Department
of Health &
Social Care

The Department of Health and Social Care's written evidence to the Senior Salaries Pay Review Body (SSRB) for the 2022-23 Pay Round

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Contents

1. Introduction and NHS strategy 4
The Health and Social Care Leadership Review and wider system changes 4
Autumn Budget and Spending Review 2021 5
2. NHS finances 8
Economic context 8
Funding growth 9
Financial position 11
Share of resources going to pay 12
Demand pressures 13
Calculating productivity in the NHS 16
Productivity and efficiency in the NHS 18
Affordability 19
3. Very Senior Managers (VSMs) 21
VSM Earnings 22
Scrutiny of VSM pay 23
Draft VSM pay framework 24
Future VSM framework 25
Diversity analysis 25
Motivation and morale 26
Labour market context 26
Non-consolidated payments 27
4. DHSC Arm's Length Bodies Executive and Senior Managers 29
Data return analysis 29
ALBs included 29
Pay analysis 30
Allowances 31
Diversity analysis 32
Motivation and morale 33
Scrutiny of ESM pay and annual pay award 33
Scrutiny of ESM pay 33
2021-22 recommended pay uplift 33

Performance related pay for ESMs 34

5. Total reward 36
NHS pensions 36
NHS pension scheme overview 36
Scheme membership for managers 38
NHS pension scheme contributions 39
Pension taxation 42
Total reward and annual benefit statements 43

1. Introduction and NHS strategy

The intention of our evidence is to provide information to the SSRB on the government's approach to the pay and reward of NHS very senior managers (VSMs) in NHS provider trusts and executive and senior managers (ESMs) within the Department of Health and Social Care's (DHSC) Arm's Length Bodies (ALBs).

In making their observations, we expect the SSRB to consider the pay and reward of other staff within the NHS, including those employed on Agenda for Change (AfC) terms and the different medical contracts along with considerations on the state of recruitment, retention, motivation and affordability for the NHS. VSM and ESM pay cannot be seen in isolation from what is happening in the wider system and it is therefore important that the SSRB is clearly sighted on the overall financial challenges. Similarities can also be drawn between ESM roles within ALBs and Senior Civil Service (SCS) roles within Civil Service organisations so we would ask that this is also taken into consideration.

This chapter sets out the wider context for department's 2022 to 2023 (2022-23) evidence, including the strategic context for NHS pay and the VSM and ESM workforce.

At the 2020 Spending Review the Chancellor of the Exchequer announced that pay for most public sector workers would be paused in 2021-22. This pay pause applied to VSMs and ESMs and the SSRB were not asked to make pay recommendations for 2021-22 but were nonetheless asked to make observations on the current levels of senior NHS and ALB manager pay. The SSRB noted that the evidence provided suggests that levels of pay were broadly appropriate.

This year, the Government is asking the SSRB to make a pay recommendation for the VSM and ESM workforce within a challenging health, economic and fiscal context.

The Health and Social Care Leadership Review and wider system changes

The government has commissioned a review into leadership within the health and social care system. This review, led by General Sir Gordon Messenger with support from Dame Linda Pollard, will look to strengthen the leadership of health and social care in England, with the aim of reducing regional disparities in efficiency and health outcomes. The Terms of Reference have now been published, which outline further detail on the scope of the review. While the Leadership Review's remit includes several areas including pay, it will focus on areas that have the most impact on leadership.

The Leadership Review is working closely and extensively with stakeholders across health and social care, including with SSRB, to discuss how to ensure the right pay and other

incentives are in place to foster good and excellent performance. The review should report to the Secretary of State for Health and Social Care in early 2022.

Research has shown that leadership plays a significant role in shaping organisational culture. Strong leadership in health and social care will ensure the best outcomes for our key priorities and that the necessary leadership behaviours, strategies and qualities are developed to maximise these efforts - which is vital in ensuring that every pound of investment is spent well.

The move to Integrated Care Boards (ICBs) in April 2022 and the need for ever closer working between NHS organisations and local authorities provides an opportunity to look at what more needs to be done to foster and replicate the best leadership and management and to address underperformance. It also provides a new focus on how leaders from both health and care work together to provide efficient and integrated care for the people they serve.

DHSC ALBs have an equally important role to play in fostering a new leadership culture. NHS England and NHS Improvement (NHSEI) and Health Education England (HEE) will merge to help ensure that service, workforce and finance planning are integrated in one place at a national and local level. It will simplify the national system for leading the NHS, ensuring a common purpose and strategic direction. This will help to ensure that the workforce is placed at the centre of the NHS strategy. NHSX and NHS Digital who are responsible for digital technology and transformation will also be transferred to the newly merged organisation.

Autumn Budget and Spending Review 2021

At the Spending Review 2021 (SR21), the Chancellor set out the Government's plan for public expenditure for the next 3 years. NHS England's day-to-day budget was given an average of 3.8% real terms growth per year. Part-funded by the new Health and Social Care Levy, this equates to £23.3 billion over 3 years.

Since SR21, the context within which the NHS operates has been rapidly changing. COVID-19 has already had a considerable impact on the NHS and while the vaccine programme has put the UK in a strong position, there is still a large degree of uncertainty as new COVID variants emerge. HMT set out in their economic evidence that there also remains uncertainty in the economic outlook, and risks that public sector pay increases exacerbate temporary inflation pressures.

In the 2022-23 financial year, the NHS is returning to its pre-pandemic financial regime following temporary arrangements in light of the pandemic. There is a need for greater financial restraint in the context of stretching efficiency requirements and making progress towards long-term financial sustainability.

The NHS and ALBs budget has now been set until 2024/25. While this gives the NHS the financial security to address challenges in a sustainable manner, the settlement is tight and there will be a need for careful prioritisation in order to stay within available funding and make progress towards long-term financial sustainability.

At SR21 the Government was clear its priorities were to improve health outcomes for patients by ensuring the NHS can tackle the elective backlog, deliver the NHS Long-Term Plan (LTP) and have the resources to continue its response to COVID-19 pandemic. This specifically included:

- more than £8 billion to tackle the elective backlog, which comes on top of £2 billion funding provided for this purpose in 2021-22. This means that the NHS in England can aim to deliver around 30% more elective activity by 2024-25 than was the case before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and guidance;

- additional funding to grow the NHS workforce. This will be achieved by progressing existing commitments for 50,000 more nurses and 50 million more primary care appointments as well as funding the training of some of the biggest undergraduate intakes of medical students and nurses ever; and

- £9.6 billion over the SR21 period for COVID-19 related health spending so that the NHS can continue to respond to and mitigate the impacts of the virus.

Chapter 2 of our evidence focuses on the impact of SR21 and how NHS finances are being specifically targeted to ensure that the NHS can meet these key priorities and keep building a bigger and better trained NHS workforce. It is important to note that as per the SR21 settlement, there is no funding set aside specifically for pay with the budget for VSMs and ESMs. Any pay recommendation for this workforce will therefore need to be absorbed within existing budgets.

NHS senior workforce

The Health and Social Care Leadership Review described above coincides with significant reform taking place more widely in the health and care system to improve integration of services around the needs of patients. Ensuring that the NHS has access to leaders who have the skills, experience, values and behaviours to lead the commissioning and delivery of high-quality and affordable care across services is a fundamental aspect of the department's overarching strategic programme for the health and care system.

DHSC has also committed to introduce a national pay framework for trust VSMs, building on existing guidance and recommendations from the Kark review of the fit and proper persons test (Kark review) to ensure fair remuneration and converge towards a 'going rate'

for each job role. More information about the VSM framework and its links with ICBs is in chapter 3 of our evidence.

Chapters 3 and 4 set out how the VSM and ESM workforce has changed in the last year in terms of numbers and diversity. Recruitment and retention of senior leaders is not only crucial to meeting objectives like elective recovery but nurturing the next generation of leaders to make a difference in the most senior positions across the NHS. The Government recognises that staff and leaders are also motivated by their workplace environment and culture, championing inclusion, diversity and prioritising health and wellbeing which has been forefront of the NHS People Plan. NHSEI evidence will provide more detail on the NHS People Plan and its aims to improve leadership culture and support current leaders to exhibit compassionate, inclusive leadership.

The NHS total reward offer remains an important recruitment and retention tool and continues to play a key role in ensuring the NHS has the workforce it needs. The total VSM/ESM remuneration offer includes a range of benefits beyond basic pay that exceed those offered in other sectors. This typically includes a generous holiday allowance, significant job security and access to a much-valued pension scheme. Chapter 5 of our evidence provides more detail of the total reward package.

The Government, as ever, has a careful balance to strike between ensuring the NHS has the workforce it needs to deliver health priorities, whilst also ensuring the NHS remains on a sustainable financial footing and delivering value for money for the taxpayer. Uplifts in pay for the VSM and ESM workforce will come out of existing budgets and as these are now set, there are stark trade-offs between pay and other NHS spending.

