

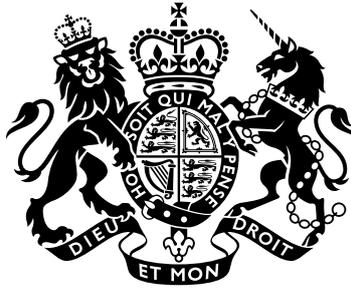


NHS Pay Review Body

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Thirty-Second Report 2019

Chair: Philippa Hird



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**Presented to Parliament by
the Prime Minister and Secretary of State for Health and Social Care
by Command of Her Majesty**

**Presented to the National Assembly for Wales by
the First Minister and the Minister for Health and Social Services**

**Presented to the Permanent Secretary
of the Department of Health, Northern Ireland**

July 2019



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NHS Pay Review Body

The NHS Pay Review Body (NHSPRB) is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for Health and Sport in Scotland, the First Minister and the Minister for Health and Social Services in Wales, and the First Minister, Deputy First Minister and Minister for Health in Northern Ireland, on the remuneration of all staff paid under Agenda for Change and employed in the National Health Service (NHS)¹.

In reaching its recommendations, the Review Body is to have regard to the following considerations:

- the need to recruit, retain and motivate suitably able and qualified staff;
- regional/local variations in labour markets and their effects on the recruitment and retention of staff;
- the funds available to the Health Departments, as set out in the Government's Departmental Expenditure Limits;
- the Government's inflation target;
- the principle of equal pay for work of equal value in the NHS;
- the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

The Review Body may also be asked to consider other specific issues.

The Review Body is also required to take careful account of the economic and other evidence submitted by the Government, Trades Unions, representatives of NHS employers and others.

The Review Body should take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief, and disability.

Reports and recommendations should be submitted jointly to the Prime Minister, the Secretary of State for Health and Social Care, the First Minister and the Cabinet Secretary for Health and Sport in Scotland, the First Minister and the Minister for Health and Social Services in Wales, and the First Minister, Deputy First Minister and Minister for Health in Northern Ireland².

Members³ of the Review Body are:

Philippa Hird (Chair)
Richard Cooper
Patricia Gordon
Neville Hounsome
Stephanie Marston
Professor David Ulph CBE
Professor Jonathan Wadsworth

The secretariat is provided by the Office of Manpower Economics.

¹ References to the NHS should be read as including all staff on Agenda for Change in personal and social care service organisations in Northern Ireland.

² In the absence of a First Minister, Deputy First Minister and Minister for Health of the Northern Ireland Executive, the report is submitted to the Permanent Secretary of the Department of Health, Northern Ireland.

³ Neville Hounsome and Stephanie Marston were appointed on 17 December 2018. Richard Cooper was appointed on 1 March 2019.

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NHS PAY REVIEW BODY 2019 REPORT

Executive Summary

1. This is the first of our reports since the implementation of the three-year Agenda for Change (AfC) pay agreements in 2018 which cover over 1.3 million AfC staff and a pay bill of around £40 billion. The agreements are the most significant change to pay arrangements in the NHS since the introduction of the AfC structure in 2004. Our report does not make pay recommendations, as the pay rates are set under the agreements, but it does assess the evidence against our standing terms of reference and considers the way in which these inform our monitoring of the implementation and impact of the agreement through to 2020/21.

Our overall conclusions

- The NHS faces a range of challenges and there is widespread recognition that the NHS workforce challenge is among the most significant. A Workforce Implementation Plan to be published later this year is intended to underpin major service changes set out in the NHS Long Term Plan for England published in 2019.
- There has been investment to reform AfC pay. The three-year agreement is designed to support the planned workforce developments and the 2018 NHS Staff Survey in England indicated that levels of satisfaction with pay had increased over the previous year.
- Our approach to monitoring the implementation and impact of the AfC pay agreement is based on the core issues in our standing terms of reference, specifically affordability, recruitment, retention and motivation.
- Affordability considerations include securing sufficient ring-fenced resource for necessary workforce developments and investment in training and development budgets, and avoiding the diversion of these resources to meet financial crises elsewhere in the NHS.
- The workforce gap we recognised in our last report persists and continues to create unsustainably high levels of vacancies, work pressures and potential risks to patient care. There are plans in place to bridge the gap but these contain significant recruitment and retention risks. The recruitment risks are pre-registration entrants, EU recruits and the development of new roles, such as nursing associates and apprenticeships. The retention risks to the plans are workload, flexible working opportunities and leadership capacity.
- The trends in the nursing workforce are a particular concern with increasing nursing vacancy rates and substantial declines in the number of people applying for nursing degrees in the last two years in particular from mature students who represent 60% of entrants.
- Workforce planning needs to be informed by requirements for services and transformation, NHS funding constraints and expected productivity improvements. The accountability for workforce planning continues to be dispersed across a number of bodies despite the need for system-wide solutions.
- The NHS Long Term Plan identifies productivity improvements to come from developing new technology, changes to skill mix and improved ways of working. For NHS staff to contribute to these improvements effectively, it is important that they are fully involved in the way in which these are planned and delivered.

- Bank working has allowed trusts to cover the workforce gap and has delivered flexibility for some staff. More work is needed to clarify the role to be played in the long term by NHS banks as part of the overall resourcing strategy.
- Despite current economic uncertainty, a tightening labour market is increasing the competition for talent. The NHS has a reformed AfC pay structure which needs to be supported by effective entry routes, new roles and career pathways and by ensuring that existing staff work in a supportive and well-managed environment and so are able to act as advocates for AfC roles.

Our remits

2. The AfC pay agreements in England, Scotland and Wales were finalised and implemented during 2018. In Northern Ireland, a 2018/19 pay award for AfC staff was announced in December 2018. The 2019/20 remit letters for England, Wales and Northern Ireland did not seek our pay recommendations but invited us to monitor the implementation and impact of AfC pay agreements. The Scottish Government told us that it had not been able to identify substantive issues for a remit for 2019/20. For England, the Secretary of State asked us to consider the difficulties recruiting and retaining IT staff. The Permanent Secretary of the Department of Health, Northern Ireland asked us to consider any issues raised regarding difficult to fill nursing specialisms.

NHS context

3. The NHS continues to operate under significant pressures with challenges from increasing demand and the need to transform services. There appears to be consensus among NHS organisations, the UK Government and external commentators, that the challenges in delivering service change, for instance through the NHS Long Term Plan in England, will require more productive systems, and an appropriately staffed and reconfigured NHS workforce.
4. The workforce gap is widely recognised as a leading challenge for the NHS. A Workforce Implementation Plan is expected to be published later in 2019. We have yet to see clear estimates of workforce demand, which assess requirements for services and transformation, NHS funding constraints and expected productivity improvements. The five-year NHS funding settlement and the Barnett consequential for the Devolved Administrations need to provide sufficient resource to deliver the necessary workforce development. The new service models and integration with social care highlighted in the NHS Long Term Plan will require new NHS roles with wider responsibilities, improved career structures and pathways, and effective supporting pay arrangements. Adequate funding is required for new and reconfigured roles, supported by investment in training and development.

The parties' evidence and our analysis

5. The main points from the evidence (Chapter 3) and our conclusions (Chapter 4) are:
 - Economy and labour market – while current economic conditions are uncertain, there are signs of a tightening labour market as evidenced by increasing employment rates and upwards revisions to forecasts for average earnings. These could have implications for AfC recruitment, retention and motivation. The Joint Staff Side continued to focus on both the recent period of pay restraint relative to inflation and the way in which inflation will influence their approach to AfC pay once the agreement has been fully implemented; (Paragraphs 4.2 to 4.16)

- AfC earnings – for nurses, we note that starting pay has lost value between 2009 and 2017, particularly compared with RPI inflation, and to a slightly lesser extent relative to full time employee earnings growth. Some of that value has been recovered as a result of the AfC pay agreement in 2018/19. The most significant effects of the agreement will be felt as the structural changes work through in 2019/20 and 2020/21. Data on graduate pay show that NHS professions, particularly nursing, were ahead of the median earnings of graduates a year after graduation and they remained above median earnings after five years, but after 10 years they fell just below the median for graduates as a whole. We consider that assessing pay across an NHS career will become an increasingly important part of our evidence-base as AfC roles and careers develop; (Paragraphs 4.17 to 4.33)
- Total reward – the parties all recognise the importance of the total reward package and we heard from AfC staff that security of employment was important, and that the value of different elements of the package would vary depending on individual circumstances and their point in an NHS career. NHS pensions could also be more flexible at different stages; (Paragraphs 4.34 to 4.40)
- Service transformation – without service transformation rising demand for services will continue to impact on AfC staff through increased workload, additional paid and unpaid overtime, an increased need to cope with vacancies and a growing reliance on the continued goodwill of staff. We await the Workforce Implementation Plan later in 2019 to understand the workforce developments needed to support the proposals in the NHS Long Term Plan; (Paragraphs 4.41 to 4.51)
- Integration – Integrated Care Systems are planned to be in place in all areas by 2021. We saw on our visits that new ways of working were being developed locally and further evidence should be provided on the way in which integration might influence the skill mix, any changes to AfC roles, any developments on employment arrangements and the implications for pay; (Paragraphs 4.44 to 4.45)
- Productivity – AfC staff can see and are supportive of the overall need to improve productivity but they are not always clear about the way in which they contribute in teams and as individuals to the productivity and efficiency measures used across the NHS. A major feature of productivity improvements will be a differently configured workforce. Understanding the drivers and definitions of productivity would allow NHS staff to be involved effectively in making change happen. Staff, managers and organisations need to be clear about which productivity improvements derive from the benefits of developing new technology, process improvement, changing the workforce skill mix and improved ways of working. For NHS staff to contribute to these improvements effectively, it is important that they are fully involved in the way in which these are planned and delivered. It is widely recognised that improving staff morale, motivation and engagement can be effective in contributing to enhanced productivity; (Paragraphs 4.46 to 4.51)
- NHS affordability and efficiency savings – while the AfC pay agreement is funded for three years, we remain aware of the overall position on affordability in the NHS so that we can build a picture over the period of the agreement. Notwithstanding the additional overall NHS funding over the next five years, there is a continued risk to the effective implementation of the NHS Long Term Plan and the expected Workforce Implementation Plan from the financial challenges faced by trusts; (Paragraphs 4.52 to 4.55)
- Workforce strategies and workforce numbers – the approach to workforce planning continues to be dispersed across a number of bodies. We consider that estimates of workforce demand should be informed by requirements for services and transformation, NHS funding constraints and expected productivity improvements; (Paragraphs 4.56 to 4.68)

- Vacancies and shortage groups – NHS organisations and external commentators agree that the emerging NHS Improvement data are improving the understanding of the size of the workforce gap. The vacancy data indicate that the total volume in England is a continuing concern to the parties. While the overall number of vacancies has varied between 2017 and 2018, there has been an increase in the nursing vacancy rate and a steady decline in the vacancy rate for other non-medical staff. The data also suggest an unequal distribution of vacancies in terms of geography and specialty. Shortages affect the workload of staff since the NHS relies on their goodwill and their willingness to do paid and unpaid overtime. These issues could impact on staff motivation and morale, their retention, their willingness to recommend the NHS as a career, and on services to patients; (Paragraphs 4.72 to 4.78)
- Supply and recruitment – the dispersed accountability for delivering the required number of entrants makes it difficult to reconcile trends and the way in which they might match rising service demand. We have seen no assessment of the potential impact of each of the proposed solutions separately to improve the number of qualified people available and willing to work in the NHS. Further evidence is needed on the effect of moving to the standard student loan system in England, increasing clinical placements, actions to reduce attrition rates during training, the introduction of new roles and apprenticeships, and the impact of changes in EU and non-EU recruitment; (Paragraphs 4.79 to 4.81)
- Pre-registration entrants – there has been a 26% fall in the number of nursing applicants since 2016 and a fall in the ratio of applicants to acceptances from 2.27 to 1.69, and a small decrease in acceptances to nursing degrees. A market now operates for university places for nursing and AfC-related health degrees, and applicants could be influenced by the availability of a broader range of health-related degrees and the increase in medical places. If the available pool of applicants are appropriately qualified, if the Government meets its target for an extra 5,000 clinical placements and this removes a current constraint on the number of places universities can offer, and if the market for university places is working, one might expect a significant rise in the number of nursing and AfC-related acceptances onto degree courses in 2020, 2021 and 2022. It is important that clear mechanisms need to be in place to improve the attractiveness of nursing within the NHS and to encourage the right numbers of suitably qualified applicants. There needs to be further evidence on the way in which the targets can be achieved given the current trends and a better understanding of the factors driving applicants, acceptances and attrition. The bursary remains in place in all countries except England, and there were increases between 2016 and 2018 in applicants accepted to study nursing in Scotland and Wales, with a slight fall in applicants accepted in Northern Ireland; (Paragraphs 4.82 to 4.101)
- Recruitment of nursing associates – we consider that the effectiveness of the introduction and impact of nursing associates will be a key leading indicator in assessing the success of workforce developments. The first nursing associates qualified in January 2019 and a further 7,500 were to be in training in 2019. The new roles represent a small part of the solution to closing the workforce gap and a strategic approach to deployment will be required to realise the ambitions of the programme. There is a need for overarching direction, leadership and a coherent strategy across the NHS in order for the role to be deployed effectively; (Paragraphs 4.105 to 4.107)

- Recruitment of apprentices – the parties reiterated that apprenticeships are an important source of supply across a range of NHS occupations. Their effective use could contribute to supporting overall workforce developments in moving to new ways of working and achieving a change in skill mix. NHS Employers raised practical concerns about ring-fencing of apprenticeship funds from the levy, capacity for supervision, the time requirements for off-the-job training and backfilling of posts. The Joint Staff Side were concerned that many lower pay band posts were being converted into apprenticeships. We encourage further discussion among the parties to reach consensus on a consistent approach to AfC apprenticeship pay arrangements. As the labour market tightens, effective apprenticeship programmes could give the NHS a competitive advantage in attracting people to the NHS; (Paragraphs 4.108 to 4.117)
- Supply of bank and agency staff – the NHS relies on a consistent source of temporary staffing enabling trusts to flex the workforce according to demand. Approximately 90% of AfC vacancies were covered by bank and agency staff. Since the introduction of the ceiling in 2015, agency spending has been more effectively controlled and there has been a shift towards bank arrangements. The parties told us that this shift provided flexible employment for staff and better continuity of care for patients. More work is needed to clarify the role to be played in the long term by NHS banks as part of the overall resourcing strategy. We were pleased to see that further negotiation on a collective framework on bank and agency working was a priority for 2019. In Northern Ireland, agency spending has increased significantly over the last five years. Actions to bring down agency spending to an affordable level in the short term could be challenging but we look forward to further evidence on any implications; (Paragraphs 4.118 to 4.121)
- Retention – a degree of turnover is normal to refresh the workforce, but, after a consistent upward trend in turnover rates since 2010, particularly for clinical staff, turnover in 2017/18 levelled off. We welcome the progress with NHS Improvement’s retention programmes and see these as a good example of implementing targeted approaches to make a significant impact. Maintaining NHS retention at a manageable level is essential given the workforce gap and current supply concerns. The data on the reasons for AfC staff leaving the NHS remain patchy at best, and inadequate to make a full assessment of the influencing factors; (Paragraphs 4.122 to 4.129)
- RRP and HCAS – on a general point, we look forward to reviewing the evidence should DHSC provide us with a remit to review RRP or HCAS as trailed in the AfC pay agreement; (Paragraphs 4.130 to 4.132 and 4.140)
- For IT staff, DHSC said that it had made only limited progress in assessing the recruitment and retention difficulties, but NHS Employers, NHS Providers and the Joint Staff Side did not see IT staff as a priority group for pay. The initial evidence provides indications of some issues in IT recruitment and retention but not at this stage sufficient evidence of a widespread national problem to support an immediate pay response. We set out the detailed evidence requirements, including on the emerging role of NHSX, to support the assessment for IT staff; (Paragraphs 4.133 to 4.137)
- With regard to difficult to fill nursing specialism posts in Northern Ireland, we did not receive any detailed evidence on which to make an assessment and therefore ask the parties to present a robust case with further evidence and supporting data should they wish us to review the position; (Paragraphs 4.138 to 4.139)

- Motivation and engagement – the NHS Long Term Plan will require a substantial measure of goodwill and engagement from AfC staff to be effective. Staff motivation, morale and engagement are enablers of delivering workforce and service change. We have heard consistent messages in the parties’ evidence and during our visits on the importance of promoting staff health and wellbeing. We note that there are a range of initiatives underway through the NHS Long Term Plan, NHS Improvement’s collaborative programme and the AfC pay agreement. In recent years, we have also commented on the concerted efforts made by NHS Employers to provide tools and materials to trusts to improve staff engagement; (Paragraphs 4.141 to 4.143)
- The 2018 Staff Surveys suggest that many indicators on job satisfaction and engagement have been on an upward trend, since 2011 in England. There are worrying indicators on harassment, bullying or abuse from the public, work-related stress, having enough staff to do their job properly, and on working additional paid and unpaid hours. In England, there was an increase in the proportion of AfC staff satisfied with pay, although only returning to the level last seen in 2015 and below that in 2011. The 2018 increase in satisfaction could reflect the introduction of the AfC pay agreement. There was also a high and increasing proportion of staff receiving appraisals. Overall, the survey results show both job satisfaction and the challenges of working in the NHS, and some emerging results to help track the implementation and impact of the AfC pay agreements. (Paragraphs 4.144 to 4.156)

AfC pay agreement – implementation and impact (Paragraphs 4.168 to 4.197)

6. While assessing the evidence on our standing terms of reference, we have identified key leading indicators on workforce and pay that provide the baselines against which to monitor the AfC pay agreement. There are a limited number of implementation issues to review at this stage and it is too early to make an assessment of the long term impact of the AfC pay agreement. Many of the major impacts, such as changes to pay structures and progression arrangements, will take time to embed and influence recruitment, retention and motivation, and will be assessed in our later reports.
7. The delivery of wider workforce developments as an integral part of pay reform has been given renewed impetus in the NHS Long Term Plan. The Workforce Implementation Plan will need to link the way in which reformed AfC pay structures can support or be adapted to reflect new workforce requirements, new roles, training and development, and career paths.
8. Priorities at April 2019. The NHS Staff Council has made progress and reached agreements or identified further negotiations under the AfC pay agreement. An objective was to increase staff engagement by putting appraisal and personal development at the heart of pay progression so that staff could make the greatest possible contribution to patient care. We note that the NHS Staff Council agreed a revised national pay progression framework coming into effect for new staff and promotees from 1 April 2019, with existing staff in post before 1 April 2019 remaining on current procedures until 31 March 2021. In practice, the approach agreed by the parties means that AfC pay increases for existing staff in Years 2 and 3 of the agreement will be made in accordance with progression arrangements already in place.

9. Shorter pay bands with larger pay increases place a greater emphasis on the performance review process with more now at stake. More staff will reach the top of pay bands earlier and the lack of further progression opportunities could be demotivating, put pressure on the grading system and could influence staff retention. Career development incentives might be required to counteract the impact. We note that staff in NHS Wales are already covered by a single national pay progression system providing opportunities to develop a consistent approach to enhancing staff contribution to patient care and developing careers. We consider that outputs from the progression framework will be a key leading indicator of the success of the AfC pay agreement in England and Wales.
10. We welcome the progress made by the NHS Staff Council on:
 - The agreement on transitional arrangements for Band 1 and 2 posts from April 2019 which takes a pragmatic approach in allowing time to reconfigure posts and to enable staff to make a choice;
 - New arrangements for unsocial hours payments from September 2018 with particular implications for ambulance staff;
 - Further negotiations on arrangements for apprenticeship pay; and
 - The agreements on enhanced shared parental leave and child bereavement leave. Further negotiations are planned on buying and selling annual leave.
11. Priorities for 2019/20. We look forward to the outcomes from the NHS Staff Council's work during 2019/20 on the opportunities for consistency in bank and agency arrangements, guidance on supporting staff taking their annual leave and Time Off In Lieu, and reviewing monitoring data, including any equality impact. We note that the parties have identified the need for further refinements to the pay structure at the end of the three-year agreement. On funding, the parties alerted us to concerns about the 2018/19 arrangements being insufficient and we ask them to keep us informed of the impact and any implications for funding within the NHS tariff from 2019/20.
12. Northern Ireland. The AfC pay agreement has not been implemented in Northern Ireland but a 2018/19 pay award has been made for AfC staff. The absence of a Northern Ireland Executive gives the Department of Health, Northern Ireland little room to manoeuvre on pay policy and implementing such major reform to AfC pay and the accompanying investment would require Ministerial decisions. The Permanent Secretary of the Department of Health, Northern Ireland has not sought our pay recommendations for 2019/20. We consider that the current situation may create risks for service delivery should the AfC workforce not be supported by appropriate pay awards and reforms. The parties have acknowledged the benefits of implementing the AfC agreement and we welcome the Department of Health's efforts on early engagement with the Joint Staff Side. We encourage these discussions to come to an early agreement for 2019/20 and a pathway to implementing appropriate pay reform.
13. Future monitoring. NHS Improvement has been given the lead responsibility on the AfC Implementation Group. The starting point for future monitoring arrangements should be the AfC agreement's key objectives which reflect many of the core issues for the Pay Review Body. These should, in the longer term, be linked to supporting new service models, improving productivity and staff contribution, and improving patient services and outcomes. The NHS Staff Council's work on monitoring will help the parties to assess the return on investment. We look forward to the NHS Staff Council's approach. In the meantime, we intend to work with the evidence and key leading and lagging indicators, alongside our core evidence considerations under the following categories:
 - Workforce, recruitment, retention and motivation;
 - Productivity and staff contribution;

- Affordability and funding arrangements, including the pay effects and the position relative to the economy, graduates and total reward; and
- Effects of changes to other terms and conditions.

Philippa Hird (*Chair*)

Richard Cooper

Patricia Gordon

Neville Hounsome

Steph Marston

David Ulph

Jonathan Wadsworth

22 May 2019

Chapter 1 – Introduction

Introduction

- 1.1 The context for this report remains the Agenda for Change (AfC) three-year pay agreements reached during 2018 in England, Scotland and Wales. The agreement has not been implemented in Northern Ireland, where for 2018/19 the AfC pay award matched the increases arising from the agreement in England but were applied to Northern Ireland rates. The Pay Review Body has not been asked to make pay recommendations for 2019/20 but has been invited to monitor the implementation and impact of the AfC pay agreements in England and Wales. The Scottish Government decided that the focus for 2019/20 should be on implementing reforms and gathering evidence and, therefore, did not provide a remit. In this report, we continue to assess the evidence against our standing terms of reference on affordability, recruitment, retention and motivation, and to consider the way in which our conclusions on the elements in our terms of reference inform our monitoring of the AfC pay agreements.
- 1.2 In drawing our conclusions we have been mindful of developments in the NHS affecting the AfC workforce. In our 2018 Report we set out our concerns about an NHS workforce gap which had been clearly identified by the draft Health and Social Care Workforce Strategy for England. The Strategy stated that, without action on productivity or service redesign, the NHS would need 190,000 additional posts by 2027 when supply trends indicated that only 72,000 were expected to join the NHS by then. For this report we evaluate the escalating concerns among NHS organisations and external commentators that the supply of entrants to the workforce will not meet increasing demand for services and the aspirations for services in the NHS Long Term Plan. There are worrying trends on the number of applicants to some AfC-related degrees and actions to increase the number of new entrants will take some time to impact on the existing NHS workforce gap. Consequently, there will be a continuing focus on supporting the retention of AfC staff, promoting flexibility in careers and working patterns, and improving productivity.
- 1.3 The NHS Long Term Plan includes a target that Integrated Care Systems would be in all areas by 2021. As the integration of health and social care becomes a policy focus, the employment and pay arrangements of all those staff engaged across the NHS and other organisations will require consideration.
- 1.4 Our conclusions, at the time of this report, recognise the impact of the Brexit process on the NHS. Despite the Department of Health and Social Care's (DHSC) priority to ensure EU staff in the NHS feel welcomed and encouraged to stay in the NHS, the numbers of EU staff joining the Nursing and Midwifery Council register have reduced significantly since the EU referendum in 2016. A continuation of this trend would affect the overall supply of qualified people willing and available to work in the NHS. The continuing uncertainty about the Brexit process through 2019 and beyond could also impact on the economy risking the level of investment available to the NHS to deliver its ambitious Long Term Plan.
- 1.5 All these developments have implications for the recruitment, retention and motivation of the AfC workforce and our report therefore sets out our conclusions on these implications.

The context for the 2019/20 pay round

- 1.6 We submitted our 2018 Report to the Prime Minister, the Secretary of State for Health and Social Care and relevant Ministers in Scotland and Wales, and the Permanent Secretary of the Department of Health, Northern Ireland on 13 June 2018. In the light of the three-year AfC pay agreement for England in June 2018 and the prospect of similar agreements in the Devolved Administrations, our report did not make any recommendations on pay.
- 1.7 Our 2018 Report did, however, draw overall conclusions on our standing remit and make observations on the AfC pay agreement. We noted that workforce issues were the highest priority for healthcare providers and that the workforce gap was creating an unsustainably high level of vacancies, work pressures and potential risks to patient care. We also highlighted recruitment and retention risks for AfC staff. We observed that the AfC pay agreement provided a balanced package of pay reforms that aimed to address the concerns of both AfC staff and employers, and to contribute to the sustainability of the workforce. We concluded that the elements of the agreement, when taken together, began to respond to our conclusions from the evidence on recruitment, retention and motivation.
- 1.8 On 27 June 2018, the UK Government accepted our report and noted the observations on the AfC pay agreement. On 21 June 2018, the Permanent Secretary of the Department of Health, Northern Ireland informed us that the report would support future discussions with key stakeholders. On 4 July 2018, the Welsh Government confirmed that there would be consultative talks with trades unions on a three-year pay agreement with Wales-specific adjustments. On 9 July 2018, the Scottish Government wrote to us stating that our observations would be factored into the modernisation process for AfC staff in Scotland.

Developments on AfC pay agreements

- 1.9 In England, the AfC pay agreement was finalised in June 2018 and implemented during the remainder of 2018. The NHS Staff Council also established the priorities for further work to be implemented from April 2019 and beyond. In Scotland and Wales, similar pay agreements were reached and implemented later in 2018. In Northern Ireland, a pay award for 2018/19 was announced in December 2018.
- 1.10 The framework agreement⁴ in England was adopted by the NHS Staff Council on 27 June 2018 following a consultation exercise by the NHS trades unions. It was ratified by the Secretary of State and took effect on 1 July 2018. Implementation of the first year of the agreement began with new AfC pay rates from July 2018 and any outstanding pay from 1 April 2018 received in August 2018. The NHS Staff Council identified the first year's priorities as: a revised national pay progression framework; closure of Band 1 and transitional arrangements to Band 2 roles; negotiations on apprenticeship pay; new arrangements for unsocial hours payments; and negotiations on leave arrangements. The NHS Staff Council also identified priorities for 2019/20, including monitoring of the agreement. The Department of Health and Social Care told us that NHS Improvement was leading an AfC Implementation Group which aimed to ensure governance structures and the development of key performance indicators helping local organisations to prepare their local implementation plans.

⁴ NHS Staff Council (June 2018), *Working in Partnership: Framework Agreement on the Reform of Agenda for Change*. Available at https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/2018-contract-refresh/Framework_agreement_27_June_2018.pdf

- 1.11 In March 2018, the Scottish Government announced a framework for AfC reforms in Scotland. It issued a joint statement⁵, in partnership with the Scottish Terms and Conditions Committee, committing to use the Barnett consequential⁶ to reform the AfC system in NHS Scotland. An agreement was reached in June 2018 and the Scottish NHS trades unions accepted the agreement in August 2018. The agreement aimed to retain suitably qualified staff and attract the skills and experience needed to ensure NHS Scotland met future demands and expectations. The Scottish agreement mirrored that for England by (i) increasing starting salaries, including for the lowest paid, to recruit staff, and (ii) restructuring pay bands by increasing pay at the top of bands and speeding up progression to support retention. The revised AfC pay structure would be reached by 2020/21, but there were variations affecting transition during each of the three years. The transition was influenced by AfC pay awards for 2018/19, higher existing AfC pay rates in Scotland than the rest of the UK, and the obligation to pay the Scottish Living Wage⁷.
- 1.12 In September 2018, a framework agreement for AfC staff in Wales was agreed between the Welsh Government and NHS trades unions. It followed that for England with some variations arising from: implementing earlier recommendations of the Living Wage Foundation; a new progression framework building on the existing policy; a separate agreement on attendance management (including a renewed emphasis on health and wellbeing); further work on temporary staff capacity; a specific agreement on eligibility for unsocial hours payments during sickness absence; and further development of local agreements on specified terms and conditions. As a result of a separate 2015 agreement on AfC pay rates in Wales, some differential pay increases were implemented in 2018/19 across the pay structure to ensure alignment with England from 2019/20 onwards.
- 1.13 In Northern Ireland the negotiations between the Department of Health and the NHS trades unions did not reach an agreement. On 20 December 2018, the Department of Health, Northern Ireland implemented the 2018/19 AfC pay award by applying the 2018/19 English NHS settlement to existing pay rates in Northern Ireland. The Department estimated that this represented a 3% increase on the pay bill for AfC staff. In announcing the pay awards, the Department said that, even though no formal agreement was reached, all sides were committed to further discussions in 2019, including work on the modernisation of the AfC pay framework.

The 2019/20 remits

Secretary of State for Health and Social Care's remit letter

- 1.14 Following the 2018 autumn budget, the Secretary of State for Health and Social Care wrote to us on 21 November 2018 setting out the approach to the pay round. The letter confirmed that the Review Body was not required to make any pay recommendations over the period of the AfC pay agreement in England (2018/19 to 2020/21). However, the Secretary of State invited us to monitor the implementation of the agreement and its impact, and sought our observations on the evidence received from the parties. The Secretary of State also asked us to consider issues that had been raised regarding the difficulties of recruiting and retaining IT staff in the NHS. He invited our observations on the labour market issues and recommendations, including any case for a national Recruitment and Retention Premium for IT staff.

⁵ Scottish Terms and Conditions Committee (March 2018), *Pay Settlement for Agenda for Change Staff*. Available at <https://www.stac.scot.nhs.uk/wp-content/uploads/STACTCS022018-AfC-Pay-Uplift-2018.pdf>

⁶ The non-statutory Barnett formula determines annual changes in the block grant from the UK Government to the Devolved Administrations. When there is a change in funding for comparable services in England, the Barnett formula aims to give each country the same pounds-per-person change in funding. House of Commons Library (2018), *The Barnett Formula*. Available at: <https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7386>

⁷ Based on the Living Wage Foundation Living Wage. Further details available at: www.livingwage.org.uk

Scottish Government

1.15 The Cabinet Secretary for Health and Sport wrote to us on 19 December 2018 to set out the Scottish Government's position on the NHS pay process for 2019/20. The Cabinet Secretary said that the Scottish Government had decided that the focus for 2019/20 should be on implementing reforms to terms and conditions and gathering evidence of the impact of the agreement. The Cabinet Secretary added that, while the independent scrutiny which the Review Body provided was always helpful, he had not been able to identify substantive issues which would form the basis of a remit for 2019/20. The Cabinet Secretary would continue to observe the process and give fresh consideration to the position in 2020/21.

Welsh Government

1.16 The Minister for Health and Social Services⁸ wrote to us on 13 December 2018 to begin the 2019/20 pay round for AfC staff in Wales. The Minister confirmed that during the life of the AfC pay agreement the Welsh Government would not ask the Review Body to make recommendations on pay. However, the Minister asked that the Review Body monitor the implementation of the agreement and its impact over its duration, and sought our observations based on the evidence received from the Welsh Government and other parties.

Northern Ireland

1.17 In the absence of a Northern Ireland Executive, the Permanent Secretary of the Department of Health, Northern Ireland wrote to us on 7 January 2019 to commence the pay round. He confirmed that the Northern Ireland public sector pay policy for 2018/19 had been set and that the Department was proceeding with the implementation of the 2018/19 AfC pay award. The Permanent Secretary confirmed that for 2019/20 Northern Ireland would not require any specific recommendations on pay. The Permanent Secretary asked the Review Body to consider any issues raised regarding difficult to fill nursing specialism posts, such as care of older people, acute medicine and critical care to include theatres, and our recommendations, including any case for a Recruitment and Retention Premium.

Visits and evidence submissions

1.18 Our report is supported by visits to NHS organisations, which are followed by the submission of written and oral evidence by the parties, and our own analysis of other sources of pay and workforce information.

Our visits

1.19 Our visits provide useful insights to AfC workforce developments and enable us to hear first-hand views on recruitment, retention, motivation and pay arrangements. Between September 2018 and January 2019, we visited the NHS organisations below and we are grateful to management, staff representatives and AfC staff that organised and participated in these visits:

- Northern Ireland Ambulance Service Health and Social Care Trust;
- Worcestershire Acute Hospital NHS Trust;
- University of Worcester; and
- Manchester Local Care Organisation.

⁸ Appointed Minister for Health and Social Services on 13 December 2018. See <https://gov.wales/vaughan-gething-am>

Parties submitting evidence

1.20 The parties listed below submitted written evidence between December 2018 and March 2019. Copies of written evidence are on the parties' websites⁹. This was followed by oral evidence with specific organisations between February and March 2019.

Government departments and NHS organisations

- The Department of Health and Social Care for England
- Health Education England
- NHS Improvement
- The Welsh Government
- The Department of Health, Northern Ireland

Employers' bodies

- NHS Employers
- NHS Providers

Bodies representing NHS Staff

- The Joint Staff Side
- The Royal College of Midwives
- The Royal College of Nursing
- UNISON
- Unite
- GMB

Our sources of evidence and information

1.21 The evidence-base for this report is completed by drawing on published information and data on the NHS, and our own analysis of specific NHS data available to us. We also draw on reports from external commentators on pressures in the NHS from demand, finances, transformation, and integration with social care. Our secretariat provides us with regular data and analysis covering the economic and labour market context, and trends in the AfC workforce, earnings and staff surveys. We also assess independent research commissioned by the Office of Manpower Economics for all Pay Review Bodies.

Our overall approach

1.22 The context for this report is the AfC agreements in England and Wales. The agreement has not been implemented in Northern Ireland, although a 2018/19 AfC pay award was made. The Scottish Government decided not to provide a remit. Against that background, we continue our approach of assessing the elements of our standing terms of reference. This approach aims to ensure that our assessments continue to support pay considerations during the period of the AfC pay agreements. Our report therefore sets out the context of NHS developments (Chapter 2) as they relate to the AfC workforce, before setting out the parties' evidence (Chapter 3), and then our analysis of the evidence and our initial views on monitoring the implementation and impact of the AfC pay agreement (Chapter 4).

⁹ Links to the parties' websites are on the OME webpages at: <https://www.gov.uk/government/publications/remittance-links-to-evidence-and-timetable-for-nhsprbs-2019-pay-round>

Chapter 2 – NHS Context

Introduction

2.1 In this chapter we set out several new and ongoing developments in the NHS which affect the AfC workforce. We consider these developments as they relate to our standing terms of reference, particularly affordability of pay awards, and recruitment, retention and motivation of AfC staff. In doing so, we aim to identify the workforce implications and our suggested key indicators arising from them as the basis for our considerations and analysis of the parties' evidence and other information later in this report. We set out the main developments as: the NHS funding settlement and the continuing pressures on NHS finances; the management of increasing demand; expected service transformation including the NHS Long Term Plan; and the way in which the NHS workforce might be developed.

NHS finances

2.2 In June 2018, the Prime Minister announced¹⁰ that the NHS in England would receive £20.5 billion in increased funding over the next five years. The Prime Minister said that this would represent an average of 3.4% a year real terms increase in funding, which would be front-loaded with increases of 3.6% in the first two years, and that the NHS would have the financial security to develop a 10-Year Plan. The Government also set five financial tests to put the NHS on a more sustainable footing. These tests were: improving productivity and efficiency; eliminating provider deficits; reducing unwarranted variation in the system so people get the consistently high standards of care wherever they live; getting much better at managing demand effectively; and making better use of capital investment. The Barnett consequential for the Devolved Administrations would be confirmed at the next Spending Review.

2.3 *NHS Improvement's 2018/19 Quarter 3 Performance Report*¹¹ noted that the provider sector reported a year-to-date deficit of £1,247 million in England. This was £34 million better than 2017/18 but £261 million more than planned, which NHS Improvement said was mainly due to a small proportion of providers whose position had significantly deteriorated. The deficit included the year-to-date distribution of £2.45 billion from the Provider Sustainability Fund¹².

2.4 NHS Improvement reported that providers made significant savings but still fell below ambitious targets and added that continued focus on productivity was critical. Efficiency savings were planned at 4.1% of total expenditure for 2018/19 and by Quarter 3 were 3.1% (against the Quarter 3 plan of 3.5%). NHS Improvement estimated that savings linked to workforce productivity, resource optimisation and benchmarking through the Model Hospital¹³ were forecast to rise to £1.8 billion by the end of 2018/19. It also noted that £1.9 billion savings were included in provider plans from the Carter Review and further savings planned from the Getting It Right First Time programme.

¹⁰ Department of Health and Social Care, Press Release, 18 June 2018. Available at: <https://www.gov.uk/government/news/prime-minister-sets-out-5-year-nhs-funding-plan>

¹¹ NHS Improvement (March 2019), *Performance of the NHS Provider Sector for the Quarter Ended 31 December 2018*. Available at: <https://improvement.nhs.uk/resources/quarterly-performance-nhs-provider-sector-quarter-3-201819/>

¹² The Provider Sustainability Fund aims to encourage trusts to provide sustainable, efficient, effective and economic care and is focused on achieving sustainability, accelerating financial recovery, and improving urgent and emergency care.

¹³ The Model Hospital is a digital information service provided by NHS Improvement designed to help NHS providers improve their productivity and efficiency. Further information is available at: <https://improvement.nhs.uk/resources/model-hospital/>

- 2.5 As a result of a ceiling on agency spend, NHS Improvement reported that the costs for agency staffing had reduced since 2015. NHS Improvement expected providers to continue to control these costs and had therefore reduced the ceiling for 2018/19. However, by Quarter 3 providers incurred a £139 million overspend on agency costs, which was a slight increase on 2017/18, and a £393 million overspend on bank costs. Overall spending on agency and bank was up by 8.0% on the same period in 2017/18, attributable to volume increases rather than price.
- 2.6 On the pay costs from the AfC pay agreement, NHS Improvement's data to Quarter 3 suggested that these accounted for an additional £620 million and were expected to be £833 million by the end of 2018/19. NHS Improvement also noted the potential for further funding subject to applications to DHSC.
- 2.7 The National Audit Office's *NHS Financial Sustainability*¹⁴ report found:
- The long term funding settlement did not cover key areas of health spending, for instance funding for doctors' and nurses' training, which could affect the NHS's ability to deliver the priorities of the NHS Long Term Plan. Without a long term funding settlement for social care, it would be difficult to make the NHS sustainable;
 - A risk that the NHS would be unable to use the extra funding optimally because of staff shortages – even if commissioning additional activity, providers might not have the staff to deliver it;
 - The NHS Long Term Plan set out a prudent approach to achieving the priorities, but risks remained, including growing pressures on services, staffing shortages, funding for social care and public health, and the strength of the economy;
 - In 2017/18, most of the financial deficit was accounted for in a small number of trusts and there were indications that underlying financial health in some trusts was getting worse. It was not clear that funding was reaching the right parts of the system;
 - The current funding flows were complicated and did not support partnership working, integration and the better management of demand;
 - Sustainability and Transformation Fund payments had helped most trusts improve performance but encouraged short term gains over long term sustainability;
 - Many parts of the NHS did not have sufficient understanding of increasing levels of demand for services. However, it was difficult to predict and quantify all variation in demand. NHS England and NHS Improvement were developing expertise in understanding demand;
 - It was difficult to say how much progress had been made by local partnerships. Most areas noted that the pace of change was slow in transforming services with few reaching major service reconfiguration. Partnership working was vulnerable and faced significant challenges; and
 - The growth in waiting lists and slippage in waiting times, and the existence of substantial deficits in some parts of the system, offset by surpluses elsewhere did not add up to a picture that the NAO could describe as sustainable.

Service transformation and demand

- 2.8 The *NHS Long Term Plan for England*¹⁵ was published in January 2019 following the 2018 announcement by the UK Government on increased NHS funding for the next five years. The NHS Plan stemmed from concern around funding, staffing, increasing inequalities, and pressure from a growing and ageing population. It stated that the redesign of patient care must be accelerated to future-proof the NHS for the decade ahead.

¹⁴ National Audit Office (January 2019), *NHS Financial Sustainability*. Available at: www.nao.org.uk/report/nhs-financial-sustainability/?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=

¹⁵ NHS England (January 2019), *The NHS Long Term Plan*. Available at: <https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>

- 2.9 The NHS Long Term Plan set out a new service model and referred to better support and properly joined-up care at the right time in the optimal care setting. Actions and targets included:
- In five years, every patient would have the right to online digital GP consultations. Hospital support would be redesigned to avoid a third of outpatient appointments;
 - GP practices would be funded to work together to deal with pressures and extend services covering community health and social care;
 - Community health teams would provide fast support to people in their own homes and a ramping up of support for people in care homes;
 - Within five years, people would benefit from social prescribing¹⁶, a personal health budget and support for managing their own health;
 - Primary and community services would have increased funding (new investment of £4.5 billion a year for five years); and
 - There would be new service channels for emergencies, such as Urgent Treatment Centres, same-day emergency care, and improving outcomes for critical illnesses. Delayed discharges would be cut by building on action with Local Authorities.
- 2.10 The NHS Long Term Plan also said that Integrated Care Systems would be in all areas by 2021 bringing integration of primary and specialist care, physical and mental health services, and health with social care. The NHS Plan would fund specific new evidence-based prevention programmes with every local area required to set out specific measurable goals and mechanisms to narrow health inequalities. There were commitments to improving cancer survival, halving maternity-related deaths, increasing the number of planned operations and cutting long waits, increasing mental health funding, and expanding and faster access to community and crisis mental health services. These changes to services were to be backed by action on workforce, technology, innovation and efficiency.
- 2.11 The NHS Plan recognised that the performance of any healthcare system depended on its people and that NHS staff were feeling the strain due in part to vacancies. It also recognised that to deliver the NHS Plan more staff would be needed, working in rewarding jobs and in a more supportive culture. A Workforce Implementation Plan would be published later in 2019 and a National Workforce Group had been established.
- 2.12 The NHS Plan highlighted that the NHS remained a highly attractive career choice with the main source of new nurses through undergraduate training. While other routes were important, restoring growth in this route was central to the success of the Long Term Plan. It noted that 22,200 applicants were accepted onto English nursing courses in 2018, which was a higher number than in seven of the last ten years, and, while the total number of applications fell, there were still nearly two applicants for each place offered. Across the UK, 14,000 applicants to nursing were not accepted onto courses. At a time of staff shortage, the Plan found it paradoxical that many thousands of highly motivated and well-qualified applicants who wanted to join the health service were being turned away. The Plan stated that a number of Higher Education Institutions had entry tariffs well above the level set by others and deemed to meet the appropriate standards by the Nursing and Midwifery Council¹⁷. To facilitate DHSC's intended 25% increase in nurse undergraduate places, clinical placements for an extra 5,000 places would be funded from 2019/20. The Plan added that from 2020/21 funding would be provided for clinical placements for as many places as universities filled, up to a 50% increase, and every nurse or midwife graduating would be offered a five-year NHS job guarantee within the region where they qualified.

