Department of Health & Social Care

The Department of Health and Social Care's written evidence to the NHS Pay Review Body (NHSPRB) for the 2023 to 2024 pay round

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1. NHS strategy and introduction

This chapter sets out the wider context for the department's evidence for the 2023 to 2024 pay round and provides an overview of this year’s written evidence to the NHS Pay Review Body (NHSPRB).

This follows the 2022 to 2023 pay round, in which the government looked to the NHSPRB for a recommendation on pay, and after careful consideration, and reprioritisation of existing departmental funding, accepted the recommendations in full. This year, the government is again inviting the NHSPRB to make a pay recommendation for the Agenda for Change (AfC) workforce.

The NHS Spending Review settlement

In the challenging economic and fiscal context in which pay recommendations will be made this year, decisions on pay awards will have a particular impact on the spending review settlement and the commitments made within it. In addition to the long term NHS settlement announced in 2018, and the additional funding announced at the last Spending Review (SR21), funding confirmed at the 2022 Autumn Statement means the NHS resource budget will increase to £160.4 billion in 2023 to 2024, and to £165.9 billion in 2024 to 2025, up from £123.7 billion in 2019 to 2020.

Since the evidence we provided last year, the context in which the NHS operates has been rapidly changing. The prolonged impact of COVID-19 has been significantly higher than assumed in SR21, with more COVID-19 patients occupying beds in 2022 than in 2021 or 2020. This will continue to have consequences for the productivity of services and bed occupancy rates. Inflation has been much higher than previously forecast. At the time of SR21, inflation was forecast to peak at over 4% but, due to higher energy prices and the invasion of Ukraine, has now peaked at just over 11% this winter (HMT have provided further evidence on the economic outlook), Whilst the government has continued to prioritise investment into the NHS, these factors have increased the costs of delivering services, and the financial pressures systems are facing. Due to these changes, and last year's pay award being significantly above the government's affordability envelope, NHS England (NHSE) is undergoing significant reprioritisation.

The Chancellor's Autumn Statement 2022 reiterated the government's priorities on delivering the Long Term Plan (LTP), improving health outcomes for patients by ensuring the NHS can tackle the elective backlog, and having the resources to continue its response to the COVID-19 pandemic. As was covered in last year's evidence, SR21 specifically included:

1. around £8 billion to tackle the elective backlog. A significant part of this funding will be invested in staff – both in terms of capacity and skills
2. additional funding to grow the NHS workforce. There are currently 72,000 nurses in training and over 9,000 people training to be midwives, as well as a record number of medical students in training
3. £9.6 billion over the SR period for COVID-19 related health spending

Chapter 2 of our evidence focuses on how the changing context has impacted the department's settlement and how NHS finances are being targeted at meeting key priorities.

Overview of the NHS workforce

The NHS settlement has been carefully prioritised to ensure that the NHS can meet these key priorities and to keep growing a diverse and skilled NHS workforce within a challenging fiscal context. Chapter 3 of our evidence outlines the department's current strategy to ensure that the NHS has the workforce it needs. The government has committed to publishing a comprehensive workforce plan in 2023 and this will include independently verified forecasts for the number of doctors, nurses and other professionals that will be needed in 5, 10 and 15 years' time, taking full account of improvements in retention and productivity. Alongside this, we are investing in and diversifying the training pipeline to increase supply throughout the nursing workforce. There is also significant reform taking place in the health and care system to improve integration of services around the needs of patients.

'Our plan for patients' focuses on the challenges facing the NHS this winter and next. Within it the department re-committed to improving productivity and identified backlogs as one of 4 key priority areas.

Work is also underway to identify the NHS's more wide-ranging strategic priorities,with further detail set out in NHSE's Planning Guidance and other documents to be developed in due course.

Recruitment and retention are not only crucial to meeting objectives like elective recovery but for safeguarding staff health, wellbeing and morale and avoiding burnout. It is important to recognise the great strain COVID-19 has placed on the health and social care workforce, and the exceptional response of those working in health and social care throughout this period. The government recognises that staff are also motivated by their workplace environment and culture, championing inclusion, diversity and prioritising health and wellbeing. Chapter 4 sets out how the workforce has changed in the last year,

outlining the current data and analysis on joiners, leavers, vacancies, and temporary staffing in the AfC workforce. Alongside chapter 3, it outlines that overall, the workforce continues to grow, with further increases in the nursing workforce and an increase in new roles following changes in education and training pipelines. However, there is more to do, and our evidence outlines the current and additional steps the government and our NHS system partners are taking to increase morale and motivation during a challenging time for the workforce.

The NHS total reward offer remains a key recruitment and retention tool in ensuring the NHS can grow the workforce it needs. Pay makes up one part of the overall reward package and, whilst important, there are other benefits which have both financial and non-financial value which impact the motivation, recruitment and retention of the NHS workforce. Chapters 5 and 6 of our evidence provide more detail of the total reward package and describe how earnings for the AfC workforce have remained broadly competitive against the wider economy and comparable labour markets, growing in line with expectations following last year's pay uplift. The relative position of NHS staff to other staff groups in the UK remains consistent.

The government needs to strike a careful balance between ensuring the NHS has the workforce it needs to deliver health priorities and ensuring the NHS delivers value for money for the taxpayer. SR21 set efficiencies targets for the NHS of 2.2% per year through to 2024 to 2025. This does not include the ask for systems to operate with reduced COVID-19 funding (by 57% in 2023 to 2024, from £5.1 billion to £2.2 billion). In this context, and with significant inflationary pressures, there is a need for even stricter prioritisation of budgets. The large size of the NHS workforce makes the impact of further pay pressures greater. Any additional funding needed for pay awards will need to be found through further reprioritisation of the existing budget and there are stark trade-offs between pay and other NHS spending.

Pay rises above affordability could materially impact government's ability to deliver on key priorities, such as manifesto commitments and the elective recovery. It is therefore essential that during this challenging fiscal and economic climate, pay remains fair, which recognises the vital importance of NHS staff, but affordable and minimises inflationary pressures and managing the country's debt. We urge NHSPRB to carefully consider this important balance when reaching your recommendations. Further information will also be provided at oral evidence.

We look forward to receiving your report in April 2023.

2. NHS finances

This chapter describes the financial context which will need to be considered when determining NHS pay awards.

The focus for the NHS continues to be balancing the priorities of managing the ongoing COVID-19 response and addressing the elective recovery challenge. NHS financial sustainability is essential to achieving these objectives.

In the challenging economic and fiscal context in which pay recommendations will be made this year, it is important that the NHSPRB understands the impact of pay awards on the SR21 settlement and the commitments made within it as funding for NHS pay is considered alongside other categories of budget. The health and social care system is in an extremely challenging position, with cost pressures resulting from the prolonged impact of COVID-19 in addition to the significant impact of inflation on budgets and the costs of delivering services. The health and social care workforce is much larger than comparable workforces, and the impact of the pay pressures are correspondingly greater.

SR21 delivers an additional £23.3 billion over 3 years for the NHS. 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 addition, a further £3.3 billion in 2023 to 2024 and 2024 to 2025 was made available in the Autumn Statement 2022. Nevertheless, given the significant inflationary pressures, budgets are being stretched and will continue to be by meeting the efficiency and productivity savings as set out in SR21. It is therefore important that the 2023 to 2024 pay awards help support NHS performance in delivering long term financial sustainability in the NHS.

Economic context

Global factors have led to a significant amount of economic uncertainty over the course of 2022 with global energy price increases being the primary driver of above-target inflation. The Consumer Prices Index (CPI) reached 10.5% in the 12 months to December 2022. CPI inflation is forecast to average around 11.1.% in Q4 2022, fall to around 5% over 2023 to 2024, before turning negative in 2024 to 2025 as fading external factors outweigh domestic pressures.

Attempts to restrain inflation have led to the Bank of England increasing their base rate to 3.5% in December 2022, its highest level in 14 years, in order to bring domestically generated cost pressures - namely nominal wage growth - down to levels consistent with their 2% inflation target. After experiencing faster than anticipated growth as the country reopened from the COVID-19 pandemic in 2021, GDP fell by 0.2% in Q3 2022. As a result of these economic conditions, the Office for Budget Responsibility (OBR) forecasts that the

UK economy has already entered a recession, expected to last until 2023 Q3, the longest on record.

In this context, pay awards need to strike a careful balance between recognising the vital importance of public sector workers, while minimising inflationary pressures and managing the country's debt. If public sector pay awards are significantly above the private sector, this could contribute to risks of higher and more persistent inflation, by placing pressure on other parts of the economy to demand higher wages. The government is committed to price stability and has re-affirmed the Bank of England's 2% CPI target at the Budget. Given that the government's inflation target is part of the terms of reference for the NHSPRB, this must be considered as part of their recommendations.

Funding growth

The NHS LTP 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 COVID-19 pandemic has understandably impacted on progress towards implementing many elements of the LTP. However, as set out in the government 2022 to 2023 mandate to NHS England, we are focused on minimising the further adverse impact of COVID-19 and then recovering delivery against commitments made in the LTP. This includes supporting the further expansion of NHS programmes and services and embedding the positive changes brought about by COVID-19, such as integration and technology advancements.

As described in chapter 1, SR21 took steps to place the NHS on a sustainable footing and to 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 COVID-19 will further enable the NHS to deliver better service and health outcomes for patients.

The SR21 settlement for Health and Social Care, together with the additional funding at the Autumn Statement 2022, will also ensure that we can keep growing a diverse and skilled NHS workforce. The government is committed to delivering its manifesto commitments and funding 7,500 medical students in training every year - a record number. 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 2.1: Mandates 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 to 2014	93.676	0.200

2014 to 2015	97.017	0.270
2015 to 2016	100.200	0.300
2016 to 2017	105.702	0.260
2017 to 2018	109.536	0.247
2018 to 2019	114.603	0.254
2019 to 2020	123.377	0.260
2020 to 2021	149.473	0.365
2021 to 2022	150,614	0.337
2022 to 2023	152,555	0.223
2023 to 2024	160,420	0.219
2024 to 2025	165,860	0.219

Source: 2022 to 2023 Variation to the Financial Directions to NHS England (PDF, 123KB)

Table 2.1 above shows the closing mandates for NHSE up to 2021 to 2022, the varied mandate in 2022 to 2023, and indicative amounts for future years, in line with the outcomes of SR21 and the 2022 Autumn Statement. The figures are adjusted annually to account for reallocation of resource, additional funding and changes of responsibility between government bodies. These figures include an increase for pensions revaluation which was provided alongside the LTP settlement. Figures exclude depreciation, annually managed expenditure (AME) and the technical accounting budget, namely capital grants or Private Finance Initiative.

Multiple calls are currently being made on available funding, including the knock-on impact of last year's pay award on the total paybill cost of this and future years. As described later in the chapter, 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 NHS LTP and elective recovery.

Financial position

The government's 2022 to 2023 mandate to NHSE outlines the headline objectives for the NHS. The 2022 to 2023 variation to the Financial Directions to NHSE reflects further funding to deliver manifesto commitments agreed at Budget 2021, as well as funding to meet pressures arising due to COVID-19 and to support the recovery of elective services in the 2022 to 2023 financial year. Following the temporary COVID-19 financial framework, the system is transitioning from block payments, which were in place to help deal with the impact of COVID-19, to blended payments.

Despite the significant challenges faced by the service, the NHS ended the 2021 to 2022 financial year in an overall underspend position. This was mainly driven by the COVID-19 Omicron variant which slowed down spending on normal NHS commissioning activity and service transformation. This led to a significant improvement in the financial position of frontline NHS organisations, with the NHS provider sector ending the year with a healthy aggregate surplus.

However, the fiscal and economic environment of the last year has pushed the NHS into a challenging financial position in 2022 to 2023 onwards. Cost pressures arising from the impact of inflation on budgets has forced the NHS to release significant reserves and savings in 2022 to 2023. These pressures will continue to be felt, and have an impact on budgets, into 2023 to 2024. Despite the headline financial plan for 2022 to 2023 being balanced, the NHS is working to manage significant additional net financial risk, mostly driven by the continuing impact of COVID-19 which is driving up costs and reducing capacity.

Table 2.2 shows the breakdown of funding provided to NHS providers over the last 5 years.

Table 2.2: NHS providers RDEL breakdown

NHS providers RDEL breakdown (£m)	2017 to 2018	2018 to 2019	2019 to 2020	2020 to 2021	202 to 2022
NHS providers' RDEL outturn as per SoPS	1,038	826	1,008	-731	-589
Provisions adjustment	-39	23	50	418	320
Other adjustments	-8	-22	-159	-342	-287
Aggregate net deficit (surplus)	991	827	899	-655	-556
Unallocated sustainability funding	-25	0	-144	0	0
Adjust net COVID-19 impact	0	0	-85	0	0
Reported net deficit (surplus)	966	827	669	-655	-556

Share of resources going to pay

Table 2.3 shows the proportion of funding consumed by NHS provider permanent and bank staff spend over the last 9 years. Note that NHS provider permanent and bank staff spend only covers staff working within hospital and community health settings.

Table 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 to 2014	93.7	42.9	45.8%	n/a	n/a
2014 to 2015	97.0	43.9	45.3%	3.57%	2.37%
2015 to 2016	100.2	45.2	45.1%	3.28%	2.80%
2016 to 2017	105.7	47.7	45.1%	5.49%	5.58%
2017 to	109.5	49.9	45.6%	3.63%	4.64%

2018					
2018 to 2019	114.4	52.6	45.9%	4.46%	5.35%
2019 to 2020	120.5	55.7	46.2%	5.35%	5.88%
2020 to 2021	140.6	62.7	44.6%	16.63%	12.63%
2021 to 2022	146.5	66.2	45.2%	4.21%	5.46%

Notes:

- 2013 to 2014, 2019 to 2020 NHSE RDEL represents the budget, while underspend was negligible. 2019 to 2020 NHSE RDEL excludes £2.8 billion for the revaluation of the NHS pensions scheme. 2020 to 2021 reflects spend and excludes £6 billion unspent funding and £2.8 billion for the revaluation of the NHS pensions scheme. 2021 to 2022 reflects spend and excludes £1.3 billion unspent funding and £2.8 billion for the revaluation of the NHS pensions scheme

- 2020 to 2021 NHS Provider permanent and bank staff revised since last year's submission due to the publication of the DHSC annual report and accounts: 2020 to 2021 on 31 January 2022

In 2022 to 2023, the pay awards were significantly above the government's affordability envelope. As a result, a significant reprioritisation exercise within NHSE has had to be undertaken to identify the funding necessary, with the consequent need to slow investment in service transformation. The DDRB recommended a 4.5% pay increase for medical and dental staff outside of multiyear deals. The NHSPRB recommended a £1,400 consolidated uplift for AfC staff, enhanced for pay points at the top of band 6 and all pay points in band 7 so it was equal to a 4% uplift. This was an impact of 4.75% on the AfC paybill - 1.75% (equivalent to £1.2 billion) above what was provisioned for pay. The government accepted and implemented these recommendations in full.

Over recent years, DHSC has embarked on pay and contract reform across the NHS workforce. AfC staff, doctors and dentists in training and specialty doctors have all benefited from modernisation of terms and conditions and changes to pay scales to better reward increasing experience and expertise. 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.

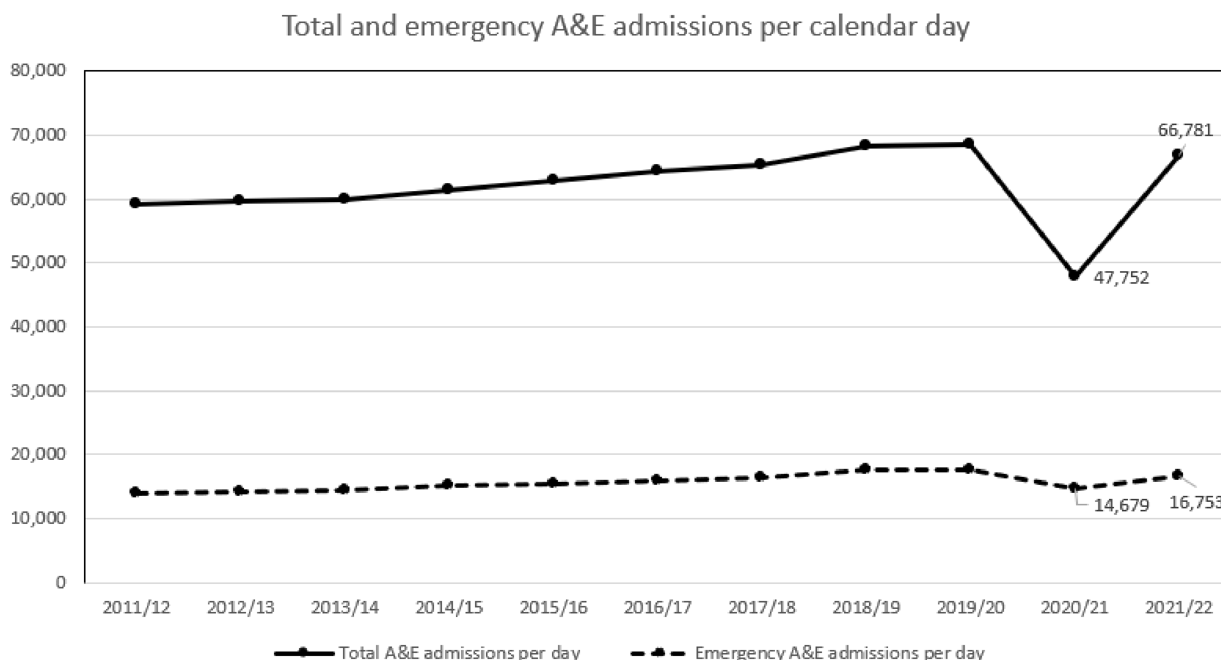
Demand pressures

Activity and demand levels in the health system for elective care dropped dramatically in 2020 to 2021 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.

Demand for non-elective care in 2021 to 2022 has returned to levels seen before the COVID-19 demand spike.

Figure 2.1: Total and emergency admissions per calendar day



Source: A&E attendances and emergency admission statistics

Figure 2.1 shows the total and emergency admissions to NHS England per calendar day between 2011 to 2012 and 2021 to 2022

In 2019 to 2020 there were 68,540 A&E attendances and 17,551 emergency admissions per day. In 2021 to 2022 there were 66,781 A&E attendances and 16,753 emergency admissions per day. This equates to a 3% decrease in attendances and a 5% decrease in emergency admissions between 2019 to 2020 and 2021 to 2022.

Table 2.4 - Total referral to treatment (RTT) pathways completed per working day.

Year	RTT estimated clock starts	RTT total completed pathways and validation removals	Waiting list
2011 to 2012	59,771	59,897	2,443,952
2012 to 2013	63,085	62,150	2,677,497

2013 to 2014	66,281	64,806	3,052,280
2014 to 2015	69,473	68,853	3,209,293
2015 to 2016	73,252	71,403	3,675,298
2016 to 2017	76,348	75,476	3,897,530
2017 to 2018	78,401	77,583	4,102,999
2018 to 2019	81,392	80,434	4,345,467
2019 to 2020	78,366	78,205	4,386,297
2020 to 2021	54,926	52,696	4,950,297
2021 to 2022	73,594	68,030	6,358,050

Source: NHSE consultant led referral to treatment statistics. Data adjusted for non-submitting trusts and exclusion of sexual health services from 2013

Compared to the year before, in 2021 to 2022 there was a 14% increase in the number of emergency admissions. There was a 28% increase in the number of completed pathways, and the referral to treatment waiting list reached 4.9 million by the end of the financial year as demand continued to outpace activity, as shown in Figure 2.1 and Table 2.4.

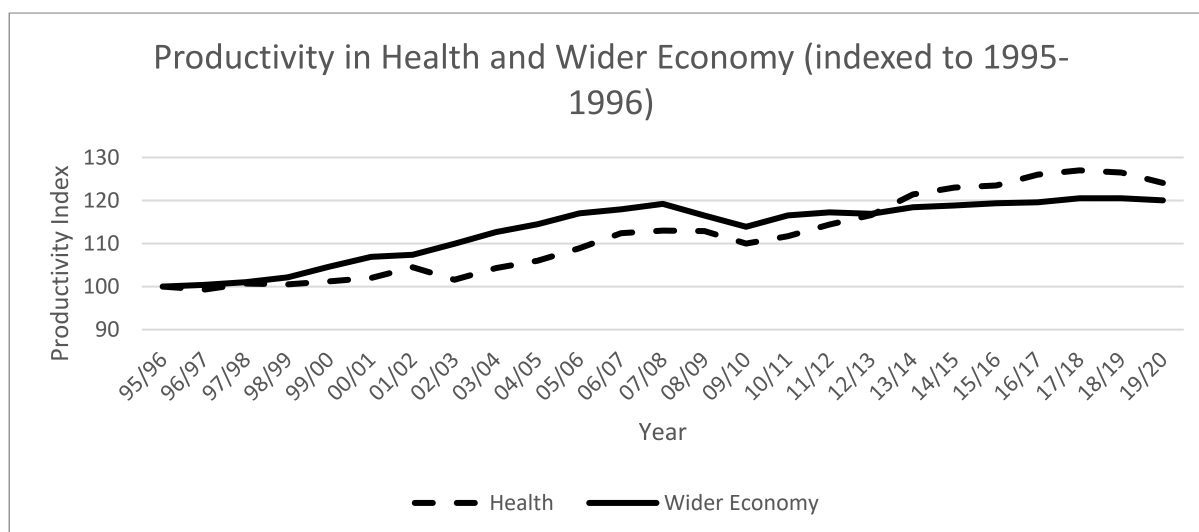
Despite the continuing best efforts of the NHS, many of the improvements between 2019 to 2020 and 2020 to 2021 in core waiting time and access targets were reversed during 2021 to 2022, or continued to deteriorate. These included A&E, referral to treatment, cancer treatment, diagnostic tests and ambulance response standards. There were improvements in recovering elective services with activity increasing throughout 2021 to 2022, although it generally remained lower than pre-COVID-19 levels.

In 'Build Back Better: Our plan for Health and Social Care' and ‘Our plan for patients’, the department has committed to reducing the elective backlog as part of improving NHS services going forwards. More than £8 billion has been provided over 3 years for this, which comes on top of £2 billion funding provided in 2021 to 2022 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 NHSE can aim to deliver the equivalent of around 30% more elective activity by 2024 to 2025 than it had delivered before the COVID-19 pandemic.

Calculating productivity in the NHS

Health productivity increased on average by 0.9% per annum from 1995 to 1996 until 2019 to 2020. This is a similar level to productivity growth in the wider economy. Health productivity was lower prior to the financial crash but higher from the financial crash to the COVID-19 pandemic.

Figure 2: Productivity growth in health and the wider economy up until 2019 to 2020. Productivity measures are indexed to 1995 to 1996 = 100



The figure above shows that the productivity level in health, indexed to 1995 to 1996, lagged behind productivity in the wider economy until 2013. Since then, the health productivity level has been higher than the wider economy.

Table 2.5: Average productivity growth in health and the wider economy, both prior and after the financial crash

Years	Health	Wider economy
Average 1998 to 2007	0.9%	1.7%
Average 2008 to 2017	1.0%	0.1%

NHS productivity measures are currently only published up until 2019 to 2020 so do not reflect the full impact of COVID-19. However, ONS does publish public service productivity measures quarterly, allowing the effect of COVID-19 to be observed. These measures do not specifically identify health productivity but as health is 40% of the measure, it is an indication of health productivity.

Although public service productivity has remained mostly steady since Q2 2021 (April to June 2021), it is still 6.5% below the pre-COVID-19 level. The volume of inputs and outputs remains higher than pre-COVID-19 levels due to an increase in expenditure and activity in response to COVID-19. However, while inputs have seen a 12.1% growth compared with pre-COVID-19, outputs have only seen a 4.8% growth.

Whilst public service productivity remains at low levels, this creates challenges for the NHS. As a result of COVID-19, there are currently large backlogs for elective care. Reductions in productivity result in reductions in outputs in the NHS, which means less of the elective backlog can be tackled.

It is important to note that infection controls and lockdowns implemented throughout the COVID-19 pandemic have delivered health benefits (for example, fewer COVID-19 cases) that will not be 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. In ‘Our plan for patients’, the department re-committed to improving productivity and identified backlogs as one of 4 key priority areas. In February 2022, the NHS published the delivery plan for tackling the COVID-19 backlog for elective care, setting out a clear vision for how the NHS will recover and expand elective services over the next 3 years. The plan commits the NHS to deliver 9 million additional elective treatments and diagnostic procedures over 3 years and around 30% more elective activity than it was doing before COVID-19 by 2024 to 2025.

Public sector productivity as a whole fell by 35.7% at the start of the COVID-19 pandemic, as estimated by ONS (between April and June 2020 compared with the same quarter a year earlier). See more information on the ONS website. The latest ONS public services productivity publication estimates that in Q2 2022 (April to June) public service productivity is still 6.5% below pre COVID-19 levels, but this has remained mostly steady since Q2 2021. They estimate that healthcare specific output, excluding Test and Trace and vaccination, has recovered to pre-COVID-19 levels.

Revised infection, prevention and control (IPC) guidance was issued to NHS organisations by NHSE in April 2022, and further revised again in June 2022. This included: stepping down inpatient COVID-19 isolation precautions by allowing isolation period to be reduced from 10 to 7 days with 2 negative LFTs; and stepping down COVID-19 precautions for exposed patient contacts, with removal of need for inpatient close contacts to isolate. These changes have helped the NHS to increase activity, while keeping patients safe.