To deliver the Government’s objectives; ensuring the NHS can tackle the elective backlog, deliver the LTP and have the resources to continue its response to COVID-19 pandemic, restraint on pay is essential. It is therefore crucial during this challenging fiscal and economic climate that the SSRB carefully consider the important balance between ensuring that existing funding can be used deliver these priorities whilst also fairly rewarding and incentivising senior staff. We ask that in reaching your recommendation you take into account the NHS' financial position detailed within chapter 2 of this evidence. Further information will also be provided at oral evidence.

We look forward to receiving your report in May 2022.

2. NHS finances

This chapter describes the financial context for the NHS.

As set out in the SR21 settlement, the focus for the NHS is balancing the priorities of managing the ongoing pandemic response and addressing the elective recovery challenge. Growing the NHS workforce is essential to achieving these objectives.

In 2020 to 2021, the government spent an estimated £45 billion of additional revenue costs to help the NHS mitigate the impacts of COVID-19. This was followed by around an additional £34 billion spent on COVID-19 across the health and social care system in 2021 to 2022. NHS financial sustainability is key to its post-pandemic recovery with increasing productivity crucial to restoring the performance of the NHS. To achieve this, funds have been allocated to put the NHS on a sustainable footing and fund the biggest catch-up programme in NHS history. Part-funded by the new Health and Social Care Levy, SR21 delivers an average 3.8% real terms growth per year for the NHS – equating to £23.3 billion over 3 years. This includes more than £8 billion to tackle the elective backlog, which comes on top of £2 billion funding already provided for this purpose in 2021 to 2022.

This is alongside a key priority of reforming and growing the NHS workforce. 2021 to 2022 was the first year following the three-year AfC deal (2018/19 - 2020/21) which invested 3% per annum. In addition to headline pay, DHSC has also embarked on pay and contract reform right across the NHS workforce over the last few years as part of our ambition to make the NHS the best employer in the world, providing the highest quality care.

There is an expectation that the NHS can catch up on some of the lost efficiency and make productivity savings in 2022 to 2023 in order to return to financial balance. It is therefore important that the 2022 to 2023 pay awards support the Government's objective to deliver long-term financial sustainability in the NHS Economic Context.

Economic context

As a result of the underlying resilience of the economy, the vaccination programme and the £378 billion of pandemic support provided to families and businesses, the UK economy has seen faster than anticipated growth after the largest quarterly decline in GDP since comparable records began in 1955. In November 2021, GDP was estimated to be above pre-pandemic levels for the first time. However, the emergence of the Omicron variant and the tightening of restrictions at the end of 2021 have increased economic uncertainty.

As set out in HMT's Economic Evidence to Review Bodies 2021, the gradual reopening of the global economy and the rapid return of economic activity has led to a substantial rise in commodity and raw material prices, as demand for inputs has outpaced production. Global supply issues, including increases in transportation and energy costs, have pushed up inflation in the UK. In the 12 months to December 2021, inflation grew to 5.4%, the highest in almost 30 years. The Bank of England now expects it to reach around 6% in April 2022. The OBR expects it to remain elevated across 2022 and 2023 before stabilising towards the target of 2% in the middle of the decade. If wages were to increase in line with the temporary spike in inflation, this increase could become more permanent. Given that price stability is part of the terms of reference for PRBs, this must be considered as part of their recommendations. The government is committed to price stability and has re-affirmed the Bank of England's 2% consumer price inflation target at the Budget.

The pandemic has highlighted the significant value of job security in both the NHS as well as the public sector more widely. Latest Labour Force Survey data for September 2021 shows that the number of people in private sector employment is 690k lower than pre-pandemic levels, whilst employment in the NHS and public sector continues to rise. As set out in SR21, PRBs must be aware that, to ensure fairness and the sustainability of public finances, public sector earnings growth over the next 3 years should retain broad parity with the private sector and continue to be affordable. Whole economy pay growth in average earnings is forecasted to be in line with the pre-pandemic period over the coming years, as the base effects of the pandemic unwind.

Funding growth

The LTP, published in January 2019, set 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 LTP 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 pandemic has understandably impacted on progress towards implementing many elements of the LTP. However, as set out in the Mandate, we are focused on minimising the further adverse impact of the pandemic and then recovering delivery against commitments made in the LTP – including supporting the further expansion of NHS programmes and services and embedding the positive changes brought about by the pandemic such as integration and technology advancements.

Since the beginning of the pandemic, the NHS has risen to the biggest challenge in its history by responding to the threat of COVID-19. In 2020 to 2021, the government spent an estimated £45 billion of additional revenue costs across the health and social care system to mitigate the impacts of COVID-19. For 2021 to 2022 the Government has so far approved £34 billion for frontline health services, including £15 billion of day-to-day funding for the NHS.

SR21 took steps to place the NHS on a sustainable footing and fund the biggest catch-up programme in NHS history. The increase in funding for elective recovery, growing the workforce and allowing the NHS to continue to respond to the pandemic will further enable the NHS to deliver better service and health outcomes for patients.

This is part-funded by the new Health and Social Care Levy introduced by government, which represents a 1.25% increase to National Insurance contributions with revenue ringfenced to support UK health and social care bodies. The NHS, in comparison to the wider public sector and the economy as a whole, will see the tangible benefits resulting from the Health and Social Care Levy more than most as the additional funds are distributed throughout the system.

The SR21 settlement for Health and Social Care will also ensure that we can keep building a bigger and better trained NHS workforce. The Government is committed to delivering 50,000 more nurses and 50 million more primary care appointments by funding the training of some of the biggest undergraduate intakes of medical students and nurses ever. The settlement will also continue to support a strong pipeline of new midwives and allied health professionals, who are key to delivering the full range of NHS services.

Table 1 - Opening mandate for NHS England

NHS England (NHSE)	NHSE Revenue Departmental Expenditure Limits (RDEL) excluding ringfence (RF) (cash) £ billion*	NHSE Capital Departmental Expenditure Limits (CDEL) excluding ringfence (RF) (cash) £ billion
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	149.473	0.365
2021-22	144.365	0.301
2022-23	151.827	0.219
2023-24	157.407	0.219
2024-25	162.678	0.219

(Source: 2021-22 Financial Directions to NHS England)

Table 1 above shows table outlining the opening mandate for NHS England (NHSE) in 2021-22, and indicative amounts for future years, in line with the outcome of SR21. These figures include an increase for pensions revaluation which was

provided alongside the LTP settlement. Figures exclude depreciation, AME and technical budget.

The SR21 settlement, and the LTP settlement that underpins it, give 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 to 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 non-ringfenced investments required to deliver the LTP and elective recovery.

It is essential that this money is spent in line with the NHS priorities which will have the most effective impact on delivering high-quality care for patients. Therefore, the Government has set 5 financial tests alongside the LTP settlement to ensure the service is put on a more sustainable footing for the future. The 5 tests are:

- the NHS (including providers) will return to financial balance
- the NHS will achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care
- the NHS will reduce the growth in demand for care through better integration and prevention
- the NHS will reduce variation across the health system, improving providers' financial and operational performance
- the NHS will make better use of capital investment and its existing assets to drive transformation

While the 5 tests remain important to the delivery of the LTP, the onset of COVID-19 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 pandemic.

Financial position

The Government's 2021-22 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 2021 as well as any funding required for the 2021-22 financial year to meet pressures arising due to COVID-19. 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.

2021-22 is the third year of the LTP period and began during the winter COVID-19 peak. Since the start of the 2020/21 financial year, the NHS's financial framework was suspended and replaced with a temporary regime to help deal with the impact of COVID-19. The temporary regime moved to a system of nationally-agreed block contracts with retrospective top-ups for reasonable COVID-19 related costs.

The NHS ended the 2020-21 financial year in an overall underspend position against its revised budget, including the additional COVID-19 related funding. Due to the revised financial framework which provided systems with fixed envelopes to operate within throughout 2020-21, in addition to a continuing focus on financial rigour and efficiency, most Trusts reported a year end position that was in surplus or financial balance.

Throughout the 2021-22 financial year, the NHS has been fully supported with the necessary funding at the right time, resulting in all spending pressures being met including those arising due to COVID-19. The NHS is now returning to its pre-pandemic financial regime, and there is a need for greater financial restraint in the context of stretching efficiency requirements. Evidence provided by NHSEI offers further information on this.

The financial impact of COVID-19 will be felt across the health and social care system for years to come.

Table 2 - NHS providers RDEL Breakdown

NHS providers RDEL breakdown (£m)	2016-17	2017-18	2018-19	2019-20	2020-21
NHS providers' RDEL outturn as per SoPS	935	1,038	826	1,008	-731
Provisions adjustment	-43	-39	23	50	418
Other adjustments	-101	-8	-22	-159	-342
Aggregate net deficit (Surplus)	791	991	827	899	-655
Unallocated sustainability funding	0	-25	0	-144	0
Adjust net COVID-19 impact	0	0	0	-85	0
Reported net deficit	791	966	827	669	-655

(Source: 2021-22 Financial Directions to NHS England)

Table 2 shows table outlining a breakdown of Resource Departmental Expenditure Limits (RDEL) for NHS providers from 2016-7 until 2020-21.