¹⁶ Social prescribing is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. See <https://www.kingsfund.org.uk/publications/social-prescribing>

¹⁷ Available at: www.nmc.org.uk/standards/standards-for-nurses/standards-for-pre-registration-nursing-programmes/

2.13 Specific workforce actions identified in the NHS Long Term Plan were:

- A workforce group to agree action to improve supply centring on nursing degrees, reducing attrition from training and improving retention, with the aim of improving the nursing vacancy rate to 5% by 2028;
- A new online nursing degree linked to guaranteed placements in the NHS (offered at substantially less than current course costs);
- Earn and learn support for an additional 4,000 mature students for flexible undergraduate degrees in mental health and learning disability nursing;
- Continued investment in apprenticeships for nursing, with 7,500 new nursing associates in 2019, and growing apprenticeships in clinical/non-clinical jobs;
- Developing a national strategy for allied health professions (AHPs), focussing on paramedics, podiatrists, radiographers, and speech and language therapists;
- New national arrangements to support recruiting overseas;
- NHS Improvement's retention support would be extended to all trusts, with an aim to improve retention by at least 2 percentage points by 2025. Also expected increases to investment in Continuing Professional Development (CPD) when Health Education England's (HEE) training budget was set;
- Shaping a modern employment culture promoting flexibility, wellbeing, and career development, and addressing discrimination, violence, bullying and harassment;
- By 2021, NHS Improvement would support using e-rosters or e-job plans;
- Developing leadership and talent management.

2.14 The NHS Plan stated that the affordability of the phased commitments had taken account of current financial pressures, and that it made realistic assumptions about continuing demand growth from the growing and ageing population. The underpinning modelling had taken a prudent approach that hospital trends of the past three years would continue.

Demand for and quality of care

2.15 The Care Quality Commission (CQC) published its 2018 report on the *State of Health Care and Adult Social Care in England*¹⁸. The CQC concluded that most people in England received good quality care and that, despite continuing challenges, quality overall had been largely maintained from 2017. Improvements in services were attributed to the focus and hard work of care staff and their leadership teams. The CQC added that quality and access were not consistent, and people's overall experiences of care varied although public sentiment about health and care services remained largely positive.

2.16 The CQC identified five factors affecting the sustainability of good care:

- Access – access to care varied. Older people lived with an unmet care need and people travelled long distances to get mental health care;
- Quality – 91% of GP practices, 79% of adult social care services, 60% of NHS acute core services and 70% of NHS mental health core services were rated as “good” by the CQC in July 2018 (improved slightly from 2017). The hallmarks of high quality care were good leadership and governance, strong organisational culture and good partnership working. One in six adult social care services, one in five NHS mental health core services and almost one in three NHS acute core services were rated as “requires improvement”;

¹⁸ Care Quality Commission (October 2018), *The State of Health Care and Adult Social Care in England 2017/18*. Available at: <https://www.cqc.org.uk/publications/major-report/state-care>

- Workforce – workforce problems had a direct impact on people’s care and getting the right workforce was crucial in ensuring services could improve. Many sectors were struggling to recruit, retain and develop their staff. In adult social care the highest vacancy rates were for regulated professions, including nurses, AHPs and social workers. Vacancy and turnover rates for all staff groups were generally higher in domiciliary care agencies than in care homes. Low staffing levels in mental health services for children and young people were a common reason for delays in receiving care;
 - Demand and capacity – demand was rising inexorably from an ageing population and people living with complex, chronic or multiple conditions, such as diabetes, cancer, heart disease and dementia. Demand for urgent and emergency care services continued to rise in 2017/18. The capacity of adult social care provision continued to be very constrained; and
 - Funding and commissioning – good structures and decision-making should be in place to help boost the ability of health and social care services to improve. Additional NHS funding was noted but there was no similar long term funding solution for adult social care.
- 2.17 The CQC pointed to the challenge for care organisations in making sure that they were joined up and strategically focused. It concluded that when services worked together it was more likely that people would get the best care and in the best environment that suited their needs.
- 2.18 The CQC identified specific workforce challenges with shortages identified across adult social care, the GP workforce, acute medical care, community health, social services and ambulance services. These shortages affected service delivery and access. The CQC recognised that growing demand coupled with limited capacity was putting pressure on hospitals, community health services and ambulance services, and was compromising the quality of care and potentially putting patients at risk. The CQC observed that the quality of leadership was a key factor in delivering high quality care.
- 2.19 *NHS Improvement’s 2018/19 Quarter 3 Performance Report* compared performance with the same quarter in 2017/18. NHS Improvement pointed to the number of emergency admissions increasing by 785 patients per day (6.3%) compared with Quarter 3 in 2017/18, continuing the upward trend of the last two years. It reported that 6.16 million people came to A&E during Quarter 3 2018/19, an increase of 2.3% on 2017/18, and, despite the significant rise in demand, the NHS treated 106,863 more patients within the four hour target than in Quarter 3 in 2017/18. On the latter, A&E performance at 87.7% of patients seen within four hours, remained below the NHS Constitution Standard of 95%. Total emergency admissions consisted of an 11% increase in patients with zero length of stay and a 2.7% increase in patients in hospital for one day or longer. There was also progress in reducing delayed discharges from hospitals with just under 43,000 fewer bed days delayed compared with 2017/18. The aim was to reduce the number of long stay patients by 25% by December 2018, equivalent to 4,800 beds but achieved nearly 1,950 beds. NHS Improvement commented that reforms across the NHS had supported both emergency and elective care by freeing up capacity and improving flow.
- 2.20 NHS Improvement also reported that 3.3% of patients waited more than six weeks for 14 of the 15 key diagnostic tests against the standard of 1%. Four of the eight cancer waiting time standards were met. The total waiting list for planned hospital care declined since Quarter 2 2018/19 and providers started treatment within 18 weeks for more patients but performance was at 86.6% compared with the standard of 92%.
- 2.21 Since the introduction of the Ambulance Response Programme in 2017, NHS Improvement had seen improvements in performance for the most seriously ill patients and most trusts were close to achieving standards on Category 1 calls but Category 2 calls remained a challenge for some trusts.

- 2.22 For mental health providers, NHS Improvement's data suggested the standard was being met on a first episode of psychosis being treated within two weeks of referral.

NHS workforce

Closing the Gap – Health Foundation, King's Fund and Nuffield Trust

- 2.23 The Health Foundation, King's Fund and Nuffield Trust published *Closing the Gap*¹⁹ which assessed the potential workforce effects of new service models in the NHS Long Term Plan. The report commented that NHS hospitals and mental health and community providers were reporting a shortage of more than 100,000 full time equivalent (FTE) staff and that one of the greatest challenges lay in nursing, with 41,000 nurse vacancies. The adult social care sector was also under pressure and faced many of the same issues as the NHS, with vacancies rising and totalling 110,000. The report proposed a "set of high-impact interventions that, if put into action now, could help to ameliorate the current workforce crisis". It focused on areas where severe national problems were having an immediate impact, particularly nursing and general practice.
- 2.24 The report highlighted that the training of new staff was a key route to supplying the staff that the NHS needed, but required significant financial investment and was not a quick fix. It advocated that the trend of falling national funding for education and training should be reversed immediately. Specific observations and proposals were: the NHS Long Term Plan's proposals on supply were either untested or, as yet, unfunded; the status quo looked unlikely to provide sufficient supply of staff to meet demand in the long term; further research was urgently needed on the impact of the removal of NHS bursaries; ensuring the funding and availability of clinical placements; reducing attrition during training; the number of students studying nursing should be substantially expanded and they should be exempt from tuition fees; and an increase in the maximum funding level and flexibility for apprenticeships.
- 2.25 The report included estimates and analysis of undergraduate nurse training based on Health Education England and UCAS data (Figure 2.1, page 9 of the report). The report commented that the figures for students starting a nursing degree with an English provider in 2014 should be treated with caution due to the limitations of the underlying data. The analysis suggested that there were over 57,000 applicants of which 22,000 (38%) were accepted and placed in training. Of those placed in training, 4,000 (19%) failed to complete the training programme. Of the 18,000 who successfully completed the training programme 14,000 (81%) joined NHS trusts, while the remainder entered primary, other health or residential care setting, or non-health work.
- 2.26 The report noted that the NHS Long Term Plan had set a target of improving the nursing vacancy rate to 5% by 2028. The report suggested that this target should be met by 2023/24 rather than by 2028. It recognised the invaluable role played by international staff in the NHS hospital and community services workforce. It concluded that they were the only realistic short term lever for dealing with current widespread vacancies and recommended that the NHS recruit an average of 5,000 international full time nurses a year to 2023/24. The report proposed a nationally funded, regionally-led programme to expand existing recruitment schemes, further action from professional regulators and the Royal Colleges to make the process easier, and all registered health professionals should be exempted from current restrictions on visas with the salary exemption guaranteed beyond January 2021.

¹⁹ Health Foundation, King's Fund and Nuffield Trust (March 2019), *Closing the Gap*. Available at: <https://www.nuffieldtrust.org.uk/files/2019-03/hea6708-workforce-full-report-web.pdf#page=133>

- 2.27 The report argued that pay should continue to at least keep up with inflation after 2020/21 and keep up with pay growth in the rest of the economy to help retention and morale among staff. For the future, the report recommended two areas for DHSC to consider in providing a remit to the Pay Review Body: (i) targeting pay to occupations and specialties with hard-to-fill vacancies, including targeted increases, loan write-offs and golden hellos, and providing a coherent recruitment and retention-driven pay framework; and (ii) identifying any areas that would require further harmonisation on pay and conditions when overcoming barriers to integrated working between acute and primary care and health and social care. In addition, the report made a series of recommendations on actions to make the NHS a better place to work and build a career, including those at different stages of an NHS career. It identified that retention was directly related to the leadership and culture of the organisation. People left because they felt overworked, underpaid, poorly treated, unable to deliver good care, and unable to progress.
- 2.28 On workforce redesign, the report observed that medical and technological advances meant that workforce policies needed to ensure the right mix of health workers, with the right skills, and providing services in the right places, to better respond to changing patient need. It recognised the blurring of traditional boundaries, team-based approaches and an expanded multi-disciplinary team, and maximising the opportunities offered by pharmacists, physiotherapists and support staff to take on significant amounts of work currently done by GPs. The report also pointed to use of new or extended roles, and nurses and AHPs acquiring additional skills. All these required a step change in the capability and capacity of local systems to deliver more effective and efficient care through service improvement.
- 2.29 The report included the Health Foundation's modelling on nurse staffing which suggested that, with concerted action now, it might be possible to eliminate shortages by 2028/29. The modelling was based on a significant expansion in the number in training, and reform to nurse training and NHS employment. The report estimated that these measures could result in an extra 54,000 nurses joining the NHS from nursing degrees and apprenticeships by 2028/29, and that new technology and productivity improvements could reduce demand by 8,000 FTE staff. The report indicated that, over the next 10 years, its proposed measures could result in a potential pool of nursing staff that exceeded demand. The modelling included high-level indicative costings that would add around £900 million in real terms to the annual HEE budget by 2023/24.
- 2.30 The report noted that the NHS had a significant potential "gravitational pull" on the social care workforce and recommended local systems to plan their workforce collaboratively with social care. The report commented that the social care sector had a major and growing problem with recruitment and retention, a significant cause of which was poor pay and conditions. It added that funding for the sector should be comprehensively addressed in the 2019 Spending Review and reformed in the longer term.
- 2.31 The report noted that the NHS Plan had recognised that the NHS now needed a comprehensive workforce plan to tackle staffing shortages, improve working lives and better utilise the talents and skills of staff. It considered that the workforce was the make-or-break issue for the NHS over the coming years. The report commented that day-to-day spending pressures had crowded out investment in the workforce and that this short termism had not served patients, staff or taxpayers.

Migration Advisory Committee

2.32 The Migration Advisory Committee (MAC) reported on the current patterns of European Economic Area (EEA) migration into the UK and the impact of EEA migrants on the economy and society of the UK²⁰. On health and social care, the MAC concluded that EEA migrants contributed much more to the health service and the provision of social care in financial resources than they consumed in services. EEA workers were an increasing share of the health and social care workforces though these sectors employed greater numbers of non-EEA migrants. The MAC also concluded that there was no evidence that migration had reduced the quality of healthcare services.

Our conclusions on the context for the AfC workforce

- 2.33 Overall, the NHS continues to operate under significant pressures with challenges from increasing demand and the need to transform services. Against this background, there appears to be consensus among NHS organisations, the UK Government and external commentators, that the challenges in delivering service change, through the NHS Long Term Plan in England, will require more productive systems, and an appropriately staffed and reconfigured NHS workforce.
- 2.34 To achieve workforce requirements, the five-year NHS funding settlement and the Barnett consequential for the Devolved Administrations would need to provide sufficient resource to deliver the necessary workforce development in the long term. In this respect we note, the NAO Report on NHS Financial Sustainability which concluded that existing transformation plans appeared to be stifled by the need to redirect available finance towards alleviating trusts' deficits.
- 2.35 The position on NHS finances and the prospects of funding workforce developments feed into our considerations of the affordability of AfC pay awards. We note that the NHS Long Term Plan aims for all NHS organisations to be in financial balance by 2023/24. Assessments of affordability include whether there is adequate funding for planned workforce developments, whether there are further proposed AfC pay developments, and the appropriate balance between staffing levels, pay and other priorities. While funding has been provided for the AfC pay agreement, we will wish to keep the financial position under review, including the parties' views on affordability during the period of the agreement.
- 2.36 The workforce gap is widely recognised as a leading challenge for the NHS. A Workforce Implementation Plan is expected to be published later in 2019. We have yet to see clear estimates of workforce demand, which assess requirements for services and transformation, NHS funding constraints and expected productivity improvements. If the NHS develops its workforce based solely on the projected financial limitations, it runs the risks of extending the existing workforce gap, which in itself discourages new entrants to the NHS, and increasing the struggle to meet service demands.
- 2.37 NHS organisations and external commentators recognise that the NHS workforce will need to be reconfigured. The new service models and integration with social care highlighted in the NHS Long Term Plan will require new NHS roles with wider responsibilities, improved career structures and pathways, and effective supporting pay arrangements. The AfC workforce will also need an enhanced range of skills to deal with patients with complex, multiple conditions and to operate in new settings. All these developments require adequate funding, both for new roles and reconfigured roles being supported by investment in training and development.

²⁰ Migration Advisory Committee (September 2018), *EEA Migration in the UK: Final Report*. Available at: <https://www.gov.uk/government/publications/migration-advisory-committee-mac-report-eea-migration>

- 2.38 Workforce developments will also need to address the longstanding issue of ensuring sufficient numbers of qualified people available and willing to work in the NHS. Action will be required to increase the number of pre-registration entrants, particularly to achieve DHSC's intended 25% increase in nurse undergraduate places and clinical placements for an extra 5,000 places in England given the recent trends in the number of applicants. Maintaining sufficient entrants to the NHS will also rely on further action on recruiting from EU and non-EU countries, and supporting the development of new roles and apprenticeships.
- 2.39 We recognise that the Devolved Administrations all have or are developing specific workforce strategies covering AfC staff. There are differences in the approaches, such as bursaries, workforce configurations, and skill mix, plus the variations in pay arrangements. The differing positions have resulted from government policy decisions in each country.
- 2.40 In conclusion, the views of NHS organisations and external commentators concur with our assessments on the most significant workforce developments relevant to our remit. Our focus is therefore on key workforce indicators such as overall workforce numbers, vacancies and shortages, entrants (including domestic, EU and non-EU, and new roles), retention and motivation. These indicators will form the basis of our future assessments against our standing terms of reference, and in monitoring the implementation and impact of the AfC agreements.

Chapter 3 – The Parties’ Evidence

Introduction

3.1 This chapter summarises the parties’ evidence as submitted between January and March 2019, including some extracts from our oral evidence sessions with the parties. It covers the main aspects of our standing terms of reference from pay policy, the economy and the labour market, NHS transformation, integration and productivity, through to specific AfC considerations, such as earnings, workforce, vacancies and shortages, supply and recruitment, retention, morale and motivation. The chapter concludes with the parties’ evidence on the AfC pay agreement. Our analysis of this evidence and other information is in Chapter 4 of this report.

UK Government pay policy, economy and labour market

- 3.2 The **Department for Health and Social Care’s (DHSC)** evidence included the UK Government’s position on public sector pay and its assessment of the economy and labour market as presented to all Pay Review Bodies. These included the economic indicators and forecasts available at the time of submission in January 2019.
- 3.3 DHSC reiterated that the UK Government’s public sector pay policy aimed to ensure that the overall package for public sector workers was fair to them and delivered world class public services which were affordable within public finances and fair to taxpayers as a whole. For the NHS, DHSC said that patients, and their experience of care, must be at the heart of everything that the system did to help ensure delivery of world class patient care, putting patients first and keeping them safe while providing high quality care. DHSC asked the Pay Review Bodies to have regard to that, as part of their standing remits. It emphasised the importance of ensuring the right balance between pay and staff numbers through systems of reward that were affordable and fit for purpose. NHS staff had told DHSC that they want the right number of colleagues working alongside them in hospital or in the community. DHSC stated that it would continue to focus on public sector pay reform to ensure that terms and conditions were fit for purpose, affordable and sustainable.
- 3.4 DHSC reaffirmed the UK Government’s longstanding aim to ensure that the NHS could recruit, retain and motivate sufficient high calibre staff to deliver government policy and ensure best value for the taxpayer. It added that it was a complex matter of judgement which included the overall impact of the NHS employment offer, pay and non-pay terms on attracting and keeping the staff the NHS needed.
- 3.5 On the general economic outlook, the UK Government’s evidence highlighted its view that:
- The UK economy had solid foundations and continued to demonstrate its resilience. Gross Domestic Product (GDP) had grown every year since 2010 and was forecast by the Office for Budget Responsibility (OBR) to continue growing;
 - There had been a sustained worldwide slowdown in productivity growth since the 2008 financial crisis. While UK productivity growth had improved since 2016, it remained below pre-crisis levels. The UK Government said that increasing productivity was the only way to boost economic growth and prosperity. The forecast for productivity remained subdued in the medium term but was expected to rise gradually to reach 1.2% per year by 2023;
 - Significant progress had been made in restoring public finances to health – the deficit had been reduced from a post-war peak of 9.9% of GDP in 2009/10 to 1.9% in 2017/18;

- Affordable pay awards would be an essential part of keeping borrowing under control – the public sector pay bill accounted for £1 in every £4 spent by the UK Government;
- Total employment reached a new record high in the three months to October 2018 and, in 2018, the unemployment rate had dropped to its lowest rate since the 1970s;
- Total nominal wage growth (including bonuses) rose to 3.3% in the three months to October 2018. A pick-up in productivity was vital for the recovery of cross-economy wage growth rates to pre-recession levels. Public sector (excluding financial services) and private sector total wage growth were above the current rate of inflation at 2.7% and 3.4% respectively; and
- Consumer Prices Index (CPI) inflation had fallen to 2.1% in the year to December 2018 and the OBR forecast it to be 2.0% in 2019. The appropriate level of public sector pay award was complex and rates of inflation were important but not the only consideration.

3.6 The UK Government said that public sector pay remained competitive and that public sector workers benefited from wider Government measures to support wages, such as the introduction of the National Living Wage and income tax changes. It said that analysis by the Office for National Statistics (ONS) showed that, after controlling for various individual and job characteristics, on average there was a positive earnings differential in favour of the public sector, when pensions were included. The UK Government requested that, when considering changes to remuneration, the Pay Review Bodies should take account of the total reward package, including progression pay, allowances and pensions. On pensions, the UK Government considered that public service schemes continued to be among the best available and significantly above the average value of pension provision in the private sector.

3.7 The **Welsh Government** said the current economic conditions were broadly favourable in Wales and across the UK in that employment and output continued to increase. It added that the economic outlook was shrouded in uncertainty owing substantially to Brexit and weak productivity. It also said that the employment rate in Wales was below the UK average although the gap was small by historical standards.

Agenda for Change earnings and total reward

Earnings

3.8 **DHSC** provided an analysis of AfC staff earnings which, in summary, showed that:

- At April 2018, 43% of AfC staff were at the top of their pay band – 86% in Band 1 and 37% in Band 6;
- The reformed AfC contract would increase starting pay by between 13% and 23%, and the reduction in points within bands meant that staff would reach the top of the pay band by the 6th year of experience;
- Just under 1% of all non-medical staff received an RRP in the year to March 2018. Professionally qualified AfC staff, more senior AfC staff and staff in the South of England were more likely to receive an RRP;
- Earnings growth had been consistently lower for non-medical staff than the wider economy since 2011. For 2017/18, mean UK earnings growth in the Annual Survey of Hours and Earnings (ASHE) was 6.2% compared with 2.5% for nurses, midwives and health visitors (and a range of growth between 0.0% and 3.8% for other AfC groups); and
- Mean annual earnings growth for AfC staff was generally behind ASHE comparator groups between 2013 and 2017.

- 3.9 The **Joint Staff Side** estimated that average annual earnings among the AfC workforce had increased by between 2.1% and 9.3% between 2011 and 2018, compared with Retail Prices Index (RPI) inflation which had increased by 24% (also reaffirmed in individual unions' evidence). The Staff Side argued that the AfC pay agreement did not make up for lost earnings over the period of pay restraint since 2010. The Staff Side stated that it was committed to ensuring that pay rounds from 2021/22 onwards continued the process of restoring lost value and ensuring meaningful pay rises for all NHS staff. It also argued that it was important that the parties started to plan ahead for 2021/22 with a return to above-inflation pay rises.
- 3.10 The **RCN** said that average annual earnings among registered nurses had grown by just 8.1% and by 11.4% among the nursing support workforce between 2010 and 2018, compared to cumulative RPI inflation of 28.3%.
- 3.11 **Unite** said that while it supported the 2018 AfC pay agreement, it was clear that the deal was only a starting point to build on in future years. Unite considered that the agreement had not reversed the impact of eight years of pay caps and freezes in the NHS, and while the rises agreed upon were significantly higher than the 1% that had previously been offered, for staff at the top of their bands this was unlikely to amount to a real terms pay rise based on inflation projections. Unite added that the impact of the Government's long term pay policy had meant that dissatisfaction with NHS pay remained a serious concern.
- 3.12 Unite highlighted its survey of members and their concerns about relative pay, with 61% of staff saying that they were not fairly paid compared to equivalent jobs outside the NHS. Unite said that this was far higher for ambulance staff (81%), estates and maintenance staff (80%) and for the main nursing roles (over 70%). Unite said that its survey also highlighted increases in unpaid overtime and lack of flexible working, and that reductions in travel expenses and mileage, carers leave, Time Off In Lieu, and car allowances had all reduced take-home pay. Unite said that changes to wider terms and conditions were having an impact on staff and wider morale and motivation in the workforce.
- 3.13 **GMB** said that NHS workers' earnings had been severely eroded in real terms since 2010 and that this had had a serious and measurable impact on recruitment, retention, and workforce morale. GMB told us that against RPI, the trade unions' preferred measure of inflation, average real annual earnings in the NHS had fallen by an eighth since 2010, and, even on the Government's preferred measure of CPI, the real value in the NHS had declined by 7%.
- 3.14 The **RCM** said that it remained concerned that low pay in Northern Ireland would exacerbate recruitment and retention issues. It would continue to work with the other health and social care trade unions to achieve pay parity for staff in Northern Ireland and it was committed to UK-wide pay structures for the NHS.

Total reward and pensions

- 3.15 **DHSC** commented that its ambition for the NHS reward strategy remained that employers should develop their capacity and capability to: utilise the employment package to recruit, retain and motivate; develop and implement local reward strategies; improve staff understanding of their reward package; strengthen staff experience of working in the NHS; contribute to improvements in workforce productivity and efficiencies; and continue to be at the leading edge of innovation in public sector reward. DHSC had commissioned the Government Actuary's Department (GAD) to analyse total reward across various private sector occupations compared to NHS staff. GAD found that between 2012 and 2017 all NHS and private sector occupations experienced an increase in total reward. GAD's comparison showed the largest increase at 20% for a Band 6 nurse with 10 years' experience working outside London, and broadly similar increases in reward at around 4% for average midwives and a Band 5 nurse with one year's experience working outside London.
- 3.16 **NHS Employers** considered the multi-year pay agreement helped employers create an employment proposition which was modern, attractive and relevant. They provided information on further work on components of total reward as: designing specific methods of communication for certain staff; health and wellbeing programmes; buying and selling leave to gain more control over staff work/life balance; salary sacrifice schemes; and tax-free childcare. Compared with the previous year, NHS Employers reported that in 2017/18 there had been an increase of over 30% in the number of staff accessing total reward statements in the NHS.
- 3.17 The **Welsh Government** told us that total reward approaches varied across all NHS Wales organisations and that total reward statements were available to all staff via Electronic Staff Records (ESR). It said that a number of benefits were provided by all organisations e.g. access to the NHS Pension Scheme, childcare vouchers, and a flu vaccination programme. However, there were some organisational variations with different benefit in kind schemes being offered.
- 3.18 **DHSC** noted that between 2011 and 2018, the proportion of NHS staff in the NHS Pension Scheme increased by 5.1% and also increased in more recent years within the lowest pay bands. DHSC acknowledged the Review Body's 2017 recommendation that annual pay awards should not have unintended consequences of reducing take-home pay when crossing pension contribution thresholds. DHSC (and NHS Employers) reported that the NHS Pension Scheme's Advisory Board had reviewed the approach to member contributions, exploring several design elements, including whether to use full time equivalent (FTE) 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. DHSC confirmed that the Scheme's Advisory Board had recommended that the current contribution structure should be retained until 2021 but that further discussion was required on a number of areas, including the approach to avoiding "cliff edges".
- 3.19 **NHS Employers** remained keen to ensure that the NHS Pension Scheme was attractive to all staff across the workforce and that more flexible options might achieve this. They said that some employers had suggested that pension members could choose a level of pension contributions or benefits to suit their personal circumstances. NHS Employers added that membership of the NHS Pension Scheme was high and that, between 2011 and 2018, membership had increased by 4.4 percentage points. However, they felt that pension tax allowances continued to present real issues for staff and employers. Trusts said that staff were leaving the scheme, cutting down their hours or retiring/leaving early. Employers felt the scheme was becoming less attractive to high earners due to the impact of tax allowances.

Service transformation, integration and productivity

- 3.20 **DHSC** recognised that the NHS continued to face significant challenges with increasing demand for health services due to an ageing, growing population. It observed that demand for services provided in the health and care system continued to rise above what would typically be expected from population growth and demographics alone. DHSC said that the NHS was shifting the focus towards transformational changes, to help reduce the long term cost pressures on NHS services by helping staff to increase their productivity.
- 3.21 DHSC said that the NHS continued to deliver more activity than before as evidenced by growth in emergency admissions and elective treatments over the last six years. DHSC reported that, compared with 2016/17, the NHS managed just over half a million more A&E attendances in 2017/18, 3.8% more people seen by a specialist for suspected cancer and 528,000 more diagnostic tests.
- 3.22 **NHS Improvement** reported that it would be delivering a new model of joint working with NHS England to provide more joined-up, effective and comprehensive system leadership to the NHS. This would include a new people function responsible for NHS leadership and NHS people management. NHS Improvement was committed to working more closely with Health Education England to ensure the national workforce system was well-aligned.
- 3.23 **NHS Employers** told us that transformation of NHS services would require NHS organisations to operate at a system level and to work more closely with other public services. They felt that NHS services would need to change to make the best use of technology. Some new technologies would fundamentally change the way some staff worked and would lead to the creation of new roles, and the need to change and retrain the existing workforce. NHS Employers strongly believed that if the NHS was to be transformed the focus must be on the workforce, including looking afresh at the type of workforce and its skills sets. They considered that successful transformation would depend on how staff were treated and involved, with change more likely to happen if staff understood and owned it, and felt an integral part of the process.
- 3.24 NHS Employers said that the current direction of travel on transformation was towards a “place-based approach” to care organised around the needs of local populations and provided through devolved, pooled budgets and collaborative partners. They said that the success of the new care models would depend on experienced organisational leaders able to work across boundaries. NHS Employers also noted that staff in primary and community care services would need a broader skills and experience base to deliver care in new settings without reference to old traditional boundaries.
- 3.25 NHS Employers said that the ongoing separation between the health and social care systems was a major obstacle to achieving better outcomes for patients. They said that the NHS was working more closely with social care and local government, yet the integration of budgets and services would be essential to deliver place-based, personalised and whole-person care. NHS Employers said that there were complex legal and funding differences, and that the private sector was a major employer in the social care sector, with workforce costs a major factor for these employers.

- 3.26 In oral evidence, the **Joint Staff Side** told us that the NHS Long Term Plan highlighted a clear need for investment in the workforce to make productivity gains. They felt that much of the transformation agenda moving to new care models could not move forward without increased funding in supply, training and development, and pay beyond 2020/21. The Staff Side supported broad consensus on the strategy for health and social care. They highlighted that the integration of services could take many forms, integration of health and social care was one way but integrating primary, secondary and community health care was another. They considered that there needed to be more clarity on integration, particularly for social care where system integration was thought more difficult than employment. The Staff Side noted that the workforce implications for integration included portability of skills and qualifications, working across organisational boundaries, and employment arrangements. They added that lessons had been learned from past integration exercises and these were being factored into future planning.
- 3.27 The **Department of Health, Northern Ireland** pointed to its 10-year approach to transforming health and social care *Health and Wellbeing 2026: Delivering Together*²¹. The Transformation Fund, under the Confidence and Supply Agreement with the UK Government, was established and for 2018/19 had funded projects as follows: elective care waiting lists; primary care, including multi-disciplinary teams; reforming community and hospital services; investment in the workforce; building capacity in communities and prevention; and transformation enablers, such as co-production and quality. The Department added that work was ongoing on the profile for investment in 2019/20.
- 3.28 The **Welsh Government** told us there had been significant developments in Welsh Government policy which had influenced the future direction of health and social care service provision. It said that the *2018 Parliamentary Review of Health and Social Care*²² in Wales concluded that Wales needed “a different system of care” and set out ten high level recommendations to deliver the transformational change required. The Welsh Government had considered the Parliamentary Review and then published its long term plan for health and social care “*A Healthier Wales*”²³ in June 2018. It also informed us that a new organisation called Health Education and Improvement Wales had been established to improve the wellbeing of the people of Wales by building a health workforce that was able to respond effectively and agilely to their needs.

Productivity

- 3.29 **DHSC** commented that the AfC pay agreement was a “something for something” deal. It said that, in return for additional pay investment, reforms would help staff to increase their productivity and help to increase the number of staff available for patient care through a range of pay and non-pay reforms e.g. improved local appraisal and performance systems. DHSC observed that there was strong evidence that where the annual appraisal experience was positive, this could lead to better staff engagement and through that better outcomes for patients. DHSC said that the AfC pay agreement also committed employers to maintain staff health and wellbeing, helping to reduce sickness absence and increasing capacity for patient care.

²¹ Department of Health, Northern Ireland (May 2017), *Health and Wellbeing 2026: Delivering Together*. Available at: <https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together>

²² The Welsh Government (January 2018), *Parliamentary Review of Health and Social Care in Wales*. Available at: <https://gov.wales/review-health-and-social-care-wales-final-report>

²³ The Welsh Government (June 2018), *A Healthier Wales: our Plan for Health and Social Care*. Available at: https://www.ahcs.ac.uk/wp-content/uploads/2018/06/A-Healthier-Wales_-our-plan-for-health-and-social-care_English.pdf

- 3.30 DHSC reported that the measure of labour productivity it used for the NHS in England was developed by the University of York (Centre for Health Economics). This measure assessed a range of outputs and inputs adjusting the output measure to take account of quality change. DHSC said that the University of York's figures showed that between 2005/06 and 2015/16 (the latest available data) the NHS's average annual labour productivity growth was 2.5% (and at 1.3% for 2015/16). Over the same period, DHSC added that the University of York's figures showed that the NHS's average annual total factor productivity growth was 1.2% (and static for 2015/16). DHSC observed that, as part of the long term funding settlement, the NHS had committed to achieve cash-releasing productivity growth of at least 1.1% a year.
- 3.31 **NHS Improvement** said that a focus of its work on improving productivity was the clinical workforce, drawing on the Carter Review by reducing unwarranted variation in clinical workforce productivity across trusts. In 2018/19, NHS Improvement estimated efficiency savings linked to workforce productivity, resource optimisation and benchmarking through the Model Hospital were forecast to rise to £1.9 billion. NHS Improvement said that it had developed the Model Hospital tool to help providers understand workforce productivity metrics. This included cost per weighted activity unit, which reflected the amount trusts spent on staff per unit of activity. NHS Improvement commented that this data suggested that providers could still use their workforce more effectively to optimise their productivity. For 2017/18, it said that the NHS delivered workforce savings, with providers reporting £445 million recurrent Cost Improvement Programmes.
- 3.32 NHS Improvement said that it found it difficult to measure productivity at a detailed staff group level, due to the wider multi-disciplinary team's contribution to delivering care and other factors affecting productivity. However, NHS Improvement's annual collection of data on the clinical operational workforce would give an overview of providers' skills mix and competency-based workforce planning. NHS Improvement was working, with HEE, to transform the NHS workforce by helping providers to develop new roles, recognising the value of non-registered care staff in Bands 2 to 4, apprentices and nursing associates. It said that employers were also developing new roles, such as advanced clinical practitioners and specialist clinical practice, giving existing nurses and AHPs the opportunity to develop their skills and provide more expert service to patients. NHS Improvement had also published draft guidance on e-rostering and e-job planning. At July 2018, it said that 59% of the clinical workforce was deployed via an e-rostering system and 12% via an e-job planning system.
- 3.33 **NHS England and NHS Improvement** estimated that the total implied productivity of the provider sector at Quarter 2 2018/19 was 1.0%, constituting pay productivity of 0.8% and non-pay productivity of 1.4%.
- 3.34 In oral evidence, the **Joint Staff Side** said that significant productivity gains to date came from existing staff meeting higher demand. They noted that solving the problems in workforce planning and increasing the supply of staff could result in a fall in productivity, as more staff would produce the same outcomes and throughputs.

NHS affordability and efficiency savings

- 3.35 **DHSC** said that the Prime Minister had set out a new multi-year funding plan for the NHS setting the real terms growth rate for spending in return for the NHS's new Long Term Plan. DHSC confirmed that the NHS would continue to see real growth in its budget and over the next five years this would average real terms increases of 3.4%. DHSC said that this long term funding commitment gave the NHS the financial security to develop the NHS Long Term Plan and that the UK Government had set five financial tests to ensure the service was being put on a more sustainable footing. It observed that the NHS Plan set out the measures to support the most challenged organisations so that all NHS organisations were in financial balance by 2023/24.
- 3.36 DHSC said that, on average between 2013/14 and 2017/18, increases to the Hospital and Community Health Services pay bill accounted for 44% of the increases in revenue expenditure. It added that in 2017/18 the increase in total revenue expenditure was 3.6% and the increase in provider permanent staff expenditure was 4.6%.
- 3.37 DHSC pointed to the overall efficiency challenge set out in the NHS 10-Point Efficiency Plan, including: (i) the Operational Productivity Programme to reduce variation in clinical practice and improve management of resources following the 2016 Carter Review – in 2017/18 the programme delivered £1.45 billion efficiency savings; (ii) Getting it Right First Time driving quality and productivity improvement in over 30 clinical specialties; and (iii) other cost improvement initiatives, such as RightCare supporting commissioners to reduce unwarranted variations in care. DHSC said that total savings in 2017/18 were £3.2 billion through Cost Improvement Programmes and a further £3.0 billion through Quality, Innovation, Productivity and Prevention plans. Alongside these, DHSC reported that reducing spending on agency workers and increasing the use of bank staff represented a cost reduction of £1.2 billion over two years. In oral evidence, DHSC said that funding for staff development would be considered as part of HEE's budgets under the 2019 Spending Review.
- 3.38 **NHS England and NHS Improvement** told us that significant financial pressures remained with providers forecasting an aggregate financial deficit of £558 million for 2018/19. They said that the outlook for providers remained challenging due to rising demand, capacity constraints and the cost of agreed AfC pay awards. 2018/19 planned efficiency savings were set at £3.6 billion or 4.1% of total expenditure, and, at Quarter 2 2018/19, the forecast outturn was £3.4 billion or 3.8%.
- 3.39 NHS England and NHS Improvement said that the long term funding settlement for the NHS represented a step change on recent years and moved closer to the long term average funding trend of 3.7% per year since 1948. Putting the NHS back on a sustainable financial path included improving productivity and efficiency (achieving at least 1.1% productivity growth per year). They added that the extra spending would be needed for current pressures, demographic change and other costs, as well as new priorities.
- 3.40 **NHS Employers** said that they continued to experience one of the most financially challenging periods for the health and social care systems in the UK. They added that the financial outlook remained challenging even with the Government's long term financial settlement. While the investment was welcomed, NHS Employers felt that it fell short of requirements and would restrict the ability of the NHS to invest in the real transformation of NHS services. They also said that the restrictions on funding in social care had a negative impact on NHS services.

- 3.41 In oral evidence, **NHS Providers** welcomed the £20.5 billion additional NHS funding and said that the new NHS Long Term Plan provided an opportunity to make substantial progress. However, NHS Providers added that the continuing background was financial constraint and that the NHS Plan needed to cut through competing priorities and to take forward short, medium and long term priorities.
- 3.42 The **Welsh Government** told us its budget will be 5% lower in real terms, on a like for like basis, in 2019/20 than in 2010/11. It said that this was equivalent to £800 million to spend on public services and that a further investment of £94.6 million would be needed to implement the AfC pay agreement. Reports by the Nuffield Trust²⁴ in 2014 clearly identified the difficult financial challenges faced by NHS Wales and the Welsh Government had used the report's evidence and modelling in the development of subsequent Welsh Government budget settlements. The findings had been updated through the Health Foundation report in 2016²⁵.

Workforce strategies and workforce numbers

- 3.43 **DHSC** told us that the overall non-medical NHS workforce had increased by 69,587 FTEs (7.9%) between March 2013 and March 2018. It said that ensuring that the NHS had access to the right mix and number of staff with the skills, values and experience to deliver high quality, affordable care was a fundamental aspect of the Department's overarching strategic programme for the health and care system. DHSC commented that it worked with partners to ensure there was a highly engaged and motivated workforce delivering NHS services to patients.
- 3.44 DHSC said that it worked through its Arm's Length Bodies on the delivery and implementation of workforce policy. Building on recent, constructive joint work to develop workforce priorities for the NHS Long Term Plan, HEE, NHS Improvement and DHSC had agreed new joint working arrangements, for example to develop HEE's mandate. DHSC said that NHS England's and NHS Improvement's joint working included the creation of a People Directorate led by a new Chief People Officer. The Chief People Officer, working closely with HEE, NHS Employers and other national partners, would have responsibility for providing a cohesive approach to improving leadership and management of the NHS workforce. Additionally, HEE and NHS Improvement had measures to improve how both organisations worked together. DHSC said that effective workforce planning required reliable and accurate workforce information at national and local level. It said that HEE's national workforce planning for England was underpinned by data from NHS Digital and a comprehensive local workforce planning process. DHSC added that a sustainable approach to long term nursing supply was essential to workforce planning.
- 3.45 DHSC commented that the NHS Long Term Plan set out a vital strategic framework to ensure that over the next ten years the NHS would have the staff it needed. It said the Secretary of State had commissioned the Chair of NHS Improvement to lead a rapid and inclusive programme of work to set out a detailed Workforce Implementation Plan to be published in 2019. The Workforce Implementation Plan would focus on delivery, detailing what progress could be made on the commitments in the NHS Long Term Plan and would identify a series of actions to deliver on these commitments. DHSC added that the NHS Long Term Plan set out that the National Workforce Group would agree action to improve supply centred on increasing the number of undergraduate nurses, reducing attrition from training and improving retention, with the aim of improving the nursing vacancy rate to 5% by 2028.

²⁴ The Nuffield Trust (June 2014), *A Decade of Austerity in Wales?* Available at: <https://www.nuffieldtrust.org.uk/files/2017-01/decade-austerity-wales-web-final.pdf>

²⁵ The Health Foundation (October 2016), *The Path to Sustainability: Funding Projections for the NHS in Wales to 2019/20 and 2030/31*. Available at: https://www.health.org.uk/sites/default/files/PathToSustainability_0.pdf

- 3.46 **NHS Improvement** said that the NHS faced several workforce challenges including: insufficient training of UK professionals to meet growing demand; international recruitment remained lengthy and complicated with concerns about the impact of Brexit; loss of professional groups choosing to work abroad or leave their profession altogether; and education and training and service needs were misaligned. NHS Improvement added that the composition of the workforce was changing, with the development of new and advanced roles, which needed to be reflected in the workforce model.
- 3.47 NHS Improvement said that ensuring patients received appropriate care from a skilled professional in a timely way would include addressing domestic and international recruitment, attrition during training and retention post-qualification, over-reliance on temporary staff, and the unequal distribution of staff across geographical areas and specialties.
- 3.48 NHS Improvement considered that securing a workforce with the appropriate skills and deploying staff appropriately was critical to effective healthcare delivery. Correct staffing levels were crucial for realising optimal outcomes for patients and for maximising productivity. NHS Improvement recognised that current workforce spending exceeded the levels planned by providers, highlighting the difficult balance between affordability and workforce supply and demand. It added that tackling these problems required co-ordinated action across a range of organisations to improve supply, improve retention, improve leadership, culture and staff engagement, and improve productivity.
- 3.49 **NHS Employers** commented that workforce shortages were the biggest challenge the NHS faced. They said that the workforce pressures required a long term and sustainable workforce strategy and welcomed the imminent Workforce Implementation Plan. They felt that this plan must ensure that there was a clear link between any future service priorities and the workforce needed to deliver them. The NHS Employers Policy Board supported the following specific actions within a national workforce strategy: prioritisation of action in areas of greatest risk; a fit for purpose migration system and regulation for overseas recruits; reform of the apprenticeship levy; restoration of national CPD funding; and a sustained annual recruitment campaign. NHS Employers considered it essential that workforce costs were sustainable to ensure the NHS met the quality and transformation challenges.
- 3.50 **Health Education England (HEE)** said that the announcement of a long term funding settlement in 2018, alongside the work to develop the NHS Long Term Plan, had further reinforced the importance of ensuring that national, regional and local organisations were working effectively together to address workforce priorities. HEE told us that there had been some constructive joint work with NHS Improvement, NHS England and DHSC to improve how these bodies worked together on workforce planning processes. HEE commented that national workforce planning was challenging for a system as large and complex as the NHS. It considered that planning needed to take account of future finances and service redesign, while medical advances and changing patient needs and expectations added to the uncertainty of projections. HEE pointed to the 2017 development of the first NHS Workforce Strategy for 25 years which recognised the need for further co-operation at national level to ensure that the supply and development of staff were discussed and actions agreed.
- 3.51 **NHS Providers** said that it was disappointing that the national workforce strategy had been further delayed. They felt that the success of the NHS Long Term Plan and the sustainability of the NHS were reliant on having sufficient staff numbers, access and funding for training and CPD, and importance being placed on the culture and staff wellbeing.

