Department of Health & Social Care

The Department of Health and Social Care's written evidence to the NHS Pay Review Body (NHSPRB) 2020/21

Published 13 February 2020

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Executive Summary

On 27 June 2018, a multi-year pay and contract reform Agenda for Change deal, was agreed between NHS trades unions and NHS Employers, supported by the majority of trades unions and their members. The deal represents the most significant reforms which apply to nearly one million staff since Agenda for Change was introduced in 2004.

The national collective agreement set out in the Agenda for Change Framework Agreement, delivers pay awards and contract reforms over three years (2018/2019 to 2020/2021). The Chancellor released £800m additional funding for 2018/2019 and funding for 2019/20 and 2020/21 has been made available as part of our Long-Term Funding settlement for the NHS.

In this context, the Department's remit letter made clear that the NHS Pay Review Body is not being asked to make any pay recommendations for 2020/21. Instead, the Review Body is asked to continue to consider the evidence it receives from the NHS Staff Council, NHS Employers, NHS England and Improvement, Health Education England and other stakeholders about progress in implementing the Agenda for Change deal in England.

Whilst we have not asked for pay recommendations, we committed to provide evidence on the state of recruitment, retention and the motivation of Agenda for Change staff throughout the period of the three-year deal to ensure members have access to information they need to consider and monitor the impact of the agreement.

The remit letter asks the Review Body to consider evidence it receives to inform observations about how trusts in England can make better use of local recruitment and retention premia to help attract and retain the workforce it needs. Of particular concern is the need to grow the nursing workforce and ensure trusts are able to attract staff with the IT skills they need to help support the efficient delivery of patient care.

Patients, and their experience of care, must be at the heart of everything the system does. We want to help ensure that, supported by the range of pay and non-pay reforms under the AfC deal, the NHS is able to continue to deliver world-class patient care, putting patients first and keeping them safe whilst providing the high-quality care we all expect.

The Government's longstanding aim remains the same. It is to ensure that we can recruit, retain, and motivate sufficient high calibre NHS staff to deliver government policy, ensure best value for the taxpayer and continue to deliver world-class patient care. It is a complex matter of judgement which includes the overall impact of the NHS employment offer, (pay and non-pay terms) in attracting and keeping the staff the NHS needs.

All of this means that Government must strike the right balance as it develops the multi-disciplinary workforce it needs, through systems of reward that are affordable and fit for purpose. Staff tell us that they want to know they will have the right number of colleagues working alongside them in hospital or in the community.

The key context for considering the evidence on recruitment, retention and motivation is NHS England's Long-Term Plan for the NHS published on 7 January 2019. Although the Review Body is not being asked to make pay or contract reform recommendations, it

should note the affordability assumptions and the importance of making planned workforce growth affordable.

As in recent years, and reflecting the roles of the Department, its Arms-Length Bodies and other organisations, the NHS Pay Review Body will be invited to consider, alongside evidence from the trade unions, professional bodies and other stakeholders:

- high-level evidence from the Department, including the strategic policy objectives and the economic and financial (NHS funding) context;
- evidence from NHS England and Improvement on its Long-Term Plan and the implications for workforce growth and affordability;
- evidence from NHS England and Improvement on provider issues, specifically its plans for ensuring employers implement the deal as expected on the ground and how to best realise the benefits of the deal which has at its heart improvements to productivity and capacity; and
- evidence from NHS Employers on how they are supporting employers to implement the deal and progress on negotiations for remaining reforms to terms and conditions of service and related workforce policies.

1. NHS Strategy and Introduction

1.1 As set out in our 2018/19 evidence, the 2015 Spending Review saw the Government commit to an additional £8 billion in real terms by 2020/21, and an additional £2.8 billion of revenue funding in the Autumn 2017 budget.

1.2 In June 2018 the Prime Minister set out a new funding settlement for the NHS, growth in spending in return for the NHS agreeing a Long-Term Plan, setting the course for the NHS for future years and allowing the NHS to plan with funding certainty. This funding provides an additional £33.9 billion cash terms annual increase by 2023-24 compared to 2018-19 budgets.

1.3 Demand for NHS and social care services continues to rise, due to amongst other things, an increasingly aging population with multiple and complex care needs. Meeting this demand whilst maintaining and improving quality, and maintaining affordability, is one of the systems significant challenges.

1.4 NHS England's Long-Term Plan was published in January 2019 and stated that NHS England would publish a Workforce Implementation Plan later in 2019. In June 2019, NHS England and Improvement published their Interim People Plan, with a full People Plan set to be published in the near future. NHS England and Improvement will set out more detail on the People Plan in their evidence.

1.5 This is the last year of the multi-year Agenda for Change (AfC) pay and contract reform deal agreed in June 2018, the Review Body is not therefore asked to make any pay recommendations for AfC staff for 2020/2021. The NHS Staff Council, a partnership of NHS trade unions and NHS Employers, will provide a joint report detailing progress in finalising the commitments agreed under the deal.

Workforce

1.6 Although the Review Body is not asked to make any pay recommendations, it is important that during the period of the multi-year deal members continue to receive evidence about the recruitment, retention and motivation of the workforce. We have continued to provide evidence to ensure Review Body is able to keep abreast of any trends which may inform future pay rounds.

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

there is a highly engaged and motivated workforce delivering NHS services to patients.

1.8 The Government has committed to delivering 50,000 more nurses by 2025 through a combination of increased supply, recruitment and retention. The first step taken on this is to increase the financial support available at university, with nursing (and midwifery, plus the majority of AHP) students receiving a £5,000 - £8,000 annual maintenance grant every year during their course. The overall NHS employment offer including the AfC contract, is also a key part of this

1.9 The Department has embarked on pay and contract reform right across the NHS workforce, including workforces not covered by the NHSPRB's remit, as part of our ambition to make the NHS the best employer in the world providing the very best and safest care.

1.10 Pay and contract reform is not just about headline pay uplifts. The AfC multi-year deal is designed to help increase productivity and help improve recruitment and retention and through a range of pay and non-pay measures help improve staff engagement. The AfC deal recognised that it is the combination of pay and non-pay reforms that will best support our ambition to make the NHS the best place to work.

1.11 The multi-year deal includes, for example, supporting staff to maintain their physical and mental health and wellbeing, improving local performance appraisal processes and through that improving staff engagement, improving the experience of working in trust banks because we know staff may be more productive if they work in familiar settings, introducing common bereavement, parental care and annual leave policies, all of which recognise that the AfC contract, which is the preferred contract for nearly one million staff, is a critical tool trusts have available to them to help them attract and keep the staff they need and helps support them as they seek to balance their working lives with family and other caring and personal commitments.

1.12 As explained at Chapter 7, this is the last year of the AfC multi-year pay and contract reform deal. Detailed information about progress and future work to complete implementation of the deal will be provided separately by the NHS Staff Council.

Staff engagement

1.13 Staff engagement is crucial to securing and retaining the workforce that the NHS needs, as is making the most effective use of the entire NHS employment offer - pay and non-pay benefits. Trust commitment to improve local appraisal processes

is based on strong evidence that improving these processes can help improve staff engagement and through that help improve patient outcomes. The NHS Staff Survey is one of a range of important mechanisms for evidencing how the AfC deal has affected staff motivation.

1.14 We strongly believe that recruitment and retention is not just about pay, it is about creating a culture and environment in the NHS where staff want to work, where staff feel safe to raise concerns and to learn from mistakes; where employers listen to and empower staff, work hard to keep them safe and ensure bullying and harassment is not tolerated.

1.15 The Department continues to work in partnership with its arms-length bodies and other organisations to support trusts in their responsibility for improving staff experience. The benefits realisation work NHS England and Improvement is leading will help trusts focus on the 'something for something' nature of the AfC deal to help ensure trust realise the benefits of reform on the ground.

Government Pay Policy and our Approach to Pay and Contract Reform

1.16 The Government's public sector pay policy aims to ensure that the overall package for public sector workers helps to deliver world class public services which are affordable within the public finances and fair to workers and taxpayers as a whole.

1.17 The government is taking direct action to increase the earnings of the lowest paid through the National Living Wage (NLW). The Chancellor has pledged to increase the NLW towards two thirds of average earnings by 2024, provided economic conditions allow, and to expand its coverage to all adults over the age of 21. On current forecasts, this would make the NLW around £10.50 per hour by 2024. The minimum pay rate in the NHS this year and in 2020/21 is already above the increased NLW announced for 2020/21. Pay in the NHS is just one element of the total reward package. It is the combination of pay and non-pay benefits that help trusts compete in local job markets for the staff they need.

1.18 The priority is to ensure the Health and Care sector can afford to attract and keep the staff it needs. The NLW increases take account of wider economic conditions and is set relative to median earnings. That is why the target for 2024 is set relative to median earnings.

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

1.20 To achieve this requires the right balance between pay and staff numbers through systems of reward that are affordable and fit for purpose. Staff tell us that they want to know they will have the right number of colleagues working alongside them in hospital or in the community.

1.21 Since the Public Sector Pay Cap was lifted, the Department has not lost sight of the need for pay discipline to ensure affordability and sustainability, and under the AfC deal this has been done on a “something for something” basis; additional pay investment over three years in return for contract reform which has productivity benefits, as well as helping to recruit and retain staff.

1.22 It is important that the benefits of the AfC deal is evidenced and measurable. Work continues, led by NHS England and Improvement, to develop a benefits realisation plan to ensure the outcomes the NHS Staff Council and government expect are realised. Further detail on progress in developing the benefits realisation plan, in partnership with the NHS Staff Council and the Department will be provided separately by NHS England and Improvement.

1.23 We welcome your observations on the information you receive on progress in implementing the AfC deal and how trusts might make better use of existing local Recruitment and Retention Premia in securing the staff they need.

2. NHS Finances

2.1 This chapter describes the financial context for the NHS

Funding Growth

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

2.3 The Spending Round 2019 also settled non-NHS revenue budgets for 2020-21 only. This confirmed a 3.4% real terms increase to the Health Education England (HEE) budget, including an additional £150 million for Continuing Professional Development (CPD) and wider education and training budgets will also get a £60 million funding boost to support delivery of the NHS Long Term Plan and the NHS People Plan. This is important in making a start towards the broader goal of addressing workforce shortages. A multi-year Spending Review is expected in 2020.

2.4 The settlement gave a 3.1% real-terms increase on 2019-20 for the overall DHSC group position. Increasing these vital budgets will further enable the NHS to deliver a better service and health outcomes for patients.

Figure 2.1 NHS England Total Departmental Expenditure Limit (TDEL) (£bn)

NHS England	NHSE Revenue Departmental Expenditure Limits (RDEL) excluding ringfence (RF) (cash) £bn	NHSE Capital Departmental Expenditure Limits (CDEL) excluding ringfence (RF) (cash) £bn
2013-14	93.676	0.200
2014-15	97.017	0.270
2015-16	100.200	0.300
2016-17	105.702	0.260

2017-18	109.536	0.247
2018-19	114.603	0.254
2019-20	123.562	0.305
2020-21	129.858	0.305
2021-22	136.134	-
2022-23	142.841	-
2023-24	151.318	-

Source: 2019-20 Financial Directions to NHS England

2.5 The table above shows the opening mandate for NHS England in 2019-20, and indicative amounts for future years, as per NHS England's Financial Directions. Figures exclude depreciation, AME and technical budget.

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

2.7 It is essential this money is spent wisely, which is why the Government has set five financial tests to ensure the service is being put on a more sustainable footing. The five tests are:

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

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

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

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

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

Financial Position

2.8 The Government's Mandate to the NHS includes a clear objective for the NHS to balance its budget. From April 2019, NHSE and NHSI have been working from a joint operating model, with oversight for NHS finance conducted by a joint CEO and joint chief finance officer who both report to NHSE/I's joint board. Together they are both responsible for stabilising finances across the system and increasing financial sustainability through improved efficiency and productivity in the provision of healthcare.

2.9 Recovering finances in the NHS continues to be a major focus. A growing deficit in 2015-16 needed to be halted, and disciplined financial management was reintroduced to stabilise finances and secure the immediate future of our health service. NHS leaders devised a plan of action, in operation since July 2016, involving a series of controls and levers designed to exert tighter control over local organisations.

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

2.11 In 2018-19, NHS England and NHS Improvement continued to work closely to build plans with individual providers and commissioners that aggregated to a balanced plan for the NHS. This plan built on the improvements made in previous years.

2.12 However, NHS providers were experiencing greater than expected planned for financial pressures. The main pressure for providers continued to be increasing staffing costs driven by growing emergency patient numbers. Equally, some clinical commissioning groups (CCGs) reported overspends as these increased patient volumes meant increased commissioning costs beyond those planned for.

2.13 The overspends in both providers and commissioners were identified early and, as a result, the NHS leadership intervened and covered the higher than planned deficit by delivering underspends in central commissioning budgets. As a result, and for the third consecutive year, the NHS has once again delivered financial balance. However, we recognised that continuing this approach was not sustainable. There are no quick fixes; new, long-term sustainable solutions will take time and effort, with those organisations facing the greatest challenges being assessed, supported and assisted by NHS Improvement and NHS England.

2.14 Building on the relative success of the last few years, we are now moving into the next phase; our plans to go further to achieve financial sustainability across the

NHS are set out in the NHS's Long Term Plan. A new financial framework that is better able to support and encourage the health system to develop in a more sustainable way with a rebalancing of its finances will form part of this. Ending 2018-19 in a stable financial position has been very important as the financial assumptions in the NHS Long Term Plan were dependent on this being the case.

Figure 2.2 Provider deficit time series

NHS Providers RDEL Breakdown	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Total Provider Deficit (£m)	(458)	(476)	(544)	107	842	2,448	791	991	827
Provisions Adjustment (£m)	(106)	(163)	(120)	53	121	74	43	39	(23)
Other Adjustments (£m)	(183)	3	68	(11)	(47)	27	101	8	22
Total Revenue DEL (£m)	(748)	(636)	(596)	149	916	2,548	935	1,038	826

Share of Resources Going to Pay

2.15 Figure 1.3 shows the proportion of funding consumed by NHS provider permanent staff spend over the last 5 years. Note that NHS provider permanent staff spend only covers staff working within hospital and community health settings, and so excludes General Practitioners, GP practice staff and General Dental Practitioners.

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

Year	NHS England RDEL (£bn)	Provider Permanent Staff Spend (£bn)	% of spend on staff	Increase in total spend	Increase in provider permanent staff spend
2013/14	93.7	43.0	45.8%	0	0
2014/15	97	43.9	45.3%	3.5%	2.26%
2015/16	100.2	45.2	45.1%	3.3%	2.80%
2016/17	105.7	47.7	45.1%	5.5%	5.58%
2017/18	109.5	49.9	45.6%	3.6%	4.64%
2018/19	114.6	52.6	45.9%	4.7%	5.35%

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

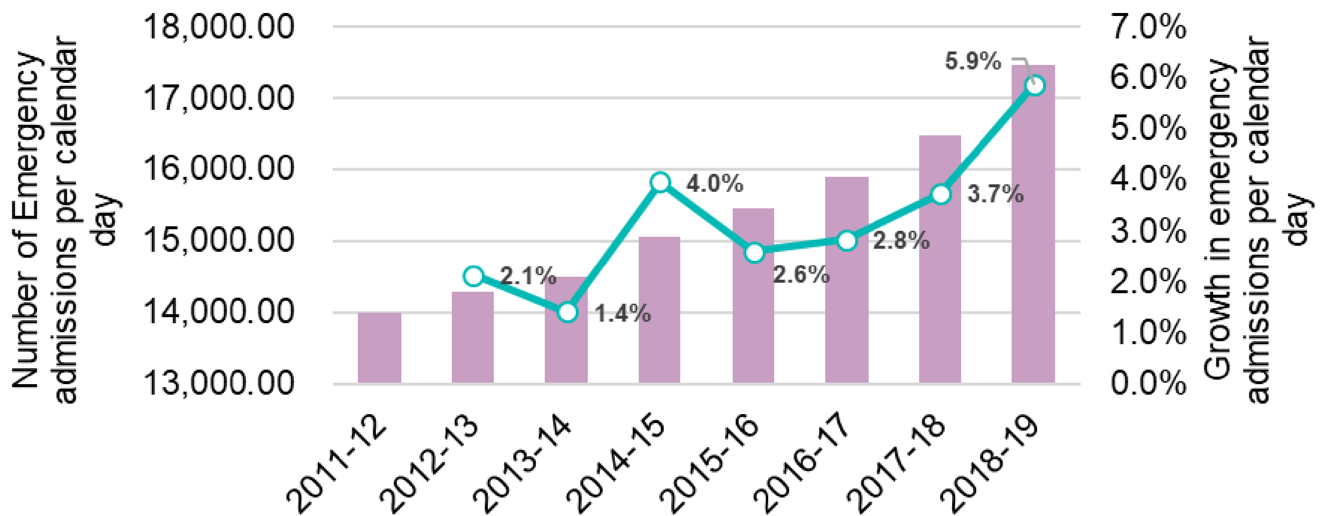
2.17 2020/21 marks the third and final year of the AfC multi-year deal. The deal reflects the Government's continued support for the NHS workforce to deliver excellent care, while reinforcing a public sector pay policy that pay flexibility should be in return for reforms that improve recruitment and retention, and boost productivity.

2.18 DHSC has embarked on contact reform right across the medical workforce, in addition to the multi-year AfC deal, as part of its continued ambition to make the NHS the Best Place to Work, as set out in the Interim NHS People Plan.

Demand Pressures

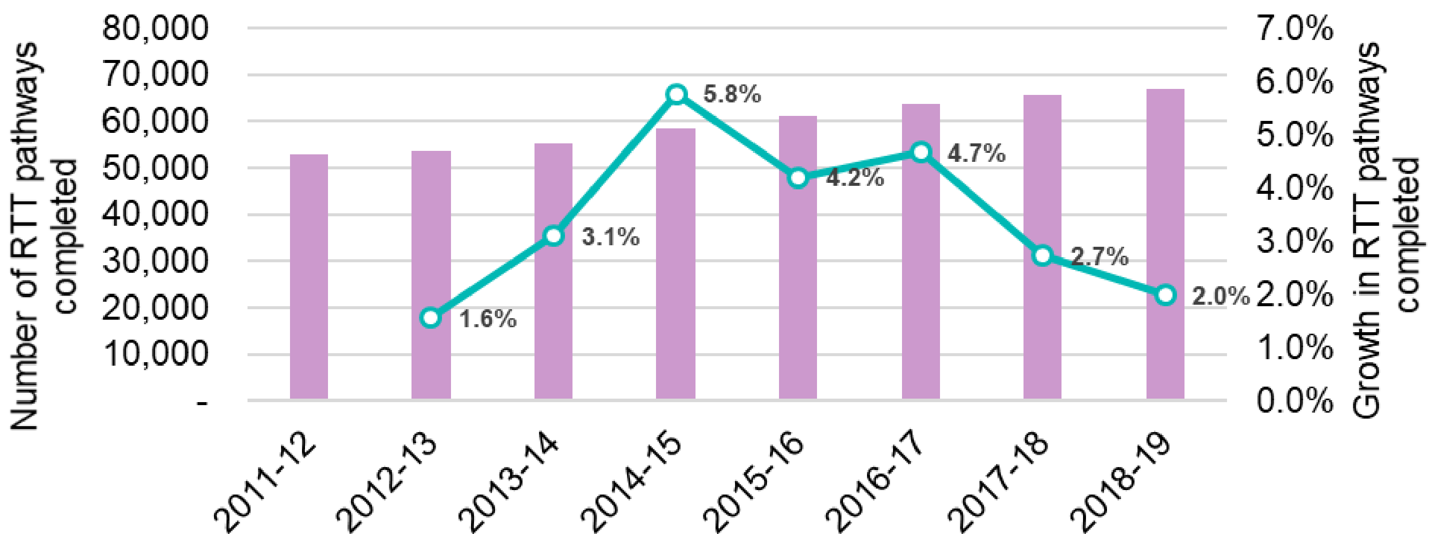
2.19 Demand for services provided in the health and care system continues to rise above what would typically be expected from population growth and demographics alone. To meet this demand the NHS continues to deliver more activity than ever before, as evidenced by the number and growth in emergency admissions and elective (i.e. non-emergency) treatments over the last 7 years.

Figure 2.4 Emergency Admissions – per calendar day



Source: A&E attendances & Emergency Admission Statistics
https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/

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



Source: NHS England Consultant Led Referral to Treatment Statistics. Data adjusted for non-submitting Trusts and exclusion of sexual health services from 2013. https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/

2.20 Compared to the year before, in 2018-19 there were 966 (5.9%) more emergency admissions per day as well as 1,336 (2.0%) more elective care pathways completed per working day, as shown in figures 1.4 and 1.5.

2.21 Despite the continuing best efforts of the NHS, many of the core waiting time and access targets were not achieved during 2018-19, partly due to the increasing

demand pressures placed on frontline services. These included A&E, referral to treatment, cancer treatment, diagnostic tests and ambulance response standards.

2.22 There is no evidence to suggest that trend in increasing demand will ease. Therefore, demand pressures represent a principal challenge faced by the NHS both now and in the future. The long-term funding settlement reflects the government's continued support to the NHS in mitigating this issue. Considering this, managing demand effectively is one of the five financial tests that the government has set as part of the settlement.

2.23 Managing demand, cutting down avoidable demand and using resources effectively therefore represent key target areas that must be improved to meet growing demand pressures and ensure the long-term sustainability of the system.

Productivity and Efficiency in the NHS

2.24 Putting the NHS back onto a sustainable financial path is a key priority in the Long Term Plan and is essential to allowing the NHS to deliver the service improvements in the plan.

2.25 The Long Term Plan commits to making re-investable productivity gains of at least 1.1% a year over the next five years. Thanks to the agreed revenue funding settlement, all these gains can be retained by the NHS and reinvested in more and better patient care.

2.26 The plan identifies ten priority areas in the first two years of implementation as part of a strengthened efficiency and productivity programme:

(a) Improving the availability and deployment of the clinical workforce.

(b) Making savings in procurement through aggregation of volume and standardisation of specifications.

(c) Delivering pathology and imaging networks to improve the accuracy and turnaround times on tests and scans.

(d) Improving efficiency in community health services, mental health and primary care.

(e) Delivering better value from the NHS medicine spend.

(f) Making further efficiencies in NHS administrative costs across providers and commissioners.

(g) Improving the way in which the NHS uses its land, buildings and equipment.

(h) Ensuring that the least effective interventions are not routinely performed, or only performed in more clearly defined circumstances.

(i) Reducing patient harm and the substantial costs associated with it.

(j) Continuing to tackle patient, contractor, payroll, and procurement fraud.

2.27 The programmes to deliver the required productivity improvements build upon the 10 Point Efficiency Plan devised as part of the NHS Next Steps on the Five Year Forward View (2017). This was an agreed plan of action as to how the NHS will deliver the necessary savings to ensure it lives within its means. Programmes from the plan key to delivering the required productivity improvements include;

(a) Operational Productivity Programme: reducing variation in clinical practice and improving management of resources in NHS acute, community, mental health, and ambulance providers, following the recommendations of the Carter Reviews of operational productivity in acute, mental health, community, and ambulance trusts.

(b) Getting it Right First Time: driving quality and productivity improvement in over 30 clinical specialities, helping to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improving patient outcomes.

(c) Other improvement initiatives: such as RightCare which is supporting commissioners to reduce unwarranted variations in care; and NHS Improvement's Financial Improvement Programme which is providing central support combined with sharing learning and guidance to help raise levels of achievement against plans.

2.28 Efficiency improvements are monitored through provider Cost Improvement Programmes (CIPs), and commissioner Quality, Innovation, Productivity and Prevention plans (QIPPs). During 2018/19, providers achieved savings through CIPs of £3.2 billion or 3.6%, almost identical to the level achieved in 2017/18 while Commissioners delivered QIPPs totalling £3.0billion.

2.29 The Carter reports identified a savings opportunity of £5.8 billion in the provider sector across specific work programmes over five years. These Operational Productivity work programmes include workforce productivity, procurement and back-office functions, clinical support functions and specific sectors (mental health, community health, ambulance). The NHS has developed and grown the Model

Hospital, which helps trusts to understand how their performance compares with their peers and identify opportunities for further improvements.

2.30 In 2018/19, these programmes helped deliver £1.18 billion in recurrent CIPs. While this is encouraging progress, there remains a significant challenge in ensuring that learning and best practice is spread across the NHS.

2.31 Alongside this, progress has been made in reducing the reliance on the use of expensive agency staff within the NHS, reducing spending on agency workers to £2.4 billion in 2018/19 compared to £3.6bn in 2015/16. Agency spend now accounts for 4.4% of the overall NHS Pay bill, down from 7.8% at its peak in 2015. The Department and NHS England and NHS Improvement are also supporting trusts to increase their use of bank staff, who are typically more committed to their trusts.

Calculating Productivity in the NHS

2.32 Productivity and economy savings are components of efficiency. While economy savings are realised through buying inputs at cheaper prices, productivity growth delivers more outputs for the same level of inputs.

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

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

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

2.36 Although the average total factor productivity growth between 2005-06 and 2015-16 reflects the progress made by the NHS workforce's committed efforts to improving productivity where possible, there still remains areas for improvement

which must be targeted if the objectives set out in the Long Term Plan are to be achieved.

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

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

2.39 The input factor of productivity can be more easily broken down by staff group. The labour input in York CHE's productivity measure is a weighted combination of different staff groups; the growths for each staff group is summarised in Chapter 6 of this evidence.

