overall nurse numbers in hospital and community health services between 2010 and 2019; 43,590 nursing vacancies between July and September 2019; and a 5% increase in students starting undergraduate nursing degrees between 2017 and 2019 compared with a target of 25%. The NAO also noted that there had been a 38% decrease in learning disability nursing numbers between 2010 and 2019. It said that 17% of the nursing workforce was from outside the UK (at March 2019). It also noted that there were an estimated 519,000 people registered to practice as a nurse in England with 320,000 NHS nurses (at September 2019).

2.28 The NAO commented that it had published several reports on workforce planning and supply, including coverage of the NHS, adult social care, the military and teachers. The NAO found common challenges in identifying the true workforce need, recruiting and retaining staff, underperformance of workforce initiatives, and managing the impact of shortages on existing staff. The NAO outlined the main challenges that the NHS People Plan must address and how these linked to the situation for nurses. These covered: accountability; workforce planning; workforce supply; and addressing short-term shortfalls.

2.29 The NAO's key findings for the NHS nursing workforce were:

- The NHS publicly acknowledged problems with current nursing shortages in 2017 (the Health Education England draft workforce strategy). There was a significant time lag before policies to train more new nurses could have an impact, meaning greater reliance in the short term on strategies such as overseas recruitment and improving retention;
- Despite increases, the NHS did not have the nurses it needed;

[22] National Audit Office (5 March 2020), *The NHS Nursing Workforce*. Available at: https://www.nao.org.uk/report/nhs-nursing-workforce/?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=

- The nature of the nursing challenge varied by trust and region. Nursing vacancy rates were particularly high for mental health trusts and in London;
- The NHS Long Term Plan set out service commitments for the additional funding settlement that did not include detailed plans to secure the workforce needed to deliver them;
- From 2017, the Government changed the funding arrangements for nursing degree students, a major source of new NHS nurses. The number of applications for nursing degrees dropped significantly following the funding changes and subsequent numbers of new students had been below DHSC's targets;
- The NHS Long Term Plan signalled the need for a step change in the recruitment of overseas nurses but recent national initiatives to increase numbers had not met targets;
- Trusts and universities said that there were financial and bureaucratic disincentives (such as not being able to use the levy for backfill costs) to increasing numbers through apprenticeship routes. There were 1,041 nursing degree apprentices in 2018/19 and a target of 7,500 nursing associates by March 2020. In 2018/19, NHS organisations spent less than 30% of their levy payments and universities considered that it was difficult to make apprenticeship courses sustainable;
- Since 2017, NHS E&I had supported trusts with an intensive retention support programme, with reductions in leaver rates for the first groups of trusts receiving support. Key issues identified by available data on reasons for leaving included career progression, health and wellbeing, and support for new starters; and
- NHS E&I and Health Education England (HEE) had brought together bodies from across the sector to produce a full NHS People Plan for the period up to 2025, but this had not been published as planned. While NHS England's budget was agreed up until 2024, this was not the case for HEE's budget, which covered workforce education and training. The NHS People Plan would detail new workforce-related roles for national, regional and local bodies, as well as responsibilities for delivery of the overall plan.

### *NHS People Plan*

2.30 Given the need for the Government and NHS to focus on managing the response to COVID-19, we understand that publication of the NHS People Plan (for England) has been delayed until later in 2020. Much of the parties' evidence for this report was influenced by their expectations of the Plan and this is summarised in Chapter 3 of this report. Our conclusions on the AfC workforce are in Chapter 4.

2.31 The NHS People Plan is expected to set out a framework for collective action on workforce priorities over the next five years and a full range of specific targeted actions. The Interim NHS People Plan aimed to implement the necessary steps if the NHS were to deliver the NHS Long Term Plan and was based on six themes: (i) making the NHS the best place to work; (ii) improving leadership culture; (iii) addressing urgent workforce shortages in nursing; (iv) delivering 21st century care; (v) a new operating model; and (vi) the immediate next steps to develop the full NHS People Plan.

### *NHS workforce announcements*

2.32 Ahead of the NHS People Plan, the Government and DHSC launched various initiatives and actions to support the NHS workforce. These were:

- The launch of the "We are the NHS" recruitment campaign[23] in 2019 highlighting the valuable and varied nursing roles available across the NHS;

[23] Health Education England, Health Careers. Available at: https://www.healthcareers.nhs.uk/working-health/we-are-nhs

- The Government's commitment[24] to deliver 50,000 more nurses by 2025 through a combination of increased supply, recruitment and retention. The Government also committed to a further increase of 6,000 primary care professional staff (over and above the additional primary and community care staff proposed in the Interim NHS People Plan); and
- From September 2020, financial support to nursing, midwifery and the majority of allied health profession students at university[25], with a £5,000 to £8,000 annual maintenance grant every year during their course.

2.33 In March 2020, plans were announced to expand the nursing and midwifery workforce to deal with the response to COVID-19. These were confirmed in a joint statement[26] issued by the Nursing and Midwifery Council (NMC), chief nursing officers, Council of Deans of Health, Department of Health and Social Care, Royal Colleges and trades unions. The actions were:

- Legislation to enable the NMC to establish a COVID-19 temporary emergency register, inviting those nurses and midwives who have left the register within the last three years to opt in should they wish to do so;
- Encouraging nurses and midwives currently on the register but not working in clinical care to consider coming into clinical practice;
- Changing the programme for undergraduate nursing and midwifery students so that they can opt to undertake their final six months of their programme as a clinical placement; and
- A further stage to the COVID-19 temporary register (as above) to establish a specific student part of the emergency register for students in the final six months of their programme, which would have specific conditions of practice to ensure appropriate safeguards are in place.

2.34 The NMC further announced[27] that two additional groups were also invited to join its COVID-19 temporary register. These were: overseas nurses and midwives who had completed all parts of their NMC registration process except for the final clinical examination; and nurses and midwives who had left the register within the last four and five years.

2.35 The Government also announced[28] that NHS staff would have their visas extended beyond October 2020. In response to COVID-19, around 2,800 doctors, nurses and paramedics would automatically have their visas extended, free of charge, for one year, where their visa was due to expire before 1 October. The extension would also apply to their family members. The Home Office also lifted the restriction on the amount of hours student nurses and doctors could work in the NHS. Also pre-registered overseas nurses currently required to sit their first skills test within three months and to pass the test within eight months would have this deadline extended to the end of 2020.

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[24] Conservative Party (November 2019), *Conservative Party Election Manifesto*. Available at: https://vote.conservatives.com/our-priorities/nhs

[25] UK Government (18 December 2019), *Prime Minister Backs NHS Staff with £5,000 Annual Payment for Nursing Students.* Available at: https://www.gov.uk/government/news/prime-minister-backs-nhs-staff-with-5000-annual-payment-for-nursing-students

[26] Nursing and Midwifery Council (19 March 2020), *NMC Joint Statement.* Available at: https://www.nmc.org.uk/news/news-and-updates/joint-statement-on-expanding-the-nursing-workforce/

[27] Nursing and Midwifery Council (2 April 2020), *Joint Statement on Expanding the Nursing and Midwifery Workforce in the COVID-19 Pandemic.* Available at: https://www.nmc.org.uk/news/news-and-updates/joint-statement-on-expanding-the-nursing-and-midwifery-workforce-in-the-COVID-19-pandemic/

[28] Home Office (31 March 2020), *NHS Frontline Workers Visas Extended so they can Focus on Fighting Coronavirus*. Available at: https://www.gov.uk/government/news/nhs-frontline-workers-visas-extended-so-they-can-focus-on-fighting-coronavirus

2.36 In April 2020 as a result of COVID-19, the Health Secretary announced a new, time-limited life assurance scheme[29] for frontline health and social care staff in England. The scheme was non-contributory and paid a £60,000 lump sum where staff died as a result of COVID-19. The scheme covered staff that provided hands-on care for people who had contracted COVID-19 or worked in health or social care settings where the virus was present. In the NHS, the scheme covered frontline staff employed by an NHS body or organisations that supported the delivery of NHS services or worked on an NHS contract, plus staff working in outsourced or subcontracted functions. In adult and children's social care, the scheme covered all staff employed in organisations registered by the CQC and those employed or engaged by local authorities, plus other organisations receiving public funding. Funding was also to be provided to Devolved Administrations to support similar schemes in Scotland, Wales and Northern Ireland.

2.37 In April 2020, DHSC published *COVID-19: Our Action Plan for Adult Social Care*[30] for England. Its approach focussed on: controlling the spread of infection; supporting the workforce; supporting independence, supporting people at the end of their lives, and responding to individual needs; and supporting local authorities and the providers of care. The Government had previously announced £1.6 billion of additional funding in March 2020 to support local government on COVID-19, which could meet some of the costs providers were facing and additional pressures on social care, as well as a further £1.3 billion for the NHS and local authorities to work together to fund the additional needs of people leaving hospital.

2.38 The Action Plan set out action to support the 1.5 million social care workforce in local authorities and the independent and not-for-profit sectors, together with five million unpaid carers. Actions included: testing for staff and families; supporting areas of workforce shortages (with further guidance expected); attracting 20,000 people into social care in the following three months and launching a recruitment campaign for the longer term; supporting 8,000 social care workers to return to the register; contacting occupational therapists to return; and use of volunteers not involving providing direct care.

2.39 The Scottish Government announced[31] that social care staff were to receive a 3.3% pay increase from 1 April 2020. Social care support workers providing direct adult support were to have their pay increased to at least the Living Wage rate of £9.30 an hour. In May 2020, the Welsh Government announced[32] that 64,600 care home workers and domiciliary care workers would receive a £500 cash bonus in Wales. The First Minister said that the payment was designed to recognise that residential and domiciliary staff were often accepting a greater degree of risk and responsibility. Further details of the extra payment were to be announced.

## Our conclusions on the context for the AfC workforce

2.40 We review the developments in the NHS to provide the context to our considerations on the AfC workforce in Chapter 4 of this report. These developments will be influenced by the impact of COVID-19 for later review, including the Government's initial response to support NHS finances and the workforce.

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[29] Department of Health and Social Care (27 April 2020), *New Guarantee on Death in Service Benefits for Frontline Health and Care Staff During Pandemic.* Available at: https://www.gov.uk/government/news/new-guarantee-on-death-in-service-benefits-for-frontline-health-and-care-staff-during-pandemic

[30] Department of Health and Social Care (15 April 2020), *COVID-19: Our Action Plan for Adult Social Care*. Available at: https://www.gov.uk/government/publications/coronavirus-COVID-19-adult-social-care-action-plan

[31] Scottish Government (12 April 2020), *Pay Rise for Social Care Staff*. Available at: https://www.gov.scot/news/pay-rise-for-social-care-staff/

[32] Welsh Government (1 May 2020), *First Minister Announces £500 Extra Payment for Care Staff.* Available at: https://gov.wales/first-minister-wales-announces-ps500-extra-payment-care-staff

2.41 In the meantime, the regular published data and reports from external commentators continue to show that the NHS faces challenges in delivering planned service changes while demand levels and financial pressures continue to increase. We have heard in evidence for this report that many trusts are focused on the immediate resources needed for services, which limits the capacity and resource to introduce longer-term service and workforce developments.

2.42 The uncertainty from COVID-19 could add to the existing risks identified in our earlier reports. These concerned the pace of delivering change and adequate funding for planned workforce developments. The CQC, NAO and the Health Foundation all reference concerns that the NHS People Plan needs to set out effective workforce planning systems in order to respond in a timely way to developing service need.

2.43 Integrated Care Systems need funding mechanisms and incentives to support collaborative working. The CQC also found that to work more closely together leaders needed an urgent focus on delivering care in innovative, collaborative ways. Progress under integration on workforce configurations and pay arrangements are a particular challenge highlighted in our recent reports and might require further impetus. We note that health and social care are two parts of the same system separated among other things by differences in the workforce and pay arrangements.

2.44 The scale of the AfC workforce gap has now persisted for a number of years and the gaps in nursing, particularly mental health and learning disability nursing, are widely acknowledged as a continuing pressure for the NHS. The CQC, NAO and Health Foundation all reported on the impact of staff shortages on existing staff and trust performance. We have seen emerging evidence of the way in which the workforce gap and high levels of vacancies affect staff working additional paid and unpaid hours, and the level of work-related stress, which feed into staff motivation and retention. The measures in the expected NHS People Plan will need to address these if the NHS is to close the AfC workforce gap through its planned short and long-term actions.

# Chapter 3 – The Parties' Evidence

## Introduction

3.1 In this chapter we set out a summary of the main points from the parties' evidence. The summaries follow the same structure as our analysis in Chapter 4 and broadly cover our terms of reference. The parties' evidence was submitted between January and February 2020 and where later data or information has become available we have set these out in Chapter 4. The full versions of the parties' evidence can be found on their websites.

3.2 COVID-19 changed the environment for our pay round and occurred after the parties had submitted written and oral evidence. While our approach is to continue with the evidence as submitted, much of the impact of COVID-19 on the economy, NHS services and the NHS workforce is, at the time of finalising our report, unknown.

## UK Government pay policy, economy and labour market

3.3 In April 2020, HM Treasury wrote to us confirming that, in the context of COVID-19, it would not be submitting economic evidence to the Pay Review Bodies in the normal way. HM Treasury asked that, despite the level of uncertainty, the Pay Review Bodies should take note of the changing economic situation as it emerged in forming their recommendations.

3.4 HM Treasury pointed to the measures to support public services and the economy during COVID-19, including: support to the NHS and other public services through a £5 billion emergency response fund; the Job Retention Scheme to help firms continue to keep people in employment; the Self-Employed Income Support Scheme to support self-employed individuals; and welfare measures.

3.5 HM Treasury said that the UK was facing significant economic disruption, but it expected the underlying causes to pass. The actions the Government had taken, along with measures taken by the Bank of England, were intended to ensure that the effects did not have a permanent "scarring" effect on the economy. HM Treasury commented that public sector pay rises should be responsive to the wider economic backdrop, which influenced recruitment and retention needs, and the Government's wider fiscal position. It expected a weaker labour market to benefit public sector retention, and increase the pool of available candidates for employment, making it easier to hit recruitment targets in some cases. It was not yet clear how the key economic indicators would evolve and therefore HM Treasury asked that the Pay Review Bodies paid attention to unemployment, average weekly earnings in the private sector and inflation as the economic situation changed.

3.6 HM Treasury said that public finances were well placed to deal with the challenges posed by COVID-19 but the impact on the economy and the Government's necessary response would lead to a significant increase in borrowing this year compared to the Office for Budget Responsibility's (OBR) forecast. HM Treasury expected this spike in borrowing to be temporary and for the medium term the impact on borrowing would likely to be limited. It added that the evidence on the affordability of pay awards set out in departmental evidence submissions remained its best current assessment of the position for public sector pay for 2020/21.

3.7 HM Treasury commented that public sector workers played a pivotal role in keeping the population healthy and safe, both during COVID-19 and in the future. It said that it was right that public sector workers benefitted from enhanced job security and stability, including at a time of economic uncertainty. It added that many also received other benefits, such as generous sick pay and flexible working arrangements. HM Treasury noted that inflation was 1.7% in the year to February 2020, lower than forecast a year ago, which meant that the public sector pay awards in 2019/20 were substantive real terms pay increases. HM Treasury asked that Pay Review Bodies take these factors into account when forming recommendations and added that the Government's principles used to agree pay awards remained unchanged by the outbreak. These were that awards should be: led by public sector productivity improvements, particularly when considering real terms rises; and funded from within existing budgets, which were set out in departmental evidence submissions. HM Treasury also asked that the Pay Review Bodies continued to refer to the Government and departmental recruitment targets in making their recommendations, albeit that COVID-19 introduced some uncertainty over staffing supply and demand.

3.8 In its evidence submission in February 2020, the **Department of Health and Social Care (DHSC)** reiterated that the Government's public sector pay policy aimed to ensure that the overall package for public sector workers helped deliver world class public services, which were affordable within the public finances and fair to workers and taxpayers as a whole. It added that the Government was taking direct action to increase the earnings of the lowest paid through the National Living Wage.

3.9 DHSC said that the Government's longstanding aim remained to ensure that the NHS could recruit, retain and motivate sufficient high-calibre staff to deliver government policy, ensure best value for the taxpayer and continue to deliver world-class patient care. DHSC considered that this was a complex matter of judgement, which included the overall impact of the NHS employment offer (pay and non-pay terms) in attracting and keeping the staff the NHS needed. DHSC said that this meant that the Government must strike the right balance as it developed the multi-disciplinary workforce it needed, through systems of reward that were affordable and fit for purpose.

3.10 The **Welsh Government** said that, since the EU referendum, GDP was estimated to be between one and two percentage points lower than would otherwise have been the case and that this was equivalent to £300 to £600 per person each year in Wales. It said that the severity of the impact would depend on the form that Brexit took and the dislocation associated with the process of leaving. It considered that Wales would be hit disproportionately by a "hard" Brexit.

3.11 The Welsh Government said that there were many forecasts published for the UK economy and in the short to medium term, the performance of the Welsh economy would be driven largely by the performance of the wider UK economy. It also said that the Bank of England forecast showed the UK economy growing at a moderate pace over the next three years and that the economy in Wales would likely follow a similar path.

3.12 The **Department of Health, Northern Ireland (DH, NI)** told us that economic growth was expected to remain subdued at around 1.3% in 2019[33] and to remain close to this rate over the next two years. It commented that the outcome of any agreed EU Exit scenario would weigh heavily on the future performance of the Northern Ireland economy and impact on future growth forecasts.

[33] Ulster University (June 2019), *Economic Policy Outlook.* Available at: https://www.ulster.ac.uk/__data/assets/pdf_file/0003/416667/UUEPC-Summer-2019-Economic-Outlook.pdf

3.13 The Department said that Northern Ireland's employment growth and improving unemployment figures had provided the key highlights for the labour market in recent years, however, longstanding structural challenges remained. It told us that 27% of all employee jobs were in the public sector in Northern Ireland, compared with 16.5% for the UK as a whole, and there had been a marginal increase of 1.0% in this proportion in 2019. The Department said that the proportion of public sector jobs was 8.1% below that in September 2009. The Department said that the unemployment rate in Northern Ireland was currently at its lowest rate on record at 2.5% (July – September 2019) and the lowest rate of all UK regions. However, it was noted that long-term unemployment remained a persistent structural problem, that Northern Ireland had the highest level of economic inactivity within the UK at 25.8%, and that the employment rate at 72.3% was ranked 11th out of the 12 UK regions.

3.14 The Department said that NI median gross full-time public sector employee earnings in April 2019 were £625 per week, representing an increase of 0.7% on April 2018, and slightly lower than the UK. It added that private sector earnings were 30.6% lower than public sector earnings in Northern Ireland and that private sector earnings experienced a 3.4% increase between 2018 and 2019.

3.15 The **Royal College of Nursing** (**RCN) Northern Ireland** welcomed the commitment in Northern Ireland to agreeing pay policy much earlier in the financial year. The RCN had highlighted the unacceptable tendency in previous years for pay awards not to be paid until February or March in the financial year to which they applied.

3.16 **GMB** argued that public sector pay was below comparable private sector rates and that official estimates demonstrated that public sector pay rates were uncompetitive. It added that, according to the most recent Office for National Statistics (ONS) modelling in 2017, public sector pay (including overtime and bonuses) was 5.7% below comparable private sector rates.

3.17 **Unite** believed that the staffing crisis in the NHS had been caused by Government funding and its pay policy, impacting on the service and forcing NHS staff to work in understaffed conditions. Unite said that the Government's pay policy had had a negative impact on staff morale and this could only be bad for the productivity and outcomes of the service as a whole. Unite added that the Government's pay policy had meant that dissatisfaction with NHS pay remained a serious concern, despite progress made in 2018. Unite stated that it was committed to ensuring that pay rounds in 2021/22 and onwards continued the process of restoring lost value and ensuring meaningful pay rises for all NHS staff. Unite added that the Government pledge to increase NHS funding by £34 billion per year by the end of the Parliament should be considered when evaluating the impact of the agreement and the future of pay within the NHS.

## Agenda for Change earnings and total reward

### *AfC earnings*

3.18 **DHSC** said that in 2018/19 average earnings growth[34] ranged between 0.9% and 5.4% across non-medical staff groups, with ambulance staff receiving the lowest growth and hotel, property and estates receiving the highest. DHSC considered that earnings growth for non-medical staff was in a good position when compared to broadly similar jobs in the rest of the economy. It noted that pay restraint had meant that overall earnings growth had been consistently lower than wider economy comparators in recent years, although public sector staff were shielded from the impacts of the financial crisis felt in the private sector.

[34] DHSC defined these as basic pay per FTE growth and additional earnings growth.

3.19 DHSC provided further analysis of non-medical pay as follows:

- In 2018/19, all staff groups saw increases in both total earnings (3.0%) and basic pay (3.3%). Within total earnings there was basic pay drift of 0.2%, with this positive effect offset by reduced use of additional earnings and a staff group mix effect of 0.1%;
- For 2018/19, the increase in basic pay for non-medical staff ranged from 2.3% and 6.0%, reflecting increased pay from reform and pay advancement;
- The proportion of additional earnings[35] varied by staff group – the highest was for ambulance staff, and the lowest for managers and senior managers;
- Over the past five years, all AfC pay bands had seen growth of at least 5.5%, with larger increases for the lower bands (up to 23.5%), while earnings in the wider economy had grown by 12.8%; and
- For 2019/20, outside London the AfC minimum hourly rate was £9.03 compared to the £9.00 recommended by the Living Wage Foundation. In inner London, the AfC rate was £11.28 compared to £10.55 recommended by the Living Wage Foundation.

3.20 DHSC commented that the 2018 AfC pay agreement would allow people to advance to the top of the pay band quicker than the previous system. It estimated that about half of staff would be at the top point of the pay band with a higher proportion of staff in the lower bands at the top. It calculated that between 10% and 24% of staff would be eligible for pay advancement (pay progression and promotion), with the higher proportions in Bands 5 to 7.

3.21 DHSC reported that data from NHS Digital showed that within staff groups there were small gender and ethnicity pay gaps in the non-medical workforce with average female basic pay around 6% lower than that of a male. It added that within staff groups these gaps tended to be smaller, for example, the difference in basic pay per annum for nurses and health visitors was only £30. DHSC concluded that there was a gender pay gap in all staff groups, and an ethnicity pay gap across all ethnicities, with black staff being the single group that had lower average pay than white staff.

3.22 **NHS England and NHS Improvement (NHS E&I)** said that a programme of work had been established to consider a coherent approach to reward and recognition, and the promotion of an equitable and accessible benefits package, which made the NHS the best place to work. NHS E&I considered that a valuable remuneration package was available, which was calibrated by: the trade-off between fair pay and the need to grow the workforce; the need to ensure that nominal salaries were broadly aligned with inflation; public sector pay, on average, being slightly higher than average private sector pay; the NHS pension scheme providing valuable benefits; the relative stability of public sector employment; and the wider investments that the NHS made in staff recruitment and retention. NHS E&I said that, despite moderation in public sector pay growth, public sector pay was competitive, and generally more insulated against macroeconomic conditions and public sector workers benefited from wider government measures to support wages, for instance following the 2008 financial crisis public sector workers were protected from the sharp drop in wages seen in the private sector.

3.23 The **Joint Staff Side** referred to ONS figures that showed that public sector pay (including overtime and bonuses[36]) was 5.74% below comparable private sector rates in 2017 (the latest year for which figures were available).

3.24 The **RCN** suggested looking ahead and supporting progress to achieve a meaningful pay rise for all nursing staff in the NHS.

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[35] DHSC defined additional earnings as comprising those from additional activity, geographical allowances, local payments, on-call, overtime, RRP, shift work and others.

[36] Excluding pensions.

3.25 The **Royal College of Midwives (RCM)** told us that the 2018 NHS Staff Survey showed a 4.2 percentage point increase in the number of midwives satisfied with their salary, with 28.9% stating they were satisfied, compared with 24.7% in 2017. It argued that these results suggested that the pay uplifts for AfC staff were a good step in the right direction, but that they did not make up for lost earnings over the period of pay restraint since 2010 and that satisfaction with salary was still lower than previous years.

3.26 **Unite's** 2019 survey of staff in the health sector indicated that: 58% were either dissatisfied or very dissatisfied with their level of pay, with only 21% expressing satisfaction; 60% of those on the top of their pay band expressed dissatisfaction compared with 57% not at the top; dissatisfaction tended to be higher for those in lower pay bands; and dissatisfaction with pay was higher for estates and maintenance staff, healthcare assistants, ambulance staff, mental health nurses, nurses, administrative and clerical, and ancillary staff. Unite noted that all regions showed similar patterns except Northern Ireland where dissatisfaction with pay was far higher at 78%.

3.27 Unite told us that a number of AfC job profiles had not been revised since 2004, while in many cases the roles attached to those profiles had evolved and developed. Unite supported a review of all AfC national job profiles as well as looking at a speedier process by which new profiles could be developed and approved.

3.28 **GMB** said that the value of NHS pay had been severely eroded since 2010 and against Retail Price Index (RPI), the trade unions' preferred measure of inflation, average real earnings had fallen by an eighth since the start of the pay constraint period. Even on the Government's preferred measure of Consumer Price Index (CPI), the real value of average earnings had fallen by 6%. GMB added that real terms erosion of wages had been most acute in ambulance services, where gross real pay had fallen by nearly a fifth reflecting, in part, a loss of access to overtime payments. GMB also commented that there was a perceived increase in the combination of various (and non-comparable) roles under the same pay bands, perhaps reflecting inadequate funding levels, which was a cause of resentment and dissatisfaction for staff.

### *Total reward and pensions*

3.29 **DHSC** said that its ambition for the NHS reward strategy remained that employers should develop their capacity and capability to:

- Utilise the NHS employment package to recruit, retain and motivate the staff they needed to deliver excellent services to patients;
- Develop and implement local reward strategies that met organisational objectives and workforce needs;
- Improve staff understanding of their reward package and what options they had to change aspects of it;
- Improve staff experience of working for the NHS;
- Contribute to improvements in workforce productivity and efficiencies in use of the NHS workforce pay bill; and
- Continue to be at the leading edge of innovation in public sector reward to help improve NHS staff satisfaction with pay.

3.30 DHSC told us that total reward was the tangible and intangible benefits that an employer offered an employee, and that it remained central to recruiting and retaining staff in the NHS. It said that there was some evidence that more employers across the NHS were developing a strategic approach to reward. DHSC added that Total Reward Statements gave NHS staff a better understanding of their benefits and provided personalised information about the value of staff employment packages, including remuneration details and benefits provided locally.

3.31 DHSC said it had commissioned the Government Actuary's Department (GAD) to analyse total reward across various private sector occupations, based on ONS data, and compared them against NHS staff for 2012 and 2018. DHSC told us that all NHS roles and private sector occupations experienced an increase in total reward over the period 2012 and 2018. DHSC added that a Band 5 nurse and Band 6 nurse saw a significant increase in total reward, at 15% and 13% respectively.

3.32 DHSC told us that the NHS Pension Scheme remained a valuable part of the total reward package available to the NHS workforce. GAD calculated that scheme members could generally expect to receive around £3 to £6 in pension benefits for every £1 contributed. DHSC said that transitional protections which allowed some members to remain in legacy schemes were to be unwound in light of the McCloud ruling.

3.33 DHSC said that scheme membership remained high across all staff groups and AfC bands, with typically 9 in 10 participating. Between 2011 and 2019, the proportion of NHS staff who were members of the Scheme increased by 5.5%, and increased by 0.7% in the 12 months to July 2019. It also said that participation increased for all bands up to, but not including, Band 7 where it had remained the same. Among the highest paid AfC bands, particularly management roles, the opt-out trends appeared to have continued. DHSC said it was reviewing recruitment and retention of high earners, where pension tax changes would be a factor. DHSC reiterated that it had commissioned the NHS Pension Scheme's Scheme Advisory Board to review the approach to member contributions in 2018. The Board concluded that the principles underpinning the current contribution structure should be retained and "cliff edges" in the contribution structure should be resolved.

3.34 **NHS Employers** stated that employers were emphasising the psychological contract between employer and employee. They considered that the challenge was to design an appropriate reward offer that would motivate staff not only in traditional hospital environments but also in new integrated, community-owned healthcare systems. NHS Employers said that since 2016 there had been a steady increase in staff viewing Total Reward Statements in the NHS, with a 30% increase in 2019/20. They noted that recognising how such a diverse workforce operated was key to designing communications strategies which effectively delivered up-to-date information on all aspects of the reward offer to staff at the same time. NHS Employers pointed to aspects of the reward offer being emphasised by employers as: staff health and wellbeing; financial education programmes; buying and selling annual leave; and salary sacrifice schemes.

3.35 On pensions, NHS Employers noted that overall scheme membership rose by 5.5 percentage points between 2011 and 2019. NHS Employers' 2019 survey of reward found that almost 85% of employers rated the NHS Pension Scheme as being "somewhat effective", "effective" or "excellent" in retaining staff, although this had fallen since the 2018 survey, which could indicate the impact of pension taxation. NHS Employers considered that the pensions taxation issues linked to the tapered annual allowance were having a major impact on senior clinical staff across the NHS. They said that if pension scheme flexibilities were introduced then they should apply to all staff in time for the 2020/21 financial year.

3.36 **NHS E&I** pointed to key areas for pension reform and flexibility were annual allowance tax and tapering, lifetime allowance and accrual flexibilities. NHS E&I added that they were supporting the Government in considering wider flexibilities through the recent consultation on the NHS Pension Scheme.

3.37 **Unite** informed us that current discussions regarding the NHS Pension Scheme were a concern and that due to delays to the implementation of benefit improvements only 7.5% of respondents to its survey thought the Government's approach to NHS pensions was fair.

3.38 **GMB** said that there was a widespread view that the value of pensions had been eroded while contributions had been hiked, cutting take-home pay and creating a barrier to progression. It said that staff could get promoted or receive an increment and be worse off with higher pension contributions. GMB was disappointed that more progress had not been made on a suitable remedy following the McCloud Judgement.

## 2018 AfC pay agreements – implementation and impact

*General*

3.39 **DHSC** commented that it had embarked on pay and contract reform across the NHS workforce as part of its ambition to make the NHS the best employer in the world providing the very best and safest care. It said that pay and contract reform was not just about headline pay uplifts. It added that the 2018 AfC pay agreement was designed to help increase productivity, to help improve recruitment and retention, and, through a range of pay and non-pay measures, to help improve staff engagement. DHSC cited the agreement as including supporting staff health and wellbeing, improving local performance appraisal processes and through that improving staff engagement, and improving the experience of those working in trust banks. DHSC said that staff satisfaction with pay had varied over time, with an improvement seen in the last year possibly due to the 2018 AfC pay agreement.

3.40 DHSC said that the benefits realisation work NHS E&I was leading would help trusts focus on the "something for something" nature of the AfC agreement to help ensure trusts realised the benefits of reform on the ground. DHSC added that it was important that the benefits were evidenced and measurable. It said that NHS E&I's work should ensure that the outcomes the NHS Staff Council and the Government expected were realised. NHS E&I was working with NHS Employers, the NHS Staff Council and DHSC to agree the most appropriate and measurable key performance indicators.

3.41 The **NHS Staff Council** provided an overview of its work on implementing the 2018 AfC pay agreement. The Council had set up several task and finish partnership subgroups to focus on work areas.

3.42 **NHS Employers** said that it was essential that NHS terms and conditions continued to keep pace with modern employment practice, to provide value for money and to make effective use of staff in the changing NHS system.

3.43 **NHS E&I** commented that the aims of the 2018 AfC pay agreement had the capability to generate operational and financial flexibilities, which had the potential to increase workforce productivity. NHS E&I noted that DHSC would be required by HM Treasury to provide assurance that the 2018 reforms and the anticipated operational flexibilities would lead to financial savings. They said that HM Treasury anticipated a return on investment through increased staff numbers as a result of effective recruitment and retention, reduced sickness absence, and reducing the cost associated with temporary staff, particularly agency workers. NHS E&I were leading the work to capture the benefits realised through the AfC reforms and the first analysis was scheduled for formal review at the end of the 2019/2020 financial year.

3.44 **NHS Providers** said that the implementation of the AfC agreement had seen a positive trend in NHS staff satisfaction with pay. They reported mixed views among trust HR Directors, with around a third agreeing that staff felt better paid than before the agreement, and a minority disagreeing. NHS Providers said that trusts had reported challenges around staff perceptions of the agreement, given some staff received smaller pay rises than they had anticipated and others were worse off in real terms due to crossing pensions contribution thresholds. They added that trusts had noted the impact on pay for different staff groups had been variable, with some groups receiving more significant pay rises than others. NHS Providers also reported that just 2% of trust leaders felt confident of receiving funding next year to cover AfC pay rises in spite of the uplift to NHS funding and no respondents were confident of receiving funding for 2020/21 and beyond. In oral evidence, NHS Providers said that the benefits of the agreement were somewhat mixed, but had brought stability and an investment in the workforce.

3.45 The **Joint Staff Side** commented that the ability to negotiate effectively at the local level was essential to ensuring the pay agreement provisions were implemented properly. They felt that building and improving this capacity would be greatly aided by regional and sub-regional levels. The Staff Side pointed to the 2018 NHS Staff Survey results showing a 5.1 percentage point increase in the proportion of staff satisfied with their salary. However, they said that the results did not capture where staff were within their pay bands, particularly whether staff were at the top of bands. The Staff Side said that the results suggested that the pay uplifts for AfC staff were a significant step in the right direction although the agreement did not make up for lost earnings over the period of pay restraint since 2010. They added that a number of detrimental features of employment in the NHS, such as the creation of wholly owned subsidiaries, outsourcing of services such as laundries and catering, and misuse of the core NHS contract particularly relating to job evaluation, meant that the pay agreement was less effective than it might otherwise have been.

3.46 On Northern Ireland, the Joint Staff Side said that full reform was only confirmed after the restoration of devolution and in response to industrial action, which caused serious damage to goodwill, trust and morale in the service. They added that much of the benefit of pay reform had been lost. However, the Staff Side said that the reasonably quick resolution of the dispute once power sharing had been restored could be seen as a statement of intent. They commented that if implementation of the pay reform were successful and without adverse incident there would be an opportunity to move on from recent poor industrial relations but that would be entirely dependent on HSC employers and the Department of Health acting in good faith and in partnership with trades unions. The Staff Side hoped that this marked a clear restoration of adherence to UK wide pay reform and future developments.

3.47 The Staff Side said that on the specific points in the Northern Ireland remit letter they had not seen enough material submitted to this round to support the Review Body drawing firm conclusions on recruitment, retention or staff motivation factors specific to the Northern Ireland health labour market, which might highlight staff migration, recruitment deficiencies and key behavioural drivers. The Staff Side's understanding was that these elements formed part of engagement between trade unions, employers and the Department of Health.

3.48 **UNISON** said that staff working for NHS wholly owned subsidiary companies and contractors delivering NHS services were a vital part of the NHS team. It had sought to secure the benefits of the pay agreement for this workforce. However, it said that the gap in pay rates for these staff was significant and growing, representing a real risk to service delivery. UNISON concluded that the spate of disputes this situation had provoked had been distressing and disruptive for staff, patients and services.

3.49 **Unite** said that the 2018 AfC pay agreement was a starting point on a pay journey for NHS staff and that it did not reverse the impact of eight years of pay caps and freezes in the NHS, and that in 2021 further increases would be necessary. Unite remained extremely worried by the fragmentation of the AfC agreement as pressures from political devolution, government under-funding, and the impact of outsourcing of NHS staff and services had contributed to the development of four distinct NHS pay spines. It said that both Unite and the Joint Staff Side had stressed on numerous occasions that there should be one single pay system across the NHS to prevent recruitment and retention issues across the four UK countries.

3.50 **GMB** said that the 2018 AfC pay agreement was flawed, inadequate and overly complex. It said that significant issues had been encountered during implementation and the agreement had had particularly negative consequences for NHS workers who were at the top of their pay band, and/or those who work in ambulance services. GMB also commented that privatisation, including outsourcing, was undermining the NHS ethos and causing disillusionment for staff. GMB pointed to research it had commissioned which found that since 2015 two-thirds of NHS contracts identified as outsourcing[37] had been won by private providers.

3.51 The **RCN Northern Ireland** said that, although the Health Minister's framework on pay parity provided AfC pay increases for 2019/20 and 2020/21 as well as a refresh of the incremental AfC system, there remained significant issues for the Department of Health and HSC employers to address. It added that it was essential that the recent agreement was embedded without delay but that the Minister's framework commitments on safe staffing and pay parity needed time to be implemented, take effect and be evaluated before any further markers were put down by the Department of Health in relation to future pay awards.

3.52 The RCN Northern Ireland told us that while restoring pay parity with England could and must be achieved comparatively quickly, its impact upon recruitment and retention would take some time. The RCN was committed to holding the Department of Health and the Northern Ireland Executive to account for this implementation but, in the interim, the circumstances that led to RCN members taking industrial action persisted.

### *Progression*

3.53 **DHSC** said that the key elements to the reformed contract included an end to virtually automatic incremental progression. It added that to move to the next pay point staff were required to demonstrate or show that they had met the requirements of their role. In oral evidence, DHSC said that the main output of the agreement had been the move away from automatic progression to a discussion between line managers and employees on performance and skills, which now had a direct link to pay. It added that the aim was to improve performance not to hold back pay.

3.54 The **NHS Staff Council** reminded us that new arrangements applied to all new starters and anyone promoted from 1 April 2019. Existing staff continued with their current progression arrangements until the end of the three-year agreement at which stage the new arrangements would apply. The Council commented that a new Annex was published (to the NHS Terms and Conditions of Service Handbook) alongside a range of material about the new progression system. It added that discussions were set to resume with the expectation that guidance on re-earnable pay in Bands 8c, 8d and 9 would be in place by March 2020.

[37] GMB stated that these were listed on Gov.uk Contracts Finder service and through Tenders Electronic Daily.

3.55 **NHS Employers** emphasised that the 2018 AfC pay agreement provided opportunities for employers to increase workforce productivity through stronger, evidence-based staff appraisals. NHS Employers cited the results of the 2018 NHS Staff Survey which saw year-on-year increases in staff support from line managers and quality of appraisals.

3.56 **NHS Providers** said a minority of trusts (30%) were still experiencing difficulties implementing aspects of the AfC agreement, many of which related to the roll out of self-service electronic staff records (ESR), and manual implementation of pay steps where ESR was not in place. NHS Providers told us that trusts considered that it was still too early to determine the effect of the link between appraisals and pay progression, with many still in the process of aligning appraisals and pay progression, and they expected to see the impact next year.

3.57 The **Joint Staff Side** said that it was more than a year to the first wave of pay step reviews. However, they said that data from the Workforce Race Equality Standard (WRES) showed that there continued to be racial disparities in the likelihood of staff being subjected to disciplinary proceedings. They said that BAME staff being more likely to face proceedings had put them at higher risk of receiving a sanction. The Staff Side concluded that this created a risk that decisions about pay step progression could compound racial inequality. They said that, before decisions to delay pay progression based on disciplinary sanctions could be made safely, racial disparities within disciplinary processes must be eliminated. In oral evidence, the Staff Side said that the move to mandatory and more meaningful appraisals would help to enable mandatory training and staff development.

3.58 The **RCM** reported that results of the Heads of Midwifery (HOMs) survey showed that only 44% were able to carry out appraisals with "all staff" and 18% did not feel confident in the process. The RCM considered that there was a potential equality impact risk with the new pay progression arrangements. It argued that having a formal live disciplinary action on record was one of the reasons that pay progression could be withheld. It stated that data from the Workforce Race Equality Standard showed that despite some improvement Black and Minority Ethnic staff were still more likely than white staff to enter the formal disciplinary process.

3.59 The RCM said that the results of its 2019 HOMs survey were worrying, given that the completion of mandatory training was one of the requirements for pay progression. Nearly one quarter (22%) of HOMs said that some mandatory training was provided during working hours, a significant increase on 2018. HOMs reported that the number of midwives and midwifery support workers (MSWs) having to pay for their own mandatory training had also increased. Only 7% of HOMs said that NHS trusts pay for some mandatory training and the RCM considered it unacceptable that any member of staff should have to pay for their own mandatory training. The RCM said that access to Continuing Professional Development (CPD) was even more of a challenge: 85% of HOMs saying that only some CPD was provided during working hours; 10% of employers had not paid for any CPD; and 31% of HOMs had to reduce training in the last twelve months.

### *Transition from Band 1 to Band 2*

3.60 The **NHS Staff Council** said that following the closure of Band 1 to new entrants in 2018 its task and finish group was managing the process of moving existing staff to Band 2. Its group had produced guidance, encouraged trusts to hold workshops and worked on job evaluation advice. The Council commented that due to the large numbers of Band 1 staff in some organisations the choice exercise had been staggered.

3.61 **NHS Employers** said that some employers still had some work to do to fully complete the migration of staff to Band 2 roles, which was mainly organisations with large numbers of Band 1 posts. NHS Employers were supporting these organisations and passing on good practice from those that had successfully completed this work.

3.62 The **Joint Staff Side** were concerned that progress on Band 1 to Band 2 was patchy with pockets of staff in some trusts not taking up the offer in the numbers expected. They added that some staff had been deterred by general concerns about the effects on in-work benefits and by poor local management behaviour. The Staff Side suggested that in some trusts high profile disputes about abandoned plans to transfer Band 1 staff into wholly owned subsidiary companies had left a legacy of staff no longer having trust in managers' intentions.

### *Apprenticeships*

3.63 The **NHS Staff Council** reported that, after extensive negotiations on apprenticeship pay, it was unable to reconcile the Employers Side need for an affordable and flexible outcome with the Staff Side need for a fair and equality-proof solution. Options explored included: graduate pay; an "in principle" approach to graduate pay; post-graduate pay; and Band 2-4 pay. It concluded that the current constraints on funding and the lack of levy funding flexibility to support backfill costs had limited the Council's ability to reach a national agreement on apprenticeship pay.

3.64 **NHS Employers** said the parties concluded that it would not be possible to reach an agreement on apprenticeship pay given competing priorities.

3.65 **UNISON** said it was deeply disappointed that an agreement on apprenticeships could not be reached in the NHS Staff Council as it believed that a fair and consistent pay framework was a vital requirement for the NHS to truly maximise the potential offered by the apprenticeship agenda.

### *Leave arrangements*

3.66 The **NHS Staff Council** said that new occupational shared parental leave provisions and new child bereavement leave provisions had been incorporated into the handbook from 1 April 2019.

3.67 The NHS Staff Council reported that DHSC had clarified the mandate for agreeing an optional framework on buying and selling leave. The Council were not able to agree on the rates for which annual leave should be sold but did produce a set of good practice principles to ensure that staff health and wellbeing was protected within local policies.

3.68 **NHS Employers** commented that many employers already had successful local systems in place and the creation of a national framework would restrict the operation of existing systems and the design of new systems.

3.69 **Unite** suggested that all NHS staff should get 33 days paid leave as well as the statutory holidays after 10 years' service, 34 days after 15 years' service and 36 days after 20 years.

### *Bank and agency working*

3.70 The **NHS Staff Council** said that, to explore the potential for a collective agreement on bank and agency working, it had issued a survey to all English trusts to gather the basic data to undertake discussions.

3.71 **NHS Employers** said that the survey would enable them to explore the scope for a collective agreement on bank working to encourage staff to offer time to banks. NHS Employers noted that NHS E&I had published a toolkit to help employers maximise the use of staff banks.

### *Ambulance staff*

3.72 **NHS Employers** pointed to the Ambulance Improvement Programme Board which continued to monitor progress in ambulance workforce development.

3.73 **GMB** said the closure of Annex 5 to new entrants had had a serious effect on ambulance staff. It said that staff reported that the transition to inferior Schedule 2 terms and conditions for unsocial hours payments for workers who change contracts was a source of significant tension that was having a negative impact on retention.

### *Priorities for 2020/21 and at the end of the pay agreement*

3.74 The **NHS Staff Council** pointed to the priorities for 2020/21 as exploring a bank and agency framework, and agreeing guidance on taking annual leave and Time Off In Lieu. The Council would also be reviewing monitoring data to ensure the agreement was being implemented as expected and that any equality impact was taken into consideration. At the end of the pay agreement, the Council would consider what priority to attach to refining the pay structure, specifically: the value of gaps between pay bands; reviewing mid-points and the jumps between steps; and the time between step points in Bands 8 and 9.

3.75 Given workforce challenges, **NHS Employers** saw it as essential to provide certainty on pay and would welcome discussions on a further multi-year pay deal. They cited the report *Closing the Gap* by the King's Fund, Health Foundation and Nuffield Trust which concluded that pay must continue to at least keep up with inflation and with pay growth in the rest of the economy. NHS Employers said that pay must always be considered in the context of long-term objectives, the future system and service operating model, and their supporting reward and workforce strategies. They added that the pressures of meeting increased demand and delivering efficiency savings meant that employers would not wish to be burdened with unfunded commitments which created additional financial pressure. NHS Employers suggested issues for further consideration included the size of steps between pay points, the numbers of steps and compression at the bottom of the pay spine.

## Service transformation, integration and productivity

3.76 **DHSC** commented that the context for considering the evidence on recruitment, retention and motivation was the NHS Long Term Plan, particularly the affordability assumptions and the importance of making planned workforce growth affordable. DHSC noted that demand for NHS and social care services continued to rise due to, among other things, an increasingly aging population with multiple and complex care needs. It considered that meeting this demand while maintaining and improving quality, and maintaining affordability, was one of the system's significant challenges.

3.77 DHSC commented that demand for services continued to rise above what would be typically expected from population growth and demographics alone, and that to meet this demand the NHS continued to deliver more activity than ever before. DHSC cited 5.9% more emergency admissions per day and 2.0% more elective care pathways completed per working day in 2018/19 compared to the year before. DHSC concluded that, despite the best efforts of the NHS, many of the core waiting time and access targets were not achieved during 2018/19, partly due to the increasing demand pressures on frontline services. It said that the long-term funding settlement reflected the Government's support to mitigating demand pressures.

3.78 DHSC said that patients, and their experience of care, must be at the heart of everything that the system did. DHSC wished to ensure that the NHS could continue to deliver world-class patient care, putting patients first and keeping them safe while providing the high quality care we all expected. It considered that to achieve this required the right balance between pay and staff numbers through systems of reward that were affordable and fit for purpose.

3.79 On productivity, DHSC noted that the NHS Long Term Plan committed to making re-investable productivity gains of at least 1.1% a year over the next five years. The measure of labour productivity used for the NHS was developed by the University of York (Centre for Health Economics) which showed that between 2005/06 and 2015/16 the NHS's average annual labour productivity growth was 2.5% and, over the same period, the average annual total factor productivity growth was 1.2%. DHSC said that the programmes to deliver the required productivity improvements built upon the 10 Point Efficiency Plan, which included: the Operational Productivity Programme; Getting it Right First Time; and other improvement initiatives, such as RightCare.

3.80 DHSC commented that during 2018/19, providers achieved efficiency savings through Cost Improvement Programmes of £3.2 billion or 3.6%, while commissioners' Quality, Innovation, Productivity and Prevention Plans delivered £3.0 billion savings. The Carter Review identified a savings opportunity in the provider sector across specific work programmes over five years, which DHSC said had helped deliver £1.18 billion in recurrent Cost Improvement Programmes in 2018/19. DHSC added that progress had been made reducing spending on agency workers to £2.4 billion in 2018/19 compared with £3.6 billion in 2015/16.

3.81 **NHS Employers** told us that the NHS Long Term Plan set the future direction for the NHS based on a new service model, which placed more emphasis on prevention and health inequalities, improving the quality of care and health outcomes, and harnessing technology. The aim was to deliver integrated health and care focused on population health with greater investment and focus on community, primary and mental health services. NHS Employers felt that these measures were essential to improve care for patients, reduce pressure on hospitals and other services, and to put the NHS on a sustainable path in the face of rapidly rising demand. They noted that Primary Care Networks were a key part of the NHS Long Term Plan and would receive funding for new roles, such as clinical pharmacists, social workers, physiotherapists, physician associates and paramedics. NHS Employers commented that these developments gave employers and staff new opportunities for more varied work placements in a greater variety of settings, which would promote career development and support retention.

3.82 NHS Employers cited the Plan as reducing demand for acute care through better integration and prevention. However, they pointed to only one in four respondents to an NHS Confederation Survey believing that their local health systems would significantly reduce the rate of growth in acute activity as a result of the Plan.

3.83 NHS Employers noted that, among other things, the Plan depended on cash-releasing productivity growth of at least 1.1% per year, with all savings reinvested in frontline care. NHS Employers viewed productivity savings at this level as a challenge given that acute hospitals had seen the amount of care increased by 3.0% a year on average between 2010/11 and 2016/17. They also cited the Health Foundation's projections that, without any improvement in the quality and range of services, acute and specialist hospital activity would need to increase by 2.7% a year over the next five years just to keep pace with demand. They added that the additional funding announced as part of the NHS Long Term Plan allowed for activity growth of up to 2.3% a year.

3.84 NHS Employers said that the growth of the NHS workforce had lagged well behind the growth in activity. They noted that, while output (including the number of operations, consultations, diagnostic procedures and A&E visits) grew by almost a quarter between 2010/11 and 2016/17, the number of nurses grew by less than a tenth of that for output. Despite the acute workforce challenge and rising demand, NHS Employers cited the Care Quality Commission's 2018/19 Report on the state of care which found that most of the care across England was good quality and, overall, that the quality was improving. In oral evidence, NHS Employers commented that increasingly the peaks of demand for services during the winter were becoming the norm for the remainder of the year.