- 3.52 In oral evidence, the **Joint Staff Side** said that there was much goodwill to increase the workforce but increased funding and capacity in the NHS was needed. They considered that achieving equilibrium on staff shortages needed to address supply, attrition rates for AfC graduates, career development, and health and wellbeing. They said that shortages took a toll on other staff, risking their retention.
- 3.53 The **Royal College of Nursing (RCN)** called for a clear and robust approach to gathering workforce data in order to ensure confidence in the implementation of the pay agreements and to support better understanding of workforce trends. The RCN said that there were more leavers than joiners to the Nursing and Midwifery Council (NMC) register and that the number of registered nurses in employment across all settings in the UK had dropped by 5.2% between 2016 and 2018. It added that the number of registered nurses, health visitors and midwives (FTE) in the four NHS systems across the UK had remained static between 2016 and 2017 while the nursing support workforce grew by just 2.2% and the whole workforce had grown by 2.3%.
- 3.54 The **Royal College of Midwives (RCM)** continued to recommend that the minimum staffing level for maternity units should be determined using Birthrate Plus which reflected the complexity of case mix and the number of births. It highlighted the significant reduction in Band 7 posts and therefore a detrimental impact on the attractiveness of midwifery as a career. The RCM also argued that the banding of maternity support workers (MSWs) at Band 2 was inappropriate (now the lowest band in the AfC pay structure) as they carried out delegated clinical tasks which did not match a Band 2 job profile. The RCM considered that if the NHS Job Evaluation Scheme was applied correctly these duties would attract a much higher level of remuneration and it was imperative that posts were correctly banded and MSWs remunerated appropriately. The RCM concluded that as the closure of Band 1 was monitored during implementation of the AfC pay agreement so should the inappropriate banding of MSWs.
- 3.55 The **Department of Health, Northern Ireland** said that plans were underway to establish oversight and implementation arrangements for its *Health and Social Care Workforce Strategy 2026*.
- 3.56 The **Welsh Government** commented on the need to maintain the quality of services to patients and to invest in the workforce wherever possible. Among other things it pointed to commissioning and implementing the recommendations of the Jenkins Review²⁶ of the workforce. It said that the provision of NHS services required the workforce to be sustainable in the face of a number of challenges. These included rising demand for care, the ageing population, multiple morbidities, and advances in technology and raised expectations of patients. As a result the workforce needed to adapt and look at not simply traditional roles but increasingly new flexible roles. It said that one of the latest challenges was the introduction of the Nurse Staffing Levels (Wales) Act 2016. The Act set out the steps to be taken to enable front line staff and managers to determine the right nursing establishment to meet the needs of the patients being cared for.
- 3.57 The Welsh Government said that the nursing and midwifery workforce in NHS Wales was relatively stable. While medical and dental, allied health professionals, and additional professional scientific and technical staff groups had steadily increased over a six year period, other staff groups such as healthcare scientists, and estates and ancillary staff had noticeably declined.

²⁶ NHS Wales Workforce Review (February 2016). Available at: <https://ruralhealthandcare.wales/resources/nhs-wales-workforce-review/>

Vacancies and shortage groups

- 3.58 **DHSC** said that NHS Improvement's data had shown the vacancy rate to remain stable over the last five quarters to the first quarter of 2018/19 – ranging from between 9.4% and 8.9%, which was equivalent to between 96,000 and 88,000 FTE staff. It said this was a new collection of data so changes in figures should be treated with caution. DHSC noted that bank and agency staff were typically used to fill these vacancies, in addition to covering sickness absence and long term leave. Approximately 90% of the 96,000 vacancies in Quarter 1 2018/19 were filled by a combination of bank (75%) and agency (25%) staff. It added that expenditure on agency staff fell by 18% in the year to 2017/18 and that for bank staff increased by 23% in the two years to June 2018. DHSC considered that staff banks ensured better quality and continuity of care. It said that 75% of nurses and midwives who worked a bank assignment also held a substantive contract.
- 3.59 **NHS Improvement, NHS Employers, NHS Providers** and the **Joint Staff Side** all highlighted NHS Improvement's June 2018 data that showed over 100,000 vacancies and over 40,000 FTE nursing posts unfilled with a nursing vacancy rate of 11.8% in England.
- 3.60 **NHS Improvement** said that there were significant staff shortages in some sectors (e.g. mental health), professions (e.g. nursing), specialties (e.g. emergency medicine) and geographies (e.g. rural and coastal areas). For registered nursing staff, NHS Improvement estimated that, even with the use of bank and agency staff, the combined total remained under plan by over 8,000 FTE. NHS Improvement added that it was leading the national programme to develop safe staffing improvement resources for specific NHS care settings. Its approach to safe staffing was based on using evidence-based tools, professional judgement and quality monitoring.
- 3.61 **NHS Employers** commented that staff shortages posed a substantial risk to the NHS's ability to sustain high quality care. NHS Employers and NHS Providers quoted the joint report²⁷ of the Nuffield Trust, King's Fund and Health Foundation and which identified a shortage of more than 100,000 staff and predicted that the workforce gap could reach 250,000 by 2030. They added from the report that this gap could be more than 350,000 by 2030 if the trend of leavers continued and the pipeline of newly trained staff and international recruits did not rise sufficiently.
- 3.62 **NHS Providers** said that at the second quarter of 2018/19 unfilled nursing posts had increased by 2,000 since the first quarter of 2017/18. NHS Providers commented that there was an urgency across the sector to address workforce shortages through immediate measures and long term sustainable solutions. Almost all trusts had reported to NHS Providers that recruitment and retention concerns were in their top three to five concerns. Trusts mentioned difficulties caused by a lack of supply, an ageing workforce and the slow pace of securing new employees.
- 3.63 The **Joint Staff Side** told us that the number of vacancies was forecast to increase further during 2019. They observed that due to high levels of vacancies, sickness absence and staff turnover, spending on bank and agency had increased by 11% in the year up to the second quarter of 2018/19. The Staff Side noted that the nursing vacancy rate in Northern Ireland was around 10% and no data were available for Wales.

²⁷ The Nuffield Trust, King's Fund and Health Foundation (November 2018), *The Health Care Workforce in England: Make or Break?* Available at: www.health.org.uk/publications/the-health-care-workforce-in-england

- 3.64 The **RCN** drew attention to the rising number of nursing vacancies across the NHS which, according to NHS Improvement, had risen by 9% to 41,722 between the first quarter of 2017 and the first quarter of 2018. It said that, of these vacancies, it was estimated that 80% were being filled by a combination of bank (64%) and agency staff (36%), leaving over 8,300 vacancies unfilled. The RCN noted that the vacancy rate had grown from 10.9% to 11.8% between 2017 and 2018. While no data was available for Wales or Northern Ireland, the RCN reported a 4.5% vacancy rate among the nursing workforce in Scotland.
- 3.65 The **RCM** told us that in England the NHS was short of the equivalent of 3,500 full time midwives. It said that, although the number of births continued to fall, this reduction was outweighed by changes in the complexity of care required by expectant mothers. The RCM also pointed to differences in complexity in Wales and Scotland.
- 3.66 The **Welsh Government** said that the overall nursing vacancy position remained challenging, particularly given the age demographic of the existing nursing workforce in Wales. It said that added factors on the nursing vacancy position were the impact of the Nurse Staffing Levels (Wales) Act coupled with the continuing uncertainty over Brexit.

Supply and recruitment

General

- 3.67 **NHS Employers** said that the demand for services was increasing faster than the increase in supply of staff and that it was not possible to respond rapidly to workforce gaps through training more people. NHS Employers considered that the following measures would help address supply: flexibility in the apprenticeship levy; a migration policy to attract and retain the workforce; new and effective national leadership for new roles; and sustainable new investment in CPD. They pointed to a range of actions with local communities to make their organisations employers of choice.
- 3.68 In oral evidence, the **Joint Staff Side** said that they were trying to work on supply areas they could control, including encouraging career opportunities in shortage areas, arguing for realistic apprenticeship offers and encouraging the retention of staff who had left for fixable reasons. They added that addressing supply for nursing required a longer term approach rather than what they viewed as the short term actions in the NHS Long Term Plan.

Pre-registration entrants

- 3.69 **DHSC** said that changes to the nurse education funding system had enabled universities to invest sustainably for the long term and increase student places to meet market demand. DHSC said that it was working with HEE and the university sector to ensure students continued to apply for the additional 5,000 nurse training places made available each year from 2018. DHSC was in the process of consulting with key stakeholders on the outcomes of changes to student funding, alongside work being done to ensure a sustainable approach to long term nursing supply, which would feed into the NHS Long Term Plan.

- 3.70 DHSC told us that bringing the funding of pre-registration nursing degrees and allied health courses into line with other undergraduate courses removed the “cap” of centrally imposed number controls and financial limitations, which a fixed envelope of Government funding for fees and bursaries represented. It explained that this change had allowed it to increase nurse training places by 25% from September 2018 and an increase of 3,000 midwifery places over the next four years, with 650 available this year. In support of this reform, DHSC had announced additional clinical placement funding to provide up to 10,000 placements, which it said would further increase the future supply of registered nurses and other clinical professionals.
- 3.71 DHSC said that having a nursing degree increased the probability of being employed compared to the average graduate and, once qualified, healthcare provided a wide range of career and development possibilities. DHSC commented that there was still strong demand for nursing courses, as 2018 UCAS data showed that there were still more applicants than places available. DHSC pointed to UCAS data which showed a 1.7% decrease in acceptances to nursing and midwifery courses, with 22,200 acceptances for 2018 compared with 22,575 in 2017.
- 3.72 DHSC told us that the Secretary of State had announced a “golden hello” payment for students commencing loan-funded postgraduate pre-registration nursing courses in 2018/19. These would be payable at £10,000 once graduated and going on to work in learning disability, mental health or district nursing.
- 3.73 HEE told us that the RePAIR (Reducing Pre-registration Attrition and Improving Retention) project²⁸ covered the four fields in nursing (adult, child, learning disabilities and mental health) along with midwifery and therapeutic radiography. It aimed to gain a better understanding of the student journey from pre-enrolment, up to two years post-registration. HEE said that the overriding message from the RePAIR Report was a positive one, in that 96% of students agreed that they had made the right decision in enrolling on their course. However, HEE observed that the study identified a range of factors which could affect the supply of newly qualified practitioners, including financial pressures, student confidence levels, and the importance of the clinical component which was heavily influenced by the clinical supervisor (or mentor) and the culture in that clinical setting. HEE noted that the RePAIR Report recommended what should be done system-wide to improve retention.
- 3.74 In oral evidence, the **Joint Staff Side** said that the removal of bursaries in England had fundamentally changed supply and had taken away one of the levers to meet supply needs and increased demand. The **RCN’s** written submission noted that applications to study for nursing were down by 9% in the UK between 2017 and 2018. The **RCM** welcomed the announcement from the Government to train an additional 3,000 midwives over the next few years. However, it said that the number of applicants to midwifery courses continued to fall since the abolition of the bursary, particularly from mature students. It also saw it as imperative that midwifery degree course places in higher education translated into jobs in the NHS.

²⁸ Health Education England (2018), *Reducing Pre-registration Attrition and Improving Retention*. Available at: www.hee.nhs.uk/our-work/reducing-pre-registration-attrition-improving-retention

3.75 The **Welsh Government** said that since 2014: nurse training places had risen by 68% with an increase across all four fields of nursing; health visitor training places had increased by 88%; and district nurse training places had more than tripled. It added that the 43% increase in midwifery training places from 2017/18 had been maintained. It told us that the first cohort of students from its increased investment would materialise in September 2019 and that it was imperative that these students were captured into NHS Wales employment. The Welsh Government argued that the NHS needed to continue to attract staff from across the UK and beyond. It said that the development of significant differences in pay, terms and conditions across UK could have significant undesirable impact on recruitment and retention in Wales. It added that fairness dictated that pay should align across the UK for those individuals fulfilling equivalent roles and to avoid unhelpful internal competition for staff.

EU and non-EU recruitment

3.76 **DHSC** said that the number of EU27 non-medical staff had increased by over 5,000 between March 2016 and March 2018. It added that they formed 4.8% of all non-medical staff on a headcount basis, and that nurses and health visitors formed the largest non-medical staff group for EU27 workers. At March 2018, DHSC observed that there were 20,787 nurses and health visitors from the EU27 but that the number had fallen by 243 since March 2016. Its own analysis suggested that the reduction in nurses and health visitors was more likely to be a consequence of more rigorous language testing for EEA applicants introduced by the NMC than the decision to leave the European Union.

3.77 DHSC said that its priority was to ensure that EU staff currently working in the NHS were not only able to stay but felt welcomed and encouraged to stay. DHSC would continue to monitor and analyse overall staffing levels across the NHS and adult social care, and it was working across Government to ensure there would continue to be sufficient staff to deliver services. DHSC noted that the Migration Advisory Committee's (MAC) review on the patterns of EEA migration to the UK had made recommendations for a future migration system. The MAC concluded that the UK should focus on enabling higher skilled migration coupled with a more restrictive policy on lower skilled migration in the design of its post-Brexit system. DHSC said it would continue to work with the Home Office to ensure that after the UK left the EU an immigration system would be in place which worked in the best interests of the whole of the UK. DHSC also said that the NHS could not rely on overseas recruitment alone and it had in place longer term plans to ensure the NHS had the right skills domestically.

3.78 **NHS Employers** commented that it would be challenging to meet workforce supply requirements without accessing labour and skills from outside the UK. NHS Employers had surveyed employers who believed that Brexit had had a negative impact on their workforce. They added that the Government's immigration proposals did not provide a long term solution to nursing and other professions.

- 3.79 In oral evidence, the **Joint Staff Side** pointed to the issue of Brexit and signs of a reduction in supply of staff from EEA areas. The **RCN's** written evidence pointed to research undertaken by the National Institute for Economic and Social Research (NIESR)²⁹ which showed that nursing staff from the EEA were being driven away due to uncertainty over their future rights in the wake of the Brexit vote. The RCN said that the number of EEA nurses joining the NMC register fell 32% from 9,389 in 2015/16 to 6,382 in 2016/17. Over the same period, there was a 55% increase in EEA nurses leaving the register, from 1,981 to 3,081. The NIESR Report estimated a potential loss of an additional 5,000 to 10,000 nurses by the end of the Brexit transition period in 2021. The RCN argued that these findings showed the pressing need for urgent action in workforce planning, the recruitment and retention of nursing staff, and a commitment to safe and effective staffing levels.
- 3.80 The **RCM** said that, despite more than 2,000 people per year graduating in midwifery, the period between September 2017 and September 2018 saw a net rise of the equivalent of just 117 full time midwives in England. The RCM said that since the Brexit referendum the number of midwives who had trained elsewhere in the EEA and registered with the NMC fell to just 33 in the year to March 2018.
- 3.81 **GMB** said that that one in 20 NHS workers were EU nationals and it was one in five in some Trusts. It commented that the long term impact of Brexit on labour supply was unknown but it had been widely reported that recruitment and retention had already been negatively affected. GMB told us that the Institute for Employment Studies had warned that Brexit could “have a significant impact on the nursing workforce in England, given that it is ageing and is increasingly reliant on the recruitment pipeline from Europe”.
- 3.82 The **Department of Health, Northern Ireland** pointed to its International Recruitment for Nursing as one approach to addressing nurse vacancies. It said that current forecasts indicated that 413 nurses would be recruited by March 2020 if market conditions remained unchanged, although there was the possibility of the original target of 622 being met. At December 2018, the Department reported 191 nurses in post – 17 from the EU and 174 non-EU. It added that there were ongoing challenges from global competition, more competitive salaries in England and the Republic of Ireland, visa delays, NMC approval delays, and the International English Language Testing System.
- 3.83 The **Welsh Government** said that the impact of the Nurse Staffing Act coupled with the continuing uncertainty over Brexit and the position of its European nurses, were an added factor to recruitment and retention.

²⁹ National Institute for Economic and Social Research (November 2018), *Brexit and the Health and Social Care Workforce in the UK*. Available at: <https://www.niesr.ac.uk/sites/default/files/publications/Report%20Brexit%20Health%20and%20Social%20Care%20Workforce%20-%20Full%20Report.pdf>

Recruitment of nursing associates

- 3.84 **DHSC** commented that the nursing associate role was one of many new roles emerging across the healthcare professions and was designed to improve patient care and form a valuable part of a contemporary multi-disciplinary workforce. It said that the role would 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 would undertake some of the duties that registered nurses currently undertook, enabling the registered nurses to spend more time on the assessment and care associated with both complex needs and advances in treatment. It said that HEE originally piloted the nursing associate role across 35 test sites, training 2,000 associates. HEE was leading a national expansion programme to train up to 5,000 nursing associate apprentices in 2018 and 7,500 in 2019. DHSC reported almost 3,000 nursing associate apprentices were enrolled on a programme as at November 2018 and that professional regulation with the NMC was now confirmed.
- 3.85 **NHS Employers** commented that the success of new roles hinged on regulatory practices that would enable the creation of new roles, training routes, and ways of working, while ensuring that the public was protected. NHS Employers noted that 82% of employers in their 2018 survey planned to feature nursing associates in future workforce strategies. They added that the NMC had published regulatory tools for when the first qualified nursing associates entered the system in January 2019. NHS Employers also highlighted that advanced clinical practitioners had been used across the NHS workforce for several years but there had been inconsistency in the deployment and governance of these roles.
- 3.86 In oral evidence, the **Joint Staff Side** noted that there had been 5,000 nursing associate starts in 2018 and retention rates during training had been over 80%. They observed that there had been co-ordination on this target at Sustainability and Transformation Partnership level and HEE had provided additional funding for supervision and support at trusts. However, they felt that a more consistent approach to pay and deployment of nurse associates was needed and that the skills mix of other Band 4 roles could be examined e.g. health care assistant and nurse assistant practitioners.

Recruitment of apprentices

- 3.87 **DHSC** told us that the NHS apprentice agenda was designed to support entry into careers in the NHS for people from all backgrounds. It said that apprentices were at the heart of an aspiration to provide careers, not just jobs for people working in the NHS. Apprentice career pathways were now open in nursing, healthcare science and to become a paramedic. DHSC said that, as part of the AfC pay agreement, there was a commitment to seek agreement on a new apprentice pay framework and that discussions in the NHS Staff Council would continue.
- 3.88 **NHS Employers** commented that there were challenges making the best use of ring-fenced funds, including the range of standards available, placement and supervisory capacity, and the cost of backfill. However, they emphasised that, despite these challenges, NHS trusts were using the apprenticeship levy to build career pathways, offer degree/higher apprenticeships, develop as training providers, strengthen leadership and management capability, build a key route for talent acquisition and management, and transfer surplus levy funds to other, smaller health employers. NHS Employers were concerned about the larger off-the-job requirement for nursing degree apprenticeships and their supernumerary time in the workplace. In oral evidence, NHS Employers said that apprenticeships needed to be a viable supply line for trusts. The increase in the proportion of trusts' workforces on apprenticeships would be driven by the need to grow their own workforce. NHS Employers said that some trusts had invested in setting up their own teams to run apprenticeship programmes.

- 3.89 In oral evidence, the **Joint Staff Side** were concerned that apprenticeships had been used to replace Band 1 and 2 posts. They pointed to anecdotal evidence from employers suggesting that the apprenticeship funding available was not sufficient to backfill posts. The Staff Side highlighted their research that had shown that many apprenticeship roles were in administrative or clinical support roles in Bands 2 to 4 and that many of these were on low starting pay rates. They said that the pay and deployment of apprentices was subject to the vagaries of decisions by individual employers and that freedoms on use of the levy was the only way to move to the strategic use of apprentices as part of the supply pipeline. The Staff Side commented that the NHS Staff Council's working group was looking at backfill funding, adequate rates of pay for apprentices and managing training time.
- 3.90 The **RCM** highlighted that the midwife apprenticeship standard had been approved, with the first degree students in 2019. The RCM argued that poor take up of nursing apprenticeships in Band 5 and above led it to believe that the 2019 midwifery apprenticeship programme would be subject to the same structural barriers around the levy and lack of funding to support salary and backfill costs. The RCM was disappointed to see a large number of apprenticeships advertised on NHS job websites on very low pay. It concluded that without additional funding it was difficult to see how apprenticeships could be a viable option to fill the NHS skills gap.
- 3.91 **UNISON** said that since the introduction of the apprenticeship levy there had been an overall decline in the numbers of apprenticeship starts in the NHS. This reflected the whole economy trend and the impact on the NHS of additional process requirements emanating from the levy system. UNISON said that many NHS organisations had found that they had to go through multiple procurement processes to select training providers. It observed that the early optimism that the majority of NHS organisations would be spending over half of their levy funds after the first two years had given way to a more cautious assessment.
- 3.92 UNISON made a series of observations on NHS apprenticeships as follows:
- The maximum funding bands set for key standards were widely viewed as falling short of the true cost to NHS employers of delivering the apprenticeships in practice e.g. for nursing associates HEE had given employers an additional £3,200 per trainee to top up the funding for training and support available via the levy (£7,900 for trainees working at least 50% of the time in a learning disability service);
 - The costs and capacity implications were greater than for the average employer because the NHS was currently so understaffed and over-stretched. A one-size-fits-all levy funding band system did not serve the particular needs of the NHS well;
 - Unless a comprehensive agreement on apprentice pay could be secured, this achievement would be rapidly undermined. Increasing numbers of employers were converting all Band 1-4 vacancies into apprenticeships and advertising them at apprentice pay rates below the AfC structure;
 - The NHS needed to develop large-scale degree apprenticeship programmes in nursing, allied health and other graduate occupations as a key plank of improving domestic workforce supply in response to the challenges of Brexit and the removal of the healthcare student bursary. There needed to be an attractive and consistent offer on apprentice pay, competitive with what was on offer in other parts of the economy; and
 - There should be a ring-fenced "National NHS Apprenticeship Fund" to associate the NHS with a gold standard of apprenticeship offer.

Supply of bank and agency staff

- 3.93 **DHSC** said the use of agency and bank staffing provided an indication of how the NHS labour market was operating. DHSC had signalled, along with NHS Improvement, an intent to make greater use of bank staff as an alternative to using agency staff for temporary staffing. An early focus included improving trusts' bank offers by providing bank staff with the ability to self-book shifts, using integrated technology, and providing prompter payment and pension flexibility for those shifts.
- 3.94 DHSC reported that trust spending on agency staff rose by 40% between 2013/14 and 2015/16 (from £2.6 billion to £3.7 billion). Following the introduction of agency spend controls, expenditure on agency staffing reduced to £2.9 billion in 2016/17 and £2.5 billion in 2017/18 (a fall of 18%). DHSC said that introducing measures to reduce agency spend only had maximum impact where trusts had a viable alternative temporary staffing solution. It considered that staff banks ensured better quality and continuity of care, while allowing the reduction of unnecessary agency spending.
- 3.95 **NHS Improvement** commented that substantive workforce gaps drove the use of temporary staffing and were a key factor contributing to high operational costs. It said that temporary staff were an expensive solution to staffing shortages and their overuse could compromise continuity and quality of care. NHS Improvement reported that agency spend remained broadly flat in the first half of 2018/19 compared with 2017/18 by providers reducing prices for agency shifts, while the number of agency shifts had increased by 8% compared with the previous year. It forecast that 2018/19 agency spending would be close to £2.4 billion, with a 14.7% reduction in expenditure on nursing staff and a 19.5% reduction for other staff.
- 3.96 The **RCM** told us that the results of their Freedom of Information request on NHS organisations' spending on agency, bank and overtime for midwives in 2017 showed an overall drop in spending in England of 17% from 2016/17. The RCM welcomed the reduction which was predominantly due to a reduction in agency spend. It noted from its survey that 65% of Heads of Midwifery still reported having to call in bank and agency staff very often or fairly often, with the most frequent times at weekends. The RCM told us that the NHS Staff Council was looking at bank and agency working as part of the AfC pay agreement and that a consistent approach to bank working should be taken, including better incentivising of staff to offer their own time to the bank (for example, by paying staff at the pay point of their substantive post for bank work). The RCM added that not all organisations in England which provided bank staff had applied the new pay rates under the AfC pay agreement from April 2018 and that the Pay Review Body should review the impact of this decision.
- 3.97 The **Department of Health, Northern Ireland** said that the supply of bank staff fluctuated at times during the year and across the region, particularly during holiday periods. The Department added that on occasion service staffing needs would be greater than the ability of internal supply to meet demand and that trusts would go to agencies for cover. The Department provided data which showed the rising agency costs within health and social care workforce groups over the last five years. In 2017/18, bank and agency spend increased to £156 million. The Department said that increasing costs were as a result of increased demand, junior doctors' vacancies, and wider recruitment and retention difficulties.

3.98 The **Welsh Government** told us that the reliance on agency staff had increased consistently in recent years and that it had taken proactive action to address the rising costs associated with agency staff and eradicate the use of off-contract agency in nursing. An all-Wales contract for agency staff in NHS Wales was introduced in 2017. The Welsh Government said that health boards and trusts were targeting agency and locum and associated cost individually, while working collaboratively to find all-Wales solutions. Examples of activity included: a communication campaign to encourage staff to sign up to bank and on-contract agency arrangements; a stronger focus on workforce planning; and proactive recruitment campaigns locally and in partnership with neighbouring health boards within the EU and globally.

Retention

3.99 **DHSC** informed us that leaver rates for nurses and health visitors, midwives, scientific, therapeutic and technical staff, ambulance staff and support roles to clinical staff had increased since 2010 in all regions. It said that ambulance staff had the lowest leaver rate at 7.9% in England at 2017/18 and that all other staff groups had a leaver rate of between 10% and 11%. DHSC noted that the Stability Index for non-medical workforce had not shown much variation in recent years with most leavers leaving through voluntary resignations, which had increased to 44% in 2017/18.

3.100 **NHS Improvement** said that ESR data indicated that the percentage of nurses leaving the NHS had gradually gone up from 6.6% in 2012/13 to 8.0% in 2016/17 but in the last year had reduced to 7.6%. However, NHS Improvement felt that these leavers cost significant amounts of money as well as affecting the quality and availability of services. It pointed to the turnover trend since 2012 showing a steady increase for all staff groups to 2016.

3.101 NHS Improvement provided information on its retention programme that included: a direct programme with support to all mental health trusts to improve clinical turnover rates, and also acute/community trusts to improve nursing turnover rates; a national retention programme, run by NHS Employers, focussing on specific retention drivers; retention masterclasses for HR Directors; and resources through a retention improvement hub. NHS Improvement said that it had seen a remarkable commitment from trusts and clinical staff at all levels to improving retention in their organisations. It reported that this commitment had enabled mental health trusts to improve national turnover rates of clinical staff from 14.3% to 13.5%, delivering 800 FTE additional mental health staff since the start of the programme. NHS Improvement added that the programme had helped drive a national improvement in nursing turnover rates of 0.5% in the first eight months, equating to around 1,000 additional nurses working in the NHS.

3.102 **NHS Employers** said that solving short term, urgent workforce issues meant that resources were not available to tackle long term complex issues around retention. They emphasised the need to retain the workforce to continue to provide high quality care. They said that high turnover forced trusts to turn to bank and agency staff but 8% of vacant shifts were still not covered resulting in greater pressure on remaining staff and increasing the possibility that staff would leave. NHS Employers identified three key retention areas: supporting new starters; greater use of flexible working and flexible retirement; and better career planning and development. They considered that the initial results of NHS Improvement's programme demonstrated that retention could be improved when trusts focused significant time, energy and resources. NHS Employers concluded that the nature of the retention challenge was complex and multi-faceted which would require a continued focus over a period of years if substantial improvements were to be made.

- 3.103 **NHS Providers** commented that staff retention added significantly to the challenges facing NHS trusts, with 5,000 more nurses leaving employment in 2016/17 than in 2011/12, and a net loss of 1,500 EU nurses and health visitors between 2017 and 2018.
- 3.104 The **RCM** pointed to the age profile of midwives in England, Scotland and Wales, where 32%, 39.8% and 34.5% respectively were in their 50s and 60s. It told us that midwifery was a physically demanding profession providing emergency care, operating a 24-7 service, working long shifts and undertaking on-call.

Recruitment and Retention Premia (RRP) and High Cost Area Supplements (HCAS)

General

- 3.105 **NHS Employers** said that they would support the Review Body in looking at the future of HCAS and RRP to support attraction, recruitment and retention. **NHS Providers** said that NHS trusts varied in their approach to local RRP and feedback was split with some favouring a national RRP system and others saying that they did not support the use of this tool at a national level. NHS Providers felt that it was essential for the provider sector to be consulted on any specific proposals to introduce national RRP and a national system would require careful consideration over appropriate incentive rates, types of role supported and affordability.
- 3.106 The **Joint Staff Side** said they would welcome the opportunity to explore national RRP. They said local and national RRP were an ingrained part of the AfC contract and added that the reduction in use of RRP was almost entirely as a result of a lack of dedicated funding. In reviewing RRP, the Staff Side said they would welcome the Pay Review Body's views on: clear and consistent criteria for the introduction and evaluation of national RRP; criteria for extending or winding up RRP; and additional funding to support national and local RRP, and the risks to the wider workforce of funding RRP from within the existing pay policy settlement.
- 3.107 The **RCM** said that recruitment and retention continued to be a concern as evidenced by the high number of vacancies particularly for Band 6 midwives. **UNISON** supported a general review of the evidence for and implementation issues involved in RRP. It noted that there were a variety of other occupational groups where shortages were particularly acute. **Unite** also requested that the Pay Review Body investigate the potential use of national RRP, where there was evidence to justify them.
- 3.108 The **Welsh Government** said it did not support the use of targeted pay to specific staff groups. It commented that although there were shortages of staff in specific specialties, evidence showed that these were UK-wide issues and related to the numbers of staff training in these areas, rather than the financial rewards. Where possible, Wales aimed to maintain parity with the other nations regarding pay and the Welsh Government wanted to see continuity of this approach as any deviations could create difficulties in recruiting staff across borders. It said the challenge of recruiting to particular specialties needed to be addressed through workforce planning, recruitment initiatives as well as changing the way roles were designed. It did not wish to consider the use of targeted pay until it had evaluated the impact of some wider measures designed to address the underlying causes of recruitment challenges.
- 3.109 The **Department of Health, Northern Ireland** told us that, under the NI Recruitment and Retention Framework, there were two long term RRP in place: a 20% premia to all non-engineering radiotherapy medical physics staff at Band 7 and above at the Radiotherapy Centre at Altnagelvin Hospital; and a 20% premia to staff working on the 1st and 2nd on-call rotas for histocompatibility and immunogenetics to sustain renal transplant services.

IT staff

- 3.110 DHSC said that it had been made aware of challenges NHS trusts were facing, in trying to recruit and retain IT staff. It understood that IT roles in the NHS had higher turnover rates compared to clinical roles and was working to establish a greater evidence-base in this area. DHSC considered that initial data suggested the issue was prevalent across the NHS. It said that qualitative evidence provided by NHS Employers suggested that trusts had struggled to recruit and retain IT staff. DHSC added that the IT profession appeared to be very different from clinical careers in the NHS and that vacancy data, provided by NHS Digital, showed that for the period June 2017 to June 2018 all NHS staff had a Stability Index of 88.4%, while senior IT staff at AfC Band 7 or above had a Stability Index of 78%.
- 3.111 DHSC told us that the evidence it had secured so far suggested that the recruitment and retention challenges were nationwide, but it was clear that the impact differed across regions. It said that NHS Employers' data suggested inconsistent benchmarking of IT roles, which meant some trusts lost IT staff to nearby trusts who benchmarked the same role at a higher AfC pay band. DHSC said that NHS Employers' survey showed that 14 of the 69 trusts responding, believed geographical location was a barrier to recruiting and retaining IT staff. The location of some trusts in rural regions or in areas a significant distance away from universities appeared to be a further barrier to their efforts to attract talent.
- 3.112 DHSC was working with Civil Service Pay and Reward to investigate the creation of an NHS version of the Digital, Data and Technology framework used to evaluate IT roles across the Civil Service. This could help establish a more accurate and consistent system for benchmarking IT roles in the NHS. DHSC said that it did not have data on IT roles with the highest vacancy and turnover rates, but that data from NHS Employers suggested high vacancy rates occurred at all AfC pay bands. DHSC reported that 38 out of 69 trusts in NHS Employers' survey said that they had recruitment and retention challenges for IT staff at Band 6 and above, and, of those 38, a further 22 trusts said recruitment and retention challenges occurred most acutely at Band 7 and above.
- 3.113 DHSC said trusts had the freedom to use local RRP though they might be reluctant to use these due to the cost pressure and the need for consistent review to ensure staff continued to receive equal pay for work of equal value. It also said that if one trust adopted a local RRP it was likely that others in the local area would be pressured to follow suit leading to inflated pay in the region without solving the problem. DHSC added that higher pay provided by a national or local RRP might still fall short of the salaries offered by the private sector.
- 3.114 DHSC said that it was reasonable to assume that, given the different working patterns of IT staff, consideration might be given to a bespoke reward package which better aligned to the experience of IT staff and the needs of NHS employers. DHSC would welcome views on the evidence so far and to understand if the current evidence-base was sufficient on which to make firm observations or recommendations.

- 3.115 **NHS Employers** noted that there were no current nationally agreed RRP for information technology and informatics roles. NHS Employers did not believe there was a case for RRP for these roles and that there were priorities elsewhere in the workforce. They felt that the broad range of diversity of NHS IT roles meant that the issues were complex and could not be addressed through pay alone. They added that there was already scope for local RRP to address specific local problems. Feedback from employers suggested that some were experiencing problems but that they rarely used RRP for these roles and NHS Employers believed there was scope to make more use of the full range of employment benefits. Some employers continued to engage self-employed specialists to work on specific, time-limited projects. NHS Employers highlighted a 2016 report for two Government Departments which estimated that the UK lacked about 40,000 IT specialists and around 72% of large companies suffered gaps in IT skills. The Migration Advisory Committee also included several IT roles on its Shortage Occupation List. Those employers experiencing recruitment difficulties in the NHS cited causes including: higher private sector salaries; limited numbers of potential candidates; location of the NHS employer; limited career development opportunities; and too few female candidates.
- 3.116 NHS Employers concluded that: more needed to be done across all sectors to address supply; a one-size fits all solution, such as RRP, would be unlikely to resolve the problems; local RRP might lead to unhelpful competition and destabilise the internal market; enhancing total reward, including training, would help; and longer term workforce planning and talent management must be a priority.
- 3.117 The **Joint Staff Side** would welcome clarity on what specific issues had been raised regarding an RRP for IT staff by this group of staff and by which organisations. In oral evidence, they added that IT was not a priority group for the Staff Side.

Northern Ireland nursing specialisms

- 3.118 In oral evidence, the **Department of Health, Northern Ireland** said that there were challenges addressing shortages in nurse specialisms. It observed that there was a need to look more widely at hard to fill posts and, while there was a Northern Ireland mechanism to agree RRP, it would welcome the Review Body's initial views on whether pay was a solution.
- 3.119 In oral evidence, the **Joint Staff Side** noted that there were shortages of nurses in most specialisms in Northern Ireland but no specific evidence for shortages in individual groups. They said that Northern Ireland had a local mechanism to decide on RRP.

High Cost Area Supplements

- 3.120 The **Joint Staff Side** told us that NHS trades unions were committed to reviewing High Cost Area Supplements, including both rates and zoning arrangements. They intended to resource a specific piece of work to develop future options to discuss with the full NHS Staff Council in advance of the next review round.

Motivation and engagement

- 3.121 **DHSC** said that the sickness absence rate had not changed materially since 2010 and was 4.19% for 2017/18 (including medical and dental staff). It informed us that NHS Improvement had committed to a target of reducing NHS staff sickness absence by 1 percentage point by 2020 and to the public services average by 2022. NHS Improvement was working with 73 trusts as part of its health and wellbeing collaborative. This identified and spread good practice, and encouraged the use of 10 evidence-based, high-impact actions, which were developed as part of NHS England's health and wellbeing framework.

- 3.122 **NHS Employers** supported employers to develop and foster staff engagement through the development of case studies and sharing of information, and NHS Improvement's culture programme tools. They said that organisations were continuing to focus on staff engagement with the Care Quality Commission, which had seen an increase in organisations rated by the CQC as "good" or "outstanding" for being well led.
- 3.123 **NHS Providers** highlighted data from the NHS Staff Survey and recent workforce statistics which painted a picture of significant pressures on staff satisfaction compounded by rates of pay, staffing levels, poor staff morale and work-related stress or poor work/life balance. Cuts to CPD funds had been a particular source of frustration for nurses and had impacted on their ability to maintain and progress their professional development. NHS Providers also commented that the RCN had reported that two-thirds of nurses said that they could not do their job properly due to understaffing. NHS Providers added that safe and effective staffing levels were crucial to maintaining morale.
- 3.124 NHS Providers said that trusts had reported other priorities in respect of recruitment, retention, morale and work/life balance as supporting flexible working, improving working conditions, and staff wellbeing. Trusts had told NHS Providers that they were developing programmes to address bullying and harassment of staff. NHS Providers recognised that staff engagement correlated to productivity, staff turnover and sickness absence. Feedback from trusts suggested that staff engagement had not been treated with serious concern among national leaders.
- 3.125 **NHS Improvement** said that improving culture and leadership in NHS providers supported recruitment, retention, workforce effectiveness and the quality of care to patients. NHS Improvement's support included tools and guidance to diagnose and address cultural issues and a professional development programme for aspiring leaders, with the NHS Leadership Academy transferring to NHS Improvement from 2019.
- 3.126 NHS Improvement had begun a health and wellbeing improvement programme in 2018 consisting of direct support as well as thematic system-wide interventions. The direct support programme included: working on health and wellbeing within the retention programme; identifying and providing intense support to trusts with more than six months of deteriorating levels of sickness absence, including all ambulance trusts; and working with trust leaders to develop positive and supportive workplace cultures. Thematic interventions centred on: line management skills development; board development; data quality improvement and data-driven decision-making; support to doctors in training; economic evaluation; cross-Arm's Length Body working; flexible working and flexible rostering; and absence management technologies. NHS Improvement had also undertaken work to better understand the AHP workforce, which identified the priorities as staff retention, workforce planning and transformation, and ensuring that the ESR adequately reflected the AHP workforce.
- 3.127 The **RCM** argued that flexible working and offering a variety of shift patterns and lengths were key to the recruitment and retention of midwives and MSWs, not only for older midwives but also those aged 35 to 44 who were likely to have childcare responsibilities. It said midwives in this age bracket were increasingly likely to leave the profession. The RCM told us that it was too early to tell whether the multi-year pay agreement had had any impact on morale and motivation of midwives and MSWs. It said that maternity units remained overworked and understaffed and relied on significant levels of goodwill.

3.128 The **Welsh Government** said it was committed to developing wider staff engagement discussions through its agreed social partnership arrangements in the Wales Partnership Forum. It had evaluated the impact of a range of measures to support and develop the workforce by commissioning regular national staff surveys, including combining the response to a number of questions to create an Engagement Index. The Welsh Government said that plans for a further survey were underway with results in autumn 2019 and that the survey would now be delivered annually. It considered that this would enable staff and managers throughout the NHS in Wales to have quality discussions about working conditions and opportunities for change and improvement. The Welsh Government also said that the health and wellbeing of NHS staff was identified by the Workforce and Organisational Development community as one of the key factors that underpinned performance at work, engagement within the workplace and sickness levels. Individual health boards and trusts were ultimately responsible for their staff wellbeing policies, although they met regularly to share best practice and discuss plans.

AfC pay agreement – implementation and impact

3.129 **DHSC** said that the three-year AfC pay agreement aimed to ensure every pound of the pay bill delivered value for money and was fair to patients, staff and the taxpayer. It also targeted recruitment, retention and capacity issues to support staff and help them meet demand within the NHS. DHSC considered that the agreement would help ensure that the NHS could continue to recruit, through targeting the lowest paid and investing in higher starting salaries, and to keep staff by guaranteeing fair basic pay awards over three years to those at the top of pay bands and faster pay progression for staff not yet at the top of their pay bands. DHSC added that capacity would be increased by employer commitment to staff health and wellbeing, and reducing sickness absence.

3.130 DHSC commented that NHS Improvement was leading the AfC Implementation Group, with the aim of ensuring governance structures and the development of key performance indicators helping local organisations to prepare their local implementation plans. DHSC said that NHS Improvement would advise it on progress and identify any areas of concern so that remedial action could be taken.

3.131 DHSC noted that additional funding for the agreement in 2018/19 would be met directly by the Department and thereafter NHS England was expected to return to the normal funding mechanism (the national tariff system). DHSC pointed to the eligibility criteria to receive funding with the aim to compensate organisations that must implement the agreement by employing staff on the AfC contract. It clarified that organisations not employing staff on the AfC contract had no such obligation but the Department was considering applications for additional funding from non-statutory, non-NHS organisations.

3.132 The **NHS Staff Council** provided a joint submission on implementation of the agreement. The Council identified priorities for the first year of the agreement as: pay progression; closing of Band 1 and the transition to Band 2 roles; apprenticeship pay; unsocial hours arrangements; and leave arrangements. The Council advised that:

- On pay progression, a new annex to the NHS Terms and Conditions of Service Handbook had been negotiated. Guidance on a revised national pay progression framework and supporting material were issued in January 2019. These will apply to new starters and promotees from 1 April 2019, with existing staff remaining on current arrangements until the end of the agreement;

- On Pay Bands 1 and 2, an agreement on transitional arrangements was reached in January 2019 which required employers by 1 April 2019 to provide Band 1 staff with the information to make a choice on moving to Band 2. The choice exercise could go on through 2019/20 with work to support employers in reviewing job descriptions and ensuring that the necessary staff training and development was in place;
- On apprenticeship pay, there had been further negotiations on graduate pay, postgraduate pay and Bands 2-4. However, funding constraints and the lack of levy funding flexibility to support backfill costs was making it very difficult to reach an agreement;
- On unsocial hours, new arrangements were in place from September 2018; and
- On leave, an agreement had been reached on enhanced shared parental leave and further work was progressing on a contractual entitlement to child bereavement leave for April 2019. Negotiations were continuing on buying and selling annual leave for implementation in April 2020.

3.133 The NHS Staff Council also advised that its priorities for 2019/20 will be guidance on taking Time Off In Lieu and exploring a bank/agency framework. There would also be a review of monitoring data to ensure implementation, including any equality impact, and identifying refinements to the pay structure post the three-year agreement.

3.134 **NHS Employers** said that the NHS Staff Council had mitigated the risks and achieved a balanced and pragmatic approach in reaching a comprehensive agreement on pay and conditions, which achieved medium term stability and longer term impact. NHS Employers added that the support and endorsement of the Review Body to the refresh of terms and conditions of service was acknowledged by employers to be genuinely helpful in supporting wider system strategic objectives. Employers commented that pay must always be considered in the context of long term objectives, the future system and service operating model, and the supporting reward and workforce strategies. NHS Employers would support the commissioning of independent research for a wider, longer evidence-based discussion when the current multi-year pay deal ended.

