Department of Health & Social Care

The Department of Health and Social Care's written evidence to the NHS Pay Review Body (NHSPRB) for the 2021/22 Pay Round

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Executive Summary

We recognise that this year has posed unprecedented challenges to our NHS. Under the most difficult conditions, the NHS has been at the forefront of the COVID-19 pandemic response.

In these most challenging times, patients, and their experience of care, must be at the heart of everything the system does. We want to help ensure that the NHS can continue to deliver world-class patient care whilst being equipped to deal with the COVID-19 pandemic and its aftermath.

The 2021/22 pay round will see the Review Body making recommendations. This folllows the multi-year pay and contract reform deal for AfC staff (2018/19-2020/21), during which the Government did not ask for recommendations on pay.

Following on from the multi-year deal, the longstanding aim of the Government remains the same. Within the current challenging economic context, we must ensure that we can continue to recruit, retain and motivate the compassionate, skilled and dedicated workforce our NHS needs in order to deliver world-class care, whilst also guaranteeing the best value for the taxpayer. Carefully balancing these aims is a complex matter that reflects the overall NHS employment offer, including pay and non-pay terms and conditions.

The COVID-19 pandemic has posed an unparalleled challenge to the UK economy and NHS finances. Funding the response to COVID-19 has been, and continues to be, a priority. In the Spending Review 2020 the Chancellor provided a further £3 billion to support the NHS recovery on top of the LTP (LTP) settlement. It is vitally important that the financial pressures that have resulted from the COVID-19 pandemic, both within the NHS and wider public finances, are considered to ensure that staff are retained and recruited, while enabling the ongoing response to COVID-19 and the provision of care to patients to be affordable.

This written evidence therefore seeks to enable the Review Body to make independent recommendations, weighing all of the evidence, including the importance of affordability within the current challenging economic and fiscal context, along with recruitment and retention trends and staff motivation.

Chapter 1 of this evidence sets out the strategy for NHS pay within this wider context, while Chapter 2 describes the specific financial context for the NHS. Chapter 3 provides evidence on AfC earnings and the impact of the multi-year agreement and Chapter 4 details staff motivation and morale and the related workforce strategy. Chapter 5 of this evidence provides information on recruitment and retention amongst the Review Body's remit group and Chapter 6 provides an update following the implementation of the deal and benefits realisation. Finally, Chapter 7 provides an update on the total reward offer that is available to AfC staff.

1. NHS Strategy and introduction

1.1 This chapter sets out the current strategic context for NHS pay and where the Agenda for Change (AfC) workforce sits within this. The chapter also provides wider context for the Government's 2021/22 evidence.

1.2 COVID-19 has had a wide-ranging impact across the whole of society, with those working in the health and social care sector playing a crucial role on the frontline of the response. In these most challenging of times, the commitment of NHS staff has never been clearer.

1.3 As part of the Spending Review (SR20) the Chancellor announced that, *"to protect jobs, pay rises in the rest of the public sector will be paused next year"*. However, given the unique impact of COVID-19 on the health service, the Government will continue to provide pay rises for NHS workers. The Chancellor highlighted that, in setting the level for these rises, the Government will need to take into account the challenging fiscal and economic context.

1.4 The Government, as always, needs to consider how to get the best value from a limited funding envelope. As the funding envelope is fixed, increased spending in one area will require diverting funding from elsewhere. Funding the response to COVID-19 has been, and continues to be, a priority. It is important to stress that the financial impact of COVID-19 will be felt across the health and social care system in the 2020-21 financial year and beyond. Chapter 2 sets out in more detail the impact COVID-19 has had on NHS finances and reiterates the importance of pay awards in 2021/22 being affordable, in order to support the Government's objective of delivering long-term financial sustainability in the NHS.

1.5 The Government remains committed to the historic long-term settlement for the NHS which provides a cash increase of £33.9 billion a year by 2023-24. This takes the NHS England (NHSE) budget from £114.6 billion in 2018-19 to £148.5 billion in 2023-24, with an increase of £6.3 billion in 2021-22. It also confirms its commitment to deliver 50,000 more nurses and to create an additional 50 million appointments in general practice a year.

1.6 The Long Term Plan (LTP) sets out the NHS's 10-year strategy to improve the quality of patient care and health outcomes, ensuring that patients will be supported with world-class care a every stage of their life. The Plan rightly sets out that putting the NHS back onto a sustainable financial path is a key priority and is essential to delivering further improvements in care, and so, within the plan, the Government set the NHS five financial tests that show how it will put the service onto a more sustainable footing.

1.7 The NHS has faced unique pressures due to COVID-19, along with pre-existing trends such as an ageing population with multiple and complex care needs. Responding to COVID-19 and meeting the continuing demand whilst maintaining and improving quality and care is a significant challenge. The additional £3 billion of funding set out in SR20 will help the NHS to get back on track to delivering the LTP, but the Government recognises that recovering previous efficiency plans will be challenging.

1.8 As the long term NHS funding settlement is held by NHSEI, they will set out the affordability constraints and financial pressures within the system. Spend on pay awards is one of the biggest financial pressures on NHS funding, a pressure which is recurrent. NHSEI will set out in their evidence the interaction between pay uplifts and their ability to deliver their wide-ranging priorities.

1.9 It is important the NHS employment offer continues to attract and retain the dedicated staff the NHS needs, and efforts to achieve this should look at the total reward package for NHS staff. This includes a range of benefits exceeding those offered in many other sectors, including a holiday allowance of up to 33 days and sickness absence arrangements well beyond the statutory minimum, as well as access to a much-valued pension scheme and support for learning, development and career progression.

Workforce

1.10 Ensuring that the NHS has access to the right mix and number of staff who have the skills, values and experience to deliver high quality, affordable care is a fundamental aspect of the Department's overarching strategic programme for the health and care system. The Department works with system partners to ensure there is a highly engaged and motivated workforce delivering NHS services to patients.

1.11 The SR20 settlement included four priority outcomes, one being to improve healthcare outcomes through a supported workforce fit for the future. The settlement provided investment in the NHS workforce via funding for Health Education England to train more new nurses and doctors, deliver some of the biggest undergraduate intakes ever and deliver training to NHS staff.

1.12 In addition, the Government has committed to delivering 50,000 more nurses by 2025 through a combination of increased supply, recruitment and retention (see Chapters 4 and 5). We have established a comprehensive delivery programme to meet the nursing manifesto commitment. We are working across a range of organisations to improve retention and support return to practice, we are investing in and diversifying our training pipeline, and we are increasing international

recruitment in an ethical and sustainable way. We continue to see positive increases in the numbers of nurses. NHS Digital data shows an increase of 14,800 FTE nurses at August 2020 compared to August 2019.

1.13 Recruitment and retention are not only driven by satisfaction with reward, but by a culture and environment where staff want to work. There is strong evidence that staff who feel well supported and engaged with their employer will deliver better care, with improved patient safety and patient satisfaction.

1.14 Following the Interim NHS People Plan published on 3 June 2019, 'We are the NHS: People Plan 2020/21 - action for us all' was published in July 2020. This plan sets out actions that NHSEI and Health Education England (HEE) will take to support transformation across the NHS. It focuses on how the NHS will foster a culture of inclusion and belonging, as well as action it will take to grow the workforce, train people, and work together differently to deliver patient care. See Chapter 4 for more information on the commitments in the 2020/21 NHS People Plan.

1.15 Published alongside 'We are the NHS: People Plan 2020/21 - action for us all' was 'Our NHS People Promise'. This sets out the vision and immediate actions to make the NHS the best place to work. One of the most important elements of the plan is to improve the day to day experience of front-line staff and make the NHS an employer of excellence, where people are valued, supported, developed and empowered.

1.16 The challenge of COVID-19 has compelled the NHS to make the best use of people’s skills and experience to provide the best possible patient care. It will be important to capitalise on this momentum to transform the ways teams, organisations and systems work together, and how care is delivered for patients.

1.17 Staff engagement is crucial to securing and retaining the workforce the NHS needs, as is making the best use of the entire employment reward offer, which includes both pay and non-pay benefits.

1.18 The AfC multi-year deal (2018/19 - 20/21) transformed the AfC offer to help increase productivity and improve recruitment and retention through a range of pay and non-pay measures. The deal included, for example, a commitment to better support staff to maintain their physical and mental health and wellbeing and improving local performance appraisal processes. The deal also introduced common bereavement, parental care and annual leave policies, all of which support staff to balance their working lives with family and other caring and personal commitments.

1.19 Recruitment and retention is not just about pay or wider reward: it is about creating a culture and environment in the NHS where staff want to work, where staff feel safe to raise concerns and to learn from mistakes; where employers listen to and empower staff; work hard to keep them safe; and ensure bullying and harassment is not tolerated. The Department continues to work in partnership with its arms-length bodies and other organisations to support trusts in their responsibility for improving staff experience.

COVID-19

1.20 Significant additional funding has been provided to support the NHS response to the COVID-19 pandemic, including provisions to ensure staff who need to self-isolate or are sick through COVID-19 are financially supported.

1.21 The NHS Terms and Conditions of Service have been supplemented by temporary non-contractual guidance introduced by DHSC in March 2020. The intention of the guidance is to ensure that where staff are told to self-isolate, they receive full pay based on what they would have received at work, and in addition to ensure that where staff are off sick with the COVID-19 virus, they receive full pay whilst they are infectious to make sure there is no incentive to attend work.

Government Pay Policy and our approach for the NHS

1.22 As has been briefly set out above and will further be detailed within the rest of our evidence, COVID-19 has placed a huge strain on both public and NHS finances. The economic outlook for 2021/22 remains uncertain and pay awards must be both fair and affordable.

1.23 The government announced a pause in public sector pay rises for all workforces, with an exception for employees with basic full-time equivalent salaries of £24,000 or under and for the NHS. In settling the DHSC and NHS budget, the government assumed a headline pay award of 1% for NHS staff. Anything higher would require re-prioritisation.

1.24 This envelope does not include the c0.7% that has already been committed in 2021/22 as part of the multi-year Agenda for Change deal (2018/19 - 20/21). This 'overhang' of the deal was agreed by all parties and further information is set out within Chapter 6. This means, we expect the total investment in AfC in 2021/22 to be 1.7%.

1.25 CPI inflation has been consistently low in 2020. The latest figure available (December 2020) shows CPI inflation at 0.6%. Whilst inflation is an important consideration of the NHSPRB it is also important to view inflation within the wider economic context set out by HMT.

Figure 1.1- CPI inflation by month, April 2020 - December 2020

Month	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
CPI Inflation	0.8%	0.5%	0.6%	1.0%	0.2%	0.5%	0.7%	0.3%	0.6%

1.26 Source: ONS Inflation and price indices

1.27 Patients, and their experience of care, must be at the heart of everything that the system does - we want to help ensure that the NHS can continue to deliver world class patient care, putting patients first and keeping them safe whilst providing the high-quality care we all expect.

1.28 To achieve this requires the right balance between pay and staff numbers through systems of rewar d that are affordable and fit for purpose. Staff tell us that they want to know they will have the right number of colleagues working alongside them in hospital or in the community. Our focus is on ensuring the overall package of reward helps to recruit and retain the staff we need whilst maintaining affordability.

1.29 The NHS budget is set for 2019/20 to 2023/24 and this budget includes money for planned workforce growth. This is why, as set out in our remit, there are trade-offs if money above affordability assumptions is spent on pay. COVID-19 has created unavoidable direct and indirect financial impacts in the 2020-21 financial year and contributed to a challenging wider economic context. As already set out above, NHSEI will set out in their evidence a more detailed financial picture, and we have asked in our remit that you take that in to account in your final report.

2. NHS Finances

2.1 This chapter describes the financial context for the NHS.

Funding Growth

2.2 The NHS LTP (January 2019) sets out the NHS's 10-year strategy to improve the quality of patient care and health outcomes, ensuring that patients will be supported with world-class care at every stage of their life. The Plan rightly sets out that putting the NHS back onto a sustainable financial path is a key priority and is essential to delivering further improvements in care. The Government signalled its clear support for this plan in the 2019 Spending Round, where it confirmed the five-year settlement for the NHS which provides an additional £33.9 billion cash terms annual increase by 2023-24 compared to 2018-19 budgets.

2.3 At Budget 20 DHSC received over £5 billion to meet the Government's manifesto commitments of 50,000 more nurses, 50 million additional appointments in primary care, more funding for hospital car parking and establishing a Learning Disability and Autism Community Discharge Grant to support discharges into the community.

2.4 The SR20 also provided a further £3 billion to support NHS recovery from the impacts of COVID-19 in 2021-22, on top of the LTP settlement. This includes around £1 billion to begin tackling the elective backlog; and around £500m for mental health services and investment in the NHS workforce.

2.5 The SR20 settled non-NHS revenue budgets for 2021-22. This includes £260 million for HEE to continue to support the education and training of the NHS's workforce and deliver on the commitments of the LTP. Included within this is funding for training more new nurses and doctors, delivering some of the biggest undergraduate intakes ever.

2.6 The SR settlement delivers a 3.5% real terms a year increase on DHSC's overall core resource budget (excluding COVID-19 funding) since 2019-20. Increasing these vital budgets will further enable the NHS to deliver a better service and health outcomes for patients. Despite the settlement, COVID-19 has placed strain on NHS finances as described below.

Figure 2.1 - Opening mandate for NHS England

NHS England (NHSE)	NHSE Revenue Departmental Expenditure Limits (RDEL) excluding ringfence (RF) (cash) £bn*	NHSE Capital Departmental Expenditure Limits (CDEL) excluding ringfence (RF) (cash) £bn
2013-14	93.676	0.200
2014-15	97.017	0.270
2015-16	100.200	0.300
2016-17	105.702	0.260
2017-18	109.536	0.247
2018-19	114.603	0.254
2019-20	123.377	0.260
2020-21	129.681	0.305
2021-22	136.134	-
2022-23	142.841	-
2023-24	151.318	-

Source: 2020-21 Financial Directions to NHS England

2.7 Figure 2.1 above shows the opening mandate for NHS England (NHSE) in 2020-21, and indicative amounts for future years, as per NHSE's Financial Directions. These figures include an increase for pensions revaluation which was provided alongside the LTP settlement. Figures exclude depreciation, AME and technical budget.

2.8 The LTP commitment gives the NHS the financial security to address challenges in a sustainable manner. There will be multiple calls on available funding, including pay, and these will need careful prioritisation in order stay within available funding. More funding put towards pay will mean less funding for other priorities, including the size of the workforce that is affordable, as well as wider investments required to deliver the NHS LTP.

2.9 It is essential this money is spent wisely, which is why the Government set five financial tests alongside the LTP settlement to ensure the service is put on a more sustainable footing for the future. The five tests are:

(a) The NHS (including providers) will return to financial balance;

(b) The NHS will achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care;

(c) The NHS will reduce the growth in demand for care through better integration and prevention;

(d) The NHS will reduce variation across the health system, improving providers' financial and operational performance.

(e) The NHS will make better use of capital investment and its existing assets to drive transformation.

2.10 While the five tests remain important to the delivery of the LTP, the onset of the global pandemic has meant reporting against the tests has rightly been temporarily put on hold to allow the system to focus on managing and responding to the developing pandemic.

Financial Position

2.11 The Government's 2020-21 Mandate to the NHS provides clarity on headline objectives for the NHS. The financial directions to NHSE published alongside the Mandate partially reflect further funding to deliver manifesto commitments agreed at Budget 2020 and do not fully reflect emergency COVID-19 funding. Given the nature of COVID-19, the Mandate reinforces the importance of public money being spent with care on targeted, timely and time-limited interventions.

2.12 Although recovering finances in the NHS continues to be a major focus, in these exceptional circumstances funding the response to COVID-19 has been, and continues to be, a priority. In 2015-16 disciplined financial management was reintroduced to stabilise finances and secure the immediate future of our health service. NHS leaders devised a plan of action, in operation since July 2016, involving a series of controls and levers designed to exert tighter control over local organisations.

2.13 This approach has been broadly successful in doing what it set out to achieve – notably we have seen a stabilising of finances across NHS providers, with the majority of trusts demonstrating strong, effective and sustainable financial management.

2.14 In the 2019-20 financial year the NHS balanced its financial budget based on opening accounts of NHS planned spend, excluding COVID-19 spend. Through continuing focus on financial rigour and efficiency, most Trusts have once again met their control totals.

2.15 This financial rigour and efficiency will need to continue in future years to help recover from COVID-19. The impact will be felt across the health and social care system in the 2020-21 financial year and beyond.

2.16 2019-20 was the first year of the LTP period and represented a step towards these longer- term ambitions; where both commissioner and provider sectors move towards aggregate financial balance and fewer organisations end the year in deficit. Significant progress was made pre COVID-19, with the NHS once again delivering overall financial balance, with the number of trusts in deficit reduced by half and finances in most trusts and commissioners in a much healthier position than seen in previous years. A minority of trusts remain with significant deficit levels, but a number of those have hit their agreed financial targets and were on track to recovery.

2.17 While the majority of COVID-19 related spend will occur in future financial years, spending impacts have been felt in February and March of 2019-20. Those trusts affected and the NHS overall have been fully supported with funding and financing at the right time, and all spending pressures have been met.

Figure 2.2 - NHS Providers RDEL Breakdown

NHS Providers RDEL Breakdown	2015-16	2016-17	2017-18	2018-19	2019-20
Total Resource DEL (£m)	2,548	935	1,038	826	1,008
Provisions Adjustment (£m)	-74	-43	-39	23	50
Other Adjustments (£m)	-27	-101	-8	-22	-159
Aggregate Net Deficit (£m)	2,448	791	991	827	899
Unallocated Sustainability Funding (£m)	0	0	-25	0	-144
Adjust Net COVID-19 Impact (£m)	0	0	0	0	-85
Reported Net Deficit (£m)	2,448	791	966	827	669

Share of Resources Going to Pay

2.18 Figure 2.3 shows the proportion of funding consumed by NHS provider permanent staff spend over the last five years. Note that NHS provider permanent staff spend only covers staff working within hospital and community health settings, and so excludes General Practitioners, GP practice staff and General Dental Practitioners.

Figure 2.3 - Increases in Revenue Expenditure and the Proportion Consumed by Pay bill

Year	NHSE RDEL (£bn)	NHS Provider Permanent and Bank Staff Spend (£bn)	% of spend on staff	Increase in total spend	Increase in provider permanent and bank staff spend
2013/14	93.7	42.9	45.8%	n/a	n/a
2014/15	97.0	43.9	45.3%	3.57%	2.37%
2015/16	100.2	45.2	45.1%	3.28%	2.80%
2016/17	105.7	47.7	45.1%	5.49%	5.58%
2017/18	109.5	49.9	45.6%	3.63%	4.64%
2018/19	114.4	52.6	45.9%	4.46%	5.35%
2019/20	120.5	56.1	46.6%	5.34%	6.76%

Notes: 2018/19 - retrospective adjustment to RDEL total (2018-19 Revised Financial Directions) 2019/20 - excludes £2.8 billion for revaluation of NHS pensions

2.19 Up until the financial year 2017-18, under the public sector pay cap, pay rises across the health service remained largely around 1%. However, in 2018 the NHS Staff Council (a partnership of NHS Employers and NHS trades unions) reached an agreement with the NHS on the multi-year AfC (AfC) pay and contract reform deal (2018/19 – 2020/21) resulting in several pay and non-pay reforms to support recruitment and retention, improve productivity and increase capacity

2.20 In 2019, the Government also reached agreement with the BMA on a multi-year deal for junior doctors (2019/20 – 22/23) providing certainty over pay and supporting recruitment, training and retention, which guaranteed an annual pay uplift of 2 per cent each year.

2.21 The Government is in negotiations with the BMA on new contractual arrangements for SAS doctors. Subject to the relevant outcomes being achieved, the Government has made a financial envelope broadly commensurate with other recent multi-year pay and contract reform agreements.

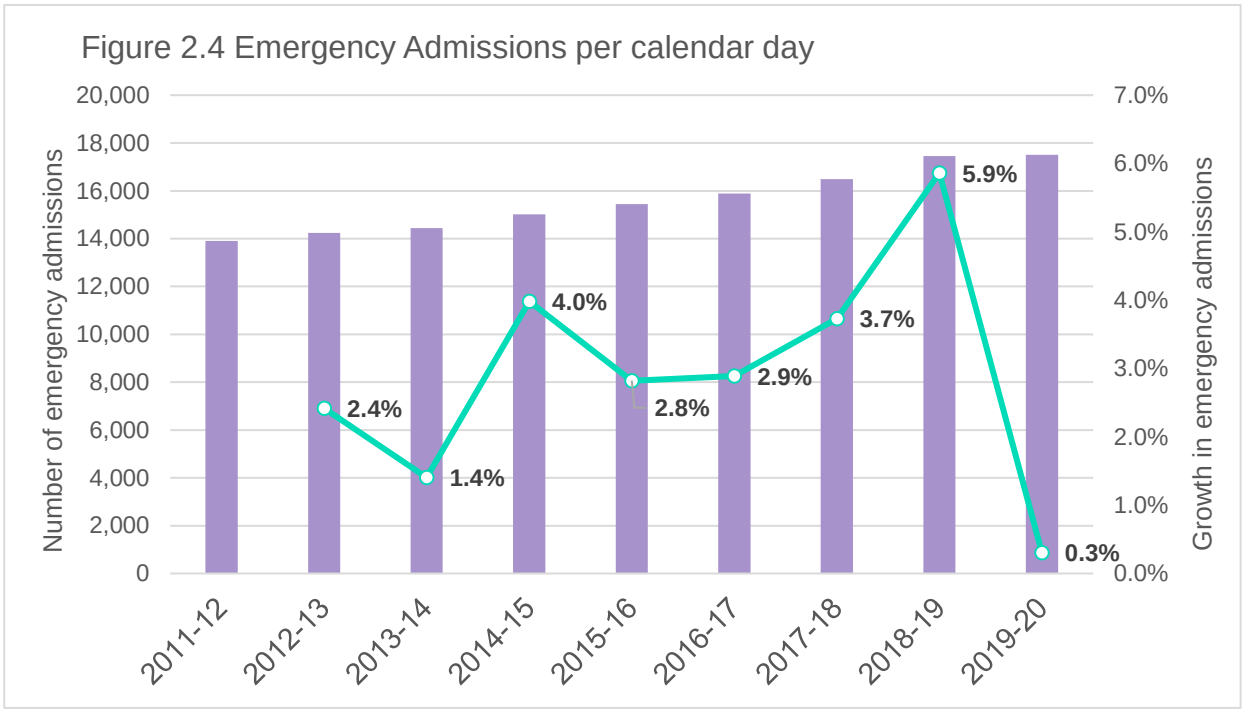
2.22 Pay over the three-year period of the AfC deal and the two years of the junior doctor deal has increased beyond the level of inflation and together with the increase in staffing numbers this has meant a greater proportion of spend going to pay and being spent on staff. This trend is important to bear in mind when considering the affordability of pay recommendations particularly considering the challenging fiscal and economic context, along with other pre-existing pressures such as an ageing population.

2.23 DHSC has embarked on pay and contract reform right across the NHS workforce as part of our ambition to make the NHS the best employer in the world providing the very best and safest care. As these reforms have illustrated this is not just about headline pay but delivering changes that will help improve the working lives and the physical and mental health and wellbeing of all our dedicated NHS staff.

Demand Pressures

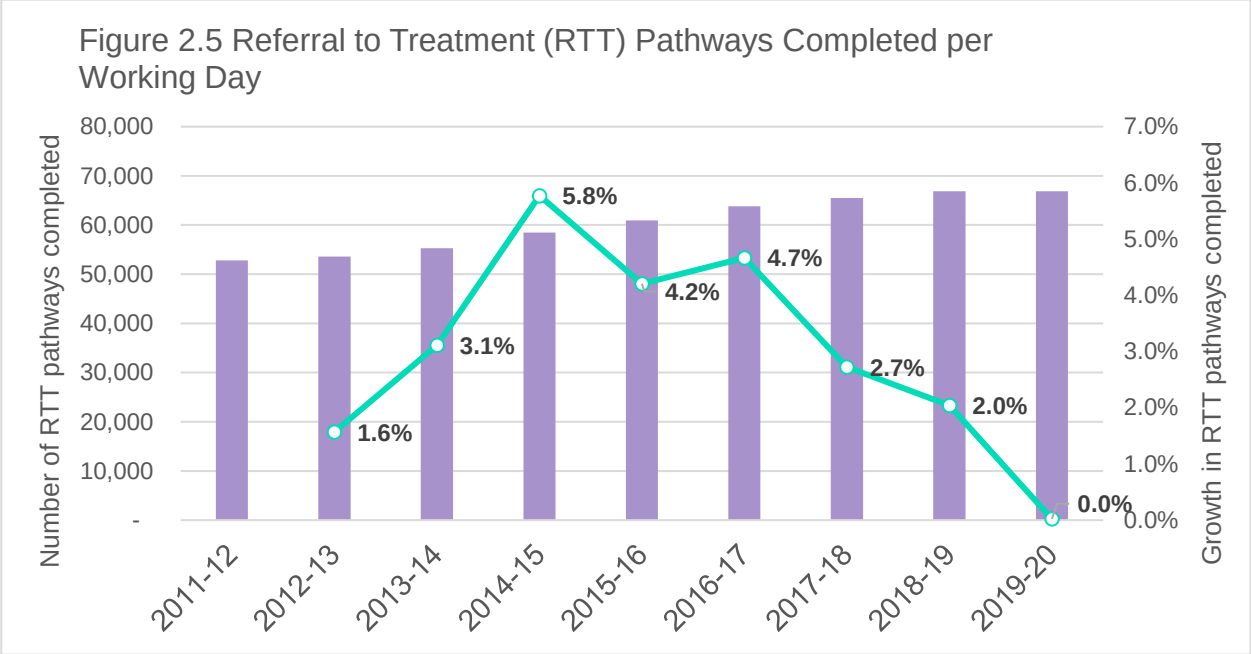
2.24 We had been seeing a rise in demand for services provided in the health system during 2019-20. However, due to the onset of COVID-19 at the end of the financial year, there was a reduction in elective and emergency activity as numbers of self-presenting patients reduced and the NHS freed-up capacity to manage COVID-19 demand. This included suspending all non-urgent elective operations. As a result, full-year growth has ultimately remained flat compared to 2018-19.

Figure 2.4 - Emergency Admissions – per calendar day



Source: A&E attendances & Emergency Admission Statistics

Figure 2.5 - Referral To Treatment (RTT) Pathways Completed per Working Day



Source: NHSE Consultant Led Referral to Treatment Statistics. Data adjusted for non-submitting Trusts and exclusion of sexual health services from 2013.

2.25 Compared to the year before, in 2019-20 there were 53 (0.3%) more emergency admissions per day. There were also only 15 more elective care pathways completed per working day, as shown in Figures 2.4 and 2.5.

2.26 Despite the continuing best efforts of the NHS, many of the core waiting time and access targets were not achieved during 2019-20, largely due to the increasing demand pressures placed on frontline services throughout the year, including prior to COVID-19. These included A&E, referral to treatment, cancer treatment, diagnostic tests and ambulance response standards.

2.27 The Government is committed to supporting NHS capacity during surges in COVID-19 cases alongside the increased pressures on the system during winter. This is whilst also working hard to deliver the maximum elective activity possible.

2.28 £3bn of additional funding was announced in July to support the NHS this winter. This ensures Nightingale hospital surge capacity is available when needed, that the NHS has ongoing access to additional independent sector bed capacity, and funding to support the safe discharge of patients from NHS hospitals which can help ease pressure on hospital beds. In addition, £450m of capital funding is being provided to hospitals across the country to upgrade A&E's this winter to increase capacity, reduce overcrowding and improve infection control

2.29 Longer term, the SR funding includes £1billion to address backlogs and tackle long waits, by facilitating up to 1 million extra checks, scans and additional operations for the 2021-22 financial year.

Productivity and Efficiency in the NHS

2.30 Putting the NHS onto a sustainable financial path will be key to its recovery from the COVID-19 pandemic. Making productivity improvements will be a central part of this path.

2.31 Through the five financial tests, the Government set the NHS a stretching but realistic goal of making productivity growth of at least 1.1% per year, with all savings reinvested in front line care. The impact of COVID-19 has caused major disruption to this goal, as the system has not had capacity to plan for and deliver efficiencies. The additional £3 billion of funding set out in SR20 will help the NHS to get back on track to delivering the LTP, but the Government recognises that recovering previous efficiency plans in the short term will be challenging.

2.32 COVID-19 has made improving productivity more important than ever. Improved efficiency will be needed to deal with increased waiting lists caused by cancellations during the epidemic and ensure that patients can be treated effectively while Infection Control Procedures are still in place. During COVID, the NHS has also found more effective ways to work and has accelerated some efficiency programmes, such as virtual appointments.

2.33 NHSEI has several priorities for improving productivity and efficiency across the NHS:

(a) Workforce productivity:

- Using the right staff in the right place at the right time: this includes using workforce deployment and planning tools (including e-rostering and e-job planning) to use the most effective staff, match workforce to need, and reduce agency spend and absence. It is supported by improved skill mix models to tackle staff shortages by staffing teams by capability instead of job title.

- Clinical productivity: NHSEI and GIRFT are collaboratively redesigning elective care pathways to reduce variation and improve performance across surgery, diagnostics and outpatients. Standardising high volume, low acuity procedures and driving to top decile performance will boost throughout and ease capacity. This is linked to improving theatre productivity by ensuring lists are full and cancellations and gaps between cases are minimised.

- Digitisation: Using digital tools such as single sign-on, improved communication tools, and shared care records to save clinical staff time that can be better spent caring for patients.

- In addition to workforce productivity programmes, the wider productivity improvements support workforce productivity improvements in specific areas:

  (b) Diagnostics improvement – This includes improvements through consolidation of imaging and pathology networks and upgrading digital infrastructure. This will enable improved skill mix and will allow diagnostics teams to work more flexibly, e.g. by allowing for home reporting.