Figure 2.6 York CHE Total Factor Productivity

Year	Quality Adjusted Output	Total Input	Total Factor productivity
2005/06	7.1%	7.2%	-0.1%
2006/07	6.5%	1.9%	4.5%
2007/08	3.7%	3.9%	-0.2%
2008/09	5.7%	4.2%	1.4%
2009/10	4.1%	5.4%	-1.3%
2010/11	4.6%	1.3%	3.2%
2011/12	3.2%	1.0%	2.1%
2012/13	2.3%	2.0%	0.4%
2013/14	2.6%	0.4%	2.2%
2014/15	2.5%	1.9%	0.5%
2015/16	2.6%	2.8%	-0.2%
2016/17	3.5%	0.6%	2.9%

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

Figure 2.7 York CHE Labour Productivity

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

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

Conclusion

2.40 The Government reiterated its commitment to the NHS when it confirmed the five-year settlement for the NHS with an additional £33.9 billion cash terms annual increase by 2023-24 compared to 2018-19 budgets.

2.41 We have made great strides in tackling the NHS provider deficit and need to build on this success to deliver the Long Term Plan commitments with a new financial framework which will support the delivery of a financially sustainable health system. It is important that the 2020/21 pay awards support the Government's objective to deliver long-term financial sustainability in the NHS, as well as aligning with the full range of investment priorities in the NHS Long Term Plan.

2.42 Government’s continued support for the NHS workforce is reflected in agreed multi-year funding deals for junior doctors and staff on Agenda for change contracts. For example, the agreed AfC multi-year deal reinforced a public sector pay policy of increased pay flexibility in return for reforms that improve recruitment and retention while boosting productivity.

2.43 Pay forms one part of a wider rewards package that includes pensions (discussed in greater detail in chapter 8), and as a whole is intended to recognise the hard work of the NHS workforce.

3. Hospital and Community Health Services (HCHS) Agenda for Change Staff Earnings

Summary

3.1 The non-medical workforce is diverse, covering roles such as administrative support and finance roles, nursing and midwifery, and management. Basic pay rates in 2018-19 ranged from £17,652 to £103,860.

3.2 In 2018-19 Average Earnings growth ranged between 0.9% and 5.4% across staff groups, with ambulance staff receiving the lowest growth and hotel, property and estates receiving the highest. Earnings growth for non-medical staff is in a good position when compared to broadly similar jobs in the rest of the economy, with staff experiencing either higher relative earnings growth or higher relative annual earnings over the last year. Pay restraint has meant that overall earnings growth has been consistently lower than wider economy comparators in recent years, although earlier comparisons show that public sector staff were shielded from the impacts of the financial crisis felt in the private sector.

3.3 Most recently the Agenda for Change (AfC) pay deal meant significant investment in basic pay levels in all bands and a reduction in the time taken to reach rates for the job through progression. In 2018-19 the increase in Basic Pay for Non-Medical staff ranged from 2.3% to 6.0% (with larger increases for lower bands) reflecting both increased basic pay from reform and pay advancement.

Agenda for Change contract

3.4 Almost all non-medical staff are employed on the AfC national contract. Under this contract, since April 2018, all roles in the NHS are placed into one of 8 pay bands relating to the skills, experience and qualifications required for the role.

3.5 In 2018, The NHS Staff Council (partnership of NHS trade unions and NHS Employers) reached agreement on reform of AfC terms and conditions of service and pay, resulting in a three-year pay and contract reform deal, which included reforms to the pay structure. The new pay structure was introduced in April 2018 and will be fully implemented by April 2021.

3.6 Key elements to the reformed contract included:

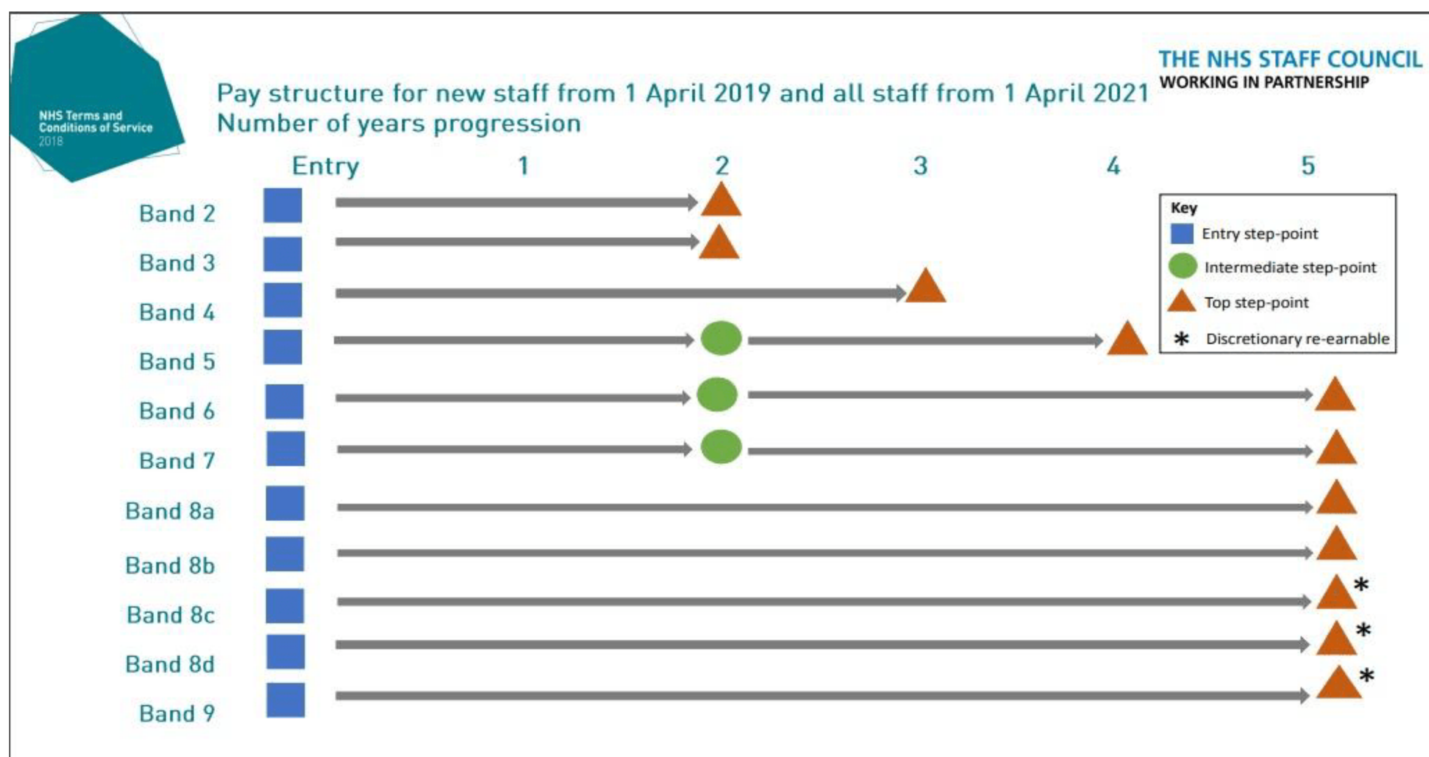
- A reduction in the number of pay points in each Band and higher basic pay in all Bands.

- In Bands 1-7 a reduction in the amount of time required to reach the top of the pay band. For example, it will take 4 years for someone to reach the top of Band 5 as opposed to 7 under the previous structure. Individuals in Bands 5, 6 and 7 will have access to intermediate pay points after 2 years of experience - these points are worth between 6% and 8% in basic day dependent on the band.

- An end to virtually automatic incremental progression - to move to the next pay point staff are required to demonstrate or show that they have met the requirements of their role.

3.7 Figure 3.1 shows what the structure of the AfC contract will be after the reformed contract has been fully implemented.

Figure 3.1 - Reformed Agenda for Change Pay Structure



Source - NHS Employers

Current Base Pay, Total Earnings and Allowances

3.8 This section provides information on the current levels of basic pay and additional earnings for non-medical staff. The non-medical workforce is diverse, covering

roles such as administrative support, nursing and midwifery, and management. As such there is wide variation in pay and earnings.

3.9 Most non-medical staff are employed on the AfC contact underpinned by the national Job Evaluation Scheme (JES). This system allocates each job role to a band based on a range of factors, with pay rates in 2018-19 ranging from £17,652 for roles at the bottom of Band 1 (Band 1 was closed to new entrants effective from December 2018) to £103,860 at the top of Band 9. The banding for a role is determined by, for example, the responsibilities held and whether professional registration is required.

3.10 Figure 3.2 shows the current value of the different AfC Bands and how basic pay values have changed over the past 5 years. All bands have seen growth of at least 5.5% over the period with larger increases for lower bands. Earnings in the wider economy have grown by 12.8% over the same period.

Figure 3.2 - Agenda for Change Pay Bands and Growth Comparison.

AfC Band	Position within Band	Basic Pay 14/15	Basic Pay 19/20	Growth in Basic Pay
Band 1	Bottom	£14,294	£17,652	23.5%
Band 1	Top	£15,013	£17,652	17.6%
Band 2	Bottom	£14,294	£17,652	23.5%
Band 2	Top	£17,425	£19,020	9.2%
Band 3	Bottom	£16,271	£18,813	15.6%
Band 3	Top	£19,268	£20,795	7.9%
Band 4	Bottom	£18,838	£21,089	11.9%
Band 4	Top	£22,016	£23,761	7.9%
Band 5	Bottom	£21,478	£24,214	12.7%
Band 5	Top	£27,901	£30,112	7.9%
Band 6	Bottom	£25,783	£30,401	17.9%
Band 6	Top	£34,530	£37,267	7.9%
Band 7	Bottom	£30,764	£37,570	22.1%
Band 7	Top	£40,558	£43,772	7.9%
Band 8a	Bottom	£39,239	£44,606	13.7%

Band 8a	Top	£47,088	£50,819	7.9%
Band 8b	Bottom	£45,707	£52,306	14.4%
Band 8b	Top	£56,504	£60,983	7.9%
Band 8c	Bottom	£54,998	£61,777	12.3%
Band 8c	Top	£67,805	£72,597	7.1%
Band 8d	Bottom	£65,922	£73,936	12.2%
Band 8d	Top	£81,619	£86,687	6.2%
Band 9	Bottom	£77,850	£89,537	15.0%
Band 9	Top	£98,453	£103,860	5.5%

Source - NHS Employers

3.11 The 19/20 minimum pay scales under Agenda for Change are higher than both the National Living Wage and the "Living Wage" as set by the Living Wage Foundation. Outside of London the minimum hourly rate is £9.03 compared to the £9.00 recommended by the Living Wage Foundation and in inner London, the AfC rate is £11.28 compared to £10.55 recommended by the Living Wage Foundation.

Figure 3.3 - Comparison of Pay Rates as of April 1st 2019

Salary Scales	Inner London	Outer London	London Fringe	Rest of England
Agenda for Change Minimum	£11.28	£10.93	£9.55	£9.03
National Living Wage	£8.21	£8.21	£8.21	£8.21
Foundation Living Wage	£10.55	£10.55	£9.00	£9.00

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

3.12 NHS Digital publish 3 variants of earnings data for the NHS workforce in England.

- Basic Pay per Person - the average amount of Basic Pay received.
- Basic Pay per FTE - the average amount of Basic Pay received. Basic Pay for Part Time employees scaled as if they were working on a Full-Time basis.
- Total Earnings per Person - based on all earnings received inclusive of additional payments for things like geographical allowances or shift work payments.

3.13 Figure 3.4 shows that the proportion of earnings as Additional Earnings varies by staff group - it is highest for Ambulance staff and lowest for Managers and Senior Managers. All staff groups saw increases in both Total Earnings and Basic Pay over the period.

Figure 3.4 - Earnings for 12 months to March 2019 and earnings growth over previous 12 months

Staff Group	Earnings per Person	Basic Pay per Person	Additional Earnings per Person	Additional Earnings Proportion	Earnings Growth	Basic Pay Growth
Nurses & health visitors	£32,478	£28,668	£3,810	12%	2.5%	2.7%
Midwives	£32,383	£27,662	£4,721	15%	2.3%	2.5%
Ambulance staff	£36,661	£26,720	£9,941	27%	0.9%	3.0%
Scientific, therapeutic & technical staff	£33,323	£30,808	£2,515	8%	2.4%	2.5%
Support to clinical staff	£19,394	£17,046	£2,348	12%	3.8%	4.2%
Support to doctors, nurses & midwives	£19,195	£16,786	£2,409	13%	4.0%	4.4%
Support to ambulance staff	£24,079	£18,666	£5,413	22%	2.4%	3.2%
Support to ST&T staff	£18,962	£17,640	£1,322	7%	3.5%	3.8%
NHS infrastructure support	£28,900	£26,707	£2,194	8%	3.4%	3.7%
Central functions	£25,374	£24,043	£1,331	5%	2.9%	3.1%
Hotel, property & estates	£18,637	£15,395	£3,241	17%	5.4%	6.0%
Senior managers	£78,321	£75,432	£2,890	4%	2.4%	2.8%

Managers	£48,627	£46,378	£2,249	5%	1.9%	2.3%
Other & Unknown	£14,262	£13,194	£1,068	7%	7.1%	6.4%

Source - NHS Digital Earnings Statistics

3.14 Additional earnings can be broken down into the different types of additional earnings. Figure 3.5 shows the proportion of people who received a payment in an area and the average value of those payments.

3.15 Ambulance and Support to Ambulance staff were the most likely to receive payments for overtime with over 50% of qualified ambulance staff and nearly 40% of support to ambulance staff receiving these payments, while Managers and Senior Managers in AfC Bands 8 and 9 are not entitled to receive overtime payments.

Figure 3.5 - Proportion of Staff in receipt of Allowances and Average Value of Allowances for those who receive them

Staff Group	Additional Activity	Geographical Allowances	Local Payments	On-Call	Overtime	RRP	Shift Work	Other
Nurses & health visitors	4.8%	21.3%	3.4%	4.2%	6.9%	0.8%	59.5%	1.9%
Average Payment	£2,973	£4,154	£1,973	£2,004	£3,724	£1,479	£3,908	£2,358
Midwives	6.8%	24.3%	5.5%	19.0%	3.2%	0.6%	78.5%	2.0%
Average Payment	£2,601	£3,855	£1,088	£1,208	£3,500	£1,845	£4,014	£2,442
Ambulance staff	23.9%	19.7%	24.6%	6.7%	54.0%	0.1%	96.0%	3.0%
Average Payment	£1,566	£3,585	£1,434	£1,275	£4,399	£4,472	£6,362	-£1,653
Scientific, therapeutic & technical staff	5.5%	21.9%	6.2%	12.2%	9.2%	1.0%	26.0%	2.0%
Average Payment	£3,611	£4,178	£3,216	£3,159	£3,156	£3,184	£1,684	£3,020
Support to clinical staff	6.3%	17.8%	3.0%	1.1%	7.7%	0.3%	42.8%	2.6%
Average Payment	£1,867	£3,049	£1,081	£1,845	£2,690	£1,732	£3,269	£1,164
Support to doctors, nurses & midwives	5.4%	18.1%	2.3%	0.7%	5.7%	0.3%	44.7%	2.7%
Average Payment	£1,944	£3,021	£1,312	£1,573	£2,659	£1,655	£3,427	£1,195
Support to ambulance staff	17.7%	11.0%	14.0%	3.5%	38.9%	0.8%	76.6%	4.0%
Average Payment	£1,497	£3,178	£1,652	£1,189	£3,320	£2,329	£4,152	£1,011
Support to ST&T staff	7.2%	17.9%	3.2%	2.1%	8.8%	0.2%	26.1%	1.6%

Average Payment	£1,846	£3,134	-£227	£2,508	£2,089	£1,848	£1,480	£1,075
NHS infrastructure support	8.1%	17.8%	4.5%	4.5%	8.3%	1.1%	23.2%	1.8%
Average Payment	£3,122	£3,847	£2,566	£2,995	£3,316	£3,897	£2,791	£2,582
Central functions	2.7%	20.9%	3.0%	2.6%	4.4%	0.6%	5.4%	1.4%
Average Payment	£3,877	£3,815	£1,806	£2,844	£3,136	£3,811	£2,013	£2,451
Hotel, property & estates	19.0%	10.9%	5.4%	4.0%	17.2%	1.8%	57.5%	2.2%
Average Payment	£1,862	£2,911	£1,592	£3,620	£3,312	£3,130	£2,928	£1,380
Senior managers	0.8%	17.7%	9.5%	14.2%	0.1%	1.2%	3.1%	1.9%
Average Payment	£105,174	£4,241	£7,195	£2,433	£7,047	£8,561	£904	£8,002
Managers	1.1%	24.9%	5.4%	9.2%	1.8%	1.0%	4.5%	1.6%
Average Payment	£24,359	£4,951	£3,220	£2,793	£5,135	£5,596	£2,115	£4,680
Others and Unknown	3.5%	11.2%	6.4%	0.7%	4.7%	0.4%	19.8%	1.8%
Average Payment	£2,088	£2,788	£1,997	£1,465	£2,089	£1,990	£2,160	£707

Source - NHS Digital Earnings Statistics

HCHS Earnings Growth

3.16 Total Earnings per FTE for non-medical staff increased by 3.0% in 2018-19. This is in line with the headline pay award and ongoing effects of contract reform, which averaged 3%.

3.17 Figure 3.6 presents trends in non-medical earnings growth and its component drivers. This comes from DHSC Headline Paybill Metrics which includes a Paybill Drivers Analysis which breakdowns Paybill growth into its constituent parts.

Figure 3.6 - Breakdown of Average Earnings Growth for Non-Medical staff

Pay Growth Element	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Basic Pay per FTE Growth	0.8%	-0.2%	0.8%	0.7%	1.3%	3.3%
Additional Earnings Growth	-4.2%	2.7%	-3.8%	-2.0%	-0.8%	0.3%
Total Earnings Growth Of Which	0.2%	0.1%	0.2%	0.4%	1.1%	3.0%
Headline Pay Awards	1.0%	0.4%	0.5%	1.0%	1.0%	3.0%
Total Earnings Drift Of Which	-0.8%	-0.2%	-0.3%	-0.6%	0.1%	0.0%
Basic Pay Drift	-0.2%	-0.5%	0.4%	-0.1%	0.2%	0.2%
Additional Earnings Drift	-0.6%	0.4%	-0.5%	-0.3%	-0.2%	-0.3%
Staff Group Mix Effect	-0.1%	-0.1%	-0.2%	-0.1%	0.1%	0.1%

Source: DHSC HCHS Paybill Metrics

3.18 As presented in the table above, several factors drive changes in Average Earnings. Some relate to changes in the composition of the workforce (e.g. more senior staff or more staff in higher earning occupations), some relate more specifically to pay rates. The data in this table is explained in more detail below:

3.19 Basic Pay per FTE grew at 3.3%. This is consistent with changes to the AfC payscale from reform, most notably restructure of the payscale and increased pay for most Pay Bands.

3.20 Average Total Earnings grew at 3.0%:

- This is in line with the 2018-19 headline pay award of 3.0%, and a neutral total earnings drift (0.0%)

3.21 Within the total earnings drift there was:

- a "Basic Pay Drift" of 0.2% (meaning Basic Pay increased by more than change to headline pay rates of 3.0%). This might be caused by having more staff at higher bands within a Staff Group or more people at higher Pay Points within an AfC Band.

- These positive effects were offset by ongoing negative Additional Earnings drift effects which are suggestive of a reduced use of Additional Earnings payments. Additional Earnings per FTE grew at 0.3%, reversing the recent trend for negative growth, but not matching the growth in Basic Pay that many types of Additional Earnings are tied to.

- a "Staff Group Mix" effect of 0.1% reflecting a slight shift toward higher earnings staff groups.

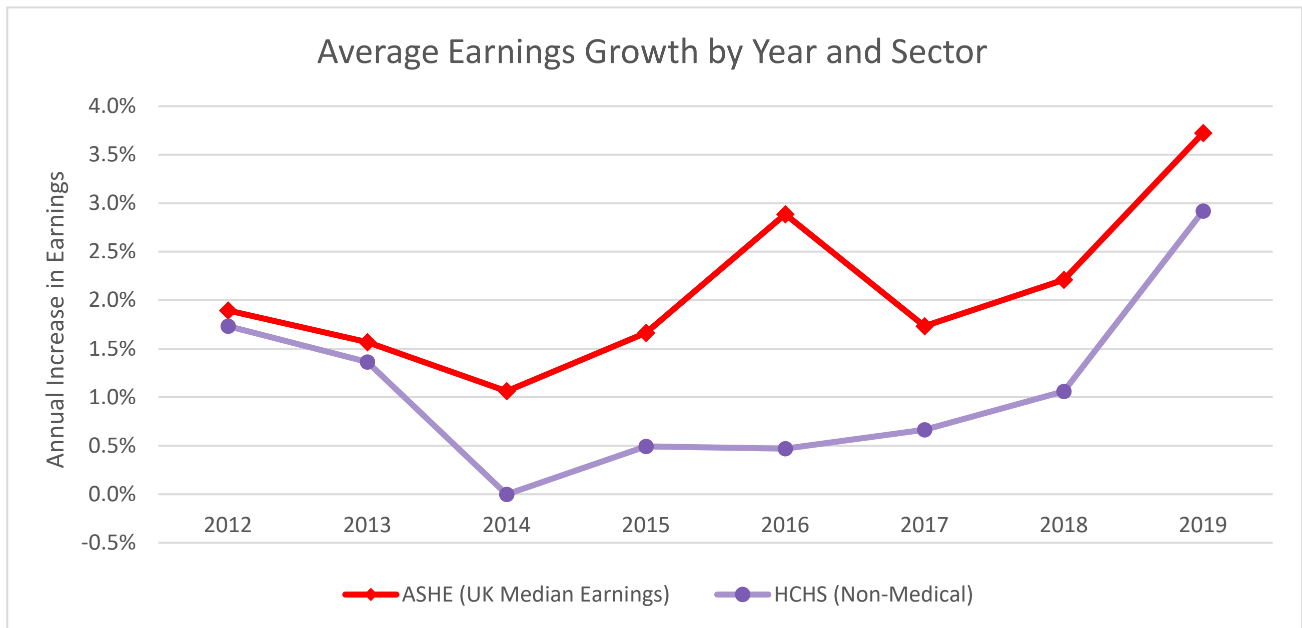
Current Pay Levels versus Comparator Groups in the Wider Economy

3.22 Earnings growth for non-medical staff is in a good position when compared to broadly similar jobs in the rest of the economy, with staff experiencing either higher relative earnings growth or higher relative annual earnings over the last year. Pay restraint has meant that overall earnings growth has been consistently lower than wider economy comparators in recent years, although earlier comparisons show that public sector staff were shielded from the impacts of the financial crisis felt in the private sector.

Earnings Growth Comparisons

3.23 Growth in Earnings in the HCHS sector can be compared to the wider economy. Over the last 3 years growth in the HCHS sector has seen pay growth around 1 percentage point lower than in the wider economy. This does not take into account other elements of the reward package in the HCHS sector (including the NHS Pension Scheme). While growth has been lower in the NHS over recent years, this follows a period, following the financial crisis, where there was no, or little, growth in earnings in the wider economy.

Figure 3.7 - Average Earnings Growth by Year and Sector



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

3.24 Comparisons can also be made between jobs at similar levels of seniority / experience by comparing NHS earnings data from NHS Digital with wider economy earnings data from the ONS Annual Survey of Hours and Earnings (ASHE).

3.25 Figure 3.8 shows that earnings growth for NHS staff between 2017-18 and 2018-19 was higher than the average annual growth over the preceding four years (2013-14 to 2017-18), reflecting the impact of the first year of the 2018 AfC pay agreement. Earnings growth for NHS staff was lower than comparators across the wider economy between 2013-14 and 2017-18. However, earnings growth in 2018-19 was higher than their wider economy comparator group for several NHS staff groups (Hotel, Property & Estates, Qualified Health Professionals, and Managers).

Figure 3.8 Growth in annual earnings for NHS staff and wider economy comparators

NHS Staff Group Wider Economy Comparator	Annual earnings 2013/14	Annual earnings 2017/18	Annual earnings 2018/19	Average Annual % Change 2013/14 to 2017/18	Average Annual % Change 2017/18 to 2018/19
NHS Hotel, Property & Estates	£16,959	£17,681	£18,637	1.0%	5.4%
Elementary / Skilled trades occupations	£18,287	£19,959	£20,878	2.2%	4.6%
NHS Support to Clinical Staff	£17,984	£18,686	£19,394	1.0%	3.8%
Caring, leisure and other service occupations	£13,587	£14,689	£15,391	2.0%	4.8%
NHS Central Functions	£23,285	£24,652	£25,374	1.4%	2.9%
Administrative and secretarial occupations	£18,844	£20,206	£21,162	1.8%	4.7%
NHS Qualified Health Professionals	£31,481	£32,132	£32,899	0.5%	2.4%
Professional / Associate professional and technical occupations	£35,676	£37,861	£38,051	1.5%	0.5%
NHS Managers	£47,366	£47,705	£48,627	0.2%	1.9%
Managers, directors and senior officials	£52,602	£55,839	£56,091	1.5%	0.5%

Source: NHS Digital Mean annual earnings per person by Staff Group, in NHS Trusts and CCGs in England; Office for National Statistics (ONS) Annual Survey of Hours and Earnings (ASHE) – Mean Gross Annual Pay for UK employee jobs by Occupation.

- NHS staff groups relate to Hospital and Community Health Service (HCHS) staff.
- ASHE annual pay data reported for e.g. 2019 (relating to the tax year ending on 5th April 2019) is compared with NHS earnings data for financial year 2018-19.
- Earnings data is not adjusted for hours worked.

3.26 Each broad NHS staff group is compared with a wider economy occupation group available in the Annual Survey of Hours and Earnings (ASHE), chosen to compare roles that are broadly similar in terms of:

- Qualifications, training and experience;
- Responsibilities and risk;
- Skills and competencies;
- Seniority; and
- Leadership and management.

3.27 While the wider economy groups are broadly similar to the corresponding NHS staff groups and allow for an indicative comparison, they cover a range of occupations, some of which may not be directly comparable with the NHS staff groups. The comparison is based on annual earnings per person and does not take into account other benefits including pensions, nor differences in the level of part-time working.

