Department of Health & Social Care

The Department of Health and Social Care's written evidence to the NHS Pay Review Body for the pay round 2024 to 2025

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Contents

Data and evidence sources

The Department of Health and Social Care (DHSC) is committed to ensuring that our evidence to the Pay Review Bodies is transparent and upholds the principles of the Code of Practice for Statistics.

Most data that we use comes from published sources and includes links to source material. Where required, we describe any transformations to source data. In a small number of cases, we include DHSC analysis of other data sets where such analysis is not possible from other sources – in these cases we outline the data that has been used and the rationale behind its inclusion.

Our core data sources, and the primary chapters they relate to, are listed below.

Core sources

Workforce planning, education and training (Chapter 3)

Chapter 3 provides more detail on the NHS England Long Term Workforce Plan (LTWP) and how current and future programmes of training, education, recruitment, and retention will support the plan's ambitions. It is supported by chapter 4 which details the size and make-up of the current workforce and how this has changed in the last year.

The NHS staff survey (Chapter 4)

The NHS staff survey continues to provide a valuable insight into the aspects of staff experience in the workplace. The latest staff survey took place in November 2023 and the results will be published on 7th March 2024. The most recent available data is from the March 2022 survey National results across the NHS in England NHS Staff Survey.

The electronic staff record (Chapters 4 and 5)

The electronic staff record (ESR) is the HR and Payroll system used by NHS providers (trusts and foundation trusts) in England but does not cover primary care, social care or the independent sector.

The ESR is a comprehensive dataset with more than 1.5 million rows of data per month. It provides high quality data on the roles people are employed to do and what they are paid. We acknowledge that there is varying robustness to this data with the quality of some data items (such as reason for leaving) being less than other data items (for example., pay) and it cannot track people moving from secondary care into other parts of the health system.

- NHS England data on average earnings for NHS Staff (based on ESR data) - NHS Staff Earnings Estimates
- NHS England data on the NHS workforce (based on ESR data) - NHS workforce statistics
- NHS England vacancy data (based on ESR and other sources) - NHS Vacancy Statistics (and previous NHS Vacancies Survey
- We also perform our own analysis of the ESR where this is not possible via standard publications (for example, longitudinal tracking) or in some cases may separately commission data where data are not routinely published or not published at the desired level of granularity. The data accompanying these commissions are available at NHS England HCHS workforce data pack 2023 - NHS Pay Review Body evidence

Labour market data (Chapter 5)

Data for the wider economy is primarily sourced from the Office for National Statistics who produce a range of statistics on average earnings across the economy, including by occupation group. We also draw on information published from other bodies including the Low Pay Commission and the Department for Education.

- ONS data on earnings in the wider economy - Labour Market Overview and Annual Survey of Hours and Earnings
- DfE data on Longitudinal Education Outcomes - LEO Graduate outcomes provider level data, Tax year 2020-21

Supplemental data

To assist the Pay Review Bodies with pay costings, we have supplied more granular estimates on the costs of employing different types of staff in the NHS. The data for 2021 to 2022 and 2022 to 2023 is Supplementary evidence to NHSPRB: hospital and community health sector. These estimates are based on ESR data which is scaled to NHS England workforce estimates.

1. NHS strategy and introduction

This chapter provides the context for the department's evidence to the NHS Pay Review Body (NHSPRB) for the 2024 to 2025 pay round, as well as a brief overview of the evidence itself.

For the 2023 to 2024 pay round, the government asked the NHSPRB to provide pay recommendations for all Agenda for Change (AfC) staff. However, after remit letters were issued, AfC unions began a period of industrial action in response to the 2022 to 2023 pay award, leading to direct negotiations with government.

Following these negotiations, the NHS Staff Council voted by a majority to accept the government's final offer in May 2023. In light of this, the Secretary of State for Health and Social Care wrote to the NHSPRB standing them down from providing recommendations for 2023 to 2024, and instead asking for observations on the AfC workforce in their report. This year the government is inviting the NHSPRB to provide pay recommendations for its full remit. It is vital that the PRBs consider the historic nature of the 2023 to 24 awards and the government’s affordability position.

The NHS workforce

Recruiting and retaining a skilled and diverse workforce is essential to meeting key health objectives such as addressing the elective backlog, improving access to primary care and bolstering urgent and emergency care. There are currently record numbers of staff working in the NHS. In the past year there are over 71,200 more people working in the NHS, including over 6,600 more doctors and 20,700 more nurses. The government has also delivered on its 50,000 additional nurses manifesto commitment 6 months early, with over 360,000 nurses working across the NHS – over 59,000 more than September 2019.

The LTWP, published by the government in June 2023, sets out the plan to train, retain and reform to meet the workforce requirements the NHS has for the future. The plan models workforce supply and demand to 2036, providing a roadmap for workforce expansion, reform and retention and highlighting the need to prioritise the NHS settlement to enable this and deliver key objectives. Having the right workforce to meet future demand will be a key driver of staff engagement and staff retention. The government's 2023 mandate to NHS England reinforces, this, making it clear that a well-trained and well supported workforce is central to the delivery of its priorities.

While the LTWP sets out a path for a more sustainable future workforce position, the NHS mandate priorities sets out the direction of travel to start this journey. Priority 2 in the mandate is 'support the workforce through training, retention and modernising the way

staff work', each of these elements will be expanded upon by our, and NHS England's, evidence.

The core of this priority is realising the intention in the LTWP to putting NHS workforce supply in England on a sustainable footing, recognising this is collectively driven by multiple factors, not just pay, but also dependent on drivers such as workload, reforms to education and training, improved working environments and more positive working cultures, more flexible working practices, and opportunities for learning and continuous professional development. So, putting the workforce on a sustainable footing is not just about size and pipeline, it is also about staff health, wellbeing, and morale. Workplace culture is an important driver of motivation, and the government recognises the role that a diverse and inclusive workplace that prioritises staff wellbeing has to play in recruitment and retention. As part of the deal made with AfC unions in May, a number of commitments were made to support the NHS workforce. This includes work to tackle violence, improve support for newly qualified health registrants and support existing NHS staff develop their careers through apprenticeships. This work is currently underway, and the implementation of these commitments is being overseen by a dedicated Programme Board. The department is working collaboratively with trade unions, NHS England and NHS Employers to make progress and to deliver changes that will benefit both NHS staff and patients.

Chapter 3 provides more detail on the LTWP and how current and future programmes of training, education, recruitment, and retention will support the plan's ambitions. It is supported by chapter 4 which details the size and make-up of the current workforce and how this has changed in the last year. Broadly, this evidence shows a growing workforce with a steadily increasing variety of entry points to an NHS career becoming available, especially through apprenticeships and growing numbers of training places in specialities like general practice. There is further to go, however, if the NHS in England is to meet the ambitions set by the LTWP, especially regarding retention.

Looking to the future, the total reward package, which includes but is not limited to pay, will continue to be important in attracting and retaining the workforce the NHS needs. Chapter 5 looks at the earning and expenses data across the remit group to demonstrate the value of total financial reward for NHS staff. Chapter 6 then gives more detail on how the NHS pension and non-pay offers from employers round out the total reward package.

The NHS settlement

In 2023 to 2024, the financial pressures on the NHS settlement have become more pronounced due to inflationary pressures, the lasting impact of COVID-19 on budgets and industrial action.

As we enter the final year of the spending review settlement agreed in 2021, and despite additional funding that has been made available in the intervening period, the NHS England and DHSC settlement is stretched. The recurrent impact of the 2023 to 2024 pay awards continues to affect budget capacity in 2024 to 2025 and means flexibility beyond the planned affordability at the 2021 spending review (SR21) is extremely constrained. The ongoing impact of inflation and industrial action is also putting unforeseen pressures on all budgets, including the costs to trusts of covering strike days. Inflation is significantly higher than the assumptions in which the SR21 settlement was made within. These pressures have necessitated the reprioritisation of budgets for 2024 to 2025 even prior to subsequent decisions on this 2024 to 2025 pay award.

While 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. HM Treasury have provided further overarching evidence on the economic impact of the PRB settlements across different workforces.

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.

We look forward to receiving your report in May 2024.

2. NHS finances

This chapter describes the financial context within which NHS pay awards will need to be set.

The focus for the NHS continues to be recovering overall performance following the COVID-19 pandemic, including addressing the significant elective recovery challenge. This will be achieved through supporting innovation, the adoption of the right digital health technologies, and through ensuring that the workforce is well supported to continue delivering the excellent care it provides. Long-term NHS financial sustainability is essential to achieving these objectives.

However, the financial landscape poses significant challenges. With inflationary pressures continuing to impact the wider economy, the pay awards should be considered in the context of the commitments made within the SR21 settlement. This is leading to unforeseen pressures on budgets. These pressures are compounded by the recurrent impacts of COVID-19 and industrial action on budgets. Taken together, the financial landscape has already necessitated the reprioritisation of budgets for 2024 to 2025.

Although SR21 and subsequent fiscal events have provided new funding for DHSC and NHS England, including substantial additional funding for the elective backlog, the health and social care system still holds significant cost pressures resulting from the lasting impact of the COVID-19 pandemic. This year, exacerbated by the impact of industrial action, it was necessary to provide additional support to the NHS to meet pressures during the winter months. This was included as part of the financial package announced in November 2023, providing systems with £800 million. Furthermore, the ongoing impact of inflation on funding and the costs of delivering services means budgets are continuously being stretched. For example, systems had initially planned to overspend by £720 million in 2023 to 2024 but are now at a significant risk of further overspends.

There is also a system challenge for 2024 to 2025 of meeting the efficiency and productivity savings as set out in SR21, as well as refining and implementing plans to deliver the labour productivity ambition of up to 2% (at a range of 1.5-2%), as set out under the LTWP. This is significantly higher than the c. 1% per year the NHS has historically delivered. The current settlement also requires the NHS to deliver annual efficiency savings of at least 2.2% each year.

Pay awards should be considered within this context.

Economic context

Inflation and the lasting financial impacts of COVID-19 and industrial action are putting unforeseen pressures on all budgets and, as a result, government borrowing. In this context, the government is committed to price stability and has re-affirmed the Bank of England's 2% CPI target at the Autumn Budget.

Inflation has more than halved since its peak in Autumn 2022 of over 11% but remained well above the 2% target in December 2023 at 4.0%. This is significantly higher than the assumptions within which the SR21 settlement was made. The expectation at the time was that inflation would peak at 4.4% in Q2 2022. The Bank of England forecast that inflation will return to the 2% target in the second quarter of 2024 before rising slightly again, towards the end of the forecast period.

The Bank of England's resulting increases in its base rate to 5.25%, the highest level in decades and necessary to bring down high inflation, have weighed on economic growth. This has resulted in additional borrowing costs for many mortgage-holders, businesses, and government. The government is committed to supporting the MPC to bring inflation back to target by aligning fiscal and monetary policy. Further borrowing, above what is forecast, would add to inflationary pressure which would in turn put upward pressure on interest rates. Despite initial economic growth at the start of the year, the UK economy formally entered into a technical recession with a contraction of 0.5% across Q3 and Q4 2023.

Funding growth

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 the lasting impact of the COVID-19 pandemic, will further enable the NHS to deliver better service and health outcomes for patients.

The government is committed to delivering its manifesto commitments on workforce, ensuring that we can keep growing a diverse and skilled NHS workforce through the Long Term Workforce Plan. The government announced £2.4 billion with the publication of the plan to fund additional education and training places over 5 years.

To support elective recovery, the government plans to spend more than £8 billion between 2022 to 2023 and 2024 to 2025. As part of the Autumn Statement 2022, the government announced an additional £3.3 billion for 2023 to 2024 and 2024 to 2025 to support the NHS in England, enabling rapid action to improve emergency, elective and primary care

performance towards pre-pandemic levels. The department has also committed to a £5.9 billion investment in capital for new beds, equipment, and technology.

Table 1 - Mandate Funding 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	158.521	0.330
2023 to 2024	163.326	0.444
2024 to 2025	165.841	0.219

Source: 2023 to 2024 financial directions to NHS England

Table 1 above shows the closing mandates for NHS England up to 2022 to 2023, the opening mandate in 2023 to 2024, and indicative amounts for future years, in line with the outcomes of SR21 and the Autumn Statement 2022. The 2023 to 2024 and 2024 to 2025 RDEL figures have not yet been adjusted for education and training budgets. 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.

Financial position

The government's 2023 mandate to NHS England outlines the headline objectives for the NHS. The 2023 to 2024 Financial Directions to NHS England reflect further funding to deliver manifesto commitments agreed at Spring Budget 2020, as well as funding to meet considerable pressures arising due to the lasting impact of the COVID-19 pandemic and to support the recovery of elective services in the 2022 to 2023 financial year.

The NHS ended the 2022 to 2023 financial year in a marginal underspend position - a smaller underspend than in 2021 to 2022. A proportion of this underspend is driven by specific ringfenced budgets, and so alternative uses of this spend would not be possible.

In the provider sector specifically (as set out in the table below), there is now a significant deficit position of nearly £1 billion, which is a marked deterioration on the year before. Final audited spend in the 2022 to 2023 financial year will be laid before Parliament and available in NHS England's published Annual Report and Accounts.

However, the fiscal and economic environment has pushed the NHS into a challenging financial position in 2023 to 2024 onwards. The 2023 to 2024 pay awards have been financially challenging on the DHSC Group in the context of the wider financial and economic context described above and will continue to have a knock-on impact on future years. NHS England are also facing increasing and significant pressures on their budgets through inflation and industrial action. For example, NHS providers are incurring additional pay costs to secure staff cover on strike days and to catch up on lost activity to reduce the elective backlog.

Table 2 shows the breakdown of funding provided to NHS providers since the 2017 to 2018 financial year, including preliminary outturn data for 2022 to 2023.

Table 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	2022 to 2023
Gross deficit	2,433	2,755	1,560	158	126	1,001
Gross surplus	-1,337	-1,889	-567	-363	-442	-299
Reporting adjustment	-105	-39	-323	-450	-240	-252
NHS providers SRP (Sector Reported Performance)	991	827	670	-655	-556	450
Plus additional RDEL adjustment	47	-1	338	-77	-39	528
Net NHS providers RDEL NRF	1,038	826	1,008	-732	-595	978

Share of resources going to pay

Table 3 shows the proportion of funding consumed by NHS provider permanent and bank staff spend since the 2016 to 2017 financial year. Note that NHS provider permanent and bank staff spend only covers staff working within hospital and community health settings, excluding agency spend by these organisations.

Table 3: Increases in revenue expenditure and the proportion consumed by pay bill

Year	NHSE RDEL (£ billion)	NHS Provider Permanent and Bank Staff Spend (£ billion)	% of spend on staff	Increase in total spend	Increase in provider permanent and bank staff spend
2016 to 2017	105.7	47.7	45.1%	n/a	n/a
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	56.1	46.6%	5.34%	6.75%
2020 to 2021	140.6	62.7	44.6%	16.65%	11.79%
2021 to 2022	146.5	66.2	45.2%	4.21%	5.47%
2022 to 2023	155.7	71.1	45.6%	6.25%	7.39%

Notes:

- 2016 to 2017 to 2019 to 2020 NHS England RDEL represents the budget, while underspend was negligible.
- 2019 to 2020 NHS England 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.
- 2022 to 2023 represents the budget, as underspend was negligible, excluding £2.8 billion for the revaluation of the NHS pensions scheme.
- 2019 to 2020 NHS provider permanent and bank staff has been revised since last year's evidence to the Pay Review Bodies due to recalculation of exclusion for the revaluation of NHS pensions.
- 2022 to 2023 NHS provider permanent and bank staff excludes £2.5 billion for the non-consolidated pay award.

- Figures in the table are correct to the specified level of significance. Percentage increases may not match increases calculated from budget or spend figures as given in the table due to rounding.

In 2023 to 2024, the pay awards were above the government's affordability envelope. As a result, a reprioritisation exercise within DHSC Group was undertaken to identify the funding necessary (together with additional HMT funding). The DDRB recommended a 6% pay increase for salaried GP practice staff, consultants and general dentist practitioners and salaried dentists. Doctors in training (junior doctors) received a permanent pay increase of on average 8.8% - between 8.1% and 10.3% depending on where they are in their training.

The government accepted and implemented the DDRB recommendations in full which was a further £1 billion above provision for DDRB.

Following an agreement between the government and NHS trade unions, non-medical staff working on the Agenda for Change (AfC) contract received a 5% consolidated pay award in 2023 to 2024 and 2 non-consolidated payments relating to 2022 to 2023. In addition, the lowest paid staff have seen their pay matched to the top of band 2, resulting in a pay uplift of 10.4%, or £2,113 in 2023 to 2024.

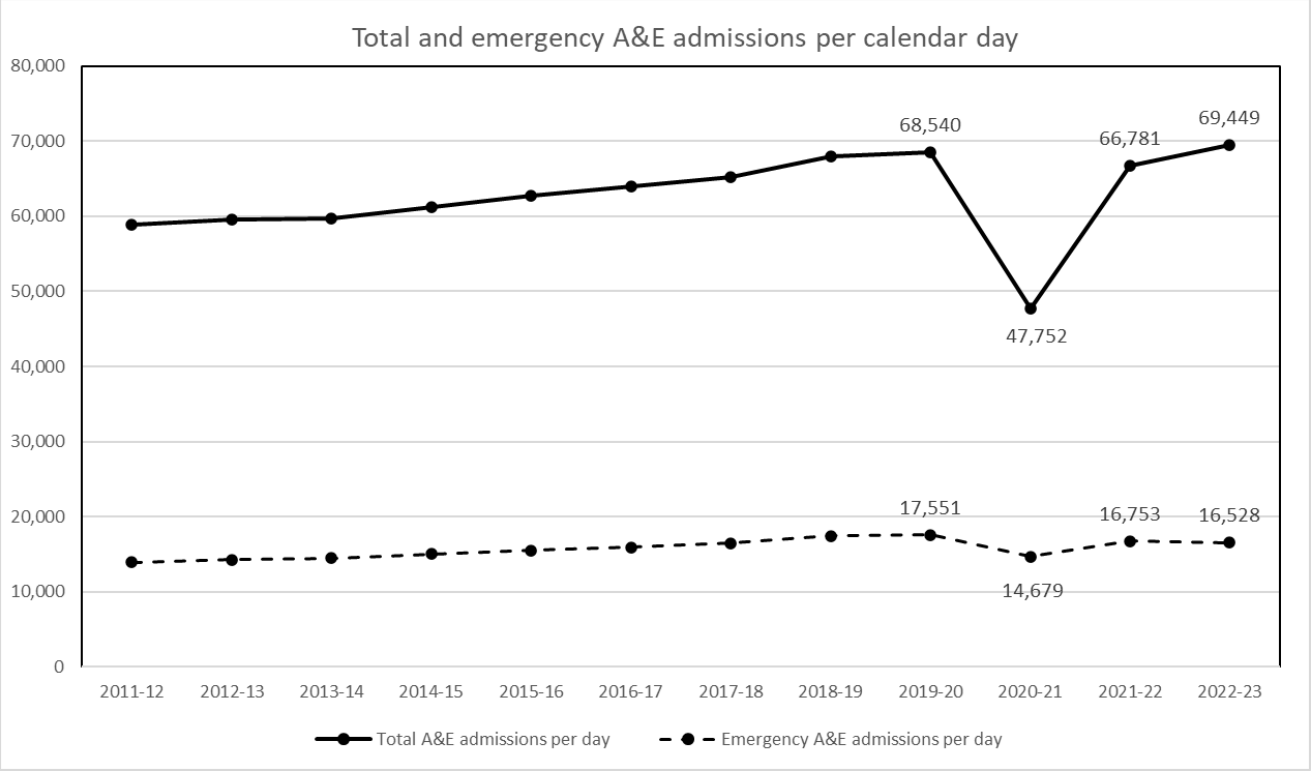
This resulted in an impact of 5.2% in 2023 to 2024 on the AfC paybill following negotiations with the NHS Staff Council - 2.2% (equivalent to £1.6 billion) above what was provisioned for pay at SR21.

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 2022 to 2023 returned to levels seen before the COVID-19 demand spike.

Figure 1: Total and emergency admissions per calendar day



Source: A&E attendances and Emergency Admission Statistics

Figure 1 shows the total attendances and emergency admissions to NHS in England per calendar day between 2011 to 2012 and 2022 to 2023.

In 2019 to 2020, there were 68,540 A&E attendances and 17,551 emergency admissions per day. In 2022 to 2023, there were 69,449 A&E attendances and 16,528 emergency admissions per day. This equates to a 1% increase in attendances and a 6% decrease in emergency admissions between 2019 to 2020 and 2022 to 2023.

