

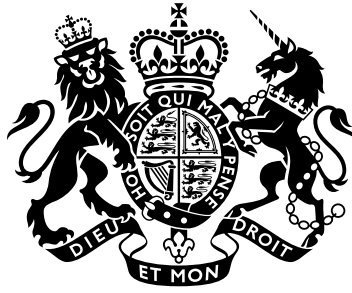


NHS Pay Review Body

NHS Pay Review Body

Thirty-Fifth Report 2022

Chair: Philippa Hird



NHS Pay Review Body

Thirty-Fifth Report 2022

Chair: Philippa Hird

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

**Presented to the Welsh Parliament by
the First Minister and the Minister for Health and Social Services**

Presented to the Northern Ireland Assembly by the Minister of Health

July 2022



© Crown copyright 2022

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication is available at www.gov.uk/official-documents.

Any enquiries regarding this publication should be sent to us at:

Office of Manpower Economics,
Windsor House,
50 Victoria Street,
London,
SW1H 0TL
www.gov.uk/ome

ISBN 978-1-5286-3385-7

E02753005 07/22

Printed on paper containing 40% recycled fibre content minimum.

Printed in the UK by HH Associates Ltd. on behalf of the Controller of Her Majesty's Stationery Office

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 Social Care in Scotland, the First Minister and the Minister for Health and Social Services in Wales, and the 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 Social Care in Scotland, the First Minister and the Minister for Health and Social Services in Wales, and the Minister for Health in Northern Ireland.

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

Members of the Review Body are:

Philippa Hird (Chair)
Richard Cooper
Patricia Gordon
Neville Hounsome
Stephanie Marston
Anne Phillimore
Stephen Boyle
Professor Karen Mumford CBE

The secretariat is provided by the Office of Manpower Economics.

Contents

Report Structure	vii
Executive summary	vii
NHS context	vii
The parties' evidence and our analysis	vii
Pay recommendations	x
<i>Chapter 1</i> Introduction	1
Introduction	1
The Review Body process	1
Wider context	2
Cost of living	2
Labour market	3
Our 2021 Report	4
Remits for 2022/23	4
Evidence submissions and visits	5
Our overall approach	7
<i>Chapter 2</i> NHS Context	9
Introduction	9
Impact of the COVID-19 pandemic	9
McCloud judgement	10
Health and Care Act (England)	10
NHS finances	12
Demand and quality of care	13
Nurses' Pay	14
Workforce Planning	15
Patient care	18
NHS Workforce initiatives	19
NHS Elective Recovery	20
<i>Chapter 3</i> The Parties' Evidence	21
Introduction	21
The COVID-19 pandemic	21
NHS Demand	23
Economy	26
Labour market	28
NHS Finances	30
Equality	34
Supply and recruitment	38
Total reward	48

	Workforce numbers	55
	Motivation and morale	58
	Workforce planning	61
	Pay approaches and affordability	65
<i>Chapter</i>	4 Agenda for Change Staff in the NHS – Our Analysis of the Evidence	71
	Introduction	71
	Economy and the labour market	71
	NHS funding, demand and affordability	80
	Vacancies and workforce planning	83
	Workforce numbers and recruitment	114
	Earnings	135
<i>Chapter</i>	5 Pay recommendations	155
	Introduction	155
	The Parties’ pay proposals	155
	Our concluding arguments	157
	Our recommendations	161
<i>Chapter</i>	6 Forward look	163
	Introduction	163
	Recovering from the COVID-19 pandemic	163
	Workforce planning	163
	Total reward	164
	Recruitment and Retention Premia (RRP)	164
	High Cost Area Supplements (HCAS)	164
	Evidence gaps and data limitations	165
<i>Appendix</i>	A Remit Letters	167
<i>Appendix</i>	B High Cost Area Supplement Considerations	171
<i>Appendix</i>	C RRP evidence requirements	173
<i>Appendix</i>	D Previous Reports of the Review Body	175

NHS PAY REVIEW BODY 2022 REPORT

Report Structure

Executive summary

1. The NHS Pay Review Body (NHSPRB) provides independent advice to the UK Government, the Welsh Government and the Northern Ireland Executive on the remuneration of all staff paid under Agenda for Change (AfC) and employed in the National Health Service.
2. The NHSPRB remit group was made up of approximately 1.4 million AfC staff as of September 2021. Of these, approximately 1,220,000 were in England, 95,000 in Wales, and 67,000 in Northern Ireland.

Our remits

3. For this pay round we received remit letters from England, Northern Ireland and Wales. The remits were broadly similar, requesting a pay recommendation that reflected fair pay, whilst ensuring affordability.
4. We received written and oral evidence from HM Treasury; Department of Health and Social Care; Welsh Government; Department of Health, Northern Ireland; Health Education England; NHS England and Improvement; NHS Employers; NHS Providers; the Joint Staff Side; Royal College of Nursing; Royal College of Midwives; Chartered Society of Physiotherapists; Royal College of Podiatry; Society of Radiographers; GMB; UNISON; Unite and Managers in Partnership.
5. We are grateful to all the parties for working with us during this challenging time, though, as we discuss in Chapter 1, the late submission of written evidence from some of the parties causes avoidable delays to the NHSPRB process.

NHS context

6. The regular published data and reports from external commentators show how the challenges the NHS faces have been exacerbated by the COVID-19 pandemic. Waiting lists have exceeded six million patients in England, and this figure is expected to rise further as 'missing patients' come forward for treatment. Emergency services also face sharply increasing demand. This is at a time where the NHS is facing significant staffing shortages as recruitment and retention are becoming more challenging.

The parties' evidence and our analysis

7. The parties' evidence (summarised in Chapter 3) was submitted between January and March 2022. Our analysis and conclusions (Chapter 4) are also informed by subsequent data on the economy, labour market, AfC earnings and the workforce.

8. Economy and labour market (4.2 - 4.35). In addition to the pandemic, there have been other substantive shocks to the UK economy and labour market, leading to unusually high levels of variation in economic forecasts. The reduced rise in GDP for 2022 reflects a deteriorating outlook for consumer spending. Inflation was at 9% in April and the Bank of England expects it will rise further to around 10% this year. Although unemployment levels remain below pre-pandemic levels, employment levels also remain below, and inactivity levels are higher resulting in a tight labour market. There are now more job vacancies than unemployed people in the UK for the first time since records began.
9. NHS funding and demand (4.36 - 4.57) The NHS saw a significant increase in its budget in response to the COVID-19 pandemic. As the immediate impact of the pandemic on the health service subsidies, the NHS is being asked to make efficiency savings of 2.2% per year. This is at a time when the pressure on the NHS is significant, and it remains unknown how high waiting lists will rise.
10. Vacancies (4.58 - 4.76) The latest data, for the third quarter of 2021/22, to December 2021, showed that overall, there were 102,034 AfC vacancies in the NHS. If vacancies continue to persist at high levels, they have the potential to impact on staff morale, service delivery and patient care. There is also a financial cost of carrying vacancies which subsequently need to be filled through bank and agency staff who are frequently more expensive than substantive staff. The high cost of agency use has been demonstrated in Northern Ireland and Wales, where a sharp increase in agency spend has been seen.
11. Workforce planning (4.77 - 4.86). There is consensus among the parties that workforce planning needs to be improved to close the workforce gap. Across England and Wales, work is ongoing to improve workforce planning. Progress on workforce planning has slowed in Northern Ireland.
12. Morale and motivation (4.87-4.107). The results from the 2021 Staff Survey for England are clearly worse than those for 2020, and in many instances the least positive since 2017, the last survey conducted before the 2018 AfC agreement. Since the 2020 Staff Survey, the proportion of staff satisfied with pay has fallen from 36.7% to 32.7%, the proportion of staff who felt that there were enough staff has reduced from 38.4% to 27.2% and the proportion of staff thinking about leaving has risen from 26.5% to 31.1%. Sickness absences peaked in conjunction with the peaks in waves of COVID-19, with 120,000 staff being absent on a single day in January 2022. The most common causes of sickness absence are anxiety, stress, depression and other psychiatric problems.

13. Workforce numbers and recruitment (4.131 - 4.174). The AfC workforce continues to increase year-on year. Compared with a year earlier, in September 2021 the number of FTE staff had risen by 3.8% in England, 3.3% in Northern Ireland and 4.1% in Wales. The latest annual report from the NMC shows increased reliance on international recruitment, with the majority of those joining the register for the first time being recruited from outside the EU/EEA. We remain supportive of ethical international recruitment. Increases in acceptances to nursing degrees rose in 2020 and 2021; however, it will be at least another year until these students begin to feed through into increased numbers of substantive staff. The NHS must continue to take the opportunity to create attractive apprenticeships which could help to secure the future supply of staff to the NHS in a tight and competitive labour market.
14. Retention (4.175 - 4.191). The staff needed to deliver the Build Back Better plan and the equivalent plans in the devolved administrations are the same staff who need time to recover from the pandemic. As staff have not yet had the space and time to recover, employers are facing retention challenges with leaver rates rising. Leaver rates amongst midwives are particularly concerning and are at their highest level since September 2010. The Ockenden report also highlighted many issues in maternity safety and the stress experienced by midwives.
15. Recruitment and Retention Premia (RRP) (4.192 - 4.193) There was consensus that local RRPs are not well used. Anecdotally, this is to avoid a competitive wage spiral within, and between, NHS Trusts. National RRPs are not the right substitute for base pay at the correct level and this year we judged that staff shortages are not limited to one occupational group.
16. High Cost Area Supplements (HCAS) (4.194) The Staff Side remain concerned the current HCAS system is outdated. The full effects of how working patterns change following the COVID-19 pandemic are yet to be fully realised and any review of HCAS should wait until this matter becomes clearer.
17. Earnings (4.195 - 4.220) Between December 2020 and December 2021, average basic pay for our remit group grew overall by 4.1% and by between 3.7% and 4.5% for most professional staff groups, the exceptions being hotel, property and estates staff (5.0%), support to ST&T staff (4.7%) and senior managers (1.9%). In the lower bands, the gap between the bottom pay point and the NLW has reduced over recent years, and strong pay rises for lower paid roles have been seen more recently in the private sector leading to NHS employers facing increased competition to recruit and retain people to lower band roles.
18. Total reward (4.221 - 4.255). The total reward offer remains a key part of the NHS employment offer. However, base pay is increasingly more important in the face of cost-of-living pressures and changes to the pension contribution structure planned for October will see staff in the three bottom tiers pay increased pension contributions. The McCloud remedy will make retirement options easier for certain staff, which creates an additional retention risk as 265,000 AfC staff are aged over 55. Positive steps are being taken through NHSEI's Pension Response project to promote the value of the pension scheme, although the pace of the rollout needs to increase.

19. Flexible working is of increased importance to staff. There is support for the new policy which was implemented on the 1st September 2021, but line management need the workforce numbers, support, education and systems to be able to offer the right solutions to ensure the implementation is as good as the policy itself.

Pay recommendations

20. Our pay recommendations are set out in Chapter 5 of this report. We have set out our key considerations for the recommendation, including the current state of the economy and labour markets; affordability as set out by the Governments of England, Northern Ireland and Wales; NHS demand; and the need to recruit, retain and motivate suitably able and qualified staff.
21. We are aware that the NHS is operating within a heavily constrained budget envelope. However, we believe that our recommendation delivers investment in staff pay that goes some way to reducing the risk that pay is a reason to leave NHS service; protecting the service from additional temporary workforce costs; and protecting risks to patient care from the impact of increased vacancies and an overstretched workforce.

Philippa Hird (Chair)

Richard Cooper

Patricia Gordon

Neville Hounsome

Stephanie Marston

Anne Phillimore

Stephen Boyle

Professor Karen Mumford CBE

14th June 2022

Chapter 1 Introduction

Introduction

- 1.1 This chapter sets out the context to our consideration of this year's remits, explains our approach to conducting the review and outlines the structure of the report. This chapter also considers ongoing developments in the National Health Service (NHS) which relate to our considerations of the Agenda for Change (AfC) workforce. The NHS Pay Review Body (NHSPRB) received remits from the UK Government, the Northern Ireland Executive and the Welsh Government for this year's pay round and this report includes our pay recommendations for 2022/23.

The Review Body process

- 1.2 Trust in the independence of the pay review body process underpins its value. To ensure the rigour and independence of the pay review report and recommendations, the NHSPRB requests written evidence from all parties. This is then shared among the parties to the process, before holding oral evidence sessions so that, in those sessions, all parties have a chance to respond to others' evidence.
- 1.3 Following the commencement of the round and given the reporting date of May 2022 requested in the Department of Health and Social Care (DHSC) remit letter, we set a deadline for written evidence of 24th January 2022. This deadline was set to allow the NHSPRB to consider evidence from the parties listed at 1.32 and to reach independent conclusions. The remit letter from the Department of Health, Northern Ireland was received on 13th December 2021 and did not give a date for report submission. The remit letter from the Welsh Government was received on 1st February 2022 and asked for the report to be submitted as soon as possible. We received most of the evidence around 24th January 2022, including that from the trade unions and employer bodies. However, there were significant delays in the receipt of evidence from government bodies – DHSC submitted evidence on 21st February 2022, NHS England and Improvement (NHSEI) on 24th February 2022 and the Department of Health, Northern Ireland on Thursday 3rd March 2022.
- 1.4 We know the importance of the Review Body process to our remit group and are concerned that late submission of evidence sends an unhelpful signal to them. We are grateful for the flexibility shown by many of the parties this year in relation to delayed written evidence and, consequently, the oral evidence process. We recognise the challenging situation brought about by the pandemic and the impact it has had on the workload of all the parties, but the lateness of some evidence made the process more difficult this year for those who had met the deadlines. We would ask, again, that next year all parties submit evidence in a timely manner, which would enable the Review Body to complete its work on its planned timescale.

- 1.5 We also note the importance of a timely pay review for NHS staff. For the last two years our remit letters have arrived after NHS budgets have been set and too late for us to be able to submit our recommendation before 1st April when any pay rise would be due. We would welcome suggestions from the parties on the best way to manage the timing of the process to allow recommendations to support resource planning and come ahead of a pay review date.

Wider context

- 1.6 Our report this year has again been completed against the ongoing background of the COVID-19 pandemic and significant volatility in the economy and labour market. The pandemic has continued to require NHS staff to work in unprecedented ways sometimes in the most difficult of circumstances and it is important to acknowledge their central role in the UK's response.
- 1.7 In addition to the pandemic, there are other substantive shocks to the UK economy and labour market such as the war in Ukraine and the UK's exit from the European Union. There is an unusually high level of variation in economic forecasts and some indicators have changed substantially between the submission of evidence and the completion of this report. The economic outlook remains hard to predict.
- 1.8 COVID-19 had a particularly acute impact on sectors reliant on social contact and GDP contracted in 2020. It grew by 7.4% in 2021 and a 3.8% increase is forecasted for 2022.

Cost of living

- 1.9 Price inflation has been outstripping wage growth since the end of 2021. CPI inflation rose to 9.0% in April 2022 and the Office for Budget Responsibility, and the Bank of England expect it to continue to increase, peaking in the fourth quarter of 2022. Combined with the increases in National Insurance contributions this significantly impacts households' disposable incomes.
- 1.10 As households struggle to cover the rising cost of living, in May 2022, the Government put in place additional cost of living support measures targeted particularly on those with the greatest need. The Energy Bills Support Scheme has been doubled to a one-off £400 payment which will now be made as a grant and a £650 one-off Cost of Living Payment will be made to those on means tested benefits, which affects over eight million households.