Distribution of Earnings Comparison

3.28 The median average earnings of non-medical staff in the NHS (£26,000) is slightly higher than in the wider economy (£24,000) and the earnings of the lowest 25% of earners are higher in the NHS than in the wider economy. The distribution in earnings between people within a Staff Group is caused by factors including the propensity to work on a Part-Time basis or take Overtime.

Figure 3.9 - Earnings Distribution and Comparison with UK Economy

Staff Group	25% Earn Less Than	Median Average	25% Earn More Than	Mean Average
UK Economy Average (ASHE Data)	£14,700	£24,000	£36,700	£29,800
Non-Medical Staff	£19,500	£26,000	£35,500	£28,400
Nurses & health visitors	£27,000	£32,500	£39,000	£32,000
Midwives	£26,500	£33,000	£39,500	£32,000
Ambulance staff	£31,500	£38,000	£44,000	£37,000
Scientific, therapeutic & technical staff	£26,000	£33,000	£41,500	£33,000
Support to clinical staff	£16,000	£20,000	£23,500	£19,000
Support to doctors, nurses & midwives	£16,000	£20,000	£23,500	£19,000
Support to ambulance staff	£20,500	£24,000	£28,000	£24,000

Support to ST&T staff	£15,000	£19,000	£22,500	£19,000
NHS infrastructure support	£18,000	£23,500	£35,500	£29,000
Central functions	£19,000	£23,500	£31,500	£25,000
Hotel, property & estates	£13,500	£18,500	£23,500	£19,000
Senior managers	£58,500	£73,500	£99,000	£78,000
Managers	£40,000	£49,000	£59,000	£49,000
Others and those with an unknown classification	£11,000	£17,000	£20,500	£14,000

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

Pay Advancement under the Agenda for Change Contract

3.29 Pay Advancement covers both pay progression and promotion.

3.30 The reformed AfC Contract will allow people to advance to the top of the Pay Band quicker than under the current system. For example, it will take only 4 years to reach the top of Band 5 as opposed to 7 years under the current system.

3.31 Figure 3.10 shows the latest distribution of staff by AfC Band and Pay Point and the proportion that would be both eligible for progression under the new system or would be at the top of the Band (meaning they would not be eligible for further Pay Advancement within the current Band). About half of staff would be at the top point of the Pay Band and a higher proportion of staff at the lower bands would be at the top of the Band. Between 10% and 24% of staff would be eligible for Pay Advancement - the number is higher in Bands 5 - 7 where there are more progression points.

Figure 3.10 - Distribution of Staff by Agenda for Change Pay Band and Point (2019)

Band	1	2	3	4	5	6	7	8	9	Proportion Eligible for Progression	Proportion at Top of Band
1	12%	88%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0%	100%
2	18%	10%	9%	11%	5%	4%	44%	N/A	N/A	10%	73%
3	15%	9%	8%	7%	8%	6%	48%	N/A	N/A	9%	77%
4	16%	9%	10%	8%	6%	5%	46%	N/A	N/A	10%	65%
5	18%	11%	9%	7%	6%	5%	3%	40%	N/A	24%	43%

6	10%	7%	7%	9%	9%	7%	6%	5%	39%	22%	44%
7	9%	6%	6%	6%	9%	8%	6%	6%	45%	21%	51%
8a	12%	8%	13%	11%	11%	45%	N/A	N/A	N/A	11%	45%
8b	10%	6%	13%	12%	9%	49%	N/A	N/A	N/A	9%	49%
8c	10%	7%	12%	13%	10%	48%	N/A	N/A	N/A	10%	48%
8d	10%	7%	11%	11%	9%	51%	N/A	N/A	N/A	9%	51%
9	12%	6%	12%	13%	10%	47%	N/A	N/A	N/A	10%	47%

Source - DHSC Analysis of Electronic Staff Record Data Warehouse

3.32 Figure 3.11 shows the current starting pay in each AfC band and the potential level of Basic Pay after 5 years in Post. All figures are based on the 2019-20 Pay Values and do not include the impact of future changes to pay scales or annual pay awards.

Figure 3.11 - Agenda for Change Starting Pay and Basic Pay after 5 Years' Experience

AfC band	Starting basic pay	Basic pay after five years
Band 1	£17,652	£17,652
Band 2	£17,652	£17,983
Band 3	£18,813	£19,917
Band 4	£21,089	£22,707
Band 5	£24,214	£27,260
Band 6	£30,401	£32,525
Band 7	£37,570	£38,765
Band 8a	£44,606	£50,819
Band 8b	£52,306	£60,983
Band 8c	£61,777	£72,597
Band 8d	£73,936	£86,687
Band 9	£89,537	£103,860

Source - NHS Employers Pay Circulars

Longitudinal Pay Analysis

3.33 About 50% of staff who were employed in the NHS in 2010 were still employed in the NHS in 2019. For these staff the average increase in Basic Pay was just over 26%. This means that, due to the impact of pay advancement and promotion, the average increase in pay was above those in the wider economy and above the changes to headline pay rates.

- The median increase in Basic Pay per FTE across all non-medical staff was 26.6%. Nurses and Health Visitors saw an average increase of 27.2%. The average increase in pay, as a consequence of pay advancement and promotions, was higher than increases in the wider economy (12.8%) and above increases in headline pay rates.

  - Increases in Basic Pay at the individual level reflect the impact of pay advancement and promotion over time. The largest increases in Basic Pay reflect cases where someone has gained promotion to a more senior staff group with a higher level of skills and responsibilities at a higher Agenda for Change Band (such as where someone has obtained Professional Accreditation). All figures are based on someone's current role and may be comparing to a time when they were in a more junior position.

  - 25% of people have experienced an increase in Basic Pay per FTE of over 40% over the period. 25% of people experienced in Basic Pay per FTE of less than 14.5% over the period.

  - Increases in Basic Pay per FTE at the individual level will be caused by a range of factors including Pay Advancement (people moving through Pay Scales over time), Promotion (people moving to higher bands over time) or changing roles (some may move to a different staff group).

Figure 3.12 - Percentage Increases in Basic Pay per FTE for people employed in both March 2010 and March 2019

Percentage Increase in Basic Pay per FTE	25th Percentile	Median	75th Percentile	Person Count
All Non-Medical Staff	14.5	26.6	41.3	545,103
Nurses & Health Visitors	13.9	27.2	42.9	178,017
Midwives	9.6	23	41.9	13,000
Qualified Ambulance Staff	19.9	33.3	50	7,883

Scientific, Therapeutic & Technical Staff	13.3	28.7	49.4	82,759
Support to Clinical Staff	14.5	23.1	33	161,540
NHS Infrastructure Support	19.2	30	48.1	101,531
Central Functions	15.3	30	47.6	50,490
Hotel, Property & Estates	23.1	25.2	31.9	24,923
Managers	25.1	43	67.1	18,135
Senior Managers	29.7	49.3	76.8	7,983

Source - DHSC Analysis of Electronic Staff Record Data Warehouse. The "Staff Group" shown is the staff group at the end of the period (March 2019). High increases for some staff groups may be due to promotion - for example people becoming Senior Managers from other Staff Groups.

3.34 Figure 3.13 shows equivalent analysis for the period between March 2018 and March 2019. There were just over 930,000 people who were employed in both March 2018 and March 2019. The median increase in Basic Pay for Non-Medical staff was 4.5% - this higher increase in a single year is driven by the introduction of the reformed AfC pay deal.

Figure 3.13 - Percentage Increases in Basic Pay per FTE for people employed in both March 2018 and March 2019

Percentage Increase in Basic Pay per FTE	25th Percentile	Median	75th Percentile	Person Count
All Non-Medical Staff	3	4.5	5.6	933,476
Nurses & Health Visitors	3	4	5.6	273,009
Midwives	3	4	5.6	21,648
Qualified Ambulance Staff	4.6	5	5.6	13,877
Scientific, Therapeutic & Technical Staff	3	4.6	5.6	136,259
Support to Clinical Staff	3	3	5.6	304,891
NHS Infrastructure Support	3	5	9.1	183,618
Central Functions	3	4.7	5.6	92,528
Hotel, Property & Estates	3	8.4	11.4	54,932
Managers	3	5	6.6	25,835
Senior Managers	2.7	5.4	7.2	10,323

Source - DHSC Analysis of Electronic Staff Record

3.35 The longitudinal analysis was conducted using data from the Electronic Staff Record Data Warehouse. Extracts were taken for two snapshots in time with records matched according to NHS ID number. Records were included in the analysis if someone had positive earnings in both monthly snapshots and had an FTE above zero.

3.36 Changes in earnings (not shown) may be more volatile than changes in Basic Pay. This will also include the impact of changes to working patterns such as moving between FT and PT employment or having a different mixture of Unsocial Hours.

3.37 Reforms to the AfC contract may lead to changes in the longitudinal patterns in future years - a reduction in the number of pay points in each band and a shorter time to reach the top of the band may lead to fewer people being eligible for advancement on an annual basis.

4. Workforce Strategy

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

4.2 The Department of Health and Social Care is responsible for leading, shaping and funding healthcare in England. The Department works with system partners to ensure there is a highly skilled and motivated workforce delivering NHS services to patients and service users.

4.3 The Department works through its Arms-Length Bodies (ALBs) on the delivery and implementation of workforce policy. NHS England and NHS Improvement is responsible for setting the priorities and direction of the NHS and encouraging and informing the national debate to improve health and care. NHS England and NHS Improvement is responsible for delivering the NHS People Plan. Education and training of the workforce is the core function of Health Education England (HEE).

4.4 The NHS Long-Term Plan published in January 2019 sets out a vital strategic framework to ensure that over the next ten years the NHS will have the staff it needs so that health professionals have the time they need to care, working in a supportive culture that allows them to provide the expert compassionate care they are committed to providing.

4.5 It highlights the following objectives as most important for the workforce:

- ensuring we have enough people, with the right skills and experience, so that staff have the time they need to care for patients well;

- ensuring our people have rewarding jobs, work in a positive culture, with opportunities to develop their skills and use state of the art equipment, and have support to manage the complex and often stressful nature of delivering healthcare;

- strengthen and support good, compassionate and diverse leadership at all levels – managerial and clinical – to meet the complex practical, financial and cultural challenges a successful workforce plan and Long-Term Plan will demand.

4.6 The 2019 Spending Round, published on 4 September 2019, announced a 3.4 per cent real terms increase in the Health Education England (HEE) budget for

2020/21. This includes an additional £150 million for Continuing Professional Development (CPD), as well as increased funding of up to £60m to support delivery of the NHS People Plan.

4.7 NHS England and NHS Improvement published the Interim NHS People Plan on 3 June 2019. The Interim NHS People Plan focusses on the action that will be taken now and over the long term to address workforce shortages, strengthen education and training, and improve culture and leadership in the NHS. These are necessary steps if the NHS is to deliver the LTP.

4.8 The Interim NHS People Plan is composed of the following six key themes:

i) making the NHS the best place to work;

ii) improving leadership culture;

iii) addressing urgent workforce shortages in nursing;

iv) delivering 21st century care;

v) a new operating model for workforce; and

vi) the immediate next steps to develop the full NHS People Plan.

4.9 The full NHS People Plan will be published in the coming months. It will set out a clear framework for collective action on workforce priorities over the next five years and a fuller range of specific targeted actions to address our biggest shared challenges.

Making the NHS the best place to work

4.10 The Interim NHS People Plan sets out the vision and immediate actions to make the NHS the best place to work. One of the most important elements of the plan is to improve the day to day experience of front-line staff and make the NHS an employer of excellence, where people are valued, supported, developed and empowered. By improving staff experience, we can improve retention of staff and drive continuous improvements in care.

4.11 There are cultural issues to address. The 2018 NHS Staff Survey indicates rates of reported bully and harassment are increasing; instances of bullying and harassment could have been exacerbated due to staff feeling under pressure because of staff shortages.

4.12 To improve the experiences of the people working in the NHS, a new core offer for NHS staff will be developed as set out by the Interim NHS People Plan. This will be set out in the full NHS People Plan and framed around the themes of creating a healthy, inclusive and compassionate culture; enabling great development and fulfilling careers; and ensuring everyone feels they have voice, control and influence.

4.13 The People Plan will be underpinned by a national action programme to help solve long standing practical issues with NHS employment, including flexible working, action to improve staff health and wellbeing, measures to tackle bullying and harassment, and steps to improve equality, diversity and inclusion.

Data on Staff Motivation and Engagement

4.14 Information regarding staff motivation and engagement is provided from the 2018 NHS Staff Survey results, Friends and Family test results and NHS staff sickness absence data.

4.15 The NHS Staff Survey is a key source of evidence that will inform action taken in the NHS People Plan. The most recent survey was published in February 2018. Over 1.1 million NHS employees in England were invited to participate in the survey between September and December 2018; 497,117 responded – a 46% response rate.

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

4.17 Data from the 2018 Staff Survey shows that compared to 2017, a higher percentage of staff in each staff group reported ‘always’ or ‘often’ looking forward to going to work. Those in central functions lower motivation scores, compared to other non-medical staff. The percentage of staff, broken down by year and job role, who look forward to going to work are detailed in Figure 4.1.

Figure 4.1 – NHS Staff Survey Question 2a, percentage of staff who look forward to going to work

Staff survey - looking forward to going to work	2014	2015	2016	2017	2018
AHPs, ST&T, healthcare scientists	53.0%	58.3%	58.9%	58.0%	59.3%
Ambulance staff	61.4%	60.5%	61.6%	59.4%	63.5%
Nurses & midwives	56.4%	63.7%	62.0%	61.1%	61.7%
Nursing & Healthcare Assistants	57.3%	64.3%	63.8%	63.6%	64.8%
Central functions	50.7%	54.1%	53.9%	53.2%	53.6%
Managers	60.6%	63.4%	62.5%	61.4%	62.0%

4.18 Whether NHS staff would recommend their workplace is another indicator of the quality of workplace environment in the NHS. Figure 4.2 shows overall scores regarding whether NHS staff would recommend their workplace to friends and family looking for care, or as a place to work. This data was collected as a part of the Staff Friends and Family Test 2019/20 is unable to be broken down by staff group

Figure 4.2 – Staff Friends and Family Test 2019/20, percentage of staff who would recommend their workplace for those seeking: care; work.

Staff friends and family test - Q1 19/20	Score (% recommend)	Score (% not recommend)
Care – all staff	81%	6%
Work – all staff	66%	16%

4.19 Part of making the NHS the best place to work is helping to improve the physical and mental health and wellbeing of NHS staff, and therefore help reduce sickness absence.

4.20 The sickness absence rate in NHS Trusts and CCGs for 2018/19 is 4.21%, this is a slight increase of 0.02% from 2017/18. The long-term trend in sickness absence shows no significant change over time – the sickness absence rate has always between 4.1% and 4.4%. A more detailed breakdown of sickness absence data - including sickness absence by job role is at Chapter 6.

4.21 Staff retention is a key metric used in the NHS Staff Survey to ensure appropriate, long-term staffing arrangements in the NHS. In the 2018 dataset, a question was posed regarding how strongly the respondent agrees with the statement, “I often think about leaving the [NHS]”. 2018 was the first year that this question was asked, therefore time-series data is unavailable. Breakdown by Job Role is contained in Figure 4.3, between 26.5% and 31.5% of staff – dependant on job role - often think about leaving the NHS.

Figure 4.3 – NHS Staff Survey, Question 23a, percentage of staff who often think of leaving the NHS

Staff survey - leaving organisation	2018
AHPs, ST&T, healthcare scientists	28.8%
Ambulance staff	30.5%
Nurses & midwives	30.3%
Nursing & Healthcare Assistants	26.5%
Central functions	31.4%
Managers	31.5%

4.22 The NHS Staff Survey also asked respondents if they have experienced harassment or abuse in the last year, in three separate questions. These questions are differentiated by the source of the abuse/harassment: from members of the public; from managers; and from other colleagues. If the respondent has not received abuse or harassment, the score for each question is recorded as a 10, otherwise 0 - therefore, a higher score indicates a preferred outcome. The theme score is the average over the three questions.

Figure 4.4 – NHS Staff Survey, Safe environment – bullying and harassment theme score

Staff group - bullying & harassment	2015	2016	2017	2018
Nurses & midwives	7.5	7.5	7.5	7.5
Nursing & Healthcare Assistants	7.7	7.7	7.7	7.7
Ambulance staff	6.8	6.8	6.9	6.9
AHPs, ST&T, healthcare scientists	8.3	8.4	8.4	8.3
Central functions	9	9	9	9

Managers	8.4	8.5	8.5	8.4

4.23 As highlighted in 4.11, the NHS Staff Survey 2018 indicates that overall bullying and harassment levels in the NHS are increasing. Conversely, Figure 4.4 shows that among non-medical staff, bullying and harassment levels remain similar to previous years. the bullying and harassment theme score only decreased by 0.1 for managers and AHPs, ST&T and healthcare scientists.

4.24 Similarly to 5.18, the NHS Staff Survey generates a theme score for equality, diversity and inclusion. This metric is composed of 4 binary response questions; with each ‘positive’ response recorded as a 10, each ‘negative’ response recorded as 0. The theme score is the average across the four questions

Figure 4.5 – NHS Staff Survey, Equality, diversity and inclusion theme score

Staff survey - equality & diversity	2014	2015	2016	2017	2018
AHPs, ST&T, healthcare scientists	9	9.1	9	8.9	8.9
Ambulance staff	8.9	8.9	8.9	8.8	8.8
Nurses & midwives	8.1	8.2	8.2	8.2	8.2
Nursing & Healthcare Assistants	9.2	9.3	9.3	9.2	9.2
Central functions	9.4	9.4	9.4	9.3	9.3
Managers	9.3	9.2	9.2	9.2	9.2

4.25 Figure 4.5 show the equality, diversity and inclusion theme score in 2018 remains the same for all staff groups compared to 2017. The longer-term trend, however, is a slowly decreasing theme score for all staff groups. This is due to more NHS staff experiencing instances of discrimination at their workplace, from either their manager, members of the public or both.

4.26 The interim NHS People Plan states that leadership is the most effective route to making real change within the NHS. As shown in Figure 4.6, The 2018 NHS Staff Survey indicates that all non-medical staff, regardless of job role, are feeling more satisfied with the support from their immediate manager compared with 2017. The long-term trend indicates a greater percentage of staff are feeling supported by their line manager across all job roles.

Figure 4.6 – NHS Staff Survey, Percentage staff satisfied with support from immediate (line) manager

Staff survey - satisfied with support from immediate manager	2014	2015	2016	2017	2018
AHPs, ST&T, healthcare scientists	70.4%	68.7%	71.6%	71.5%	73.3%
Ambulance staff	61.6%	57.5%	63.2%	63.3%	65.6%
Nurses & midwives	69.8%	71.0%	72.3%	72.5%	72.7%
Nursing & Healthcare Assistants	66.5%	68.7%	68.3%	69.5%	71.1%
Central functions	73.6%	73.9%	74.0%	74.1%	76.0%
Managers	74.2%	75.2%	74.6%	75.4%	75.4%

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

Improving the Leadership Culture

4.28 The interim NHS People Plan places an emphasis on supporting leaders, enabling them to create positive and inclusive cultures. It means supporting leaders to work together across whole systems – encompassing social care, community services and GPs – for the benefit of patients.

4.29 NHS England and NHS Improvement are undertaking system-wide engagement on a new 'NHS Leadership Compact' that will establish the cultural values and leadership behaviours expected from NHS leaders, along with the support and development leaders should expect in return. This will be aligned with the NHS Oversight Framework and Well-Led Framework.

4.30 NHS England and NHS Improvement are now responsible for the NHS Leadership Academy; the organisation having transferred from HEE in April 2019. This means that they are able to ensure our efforts to improve leadership culture are aligned with our wider objectives around sustainability, quality and improvement.

Tackling the Nursing Challenge

4.31 The interim NHS People Plan recognises there are significant staff shortages across the country in many parts of our workforce. The full People Plan will set out a range of further actions to move towards having the optimal number and mix of staff, with the right skills. However, shortages in nursing are the single biggest and

most urgent that needs to be addressed. The interim NHS People plan emphasises a multifaceted approach to improve long-term Nurse Supply.

4.32 The interim NHS People Plan sets out current actions to grow the NHS nursing workforce, to keep pace with rising demand and make initial progress in bringing down substantive vacancy levels. The government has committed to 50,000 more nurses by 2024/25, and announced further details to provide eligible pre-registration nursing and midwifery students enrolled on courses at English universities from September 2020 with a payment of at least £5,000 per academic year which they will not need to pay back.

4.33 The full NHS People Plan will need to contain further action to enable us to radically reduce vacancy levels for substantive roles so there is much less reliance on temporary staffing.

4.34 NHS Improvement and NHS Employers have been delivering a retention programme – the Direct Support Programme - with NHS trusts since 2017, working to ensure newly qualified staff are well supported and developing flexible working. The interim People Plan seeks to expand the retention programme to all trusts and provide support in other specialised areas, dependent on need.

4.35 The interim NHS People Plan sets out collaborative actions that the health and education sector can take to increase clinical placement capacity, which included delivery of a rapid expansion programme to increase capacity by 5,000 for September 2019 intakes. Additional placement capacity to support the government commitment to 50,000 more nurses by 2024/25 will be included in the full NHS People Plan.

4.36 The interim NHS People Plan highlights the development of number of a number of alternative routes into nursing over recent years, including the nurse degree apprenticeship and the nursing associate route. The plan states that the nursing associate pilot programme should be expanded to allow nursing associates who want to continue their studies to do so, to become registered nurses.

4.37 The interim NHS People Plan also states that a clear model should be developed that sets out the different entry routes into nursing, highlighting the different approaches and benefits, to inform employer and entrant decisions.

4.38 Proposals are being developed by HEE for a blended learning nursing degree programme that maximises the opportunities to provide a fully interactive and innovative programme through a digital approach.

4.39 NHS England and NHS Improvement is working with DHSC to review and identify how to improve the financial support programmes currently available through the

Learning Support Fund (LSF), as well as considering how to streamline the process between applications for and awards of LSF payments.

4.40 HEE, NHS England and NHS Improvement will review how to increase both national and local investment in continuing professional development (CPD), the government has committed to provide £150m for central CPD budgets in 2020/21.

International Recruitment

4.41 Since 2014 Health Education England has recruited more than 5,400 nurses onto return to practice courses. The interim People Plan will build on this work and launch a new return to practice campaign to boost this number further, alongside a new marketing campaign to highlight the opportunities and support available to them and inspire more nurses to return.

4.42 Health Education England will continue its work to build global partnerships and exchanges, while NHS England and NHS Improvement regional teams will become responsible for the coordination of local health systems' recruitment efforts.

4.43 Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) will be supported to implement 'lead recruiter' arrangements, as part of delivering their five-year workforce plans. A new national procurement framework of approved international recruitment agencies and a best practice toolkit will be developed to support 'lead recruiters', ensuring consistent operational and ethical standards and to support increased international recruitment.

Delivering 21st Century Care

4.44 It is important that we free up health and care teams from duplicative, administrative and non-essential tasks that get in the way of providing care and support to patients and service users. This means designing pathways that explicitly match staff resources to activities and interventions that have the greatest impact on quality and outcomes; developing multidisciplinary teams with a stronger focus on care pathways, preventive interventions and community-based care; and removing non-productive tasks and making essential tasks more efficient, supported by a clear pipeline of digital and technological innovations.

4.45 The full People Plan will set out how we can redesign the workforce to better reflect changing patient needs and models of care, contribute to better outcomes,

deliver more rewarding careers for those who work in the NHS, and more sustainable patterns of workforce growth.

4.46 The Interim NHS People Plan supports the ongoing development of a pipeline of Allied Health Professions (AHPs) to ensure sufficient staff to deliver the new service models set out in the NHS Long Term Plan, particularly as part of multidisciplinary teams working in primary care networks. Eligible pre-registration AHPs enrolled on courses at English universities will also be eligible for maintenance grants of at least £5,000, from September 2020.

4.47 NHS England and NHS Improvement, along with HEE will develop this pipeline by increasing applications to undergraduate AHP education and identifying how to expand clinical placement capacity, while supporting continuing education and training of AHPs in current practice including the development of advanced practice roles.

4.48 The Interim NHS People Plan acts to ensure that those providing care in the NHS, both now and over the coming years, are equipped with the knowledge and skills to keep up with scientific and technological advances and that we have the right specialist workforce to support the broader multi-professional team in applying these advances.

4.49 NHS England and NHS Improvement and HEE will begin work to review current models of multidisciplinary working within and across primary and secondary care. They will also develop accredited multidisciplinary credentials for mental health, cardiovascular disease and older people’s services, with a focus on multidisciplinary training in primary care.

A new operating model for workforce

4.50 The NHS Long Term Plan is clear that integrated care systems (ICSs) should be the main organising unit for local health services and that we will support all local health systems in becoming ICSs by 2021.

4.51 The full People Plan will set out how we implement a new operating model for workforce, with greater clarity about respective roles of individual employers, local health systems and regional/national teams. This will include a greater role for ICSs to lead collaborative, system wide approaches on workforce and people priorities.

4.52 Health Education England, NHS England and NHS Improvement will support local health systems (STPs/ICSs) to develop five-year workforce plans, as an integral part of service and financial plans, enabling us to understand better the number

and mix of roles required to deliver the NHS Long Term Plan and inform national workforce planning.

4.53 Whilst the NHS People Plan is tasked to focus on NHS staff, there are substantial areas where the Plan impacts on social care and the wider health system. The People Plan team has agreed to work with the social care sector on these touch points to provide positive outcomes for the integrated health and care system and the populations they serve.

4.54 Workforce plans developed jointly and reflecting the needs of the whole health and care system must be advocated at the local (ICS) level and at the system levels. All stakeholders, including providers of all sizes and sectors and the workforce at every level, must be and feel that they are part of any local strategy for it to be successful.