Table 4: Total referral to treatment (RTT) pathways completed per working day

Year	RTT clock starts	RTT total completed pathways and unreported removals	Waiting list at year end (31 March)
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	77,956	77,085	3,897,530
2017 to 2018	79,764	78,945	4,102,999
2018 to 2019	82,231	81,272	4,345,467
2019 to 2020	79,712	79,552	4,386,297
2020 to 2021	55,824	53,595	4,950,297
2021 to 2022	74,916	69,322	6,365,772
2022 to 2023	79,511	75,665	7,331,186

Source: NHS England consultant led referral to treatment statistics. Data adjusted for non-submitting trusts and exclusion of sexual health services from 2013. Clock start data was not submitted prior to 2016. Therefore, clock start figures, and unreported removals figures are based on estimated clock start figures for 2015 to 2016 and earlier.

In recent years, pay review bodies have asked about the scale of increases to care backlogs. During the first wave of the COVID-19 pandemic, activity levels dropped to around 40% of normal levels. This reduction in activity meant that patients who would have normally been treated were not, and therefore the waiting list has grown to over 7 million, an increase from 4.4 million at the start of COVID-19.

The Elective Recovery Delivery Plan looks to boost activity levels to around 30% higher than they were before COVID-19, and therefore help reduce the overall waiting list in the longer term. Activity has been recovering to pre-COVID-19 levels and, including the impact of advice and guidance, the estimated year to date (YTD) figure for 2023 to 2024 is

111.5% compared to pre-pandemic levels. Excluding adjustments for advice and guidance the estimated YTD figure is 102.5% compared to pre-pandemic levels.

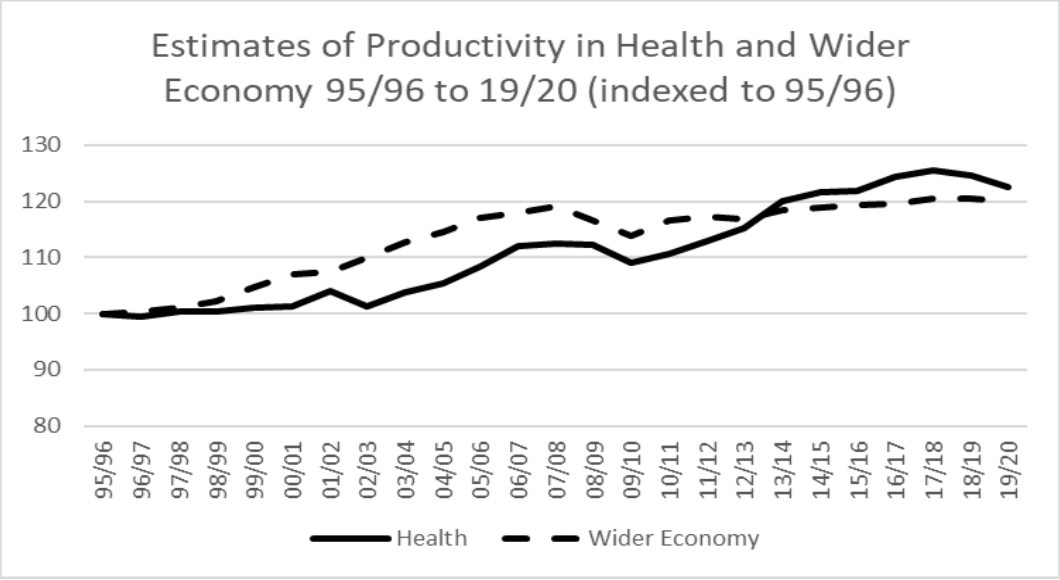
The impact of the more than 40 days of industrial action in 2023 to 2024 has also created a further loss of elective activity as well as unavoidable financial costs, estimated to be around £1 billion. To cover these costs, £800 million has been allocated to systems and the elective activity target for 2023 to 2024 has been adjusted to a national average of 103%, to be maintained for the remainder of the financial year.

Productivity in the NHS

Historically, the NHS had been able to achieve productivity improvements in the acute sector through a combination of medical and operational advancement (for example, moving planned care from overnight stays to day-case settings, with surgical techniques becoming less invasive) and reducing lengths of stay for medical admissions, meaning the NHS was able to deliver more care with our workforce and infrastructure. Productivity improvements have built on the achievements of the 2016 Carter Review and the operational productivity programmes which saw a saving of £3.57 billion by January 2020. Productivity continues to be a priority as looking ahead, the NHS will serve an increasingly older population with more complex needs.

NHS productivity has increased on average by 0.8% per annum from 1995 to 1996 until 2019 to 2020. This is a similar level to wider economy productivity growth – health was lower prior to the 2008 financial crash but higher from the 2008 financial crash to the COVID-19 pandemic in 2020.

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



Note: The latest figure is 2020 to 2021, it is not included in this graph as an outlier (see below)

Table 5: Average productivity growth in health and the wider economy, both prior and after the financial crash.

Years	Health	Wider Economy
1996 to 1997 - 2007 to 2008	1.0%	1.5%
2008 to 2009 - 2019 to 2020	0.7%	0.1%

NHS productivity fell by 25.6% in 2020 to 2021. This was the result of increasing inputs (for example, staff) to cover the risk of surges in COVID-19 patients and reductions in the number of outputs (for example, operations) due to infection controls and limiting elective treatments. 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 are not captured in our usual measures of productivity.

Formal ONS NHS productivity estimates are currently only published up until 2020 to 2021. The post-pandemic environment the NHS is facing is still materially different from the pre-pandemic environment. Although the formal measure has a long lag time, the ONS publish a total public sector productivity measure to shorter time scales, of which the health sector comprises 40%. The latest publication (April to June 2023) showed public sector productivity is recovering but is still 6.3% below the equivalent pre-pandemic level. The ONS's experimental 'nowcast' statistics suggest health productivity is 5.5% below the pre-pandemic level. It should be noted that this is an untested methodology which is giving lower figures than those suggested by the Institute for Fiscal Studies and Institute for Government. It is likely that NHS productivity has improved since 2020 to2021 but is still well below the pre-pandemic level.

While public service productivity remains at low levels, this creates challenges for the NHS. As a result of the COVID-19 pandemic, there are currently large backlogs for elective care due to issues such as the direct effects of managing COVID-19, delays to discharge and longer non-elective length of stay (therefore constraining elective capacity), higher staff sickness and absence, use of agency staff and wider vacancies, and opportunity loss as a consequence of industrial action. Reductions in productivity result in reductions in outputs in the NHS, which means less of the elective backlog can be tackled.

The government is clear that recovering and increasing productivity will be crucial to recovering the performance of the NHS. In June 2023, the Chancellor announced that the

Chief Secretary of the Treasury would lead a major public sector productivity programme across all government departments. This is currently underway.

In addition, the LTWP is underpinned by an ambitious labour productivity assumption of 1.5 to 2%, over double the long-run historical average for the NHS. This sets an ambitious target to be delivered.

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 recovering key services. Key productivity programmes supported by this investment are:

- improving patient pathways
- surgical hubs
- expanding community diagnostic centres (CDCs)
- making outpatient care more personalised
- digital productivity programmes

Productivity improvements going forward now need to come from a combination of delivery of the same care in lower cost settings for example, moving treatment from theatres into outpatient settings, moving hospital admissions to hospital at home, delivering large-scale skills mix opportunities as well as upskilling and retaining our staff, and reducing the administrative burden on clinicians through technological advancement, such as artificial intelligence (AI) and robotic process automation.

Affordability

Previously in this chapter we have set out the economic and NHS financial landscape for 2024 to 2025 which builds on the challenging position following the 2023 to 2024 pay round.

The SR21 settlement provided DHSC with a budget allocation for each year of 2022 to 2023, 2023 to 2024 and 2024 to 2025. Since this point, the financial landscape has changed with both inflation and pay awards across the economy substantially higher than anticipated and planned for at the Spending Review 2021. The resulting financial pressures have been compounded by the costs of recovering services disrupted so significantly by COVID-19 and by the direct and indirect costs of industrial action. All of these have a recurrent financial impact into 2024 to 2025, which has necessitated the reprioritisation of budgets for 2024 to 2025, even prior to the submission of this evidence and subsequent decisions on the pay award. The pay award should be considered in the

context of the SR21 settlement and its underpinning assumptions, as well as changes to the broader context since.

If further reprioritisation were also required, this would impact on NHS priorities. These NHS priorities are currently to support urgent and emergency care services, tackle the elective backlog, establish a strong care sector, and improve access to primary care. Pay awards above affordability may also necessitate further government borrowing at a time when inflation remains above target and headroom against fiscal rules is historically low.

Meeting the DDRB recommendations and the AfC pay deal for 2023 to 2024 has necessitated challenging decisions on how the NHS budget could be allocated and with recurrent impacts into 2024 to 2025. To put this into context, each additional 1% of pay for the whole Hospital and Community Health Service (HCHS) workforce costs around £1.1 billion per year allowing for the full system costs beyond the substantive workforce. The previous 2 years have provided recommendations above what was considered affordable at SR21 by £1.4 billion and £2.6 billion respectively and so required reprioritisation of budgets. The £2.6 billion in 2023 to 2024 is comparable to the amount (£2.4 billion) announced in June 2023 for the LTWP. However, these costs were also higher than SR21 had planned due to increased workforce growth and changes in workforce mix. This will have the same knock-on impact into 2024 to 2025. While every effort was made to protect frontline 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 DDRB recommendations and AfC pay deal for 2023 to 2024 necessitated some tough decisions.

As part of our decisions around wider affordability across the NHS, the government has increased the rates of the immigration health surcharge. These rates have remained unchanged for the last 3 years despite high inflation and wider pressures facing the system. The increase is intended to ensure that the surcharge reflects the genuine cost to the NHS of providing healthcare to those who pay it.

These are challenging times for everyone, and our focus is ensuring a fair pay award which recognises the vital importance of public sector workers while minimising inflationary pressures and managing the country’s debt. It is therefore essential that within this fiscal and economic climate, pay remains fair but affordable.

3. Workforce planning, education and training

Chapter summary

This chapter sets out what the government and NHS England are doing to grow the NHS workforce and ensure its long-term sustainability to meet the changing and growing demands being placed on the NHS.

It covers publication of the LTWP and what it means for expansion of training, retention of current staff, and training reforms. It also sets out how local workforce planning should work through integrated care systems (ICSs).

This chapter also covers the Leadership Review and the work that NHS England is taking forward to implement its recommendations, as well as the Nursing and Midwifery Review that is underway to ensure job profiles for these groups are fit for purpose.

There is a detailed section on education and training expansion, with more staff being trained domestically, expanding the use of apprenticeships, and blended learning innovations. There is also a section on education and training reform which is an important part of the LTWP, covering new roles, including training more nursing associates (NAs) and physician associates (PAs), shortened courses and continued professional development.

Workforce planning

The NHS in England is the largest employer in the country and is staffed by an incredibly dedicated and hugely diverse workforce. There are over 1 million people on AfC 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 June 2023, there were almost 63,600 more staff, including over 6,000 more doctors and over 16,400 more nurses, compared with a year earlier. The government has completed a 25% increase in medical school places and has delivered on its commitment to 50,000 nurses, with 51,245 more nurses in September 2023 compared with September 2019.

While we have made progress in recruiting more staff and increasing the number of training places on offer, the workforce remains under pressure. Staff vacancies remain high across different roles and specialities, and there are challenges related to

geographical differences across the country, with it being more difficult to recruit in certain areas.

The NHS is evolving, with new models of care transforming services for patients, allowing greater choice and options, integration of services and an increased focus on prevention and providing more services within the community. We know that the demand on the NHS and wider social care system will continue to grow, impacted by the changes in the way services are provided, population growth in the coming years, and demographic changes leading to an increasingly ageing population with different and more complex health needs. This is why it is essential that we have an effective workforce strategy in place to ensure we have the right mix and number of staff, with the rights skills and experience, in the right places to deliver the safe, high-quality care that patients expect from the NHS.

DHSC is responsible for setting the strategic direction for national workforce policy, and in partnership with NHS England and other delivery partners, the implementation of those policies. The merger of NHS England and HEE (and NHS Digital) has brought together service planning and delivery, education and training and financial planning into one organisation which will ensure a common strategic approach to workforce planning and deployment.

On the 30 June 2023, the NHS published the NHS LTWP which the government backed with over £2.4 billion of investment over the next 5 years to fund additional education and training places. The LTWP is an ambitious plan which demonstrates a very real commitment to growing and expanding the workforce. It sets out the steps the NHS and its partners need to take to deliver an NHS workforce that will meet the changing needs of the population over the next 15 years to put the workforce on a sustainable footing for the long term.

The LTWP sets out ambitions to recruit more staff, including doubling medical school places, increasing the number of GP training places by 50 per cent and almost doubling the number of adult nurse training places by 2031. This represents a significant expansion of domestic education, training, and recruitment, which will mean more healthcare professionals working in the NHS. The plan also sets out how the NHS plans to retain its dedicated workforce by allowing greater flexibility and career progression and improving culture, leadership and wellbeing, while continuing to focus on equality and inclusion. This will lead to up to 130,000 fewer people leaving the NHS over the next 15 years. There are also commitments to reform the way the NHS works so that staff have the right multidisciplinary skills and can harness new digital and technological innovations, allowing them to focus on patient care.

Integrated care systems (ICSs) and local workforce planning

ICSs are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities for people living and working in their localities. Each ICS will have an integrated care board (ICB), which is a statutory body responsible for planning and funding most NHS services, and an integrated care partnership (ICP) which are statutory committees that bring together system partners including NHS organisations, local authorities, independent care providers and the voluntary sector.

Working through ICBs and ICPs, ICSs have a key role to play in ensuring joined up workforce planning, working with system partners to ensure effective system wide coordination of recruitment, retention, and growing the workforce to meet the future needs of their local populations. Furthermore, these new structures will enable local NHS systems and local authorities to work together more effectively to provide integrated care that will meet the health and care needs of people within their localities. Integrated workforce planning requires a joined-up approach to bring together workforce, service and financial planning, that also considers the education and training needs of the workforce.

International recruitment

Internationally trained staff have been part of the NHS since its inception in 1948 and continue to play a vital role. While the LTWP envisages a reduction in the proportion of international new joiners to the NHS (from 24% to 9 t10.5% by 2036 to 2037) there will continue to be a role for international recruitment and the new insights and ways of working that it brings. In 2022 to 2023, of the nurses who joined the UK workforce, half of new nursing registrants were trained overseas.

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 the International Recruitment of Health and Social Care Personnel in March 2023 to align with the latest World Health Organisation (WHO) advice with 8 new countries added to the Code red list.

The Code prohibits active recruitment from red list countries identified by the WHO as having significant health workforce challenges. However, the Code is mindful of an individuals' right to migrate and where individuals in red list countries want to come to the UK to work, they have every right to apply to a health and social care employer for a job directly and can expect equitable and fair treatment during the process.

In December 2022, DHSC published guidance to ensure prospective candidates are well informed about the process, benefits and challenges of seeking a health or care job in the UK. The guidance raises awareness, sets out working rights and standards, how to identify and deal with exploitation and signposts to further help or support. The guidance is published alongside an easy read leaflet which aims to engage international candidates and summarise the key messages. We are working with FCDO in-country health advisors and diaspora organisations to ensure the guidance is disseminated widely and reaches potential international candidates before they have taken the decision to move to the UK.

Health and care staff coming to the UK can do so quickly and easily. The bespoke Health and Care Worker Visa provides a guaranteed decision within 3 weeks, discounted visa fees and an exemption from the Immigration Health Surcharge for those coming to work in UK health and care roles.

Since 2016, we have seen increases in non-UK nationality joiners. By proportion, 16.5% (4.9% EU/EEA, 11.7% rest of world) of non-medical hospital and community health staff have a non-UK nationality (June 2023). The proportion of nurses and health visitors with a non-UK, non-EU/EEA nationality in September 2019 was 10.5%; this has risen to 22.0% by June 2023. This increase correlates with the programme to deliver the 50,000 manifesto commitment, of which an increase in international recruitment has been part.

50,000 Nurses Programme

The government has delivered on its commitment to increase the number of registered nurses by 50,000 6 months early. There are, as of September 2023, 352,149 nurses working across the NHS – that is 51,245 more that September 2019, the starting point for the commitment.

To achieve the commitment, DHSC established a comprehensive delivery programme. which involved investing in and diversifying our training pipeline, ethically recruiting internationally, improving retention and supporting return to practice.

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.

Published in June 2022, the Leadership for a Collaborative and Inclusive Future review, focusses on the best ways to strengthen leadership and management across health and with its key interfaces with adult social care.

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.

The recommendations were accepted by government and work to implement all 7 recommendations has commenced, with planning and implementation led by NHS England and Skills for Care. There are plans to launch a new national induction framework for all new staff later this year, as well as the development of a management and leadership programme for first time managers.

The Hewitt Review

The Hewitt Review was published in April 2023 and the government's response in June 2023. The Hewitt Review set out a number of recommendations to enable ICSs to succeed. These centred on collaboration within and between systems and national bodies, ensuring a more streamlined set of shared priorities and allowing local leaders the space and time to lead. The Hewitt Review also supported many of the recommendations of the "Leadership for a Collaborative and Inclusive Future" review as set out above. In the government's response to the Hewitt Review, we affirmed our commitment to fostering the success of systems by committing to:

1. Aim for a smaller number of national priorities, and reflect these in a shorter, streamlined mandate;

2. Continue to support systems as they mature including through changes to NHS England's new Operating Framework;

3. Continue to work to reduce small in-year funding pots to where absolutely necessary and ensure any additional reporting requirements accompanying future funding of this type are proportionate.

Nursing and Midwifery Review

Following a request made by the Royal College of Nursing (RCN), and later followed by the Royal College of Midwifery (RCM), the NHS Staff Council's Job Evaluation Group (JEG) has begun work to review the national job profiles for nursing and midwifery (band 4 and above).

The review started in the summer of 2022 and is expected to reach completion in 2024. The aim of the review is to ensure that the profiles reflect current nursing and midwifery practice and are fit for purpose in all health and care settings. This will help employers meet their legal obligation to ensure pay equality across their workforce.

The evidence gathering stage of this review is now complete, with the report being published on NHS Employer's website: Nursing and midwifery national job profile review - evidence report. A review of the language and terminology used in the profiles is being taken forward and the findings will be shared with the NHS Staff Council for comment and consultation. Other stakeholders will be better placed to speak to this in further detail in their evidence.

Analysis of the evidence indicates that the majority of profiles remain fit for use, with only minor improvements required to the language and terminology to assist matching panels in using them. For this reason, the department does not anticipate there to be any associated costs at a national level, as the national banding of roles has not been changed. However, the re-release of the national profiles, including those that may have been subject to minor language modifications, may trigger a local review of job descriptions. It is the responsibility of employing organisations to ensure that job descriptions are regularly reviewed and accurately describe the skills, responsibility and experience a role entails to ensure that they are correctly evaluated. Where job descriptions have not been kept up to date this could lead to banding changes.

Education and training

Through the LTWP we are setting an ambition to:

1. Train more NHS staff domestically. This will mean that we can reduce reliance on international recruitment and agency staff – in 15 years' time, we expect around 9-10.5% of our workforce to be recruited from overseas, compared to nearly a quarter now.

2. Increase adult nursing training places by 92%, taking the number of total places up to nearly 38,000 by 2031 to 2032. To support this ambition, we will increase training places to nearly 28,000 in 2028 to 2029. This forms part of our ambition to increase the number of nursing and midwifery training places to around 58,000 by 2031 to 2032. We will work towards achieving this by increasing places to over 44,000 by 2028 to 2029, with 20% of registered nurses qualifying through apprenticeship routes compared to just 9% now.

3. Provide 22% of all training for clinical staff through apprenticeship routes by 2031 to 2032, up from just 7% today. To support this ambition, we will reach 16% by 2028 to 2029. This will ensure we train enough staff in the right roles. Apprenticeships will help widen access to opportunities.

Overall, education and training are estimated to need to increase by around 50% to 65% by 2030 to 2031.

Part of this expansion also means doing things differently. We will:

4. Focus on expanding enhanced, advanced, and associate roles to offer modernised careers, with a stronger emphasis on the generalist and core skills needed to care for patients with multimorbidity, frailty or mental health needs.

5. Work with professions to embrace technological innovations, such as artificial intelligence and robotic assisted surgery. NHS England will convene an expert group to identify advanced technology that can be used most effectively in the NHS, building on the findings of the Topol Review.

6. Work with regulators and others to take advantage of EU exit freedoms and capitalise on technological innovation to explore how nursing and medical students can gain the skills, knowledge and experience they need to practise safely and competently in the NHS in less time. Doctors and nurses would still have to meet the high standards and outcomes defined by their regulator.

Education and training expansion

In order to meet the ambitions of the LTWP, DHSC and NHS England continue to work to remove the barriers to training in clinical roles. Since September 2020, all eligible nursing, midwifery and allied health profession degree students have received a non-repayable training grant of a minimum of £5,000 per academic year. Additional funding is also available for studying certain courses – for example, Mental Health Nursing and Learning Disabilities Nursing – with further financial support available to students for childcare, dual accommodation costs and travel.