3.85 The **Welsh Government** told us that, before the financial crisis, labour productivity had increased at an annual rate of 2.3% but since then had averaged an annual growth rate of 0.4%. It added that this year there would likely be no growth in productivity at all and only weak growth was expected in the next three years.

3.86 The **Department of Health, Northern Ireland** told us that the 10-year approach to transforming health and social care was under "Health and Wellbeing 2026: Delivering Together". The Department said that the current 20th century configuration of health and social care services was "unsustainable" and could not meet the needs of a growing and ageing 21st century population. It pointed to the Transformation Fund of £200 million from 2018/19 which aimed to cover: tackling elective care waiting lists; supporting services in primary care; workforce developments; reforming hospital/community services; building capacity in communities and prevention; and enabling transformation. The Department outlined the programme highlights, including multi-disciplinary teams in primary care, elective care centres, waiting list initiatives, and consultations on breast assessment and stroke services, enabling transformation.

3.87 **RCN Northern Ireland** said that the process of transformation had been undermined by an *ad hoc* approach to planning and budgeting. It added that transformation was viewed as an isolated series of "projects" rather than as a strategic system-wide refocusing and there had been a failure to underpin transformation by appropriate workforce planning. It said that transformation required a significant expansion of the specialist community nursing workforce to deliver the district nurses, school nurses, health visitors and community mental health nurses, for example, who would deliver the new public health-focused early intervention and prevention services.

## NHS affordability and efficiency savings

3.88 **DHSC** said that the Government set out the new funding settlement for the NHS in return for agreeing the NHS Long Term Plan setting the course for the NHS for future years and allowing the NHS to plan with funding certainty. The funding provided an additional £33.9 billion cash terms annual increase by 2023/24 compared with 2018/19 budgets.

3.89 DHSC emphasised that more funding put towards pay would mean less funding for other priorities, including the size of the workforce that was affordable, as well as investments required to deliver the NHS Long Term Plan. DHSC said that it had not lost sight of the need for pay discipline to ensure sustainability, and that the 2018 AfC pay agreement had been done on a "something for something" basis, additional pay investment in return for contract reform which had productivity benefits. DHSC provided information for 2018/19 which showed that 45.9% of NHS Revenue Expenditure was spent on NHS staff and that the increase in provider spend on permanent staff was 5.35% compared to the 4.7% increase in total expenditure.

3.90 DHSC noted that the Spending Round 2019 also confirmed a 3.4% real terms increase to the Health Education England budget for 2020/21, including an additional £150 million for Continuing Professional Development and £60 million for wider education and training budgets to support delivery of the NHS Long Term Plan and the NHS People Plan.

3.91 DHSC said that the Government's mandate to the NHS included a clear objective for the NHS to balance its budget and that recovering finances in the NHS continued to be a major focus. DHSC considered that its approach had been broadly successful in stabilising finances across NHS providers with the majority of trusts demonstrating strong, effective and sustainable financial management. However, DHSC acknowledged that NHS providers were experiencing greater than expected financial pressures, with the main pressure continuing to be increasing staff costs driven by growing emergency patient numbers. It said that for the third consecutive year the NHS had delivered financial balance but it recognised that this was not sustainable. DHSC pointed to the plans to achieve financial sustainability in the NHS Long Term Plan with a new financial framework.

3.92 **NHS Employers** told us that the 2019 Spending Review, provided the basis for a five-year funding programme up to 2024/25. They said that the NHS continued to feel the combined effects of rising demand, workforce shortages and financial pressure. They considered that, while the five-year funding settlement provided a much-needed boost to an overstretched system, some doubt remained on whether it would be enough to modernise and transform services to deliver the ambitions of the NHS Long Term Plan. They added that, while there was some stability for longer-term planning, the overall level of investment was still lower than in previous years. NHS Employers welcomed additional NHS capital investment but did not believe it would be enough to modernise services and working environments. They emphasised that the physical environment mattered to staff and patients. They also said that a further challenge was the ongoing uncertainty on future funding for social care and the impact that this had on NHS services.

3.93 On pay, NHS Employers said that there would remain difficult choices ahead where available funding should be directed against agreed workforce priorities as well as what investment in pay should be made. They considered that managing expectations on pay would be important as they developed pay and reward beyond the current AfC pay agreement. They felt that their priorities would be shaped by the delivery of the NHS Long Term Plan, consolidating the benefits of the restructuring of AfC terms and conditions, and continuing to support recruitment and retention initiatives. Employers would also face competing pressures on capital budgets, balancing rising demand and efficiency savings, and the possibility of having to fund increases in the level of the National Minimum Wage.

3.94 The **Welsh Government** said from 2018/19 onwards there had been a 5% increase in all Barnett formula consequentials above the 2017/18 level for Wales. However, it also told us that, while the UK Government's 2019 Spending Review delivered a real terms increase to funding, these increases meant that the Welsh Budget for 2020/21 remained nearly £300 million lower in real terms compared with 2010/11. The Welsh Government's 2020/21 budget would be over £18 billion, with £8.74 billion allocated to the health and social services budget. It would invest an extra £421 million in health and social care in 2020/21. The Welsh Government also said that it had spent more per person on health and social services in 2018/19 than anywhere else in the UK (more than £3,000 per person in Wales, almost £300 more per person than in England).

3.95 The Welsh Government said that for the past six years the total NHS pay bill had increased year on year, from £3 billion in 2013/14 to £3.7 billion in 2018/19 (a 23% increase). It said that in November 2018 there was a spike in the total pay, which in part could be attributed to the back-pay from the three-year AfC pay agreement.

3.96 The **Department of Health, Northern Ireland** told us that the UK Spending Round 2019 provided a 2.6% real terms increase in non-ring-fenced resource. However, given the significant pressures facing the Resource Budget it anticipated that departments would face significant resource constraints. The Department considered that efficiency and productivity improvements would continue to be essential to meet key targets within current resources.

## Workforce strategies and workforce numbers

3.97 **DHSC** said that ensuring that the NHS had access to the right mix and number of staff who had the skills, values and experience to deliver high quality, affordable care was a fundamental aspect of the Department's overarching strategic programme for the health and care system. DHSC pointed to the Government's commitment to delivering 50,000 nurses by 2025 through a combination of increased supply, recruitment and retention. It added that the first step taken had been to increase the financial support available at university with nursing, midwifery and the majority of allied health professions (AHP) students receiving a £5,000 to £8,000 annual maintenance grant.

3.98 DHSC said that the NHS People Plan would set out a clear framework for collective action on workforce priorities over the next five years. The Plan would include a new core offer for NHS staff, which DHSC said would be framed around the themes of creating a healthy, inclusive and compassionate culture, enabling great development and fulfilling careers, and ensuring everyone felt they had a voice, control and influence. In oral evidence, DHSC said that the Chief People Officer at NHS E&I would have responsibility for delivering the Plan but that it was a plan for the NHS so all organisations would be responsible for delivery. In the longer term, DHSC noted that ICSs would take the lead for workforce planning and deployment.

3.99 DHSC also set out the following features for the NHS People Plan:

- Improving the leadership culture – a new NHS Leadership Compact would establish the cultural values and leadership behaviours expected from NHS leaders;
- Tackling the nursing challenge – further action would include reducing vacancy levels with less reliance on temporary roles, expanding the retention programme, increasing clinical placement capacity, developing alternative routes into nursing, developing a blended learning programme, improving financial support through the Learning Support Fund, increasing investment in CPD and launching a new return to practice campaign;
- International recruitment – building global partnerships, regional co-ordination of recruitment, and lead recruiters for Sustainability and Transformation Partnerships (STPs) and ICSs;

- Delivering 21st century care – designing pathways that explicitly match staff resources to activities and interventions that had the greatest impact on quality and outcomes. Also developing multi-disciplinary teams, including ensuring sufficient AHPs to deliver new service models in Primary Care Networks; and
- A new operating model for workforce – a greater role for ICSs to lead collaborative system-wide approaches on workforce and people priorities.

3.100 DHSC pointed to the NHS Staff Survey as a key source of evidence to inform action taken in the NHS People Plan. It highlighted measures such as: staff who look forward to going to work; those thinking of leaving the NHS; bullying and harassment theme scores; equality, diversity and inclusion theme scores; and staff satisfied with support from their immediate manager. DHSC advocated other data to monitor the Plan, including the Friends and Family Test, and sickness absence rates.

3.101 DHSC noted that health and social care employers said that they needed a more flexible workforce to keep pace with developments in treatments and interventions. It also said that the NHS Long Term Plan identified areas where earlier diagnosis, new and integrated models of care, and better use of technology offered the potential to significantly improve population health and patient care. The Plan also set out the need to transform the way the entire NHS workforce worked together and DHSC added that getting the skill mix right was critical to addressing workload pressures. DHSC said that work would be much more multi-disciplinary with this becoming the norm in all healthcare settings over the next five years. It said that work had begun to review current models of multi-disciplinary working within and across primary and secondary care. DHSC added that people would have less linear careers and that technology would enable staff to work to their full potential.

3.102 DHSC told us that there was a record and growing number of non-medical staff in the NHS, with an FTE increase of 10.5% between March 2014 and March 2019. The two largest groups of staff were nurses and health visitors, and support to doctors, nurses and midwives, and they had seen an increase of 3.3% and 13.8% respectively. DHSC said that Health Education England predicted that the annual output of physician associate graduates was likely to reach at least 900, with other new professional routes including anaesthesia associate and advanced clinical practitioner.

3.103 DHSC said that BME representation in the overall workforce and the gender balance had been stable over the past four years. It noted that BME representation was around 17% in 2018, and the proportion of females in the workforce was around 80% in 2019. In most staff groups, DHSC said that there had been increases in the proportion of BME staff since 2015, and that this had generally been caused by either a reduction in the proportion of white staff or those where data on ethnicity was not available.

3.104 **NHS E&I** said that to meet the demand for health and care services and to meet the vision of the NHS Long Term Plan more people needed to be working in the NHS over the next 10 years across most professions and disciplines. NHS E&I pointed to the Government's pledge to the NHS having an extra 50,000 nurses, 26,000 primary care staff[38] and 6,000 doctors in general practice. They said that the NHS needed different people in different professions working in different ways, cultural change, and a pipeline of compassionate and engaging leaders. They noted that the NHS People Plan would set out actions to address growing workload pressures felt by all staff groups, including frustration from staff that they cannot spend enough time with patients, and to address cultures of bullying and harassment in the workplace to create an inclusive and compassionate culture, where staff felt that they have a voice. In oral evidence, NHS E&I said that the lead on the implementation of the Plan would be through the Chief People Officer, with an operating model including oversight by the National People Board and delivery through the regions and Integrated Care Systems.

3.105 NHS E&I said that the recruitment and retention of existing staff, workforce transformation and new roles would help to meet the current staffing shortfalls. They considered the workforce challenges as: the overall vacancy rate at 9.2% (12.3% for nursing); the health and wellbeing of the NHS workforce, as measured by the overall sickness absence rate (4.06%); and bullying in the workplace.

3.106 In the five years to 2019, NHS E&I noted that there had been an overall increase in the workforce of 10.5% (92,500 FTE), with expansion across all staff groups. They said that the biggest increase was in roles supporting doctors, nurses and midwives reflecting changes in workforce planning and the creation of new nursing support roles as an alternative to addressing the nursing supply and shortfall issues. They added that increasing nursing capacity was a priority in the NHS People Plan.

3.107 NHS E&I highlighted its programmes of work looking at: alignment between the NHS terms and conditions and very senior manager terms and conditions; mandatory training coverage; Recruitment and Retention Premia; and immigration thresholds. NHS E&I were also committed to a review of wholly owned subsidiaries, with work underway on a joint agreement of an employee engagement checklist developed in partnership with trade unions. Priority considerations for NHS E&I in the Interim NHS People Plan were: reducing the gender pay gap; and using the Workforce Race Equality Standard indicators to reduce the gap in BAME and white staff disciplinary action, and increasing BAME representation across the NHS workforce.

3.108 **NHS Employers** commented that the Interim NHS People Plan accepted that the workforce planning model needed to change, with functions undertaken at the best level to meet the needs of services, and devolution of responsibility to ICSs over time. NHS Employers noted that STPs and ICSs would have a core role in testing emerging proposals in the development of the new workforce structure. They commented that the shift from competition to collaboration would provide opportunities for employers to work dynamically across organisations, for instance, collaborating on health and wellbeing initiatives, training and development, and, possibly, pay and workforce policy. In oral evidence, NHS Employers commented on a top-down delivery model for the NHS People Plan, through STPs and ICSs, with leads on specific areas by national organisations.

[38] The Conservative Party Election Manifesto announced 6,000 more primary care professionals, such as physiotherapists and pharmacists, on top of the 20,000 primary care professionals previously announced.

3.109 NHS Employers cited an NHS Confederation survey where 65% of respondents said that they were either "not very" or "not at all" confident that their local health system would be able to meet their staffing needs. They pointed to the need to increase the number of nurses by improving international and domestic supply, and by focusing on recruitment and retention. Across the workforce, NHS Employers noted that the needs of staff varied at different stages in their careers and personal lives. They said that they were building on the extensive work already undertaken to support employers to value and engage their staff, to promote health and wellbeing, to improve the leadership culture, and to safeguard staff from bullying and harassment.

3.110 **Health Education England (HEE)** said that national workforce planning was challenging for a system as large and complex as the NHS. HEE felt that planning needed to take account of future finances and service redesign, while medical advances and changing patient needs and expectations added to the uncertainty of projections. HEE said that the long-term funding settlement alongside the development the NHS Long Term Plan further reinforced the importance of ensuring that national, regional and local organisations were working effectively together to address workforce priorities. HEE told us that the Interim NHS People Plan had been developed collaboratively with national leaders and partners.

3.111 **NHS Providers** said 79% of trusts in its survey had named a greater use of staff in new roles including nursing associates and physician associates as a factor which would enable greater workforce productivity within their trust. It said that growing the workforce through training new staff, both via traditional courses and new pathways such as apprenticeships, was vital. It added that a long-term solution to CPD and training budgets should be addressed by the NHS People Plan and the 2020 Spending Review.

3.112 In oral evidence, the **Joint Staff Side** emphasised the need to improve the staff experience of working in the NHS and making the NHS a better place to work. They said that this included culture challenges around bullying, harassment, treatment of BME staff, removing stress and improving the core employment offer.

3.113 The **RCN** told us that the registered nursing workforce had grown by just 1.5% between 2015 and 2019 in England, while the nursing support workforce had grown by 7.5% and the whole NHS workforce had grown by 5.9%. The RCN commented that there had been worrying decreases in the number of nursing staff in certain work areas, including learning disabilities and mental health nursing. It added that: in Wales, the registered nurse workforce had grown by 1.7%, while the nursing support workforce had grown by 6.5%; in Scotland, the number of registered nurses grew by just 0.3% between 2015 and 2018 and the number of nursing support staff grew by 2.8%; and in Northern Ireland, the number of registered nurses had grown by 3.4% and the number of nursing support staff had grown by 8.8%. The RCN noted that skill mix changes were necessary in order to respond to new evidence and ways of working. However, it said the combination of ever-increasing registered nursing vacancies and the below trend growth in the workforce were alarming.

3.114 In addition to submission of written evidence, the RCN produced a report on *Standing Up for Patient and Public Safety*[39] in October 2019. This report provided helpful information on the nursing workforce and the impact of staff shortages and is therefore summarised here alongside the RCN's main evidence. The RCN introduced the report by commenting that while the health and care workforce gap was growing, patient need for care continued to rise. The RCN noted that it would take some years to start closing the gap which stood at over 100,000 vacancies across all the professions in the NHS, with thousands more in social care and public health. The RCN's report sought to ask how the crisis became so serious and what needed to happen now.

3.115 The RCN commented that, despite the Government rhetoric that there were more nurses than ever before, the growth of the workforce was not keeping pace with demand for health and care services. Based on RCN modelling, it estimated that in the last year alone for every extra NHS nurse employed there had been an extra 217 admissions, and that this was unsustainable.

3.116 The RCN welcomed NHS E&I's recommendation that the Government review whether national responsibilities and duties in relation to workforce functions were sufficiently clear. It considered that this review should enable all those with a role in workforce supply and planning to understand their own responsibilities and what they can expect for others. The RCN said that without this clarity it had been a challenge for the Government and the system to come together to find solutions to the workforce crisis. It criticised the lack of long-term solutions and funding to ensure an overall supply of nurses and nursing staff. Solutions to date had been short term and incentivising new recruits into shortage areas would syphon off workforce into the services under the highest pressure. The RCN added that poor retention, as well as a drop off in supply to non-incentivised areas, would be inevitable.

3.117 As part of its analysis of the impact of staffing levels on patient care, the RCN cited its *Nursing on the Brink* report from 2018 in which survey respondents reported on their fears of being prevented from providing the care their patients needed as follows:

- Nursing staff reporting less than 50% of the registered nurses planned for were almost twice as likely to report that care had been compromised in comparison to those that had the planned number;
- Those with less than half of planned registered nurses were four times more likely to report that care was "poor" or "very poor" in comparison to those with all of their planned registered nurses;
- A quarter of nursing staff reporting all planned registered nurses on shift reported that care was left undone, compared to half of those with less than 50% of their planned registered nurses on shift; and
- Less than half with the full complement of registered nurses missed their break, compared to more than 80% of those who were missing half of the registered nurses due on that shift.

3.118 In conclusion the RCN made a series of recommendations for Government and system players, as well as commitments from the RCN. It called for: a costed and funded workforce strategy with short and long-term solutions for health and care workforce supply, recruitment and retention; and clear legal duties and accountability for all those who contributed to workforce supply and planning.

[39] Royal College of Nursing (October 2019), *Standing Up for Patient and Public Safety*. Available at: https://www.rcn.org.uk/professional-development/publications/007-743

3.119 The **RCN Northern Ireland** said that Nursing and Midwifery Council (NMC) data illustrated that the number of nurses and midwives on the UK professional register with an address in Northern Ireland fell from 24,811 in April 2019 to 24,768 in September 2019, with Northern Ireland the only one of the four UK countries to experience a decline. The RCN said that, given the increasingly ageing profile of the HSC nursing workforce, this had raised questions in relation to recruitment and retention, and the capacity of the system to produce the numbers of nurses that would be required to meet the future health care needs.

3.120 The RCN Northern Ireland told us that nursing practice had developed considerably since the introduction of AfC but that HSC employers were often reluctant to rewrite job descriptions and re-match/evaluate roles when staff had taken on additional responsibilities and skills. The RCN said that nurses had lost faith in the job evaluation process and felt that their contribution was not adequately valued or rewarded to reflect their levels of responsibility. It advocated a review of the job evaluation process to ensure that staff were able to maximise their contribution to the transformation agenda and were rewarded appropriately for their key role in an evolving and modern health and social care system. The RCN added that there had been a reduction of senior nurse leadership posts and a perception that clinical leadership had been eroded. It said that this had impacted negatively on nurses' ability to act as autonomous professionals and had led them to feeling increasingly "micromanaged" by people who did not understand clinical issues.

3.121 The **RCM** said that continuity of care was the cornerstone of "Better Births" the maternity transformation plan for England, but that successful implementation relied on adequate investment and safe staffing levels. The RCM remained concerned that Band 2 MSWs were undertaking, as standard, a range of delegated clinical duties which did not match a Band 2 job profile. It said that job evaluation underpinned the entire AfC pay structure and every job description should go through a job matching process, which should be done in partnership by a panel including employers and staff side representatives. The RCM argued that it was possible to pay staff a salary uplift to cover unsocial hours and on-call payments, but that this must be agreed by local staff sides. It said that this approach was sometimes used as a way to support the development of more flexible working arrangements and to reduce bureaucracy for individual staff and managers.

3.122 The **Welsh Government** told us that the provision of NHS services required the workforce to be sustainable in the face of a number of challenges, including rising demand for care, the ageing population, multiple morbidities, advances in technology and raised expectations of patients. It said that the workforce needed to adapt and to look at not simply traditional roles but increasingly at new flexible roles. The Welsh Government said that key to sustaining the workforce was the introduction of greater flexibility in routes to education and training. It had asked its commissioners to identify where additional flexibility could be introduced into current centrally funded education and training programmes. The Welsh Government said that its strategy "A Healthier Wales[40]" enabled it to provide a stronger focus on a programme of coordinated activities and to drive delivery in a more rigorous way.

3.123 The Welsh Government said that at August 2019 NHS Wales employed 92,643 staff (headcount), which had increased from 90,592 since 2018. It added that the FTE figure was 80,362 staff in 2019.

[40] Welsh Government (June 2018), *A Healthier Wales: Our Plan for Health and Social Care.* Available at: https://gov.wales/healthier-wales-long-term-plan-health-and-social-care

3.124 The **Department of Health, Northern Ireland** said that the implementation of its Health and Social Care Workforce Strategy 2026 was well underway and that a Programme Board and Reference Group had been established, with progress being made across all themes of the strategy. The Department provided information which showed that as at March 2019 there were 62,015 health and social care staff (by headcount) – an increase from 60,611 in 2018. This included 17,405 qualified nursing, midwifery and health visiting staff (an increase of 165 since 2018) and 8,402 social services staff. It also said that there were 53,884.3 health and social care staff by WTE – an increase from 52,552.5 in 2018. This included 15,303.3 qualified nursing, midwifery and health visiting staff, and 7,498.3 social services staff.

## Vacancies and shortage groups

3.125 **DHSC** said that vacancies still presented a problem across the NHS but that the vacancy rate for all non-medical staff had fallen slightly since early 2017/18. The overall vacancy rate had showed some variation over 2018/19, ranging from 8.2% to 9.3%, which was equivalent to 87,000 to 98,000 vacancies. It said that the vacancy rate for nurses and midwives was slightly higher than the overall non-medical rate and had increased over the last two years from 10.9% to 12.1% (38,000 to 44,000 FTE vacancies). In oral evidence, DHSC said that staff shortages forced trusts to take a critical look at supply and ways to manage resources, although many trusts struggled to think strategically about addressing shortages as they focused on immediate demand pressures.

3.126 **NHS Employers** commented that across trusts there was currently a shortage of more than 100,000 staff (around 1 in 11 posts) and that these were severely affecting some key groups of essential staff including nurses, AHPs and care staff. They noted that vacancies in adult social care were around 110,000 and rising. They commented that the number of NHS vacancies was unacceptable and that leaders were focused on bringing it down. NHS Employers said that severe workforce shortages were frequently highlighted for mental health staff (nurses, psychiatrists and psychologists), community and primary care nurses, and general nursing roles. In a NHS Confederation survey, most health leaders said that the workforce was a priority and more than 90% either agreed or agreed strongly that understaffing across the NHS was putting patient safety and care at risk. In oral evidence, NHS Employers pointed to a range of impacts of staff shortages, including: hindering the introduction of new care models; limiting the time available for action to change cultures, improve leadership and deliver workforce developments; putting pressure on existing staff and stretching their goodwill; and impacting on patient experience. NHS Employers said that some operations had been cancelled and waiting times increased as the capacity to deliver treatment depended on working within current resources.

3.127 **NHS Providers** said that the gap between supply and demand for staff had been growing for some time, and analysis by the Nuffield Trust, Health Foundation and the King's Fund estimated that the number of vacancies could grow to as many as 250,000 by 2030 as a changing population's healthcare needs rose faster than the NHS could recruit the staff needed to meet demand. In oral evidence, NHS Providers said that the current workforce gap affected the discretionary effort staff were willing to commit to the NHS and there was an effect on the efficiency of services and, in some extreme cases, services were not able to run or units closed. NHS Providers added that staff shortages led to increased pressure on staff, additional workload, stress and sickness absence.

3.128 The **Joint Staff Side** told us that the NHS across the UK was facing major staff shortages. They pointed to vacancies at 105,518 at the second quarter of 2019/20, equating to a vacancy rate of 8.7% and higher in certain occupations, notably nursing at 12.1%. The Staff Side cited the King's Fund and Picker Institute[41] which warned that the "deepening crisis in NHS staffing could cause a deterioration in the quality of care". In oral evidence, the Staff Side said that staff shortages impacted on delayed discharges and the lack of continuity of care in using agency staff.

3.129 The **RCN** commented that the NHS in England faced its highest nursing vacancy rate of 12.1%, with variations across the country ranging from 15.3% in London and 13.1% in the South East to 9.9% in the North West and 9.5% in the North East and Yorkshire. It also noted that parts of the UK faced rising vacancy levels: in Scotland, the registered nurse vacancy rate was 7.1% and the nurse support staff vacancy rate was 4.2%; in Northern Ireland, the RCN estimated rates to be 15% for the registered nurse workforce and 9% for the nursing support workforce; and in NHS Wales, the RCN estimated a vacancy level of over 1,600 registered nurses and noted that agency spending on nursing staff stood at £63.8 million in 2018/19, representing an annual rise of 24%. Overall, the RCN said that nursing vacancy rates were higher in the UK than those in the UK economy as a whole.

3.130 The **RCM** told us that the NHS in England was currently short of the equivalent of almost 2,500 full time midwives. In the RCM's 2019 survey HOMs reported difficulty in recruiting to Band 5 newly qualified posts. The RCM said that 80% of HOMs had vacancies in their unit, a slight increase on 2018. The total number of vacancies had almost doubled from 611 WTE in 2018 to 1,056 WTE in 2019.

3.131 **GMB** said that in 2018 the NHS had the highest vacancy rate of any part of the public sector at 8.5%, which also compared to an "all industries" average of 2.8%.

3.132 The **Welsh Government** said that in August 2019 there were 2,133 vacancies in the NHS in Wales, down from 2,330 in August 2018[42]. It said that there were national and international labour shortages in particular areas, and that external factors had also precipitated the need for higher levels of qualified staff, including the Francis Report and the Welsh Nurse Staffing Act 2016. It added that health boards and trusts looked to overseas recruitment to fill gaps in medical staff and nursing.

3.133 The **Department of Health, Northern Ireland** provided information on permanent and temporary vacancies which were at 6,984 at September 2019, an increase from 5,860 in 2018. In the same period, registered nurses' vacancies increased from 1,922 to 2,269, midwives from 50 to 122, nurse support from 403 to 521, and social workers' vacancies from 259 to 370.

3.134 The **RCN Northern Ireland** informed us that nursing staff in Northern Ireland were working under considerable pressure and that, as at 31 December 2019, there were 2,659 unfilled nursing posts in the HSC. It estimated that the current nursing vacancy rate was in the region of 15% and that although the number of vacant registered nursing posts had fallen slightly since 30 September 2019, the number of vacant nursing assistant posts had continued to increase, from 521 to 545.

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[41] Picker Institute (2018), *The Risks to Care Quality and Staff Wellbeing of an NHS System Under Pressure*. Available at: https://www.picker.org/wp-content/uploads/2014/12/Risks-to-care-quality-and-staff-wellbeing-VR-SS-v8-Final.pdf

[42] In evidence, the Welsh Government added that vacancies were advertised FTE where the "advertised" date fell between the first and last calendar day of the reporting period. This metric was a proxy metric for vacancies. There would be a level of under-reporting within these figures because the system allowed the use of rolling adverts (i.e. adverts kept open continually).

## Workload and additional hours

3.135 **DHSC** said that the proportion of staff who worked additional paid hours had remained consistent over the last four years. It noted that there was a significant variability for staff groups, with those working in more direct care roles more likely to work additional hours.

3.136 The **Joint Staff Side** said that HEE had highlighted the effects of long hours and difficult shift patterns, with 76% of frontline NHS staff experiencing mental distress at work. The Staff Side noted that 58% of staff reported working additional unpaid hours in the 2018 NHS Staff Survey. They cited union survey results as follows: 79% of nursing staff worked in excess of contracted hours at least once a week and, of these, 57% said these hours were usually unpaid (RCN Employment Survey 2019); 38% worked longer than contracted hours, rising to 53% among ambulance staff and 48% among nurses and midwives (UNISON survey); and 63% frequently or always worked more than their contractual hours (Unite survey). The Staff Side concluded that unpaid overtime represented enormous goodwill from a workforce that was approaching its breaking point.

3.137 **UNISON** told us that large parts of the service relied heavily on discretionary effort with staff regularly working additional hours for which they were not paid. It said that many staff felt unable to demand paid overtime, while taking Time Off In Lieu was often operationally impossible.

3.138 The **RCN Northern Ireland** informed us that the 2019 RCN Employment Survey for Northern Ireland had found that 73% of nursing staff worked additional hours at least once per week and that 48% of those who work additional hours did so unpaid. The RCN said that 66.5% of nursing staff felt under too much pressure at work, compared with a UK average of 62.7%.

## Supply and recruitment

*General*

3.139 **DHSC** said it had continued to act to increase the supply of non-medical staff including increasing the nursing associate numbers and expanding the number of training places for nursing and midwifery. It commented that the NHS Long Term Plan set out a strategic framework to ensure that over the next 10 years the NHS will have the staff it needs. It said that the Plan set out that the national workforce group would agree action to improve supply centring on increasing undergraduate nursing, reducing attrition from training and improving retention.

3.140 DHSC considered that it could not rely on overseas recruitment alone and longer-term plans were in place to ensure the NHS had the right skills domestically. DHSC had oversight of a package of measures currently being implemented by Arm's Length Bodies to ensure the required workforce was in place to deliver safe and effective services. It said that these measures looked to broaden routes into nursing working with trusts on a range of recruitment, retention, sickness absence and return to practice programmes, and growing the undergraduate nursing supply route. DHSC (and NHS E&I) told us the overall joiner rate was 13.2% in 2018/19, with over 144,000 joiners and rates varied between 8.4% and 20.5% across staff groups.

3.141 **NHS Employers** said that they had identified policy changes to help workforce supply as: flexibility in the apprenticeship levy; an immigration policy to attract and retain the workforce; visible national leadership for new roles; investment in staff health and wellbeing; and targeted incentives in critical areas. They considered that the NHS must be an employer of choice and that employers worked with local populations to encourage and attract new staff. Employers worked with local schools and colleges to publicise the range of healthcare careers and pathways available.

*Pre-registration entrants*

3.142 **DHSC** said that students applying and entering into nursing had fallen since 2016, which coincided with the move from a bursary to a student loan system. It said that since 2016, UCAS data showed applicants to undergraduate nursing courses had fallen by an overall 28% (from 56,790 in 2016 to 40,770 in 2019) and UK applicants had decreased by 29% (from 54,940 to 39,140). It added that applicants from the EU had decreased from 1,430 to 730 (-49%) but, in contrast, there had been a rising trend in applicants from overseas, from 420 in 2016 to 900 in 2019. DHSC noted that between 2016 and 2019 the number of acceptances to nursing courses at English providers had increased from 23,275 to 23,625 (1.5%) and, while EU acceptances had decreased from 370 to 150 (-59%), overseas entrants had increased from 45 to 185 (311%).

3.143 DHSC said that to support universities in expanding the number of nurse training places they could offer the Government had made funding available to support an additional 5,000 nurse clinical placements each year and an additional 3,000 midwifery training places over a four-year period. DHSC noted that the attrition rate had been 7% in nursing, 6% in midwifery, and 6% for AHPs between July 2016 and July 2017. DHSC also said that UCAS data showed that men made up around 9% of overall entrants onto nursing courses in 2019, remaining broadly the same since 2015. It commented that between 2015 and 2019 the proportion of nursing entrants from the most disadvantaged backgrounds (by quintile) increased from 15% to 17% and those from the least disadvantaged backgrounds (by quintile) decreased from 22% to 19%.

3.144 **NHS Employers** told us that the national "We are the NHS" recruitment campaign had resulted in increased university applications for health education courses. However, NHS Employers noted variation between the four branches of nursing education and between different parts of the country, with concerns about mental health and learning disability nurses. They said that NHS E&I had funded an extra 7,500 nursing placements in 2019/20. Employers were increasing the number of clinical placements offered to students and were developing local coaching models, increasing capacity in areas such as outpatients.

3.145 **NHS Providers** welcomed the Government's proposals to reinstate the nursing bursary, which it commented might contribute to both a reduction in the attrition rate on nursing courses and a reverse in the trend of declining rates of applications to courses.

3.146 The **RCN** told us that the number of placed applicants onto nursing courses had risen by 4.6%, but there were variations across the UK: in England, a 3.9% increase, but this was below the number accepted in 2016 and behind the UK Government's pledge to increase places by 25%; in Scotland, numbers had increased by 6.9%; in Wales by 5.2%; and in Northern Ireland by 4.8%. The RCN called for at least £1 billion to be invested in higher education to stop the nursing shortage spiralling upwards further.

3.147 The **RCM** said that, although the number of student midwives had continued to increase, the financial pressures on student midwives in England were immense. It also told us that applicants to midwifery courses in England had fallen by 41% since 2013 and the fall in the year after the bursary was taken away was 20%. It commented that decreases had been especially marked in those applicants in their 20s and 30s, who traditionally make up the bulk of student midwives, but even fewer 18 year olds were applying than five years ago. The RCM's 2019 survey of student midwives found that almost 80% felt financially precarious, rising to 85% for those in their 40s. However, the RCM noted that HOMs felt that if universities increased the number of student midwives they would be able to increase the number of student placements in their unit. The RCM called for a thorough review of financial support for student midwives, and a commitment to ensuring student midwives were properly supported throughout their studies.

3.148 **GMB** told us the supply of new nursing entrants had been hit by the "toxic" combination of the removal of bursaries and uncertainty in the aftermath of the 2016 Brexit referendum. Despite a welcome but small increase in 2018, GMB noted that overall applications had fallen by 29.4% since 2016.

3.149 The **Welsh Government** said that it had maintained the bursary in Wales for students starting their studies in the academic year 2021/22 and 2022/23, including the commitment in advance to work in Wales for up to two years post qualification.

3.150 The **RCN Northern Ireland** said that information was needed on training programme attrition rates, the numbers who successfully complete programmes and then register with a Northern Ireland address, and the numbers entering employment within the HSC. The RCN commented that, if the safe staffing framework were to have the desired impact, it was essential that progress was measured and evaluated.

### *EU and non-EU recruitment*

3.151 **DHSC** said that around 11% of non-medical staff had a non-UK nationality, with 4.9% from the EU27 up from 4.6% in 2016. Despite this overall increase, DHSC noted that the number of EU27 nurses, health visitors and midwives had fallen since 2016 and suggested that this was most likely a consequence of the NMC introducing more rigorous language testing than the decision to leave the European Union. DHSC said that its priority was to ensure that those currently working in NHS were not only able to stay but felt welcomed and encouraged to do so. DHSC would continue to work with the Home Office to ensure that after the UK leaves the EU the UK will have in place an immigration system which works in the best interests of the whole of the UK.

3.152 DHSC told us that there may be a reduction in the in-flow of staff from the EEA (European Economic Area) after EU Exit, due to new immigration requirements and economic uncertainty. DHSC and delivery partners had taken a number of steps to help mitigate any supply impacts, including: passing legislation to unilaterally recognise qualifications from the EEA after Exit Day; a reduction of language test requirements by both the NMC and the Home Office; and the introduction of a streamlined international registration process by the NMC and development of system guidance on "passporting" of staff between different providers.

3.153 **NHS Employers** commented that health leaders were concerned about the extra demands on existing staff making EU exit preparations and the effects of ending freedom of movement. NHS Employers recognised that there were shortages of key staff groups in many other countries. They said that a more co-ordinated approach was needed to international recruitment and that providers needed to work collaboratively to recruit, support and embed this new workforce and their families. NHS Employers were working on the development of a good practice toolkit for overseas recruitment and settlement. Information from employers at February 2019 suggested that intentions for international nurse recruitment were smaller for 2019/20 than the previous year, but there were plans to increase radiographer and paramedic recruitment.

3.154 **NHS Providers** said that the uncertain political climate had added to the challenges trusts faced in recruiting enough staff, with proposals for new immigration policy and the ongoing uncertainty around Brexit leading to a drop in the number of staff joining the NHS from overseas. It said that it was essential that the NHS could respond dynamically to workforce fluctuations and shortages through international recruitment, especially in the interim period before new measures to grow the domestic workforce took effect over the coming years.

3.155 The **RCN** said that in 2019 the Migration Advisory Committee advised that nurses should remain on the shortage occupation list in order to aid international recruitment and fill vacancies. It commented that this had become particularly important as there had been a rapid decline in nurses on the NMC register from the EEA – an 85% fall in new entrants between 2016/17 and 2018/19.

3.156 **GMB** said the fall in applicants from other EU nations had been dramatic with applications having fallen by 49.6% in the last three years. It said that the UK Government had set a target of recruiting and retaining 50,000 nurses above current levels, and therefore should take all possible steps to end the ambiguity over the status of EU nationals that worked in the NHS.

3.157 The **Department of Health, Northern Ireland** told us that its International Recruitment for Nursing aimed to address escalating vacancies by recruiting 622 nurses by March 2020. It said that current forecasts indicated that 542 nurses would be recruited by March 2020.

3.158 The **RCN Northern Ireland** said that the consequences of leaving the EU upon international nurse recruitment remained unclear and there could have been an influence of pay inequality on the inability of the Department of Health to meet its own recruitment target. The RCN commented that the restoration of pay parity with England would hopefully help to address this issue.

### *Recruitment of nursing associates in England*

3.159 **DHSC** informed us that HEE was leading a national expansion programme to train up to a further 7,500 nursing associate apprentices in 2019 in addition to the thousands that entered training in 2018 and 2017. It suggested that employers were starting to realise the benefits of the new nursing associate role, which built capacity of the nursing workforce and supported nurses and the wider multi-disciplinary team to focus on more complex clinical duties. DHSC had commissioned a three-year programme of research to evaluate the impact of nursing associates in the workforce, with an interim report in 2020 and a final report in 2023.

3.160 **NHS Employers** said that the numbers of nursing associates joining the NMC register showed the individual and employer appetite for the role. They said that further knowledge about the role and how it fitted with the multi-disciplinary team was spreading. Employers were expanding the use of new roles, such as the physician's associate and nursing associates, and exploring how the advanced clinical practice workforce could be scaled up and deployed effectively.

*Recruitment of apprentices*

3.161 **DHSC** told us that the apprenticeship levy would be used more effectively to provide more routes into healthcare careers, with apprenticeships designed to support entry into careers in the NHS for people from all backgrounds. DHSC continued to work closely with key stakeholders to implement an NHS-wide strategy for apprenticeships. It said that NHS apprenticeship numbers and levy spend continue to increase as employers worked to embed apprenticeships within their future workforce planning.

3.162 DHSC said that the number of entrants through apprenticeships between April 2017 and March 2018 was 13,800. There was now a complete apprenticeship pathway available into the nursing profession from healthcare assistant to nursing associate, to nurse degree apprentice and onto advanced clinical practitioner. DHSC estimates from DfE data[43] that the number of nursing associate apprenticeships starting between May 2017 to March 2018 was 500, and the number of apprenticeships through advanced roles between May 2017 and March 2018 was 5,060.

3.163 **NHS Employers** commented that employers were collaborating regionally to deliver apprenticeships and to obtain the maximum benefit from the levy. The challenges faced, according to NHS Employers, were: entry requirements for some higher-level programmes; access to education providers; delays in standards being agreed; the closure of the option to be a training provider; placement and supervisory capacity; and the cost of backfill for supernumerary training time. However, NHS Employers reported many employers were using the apprenticeship levy to build career pathways, offer degree and higher apprenticeships, develop capacity and capability as training providers, strengthen leadership and management capability, and build apprenticeships into workforce planning. From 2020, NHS Employers noted that "T Levels" would include an industry placement.

3.164 **NHS Providers** said that trusts had highlighted challenges with the way the apprenticeship levy had been administered, including the lack of flexibility to spend levy funding on backfill for supervision or the supernumerary status of apprentices. It said that these challenges increased the net cost of training an apprentice beyond the point at which it was affordable for trusts to employ the number of apprentices they could otherwise fund with the levy.

3.165 **UNISON** pointed to its recent report "It doesn't add up: the apprenticeship levy and the NHS" which it said showed the extent of the apprenticeship levy under-spend, and the continuing incidence of unfair and unequal pay rates for substantive roles labelled as an apprenticeship.

[43] Department for Education (December 2018), *Apprenticeship and Levy Statistics*. Available at: https://www.gov.uk/government/statistics/apprenticeship-and-levy-statistics-december-2018

3.166 **GMB** said that there was some evidence that employers were using low paid apprentice roles and volunteers to cover work formally undertaken by regularly salaried staff. GMB also said that over a third of respondents to its survey said that the use of apprentices and volunteers for this purpose had increased, with the trend being more marked in ambulance services. GMB said that it was vital that apprentices were integrated into the AfC framework and it was disappointing that progress in this area had stalled. GMB noted that there were examples of NHS apprenticeships being advertised on the year one statutory minimum rate of £3.90 an hour.

### *Supply of bank and agency staff*

3.167 **DHSC** said that bank and agency staff were used to cover some vacancies, in addition to covering sickness absence and long-term leave. It said the use of agency and bank staffing provided some indication of how the NHS labour market was operating. It reported that spending on agency staff rose by 40% between 2013/14 and 2015/16 (£2.6 billion to £3.7 billion) but, following the introduction of agency spend controls, expenditure on agency staffing had reduced to £2.4 billion in 2018/19. DHSC told us that since April 2017, agency costs had consistently been below 5% of overall pay costs and had now fallen to 4.4%, which was a significant achievement in view of the record levels of demand and the extreme pressure on the acute sector. It noted that spending on agency staff was the same in 2018/19 as in 2017/18 but procured 5.3% more shifts and managed the cost pressures associated with the first year of the 2018 AfC pay agreement, which were higher than anticipated.

3.168 DHSC said that introducing measures to reduce agency spend could only have maximum impact where trusts had a viable alternative temporary, or flexible, staffing solution. It considered that staff banks ensured better quality and continuity of care, while allowing the reduction of unnecessary agency spending. DHSC had encouraged trusts to develop in-house staff banks as an alternative source of flexible staffing that, when properly deployed, could avoid the cost of commission paid to agencies and provide flexible working opportunities for existing staff. At the end of 2018/19, DHSC said that £6 out of every £10 spent on temporary staffing was being spent through a staff bank.

3.169 DHSC told us that the Interim NHS People Plan committed to increase flexible working opportunities to make the NHS a better place to work. The final People Plan would ensure that bank developments and the effective deployment of staff through collaborative banks were aligned with the overall recruitment strategy of the NHS. While there was a general expectation that ICSs would operate regional banks, there would be circumstances in which trusts who were not part of the same ICS would share a collaborative bank. DHSC said that an early focus of pilot programmes aimed at using integrated technology, such as e-rostering. Following learning from the pilots, DHSC said that NHS E&I planned to launch a new suite of bank programmes with targeted improvement processes in those trusts with the least mature banks.

3.170 **NHS E&I** suggested that, on agency and bank staff, there was a limit to further reductions that could be achieved above and beyond the initiatives already planned. They said that agency spend as a proportion of the total pay bill reduced from 8.2% at its peak in 2015 to just 4.4% at September 2019. They added that in the first six months of 2019/20 trusts had spent £1.19 billion on agency staff, which was 1% lower than the same period in 2018/19. NHS E&I had introduced two measures to help trusts bring down agency spend: a restriction on the use of off-framework agency workers to fill non-clinical and unregistered clinical shifts; and a restriction on the use of administrative and estates agency workers, with exemptions for special projects and shortage specialties. NHS E&I considered that bank arrangements were more cost-effective than using agencies and provided better continuity of care for patients. They said that the percentage of temporary staffing spend through the bank had risen from 58% in 2018/19 to 61% at month six in 2019/20. NHS E&I's Temporary Staffing Models Programme included various collaborative pilots and they were considering the aim of 65% of temporary staffing shifts being booked via banks by 2023.

3.171 The **RCM's** survey indicated that the number of HOMs frequently having to call in bank or agency staff had risen since 2018, with 73% doing so nearly every day or a few times a week.

3.172 **Unite** said the NHS staffing crisis had led to perverse outcomes including cost savings made through the cover of additional hours via the in-house bank. It reported that staff had found examples of bank rates being cut and staff were being paid on bank rates as a way to avoid paying overtime for extra shifts. Unite also said the effect of bank and agency pay rates and in particular how the emergence of NHS Professionals had impacted the use and deployment of bank and agency staff should be considered.

3.173 **GMB** said the ongoing reliance on agency staffing, which was driven in large part by a desire for a more positive work/life balance, represented a subtler form of privatisation. It said that staff directly employed reported an increase in their workloads due to agency working, which in turn had negative implications for retention.

3.174 The **Welsh Government** told us that deployment of some temporary staffing capacity was essential to manage the safe and effective delivery of services, and might be needed to provide cover during absence due to sickness, temporary cover during times of staff turnover, or to provide additional capacity during times of peak demand. It added that their use was only on a short-term basis. The Welsh Government noted that the deployment of temporary staffing began to increase rapidly after 2013 across the whole of the UK in response to increasing demand for services, competition for limited numbers of healthcare staff and increased mobility of the workforce internationally. In response to this trend and in collaboration with NHS Wales organisations, it had introduced a new national control framework designed to halt the rapid rise in expenditure. The framework included increasing Health Board level scrutiny, minimising deployment, and improving value for money through capping rates and more effective procurement.

3.175 The **Department of Health, Northern Ireland** provided information on bank and agency costs which continued to increase, with 2018/19 agency and locum spend at over £200 million (£52 million on nursing and midwifery staff) and bank spending for nursing and midwifery at almost £63 million. The Department told us that it was working with employers on proposals to reduce all agency and locum spend, beginning with off-contract expenditure. It confirmed that Northern Ireland had a Regional Agency Framework paying the hourly rate as if directly employed by the trust and that bank staff were currently paid their AfC normal rates.

3.176 The **RCN Northern Ireland** informed us that HSC expenditure on agency nursing had escalated from just under £10 million in 2012/13 to £52.1 million in 2018/19 and for the first six months of 2019/20 was £39.1 million. The RCN commented that this level of expenditure was unsustainable and that it reflected the absence of effective workforce planning for nursing in Northern Ireland. It added that excessive agency expenditure not only had significant financial implications for services but also impacted upon the quality of care, continuity of care and the patient experience.

## Retention

3.177 **DHSC** informed us that leaving and retention rates were stable, and that retention was generally high, although voluntary resignation had accounted for almost half of all reasons for leaving over the past five years. Overall, DHSC concluded that leaver rates had fallen in 2018/19 for all major staff groups in England and that overall, leaver rates had changed little since 2014. It said that leaver rates remained a little over 10% for nurses and health visitors and midwives, 7.6% for ambulance staff, 10.5% for scientific, therapeutic and technical staff, 9.9% for support to clinical staff, and the leaver rate for infrastructure staff decreased from over 11% to below 10%. DHSC added that the 2018/19 figures showed that voluntary resignations had been increasing steadily and were 3.3 percentage points higher than in 2013/14.

3.178 **NHS E&I** also reported that leaver rates across England had changed little since 2014. They said that the highest reason for leaving was voluntary resignation with known reasons including "work/life balance", which has increased year on year over the last three years. On the Stability Index, NHS E&I suggested that the scientific, therapeutic and technical staff groups had the highest change in percentage points across the last five years (since 2014/15). They commented that ambulance staff had the highest Stability Index at 92.2% in 2018/19 and that the support to clinical care group had the lowest index at 88.9%.

3.179 NHS E&I told us that their Retention Programme supported trusts in developing interventions that had the biggest impact in improving retention. The programme gave trusts the tools, knowledge and expertise to develop initiatives, and to access both a universal support offer and a targeted, clinically-led, direct support model to improve staff turnover rates. NHS E&I reported that 150 trusts had already completed the programme, with an initial focus on nursing and mental health now being extended to include direct support to GPs and allied health professionals.

3.180 NHS E&I highlighted two programmes as follows:

- The Nursing Retention Programme had enabled a 0.5% improvement in the NHS nursing leaver rate, with estimated retention of 2,300 FTE nursing staff (between June 2017 and March 2019). The programme was on track to achieve the Long Term Plan target of retaining the equivalent of an additional 12,400 nurses by end of 2024; and
- The Mental Health Retention Programme had seen the clinical staff leaver rate reduce from 9.6% to 8.6% since June 2017, retaining 2,300 FTE clinical staff (between June 2017 and March 2019) and indicating that the programme was on track to achieve the 6,000 retention target by end of 2020/21, as outlined in the Mental Health Workforce Plan.

3.181 **NHS Employers** also noted the NHS E&I retention programmes. They considered that addressing turnover and leaving rates was complex and that NHS Employers had supported local employers to develop their own approach. They said that the programme would continue in 2020 and that NHS Employers would focus on flexible working practices.

3.182 The **Joint Staff Side** said, with around one in ten members of staff leaving every year, staff numbers were not keeping pace with the number of people they were expected to care for. The Staff Side added that their members repeatedly told them that there were not enough staff to do their job properly.

3.183 The **RCN** said that 39% of nurses responding to its 2019 survey were seeking a new job, compared with 37% in 2017. It reported that staff employed in Bands 2-5 were most likely to state they were looking for a new job. It added that less than half (47%) of respondents were exclusively considering the NHS for their next job, with a quarter considering a job outside the NHS and another quarter considering either the NHS or outside the NHS. The RCN argued that while turnover of staff was normal for any organisation, these were problematic findings for the NHS as it desperately needed to retain existing staff. In responding to a request for further information, the RCN highlighted that in its 2019 survey 52% of those who said they were seeking a new job said they had experienced bullying compared to 31% of those who said they were not seeking a job (43% and 25% in the 2017 survey).