Share of resources going to pay

Table 3 shows the proportion of funding consumed by NHS provider permanent and bank staff spend over the last 8 years. Note that NHS provider permanent and bank staff spend only covers staff working within hospital and community health settings.

Table 3 - Increases in Revenue Expenditure and the Proportion Consumed by Pay bill

Year	NHSE RDEL (£ billion)	NHS provider permanent and bank staff spend (£ billion)	% 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	55.7	46.2%	5.35%	5.88%
2020/21	141.5	62.5	44.1%	17.37%	12.22%

(Source: trust accounts consolidation (TAC) data)

Table 3 shows table outlining Resource Departmental Expenditure Limits (RDEL) for NHS providers from 2013-14 until 2020-21, alongside their expenditure on bank staff, expenditure on bank staff as a percentage of overall staff spend, the increase in total spend and the increase in provider permanent and bank staff spend.

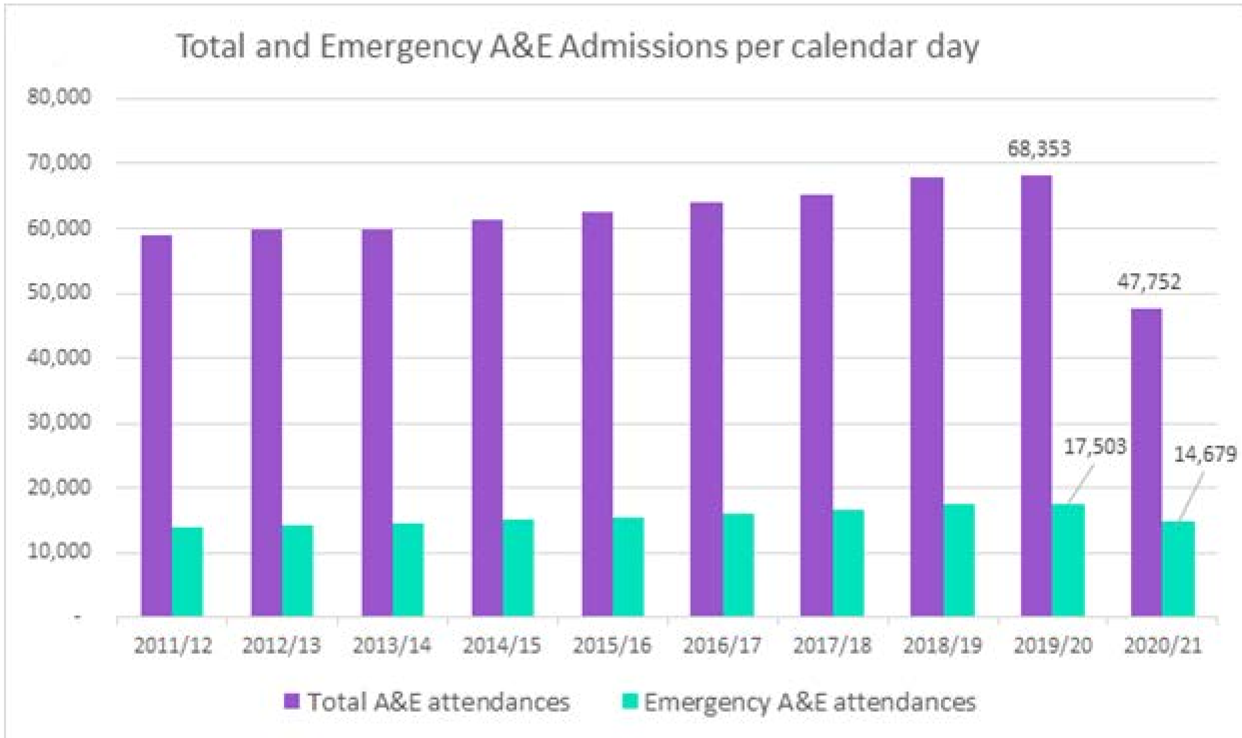
Notes:

- 2019/20 and 2020/21 NHSE Revenue Departmental Expenditure Limits (RDEL) excludes £2.8 billion for the revaluation of the NHS pensions scheme.
- 2019/20 NHS Provider Permanent and Bank Staff revised since last year's submission due to delays in finalising the accounts of one NHS provider.
- 2013/14 to 2019/20 NHSE RDEL represents the budget. 2020/21 NHSE RDEL represents the outturn expenditure (the higher budget of £146.6 billion reflects the high level of uncertainty around the financial pressures arising from the pandemic).

Demand pressures

Activity and demand levels in the health system for elective care dropped dramatically in 2020/21, as numbers of self-presenting patients reduced and the NHS freed up capacity to manage COVID-19 demand, including the suspension of all non-urgent elective operations. As a result, there was a reduction in the number of patients seen for both elective and non-elective care compared to 2019/20.

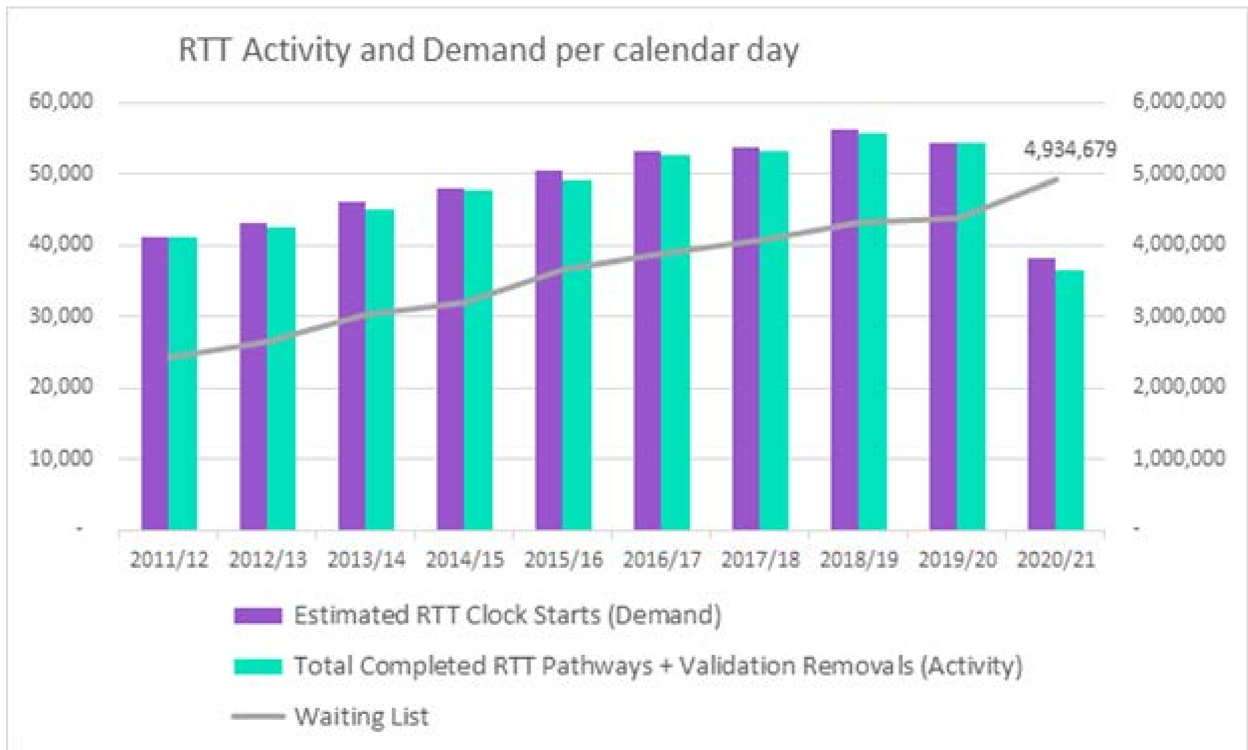
Figure 1 - Emergency Admissions – per calendar day



(Source: accident and emergency (A&E) attendances and Emergency Admission Statistics)

Figure 1 shows table outlining a graph outlining the total number of emergency accident and emergency admissions per calendar day and the number of accident and emergency attendances per calendar from 2011-12 until 2020-21.

Figure 2 - Referral to Treatment 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)

Figure 2 shows a graph outlining the total number of emergency accident and emergency admissions per calendar day and the number of accident and emergency attendances per calendar from 2011-12 until 2020-21.

Compared to the year before, in 2020/21 there was a 16.1% reduction in the number of emergency admissions. There was a 32.7% reduction in the number of completed pathways, and the RTT waiting list reach 4.9 million by the end of the financial year as demand continued to outpace activity, as shown in Figures 1 and 2.

Despite the continuing best efforts of the NHS, many of the core waiting time and access targets were not achieved during 2020/21. These included accident and emergency, referral to treatment, cancer treatment, diagnostic tests and ambulance response standards.

The Government is committed to tackling the elective recovery backlog as well as continuing to support the NHS in responding to COVID-19 and the increased pressures on the system during winter. This is whilst also working hard to deliver the maximum elective activity possible.