On 1 September, we announced a significant uplift to the travel and accommodation funding available through the Learning Support Fund, to ensure students are appropriately reimbursed for the cost of travelling for clinical placements. Eligible students will now be able to claim 50% more for their travel and accommodation expenses.

To help deliver the ambitious future expansion numbers set out above, NHS England is working with DHSC to deliver the Education Funding Reform Programme to develop a new and agile education funding policy for healthcare education and training in England, including a proposal to introduce a consistent policy for funding excess travel and accommodation costs incurred by students undertaking placements.

Alongside funding, we recognise the important role of clinical educators in developing the current and future workforce. A new Educator Workforce Strategy was published in 2022 to 2023 setting out the actions that will lead to sufficient capacity and quality of educators to allow the growth in the healthcare workforce needed now and in the future. We will continue to build on this Strategy as part of our work to implement the Plan.

Service providers, ICSs and NHS England will all have a role in leading and commissioning sustainable education supply, including the supply of educators. To support this, we will continue to build strong relationships with the education sector and our key partners in Higher Education Institutions (HEIs) and other education bodies.

Linked to educator capacity, we are also working to ensure a sufficient number, spread and quality, of clinical placements. Over recent years, Health Education England (now part of NHS England) has invested £55 million to increase clinical placement capacity and support HEIs to develop their simulated learning capacity. This is in addition to providing placement tariff for nursing, midwifery and AHP students. The amount of tariff paid per clinical student rose from £3,400 per FTE in 2021 to 2022 to £5,000 in 2022 to 2023.

As set out in the LTWP, NHS England will work with stakeholders, informed by the issues we identified through a discovery exercise in 2022 to 2023, to ensure clinical placements are designed into health and care services, and placement providers know what core standards they need to meet. Co-design of a nationwide approach to clinical placement management will place students at the centre of placement management and practice, with consistent and clear national core standards for placement providers. It will enable a more strategic view of capacity so that the NHS can work more effectively with the education sector to ensure the right volume of training, in the right settings, for each profession, provide better support for placement providers, and better meet the needs of students.

Blended learning

NHS England has introduced a highly 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, or who have an interest in technology and using digital skills to study.

NHS England are working with 7 universities to deliver the blended learning nursing degree programme and 4 universities to deliver the blended learning midwifery degree programme. NHS England 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. NHS England will also encourage and support HEIs to adopt the Nursing Midwifery Council's new standard, allowing up to 600 hours of practice learning to be undertaken via simulation (an increase from 300 hours in November 2021) alongside an expansion of the Virtual Hybrid Learning Faculty and Simulation Faculty programmes.

Apprenticeships

A key part of our expansion work is focussed on continuing to increase the range of training pathways into clinical professions.

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 2022 to 2023 financial year, the NHS was the largest employer of new apprentice starts, with 19,900 apprentices starting training. This is out of 60,300 new apprentice starts across public sector bodies. 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).

In recent years, there has been growth in the Nurse Degree Apprenticeship with 3,400 starts occurring in the 2021 to 2022 academic year, compared to around 2,200 RNDA starts in 2020 to 2021, across NHS and non-NHS organisation (for example, primary and social care, independent health organisations and so on.). While the 2022 to 2023 academic year is yet to be finalised, between August 2022 and May 2023 there have been more than 2,500 Nurse Degree Apprentice starts, which is 14% higher than finalised 2020 to 2021 figures.

Currently, only approximately 9% of nurses qualify through apprenticeships. We will work towards an almost doubling of nursing training places by 2031 to 2032 by expanding nursing apprenticeships, so that by 2028 to 2029, 20% of registered nurses are qualifying through this route, including 33% of learning disability nurses, 20% of adult nurses and 28% of mental health nurses.

To implement this plan, NHS England will develop an apprenticeship funding approach that better supports employers with the cost of employing an apprentice. NHS England is committed to working with NHS employers, ICSs, providers and other partners to develop a national policy framework that can be used locally to guide the use of funding, targeting those apprenticeship schemes that would have the greatest impact on patient outcomes.

NHS England will also work to ensure than any changes to its apprenticeship funding approach will align with wider government apprenticeship funding policy, including working with DHSC and DfE to ensure apprenticeship levy funds are more easily transferred between employers in an ICS. Data on the use of apprenticeship funding in the NHS will be visible to decision-makers at national and local level to ensure a joined-up apprenticeship funding approach which supports strategic delivery of apprenticeships by employers.

Integrated system-level apprenticeship planning

There are already many examples of how employers and systems have used apprenticeships (pdf, 248kb) 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.

To support ICSs, we are committed to moving to a position where nationally, education and training plans are formulated at least 3 years in advance to support a more strategic approach to delivering the right pipeline of staff across the NHS.

Local strategies would support quality apprenticeship programmes targeted at specific occupational shortages and skills gaps, while system-level working would help employers engage their local population, schools, and colleges to improve access to apprenticeship programmes and maximise innovative approaches to delivery.

We anticipate that as ICSs become more involved in education and training planning, there will be an opportunity to develop more multi-profession, system-based rotational clinical placements. This would include extending the provision of placements across primary, community and social care, and in the independent and voluntary sectors, to give students valuable experience in the delivery of care outside hospitals and introduce them to wider career opportunities.

DHSC continues to work closely with key stakeholders - NHS England, the Department for Education, the Education and Skills Funding Agency, and the Institute for Apprenticeships and Technical Education - to implement an NHS-wide strategy for apprenticeships.

Education and training reform

Training will be reformed to support education expansion as outlined above.

New roles

A key part of our reform agenda is continuing to develop and expand new roles, particularly associate and assistant roles, to help ensure a strong talent pipeline into registered professions, 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.

There has been a steady rate of nursing associate (NA) apprenticeship starts in recent years with more than 4,300 NA starts in the 2020 to 2021 academic year and more than 4,100 starts in 2021 to 2022, across NHS and non-NHS organisation (for example, primary, and social care, independent health organisations and so on.). While the 2022 to 2023 academic year is not finalised, between August 2022 to May 2023 there have been

more than 4,300 NA starts. This is in line with the full 2020 to 2021 academic year and a 5% increase compared to the 2021 to 2022 academic year.

Investment in education and training is planned to increase from £5.5 billion to £6.1 billion over the next 2 years, and actions are underway to:

1. Train 5,000 nursing associates (NAs) and around 1,300 physician associates (PAs) in 2023 to 2024 and 2024 to 2025. The plan emphasises the need to target more PA roles towards primary care and mental health services.

2. Ensure at least 3,000 clinicians start advanced practice pathways in both 2023 to 2024 and 2024 to 2025, tailored to support service demand.

To go further, the LTWP sets an ambition to grow the proportion of staff in these newer roles from around 1% to 5% by the end of the plan by:

1. Ensuring that more than 6,300 clinicians start advanced practice pathways each year by 2031 to 2032. We will support this ambition by having at least 3,000 clinicians start on advanced practice pathways in both 2023 to 2024 and 2024 to 2025, with this increasing to 5,000 by 2028 to 2029.

2. Increasing training places for nursing associates (NAs) to 10,500 by 2031 to 2032. We will work towards this by training 5,000 NAs in both 2023 to 2024 and 2024 to 2025, increasing to 7,000 a year by 2028 to 2029. By 2036 to 2037, there will be over 64,000 nursing associates working in the NHS, compared to 4,600 today.

3. Increasing physician associate (PA) training places to over 1,500 by 2031 to 2032. In support of this, over 1,200 physician associates (PAs) will be trained per year from 2023 to 2024, increasing to over 1,400 a year in 2027 to 2028 and 2028 to 2029, establishing a workforce of 10,000 PAs by 2036 to 2037.

To support the expansion of new roles, we will work with partners to ensure new roles are appropriately regulated to ensure they can use their full scope of practice and are freeing up the time of other clinicians as much as possible – for example by bringing anaesthesia and physician associates in scope of GMC registration by the end of 2024 with the potential to give them prescribing rights in the future.

Shortened courses

As set out in the LTWP, an important part of our reform agenda is bringing people into the workforce more efficiently. This includes:

1. Promoting uptake by education institutions of the opportunity for newly qualified nurses to join the NMC register on qualification at the end of the third academic year. This permits new registrants to be in paid employment up to 4 months earlier and can reduce employers' reliance on temporary staff, reduce costs and vacancies. It also gives new joiners time to get embedded ahead of the winter months when pressures on health services are typically at their highest. Some education institutions already enable this.

2. Work with the NMC on its welcomed commitment to explore the potential for further changes to nursing degrees. To train staff more flexibility, taking into account the opportunities presented by EU exit and leveraging new technologies, we encourage the NMC to consider how graduate nurses can join its register after fewer practice hours, mirroring the approach in many other countries, and enabling the increase in training capacity set out in the LTWP. A reduction in placement hours from 2,300 to 1,800 over the course of a nursing degree would reduce pressure on our learners while significantly increasing placement capacity across the NHS to give pre-registration students the high-quality learner experience, they need to prepare to work in the NHS.

Accreditation of prior learning

Pathways into health and care professions can be shortened depending on the level of someone's prior learning through a process called Accreditation of Prior Learning (APL), which recognises previous learning and experience. We will continue to work with higher education institutions (HEIs) to maximise recognition of prior learning (RPL) and accredit prior experiential learning (APEL). Expanding these opportunities will help support multiple entry routes into health careers and make education pathways as efficient as possible, widening access and attracting more students. This includes pathways into midwifery and paramedic programmes where shortened programmes will increase staff supply quicker than the traditional 3 years.

NHS England has commissioned Middlesex University and partners to establish standardised approaches for recognising previous learning within the healthcare sector to support people who do not follow a traditional career path. These are due to be published in 2023 to 2024.

Continuing professional development

From 2020, employers began receiving national funding equivalent to £1,000 per person over 3 years to support the personal learning and development of all nurses, midwives and AHPs working in trusts and in general practice. To supplement local employer investment

for staff CPD, we are committed to continuing national CPD funding for nurses, midwives and AHPs.

Healthcare student attrition and improving learner experience

NHS England will work with students, HEIs, royal colleges and clinical placement providers in 2023 to 2024 to understand and address the reasons students leave training and the variation in their experiences, committing to reduce the proportion of students who leave nursing training from 16% in 2019 to 14% by 2024. We will also aim to bring the attrition rate down to 14% for paramedics and operating department practitioners (ODPs).

Evidence shows that the use of apprenticeship pathways could reduce the number of students leaving training compared to those in traditional undergraduate training programmes. For example, attrition rates for all current cohorts of the registered nurse degree apprenticeship programmes are 4%, compared to over 15% for traditional nursing undergraduate and postgraduate courses.

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.

The size of the non-medical workforce is at record levels. There have been notable increases in the size of the nursing workforce, with the government's commitment for 50,000 more nurses being achieved 6 months early. The workforce also continues to become ever more diverse.

The NHS LTWP sets out how the NHS will build on the NHS England People Plan to improve the culture and leadership of the NHS so that up to 130,000 fewer staff leave the NHS over the next 15 years, helping staff to work flexibly, have access to health and wellbeing support and work in teams that are well-led.

NHS Hospital and Community Health Services (HCHS) workforce

The overall HCHS workforce is at record levels. The non-medical NHS workforce, as of June 2023, is 1,154,449 full time equivalents (FTEs). This is more than 57,519 (5.2%) more than June 2022.

Despite record workforce numbers, there are signs that the workforce is feeling stretched and burnt out. NHS staff are reporting high levels of stress and report not having sufficient resource in the NHS Staff survey. Sickness absence rates, although falling, remain above pre-pandemic levels and the single largest cause of absences is stress.

Workforce trends described below continue to be impacted by COVID-19 and there is therefore a need to be cautious in reading too much into any single year’s change. These include in areas such as:

- Student nurses temporarily joining the workforce in 2020 and subsequently leaving to return to education;
- A drop in international recruitment in 2020;
- Delayed leavers in 2020, followed by an increase in leavers in 2021 and 2022 (a trend that is common across the public sector);

- Falls in recorded vacancies in 2020 followed by rebound afterwards largely reflecting the impact of covid in recruitment behaviour rather than changes in underlying shortage; and

- High levels of sickness absence in 2022 to 2023 partly reflecting high levels of covid 19 circulating in the wider community.

Staff numbers

The non-medical workforce continues to grow, with proportionately larger increases in staffing groups such as ‘support to scientific, technical and therapeutic staff’ and ‘central functions’ staff. Nursing numbers have grown as a result of the commitment to grow the nursing workforce by 50,000 over the course of the parliament. The overall non-medical NHS workforce as at June 2023 is 1,154,449 full time equivalents (FTEs). This has increased by 171,120 FTEs (17.4%) since June 2019 and by 57,519 (5.2%) over the past year. Further detail is shown in Table 6.

Table 6: HCHS Non-medical staff FTE, June 2019 to June 2023.

Staff group	Jun-19	Jun-20	Jun-21	Jun-22	Jun-23	Change since June 2019
All non-medical staff groups	983,329	1,044,821	1,071,498	1,096,931	1,154,449	171,120 (17.4%)
Nurses and health visitors	288,646	301,612	310,251	319,481	335,479	46,834 (16.2%)
Midwives	21,632	22,010	22,090	21,541	22,149	517 (2.4%)
Ambulance staff*	15,763	16,961	17,684	17,847	18,734	2971 (18.8%)
Scientific, therapeutic and technical staff	140,975	147,051	152,722	156,367	162,940	21,965 (15.6%)
Support to doctors, nurses and midwives	254,598	282,916	279,321	280,655	294,446	39,848 (15.7%)
Support to ambulance staff	22,262	23,911	24,713	24,979	25,587	3,325 (14.9%)
Support to ST&T staff	59,644	64,562	70,460	74,247	81,648	22,004 (36.9%)
Central functions	87,246	93,587	99,581	104,823	110,460	23,214 (26.6%)
Hotel, property and estates	54,908	57,280	59,913	60,556	64,421	9,512 (17.3%)
Senior managers	10,825	11,140	11,882	12,485	13,182	2,358 (21.8%)
Managers	23,732	21,760	22,025	23,469	24,868	1,136 (4.8%)
Other staff or unknown classification	3,098	2,030	857	481	535	-2,563 (-82.7%)

Source: NHS England HCHS monthly workforce statistics (formerly published by NHS Digital)

Joiner rates and trends

The joiner and leavers data discussed below shows those joining and leaving NHS Trusts and other core organisations. The joiner rates show the percentage of the workforce joining active service in NHS trusts and other core organisations each year. Not all joiners will be new recruits to the non-medical workforce; many will be moving into the NHS trust sector after working for other sectors not included in the statistics, for example primary care, social care or the independent sector. Some will also be returning after breaks from service such as maternity leave or a career break.

The overall non-medical joiner rate for the year to June 2023 for all regions and staff is 15.7% with over 199,000 individuals joining the HCHS workforce.

Annual joiner numbers are at record levels and rates have increased in the last 2 years following the fall in 2020 to 2021. Joiner rates in 2019 to 2020 and 2020 to 2021 were impacted both positively and negatively by COVID-19 as some staff joined earlier than normal (students entered the workforce to support the response) but also some staff were unable to, or chose to delay, moves from roles outside the NHS. International recruitment was also impacted.

Overall joiner rates are now above rates seen in the 2 years pre-pandemic.

Joiner rates by staff groups for the year to June 2023 vary between 7.2% for senior managers and 21.0% for support to ST&T staff, as shown in Table 7. Relatively low joiner rates for senior managers reflect the fact that many senior manager posts are filled internally within NHS trusts rather than externally. Higher rates for staff working in clinical support roles potentially reflects the wider range of potential sources of recruitment for these staff group as well as the more fluid nature of employment that we usually observe in lower pay grade roles.

Table 7: Annual non-medical joiners to active service by staff group, years to June 2018 to June 2023, headcount

Staff group	2017 to 2018	2018 to 2019	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023
All non-medical staff	12.5%	13.4%	15.4%	12.4%	14.4%	15.7%
Nurses and health visitors	10.5%	11.4%	12.6%	9.0%	12.7%	12.9%
Midwives	11.3%	11.5%	12.3%	6.9%	12.6%	14.6%
Ambulance staff	7.6%	7.8%	9.7%	7.2%	9.2%	11.4%
Scientific, therapeutic and technical staff	12.0%	12.4%	12.6%	11.3%	12.1%	12.8%
Support to doctors, nurses and midwives	13.7%	15.2%	21.0%	15.6%	16.9%	20.0%
Support to ambulance staff	19.8%	20.9%	20.0%	14.4%	16.5%	17.3%
Support to ST&T staff	15.9%	16.9%	18.9%	18.8%	19.8%	21.0%
Central functions	13.3%	14.6%	13.7%	13.9%	15.1%	14.5%
Hotel, property and estates	12.5%	13.7%	12.4%	11.6%	13.4%	16.9%
Senior managers	7.4%	8.2%	7.7%	7.5%	7.2%	7.2%
Managers	8.8%	8.8%	7.5%	8.2%	8.2%	8.1%
Other staff or those with unknown classification	58.7%	35.4%	24.4%	36.5%	44.2%	66.7%

Source: NHS England HCHS workforce statistics

Joiner rates by region for the year to June 2023 for non-medical staff groups are shown in Table 8. The pattern by region is consistent with the national picture: there are higher rates for support staff and lower rates for senior managers.

Table 8: Annual non-medical staff joiner rates to active service, by region and staff group, June 2022 to June 2023

Staff group	All NHSE regions	East of England	London	Midlands	North East and Yorkshire	North West	South East	South West
All nonmedical staff groups	15.7%	15.8%	17.3%	15.1%	14.3%	15.0%	16.4%	16.6%
Nurses and health visitors	12.9%	12.0%	13.9%	12.6%	12.0%	13.2%	12.9%	13.7%
Midwives	14.6%	18.0%	14.7%	14.4%	13.4%	14.2%	14.2%	13.8%
Ambulance staff	11.4%	10.5%	17.4%	7.1%	13.4%	9.2%	13.9%	10.0%
Scientific, therapeutic and technical staff	12.8%	13.9%	15.0%	12.2%	11.4%	11.4%	13.5%	12.4%
Support to doctors, nurses and midwives	20.0%	21.4%	20.4%	19.4%	17.9%	19.3%	21.2%	22.3%
Support to ambulance staff	17.3%	16.3%	17.6%	13.4%	14.8%	19.0%	21.2%	22.4%
Support to ST&T staff	21.0%	20.2%	25.0%	20.6%	18.8%	18.7%	22.0%	22.2%
Central functions	14.5%	14.6%	17.8%	14.2%	13.5%	13.0%	14.9%	13.7%
Hotel, property and estates	16.9%	14.6%	30.0%	14.3%	14.8%	16.5%	16.6%	16.8%
Senior managers	7.2%	7.3%	8.0%	6.2%	6.8%	6.7%	7.8%	7.6%
Managers	8.1%	7.7%	11.1%	6.9%	6.1%	7.0%	8.5%	6.9%
Other staff or those with unknown classification	66.7%	92.5%	65.6%	69.3%	42.7%	33.3%	66.7%	27.8%

Source: NHS England HCHS monthly workforce statistics

Leaver rates and trends

NHS leaver rates measure people leaving NHS trusts and other core organisations – they are not necessarily leaving the health sector overall. The measure will also include those

going on breaks in active service such as maternity or career breaks. Many leavers from these bodies move into primary care, social care, or to private providers.

It is important for registered professions, such as nursing, to place this in the context of analysis from wider datasets which suggest that annual leaver numbers from the nursing profession are low. Leaver rates from the Nursing and Midwifery Council (NMC) register are around 4% a year, which includes those retiring. As such, the higher leaver rate here is driven by the significant movement of staff between different part of the health and care system rather than those leaving the system entirely.