  (c) Hospital medicines and pharmacy improvement – This includes aseptic pharmacy transformation that will free up time equivalent to 4000 WTE nurses through development of hub and spoke networks and use of robotics, continued roll-out of electronic prescribing to save time on routine medicines administration, and making better use of clinical pharmacists to release medical staff.

  (d) Outpatients transformation – Reducing the number of face-to-face appointments by a third by 2023/24 through improved clinical pathways, use of virtual consultations, and a greater role for patient decision making.

  (e) Mental health improvement, Ambulances, and Community Health – This includes a range of tools to improve productivity, including a no wrong door approach in mental health to cut the cost of repeat assessments and admin, make ready hubs so that ambulance crews can start shifts immediately, and greater use of digital in community healthcare.

  (f) Primary Care – This includes continuing the Time for Care programme that uses similar approaches to general workforce productivity programmes to free up GP time.

2.34 Planned improvements to workforce productivity are linked to the ambitions of the 2020/21 NHS People Plan to deliver new ways of working and delivering care while supporting staff. The People Plan supports more flexible and remote working, as supported by e-rostering software and digitisation in diagnostics and outpatients. The Plan states the NHS will make the best use of skills within its teams, as supported by NHSEI's new skill mix models and multi-professional workforce planning teams. Further information on the NHS People Plan is set out in Chapter 4.

2.35 The programmes to deliver the required productivity improvements build on the recommendations of the 2016 Carter Review and the Operational Productivity

programme that aimed to reduce unwarranted variation across NHS acute, mental health, ambulance, and community Trusts. Lord Carter's review identified £5.8bn in potential savings from improving productivity across workforce, diagnostics, medicines and pharmacy, corporate services, estates, procurement, ambulances, and mental and community health. In 2018/19, these programmes delivered £1.45bn in savings and had delivered £801.7m in recurrent Cost Improvement Plans through to January 2020 (collection of data was paused due to COVID-19). In total, the Carter Programme had delivered £3.57bn in savings by January 2020.

2.36 The productivity programmes are also closely linked to NHSEI's Clinical Improvement programmes, Getting It Right First Time and Right Care. These programmes aim primarily to improve patient outcomes and patient safety by reducing unwarranted variation in surgical and clinical practice, with the secondary benefits of improving productivity and saving money.

2.37 Alongside this, progress has been made in reducing the reliance on the use of expensive agency staff within the NHS, reducing spending on agency workers to £2.38 billion in 2019/20 compared to £3.6bn in 2015/16. Agency spend in 19/20 accounted for 4.0% of the overall NHS Pay bill, down from 7.8% at its peak in 2015/16. The overall average price per agency shift decreased by 1.3% from 2018/19, resulting in an overall saving of £19m (0.8%).

2.38 The Department and NHSEI have created a Flexible Staffing strategy that aims to reduce agency spend by developing and promoting alternative flexible working arrangements (see Chapter 4 for NHS People Plan commitments on flexible working). We aim to:

- Grow and develop the NHS substantive flexible offer.
- Continue our work on the development of Trust level bank capability, including the development of collaborative banks across several NHS Trusts.
- Support NHSEI and the Department to capture the returners and volunteers from the COVID-19 response and create a model that can be used to ease pressure in the NHS in the future.
- Continue the monitoring of compliance with Agency rules as well as continuing our work with NHSEI on reducing agency spend.

Calculating Productivity in the NHS

2.39 Labour productivity is calculated by dividing total NHS output by an appropriate measure of labour input (usually some form of a weighted sum of staff numbers and hours worked). It measures the amount of output generated per 'unit' of labour, and as such, is an important component of efficiency.

2.40 The measure of labour productivity we use for the NHS in England is that developed by the University of York (Centre for Health Economics, CHE). The York measure uses a range of NHS data sources to assess outputs and inputs, as well as adjusting the output measure to take some account of quality change, including change in waiting times and death rates. Their figures show between 2005/06 and 2015/16 the NHS's average annual labour productivity was 2.5%.

2.41 Labour productivity is an important component of efficiency, but labour inputs account for only around half of the total cost of the NHS. A broader measure of productivity divides total output by an appropriate measure of all inputs, e.g. including drugs as an input. This is called total factor productivity and is also measured by York University (CHE). Their figures show that between 2005/06 and 2015/16 the NHS's average annual total factor productivity growth was 1.2%.

2.42 Although the average total factor productivity growth between 2005-06 and 2015-16 reflects the progress made by the NHS workforce's committed efforts to improving productivity where possible, there still remains areas for improvement which must be targeted if the objectives set out in the LTP are to be achieved.

2.43 More generally, productivity, as formally defined here, does not take into account the costs of inputs, including changes in staff pay. A full measure of technical efficiency would, in addition, factor in changes in pay and the cost of inputs relative to a suitable deflator. If pay increases more quickly than GDP deflator, this would have a negative effect on technical efficiency.

2.44 It is hard to identify productivity for individual staff groups as each unit of output is generated by a combination of different staff groups, from consultants and nurses, to management and support staff. It is difficult to disaggregate the productivity of these groups when they are contributing to the same unit of output.

2.45 The input factor of productivity can be more easily broken down by staff group. The labour input in York CHE's productivity measure is a weighted combination of different staff groups; the growths for each staff group is summarised in Chapter 4 of this evidence.

Figure 2.6 - York CHE Total Factor Productivity

Year	Quality Adjusted Output	Total Input	Total Factor productivity
2005/06	7.1%	7.2%	-0.1%
2006/07	6.5%	1.9%	4.5%
2007/08	3.7%	3.9%	-0.2%
2008/09	5.7%	4.2%	1.4%
2009/10	4.1%	5.4%	-1.3%
2010/11	4.6%	1.3%	3.2%
2011/12	3.2%	1.0%	2.1%
2012/13	2.3%	2.0%	0.4%
2013/14	2.6%	0.4%	2.2%
2014/15	2.5%	1.9%	0.5%
2015/16	2.6%	2.7%	-0.2%
2016/17	3.5%	0.6%	2.9%
2017/18	1.7%	0.5%	1.3%

Note: Figures are all quality adjusted so take into account changes in quality of care (e.g. waiting times)

Figure 2.7 - York CHE Labour Productivity

Year	Quality Adjusted Output	Labour Input	Labour Productivity
2005/06	7.1%	3.4%	3.6%
2006/07	6.5%	0.6%	5.9%
2007/08	3.7%	0.7%	2.9%
2008/09	5.7%	4.1%	1.5%
2009/10	4.1%	4.5%	-0.4%
2010/11	4.6%	1.4%	3.1%
2011/12	3.2%	0.1%	3.1%
2012/13	2.3%	-2.0%	4.4%
2013/14	2.6%	0.4%	2.3%
2014/15	2.5%	2.8%	-0.3%
2015/16	2.6%	1.3%	1.3%
2016/17	3.5%	2.4%	1.1%
2017/18	1.7%	2.4%	-0.6%

Note: Figures are all quality adjusted so take into account changes in quality of care (e.g. waiting times)

2.46 If the NHS is 1% more productive than last year it will produce 1% more output (e.g. treatments) per input (e.g. per doctor/nurse). Hence, with fixed inputs it will deliver 1% more output (e.g. treatments). This means within a fixed funding envelope the NHS can increase treatments by 1% (to meet increased demand) or increase input prices by 1% (e.g. increase wages) or a mixture of the two.

2.47 The 2019 Report from the DDRB included a request for an update on progress with regards to a common understanding of NHS productivity. A working group has been formed between DHSC and NHSEI which has begun to examine early outputs; we will provide a further update when these are mature enough to report on.

Conclusion

2.48 The additional funding provided to handle COVID-19 has further reinforced the Government's continued financial commitment to the NHS. The SR20 provided a further £3 billion to support NHS recovery from the impacts of COVID-19 in 2021-22, on top of the LTP settlement. This includes around £1 billion to begin tackling the elective backlog; and around £500m for mental health services and investment in the NHS workforce.

2.49 To help control the spread of infection, employers have been supported financially to ensure that staff are given full pay where they are told to self-isolate and where they are off sick because they are infectious with the COVID-19 virus. Funding has not only been given to recognise the increased cost of sickness absence during the pandemic, but also to cover the unprecedented backfill costs which have arisen through staff having to self-isolate.

2.50 This support is also evident in the agreed multi-year funding deal for junior doctors and staff on AfC contracts. The agreed 2018 AfC multi-year deal provided a new pay structure that reinforced public sector pay policy of increased pay flexibility in return for reforms that improve recruitment and retention while boosting productivity. Over a million NHS staff received pay rises in April 2020 from existing multi-year deals and in July we accepted the independent pay review body’s recommendations of a 2.8% pay rise for SAS doctors, dentists, consultants and salaried GPs.

2.51 Additionally, the Government accepted most of the recommendations made by the DDRB for 2020-21, rewarding staff dedication and productivity improvements, as well as encouraging recruitment and retention.

2.52 The NHS employment and reward offer is not just about headline pay but includes a much broader total reward package. This includes a range of benefits exceeding

those offered in many other sectors such as annual leave and sickness absence arrangements well beyond the statutory minimum, as well as access to a much-valued pension scheme and support for learning, development and career progression. Total reward is discussed in greater detail in Chapter 7.

2.53 COVID-19 has resulted in additional financial pressures. These are not only the direct costs of dealing with the pandemic, but also indirect costs into future years from the consequences of lost efficiency opportunities during the course of 20/21. These indirect costs include potential productivity gains foregone. Indirect costs have been recognised in the SR settlement, but there is still an expectation that the NHS can catch-up on some of the lost efficiency and make greater productivity savings in 21/22 than the LTP originally expected. This is so that the NHS can get back towards the longer-term ambition of returning all organisations within the NHS to financial balance.

2.54 It is consequently important that the 2021/22 pay awards support the Government's objective to deliver long-term financial sustainability in the NHS, as well as aligning with the full range of investment priorities in the NHS LTP, in light of COVID-19.

3. Hospital and Community Health Sector (HCHS) Staff Earnings for Staff working under NHS Terms and Conditions

3.1 This chapter provides detail on earnings for AfC staff in the HCHS sector (NHS Terms and Conditions).

Introduction and Summary

3.2 The NHSPRB's remit group covers staff working under NHS Terms and Conditions (NHS TCS) formerly known as "Agenda for Change". It is a wide and diverse workforce covering over 1 million clinical and non-clinical Staff working in the Hospital and Community Health Sector (HCHS) in England. In 2020-21 basic pay for the group ranges from £18,005 in Band 1 through to £104,927 at the top of Band 9.

3.3 This chapter provides information on the pay and earnings of staff employed in the HCHS sector in England working under the NHS TCS Contract and makes comparisons to those working elsewhere in the economy. On a broader scale the goals of pay policy include supporting recruitment & retention and delivery of manifesto commitments (see **Chapter 5**) while ensuring the workforce remains affordable (see **Chapter 2**).

3.4 Over the last financial year (2019/20) average earnings for NHS TCS staff increased by 3.1% and have risen by 6.1% since the start of the multi-year agreement of 2018 and are expected to increase by around 3% in 2020/21 as a result of the final year of the agreement.

3.5 Earnings growth during the first two years of the deal were similar to that in the wider economy, and above the level of inflation, before the economic impacts of the COVID-19 pandemic began to emerge. Assessments of longer-term HCHS earnings should consider the impact of the pandemic on the wider labour market which are not yet fully apparent.

3.6 In addition to the headline pay award individual members of staff may also be eligible to access higher earnings growth as a result of pay progression, promotion or , in 2021/22, due to pay scale reform completion. The impact of this is dependent on an individuals band and how long they have been employed in the NHS.

3.7 2020/21 sees the end of the three-year deal agreed in 2018 which made key changes to reform the contract and support recruitment, retention and productivity by investing in all pay points, reducing the number of pay points in each band and ending automatic pay progression (see Chapter 6 for an update on the implementation of the multi-year deal). The pay scale reform will be fully implemented in 2021.

3.8 Whilst we have invested in all parts of the contract, we understand that pay progression and promotion may mean that the experiences of individual members of staff may vary depending on what role they are in and where they sit within their band.

3.9 The ongoing impacts of the pandemic have introduced a great deal of uncertainty in the NHS and beyond. In response to the emergency, changes were made to Terms & Conditions, to support individuals and the service, including enhanced sick pay for those with the virus. It has also been an unprecedented period for the wider economy, with the full impacts likely not yet visible in the data. As such this evidence should be read in conjunction with evidence submitted by HMT.

3.10 The remainder of this chapter will present the latest data on pay including information on trends and the key factors driving change. We then look at how individual employees experience the pay system and make comparisons with the wider economy.

Average Pay & Earnings in HCHS Sector

3.11 This section looks at the current levels of average pay and earnings for staff in the HCHS sector and how it varies by workforce. Pay and earnings form only part of the total reward package, which also includes access to sick pay and the opportunity to join the NHS pension scheme. More information on the value of the total reward package is available in **Chapter 7**.

3.12 Pay and earnings within a staff group reflect the "band-mix" of that group. A staff group, such as Nurses, that are predominately in Bands 5-7, will have higher average earnings than staff in support roles, typically Bands 2-4. There may be times when differences in earnings growth between staff groups can be explained by what pay increases were given to each band. If pay is increased more in the lower bands than staff groups with more staff at lower bands will receive a higher average award.

3.13 NHS Digital produce three ways to measure levels of pay. These are:

(a) Basic Pay per FTE - The average level of basic pay per unit of capacity (FTE). In cases where someone works on a part-time basis (FTE <1) the basic pay is scaled as if they were working on a full-time basis.

(b) Basic Pay per Person - The average level of basic pay received without applying any scaling for people working on a part-time basis. Effectively this is the total amount of basic pay divided by total headcount.

(c) Total Earnings per Person - The average amount of total earnings without applying any scaling for people working on a part-time basis. This is the total amount paid to staff, including any additional earnings like geographical payments or shift work, divided by total headcount.

3.14 When comparing the NHS TCS with other workforce groups care may be required due to the make up of the workforce and demands of the healthcare service. For instance, the need to maintain around the clock services may mean that staff will have different working patterns, including increased requirements for work during evenings, weekends and Bank Holidays.

3.15 Figure 3.1 shows the current level of these measures split by staff group for the 12-months to the end of March 2020 and growth compared to the 12-months to the end of March 2019.

Figure 3.1 - Average Pay and Earnings by Staff Group - 12 months to March 2020

Staff Group	Total Earnings per Person	Basic Pay per Person	Additional Earnings per Person	Additional Earnings Proportion	Earnings Growth	Basic Pay Growth
Nurses & health visitors	£33,540	£29,513	£4,028	12%	3.3%	2.9%
Midwives	£33,505	£28,547	£4,958	15%	3.5%	3.2%
Ambulance staff	£40,782	£29,863	£10,919	27%	11.2%	11.8%
Scientific, therapeutic & technical staff	£34,658	£31,911	£2,747	8%	4.0%	3.6%
Support to clinical staff	£20,063	£17,546	£2,519	13%	3.4%	2.9%
Support to doctors, nurses & midwives	£19,654	£17,186	£2,469	13%	2.4%	2.4%
Support to ambulance staff	£26,166	£19,885	£6,284	24%	8.7%	6.5%

Support to ST&T staff	£19,637	£18,190	£1,456	7%	3.6%	3.1%
Infrastructure support	£29,779	£27,440	£2,339	8%	3.0%	2.7%
Central functions	£26,368	£24,913	£1,454	6%	3.9%	3.6%
Hotel, property & estates	£19,025	£15,696	£3,330	18%	2.1%	2.0%
Senior managers	£80,357	£76,971	£3,386	4%	2.6%	2.0%
Managers	£50,942	£48,396	£2,546	5%	4.8%	4.3%
All NHS TCS	£28,387	£26,261	£2,126	7%	3.1%	3.0%

Source: NHS Digital Earnings Statistics

3.16 The largest growth in earnings over the past year appear in the ambulance (11.2%) and support to ambulance (8.7%) staff groups. This is largely a result of changes to staff coding which resulted in some, mainly Band 4, staff being reclassified as being in the support grouping rather than the qualified group. This increases the average banding for both groups and thus increases average pay for both.

3.17 Additional earnings cover all payments to staff other than basic pay such as geographical payments, unsocial hours premiums or overtime enhancements. Those working for the Ambulance service have the highest proportion of additional hours due to higher than average levels of unsocial hours and overtime pay.

3.18 Variation in additional earnings reflect differences in things like working patterns and responsibilities between staff groups. For example, some groups may be more likely to work unsocial hours in order to maintain a 24/7 service.

3.19 The Review Body has previously asked for analysis relating to unsocial hours payments for ambulance staff, following changes as part of the 2018 NHS agreement which meant that unsocial hours payments for new ambulance staff would be on the same terms as other NHS TCS staff. This does not appear to have impacted the proportion of earnings that come through unsocial hours for ambulance staff which has been constant at around 15% for qualified staff and 12% for those in support roles.

3.20 Usage of RRPs remains low across the NHS TCS contract and has fallen in recent years. For NHS TCS staff the use of RRPs may reflect the legacy use of "Cost of Living" payments under the precursor to AfC.

3.21 The Review Bodies have requested evidence on earnings for staff in Bands 8a and above. Average earnings in the 12 months to the end of March 2020 range from just over £45,000 for staff in Band 8a to over £98,000 for those in Band 9. The proportion of additional earnings are lower for staff in the highest bands as

they are less likely to work unsocial hours and are not eligible to receive overtime payments.

Figure 3.2 - NHS TCS Earnings by Band - 2015/16 to 2019/20

Basic Pay per FTE	2015/16	2016/17	2017/18	2018/19	2019/20	1 Year Increase
Band 8a	£45,166	£45,372	£45,857	£47,007	£47,997	2.1%
Band 8b	£54,101	£54,281	£54,926	£56,249	£57,384	2.0%
Band 8c	£64,089	£64,314	£65,042	£66,730	£68,098	2.0%
Band 8d	£77,120	£77,389	£78,247	£79,940	£81,454	1.9%
Band 9	£92,518	£93,100	£94,371	£96,258	£98,251	2.1%

Total Earnings per person	2015/16	2016/17	2017/18	2018/19	2019/20	1 Year Increase
Band 8a	£43,118	£43,244	£43,616	£44,560	£45,671	2.5%
Band 8b	£52,385	£52,516	£53,091	£54,245	£55,430	2.2%
Band 8c	£62,459	£62,816	£63,428	£64,978	£66,520	2.4%
Band 8d	£76,750	£76,898	£77,881	£79,622	£81,368	2.2%
Band 9	£93,183	£94,162	£95,275	£96,998	£98,787	1.8%

Source: NHS Digital Earnings Statistics (NHS Trusts & CCGs only)

Source data for use of basic pay, additional earnings and RRP payments is available as part of NHS Digital Earnings publications. The data used in this evidence is available at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-staff-earnings-estimates/march-2020-provsional-statistics

Drivers of Growth in Earnings

3.22 Average earnings change for many reasons. Some relate to changes in the composition of the workforce (e.g. more senior staff or more staff in higher earning occupations), some relate more specifically to pay rates. Figure 3.3 presents trends in earnings growth and its component drivers over recent years. This is based on DHSC analysis of earnings and workforce data from NHS Digital, combined with information on pay awards, and is based on growth in earnings per FTE.

Figure 3.3 - Breakdown of Average Earnings Growth for NHS TCS staff

Pay Growth Element	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Basic Pay per FTE Growth	-0.2%	0.7%	0.7%	1.3%	3.2%	2.9%
Additional Earnings per FTE Growth	2.7%	-3.8%	-2.0%	-0.8%	0.2%	5.4%
Total Earnings per FTE Growth	0.1%	0.2%	0.4%	1.1%	2.9%	3.2%

Of which:

Headline Pay Awards	0.4%	0.5%	1.0%	1.0%	3.1%	3.3%
Total Earnings Drift	-0.3%	-0.2%	-0.6%	0.1%	-0.1%	-0.1%

Of which:

Basic Pay Drift	-0.1%	0.0%	-0.1%	0.2%	0.1%	0.3%
Additional Earnings Drift	-0.1%	0.0%	-0.3%	-0.2%	-0.3%	-0.1%
Staff Group Mix Effect	-0.1%	-0.2%	-0.1%	0.1%	0.1%	-0.3%

Source: DHSC HCHS Paybill Metrics

3.23 Average total earnings per FTE grew by 3.2% in 2019-20, reflecting the combined impact of the 2019-20 headline pay award of 3.3% (which includes a one-off non-consolidated payment to staff at the top of their band and the impact of payscale reform), and a slightly negative total earnings drift (-0.1%). Growth in earnings per FTE (3.2%) are slightly higher than growth in earnings per person (3.1%, Table 3.1). This might happen when more people work part-time and headcount increases more than FTE.

3.24 Total earnings drift, the difference between earnings growth and headline pay awards, reflects the combined effect of:

- A positive "basic pay drift" of 0.3% in 2019/20 (meaning that average basic pay increased by more than the change to headline basic pay rates). This might be caused by having more staff at higher bands within a staff group or more people at higher pay points within an NHS TCS Band.

- An ongoing negative "additional earnings drift" which is suggestive of a reduced use of additional earnings payments. Although additional earnings per FTE grew at 5.4%, this includes the effect of the one-off non-consolidated payment in 2019-20 to staff at top of their band (which counts towards additional earnings). The negative additional earnings drift indicates that, excluding the non-consolidated payments, growth in other additional earnings did not match the growth in basic pay that many types of additional earnings are tied to.

- A negative "staff group mix" effect of -0.3% reflecting a shift toward lower earning staff groups in 2019-20.

Impact of the 2018 NHS TCS Agreement

3.25 In 2018 a three-year deal was reached for staff working under NHS TCS covering the years 2018-19, 2019-20 and 2020-21, chapter 6 provides further implementation on the deal. The agreement:

(a) Supports recruitment and retention by increasing starting pay for all bands, increasing pay for those already at the top of band and reducing the length of time to reach the top of band.

(b) Supports staff engagement by placing a firmer emphasis on staff appraisal and development. It also makes staff wellbeing, including a reduction in sickness absence, a priority.

(c) Made other changes to Terms & Conditions including an end to automatic pay progression alongside other changes in relation to unsocial hours payments and enhanced Shared Parental Leave.

3.26 This section provides information on changes to paybill under the agreement, some of the factors driving those changes and answers to specific questions set by the PRB. NHSEI are leading work to assess the benefits of the agreement and the latest detail on this is included in their evidence although at this stage it is likely too early to determine the impact of the agreement as it has yet to be fully implemented and confounding factors, including COVID-19, will complicate analysis.

Paybill Growth over the course of the Agreement

3.27 Growth in aggregate paybill is driven by the growth in average earnings per FTE discussed above, plus changes in employer on-costs (employer National Insurance and pension contributions) and growth in the overall workforce.

3.28 Figure 3.4 presents growth in aggregate paybill for the remit group and its component drivers over the first two years of the three-year deal agreed in 2018. The final year of the agreement will conclude in March 2021.

3.29 Aggregate paybill grew by 17.0% between 2017-18 and 2019-20, reflecting the combined effect of 5.2% growth in total FTE and 11.2% growth in paybill per FTE.

3.30 The growth in paybill per FTE reflects the impact of headline pay awards plus paybill drift, which differs from total earnings drift discussed above due to the additional effect of employer on-costs drift. (The headline pay award figures in Table 3.4 reflect the impact of awards on paybill per FTE, which may differ slightly from the corresponding impact on earnings per FTE in Table 3.3).

3.31 On-costs drift had a neutral effect (0.0%) in 2018-19, with average paybill growth being similar to average earnings growth.

On-costs drift had a large positive effect (4.7%) in 2019-20. This is due to an increase in the employer pension contribution rate from April 2019.

Figure 3.4 - Breakdown of Aggregate Paybill Growth for NHS TCS staff

Pay Growth Element	**2018/19**	**2019/20**	**Cumulative** **2018/19 and 2019/20**
Aggregate Paybill Growth	5.1%	11.4%	17.0%
Components of Paybill Growth: FTE Growth	2.0%	3.2%	5.2%
Components of Paybill Growth: Paybill per FTE Growth	3.1%	7.9%	11.2%

Of which:

Headline Pay Awards	3.1%	3.3%	6.6%
Paybill Drift	-0.1%	4.6%	4.6%

Of which:

Total Earnings Drift (excluding Staff Group Mix Effect)	-0.2%	0.1%	-0.1%

Employer On-costs Drift	0.0%	4.7%	4.9%
Staff Group Mix Effect	0.1%	-0.3%	-0.2%

Source: DHSC HCHS Paybill Metrics

3.32 For employees a key objective of the agreement was to support recruitment and retention by increasing pay for new entrants as well as those who are at the top of the pay band. Figure 3.5 shows how pay rates have changed since 2015/16. Starting salaries in each band have increased by between 15% (Band 8c) and 25% (Band 7). Staff who have been at the top of bands 2-8c have seen increases of 8.6% over the period. It should be noted this only covers basic pay and does not account for additional earnings, which can form a significant part of total remuneration for some staff depending on band and occupation.

3.33 The final column shows the value of pay progression by band, which is defined as the difference in between basic pay between the top and bottom pay steps within the band. For example, the difference between the bottom and top pay step in Band 5 is 23%, which is the increase in earnings someone might receive before taking into account annual pay awards.

Figure 3.5 - NHS TCS Pay at Top / Bottom of Band - 2015/16 to 2020/21

Band/ position on scale	Basic Pay 15/16	Basic Pay 20/21	Increase since 2015/16	Pay Progression
Band 1 bottom	£15,100	£18,005	19%	N/A
Band 1 top	£15,363	£18,005	17%	0%
Band 2 bottom	£15,100	£18,005	19%	N/A
Band 2 top	£17,800	£19,337	9%	7%
Band 3 bottom	£16,633	£19,737	19%	N/A
Band 3 top	£19,461	£21,142	9%	7%
Band 4 bottom	£19,027	£21,892	15%	N/A
Band 4 top	£22,236	£24,157	9%	10%
Band 5 bottom	£21,692	£24,907	15%	N/A
Band 5 top	£28,180	£30,615	9%	23%
Band 6 bottom	£26,041	£31,365	20%	N/A
Band 6 top	£34,876	£37,890	9%	21%
Band 7 bottom	£31,072	£38,890	25%	N/A
Band 7 top	£40,964	£44,503	9%	14%
Band 8a bottom	£39,632	£45,753	15%	N/A
Band 8a top	£47,559	£51,668	9%	13%
Band 8b bottom	£46,164	£53,168	15%	N/A
Band 8b top	£57,069	£62,001	9%	17%
Band 8c bottom	£55,548	£63,751	15%	N/A

Band 8c top	£67,805	£73,664	9%	16%
Band 8d bottom	£65,922	£75,914	15%	N/A
Band 8d top	£81,618	£87,754	8%	16%
Band 9 bottom	£77,850	£91,004	17%	N/A
Band 9 top	£98,453	£104,927	7%	15%

Source: NHS Employers Pay Circulars

3.34 Bands 5-7 have not yet moved to the new pay point structure. In 2020/21 these bands included an additional pay step, known as a "transitional point" which will be removed in 2021/22 by merging with the top point. This will complete reform and leave only three pay points in these bands. Staff in these points will receive a pay rise of between 6% and 12% once the final transition points are removed.

Comparisons with National Living Wage / Foundation Living Wage

3.35 In 2020/21 minimum pay in the NHS is £9.21 per hour for staff outside of London and £11.50 for those working in Inner London. This compares to the "National Living Wage", the statutory minimum for workers over the age of 25, of £8.72 and the "Real Living Wage", set by the Living Wage Foundation which is currently set at £9.30 outside of London and £10.75 in London.

3.36 Following the Spending Review announcement, the National Living Wage will increase to £8.91 from April 2021 and be expanded to 23- & 24-year olds. The Real Living wage will also increase to £9.50 (£10.85 in London) by May 2021.

3.37 NHS pay scales apply to all staff regardless of age. This differs from the "National Living Wage" which applies only to staff aged 25 & over (this will change to 23 & over from April 2021). Lower rates apply to workers aged 22 & under.