3.184 The **RCN Northern Ireland** told us that in the 2019 RCN Employment Survey for Northern Ireland the principal reason why nursing staff were thinking of leaving the profession was of feeling undervalued, expressed by 70.1% of those responding to the survey.

3.185 **GMB** said that the most commonly raised complaint by staff was workload, which had become progressively more unmanageable as demand on NHS services had outstripped investment. It said that while overall levels of leavers had remained broadly stable (if subject to a high degree of seasonal fluctuation), exits attributed to the desire for a better work/life balance had increased more than threefold since 2011/12.

3.186 The **Department of Health, Northern Ireland** provided information which showed that in the year to March 2019 nursing and midwifery leaver rates were at 6.6% (down from 6.9% in 2018). Over the same period nursing and midwifery joiner rates increased from 7.3% to 7.5%. Social services leaver rates were at 5.8% (joiners at 8.5%).

## Motivation and engagement

3.187 **DHSC** said that staff engagement was crucial to securing and retaining the workforce that the NHS needed, as was making the most effective use of the entire NHS employment offer. DHSC strongly believed that recruitment and retention was not just about pay, but was about creating a culture and environment in the NHS where staff wanted to work, where staff felt safe to raise concerns and to learn from mistakes, and where employers listened to and empowered staff, worked hard to keep them safe, and ensured bullying and harassment was not tolerated.

3.188 DHSC said that health and wellbeing scores in the 2018 NHS Staff Survey were unchanged from previous years. It also said that recorded sickness absence rates remained low, staff engagement indicators were holding firm and pay satisfaction had increased across all staff groups over the last year, probably as a result of the 2018 AfC pay agreement. DHSC told us that staff engagement scores had remained generally consistent over the last five years. It said that staff satisfaction with flexible working had shown some improvement over the last four years, particularly so for ambulance staff. It also noted that scores for health and wellbeing had been mostly unchanged over the last four years, although ambulance staff scored lower than other groups.

3.189 DHSC told us that much of the work to improve the health and wellbeing of the workforce centred around long-term cultural and leadership change, developing skills and modifying behaviours so improvement was expected to take time, although participating organisations were showing improved sickness absence rates. It noted that sickness absence rates had not changed since 2010, being between 4.1% and 4.4%.

3.190 **NHS Employers** said that the 2018 NHS Staff Survey showed a service under continuing pressure with impacts on staff, but that there was some progress on people management. They highlighted that staff engagement had held stable overall, with a minority of organisations managing to improve, and a small improvement in the willingness of staff to recommend the NHS as a place to work. NHS Employers said that the NHS People Plan would include a national framework designed to promote improved staff experience in the NHS, known as Best Place to Work. This included the concept of a core offer which would set out expectations for staff in areas ranging from health and wellbeing to flexible working. NHS Employers added that new metrics had been included in the outcomes framework for the NHS supporting work to address bullying and harassment, to promote teamworking, and to enhance equality, diversity and inclusion.

3.191 **NHS E&I** said that the average rate of sickness absence in the NHS was 4.21% in 2018/19. They noted that the ambulance sector reported the highest levels of sickness absence at 5.40% followed by mental health and learning disability services at 4.85% and community provider trusts at 4.70%. Within non-medical staff groups, NHS E&I pointed to ambulance staff, midwives, nurses and health visitors consistently reporting the highest levels of sickness absence over the last three years.

3.192 NHS E&I said that the 2018 NHS Staff Survey showed an improvement across several areas compared with 2017, including staff motivation, job satisfaction, recognition and feeling valued. However, they considered that there was still more to do as many staff reported that there were not enough staff to do their job properly, and over half said they did not have adequate equipment to do their job. NHS E&I added that nearly a third of staff reported that they often think about leaving their job and one in five reported personally having experienced harassment, bullying or abuse at work from other colleagues.

3.193 NHS E&I pointed to their Improving Health and Wellbeing Programme which supported providers to improve their understanding and approach in relation to sickness absence and bullying in the workplace. NHS E&I had been working with 70 trusts to implement the framework with a positive difference in the sickness absence rates. They anticipated that in-month sickness absence across the trusts in the programme would be at 4.44% by June 2020, instead of 4.73% for those not in the programme.

3.194 NHS E&I provided information on their Improving People Practices Programme, which included: a toolkit to help remove barriers to movement of staff between NHS organisations; agreeing a national framework for statutory and mandatory training; and working with key partners to reduce the fragmentation of workforce IT systems and increase interoperability.

3.195 The **Joint Staff Side** referred to the Picker Institute's 2018 analysis of the NHS Staff Survey which showed that "staff experience was associated with sickness absence rates, spend on agency and staffing levels, indicating that staff wellbeing was impacted negatively by a workforce that was overstretched and supplemented by temporary staff … patient experience was also negatively associated with workforce factors". The Staff Side pointed to 2018 NHS Staff Survey results showing 39.8% of respondents reported being unwell as a result of work-related stress in the previous 12 months and 56.6% said they had gone to work when ill. The Staff Side cited that sickness absence rates rose from 3.8% in 2018 to 4.1% in 2019, and were running at 2.3% higher than the rest of the economy.

3.196 The **RCM** said that morale had not improved since 2018 and in many areas was worse. It said that almost three quarters (72%) of HOMs responding to its survey said that morale was "just ok or poor", compared with half in 2018. It said that HOMs themselves were feeling less supported and under pressure compared with the previous year and although 77% agreed that maternity was a priority in their organisation this was a steep fall from 87% in 2018.

3.197 On the experience at work, **Unite** said that a third of respondents to its survey raised attacks on their terms and conditions, and that local changes could have a significant impact on take-home pay. It felt that these changes were having an impact on wider morale and motivation in the workforce. Unite told us that its survey had the following responses:

- 64% "always" or "frequently" worked more than their contracted hours;
- 72% experienced frequent staff shortages in the last year;
- 66% said morale/motivation was worse than last year;
- 83% experienced workplace stress in the last year; and
- 39% were very seriously considering leaving their current position.

3.198 The **Welsh Government** told us that all partners in Wales recognised that supporting the health and wellbeing of the workforce was a broad area of work and needed to be addressed on a number of fronts to be effective. It had implemented an All Wales Managing Attendance at Work Policy[44] in 2018, and the 2018 AfC pay agreement made a commitment to developing and implementing a new approach to attendance management. It was agreed that the policy would provide a greater emphasis on the prevention of illness by improving staff health and wellbeing; as well as improved arrangements for returning staff to work after illness including the consideration of rapid access and early referral of staff to certain key services.

3.199 The **RCN Northern Ireland** told us that in the HSC Staff Survey just 27% of nurses believed that there were enough staff in their employing organisation for them to be able to do their job properly. The RCN commented that, more worryingly, 52% of nursing staff reported being injured or unwell as a result of work-related stress during the preceding 12 months. The RCN said that the Department of Health had recently confirmed that the total cost of sickness absence within the HSC during 2018/19 was £119,198,185, with a total of 2,881,383 nursing and midwifery working hours lost to sickness absence.

[44] NHS Wales (2018), *All Wales Managing Attendance at Work Policy*. Available at: http://www.wales.nhs.uk/sitesplus/862/opendoc/335874

## Recruitment and Retention Premia (RRP)

*General*

3.200 **DHSC** commented on making better use of local RRP to help attract and retain the workforce, adding that of particular concern was the need to grow the nursing workforce and to ensure trusts were able to attract staff with the IT skills they needed to support the efficient delivery of patient care.

3.201 DHSC told us that trusts already had available additional pay flexibilities like RRPs. These allowed additional payments to an individual post or specific group of posts where market pressures would otherwise prevent the employer from being able to recruit or retain staff in sufficient numbers to fulfil the roles the trust needed at the normal salary. DHSC stressed that RRPs could not, independently, resolve the nurse supply challenges but all trusts had the freedom to use local RRPs to address any local supply issues depending on their assessment of the labour market conditions. It said that trusts were required to review their premia regularly and should withdraw a premium if the market conditions changed and the need for the premium ceased or diminished.

3.202 DHSC told us that some trusts might be reluctant to pay RRPs. It suggested that: some trusts might be risk averse; the need to justify the payment and the consequences of failure to properly manage these payments could create successful challenge under equal pay law; and concerns that payment by some trusts and not others could create unhelpful competition for skilled staff. DHSC recognised that some trusts in a particular area could afford to pay RRPs but some could not, which could inadvertently make supply issues worse. It added that trusts were encouraged to liaise with neighbouring trusts when considering using local RRPs, and that collaboration between trusts was clearly in the best interest of trusts and most importantly patients.

3.203 DHSC said that of particular concern was the recruitment and retention of nurses. It pointed to the Government's commitment to attract and retain 50,000 nurses, and to the introduction of nursing students grants. For new and existing nurses, DHSC's shared ambition was to make the NHS the best place to work and it suggested that local strategies needed to strike the right balance between pay and non-pay benefits, adding that pay alone might not be sufficient. DHSC also highlighted that nurses were employed on the AfC contract which showcased the benefits of NHS employment, including learning and development, excellent pensions, a range of maternity, paternity and other policies that went beyond statutory requirements, and enabling staff to work flexibly.

3.204 **NHS Employers** said that RRP could not solve supply problems and could lead to unnecessary pay escalation. They strongly advocated a greater role for local NHS human resources in the determination of workforce supply, and that accurate determination of demand and supply would avoid the need for expensive pay solutions. NHS Employers felt that RRP were an important flexibility for employers and could be a cost-effective tool given the comparative costs of recruiting, use of agency staff or overtime. They said that local targeting of pay by employers was a more flexible approach than a national award, which could not respond to local differences. Employers often regarded the use of RRP as a last resort and preferred to investigate if problems were related to avoidable work-related pressures, working environment, and work volumes and procedures that required attention.

3.205 NHS Employers welcomed the opportunity to have a broader look at the future of RRP and noted that it would be necessary to understand how new care systems related to the labour markets in which they were operating. NHS Employers made the following comments on RRP:

- Employer feedback suggested that decisions to leave were motivated by a wide range of factors, not just pay. The causes of local recruitment and retention difficulties were complex;
- The NHS employed most registered nurses and other health professions and therefore set the market rate. Around one-third of non-clinical NHS roles were comparable with the private sector and the NHS needed to be able to compete on pay;
- Where the private sector used pay differentiation, it used relatively few pay bands linked to geographies;
- The NHS had a wide-ranging, sophisticated workforce that related to international, national, regional and local labour markets. Employers must be careful not to take local action leading to pay escalation or labour market instability;
- Just under half of employers responding to NHS Employers' 2019 Total Reward Survey said that they used recruitment and retention payments to support recruitment to hard-to-fill posts (for instance, clinical coders and some estates roles);
- Systems must be simple to operate and understood by staff and trades unions, and appropriate review mechanisms were essential. Once in place, RRP could be difficult to remove. Central collection and analysis of local labour market indicators would be welcomed; and
- Employers faced funding challenges and were reluctant to fund RRP from local budgets when there was no related allocation in the tariff.

3.206 The **Joint Staff Side** said that NHS trade unions had previously given a cautious welcome to the use of RRP. These were embedded in the AfC contract but the Staff Side's strong view was that the reduction on the use of RRP was almost entirely as a result of a lack of dedicated funding. The Staff Side noted that about 0.6% of all NHS staff received some kind of RRP payment. On national RRP, they said that it would not be acceptable for recurrent workforce funding to be diverted to support RRP, not least because these payments were reviewable on an annual basis and could be removed. On local RRP, the Staff Side argued that there appeared to be no direct relationship between the cost commitments faced by providers on pay, terms and conditions, and the funding providers received to cover these costs, as part of the NHS tariff. They said that there was also no direct relationship between additional money received by trusts for recruitment and retention difficulties, and whether the trust actually paid staff at a higher rate designed to account for those difficulties.

3.207 The Staff Side would welcome observations on: the criteria for the introduction, evaluation and extending/winding up of national RRP; the case for additional funding and the risks of funding within existing pay settlements; and ICSs taking on responsibility for workforce planning in their area.

3.208 The **Welsh Government** did not support the use of targeted pay to specific staff groups. It said that, although there were shortages of staff in specific specialities, evidence showed that these were UK-wide issues and related to the numbers of staff training in these areas, rather than the financial rewards. Where possible, NHS Wales aimed to maintain parity with the other nations regarding pay and any deviations could create difficulties in recruiting staff across borders. The Welsh Government said the challenge of recruiting to particular specialities needed to be addressed through workforce planning, recruitment initiatives and changing the way roles are designed.

3.209 The **Department of Health, Northern Ireland** told us that a Recruitment and Retention Framework was introduced in 2007 to address local recruitment difficulties and under these arrangements there were currently two long-term RRP in place.

3.210 The **RCN Northern Ireland** informed us that there was currently an extremely limited use of local RRP and that there was a recognised staffing crisis in many areas of nursing but there had not been any active proposals to utilise locally-targeted RRPs.

*IT staff*

3.211 **DHSC** agreed that the evidence base it provided in 2019 would not enable the identification of specific recruitment and retention issues for IT staff nor the case for a national RRP. DHSC said that, given it could not improve the evidence base and that neither NHS trades unions nor NHS trusts saw this group as the most pressing concern, the remit letter sought observations on how trusts might make better use of local RRPs to address any local challenges recruiting and retaining IT staff.

3.212 DHSC said that the previous evidence on IT staff suggested that the geographical location of trusts could be a barrier, for instance, trusts located in rural regions or where there is an absence of universities could make it harder to attract talent. It added that the pull of better paid private sector work could prove challenging for trusts located within major urban conurbations. DHSC also noted the conclusion that a "one size fits all" approach might not achieve its aims.

3.213 **NHS Employers** told us that they had not received new representations from employers on the need for national action on RRP for staff working in information technology. They considered that the central issue remained one of supply and, in a varied and very broad field, employers had varying needs for staff with a very wide range of knowledge, skills and experience. NHS Employers emphasised that local RRP, operated by employers when they identified appropriate circumstances, were the best way to address shortages and that they did not support new national RRP for staff in IT roles. They concluded that new RRP imposed on employers without associated new funding would inevitably create new financial pressures locally.

3.214 **NHS Providers** told us that support for targeting of pay awards and RRP for IT staff was mixed among HR Directors who gave feedback to its survey. They reported that, while 51% were in favour of RRPs for IT staff, 28% were not, and 21% did not know. They added that 66% of HR Directors said that they found recruiting IT staff difficult, and among those who supported the use of RRP for IT staff, respondents noted that the loss of staff to the private sector was a challenge in this area. They also reported that some HR Directors felt it would be divisive, given that there were shortages of staff across clinical and non-clinical roles.

## High Cost Area Supplements (HCAS)

3.215 The **Joint Staff Side** told us that an estimated 200,000 posts attracted a HCAS payment, which was a significant proportion of the overall workforce. They highlighted the following issues with the existing HCAS system:

- The system owed more to evolution than design and had not been reviewed in nearly two decades;
- HCAS should be paid as a proportion of basic pay but was effectively a two-tier flat rate payment. The minima and maxima had increased by the "headline" pay award under the 2018 AfC pay agreement;

- Payment areas were based on the Primary Care Trust geographical boundaries, which were replaced in 2013 by Clinical Commissioning Groups. Reforms to service delivery through STPs and ICSs had changed the way staff were employed and deployed;
- It was becoming increasingly difficult to see a clear distinction between inner and outer London in areas such as house prices, transport links and employer/service configurations. There was no rationale for why some areas on the edge of London were included and some not;
- Funding through the Market Forces Factor used Travel To Work Areas (TTWAs) to estimate staff costs and all trusts in the greater London TTWA received the same proportion of payment for employing staff, regardless of whether they paid inner, outer or fringe HCAS payments;
- The primary purpose of HCAS was to preserve the relative value of AfC pay by compensating for the additional costs of living. The ONS[45] estimated that in 2016 the cost of living in London was 8.3% higher than the rest of England and experimental ONS work also suggested that it was increasing at a faster rate in London than elsewhere in the UK; and
- HCAS had lost value in relation to inflation, and the minima and maxima should be 21% higher based on uprating by RPI inflation since 2010.

3.216 **Unite** told us that there was not enough use of HCAS for areas outside London and the fringe. It said that this failed to recognise the high costs imposed upon others who live outside the current supplement area and that average house prices in some other parts of the country were similar to some parts of London resulting in the inability to either purchase or rent in a location within reasonable distance to their workplace. Unite concluded that the cost of living outside HCAS areas should be considered as part of wider recommendations on NHS pay and when reviewing HCAS.

[45] Office for National Statistics (2018), *UK Relative Regional Consumer Price Levels for Goods and Services, UK: 2016*. Available at: https://www.ons.gov.uk/economy/inflationandpriceindices/articles/relativeregionalconsumerpricelevelsuk/2016

# Chapter 4 – Agenda for Change Staff in the NHS – Our Analysis of the Evidence

## Introduction

4.1 Our analysis in this chapter is based on the evidence submitted by the parties before COVID-19 and subsequent available data on the economy, labour market, AfC earnings and the AfC workforce. This chapter covers our analysis of the trends as they relate to our terms of reference. We also assess the remit matters referred to us, which are monitoring the 2018 AfC pay agreements, observations on Recruitment and Retention Premia in England, views on the factors specific to the Northern Ireland health and social care labour market, and the re-establishment of AfC pay parity in Northern Ireland.

## Economy and labour market

4.2 In normal circumstances we would assess the latest and forecast economic indicators to inform our conclusions. We are in an unprecedented position at the time of this report in that we are at the start of a period that will have significant impacts on the economy and labour market. The length and magnitude of the effects are highly uncertain and there will be a time lag before official data shows the effects.

4.3 We comment in Chapter 1 on the broad effects we might expect to see as they relate to the economy, the labour market, the NHS and its workforce. We also note the context for our deliberations provided by HM Treasury, and the emerging forecasts and scenarios from economic commentators. In this chapter, we therefore set out the Government's response to COVID-19 and the latest available data at the time of this report, including the latest OBR scenario to model the potential scale of the economic disruption. We note that this scenario was based on the assumption that the downturn was confined to the second quarter of 2020 with a return to pre-crisis levels of GDP over the following two quarters with no subsequent effects on the long-term growth path for GDP. We also take note of the more recent illustrative economic scenario produced by the Bank of England.

4.4 The Government has made a number of responses in an effort to mitigate the damage from the restrictions from COVID-19 on the economy and to support a return to work. These included: a scheme to pay 80% of the wages of furloughed workers and the self-employed up to £2,500 per month; increases to Universal Credit and housing benefit; business rates support and grants to small businesses; and additional public service spending, including a £5 billion emergency response fund. The OBR[46] estimated that these responses would cost £100 billion in 2020/21, with receipts estimated to be £130 billion lower, mostly due to lower income tax and VAT, and this being offset by lower debt interest payments of around £10 billion, reflecting the lower bank rate, and a small underspend of £2 billion by departments. Overall, the OBR estimated that this would increase public sector borrowing in 2020/21 by £218 billion relative to its March Budget forecast to reach £273 billion or around 14% of GDP.

4.5 We summarise below the economic and labour market indicators at the time of our considerations for this report:

- Economic growth. Before COVID-19, UK GDP grew by 1.4% in 2019, in line with the EU and G7 average. Data from the ONS showed that, compared with the previous quarter, GDP was flat in the final quarter of 2019 and fell by 2.0% in the first quarter of 2020;

[46] Office for Budget Responsibility (April 2020), *Coronavirus Reference Scenario.* Available at: https://obr.uk/coronavirus-reference-scenario/

- The Bank of England[47] constructed an illustrative economic scenario which incorporated a 30% fall in UK GDP in the first half of 2020 and a substantial increase in unemployment. While the Bank expected the fall in activity to be temporary, the economy would take some time to recover towards its previous path. Over the next two years, because of spare capacity in the economy and a fall in many commodity prices, the Bank's scenario showed Consumer Prices Index (CPI) inflation to be in the region of 0.5%;
- The OBR's scenario showed a drop in output in the second quarter of 2020 of 35% and even though GDP was assumed to return to the pre-crisis levels by the end of the fourth quarter of 2020, there would be a 12.8% reduction in GDP over the year;
- Inflation. At April 2020, CPI was at 0.8%, Consumer Prices Index Including Owner Occupiers' Housing Costs (CPIH) inflation was at 0.9% and Retail Price Index (RPI) inflation at 1.5%. Inflation had been on a broad downward path since 2018;
- The OBR expected a temporary drop in CPI inflation to 0.7% in the second quarter of 2020, as a result of the falling oil price, followed by a rise to 2.7% in 2021 and then a move back towards the 2% target. The OBR expected RPI inflation to see a greater fall due to lower mortgage interest payments and lower house prices;
- Labour market. Employment rose by 1.4% over the year to March 2020 to reach 33.1 million. The employment rate was at 76.6% in the three months to March 2020, up 0.6 percentage points over the year. The unemployment rate was 3.9% in March 2020, up from 3.8% in the three months to December 2019;
- The OBR's model estimated a steep rise in the unemployment rate to 10% in the second quarter of 2020, equivalent to an increase in the level of unemployment of 2.1 million (to a total of 3.4 million). The OBR pointed out that levels of unemployment would be very dependent on the success of the job retention scheme and the support for the self-employed. The OBR expected the reversal of unemployment to be slower than that of GDP;
- The ONS's Business Impact of Coronavirus Survey and a Chartered Institute of Personnel Development's (CIPD) survey of HR professionals suggested a range of employer responses, including reduced working hours, short-term reductions in staffing levels, temporary layoff of staff, and staff working from home. In the CIPD survey, 4% of employers said that they would continue to hire and need more staff to cope with demand;
- The ONS[48] estimated that there were 637,000 vacancies in businesses across the UK as a whole in the three months to April 2020, a fall of 170,000 (21%) from the previous quarter and the largest quarterly decrease since the time series started in 2001. The ONS reported that, between January to March 2019 and January to March 2020, average weekly hours fell by 0.8 hours to 31.4 hours. It cited experimental estimates based on returns for individual weeks which suggested that this fall was mostly caused by the decrease in hours in the last week of March 2020, which was around 25% fewer than in other weeks within the quarter;
- Pay settlements. Median pay settlements were at 2.5% in 2019 and the latest estimates ranged from 2.4% to 2.5% in the first quarter of 2020;
- Average earnings. For the three months to March 2020, whole economy average weekly earnings growth was at 2.4% and regular pay growth (excluding bonuses) was at 2.7%. Public sector average earnings growth (excluding financial services), having peaked at 3.9% in the three months to June 2019, was at 3.4%. Private sector average earnings growth, having peaked at 4.0% in the three months to June 2019, was at 2.2%;

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47 Bank of England (May 2020), *Monetary Policy Report May 2020.* Available at: https://www.bankofengland.co.uk/-/media/boe/files/monetary-policy-report/2020/may/monetary-policy-report-may-2020

48 Office for National Statistics (May 2020), *Labour Market Review, UK: May 2020*. Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/uklabourmarket/may2020

- National Living Wage. In the March 2020 Budget, the Government confirmed its ambition for the National Living Wage (NLW) to continue increasing towards two-thirds of median earnings by 2024. The remit to the Low Pay Commission (LPC) included an "emergency brake" which asked the LPC to monitor the labour market and the impacts on the NLW closely, to advise on any emerging risks and, if the evidence warranted it, to recommend that the Government reviewed its target or timeframe;
- Employers' response to COVID-19. Employers in some areas of the private sector, where demand had increased, had made a number of temporary pay increases to staff. Tesco announced a temporary 10% pay uplift for staff[49], Aldi and Sainsbury's offered a similar 10% temporary uplift, Marks & Spencer had reportedly offered a 15% uplift[50], Morrisons said it would pay an additional bonus to frontline staff worth around £700[51], Asda announced that customer-facing staff would receive an additional weeks' pay in June (worth around 2%)[52], and Barclays Bank was reportedly offering triple overtime pay to frontline staff[53]. Amazon had temporarily increased pay for employees in its UK fulfilment and delivery roles by £2 an hour;
- There had also been some effects on executive pay[54] – 37% of FTSE 100 companies had cut executive pay in order to reduce costs during the shutdown, although only 13% had cut bonuses and long-term incentive payments. 33% of FTSE 100 companies had withdrawn or withheld dividend payments.

4.6 In April 2020, the Institute for Fiscal Studies (IFS) published a report[55] on differences in pay for key workers[56] in the light of COVID-19. The IFS found that key workers were more likely to be female and were somewhat lower paid than other employees. The median key worker earned £12.26 per hour in today's prices last year, 8% less than the £13.26 per hour earned by the median earner in a non-key occupation.

4.7 The IFS found that there were big differences between key workers in different sectors. In the food and social care sectors employees typically earned lower wages and held lower levels of qualifications. A quarter of health and social care workers were born somewhere other than the UK. There were also significant variations in key worker wages. The median key worker in the health sector[57] earned £14.67 per hour, 13% more than the median employee, and the median key worker in social care earned £9.13 an hour, 30% less than the median employee.

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49 Tesco Plc (March 2020), *Tesco Thanks Colleagues with Pay Bonus for Going Above and Beyond.* Available at: https://www.tescoplc.com/news/2020/tesco-thanks-colleagues-pay-bonus/

50 Aldi (March 2020), *Aldi to Pay Store and Distribution Colleagues a 10% Bonus*. Available at: https://www.aldipresscentre.co.uk/press-releases/view/909

51 Morrisons (March 2020), *Morrisons Thanks Army of Colleagues with Threefold Increase in Bonus for Next 12 Months.* Available at: https://www.morrisons-corporate.com/media-centre/corporate-news/morrisons-thanks-army-of-colleagues-with-threefold-increase-in-bonus-for-next-12-months/

52 Asda (March 2020), *Asda Extends Pay Support for Colleagues Through COVID-19.* Available at: https://corporate.asda.com/newsroom/2020/03/27/asda-extends-pay-support-for-colleagues-through-COVID-19

53 The Guardian (April 2020), *Barclays Offers Triple Overtime Pay for Staff on Coronavirus Frontline.* Available at: https://www.theguardian.com/business/2020/mar/31/barclays-offers-triple-overtime-pay-for-staff-on-coronavirus-frontline?CMP=Share_AndroidApp_Raindrop

54 High Pay Centre (April 2020), *High Pay Centre Briefing: Corporate Response to the Economic Shutdown.* Available at: http://highpaycentre.org/pubs/high-pay-centre-briefing-corporate-response-to-the-economic-shutdown

55 Institute for Fiscal Studies (April 2020), *Differences Between Key Workers*. Available at: https://www.ifs.org.uk/publications/14818

56 The IFS focussed on six of the Government's classification of eight different categories of key workers, covering: health and social care; education and childcare; professional services; the food supply chain; public order and defence; and transport. Key workers in local and national government, and utilities, communication and financial services could not easily be identified in the available data. This definition includes groups of NHS workers, such as medical staff, that are outside the remit of the NHSPRB.

57 The main source for the IFS comparisons was the Labour Force Survey. Health sector workers included medical staff.

4.8 The CIPD's quarterly Labour Market Outlook[58] for spring 2020 indicated that employment intentions had declined significantly since its winter 2019/20 Labour Market Outlook. Almost half (49%) of organisations surveyed said they would maintain total staff levels in the three months to July 2020, almost a fifth (19%) said that they would increase staff levels and just over a fifth (22%) intended to decrease staff levels – the latter up from 11% from the winter 2019/20 survey. There had been a significant drop from the positive employment intentions recorded in the winter quarter, with the main drop in the private sector. This contrasted with increased employment intentions in the public sector, with intentions being most positive in healthcare and public administration. Recruitment intentions among those surveyed also declined with 40% of employers planning to recruit in the three months to July 2020, down 26 percentage points from the winter quarter, to its lowest level since the CIPD survey began in 2005. The survey indicated that 22% of organisations expected to make some redundancies in the next three months, up 6 percentage points from the winter quarter.

4.9 The CIPD reported that 67% of employers surveyed intended to review wages in the next 12 months, with 33% intending to postpone their pay decision this year, up from 14% in the winter quarter. The resulting average pay increase (excluding bonuses) following the reviews was expected to drop significantly over the next 12 months, particularly in the private sector. Over half (51%) of private sector employers planned to freeze pay following their next pay review. The CIPD survey found that employers' median basic pay expectations were for a 1% increase, down from 2% in the winter quarter. Basic pay expectations in the private sector were 0%, compared with 2% three months ago, with pay expectations remaining unchanged in the public sector at 1.5%. Just over half (52%) of employers planned to take part in the Government's new Job Retention Scheme. Of those participating in the scheme, employers indicated that 60% of workers would be furloughed on average, with participants saying that they would have made 35% of their workforce redundant on average if it was not for the scheme.

### *Our conclusions on the economy and labour market*

4.10 We comment in Chapter 1 that the effects of COVID-19 on the economy and labour market are unknown at present. The effects on the labour market could be felt for some time to come, which might in turn impact on pay including potential differences between the public and private sector. There is uncertainty over the length and depth of the economic downturn and the associated state of Government finances and this, plus other considerations, will affect future spending plans on health and social care, which play into our considerations of the affordability of pay awards. While there have been some initial scenarios and forecasts published on the economy and some data has been released on the immediate effects of COVID-19, the data and information fully to understand the short and long-term effects are not available and we will return to these as they emerge for our future reports. In the meantime, we continue to look at the longer-term trends to inform our pay considerations.

4.11 At the beginning of 2020 employment growth continued to be strong and unemployment had slightly increased but had been low throughout 2019. However, by March 2020 average earnings in both the public and private sectors had fallen back after reaching the highest rates in June 2019 since the 2008 recession. Median pay settlements were at 2.5% in 2019. Economic growth throughout 2019 remained subdued at 1.4% reflecting global economic uncertainties and those uncertainties from the trade deals which might be reached with both the EU and the rest of the world following the UK's exit from the EU. Inflation was on a downward path through 2018 and 2019.

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[58] CIPD (May 2020), *Labour Market Outlook Spring 2020*. Available at: https://www.cipd.co.uk/knowledge/work/trends/labour-market-outlook

4.12 We note that the Staff Side's evidence refers to the effects of pay restraint since 2010 relative to inflation. In this context, we continue to report on both CPI and RPI measures of inflation, alongside other economic and labour market indicators, although we note as we have said in previous reports that the different inflation measures reflect the different concerns of the parties.

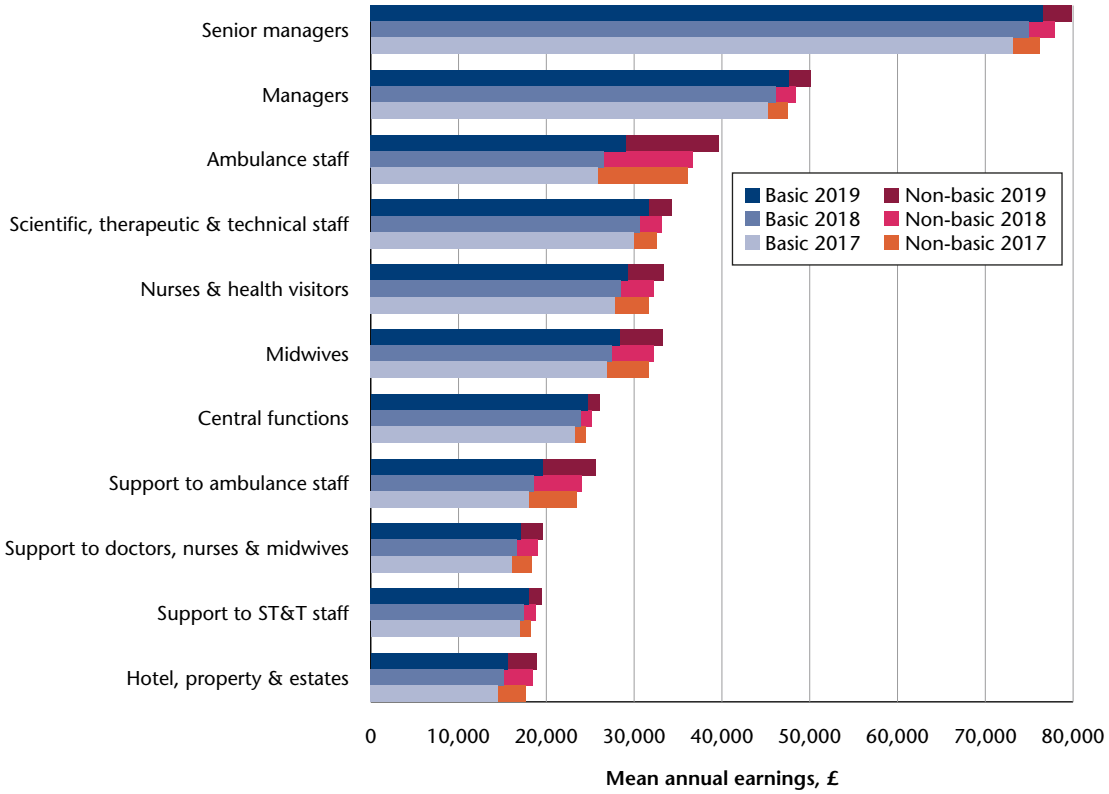
4.13 The indicators on the economy and labour market had already begun to indicate that the tightening we saw in the labour market during 2019 might have been easing in early 2020. However, the NHS continues to carry significant levels of vacancies and has widespread staff shortages, which require the NHS to continue to offer attractive posts and careers. The longer-term trends in the economy and labour market and the short-term effects of COVID-19 will provide the backdrop to our considerations of AfC recruitment, retention and motivation in later reports.

## Agenda for Change earnings and total reward

4.14 In this section we assess AfC earnings covering the first period of the 2018 AfC pay agreements. Over the three years of the AfC pay agreements there will be different pay and earnings effects for individual AfC staff depending on whether they are at the start of a career, progressing through the system or reaching the top of pay bands. Earnings data for the calendar year of 2019, published by NHS Digital (see Figure 4.1), show that all AfC staff groups in England, compared with 2018, experienced growth in total earnings of at least 2.4%. The largest increases in total earnings were for ambulance staff (8.2%) and support to ambulance staff (6.6%). Except for senior managers (2.2%), all AfC staff experienced growth in basic pay of at least 2.8%. Ambulance staff (9.5%) and support to ambulance staff (5.6%) saw the largest increases in basic pay. All staff groups saw an increase in additional earnings[59], and except for ambulance staff, the percentage increases were as least as large as the percentage increase in their basic earnings. The staff groups with the largest increases in additional earnings were support to scientific, therapeutic and technical staff (10.5%) and support to ambulance staff (10.1%).

[59] Additional earnings include payments for additional activity, geographic allowances, local payments, on-call, overtime, recruitment and retention premia, shift work payments, other payments.

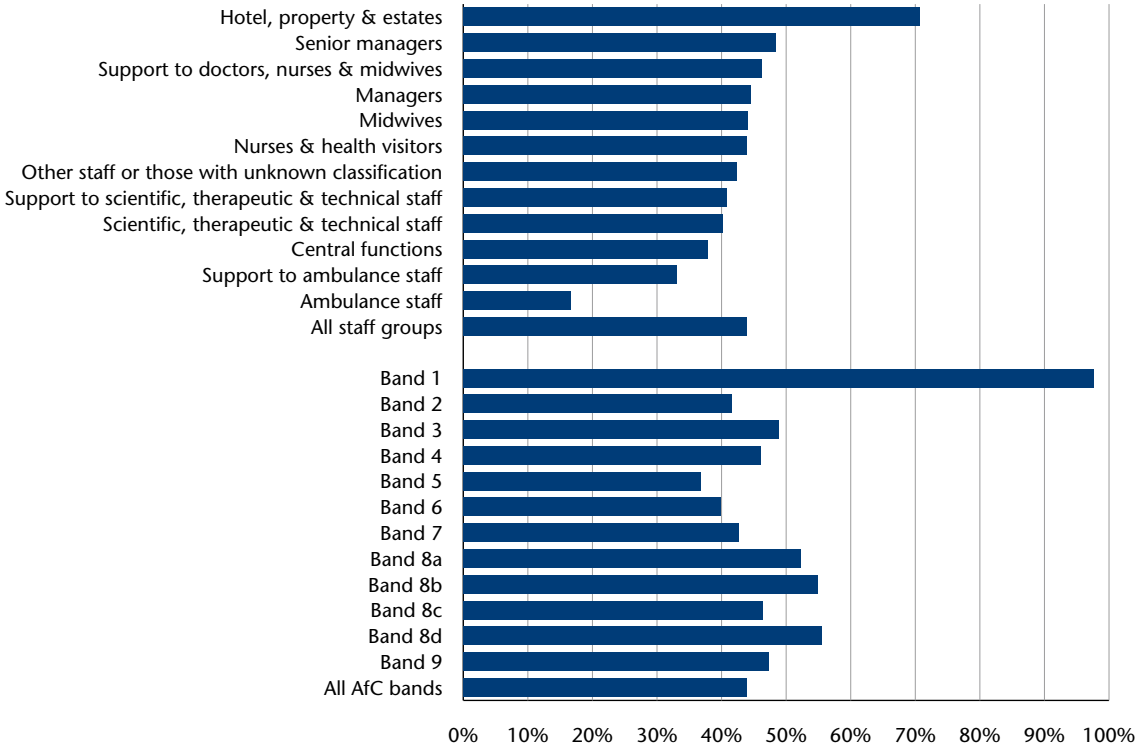
**Figure 4.1: Mean basic and non-basic salary per person, by main staff groups, 2017 to 2019, England**




*Source: NHS Digital*

4.15 Figure 4.2 shows that in England, at the end of March 2019, 44% of AfC staff were at the top of their pay band. The proportion varied across staff groups with most having between one-third and one-half at the top of their band, the exceptions being qualified ambulance staff (17%) and hotel, property and estates staff (71%). Other than Band 1, which now only has one pay point, just over a half of Band 8 staff were on the top of their band while between 37% and 49% of staff on all other bands were on the top of their band.

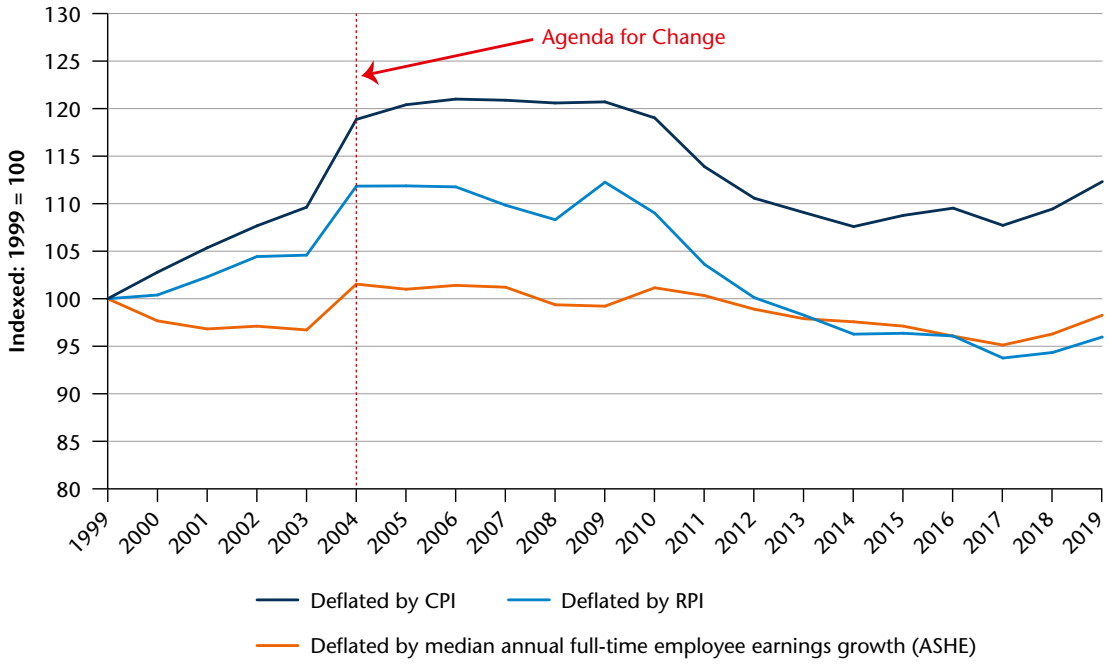
**Figure 4.2: Estimated share of staff (FTE) on top of band by staff group and band, 31 March 2019, England**




*Source: NHS Digital*

4.16 Figure 4.3 shows changes to the nurse starting pay point in England since 1999, adjusted either for inflation or earnings growth in the wider economy. The Figure shows the impact on nurse starting pay of the introduction of the Agenda for Change pay system in 2004, compared with both CPI and RPI measures of inflation and with earnings growth. Following the introduction of Agenda for Change, the nurse starting pay point in England maintained its value against both inflation and average earnings growth until 2009, shortly after the financial crash. Between 2009 and 2017, the first point on the scale lost value, particularly compared with inflation as measured by RPI, and to a slightly lesser extent relative to full-time employee earnings growth. The increase in value of the starting pay point for nurses contained in the 2018 AfC pay agreement meant that for both 2018 and 2019 starting pay for nurses grew more quickly than price inflation and average earnings.

**Figure 4.3: Nurse starting pay point deflated by the growth in median average earnings and inflation, England, 1999 to 2019**




*Source: OME analysis of ONS data (Annual Survey of Hours and Earnings (ASHE), CPI (D7G7) April each year, RPI (CZBH) April each year)*

## *Pay comparisons*

4.17 The level of pay in the human health and social work activities sector remained below that of all employees across the economy as a whole and that of professional, associate professional and technical occupations. Data from the Annual Survey of Hours and Earnings (ASHE), in Table 4.1, show that median weekly pay in the human health and social work activities sector increased by 4.4% in 2019, a larger increase than that recorded for employees in the private sector and the economy as a whole.

**Table 4.1: Change in median gross weekly pay for full time employees at adult rates, 2017 to 2019, April each year, United Kingdom**

| United Kingdom | Median gross weekly pay (change on previous year) | | | | | | |
|---|---|---|---|---|---|---|---|
| | 2017 | | 2018 | | 2019 | | Change 2017-2019 |
| Human health and social work activities sector | £510 | (0.0%) | £530 | (3.9%) | £553 | (4.4%) | 8.5% |
| All employees | £550 | (2.1%) | £568 | (3.3%) | £585 | (2.9%) | 6.3% |
| Public sector | £600 | (1.0%) | £613 | (2.2%) | £632 | (3.2%) | 5.4% |
| Private sector | £531 | (2.7%) | £548 | (3.3%) | £570 | (4.0%) | 7.3% |
| Professional occupations[1] | £733 | (1.0%) | £745 | (1.6%) | £768 | (3.2%) | 4.8% |
| Associate professional and technical occupations[2] | £605 | (2.3%) | £619 | (2.4%) | £624 | (0.8%) | 3.2% |
| Administrative and secretarial occupations | £431 | (2.0%) | £445 | (3.2%) | £458 | (2.9%) | 6.2% |
| Skilled trades occupations | £510 | (2.6%) | £524 | (2.7%) | £541 | (3.3%) | 6.2% |
| Caring, leisure and other service occupations | £361 | (2.4%) | £374 | (3.4%) | £392 | (5.0%) | 8.6% |

*Source: ONS (Annual Survey of Hours and Earnings)*

*Notes:*

*[1] Includes, for example, teachers, solicitors, accountants, doctors and some AHPs and ST&Ts. Nurses and midwives are in this group from April 2011.*

*[2] Includes, for example, police officers and some AHPs and ST&Ts.*

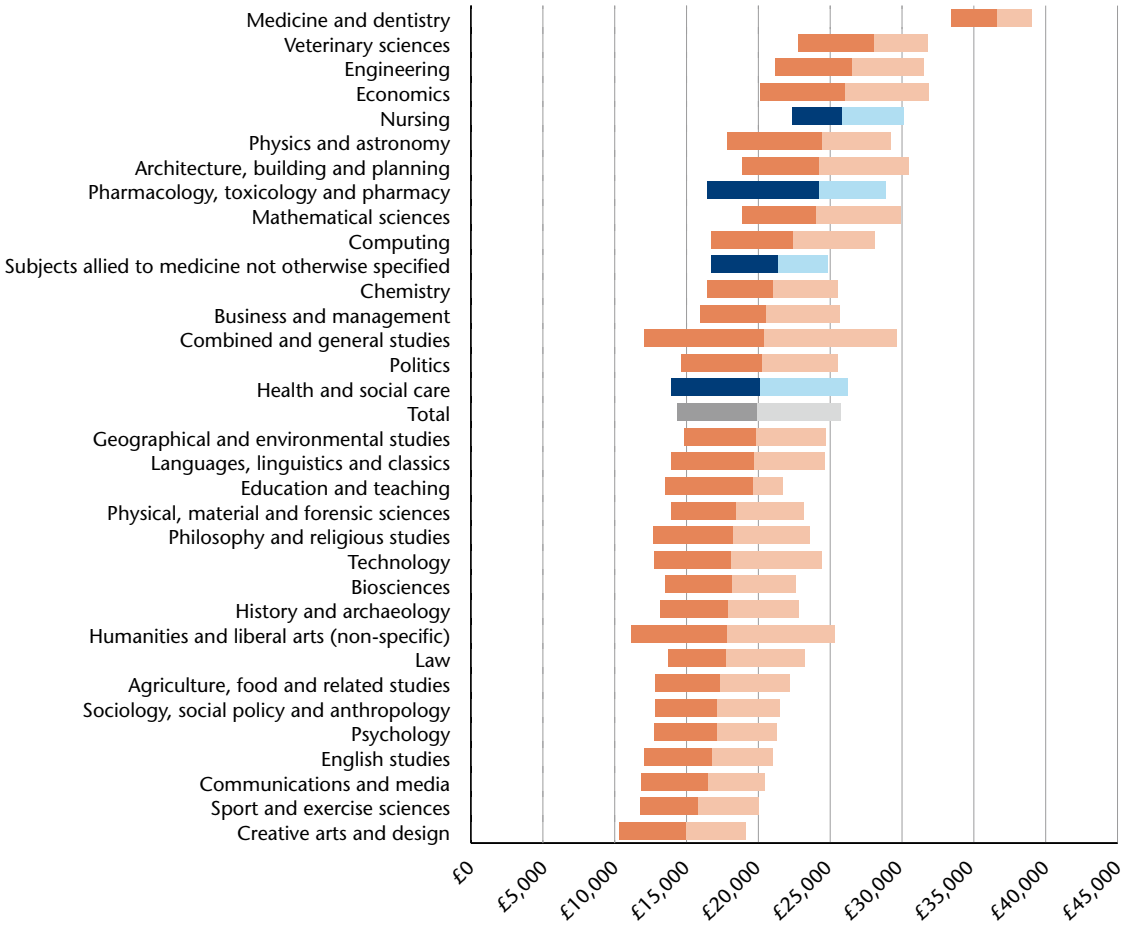
4.18 Data from the Longitudinal Education Outcomes (LEO) data set, published by the Department for Education, tracks the nominal earnings[60] of UK-domiciled first-degree graduates from English Higher Education Institutions and Further Education Colleges, using HMRC data. The data show median earnings in 2016/17, by subject studied, for those one, five and ten years after graduation. The LEO data covers annual earnings, including both full and part time workers, and is not adjusted for geography, age or other factors. It also includes the earnings of those working in areas unrelated to their degree subject, for example someone with a nursing degree working outside the health sector.

4.19 Figure 4.4 shows median earnings (the centre line of the bars), and the inter-quartile range of earnings (the end points of the bars), one year after graduation. Median earnings were £25,800 for those who studied nursing, £24,200 for those who studied pharmacology, toxicology and pharmacy, £21,300 for those who studied other subjects allied to medicine and £20,100 for those who studied subjects related to health and social care. Overall graduate median earnings were £19,900.

4.20 Only those who studied medicine and dentistry, veterinary science, engineering and economics had higher median earnings than those who had studied nursing. Median earnings for those who had studied pharmacology, toxicology and pharmacy and other subjects allied to medicine were above the median for graduates as a whole, and those who studied health and social care had median earnings in line with that for graduates as a whole.

[60] Nominal earnings defined as the cash amount an individual was paid, not adjusted for inflation.

