Department of Health & Social Care

The Department of Health and Social Care's written evidence to the Senior Salaries Pay Review Body (SSRB) for the 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 also provides an overview of this year’s written evidence to the Senior Salary Review Body (SSRB).

This follows the 2022 to 2023 pay round, in which the government looked to the SSRB for a recommendation on pay for NHS Very senior managers (VSMs) and executive and senior managers (ESMs) and, after careful consideration, accepted the recommendations in full. This year, the government is again inviting the SSRB to make a pay recommendation for the senior NHS workforce.

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

Our evidence aims to provide information on the government’s approach to the pay and reward of NHS VSMs in NHS provider trusts and integrated care boards (ICBs) and ESMs within the Department of Health and Social Care’s (DHSC) ALBs. The evidence should be considered alongside that provided by NHS England (NHSE).

The NHS spending review settlements

In the challenging economic and fiscal context of 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 financial year 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 (HM Treasury have provided further evidence on the economic outlook). Whilst the UK 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 already 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. Furthermore, it is important to note that no funding is set aside for any VSM and ESM pay uplift. As such, any uplift would have to be funded through local reprioritisation of expenditure.

The 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, published 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 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 through:

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, the NHS, social care and local government has been set up to drive forward implementation of recommendations 1 and 2, 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.

The senior NHS workforce

Having leaders with the right skills, experience, values and behaviours is essential to the NHS delivering its priorities in a challenging fiscal context.

Chapter 3 of our evidence sets out the department's strategy for senior manager pay in the NHS and its commitment to a new national pay framework for VSMs. We ask that the SSRB consider their recommendations with the department's strategy in mind.

A VSM is defined as someone who holds an executive position on the board of an NHS trust, NHS Foundation Trust or ICB, or someone who, although not a board member, holds a senior position typically reporting directly to the chief executive. In some larger trusts, there is a growing number of senior staff being appointed to roles on local non-agenda for

change contracts who may report to other non-board level VSMs further down the organisational structure.

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

Chapters 4 and 5 set out how the VSM and ESM workforce has changed in the last year and should be read alongside the data provided by NHSE on VSMs. Recruitment and retention of senior leaders is crucial for the delivery of high-quality care and developing the next generation. Staff are motivated by their workplace environment and culture, and it is important to recognise the great strain COVID-19 has placed on all the health and social care workforce, including its leaders. Championing inclusion, diversity and prioritising health and wellbeing is therefore at the forefront of the NHS People Plan, and NHSE evidence will provide more detail on its aims to improve leadership culture.

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. While VSM terms and conditions are agreed locally, many are in line with those of AfC and many ESMs also benefit from flexible working conditions and performance-related pay. The total reward package is detailed in chapter 6.

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 efficiency targets for the NHS of 2.2% per year through to 2024 to 2025. This does not include the requirement 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 existing budgets. 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.

Excessive pay rises could impact trusts' ability to deliver on key priorities, such as manifesto commitments and elective recovery. It is therefore essential during this challenging fiscal and economic climate that pay remains fair, to recognise the vital importance of NHS staff, but affordable, to minimise inflationary pressures and help manage the country's debt. We urge SSRB 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 May 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 SSRB understands the impact of pay awards on the SR21 settlement and the commitments made within it. 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 its base rate to 3.5% in December 2022, its highest level in 14 years, to bring domestically generated cost pressures – namely nominal wage growth – down to levels consistent with its 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 SSRB, 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's 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) £billion	NHSE Capital Departmental Expenditure Limits (CDEL) excluding ringfence (RF) (cash) £billion
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: 2022-23 Variation to the Financial Directions to NHS England

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	2021 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 (£billion)	NHS provider permanent and bank staff spend (£billion)	% of spend on staff	Increase in total spend	Increase in provider permanent and bank staff spend
2013 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 2018	109.5	49.9	45.6%	3.63%	4.64%
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%

Table notes:

- 2013 to 2014 to 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 £6.0 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.

Doctors and dentists in training are currently in the final year of a 4-year pay and reform deal, covering up to financial year 2022 to 2023. Overall investment in 2022 to 2023 was 3% with headline pay awards of 2%, with the further investment in the form of enhanced terms and conditions and a new top pay point, nodal Point 5. Specialty and Associate Specialist (SAS) doctors are also currently in a multiyear deal, covering financial years 2021 to 2022 to 2023 to 2024. This agreement sets out increases to pay and amendments to the 2008 Specialty Doctor contract and introduced a new senior Specialist contract, which increased the earnings potential for the workforce. Investment averages at 3% per year of the deal.

The British Medical Association's (BMA) General Practitioners Committee (GPC) and NHSE agreed a 5-year GP General Medical Services (GMS) contract framework from 2019 to 2020 to 2023 to 2024. This agreement, along with £4.5 billion of additional investment by 2023 to 2024, aims to expand the general practice workforce, transforming the system to address workload and retention issues and better meet patient needs.