Figure 3.6 - Comparison of Minimum Pay Rates as of April 1st 2020

Salary Scales	Inner London	Outer London	London Fringe	Rest of England
NHS TCS Minimum	£11.50	£11.14	£9.74	£9.21
National Living Wage	£8.72	£8.72	£8.72	£8.72
Foundation Living Wage	£10.75	£10.75	£9.30	£9.30

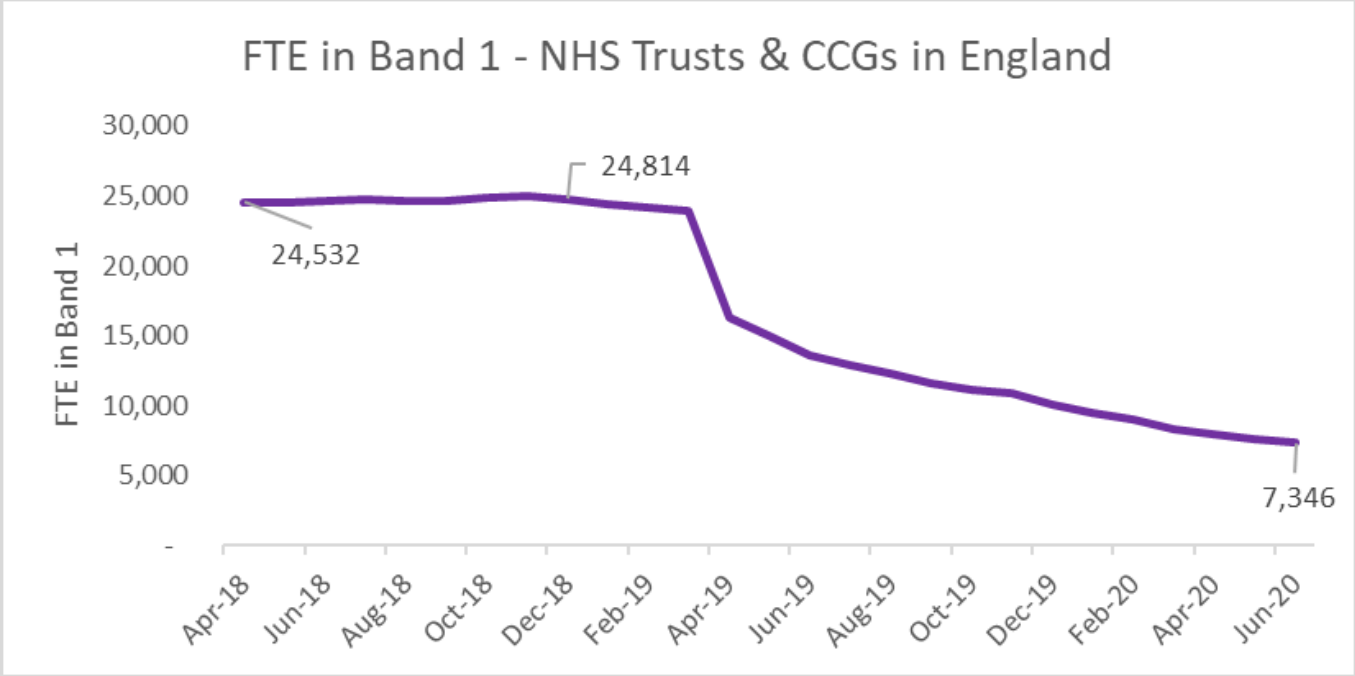
Source: NHS Employers, Gov.UK, Living Wage Foundation

3.38 In December 2018 Band 1 was closed to new entrants with existing staff given the opportunity to transfer to Band 2 by March 2021. In June 2020 there were around

7,300 staff remaining in Band 1 compared to 25,000 in December 2018. Pay values at the top of Band 1 and the bottom of Band 2 are the same.

3.39 For those remaining at Band 1 NHSEI and NHS Employers are working with trusts to better understand the reasons why staff are choosing to remain in Band 1 and providing advice on upskilling opportunities.

Figure 3.7 - FTE in NHS TCS Band 1 between April 2018 and June 2020



Source: NHS Digital Workforce Statistics

3.40 Examples of roles in Band 2 include domestic support worker, housekeeping assistant, driver, nursery assistant, domestic team leader, security officer, secretary/typist and healthcare assistant.

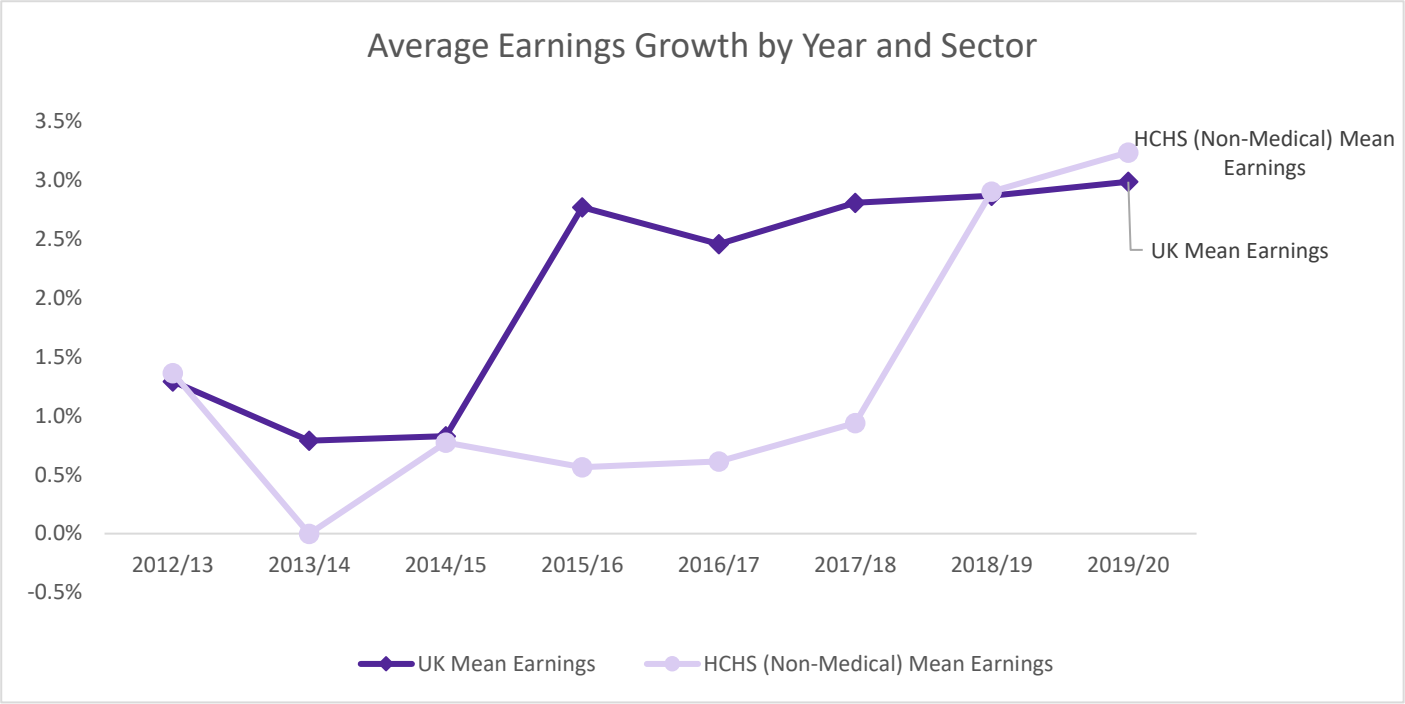
Comparison with the Wider Economy

3.41 This section will compare earnings in the HCHS sector with the wider economy including making sector specific comparisons where available using data from the Annual Survey of Hours and Earnings (ASHE) published by the Office for National Statistics (ONS) and makes comparisons at both the aggregate and granular level.

3.42 Over the last two years, the HCHS sector has seen significant growth in annual earnings and grew slightly faster than the wider economy in 2019/20. Nonetheless, this growth occurred after a period of lower growth, where it was growing significantly slower than the wider economy for the previous three years.

3.43 Figure 3.8 shows that the average earnings growth for HCHS workers has increased in 2018/19 and 2019/20, reaching a peak of 3.2%, above the wider economy's 3.0%. However, over the past 5 years, the wider economy's growth rate has been stable between 2.5% and 3.0%, while the HCHS has seen growth rates at below 1% for 5 years (from 2012/13 to 2017/18), before its recent growth above 3.0%.

Figure 3.8 - Average Earnings Growth by Year and Sector



Source: NHS Digital Earnings Statistics, Annual Survey of Hours and Earnings

UK average earnings based on ASHE data as of April in each year (e.g. 19/20 = Apr 20)
HCHS average earnings based on NHS Digital earnings for the 12 months to the end of March each year.

3.44 At a more granular level we can compare earnings for individual staff groups with comparators from the wider economy using data from ASHE to make a more like-for-like comparison.While both ASHE and NHSD produce data on a "per person" basis it should be noted that working patterns may differ from sector to sector. For example, NHS staff are more likely to work unsocial hours in order to maintain round-the-clock services and more heavily draw staff from certain demographic groups.

3.45 Figure 3.9 shows the earnings levels for HCHS staff groups and their comparators in 2014/15, 2018/19 and 2019/20, as well as the average level of annual growth between these periods. HCHS staff groups have seen slightly higher growth between 2018/19 and 2019/20, but over the past 5 years this advantage

disappears, with similar or lower growth for HCHS workers. We do not recommend comparing the absolute level of earnings, as comparator groups are not intended to be exact matches, but to indicate trends.

Figure 3.9 - Comparison of HCHS Earnings with Wider Economy Comparators

NHS Staff Group Wider Economy Comparator	Annual Earnings (2014/15)	Annual Earnings (2018/19)	Annual Earnings (2019/20)	Average Annual % Change (2014/15 to 2019/20)	Average Annual % Change (2018/19 to 2019/20)
NHS Hotel, Property & Estates	£16,995	£18,637	£19,025	2.3%	2.1%
Elementary / Skilled trades occupations	£18,732	£20,839	£21,110	2.4%	1.3%
NHS Support to Clinical Staff	£18,139	£19,394	£20,063	2.0%	3.4%
Caring, leisure and other service occupations	£13,677	£15,398	£15,873	3.0%	3.1%
NHS Central Functions	£23,436	£25,374	£26,367	2.4%	3.9%
Administrative and secretarial occupations	£18,967	£21,161	£21,394	2.4%	1.1%
NHS Qualified Health Professionals	£31,588	£32,900	£34,112	1.5%	3.7%
Professional / Associate professional and technical occupations	£35,818	£38,093	£38,480	1.4%	1.0%
NHS Managers	£47,256	£48,627	£50,942	1.5%	4.8%
Managers, directors and senior officials	£51,588	£56,430	£56,252	1.7%	-0.3%

Source: NHS Digital mean annual earnings per person by Staff Group, in NHS Trusts and CCGs in England; NHS Digital Mean annual earnings by staff group and grade in NHS Trusts and CCGs in England; ONS ASHE – Mean gross annual pay for UK employee jobs by occupation.

Note: NHS staff groups relate to HCHS staff. ASHE annual pay data reported for e.g. 2020 (relating to the tax year ending on 5th April 2020) is compared with NHS earnings data for the 12 months to March 2020. Earnings data is not adjusted for hours worked. Each broad NHS staff group is compared with a wider economy occupation group chosen to compare roles that are broadly similar in terms of qualifications, training and experience; responsibilities and risk; skills and competencies; seniority; and leadership and management. Comparator groups have been selected to provide context, however, they cover a wide range of occupations, and may not be directly comparable with NHS staff

groups. Additionally, changes to non-earnings components of benefits packages may cause divergence which is not included in above figure.

3.46 Median earnings of NHS TCS (£25,500) are equivalent to the wider economy (£25,780). Earnings at the 25th percentile are £19,000, and earnings at the 75th percentile are £36,000. Average earnings vary by staff group. Some, such as those requiring professional qualifications, have median earnings above the UK average, whilst others, such as those in support roles, are below the UK average. However, when comparing NHS staff groups to roles with equivalent levels of qualification and experience, NHS TCS earnings are in line with those in the wider economy

3.47 The distribution of earnings per person, shown in Figure 3.10, shows the range of earnings within any staff group. Much of the difference, for example between the upper and lower quartile, will be due to differences in working patterns as earnings per person do not adjust for the impact of part-time working. NHS Digital are unable to provide information on a distribution of earnings per FTE as not all elements of pay can be scaled in the same way as basic pay.

Figure 3.10 - Earnings Distribution and Comparison with UK Economy

Staff Group	25% Earn Less Than	Median Earnings	25% Earn More Than	Mean Earnings
UK Average (ASHE Data)	£16,200	£25,780	£39,000	£31,590
NHS TCS Staff	£19,000	£25,500	£36,000	£28,500
Nurses & Health Visitors	£26,500	£33,000	£39,500	£33,500
Midwives	£26,500	£34,000	£40,500	£33,500
Ambulance Staff	£35,500	£42,000	£47,500	£40,800
Scientific, Therapeutic & Technical Staff	£25,000	£33,000	£42,000	£34,700
Support to Clinical Staff	£15,500	£20,000	£24,000	£20,100
Support to Doctors, Nurses & Midwives	£15,500	£20,000	£23,500	£19,700
Support to Ambulance Staff	£22,500	£26,500	£31,500	£26,200
Support to ST&T Staff	£15,000	£19,500	£23,000	£19,600
NHS Infrastructure Support	£17,500	£23,000	£36,000	£29,800
Central Functions	£19,000	£24,500	£32,500	£26,400
Hotel, Property & Estates	£13,500	£18,500	£23,500	£19,000
Senior Managers	£56,500	£74,000	£98,500	£80,400
Managers	£43,000	£51,500	£62,000	£50,900
Other Staff	£14,000	£19,000	£21,500	£17,700

Source: NHS Digital Earnings Statistics, Annual Survey of Hours and Earnings

3.48 The Pay Review Bodies have sought evidence on how HCHS earnings compare to those for other professional groups. When assessing starting salaries in the HCHS sector it is important to account for both basic pay, as determined by the pay band, but also any additional earnings. A newly qualified nurse starting at the bottom of band 5, would have basic pay of just under £25,000, but would also be likely to receive additional earnings due to some of the factors specific to working in the health system, including the need to work unsocial hours to ensure a 24/7 service (see Chapter 7, total reward).

3.49 The Pay Review Bodies have sought evidence on how HCHS earnings compare to those for other professional groups. When assessing starting salaries in the HCHS sector it is important to account for both basic pay, as determined by the pay band, but also any additional earnings. A newly qualified nurse starting at the bottom of band 5, would have basic pay of just under £25,000, but would also be likely to receive additional earnings due to some of the factors specific to working in the health system, including the need to work unsocial hours to ensure a 24/7 service (see Chapter 7, total reward).

3.50 Figure 3.11 presents data from the LEO Graduate Outcome dataset produced by the Department for Education. In the first year following graduation nurses and midwives have relatively high earnings compared to graduates from other subjects as well as having relatively high employment levels. Teachers are not included in this data as a degree is not required to become a teacher - the starting pay for "main scale" teachers is currently £25,714 but they will not have access to the same additional earnings as those in the health service.

Figure 3.11 - Graduate Outcomes by degree subject 1 year after graduation

Subject	Lower Quartile	Median	Upper Quartile
Medicine and dentistry	£34,300	£36,500	£39,100
Veterinary sciences	£24,100	£29,200	£32,500
Engineering	£21,500	£26,600	£31,800
Economics	£20,100	£26,300	£32,100
Nursing and midwifery	£22,600	£25,900	£30,300
Physics and astronomy	£18,600	£24,800	£29,600
Architecture, building and planning	£19,300	£24,800	£31,800
Medical sciences	£20,800	£24,100	£28,500
Mathematical sciences	£19,000	£24,100	£29,900
Pharmacology, toxicology and pharmacy	£16,800	£23,700	£28,500
Computing	£17,200	£22,700	£28,800
Chemistry	£17,900	£21,900	£27,000
Allied health	£16,400	£21,200	£24,100

Business and management	£16,400	£20,800	£25,900
Languages and area studies	£15,300	£20,800	£25,200
All Graduates	£14,600	£20,400	£25,900

Source: Department for Education Graduate Outcomes (LEO) - 2017/18

3.51 Evidence submitted by HMT provides more detailed information on the impact of Covid on the UK economy and how that might need to impact pay policy decisions.

3.52 Graduates may experience large increases in earnings in their first years in the workforce. Figure 3.12 shows that after 10 years median pay is over 50% higher than in the first year after graduation across all subjects. For comparison the figure for Nurses is lower (17%), however this does not account for the composition and working patterns of the workforce. Separate analysis, undertaken in response to a Parliamentary Question, shows that the Basic Pay per FTE for nurses who were at the bottom of Band 5 in 2010 had increased by around 61% by 2020.

Figure 3.12 - Average pay "x" years after graduation for UK graduates

LEO Graduate Outcomes	1 Year After Graduation	3 Years After Graduation	5 Years After Graduation	10 Years After Graduation
All Graduates - Lower Quartile	14,600	17,900	19,000	19,300
All Graduates - Median	20,400	23,700	26,600	31,000
All Graduates - Upper Quartile	25,900	30,700	35,000	43,400
Nursing & Midwifery - Lower Quartile	22,600	21,500	21,500	20,800
Nursing & Midwifery - Median	25,900	27,400	28,500	30,300
Nursing & Midwifery - Upper Quartile	30,300	32,500	34,700	37,600

Source: Department for Education Graduate Outcomes (LEO) - 2017/18

Employee Experience of the Pay System

3.53 The first part of this chapter focussed on the aggregate position for the HCHS sector. The experience of individual members of the workforce may differ due to factors including pay advancement or progression which form a normal part of the NHS TCS reward package. This section looks at how pay advancement works under the NHS TCS system, presents the results of longitudinal tracking and compares this to the wider graduate jobs market.

Pay Advancement & Progression

3.54 Under NHS TCS pay advancement is an expected part of the career journey. Staff will usually start work at the bottom of a pay band and then progress through pay steps as they develop skills and competence over time. They may also be able to secure promotion to roles in more senior bands.

3.55 Staff eligible for pay progression may receive substantial increases in pay due to pay progression in excess of annual pay awards. Someone starting at the bottom of Band 5 might expect basic pay to increase by 23% over 5 years without accounting for annual increases to pay values.

3.56 As part of the 2018 agreement key changes were made to the structure of NHS TCS including:

(a) In Bands 2-7 the number of pay steps was reduced, enabling staff to reach the top of the band sooner.

(b) Pay progression is to be made conditional rather than being automatic although the implementation has been delayed due to COVID-19.

3.57 Figure 3.13, by Band, the current proportion of staff working at the top of the pay band as of March 2020. These figures will not consider the continuation of NHS TCS reform, for bands 2-4, that took place in April 2020 or the final implementation of reform in April 2021 as transition points are removed for Band 5 & 6.

3.58 Between 2017 and 2020 the proportion at the top of band has fallen in most bands. One reason for this is the growth in the workforce meaning that newly recruited staff will not have had the time to progress to the top of band.

3.59 As the reform of the pay structure is completed there may be an increase in the proportion of people at the top of each band as the time taken to reach that position is reduced. For example, the minimum time taken to reach the top of Band 5 will reduce from 8 to 5 years.

3.60 There are differences by staff group in the proportion of staff who are at top of band ranging from 14% (qualified ambulance staff) to 47% (senior managers). The low proportion for ambulance staff follows many paramedics being re-banded to Band 6 and there has not yet been enough time for these staff to reach top of band. The figure for Band 2 is lower than in previous years following the closure of Band 1 to new entrants and transfer of existing staff into Band 2 as these staff will start at a lower point within Band 2.

Figure 3.13 - Proportion of Staff at Top of Band by NHS TCS Band (2019-20)

Pay Band	1 April 2017	1 April 2018	31 March 2019	31 March 2020	Change April 17 - Mar 20
Band 2	44%	44%	42%	38%	-6%
Band 3	50%	48%	49%	43%	-7%
Band 4	48%	46%	46%	41%	-7%
Band 5	40%	39%	37%	37%	-4%
Band 6	37%	37%	40%	36%	-2%
Band 7	46%	44%	43%	45%	-1%
Band 8a	44%	42%	52%	44%	1%
Band 8b	46%	46%	55%	54%	9%
Band 8c	44%	44%	46%	46%	1%
Band 8d	48%	47%	55%	46%	-2%
Band 9	43%	44%	47%	58%	15%
All NHS TCS	43%	43%	44%	40%	-3%

Source: NHS Digital Workforce Statistics

Note - Data for 2017 and 2018 includes all HCHS staff including those working in Central and Support Organisations. Data for 2019 and 2020 covers NHS Trusts, Foundation Trusts & CCGs only.

Staff Tracking Analysis

3.61 The system of pay advancement & promotion under NHS TCS means that the individual "pay journey" may differ from what is implied by annual pay awards. Individuals may progress to a higher pay step within the same band or secure promotion to a more senior band.

3.62 Using data from the Electronic Staff Record Data Warehouse we can track individual members of the workforce to assess individual experience of the pay system.

3.63 The data presented here looks at the change in basic pay per FTE for individuals employed in the HCHS sector at different points in time. Basic pay per FTE is used to minimise any impact from people changing working patterns over time.

3.64 There were over 500,000 NHS TCS Staff employed in the HCHS sector in both 2010 and 2020. The median increase in basic pay per FTE was around 31% with a quarter a staff having an increase of less than 17.7% and a quarter experiencing an increase of at least 48%. Figure 3.14 shows these results partitioned by staff

group. In cases where someone changes staff group, for example progressing to a managerial role, the most recent staff group is used.

3.65 Differences between individual members or staff or staff groups may reflect an individual's position within a band, promotion or movement between staff groups. Newer staff, including those not already at the top of band, will have larger increases due to pay progression and this will include those with pay below band median. Staff promoted to more senior staff groups (e.g. managers becoming senior managers) will also see higher increases associated with increased seniority.

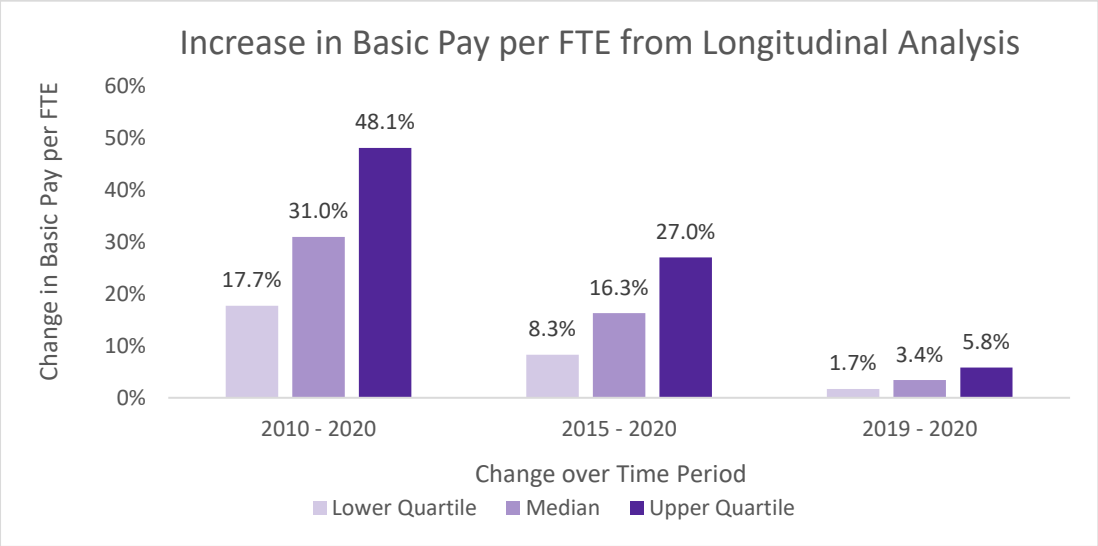
Figure 3.14 - Change in Basic Pay per FTE between March 2010 & March 2020

Staff Group	Count	Mean	25th Percentile	Median	75th Percentile
Nurses & health visitors	170,000	35.7%	16.6%	30.8%	48.9%
Midwives	12,000	32.6%	11.5%	26.0%	44.3%
Ambulance staff	8,000	46.6%	25.1%	39.9%	59.4%
Scientific, therapeutic & technical	79,000	40.7%	16.5%	33.7%	57.0%
Support to doctors, nurses & midwives	118,000	27.0%	16.5%	25.2%	36.4%
Support to ambulance staff	7,000	29.4%	14.5%	27.3%	39.0%
Support to ST&T staff	26,000	29.1%	16.5%	27.3%	36.9%
Central functions	49,000	41.3%	18.2%	34.0%	55.2%
Hotel, property & estates	24,000	29.6%	25.2%	26.6%	33.4%
Senior managers	8,000	70.6%	33.7%	58.2%	90.9%
Managers	16,000	61.2%	29.4%	51.2%	79.6%
All NHS TCS Staff	518,000	35.7%	17.7%	31.0%	48.1%

Source: DHSC Analysis of Electronic Staff Record. For people who have changed staff groups between 2010 and 2020 the 2020 staff group isshown.

3.66 Similar analysis can be undertaken for different periods of time as shown in Figure 3.15. Over the last 12-months (2019-20) the median increase was 3.4% (IQR = 1.7% - 5.8%) which is consistent with changes to headline pay scales.

Figure 3.15 - Increase in Basic Pay per FTE over alternative time periods



Source: DHSC Analysis of Electronic Staff Record

3.67 Tracking analysis highlights the fact that individual employees will have different experiences of the pay system. Those eligible for pay progression will have seen increases in excess of annual pay rounds while those already at the top of band will have seen smaller increases.

Equalities

Gender & Ethnicity Pay Gaps

3.68 A "Pay Gap" is the difference in average Pay or Earnings between people with different demographic characteristics across either a staff group or the entire workforce. Chapter 4 provides further information on the work that is being done to address pay gaps in the NHS.

3.69 There are three main factors that can lead to the development of a pay gap:

- Across the entire workforce a "staff group mix" effect may occur if staff from one demographic group are more likely to be in higher / lower paid staff groups. For example, if a high proportion of male staff are in managerial positions this will increase the average wage for males and a gap may develop.

- Within a staff group a "band mix" effect will occur if there is a difference in how staff are distributed between NHS TCS bands. For example, in the nursing staff group around 60% of white nurses are at Band 6 and above compared

with 40% of BAME nurses. This increases the average wage for white nurses and a gap may develop.

- The gap on total earnings may differ from that of basic pay per FTE if staff from one group are more likely to receive additional earnings or work on a part-time basis.

3.70 Data from NHS Digital can be used to show the extent of the gender and ethnicity pay gaps on either a "basic pay per FTE" or "earnings per person" basis. It is helpful to look at both gender and ethnicity at the same time due to the intersection of gender & ethnicity within the workforce.

3.71 Figure 3.16 shows the latest data on the gender and ethnicity pay gaps for the period to the end of May 2020 on a basic pay per FTE basis. The data suggests that, on average, women have lower average pay than men and BAME staff have lower average pay than white staff. For example, the average pay for a white female nurse is around 3% (£110 pa) lower than that of a white male nurse.

3.72 Gaps tend to be smaller within staff groups than across the wider TCS workforce. This would suggest that gaps are largely being caused by staff group effects (with more white and male staff in the higher paying staff groups) with smaller band effects.

3.73 The largest gaps within a single staff groups are in the Infrastructure Support staff group with a 13% gap (£390) for white females compared to white males and a 14% (£430) gap for BAME males compared to white males. This may reflect the relatively low numbers of BAME staff in leadership positions.

Table 3.16 - NHS TCS Gender Pay Gap - Basic Pay per FTE by Gender, Ethnicity & Staff Group - May 2020

Staff Group	GPG – White	GPG - BAME	EPG - Female	EPG – Male
Description	Comparison of white female & white male	Comparison of BAME female & BAME male	Comparison of BAME female & white female	Comparison of BAME male & white male
All NHS TCS	-6%	-0%	-4%	-10%
Nurses & Health Visitors	-3%	-2%	-10%	-11%

All Professionally Qualified	-4%	-3%	-9%	-10%
Support to Clinical Staff	-3%	-0%	-2%	-4%
NHS Infrastructure Support	-13%	-5%	-7%	-14%

Source: NHS Digital Earnings Statistics

3.74 Over the past five years, across all NHS TCS staff, the gender pay gap has increased by 1 percentage point for white staff and 2 percentage points for BAME staff. The ethnicity pay gap has been relatively stable for both male and female staff but is higher for male staff (-10% , £250) than for female staff (-4% , £110)

3.75 The gender pay gap tends to be higher when looking at average earnings rather than basic pay. This might suggest that male staff are more likely to receive additional earnings even after controlling for differences in working patterns.

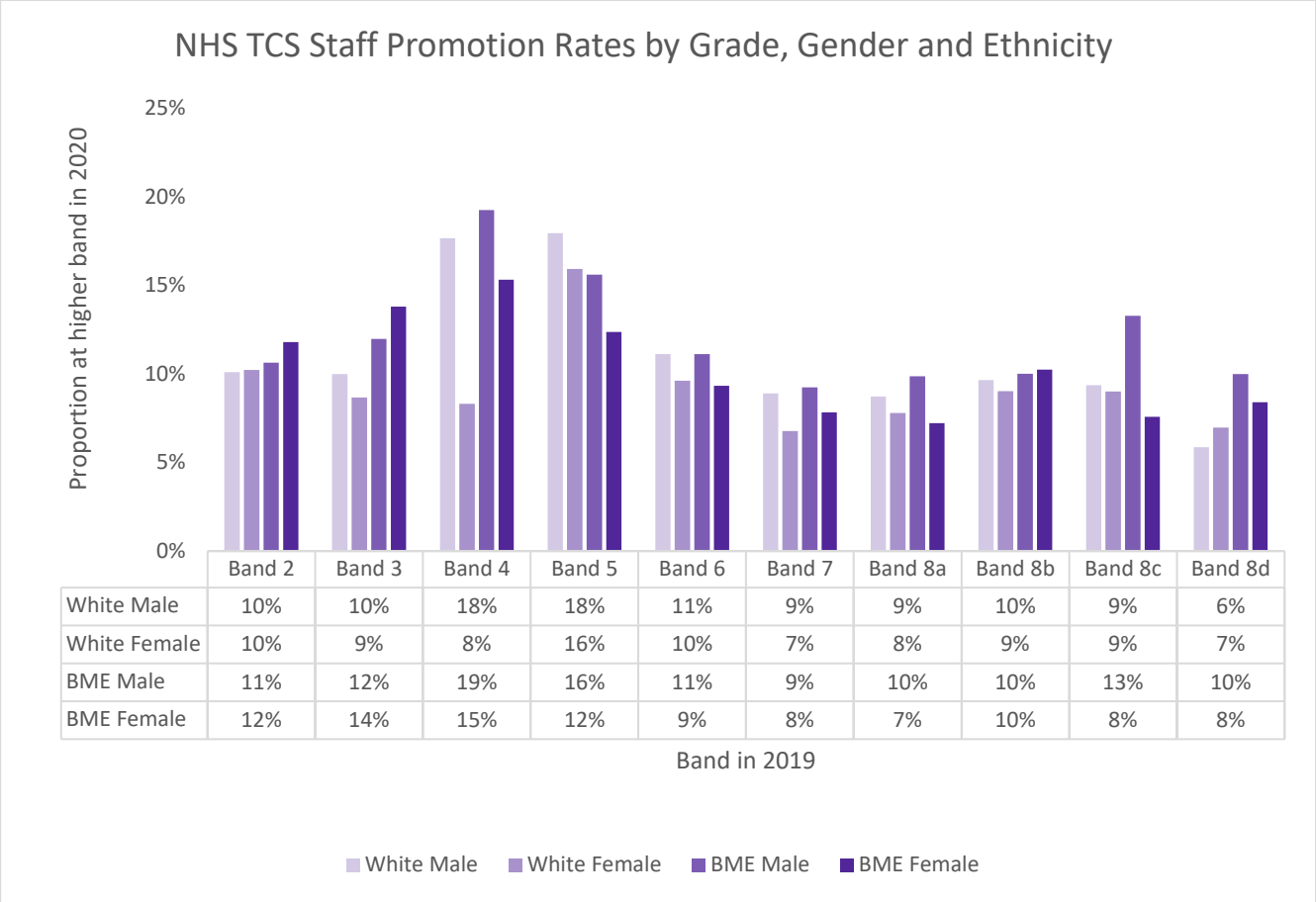
GPG Determinants

Promotion

3.76 One of the factors which can lead to the development of a pay gap is a difference in band-mix between staff from different demographic groups. This could happen if there are differences in the likelihood of staff being promoted to more senior bands.