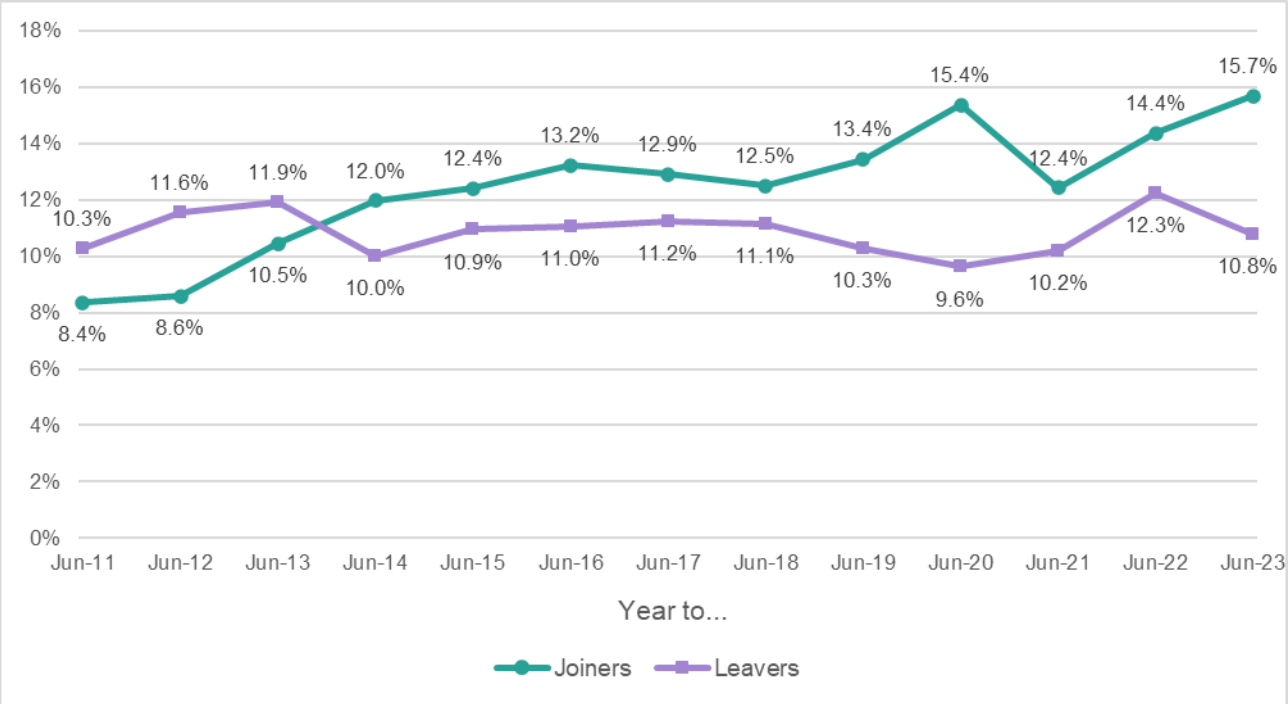
All staff leaver rates were falling prior to COVID-19 and reached a low of 9.6% in the year to June 2020 as staff delayed retirements and career moves during the COVID -19 pandemic. Rates subsequently increased in the years 2020 to 2021 and 202 to 20/22 but have since fallen back to around pre pandemic levels. There is some variation by staff group: ambulance staff are amongst those with the lowest leaver rates while support staff (Bands 1-4) generally have higher rates than professionally qualified staff, reflecting opportunities for employment outside the NHS.

Table 9: Annual non-medical rates of staff leaving active service, year to June 2018 to June 2023, Headcount

Staff Group	2017 to 2018	2018 to 2019	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023
All non-medical staff	11.1%	10.3%	9.6%	10.2%	12.3%	10.8%
Nurses and health visitors	10.6%	10.2%	9.4%	9.5%	11.5%	10.4%
Midwives	10.7%	10.6%	10.2%	10.8%	13.2%	11.0%
Ambulance staff	7.9%	8.8%	6.8%	6.7%	10.3%	9.1%
Scientific, therapeutic and technical staff	10.8%	10.3%	10.1%	9.8%	11.6%	10.7%
Support to doctors, nurses and midwives	11.5%	10.4%	9.8%	12.3%	13.3%	11.6%
Support to ambulance staff	11.8%	8.0%	8.0%	8.5%	12.9%	12.5%
Support to ST&T staff	12.2%	11.5%	10.5%	10.9%	14.1%	11.6%
Central functions	11.7%	10.7%	9.8%	8.6%	12.3%	10.9%
Hotel, property and estates	11.2%	8.6%	8.5%	8.2%	11.2%	9.2%
Senior managers	12.0%	10.4%	9.7%	8.4%	10.9%	9.8%
Managers	10.4%	9.4%	9.0%	7.7%	9.9%	8.7%
Other staff or those with unknown classification	22.7%	24.6%	19.1%	21.3%	13.1%	11.5%

Source: NHS England HCHS monthly workforce statistics

Figure 3: Annual all non-medical staff joiner and leaver rates from active service, years to June 2011 to June 2023, headcount



Source: NHS England HCHS monthly workforce statistics

Retention

Reasons for leaving

Reasons for leaving data is published by NHS England and is based on pre-defined categories within the Electronic Staff Record (ESR) system. Data is impacted by the high level of leavers for whom a reason is not recorded but in the years to March 2022 and March 2023, voluntary resignation accounted for almost 46% of all reasons for leaving. Retirement was the next biggest reason for leaving at 13% of the leaver workforce.

Table 10: Electronic staff record reasons for leaving data, years to March 2018, to March 2023

Reason for leaving	2017 to 2018	2018 to 2019	2019 to 2020	2020 to 2021	2021 to 2022	2022 to 2023
Dismissal	4,105 (3.4%)	3,813 (3.3%)	3,544 (3.1%)	2,736 (2.6%)	2,925 (2.0%)	3,258 (2.2%)
Employee transfer	6,159 (5.1%)	3,103 (2.7%)	3,070 (2.7%)	1,544 (1.5%)	2,693 (1.9%)	1,683 (1.2%)
End of fixed term contract	2,237 (1.9%)	2,059 (1.8%)	2,068 (1.8%)	2,220 (2.1%)	2,969 (2.1%)	3,079 (2.1%)
End of fixed term contract - completion of training scheme	471 (0.4%)	495 (0.4%)	440 (0.4%)	409 (0.4%)	437 (0.3%)	404 (0.3%)
End of fixed term contract - end of work requirement	300 (0.2%)	269 (0.2%)	352 (0.3%)	328 (0.3%)	429 (0.3%)	981 (0.7%)
End of fixed term contract - external rotation	8 (0.0%)	6 (0.0%)	3 (0.0%)	8 (0.0%)	6 (0.0%)	12 (0.0%)
End of fixed term contract - other	449 (0.4%)	374 (0.3%)	361 (0.3%)	365 (0.4%)	555 (0.4%)	553 (0.4%)
Mutually agreed resignation	510 (0.4%)	341 (0.3%)	250 (0.2%)	160 (0.2%)	132 (0.1%)	190 (0.1%)
Others	879 (0.7%)	841 (0.7%)	933 (0.8%)	1,286 (1.2%)	1,172 (0.8%)	1,205 (0.8%)
Redundancy	1,262 (1.0%)	918 (0.8%)	752 (0.7%)	492 (0.5%)	403 (0.3%)	404 (0.3%)
Retirement	17,102 (14.2%)	16,044 (14.0%)	16,635 (14.5%)	17,703 (17.0%)	20,538 (14.3%)	18,747 (12.9%)
Voluntary resignation	53,487 (44.3%)	52,298 (45.5%)	50,549 (44.1%)	41,602 (39.9%)	65,906 (45.9%)	66,528 (45.9%)
Unknown	33,754 (28.0%)	34,281 (29.9%)	35,757 (31.2%)	35,403 (34.0%)	45,410 (31.6%)	47,901 (33.0%)
All reasons for leaving	120,725 (100.0%)	114,843 (100.0%)	114,715 (100.0%)	104,256 (100.0%)	143,577 (100.0%)	144,945

Source: NHS England HCHS monthly workforce statistics. Note: totals may not equal the sum of the parts due to staff holding more than one role.

Vacancies

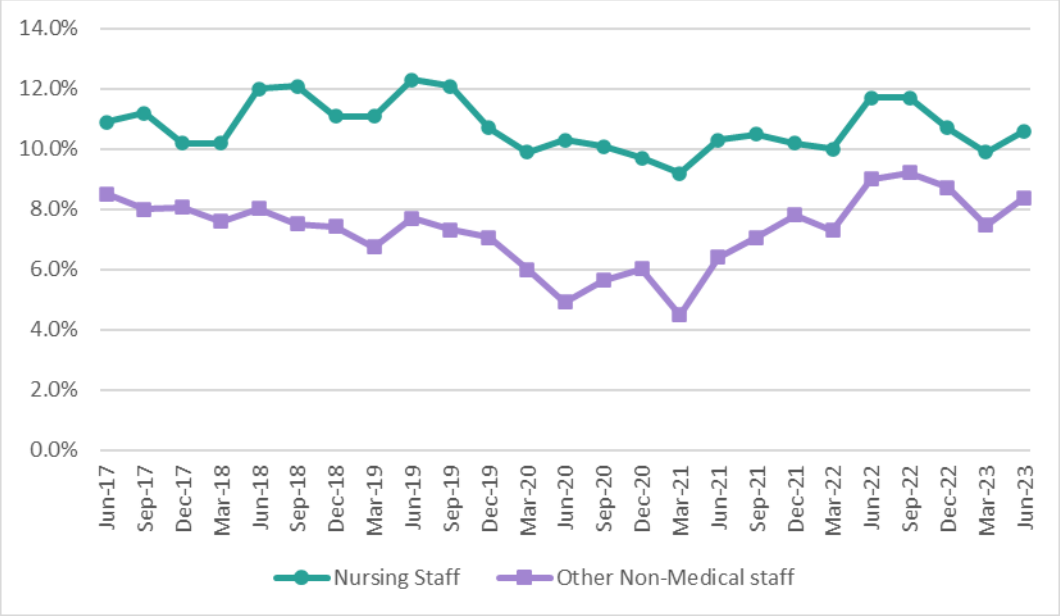
NHS England collects and publishes vacancy data for NHS trusts. Vacancies are defined as the gap between staff in post and funded planned staff. They do not necessarily mean unfilled shifts as many shifts in practice will be covered by temporary staff and the figures may not represent ‘gaps’ in the workforce, or that work is not being carried out. More generally, due to the complex nature of how NHS vacancy data is defined and collected, this source of data should be treated with a degree of caution.

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 England.

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 of the financial year.

Vacancies during Covid 19 fell as the pandemic disrupted the usual workforce planning process for NHS trusts and then vacancies subsequently rose. But for registered nurses, they are still below pre-pandemic levels. For other non-medical staff though, rates are now above pre-pandemic levels.

Figure 4: Nursing and other non-medical staff vacancy rates, June 2017 to June 2023, FTE



Source: NHS England HCHS monthly workforce statistics

Sickness absence

Table 11 shows annual sickness absence rates for NHS trusts and other core organisations and NHS support organisations and central bodies for the years to March 2011 to March 2023. Pre-pandemic there had been no major change over the long term with rates remaining around 4.5%.

Table 11: Sickness absence in NHS trusts and other core organisations, year to March 2011 to March 2023 – total HCHS non-medical staff, FTE

Year	Sickness absence rate (%)
March 2011	4.46%
March 2012	4.42%
March 2013	4.56%
March 2014	4.37%
March 2015	4.58%
March 2016	4.47%
March 2017	4.50%
March 2018	4.52%
March 2019	4.55%
March 2020	4.83%
March 2021	5.02%
March 2022	5.82%
March 2023	5.79%

Source: NHS England sickness absence statistics

NHS sickness absence rates have since increased largely due to continued prevalence of COVID-19 in the population[1]. The most recent data, at the time of writing, show that the non-medical sickness absence rate for September 2023 is 5.3% higher than the pre-pandemic rate in September 2019 rate of 4.6%

Sickness absence varies by staff group with ‘frontline staff’ (nurses, midwives, ambulance staff and clinical support staff) having some of the highest reported rates of absence while non-frontline groups have lower reported absence rates. Patient-facing staff group

[1] Coronavirus (COVID-19) Infection Survey, UK Statistical bulletins - Office for National Statistics

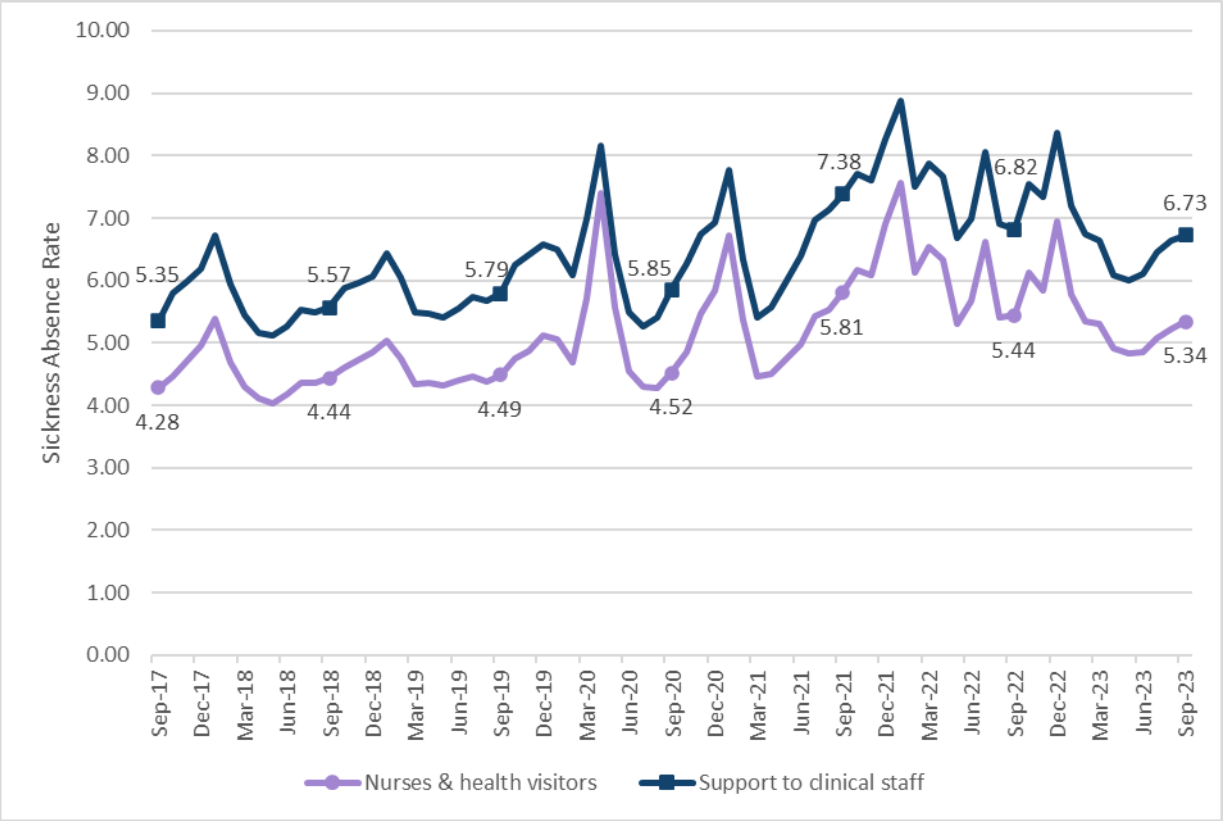
sickness absence continues to remain higher than pre-pandemic levels. Some of this will be related to the nature of the work undertaken.

Table 12: Sickness absence rates by non-medical staff group years to March 2018 to March 2023, FTE

Staff group	Year to March 2018	Year to March 2019	Year to March 2020	Year to March 2021	Year to March 2022	Year to March 2023
Nurses and health visitors	4.47%	4.48%	4.73%	5.28%	5.88%	5.85%
Midwives	4.93%	4.80%	5.11%	5.02%	6.73%	6.43%
Ambulance staff	5.31%	5.31%	5.38%	5.83%	7.53%	7.07%
Scientific, therapeutic and technical staff	2.97%	3.02%	3.24%	3.21%	4.04%	4.12%
Support to clinical staff	5.63%	5.67%	6.04%	6.32%	7.28%	7.25%
NHS infrastructure support	3.74%	3.79%	4.04%	3.62%	4.31%	4.36%
Other staff or unknown classification	1.18%	1.20%	1.41%	1.08%	1.36%	1.08%

Source: NHS England Sickness Absence statistics

Figure 5: monthly sickness absence rates for ‘Nurses and health visitors’ and ‘Support to clinical staff’, September 2017 to September 2023, FTE



Source: NHS England Sickness Absence statistics

Sickness absence rates for non-medical staff vary by region. This largely reflects historic differences in sickness absence by region more widely. Rates tend to be higher in the North of England (6.8% in the North West and 6.3% in the North East and Yorkshire) compared to London (5.1%) and the South East (5.3%).

Table 13: Non-medical staff sickness absence by NHS England region year to March 2023, FTE

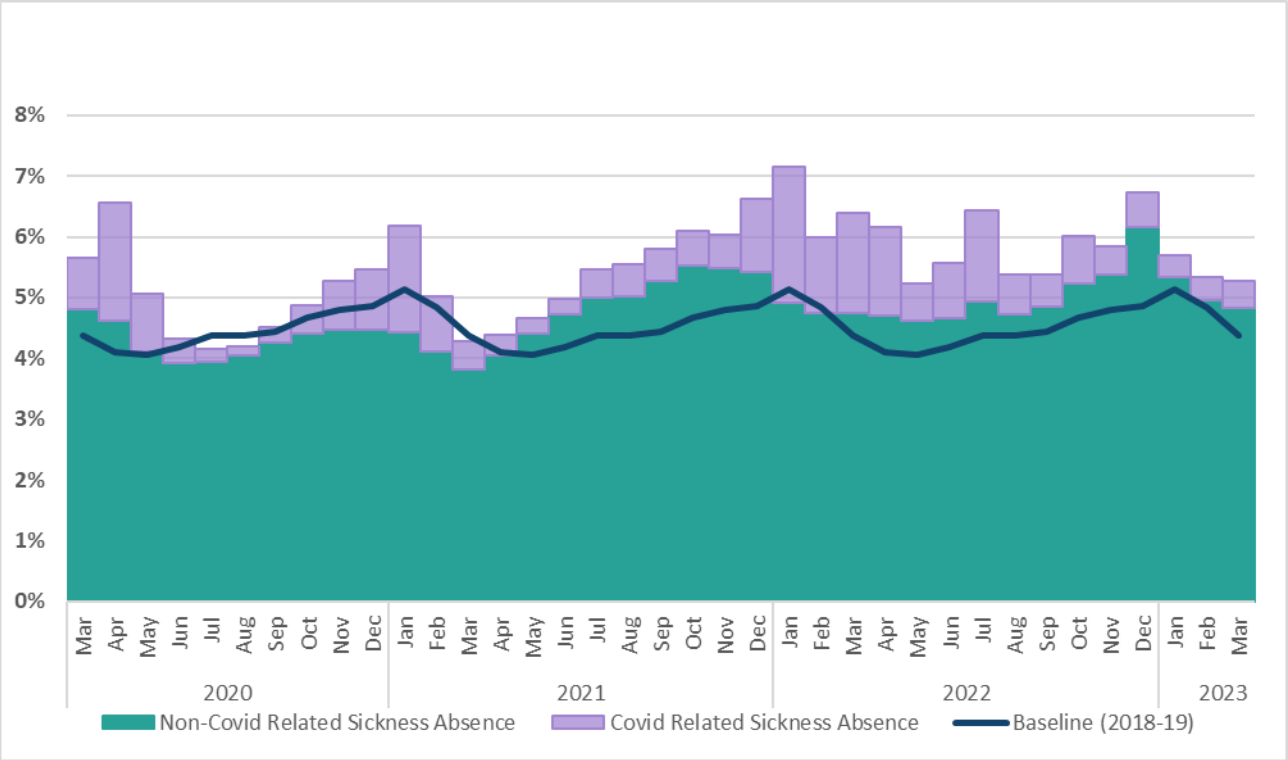
Region	Year to March 2023
England	5.8%
London	5.1%
South West of England	5.7%
South East of England	5.3%
Midlands	6.1%
East of England	5.6%
North West	6.8%
North East and Yorkshire	6.3%

COVID-19 related sickness absence

NHS England data is available to describe trends in COVID-19 related sickness absence. Additional coding has been made available on ESR for organisations to record sickness absence as COVID-19 related or not.

Figure 6 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 to 2019. High levels of COVID-19 in the population in 2022 meant the rate was high in the NHS and the wider economy (see ONS sickness absence in the UK labour market).

Figure 6: Monthly non-medical sickness absence rates split by COVID and non-COVID coding March 2020 to March 2023, FTE



Source: NHS England Sickness Absence statistics

Diversity analysis

The NHS workforce remains more ethnically diverse than the workforce in the wider economy. Across the non-medical workforce, 71% of the workforce is white with a further 11% Asian or Asian British and 8% black or black British.