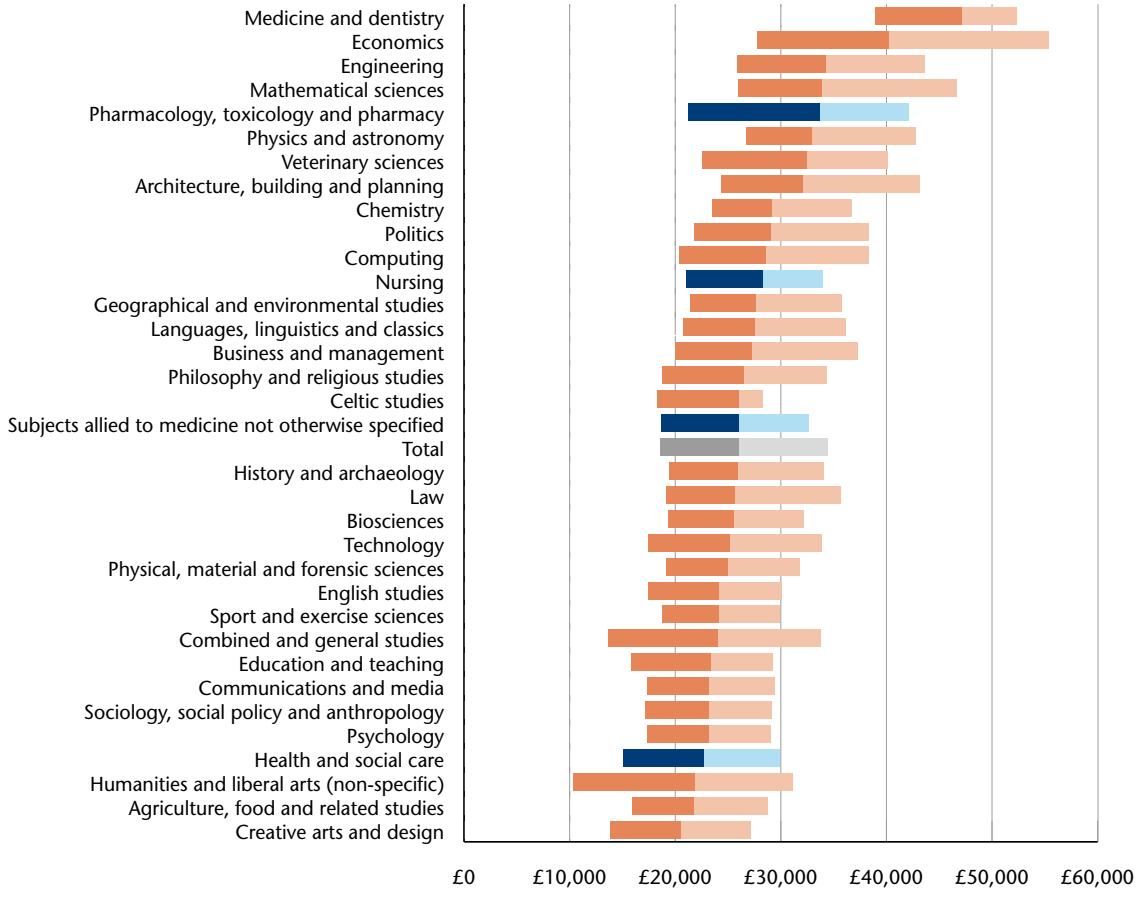
**Figure 4.4: Annual gross earnings one year after graduation (2014/15 cohort), lower quartile, median and upper quartile, £**




*Source: OME analysis of LEO data set*

4.21 Figure 4.5 shows that median earnings, five years after graduation, were £33,700 for those who studied pharmacology, toxicology and pharmacy, £28,300 for those who studied nursing, £26,000 for those who studied other subjects allied to medicine and £22,700 for those who studied subjects related to health and social care. Median earnings for those studied pharmacology, toxicology and pharmacy were behind only those who had studied medicine and dentistry, economics, engineering and mathematical sciences. Median earnings for those who studied nursing remained above that for graduates as a whole, while median earnings for those who had studied subjects allied to medicine was in line with the overall median and those who studied health and social care had median earnings 13% below those for graduates as a whole.

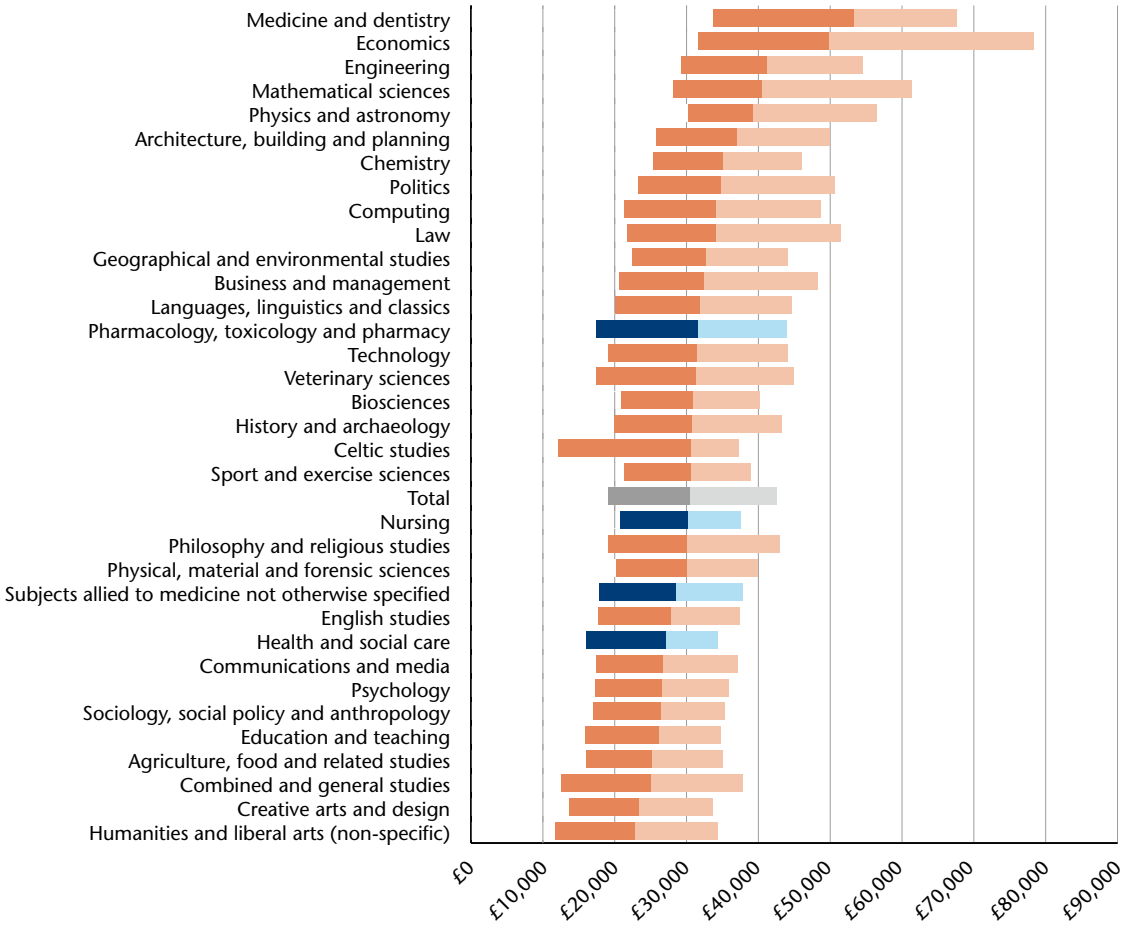
**Figure 4.5: Annual gross earnings five years after graduation (2010/11 cohort), lower quartile, median and upper quartile, £**




*Source: OME analysis of LEO data set*

4.22 Figure 4.6 shows that median earnings, ten years after graduation, were £31,600 for those who studied pharmacology, toxicology and pharmacy, £30,100 for those who studied nursing, £28,500 for those who studied other subjects allied to medicine, and £27,100 for those who studied subjects related to health and social care. Median earnings for those who studied pharmacology, toxicology and pharmacy remained above the median for graduates as a whole, median earnings for those who studied nursing were in line with those for graduates as a whole, while median earnings for those who had studied subjects allied to medicine and health and social care were below the overall median.

**Figure 4.6: Annual gross earnings ten years after graduation (2005/06 cohort), lower quartile, median and upper quartile, £**




*Source: OME analysis of LEO data set*

*Pay by gender and ethnic group*

4.23 NHS Digital published data showing the difference in mean annual basic pay of male and female staff across the NHS in England, by staff group, in January 2019. Table 4.2 shows that for all AfC staff groups the pay gap is 6% for basic pay. Among the different AfC staff groups, the pay gap for basic pay is widest for staff in infrastructure support groups, including: central functions (12%); senior managers (11%); and hotel, property and estates staff (10%). For support staff to ambulance staff (1%) and those supporting doctors, nurses and midwives (1%) there is a small pay gap for basic pay in favour of women. Compared to the position at the time of our 2019 Report these data show little change in the size of pay differences between men and women in each staff group. These data do not include other elements of pay, such as overtime or shift work payments, which may not be distributed between men and women in the same way as basic pay.

**Table 4.2: Mean monthly basic pay per FTE by gender for AfC staff, England, January 2019**

| | Mean basic pay £ per FTE | | |
|---|---|---|---|
| | **Male** | **Female** | **Gap (F/M) %** |
| *All AfC staff* | 2,507 | 2,349 | -6 |
| | | | |
| *Clinical staff* | | | |
| Nurses & health visitors | 2,730 | 2,699 | -1 |
| Midwives | 2,936 | 2,826 | -4 |
| Ambulance staff | 2,415 | 2,292 | -5 |
| Scientific, therapeutic & technical staff | 3,080 | 2,986 | -3 |
| *Support to clinical staff* | | | |
| Support to doctors, nurses & midwives | 1,638 | 1,647 | +1 |
| Support to ambulance staff | 1,689 | 1,706 | +1 |
| Support to ST&T staff | 1,747 | 1,734 | -1 |
| *NHS infrastructure support* | | | |
| Central functions | 2,536 | 2,228 | -12 |
| Hotel, property & estates | 1,701 | 1,528 | -10 |
| Senior managers | 7,295 | 6,485 | -11 |
| Managers | 4,426 | 4,161 | -6 |

*Source: NHS Digital*

*Note: A negative pay gap means female pay is below that of male pay*

4.24 The key features of the data in Table 4.3 are that the mean monthly basic pay of all non-white AfC groups is below that of white employees (based on NHS Digital definitions) and, for identified groups, the size of the shortfall is between 3% and 8%. For future reports, we would be interested in data on the gender and ethnicity pay gap for Scotland, Wales and Northern Ireland.

**Table 4.3: Ethnicity pay gap, mean monthly basic pay per FTE, for AfC staff, England, January 2019**

| | Mean basic pay £ per FTE | |
|---|---|---|
| | | Ethnicity pay gap (ethnic group/ white) % |
| White | 2,406 | |
| Asian/Asian British | 2,292 | -5 |
| Black/African/Caribbean/Black British | 2,220 | -8 |
| Mixed/Multiple ethnic groups | 2,262 | -6 |
| Other ethnic group | 2,323 | -3 |
| Unknown | 2,383 | -1 |

*Source: OME calculations using data from NHS Digital*

*Note: A negative pay gap means the pay of AfC staff in a particular ethnic group is lower than that of those in the white ethnic group(s). More detailed definitions of each group can be found at https://www.ethnicity-facts-figures.service.gov.uk/*

### *Take-home pay*

4.25 In the two years since the introduction of the 2018 AfC pay agreements, basic pay for NHS staff at the top of their band in England had increased by between 12.6% for Band 1 and 3.4% for Band 9. After taking account of changes to income tax, national insurance and pension contributions, take-home pay increased by between 11.4% for Band 1, the highest increase, and 4.2% for Band 8a, the lowest increase, over the same period.

**Table 4.4: Basic full time pay and take-home pay, at the top of pay bands, England 2017/18 to 2019/20**

| | Basic Pay | | | 1-year change | | 2-year change | |
|---|---|---|---|---|---|---|---|
| Top of: | 2017/18 | 2018/19 | 2019/20 | £ | % | £ | % |
| Band 1 | £15,671 | £17,460 | £17,652 | £192 | 1.1 | £1,981 | 12.6 |
| Band 2 | £18,157 | £18,702 | £19,020 | £318 | 1.7 | £863 | 4.8 |
| Band 3 | £19,852 | £20,448 | £20,795 | £347 | 1.7 | £943 | 4.8 |
| Band 4 | £22,683 | £23,363 | £23,761 | £398 | 1.7 | £1,078 | 4.8 |
| Band 5 | £28,746 | £29,608 | £30,112 | £504 | 1.7 | £1,366 | 4.8 |
| Band 6 | £35,577 | £36,644 | £37,267 | £623 | 1.7 | £1,690 | 4.8 |
| Band 7 | £41,787 | £43,041 | £43,772 | £731 | 1.7 | £1,985 | 4.8 |
| Band 8a | £48,514 | £49,969 | £50,819 | £850 | 1.7 | £2,305 | 4.8 |
| Band 8b | £58,217 | £59,964 | £60,983 | £1,019 | 1.7 | £2,766 | 4.8 |
| Band 8c | £69,168 | £71,243 | £72,597 | £1,354 | 1.9 | £3,429 | 5.0 |
| Band 8d | £83,258 | £85,333 | £86,687 | £1,354 | 1.6 | £3,429 | 4.1 |
| Band 9 | £100,431 | £102,506 | £103,860 | £1,354 | 1.3 | £3,429 | 3.4 |

| | Take-home pay | | | 1-year change | | 2-year change | |
|---|---|---|---|---|---|---|---|
| Top of: | 2017/18 | 2018/19 | 2019/20 | £ | % | £ | % |
| Band 1 | £13,234 | £14,471 | £14,748 | £277 | 1.9 | £1,514 | 11.4 |
| Band 2 | £14,813 | £15,260 | £15,617 | £357 | 2.3 | £804 | 5.4 |
| Band 3 | £15,890 | £16,369 | £16,745 | £375 | 2.3 | £855 | 5.4 |
| Band 4 | £17,416 | £17,941 | £18,344 | £403 | 2.2 | £928 | 5.3 |
| Band 5 | £20,688 | £21,311 | £21,772 | £460 | 2.2 | £1,083 | 5.2 |
| Band 6 | £24,825 | £25,572 | £26,105 | £532 | 2.1 | £1,280 | 5.2 |
| Band 7 | £28,586 | £29,447 | £30,044 | £598 | 2.0 | £1,458 | 5.1 |
| Band 8a | £31,769 | £32,725 | £33,093 | £368 | 1.1 | £1,324 | 4.2 |
| Band 8b | £37,179 | £38,298 | £39,332 | £1,035 | 2.7 | £2,153 | 5.8 |
| Band 8c | £42,710 | £43,566 | £44,762 | £1,196 | 2.7 | £2,052 | 4.8 |
| Band 8d | £49,325 | £50,597 | £51,793 | £1,196 | 2.4 | £2,467 | 5.0 |
| Band 9 | £57,895 | £59,166 | £60,362 | £1,196 | 2.0 | £2,467 | 4.3 |

*Source: OME analysis of NHS Employers data*

### *National Living Wage and National Minimum Wage*

4.26 The 2018 AfC pay agreement in England increased the minimum level of basic pay from £15,404 in 2017, to £18,005 from April 2020, an increase of 17%. However, increases to the National Living Wage, of 16% over the same period, from, £7.50 per hour to £8.72 per hour, mean that minimum AfC pay rates are little changed in relation to the NLW. The Government has asked the LPC to increase the NLW towards a target of two-thirds of median earnings by 2024. To meet this target the LPC is projecting that the NLW will increase to £9.21 per hour in 2021 and £10.69 per hour by 2024[61]. Compared with the existing rate these projections would require increases to the NLW of 5.6% in 2021 and 22.6% by 2024. For a 37.5-hour week, the Band 1 annual salary of £18,005 from April 2020, equates to an hourly rate of £9.22, similar to the Low Pay Commission projected NLW for April 2021 of £9.21. At the March 2020 Budget, the Government's remit for the LPC included an "emergency brake" which asked the LPC to monitor the labour market and the impacts of the NLW closely, to advise on any emerging risks and, if the evidence warranted it, to recommend that the Government reviewed its target or timeframe.

4.27 The April 2020 rates for the National Minimum Wage, National Living Wage and the Living Wage Foundation Living Wage are in Table 4.5 below.

**Table 4.5: National Minimum Wage, National Living Wage and the Living Wage Foundation Living Wage rates per hour, April 2020**

| Age group | National Minimum Wage £ | National Living Wage £ | Living Wage Foundation Living Wage £ | |
|---|---|---|---|---|
| | | | UK | London |
| 25+ | | 8.72 | 9.30 | 10.75 |
| 21–24 | 8.20 | | | |
| 18–20 | 6.45 | | | |
| Under 18 | 4.55 | | | |
| Apprentice | 4.15 | | | |

*Source: Low Pay Commission, National Living Wage Foundation*

[61] Low Pay Commission (March 2020), *Open Consultation: Low Pay Commission Consultation 2020*. Available at: https://www.gov.uk/government/consultations/low-pay-commission-consultation-2020

*Our assessment of AfC earnings*

4.28 The data on AfC earnings suggests that the 2018 AfC pay agreements are increasing basic pay, total earnings, additional earnings and improving the position of AfC groups against pay in the wider economy. For this report, data was available for the calendar year 2019, which covered the first full year of the AfC pay agreement. In England, the pay bill increased by 4.6% and 5.4% in 2017/18 and 2018/19 respectively, leading the share of expenditure consumed by the pay bill to rise to 45.9% in 2018/19. This share had fallen from 45.8% to 45.1% between 2013/14 and 2015/16.

4.29 Our assessments of AfC earnings indicate that there were significant pay increases across AfC groups in 2019. In England, AfC basic pay increased by between 2.2% and 9.5%, total earnings increased between 2.4% and 8.2%, and all groups received an increase in additional earnings. We have also tracked the starting salary of nurses. Previous analysis indicated that the starting salary of nurses had seen a decrease in purchasing power since 2010 but the increases in the 2018 AfC pay agreement allowed the value of the starting pay point for nurses to grow more quickly than all the measures of price inflation and average earnings in 2018 and 2019. On wider comparisons, the rate of growth of earnings was greater in the human health and social work activities sector than across the economy as a whole and professional, associate professional and technical occupations.

4.30 While the overall assessment of AfC earnings suggests the position has improved following the 2018 AfC pay agreement, there continue to be signs that relative AfC earnings could vary across an NHS career. The data continues to show that the earnings of those studying nursing; subjects allied to medicine; and pharmacology, toxicology and pharmacy; were higher than the median earnings for other graduates both one year and five years after graduation, but were much closer to the median earnings of graduates after ten years.

4.31 We have commented in our recent reports on the potential for earnings to vary across careers in the NHS and for earnings to flatten out as a career progresses, particularly for AfC professions such as nursing. We would welcome the parties' evidence on the influencing factors, including among other things: (i) the specialised nature of a nursing degree and the dominance of the NHS as an employer in the market; (ii) the limited alternatives for health care employment; (iii) the attractiveness of pay for retention purposes; and (iv) as we have observed in previous reports, the impact of individual choices on the balance between pay and other factors as a career progresses, including moving to part time and flexible working hours.

4.32 As further data emerges we could see this earnings profile being affected by the pay reforms within the 2018 AfC pay agreements, particularly the effects of increased AfC starting pay and faster progression to the top of pay bands. We comment later in this chapter on the need to incentivise AfC staff at the top of pay bands. This faster progression could exacerbate the way in which AfC pay flattens out for professional groups as they move through an NHS career and we also note that fewer women reach the higher AfC pay bands. In this regard, the gender pay gap is at 6% for basic pay across all AfC groups[62] in England but the gap is much higher for senior managers and central functions. Our analysis of NHS Digital data also indicated an ethnicity pay gap of up to 8% for basic pay in favour of white staff compared with other ethnic groups.

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[62] Research conducted on behalf of the Pay Review Bodies found that the gender pay gap in 2018 in the AfC workforce was 5%, compared with 20% for medical staff (covered by the Doctors' and Dentists' Review Body), 19% for the public sector workforce as a whole and 21% in the private sector. Cardiff Business School (2019), *Understanding the Gender Pay Gap Within the UK Public Sector.* Available at: https://www.gov.uk/government/publications/understanding-the-gender-pay-gap-within-the-uk-public-sector

4.33 We are keeping the differences in pay across an NHS career and the pay gap by gender and ethnicity under review as the effects of the 2018 AfC pay agreement work through. We also ask the parties to provide any data and insights into the dynamics influencing pay and progression over an NHS career. DHSC has commissioned an independent review of the gender pay gap for medical staff[63]. For our reports, evidence would be welcome on the reasons behind the different rates of progression through the AfC pay bands by gender and ethnicity, including any differences between those moving through the pay bands and those directly entering the higher pay bands.

### *Total reward*

4.34 Total reward for AfC staff remains an important part of our considerations. Forward thinking employers focus on total reward to ensure that they can recruit, retain and motivate their staff. We continue to define total reward as including pay, pensions, other benefits, learning and development opportunities, and the overall work experience. In the context of total reward, we note that the NHS offers secure, continuous employment and has developed career pathways for AfC professional groups.

4.35 We acknowledge that DHSC and NHS Employers place great emphasis on the value of the AfC total reward package in their evidence, including the value of the NHS Pension Scheme. DHSC said that an aim of the NHS reward strategy was to develop capacity and capability, and that it wanted to be at the leading edge of innovation in public sector reward. DHSC commissioned NHS Employers to provide guidance on a strategic approach to reward based on the Hay model, which covered: tangible rewards; quality of work; work/life balance; inspiration/values; enabling environment; and future growth opportunity. NHS Employers also pointed to other aspects of reward being emphasised by employers, including staff health and wellbeing, financial education programmes, buying and selling annual leave, and salary sacrifice schemes. We also welcome NHS Employers' recognition in their evidence of the challenge presented by designing an appropriate reward offer which would work not only in traditional hospital environments but also in new integrated, community-owned healthcare systems.

4.36 On a general point, our discussions with AfC staff show that they clearly value different aspects of the reward package at different stages of an NHS career. We have noted before that younger staff tend to focus on security of employment, staff discounts and quality of life as well as earnings, but that, as staff move through a career, they tend to also focus on flexible working arrangements, training and development, and pensions. The reward package therefore needs to be able to respond to the various influences during an NHS career. It would also be appropriate to consider the way in which the offer to retired staff returning to the NHS could be more flexible to attract much-needed higher skilled, experienced and specialist staff, and returners to the NHS. The different perspectives of a diverse workforce require a range of different approaches to communications, as NHS Employers recognised in evidence, to ensure that the value of the package plays a full role in influencing staff recruitment, retention and motivation. We note that NHS Employers and trusts are actively promoting the value of the total reward package to NHS staff and that there have been significant increases in staff viewing their Total Reward Statements in recent years.

4.37 The NHS People Plan is expected to place importance on developing the NHS employment offer as part of making the NHS the best place to work. We would draw attention to the overall shape of the employment offer in relation to total reward, the importance of specific pay elements and the need for flexibility in reward to reflect staff views at different stages of an NHS career.

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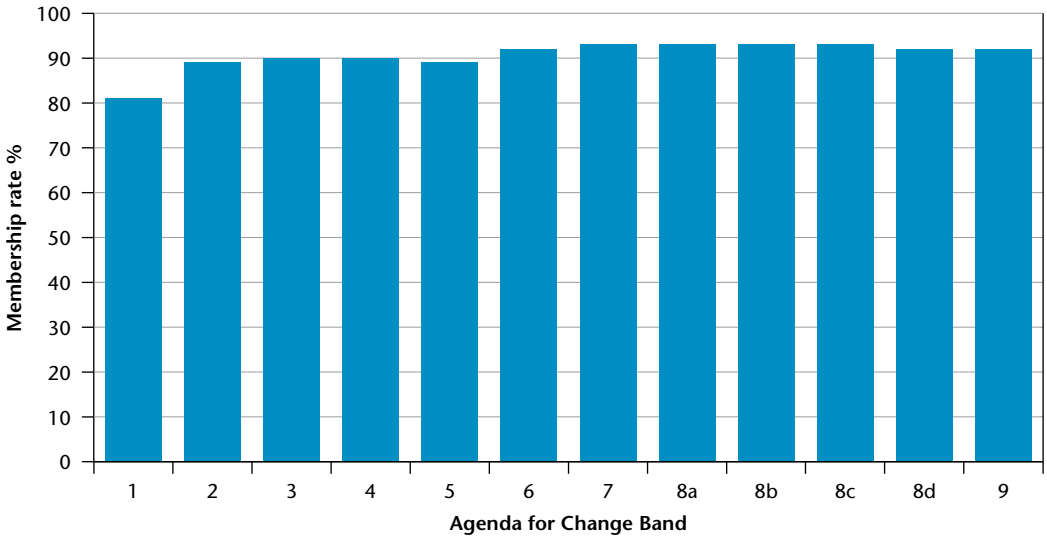
[63] Department of Health and Social Care (March 2019), *New Data on Gender Pay Gap in Medicine*. Available at: https://www.gov.uk/government/news/new-data-on-gender-pay-gap-in-medicine

4.38 The three-year AfC pay agreements include pay increases from restructured pay and improved progression that will feed into additional earnings, allowances linked to basic pay and the value of pensions, and therefore aim to improve the value of the total reward package. We comment later on the emerging impact of the 2018 AfC pay agreements on pay and earnings.

*Pensions*

4.39 In July 2019 approximately 90% of AfC staff were members of the NHS Pension Scheme (Figure 4.7). Staff in Bands 6 to 9 (92-93%) were most likely to be scheme members while those in Band 1 were least likely (81%).

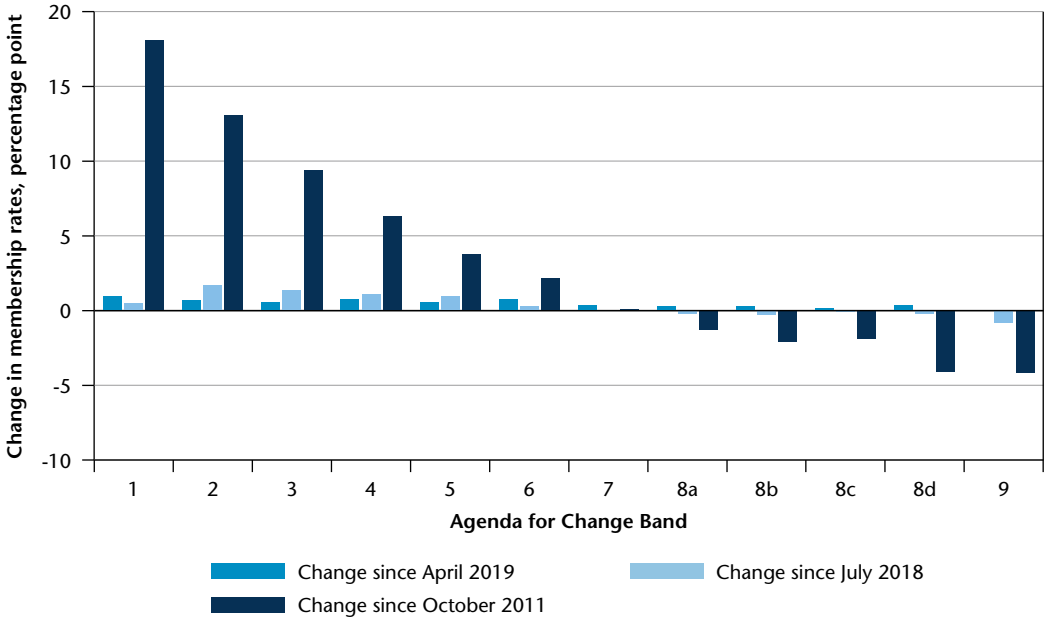
**Figure 4.7: Estimated pension membership rate by Agenda for Change band, July 2019, England**




*Source: Department of Health and Social Care*

4.40 Figure 4.8 shows changes in the membership rate of the NHS Pension Scheme in July 2019, by AfC band, compared with April 2019 (three-months earlier), July 2018 (a year earlier) and October 2011. Membership rates in July 2019, were higher for every band than three months earlier. Longer-term changes show increased membership rates for each band up to and including Band 7, while beyond this point membership rates had declined. The membership rate for Band 1 remained lower than those for other bands, but the rate of membership growth over the last eight years has been strongest at this band. Auto-enrolment in pensions, which began in 2013, may have had some effect.

**Figure 4.8: Changes in pension membership rate by Agenda for Change band, between July 2019 and April 2019, July 2018 and October 2011, England**




*Source: Department of Health and Social Care*

4.41 The parties presented a range of pension issues in their evidence. The pattern of NHS pension membership by AfC pay band suggests that the proportion of staff membership is lower in the lower bands. We have heard that some younger AfC staff preferred enhanced pay to investing in pension contributions. Future monitoring of membership in the lower bands will need to account for the transition of staff from Band 1 to Band 2 over the three years of the AfC pay agreements. We also note that membership rates have reduced slightly for some AfC staff in Bands 8a to 9.

4.42 We note that the Government announced measures in the March 2020 budget to reduce the impact of taxation through the annual allowance taper by raising the two thresholds by £90,000. This means that no pension scheme member with "threshold income" below £200,000 will be in scope of the tapered annual allowance.

4.43 We have emphasised the importance of assessing the impact on AfC take-home pay of staff crossing cliff edges in pension contribution tiers as a result of pay increases in the 2018 AfC pay agreements. The contribution rates start at 5% for those earning up to and including £15,431 and increase to 14.5% for those earning £111,377 and above. We note that pension contribution thresholds are to be reviewed by the NHS Pension Scheme Advisory Board in 2021. Further evidence from the parties would be helpful on the way in which these developments and staff attitudes towards their NHS pensions are influencing staff recruitment, retention and motivation.

4.44 We have heard on our visits that staff do not perceive that new pension arrangements are as valuable as the previous schemes. The previous final salary, defined benefit schemes (1995 and 2008) are now closed with the new 2015 scheme providing benefits on career average revalued earnings. The differences between the two schemes are the way in which benefits are calculated, retirement ages and accrual rates. Given the perceptions of staff, we reiterate the importance of making the most of opportunities, such as Total Reward Statements, better to set out the benefits of new pension arrangements.

## 2018 AfC pay agreements

*Introduction*

4.45 The three-year AfC pay agreements were reached in 2018 in England, Scotland and Wales covering the period 2018/19 to 2020/21. An AfC framework agreement was agreed in Northern Ireland in February 2020 covering 2019/20 and 2020/21. The remit letters for this report from the Minister for Health in England and the Minister for Health and Social Services in Wales asked us to monitor the implementation of the agreements. No remit was received for Scotland. The Northern Ireland Minister of Health wrote to us following the AfC framework agreement in February 2020 and sought our views on the impact of the re-establishment of pay parity with England and Wales, on which we comment later in this chapter (see paragraphs 4.87 to 4.105).

4.46 For this report, we continue to follow our overall approach to monitoring the implementation and impact of the 2018 AfC pay agreements based on the core issues in our standing terms of reference, specifically affordability, recruitment, retention and motivation. Our observations therefore cover: the aims of the agreement; the positions of the Devolved Administrations; progress on implementation; and initial conclusions on the emerging effects as they relate to our terms of reference. Our conclusions are limited by the fact that, at this stage, the data only relates to the first year of the agreements in 2018/19.

4.47 We note that DHSC commented on the "something for something" nature of the 2018 AfC pay agreement and the importance of evidenced and measurable benefits. In addition, NHS E&I pointed to the agreement having the capability to generate operational and financial flexibilities. We welcome the NHS Staff Council's update on implementation and note that several partnership subgroups have been set up to deliver the detailed implementation of the agreement. However, the parties' evidence so far has focused on implementation rather than the outcomes and benefits.

4.48 We understand that work is underway through the NHS Staff Council and NHS E&I on benefits measurement and realisation. Given that the elements of the 2018 AfC pay agreements were negotiated by the parties and include a significant level of investment in pay reform, we would expect the parties to specify the value of and to evidence the return on investment. In our view, this should include an assessment of progress for each of the elements of the agreement to show what has been achieved and what requires more impetus or resource.

*Aims of the 2018 AfC pay agreements*

4.49 The pay agreements set out the pay investment to be made and the reforms agreed by the employers, NHS trades unions and Departments. The key objectives are the same in each of the agreements for England, Scotland and Wales. The objectives were set out as to:

- Support the attraction and recruitment of staff by increasing starting pay in every pay band;
- Support the retention of staff by increasing basic pay for the 50% of staff who are at the top of pay bands and speeding up progression to the top of the pay band;
- Increase staff engagement by putting appraisal and personal development at the heart of pay progression, so that staff are supported to develop their skills and competences in each pay band and are rewarded for this. This will help ensure that all staff have the appropriate knowledge and skills they need to carry out their roles, so make the greatest possible contribution to patient care. It will be underpinned by a commitment from employers to enhance the relationship line managers have with their staff and to fully utilise an effective appraisal process;

- Ensure that the pay system can support the growing use of apprenticeships in the NHS;
- Ensure that the pay system is supportive of new training pathways and that the health service can deliver on the aspiration to focus on "careers, not jobs";
- Map out future work that the NHS Staff Council will undertake to encourage consistency of approach to bank working (including how the service can better incentivise staff to offer their own time to the bank) and to the development of apprenticeship routes to healthcare careers; and
- Improve the health and wellbeing of NHS staff to improve levels of attendance in the NHS with the ambition of matching the best in the public sector.

4.50 The pay agreements then set out specific key actions which were:

- Increases to starting salaries by removing pay points from the bottom of each pay band which overlap with a lower band, with one point removed in 2018/19 and further points being removed in 2019/20;
- The intention of the reforms was for individuals to have basic pay of greater value at the end of the three-year period than under expectations at the time of the agreement (which were defined as a 1% pay award per annum plus contractual agreements). This included increases to the top of pay bands and faster progression to the top of pay bands;
- Introducing a minimum basic rate from April 2018 to future proof the pay structure, stay ahead of statutory requirements and to ensure that the NHS retained a competitive market advantage. Also upskilling of roles from Band 1 to Band 2;
- The NHS Staff Council to negotiate a new provision detailing pay for apprentices;
- A new pay progression framework to help ensure that all staff have the appropriate knowledge and skills they needed to carry out their roles and so make the greatest contribution to patient care;
- NHS Staff Council work to improve levels of attendance through a focus on staff health and wellbeing at a national and local level. The ambition was that through the positive management of sickness absence the NHS will match the best in the public sector. Also the NHS Staff Council would explore the scope for a collective agreement on bank and agency working; and
- Work on guaranteed access to annual leave and Time Off In Lieu, child bereavement leave, shared parental leave, buying and selling annual leave, and reducing the variation in approach to payment schemes for unsocial hours payments.

*Devolved Administrations*

4.51 The Devolved Administrations reached separate AfC pay agreements for each country at different times. They included the main features of the England agreement with some variations and different initial transitional arrangements. These are summarised below.

4.52 Scotland. The three-year AfC pay agreement reached in August 2018 aimed to deliver the same overall AfC pay structure as in England by 2020/21, although with variations in pay rates. The variations stemmed from the Scottish Government's public sector pay policies, which resulted in: existing AfC pay rates being higher in Scotland than the rest of the UK before the agreement; higher overall pay awards in 2018/19; higher rates at the bottom of the pay structure under the Scottish Living Wage; and the flattening of rates for those earning over £80,000. Across the three years of the AfC pay agreement in Scotland the pattern of individual pay increases and the transition for AfC staff varied significantly from those in England and Wales.

4.53 Wales. The framework agreement reached in September 2018 mirrored the increases and changes to the pay structure in England. It included some variations covering: 2018/19 pay increases to align with England and reserved rights for staff in Bands 8c, 8d and 9; payment of the Living Wage Foundation rate; the introduction of a new progression framework; a separate agreement on attendance management; further work on developing and deploying temporary staff capacity; a specific agreement on eligibility for unsocial hours payments during sickness absence; and other local agreements.

4.54 Northern Ireland. In the absence of the Northern Ireland Executive the 2018 AfC pay agreement and accompanying reforms were not implemented for AfC staff in 2018/19. For that year, the Department of Health implemented an award for AfC staff by applying the 2018/19 English settlement to the pay rates in Northern Ireland. For the 2019/20 pay award the Department of Health reported in November and December 2019 that there had been a failure to reach agreement between the Department, employers and trades unions. Industrial action by the health unions followed in December 2019 and early January 2020.

4.55 Following the restoration of the Northern Ireland Executive, the Minister of Health made a statement on 14 January 2020 on bringing industrial action to an end. The statement included: applying England's pay values to current pay scales in Northern Ireland with effect from 1 April 2019, which would create pay parity with England; a commitment to working with trades unions on the refresh of Agenda for Change; and a commitment to urgent work to produce a costed implementation plan for safe staffing.

4.56 In February 2020, the Department of Health's AfC draft framework agreement was published and included:

- Mirroring the 2018 AfC pay agreement in England in the AfC pay rates, the structure of pay bands and the time taken to progress through bands;
- Northern Ireland pay structures being in line with England from 1 April 2020;
- A "no detriment" commitment, with the implementation programme running through the regional Joint Negotiation and Consultation Forum;
- Varying pay increases from 2018/19 to 2020/21 between 4.4% (at the top of pay bands) to 24.3%, although there were lower increases for those at the top of Bands 8c to 9 (of between 2.4% and 3.4%). Detailed individual pay journeys were provided;
- For 2019/20 only, a non-consolidated award of 1.1% for those on the top of pay bands (as in England), capped for Bands 8d and 9 (at the value given to Band 8c); and
- A section on safe staffing largely drawing on previously published initiatives and a Nursing and Midwifery Task Group report yet to be published. Actions included additional funding to develop the nursing and midwifery workforce, increasing commissioned pre-registration places, an intention to increase the post-registration budget (for training), and detailed engagement on the social care workforce.

4.57 Following a consultation exercise with members, the trades unions announced their acceptance of the AfC framework agreement on 24 February 2020, although the Northern Ireland Public Service Alliance rejected the framework.

### *Implementation of the 2018 AfC pay agreements*

4.58 We now set out our understanding from the evidence on progress implementing the specific key actions in the agreements, including any relevant data for 2018/19 as the first full year covered by the agreements. Where available, the data covers the UK or England and there could be variations in each individual UK country.

4.59 Progress on implementation and initial measures was as follows:

- Increases to the starting pay points of AfC pay bands of between 8.7% and 18.5%;
- AfC staff received increases in total earnings of between 2.4% and 8.2% between 2018 and 2019. In 2018/19, the pay bill in England was £52.6 billion, an increase of 5.35% from 2017/18;
- Increases in the value of the top points in Bands 2 to 8b by 3% in 2018/19, 1.7% (plus a non-consolidated cash lump sum of 1.1%) in 2019/20 and 1.67% in 2020/21. The value of the top point in Band 8c increased by 3% in 2018/19, 1.9% in 2019/20 and 1.5% in 2020/21. The increase in value of the top point in Bands 8d and 9 in each of the three years was capped at the cash value of the increase in value at the top of Band 8c;
- Existing Bands 2 to 7 have been restructured over the three-year period. Bands 8c, 8d and 9 continue to include re-earnable pay of up to 10% after a year on the top of the band;
- For England, the minimum level of basic pay increased from £15,404 in 2017 to £18,005 from April 2020, an increase of 17%, slightly more than the increases to the National Living Wage of 16% over the same period;
- Band 1 was closed to new entrants from December 2018 and support provided to provider organisations to upskill roles from Band 1 to Band 2. Data from DHSC shows that between April 2018 and December 2019 the number of staff remaining on Band 1 had reduced from 24,500 to 10,910 (a change of 14,400). After a sharp fall in April 2019, the number of staff remaining on Band 1 levelled out to December 2019;
- After negotiations through the NHS Staff Council, no national agreement was reached on apprenticeship pay;
- The new NHS Staff Council progression framework was in place and applies to new staff and promotees from 1 April 2019 with existing staff remaining on current arrangements until April 2021. Supporting guidance was issued for trusts, managers and staff in early 2019. The first decisions on pay steps arising from appraisals under the new system for new starters would be later in 2020/21 and for existing staff in 2021/22;
- A survey had been issued to trusts in England to gather basic data for further discussions in the NHS Staff Council on a collective framework on bank and agency working;
- The NHS Staff Council reached agreements from April 2019 on child bereavement leave and shared parental leave. The Staff Council was not able to agree on the rates for buying and selling annual leave, but produced a set of good practice principles for local policies. The Staff Council continues to work on guidance on staff taking annual leave and Time Off In Lieu;
- New arrangements for unsocial hours payments were introduced from September 2018 for new staff and promotees. In the year to September 2019, compared with the previous year, the percentage of staff in each staff group receiving shift work payments declined, except for those providing support to ambulance staff. However, the mean value of those payments increased for all staff groups, except for managers and senior managers; and
- DHSC is considering any proposals to be submitted to the Senior Salaries Review Body on the scope for further alignment between AfC and other senior NHS pay arrangements.

*Initial conclusions on emerging effects against our terms of reference*

4.60 We frame some initial conclusions in line with our overall approach to monitoring the 2018 AfC pay agreements against the core issues in our standing terms of reference. We first draw some general conclusions on the effects of the agreements, and then highlight specific issues relating to affordability and productivity, recruitment, retention and motivation. We also include what we might expect to see as indicators that the agreements are achieving their outcomes, although a range of other initiatives and factors could also influence these outcomes.

4.61 General conclusions. We have commented in our previous reports on the importance of AfC pay reform supporting the impetus for wider workforce developments under the NHS Long Term Plan and the expected NHS People Plan. The AfC agreements reflected the significant ambitions of the Governments, employers and NHS trades unions for pay reform. These included the effects on the NHS workforce and their contribution to patient services. We look forward to evidence from the parties on how the reformed pay structures are supporting the implementation of the service and workforce requirements expected to be set out in the NHS People Plan and in the workforce strategies in the Devolved Administrations, for instance, new service models, integration of health and social care, new roles, training and development, and career paths.

4.62 We have considered the way in which features of other long-term pay agreements might be helpful in assessing the outcomes. Research by IDS on Long Term Pay Deals[64] (2005) suggested that the characteristics of such deals were inflation linking, fixed percentage increases, fixed increases with inflation protection, re-opener clauses, and ceilings on increases. IDS concluded that many long-term agreements represented a trade-off between the aspirations of employers for changes to working practices, and improvements to company performance and profitability, and those of unions for changes to working time. It also highlighted the importance of union and employee co-operation on the introduction of new working practices.

4.63 We highlight that long-term agreements are often linked to modernisation and transformation of services. However, in reaching such agreements some elements can be neglected or areas important to the initial negotiations lose their impetus over the time of the agreement. IDS identified the advantages of long-term pay deals as: pay and labour cost stability; saving management time; restructuring of terms and conditions or working practices; pay modernisation; predictability and transparency for forward planning; an aid to recruitment and retention; phasing in the absorption of higher increases; dispute resolution; and harmonisation of pay and conditions. In contrast, the disadvantages found by IDS were: lack of short-term flexibility; higher increases than under a one-year review; focus on pay; terms and conditions getting out of line; unexpected inflation rate fluctuations; and reneging on deals. In this context, we have found the IDS research helpful in setting out some of the areas for consideration and assessment in the longer term.

4.64 Affordability and productivity. The 2018 AfC pay agreements represented a significant investment of NHS funding. In England, the investment was £4.2 billion over the three years to deliver a 3% annual increase in the AfC pay bill. In oral evidence, DHSC also informed us that there will be an overhang from the agreement costing an additional 0.7% on the pay bill in 2021/22.

[64] Incomes Data Services (2005), *Long Term Pay Deals*. Available at: https://webarchive.nationalarchives.gov.uk/20130705001103/http://www.ome.uk.com/Cross_cutting_Research.aspx

4.65 The agreements were based on securing additional funding for pay reform in order to provide NHS resources and capacity through the recruitment and retention of the AfC workforce. In order to assess the return on this investment we will track data on the AfC pay bill and earnings. To assess whether the agreement is effective we would expect to see:

- In-year and cumulative increases in the AfC pay bill (accounting for workforce changes and pay drift);
- Increases to AfC basic pay and earnings – overall and for specific AfC groups;
- Increases to take-home pay (accounting for changes in tax, National Insurance and pension thresholds) and the consequences for other pay elements, pensions and the total reward package;
- Increases to AfC starting pay in each pay band and comparisons with starting pay for other professionals groups, and any impact on gender of entrants or those with protected characteristics;
- Increases in pay for those at the top of their pay bands;
- Increases in basic pay and earnings for staff in Bands 8a and above, including pay changes showing re-earnable pay in Bands 8c to 9;
- An impact on closing the gender and ethnicity pay gap;
- Changes in earnings for groups moving (or not moving) to revised unsocial hours payments, including specific data for ambulance staff.

4.66 As we have noted above the parties made it clear that the cornerstone of the agreement in England was revised progression arrangements that enabled improvements to staff contribution to patient services and productivity. The effects will not start to be seen until after the first assessments from April 2021.

4.67 The NHS Staff Survey for England provides some indicators on the current performance management arrangements. The survey results showed that the proportion of NHS staff receiving appraisals was 88.4% in 2018 and there was a slight drop in 2019 to 87.9%. In 2019, compared with previous years, there was an increase in the percentage of staff saying their appraisal had helped them improve how they do their job, agree clear objectives for their job, and left them feeling their work was valued by their organisation. There was an increase in the proportion of staff (71%) satisfied with the support they get from their immediate line manager. In the RCN's 2019 Employment Survey 73.8% of respondents said that they received an appraisal or development review in the previous 12 months (almost unchanged on the 74% in 2017). The RCM's 2019 Survey reported challenges for staff carrying out appraisals with only 44% of Heads of Midwifery carrying out appraisals with all their staff and 18% not feeling confident in the process.

4.68 We heard from the parties that the expectation was that most staff would progress through the pay steps in the progression framework as the aim was to deliver better appraisals which focused on improving staff development. We note from NHS Providers that 30% of trusts were experiencing difficulties related to the roll out of self-service Electronic Staff Records. Supporting systems are needed to ensure effective management of the process for pay steps. We commented on the introduction of the agreement that shorter pay bands with larger pay increases at longer intervals of time would place greater emphasis on the performance review process, and on the standards required for progression. The Staff Side pointed to data from the Workforce Race Equality Standard which indicated that Black and Minority Ethnic (BME) staff were more likely to be subject to disciplinary procedures. The Staff Side were therefore concerned at the potential for such staff not to receive pay progression. We agree that this position needs to be closely monitored at individual and trust level and through the NHS Staff Council. On a wider point, we continue to await the Equality Impact Assessment for the 2018 AfC pay agreement through the NHS Staff Council which should assess the impact on diversity and staff with protected characteristics.

4.69 We consider that the emphasis on quality appraisals should be supported by access to funded CPD. We welcome the announced increases to the CPD budget through HEE. We heard frequently on our visits that AfC staff attach significant priority to the availability and funding of CPD. If the objectives of the progression framework are to be achieved, it remains important that staff have access to and time available for CPD.

4.70 DHSC has an ambition in the Interim NHS People Plan for the NHS to become the best place to work and NHS Employers see the importance of the NHS keeping pace with modern employment practice. One element of these ambitions will be an effective progression framework that begins to deliver its promised link to improving staff contribution to patient services. We have commented in previous reports on the difficulty implementing and operating effective performance management systems. This is a particular challenge given the current pressures on NHS leadership who have limited capacity to support longer-term workforce developments. We said that implementation would require effective staff involvement and that organisations should not underestimate the substantial volume of work required to implement and run the new system.

4.71 The pay agreement in England aimed to create a partnership approach between staff and line managers where the latter were supported to make the appraisal experience as positive as possible and where staff were supported to take shared responsibility for showing how they met the required standards. The agreement (Annex B, paragraph 8) aimed for the new system to: create a simple process for assessing standards; help drive consistency while allowing local flexibility to develop assessments; allow faster progression to the top of each pay band; provide meaningful pay increases at each pay step point; encourage staff to take responsibility for meeting standards; ensure line managers make available to their staff the appropriate training, support and development opportunities; encourage organisations to assess staff against local values and behaviours; and ensure pay step points are achieved only where managers were satisfied that their staff had met the required standards. In our view, these aims provide a useful framework to assess the effectiveness of the new progression arrangements.

4.72 It is too early to monitor progress but when the progression framework is fully in place we would expect to see:

- Data on the number of staff moving through the pay steps, and the number of staff and reasons for not moving through the pay steps. Data on staff with protected characteristics should be included;
- An increase in the proportion of staff receiving appraisals and in the quality of appraisals as captured in the NHS Staff Survey and in trades unions' surveys. Also any variations in indicators from surveys on the views of those staff who were between progression pay steps;
- Improvements in the staff engagement index and in staff views on line management in the NHS Staff Survey; and
- Appropriate access to and expenditure on CPD, including any data on training and development to enable staff to pass through the pay steps.

4.73 The pay agreement in England also included the upskilling of Band 1 roles to Band 2 roles. The transitional arrangements for Band 1 posts were extended by the NHS Staff Council to allow activity to reconfigure posts and the choice exercise to run through 2019/20. We have yet to see evidence on the effects of the transition and the parties' evidence acknowledged that progress on the transition exercise through 2019/20 had been slow and patchy across trusts. NHS Employers provided further information from its workshops and other contacts with employers which suggested that trusts who had yet to offer the transition to staff had encountered problems of management buy-in, project management and lack of capacity. We heard on our visits that some trusts had encountered difficulties persuading staff of the merits of the transition and this was echoed in the Staff Side evidence which suggested that the transition had been hampered by suspicions over trusts' intentions, including the use of wholly owned subsidiaries.

4.74 We will continue to monitor the transition arrangements and look forward to any emerging impact of upskilling to Band 2 roles, particularly on staff contribution to patient services. For the purposes of assessing recruitment, we will also continue to compare AfC pay rates in Bands 1 and 2 against the National Minimum Wage, National Living Wage and the Living Wage Foundation Living Wage. We note that in Scotland and Wales pay policies had been implemented for lower paid AfC staff prior to the 2018 AfC pay agreements. Given the different approaches, we would welcome separate data on the effects in each UK country.

4.75 Recruitment. On a general point, the reformed pay structure should support recruitment to NHS roles through all the available channels. These include domestic supply, overseas recruitment, new roles, apprenticeships and returners. Increased starting pay, quicker pay progression and improved career prospects should, among other elements of the employment offer, ensure that the NHS remains an attractive employment prospect.

4.76 The available data indicates that across all AfC staff groups joining rates in England have been stable in recent years, prior to the agreements, and in the year to March 2019 were between 7.6% and 10.9% in England. In general, leaving rates in England were slightly lower and joining rates slightly higher than in 2018. We also note that, for the UK, the number of applicants and acceptances for nursing degrees increased by 6.7% and 6.5% respectively between 2018 and 2019.