3.77 Figure 3.17 shows the proportion of staff, by ethnicity and gender, who were working in a more senior band in March 2020 than in March 2019. Across most bands the proportion of males who were promoted to a higher band was higher than for females, with the largest gap at Band 4. Patterns were consistent for both white and BAME staff groups. It also shows some evidence of a gap by ethnicity, for examples, where BAME promotion rates are lower than for white staff; however this does not apply for all groups.

Figure 3.17 - NHS TCS Staff Promotion Rates by Grade, Gender and Ethnicity (March 2019-March 2020)



	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d
White Male	10%	10%	18%	18%	11%	9%	9%	10%	9%	6%
White Female	10%	9%	8%	16%	10%	7%	8%	9%	9%	7%
BME Male	11%	12%	19%	16%	11%	9%	10%	10%	13%	10%
BME Female	12%	14%	15%	12%	9%	8%	7%	10%	8%	8%

Source: DHSC analysis of NHS Electronic Staff Record data (March 2019 - March 2020)

3.78 It is important to separate any interactions between gender and ethnicity, so comparisons are drawn from a single gender or ethnic group. We have also split results by grade, to reduce any compositional affect from variable rates of promotion.

3.79 Analysis suggests that the 'promotion gap' between genders and ethnicities are smaller within specific staff groups. As such, the specific staff group mix of different groups may be responsible for some portion of any apparent gap. For example, a support to midwife staff member (within the support to doctors, nurses & midwives staff group) would very infrequently be promoted above Band 4. Within that role, both men and women are equally likely (or unlikely) to be promoted, but as the role is predominantly occupied by women, this produces an overall 'promotion gap'. Controlling for this effect would reduce any such gap. We also see some evidence of working patterns being important, with part-time staff being much less likely to be working at a higher band compared to full-time staff.

Distribution of New Joiners

3.80 We can also look at the distribution of new joiners, defined as people who were not employed the previous year. Any apparent gender or ethnicity pay gap may not be due to any individuals being paid more or less for the same work, but rather band or compositional distributions, which may differ by gender or ethnic group. Different distributions could be indicated by the data below. Unfortunately, these proportions are influenced by any over or under-representation by those existing groups within each grade. Due to the number of staff not disclosing their ethnicity, these values may not always match other totals.

Figure 3.18 - NHS TCS Staff New Entrants Proportion by Grade, Gender and Ethnicity (March 2019 - March 2020)

Band	All Staff	Male	Female	White	BAME
Band 1	0.2%	0.3%	0.2%	0.2%	0.1%
Band 2	30.4%	30.2%	30.5%	33.9%	23.4%
Band 3	17.3%	18.7%	17.0%	18.2%	15.8%
Band 4	8.8%	9.9%	8.6%	8.9%	8.6%
Band 5	31.5%	25.0%	33.2%	26.3%	42.7%
Band 6	6.4%	7.4%	6.1%	6.7%	5.6%
Band 7	3.1%	4.4%	2.8%	3.4%	2.5%
Band 8a	1.1%	1.9%	0.9%	1.2%	0.8%
Band 8b	0.5%	0.9%	0.3%	0.5%	0.3%
Band 8c	0.3%	0.6%	0.2%	0.3%	0.2%
Band 8d	0.2%	0.4%	0.2%	0.3%	0.1%
Band 9	0.1%	0.3%	0.1%	0.2%	0.0%
Total	100%	100%	100%	100%	100%

Source: DHSC analysis of NHS Electronic Staff Record data (March 2019 - March 2020)

3.81 Figure 3.18 shows that each group of new entrants' have different proportions of grades. Men are much less likely to join as a Band 5 than women, but more likely to join as almost any other grade. These differences appear especially stark at the higher grades, although due to the higher number of female new entrants, females still actually have larger number of new entrants of each grade up to Band 8d. White and black, asian and minority ethnic (BAME) staff also see similar divides: more white staff join at Band 2, while more BAME staff join at Band 5. Men are more likely to join at more senior grades than women, and white staff are more likely to join at more senior grades than BAME staff. Women were 60% as likely to join as a Band 9 than expected, while non-white staff were 30% as likely. Men were over 250% as likely to join at Band 9 than an average joiner.

Conclusion

3.82 In this evidence we have shown that average earnings for those on NHS TCS have increased by 3.1% over the past year, and 6.1% over the first two years of the three-year agreement reached in 2018, which was similar to growth in the wider economy before the impacts of the pandemic began to emerge. Assessments of longer-term HCHS earnings should consider the impact of the pandemic on the wider labour market which are not yet fully apparent. In addition to the annual headline pay award individual members of staff may also be eligible to access higher earnings growth as a result of pay progression, promotion or , in 2021-22, due to contract reform although the precise impact will vary from person to person.

4. Workforce Strategy

4.1 This chapter discusses the current strategy for both the AfC and NHS workforce more widely and provides further information on the NHS People Plan 20/21.

4.2 Effective workforce strategy is critical to the delivery of safe, affordable, high quality care. Ensuring that the NHS has access to the right mix and number of staff who have the skills, values and experience to deliver high quality, affordable care is a fundamental aspect of the DHSC's overarching strategic programme for the health and care system.

4.3 The Department works through its ALBs on the delivery and implementation of workforce policy. NHSEI is responsible for setting the priorities and direction of the NHS and encouraging and informing the national debate to improve health and care. NHSEI is responsible for delivering the NHS People Plan. The NHS People Plan is a key route for setting out policy and actions to expand the NHS workforce, strengthening recruitment and retention through improving staff health and wellbeing, equality diversity and inclusion and the NHS leadership culture. Education and training of the workforce is the core function of HEE.

4.4 The NHS LTP published in January 2019 sets out how models of care will be transformed over the next five years to allow patients to have more options, better support and properly joined-up care at the right time in the optimal care setting.

4.5 The LTP highlights the following objectives as most important for the workforce:

- Ensuring we have enough people, with the right skills and experience so staff have the time they need to care for patients well.
- Ensuring NHS staff have rewarding jobs, work in a positive culture, with opportunities to develop their skills and use state of the art equipment, and have the support to manage the complex and often stressful nature of delivering healthcare.
- Strengthening and supporting good, compassionate diverse leadership at all levels - managerial and clinical - to meet the complex practical, financial and cultural challenges a successful workforce plan and LTP will demand.

The NHS People Plan

4.6 'We are the NHS: People Plan 2020/21 – action for us all' was published in July 2020. This plan sets out actions that NHSEI and HEE will take to support

transformation across the whole NHS acknowledging the impact of the COVID-19 pandemic.

4.7 COVID-19 has placed greater focus on these issues and highlighted just how important work on staff wellbeing is. The People Plan puts health and wellbeing at its core with a new support package. Since April 2020, NHS staff have been able to access:

- A dedicated and confidential staff support line, operated by Samaritans and a 24/7 text support line operated by Frontline;
- Specialist bereavement support through a helpline provided by Hospice UK, manned by a team of fully qualified and trained bereavement specialists;
- Free access to mental health and wellbeing apps;
- Virtual staff common rooms, in partnership with NHS Practitioner Health which have given staff the opportunity to reflect, share experiences and find ways to cope with how COVID-19 is affecting their life at home and at work.

4.8 Through the NHS People Plan, a range of further measures are also being introduced to support staff wellbeing including:

- A new wellbeing guardian role which will ensure board level scrutiny of health and wellbeing support for staff;
- Continued support for staff to get to work and free car parking;
- A focus on healthy working environments and safe spaces for staff to rest and recuperate;
- Support to switch off from work, take breaks and annual leave
- An extra £15m has been invested to strengthen mental health support for NHS staff. This funding is being used to set up a first wave of mental health hubs that will provide outreach and assessment services to help frontline staff receive rapid access to evidence based mental health services. It will also create a national support service for critical care staff, and support the development of wellbeing and psychological training; and
- Improved occupational health support.

4.9 The People Plan is ensuring flexible working is being made a priority, actions include:

- From January 2021, all clinical and non-clinical permanent roles will offer flexible working patterns;

- Flexible working will be covered in standard induction conversations and the right to request flexible working will not require a justification and will be available from day one;

- Board members should give flexible working their focus and support, with the NHS oversight and performance frameworks now including a key performance indicator on the percentage of posts advertised as flexible; and

- Organisations being supported to implement and make effective use of e-rostering systems.

Belonging in the NHS

4.10 It has never been more urgent for leaders to take action and create an organisational culture where everyone feels they belong – in particular to improve the experience of NHS people from BAME backgrounds.

4.11 Respect, equality and diversity is central to improving the culture in the NHS and is at the heart of the NHS People Plan. Actions include:

- The appointment of a named equalities champion in every NHS organisation;

- Ensuring all trusts have a thriving BAME network;

- A five-year plan to ensure organisations reflect the communities they serve;

- Overhauling recruitment and promotion practices to ensure that staffing reflects the diversity of communities and labour markets;

- Resources training and guidance to support line managers to discuss equality and diversity;

- Stretching targets to reduce the likelihood of entry into disciplinary processes;

- Competency frameworks for every board level position that will reinforce that responsibility for leading and making progress on equality diversity and inclusion;

- The CQC placing increasing emphasis on whether organisations have made real and measurable progress on equality diversity and inclusion; and

- Joint training for Freedom to Speak Up Guardians and WRES leads with more BAME staff recruited to Freedom to Speak Up Guardian roles.

4.12 The following actions are being taken to support leaders to build compassionate and inclusive cultures:

- Refreshed support for leaders in response to the current operating environment including expert-led seminars on health inequalities and racial injustice;

- Expansion of the number of placements for talented clinical leaders each year;

- An updated talent management process to make sure there is greater prioritisation and consistency of diversity of talent being considered for director, executive senior manager, chair and board roles;

- All central NHS leadership programmes will be available in digital form and accessible to all, updated by the principle of inclusion;

- NHSEI have completed the engagement exercise commissioned by government in response to Tom Kark QC's review of the Fit and Proper Persons Test and are working with the Department of Health and Social Care to finalise a response to the review's recommendations;

- NHSEI will launch a new leadership observatory which will highlight areas of best practice globally, commission research and translate learning into advice and support for leaders.

Growing for the Future

4.13 The People Plan sets out plans to build on the increased interest in NHS careers, strengthen retention and reverse the trend of early retirement.

4.14 HEE will make progress through 2020/21 in addressing the most pressing workforce shortages in those service areas with the highest demand and those professions that require urgent focus including mental health, cancer, advanced clinical practice, expanding shortage specialities, expanding undergraduate places and developing clinical pharmacists.

4.15 A greater focus will also be placed on recruitment locally. Employers should offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles.

4.16 Internationally, the People Plan details commitments to increase ethical recruitment; pilot new English language training programmes for international nurses and launch a new health and care visa which will make it easier and cheaper for registered health staff to come from overseas to work.

4.17 Employers will also encourage staff to return to practice building on interest to support the NHS through the pandemic. HEE is exploring the development of a return to practice scheme.

4.18 The People Plan also encourages employers to:

- Do more to retain staff aged 55 years and over - who comprise over 19% of the workforce - by ensuring those approaching retirement have a career conversation with their line manager, HR and occupational health; and

- Make sure future potential returners, or those who plan to retire are aware of the ongoing pension flexibilities under the current emergency rules.

NHS Staff Survey 2019

4.19 The NHS Staff Survey is a key source of evidence that has informed the NHS People Plan. It is one of the largest workforce surveys in the world and has been conducted every year since 2003. It asks NHS staff in England about their experiences of working for their respective NHS organisations and provides essential information to employers and national stakeholders about staff experience across the NHS.

4.20 The most recent survey was published in February 2020. The survey went out to over 1.1 million staff across 300 NHS organisations in England of which 569,440 responded - a 48% response rate.

Key Findings

4.21 Broadly, the 2019 NHS Staff Survey results show an improvement in responses regarding immediate managers, quality of appraisals and safety culture.

4.22 There was a decrease in the percentage of NHS staff that were looking to leave the NHS. This is a strong and positive step, but more work needs to be done.

4.23 No theme scores have worsened over the last four years of the survey. However, Ambulance Trust staff continue to perform poorly across a range of staff experience metrics, although have made improvements in most metrics since 2015.

4.24 A full list of theme and questions for the NHS Staff survey and further breakdowns are available online at: www.nhsstaffsurvey.com.

NHS People Pulse and Morale Tracker

4.25 Alongside the annual staff survey NHSEI launched the NHS People Pulse Survey on 1 July. This gives staff the chance to have a say on issues such as the level of support they're receiving at work during the COVID-19 pandemic, what support would make the biggest difference to them and secure feedback on staff morale. The main purpose of the tool is to support organisations with listening, engaging and supporting decision making to improve working experiences for our NHS People. Employees who feel listened to are more likely to feel connected and engaged with the NHS, which results in improved performance. There are currently over 100 organisations using the People Pulse which reports monthly.

4.26 The People Plan also commits to a new quarterly staff survey to track people's morale in the first quarter of 2021/22. In the interim there has been an effort to use the NHSEI Staff Feedback Hub to get a more frequent temperature check. This hub provides confidential access to approximately 1200 members of the NHS workforce, across a variety of professions and geographical regions.

Addressing Gender and Ethnicity Pay Gaps

4.27 To support the wider equality, diversity and inclusion work of the NHS People Plan the Department has been focussing on pay gap issues.

4.28 Chapter 3 outlined the data on gender and ethnicity pay gaps amongst the Agenda for Change workforce.

4.29 Pay gaps are defined as differences in the average pay for one group of staff compared to those from a different demographic group. As detailed in Chapter 3, this is different to pay discrimination, paying different people different amounts for the same job, which is illegal.

The Gender Pay Gap in Medicine Review

4.30 While NHS staff employed on Agenda for Change terms and conditions were not included within the remit of the Gender Pay Gap in Medicine Review, many of the 47 recommendations made within the review, including contractual and structural changes, may still in turn impact the Agenda for Change workforce.

4.31 The full report can be found here: https://www.gov.uk/government/publications/independent-review-into-gender-pay-gaps-in-medicine-in-england

The Ethnicity Pay Gap Review

4.32 One of the recommendations in the The Gender Pay Gap in Medicine Review relates to extending pay gap research to other protected characteristics.

4.33 The Minister for Care will be chairing a roundtable in 2021 that brings together stakeholders from across the health system to understand the causes of the Ethnicity Pay Gap across the NHS workforce, including those employed on Agenda for Change terms and conditions.

4.34 The Department will also be exploring ways to capture the employee experience on the barriers and causes of the Ethnicity Pay Gap across the NHS workforce.

4.35 This will complement the ongoing work of the Workforce Race Equality Standard to close the gaps in experience between BAME and white staff throughout the NHS.

Integration of Health and Social Care

4.36 The recent Health and Care White Paper sets the platform for the wider reforms we will introduce later in the year. The Bill is about improving the integration of local councils and the NHS to make sure people, whether at home or in a care home receive the fast, high quality, joined up care they need. Better integration will remove the barriers stopping people accessing care. These reforms will put in place a system to help people access care and contribute to preventing people being passed from pillar to post when having their care needs assessed. This process should be seamless.

4.37 Within this ambition, important consideration needs to be given to the workforce experience and how staff move within it. It's important the health and social care system can recruit and retain the staff it needs and that staff are enabled to work across boundaries and operate seamlessly across the two areas. We want to provide as much stability of employment as possible while ICS NHS bodies develop new roles and functions that not only improve health and care but also make better use of the skills, experience and expertise of all our NHS people. There will be a set of HR principles developed nationally to support this transition and these will be available in April 2021. The aim of these principles is to provide a framework for a consistent approach, including the employment commitment, but

to enable local implementation, recognising the differences in systems across the country.

4.38 The NHS Long Term Plan is clear that integrated care systems (ICSs) should be the main organising unit for local health services. ICS's bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. Local authorities remain responsible for ensuring that care providers recruit the staff necessary to deliver services, and successful integration of health and social care services takes place where the NHS and local government work together to plan for the needs of the local population.

4.39 Health Education England and NHS England and NHS Improvement are supporting local health systems (STPs/ICSs) to develop workforce plans, as an integral part of service and financial plans, enabling us to understand better the number and mix of roles required to deliver the NHS Long Term Plan and inform national workforce planning.

Releasing Time to Care

4.40 Digital and technological solutions that improve staff experience and support better models of care for patients will allow increased productivity and release staff time to care for patients. The 2019 NHS Staff Survey shows that 89.6% of staff felt their role makes a difference to patients / service users however only 68.5% said they are able to deliver the care they aspire to and only 55.9% said they are able to make improvements happen in their area of work. This highlights the importance of releasing time to care.

4.41 Digital transformation has occurred rapidly across the NHS during the COVID-19 pandemic, with an increase in video consultations taking place in primary and secondary care. The number of weekday remote meetings has also risen enabling teams to run virtual multidisciplinary team meetings, case presentations and handovers, and teaching sessions.

4.42 This digital transformation has allowed an increase in remote and flexible working which many colleagues across the NHS have noted as more productive, with less time spent travelling and better turnout at meetings, as well as improved work-life balance for NHS staff. Where new approaches have worked well, they should be adopted systematically.

4.43 NHSEI are also supporting organisations to continue the implementation and effective use of e-rostering systems. These systems will ensure staff use their time optimally to provide patient care and help providers make the most of their

available workforce, thereby reducing the reliance on costly temporary staff. Whilst promoting continuity of care and safe staffing these systems allow NHS staff to book leave and request preferred working patterns up to 12 weeks in advance.

4.44 Digital and technological solutions will support better models of care for patients. The NHS LTP states that in the next 5 years, every patient will have the right to online 'digital' GP consultations and redesigned hospital support will be able to avoid up to a third of outpatient appointments - saving 30 million trips to hospital and saving the NHS over £1 billion a year in new expenditure.

4.45 The LTP endeavours to reduce the administrative burden for staff by enabling staff to capture all health and care information digitally at the point of care and optimise clinical processes. This will allow staff to focus on high value activities in which they have specialist training. Mobile access to digital services will allow health and care workers to work more flexibly.

Tackling the Nursing Challenge

4.46 The government is committed to growing and supporting the NHS Workforce to ensure it continues to provide world class health and care.

4.47 The delivery of 50,000 more nurses will put the NHS on a trajectory to sustainable long-term supply in the future. A comprehensive work programme has been set up to improve retention and support return to practice, invest in and diversify our training pipeline and ethically recruit internationally.

4.48 From September 2020, eligible students will benefit from at least £5,000 additional funding per academic year, with up to a further £3,000 to support students with childcare costs, students studying specialist subjects or in areas struggling to recruit.

4.49 The Government is also supporting alternative routes into nursing and announced in August a multimillion funding package to significantly increase the number of nurse apprenticeships.

4.50 Delivery of 50,000 more nurses in the NHS in England will support the 1.4 million people who make up the NHS workforce and address the longstanding NHS nursing shortages.

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

5.1 This chapter discusses and describes the existing size of the workforce, how it has changed with regards to patterns of recruitment, retention and motivation amongst the AfC workforce. The remainder of the chapter reflects on and updates on aspects of workforce planning and key topics of interest as requested by the review body.

Summary and Background

5.2 The evidence suggests that whilst the non-medical workforce growth remains strong overall, demand also continues to grow and there are still supply issues to address. Chapter 4 introduced the strategic framework set out by the NHS LTP to ensure that over the next ten years the NHS will have the staff it needs and the below sections explore and analyse the trends related to these commitments.

Numbers in work

5.3 The overall non-medical NHS workforce as at June 2020 is 1,047,264 FTEs, this has increased by over 145,607 FTEs between June 2015 and June 2020. Further detail is shown below.

Figure 5.1 - Non-medical staff FTE June 2015 to June 2020

Staff group	June 2015	June 2020	Change	% Change
All staff groups	901,656	1,047,264	145,607	16.1%
Nurses & health visitors	280,962	302,471	21,509	7.7%
Midwives	21,193	22,128	935	4.4%
Ambulance staff	17,583	16,971	-612	-3.5%
Scientific, therapeutic & technical staff	125,395	147,554	22,159	17.7%
Support to doctors, nurses & midwives	229,528	283,463	53,935	23.5%
Support to ambulance staff	14,571	23,932	9,362	64.3%
Support to ST&T staff	52,166	64,680	12,515	24.0%
Central functions	77,358	93,774	16,416	21.2%
Hotel, property & estates	50,297	57,308	7,011	13.9%
Senior managers	9,093	11,151	2,059	22.6%
Managers	19,990	21,795	1,805	9.0%

Other staff / unknown classification	3,521	2,035	-1,486	-42.2%

Source: NHS Digital HCHS monthly workforce publication.

Note - Managers and Senior Managers include those who do not hold a clinical qualification e.g. a Medical Director or a qualified nurse would be coded to their specialty, with the relevant Job Role. Managers include staff on majority Band 8 and some at Band 7 and 6; Senior Managers typically include Band 8+ staff.

Joiners

5.4 The overall non-medical joiner rate for the year to March 2020 for all regions and staff is 13.8% with over 157,000 headcount joining the workforce. Joiner rates vary between 7.6% and 21.3% across staff groups.

Figure 5.2a - Joiners by Staff Group March 2019 - March 2020

Staff group	Number of Joiners	Joiner Rate
All staff groups	157,481	13.8%
Nurses & health visitors	41,025	12.4%
Midwives	3,174	12.0%
Ambulance staff	1,697	8.3%
Scientific, therapeutic & technical staff	20,397	12.4%
Support to doctors, nurses & midwives	47,414	15.9%
Support to ambulance staff	4,509	21.3%
Support to ST&T staff	12,696	17.9%
Central functions	14,509	14.7%
Hotel, property & estates	8,802	12.5%
Senior managers	873	7.6%
Managers	1,864	7.8%
Other staff or those with unknown classification	617	17.9%

Source: NHS Digital HCHS Workforce Statistics

Note: the joiner rate has been calculated by dividing the number of joiners by the average headcount in that category at the beginning and end of the period, expressed as a percentage.

Staff Group Joiner Rates by Region

5.5 Whilst joiner rates vary across staff groups and regions, it is generally true that joiner rates in main staff groups are higher in the South and East than they are in the North and Midlands.

5.6 Joiner rates for the year to March 2020 for some of the larger non-medical staff groups are shown in figure 5.2b.

Figure 5.2b - Joiners by Staff Group March 2019 - March 2020

Staff group	All Regions	London	South West	South East	Midlands	East of England	North West	North East and Yorks
Nurses & health visitors	12.4%	13.2%	14.6%	14.3%	11.5%	13.9%	11.3%	10.0%
Midwives	11.9%	12.6%	12.0%	13.8%	11.8%	12.0%	10.7%	10.5%
Scientific, therapeutic & technical staff	12.4%	14.2%	13.5%	13.5%	11.3%	12.2%	11.0%	11.2%
Support to doctors, nurses & midwives	15.8%	17.3%	17.3%	18.5%	15.1%	18.2%	13.7%	12.9%
All staff groups	14.4%	15.6%	16.2%	16.1%	13.7%	15.6%	12.9%	12.2%
All non-medical staff groups	13.8%	15.2%	15.9%	15.7%	13.1%	15.1%	12.1%	11.5%

Leaver Rates and Trends

Staff Group Leaver Rates

5.7 Leaver rates have fallen since last year for all large staff groups in England. The leaver rate is the share of the workforce leaving their staff group in the NHS Trusts and CCGs in a year. It excludes staff moving between Trusts, but for example includes people moving from a Trust to a GP Practice. The leaver rate does not include those on maternity leave as staff do not leave the trust, they are classed as being on occupational absence. Overall, leaver rates across England appear to be falling from peaks in 2016-17 and 2017-18 in the past two years.

Figure 5.3 - Leaver rates by Staff Group

Staff Group	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Nurses and Health Visitors	10.1%	10.4%	10.7%	10.7%	10.2%	9.6%
Midwives	9.5%	10.0%	10.6%	10.5%	10.4%	10.1%
Ambulance Staff	7.4%	7.6%	7.3%	7.9%	7.6%	7.8%
Scientific, Therapeutic and Technical Staff	11.1%	11.2%	11.0%	10.9%	10.5%	10.0%
Support to Clinical	11.1%	11.2%	11.9%	11.7%	10.9%	10.2%
Infrastructure Support	11.3%	11.4%	11.3%	11.5%	9.9%	9.5%

5.8 The leaver rate for nurses and health visitors, midwives and ambulance staff is slightly higher than 2014 for England as a whole, although rates fell in some regions.

5.9 In 2019/20 Ambulance staff have the lowest leaver rate at 7.8% in England whilst support to clinical staff have the highest leaver rate of 10.2%.

Retention

5.10 Another way to express outflows from the workforce is the stability index. This has held relatively steady over recent years as shown in Figure 5.4. The stability index captures how successful the NHS is in retaining its staff. The index is computed by NHS Digital on data for England. The chart below shows that there has not been much variation in the stability index for the HCHS non-medical workforce in each staff group, with the maximum variation being 2.5 percentage points for infrastructure staff between 2014-15 and 2019-20. NHS Digital data shows retention has increased slightly for several staff groups compared to 2014 and around 90% of most NHSPRB staff groups were retained over the 12 months up to March 2019-20.

5.11 More recently, due to the ongoing pandemic, retention rates have improved as staff and NHS trusts respond to the situation. Vacancy rates in the NHS have dropped, and looking more widely at the UK labour market, vacancies have dropped significantly whilst redundancies have increased to record levels. As a result, opportunities for NHS staff to move jobs or leave the NHS are more limited

than usual. The NHS has been and continues to be fully focused on dealing with the pandemic.

Figure 5.4 - Stability Index for the Non-Medical Workforce

Staff groups	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	Change Percentage points 2014-2020
Nurses & Health Visitors	89.7%	89.5%	89.1%	89.3%	89.8%	90.2%	0.5
Midwives	90.2%	89.7%	89.2%	89.4%	89.6%	89.8%	-0.4
Ambulance	92.6%	92.4%	92.7%	91.9%	92.2%	93.0%	0.4
STT	88.5%	88.3%	88.6%	89.0%	89.3%	89.8%	1.3
Support to Clinical	88.4%	88.4%	87.6%	88.2%	88.9%	89.5%	1.2
Infrastructure	87.9%	88.3%	88.4%	88.4%	89.8%	90.3%	2.5

Source: NHS Digital HCHS monthly workforce publication
The definition of the stability index is provided by NHS Digital.

Reasons for leaving

5.12 In the 2018/19 financial year, voluntary resignation accounted for almost half of all reasons for leaving (45.6%). Retirement was the next biggest reason for leaving at over 13% of the leaver workforce. The latest 2018/19 figure for Voluntary Resignation has been increasing steadily and is 3.3 percentage points higher than it was in 2014/15. There have been year-on-year decreases in the number of redundancies of non-medical staff between 2014 and 2019.

Figure 5.5 - Reasons for Leaving Numbers (Absolute and Percentage)

Reason for Leaving	14/15	15/16	16/17	17/18	18/19	19/20	14/15	15/16	16/17	17/18	18/19	19/20
Dismissal	4,272	4,464	4,282	4,006	3,816	3,545	3.9%	3.9%	3.6%	3.3%	3.3%	3.2%
Employee Transfer	6,950	5,234	6,480	6,134	3,105	3,041	6.3%	4.6%	5.4%	5.1%	2.7%	2.7%
End of Fixed Term Contract	2,298	2,317	2,227	2,223	2,060	2,069	2.1%	2.0%	1.9%	1.8%	1.8%	1.8%
Completion of Training Scheme	626	575	529	470	495	440	0.6%	0.5%	0.4%	0.4%	0.4%	0.4%
End of Work Requirement	301	271	322	299	269	351	0.3%	0.2%	0.3%	0.2%	0.2%	0.3%
End of Fixed Term	452	475	390	448	375	361	0.4%	0.4%	0.3%	0.4%	0.3%	0.3%
Other												
Mutually Agreed Resignation	1,143	740	789	507	342	251	1.0%	0.7%	0.7%	0.4%	0.3%	0.2%
Others	845	790	821	878	1,238	1,561	0.8%	0.7%	0.7%	0.7%	1.1%	1.4%
Redundancy	1,819	1,639	1,324	1,258	920	751	1.7%	1.4%	1.1%	1.0%	0.8%	0.7%
Retirement	18,241	18,119	17,690	17,051	15,522	16,023	16.6%	15.9%	14.8%	14.1%	13.5%	14.3%
Unknown	26,574	29,663	33,318	34,480	34,311	33,432	24.1%	26.1%	27.9%	28.5%	29.9%	29.8%
Voluntary Resignation	46,640	49,429	51,365	53,148	52,341	50,529	42.3%	43.5%	43.0%	44.0%	45.6%	45.0%
All Reasons for Leaving	110,161	113,716	119,537	120,902	114,794	112,220	100%	100%	100%	100%	100%	100%

Recruitment & Retention Premia

5.13 Recruitment and Retention Premia (RRPs) are pay supplements which can be applied to individual jobs, or groups of jobs, where labour market pressures make it difficult for employers to recruit and retain staff in sufficient numbers at the normal salary rate. These can either be short or long term depending on whether retention problems are likely to be resolved in the near term or if the labour market conditions are more deep-rooted and will take more time to resolve

5.14 For staff working on NHS Terms & Conditions there are a small proportion of staff who are currently in receipt of RRP payments (see Figure 5.6) although the majority of these are as a result of legacy "Cost of Living Supplement" payments (COLS) that were the forerunner to the High Cost Area Supplement and as such the proportion of people in receipt of RRPs has reduced over time.