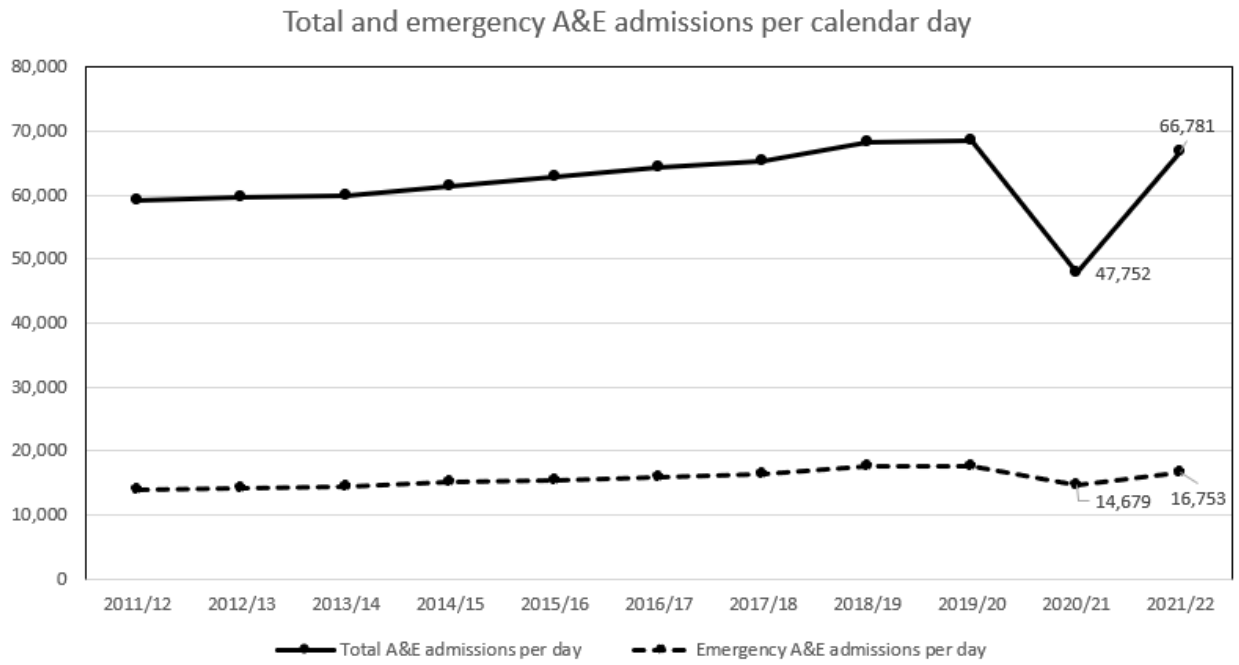
This shows that over recent years, DHSC has embarked on both pay and contract reform across the NHS workforce. AfC staff, doctors and dentists in training and specialty doctors have all benefited from modernisation of terms and conditions and changes to pay scales to better reward increasing experience and expertise. As these reforms have illustrated, this is not just about headline pay uplifts but reforming pay structures to increase career earnings potential and 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 financial years 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 figures 2.1 and 2.2.

Despite the continuing best efforts of the NHS, many of the improvements between years 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 this 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 financial year 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 2.2 shows increases in productivity in the health and wider economy from 1995 to 1996 until 2019 to 2020.

Figure 2.2 - Productivity growth in health and the wider economy up until financial year 2019 to 2020

Productivity measures are indexed to 1995 to 1996 = 100.

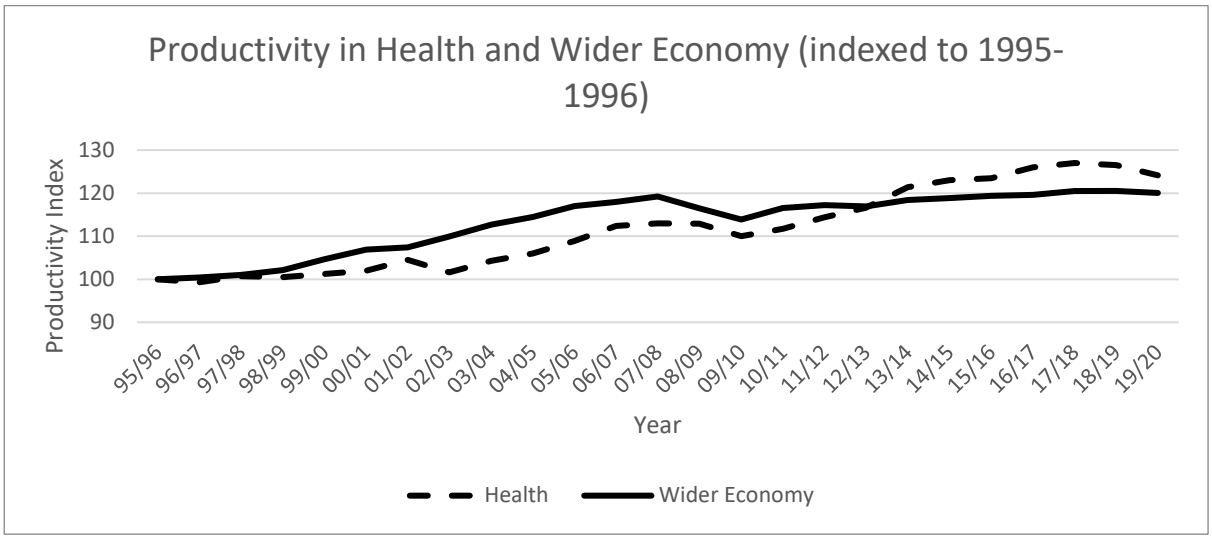


Table 2.5 - Average productivity growth in health and the wider economy, both prior and after the financial crash.

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, the Office for National Statistics (ONS) does publish public service productivity measures quarterly, allowing the effect of COVID-19 to be observed. These measures don't 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 financial year 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). More information is given 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, 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 the isolation period to be reduced from 10 to 7 days with 2 negative lateral flow tests; and stepping down COVID-19 precautions for exposed patient contacts, with removal of the 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 United Kingdom 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 so 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 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 that saw a saving of £3.57 billion by January 2020, supporting average productivity growth of 1.6% from 2010 to 2019.

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.

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

Against the backdrop of substantial inflationary pressures that are having a widespread impact on the whole economy, it is important that the SSRB 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 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). 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 that 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.

Pay rises above what is affordable will impact the government's commitments and what the NHS has set out to achieve. These are challenging times for everyone, and our focus is ensuring a fair pay award that 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 SSRB 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. Senior manager pay

Scrutiny of senior manager pay

VSMs and ESMs are not typically covered by a national contract which is subject to national collective bargaining; they hold local contracts of employment with their employer. Medical directors, however, who are employed on consultant contracts, have their pay framework and other terms agreed through the consultants' joint negotiating committee.

It is therefore right that senior manager pay is properly scrutinised at a national level to ensure value for money, transparency and consistency. Senior manager pay is determined through national guidance, but additional scrutiny is put in place where pay above £150,000 requires DHSC oversight. Similar requirements exist for ICBs.

For NHS trusts and foundation trusts (FTs), ministers review all cases that propose paying £150,000 or above where the proposed pay does not fall within the parameters of the framework ('non-routine' cases). Where the proposed pay is £150,000 or above but does fall within the parameters of the framework, these cases are reviewed and signed off at DHSC director level. FTs have legislative freedom to set their own pay rates for VSMs, so although they are required to submit pay cases above the threshold, they do so on a ‘comply or explain’ basis. Where the department does not agree with the rationale for the remuneration level offered, the minister will inform the FT of this.