Table 14: Ethnicity makeup of non-medical NHS roles

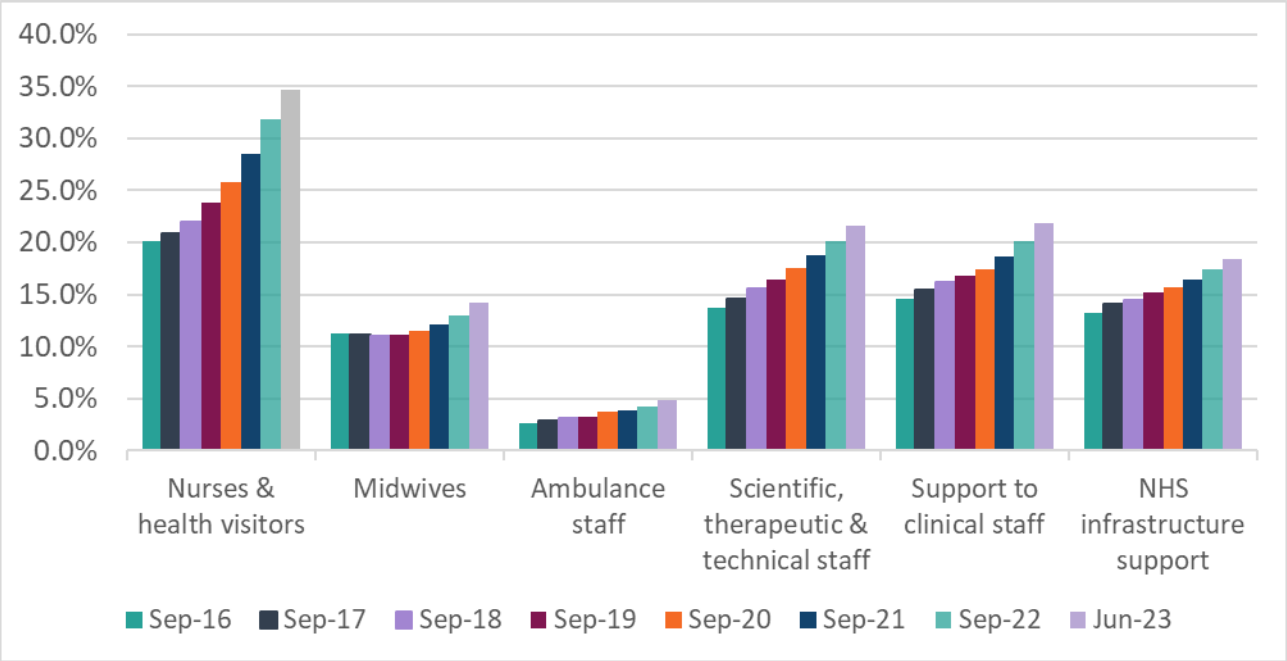
June 2023 (% of headcount)	Asian or Asian British	Black or black British	Chinese	Mixed	White	Any other ethnic group	Not stated	Unknown and discount. codes
All nonmedical staff	11.2%	8.0%	0.4%	1.9%	71.4%	2.9%	3.2%	1.0%
Nurses and health visitors	15.9%	11.1%	0.3%	1.6%	60.8%	5.7%	3.5%	1.1%
Midwives	2.6%	8.4%	0.2%	2.2%	82.5%	0.8%	2.6%	0.8%
Ambulance staff	1.6%	1.0%	0.2%	1.7%	92.7%	0.4%	2.2%	0.2%
Scientific, therapeutic and technical staff	10.9%	5.7%	1.0%	2.2%	75.1%	1.8%	2.6%	0.7%
Support to doctors, nurses and midwives	10.1%	8.7%	0.3%	2.0%	72.7%	2.3%	2.9%	1.0%
Support to ambulance staff	3.6%	2.5%	0.1%	1.8%	88.1%	0.3%	2.9%	0.7%
Support to ST&T staff	9.7%	5.5%	0.5%	2.5%	76.3%	1.8%	2.6%	1.0%
Central functions	9.6%	5.8%	0.5%	2.0%	77.5%	1.0%	2.8%	0.7%
Hotel, property and estates	8.8%	6.8%	0.2%	1.7%	72.3%	2.1%	6.7%	1.3%
Senior managers	5.7%	3.4%	0.3%	1.6%	84.4%	0.6%	3.1%	1.0%
Managers	7.3%	4.7%	0.5%	2.0%	81.2%	0.8%	2.8%	0.7%
Other staff or those with unknown classification	26.7%	22.0%	0.5%	3.1%	31.6%	6.1%	4.4%	5.4%

Source: NHS England HCHS monthly workforce publication – June 2023

Figure 6 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 7: Aggregated percentage of staff reporting non-white ethnic grouping by selected staff groups: September 2016 to June 2023



Source: NHS England workforce statistics

Gender balance in the non-medical workforce

Data from June 2023 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 nursing (88.2%), midwifery (99.6%) and staff supporting doctors and nurses (83.9%). Compared to the rest of the NHS workforce, males have higher representation in staff groups including ambulance staff (52.8%), support to ambulance staff (44.8%) and senior managers (41.6%).

Table 15: Workforce gender representation by staff group (June 2023)

Staff group	Female	Male
All non-medical staff	79.4%	20.6%
Nurses and health visitors	88.2%	11.8%
Midwives	99.6%	0.4%
Ambulance staff	47.2%	52.8%
Scientific, therapeutic, and technical staff	77.1%	22.9%
Support to doctors, nurses, and midwives	83.9%	16.1%
Support to ambulance staff	55.2%	44.8%
Support to ST&T staff	78.3%	21.7%
Central functions	70.9%	29.1%
Hotel, property, and estates	57.0%	43.0%
Senior managers	58.4%	41.6%
Managers	62.4%	37.6%
Other staff or those with unknown classification	79.2%	20.8%

Source: NHS England workforce Statistics

Temporary staffing

The deployment of a temporary 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. Staff can be drawn from internal staff banks or external agencies.

The department and NHS England's temporary staffing strategy aims to support NHS providers to reduce their agency staff bills and encourage workers back into substantive and bank roles.

Measures were introduced in 2016 to curb NHS agency spending including price caps, the mandatory use of approved frameworks for procurement, and the requirement for all systems to stay within the specified annual expenditure ceilings for agency staff. The measures, which are regularly monitored for compliance and effectiveness, aim to reduce cost and give greater assurance of quality.

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.

Trusts are encouraged to develop and improve their strategy, procurement, and commercial negotiation in their approach to temporary staffing. NHS England supports the

NHS to reduce off-framework supply and to develop staff banks, increasing transparency and collaborative arrangements.

The NHS is experiencing a period of unprecedented demand and there was an increase in expenditure on both bank and agency staff in the 3 years to 2021 to 2022. Bank expenditure increased by 51% (from £3.45 billion to £5.2 billion) and agency expenditure increased 23% from £2.4 billion to £2.96 billion. Bank and agency spend increased further in 2022 to 2023 to £5.8 and £3.46 billion respectively, although there are signs that agency spend is beginning to decrease again in 2023 to 2024.

Price cap compliance for all staff groups has remained constant at 60% since 2018 until 2022 to 2023 when it dropped to 55%. However, for the medical and dental staff group compliance is typically around 13% (13.3% in 2021 to 2022). The national shortages of medics in certain specialities (such as orthopaedics, geriatrics, cardiothoracic oncology, and radiology) may contribute to poor compliance rates amongst this group. This causes greater variability in hourly rates between on and off-framework spending.

Agency spend accounted for 4.5% of the NHS pay bill in 2022 to 2023. NHS Planning guidance states that the system should reduce agency spending across the NHS to 3.7% of the total pay bill in 2023 to 2024.

The investment set out in the LTWP will reduce reliance on agency staff over time. The plan estimates that reliance on temporary staffing in FTE terms would reduce from 9% in 2021 to 2022 to around 5% in 2032 to 2033.

Staff engagement and wellbeing

The NHS staff survey continues to provide useful information on the many aspects of staff experience at work.

The most recent NHS staff survey was undertaken in November 2022 and published in March 2023. As in the previous year, the results were aligned with the 7 themes of the NHS People Promise. As this is only the second year of the change away from the earlier themes, it is no longer possible to provide a year-one year comparison on themes other than staff engagement and morale, which have remained. However, the individual questions have largely remained the same, enabling comparisons with previous years to be made.

The 2022 results were fairly consistent with the previous year with staff engagement remaining at 6.79. Satisfaction with pay dropped considerably by 7 points (2021 32.6% to 25.6% in 2022). Numbers of staff wishing to leave the NHS and seek work outside of the

NHS also saw a decrease from 5.96 in 2021 to 5.88 (out of 10) in 2022 and represents the lowest score of the past 5 years.

Morale saw the lowest score in the last 5 years shifting from 5.77 in 2021 to 5.74 in 2022. There are measures in place including the continuing investment in workforce growth to alleviate workforce pressures and ongoing work to improve leadership, culture, and staff experience.

The positive results that emerged from the survey were where there has been sustained action in areas such as flexible working, the quality of line management and staff engagement. For example, the number of respondents who feel they can approach their manager to talk openly about flexible working has increased from 66.9% in 2021 to 68.5% in 2022.

The NHS People Promise remains the key vehicle for action to support staff wellbeing, create a compassionate and inclusive culture and leadership, and promote flexible working opportunities. The aims of the People Promise align closely with the NHS LTWP.

The NHS Long Term Plan is clear that opportunities for flexible working must be prioritised and go beyond minimum statutory requirements. The ambition is that flexible working options be considered for all roles and jobs to ensure the NHS remains competitive in attracting and retaining talent.

NHS England are continuing to invest in specialist mental health support and wellbeing. The department has worked with NHS England to ensure that support continues to be available to NHS staff through the mental health hubs that are in place in every region during 2023 to 2024. £2.3 million has been invested by NHS England into local ICSs to help support them in developing their own, locally delivered health and wellbeing offers where they are best placed to tailor this support to the needs of their workforce. NHS England have provided more detail on the initiatives and programmes in place to support the health and wellbeing of the NHS workforce.

The role of Health and Wellbeing guardians is now well established and supports boards in creating the organisation culture that prioritise the health and wellbeing needs of its staff. This is coupled with training for line managers to enable them to facilitate health and wellbeing conversations with their staff.

Women between the ages of 45 and 54 make up a fifth of all NHS employees, and the majority of women will experience menopause symptoms. Good menopause care has both direct and indirect impacts on workforce retention, productivity, presenteeism and absenteeism. In November 2022 NHS England published menopause guidance for NHS line managers and colleagues. NHS England has also launched e-learning packages for staff and have launched a menopause specific section in the health and wellbeing app,

Shiny Mind, which is available to the nursing workforce. https://www.england.nhs.uk/long-read/supporting-our-nhs-people-through-menopause-guidance-for-line-managers-and-colleagues/Many of these programmes of work are focused on creating a sustainable long-term cultural shift, as identified in the NHS LTWP. The impact will not be seen immediately; they require time and sustained investment. NHS staff continue to work in challenging circumstances, so it remains vital that this support continues to ensure that they feel supported and have a positive experience of working within the NHS. Provision of occupational health services has been variable with some organisations providing in house support or others contracting out to external providers with the NHS staff survey reporting 56.6% of staff believed that their organisation was taking positive action on health and wellbeing. NHS England has published a strategy to improve occupational health and wellbeing - 'Growing Occupational Health and Wellbeing Together'. This sets out a roadmap for the NHS and partner organisations with the expectation that they will work together to develop and invest in occupational health and wellbeing services for the NHS over the course of the next 5 years.

Violence and sexual misconduct

Sexual assault in the NHS has received national and trade media attention, with the recent publication of an independent report in sexual misconduct in surgery, bringing the issue rightly to the forefront.

To tackle the issues of sexual misconduct and violence, in July 2023, NHS England established a Domestic Abuse and Sexual Violence programme to build on safeguarding processes to protect patients, improve the support available to victims and with a focus on early intervention and prevention. The programme has also been expanded to address sexual safety in the healthcare workplace with NHS England expecting every NHS trust and local health system in England to have a domestic abuse and sexual violence lead in place.

NHS England have also developed the health service's first organisational Sexual Safety Charter following an urgent call for action to tackle the issue of sexual misconduct in the workplace. The Charter, produced in conjunction with Royal Colleges, those with lived experience, trade unions and regulators, sets out 10 principles with those organisations signing up to the Charter committing to taking and enforcing a zero-tolerance approach to this behaviour, with a commitment to implement these pledges by July 2024.

The 2023 NHS staff survey will also include a question focussed on how many times staff have been the target of unwanted behaviour of a sexual nature and will provide a clearer indication of the prevalence of this behaviour within the workplace.

International workforce

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

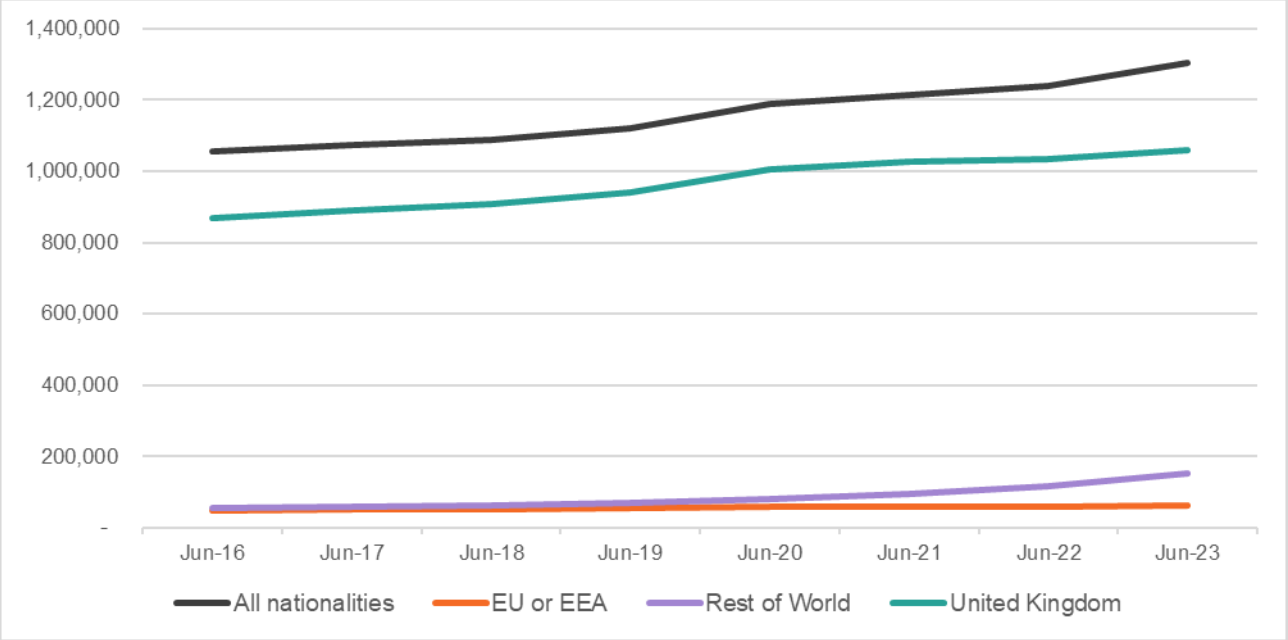
Table 16: HCHS non-medical staff by nationality, headcount, June 2016 to June 2023

Date	All nationalities	EU or EEA	Rest of World	United Kingdom	Unknown
June 2016	1,054,912	48,864	55,437	867,203	83,734
June 2017	1,072,407	51,613	57,985	889,556	73,555
June 2018	1,087,419	52,701	61,679	907,372	65,940
June 2019	1,121,430	54,854	69,080	941,905	55,839
June 2020	1,187,739	58,700	81,485	1,005,009	42,816
June 2021	1,214,560	59,580	95,190	1,026,447	33,550
June 2022	1,240,592	60,303	118,091	1,032,556	29,851
June 2023	1,302,742	63,675	151,861	1,059,861	27,579

Source: NHS England: NHS Workforce Statistics, June 2023 - staff in post

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 [30% increase in headcount of EU or EEA non-medical staff and a 174%] increase in headcount from rest of the world non-medical staff.

Figure 8: HCHS non-medical staff by nationality, headcount, June 2016 to June 2023



The ethical recruitment of health and care staff from overseas is vital. Our approach through the Code of Practice for the International Recruitment of Health and Social Care Personnel is covered in chapter 3.

Table 17: Non-medical joiners to NHS trusts and other core organisations in England by top 10 nationalities, headcount, year to June 2023

Nationality Group	Listing	Headcount	Proportion of all non-medical staff
British	N/A	134,303	67.8%
Indian	Green	18,199	9.1%
Nigerian	Red	9,080	4.5%
Filipino	Green	6,939	3.5%
Unknown	N/A	5,082	2.5%
Ghanaian	Red	2,104	1.1%
Polish	Green	1,864	0.9%
Irish	Green	1,575	0.8%
Portuguese	Green	1,403	0.7%
Zimbabwean	Red	1,270	0.6%

5. Earnings and expenses

Introduction and headline narrative

It is important that the NHS pay offer can effectively recruit, retain and motivate the staff that it needs across the full range of roles, seniority and geographical locations. 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 overall pay rates, the relative pay of different groups, or when deciding if the evidence supports pay targeting.

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:

- 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.
- In financial year 2023 to 2024, the government reached agreement with the NHS Staff Council on a pay agreement which included a 5% consolidated uplift for all staff. Staff in band 1 and the bottom of band 2 received 10.4% to raise them to the same level as the top of band 2. Eligible staff also received 2 non-consolidated payments worth between £1,655 and £3,789 relating to pay in 2022 to 2023.
- In 2022 to 2023, average basic pay per FTE for non-medical staff increased by (4.1%. This is broadly consistent with the outcome of the 2022 to 2023 pay decision which included a consolidated increase of £1,400 to all pay points enhanced to a minimum of 4% in bands 1-7. Due to the targeted nature of this award, the percentage value of this award was higher in support roles and lower in managerial grades.
- Data on the wider economic context suggests that NHS pay remains broadly competitive with other employment. The position of NHS staff within the overall

income distribution is stable and the most recent pay award was broadly in line with other sectors with non-consolidated payments helping to provide support during a period of economic pressure.

- 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.

The Agenda for Change Pay System (AfC)

Background to the Agenda for Change Pay System

Almost all non-medical staff working in the Hospital and Community Health sector (HCHS) sector in England are employed under the Agenda for Change (AfC) contractual framework. Together with pay, AfC provides the terms and conditions of employment for non-medical staff in the NHS. There are a small number of non-medical staff who are not directly engaged under AfC, including Very Senior Managers and Executive Senior Managers and those who are not directly employed by an NHS organisation (NHS Terms and Conditions of Service Handbook | NHS Employers), for example bank staff, where other local contractual arrangements apply.

The Job Evaluation Scheme (JES) is a fundamental part of AfC. It 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.

Under 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. Setting aside slight variance between some of the pay bands, the maximum length of time it takes staff to reach the top point of the same pay band is 5 years. This is dependent on successful progression which should be reviewed at each relevant pay step point.

- promotion occurs when a staff member secures a job which has been evaluated at a higher pay band than the current role. This may be due to the qualification level, responsibility or expertise needed being higher than in the current role. As pay bands no longer overlap, base pay in the higher band is

more than in the lower band. In addition, the individual will also be able to benefit from progression within the higher pay band.

Staff can also receive additional earnings if they work unsocial or additional hours. This is described in more detail later in the chapter.

Table 18: Example of difference in pay bands and pay steps in band 5 and 6 of Agenda for Change

	Band 5	Band 6
0 - 1 Year	Pay Point 1	Pay Point 1
1 - 2 Years		
2 - 3 Years	Pay Point 2	Pay Point 2
3 - 4 Years		
4 - 5 Years	Pay Point 3 (Max)	
5 - 6 Years		Pay Point 3 (Max)
6 - 7 Years		
7 - 8 Years		

Source - NHS Terms and Conditions 2023 (Agenda for Change) (pdf, 40kb)

A significant amount of structural reform was undertaken as part of the 2018 AfC agreement. This removed overlaps between all pay bands and reduced the length of all pay bands by reducing the number of pay step points in each band. As a result, quicker pay progression was facilitated for bands 2 to 7 inclusive. The new pay progression system was fully operational from 1 April 2021 when the final transition points were removed from bands 5 to 7. Table shows the current pay structure in operation in the financial year from April 2023.

Table 19: Agenda for Change pay structure from 1 April 2023

Band	Band Minimum	Band Intermediate	Band Maximum	Minimum Time to Top of Band	Within Band Progression
Band 1	N/A	N/A	£22,383	N/A	N/A
Band 2	N/A	N/A	£22,383	N/A	N/A
Band 3	£22,816	N/A	£24,336	2 Years	7%
Band 4	£25,147	N/A	£27,596	3 Years	10%
Band 5	£28,407	£30,639	£34,581	4 Years	22%
Band 6	£35,392	£37,350	£42,618	5 Years	20%
Band 7	£43,742	£45,996	£50,056	5 Years	14%
Band 8a	£50,952	N/A	£57,349	5 Years	13%
Band 8b	£58,972	N/A	£68,525	5 Years	16%
Band 8c	£70,417	N/A	£81,138	5 Years	15%
Band 8d	£83,571	N/A	£96,376	5 Years	15%
Band 9	£99,891	N/A	£114,949	5 Years	15%

Source - NHS Employers Pay Scales for 2023 to 2024. Bands 1 and 2 operate a single "spot rate" and Band 1 was closed to new entrants from October 2018.

In financial year 2022 to 2023, a small number of staff (~3,800 FTE) in bands 8a and above received non-consolidated payments worth between £2,934 and £8,083 to ensure their base salary was not below what it was prior to the 2018 AfC pay agreement. These payments are not required in 2023 to 2024 as all impacted staff will have either had the opportunity to progress to the top of the pay band or have been promoted to a higher pay band from which point payment of the temporary payment should have ceased. More information on these payments is set out in Annex 2 of the NHS Terms and Conditions Handbook.