Figure 5.6 – Proportion of NHS TCS Workforce in Receipt of RRP – 12 Months to March 2020

Proportion in Receipt	Mar-16	Mar-17	Mar-18	Mar-19	Mar-20
Nurses & health visitors	1.2%	0.9%	0.8%	0.8%	0.7%
Midwives	0.8%	0.8%	0.7%	0.6%	0.6%
Ambulance staff	0.4%	0.2%	0.1%	0.1%	0.3%
Scientific, therapeutic & technical staff	1.1%	1.0%	1.0%	1.0%	1.0%
Support to Clinical Staff	0.5%	0.3%	0.3%	0.3%	0.3%
Support to doctors, nurses & midwives	0.5%	0.3%	0.3%	0.3%	0.3%
Support to ambulance staff	0.3%	0.3%	0.1%	0.8%	0.7%
Support to ST&T staff	0.3%	0.2%	0.2%	0.2%	0.2%
NHS Infrastructure Support	1.0%	1.0%	1.1%	1.1%	1.0%
Central functions	0.5%	0.5%	0.6%	0.6%	0.6%
Hotel, property & estates	1.8%	1.8%	1.8%	1.8%	1.6%
Senior managers	1.4%	1.0%	1.1%	1.2%	1.2%
Managers	1.0%	0.8%	0.9%	1.0%	1.0%

Source: NHS Digital Earnings Statistics

5.15 The Pay Review Bodies have sought additional evidence on the potential of RRPs to help address recruitment and retention challenges. While there are potential benefits to increasing the use of RRPs to attract and retain talent there are also some aspects that need to be considered.

(a) Pay is not the only factor in either attracting someone to a position or helping to retain them but part of a broader range of factors including wellbeing,

morale and the opportunity for career progression Some of these factors are considered as part of the ongoing work in this area by NHSEI (see Chapter 4 for NHS People Plan).

(b) Care would need to be taken to ensure that it did not lead to a situation where some trusts were unable to hire the staff, they need because of higher pay being offered in a neighbouring trust.

(c) Management would require the capacity and resources to effectively run the RRP system.

(d) Evidence of a recruitment and retention problem would need to be available to justify the application of an RRP payment and avoid a potential equal pay legal challenge under the NHS TCS Job Evaluation Scheme.

The Effect of Moving from the Bursary System in England

5.16 The Pay Review Body asked for additional information on the effect of moving from the Bursary System. UK nationals and EU students were eligible for the NHS bursary until 2016. In 2017, all students were moved to the standard student finance package.

5.17 From September 2020, as well as the funding available through the standard student finance package, eligible new and continuing nursing, midwifery and most allied health profession students on pre-registration courses at English universities will also benefit from a training grant of at least £5,000 per academic year. The introduction of the grant has contributed to a significant increase in the number of students applying to these courses. The latest data from UCAS shows a 26% increase in the number of placed applicants on nursing and midwifery courses in England this year. This is an increase of 6,110, from 23,630 last year to 29,740 this year.

5.18 UCAS data also shows that overseas applicants have more than doubled since 2019 and applicants from the EU has fallen by 49% since 2016, as in Figure 5.7.

Figure 5.7 – Number of applicants on nursing and midwifery courses in England by country of domicile

Country of domicile	2016/17	2017/18	2018/19	2019/20	2020/21	Change 2020 versus 2019	Change 2020 versus 2016
UK	54,940	42,620	37,530	39,150	45,210	15%	-18%
EU (excluding UK)	1,430	940	760	730	780	7%	-45%
Overseas	420	600	690	900	1,320	47%	214%

Source: Universities and Colleges Admissions Service (UCAS) End of June 2020 publication

5.19 When compared to 2016, the final year of NHS bursary, UK acceptances have increased by 28% in 2020.

5.20 There has also been increases in EU applicants being accepted onto nursing and midwifery courses. In 2020, acceptances from the EU increased by 30% on the same time last year. When compared to pre-bursary reforms (2016), EU acceptances are 47% lower in 2020. Further acceptance data from UCAS is shown in figure 5.8.

Figure 5.8 – Acceptances on nursing and midwifery courses in England by country of domicile

Country of domicile	2016/17	2017/18	2018/19	2019/20	2020/21	Change 2020 versus 2019	Change 2020 versus 2016
UK	23,280	22,575	22,200	23,630	29,740	26%	28%
EU (excluding UK)	370	230	180	150	195	30%	-47%
Not EU	45	80	115	185	320	73%	611%

Source: Universities and Colleges Admissions Service (UCAS) data - end of cycle 2020

Note - Some of the figures relate to small numbers of applicants and acceptances and are sensitive to small changes.

5.21 Further evidence on increasing clinical placements was also requested. Work on this is currently ongoing and is led by HEE and NHSEI. In August 2020, HEE

announced that £15m would be made available through their Clinical Placements Expansion Programme to increase clinical placements in the NHS and support growth in Nursing, Midwifery and the Allied Health Professions.

5.22 Further to this, evidence on how targets can be achieved and the factors driving applicants and acceptances was also requested, however we do not currently have evidence available for these areas. There is some evidence on factors impacting attrition from courses from HEE's Reducing Pre-registration Attrition and Improving Retention (RePAIR) programme, which suggested that some of the reasons for students leaving included finances, workload and stress.

5.23 The PRB also asked for pre-registration application numbers. The Department monitors unique applicants to nursing courses because these are a more accurate measure of who could potentially be offered a place and be accepted onto a course. Students can apply to five different courses but can only begin one course and consequently the number of applications can give a misleading picture, unless the objective is to study student choice.

Vacancies

5.24 NHS Improvement undertake monthly workforce data collection from NHS trusts, which includes data on staff in post (including bank and agency) and vacancies (defined as the difference between the reported whole-time equivalent substantive staff in post and planned workforce levels). Vacancies typically show seasonal variation with peaks occurring at the start of the financial year, and troughs occurring at the end. The overall nursing vacancy rate has showed some variation over the last year, ranging from 12.1% to 9.9%, which is equivalent to vacancies of 43k to 36k. Further figures are published by NHS Digital[i].

5.25 Vacancies should reflect the headroom for sickness absence, maternity leave and temporary staffing which a trust is expecting to require. Bank and agency staff are used to cover some vacancies in addition to covering sickness absence and long term leave.

5.26 NHS Digital also highlight that these experimental statistics should be treated with caution especially considering disruption from the COVID-19 pandemic. NHS Digital say:

"Due to the COVID-19 pandemic, there has been a significant disruption to recruitment activity within the NHS. This is apparent from the significantly lower reported advertised vacancies between March and June 2020 as the NHS was fully focused on dealing with the pandemic and the typical seasonal pattern not shown.

"Whilst some critical recruitment increased in response to the situation, other elements were significantly reduced – this is particularly the case for certain Staff Groups. However, we believe that the headline figures included in the bulletin remain of immediate use, as they represent the situation as it was at the time, but year on year comparisons should be avoided."

Figure 5.9 – Nursing Vacancies and vacancy rates from Q1 2018/19 - Q1 2020/21

Measure	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	20/21 Q1
Vacancies	42,589	42,679	39,686	39,524	44,195	43,452	38,736	36,083	37,821
Vacancy rate	12.0%	12.1%	11.1%	11.1%	12.3%	12.1%	10.7%	9.9%	10.3%

Source: NHS Digital Vacancy Statistics

The International Workforce

5.27 The Government is committed to ensuring that the NHS and social care system have the nurses, midwives, doctors, carers and other health professionals that it needs. Specifically, it has committed to delivering 50,000 more nurses to ensure the NHS continues to deliver world class care. International recruitment will be fundamental to delivering these commitments.

5.28 Internationally trained staff have always been part of the (NHS and we value the enormous contribution of all the international staff working in health and social care. There are two current Government policies in place to support internationally trained health and care staff in the UK:

(a) The Home Office EU Settlement Scheme is a simple registration process for EU nationals who arrive in the UK to live before the end of 2020, allowing them to remain living in the UK with broadly the same rights as they currently enjoy. Any EU Citizens living in the UK by 31 December 2020 have until 30 June 2021 to apply for the scheme.

(b) From October 2020 all health and social care staff, including EEA staff who come to work in the UK from January 2021 will be exempt from paying the Immigration Health Surcharge (IHS).The purpose of the NHS surcharge is to benefit the NHS, help to care for the sick and save lives. NHS, wider health and social care workers from abroad who are granted visas are doing this

already through the fantastic contribution they make. A reimbursement is available for those staff that have been working from 31 March 2020.

5.29 The Government is clear that international recruitment of health and care staff must be managed in accordance with high ethical standards. We have a long list of countries that UK health and care employers should not actively recruit from: this is currently under review, with engagement from other Government Departments and the World Health Organisation (WHO). Government-to-Government agreements are in place where we proactively recruit from countries that receive aid. This is the case in the Philippines and several states in India.

5.30 The COVID-19 pandemic and resultant border closures saw a significant fall in the numbers of health and care professionals able to travel to the UK to take up NHS posts in the first half of 2020. As restrictions have eased, we have seen a steady increase in joiners. While future restrictions remain a possibility, we expect a return to pre-covid levels once the pandemic impact decreases.

5.31 Around 11% of non-medical staff have a non-UK nationality. Of these, 5.6% are from the EU27, an increase from 4.6% in 2016. Figure 5.10 shows the percentage of Hospital and Community Health Service (HCHS) EU and EEA and Rest of World (excluding UK) workers for each staff group.

Figure 5.10 - International Workforce (non-medical) by Nationality Group (June 2020)

Staff group	EU and EEA	Rest of World (excluding UK)
Total non-medical HCHS workforce	5%	7%
Nurses and health visitors	6%	12%
Midwives	5%	2%
Ambulance staff	3%	4%
Scientific, therapeutic and technical staff	6%	4%
Support to Clinical Staff	4%	6%
Infrastructure Support Staff	4%	4%

Source: NHS Digital Workforce Statistics

Note: Figures are % of all nationalities including unknown nationality. Around 5% of non-medical staff are recorded as unknown nationality

5.32 Since 2016, we have seen increases in joiners of nearly all staff types from the EU and EEA, and the rest of the world. The exceptions to this trend are EU and EEA nurses and health visitors, which have shown a decline from 6.9% to 5.7%, and midwives from the EEA and EU (5.3% to 4.9%) and rest of the world (2.1% to

1.7%). In the case of nurses and health visitors the fall in EEA and EU joiners been offset by increases in joiners from the rest of the world – 8.00% to 12.3%.

Figures 5.11, 5.12 and 5.13 - NHS Hospital and Community Health Services: Proportion of all non-Medical Joiners by Staff Grade to NHS Trusts and CCGs in England, by nationality, annual to 30th June

UK	Jun-16	Jun-17	Jun-18	Jun-19	Jun-20
Nurses & health visitors	77.7%	78.6%	79.3%	79.5%	79.0%
Midwives	84.5%	85.9%	87.1%	88.5%	90.3%
Ambulance staff	78.0%	79.3%	80.0%	80.4%	82.8%
Scientific, therapeutic & technical staff	84.9%	85.3%	85.6%	86.3%	87.4%
Support to clinical Staff	83.9%	84.4%	84.6%	85.3%	86.1%
Infrastructure Support Staff	84.6%	85.7%	86.2%	86.7%	87.9%
Other staff or those with unknown classification	83.1%	83.6%	84.1%	81.1%	85.0%
All Non-Medical Staff	82.2%	82.9%	83.4%	84.0%	84.6%

Figure 5.12

EU+EEA	Jun-16	Jun-17	Jun-18	Jun-19	Jun-20
Nurses & health visitors	6.9%	6.8%	6.4%	6.0%	5.7%
Midwives	5.3%	5.4%	5.2%	5.1%	4.9%
Ambulance staff	1.3%	1.9%	2.1%	2.5%	2.5%
Scientific, therapeutic & technical staff	4.5%	5.0%	5.3%	5.5%	5.7%
Support to clinical Staff	3.3%	3.6%	3.8%	4.1%	4.3%
Infrastructure Support Staff	3.5%	3.8%	4.0%	4.2%	4.4%
Other staff or those with unknown classification	4.9%	4.3%	4.0%	4.8%	5.5%
All Non-Medical Staff	4.6%	4.8%	4.8%	4.9%	4.9%

Figure 5.13

Rest of World	Jun-16	Jun-17	Jun-18	Jun-19	Jun-20
Nurses & health visitors	8.0%	8.2%	8.8%	10.1%	12.3%
Midwives	2.1%	2.0%	1.8%	1.7%	1.7%

Ambulance staff	2.4%	2.9%	3.2%	4.2%	4.3%
Scientific, therapeutic & technical staff	3.4%	3.6%	3.7%	3.9%	4.1%
Support to clinical Staff	4.9%	5.1%	5.3%	5.5%	5.5%
Infrastructure Support Staff	3.5%	3.6%	3.6%	3.7%	3.8%
Other staff or those with unknown classification	5.0%	5.6%	7.0%	9.0%	5.8%
All Non-Medical Staff	5.3%	5.4%	5.7%	6.2%	6.9%

Exiting the European Union

5.33 The Department's priority is to ensure that EU staff currently working in the NHS are not only able to stay but feel welcomed and encouraged to do so. As negotiations around the UK's exit from the EU have now ended, DHSC and its ALBs will continue to support the health and care system to ensure they are able to deliver the services on which patients rely.

5.34 As set out above, the Home Office EU Settlement Scheme will allow EU nationals who arrive in the UK to live before the end of 2020 to remain living in the UK, with broadly the same rights as they currently enjoy.

5.35 The number of EU non-medical staff has increased by over 10,000 between June 2016 and June 2020 and now forms 5.6% of all non-medical staff on a headcount basis, an increase of 1%.

Figure 5.14 - Number and percentage of non-medical staff from EU27

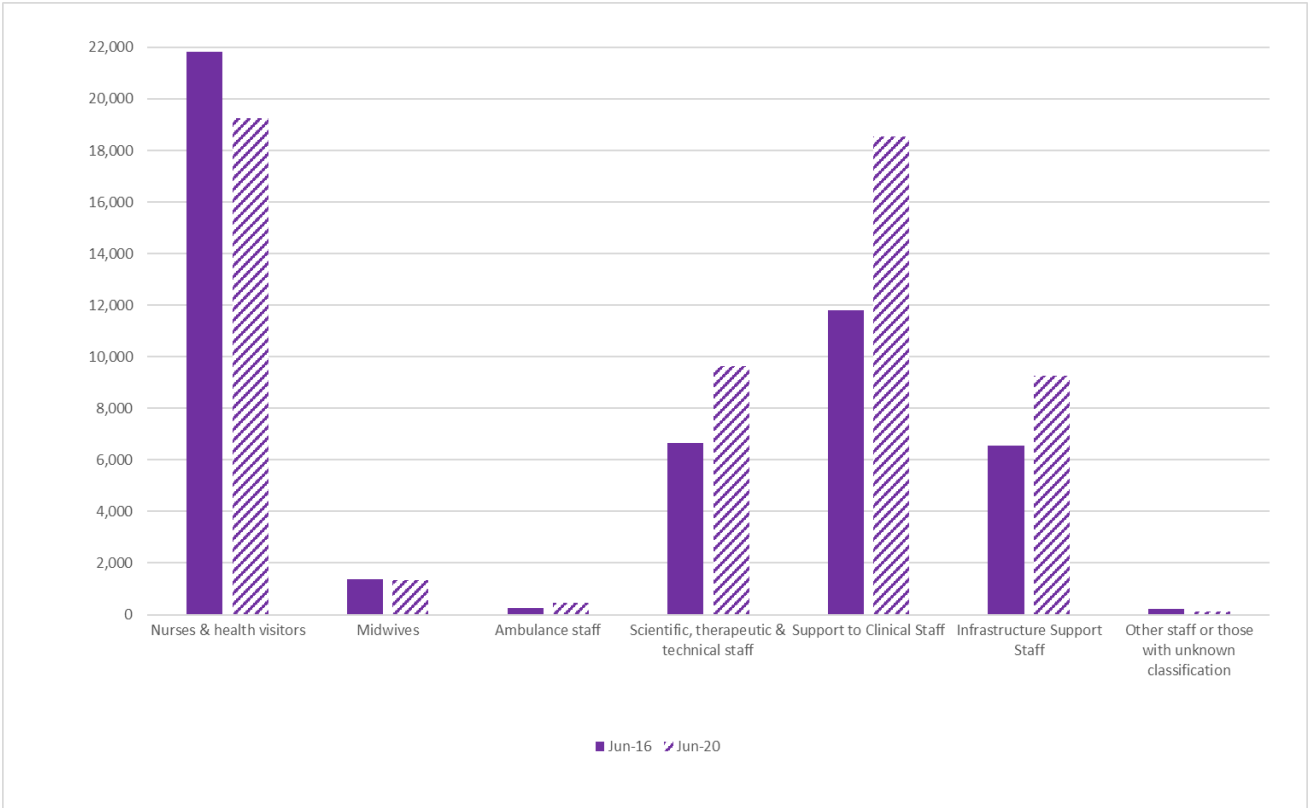
Staff Group	Jun-16	Jun-20	Change
All non-medical staff from EU	48,592	58,597	10,005
As a percentage of all non-medical staff	4.60%	5.60%	1.0 percentage points

Source: NHS Digital Workforce Statistics

5.36 Despite this increase in overall EU non-medical staff, Figure 5.15 shows that between June 2016 and June 2020, the number of EU nurses, midwives and health visitors decreased by over 2,500. Departmental analysis suggests this is

most likely a consequence of the Nursing and Midwifery Council (NMC) introducing more rigorous language testing for EEA applicants in January 2016. Nurses and health visitors form the largest non-medical staff group for EU27 workers. As at June 2020 there are over 19,200 nurses and health visitors from the EU27.

Figure 5.15 - Non-UK EU Nationals by Staff Group



5.37 DHSC does not expect EU Exit to have a significant short-term impact on availability of health and care staff in the NHS. In the longer term there may be a reduction in the in-flow of staff from the EEA, due to new immigrations requirements and economic uncertainty. The Department has taken a number of steps to help mitigate any supply impacts, for instance by passing legislation that allows regulators to accept qualifications unilaterally from the EU after exit day as they currently do, a reduction of language test requirements by both the NMC and the Home Office, introduction of a streamlined international registration process by the NMC and development of system guidance on 'passporting' of staff between different providers.

5.38 We continue to monitor and analyse overall staffing levels across the NHS and Adult Social Care, and we are working across Government to ensure there will continue to be sufficient staff to deliver the high-quality services on which patients rely following the UK's exit from the EU.

5.39 From January 2021 the UK introduced a new points-based immigration system to replace free movement from the EU. This system is global, meaning overseas recruits face the same immigration control whether they come from the EU or further afield. The new system has several significant changes, including a reduction to the salary threshold, from £30,000 to £25,600 (or the appropriate national NHS pay scale for the job) and a reduction in the skill threshold from RQF-6 (a degree-level role) to RQF-3 (an A-Level equivalent role).

5.40 On 4 August 2020 the Government also introduced a new Health and Care Visa, which is a subset of the current Tier 2 (General) visa. This visa provides anyone working in eligible health and care roles, such as doctors, nurses, AHPs and social workers, 50% reduction in visa fees, a full exemption from the Immigration Health Surcharge and a guaranteed decision with 3 weeks.

Agency and Bank Staff

5.41 The use of agency and Bank staffing provides some indication of how the NHS labour market is operating. The available national expenditure figures do not separate the NHSPRB Remit from medical and dental staff. They include all expenditure on 'off-payroll' staffing, including agency, self-employed contractors and externally-managed banks.

Agency reduction measures

5.42 NHS Trust spending on agency staff rose by 40% between 2013/14 and 2015/16 (£2.6bn to £3.6bn). However, following the subsequent introduction of agency spend controls, expenditure on agency staffing has reduced to £2.38bn in 2019/2020. This spend by staff group is set out in Figure 5.16 below.

Figure 5.16 Agency Staff 2019/20

Staff Group	Annual Expenditure (£m)
Admin & Estates	189.4
Healthcare Assistant & Other Support	120.5
Healthcare Science	31.9
Medical & Dental	918.7
Nursing, Midwifery & Health Visiting	878.5
Scientific, Therapeutic & Technical (AHPS)	238.9
Other	2.3
Total	2,380.2

5.43 The 2015 controls included:

- The introduction of price caps limiting the amount a trust can pay to an agency for temporary staff.

- Mandatory use of approved frameworks for procurement. The agency fee is a fixed percentage in the majority of framework cases, although some agreements allow agencies to set a higher fee.

- A requirement for all trusts to stay within specified Annual Expenditure Ceilings for agency staff. The annual expenditure ceilings set a target reduction in agency spend, which ranges from 0-35% depending on what proportion of trust's paybill was spent on agency staff.

5.44 In 2019, NHSEI updated the agency rules to include two new policy initiatives:

(a) further restrictions on the use of off-framework agency workers to fill non-clinical and unregistered clinical shifts;

(b) a restriction on the use of administration and estates agency workers, with exemptions for special projects, shortage specialties, and IT staff.

5.45 These changes came into effect on 16 September 2019. NHSEI are now carrying out their next round of stakeholder engagement to understand if further updates to the Agency Rules are required 2021.

5.46 For trusts, this will reduce cost and give greater assurance of quality. It will enable non-clinical (and clinical unregistered) workers who play vital roles across a range of fields to benefit from a better flexible bank offer and increase the number benefiting from substantive roles in the NHS.

5.47 NHSEI have also committed to eliminating off-framework spend by 2022, which will reduce agency spend further and make the supply of agency healthcare staff safer.

5.48 All of the above measures are regularly monitored for compliance and effectiveness.

5.49 Since April 2017, agency costs have consistently been below 5% of overall pay costs and have now fallen to 4%. The continued reduction in the proportion of agency staff costs to total pay bill is a significant achievement in view of the record levels of demand and the extreme pressure on the acute sector.

5.50 Agency shifts have increased by 0.5% from 2018/19 to 2019/20, however, the overall average price per shift decreased by 1.3% from 2018/19, resulting in an overall saving compared to 2018/19 of £19m (0.8%).

COVID-19 impact on managing agency and bank

5.51 During the COVID-19 pandemic there has been significant disruption to the health system, a lot of which is due to the cancellation of elective work. This has meant a reduction in the number of available agency and bank shifts but has been necessary to control the spread of the virus.

5.52 Under normal circumstances, it is up to each individual Trust to manage their recruitment locally. During the pandemic, a number of programmes were set up to identify and deploy more flexible resources into the NHS. This included NHSEI's Bring Back Staff (BBS) and NHS Professional's (NHSP) COVID-19 National Rapid Response Programmes. However, due to less demand than initially anticipated, many of these volunteers were not called upon.

5.53 Many flexible workers, both agency and bank, were unable to pick up shifts during the first wave of COVID-19, and due to the nature of their employment, had different support schemes to cover this absence.

5.54 The nature of agency work is that it is ad hoc and there is no expectation of a minimum level of supply. Agency workers are also not employed by the NHS and are therefore subject to their agency's terms, conditions and entitlements, including sick pay. The Government has made it clear that agencies are required to pay Statutory Sick Pay (SSP) to their workers where they cannot work due to COVID-19. It is also up to the agency whether to furlough their staff.

5.55 Bank workers should receive full pay for self-isolating, sickness, or closure of the workplace due to COVID-19, for all pre-booked bank shifts that they would have worked had they not self-isolated. This applies to staff who have a substantive contract with their employer, and to 'bank only' staff. Bank workers should be given priority for shifts where substantive vacancies are available. We also know that NHS Professionals offered many bank workers shifts through their Track and Trace Programme.

5.56 Figure 5.17 shows that there was a significant decrease in agency shifts during the first wave of COVID-19, which at the end of August had yet to show signs of increasing. The volume of shifts decreased by 15% in the first five months of 2020/21 and during this period Trusts have spent £0.91bn on agency staff, which is 10% lower than the same period in 2019/20. Of this £0.91bn, £0.36bn related to Medical and Dental agency staff, down 9% from the same time last year. The

percentage of medical agency staff paid in line with the price cap between April and August 2020 was roughly the same as the corresponding period last year.

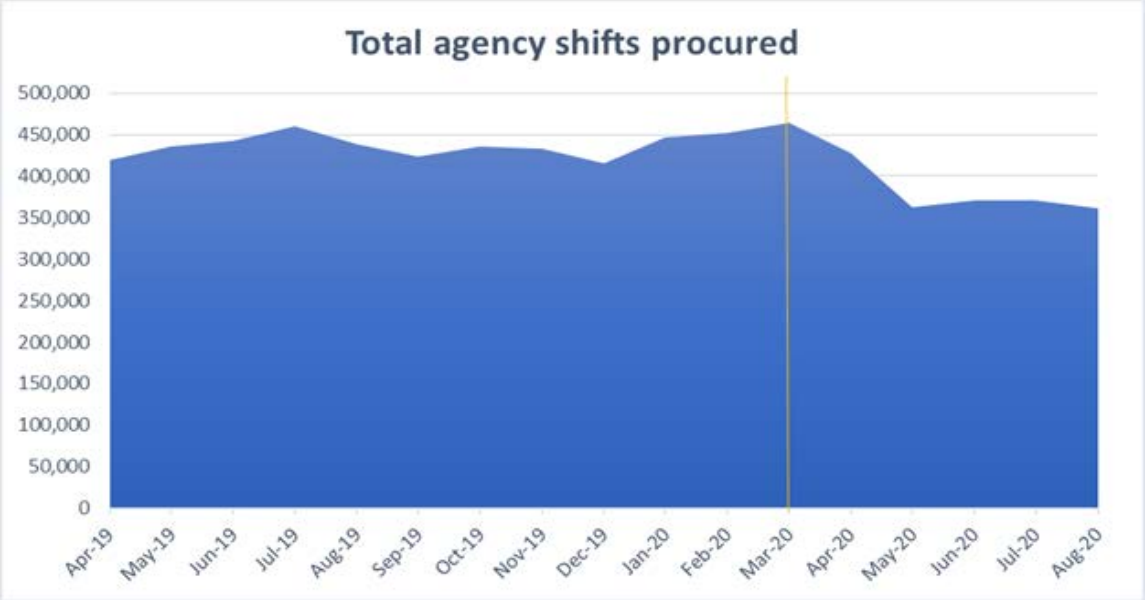


Figure 5.17 Total agency shifts procured April 2019- August 2020

5.57 However, with the second wave, additional pressure during the winter months and backlog of electives, agency shifts have increased to pre- March 2020 levels during the latter end of 2020. From the end of August to November 2020 we saw an increase of 12.4% in agency shifts in the NHS and we predict that data in early 2021 will show us a similar trend when that is made available. Figures 5.18 and 5.19 respectively show the change in total agency spend across the 12-month period, November 2019 - November 2020 and agency shifts by staff group in the period April 2019 - November 2020.