ICBs are also required to submit pay cases for proposed salaries for executive directors (other than for chief executives) above the agreed thresholds or £170,000, whichever is the lower. For ICB chief executives the threshold is the ‘operational maximum’ of the relevant sized ICB – running from £197,500 for the smallest ICBs to £270,000 for the largest. For ICB executive directors, besides the chief executive, the relevant thresholds are based on ICB size and on 4 role types: director of finance, director of nursing, medical director and other executives. Where an ICB wishes to pay a higher salary it must submit a pay case to ministers for approval.

The DHSC Remuneration Committee has oversight of ESM pay. They have delegated some authority to ALB remuneration committees – for example, salaries for appointments into existing roles at ESM 1 and ESM 2, up to the operational maximum. DHSC Remuneration Committee approval is required for the salary of all new roles, salaries for ESM 1 and ESM 2 replacements with a salary above the operational maximum, and all chief executive, ESM 3 and ESM 4 roles.

All roles with a remuneration package of £150,000 or more require both DHSC Remuneration Committee and Secretary of State approval prior to an appointment (this includes salaries for those on medical, dental and GP contracts). In addition to DHSC Remuneration Committee and DHSC ministerial approval, Chief Secretary to the Treasury

approval is required for all salary packages of £150,000 or more that are also above the exception zone maximum for their band (in line with the HM Treasury Guidance for approval of senior pay).

The oversight of senior manager pay helps reduce excessive pay competition between providers and helps deliver value for money for the taxpayer, while still ensuring that exceptions can be made if there is sufficient justification. The new framework can enable ministerial scrutiny to be focussed where it is most beneficial.

NHS senior pay strategy

Pay levels for VSMs and ESMs should ensure that the right talent is maintained to ensure effective leadership across the health and social care system, whilst assuring the taxpayer that it remains good value for money. In the current challenging economic climate, which is putting increased pressure on NHS budgets, it is increasingly important that senior manager pay is fair, but not beyond what is required.

Following last year's helpful recommendations from the SSRB on NHSE's VSM framework proposals, the department has worked closely with NHSE to ensure its strategy for senior manager pay is reflected in this new VSM pay framework, setting pay for senior managers at the right level. We continue to progress the framework with NHSE.

We welcomed the comments the SSRB made on the draft proposals last year, which NHSE have now incorporated into the framework, alongside the recommendations of the Kark Review, including that all directors should meet specified standards of competence to sit on the board of any health providing organisation.

As with the existing draft provider framework, the new framework benchmarks provider VSM pay against a relevant range based on trust type and size. For ICBs, it benchmarks VSM pay against population size weighted against criteria, including socioeconomic geography (with struggling areas allowed to pay higher salaries). For providers, the criteria for higher pay in struggling areas continues to be based on existing criteria, such as the single oversight framework (SOF) rating and/or the CQC rating of ‘requires improvement’. Payments may also be made for additional responsibilities.]

The framework aims to provide consistency to VSM pay in a non-inflationary manner. Additional payments have become more focussed, such as with the new very challenged trust premia, where payments are now time limited. The application of VSM pay will remain broadly the same as the previous draft framework and employers will continue to be able to seek exceptions from DHSC where they have a strong justification.

The annual pay uplift, informed by the recommendations of the SSRB, is separate to the pay setting process. The exception to this is where an employer proposes to pay an annual uplift above the recommended amount, in which case the regular pay-setting process, outlined above, applies.

There is no intention to increase the pay band maxima (the upper quartiles for VSMs and the exception zone maximum for ESMs) during the 2023 to 2024 pay year. Within the challenging economic context, we expect that any consolidated pay increases should only apply for those whose pay is in line with the VSM framework or within the ESM pay bands. This includes those who were appointed at levels in line with the framework and have subsequently been given annual uplifts as approved from the government. As a result, any pay awards to people paid above such thresholds should be non-consolidated to avoid expanding, instead of narrowing, pay discrepancies.

With regards to recruitment and ensuring that salary levels are sufficient, the government can, and will, continue to approve exceptional pay cases where an additional pay premium is needed, for instance because of specific skill shortages or particularly challenging geographies, providing sufficient justification is given. Approving by exception, therefore, can represent a better targeted use of resource compared with an unnecessary higher across-the-board uplift.

Last year, the SSRB recommended a further 0.5% to ameliorate the erosion of the differential with the top of Agenda for Change (AfC) band 9 and facilitate the introduction of the new VSM pay framework. If the SSRB were to recommend a similar style of award for 2023 to 2024, while noting that any uplift should only be given where necessary, we would welcome more flexibility to enable organisations to use any additional percentage to address a wider range of pay anomalies and allow organisations to target areas specific to their workforce.

4. Very senior managers (VSMs)

We estimate there are just under 2,900 (headcount) VSMs working across both trusts and ICBs. The number of VSMs working across trusts has increased by 145 when compared to June 2021. Table 4.1 shows a table with an estimate of VSMs in trusts, FTs and ICBs in June 2022.

Workforce numbers

Table 4.1 - Number of VSMs as of June 2022

Organisation type	Headcount	FTE
Trusts and FTs	2,183	2,096
ICBs	691	464

Source: NHS Digital Workforce Statistics.

Note: includes staff with the following job roles: board level director, chief executive, director of nursing, finance director, medical director, Other executive director, chief information officer, chief operating officer, chief people officer, chief strategy officer, chief sustainability officer, deputy chief executive, estates and facilities director, improvement director.

There are limitations in identifying VSMs and ESMs through administrative data systems. Together with the department, NHSE is making progress in attributing VSMs and ESMs on the Electronic Staff Record (ESR). We expect the completion of this work to follow development of the new framework.

Because the definition that has been used to identify VSMs includes an earnings threshold, it may not be suited to identifying workforce trends over time. (Due to wage growth we would expect more staff to earn over a given threshold in 2021 to 2022 than would have done 10 years ago.) As an alternative, table 4.2 shows how the number of people with a 'job role' that indicates they are a member of the executive team has changed since 2010, with a small increase over the past year.