Under the reformed contract, which was fully implemented in 2021, staff are not entitled to automatic time served progression. Instead, staff spend a minimum of 2 years at each pay point before becoming eligible to move to the next pay point in their band.

Staff can be split into the following categories:

- top of band - staff who have reached the top pay step point 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; and
- staff between pay points - 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 pay step point.

Table 20 shows the number of staff in different progression categories during 2022 to 2023. It shows that across the HCHS workforce, just over 50% of staff were already at the top of the pay band and just under 50% eligible for further progression within their current band. The proportion of staff already at band maxima is higher for bands where it takes less time to progress and there are more "in-year progressors" in cases where there are more progression steps. The estimated average value of progression for those eligible for progression in 2023 to 2024 is around 8% after accounting for the removal of progression in band 2 as part of the AfC pay agreement.

Table 20: Staff by band and eligibility for pay step progression in 2022 to 2023

Band	FTE	Top of Band	All Progressors	In-Year Progressors	Staff Between Increments
Band 1	2,303	100%	0%	0%	0%
Band 2*	175,687	100%	0%	0%	0%
Band 3	159,412	63%	37%	13%	24%
Band 4	115,489	52%	48%	8%	40%
Band 5	224,466	42%	58%	23%	35%
Band 6	214,339	46%	54%	18%	36%
Band 7	140,633	45%	55%	18%	37%
Band 8a	56,291	39%	61%	4%	56%
Band 8b	23,654	40%	60%	4%	56%
Band 8c	12,643	42%	58%	4%	54%
Band 8d	6,762	44%	56%	4%	52%
Band 9	3,436	47%	53%	4%	39%
All AfC	1,135,116	51%	49%	15%	34%

Source - DHSC Sub-Group Metrics 2022 to 2023 (Publication Link When Available)

* From 1 April 2023 all pay steps in band 2 had the same pay value. This means that all staff will be at "top of band" in 2023 to 2024.

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

The High-Cost Area Supplement (HCAS)

The High-Cost Area Supplement (HCAS) is a supplement paid to staff working in defined locations in and around London to reflect the higher cost of living in those areas. The supplement has 3 different zones (fringe, outer and inner) with the highest 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 factors 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 the pandemic 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 (RRPs)

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 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 RRPs should they wish.

Our understanding is that these flexibilities are seldom used by employers locally due to 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 local health labour market.

NHS England Earnings Data, Table 3a (xlsx, 326kb) estimates the proportion of staff who have received a payment categorised as an "RRP" and the average value of those payments. In the 12 months to March 2023 the proportion of staff who received these payments ranged from 0.2% (support to ST&T staff) to 1.6% (hotel, property and estates). However, we are not able to verify that all of these payments are RRPs as per the terms of the handbook. The proportion of nurses in receipt of an RRP is unchanged at 0.6%.

Average pay and earnings in 2022 to 2023

Average pay and earnings by staff group

NHS England publish information on average pay and earnings for staff working in the 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 21: Average pay and earnings for non-medical staff in the 12months to March 2023 with comparison to the 12 months to March 2022. HCHS trusts and 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	£31,924	£32,313	3.7%	4.1%
Nurses and health visitors	£37,198	£36,983	3.4%	3.9%
Midwives	£36,519	£38,844	2.2%	3.8%
Ambulance staff	£46,694	£37,024	0.1%	4.8%
Scientific, therapeutic and technical staff	£38,812	£41,351	3.7%	4.0%
Support to doctors, nurses and midwives	£22,557	£23,164	6.1%	6.7%
Support to ambulance staff	£30,024	£24,837	3.0%	6.0%
Support to ST&T staff	£23,153	£24,619	6.7%	6.4%
Central Functions	£30,562	£31,466	5.4%	5.2%
Hotel, Property and Estates	£22,146	£22,772	6.0%	7.0%
Senior Managers	£85,651	£85,791	2.6%	1.6%
Managers	£57,574	£57,186	2.5%	2.9%

Source - NHS England Earnings Statistics - 12 months to March 2023 - Tables 1, 2a and 2b (xlsx, 326kb)

Average basic pay per FTE in 2022 to 2023 ranges between £22,772 (Hotel, Property and Estates) and £85,791 (Senior Managers), while average earnings per person ranges between £22,146 (Hotel, Property and Estates) and £85,651 (Senior Managers).

The growth in basic pay per FTE and total earnings in 2022 to 2023 varies by staff group following the targeted pay award in 2022 to 2023 which included a uniform cash payment of £1,400 to all staff (enhanced to a minimum of 4% in bands 2 to 7). The percentage increase in basic pay was highest in those staff groups with more staff in the lower bands (for example, Hotel, Property and Estates and Support roles) and lowest in groups with more senior staff (for example, Managers and Senior Managers) where £1,400 equates to a smaller percentage. Staff in band 8a and above did not receive the 4% minimum.

Across many staff groups the increase in total earnings per person is smaller than the growth in basic pay per FTE. There are several factors specific to this year which can help explain this anomaly and why we might think that increases in basic pay per FTE are more representative of changes to the pay system and reward:

- During 2021 to 2022, staff who worked regular overtime received a one-off non-consolidated payment as part of a settlement between employer and staff side

representatives which were not repeated in 2022 to 2023 (more detail on those payments is available at NHS Employers website). This especially impacts certain staff groups, including ambulance staff and support to ambulance staff, who are most likely to work regular overtime as part of their role. For context "other" payments, which include these payments, were worth over 2.5% of total earnings in 2021 to 2022 compared to only 0.5% in 2022 to 2023.

- During 2021 to 2022, additional earnings were higher than average reflecting the unique circumstances and working patterns during the pandemic.

- In 2022 to 2023, some staff will have also seen lower earnings growth in 2022 to 2023 following industrial action in the NHS.

Average pay and earnings by pay band

Table 22 presents information on average earnings by AfC band in the 12 months to March 2023 and growth in earnings compared to the 12 months to March 2022. As per other data, this will not include the impact of the 2023 to 2024 pay award implemented from June 2023.

Across all bands, average earnings increased by 3.7% to over £31,900 and average basic pay per FTE increased by 4.1% to over £32,300. The increases seen in 2022 to 2023 are broadly in line with expectations following the 2022 to 2023 pay award. The targeted, uniform cash nature of that award means that those in less senior bands will have seen a higher percentage award compared to those in more senior bands. This is shown in this data as the increase in basic pay per FTE which was highest in band 1 (9.1%) and smallest in band 9 (1%). The increase in average earnings tends to be slightly smaller than the growth in basic pay per FTE - this is consistent with a smaller growth in additional earnings as explained in further detail in the pay drivers section below.

This data does not include the impact of the 2023 to 2024 pay award which increases basic pay for most staff by 5%.

Table 22: Average basic pay per FTE and total earnings by AfC band - 12 months to March 2023.

Band or grade	Average earnings per person	Average basic pay per FTE	Annual growth in earnings per person	Annual growth in basic pay per FTE
Band 1	£15,447	£20,204	4.3%	9.1%
Band 2	£19,816	£20,907	6.0%	7.3%
Band 3	£21,980	£22,576	5.6%	6.1%
Band 4	£24,527	£25,090	5.1%	5.3%
Band 5	£30,924	£29,961	3.8%	4.0%
Band 6	£36,782	£37,370	2.5%	3.3%
Band 7	£43,191	£44,888	2.8%	3.2%
Band 8a	£48,748	£51,003	1.9%	2.4%
Band 8b	£57,906	£60,018	1.0%	1.7%
Band 8c	£70,162	£71,664	0.8%	1.4%
Band 8d	£85,387	£85,382	0.5%	1.3%
Band 9	£103,486	£102,493	0.6%	1.0%
All Bands	£31,924	£32,313	3.7%	4.1%

Source - NHS England Earnings Statistics, 12 months to March 2023, NHS trusts and core Organisations in England

Income distribution

Across the workforce, and within staff groups, there will be differences in earnings linked to factors including an individual's pay point, contract and working patterns.

Table 23 is based on data on the income distribution for non-medical staff published by NHS England and is split by staff group. To ensure the analysis is not impacted by people leaving or moving between staff groups, this data only includes staff who were employed in the same staff group throughout the period between April 2022 and March 2023.

For most staff groups, we see there are only small differences between the median and mean.

Table 23: Distribution of average earnings per person by staff group, 12 months to March 2023.

Staff group	25th Percentile	Median	75th Percentile	Mean
United Kingdom (ASHE)	19,783	29,669	43,157	35,404
Nurses and health visitors	£31,293	£37,184	£44,299	£37,198
Midwives	£29,930	£37,625	£44,452	£36,519
Ambulance staff	£40,715	£49,252	£55,600	£46,694
Scientific, therapeutic and technical (ST&T) staff	£30,697	£39,047	£47,782	£38,812
Support to doctors, nurses and midwives	£18,442	£23,177	£26,773	£22,557
Support to ambulance staff	£25,090	£30,346	£35,690	£30,024
Support to ST&T staff	£18,599	£23,217	£26,855	£23,153
Central Functions	£23,177	£28,210	£39,560	£30,562
Hotel, property and estates	£16,054	£21,820	£26,827	£22,146
Senior Managers	£65,262	£80,966	£109,348	£85,651
Managers	£48,588	£55,948	£65,833	£57,574

Source - NHS England Earnings Statistics, 12 months to March 2023

The impact of the 2023 to 2024 pay award

Data to the end of March 2023 will not include the impact of the most recent pay award. which was implemented in June 2023 and backdated to 1 April 2023.

- The consolidated award for 2023 to 2024 sees all pay points increase by 5% with the lowest paid staff seeing their pay brought up to the top of band 2 (a 10.4 per cent pay increase)

- Eligible staff employed at the end of March 2023 will have also been eligible to receive 2 non-consolidated awards on top of the 2022 to 2023 pay award:

    - A non-consolidated award worth 2%of basic pay in 2022 to 2023

    - A one-off NHS backlog bonus worth between £1,250 and £1,600

- In total, non-consolidated payments are worth between £1,655 and £3,789 which is equivalent to between 3.5% and 8.2% of basic pay in 2022 to 2023.

We anticipate that the consolidated pay award in 2023 to 2024 will add around 5.2% to the paybill.

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 (see the NHS Terms and Conditions of Service Handbook).

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 while 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 24: Proportion of total earnings that are not basic pay by staff group in NHS trusts and core organisations, 12 months to March 2022 and 12 months to March 2023.

Staff group	12 months to March 2022	12 months to March 2023
Nurses and health visitors	13.7%	13.0%
Midwives	17.0%	15.9%
Ambulance staff	41.1%	36.1%
Scientific, therapeutic and technical staff	8.9%	8.4%
Support to doctors, nurses and midwives	14.0%	13.3%
Support to ambulance staff	36.8%	32.8%
Support to ST&T staff	8.4%	7.6%
Central Functions	6.2%	5.9%
Hotel, Property and Estates	20.9%	19.4%
Senior Managers	4.7%	4.4%
Managers	5.6%	5.2%

Source - NHS England Earnings Statistics - NHS trusts and core organisations - 12 months to March 2023 - Table 2c/d (xlsx, 326kb)

For all staff groups there has been a reduction in the proportion of earnings from sources other than basic pay. This was to be expected following the expiry of one-off non-consolidated payments for staff working regular overtime (Flowers case). The latter particularly impacted ambulance and support to ambulance staff.

In 2023 to 2024, we would expect the "additional earnings" proportion to increase as a result of the non-consolidated payments made as part of the most recent pay agreement for 2023 to 2024.

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 England 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.

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), while some relate more specifically to pay rates. Table xx presents trends in earnings growth and its component drivers over recent years.

The headline pay award is the expected change in total earnings per FTE due to changes in pay rates following the annual pay award. The difference between observed total earnings per FTE growth and the headline pay award is ‘total earnings drift,’ which represents the change in average earnings that is not explained by the pay award. Total earnings drift can be broken down into the different components shown in the table:

- basic pay drift (excluding staff group mix effect), reflecting changes in average basic pay per FTE due to changes in the distribution of staff across pay points and bands within staff groups (for example, band 6 vs band 5 nurses).

- additional earnings effects due to additional earnings changing at a different rate to basic pay (this may include increased or decreased use of payments for overtime, shift working, geographical allowances and so on.) staff group mix effects, reflecting shifts in the distribution of staff between higher and lower earning staff groups (for example, nurses vs support staff). This is based on the HCHS non-medical staff groups that are presented in NHS England published data (and used in Table 24).

Pay growth estimates are based on analysis of data on workforce earnings and size published by NHS England. Drift estimates, the difference between pay growth and the pay award, are based on changes to pay values from pay circulars weighted by pay point workforce size estimates based on NHS England workforce data. The analysis is based on data for all HCHS organisations including NHS trusts, NHS foundation trusts, ICBs and central and support organisations, so figures for average basic pay and earnings growth may differ slightly from the figures based on NHS trusts and core organisations in Table 22. Growth in earnings per FTE may also differ from growth in earnings per person due to changes in average FTE per person.

Table 25: Breakdown of average earnings growth for HCHS non-medical staff

Pay growth element	2017 to 18	2018 to 19	2019 to 20	2020 to 21	2021 to 22	2022 to 23
Basic pay per FTE growth	1.3%	3.2%	2.9%	3.1%	4.0%	4.8%
Additional earnings per FTE growth	-0.7%	0.2%	5.4%	5.5%	3.2%	-2.0%
Total earnings per FTE growth	1.1%	2.9%	3.1%	3.4%	3.9%	4.0%
Components of Total earnings per FTE Growth	-	-	-	-	-	-
(a) Headline pay awards	1.0%	3.0%	3.3%	2.9%	3.6%	4.7%
(b) Total earnings drift	0.1%	-0.1%	-0.1%	0.5%	0.3%	-0.7%
Components of (b) Total earnings drift	-	-	-	-	-	-
(b1) Basic pay drift (excluding staff group mix effect)	0.2%	0.1%	0.3%	0.4%	0.2%	0.1%
(b2) Additional earnings drift impact (excluding staff group mix effect)	-0.2%	-0.3%	-0.1%	0.5%	0.0%	-0.7%
(b3) Staff group mix effect	0.1%	0.1%	-0.3%	-0.4%	0.1%	0.0%

Source: DHSC analysis based on NHS England workforce earnings and size data and NHS Employers pay circulars

Average total earnings per FTE grew by 4.0% in 2022 to 2023. This takes into account the combined impact of the 2022 to 2023 headline pay award of 4.7% and the negative total earnings drift of -0.7%. The headline pay award is the average impact of a % uplift varying by pay point, based on the £1,400 uplift to all pay points subject to a 4% minimum uplift up to and including band 7. This was the largest annual increase in total earnings per FTE over the last 6 years, which is consistent with the average headline pay award 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 0.1% in 2022 to 2023 (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 negative 'additional earnings drift impact' (excluding staff group mix effects) of -0.7%, which indicates a decrease in the overall use of additional earnings payments in 2022 to 2023. This largely reflects the expiry of one-off payments in 2021 to 2022 relating to holiday pay for staff working regular overtime, which added around £150m

to additional earnings in 2021 to 2022, with a decrease in shift working payments in 2022 to 2023 also having an impact (shift working payments being the largest component of additional earnings for non-medical staff overall).

- A neutral 'staff group mix' effect of 0.0% reflecting no overall shift in the distribution of staff towards higher or lower earning staff groups in 2022 to 2023.

The National Living Wage (NLW) and low pay policy

In 2023 to 2024, the minimum pay rate under Agenda for Change is £11.45 per hour (increasing to £14.07 per hour for those working in Inner London) compared to the National Living Wage (NLW) of £10.42 per hour, which is the statutory minimum payable to most employees aged 23 and over. In the NHS, this represents an increase of 10.4% in the minimum pay rate compared to 2022 to 2023 following the decision to increase pay in band 1 and the bottom of band 2 to the same rate as the top of band 2 as part of the 2023 to 2024 pay agreement.

The current government commitment is for the NLW to reach two-thirds of median earnings by 2024, taking economic conditions into account. At the Autumn Statement, the government announced that the NLW will increase to £11.44 in April 2024 and will apply to individuals aged 21 and over. This is an increase of 9.8% (£1.02 per hour) from the current rate of £10.42 per hour in 2023 to 2024, which the LPC believe will be sufficient to fulfil the existing commitment.

We note that the new level of the NLW from April 2024 is only marginally (1p) lower than the current minimum pay rate in the NHS (£11.45), however this is before the 2024 to 2025 pay award which will restore a gap between the NLW, and the NHS minimum pay rate. As part of its remit this year, the Low Pay Commission has stated that it will be providing advice to the government on the post 2024 minimum wage framework.

The outcome of the 2023 to 2024 pay round was most beneficial to the lowest earners with the decision to increase pay for those in band 1 and the bottom of band 2 to the rate at the top of band 2, resulting in a 10.4% increase in pay for those groups and maintaining a premium of around 9.9% above the NLW. This was a limited form of low-pay targeting with all other pay points receiving a consolidated 5% uplift. This means there was a limited impact on the overall pay structure but does mean that the pay gaps between some bands remain small following the stronger targeting in 2022 to 2023. For example, the gap between band 2 and band 3 is 1.9% (£433) and the gap between band 7 and band 8a is 1.8% (£896). It is possible that small differentials between bands can impact on promotion incentives, particularly where there is an interaction with unsocial hours premia and or recruitment and retention premia.

This trade-off between competing objectives will also be a factor for setting pay at the lower end of the pay scale in 2024 to 2025. 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.

The broader economic context, as well as the recruitment and retention situation, will be key in determining whether further pay targeting is required in 2024 to 2025 and, if so, where it may be justified. 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 our oral evidence session.

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 individual 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 Electronic Staff Record (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 26 presents this information by staff group for the 10 years between March 2013 and March 2023 and covers almost 540,000 staff employed in both periods. IT is based on the staff group in the most recent period.

For staff employed in both 2013 and 2023, the median average increase in basic pay per FTE was around 38% with a quarter of staff experiencing increases of more than 57% over the period. Where there are differences between sections of the workforce, these can mostly be explained by either the methodology that has been used or specific events that have impacted pay for certain groups.

- The median increase is higher for ambulance staff than most other staff groups following the decision to re-band paramedics at band 6 and the re-classifying of some roles to the support category.

- The median increases for managers and senior managers are higher than other staff groups. This is because the analysis is based around an individual's current

staff group and many staff in the managerial groups will have been promoted into those groups from other sections of the workforce.

- For most staff groups, around 25% of staff saw an increase in basic pay of around 19-22%, which is consistent with the increase someone would have expected if they had remained at the top point of a single pay band throughout the period.

Table 26: Increases in basic pay per FTE for staff employed in March 2013 and March 2023. By staff group.

Staff Group	Frequency	Mean increase	Median increase - 50% of staff saw increases of at least	25th Percentile - 75% of staff saw increases of at least	75th Percentile - 25% of staff saw increases of at least
All Agenda for Change	540,000	45%	38%	22%	57%
Nurses and health visitors	176,000	46%	40%	19%	59%
Midwives	12,000	43%	38%	19%	59%
Ambulance staff	9,000	69%	60%	47%	86%
Scientific, therapeutic and technical staff	84,000	50%	40%	21%	70%
Support to doctors, nurses and midwives	116,000	34%	28%	21%	43%
Support to ambulance staff	7,000	39%	34%	21%	51%
Support to ST&T staff	27,000	35%	32%	22%	44%
Central Functions	53,000	53%	43%	24%	68%
Hotel, Property and Estates	29,000	39%	43%	26%	43%
Senior Managers	7,000	78%	66%	40%	103%
Managers	18,000	74%	63%	38%	98%

Source - DHSC Analysis of Electronic Staff Record Data Warehouse

Median growth over the past year was 5.6% which is consistent with the outcome of the 2022 to 2023 pay round. Median growth over the past 5 years has been around 4.4% per annum which we consider to be consistent with pay awards over that period, as well as the average impact of pay progression and promotion.

Career journeys and pay disparities

This section presents information on the current extent of pay gaps within the HCHS workforce and data on the profile of new staff entering the workforce. NHS England

publish more detailed information on these issues through the Workforce Equality Data Standards and Equality and Diversity Statistics which can provide additional detail on the factors underlying this data.

Gender and ethnicity pay gaps

The government is committed to tackling the issue of gender or ethnicity pay gaps where some demographic groups have lower average pay than others. While the AfC contract upholds the principles of "equal pay for equal work" there are some reasons why gaps may form across the wider workforce including:

- 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 ethnic minority 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, within staff groups, compared to female or ethnic minority staff; and
- 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 ethnic minority staff.

Within the non-medical workforce, the most important factor is staff group effects (for example, some groups being more likely to be in managerial roles) while differences within staff groups are caused by any differences in either grade mix or point mix.