- 1.11 Although the Cost of Living support package will provide support to those who need it most, it is expected that income growth will continue to sit below price growth in a way that severely impacts our remit group. The majority of AfC staff are in Bands 1 – 5, and so the basic hourly pay of most of our remit group is below median hourly earnings across the economy as a whole. Lower income households spend a higher proportion of their incomes on food and non-alcoholic drinks, housing, fuel and power. Thus, much of our remit group is especially vulnerable to current high inflation.

Labour market

- 1.12 There was a fall in unemployment in January 2022- March 2022 from the previous quarter. Employment levels and economic inactivity both rose. Job vacancies are greater than unemployment for the first time in history.
- 1.13 In 2021, The Low Pay Commission was given an updated remit by the Government. This asked them to recommend the rate to apply from April 2020 if following a path that reaches two-thirds of median earnings by 2024, taking economic conditions into account. As of 1st April 2022, the National Living Wage (NLW) rose from £8.91 an hour to £9.50 an hour for people aged over 22. In response to this change, the UK Government temporarily uplifted Band 1 and the bottom of Band 2 pay to £9.65 an hour in England; the Department of Health, Northern Ireland temporarily uplifted Band 1 and the bottom of Band 2 pay to £9.51 an hour in Northern Ireland; and the Welsh Government temporarily uplifted Band 1 and the bottom of Band 2 pay to £9.90 an hour in Wales, all pending the outcome of the NHS Pay Review Body process.
- 1.14 There remains no doubt that the pandemic will have lasting implications on labour demand, the mix of occupations, and the workforce skills required. Research has shown that the pandemic has changed the priorities of existing and potential employees. Flexible working and work-life balance are two of the fastest growing priorities and there is evidence of widespread, radical change in working practices³. Many organisations are now adopting hybrid working practices – and some are adopting remote working options for employees – to attract and retain talent in their workforce. The health workforce is not immune to these general trends.

³ Torkington, S., 2022. *Looking for a new job? This is what people are prioritizing when planning their next career move.* [online] World Economic Forum. Available at: <<https://www.weforum.org/agenda/2021/12/career-planning-new-job-priorities/>>

NHS Demand

- 1.15 Following on from the intense pressure created by the pandemic, the NHS continues to experience exceptionally high demand for services with increases in waiting lists and emergencies and ambitious plans for elective recovery which are designed to reduce the care backlog. Health spending was significantly increased throughout 2020/21 and 2021/22. Funding rose from £148.9bn in 2019/20 to £191bn in 2020/21 and £190.3bn in 2021/22. There are, at present, insufficient staff to support this level of activity, and this has substantially exacerbated the pressures on existing staff. There are also additional specific challenges for the NHS in Northern Ireland and Wales relating in particular to rising costs of agency staff. Additionally, in Northern Ireland, the remit group includes the social care workforce.
- 1.16 As ever, we make judgements based on the best available evidence. This continues to be particularly challenging as the long-term impact of COVID-19 on the economy, society and the health of the population is still emerging, and the economic and labour market data and forecasts remain unusually volatile.

Our 2021 Report

- 1.17 We submitted our 2021 Report to the Prime Minister, the Secretary of State for Health and Social Care, Minister of Health in Northern Ireland and the Minister for Health and Social Services in Wales on 23rd June 2021.
- 1.18 On 21st July 2021, the UK Government accepted our recommendations in full for the year and noted the pay rise would be backdated to April 2021. On 30th July 2021, the Welsh Government's Minister for Health and Social Services announced that the recommendation had been accepted in full and was in addition to the NHS and Social Care bonus payment made in March 2021. On 13th December 2021, the Minister of Health for Northern Ireland wrote to us and noted they would be accepting the recommendation in full, in addition to the £500 non-consolidated payment given to all health and care staff.
- 1.19 On 17th December, the Welsh Government also confirmed a one-off non-consolidated additional payment of 1% to all AfC staff at bands one to five; an additional annual leave day for all NHS staff and the option to sell back a proportion of unused annual leave days. They also amended the bottom pay point to £18,731 per annum, backdated to 1st April 2021.
- 1.20 Many Trade Unions expressed their view that the recommended pay award failed to keep pace with the predicted level of inflation and responded by holding consultative ballots to gauge their members' reactions.

Remits for 2022/23

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

- 1.21 The Secretary of State wrote to us on 30th November 2021 to commence the 2022/23 pay round. The Secretary of State noted it was vital that planned workforce growth is affordable and within the budgets set and stated their view that there is a direct trade-off between pay and staff numbers.

The Minister of Health, Northern Ireland

- 1.22 The Minister of Health, Northern Ireland wrote to us on 13th December 2021 to commence the 2022/23 pay round. They also noted the need for affordability and sustainability must be balanced with the need for fair pay.
- 1.23 They further note their integrated system of health and social care, which brings proportionately more staff into AfC terms and conditions.
- 1.24 The Minister noted they would be interested to have the views of the NHSPRB into wider recruitment, retention and staff motivation factors specific to health labour markets for regions, such as Northern Ireland and northern England, which have land borders across which individuals might reasonably commute.

The Minister of Health and Social Services, Welsh Government

- 1.25 The Minister for Health and Social Services wrote to us on 1st February 2022 to commence the 2022/23 pay round. The Minister asked for a recommendation that would represent a sufficient pay rise for AfC staff to recognise their dedication and hard work during the pandemic and the work they will continue to undertake in the coming year to support the recovery efforts.
- 1.26 The Minister further noted the increase in National Insurance contributions and cost of living increases many NHS staff will be facing this coming year given the rises in inflation and energy prices.
- 1.27 The Minister urged the NHSPRB to make a pay rise recommendation that truly recognises the commitment and hard work of NHS staff and takes into consideration the significant cost of living increases they face.
- 1.28 However, they commented that affordability is a key issue for the Welsh Government, that they have to balance rewarding all their public sector within finite budgets set by the UK Government, and that to afford substantial pay increases, the UK Government needs to make sufficient funding available.
- 1.29 The Minister requested advice and recommendations as soon as possible to ensure that payment of any award is not unduly delayed past April 2022.

Scottish Government

- 1.30 The Scottish Government did not provide a remit for the 2022/23 pay round.

Evidence submissions and visits

- 1.31 Our considerations were informed by the parties' written and oral evidence submissions and our analysis of a range of pay and workforce information, which were supplemented by our visits to NHS organisations and education providers.

Parties submitting evidence

1.32 Between January and April 2022, we received written and oral evidence and the majority of the parties published their evidence on their websites. Those who submitted evidence were as follows:

Government departments

- HM Treasury
- Department of Health and Social Care
- Welsh Government

Staff representatives

- Joint Staff Side
- Royal College of Nursing
- Royal College of Midwives
- Chartered Society of Physiotherapists
- Royal College of Podiatry
- Society of Radiographers

NHS organisations

- Health Education England
- NHS England and Improvement

- GMB
- Unison
- Unite
- Managers in Partnership

Employers' bodies

- NHS Employers
- NHS Providers

Other pay and workforce information

1.33 We drew on the parties' evidence throughout our analysis in Chapter 4 of this report and we also considered published data and information on the NHS. This included reports from external commentators providing wider analysis of issues relevant to our considerations. We supplemented these with analyses of the latest economic and labour market indicators, and research commissioned by the Office of Manpower Economics.

Our visits

1.34 We conducted visits across NHS trusts in England, a Welsh health board, a health and social care trust in Northern Ireland, and a university, between September and December 2021. Because of the pandemic, our programme of visits was conducted virtually this year and operational pressures meant some of our visits were unfortunately cancelled. These visits helped us to understand the experience of staff, managers and students, and the pressures they have faced throughout the pandemic. The visits were particularly useful in hearing first-hand views on pay arrangements and the way in which they relate to recruitment, retention and motivation. We are grateful to the management, staff representatives, AfC staff and students who participated in these visits, and particularly those involved in their organisation. We visited the following organisations:

- Belfast Health and Social Care Trust
- Betsi Cadwaladr University Health Board
- Leeds Teaching Hospital
- North Cumbria Integrated Care Foundation Trust
- South West Ambulance Trust

- University of Surrey

Our overall approach

- 1.35 Our report provides recommendations for 2022/23. We have made our independent pay recommendation in the context of our remit letters and have assessed the evidence, data and information as they relate to our standing terms of reference.
- 1.36 Our report therefore sets out the context of NHS developments relevant to our considerations of the AfC workforce (in Chapter 2), and then provides a summary of the parties' evidence submissions (in Chapter 3), followed by our analysis and conclusions (in Chapter 4), pay recommendations (in Chapter 5) and a forward look (in Chapter 6).

Chapter 2 NHS Context

Introduction

2.1 We set out in this chapter the ongoing developments in the NHS which relate to our considerations on the AfC workforce. It covers published data and reports by external commentators on NHS finances and performance, demand and quality of care and the AfC workforce. The developments in the NHS feed into our analysis in Chapter 4 of this report.

Impact of the COVID-19 pandemic

- 2.2 In England, as reported by the King's Fund and the Health Foundation, elective waiting lists were growing and performance targets were being routinely missed pre-pandemic. They assess that the situation has significantly deteriorated, and will continue to worsen, as more people wait for treatment and people wait longer than they did before^{4,5}.
- 2.3 The Health Foundation note that there is substantial variation between clinical specialities in terms of both the impact of COVID-19 and the challenges involved with addressing the backlog. Compared to 2019, the number of patients completing treatment in 2020 fell by 37-38% for trauma and orthopaedics, oral surgery and ear, nose and throat, while, dermatology, thoracic medicine and neurology fell by only 19-20%. Elective care was also less disrupted, and recovered more quickly, in regions with generally lower COVID-19 infection rates. Compared to 2019, elective activity during 2020 fell by 31% in the North West, while activity in the South West fell by 24%.
- 2.4 The King's Fund say that to create a sustained fall in waiting times, the NHS needs both to meet the ongoing increases in demand generated by an ageing population and, for a period, to increase activity over and above underlying demand to reduce the backlog. The key rate-limiting factor on the ability to increase activity and treat more patients is the availability of staff. They say that any plan to reduce waiting times needs to build explicitly from an analysis of existing staff and the potential for workforce growth alongside a realistic assessment of any scope for increased productivity. Other longer-term investments will also be necessary, such as in operating theatres and large-scale diagnostic equipment.
- 2.5 The King's Fund further say that without extra staff, tackling the backlog and reducing waiting times means asking staff to work harder, at a time when the NHS workforce is exhausted with high levels of burnout as a result of the pandemic. They recommend that leaders at all levels recognise the importance and value of supporting staff to recover. They believe if the system does not focus on workforce wellbeing and making the NHS a more compassionate and inclusive workplace, then there is a risk that falling staff retention rates will undermine efforts at recovery.

⁴ *The King's Fund*, 2021. The King's Fund submission to the Public Accounts Committee inquiry into NHS backlogs and waiting times.

⁵ Gardner, T. and Fraser, C., 2021. Longer waits, missing patients and catching up. The Health Foundation.

- 2.6 The Health Foundation have noted that it is important to recognise the impact of COVID-19 on staff at all levels across the NHS and ensure that staff recovery is prioritised alongside service recovery. They say that COVID-19 has had a significant negative impact on the NHS workforce including high levels of burnout, sickness absence, increased risk of 'moral injury' and the sustained longer-term repercussions of this.

McCloud judgement

- 2.7 As discussed in our 34th Report, the McCloud Court of Appeal Judgement relating to the reform of public sector pensions will provide new options for staff about whether to remain in the service or to retire and take their pension. Members transferring to the 2015 NHS Pension Scheme will retain a final salary link, so that their 1995 and/or 2008 NHS Pension Scheme benefits are calculated using pensionable pay at retirement rather than the point of transfer. In March 2022, the Government set out their proposals to ensure equal treatment for all members within each of the main public service pension schemes by moving all members into the new schemes on 1st April 2022 irrespective of age.

Health and Care Act (England)

- 2.8 The Governments stated aim for the Health and Care Act is to build on the proposals brought forward by the NHS following the publication of the Long-Term Plan. The proposals build on extensive engagement by the NHS in 2019 and were further developed in the 2021 White Paper *Integration and Innovation: Working Together to Improve Health and Social Care for All*. The Act aims to advance on the collaborative working seen throughout the pandemic, to shape a system which is best placed to serve the needs of the population.
- 2.9 The core measures in the Act follow three themes, all of which the Government has said are integral to helping the system to recover from the pandemic and transform patient care for decades to come.
- i. removing barriers which stop the system from being truly integrated, with different parts of the NHS working better together, alongside local government, to tackle the nation's health inequalities.
 - ii. reducing bureaucracy across the system. The Government wants to remove barriers which make sensible decision-making harder and distracts staff from delivering what matters – the best possible care.
 - iii. ensuring appropriate accountability arrangements are in place so that the health and care system can be more responsive to both staff and the people who use it⁶.

⁶ GOV.UK. 2022. *Health and Care Bill: information*. [online] Available at: <<https://www.gov.uk/government/publications/health-and-care-bill-factsheets/health-and-care-bill-information>>

Integrated Care Systems (ICSs)

- 2.10 ICSs are geographically based partnerships that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, coordinate and commission health and care services. Although ICSs have been developing for several years, the Health and Care Act puts them on a statutory footing from July 2022.
- 2.11 The statutory ICSs will be made up of two key bodies – an integrated care board (ICB) and an integrated care partnership (ICP). ICBs will take on the NHS planning functions previously held by clinical commissioning groups and are likely to absorb some planning roles from NHSEI. In consultation with local partners, the ICB will produce a five-year plan (updated annually) for how NHS services will be delivered to meet local needs. ICPs will operate as a statutory committee, bringing together the NHS and local authorities as equal partners to focus more widely on health, public health and social care. They will be responsible for developing an integrated care strategy, which sets out how the wider health needs of the local population will be met.
- 2.12 NHS systems in both Northern Ireland and Wales have operated as integrated systems for some years. In Northern Ireland, the system also includes the provision of social care as well as health, again based on geographical areas. In Wales, the system covers NHS Healthcare provision within a geographical area aligned with one or more Local Authorities.

Merger of Health Education England, NHS England & Improvement, NHS Digital and NHSX

- 2.13 In November 2021, the Secretary of State for Health and Social Care announced that he will use powers in the Act to merge HEE, NHSX and NHS Digital with NHSEI. The aim of merging HEE is to create a stronger organisation that aligns workforce, financial and service planning with education and training, COVID-19 recovery, the People Plan, and a robust workforce reform programme for the benefit of patients and the public.
- 2.14 It is hoped that combining NHS Digital and NHSX will improve cooperation between the key digital bodies of the NHS.

Workforce and the Health and Care Act

- 2.15 A number of key stakeholders have argued that accountabilities for workforce planning and supply are currently not sufficiently clear. NHSEI have also recommended that DHSC should review the measures for workforce accountability as part of any new legislation.
- 2.16 A new duty in the Act will require the Secretary of State to publish a report that sets out how workforce planning, and supply is organised in England, in order to provide greater transparency and accountability. This report must be published, at a minimum, every five years.

NHS Reform

- 2.17 Alongside the Health and Care Act, in March 2022 the Health and Social Care Secretary set out his plan for NHS reform including three main themes – prevention, personalisation and performance. He noted his four underlying principles as:
- Services are redesigned around the patient by prioritising prevention and personalisation;
 - Clear performance standards and accountability;
 - More choice, power, technology and funding in the hands of the patients; and
 - More freedom and support for system leaders and front-line innovators to partner and to deliver.
- 2.18 In his speech, the Secretary of State made reference to a long-term workforce plan, so the NHS can build their workforce and skills, and take tougher action on racism, sexism and bullying⁷.