3.135 On pay progression, **DHSC** said that productivity would be improved through ending virtually automatic incremental pay, and replacing it with less frequent increases subject to meeting the required standards and supporting staff to develop skills and competencies. **NHS Employers** set out the next steps on progression as: training and development for line managers; reviewing and amending current performance management and appraisal systems; development of a pay step form/checklist; and continuing communication with staff. NHS Employers said that the new progression system allowed employers to promote a focus on staff development and training during appraisals. **NHS Improvement** reiterated that the salary restructure was linked to the requirement to implement a non-automatic, pay progression system, which strengthened the mandatory appraisal process and so made the greatest possible contribution to patient care.

3.136 The **Joint Staff Side** commented that useful discussions had taken place to support the pay progression component of the pay agreement. In oral evidence, the Staff Side felt that the new appraisal process was critical to the implementation of the agreement and that the NHS Staff Survey suggested more work needed to be done on the quality of appraisals as this varied between trusts. They said that there was more at stake in appraisals now and that the process would force a change in culture between manager and job holder. They noted that staff operated in teams in the NHS, but that appraisals and links to pay would be for individual AfC staff. The Staff Side commented that the first pay decisions arising from the new arrangements were two years away.

- 3.137 The **RCM** said that the pay progression of staff subject to the new appraisal process (from April 2019) should be stringently monitored and equality impact assessed to ensure midwives and maternity support workers were not unfairly held back from progressing to the next pay step. It said that there was worrying evidence about the number of staff not having an appraisal, cuts to training budgets and time off for staff to attend training. The RCM was concerned that only 37% of Heads Of Midwifery were able to conduct appraisals with all their staff once a year. It said that midwifery managers should also be trained and supported to carry out supportive and developmental appraisals with their staff.
- 3.138 **NHS Improvement** commented that the three-year pay agreement intended to provide a graded salary increase across bands linked with addressing recruitment and retention issues. On the key pay reform issues and priorities, NHS Improvement said that work was underway to identify trusts needing support to implement the closure of Band 1, including the financial requirements of the transition and not disadvantaging individuals (e.g. affecting universal credit). It noted that the development of an apprentice pay offer would help grow the workforce to meet both current and future requirements.
- 3.139 **NHS Providers** welcomed the AfC pay agreement and the headline pay increases as an important step in improving the working lives of staff. They welcomed the Government's pledge of new funding which had, to some degree, mitigated affordability concerns around pay for NHS trusts. However, NHS Providers found the 2018/19 allocation to be insufficient because of changes related to the workforce baseline used and a failure to capture staff working for trust sub-contractors or in NHS wholly-owned subsidiary companies, and agency staff whose salaries were linked to AfC rates. They added that DHSC would provide additional funding to cover sub-contractors where staff on AfC contracts had been transferred from employment in an NHS body to a non-statutory NHS sub-contractor but had retained the right to receive any future AfC pay uplifts or changes to other terms and conditions within their new contracts. NHS Providers also highlighted that funding was not covered for staff in new and vacant posts making it difficult to recruit and fill.
- 3.140 **NHS England and NHS Improvement** said that for 2019/20 the national tariff assumed an increase of 3.4% for the impact of the AfC pay agreement (plus 0.1% for pay drift) and 3.2% for non-AfC costs, which corresponded to 3.4% when weighted across all NHS staff. They confirmed that the tariff also included a further 2.1% increase to move the AfC top-up funding from being paid directly by DHSC into the 2019/20 tariff. The total pay increase in the tariff would be 5.0%. They also said that the NHS received funding from other organisations for staff with AfC contracts, which had yet to have their funding settled, and that uplifts failed to fully reflect the AfC pay award creating additional cost pressures.
- 3.141 The **Joint Staff Side** said that the lifting of the pay cap and the commitment of £4.2 billion investment by the UK Government were a major step in the right direction towards fairer pay and improved recruitment and retention. The Staff Side considered that they were able to secure the structural reforms to the AfC framework that they had long argued for. The Staff Side noted that they were able to agree shared aims with NHS Employers to pay above the living wage, supporting the attraction and recruitment of new starters, as well as for retention, health and wellbeing, and improved engagement of existing staff. The Staff Side said that they were committed to supporting and growing the number of apprenticeships in the NHS and developing new training pathways. They were also committed to ensuring that the agreements were fully implemented, monitored and evaluated over the next three years and that all members received what they were due.

- 3.142 The Joint Staff Side commented that, for the purposes of monitoring the agreement, it was vital that all NHS organisations collected relevant information and made it available to all parties in advance of each evidence round, even if the same information was used for regulation purposes. They said it would be helpful for representatives of the Electronic Staff Record teams in England and Wales to work closely with the NHS Staff Council on data collection and how it could support implementation of the AfC pay agreement.
- 3.143 In oral evidence, the Joint Staff Side commented that there was a willingness among the parties in Northern Ireland to reach a similar three-year pay agreement to the one in England. However, it said that the political situation in Northern Ireland was hampering progress and that the difference in AfC pay with other UK countries was creating problems for recruitment and retention in Northern Ireland trusts.
- 3.144 **Unite** remained extremely worried by the fragmentation of AfC as a result of the pressures from political devolution, Government under-funding, and the impact of outsourcing of NHS staff and services. It added that recent moves by trusts to transfer staff to subsidiary companies were just the latest example of the ongoing erosion of the national AfC agreement.
- 3.145 **GMB** reported that an overwhelming majority (98%) of its NHS members believed that increases under the pay agreement were not high enough. GMB also said that it was likely that earnings would continue to be devalued in real terms over the next three years, especially for staff at the top of their pay bands.
- 3.146 The **Welsh Government** said the AfC agreement had made a commitment to developing and implementing a new approach to attendance management in Wales by September 2018. It said that the policy would provide a greater emphasis on the prevention of illness by improving staff health and wellbeing, as well as improved arrangements for returning staff to work after illness. The current Sickness Absence Policy had been reviewed and approved for implementation by the Welsh Partnership Forum. The Welsh Government commented that the effective implementation of this policy had been a key element in addressing attendance at work and supporting a real reduction in sickness absence levels across NHS Wales.

Ambulance staff

- 3.147 **GMB** said the erosion of earnings had been most dramatic in ambulance services, where staff earnings had fallen by a fifth between 2010 and 2018, when adjusted for RPI, and had barely increased in cash terms. It reported that ambulance staff were specifically concerned about the closure of Annex 5 terms for unsocial hours payments to new entrants, as on average 28% of ambulance staff earnings were non-basic earnings with shift payments the most significant component. **Unite's** survey of members found that the highest proportion of staff that felt they were not fairly paid compared to equivalent jobs outside the NHS was ambulance staff at 81%.

Chapter 4 – Agenda for Change Staff in the NHS – Our Analysis of the Evidence

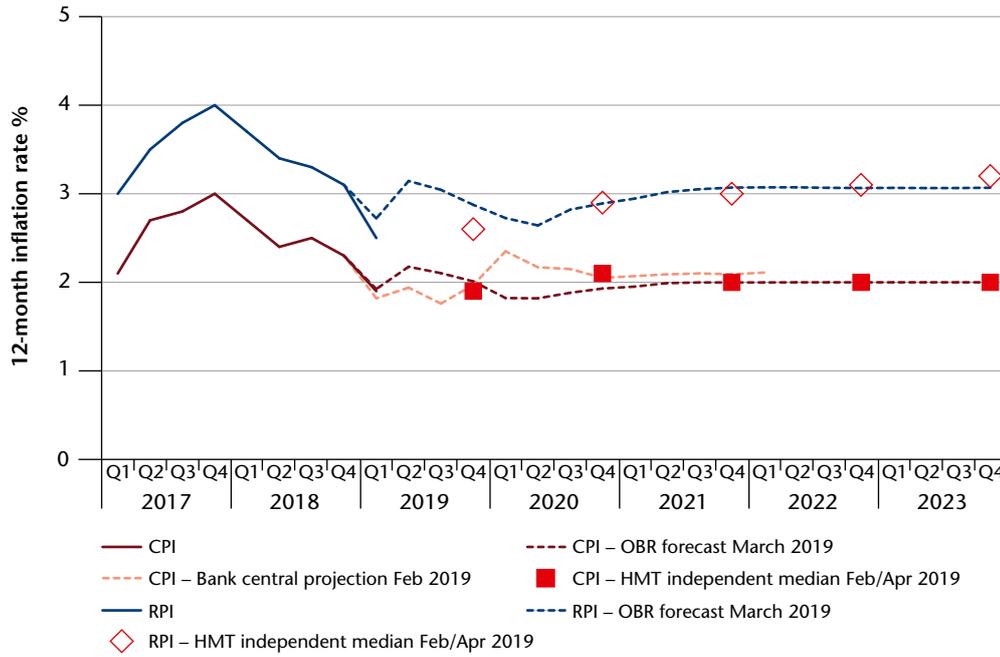
Introduction

- 4.1 In this chapter we set out our analysis of the evidence as it relates to our standing terms of reference. We draw conclusions on current economic and labour market conditions, AfC earnings, workforce, supply, retention, and motivation and morale. In doing so we supplement the parties' evidence with the latest economic, earnings and workforce data available to us to enhance the evidence-base. Our conclusions in this chapter also set out key leading and lagging indicators that will allow us to monitor the implementation and impact of the AfC pay agreement.

Economy and labour market

- 4.2 We examine a range of the latest and forecast economic and labour market indicators in reaching our conclusions. The data on GDP provide a measure of economic performance which helps us assess overall public sector pay policy and affordability considerations. Measures of inflation, earnings and settlements help us assess the relative value and position of AfC pay.
- 4.3 GDP growth was estimated to have been 1.4% in 2018 overall, the lowest calendar year growth since 2012, with the quarterly growth rate slowing to 0.2% in the fourth quarter of 2018. In the first quarter of 2019 the Office for National Statistics (ONS) estimated GDP growth to have increased by 0.5%.
- 4.4 In its Inflation Report of February 2019, the Bank of England said that this slowdown mainly reflected softer activity abroad, and the greater effects from Brexit uncertainties at home. It expected quarterly GDP growth to recover later in 2019, with four-quarter growth rising to 2% in 2021. The projections were conditioned on a relatively smooth Brexit at the end of March 2019, and a subsequent smooth adjustment to the average of a range of possible outcomes for the UK's eventual trading relationship with the European Union.
- 4.5 Inflation figures at March 2019 put the CPI rate at 1.9%, having fallen steadily from a peak of 3.1% in November 2017. The RPI rate of inflation was at 2.4% in March 2019, down from a peak of 4.1% in December 2017. Consumer Prices Index Housing (CPIH) inflation was at 1.8% in January 2019. All measures of inflation fell in January 2019 as energy and fuel prices fell, with the rises of a year earlier falling out of the 12-month comparison. In its March 2019 Report, the OBR expected CPI inflation to dip from 2.1% in 2019 to 1.9% in 2020, returning to the 2% target thereafter.

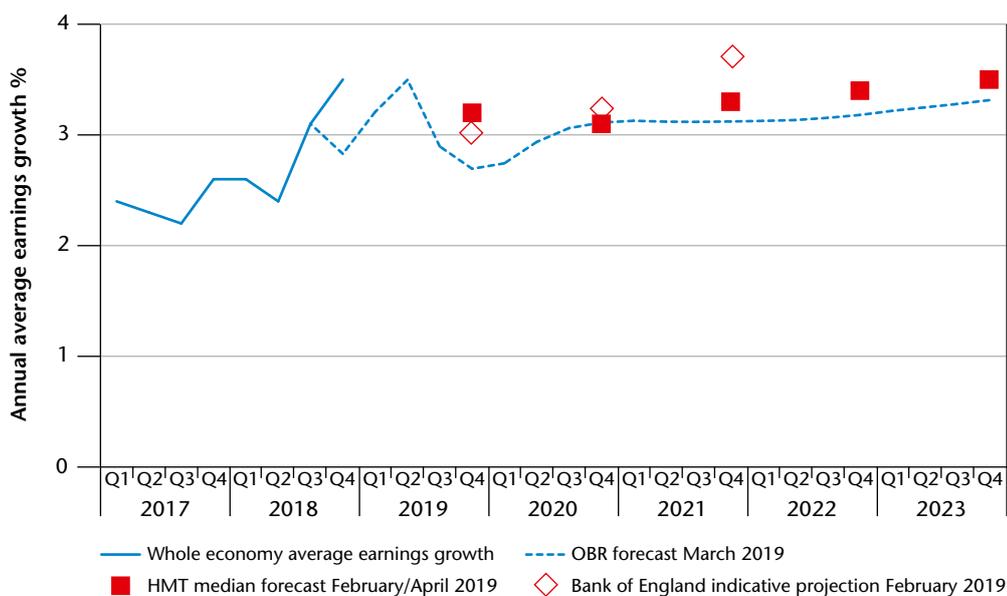
Figure 4.1: CPI and RPI forecasts, 2017 to 2023



Source: ONS, CPI (D7G7), RPI (CZBH), quarterly, not seasonally adjusted, UK, Q1 2017-Q1 2019; Bank of England Inflation Report, February 2019; OBR, March 2019; HM Treasury February/April 2019.

- 4.6 ONS data indicated that whole economy average weekly earnings growth was at 3.5% in the three months to February 2019, the highest rate since July 2008. Public sector average earnings growth (excluding financial services) was at 2.6% in February 2019, having reached 2.9% in September 2018, the highest rate since August 2009.
- 4.7 The pick-up in earnings growth and lower CPI inflation meant that earnings growth adjusted for inflation had been positive for the last year, picking up to 1.6% in the three months to February 2019. This followed a period of falling wages adjusted for inflation in 2017. The level of average regular earnings (i.e. excluding bonus payments) was still 1.7% below its spring 2008 peak adjusted for inflation, while average total earnings (i.e. including bonus pay) was 5.9% below the peak seen in the three months to March 2008.
- 4.8 The OBR expected wage growth to ease slightly in 2019, partly reflecting the continued roll-out of auto-enrolment into workplace pensions. The OBR forecast average earnings to rise gradually from 2020 onwards, reaching 3.2% in 2023, reflecting an expected modest pick-up in productivity growth in those years. Throughout the forecast period, average earnings growth adjusted for inflation was expected to remain well below the rates typical before the financial crisis.

Figure 4.2: Average earnings growth and forecasts, 2017 to 2023



Source: ONS, average weekly earnings annual three-month average change in total pay for the whole economy (KAC3), quarterly Q1 2017-Q4 2018, GB; Bank of England Inflation Report, February 2019; OBR March 2019; HM Treasury February and April 2019.

- 4.9 The median pay settlement, based on data from XpertHR, IDR and LRD, increased in 2018 to around 2.5%, having been close to 2.0% for over five years. The median private sector pay settlement was also 2.5% in 2018, while the median public sector pay settlement was 2.0%, according to XpertHR. Data for the first quarter of 2019 also showed a 2.5% pay review median. In a survey of private sector pay expectations for 2019, conducted by XpertHR and published in March 2019, private sector employers predicted a 2.5% median pay award for 2019, suggesting that the increase in pay awards seen in 2018 would sustain, but that there would not be a further pick-up for the next year.
- 4.10 The Chartered Institute of Personnel Development’s (CIPD) quarterly report³⁰ on the labour market for winter 2018/19 indicated that basic pay expectations in the private sector had risen for the first time since 2012. The CIPD said that after more than six years at 2%, the median basic pay increase expected in the private sector had risen to 2.5%. In the CIPD survey, key indicators suggested that there was increased pressure on recruitment, including an increase in the proportion of employers reporting hard-to-fill vacancies (from 64% the previous year to 71%). The CIPD noted that the ONS put the number of unemployed people per vacancy at a historic low of 1.6 and that this had been on a downward trend since 2011. Of the private sector employers with recruitment problems, the CIPD reported that 66% had raised starting salaries, up from 56% the previous quarter, and 62% were likely to raise starting salaries.

³⁰ CIPD (February 2019), *Labour Market Outlook: Winter 18-19*. Available at: www.cipd.co.uk/knowledge/work/trends/labour-market-outlook

Our analysis

- 4.11 We note the UK Government's assessment of the UK economy and labour market at the time of submission of evidence. Since then, and up to the time we submitted this report, the uncertainty around Brexit had continued to influence the performance of the economy. When the UK Government made its Spring Statement³¹, the latest OBR forecasts³² suggested weaker economic growth for 2019 of 1.2%, due to the worsening outlook both in the UK and globally, although the medium term GDP growth forecast was little changed at around 1.5% a year between 2020 and 2023.
- 4.12 The OBR suggested that the momentum in average earnings growth would be maintained, and forecast slightly higher average earnings growth by 2023, reflecting a modest increase in productivity growth. Median pay settlements were also increasing and the CIPD's survey suggested employers saw improved pay prospects. We note the forecast increase in average earnings growth picks up from 2021, the point at which the AfC pay agreement comes to an end.
- 4.13 The UK Government said in its 2019 Spring Statement that the three-year Spending Review would conclude alongside the autumn Budget. This could have significant implications for the AfC workforce as it would set the budget for Health Education England, which determines their education and development budget. We comment elsewhere in this report on the importance of funding for training and development as the critical support to progression arrangements as part of the AfC pay agreement and to the aspirations for workforce development in the NHS Long Term Plan for England. The Devolved Administrations will also need to consider funding training and development to meet their workforce strategies. In the longer term, workforce developments might be a contributing factor to achieving the five financial tests set by the UK Government, which focus on improving productivity and efficiency, eliminating provider deficits, reducing unwarranted variation in the system so people get the consistently high standards of care wherever they live, getting much better at managing demand effectively and making better use of capital investment.
- 4.14 Our analysis suggests that, while current economic conditions are uncertain, there are signs of a tightening labour market, as employment rates increase in the UK, and forecasts have been revised upwards for average earnings. These could have implications for AfC recruitment, retention and motivation. In these labour market conditions employers will make more significant efforts to attract new recruits including to attract those not in the labour market. We note that the report on *Closing the Gap* (see Chapter 2) emphasised the need to remove barriers to encourage staff to return to NHS employment. We will continue to review key indicators to inform considerations on AfC pay, given the potential uncertainties in the UK economy and labour market.
- 4.15 The data on the economy and labour market suggest there remain continuing differences in England between London and the South East and the rest of England. Taken together, the data on economic and labour market conditions in Scotland and Wales tend to reflect a similar picture to that for the rest of England (excluding London and the South East). We note the Scottish Government's different set of social care and health policies, which impact on its approach to public sector pay. The economic and labour market picture is different in Northern Ireland given higher levels of public sector employment, higher levels of economic inactivity and the relative position of AfC pay against the market.

³¹ UK Government (March 2019), *Spring Statement 2019*. Available at: <https://www.gov.uk/government/news/spring-statement-2019-what-you-need-to-know>

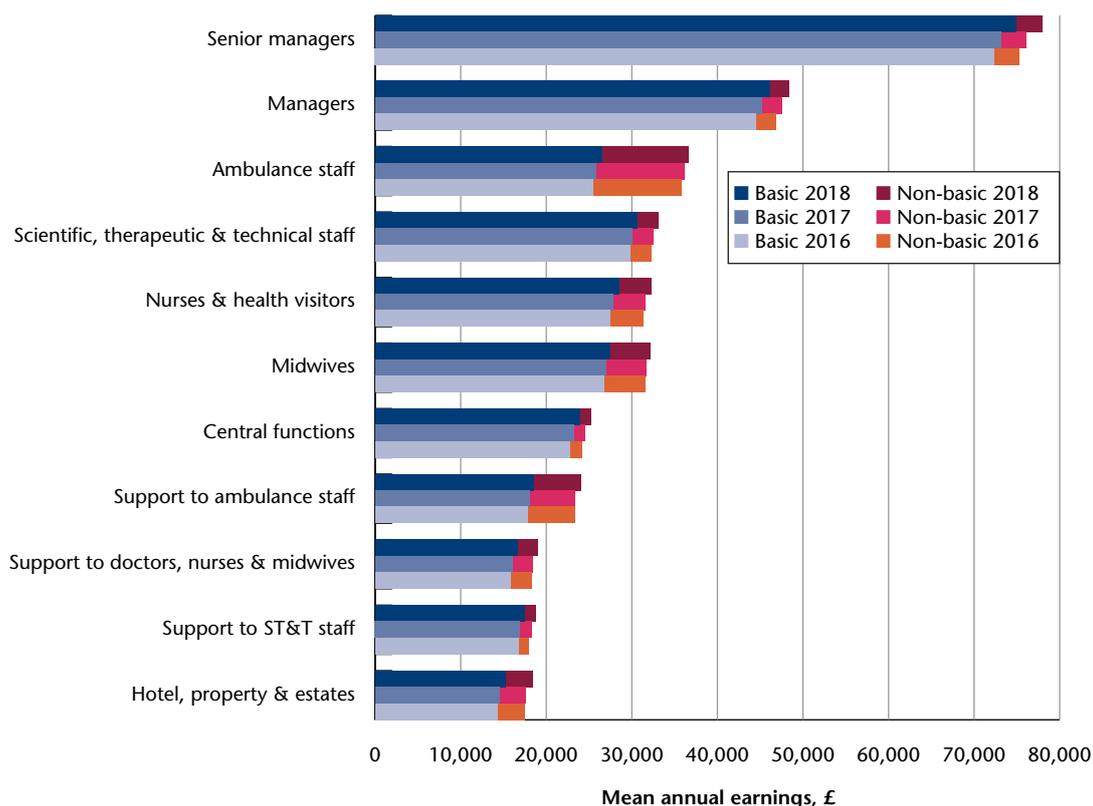
³² Office for Budgetary Responsibility (March 2019), *The Economic and Fiscal Outlook – March 2019*. Available at: <https://obr.uk/efo/economic-fiscal-outlook-march-2019/>

4.16 We note the Staff Side’s focus on both the recent period of pay restraint relative to inflation and the way in which inflation will influence their approach to AfC pay once the agreement has been fully implemented. We refer to our conclusions in our 2018 Report, that the use of different inflation measures reflects the different concerns of the Joint Staff Side and the HM Treasury. We will continue to report on both CPI and RPI measures of inflation, alongside the range of indicators across the economy and labour market that we have used consistently as part of the evidence-base for our pay recommendations.

Agenda for Change earnings and total reward

4.17 Earnings data for the calendar year of 2018, published by NHS Digital (see Figure 4.3), show that all AfC staff groups in England, compared with 2017, experienced growth in total earnings of between 1.3% (ambulance staff) and 4.2% (hotel, property and estates staff). All AfC groups experienced growth in basic pay of at least 2%. Support staff to doctors, nurses & midwives, support to scientific, therapeutic & technical, and hotel, property & estates staff saw basic pay increase by more than 3%. However, changes in additional earnings³³ were less uniform. Seven of the eleven AfC staff groups reported a fall in additional earnings of between 0.1% (scientific, therapeutic & technical staff) and 3.5% (managers). Increases in additional earnings were between 0.5% (nurses & health visitors) and 2.1% (hotel, property & estates staff).

Figure 4.3: Mean basic and non-basic salary per person by main staff groups, 2016 to 2018, England

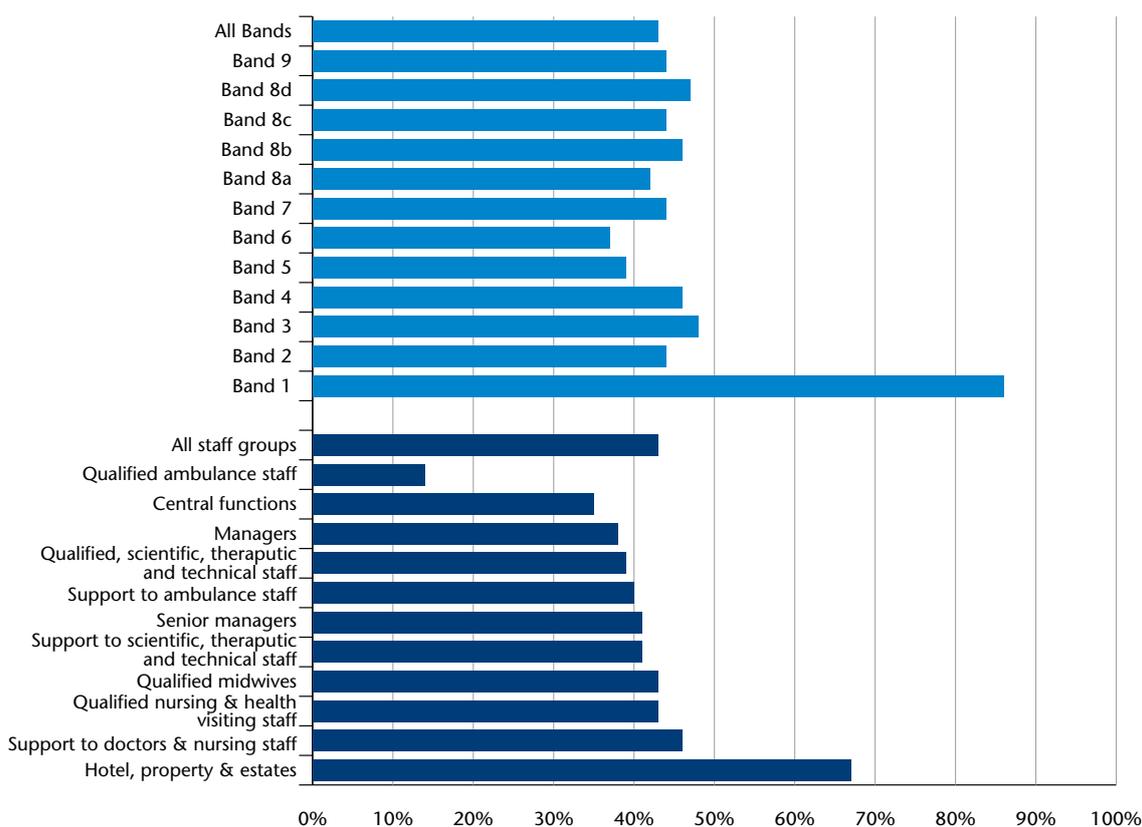


Source: NHS Digital

³³ Additional earnings includes payments for additional activity, geographic allowances, local payments, on-call, overtime, recruitment and retention premia, shift work payments, other payments.

4.18 As we noted in our 2018 Report, under the AfC pay agreement shorter pay bands and quicker progression could lead to a larger proportion of staff at the top of all pay bands for a longer part of their career. The lack of further progression opportunities could be demotivating, put pressure on the grading system and could influence retention. Career development incentives might be required to counteract the impact. We will continue to assess the position as the AfC agreement is implemented. In the meantime, Figure 4.4 shows that in England at April 2018 over 40% of AfC staff were at the top of their pay band. This was consistent across most staff groups, the exceptions being hotel, property & estates staff (67%) and qualified ambulance staff³⁴ (14%). The same applies across pay bands, with the exception being Band 1 (86%).

Figure 4.4: Estimated share of staff (FTE) on top of band by staff group and band, April 2018, England

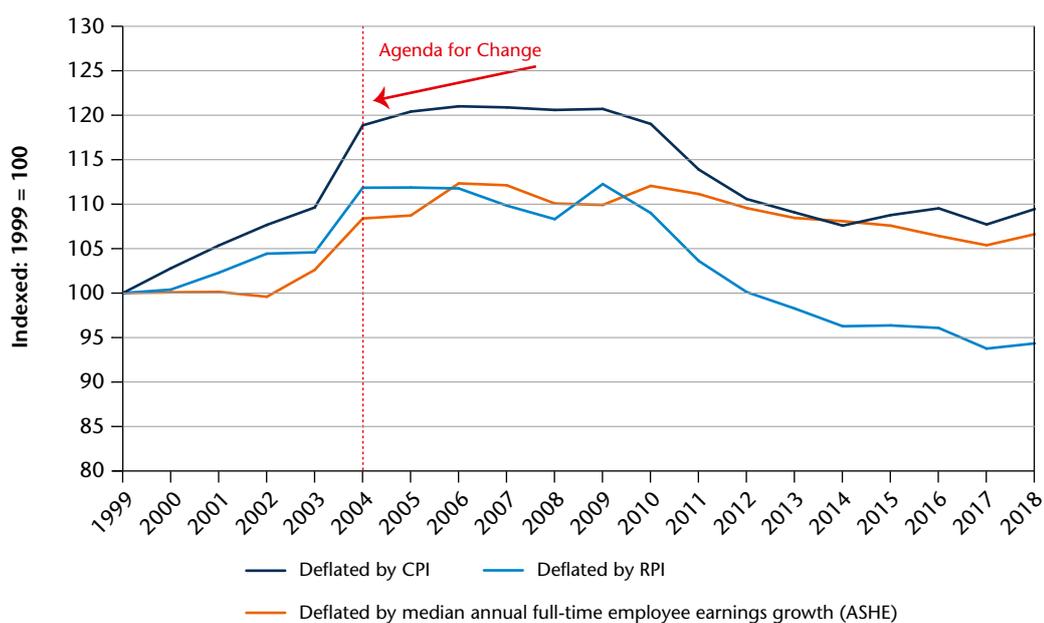


Source: NHS Digital, Provisional NHS Staff Earnings Estimates.

4.19 Figure 4.5 shows changes to the nurse starting pay point in England since 1999, adjusted either for inflation or earnings growth in the wider economy. The Figure shows the impact on nurse starting pay of the introduction of the Agenda for Change pay system in 2004, compared with both CPI and RPI measures of inflation and with earnings growth. Following the introduction of Agenda for Change the nurse starting pay point in England maintained its value against both inflation and average earnings growth until 2009, shortly after the financial crash. Between 2009 and 2017, the first point on the scale lost value, particularly compared with inflation as measured by RPI, and to a slightly lesser extent relative to full time employee earnings growth. The increase in value of the starting pay point for nurses contained in the AfC pay agreement for 2018 was greater than the recorded increase in inflation, and to a lesser extent, average earnings.

³⁴ A low proportion of qualified ambulance staff are at the top of their pay band. There was a rebanding of roles in 2016.

Figure 4.5: Nurse starting pay point deflated by average earnings and inflation, England, 1999-2018



Source: OME analysis of ONS data (Annual Survey of Hours and Earnings, CPI (D7G7) April each year, RPI (CZBH) April each year)

Pay comparisons

4.20 Data from the Annual Survey of Hours and Earnings (ASHE), in Table 4.1, show that median weekly pay in the human health and social work activities sector increased by 3.8% in 2018, a larger increase than that recorded for employees in the private sector and the economy as a whole. The level of pay in the human health and social work activities sector remained below that of all employees across the economy as a whole and that of other graduate-entry professions.

Table 4.1: Change in median gross weekly pay for full time employees at adult rates, 2016 to 2018, April each year, United Kingdom

United Kingdom	Median gross weekly pay (change on previous year)						Change 2016-2018
	2016		2017		2018		
Human health and social work activities sector	£510	(2.6%)	£510	(0.0%)	£529	(3.8%)	3.8%
All employees	£539	(2.2%)	£550	(2.1%)	£569	(3.5%)	5.6%
Public sector	£594	(0.7%)	£600	(1.0%)	£613	(2.3%)	3.3%
Private sector	£517	(3.4%)	£531	(2.7%)	£549	(3.5%)	6.2%
Professional occupations ^[1]	£726	(1.3%)	£733	(1.0%)	£746	(1.7%)	2.7%
Associate professional and technical occupations ^[2]	£591	(-0.2%)	£605	(2.3%)	£620	(2.5%)	4.9%
Administrative and secretarial occupations	£423	(2.0%)	£431	(2.0%)	£446	(3.5%)	5.5%
Skilled trades occupations	£497	(1.6%)	£510	(2.6%)	£525	(2.9%)	5.6%
Caring, leisure and other service occupations	£353	(3.4%)	£361	(2.4%)	£374	(3.4%)	5.9%

Source: ONS (Annual Survey of Hours and Earnings)

Notes:

[1] Includes, for example, teachers, solicitors, accountants, doctors and some AHPs and ST&Ts. Nurses and midwives are in this group from April 2011.

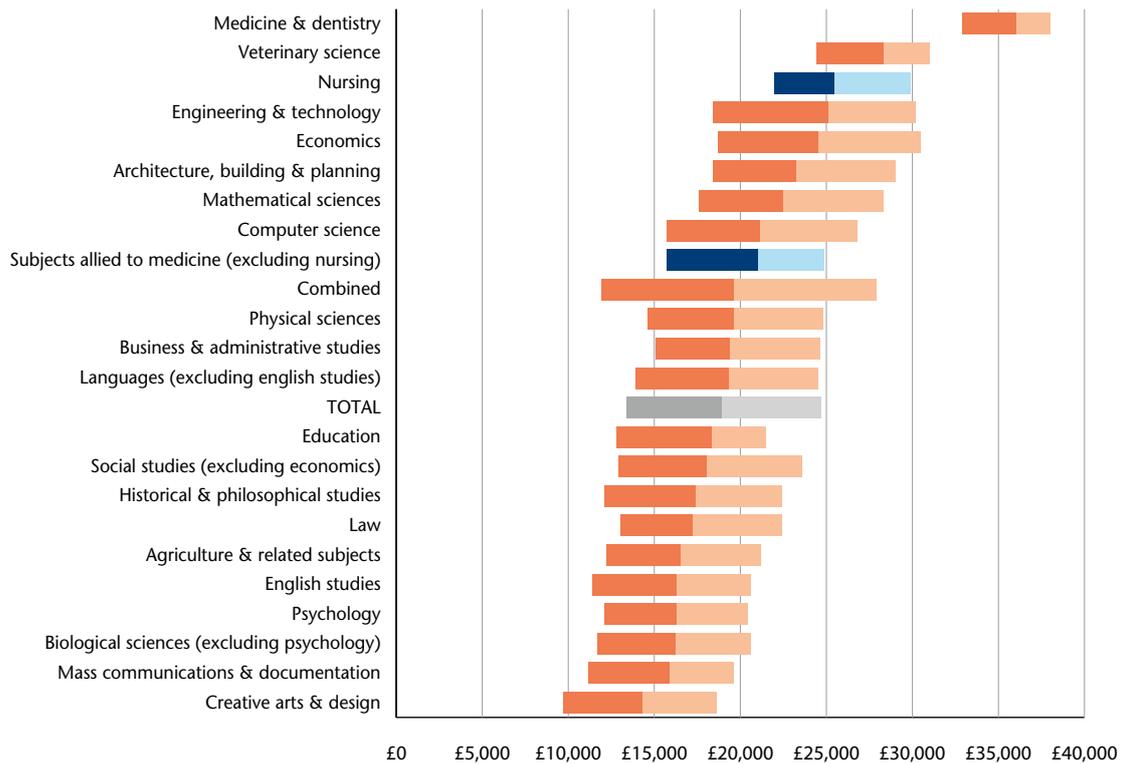
[2] Includes, for example, police officers and some AHPs and ST&Ts. Nurses and midwives were in this group until April 2010.

4.21 Data from the Longitudinal Education Outcomes (LEO) data set, published by the Department for Education, track the nominal earnings³⁵ of UK-domiciled first degree graduates from English Higher Education Institutions and Further Education Colleges, using HMRC data. The data show median earnings in 2015/16, by subject studied, for those one, five and ten years after graduation.

³⁵ Nominal earnings defined as the cash amount an individual was paid, not adjusted for inflation.

4.22 Figure 4.6 shows that median earnings, one year after graduation (the centre line of the bar), for those who studied nursing were £25,500, while those above the lower quartile earned over £22,000 and those above the upper quartile earned over £29,900. For those who studied other subjects allied to medicine, median earnings were £21,000, with earnings of £15,700 at the lower quartile and £24,900 at the upper quartile. Only those who studied medicine and dentistry and veterinary science had higher median earnings than those who had studied nursing, while median earnings for those who had studied other subjects allied to medicine was above the median for graduates as a whole.

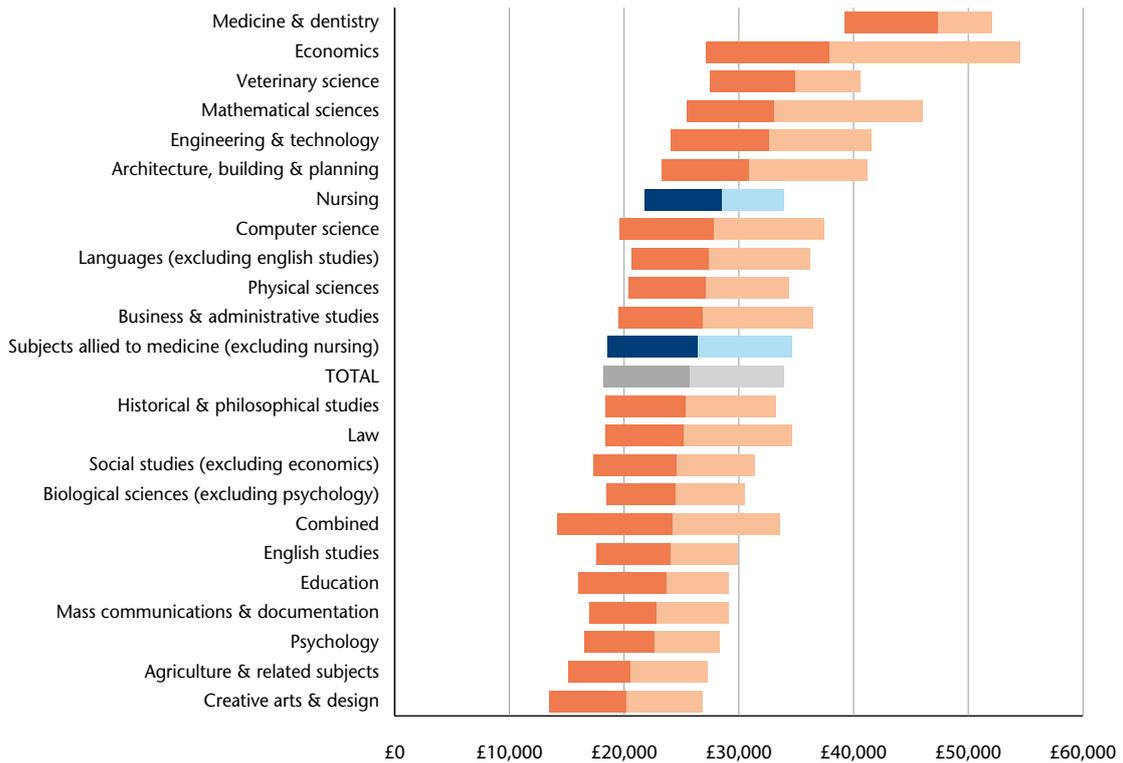
Figure 4.6: Annual gross earnings 1 year after graduation (2013/14 cohort), lower quartile, median and upper quartile, £



Source: OME analysis of LEO data set

4.23 Figure 4.7 shows that median earnings five years after graduation for those who studied nursing were £28,500, while those above the lower quartile earned over £21,800, and those above the upper quartile earned over £33,900. For those who studied other subjects allied to medicine, median earnings were £26,400, with earnings of £18,600 at the lower quartile and £34,600 at the upper quartile. Compared with the earnings of those who studied all other subjects, the position of those studying nursing and other subjects allied to medicine had declined, but their median pay remained well above the median for graduates as a whole.

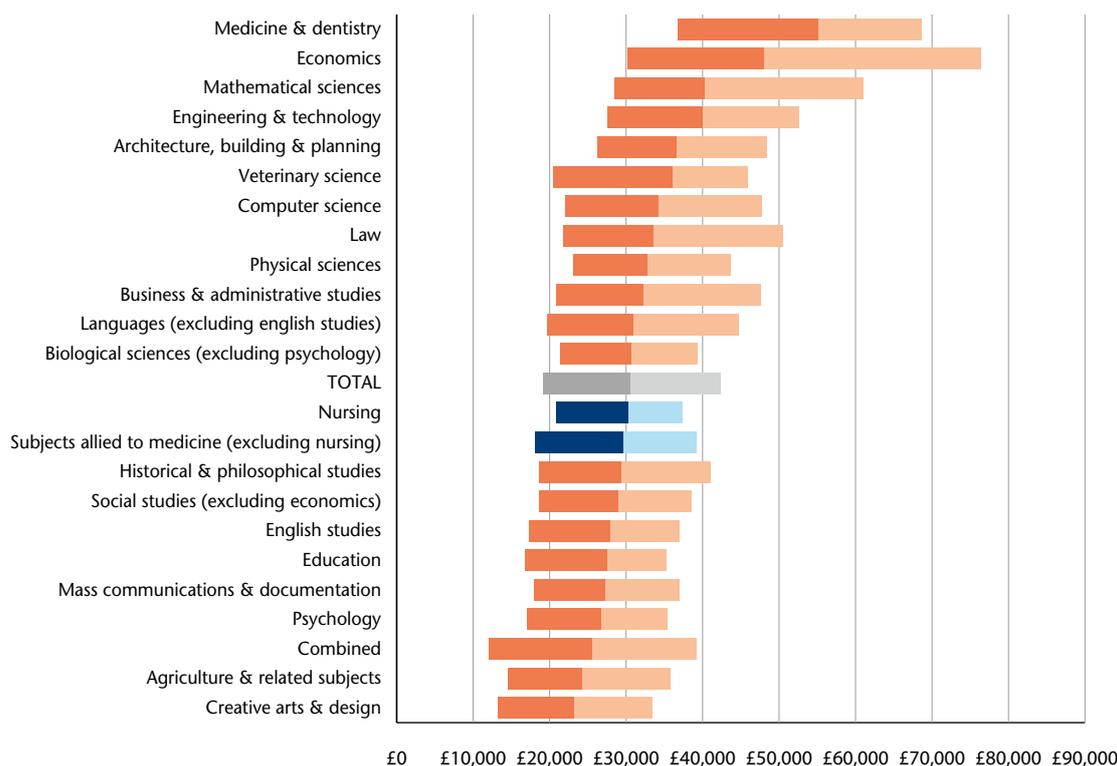
Figure 4.7: Annual gross earnings 5 years after graduation (2009/10 cohort), lower quartile, median and upper quartile, £



Source: OME analysis of LEO data set

4.24 Figure 4.8 shows that median earnings ten years after graduation for those who studied nursing were £30,300, while those above the lower quartile earned over £20,900, and those above the upper quartile earned over £37,300. For those who studied other subjects allied to medicine, median earnings were £29,600, with earnings of £18,100 at the lower quartile and £39,200 at the upper quartile. Compared with the earnings of those who studied all other subjects, the median earnings of those who studied both nursing and other subjects allied to medicine were just below the median earnings for graduates as a whole.

Figure 4.8: Annual gross earnings 10 years after graduation (2004/05 cohort), lower quartile, median and upper quartile, £



Source: OME analysis of LEO data set

Gender pay

4.25 NHS Digital published data showing the difference in mean annual basic pay of all men and women across the NHS in England, by staff group, between October 2017 and September 2018. Table 4.2 shows that there has been little change in the position of the gender pay gap for AfC staff groups since the previous year. Among the different AfC staff groups, the pay gap is widest for staff in infrastructure support: for hotel, property & estates staff (12%), central functions (11%) and senior managers (11%), while there is a slightly negative gender pay gap, i.e. one which favours female staff, among support to clinical staff groups. While the gap for senior managers has reduced slightly on the previous year, we note that the proportion of women in Bands 8 and 9 is smaller than other AfC pay bands, which will impact on the gender pay gap. These data do not include other elements of pay, such as overtime or shift work payments, which may not be distributed between men and women in the same way as basic pay.