The most recent data, published by NHS England (csv, 24.5mb), describes the position as at the end of May 2023 and is shown in table 27. This table is based on basic pay per FTE which excludes any differences in earnings caused by other factors such as participation rates or proclivity to undertake additional work.

The data shows only very small changes from previous years. Smaller gaps within smaller sections of the workforce may reflect some of the typical differences in how staff are distributed across the workforce - for example a higher proportion of male staff are in managerial positions while a higher proportion of female staff are in support roles. The pay structure and the system of job evaluation are built around the principals of equal pay for equal work.

Table 27: Gender and ethnicity pay gaps - May 2023 - basic pay per FTE

Group	GPG - white	GPG - ethnic minority	EPG - female	EPG - male
Description	Comparison of white female to white male	Comparison of BME female to BME male	Comparison of BAME female to white female	Comparison of BAME male to white male
All Agenda for Change	-8%	0%	-6%	-13%
Nurses and Health Visitors	-4%	-2%	-14%	-16%
Professionally Qualified Clinical Staff	-5%	-4%	-13%	-13%
Support to Clinical Staff	-3%	1%	-1%	-5%
Infrastructure Support	-11%	-2%	-6%	-14%

Source - NHS England Earnings Statistics, June 2023 (csv, 24.5mb)

Promotion and new starter analysis

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 28 shows the distribution of new joiners (those employed in March 2023 but not March 2022) 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), with males more likely to be employed at band 2;
- at bands 2 to 3, males are more likely than females to be recruited and white staff are more likely than minority ethnicity staff;
- males and females have a similar likelihood to be recruited at band 7 and above, however this makes up a very small proportion of new joiners;

- larger numbers of minority ethnicity staff are recruited at band 5 but fewer in more senior bands. This is consistent with the increase in the size of the nursing workforce.

Table 28: Band profile of new joiners - staff employed in March 2023 but not March 2022

Band	All staff	Female	Male	White	BME
Band 1	0%	0%	0%	0%	0%
Band 2	25%	24%	31%	28%	22%
Band 3	17%	17%	19%	18%	16%
Band 4	11%	11%	10%	10%	12%
Band 5	28%	30%	22%	21%	38%
Band 6	10%	11%	8%	12%	8%
Band 7	5%	5%	5%	7%	3%
Band 8a	2%	2%	2%	3%	1%
Band 8b	1%	1%	1%	1%	0%
Band 8c	0%	0%	1%	0%	0%
Band 8d	0%	0%	0%	0%	0%
Band 9	0%	0%	0%	0%	0%

Source: DHSC analysis of Electronic Staff Record

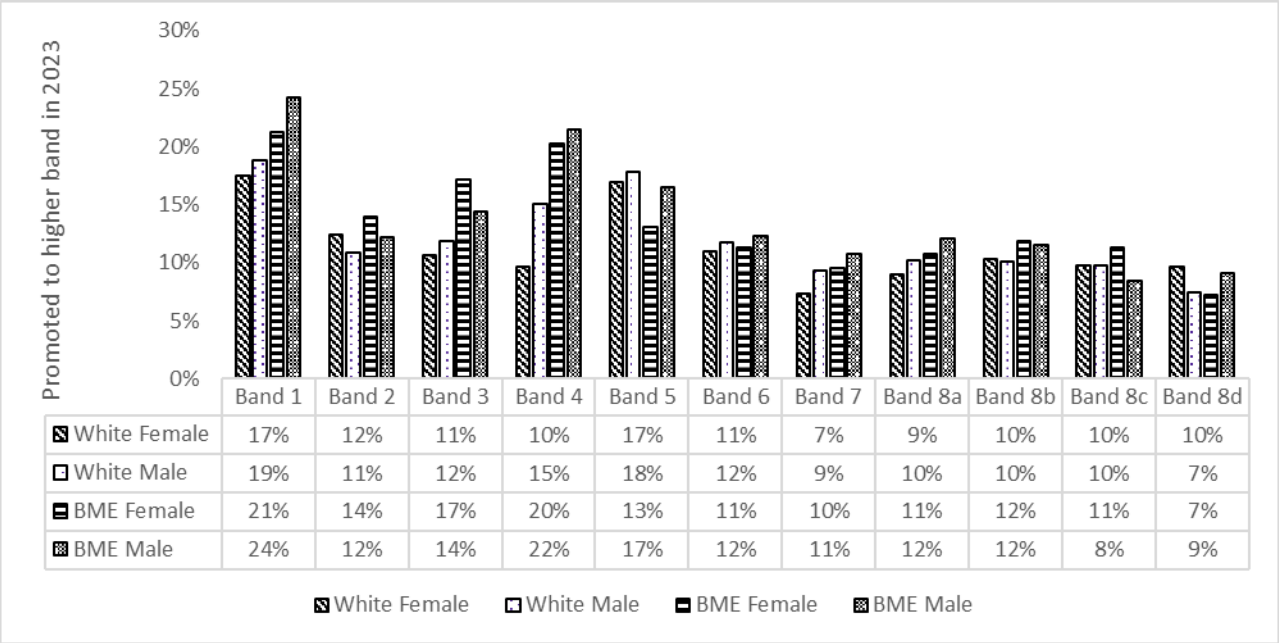
Figure 9 shows the proportion of individuals who obtained a promotion (being in a higher band in March 2023 than March 2022) and how it differs by demographics. The higher rate of promotion in band 1 follows the closure of the band to new entrants in December 2018 and the ensuing push to transition staff to band 2. Key findings are:

- at bands 3 to 8a, white females are slightly less likely to achieve a promotion than white males;

- at bands 3 to 4, ethnic minority 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 9: Promotion by gender, ethnicity and band before promotion - March 2022 to March 2023



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d
White Female	17%	12%	11%	10%	17%	11%	7%	9%	10%	10%	10%
White Male	19%	11%	12%	15%	18%	12%	9%	10%	10%	10%	7%
BME Female	21%	14%	17%	20%	13%	11%	10%	11%	12%	11%	7%
BME Male	24%	12%	14%	22%	17%	12%	11%	12%	12%	8%	9%

Source: DHSC analysis of electronic staff record

Labour market assessment

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, public sector earnings growth should retain broad parity with the private sector and continue to be affordable. Current information might indicate that:

- Latest information on pay settlements point toward median increases of between 5% and 6%. Other surveys indicate expected settlements over the next year of between 4% and 5% as the labour market loosens and inflation subsides;

- Evidence from the Annual Survey of Hours and Earnings (ASHE) suggests that the relative position of non-medical staff is broadly unchanged in recent years.

Contextual summary

Comparison with the wider economy - average weekly earnings

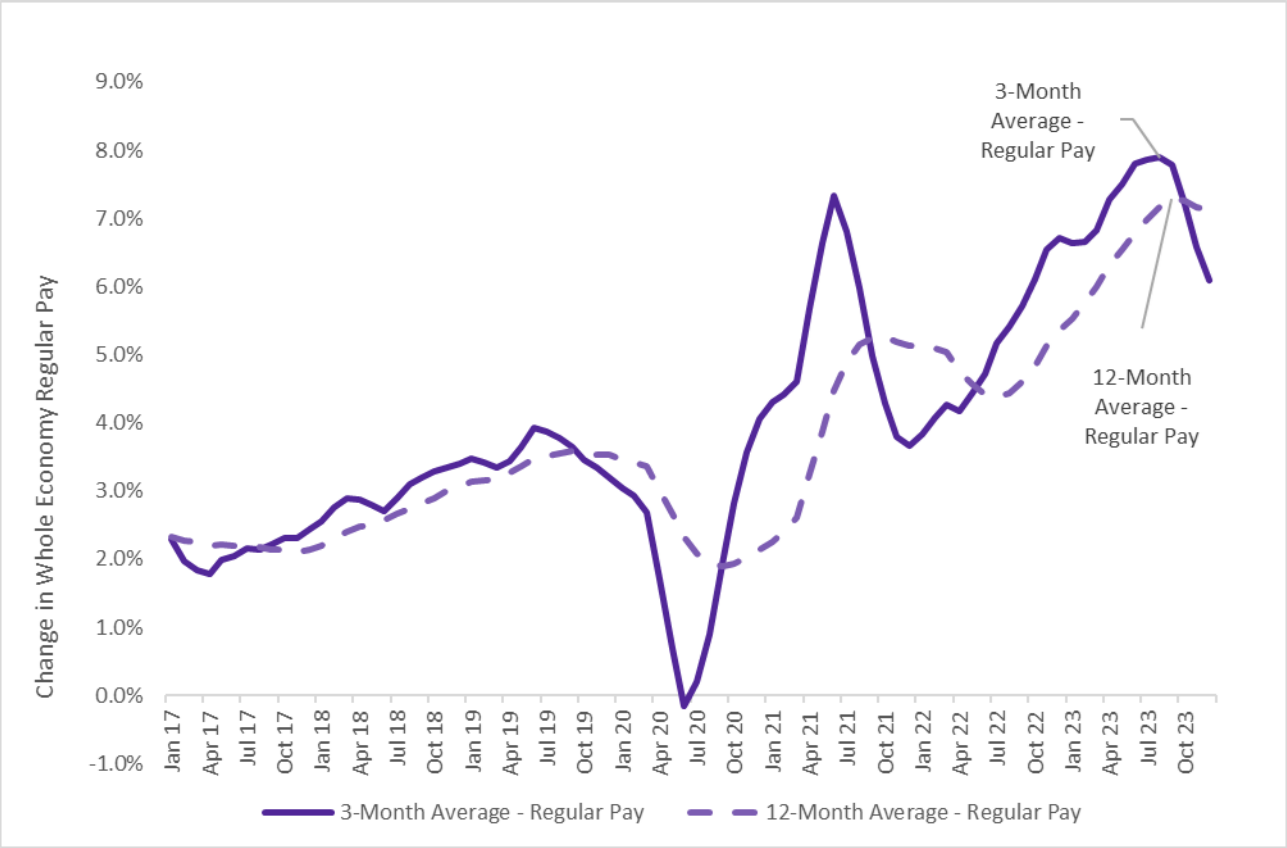
While ASHE data is comprehensive it is only available once per year and we acknowledge that the pay review bodies will want to consider more timely data on changes to earnings when making decisions.

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 changes in average working hours, or the composition of the workforce. The latter was particularly important during the COVID-19 period when the furlough scheme was in operation and supporting the pay of millions of employees. Although we are now out of the period when these "base effects" should be having a direct impact on pay figures.

Figures for the period to December 2023 show that across the whole economy, average total pay increased by 5.8% compared with the same period 12 months ago and average regular pay (excluding bonuses) increased by 6.2%. These growth rates should not be impacted by the one-off payments made to civil servants in July and August 2023. As shown in figure 9, there is some evidence that the pace of growth may now be declining following a recent peak in September 2023.

Data on pay growth is broader than just pay settlements as it includes the impact of pay drift or changes to workforce composition. Current estimates of average pay settlement may point to pay settlements being lower than headline wage growth. The most recent pay survey from XPertHR (Word, 180kb) shows a median basic pay award in the 3 months to the end of December 2023 of 6%, although this is based on a limited number of pay settlements between October and December 2023. Information from the Bank of England Decision Maker Panel estimated year ahead wage growth of 5.2% in January 2024, which was unchanged from the previous month. Please see HMT’s economic evidence for more commentary on the relationship between average earnings growth and settlement.

Figure 10: Increase in average weekly earnings, 3-month and annual growth rates between January 2017 and December 2023



Source: Office for National Statistics, average weekly earnings

General economic and pay analysis

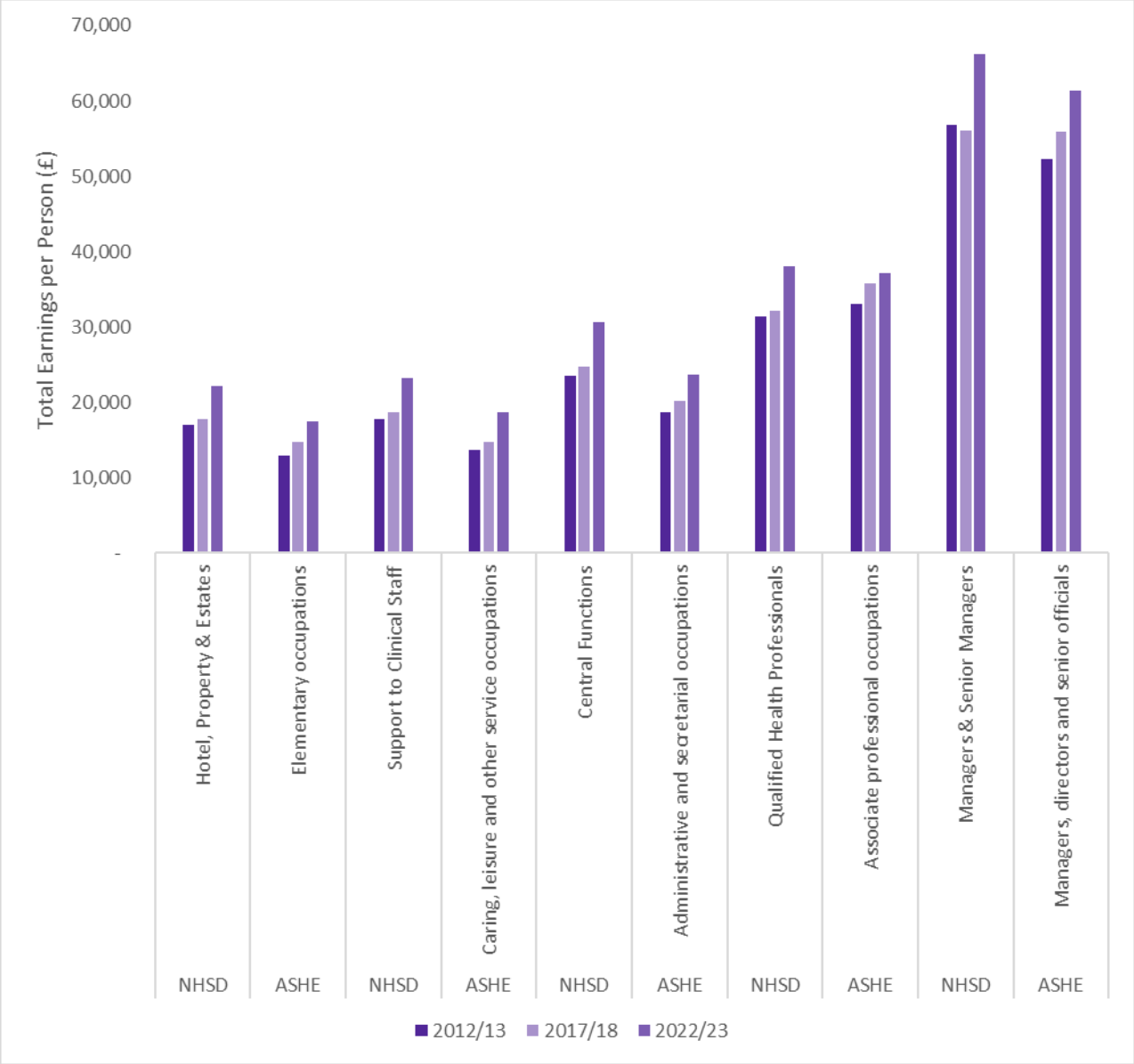
Comparator analysis

ASHE data can be used to make comparisons between occupations within the HCHS sector and comparator industries. This gives an indication of how earnings within the HCHS sector compare to earnings for other occupations that may require similar qualifications or skillsets. These are comparisons that we have previously provided, and we recognise that they are not like-for-like; NHS and ASHE groups do not align perfectly due to the differing categorisation of occupations between the organisations. The resulting differences in working patterns, and individuals' skill and experience levels are not controlled for and therefore affect the earnings of each group.

Figure 11 illustrates how the mean total annual earnings per person have changed between the financial years 2012 to 2013 and 2022 to 2023 for 5 NHS staff groups and their comparator groups from the wider economy. In all cases, the earnings of the NHS groups were higher than those for their comparator groups in the year 2022 to 2023.

Broadly the earnings are similar within each pair, which implies that they may be suitable for comparison. Other than the potential misalignment of occupations in each group mentioned above, the disparity within pairs could be affected by several factors, such as the number of full-time versus part time workers in each group, the ongoing impact of the pandemic, and survey participation rates.

Figure 11: Mean average total annual earnings for HCHS and comparator sectors between 2012 to 13 and 2022 to 2023.



Source - [Earnings and hours worked, region by occupation by two-digit SOC: ASHE Table 3 - Office for National Statistics (ons.gov.uk)](), [NHS Staff Earnings Estimates - NHS Digital]()

Income percentile analysis

One way of assessing how the relative power of NHS earnings is changing over time is to compare average earnings in the HCHS sector to the overall earnings distribution. This provides insight as to whether the position of NHS staff in terms of the overall income distribution is improving, worsening, or remaining stable.

Table 29 uses data on average earnings per person published by NHS England and data on the overall income distribution published as part of ASHE to estimate where NHS earnings, by staff group, fall in the overall distribution. This data can be volatile from year to year. For example, following the impact that COVID-19 had on wider incomes or one-off payments to NHS staff. Therefore, it is best to look at longer term trends. On average, we see that the position of most staff has been broadly stable - average earnings for nursing staff are consistently around the 66th percentile, while those supporting doctors, nurses and midwives are around the 33rd percentile. The groups with the largest changes (ambulance staff / support to ambulance staff) may have been impacted by changes to job classifications which impacted average earnings for those groups.

Generally, earnings of groups with larger proportions of employees in higher bands would be expected to lie within higher earnings percentiles. Sometimes this is not the case due to the difference in average contracted hours between groups. For example, earnings for nurses and health visitors (a predominantly Band 5 group) are 2 percentile points higher than those of midwives (a predominantly Band 6 group). This results from nurses having a higher participation rate than for midwives.

Table 29: Estimated income percentile for NHS staff groups based on average earnings per person in the NHS mapped against ASHE.

	12-month period ending:						
Staff group / medical grade	March 2018	March 2019	March 2020	March 2021 (SOC 10)	March 2021 (SOC 20)	March 2022	March 2023
Nurses and health visitors	66	66	65	68	68	66	65
Midwives	66	65	65	67	67	66	63
Ambulance staff	74	73	77	80	80	81	79
Scientific, therapeutic and technical staff	68	67	67	70	70	69	67
Support to doctors, nurses and midwives	34	34	33	35	35	32	31
Support to ambulance staff	48	47	50	53	53	53	50
Support to ST&T staff	34	34	33	35	35	33	33
Central functions	51	51	51	54	54	52	51
Hotel, property and estates	32	33	31	33	33	31	30
Senior managers	96	95	96	96	96	96	96
Managers	85	85	86	89	89	89	87

Source: NHS England Earnings Statistics (Table 2a) , Annual Survey of Hours and Earnings (Table 1.7a) , Gross Annual Earnings for 90th to 99th Percentile .

* Earnings fall within 90 to 99th percentile, data on which is not yet available from ONS.

Based on a comparison of NHS average earnings per person with gross total pay from annual survey of hours and earnings. Note - this may differ slightly from previous Office of Manpower Economics (OME) analysis as this is based on average earnings per person rather than FTE salaries.

Longitudinal educational outcomes

Data from the longitudinal education outcomes (LEO) dataset can be used to compare outcomes for graduates and postgraduates from English higher education 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 analyse the performance of healthcare graduates (including nursing and midwifery graduates) against those from other courses.

Overall, the data indicates that graduates from nursing degrees have higher than average (median) earnings for the first 5 years after graduation but this slips to just below average

after 10 years although this may reflect differences in working patterns or cohort effects related to the transition to nursing becoming a profession requiring a degree. Nursing graduates are amongst the most likely to be in sustained employment at all periods after graduation which highlights the value of nursing degrees to individuals and employers.

Table 30 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 37% higher than the average for all graduates before falling to around 2% below average after 10 years. Over 10 years, median pay for nurses and midwives increases by around 11% compared to just over 55% across all subjects. This may show a different profile to earnings over the course of an individual's 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 degree which was announced in 2009 and implemented from 2013.

Table 30: 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	£29,600	£31,000	£31,800	£32,800
Nursing and midwifery rank (35 subjects)	3	8	11	20
All subjects (student weighted)	£21,600	£26,100	£29,500	£33,600
Subject average (no weight)	£21,500	£25,600	£28,800	£32,800

Source: Longitudinal education outcomes (LEO) (Department for Education). This will include nurses employed outside the NHS.

LEO also includes information on employment which highlights the benefit of a nursing degree when it comes to employability. Of the 35 subjects that are monitored, individuals with a nursing and midwifery degree had the second highest proportion of graduates in sustained employment or training at all stages after graduation. After 10 years of graduation, 90% of nursing and midwifery graduates are in sustained employment, training or both which is over 5 percentage points higher than average.

Table 31: Proportion of nursing first degree graduates in sustained employment, 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	94.8	94	92.2	90.0
Nursing and midwifery rank (35 subjects)	2	2	2	2
All subjects (student weighted)	86.7	87.6	86.8	84.2

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

6. Total reward

Introduction to total reward

Pay makes up one part of the overall reward package, and while 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 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, 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.