IPC rules have relaxed due to the success of vaccination programmes and a reduction in COVID-19 cases in 2021 to 2022. However productivity is yet to fully recover to pre-COVID-19 levels due to issues such as the combined prevalence of flu and COVID-19 in communities, staff absence (due to COVID-19), use of agency staff and wider vacancies. The NHS is committed to implementing the UK Health Security Agency (UKHSA) IPC guidance consistently and safely, and in doing so, move towards delivering services in a more productive way. Any adjustments to these measures will be dependent on emerging COVID-19 variants and seasonal flu.

As part of the £8 billion funding announced at SR21, the government has invested in programmes to help the NHS achieve an ambitious productivity trajectory while delivering on the elective recovery challenge. The key productivity programmes prioritised by NHS England 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

- surgical hubs – increasing surgical productivity will increase efficiency for some of the costliest parts of the NHS. Surgical hubs are separate from a hospital or occupy dedicated space within a hospital in order that they are protected from the pressures in the urgent and emergency care system. This separation of elective procedures with urgent and emergency care, provides the opportunity for patients to be seen and treated faster which will reduce the number of patients on the waiting list faster. Currently 89 elective surgical hubs are operational across England, with a further 56 business cases approved

- expanding community diagnostic centres (CDCs) – the NHS will increase the number of CDCs up to 160 by March 2025. CDCs separate elective diagnostics from acute hospital settings, reducing the risk of COVID-19 infection, and offering improved productivity by reserving facilities for elective care. There are currently 91 operational CDCs that have delivered over 2.4 million additional tests as of November 2022

- 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. DHSC will support all trusts to put electronic patient records in place by 2025

Improving productivity and efficiency continues to be important for ensuring that demand growth for health services can be met. 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 NHSE 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 4 of this evidence.

Affordability

In chapters 1 and 2, we have set out the challenging economic and NHS financial landscape for 2023 to 2024, which builds on the difficult position following the 2022 to 2023 pay round.

Against the backdrop of substantial inflationary pressures which are having a widespread impact on the whole economy, it is important that the NHSPRB understands the impact of pay awards on the SR21 settlement and the commitments made within it. The health and social care system is in a particularly difficult position, with financial pressures most felt due to the prolonged impact of COVID-19, in addition to the wider impact of inflation on budgets. Pay remains the largest component of NHS costs (approximately 65% of total operating costs). Therefore, pay inflation represents a significant cost pressure to be managed. In the context of efficiency requirements that the NHS has committed to deliver as part of SR21, there is a need for strict financial prioritisation of existing budgets.

As previously mentioned in this evidence, the department's 'Our plan for patients' re-committed to improving productivity and delivering the Long Term Plan. The NHS budget prioritises investments which will enable the NHS to support ambulance services more effectively, tackle the elective backlog, establish a strong care sector and make it easier to access primary care.

Through the current financial settlement provided by HM Treasury to the department and reprioritisation decisions, funding is available for pay awards up to 3.5%. Pay awards above this level would require trade-offs for public service delivery or further government borrowing at a time when headroom against fiscal rules is historically low and sustainable public finances are vital in the fight against inflation.

Meeting the NHSPRB recommendations for 2022 to 2023 had a significant impact on the NHS budget. To put this into context, each additional 1% of pay for the whole Hospital and Community Health Service (HCHS) workforce cost around £900 million for 2022 to 2023, allowing for the full system costs beyond the substantive workforce. The NHS pay recommendations cost £1.4 billion more than was considered affordable. While every effort was made to protect front-line services, and the department went as far as possible in making further efficiencies by looking at all areas of central and corporate spend, meeting the NHSPRB recommendations in 2022 to 2023 necessitated some tough decisions, including the review of investment in transformation programmes such as reductions to IT transformation funding.

The large size of the NHS workforce compared to other workforces makes the impact of pay pressures correspondingly greater. Pay rises above what has been provisioned will have a material impact on delivery of the government's commitments and what the NHS has set out to achieve, and further reprioritisation beyond that set out above would be required. NHS budgets are already tight following reprioritisation exercises to fund the ongoing costs of maintaining Living with COVID-19 testing, surveillance and treatment architecture, and the pay deal for 2022 to 2023. As a result there are a decreasing number of areas where we can look for funding.

These are challenging times for everyone, and our focus is ensuring a fair pay award which recognises the vital importance of public sector workers whilst minimising inflationary pressures and managing the country's debt.

It is therefore essential that during this challenging fiscal and economic climate, pay remains fair but affordable. We urge the pay review body to carefully consider the important balance between ensuring that existing funding can be used to deliver essential services, prioritising key commitments to improve care, and fairly rewarding staff.

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

3. Workforce planning, education and training

The NHS in England is staffed by a hugely diverse and dedicated workforce. There are over 1 million people on Agenda for Change contracts, working in over 300 different job roles across acute, mental health and community services. The NHS workforce has grown significantly over recent years, with more people employed by the NHS now than at any time in its history. As of October 2022, there were over 42,000 more staff, including almost 4,700 more doctors and over 10,500 more nurses, compared with a year earlier. The government has completed a 25% increase in medical school places and have made good progress towards delivering 50,000 nurses by the end of this parliament, with over 36,000 more nurses in post in October 2022 compared with September 2019. We have also announced that in 2023 we will publish an independently verified long term workforce plan, including supply and demand projections.

However, there are challenges and the workforce remains under pressure. There are high levels of vacancies and leaver rates have increased since April 2021, after having fallen significantly during the COVID-19 pandemic. NHS organisations have increased their use of temporary staff while expenditure on both bank and agency shifts has increased in the past 2 years. Results from the most recent staff survey show that, save for a limited number of measures, staff experience has declined since the previous survey in 2020 (though it is more comparable with earlier years).

Despite these pressures, NHS staff have met the challenges of the past few years. Services have continued to transform in order to deliver the care models set out in the NHS LTP, and to meet the new needs generated by the COVID-19 pandemic (such as the vaccination programme). This wouldn’t have been possible without the huge dedication of staff working in every part of the NHS.

Looking to the future, demand for services will continue to grow with demographic and societal shifts. Over the next 15 years, the population of England is projected to increase by 4.2%. The population is also ageing and over the same period the number of people aged over 85 is estimated to grow by 55%. An older population, with different health needs, means that the size and shape of the workforce, and the skills that NHS staff have, will need to shift.

The government, working together with NHSE, HEE and partners across the health and care system, is undertaking a large programme of work to train and grow the workforce, recruit internationally and support and retain the current workforce. It is also working, as part of the long term workforce plan, to set out the future drivers of demand, to help

support the workforce to meet new models of care, and to set out the actions needed to help meet future workforce demand over the long term.

DHSC works through its arm’s length bodies and sector delivery partners on the delivery and implementation of workforce policy. In conjunction with the department, NHSE is responsible for setting the priorities and direction of the NHS workforce and encouraging and informing the national debate to improve healthcare. As part of this work, NHSE is responsible for delivering the NHS People Plan. Education and training of the regulated health workforce in health and social care is the core function of HEE and, subject to parliamentary approval of regulations made under Part 3 of the Health and Care Act (2022), will be merged with NHSE. The merger will help ensure that this workforce is placed at the forefront of the national NHS agenda as it will integrate service, workforce and finance planning in one place, reflecting its importance to NHS delivery. It will also simplify the national system for leading the NHS, ensuring a common purpose and strategic direction.

To support this joint strategic direction DHSC has commissioned NHSE to develop a long term workforce plan, including long term supply projections. The plan focusses on the practical action the NHS must take, working with partners in government, to grow and transform the workforce, and continue to embed compassionate and inclusive cultures. Guided by a new strategic framework for the health and care workforce, the long-term workforce plan will provide a roadmap that will ensure the NHS has the right number of people, with the right skills, working in the right areas to deliver high quality care. In the Autumn Statement the government commited to publishing the plan in 2023 including independently-verified forecasts for the number of doctors, nurses and other key professionals that will be needed in 5, 10 and 15 years' time, taking full account of improvements in retention and productivity. Combined, these actions will help put the NHS on a sustainable footing over the long term.

NHSE and HEE have responsibility for shorter term health workforce planning and the deployment of the health workforce to meet service need. Following the passage of the Health and Care Act (2022), each integrated care system (ICS) now has a role in planning workforce requirements for its own service.

The approach NHSE has taken to planning in 2022 to 2023 aligns with the long-term objectives and aims to embed compassionate and inclusive cultures alongside an evidence-based, system-wide approach to workforce planning.

DHSC retains strategic oversight for the health and care workforce and is delivering longer term strategic workforce planning. This includes working closely with NHSE on the plan for elective recovery, which emphasises the importance of workforce in any recovery.

Workforce planning

Growing the workforce

The monthly workforce statistics for October 2022 show that there are record numbers of staff working in the NHS, with over 1.25 million Full-Time Equivalent (FTE) staff (which is over 1.4 million in headcount). Since October 2021, there are now over 19,400 (3.0%) more professionally qualified clinical staff working in NHS hospital trusts and integrated care boards (ICBs), including almost 4,700 (3.7%) more doctors and over 10,500 (3.4%) more nurses. In total there are over 42,000 (3.5%) more hospital and community health service staff (HCHS) compared to October 2021.

The government has committed to deliver 50,000 more nurses by March 2024. This will be achieved through a combination of investing in and diversifying the training pipeline, recruiting and retaining more nurses in the NHS. There are already over 36,000 more nurses working in the NHS since September 2019 as the result of the work of the 50,000 Nurse Programme.

To support both the 50,000 Nurses Programme and recruitment in general, since September 2020 the government has offered non-repayable grants of at least £5,000 per academic year to all eligible students studying pre-registration programmes across nursing, midwifery and allied health professions. Additional funding is available to students with child dependents (£2,000 per year) and students studying specialist subjects (£1,000 per year), alongside reimbursement of travel and accommodation costs and support for exceptional hardship. Through HEE, we have also increased the supply of clinical placements through £55 million of investment in improved capacity.

The University and College Admissions Services (UCAS) end-of-cycle data shows over 30,000 students accepted places to study nursing and midwifery in England in the 2021 recruitment cycle. This is the highest combined nursing and midwifery total since these statistics were first recorded and a 28% increase compared to the 2019 cycle. There are currently over 72,000 people training to be nurses, over 9,000 people training to be midwives and over 30,000 training to become Allied Health Professionals.

As you are aware, the government has funded an additional 1,500 undergraduate medical school places each year for domestic students in England: a 25% increase over 3 years. This expansion was completed in September 2020.

Maternity

NHSE has invested significantly in maternity services. £95 million was provided in 2021 and 2022 and in March 2022, NHSE announced a further £127 million to support maternity

and neonatal services, including to grow midwifery and obstetric staff numbers and support retention.

There is an existing commitment to increase the undergraduate pipeline by expanding training places by 3,650 from 2018 and 2019 to 2022 and 2023, with an increase of 650 in 2019 to 2020 and 1,000 over subsequent years. The target to date has been overachieved by 166 places and HEE remains confident of achieving the additional 1,000 this year. DHSC and NHSE are working to open new international recruitment markets, to support the arrival of up to 500 international midwives in 2022 and 2023. In 2022, we will also see the first graduates from midwifery apprenticeship programmes.

NHSE has also provided each maternity unit £50,000 (a total of circa £8 million across England) in 2022 and 2023 to continue to enhance supernumerary support to midwives, including newly qualified and return to midwifery practice learners with a continued focus on retention and pastoral support activities.

The Maternity Transformation Programme has provided transformation funding to Local Maternity and Neonatal Systems (LMNS) with several deliverables, including ensuring that every LMNS has an adequate workforce plan in place such that each provider is taking appropriate steps to achieve and maintain identified maternity staffing requirements. The plans should include compliance with National Institute for Health and Care Excellence (NICE) Guideline [NG4] (safe midwifery staffing for maternity settings) and that obstetric staffing levels are sufficient to meet the Ockenden recommendations.

Nurse 50,000

The government is committed to deliver 50,000 more nurses by the end of this Parliament and put the NHS on a trajectory to a sustainable long-term supply in future. The target is ambitious, and delivery is complex, requiring cooperation and coordination on a system-wide basis.

The department published a delivery update in March 2022 on the 50,000 Nurses manifesto commitment. This update sets out more detail about the programme, including progress so far; plans for meeting the target; uncertainties, risks and mitigations; and next steps. It also sets out the definition, scope and timing of the target.

The department has established a comprehensive delivery programme to meet the nursing manifesto commitment. Working across a range of delivery partners to invest in and diversify our training pipeline, and ethically recruit internationally, improve retention and support return to practice.

Delivery of 50,000 more nurses in the NHS in England will support the 1.2 million full-time equivalent staff who make up the NHS workforce and address nursing shortages. As of October 2022, there are over 337,000 nurses in HCHS and General Practice settings

working in the NHS. This is an increase of over 36,000 since September 2019 (the baseline for the 50,000 nurse programme).

The government has taken steps to deliver this commitment by providing a financial support package as outlined in the education section below. In our evidence last year we outlined the additional funding for registered nurse degree apprenticeships, training grants and parental support allowance.

Retention

Work to support existing staff has been ongoing since before the COVID-19 pandemic. The pandemic has brought this into sharper focus, and we have worked to help ensure that the existing workforce is well supported and looked after. Retaining NHS staff is a priority and the NHS priorities and operational planning guidance 2022 and 2023 is clear that the wellbeing of the workforce is crucial. The 2020 NHS People Plan sets out a comprehensive range of actions to improve staff retention. It provides a strong focus on creating a modern, compassionate and inclusive NHS culture by strengthening health and wellbeing, equality and diversity, culture and leadership and flexible working. In addition, the NHS Retention Programme is continuously seeking to understand why staff leave, resulting in targeted interventions to support staff to stay whilst keeping them well.

National workforce planning

The announcement of the government's intention to integrate HEE and NHSE is a major step towards unifying workforce planning across the health system so that we are better able to train and recruit the right mix of staff which will maximise the return on our investment. This integration will help ensure that service, workforce and finance planning are integrated in one place at a national and local level. It will also simplify the national system for leading the NHS, ensuring a common purpose and strategic direction. It is our intention to formalise the integration of HEE and NHSE using the transfer of functions powers contained in the Health and Care Act (2022). Ahead of the exercise of these legal powers, HEE and NHSE will begin to integrate their structures and work. This 2-stage process will help smooth the transition.

Note: building on HEE's strategic planning work and the work already delivered through the NHS People Plan, DHSC has commissioned NHSE to develop a long term NHS workforce plan. The high level plan will look at the next 15 years and will set out the actions and reforms needed to help ensure the NHS has the workforce it needs for the future. We have committed to publishing the workforce plan this year, including independently verified projections for the number of doctors, nurses and other professionals we will need in 5, 10 and 15 years' time, taking full account of the need for better retention and productivity improvements.

Integrated care systems (ICS) - local workforce planning

ICSs are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area, including working to ensure the system is retaining, recruiting and, where required, growing its workforce to meet future need. Each ICS will have an ICB, a statutory organisation bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS. As we respond to the challenges that COVID-19 has placed upon the health and care system, ICBs will have a critical role to play in growing, developing, retaining and supporting the entire health and care workforce locally.

To support them in fulfilling this role, in August 2021, NHSE published draft guidance for ICBs, including specific guidance on the ICS people function. ICBs will have specific responsibilities for delivering against the themes and actions set out in the NHS People Plan, as well as new people requirements outlined in guidance. These include a role for ICBs in growing the workforce for the future and enabling adequate workforce supply, through strategic planning and collaboration across the system to ensure that current and future population, service and workforce needs are met.

In addition, the draft ICS people function guidance sets out the expectation that ICBs will work with partners within the ICB area to develop system workforce plans for the entire health and care workforce. These should be based on population health needs and taking an integrated planning approach across workforce, finance and activity. The draft guidance also asks ICBs to work with regional and national workforce teams to support aggregated workforce planning and to inform prioritisation of workforce initiatives. In addition to this, the draft guidance also has a focus on the training and development of the current workforce. ICBs are expected to enable staff to learn and work together, as well as flexibly across different parts of the system, whilst developing a consistent system approach to managing talent, supporting social mobility and the potential for lifelong careers across health and care. ICBs will also have a responsibility in ensuring there is accountability for delivering the health and wellbeing agenda across the ICS, including strengthening staff engagement, experience and wellbeing to build workforce resilience across the system.

NHSE will, including through its regional teams, have a role in supporting ICBs to deliver these priorities and responsibilities. Integration requires a workforce equipped with the skills and opportunities to move across the health, public health and social care family, supported by holistic workforce planning to ensure there are the right people to deliver the best outcomes for service users and populations. The Integration White Paper sets out our intention to accelerate workforce integration by removing barriers to collaborative planning and working. Integration will happen at a local level – central government's role is in

facilitating and supporting that, ensuring the right structures, accountability and leadership are in place to enable workforce integration locally.

In 2021, the NHS invested in increasing training places across a number of key service areas – including critical care, learning disability and autism, and mental health. Upskilling staff to work in these settings will mean the NHS can increase capacity to treat patients and improve the quality of services. As these staff complete training, ICSs will need to ensure that their skills are used to best effect.

Additionally, ICSs will play a crucial role in ensuring the actions set out in the long-term workforce plan are delivered.

Education and training

DHSC, NHSE and HEE are united in the aim of expanding the health and care workforce, including through ensuring there are diverse routes into healthcare professions to attract a wide range of people and increase social participation.

Blended learning

HEE has introduced a truly innovative blended learning nursing programme to utilise a combination of innovative learning approaches supported by technology, coupled with more traditional learning approaches. Courses are designed to appeal to a wider range of potential students who, for example, have to balance commitments such as having a young family or a caring role, have challenges in relation to travel or the remoteness of where they live, as well as those who have an interest in technology and using digital skills to study.

HEE are working with 7 universities to deliver the blended learning nursing degree programme and 4 universities to deliver the blended learning midwifery degree programme. HEE will appoint a partner to complete an independent evaluation of the nursing and all other commissioned blended learning programmes to understand the quality, impact and social and financial return on investment.

Apprenticeships

We continue to grow apprenticeship opportunities from entry level to postgraduate advanced clinical practice. Apprenticeships provide NHS organisations with the opportunity to attract and recruit from a wider pool of people in the local community, including individuals who are not able to attend university full time, helping to create a workforce which better mirrors the population they serve, and fill posts in currently under-resourced areas as well as offering an ‘earn as you learn’ route into an NHS career.

As of the 2021 to 2022 academic year, the NHS was the largest public sector employer of apprentices across the country with 20,900 apprentices starting training, out of around 62,900 starts aross public sector bodies in England in 2021 to 2022. We have developed and driven the implementation of 97 apprentice standards across Health and Science and, across the 350 different careers in the NHS, there is currently an apprenticeship pathway for all of them. NHS apprenticeship numbers and levy spend continue to increase as employers work to embed apprenticeships within their future workforce planning.

Up to £172 million of additional funding has been made available to employers as part of the 50,000 Nurses manifesto commitment to support the specific growth of registered nurse degree apprentices (RNDAs) (equivalent to £8,300 per year, per apprentice). RNDA starts across NHS and non-NHS organisations have grown from around 1,000 in the 2018 to 2019 academic year, to over 3,400 starts in provisional 2021 to 2022 academic year data.

New roles

A key part of our apprenticeship strategy includes a focus on continuing to develop and expand new roles, particularly associate and assistant roles, to help ensure a strong talent pipeline into registered professions (a 'skills escalator'), enhance skills mix to support professionals to work at the top of their licence, and address key workforce shortages and clinical priorities. For example, there is now a complete apprenticeship pathway available into the nursing profession from healthcare assistant to nursing associate, to nurse degree apprentice and onto advanced clinical practitioner.

We have already developed a wide range of associate and assistant roles which align with clinical priorities and workforce shortages. Example apprenticeship routes include nursing associate, associate ambulance practitioner, podiatry assistant, healthcare assistant practitioner, healthcare support worker, healthcare science assistant and pharmacy services assistant.

The nursing associate apprenticeship was added onto the Nursing Midwifery Council register in 2019. HEE continues to lead the national nursing associate expansion programme in 2022 with an annual delivery target of 5,000 new nursing associates per year across NHS and non-NHS organisations. Nursing associate starts across NHS and non NHS organisations show there where more than 4,300 starts in the 2018 to 2019 and 2020 to 2021 academic year, with a drop in the 2019 to 2020 to around 3,600 starts. Provisional data for the 2021 to 2022 academic year shows that there were around 4,100 starts.

A further new role recently developed to enhance access to clinical services is the

Mammography Associate. The first cohort has now graduated and are supporting mammography screening services.

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.

Integrated system-level apprenticeship planning

There are many examples of how employers and systems have used apprenticeships (PDF, 238KB) in their planning and partnership approaches to grow their workforce, target particular areas of need, and develop and retain their staff. With access to a growing number of specialist healthcare standards, employers are keen to invest in apprenticeships as a way to obtain the right skills mix, and to think and act differently about opportunities to encourage staff development and progression through different routes.

The 'Joined up Derbyshire' (JUCD) programme (PDF, 2MB) provides a good example of innovation at system level, with system-wide planning to embed apprenticeships across health and social care and rotational apprenticeships across the system creating new opportunities and helping to target resource to where it is most needed. Other examples of emergent system-wide approaches to planning include the Hampshire Hospitals NHS Foundation Trust and the Health Education England Primary Care Training hubs (PDF, 416KB) which worked together to plan new apprenticeship roles, maximise their levy spend, and help manage vacancy rates. There is also the development of an integrated care system apprenticeship sub-group (PDF, 621KB) in the South West which plans and procures apprenticeships against their workforce plan priorities across their local system.

DHSC continues to work closely with key stakeholders; HEE, 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.

Accreditation of Prior Learning

We are also looking to improve the efficiency of how we train our professionals. Pathways into health and care professions can also be shortened depending on the level of someone's prior learning through a process called Accreditation of Prior Learning (APEL) which recognises previous learning and experience. HEE is leading a programme to work to standardise this approach across the country and maximise the opportunity from shortened programmes to deliver more professionals more quickly.

Leadership review

Strong leadership across health and social care is an important driver of performance. It is key to building a positive organisational culture and an engaged and motivated workforce which will help ensure high quality care and the efficient and innovative use of public resources.

Leadership for a collaborative and inclusive future review, published in June 2022, focusses on the best ways to strengthen leadership and management across health and with its key interfaces with adult social care in England. The report found that 'a well-led, motivated, valued, collaborative, inclusive, resilient workforce is the key to better patient and health and care outcomes.'

The review identified 7 recommendations to foster and replicate the best examples of leadership through improved training, career development and talent management, and through embedding inclusive cultures and behaviours within health and care:

1. targeted interventions on collaborative leadership and organisational values
2. positive equality, diversity and inclusion (EDI) action
3. consistent management standards delivered through accredited training
4. a simplified, standard appraisal system for the NHS
5. a new career and talent management function for managers
6. effective recruitment and development of non-executive directors (NEDs)
7. encouraging top talent into challenged parts of the system

Following a positive reception of the report by the health and care sector, a 'Review Implementation Office' (RIO) comprised of stakeholders across DHSC, NHS, social care and local government has been set up to drive forward implementation of recommendations 1 and 2, which are across health and social care. NHSE will lead on delivery of the NHS specific recommendations 3 to 7, working closely with the RIO and the broader health and social care sectors.

Hewitt Review

In the Autumn Budget, the Chancellor announced that there will be an Independent Review into ICSs (integrated care systems) accountability, targets and performance. The Secretary of State for Health and Social Care has appointed the Rt. Hon. Patricia Hewitt to

chair this independent review. Patricia Hewitt will bring an immense amount of expertise and knowledge when leading this review.

As defined in the terms of reference, this review will consider how the oversight and governance of integrated care systems (ICSs) can best enable them to succeed, balancing greater autonomy with robust accountability with a particular focus on real time data shared digitally with DHSC, and on the availability and use of data across the health and care system for transparency and improvement. It will cover ICSs in England and the NHS targets and priorities for which ICBs are accountable, including those set out in the government's mandate to NHS England.

In particular, it will consider and make recommendations on:

- how to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending

- the scope and options for a significantly smaller number of national targets for which NHS integrated care boards (ICBs) should both be held accountable and supported to improve by NHS England and other national bodies, alongside local priorities reflecting the particular needs of communities

- how the role of CQC can be enhanced in system oversight

The review will provide recommendations on how we can further empower and enable local leadership to deliver improved outcomes for the populations they serve. The review is currently on-going and recommendations will be delivered in early 2023.

International workforce

Internationally trained staff have been part of the NHS since its inception in 1948 and continue to form a key part of our workforce planning. This government is proud that international health and care workers choose to further their careers and provide world-class care in the NHS.

International recruitment must be done ethically, acknowledging that health and care professionals are globally mobile and that migration provides opportunities and challenges for the individual, home country and receiving country. DHSC updated its code of practice for International Recruitment of Health and Social Care Personnel in August 2022, providing clearer guidance on the scope and application of the code and some ethical issues, for example repayment clauses. As well as according to the requirements of the Code, all recruitment must align with domestic employment legislation.

Throughout this Parliament, we have worked to make sure that health and care staff coming to the UK can do so quickly and easily. The implementation of the Health and Care Visa, which was introduced in August 2020, is open to certain UK health and care roles. Applicants are guaranteed a decision within 3 weeks and the visa fee is substantially reduced compared to standard skilled worker visa costs (from £247 compared to £625). Also, from August 2020 health and social care staff were exempt from paying the immigration health surcharge.