NHS finances

NHS funding for 2022/23

- 2.19 The Government announced an additional £36 billion (£30.3 billion for England) in funding for health and social care up to 2024/25, funded in part by a new health and care levy: a 1.25 percentage points increase in National Insurance contributions.
- 2.20 DHSC and NHSEI will now receive £180.2bn in funding across 2022/23 and the government plans to spend over £8 billion between 2022 and 2025, the period covered by the Spending Review 2021 (SR21), to tackle the elective backlog. Additional investments include:
- A £5.9 billion fund to help reduce the elective backlog, including £2.3 billion for increased diagnostic capacity, including funding for 100 new community diagnostic hubs; £2.1 billion to support the innovative use of digital technology; and £1.5 billion over the SR21 period for new surgical hubs, increased bed capacity and equipment to help elective services recover.
 - £300 million over the SR21 period to complete the programme to replace mental health dormitories with single en-suite rooms and £150 million over the SR21 period to invest in NHS mental health facilities linked to A&E and to enhance patient safety in mental health units.
 - £4.2 billion over the next three years for 40 new hospitals and over 70 hospital upgrades. This is unchanged from the March 2021 Budget.

⁷ GOV.UK. 2022. *Health and Social Care Secretary speech on Health Reform*. [online] Available at: <<https://www.gov.uk/government/speeches/health-and-social-care-secretary-speech-on-health-reform>>

NHS finances in the Devolved Administrations

- 2.21 The 3 year budget, proposed by the Department of Finance, Northern Ireland, would have increased the DoH allocations by c£1.03bn over the 3 year budget period and by £700m from the baseline in 2022/23. This does not however reflect the further in-year funding provided in 2021/22 to meet additional pressures. While the proposed budget would have seen an increase in the baseline position, this means a reduction of around £300m when compared to actual spend in 2021/22. It should be further noted that this draft budget was not passed by the NI Executive and the Department of Health is therefore working on an opening budget based on the 2021/22 baseline.
- 2.22 The Welsh Government announced NHS Wales would receive an additional £893m for 2022/23, an increase of 10.7% on its 2021/22 budget. The total budget for Health and Social Services for 2022/23 is approximately £10.1bn.

Demand and quality of care

- 2.23 6.35 million people were on the waiting list for planned NHS treatment in England in March 2022. This represents more than 10% of the population.
- 2.24 There are several million ‘missing patients’ whom the NHS would have expected to come forward for treatment during the pandemic. The proportion of these who will now come forward is unknown.
- 2.25 The Institute for Fiscal Studies have completed some modelling based on the likely number of ‘missing patients’ who will now come forward for treatment.
- On the assumption that 30% of ‘missing patients’ come forward, waiting lists will peak at 7.4 million in June 2023 before falling to pre-pandemic levels in the summer of 2025.
 - On the assumption that 50% of ‘missing patients’ come forward, the waiting list will peak at 8.7 million in October 2023, before falling to pre-pandemic levels by the end of 2025.
 - On the assumption that 80% of ‘missing patients’ come forward, waiting lists will peak at 10.8 million in December 2023 and remain above pre-pandemic levels at the end of 2025⁸.

NHS England and Improvement – performance

- 2.26 As set out above, there were 6.35 million patients on NHS waiting lists in England in March 2022 with the median wait time for treatments reported to be 13.1 weeks, compared with 7.5 weeks in February 2020.
- 2.27 The total number of A&E attendances in March 2022 was 2,174,000, an increase of 28.5% on March 2021 and 0.3% higher than March 2019. 63.8% were admitted, transferred or discharged within four hours, a 7.1% increase on the equivalent figure for March 2021 and a 17.3% decrease on March 2019.

⁸ Stoye, G., Warner, M. and Zaranko, B., 2022. *The NHS backlog recovery plan and the outlook for waiting lists*. [online] Available at: <<https://ifs.org.uk/publications/15941>>

- 2.28 71.6% of patients were seen within four hours, compared with 73.3% in February 2022, 86.1% in March 2021, and 86.7% in March 2018. This is the lowest performance on this indicator since collection of data about it began.
- 2.29 Waiting times for cancer services are improving – 80.7% of people were seen by specialist in March 2022 within two weeks of an urgent referral for suspected cancer compared to 75.0% in January 2022, and 93.7% of people treated began first definitive treatment within 31 days of receiving their diagnosis, compared to 89.6% in January 2022⁹.

Performance data for the Devolved Administrations

- 2.30 As of December 2021, there were 354,756 patients on NHS waiting lists in Northern Ireland, with around 85% of patients reportedly waiting over nine weeks and around 55% waiting over 52 weeks.
- 2.31 From October-December 2021, there were 58,791 attendances at A&E in Northern Ireland, with 53.1% treated, discharged or admitted within four hours.
- 2.32 In December 2021, 43.0% of cancer patients in Northern Ireland started treatment within 62 days, a slight improvement from 41.6% in November 2021¹⁰.
- 2.33 As of February 2022, there were 692,000 patients on NHS waiting lists in Wales, with the median wait time reported to be 22.9 weeks – up from approximately 10 weeks in February 2020.
- 2.34 Latest data from NHS Wales, up to December 2021, showed there were 74,000 attendances at all NHS Wales emergency departments. This was 8.3% lower than the previous month, but 25% higher than in the same month last year. 66.5% of patients spent less than four hours in the department until admission, transfer or discharge. 1.3% lower than the previous month and 4.3% lower than the same month in 2020.
- 2.35 Waiting times for cancer services are not improving in Wales. In November 2021, 57.9% of patients (1,021 out of 1,762) newly diagnosed with cancer started their first definitive treatment within 62 days of first being suspected of cancer. This was the second lowest on record since comparable data was first collected in June 2019, 1.7 percentage points lower than October 2021 and 1.8 percentage points lower than October 2019¹¹.

Nurses' Pay

- 2.36 In November 2021, the Health Foundation released a report titled *Nurses' pay over the long term: what next?*¹²

⁹ England.nhs.uk. 2022. *Statistics » Combined Performance Summary*. [online] Available at: <<https://www.england.nhs.uk/statistics/statistical-work-areas/combined-performance-summary/>>

¹⁰ Department of Health, Northern Ireland. 2022. *Diagnostic waiting times | Department of Health*. [online] Available at: <<https://www.health-ni.gov.uk/articles/diagnostic-waiting-times>>

¹¹ GOV.WALES. 2022. *NHS activity and performance summary: February and March 2022 | GOV.WALES*. [online] Available at: <<https://gov.wales/nhs-activity-and-performance-summary-february-and-march-2022.html>>

¹² Buchan, P., Shembavnekar, N. and Bazeer, N., 2021. *Nurses' pay over the long term: what next?*. *The Health Foundation*.

2.37 They made the following key points about the pay of the nursing workforce:

- 88% of nurses and health visitors are female;
- Since 1989, gross earnings of nurses and health visitors have grown more rapidly than police officers and school teachers;
- Earnings of those who study nursing are almost always higher than non-graduates;
- It is more than 15 years since the Agenda for Change reform, the last significant restructure which gave nurses a substantial pay boost.
- Earnings amongst the nursing and health visitor workforce has been lower than earnings in Australia, USA, New Zealand and Canada since 2009; and
- Average hospital nurse earnings exceeded the average full time employee earnings in 2009, however, they had fallen below the average in 2019.

The Health Foundation also recommended some areas for focus. It:

- Suggests a broad focus on assessing if the NHS national pay system remains fit for purpose;
- Notes there is widespread recognition of the scope to optimise and update pay progressive mechanisms to better recognise the skills, experience and advanced practice contributions;
- Proposes exploring the extent to which pay supplements should be targeted at hard to fill posts or high cost of living areas;
- Notes the ongoing requirement to assess the extent to which the pay system established under the AfC contract meets one of its initial objectives – to support pay equity;
- Notes that pensions remain a major part of an employment package and it must be recognised that the workforce is ageing with a high proportion nearing retirement age.
- Notes that flexibilities in pension contributions and payments could encourage more nurses to remain in work or return to work; and
- Highlights the issue of diverging pay processes across the nations which adds tension to the process.

2.38 Finally, the report notes that the full impact of the COVID-19 pandemic remains to be seen. One notable short-term positive impact is the increase in applications to nursing education. Negative impacts include the effects on health and wellbeing, a drop in retention and an increase in early retirement and long-term absence.

Workforce Planning

2.39 Northern Ireland and Wales have had workforce planning functions in place for years and continue to fund training places for nursing, midwifery and other healthcare professions.

2.40 In England, the King's Fund believes that workforce shortages are the key limiting factor on efforts to boost NHS activity and tackle the rising backlog of care and although there are workforce planning functions in place in Northern Ireland and Wales, they note that there has been no national NHS workforce strategy since 2003.

- 2.41 In order to recruit and retain staff, the King's Fund recommends the NHS focuses on becoming a more attractive employer by tackling bullying and discrimination, offering more opportunities for flexible working, and embedding collective, compassionate and inclusive leadership across the NHS to create cultures in which staff want to work and build their careers¹³.
- 2.42 Furthermore, the Health Foundation say that a fully funded workforce strategy needs to be central to NHS recovery plans and failure to come forward with a long-term workforce plan will undermine efforts to bring down waiting lists and put the NHS's recovery at risk¹⁴.
- 2.43 The NHS Confederation commented on workforce planning workforce planning in their response to Health Education England's Call for Evidence Long-Term Workforce Planning.
- 2.44 They commented on the ageing workforce. One third of the nursing workforce are aged between 45 and 55 and one in six are aged between 55 and 64. Supporting the older workforce will become one of the biggest issues for organisations.
- 2.45 They noted the need to improve the flexible working offer. 76.7% of the NHS workforce is female and three times more women aged 50-64 are working part time compared with men of the same age.
- 2.46 They noted the importance of international recruitment and that any policy must remain supportive of ethical recruitment.
- 2.47 The combination of several regulatory and legal changes has the potential to cause uncertainty around workforce supply in the future. Changes include the end of transitional arrangements for recognition of EU professional qualifications; and proposals to reform the regulation of healthcare professionals.
- 2.48 The NHS Confederation note the future must be based on collaboration and partnership working at a local level. The Health and Care Act provides an opportunity for a new and different regulatory environment.
- 2.49 The labour market has changed, and the increased importance of work-life balance is having an impact on recruitment and retention. For example, there has been a trend of migration away from cities.
- 2.50 They believe the unbalanced geographical distribution of course offerings are not ideal and problematic for future workforce supply. There needs to be support to increase placement capacity so it is not a rate-limiting factor in training.
- 2.51 Staff burnout and the mental health impact of the pandemic are of major concern. Healthcare professionals need the time and space to recover.

¹³ The King's Fund. 2022. *NHS workforce: our position*. [online] Available at: <<https://www.kingsfund.org.uk/projects/positions/nhs-workforce>>

¹⁴ Gardner, T., 2022. *Fully funded workforce strategy needs to be central to NHS recovery plans*. [online] The Health Foundation. Available at: <<https://www.health.org.uk/news-and-comment/news/fully-funded-workforce-strategy-needs-to-be-central-to-nhs-recovery-plans#:~:text=Fully%20funded%20workforce%20strategy%20needs%20to%20be%20central%20to%20NHS%20recovery%20plans,-10%20March%202022&text=Responding%20to%20the%20publication%20today,in%20Omicron%20cases%20over%20winter.>>

- 2.52 As there is a move towards more use of technologies, NHS Confederation believe strategies must address the workforce, skills and infrastructure needs of the NHS to be able to exploit modern technologies.
- 2.53 The absence of a long-term strategy for social care only exacerbates the pressure on health services. The main barrier to a successful partnership is parity in terms and conditions and pay.

Equalities

- 2.54 In March 2022, NHS Providers published a report titled '*Race 2.0 – Time for Real Change*'. They surveyed board members from across NHS organisations, and only 4% of respondents to their survey felt that race equality is fully embedded as a core part of their Board's business¹⁵.
- 2.55 They also note that leaders recognise the need for greater support for their workforce, particularly for those experiencing discrimination. 77% of leaders reported that they have made progress on actions to improve workforce wellbeing, however, only 22% have made progress in actions to retain ethnic minority staff. Even fewer (6%) felt they had made progress on procurement, which includes monitoring all suppliers by race and seeking commitment from service providers on race equality.
- 2.56 Leaders reported that one of their biggest challenges is having the time and capacity to make an impact on race equality. They also describe attracting diverse talent, particularly where local communities are less diverse, as a particular challenge. Few trusts described proactively developing their ethnic minority talent pipeline in response.
- 2.57 NHS Providers also reported that ethnic minority leaders face a double burden of experiencing discrimination whilst also feeling pressure to lead on race, especially when their white peers are not comfortable playing a leadership role. A key challenge from their experience is how to foster a sense of shared responsibility and ownership.

House of Commons Health and Social Care Committee

- 2.58 The House of Commons Health and Social Care Committee is currently undertaking an inquiry titled *Workforce: recruitment, training and retention in health and social care* following their report titled *Workforce burnout in health and social care* which we referenced in the 34th Report.

¹⁵ Nhsproviders.org, 2022. *Race 2.0 – Time For Real Change*. [online] Available at: <<https://nhsproviders.org/race-2-0-time-for-real-change>>

CQC State of Care report

- 2.59 In October 2021, the Care Quality Commission produced their report *The state of health care and adult social care in England*. They noted that the system has not collapsed – but the system is composed of individuals, both those who deliver and receive care, and the toll taken on many of these individuals has been heavy. The report noted also that the vital role of adult social care was made clear during the pandemic, but urgent action is needed to tackle staffing issues and the increased pressures and stresses caused by staff shortages.
- 2.60 It also highlighted the interdependencies between health and social care and that increased stability in social care is the key to easing the pressure on the NHS by reducing emergency attendances and delayed discharges.

Patient care

- 2.61 The King's Fund have commented on the vicious circle of staff shortages, excessive workloads and patient care. Excessive workload is one of the most cited reasons for staff leaving health and social care organisations and the high levels of stress this causes are linked to medical and nursing errors, patient dissatisfaction and poor care quality.

AACE review on delayed hospital handovers

- 2.62 In November 2021, the Association of Ambulance Chief Executives (AACE) published a clinical review to assess the potential harm that patients experience as a result of extended delays in their handover between ambulance staff and hospital clinicians.
- 2.63 They found that over eight out of ten of those whose handover was delayed beyond 60 minutes were assessed as likely to have experienced some level of harm, with just under one in 10 being classified as potentially experiencing severe harm.
- 2.64 AACE concluded that not enough is being done to address adequately the risk of harm and tangible steps need to be taken to implement rapid system improvement¹⁶.

Ockenden review

- 2.65 In March 2022, Donna Ockenden published her final report the *Independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust*. The Independent review commenced in the summer of 2017 on the basis of 23 deaths at the Trusts and has since expanded to include the cases of 1,486 families, the majority of which were patients at the trust between the years 2000 and 2019.

¹⁶ AACE. 2022. *AACE report published: Hospital handover delays potentially causing significant harm to patients* – aace.org.uk.

- 2.66 The report found there were in many cases significant or major concerns in maternity care, which if managed appropriately, might, or would have, resulted in a different outcome. It identified fifteen “immediate and essential actions” needed to improve maternity care in England. Recommendations included the financing of a safe maternity workforce, ring-fencing training budgets, and a requirement for teams to train together, as well as clear policies where staffing fall below minimum levels¹⁷.
- 2.67 In the same month, the NHS announced a funding boost for patients and families, which included £50 million intended to boost staffing numbers, £34 million intended to be invested in culture and leadership development programmes and £45 million to support neonatal care.