The department 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 the continuation of retire and return easements, and new retirement flexibilities for late career staff.

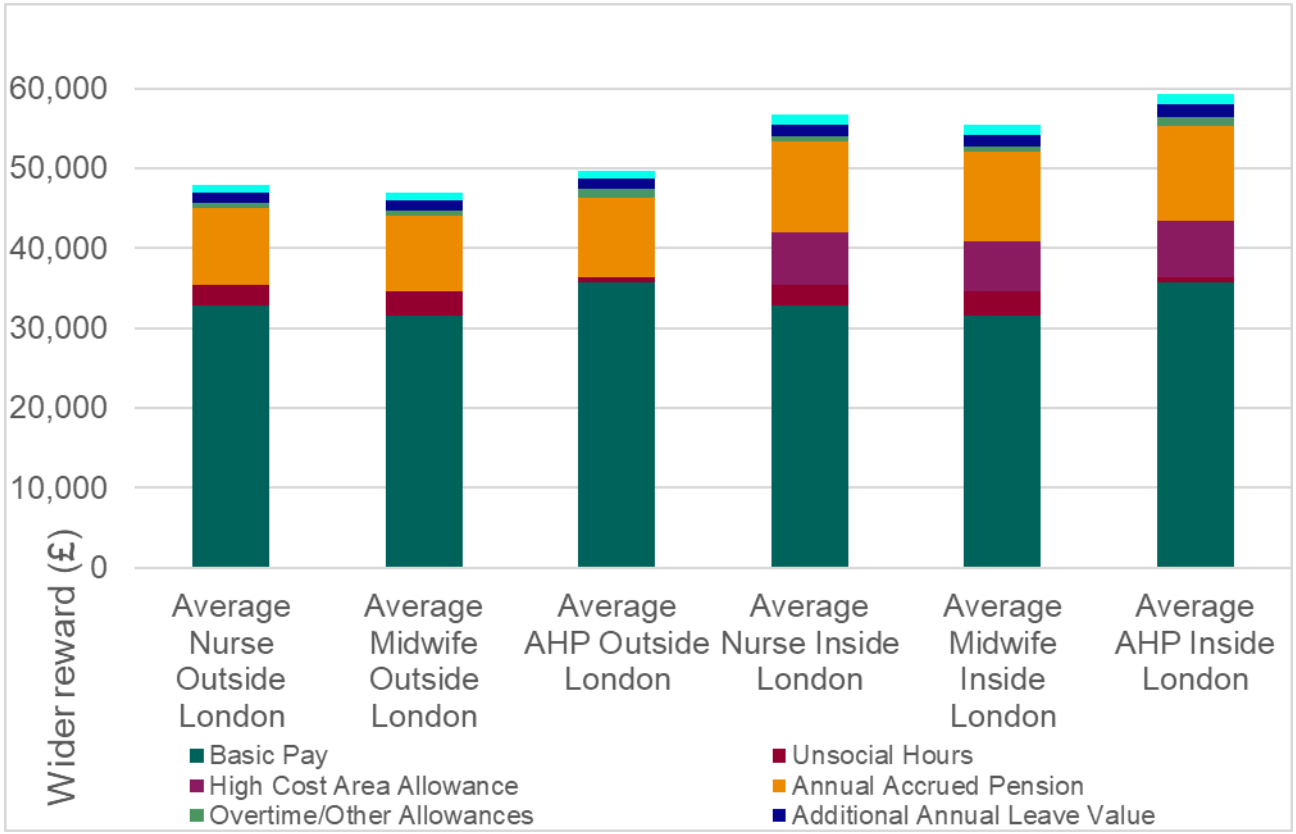
Measuring the value of the package

The department commissions the Government Actuary Department (GAD) to measure the value of the total reward package for a range of NHS roles, as shown in the analysis below.

The elements included in the package are basic pay, high cost area allowances (HCAS), overtime or other allowances, unsocial hours, annual accrued pension, and additional annual leave. Annual accrued pension is a measure of the 2015 Scheme pension, which is calculated as the pension accrued over the year multiplied by a factor of 20, less employee contributions.

It is important to note that the basic pay definition used for the analysis this year is mean annual basic pay per person, whereas in previous years this was per FTE. This change was made for last year’s analysis and has been retained for this year. This also applies for the trend analysis below.

Figure 12: Value of the total reward package for NHS staff



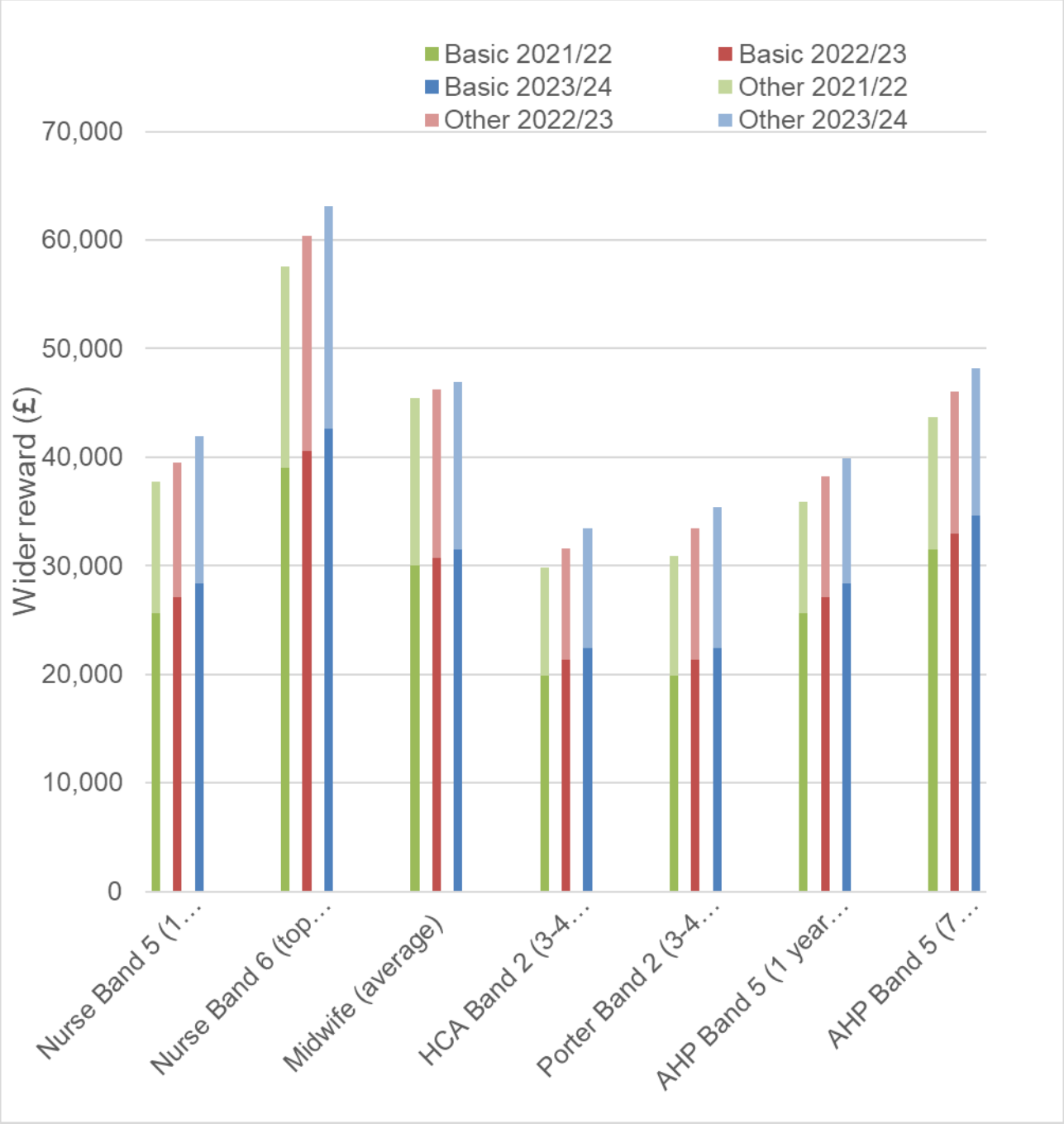
The department also commissions GAD to provide analysis of the trend in wider reward for NHS staff over time. The chart below shows the split of total reward packages between basic and other pay for NHS staff over the years 2021 to 2022, 2022 to 2023 and 2023 to 2024.

It is important to note that for midwives, the analysis compares average rewards on 30 September 2021, 30 June 2022 and 31 March 2023 with pay bands at 2021 to 2022, 2022 to 2023 and 2023 to 2024 for all other roles. However, this will only cause a negligible difference for the purpose of comparison. This is consistent with the approach used in previous years and reflects the availability of the relevant data.

The analysis shows that all the NHS roles considered as part of the analysis have experienced an increase in total reward in monetary terms over the period 2021 to 2022 to 2023 to 2024. Overall, increases were largely driven by increases to basic pay over the period.

Band 2 porters with 3 to 4 years' experience received the highest increase in reward over the period, of around 14.5%. For all roles considered, at least 28% of the total reward package is made up of non-basic pay.

Figure 13: Wider reward trend for NHS staff over the period 2021 to 2022 to 2023 to 2024



In previous years' evidence to the NHSPRB, the department has commissioned GAD to provide analysis of reward across various NHS roles and private sector occupations. These calculations use the ONS datasets for salary and pension data. However, this year GAD has not been able to update this analysis for this year’s evidence as no new data has been released by the ONS since the information used last year.

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, adoption and shared parental leave benefits above the statutory entitlement. GAD estimate that an average member of NHS staff on an AfC contract in 2023 to 2024, calculated as having annual pay of £34,000, would be eligible to receive maternity pay of £16,000 in total. This includes £7,000 in excess of what they would be entitled to under the statutory maternity leave allowance.

This estimate is provided for illustrative purposes only and represents the additional value of NHS staff entitlement in excess of statutory maternity leave. Maternity pay depends on the member's contractual entitlements and is calculated relative to the current statutory maternity pay entitlements. The figures have been rounded to the nearest £1,000.

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. 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. The blue light card is also available to all NHS staff at a cost of £4.99 for 2 years.

Many trusts have also partnered with third party providers offering staff up to 20% discount on shopping, insurance and travel. Staff may also be entitled to cashback on purchases at specified retailers of up to 12% using prepaid cards. Therefore, employees spending around £3,000 per year at a participating supermarket could offset spending by up to £360 (around 1% of basic pay on average). The overall value to staff can vary depending on the specific benefits options offered across employers and the level of benefits taken up, but GAD estimate these additional flexible benefits could be valued at up to 1% - 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 and flexible retirement

'We work flexibly' is one of the elements on the People Promise, with a commitment to deliver this to staff by 2024 to 2025. This ambition is that all NHS staff should be offered the chance to work flexibly. Flexible working is a strong driver of retention and an important factor in improving the mental health and wellbeing of staff. Programmes of work to improve the flexible working offer are evidenced through the improving score in this year's NHS Staff Survey results. The publication of both the NHS LTWP and the NHS Equality, Diversity and Inclusion Improvement plan earlier this year, will be important in the continued drive to improve access to flexible working.

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

- A published flexible working definition 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 conversations in requesting it;
- Proactive work with several organisation to review their approaches to flexible working and to encourage implementation;
- Development of a simple cost calculator to help organisations identify potential costs savings by calculating turnover, recruitment and bank and agency expenditure;

- Support to organisations in the implementation of effective use of e-rostering systems, accelerating where possible;

- NHS England 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 EDI Improvement Plan sets out to improve the culture of the NHS workforce and to boost retention by addressing inflexible working practices that may deter people entering the workforce or leaving the workforce entirely.

The department envisages that those members who wish to take partial retirement (as described in the section on new retirement flexibilities below) will be able to agree with their employer a change to their working pattern, much like those who wish to work flexibly for other reasons. In October 2023, the NHS Staff Council published guidance on the NHS Employers website that ties flexible working and flexible retirement together.

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 32: Comparison of retirement ages and accrual rates for members of the 1995 Section, 2008 Section and 2015 Scheme

Scheme or section	Normal Pension Age (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 Pension Scheme.

The public service pension schemes remedy (the ‘remedy’) for this discrimination has 2 parts, both of which have now been delivered. The first and prospective part closed the legacy public service pension schemes on 31 March 2022 and ensured equal treatment for all public service pension scheme members by moving all active members into the reformed public service pension schemes on 1 April 2022. The second and retrospective part of the remedy removed the effect of the transitional protections from 1 October 2023.

One key benefit of the 2015 scheme is that for active members, the pension they earn is increased every April by the Consumer Price Index (CPI) in the year before, plus an additional 1.5%. This is known as ‘in-service revaluation’. This means that pension benefits keep up with rises in the cost of living. In April 2023, this rise was 11.6%.

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 retire and return easements and new retirement flexibilities for late career staff.

NHS pension projections

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 who joins the NHS Pension Scheme in 2023 age 21 and works at AfC band 5 before retiring at age 65, can expect an annual pension of around £34,000 in today’s earnings terms. A nurse who joins the NHS Pension Scheme in 2023 age 21 and progresses through AfC bands 5 and 6 before retiring at age 65 can expect an annual pension of around £39,000 in today's monetary terms. These estimates assume that members remain in service and work full-time to retirement.

These projections are higher than those provided in previous years due to several factors:

- The updated pay profiles report higher pensionable pay than the pay profiles used in the previous years’ projections.

- The approach used has been amended for consistency with the consultants' pension projections carried out for DHSC in August 2023. This assumes that earnings increase with CPI and therefore also discount at CPI and allows for retirement at age 65.

- The projections allow for the changes to pension tax introduced in the March 2023 Budget.

The figures are therefore not directly comparable with those produced for last year's evidence. The calculation method has been refined over recent years and hopefully the current approach reflects a stable methodology that can be following in subsequent years.

The table below shows the pension benefits the example members above could expect to receive, assuming that they commute 20% of their pension for a tax-free pension commencement lump sum (PCLS) at retirement, on current commutation terms (£12 lump sum per £1 of pension commuted). These projected lump sums are within the maximum amount of £268,275 announced at the Spring 2023 Budget.

Table 33: Projected annual pensions and lump sums for nurses joining the NHS Pension Scheme in 2015 and retiring age 65 (in today's monetary terms)

At retirement age	Projected residual pension (pa)	Projected PCLS
Nurse – band 5	£27,000	£81,000
Nurse – band 5 or 6	£31,000	£93,000

NHS Pension Scheme membership

The department regularly monitors membership trends for the NHS Pension Scheme through ESR. Overall, membership rates continue to be high, with an average of 90% of NHS staff being members of the scheme in June 2023.

The table below shows the percentage of staff members, by staff group and AfC band, who were members of the scheme at June 2023, and in comparison to June 2022, June 2018 and June 2013. Staff group workforce totals and band workforce totals are based on data published by NHS England.

This shows that membership rates have remained stable over the past year, albeit with noticeable decreases for both nurses and health visitors (-2%) and Band 5 staff (-3.5%).

We understand that this is related to the higher than average rates of staff with non-British nationality who may fall into these categories, and the increase in international recruitment into the NHS in recent years. These members of staff have traditionally been less likely to be members of the NHS pension scheme than those with British nationality. Further analysis of membership rates for Band 5 staff by nationality and pay point is in the subsequent table.

Table 34: NHS Pension Scheme membership for non-medical staff

	June 2023	One Year Change	Five Year Change	Ten Year Change
Ambulance staff	93%	-1%	0%	-3%
Central functions	89%	0%	2%	3%
Hotel, property and estates	88%	0%	4%	12%
Managers	91%	-1%	0%	-2%
Midwives	92%	-1%	-1%	-2%
Nurses and health visitors	87%	-2%	-3%	-4%
Scientific, therapeutic and technical staff	93%	-1%	0%	0%
Senior managers	92%	0%	0%	-4%
Support to ambulance staff	93%	0%	0%	3%
Support to doctors, nurses and midwives	91%	0%	2%	6%
Support to ST&T staff	92%	0%	2%	6%
Grand Total	90%	-1%	0%	2%
Band 1	79%	-1%	-3%	8%
Band 2	90%	0%	2%	8%
Band 3	91%	0%	2%	6%
Band 4	91%	0%	1%	3%
Band 5	85%	-4%	-4%	-5%
Band 6	91%	-1%	-1%	-1%
Band 7	93%	0%	-1%	-2%
Band 8a	93%	0%	-1%	-3%
Band 8b	94%	0%	-1%	-3%
Band 8c	94%	0%	-1%	-2%
Band 8d	94%	0%	1%	-2%
Band 9	92%	1%	-2%	-4%

Table 35: NHS Pension Scheme membership for Band 5 staff by pay point and nationality in June 2023

Pay point	Years' experience	United Kingdom	Rest of World	Other (EU , EEA , Unknown)	All
Point 1	0-2 Years	92%	69%	87%	84%
Point 2	2-4 Years	90%	59%	85%	80%
Point 3	4+ Years	90%	77%	88%	88%
All Points		91%	69%	87%	85%

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.

The current employer rate came into force on 1 April 2019 following the 2016 valuation, which required the employer contribution rate to increase from 14.3% to 20.6%.

Results from the 2020 valuation show an increase in benefit costs, requiring a 3.1% rise in the employer contribution rate to 23.7%. This figure has been confirmed by the Government Actuary's Department in their final 2020 valuation report. The updated employer contribution rate will apply from 1 April 2024. Further detail on this is set out in DHSC's response to the recent consultation on changes to the NHS Pension Scheme from 1 April 2024. This consultation ran from 26 October 2023 to 7 January 2024.

As part of this consultation, the department also outlined plans to deliver phase 2 of the ongoing review of member contributions in the NHS pension scheme. 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. This is therefore an appropriate time to reform the member contribution structure.

Under the structure proposed in the consultation, the number of tiers and range between the lowest and higher tier will be reduced. This means that the gap between some tier boundaries will be reduced. As part of the previous consultation process which delivered phase 1 of the review, it was agreed that the move to implement the final updated member contribution structure would be staggered over 2 phases in order to give members time to adjust.

Following consultation, DHSC has now confirmed that the following member contribution structure will apply from 1 April 2024.

Table 36: NHS Pension Scheme member contribution threshold structure from 1 April 2024:

Pensionable earnings thresholds	Contribution rate from 1 April 2024
Up to £13,259	5.2%
£13,260 to £26,831	6.5%
£26,832 to £32,691	8.3%
£32,692 to £49,078	9.8%
£49,079 to £62,924	10.7%
£62,925 and above	12.5%

Retire and return easements

Since March 2020, certain retire and return rules in the NHS Pension Scheme, for staff members with Special Class Status, 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 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.

Following concerns from stakeholders that an extension was required, the department consulted on an extension of these easements to 31 March 2023, and as a result decided to extend the suspension to 31 March 2025. Furthermore, as part of the 2022 to 2023 pay deal for AfC staff, DHSC plans to permanently remove abatement from 1 April 2025. This

will mean that abatement, which restricts SCS staff who return to work after retirement from earning more (in pay plus pension) than they did pre-retirement, will only apply to NHS staff in very limited circumstances. Further detail on this is set out in the recent consultation on changes to the NHS Pension Scheme from 1 April 2024. This consultation will run from 26 October 2023 to 7 January 2024.

New retirement flexibilities

As signalled in our plan for patients, as well as making it easier for staff with special class status to return to work if they wish, over the past year the department has also introduced a package of new retirement flexibilities for other staff who are members of the 1995 section of the NHS pension scheme.

On 1 April 2023, the department abolished the rule that staff could only work up to 16 hours a week in the first month after returning from retirement without affecting their pension. Also on 1 April 2023, it removed the rule that prevented retired staff who return to NHS work from re-joining the scheme and building up more pension.

On 1 October 2023, the department also made a new ‘partial retirement’ option available to staff in the 1995 section as an alternative to full retirement. This means that staff can now draw down some or all of their pension while continuing to work and build up further pension, subject to a reduction in pensionable pay of at least 10%.

These new flexibilities will make retirement more flexible and help to support staff with their work/life balance later in their careers. The new partial retirement option may also help staff to bridge the financial gap between receiving their NHS Pension at normal pension age and their state pension some years later. For instance, a member at the top of Band 6 taking their 1995 section pension at 60, working at 0.6FTE to age 65, could build up around £2,400 per annum in CPI linked additional pension at current values (taken at State Pension Age). This would be worth around £50,000 over the course of an expected retirement.

At the same time, on 1 October, we also amended the partial retirement rules for the 2008 section and the 2015 scheme so that members of these schemes can take up to 100% of their benefits and continue working if they wish. This means that the rules are now aligned across the 1995 section, 2008 section and the 2015 scheme.

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 13 October 2023, the number of statements available was 2,734,642, with 337,043 views. In comparison, on 23 September 2022 the number of statements available was 2,812,443 and the number of views was 297,035.

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 NHS England. NHS England 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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