Since 2016, we have seen increases in joiners from the EU and EEA, and from rest of world nationalities. By proportion, 14.4% (4.9% EU/EEA, 9.5% rest of world) of non-medical hospital and community health staff have a non-UK nationality (June 2022). While some of these professionals will stay in the UK to further their career, some return to their home countries, taking with them enhanced experience in new clinical settings and new skills. Particularly notable is the increase in international nurses and health visitors between 2018 and 2022 (15.2% of nurses had a non-UK nationality in 2018 compared to 23.3% in 2022). This increase correlates with the programme to deliver the 50,000 manifesto commitment, of which an increase in international recruitment is part.

4. Data on recruitment, retention and motivation

This chapter describes and discusses the existing size of the workforce and how it has changed with regards to patterns of recruitment, retention and motivation. We have highlighted and discussed where there might be COVID-19 impacts as part of sections if apparent.

The size of the non-medical workforce is at record levels with notable increases in the nursing workforce which aligns with the government's commitment to increase nurse numbers by 50,000. The workforce also continues to become an ever more diverse workforce in terms of nationality, ethnicity, and gender.

However, trends in vacancies, temporary staffing, retention rates and the numbers of staff joining and leaving the non-medical workforce continue to be impacted by COVID-19. Leaver rates fell significantly during the first year of COVID-19, though more recent data shows a return to pre-COVID-19 levels for joiner and leaver rates with rates at record levels for some professions such as nurses and health visitors as well as midwives.

Numbers in work

The non-medical workforce continues to grow. The overall non-medical NHS workforce as at June 2022 is 1,096,931 full time equivalents (FTEs). This has increased by 144,127 FTEs (15.1%) since June 2018 and by 25,433 (2.4%) over the past year. Further detail is shown in Table 4.1. From June 2021, the number of FTEs in all staff group classifications, other than midwives, has increased.

Table 4.1: HCHS Non-medical staff FTE, June 2018 to June 2022. The table shows the number of full-time equivalents for each year between June 2018 to June 2022 by staff group

Staff group	June 2018	June 2019	June 2020	June 2021	June 2022	Change since June 2018
All non-medical staff groups	952,804	983,329	1,044,821	1,071,498	1,096,931	144,127 (15.1%)

Nurses and health visitors	283,327	288,646	301,612	310,251	319,481	36,154 (12.8%)
Midwives	21,517	21,632	22,010	22,090	21,541	24 (0.1%)
Ambulance staff*	20,664	15,763	16,961	17,684	17,847	-2,817 (-13.6%)
Scientific, therapeutic and technical staff	136,066	140,975	147,051	152,722	156,367	20,301 (14.9%)
Support to doctors, nurses and midwives	245,362	254,598	282,916	279,321	280,655	35,293 (14.4%)
Support to ambulance staff	15,227	22,262	23,911	24,713	24,979	9,753 (64.1%)
Support to ST&T staff	57,619	59,644	64,562	70,460	74,247	16,628 (28.9%)
Central functions	83,060	87,246	93,587	99,581	104,823	21,763 (26.2%)
Hotel, property and estates	52,709	54,908	57,280	59,913	60,556	7,847 (14.9%)
Senior managers	10,195	10,825	11,140	11,882	12,485	2,290 (22.5%)
Managers	22,606	23,732	21,760	22,025	23,469	863 (3.8%)
Other staff or unknown classification	4,453	3,098	2,030	857	481	-3,972 (-89.2%)

Source: NHS Digital HCHS monthly workforce statistics

*In April 2019, around 6,000 ambulance staff were reclassified as support to ambulance staff, which has resulted in the drop in ambulance staff and increase support to ambulance staff between September 2018 and September 2019

Joiners

The overall non-medical joiner rate for the year to June 2022 for all regions and staff is 14.4% with over 176,000 headcount joining the workforce. Joiner rates vary between 7.2% for senior managers and 19.8% for support to ST&T staff. Annual joiner rates have increased in the year to June 2022 compared to the previous year for a range of reasons including the delayed effect of staff joining post lockdown and also international recruitment decisions.

Table 4.2: Annual non-medical joiners to active service by staff group, years to June 2017 to June 2022, headcount

Staff group	June 2017	June 2018	June 2019	June 2020	June 2021	June 2022
All non-medical staff	12.9%	12.5%	13.4%	15.4%	12.4%	14.4%
Nurses and health visitors	10.2%	10.5%	11.4%	12.6%	9.0%	12.7%
Midwives	11.0%	11.3%	11.5%	12.3%	6.9%	12.6%
Ambulance staff	7.8%	7.6%	7.8%	9.7%	7.2%	9.2%
Scientific, therapeutic and technical staff	12.3%	12.0%	12.4%	12.6%	11.3%	12.1%
Support to doctors, nurses and midwives	14.7%	13.7%	15.2%	21.0%	15.6%	16.9%
Support to ambulance staff	23.4%	19.8%	20.9%	20.0%	14.4%	16.5%
Support to ST&T staff	15.9%	15.9%	16.9%	18.9%	18.8%	19.8%
Central functions	14.3%	13.3%	14.6%	13.7%	13.9%	15.1%
Hotel, property and estates	13.1%	12.5%	13.7%	12.4%	11.6%	13.4%
Senior managers	9.4%	7.4%	8.2%	7.7%	7.5%	7.2%
Managers	9.3%	8.8%	8.8%	7.5%	8.2%	8.2%
Other staff or those with unknown classification	56.7%	58.7%	35.4%	24.4%	36.5%	44.2%

Source: NHS Digital HCHS workforce statistics

Note: the joiner rate is calculated by dividing the number of joiners to active service over the year by the average headcount in that category at the beginning and end of the period, expressed as a percentage.

Joiner rates for the year to June 2022 for non-medical staff groups are shown in Table 4.3. We see the highest joiner rates in support staff, and the lowest joiner rates in senior managers. This is consistent across all regions, with the highest joiner rates for all staff in the south and east, and the lowest joiner rates in the north and Midlands.

Table 4.3: Annual non-medical staff joiner rates to active service, by region and staff group, June 2021 to June 2022

Staff group	All NHSE Regions	East of England	London	Midlands	North East and Yorkshire	North West	South East	South West
All non-medical staff groups	14.4%	15.1%	15.2%	13.7%	13.0%	13.5%	15.8%	15.4%
Nurses and health visitors	12.7%	12.3%	13.0%	12.0%	11.7%	12.8%	14.1%	13.3%
Midwives	12.6%	15.1%	12.4%	11.9%	10.7%	11.1%	15.6%	11.7%
Ambulance staff	9.2%	8.0%	12.6%	6.9%	9.6%	7.9%	9.8%	10.5%
Scientific, therapeutic and technical staff	12.1%	13.4%	13.9%	11.6%	10.5%	10.9%	13.1%	12.1%
Support to doctors, nurses and midwives	16.9%	19.3%	17.4%	16.0%	15.0%	15.7%	18.8%	18.4%
Support to ambulance staff	16.5%	11.5%	18.3%	18.6%	15.9%	12.8%	17.5%	20.1%
Support to ST&T staff	19.8%	20.0%	24.4%	18.4%	16.9%	17.9%	22.4%	19.5%
Central functions	15.1%	15.4%	15.9%	15.1%	13.6%	13.8%	16.4%	16.3%
Hotel, property and estates	13.4%	12.6%	15.2%	11.6%	13.9%	12.9%	11.9%	17.1%
Senior managers	7.2%	7.0%	9.5%	5.9%	6.7%	5.2%	8.7%	8.0%
Managers	8.2%	9.1%	9.7%	7.5%	6.4%	6.4%	9.5%	7.6%
Other staff or those with unknown classification	44.2%	57.4%	51.5%	32.1%	27.2%	4.5%	25.0%	37.5%

Source: NHS Digital HCHS monthly workforce statistics

Leaver rates and trends

Leaver rates had been falling prior to COVID-19 but have increased since last year for all staff groups in England. The leaver rate is the share of the workforce leaving active service in their staff group in the NHS trusts and ICBs in a year. This includes people moving to

different parts of the health and social care sector (for example to general practice), as well as people going on parental leave but would not count those moving between NHS hospital trusts. Leaver rates have increased since the peak of the COVID-19 pandemic and for all non-medical staff are now at the highest level on record.

Table 4.4: Annual non-medical rates of staff leaving active service, year to June 2016 to June 2022, Headcount

Staff Group	2016 to 2017	2017 to 2018	2018 to 2019	2019 to 2020	2020 to 2021	2021 to 2022
All non-medical staff	11.2%	11.1%	10.3%	9.6%	10.2%	12.3%
Nurses and health visitors	10.9%	10.6%	10.2%	9.4%	9.5%	11.5%
Midwives	10.6%	10.7%	10.6%	10.2%	10.8%	13.2%
Ambulance staff	7.3%	7.9%	8.8%	6.8%	6.7%	10.3%
Scientific, therapeutic and technical staff	10.8%	10.8%	10.3%	10.1%	9.8%	11.6%
Support to doctors, nurses and midwives	11.8%	11.5%	10.4%	9.8%	12.3%	13.3%
Support to ambulance staff	11.9%	11.8%	8.0%	8.0%	8.5%	12.9%
Support to ST&T staff	12.1%	12.2%	11.5%	10.5%	10.9%	14.1%
Central functions	11.6%	11.7%	10.7%	9.8%	8.6%	12.3%
Hotel, property and estates	11.2%	11.2%	8.6%	8.5%	8.2%	11.2%
Senior managers	10.9%	12.0%	10.4%	9.7%	8.4%	10.9%
Managers	10.4%	10.4%	9.4%	9.0%	7.7%	9.9%
Other staff or those with unknown classification	26.4%	22.7%	24.6%	19.1%	21.3%	13.1%

Source: NHS Digital HCHS monthly workforce statistics

Figure 4.1: Annual all non-medical staff joiner and leaver rates from active service, years to June 2012 to June 2022, headcount

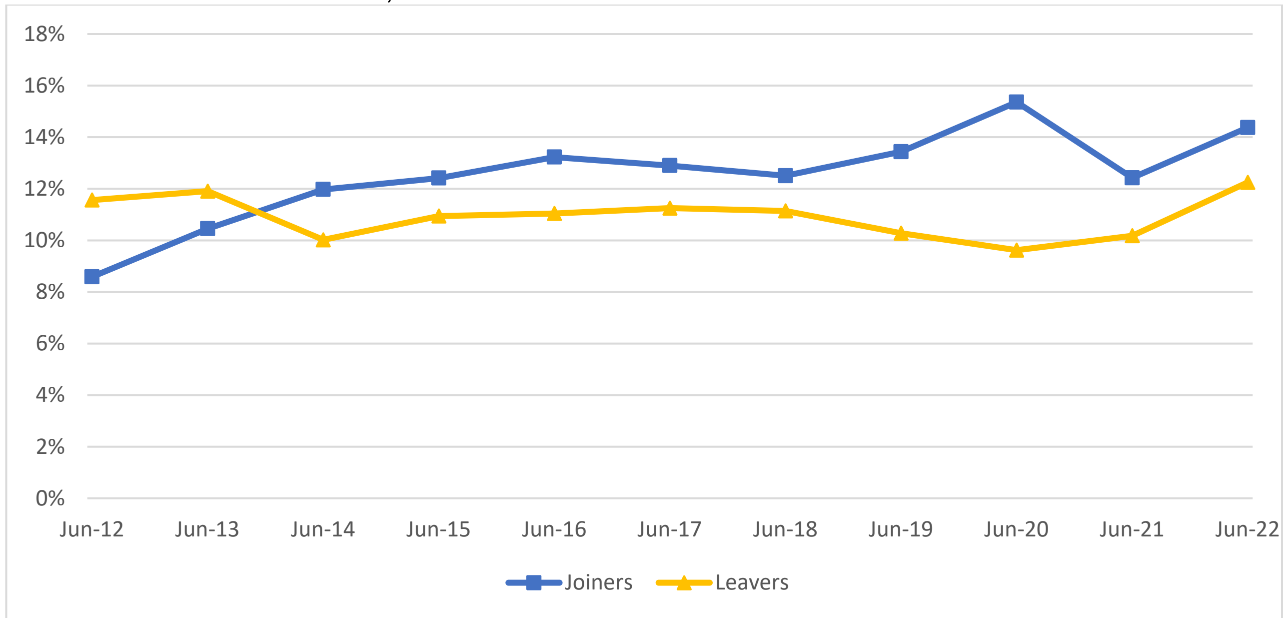
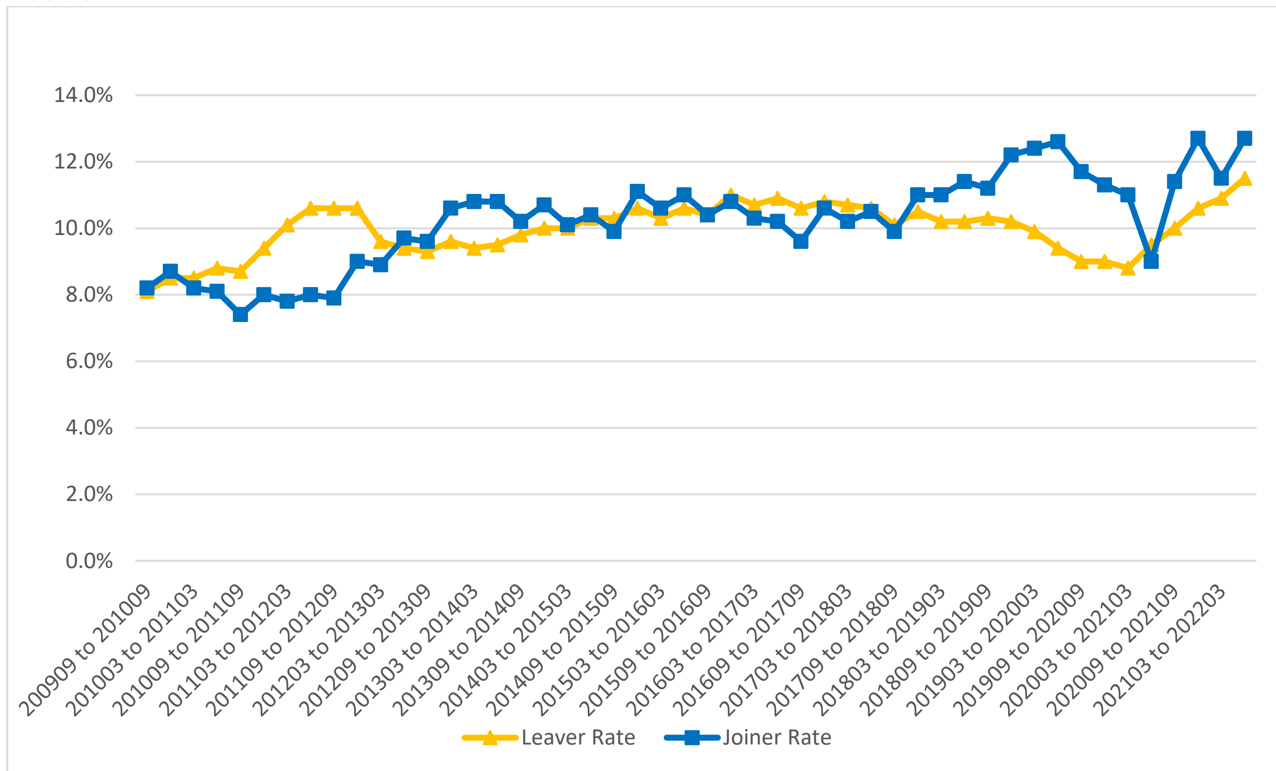


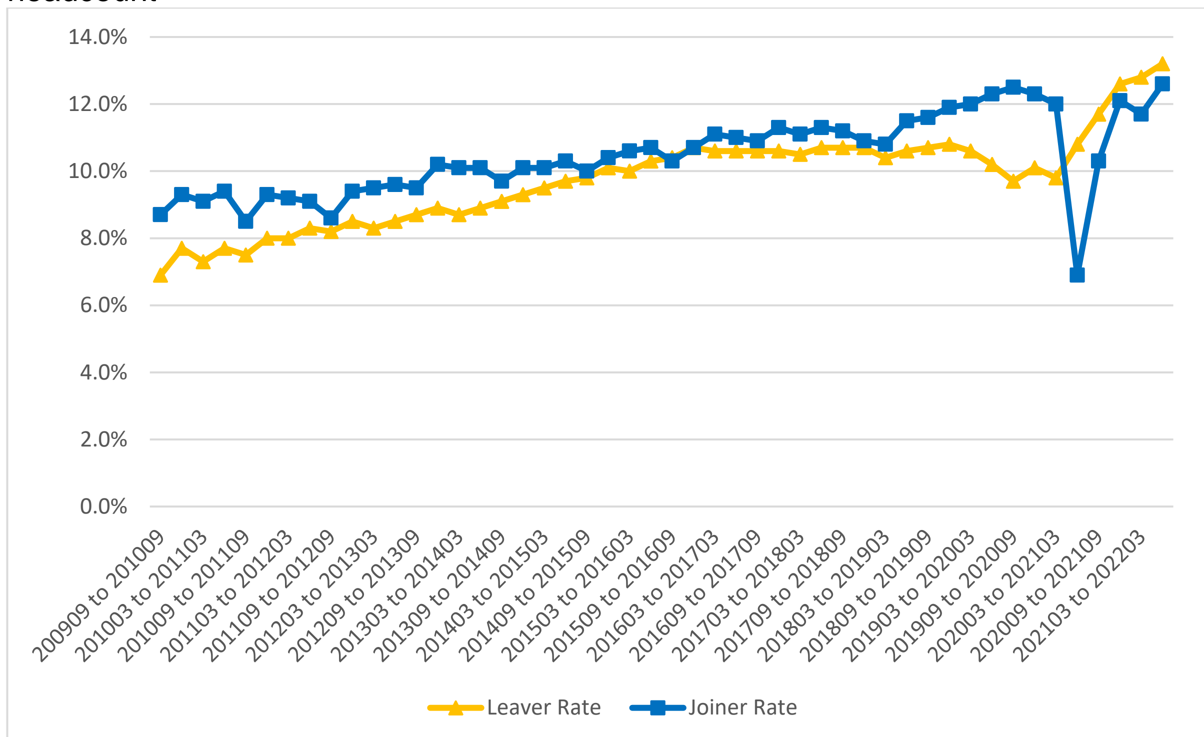
Figure 4.1 shows a decline in the joiner rates for non-medical staff during the COVID-19 pandemic 2020. However, joiner rates for non-medical staff have since recovered. Figure 4.1 also shows following a decline, an increase in the leaver rates for non-medical staff since June 2020 to 2021.

Figure 4.2: Annual joiner and leaver rates for nurses and health visitors, 2009 to 2022, headcount



Source: NHS Digital HCHS monthly workforce statistics

Figure 4.3: Annual joiner and leaver rates from active service for midwives, 2009 to 2022, headcount



Source: NHS Digital HCHS monthly workforce statistics

Figure 4.2 highlights a sharp decline in the joiner rates for nurses and health visitors during the COVID-19 pandemic 2020. However, joiner rates for nurses and health visitors have since recovered. Figure 4.2 also shows an increase in the leaver rates for nurses and health visitors since June 2020 to 2021. Figure 4.3 shows there has also been a sharp rise in the leaver rates for midwives since the peak of the COVID-19 pandemic.

The international workforce

Internationally trained non-medical staff numbers continue to grow and make up just less than a fifth of the workforce.

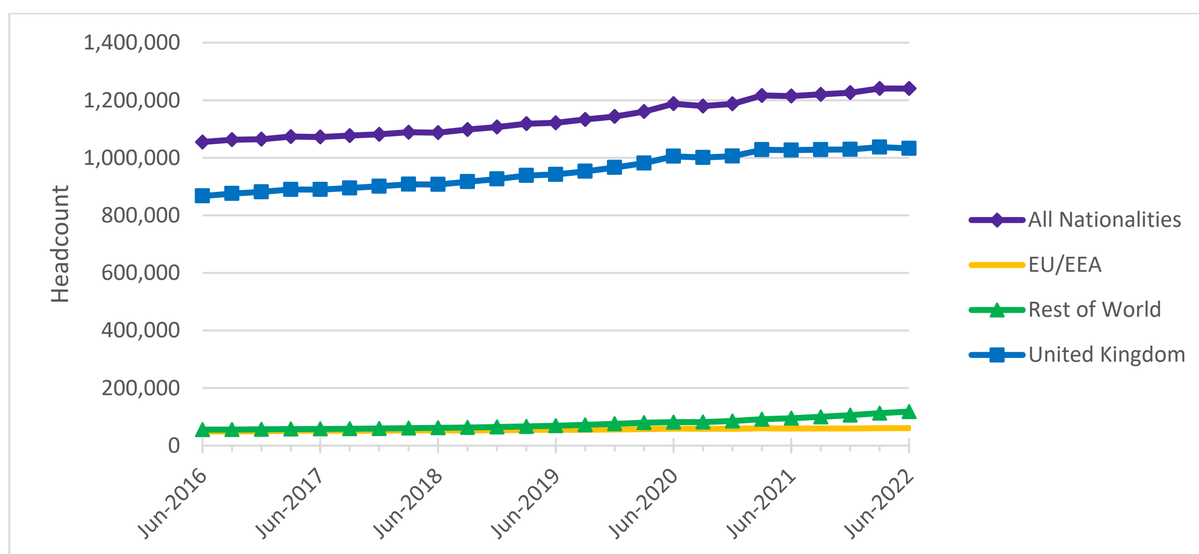
Table 4.5: HCHS non-medical staff by nationality, headcount, June 2016 to June 2022

Date	All nationalities	EU or EEA	Rest of world	United Kingdom	Unknown
30 June 2016	1,054,912	48,864	55,437	867,203	83,734
30 June 2017	1,072,407	51,613	57,985	889,556	73,555
30 June 2018	1,087,419	52,701	61,679	907,372	65,940
30 June 2019	1,121,430	54,854	69,080	941,905	55,839
30 June 2020	1,187,739	58,700	81,485	1,005,009	42,816
30 June 2021	1,214,560	59,580	95,190	1,026,447	33,550
30 June 2022	1,240,592	60,303	118,091	1,032,556	29,851

Source: NHS Digital - NHS Hospital and Community Health Service (HCHS) workforce statistics

In 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. Set against an overall increase in headcount since 2016, we have seen a slight increase in EU or EEA non-medical staff but a significant proportional increase in rest of the world non-medical staff, with headcount doubling since June 2016.

Figure 4.4: HCHS non-medical staff by nationality, headcount, June 2016 to June 2022



Source: NHS Digital - NHS Hospital and Community Health Service (HCHS) Workforce Statistics

Since 2016 there has been an increase of HCHS non-medical staff (headcount) in all nationality groups (Figure 4.4). The ethical recruitment of health and care staff from overseas is vital. We updated our code of practice for international recruitment on 2 August 2022 in line with latest advice from the World Health Organisation (WHO). This guarantees the most stringent ethical standards when recruiting health and social care staff from overseas and prohibits active recruitment from those countries that the WHO identifies as having the most vulnerable health systems (also known as ‘red list’ countries). Red list countries where we have a bilateral agreement are categorised as ‘amber list’ – and all recruitment must be undertaken in line with the agreement.

While we are concerned about the increase in migration from countries on the red list, this must be balanced against an individual’s right to migrate, which is also supported by WHO guidance, domestic employment and equalities law.

Table 4.6: Non-medical joiners to NHS trusts and other core organisations in England by top 10 nationalities, headcount, year to June 2022

Nationality group	Listing	Headcount	Proportion of all staff
British	N/a	126,743	63.2%
Indian	Green	12,726	6.3%
Filipino	Green	6,257	3.1%
Nigerian	Red	5,283	2.6%
Unknown	N/a	4,450	2.2%
Irish	Green	1,605	0.8%
Polish	Green	1,589	0.8%
Ghanaian	Red	1,442	0.7%
Zimbabwean	Green	1,355	0.7%
Portuguese	Green	1,221	0.6%

Source: NHS Digital - NHS Hospital and Community Health Service (HCHS) Workforce Statistics

Retention

Reasons for leaving

Reasons for leaving data is published by NHS Digital and is based on set pre-defined categories within the ESR system, without organisations explaining further detail such as the cause of an employee voluntarily resigning. In 2021 and 2022, voluntary resignation accounted for almost 46% of all reasons for leaving. Of all recorded reasons, retirement was the next biggest reason for leaving at 14% of the leaver workforce.

We have noted the requests for the past few years for more information in this area, but we are limited to the data captured within the ESR system. Consideration of the burden on the health system of any changes to current data collection are key in this area and the department has no current plans to seek an expansion of data collected in this area.