NHS Workforce initiatives

- 2.68 Various schemes have been put in place to grow the workforce throughout the pandemic; however, a lot of those recruited were on a temporary basis. The Bringing Back Staff (BBS) scheme brought over 4000 clinicians back into the workforce to provide valuable support to health and social care, in frontline acute services and other settings, as COVID-19 vaccinators, and through national programmes like continuing health care and clinical trials. There has also been success in bringing non-clinical volunteers into permanent employment in the NHS. 11,483 people who joined the NHS COVID-19 vaccination programme have decided to stay on in the health service in other roles, in a huge boost to the workforce.
- 2.69 In 2021, NHSEI also launched their generational retention programme, which has focused on finding solutions to better support people in the early and later stages of their careers. Through focus groups, NHSEI have published their key themes to explore further:
- Preceptorship. Preceptorship support has always been important for nurses, and the pandemic has had a significant impact on how staff are able to access support.
 - Flexible working. A variety of choices in their career is important to staff. Those in later stages of their career want to continue working and may want to work fewer hours and perhaps a less demanding role but it has been difficult for some staff to achieve this in their organisation.
 - Health and Wellbeing. This has become even more important due to the pandemic and how staff feel cared for in an organisation has been a deciding factor in helping them stay.
 - Pensions. NHS England have learnt many staff are finding it difficult to access ‘easy to understand’ pension information that can help them make informed decisions. Instead, some staff are relying on friends and family to help them understand what decisions they should make about their retirement.

¹⁷ Ockenden, D., 2022. *Final report of the Ockenden review*. [online] GOV.UK. Available at: <<https://www.gov.uk/government/publications/final-report-of-the-ockenden-review>>

NHS Reserves

2.70 In response to the interest in healthcare careers displayed throughout the pandemic, the NHS has set up the NHS reserves. According to NHSEI, pilots of the programme completed in 2021 saw over 17,000 people sign up. NHSEI describe the purpose of the scheme as a resource for local hospitals and NHS services to call on depending on their staffing requirements and pressures in their area, creating a bank of extra resource for when it is needed.

NHS Elective Recovery

2.71 The NHS Elective Recovery Plan was published on 8th February 2022 by NHSEI. The plan sets out several ambitions which include the delivery of around 30% more elective activity by 2024/25 than before the pandemic, and that the NHS will continue to work to return to pre-pandemic performance as soon as possible.

2.72 However, they do note that the ongoing uncertainties in relation to the COVID-19 pandemic and demand for hospital treatment makes it challenging to be able to predict how quickly the NHS will be able to recover elective services. It is expected that the overall size of the waiting list will increase in the short term. It is then expected that waiting lists will begin to reduce around March 2024.

2.73 The Department of Health, Northern Ireland launched their new Elective Care Framework and an investment of £700m over five years to support their ambition to eradicate waits over 52 weeks for outpatients and 26 weeks for diagnostics by March 2026.

2.74 In Wales, the government also published its Health and Care Services Recovery Plan in March 2022. The priority was to build more resilient health and social care services and support and develop the workforce by reframing services to provide the integrated health and care support needed. The scale of the costs of recovery would be considerable and detailed plans were in development.

Health and Social Care Levy

- In September 2021, the Prime Minister announced plans for a new Health and Social Care Levy. The Levy is a 1.25% tax on earnings for employees, the self-employed and employers. The Levy will raise around £12.4bn a year (£36bn in total) for health and social care over three years and it is expected that £24.9bn of the Levy will be spent on health services over the next three years. This spending is front loaded with proportionately higher budgets in 2022/23.
- £8bn of the £24.9bn will be used to tackle growing waiting list and the government indicated that this extra funding should allow the NHS to deliver around 30% more elective activity by 2024/25 than before the pandemic (with the caveat that this target will be adjusted for changes to how the NHS delivers services, including increased use of advice and guidance services)¹⁸.

¹⁸ The King's Fund. 2022. *The Health and Care Levy: what was announced and what does it mean for health spending?*. [online] Available at: <<https://www.kingsfund.org.uk/blog/2021/10/health-and-care-levy-announcement-for-health-spending>>

Chapter 3 The Parties' Evidence

Introduction

3.1 In this chapter we set out a summary of the main points from the parties' evidence. The summaries follow the same structure as our analysis in Chapter 4 and broadly cover our terms of reference. We took evidence from the parties in writing between January and March 2022 and orally during March and April 2022. Where later data or information has become available, we have set these out in Chapter 4. The full versions of the parties' evidence can be found on their websites.

The COVID-19 pandemic

3.2 All parties set out the extremely challenging working environment and the personal impact on staff brought about by the coronavirus pandemic.

3.3 **The Department of Health and Social Care** told us that there have been a broad range of workforce changes as part of responding to the COVID-19 pandemic. This includes:

- student nurses being deployed either as healthcare assistants or nurses depending on where they were in their studies. This meant typical patterns of joiners to the NHS have changed;
- vacancy numbers and rates appearing to be artificially suppressed due to NHS Trusts focusing on the COVID-19 response and therefore pausing and / or focusing less on assessing their establishment. We expect there also have been some data quality or coverage issues as highlighted by NHS Digital;
- whilst the international workforce continues to grow, international recruitment flows were briefly impacted, reduced, or paused whilst travel restrictions were in place;
- some staff were employed via NHS Professionals and other routes, and these are likely to have had an effect on workforce statistics;
- many NHS staff were working and continue to work longer hours, but other NHS professions, depending on their specialism, may not have seen the same demands as part of the pandemic response. There were also a number of redeployments of staff which make it challenging to understand what care areas they did or did not provide service in at times.

3.4 **The Joint Staff Side** told us that the NHS was struggling with the tidal wave of the usual winter pressures and attempting to catch up with the backlog of the last 18 months, whilst dealing with a rise in coronavirus cases. They further noted that NHS staff have had no respite from the pandemic, or its consequences such as the care backlog. They told us that staff need recognition urgently if burnout, high vacancy rates and staff exits are to be meaningfully addressed.

- 3.5 **The Royal College of Nursing** told us that many nurses and nursing support workers are now experiencing the toll of years of unrelenting pressure through physical and mental health and burnout while having to work in environments which are short of staff across all occupations.
- 3.6 **The Chartered Society of Physiotherapy** told us that COVID does not present as a typical respiratory illness. Long COVID has a variety of symptoms and so there is a need to re-skill.
- 3.7 **Unite** told us the Covid-19 pandemic continues to push the NHS to the brink, compounding already endemic concerns around staffing following years of underinvestment and the impact of Brexit. NHS staff have worked over and above the call of duty, putting themselves and their families at risk to support the nation's health during the pandemic.
- 3.8 **NHS Providers** told us that throughout the COVID-19 pandemic, there has been considerable and sustained pressure on the NHS and its workforce as the country has moved through a number of waves of increased COVID-19 transmission and the unprecedented national vaccination programme, while a large care backlog has emerged. The service entered the pandemic with 100,000 vacancies, and 22 months of additional pressure has led to 94% of trust leaders telling them they are 'extremely or moderately' concerned about levels of burnout across their workforce.
- 3.9 **NHS Employers** told us that during the pandemic, the NHS has delivered a lot of change in a small amount of time, demonstrating that it can be agile and innovative. This has created a sea-change in attitudes to finding solutions and a real commitment to keep up the momentum with improvement and innovation in healthcare delivery. The commitment of people to doing things differently must be supported by adequate resources, including enough people to create the capacity that is needed to embed what has been learned so far and continue to learn and improve as the pandemic evolves.
- 3.10 **The Welsh Government** told us that a great deal of policy work has continued in response to the COVID-19 pandemic. The following measures have been agreed in partnership:
- a. COVID-19 sickness absence transition from enhanced provisions to application of regular sickness absence arrangements with effect from 1st April 2022.
 - b. NHS Wales guidance for managers on supporting employees on long-term sickness absence with a diagnosis of post-COVID-19 syndrome.
- 3.11 **NHS England and Improvement** told us that the NHS is continuing to incur significant additional costs due to the ongoing impact of COVID-19. Higher costs are driven by several factors relating to the prevalence of Covid including enhanced infection prevention and control (IPC), ward reconfigurations, staff redeployment and cancellations of elective activity, as well as increased staff sickness absence. Since the SR21 outcome, the Omicron variant has generated further uncertainty over the ongoing impact that COVID-19 will have on NHS operational needs.

- 3.12 They told us that the NHS is also managing the challenges of competing workforce and financial pressures from continuing to deliver COVID-19 care, delivering increased capacity for elective recovery to improve waiting times for patients, and ensuring staff are given adequate rest and recuperation after a sustained period of intense pressure.
- 3.13 They added that the NHS will continue to be under pressure for the next few years. In addition to recovering elective care performance by significantly increasing diagnostic and treatment capacity, the restoration of other impacted services –such as primary, community and mental health care –will continue to be a priority, as will making progress on the NHS Long Term-Plan ambitions and responding to independent service reviews (such as the Ockenden Review of maternity services).
- 3.14 **The Department of Health, Northern Ireland** told us the pandemic has created huge challenges over the last 18 months. However, the pandemic has also presented an opportunity to accelerate transformation through rebuilding. New ways of working and service innovations have arisen that can be embraced going forward. This includes changes in how primary care operates with much work happening remotely, new procedures in urgent and emergency care and the development of elective care centres.
- 3.15 **The Department of Health, Northern Ireland**, also told us that the pressures created by the pandemic, combined with the challenges existing prior to COVID-19 have required a rethink of transformation, and a rebuild framework and action plan – Building Better, Delivering Together – has been created. The framework and action plan are in line with transformation goals of the Transformation Programme.

NHS Demand

- 3.16 **NHS Employers** told us that growth in patient demand is hard to predict but they know that millions of patients did not access care during the pandemic and the health problems of many of these have worsened. As they now come forward for treatment their needs will be greater. There are many patients who will place increased and possibly long-term demand on mental health services. One estimate from the Institute for Fiscal Studies is that this alone could cost around £1 billion.
- 3.17 **The Joint Staff Side** told us the NHS is struggling with a tidal wave of usual winter pressures and attempting to catch up with the backlog of the last 18 months which has seen far too many patients suffer delays in urgent treatment.
- 3.18 They also told us that bed occupancy surpassed the 85% international standard across the NHS England area in the final week of November 2021, and at 92.9% was falling just short of the 95.0% level assessed as dangerous by NHS England and Improvement.

- 3.19 **The Royal College of Nursing** told us that NHS entered the pandemic with growing waiting lists, missed performance targets and workforce shortages. The response to the pandemic has meant attention has been diverted elsewhere and exacerbated these problems.
- 3.20 **The Royal College of Nursing** also told of their concern about the impact of increased demand on the ability to provide safe nursing care.
- 3.21 **The Chartered Society of Physiotherapy** told us demand for physiotherapy services remains high because:
- People with long-term conditions and frailty have deconditioned and deteriorated during lockdown;
 - There is a backlog of elective procedures; and
 - There are significant new rehabilitation needs of people recovering from post-Covid syndrome.
- 3.22 **NHS England and Improvement** told us that workforce demand continues to increase. Allied Health Professionals (AHPs) have been essential in supporting the COVID-19 response, including in fulfilling acute care, long COVID rehabilitation and COVID recovery requirements. The *Diagnostics: Recovery and renewal* report of the Independent Review of Diagnostic Services for NHS England makes recommendations for improving registered and support capacity to meet demand. In 2020 the Network Contract (Directed Enhanced Service) provided funding through the Additional Roles Reimbursement Scheme to support expansion of the primary care workforce by an extra 26,000 roles by 2023/24.
- 3.23 **NHS Providers** told us Trusts are running at full capacity with increasing demand for care outstripping capacity given that the service has almost 100,000 staff vacancies, and large numbers of staff self-isolating from week to week due to the ongoing COVID-19 pandemic. Despite these constraints, in November 2021 there were record numbers of patients seen by a consultant following an urgent two-week GP referral, all activity in cancer care increased and diagnostic activity reached the highest level since January 2020. NHS Providers told us this is testament to the dedication of NHS staff.
- 3.24 **The Department of Health and Social Care** told us that activity and demand levels in the health system for elective care dropped dramatically in 2020-21, as numbers of self-presenting patients reduced and the NHS freed up capacity to manage COVID-19 demand, including the suspension of all non-urgent elective operations. As a result, there was a reduction in the number of patients seen for both elective and non-elective care compared to 2019-20.
- 3.25 Despite the continuing best efforts of the NHS, many of the core waiting time and access targets were not achieved during 2020-21. These included A&E, referral to treatment, cancer treatment, diagnostic tests, and ambulance response standards.

- 3.26 The Department of Health and Social Care told us that they have committed in *Build Back Better: Our Plan for Health and Social Care* to reducing the elective backlog as part of improving NHS services going forwards. As a part of this they have committed £8 billion over the next three years to step up elective activity and transform elective services. This funding could deliver the equivalent of around nine million more checks, scans, and procedures. It will also mean NHSEI can aim to deliver the equivalent of around 30% more elective activity by 2024/25 than it was before the pandemic.
- 3.27 **The Welsh Government** told us that at the end of November 2021, there were just over 682,000 people waiting for appointments or treatment, the highest ever recorded. During November 2021, performance on the suspected cancer pathway was 57.9% against the 75.0% target.
- 3.28 The Welsh Government also told us that during December 2021, 5,504 people waited over an hour for handover from ambulance service to the care of NHS hospital staff.

Elective recovery

- 3.29 **NHS England and Improvement** told us that the pivot in the early stages of the pandemic from routine elective work to treating patients with COVID-19 has had an impact on waiting lists for diagnostic and surgical interventions, exacerbated by delays in some patients presenting for initial assessment in primary care during the pandemic. Recovery of elective services to pre-pandemic levels and dealing with the backlog of cases delayed due to COVID-19 is a key priority for NHS England and NHS Improvement, and requires a net increase in the rate patients are treated. Supporting the recovery of NHS staff is also key in the overall elective recovery programme, both to increase workforce capacity and for maintaining staff health and wellbeing.
- 3.30 They also told us that the delivery plan for tackling the COVID-19 backlog of elective care aims to support local health systems and other partners to address short, medium and long-term issues which were either caused by the pandemic response or which were already present prior to March 2020. The key to recovering NHS services will be 'people recovery', focusing on initiatives that improve staff experience and promote the retention of staff, and attract new talent into the service in key areas.

Economy

- 3.31 In its December 2021 evidence, **HM Treasury** said that the economy was expected to reach its pre-pandemic size around the turn of the year, and the Office for Budget Responsibility (OBR) expected the pandemic to have had a smaller long-term effect on the economy than previously anticipated. HMT said that public sector recruitment trends were generally positive, as leaver rates dropped and vacancy rates dropped across the board. It also said that private sector employment had not returned to pre-pandemic levels whilst public sector employment continued to grow. **HM Treasury** highlighted that headline earnings data were affected by comparisons made against a period when wages were deflated by furlough. It said that later forecasts suggested growth in earnings would be in line with the pre-pandemic period.
- 3.32 **HM Treasury** said that CPI was 4.2% in the 12 months to September 2021 and was driven by pressure on global supply chains leading to higher prices for energy, raw materials and goods. At that time, the OBR forecast was that inflation would peak at around 4% in 2022, before falling back as global markets were expected to adjust as supply responded to higher prices and demand conditions normalise.
- 3.33 **The Department of Health and Social Care** told us that as a result of the underlying resilience of the economy, the vaccination programme and the £378 billion of the pandemic support provided to families and businesses, the UK economy had seen faster than anticipated growth after the largest quarterly decline in GDP since comparable records began in 1955. In November 2021, GDP was estimated to be above pre-pandemic levels for the first time. However, the emergence of the Omicron variant and the tightening of restrictions at the end of 2021 increased economic uncertainty.
- 3.34 The Department also told us that the gradual reopening of the global economy and the rapid return of economic activity has led to a substantial rise in commodity and raw material prices, as demand for inputs has outpaced production. Global supply issues, including increases in transportation and energy costs, have pushed up inflation in the UK. In the 12 months to December 2021, inflation as measured by the Consumer Prices Index (CPI) grew to 5.4%, the highest in almost 30 years. The Department further told us that the Bank of England now expects it to reach around 6% in April 2022. They said that the OBR expects it to remain elevated across 2022 and 2023 before stabilising towards the target of 2% in the middle of the decade.
- 3.35 They further noted that the pandemic has highlighted the significant value of job security in both the NHS as well as the public sector more widely. They observed that latest Labour Force Survey data for September 2021 that the number of people in private sector employment was 690k lower than pre-pandemic levels, whilst employment in the NHS and public sector continues to rise.