We have committed in 'Build Back Better: Our Plan for Health and Social Care', to reducing the elective backlog as part of improving NHS services going forwards. As a part of this we have committed £8 billion over the next 3 years to step up elective activity and

transform elective services. This funding could deliver the equivalent of around 9 million more checks, scans, and procedures. It will also mean NHSEI can aim to deliver the equivalent of around 30 per cent more elective activity by 2024-25 than it was before the pandemic.

Calculating productivity in the NHS

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.

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). Their 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 that between 2005/06 and 2018/19 the NHS’s average annual labour productivity growth was 2.0%.

Labour productivity is an important component of efficiency, but labour inputs account for only around half of the total cost of the NHS. A broader measure of productivity divides total output by an appropriate measure of all inputs, for example including drugs 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 2018/19 the NHS’s average annual total factor productivity growth was 1.1%.

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.

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.

Table 4 - York CHE Total Factor Productivity (Figures are all quality adjusted so take into account changes in quality of care (for example, waiting times)

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	3.0%	1.0%	1.9%
2017/18	2.6%	0.9%	1.7%
2018/19	2.2%	3.0%	-0.8%

Table 4 shows a table outlining changes in NHS quality adjusted output, total input and total factor productivity from 2005-06 until 2018-19.

Table 5 - York CHE Labour Productivity (Figures are all quality adjusted so take into account changes in quality of care (for example, waiting times)

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	3.0%	2.4%	0.6%
2017/18	2.6%	2.4%	0.2%
2018/19	2.2%	2.4%	-0.2%

Table 5 shows a table outlining changes in NHS quality adjusted output, labour input and labour productivity from 2005-06 until 2018-19.

Even though the annual measures haven't captured this yet, the ONS quarterly measures have explicitly stated that reductions in health output have reduced the total public sector productivity figures (Source: UK productivity introduction - April to June 2020).

It is important to note that infection controls and lockdowns have delivered health benefits (for example, less COVID cases) that aren't captured in our usual measures of productivity.

Productivity and efficiency in the NHS

The Government has set out in "Build Back Better" that recovering and increasing productivity will be crucial to restoring the performance of the NHS.

The ONS estimated public service productivity as a whole fell by 32.6% between April and June 2020 and 22.4% between July and September 2020 compared with the same quarter a year earlier, and that even as it recovered productivity was still nevertheless 9.8% lower in Q1 2021 compared with Q1 2019. It is reasonable to expect that the impact on NHS productivity would be similar. NHS productivity will have fallen significantly during 2020/21 because of the cancellation of non-urgent elective work, staff shortages and absences, and enhanced infection prevention and control. These were combined with rising costs and inputs due to increased critical care and PPE requirements.

The impact of COVID, including enhanced infection prevention and control (IPC) measures, remains a challenge for productivity. Enhanced IPC guidance, which is necessary to protect patients and staff, has reduced productivity by reducing capacity (for example, physical distancing of beds), increasing costs (for example, buying PPE), and reducing throughput (for example, longer gaps between scans for enhanced cleaning).

The vaccination programmes and reductions in cases have allowed for some relaxation of IPC rules, but productivity is yet to recover to pre-pandemic levels. NHS and UKHSA will work together to review IPC rules and determine what adjustments can be made to improve productivity without compromising patient safety.

As part of the funding announced at the Spending Review, the Government will invest in programmes to help the NHS return to productivity growth and achieve an ambitious productivity trajectory while delivering on the elective recovery challenge. Key productivity programmes prioritised by NHSEI are:

- improving patient pathways – simplifying a patient pathway will ensure patients are seen faster at the right speciality, diagnosed earlier and treated sooner. Improving the skills mix and enhancing digital connections between primary, secondary and community services in a pathway will reduce unnecessary referrals and encourage treatments closer to or at home

- setting up surgical hubs – increasing surgical productivity will increase efficiency for some of the costliest parts of the NHS. Surgical hubs will provide opportunity

for patients to be seen and treated faster which will reduce the number of patients on the waiting list faster

- expanding Community Diagnostic Centres (CDCs) – the NHS will increase the number of CDCs to at least 100 by 2024/25. CDCs separate elective diagnostics from acute hospital settings, reducing the risk of COVID infection, and offering improved productivity by reserving facilities for elective care

- making outpatient care more personalised – the NHS will give patients greater control and convenience over their outpatient appointments by supporting them to initiate follow-up care and to self-manage their conditions. This will also reduce the number of unnecessary or low-value follow-up appointments

- digital productivity programmes – using digital tools such as single sign-on, e-rostering, digital staff passports, improved communication tools, and shared care records to save clinical staff time that can be better spent caring for patients

The productivity programmes aligned with the elective recovery will build on the achievements of the 2016 Carter Review and the Operational Productivity programmes which saw a saving of £3.57 billion by January 2020, supporting average productivity growth of 1.6% from 2010 to 2019.

Alongside this, the Department and NHSEI have created a Flexible Staffing Strategy that aims to meet fluctuations in demand by building a flexible workforce that is sustainable, high quality and value for money for the NHS. A series of measures have been introduced to bring NHS agency spending under control. These measures and the impact they have had on spending are described in Chapter 5 of this evidence.

Affordability

In chapters 1 and 2, we have described the challenging economic and NHS financial landscape for 22/23.

With the NHS moving away from temporary COVID-19 arrangements and returning to its pre-pandemic financial regime, there is a need for financial restraint in the context of stretching efficiency requirements the NHS has committed to deliver as part of SR21, building on the LTP commitments and delivering value for money for the taxpayer.

The outcome of SR21 has provided a tight settlement for the NHS, which both local trusts and ALBs will have to manage. It will require the delivery of a range of priorities and efficiencies which will need careful prioritisation to stay within available funding. Since SR21, the emergence of Omicron has placed additional uncertainty on the economy, and

could further reduce the NHS's ability to prioritise significant new pay interventions, above that which was accounted for in SR21.

As already mentioned earlier in this evidence, the budgets have been fixed to prioritise investments which will enable the NHS to tackle the elective backlog, grow the NHS workforce, continue the fight against COVID-19 and deliver the LTP. This includes the significant step government has already undertaken to increase National Insurance Contributions by 1.25% to fund the Health and Social Care Levy. This leaves extremely limited room for any further investment in pay and therefore in order to achieve these objectives, financial restraint on pay is needed.

VSM and ESM pay cannot be seen in isolation from what is happening in the wider system and it is therefore important that the SSRB is clearly sighted on the overall financial challenges. As per the SR21 settlement, there is no funding set aside specifically for pay with the budget for VSMs and ESMs. Any pay recommendation for this workforce will therefore need to be absorbed within existing budgets.

To put this into context, each additional 1% of pay for the VSM & ESM workforce costs around £6m per year allowing for the full system costs. This equates to around 100 full-time nurses or 3,500 procedures. For the HCHS workforce as a whole, an additional 1%of pay costs around £900m which is equivalent to around 16,000full-time nurses or 500,000 Procedures.

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 put patients first and deliver world class patient care.

More funding allocated towards pay than what is affordable will lead to reduced progress in expanding clinical capacity and tackling the wider priorities required to deliver a more effective health and social care system.

Our focus is on ensuring that the overall package of reward helps to recruit and retain the leaders we need whilst maintaining affordability. This is the careful balance the Government must strike in order to ensure the NHS remains an affordable, value-for-money service for the taxpayer.

It is therefore crucial during this challenging fiscal and economic climate that the SSRB carefully consider the important balance between ensuring that existing funding delivers these priorities whilst fairly rewarding and incentivising leaders.

DHSC ministers and officials will be able to provide further information on affordability at oral evidence.

3. Very Senior Managers (VSMs)

A VSM is someone who holds an executive position on the board at an NHS trust or NHS foundation trust or someone who, although not a board member, holds a senior position typically reporting directly to the chief executive. The chief officer, finance officer, chief nurse and similar senior staff employed by Clinical Commissioning Groups (CCGs) are also VSMs, but it is expected that 106 CCGs will be replaced by 42 ICBs following the passing of the Health and Care Bill in July 2022 and so data relating to CCGs has not been included.

While many standard terms and conditions for VSMs, such as annual leave and redundancy are usually linked to AfC terms and conditions, and there is a national framework for setting VSM pay, individual VSMs are employed on local contracts. A frequent exception is medical directors, who are largely employed on consultant contracts and therefore are remunerated according to national collective bargaining arrangements but may also be in receipt of a management allowance.

Due to the local nature of VSM contracts, the cohort of VSMs under the remit of the SSRB is challenging to identify using national workforce data systems as they are not separately identified in the Electronic Staff Record (ESR) payroll system. To estimate the size of the VSM workforce, NHSEI and the Department has worked with NHS Digital to develop a method to identify potential VSMs based on proxy measures including earnings level, occupation code and job role[1]. We will continue to work with partners to develop methods to identify VSMs in workforce data.

Using this definition there are 2,038 VSMs (headcount) working in NHS providers as of June 2021 with a total FTE of 1,966. Part of future development includes improving time series analysis as using a static earnings threshold may underestimate the size of the VSM workforce in previous years. An alternative definition based around people with "board level[2]" job roles suggests that numbers in board level roles have been slowly increasing over the past 5 years from around 1,500 in 2016 to just under 1,700 in 2021 although some of this may reflect improvements in job coding.