Figure 5.18 Total Bank and Agency Spend November 2019 - November 2020

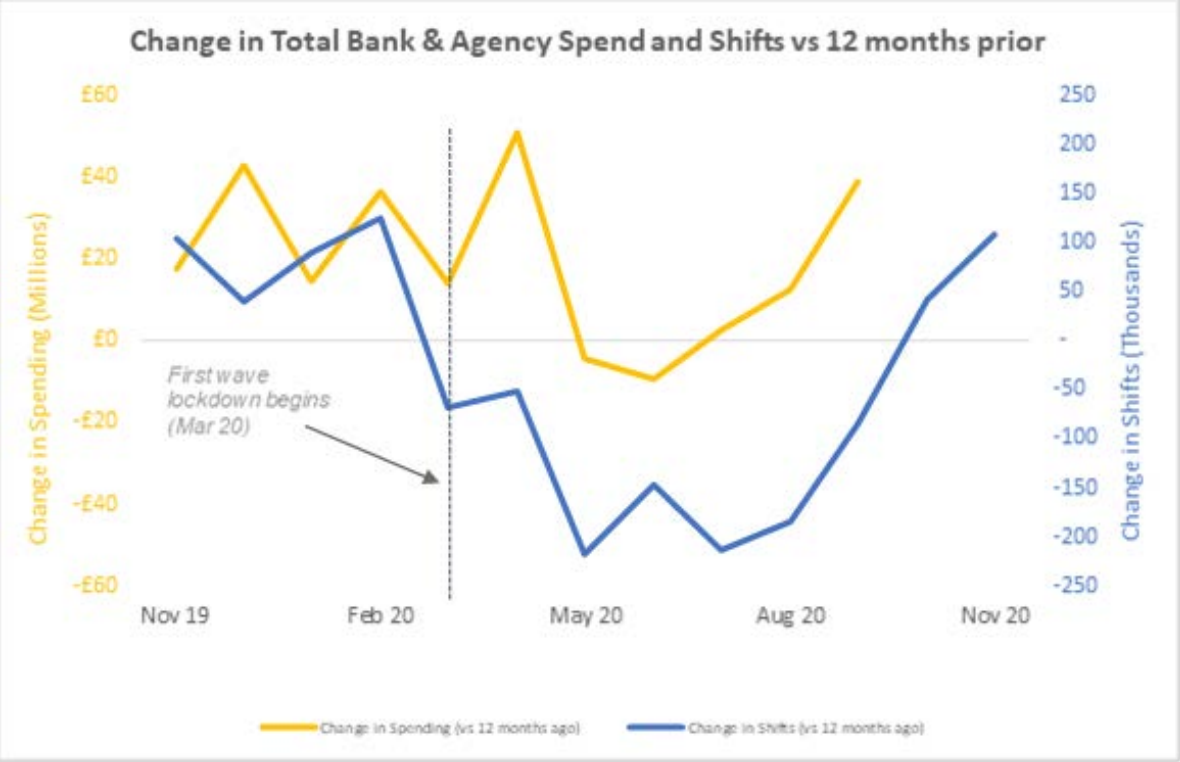
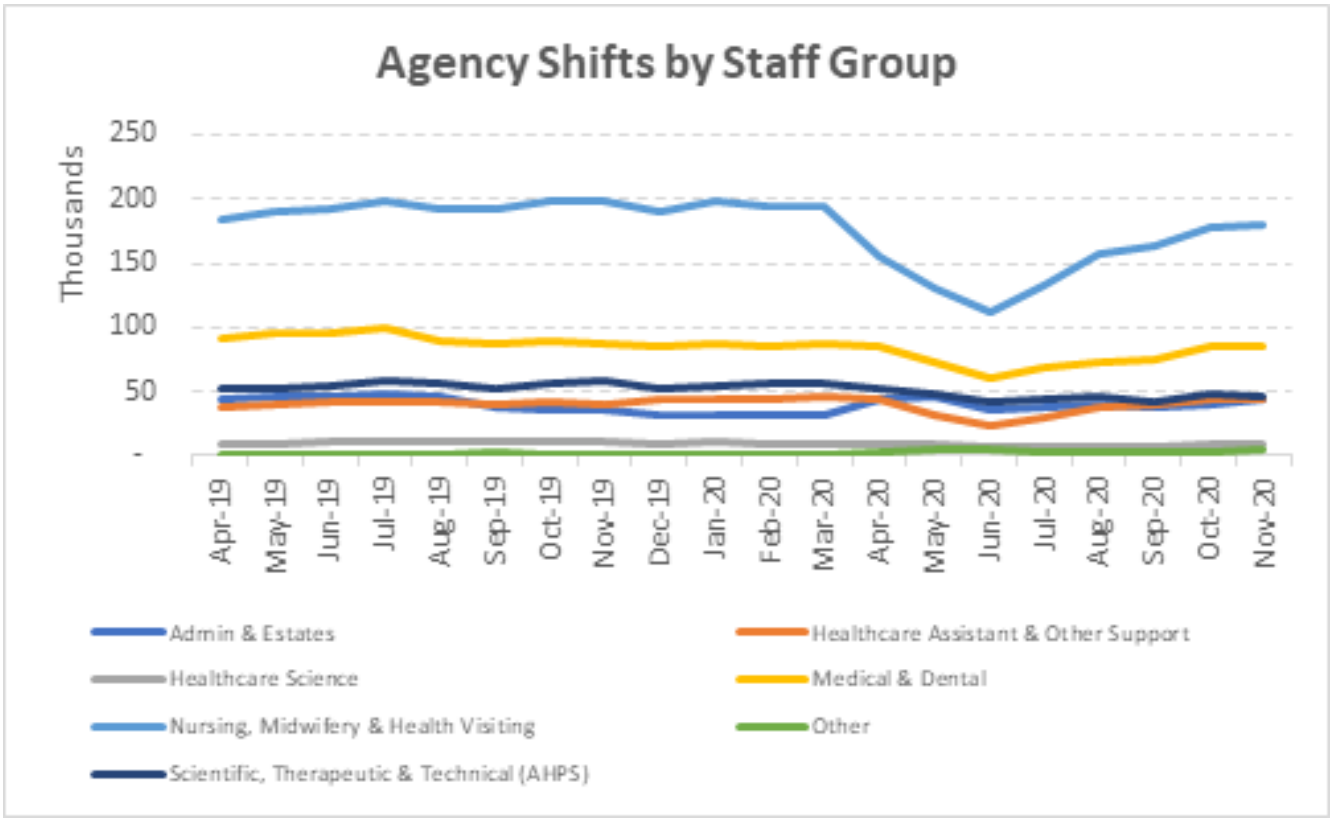


Figure 5.19 Agency Shifts by Staff Group, April 2019 - November 2020



5.58 Figures, 5.20, 5.21 and 5.22 shows that doctors shifts held up more than nursing during the pandemic period, hence the slight increase in average cost per shift seen in recent months.

5.59 Overall this year, there is a bigger reduction of agency staff, and therefore agency shifts, than of NHS bank workers and NHS substantive workers. There were less agency and bank shifts during the first wave of COVID-19, with agency staff seeing the biggest reduction.

Figure 5.20 Medical and Dental Shifts

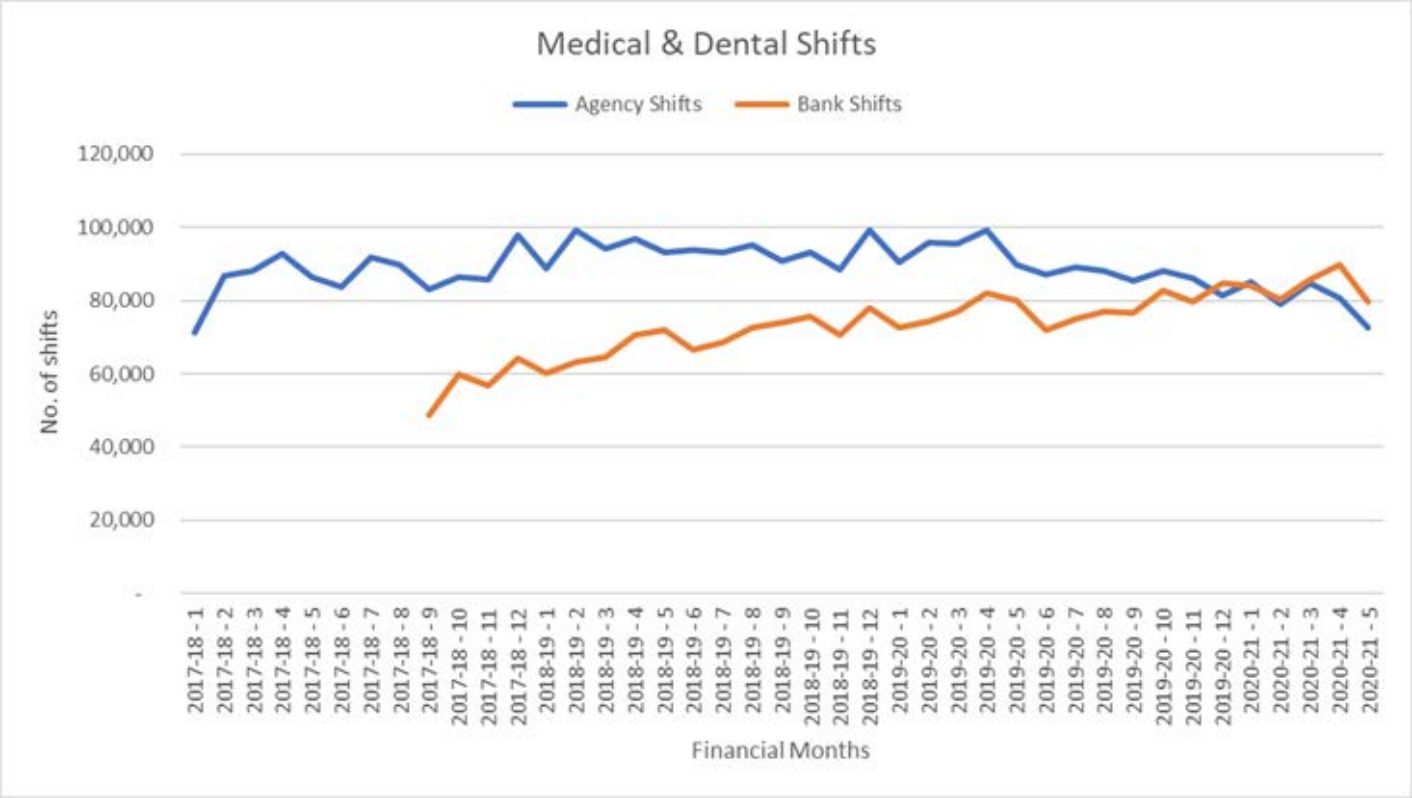


Figure 5.21 Nurses and Midwives Shifts

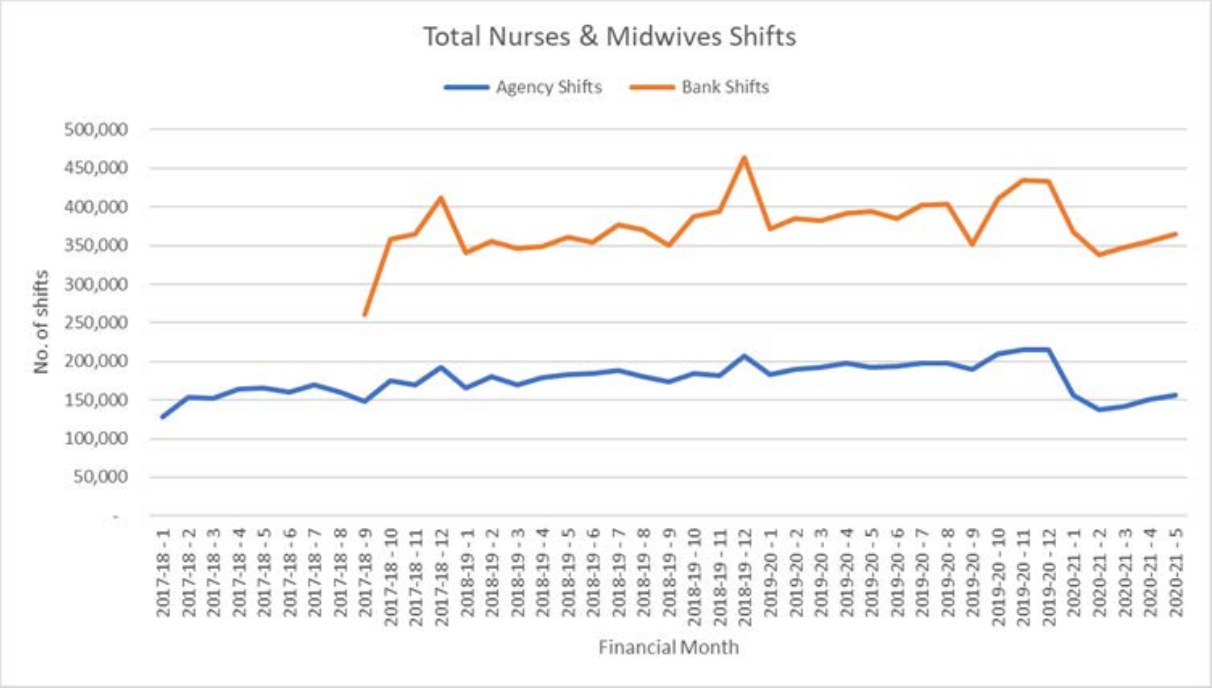


Figure 5.22 Overall Price Cap Compliance

Diversity Analysis

5.60 The NHS Workforce is more ethnically diverse than the wider economy. Across the Non-Medical workforce about 78% of the workforce is White with a further 6% Black, 8% Asian or Asian British. There are currently just over 4% of the workforce with Unknown or Not Stated Ethnicity. BAME representation in the workforce has been relatively stable over the past 5 years.

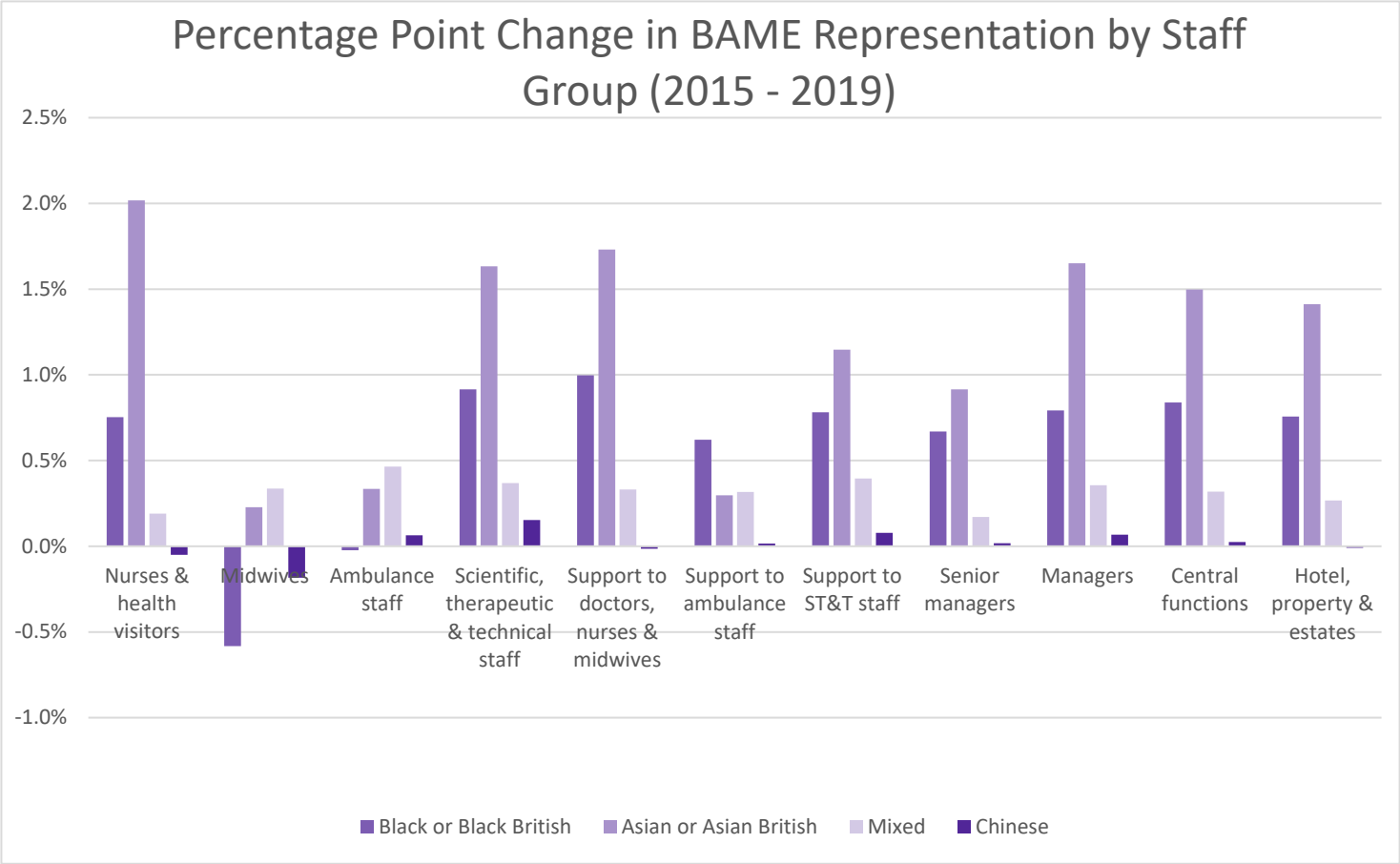
Figure 5.23 - Ethnicity makeup of Non-Medical NHS roles

September 2019 (Headcount)	Asian or Asian British	Black or Black British	Chinese	Mixed	White	Any Other Ethnic Group	Not Stated & Un-known
Nurses & health visitors	9.8%	8.1%	0.3%	1.4%	72.1%	4.0%	4.3%
Midwives	2.0%	6.7%	0.3%	1.6%	85.6%	0.6%	3.4%
Ambulance staff	1.1%	0.5%	0.1%	1.3%	93.8%	0.3%	2.9%
Scientific, therapeutic & technical staff	8.7%	3.8%	0.8%	1.7%	79.9%	1.3%	3.8%
Support to doctors, nurses & midwives	7.4%	6.9%	0.2%	1.7%	77.9%	1.9%	4.0%
Support to ambulance staff	2.5%	1.9%	0.1%	1.4%	89.7%	0.1%	4.2%
Support to ST&T staff	7.1%	4.5%	0.3%	1.8%	80.9%	1.3%	4.0%
Central functions	8.0%	5.0%	0.4%	1.7%	79.8%	0.8%	4.3%
Hotel, property & estates	7.2%	5.8%	0.2%	1.4%	77.2%	1.8%	6.5%
Senior managers	4.2%	2.3%	0.3%	1.0%	86.5%	0.4%	5.3%
Managers	6.3%	3.7%	0.3%	1.4%	83.4%	0.6%	4.1%
Other staff or unknown	13.1%	5.8%	0.3%	2.2%	69.6%	3.7%	5.3%
Grand Total	8.0%	6.1%	0.3%	1.6%	77.7%	2.1%	4.2%

Source: NHS Digital HCHS monthly workforce publication – September 2019

5.61 While the overall BAME representation in the workforce has been stable since 2015, there have been some changes within staff groups as shown in Figure 5.24. In most staff groups there have been increases in the proportion of BAME staff since 2015.

Figure 5.24 - Change in BAME Representation by Staff Group (2015 - 2019)



Source: NHS Digital Workforce Statistics

Gender Balance in The Non-Medical Workforce

5.62 Data from March 2020 shows that just over 80% of the Non-Medical workforce are female. The proportion of female staff varies by staff group with higher proportions of female staff in the Nursing (89%), Midwifery (100%) and Support to Doctors & Nurses (86%). Compared to the rest of the NHS workforce, Males have higher representation in Staff Groups including Ambulance Staff (58%), Support to Ambulance (48%) and Senior Managers (42%). The proportion of female staff is broadly unchanged over time.

Figure 5.25 – Workforce Gender Representation by Staff Group (March 2020)

Staff Group	Male	Female
Nurses & health visitors	11.4%	88.6%
Midwives	0.4%	99.6%
Ambulance staff	58.4%	41.6%
Scientific, therapeutic & technical staff	22.3%	77.7%
Support to doctors, nurses & midwives	14.4%	85.6%
Support to ambulance staff	48.1%	51.9%
Support to ST&T staff	20.3%	79.7%
Central functions	27.8%	72.2%
Hotel, property & estates	41.7%	58.3%
Senior managers	42.2%	57.8%
Managers	37.7%	62.3%
Other staff or those with unknown classification	27.1%	72.9%
Grand Total	19.7%	80.3%

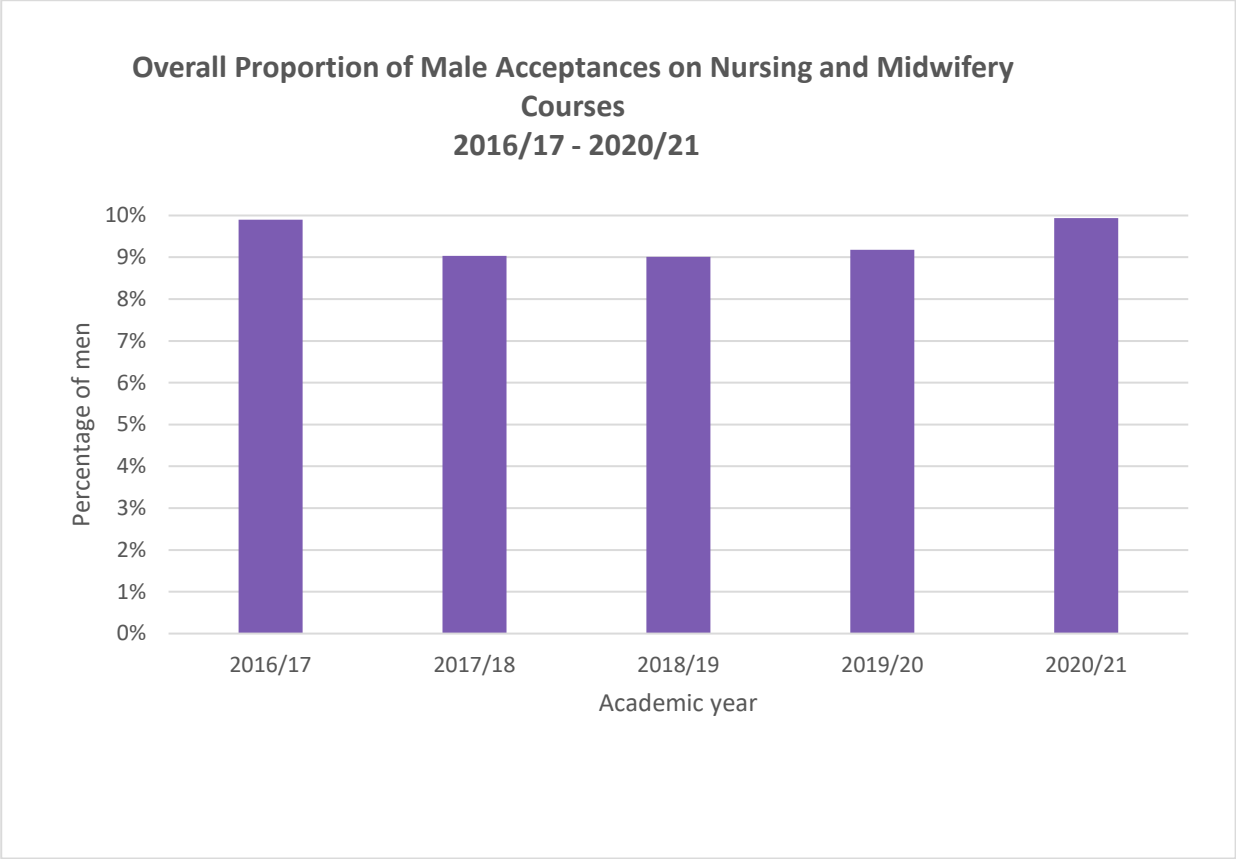
Source: NHS Digital Workforce Statistics

Gender Balance in Healthcare Education

5.63 Given the balance of men and women in AfC roles and the importance of appealing to the widest possible range of talent to work in the NHS at all levels, the Pay Review Body asked for information on gender and degree choices for nursing, midwifery and Allied Health Professionals.

5.64 UCAS data shows that men made up around 10% of overall acceptances on nursing and midwifery courses in 2020. Over the period 2016/17 – 2020/21 academic years, this has remained broadly the same as shown in Figure 5.26.

Figure 5.26 - Overall Proportion of Male Acceptances on Nursing and Midwifery Courses in the UK



Entrants to nursing, midwifery and Allied Health Professionals by POLAR3 - a participation measure

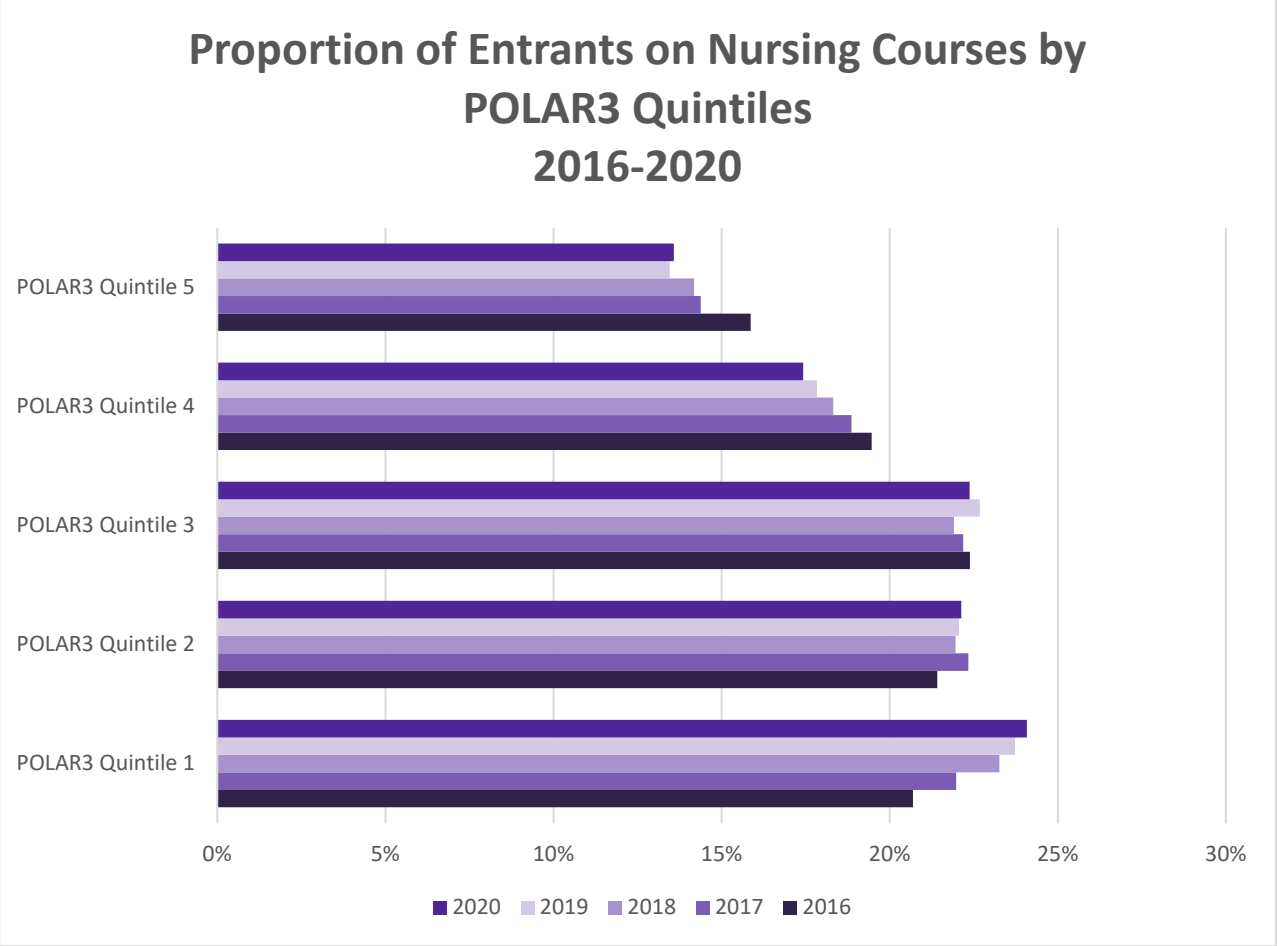
5.65 Given the importance of appealing to the widest possible range of talent to work in the NHS at all levels, the Pay Review Body asked for information on socio-economic background and degree choices for entrants to nursing, midwifery and Allied Health Professions.

5.66 The Participation of Local Areas (POLAR) is a participation measure which classifies local areas into five groups, based on the proportion of 18 year olds who enter higher education aged 18 or 19. Group 1 (quintile 1) represents the most disadvantaged fifth of backgrounds, and group 5 (quintile 5) represents the least disadvantaged fifth.

5.67 Data, in Figure 5.27 shows that the proportion students entering nursing degree courses from POLAR3 quintile 1, the most disadvantaged fifth of backgrounds increased from 21% in 2016 to 24% in 2020.

5.68 The proportion of entrants to nursing from the least disadvantaged fifth of backgrounds decreased from 16% in 2015 to 14% in 2019.

Figure 5.27 - Proportion of Entrants on Nursing Courses by POLAR3 Quintiles 2016 - 2020



Source: End of cycle 2020 Universities and Colleges Admissions Service (UCAS) data

Engagement

5.69 The "Staff Engagement" score in the Staff Survey is based on responses to three sections of the survey covering staff motivation and satisfaction, involvement and willingness to be an advocate for the service. This score can then be used for comparison purposes between different organisations.

5.70 Staff engagement scores have generally remained consistent over the last five years, with ambulance staff continuing to score below average.

5.71 The score is very consistent across age ranges - those who were aged 66 or over scored a little higher than average. There is no variation in staff engagement by gender.

Satisfaction with Pay

5.72 At a national average, the percentage of staff satisfied with their level of pay is 38%. Staff satisfaction with pay shows variation across some of the key staff groups. Typically, staff in higher paying roles (managers for example) were more satisfied than those in lower paying roles. Satisfaction has varied over time, with an improvement seen in the last couple of years, possibly due to the AfC multi year pay and contract reform deal.

5.73 There is little variation across gender with satisfaction in pay, with 38.4% of female staff being satisfied with their pay compared to 39% of male staff. Generally, satisfaction with pay increases the older an individual is, as older staff are more likely to be in more senior, high paying roles.

Flexible Working and Additional Hours

5.74 Staff satisfaction with flexible working has shown some improvement over the last four years, particularly so for ambulance staff.

5.75 The proportion of staff who work any additional paid hours has remained mostly consistent over the last four years, increasing 1.1% since last year. There is a significant amount of variability in this question based on the staff group. Those working in more direct care roles are more likely to work additional hours. More information on plans to increase flexibility in the NHS can be found in Chapter 4.

Recommend as a place of work

5.76 As part of the 'friends and family test' staff are asked two questions:

- would they recommend the care at the organisation to friends and family, and
- would they recommend the organisation to friends and family as a place to work.

5.77 Results are published monthly by NHS England.

5.78 Q1 2019-2020 (1st April – 30th June) results demonstrate that staff remain favourable about their organisation as a place of both work and care, with results remaining in line with Q1 2018-2019 and having stayed fairly consistent since

2015. When asked if they would recommend the care at the organisation, 81% of staff would recommend the care whilst 6% would not recommend it. When asked if they would recommend the organisation as a place to work, 66% would recommend it whilst 16% would not recommend it.

5.79 Published Staff Friends and Family Test data is available here: https://www.england.nhs.uk/fft/staff-fft/data/

Staff Health and Wellbeing

5.80 The national average health and wellbeing score stands at 5.9/10 for 2019. Scores for health and wellbeing have been mostly unchanged over the last five years. Ambulance staff score 4.7, which is notably lower than other staff groups. Similarly to last year, there is no variation by age for those 31-65 (5.9), however those age 66+ score highest (6.8) whilst those age 21-30 score lowest (5.7). There is little variation across health and wellbeing scores for gender.