Table 4.2: Mean annual basic pay per FTE by gender for AfC staff, England, October 2017 to September 2018

	Mean basic pay £ per FTE		
	Male	Female	Gap
<i>Clinical staff</i>			
Nurses & health visitors	32,236	31,924	1%
Midwives	34,854	33,552	4%
Ambulance staff	28,416	27,257	4%
Scientific, therapeutic & technical staff	36,424	35,323	3%
<i>Support to clinical staff</i>			
Support to doctors, nurses & midwives	19,161	19,342	-1%
Support to ambulance staff	20,032	20,438	-2%
Support to ST&T staff	20,440	20,413	0%
<i>NHS infrastructure support</i>			
Central functions	28,522	25,401	11%
Hotel, property & estates	19,917	17,591	12%
Senior managers	84,689	75,285	11%
Managers	50,081	47,287	6%

Source: NHS Digital

Take-home pay

4.26 Over the seven years between 2011/12 and 2018/19 data from NHS Digital show that the change in AfC basic pay varied from an increase of 19.5% for Band 1 to 5.2% for Band 9. Between 2017/18 and 2018/19, basic pay for NHS staff at the top of their band in England had increased by between 11.4% for Band 1 and 2.1% for Band 9. However, much of the increase at Band 1 was due to the 2018/19 increase as part of the AfC pay agreement. After taking account of changes to income tax, national insurance and pension contributions, take-home pay increased by between 22.7% for Band 1, increased by 6.2% for Band 5 and fell by 0.3% for Band 9 over the period from 2011/12 to 2018/19.

Table 4.3: Basic pay and take-home pay, England 2011/12 to 2018/19

Top of:	Basic pay								1-year change		7-year change	
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	£	%	£	%
Band 1	£14,614	£14,864	£15,013	£15,013	£15,363	£15,516	£15,671	£17,460	£1,789	11.4	£2,846	19.5
Band 3	£18,827	£19,077	£19,268	£19,268	£19,461	£19,655	£19,852	£20,448	£596	3.0	£1,621	8.6
Band 5	£27,625	£27,625	£27,901	£27,901	£28,180	£28,462	£28,746	£29,608	£862	3.0	£1,983	7.2
Band 7	£40,157	£40,157	£40,558	£40,558	£40,964	£41,373	£41,787	£43,041	£1,254	3.0	£2,884	7.2
Band 9	£97,478	£97,478	£98,453	£98,453	£98,453	£99,437	£100,431	£102,506	£2,075	2.1	£5,028	5.2

Top of:	Take-home pay								1-year change		7-year change	
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	£	%	£	%
Band 1	£11,864	£12,177	£12,558	£12,692	£13,053	£13,097	£13,221	£14,552	£1,330	10.1	£2,688	22.7
Band 3	£14,628	£14,932	£15,294	£15,383	£15,640	£15,652	£15,877	£16,369	£492	3.1	£1,742	11.9
Band 5	£20,068	£19,859	£20,094	£20,161	£20,466	£20,404	£20,676	£21,311	£636	3.1	£1,244	6.2
Band 7	£28,136	£27,753	£27,959	£27,996	£28,374	£28,223	£28,573	£29,447	£873	3.1	£1,310	4.7
Band 9	£59,316	£58,011	£57,282	£56,749	£56,933	£57,086	£57,882	£59,166	£1,284	2.2	-£150	-0.3

Source: OME analysis of NHS Employers data

National Living Wage and National Minimum Wage

- 4.27 The AfC pay agreement in England introduced a new minimum rate of basic pay in the NHS to future proof the structure, stay ahead of statutory requirements and ensure the NHS retained a competitive advantage in the jobs market at that level. There were also impacts on the minimum rate of AfC basic pay as a result of the approaches taken under the AfC pay agreements in Scotland and Wales, which had previously increased the lowest AfC pay rates. While the AfC pay agreement is not in place in Northern Ireland, the 2018/19 AfC pay award applied the increases in the English agreement to Northern Ireland rates. This included a 15.5% increase for the lowest paid AfC staff, which allowed the pay rate to be above the National Living Wage, including staff aged under 25. We will continue to review the position in our reports through the period of the agreement.
- 4.28 The April 2019 rates for the National Minimum Wage, National Living Wage and the Living Wage Foundation Living Wage are in Table 4.4 below. In the 2019 Spring Statement, the UK Government announced a review of the international evidence on the impacts of minimum wages³⁶. We will be interested to see the outcome and any implications for AfC pay rates.

Table 4.4: National Minimum Wage, National Living Wage and the Living Wage Foundation Living Wage rates per hour, April 2019

Age group	National Minimum Wage £	National Living Wage £	Living Wage Foundation Living Wage £	
			National	London
25+		8.21	9.00	10.55
21-24	7.70			
18 – 20	6.15			
Under 18	4.35			
Apprentice	3.90			

Our assessment of AfC earnings

- 4.29 Before the implementation of the AfC pay agreement, we observed in our 2018 Report that the starting salary of nurses might have seen a decrease in purchasing power since 2010. There was the same effect across the economy, but there was a slight reduction in nurses' earnings each year relative to the whole economy. As acknowledged in DHSC's evidence for this report, up to 2018 the overall trend continued, in that AfC earnings could be argued to have been behind the rest of the economy and comparators. The Joint Staff Side continued to argue on the effects of pay restraint on AfC pay rates relative to inflation.

³⁶ Department for Business, Energy and Industrial Strategy (March 2019), *Review of the International Evidence on the Impacts of Minimum Wages*. Available at: <https://www.gov.uk/government/publications/review-of-the-international-evidence-on-the-impacts-of-minimum-wages>

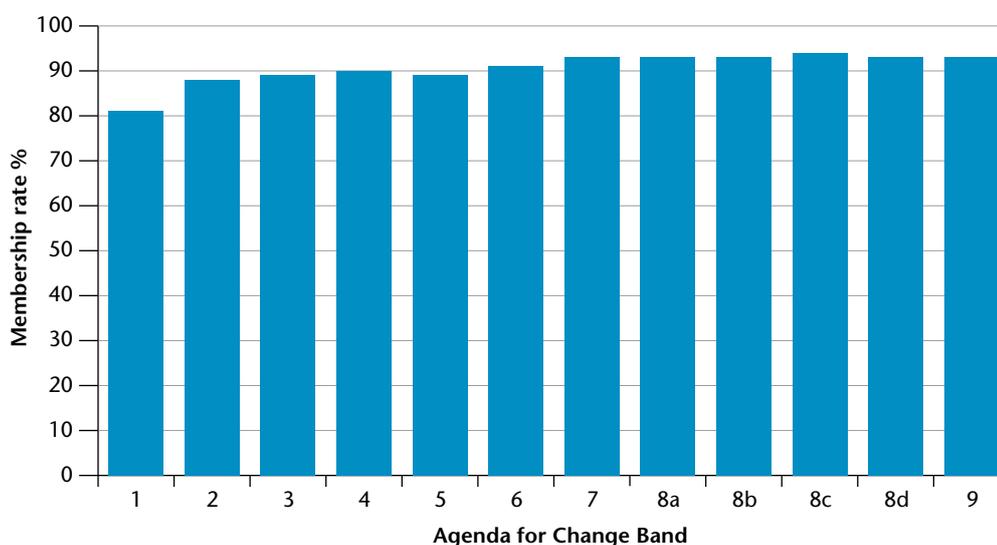
- 4.30 For nurses, we note that pay at the starting point in the scale has lost value between 2009 and 2017, particularly compared with inflation as measured by RPI, and to a slightly lesser extent relative to full time employee earnings growth. Some of that value has been recovered as a result of the AfC pay agreement in 2018/19. We note that the way in which AfC staff view their pay is likely to depend on both how their pay relates to inflation and what other comparable jobs are being paid across the economy and, therefore, both such relative changes could impact on their recruitment, retention and motivation. The most significant effects of the AfC pay agreement will be felt as structural changes work through in 2019/20 and 2020/21. These changes could have implications for the position of AfC earnings relative to the wider economy. We will be able to assess the position in our future reports, including the way in which different AfC rates in Scotland and Northern Ireland might impact on the AfC workforce.
- 4.31 We note that trends in earnings data do not assess variations in earnings across careers in the NHS. The patterns of earnings might vary as staff move through a career, such as the extra earnings from unsocial hours working early in a career, the move to part time and flexible working hours, and the balance between pay and other factors later in a career. The AfC agreement sought to arrive at a pay structure by 2020/21 that would be fit for purpose and could adapt to workforce developments. We consider that assessing basic AfC pay and earnings across an NHS career will become an increasingly important part of our evidence-base, as AfC roles and careers develop in the longer term under new models of care and integration with social care. The differential pay effects of the AfC agreement could impact on those starting a career, progressing through the system and reaching the top of pay bands.
- 4.32 We recognise that a proportion of staff in AfC professions will compare their pay with that of other graduates working outside the NHS. We therefore continue to assess the pay position of AfC graduates against other graduates. Data on graduate pay show that NHS professions, particularly nursing, were ahead of the median earnings of graduates a year after graduation. After five years the earnings of graduates in nursing and subjects allied to medicine remained above the median, but after 10 years they fell just below the median earnings for graduates as a whole. This position could change with other developments in the labour market and pay settlements elsewhere, and in the light of increased AfC starting pay, faster pay progression through the AfC pay bands and the potential for pay to flatten out as staff reach the top of pay bands.
- 4.33 We have not been invited to make pay recommendations during the period of the AfC pay agreement to 2021/22, but we will continue to keep track of and report on prevailing economic and labour market indicators. This will enable us to have a clear picture on current and forecast indicators to prepare our evidence-base for future AfC pay considerations.

Total reward and pensions

- 4.34 We continue to consider total reward when assessing AfC earnings. Our starting point is that modern employers focus on total reward to ensure that they can recruit, retain and motivate staff. The parties all recognise the importance of the total reward package and provided a substantial level of information. We acknowledge the UK Government's emphasis, in evidence, on total reward, which in its view includes progression pay, allowances and pensions. Employers and employees have a range of views and interests on the value of different elements of total reward. In our 2018 Report we considered that total reward included pay, pensions, other benefits, learning and development opportunities, and the overall work experience. As a nationwide service, the NHS provides its staff with secure employment and we should not underestimate this as a factor in attracting, retaining and motivating staff.

- 4.35 We also note that the parties negotiated a range of elements within the NHS package under the AfC pay agreement. These reforms, which include both pay and conditions, could enhance the total reward package over the next few years.
- 4.36 The NHS employment offer needs to ensure that it meets staff expectations if it is to support the workforce developments in the NHS Long Term Plan. Employers should be encouraged to promote the NHS total reward offer, particularly to improve supply, encourage new roles, develop career paths and retain staff. We recognise the benefit of promoting total reward could be significant in positioning the NHS as the external labour market tightens and pay prospects improve. The NHS could be considered to offer a guaranteed post and continuous employment to graduates in AfC-related subjects, and we acknowledge DHSC's view that having a nursing degree increases the probability of being employed compared to the average graduate and that healthcare provides a wide range of career and development possibilities. AfC staff on our visits told us about the importance of different elements within the total reward package, which would vary over time and depend on the circumstances of the individual member of staff and the point they had reached in their NHS career. Staff also told us that they were looking for opportunities to vary elements of total reward to fit their individual careers. Younger AfC staff focussed on a number of aspects of the employment offer, such as security and quality of life, as well as earnings. As staff moved through an NHS career they focussed on specific aspects of the package, such as more flexibility in working arrangements, access to and funding for training and development, and pensions. These examples indicate that the total reward package needs to be flexible and adaptable at different stages of a career.

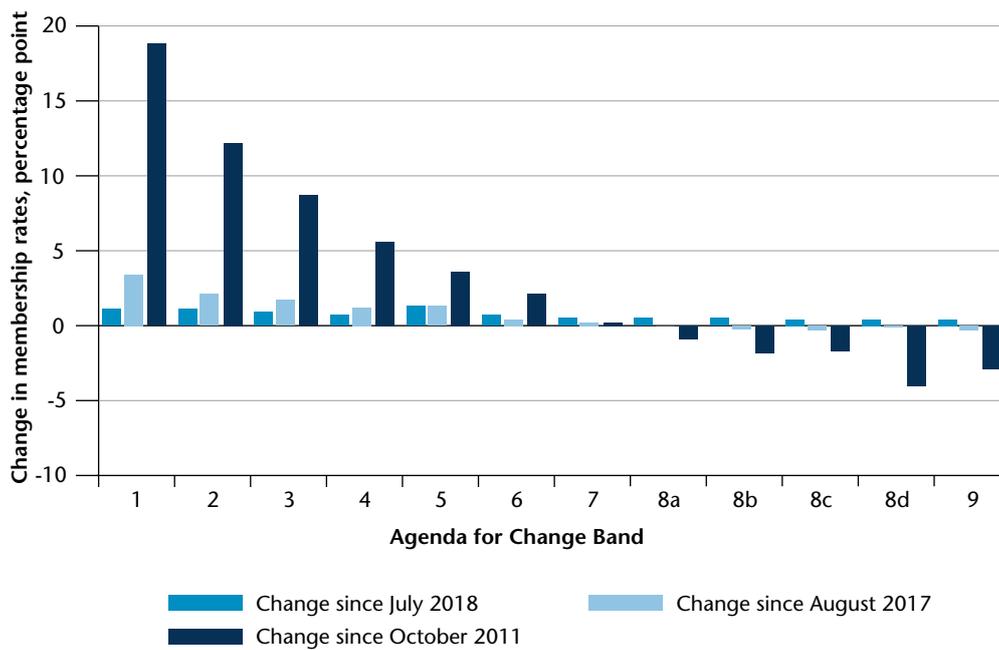
Figure 4.9: Estimated pension membership rate by Agenda for Change band, August 2018, England



Source: Department of Health and Social Care

- 4.37 In August 2018, approximately 90% of AfC staff were members of the NHS Pension Scheme (Figure 4.9). Staff in Bands 7-9 (93-94%) were most likely to be scheme members while those in Band 1 were least likely (81%). AfC staff on our visits indicated it is still the case that some lower paid staff opt out of the scheme to make more of their pay available in cash.

Figure 4.10: Changes in pension membership rate by Agenda for Change band, between August 2018 and July 2018, August 2017 and October 2011, England



Source: Department of Health and Social Care

- 4.38 Figure 4.10 shows changes in the membership rate of the NHS Pension Scheme in August 2018, by AfC band, compared with July 2018 (a month earlier), August 2017 (a year earlier) and October 2011. Membership rates in August 2018, were higher for every band than in the previous month. Longer term changes show increased membership rates for each band up to and including Band 7, while beyond this point membership rates had declined. Membership rates for staff in Band 1 and Band 2 remained lower than those for other bands, but the rate of membership growth over the last year and the last seven years had been strongest at these bands. There could be some effect of auto-enrolment in pensions which commenced in 2013.
- 4.39 In the context of total reward, the UK Government’s evidence stressed the value of public sector pensions compared with the private sector. While we acknowledge that the NHS pension represents a significant benefit to AfC staff, its value needs to be seen by staff as a benefit across an NHS career. We have heard from AfC staff and in evidence that NHS pensions could be more flexible at different stages. Some younger AfC staff did not see the benefits of investing significant levels of their pay in pensions and would prefer to have some of the value of their pension contributions available for a range of other purposes. Pension benefits could also be of less value to a more limited number of longer serving or more senior NHS staff, particularly those affected by the potential impact of changes to Lifetime and Annual Allowances. These concerns have been raised across the public sector not just in the NHS. Providing the right level of pension benefits could help attract new entrants and retain the experienced AfC staff needed to deliver transformation under the NHS Long Term Plan. Therefore, more flexible pension options might be considered across an NHS career although we acknowledge that achieving this might be challenging given the structure of the NHS Pension Scheme and the criticality of ensuring that NHS staff save for their retirement.

4.40 In 2017 we recommended that annual pay awards should not have the unintended consequences of reducing take-home pay for AfC staff when crossing pension contribution thresholds. We note that this issue has been acknowledged by the NHS Pension Scheme Advisory Board in its review of member contributions although no change was recommended until 2021. It is helpful that the Board pointed to the requirement for further discussion on avoiding “cliff edges” in contribution rates. However, we stress the importance of avoiding further delays in changing the contribution thresholds given their potential impact on the recruitment, retention and motivation of AfC staff³⁷. We also emphasise that the parties should consider the consequences for take-home pay when crossing pension, tax and National Insurance thresholds as a result of pay reforms under the AfC pay agreement.

Service transformation, integration and productivity

4.41 The environment for service transformation in the NHS, integration with social care and productivity needs to be seen in the light of ongoing demand. The parties to our process, and all external commentators, acknowledge that rising demand, the increasing complexity and the need to treat patients with multiple conditions all put pressure on the NHS workforce.

4.42 The evidence for this report, and views heard on our visits, confirm that without service transformation the rising demand for services will continue to impact on AfC staff through increased workload, additional paid and unpaid overtime, an increased need to cope with vacancies and a growing reliance on the continued goodwill of staff. External commentators have indicated that the management of increasing demand could be reducing the capacity required for service transformation. We also note the NAO’s conclusions that existing transformation plans appeared to be stifled by the need to redirect available finance towards alleviating trusts’ deficits.

4.43 We await the publication of the Workforce Implementation Plan later in 2019 to understand the way in which the proposals in the NHS Long Term Plan will be supported by effective workforce developments. Most external commentators, and the parties, have given the NHS Plan a cautious welcome as an attempt to set out the priorities for the long term, but they were awaiting more detail on the way in which it would be delivered. This detail is particularly relevant, given that the workforce requires significant investment to meet transformation and new service models. As the NHS Plan includes many priorities, there could be a risk that the required investment in workforce supply and development might not be fully funded. We comment later in this chapter on the workforce implications arising from the NHS Plan. In the meantime, we look forward to further detail on the way in which the Sustainability and Transformation Partnerships expect to tackle transformation and the implications for the workforce when they set out their local five-year plans by autumn 2019. We would welcome further evidence on the progress and impact of transformation programmes in Scotland, Wales and Northern Ireland.

³⁷ Further developments on public sector pensions could result from the December 2018 Court of Appeal ruling that the “transitional protection” offered to some members of the judicial and fire fighters’ schemes as part of the reforms amounted to unlawful discrimination. The Government is seeking permission to appeal this decision. See: www.civilservicepensionscheme.org.uk/members/mccloud-judgment/

- 4.44 The NHS Long Term Plan proposed that Integrated Care Systems would be in place in all areas by 2021. In evidence, the parties recognised that there were system and financial barriers to integrating health and social care, and that these barriers needed to be overcome to meet the ambitious target in the NHS Plan. In addition, external commentators pointed to the need for significant investment in social care in order to deliver services, to avoid over-reliance on the NHS and other public sector services, and to support integration. Further evidence should be provided on the strategies being developed on integration across the countries in the UK.
- 4.45 On our visits, AfC staff working in integrated settings told us that there were gains for patients and staff in integrating health and social care. AfC staff reported tangible benefits to patients, and more enjoyable jobs and working arrangements. Developing the required organisation and employment structures to support integration will take time. We saw on our visits that new ways of working were being developed locally. Further evidence should be provided on the way in which integration might influence the skill mix of the health and social care workforce, any changes to AfC roles, any developments on employment arrangements and the implications for pay. It would also be helpful to hear the parties' views on any impact of the AfC pay agreement in relation to the labour market for health and social care staff.

Productivity

- 4.46 While AfC staff can see and are supportive of the overall need to improve productivity, they are not always clear about the way in which they contribute in teams and as individuals to the productivity and efficiency measures used across the NHS. AfC staff have told us on our visits in recent years that they feel they have already made significant contributions to NHS productivity through a long period of pay restraint, working longer hours and through additional goodwill. Recent Pay Review Body reports also concluded that a significant part of the productivity gains in the NHS came from previous pay restraint policies, with accompanying savings to the NHS.
- 4.47 The NHS Long Term Plan emphasised improving productivity with a focus on new service models, new technology and digital services. Throughout the NHS there may be significant productivity gains to be achieved through, among other things, process rationalisation, reducing unwarranted variations in treatments, and more effective use of technology and data. The range of productivity initiatives already in place or planned are being evaluated with regard to their respective contribution to supporting financial sustainability, transformation, patient outcomes and staff satisfaction.
- 4.48 Integration across a range of public services will create additional productivity opportunities and challenges. As the integration of primary, community and social care services is developed additional opportunities and new measures of productivity could be generated, most notably through the integration of health and social care.

- 4.49 It is clear that a major feature of productivity improvements will be a differently configured workforce. The NHS Long Term Plan for England reinforces the conclusions in our 2018 Report on the need to understand the drivers and definitions of productivity to allow NHS staff to be involved effectively in making change happen. It would be helpful to staff, managers and organisations to be clear about which productivity improvements derive from the benefits of developing new technology, process improvements, changing the workforce skill mix and improved ways of working (e.g. multi-disciplinary teams). For NHS staff to contribute to these improvements effectively, it is important that they are fully involved in the way in which these are planned and delivered. Improving productivity could also come from improving the supply of people, developing new and advanced roles, and retaining experienced AfC staff. The potential gains from the underpinning workforce developments could be substantial but have yet to be quantified. We look forward to seeing further detail in the Workforce Implementation Plan later in 2019.
- 4.50 In this context, it is widely recognised that improving staff morale, motivation and engagement can be effective in contributing to enhanced productivity. Employers have made considerable progress in this area in recent years but renewed activity would support the major developments ahead. We comment elsewhere on the need for new service models to be supported by investment in training and development.
- 4.51 On its launch in 2018, a central part of the AfC pay agreement was enhanced staff contribution through new progression arrangements in return for the investment in additional AfC pay. We comment later in this report on developments but note here that the AfC pay agreement provides opportunities to improve staff contribution, where supported by an effective progression system delivering high quality staff appraisals.

NHS affordability and efficiency savings

- 4.52 While the AfC pay agreement is funded for three years and we are not required to make pay recommendations during this period, we remain aware of the overall position on affordability in the NHS so that we can build a picture over the period of the pay agreement.
- 4.53 On the general position, NHS Improvement's analysis of the provider sector in England suggests small improvements in provider finances during 2018/19 but the significant financial deficit remains. The provider sector also continues to be supported by the use of the Provider Stability Fund to manage deficits. A similar pattern to recent years was seen on efficiency savings where improvements were made, but against challenging targets. The evidence emphasised the continued impetus from the Carter Review on reducing unwarranted variations. We also note the NAO's conclusions in its NHS Financial Sustainability Report that deficits in one part of the system were offset by surpluses elsewhere that did not add up to a sustainable picture. The NAO was also critical of current funding flows and cited risks around future funding plans.
- 4.54 Against this overall background, we note that DHSC continues to emphasise the affordability of pay awards linked to other priorities, including the balance between pay awards and staff numbers. We also note that the evidence on the proportion of expenditure on staff in the NHS is increasing at a faster rate than overall NHS expenditure in 2017/18. Notwithstanding the additional overall NHS funding over the next five years, there is a continued risk to the effective implementation of the NHS Long Term Plan and the expected Workforce Implementation Plan from the financial challenges faced by trusts, which will constrain the resources available for the AfC workforce and pay. We will continue to monitor staff expenditure and pay bill costs through the period of the AfC pay agreement alongside other matters in our remit.

4.55 The five-year NHS financial settlement in England and the Barnett consequential for the Devolved Administrations could provide some financial certainty to address identified priorities. It would be helpful to have a clear view from the parties on the way in which additional funding is being used to support workforce development. As we have said elsewhere, insufficient funding for the workforce risks failing to achieve the developments to support delivering new models of care. On a specific point, training and development budgets will underpin the anticipated workforce developments and will be influenced by the setting of Health Education England's budget later in 2019.

Workforce strategies and workforce numbers

4.56 We comment in Chapter 2 on the overall workforce considerations in the light of developments in the NHS. All the parties to our process and external commentators continue to recognise the significance of NHS workforce developments. Our overall conclusions centre around strategic planning, workforce development to support stated plans, sufficient funding against other priorities, ensuring effective supply of people, developing new roles, enhancing skills through funded training and development, managing shortages, and retaining existing staff.

4.57 On a general point, the NHS Long Term Plan places workforce issues at the centre of its proposals, with new service models and integration of health and social care having the potential impetus for reconfiguring the workforce and addressing longstanding concerns. However, the NHS Plan provides no overall assessment of workforce numbers, nor any projections on supply and demand. Much detail is also awaited on the way in which the actions will be put into effect when the Workforce Implementation Plan is published later in 2019. Until these are set out, it is difficult to make any early assessment on their potential effectiveness. The approach to workforce planning in the NHS continues to be dispersed across a number of bodies, although we note the new responsibilities for NHS Improvement on leading some workforce aspects. We consider that estimates of workforce demand should be informed by requirements for services and transformation, NHS funding constraints and expected productivity improvements. Further information would be helpful from Scotland, Wales and Northern Ireland on the different approaches taken to workforce planning and any different policies impacting on workforce requirements and skill mix e.g. in Wales, safe staffing legislation for nurses. In this regard, we would also welcome evidence on any effects of variations in AfC pay rates in Scotland, Wales and Northern Ireland.

Northern Ireland Health and Social Care Workforce Strategy

4.58 The Northern Ireland Health and Social Care Workforce Strategy 2026 was published in April 2018 at the time we reported last year. We would welcome further evidence from the Department of Health, Northern Ireland, and the Joint Staff Side on the way in which the measures are being implemented.

NHS Wales Workforce Strategy

4.59 We understand from the Welsh Government that a long term strategy for planning and developing the health and social care workforce is to be developed during 2019. Health Education and Improvement Wales would lead on the strategy working with other NHS and appropriate organisations. We look forward to hearing more about the strategy in evidence for our next report and ask that the strategy take into account our overall views on the AfC workforce. It would also be helpful for evidence to cover the impact and implications of the introduction of the Nurse Staffing Levels (Wales) Act.

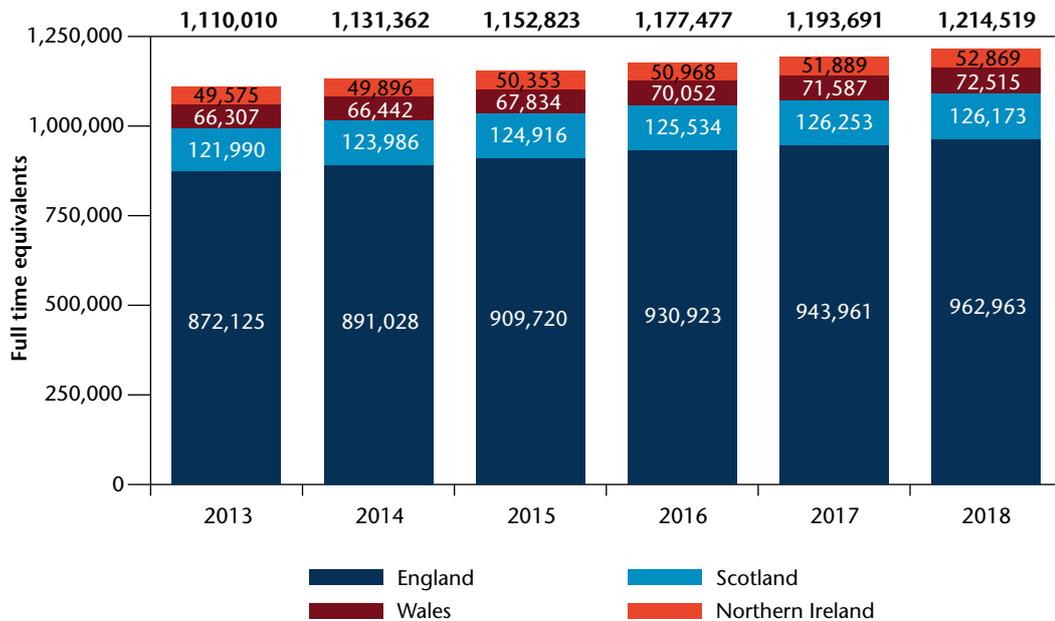
Scottish Workforce Plan

4.60 We note that the Scottish National Health and Social Care Workforce Plan was published in three parts starting in 2017. The first part focused on the workforce within NHS Scotland, the second part on the challenges facing the social care workforce and the third part on primary care. Future editions of the plan would address the size and diversity of the health and social care workforce, and its workforce planning needs.

Staffing numbers

4.61 Figure 4.11 shows that in September 2018 there were over 1.2 million full time equivalent (FTE) staff, an increase of 1.7% since September 2017. In the year to September 2018 the number of FTE staff rose in England (2.0%), Wales (1.3%) and Northern Ireland (1.9%) but fell slightly in Scotland (0.1%). Since 2013, FTE numbers have increased by 9.4% across the UK as a whole and by 10.4% in England, 9.4% in Wales, 6.6% in Northern Ireland and 3.4% in Scotland. In September 2018 there were 1.4 million people (on a headcount basis) working in the AfC grades across the UK, also an increase of 1.7% from September 2017.

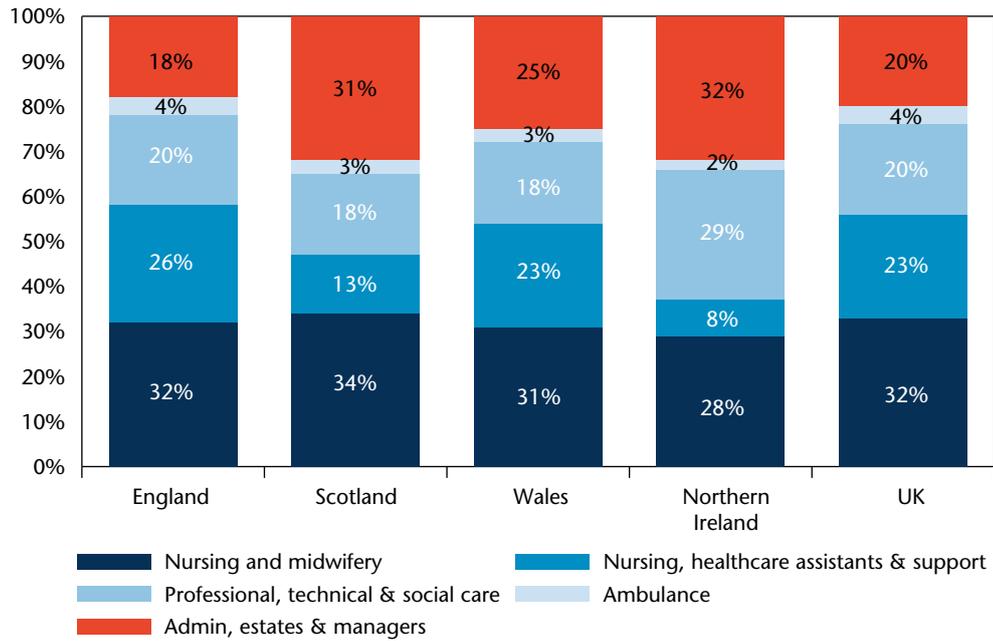
Figure 4.11: NHS AfC full time equivalent workforce by United Kingdom country, September 2013 to September 2018



Source: NHS Digital; StatsWales; Information Services Division, Scotland; and Department of Health, Northern Ireland

4.62 Figure 4.12 shows a breakdown of AfC by broad staff group in each country within the UK. In Scotland and Northern Ireland there is a relatively high share of administration, estates and management staff compared with England and Wales. Scotland has a relatively high proportion of nursing and midwifery staff, while England and Wales have a relatively high proportion of nursing and healthcare assistants.

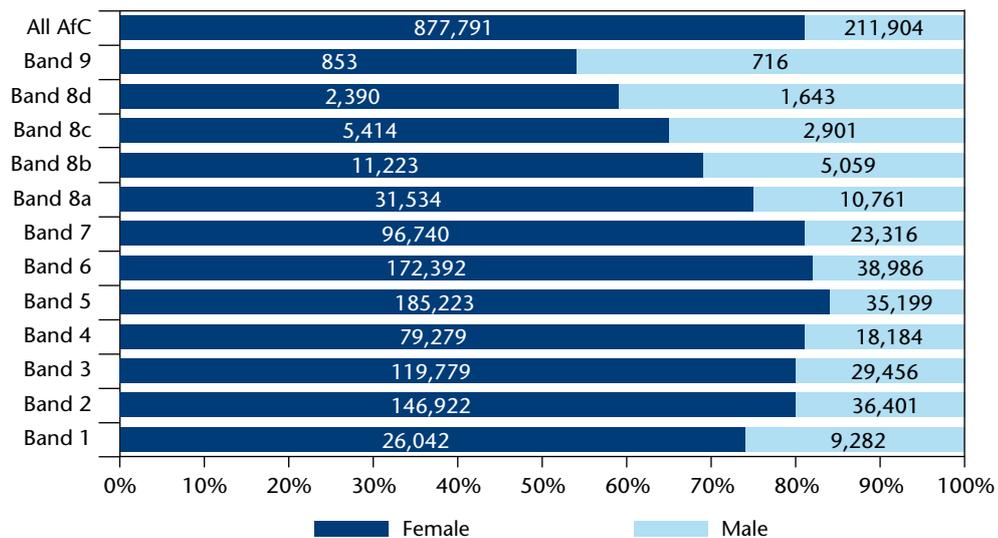
Figure 4.12: NHS AfC full time equivalent workforce by broad staff group and by United Kingdom country, September 2018



Source: NHS Digital; StatsWales; Information Services Division, Scotland; and Department of Health, Northern Ireland

4.63 The NHS workforce is predominantly female and Figures 4.13-4.15 show gender breakdowns in England, Scotland and Northern Ireland. Figure 4.13 shows that in England women account for 80% of the AfC workforce and constitute a majority at each pay band, although the share accounted for by women reduces as the pay bands increase, which will impact on the gender pay gap as we noted earlier. We note the balance of men and women in AfC roles and, given the importance of appealing to the widest possible range of talent to work in the NHS at all levels, we would be interested in the parties' views on the developments in recruitment and on the degree choices of pre-registration applicants.

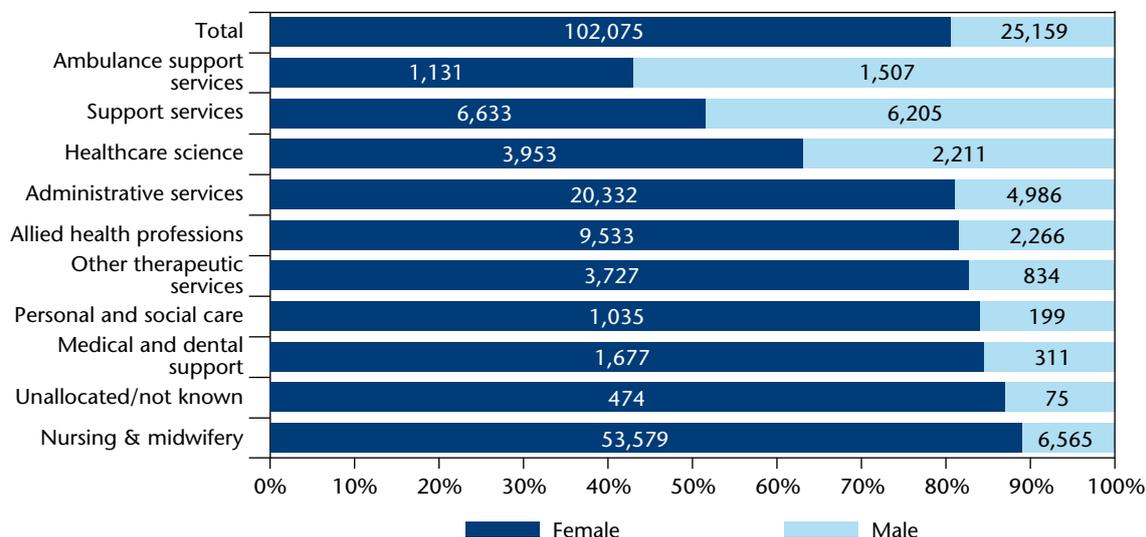
Figure 4.13: Staff in Agenda for Change pay bands by gender in England, headcount, September 2018



Source: NHS Digital

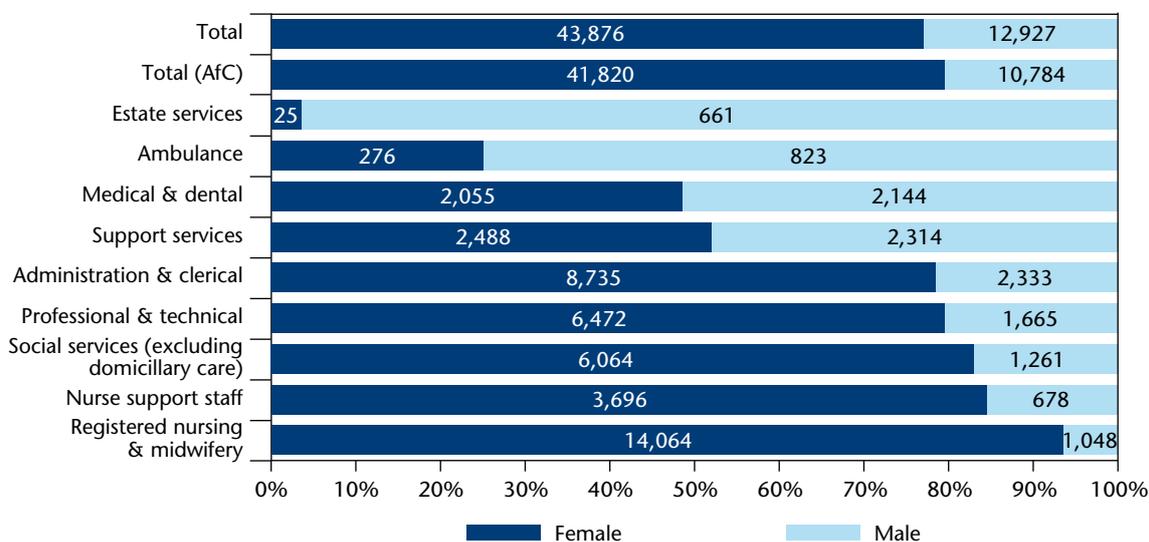
4.64 Figures 4.14 and 4.15 show that in both Scotland and Northern Ireland women form the majority of staff in most staff groups. In Scotland, women make up a majority of all staff groups except ambulance services and the same applies in Northern Ireland, except for the ambulance and estates staff groups.

Figure 4.14: Staff in Agenda for Change roles by gender in Scotland, December 2018, FTE



Source: Information Services, Division, Scotland

Figure 4.15: Staff in Agenda for Change roles by gender in Northern Ireland, March 2018, FTE

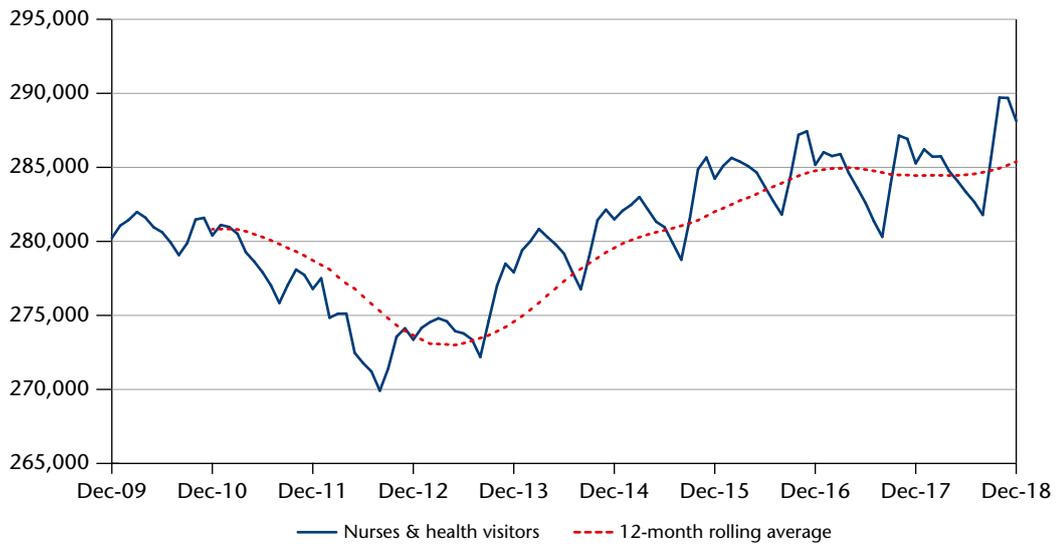


Source: Department of Health, Northern Ireland

Nursing workforce

4.65 In England, the number of nurses and health visitors (FTE) grew between 2012 and 2016, and then levelled out between 2016 and 2018 (Figure 4.16). In the three months to December 2018, nurse and health visitor numbers were 1.0% higher than a year earlier.

Figure 4.16: Number of nurses and health visitor staff, FTE, England, December 2009 to December 2018

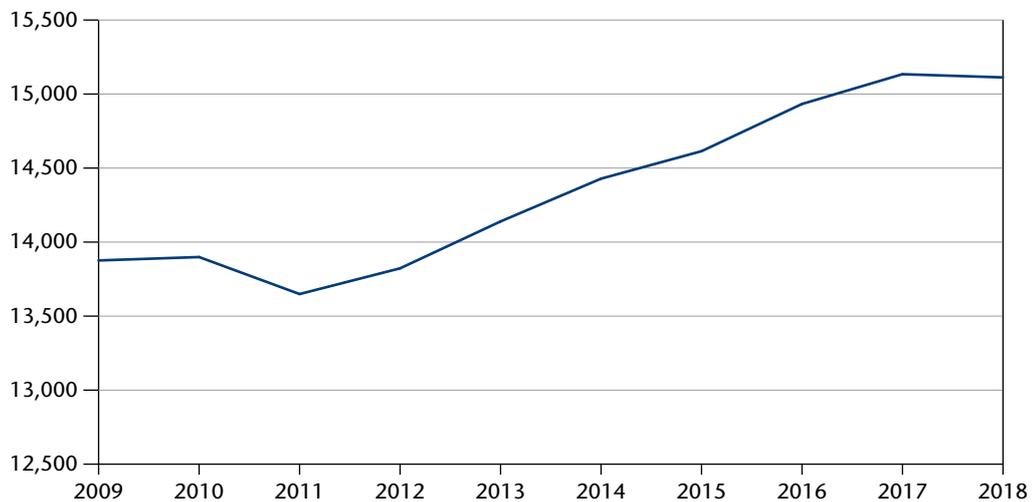


Source: NHS Digital workforce statistics

Note: The full time equivalent axis has been cropped to allow small differences between periods to be seen more clearly.

- 4.66 In Northern Ireland, the number of nurses and midwives rose year-on-year between 2011 and 2017, after having fallen between 2010 and 2011 (Figure 4.17). However, between March 2017 and March 2018 (the latest month for which data are available) numbers fell slightly, from 15,130 to 15,110 FTE.