Table 4.7: Electronic staff record reasons for leaving data, 2016 to 2017, to 2021 to 2022

Reason for leaving	2016 to 2017	2017 to 2018	2018 to 2019	2019 to 2020	2020 to 2021	2021 to 2022
Dismissal	4,281 (3.6%)	4,105 (3.4%)	3,813 (3.3%)	3,544 (3.1%)	2,736 (2.6%)	2,925 (2.0%)
Employee transfer	6,472 (5.4%)	6,159 (5.1%)	3,103 (2.7%)	3,070 (2.7%)	1,544 (1.5%)	2,693 (1.9%)
End of fixed term contract	2,221 (1.9%)	2,237 (1.9%)	2,059 (1.8%)	2,068 (1.8%)	2,220 (2.1%)	2,969 (2.1%)
End of fixed term contract - completion of training scheme	528 (0.4%)	471 (0.4%)	495 (0.4%)	440 (0.4%)	409 (0.4%)	437 (0.3%)
End of fixed term contract - end of work requirement	322 (0.3%)	300 (0.2%)	269 (0.2%)	352 (0.3%)	328 (0.3%)	429 (0.3%)
End of fixed term contract - external rotation	6 (0.0%)	8 (0.0%)	6 (0.0%)	3 (0.0%)	8 (0.0%)	6 (0.0%)
End of fixed term contract - other	390 (0.3%)	449 (0.4%)	374 (0.3%)	361 (0.3%)	365 (0.4%)	555 (0.4%)
Mutually agreed resignation	789 (0.7%)	510 (0.4%)	341 (0.3%)	250 (0.2%)	160 (0.2%)	132 (0.1%)
Others	815 (0.7%)	879 (0.7%)	841 (0.7%)	933 (0.8%)	1,286 (1.2%)	1,172 (0.8%)
Redundancy	1,323 (1.1%)	1,262 (1.0%)	918 (0.8%)	752 (0.7%)	492 (0.5%)	403 (0.3%)
Retirement	17,688 (14.8%)	17,102 (14.2%)	16,044 (14.0%)	16,635 (14.5%)	17,703 (17.0%)	20,538 (14.3%)
Voluntary resignation	51,309 (43.0%)	53,487 (44.3%)	52,298 (45.5%)	50,549 (44.1%)	41,602 (39.9%)	65,906 (45.9%)
Unknown	33,209 (27.8%)	33,754 (28.0%)	34,281 (29.9%)	35,757 (31.2%)	35,403 (34.0%)	45,410 (31.6%)
All reasons for leaving	119,353 (100.0%)	120,725 (100.0%)	114,843 (100.0%)	114,715 (100.0%)	104,256 (100.0%)	143,577 (100.0%)

Source: NHS Digital HCHS monthly workforce statistics. Note: Totals may not equal the sum of the total

Vacancies

There are multiple measures for vacancies which NHS Digital collates as an experimental statistics release. As part of that series NHSE undertakes a monthly workforce data collection from NHS trusts, which includes data on staff in post and vacancies (defined as the difference between the reported whole-time equivalent substantive staff in post and planned workforce levels). This is considered the best available measure presently and represents the variance between the reported whole-time equivalent (WTE) substantive staff in post and planned workforce levels. Data is collected for i) all staff, ii) registered nurses (nurses, midwives and health visitors) and iii) medical staff. This data is published quarterly by NHS Digital.

NHS England defines a vacancy as the gap between staff in post and funded establishment at a trust. Though we do not have good information on this, many of the vacancies will be covered by bank and agency staff, and the figures may not represent 'gaps' in the workforce, or that work is not being carried out. This means that although the vacancy figures are a measure of shortfall, they are not measure shifts which are unfilled.

Vacancies typically show seasonal variation with peaks occurring at the start of the financial year as workforce plans are set, and troughs occurring at the end. The number of registered nursing vacancies is currently at a record level (although not the rate as staffing levels have increased) and the rate of other non-medical vacancies is also at a record level (Table 4.8).

NHS Digital reports that the drop in vacancy rates over 2020 and 2021 is in part due to the impact of COVID-19 on the ability of trusts to complete comprehensive workforce planning during the COVID-19 pandemic. The increase in vacancy rates in 2022 is likely to be in part this effect unwinding.

Table 4.8: Nursing and other non-medical staff vacancies and vacancy rates, June 2019 to June 2022

Year	Nursing staff: vacancy rate	Nursing staff: WTE vacancies	Other non-medical staff: vacancy rate	Other non-medical staff: WTE vacancies
2019 to 2020 Q1 (June 2019)	12.3%	44,195	7.7%	56,039
2019 to 2020 Q2 (September 2019)	12.1%	43,452	7.3%	53,067
2019 to 2020 Q3 (December 2019)	10.7%	38,736	7.1%	52,312
2019 to 2020 Q4 (March 2020)	9.9%	36,083	6.0%	43,926
2020 to 2021 Q1 (June 2020)	10.3%	37,760	4.9%	37,368
2020 to 2021 Q2 (September 2020)	10.1%	37,144	5.6%	42,835
2020 to 2021 Q3 (December 2020)	9.7%	36,277	6.0%	45,913
2020 to 2021 Q4 (March 2021)	9.2%	34,678	4.5%	34,770
2021 to 2022 Q1 (June 2021)	10.3%	38,814	6.4%	50,354
2021 to 2022 Q2 (September 2021)	10.5%	39,931	7.1%	56,023
2021 to 2022 Q3 (December 2021)	10.2%	39,721	7.8%	62,249
2021 to 2022 Q4 (March 2022)	10.0%	38,972	7.3%	58,867
2022 to 2023 Q1 (June 2022)	11.8%	46,828	9.1%	74,729

Source: NHS Digital HCHS monthly workforce statistics

Diversity analysis

The NHS workforce remains more ethnically diverse than the workforce in the wider economy. Across the non-medical workforce, nearly 74% of the workforce is white with a further 7% black or black British and 10% Asian or Asian British. There are currently just under 4% of the workforce with unknown or not stated ethnicity.

Table 4.9: Ethnicity makeup of non-medical NHS roles

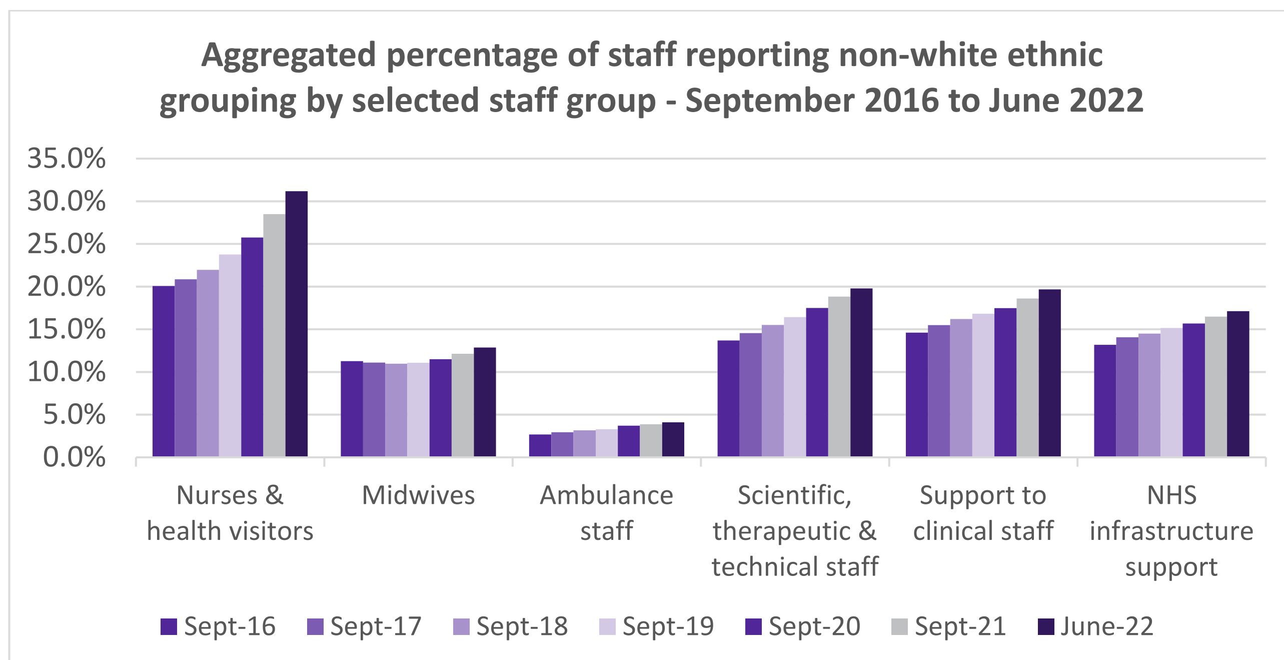
June 2022 (% of Headcount)	Asian or Asian British	Black or black British	Chinese	Mixed	White	Any other ethnic group	Not stated	Unknown and discont. codes
All non-medical staff	10.0%	7.2%	0.4%	1.8%	73.8%	2.7%	3.1%	1.0%
Nurses and health visitors	13.8%	10.2%	0.3%	1.6%	64.4%	5.3%	3.4%	1.0%
Midwives	2.4%	7.6%	0.2%	2.0%	83.9%	0.6%	2.5%	0.7%
Ambulance staff	1.4%	0.7%	0.2%	1.5%	93.4%	0.4%	2.2%	0.3%
Scientific, therapeutic and technical staff	10.2%	5.0%	0.9%	2.1%	76.8%	1.6%	2.6%	0.8%
Support to doctors, nurses and midwives	9.0%	7.7%	0.2%	2.0%	75.2%	2.2%	2.8%	1.0%
Support to ambulance staff	3.9%	2.4%	0.1%	1.7%	87.8%	0.2%	3.3%	0.6%
Support to ST&T staff	8.8%	5.0%	0.4%	2.3%	77.9%	1.7%	2.8%	1.1%
Central functions	9.0%	5.3%	0.5%	2.0%	78.7%	0.9%	2.9%	0.8%
Hotel, property and estates	8.1%	6.4%	0.2%	1.6%	74.9%	2.0%	5.3%	1.5%
Senior managers	5.4%	3.2%	0.2%	1.4%	84.9%	0.6%	3.3%	1.0%
Managers	7.0%	4.5%	0.4%	1.8%	81.7%	0.7%	2.9%	1.0%
Other staff or those with unknown classification	26.4%	12.2%	0.4%	2.4%	33.5%	15.2%	4.9%	5.1%

Source: NHS Digital HCHS monthly workforce publication – June 2022

Figure 4.5 shows for selected staffing groups the aggregated proportion of staff who reported a non-white ethnic grouping since 2016. This shows both the disparity in the proportion of staff from non-white ethnic groups between some staffing groups but also the

general trend of increased non-white ethnicities being reported in recent years in all staff groups.

Figure 4.5: Aggregated percentage of staff reporting non-white ethnic grouping by selected staff groups: September 2016 to June 2022



Source: NHS Digital workforce statistics

Gender balance in the non-medical workforce

Data from June 2022 shows that just under 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 (88.3%), midwifery (99.7%) and support to doctors and nurses (84.7%). Compared to the rest of the NHS workforce, males have higher representation in staff groups including ambulance staff (55.1%), Support to ambulance staff (46.0%) and senior managers (42.1%). The proportion of female staff is broadly unchanged over time.

Table 4.10: Workforce gender representation by staff group (June 2022)

Staff group	Female	Male
All non-medical staff	79.7%	20.3%
Nurses and health visitors	88.3%	11.7%
Midwives	99.7%	0.3%
Ambulance staff	44.9%	55.1%
Scientific, therapeutic and technical staff	77.3%	22.7%
Support to doctors, nurses and midwives	84.7%	15.3%
Support to ambulance staff	54.0%	46.0%
Support to ST&T staff	78.6%	21.4%
Central functions	71.2%	28.8%
Hotel, property and estates	57.5%	42.5%
Senior managers	57.9%	42.1%
Managers	62.2%	37.8%
Other staff or those with unknown classification	77.4%	22.6%

Source: NHS Digital workforce statistics.-16-17-18-19-20-21-22

Gender balance in healthcare education

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.

Table 4.11: Percentage of female applicants to courses in nursing, midwifery and allied health professions in England

Profession	2015 to 2016	2016 to 2017	2017 to 2018	2018 to 2019	2019 to 2020	2020 to 2021	2021 to 2022
Nursing	89%	89%	90%	90%	90%	89%	90%
Midwifery	99.8%	99.8%	99.8%	99.6%	99.7%	99.9%	99.6%
Allied health professions	72%	73%	73%	75%	75%	75%	76%
Combined	86%	86%	86%	86%	86%	86%	87%

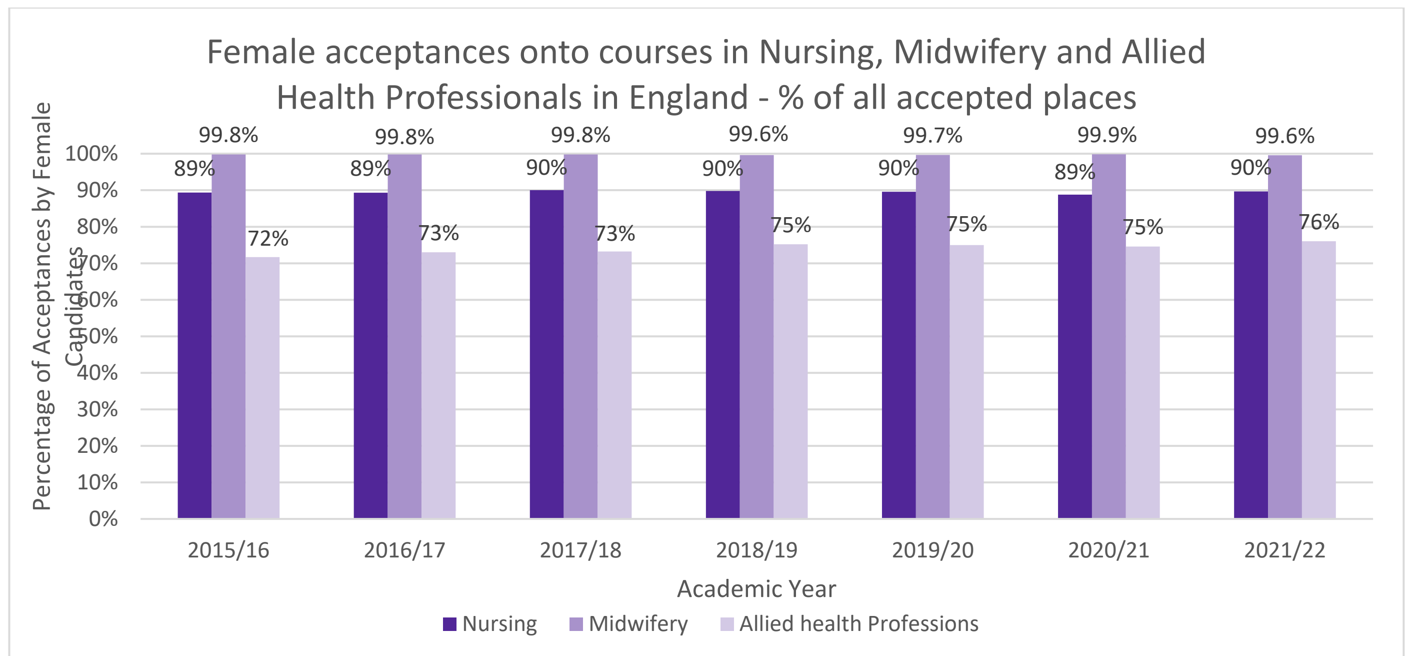
Source: Universities and Colleges Admissions Service (UCAS) end of cycle 2021

UCAS data in the above table shows female applicants as a percentage of all applicants to courses in nursing, midwifery and allied health professions, every year since 2015 to 2016.

The overall gender split for places accepted to study nursing, midwifery and allied health professions has remained broadly the same since 2016 to 2017, with a 1% increase in female acceptances in 2021 to 2022.

Places on midwifery courses are accepted almost entirely by female candidates. In 2021 to 2022 0.4% of midwifery acceptances were by men. In 2021 to 2022, 10% of places accepted onto nursing courses were from male candidates, as shown in Figure 4.6.

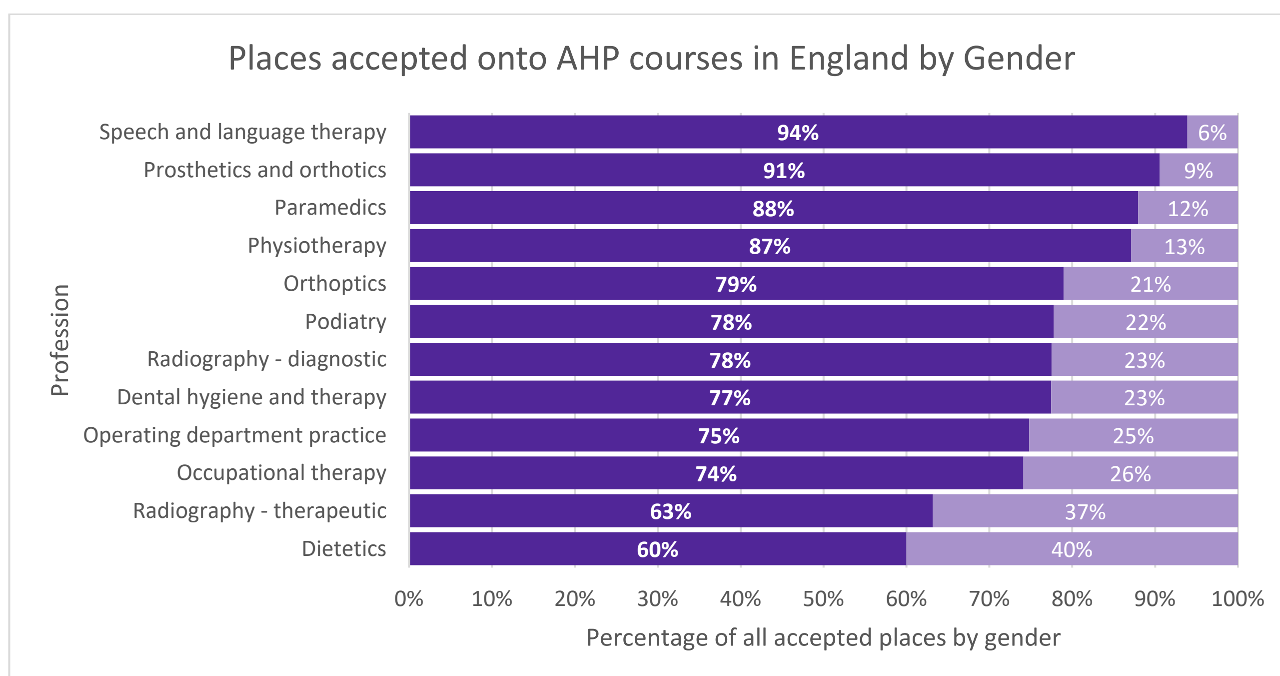
Figure 4.6: Overall proportion of female acceptances onto courses in nursing, midwifery and allied health professions in England.



Source: UCAS data - end of cycle 2021

Acceptances to Allied Health Profession courses are more balanced in terms of gender, however this varies by profession, as shown in Figure 4.7.

Figure 4.7: Acceptances onto courses in allied health professions in England by gender - % of all acceptances



Source: UCAS data - end of cycle 2021

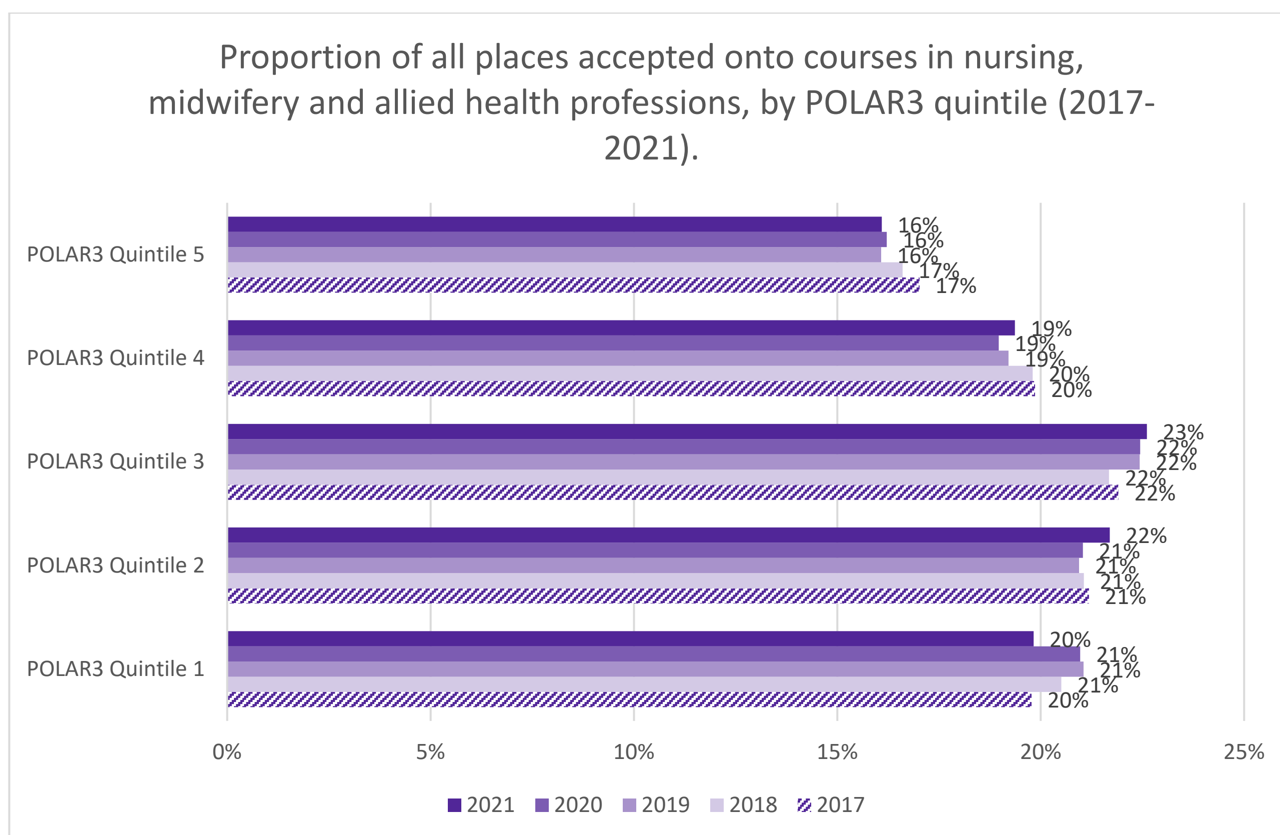
Entrants to nursing, midwifery and allied health professionals by POLAR3 - a participation measure

The Participation of Local Areas (POLAR) is a participation measure which classifies local areas into 5 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.

Data, in Figure 4.8 shows that 20% of students entering courses in nursing, midwifery and allied health professions in 2021 were from POLAR3 quintile 1, the most disadvantaged fifth of backgrounds.

The proportion of entrants to nursing from the least disadvantaged fifth of backgrounds was 16% in 2021.

Figure 4.8: Proportion of all places accepted onto nursing courses by POLAR3 quintiles between 2017 and 2021



Source: UCAS data - end of cycle 2021

Table 4.12 shows the proportion of all places accepted by students in POLAR3 quintile 1, the most disadvantaged fifth of backgrounds, split by profession.

Table 4.12: The proportion of places accepted onto healthcare related degrees by the most disadvantaged students (2017 to 2021).

Profession	2017 to 2018	2018 to 2019	2019 to 2020	2020 to 2021	2021 to 2022
Nursing	22%	23%	24%	24%	22%
Midwifery	16%	17%	17%	16%	17%
Allied health professions	16%	16%	17%	15%	15%
All professions	20%	21%	21%	21%	20%

Attrition from healthcare related degrees

Data provided below remains the same as shared last year from the Office for Students, this is the latest available that the department has access to. Table 4.13 shows continuation rates of full-time entrants to first degree level study at English universities. 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.

Table 4.13: 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

Table 4.14: Continuation rates for other subject areas (excluding transfers)

Subject area	2010 to 2011	2011 to 2012	2012 to 2013	2013 to 2014	2014 to 2015	2015 to 2016	2016 to 2017
Creative arts and design	88%	88%	87%	88%	87%	87%	86%
Humanities	91%	92%	91%	91%	91%	90%	90%
Natural sciences	89%	91%	90%	90%	89%	90%	90%

Source: OfS Continuation, non-continuation and transfer rates

Temporary staffing

The deployment of a flexible workforce is an important element of efficiently running the NHS, allowing the NHS to meet demand fluctuations without the need to increase capacity above that which would be required on a sustained basis. Trusts use their own banks (managed in-house or via management companies) and external agencies to resource extra temporary staff.

The NHS is experiencing a period of unprecedented demand so providers may need to use temporary staff.

Measures were introduced in 2015 to curb NHS agency spending including price caps, the mandatory use of approved frameworks for procurement, and the requirement for all trusts to stay within the specified annual expenditure ceilings for agency staff.

The measures are regularly monitored for compliance and effectiveness and aim to reduce cost and give greater assurance of quality.

The department and NHSE's flexible staffing strategy aims to support NHS providers to reduce their agency staff bills and encourage workers back into substantive and bank roles. Trusts are encouraged to develop and improve their strategy, procurement, and commercial negotiation in their approach to temporary staffing. There are 3 workstreams:

- off-framework: work in partnership with trusts, systems, and our approved framework operators to reduce or eliminate off-framework supply into the NHS to give assurance on quality and value for money standards of the staff working via agencies

- price cap compliance: continue to implement and monitor the agency rules with ongoing collection and analysis of data and working with ICSs and trusts to support intervention where necessary

- the bank development programme: develop and deliver the bank programme and measure and report key programme outcomes. Increase transparency and collaborative working within the NHS to reduce competitive behaviours. Increase the number of collaborative banks in England to reduce the reliance on agency by offering increased flexibility to bank staff.

NHSE has re-established measures in September 2022 to control agency expenditure, including a system agency expenditure limit. Metrics used to monitor performance on agency usage are included in the NHS Oversight Framework, which reinforce the rules that NHS trusts and FTs should comply with.

Price cap compliance

Trusts are required to procure agency staff via approved frameworks and within price caps unless there are exceptional circumstances (known as 'break glass'). The national average price cap compliance has remained consistent at 60% since April 2018. There is however wide variation across regions and staff groups. Generally speaking, challenges with price cap adherence fall into 4 main categories: staff shortages; preferences with geographical location; use of workforce planning tools (such as e-rostering) and sourcing delays; elective recovery.

Trends in agency use

The 'Agency Rules' have contributed to a reduction in spending on agency workers to £2.4 billion in 2020 to 2021 compared to £3.6 billion in 2015 to 2016. Agency spend in 2020 to 2021 accounted for less than 4.0% of the overall NHS pay bill, down from 7.8% at its peak in 2015 to 2016. The 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 pressure on the acute sector.