- 3.36 **The Welsh Government** told us that the economy in Wales has recovered quite strongly from the effects of the pandemic, but uncertainty remains high, with supply chain disruption and rising inflation. In particular, the labour market has performed much better than in previous recessions owing to aggressive labour market policies including job subsidies. These labour market interventions represent major policy successes.
- 3.37 **The Department of Health, Northern Ireland**, told us that Northern Ireland is particularly vulnerable to national and international conditions outside of its control. Currently, the Northern Ireland economy is recovering with growth in business activity and employment returning. However, the effects of COVID-19 are still being felt and many citizens continue to face significant pressures and the recent emergence of the Omicron variant has the potential to exacerbate these pressures and damage the recovery. Further, many of the issues that have limited economic growth in the past remain, such as low pay, regional imbalances, high economic inactivity rate, and deprivation.
- 3.38 Research from the Department for the Economy, Northern Ireland estimates that from March 2020 to March 2021, the lost economic activity due to Covid-19 in Northern Ireland amounted to £6.1 billion in Gross Value Added (GVA)¹ terms.
- 3.39 Local forecasters previously expected the Northern Ireland economy to recover to 5.8% growth in 2021 and 4.1% in 2022, which is in line with the growth expected in the UK and Republic of Ireland. The Department of Health noted however that these forecasts would not account for any emergence of further waves of the pandemic. They observed that the potential impact of Omicron is not yet clear and the situation is rapidly evolving.
- 3.40 **The Joint Staff Side** told us that economic modelling has been tested to its limits as the UK has sought to map out its economic recovery whilst trying to predict consumer and business behaviour within the context of a constantly changing global economic picture. Over the last two years, economists have struggled to accurately forecast how the economy will react as restrictions on economic activity have been imposed and then lifted in response to the COVID-19 pandemic, not just in the UK but around the world. In 2020, GDP as a whole fell by 9.9%, the largest annual fall in 300 years. This led economists to forecast that growth would not return to pre-pandemic levels until the end of 2022.
- 3.41 **The Joint Staff Side** also commented on the cost of living. They told us that the origins of the cost of living crisis dated back many years and are rooted in wages not keeping pace with costs over a sustained period. For most people, their largest monthly expenditure will be on housing and those costs have been outstripping wage growth for years. They set out how according to the Office of National Statistics (ONS), private renters could expect to spend 23% of their income on a median-priced rented home in England, rising to almost 38% in London. According to the Organisation for Economic Co-operation and Development (OECD), this makes the UK the sixth most expensive market in the world for housing relative to income.

- 3.42 **UNISON** told us that increases to the cost of living do not hit staff equally. This is particularly relevant at the present time, with enormous increases to the cost of energy bills and staple foods over the last year or so. But they commented that this problem is also structural. While higher earners often have the option to change spending habits or restructure household finances, lower earners do not. A much higher proportion of expenditure is on unavoidable costs such as food, fuel and housing. They set out that price increases to these items are felt across the workforce but have a devastating impact for lower earners. The ratio of headcount to full-time equivalents (FTE) in the NHS is around 1:0.9, and at current rates, a single parent working at the top of Band 2 at 0.9 FTE falls below the poverty threshold.
- 3.43 **The Royal College of Podiatry** told us that 77% of their members do not think their pay is fair and reasonable for the work they undertake and 87% of members do not feel their pay has kept up with the costs of everyday living. Last year this figure was 82%, so the frustration is increasing year on year.

Labour market

- 3.44 **The Department for Health and Social Care** told us average earnings in the Hospital and Community Health Service (HCHS) sector increased by 3.7% in the 12-months to the end of March 2021 which was slightly higher than the 3.5% growth in basic pay per person. Earnings growth varied between bands, with staff in clinical support tending to see higher growth compared to those in professionally qualified roles. This partly reflects the changes to the structure of AfC in April 2020 which benefitted staff in Bands 2 to 4 when the number of Pay Steps in these bands was reduced and more staff moved to top of band. Some staff will have had higher earnings in 2020-21 due to an increase in workload during the pandemic, but this will not impact all staff equally.
- 3.45 The Department added that earnings remain broadly competitive with both the wider economy and selected connected labour markets. In 2020-21, average earnings in the HCHS sector increased by 3.7% (NHS Digital Earnings) compared to a reduction of 0.6% in the wider economy (Annual Survey of Hours and Earnings, 2021 provisional). However, this is likely to be impacted by the pandemic and there is some evidence of recovery in more recent data.
- 3.46 The Department provided evidence saying that NHS Digital release data on the (HCHS) workforce in England and this covers substantive staff who are directly employed by an NHS organisation. Table 3.1 below shows average pay and earnings for AfC staff working in NHS Trusts and Clinical Commissioning Groups (CCGs) in 12 months to end of March 2021 and growth over the previous 12 months.

Table 3.1: Average Earnings and Basic Pay across the AfC workforce, NHS Digital

Staff Group	Earnings per Person	Basic Pay per Person	Basic Pay per FTE	Growth in Earnings	Growth in Basic Pay
All Agenda for Change	£29,543	£26,175	£29,876	3.7%	3.5%
Nurses and Health Visitors	£34,671	£30,431	£34,275	3.4%	3.1%
Midwives	£34,473	£29,440	£36,059	2.9%	3.1%
Ambulance Staff	£43,384	£31,282	£33,487	6.4%	4.8%
Scientific, Therapeutic and Technical Staff	£35,883	£32,974	£38,316	3.5%	3.3%
Support to Doctors, Nurses and Midwives	£20,532	£18,033	£21,037	4.5%	4.9%
Support to Ambulance	£27,623	£20,669	£22,752	5.6%	3.9%
Support to STT	£20,668	£19,169	£22,319	5.3%	5.4%
Central Functions	£27,807	£26,189	£28,785	5.5%	5.1%
Hotel, Property and Estates	£19,779	£16,431	£20,348	4.0%	4.7%
Senior Managers	£82,284	£78,131	£82,648	2.4%	1.5%
Managers	£54,284	£50,987	£53,381	6.6%	5.4%

- 3.47 The data shows that average total earnings grew by 3.4% for Nurses and Health Visitors in 2020-21, reflecting the combined impact of the 2020-21 headline pay award of 2.9% and positive total earnings drift of 0.5%.
- 3.48 **The Department of Health Northern Ireland**, told us the pandemic had a significant negative impact on Northern Ireland's labour market, which already faced persistent, long standing structural challenges. The employment rate for Northern Ireland currently sits at 70.4% – this is the lowest of the 12 UK nations and regions and around 5.1 percentage points lower than the UK average. Northern Ireland also continues to have the highest level of economic inactivity in the UK at 26.9% – approximately 5.7 percentage points higher than the UK average.
- 3.49 The public sector in Northern Ireland employs 216,710 people or 28% of all employee jobs in Northern Ireland, a significantly higher share compared to 17.5% for the UK as a whole. They said however that such comparisons should be treated with caution given the different structure and coverage of the public sector workforces.
- 3.50 **The Joint Staff Side** also told us that pay is rising in the private sector. On the basis of their research, they told us that employers are offering signing-on bonuses of £1,000, enhanced overtime rates, incentive bonuses and even retention payments of various sorts. They told us that the shortage of HGV drivers was estimated to be more than 100,000 by the Road Haulage Association in October 2021, which has led to a 10% increase in average driver pay in the nine months to October 2021. They also told us they had found evidence that 75% of employers in the hospitality sector were increasing pay to attract staff.

- 3.51 **Unison** told us in oral evidence that it is difficult to retain staff and the NHS was losing staff to competitors such as IKEA, Aldi and Lidl. **Unite** also told us that the NHS is losing Band 2 staff to Asda and Tesco.

NHS Finances

- 3.52 **The Department of Health and Social Care** told us that at the SR21, the Chancellor set out the government's plan for public expenditure for the next three years. NHS England's day-to-day budget was given an average of 3.8% real terms growth per year. Part-funded by the new Health and Social Care Levy, this equates to £23.3bn over three years.
- 3.53 They added that since SR21, the context within which the NHS operates has been rapidly changing. COVID-19 has already had a considerable impact on the NHS and, while the vaccine programme has put the UK in a strong position, there is still a large degree of uncertainty as new COVID variants emerge. They repeated what HMT set out in their economic evidence that there remains uncertainty in the economic outlook, and risks that public sector pay increases exacerbate temporary inflation pressures.
- 3.54 The Department told us that the NHS budget has now been set until 2024-25. While this gives the NHS the financial security to address challenges in a sustainable manner, the settlement is tight and there will be a need for careful prioritisation to stay within available funding and make progress towards long-term financial sustainability.
- 3.55 They commented on the SR21 settlement for Health and Social Care which will ensure that we can keep building a bigger and better trained NHS workforce. They told us they are committed to delivering 50,000 more nurses and 50 million more primary care appointments by funding the training of some of the biggest undergraduate intakes of medical students and nurses ever. The settlement will also continue to support a strong pipeline of new midwives and AHPs, who are key to delivering the full range of NHS services.
- 3.56 The Department of Health and Social Care provided Table 3.2 which shows the opening mandate for NHS England (NHSE) in 2021-22, and indicative amounts for future years, in line with the outcome of SR21. These figures include an increase for pensions revaluation which was provided alongside the LTP settlement. Figures exclude depreciation, Annually Managed Expenditure and technical budget.

Table 3.2: Opening Mandate for NHS England, DHSC

NHS England (NHSE)	NHSE Revenue Departmental Expenditure Limits (RDEL) excluding ringfence (RF) (cash) £bn	NHSE Capital Departmental Expenditure Limits (CDEL) excluding ringfence (RF) (cash) £bn
2013-14	93.676	0.200
2014-15	97.017	0.270
2015-16	100.200	0.300
2016-17	105.702	0.260
2017-18	109.536	0.247
2018-19	114.603	0.254
2019-20	123.377	0.260
2020-21	149.473	0.365
2021-22	144.365	0.301
2022-23	151.827	0.219
2023-24	157.407	0.219
2024-25	162.678	0.219

- 3.57 The Department also told us that it is essential that this money is spent wisely and in line with the NHS priorities which will have the most effective impact on delivering high-quality care for patients. Therefore, the government has set five financial tests alongside the Long Term Plan settlement to ensure the service is put on a more sustainable footing for the future. The five tests are:
- a. the NHS (including providers) will return to financial balance;
 - b. the NHS will achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care;
 - c. the NHS will reduce the growth in demand for care through better integration and prevention;
 - d. the NHS will reduce variation across the health system, improving providers' financial and operational performance; and
 - e. the NHS will make better use of capital investment and its existing assets to drive transformation.
- 3.58 While the five tests remain important to the delivery of the LTP, COVID-19 has meant reporting against the tests has been temporarily put on hold to allow the system to focus on managing and responding to the pandemic.
- 3.59 **NHS England and Improvement** told us the government's SR21 multi-year settlement for the NHS covers 2022/23–2024/25. The NHS priorities are to deliver on the NHS LTP commitments, tackle the elective backlog, continue to provide COVID services and increase the NHS workforce, which is currently 10% larger than in March 2019, all within a financial settlement which is predicated on stretching efficiency targets and a significant reduction of COVID-related costs.

- 3.60 They also told us that for 2022/23, the total NHS resource budget (including COVID costs) is expected to reduce in real terms by c1.9% compared to the previous year. The NHS resource budget (including COVID costs) in 2023/24 and 2024/25 will see real terms growth on the previous year of c1.4%.
- 3.61 **The Welsh Government** told us that in response to the pandemic, they are increasing their core investment in the NHS by almost an additional £1.3bn in this Budget, with a total of health and social services to £10.3 billion.
- 3.62 Out of the £10.3 billion, £1bn will be invested in NHS recovery over the course of this Senedd. They will also be investing a further £31m in educating and training the workforce of the future and will continue to provide £7m towards meeting their commitment to establish a new medical school in North Wales.
- 3.63 **The Department of Health, Northern Ireland**, told us Northern Ireland had yet to agree a Budget for 2022/23.

Labour productivity

- 3.64 **The Department of Health and Social Care** told us that the ONS estimated public service productivity as a whole fell by 32.6% between April and June 2020 and 22.4% between July and September 2020 compared with the same quarter a year earlier, and that productivity was 9.8% lower in Q1 2021 compared with Q1 2019. It is reasonable to expect that the impact on NHS productivity would be similar. NHS productivity will have fallen during 2020-21 because of the cancellation of non-urgent elective work, staff shortages and absences, and enhanced IPC.
- 3.65 **The Department of Health and Social Care** also told us that as part of the funding announced at the spending review, the government will invest in programmes to help the NHS return to productivity growth and achieve an ambitious productivity trajectory while delivering on the elective recovery challenge. Key productivity programmes prioritised by NHSEI are:
- a. improving patient pathways – simplifying a patient pathway will ensure patients are seen faster at the right speciality, diagnosed earlier, and treated sooner. Improving the skills mix and enhancing digital connections between primary, secondary and community services in a pathway will reduce unnecessary referrals and encourage treatments closer to, or at, home.
 - b. setting up surgical hubs – increasing surgical productivity will increase efficiency for some of the costliest parts of the NHS. Surgical hubs will provide opportunity for patients to be seen and treated faster which will reduce the number of patients on the waiting list faster.
 - c. expanding Community Diagnostic Centres (CDCs) – the NHS will increase the number of CDCs to at least 100 by 2024-25. CDCs separate elective diagnostics from acute hospital settings, reducing the risk of COVID infection, and offering improved productivity by reserving facilities for elective care.

- d. making outpatient care more personalised – the NHS will give patients greater control and convenience over their outpatient appointments by supporting them to initiate follow-up care and to self-manage their conditions. This will also reduce the number of unnecessary or low-value follow-up appointments; and
- e. digital productivity programmes – using digital tools such as single sign-on, e-rostering, digital staff passports, improved communication tools, and shared care records to save clinical staff time that can be better spent caring for patients.

3.66 **The Department of Health and Social Care** told us that labour productivity is an important component of efficiency. It is calculated by dividing total NHS output by an appropriate measure of labour input. It measures the amount of output generated per 'unit' of labour. However, labour inputs account for only around half of the total cost of the NHS. A broader measure of productivity divides total output by an appropriate measure of all inputs, for example, including drugs as an input. The Department calls this total factor productivity and it is measured by the Centre for Health Economics (CHE) at the University of York. Their figures show that between 2005-06 and 2018-19 the NHS's average annual total factor productivity growth was 1.1%.