Figure 4.17: Number of registered nurses and midwives, FTE, Northern Ireland, March 2009 to March 2018

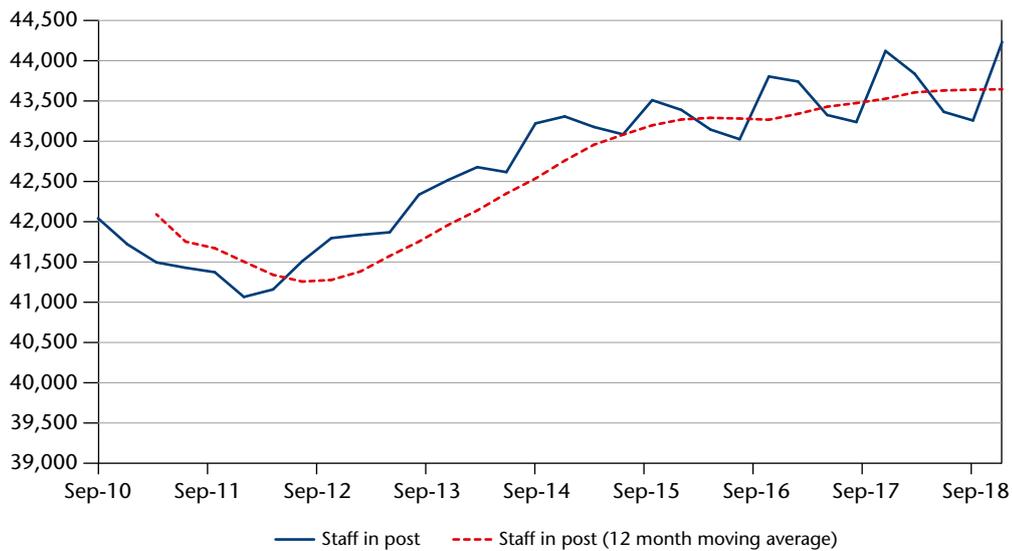


Source: Department of Health workforce statistics

Note: The full time equivalent axis has been cropped to allow small differences between periods to be seen more clearly.

- 4.67 The 12-month rolling average number of Band 5-9 nursing and midwifery staff in Scotland rose in every quarter between December 2012 and March 2016 (Figure 4.18). After a slight drop in numbers, from a 12-month average of 43,290 in March 2016 to 43,270 in September 2016, growth resumed at a slower pace but with larger seasonal fluctuations. As of December 2018, there were 44,230 FTE Band 5-9 nursing and midwifery staff working in NHS Scotland.

Figure 4.18: Number of Band 5-9 nursing and midwifery staff, FTE, Scotland, March 2011 to December 2018

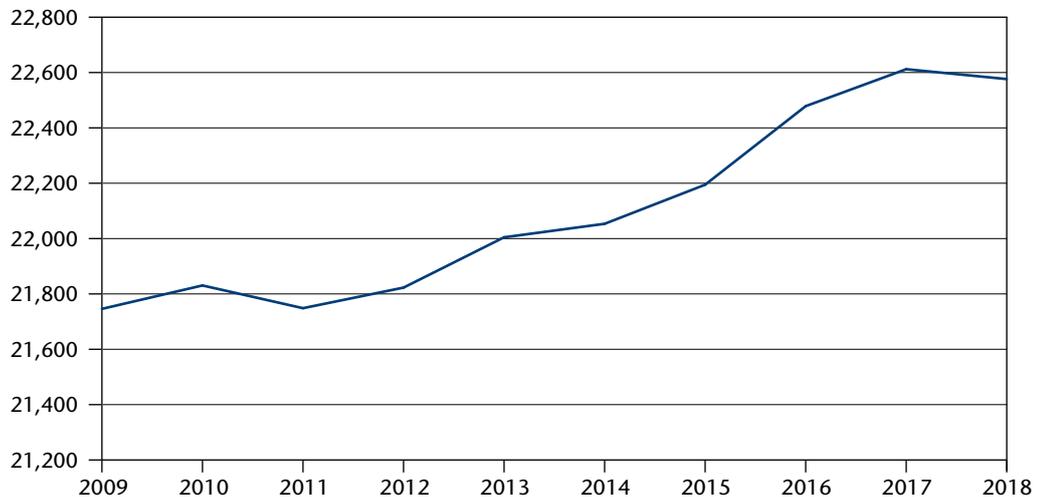


Source: Information Services Division Scotland

Note: The full time equivalent axis has been cropped to allow small differences between periods to be seen more clearly.

4.68 In Wales, the number of qualified nursing staff rose year-on-year between 2011 and 2017, after having fallen between 2010 and 2011 (Figure 4.19). However, between September 2017 and September 2018 numbers fell slightly, from 22,610 to 22,580 FTE.

Figure 4.19: Number of qualified nursing staff, FTE, Wales, September 2009 to September 2018



Source: StatsWales

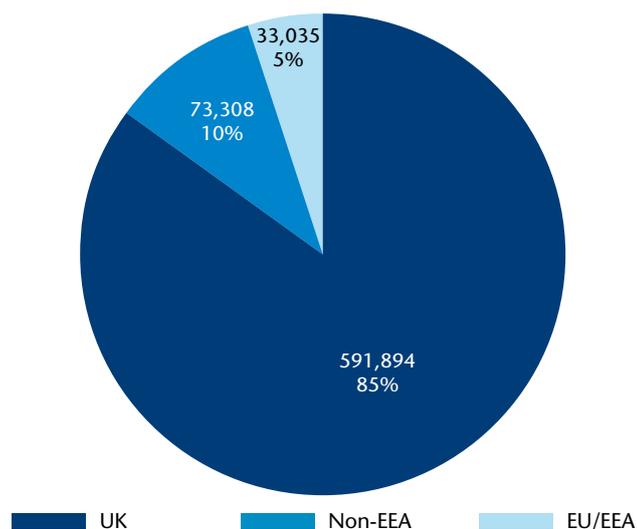
Note: The full time equivalent axis has been cropped to allow small differences between periods to be seen more clearly.

Nursing and Midwifery Council Register

4.69 The latest data from the Nursing and Midwifery Council (NMC), for March 2019, showed that there were 698,237 nurses and midwives registered to work in the United Kingdom (Figure 4.20). Of the total number 591,894 (84.8%) were from the UK, 33,035 (4.7%) were from the European Economic Area (EEA) and 73,308 (10.5%) were from outside the EEA.

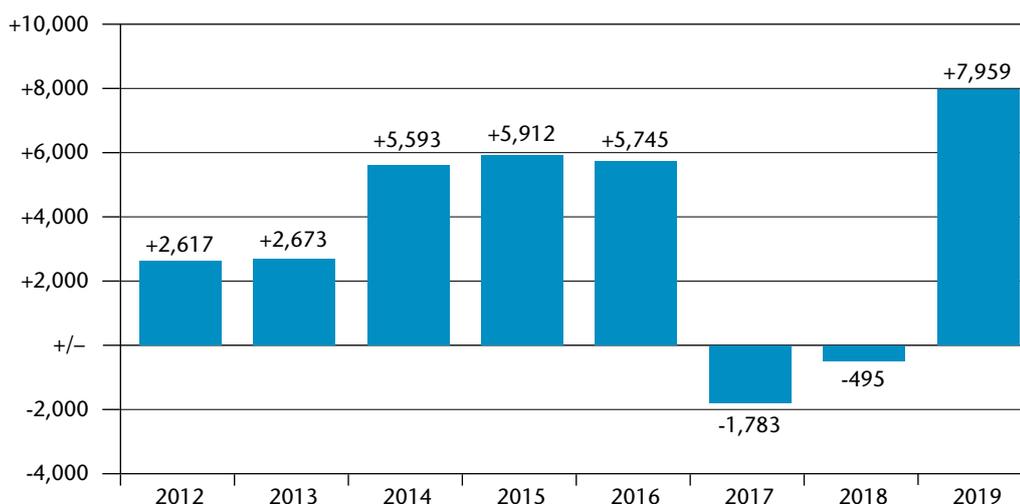
- 4.70 In the year to March 2019, there was an increase of 7,959 nurses and midwives on the register. Previous NMC data showed that the number leaving the register exceeded the number of joiners by 1,783 in the year to March 2017 and by 495 in the year to March 2018, leading to an overall reduction in the number of nurses and midwives registered with the NMC by 2,278 (0.3%) between March 2016 and March 2018.
- 4.71 The latest NMC data presents a complex picture on those joining and leaving the register. The register shows the number of nurses, midwives and nursing associates currently able to practice in the UK although not everyone on the register will be working in these roles or the field they registered in. The NMC is working to improve its systems to provide a more complete picture on joiners and leavers. The increase of 7,959 people in the year to March 2019 reflects significant increases of 5,169 (0.9%) in the number of UK-trained professionals and of 4,870 (7.1%) in those from outside the EEA. For the first time, 489 nursing associates joined the register since it opened to these grades in January 2019 with many more to join, according to the NMC. These increases were in part offset by a further reduction in the number from the EEA of 2,080 (5.9%) continuing the trend since 2017. A survey of those leaving the register between May and October 2018 found that 51% of EEA nurses and midwives leaving had been encouraged by Brexit to consider working outside the UK. Overall, the numbers on the NMC register increased for the first time since 2016.

Figure 4.20: Overall numbers of nurses and midwives on the NMC register by country of qualification, UK, March 2019



Source: NMC Register, March 2019

Figure 4.21: Yearly change in the number of nurses and midwives on the NMC register, UK, March 2012 to March 2019



Source: NMC Register, March 2019

Vacancies and shortage groups

4.72 NHS Improvement, in its quarterly performance reports, publishes vacancies across the NHS in England. The latest data, for the third quarter of 2018/19, showed that overall, there were just over 100,000 vacancies, or a rate of 8.4%, compared with a rate of 8.7% in the same quarter a year earlier. Table 4.5 shows that in the third quarter of 2018/19 there were 39,000 nursing vacancies, 9,000 medical vacancies and over 52,000 vacancies for non-nursing AfC staff. Compared with the third quarter of 2017/18 while the rates for both medical and non-nursing AfC staff fell, the vacancy rate for nurses increased to 11.0% at the third quarter of 2018/19.

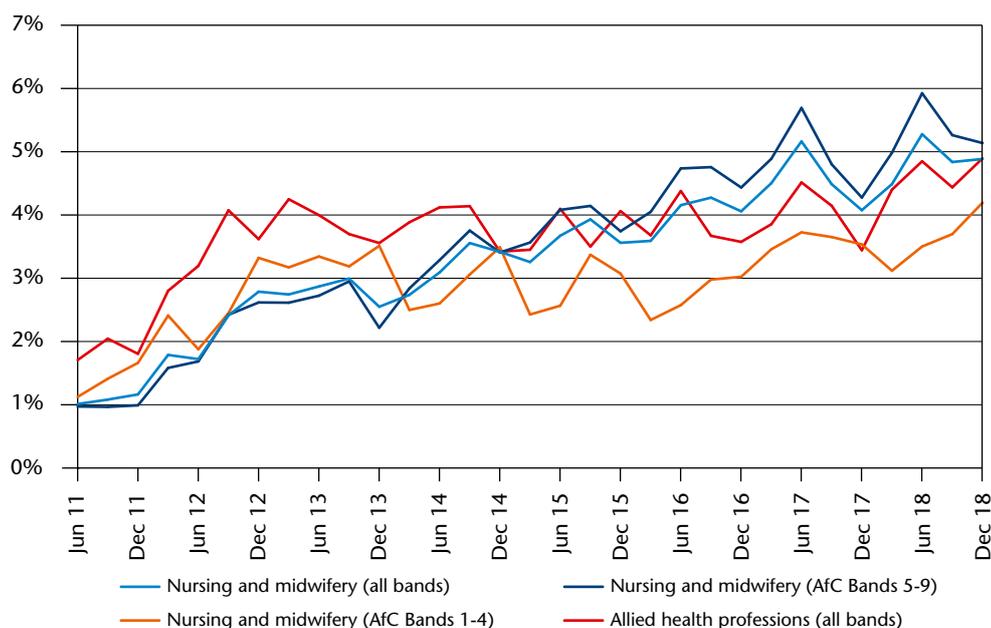
Table 4.5: NHS Provider vacancies, England, 2017/18 Quarter 3 to 2018/19 Quarter 3

		2017/18	2017/18	2018/19	2018/19	2018/19
		Q3	Q4	Q1	Q2	Q3
Nursing	Vacancy rate	10.2%	10.2%	12.0%	12.0%	11.0%
	FTE vacancies	35,934	35,794	42,231	42,370	39,148
Medical	Vacancy rate	7.9%	7.8%	9.4%	7.6%	7.1%
	FTE vacancies	9,738	9,635	11,870	9,670	8,953
Other staff	Vacancy rate	8.1%	7.7%	8.0%	7.7%	7.4%
	FTE vacancies	55,896	53,325	55,971	53,854	52,420
Total workforce	Vacancy rate	8.7%	8.4%	9.3%	8.9%	8.4%
	FTE vacancies	101,567	98,755	110,073	105,894	100,521

Source: NHS Improvement

4.73 The latest data for Scotland, for the third quarter of 2018/19, show vacancy rates of 4.9% for nurses, midwives and health visitors (up from 4.1% a year earlier) and 4.2% for allied health professionals (up from 3.5% a year earlier). However, the three-month vacancy rates for both nurses, midwives and health visitors and allied health professionals fell, to 1.2% from 1.4%, and to 0.9% from 1.1% respectively. These low rates of vacancies remaining unfilled suggests that employers in Scotland are usually able to fill these posts within three months of the vacancy arising.

Figure 4.22: Vacancy rates in Scotland by main staff group, 2011-2018



Source: Information Services Division, Scotland

- 4.74 In Wales, total advertised vacancies were 1,574.87 FTE between April 2017 and March 2018, including medical and dental staff. Total vacancies reduced for most AfC groups over 2017/18, particularly for nursing and midwifery staff and AHPs.

Our assessment of shortage groups and vacancy data

- 4.75 The NHS Improvement data have only been available since 2017 and therefore it will take time to establish the overall trend in vacancies and patterns relating to the staff groups affected. However, the data do enable some initial conclusions and there appears to be consensus across NHS organisations on the impact of workforce shortages. NHS organisations and external commentators agree that the emerging data on NHS vacancies from NHS Improvement are improving the understanding of the size of the workforce gap, the geographical and specialty areas affected and the extent to which these are covered by temporary staffing.
- 4.76 The vacancy data indicate that the total volume of NHS vacancies in England is a continuing concern to the parties. The overall number of vacancies has varied between 2017 and 2018, but there has been an increase in the nursing vacancy rate comparing Quarter 3 in 2017/18 with that in 2018/19. In contrast, over the same period there has been a steady decline in the vacancy rate for other non-medical staff (representing over half of the total vacancies) and a decrease in the rate for medical staff. The data also suggest an unequal distribution of vacancies in terms of geography and specialty. These variations imply that different actions may be needed to tackle different types of shortage. Variations in vacancies could therefore highlight the extent to which the skills mix required to treat multiple and complex patient conditions are available where the service is to be delivered. Increasing specialisation could make it harder to recruit and deploy all the various specialisms required for effective delivery. Further detailed vacancy data would help identify shortage areas and the required responses.

- 4.77 The CQC assessment of the state of care linked workforce shortages, safe levels of staffing and patient care. AfC staff and trust management on our visits also told us about the impact of staff shortages. They tended to focus on the effect of nursing shortages and we note that over half of vacancies are for other non-medical staff. Views on our visits centred on the way in which shortages affected the workload of staff since the NHS relied on their goodwill and in particular their willingness to do paid and unpaid overtime. These issues affect the morale and motivation of individual staff and across teams, which could impact on their retention or willingness to recommend the NHS as a career. Staff also told us that shortages had implications for services to patients as there were difficulties using temporary staff, particularly maintaining continuity of care. We would welcome further evidence on the impact on existing AfC staff of shortages in nursing and other AfC occupations.
- 4.78 We are concerned that targeted or local responses to staff shortages, including pay, may simply redistribute a finite pool of AfC staff and could detract from areas elsewhere in the NHS and we comment later in this chapter on the use of Recruitment and Retention Premia. As we state earlier, the long term solutions rely on increasing the numbers of entrants, which also include support through training in the early part of a career and at key stages of a career. Only once these are in place can incentives be provided to join or retrain in shortage areas. Current gaps do not allow the NHS to manage the demand for services, and the gaps can only be met by expensive alternatives, such as the short term use of agency staff. Notwithstanding the immediate costs of addressing staff shortages, if the problem is not addressed, there could be more significant long term workforce and pay costs of recruiting and retaining staff to meet demand.

Supply and recruitment of AfC staff

General

- 4.79 The problem of ensuring sufficient numbers of qualified people available and willing to work in the NHS has been a longstanding issue for NHS organisations, and a consistent feature of our recent reports. Addressing this is a long term issue which requires careful planning, taking into account a wide range of factors. Despite a range of initiatives to encourage more people to work in AfC roles in the NHS, we have yet to see an impact on the workforce gap, particularly in nursing.
- 4.80 Our assessment of the supply of qualified people available and willing to work in the NHS covers a range of sources. We examine the position of pre-registration entrants, including the period since the move from the NHS bursary to the standard student loans system in England, measures to increase clinical placements, and actions to reduce attrition rates during training. We also look at trends in EU and non-EU recruitment, the development of nursing associates and apprenticeships, and the use of bank and agency staff.
- 4.81 The lack of clarity on workforce planning and the dispersed accountability for delivering the required numbers of entrants makes it difficult to reconcile the trends in workforce numbers and the way in which they might match rising service demand. Also more explicit information on expected workforce productivity gains would help determine future workforce requirements. We have seen no assessment of the potential impact of each of the proposed solutions separately to improve the number of qualified people available and willing to work in the NHS, and whether these will be sufficient to close the workforce gap, meet growing demand and underpin new service models. None of the planned actions to increase the number of entrants will be effective in isolation. We would therefore welcome further evidence on the effect of moving from the bursary to the standard student loans system, increasing clinical placements, actions to reduce attrition rates during training, the introduction of new roles and apprenticeships, and the impact of changes in EU and non-EU recruitment.

Data on pre-registration entrants

- 4.82 Table 4.6 shows the number of applications³⁸, unique applicants (hereafter referred to as applicants)³⁹ and acceptances⁴⁰ to study for a nursing degree between 2011 and 2018. For several years we have included data from UCAS showing the number of applications and acceptances to study nursing, but this year we have also obtained data from UCAS showing the number of applicants to study nursing. We consider that applicants better reflect the number of people willing to study for a nursing degree and therefore provides a better indicator of potential nursing labour supply.
- 4.83 In 2018 there were over 162,565 applications to study a nursing degree in the UK from 48,185 applicants, with 28,540 acceptances. Compared with 2016, the number of applications and applicants have both fallen sharply, by 31% and 26% respectively. Over the same period there was a small decrease of 1% in the number of acceptances to nursing degrees. Once expressed as a ratio to the number of acceptances the number of applicants has fallen from 2.27 to 1.69 (see Figure 4.23). This fall between 2016 and 2018 has occurred since the move to the standard student loans system in England to study nursing and other AfC-related degrees.
- 4.84 The number of applicants to study nursing increased between 2011 and 2016 (Figure 4.24). As the number of acceptances also increased over that period, the ratio of applicants to acceptances has fallen continuously since 2011.
- 4.85 Mature students make up a significant proportion of those studying nursing, with around 60% of applicants to study nursing and those accepted to study aged 21 and over. The decline in the ratio of applicants to acceptances for this age group, was particularly sharp, falling from 2.69 in 2011 to 1.65 in 2018, with the numbers of applicants falling from 38,920 to 27,520.

Table 4.6: Numbers of applications, applicants and acceptances for nursing degrees, UK, 2011-2018

	Number of applications	Number of applicants	Number of acceptances	Applications per acceptance	Applicants per acceptance
2011	206,180	62,000	23,995	8.6	2.58
2012	212,375	60,570	23,835	8.9	2.54
2013	224,365	62,520	24,700	9.1	2.53
2014	237,990	66,460	26,965	8.8	2.46
2015	232,285	64,885	27,535	8.4	2.36
2016	234,760	65,555	28,890	8.1	2.27
2017	188,110	52,975	28,620	6.6	1.85
2018	162,565	48,185	28,540	5.7	1.69

Source: OME estimates using UCAS data

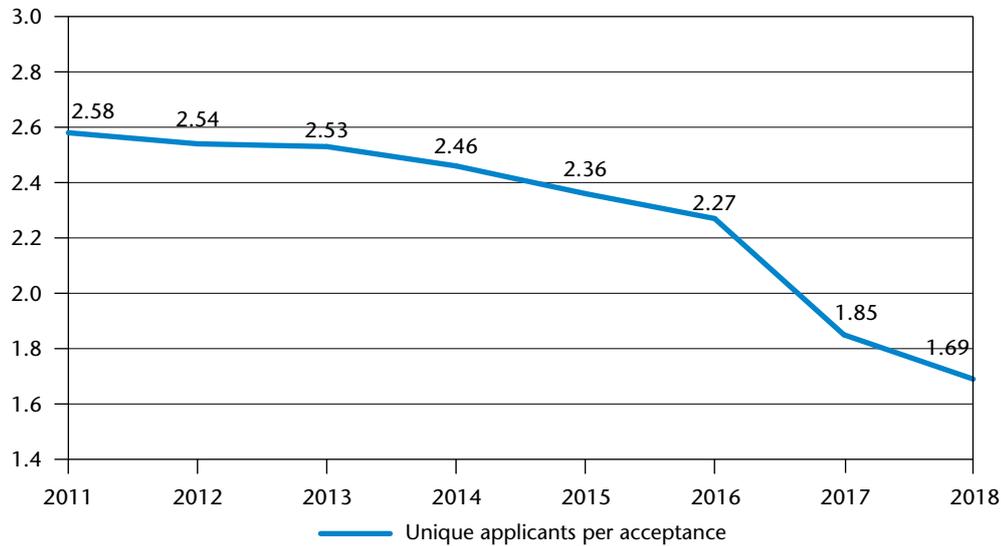
³⁸ Number of applications: defined as a choice to a course in higher education through the UCAS main scheme. Each applicant can make up to five choices.

³⁹ Number of unique applicants: defined as the number of applicants making at least one choice through the UCAS main scheme.

⁴⁰ Acceptance: defined as an applicant who has been placed for entry into higher education.

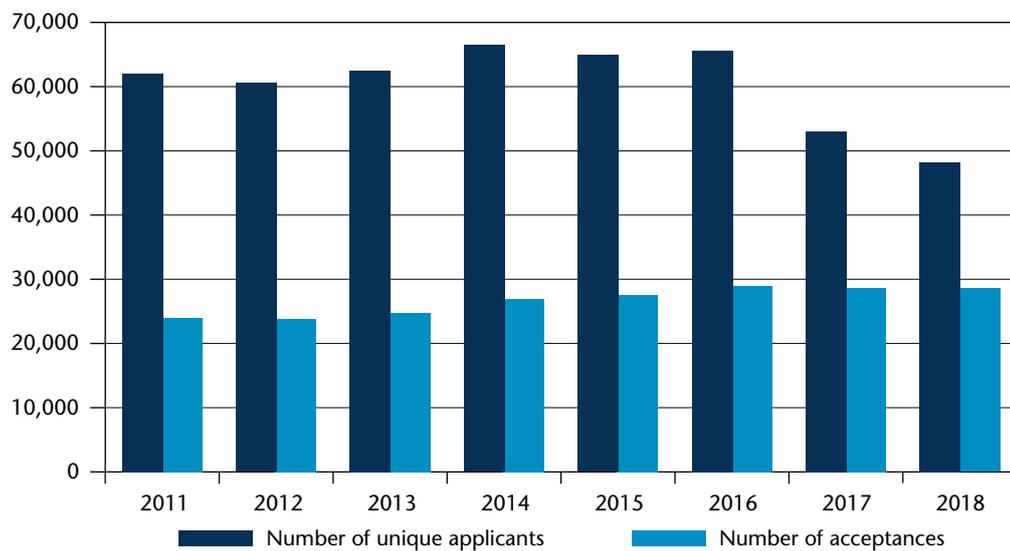
4.86 An aim of moving to the standard student loans system in England to study nursing and other AfC-related health degrees was that more people would be accepted to study these subjects as universities expanded the number of places available. The UCAS data show that between 2016 and 2018 the number of applicants accepted to study nursing that were domiciled in England had fallen by 4% while the numbers domiciled elsewhere in the UK increased by 10% (Scotland 14%, Wales 10%, Northern Ireland -1%).

Figure 4.23: The ratio of applicants to acceptances for nursing degrees, UK, 2011-2018



Source: OME estimates using UCAS data

Figure 4.24: The number of applicants and acceptances for nursing degrees, UK, 2011-2018



Source: OME estimates using UCAS data

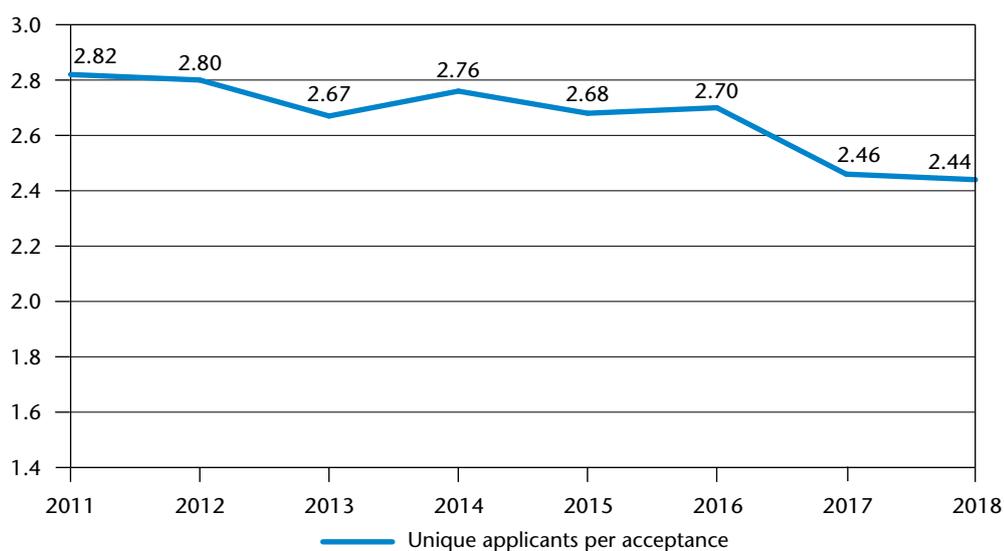
- 4.87 Table 4.7 shows that in 2018 there were 146,420 applications to study for a degree in AfC-related subjects⁴¹, excluding nursing. These applications came from 67,515 applicants, with 27,715 acceptances. Compared with 2016, the number of applications and applicants have both fallen, by 12% and 6% respectively. Over the same period the number of acceptances increased by 4%. Once expressed as a ratio to the number of acceptances, the number of applicants has fallen from 2.70 to 2.44 (see Figure 4.23).
- 4.88 Over a longer period, both applicants and acceptances increased between 2011 and 2016, meaning that the ratio of applicants to acceptances, at around 2.7 to 2.8, remained relatively stable over that period (Figure 4.25). However, since 2016 the number of applicants has declined, mainly between 2016 and 2017, while the number of acceptances has continued to rise, meaning that the ratio of applicants to acceptances has fallen since 2016.

Table 4.7: Numbers of applications, applicants and acceptances for each AfC-related health degree (excluding nursing), UK, 2011-2018

	Number of applications	Number of applicants	Number of acceptances	Applications per acceptance	Applicants per acceptance
2011	161,925	67,555	23,960	6.8	2.82
2012	155,895	63,710	22,785	6.8	2.80
2013	159,340	66,105	24,775	6.4	2.67
2014	161,510	70,155	25,440	6.3	2.76
2015	161,915	69,730	26,000	6.2	2.68
2016	165,930	71,825	26,565	6.2	2.70
2017	151,590	66,885	27,135	5.6	2.46
2018	146,420	67,515	27,715	5.3	2.44

Source: OME estimates using UCAS data

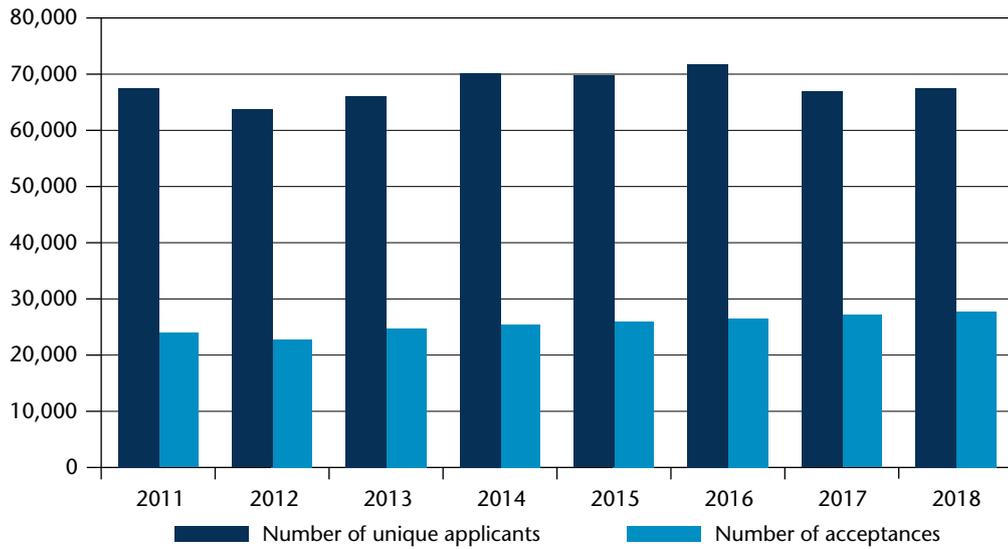
Figure 4.25: The ratio of applicants to acceptances for AfC-related health degrees (excluding nursing), UK, 2011-2018



Source: OME estimates using UCAS data

⁴¹ Subjects covered are: B1 – anatomy, physiology and pathology, B2 – pharmacology, toxicology and pharmacy, B3 – complementary medicine, B4 – nutrition, B5 – ophthalmics, B6 – aural and oral sciences, B8 – medical technology, B9 – others in subjects allied to medicine, BB – combinations within subjects allied to medicine.

Figure 4.26: The number of applicants and acceptances for AfC-related health degrees (excluding nursing), UK, 2011-2018



Source: OME estimates using UCAS data

4.89 The Higher Education Statistics Agency (HESA) publishes data on the number of graduates each year. Table 4.8 shows the number of people graduating between 2015/16 and 2016/17 (before moving to the standard student loans system in England). The latest data show that 49,512 people graduated with an AfC-related degree in 2016/17, of which over half graduated with a nursing degree. Compared with 2015/16, the number of nursing graduates increased by 10.0% and the numbers graduating with other AfC-related degrees increased by 6.3%. Over the same period, the number of graduates, across all subjects, increased by 1.7%.

Table 4.8: Graduates from AfC-related health degree courses, UK, 2015/16 to 2016/17

Year of entry	2015/16	2016/17	Change 15/16- 16/17
B1 – Anatomy, physiology and pathology	3,967	4,301	8.4%
B2 – Pharmacology, toxicology and pharmacy	3,997	4,138	3.5%
B3 – Complementary medicine	739	469	-36.5%
B4 – Nutrition	1,126	1,237	9.9%
B5 – Ophthalmics	789	873	10.6%
B6 – Aural and oral sciences	944	965	2.2%
B7 – Nursing	22,667	24,937	10.0%
B8 – Medical technology	1,812	1,924	6.2%
B9 – Others in subjects allied to medicine	9,315	10,505	12.8%
BB – Combinations within subjects allied to medicine	150	161	7.3%
Grand total (Section B)	45,505	49,215	8.2%
Grand total (Section B less B7 nursing)	22,838	24,278	6.3%
Grand total (all subjects)	394,304	400,918	1.7%

Source: OME analysis of HESA data

- 4.90 Although almost 50,000 people graduated with an AfC-related degree, not all of those will become NHS workers. Table 4.9 shows the destination of 2016/17 graduates from AfC-related degree courses. For example, of the almost 23,600 nursing graduates with a known destination, 79% were employed in the hospital sector, 4% in the GMP sector, 2% in residential care and a further 11% in other health activity⁴².
- 4.91 Each AfC-related subject saw a smaller proportion of its 2016/17 graduates enter the hospital sector than the 2015/16 cohort, with numbers dropping by between 1 and 4 percentage points depending on the course. Conversely, the proportion of graduates entering the other health activity sector rose for all subjects, except ophthalmics and broadly-based programmes within subjects allied to medicine.

⁴² Other health activity includes activities for human health not performed by hospitals or by practicing medical doctors but by paramedical practitioners legally recognised to treat patients. See: <https://www.siccodes.net/classification/division/86>.

Table 4.9: Destination of graduates from AfC-related health degree courses, by proportions, 2016/17 (row percentages)

	Hospital sector	GMP sector	Specialist medical activity	Dental sector	Residential care	Other health activity	Total non-health ⁴³	Number with known destination (% known of total)
Anatomy, physiology & pathology	50%	1%	6%	0%	1%	8%	33%	3,234 (75%)
Pharmacology, toxicology & pharmacy	29%	2%	0%	0%	0%	3%	67%	3,492 (84%)
Complementary medicines, therapies & well-being	3%	1%	38%	0%	0%	20%	38%	367 (78%)
Nutrition	32%	2%	1%	0%	1%	7%	58%	941 (76%)
Ophthalmics	11%	0%	0%	0%	0%	1%	87%	818 (94%)
Aural & oral sciences	38%	2%	1%	0%	1%	21%	37%	840 (87%)
Nursing	79%	4%	0%	0%	2%	11%	5%	23,583 (95%)
Medical technology	84%	1%	0%	1%	0%	4%	10%	1,756 (91%)
Others in subjects allied to medicine	31%	4%	1%	0%	2%	27%	36%	8,461 (81%)
Broadly-based programmes within subjects allied to medicine	2%	0%	0%	0%	0%	1%	97%	80 (50%)

Source: OME analysis of HESA 2016/17 data

4.92 We heard on our visits, and saw in HEE's Reducing Pre-registration Attrition and Improving Retention (RePAIR) project, that there were pressures on students during training. These included financial concerns and the timing and quality of clinical placements, which influenced whether students completed their courses and qualified to enter the NHS. We note that the NHS Long Term Plan refers to several actions which could help improve attrition rates, such as increased funding for clinical placements, a new online nursing degree, and support for mature students in mental health and learning disability nursing. We look forward to further information on the effectiveness of these measures and, in the meantime, we will continue to include students in our visit programme so we can hear their concerns.

⁴³ Total non-health includes tertiary education and other non-health activities.

Our analysis of pre-registration entrants

- 4.93 Our assessments on pre-registration entrants will continue to be informed by trends in applicants, acceptances, wastage, destinations and comparative pay rates. As mentioned earlier, the number of applicants provides a better indicator of potential nursing labour supply than the number of applications. There are several specific concerns on the supply of pre-registration entrants. There has been a 26% fall in the number of nursing applicants between 2016 and 2018, a fall in the ratio of applicants to acceptances and a particularly sharp fall in applicants aged 21 and over, with the latter being 60% of applicants which is a significant proportion of students.
- 4.94 Despite these recent trends, there has been only a small effect on acceptances to nursing degrees between 2016 and 2018 which fell by only 1%. The fall in applicants has occurred since the move to the standard student loans system in England although there has yet to be any indication that the reduction in applicants has affected the quality or attrition of entrants to nursing degrees. The recent trend needs to be seen in the context of the overall fall in the population of 18 year olds in the UK population by 10.4% since 2009, projected by the ONS to continue until 2020⁴⁴, which will have affected the number of applicants for all degree courses.
- 4.95 There is now a market operating for university places for nursing and AfC-related health degrees, and the number of applicants per acceptance could, therefore, be a reflection of the intrinsic popularity of a course. Changes in the number of applicants for nursing could also be influenced by the availability of a broader range of health-related degrees and the increase in medical places available to those with higher entry qualifications. This balance and any resulting shifts will need to be monitored to ensure nursing and AfC-related degree courses remain attractive in relation to other options.
- 4.96 We did not hear any support from the parties for the suggestion in the NHS Long Term Plan of reviewing the entry tariff points by universities to encourage more entrants (see Chapter 2, paragraph 2.12). The parties felt that such a move could have implications for wastage rates and quality of entrants to the NHS. We note from the NHS Long Term Plan for England that, in practice, universities turned down 14,000 applicants for nursing degrees in 2018. It would be helpful to understand the proportion of these who had the appropriate qualifications but were not offered a place and the extent to which this was because of limited clinical placements. The parties' evidence and views on our visits confirmed that the volume of available clinical placements depends on capacity, supervision and backfill costs within trusts and other providers. Trusts remained concerned that clinical placements represented a cost, as the students could not substitute for full time, fully trained staff and were considered supernumerary.
- 4.97 DHSC intends a 25% increase in nurse undergraduate places facilitated by clinical placements for an extra 5,000 places from 2019/20 in England and, from 2020/21, funding for clinical placements for as many places as universities fill (up to a 50% increase). If the available pool of applicants are appropriately qualified, if the Government meets its target for additional clinical placements and this removes a current constraint on the number of places universities can offer, and if the market for university places is working, one might expect a significant rise in the number of nursing and AfC-related acceptances onto degree courses in 2020, 2021 and 2022.

⁴⁴ Office for National Statistics (September 2018), *Being 18 in 2018*. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/articles/being18in2018/2018-09-13>

- 4.98 The central objective of training enough qualified AfC staff to close the workforce gap will remain challenging. The trend in the number of applicants suggests that nursing, and possibly other AfC professions, could be becoming less attractive to entrants. Against this background, it is important that clear mechanisms need to be in place to improve the attractiveness of nursing within the NHS and to encourage the right numbers of suitably qualified applicants. We note that the NHS Long Term Plan included some innovative measures, including a new online nursing degree, alongside initiatives already underway. We await further detail on how these would be delivered and co-ordinated in a consistent way, including the expected impact on workforce numbers. Pay has a part to play in increasing the attractiveness of NHS careers and the increases to starting pay under the AfC pay agreement should start to support other mechanisms to attract entrants.
- 4.99 Attrition during training represents a significant loss of potential qualified employees at a time when the NHS is experiencing a significant workforce gap. HEE's RePAIR research has identified key issues affecting attrition, but as yet there is little sign of any response or action being taken. Further evidence on the impact of these issues during training should be provided by the parties.
- 4.100 Overall, we look forward to more evidence on the way in which the targets can be achieved given the current trends and a better understanding of the factors driving applicants, acceptances and attrition.
- 4.101 We have also examined the position on applicants accepted across the UK countries. In England, student funding moved from the NHS bursary to the standard student loans system in 2017, but the bursary remains in place in Scotland, Wales and Northern Ireland allowing the effects to be compared as the trends emerge. The fall in applicants accepted to nursing degrees between 2016 and 2018 was notable for those domiciled in England, and contrasted with increases in applicants accepted in Scotland and Wales, with a slight fall in applicants accepted in Northern Ireland. We note from the evidence and our previous reports that the Devolved Administrations have decided to increase the number of commissioned places available, particularly in nursing. We ask that the parties keep us informed of the underlying trends and factors influencing pre-registration entrants for each of the countries in the UK.

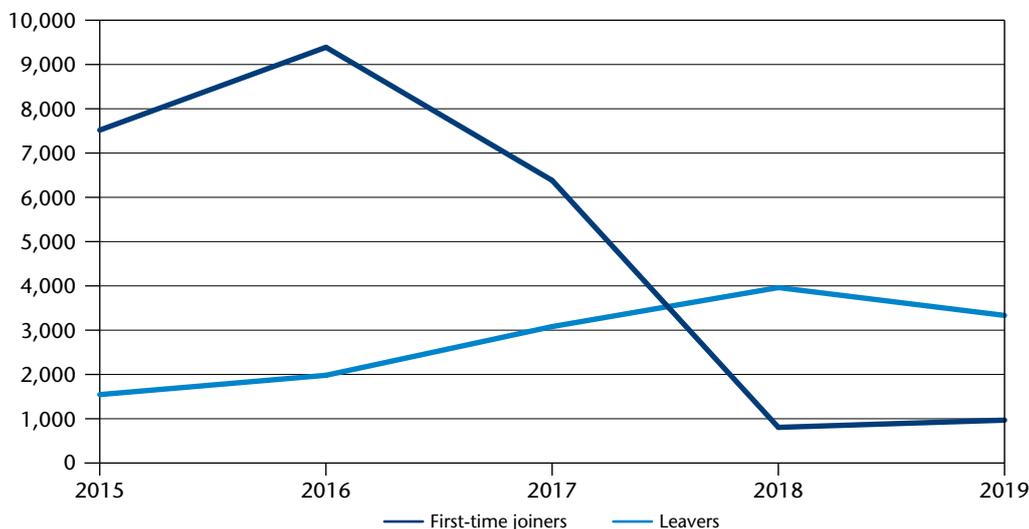
EU and non-EU recruitment

- 4.102 The NMC data on registrations at March 2019 showed that the number of initial registrants from the EEA was slightly higher in 2019 than in 2018, at 968 compared to 805. However, the number of initial registrants was still almost 90% lower than it was at its peak of 9,389 in 2016. The number of EEA-qualified nurses and midwives leaving the register fell slightly between 2018 and 2019, from 3,962 to 3,333, though this was still 16% more than in 2015.
- 4.103 Between 2018 and 2019 the number of joiners from outside the EEA more than doubled, from 2,724 to 6,157. This increase is consistent with the nursing profession being included on the Shortage Occupation List⁴⁵ by the Migration Advisory Committee. The number of leavers from the register fell for the second consecutive year, from 2,002 in the year to March 2018 to 1,730 in the year to March 2019.

⁴⁵ UK Tier 2 Restricted Certificates of Sponsorship are subject to an annual cap of 20,700 although nurses and medics are no longer included in the cap.

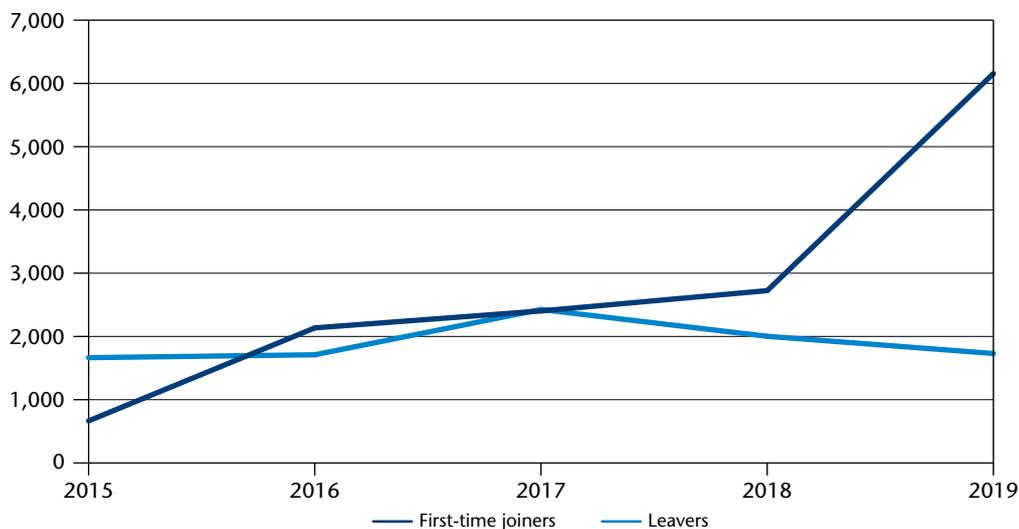
4.104 We note that in March 2019 the UK Government announced⁴⁶ a temporary extension to January 2021 to the salary exemption for nurses, paramedics and medical radiographers which reduced the salary threshold for experienced professional staff to £20,800 from the £30,000 threshold for other professions.