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

Summary and Background

5.1 Effective workforce policy is critical to the delivery of affordable, high quality care. Securing the people with the right values, skills, experience and expertise which the NHS needs is central to the future of England's health and care system. NHS England's Long-Term Plan published on 7 January 2019 describes the approach to shaping the face of the NHS for the next decade.

5.2 There is a record and growing number of non-medical staff in the NHS, with an FTE increase of 10.5% between March 2014 and March 2019. The two largest groups of staff are nurses and health visitors, and support to doctors, nurses and midwives, and they have seen an increase of 3.3% and 13.8% respectively.

5.3 However, demand for NHS services continues to grow and recruitment and retention indications are mixed - the need to address supply issues remains:

- Vacancies still present a problem across the NHS. The Vacancy rate for all non-medical staff has fallen slightly since early 17/18. The vacancy rate for nurses and midwives is slightly higher than the overall non-medical rate and has increased over the last two years from 10.9% to 12.1% (which is equivalent to vacancies of 38,000 to 44,000 FTE)

- Around 11% of non-medical staff have a non-UK nationality, with 4.9% from the EU27 up from 4.6% in 2016. Despite this overall increase, since 2016 the number of EU27 nurses, health visitors and midwives has fallen. Departmental analysis suggests this is most likely a consequence of the Nursing and Midwifery Council (NMC) introducing more rigorous language testing for applicants from the European Economic Area, than the decision to leave the European Union. The Department is clear that our priority is to ensure those currently working in NHS are not only able to stay but feel welcomed and encouraged to do so.

- Bank and agency staff are also used to cover some vacancies, in addition to covering sickness absence and long-term leave, although agency spend has now fallen to 4.4% of pay costs.

- Leaving and retention rates are stable, and retention is generally high. But voluntary resignation has accounted for almost half of all reasons for leaving over the past five years.

- Students applying and entering into nursing has fallen since 2016 which coincides with the move from a bursary to a student loan system

- BME representation in the overall workforce and the gender balance has been stable over the past 4 years. BME representation was around17% in 2018, and the proportion of females in the workforce was around 80% in 2019. There is a gender pay gap in all staff groups, and an ethnicity pay gap across all ethnicities with Black staff being the single group to have lower average pay than White staff.

- Health and wellbeing scores, in the staff survey, ranged from 4.6 - 6.6 across staff groups in 2018, and have broadly remained unchanged on previous years. Recorded sickness absence rates remain low.

- Staff engagement indicators are holding firm and pay satisfaction has increased across all staff groups over the last year, which is likely to be because of the implementation of the new Agenda for Change pay and contract reform deal.

5.4 The Department is responsible for leading, shaping and funding healthcare in England. The Department works with system partners to ensure there is a highly engaged and motivated workforce delivering NHS services to patients. The Department works through its Arms-Length Bodies (ALBs) on the delivery and implementation of workforce policy including to help ensure that our organisations work closely together to support local health systems to recruit, train, develop and retain the staff the NHS depends upon. NHS England and NHS Improvement's NHS Long-Term Plan published on 7 January 2019 sets out a strategic framework to ensure that over the next ten years the NHS will have the staff it needs. The interim NHS People Plan was published on 3 June 2019 and details how the workforce ambitions of the Long Term Plan will be met, the final version of the People Plan will be published shortly.

5.5 A sustainable approach to long-term nursing supply is essential to workforce planning, therefore we will continue to work with the Home Office to ensure that after we leave the EU we will have in place an immigration system which works in the best interests of the whole of the UK. We deeply value the contribution of all EU nurses working in the NHS and social care, and our first priority has always been to provide certainty to these EU citizens.

5.6 We are aware, however, that we cannot rely on overseas recruitment alone and have in place longer term plans to ensure we have the right skills domestically. In view of this, the Department has oversight of a package of measures currently being implemented by ALBs to ensure the required workforce is in place to deliver safe and effective services. These measures look to broaden routes into nursing, work with trusts on a range of recruitment, retention, sickness absence and return to practice programmes, and grow the undergraduate nursing degree supply route.

5.7 The NHS Long Term Plan sets out that the national workforce group will agree action to improve supply. This will centre on increasing the number of undergraduate nursing degrees, reducing attrition from training and improving retention, with the aim of improving the nursing vacancy rate to 5% by 2028. Additionally, HEE is leading the national expansion of the Nursing Associate role through the apprentice route, which aims to recruit up to another 7,500 Nursing Associates onto training this year.

5.8 Getting the skills mix right is critical in addressing workload pressures and delivering appropriate patient care. As set out in the Long-Term Plan, there is a need to transform the way the entire NHS workforce work together. Work will be much more multidisciplinary, people will be able to have less linear careers, and technology will enable staff to work to their full potential.

Numbers in work

5.9 The overall non-medical NHS workforce has increased by over 93,500 FTEs (10.5%) between March 2014 and March 2019. All areas have seen an increase, with nurses and health visitors seeing the smallest percentage increase of 3.3%, but with support to doctors, nurses and midwives seeing an increase of 13.8%. Managers and senior managers decreased between 2013 and 2014 following the 2013 NHS Reforms. Since 2014 there has been a consistent increase by almost 27%. Support to doctors, nurses & midwives saw the biggest increase in absolute terms, by over 30,500 FTE in the five-year period.

Figure 5.1: Non-medical staff FTE March 2014 to March 2019

Staff group	Mar-14	Mar-19	Change	% Change
Nurses & Health Visitors	280,836	290,010	9,175	3.3%
Midwives	21,079	21,870	791	3.8%
Ambulance staff	17,548	21,610	4,062	23.1%
Scientific, Therapeutic & Technical Staff	125,296	141,250	15,954	12.7%

Support to Doctors, Nurses & Midwives	221,499	252,060	30,561	13.8%
Support to Ambulance Staff	12,907	15,979	3,072	23.8%
Support to ST&T staff	50,876	58,980	8,104	15.9%
Senior Managers	8,542	10,816	2,274	26.6%
Managers	18,730	23,740	5,011	26.8%
Central Functions	75,148	86,157	11,009	14.7%
Hotel, Property & Estates	52,090	54,763	2,673	5.1%
Other staff or those with unknown classification	3,383	4,373	990	29.2%
Total	887,934	981,608	93,676	10.5%

Source: NHS Digital HCHS monthly workforce publication

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

Joiners

5.10 The overall joiner rate for all regions and staff is 13.2% with over 144,000 headcount joining the workforce. Joiner rates vary between 8.4% and 20.5% across staff groups (excluding the Other and unknown category) however these again will vary by region.

Figure 5.2 - Joiners by Staff Group

Staff group	Number of Joiners	Joiner rate
All staff groups	144,428	13.2%
Nurses & health visitors	35,285	11.0%
Midwives	2,837	10.8%
Ambulance staff	1,964	8.8%
Scientific, therapeutic & technical staff	19,292	12.2%
Support to doctors, nurses & midwives	42,399	14.7%
Support to ambulance staff	3,495	20.5%
Support to ST&T staff	11,157	16.5%

Central functions	13,134	14.2%
Hotel, property & estates	9,570	14.2%
Senior managers	924	8.4%
Managers	2,164	9.0%
Other staff or those with unknown classification	2,287	49.0%

Source: NHS Digital HCHS Workforce Statistics

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

Staff Group Joiner Rates by Region

The North East region has the lowest joiner rate for nurses and health visitors (8.1%), midwives (9.1%), clinical support staff (9.7%), and scientific, therapeutic and technical staff (9.0%). The highest joiner rates in each staff group varied across regions.

5.11 For midwives, the highest joiner rate was seen in the Thames Valley region, 14.2% in 2018/19, up by 4 percentage points since 2014. For ST&T staff the highest joiner rate was in the North West London region, 14.4% in 2018/19. The highest joiner rates for Support to clinical staff and Infrastructure support staff were 19-20% in 2018/19, in Thames Valley and Kent, Surrey and Sussex respectively.

5.12 More detailed analysis of staff group leaver rates by region are provided in Annex 2.

Leaver Rates and Trends

Staff Group Leaver Rates by Region

5.13 Leaver rates have fallen since last year for all major staff groups in England. The leaver rate is the share of the workforce leaving their staff group in the NHS Trusts and CCGs in a year. It excludes staff moving between Trusts, but includes people moving from a Trust to e.g. a GP Practice. The leaver rate does not include those on maternity leave as staff do not leave the trust, they are classed as being on occupational absence. Overall, leaver rates across England have changed little since 2014 and remained a little over 10% for nurses and health visitors and midwives, 7.6% for ambulance staff, 10.5% for scientific, therapeutic and technical staff and 9.9% for support to clinical staff. The leaver rate for infrastructure staff

decreased from over 11% to below 10% overall. The breakdowns by region are discussed below.

Figure 5.3 - Leaver rates by Staff Group

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

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

5.14 In 2018/19 Ambulance staff have the lowest leaver rate at 7.6% in England whilst support to clinical staff have the highest leaver rate of 10.9% in 2018/19.

5.15 For midwives, the highest leaver rate was seen in the Thames Valley region, 12% in 2018/19, down 0.5 percentage points since 2014/15. For nurses and health visitors and ambulance staff, the highest rate was seen in the South West region, 12.2% and 10%, respectively in 2018/19. For ST&T staff the highest leaver rate was in the North West London region, 12.9% in 2018/19. More detailed analysis of staff group leaver rates by region are provided in Annex 2.

Retention

5.16 Another way to express outflows from the workforce is the stability index. This has held relatively steady over recent years as shown in Table x. The stability index captures how successful the NHS is in retaining its staff. The index is computed by NHS Digital on data for England. The chart below shows that there has not been much variation in the stability index for the HCHS non-medical workforce in each staff group, with the maximum variation being 1.9 percentage points for infrastructure staff between 2014-15 and 2018-19. NHS Digital data shows retention has increased slightly for several staff groups compared to 2014 and almost 90% of most NHSPRB staff groups were retained over the 12 months up to March 2018-19.

Figure 5.4 - Stability Index for the Non-Medical Workforce

Staff groups	2014-15	2015-16	2016-17	2017-18	2018-19	Change Percentage points 2014-2019
Nurses & Health Visitors	89.7%	89.5%	89.1%	89.3%	89.8%	0.1
Midwives	90.2%	89.7%	89.2%	89.4%	89.6%	-0.6
Ambulance	92.6%	92.4%	92.7%	91.9%	92.2%	-0.4
STT	88.5%	88.3%	88.6%	89.0%	89.3%	0.8
Support to Clinical	88.4%	88.4%	87.6%	88.2%	88.9%	0.5
Infrastructure	87.9%	88.3%	88.4%	88.4%	89.8%	1.9

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

Reasons for leaving

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

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

Reason for Leaving	14/15	15/16	16/17	17/18	18/19	14/15	15/16	16/17	17/18	18/19
Dismissal	4,272	4,464	4,282	4,006	3,816	3.9%	3.9%	3.6%	3.3%	3.3%
Employee Transfer	6,950	5,234	6,480	6,134	3,105	6.3%	4.6%	5.4%	5.1%	2.7%
End of Fixed Term Contract	2,298	2,317	2,227	2,223	2,060	2.1%	2.0%	1.9%	1.8%	1.8%
Completion of Training Scheme	626	575	529	470	495	0.6%	0.5%	0.4%	0.4%	0.4%

End of Work Requirement	301	271	322	299	269	0.3%	0.2%	0.3%	0.2%	0.2%
End of Fixed Term Other	452	475	390	448	375	0.4%	0.4%	0.3%	0.4%	0.3%
Mutually Agreed Resignation	1,143	740	789	507	342	1.0%	0.7%	0.7%	0.4%	0.3%
Others	845	790	821	878	1,238	0.8%	0.7%	0.7%	0.7%	1.1%
Redundancy	1,819	1,639	1,324	1,258	920	1.7%	1.4%	1.1%	1.0%	0.8%
Retirement	18,241	18,119	17,690	17,051	15,522	16.6%	15.9%	14.8%	14.1%	13.5%
Unknown	26,574	29,663	33,318	34,480	34,311	24.1%	26.1%	27.9%	28.5%	29.9%
Voluntary Resignation	46,640	49,429	51,365	53,148	52,341	42.3%	43.5%	43.0%	44.0%	45.6%
All Reasons for Leaving	110,161	113,716	119,537	120,902	114,794	100%	100%	100%	100%	100%

The Effect of Moving from the Bursary System in England

5.18 The Pay Review Body asked for additional information on the effect of moving from the Bursary System to the student loans system during the period 2017 - 2019. UK nationals and EU students were eligible for the NHS bursary until 2016. In 2017, the education funding reforms meant that pre-registration nursing, midwifery and allied health degrees were no longer funded by the NHS bursary.

5.19 Since the final year of the Bursary System in 2016, UCAS data in figure 5.6 shows applicants to undergraduate nursing courses have fallen by an overall 28%, from 56,790 in 2016 to 40,770 in 2019. Between 2016 and 2019, UK applicants have decreased from 54,940 to 39,140 (or 29%) and those from the EU have decreased from 1,430 to 730 (or 49%). In contrast, there has been a rising trend in applicants from overseas, increasing from 420 in 2016 to 900 in 2019.

Figure 5.6 - Number of applicants to undergraduate nursing courses in England (UK, EU, overseas domiciled) by entry year

Entry year	2015-16	2016-17	2017-18	2018-19	2019-20	Change 2019 versus 2018	Change 2019 versus 2016
UK	54,160	54,940	42,620	37,520	39,140	4%	-29%
EU (excluding UK)	1,360	1,430	940	760	730	-4%	-49%
Overseas	500	420	600	690	900	30%	114%
Total	56,020	56,790	44,160	38,970	40,770	5%	-28%

Source: UCAS June deadline publication 2019

5.20 Further data on acceptances shows that between 2016 and 2019 the number of students who entered undergraduate nursing courses at English providers has increased from 23,275 to 23,625 (1.5%). Over the same period, EU acceptances have decreased from 370 to 150 (-59%), whilst overseas entrants have increased from 45 to 185 (311%), as in figure 5.7.

Figure 5.7 - Number of acceptances to undergraduate nursing courses in England (UK, EU, overseas domiciled) by entry year

Entry year	2015	2016	2017	2018	2019	Change 2019 versus 2018	Change 2019 versus 2016
UK	21,715	22,860	22,260	21,905	23,290	6%	2%
EU (excluding UK)	350	370	230	180	150	-17%	-59%
Overseas	65	45	80	115	185	61%	311%
Total	22,130	23,275	22,570	22,200	23,625	6.4%	1.5%

Source: End of cycle Universities and Colleges Admissions Service (UCAS) data, 2019

5.21 Figure 5.8 below shows the number of acceptances in the rest of the UK where bursary reforms did not take place. The number of acceptances in Scotland, Northern Ireland and Wales increased steadily since 2015. Between 2016 and 2019, acceptances in Northern Ireland increased from 760 to 910 (20%). In Scotland, there was an increase in acceptances from 3,350 to 4,040, or 21%. Wales also saw an increase in acceptances by 21%, from 1,500 to 1,815 between 2016 and 2019.

Figure 5.8 - Number of acceptances in the rest of the UK where bursary reforms did not take place

Acceptances by country of provider	2015	2016	2017	2018	2019	Change 2019 versus 2018	Change 2019 versus 2016
Northern Ireland	680	760	805	855	910	6%	20%
Scotland	3,355	3,350	3,615	3,725	4,040	8%	21%
Wales	1,370	1,500	1,625	1,760	1,815	3%	21%

Source: End of cycle Universities and Colleges Admissions Service, 2019

Note: The figures for Northern Ireland are an underestimate as the data does not capture all the acceptances.

5.22 Further evidence on increasing clinical placements was also requested Work on this is currently ongoing and is led by Health Education England and NHS England and Improvement. Further to this, evidence on the factors driving applicants, acceptances and attrition was also requested however we do not have evidence available for these areas.

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

Vacancies

5.24 There is no one perfect measure of NHS vacancies available. NHS Improvement undertake monthly workforce data collection from NHS trusts, which includes data on staff in post (including bank and agency) and vacancies (defined as difference between staff in post and establishment or funded staff). Vacancies typically show seasonal variation with peaks occurring at the start of the financial year, and troughs occurring at the end. The overall vacancy rate has showed some variation over the last year, ranging from 8.2% to 9.3%, which is equivalent to vacancies of 87k to 98k.

5.25 Bank and agency staff are used to cover some vacancies in addition to covering sickness absence and long term leave.

Figure 5.9 - Vacancies and vacancy rates from Q1 2017/18 - Q1 2019/20

Vacancies (FTE & rate)	Measure	17/18 Q1	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1
Nurses and midwives	Vacancies	38,328	42,589	42,679	39,686	39,520	43,617
Nurses and midwives	Vacancy rate	10.9%	12%	12.1%	11.1%	11.1%	12.1%
Other non-medical staff	Vacancies	58,226	55,664	53,416	52,311	47,645	52,559
All non-medical staff	Vacancies	96,554	98,253	96,095	91,997	87,165	96,176
All non-medical staff	Vacancy rate	9.3%	9.3%	9.1%	8.7%	8.2%	8.9%

Source - NHS Digital Vacancy Statistics

The International Workforce

5.26 Around 11% of non-medical staff have a non-UK nationality, with 4.9% from the EU27 up from 4.6% in 2016.

5.27 The table below shows the percentage of HCHS EEA and non-EEA workers for each staff group. For the total non-medical workforce as at June 2019, 5% of workers are from the EEA and 6% are non-EEA.

Figure 5.10 - International Workforce by Nationality Group (June 2019)

Staff group	EEA	Non-EEA
Total non-medical HCHS workforce	5%	6%
Nurses and health visitors	6%	10%
Midwives	5%	2%
Ambulance staff	3%	4%
Scientific, therapeutic and technical staff	6%	4%
Support to clinical staff	4%	5%
Infrastructure support staff	4%	4%

Source - NHS Digital Workforce Statistics

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

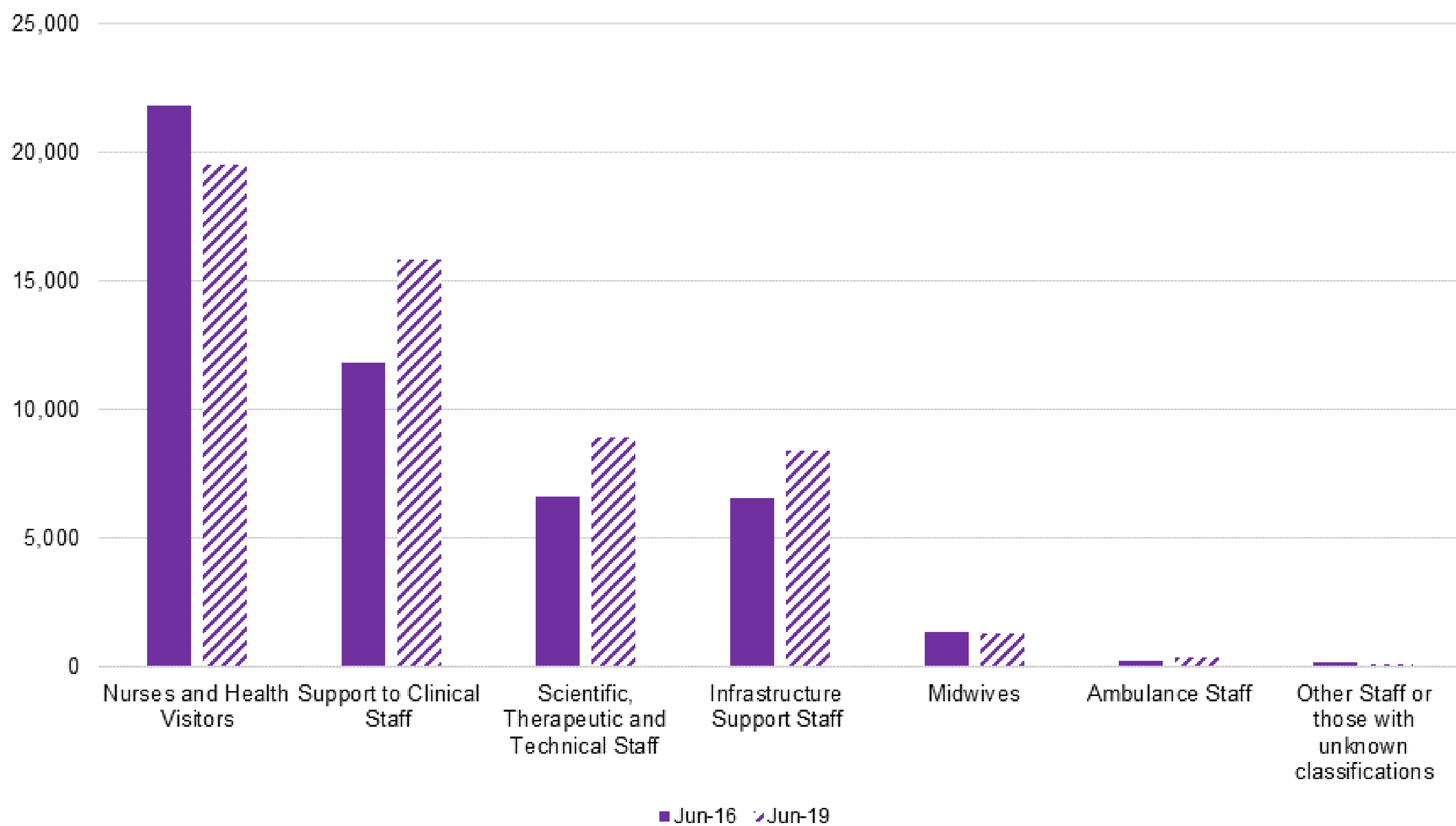
5.28 The number of EU27 non-medical staff have increased by over 5,900 between June 2016 and June 2019 and now forms 4.9% of all non-medical staff on a headcount basis.

Figure 5.11 - Number and percentage of non-medical staff from EU27

Staff Group	June 2016	June 2019	Change
All non-medical staff from EU27	48,592	54,505	5,913
As a percentage of all non-medical staff	4.6%	4.9%	0.3%

Source - NHS Digital Workforce Statistics

5.29 Despite this increase in overall EU27 non-medical staff, the graph below shows that between June 2016 and June 2019, the number of EU27 nurses, midwives and health visitors decreased by over 2,300. Departmental analysis suggests this is most likely a consequence of the Nursing and Midwifery Council (NMC) introducing more rigorous language testing for EEA applicants. Nurses and health visitors form the largest non-medical staff group for EU27 workers. As at June 2019 there are over 19,500 nurses and health visitors from the EU27.



Exiting the European Union

5.30 The Department of Health and Social Care is clear that our priority is to ensure that EU staff currently working in the NHS are not only able to stay but feel welcomed and encouraged to do so.

5.31 The Home Office has launched the EU Settlement Scheme – a simple registration process for EU nationals who arrive in the UK to live before the end of 2020 (or by Exit Day in the event of 'no deal') to remain living in the UK, with broadly the same rights as they currently enjoy.

5.32 There are over 6,600 more EU27 nationals since the referendum employed in NHS Trusts and CCGs. This includes over 5,900 more Non-Medical Staff including over 4,000 more support to clinical staff and over 2,200 more Scientific, Therapeutic and Technical Staff but over 2,300 fewer Nurses. Departmental analysis suggests the reduction in Nurses is most likely a consequence of the Nursing and Midwifery Council (NMC) introducing more rigorous language testing for EEA applicants, rather than the decision to leave the European Union.

5.33 The data so far provides little evidence of an adverse EU exit impact on the employment of EU27 nationals in the NHS, particularly given other factors such as the additional language controls.

5.34 It is clear there may be a reduction in the in-flow of staff from the EEA after EU Exit, due to new immigrations requirements and economic uncertainty. However, DHSC does not expect EU Exit to have a significant short-term impact on availability of staff in the NHS. The Department and delivery partners have taken a number of steps to help mitigate any supply impacts, including passing legislation to unilaterally recognise qualifications from the EEA after Exit Day, reduction of language test requirements by both the NMC and the Home Office, introduction of a streamlined international registration process by the NMC and development of system guidance on ‘passporting’ of staff between different providers.

5.35 We continue to monitor and analyse overall staffing levels across the NHS and adult social care, and we’re working across Government to ensure there will continue to be sufficient staff to deliver the high-quality services on which patients rely following the UK’s exit from the EU.

5.36 From January 2021 the UK will introduce a new immigration system to replace free movement from the EU. This system will be global, meaning overseas recruits will face the same immigration control whether they come from the EU or further afield.

5.37 The Prime Minister announced plans for a Points-Based Immigration System and the Home Secretary commissioned the Migration Advisory Committee to give advice on how this could work in the UK. The Migration Advisory Committee will publish it's report in January 2020. Following this, the Government will take policy decisions on the shape of the immigration system post-2020

Agency and Bank Staff

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

Agency reduction measures

5.39 NHS Trust spending on agency staff rose by 40% between 2013/14 and 2015/16 (£2.6bn to £3.7bn). However, following the subsequent introduction of agency

spend controls, expenditure on agency staffing has reduced to £2.4bn in 2018/2019. This £2.4bn is broken down by staff group in Table x

5.40 The 2015 controls included:

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

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

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

5.41 In 2019, NHS England and NHS Improvement updated the agency rules to include two new policy initiatives:

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

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

5.42 These changes came into effect on 16 September 2019. NHS E and I are working with providers to help implement these changes.