Table 4.2 - Board level time series for staff working in NHS trusts and FTs 2010 to 2022

Month	Headcount	FTE
June 2010	2,206	2,122
June 2011	2,074	1,992
June 2012	2,011	1,924
June 2013	1,454	1,424
June 2014	1,469	1,435
June 2015	1,491	1,459
June 2016	1,525	1,492
June 2017	1,568	1,525
June 2018	1,588	1,549
June 2019	1,618	1,578
June 2020	1,658	1,617
June 2021	1,676	1,626
June 2022	1,734	1,683

Source: NHS Digital Workforce Statistics.

Table 4.2 shows a table with a time-series of staff with 'board level' job roles.

Note: board level includes Sustainability Officer, Deputy Chief Executive, Estates and Facilities Director and Improvement Director.

Very senior manager earnings

Table 4.3 shows average pay and earnings for VSMs based on the staff definition used in table 4.1.

Average earnings for the cohort are over £143,000, which is broadly similar to the previous year. These statistics will not yet take into account the impact of the 2022 to 2023 pay award that was implemented, with backpay, in September 2022, and which allowed for basic pay for VSMs to increase by 3%, with an additional 0.5% to manage potential overlaps with the AfC workforce. The changes will include the impact of any changes in the composition of the workforce over the period and where they sit on the relevant pay framework.

Table 4.3 - Average pay and earnings for VSMs in NHS trusts - July 2021 to June 2022

Average pay and earnings	VSMs in trusts	Change in average earnings
Basic pay per FTE	£140,153	-0.3%
Basic pay per person	£134,401	-1.1%
Non-basic pay per person	£9,435	7.3%
Total earnings per person	£143,836	-0.6%

Source: NHS Digital Earnings Statistics.

Table 4.3 features a table showing average pay for VSMs in trusts, broken down by different types of income, and how that pay has changed.

As already described, DHSC has worked with NHSE on a new national pay framework for VSMs in the NHS.

With the establishment of ICBs in July 2022, a temporary VSM pay oversight criteria has been put in place as an interim measure while the new comprehensive framework was negotiated. Officials agreed provisional frameworks with NHSE for CEOs and other executive directors in ICBs. Currently, CEOs should typically be paid amounts slightly above a comparable role at a trust and with a similar approvals process. Furthermore, socioeconomic factors are used to weight the ICB turnover size and set a corresponding salary, rather than as a supplementary measure as with the trust framework. With the salaries predicated on those in trusts rather than existing salaries (given the organisations are new), the threshold is the ‘operational max’ of the relevant sized ICB – running from

£197,500 for the smallest ICBs to £270,000 for the largest. For other executive directors, the salary is determined in a similar manner to CEOs, but the rates are compressed so that the lower-tier and upper-tier pay rates are more closely aligned with those in the middle.

Three CEO pay cases out of 42 positions and 31 other executive directors out of hundreds of other positions were submitted for higher salary amounts – the cases that have been submitted to us therefore suggests that the pay agreements were largely sufficient.

The SSRB should expect to receive information on the levels of VSM pay and the total remuneration of VSMs from NHSE. To collect this information for the 2022 to 2023 pay round NHSE have undertaken a data collection exercise of a sample of trusts.

Beyond this data collection exercise, NHSE publishes VSM pay benchmarking data that plots VSM pay across different VSM roles and different types and sizes of trust. This benchmarking data forms part of the current VSM pay guidance, where it is expected trusts appoint VSMs at no higher than the median for the benchmarked range.

In addition to information on pay, it is also expected that NHSE will provide the SSRB with information on the recruitment and retention of VSMs along with diversity information as is presented within chapter 5 on ESMs below.

Diversity analysis

It is possible to split the number of VSMs in trusts and ICBs according to various demographic groups including gender, ethnicity and age. The data suggests that most VSMs are white with only 9% of VSMs in trusts being from ethnic minorities, although this represents an increase of 0.8 percentage points since June 2021. This figure is 15% for VSMs in ICBs. There is now an even gender split. Around 82% of VSMs in trusts and 76% of VSMs in ICBs are aged between 45 and 64, which is not unexpected given the level of experience required to be equipped for these roles.

Table 4.4 - VSM diversity analysis, June 2022

Group	Proportion in trusts	Proportion in ICBs
Ethnicity: white	85%	76%
Ethnicity: ethnic minorities	9%	15%
Ethnicity: not stated or unknown	6%	9%
Gender: male	50%	50%
Gender: female	50%	50%
Age: 25 to 34	0%	1%
Age: 35 to 44	15%	18%
Age: 45 to 54	45%	43%
Age: 55 to 64	37%	33%
Age: 65 and over	3%	4%

Source: NHS Digital Workforce Statistics. Note: Figures may not add to 100% due to rounding.

Table 4.4 shows a table outlining diversity information by ethnicity, gender and age band for VSMs.

NHS Digital has supplied information on average basic pay per FTE split by gender or ethnicity group as shown in table 4.5, which provides information from June 2022 and shows the current gender and ethnicity pay gaps for VSMs working in NHS trusts.

For staff in the VSM grade there appears to be a relatively small gender pay gap (indicated by female staff within a particular ethnicity having lower pay than male staff of the same ethnicity) and a small ethnicity pay gap (where ethnic minority staff of one gender have lower pay than white staff of the same gender).

Table 4.5 - Gender and ethnicity pay gap (GPG) and ethnicity pay gap (EPG) for VSMs in NHS trusts based on basic pay per FTE, June 2022

Grade	Ethnic group	Female	Male	GPG (female to male)	Female EPG (to white)	Male EPG (to white)
VSM	Asian and Asian British	£11,402	£11,479	-1%	-2%	-6%
VSM	Black and black British	£10,872	£11,926	-9%	-6%	-2%
VSM	Mixed or multiple groups	£11,572	£11,716	-1%	0%	-4%
VSM	White	£11,612	£12,176	-5%	N / A	0%
VSM	Other ethnicity groups	£10,382	N / A	N / A	-11%	N / A
VSM	Unknown	£11,054	£11,677	-5%	-5%	-4%
Non AfC grade	Asian and Asian British	£10,616	N / A	N / A	-5%	N / A
Non AfC grade	Black and black British	£10,802	N / A	N / A	-4%	N / A
Non AfC grade	Mixed or multiple groups	£11,202	£10,878	3%	N / A	N / A
Non AfC grade	Unknown	£12,709	£11,876	7%	13%	6%

Source: NHS Digital Earnings Statistics.

Recruitment and retention

As part of its remit, the SSRB should consider how the reward package is able to attract people to join the workforce and then retain them.