Figure 4.27: Nurses and midwives from the EEA joining and leaving the NMC register each year, UK, March 2015 to March 2019



Source: NMC Register, March 2019

Figure 4.28: Nurses and midwives from outside the EEA joining and leaving the NMC register each year, UK, March 2015 to March 2019



Source: NMC Register, March 2019

⁴⁶ Home Office (March 2019), *Changes to the Immigration Rules*. Available at: www.gov.uk/government/news/changes-to-the-immigration-rules--3

Recruitment of nursing associates

- 4.105 The expanded nursing associate programme aimed to train 5,000 nursing associates in 2018 and HEE reported that almost 3,000 had enrolled at November 2018. A further 7,500 nursing associates were to be in training in 2019. The first nursing associates qualified in January 2019 and, at the time of this report, were being deployed to trusts in England. The NMC included 489 nursing associates in its register for the first time at March 2019. The NMC published extensive information on the standards of proficiency for nursing associates⁴⁷ and NHS Employers issued a guide for employers⁴⁸ which included information on deployment. We consider that the development of nursing associates and other new roles could make a significant contribution to meet rising demand and new service models. The new roles potentially represent a small part of the solution to closing the workforce gap. A strategic approach to deployment under the forthcoming Workforce Implementation Plan will be required for the ambitions of the nursing associate programme to be realised. We consider that the effectiveness of the introduction and impact of nursing associates will be a key leading indicator in assessing the success of workforce development.
- 4.106 We received conflicting evidence from the parties, and from AfC staff on our visits, on the potential for effective deployment of nursing associates. There were indications that nursing associates had not been deployed consistently within trusts, and some confusion on their roles and responsibilities. We conclude that there is a need for overarching direction, leadership and a coherent strategy across the NHS for nursing associates in order for the role to be deployed effectively.
- 4.107 We have heard from AfC staff on our visits that there is a need for clear career pathways and opportunities to progress into registered roles. The development of nursing associates and other new roles should be accompanied and supported by clear career mapping. These groups could require attention to match their career aspirations.

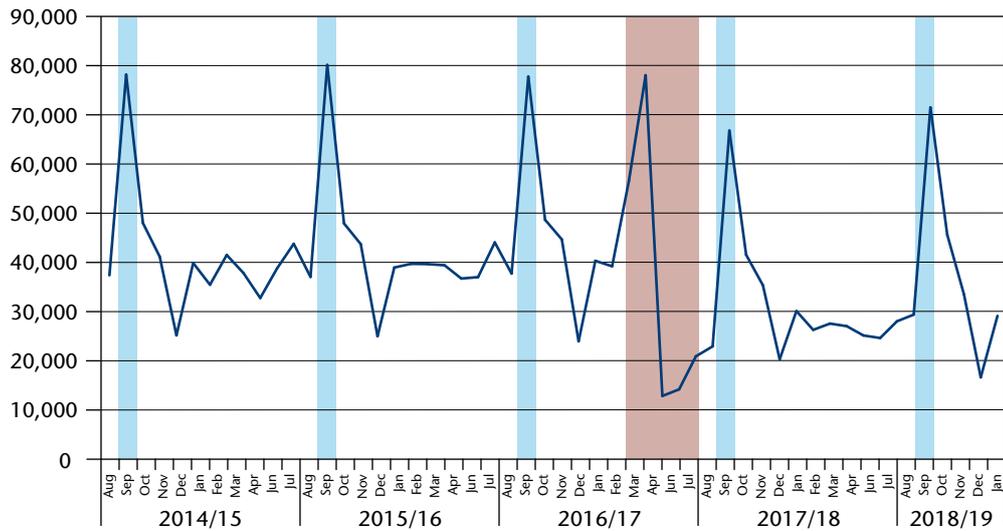
Recruitment of apprentices

- 4.108 Following the introduction of the apprenticeship levy in 2017, the number of all apprenticeship new starts in 2017/18 fell by 26%, compared with 2015/16, to a total of 375,800 new starts in England. Between August 2018 and January 2019, there were 22% less than the equivalent period in 2015/16.

⁴⁷ Nursing and Midwifery Council (October 2018), *Standards of Proficiency for Nursing Associates*. Available at: <https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/nursing-associates-proficiency-standards.pdf>

⁴⁸ NHS Employers (2019), *Employer Guide to Nursing Associates*. Available at: https://www.nhsemployers.org/employershandbook/nursingassociates/employer_guide_to_nursing_associates.pdf

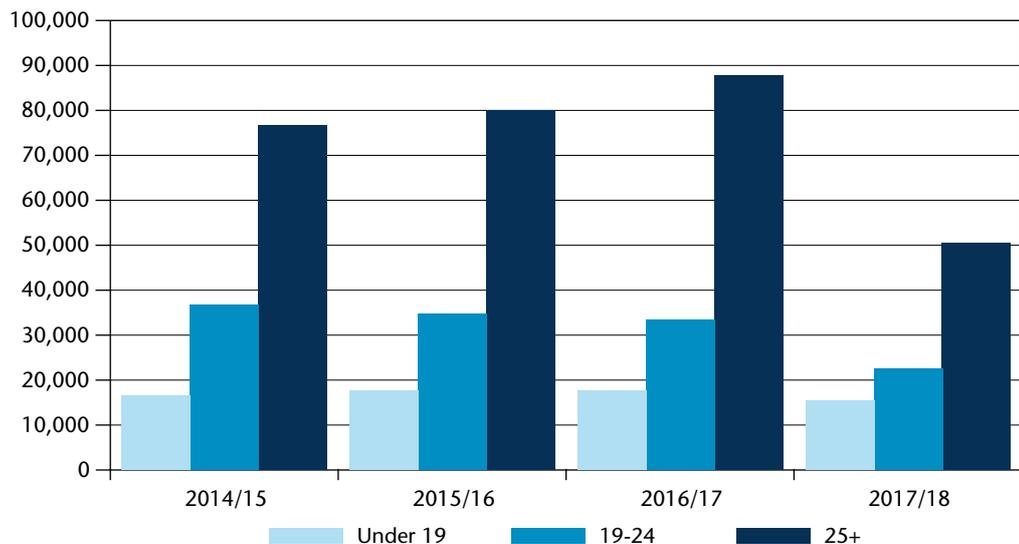
Figure 4.29: Number of apprenticeships started in England each month, August 2014 to January 2019



Source: OME analysis of Department for Education data
 Notes: The blue highlighted areas indicate the yearly September peak. The red highlighted area indicates the period around the introduction of the apprenticeship levy, when the number of starts deviated from the ordinary seasonal pattern.

4.109 The number of Health, Public Services and Care apprenticeship starts exhibited a similar pattern to that of all apprenticeship starts in England. In 2017/18, there were 88,300 starts, compared with 132,400 in 2015/16, representing a fall of 33%. Between August 2018 and January 2019, the number of Health, Public Services and Care apprenticeships started in 2018/19 was 22% lower than the equivalent period in 2015/16. The drop was particularly pronounced among older age groups. Between 2015/16 and 2017/18, there was a 37% decrease in the number of starters aged 25 or over, a 35% decrease in the number aged between 19 and 24, and a 14% decrease in the number aged 18 or under. This aligns with the trend for all apprenticeships across England, where the equivalent decreases were 31%, 26%, and 19%, respectively.

Figure 4.30: Number of Health, Public Services and Care apprenticeships started in England, by age band, 2014/15 to 2017/18



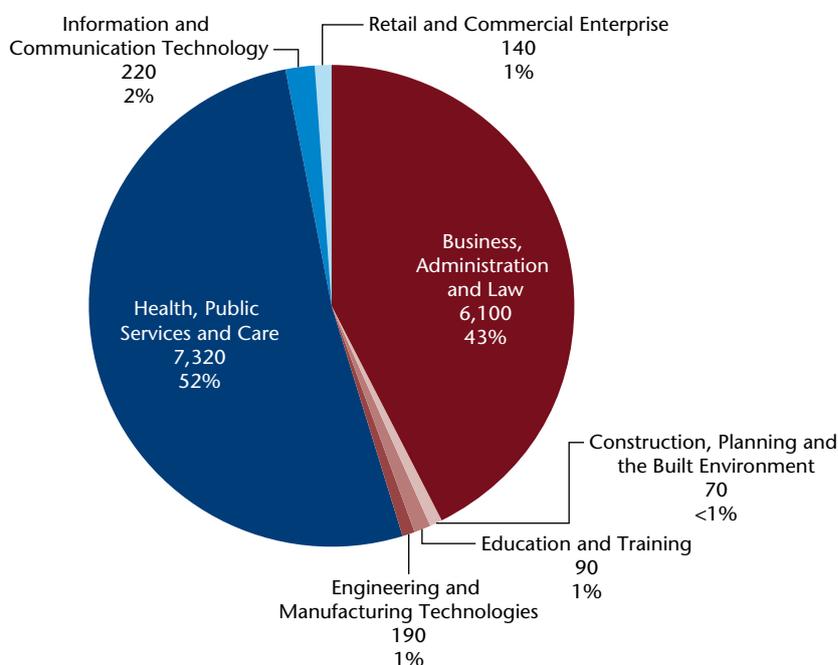
Source: OME analysis of Department for Education data

4.110 The Department for Education has published figures on the number of apprenticeships started with public sector employers, including the NHS, in England between May 2017 and March 2018. These show that, of a total of 318,900 apprenticeship starts during this period, 44,900 (14%) were in the public sector, including 14,160 in the NHS. The NHS therefore accounted for just over 4% of all apprenticeship starts, and 32% of all public sector starts.

4.111 There were 68,300 individuals who started a Health, Public Services and Care apprenticeship in England between May 2017 and March 2018; of these, 7,320 (11%) did so through the NHS and 6,320 (9%) did so through some other public sector employer. The remaining 80% either began their apprenticeship with a non-public sector employer or with an employer without a registered apprenticeship service account.

4.112 Although the majority (52%) of NHS apprenticeship starts were in the Health, Public Services and Care sector subject area, there was a significant minority of individuals (43%) who started an NHS apprenticeship in Business, Administration and Law.

Figure 4.31: Number of NHS apprenticeship starts by sector subject area, England, May 2017 to March 2018



Source: Department for Education

Notes: Figures are rounded to the nearest 10. There were 10 starters in Arts, Media and Publishing and 10 starters in Science and Mathematics who are not shown on the above chart. There were fewer than 5 starters in Agriculture, Horticulture and Animal Care, and in Leisure, Travel and Tourism.

4.113 DHSC, NHS Employers and the Joint Staff Side reiterated, in evidence, that apprenticeships are an important source of supply across a range of NHS occupations. They are in place for many entry-level NHS roles and at degree-level for entry to AfC professions. The effective use of apprenticeships in the NHS could contribute to supporting overall workforce developments in moving to new ways of working and achieving a change in skill mix.

- 4.114 Despite the efforts of trusts, we have heard from NHS Employers a number of practical concerns about apprenticeship programmes. These concerns were echoed by what we heard from trust management and staff on our visits. There are frustrations about the ring-fencing of apprenticeship funds from the levy since its introduction in 2017. There are also concerns about the capacity for supervision, the time requirements for off-the-job training and backfilling of posts. All these have a cost to employers. We also note the extensive evidence from UNISON, which said that the funding bands were inadequate for the NHS and a national fund was needed; that capacity was affected by staff shortages; and that large-scale programmes were needed for degree-level apprenticeships. The range of these concerns suggest to us that, in order to realise the full benefits of apprenticeships, a coherent NHS-wide strategy is required on the approach supported by national leadership. Trusts also told us on our visits and during our evidence sessions that investing resource in teams to manage their local apprenticeship programmes paid dividends in ensuring that such programmes were effective.
- 4.115 When the nursing degree apprenticeships were introduced in 2017, the UK Government envisaged 1,000 starters a year. In reviewing nursing degree apprenticeships, the House of Commons Education Committee⁴⁹ reported that initial provision was small, with only 30 starters across two universities in 2017/18, although there were 61 providers approved by the NMC to deliver nursing degrees in England. The Education Committee reported that there were barriers to overcome, and looked forward to the expansion of the programme, but recommended more flexibility on the use of levy funds. We note from the RCM's evidence that midwifery degree apprenticeships are due to start in 2019 and that there are similar concerns. Given these concerns, we would welcome further evidence from the parties on the way in which degree-level apprenticeships are developing.
- 4.116 The Joint Staff Side were concerned that many lower pay band posts were being converted into apprenticeships and that posts in Bands 1 and 2 in particular were being replaced by apprenticeships. These posts were being offered at apprentice rates of pay rather than at AfC rates. We heard similar views on our visits. The parties will wish to consider the way in which the level of AfC apprenticeship pay interacts with the apprentice rate of the National Minimum Wage. We commented in our 2018 Report on the need for consistency in identifying apprenticeship routes, career pathways and supporting pay arrangements. On the latter point, we note that there had been further negotiations on apprenticeship pay in the NHS Staff Council although funding constraints were making it difficult to reach agreement. We encourage further discussion among the parties to reach consensus on a consistent approach to AfC apprenticeship pay arrangements to support a stable source of workforce supply. We stand ready to review arrangements if required.
- 4.117 As the labour market tightens there will be increasing competition for those already in, joining and re-joining the labour market. Effective apprenticeship programmes could give the NHS a competitive advantage in attracting people into the NHS, delivering high quality training and providing a clear route into NHS careers.

Supply of bank and agency staff

- 4.118 We note from the latest *NHS Improvement 2018/19 Quarter 3 Performance Report*⁵⁰ that the ceiling for agency spend had been further reduced. However, agency spend had increased slightly compared with 2017/18, and there was an overspend on bank costs. Taken together, agency and bank spend increased by 8.0% on 2017/18, but NHS Improvement attributed this to an increase in volume rather than price.

⁴⁹ House of Commons Education Select Committee (December 2018), *Nursing Degree Apprenticeships: In Poor Health?* Available at: <https://publications.parliament.uk/pa/cm201719/cmselect/cmeduc/1017/101702.htm>

⁵⁰ NHS Improvement (March 2019), *Performance of the NHS Provider Sector for the Quarter Ended 31 December 2018*. Available at: <https://improvement.nhs.uk/resources/quarterly-performance-nhs-provider-sector-quarter-3-201819/>

- 4.119 The NHS relies on a consistent source of temporary staffing enabling trusts to flex the workforce according to demand levels. Approximately 90% of AfC vacancies were covered by bank and agency staff. Since the introduction of the ceiling in 2015, agency spending has been more effectively controlled and there has been a shift towards bank arrangements. The parties told us that moving staff from agency to bank was a positive development, as it provided flexible employment for staff and better continuity of care for patients. We note this point is supported by the fact that 75% of nurses and midwives who work bank assignments also hold a substantive contract.
- 4.120 We continue to consider that bank working could be part of the solution to offering AfC staff more flexible working arrangements, which benefit both staff and trusts. More work is needed to clarify the role played in the long term by NHS banks as part of the overall resourcing strategy. We were therefore pleased to see that the AfC pay agreement proposed further negotiations through the NHS Staff Council on a collective framework on bank and agency working as a priority for 2019. On reward arrangements, these negotiations might seek some consistency in the rationale for bank and agency pay rates, the implications of differences in rates with AfC rates, and any equal value considerations. We look forward to the outcome and the parties' evidence for our next report, which might also include information on developments in bank arrangements in recent years, such as e-rostering, regionalising banks under Sustainability and Transformation Partnerships, and other pilot programmes.
- 4.121 We note that there is an all-Wales contract for agency staff in NHS Wales which, although enabling a cost effective solution, has seen a steady rise in expenditure since its introduction 2017. In Northern Ireland, agency spending has increased significantly over the last five years. Health and Social Care Trusts have a regional agency framework in Northern Ireland which aims to control the level of spending through trust-specific protocols governing the employment of agency staff. We consider that actions to bring down agency spending to an affordable level in the short term could be challenging. Further evidence from the Welsh Government, the Department of Health, Northern Ireland and the Joint Staff Side would be helpful on any implications of increased spending and the way in which the management of temporary staff is covered within their respective workforce strategies.

Retention

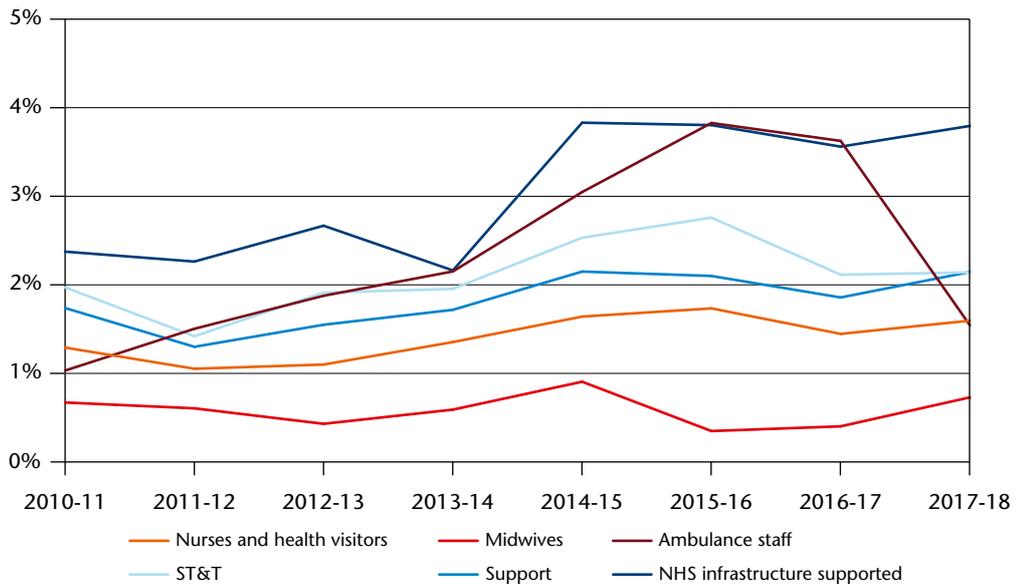
- 4.122 In England, the overall leaving rate stabilised between 2017 and 2018. At March 2018, leaving rates for individual AfC groups remained at similar levels to March 2017. There was a slight narrowing of the difference between the joining and leaving rates as a result of a reduction in the joining rate.
- 4.123 In Scotland, there was a slight fall in leaving rates in 2017/18, with no change in the rate for nursing and midwifery staff but an increase for personal and social care, and ambulance services. There was an overall increase in the leaving rate in NHS Wales, with a slight fall for registered nursing and midwifery staff, and an increase in the leaving rate for AHPs.
- 4.124 There were increases in the leaving rate in Northern Ireland across AfC staff as a whole. Between 2017 and 2018, the leaving rate for nursing and midwifery staff increased from 5.9% to 6.8%. There were also smaller increases in the leaving rate for social services staff.

Table 4.10: Leaving and joining rates to the NHS by staff group headcount and country, year to March 2018

England	Leaving rate	Joining rate	Percentage point difference
AfC staff (exc. bank and locums)	11.2%	11.3%	0.1
Nurses & health visitors	10.7%	10.3%	-0.4
Midwives	10.5%	11.1%	0.6
Ambulance staff	7.9%	7.6%	-0.3
Scientific, therapeutic & technical staff	10.9%	12.8%	1.9
Support to clinical staff	11.7%	14.6%	2.9
NHS infrastructure support	11.5%	6.1%	-5.4
Scotland	Leaving rate	Joining rate	Percentage point difference
AfC staff	6.9%	7.1%	0.2
Nursing and midwifery	7.6%	7.7%	0.1
Allied health professions	6.8%	7.5%	0.7
Other therapeutic services	7.0%	11.0%	4.0
Personal and social care	14.2%	21.5%	7.3
Healthcare science	8.1%	7.1%	-1.0
Ambulance services	11.0%	11.8%	0.8
Administrative services	7.8%	7.9%	0.1
Support services	9.1%	9.4%	0.3
Northern Ireland	Leaving rate	Joining rate	Percentage point difference
AfC staff	5.9%	7.2%	1.3
Administration & clerical	5.6%	5.8%	0.2
Estates services	6.4%	6.0%	-0.4
Support services	6.1%	9.9%	3.8
Nursing & midwifery	6.8%	7.3%	0.5
Social services (excl. domiciliary care)	5.4%	7.7%	2.3
Professional & technical	4.6%	7.5%	2.9
Ambulance	2.9%	3.5%	0.6
Wales	Leaving rate	Joining rate	Percentage point difference
NHS Wales (inc. medical and dental)	6.7%	8.2%	1.5
Nursing and midwifery registered	7.0%	7.4%	0.4
Allied health professionals	8.3%	9.3%	1.1
Estates and ancillary	8.3%	7.5%	-0.8
Healthcare scientists	6.1%	7.8%	1.7
Additional professional scientific & technical	9.6%	13.7%	4.1
Additional clinical services	9.6%	11.9%	2.3
Administrative and clerical	7.8%	11.1%	3.4

Source: NHS Digital; Information Services Division Scotland; StatsWales; and Department of Health, Northern Ireland.

Figure 4.32: Percentage of leavers citing “voluntary resignation for better reward package” as a reason for leaving by staff group, England 2010/11 to 2017/18



Source: NHS Digital

4.125 NHS Digital publishes data which identify the reasons why staff leave the NHS in England. The percentage of leavers citing “voluntary resignation for better reward package” as a reason for leaving by staff group between 2010/11 and 2017/18 is set out in Figure 4.32. NHS infrastructure support staff are most likely (3.8%) to cite this as a reason for leaving, with between 0.7% and 2.1% of other staff groups leaving for a better reward package. However, there is a large percentage of leavers where the reasons for leaving are unknown (for example over 40% of nurses, midwives and health visitors) which means that the real percentage leaving for a better reward package is likely to be higher.

4.126 The data on the reasons for AfC staff leaving the NHS remain patchy at best, and inadequate to make a full assessment of the influencing factors. Companies and institutions use leaver data to judge the appropriateness of the reward package and to check for risks to their operations, and the NHS needs to be able to test the same risks. We would welcome urgent action on developing this information, including whether there are any specific data that can be drawn from NHS Improvement’s retention programmes with individual trusts. The parties’ evidence and our visits highlight that retention is influenced by factors relating to working arrangements and pressures. These include sufficient staffing levels, addressing workload, CPD access, work/life balance and flexible working to support different career stages. We note that some aspects are being covered by discussions under the AfC pay agreement, including health and wellbeing and bank/agency arrangements.

4.127 A degree of turnover is normal to refresh the workforce. Employers in the NHS would also expect a number of staff to move between trusts which reinforces the need for better data on leavers to understand any operational implications. The most recent data on turnover indicate that, after a consistent upward trend in turnover rates since 2010 particularly for clinical staff, turnover in 2017/18 levelled off. There has been an increase in the proportion of leavers doing so by voluntary resignation although the proportion leaving for better reward has remained stable.

- 4.128 While the stabilising position on turnover is a welcome first step in halting the trend, it remains questionable whether retention rates could be brought to a level approaching that required to close the workforce gap. The NHS Long Term Plan included the target to improve retention by 2 percentage points by 2025. Some of the loss of experienced staff is to be made up by increased numbers entering the AfC workforce through new routes, including nursing associates and apprenticeships. However, this balance between improved retention and new supply needs to be quantified to help employers manage their workforce.
- 4.129 We welcome the progress with NHS Improvement's retention programmes for individual trusts and see these as a good example of implementing targeted approaches to make a significant impact. These programmes appear to be having an effect for those participating, particularly on nursing retention, and the NHS Long Term Plan pointed to the programmes being extended to all trusts. We would encourage all trusts to build on the lessons learned from the programme and to share good practice and effective solutions on retention.

Recruitment and Retention Premia and High Cost Area Supplements

General

- 4.130 The Agenda for Change pay system includes a mechanism which allows Recruitment and Retention Premia (RRP) to be awarded on a national basis to particular groups, based on Pay Review Body recommendations, when it can be demonstrated there are national recruitment and retention pressures. In the light of the remit letter requesting considerations for IT staff, the parties commented more widely on RRP in their evidence. Both NHS Employers and the Joint Staff Side said that they would welcome our examination of RRP and provided commentary on some general principles. We look forward to reviewing the evidence should DHSC provide us with a remit to review RRP as trailed in the 2018 AfC pay agreement.
- 4.131 Any review of RRP would need to consider the prevailing labour market conditions. These differ markedly for different AfC staff groups. For those AfC professions where supply is currently restricted, the short term use of RRP is not an effective solution as it simply serves to divert resource from one trust to another and risks impacting on neighbouring trusts. For those occupational groups where there is open competition for skills available within local labour markets, a variety of solutions could be needed, including an RRP. The Pay Review Body will remain mindful that pay developments, including any targeted solutions, may create distortions across the pay structure, such as shifting the pay relativities between clinical and non-clinical staff.
- 4.132 We were also provided with a helpful update on RRP in Wales and Northern Ireland (see Chapter 3, paragraphs 3.108 and 3.109). Any review of RRP would need to include evidence from the Devolved Administrations given the internal arrangements in each country.

IT staff

- 4.133 The Secretary of State for Health and Social Care's remit letter asked us to consider issues regarding the difficulties of recruiting and retaining IT staff in the NHS in England. The Secretary of State sought our observations on the labour market issues and our recommendations, including any case for a national Recruitment and Retention Premium. We note the context for this request is the emphasis in the NHS Long Term Plan on the development of medical technology and digital services which would require a skilled, effective supporting AfC workforce and could enhance NHS productivity. A new NHSX unit is also being established to take forward digital transformation in the NHS, allowing patients and staff to benefit from the latest digital systems and technology. We have heard consistent messages on our visits of the value to trusts and staff of effective IT systems in delivering high quality patient services.
- 4.134 DHSC's evidence suggested that it had made only limited progress in assessing the recruitment and retention difficulties for IT staff. DHSC had yet to form a comprehensive evidence-base and was seeking to establish data sources. NHS Employers, NHS Providers and the Joint Staff Side did not see IT staff as a priority group for pay, and said they would need to see further evidence to support any move to a pay solution. However, there was some limited, emerging evidence on shortages, suggested by a lower Stability Index for senior IT staff at AfC Band 7 and above than for all NHS staff as a whole. Data from an NHS Employers' survey suggested that over half of trusts responding had recruitment and retention challenges for IT staff at Band 6 and above, with the majority of these trusts reporting that these were most acute at Band 7 and above. The same survey indicated geographical barriers to recruiting and retaining IT staff.
- 4.135 There are likely to be considerable variations by geographical area. Local labour markets can be influenced by the prevalence of larger IT firms or higher demand for IT skills in the local economy. A better identification of the specific IT roles experiencing recruitment and retention difficulties would be essential, given the range and levels of roles covered by this occupational group. We also understand that IT staff might be employed or engaged in different ways in the NHS reflecting both the varying business needs and, to some extent, the preferences of staff. These include permanent employment, short term employment, fixed term linked to the length of specific IT projects, and on fixed contracts. These variations suggest that a "one-size fits all", national pay approach might not achieve its aims and we note that the existing mechanism of local RRP is available to tailor pay solutions to local needs.
- 4.136 The initial evidence provides indications of some issues in IT recruitment and retention but not at this stage sufficient evidence of a widespread national problem to support an immediate pay response. We consider the assessment for IT staff would need to be supported by evidence on the following:
- The development of a clear strategy on the IT workforce in the NHS, particularly to support the NHS Long Term Plan and the emerging role of NHSX;
 - The completion of a strategic assessment of the measures required to increase the supply of IT staff to the NHS, with reference to the nature of the external market;
 - Clear identification of the IT roles and levels affected by recruitment and retention difficulties, and the specific skills in short supply;
 - The role of pay in addressing recruitment and retention in the IT labour market, and the way in which pay could increase supply in the longer term;
 - The supporting business benefits of any pay solutions, plus clear criteria for their application, including roles to be targeted, pay values (and any flexibility), and time limitations to be applied. Any pay solution would require an equality impact assessment; and
 - An assessment of the impact of any IT pay solution on other AfC groups, including recruitment, retention and motivation.

4.137 We note that the request to consider recruitment and retention of IT staff was for England only. Should a full case be presented we would welcome contributions from the Devolved Administrations on whether similar considerations would apply in individual countries.

Northern Ireland nursing specialisms

4.138 The Permanent Secretary's letter asked us to consider any issues raised regarding difficult to fill nursing specialism posts, such as care of older people, acute medicine and critical care to include theatres in Northern Ireland, and our recommendations, including any case for an RRP. While the Department of Health pointed to challenges in addressing shortages, it put this in the context of needing a wider examination of hard to fill posts. We note that the Joint Staff Side pointed to shortages but had no specific evidence for individual groups. In addition, Northern Ireland has a local mechanism to determine whether an RRP is an appropriate solution. In relation to targeted pay solutions, we consider that the supply of AfC nurses is restricted suggesting that the short term use of RRP risks diverting resource from one specialism to another without reducing shortages overall.

4.139 As we did not receive any detailed evidence on which to make an assessment, we can only ask the parties to present further evidence on the recruitment and retention issues for nurses should they wish us to review the position. In this regard, we reiterate our conclusions elsewhere on pay solutions requiring a robust case with supporting evidence and data. This should include a strategic assessment of the nursing workforce, the specific roles affected, the way in which supply could be increased, other non-pay factors and the impact of any pay solutions on other groups.

High Cost Area Supplements

4.140 We note that the 2018 AfC pay agreement allowed for further consideration of the role of High Cost Area Supplements (HCAS). We await DHSC's views on whether to provide a remit to review HCAS.

Motivation and engagement

4.141 The planned service transformation in the NHS and the implementation of the NHS Long Term Plan will require a substantial measure of goodwill and engagement from AfC staff to be effective. Staff motivation, morale and engagement are key elements of our terms of reference and are enablers of delivering workforce and service change. In this section we therefore review the evidence on motivation and engagement through the results of recent Staff Surveys, the results of the Friends and Family Test, and sickness absence rates. These sources are important to our deliberations as they provide indications of staff satisfaction with the total reward package. AfC staff who are content with their work and the organisation in which they work are more likely to perform well, stay in the NHS and to act as advocates for AfC roles to others.

4.142 We have heard consistent messages in the parties' evidence and during our visits on the importance of promoting staff health and wellbeing. We note that there are a range of initiatives underway through the NHS Long Term Plan, NHS Improvement's collaborative programme and the AfC pay agreement. In recent years, we have also commented on the concerted efforts made by NHS Employers to provide tools and materials to trusts to improve staff engagement. In future reports, we will be able to assess the impact of these initiatives alongside other developments in the overall NHS employment offer.

4.143 We review below the results of the 2018 NHS Staff Surveys for England, Wales and Scotland, which suggest some early impacts of the AfC pay agreement. It is too early to assess any overall effect of pay reform on staff satisfaction and motivation, and future survey results could provide a more complete picture.

NHS Staff Survey (England)

4.144 Since our 2018 Report, the 2018 survey of NHS Staff in England was published. It was conducted in the autumn of 2018 and over 497,000 staff responded (a response rate of 46%, up from 45% in 2017).

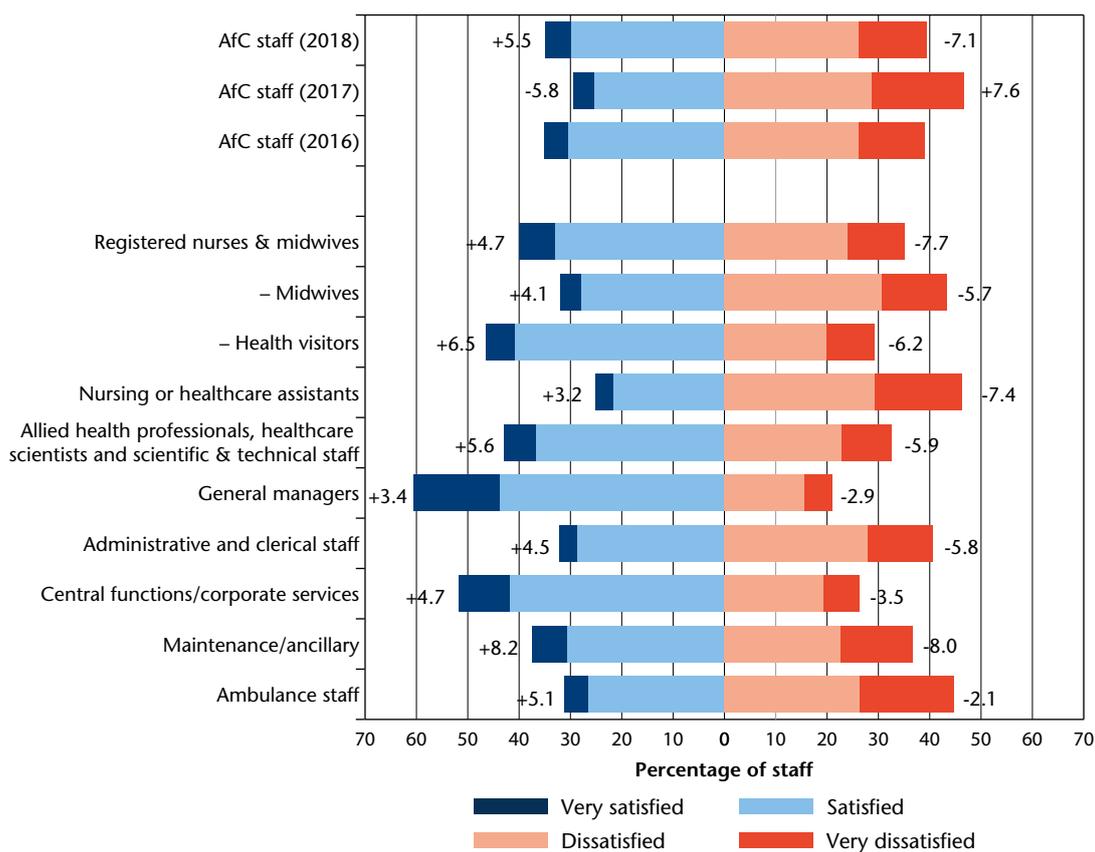
4.145 In England, AfC staff satisfaction⁵¹ with pay increased sharply in 2018, compared with 2017, by 5.5 percentage points. This reverses almost all of a sharp fall of 5.8 percentage points between 2016 and 2017. Nevertheless, levels of satisfaction with pay remain low, with just over one-third responding positively to the survey, compared with just under 40% who expressed dissatisfaction⁵² with their pay. The results also compare less favourably with the results of the 2011 and 2012 surveys. For specific groups the 2018 results showed:

- Registered nurses and midwives satisfaction increased by 4.7 percentage points to 39.9%;
- The largest increase in satisfaction with pay between 2017 and 2018 was for maintenance and ancillary staff, of 8.2 percentage points, to 37.4%;
- General managers remained the most satisfied group (60.5%) and also the least dissatisfied with their levels of pay;
- Nursing and healthcare assistants continued to have the lowest satisfaction with pay, at 25.2%, despite an increase of 3.2 percentage points between 2017 and 2018.

⁵¹ In each case, satisfied refers to participants answering that they were “satisfied” or “very satisfied” with their level of pay.

⁵² In each case, dissatisfied refers to participants answering that they were “dissatisfied” or “very dissatisfied” with their level of pay.

Figure 4.33: Satisfaction with level of pay by staff group, England, 2018



Source: National NHS Staff Survey (England)

Note:

(1) Those who answered “neither satisfied nor dissatisfied” are not included in this chart.

(2) Labels indicate change in percentage points from previous year.

4.146 Table 4.11 below provides a selection of staff survey results on engagement and satisfaction. Generally, the 2018 results show an improvement from 2017. The numbers saying that they looked forward to work and were enthusiastic about their job increased, by 1.3 and 1.0 percentage points respectively. A larger percentage of staff said that they were satisfied with the support they received from their colleagues and immediate line manager, and there was an increase in the proportion expressing satisfaction with the extent to which their organisation valued their work. However, the percentage of staff who said that they experienced harassment or bullying remained high, at almost 28%, and showed little sign of falling appreciably. The percentage of staff saying they had had an appraisal in the last 12 months increased to 88.1%. Of these:

- 67% said that training, learning or development needs were identified;
- 71% said it helped them improve how they did their job;
- 77% said it left them feeling their work was valued;
- 84% said it helped to agree clear objectives for their work.

Table 4.11: Selected job satisfaction results from the national NHS Staff Survey, AfC staff, England, 2011 to 2018

Measure	2011	2012	2013	2014	2015	2016	2017	2018	Trend ¹
Engagement and job satisfaction									
I look forward to going to work	49.9	51.7	52.1	51.6	57.1	57.9	56.9	58.2	
I am enthusiastic about my job	65.1	67.3	68.1	67.7	73.3	73.8	73.1	74.1	
Time passes quickly when I am working	73.3	74.2	74.3	73.8	76.8	76.6	75.8	75.8	
The recognition I get for good work	45.8	48.7	49.4	49.9	51.8	53.0	52.8	56.5	
The support I get from my immediate manager	63.5	65.4	66.0	66.1	67.2	68.3	68.8	70.2	
The support I get from my work colleagues	76.4	78.4	78.3	78.4	80.8	81.5	81.3	81.6	
The amount of responsibility I am given	70.5	73.4	73.1	72.8	73.3	73.8	73.1	74.1	
The opportunities I have to use my skills	65.5	69.9	69.6	69.6	69.9	70.6	69.9	71.0	
The extent to which my organisation values my work	33.3	40.0	40.4	40.8	41.1	43.1	42.9	46.3	
My level of pay	38.7	37.4	35.8	30.9	34.6	35.2	29.4	34.9	
Percentage of staff appraised in the last 12 months	80.6	83.2	83.8	83.5	85.4	86.5	86.4	88.1	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months ²		29.5	28.9	28.2	28.0	27.5	27.5	27.8	

Source: National NHS Staff Survey (England)

Notes:

- (1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and full range of possible scores for each measure.
- (2) Lower scores are better in this case.

4.147 Table 4.12 provides a selection of staff survey results on working pressures. Compared with 2017, there were increases in the percentage saying there were enough staff at their organisation to do their job properly, they had adequate supplies to do their work and that they were able to meet all the conflicting demands on their time at work. However, there were still fewer than one-third saying that there were enough staff in their organisation and fewer than a half were able to meet the demands on their time at work. There was also an increase, of 1.2 percentage points, in staff reporting they had felt unwell as a result of work-related stress, to 40%. Midwives were the staff group most likely to report feeling unwell as a result of work-related stress (50%). The percentage of staff working paid overtime had increased by 1.0 percentage points to 33% while the percentage working unpaid hours decreased by 0.7 percentage points to 56%. Ambulance staff were the group most likely to work paid overtime (48%) while general managers were most likely to work unpaid hours (85%).

Table 4.12: Selected working pressures results from the national NHS Staff Survey, AfC staff, England, 2011 to 2018

Measure	2011	2012	2013	2014	2015	2016	2017	2018	Trend ¹
Workload									
I am unable to meet all the conflicting demands on my time at work ^{2,3}	41.9	43.2	44.3	44.7					
I am able to meet all the conflicting demands on my time at work ⁴					42.9	45.1	45.0	45.6	
I have adequate materials, supplies and equipment to do my work	58.9	56.5	55.8	55.7	54.6	55.5	54.7	55.4	
There are enough staff at this organisation for me to do my job properly	30.2	30.1	29.2	28.6	29.9	31.4	31.2	32.3	
During the last 12 months have you felt unwell as a result of work related stress ²		38.6	39.6	40.0	37.8	37.2	38.7	40.0	
Percentage of staff working PAID hours over and above their contracted hours ²	25.4	30.0	30.2	30.2	31.1	31.5	32.2	33.2	
Percentage of staff working UNPAID hours over and above their contracted hours ²	53.1	56.1	57.0	58.1	59.0	57.1	56.4	55.7	

Source: National NHS Staff Survey (England)

Notes:

- (1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and full range of possible scores for each measure.
- (2) Lower scores are better in this case.
- (3) For 2015, this question was reversed to "I am able to meet..."
- (4) This question was introduced in 2015.

NHS Staff Survey (Wales)

4.148 In the summer of 2018 NHS Wales conducted a survey of its staff, with 25,500 responding (a response rate of 29%). This follows similar surveys in 2013 and 2016. The survey does not include a question about satisfaction with pay. In general the results for 2018 are more positive than in 2016 and 2013. Key results from the 2018 survey included:

- 60% of staff said that they looked forward to going to work, an increase from 56% in 2016 and 50% in 2013;
- 73% of staff said that they were enthusiastic about their job, an increase from 68% in 2016 and 63% in 2013;
- 71% of staff said that they were satisfied with the support they got from their immediate manager, an increase from 67% in 2016 and 61% in 2013;
- 34% of staff said that during the last 12 months they had been injured or felt unwell as a result of work-related stress, an increase from 28% in 2016 and 33% in 2013;
- 21% of staff said that during the last 12 months they had personally experienced harassment, bullying or abuse at work from patients or the public, an increase from 16% in 2016 and 19% in 2013;

- 49% of staff said that they could meet all of the conflicting demands on their time at work, an increase from 25% in 2016 and 26% in 2013;
- 57% of staff said that they had adequate supplies, materials and equipment to do their work, unchanged from 2016 and an increase from 43% in 2013;
- 32% of staff said that there were enough staff at their organisation for them to be able to do their job properly, an increase from 30% in 2016 and 26% in 2013; and
- 83% of staff said that during the last 12 months they had had a Personal Appraisal and Development Review, an increase from 74% in 2016 and 55% in 2013.

Health & Social Care Staff Experience Report (Scotland)

4.149 Between February and September 2018 Health & Social Care Staff in Scotland were surveyed, with 104,000 responding (a response rate of 59%). This survey used the same method and questionnaire as 2017 thus allowing comparisons between the two years to be made. Key results included:

- 78% of staff said that they had sufficient support to do their job well, an increase from 77% in 2017;
- 81% of staff said that their work gave them a sense of achievement, unchanged from 2017;
- 74% of staff said that they felt appreciated for the work they do, an increase from 73% in 2017;
- 71% of staff said that their organisation cared about their health and wellbeing, an increase from 70% in 2017; and
- 72% of staff said that they got the help and support from other teams and services within the organisation to do their job, an increase from 71% in 2017.

Our conclusions on the Staff Surveys

4.150 The Staff Survey results across the UK allow an analysis of a range of indicators of staff satisfaction and, where available, the results can be tracked over time to identify any trends.

4.151 Overall, the results from the surveys suggest that many indicators on job satisfaction and engagement have been on an upward trend. In England these indicators have been on an improving path since 2011. This suggests that staff continue to believe their work has an intrinsic value and support is available from colleagues and managers. In the longer term, we look forward to assessing the trend in the staff engagement index in England which was revised in 2018.