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

Figure 5.13 - Agency cost by staff group 2018/19

Staff Group	Annual Expenditure (£m)
Admin & Estates	£212.9
Healthcare Assistant & Other Support	£124.8
Healthcare Science	£35.7

Medical & Dental	£937.9
Nursing, Midwifery & Health Visiting	£843.2
Scientific, Therapeutic & Technical (AHPS)	£242.7
Other	£2.4
Grand Total	£2,399.6

Source - NHS England and NHS Improvement, Temporary Staffing Team

Figure 5.14 - Bank cost by staff group - 2018/19

Staff Group	Annual Expenditure
Admin & Estates	£354.4
Healthcare Assistant & Other Support	£989.3
Healthcare Science	£14.7
Medical & Dental	£828.7
Nursing, Midwifery & Health Visiting	£1,127.7
Scientific, Therapeutic & Technical (AHPS)	£118.9
Other	£11.4
Grand Total	£3,445.2

Source - Source: NHS England and NHS Improvement, Temporary Staffing Team

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

5.45 Since April 2017, agency costs have consistently been below 5% of overall pay costs and have now fallen to 4.4%. The continued reduction in the proportion of agency staff costs to total pay bill is a significant achievement in view of the record levels of demand and the extreme pressure on the acute sector.

5.46 Essentially, the sector has spent the same on agency staff in 2018/19 as in 2017/18 but procured 5.3% more shifts and managed the cost pressures associated with the first year of the Agenda for Change agreement, which were higher than trusts originally anticipated.

5.47 In 2018, the NHS Staff Council (partnership of NHS Employers and NHS trades unions) agreed to explore what scope there is for a framework agreement on bank and agency working, including the opportunity to provide cost-effective incentives to encourage staff to offer their own time to internal staff banks to increase

capacity. This work is ongoing, the NHS Staff Council will separately provide joint evidence on progress so far.

Banks

5.48 Introducing measures to reduce agency spend can only have maximum impact where trusts have a viable alternative temporary, or flexible, staffing solution. Staff banks ensure better quality and continuity of care, while allowing the reduction of unnecessary agency spending.

5.49 The Department and NHS England and NHS Improvement have encouraged trusts to develop in house staff banks as an alternative source of flexible staffing that, when properly deployed, can avoid the cost of commission paid to agencies, and can provide flexible working opportunities for existing staff. At the end of 2018/19, £6 out of every £10 spent on temporary staffing was being spent through a staff bank.

5.50 An early focus of the Department's work included a pilot programme aimed at improving trusts' bank offers by providing bank staff with the ability to self-book shifts; allowing them to see those shifts alongside their normal rota using integrated technology such as e-rostering; and providing prompter payment and pension flexibility for those shifts. The evaluation for the pilot will be published in due course.

5.51 Following these pilots, and based on the learning of the evaluation, NHS England and NHS Improvement plan to launch a new suite of bank programmes, which will have central responsibility for guidance and national standards, and will oversee targeted improvement processes in those trusts with the least mature banks. The programme involves the establishment of an entirely new Bank Acceleration team, who will provide bespoke support to cohorts of trusts, and which is due to be operational from April 2020.

Development of Banks

5.52 NHS England and NHS Improvement have committed in the Interim People Plan to increase flexible working opportunities to make the NHS a better place to work. We see the development of better staff banks as a key element of improving flexible working in the NHS.

5.53 Trusts also recognise the importance of attracting staff to work on cost effective banks and have introduced many other initiatives including:

- being clear about the benefits of NHS employment (i.e. pension scheme, paid training, indemnity cover);

- making improvements to NHS staff banks including making it easier for substantive staff to choose and be paid promptly for additional shifts; and

- making substantive contracts more flexible (for example if a doctor can only work 2 days in a week the trust will give them a contract for 2 days per week).

5.54 The final People Plan will ensure that these bank developments, and the effective deployment of staff through collaborative banks are aligned with the overall recruitment strategy of the NHS. In particular, NHS England and NHS Improvement will expect all trusts to be a member of a collaborative bank, whereby multiple trusts pool their resources to facilitate the free movement of staff across an expanded footprint. While there is a general expectation that Integrated Care Systems (ICSs) will operate regional banks, there will be certain circumstances in which trusts who are not part of the same ICS will share a collaborative bank.

Diversity Analysis

5.55 The NHS Workforce is more ethnically diverse than the wider economy. Across the Non-Medical workforce about 79% of the workforce is White with a further 5.9% Black, 7.5% Asian or Asian British and 1.5% coming from a Mixed Background. There are currently just over 4% of the workforce with Unknown or Not Stated Ethnicity. BME representation in the workforce has been stable over the past 4 years.

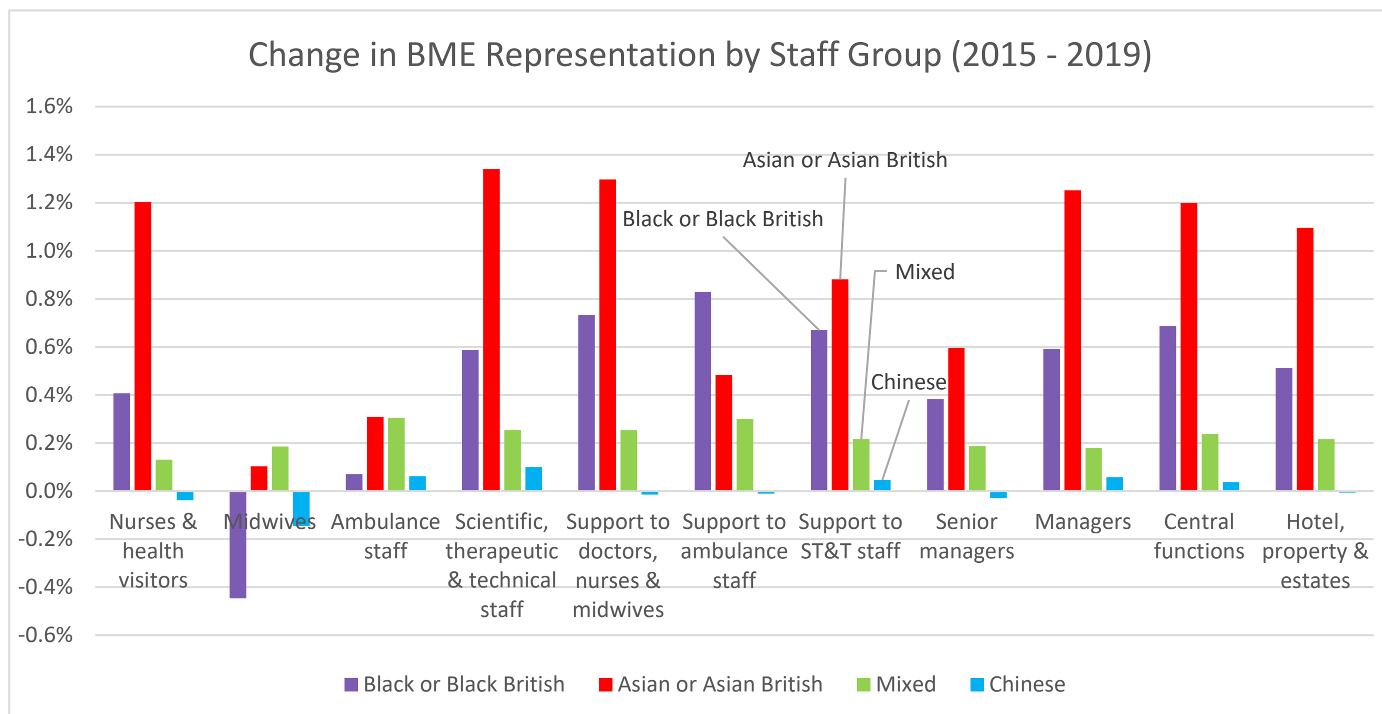
Figure 5.15 - Ethnicity makeup of NHS roles

September 2018 (Headcount)	White	Black or Black British	Asian or Asian British	Mixed	Chinese	Any Other Ethnic Group	Not Stated & Unknown
Nurses & health visitors	74.0%	7.8%	9.0%	1.3%	0.3%	3.4%	4.1%
Midwives	85.7%	6.8%	1.9%	1.4%	0.3%	0.6%	3.4%
Ambulance staff	93.4%	0.6%	1.1%	1.1%	0.1%	0.3%	3.4%
Scientific, therapeutic & technical staff	80.9%	3.5%	8.4%	1.6%	0.7%	1.2%	3.6%

Support to doctors, nurses & midwives	78.9%	6.6%	7.0%	1.6%	0.2%	1.8%	3.9%
Support to ambulance staff	88.2%	2.1%	2.7%	1.4%	0.1%	0.1%	5.4%
Support to ST&T staff	81.7%	4.4%	6.8%	1.6%	0.3%	1.2%	3.9%
Central functions	80.6%	4.9%	7.7%	1.6%	0.4%	0.7%	4.1%
Hotel, property & estates	77.1%	5.5%	6.9%	1.4%	0.2%	1.7%	7.3%
Senior managers	86.8%	2.0%	3.9%	1.0%	0.3%	0.3%	5.7%
Managers	84.0%	3.5%	5.9%	1.3%	0.3%	0.6%	4.4%
Other staff or those with unknown classification	75.2%	4.5%	10.7%	2.3%	0.3%	1.3%	5.7%
Grand Total	78.7%	5.9%	7.5%	1.5%	0.3%	1.9%	4.2%

5.56 While the overall BME representation in the workforce has been stable since 2015, there have been some changes within staff groups as shown in figure 5.16. In most staff groups there have been increases in the proportion of BME staff since 2015. This has generally been caused by either a reduction in the proportion of White staff or those where data on Ethnicity is not available.

Figure 5.16 - Change in BME Representation by Staff Group (2015 - 2019)



Source - NHS Digital Workforce Statistics

Gender Balance in The Non-Medical Workforce

5.57 Data from March 2019 shows that just over 80% of the Non-Medical workforce are female. The proportion of female staff varies by staff group with higher proportions of female staff in the Nursing (89%), Midwifery (99%) and Support to Doctors & Nurses (86%). Compared to the rest of the NHS workforce, Males have higher representation in Staff Groups including Ambulance Staff (60%), Support to Ambulance (48%) and Senior Managers (42%). The proportion of female staff is broadly unchanged over time.

Figure 5.17 - Female Representation by Staff Group (March 2019)

Staff group	Male	Female
Nurses & health visitors	11.3%	88.7%
Midwives	0.4%	99.6%
Ambulance staff	59.5%	40.5%
Scientific, therapeutic & technical staff	22.3%	77.7%
Support to doctors, nurses & midwives	14.2%	85.8%
Support to ambulance staff	48.0%	52.0%

Support to ST&T staff	20.1%	79.9%
Central functions	27.4%	72.6%
Hotel, property & estates	41.2%	58.8%
Senior managers	42.2%	57.8%
Managers	37.0%	63.0%
Other staff or those with unknown classification	28.5%	71.5%
Grand Total	19.7%	80.3%

Source - NHS Digital Workforce Statistics

The Gender and Ethnicity Pay Gap

5.58 The Gender, or Ethnicity Pay Gap is the difference in average Pay or Earnings between people with different demographic characteristics across either a staff group or the entire workforce. The existence of a Pay Gap is caused by having a difference in the average level of seniority within a Staff Group or having more well paid staff sharing a particular demographic group - it does not mean that there is unequal pay for the same work.

5.59 Data from NHS Digital shows that within Staff Groups there are small Gender and Ethnicity Pay Gaps in the Non-Medical workforce. For Gender Table 4.xx shows the average Basic Pay per FTE for Males and Females by staff group. Overall it shows that the average female in the Non-Medical workforce has Basic Pay around 6% lower than that of a Male. Within Staff Groups the gaps tend to be smaller - for example the difference in Basic Pay for Nurses and Health Visitors is only £30.

Figure 5.18 - Gender pay gap between different staff groups

Staff group	Female	Male	Pay Gap
Ambulance staff	£2,292	£2,415	-5%
Central functions	£2,228	£2,536	-12%
Hotel, property & estates	£1,528	£1,701	-10%
Managers	£4,161	£4,426	-6%
Midwives	£2,826	£2,936	-4%
Nurses & health visitors	£2,699	£2,730	-1%
Other staff or those with unknown classification	£1,653	£1,679	-2%

Scientific, therapeutic & technical staff	£2,986	£3,080	-3%
Senior managers	£6,485	£7,295	-11%
Support to ambulance staff	£1,706	£1,689	1%
Support to doctors, nurses & midwives	£1,647	£1,638	1%
Support to ST&T staff	£1,734	£1,747	-1%
Grand Total	£2,349	£2,507	-6%

Source - NHS Digital Earnings Statistics

5.60 Analysis on the Ethnicity Pay Gap should be conducted after controlling for the impact of Gender. Black staff were the only group to have lower average pay than White staff for both Male and Female employees.

Figure 5.19 - Ethnicity Pay Gap for Female Non-Medical Staff

Gender	Ethnic group	Total	Gap to White
Female	Asian/Asian British	£2,717	9%
Female	Black/African/Caribbean/Black British	£2,320	-7%
Female	Mixed/Multiple ethnic groups	£2,503	1%
Female	Other ethnic group	£2,687	8%
Female	Unknown	£2,588	4%
Female	White	£2,491	N/A

Source - NHS Digital Earnings Statistics

Figure 5.20 - Ethnicity Pay Gap for Male Non-Medical Staff

Gender	Ethnic group	Total	Gap to White
Male	Asian/Asian British	£3,864	23%
Male	Black/African/Caribbean/Black British	£2,646	-16%
Male	Mixed/Multiple ethnic groups	£3,245	3%
Male	Other ethnic group	£3,814	21%
Male	Unknown	£3,485	11%
Male	White	£3,145	N/A

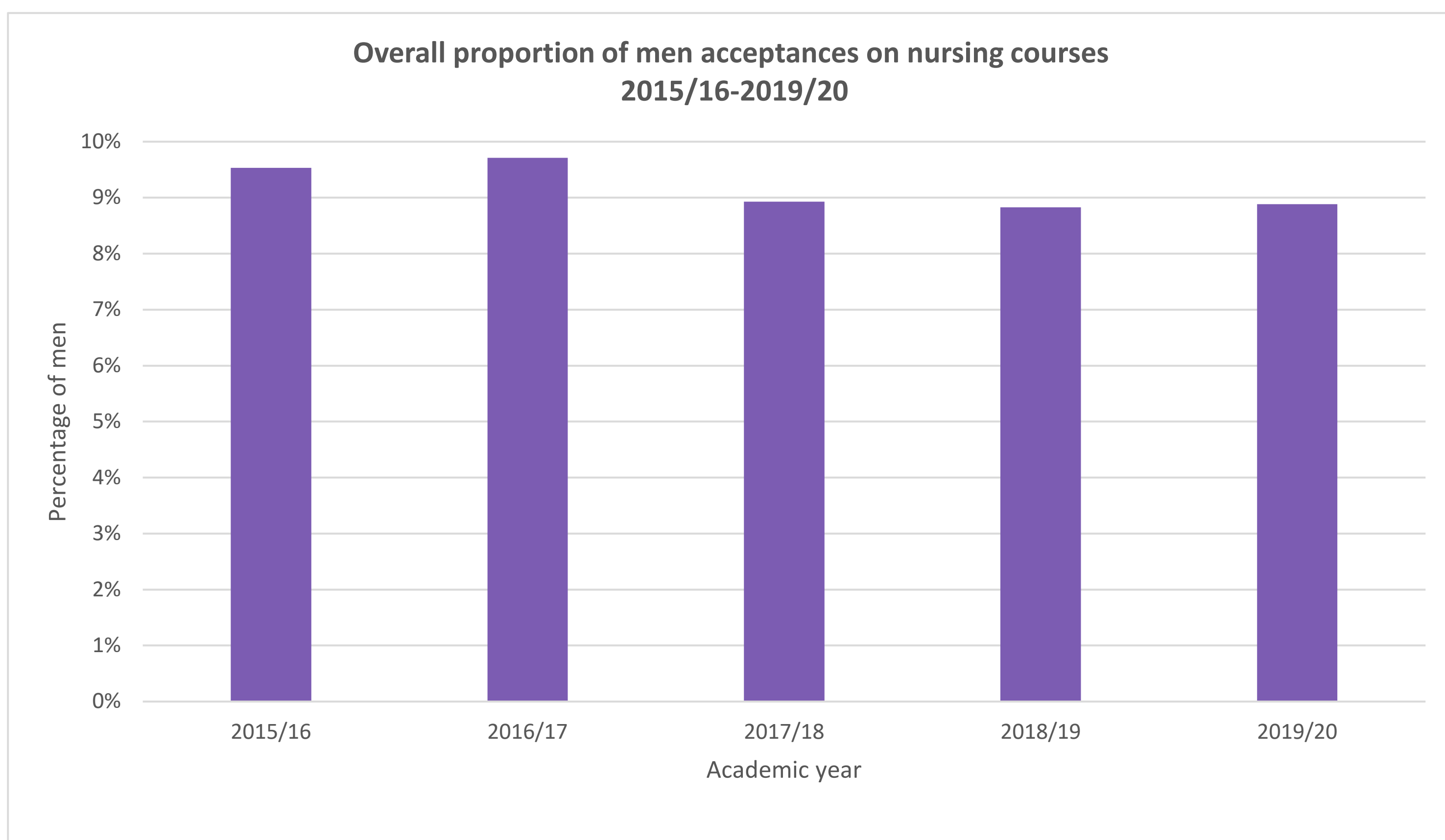
Source - NHS Digital Earnings Statistics

Gender Balance in Healthcare Education

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

5.62 UCAS data shows that men made up around 9% of overall entrants onto nursing courses in 2019. Over the period 2015-2019 academic years, this has remained broadly the same as shown in figure 5.21.

Figure 5.21 - Overall proportion of men acceptances on nursing courses 2015/16 - 2019/20



Source: End of cycle 2019 Universities and Colleges Admissions Service (UCAS) data

Note: The percentage figures relating to gender proportions are at the UK level, which holds for England as almost 80 percent of acceptances are at English providers.

Entrants to nursing, midwifery and Allied Health Professions by POLAR4 - a participation measure

5.63 Given the importance of appealing to the widest possible range of talent to work in the NHS at all levels, the Pay Review Body asked for information on socio-

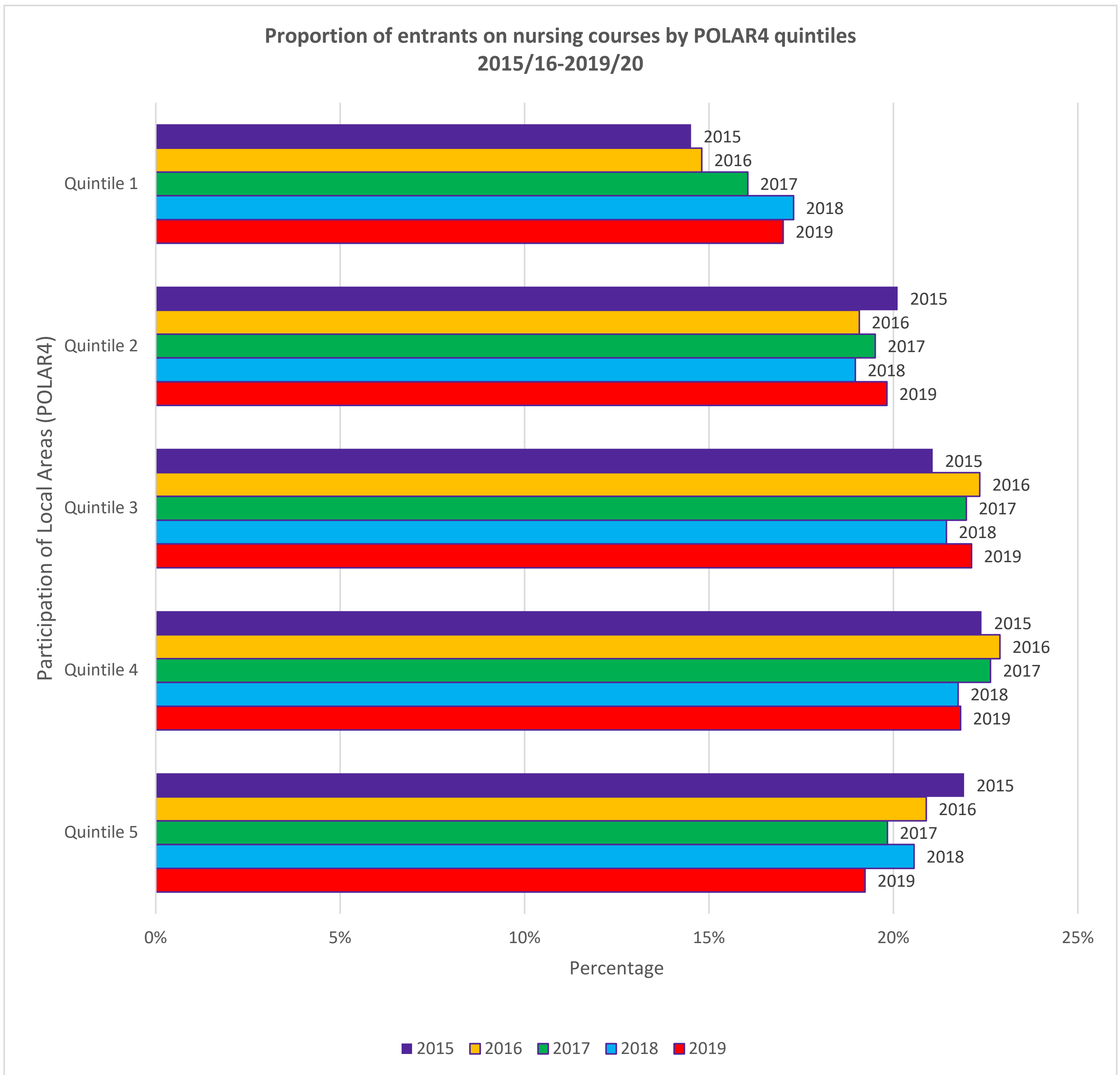
economic background and degree choices for entrants to nursing, midwifery and Allied Health Professions.

5.64 The Participation of Local Areas (POLAR) is a measure of the proportion of 18 and 19 years olds in a geographic area who enter higher education. It classifies local areas into five quintiles from low to high participation in higher education. Low polar quintiles are the areas with lowest participation, with quintile 1 representing the most disadvantaged fifth.

5.65 Data, in figure 5.22 shows that the proportion students entering nursing degree courses from POLAR4 quintile 1, the most disadvantaged fifth of backgrounds increased from 15% in 2015 to 17% in 2019.

5.66 The proportion of entrants to nursing from the least disadvantaged fifth of backgrounds decreased from 22% in 2015 to 19% in 2019.

Figure 5.22 - Proportion of entrants onto nursing courses by POLAR4 quintiles 2015/16 - 2019/20



Source: End of cycle 2019 Universities and Colleges Admissions Service (UCAS) data

Staff Engagement and Wellbeing

5.67 The NHS Staff Survey provides useful information about many aspects of staff experience at work. The sections below provide information and headlines on the survey results. Staff survey scores across the headline themes, such as engagement and health and wellbeing, have generally remained unchanged on previous years. Ambulance staff continue to score poorer on many measures, while staff who are not in direct care roles (managers) score slightly better.

5.68 Staff were more satisfied with the recognition and the value an organisation gives to their work compared to last year, alongside a continuing positive trend in quality of appraisals.

5.69 Staff were less satisfied with organisation action on health and wellbeing compared to last year, as well as more staff experiencing musculoskeletal problems.

5.70 Satisfaction with pay has increased over the last year, which is likely due to the implementation of the new Agenda for Change pay and contract reform deal.

Engagement

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

5.72 Staff engagement scores have remained generally consistent over the last five years, with a notable improvement in the ambulance staff score from 2014, who also score below average overall.

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

Figure 5.23 - Staff engagement score over the last five years by staff group

Staff group - staff engagement score	2014	2015	2016	2017	2018
Nurses & midwives	6.9	7.1	7.2	7.1	7.2
Nursing & Healthcare Assistants	6.8	7	7.1	7	7.1

Ambulance staff	5.2	5.7	5.9	5.9	6.1
AHPs, ST&T, healthcare scientists	6.8	7	7	7	7
Central functions	7	7.1	7.1	7.1	7.1
Managers	7.6	7.6	7.7	7.6	7.6

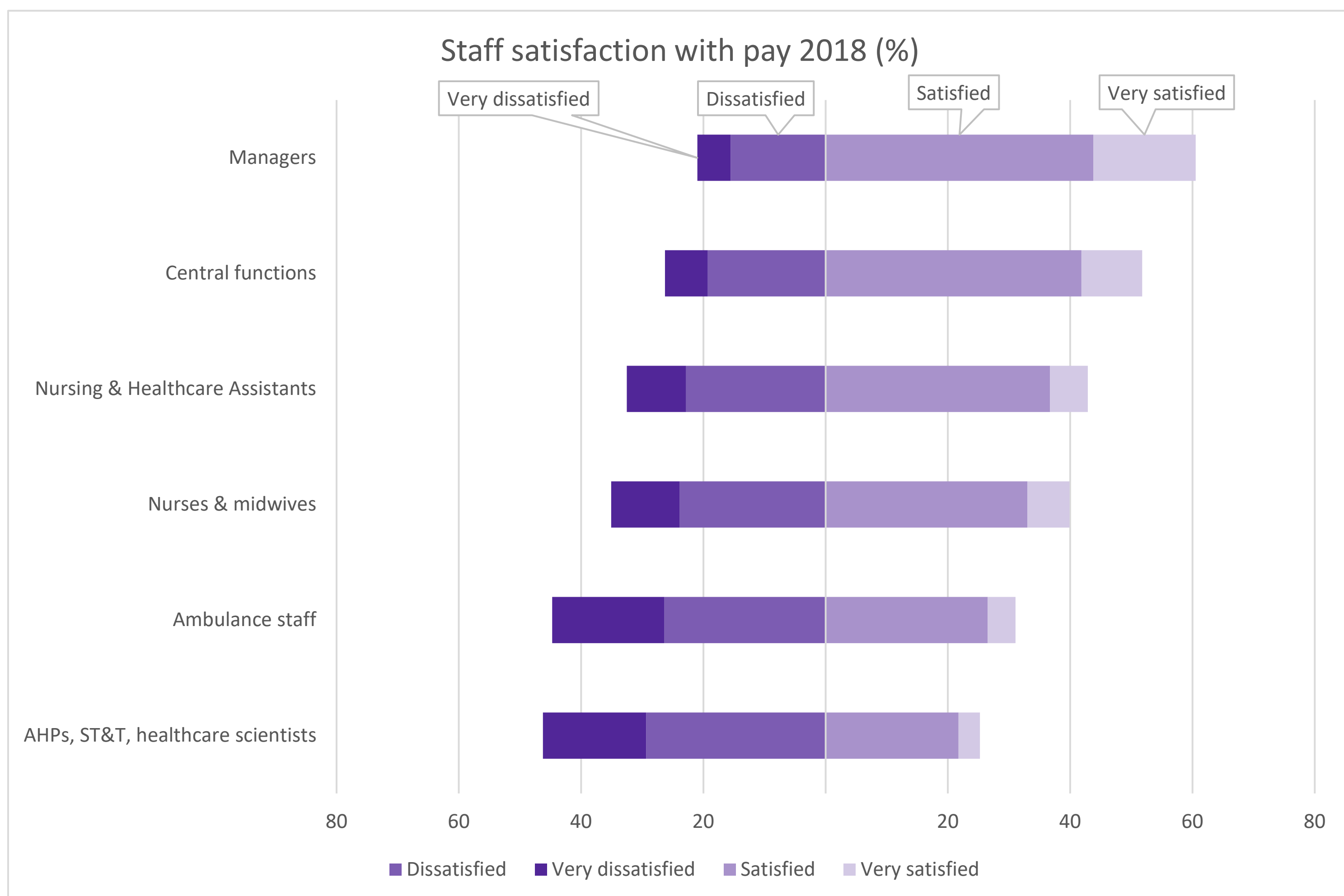
Source: NHS staff survey

Satisfaction with Pay

5.74 Staff satisfaction with pay shows variation across some of the key staff groups. Typically, staff in higher paying roles (managers for example) were more satisfied than those in lower paying roles. Satisfaction has varied over time, with an improvement seen in the last possibly due to the AfC multi-year pay and contract reform deal.