4.77 While it might not be straightforward to isolate the direct influence of pay reform from other recruitment measures, to help monitor the effect of the agreement on recruitment, supporting new training pathways and focussing on careers not jobs we would expect to see:

- An increase in the number of staff entering AfC roles from different recruitment sources. Also the impact this might have on reducing AfC vacancy rates;
- An increase in the supply of entrants to AfC professional groups entering the NHS, including an increase in applicants and acceptances to AfC-related degree courses, an increase in available clinical placements and a reduction in wastage during courses;
- An improvement in the relative earnings position of AfC graduate entrants compared with other graduates at selected career points after graduation;
- An increase in overseas recruitment into the NHS;
- An increase in the number of re-joiners;
- An increase in the numbers of entrants into training in new roles, for example nursing associates, physician's associate and advanced clinical practitioner. Data is required on pay arrangements and AfC banding for new roles and expected progression through their career pathways;
- An increase in numbers moving from support roles into registered roles; and

- Any changes to pay banding of AfC roles arising from job evaluation exercises, particularly to capture new and changing roles.

4.78 The recruitment of apprentices in the NHS was an objective of the agreement which sought to make maximum use of the apprenticeship levy, to develop the workforce and to increase capacity. The NHS Staff Council could not reach a national agreement on apprenticeship pay rates as it was unable to reconcile the Employers' Side need for an affordable and flexible outcome with the Staff Side's need for a fair and equality-proof solution. Current guidance on existing trainee pay rates continues to apply. The Staff Side evidence provided useful examples of the differing approaches of trusts to apprentice pay. We comment later in this report on the recruitment opportunities an NHS apprenticeship could present. We will continue to track apprentice numbers and any qualitative data on pay rates.

4.79 Retention. As for recruitment, there will be many factors influencing the retention of AfC staff. We did not receive any specific evidence on the way in which the pay agreements might have contributed to support retention. To monitor retention, we would expect to see the following:

- A reduction in turnover rates and an improvement in the stability index, broken down for specific AfC groups. Also whether these have impacted on any reduction in the AfC vacancy rates;
- A reduction in the numbers of leavers citing better reward packages as a reason for leaving; and
- A reduction in leaver rates at trusts within NHS E&I's retention programmes.
  We comment later in the report about the importance of further detail from the programmes on outcomes, particularly data on reasons for leaving (see paragraph 4.209).

4.80 The agreement specifically aimed to help retain staff at the top of their pay bands. The changes to AfC pay bands were designed so that more staff would reach the top of pay bands earlier and their pay would then flatten out. At the end of March 2019 there were 44% of staff at the top of their pay bands. In addition to Band 1, which has a single pay point, the percentage of staff on top of their band ranged from between 37% in Band 5 and 55% in Band 8d. There are no specific data on retention rates for staff at the top of pay bands and, as yet, there was no evidence on what measures were being taken to manage these staff. In our 2018 and 2019 Reports, we pointed to the retention and motivation risks of higher proportions of staff reaching and remaining on the top of their pay bands. We continue to request further insights from the parties into the way in which trusts are incentivising these staff through training and development to support their careers and personal aspirations, as was highlighted when the AfC agreements were introduced.

4.81 Work/life balance and accessing flexible working arrangements continue to be an influence on staff retention. We have heard that many staff see bank and agency work as a mechanism to achieve a degree of flexible working. In this context, we therefore note that developments on any bank and agency framework will need to await the results of the NHS Staff Council's survey.

4.82 On a specific point, we note that in evidence GMB pointed to the potential for changes in unsocial hours payments for ambulance staff to be a source of significant tension and a negative impact on retention. Additional information from NHS Employers suggested that a wide variety of practice was in place for paying for additional hours with many staff on the maximum level for shifts thereby dissuading them from opting for the new arrangements. As yet, there is no definitive analysis of any specific impact on ambulance staff on additional earnings or retention. However, we recognise that the position requires monitoring and comment later in this report on a range of workforce, earnings and staff survey information relating to ambulance staff.

4.83 Motivation. A major output from the agreements should be improved satisfaction with pay among staff. From the NHS Staff Survey for England the proportion of staff satisfied with pay increased sharply from 29.4% in 2017, before the pay agreement, to 34.9% in 2018 and then again to 36.4% in 2019. NHS Providers' survey of trust HR Directors reported mixed views with only a third agreeing that staff felt better paid than before the agreement and there were challenges around staff perceptions of the agreement. On our visits to trusts, we heard from Chief Executives and staff that, while the pay increases in the agreements were welcome and might have removed some staff concerns around pay, there was a muted response to the impact of the agreements, including on staff motivation and morale.

4.84 Many of the measures in the NHS Staff Surveys, including those in the Devolved Administrations, suggest that staff satisfaction and the engagement index have remained stable in recent years. We note that the proportions of staff recommending their trusts as a place to work or receive treatment through the Friends and Family Test have also been at consistent levels in recent years. As for other measures, these will continue to be monitored as part of our overall consideration of staff motivation and morale.

4.85 The agreement also emphasised supporting the service and staff by improving levels of attendance through a focus on staff health and wellbeing at national and local level. In this context, we note that NHS sickness absence rates have tended to be constant over the last decade. For England, the rates have remained in a narrow range between 4.1% and 4.4% since 2010, with consistently higher rates for ambulance staff, midwives, support to clinical staff, and nurses and health visitors. In the NHS in Wales for the three months to September 2019 the sickness rate was 5.4%, and in Scotland the rate was 5.4% in the year to March 2019. The agreement included the ambition that through the positive management of sickness absence the NHS would match the best in the public sector. Comparisons suggest that currently NHS sickness rates are higher than those in the public sector and the economy as a whole, as ONS data for 2018 showed sickness rates of 2.7% for the public sector and 1.8% for the private sector.

4.86 We understand the impetus behind this element of the agreement and highlight the importance of better management in reducing the high levels of work-related stress reported in Staff Surveys. Notwithstanding the fact that measures might be distorted by COVID-19, future monitoring will include assessing any impact of measures developed under the pay agreements, and NHS E&I's Health and Wellbeing Framework will provide the basis for assessing future progress.

## Northern Ireland economy, labour market and pay parity

4.87 The Minister of Health in Northern Ireland sought our views on the wider recruitment, retention and staff motivation factors specific to the Northern Ireland health and social care labour market which might highlight staff migration, recruitment deficiencies and key behavioural drivers. We did not receive specific evidence from the parties on the way in which the Northern Ireland economy and wider labour market influences the Health and Social Care (HSC) workforce. We have therefore assessed the limited available information at the time of this report, which does not take into account the impact of COVID-19.

### *Economic and labour market indicators in Northern Ireland*

4.88 Under our terms of reference, we assess a range of economic and labour market indicators. The indicators for Northern Ireland are summarised as follows:

- Estimates from 2018 were that GDP per capita in Northern Ireland was £24,685. This was 20.4% less than the UK as a whole at £31,028. Economic growth in Northern Ireland was 0.6% in the year to Quarter 4 2019, compared with 1.1% for the UK as a whole. GDP in the UK as a whole had grown by 18% between 2006 and 2019, while Northern Ireland economic output in 2019 was still below 2006 levels;
- The latest estimate of regional price levels[65] from 2016, when the Northern Ireland price level was 2.3% below the UK average and 1% below the England average (excluding London);
- In the three months to March 2020, Northern Ireland had the lowest employment rate in the UK (72.4%), the lowest unemployment rate (2.4%) and the highest economically inactive rate (25.8%);
- Jobs growth in Northern Ireland had been slower since the 2008 financial crisis than in the UK as a whole, with growth in employment of 10.8% since March 2008, compared with 11.5% for the UK as a whole. This was mostly accounted for by a more severe contraction of the public sector of 5.4% compared with 3.7% for the UK as a whole;
- Over the same period, the private sector grew more in Northern Ireland than in the UK as a whole, by 17.2% compared with 14.8%, but this was not enough to compensate for the greater public sector contraction in Northern Ireland. The public sector in Northern Ireland accounts for a larger portion of employment than in the rest of the UK, at 24.4% compared with 16.1% in December 2019;
- Median weekly earnings in Northern Ireland for all workers were £429.20, compared to £479.10 for the UK as a whole in April 2019. Gross weekly median earnings for all workers grew 2.1% in the year to April 2019 in Northern Ireland, compared with 4.2% in the UK; and
- The difference between public sector and private sector pay, measured by full-time median earnings, was greater in Northern Ireland than in the UK as a whole, at 30.6% (in favour of the public sector) in April 2019. It had reduced, however, from 33.7% in April 2018. For the UK as a whole in April 2019 the corresponding difference was 10.9%. This gap has been falling in both Northern Ireland and the UK as a whole over the last decade due to a mix of public sector pay restraint and, more recently, strong private sector wage growth.

[65] These figures do not include housing, for which data is not available. Office for National Statistics (2018), *Relative Regional Consumer Price Levels of Goods and Services, UK: 2016*. Available at: https://www.ons.gov.uk/economy/inflationandpriceindices/articles/relativeregionalconsumerpricelevelsuk/2016

*Our conclusions*

4.89 We conclude from these indicators that economic growth in Northern Ireland has been slower than in the UK as a whole. Looking forward there could be different implications for the Northern Ireland economy from the impact of the UK's exit from the EU, given the land border with the Republic of Ireland. The regional price level data from 2016, the most recent available, suggested a slightly lower cost of living in Northern Ireland compared with the rest of the UK, though this measure did not include housing costs.

4.90 On some key labour market indicators, there are variations from the rest of the UK. While the rate of increase in employment growth has been strong and has fed into low unemployment, a longstanding feature of the Northern Ireland labour market remains a relatively high economic inactivity rate. Northern Ireland has a much larger public sector than in the rest of the UK and earnings in the public sector in Northern Ireland remain considerably higher than the private sector despite a narrowing in 2019. There is considerable variation in earnings across regions in Northern Ireland, although earnings are generally higher in areas that are closer to Belfast.

4.91 We were also asked to comment on migration, although we were not presented with any evidence from the parties. The Department of Health confirmed in oral evidence that it had no data or evidence on the number of AfC staff that migrated from Northern Ireland to other parts of the UK. It would be helpful to see further detailed work from potential sources, such as the Labour Force Survey, to understand any patterns of migration for AfC staff and those students moving to other UK countries to study AfC-related degrees and not returning to Northern Ireland.

4.92 While we did not find specific data on the number of health workers commuting between Northern Ireland and the Republic of Ireland, some aggregate information was available from 2016[66]. This indicated that there were between 23,000 and 30,000 commuters across the border, including commuters from both directions. Further research[67] found that the propensity of those living near the border to commute across it was estimated at 7 to 10% of those living on the Northern Ireland border commuting to the Republic of Ireland. The research also found that despite higher wages in the Republic of Ireland, the propensity of those from the Republic of Ireland to commute into Northern Ireland appeared to be greater than the reverse. The Department of Health told us that the Common Travel Area arrangement with the Republic of Ireland would remain in place following the UK's exit from the EU allowing movement across the border to work.

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66 Centre for Cross Border Studies (June 2016), *Briefing Paper – EU Referendum & Free Movement of People.* Available at: https://borderpeople.info/media_news/briefing-paper-eu-referendum-free-movement-of-people

67 Achim Aherns, John FitzGerald, Seán Lyons (2020), *Commuting Across the Irish Border*. Available at: https://www.sciencedirect.com/science/article/abs/pii/S0165176520300677

4.93 In the context of migration, pay scales in the Republic of Ireland health sector[68] suggest that health workers are paid more for the same role in the Republic of Ireland. Direct comparisons are limited as the available employment package and terms and conditions could vary considerably, particularly the value of pensions. With these caveats, we note that on basic pay a newly qualified nurse in the Republic of Ireland earned €29,860 (the equivalent of £26,300[69]) at September 2019, which is 8.7% more than a newly qualified nurse on the bottom pay point of AfC Band 5[70] in Northern Ireland. A newly qualified social worker in Republic of Ireland earned €41,330 (the equivalent of £36,400), which is 19.8% more than a newly qualified social worker on the bottom of AfC Band 6[71] in Northern Ireland.

4.94 While there are differences in AfC pay, there is no specific data on migration of healthcare workers to and from Northern Ireland. The aggregate data does not suggest there is a major flow of commuters to the Republic of Ireland. The drivers of migration are likely to cover a wider range of factors not just pay and could include the proximity to large population centres, cultural differences and difficulties of poor public transport. Further analysis would be required to understand the value of employment packages, but there are indications, as we have also heard from staff on our visits, that the HSC in Northern Ireland needs to be competitive with the Republic of Ireland in order to recruit and retain nursing, other AfC professions and social care staff.

4.95 Our workforce analysis later in this chapter includes the Health and Social Care workforce in Northern Ireland. We therefore highlight below some workforce data relevant to this remit:

- At September 2019, Northern Ireland accounted for 2.9% (54,488 FTE including social care staff) of the UK AfC workforce whereas the Northern Ireland population only accounted for 1.9% (1.89 million people) of the UK population according to mid-2019 population estimates;
- The HSC workforce increased by 3.1% between September 2018 and September 2019;
- In the HSC, 28% of AfC staff were qualified nurses and midwives, compared with 32% in England. 30% of the HSC workforce were professional, technical and social services staff, compared with 21% in England, reflecting the inclusion of social care staff in Northern Ireland;
- At September 2019, there were 6,984 AfC vacancies, an increase of 19% on September 2018. The vacancy rate was 12.8%, up from 11.1% over the same period. Registered nurse vacancies increased from 1,922 to 2,269, midwives from 50 to 122, nurse support from 403 to 521, and social workers' vacancies from 259 to 370;
- In 2018/19, the leaving rate was 5.7%, down 0.2 percentage points on 2017/18. The joining rate was 7.9%, an increase on the previous year, higher than leaving rates for all staff groups;
- At March 2019, nursing and midwifery leaver rates were at 6.6% (down from 6.9% in 2018). Nursing and midwifery joiner rates increased from 7.3% to 7.5% over the same period. Social services leaver rates were at 5.8% (joiners at 8.5%) at March 2019; and

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68 Irish Government, Department of Health (August 2019), *1st September 2019 Consolidated Pay Scales and Department of Health Circular 10/2019*. Available at: https://www.gov.ie/en/publication/0aaece-1st-september-2019-consolidated-pay-scales-and-department-of-health-/

69 OECD purchasing power parity exchange rate is used to convert to a common currency.

70 A nurse qualified in the UK is automatically eligible to register as a qualified nurse in the Republic of Ireland if they trained in the UK after June 1979. If they trained in the UK before that date, they would be required to do competency tests. Nursing and Midwifery Board of Ireland (April 2018). Available at: https://www.nmbi.ie/Registration/Trained-outside-Ireland/Group-1-Applicants

71 Social workers qualified in the UK would need their qualification to be recognised by the Irish regulator of health and social care professionals before being eligible to register with the Irish Association of Social Workers.

- Between 2018 and 2019, acceptances onto nursing degrees in Northern Ireland rose by 6.4%.

4.96 The HSC data reflect the differences in the workforce and skill mix in Northern Ireland, compared with the rest of the UK, including that social care staff are within the AfC pay system in Northern Ireland. While there have been moderate increases in overall workforce numbers, we have not seen any evidence that this will be at a rate required to match increasing demand for services and to support the transformation programme already underway. As we have commented for the NHS across the UK, the workforce developments required to support moving to new models of service require investment in learning and development. This will include supporting the development of new roles and, as the RCN Northern Ireland highlighted, changing nursing roles as they become more specialised.

4.97 Overall, recruitment and retention appear stable across the HSC workforce. The number of joiners continues to exceed leavers and leaving rates are considerably lower than those in the UK, particularly England. However, of specific concern is the rising vacancy rate which has seen a significant increase in the last year. Vacancies appear to be predominately in front line professional groups and the rise in the rate is particularly notable in nursing.

4.98 The nursing workforce has only increased at a slow rate in recent years and we note from the RCN that NMC registrations of nurses and midwives with an address in Northern Ireland has fallen slightly between March and September 2019. Nursing vacancies might be a reflection of training numbers in recent years not meeting increasing levels of demand for services, although we note the increase in acceptances to nursing degrees in 2019. In Northern Ireland, training places are commissioned by the Department of Health each year depending on requirements, as is the case in Scotland and Wales, but not in England where numbers are driven by the market for university places. We welcome the plan in the AfC framework agreement in Northern Ireland to increase training places by 900 places over the next three years. In May 2020, the Health Minister announced[72] 300 additional nursing and midwifery undergraduate places for 2020/21, bringing the total number of places to 1,325. The recruitment of international nurses in Northern Ireland was forecast to reach 542 against a target of 622 by March 2020 and, as for the rest of the UK, future recruitment could be curtailed significantly by the UK's exit from the EU and COVID-19. We will monitor the impact of these in the next few years.

4.99 The response to managing staff shortages has been substantial increases in bank and agency costs since 2010. By 2018/19, total agency and locum spend was over £200 million, including £52 million on nursing and midwifery staff, and bank spending for nursing and midwifery had reached almost £63 million. We were told in oral evidence that the use of such resource was required to handle increasing demand for services and, in some cases, a necessity to keep services open to patients. The RCN also pointed to the impact of excessive agency expenditure on the quality and continuity of care, and the patient experience. We also recognise that Northern Ireland operates with a restricted pool of HSC staff and that travel difficulties could limit the availability of staff. We have heard that actions to control agency spending are being developed and we look forward to updates on their effectiveness.

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[72] Department of Health, Northern Ireland (3 May 2020), *Funding Secured for 300 Additional Nursing and Midwifery Undergraduate Places*. Available at: https://www.health-ni.gov.uk/news/funding-secured-300-additional-nursing-and-midwifery-undergraduate-places

4.100 We set out later in this chapter the results of the 2019 Health and Social Care Staff Survey in Northern Ireland, which includes indicators of staff motivation and morale. The RCN Northern Ireland also provided us with responses to its 2019 Employment Survey. In general the surveys indicated concerns over the level of resource available for staff to do their jobs properly, the difficulties meeting the demands of the job, high numbers doing additional hours (some unpaid), increases in bullying and harassment, and high levels of stress and sickness absence.

4.101 We conclude from the limited evidence that there are some differences in the economy and labour market between Northern Ireland and the rest of the UK. The public sector plays a larger role in the Northern Ireland labour market and the HSC is a significant employer. With public sector earnings ahead of those in the private sector and the recent restoration of AfC pay parity, the HSC should be well placed in the Northern Ireland labour market, when also considering the value of the NHS total reward package and the secure employment offer. However, the levels of vacancies and agency spending suggests that the HSC workforce is under staffing pressure, which needs to be managed effectively. The inclusion of social care staff within Agenda for Change adds a further dimension to assessments in Northern Ireland.

4.102 Our overall conclusions on the factors influencing HSC recruitment, retention and motivation must be seen in the light of current and planned actions on the HSC workforce. We note that the HSC Workforce Strategy aims to resolve many workforce issues by 2026 and we would welcome more detailed evidence on progress against its targets, including developments on the workforce implications from the evaluations of transformation projects.

4.103 Within the AfC framework agreement we understand that many of the factors we have identified as influencing the workforce are planned to be reviewed as part of the safe staffing discussions between the Department, employers and unions. The AfC framework agreement promised £60 million over five years to support the resulting actions for safe staffing. The discussions could also be informed by the Nursing and Midwifery Task Group report and the Department of Finance's public sector labour market review, which we look forward to being included in future evidence submissions.

### *Re-establishing AfC pay parity*

4.104 The Minister of Health's remit letter also asked for our views on the impact that the re-establishment of pay parity, with England and Wales, might have in making Northern Ireland a more attractive destination in which to pursue a career in health and social care. This remit followed the acceptance of the AfC framework agreement in February 2020 (see paragraph 4.54).

4.105 It is clear from our overall assessment of the economic, labour market and workforce indicators that the HSC in Northern Ireland needs to remain attractive to recruit, retain and motivate staff. We recognise that the HSC workforce faces significant pressures. We have heard on our visits that staff place great value on the AfC pay structure and some staff compare their pay with other parts of the UK. We also heard from staff that this might be leading younger AfC staff who ultimately intend to return to Northern Ireland to spend longer working in other parts of the UK. However, other economic, labour market and pay indicators suggest that the HSC is a relatively attractive place to work in Northern Ireland. At this stage, we can draw no firm conclusions about the impact of re-establishing pay parity, although we heard from the parties that pay parity was seen as a positive move. As data and information emerges we look forward to monitoring the effects of the AfC framework agreement in Northern Ireland, including the effects of pay parity, as we have begun to monitor the impact of AfC pay agreements in other UK countries.

## Service transformation, integration and productivity

4.106 Planned service changes are driven by the NHS Long Term Plan and our specific interest is in the impact on the AfC workforce. Three areas relate to our remit as they impact on the way in which the AfC workforce is configured and deployed: (i) new service models focused on primary care and community services and the associated workforce requirements; (ii) the integration of health and social care; and (iii) staff contributions to new ways of working and therefore productivity improvements.

4.107 The evidence from all parties continues to emphasise the rising demand for services and the pressures this places on the existing AfC workforce. NHS E&I's Combined Performance Summary at February 2020 (summarised in Chapter 2) continued to show the volumes of demand placing pressure on services and significant challenges in meeting performance targets in England, with similar pressures shown in the data for the Devolved Administrations. We heard from NHS Employers in oral evidence that high levels of demand pressures on services were becoming the new norm throughout the year and that staff shortages put further pressure on existing staff. They added that employers were spending much of their time resolving immediate resourcing problems and that this prevented their being able to look forward and plan their longer-term workforce strategies, change their cultures and improve leadership.

4.108 Pressures on providers from finances and demand for services could also be squeezing out time and resources required to transform services as envisioned in the NHS Long Term Plan. These pressures on the NHS will be exacerbated by COVID-19 although the full effects will take time to be seen. Several external commentators have already commented on the difficulties transforming services and the impact on the workforce as follows:

- The NAO's *NHS Financial Management and Sustainability Report*[73] concluded that the NHS was treating more patients but had not yet achieved the fundamental transformation in services and finance regime needed to meet rising demand;
- The CQC's 2019 *State of Care 2018/19 Report*[74] found that staff had limited time and space to engage in quality improvement initiatives or to attend relevant training. The CQC also referred to workforce challenges continuing to affect the delivery of health and social care in all sectors; and
- The Health Foundation's *Falling Short: The NHS Workforce Challenge*[75] concluded that the effect of shortages in key areas was increasingly felt through problems with access and quality, and that this was rippling out to other sectors, notably social care and the nursing home sector. The Foundation added that without radical and concerted action in the NHS People Plan, there was a very real risk that the additional funding committed to the NHS would not deliver tangible improvements to care.

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73 National Audit Office (February 2020), *NHS Financial Management and Sustainability Report*. Available at: https://www.nao.org.uk/report/nhs-financial-management-and-sustainability/?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=

74 Care Quality Commission (October 2019), *State of Care 2018/19*. Available at: https://www.cqc.org.uk/publications/major-report/state-care

75 The Health Foundation (November 2019), *Falling Short: The NHS Workforce Challenge.* Available at: https://www.health.org.uk/sites/default/files/upload/publications/2019/S05_Falling%20short_The%20NHS%20workforce%20challenge.pdf

*New service models*

4.109 As highlighted in evidence, new service models under the NHS Long Term Plan placed more emphasis on prevention and health inequalities, improving the quality of care and health outcomes, and harnessing technology. The Plan aimed for greater focus on community, primary and mental health services. The Plan sought to fund GP practices to work together to deal with pressures in primary care and extend the range of convenient local services, creating integrated teams of GPs, community health and social care staff. Expanded community health teams will be required to provide fast support to people in their own homes as an alternative to hospitalisation. The Government has made commitments to significant increases in staff for these new service models. However, we have yet to see evidence of the workforce planning mechanisms to support new models of care. We would again welcome clarity on where the lead responsibility for workforce planning sits under these new arrangements and what actions might be taken at national, regional and local level. The Interim NHS People Plan pointed to a growing role for Integrated Care Systems in workforce planning and deployment.

4.110 We have heard from DHSC on the progress developing multi-disciplinary teams in primary care under the NHS Long Term Plan. DHSC also told us that, while this move would ultimately sit with Integrated Care Systems, the ICSs were at different stages of development. However, we heard from NHS Employers in oral evidence that the expected growth in the primary care workforce under multi-disciplinary teams would put pressure on overall healthcare shortages for, among others, nursing, diagnostics and paramedicine. There were some emerging indications on our visits that AfC staff from the acute sector could be attracted by primary care offering more flexible or stable working arrangements and different local pay structures. The effect could be significant for shortage staff groups who could be in demand from different health sectors. Further evidence is required on this impact as it develops.

4.111 We will continue to monitor any emerging effects of the way in which new roles are supporting new ways of working and changing the skill mix in the NHS workforce. For AfC groups, these are nursing associate, physician's associate, advanced clinical practitioner, and new roles in the expansion of primary and community care.

*Integration of health and social care*

4.112 The NHS Long Term Plan in England contains a target that Integrated Care Systems will be in place in all areas by 2021. The NHS Long Term Plan aims for ICSs to bring together local organisations to deliver the triple integration of primary and specialist care, physical and mental health services, and health and social care. ICSs will have a key role working with local authorities and through ICS commissioners to make shared decisions with providers on population health, service redesign and Long Term Plan implementation. Progress appears to be variable. We were told in evidence that while there were examples of trusts, other providers and local authorities working well together, the funding, administrative and cultural barriers remained considerable. We note that the NAO's recent report concluded that, if Integrated Care Systems were to be successful, funding mechanisms and incentives needed to support collaborative behaviours.

4.113 The Health Foundation[76] provided some initial comments on the effects of COVID-19 on the capacity and resilience in the NHS and social care. The Foundation cited both sectors having significant staff shortages and that assessing the cumulative impact on the NHS, social care and wider society would include, among other things, the relationships between disrupted and changed services, and public awareness strengthening the impetus for social care reform. The parties' evidence for our report stressed that managing demand in the NHS depended on capacity in social care, where much care is supplied by the private sector. The Government has promised consultation on a plan for social care where workforce pressures are significant. The NHS AfC workforce in England was 998,057 (FTE) at September 2019. This compares with 1,620,000 adult social care jobs in England in 2018 as estimated by Skills for Care, of which 1,225,000 (76%) were direct care staff jobs and another 84,000 (5%) were regulated professionals, including 41,000 registered nurses. The Health Foundation reported[77] that the number of registered nurse jobs in adult social care had decreased by 20% since 2010. Recent AfC pay increases under the agreement could be exacerbating recruitment and retention concerns in the social care sector. Workforces in both sectors will continue to be affected by the UK's exit from the EU, given their use of EU and overseas recruitment. As integration develops in England, we will continue to assess the impacts on the AfC workforce. We would also welcome updates on the workforce implications of the development of Integrated Health Boards in Scotland, and the long-term plan for health and social care in Wales.

4.114 We have commented in recent reports on the ways in which Integrated Care Systems will require new organisation and employment structures, and consideration of staff terms and conditions. The parties continue to highlight that overcoming the barriers to common employment and pay arrangements would need significant work, including pay levels, grading, pensions and career pathways. There are considerable differences between reward packages in social care and the NHS, including different pay structures, pension schemes, and terms and conditions. The social care sector employs a large proportion of lower paid workers in a mix of provider settings, many in the private sector, and therefore there is an interaction with changes in the National Living Wage and AfC pay rates at Band 2. We note that DHSC told us in oral evidence that the vast majority of the adult social care workforce was paid less than the equivalent of the bottom of AfC Band 2 and that, if the wages of these workers were raised to at least the bottom of AfC Band 2, the Government estimates it would cost around £1.2 billion. We consider that integrating health and social care needs to be backed up by a reward strategy across both workforces. We stress that any move to harmonise terms and conditions would require a consistent approach to reward packages and to be supported by appropriate financial investment.

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[76] Health Foundation (April 2020), *COVID-19: Five Dimensions of Impact*. Available at: https://www.health.org.uk/news-and-comment/blogs/COVID-19-five-dimensions-of-impact

[77] Health Foundation (November 2019), *Falling Short: The NHS Workforce Challenge*. Available at: https://www.health.org.uk/publications/reports/falling-short-the-nhs-workforce-challenge

*Productivity*

4.115 All NHS organisations point to the continuing need for improved productivity. The NHS Long Term Plan has set a target of making re-investable productivity gains of at least 1.1% a year over the next five years. DHSC's evidence pointed to the productivity gains from its efficiency plan and repeated its measures of labour productivity from the Centre for Health Economics showing the NHS's average annual growth was 2.5% between 2005/06 and 2015/16. We note that, since the evidence was submitted, data for 2016/17 has been published, which reduces the average annual growth since 2005/06 slightly to 2.4%[78].

4.116 While we recognise the difficulties in measuring productivity and its rate of growth in a complex organisation such as the NHS, we note that the way these measures are constructed depends on data relating to the cost of labour. This carries two risks. The first is that it fails to take account of unpaid overtime which has been a feature of work in the NHS for many years. This could mean that, other things being equal, the reported level of productivity is overstated and, without knowing how the amount of such overtime has changed, the reported figures for productivity growth could also be misleading. Second, it conflates cost saving through wage restraint with productivity increases. While there may be many other factors at work, this may partly explain why these figures for productivity growth in the NHS are so much higher than in the rest of the economy.

4.117 Given the lag in data on productivity measures, these are likely to reflect the productivity gains in recent years being driven by pay restraint. This will not be the case in productivity from 2018/19 onwards and therefore there will need to be renewed emphasis on gains from new models of service, new ways of working, process improvements, changing the workforce skill mix, and the development of technology and digital services. The 2018 AfC pay agreement also drew links between the new progression arrangements and enhanced staff contribution. We look forward to hearing more from the parties on the way in which these developments will feed into future productivity gains.

## NHS affordability and efficiency savings

4.118 We continue to review the position of NHS finances and affordability in preparation for our return to pay recommendations following the end of the 2018 AfC pay agreements. We are working on the evidence as presented to us by DHSC in January 2020 although we are fully aware that COVID-19 has had a major impact on Government finances and those of the NHS. We noted in Chapter 2 of this report, that the March 2020 budget and following Government announcements provided additional resources for the NHS to manage its response to COVID-19. We will be able to assess this impact in our next report.

4.119 The financial environment is steered by the NHS Long Term Plan's five financial tests, which were set to ensure the service was being put on a more sustainable footing. Although the tests do not aim to measure the impact of additional funding on service outcomes, the areas of particular interest for us relate to productivity, efficiency and unwarranted service variations. We look forward to assessments against these tests for our future reports as they are important considerations in assessing the affordability of pay awards.

[78] Centre for Health Economics (April 2019), *Productivity of the English National Health Service: 2016/17 Update.* Available at: https://www.york.ac.uk/che/news/news-2019/che-research-paper-163/

4.120 In the meantime, we also note that the recent NAO Report on NHS financial sustainability concluded that the short-term fixes in place to manage resources in a constrained financial environment were not sustainable. The NAO's conclusions for 2018/19 and NHS E&I's Financial Performance Report for the second quarter of 2019/20 (see Chapter 2) reinforce our view on the constraints within trusts from finances, demand and workforce shortages. The Government announced in April 2020 the write-off of £13.4 billion of debt as part of a major financial reset for providers in the NHS, which could have implications for future considerations of available funding and affordability of AfC pay awards. We will continue to monitor the financial pressures in the NHS in the context of the significant investment in the 2018 AfC pay agreements to 2020/21 and the continuing requirement for investment in NHS workforce developments expected in the NHS People Plan.

4.121 We also recognise that trusts continue to make efficiency savings under various efficiency plans. However, there is a consensus that this work focuses on cost control and that the achievement of transformational savings that can be realised through new ways of working is challenged by workforce and operational pressures. We consider that there would be benefit in the efficiency and productivity measures in DHSC's 10-point plan being mapped against the expected aims of the NHS People Plan. This would enable a clear demonstration of the links between the Plan and the contribution of AfC staff to efficiency and productivity gains.

4.122 We conclude that several affordability arguments play into our future considerations of AfC pay awards. We note that, while DHSC acknowledged the NHS funding settlement through to 2023/24, it warned that more funding put towards pay would mean less funding for other priorities, including affordable workforce numbers and the investments required to deliver the NHS Long Term Plan. DHSC also placed emphasis on the need for pay discipline to help ensure sustainability in the NHS.

## Workforce strategies and workforce numbers

### *NHS People Plan for England*

4.123 Following the publication of the Interim NHS People Plan for England in June 2019, we expected much of our consideration for this report to be informed by the NHS People Plan. We note that publication of the Plan has been delayed until later in 2020 in the light of COVID-19. The Plan has dominated AfC workforce considerations for the last year since the publication of the Interim NHS People Plan in June 2019, including the evidence presented for this report.

4.124 We look forward to the publication of the NHS People Plan, which DHSC told us in evidence would set out a clear framework for collective action. We have been told that there has been a collaborative and inclusive approach among NHS organisations, employers and unions in developing the Plan. While this is encouraging, we commented in our 2019 Report on the continuing lack of clarity on responsibility for enacting and delivering the Plan, and it is a priority for us that there is system-wide action on workforce priorities. From the evidence for this report, we continue to consider that further clarity is required on delivery through DHSC, NHS lead organisations, Integrated Care Systems and individual NHS trusts.

4.125 The Interim NHS People Plan emphasised leadership as a key theme. DHSC, NHS organisations and external commentators also recognised the importance of effective leadership to improving staff engagement. We therefore see merit in drawing on any measures in the expected NHS People Plan and the Care Quality Commission's inspections assessing whether trusts are "well-led". Specifically, the CQC's assessment of the following might provide some insights: (i) are there clear and effective processes for managing risks, issues and performance; (ii) are the people using the services, the public, staff and external partners, engaged and involved to support high quality sustainable services; and (iii) are there robust systems and processes for learning, continuous improvement and innovation.

4.126 When published the NHS People Plan will become the reference point for much of the required workforce development we have signalled in our recent reports. The NHS People Plan and the workforce strategies in the Devolved Administrations will need to be revised to account for the impact of COVID-19 on managing the existing NHS workforce, trust and provider management, the planned workforce developments, and the funding available to deliver much needed service and workforce transformation.

### *Northern Ireland Health and Social Care Workforce Strategy*

4.127 The Department of Health, Northern Ireland launched its *Health and Social Care Workforce Strategy 2026*[79] in 2018. The strategy had three key objectives of a reconfigured health and social care system with the best possible combination of skills and expertise, that health and social care will be a fulfilling place to work and train, and that the Department of Health, Northern Ireland and health and social care providers would be able to monitor workforce trends and issues effectively. We look forward to hearing more about the implementation of the strategy in further evidence submissions.

### *NHS Wales Workforce Strategy*

4.128 The Welsh Government published *A Healthier Wales: Our Workforce Strategy for Health and Social Care*[80] in draft in December 2019. The draft strategy aimed to achieve a motivated, engaged and valued workforce by 2030. The strategy's seven themes were: an engaged, motivated and healthy workforce; attraction and recruitment; seamless workforce models; building a digitally ready workforce; excellent education and learning; leadership and succession; and workforce supply and shape. The strategy would be delivered in a series of implementation plans co-produced with social partners. In the context of these plans, we ask that the parties' evidence covers the impact and implications of the Nurse Staffing Levels (Wales) Act.

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79 Department of Health, Northern Ireland (May 2018), *Health and Social Care Workforce Strategy 2026*. Available at: https://www.health-ni.gov.uk/publications/health-and-social-care-workforce-strategy-2026

80 Welsh Government (December 2019), *A Healthier Wales: Our Workforce Strategy for Health and Social Care*. Available at: https://heiw.nhs.wales/files/workforce-strategy-for-health-and-social-care/workforce-strategy-for-health-and-social-care-final-draft/

### *Scottish Health and Social Care Workforce Plan*

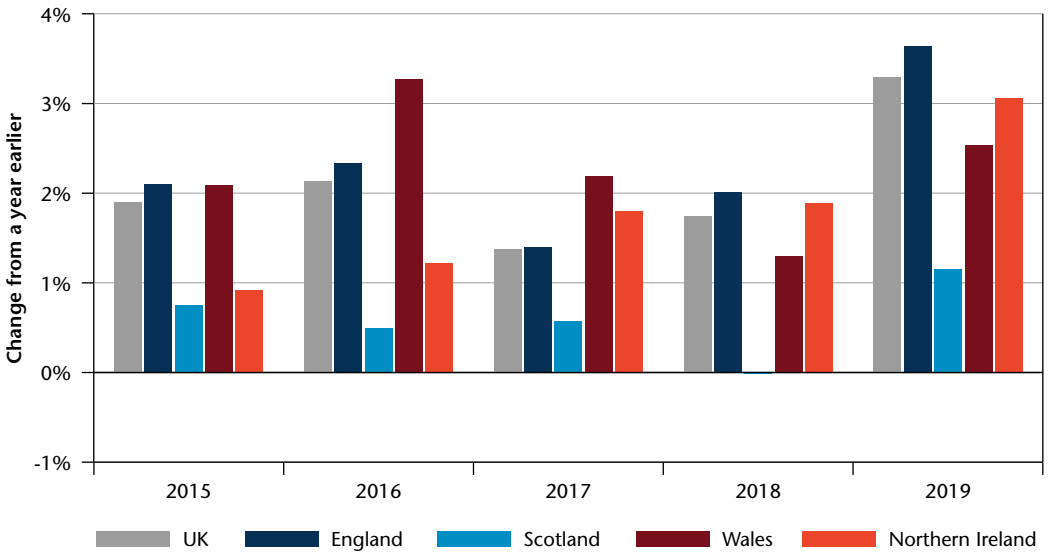
4.129 The Scottish Government published *An Integrated Health and Social Workforce Plan for Scotland*[81] in December 2019. The plan set out future workforce requirements in a national context and provided revised workforce planning guidance to health and social care employers. The plan included commitments to: increase training places for physiotherapists; increase the cardiac physiologist workforce; create more pharmacist roles to work in primary care settings; support more clinical psychologists and mental health officers; increase radiography training places; develop a workforce planning qualification; and provide additional support in 2020/21 to the third and independent social care sectors.

### *Staffing numbers*

4.130 In the context of the various workforce strategies, we review below the overall AfC staffing numbers and breakdowns for staff groups for each UK country, where data is available. We examine data on gender and ethnicity of AfC staff in England. Given the recognition in the Interim NHS People Plan on the urgency of addressing the nursing workforce, this section then looks at the specific data on the nursing workforce, nursing groups and the latest available data from the Nursing and Midwifery Council.

4.131 The AfC workforce continues to increase year-on-year, both overall and in each UK country. We note that at September 2019 there were over 1.25 million full time equivalent (FTE) AfC staff in the United Kingdom. Of these, approximately 1 million were working in England, 130,000 in Scotland, 75,000 in Wales and 55,000 in Northern Ireland. We also track the trends in the workforce and Figure 4.9 shows the change in staffing numbers in each year since 2015. We note that, in the year to September 2019, compared with a year earlier, the number of FTE staff rose in the United Kingdom overall by 3.3%, with increases in England of 3.6%, Northern Ireland 3.1%, Wales 2.5% and Scotland 1.2%. We also see that on a headcount basis there were 1,450,000 AfC staff, as at September 2019. Of those, approximately 1,140,000 were in England, 150,000 in Scotland, 90,000 in Wales, and 70,000 in Northern Ireland.

**Figure 4.9: Change in AfC full time equivalent workforce by United Kingdom country, 2015 to 2019**

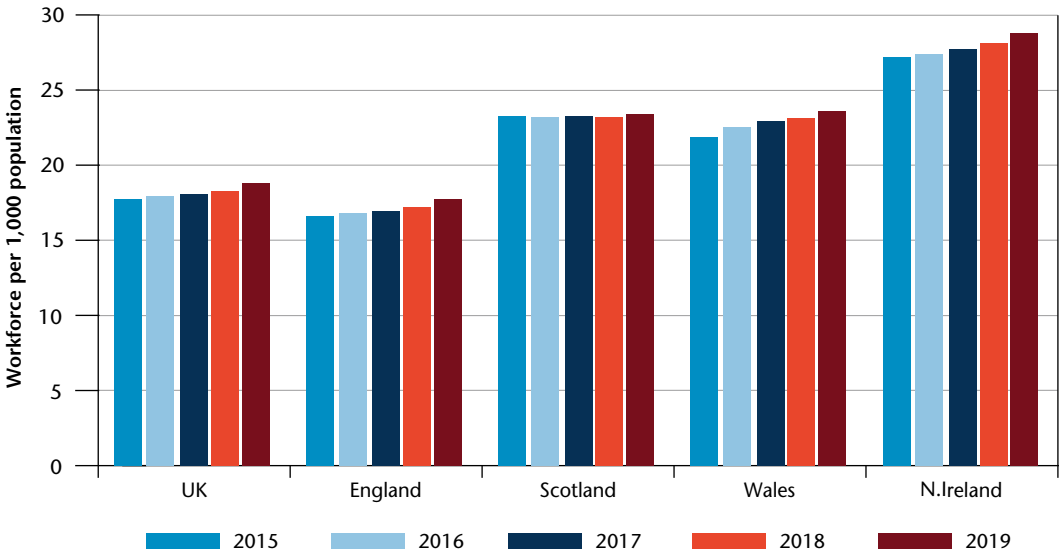



*Source: NHS Digital, NHS Education for Scotland, Stats Wales, Department of Health, Northern Ireland*

[81] Scottish Government (December 2019), *An Integrated Health and Social Care Workforce Plan for Scotland.* Available at: https://www.gov.scot/publications/national-health-social-care-integrated-workforce-plan/

4.132 We have seen in our previous assessments and continue to be told by the parties in evidence that, the number of FTE AfC staff has increased year on year, the population and demands on the service have also grown. Against this background, we have examined the number of AfC staff per head of population. Our analysis in Figure 4.10 shows the number of FTE AfC staff per 1,000 of the population of the UK and in each UK country. We note that the increase in the height of the bars shows that the number of FTE staff is growing more quickly than the population. However, while AfC staff per head of population has grown in the UK as a whole and in Wales and Northern Ireland, it has remained constant in Scotland. We can also see that England has fewer FTE AfC staff per 1,000 population than other parts of the UK, whereas Northern Ireland has the largest number of AfC staff relative to population as the Northern Ireland AfC workforce includes those working in social care.

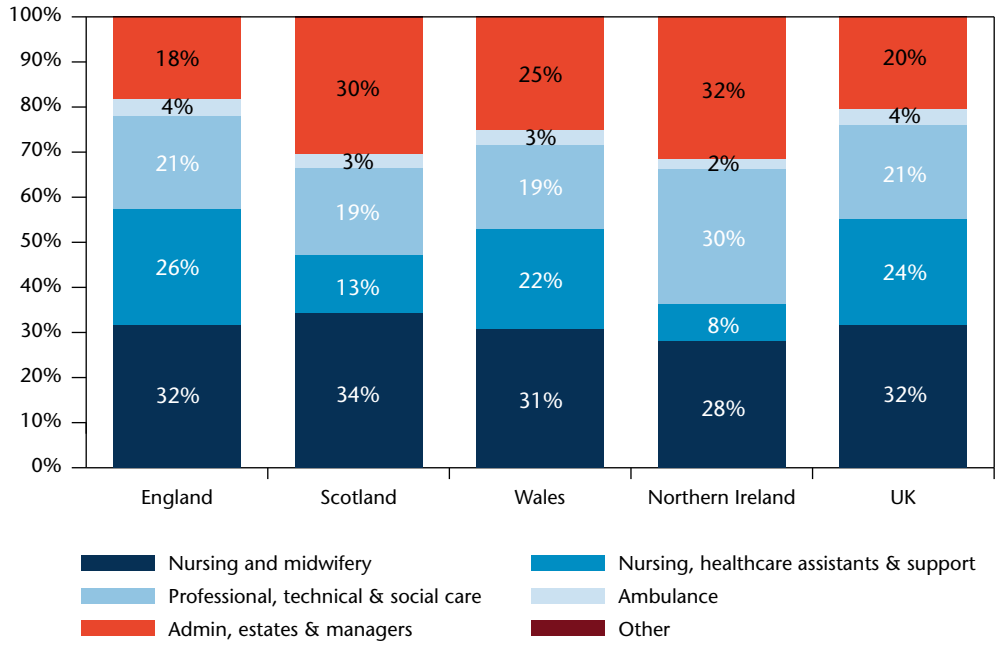
**Figure 4.10: NHS AfC full time equivalent workforce per 1,000 population by United Kingdom country, 2015 to 2019**




*Source: OME calculations based on data from NHS Digital, NHS Education for Scotland, Stats Wales, Department of Health, Northern Ireland, ONS*

4.133 Our analysis in Figure 4.11 shows a breakdown of AfC by broad staff group in each country within the UK. We observe that in Scotland and Northern Ireland there is a relatively high share of administration, estates and management staff, compared with England and Wales. We note that other variations by AfC staff group include that Scotland has a relatively high proportion of nursing and midwifery staff, while England and Wales have a relatively high proportion of nursing and healthcare assistants.

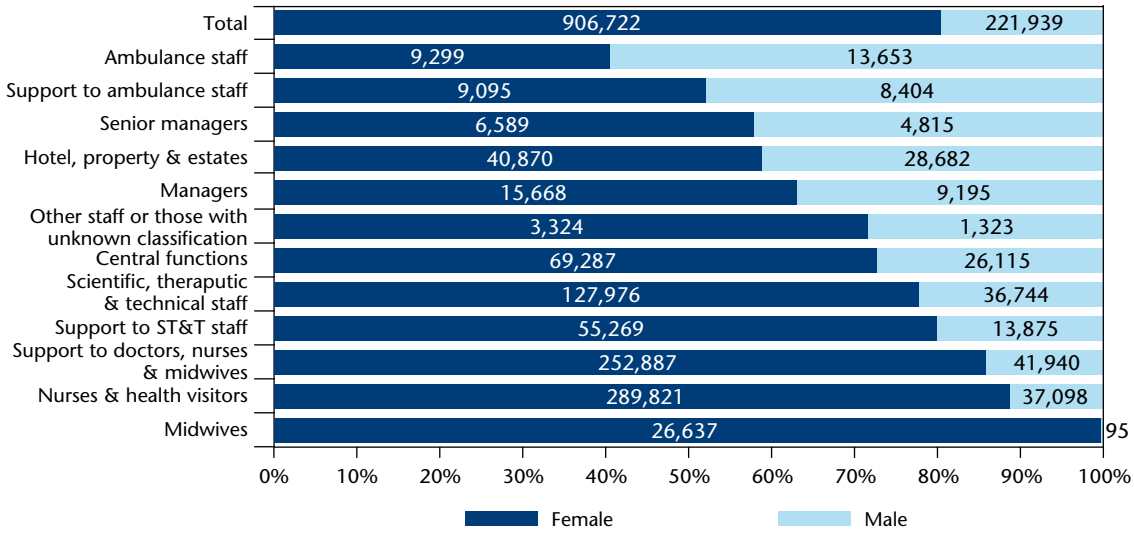
**Figure 4.11: NHS AfC full time equivalent workforce by broad staff group and by United Kingdom country, September 2019**




*Source: NHS Digital, NHS Education for Scotland, Stats Wales, Department of Health, Northern Ireland*

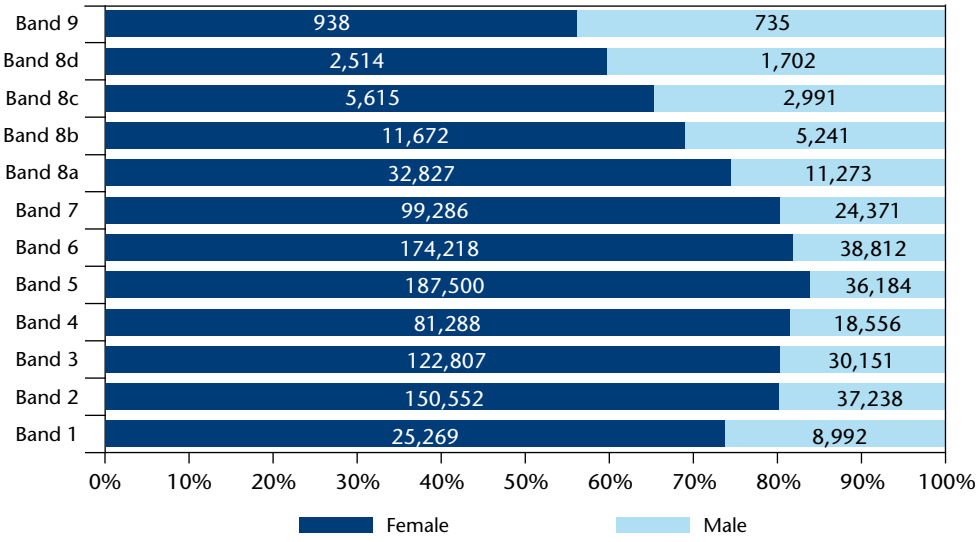
4.134 We consider the data on the gender breakdown of AfC staff to monitor any changes in workforce trends, given that the AfC workforce is predominantly female. The analysis in Figures 4.12 and 4.13 show a breakdown of AfC staff by gender, by broad staff group and by band, in England in March 2019. Overall, we note that men make up 20% of AfC staff, and that in all staff groups, other than ambulance staff (59%), women make up a majority of the workforce. We also see from the data that the only other staff groups where men make up more than 40% of the workforce are support to ambulance staff (48%), senior managers (42%) and hotel, property and estates staff (41%). The analysis by AfC pay band also shows that women make up a majority of staff in every pay band, and over 70% of staff in every band except Bands 8b-8d and Band 9. We comment earlier in this report on the gender pay gap and ask the parties for evidence on progression for women across an NHS career. We also comment later in relation to the supply of postgraduate entrants to AfC professions that men remain a potential source of nursing recruits.