4.152 Despite the increase in job satisfaction, some other indicators point to a worryingly high proportion of staff reporting harassment, bullying or abuse from the public, and also an increasing proportion reporting feeling unwell as a result of work-related stress. The proportion responding that there were enough staff at their organisation to do their job properly has risen, but is still at a consistently low level at 32.3%.

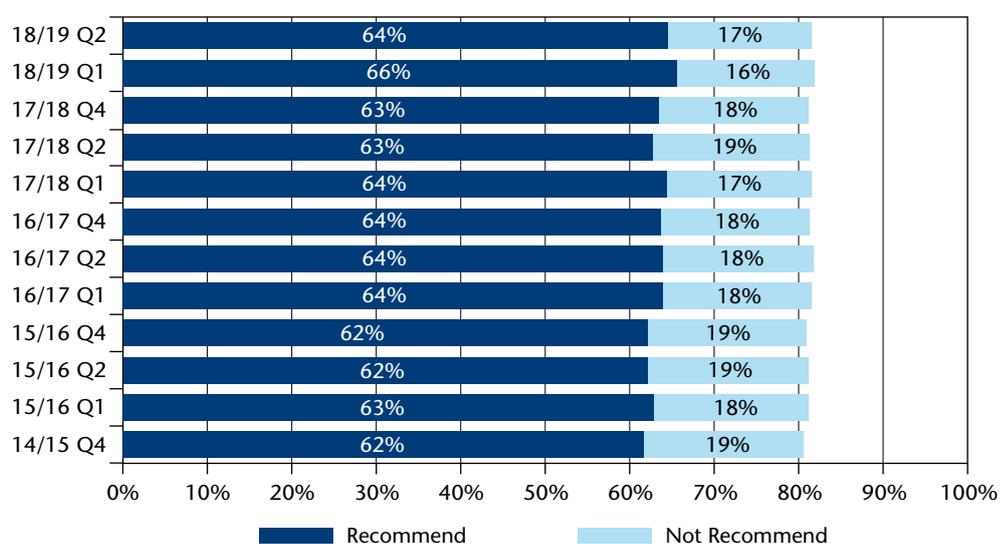
4.153 The proportion of staff working paid hours over and above their contracted hours has increased since 2011, which is in part responding to the workforce gap. It also might reflect the opportunities for additional earnings for staff and flexible working arrangements as we heard from staff on our visits. The proportion of staff working unpaid hours over and above their contracted hours has fallen slightly over the past few years but still reflects a high number of staff with the goodwill to do additional hours.

- 4.154 A particular focus of our deliberations are the surveys coverage of staff satisfaction with pay. In England, there was an increase in the proportion of AfC staff satisfied with the level of their pay in 2018. This change could reflect the introduction of the AfC pay agreement. Despite this increase, the proportion of staff expressing satisfaction has only returned to the level last seen in 2015 and remains below the level of satisfaction with pay in 2011. This indicator will need to be tracked as the remaining two years of the agreement are implemented to arrive at the reformed AfC pay structure by 2020/21.
- 4.155 The AfC pay agreements also placed emphasis on progression, including a new framework in England, to support increased staff engagement and staff contribution to patient care. In this regard, the results of the Staff Survey in England suggest a high and increasing proportion of staff receiving appraisals in the last 12 months, although only two-thirds of staff report that training, learning or development needs were identified. As the new progression framework develops in England and the Devolved Administrations review their arrangements, we would expect to see an ongoing, improving position on the proportion of staff receiving appraisals and their value to staff during the implementation period and beyond.
- 4.156 The overall results across the surveys show both job satisfaction and the challenges of working in the NHS. They also show some emerging results which will help track progress with the implementation and impact of the AfC pay agreements. We view the staff surveys as a useful source of information and encourage efforts to increase the response rates and to produce timely results for the parties' evidence submissions and our reports.

Friends and Family Test

- 4.157 The Friends and Family Test records the percentage of staff who would recommend their organisation as either a place to work or a place to receive care. Based on responses from 131,000 staff, Figure 4.34 shows that in the second quarter of 2019 when asked whether they would recommend their organisation as a place to work to friends and family, 64% of staff in England said they would do so, while 17% would not recommend their organisation as a place to work. The results for staff working in ambulance trusts, where fewer than half of staff recommend their organisation as a place to work, are worse than those for other trusts.

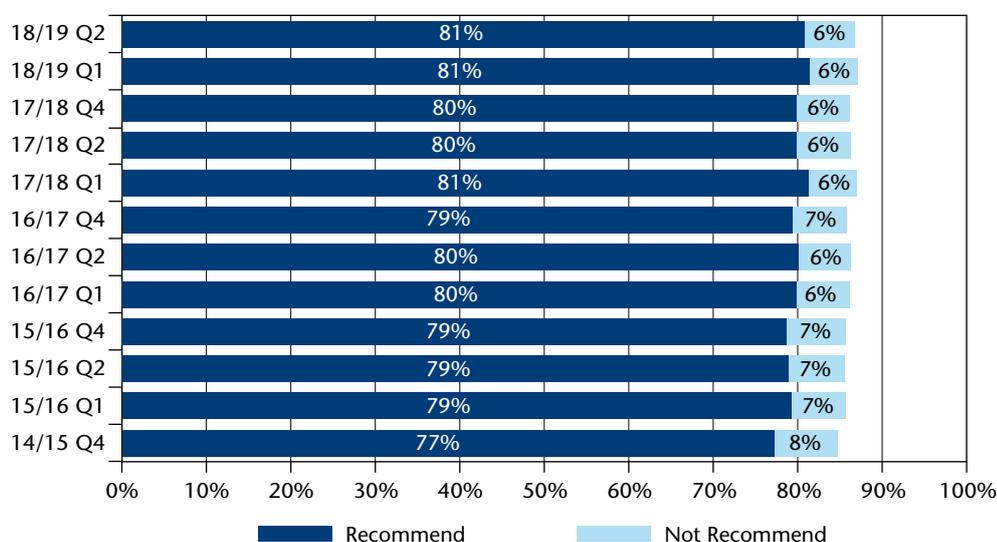
Figure 4.34: Recommendation as a place to work, Friends and Family Test (staff), England, 2014/15 Q4 to 2018/19 Q2



Source: NHS England

- 4.158 In its 2018 Staff Survey NHS Wales reported that 66% of staff would recommend their organisation as a place to work, an increase from 61% in 2016 and 48% in 2013.
- 4.159 In its 2018 Health & Social Care Staff Experience Report 74% of staff in Scotland said that they would recommend their organisation as a good place to work. This was unchanged from 2017. In 2018 there were positive responses from 80% of staff in NHS Health Scotland and Health Improvement Scotland and 67% of staff in the Scottish Ambulance Service.
- 4.160 Figure 4.35 shows that in the second quarter of 2019 when asked to recommend their organisation as a place to receive care to friends and family, 81% of staff in England said they would do so, while 6% would not recommend their organisation as a place to receive care.

Figure 4.35: Recommendation as a place to receive care, Friends and Family Test (staff), England, 2014/15 Q4 to 2018/19 Q2



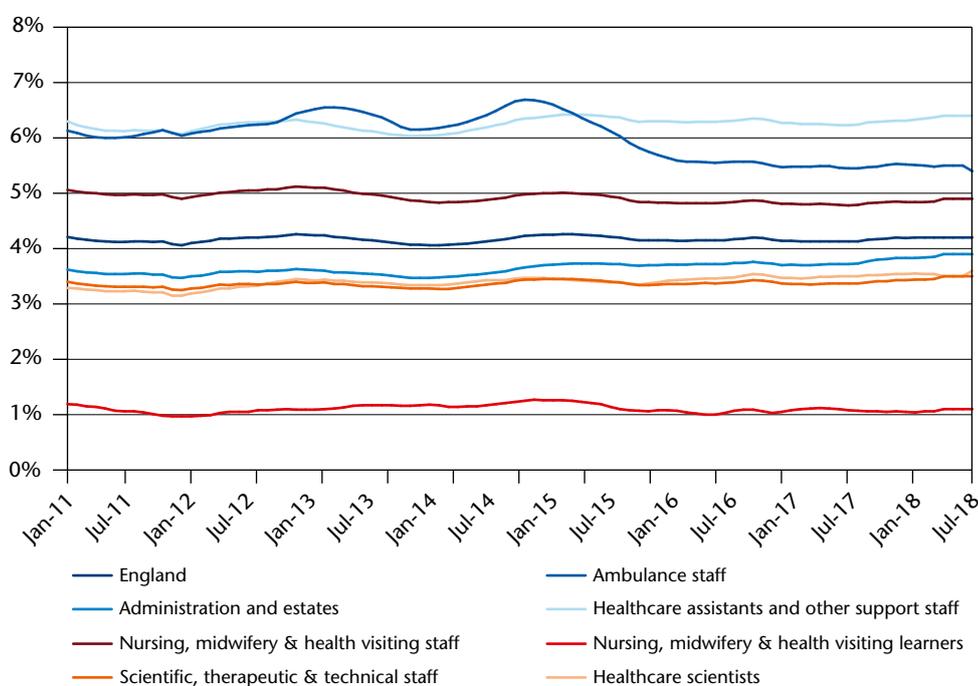
Source: NHS England

- 4.161 In its 2018 Staff Survey NHS Wales reported that 73% of staff said that if a friend or relative needed treatment they would be happy with the standard of care provided by their organisation, an increase from 68% in 2016 and 53% in 2013.
- 4.162 In its 2018 Health & Social Care Staff Experience Report 79% of staff in Scotland said that they would be happy for a friend or relative to access services within their organisation. This represents an increase from 78% in 2017. In 2018 there were positive responses from 82% of staff in NHS Health Scotland and Health Improvement Scotland and 72% of staff in the Scottish Ambulance Service.
- 4.163 The Friends and Family Test in England and the Staff Surveys in Wales and Scotland provide indicators of how NHS staff view their working environment. The proportions of staff recommending their organisations as a place to work or receive care have changed little over the previous four years, although we note that there have been increases in the positive recommendations in the Staff Surveys in Wales and Scotland.

Sickness absence

4.164 Figure 4.36 shows sickness absence rates in England by staff group between 2011 and 2018, averaged over a 12-month period. For NHS staff as a whole sickness absence rates over this period have fluctuated between a very narrow range of 4.1% to 4.3%. In the 12 months to December 2018, sickness absence rates for healthcare assistants and other support staff (6.4%), ambulance staff (5.4%), and nursing, midwifery and health visiting staff (4.9%) were above the overall average. Those groups with below average sickness absence rates were administration and estates (3.9%), healthcare scientists (3.6%), scientific, therapeutic and technical staff (3.5%), and nursing, midwifery and health visiting learners (1.1%). Since 2011 there has been relatively little variation in sickness absence rates by staff group although since 2015 sickness absence rates for ambulance staff have fallen back from 6.7% to 5.4%.

Figure 4.36: Sickness absence rates in England by main staff group, 12-month moving average, 2011 to 2018



Source: NHS Digital

4.165 Data published by StatsWales showed sickness absence rates in the NHS in Wales between 2010 and 2018. In 2018 the sickness absence rate was 5.3%, up from 5.1% in 2017. In 2018 ambulance staff had the highest sickness rate at 8.0%, just above that for healthcare assistants and support workers (7.0%). The AfC staff group with the lowest sickness absence rate was scientific, therapeutic and technical staff with a rate of 4.2%. The overall sickness rate has been between 5.1% and 5.3% in each year since 2015.

4.166 The Scottish Government requires NHS Boards to achieve a sickness absence rate of 4% or lower. Data covering the period from 2001/02⁵³ showed sickness absence rates fluctuating between 5.55% (in 2006/07) and 4.63% (in 2011/12). The latest data for 2017/18 showed an absence rate of 5.39%, up from 5.20% in 2016/17.

⁵³ Scottish Government, Sickness absence – LDP. Available at: <http://www2.gov.scot/About/Performance/scotPerforms/NHSScotlandperformance/Sickness-LDP>

4.167 Sickness levels across the NHS have been relatively stable in recent years with some minor variations across AfC groups. We note that a national target has been set for England to reduce NHS sickness absence by 1 percentage point by 2020 and to the public services average by 2022. The latest data shows that the public sector sickness absence rate, across the UK as a whole, was 2.6% in 2017⁵⁴. As an indicator of the impact of the working environment on staff, we will continue to monitor progress, particularly as there are a range of staff wellbeing initiatives underway through NHS Improvement and the Devolved Administrations, and the AfC agreements included an objective to improve the health and wellbeing of staff to improve attendance levels.

AfC pay agreement – implementation and impact

Overview

- 4.168 The Secretary of State's remit letter for England and those for Wales and Northern Ireland confirmed our role to monitor the implementation and impact of the 2018 AfC pay agreement. While assessing the evidence and data on our standing terms of reference in this report, we have been mindful of identifying key leading indicators on workforce and pay that provide the baselines against which to monitor the AfC pay agreement. The work of the NHS Staff Council on monitoring data will also help inform our ongoing assessments.
- 4.169 At the time of this report, the planned changes to the AfC pay structure for 2018/19 had been implemented and those for Year 2 had started to take effect in 2019/20. Northern Ireland had implemented a pay award for AfC staff for 2018/19. There are a limited number of implementation issues to review at this stage and it is too early to make an assessment of the long term impact of the AfC pay agreement and the way in which progress is being made towards achieving its objectives. We expect that there will be some emerging information for an initial assessment for our next report in 2020, depending on available data.
- 4.170 Our focus is on the main elements of our terms of reference, namely recruitment, retention and motivation of AfC staff. Many of the major impacts, such as changes to pay structures and progression arrangements, will take time to embed and influence recruitment, retention and motivation, and will be assessed in our later reports. We aim to build the picture on implementation and its impact over the period of the agreement through to 2021/22. In doing so, we emphasise the importance of differentiating between the effects of AfC pay reforms and those of wider workforce developments.
- 4.171 In our 2018 Report we stressed the importance of delivering wider workforce developments as an integral part of pay reform. These have been given renewed impetus in the aims of the NHS Long Term Plan. As the more detailed actions are to be set out in the Workforce Implementation Plan, there will need to be linkages to the way in which reformed AfC pay structures can support or be adapted to reflect new workforce requirements, new roles, training and development, and career paths. Our 2018 Report also included a series of our observations on the pay reforms. These covered the way in which the new pay structure might impact on starting pay, specific pay bands, those on the top of bands and AfC occupational groups. We will return to these as the reforms move through the three-year transition period to the new pay structure in steady state.

⁵⁴ Office for National Statistics, Sickness absence in the labour market. Available at: <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/sicknessabsenceinthelabourmarket>

Implementation in 2018/19 and 2019/20

- 4.172 On implementation in England, we note that NHS Improvement has been given the lead responsibility on the AfC Implementation Group. The NHS Staff Council⁵⁵ will continue to provide the forum for negotiating the detailed proposals on elements of the agreement, and we are grateful to the Council for its updates. NHS Employers continue to be the main source of support to providers, including the development and publication of guidance and support materials.
- 4.173 We heard on our visits late in 2018 that there were difficulties in the initial communications on the impact of the AfC agreement given the complex variations for individual AfC staff. We also heard about the efforts of individual trades unions at national and local level in helping AfC staff understand the pay reforms. We continue to stress the importance of extensive and regular communications to AfC staff and trust management during the implementation of pay reforms given the complexity of structural change ahead in Years 2 and 3, and the resulting individual pay journeys. The 2018 NHS Staff Survey results indicate an increase in satisfaction with pay among AfC staff. The results of similar surveys in the Devolved Administrations will help assessments of the staff reactions. We look forward to hearing feedback on 2019/20 implementation initially on our visits followed by the parties' evidence to our next report.
- 4.174 The main issues on implementation have been delivering the priorities for April 2019, establishing the priorities for 2019/20 onwards, and operating the funding arrangements for 2018/19 and 2019/20. We are grateful to the NHS Staff Council and the individual parties in bringing us up to date on these issues for England. There are also differing positions on implementation for each of the Devolved Administrations. In Scotland AfC pay awards were made for 2018/19 with the effects of the pay reforms mainly to be implemented from 2019/20 onwards and reaching a similar revised pay structure by 2020/21. In Wales, there were delays in implementing reforms as the agreement was achieved later in 2018 and to allow for specific considerations for NHS Wales. The AfC agreement has not been implemented in Northern Ireland although a pay award has been made for AfC staff for 2018/19.
- 4.175 Priorities at April 2019. The NHS Staff Council has made progress and reached agreements or identified further negotiations on a series of terms underpinning the AfC pay agreement. These covered (in bold in the paragraphs below): pay progression; Bands 1 and 2; unsocial hours payments; apprenticeship pay; and leave arrangements.
- 4.176 The AfC agreement clearly stated that one of its key objectives was to increase staff engagement by putting appraisal and personal development at the heart of **pay progression** so that staff could make the greatest possible contribution to patient care. In acknowledging the significance of new progression arrangements, we commented in our 2018 Report that such systems could improve organisational performance and working lives for staff and would require effective staff involvement. However, we observed that implementing and operating effective progression systems were difficult and that NHS organisations should not underestimate the substantial volume of work required.

⁵⁵ The NHS Staff Council operates across all four countries of the UK.

- 4.177 We note that the NHS Staff Council reached agreement on a revised national pay progression framework and issued supporting guidance⁵⁶ for trusts, managers and staff in January 2019. The new pay progression system comes into effect for new staff and promotees from 1 April 2019, and staff in post before 1 April 2019 remain on current organisational progression procedures until 31 March 2021. For existing staff, this would include any locally agreed arrangements for progression in accordance with the NHS Staff Council's 2013 pay progression agreement. The differing arrangements for new and existing staff will need careful handling within trusts and clarity is needed to avoid the potential confusion and fairness in operating two progression systems. Early preparations and extensive training are required to enable a smooth transition for existing staff in 2021. In practice, the approach agreed by the parties means that AfC pay increases in Years 2 and 3 of the agreement for staff in post before April 2019 will be made in accordance with progression arrangements already in place.
- 4.178 The guidance issued by the NHS Staff Council emphasised that the new pay progression framework would be underpinned by the mandatory annual appraisal process. It highlighted changes to the operation of the Electronic Staff Record and set out the framework's principles, responsibilities, policies and procedures, systems and processes, preparation for staff, and data and monitoring.
- 4.179 As the framework is implemented, we repeat our observations from our 2018 Report. The pay reforms produce shorter pay bands with larger pay steps within and between pay bands, which place a greater emphasis on the performance review process and on the standards required for progression. We agree with the Joint Staff Side that more is now at stake and therefore a partnership approach between line managers and staff will be required. Under the new structure, more staff will reach the top of pay bands earlier and there will need to be more emphasis on training, personal development or other incentives. This specific situation, and more generally the focus on skills and development to improve staff contribution to patient care, require a renewed commitment on funding and access to training and development. In addition, the NHS Long Term Plan emphasises developing multi-disciplinary teams and therefore the progression framework will need to account for managing both team and individual performance.
- 4.180 We highlight that outputs from the progression framework, particularly on staff development and contribution to patient care, will be a key leading indicator of the success of the AfC pay agreement. We look forward to evidence on early progress on implementing the pay progression framework, which will include data on the proportion of staff who have had appraisal and development meetings, and the impact of the process on staff engagement.
- 4.181 We welcome the agreement on transitional arrangements for **Band 1 and 2** posts from April 2019. The agreement requires employers by April 2019 to provide Band 1 staff with information to make the choice on moving to Band 2. However, the agreement takes a pragmatic approach in allowing time to reconfigure posts and for the exercise for staff to make a choice to run through 2019/20. As the reconfiguration of posts progresses, there could be issues for this group with compressed pay arrangements across Bands 1 and 2 covering a wide range of occupational groups where there could be competition from local labour markets. We will also continue to monitor pay rates against changes in the National Living Wage and Living Wage Foundation Living Wage. We note that the parties agreed that the 1.1% non-consolidated lump sum payment in 2019/20 should also apply to existing Band 1 staff.

⁵⁶ NHS Employers (January 2019), *Pay Progression Guidance*. Available at: www.nhsemployers.org/your-workforce/2018-contract-refresh/pay-progression

- 4.182 In the light of the closure of Band 1, the RCM raised whether the banding of maternity support workers at Band 2 was inappropriate, as the workers concerned carried out delegated clinical tasks. We consider that this is a matter for NHS Employers and the Joint Staff Side to resolve, as the banding of AfC roles results from applying the agreed NHS Job Evaluation Scheme.
- 4.183 The NHS Staff Council also implemented new arrangements for **unsocial hours payments** from September 2018. These have particular implications for ambulance staff and therefore we expect the parties to keep us informed of progress and any concerns.
- 4.184 We comment earlier in this chapter on the need for consistency on arrangements for **apprenticeship pay** to support a stable source of workforce supply. We welcome the parties' further negotiations and, while we can see the challenges, we encourage reaching consensus on a consistent approach.
- 4.185 Agreements were reached on **enhanced shared parental leave and child bereavement leave**⁵⁷, with further negotiations planned on **buying and selling annual leave**.
- 4.186 Priorities for 2019/20. The NHS Staff Council identified further work to conclude during 2019/20. We comment earlier in this chapter on the opportunities for consistency in bank and agency arrangements and look forward to the outcomes of further discussions on a framework. The Council will continue to work on guidance on supporting staff taking their annual leave and Time Off In Lieu. The Council will also be reviewing monitoring data to ensure that the agreement is being implemented as expected, including any equality impact.
- 4.187 The parties have identified that there could be the need for further refinements to the pay structure at the end of the three-year agreement. These centre on the gaps between bands, reviewing mid-points and reducing the time between steps in Bands 8 and 9. We welcome this early recognition and request further information on the likely structural change needed in preparation for 2021/22.
- 4.188 Funding arrangements. The parties' evidence alerted us to concerns about the 2018/19 arrangements for additional funding for the AfC pay agreement. For instance, NHS Providers were critical that funding was insufficient, based on earlier workforce numbers, and covered neither vacant posts nor agency and contract staff. We note that DHSC has responded by providing guidance on coverage where existing and new staff are being employed dynamically on the AfC contract. DHSC had also made additional funding available for 2018/19 on a case by case basis. We ask that the parties keep us informed of the impact of this approach, specifically on wider affordability issues, and whether there are implications for providers as additional funding is incorporated into the NHS tariff from 2019/20.
- 4.189 Devolved Administrations. The Welsh Government informed us that progress on the Welsh AfC pay agreement was a few months behind that in England. With some exceptions relating to earlier Welsh agreements including attendance management and eligibility for unsocial hours payments during sickness absence, there was an expectation that Wales would follow the same priorities as under the England agreement. We therefore look forward to further updates on progress in Wales. On progression, we note that staff in NHS Wales are already covered by a single national pay progression system. This should provide opportunities to develop a consistent approach to enhancing staff contribution to patient care and developing careers.

⁵⁷ Sections of the NHS Terms and Conditions of Service Handbook now include revised arrangements for shared parental leave and child bereavement leave. Available at: www.nhsemployers.org/news/2019/04/nhs-terms-and-conditions-updated-handbook-and-resources

- 4.190 We received no remit to monitor arrangements in Scotland, although we hope that, where appropriate, our initial conclusions in this report might help support the parties in monitoring the AfC agreement in Scotland.
- 4.191 The AfC pay agreement has not been implemented in Northern Ireland, although the pay increases for 2018/19 matched those arising from the agreement in England but applied to Northern Ireland AfC pay rates. The Department of Health, Northern Ireland confirmed that, in the absence of a Northern Ireland Executive and Ministers, there was little room to manoeuvre on pay policy and that implementing such major reform to AfC pay and the accompanying investment would require Ministerial decisions.
- 4.192 The letter from the Permanent Secretary of the Department of Health, Northern Ireland did not seek our AfC pay recommendations for 2019/20. However, the current situation may create risks for service delivery should the AfC workforce not be supported by appropriate pay awards and reforms. It is clear from our discussions with the parties that there is an acknowledgement on the benefits of implementing the AfC agreement and we welcome the Department of Health's efforts on early engagement with the Joint Staff Side. These included discussions on the scope to implement Year 2 of the AfC pay agreement. We encourage these discussions to come to an early agreement for 2019/20 and a pathway to implementing appropriate pay reform. We note that the increased funding for AfC pay awards from Barnett consequentials did not cover social care staff in Northern Ireland, and that the extra funding had to be found from within existing budgets risking service delivery.

Future monitoring arrangements

- 4.193 During the period of the AfC agreement we will continue to monitor the position of AfC pay against our standing terms of reference. Specifically, we will focus on recruitment, retention and motivation of AfC staff and affordability considerations. As full AfC earnings and comparator data becomes available, we will assess AfC pay in the context of the current and forecast economic and labour market indicators. In this respect, we highlight the potential for any major economic or labour market shocks to impact on the workforce and therefore the relative position for AfC staff under the pay agreement. The pay and conditions reforms will also impact on the AfC total reward package, and therefore the NHS employment offer, and we look forward to assessing the effects.
- 4.194 As set out in our 2018 Report, the starting point for future monitoring arrangements should be the AfC agreement's key objectives. These were to: support attraction and recruitment; support retention; increase staff engagement; support the use of apprenticeships; support new training pathways and focus on careers; map out work on consistency for bank working; and improve the health and wellbeing of staff to improve attendance. These objectives feed into supporting the workforce themes in the NHS Long Term Plan and the expected Workforce Implementation Plan. They also reflect the core issues of concern to the Pay Review Body, which are recruitment, retention and motivation. In the longer term, these objectives can be linked to supporting new service models, improving productivity and staff contribution, and improving patient services and outcomes.
- 4.195 The NHS Staff Council's work on monitoring the agreement will help DHSC and the other parties to assess the return on investment. We look forward to the NHS Staff Council's approach. In the meantime, we intend to work with the evidence and key leading and lagging indicators, alongside our core evidence considerations, and we see advantage in reviewing the indicators under the following categories:

- **Workforce, recruitment, retention and motivation**
 - Overall, workforce numbers and change by AfC group
 - Workforce supply – pre-registration applicants, acceptances, wastage, level of EU and non-EU recruitment, numbers of entrants through nursing associates, apprenticeships and advanced roles
 - Trends and costs for bank and agency working
 - Vacancy levels and their impact on workload and overtime
 - Retention – turnover trends, and improved data on reasons for leaving
 - Motivation and staff engagement – results from the NHS Staff Surveys, results from the Friends and Family Test, and data on sickness absence;
- **Productivity and staff contribution**
 - Information on workforce contribution to improved productivity
 - Data from the new progression framework, appraisal rates, numbers passing and not passing through pay steps;
- **Affordability and funding arrangements**
 - Pay bill effects, and specific structural and individual pay effects
 - AfC earnings – change, position relative to the rest of the economy, graduates and impact on total reward;
- **Effects of changes to other terms and conditions**
 - Data on other changes under the agreement including unsocial hours payments and various leave arrangements
 - Other key indicators on health and wellbeing identified through the further work in the NHS Staff Council.

4.196 We consider that there could be wider implications to monitor. It will be important to distinguish any impact on specific AfC groups, particularly specific professions, shortages groups, those affected by external markets and those with protected characteristics. Similarly, there could be different outcomes within the Devolved Administrations, which could provide useful lessons for other countries. Finally, the agreement could impact on the social care workforce with implications for the integration of health and social care and building effective employment arrangements.

4.197 Our future reports will look to framing these monitoring arrangements to fulfil our role over the period of the AfC agreement through to 2020/21.

Appendix A – Remit Letters

Letter from Secretary of State for Health and Social Care to NHSPRB Chair



*From the Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care*

39 Victoria Street
London
SW1H 0EU

020 7210 4850

Philippa Hird
Chair NHS Pay Review Body
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

21 November 2018

Dear Ms Hird,

I am writing firstly to express my thanks for the NHSPRB's invaluable work which informed its report and observations for the 2018-19 pay round and secondly, to formally commence the 2019-20 pay round. In particular, I would like to thank you and your members for your support as the partners completed the Agenda for Change negotiations. It was important that the Review Body had an opportunity to see the final agreement as part of your report to government.

You are aware that the reforms were agreed by all parties. I am pleased that the final agreement takes on board recommendations and observations the Review Body has made in a number of its reports over recent years for achieving a balanced package of reforms.

The NHS Staff Council is at the early stages of an extensive work programme and will work with its partners to develop the new terms, conditions and guidance to support implementation of some of the most significant reforms since Agenda for Change was first introduced in 2004.

You are aware that over the period of the multi-year pay deal (2018-2019 to 2020-2021) we will not ask the NHSPRB to make any pay recommendations. We will however, as agreed, ask your members to monitor the implementation of the deal and its impact over the duration of the agreement. We will also ensure that your members continue to receive data on the state of recruitment, retention and motivation as part of the public sector annual pay rounds.

This year, the NHSPRB is invited to make observations on evidence you receive from the NHS Staff Council and other parties on implementing the Agenda for Change pay agreement.

I am also asking the NHSPRB to consider issues that have been raised regarding the difficulties of recruiting and retaining IT staff. I would welcome your observations on the labour market issues and your recommendations, including any case for a national recruitment and retention premium.

As always, whilst your remit covers the whole of the United Kingdom, it is for each administration to make its own decisions on its approach to this year's pay round and to communicate this to you directly.

We would welcome your report by week commencing 6 May 2019.

Yours ever,

A handwritten signature in blue ink that reads "Matt". The signature is written in a cursive, slightly slanted style.

MATT HANCOCK

Letter from Scottish Government Cabinet Secretary for Health and Sport to NHSPRB Chair

Cabinet Secretary for Health and Sport
Jeane Freeman MSP



Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0300 244 4000
E: scottish.ministers@gov.scot

Philippa Hird
Chair, NHS Pay Review Body
Office of Manpower Economics
8th Floor, Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

19 December 2018

I am writing to set out the Scottish Government's position with regard to the NHS Pay Review process for 2019-20. As I highlighted in my letter dated 9 July, we have undertaken a fundamental reform to the Agenda for Change (AfC) system and put in place a three year pay deal from 2018-21.

I know that all sides have been thoughtful about the role the NHS Pay Review Body (NHSPRB) will play during the period of the pay deal, and note that the UK Government's Department for Health and Social Care submitted a remit to you for 2019-20 on the 21st of November. This sought observations on the implementation of the AfC pay deal in England and the case for a Recruitment and Retention Premium for IT staff. The Welsh Department of Health and Social Care subsequently submitted a remit on the 13th of December asking you to monitor the implementation of the Welsh pay deal.

I have decided the focus for 2019-20 should be on implementing the recommendations on the four areas of reform to terms and conditions from 1 April 2019, and also gathering evidence of the impact of the deal. Whilst the independent scrutiny which the NHSPRB provides is always helpful, I have not been able to identify substantive issues which would form the basis of a remit to be provided to you for 2019-20. I will continue to observe the process closely over 2019-20 and give fresh consideration to our position in 2020-21.

Kind regards

JEANE FREEMAN

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot



Letter from Welsh Government Minister for Health and Social Services to NHSPRB Chair

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health & Social Services



Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA-P/VG/4241/18

Philippa Hird
Chair NHS Pay Review Body
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX
Email: Craig.Marchant@beis.gov.uk

13 December 2018

Dear Philippa,

NHS Pay Review Body remit for Wales 2019-20

Thank you for the NHSPRB's hard work and independent report and observations which have been invaluable during the 2018-19 pay review round. Your invaluable work this year and in previous years informed discussions to agree an amended Agenda for Change (AfC) Framework based on the agreed Framework in England which you were able to consider as part of your 2018-19 report.

I am now writing to formally commence the 2019-20 pay found for AfC staff in Wales. You will be aware that the amended Framework, which underpins a three year pay deal and radical restructure of the payscales for AfC staff and provides pay parity with staff in England, was unanimously agreed by all parties in September following a period of consultation of members by trade unions and is now being implemented.

During the life of this multi-year pay deal (2018-19 to 2020-21) we will not ask the NHSPRB to make any specific recommendations on pay. We will however ask that your members monitor the implementation of the deal and its impact over the duration of the deal.

I will continue to provide data and appropriate narrative on the state of recruitment, retention and motivation as part of the public sector annual pay rounds and so for 2019-20 I would ask you to consider and make observations based on evidence you receive from Welsh Government and other parties on implementing the AfC agreement.

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

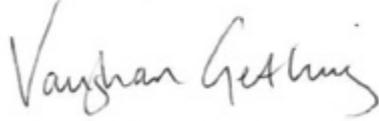
Canolfan Cyswilt Cyntaf / First Point of Contact Centre:
0300 0604400
Gohebiaeth.Vaughan.Gething@llyw.cymru
Correspondence.Vaughan.Gething@gov.wales

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

I would be most grateful to receive your report in early May 2019.

Yours sincerely,

A handwritten signature in black ink that reads "Vaughan Gething". The signature is written in a cursive style with a large initial 'V'.

Vaughan Gething AC/AM

Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health & Social Service

Letter from Permanent Secretary of the Department of Health, Northern Ireland to NHSPRB Chair

**From the Permanent Secretary
and HSC Chief Executive**



Philippa Hird
Chair of NHS Pay Review Body
Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London
EC4Y 8JX

Castle Buildings
Upper Newtownards Road
BELFAST, BT4 3SQ

Tel: 02890520559
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Email: richard.pengelly@health-ni.gov.uk

By email: craig.marchant@beis.gov.uk

Our ref: RP3372
SSUB-0008-2019

Date: 7 January 2019

Dear Ms Hird

NHSPRB 2019/20 PAY ROUND

I am writing to formally commence the 2019/20 pay round for Agenda for Change (AfC) staff in Northern Ireland and to submit my Department's evidence. I wish to begin by thanking the NHS Pay Review Body for its invaluable work on the 2018/19 pay round and, in particular, for its observations on the AfC pay agreement.

On 22 November 2018, the Department of Finance (DoF) set Northern Ireland's [public sector pay policy for 2018/19](#). In light of this announcement, and subject to the Department of Finance's approval, we are proceeding with the implementation of the 2018/19 AfC pay award. Details of the award, which is based on the AfC refresh principles, are set out in the Department's Press Release of 20 December 2018 available at: <https://www.health-ni.gov.uk/news/hsc-pay-award-confirmed>

This year, Northern Ireland will not require any specific recommendations on pay, however, we would ask that your members continue to monitor the implementation of the pay agreement and its impact. We would also ask the NHSPRB to consider any issues that have been raised regarding difficult to fill nursing specialism posts, such as, care of older people, acute medicine and critical care to include theatres and would welcome your recommendations, including any case for a recruitment and retention premium.

Yours sincerely

RICHARD PENGELLY

Working for a Healthier People



Appendix B – Agenda for Change Pay Bands Under The Framework Agreement In England 2018/19 – 2020/21

Band 1

2017/18	2018/19	2019/20	2020/21
15,404			
15,671	17,460	17,652	18,005

Band 2

2017/18	2018/19	2019/20	2020/21
15,404			
15,671			
16,104			
16,536	17,460		
16,968	17,460	17,652	18,005
17,524	17,787	17,983	
18,157	18,702	19,020	19,337

Band 3

2017/18	2018/19	2019/20	2020/21
16,968			
17,524	17,787		
18,157	18,429		
18,333	18,608	18,813	19,737
18,839	19,122	19,332	
19,409	19,700	19,917	
19,852	20,448	20,795	21,142

Band 4

2017/18	2018/19	2019/20	2020/21
19,409			
19,852	20,150		
20,551	20,859	21,089	21,892
21,263	21,582	21,819	
21,909	22,238	22,482	
22,128	22,460	22,707	
22,683	23,363	23,761	24,157

Band 5

2017/18	2018/19	2019/20	2020/21
22,128			
22,683	23,023		
23,597	23,951	24,214	24,907
24,547	24,915		
25,551	25,934	26,220	26,970
26,565	26,963	27,260	27,416
27,635	28,050	28,358	
28,746	29,608	30,112	30,615

Band 6

2017/18	2018/19	2019/20	2020/21
26,565			
27,635	28,050		
28,746	29,177	30,401	31,365
29,626	30,070	32,525	
30,661	31,121		
31,696	32,171	32,525	33,176
32,731	33,222	33,587	33,779
33,895	34,403	34,782	
35,577	36,644	37,267	37,890

Band 7

2017/18	2018/19	2019/20	2020/21
31,696			
32,731	33,222		
33,895	34,403		
35,577	36,111	37,570	38,890
36,612	37,161		
37,777	38,344	38,765	40,894
39,070	39,656	40,092	41,723
40,428	41,034	41,486	
41,787	43,041	43,772	44,503

Band 8a

2017/18	2018/19	2019/20	2020/21
40,428			
41,787	42,414		
43,469	44,121	44,606	45,753
45,150	45,827	46,331	46,518
47,092	47,798	48,324	48,519
48,514	49,969	50,819	51,668

Band 8d

2017/18	2018/19	2019/20	2020/21
67,247			
69,168	70,206		
72,051	73,132	73,936	75,914
75,573	76,707	77,550	77,863
79,415	80,606	81,493	81,821
83,258	85,333	86,687	87,754

Band 8b

2017/18	2018/19	2019/20	2020/21
47,092			
48,514	49,242		
50,972	51,737	52,306	53,168
53,818	54,625	55,226	55,450
56,665	57,515	58,148	58,383
58,217	59,964	60,983	62,001

Band 9

2017/18	2018/19	2019/20	2020/21
79,415			
83,258	84,507		
87,254	88,563	89,537	91,004
91,442	92,814	93,835	94,213
95,832	97,269	98,339	98,736
100,431	102,506	103,860	104,927

Band 8c

2017/18	2018/19	2019/20	2020/21
56,665			
58,217	59,090		
60,202	61,105	61,777	63,751
63,021	63,966	64,670	64,931
67,247	68,256	69,007	69,285
69,168	71,243	72,597	73,664

High Cost Area Supplement (HCAS)

		2017/18	2018/19	2019/20	2020/21
Inner London	Minimum	4,200	4,326	4,400	4,474
	Maximum	6,469	6,664	6,778	6,892
Outer London	Minimum	3,553	3,660	3,723	3,786
	Maximum	4,528	4,664	4,744	4,824
Fringe	Minimum	971	1,001	1,019	1,037
	Maximum	1,682	1,733	1,763	1,793

Appendix C – Previous Reports of the Review Body

NURSING STAFF, MIDWIVES AND HEALTH VISITORS

First Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9258, June 1984
Second Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9529, June 1985
Third Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9782, May 1986
Fourth Report on Nursing Staff, Midwives and Health Visitors	Cm 129, April 1987
Fifth Report on Nursing Staff, Midwives and Health Visitors	Cm 360, April 1988
Sixth Report on Nursing Staff, Midwives and Health Visitors	Cm 577, February 1989
Supplement to Sixth Report on Nursing Staff, Midwives and Health Visitors: Nursing and Midwifery Educational Staff	Cm 737, July 1989
Seventh Report on Nursing Staff, Midwives and Health Visitors	Cm 934, February 1990
First Supplement to Seventh Report on Nursing Staff, Midwives and Health Visitors: Senior Nurses and Midwives	Cm 1165, August 1990
Second Supplement to Seventh Report on Nursing Staff, Midwives and Health Visitors: Senior Nurses and Midwives	Cm 1386, December 1990
Eighth Report on Nursing Staff, Midwives and Health Visitors	Cm 1410, January 1991
Ninth Report on Nursing Staff, Midwives and Health Visitors	Cm 1811, February 1992
Report on Senior Nurses and Midwives	Cm 1862, March 1992
Tenth Report on Nursing Staff, Midwives and Health Visitors	Cm, 2148, February 1993
Eleventh Report on Nursing Staff, Midwives and Health Visitors	Cm 2462, February 1994
Twelfth Report on Nursing Staff, Midwives and Health Visitors	Cm 2762, February 1995
Thirteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 3092, February 1996
Fourteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 3538, February 1997
Fifteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 3832, January 1998
Sixteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 4240, February 1999
Seventeenth Report on Nursing Staff, Midwives and Health Visitors	Cm 4563, January 2000
Eighteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 4991, December 2000
Nineteenth Report on Nursing Staff, Midwives and Health Visitors	Cm 5345, December 2001

PROFESSIONS ALLIED TO MEDICINE

First Report on Professions Allied to Medicine	Cmnd. 9257, June 1984
Second Report on Professions Allied to Medicine	Cmnd. 9528, June 1985
Third Report on Professions Allied to Medicine	Cmnd. 9783, May 1986
Fourth Report on Professions Allied to Medicine	Cm 130, April 1987
Fifth Report on Professions Allied to Medicine	Cm 361, April 1988
Sixth Report on Professions Allied to Medicine	Cm 578, February 1989
Seventh Report on Professions Allied to Medicine	Cm 935, February 1990
Eighth Report on Professions Allied to Medicine	Cm 1411, January 1991
Ninth Report on Professions Allied to Medicine	Cm 1812, February 1992
Tenth Report on Professions Allied to Medicine	Cm 2149, February 1993
Eleventh Report on Professions Allied to Medicine	Cm 2463, February 1994
Twelfth Report on Professions Allied to Medicine	Cm 2763, February 1995
Thirteenth Report on Professions Allied to Medicine	Cm 3093, February 1996

Fourteenth Report on Professions Allied to Medicine	Cm 3539, February 1997
Fifteenth Report on Professions Allied to Medicine	Cm 3833, January 1998
Sixteenth Report on Professions Allied to Medicine	Cm 4241, February 1999
Seventeenth Report on Professions Allied to Medicine	Cm 4564, January 2000
Eighteenth Report on Professions Allied to Medicine 2000	Cm 4992, December
Nineteenth Report on Professions Allied to Medicine 2001	Cm 5346, December

NURSING STAFF, MIDWIVES, HEALTH VISITORS AND PROFESSIONS ALLIED TO MEDICINE

Twentieth Report on Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine	Cm 5716, August 2003
Twenty-First Report on Nursing and Other Health Professionals	Cm 6752, March 2006
Twenty-Second Report on Nursing and Other Health Professionals	Cm 7029, March 2007

NHS PAY REVIEW BODY

Twenty-Third Report, NHS Pay Review Body 2008	Cm 7337, April 2008
Twenty-Fourth Report, NHS Pay Review Body 2009	Cm 7646, July 2009
Decision on whether to seek a remit to review pay increases in The three year agreement – <i>unpublished</i>	December 2009
Twenty-Fifth Report, NHS Pay Review Body 2011	Cm 8029, March 2011
Twenty-Sixth Report, NHS Pay Review Body 2012	Cm 8298, March 2012
Market-Facing Pay, NHS Pay Review Body 2012	Cm 8501, December 2012
Twenty-Seventh Report, NHS Pay Review Body 2013	Cm 8555, March 2013
Twenty-Eighth Report, NHS Pay Review Body 2014	Cm 8831, March 2014
Scotland Report, NHS Pay Review Body 2015	SG/2015/21
Enabling the delivery of healthcare services every day of the week – the implications for Agenda for Change	Cm 9107, July 2015
Twenty-Ninth Report, NHS Pay Review Body 2016	Cm 9210, March 2016
Thirtieth Report, NHS Pay Review Body 2017	Cm 9440, March 2017
Thirty-First Report, NHS Pay Review Body 2018	Cm 9641, June 2018