There are different ways to measure recruitment and retention by looking at the numbers of people who join and leave the VSM group, as well as those who may move around the system.

Data from NHS Digital estimates there were 211 VSMs in NHS trusts who left the sector between July 2021 and June 2022 (a turnover rate of around 10%) and a further 151 who left their current organisation but remained within the sector by moving to a different NHS organisation. The overall turnover rate is a little higher than last year (9.1%) but comparable with the wider NHS. Turnover may have been lower than usual during the pandemic.

Table 4.6 shows reasons for leaving for those staff who left the NHS entirely over the period. Around 45% of staff record a reason for leaving linked to retirement with a further third of staff making a voluntary resignation. Data on reason for leaving is self-reported and not validated.

Table 4.6 - Reasons for leaving for VSMs leaving NHS trusts between June 2021 and June 2022

Reason for leaving	Count	Proportion
Linked to retirement	95	45%
Voluntary resignation	68	32%
End of fixed-term contract	23	11%
Unknown	10	5%
Redundancy	9	4%
Other	6	3%

Source: NHS Digital Workforce Statistics.

Over the same period there were 105 staff who became VSMs from outside of the NHS and 220 who joined the VSM group from within the NHS (including staff moving organisation).

Motivation and morale

As mentioned above, we are continuing to work with NHSE and ESR to ensure that VSMs and ESMs are better captured, allowing NHSE to access NHS staff survey results through use of background ESR data. NHSE has provisionally designated codes for VSM roles as per the new VSM framework, which should enable better capturing of such data. NHSE will provide information regarding motivation and morale from the National Salary Survey Team and will additionally provide the Leadership Academy's statistics on this area.

Labour market context

It is instructive to compare earnings for VSMs against similar professions in the wider economy based on either the role profile or earnings level. NHS VSMs in trusts and ICBs have a high level of remuneration compared to the rest of the healthcare workforce and the wider economy, as might be expected for staff working at such a high level of responsibility.

As shown in table 4.3, average earnings for VSMs working in NHS trusts and FTs were just under £144,000 in the 12 months to June 2022. Compared to data from the Annual Survey of Hours and Earnings (ASHE) UK, published by the ONS, this places VSMs in the top 1% of the earnings distribution (99th percentile = £130,378).

ASHE data can also be used to assess how earnings for similar groups of staff in the wider economy have changed over time. For NHS VSMs, the most natural comparator might be the ASHE group of "Chief Executives and Senior Officials", which includes chief executives, senior civil servants and elected representatives.

Table 4.7 shows that this group had median gross annual earnings of £67,026 in 2022 and have consistently had some of the highest median gross annual earnings compared to other professions. Although median earnings appear to have fallen for this group over the past decade, it is unclear the extent to which this is a genuine decrease or if it reflects changes to the composition of the workforce or sampling effects. Mean annual earnings for this group were just over £104,000 in 2022, which was a small reduction (3.3%) on the previous year compared to the mean change for NHS VSMs of -0.6%, as shown in table 4.3, based on data preceding the 2022 to 2023 pay award.

Table 4.7 - Ranking of chief executive and senior officials median gross annual earnings compared to the wider population in 2012, 2017 and 2022

Group	SOC10 code	SOC20 code	2012 median gross annual earnings (SOC10)	Rank	2017 median gross annual earnings (SOC10)	Rank	2022 median gross annual earnings (SOC20)	Rank
Chief executives and senior officials	111	111	£76,732	1	£81,302	1	£67,026	1
Transport associate professionals	351	351	£60,809	3	£75,487	2	£61,845	2
Functional managers and directors	113	113	£51,801	5	£56,760	4	£57,337	3
Senior officers in protective services	117	116	£54,923	4	£56,651	5	£57,179	4
Medical practitioners	2211	221	£61,007	2	£61,289	3	£54,663	5
Other drivers and transport operatives	823	823	£38,314	10	£40,947	10	£49,136	6
Business and financial project management professionals	2424	244	£41,999	7	£45,355	6	£48,780	7
Health and social services managers and directors	118	117	£41,151	8	£40,988	9	£46,172	8
IT professionals	213	213	£39,024	9	£41,837	8	£45,826	9
Research and development and other research professionals	215	216	£42,759	6	£45,101	7	£45,057	10

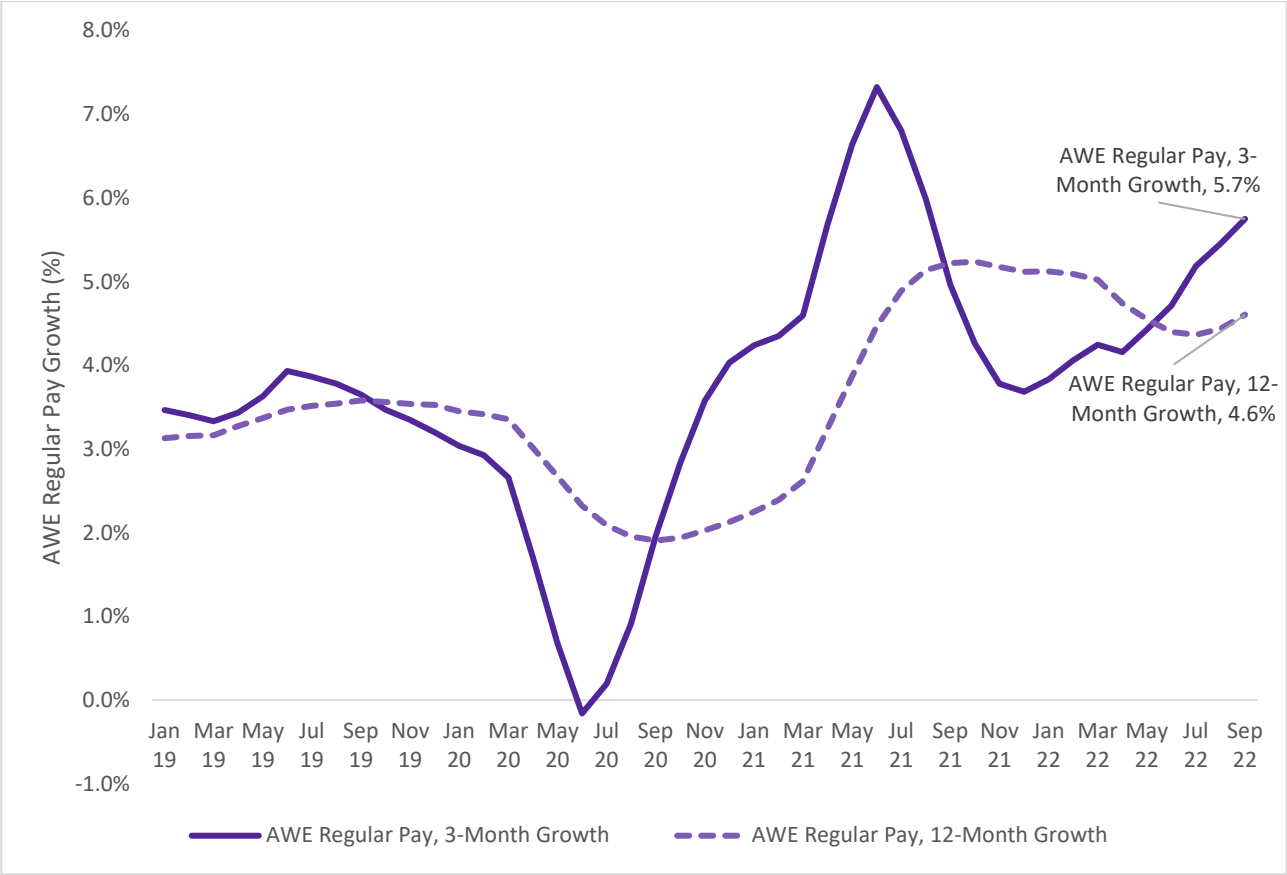
Source: Annual Survey of Hours and Earnings.