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[1] To be included an individual should have earnings of at least £110,000 per year, not be employed on Agenda for Change conditions and either be Non-Medical staff with any Job Role or be Medical staff with a specified Job Role that signifies they are a member of the executive team.

[2] Includes staff not on Agenda for Change with job roles of Board Level Director, Chief Executive, Director of Nursing, Finance Director, Medical Director or Other Executive Director.

VSM Earnings

NHS Digital publish information on pay and earnings for the HCHS workforce in England and covers substantive staff who are directly employed by an NHS organisation. This data does not include other earnings including any agency, bank, or independent employment. NHS Digital have supplied data on earnings for staff identified as VSMs using our definition previously outlined.

There are 3 principal measures of earnings which can be used dependent on the context.

- Total Earnings Per Person - This calculates the average earnings received per member of staff over the period. It does not adjust for part-time working and so is effectively the total paid to staff divided by the total headcount.

- Total Basic Pay Per Person - This calculates the average basic pay received per person over the period and does not adjust for part-time working. It is the total amount of basic pay paid to staff divided by the total headcount.

- Total Basic Pay Per FTE - The level of basic pay received is directly proportional to the number of hours worked. As such this measure calculates the average amount of basic pay if it is assumed that all staff were to work on a full-time basis.

Table 6 - VSM Average Earnings in English Trusts & Foundation Trusts in 12 Months to June 2021

Definition	12 months to June 2021
Average Basic Pay per FTE	£140,531
Average Basic Pay per person	£135,868
Average Non-Basic Pay per person	£8,789
Average Earnings per person	£144,657

Source - NHS Digital Earnings Statistics

Table 6 shows information on average pay and earnings for VSMs in the 12 months to June 2021.

Average earnings per person in the 12 months to the end of June 2021 were just under £145,000 of which around £135,000 was basic pay and the remainder was from other pay

types including local payments, additional activity, and medical awards for Medical Directors also in receipt of Clinical Excellence Awards.

NHSEI will provide SSRB further information on VSM remuneration. Furthermore, NHSEI publish VSM pay benchmarking data which plots VSM pay across different VSM roles and different types and sizes of trust. This benchmarking data forms part of the current VSM pay guidance where it is expected trusts appoint VSMs at no higher than the median for the benchmarked range.

Scrutiny of VSM pay

It is important that VSMs pay, terms and conditions are fair to the taxpayer, that transparency exists with regards to decision-making and pay totals, and that these decisions are evidence-based.

VSMs are not ministerial appointments and providers hold the prerogative on recruitment. However, since 2015, the Secretary of State for Health and Social Care has nonetheless required that the same pay threshold as set by HMT for the scrutiny of ministerial appointment pay is applied to VSMs. This and other measures include:

- a requirement for all proposed VSM pay at or above £150,000 (raised from £142,500 in January 2018) in NHS trusts to be subject to ministerial approval (or ministerial comment in FTs and CCGs) before appointments are made
- a cap on the daily rates paid to off-payroll VSMs
- the development of a national VSM pay framework, likely covering all VSMs, with benchmarked rates for executive roles together with a more effective approach to transparency and disclosure for VSM pay
- clamping down on ‘retire and return’ so that VSMs do not gain financially by returning to the same job after drawing down pension benefits

Furthermore, the then Secretary of State also urged Chairs to ensure that the new redundancy terms agreed for AfC staff (with a maximum payment of £160,000) should be applied to all VSMs wherever possible.

The annual pay uplift is separate to the pay setting process (with the exception of where an employer proposes to pay an annual uplift above the recommended amount and the individual is either already being paid £150,000 or more or the proposed uplift will take their pay above that threshold).

Draft VSM pay framework

From February 2018, ministers and HMT supported a new process whereby any pay proposal above the £150k threshold that adheres to the draft provider VSM pay framework principles could be cleared at senior official level rather than by ministers.

Ministers are only presented with cases that do not adhere to the draft framework. In such cases, officials and NHSEI will present whether they do or do not support each case. This will be based on whether the evidence provided is strong enough to justify the proposed higher pay.

The draft framework uses market rate pay data to benchmark pay. The benchmarking ranges are drawn up by NHSEI, using pay data from trusts. Salary ranges include a lower quartile (LQ), median and upper quartile (UQ), and cover the Chief Executive and 9 other key executive roles. The benchmarking ranges are broken down by trust size (£ turnover) and type (acute, mental health, ambulance and community).

The policy of scrutinising VSM pay aims to reduce excessive pay above the UQ and remove outlying salaries. An aim, therefore, is for the gap between the LQ and UQ to narrow, and for salaries to thereby converge towards a 'going rate' for each job role. The draft framework aims to achieve this by applying a number of key principles, including that:

- pay should not exceed the median without being justified by a strong case
- pay should be more closely linked to performance

The framework allows for some flexibility, including:

- a 'challenged trust' payment premium of up to 10% above the median value or the UQ whichever is the highest, where necessary. A challenged trust is typically defined where it has a Single Oversight (SOF) rating of 4 and/or a CQC rating of 'requires improvement'. The current framework also includes the principle of 'earnback', where up to 10% of base pay should be put at risk if some or all key objectives are not met
- an 'interim' payment premium of up to the UQ, or up to 10% above the UQ where the trust is a challenged trust

Where earnback is included in contracts, there is also the option for trusts to award a bonus of up to 10% where objectives are exceeded. Last year, the SSRB recommended against this mechanism, recommending that team working is instead incentivised. NHSEI is currently revising proposals for the new VSM framework as outlined below

Further guidance on the current framework and pay for VSMs can be found on NHS England and NHS Improvement website.

Future VSM framework

DHSC and NHSEI have undertaken to introduce a national pay framework for trust VSMs in the NHS and officials continue to work with NHSEI to build on the existing guidance, with an aim of including all VSMs including those earning below £150,000.

The new framework will consider the Kark Review's recommendations, including its assertion that competence standards should be a prerequisite of directors who wish to sit on a board of a health providing organisation, as well as recommendations made by the SSRB in its 2021 report. We expect that, once the new VSM pay framework is in use, no trust will be required to send in a VSM pay proposal for approval if it adheres to the framework - even where the pay is above the £150k threshold. The final framework is expected in the second half of this year.

The new framework will also take into account the establishment of Integrated Care Boards (ICBs). In anticipation of this, chief executive salary ranges for ICBs were agreed with NHSEI after they undertook a job evaluation exercise (at the time of writing, other executive director salaries are pending agreement). It was determined that ICB VSM pay should, in general, be slightly higher than provider pay, to reflect the breadth, complexity and strategic importance of the role of these new organisations. ICBs will be responsible for the development and delivery of a long-term strategy and plan, integrating the strategies of all relevant partner organisations within the Integrated Care System (ICS), to meet their population health needs.

The SSRB's opinion on the agreement, with particular regard to whether the proposed pay levels are sufficiently constrained, would be welcomed.

Diversity analysis

Data from NHS Digital show there were just over 2,000 VSMs in Trusts and Foundation Trusts in England in June 2021. It is possible to split these staff according to various demographic groups including gender, ethnicity, and age.

The data suggests that most VSMs are White with only 8% of VSMs being from ethnic minorities. There is a near even gender split with very slightly more Male VSMs than Female ones and just under 85% of VSMs are aged between 45 and 64 which is not unexpected given the level of experience required to be equipped for these roles.

Table 7 - VSM Diversity Analysis - June 2021

Dimension	Group	Proportion

Ethnicity	White	86%
-	Ethnic Minorities	8%
-	Not Stated or Unknown	5%
Gender	Male	51%
-	Female	49%
Age Band	25 - 34	0%
-	35 - 44	14%
-	45 - 54	46%
-	55 - 64	37%
-	Over 65	2%

(Source - NHS Digital Workforce Statistics - Figures may not add to 100% due to rounding)

Table 7 shows a table outlining diversity information by ethnicity, gender and age band for VSMs.

Motivation and morale

We note that the SSRB has previously asked for further data and information on the motivation and morale of the VSM workforce, specifically asking for the staff group to be made identifiable in the NHS staff survey. This request has been put forward to NHSEI, however an identifying question within the survey itself cannot be taken forward due to confidentiality reasons. Instead, NHSEI have recommended that we seek to access survey results through use of background ESR data. Parties are exploring how data on motivation and morale can be collated via other mechanisms, such as through ESR, and aim to provide an update to the SSRB in future years

Labour market context

It is instructive to compare earnings for VSMs against similar professions in the wider economy based on either the role profile or earnings level. NHS VSMs in Trusts &

Foundation Trusts have a high level of remuneration compared to the rest of the HCHS, and the wider economy. While individual levels of pay will vary average earnings of almost £145,000puts VSMs in the top 1% of earners in the UK

HCHS staff in NHS Trusts saw an average level of total earnings of £34,846 in March 2021, and among the wider economy, there was an average gross pay of £31,447 in 2021 for all employees. This means that VSMs earn approximately 4.2 times the HCHS average and around 4.6 times the average of the wider economy.