In 2020 to 2021 and 2021 to 2022, total spend on agency and bank increased, reflecting workforce pressures and the recovery of services. Higher temporary staffing costs are being driven by both volume effects (more shifts) and price pressures (inflation on price per shift). These are related because higher demand for staff generates a supply shortfall and will result in some price inflation.

There will be continued pressures on temporary staffing in 2022 to 2023 and spend is not expected to reduce in the short term as we prioritise workforce and elective recovery. We

are working to ensure that agency staff are used in a fiscally responsible way that continues to put in the building blocks for sustainably reducing agency spend in the future.

Staff engagement and wellbeing

The NHS staff survey gives useful information about many aspects of staff experience at work.

The most recent NHS staff survey was undertaken in November 2021 and published in March 2022. The results were aligned to the 7 themes of the NHS People Promise in 2021, replacing the old themes except for staff engagement and morale. As a result of this change, it is no longer possible to provide a year-on-year comparison with the previous theme scores except for staff engagement and morale. However, the individual questions have largely remained the same, and comparisons with previous years can be made.

The results of the 2021 NHS staff survey have seen a decline on many measures, including thinking there are sufficient staff, satisfaction with pay, morale, stress, and the number of people thinking about leaving. Staff engagement has decreased from 7.0 in 2020 to 6.8 in 2021 and is at the lowest level seen in the last 5 years.

Perhaps unsurprisingly, given the pressure of COVID-19, the survey suggests a picture of a system under sustained pressure which is impacting on staff's experience of working in the NHS.

While the context helps to explain the 2021 results, considerable work through the NHS People Promise has been undertaken to support staff wellbeing, create a compassionate and inclusive culture and leadership, and promote flexible working opportunities. NHS England is leading a programme of work to grow and strengthen occupational health services across the NHS.

‘We work flexibly’ is one element of the People Promise. Becoming a more flexible, modern employer will help to recruit and retain people more effectively. NHS staff now have a day one right to request flexible working in the NHS Terms and Conditions.

In addition to national investment in specialist mental health and wellbeing support, NHS organisations now have wellbeing guardians, a role that supports boards in creating an organisational culture that prioritises the health and wellbeing needs of staff. Line managers have been given training to support them to facilitate wellbeing conversations with staff.

In addition, the NHS national health and wellbeing team are now working with systems who are piloting tailored, locally owned health and wellbeing offers to suit the needs of their workforce.

Many of these programmes of work are focused on creating a sustainable long -term cultural shift and impact will not be seen immediately; they require time and sustained investment. Within the current challenging context that NHS staff are operating, it is vital that this support continues to ensure that they feel supported and have a positive experience of working in the NHS.

Satisfaction with pay and additional hours

Satisfaction has varied over time with an improvement since the beginning of the AfC multi-year pay and contract reform deal. However, across all respondents there was a modest reduction (1.3 percentage points) in 2020.

Across all respondents to the survey, the percentage of staff satisfied with their level of pay is 36.7%. However, there is 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.

There is some variation across gender with satisfaction in pay, with 36.9% of female staff being satisfied with their pay compared to 38.9% of male staff. Staff aged 21 to 30 have lower satisfaction with pay which may reflect the tendency for staff to progress into higher pay bands over time.

The proportion of staff who work any additional paid hours has remained mostly consistent over the last 4 years, falling by 1.3 percentage points 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 6.

Sickness absence

Table 4.15 shows sickness absence rates for NHS trusts and commissioning bodies since 2010 to 2011. It shows that pre-COVID there had been no major change over the long term with rates remaining between 4.37% and 4.58%. COVID-19's impact on sickness absence is reflected in the latest figures.

Table 4.15: Sickness absence in NHS trusts and CCGs between 2010 to 2011 and 2021 to 2022 – total HCHS non-medical staff

Year	Sickness absence rate (%)
2010 to 2011	4.46%
2011 to 2012	4.42%
2012 to 2013	4.56%
2013 to 2014	4.37%
2014 to 2015	4.58%
2015 to 2016	4.47%
2016 to 2017	4.50%
2017 to 2018	4.52%
2018 to 2019	4.55%
2019 to 2020	4.83%
2020 to 2021	5.02%
2021 to 2022	5.82%

Source: NHS Digital sickness absence statistics

Sickness absence rates for non-medical staff vary by region. Whilst some may be the impact of varying rates of COVID-19 infection, historic differences have persisted. Rates tend to be higher in the North of England (6.9% in North West and 6.4% in North East and Yorkshire) compared to London (5.2%) and South East (5.2%).

Table 4.16: Non-medical staff sickness absence by NHS England region 2021 to 2022

Region	2021 to 2022
England	5.8%
London	5.2%
South West of England	5.5%
South East of England	5.2%
Midlands	6.0%
East of England	5.6%
North West	6.9%
North East and Yorkshire	6.4%

Source: NHS Digital sickness absence statistics

Sickness absence also varies by staff group with ‘frontline staff’, nurses, midwives, ambulance staff and clinical support staff having some of the highest rates of absence while non-frontline groups have lower reported absence rates. Some of this will be related to the nature of the work undertaken. COVID-19 have increased the distinction between the 2 groups recently.

Table 4.17: Sickness absence rates by non-medical staff group 2016 to 2017 and 2020 to 2021

Staff group	2016 to 2017	2017 to 2018	2018 to 2019	2019 to 2020	2020 to 2021	2021 to 2022
Nurses and health visitors	4.44%	4.47%	4.48%	4.73%	5.28%	5.88%
Midwives	4.75%	4.93%	4.80%	5.11%	5.02%	6.73%
Ambulance staff	5.49%	5.31%	5.31%	5.38%	5.83%	7.53%
Scientific, therapeutic and technical staff	2.98%	2.97%	3.02%	3.24%	3.21%	4.04%
Support to clinical staff	5.57%	5.63%	5.67%	6.04%	6.32%	7.28%
NHS infrastructure support	3.73%	3.74%	3.79%	4.04%	3.62%	4.31%
Other staff or unknown classification	1.66%	1.18%	1.20%	1.41%	1.08%	1.36%

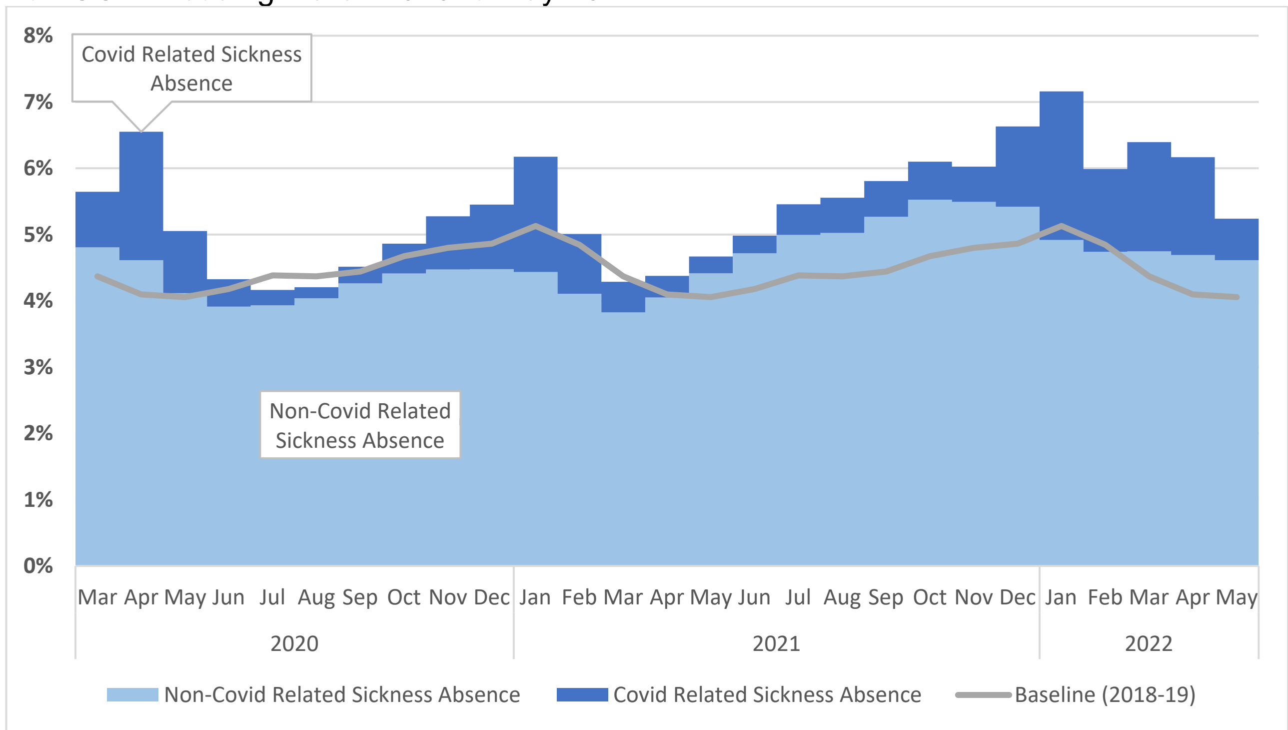
Source: NHS Digital sickness absence statistics

COVID-19 related sickness absence

NHS Digital data is available to describe trends in sickness absence during the on-going response to COVID-19. Additional coding has been made available on ESR for organisations to record against. This data will not though track staff absence for non-sickness reasons.

Figure 4.9 shows the ESR reported rates of sickness absence for non-medical staff split by those coded as COVID-19 related or not. The underlying rate of non-covid absence is now above that seen in the baseline year of 2018 to 2019.

Figure 4.9: Monthly non-medical sickness absence rates split by COVID and non-COVID coding March 2020 to May 2022



5. Earnings and expenses

Note: evidence in this chapter is subject to due-diligence QA during HMT clearance process. We do not anticipate this will impact key messages.

It is important that the NHS pay offer can effectively recruit and retain the staff that it needs across the full range of roles and seniority. Similarly, the pay system should ensure that all staff are rewarded fairly for the service they deliver and have the opportunities and incentives to progress and develop in their chosen line of work. As such, the competitiveness of NHS pay for both existing staff and potential new recruits is an important consideration when setting pay rates.

This chapter includes an assessment of the latest data relating to pay and earnings, including comparisons to the wider economy, and introduces some of the key factors that will shape the pay decision including:

- the latest data on pay and earnings, including growth patterns
- information on how individual members of staff experience the pay system including the impact of pay progression and promotion
- information pertaining to equalities including data on the gender pay gap, ethnicity pay gap and promotion patterns
- an assessment of how pay in the NHS compares to the wider economy in general and the comparator occupations against which the NHS might compete for staff

For 2022 to 2023, the government accepted the NHSPRB recommendations in full. This increased basic pay by £1,400. For staff at the top of band 6 and all of band 7 this was increased to between £1,561 and £1,834 to ensure those staff received an increase of at least 4%. For staff in band 1 and bottom pay point of band 2, this was on top of the £324 increase applied in April 2022 that increased pay at the bottom point to £9.65ph. This resulted in pay awards of between 1.3% (top of band 9) and 9.3% (band 1 and bottom of band 2) compared to 2021 to 2022 pay scales.

Average Basic Pay per FTE for the non-medical workforce increased by 3.9% in 2021 to 2022 which is broadly consistent with the outcome of the 3% pay award combined with the final changes to the AfC pay structure that were implemented in April 2021.

NHS pay remains competitive with what is available in the wider economy. Data shows the average value of the pay award in 2022 to 2023 was broadly comparable with the wider

economy and earnings at staff group level have retained their position in the overall wage distribution.

We expect that the NHSPRB will want to consider the latest available data and developments in the wider economy and labour market when making its recommendation. We welcome the opportunity to give our views on the emerging situation and what that might mean for pay policy during oral evidence.

Background to the Agenda for Change pay system

Almost all non-medical staff working in the HCHS sector in England are employed under the 'AfC' contractual framework. In addition to pay, AfC establishes the terms and conditions of employment for non-medical staff in the NHS. A small number of non-medical staff are not directly engaged under AfC, including very senior managers and executive senior managers where other local arrangements apply.

The Job Evaluation Scheme (JES) is an integral part of AfC and was developed specifically to ensure all roles support equal pay for work of equal value. Using the JES, the skills, responsibilities and effort required for a role are assessed with the scoring outcome determining which pay band the role sits within. In some cases, for example midwives and paramedics, a 'run-through' system operates whereby someone may start in one band and then progress into the next pay band as they develop experience and competence.

In AfC, staff can move through the pay structure, and increase their basic pay, through either pay progression or promotion:

- pay progression occurs when staff move to a higher step point within their current band. Staff should expect to spend at least 2 years in each pay step with progression dependent on satisfactory performance and development. Staff are able to progress from being a new entrant to reach the top of their pay band in a maximum of 5 years

- promotion occurs when a staff member secures a job which has been evaluated at a higher pay band than the current role with a higher level of qualification, responsibility or expertise is required. Pay bands do not overlap so the base pay in the higher band is more than in the lower band and in addition the individual can then start to progress within the next band

Staff may also access 'additional earnings' if they work additional hours or at unsocial times. This is described in more detail later in the chapter.

An example of the difference between pay progression and promotion is shown in figure 5.1. Staff do not have to be at the top of their current pay band to apply for promotion and may do so when a suitable opportunity becomes available regardless of where they currently sit within the band.

Fig 5.1: Example of difference in pay bands and pay steps in band 5 and 6 of agenda for change

	Band 5	Band 6
0 to 1 year	Pay point 1	Pay point 1
1 to 2 years		Promotion
2 to 3 years	Pay point 2	Pay point 2
3 to 4 years		
4 to 5 years	Pay point 3 (Max)	Progression
5 to 6 years		Pay point 3 (max)
6 to 7 years		
7 to 8 years		

Source: NHS Employers pay circulars

As part of the 2018 agreement, a significant amount of structural reform was undertaken which reduced the length of all pay bands by reducing the number of pay step points in each band. For Bands 2 to 7 inclusive, this facilitated quicker progression to the top of the band. The new system was fully implemented in April 2021 when the final transition points were removed from Bands 5 to 7. Table 5.1 shows the current pay structure in operation in the financial year from April 2022.

Table 5.1: Agenda for change pay structure from 1 April 2022

Band	Band minimum	Band intermediate	Band maximum	Minimum time to top of band	Within band progression
Band 1	20,270	N/A	20,270	N/A	N/A
Band 2	20,270	N/A	21,318	2 Years	5.2%
Band 3	21,730	N/A	23,177	2 Years	6.7%
Band 4	23,949	N/A	26,282	3 Years	9.7%
Band 5	27,055	29,180	32,934	4 Years	21.7%
Band 6	33,706	35,572	40,588	5 Years	20.4%
Band 7	41,659	43,806	47,672	5 Years	14.4%
Band 8a	48,526	N/A	54,619	5 Years	12.6%
Band 8b	56,164	N/A	65,262	5 Years	16.2%
Band 8c	67,064	N/A	77,274	5 Years	15.2%
Band 8d	79,592	N/A	91,787	5 Years	15.3%
Band 9	95,135	N/A	109,475	5 Years	15.1%

Source: NHS Employers pay circulars. Band 1 has a single pay point and was closed to new entrants in 2018.

A small number of staff in bands 8a and above will continue to receive temporary consolidated payments in 2022 to 2023 to ensure their base salary is not below what it was prior to the 2018 agreement. A maximum of around 0.4% (3,800 FTE) of the AfC workforce are eligible for these payments. They are worth between £2,934 and £8,083 over the course of the financial year starting in April 2022. This is the last year in which consolidated payments will be required as by 31st March 2023 all impacted staff will have had the chance to progress to the top of their respective pay bands or will have been promoted to a higher pay band where eligibility for the temporary consolidated payment will cease.

More information on these payments is set out in Annex 2 of the NHS Terms and Conditions Handbook.

In-year pay progression in 2022 to 2023

Under the reformed contract, which was fully implemented in 2021, staff are not entitled to automatic progression based on time served and are expected to spend at least 2 years at each pay point before being able to move to the next pay point in their band. The reforms also shortened the length of time required for someone in Bands 2 to 7 inclusive to be eligible to reach the top of band.

These changes reduce the proportion of people eligible for a pay increase outside of either the pay review body process or through promotion to a more senior position.

Staff can be split into the following categories:

- top of band - staff who have reached the maximum pay step within their current pay band and are not eligible for further pay progression in their current role

- in-year progressors - staff who, in the next 12-months, will be able to move to a higher pay step in their current pay band

- staff between increments - staff who are not yet at the top of their current pay band and are not eligible to move to a higher pay step in the next 12-months. For example, someone who has just started a new role in Band 5 must spend at least 2 years at the introductory pay step before they are able to move to the intermediate step

Table 5.2: Staff by band and eligibility for pay step progression at 31 March 2022

Band	FTE (March 2022)	Top of band	All progressors	In-year progressors	Staff between increments
Band 1	2,836	100%	0%	0%	0%
Band 2	176,922	71%	29%	11%	19%
Band 3	152,196	66%	34%	12%	22%
Band 4	107,952	54%	46%	9%	37%
Band 5	219,780	43%	57%	21%	36%
Band 6	207,440	49%	51%	16%	35%
Band 7	130,576	49%	51%	15%	35%
Band 8a	50,009	42%	58%	5%	53%
Band 8b	19,289	44%	56%	4%	52%
Band 8c	9,774	46%	54%	4%	50%
Band 8d	4,927	48%	52%	5%	47%
Band 9	2,296	50%	50%	4%	46%
All AfC	1,083,998	54%	46%	14%	32%

Source: NHS Digital workforce statistics. Band 1 has a single 'spot' rate and was closed to new entrants in 2018.

Across the AfC workforce over half of staff are at the top of their band. Bands 2, 3, 4 and 9 have the most staff already being at top of band. One reason for this is that in the lower bands it takes less time to reach the top of those bands. For example, in Band 3 it takes 2 years to reach the top pay after starting on the entry point.

Only around 14% of staff (FTE basis) are expected to be eligible for pay progression within their current band in 2022 to 2023 which will be worth an average of around 8%. The other 85% of staff are not eligible for progression during 2022 to 2023 and will only see an

increase in pay through the annual pay round or if they seek promotion to a more senior position.

Now that the 2018 AfC reform has been completed, we expect the proportion of staff in different 'states' to be relatively constant.

National Living Wage

In 2022 to 2023, the minimum rate of pay in the NHS is £10.37 per hour (increasing to up to £12.87 per hour for those working in Inner London). The statutory minimum, payable to most employees aged 23 and over, is currently £9.50, so the minimum rate in the NHS is 9.1% above the statutory minimum.

Following the announcement made by the Chancellor on 17 November, the National Living Wage (NLW) will increase to £10.42 per hour from 1 April 2023, in line with the target for the NLW to reach 2/3 of median earnings by 2024.

Pay recommendations for the 2023 to 2024 pay round will be announced after 1 April 2023, meaning the NLW will be temporarily higher than the minimum rate of pay in the NHS. The government therefore is required to act prior to April to ensure the NHS remains legally compliant and will work with necessary systems to ensure NHS staff are paid at least the NLW in the interim until the 2023 to 2024 pay uplifts are agreed. Like in 2022-2023, this process will not interfere or undermine the independent pay review body process.

The NHS Pay Review Body recommendation for 2022 to 2023 benefitted the lowest earners most and meant the minimum NHS pay rate remained above the NLW by 9.1%. Given the recruitment and retention challenges at the lower end of the pay scale and the context of increasing cost-of-living, government felt that this level of targeting was appropriate this year and accepted the recommendations in full. However, the award did result in compression of the pay bands which may have a potential impact on promotion incentives and additional complexities particularly where there is an interaction with unsocial hours premia. For example the gap between the top of band 2 and the bottom of band 3 fell to 1.9% (£412) and the gap between band 7 and band 8a fell to 1.8% (£853) as this was where the enhancement to 4% stopped. With a given budget, it also limited how pay could help recruit, retain and motivate staff across the rest of the workforce.

This trade-off between competing objectives will also be a factor for setting pay at the lower end of the pay scale in 2023 to 2024. When making recommendations we ask the NHSPRB to consider: the pattern of recruitment and retention issues across both the NHS and the wider labour market and where pay can be most effectively deployed to address these problems; how much more for one part of the workforce means less for other parts

of the workforce or other priorities for the NHS budget; and the impact that any targeting of pay has on the smooth functioning and incentives associated with the pay scale.

Managing this balance will be particularly challenging given the uncertainty surrounding the wider economy and labour market. Developments over the coming months may impact the appropriate decision and we expect the NHSPRB will want to consider the latest available data and intelligence as it makes its recommendation. We will be happy to give our views on the emerging situation and what that might mean for pay policy at the process's oral evidence session.

Band 8 and 9

The NHSPRB have expressed interest in having additional evidence on staff at the top of the AfC structure in Band 8a and above. These staff did not benefit from the enhancement to 4% in the 2022 to 2023 pay award and have the longest time (5 years) before they are eligible to move from a band minimum salary to the top of the pay band. As part of the 2018 pay agreement, the length of time it takes to reach the top of Bands 8a and above was not reduced like it was for other bands.

As shown in Table 5.2, the proportion of staff at the top of these bands is lower at the top of the structure (between 40% and 50%) where it takes longer to be eligible to reach the top of band.

The proportion of staff who are eligible to progress within the band over the next 12-months is lower than in other bands (around 5%) which indicates a small proportion of staff have been in post for between 4 and 5 years, however we note that the number of staff in these bands has increased substantially over time (for example the number in Band 9 has increased from around 1,400 to around 2,400 over the past 5 years) and so many of these staff will still be relatively new to the band.

Similarly to the discussions on NLW above, we ask the NHSPRB to consider the distribution of the pay award and the impact of recruitment and retention issues across the NHS and wider labour market when making their recommendations.

The high-cost area supplement

The high-cost area supplement (HCAS) is a pay supplement paid to staff working in defined locations in and around London to reflect higher cost of living in those areas. The supplement has 3 different zones (fringe, outer and inner) with higher payments for those working in inner London.

The NHSPRB has asked for opinions on the current system of HCAS and whether reform should be considered. The department believes that any attempt to reform HCAS should

be centred around other NHSPRB decision frameworks such as recruitment, retention, and motivation.

At this point we do not have conclusive evidence that there are differences in recruitment and retention indicators that are related to HCAS and could be alleviated if the system were changed. In addition, the longer-term impacts of COVID-19 on hybrid working in the NHS and wider economy are yet to be fully realised. This may alter the pattern of where people choose to live and work in the future which will then influence what an optimal pay policy should look like.

For these reasons the department does not believe that HCAS reform is a pressing issue for this year. We do however acknowledge that this is an area which we will want to keep under review and welcome evidence that other parties are able to provide.

Recruitment and retention premia

A recruitment and retention premium (RRP) is an addition to the pay of an individual post or specific group of posts where market pressures would otherwise prevent the employer from being able to recruit staff to and retain staff in sufficient numbers at the normal salary for a job of that weight.

Flexibility exists within the national terms and conditions for employers to use local recruitment and retention premia should they wish.

Our understanding is that these flexibilities are seldom used by employers locally due the administrative load of operating them on a wide basis, complying with equal pay legislation, and the risk of passing recruitment and retention issues to neighbouring trusts and creating a competitive wage spiral within the labour market for the local health market.

Data from NHS Digital shows the proportion of staff who are in receipt of a payment categorised as an 'RRP' (XLSX, 288KB) in the payment system. For non-medical staff the proportion of staff in receipt of such a payment range from 0.2% (support to ambulance staff) to 1.5% (hotel, property and estates) however we recognise this may include some payments that are linked to the predecessor to HCAS known as the 'cost of living Supplement'. The proportion of nurses in receipt of these payments is unchanged at 0.6%.

Average pay and earnings in 2021 to 2022

NHS Digital publish information on average pay and earnings for staff working in HCHS in England. This data does not include any outside earnings such as bank, agency or independent work.

There are 3 principal measures of earnings which may be considered dependent on the context:

- total basic pay per FTE - This would be the average amount of basic pay per person if it is assumed that all staff work full-time hours. This calculation is possible because the amount of basic pay received is directly proportional to the number of hours worked

- total earnings per person - This is the average amount of earnings received per person and includes non-basic pay elements such as unsocial hours premium or High-Cost Area Supplements. It is not possible to provide this 'per FTE' because total earnings do not scale in the same way as basic pay

- total basic pay per person - This is the average amount of basic pay received with no adjustment for FTE and will therefore be lower than the 'per FTE' measure.

Table 5.3 presents the average pay and earnings for the 12-months to the end of March 2022 and the level of growth compared to the 12-months to the end of March 2021 for staff working in NHS trusts and Core organisations in England.

Table 5.3: Average pay and earnings for non-medical staff in the 12-months to March 2022 with comparison to 12-months to March 2021. HCHS core organisations in England

Staff group	Earnings per person	Basic pay per FTE	Earnings per person growth	Basic pay per FTE growth
All non-medical staff	£30,775	£31,028	4.2%	3.9%
Nurses and health visitors	£35,989	£35,600	3.8%	3.9%
Midwives	£35,738	£37,406	3.7%	3.7%
Ambulance staff	£46,643	£35,335	7.5%	5.5%
Scientific, therapeutic and technical staff	£37,415	£39,759	4.3%	3.8%
Support to doctors, nurses and midwives	£21,253	£21,715	3.5%	3.2%
Support to ambulance staff	£29,139	£23,422	5.5%	2.9%
Support to ST&T staff	£21,692	£23,132	5.0%	3.6%
Central functions	£29,004	£29,905	4.3%	3.9%
Hotel, property and estates	£20,883	£21,285	5.6%	4.6%
Senior managers	£83,483	£84,435	1.5%	2.2%
Managers	£56,167	£55,548	3.5%	4.1%

Source: NHS Digital earnings statistics

Average earnings growth across all non-medical staff was 4.2% and ranges between 2.2% (senior managers) and 5.5% (ambulance staff).