5.75 There is little variation across gender with satisfaction in pay. Male staff had larger proportions in the very satisfied/dissatisfied options. Satisfaction with pay increases the older an individual is, older staff are more likely to be in more senior, high paying roles.

Figure 5.24 - Staff satisfaction with pay in 2018 NHS staff survey by staff group



Source: NHS staff survey

Figure 5.25 - Staff satisfaction with level of pay over the last five years by staff group

Staff survey - satisfied or very satisfied with level of pay	2014	2015	2016	2017	2018
AHPs, ST&T, healthcare scientists	38.6%	42.7%	43.5%	37.3%	42.9%
Ambulance staff	28.9%	30.3%	35.2%	26.0%	31.1%
Nurses & midwives	35.4%	41.6%	42.1%	35.2%	39.9%
Nursing & Healthcare Assistants	21.9%	26.6%	25.1%	22.1%	25.2%
Central functions	46.7%	48.8%	48.5%	47.1%	51.8%
Managers	58.1%	59.7%	58.2%	57.2%	60.5%

Source: NHS staff survey

Flexible Working and Additional Hours

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

Figure 5.26 - Staff satisfaction with opportunities for flexible working over the last four years by staff group.

Staff survey - satisfaction with flexible working	2015	2016	2017	2018
AHPs, ST&T, healthcare scientists	55.2%	58.6%	58.0%	59.3%
Ambulance staff	44.6%	46.6%	44.7%	54.4%
Nurses & midwives	56.6%	58.0%	58.0%	59.8%
Nursing & Healthcare Assistants	50.2%	51.6%	52.2%	53.5%
Central functions	68.6%	68.9%	69.4%	71.5%
Managers	69.5%	70.5%	69.7%	71.8%

Source: NHS staff survey

5.77 The proportion of staff who work any additional paid hours has remained mostly consistent over the last four years. There is a significant amount of variability in this question based on the staff group. Those working in more direct care roles are more likely to work additional hours.

Figure 5.27 - Staff who worked any number of additional paid hours over the last five years, by staff group.

Staff survey - additional paid hours	2015	2016	2017	2018
AHPs, ST&T, healthcare scientists	25.9%	24.4%	24.3%	24.0%
Ambulance staff	57.1%	51.0%	54.3%	48.4%
Nurses & midwives	31.3%	30.7%	31.7%	32.0%
Nursing & Healthcare Assistants	41.9%	44.6%	43.8%	45.4%
Central functions	9.5%	9.3%	9.5%	9.5%
Managers	10.5%	11.4%	11.6%	11.2%

Source: NHS staff survey

Recommend as a place of work

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

i) would they recommend the care at the organisation to friends and family, and

ii) would they recommend the organisation to friends and family as a place to work.

5.79 Results are published monthly by NHS England.

5.80 Staff remain favourable about their organisation as a place of both work and care, as shown in figure 5.18

Figure 5.28 - Friends and Family Test results by Test Type

Staff friends and family test - Q1 18/19	% recommend	% would not recommend
Would Recommend as place to receive care	81%	6%
Would Recommend as place to Work	66%	16%

Source: NHS friends and family test

Staff Health and Wellbeing

5.81 Scores for health and wellbeing have been mostly unchanged over the last four years. Ambulance staff score lower than other groups.

Figure 5.29 - Health and wellbeing theme score over the last four years by staff group

Staff group - HWB theme score	2015	2016	2017	2018
Nurses & midwives	5.7	5.8	5.7	5.7
Nursing & Healthcare Assistants	5.9	5.9	5.8	5.7
Ambulance staff	4.4	4.5	4.6	4.6
AHPs, ST&T, healthcare scientists	6	6.1	6	5.9
Central functions	6.7	6.7	6.7	6.6
Managers	6.6	6.7	6.7	6.5

Source: NHS staff survey

5.82 Staff who recommend their organisation remains mostly consistent across a range of staff groups, with some small increases and decreases over the last five years.

Figure 5.30 - Staff who would recommend their organisation as a place to work, over the last five years by staff group.

Staff survey - recommend organisation for work	2014	2015	2016	2017	2018
AHPs, ST&T, healthcare scientists	58.5%	61.4%	62.2%	62.1%	64.5%
Ambulance staff	64.9%	62.2%	59.3%	63.2%	62.2%
Nurses & midwives	59.0%	62.0%	61.7%	61.6%	63.2%
Nursing & Healthcare Assistants	60.8%	64.2%	63.3%	63.6%	64.8%
Central functions	63.0%	62.8%	62.4%	62.3%	64.7%
Managers	69.0%	67.8%	66.2%	66.1%	66.5%

Source: NHS staff survey

Learning and Development

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

5.84 On the 5 November, NHS Trust Executives received letters confirming their Trust indicative funding allocations ranges.

Sickness Absence

5.85 Sickness absence rates have not changed materially in the period since 2010. figure 5.31 shows sickness absence rates for NHS Trusts and CCGs since 2009. It shows that there has been no major change over time with rates always between 4.1% and 4.4%.

Figure 5.31 Sickness Absence in NHS Trusts and CCGs between 2009-10 and 2018-19

Year	Sickness Absence Rate
2009-10	4.40%
2010-11	4.16%
2011-12	4.12%
2012-13	4.24%
2013-14	4.06%
2014-15	4.25%
2015-16	4.15%
2016-17	4.16%
2017-18	4.19%
2018-19	4.21%

Source - NHS Digital Sickness Absence Statistics

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

Figure 5.32 Sickness Absence by Health Education Region 2016-17 to 2018-19

Region	2016-17	2017-18	2018-19
England	4.16%	4.19%	4.21%
Health Education East Midlands	4.35%	4.48%	4.40%
Health Education East of England	4.08%	4.04%	4.11%
Health Education Yorkshire and the Humber	4.58%	4.54%	4.43%
Health Education Wessex	3.94%	3.94%	3.97%
Health Education Thames Valley	3.80%	3.86%	3.85%
Health Education North West London	3.25%	3.35%	3.42%
Health Education South London	3.55%	3.57%	3.63%
Health Education North Central and East London	3.34%	3.40%	3.53%
Health Education Kent, Surrey and Sussex	3.84%	3.92%	3.85%

Health Education North East	4.65%	4.61%	4.63%
Health Education North West	4.82%	4.82%	4.86%
Health Education West Midlands	4.32%	4.49%	4.62%
Health Education South West	4.23%	4.23%	4.22%
Special Health Authorities and other statutory bodies	3.11%	2.79%	2.77%

Source - NHS Digital Sickness Absence Statistics

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

Figure 5.33 - Sickness Absence Rates by Staff Group 2016-17 to 2018-19

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

Source - NHS Digital Sickness Absence Statistics

5.88 NHS Improvement committed to a target of reducing NHS staff sickness absence by 1% by 2020 and to the public services average by 2022 and a plan to reduce sickness absence formed part of the Agenda for Change contract reform. They are

working with 73 trusts as part of their health and wellbeing collaborative which, through identifying and spreading of good practice, is encouraging the NHS to use 10 evidence based high impact actions. These were developed as part of NHS England's NHS staff health and wellbeing framework (published in May 2018). Twelve of the trusts are also testing different models of fast access to accredited occupational health services. Participation in the collaborative is voluntary and no targets have been set for these trusts although NHS Improvement encourage them to assess what they think might be possible.

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

Workforce planning response

5.90 The evidence suggests that whilst the non-medical workforce growth remains strong overall, demand also continues to grow and there are still supply issues to address.

5.91 The Department continues to act to increase the supply of non-medical staff including increasing the nurse associate numbers and expanding the number of training places for nursing and midwifery. NHS England's NHS Long-Term Plan published on 7 January 2019 sets out a strategic framework to ensure that over the next ten years the NHS will have the staff it needs.

5.92 Getting the skills mix right is critical in addressing workload pressures and delivering appropriate patient care. As set out in the Long-Term Plan, there is a need to transform the way the entire NHS workforce work together.

Education and Training funding reforms

5.93 The funding arrangements from 2017 - 2019 saw a move away from the NHS Bursary to the standard student loans system. Under those arrangements healthcare students typically received an increase of up to 25% in the up-front financial resources available to them whilst they study, compared to previous arrangements. As part of the new Government's commitment to have 50,000 more nurses by 2025, nursing, midwifery and the majority of allied health students will receive additional non-repayable funding of between £5000 and £8000 per academic year, depending on their circumstances

5.94 Nursing students will remain on the student loans system, and currently the student loan re-payment threshold introduced by the Department for Education,

from April 2018 means a newly qualified nurse will not pay back their loan on earnings up to £25,000.

5.95 From April 2020 student loan repayments will fall after the earnings threshold at which graduates must pay off their debt is raised. From April 6th 2020 the repayment threshold for new graduates will become £26,575, up from the current £25,725. Graduates start repaying their student loan from the April after they finish university.

5.96 The latest Universities and Colleges Admissions Service (UCAS) data December 2019 in figure 5.34 shows that continuing demand for nursing courses has seen the number of acceptances increase in 2019 when compared to 2016 from 23,280 to 23,630 despite decreases in the earlier years following the reforms.

Figure 5.34 - Number of acceptances to undergraduate nursing courses at English providers

Entry year	2015	2016	2017	2018	2019	Change 2019 versus 2018	Change 2019 versus 2016
Acceptances at English providers	22,130	23,280	22,575	22,200	23,630	6.4%	1.5%

Source: End of cycle 2019 Universities and Colleges Admissions Service (UCAS) data

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

5.98 To support universities in expanding the number of nurse training places they can offer, the government has made available additional clinical placement funding to support an additional 5,000 nurse training places each year. In addition, 3,000 extra midwifery training places have been made available over a four-year period with 650 being available from September 2019 and 1,000 in subsequent years.

5.99 In acknowledgement of the unique position of nursing students undertaking clinical placements, both undergraduate and postgraduate nursing, midwifery and allied

health profession students can access additional financial support whilst undertaking the mandatory clinical placement aspects of their courses. The Department made provisions for these students to apply for financial support from the Learning Support Fund through the NHS Business Services Authority (NHSBSA). This currently offers specific and targeted support for students; £1,000 per student per year non-means tested child dependents allowance, travel and dual accommodation expenses for clinical placements, and students experiencing extreme financial hardship can also apply for additional support of up to £3,000 through the Exceptional Support Fund. However, the new funding available from 2020 will see increased funding available through the Learning Support Fund.

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

Attrition

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

5.102 Figure 5.35 shows continuation rates of full-time entrants to first degree level study at Health Education (HEE) providers between July 2016 and July 2017. Continuation rate is defined as the proportion of students that were continuing in HE study, not necessarily on the same course or at the same provider, or had qualified one year and 14 days after starting their course. As such wastage/attrition rate was 7 percent in nursing, 6 percent in midwifery, and 6 percent in allied health professions between July 2016 and July 2017.

Figure 5.35 - Continuation rates of full-time entrants to first degree level study at HEE providers, July 2016 - July 2017

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

Source: Office for Students' analysis of Higher Education Statistics Agency (HESA) data, July 2016 - July 2017

Apprenticeships

5.103 Apprenticeships play a key role in ensuring the NHS has a future workforce which is representative of the local population it serves. The NHS apprentice agenda is designed to support entry into careers in the NHS for people from all backgrounds. The apprentice agenda is at the heart of an aspiration to provide careers, not just jobs for people working in the NHS. There is a range of healthcare apprenticeships available in the NHS, including nurse degree apprenticeship, nursing associate, associate ambulance practitioner, podiatrist, healthcare assistant practitioner, healthcare support worker, healthcare science assistant and pharmacy services assistant. These pathways allow people to start at entry level apprenticeship roles and progress to becoming a registered healthcare professional.

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

5.105 For the first time 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. A new T Level qualification in Health is also in development and will be ready for delivery in 2021 offering an alternative route into health and care professions.

5.106 As at July 2019 there were 46 apprenticeship standards approved for delivery and 16 in development for use in the NHS. Recently approved apprentice standards include; Diagnostic Radiographer (at level 6), Arts Therapist (at level 7) and Oral Health Practitioner (at level 4).

5.107 The number of entrants through apprenticeships between April 2017 and March 2018 was 13,800 (source: Department for Education (DfE)

5.108 Using data published in a DfE report (source: DfE) the Department estimates the number of Nursing Associate apprenticeships starting between May 2017 to March 2018 was 500, and the number of apprenticeships through advanced roles between May 2017 and March 2018 was 5,060. Advanced apprenticeships are defined as level 3 apprenticeships.

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

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

5.111 NHS trade unions and NHS Employers, under the auspices of the NHS Staff Council will separately provide to the Review Body a detailed joint report about the work, completed in partnership.

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

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

5.114 There are now a range of degree level apprenticeship standards in development and delivery. Standards currently approved for delivery include; Nurse Degree Apprentice, Dietician, Diagnostic Radiographer, Paramedic, Podiatrist and Physiotherapist. There are also a number of post-graduate level apprenticeship standards available for use by the NHS including Advanced Clinical Practitioner, Senior Leader, and Arts Therapist.

Nursing Associates

5.115 Much of the focus of the NHS programme in 2019 continues to be the expansion of the Nursing Associate role through the apprentice route. HEE are leading the national expansion of the Nursing Associate role in 2019, which aims to recruit up to another 7,500 Nursing Associates onto training this year.

5.116 The Nursing Associate role is designed to provide the NHS with a new profession, allowing employers to make the most of current and emerging talent and help them to address some of their supply challenges. Following their training, Nursing Associates will undertake some of the duties that registered nurses currently

undertake, enabling registered nurses to spend more time on the assessment and care associated with both complex needs and advances in treatment.

5.117 DHSC continues to work closely with HEE, NMC, Health Careers, NHS England and Improvement, Care Quality Commission, and other key system stakeholders to ensure the safe and effective deployment of the Nursing Associate role within the NHS workforce. NHS Employers have published a variety of supportive materials for employers wishing to train or employ Nursing Associates, including an Employer Guide to Nursing Associates. This is complemented by resources published by the Nursing and Midwifery Council, NHS Improvement and the Care Quality Commission on Nursing Associates. NHS Improvement's Safe, sustainable and productive staffing improvement resource for the deployment of Nursing Associates in secondary care is designed to help providers of NHS-commissioned services, boards and executive directors to support their secondary care professionals to deploy Nursing Associates as part of their clinical teams

5.118 DHSC has also commissioned a robust programme of research over the next three years to evaluate the impact of the Nursing Associate role within the workforce.

Skill Mix

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

5.120 The NHS Long Term Plan identifies areas where earlier diagnosis, new and integrated models of care, and better use of technology offer the potential to significantly improve population health and patient care. Together, these provide a major opportunity for a multi-professional workforce to come together to deliver this 21st century care. To deliver this vision will require both continued growth in our workforce and its transformation to one that has a different skill mix.

5.121 The Long Term Plan also sets out the need to transform the way the entire NHS workforce, including doctors, nurses, allied health professionals (AHPs), pharmacists, healthcare scientists, dentists, non-clinical professions, social workers in the NHS, commissioners, non-executives and volunteers, work together. Work will be much more multidisciplinary. People will be able to have less linear careers, and technology will enable staff to work to their full potential. This multidisciplinary way of working will become the norm in all healthcare settings over the next five years. Work has begun to review current models of multidisciplinary working within and across primary and secondary care.

5.122 To accelerate this richer skill mix, multi-professional credentials will be developed to enable people to widen their knowledge and skills and develop their careers. The Apprenticeship Levy will be used more effectively to provide more routes into healthcare careers. The skill mix of our workforce will continue to be enhanced by scaling up the development and implementation of new roles and new models of advanced clinical practice and by providing clear career pathways that enable people to continue developing and achieve their maximum potential.

5.123 HEE is leading a national expansion programme to train up to a further 7,500 Nursing Associate apprentices in 2019 in addition to the thousands that entered training in 2018 and 2017. The first cohorts of Nursing Associates completed their training in December 2018 and began to enter the workforce from January 2019.

5.124 The Nursing Associate role is now an establishing NHS profession, contributing to patient care and forming a valuable part of a contemporary multidisciplinary workforce.

5.125 Employers are starting to realise the benefits of the new Nursing Associate role. The Nursing Associate builds capacity of the nursing workforce and supports nurses and the wider multidisciplinary team to focus on more complex clinical duties.

5.126 The NMC was confirmed as the professional regulator for Nursing Associates in July 2018.The first successful Nursing Associates from HEE's pilot began to join the NMC's register in January 2019. DHSC has commissioned a robust three-year programme of research to thoroughly evaluate the impact of Nursing Associates in the workforce, this research commenced in January 2019, an interim report will be available by early 2020 and final reporting will take place by early 2023.

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

5.128 In October 2018 the Secretary of State announced the Department of Health and Social Care's intention to introduce statutory regulation for Physician Associates and Anaesthesia Associates. On 29th July 2019 the General Medical Council confirmed that they were content to take on the regulation of these roles and work is currently underway to take this forward.

5.129 The further growth of the Physicians' Associate (PA) role is supported by HEE who have developed the role through a defined career framework, professional identity, and targeted investment in training. This is a key part of the Government's policy to develop a more effective, strong and expanding general practice to meet future need. Since 2014, the PA workforce has grown considerably and workforce demand is increasing rapidly. By 2020, HEE predict that the annual output of PA graduates is likely to reach at least 900 and cumulative numbers of PAs to reach 2,500-3,000. The Five Year Forward View (FYFV) set out a plan to strengthen general practice in the short term and support sustainable transformation of primary care for the future. HEE has committed to train 1000 Physician Associates (PA) and help secure increases in the number of PAs taking up new roles in primary care as part of the wider system commitment to make available 10,000 health care professionals in primary care within this timeframe.

5.130 HEE has also developed a national investment strategy to support and enable integration, recruitment and retention of PAs across healthcare systems, in particular in primary care, as well as a national marketing campaign and PA Ambassador programme.

5.131 HEE and NHS England and Improvement are also working to embed the national framework for training Advanced Clinical Practitioner (ACP) roles. In common with other new roles, ACPs can add valuable skills into wider skill mix and often complement work of doctors in Emergency and Cancer Care.

Recruitment and Retention Premia

Nursing Staff

5.132 The aim of recruitment and retention premia (RRPs) is to help address problems in attracting and keeping the staff they need through pay enhancement. The PRB has, in previous reports, expressed concern that trusts appear not to be using RRPs available to them. The evidence continues to suggest that the use of RRPs remains low across the NHS in England.

5.133 Of particular concern is the recruitment and retention of nurses. The government has made clear it's commitment to attract fifty thousand nurses by retaining nurses who might otherwise leave and through recruitment. For example, all nursing students on courses from September 2020 will receive a £5,000 a year grant, with additional payments of up to £3,000 available for students in regions or specialisms struggling to recruit or to help students cover childcare costs

5.134 These initiatives which will make a significant difference to those considering making nursing their career. In addition, trusts already have available to them additional pay flexibilities like RRPs which allows them to make additional payments to an individual post or specific group of posts where market pressures would otherwise prevent the employer from being able to recruit or retain staff in sufficient numbers to fulfil the roles the trust needs at the normal salary.

5.135 It is important to stress that RRPs cannot, independently, resolve the nurse supply challenges but all trusts have the freedom to use local RRPs to address any local supply issues and can make their premiums long or short-term depending on their assessment of the labour market conditions and how they will develop. Trusts are required to review their premiums regularly and should withdraw a premium if the market conditions change and the need for the premium, and therefore the need to objectively justify the RRP ceases to exist or diminishes.

5.136 NHS Employers, in their evidence will provide more information, informed by their survey of trusts which may shed some light on why trusts may be reluctant to pay RRPs.

5.137 For example, some trusts may be risk adverse i.e. that the need to justify the payment of RRPs and the consequences of failure to properly manage these payments which could create successful challenge under equal pay law; concerns that payment of RRPs by some trusts and not others could create unhelpful competition for skilled staff.

5.138 There is recognition that where some trusts in a particular area can afford to pay RRPs but some cannot, this could inadvertently make supply issues worse. This is why under AfC, trusts are encouraged to liaise with neighbouring trusts when they are considering using local RRPs. Collaboration between trusts is clearly in the best interest of trusts and most importantly patients.

5.139 Annex 5 of the NHS Terms and Conditions of Service Handbook:

" ……the employer should decide in partnership with local staff representatives whether the problem is likely to be resolved in the foreseeable future (in which case any premium should be short-term) or whether it is likely to continue indefinitely (in which case any premium should be long-term (see Section 5). The employer should then consult with neighbouring employers, staff organisations and other stakeholders, before implementing any premium".

5.140 For new and existing nurses and the entire health care team, our shared ambition to make the NHS the best place to work. There is strong evidence that the relationship between trusts and their workforce is governed by what motivates staff to do their best and the satisfaction they derive from their activites. This suggests that local strategies need to strike the right balance between pay and non-pay benefits; pay alone may not be sufficient.

5.141 The government is committed to helping trusts secure the staff they need and want trusts to use all the tools at their disposal to attract and keep staff in an affordable way. Virtually all nurses are employed on the AfC contract which provides a platform for trusts to utilise the AfC contract, as part of the overall NHS employment offer, to showcase the benefits of NHS employment, for example, Learning and Development, excellent pension scheme providing personal and family benefits, a range of maternity, paternity and other local policies and benefits that go well beyond statutory requirements, enabling staff to work flexibly, participating in the workforce while accommodating their non-work commitments.

5.142 We welcome your observations on the financial and any other barriers that may be preventing trusts considering the payment of RRPs as part of their local recruitment and retention strategies. In particular, your observations on how local RRPs may be better used by trusts to address any local challenges recruiting and retaining nursing staff.

IT Staff

5.143 As part of the Review body's remit for 2019/2020, we asked for observations on any labour market issues, including any case for a national recruitment and retention premium for IT staff.

5.144 Your report confirmed that whilst the initial evidence provided an indication that there were some issues recruiting IT staff, the variations in employment type and geographical variations in recruitment and retention issues suggested that a "one-size fits all" pay response was not appropriate. Instead, it was noted that the existing mechanism of local Recruitment an d Retention Premia (RRPs) is available to tailor pay solutions to local needs.

5.145 We agree that the evidence base we were able to provide last year would not enable the Review body to identify specific recruitment and retention issues nor the case for a national RRP. Given we cannot improve the evidence base and neither NHS trades unions nor NHS trusts see the recruitment and retention of IT staff as the most pressing concern, for this pay round we asked that the PRB make observations on how trusts might make better use of local RRPs which

might help those organisations that may be experiencing particular problems in this area.

5.146 The evidence that the Department provided last year on the recruitment and retention of IT staff suggested that the geographical location of trusts can be a barrier, for instance, trusts located in rural regions or where there is an absence of universities can make it harder to attract talent. The pull of better paid private sector work can also prove challenging for trusts located within major urban conurbations. The evidence provided last year was also not conclusive on the grade and type of IT roles trusts were struggling to fill and there was little correlation to show exactly which types of IT roles are most in demand.

5.147 The evidence needed to progress this work has been particularly challenging for multiple reasons:

- IT staff working in the NHS can be difficult to identify with precision. IT staff do not have a unique NHS Occupation code and are classified alongside other administrative and clerical staff. While there is an "Area of Work" of Information and Communication Technology, this is clearly a broad area and does not allow a more detailed examination of the workforce. Previously, we have separated the IT workforce by searching for associated terms within the "Job Title" field but as this is a free-text field within the ESR system there is not consistency between trusts and different organisations may, legitimately, describe these staff in different ways leading to some staff being omitted.

- IT staff are not identified in NHS England and Improvement vacancy numbers and is much too granular for NHS jobs. Data on NHS Jobs would only be available for the Area of Work of ICT which does not provide the level of detail on the nature of the role or the level of skills and expertise required.

5.148 Given the difficulties in collecting this information to form a comprehensive national picture and the observations made by the Review body last year, particularly that a ‘one size fits all’ approach may not achieve its aims, we would welcome your observations on how local RRPs may be better used by trusts to address any local challenges recruiting and retaining IT staff.