**Figure 4.12: Staff in Agenda for Change roles by gender, by staff group, in England, March 2019, headcount**




*Source: NHS Digital*

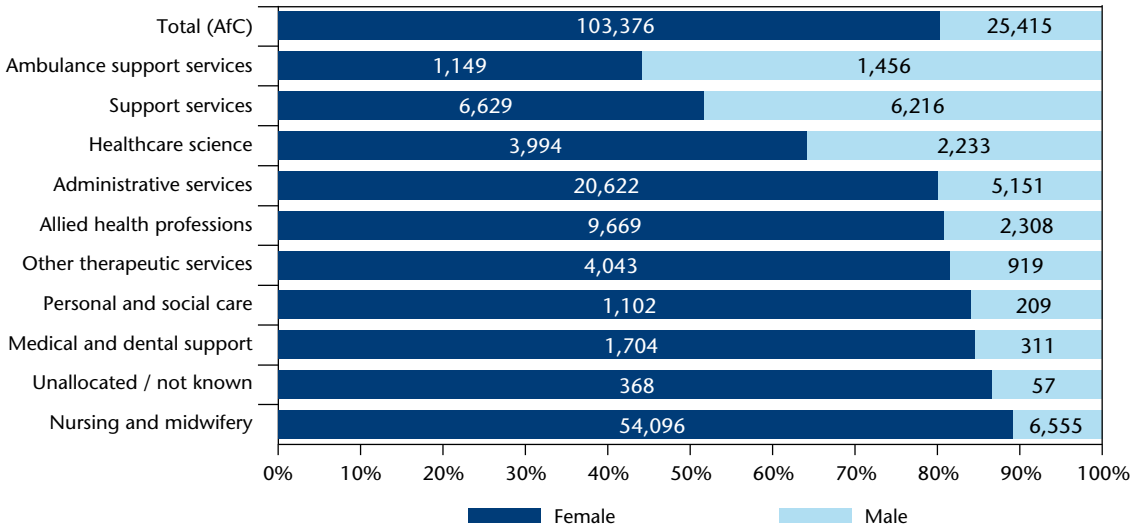
**Figure 4.13: Staff in Agenda for Change roles by gender, by band, in England, March 2019, headcount**




*Source: NHS Digital*

4.135 Figure 4.14 shows a breakdown of AfC staff by broad staff group by gender in Scotland in December 2019. In all staff groups other than ambulance support services (56%), support services (48%) and healthcare science (36%), men make up 20% or less of the workforce.

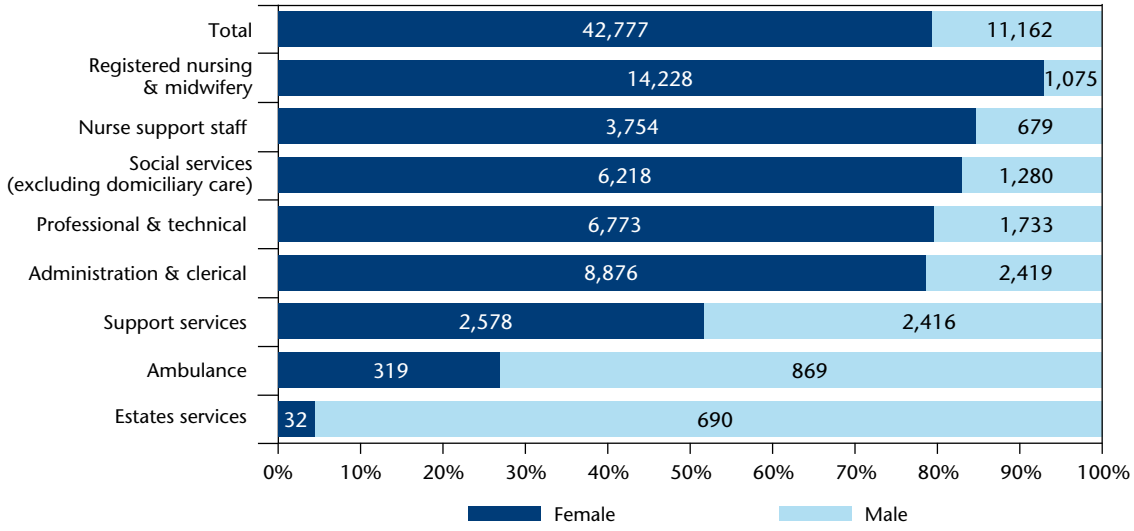
**Figure 4.14: Staff in Agenda for Change roles by gender in Scotland, December 2019, FTE**




*Source: NHS Education for Scotland*

4.136 Figure 4.15 shows a breakdown of AfC staff by broad staff group by gender in Northern Ireland in March 2019. In all staff groups other than estates services (96%), ambulance staff (73%) and support services (48%), men make up less than 25% of the workforce.

**Figure 4.15: Staff in Agenda for Change roles by gender in Northern Ireland, March 2019, FTE**

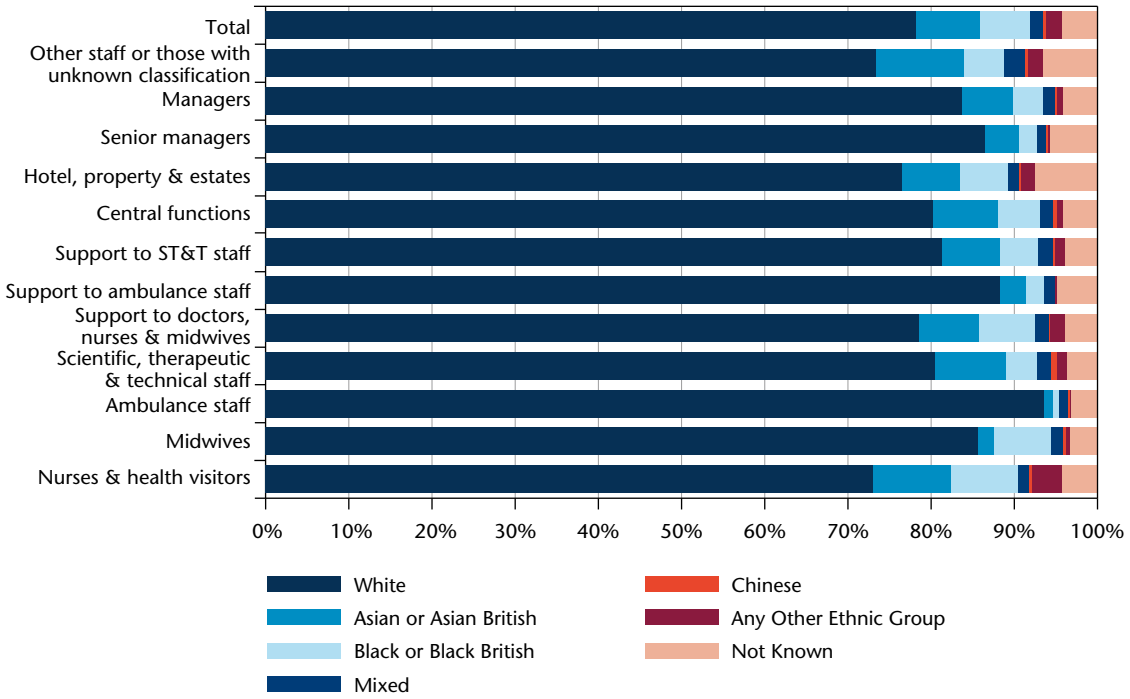



*Source: Department of Health, Northern Ireland*

4.137 Our workforce analysis for this report also included ethnicity among AfC staff (based on NHS Digital definitions). Figures 4.16 and 4.17 show a breakdown of AfC staff by ethnic group, by broad staff group and by band, in England in March 2019. Overall, we note that 78% of staff were White, 8% Asian or Asian British, 6% Black or Black British, 2% mixed ethnicity, fewer than 1% Chinese, 2% any other ethnic group and 4% where ethnic group was unknown. The data suggests that by staff group, the least ethnically diverse group were ambulance staff, where 94% were White with just 1% Asian or Asian British, 1% Black or Black British and 1% mixed. We can see that, in contrast, 73% of nurses and health visitors were White, 9% Asian or Asian British, and 8% Black or Black British. There are also variations in ethnicity by AfC pay band. We note that the pay bands with the highest percentage of White staff were Band 7 and above (at least 82%). Only 71% of Band 5 staff were White, with 11% Asian or Asian British staff and 8% Black or Black British staff. The only other pay band to have fewer than 75% White staff was Band 1, 74% White, 9% Asian or Asian British staff and 7% Black or Black British staff.

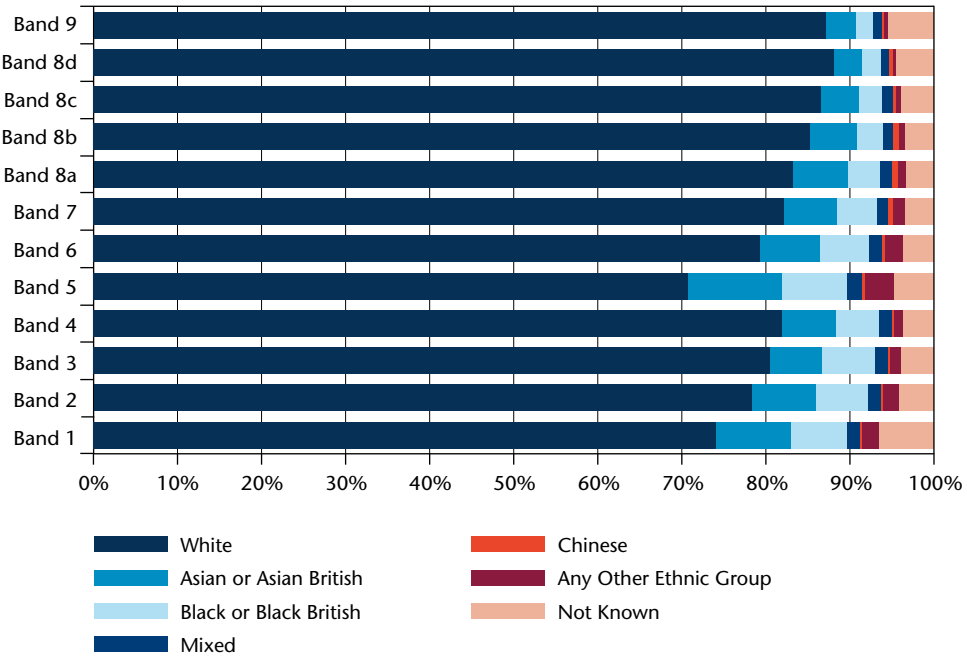
4.138 We consider that understanding the drivers of the underlying causes of the pay gaps by gender or ethnicity reported here also requires an understanding of the interactions between many characteristics that affect pay and employment opportunities. For example, it is known that pay gaps by ethnicity or gender also depend on immigration status, region of residence or age of the individual and the interaction of these characteristics. We would welcome more information on these other characteristics of the AfC workforce.

**Figure 4.16: Staff in Agenda for Change roles by ethnicity, by staff group, in England, March 2019, headcount**




*Source: NHS Digital. More detailed definitions of each group can be found at https://www.ethnicity-facts-figures.service.gov.uk/*

**Figure 4.17: Staff in Agenda for Change roles by ethnicity, by band, in England, March 2019, headcount**




*Source: NHS Digital. More detailed definitions of each group can be found at https://www.ethnicity-facts-figures.service.gov.uk/*

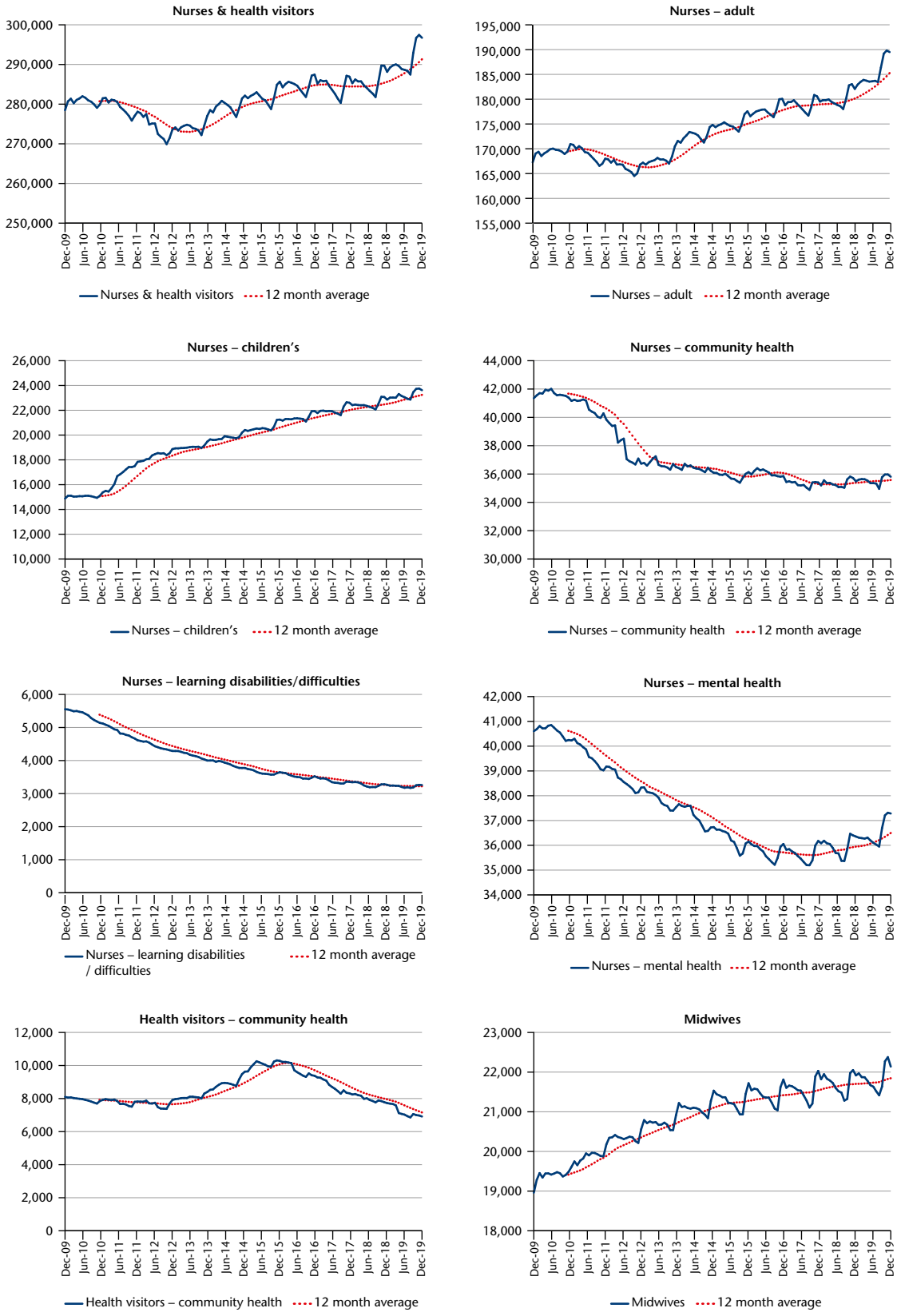
## *Nursing workforce*

4.139 Figure 4.18 shows the FTE number of nurses, health visitors and midwives in England, between December 2009 and December 2019. Overall, the number of nurses and health visitors fell between 2010 and 2012, then grew between 2012 and 2016. However, numbers then levelled out until the first half of 2018, before increasing through the remainder of 2018 and 2019. In 2019, the number of nurses and health visitors, as a whole, was 4% higher than in 2010.

4.140 Groups within the nursing and health visitor and midwifery populations experienced different levels of growth between 2010 and 2019. Over the period there was growth in the number of nurses – adult (9%), midwives (12%) and nurses – children's (53%). However, over the same period there were falls in the number of health visitors – community health (9%), nurses – mental health (10%), nurses – community health (14%), and nurses – learning disabilities/difficulties (39%).

4.141 The data, for the three months to December 2019, show nurse and health visitors numbers in England were 2.7% higher than a year earlier. Within that overall total, there were increases in the number of adult nurses (3.8%), children's nurses (3.0%), mental health nurses (2.4%) and community health nurses (0.7%) but falls in the number of health visitors (10.5%) and learning disabilities nurses (0.5%). Over the same period there was an increase in the number of midwives of 1.3%.

## Figure 4.18: Number of nurses, health visitor staff and midwives, FTE, by nursing category, England, December 2009 to December 2019

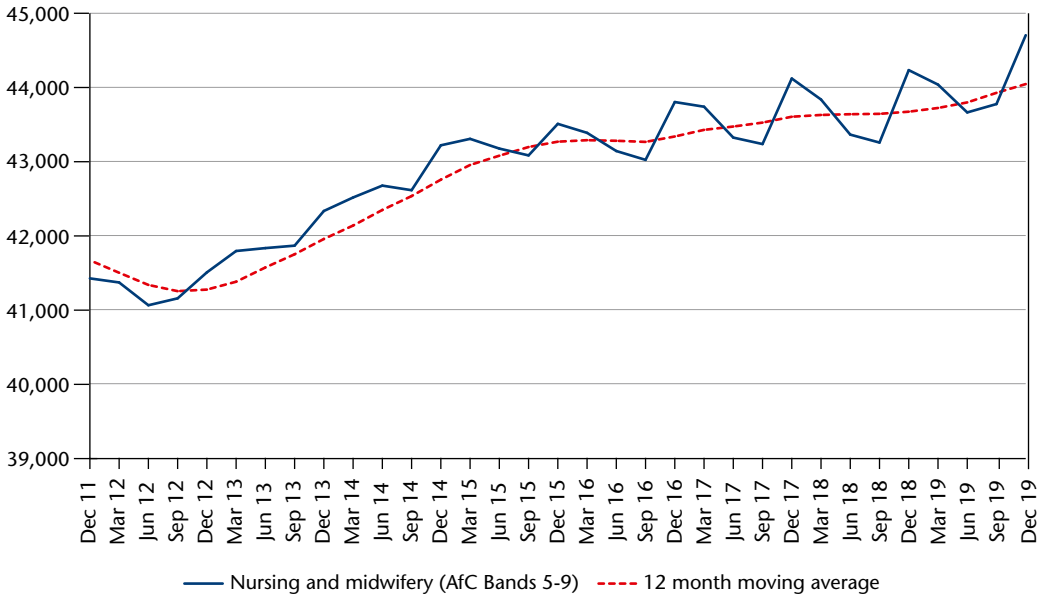



*Source: NHS Digital*

4.142 Figure 4.18 for England reaffirms the evidence from the parties that there are variations in the trends within the nursing and midwifery workforce. We note that the variations for different groups across a year reflect the different patterns of recruitment, the registering process with the NMC and retirement patterns. We can see from the general trends over the last decade that there has been a steady increase in the overall numbers of nurses and health visitors, driven by rising numbers in adult and children's nursing and midwifery. However, the trends reinforce the concerns of all the parties in showing the significant decline in numbers of nurses in learning disability and mental health. We also note falls in health visitors in community health and little change in numbers of community health nurses. We comment elsewhere on the range of measures to improve the supply and retention of nurses. In particular, we highlight our conclusions on the limited use of Recruitment and Retention Premia where there are significant shortages of key groups.

4.143 The 12-month rolling average number of Band 5-9 nursing and midwifery staff in Scotland rose in every quarter between December 2012 and March 2016 (Figure 4.19). Between the final quarter of 2016 and the mid-point of 2019 nursing and midwifery numbers grew at an annual rate of between 0% and 0.8%, before growing by more than 1% in each quarter of the second half of 2019.

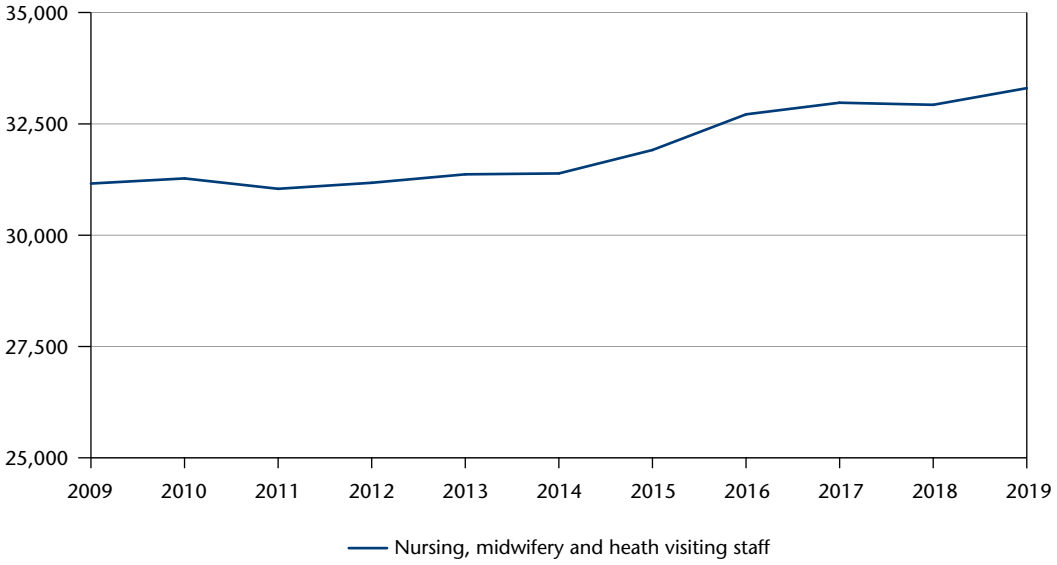
**Figure 4.19: Number of Band 5-9 nursing and midwifery staff, FTE, Scotland, December 2011 to December 2019**




*Source: NHS Education for Scotland*

4.144 In Wales, the number of qualified nursing and midwifery staff rose each year between 2012 and 2017, before falling by 0.2% in 2018 (Figure 4.20). However, between September 2018 and September 2019 numbers increased by 1.1%.

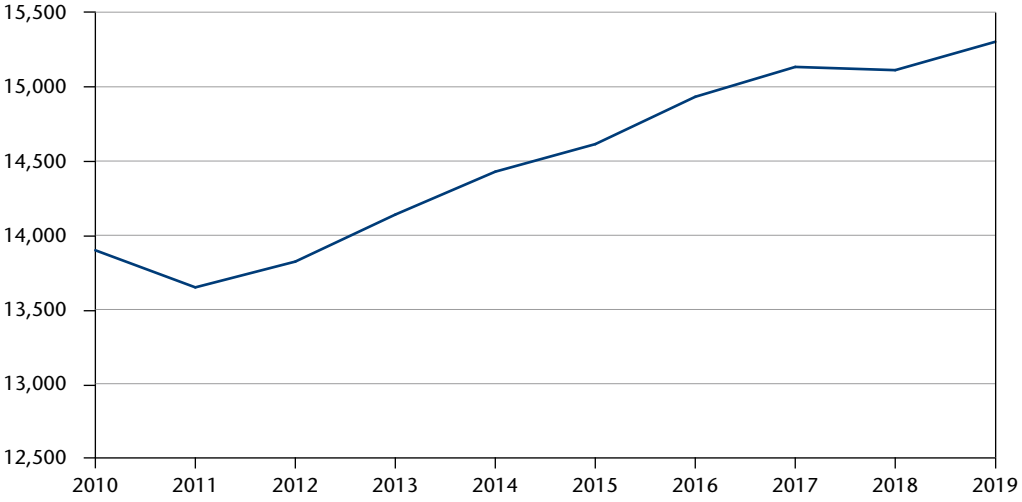
**Figure 4.20: Number of nursing, midwifery and health visiting staff, FTE, Wales, 2009 to 2019**




*Source: Stats Wales*

4.145 In Northern Ireland, the number of qualified nurses and midwifery staff grew each year between 2012 and 2017, before falling back slightly in 2018. However, numbers rose by 1.3% in 2019.

**Figure 4.21: Number of registered nursing and midwifery staff, FTE, Northern Ireland, March 2010 to March 2019**

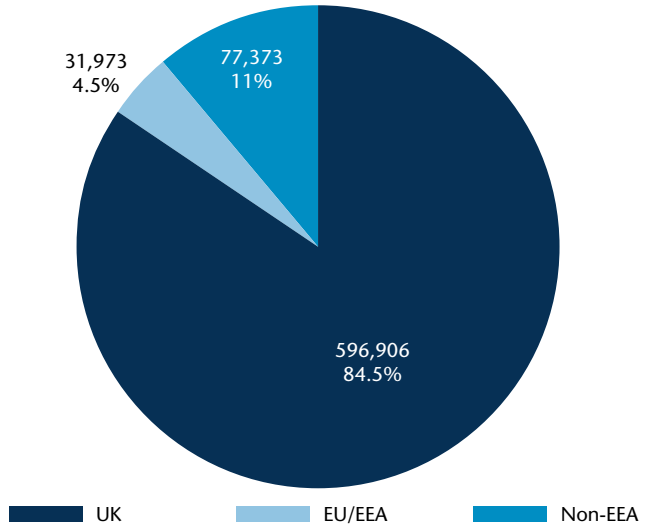



*Source: Department of Health, Northern Ireland*

*Nursing and Midwifery Council Register*

4.146 Data on the NMC Register helps us understand the total available workforce for nurses, midwives and nursing associates. It shows the current numbers able to practice in the UK although this will cover those working in the NHS, private and independent sectors or the third sector, and not all those on the register will be working in their registered roles or working at all. The latest data, for September 2019, showed that there were 706,252 nurses and midwives registered to work in the United Kingdom (Figure 4.22). Of the total number 596,906 were initially registered in the UK, 31,973 were initially registered in the EEA and 77,373 initially registered outside the EEA.

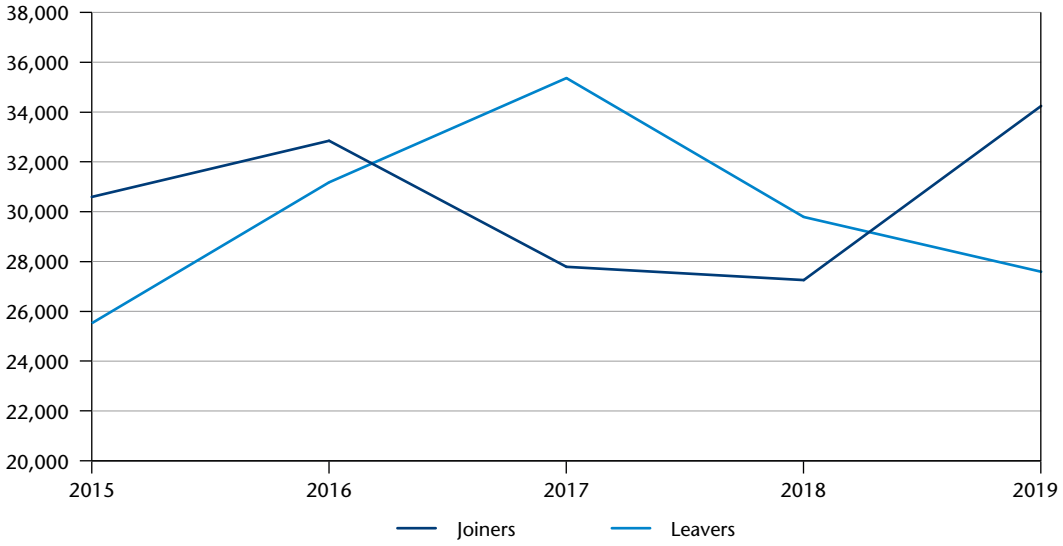
**Figure 4.22: Overall numbers of nurses and midwives on the NMC register by country of qualification, UK, September 2019**




*Source: Nursing and Midwifery Council (NMC) Register, September 2019*

4.147 In the year to September 2019, there was an increase of 12,634 (1.8%) nurses and midwives on the register. This increase resulted from an increase in joiners to the register, for the first time since 2016, and a fall in the number of leavers for the second consecutive year (Figure 4.23).

**Figure 4.23: Joiners and leavers to the NMC register, UK, between year to September 2015 and year to September 2019**




*Source: Nursing and Midwifery Council (NMC) Register, September 2019*

## Vacancies and shortage groups

4.148 NHS E&I publishes quarterly estimates of vacancies across the NHS in England. The latest data, for the third quarter of 2019/20, showed that overall, there were just under 100,000 total NHS vacancies, or a rate of 8.1%, compared with a rate of 8.5% in the same quarter a year earlier. Table 4.6 shows that in the third quarter of 2019/20 there were 39,000 nursing vacancies, 9,000 medical vacancies and 52,000 vacancies for non-nursing AfC staff. Compared with the third quarter of 2018/19 the rates for nursing, medical and non-nursing AfC staff all fell.

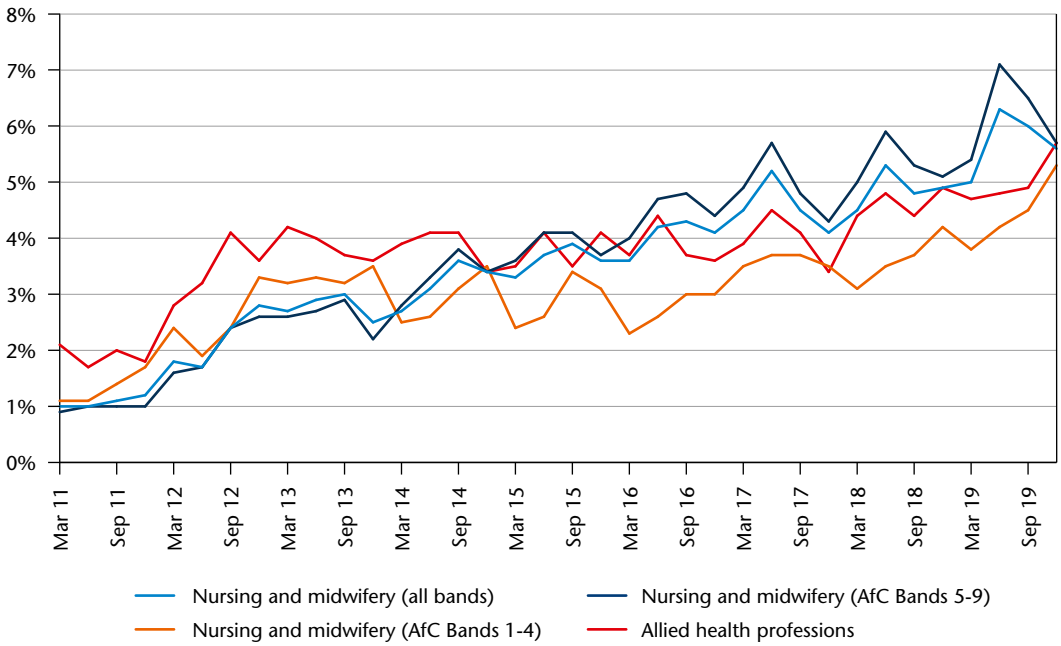
**Table 4.6: NHS Provider vacancies, England, 2017/18 quarter 3 to 2019/20 quarter 3**

| | | 2017/18 | 2018/19 | | 2019/20 | | |
|---|---|---|---|---|---|---|---|
| | | Q3 | Q3 | Q4 | Q1 | Q2 | Q3 |
| Nursing | Rate (%) | 10.2 | 11.1 | 11.1 | 12.3 | 12.1 | 10.7 |
| | Vacancies | 35,934 | 39,686 | 39,524 | 44,048 | 43,463 | 38,785 |
| Medical | Rate (%) | 7.9 | 7.1 | 7.2 | 9.0 | 7.1 | 6.6 |
| | Vacancies | 9,738 | 8,989 | 9,181 | 11,602 | 9,265 | 8,734 |
| Other staff | Rate (%) | 8.1 | 7.4 | 6.7 | 7.7 | 7.3 | 7.1 |
| | Vacancies | 55,895 | 52,311 | 47,656 | 55,989 | 52,652 | 52,324 |
| Total workforce | Rate (%) | 8.7 | 8.5 | 8.1 | 9.2 | 8.7 | 8.1 |
| | Vacancies | 101,567 | 100,986 | 96,361 | 111,639 | 105,380 | 99,843 |

*Source: NHS E&I*

4.149 The latest data for Scotland, for the third quarter of 2019/20, in Figure 4.24, show vacancy rates of 5.6% for nurses, midwives and health visitors (up from 4.9% a year earlier) and 5.7% for allied health professionals (up from 4.9% a year earlier). As well as increases in the overall vacancy rates, the three-month vacancy rates for both nurses, midwives and health visitors and allied health professionals increased from 1.3% to 1.5% and 1.8% respectively.

**Figure 4.24: Vacancy rates in Scotland by main staff group, 2011 to 2019**




*Source: NHS Education for Scotland*

4.150 The NHS in Wales had 2,133 FTE advertised vacancies in August 2019, down from 2,330 in August 2018, a fall of 8.5%.

4.151 For Northern Ireland, the most recent data shows that at the end of September 2019 there were 6,984 AfC vacancies, an increase of 1,124, or 19%, on September 2018. This is equivalent to a vacancy rate of 12.8%, up from 11.1%. In the same period, registered nurses' vacancies increased from 1,922 to 2,269, midwives from 50 to 122, nurse support from 403 to 521, and social workers' vacancies from 259 to 370.

### *Our assessment of shortage groups and vacancy data*

4.152 We recognise that vacancies arise naturally in all organisations as part of the process of churn of staff leaving and joining. For the NHS, there is a consensus on the scale of the AfC workforce gap and a clear picture of the impact of staff shortages. We now have almost three years of consistent data on vacancies in England, as collated by NHS E&I since 2017, which show that the level of vacancies across the NHS workforce as a whole has remained persistently high. We are also being provided with evidence on the impact of staff shortages on trust performance, service delivery and patient experience, as well as staff workload, additional paid and unpaid working hours, stress and sickness. For the AfC workforce these all exacerbate recruitment and retention difficulties, and influence staff motivation and morale.

4.153 In England, the NHS has experienced a sustained pattern of a high level of vacancies for medical, nursing and other staff at around 100,000 for the last three years at the same time as demand levels have increased. While the latest data shows falls in the vacancy rates for all AfC groups in the year to the third quarter of 2019/20, the overall level of vacancies remains high and was at an overall vacancy rate of 8.1%. The vacancy rate for nurses remains above that for other groups at 10.7% representing a fall since the start of 2019/20 but at a similar rate to the same period in 2017/18. There was a common view among the parties that there were significant shortages of mental health and learning disability nurses, which can be seen in the charts in Figure 4.18.

4.154 We note that the vacancy rates vary considerably across the Devolved Administrations. In Northern Ireland, the rate is high and has increased, particularly for key frontline groups, with a consequent increase in agency expenditure. The planned programme in Northern Ireland on safe staffing will need to address these groups as a priority. In Scotland, vacancy rates tend to be lower than the rest of the UK but have seen an increase in the latest data. In Wales, the number of vacancies has fallen although we would welcome improved data, including the rates.

4.155 The implications of persistent high levels of vacancies do not mean that AfC roles are not being covered and that a corresponding amount of work is not being done. Vacancies can result, in part, in some work that is not being done and, in part, through the use of agency and bank staff, and through staff working extra hours, both paid and unpaid.

4.156 Survey information and the parties' evidence provided some indications of the way in which vacancies and shortages impact on existing staff. Examples of these are:

- The NHS Staff Survey for England shows that the percentage of staff working paid hours over and above their contracted hours had increased from 25.4% in 2011 to 34.4% in 2019, and the percentage of staff working unpaid hours was 53.9% in 2019, although this had fallen from a peak of 59.0% in 2015;
- These increases were emphasised in the Staff Side's evidence, individual union member surveys and the views of staff on our visits. The latter also commented on coping with staff shortages largely relying on the discretionary effort and goodwill of existing staff, and there were suggestions that goodwill was running out; and
- The NHS Staff Survey for England shows a consistent proportion of staff feeling unwell as a result of work-related stress, which reached 40.6% in 2019.

4.157 We heard from the parties in evidence on the direct impact of staff shortages on trust performance, managing patient services and waiting lists while maintaining patient safety, delayed discharges, increased agency costs, and shortages limit time for organisational and culture change, improving leadership and delivering workforce developments. These were reflected in NHS E&I's data on performance and equivalent data for the Devolved Administrations. These pressures can often delay treatment potentially leading to patients' conditions deteriorating and so increasing the amount and complexity of the care required when they are admitted. We are also concerned that the shortage of staff could be leading to a cycle of reduced care, longer patient stays and a higher probability of earlier return adding to demand in the acute sector.

4.158 There have been some emerging signs of the impact of staff shortages and staff experience on patient care in various reports as follows:

- The CQC's 2019 State of Care Report concluded that workforce challenges continued to affect the delivery of health and social care in all sectors, and could further increase the strain on the workforce;

- The Picker Institute (with the King's Fund) Report[82] included an analysis of various surveys which found that staff experience was associated with sickness absence rates, spend on agency staff and staffing levels. Patience experience was negatively associated with workload factors. These associations resonated with other research and that the deepening crisis in NHS staffing and availability of beds could cause a deterioration in the quality of care; and
- The RCN's 2019 Report on *Standing Up for Patient and Public Safety*[83] included its estimate that in the last year alone for every extra NHS nurse employed there had been an extra 217 admissions, and that this was unsustainable. As part of the RCN's 2018 Report *Nursing on the Brink*, survey respondents reported that when there had been insufficient planned registered nurses care had been compromised, care was "poor" or "very poor", and care was left undone.

4.159 We are concerned that once the volume of vacancies reaches a certain level and persist, they are potentially very difficult to address because the impact is to set up two vicious circles. On the demand side, the failure to treat patients quickly has the potential simply to add to future demand for services. On the supply side, the pressure on existing staff leads to sickness absences and to difficulties of staff recruitment, retention and motivation, and problems achieving acceptable work/life balance thereby further risking recruitment and retention. We conclude that once the volume of vacancies reaches a certain level they can breed yet more vacancies.

4.160 It is clear that the workforce gap risks the available capacity required to deliver patient care, service delivery and developing new service models under the NHS Long Term Plan. So that we can better understand the validity of these concerns, we consider that there needs to be further work to understand the impact of vacancies and staff shortages and the way in which trusts' approach managing their resourcing strategies to mitigate the impact. Without this work there is a risk that the impact of staff shortages could be underestimated and the opportunity to take the right mitigating actions could be missed.

4.161 We have heard a consensus among the parties on the scale of the overall AfC workforce gap, the required action and the need to front-load the response. The interim measures expected in the NHS People Plan will be affected by COVID-19 and we are particularly concerned that the front-loading of overseas recruitment as an initiative to close the workforce gap and reduce vacancies could be curtailed significantly. More widely, COVID-19 will necessitate reassessments of workforce planning in the medium and long term. We have two further concerns. First, implementing such action requires trust leaders to have sufficient capacity and they have told us that this is being constrained at present by the imperative to manage demand and address immediate resource pressures. Second, growing domestic supply of new entrants into AfC professions to an appropriate level will take time and there will be a lag in these initiatives taking effect.

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82 Picker Institute and the King's Fund (January 2018), *The Risks to Care Quality and Staff Wellbeing of an NHS System Under Pressure*. Available at: https://www.picker.org/news/nhs-reliance-agency-healthcare-workers-related-staff-wellbeing-patient-experience-care/

83 Royal College of Nursing (October 2019), *Standing Up for Patient and Public Safety*. Available at: https://www.rcn.org.uk/professional-development/publications/007-743

## Supply and recruitment of AfC staff

### *General*

4.162 The NHS Long Term Plan and the Interim NHS People Plan placed great emphasis on the need to increase the supply of qualified people available and willing to work in the NHS. The NHS workforce will need to grow at a significant rate to meet increasing demand for services and to achieve the transition to new service models. There is a widespread recognition among NHS organisations and external commentators that the main source for increasing supply will come from domestic recruits in the longer term. While there are recruitment campaigns and planned initiatives in place, there will be a lag before these result in newly qualified staff available for AfC roles. This suggests a need to front-load initiatives in an effort to mitigate the workforce gap, which all the parties acknowledged in their oral evidence. There will also be risks to sources of supply as a result of COVID-19, which will need review.

4.163 Our analysis covers a range of sources of supply. We assess the position for pre-registration entrants to AfC professional groups where the numbers across the UK appear to be increasing and, in England, new grants will be in place to support students later in 2020. We also examine the latest trends in EU and non-EU recruitment, which have been affected by the uncertainty of the UK's exit from the EU in the last few years and could be at risk in the short term by restrictions following COVID-19. For nursing associates, there is a positive picture emerging on the numbers being trained and their value to trusts when deployed. However, on the use of apprenticeships in the NHS there is a more mixed picture and there may be a risk that the NHS will miss an opportunity to create an attractive and competitive apprenticeship offer. Finally, we examine developments in the use of bank and agency staff as a valued temporary resource to meet fluctuations in demand and plugging the existing workforce gap.

### *Data on pre-registration entrants*

4.164 Table 4.7 shows the number of unique applicants (hereafter referred to as applicants)[84] and acceptances[85] to study for a nursing degree between 2011 and 2019.

**Table 4.7: Numbers of applicants and acceptances for nursing degrees, UK, 2011-2019**

| | Number of applicants | Number of acceptances | Applicants per acceptance |
|---|---|---|---|
| 2011 | 63,275 | 23,995 | 2.64 |
| 2012 | 61,770 | 23,835 | 2.59 |
| 2013 | 63,675 | 24,700 | 2.58 |
| 2014 | 67,415 | 26,965 | 2.50 |
| 2015 | 66,190 | 27,535 | 2.40 |
| 2016 | 66,730 | 28,890 | 2.31 |
| 2017 | 54,985 | 28,620 | 1.92 |
| 2018 | 50,805 | 28,540 | 1.78 |
| 2019 | 54,225 | 30,390 | 1.78 |

*Source: OME estimates using UCAS data*

[84] Number of unique applicants: defined as the number of applicants making at least one choice through the UCAS main scheme.

[85] Acceptance: defined as an applicant who has been placed for entry into higher education.

4.165 In 2019, there were 54,225 applicants to study a nursing degree in the UK with 30,390 acceptances. Compared with 2018, the number of applicants and acceptances both increased, by 6.7% and 6.5% respectively. Once expressed as a ratio to the number of acceptances the number of applicants in 2019 is unchanged since 2018, remaining at 1.78. This follows a sharp fall between 2016 and 2018, which occurred following the move to the standard student loans system in England to study nursing and other AfC-related degrees.

4.166 Table 4.8 shows the number of unique applicants and acceptances to study for a degree in AfC-related subjects between 2011 and 2019.

**Table 4.8: Numbers of applicants and acceptances for AfC-related degrees (excluding nursing), UK, 2011-2019**

| | Number of applicants | Number of acceptances | Applicants per acceptance |
|---|---|---|---|
| 2011 | 67,555 | 23,960 | 2.82 |
| 2012 | 63,710 | 22,785 | 2.80 |
| 2013 | 66,105 | 24,775 | 2.67 |
| 2014 | 70,155 | 25,440 | 2.76 |
| 2015 | 69,730 | 26,000 | 2.68 |
| 2016 | 71,825 | 26,565 | 2.70 |
| 2017 | 66,885 | 27,135 | 2.46 |
| 2018 | 67,515 | 27,715 | 2.44 |
| 2019 | 74,680 | 29,580 | 2.52 |

*Source: OME estimates using UCAS data*

4.167 In 2019, there were 74,680 applicants to study for a degree in AfC-related subjects, excluding nursing, with 29,580 acceptances. Compared with 2019, the number of applicants and acceptances both increased, by 10.6% and 6.7% respectively. Once expressed as a ratio to the number of acceptances the number of applicants in 2019 was 2.52, up from 2.44 in 2018.

*Our analysis of pre-registration entrants*

4.168 For England, the Government announced new annual maintenance grants for nursing, midwifery and the majority of allied health profession students from September 2020. Table 4.9 provides details on the financial support arrangements provided to healthcare students in England and the other UK countries. Scotland provides the highest level of direct financial support at £10,000. England is the only UK country that does not fund tuition fees.

**Table 4.9: Financial support for healthcare students in UK countries**

| | **England** | **Scotland** | **Wales** | **Northern Ireland[86]** |
|---|---|---|---|---|
| Groups included | Nurses, midwives and some allied health professions | Nurses and midwives only | All healthcare students | Nurses and midwives only |
| Tuition fees | No | Full | Full | Full |
| Basic amount | £5,000 | £10,000 | £3,207[87] | £5,165 |
| Additional conditional payments | £1,000 extra for degrees in shortage occupations, shortage region and childcare support, to a maximum of £3,000 extra | None | £436 extra for those not living in parents' home | None |

*Source: Gov.scot, Gov.uk, NI Direct, NHS Wales Shared Services Partnership.*

4.169 The Interim NHS People Plan in England and the workforce strategies in the Devolved Administrations each pointed to the importance of a domestically grown workforce to address urgent workforce shortages, particularly through increasing the supply of graduate entrants.

4.170 While the general trend since 2011 has been a reduction in the ratio of applicants to acceptances, there has been an increase in the number of acceptances on undergraduate nursing and AfC-related degree courses in 2019/20 across the UK. For nursing degrees, there was an increase in acceptances onto courses of 6.4% in England, 8.5% in Scotland, 3.1% in Wales and 6.4% in Northern Ireland. The increase in applications was driven by 10% increases in applicants aged 18, 19, and 35 and over – the latter group increased by 12.9%. The number of applicants in 2019 rose by 6.7% compared with 2018, but continued to remain 19% below the peak recorded in 2016. The growth in applicants in 2019 for each of the four countries of the UK was stronger than in 2018.

4.171 There was also a 33% rise in applicants from non-EU countries, with the largest increases in applicants coming from Nigeria (100 more applicants than in 2018), Ghana (30), India (30) and Zimbabwe (25).

[86] Student support in Northern Ireland includes various additional allowances.

[87] This amount is means tested in Wales, meaning that those with parental incomes above £24,279 will receive a reduced amount, to a minimum of £1,000.

4.172 The increases in acceptances across the UK are encouraging and reflect the priority attached to domestic recruitment across the NHS. Recent recruitment campaigns have raised the profile of NHS careers and we acknowledge DHSC's efforts to sell the NHS as a career to a broader spectrum of potential entrants, particularly through the apprenticeship route, and its offer of financial support to every trust to employ a Band 7 nurse specifically to manage clinical placements.

4.173 The introduction of annual maintenance grants in England is intended to support an upturn in applicants and acceptances from 2020 onwards. These appear to be well targeted in seeking to address shortages by specialty and geography, and in supporting childcare costs. The Government has also set a target of 50,000 more nurses by 2025 through increased supply, recruitment and retention. We welcome this target and the introduction of annual maintenance grants in England, and we see this as a sign that the Government recognises the urgency of increasing the number of entrants, and tackling workforce shortages and vacancies. The introduction of the maintenance grants might also help to support students while on clinical placements in trusts, specifically including covering travel and related costs, which were a specific concern expressed by university tutors, course administrators and students on our visits. It would be helpful to understand the extent to which graduate entrants will contribute towards the Government's nursing target, and to closing the workforce gap, meeting increasing demand for services and delivering on new service models.

4.174 The availability of undergraduate university places can depend on available clinical placements in trusts. The Government had also provided funding to increase the number of clinical placements to support a 25% increase in nurse undergraduate places. For 2019/20, this expected to provide 5,000 places and from 2020/21 funding as many places as universities could fill up to a 50% increase. We commented in our 2019 Report that there is now a market operating for university places and that if this was working properly a significant rise in acceptances might be expected. Health Education England told us in oral evidence that marketing campaigns had generated increased interest in courses, which had enabled HEE to fund clinical placements thereby helping universities to increase course capacity. We would welcome further evidence on the relationship between the funding support for clinical placements removing a constraint on universities offering places to appropriately qualified applicants and therefore increasing acceptances.

4.175 Support during training might also be targeted at increasing and retaining entrants in shortages areas as a priority, for example mental health and learning disability nursing. An increase in older entrants might help these specialisms, which are traditionally dependent on more mature students, with more tailored support. Women represent 91% of those accepted onto nursing courses suggesting that men remained an untapped source of potential nursing recruitment. We note that DHSC had tailored advertisements in the recent recruitment campaign in an effort to break from stereotypes and we await information on its effect in appealing to the widest range of talent to work in the NHS at all levels.

*EU and non-EU recruitment*

4.176 Table 4.10 shows that in September 2019 there were 706,252 nurses and midwives on the NMC Register, 596,906 of whom were initially registered in the UK, 31,973 were initially registered in the EEA and 77,373 initially registered outside the EEA.

**Table 4.10: Numbers of nurses and midwives on the NMC Register, by place of initial registration, September 2015 to September 2019**

| September | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| UK | 589,472 | 585,369 | 585,796 | 589,253 | 596,906 |
| EEA | 31,099 | 38,992 | 36,259 | 33,874 | 31,973 |
| Outside EEA | 66,430 | 67,055 | 67,683 | 70,491 | 77,373 |
| **Total** | **687,001** | **691,416** | **689,738** | **693,618** | **706,252** |

*Source: NMC Register, September 2019*

4.177 Table 4.11 shows changes in registrations each year between 2016 and 2019. In September 2019, compared with a year earlier, the Register grew by 12,634, or 1.8%. There were increases in the number of UK (1.3%) and non-UK registrations (4.8%). Within the non-UK data there was an increase in non-EEA registrations (9.8%) and a fall in EEA registrations (5.6%).