Differences in the rate of pay growth between staff groups and deviation from the 3% pay award in 2021 to 2022 will reflect factors including:

- in April 2021, the reform of the AfC structure was completed with the removal of the final 'transition points' in bands 5 to 7. This means that some staff, predominately those in professionally qualified staff groups, received larger pay increases as those pay points were moved to the top of band

- some staff groups, especially ambulance staff and support to ambulance staff, saw higher increases in earnings than basic pay as a result of an increase in additional earnings. One reason for this is that some staff received a one-off payment relating to holiday pay for working regular overtime following an agreement between NHS Employers and the NHS Trade Unions. Because ambulance staff are most likely to work overtime (around 55% of ambulance staff work overtime compared to 7% of Nurses) they are more likely to have received this payment which did not impact basic pay

Data to the end of March 2022 will not include the impact of the 2022 to 2023 pay award which included:

- an increase in the NHS minimum rate (from £9.49ph to £9.65ph), paid in band 1 and the bottom of band 2, in April 2022 to ensure compliance with the national living wage

- a £1,400 increase to the value of all pay points, enhanced to a minimum of 4% for staff working in bands 1 to 7. For those in band 1 and the bottom of band 2 this was in addition to the April increase

- a small number of staff in bands 8 and 9 will continue to receive consolidated payments to ensure they do not see a reduction in basic pay following the 2018 pay agreement. 2022 to 2023 is the last year these payments will apply as by 1st April 2023 all impacted staff will have had the opportunity to progress to the top of the band

The impact of these changes will differ according to an individual's position within the AfC structure. We estimate the total impact of the 2022 to 2023 pay award on the AfC paybill to be around 4.75% with basic pay increases of between 1.3% (top of band 9) and 9.3% (band 1 or bottom of band 2) compared to the 2021 to 2022 pay system with the mean award on a headcount basis being around 5.3%.

Additional earnings

In addition to basic pay, staff can access additional earnings depending on time, location or if it was paid at overtime rates under the terms set out in the agenda for change contract (https://www.nhsemployers.org/publications/tchandbook)

The structure of the AfC contract means that some staff groups are more likely to receive additional earnings. For example, clinical staff are more likely to work unsocial hours to maintain a 24/7 service whilst ambulance staff have relatively high levels of overtime due to things like 'shift overruns' if an emergency occurs at the end of a shift which results in them having 'compulsory overtime' to complete a job.

Table 5.4 shows the proportion of contribution of additional earnings by staff group in the 12 months to March 2022 and how that has changed over the past 12-months.

Table 5.4: Proportion of total earnings that are not basic pay by staff group in NHS trusts and core organisations, 12 months to March 2021 and 12 months to March 2022

Staff group	12 months to March 2021	12 months to March 2022
Nurses and health visitors	12.2%	12.0%
Midwives	14.6%	14.5%
Ambulance staff	27.9%	29.1%
Scientific, therapeutic and technical staff	8.1%	8.1%
Support to doctors, nurses and midwives	12.2%	12.3%
Support to ambulance staff	25.2%	26.9%
Support to ST&T staff	7.3%	7.7%
Central functions	5.8%	5.8%
Hotel, property and estates	16.9%	17.3%
Senior managers	5.0%	4.4%
Managers	6.1%	5.3%

Source: NHS Digital earnings statistics

In most cases there have been only small changes in the proportion of additional earnings over the last 12-months. The most noticeable exception is for qualified ambulance staff and support to ambulance staff where the measure changed by more than 1 percentage point. Ambulance staff were most likely to receive a one-off payment relating to the case around unpaid holiday pay for staff completing regular overtime as well as continued service pressures.

Payments for 'additional earnings' include payments that are linked to 'overtime' on the payment system. These are payments, paid at enhanced rates, for hours worked above standard full-time working hours for the role (FTE = 1). Data from NHS Digital shows significant variation in the proportion of staff who have completed at least one instance of 'overtime' in the past year ranging from 0.1% of senior managers (who will typically be in band 8 or 9 and not eligible for enhanced payments) to 54% of ambulance staff who may be required to complete 'compulsory overtime' in the event of shift overruns.

Average earnings by agenda for change band

Table 5.5 presents information on average earnings by AfC band in the 12-months to March 2022 and growth in earnings compared to the 12-months to March 2021. As per other data this will not include the impact of the 2022 to 2023 pay award implemented from September 2022.

The overall increase in basic pay per FTE for non-medical staff was 3.9% with changes ranging from 2.6% in band 4 to 3.7% in band 6. This increase, and differences between bands, can be explained by the impact of the 2021 to 2022 pay award, the removal of transition points in bands 5 to 7 and any changes to 'point mix' which changes the balance of staff between different pay bands and steps - the overall increase is higher than that in any band which supports a slightly richer (more senior) band mix. Band 1 (around 3,000 FTE) was closed to new entrants in 2018 and so changes in earnings in this band reflect the characteristics and working patterns of staff who have chosen to not transition into band 2

Table 5.5: Average basic pay per FTE and total earnings by AfC band - 12 months to March 2022.

Band or Grade	Average earnings per person	Average basic pay per FTE	Annual growth in earnings per person	Growth in basic pay per FTE
All grades	£30,775	£31,028	4.2%	3.9%
Band 1	£14,815	£18,515	-2.0%	2.8%
Band 2	£18,699	£19,491	3.6%	3.3%
Band 3	£20,812	£21,276	3.3%	2.8%
Band 4	£23,343	£23,824	3.2%	2.6%
Band 5	£29,789	£28,815	3.8%	3.6%
Band 6	£35,893	£36,159	4.2%	3.7%
Band 7	£42,011	£43,495	3.4%	3.0%
Band 8a	£47,825	£49,828	2.5%	2.7%
Band 8b	£57,334	£59,013	1.6%	2.8%
Band 8c	£69,572	£70,652	2.0%	2.9%
Band 8d	£84,945	£84,321	1.8%	3.1%
Band 9	£102,840	£101,437	1.7%	3.1%
Non AfC band	£43,299	£50,260	-0.5%	-1.6%

Source: NHS Digital earnings statistics

Gross earnings and take-home pay

The figures presented above relate to gross earnings and do not take into account changes in tax, National Insurance, and pension contribution deductions that affect take-home pay. There have been a number of changes during 2022 to 2023 that affected take-home pay, including:

- a 1.25 percentage point increase in National Insurance rates applying between April and October, which increased deductions from gross earnings over that period
- an increase in the National Insurance primary threshold from July, which decreased deductions from gross earnings
- and changes to NHS pension contribution rates in October, which increased or decreased deductions from gross earnings for pension members depending on their earnings and whether they work full-time or part-time. Further changes in contribution rates are planned for 2023

Only the NHS pension contribution changes are specific to NHS staff, with changes in tax and National Insurance deductions affecting employees across the whole economy. Further information on the NHS Pension Scheme is in chapter 6 on total reward.

Pay growth drivers

Average earnings can change for many reasons. Some relate to changes in the composition of the workforce (for example, more senior staff or more staff in higher earning occupations), some relate more specifically to pay rates. Table 5.6 presents trends in earnings growth and its component drivers over recent years.

Analysis is based on the DHSC headline paybill metrics. The paybill metrics use data on workforce earnings and size published by NHS Digital to calculate the paybill cost of employing different types of staff, including pension and National Insurance contributions, and how this has changed. Observed growth in pay can then be compared with the pay award to determine if growth is higher or lower than can be explained by the pay award and then to investigate the reasons behind this. The paybill metrics are based on data for NHS trusts and core organisations and NHS support organisations and central bodies combined, so figures for average basic pay and earnings growth may differ slightly from the figures based on NHS trusts and core organisations in Table 5.6. Growth in earnings per FTE may also differ from growth in earnings per person due to changes in average FTE per person.

Table 5.6: Breakdown of average earnings growth for HCHS non-medical staff

Pay growth element	**2016 to 2017**	**2017 to 2018**	**2018 to 2019**	**2019 to 2020**	**2020 to 2021**	**2021 to 2022**
Basic pay per FTE growth	0.8%	1.3%	3.2%	2.9%	3.1%	4.0%
Additional earnings per FTE growth	-1.9%	-0.7%	0.2%	5.4%	5.5%	3.2%
Total earnings per FTE growth	0.4%	1.1%	2.9%	3.1%	3.4%	3.9%
Of which	-	-	-	-	-	-
(a) Headline pay awards	1.0%	1.0%	3.0%	3.3%	2.9%	3.6%
(b) Total earnings drift	-0.6%	0.1%	-0.1%	-0.1%	0.5%	0.3%
Of which	-	-	-	-	-	-
(b1) Basic pay drift (excluding staff group mix effect)	-0.1%	0.2%	0.1%	0.3%	0.4%	0.2%
(b2) Additional earnings drift Impact (excluding staff group mix effect)	-0.3%	-0.2%	-0.3%	-0.1%	0.5%	0.0%
(b3) Staff group mix effect	-0.1%	0.1%	0.1%	-0.3%	-0.4%	0.1%

Source: DHSC headline paybill metrics

The staff group mix effect reflects shifts in the distribution of staff between higher and lower earning staff groups (for example, nurses vs support staff), whereas basic pay drift (excluding staff group mix effect) reflects shifts in the distribution across bands and points within staff groups (for example, band 6 vs band 5 nurses). Staff group mix is based on the HCHS non-medical staff groups that are presented in NHS Digital published data (and used in Table 5.6).

Average total earnings per FTE grew by 3.9% in 2021 to 2022, reflecting the combined impact of the 2021 to 2022 headline pay award of 3.6% and positive total earnings drift of 0.3%. The headline pay award reflects the 3% uplift to the AfC pay scale plus an additional 0.6% reflecting the average impact of the higher uplifts for staff on 'transition points' in bands 5 to 7. This was the largest increase in total earnings per FTE on this series (since 2011 to 12), which is consistent with the average headline pay award, including the impact of structural reform, being higher than recent years.

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

- a positive 'basic pay drift' (excluding staff group mix effects) of 0.2% in 2021 to 2022 (meaning that average basic pay increased by more than the change to headline basic pay rates). This indicates that the mix of staff across pay points and bands within staff groups has become more expensive, continuing the pattern of positive basic pay drift over recent years

- a neutral 'additional earnings drift impact' (excluding staff group mix effects) of 0.0%, which indicates neither an increase nor decrease in the overall use of additional earnings payments in 2021 to 2022. Average additional earnings per FTE for overtime and shift working decreased in 2021 to 2022, following increases in 2020 to 2021 (consistent with additional hours being worked by some staff due to the COVID-19 pandemic) which contributed to positive additional earnings drift impact that year. Increased use of some other elements of additional earnings, particularly a one-off payment relating to holiday pay for staff working regular overtime, was sufficient to offset the effect of these decreases in overtime and shift working payments in 2021 to 2022 resulting in neutral drift impact overall

- a positive 'staff group mix' effect of 0.1% reflecting a shift in the distribution of staff towards higher earning staff groups in 2021 to 2022 - for example there was a small reduction in the proportion of staff in 'support to clinical' staff groups who are more likely to be in bands 2 to 4

Career journeys and pay disparities

This section provides information on how individual staff experience the pay system and how pay for individual members of staff changes over time. It then provides information on pay disparities which can be caused by, amongst other factors, differences in progression including the ethnicity and gender pay gaps.

Longitudinal pay analysis

Previous analysis in this chapter has focussed on average pay and earnings across the entirety of the workforce. While this is instructive to assess what is happening in aggregate, and influences the total cost of employing the workforce, we should also be interested in how individuals' members of the workforce experience the pay system which will include the impact of pay progression, promotion and pay scale reform.

We can use data from ESR, the HR and payroll system used throughout the HCHS sector, to track individual members of staff over time and look at how their pay (and grade) changes over time. Table 5.7 presents this information by staff group for the 10 years between March 2012 and March 2022 and covers almost 550,000 staff employed in both periods and is based on the staff group in the most recent period.

For staff employed in both 2012 and 2022 the median average increase in basic pay per FTE was over 32% with a quarter of staff experiencing increases of more than 50% over the period.

Most of the variation between staff groups can be explained by either methodological decisions or specific events that have impacted certain staff groups.

- Higher growth for ambulance staff is partly due to re-banding that has taken place with the primary starting band for paramedics changing from band 5 to band 6 which has increased pay for this group

- Higher growth for senior managers is likely a result of selection bias. The analysis is based on an individuals most recent (2022) staff group and so average growth for senior managers will be skewed by individuals being promoted into that staff group from other staff groups

Table 5.7: Increases in basic pay per FTE for staff employed in March 2012 and March 2022 by staff group.

Staff group	Frequency	Mean	Median	25th percentile	75th percentile
All agenda for change	548,000	39.8%	32.5%	17.1%	51.3%
Nurses and health visitors	177,000	40.4%	34.1%	14.2%	54.7%
Midwives	13,000	38.0%	32.5%	14.2%	50.8%
Ambulance staff	9,000	62.0%	52.9%	41.3%	79.0%
Scientific, therapeutic and technical staff	85,000	45.3%	36.4%	17.4%	63.4%
Support to doctors, nurses and midwives	119,000	28.0%	22.0%	16.9%	36.3%
Support to ambulance staff	7,000	33.4%	28.1%	15.7%	44.7%
Support to ST&T staff	27,000	30.0%	25.4%	17.1%	37.3%
Central functions	53,000	46.7%	37.1%	18.7%	61.8%
Hotel, property and estates	31,000	32.3%	36.3%	21.5%	36.3%
Senior managers	18,000	67.7%	55.7%	33.7%	91.9%
Managers	9,000	75.1%	62.7%	36.4%	98.5%

Source: DHSC analysis of electronic staff record

We can also look at this data over shorter time periods. The median growth rate over the past year was 3% which is consistent with the 2021 to 2022 pay award and over the past 5 years median growth was around 4.0% per annum which is consistent with the 2018 AfC pay agreement as well as the impact of pay progression and promotion.

Equalities and pay disparities

The government is committed to ensuring that the pay system is fair to all members of staff and that any disparities between groups, which may be explained by past or present patterns of entry grades, promotion or working patterns are removed. This section sets out information on some of these but is not a comprehensive overview. Chapter 4 contains more equality data which may be useful in interpreting these figures.

Gender and ethnicity pay gaps

The government is committed to eliminating pay gaps which occur when men are paid more than women (gender pay gap), or white staff are paid more than BME colleagues (ethnicity pay gaps).

In 2020, the Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England (PDF, 6.3MB) ('GPG review') was published which highlighted the extent of the issue in the medical workforce and some of the reasons why it exists.

While this review was conducted using data for medics most of the results can be generalised to the wider workforce - including staff on AfC. A similar piece of work is being undertaken by NHS England to better understand the ethnicity pay gap. This will cover all NHS staff.

Factors that can contribute to a pay gap developing include:

- difference in staff group mix - a gap will develop if male or white staff are more likely to be in more senior staff groups compared to female or BME staff
- differences in career grade mix - a gap will develop if male or white staff are more likely to be in more senior career grades compared to female or BME staff
- differences in point mix - a gap will develop if male or white staff are more likely to be further up established pay scales than female or BME staff

When considering pay gaps across the entire non-medical (or HCHS) workforce the impact of staff group mix is strongest while pay gaps within individual staff groups reflect differences in grade and point mix.

Table 5.8 shows the extent of the gender and ethnicity pay gaps as of May 2022 using the basic pay per FTE measure. Gender and ethnicity gaps are shown separately to isolate the impact of either characteristic.

Table 5.8: Gender and ethnicity pay gaps - May 2022 - basic pay per FTE

Staff group	GPG - white	GPG - BAME	EPG - female	EPG - male
Description	Comparison of white female and white male	Comparison of BAME female and BAME male	Comparison of BAME female and white female	Comparison of BAME male and white male
All agenda for change	-8%	-1%	-5%	-12%
Nurses and health visitors	-4%	-2%	-13%	-15%
All professional qualified	-5%	-4%	-12%	-12%
Support to clinical staff	-3%	1%	-1%	-5%
NHS infrastructure support	-12%	-3%	-5%	-14%

Source: NHS Digital earnings statistics.

Table 5.8 is based on differences in basic pay per FTE. A similar table based on differences in average earnings per person would also be impacted by any variation in working patterns or additional earnings between different groups of staff. Key findings are:

- across all AfC staff there is some evidence of both a gender and ethnicity pay gap. For example, average basic pay per FTE for white females is 8% lower than for white males and BME males have basic pay per FTE 12% lower than white males. These results are very similar when compared to last year

- as in previous years the gaps are smaller within individual staff groups which suggests that most of the overall gap is linked to differences in the staff group mix. The system of national pay contracts, underpinned by job evaluation, ensures equal pay for equal work

The gender pay gap implementation panel

The panel is independently chaired by Professor Dame Jane Dacre. Membership is wide ranging and includes senior leaders from across the health system, representing among others, NHSE, NHS Employers and the trade unions. The panel have agreed the second year work programme, informed by the recommendations from the GPG review and the progress from the first year. The work plan is soon to be submitted to the Minister of State. Policy teams across the department are working closely with colleagues in partner organisations to deliver the programme. Quarterly progress updates are submitted to the panel for review.

The work of the panel underpins our ambition to embed pay gap considerations into policy development and we are already seeing successful outcomes for example, through the reduction in pay points agreed in the SAS contract reform.

The panel is making positive progress on multiple recommendations across all 7 themes identified in the review and will continue to work on recommendations throughout 2023.

The ethnicity pay gap review

NHSE are conducting a research project examining the EPG across the NHS. The research aims to analyse pay related data in a manner that gives a clearer and more accurate picture of where there are potential ethnic inequalities in pay and, presenting recommendations aimed at reducing inequalities where they exist.

Promotions and new joiners by gender and ethnicity

One of the factors that may help to explain the continuing presence of a pay gap is to consider the bands at which new starters enter the workforce and the rates at which staff from different demographics attain promotion.

Table 5.9 shows the distribution of new joiners (those employed in March 2022 but not March 2021) to the HCHS sector split by band, gender and ethnicity group. Key findings are:

- most staff are recruited at either band 2 or band 5
- females are more likely to be employed at band 5 which may reflect the increase in the nursing workforce)
- at bands 2 to 4 males are more likely than females to be recruited and white staff are more likely than BME staff
- males are slightly more likely to be recruited at band 8a and above, however this makes up a very small proportion of new joiners
- larger numbers of BME staff recruited at band 5 but fewer in more senior bands

Table 5.9: Band profile of new joiners - staff employed in March 2022 but not March 2021

Band	All staff	Female	Male	White	BME
Band 1	0%	0%	0%	0%	0%
Band 2	24%	23%	27%	27%	19%
Band 3	16%	16%	18%	17%	14%
Band 4	10%	10%	10%	10%	10%

Band 5	28%	29%	23%	21%	41%
Band 6	11%	12%	9%	13%	9%
Band 7	6%	6%	6%	7%	4%
Band 8a	2%	2%	3%	3%	2%
Band 8b	1%	1%	1%	1%	1%
Band 8c	0%	0%	1%	1%	0%
Band 8d	0%	0%	0%	0%	0%
Band 9	0%	0%	0%	0%	0%

Source: DHSC analysis of electronic staff record

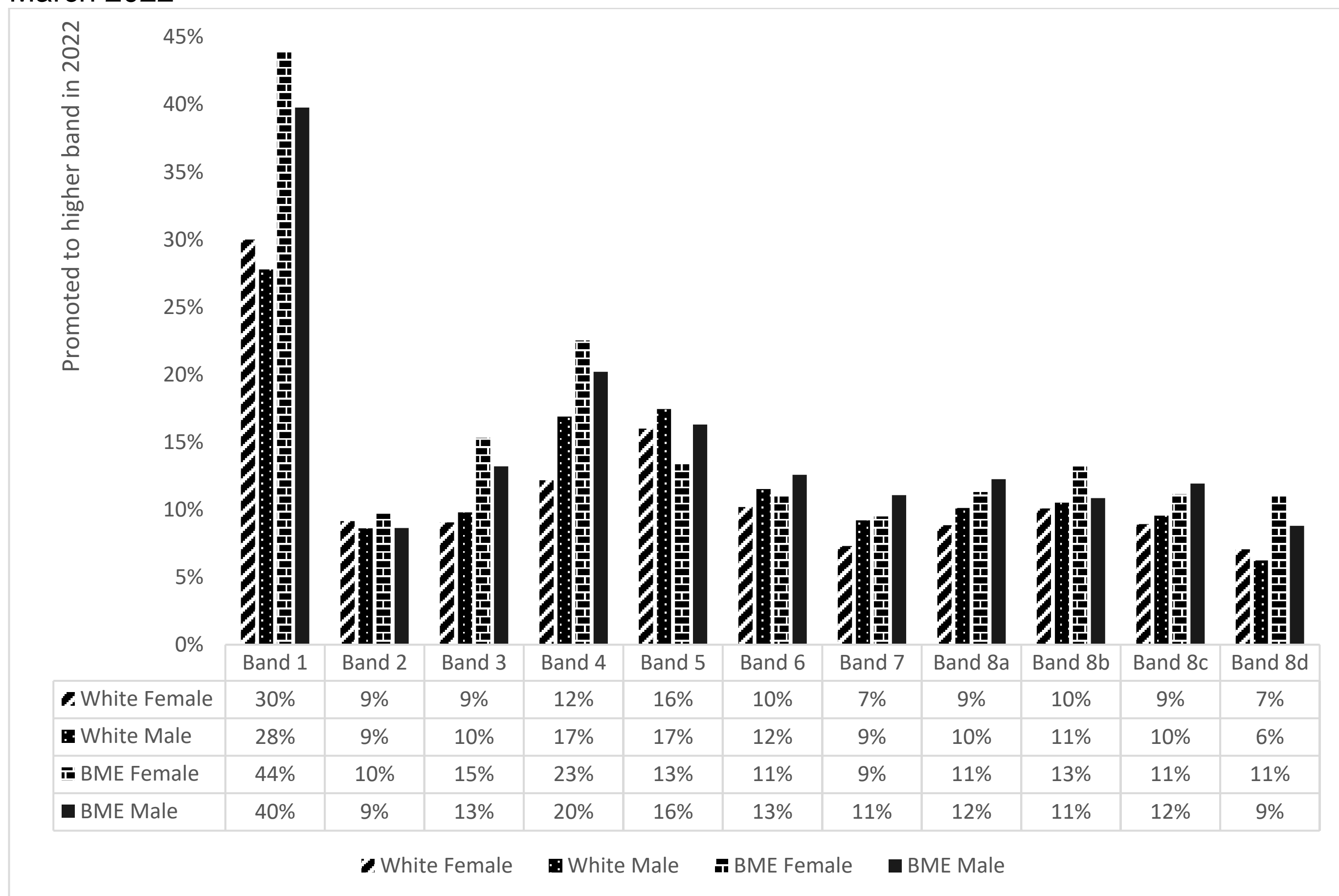
Figure 5.1 shows the proportion of individuals who obtained a promotion (being in a higher band in March 2022 than March 2021) and how it differs by demographics. The higher rate of promotion in band 1 follows the closure of the band to new entrants in December 2018 and the ensuing push to transition staff to band 2. Key findings are:

- across most bands' white females are slightly less likely to achieve a promotion than white males

- at bands 3 to 4, BME staff are more likely to see promotion than white staff. In the case of staff at band 4 this may include staff moving to professionally qualified roles from support roles

- data is not available on the proportions of staff applying for promotion or the reasons why differences in promotion between groups might exist

Figure 5.1: Promotion by gender, ethnicity and band before promotion - March 2021 to March 2022



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d
White Female	30%	9%	9%	12%	16%	10%	7%	9%	10%	9%	7%
White Male	28%	9%	10%	17%	17%	12%	9%	10%	11%	10%	6%
BME Female	44%	10%	15%	23%	13%	11%	9%	11%	13%	11%	11%
BME Male	40%	9%	13%	20%	16%	13%	11%	12%	11%	12%	9%

Source: DHSC analysis of Electronic Staff Record

Career choices and earnings

The NHSPRB has previously asked for information about the impact that 'career decisions' have on earnings.

Many decisions will have an immediate impact of earnings due to how that decision interacts with the AfC contract - for example, earnings will change if someone moves to a different pay band or if they undertake more work at unsocial hours with more hours paid at premium rates.