Data from the Annual Survey of Hours and Earnings (ASHE) published by the Office for National Statistics can be used to compare trends in earnings between occupations. Within ASHE, the most natural comparators for VSMs are the occupation group of "Senior Officials and Chief Executives" and a comparison based on the earnings percentile.

Average earnings for Senior Officials and Chief Executives increased steadily between 2014 and 2019 before falling, by over 10%, in 2020 and recovering somewhat in 2021. Average gross pay for those in the 99th percentile of earnings shows a similar pattern with increases in the years before the pandemic but reductions in the last 2 years. When analysing data from 2020 and 2021 it is important to remember the impact of the pandemic on earnings in different occupations - for example due to changes in the composition of the workforce and furlough.

With average earnings of almost £145,000 VSMs are in the top 1% of earnings in the UK, although this does not appear to be out of line with roles in other sectors that have similar levels of experience and responsibility and the ratio of average earnings for VSMs to those in the workforce (4.2) should be judged against this ratio in comparable companies in the private sector.

While there remains considerable uncertainty, in particular since the emergence of the Omicron variant, the wider economy has shown signs of recovery in recent months. However, the labour market affecting VSMs will be a restricted subset of this, with different dynamics affecting their expectations and behaviour.

Non-consolidated payments

Trusts and Foundation Trusts may make non-consolidated payments to VSMs, although not all trusts choose to use this as part of their approach to total reward. For the 2021-22 pay round, and in light of the pay pause, NHSEI sent a letter to trusts outlining that:

- each Trust may from time to time use its discretion to make exceptional pay awards to acknowledge exceptional performance

- non-consolidated awards should not make up more than 2% of trust pay bills
- while there is no cap on the percentage of employees that can receive an award, there was an expectation to see differentiation in performance, a spread of performance ratings and a difference in the amount awarded to individuals
- it is recommended that individuals do not receive a non-consolidated award which exceeds 5% of their reckonable pay pot
- money spent on non-consolidated awards must come from existing budgets

4. DHSC Arm's Length Bodies Executive and Senior Managers

An Executive Senior Manager (ESM) is defined as someone who holds an executive position in one of DHSC's ALBs or someone who, although not a board member, holds a senior position typically reporting directly to the chief executive.

ALBs range in size, budgetary control and breadth of responsibility but all ALBs have a national role and are key components in the health and social care system. They undertake an extraordinarily wide and diverse range of functions, encompassing highly specialised services on the one hand, to responsibilities affecting the entire health and social care system on the other. This level of responsibility is reflected in the size, budgets, and complexity of each ALB.

ESM pay is governed by the ESM Pay Framework, first implemented in 2016. The framework is based on a job evaluation system developed by Monks, implemented independently on behalf of ALBs and DHSC by the NHS Business Services Authority (NHSBSA).

There are just under 500 ESMs working in our Executive Agencies and ALBs, a slight increase from last year.

Data return analysis

As part of the work to develop an evidence base for the SSRB for the 2022-2023 pay round and beyond, DHSC requested in-depth data on their ESMs from 11 different Executive Agencies and ALBs. DHSC also completed a data return due to a small number of ESMs that transferred to the Department as a result of the closure of Public Health England. This is referred to henceforth as the ALB data collection.

The raw data return has been submitted to the SSRB separately.

This analysis provides an overview of the 12 data returns received.

ALBs included

This return consists of 12 different organisations and 495 ESM roles.

Table 8 - ALBs

Care Quality Commission	NHS Blood and Transplant

Health Education England	NHS Business Services Authority
Health Research Authority	NHS Digital
Human Tissue Authority	NHS England and Improvement
Human Fertilisation and Embryology Authority	NHS Resolution
National Institute for Health and Care Excellence	DHSC Office for Health Improvement and Disparities

(Source: ALB data collection)

Table 8 shows a table outlining a list of ALBs.

Pay analysis

Given the specialist nature of the ALBs, there are not necessarily common and comparable roles to be found across all organisations. The ESM pay framework clusters roles into 4 ESM grades. These 4 ESM grades each have a broad pay band.

This approach seeks to cluster roles at similar levels in the management hierarchy of the larger ALBs while also being able to reflect the responsibilities of Executive Director and CEO roles of the smaller organisations.

Table 9 - Role and Pay Bands

Role grade	Pay band - minimum	Pay band - operational max	Pay band - exception zone
1	£90,900	£113,625	£131,300
2	£131,301	£146,450	£161,600
3	£161,601	£176,750	£191,900
4	£191,901	£207,050	£222,200

(Source: ESM Pay Framework)

Table 9 shows a table outlining pay bands for ESM grades.

Below is a summary of the average basic pay and average total pay for all ESMs. The average has gone down slightly since 2020/21, probably due to the creation of new ESM 1 roles at the lower end of the full ESM pay range (£90,900-£222,200). Some ESMs may benefit from additional payments such as car/travel allowances and on-call allowances along with other payments (see table 12 for more detail).

Table 10 - Basic and total pay by year

Year	Average basic pay	Average total pay
20-21	£125,470	£126,890
21-22	£125,284	£126,390

(Source: ALB data collection)

Table 10 shows a table outlining average basic pay and average total pay by for the years 2020-21 and 2021-22.

Below is a summary of the average basic pay and average total pay broken down by ESM Grade.

Table 11 - Basic and total pay by year

Grade	Average Basic Pay	Average Total Pay
ESM 1	£115,034	£115,858
ESM 2	£143,988	£144,302
ESM 3[3]	£191,055	£191,571

(Source: ALB data collection)

Table 11 shows a table outlining average basic pay and average total pay for ESM grades.

Allowances

ESMs may have different allowances included within their total remuneration package. A large number of these are legacy allowances that are not available to new starters (for example, vehicle allowance) or are protected payments. The most prevalent allowance within the data sample was a responsibility allowance which 3% of ESMs had included within their total package. This increased from 1.3% last year, possibly due in part to additional responsibilities required in light of Covid-19. The average allowance amount received was £9,696.

Table 12 - Allowances

Allowance	% of ESMs	Average Allowance Value
Additional responsibilities	3%	£12,085
Miscellaneous (including RRAs)	2%	£9,385
On-call allowance	0.6%	Withheld[4]
Vehicle allowance	0.6%	Withheld

(Source: ALB data collection)

Table 12 shows a table outlining additional allowances, containing information on the percentage of ESMs who receive them and the average allowance value.

[3] ESM 4 not included due to low numbers
[4] Withheld due to GDPR (sample size represents 5 or less individuals)

Diversity analysis

Ethnicity breakdown

Table 13 - Ethnicity Proportions

Ethnicity	Proportion 21/22	Proportion 20/21
White	81%	79%
Ethnic Minorities	7%	8%
Not stated	12%	14%

(Source: ALB data collection)

Table 13 shows a table outlining the proportion of white and minority ethnic ESM employees.

The proportion of ESMs from an Ethnic Minority background has decreased by 1% since last year.

Gender

Table 14 - Gender Proportions

Gender	Proportion 21/22	Proportion 20/21
Male	48%	52%
Female	52%	47%

(Source: ALB data collection)

Table 14 shows a table outlining the proportion of white and minority ethnic ESM employees.

The proportion of women in ESM roles has increased since last year to 52%. The % of women decreases slightly as the grade increase with women making up 53% of ESM 1, 49% of ESM 2 and 44% of ESM 3, although the overall numbers decrease as the grade increases so the sample size is smaller. Overall men are paid more than women in the ESM sample although the total average pay gap has reduced from last year (3.2%) by 1.8%.

Table 15 - Gender and Basic Pay

ESM Grade	Female Average Basic Pay	Female Average Total Pay	Male Average Basic Pay	Male Average Total Pay	Total Pay Gap
Total	£124,258	£125,569	£126,414	£127,294	1.4%

(Source: ALB data collection)

Table 15 shows a table outlining average basic and total pay for ESM employees by gender.

Motivation and morale

ALBs use a range of differing surveys/methods to understand the engagement levels of their employees. As there is not a consistent approach, it is challenging to give meaningful information on ESM motivation and morale.

For the ALBs that use the standard NHS staff survey, as outlined in chapter 3, it is not currently possible to separate out VSM/ESM responses, although this is being explored for future years. The smaller ALBs which run their own engagement surveys are not able to identify ESM results as the cohorts are too small. Only one ALB was able to provide engagement scores for ESMs. These results showed ESM engagement scoring highly compared to the organisation's overall engagement scores in both 2021 and 2020.

Scrutiny of ESM pay and annual pay award

Scrutiny of ESM pay

DHSC Remuneration Committee have oversight of ESM pay. They have delegated some authority to ALB Remuneration Committees – for example, salaries for appointments into existing roles at ESM 1 and ESM 2 up to the operational maximum.

DHSC Remuneration Committee approval is required for the salary of all new roles, salaries for ESM 1 and ESM 2 replacements with a salary above the operational maximum and all Chief Executive, ESM 3 and ESM 4 roles.