5.81 Recommendation of the organisation as a place to work at total level is 63.3% which is slightly higher than last year, but remains fairly consistent since 2015. There is variation in recommendation across age, with those age 16-20 being the most likely to recommend (72.8%), and those age 51-65 being the least likely to recommend (59.5%). There is also variation amongst ethnicity, with 69.3% of BAMEBAME staff saying they would recommend compared to 62.4% of white staff, and further variation amongst ethnicity subgroups.

5.82 Staff who recommend their organisation remains mostly consistent across a range of staff groups, with some small increases and decreases over the last five years. Ambulance staff have consistently recommended their organisation the least over the last five years, however the proportion recommending it as a place to work has increased 3.7% since last year and 12.5% since 2015.

Sickness Absence

5.83 Sickness absence rates have not changed materially in the period since 2010. figure 5.28 shows sickness absence rates for NHS Trusts and CCGs since 2009. It shows that there has been no major change over time with rates always between 4.1% and 4.5%. COVID-19's impact on sickness absence is not covered in the first section of statistics presented and discussed below. Towards the end of this section, we refer to COVID-19 sickness absence data.

Figure 5.28 Sickness Absence in NHS Trusts and CCGs between 2009-10 and 2019-20 – Total HCHS non-medical staff

Year	Sickness Absence Rate (%)
2009-10	4.72%
2010-11	4.46%
2011-12	4.42%
2012-13	4.56%
2013-14	4.37%
2014-15	4.58%
2015-16	4.47%
2016-17	4.49%
2017-18	4.51%
2018-19	4.54%
2019-20	4.82%

Source: NHS Digital Sickness Absence Statistics

5.84 Sickness absence rates vary by staff group and region. Rates tend to be higher in the North of England compared to London.

Figure 5.29 Sickness Absence by Health Education Region 2016-17 to 2019-20

Region	2016-17	2017-18	2018-19	2019-20
England	4.16%	4.19%	4.21%	4.48%
London	3.39%	3.44%	3.54%	3.87%
South West of England	4.16%	4.17%	4.18%	4.41%
South East of England	3.85%	3.91%	3.87%	4.16%
Midlands	4.33%	4.48%	4.52%	4.80%
East of England	4.09%	4.04%	4.11%	4.27%
North West	4.82%	4.83%	4.87%	5.20%
North East and Yorkshire	4.62%	4.57%	4.51%	4.76%
Special Health Authorities and other statutory bodies	3.11%	2.79%	2.77%	2.95%

Source: NHS Digital Sickness Absence Statistics

5.85 Sickness absence also varies by staff group with Nurses and Support staff having some of the highest rates of absence while Managers and Senior Managers have lower reported absence rates. Some of this will be related to the nature of the work undertaken. These trends show no signs of change over the last 3 years.

Figure 5.30 - Sickness Absence Rates by Staff Group 2016-17 to 2019-20

Staff Group	2016-17	2017-18	2018-19	2019-20
Nurses & health visitors	4.44%	4.47%	4.48%	4.73%
Midwives	4.75%	4.93%	4.80%	5.11%
Ambulance staff	5.49%	5.31%	5.31%	5.38%
Scientific, therapeutic & technical staff	2.98%	2.97%	3.02%	3.24%
Support to clinical staff	5.57%	5.63%	5.67%	6.04%
Support to doctors, nurses & midwives	5.74%	5.77%	5.84%	6.18%
Support to ambulance staff	5.90%	6.36%	6.17%	6.70%
Support to ST&T staff	4.74%	4.82%	4.84%	5.23%
NHS infrastructure support	3.73%	3.74%	3.79%	4.04%
Central functions	3.31%	3.35%	3.44%	3.66%
Hotel, property & estates	5.61%	5.58%	5.66%	6.06%
Senior managers	1.78%	1.73%	1.75%	1.79%
Managers	2.15%	2.24%	2.18%	2.33%
Other staff or those with unknown classification	1.66%	1.18%	1.20%	1.41%

Source: NHS Digital Sickness Absence Statistics

5.86 NHS Improvement committed to a target of reducing NHS staff sickness absence by 1% by 2020 and to the public services average by 2022 and a plan to reduce sickness absence formed part of the AfC contract reform. They are working with 73 trusts as part of their health and wellbeing collaborative which, through identifying and spreading of good practice, is encouraging the NHS to use 10 evidence based high impact actions. These were developed as part of NHS England's NHS staff health and wellbeing framework (published in May 2018). Twelve of the trusts are also testing different models of fast access to accredited occupational health services. Participation in the collaborative is voluntary and no targets have been set for these trusts although NHS Improvement encourage them to assess what they think might be possible.

5.87 Much of the work to improve the health and wellbeing of the workforce centres around long-term cultural and leadership change, developing skills and modifying behaviours so improvement is expected to take time, although participating organisations are showing improved sickness absence rates.

COVID-19 related sickness absence

5.88 NHS Digital data is available to describe trends in sickness absence during the initial response period to the pandemic. During this period, additional coding was made available on ESR for organisations to record against. However, organisations were not mandated as to how the codes should be used so there are likely to be different patterns of use.

5.89 NHS Digital as part of their publication NHS Sickness Absence Rates August 2020 that:

"Over 60,800 full time equivalent days (from a total of 1,488,000 FTE days lost) were lost due to COVID-19 related sickness absence in August 2020, equating to 4.1% of all absences recorded, compared to 5.7% in July 2020.

During the March to July 2020 period, overall sickness absence rates peaked nationally at 6.2% in April. However, the equivalent rate for COVID-19 reported absences was 1.9%."

Figure 5.31a - Monthly Total Sickness Absence Rates by Staff Group

Staff type	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
All staff	5.3%	6.2%	4.7%	4.0%	3.9%	3.9%
HCHS doctors	2.7%	3.0%	1.7%	1.4%	1.3%	1.1%
Nurses & health visitors	5.7%	7.4%	5.6%	4.5%	4.3%	4.3%
Midwives	5.9%	5.8%	4.4%	4.1%	4.2%	4.6%
Ambulance staff	6.0%	7.0%	4.9%	4.3%	4.4%	4.8%
Scientific, therapeutic & technical staff	4.1%	4.1%	3.1%	2.8%	2.7%	2.6%
Support to clinical staff	6.9%	8.1%	6.4%	5.5%	5.2%	5.4%
NHS infrastructure support	4.5%	4.4%	3.5%	3.2%	3.1%	3.1%
Other staff or those with unknown classification	4.0%	4.0%	3.2%	2.7%	2.9%	2.7%

Figure 5.31b - Monthly COVID-19 Related Sickness Absence Rates by Staff Group

Staff type	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
All staff	0.8%	1.9%	0.9%	0.4%	0.2%	0.2%
HCHS doctors	1.0%	1.5%	0.5%	0.2%	0.1%	0.1%
Nurses & health visitors	1.0%	2.7%	1.3%	0.5%	0.3%	0.2%
Midwives	1.0%	1.6%	0.6%	0.3%	0.2%	0.2%
Ambulance staff	0.7%	1.7%	1.1%	0.6%	0.3%	0.3%
Scientific, therapeutic & technical staff	0.8%	1.3%	0.6%	0.3%	0.2%	0.1%
Support to clinical staff	0.9%	2.2%	1.1%	0.5%	0.3%	0.2%
NHS infrastructure support	0.5%	0.9%	0.4%	0.2%	0.1%	0.1%
Other staff or those with unknown classification	0.6%	1.2%	0.5%	0.1%	0.1%	0.1%

Source: NHS Digital Monthly Sickness Absence Statistics Publication

5.90 NHS Digital publish further tables and information at the following link https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/august-2020

Education and Training funding reforms

5.91 There was a move from the NHS Bursary system to the standard student loans system from August 2017.

5.92 From April 2020 student loan repayments will fall after the earnings threshold at which graduates must pay off their debt is raised. From April 6th 2020 the repayment threshold for new graduates went up to £26,575 from £25,725. This means that newly qualified nurses will not pay back their loan on earnings up to this amount. Graduates start repaying their student loan from the April after they finish university.

5.93 From September 2020, as well as the funding available through the standard student finance package, eligible new and continuing nursing, midwifery and most allied health profession students on pre-registration courses at English universities will also benefit from a training grant of at least £5,000 per academic year. Additional funding of up to £3,000 will also be available to students depending on their circumstances, including additional support for students with children and those studying in regions or specialisms struggling to recruit.

5.94 This new funding package is in addition to the financial support available from the existing Learning Support Fund administered by the NHS Business Services Authority (NHSBSA). This offers specific and targeted support including reimbursing the costs of travel and dual accommodation expenses for clinical placements, and making available additional support of up to £3,000 to students experiencing extreme financial hardship through the Exceptional Support Fund.

5.95 The latest UCAS data shows acceptances on nursing and midwifery courses have increased for the second consecutive year (Figure 5.32). In 2020, there have been 29,740 acceptances at English providers. This is 26% higher compared to the same time in 2019, and it is 28% higher when compared to the final year of NHS bursary (2016).

Figure 5.32 - Number of acceptances on nursing and midwifery courses at English providers

Entry year	2016/17	2017/18	2018/19	2019/20	2020/21	Change 2020 versus 2019	Change 2020 versus 2016
Acceptances at English providers	23,280	22,575	22,200	23,630	29,740	26%	28%

Source: Universities and Colleges Admissions Service (UCAS) data - 24 September 2020

5.96 You asked for further information on the numbers of applicants for nursing degrees who held the appropriate qualifications but were not offered a place by universities, and the extent to which this was because of limited clinical placements. Data on the qualifications of nursing students is only partially available and doesn't cover mature students who make up the bulk of those applying to study and those accepting places on nursing courses. The Department is working with stakeholders to gain a better understanding of the relationship between qualifications and acceptances, and has made funding available to increase the number of clinical placements available to students who wish to study nursing.

5.97 To support universities in expanding the number of training places they can offer, HEE announced that £15m would be made available through their Clinical Placements Expansion Programme to increase clinical placements in the NHS and support growth in Nursing, Midwifery and the Allied Health Professions.

5.98 As an acknowledgement of the additional student debt postgraduate students are likely to incur, in May 2018 the Secretary of State announced a £10,000 payment incentive applicable to learning disability, mental health or district nurse students who commence pre-registration nursing courses in the 2018-19 academic year. Payments will be made to these graduates once they take up employment in the health and care sector in England. Working with the NHS and the university sector, the Government is finalising the most effective way to administer and introduce the scheme and will set out details in due course.

5.99 In October 2019, as part of the Spending Review we announced a £210 million package of support for frontline NHS staff. Funding includes a personal development budget for eligible nursing, midwifery and allied health professionals working in the NHS to support their learning and development needs. The department is working with NHSEI and Health Education England to continue to operationalise this effectively.

5.100 Furthermore, in August 2020, the Government announced additional funding was being made available to employers of Registered Nurse Degree Apprentices of £8,300 per placement per year, during 2020/21 academic year and for the next four years (until 2024/5 academic year). This is to support employers in making an apprenticeship place available to individuals wishing to train to be a Nurse via the apprenticeship route. This funding is available to employers to support with the costs of training both existing nurse apprentices and future ones joining the apprenticeship programme. The funding applies to all four fields of nursing i.e. Adult, Children, Mental Health and Learning Disabilities.

Attrition

5.101 Continuation rates of pre-registration nursing, midwifery and allied health professions in England.

5.102 Figure 5.33 shows continuation rates of full-time entrants to first degree level study at English providers. For the cohorts of entrants between July 2016 and July 2017, the continuation rates were 93 percent for nursing, 94 percent for midwifery, and 94 percent for allied health professions.

5.103 Continuation rate is defined as the proportion of students that were continuing in HE study, not necessarily on the same course or at the same provider, or had qualified one year and 14 days after starting their course.

5.104 Non-continuation rates for nursing, midwifery and allied health professions are similar to the average for all courses (6%) .

Figure 5.33 - Continuation rates of full-time entrants to first degree level study in England between July 2016 and July 2017

Subject	Continuation Rate
Nursing	93%
Midwifery	94%
Allied health professions	94%

Source: Office for Students (OfS) analysis of Higher Education Statistics Agency (HESA) data – October 2019

Apprenticeships

5.105 Apprenticeships play a key role in ensuring the NHS has a future workforce which is representative of the local population it serves. The NHS apprentice agenda is designed to support entry into careers in the NHS for people from all backgrounds.

The apprentice agenda is at the heart of an aspiration to provide careers, not just jobs for people working in the NHS. There is a range of healthcare apprenticeships available in the NHS, including nurse degree apprenticeship, nursing associate, associate ambulance practitioner, podiatrist, healthcare assistant practitioner, healthcare support worker, healthcare science assistant and pharmacy services assistant. These pathways allow people to start at entry level apprenticeship roles and progress to becoming a registered healthcare professional.

5.106 There is also a range of non-clinical apprentice standards that may be used in the healthcare sector in areas such as facilities, digital and business administration.

5.107 There is a complete apprenticeship pathway available into the nursing profession from Healthcare Assistant, to Nursing Associate, to Nurse Degree Apprentice and onto Advanced Clinical Practitioner. Apprenticeship pathways are also avaliable for Allied Health Professionals. A new T Level qualification in Health and Science will be ready for delivery in 2021 offering an alternative route into health and care professions.

5.108 As at October 2020, there were 70 apprenticeship standards approved for delivery in the health and science category and 12 in development for use in the health and science sectors. Recently approved apprentice standards include; Midwife (at level 6); Healthcare cleaning operative (at level 2) and Physician Associate (at level 7).

5.109 There were 18,100 new apprentices starting training in the NHS in 19/20 academic year. (source: Department for Education https://explore-education-statistics.service.gov.uk/find-statistics/apprenticeships-and-traineeships/2019-20#dataBlock-c8380faa-78b6-4160-9119-d7b105762fb4-tables)

5.110 The NHS Staff Council worked hard to reach consensus on a new Apprentice Pay Framework under the AfC pay and contract reform deal, but could not agree the minimum pay rate for all apprenticeships.

5.111 Although the partners are disappointed that they could not reach a national collective agreement, they remain committed to support trusts to widen participation and help grow the domestic workforce. There is existing guidance in the NHS Terms and Conditions of Service Handbook for AfC staff to ensure trainees are fairly paid, which the partners agree trusts should continue to use.

5.112 Apprenticeships offer individuals from all backgrounds the opportunity to enter a career in the NHS. DHSC also announced last year, a £20million grant to The Prince's Trust to deliver a series of pre-employment programmes on a national scale, supporting 10,000 young people from less advantaged backgrounds to build the skills they need to start a career in the NHS through a job or apprenticeship

over the next four years. The programme of work is called ‘Securing a diverse future workforce for the NHS and Social Care'.

5.113 DHSC continues to work closely with key stakeholders; Health Education England, The Department for Education, Education and Skills Funding Agency, and the Institute for Apprenticeships and Technical Education to implement an NHS-wide strategy for apprenticeships. NHS apprenticeship numbers and levy spend continue to increase as employers work to embed apprenticeships within their future workforce planning.

Nursing Associates

5.114 The Nursing Associate role is designed to provide the NHS with a new profession, allowing employers to make the most of current and emerging talent and help them to address some of their supply challenges. Following their training, Nursing Associates will undertake some of the duties that registered nurses currently undertake, enabling registered nurses to spend more time on the assessment and care associated with both complex needs and advances in treatment.

5.115 The NMC was confirmed as the professional regulator for Nursing Associates in July 2018.The first successful Nursing Associates from HEE’s pilot began to join the NMC’s register in January 2019.

5.116 HEE continue to lead the national Nursing Associate expansion programme in 2020. DfE data on Nursing Associate apprentice starts shows 1,420 started training in the 2017/18 academic year, 4,390 in 2018/19 and 3,620 in 2019/20. Reduced numbers of Nursing Associate apprentices starting training in 2020 because of the impact of the pandemic where many NHS employers halted recruiting new staff into training programmes.

5.117 DHSC commissioned a robust programme of research to evaluate the impact of the Nursing Associate role within the workforce. An interim research report, ‘Evaluating the Introduction of the Nursing Associate role Health & Social Care’, and accompanying case studies, have now been published and explain the value of the role as well as areas for improvement.[ii]

Skill Mix

5.118 Health and Care employers say they need a more flexible workforce to keep pace with developments in treatments and interventions. There are a range of new roles designed to provide employers with a wider skill mix within multidisciplinary teams.

5.119 The skill mix of the workforce will continue to be enhanced by scaling up the development and implementation of new roles and new models of advanced clinical practice and by providing clear career pathways that enable people to continue developing and achieve their maximum potential.

5.120 The NHS Five Year Forward View provided an increased focus on the value of embedding and increasing the use of new professional roles within multi-disciplinary teams as part of a continuing drive to provide safe, accessible and high-quality care for patients. Roles such as Physicians Associate, Anaesthesia Associate and Advanced Clinical Practitioners could contribute to this improved skill mix and facilitate high quality patient care in both primary and secondary care settings. These roles primarily support doctors but can free up time for other clinical practitioners across the care spectrum when deployed as part of a carefully considered skills mix in interdisciplinary teams.

5.121 In October 2018, the Secretary of State for Health and Social Care announced the Department's intention to introduce statutory regulation for Physician Associates and Anaesthesia Associates. On 29th July 2019, the General Medical Council (GMC) confirmed that it was content to take on the regulation of these roles. We are now working with the GMC and stakeholders to develop the required legislative framework. A public consultation on the draft legislation will then be required and will be subject to the agreement of health ministers across the UK in advance of it going before Parliament. We intend to consult on the draft legislation in the coming months.

5.122 The further growth of the Physician Associate (PA) role is supported by HEE who have developed the role through a defined career framework, professional identity, and targeted investment in training. This is a key part of the Government's policy to develop a more effective, strong and expanding general practice to meet future need. Since Sept 2015, the PA workforce has grown considerably, and workforce demand is increasing rapidly. There are now 364 FTE PAs in primary care against a baseline of 15 FTE. In line with HEE's mandate to train 1000 PAs and help secure increases in the number of PAs taking up new roles in primary care, it is predicted that the annual output of PA graduates is likely to reach at least 1,000 and cumulative numbers of PAs to reach 3,000 in line with the Government's Manifesto to grow the NHS workforce by 26,000 additional primary care professionals by 2023/24. There are approximately 1,800 PAs currently on a PA programme across the HEE geography.

5.123 Advanced clinical practitioners come from a range of professional backgrounds such as nursing, pharmacy, and allied health professionals. They are healthcare professionals educated to Master's level and have developed the skills and knowledge to allow them to take on expanded roles and scope of practice caring

for patients. In common with other new roles, ACPs can add valuable skills into wider skill mix and often complement work of doctors in Emergency and Cancer Care.

5.124 Health Education England has established the Centre for Advancing Practice to support education and training for advanced practitioners in England by developing agreed national training standards for advanced practice education and delivering a programme accreditation process (kitemarking) for training courses for advanced level practice.

5.125 The growth and development of new and extended roles is designed to add to the skill mix of the NHS, improving staff retention and providing better care for patients. Supporting registered healthcare professionals to develop new skills through advanced practice or training for new credentials will allow those people to work at the top of their license and reduce reliance on professions such as doctors. This also provides opportunities to progress and job satisfaction for experienced NHS workforce that we want to retain and provides NHS patients with better care.

6. AfC Multi-Year Pay and Contract Reform Deal

6.1 This chapter provides an update on the outstanding issues that remain following the implementation of the multi-year AfC pay and contract reform deal and an update on benefits realisation.

Outstanding issues

6.2 The NHS Staff Council (a partnership of NHS trade unions and NHS Employers) reached agreement on the AfC deal in June 2018. Since then, the partners have made good progress implementing the benefits of the deal. Where agreement could not be reached, the NHS Staff Council provided an update to the NHS Pay Review Body as part of last year's round.

6.3 The multi-year deal represents a significant investment in the AfC workforce. In 2021/22 there remain a small number of outstanding elements as a consequence of the multi-year deal, some of which will result in further benefit to individual members of AfC staff.

6.4 Firstly, the three-year deal committed to reforms on pay progression, moving away from an automatic annual increment system, to a system containing fewer pay points, with larger increases, enabling progression to the top of the band more quickly in most cases. Having pay steps at less frequent intervals but for larger increases should help to put learning and development at the heart of appraisals and career development discussions, focusing staff and employers on the issue and allowing better engagement compared to the almost automatic annual increment process. Shortening the pay spines allows staff to fully demonstrate they are working to the top of the competencies required for the role sooner by reaching the top of the band, it also helps to lessen any gender pay gaps amongst the workforce.

6.5 This new system of pay progression came in to force from 1 April 2019 for new starters and staff who were promoted. The new system of pay progression comes in to force for all AfC staff from 1 April 2021. The new progression system means that staff will have to meet the required criteria in order to progress to their next pay point. Progression will no longer be actioned automatically by the ESR system. The line manager of the individual will have to ensure that they have marked on the ESR system that the individual has met relevant criteria and can therefore progress. Depending on local arrangements, employers may have

processes that also involve HR/payroll colleagues, to quality assure the progression process).

6.6 Secondly, as a result of the deal we have committed c0.7% in 2021/22. This 'overhang' of the deal was agreed by all parties, to enable completion of the restructuring of the AfC pay structure. Specifically, the c0.7% is the cost of removing the transitional pay points that exist in the 2020/21 pay structure for bands 5, 6 and 7. Removing these pay points completes the AfC structural reform, leaving bands 5, 6 and 7 each with three pay points. Removing the transitional pay points in each of these pay bands has the effect of moving affected staff directly to the top of the pay band on 1 April 2021, resulting in significant pay increases of 11.67% for the affected point in band 5, 12.17% for the affected point in band 6, and 6.66% for the affected point in band 7.

6.7 Thirdly, as part of the 3 year pay and reform deal, staff on some pay points in bands 8 and 9 were given consolidated payments during the third year of the deal (2020/21). This was to ensure that their pay did not drop below what they would have expected to earn under the previous pay structure, plus an assumed pay uplift. The same issue did not arise in years 1 and 2 of the deal so no separate arrangement was required. The method for year 3 was agreed by the parties to ensure staff in these bands also benefited in terms of being better off than they would have been under the previous arrangements, whilst ensuring the deal remained affordable within the funding envelope. No agreement was reached on what would happen to these consolidated payments in 2021/22, the first year outside of the three-year deal.

6.8 The decision on what should happen to affected staff in these bands will need to be considered as part of the 2021/22 pay round by Ministers, taking in to account any Review Body Recommendations. However, given Pay Review Body Recommendations will not be known until after 1 April 2021, there is a need to preserve current pay for effected staff so that it does not drop. The NHS Staff Council Executive has agreed that affected staff should continue to be paid the payments they are currently receiving, to ensure their pay is preserved until a decision is made as part of the 2021/22 pay round. DHSC supports this approach of ensuring staff impacted by this issue have their pay level preserved until a decision can be made as part of the pay round. This represents an additional commitment on top of the 0.7% overhang.

Benefits Realisation

6.9 NHSEI is leading the work to develop a benefits realisation plan to underpin the implementation of the AfC deal. This will help ensure the AfC deal delivers the outcomes the partners expect including provideing the data necessary for them to

measure the success of the deal. They are working with NHS Employers, the NHS Staff Council and the Department of Health and Social Care to agree the most appropriate and measurable key performance indicators and intend to share a draft with the Staff Council co-chairs for feedback soon. More information will be provided within their evidence.

6.10 We will continue to work in partnership to ensure there is a shared understanding of the data that is needed and a clear line of sight between the AfC pay and contract reform deal and the expected outcomes.

7. Total Reward

Introduction to Total Reward

7.1 Total reward is the tangible and intangible benefits that an employer offers an employee, and it remains central to recruiting and retaining staff in the NHS. The value of the NHS total reward package remains high, as has been noted in previous rounds of PRB evidence.

7.2 The Department's ambition for the NHS reward strategy remains that employers should develop their capacity and capability to:

a. Utilise the NHS employment package to recruit, retain and motivate the staff they need to deliver excellent services to patients;

b. Develop and implement local reward strategies that meet organisational objectives and workforce needs;

c. Improve staff understanding of their reward package and what options they have to change aspects of it;

d. Improve staff experience of working for the NHS;

e. Contribute to improvements in workforce productivity and efficiencies in use of the NHS workforce pay bill; and

f. Continue to be at the leading edge of innovation in public sector reward to help improve NHS staff satisfaction with pay.

7.3 The Department commissions NHS Employers to provide advice, guidance and good practice to the NHS on developing a strategic approach to reward based on the Hay Model, shown in Figure 7.1.

Figure 7.1 - Hay Model

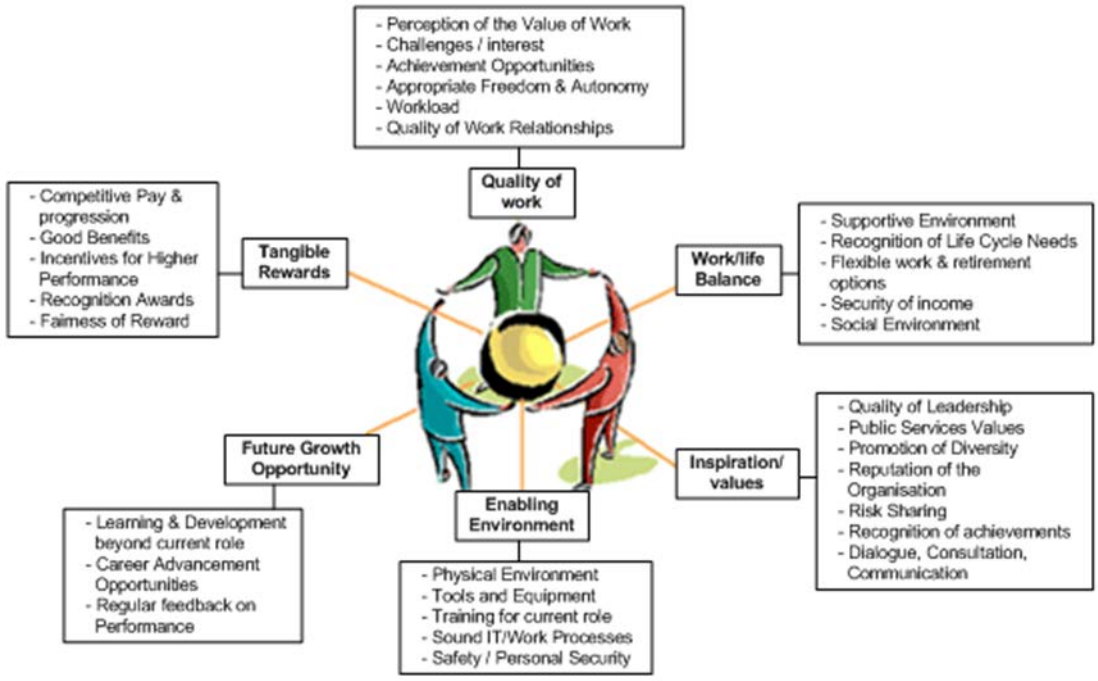
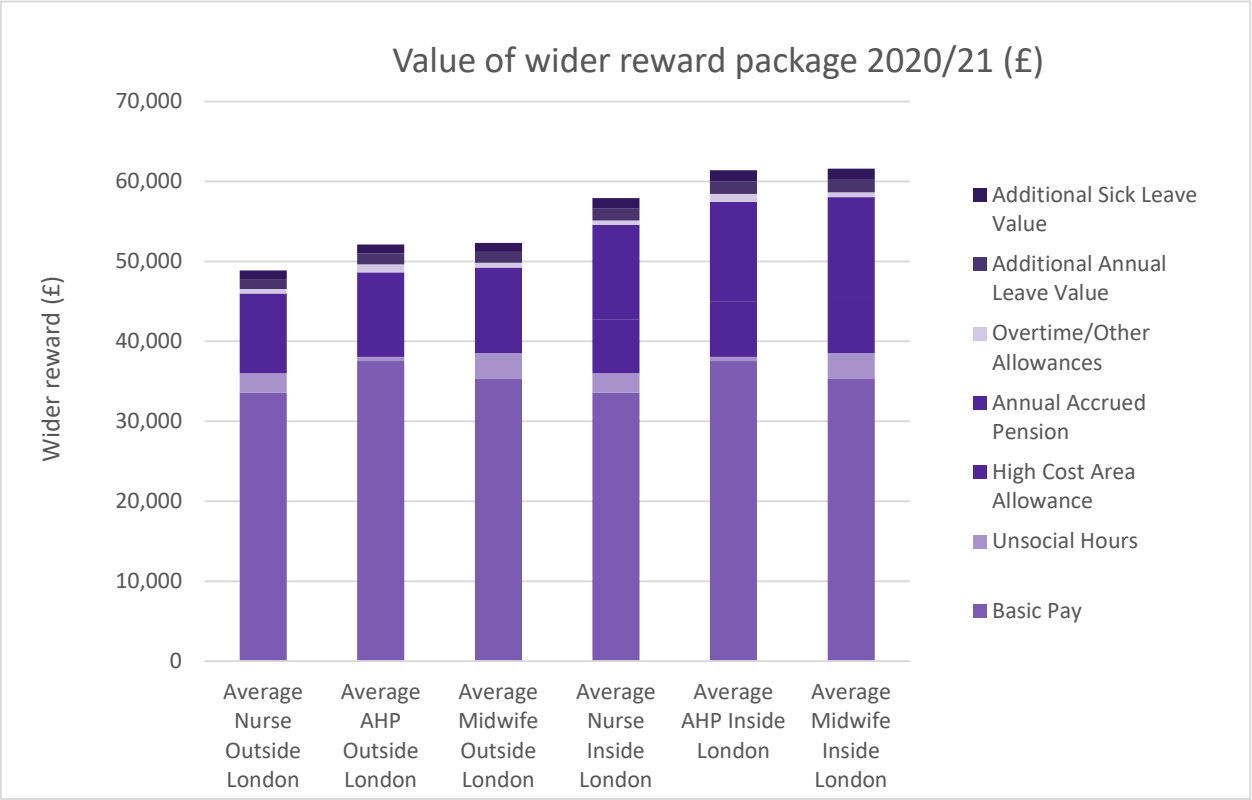


Figure 7.2 - Total Value of Wider Reward Package 2020/21 (£)



7.4 The value of the reward package for a range of NHS staff roles is shown in Figure 7.2, which has been produced for the Department by the Government Actuary's Department (GAD). It includes basic pay, other pay such as unsocial hours payments, High Cost Area Allowances (HCEAs) for staff inside London, annual

accrued pension and overtime/other allowances. It also includes additional leave over the statutory minimum and additional sick leave over statutory sick pay. GAD expanded their analysis this year to include Allied Health Professionals (AHPs) inside and outside of London.