6. Agenda for Change Multi-Year Pay and Contract Reform Deal

6.1 The NHS Staff Council (partnership of NHS trade unions and NHS Employers) reached agreement on the AfC deal in June 2018. The partners have made good progress and continue to discuss commitments to help improve and incentivise Bank working so staff choose trust Banks over expensive Agencies, supporting staff maintain their health and wellbeing and helping to increase capacity for patient care. The partners were not able to reach agreement on commitments for:

- a new Apprentice Pay Framework - the partners remain committed to encouraging trusts to widen participation and help grow the domestic workforce but could not agree on the minimum pay rate.

- ii Buying and Selling Annual Leave - the partners agree that trusts should operate local policies for buying and selling annual leave to help support staff manage their work live balance. The partners could not agree on the pay rates that should apply where staff choose to sell annual leave, but agree that all trusts should operate local policies.

6.2 The NHS Staff Council will separately submit a detailed joint progress report.

Benefits Realisation

6.3 NHS England and Improvement is leading work to develop a benefits realisation plan to underpin implementation of the AfC deal and help ensure the AfC deal delivers the outcomes the partners expect. They are working with NHS Employers, the NHS Staff Council and the Department of Health and Social Care to agree the most appropriate and measurable key performance indicators. We will continue to work in partnership to ensure there is a shared understanding of the data that is needed and a clear line of sight between the AfC pay and contract reform deal and the expected outcomes.

7. Pensions and Total Reward

Introduction

7.1 The NHS Pension Scheme ('the Scheme') remains a valuable part of the total reward package available to the NHS workforce. Employers now contribute more towards the cost of the Scheme than members, currently contributing 20.6% with an additional administration charge of 0.08%. Employee contributions are tiered according to income, with the rate paid by the lowest earners is 5% and the highest 14.5% (for those earning £111,377 or above).

7.2 Eligible members of the NHS workforce will now belong to one of the two existing Schemes. The final salary defined Scheme consisting of the 1995 and 2008 Sections is now closed to new membership, and new NHS staff will join the NHS Pension Scheme 2015. The 2015 Scheme is a career average revalued earnings (CARE) scheme which provides benefits based on average earnings over a member's career. The key differences between the two Schemes, other than the way benefits are calculated, are different normal pension ages (1995 Section – 60, 2008 Section 65, and 2015 Scheme – State Pension Age) and accrual rates (1995 Section – 1/80th, 2008 Section – 1/60th, 2015 Scheme – 1/54th). Under the new Care Scheme, most low and middle earners working a full career will continue to receive pension benefits that are at least as good, if not better than those under the former final salary schemes.

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

7.4 The new NHS Pension Scheme 2015 continues to provide a generous pension for NHS staff and remains one of the best schemes available. The Government Actuary's Department (GAD) calculates that Scheme members can generally expect to receive around £3 to £6 in pension benefits for every £1 contributed. The Scheme is backed by the Exchequer and is revalued in line with price inflation; providing a guaranteed retirement income. A band 5 or 6 nurse (retiring at 68, with

service wholly in the 2015 Scheme), with 35 years' service, can expect a pension of around £19,000 a year.

NHS Pension Scheme Membership

7.5 The Department has continued to monitor scheme participation rates using data from the Electronic Staff Register (ESR). Annex 3 provides membership rates by AfC band at July 2019 and shows the percentage point change from April 2019, the previous 12 months and from October 2011.

7.6 Scheme membership remains high across all staff groups and AfC bands, with typically 9 in 10 participating. Between October 2011 and July 2019, the proportion of NHS staff who were members of the Scheme increased by 5.5%. Membership rates increased by 0.7% in the 12 months to July 2019 and by 0.6% between April and July 2019.

7.7 Participation increased for all bands of AfC up to but not including band 7, where it remained the same. However, participation reduced by 1.2% for non-AfC staff.

7.8 Amongst the highest paid AfC bands, particularly management roles, the opt-out trends observed in previous years appears to have continued. We are reviewing recruitment and retention of high earners, of which pension tax changes will be a factor. We will explore what, if any, mitigation might be appropriate in the context of total reward.

NHS Pension Scheme Contributions

7.9 Contributions are tiered according to earnings, with higher earners contributing proportionately more, factoring the beneficial effect of higher tax relief.

Figure 7.1 - Employee contribution rates

Whole-time equivalent Pensionable Earnings/Pay	Contribution Rate (gross)
≤ £15,431	5.0%
£15,432 - £21,477	5.6%
£21,478 - £26,823	7.1%
£26,824 - £47,845	9.3%
£47,846 - £70,630	12.5%

£70,631 - £111,376	13.5%
≥ £111,377	14.5%

7.10 Member contribution rates and earnings tiers have been frozen since 1st April 2015, and will remain set until 31st March 2021. It is expected that around 12% of members will be in a higher contribution rate band (increases are between 0.6% and 3.2% of pensionable pay, depending where they are in the pay range) in 2021 compared to 2018. A proportion of members are expected to progress to higher contribution tiers year to year through pay progression.

7.11 The Review Body previously recommended that annual pay awards should not have the unintended consequence of reducing take-home pay where a pay award means members must pay higher pension contributions. The Department commissioned the NHS Pension Scheme's Scheme Advisory Board (SAB) to review the approach to member contributions. The review explored several design elements, including whether the rate payable should be determined using whole-time equivalent or actual earnings, the range and number of tiers, and whether tier boundaries should be revalorised to avoid pay awards placing individuals in higher contribution tiers.

7.12 The SAB their review and submitted their conclusions in July 2018, and reached full agreement that:

- The principles underpinning the current contribution structure should be retained; include protection for the low paid;
- The risk of opt-outs should be minimised;
- Work should be done to ensure the Scheme remains a sustainable and valuable part of the NHS reward offer;
- 'cliff edges' in the contribution structure should be resolved.
- There is a pressing need to explore ways to minimise scheme opt-outs and mitigate other issues caused by the impact of pension taxation.
- A move to use actual pay, rather than whole-time equivalent pay, to determine contribution rates would be appropriate.

7.13 Cliff edges refer to areas of the current contribution structure where a pension scheme member receives a pay award which causes them to move to a higher contribution band. Although this increases the overall value of a member's total reward package, it has the potential to reduce their take-home pay.

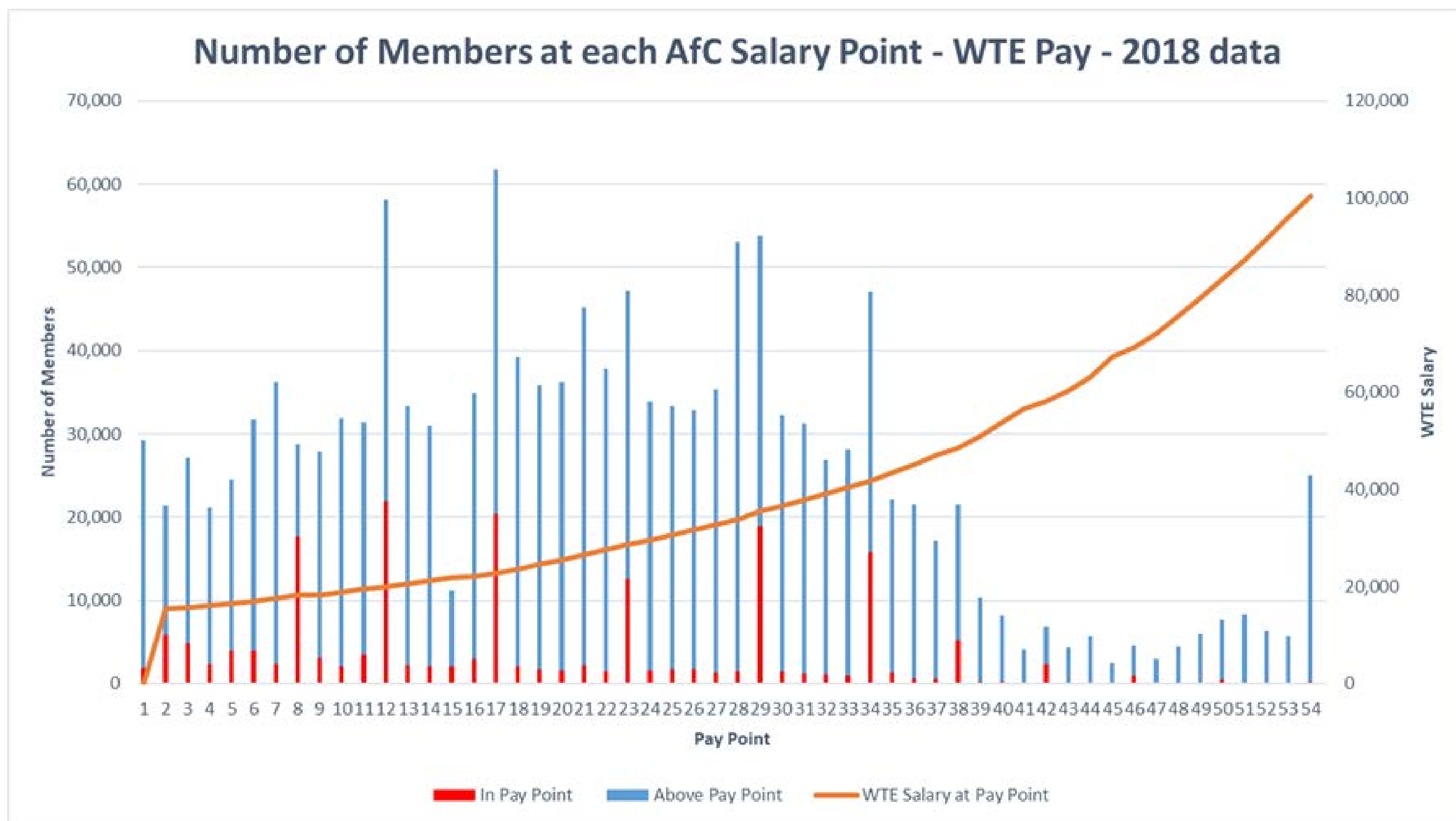
7.14 The SAB reached a majority recommendation that the existing contribution structure be retained for a further two years until 31st March 2021, this recommendation was accepted by the Department in February 2019.

7.15 There was a recognition that further discussion was need in several areas, including the approach to avoiding cliff edges. Most trade unions want to secure a formal mandate from their members before recommending any move to actual pay as the basis for determining contribution rates.

7.16 Further, the SAB expressed concern that if a part of the 2018 Agenda for Change (AfC) pay deal (which covers the majority of members) is seen to be offset by increases to contribution rates, member confidence in both the pay agreement and pension scheme would be undermined and the take-home benefit of the pay deal would be eroded.

7.17 The Department has accepted these recommendations and has commenced work on a contribution structure which avoids cliff edges. It is common for AfC staff to earn supplementary payments for on-call or out-of-hours work, which will increase pensionable pay. This means that only 13% of officer members of the NHS Pension Scheme have pensionable pay which match the AfC pay scales. It is therefore difficult to design a contribution structure which avoids cliff edges.

Figure 7.2 - Number of Members at each AfC Salary Point – WTE Pay – 2018 data



The above chart is based on the valuation data for officers as at 31st March 2019 (un-excluded data) and AfC 2017/18 Pay Scales.

Pension Flexibilities

7.18 To encourage individuals to plan for their retirement the Government provides tax incentives by allowing pension scheme contributions to be made tax-free. However, the cost of providing this tax incentive is very substantial and costs around £50billion a year. To ensure sustainability, since 2010 there have been progressive restrictions on the amount that individuals can save into their pension tax-free.

7.19 The Government applies two mechanisms;

- The Lifetime Allowance limits the total amount of tax-free pension savings that an individual can make over their career. A tax charge is applied to pension savings above the lifetime allowance. The charge is deducted from the value of the pension pot, and individuals do not pay a lifetime allowance tax charge in cash. The lifetime allowance is currently £1.055m.

- The Annual Allowance limits the amount by which an individual's pension savings can grown tax-free in the year. A tax charge is applied to pension savings above

the individual's annual allowance. Members can either pay the charge upfront in cash or use the Scheme Pays facility to have the charge deducted plus interest from their pension pot at retirement. The annual allowance is currently £40,000.

7.20 On September 11th 2019 the Department launched a consultation proposing new national flexibilities for senior clinicians which will be available from April 2020. The flexibilities will allow senior clinicians to control their pension growth so that it builds up to a level within their tax-free allowance. The Government is taking an evidence-based approach to this issue and is prepared to provide pension flexibility where there is evidence that pension tax is affecting delivery of public services.

7.21 Whilst the evidence of service impact is strongest for consultants and GPs, there is a less clear case that annual allowance tax charges are creating similar retention and productivity issues in the non-clinical NHS workforce. Whilst non-clinical staff may exceed their annual allowance, the Department has not yet seen evidence that it has the same impact on the capacity of NHS services and patient care.

7.22 The Department is open-minded on this issue and encouraged non-clinical groups to make representations and bring forward evidence demonstrating that pension tax is driving systematic retention and productivity issues for such roles, with corresponding impact on service delivery and patient care. The Department is currently reviewing consultation responses and will publish a response in due course.

7.23 For individuals with an annual allowance tax charge, HMRC offers an alternative payment facility. The 'Scheme Pays' facility allows the individual to elect for the pension scheme to pay the tax change on their behalf. The scheme then recoups the cost by reducing the value of the individual's pension by an amount equivalent to the tax charge plus interest. It means members can settle their tax charges without needing to pay up front.

7.24 In 2018, the Department closed a gap in the Scheme Pays coverage operated by the NHS Pension Scheme, which prevented those with charges arising from the tapered annual allowance or charges under £2,000 from utilising it. From tax year 2017-18 the scope of Scheme Pays was extended so it can be used to meet any pension tax charge of any amount.

Total Reward

7.25 Total reward is the tangible and intangible benefits that an employer offers an employee, and it remains central to recruiting and retaining staff in the NHS. There

is some evidence that more employers across the NHS are developing a strategic approach to reward which may be due to:

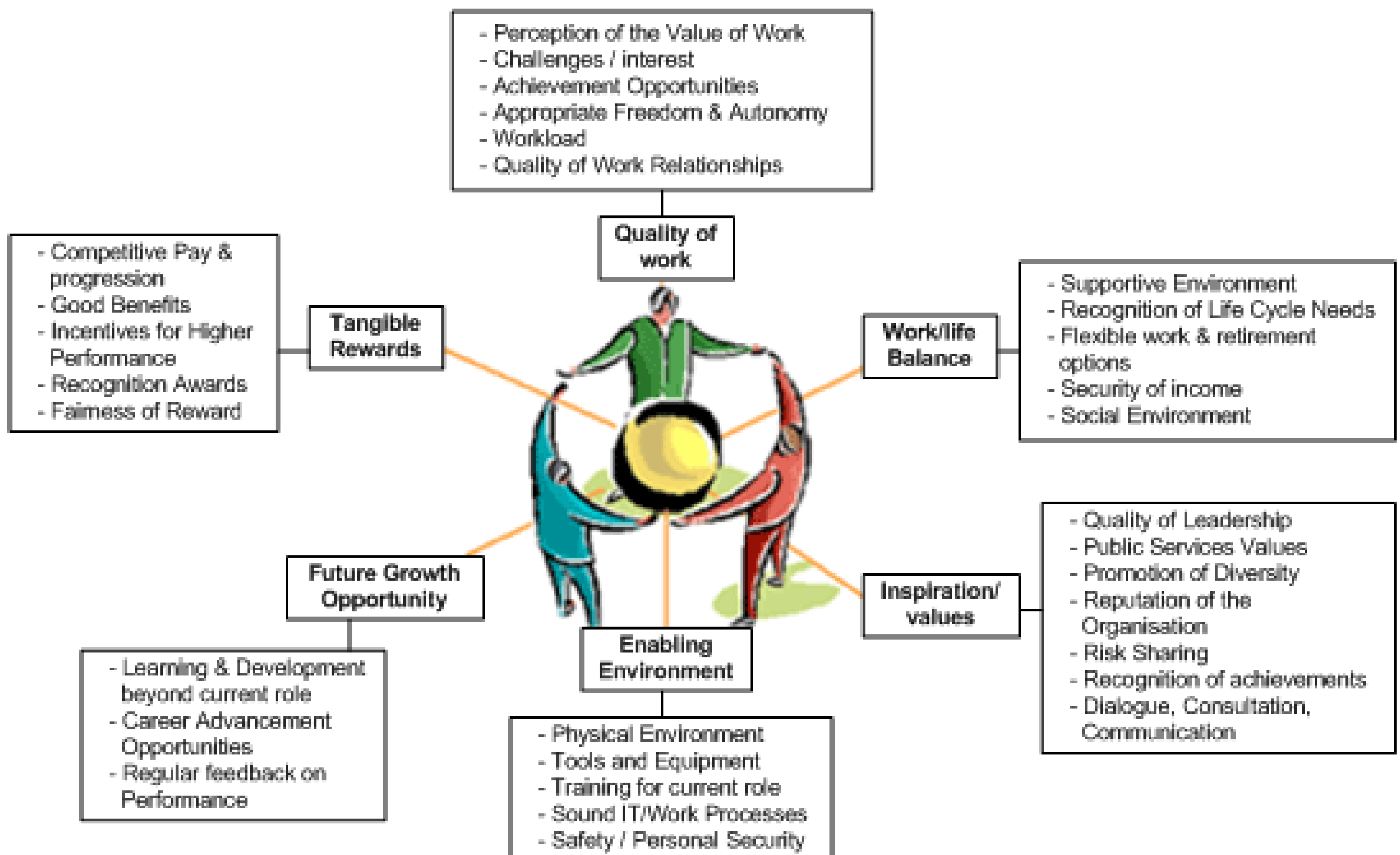
- Staff demand arising from total reward statements
- recognising that they need to do more to recruit and retain staff in an increasingly competitive employment market and
- offering the support that staff need for their physical, mental and financial wellbeing helping to reduce sickness and other absences

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

- Utilise the NHS employment package to recruit, retain and motivate the staff they need to deliver excellent services to patients;
- Develop and implement local reward strategies that meet organisational objectives and workforce needs;
- Improve staff understanding of their reward package and what options they have to change aspects of it;
- Improve staff experience of working for the NHS;
- Contribute to improvements in workforce productivity and efficiencies in use of the NHS workforce pay bill; and
- Continue to be at the leading edge of innovation in public sector reward to help improve NHS staff satisfaction with pay.

7.27 The Department commissions NHS Employers to provide advice, guidance and good practice to the NHS on developing a strategic approach to reward based on the Hay Model (below)

Figure 7.3 - Hay Model



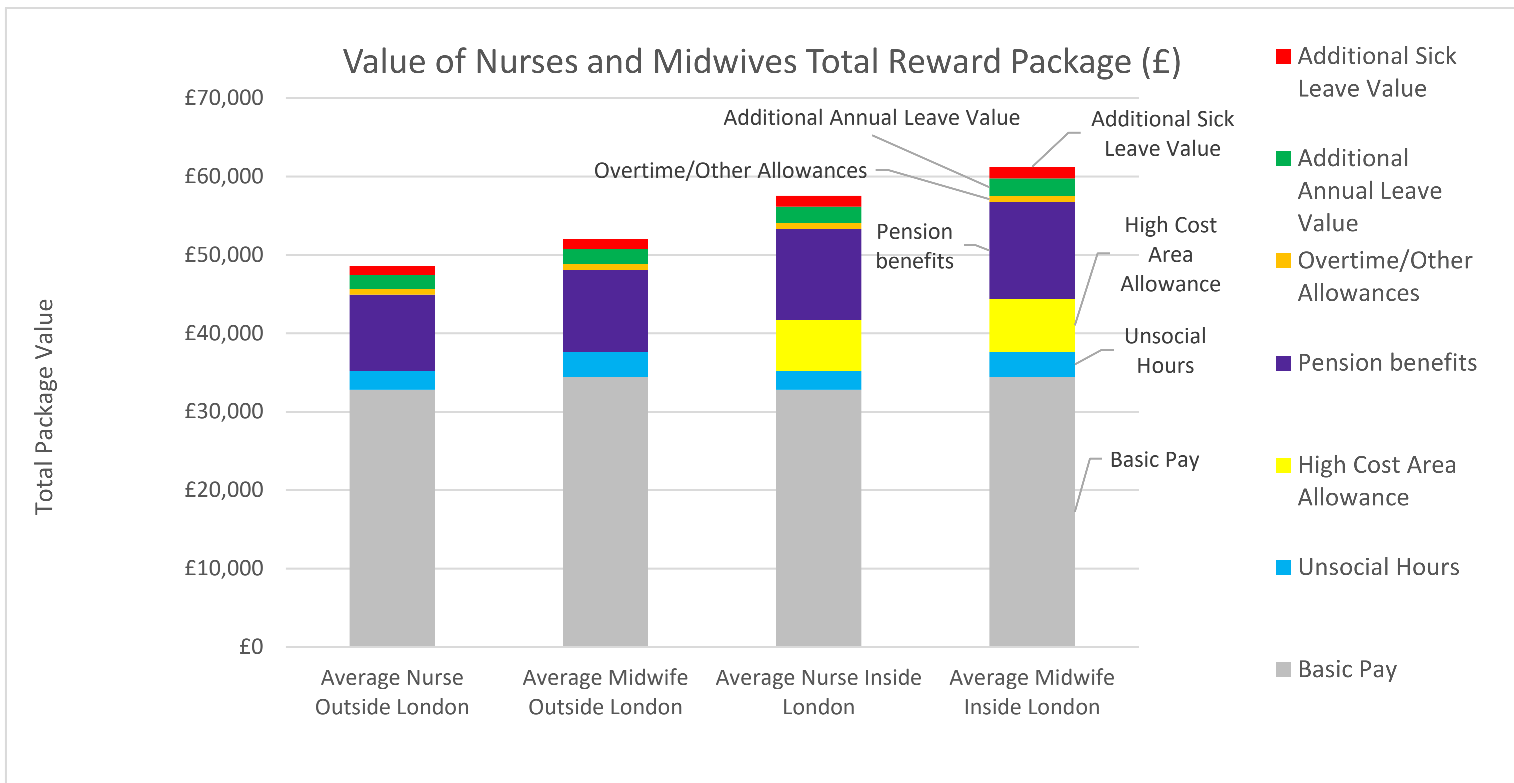
7.28 NHS Employers will separately provide evidence on progress in:

- Ensuring the strategic context for total reward in the NHS remains ‘fit for purpose’ and aligned with their other programmes;
- How their engagement with employers is improving NHS understanding of total reward and why they should be developing their own local reward strategies;
- Their promotion of existing and new tools to support trusts in using strategic reward to deliver local workforce priorities;
- Their approach to gaining and sharing intelligence about the evolution of total reward across the NHS; and
- Their promotion of better uptake and understanding of total reward statements.

7.29 The value of the pay package for this remit group, based on data from NHS Digital NHS Staff Earnings Estimates to June 2019 is shown in the graph below and

includes: basic pay, employer's pension contributions, other pay such as unsocial hours, overtime, other allowances, high cost area supplements (for staff working in and around London), difference between NHS sick pay and statutory sick pay, difference between NHS paid holiday and statutory paid holiday, difference between NHS maternity leave and statutory maternity leave, difference between NHS redundancy pay and statutory redundancy pay.

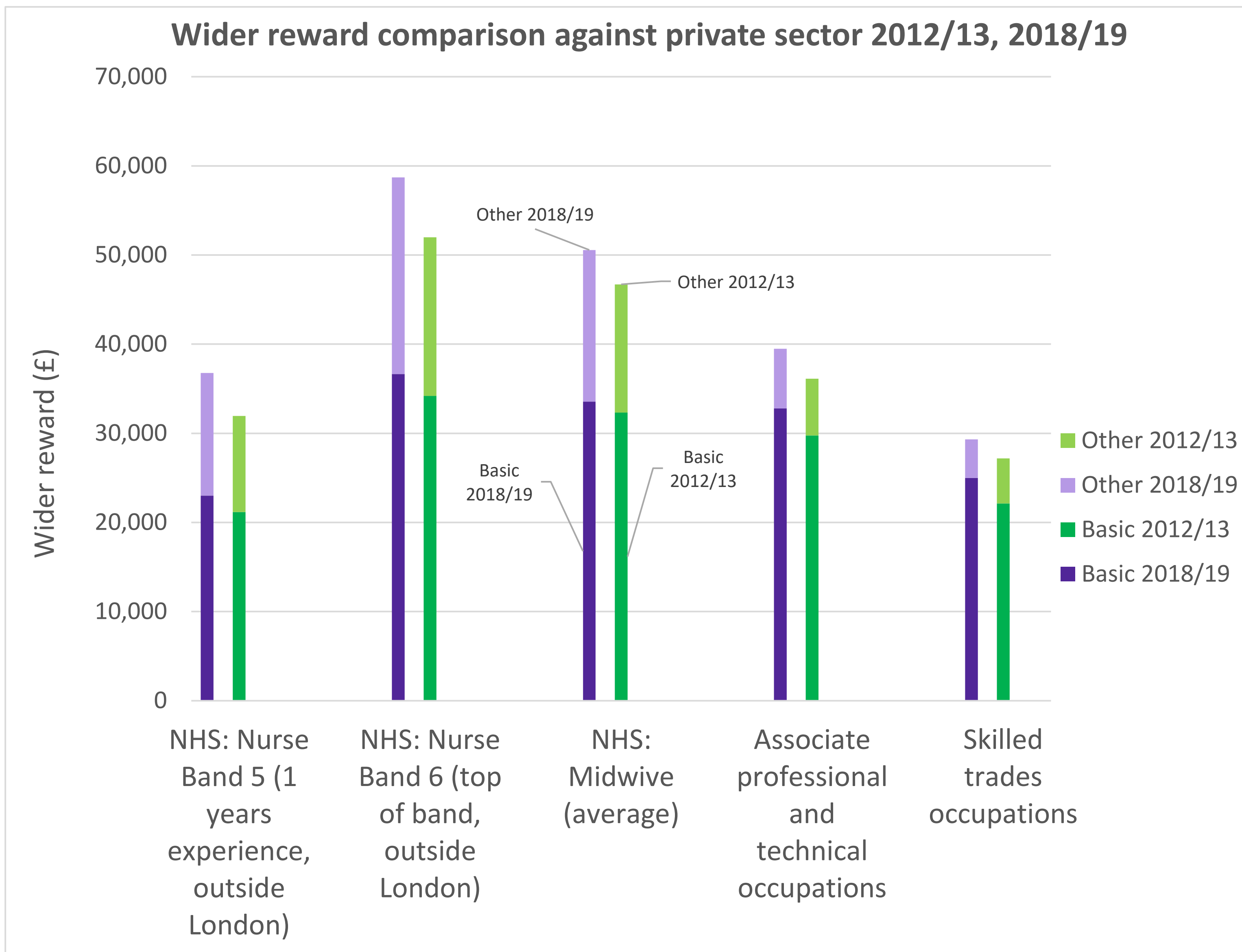
Figure 7.4 - Value of Nurses and Midwives total reward package



Source: NHS Digital NHS Staff Earnings Estimates to June 2019

7.30 The Department commissioned the Government Actuary's Department (GAD) to analyse total reward across various private sector occupations, based on Office for National Statistics (ONS) data for salary and pension benefits, and compared them against pay rewards for various NHS staff based on previous GAD analysis for 2012 and 2018. This analysis is intended to give an approximate indication on how the NHS reward package for this remit group compares with other occupations and how it has changed over time, it is not intended to provide a direct comparison between NHS roles and other occupations.