All roles with a remuneration package of £150,000 or more require both DHSC Remuneration Committee and Secretary of State approval prior to an appointment (this includes salaries for those on medical, dental and GP contracts). In addition to DHSC Remuneration Committee and DHSC Ministerial approval, Chief Secretary to the Treasury approval is required for all salary packages of £150,000 or more that are also above the exception zone maximum for their band (in line with the HM Treasury Guidance for approval of senior pay - GOV.UK (www.gov.uk)).

2021-22 recommended pay uplift

The remuneration and annual performance related pay of ALB CEOs and their Executive Directors paid under the terms of the ESM Pay Framework is determined by the DHSC

Remuneration Committee. The Committee operates within the parameters set by the Cabinet Office and in light of the Government's response to the Senior Salaries Review Body's recommendations for any pay round.

For the 2021-22 pay round, ESMs returned explicitly to the remit of the SSRB. However, given the challenging economic environment, the SSRB were not asked for a pay recommendation for any senior managers in their remit, including Health. In line with the Spending Review 2020 position, it was agreed that ESMs would not receive a consolidated pay increase as they, along with VSMs in the NHS, were included within the wider public sector pay pause. Therefore, for the 2021-22 pay round, no ESMs received a consolidated pay increase across any of the ALBs.

For context, in previous years, pay uplift for ESMs have been in line with uplifts for other senior roles in the public sector. For example, for the pay year 2020/21 the DHSC Remuneration Committee agreed to the following recommendations for staff covered by the ESM Pay Framework:

- that ALBs implement an award of 1% for their ESMs, with salaries below the respective exception zone maximum

- a ring-fenced pot of up to 1% of the ALB's ESM paybill to address pay progression and pay anomalies, with awards dependent on demonstration of sustained high performance, increased effectiveness and deepened expertise and their position in the pay range

Performance related pay for ESMs

DHSC Remuneration Committee have approved the use of non-consolidated performance related pay in ALBs, although not all ALBs choose to use this as part of their approach to total reward.

Historically, non-consolidated payments are only made to top performers. Usually, these awards can be no more than 5% of an employee's reckonable pay.

In previous years there has been a cap on the % of ESMs who can be awarded a non-consolidated award. For example, in the 2020/21 pay round, ALBs had to submit a business case to DHSC Remuneration Committee if they proposed to pay awards to more than 40% of their employees. ALBs could therefore use a maximum of 2% of their ESM paybill for non-consolidated awards.

For the 2021-22 pay round, and in light of the pay pause, DHSC Remuneration Committee agreed that:

- in line with the previous year's spend, ALBs can use up to 2% of their ESM paybill for non-consolidated awards for the 2020/21 performance year

- there was no cap on the percentage of employees that can receive an award. However, there was an expectation to see differentiation in performance and a spread of performance ratings and therefore a difference in the amount awarded to individuals. An approach of a blanket award to all ESMs was not supported

- individuals could receive a non-consolidated award of up to 5% of their reckonable pay

- any money spent on non-consolidated awards must come from existing budgets

At the time of data collection, only 3 ALBs gave evidence to show they are using the flexibilities surrounding performance related pay and one shared their intention to use it to determine awards in January 2022 but were unable to submit the amounts at the time of data collection. Of the 1.2% of ESMs who the data showed received any performance related pay, the average award was £4,558.

5. Total reward

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 reward package for VSMs and ESMs is made up a range of benefits, including basic pay, access to a much-valued pension scheme, annual leave entitlement, maternity leave, and redundancy entitlement. Arrangements regarding additional annual leave, maternity pay and redundancy entitlement above the statutory minimum for VSMs are for employers to decide locally, although we understand these terms and conditions are in many cases broadly similar to those offered under AfC. VSMs may also benefit from local arrangements such as car and relocation allowances. ESMs within the ALBs benefit additionally from flexible and hybrid working conditions, including the ability to work from home and may also benefit from allowances and performance related pay. The SSRB has previously found that these additional benefits, in general, are competitive. When determining if the overall VSM/ESM remuneration package is sufficient, it is important for any such analysis to include them.

As part of the total reward package and to improve the experience of working in the NHS NHSE/I have developed the NHS People Promise, which accompanied the July 2020 People Plan publication. The intention is to make the promise's principles a reality by 2024. It is structured around 7 principles aimed to make the NHS "the best place to work". The 7 principles are: We are compassionate and inclusive; We are recognised and rewarded; We each have a voice that counts; We are safe and healthy; We are always learning; We work flexibly; We are a team. More detail on the People Promise will be provided in NHSE/I's written evidence.

NHS pensions

We understand that the majority of VSMs and ESMs under this remit will be eligible to be part of the NHS Pension Scheme ("the Scheme"), with a very small minority who may be members of the Civil Service Pension Scheme.

NHS pension scheme overview

The NHS Pension Scheme is one of the best pension schemes available. Membership of the Scheme is high, with around 9 in 10 NHS staff actively participating.

Eligible members of the NHS workforce will now belong to one of the 2 existing schemes, both of which are defined benefit schemes. The final salary 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.

The key differences between the 2 schemes, other than the way benefits are calculated, are different normal pension ages and accrual rates, as shown in Table 1 below.

Table 16: Comparison of Scheme, Retirement Age and Accrual Rate

Scheme or section	Retirement age	Accrual rate
1995 Section	60	1/80th
2008 Section	65	1/60th
2015 Scheme	State Pension age	1/54th

Table 16 shows table outlining a comparison of different pension schemes, outlining differences in retirement age and accrual rates.

It is currently difficult to show the size of an average VSM pension accrued in the scheme, as we do not hold data on local employment arrangements. Table 2 shows the annual pension that would be accrued by a VSM should they join the 2015 Scheme from 1 April 2022 at pensionable pay levels of £110,000, £125,000, £150,000, £175,000 and £200,000. Salary and CPI increases are assumed to be 2% p.a. in each future year.

It is important to note that these figures do not include any allowance for Annual (AA) or Lifetime Allowance (LTA) tax charges. It is likely that salary levels of £125,000 and above will incur AA charges almost immediately, with the £110,000 level incurring AA charges within 10 years, without any allowance for non-pensionable income. The highest earning example of £200,000 would also start to reach the LTA towards 10 years of service. More information on pension tax is included in the section on pension flexibilities.

Table 17: Pensions Accrual by Salary and Years of Service

Salary	5 years' service	10 years' service	15 years' service
£110,000	£11,752	£26,935	£46,325
£125,000	£13,355	£30,608	£52,642
£150,000	£16,026	£36,730	£63,170
£175,000	£18,697	£42,851	£73,699
£200,000	£21,368	£48,973	£84,227

(Source: Government Actuary's Department)

Table 17 shows a table outlining how much pension is accrued depending on salary and years of service.

The 2015 Scheme was introduced as part of wider reforms implemented by regulations made under the Public Service Pensions Act 2013. As part of these reforms, public service pension scheme members within 10 years of retirement were given transitional protection, and so remained in their legacy pension schemes. In December 2018, a judgement by the

Court of Appeal in the cases of McCloud and Sargeant ("the McCloud judgment") found that these transitional protection arrangements gave rise to unlawful discrimination.

The Department set out the Government's proposed response to the McCloud judgment its 2021 evidence. Since then, the Government has laid proposed primary legislation, the Public Service Pensions and Judicial Offices Bill, before Parliament to implement changes in public service pension schemes to remedy the discrimination identified by the McCloud judgment. The bill was introduced into the House of Lords on 19 July 2021. Subject to Parliamentary approval, this puts in place a legal framework which requires departments to make amendments to pension scheme regulations to facilitate implementation of the remedy as directed by the bill.

The remedy has 2 parts:

- to ensure equal treatment for all members within each of the main public service pension schemes by moving all members into the new schemes on 1 April 2022 irrespective of age
- to remove the effect of transitional protection by offering eligible members a choice over the set of benefits (legacy scheme or new scheme) they wish to receive for any pensionable service during the period 1 April 2015 to 31 March 2022

On 9 December 2021, the Department launched a consultation on a draft Statutory Instrument (SI), which will make changes to the NHS Pension Scheme regulations as part of the first part of the McCloud remedy.

Scheme membership for managers

The department continues to monitor scheme membership rates through the Electronic Staff Record (ESR). Data from June 2021 shows that Scheme membership among VSMs is high, (79%), although slightly less than membership among all NHS staff groups (89%).

Table 3 shows the estimated pension membership rate for VSMs with basic pay of over £110,000 per year as of June 2021.This shows that while 79% of all VSMs with basic pay over £110,000 per year are members of the scheme, membership rates decrease as basic pay increases. Further investigation is necessary to explain this, however the department recognises that experience of pension tax may be a factor. This is explained in more detail in the pension flexibilities section. Table 4 shows that there has been no notable change in scheme membership rate for VSMs with basic pay of over £110,000 between June 2020 and June 2021.