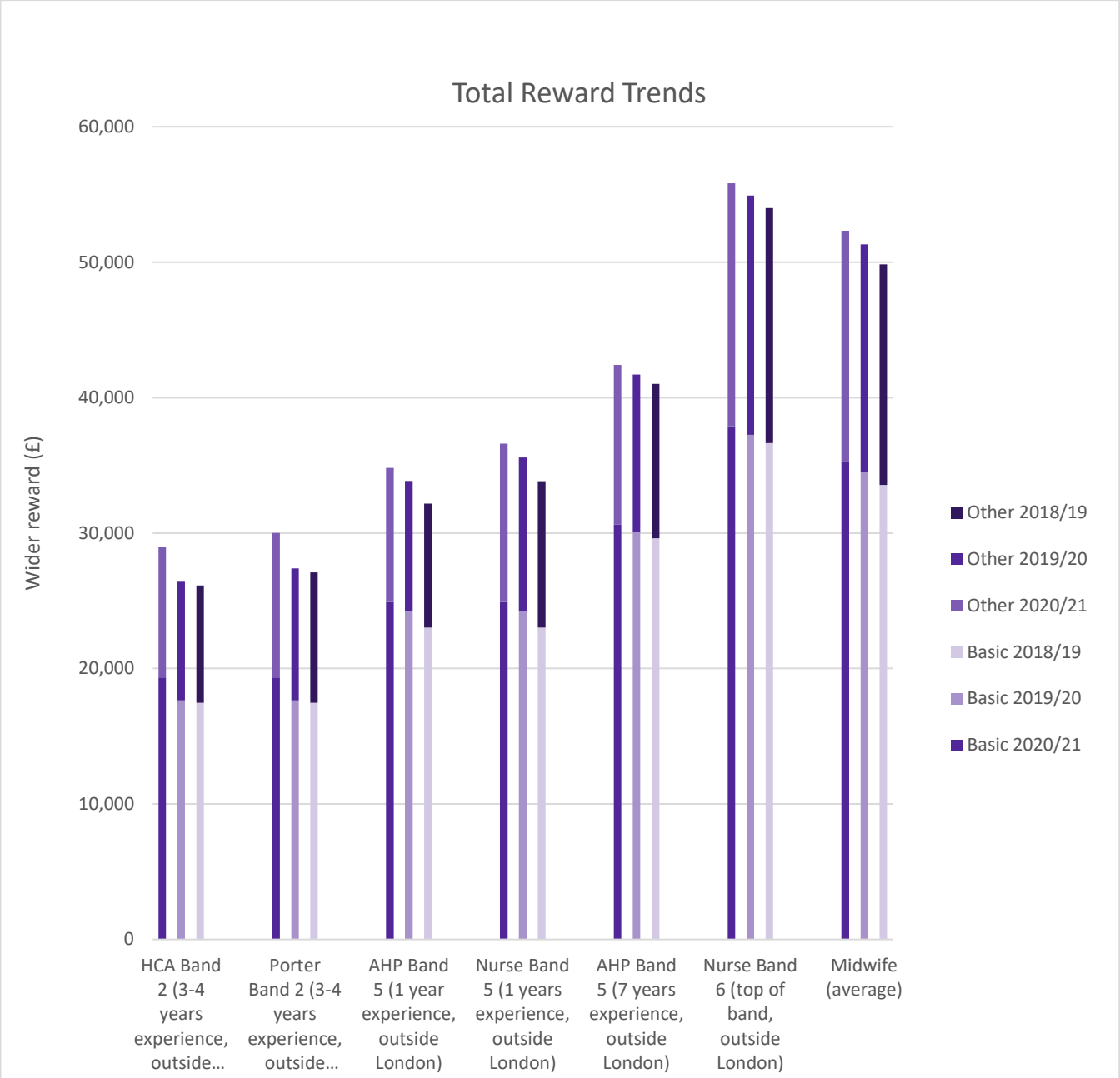
NHS Trend Analysis

7.5 The Department also commissioned GAD to carry out trend analysis for different NHS staff, based on the previous total reward analysis at 2017/18, 2018/19 and 2019/20.

7.6 The roles and relevant AFC bands considered are band 5 nurse (1 year experience), band 6 nurse (10 years' seniority, earning at top point of band), midwife (average), band 2 healthcare assistant (HCA) (3-4 years' experience), band 2 porter (3-4 years' experience), band 5 AHP (1 year experience), and band 5 AHP (7+ years' experience). The chart below compares average rewards at 30 September 2018, 30 September 2019 and 30 June 2020 with pay bands at 2018/19, 2019/20 and 2020/21. It is believed that this will only cause a negligible difference for the purpose of comparison.

7.7 Figure 7.3 shows that all NHS roles considered as part of the analysis have experienced an increase in total reward over the period 2018/19 to 2019/21. Both HCAs and porters at band 2 received the highest increase in reward over the period, of 11%. This is largely driven by increases to pensionable pay for AfC band 2 staff from 2019/20 to 2020/21. Nurses at band 5 (1 years' experience) and AHPs at band 5 (1 years' experience) experienced an increase of 8% over the period 2018/19 to 2020/21. Annual increases in basic pay were slightly higher in 2018/19 to 2019/20 at 5%, relative to the 3% increases to basic pay awarded in 2019/20 to 2020/21. Nurses at the top of band 6 and AHPs at band 5 (7 years' experience) experienced an increase of just over 3% over the period, with consistent increases of just under 2% each year over the period 2018/19 to 2020/21. Average midwives experienced an increase of 5% over the period 2018/19 to 2020/21. All roles considered have over 28% of total rewards made up of non-basic pay.

Figure 7.3 - Total Reward Trends



7.8 GAD also analysed total reward across various private sector occupations, based on Office for National Statistics (ONS) data for salary and pension benefits, and compared them against pay rewards for NHS staff based on their previous analysis from 2012 to 2019.

7.9 This analysis is intended to give an approximate indication on how wider reward between roles and occupations change over time; it is not intended to provide a direct comparison between any direct NHS role and other occupation. The NHS roles included in this analysis are band 5 nurse (1 year experience), band 6 nurse (10 years' seniority, earning at top point of band), midwife (average) and band 2

porter, (3-4 years’ experience). The private sector occupations considered are associate professional & technical occupations and skilled trades occupations.

7.10 Figure 7.4 shows that all roles considered as part of this analysis across both NHS roles and private sector occupations experienced an increase in total wider reward packages over the period 2012 to 2019. Nurses at band 5 (1 years' experience) experienced an increase of 21% over the period, whereas nurses at the top of band 6 experienced a 15% increase in total reward. The average midwife role received a 12% increase, whereas porters in band 2 have received a 22% increase over the period. Overall, increases are largely driven by increases to basic pay over the period.

7.11 Skilled trades occupations in the private sector experienced similar increases to an average midwife, with an increase in total wider reward of 12% respectively over the period. Private sector associate professional & technical occupations experienced an increase in total reward of 8% over the period.

7.12 Non-basic pay makes up a larger proportion of NHS reward relative to private sector occupations, with ‘other’ pay making up around 33% of total wider reward. Across the private sector occupations considered non-basic pay makes up around 15% of total wider reward. One driver for this might be the value of public sector pension benefits available to NHS staff and the additional pay elements and awards available, relative to the private sector.

Figure 7.4 - Total Reward Trends

7.13 Although they are not included in the chart, the additional non-basic pay elements of the total reward package available to NHS staff should be considered as they usually exceed that available in other sectors. These include benefits available to members of the NHS Pension Scheme (other than the value of pension benefits accrued each year), maternity leave and other flexible benefits.

NHS Pension Scheme

7.14 Staff working in the NHS have access to the NHS Pension Scheme ('the Scheme'), which remains a valuable part of the total reward package available to the NHS workforce and one of the best pension schemes available. Membership of the Scheme is high, with around 9 in 10 NHS staff actively participating.

7.15 Employers now contribute more towards the cost of the scheme than members, with a current contribution rate of 20.6%, and an additional administration charge of 0.08%. Employee contributions are tiered according to income, with the rate paid by the lowest earners being 5% and the highest 14.5%, for those earning over £111,377.

7.16 Eligible members of the NHS workforce will now belong to one of the two existing Schemes. The final salary defined Scheme, or legacy scheme, is made up of the 1995 and 2008 Sections and is now closed to new members. All new NHS staff will join the 2015 Scheme, a career average revalued earnings (CARE) scheme which provides benefits based on average earnings over a member's career.

7.17 The key differences between the two Schemes, other than the way benefits are calculated, are different normal pension ages (1995 Section – 60, 2008 Section 65, and 2015 Scheme – State Pension Age) and accrual rates (1995 Section – 1/80th, 2008 Section – 1/60th, 2015 Scheme – 1/54th). Under the new CARE scheme, most low and middle earners working a full career will continue to receive pension benefits that are as good, if not better, than those they would receive under the former final salary schemes.

7.18 A judgement by the Court of Appeal in the cases of McCloud and Sargeant found that the transitional protection arrangements that were awarded to members of the final salary schemes gave rise to unlawful discrimination. These arrangements allowed members closer to retirement age to remain in their legacy scheme and not move to the 2015 Scheme. Whilst the judgement was found against the Judges' and Firefighters' pension schemes, the Government announced on 15th July 2019 that it accepts the judgement applies to other public service schemes, including the NHS, and will remedy the discrimination in all schemes.

7.19 In light of the judgment, work to remedy the discrimination is currently underway. This will unwind the transitional protections which allowed some members to remain in the legacy schemes. Between 16 July and 11 October 2020, the Government consulted on two possible options to remove this discrimination. The Government published its response to the consultation on 4 February 2021[iii]. After the remedy period ends, all those who continue in service will do so as members of their respective reformed scheme. For NHS staff, this is the 2015 Scheme.

7.20 The 2015 Scheme provides a generous pension for NHS staff and is one of the best pension schemes available. The Government Actuary's Department (GAD) calculates that Scheme members can generally expect to receive around £3 to £6 in pension benefits for every £1 contributed. The Scheme is backed by the Exchequer and is revalued in line with price inflation, providing a guaranteed income in retirement. A band 5 or 6 nurse retiring at 68 with 35 years' service wholly in the 2015 Scheme can expect an annual pension of around £19,000.

NHS Pension Scheme Membership

7.21 The Department continues to monitor scheme membership rates through the Electronic Staff Record (ESR). Figure 7.5 shows the total number of NHS Pension

Scheme members by staff group and AfC band at July 2020. It also compares the change in membership rates from October 2011 to July 2020, July 2019 to July 2020 and April 2020 to July 2020.

Figure 7.5 - Membership in the NHS Pension Scheme

Staff group	FTE (Jul 20)	NHS Digital Headcount Jul 20	% with pension contributions Jul 2020	% points change Apr 2020 and Jul 2020	Jul 2019 and Jul 2020	Oct 2011 and Jul 2020
All	1,169,045	N/A	89%	0.0%	-0.6%	4.8%
Doctor	120,607	128,307	88%	-0.1%	-1.1%	-3.4%
Qualified nursing, midwifery & health visiting staff	323,885	26,718	90%	-0.2%	-1.1%	2.5%
Qualified Scientific, therapeutic and technical staff	148,319	169,674	92%	-0.1%	-0.5%	1.8%
Qualified Ambulance Staff	17,019	18,103	92%	0.0%	-1.5%	-2.9%
Support to Clinical Staff	372,987	429,301	89%	0.3%	-0.1%	9.8%
Central Functions & Hotel, Property & Estates	151,590	175,710	86%	0.1%	-0.4%	9.0%
Managers	21,588	22,534	89%	-0.1%	-0.5%	-2.7%
All Non-Medical	1,048,438	1,191,625	90%	0.0%	-0.6%	5.6%
AfC Band 1	7,226	N/A*	77%	-0.3%	-3.4%	14.0%
AfC Band 2	175,953	N/A*	88%	-0.1%	-0.5%	12.0%
AfC Band 3	151,260	N/A*	90%	0.4%	0.1%	9.1%
AfC Band 4	105,801	N/A*	90%	0.5%	0.1%	6.4%
AfC Band 5	207,499	N/A*	88%	-0.2%	-1.1%	2.6%
AfC Band 6	195,371	N/A*	91%	-0.1%	-1.0%	1.6%
AfC Band 7	117,240	N/A*	92%	-0.1%	-0.7%	-0.3%
AfC Band 8a	43,435	N/A*	92%	-0.1%	-0.6%	-1.5%
AfC Band 8b	16,847	N/A*	93%	0.0%	-0.4%	-2.1%
AfC Band 8c	8,421	N/A*	93%	0.0%	-0.7%	-2.5%
AfC Band 8d	4,379	N/A*	92%	-0.2%	0.0%	-3.1%
AfC Band 9	1,844	N/A*	92%	-0.1%	0.0%	-3.3%
Non AfC	133,769	N/A*	87%	-0.1%	-1.2%	-0.7%

Note: NHS Digital Does Not Publish Headcount by AfC Band

7.22 Overall membership of the Scheme amongst NHS staff is high. Between October 2011 and July 2020, the percentage of NHS staff who are members of the NHS Pension Scheme increased by 4.8%.

7.23 Membership rates for the NHS Pension Scheme compare favourably with private sector pension scheme participation. The Department for Work and Pensions published a report in June 2019 comparing the participation rates and savings trends between public and private sector pension schemes.[iv] The report studied pension scheme data between 2008 and 2018. Although private sector pension scheme participation has risen since the introduction of auto-enrolment, participation in private sector schemes (85%) is still lower than the public sector (93%). The report also shows that scheme participation for lower earners in public sector schemes is higher than that of lower earners in private sector schemes.

7.24 For AfC staff in all bands up to and including band 6, membership rates increased between October 2011 and July 2020. Whilst membership for lower bands remains lower than that of higher banded staff, rates have been increasing since auto-enrolment requirements for employers were introduced in 2013.

7.25 The membership rate for AfC Band 1 staff decreased by 3.4% between July 2019 and July 2020. This is linked to the closure of the Band to new entrants as of December 2018, and the subsequent transfer of remaining staff into Band 2.

NHS Pension Scheme Contributions

7.26 Member contributions are set in tiers based on earnings, with higher earners contributing proportionately more, factoring the beneficial effect of higher tax relief.

Figure 7.6 - Contribution Rates by Pensionable Pay

Tier	Pensionable Pay (whole-time equivalent)	Contribution Rate
1	Up to £15,431.99	5.0 per cent
2	£15,432.00 to £21,477.99	5.6 per cent
3	£21,478.00 to £26,823.99	7.1 per cent
4	£26,824.00 to £47,845.99	9.3 per cent
5	£47,846.00 to £70,630.99	12.5 per cent
6	£70,631.00 to £111,376.99	13.5 per cent
7	£111,377.00 and over	14.5 per cent

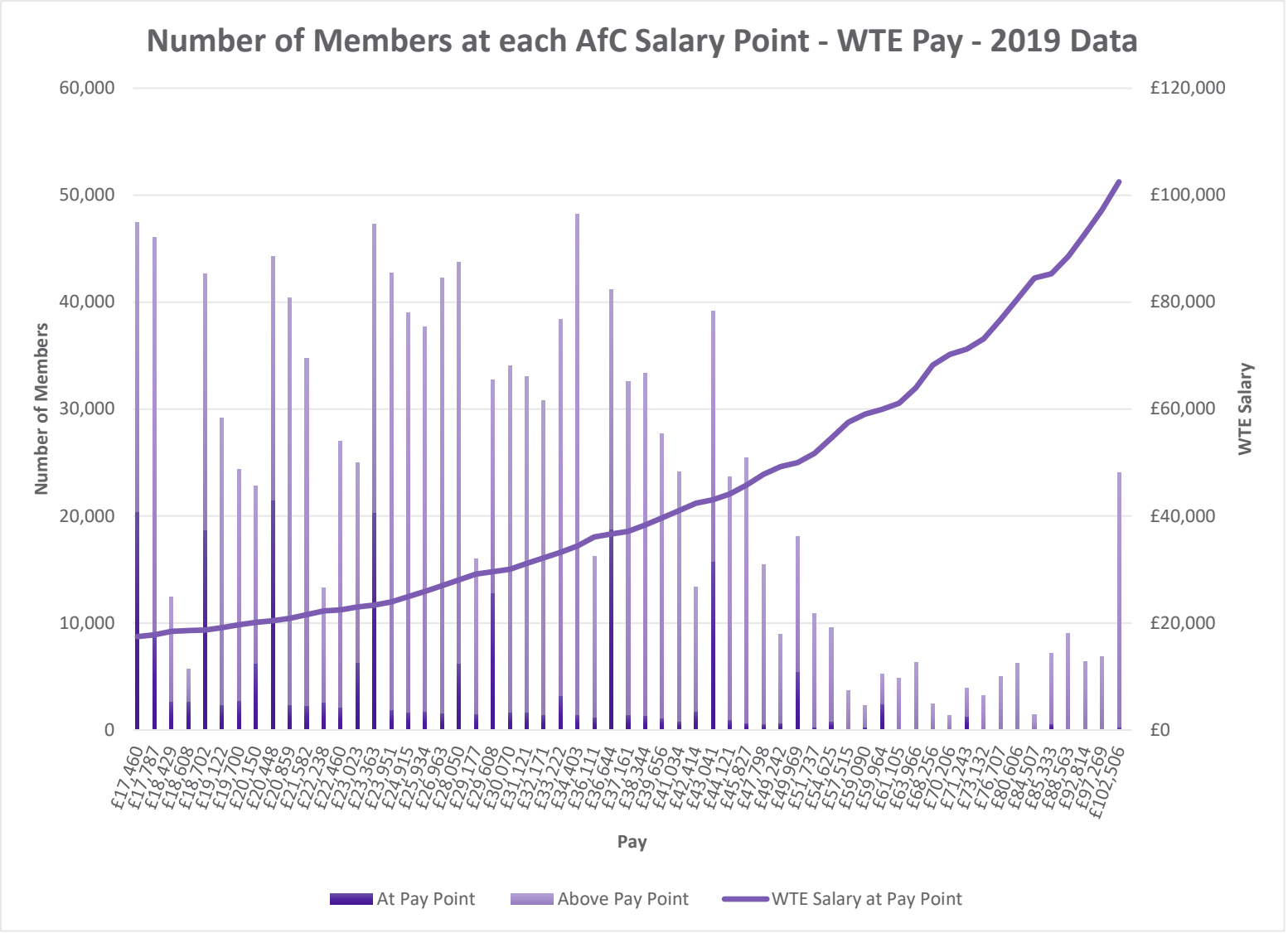
7.27 Member contribution rates and earnings tiers have been frozen since 1st April 2015. It is expected that around 12% of members will be in a higher contribution rate band (increases are between 0.6% and 3.2% of pensionable pay, depending where they are in the pay range) in 2021 compared to 2018. A proportion of members are expected to progress to higher contribution tiers year to year through pay progression.

7.28 The Department keeps member pension contributions under review, in dialogue with NHS trade unions and employers through the NHS Pension Scheme's Scheme Advisory Board (SAB). The Pay Review Body previously concluded that annual pay awards should not have the unintended consequence of reducing take-home pay where a pay award means members must pay higher pension contributions. The Department commissioned the SAB to review the approach to member contributions and provide recommendations by the end of March 2020 on an appropriate structure to implement from 1 April 2022, as the point which all members will join the 2015 NHS Pension Scheme for future accrual in line with the measures to remedy McCloud as announced by HMT. This builds on previous work by the SAB to explore several design elements, including whether the rate payable should be determined using whole-time equivalent or actual earnings, the range and number of tiers, and whether tier boundaries should be revalorised to avoid pay awards placing individuals in higher contribution tiers.

7.29 In their review work to date, the SAB concluded that a move to assessing contributions based on actual earnings was appropriate and recognised that further discussion was needed with regards to the approach to avoiding cliff edges. Cliff edges refer to areas of the current contribution structure where a pension scheme member receives a pay award which causes them to move to a higher contribution band. Although this increases the overall value of a member's total reward package, it has the potential to reduce their take-home pay. However, it is common for AfC staff to earn supplementary payments for on-call or out-of-hours work, which increase their pensionable pay. This means that only 13% of officer members of the NHS Pension Scheme have pensionable pay which match the AfC pay scales. It is therefore difficult to design a contribution structure which avoids cliff edges.

7.30 Figure 7.7 is based on the valuation data for officers as at 31 March 2019 (un-excluded data) and AfC 2018/19 Pay Scales and uses a threshold of plus/minus £20 WTE annual salary to determine whether a member is on each pay point. No adjustments have been made for part-time proportion since a number of records have missing part-time proportion. The proportion of officer members with WTE pensionable pay equal to one of the AfC pay points is 15%, a small increase from 13% last year.

Figure 7.7 - Members at each AfC Salary Point



Pension Flexibilities

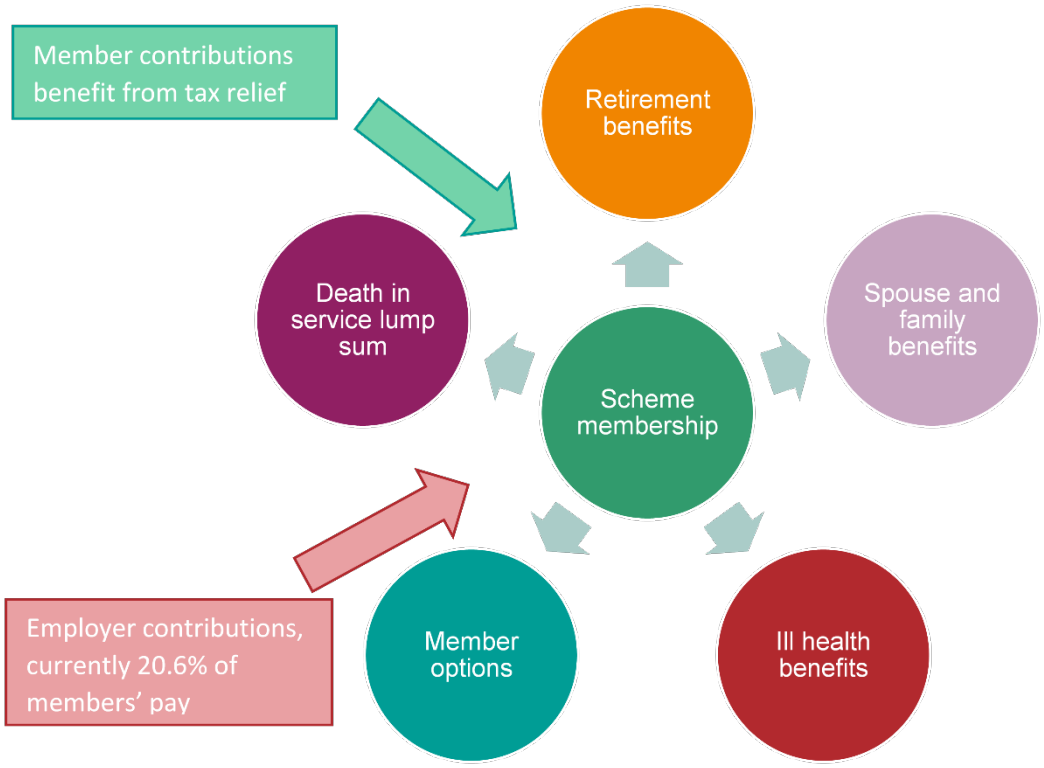
7.31 The Government's manifesto committed to resolving the pension taper issue that was causing many senior clinicians to turn down extra shifts for fear of high tax bills. To address this, the Chancellor announced changes to the annual allowance taper thresholds in the March 2020 budget. Raising the thresholds means that no one with net income before tax below £200,000 will be caught by the tapered annual allowance. Due to AfC pay scales, these staff are unlikely to be affected by the pension taper issue.

7.32 Prior to the 2019 election, the Department consulted on a proposal for pension flexibility[v]. However, following the annual allowance changes, the Department will not be implementing the pension flexibility proposal they consulted on.

7.33 The Department welcomes local solutions proposed by employers where pension scheme membership can be improved to encourage recruitment and retention and continues to work with NHS Employers to facilitate this.

NHS Pension Scheme Benefits

Figure 7.8 - Pension Scheme Benefits



7.34 Figure 7.8 presents an illustrative analysis of the wider scheme benefits for a member of the 2015 Scheme at 1 April 2021, beyond the pension which is payable for life following retirement.

7.35 Members of the NHS Pension schemes are also entitled to protection benefits. In particular, if a member dies while working, their dependants are entitled to a death in service lump sum equivalent to 2 x salary. Therefore, if a scheme member earning £37,000 dies in active service, their dependants would be entitled to a lump sum payment of £74,000

7.36 Pensions are also paid to a spouse following the death of pensioner members. The level of benefits paid to a spouse varies across the NHS schemes. For a retired member of the 2015 scheme with a pension of £30,000, following their death in retirement, their spouse is entitled to a pension for life of £10,125,

increasing annually each year. Children's pensions are also available in some cases.

7.37 Members are also entitled to ill health retirement benefits. Under ill health Tier 1, members are entitled to full retirement benefits accrued without reduction. Under ill health Tier 2, members are entitled to enhanced benefits for prospective service up to normal retirement age.

7.38 Members have the option to exchange pension for a tax-free cash lump sum (subject to limits). There are a range of options available to members including early and late retirement options (subject to limits) and the option to purchase additional pension.

7.39 Members of the NHS Pension scheme are also entitled to tax relief on their contributions to the scheme, which reduces the cost of the scheme to members. The Employer contribution meets the balance of the cost of the scheme

Maternity Leave

7.40 Employees with 12 months continuous service with one or more NHS employers are entitled to maternity benefits above the statutory entitlement. An NHS employee earning £33,000 would be entitled to earn maternity pay of around £2,300 more than that they would be entitled to under the statutory maternity leave allowance.

7.41 This calculation is provided for illustrative purposes only. Maternity pay depends on the member's contractual entitlements and is calculated relative to the current statutory maternity pay[vi] entitlements.

Flexible Benefits

7.42 Other than the reward elements included in the above analysis, many employers also offer a range of flexible benefits, discounts and support offered to staff that may support recruitment and retention of staff and improve employee engagement. Although the range of flexible benefits offered varies across employers, some popular flexible benefits can include salary sacrifice schemes, options to buy and sell leave and a range of discount vouchers. Employers may offer travel benefits such as season ticket loan and cycle to work scheme, as well as health and wellbeing benefits including discounted gym memberships.

7.43 Many trusts have also partnered with third party providers offering staff up to 20% discount on shopping, insurance and travel. Staff may also be entitled to cashback

on purchases at specified retailers of up to 12% using prepaid cards. Therefore, employees spending around £3,000 per year at a participating supermarket could offset spending by up to £360 (around 1% of basic pay on average). The overall value to staff can vary depending on the specific benefits options offered across employers and the level of benefits taken up but we estimate these additional flexible benefits could be valued up to 1% - 3% of basic pay on average across NHS employees.

Total Reward Statements

7.44 Total reward statements (TRS) are provided to NHS staff and give staff a better understanding of the benefits they have or may have access to as an NHS employee. TRS provide personalised information about the value of staff employment packages, including remuneration details and benefits provided locally by their employer. Individual NHS employing organisations may also offer other forms of local reward[vii].

Annual Benefit Statements

7.45 NHS Pension Scheme members also receive an annual benefit statement (ABS), which shows the current value of their NHS Pension benefits.

7.46 Data obtained from the BSA, who issue these statements, shows that from August 2019 to August 2020, the number of combined statements (which includes where there is an ABS available or where there is just employer benefits) available increased by 70,665. The calculation success rate, which represacents the percentage of members for whom it is possible to calculate an ABS, increased from 90.08% in 2019 to 91.56% in 2020.

7.47 On 10 October 2020, the number of statements viewed by staff was 375,457, an increase from the 314,916 that had been viewed at the same point in 2019. This may indicate that more people are viewing their updated statements earlier.

7.48 Since 2016, the BSA have held stakeholder engagement events across the country for a range of different NHS organisations to help employers better understand their role in promoting TRS. The workshops also explain the difference between a TRS and an ABS.

Endnotes

[i] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---september-2020

[ii] Kessler, I., Steils, N., Samsi, K., Moriarty, J., Harris, J., Bramley, S., & Manthorpe, J. (2020). Evaluating the Introduction of the Nursing Associate Role in Health and Social Care: Interim Report London: NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London.

[iii] The consultation document and consultation response can be found at: https://www.gov.uk/government/consultations/public-service-pension-schemes-consultation-changes-to-the-transitional-arrangements-to-the-2015-schemes

[iv] Workplace Pension Participation and Savings Trends of Eligible Employees Official Statistics: 2008 to 2018, available from: https://assets.publishing.service.gov.uk/Government/uploads/system/uploads/attachment_data/file/806513/workplace-pension-participation-and-saving-trends-2008-2018.pdf

[v] A copy of the consultation document is available at: https://assets.publishing.service.gov.uk/Government/uploads/system/uploads/attachment_data/file/830862/NHSPS_flexibility_consultation_document.pdf

[vi] See https://www.gov.uk/maternity-pay-leave/pay

[vii] Examples of local reward: recommend a friend schemes; affordable accomodation; childcare and carer support; counselling and support; various salary sacrifice schemes; retail discounts; education and learning support; financial wellbeing support; physical and mental health and wellbeing support; signposting to pensions advice services.

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