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

Table 3.3: York CHE Total Factor Productivity (Figures are all quality adjusted so take into account changes in quality of care (for example, waiting times))

Year	Quality Adjusted Output	Total Input	Total Factor productivity
2005-06	7.1%	7.2%	-0.1%
2006-07	6.5%	1.9%	4.5%
2007-08	3.7%	3.9%	-0.2%
2008-09	5.7%	4.2%	1.4%
2009-10	4.1%	5.4%	-1.3%
2010-11	4.6%	1.3%	3.2%
2011-12	3.2%	1.0%	2.1%
2012-13	2.3%	2.0%	0.4%
2013-14	2.6%	0.4%	2.2%
2014-15	2.5%	1.9%	0.5%
2015-16	2.6%	2.7%	-0.2%
2016-17	3.0%	1.0%	1.9%
2017-18	2.6%	0.9%	1.7%
2018-19	2.2%	3.0%	-0.8%

Table 3.4: York CHE Labour Productivity (Figures are all quality adjusted so take into account changes in quality of care (for example, waiting times))

Year	Quality Adjusted Output	Labour Input	Total Factor productivity
2005-06	7.1%	3.4%	3.6%
2006-07	6.5%	0.6%	5.9%
2007-08	3.7%	0.7%	2.9%
2008-09	5.7%	4.1%	1.5%
2009-10	4.1%	4.5%	-0.4%
2010-11	4.6%	1.4%	3.1%
2011-12	3.2%	0.1%	3.1%
2012-13	2.3%	-2.0%	4.4%
2013-14	2.6%	0.4%	2.3%
2014-15	2.5%	2.8%	-0.3%
2015-16	2.6%	1.3%	1.3%
2016-17	3.0%	2.4%	0.6%
2017-18	2.6%	2.4%	0.2%
2018-19	2.2%	2.4%	-0.2%

3.68 Even though the annual measures have not yet captured this, the ONS quarterly measures have explicitly stated that reductions in health output have reduced the total public sector productivity figures.

Equality

3.69 **The Department of Health and Social Care** told us that the NHS workforce is more ethnically diverse than the wider economy and the ethnicity make up of non-medical NHS roles is as presented in Table 3.5.

Table 3.5: Ethnicity makeup of non-medical NHS roles, DHSC

June 2021 (%age of headcount)	Asian or Asian British	Black or Black British	Chinese	Mixed	White	Any Other Ethnic Group	Not Stated	Unknown codes
All non-medical staff	9.0%	6.8%	0.4%	1.8%	75.8%	2.5%	3.0%	0.8%
Nurses and health visitors	11.9%	9.2%	0.3%	1.5%	68.2%	4.8%	3.1%	0.9%
Midwives	2.2%	7.2%	0.2%	1.9%	84.9%	0.6%	2.4%	0.7%
Ambulance staff	1.3%	0.6%	0.2%	1.4%	93.7%	0.3%	2.3%	0.2%
Scientific, therapeutic and technical staff	9.6%	4.6%	0.8%	1.9%	78.3%	1.4%	2.6%	0.7%
Support to doctors, nurses and midwives	8.0%	7.5%	0.2%	1.9%	76.7%	2.1%	2.8%	0.8%
Support to ambulance staff	3.7%	2.3%	0.1%	1.7%	88.3%	0.2%	3.6%	0.3%
Support to ST&T staff	7.9%	4.9%	0.4%	2.2%	79.7%	1.5%	2.7%	0.9%
Central functions	8.4%	5.2%	0.4%	1.9%	79.5%	0.8%	3.0%	0.8%
Hotel, property and estates	7.6%	6.2%	0.2%	1.6%	76.1%	2.0%	5.2%	1.3%
Senior managers	5.1%	3.0%	0.2%	1.1%	85.7%	0.5%	3.3%	1.1%
Managers	6.7%	4.1%	0.4%	1.7%	82.4%	0.7%	3.1%	1.0%
Other staff or unknown classification	26.3%	7.6%	0.3%	2.0%	36.7%	23.7%	2.1%	1.3%

3.70 The Department of Health and Social Care noted there is evidence of both a gender pay gap (GPG) and an ethnicity pay gap (EPG). Pay gaps tend to be smaller within individual staff groups than across the whole workforce – this might be that the staff group effect is more significant than grade or point mix effect.

Table 3.6: Comparison of pay between genders and ethnicities, DHSC

Staff Group	GPG – White	GPG – BME	EPG – Female	EPG – Male
Description	Comparison of White Female to White Male	Comparison of BME Male to BME Female	Comparison of BME Female to White Female	Comparison of BME Male to White
All Agenda for Change	-8% (White Females have pay 8% lower than White Males)	-1%	-4%	-11%
Nurses and health Visitors	-4%	-2%	-11%	-12%
Professionally Qualified Staff	-4%	-3%	-10%	-11%
Support to Clinical Staff	-3%	0%	-1%	-4%
Infrastructure Support	-12%	-5%	-5%	-13%

- 3.71 **NHS Providers** told us that they believe it is a critical priority for the NHS to both accept the existence of structural racism in the service, and work to dismantle it. They are working to support trust leaders in this goal through their member benefits and board development programmes.
- 3.72 **The Royal College of Midwives** told us that career progression was an equalities issue. Women make up 77% of the NHS workforce, but the AfC higher pay bands have a disproportionately high number of men. The 2021 Workforce Race Equality Standard (WRES) report showed that white applicants were 1.61 times more likely to be appointed from shortlisting, higher than in 2019 (1.46). The 2022 WRES report is discussed in Chapter 4.
- 3.73 **The Royal College of Midwives** also told us that as of May 2020, fewer than 10 of the 136 (7.4%) maternity units in England had a Head or Director of Midwifery from a Black, Asian or minority ethnic background. However, approximately 12-14% of the midwifery and midwifery support worker (MSW) workforce are from a Black, Asian or minority ethnic background. Lack of opportunities for career progression can only worsen poor morale and motivation and means that low or no pay awards are more keenly felt.
- 3.74 **The Department of Health and Social Care** told us that across the Non-Medical workforce about 76% of the workforce is White with a further 7% Black or Black British and 9% Asian or Asian British. There are currently just under 4% of the workforce with Unknown or Not Stated Ethnicity. BME representation in the workforce has been increasing slightly over the past five years.

- 3.75 **The Department of Health and Social Care** also told us that data from June 2021 shows that just under 80% of the non-medical workforce are female. The proportion of female staff varies by staff group with higher proportions of female staff in the Nursing (88%), Midwifery (99%) and Support to Doctors and Nurses (85%). Compared to the rest of the NHS workforce, males have higher representation in Staff Groups including Ambulance Staff (57%), Support to Ambulance (46%) and Senior Managers (42%). The proportion of female staff is broadly unchanged over time.
- 3.76 **NHS England and Improvement** told us that, while progress has been made in some areas, more remains to be done to embed workforce equalities from a race and disability perspective. An action plan is being developed to identify where trusts need to reverse deteriorating key performance indicators (KPIs), while continuing to strive for improvement across all the indicators.
- 3.77 **NHS Employers** told us that as male and white people are more likely to be in higher paid roles, they will have benefited more on average from a percentage uplift to pay than their female and BME colleagues.
- 3.78 **The Welsh Government** told us about their Race Equality Action Plan (REAP), recognising that urgent action was needed, culminated by the inequities faced by their ethnic minority communities from the impact of Covid-19. The consultation on the draft Race Equality Action Plan (REAP) concluded on 15 July 2021 and the responses were analysed.
- 3.79 The Health goals and action in the REAP contain key actions specifically related to workforce and focus on fundamental areas for action to ensure that all NHS Wales staff “work in safe, inclusive environments, built on Allyship, supported to reach their full potential, and be empowered to identify and address racist practise. Ethnic diversity will be achieved at all levels, in our NHS Workforce across Wales”
- 3.80 Following the consultation process and further engagement with key stakeholders, priority actions were identified. One of the key actions is the introduction of a Workforce Race Equality Standard, and a scoping group has been established to make recommendations based on best practice.
- 3.81 Additionally, by December 2022, the Welsh Government will independently review existing workforce policies and procedures through an anti-racist lens, and expect representation of ethnic minority groups within forums or groups established to support their effective implementation and application.
- 3.82 They told us they also have actions to address public appointments to ensure their senior leadership is visibly representative and inclusive of their workforce and that anti-racist training is redesigned for all staff, volunteers and students.

Supply and recruitment

- 3.83 **Health Education England** told us about their role in meeting the target of 50,000 more nurses by March 2024. HEE told us they lead on the expansion of domestic supply routes which include increasing undergraduate supply; expanding post-graduate pre-registration entry to nursing; encouraging those who have left the NMC register to Return to Practice; growth in those entering nursing via the apprentice route; and reducing attrition from pre-registration programmes.
- 3.84 **Health Education England** also told us that interest in working in mental health has increased since the start of the year, with a 133% rise in people seeking information about the psychological professions. Non-clinical roles in NHS management and health informatics have also seen surges in interest since the start of the year.
- 3.85 **Health Education England** commented on the blended learning nursing degree. The Blended Learning Nursing Degree provides a flexible way to fit study around work and life, using mainly digital technologies, but still including practical, hands-on experience. It is driving a lot of innovation in training and education which was in turn attracting people who would not have previously considered a career in healthcare.
- 3.86 **Health Education England** commented on apprenticeships. Since the implementation of the apprenticeship reforms and inception of the levy in 2016 there have been over 86,000 apprenticeships starts. HEE recommend that to maximise the potential that apprenticeships present in their contribution to the domestic workforce supply into health and care careers, the NHS should take an 'Apprenticeship First' approach to commissioning (i.e. ensure apprenticeships are considered at all points of commissioning activity and that decisions for not using apprenticeships are clearly recognised).
- 3.87 **NHS Employers** told us that the employer-led nurse degree apprenticeship route has very low levels of attrition and high levels of retention. However, employers have reported several issues including backfill costs while apprentices are undertaking off-the-job learning are over and above Levy funding.
- 3.88 **NHS Employers** told us that employers in certain parts of the wider system still face challenges in attracting high-calibre people, considering present labour market conditions resulting from post-Brexit migration rules and the impact of the pandemic. NHS Employers are also concerned that the opportunities for nurses and other professionals to move upwards in the grade structure are limited.
- 3.89 **NHS Employers** also told us that recruitment of graduates had increased with the country's top employers having received 42% more graduate job applications in 2020-2021, compared with the equivalent period in the 2019-2020 recruitment round, the highest-ever annual increase recorded by the research.

- 3.90 **The Royal College of Midwives** told us that NHS Digital figures from October 2021 showed an annual fall of 278 FTE midwives in England. This is on top of data from July 2021, which recorded the first year-on-year fall since NHS Digital first published these figures in 2009.
- 3.91 **The Royal College of Midwives** also told us that they are finding it increasingly difficult to recruit to vacancies with 77% of Heads of Midwifery describing recruitment of Band 6 midwives as 'difficult' or 'very difficult'.
- 3.92 **The Society of Radiography** told us starting pay was currently £25,655 per annum in England. This compares to graduates in social work, probation, the prison service or police who all start on more than £30,000 per annum. They also noted the government policy to make graduate starting pay in teaching £30,000.
- 3.93 **The Welsh Government** told us that health boards and trusts are responsible for planning their workforce. All organisations are required to provide Integrated Medium Term Plans (IMTPs) to provide a framework of continuous improvement and increased accountability. The IMTPs are scrutinised by Welsh Government, who support organisations in the development of their plans.
- 3.94 Vacancies are monitored and managed by individual organisations through the management structure and are a key performance measure. These are reported on regularly to the health board's workforce and OD Committee.
- 3.95 They set out that there are a number of local and national initiatives aimed at tackling recruitment challenges. The Train Work Live (TWL) marketing campaign continues to promote the benefits of working as a healthcare professional in Wales and is currently in its sixth year. The campaign was successfully transferred to Health Education and Improvement Wales (HEIW) in 2020 having previously been managed directly by the Welsh Government. They have developed a co-ordinated Wales-wide approach to ethical overseas nurses recruitment, recognising there is significant potential for a "One Wales" approach to enable accelerated recruitment plans across all regions of Wales. Health boards and trusts continue to be responsible for their own recruitment plans.
- 3.96 **NHS England and Improvement** told us about the workstreams of the 50k nurses programme intended to increase supply:
- a. retaining more registered nurses in the NHS in England
 - b. encouraging Nursing and Midwifery Council (NMC) registered nurses to return to practice
 - c. developing an ethical and sustainable international recruitment model to increase international nursing supply
 - d. increasing numbers of nurses qualifying through undergraduate degrees
 - e. reducing attrition rates for pre-registration nursing students
 - f. increasing the pipeline of trainee nursing associates

- g. developing more qualified nursing associates and assistant practitioners into registered nurses

Students

- 3.97 **Health Education England** told us that interest in health and care careers soared during the pandemic, with a huge surge in visitors to the NHS Health Careers website seeking information about scores of different roles. Record numbers of students applied to begin nursing courses at English universities in 2021. Data suggests that more people are not only looking for an NHS career, but looking to find one that matches their skills and interests. The number of people completing the 'Find your Career' tool on the website increased by 150% in the two months to March 2022 compared with the same period in 2020.
- 3.98 **The Department of Health and Social Care** told us the pandemic severely disrupted the studies of students during the pandemic. This was caused by (a) students being deployed to the front line to help support the COVID-19 effort and (b) a reduction in clinical placements as the healthcare system shifted its focus to immediate priorities.
- 3.99 Led by HEE, the system has worked hard to ensure the education and training system continues to operate effectively:
- a. they have allowed students affected by delays caused by COVID-19 to apply for extended funding from the NHS Learning Support Fund until the 31 August 2022
 - b. through their Clinical Placement Expansion Programme (CPEP), HEE have released over £50 million over recent years to support growth in clinical placements
 - c. HEE, education providers and placement providers have invested in new ways of delivering placements (for example, simulation) which meet requirements of professional bodies and regulators
 - d. HEE have supported growth in infrastructure and academic capacity. They have invested over £6 million in blended learning programmes to increase capacity and widen participation
- 3.100 This effort has supported further expansion of training. UCAS data showed 30,185 acceptances to nursing and midwifery courses in England for the 2021 academic year. This is the highest figure since these statistics were first recorded.
- 3.101 They further told us that for existing staff, in September 2019 the government announced a £210 million funding boost for frontline NHS staff which included a £1,000 personal development budget for every nurse, midwife and allied health professional working in the NHS to support their continuing professional development over three years.

- 3.102 **The Welsh Government** told us that on the 6 December 2021 the Minister for Health and Social Services announced a £262.295m investment package to support education and training programmes for healthcare professionals in Wales. This represents an increase of 15% compared with 2021/22.
- 3.103 **The Welsh Government** told us that this is the eighth consecutive year that funding to support health professional education and training in Wales will increase. £262m will be invested in 2022/23, this equates to a 15% increase from 21/22 which is an extra £18m (14% increase) for education and training programmes for healthcare professionals in Wales. £5m (9.5% increase) extra for medical training places, an extra £8m (30.4% increase) to support core GP training numbers and a net increase of £3m (29% increase) for pharmacy training across Wales. This means for the last six years since 2016:
- a. Nurse training places have increased by 69%
 - b. Midwifery training places increased by 96.8%
 - c. Health Visiting training places have increased by 29.5%
 - d. Physiotherapist training places increased by 29.8%
 - e. Therapeutic Radiographer training places have increased by 18%

International Recruitment

- 3.104 **NHS Providers** told us that the introduction of the Health and Care Worker visa in August 2020 continues to be helpful for international recruitment efforts and reflects a largely favourable new immigration system for the NHS.
- 3.105 **The Department of Health and Social Care** told us that international staff benefit enormously from the opportunity to work in the NHS – both in terms of professional development and economically – and they have made it easier for those wanting to further their career to come to work in the NHS. Since 2016, they have seen increases in joiners of nearly all staff types from the EU and EEA. The growth in Rest of World nationalities has increased at a particularly fast pace, from 5.4% of all non-medical joiners in 2017 to 11.8% in 2021.
- 3.106 **The Department of Health and Social Care** told us that from August 2020, all health and social care staff have been exempt from paying the Immigration Health Surcharge (£624 per year).
- 3.107 **The Society of Radiographers** told us that 56% of the 3% growth in diagnostic radiographer recruitment into the NHS between 2016 and the end of 2020 was due to international recruitment. Whilst the number of UK based FTE radiographers in the NHS grew by 9%, the number of internationally trained FTE working in the NHS grew by 147%.
- 3.108 **The Department of Health, Northern Ireland**, recruited 1005 nurses from overseas from January 2016 to October 2021, 941 of these remain in post. The Department is now looking to recruit an additional 3,000 nurses from overseas by 25/26, subject to funding.