There may be some evidence that remuneration in the NHS is flatter than for large companies in the private sector. Analysis from the High Pay Centre, based on statutory disclosures, shows that the average ratio of chief executive pay to that of the median employee in the FTSE 350 was 44:1 in 2020 to 2021 (and potentially even higher in 2021 to 2022). Meanwhile, in the NHS, average earnings for those with a job role of chief executive was £203,652 against median average earnings for non-medical staff of around £29,000, which is a ratio of around 7:1.

For more timely information on changes in pay and earnings across the economy, ONS publishes 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 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 pandemic period.

The latest 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 means 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 4.1 - Increase in average weekly earnings, 3-month growth and annual growth rates



Source: ONS, Average Weekly Earnings (all sectors).

For the VSM cohort we might also be interested in how earnings have changed at the very top of the earnings distribution. 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 September 2022, earnings increased by between 5% and 7% at all points of the earning distribution above the lower quartile. Earnings growth for the 99th percentile (around £14,400 per month) was just under 6% over the last 12 months.

Table 4.8 - Comparison of average monthly pay at different points in the UK wage distribution from HMRC real-time information

Amount	10th percentile	25th percentile (LQ)	50th percentile (median)	75th percentile (UQ)	90th percentile	95th percentile	99th percentile
£ 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: ONS, HMRC real-time information, seasonally adjusted.

5. DHSC arm's length bodies (ALBs) executive and senior managers

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

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

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

There are around 470 ESMs working in our executive agencies and ALBs and within the core department.

Data return analysis

As part of the work to develop an evidence base for the SSRB for the 2023 to 2024 pay round and beyond, DHSC requested in-depth data on their ESMs from 12 ALBs. DHSC also completed a data return due to a small number of ESMs that transferred to the department as a result of the closure of Public Health England. This is referred to henceforth as the ALB data collection.

This analysis therefore provides an overview of the 13 data returns received. The raw data return has been submitted to the SSRB separately.

ALBs included

Table 5.1 shows a table outlining a list of organisations that have submitted data for this report.

Table 5.1 - ALBs that have submitted data for this report

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

Source: ALB data collection.

Pay analysis

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

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

Table 5.2 - ESM pay bands

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

Source: ESM Pay Framework.

Table 5.2 shows a table outlining pay bands for ESM grades.

Due to the timing of the 2022 to 2023 pay award communications and the timing of the ALB data collection, not all organisations have had the opportunity to implement the 2022 to 2023 pay award in advance of the data collection.

Below is a summary of the average basic pay and average total pay for all ESMs. Following very little change between 2020 to 2021 and 2021 to 2022 due to the one-year public sector pay pause, average basic pay has increased by around 2.4% in 2022 to 2023, most likely due to the partial implementation of the annual pay uplift.

Some ESMs benefit from additional payments, such as additional responsibilities allowances, along with other payments that are included in the average total pay calculation. This year we have more information on the performance-related pay elements that some ESMs received, which could explain the slightly higher increase in the average total pay by around 2.6%.

Table 5.3 - Basic and total pay by year

Year	Average basic pay	Average total pay
2020 to 2021	£125,470	£126,890
2021 to 2022	£125,284	£126,390
2022 to 2023	£128,263	£129,637

Source: ALB data collection.

Below is a summary of the average basic pay and average total pay broken down by ESM grade. For ESM 1 the average is just above the midpoint of the range, for ESM 2 is it at the midpoint of the range and for ESM 3 the average pay is above the top of the range.

Table 5.4 - Basic and total pay by ESM grade for 2022 to 2023

Grade	Average basic pay	Average total pay
ESM 1	£118,348	£119,052
ESM 2	£146,478	£148,176
ESM 3	£199,437	£200,204

Source: ALB data collection. ESM 4 not included due to low numbers.

Allowances

ESMs may have different allowances included within their total remuneration package. A number of these are legacy allowances that are not available to new starters (for example, vehicle allowance) or are protected payments. The average allowance received was £9,709. The most prevalent allowance within the data sample was an additional responsibility allowance which 6% of ESMs had included within their total package. The average additional responsibilities allowance was £11,063.

Diversity analysis

Ethnicity breakdown

Table 5.5 - Proportions of white and minority ethnic ESM employees

Ethnicity	Proportion 2020 to 2021	Proportion 2021 to 2022	Proportion 2022 to 2023
White	79%	81%	78%
Ethnic minorities	8%	7%	9%
Not stated	14%	12%	13%

Source: ALB data collection.

The proportion of ESMs from an ethnic minority background has decreased by 2% since last year.