Some examples of the types of decisions that can impact earnings include:

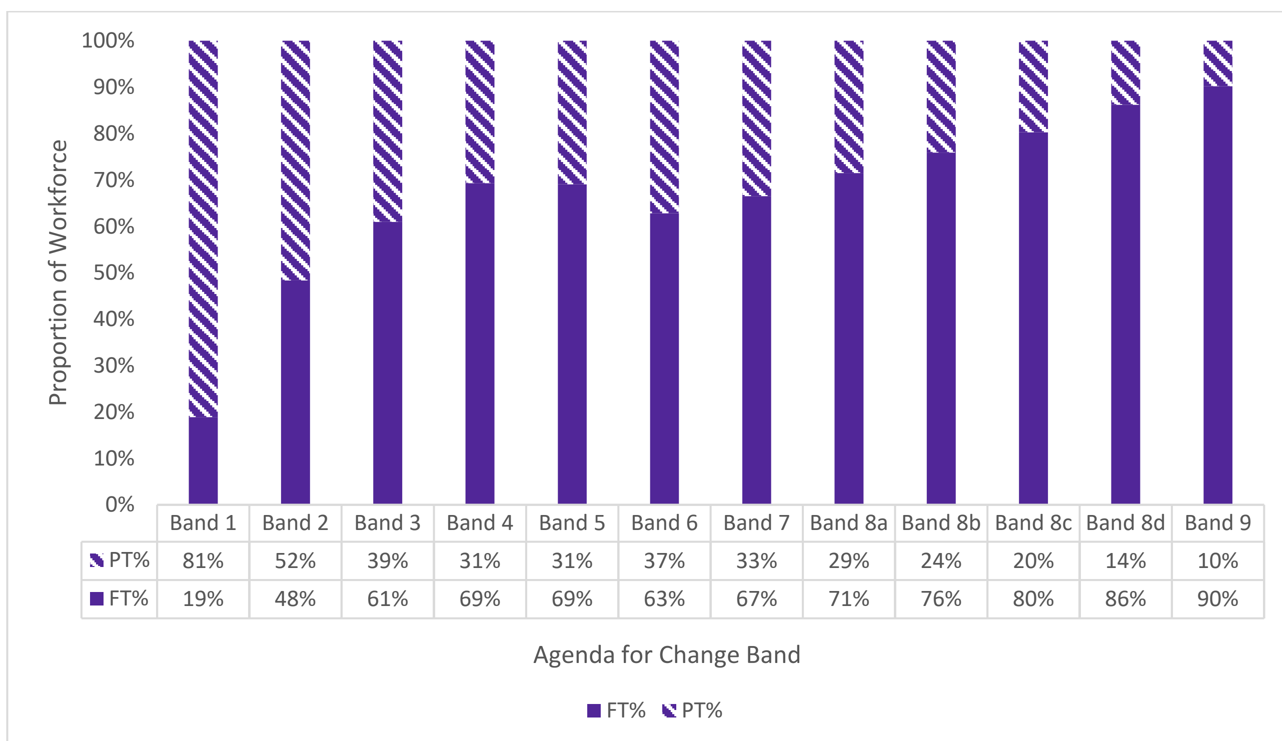
- working patterns - the NHS offers a variety of flexible working patterns for staff including working part-time which may mean that staff build experience, and seek promotion, at different rates
- career breaks - NHS Staff may choose to take some time out of the workforce during their careers which can impact both their current and future earnings.

For example, research from the Institute for Fiscal Studies shows that women who take maternity leave are likely to return to work on fewer hours than before the maternity leave

- occupation or organisation - some roles are more likely to access high levels of additional earnings due to the requirements of the role. For example, some branches of nursing may be more likely to work unsocial hours and ambulance staff may be contractually required to complete overtime however these differences in pay reflect real differences between jobs when it comes to things like the need to work unsocial or extra hours

- figure 5.2 indicates that the proportion of part-time staff is lower in the more senior bands. For example, just under one-third (31%) of staff in band 5 work on a part-time basis compared to only 14% in band 8d and 10% in band 9.

Figure 5.2: Agenda for change staff by working pattern and AfC band - March 2022



Source: NHS Digital workforce statistics

There is also some evidence that staff who work on a part-time basis maybe less likely to gain promotion each year compared to someone who works on a full-time basis. From ESR we estimate that around 13% of full-time staff (full time equivalent equals 1) gained promotion in the 12-months to March 2022 compared with around 8% of those working part-time (full time equivalent of less than 1).

Labour market context

This section provides comparisons between earnings for those working on AfC, the wider economy in general and specific comparator occupations which may attract candidates with similar skills or qualifications. This section only looks at earnings and does not adjust for the value of the wider reward package which for NHS staff is explored in chapter 6.

As set out in HMT's economic evidence to PRBs, public sector earnings growth should retain broad parity with the private sector and continue to be affordable.

- According to surveys by XpertHR, median private sector pay settlements, analogous to the pay awards recommended by the pay review bodies, were 3.5% in the last quarter on 2021 to 2022 and 4% in the first quarter of 2022 to 2023, broadly in line with the 2022 to 2023 pay awards for non-medical staff in the hospital and community health services workforce which averaged around 5.3% at a cost of around 4.75%

- Evidence from the annual survey of hours and earnings suggests growth in individual sectors has been broadly comparable

- The relative position of NHS staff groups within the overall income distribution has been maintained

When considering wage growth and pay settlements in the wider economy and comparator sectors, it is important to consider a range of sources as there is no single definitive data source. Instead, we should look across available indicators for the best view of the current, and prospective position. We are basing our expectations of comparable pay growth across the economy in 2023 to 2024 on OBR average earnings growth forecasts. They suggest it will fall to 3.5% as the labour market loosens. Please see HMT's economic evidence for more commentary on the relationship between average earnings growth and settlement.

Comparisons with the wider economy - annual survey of hours and earnings

The main source used to make comparisons between pay in different sectors is the annual survey of hours and earnings (ASHE) which provides information about the levels, distribution, and make-up of earnings for employees across the UK and is based on a sample of around 1% of the PAYE register covering around 180,000 jobs from 60,000 employers. Data from ASHE can be used to make comparisons between the NHS and wider economy at both the aggregate and granular level. ASHE data is measured in April of each year and therefore the 2022 data won't reflect 2022 to 2023 awards in the public sector which didn't reach pay packets until later in the year. However, it will capture some 2022 pay awards in the private sector, which are concentrated in January and April.

The Office for National Statistics point out that ASHE data for 2020 and 2021 was particularly impacted by COVID-19 due to factors such as changes in the composition of the workforce and the impact of the Coronavirus Job Retention Scheme (furlough). As such it is advised to concentrate on trends over the longer term rather than annual changes. In addition, the data published in 2022 uses the 2020 standard occupation code system which means data for 2022 is not directly comparable with prior years - especially at more granular levels where some jobs will have changed classifications.

Table 5.10 compares average earnings from the ASHE to average earnings for different staff groups published by NHS Digital. For all non-medical staff in the NHS, the earnings distribution is broadly similar to the wider economy with earnings at the lower quartile and median slightly higher for the NHS than in the wider economy. At staff group level, median earnings for professionally qualified roles (including nursing) are above that of the wider economy but are lower in some support roles which is consistent with the AfC pay ranges.

Table 5.10: Comparison of earnings distribution for the United Kingdom from the annual survey of hours and earnings and NHS Digital staff groups.

Earnings per person:

12-months to Mar 2022	Lower quartile	Median	Upper quartile	Mean
All United Kingdom (ASHE)	£18,224	£27,756	£40,989	£33,402
All non-medical staff groups	£22,000	£29,000	£39,500	£30,775
Nurses and health visitors	£30,000	£36,500	£43,500	£35,989
Midwives	£29,500	£37,000	£44,000	£35,738
Qualified ambulance staff	£41,000	£49,000	£55,000	£46,643
Scientific, therapeutic and technical staff	£29,500	£37,500	£46,500	£37,415
Support to doctors, nurses and midwives	£17,500	£22,000	£25,500	£21,253
Support to ambulance staff	£24,000	£29,500	£35,000	£29,139
Support to STT staff	£17,500	£22,000	£25,500	£21,692
Central functions	£21,500	£26,500	£38,000	£29,004
Hotel, property and estates	£15,000	£20,500	£25,500	£20,883
Senior managers	£64,000	£80,000	£108,500	£83,483
Managers	£47,500	£55,000	£65,000	£56,167

Source: Annual survey of hours and earnings, NHS Digital earnings statistics

Comparisons of HCHS earnings with selected connected labour markets

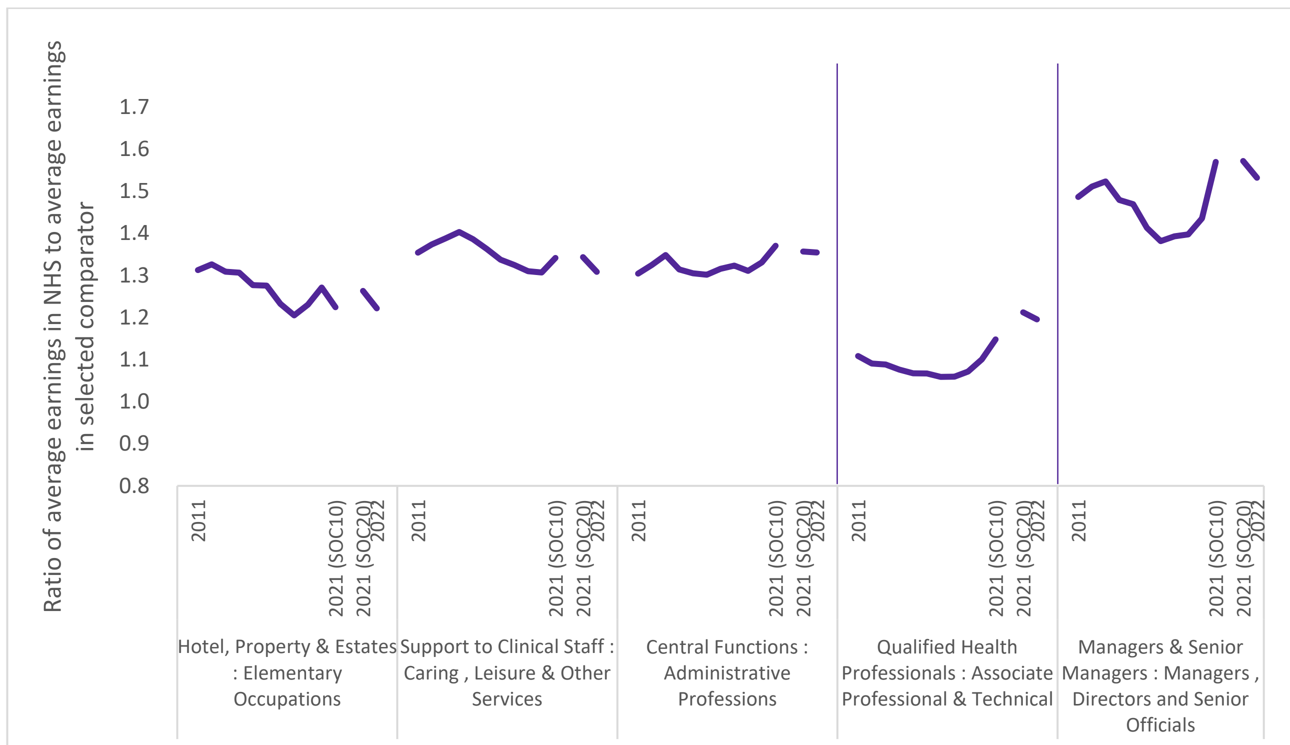
From ASHE data we can compare average earnings in NHS staff groups with comparable staff in other parts of the economy. This can be useful in assessing the competitiveness of pay in the NHS, how it has changed and provides an indication of what outside options individuals might be considering when deciding whether to join or stay in the NHS.

Figure 5.3 shows the ratio of average earnings for sections of the NHS workforce compared to gross annual earnings per person for headline ASHE groups and how they have changed. In general, this suggests that there have been only relatively small changes over time with most staff groups remaining in a relatively tight band against their selected comparator which suggests NHS pay has broadly maintained its position. The larger than average movements over the COVID-19 period may be related to the impact of COVID-19 on the wider economy and as such it is advised to consider changes over a longer time period.

While the NHS value tends to be higher than the comparator, we accept that these are not perfect like-for-like comparisons and so differences in pay can reflect factors including individuals' skills and experience as well as necessary differences in working patterns including the requirement to work unsocial hours.

In 2022, data has been produced using the 2020 version of the standard occupation codes meaning there has been a break to the previous series with some occupations being reclassified. As such data for 2022 is not directly comparable to previous years.

Figure 5.3: Comparison of average earnings in NHS staff groups compared to selected wider economy comparators from the annual survey of hours and earnings.



Source: Annual survey of hours and earnings, NHS Digital earnings statistics

HCHS earnings percentiles

Using ASHE data, it is possible to look at where average earnings for different staff groups fall within the UK earnings distribution and how that has changed. This can be useful in seeing how pay in the NHS has tracked the wider economy and helps to inform our assessment of the relative competitiveness of NHS pay.

Table 5.11, which is based on average earnings per person, shows that while there is some variation between staff groups (with senior managers towards the very top of the earnings distribution and support staff below the median) the relative position of different staff groups is largely unchanged - for example nurses have consistently been around the 66th percentile throughout. The largest change in position is for ambulance staff who went from around the 73rd percentile in 2019 to the 81st percentile in 2022 due to a combination of paramedic re-banding, increased intensity during the pandemic and the one-off impact of payments for staff working regular overtime - which would support the idea that the relative value of different occupations has been stable over time.

Table 5.11: Estimated income percentile for NHS staff groups based on average earnings per person in NHS mapped against annual survey of hours and earnings

Staff group	2016	2017	2018	2019	2020	2021 (SOC 10)	2021 (SOC 20)	2022
Nurses and health visitors	67	67	66	66	65	68	68	66
Midwives	68	67	66	65	65	67	67	66
Ambulance staff	76	75	74	73	77	80	80	81
Scientific, therapeutic and technical staff	70	69	68	67	67	70	70	69
Support to doctors, nurses and midwives	36	35	34	34	33	35	35	32
Support to ambulance staff	50	49	48	47	50	53	53	53
Support to ST&T staff	35	34	34	34	33	35	35	33
Central functions	51	51	51	51	51	54	54	52
Hotel, property and estates	34	33	32	33	31	33	33	31
Senior managers	96	96	96	95	96	96	96	96
Managers	86	86	85	85	86	89	89	89

Source: NHS Digital earnings statistics, annual survey of hours and earnings. Comparison of average earnings per person (NHS) with annual gross pay for all employee jobs (ASHE)

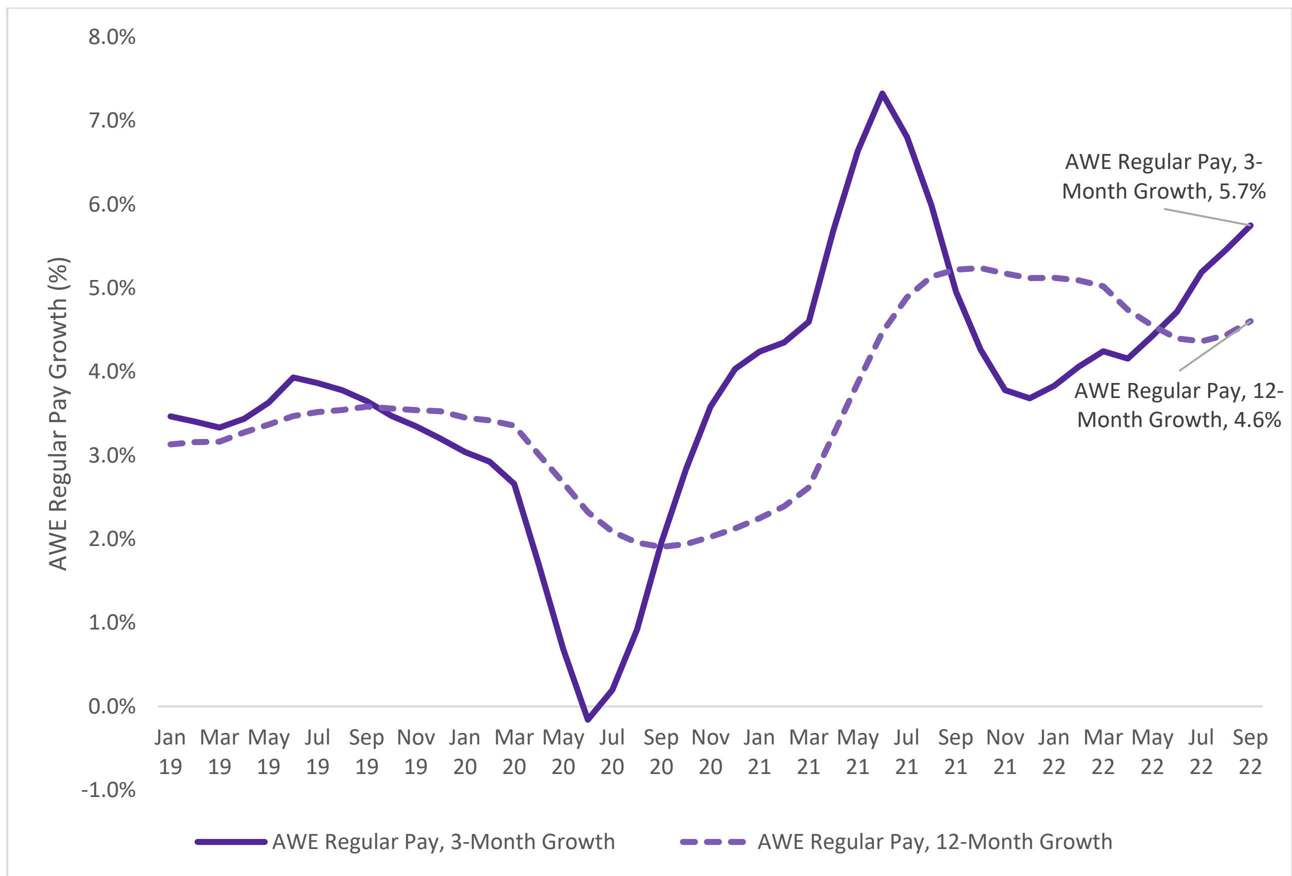
Comparison with the wider economy - average weekly earnings

While ASHE data is comprehensive it is only available once per year and we acknowledge that the pay review bodies will want to consider more timely data on changes to earnings when making decisions.

ONS publish data on average weekly earnings which is the lead measure on average weekly earnings per employee and is based on data collected from the monthly wages and salaries survey. These estimates cover more than just pay settlements and will include the impact of factors including changes in average working hours or changes in the composition of the workforce which was of particular importance during the COVID-19 period when the furlough scheme was reducing the pay of over a million employees. Please see HMT's economic evidence for more commentary on the relationship between average earnings growth and settlement

Figures for the period to September 2022, show that across the whole economy average total pay increased by 6% compared with the same period 12-months ago and average regular pay (excluding bonuses) increased by 5.7%. In both cases these figures are below the level of inflation which mean that real total pay has fallen by 2.6% and real regular pay (excluding bonuses) has fallen by 2.7%. This indicates that pay settlements in the wider economy are not keeping pace with the current very high levels of inflation.

Fig 5.4: Increase in average weekly earnings, 3-month and annual growth rates



Source: Office for National Statistics, average weekly earnings

Please note that figures for AWE growth a year beyond when the furlough was active (to end September 2022), will be inflated by a base effect meaning headline average earnings will be higher than the underlying rate and settlements. For more info see the following ONS blog: Far from average: How COVID-19 has impacted the Average Weekly Earnings data | National Statistical.

Separate data, based on HMRC pay-as-you-earn (PAYE) data, shows that earnings have increased across the earnings distribution. In the 3 months to August 2022 earnings increased by between 5% and 7% at all points of the earning distribution above the lower quartile. Earnings growth was lowest at the 10th percentile although the earnings level (£700pm) indicates people not working full-time hours.

Table 5.12: Comparison of average monthly pay at different points in the United Kingdom wage distribution from HMRC real-time information.

Percentile	10th	25th (LQ)	50th (median)	75th (UQ)	90th	95th	99th
£ Per month	697	1,220	2,128	3,331	5,063	6,897	14,384
Annual increase	3.4%	5.9%	6.7%	6.4%	6.8%	6.4%	5.9%

Source: Office for National Statistics, HMRC real-time information - seasonally adjusted

Latest forecasts for whole economy pay growth, published by The Office for Budget Responsibility (OBR), are for average earnings to increase by 5.4% in 2022 to 2023, 3.5% in 2023 to 2024 and 1.6% in 2024 to 2025 which will include the impact of pay settlements, changes to workforce composition and pay drift. More information is available in HMT evidence.

Graduate level outcomes

Data from the longitudinal education outcomes (LEO) dataset can be used to monitor employment and earnings outcomes for graduates and postgraduates from English higher eduction providers 1, 3, 5 and 10 years after graduation based on information provided by the Department for Education, Department for Work and Pensions and HMRC. The data can be used to compare outcomes for healthcare graduates (including nursing graduates) against those from other courses.

Table 5.13 compares median earnings for nursing graduates to median earnings for graduates from other subjects 1, 3, 5 and 10 years after graduation. It shows that median earnings for nurses are initially around 29% higher than average before falling to around 7% below the median after 10-years. Over 10-years median pay for nurses and midwives increases by around 14% compared to just under 50% across all subjects. This may show a different profile to earnings over the course of someones career and this analysis may not adjust for differences in working patterns or individuals who may take time out of the workforce. The sample size for the period 10 years after graduation is smaller than for other time periods - one reason for this might be linked to the point at which nursing became a profession requiring a university which was announed in 2009 and implemented from 2013.

Outcomes for nursing graduates are shown to be consistently better than for some other subjects - courses consistently below average include performing arts, creative arts, agriculture, and media.

Table 5.13: Median earnings for nursing and midwifery graduates 1, 3, 5 and 10 years after graduation with comparison to all other subjects

Average earnings for first degree students	1 year after graduation	3 years after graduation	5 years after graduation	10 years after graduation
Nursing and midwifery	£27,800	£29,300	£30,000	£31,800
Nursing rank (34 subjects)	3	10	15	20
All subjects (student weighted)	£21,600	£25,100	£28,200	£32,200
Subject average (no weight)	£22,335	£26,718	£29,894	£34,014

Source: Longitudinal education outcomes (LEO) (Department for Education)

LEO also includes information on employment which shows that individuals with a nursing degree are more likely to be in sustained employment or training at all stages after graduation further highlighting the value of holding a nursing degree.

Table 5.14: Proportion of nursing first degree graduates in sustained employement, training or both after 1, 3, 5,and 10 years with comparison to other subjects.

Proportion in sustained employment, training or both (first degree only)	1 year after graduation	3 years after graduation	5 years after graduation	10 years after graduation
Nursing and midwifery	95.5	94.1	92.6	88.9
Nurse rank	2	1	1	2
All subjects (student weighted)	88.4	88.0	86.8	84.3

Source: Longitudinal education outcomes (Department for Education)

On this measure the figure of 92.6% being in work or training after 5 years for nursing is the highest of any subject with medicine being second at 92.5% and veterinary science at 91.6%. At the other end of the scale there are some subjects below 85% including 'combined and general studies' at 80.5% and business management (84.3%)

6. Total reward

Introduction to total reward

Pay makes up one part of the overall reward package, and whilst important, there are other benefits which have both financial and non-financial value which impact the motivation, recruitment and retention of the NHS workforce and should therefore be considered by the NHSPRB.

The total reward package in the NHS is generous, with non-basic pay making up an average of 29% of reward according to Government Actuary's Department (GAD) analysis.

The NHS reward package includes a generous holiday allowance, which goes up to 33 days annual leave per year on top of public holidays, sickness absence arrangements of up to 12 months of payment - well beyond the statutory minimum, access to a defined benefit pension scheme with an employer contribution rate of over 20%, enhanced parental leave, and support for learning, development, and career progression. These benefits are above the statutory minimum and exceed those offered in other sectors. Comparisons with the wider labour market should not just be limited to pay but include the full reward package.

DHSC has made a number of changes in the last year which are likely to have a positive impact on the reward package of staff. These include reforms to pension contributions, the continuation of retire and return easements, and new retirement flexibilities for late career staff.

Over the last year, NHSE and NHS Employers have furthered their guidance to employers to develop packages which support the recruitment, retention and motivation of staff.

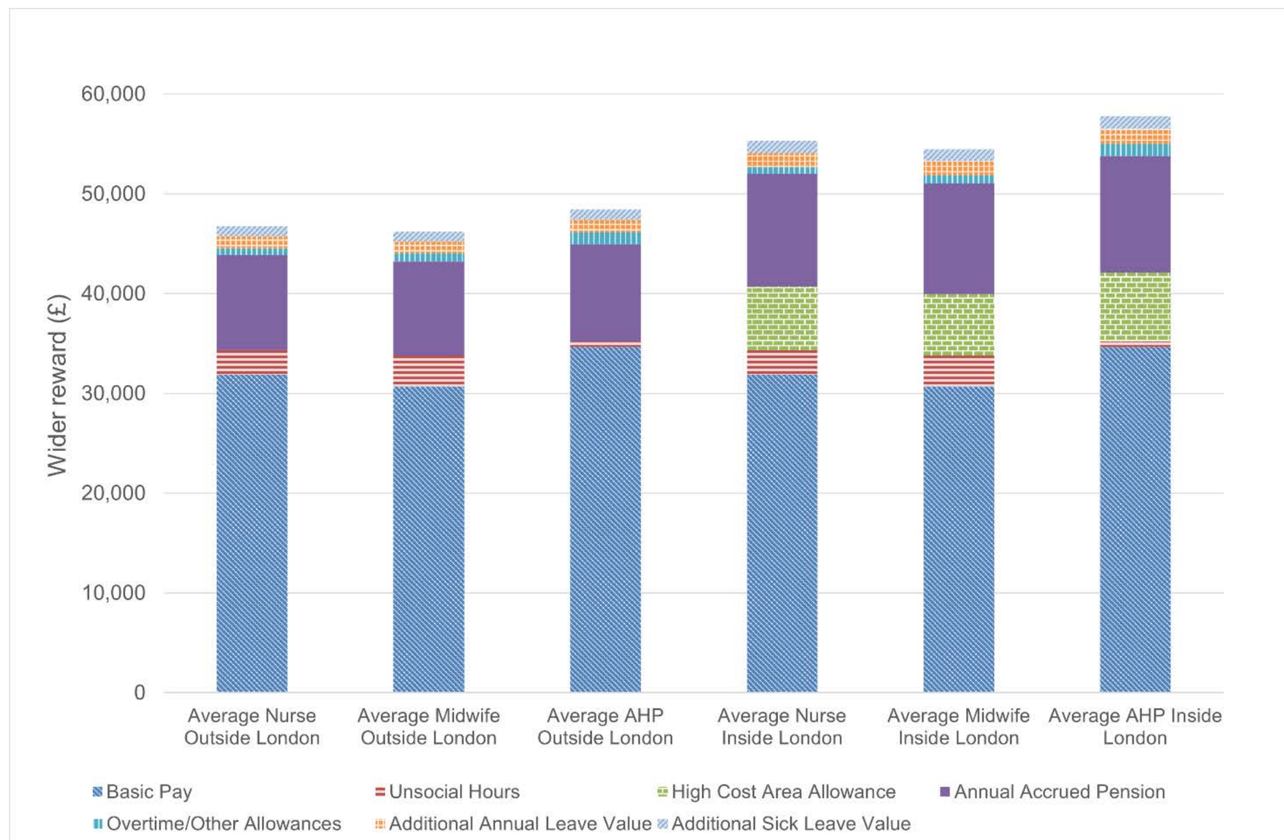
Measuring the value of the package

The department commissions GAD to measure the value of the total reward package for a range of NHS roles, as shown in Figure 6.1 below. The elements included in the package are basic pay, unsocial hours, high cost area allowances (HCAS), annual accrued pension, overtime or other allowances, additional annual leave and additional sick leave.