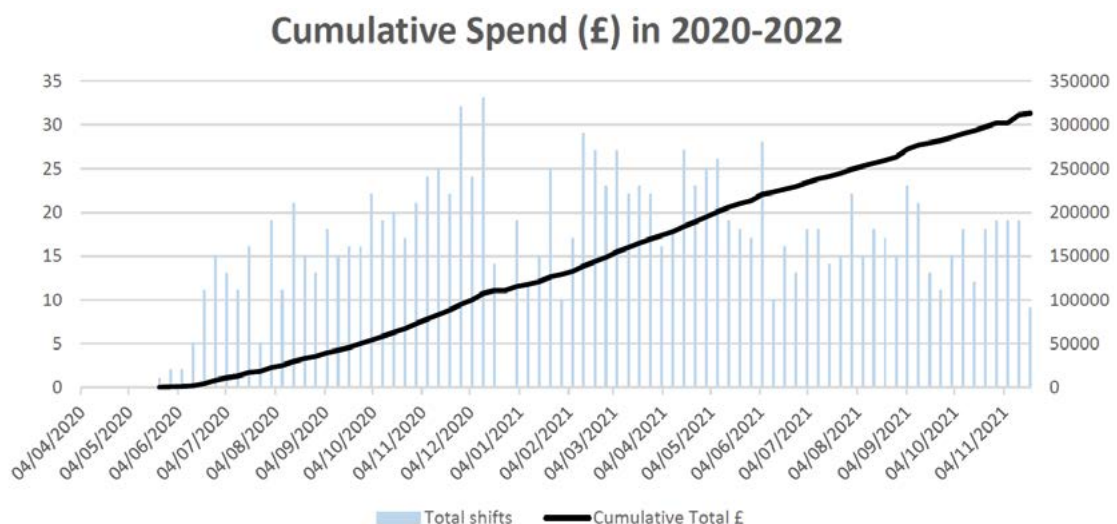
- 3.109 **NHS Employers** told us that employers have turned to overseas recruitment to fill gaps in the workforce. They further note that NHS organisations need to ensure that the UK remains an attractive place to live and work both for EEA nationals and colleagues from across the world. The NHS Employers international recruitment toolkit refers to the importance of pastoral support to help overseas recruits settle into their new roles and communities in the UK.
- 3.110 **The Welsh Government** told us work was ongoing on an international recruitment programme. To date they had issued 430 contracts primarily to staff from India and the Philippines.

Bank and agency

- 3.111 **The Department of Health and Social Care** told us NHS Trusts use flexible staffing arrangements to efficiently manage the fluctuating demands of healthcare, which is regularly subject to unavoidable increases in demand. A temporary workforce market allows the NHS to meet demand fluctuations without the need to increase capacity above that which would be required on a sustained basis. Trusts use their own banks (managed in-house or via management companies) and external agencies to resource extra temporary staff.
- 3.112 In response to an escalation in agency spend (NHS trust spending on agency staff rose by 40% between 2013-14 and 2015-16 from £2.6 billion to £3.6 billion) measures were introduced in 2015 to bring NHS agency spending under control. Price caps limiting the amount a trust can pay to an agency for temporary staff of 55% above basic substantive pay rates were introduced, as were the mandatory use of approved frameworks for procurement, and the requirement for all trusts to stay within the specified Annual Expenditure Ceilings for agency staff.
- 3.113 They told us how the 'Agency Rules' have contributed to a reduction in spending on agency workers to £2.38 billion in 2019-20 compared to £3.6 billion in 2015-16. Agency spend in 2019-20 accounted for 4.0% of the overall NHS pay bill, down from 7.8% at its peak in 2015-16. The Department estimate that spend on temporary staffing will rise further in the short term as it prioritises workforce and elective recovery. This is likely to be driven by both price and volume effects, with overall demand for staff increasing with corresponding implications for overall price. They set out how they are working to ensure that agency staff are used in a fiscally responsible manner.
- 3.114 **NHS England and Improvement** told us that the NHS has made progress in optimising temporary staffing spend, despite workforce and capacity shortages. They explained how increased bank spend as a proportion of total temporary staffing spend demonstrates greater flexibility in meeting fluctuations in demand, and doing so more economically.
- 3.115 They also told us that total agency spend as a percentage of total wage bill has decreased from 7.9% in 2015/16 to 3.7% in 2020/21. This has largely been delivered by the NHS reducing the proportion of shifts filled by agency staff across temporary staffing shifts from 28% in 2018/19 to 23% in 2020/21.

- 3.116 **The Welsh Government** told us about the concept of the Collaborative Bank Partnership (CBP) which was established in April 2020, to support cross boundary working and to deliver weekly pay to all bank workers (including those with substantive posts), thus reducing the reliance on premium cost nursing agency spend.
- 3.117 Launching the CBP during Covid-19 was not without risk, but they deployed additional temporary workers across the organisations at its most critical time. Since April 2020, the Collaborative Bank Partnership has grown, it currently has a workforce headcount of 181 employees, 167 of these are active bank workers, cleared to work across NHS Wales organisations, with an average time to recruitment and deploy a nurse to the front line in under seven days. The Collaborative Bank is currently open to Registered Nurses, but additional staff roles are currently being explored (i.e., Endoscopy, Physiotherapy, Midwifery and Mental Health).
- 3.118 To date, this supplementary NHS workforce in Wales has benefited from receiving weekly pay for over 1,374 shifts, providing circa 13,000 hours of nursing care at a cost of circa £313.2K; which has realised significant costs savings compared to Nursing Agency spend. The graph at Figure 3.1 shows the total number of shifts worked in month, along with total spend to date.
- 3.119 **The Royal College of Nursing, Wales** told us that the rise in agency nursing and overtime indicate a struggling workforce and that while there will always be a need for agency nursing to cover short term sickness or provide maternity cover, the rate at which the NHS is using agency nursing is unsustainable. Agency nurses are less familiar with ward layout, policies and equipment, and less able to provide continuity of care.

Figure 3.1: Total number of agency shifts and cumulative spend, Welsh Government



- 3.120 **The Department of Health, Northern Ireland**, told us agency spend continues to rise year on year. For the 2020/21 financial year Health and Social Care (HSC) Trusts' combined expenditure on agency and locum staff was £282.2m, up from £254.7m in 2019/20, a rise of 10.8%. Nursing and midwifery expenditure accounts for 39% of the overall agency spend. In oral evidence, they told us that they had assembled a designated project team to look at the issue with the Department aiming to end off contract agency spending in the next year.
- 3.121 **UNISON** told us that they believe that the over reliance on the temporary workforce is masking a number of issues within the substantive workforce.

Progression and promotion

- 3.122 **The Department of Health and Social Care** told us that there are fewer part-time staff in more senior bands with the proportion of part-time staff falling from 37% in Band 6 to 14% in Band 8d and 10% in Band 9.
- 3.123 The Department also told us there is some evidence that part time staff are less likely to obtain promotion than those who work full-time. For example, around 16% of full-time staff at Band 5 obtained promotion between March 2020 and March 2021 compared with only 5% of part-time staff but there is no information on whether this is because they are less likely to apply for promotion (for example, for work-life balance constraints) or if they are less likely to be successful in applications.
- 3.124 **The Joint Staff Side** told us that equipping employers to use the AfC agreement more effectively to support career development and progressing to more advanced roles would also support retention of staff.
- 3.125 Their key ask in relation to progression is to address the inconsistent gaps between the current pay bands and address cliff edges in the structure where promotion to a higher pay band results in a reduction in other parts of the earnings package. In some cases, the gaps between bands are incredibly narrow and act as a disincentive towards upward career progression. This is particularly relevant to progression between Band 2 and 3 where movement in the English system not only delivers a narrow pay increase but also results in a reduction in the rate paid for unsocial hours. In the current climate, where retaining and developing the skills of clinical support workers will be ever more crucial, removing this barrier to progression to Band 3 could boost skill mix and enable progression from support worker through to Nursing Associate/ Assistant Practitioner as part of routes through to registered status. Similarly, moving between Bands 7 and 8 is accompanied by a significant reduction in other terms like unsocial hours and overtime payments.
- 3.126 **The Royal College of Nursing** told us that the scope for career progression is largely limited by workforce planning and the restricted number of posts available to nursing staff. This results in a concentration of registered nurses employed in Band 5 positions. The Royal College of Nursing said that if nurses are not deployed to fully utilise their potential, this cannot be recognised by the pay structure and that it is important that employers recognise enhanced practice in skill mix and workforce planning.

- 3.127 **The Society of Radiographers** told us that a long-term strategy is needed to provide a career pathway that goes all the way from Assistant Practitioner roles to Senior Management and Advanced Practice.
- 3.128 **The Chartered Society of Physiotherapy** told us that a key issue was that there is no clear pathway beyond Band 7.
- 3.129 **The Royal College of Podiatry** told us 70% of podiatrists are now at the maximum pay rate for their grade (compared with 64% last year) with only 19% at or near the bottom of their pay band. This would suggest to us that the number of members hitting the salary ceiling is increasing meaning that wage and career stagnation is becoming more pronounced.
- 3.130 44% of members cannot see any possibility of any progression to a higher band /role (up from 38% in 2021) and 19% only see the opportunity to move up one additional pay band. Over 20% now see that the only avenue for pay progression is to change employer.

Retention

- 3.131 **The Department of Health and Social Care** told us the NHS Retention Programme is working to understand why staff are leaving, resulting in targeted interventions to support staff to stay whilst keeping them well. While much is being done, they are not complacent and both the Department and NHSEI will continue to seek to understand what further action will help support staff in keeping well and feeling supported while doing the difficult jobs that they do. They told us that HR Directors most commonly wanted measures that focused on giving staff the time and space to recover from the pandemic.
- 3.132 **The Department of Health and Social Care** also told us that retention remains stable and it was too early to draw any firm conclusions on the impact of the pandemic. Data shows that in 2020-21, voluntary resignation accounted for almost 40% of all reasons for leaving. Of all recorded reasons, retirement was the next biggest reason for leaving at 17% of the leaver workforce. This reason increased significantly in 2020-21, likely due to the number of short term positions created in response to the pandemic.
- 3.133 **NHS Employers** told us that retention remains a challenge. Around 28% of nurses and health visitors leave the NHS within the first three years of their service and the NHS loses around 50,000 people per year on average.
- 3.134 **The Joint Staff Side** told us that there is some emerging anecdotal evidence to suggest that private health providers are targeting NHS staff and successfully attracting talent at all stages of their careers. This is creating additional pressure for NHS employers who are now competing with each other for an increasingly scarce pool of applicants as demand is driven higher.

- 3.135 **The Joint Staff Side** told us that the primary driver of staff wanting to leave is the pressure that they feel at not being able to deliver the appropriate quality and standard of care. They said that across all Staff Side unions staff are not just frustrated, but often traumatized by their inability to deliver care at the level and quality that they are required to. They explained that, as in any employment, if you consistently are not able to do your job to the minimum standards that are set, and which you know are necessary to support patient care, you become frustrated and disillusioned. They said that staff are not just concerned about the impact on patient safety but also the impact on their personal professional standard and registration status.
- 3.136 In order to retain staff, **the Joint Staff Side** noted their ask for the Government to use the AfC agreement to retain existing staff via an urgent package in advance of the conclusion of the pay round, giving priority to measures that will (1) ensure banding outcomes reflect job content; (2) reward additional hours fairly; (3) prevent burnout by limiting excess hours; (4) support progression and career development; and (5) encourage employers to use RRP to retain staff where shortages are a risk to staff wellbeing and care. They asked that this package is delivered alongside a pay increase that is set at a level which will retain existing staff within the NHS and which recognises and rewards the skills and value of health workers.
- 3.137 **NHS England and Improvement** told us that the number of nurses leaving the NHS has been low compared to historical levels during the pandemic, but since September 2021 the annual NHS leaver rates have started to return to what they were pre-pandemic (February 2020).
- 3.138 They also told us that amongst Allied Health Professionals, leaver and turnover rates are significantly higher at the start of an AHP's career and as they approach retirement. Of leavers in the first five years of their career, 44% leave the NHS and 45% change post within the NHS. The top two reasons for AHPs leaving the NHS in the first two years of their career are relocation (30.1%) and pay and reward (24.5%).
- 3.139 Their all-staff retention programme has been supporting trusts and ICSs to improve retention locally. Structured around elements of the People Promise, the programme, nationally and through regions, is helping to embed a consistent offer across a number of areas to all staff in the NHS, to improve their experience and with this their retention. The programme has targeted interventions across sectors and staff groups where they are most needed, and at different career stages, recognising that there are differences across the generations in the workplace needs, motivations and challenges that influence people's intention to stay.
- 3.140 **NHS Employers** noted that the most common issue stakeholders highlighted for examination was the need to improve pay rates and career pathways for experienced, enhanced and advanced practice nurses.

- 3.141 **The Royal College of Podiatry** told us there is an alternative private sector employment market which is easy to move to. They told us that to ensure the NHS is seen as the preferred employer and to continue to provide vital services for patients a competitive package of terms and conditions is needed to recruit and retain podiatrists.
- 3.142 They also told us that the number of people in their first year of practice has fallen in the NHS since their evidence from last year at a time when vacancies are high. This would suggest that more podiatrists graduating from university find a career in the private sector to be more attractive.
- 3.143 **GMB** noted from their survey that 71% of respondents said that they had considered leaving the NHS in the past six months (up from 61% in our 2021 survey). Pay was cited as a factor by half of respondents who had considered leaving the NHS.
- 3.144 **Unison** told us almost half of staff (48%) are seriously considering leaving the NHS in the next year, with 16% currently actively looking for work elsewhere.
- 3.145 **The Royal College of Nursing** told us that in their Employment Survey 19% of respondents reported they were actively planning to leave their job, with only a minority exclusively considering the NHS for their next job.

Job Banding

- 3.146 **Unite** calls for a review of Agenda for Change national job profiles to ensure that they are still fit for purpose. The process takes far too long, as a number of profiles have not been revised since 2004 despite many roles attached to those profiles having evolved and developed.
- 3.147 **NHS Providers** told us that the current pay and progression structure for nurses is too rigid, based on length of service rather than ability, which is seen as “unhelpful” and often leads to staff “moving from one organisation to another to accelerate their pay progression”. These ensuing issues with retention were highlighted by several respondents to their survey. NHS Providers say they would support an examination of how AfC can be better structured to support NHS careers and staff progression, but this work will require considerable thought before it begins and will likely need to look beyond registered nurses to all AfC staff.