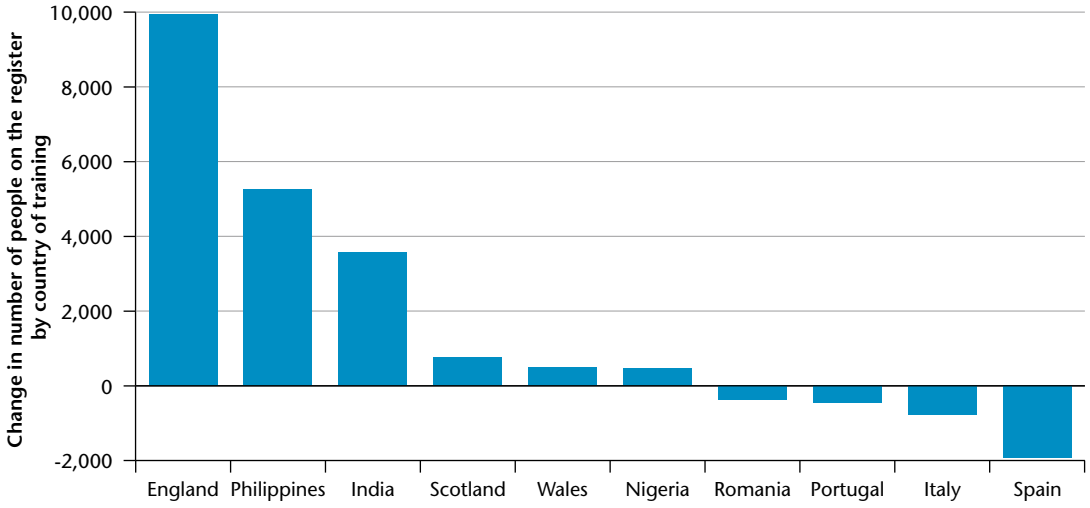
**Table 4.11: Change in the numbers of nurses and midwives on the NMC register, from a year earlier, by place of initial registration, 2016 to 2019**

| | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|
| UK | -4,103 (-0.7%) | 427 (0.1%) | 3,457 (0.6%) | 7,653 (1.3%) |
| Non-UK | 8,518 (8.7%) | -2,105 (-2.0%) | 423 (0.4%) | 4,981 (4.8%) |
| *Of which:* | | | | |
| *EEA* | *7,893 (25.4%)* | *-2,733 (-7.0%)* | *-2,385 (-6.6%)* | *-1,901 (-5.6%)* |
| *Outside EEA* | *625 (0.9%)* | *628 (0.9%)* | *2,808 (4.1%)* | *6,882 (9.8%)* |
| **Total** | **4,415 (0.6%)** | **-1,678 (-0.2%)** | **3,880 (0.6%)** | **12,634 (1.8%)** |

*Source: NMC Register, September 2019*

4.178 Between September 2018 and September 2019, there was an increase of 7,653 (1.3%) in those initially registered in the UK, a fall of 1,901 (5.6%) in those initially registered in the EEA, and an increase of 6,882 (9.8%) of those initially registered outside the EEA (Table 4.11). In each of the last three years there has been a fall in the numbers initially registered in the EEA, although in each of the last two years the fall in EEA registered nurses and midwives has been more than matched by an increase in the number initially registered outside the EEA, especially from the Philippines and India (Figure 4.25). The four largest falls in registrations came from countries inside the EEA.

**Figure 4.25: Changes in the numbers on the NMC register, by country of training, September 2017 to September 2019**



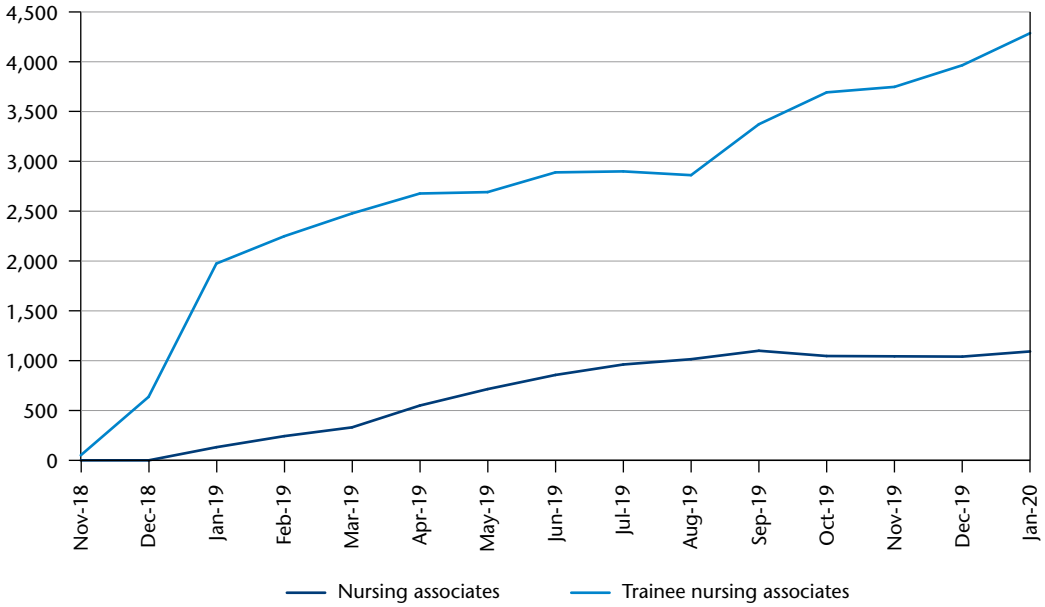

*Source: NMC Register. Note: Only includes those countries where the net change was greater than +/- 250*

4.179 We look forward to data from the NMC Register providing insights into the longer-term trends on the recruitment and retention of EU and non-EU staff. Data on the Register through 2020 and beyond should also begin to show the impact of the Government's measures to allow temporary registrations of returners and students, and extending visas for overseas staff to manage the impact of COVID-19. Proposals in the expected NHS People Plan are designed to support recruitment while longer-term measures take effect to increase the supply of domestic entrants. However, front-loaded solutions that rely on overseas recruitment might be at risk through the impact of COVID-19 and the UK's exit from the EU.

*Recruitment of nursing associates in England*

4.180 Since March 2019, the NMC has registered nursing associates and its latest data, for September 2019, showed that there were 1,488 nursing associates registered. Data from NHS Digital showed that in January 2020 there were 1,093 FTE nursing associates working in the NHS in England (Figure 4.26), slightly below the peak of 1,100 recorded in September 2019. NHS Digital data also shows that the number of trainee nursing associates grew through 2019, with almost 4,300 working in the NHS in England in January 2020.

**Figure 4.26: Nursing associates and trainee nursing associates, FTE, England, November 2018 to January 2020**




*Source: NHS Digital*

4.181 In October 2019, Health Education England published its commissioned independent evaluation[88] of the introduction of nursing associates looking at the first two years of the programme up to June 2019. HEE reported that 8,000 people had applied for 2,000 places with the majority aiming to progress their careers and to develop their skills and capabilities. The programme was seen by trainees as a stepping stone to nursing and an opportunity to go to university that might otherwise not have been possible due to family and financial circumstances. Also most trainees felt the new role would lead to improvements in the quality and safety of patient care by supporting and freeing up other health professionals.

4.182 During training, HEE reported that: 85% of trainees felt prepared to enter the workforce as a nursing associate; four-fifths were satisfied with progress in the academic, placement and home learning environment; and the attrition rate was 16% (at September 2018). A key challenge had been the limited understanding and acceptance of the role among colleagues and more action was needed to raise awareness. However, key success factors had been investing time in preparing for placements, and providers giving trainees protected learning time and active support. Trainees also valued a breadth of placement settings.

[88] Health Education England (October 2019), *Introduction of Nursing Associates – Year 2 Evaluation*. Available at: https://www.hee.nhs.uk/news-blogs-events/news/independent-evaluation-finds-trainee-nursing-associates-are-very-positive-about-their-training

4.183 HEE concluded that, while trainees had developed new skills and knowledge, they had struggled with the workload which had impacted on their personal lives and work/life balance. At the service level, trainees were making a greater contribution to service delivery and patient care by: improved patient communication; assisting nurses with a greater range of care; more patient-centred care and acting as a patient advocate; identifying and escalating patients with deteriorating health; and nursing associates showing leadership qualities and supporting other trainees' development. On qualifying, 65% of trainees intended to continue working as a nursing associate in their current setting in the next year, 19% intended to move to a role in an external setting, and 47% intended to enrol onto a pre-registration nursing degree programme within three years of qualifying. HEE made a series of recommendations to improve perceptions, to quality assure education, to strengthen the nursing associate programme and the support available to trainees, and to conduct further research.

4.184 The initial research by Health Education England has provided some insights into the motivation of entrants, the support needed during training and, most importantly, where clinical placements can be made more effective. We look forward to DHSC's commissioned research to evaluate the impact of nursing associates in the workforce. An interim research report is expected in 2020 and a final report in 2023.

4.185 We note that the NHS Long Term Plan and Interim NHS People Plan placed great store on new service models driven by the development of new roles and changing the workforce skill mix. In this context, nursing associates are being seen as a leading development for NHS workforce changes. We note the increasing numbers of nursing associates entering training and now feeding into the NHS. DHSC's target to recruit 7,500 nursing associates has proved ambitious and, although not met, the growth in numbers suggests the role is becoming attractive to entrants and trusts.

4.186 NHS Employers' evidence and our visits to trusts suggest that there has been a positive response to the use of nursing associates within trusts, both from management and other registered and support staff. However, we were told that there was a need to manage the additional training burdens on an already overstretched workforce while nursing associates were on placements and when entering as newly qualified staff. These pressures might be exacerbated by COVID-19, which will impact on nursing associates' workload and deployment, but might also provide some acceleration in how the role develops within trusts.

4.187 We heard from the parties that the nursing associate role was being viewed as both a registered profession in itself and as a stepping stone to registered nursing. The development of these two, but not exclusive, views suggests it will become increasingly important to design effective routes into and career pathways for nursing associates accompanied by a clear employment offer to help individuals meet their aspirations. There should be specific opportunities and support to progress nursing associates into registered roles. There could be significant lessons to be learned from the introduction of nursing associates to inform the development of other roles for support staff and other AfC professions, such as advanced clinical practitioner and physician's associate.

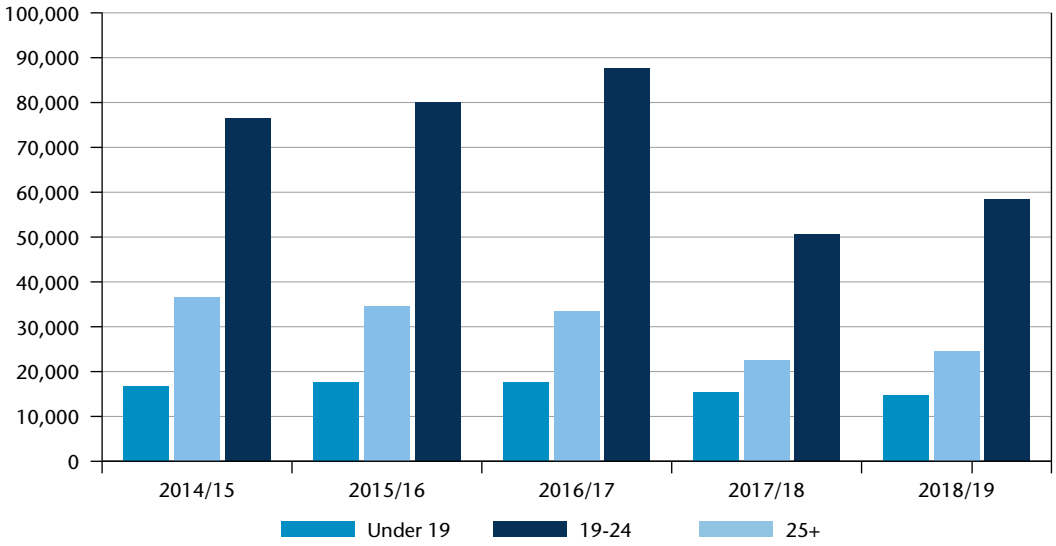
4.188 In conclusion, there is clear support from NHS organisations, employers and unions to the development of nursing associates. As others do across the NHS, we continue to see nursing associates as an opportunity to make a significant contribution to the envisaged transformation of services and the development of new NHS careers. The steps made so far are very encouraging although we continue to see the need for a national strategic or co-ordinating approach to the use and deployment of nursing associates in trusts.

*Recruitment of apprentices*

4.189 Following the introduction of the apprenticeship levy in 2017, the number of all apprenticeship starts in 2017/18 fell 24% to 375,761, from 494,882 in 2016/17. In 2018/19 some of this fall was reversed, with total apprenticeship starts rising by 5% to 393,375. In 2019/20 to date, apprenticeships are down 15% on the equivalent period in 2018/19, and down 25% on the equivalent period in 2016/17.

4.190 The number of Health, Public Services and Care apprenticeship starts broadly exhibited the same pattern as that of all apprenticeship starts. Starts dropped dramatically after the introduction of the apprenticeship levy, then recovered slightly in 2018/19. In 2018/19, there were 97,715 starts, an increase of 10.7% on the 88,319 in 2017/18. This leaves overall starts still 30% below what they were in 2016/17. The changes in numbers were not uniform across ages. Between 2016/17 and 2018/19, there was a 17% fall in the number of starters aged 18 or under, a 26% fall in the number of starters aged 19-24 and a 33% fall in numbers of starters aged 25+. Most of the increase in starts between 2017/18 and 2018/19 can be accounted for by increases in older starters, with numbers aged 25+ rising 16%, compared with a 4% fall in the number of starters aged 18 and under, and a 10% rise in number of starters aged 19-24. For 2018/19, the proportion of Health, Public Services and Care apprenticeship starts aged 25+ was 59.8%, compared with 45.6% for all apprentices. For those starts in Health, Public Services and Care 15% were under 19, compared with 24.8% for all apprentices[89]. Overall, the trend in Health, Public Services and Care apprenticeship starts aligns with the trend for all apprenticeships. This trend also suggests that the demographic composition is converging to similar patterns as before the introduction of the apprenticeship levy.

**Figure 4.27: Number of Health, Public Services and Care apprenticeships started in England, by age band, 2014/15 to 2018/19**




*Source: OME analysis of Department for Education data*

[89] Monthly apprenticeship starts by sector subject area, framework or standard, age, level, funding type and degree apprenticeship 2014/15 to 2019/20 (August to January 2020). Available at: https://www.gov.uk/government/statistical-data-sets/fe-data-library-apprenticeships

4.191 We note that the Interim NHS People Plan placed an emphasis on NHS apprenticeships supporting both overall supply to the workforce and supply to professional groups. Meeting the Government's overall target for apprenticeships in the public sector[90] will depend on a major contribution from the NHS. When the levy was introduced in 2017, the NHS had a target of creating 100,000 more apprenticeships in England by 2020 across a range of AfC roles and, according to DHSC, there had been 13,800 entrants in 2017/18.

4.192 As for other sources of new entrants, we have yet to see the numbers of apprentices required or expected in the NHS and the staff groups they should cover. Our general conclusion remains that the use of apprentices is an untapped source of much-needed supply for the NHS.

4.193 We note from NHS Employers and NHS Providers that, while trusts are using apprenticeships to build supply and capacity, there are continuing problems using the levy to support apprenticeship programmes. The evidence we received and views expressed on our visits suggest that there are some structural difficulties in covering backfill costs[91] for apprentices supernumerary status, resources for supervisory capacity, and access to and use of training providers. However, it is encouraging that employers in the NHS are beginning to collaborate at a regional level. We look forward to further opportunities to alleviate the barriers to using apprenticeships as Integrated Care Systems mature and bring together such workforce developments.

4.194 We comment earlier in this report on the progress made on introducing the nursing associate role under the apprenticeship route. However, the degree-level apprenticeships designed for registered nurses have yet to take hold in the way the NHS envisaged. The numbers of nursing degree apprenticeships has increased but there have only been limited numbers of entrants so far and the new midwifery apprenticeship was only launched in 2019. We would welcome in the NHS People Plan a renewed emphasis on the way in which the NHS can make better use of degree-level apprenticeships as a route into registered roles, including developing the "blended" online degrees proposed in the Interim NHS People Plan.

4.195 We welcome DHSC's efforts to promote NHS apprenticeships to different social groups as an alternative to degree-entry to NHS roles. Widening participation will be an important strand of improving supply into key roles. We also note the Staff Side's view that employers in the NHS were focussing apprenticeships at lower AfC levels, particularly concerns that trusts are substituting low paid jobs for permanent jobs for apprentices. Further evidence would be helpful on these roles.

4.196 We continue to conclude that effective apprenticeship programmes could help the NHS to compete with both the public and private sectors in attracting joiners, delivering high quality training, providing a clear route into NHS careers and offering long-term employment. We comment earlier in this report on the failure to agree national apprenticeship pay rates is a missed opportunity for the NHS Staff Council. We consider that the employment offer being developed under the NHS People Plan should include the benefits to individuals of joining through apprenticeship programmes.

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[90] Public sector bodies with 250 or more staff in England have a target to employ an average of at least 2.3% of their staff as new apprentice starts annually over the period 1 April 2017 to 31 March 2020. Available at: https://www.gov.uk/government/publications/public-sector-apprenticeship-target-reporting-research-brief

[91] The additional staff costs of covering roles while apprentices are away from the workplace on formal training.

*Supply of bank and agency staff*

4.197 Bank and agency staff remain an important source of temporary staffing, which allows trusts to respond to fluctuations in resourcing requirements. In addition, some AfC staff view bank and agency work as offering a degree of flexible working and, in this regard, we have heard from trusts that they are looking at developing a broad range of flexible working arrangements for permanent staff. However, bank and agency resources have also come to be one way of enabling trusts to meet growing levels of demand for services in recent years. Trusts need different patterns of resource to manage different service demands.

4.198 We note that following the introduction of agency spend controls in England in 2015, expenditure on agency staffing reduced to £2.4 billion in 2018/19 (from £3.7 billion in 2015/16). In the same period, agency costs had also now fallen below 5% of overall pay costs. NHS E&I provided us with data on the proportion of agency spend that can be attributed to different staff groups and by region in 2018/19:

- A total of £843 million (35% of total agency spend) was for nursing, midwifery and health visiting staff. Compared with 2017/18, this represents a fall of £35 million (4.3%). Data for the first half of 2019/20 shows nursing, midwifery and health visiting staff agency spend of £428 million, an increase of 2.1% from the same period a year earlier;
- A total of £618 million (26% of total agency spend) was for AfC staff, excluding nursing, midwifery and health visiting staff. Compared with 2017/18, this represents a fall of £30 million (4.6%). Data for the first half of 2019/20 shows other AfC staff agency spend of £298 million, a fall of 4.6% from the same period a year earlier; and
- By halfway through 2019/20, the proportion of expenditure on temporary staffing through bank arrangements had risen from 58% to 61% since 2018/19.

4.199 We understand that approximately 90% of AfC vacancies are covered by these sources and where vacancies are filled, 75% are filled by bank staff and 25% by agency staff. The 2015 cap on agency spending in England appears to have been effective in reducing expenditure and, in doing so there has been a year-on-year shift to bank working. We note, however, NHS E&I's view that costs appear to have flattened out and that actions introduced since 2015 had achieved as much as could be expected. We look forward to any evidence of the impact of COVID-19 on managing the use of bank and agency staff, including the volumes of additional work and any impact on pay rates.

4.200 The parties' evidence suggests that trusts prefer to use bank arrangements as they are more cost-effective and offer continuity of care as, in the main, permanent staff cover additional shifts. Also, AfC staff see bank working as a means to achieve flexible working arrangements and/or work/life balance, which are significant factors influencing staff retention. We have heard on our visits some discomfort among staff that there could be detrimental treatment of staff who work only bank compared with permanent staff and are concerned that this could impact on trusts' ability to retain their available bank workforce.

4.201 We welcome the more collaborative approach to bank working through pilot programmes. We would expect that Integrated Care Systems should be in an increasingly strong position to develop these approaches and, more generally, to implement the supporting technology for rostering. In this context, we suggest that developments should assess the way in which the market operates for managing the bank workforce, the ways in which managing this flexibility can be enhanced and the offer being made to staff, including the terms of their availability. If these developments simply focus on controlling costs or savings through better use of technology, this could miss the opportunity to develop a more coherent, strategic approach to bank working to the advantage of trusts and staff alike. We have heard from staff on visits that they value having some control over when and where they work bank shifts. We look forward to receiving further evidence on the way in which new approaches are being developed and NHS E&I's targeted improvement programmes, plus further analysis of the factors influencing staff choices to work bank and agency.

4.202 We note that agency cover in NHS Wales is provided by the All Wales Framework Contract. The Welsh Government's evidence points to expenditure on nursing and midwifery increasing significantly from £28.7 million in 2014/15 to £65.4 million in 2018/19. The increase was attributed to the significant increase in demand on NHS Wales services and the introduction of the first full year of the requirements of the Nurse Staffing Levels (Wales) Act. The Welsh Government introduced a programme[92] in 2017 to drive down agency deployment and expenditure while maintaining safe and sustainable services. We look forward to further data on the effects of the programme.

4.203 We commented in our 2019 Report on the significant increase in agency spending in Northern Ireland in the previous five years and note that costs continued to increase. In 2018/19 agency and locum spend was over £200 million, of which £52 million was spent on nursing and midwifery staff, and bank spending on nursing and midwifery was almost £63 million. We note the Department of Health is developing actions to control agency spending but also that there could be limitations on what can be achieved including the imperative to keep NHS services open for patients. There is a finite pool of staff available for bank and agency work, and travel difficulties could limit availability across Northern Ireland. In future evidence on actions under the Health and Social Care Workforce Strategy 2026, we would welcome the Department's views on the extent to which agency staff should be used given the limitations and the effect of its actions to control spending when in place.

## Retention

4.204 In the year to March 2019, the data suggest a continuing trend of joiners just exceeding leavers for most AfC groups in England, Scotland and Northern Ireland (Table 4.12). Leaving rates have stabilised in recent years but remain high for some AfC groups. In the context of the balance between joiners and leavers, NHS organisations continue to recognise that staff turnover is necessary to refresh the workforce.

4.205 For nurses, health visitors and midwives, the difference between joiners and leavers was noticeably narrower than for most other AfC groups. Leaver rates were also at a high level for these groups. Therefore, there could be a greater risk than other groups that increases in the leaving rate for nurses, health visitors and midwives could affect the available workforce and capacity.

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92 Welsh Government (October 2017), *NHS Wales Agency and Locum Programme (WHC/2017/042)*. Available at: https://gov.wales/nhs-wales-agency-and-locum-programme-whc2017042

4.206 Improving retention rates across the NHS workforce was a major part of the Interim NHS People Plan, and is expected to be a feature in the NHS People Plan. The Interim Plan proposed a range of actions to address the urgent workforce shortages in nursing, including retention measures and a target to reduce nursing vacancy levels to 5% by 2028. Such action would need to be concerted to improve the net effect between joiners and leavers and thereby contribute towards the Government's target of 50,000 more nurses by 2025. We commented in our 2019 Report on the impact of NHS E&I's retention programmes supporting retention rates in individual trusts. We look forward to further information on the effectiveness of specific retention measures and the lessons learned from the programme.

4.207 The focus on retention is an important immediate measure while the longer-term plans for increasing supply into AfC professional groups can start to take effect. While there are announcements on increasing workforce numbers for nurses and professions in primary and community care, we have yet to see clear targets for retention rates across the AfC workforce and for specific shortage groups. Without a clear view on retention targets it will be difficult to assess progress towards closing the current workforce gap.

**Table 4.12: Leaving and joining rates to the NHS by staff group headcount and country, year to March 2019**

| **England** | **Leaving rate** | **Joining rate** | **Percentage point diff** |
|---|---|---|---|
| AfC staff (exc bank and locums) | 10.4% | 13.4% | 3.0 |
| Nurses & health visitors | 10.2% | 11.3% | 1.1 |
| Midwives | 10.4% | 10.9% | 0.5 |
| Ambulance staff | 7.6% | 7.7% | 0.1 |
| Scientific, therapeutic & technical staff | 10.5% | 12.6% | 2.1 |
| Support to clinical staff | 10.9% | 16.1% | 5.2 |
| NHS infrastructure support | 9.9% | 13.6% | 3.7 |
| | | | |
| **Scotland** | **Leaving rate** | **Joining rate** | **Percentage point diff** |
| AfC staff | 6.6% | 7.1% | 0.5 |
| Nursing and midwifery | 7.2% | 7.6% | 0.3 |
| Allied health professions | 6.8% | 8.7% | 1.9 |
| Other therapeutic services | 7.2% | 12.2% | 5.0 |
| Personal and social care | 12.8% | 13.1% | 0.3 |
| Healthcare science | 7.4% | 20.8% | 13.3 |
| Ambulance support services | 9.9% | 9.5% | -0.4 |
| Administrative services | 7.5% | 8.3% | 0.8 |
| Support services | 12.9% | 7.5% | -5.4 |
| | | | |

| Northern Ireland | Leaving rate | Joining rate | Percentage point diff |
|---|---|---|---|
| AfC staff | 5.7% | 7.9% | 2.3 |
| Administration & clerical | 4.9% | 6.6% | 1.7 |
| Estates services | 6.1% | 10.0% | 4.0 |
| Support services | 6.0% | 10.8% | 4.8 |
| Nursing & midwifery | 6.5% | 7.5% | 1.0 |
| Social services (excl. home helps) | 5.4% | 7.8% | 2.4 |
| Professional & technical | 5.1% | 8.9% | 3.8 |
| Ambulance | 2.7% | 8.4% | 5.7 |

*Sources: NHS Digital, NHS Education for Scotland, and the Department of Health, Northern Ireland.*

4.208 We have commented in our recent reports that the data on reasons for leaving are poor as they include a high proportion of staff leaving for "unknown" reasons. UNISON told us that efforts should be focused on those areas which the service has control over or responsibility for. It said that these included voluntary resignations for: work/life balance; health; better reward; responsibility for dependants; lack of opportunities; incompatible working relationships; and early retirement. From the limited data available achieving a work/life balance remains a significant influence and reinforces the need to develop effective flexible working arrangements. From our visits, we heard that flexibility was increasingly important for those later in their NHS careers as these staff in the acute sector were less inclined to do shift working and looked for more sociable hours. Such flexible working arrangements might be more readily available in the expansion of professional roles in primary and community care under new service models, and therefore could be more attractive to those in acute roles. We also note from the RCN's 2019 Employment Survey that 55% of nurses were confident that they could find a similar job elsewhere, a high number could find a similar job with improved pay and/or working conditions, and a perception of less mobility in the labour market as employees grew older.

4.209 The results of the RCN survey highlight the need for more granular information on reasons for leaving. While we understand that some trusts have their own detailed information, these are not collated nationally. We have already commented on the limitations of current national data. The absence of leaving data is a significant weakness in current workforce planning arrangements. It is clear to us that a better understanding is required of trends in the reasons for leaving and motivations at different stages of a career to help inform retention policies, covering areas such as work/life balance, flexible retirement (and pensions), job satisfaction, workload and staff engagement. We request that the parties examine the way in which data on reasons for leaving could be improved and we stand ready to contribute to those discussions.

## Motivation and engagement

4.210 A key element of our terms of reference is the motivation of AfC staff. We have commented in recent reports on the importance of staff motivation and engagement as enablers of new service models and workforce developments. These are recognised in the Interim NHS People Plan and through initiatives to support staff health and wellbeing, including measures under the 2018 AfC pay agreements.

4.211 Our assessment of staff motivation and engagement therefore examines the evidence from the various Staff Surveys across the countries of the UK, the Friends and Family Test, and sickness absence rates. The motivation and goodwill of staff will have been severely tested by COVID-19, the impact of which we will be able to assess in our future reports.

*NHS Staff Survey (England)*

4.212 Since our 2019 Report the 2019 survey of NHS staff in England was published. It was conducted in the autumn of 2019 and 569,440 staff responded (a response rate of 48%, up from 46% in 2018).

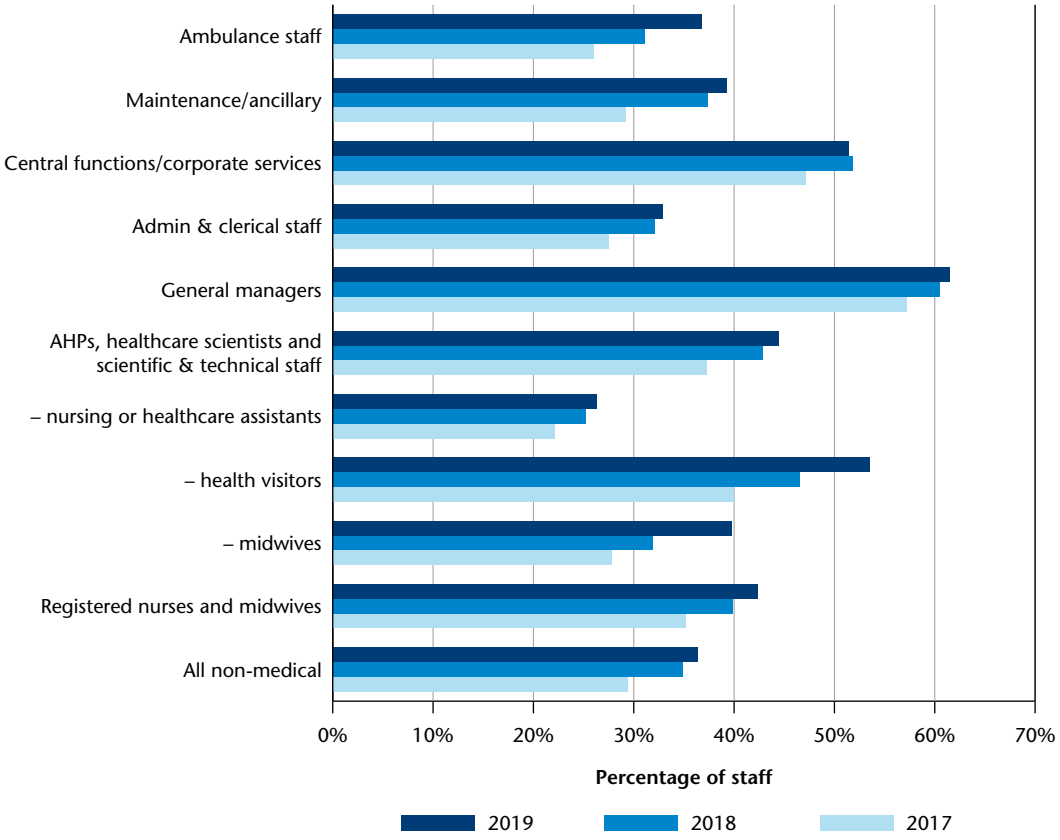
4.213 In England, AfC staff satisfaction[93] with pay increased in 2019, compared with 2018, by 1.5 percentage points. This builds on an increase of 5.5 percentage points between 2017 and 2018. In 2019, 36.4% of staff responded positively to the survey, the highest such response since 2012, and compares with 37.6% who said they were dissatisfied[94] with their pay. For specific groups, the 2019 results showed:

- Registered nurses and midwives satisfaction increased by 2.5 percentage points to 42.4%;
- The largest increases in satisfaction with pay between 2018 and 2019 were for midwives, of 7.8 percentage points, and health visitors, of 7.0 percentage points;
- There was a fall of 0.3 percentage points in the number of staff in central functions/ corporate services expressing satisfaction with pay;
- General managers remained the most satisfied group (61.5%) and also the least dissatisfied with their levels of pay; and
- Nursing and healthcare assistants continued to have the lowest satisfaction with pay, at 26.3%, despite an increase of 1.1 percentage points between 2018 and 2019.

[93] In each case, satisfied refers to participants answering that they were "satisfied" or "very satisfied" with their level of pay.

[94] In each case, dissatisfied refers to participants answering that they were "dissatisfied" or "very dissatisfied" with their level of pay.

**Figure 4.28: Satisfaction with level of pay by staff group, England, 2017 to 2019**




*Source: National NHS Staff Survey (England)*

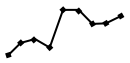
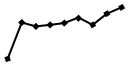
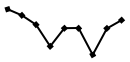
4.214 Table 4.13 below provides a selection of Staff Survey results on engagement and satisfaction. Generally, the 2019 results show an improvement from 2018, as did the 2018 results when compared with 2017. The numbers saying that their organisation valued their work, that they were satisfied with their pay, the recognition they got for good work and the support they got from their immediate line manager all increased by at least one percentage point. However, there was an increase in the percentage of staff saying that they had experienced harassment, bullying or abuse from patients, relatives or the public in the previous 12 months. There was a small fall in the percentage of staff saying they had had an appraisal in the previous 12 months. Of those who had had an appraisal:

- 67% said that training, learning or development needs were identified, unchanged from 2018;
- 72% said it helped them improve how they did their job, up from 71%;
- 78% said it left them feeling their work was valued, up from 77%; and
- 85% said it helped to agree clear objectives for their work, up from 84%.

4.215 Table 4.14 provides a selection of Staff Survey results on working pressures. Compared with 2018, the results were generally more positive, with increases in the percentage who said that they were able to meet all the conflicting demands on their time at work, that they had adequate materials, supplies and equipment to do their work and that there were enough staff at their organisation to do their job properly. However, there was also an increase in the percentage of staff who said that they had felt unwell as a result of work-related stress. Midwives were the staff group most likely to report feeling unwell as a result of work-related stress (49%).

4.216 The percentage of staff working paid overtime (just over one-third) was higher than in 2018 while the percentage working unpaid overtime (just over a half) was lower than in 2018. Ambulance staff were the group most likely to work paid overtime (50%) while general managers were most likely to work unpaid hours (84%).

**Table 4.13: Selected job satisfaction results from the national NHS staff survey, AfC staff, England, 2011 to 2019**

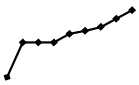
| Measure | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | Trend[1] |
|---|---|---|---|---|---|---|---|---|---|---|
| **Engagement and job satisfaction** | | | | | | | | | | |
| I look forward to going to work | 49.9 | 51.7 | 52.1 | 51.6 | 57.1 | 57.9 | 56.9 | 58.2 | 58.8 |  |
| I am enthusiastic about my job | 65.1 | 67.3 | 68.1 | 67.7 | 73.3 | 73.8 | 73.1 | 74.1 | 74.5 |  |
| Time passes quickly when I am working | 73.3 | 74.2 | 74.3 | 73.8 | 76.8 | 76.6 | 75.8 | 75.8 | 76.2 |  |
| The recognition I get for good work | 45.8 | 48.7 | 49.4 | 49.9 | 51.8 | 53.0 | 52.8 | 56.5 | 57.9 |  |
| The support I get from my immediate manager | 63.5 | 65.4 | 66.0 | 66.1 | 67.2 | 68.3 | 68.8 | 70.2 | 71.2 |  |
| The support I get from my work colleagues | 76.4 | 78.4 | 78.3 | 78.4 | 80.8 | 81.5 | 81.3 | 81.6 | 81.7 |  |
| The amount of responsibility I am given | 70.5 | 73.4 | 73.1 | 72.8 | 73.3 | 73.8 | 73.1 | 74.1 | 74.5 |  |
| The opportunities I have to use my skills | 65.5 | 69.9 | 69.6 | 69.6 | 69.9 | 70.6 | 69.9 | 71.0 | 71.5 |  |
| The extent to which my organisation values my work | 33.3 | 40.0 | 40.4 | 40.8 | 41.1 | 43.1 | 42.9 | 46.3 | 48.0 |  |
| My level of pay | 38.7 | 37.4 | 35.8 | 30.9 | 34.6 | 35.2 | 29.4 | 34.9 | 36.4 |  |
| Percentage of staff appraised in the last 12 months | 80.6 | 83.2 | 83.8 | 83.5 | 85.4 | 86.5 | 86.4 | 88.1 | 87.9 |  |
| 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 | 27.5 | 27.5 | 27.8 | 28.1 |  |

*Source: NHS Staff Survey (England)*

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

*(2) Lower scores are better in this case.*

**Table 4.14: Selected working pressures results from the national NHS Staff Survey, AfC staff, England, 2011 to 2019**

| Measure | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | Trend[1] |
|---|---|---|---|---|---|---|---|---|---|---|
| **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 am able to meet all the conflicting demands on my time at work[4] | | | | | 42.9 | 45.1 | 45.0 | 45.6 | 46.7 |  |
| I have adequate materials, supplies and equipment to do my work | 58.9 | 56.5 | 55.8 | 55.7 | 54.6 | 55.5 | 54.7 | 55.4 | 56.6 |  |
| There are enough staff at this organisation for me to do my job properly | 30.2 | 30.1 | 29.2 | 28.6 | 29.9 | 31.4 | 31.2 | 32.3 | 32.6 |  |
| During the last 12 months have you felt unwell as a result of work related stress[2] | | 38.6 | 39.6 | 40.0 | 37.8 | 37.2 | 38.7 | 40.0 | 40.6 |  |
| Percentage of staff working PAID hours over and above their contracted hours[2] | 25.4 | 30.0 | 30.2 | 30.2 | 31.1 | 31.5 | 32.2 | 33.2 | 34.4 |  |
| Percentage of staff working UNPAID hours over and above their contracted hours[2] | 53.1 | 56.1 | 57.0 | 58.1 | 59.0 | 57.1 | 56.4 | 55.7 | 53.9 |  |

*Source: NHS Staff Survey (England)*

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

*(2) Lower scores are better in this case.*

*(3) For 2015 this question was reversed to "I am able to meet ..."*

*(4) This question was introduced in 2015.*

4.217 Ambulance staff were among the staff groups most likely to say that they looked forward to going to work (63.7%, compared with 58.8% for all AfC staff). However, ambulance staff were the group most likely to experience harassment, bullying or abuse (38.3%, compared with 28.1% for all AfC staff) and were less likely than most other groups to express satisfaction with the support they get from their immediate manager (66.6%, compared with 71.2%). Ambulance staff were less likely to agree that there were enough staff at their organisation for them to do their job properly (31.1%, compared with 32.6%). Ambulance staff were also the least likely to say that they had had an appraisal in the last 12 months (79.8%, compared with 87.9%).

### *NHS Wales Staff Survey*

4.218 The last published survey of NHS staff in Wales relates to 2018, based on 25,500 responses (a response rate of 29 per cent) which we discussed in our 2019 report. Key results included:

- 60% of staff said that they looked forward to going to work, an increase from 56% in 2016 and 50% in 2013;
- 73% of staff said that they were enthusiastic about their job, an increase from 68% in 2016 and 63% in 2013;

- 71% of staff said that they were satisfied with the support they got from their immediate manager, an increase from 67% in 2016 and 61% in 2013;
- 34% of staff said that during the last 12 months they had been injured or felt unwell as a result of work-related stress, an increase from 28% in 2016 and 33% in 2013;
- 21% of staff said that during the last 12 months they had personally experienced harassment, bullying or abuse at work from patients or the public, an increase from 16% in 2016 and 19% in 2013;
- 49% of staff said that they could meet all of the conflicting demands on their time at work, an increase from 25% in 2016 and 26% in 2013;
- 57% of staff said that they had adequate supplies, materials and equipment to do their work, unchanged from 2016 and an increase from 43% in 2013;
- 32% of staff said that there were enough staff at their organisation for them to be able to do their job properly, an increase from 30% in 2016 and 26% in 2013; and
- 83% of staff said that during the last 12 months they had had a Personal Appraisal and Development Review, an increase from 74% in 2016 and 55% in 2013.

### *Health and Social Care Staff Experience Report (Scotland)*

4.219 Between February and September 2019 Health and Social Care staff in Scotland were surveyed, with 111,500 responding (a response rate of 62%). For the first time the results were able to identify NHS Scotland employees and their staff grouping. Key results included:

- 78% of staff said that they had sufficient support to do their job well, ranging from 80% for medical and dental support staff to 67% for ambulance service staff;
- 81% of staff said that their work gave them a sense of achievement, ranging from 85% for senior managers to 78% for administrative services, health sciences and support services;
- 73% of staff said that they felt appreciated for the work they do, ranging from 81% for senior managers to 60% for ambulance service staff;
- 70% of staff said that their organisation cared about their health and wellbeing, ranging from 78% for senior managers to 57% for ambulance service staff; and
- 71% of staff said that they got the help and support from other teams and services within the organisation to do their job, ranging from 75% for senior managers to 60% for ambulance service staff.

### *HSC Northern Ireland Staff Survey*

4.220 The survey of Health and Social Care staff for 2019 had 19,094 responses, a response rate of 25%. A summary of the results, compared with the results from the 2015 survey, where available, are set out below. Key results include:

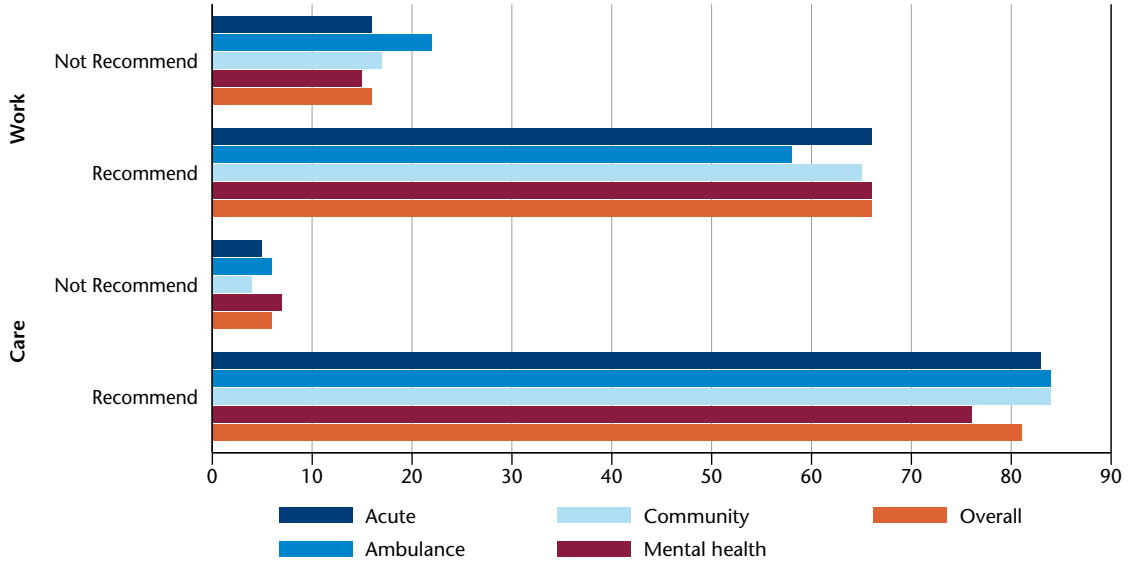
- 73% said that they were enthusiastic about their job, up from 71% in 2015;
- 56% said that they looked forward to going to work, down from 57% in 2015;
- 32% said that they had experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. This was an increase from 25% in 2015;
- 28% said that they had experienced harassment, bullying or abuse from staff in the past 12 months. This was an increase from 22% in 2015;
- 40% said that were able to meet all the conflicting demands on their time at work, down from 44% in 2015;
- 47% said that they felt unwell as a result of stress in the past 12 months, up from 36% in 2015;
- 34% said that there were enough staff for me to do my job properly, down from 35% in 2015;
- 50% said that they worked unpaid hours, down from 71% in 2015;
- 34% said that they worked additional paid hours, down from 50% in 2015; and

- 35% said that they often thought about leaving their organisation. Of those who said they thought about leaving, 58% said it was because they were not valued for their work and 42% said they would like more pay.

*Friends and Family Test*

4.221 The Friends and Family Test data records the percentage of staff who would recommend their organisation as either a place to work or a place to receive care. Based on responses from 131,000 staff, Figure 4.29 shows that in the second quarter of 2019/20 when asked whether they would recommend their organisation as a place to work to friends and family, 66% of staff in England said they would do so, while 16% would not recommend their organisation as a place to work. The results were similar for trusts of different types, except for staff working in ambulance trusts, where 58% of staff recommend their organisation as a place to work.

**Figure 4.29: Recommendation as a place to work, and as a place to receive care, Friends and Family Test (staff), England, 2019/20 Q2**




*Source: NHS England*

4.222 Figure 4.29 also shows that in the second quarter of 2019/20 when asked to recommend their organisation as a place to receive care to friends and family, 81% of staff in England said they would do so, while 6% would not recommend their organisation as a place to receive care. The results were similar for trusts of different types, except for staff working in mental health trusts, where 76% of staff recommend their organisation as a place to receive care.

4.223 In its 2018 Staff Survey NHS Wales reported that 66% of staff would recommend their organisation as a place to work, an increase from 61% in 2016 and 48% in 2013.

4.224 In its 2018 Staff Survey NHS Wales reported that 73% of staff said that if a friend or relative needed treatment they would be happy with the standard of care provided by their organisation, an increase from 68% in 2016 and 53% in 2013.

4.225 In the 2019 Survey of Health and Social Care Staff in Scotland, staff were asked if they would recommend their organisation as a good place to work, and if they would be happy for a friend or relative to access services within their organisation. For the first time the results were able to identify NHS Scotland employees and their staff grouping.

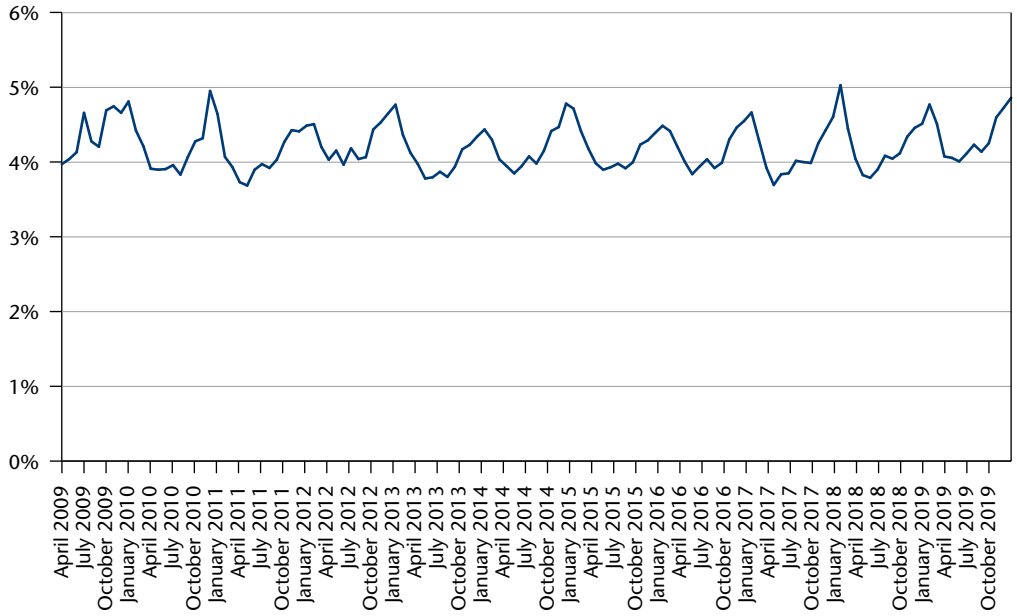
4.226 In 2019, 74% of NHS Scotland staff said that they would recommend their organisation as a good place to work. Broken down by staff group, the percentage of positive responses ranged between 80% (NHS senior managers) and 65% (ambulance services staff).

4.227 In 2019, 78% of NHS Scotland staff said that they would be happy for a friend or relative to access services within their organisation. Broken down by staff group, the percentage of positive responses ranged between 85% (NHS senior managers) and 71% (ambulance services staff).

### *Sickness absence*

4.228 Figure 4.30 shows sickness absence rates in England for staff as a whole between April 2009 and December 2019. Over this period, monthly sickness absence rates fluctuated between a narrow range of 3.7% to 5.0%. Taking an average over a 12-month period, which eliminates seasonal variations, sickness absence fluctuated between 4.1% and 4.4%.

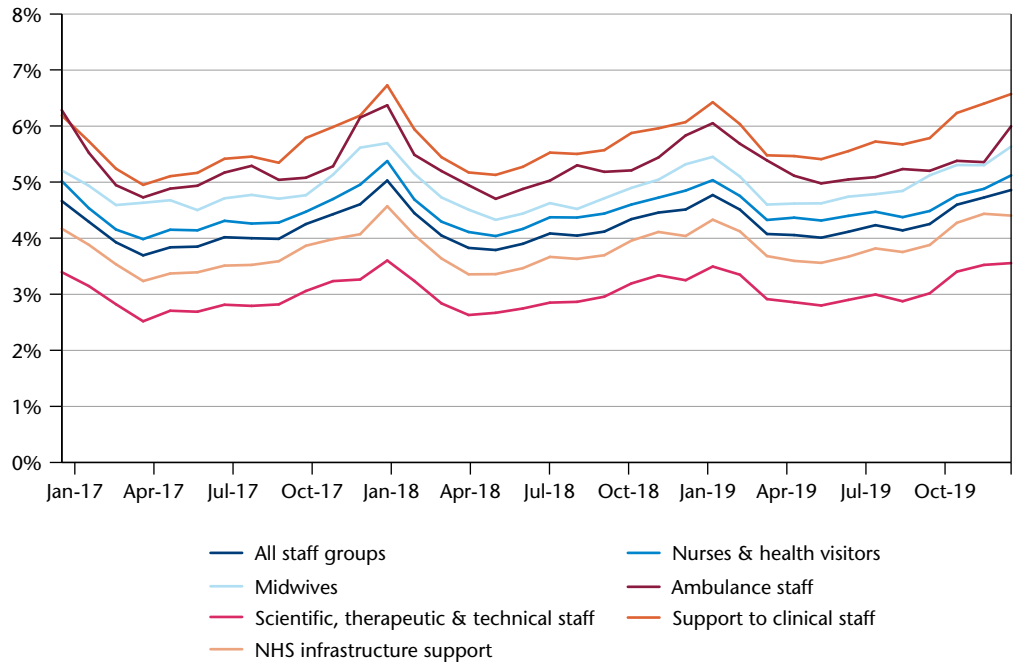
**Figure 4.30: Sickness absence rates in England, all staff, 2009 to 2019**




*Source: NHS Digital*

4.229 Figure 4.31 shows sickness rates by staff group between January 2017 and December 2019. Over the period covered by the chart, sickness rates for: ambulance staff; midwives; support to clinical staff; and nurses and health visitors were consistently higher than the overall average, while the rates for: support to clinical staff; and NHS infrastructure staff were consistently below the overall average.