Gender

Table 5.6 - Proportions of male and female ESM employees

Gender	Proportion 2020 to 2021	Proportion 2021 to 2022	Proportion 2022 to 2023
Male	52%	48%	47%
Female	47%	52%	53%

Source: ALB data collection.

The proportion of women in ESM roles has increased since last year to 53%. There is a higher ratio of women to men at ESM 1 (54%:46%) and ESM 3 (67%:33%) although it is worth noting the small sample size at ESM 3 (4.5% of ESMs are ESM 3). At ESM 2, the female to male ratio is 48%:52%. Overall, there is little disparity between average male and female pay as shown in table 5.7.

Table 5.7 - Average basic and total pay for ESM employees by gender

ESM Grade	Female average basic pay	Female average total pay	Male average basic pay	Male average total pay
Total	£127,776	£129,188	£127,524	£128,721

Source: ALB data collection.

Motivation and morale

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

For the ALBs that use the standard NHS staff survey, as outlined in chapter 3, it is not currently possible to separate out VSM and ESM responses, although this is being explored for future years. The smaller ALBs that run their own engagement surveys are not able to identify ESM results, as the cohorts are too small. Of the 3 ALBs who were able to provide engagement data, all 3 showed ESM engagement scores higher than those of the general population.

ESM annual pay award

Annual pay uplift

The remuneration and annual performance-related pay of ALB CEOs and their executive directors paid under the terms of the ESM Pay Framework is determined by the DHSC Remuneration Committee. The Committee operates within the parameters set by the Cabinet Office and in light of the government’s response to the SSRB's recommendations for any pay round.

For the 2021 to 2022 pay round, the SSRB was not asked for a pay recommendation for any senior managers in their remit, including health. In line with the Spending Review 2020 position, it was agreed that ESMs would not receive a consolidated pay increase as they, along with VSMs in the NHS, were included within the wider public sector pay pause. Therefore, for the 2021 to 2022 pay round, no ESMs across any of the ALBs received a consolidated pay increase.

For the 2022 to 2023 pay round, the government accepted the SSRB recommendations in full for VSMs and ESMs. These were:

- an across-the-board increase of 3% for all VSMs and ESMs from 1 April 2022
- a further 0.5% to ameliorate the erosion of differentials and facilitate the introduction of the new VSM pay framework

This was communicated to ALBs, alongside confirmation that:

- the funding for any uplifts will need to come from existing budgets and that spending should be approved by ALB remuneration committees
- ESMs undertaking performance improvement plans should not receive pay increases, including annual pay awards

As mentioned above, at the time of data collection not all ALBs had had the opportunity to implement the pay award but all indicated that the award would be taken forward by the December pay period.

Performance related pay for ESMs

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

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

For the 2022 to 2023 pay round, the DHSC Remuneration Committee agreed that:

- there was no formal restriction on the percentage of ESMs who could be given an award. However, they still expected to see differentiation in performance and a spread of performance ratings
- if ALBs proposed to pay awards to more than 40% of ESMs, a business case had to be submitted to the DHSC Remuneration Committee
- individuals could receive a non-consolidated award of up to but no more than 5% of their reckonable pay (the exception to this being if a higher percentage has been agreed previously as part of a total remuneration package approved by DHSC Remuneration Committee and Ministers and/or HMT where appropriate)
- any money spent on NCPRP must come from existing budgets

At the time of data collection, only 4 organisations gave evidence to show they are using the flexibilities surrounding performance-related pay. Of the 3% of ESMs that the data showed received any performance-related pay, the average award was £4,844, a slight increase on last year's average of £4,558, probably linked to the fact that a number of the awards were a percentage of base salary, and base salary has increased as a result of the pay award. A further 4 ALBs indicated their intention to use the flexibilities surrounding

performance-related pay following discussions at their internal Remuneration Committee but, as decisions had not been taken, were unable to submit the amounts at the time of data collection.

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 and impact the motivation, recruitment and retention of VSMs and ESMs, and should therefore be considered by the SSRB.

The total reward package in the NHS is generous. Whilst arrangements for VSMs and ESMs are for employers to decide locally, terms and conditions are in many cases broadly similar to those offered under Agenda for Change. These often include: 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. VSMs may also benefit from local arrangements, such as car and relocation allowances. ESMs within the ALBs may also benefit from flexible and hybrid working conditions, including the ability to work from home, allowances and performance-related pay. Comparisons with the wider labour market should not just be limited to pay but include the full reward package. The SSRB has previously found that these additional benefits, in general, are competitive.

Over the past year the government has made a number of changes which are likely to have a positive impact on the reward package of senior staff. These include reforms to pension contributions, new retirement flexibilities for late career staff and measures to support those impacted by pension tax.

Over the last year, NHS England and NHS Employers have also furthered their guidance to employers to develop packages that support the recruitment, retention and motivation of staff, including VSMs and ESMs.

Wider benefits

Other than the national reward elements, employers have the flexibility to enhance their local reward package, which benefits senior NHS staff, too. Offers often include a range of benefits and discounts that have financial value to staff and may support recruitment and retention.

Although the range of benefits offered varies, 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 also 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 a 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 will vary depending on the specific benefits options offered and the level of benefits taken up.

The NHS Pension Scheme

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

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, new retirement flexibilities for late-career staff, and measures to support VSMs and ESMs impacted by pension tax.

NHS Pension Scheme membership

The department continues to monitor scheme membership rates through ESR. Table 6.2 shows that the scheme membership for VSMs with basic pay of over £110,000 per year is high, at 80%, and table 6.3 shows that there has not been a notable change in membership rate for this group between June 2021 and June 2022.

However, membership rates for VSMs decrease as basic pay increases, from an estimated membership rate of 84% for those with basic pay of £110,000 to £125,000, to an estimated membership rate of 57% for those with basic pay of over £200,000. Further investigation is necessary to explain this. However, the department recognises that pension taxation may be a factor. This is explained in more detail later in this evidence chapter.