Figure 7.5 - Comparison of total reward for private sector occupations vs NHS roles at 2012 and 2018



7.31 All roles considered as part of this analysis from the NHS and private sector occupations experienced an increase in total reward over the period 2012 and 2018. Out of the roles considered, the Band 5 nurse and Band 6 nurse saw a significant increase in total reward, at 15% and 13% respectively. This was largely driven by a significant increase in 'other' reward elements, including the value of pension benefits. The average midwife had a similar increase in 'other' benefits but had a relatively lower increase of 8% in total wider reward due to a lower increase in basic pay.

7.32 Non-basic pay makes up a larger proportion of NHS reward relative to private sector occupations, with 'other' pay for the average midwife, Band 5 nurse and Band 6 nurse making up around 35% of total wider reward. Across the private

sector occupations considered, non-basic pay makes up around 15% of total wider reward. One driver for this might be the value of public sector pension benefits available to NHS staff and additional pay elements and awards available, relative to the private sector.

7.33 Although they are not included in the graph above, the additional non-basic pay elements of the total reward package available to NHS staff should be considered as they usually exceed that available in other sectors. NHS staff are entitled to redundancy up to a maximum of £160,000 which would be reached for those made redundant after 24 years' service and earning £80k pa, whereas statutory redundancy has a maximum cap of £15,240. NHS staff receive one month's pay for every year of service up to a maximum of 24 months, whilst statutory redundancy provides 0.5 weeks per each year of service below age 22, 1 week for service for each year worked up to age 41 and 1.5 weeks for each year worked service beyond age 41.

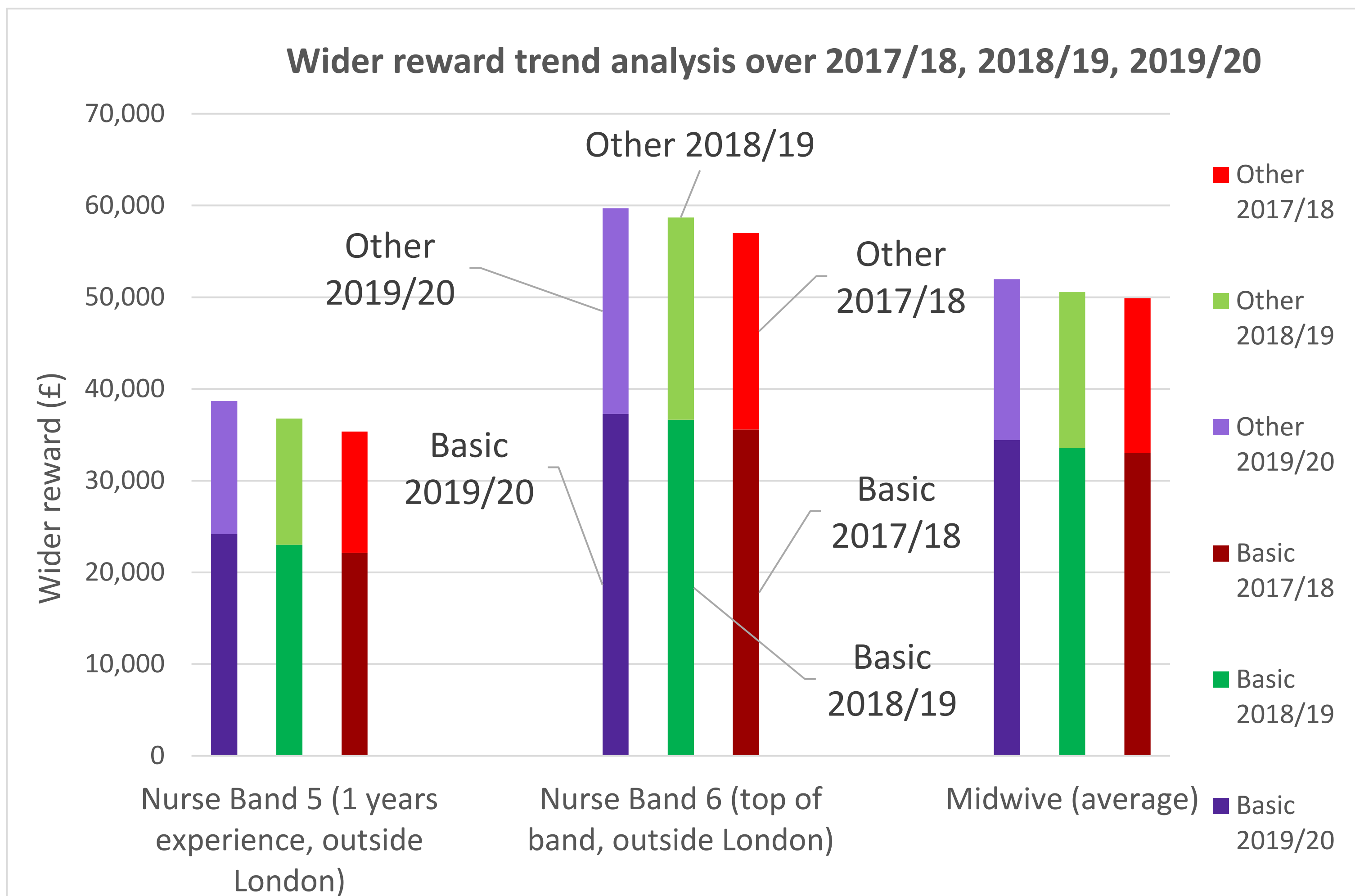
7.34 It is difficult to quantity the value of redundancy benefits given the sometimes-difficult circumstances when it would apply. The likelihood of redundancy in the NHS may be less in some NHS occupations than others and less than in some other sectors Eversheds Sutherland conducted a survey of employers in 2016, which found that one third of respondents offer statutory benefits only. Sixty percent of respondents consider enhanced redundancy to be discretionary, unlike the NHS, suggesting the redundancy offer made by those included in the survey is less generous than that offered by the NHS.

7.35 NHS staff are also entitled to generous sick pay benefits of up to six months full pay and six months half pay subject to length of service. By comparison statutory sick pay provides £92.05 per week for 28 weeks.

NHS Trend Analysis

7.36 GAD also carried out trend analysis for different NHS staff groups, based on the previous total reward analysis from 2017-18, 2018-19 and 2019-20.

Figure 7.6 - Total reward trend analysis



Source: NHS Digital NHS Staff Earnings Estimates at June 2019

7.37 The wider reward packages for all roles considered increased over the period 2017-18 and 2019-20. Band 5 Nurse experienced the highest increase in reward over this period at nine percent. This was largely driven by an increase in basic pay of over four percent in 2017-18 and 2018-19. Band 6 Nurse experienced an increase of almost five percent across the period 2017-18 and 2018-19. Similarly, the value of Midwives (average) reward packages increased by over four percent during the same period. All roles considered have over thirty percent of total reward made up of non-basic pay.

Total Reward Statements

7.38 Total reward statements (TRS) are provided to staff by their employer and give NHS staff a better understanding of the benefits they have or may have access to as an NHS employee. TRS provide personalised information about the value of staff employment packages, including remuneration details and benefits provided

locally by their employer. Local reward offers from NHS organisations might include:

- Recommend a friend scheme;
- Affordable accommodation
- Childcare and carer support;
- Counselling and support;
- Va rious salary sacrifice schemes;
- Retail Discounts;
- Education and learning support;
- Financial wellbeing;
- Physical and mental health and wellbeing;
- Signposting to pensions advice services;

7.39 Data on staff accessing TRS from August 2019 shows that 359,779 statements were accessed, compared to 366,527 at the same point in the previous year. There are 2,342,146 statements available for staff to access from August 2019.

7.40 TRS improvements include changes to the embedded links following the introduction of BSA's new website and an update to branding in line with the rest of the NHS.

Annual Benefit Statements

7.41 Members of the NHS Pension Scheme also receive an annual benefit statement (ABS), which shows the current value of their NHS Pension benefits. An ABS is included as part of a staff member's TRS if they are a member of the NHS Pension Scheme.

7.42 Since 2016, the NHS Business Services Authority (NHSBSA), which is responsible for issuing ABSs, hold stakeholder engagement events across the country for a range of different NHS organisations, including workshops on TRS, to help employers better understand their role in promoting TRS within their organisations. The workshops also explain the difference between a TRS and an ABS

Annex 1 - Joiner rates by region

Note: percentage point change figures have been calculated based on unrounded percentages

Joiner Rates by Region- Nurses and Health Visitors

Region	March 2014-15	March 2015-16	March 2016- 17	March 2017-18	March 2018-19	Percentage Point Change 2014-19
East Midlands	10%	9%	10%	9%	11%	1
East of England	12%	13%	11%	12%	12%	0
Kent, Surrey and Sussex	11%	11%	10%	11%	12%	1
North Central and East London	12%	12%	12%	13%	12%	0
North East	7%	7%	9%	10%	8%	1
North West	9%	9%	9%	10%	10%	1
North West London	12%	11%	10%	10%	13%	1
South London	13%	13%	12%	12%	13%	1
South West	11%	12%	14%	9%	12%	1
Thames Valley	12%	13%	10%	9%	11%	-1
Wessex	11%	12%	10%	12%	12%	0
West Midlands	9%	9%	10%	10%	10%	1
Yorkshire and the Humber	9%	9%	9%	10%	10%	1

Joiner Rates by Region- Midwives

Region	March 2014-15	March 2015- 16	March 2016- 17	March 2017-18	March 2018-19	Percentage Point Change 2014-19
East Midlands	10%	10%	10%	8%	11%	0
East of England	12%	12%	12%	13%	12%	0
Kent, Surrey and Sussex	10%	11%	11%	10%	13%	2
North Central and East London	9%	14%	14%	14%	12%	3
North East	8%	8%	10%	14%	9%	1
North West	9%	8%	9%	12%	10%	1
North West London	13%	13%	13%	10%	11%	-2
South London	14%	13%	14%	13%	12%	-2
South West	10%	11%	10%	10%	12%	2
Thames Valley	10%	12%	13%	8%	14%	4

Wessex	10%	9%	14%	13%	10%	0
West Midlands	9%	10%	10%	10%	9%	0
Yorkshire and the Humber	9%	10%	10%	13%	10%	0

Joiner Rates by Region - Ambulance staff

Region	March 2014-15	March 2015-16	March 2016- 17	March 2017-18	March 2018-19	Percentage Point Change 2014-19
East Midlands	6%	13%	12%	8%	14%	9
East of England	4%	4%	8%	8%	11%	7
Kent, Surrey and Sussex	9%	7%	10%	9%	7%	-2
North Central and East London	x	x	x	x	x	x
North East	3%	3%	6%	7%	7%	4
North West	5%	8%	8%	9%	9%	4
North West London	8%	18%	9%	8%	11%	2
South London	x	x	x	x	x	x
South West	6%	7%	6%	5%	8%	3
Thames Valley	7%	9%	7%	7%	7%	0
Wessex	4%	4%	6%	x	3%	-1
West Midlands	4%	4%	4%	5%	5%	1
Yorkshire and the Humber	4%	4%	6%	9%	6%	3

Figures for South London and North, Central and East London regions are not included as percentages are misleading compared to other regions due to low staff in post figures. A reliable 2017-18 figure for Wessex is not available.

Joiner Rates by Region- Scientific, Therapeutic and Technical staff

Region	March 2014-15	March 2015-16	March 2016- 17	March 2017-18	March 2018-19	Percentage Point Change 2014-19
East Midlands	10%	11%	11%	10%	12%	1
East of England	12%	14%	13%	14%	13%	1
Kent, Surrey and Sussex	12%	12%	12%	12%	14%	2
North Central and East London	12%	14%	14%	15%	14%	1
North East	9%	10%	11%	14%	9%	0
North West	10%	11%	11%	13%	12%	2

North West London	13%	14%	15%	11%	14%	2
South London	13%	13%	15%	15%	14%	1
South West	11%	11%	15%	19%	13%	2
Thames Valley	12%	13%	14%	10%	14%	2
Wessex	12%	12%	13%	13%	12%	0
West Midlands	10%	10%	11%	11%	11%	1
Yorkshire and the Humber	10%	11%	11%	13%	11%	1

Joiner Rates by Region- Support to Clinical staff

Region	March 2014-15	March 2015-16	March 2016- 17	March 2017-18	March 2018-19	Percentage Point Change 2014-19
East Midlands	14%	14%	15%	13%	15%	1
East of England	17%	18%	16%	17%	17%	1
Kent, Surrey and Sussex	17%	18%	17%	15%	18%	1
North Central and East London	17%	18%	18%	20%	17%	0
North East	10%	11%	11%	19%	10%	0
North West	12%	13%	14%	17%	14%	2
North West London	19%	20%	17%	13%	19%	0
South London	20%	18%	19%	18%	19%	-1
South West	16%	17%	18%	12%	16%	1
Thames Valley	20%	20%	21%	10%	20%	0
Wessex	16%	17%	17%	17%	17%	1
West Midlands	13%	14%	14%	13%	13%	0
Yorkshire and the Humber	12%	13%	14%	16%	13%	1

Joiner Rates by Region- Infrastructure Support Staff

Region	March 2014-15	March 2015-16	March 2016- 17	March 2017-18	March 2018-19	Percentage Point Change 2014-19
East Midlands	10%	12%	22%	13%	12%	2
East of England	14%	14%	15%	6%	14%	0
Kent, Surrey and Sussex	14%	18%	14%	5%	19%	5
North Central and East London	13%	14%	15%	5%	15%	2
North East	8%	10%	10%	6%	12%	5
North West	10%	12%	12%	6%	12%	2

North West London	17%	15%	14%	4%	14%	-3
South London	13%	15%	15%	6%	13%	0
South West	13%	13%	14%	7%	14%	1
Thames Valley	13%	13%	12%	4%	12%	0
Wessex	14%	11%	13%	4%	13%	-1
West Midlands	11%	12%	11%	7%	11%	0
Yorkshire and the Humber	12%	12%	12%	6%	13%	1

Annex 2 – Leaver rates by region

Note: percentage point change figures have been calculated based on percentages rounded to 1dp

Leaver rates by region - Nurses and Health Visitors

Region	14-15	15-16	16-17	17-18	18-19	Change Percentage points 2014-2019
East Midlands	9.5%	9.7%	10.3%	10.8%	9.5%	0.0
East of England	11.0%	11.1%	10.7%	11.1%	10.2%	-0.8
Yorkshire & Humber	9.2%	9.7%	10.4%	10.6%	9.4%	0.2
Wessex	10.5%	10.3%	10.9%	11.1%	11.6%	1.1
Thames Valley	12.4%	11.7%	12.4%	12.3%	11.9%	-0.5
North West London	11.6%	12.2%	12.1%	11.3%	11.3%	-0.3
South London	11.4%	11.8%	12.1%	11.3%	11.1%	-0.3
North, Central and East London	11.7%	11.8%	12.0%	11.5%	10.3%	-1.4
Kent, Surrey & Sussex	10.5%	10.7%	11.6%	11.4%	10.6%	0.1
North East	7.7%	8.4%	8.5%	9.7%	8.6%	0.9
North West	8.7%	9.1%	9.4%	9.7%	9.2%	0.5
West Midlands	9.3%	10.1%	10.3%	10.2%	9.8%	0.5
South West	11.7%	11.6%	12.3%	11.5%	12.2%	0.5
England	10.1%	10.4%	10.7%	10.7%	10.2%	0.1

Source: NHS Digital HCHS workforce publication

Leaver rates by region – Midwives

Region	14-15	15-16	16-17	17-18	18-19	Change Percentage points 2014-2019
East Midlands	9.1%	9.1%	8.7%	9.2%	11.3%	2.2
East of England	10.7%	10.7%	12.0%	10.8%	10.8%	0.1
Yorkshire & Humber	8.5%	8.8%	9.4%	10.0%	9.3%	0.8
Wessex	9.9%	10.3%	10.7%	9.3%	9.3%	-0.6
Thames Valley	12.5%	13.5%	12.7%	13.6%	12.0%	-0.5
North West London	13.4%	11.6%	11.8%	11.7%	11.8%	-1.6
South London	10.7%	13.4%	11.8%	12.5%	10.4%	-0.3
North, Central and East London	9.6%	11.2%	11.8%	12.2%	11.3%	1.7
Kent, Surrey & Sussex	10.8%	10.0%	12.3%	12.3%	11.2%	0.4
North East	7.5%	8.1%	8.2%	11.4%	10.0%	2.5
North West	7.5%	9.1%	9.6%	8.6%	9.5%	2.0
West Midlands	8.4%	8.6%	9.2%	9.5%	9.8%	1.4
South West	9.8%	9.8%	11.2%	10.9%	10.6%	0.8
England	9.5%	10.0%	10.6%	10.5%	10.4%	0.9

Source: NHS Digital HCHS workforce publication

Leaver rates by region - Ambulance Staff

Region	14-15	15-16	16-17	17-18	18-19	Change Percentage points 2014-2019
East Midlands	6.0%	7.9%	7.1%	7.9%	6.6%	0.6
East of England	8.5%	8.7%	6.7%	6.9%	9.4%	0.9
Yorkshire & Humber	6.6%	7.6%	6.6%	6.8%	5.1%	-1.5
Wessex	11.9%	11.9%	9.8%	6.3%	9.0%	-2.9
Thames Valley	8.9%	9.4%	8.1%	11.1%	9.1%	0.2
North West London	9.8%	7.9%	6.6%	8.3%	9.5%	-0.3
South London	x	x	x	x	x	x
North, Central and East London	x	x	x	x	x	x
Kent, Surrey & Sussex	8.5%	7.3%	11.1%	9.5%	9.7%	1.2
North East	7.7%	6.1%	4.8%	6.1%	5.8%	-1.9
North West	5.1%	6.2%	6.2%	7.8%	6.2%	1.1
West Midlands	5.7%	6.5%	6.6%	5.8%	5.3%	-0.4
South West	8.5%	8.8%	9.0%	10.1%	10.0%	1.5
England	7.4%	7.6%	7.3%	7.9%	7.6%	0.2

Source: NHS Digital HCHS workforce publication
Figures for South London and North, Central and East London regions are not included as percentages are misleading compared to other regions due to low staff in post figures.

Leaver rates by region - Scientific, Therapeutic & Technical staff

Region	14-15	15-16	16-17	17-18	18-19	Change Percentage points 2014-2019
East Midlands	9.5%	9.3%	9.9%	9.5%	9.5%	0.0
East of England	13.8%	11.6%	11.7%	11.2%	10.8%	-3.0
Yorkshire & Humber	9.7%	10.1%	9.2%	10.0%	8.9%	-0.8
Wessex	12.0%	11.6%	10.7%	10.4%	10.4%	-1.6
Thames Valley	12.7%	12.1%	12.0%	13.6%	12.4%	-0.3
North West London	12.9%	13.7%	13.9%	13.2%	12.9%	0.0
South London	16.1%	13.5%	14.3%	13.3%	12.7%	-3.4
North, Central and East London	12.6%	15.4%	13.4%	12.9%	12.2%	-0.4
Kent, Surrey & Sussex	11.3%	11.3%	11.5%	11.9%	11.0%	-0.3
North East	9.2%	9.4%	9.4%	10.1%	8.9%	-0.3
North West	9.4%	9.8%	9.5%	9.6%	9.2%	-0.2
West Midlands	9.2%	10.0%	10.2%	9.9%	9.8%	0.6
South West	11.2%	12.3%	12.0%	11.2%	12.0%	0.8
England	11.1%	11.2%	11.0%	10.9%	10.5%	-0.6

Source: NHS Digital HCHS workforce publication

Leaver rates by region - Support to Clinical Staff

Region	14-15	15-16	16-17	17-18	18-19	Change Percentage points 2014-2019
East Midlands	10.3%	10.6%	11.0%	10.5%	9.9%	-0.4
East of England	13.4%	12.9%	12.1%	12.8%	11.9%	-1.5
Yorkshire & Humber	9.1%	9.9%	10.3%	11.2%	9.2%	0.1
Wessex	14.1%	12.6%	16.4%	12.7%	11.9%	-2.2
Thames Valley	15.0%	14.3%	16.3%	15.0%	14.1%	-0.9
North West London	11.2%	12.6%	12.7%	12.5%	11.9%	0.7
South London	12.3%	12.4%	13.1%	13.5%	12.8%	0.5
North, Central and East London	12.1%	12.8%	11.9%	13.0%	12.4%	0.3
Kent, Surrey & Sussex	12.2%	11.9%	13.7%	13.3%	12.5%	0.3
North East	9.3%	8.3%	8.8%	11.0%	8.6%	-0.7
North West	9.3%	9.3%	10.2%	9.9%	9.4%	0.1
West Midlands	9.7%	10.4%	11.3%	10.8%	10.4%	0.7
South West	13.1%	13.2%	13.9%	13.1%	12.7%	-0.4
England	11.1%	11.2%	11.9%	11.7%	10.9%	-0.2

Source: NHS Digital HCHS workforce publication

Leaver rates by region - Infrastructure Support staff

Region	14-15	15-16	16-17	17-18	18-19	Change Percentage points 2014-2019
East Midlands	19.7%	10.6%	10.4%	9.3%	9.0%	-10.7
East of England	12.7%	13.9%	11.5%	12.2%	11.5%	-1.2
Yorkshire & Humber	9.0%	10.3%	9.6%	10.7%	8.9%	-0.1
Wessex	12.0%	13.5%	11.9%	11.0%	11.1%	-0.9
Thames Valley	13.3%	12.6%	12.0%	12.3%	10.2%	-3.1
North West London	11.6%	14.5%	12.5%	12.2%	12.9%	1.3
South London	11.3%	12.7%	12.9%	12.7%	11.9%	0.6
North, Central and East London	12.3%	12.7%	11.2%	12.0%	11.7%	-0.6
Kent, Surrey & Sussex	11.2%	11.9%	12.5%	12.6%	10.7%	-0.5
North East	8.7%	10.5%	14.6%	21.7%	8.9%	0.2
North West	8.5%	9.9%	9.6%	9.1%	8.3%	-0.2
West Midlands	10.0%	10.1%	11.5%	10.8%	9.3%	-0.7
South West	13.4%	11.8%	11.7%	12.5%	10.4%	-3.0
England	11.3%	11.4%	11.3%	11.5%	9.9%	-1.4

Source: NHS Digital HCHS workforce publication

Annex 3 - Pension Scheme Membership at July 2019

Staff Groups	FTE (Jun 2019)	% with pension contributions - Jul 2019	% Change Apr 2019 and Jul 2019	% Change Jul 2018 and Jul 2019	% Change Oct 2011 and Jul 2019
All	1,095,189	90%	0.6%	0.7%	5.5%
Doctor	111,860	89%	-0.4%	-1.5%	-2.2%
Qualified nursing, midwifery & health visiting staff	310,278	91%	0.7%	0.8%	3.5%
Qualified Scientific, therapeutic and technical staff	133,701	93%	0.5%	0.3%	2.2%
Qualified Ambulance Staff	15,763	94%	1.4%	-0.2%	-1.7%
Support to Clinical Staff	336,504	90%	0.7%	1.5%	10.5%
Central Functions & Hotel, Property & Estates	142,154	87%	0.5%	1.3%	9.4%
Managers	31,773	90%	0.3%	-0.5%	-3.1%
All Non-Medical	983,329	90%	0.7%	1.0%	6.3%
AfC Band 1	24,439	81%	1.0%	0.5%	18.1%
AfC Band 2	151,875	89%	0.7%	1.7%	13.1%
AfC Band 3	125,342	90%	0.6%	1.4%	9.4%
AfC Band 4	84,175	90%	0.8%	1.1%	6.3%
AfC Band 5	197,367	89%	0.6%	1.0%	3.8%
AfC Band 6	180,409	92%	0.8%	0.3%	2.2%
AfC Band 7	102,500	93%	0.4%	0.0%	0.1%
AfC Band 8a	35,751	93%	0.3%	-0.2%	-1.3%
AfC Band 8b	14,342	93%	0.3%	-0.3%	-2.1%
AfC Band 8c	7,527	93%	0.2%	-0.1%	-1.9%
AfC Band 8d	3,703	92%	0.4%	-0.2%	-4.1%
AfC Band 9	1,419	92%	0.0%	-0.8%	-4.2%
Non AfC	166,339	88%	-0.2%	-1.2%	0.6%