It is important to note that the basic pay definition used by GAD for the analysis this year is mean annual basic pay per person, whereas in previous years the definition used was mean annual basic pay per FTE. As a result of this change, basic pay for the average midwife is lower than basic pay for the average nurse, whereas last year it was higher

when based on pay per FTE. This suggests that more midwives than nurses work part time, which reduces the pay per person measure.

Figure 6.1: Value of the wider reward package for NHS staff



Description: a graph which shows the total reward package for an average nurse outside London, an average midwife outside London, an average AHP outside London, an average nurse inside London, an average midwife inside London and an average AHP inside London. The elements included in the package are basic pay, unsocial hours, high cost area allowances (HCAS), annual accrued pension, overtime or other allowances, additional annual leave and additional sick leave.

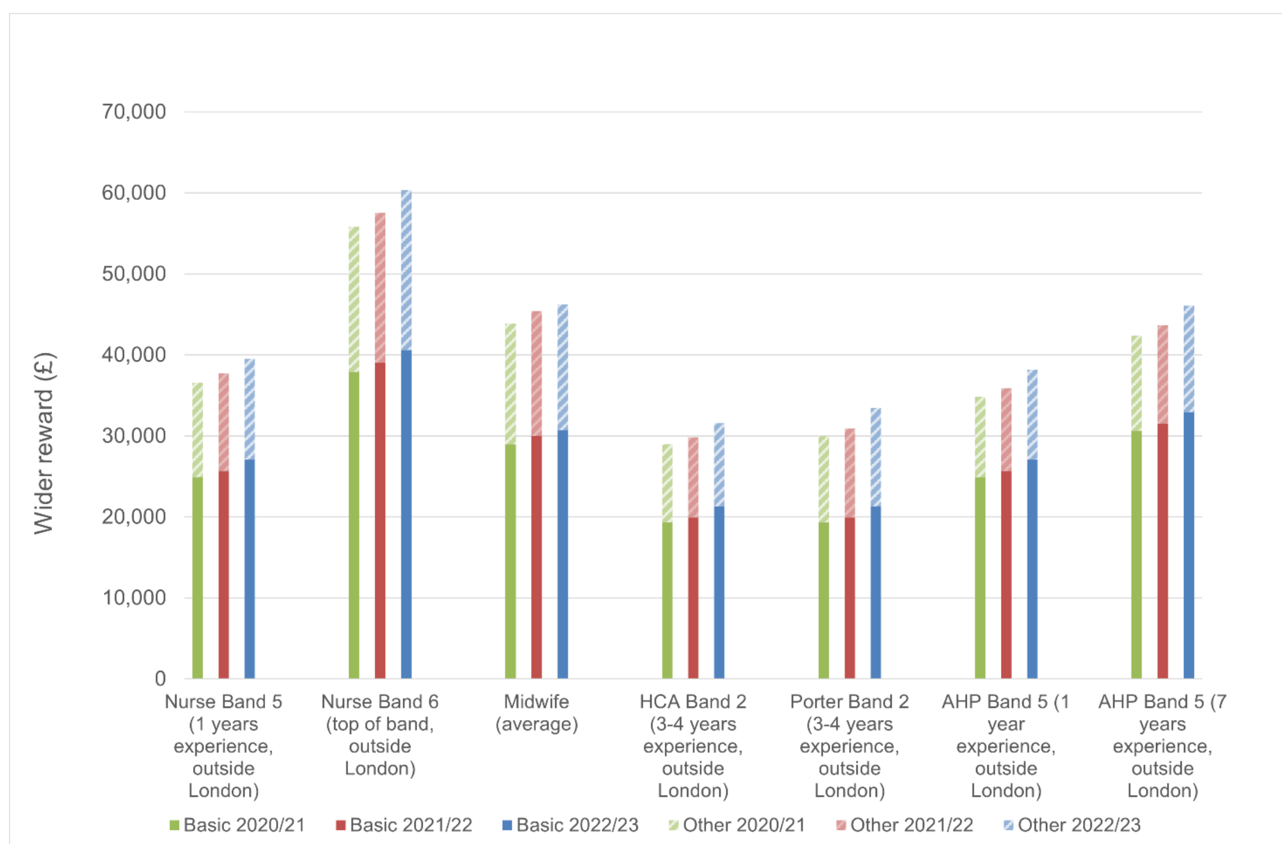
The department also commissions GAD to provide analysis of the trend in wider reward for NHS staff over time. Figure 6.2 shows average reward at 30 September 2020, 30 September 2021 and 30 June 2022. GAD believes the use of June data will only cause a negligible difference for the purpose of comparison. This is also consistent with the approach used in previous years and reflects the availability of the relevant data.

As above, the basic pay definition used for the analysis this year is mean annual basic pay per person so the analyses over 2020 to 2021 and 2021 to 2022 have also been updated for consistency.

The chart shows that all of the NHS roles considered have experienced an increase in total reward between 2020 to 2021 and 2022 to 2023, and all have at least 29% of their total reward package made up of non-basic pay. Overall, increases in the value of the total reward package are largely driven by increases to basic pay.

Of the roles considered, those in the lower bands generally received higher increases in total reward than those in higher bands. For example, band 2 porters (3 to 4 years' experience) received an increase of around 12%, and band 2 HCAs (3 to 4 years' experience) and band 5 AHPs (1 year experience) an increase of 9 to 10%. Band 5 AHPs (7 years' experience), band 5 nurses (1 year experience) and nurses at the top of band 6 experienced an increase of around 8%, and average midwives an increase of around 5%.

Figure 6.2: Wider reward trend for NHS staff, 2020 to 2021 and 2022 to 2023



Description: a graph which shows the average reward at 30 September 2020, 30 September 2021 and 30 June 2022 for a band 5 nurse (1 year experience) outside London, a nurse at the top of band 6 outside London, an average midwife, a band 2 HCA (3 to 4 years experience) outside London, a band 2 porter (3 to 4 years experience) outside London, a band 5 AHP (1 year experience) outside London, and a band 5 AHP (7 years experience) outside London.

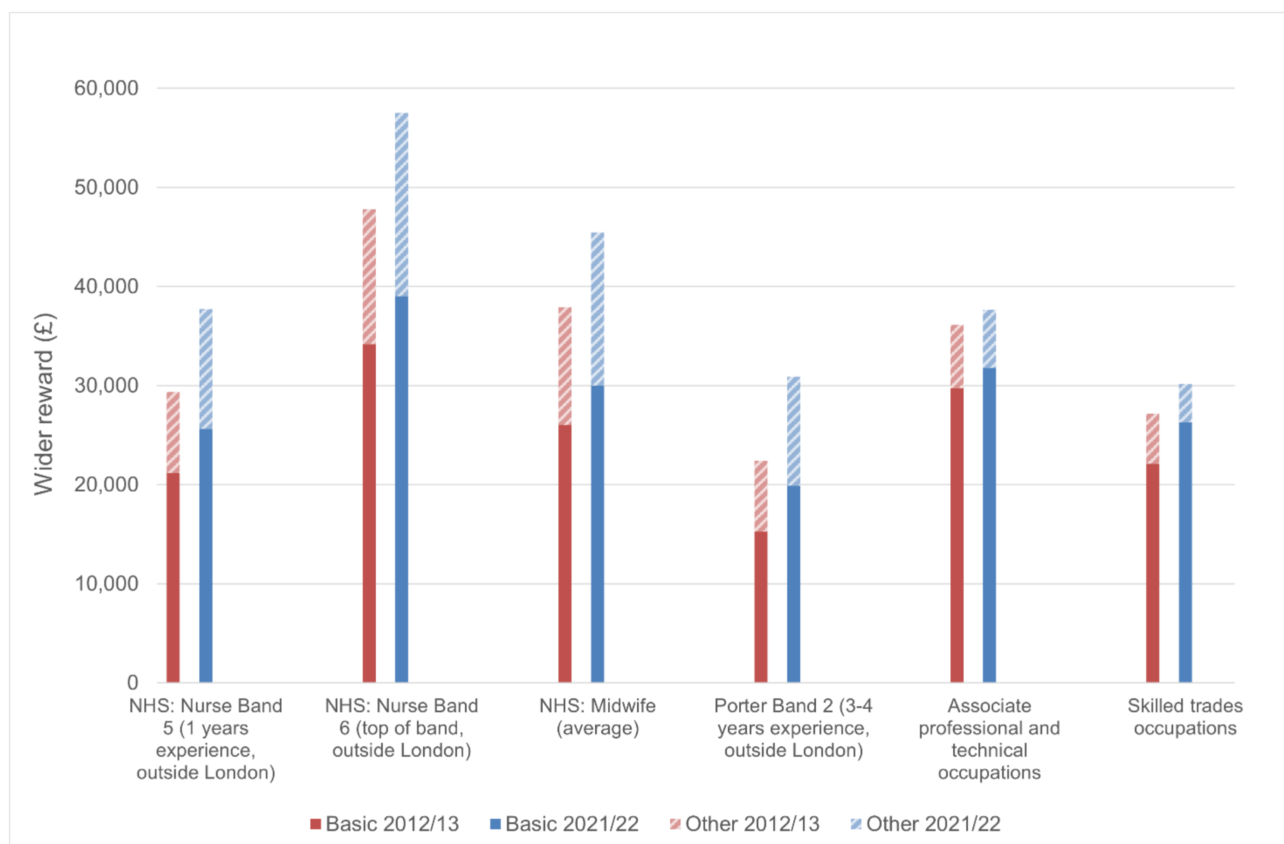
GAD also provide analysis of reward across various NHS roles and private sector occupations. This is designed to give an approximate indication on how wider reward

between roles and occupations change over time and not intended to provide a direct comparison between any NHS role and other occupation. This is largely due to the availability of data and difficulty between drawing appropriate comparisons with any one NHS role and other roles.

Figure 6.3 shows that all the NHS and private sector roles considered as part of the analysis experienced an increase in total wider reward over the period 2012 and 2021, with increases largely driven by increases to basic pay over the period, although the NHS roles experienced increases in total reward of between 20% and 38%, higher than the increases of 4 to 11% for the private sector occupations considered.

Non-basic pay makes up a larger proportion of total reward for NHS staff relative to private sector occupations, with ‘other’ pay making up at least 32% of total wider reward in 2021 to 2022 for all NHS roles considered. Across the private sector occupations considered, non-basic pay makes up around 16% of total wider reward for private sector associates and around 13% of total wider reward for skilled trades occupations. This may reflect the value of pension benefits and additional pay elements and awards available to NHS staff, relative to private sector employees.

Chart 6.3: Wider reward trends for NHS staff relative to private sector roles, 2012 and 2013 to 2021 and 2022



Description: a graph showing the wider reward trends over the period 2012 and 2021 for a band 5 NHS nurse (1 year experience) outside London, a band 6 NHS nurse at the top of the band outside London, an average NHS midwife, a band 2 NHS porter (3 to 4 years experience) outside London, a private sector employee in an associate professional and technical occupation, and a private sector employee in a skilled trade occupation'.

Enhanced parental leave

As well as the total reward elements included in the analysis above, NHS staff with 12 months continuous service with one or more NHS employers are also entitled to maternity benefits above the statutory entitlement. GAD estimate that an NHS employee earning £33,000 would be entitled to earn maternity pay of around £7,000 more than that they would be entitled to under the current statutory maternity pay (SMP) allowances.

This estimate is provided for illustrative purposes only and represents the additional value of NHS staff entitlement in excess of SMP. Maternity pay for NHS staff depends on the member's contractual entitlements and is calculated relative to the current statutory maternity pay entitlements.

Other benefits

Other than the national reward elements included in the above analysis, employers have the flexibility to enhance their local reward package, and many offer a range of benefits and discounts which have financial value to staff and may support recruitment and retention of staff and improve employee engagement.

Although the range of benefits offered varies across employers, some popular flexible benefits can include salary sacrifice schemes, options to buy and sell annual leave, and a range of discount vouchers, including the blue light card which is available to all NHS staff at a cost of £4.99 for 2 years. Some employers offer travel benefits such as season ticket loan and cycle to work scheme, as well as health and wellbeing benefits including discounted gym memberships. 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 using prepaid cards.

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% to 3% of basic pay on average across NHS employees.

Employers are stepping up this support, to make benefits go further. NHS Employers has developed guidance to support employers when offering benefits to mitigate higher living costs and to highlight what is available. These benefits can include:

- housing and utilities: rental deposit schemes, home electronics salary sacrifice scheme, accommodation and rent subsidies
- childcare: subsidised childcare, on-site nurseries, government tax free child support scheme
- travel: free parking, transport season ticket loans, public transport subsidies, pay expenses weekly
- food and leisure: free or subsidised meals on site, signposting to emergency service discount sites, access to free sanitary products
- other financial support: saving schemes, will writing services, financial education workshops, budget planning guidance, early access to pay

Flexible working

As a strong driver of retention, it is important to many NHS staff to have the opportunity to work flexibly, regardless of role, team, organisation, grade, or reason. 'We work flexibly' is one element of the people promise, which the NHS is committed to delivering for staff by 2024 to 2025.

The ambition is that all NHS staff should be offered the chance to work flexibly. This won't happen overnight and it's not always straightforward to accommodate all individual work preferences, but becoming a more flexible, modern employer in line with other sectors is vitally important and is key to retaining our existing staff and attracting new people into the NHS workforce. Flexible working is about more than just retention. It can unlock new opportunities and contribute to improving people's mental health, wellbeing and engagement with their role.

NHSE have developed a range of flexible working interventions and resources nationally to support local organisations to adopt flexible working practices across their organisations. These include:

- a published flexible working definition (Word, 220KB) and set of principles for all staff
- publication of 2 toolkits to support line managers in leading flexible workplaces for all and to help staff to prepare for positive conversations in requesting it

- proactive work with several organisations to review their approaches to flexible working and to encourage implementation
- development of a simple cost calculator to help organisations identify potential cost savings by calculating turnover, recruitment and bank and agency expenditure
- support to organisations in the implementation of effective use of e-rostering systems, accelerating roll-out where possible
- NHSE also encourages employers to implement the working carers passport to support timely, compassionate conversations about what support including flexible working arrangements would be helpful

The NHS Pension Scheme

The NHS Pension Scheme remains a valuable part of the total reward package available to NHS staff and is one of the best pension schemes available.

Eligible NHS staff 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 staff 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 the table below.

Table 6.1: Comparison of scheme, retirement age and accrual rate

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

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 originally given transitional protection, and so remained in their legacy pension schemes. In December 2018, the Court of Appeal found this protection to be discriminatory against younger members. This has become known as the 'McCloud judgment'. The government accepted the judgment applies to other public service schemes, including the NHS, and has set out how the discrimination will be remedied. This is known as the 'McCloud remedy'.

GAD calculates that scheme members can generally expect to receive around £3 to £6 in pension benefits for every £1 contributed. GAD has also estimated that a nurse with membership wholly in the 2015 scheme, progressing through AfC bands 5 and 6 and retiring at normal pension age, can expect an annual pension of around £30,000 in today's earnings terms.

It is important to note that this estimate assumes that the example member works full-time without any part-time working or career breaks. However, this figure would suggest that members who choose to work part time during their career or make use of the new retirement flexibilities (set out later in this document) can still expect to receive a good level of income in retirement, as measured against the retirement living standards as published by the pensions and lifetime savings association, especially when combined with their state pension entitlement.

The department keeps the rules of the pension scheme under review to ensure it continues to help the NHS attract and retain the staff needed to deliver high quality care for patients. In the past year it has made a number of changes in this area, including reforms to member contributions, the continuation of retire and return easements, and new retirement flexibilities for late career staff.

NHS Pension Scheme membership

The department continues to monitor scheme membership rates through ESR. Table 6.2 shows the total number of scheme members by staff group and AfC band remains high. Between June 2012 and June 2022, the percentage of all non-medical NHS staff who are members of the NHS Pension Scheme increased by 6%.

Staff group workforce totals and band workforce totals are based on data published by NHS Digital. It is important to note that this data differs from the data on scheme membership provided as part of its evidence to the NHSPRB in previous years, as the department has made adjustments to the ESR extract used to produce opt-out estimates in order to better reflect the actively working population. The membership rates do not include bank staff on zero hour contracts. However, these staff will be included if they also hold a substantive role and are members of the NHS Pension Scheme. The department has also chosen to use data from June rather than July going forward to ensure consistency with that provided in the evidence to the DDRB.

Table 6.2: NHS Pension Scheme membership for non-medical staff

Band	June 2022 headcount	June 2022 membership	1 year change	5 year change	10 year change
Band 1	4,000	80%	3%	0%	16%
Band 2	215,000	91%	1%	4%	14%
Band 3	177,000	91%	1%	3%	10%
Band 4	121,000	91%	0%	2%	6%
Band 5	239,000	88%	0%	0%	2%
Band 6	235,000	92%	0%	0%	1%
Band 7	148,000	93%	0%	-1%	-1%
Band 8a	56,000	94%	0%	-1%	-2%
Band 8b	21,000	94%	0%	-1%	-2%
Band 8c	11,000	94%	0%	-1%	-2%
Band 8d	5,000	94%	0%	0%	-2%
Band 9	2,000	91%	-1%	-3%	-5%
Nurses and health visitors	356,000	90%	0%	-1%	1%
Midwives	26,000	93%	0%	0%	1%
Ambulance staff	19,000	94%	1%	0%	-2%
Scientific, therapeutic and technical staff	178,000	94%	0%	0%	2%
Support to doctors, nurses and midwives	324,000	91%	1%	3%	11%
Support to ambulance staff	27,000	94%	1%	1%	4%
Support to ST&T staff	85,000	92%	1%	3%	11%
Central functions	115,000	90%	1%	3%	7%
Hotel, property and estates	75,000	89%	2%	6%	17%
Senior managers	13,000	92%	0%	-1%	-3%
Managers	24,000	92%	1%	1%	-1%
All groups and bands	1,243,000	91%	1%	1%	6%

NHS Pension Scheme contributions

Members and employers are required to pay towards the cost of benefits built up in the NHS Pension Scheme. At present employers contribute 20.6% of each member's pensionable earnings, plus a charge of 0.08% to fund the administration of the scheme. This is far more generous than most pension schemes offered in the private sector.

Member contributions have historically been tiered based on earnings, with higher earners paying more than lower earners. However, the scheme has moved from final salary linked to a career average revalued earnings (CARE) model, and all members have been accruing CARE benefits from 1 April 2022.

As DHSC's evidence to the NHSPRB last year set out, the department therefore considered that reforming the member contribution structure was appropriate, and it

launched a consultation NHS Pension Scheme: proposed changes to member contributions in October 2021. This was designed to ensure that the costs and benefits of the scheme are more evenly shared, with a view to preserving participation in the scheme and protecting its substantial value for members in retirement. The consultation initially proposed introducing the new structure from 1 April 2022. However, in recognition of wider economic challenges the department decided to delay the introduction of the updated member contribution structure to 1 October 2022.

For the scheme to be fair to all members, it was necessary to reduce the level of cross-subsidy by narrowing the range between the lowest and highest contribution rates. However, to encourage participation in the scheme, the contribution rates remain tiered and a discounted rate is provided for lower earning members in order to reduce the financial barriers that some staff may face when considering whether to save towards their retirement.

The new structure is being rolled out in 2 phases, the first of which was implemented from 1 October 2022. Under the new member contribution structure, 54% of members pay less than the average 9.8% yield and therefore receive a reduction on the average amount paid by members. Members who are paid at the bottom of AfC band 5 now pay member contributions at a rate of 7.7% from 1 October 2022, a reduction of 2.1 percentage points against the average rate. The discount is even greater for those whose annual pay equates to AfC bands 1 to 4.

The new member contribution structure also sees contribution rates based on actual pensionable pay rather than notional whole-time equivalent from 1 October 2022. Consequently, many part-time staff are now paying less pension contributions than they were last year.

Table 6.3: Member contribution structure from 1 October 2022

Tier	Pensionable earnings (rounded down to the nearest pound)	Contribution rate from 1 October 2022
1	£0 to £13,231	5.1%
2	£13,232 to £16,831	5.7%
3	£16,832 to £22,878	6.1%
4	£22,879 to £23,948	6.8%
5	£23,949 to £28,223	7.7%
6	£28,224 to £29,179	8.8%
7	£29,180 to £43,805	9.8%
8	£43,806 to £49,245	10%
9	£49,246 to £56,163	11.6%
10	£56,164 to £72,030	12.5%
11	£72,031 and above	13.5%

Retire and return easements

In Our plan for patients, DHSC announced an extension to the ‘retire and return easements’ in order to support retired staff to deliver their NHS work without impacting their pension.

Since March 2020, certain retire and return rules in the NHS Pension Scheme have been suspended to allow retired and partially retired staff to return to work or increase their working commitments without having the payment of their pension benefits abated or suspended. These measures were provided by Section 45 of the Coronavirus Act from March 2020 to March 2022 and continued until 31 October via temporary amendments to scheme regulations. This has allowed skilled and experienced staff to do more work for the NHS, providing a valuable capacity boost during peak periods of the COVID-19 response.

The department consulted on an extension of these easements to 31 March 2023 following concerns from stakeholders that an extension was required during the upcoming winter period, due to the expected increased demand on NHS services over winter. During consultation, a number of respondents felt that the suspension of special class status (SCS) abatement should be extended for a further period beyond 31 March 2023. The department has listened to these concerns and will extend the suspension of SCS abatement to 31 March 2025. More information about the suspension of other abatement rules is provided in the consuiltation response.

New retirement flexibilities

In Our plan for patients, the department announced its intention to introduce new retirement flexibilities to the 1995 section, subject to consultation. It launched a consultation 'NHS Pension Scheme: proposed amendments to scheme regulations' on a package of new retirement flexibilities, alongside other pensions measures, on 5 December 2022. The package includes a new partial retirement option for staff to draw on their pension and continue building it while working more flexibly and provisions to allow retired staff to build more pension in the 2015 scheme if they wish. As part of this package, the department also plans to permanently remove the ’16-hour rule’, which limits the amount of work retired staff can do in the first month of returning to service.

As a result of the McCloud remedy, all eligible staff were moved to the 2015 scheme for future accrual from 1 April 2022. This means that some members will now have service in both the 1995 Section and 2015 scheme, which have different rules on how members can claim their benefits. The department has therefore designed the proposed retirement flexibilities to address this issue and ensure that the rules are aligned for all members of the NHS Pension Scheme.

Because the McCloud remedy will mean that some staff may now be able to retire earlier than they had previously planned, the department has also considered that the flexibilities may also support workforce capacity, by providing incentives for staff to remain in service for longer on a more flexible basis. We would expect partial retirement in particular to strongly incentivise staff to continue working for the NHS rather than doing agency work or leaving completely.

Furthermore, when the 1995 section was designed, retirement patterns were understood to be relatively binary; staff would typically work full-time until claiming their benefits and retiring. After this point, members were unlikely to return to NHS service, and the rules of the scheme restricted the incentives to do so by preventing any further pension accrual. However, the department recognises that retirement today is often a gradual process over many years, and staff value the ability to retire flexibly, in a way that suits their work/life balance. The new retirement flexibilities will offer staff increased options at the end of their careers, so that they can partially retire or return to work seamlessly and continue building pension after retirement if they wish. The age group who are able to retire will not access their state pension until they are 66 or 67 and will benefit from continuing to work part time and building up more pension to both bridge the gap to the state pension and provide for a better retirement.

To ensure that members understand the new flexibilities and can make best use of them, the department has commissioned a programme of communications from NHS England and NHS Employers. This also includes producing materials that will show the value of the new flexibilities to employers and support them to provide the types of employment offers that complement the new options for staff.

Communicating the package

So that staff can unlock the full value of their reward package, ensuring that they receive clear and accurate communications is important.

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.

NHS Pension Scheme members also receive an annual benefit statement (ABS), which shows the current value of their Scheme benefits. On 23 September 2022, the number of statements was 2,812,443, with 297,035 views. This is a small increase compared to the same point the previous year, when the number of statements was 2,716,235 and the number of views 232,008.

The department commissions NHS Employers to provide advice, guidance, and good practice to the NHS on developing a strategic approach to reward, and communications with staff are coordinated by NHSE. NHSE and NHS Employers will provide further information on how individual employing organisations approach reward for their staff in their written evidence submissions.

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