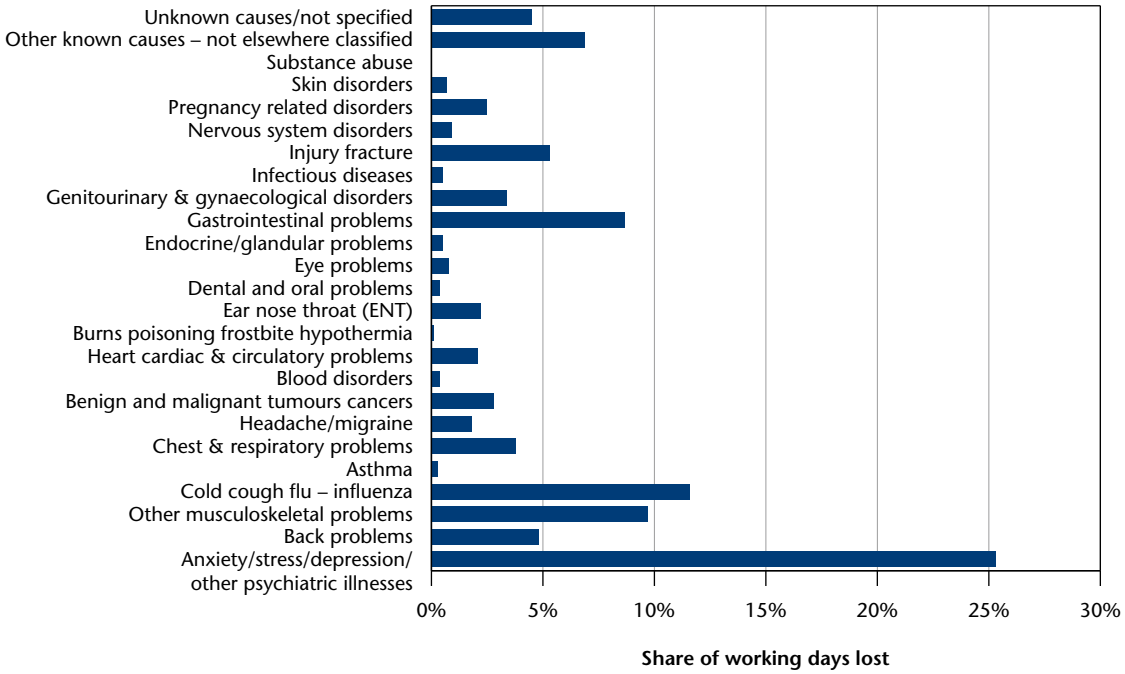
**Figure 4.31: Sickness absence rates in England, by main staff group, January 2017 to December 2019**




*Source: NHS Digital*

4.230 Figure 4.32 shows the percentage of sickness absence days in December 2019 by cause. Anxiety/stress/depression/other psychiatric illnesses (25.3%) accounted for over a quarter of all days lost to sickness. Cold, cough, flu, influenza (11.6%), other musculoskeletal problems (9.7%), and gastrointestinal problems (8.7%) were other categories accounting for more than 8.0% of sickness days

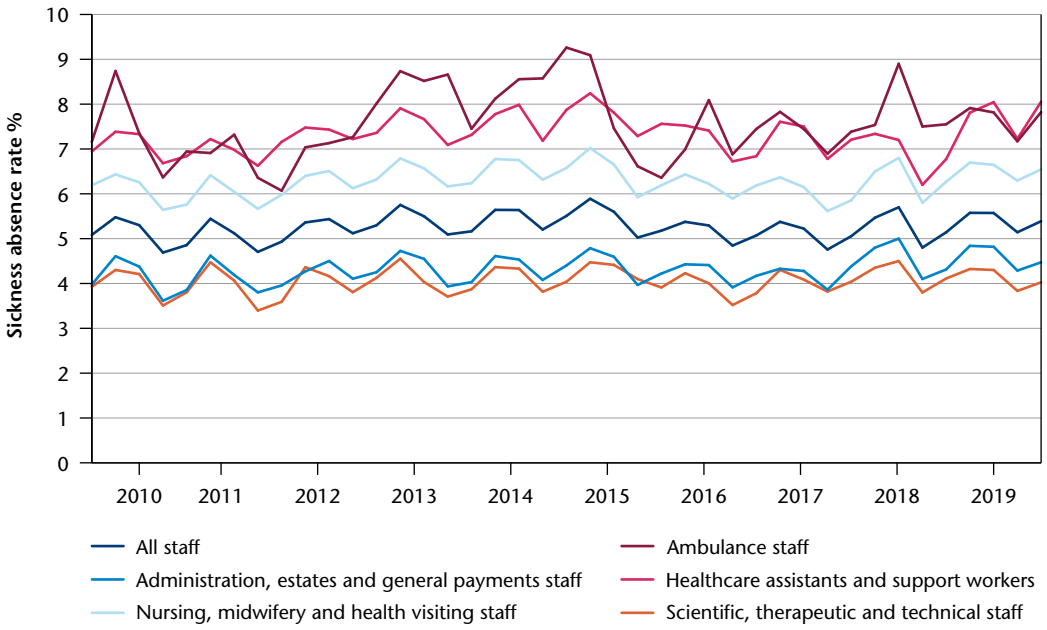
**Figure 4.32: Reasons for sickness absence, England, December 2019**




*Source: NHS Digital*

4.231 Figure 4.33 shows sickness absence rates in the NHS in Wales since 2010. The latest data, for the three months to September 2019, showed an overall sickness absence rate of 5.4%, up from 5.1% in the same period a year earlier. Since the third quarter of 2009, the overall sickness rate has varied between 4.7% and 5.9%. Figure 4.33 also shows sickness rates by staff group. Over the period covered by the figure sickness rates for: ambulance staff; healthcare assistants and support workers; and nursing, midwifery and health visiting staff were consistently higher than the overall average, while the rates for: scientific, therapeutic and technical staff; and administration, estates and general payments staff were consistently below the overall average. In the three months to September 2019, compared with a year earlier, the largest change in sickness absence rates was for healthcare assistants and support workers, up to 8.1% from 6.8%.

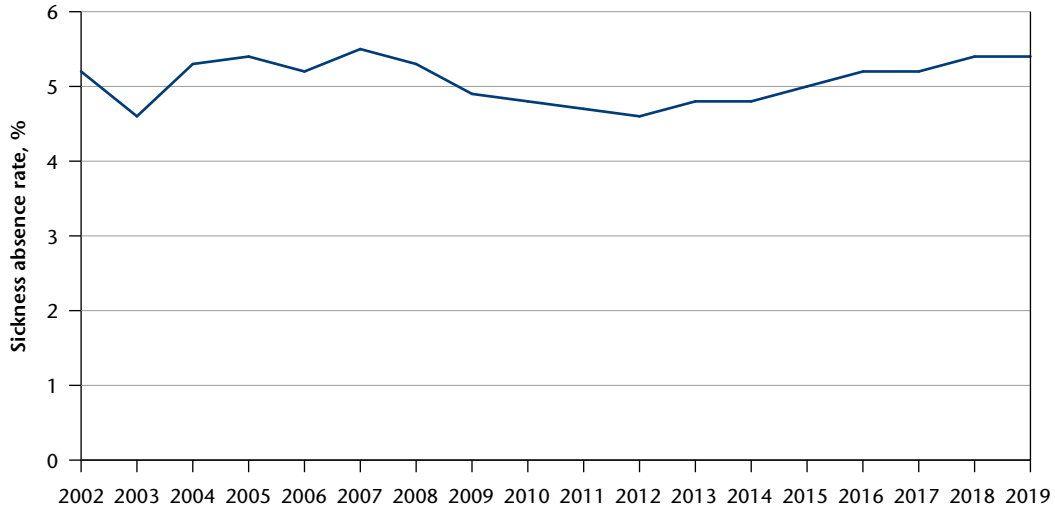
**Figure 4.33: Sickness absence rates, Wales, 2009 to 2019, by staff group, %**




*Source: Stats Wales*

4.232 Figure 4.34 shows sickness absence rates in the NHS in Scotland between 2001/02 and 2018/19. The latest data, for the twelve months to March 2019, showed an overall sickness absence rate of 5.4%, unchanged from a year earlier. Over the period as a whole sickness absence rates varied between 4.6% (in 2011/12) and 5.5% (in 2006/07).

**Figure 4.34: Sickness absence rates, Scotland, 2001/02 to 2018/19, %**




*Source: NHS Education for Scotland*

### *Ambulance staff*

4.233 We have heard from the parties' evidence and our visits to NHS ambulance trusts that there are varied concerns raised by ambulance staff, and the workforce and pay indicators suggest some variations from other AfC groups. From the earnings data for England, ambulance staff and support to ambulance staff saw the largest increases in basic pay between 2018 and 2019. At March 2019, only 17% of qualified ambulance staff were at the top of their pay bands, compared with 44% of all AfC groups. These differences in pay might be as a result of the re-evaluation and banding of qualified ambulance staff in 2016. We also note that the change to unsocial hours payments from September 2018 under the AfC pay agreement is a concern for ambulance staff and we await definitive analysis of the impact on additional earnings or retention.

4.234 The profile of the ambulance service workforce in England also differed from other AfC groups in that ambulance staff and support to ambulance staff were among a small number of groups where men make up the majority of the workforce. Ambulance staff were also the least ethnically diverse group, as 94% were White with only very small proportions of staff from Asian or British Asian, Black or British Black, and mixed ethnic groups. Ambulance staff were also less likely to be non-UK nationals than other staff groups, with 5% of ambulance staff having non-UK nationality, compared with 11% of all AfC staff. Ambulance staff have the lowest leaving and joining rates in England, compared with other AfC groups, although the picture is mixed in Scotland and Northern Ireland. Of those staff leaving the service in England, a greater percentage of ambulance staff (5.5%) and ambulance support staff (8.3%) left because they were dismissed than for most other staff groups (2.9%). Ambulance staff had the second highest rate of sickness absence across all AfC groups. In the 2019 Staff Survey, ambulance staff were the group most likely to experience harassment, bullying or abuse and were less likely than most other groups to express satisfaction with aspects of their work, and less likely to agree that equipment and staffing levels were sufficient. Ambulance staff were also the least likely to say that they had had an appraisal in the last 12 months.

4.235 Demand for paramedic skills could be increased as a result of their increasing role in primary care roles under the NHS Long Term Plan. Against this background and the variations in pay and workforce data, we would welcome further analysis of the impacts on the ambulance workforce in England and any specific concerns in the Devolved Administrations.

*Our overall conclusions on motivation and engagement*

4.236 The Staff Surveys conducted across the UK allow us to analyse a range of indicators, often over time and across different groups of staff. The surveys conducted in England, Wales, Scotland and Northern Ireland showed similar broad patterns in the results. One area of particular interest is staff satisfaction with pay. However, the Scottish and Welsh surveys do not cover this subject and the Northern Ireland survey only raises pay with those surveyed who have expressed some thoughts about leaving the health and social care service. We note that the results for England show that since the start of the 2018 AfC pay agreement, satisfaction with pay has increased in each of the last two years. By way of comparison, satisfaction with pay in the NHS in England in 2019 was at a similar level to that recorded in the civil service[95].

4.237 One aspect of the AfC pay agreement in England was the emphasis on progression. Following an increase in 2018 in the percentage of staff receiving an appraisal we note that in 2019 this has stalled and indeed fallen slightly, although there were increases in the percentages saying that their appraisals helped to agree clear work objectives, left them feeling their work was valued and helped them improve how they did their job.

4.238 Encouragingly, most AfC staff said that they look forward to going to work and that they were enthusiastic about their job, and the percentage saying so in 2019 was higher than in 2018. However, there are other aspects of the results which are concerning: fewer than one-third of staff said that there were enough staff at their organisation; fewer than half of staff said that they were satisfied with the extent to which their organisation values their work and that they were able to meet all the conflicting demands on their time; and only just over a half said that they were satisfied with the recognition they got for good work and that they agreed that they had adequate materials, supplies and equipment to do their job.

4.239 We are concerned that approaching one-third of staff said they had experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. It is particularly worrying that the percentages saying they had experienced such behaviour were increasing. We are also concerned that the percentage of staff saying they had felt unwell as a result of work-related stress had remained high at 40.6%.

[95] UK Government Data (March 2020), *Transparency Data Civil Service People Survey: 2019 Results*. Available at: https://www.gov.uk/government/publications/civil-service-people-survey-2019-results

4.240 There has been little change in overall sickness rates over recent years. In England, in the Interim NHS People Plan there is a recognition that sickness absence rates in the NHS are higher than in the rest of the economy and that supporting providers to help reduce sickness will contribute towards making the NHS a better place to work. DHSC told us that there is a target to reduce sickness absence by 1 percentage point by 2020 and to the public service average by 2022. The Scottish Government is also looking to reduce sickness absence, requiring NHS Boards to achieve a sickness absence rate of 4% or lower, from an average of 5.4% in 2018/19. The latest data shows that the public sector sickness absence rate, across the UK as a whole, was 2.7% in 2018[96]. Data for England showed that around a quarter of all sickness absence in the NHS is accounted for by anxiety, stress, depression and other psychiatric illnesses, whereas absence of this sort accounts for around a tenth of sickness absence across the economy as a whole[97].

4.241 The Friends and Family Test results provide indicators of how NHS staff view their working environment. The figures for England show little change over time in the overall proportions of staff recommending their organisation as a place to work or to receive care and are generally consistent across different types of trusts. The exceptions are staff at ambulance trusts who were less likely to recommend their organisation as a place to work than staff at other types of trust, and staff at mental health trusts were less likely to recommend their organisation as a place to receive care than staff at other trusts. The results for Scotland also show that ambulance service staff are less likely to recommend their organisation as a place to work or receive care than other groups of staff.

4.242 Overall, the sources of information on motivation and engagement suggest a mixed picture for AfC staff. Despite some positive improvements in the trends for each of the last two years, the Staff Survey results suggest low levels of satisfaction with a range of workplace issues. These results are also consistent with other evidence we have received from the parties and the views of external commentators. They reflect the nature of the work in the NHS, the challenging work environment and the increasing levels of demand placed upon staff. In general and before the impact of COVID-19, our overall conclusions point to a service and staff operating under severe pressure.

## Recruitment and Retention Premia

4.243 The Minister of State for Health's remit letter asked us to consider the role of RRPs for England and how they might help support the recruitment and retention of staff. The Minister also asked for observations on the potential for the greater use of RRPs on, but not limited to, the recruitment and retention of IT staff. In the context of RRP, DHSC's evidence also suggested that of particular concern was the recruitment and retention of nurses in relation to the Government's commitment to attract and retain 50,000 more nurses. The remit from the Minister was for England only.

4.244 In considering the remit we therefore set out: (i) the current arrangements for implementing national and local RRPs; (ii) how national and local RRPs have been used; (iii) our observations on how RRP might better support recruitment and retention; and (iv) the evidence required to support RRP. In doing so, our observations are intended to help inform any future in-depth review of RRP.

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96 Office for National Statistics (2019), *Sickness Absence in the Labour Market*. Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/sicknessabsenceinthelabourmarket

97 Office for National Statistics (2019), *Sickness Absence in the Labour Market*. Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/sicknessabsenceinthelabourmarket

*Current arrangements for RRP*

4.245 Current arrangements for RRP are set out in the NHS Terms and Conditions of Service Handbook[98]. This states that RRP: (i) are additions to pay where market pressures would otherwise prevent an employer from recruiting or retaining staff in sufficient numbers at the normal salary for a job of that weight; (ii) can be awarded on a short term basis as a one-off or a fixed period and are non-pensionable, or on a long term basis where the shortage is considered permanent; (iii) apply to posts and not to individuals; and (iv) should not normally exceed 30% of basic salary.

4.246 To ensure consistency in the application and payment of local RRP, employers are required to follow the protocol in the NHS Terms and Conditions of Service Handbook, which among other things requires employers to consult with neighbouring employers, staff organisations and other stakeholders, before implementing any local RRP.

*Use of national RRP*

4.247 The NHS Terms and Conditions of Service Handbook sets out that RRP can be awarded on a national basis subject to a recommendation from the Review Body and on a local basis by employers. A recommendation for a national RRP would be based on an assessment of recruitment and retention pressures with employers given guidance on the appropriate level of payment.

4.248 On the introduction of AfC in 2004, a list of occupational groups was agreed for national RRP drawing on evidence from the work on the NHS job evaluation scheme and in consultation with management and staff representatives. Since 2004, a number of cases for national RRP have been considered but only one case, for pharmacists, was recommended by the Review Body and this recommendation was not accepted by the UK Government. Following an independent review in 2011 conducted through the NHS Staff Council, all national RRP were withdrawn with protection arrangements or converted to local RRP. Since then no national RRP have been in place.

4.249 For this report, there was no specific support among the parties for any review of national RRP arrangements. While national RRPs are centrally funded, employers in the NHS have held a clear position since 2011 that the national approach has not been a priority and that they prefer to use local flexibilities. The Joint Staff Side are also concerned that any funding for national RRP (and any targeted pay) would reduce the funds available for across-the-board AfC pay awards.

4.250 There is a significant burden on the parties to provide a substantial national evidence base for introducing a new national RRP. It has proved difficult for individual parties to make a case for a national RRP without widespread support from other NHS organisations and the Staff Side. Even where a case can be made, it also requires a recommendation from the Review Body and acceptance by the Health Departments (including the Devolved Administrations).

*Use of local RRP*

4.251 The decision to award a local RRP is taken by the local employer. Local RRPs are funded from the budget of the local employer's overall funding. In the 12-months to December 2019, less than 0.7% of NHS non-medical staff, on average, received RRPs, although this varied by staff group. Managers (1.0%), senior managers (1.2%) and hotel, property and estates (1.7%) were the most likely to be receiving RRPs, while ambulance staff (0.2%) and support to scientific, therapeutic and technical staff (0.2%) were the least likely to receive an RRP.

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[98] NHS Terms and Conditions of Service Handbook. Available at: https://www.nhsemployers.org/tchandbook/part-2-pay/section-5-recruitment-and-retention-premia

4.252 The reasons for the limited use of local RRP by trusts were commented on by several parties in their evidence submissions. Two main themes emerged from this evidence and from our visits to trusts in recent years: (i) that trusts were reluctant to fund local RRP; and (ii) trusts were concerned about RRP creating local competition for staff and possibly local wage spirals.

4.253 The lack of specific funding for local RRP has been a major barrier to usage by trusts. With the challenging financial pressures and deficits in trusts it might have been difficult to justify the benefits of using local RRPs when local affordability arguments are a primary consideration in the decision-making process. Funding for local RRP might not have been a priority to address specific workforce shortages when other more temporary actions are available, for instance through the use of bank and agency staff.

4.254 While trusts often argue that there is no additional funding available for local RRP, there is no information on how current funding is being used by trusts. The funding system in England uses NHS tariff payments which are weighted by the Market Forces Factor[99] (MFF) including the staff MFF accounting for the staff costs in a particular area. Trusts could be using this additional funding in a variety of ways to manage staff resources, including introducing different skill mixes, upbanding existing AfC posts by recognising additional complexity or high level work, using temporary or agency and bank staff, and using local RRP. Any further in-depth review of RRP would need to examine the way in which current funding is being used and the variety of strategies employed by trusts to manage workforce shortages.

4.255 In addition to funding concerns, labour market conditions might have limited the use of RRP in recent years. This could be changing as the labour market tightens and staff shortages have become more prevalent. The evidence and views on our visits suggest that, even where staff shortages are particularly acute, trusts are reluctant to create a bidding war for staff with neighbouring trusts leading to escalating pay costs. Against this background we have commented in our recent reports on the need for RRP to be based on specific labour market conditions. We have noted that for occupational groups where there was open competition for skills available within local markets, a variety of solutions could be needed, including an RRP. We have commented in previous reports that targeted or local responses to staff shortages might simply redistribute a finite pool of AfC staff and could detract from areas elsewhere in the NHS. Where supply is restricted, as it is currently for some AfC professions, RRPs may not be a solution as they divert resources from one organisation to another and risk impacting on neighbouring trusts. Targeted pay solutions might create distortions across the pay structure and thereby influence the attitudes of other staff groups. The latest data suggest that roles receiving local RRP are mainly non-clinical groups, such as managers and roles in hotel, property and estates, where there is competition in the local labour market rather than clinical groups where there might be a wider, possibly regional or national, labour market.

4.256 The introduction of local RRP also requires a firm evidence base. Trusts might struggle to access and analyse good quality local labour market information to support a case. This might include data on: local pay rates (general and occupation specific); the supply of AfC groups including the range of routes into roles; the demand for local labour; and local factors influencing AfC recruitment and retention (including reasons for leaving). Without such comprehensive information, robust cases cannot be made and therefore there could be a lack of confidence in whether RRPs would be effective. On a practical point, employers might find local RRP difficult to remove without an adverse effect on retention.

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[99] NHS E&I (January 2019), *Guide to the Market Forces Factor*. Available at: https://improvement.nhs.uk/documents/475/Guide_to_the_market_forces_factor.pdf

4.257 Isolating the recruitment and retention factors influencing specific groups has been a longstanding problem in the NHS. We have commented in recent reports on how various factors influence staff at different points of a career, including ensuring newly qualified staff are well supported, developing flexible working and offering career development opportunities. There is a delicate balance between the influence of pay and non-pay factors in recruiting and retaining AfC staff. In this respect, some trusts might be tackling shortages by specific local recruitment or staff engagement initiatives, including the important development of flexible working. Such initiatives could be effective in conjunction with local RRPs.

4.258 The limited use of RRP in recent years also suggest that trusts might be inexperienced in their implementation and use. Unless trusts have a strategic approach and continuity among HR Directors and their departments, there is likely to be a piecemeal approach to targeted measures, which make their justification and benefits difficult to evaluate.

### *Our general observations*

4.259 We have heard from all parties that they generally support an in-depth review of RRP. This stemmed from the 2018 AfC pay agreement where NHS Employers and the Staff Side referred to our role including an "expectation of further consideration of the role of Recruitment and Retention Premia". We also note that the Health Foundation's Report *Closing the Gap*[100] in March 2019 recommended that the Review Body should: (i) identify shortage occupations and recommend appropriate incentives to tackle them; and (ii) examine why local pay flexibility had not been more widely used, and how local areas could be supported to respond to shortages of certain groups of staff.

4.260 The existing system of RRP has been in place since 2004, and the design of and requirements for national and local RRP have not changed since their introduction. However, despite support for an in-depth review the evidence presented for this report did not seek any changes to existing arrangements or suggest alternatives that might be considered. We have therefore confined our observations to the limitations of the current arrangements (as above) and the following general observations which might help inform a further review.

4.261 The Interim NHS People Plan placed great emphasis on the need to increase the supply and improve the retention of AfC staff. However, from the Interim Plan there appears little direct link between the proposed recruitment and retention actions and existing or new pay measures, such as RRP. Future pay considerations will also need to be informed by the impact on recruitment and retention of the pay reforms under the 2018 AfC pay agreements.

4.262 The use of RRP might also be affected by their interaction with other parts of the pay package. On the introduction of RRP, many cost of living supplements were converted into local RRP. Trusts have mentioned that cost of living is a key recruitment and retention factor and therefore could be influencing decisions on using local RRP. Where High Cost Area Supplements are in place there might be a mixture of factors influencing staff. As mentioned above, this reinforces the need for further information on the way in which employers currently use the additional MFF funding.

[100] Health Foundation (March 2019), *Closing the Gap.* Available at: https://www.health.org.uk/publications/reports/closing-the-gap

4.263 The NHS Long Term Plan and NHS People Plan anticipate a growing role for Integrated Care Systems in AfC workforce planning. This could lead to a more collaborative, regional approach to the assessment of measures required to address AfC shortage groups and could provide an effective method to determine targeted pay such as local RRP. These assessments would be well-placed to identify the nature of external labour market pressures for specific AfC roles and to take account of broader measures to increase the supply of AfC professional groups.

4.264 We await further detailed information on factors influencing retention emerging from the NHS E&I retention programme. RRP could be seen as an effective tool in addressing retention, alongside other non-pay measures. DHSC, employers, unions and external commentators all agree that retention factors are complex and therefore NHS E&I's programmes should be providing a clear steer to employers on the interventions having the biggest impact in improving retention.

4.265 The Agenda for Change pay spine was agreed between the social partners in 2004 and determines pay for all staff paid under Agenda for Change and employed in the NHS on the basis of two factors. Firstly, pay is set by job weighting. Jobs are assessed through an agreed mechanism and assigned a pay band and the larger the job weighting the higher the pay band. We note that Unite told us in evidence that a number of job profiles had not been reviewed since 2004 and we heard a range of concerns on pay banding from AfC staff on our visits. Secondly, pay is set to a very limited extent by geography. Those who live in HCAS areas, which are largely London and Greater London, are paid higher rates than those who live and work in the rest of the UK.

4.266 The Review Body notes the following:

- Despite the existence of the RRP mechanism, there is no established practice in England of differentiating pay other than by job weighting or, to a limited extent, geography;
- RRP are intended to create flexibility to pay specific groups of staff additional sums of money for other factors than the two set out above, but the strategic case for doing this at a regional or a national level has almost never been made successfully. We have heard in evidence a number of reasons suggested for why this might be the case and we have set these out in paragraphs 4.243 to 4.258;
- In the first instance, however, there might be merit in the NHS Staff Council examining the basis on which RRP might be applied, including whether there are factors other than that of job weighting and HCAS, such as scarcity of skills, on which the social partners would agree pay levels should be differentiated; and
- In addition, we note that there is some practice in the NHS, and more widely in the public sector, of offering additional support for training or on appointment for shortage groups and scarce skills. Maintenance grants for student nurses in England to be offered from September 2020 are an example of this, including the differentiation for shortage groups.

4.267 In this context, we set out below our observations on RRP, as requested, which might help the parties in their wider discussions on pay differentiation. The evidence requirements to support the approach to national and local RRP under the current arrangements should include:

- Determining the approach to the NHS employment offer, reward strategy and role of RRP;
- A clear assessment of the extent of AfC shortage groups, including identification of the AfC roles and levels affected by recruitment and retention difficulties, and the specific skills in short supply nationally, regionally and locally;

- Further, improved and robust data and information on the factors influencing recruitment and retention, including the role of pay and targeted measures and any actions that have been tried and failed;
- Specific analysis of the way in which pay or RRP could increase the supply of AfC groups in the longer term, including whether pay influences those not joining the NHS;
- Assessments of the relevant labour markets, including roles experiencing local market pressures and those operating in regional or national markets. This should identify variations by geography and AfC speciality;
- The supporting business benefits of any pay solutions, plus clear criteria for their application, including roles to be targeted, pay values (and any flexibility), time limitations and the evaluation criteria to be applied;
- An assessment of the impact of any pay solution on other related AfC groups not receiving RRPs, including recruitment, retention and motivation; and
- An equality impact assessment of implementing any national and local RRP.

### *Devolved Administrations*

4.268 Our remit on providing observations on RRP was for England only. The arrangements operating in the Devolved Administrations are as follows:

- In Scotland, the Scottish Terms and Conditions Committee oversees the Agenda for Change system and considers all applications for RRPs. There are four local RRPs in operation;
- In Wales, the mechanism is through a RRP Payment Protocol operated through the NHS Partnership Forum, with six local RRPs currently in operation;
- In Northern Ireland, a Recruitment and Retention Framework operates to address local recruitment difficulties, with currently two long-term RRPs in place.

4.269 We note that no specific issues were raised for the Devolved Administrations, which suggests that their own internal frameworks for requesting and approving RRP are operating effectively for the required purposes in each country. However, the system of national and local RRP was designed under a UK-wide pay system and therefore any further in-depth review would need to consider whether there is benefit in including considerations for all four UK countries.

### *Recruitment and retention of nurses*

4.270 DHSC's evidence submission suggested that the recruitment and retention of nurses was of particular concern. The Government's target of 50,000 more nurses by 2025, its introduction of maintenance grants for students and the expected priority on nursing in the NHS People Plan has increased the emphasis on supporting the nursing workforce. We have commented earlier in this chapter on the importance of recruiting and retaining sufficient nurses in the NHS.

4.271 While the parties made no specific case for the use of RRP for nurses beyond the availability of local RRP, it is clear that a range of measures are required to support the nursing workforce. As these measures are developed including the reward package under the NHS People Plan, consideration will need to be given to whether targeted pay solutions are required. Our wider observations on RRP might help inform the development of any reward mechanisms. In this context, there has been much focus on improving the supply of nurses through a range of sources which might provide further evidence on the effect of pay as a factor in recruitment. RRPs could be a useful mechanism to attract nurses into shortage areas by geography or specialty after graduation or to encourage returners into shortage areas providing that it can be shown that this would add to the total number of nurses rather than draw from one stretched provider to another. On retention, NHS E&I's retention programme targeted at nurses should provide some detailed analysis of the factors specifically influencing retention, including whether targeted pay measures are required.

### *Recruiting and retaining IT staff*

4.272 The remit for this report followed a similar request to the previous year in considering the potential for the greater use of RRP on the recruitment and retention of IT staff.

4.273 The evidence submitted from the parties was again limited. DHSC agreed that the evidence on IT staff for the last report did not support the case for a national RRP and that, in the submission for this report, it could not improve the evidence base and therefore sought observations on how trusts might make better use of local RRP. We note that NHS Employers continued to consider this a supply issue and did not support a national RRP for IT staff with the preferred use of local RRP. NHS Providers suggested that there was mixed support in trusts for targeting of pay awards and RRP for IT staff with a high proportion (66%) of HR Directors reporting difficulties recruiting IT staff. We also heard on our visits that some trusts were having issues recruiting IT staff and that this had caused problems with the implementation and maintenance of IT systems, but the use of local RRP for IT staff was not evident.

4.274 We continue to acknowledge the importance of the AfC workforce in developing and delivering IT systems, new technology and digital services, as emphasised in the NHS Long Term Plan. The recruitment and retention of quality IT staff are essential to both maintaining and developing IT services as part of the transformation programme in the NHS and to support the improvements sought in productivity.

4.275 Against this background and in the absence of further substantial evidence, we note that the parties have not urged the case for a national RRP for IT staff or for greater use than already available under local RRP. A "one-size-fits-all", national pay approach might not achieve its aims as there could be significant geographical variations in recruitment and retention for IT staff and they are often employed or engaged in different ways. We note that NHSX is a relatively new organisation within the NHS system and might have new approaches to defining IT roles, which might have an impact on AfC pay banding for these roles. We therefore continue to conclude that there are indications of some issues in IT recruitment and retention but the parties did not feel these represented a widespread national problem requiring an immediate pay response.

4.276 We set out in our 2019 Report a comprehensive list of requirements to underpin future assessments for IT staff, including: developing a clear strategy on the IT workforce; measures to increase supply with reference to the external market; clear identification of the specific IT roles and levels experiencing recruitment and retention difficulties; the role of pay in addressing recruitment and retention; and the supporting business benefits of any pay solutions and the impact on other AfC groups. Our overall observations on RRP would also apply to any considerations of measures for IT staff.

## High Cost Area Supplements

4.277 The AfC pay agreement reached in 2018 included reference to our continuing role with an expectation of further consideration of HCAS. In determining our remit for this report there was some discussion in readiness for a review and we understand from the parties that there is a general consensus in favour of a review. We have, therefore, explored some broad considerations and data requirements, which might inform such a review of HCAS should DHSC provide us with a remit to do so.

4.278 The NHS Terms and Conditions of Service Handbook[101] describes HCAS as applying to all Agenda for Change staff with supplements expressed as a proportion of basic pay, subject to a minimum and maximum level of extra pay. HCAS payments are pensionable but do not count as basic pay for the purposes of calculating the rate of overtime payments, unsocial hours payments, on-call availability payments or any other payment, excluding sick pay. They are based on rates for Inner London, Outer London and Fringe areas as defined in the Handbook. The value of HCAS payments is reviewed annually based on the recommendations of the Review Body, which can also consider geographical coverage.

4.279 The Handbook also describes how employers who employ staff in more than one HCAS zone can agree locally a harmonised rate of payment across their organisation, provided they agree with neighbouring employers if the proposed rate would exceed the average rate payable in their area. Employers or staff organisations in a specified geographic area can also propose an increase in the level of HCAS in that area or to introduce a supplement in areas where no supplement exists.

4.280 On the introduction of Agenda for Change in 2004, previous arrangements to pay London weighting, fringe allowances and cost of living supplements were discontinued. "Extra-territorially managed" payments not falling within the inner, outer or fringe definitions were converted into long-term Recruitment and Retention Premia.

4.281 A starting point for any review might be the purpose of HCAS. The Staff Side's evidence suggested that the HCAS system owed more to evolution than design. They added that although the history of London Weighting in the NHS provided some explanation of the quirks of the system it did not provide a justification for them. While the Handbook sets out the operation of HCAS it does not specifically define its purpose beyond the name itself in compensating for working in high cost areas. Reviewing the purpose of HCAS would allow a clearer view for all parties, AfC staff and trust management in determining how it might be revised to meet changed requirements. The purpose should focus on the drivers for HCAS, including compensating for cost of living and additional costs, what is needed to support recruitment and retention in high cost areas, and what other support mechanisms might be needed (including significant drivers of costs such as housing and transport).

[101] NHS Terms and Conditions of Service Handbook, Section 4. Available at: https://www.nhsemployers.org/tchandbook/part-2-pay/section-4-pay-in-high-cost-areas

4.282 On a general point, defining the purpose of HCAS and reviewing its applications and any move for greater alignment with NHS funding arrangements would need to be underpinned by further examination of how trusts use existing funding. The NHS tariff is adjusted to account for local labour market conditions through the staff element of the Market Forces Factor. As yet there is little information available on how trusts use the additional funding, such as additional resources to manage vacancies, using agency and bank staff, changing the skills or grade mix of the workforce, upbanding roles, using local RRP and using HCAS. This analysis would help identify the role of HCAS among a wide range of other actions to recruit and retain staff. It would also provide some indications of any geographical variations (within HCAS zones and across England) where trusts might be tackling staff shortages which result from living in high cost areas. There could be an interaction between local RRP and HCAS which might need clearer definitions to help trusts and staff better to understand their purposes.

4.283 On the structure of HCAS, there is a clear case to review the geographical coverage, minima and maxima, and rates. Much of the structure derives from legacy arrangements for a range of healthcare staff groups from before Agenda for Change was introduced. The Inner, Outer and Fringe areas are based on Primary Care Trust areas determined by boundaries within Strategic Health Authorities in 2005. When mapped out these appear arbitrary and the rationale for boundaries at that time has shifted with the organisational structure of the NHS. There could be a rationale in moving to areas that reflect the development of Integrated Care Systems. The Staff Side's helpful analysis and views expressed on our visits suggest that there are tensions between both the HCAS zones themselves, particularly the rationale for differentials between inner and outer London, and between HCAS zones and bordering areas without HCAS. Areas to the south east and north west of the zones are excluded from HCAS, although there does not appear to be evidence to justify these boundaries.

4.284 On the HCAS rates, there are a number of strands which might require review. The rationale for the differentials in HCAS rates across the three zones and the use of minima and maxima might continue to hold true, but could require substantive evidence to clarify the rationale. If the purpose is to offer direct compensation for the impact of higher costs of living in these areas, then there could be logic in retaining a structure that offers a minimum level to protect the lowest paid NHS staff and a maximum to avoid differentials between the lowest and the highest paid to widen. In this respect, we note that the London rate of the Living Wage (as calculated by the Living Wage Foundation and determined by qualitative research called the Minimum Income Standard[102]) could impact on minimum AfC basic pay rates with the addition of HCAS. For 2019/20, the London Living Wage is £10.75 an hour, which equates to an annual salary of £21,002 using the standard NHS FTE 37.5 hour week. The 2019/20 AfC Band 1 rate plus the minimum HCAS rate for Inner London would result in an annual salary of £22,052, for Outer London £21,375 and for Fringe areas £18,671.

4.285 We heard on our visits that AfC staff in the lower pay bands receiving HCAS found that the additional payments were absorbed by commuting costs. This might also influence decisions by Band 5 AfC professions, including nurses, on taking up posts in HCAS areas. We heard that more senior AfC professional groups had more flexibility to take up such posts.

[102] Joseph Rowntree Foundation (July 2018), *A Minimum Income Standard for the UK 2008-2018: Continuity and Change.* Available at: https://www.jrf.org.uk/report/minimum-income-standard-uk-2018

4.286 The Review Body looked at HCAS as part of a wider review of market-facing pay in 2012[103]. Among a range of other pay recommendations, the Review Body recommended a fundamental review of HCAS including its purpose, funding, zones, rates and mechanisms for regular review. Commissioned research at that time suggested that where the private sector used pay differentiation it typically only used up to four or five geographical bands, including a national scale and specific rates for London and the South East. Following the Review Body's recommendation, HCAS was reviewed by the NHS Staff Council in 2014 (supported by commissioned research from IER) but no change was recommended. Since then, there has been a sustained period of austerity and public sector pay restraint which suggests that there are no specific reasons to assume that employers in the public and private sector have made major changes to their pay structures when labour market conditions have been relatively stable. Any review of HCAS might further examine any changes in geographical pay practice in other national, multi-site private and public sector employers.

4.287 Finally, the level of compensation through HCAS might need examination. It could be argued that most systems using a form of London Weighting as an addition to basic pay seek to offer a level of notional compensation rather than a direct link to a package of costs relevant to a defined area. However, should the level of compensation fall too low there would be implications for recruiting and retaining AfC staff. Some comparative information might help reassure staff and trust management that HCAS is in line with other public sector employers.

4.288 In conclusion, we summarise below some considerations which might help DHSC decide whether to review HCAS:

- Whether the HCAS structure reflects modern practice in the use of London and South East allowances across the public and private sector;
- Defining the purpose of HCAS – whether it is simply to compensate for cost of living or whether other factors should be accounted for;
- Examining the structure, rates, minima and maxima, definitions and differentials between zones, and "cliff edges" with border areas;
- The interaction of HCAS and other parts of the pay package, such as AfC banding and use of RRP;
- Whether there are cases for extending HCAS or similar cost of living allowances elsewhere in England and what would be mechanism to introduce and review new areas; and
- Accompanying comprehensive workforce and pay data, not least on current practice and use of funding, such as the staff element of the Market Forces Factor.

[103] NHSPRB (2012), *Market-Facing Pay*. Available at: https://www.gov.uk/government/publications/nhs-local-pay-2012

# Appendix A – Remit Letters

## Letter from Minister of State for Health to NHSPRB Chair

Department of Health & Social Care

*Edward Argar MP*
*Minister of State for Health*

*39 Victoria Street*
*London*
*SW1H 0EU*

*020 7210 4850*

Philippa Hird
Chair, NHS Pay Review Body
Office of Manpower Economics
Fleetbank House, 2-6 Salisbury Square
London EC4Y 8AE

05 November 2019

Dear Philippa,

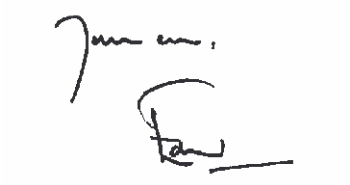
I am writing to thank you for the NHS Pay Review Body's invaluable work on the report and observations for the 2019-20 pay round and to formally commence the 2020-21 pay round.

As you know, over the period of the multi-year pay deal (2018-19 to 2020-21) we will not be asking the NHSPRB to make any pay recommendations. We will however, as agreed, ask your members to monitor the implementation of the deal. We will also ensure that your members continue to receive data on the state of recruitment, retention and motivation as part of the public sector annual pay rounds.

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

I am also asking the NHSPRB to consider the role of Recruitment and Retention Premia (RRPs) and how they might help support the recruitment and retention of staff. I would be grateful for your observations on the potential for the greater use of RRPs on, but not limited to, the recruitment and retention of IT staff.

As always, whilst your remit covers the whole of the UK, 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.



**EDWARD ARGAR MP**

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

Cabinet Secretary for Health and Sport
Jeane Freeman MSP

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0300 244 4000
E: scottish.ministers@scotland.gsi.gov.uk

Philippa Hird
Chair, NHS Pay Review Body
Office of Manpower Economics

By Email.

5 December 2019

Dear Ms Hird

I am writing to set out the Scottish Government's position with regard to the NHS Pay Review process for 2020-21.

We note that the UK Government's Department for Health and Social Care has provided a remit to the Pay Review Body seeking observations on the evidence submitted by the various interested parties and on the role and use of Recruitment and Retention Premia, particularly as this applies to IT staff. Whilst I will await with interest the Review Body's conclusions on this issue, I continue to be of the view that, at the present time, Scotland should focus on implementation of the current pay deal and the reforms which we have agreed as part of this.

This being the case, I am writing to confirm that Scotland will not be supplying a remit to the PRP for the 2020-21 pay year. Thank you for the informal assistance which OME contacts continue to provide to my officials at this time and I will write to you again in respect to the 2021-22 pay round at the appropriate time.

Kind regards

JEANE FREEMAN

# Letter from Welsh Government Minister for Health and Social Services to NHSPRB Chair

**Vaughan Gething AC/AM**
**Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol**
**Minister for Health and Social Services**

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA/VG/5602/19

Philippa Hird
Chair of NHS Pay Review Body
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8AE

6 January 2020

Dear Phillippa Hird,

Thank you for the NHSPRB's hard work and independent report and observations which have been invaluable during the 2019-20 pay review round.

I am now writing to formally commence the 2020-21 pay round for AfC staff in Wales. You will be aware that the amended Framework, which underpins a three year pay deal and radical restructure of the payscales for AfC staff and provides pay parity with staff in England, has now been in place in Wales for a full year.

As last year, during the life of this multi-year pay deal (2018-19 to 2020-21) we will not ask the NHSPRB to make any specific recommendations on pay. We will however ask that your members continue to monitor the implementation of the deal and its impact over the duration of the deal.

I will continue to provide data and appropriate narrative on the state of recruitment, retention and motivation as part of the public sector annual pay rounds and so for 2020-21 I would ask you to consider and make observations based on evidence you receive from Welsh Government and other parties on implementing the AfC agreement.

Yours sincerely,

Vaughan Gething

**Vaughan Gething AC/AM**
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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Bae Caerdydd • Cardiff Bay
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CF99 1NA

## Letter from Minister of Health, Northern Ireland to NHSPRB Chair

FROM THE MINISTER OF HEALTH

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
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Telephone: 028 9052 2556
email: private.office@health-ni.gov.uk

Philippa Hird
Chair of NHS Pay Review Body
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

By email: craig.marchant@beis.gov.uk

Our ref: SUB-1105-2020
Date: 24 February 2020

Dear Philippa,

**NHSPRB 2020/21 PAY ROUND**

I am writing to formally commence the 2020/21 pay round for Agenda for Change (AfC) staff in Northern Ireland and to submit my Department's evidence. I wish to begin by thanking the NHS Pay Review Body for its invaluable work on the 2019/20 pay round and, in particular, for its observations on the AfC pay agreement.

On 31 October 2019, the Department of Finance (DoF) set out Northern Ireland's Public Sector Pay Policy for 2019/20. Following considerable engagement with employers and trade unions throughout the year, a proposed agreement on a pay deal for 2019/20 is currently out for consultation with Trade union members. This proposed deal restores pay parity, with England, for Agenda for change staff in Northern Ireland.

This year, Northern Ireland will not require any specific recommendations on pay, however, I would be most interested to have the views of the NHSPRB into wider recruitment, retention and staff motivation factors specific to the Northern Ireland health labour market which might highlight staff migration, recruitment deficiencies and key behavioural drivers. I would welcome views on the impact the re-establishment of pay parity, with England and Wales, may have in making Northern Ireland a more attractive destination in which to pursue a career in health and social care.

Yours sincerely

Robin Swann MLA
Minister for Health

Working for a Healthier People

## Appendix B – Agenda for Change Pay Bands Under The Framework Agreement In England 2018/19 – 2020/21

### Band 1

| 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|
| 15,404 | | | |
| 15,671 | 17,460 | 17,652 | 18,005 |

### Band 2

| 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|
| 15,404 | | | |
| 15,671 | | | |
| 16,104 | | | |
| 16,536 | 17,460 | | |
| 16,968 | 17,460 | 17,652 | 18,005 |
| 17,524 | 17,787 | 17,983 | |
| 18,157 | 18,702 | 19,020 | 19,337 |

### Band 3

| 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|
| 16,968 | | | |
| 17,524 | 17,787 | | |
| 18,157 | 18,429 | | |
| 18,333 | 18,608 | 18,813 | 19,737 |
| 18,839 | 19,122 | 19,332 | |
| 19,409 | 19,700 | 19,917 | |
| 19,852 | 20,448 | 20,795 | 21,142 |

### Band 4

| 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|
| 19,409 | | | |
| 19,852 | 20,150 | | |
| 20,551 | 20,859 | 21,089 | 21,892 |
| 21,263 | 21,582 | 21,819 | |
| 21,909 | 22,238 | 22,482 | |
| 22,128 | 22,460 | 22,707 | |
| 22,683 | 23,363 | 23,761 | 24,157 |

### Band 5

| 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|
| 22,128 | | | |
| 22,683 | 23,023 | | |
| 23,597 | 23,951 | 24,214 | 24,907 |
| 24,547 | 24,915 | | |
| 25,551 | 25,934 | 26,220 | 26,970 |
| 26,565 | 26,963 | 27,260 | 27,416 |
| 27,635 | 28,050 | 28,358 | |
| 28,746 | 29,608 | 30,112 | 30,615 |

### Band 6

| 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|
| 26,565 | | | |
| 27,635 | 28,050 | | |
| 28,746 | 29,177 | 30,401 | 31,365 |
| 29,626 | 30,070 | 32,525 | |
| 30,661 | 31,121 | | |
| 31,696 | 32,171 | 32,525 | 33,176 |
| 32,731 | 33,222 | 33,587 | 33,779 |
| 33,895 | 34,403 | 34,782 | |
| 35,577 | 36,644 | 37,267 | 37,890 |

### Band 7

| 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|
| 31,696 | | | |
| 32,731 | 33,222 | | |
| 33,895 | 34,403 | | |
| 35,577 | 36,111 | 37,570 | 38,890 |
| 36,612 | 37,161 | | |
| 37,777 | 38,344 | 38,765 | 40,894 |
| 39,070 | 39,656 | 40,092 | 41,723 |
| 40,428 | 41,034 | 41,486 | |
| 41,787 | 43,041 | 43,772 | 44,503 |

### Band 8a

| 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|
| 40,428 | | | |
| 41,787 | 42,414 | | |
| 43,469 | 44,121 | 44,606 | 45,753 |
| 45,150 | 45,827 | 46,331 | 46,518 |
| 47,092 | 47,798 | 48,324 | 48,519 |
| 48,514 | 49,969 | 50,819 | 51,668 |

### Band 8b

| 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|
| 47,092 | | | |
| 48,514 | 49,242 | | |
| 50,972 | 51,737 | 52,306 | 53,168 |
| 53,818 | 54,625 | 55,226 | 55,450 |
| 56,665 | 57,515 | 58,148 | 58,383 |
| 58,217 | 59,964 | 60,983 | 62,001 |

### Band 8c

| 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|
| 2017/18 | 2018/19 | 2019/20 | 2020/21 |
| 58,217 | 59,090 | | |
| 60,202 | 61,105 | 61,777 | 63,751 |
| 63,021 | 63,966 | 64,670 | 64,931 |
| 67,247 | 68,256 | 69,007 | 69,285 |
| 69,168 | 71,243 | 72,597 | 73,664 |

### Band 8d

| 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|
| 67,247 | | | |
| 69,168 | 70,206 | | |
| 72,051 | 73,132 | 73,936 | 75,914 |
| 75,573 | 76,707 | 77,550 | 77,863 |
| 79,415 | 80,606 | 81,493 | 81,821 |
| 83,258 | 85,333 | 86,687 | 87,754 |

### Band 9

| 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|
| 79,415 | | | |
| 83,258 | 84,507 | | |
| 87,254 | 88,563 | 89,537 | 91,004 |
| 91,442 | 92,814 | 93,835 | 94,213 |
| 95,832 | 97,269 | 98,339 | 98,736 |
| 100,431 | 102,506 | 103,860 | 104,927 |

### High Cost Area Supplement (HCAS)

| | | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|---|---|
| Inner London | Minimum | 4,200 | 4,326 | 4,400 | 4,474 |
| | Maximum | 6,469 | 6,664 | 6,778 | 6,892 |
| Outer London | Minimum | 3,553 | 3,660 | 3,723 | 3,786 |
| | Maximum | 4,528 | 4,664 | 4,744 | 4,824 |
| Fringe | Minimum | 971 | 1,001 | 1,019 | 1,037 |
| | Maximum | 1,682 | 1,733 | 1,763 | 1,793 |

# Appendix C – 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 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 | Cm 4992, December 2000 |
| Nineteenth Report on Professions Allied to Medicine | Cm 5346, December 2001 |

## 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 – *unpublished* | 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 |
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