It is important to note that as there is no single way to identify VSMs, a number of proxy measures have been used to identify individuals for inclusion in the analysis:

- estimates are based on staff with a recorded basic pay per FTE of at least £110,000 who were working in June 2021

- estimates cover staff working in the Hospital and Community Health Sector – including NHS Trusts and Support Organisations. CCGs are not included due to the introduction of ICBs from April 2022

- estimates include all Non-Medical staff who reach the salary threshold and are not working under AfC

- estimates include Medical Staff if they are not working under AfC and have a job role that indicates they are a member of the Executive Team (for example, Medical Director)

- a positive employer pension contribution is used as the proxy of pension membership

Table 18: NHSPS Membership for VSMs at June 2021

Pay Range	Rate
£110k - £125k	85%
£125k - £150k	84%
£150k - £175k	71%
£175k - £200k	61%
Over £200k	44%
All Over £110k	79%

(Source: DHSC Analysis of Electronic Staff Record)

Table 18 shows a table outlining pension membership rates for VSMs by salary bands.

Table 19: Change in NHSPS Membership for VSMs, 2020-2021

June 2021 Membership Rate (HC Basis)	1 Year Change, June 2020-June 2021
79%	0.2%

(Source: DHSC Analysis of Electronic Staff Record)

Table 19 shows a table outlining membership rates and of pensions and yearly changes.

NHS pension scheme contributions

The Scheme collects contributions from both employers and members, with employers contributing 20.6% (plus a 0.08% administration charge) of a member's earnings. Members are required collectively to contribute 9.8% across the whole Scheme membership. This is the average member contribution rate and is known as the member contribution "yield".

Tiered contribution rates were introduced in 2008, to reflect that higher earners were likely to receive proportionally more benefits than lower earners over the course of their retirement, due in part to their final salary link. To ensure the cost of the Scheme is affordable for all members, these tiered contribution rates ask higher earners to pay proportionally more than lower earners to access the valuable benefits of the Scheme. 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 Department launched its consultation on changes to member contributions on 19 October 2021. The consultation set out that whilst the generous cross-subsidy provided by the current tier structure was intended to reduce potential financial barriers and encourage all staff to participate in the Scheme, the Department could no longer justify keeping the cross-subsidy at the same level. In the old final salary scheme, higher earners tended to derive more value from their ultimate pension benefits relative to the amount they contributed over their career, and so they were charged higher contribution rates. However, under a CARE scheme this advantage no longer exists for higher earners, as all members receive the same proportional benefit for their contributions.

Given that all members will be moved to the 2015 Scheme, a CARE scheme, for future accrual from 1 April 2022, the consultation set out a new structure (Table 5), which narrows the range between the lowest and highest contribution rates and ensures that the costs and benefits of the scheme are more evenly shared. Other changes set out in the consultation document include a move to base members' contribution rates on their actual pensionable pay rather than their whole-time equivalent (WTE) earnings, and annual increases to each tier in line with uplifts to AfC pay bands.

Adjustments to contribution tiers will be phased in over 2 years, to dampen the impact on take-home pay for staff and mitigate the risk of staff leaving the scheme on grounds of affordability. For the purpose of determining a member's contribution tier, their pensionable earnings are rounded down to the nearest whole pound. In practice, as the tier thresholds will be increased annually in line with AfC pay awards the figures will be slightly different for future scheme years.

Table 20: New member contribution structure, as proposed in the consultation document

Current tiers	Pensionable earnings (rounded down to nearest pound)	Current rate	Rate from 1 April 2022	Rate from 1 April 2023	Proposed tiers
-	n/a	(WTE pay)	(Actual pay)	(Actual pay)	-
Tier 1	Up to £13,231	5.0%	5.1%	5.2%	Tier 1
Tier 1	£13,232 to £15,431	5.0%	5.7%	6.5%	Tier 2
Tier 2	£15,432 to £21,478	5.6%	6.1%	6.5%	Tier 2
Tier 3	£21,479 to £22,548	7.1%	6.8%	6.5%	Tier 2
Tier 3	£22,549 to £26,823	7.1%	7.7%	8.3%	Tier 3

Tier 4	£26,824 to £27,779	9.3%	8.8%	8.3%	Tier 3
Tier 4	£27,780 to £42,120	9.3%	9.8%	9.8%	Tier 4
Tier 4	£42,121 to £47,845	9.3%	10.0%	10.7%	Tier 5
Tier 5	£47,846 to £54,763	12.5%	11.6%	10.7%	Tier 5
Tier 5	£54,764 to £70,630	12.5%	12.5%	12.5%	Tier 6
Tier 6	£70,631 to £111,376	13.5%	13.5%	12.5%	Tier 6
Tier 7	£111,377 and above	14.5%	13.5%	12.5%	Tier 6
-	Expected yield	9.8%	9.8%	9.8%	-

Table 20 shows a table outlining pension tiers and the associated pensionable earnings and contribution rates, as proposed in the consultation document.

In order to balance clarity for members and a timely move to the new structure with minimising the impact of the new member contribution structure on take-home pay, the Department decided to delay the implementation of the new member contribution structure until 1 October 2022. As set out in the consultation document, the new member contribution structure will be phased in slowly to protect scheme affordability and minimise the risks to take-home pay of increases to member contribution rates.

In October 2022, approximately 40% of members are expected to receive a reduction in their contribution rates compared to the previous contribution rate structure. VSMs, who are some of the highest earning members of the NHS, are particularly likely to see a decrease in their contribution rate as the gap between the lowest and highest contribution rates is narrowed. Members with pensionable pay between £70,631 and £111,376, who currently contribute 13.5%, will contribute 12.5% by the end of the phasing in period. Members with pensionable pay above this amount, who currently contribute 14.5%, will also see this decrease to 12.5% by the end of the same period.

Moving to using actual annual rates of pensionable pay (instead of WTE) will also benefit VSMs who work part-time, as their contribution rate will be lower and better reflective of the amount of pension that they are building. Around 40% of the Scheme membership work part-time, and it is estimated that 30% of the whole Scheme membership would pay less in contributions as a result of moving to actual annual rates of pay.

The SAB have previously considered that it is important for any tier structure to avoid "cliff edges", whereby members are placed in a higher tier as the result of moving up a pay band, and so see a decrease in their take-home pay. Whilst the Department has sought to mitigate this in designing the new contribution structure, in a tiered contribution structure some cliff edges will always exist.

Pension taxation

To encourage individuals to plan for their retirement, the Government provides tax incentives by allowing pension scheme contributions to be made tax-free. However, the cost of this is over £50 billion a year. To ensure sustainability, there are progressive restrictions on the amount that individuals can save into their pension tax-free. These are the tapered Annual Allowance (AA) and the Lifetime Allowance (LTA).

The Government's 2019 manifesto committed to resolving the pension taper issue that was causing some high earning staff to opt out of the scheme or leave NHS employment through early retirement for fear of high tax bills. Although the evidence of the impact of pension tax on service delivery was strongest for senior clinicians, the Government took an evidence-based approach to the issue, which also considered the impact on VSMs. At Budget in March 2020, the Chancellor therefore increased the tapered annual allowance thresholds by £90,000 from 6th April 2020. The net income and adjusted income thresholds were increased to £200,000 and £240,000 respectively. These changes ensure that scheme members with earnings below £200,000 are outside the scope of the tapered annual allowance.

As of 1 April 2021, the allowances are as follows:

- £1.073m for the LTA; and
- £40,000 for the AA, tapering down to £4,000 at a rate of £1 less allowance per £2 of relevant earnings above £240,000. HMRC calculates relevant earnings to include the value of pension growth over the year

Those who still experience tapering following the changes are the very highest earners in the NHS, and a very small minority of VSMs. The "Scheme Pays" facility is a proportionate way for them to meet annual allowance tax charges without needing to pay any cash up front. It allows the tax to be paid by debiting the annual pension at retirement. Staff will still increase their annual pension substantially once the tax charge is taken off.

NHS Employers have also published guidance on local approaches employers can take to support staff who remain within scope of the AA or who have exceeded their LTA. One example of this is to recycle the unused employer contribution as additional pay where a staff member opts-out of the scheme as they have exceeded their allowance for tax-free pension saving. The guidance is clear that this should provide no net increase to the individual's total reward package and therefore should not increase costs for employers.

In line with NHS Employers guidance, DHSC ministers have confirmed that where an employer offers their unused contribution as pay, they do not need to submit a case to the department for approval providing that:

- contribution recycling is only permitted where an individual is expected to breach the tapered annual allowance or exceed the lifetime allowance

- recycling arrangements are short-term and comply with pension auto-enrolment legislation

- contribution recycling does not increase the value of an individual's total reward package, and the increased pay in lieu of pension is reflected in trust annual reports

Total reward and annual benefit statements

Total reward statements (TRS) are provided to staff and give NHS 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 employers.

Examples of local reward individual NHS employers and ALBs may offer include recommend a friend schemes, affordable accommodation, 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, and signposting to pensions advice services.

NHS Pension Scheme members also receive an annual benefit statement (ABS), which shows the current value of their Scheme benefits. Data from the NHS Business Services Authority (NHSBSA) shows that on 7 December 2021, the number of statements viewed by staff was 349,349, a slight decrease from 375,457 that had been viewed at around the same point in 2020.

Since 2016, the NHSBSA 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.

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