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

- estimates are based on staff with a recorded basic pay per FTE of at least £110,000, who were working in June 2022
- estimates cover staff working in the Hospital and Community Health Sector – including NHS trusts and support organisations. CCGs and ICBs are not included
- estimates include all non-medical staff who reach the salary threshold and are not working under AfC

- estimates include medical staff if they are not working under AfC and have a job role that indicates they are a member of the executive team (for example, Medical Director). A positive employer pension contribution is used as the proxy of pension membership

Table 6.2 - Membership of the NHS Pension Scheme for VSMs at June 2022

Salary range	Estimated membership rate
£110,000 to £125,000	84%
£125,000 to £150,000	84%
£150,000 to £175,000	73%
£175,000 to £200,000	61%
> £200,000	57%
All	80%

Table 6.3 - Annual change in membership of the NHS Pension Scheme, June 2021 to June 2022

All	+ 0.2%

It is possible that some VSMs who opt out may be in receipt of recycled employer contributions. This means that they would not appear in scheme membership data but would continue to receive the full value of their reward package. Others may feel that they have already saved sufficiently for their retirement.

It is currently difficult to show the size of an average VSM pension accrued in the scheme, as the department does not hold data on local employment arrangements. Table 6.4 shows the annual pension that would be accrued by a VSM should they join the 2015 Scheme from 1 April 2023 at pensionable pay levels of £110,000, £125,000, £150,000, £175,000 and £200,000. Salary and CPI increases are assumed to be 2% per year in each future year. It is important to note that these figures do not include any allowance for Annual (AA) or Lifetime Allowance (LTA) tax charges.

It is also important to note that this year's pension projections are lower than previous projections provided in evidence to the SSRB. This is solely attributable to updating the assumptions that are used to project pension benefits to NPA and to discount the pension projections to present the figures in current earnings terms. Previously, we assumed that CPI and general earnings increases would each be 2% per year, whereas this year's projections assumed that CPI will be 2% per year and general earnings increases will be 4.2% per year (in line with the 2016 valuation assumptions). Using a higher earnings assumption has resulted in pension projections being discounted by a higher rate resulting in lower pension amounts in today's earnings terms.

Table 6.4 - Estimated pension accrual by pensionable pay and length of service

Pensionable pay	5 years' service	10 years' service	15 years' service
£110,000	£10,000	£19,600	£29,000
£125,000	£11,300	£22,300	£32,900
£150,000	£13,600	£26,800	£39,500
£175,000	£15,900	£31,200	£46,100
£200,000	£18,100	£35,700	£52,700

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 SSRB last year set out, the department therefore considered that reforming the member contribution structure was appropriate, and it launched a consultation on a new member contribution structure 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 to reduce the financial barriers that some staff may face when considering whether to save towards their retirement.

The new structure narrows the range between the lowest and highest contribution rates and is being rolled out in 2 phases, the first of which was implemented from 1 October 2022. As the new contribution structure is implemented, full-time lower earners are more likely to pay a slightly higher percentage than in previous years, and higher earners are more likely to pay slightly less. This is likely to benefit VSMs and ESMs, who are generally higher earners in the NHS.

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 6.5 - Member contribution structure from 1 October 2022

Tier	Pensionable earnings (rounded down to 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%

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 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, as well as 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. In particular, we would expect partial retirement to strongly incentivise staff to continue working for the NHS rather than 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.

The department also believes that the new flexibilities could also support VSMs and ESMs impacted by pension tax to continue to deliver their NHS work whilst reducing their pension tax exposure. This is because if they choose to partially retire and take 100% of their 1995 Section benefits, they will be able to crystallise their legacy pension, making future work planning easier.

Pension tax

As discussed in previous evidence submissions, the generosity of the NHS Pension Scheme and well-remunerated careers means that some VSMs and ESMs exceed the AA and LTA for tax-free saving. The department is aware that experience of pension tax is important to the retention of these staff.

To address this, the government previously delivered on a manifesto commitment to solve the taper issue in the NHS Pension Scheme, by increasing the tapered annual allowance thresholds by £90,000. Although the evidence of the impact of pension tax on service delivery was strongest for senior clinicians, the government took an evidence-based approach to the issue, which also considered the impact on VSMs. This £2.2 billion commitment therefore excluded all staff with earnings below £200,000 from the scope of the taper.

For those who do receive charges, the ‘Scheme Pays’ facility allows members to meet the cost of a tax bill from the value of their pension benefits, without needing to find funds upfront. Where a member uses Scheme Pays, the scheme applies an interest rate that will reduce the value of pension benefits at retirement.

All members who pay into the 2015 NHS Pension Scheme and those members with career average benefits in the 1995 and 2008 Sections of the NHS Pension Scheme have their pension benefits revalued at the end of each scheme year by the 12-month increase in the Consumer Price Index (CPI) to the previous September, plus 1.5%. This revaluation helps maintain the purchasing power of career average pension benefits over time.

A higher rate of revaluation benefits members by increasing the size of their career average pension pots, resulting in an increased pension pot at retirement. There is an increased risk of an AA tax charge in a situation where inflation is increasing. However, in situations where inflation is reducing, there may be increased headroom for more pension growth before incurring a tax charge. To reduce the risk that senior staff could face an AA tax charge as a consequence of the current high rate of CPI, the department announced in Our plan for patients that it would amend the revaluation date for career average pension benefits in the NHS Pension Scheme for scheme year 2022 to 2023 and future scheme years.

This measure will move the revaluation of career average accrued pension and earnings in a scheme year by 5 days, from 1 April, at the end of a tax year, to 6 April, at the start of the following tax year. The effect would be that the same rate of CPI would then be used for the revaluation and the calculation of pension benefit growth for annual allowance purposes. This ensures that the annual allowance operates as intended in relation to NHS pensions and the high inflation environment does not create higher tax charges. The department set out more detail on this proposal in the consultation launched on 5 December 2022.

The department is also working with NHSE to encourage NHS trusts to develop appropriate local solutions and has asked NHSE to support NHS trusts to explore local flexibilities that are available to them within the NHS Pension Scheme. These local solutions include employer contribution recycling, where employers pay the unused portion of employer contribution as additional pay where staff opt-out of the scheme because they have exceeded their allowances for tax-free pension saving.

NHSE is also delivering a retention programme focused on employers making flexible employment offers to staff, engaging their high earners on pension tax issues and promoting the value of the pension scheme. This includes comprehensive communications and piloted seminars to engage staff on flexible retirement options and pension tax.

Communicating the package

For staff to unlock the full value of their reward package, it is important that they receive clear and accurate communications.

Total reward statements (TRS) are provided to all 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.