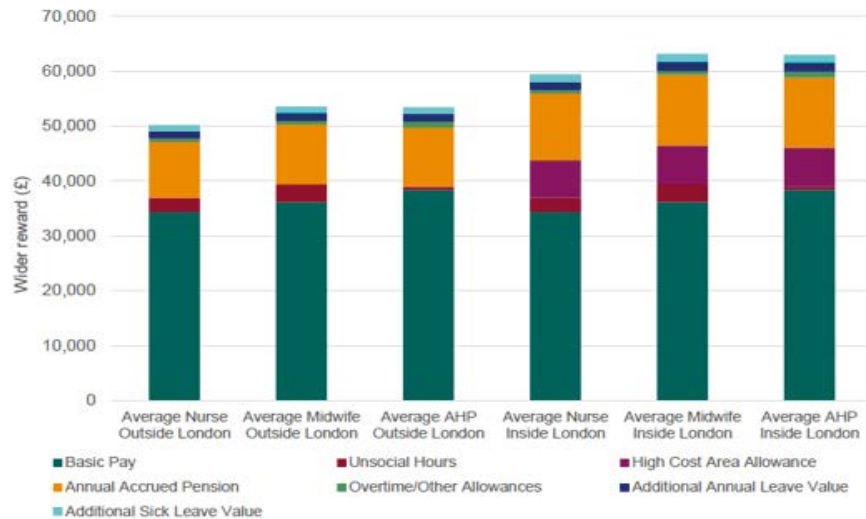
Unsociable Hours

- 3.148 **The Joint Staff Side** also told us there are very different approaches between groups/workplaces with some staff routinely and rightly having all hours worked ‘on the clock’ and paid at the relevant rate, while others potentially work an extra shift for free most months. They have also seen evidence of employers requiring workers to sign additional contracts to move them on to bank working. The Staff Side are concerned that there is a specific gendered dimension to this, with roles historically performed by majority women workers less likely to be paid correctly for additional labour.
- 3.149 **The Joint Staff Side** believe there needs to be a change in the culture of under-claiming, and to properly evaluate the real hourly earnings of staff.

- 3.150 **Unite** told us that they are calling for an amendment to the definition of Unsocial Hours to change to 7 pm to 7am instead of the current 8 pm to 6 am which is currently applied in section 2 of the AfC terms and conditions handbook. They believe this would go a small way to improve compensation for staff working long hours to keep the service running.
- 3.151 **GMB** told us the closure of Annex 5 provisions for unsociable hours payments to new entrants has been one of the most detrimental conditions of the 2018 pay settlement, which was opposed by GMB members.

Total reward

- 3.152 **The Department of Health and Social Care** told us the NHS total reward package includes a range of benefits that are above the statutory minimum and exceed those offered in other sectors. These benefits include a holiday allowance of up to 33 days (plus eight public holidays), sickness absence arrangements well beyond the statutory minimum, enhanced rates for nights and weekend work, access to a much-valued pension scheme, enhanced parental leave, and support for learning, development, and career progression.
- 3.153 An analysis by the Department covering 2012 - 2020/21 showed nurses at band 5 (one years' experience) experienced an increase in total reward of 25% over the period, whereas nurses at the top of Band 6 experienced a 17% increase in total reward. The average midwife role received a 15% increase, whereas porters in band 2 have received a 34% increase over the period.
- 3.154 **The Department of Health, Northern Ireland**, told us an allocation of £15m had been made by the Department to the Charitable Funds of HSC Trusts in 20/21. This funding has been explicitly earmarked to support staff welfare.
- 3.155 The Department extended the scheme to buy-back unused annual leave that was introduced at the start of 2021/22 for Northern Ireland HSC staff. It is proposed that this be further extended for additional annual leave to prevent excess carry-over into 2022/23 leave year.
- 3.156 A further pay award backdated to 1st April 2021 has been authorised by the Department which includes:
- a. An additional 1.5% non-consolidated pay uplift for AfC Bands 1-3.
 - b. An additional 1% non-consolidated pay uplift in AfC Bands 4-7 and for F1 doctors.
 - c. And an additional 0.5% non-consolidated pay uplift for all other directly employed HSC staff
- 3.157 **NHS England and Improvement** told us that the NHS employment offer includes a range of pay and non-pay benefits which together make up the total reward available to NHS staff.

Figure 3.2: Value of nurses and midwives' total reward package (£), NHSEI

Source: Government Actuary's Department

- 3.158 **NHS England and Improvement** also told us about the Employee Value Proposition (EVP) which describes the tangible and intangible offer, the psychological contract between staff and their employer, expectations and obligations, which informed the NHS Constitution.
- 3.159 They added that some NHS organisations already use the terminology of EVP as part of their local people strategies, which provide a focus on the employee–employer relationship in the context of challenges organisations have been facing such as recovering services.
- 3.160 **NHS Employers** told us it was important to create a culture and environment where people want to work; where they feel safe to raise concerns and to learn from mistakes; where employers listen to and empower their people work hard to keep them safe; and ensure bullying and harassment is not tolerated.
- 3.161 **NHS Employers** told us that non-pay solutions are as important as pay in improving recruitment and retention, especially flexible working, but also education, training and development, and childcare provisions.
- 3.162 **Health Education England** told us that there is a welcome focus on staff training, learning and development in national workforce plans, which is another important part of total reward and was also a focus of the three-year deal, of which we are now in the final year. There has been an understandable but significant pause in training, learning and development activity for students and staff during the pandemic. HEE have provided financial support in the context of COVID-19, including extra funding for simulated learning and development of skills of knowledge for example among critical care nurses. HEE told us that they will work with university and provider partners to enable training, learning and development to be brought back on track.

Pensions

- 3.163 **NHS England and Improvement** told us that the NHS Pension makes up around 30% of the NHS reward offer and is one of the most comprehensive and generous schemes in the UK. It provides valuable benefits for staff and their loved ones and supports staff through flexible retirement options, such as working differently or retiring gradually through flexible working options such as reduced hours or change in role.
- 3.164 They also told us about the Pension Response Project. During summer 2021, NHS England and NHS Improvement, working with their pension partners Isio and behavioural insight specialists, developed Phase One of the Pension Response Project. Phase One is an early example of using EVP techniques to segment the workforce, personalising their offer to those in late career who may be thinking about retiring earlier (from age 50 or 55) than they had previously planned due to, for example, pandemic fatigue, concerns about pensions tax, higher pension contributions and National Insurance contributions from 1 April 2022, misunderstanding about the scheme. In oral evidence, NHS England and Improvement told us that 3,670 members of staff had attended seminars as part of the Pension Response Project so far.
- 3.165 The project found that staff aged 50 or older prefer face-to-face communications about the NHS Pension Scheme and are more likely to secure information about the Scheme from family and friends, rather than 'official' sources. The complexity of the Scheme, including the different sections/schemes, each with different normal pension ages and multiple, often complex rules, is a barrier to engagement. On 19 November 2021, NHSEI launched a series of staff communication materials that explain, as simply as possible, the key benefits of NHS Pension Scheme membership and how staying in work longer could help staff increase their pension savings.
- 3.166 **The Department of Health and Social Care** told us eligible members of the NHS workforce will now belong to one of the 2 existing schemes, both of which are defined benefit schemes. The final salary scheme, or legacy scheme, is made up of the 1995 and 2008 Sections and is now closed to new members. All new NHS staff join the 2015 Scheme, a career average revalued earnings (CARE) scheme which provides benefits based on average earnings over a member's career. The key differences between the 2 schemes, other than the way benefits are calculated, are different normal pension ages and accrual rates, as shown in Table 3.7 below.

Table 3.7: Comparison of scheme, retirement age and accrual rate, DHSC

Scheme or Section	Retirement Age	Accrual rate
1995 Section	60	1/80th
2008 Section	65	1/60th
2015 Scheme	State Pension Age	1/54th

- 3.167 The Government Actuary Department calculates that members can generally expect to receive around £3 to £6 in pension benefits for every £1 contributed. A band 5 or 6 nurse retiring at 68 with 35 years' service wholly in the 2015 Scheme can expect an annual pension of around £19,000.
- 3.168 The Department set out the McCloud judgement and the proposed response in the evidence for the 34th report. Since then, the Government has laid proposed primary legislation, the Public Service Pensions and Judicial Offices Bill, before Parliament to implement changes in public service pension schemes to remedy the discrimination identified by the McCloud judgment. The bill was introduced into the House of Lords on 19 July 2021. Subject to Parliamentary approval, this puts in place a legal framework which requires departments to make amendments to pension scheme regulations to facilitate implementation of the remedy as directed by the bill.
- 3.169 The remedy has 2 parts:
- a. to ensure equal treatment for all members within each of the main public service pension schemes by moving all members into the new schemes on 1 April 2022 irrespective of age; and
 - b. to remove the effect of transitional protection by offering eligible members a choice over the set of benefits (legacy scheme or new scheme) they wish to receive for any pensionable service during the period 1 April 2015 to 31 March 2022
- 3.170 On 9 December 2021, the Department launched a consultation on a draft Statutory Instrument, which will make changes to the NHS Pension Scheme regulations as part of the first part of the McCloud remedy.
- 3.171 Data from the Department indicates that membership of the scheme remains high. Between July 2011 and July 2021, the percentage of all non-medical NHS staff who are members of the Scheme increased by 5.4%.
- 3.172 The Scheme collects contributions from employers and members, with employers contributing 20.6% of a member's earnings. Members are required collectively to contribute 9.8% across the whole scheme membership. Tiered contribution rates were introduced in 2008, to reflect that higher earners were likely to receive proportionally more benefits than lower earners over the course of their retirement, due in part to their final salary link.
- 3.173 The Department launched its consultation on changes to member contributions on 19 October 2021. The consultation set out that whilst the generous cross-subsidy provided by the current tier structure was intended to reduce potential financial barriers and encourage all staff to participate in the Scheme, the Department could no longer justify keeping the cross-subsidy at the same level. In the old final salary scheme, higher earners tended to derive more value from their ultimate pension benefits relative to the amount they contributed over their career, and so they were charged higher contribution rates. However, under a CARE scheme this advantage no longer exists for higher earners, as all members receive the same proportional benefit for their contributions.

3.174 Given that all members will be moved to the 2015 Scheme, a CARE scheme, for future accrual from 1 April 2022, the consultation set out a new structure (Table 3.8), which narrows the range between the lowest and highest contribution rates and ensures that the costs and benefits of the scheme are more evenly shared. Other changes set out in the consultation document include a move to base members' contribution rates on their actual pensionable pay rather than their whole-time equivalent (WTE) earnings, and annual increases to each tier in line with uplifts to AfC pay bands. This will to some extent mitigate the "cliff edge" issue, previously highlighted by the NHS Pay Review Body, that sees some members charged a higher contribution rate because a pay uplift has put them into a different tier.

3.175 The Department further added that adjustments to contribution tiers will be phased in over two years, to dampen the impact on take-home pay for staff and mitigate the risk of staff leaving the scheme on grounds of affordability. For the purpose of determining a member's contribution tier, their pensionable earnings are rounded down to the nearest whole pound. In practice, as the tier thresholds will be increased annually in line with AfC pay awards the figures will be slightly different for future scheme years.

Table 3.8: New member contribution structure, as proposed in the consultation document, DHSC

Current tiers	Pensionable earnings (rounded down to nearest pound)	Current rate	Rate from 1 April 2022	Rate from 1 April 2023	Proposed
-	-	(WTE pay)	(Actual pay)	(Actual pay)	-
Tier 1	Up to £13,231	5.0%	5.1%	5.2%	Tier 1
Tier 1	£13,232 to £15,431	5.0%	5.7%	6.5%	Tier 2
Tier 2	£15,432 to £21,478	5.6%	6.1%	6.5%	Tier 2
Tier 3	£21,479 to £22,548	7.1%	6.8%	6.5%	Tier 2
Tier 3	£22,549 to £26,823	7.1%	7.7%	8.3%	Tier 3
Tier 4	£26,824 to £27,779	9.3%	8.8%	8.3%	Tier 3
Tier 4	£27,780 to £42,120	9.3%	9.8%	9.8%	Tier 4
Tier 4	£42,121 to £47,845	9.3%	10.0%	10.7%	Tier 5
Tier 5	£47,846 to £54,763	12.5%	11.6%	10.7%	Tier 5
Tier 5	£54,764 to £70,630	12.5%	12.5%	12.5%	Tier 6
Tier 6	£70,631 to £111,376	13.5%	13.5%	12.5%	Tier 6
Tier 7	£111,377 and above	14.5%	13.5%	12.5%	Tier 6
-	Expected yield	9.8%	9.8%	9.8%	-

- 3.176 To balance clarity for members and a timely move to the new structure with minimising the impact of the new member contribution structure on take-home pay, the Department decided to delay the implementation of the new member contribution structure until 1 October 2022. As set out in the consultation document, the new member contribution structure will be phased in slowly to protect scheme affordability and minimise the risks to take-home pay of increases to member contribution rates.
- 3.177 In October 2022, approximately 40% of members are expected to receive a reduction in their contribution rates compared to the previous contribution rate structure. Whilst some members will be paying higher contribution rates, the new rates will be phased in over 2 years so that the largest increase in either year will be 0.8 percentage points.
- 3.178 **NHS England and Improvement** told us that changes to pension contributions will be felt most keenly by their lower paid staff. In addition, the timing of when the pay award is made could move some staff into a higher pension contribution tier, potentially creating an overpayment which staff must repay. Increases in staff pension contributions (lower paid staff will pay more and higher paid staff less) and increases in National Insurance contributions, in the context of higher inflation could have a detrimental impact on both the quantum and value of take home pay, affecting the morale of our NHS staff.
- 3.179 NHS Wales pension scheme is not devolved to Welsh Government, the scheme applies to NHS staff in England and Wales.
- 3.180 In addition to the NHS Pension Scheme, employers offer an alternative auto-enrolment scheme (NEST), for employees who aren't eligible to join the NHS pension scheme or choose to join NEST as an alternative.
- 3.181 Noting the comments of the Review Body on the potential impact of pension and wider Total Reward strategies, the Welsh Government will continue to monitor the scheme membership rates and to seek to identify the impact of the wider reward packages on recruitment and retention.
- 3.182 On the changes to the pension contribution structure, **the Staff Side** told us the responses from health unions to the formal consultation have highlighted both the risk that increased cuts to take home pay will have on retention of staff over the year ahead, and their view that there is a risk to long-term stability of the scheme if those facing the bigger increases chose to opt out in greater numbers.
- 3.183 **NHS Providers** told us that they believe while some elements of these proposals – including alignment of tiers to AfC pay uplifts and fairer contribution rates for less than full time staff –are positive. They believe the central initiative to flatten the contribution rate structure and increase employee contribution levels for some lower and middle-banded staff is ill-advised.

- 3.184 **NHS Employers** told us that they think the new proposed structure for employee contributions in the NHS pension scheme moves too quickly and are concerned about the disproportionate impact on the lowest earning people. Employers are concerned that this will increase the risk of members with lower earnings opting out of the scheme on the grounds of affordability.
- 3.185 **UNISON** told us that changes to the NHS pension employee contributions will flatten the contribution model but will lead to a reduction in take-home pay for a number of lower paid salary bands compounding the disproportionate living cost impact they face, whereas some higher earners will contribute less. They added that there could be an increase in staff cutting their pension contributions which only causes more issues further down the line.

Flexible working

- 3.186 **The Department of Health and Social Care** told us that NHSEI is working with the NHS Staff Council, a partnership of NHS trade unions and NHS Employers, to create a range of tools and support for organisations to embed flexible working. This includes toolkits aimed at line managers and individuals to support managing flexible working requests. In addition, there is a national collective agreement to include the right to flexible working from day one within the NHS Terms and Conditions of Service Handbook.
- 3.187 **NHS England and Improvement** told us that the pandemic has caused many NHS staff to reflect on their work–life balance. For many people the last two years have been the most challenging of their careers and they may be looking to set clearer boundaries between their work and personal lives by not working 'full time' hours or taking on additional shifts.
- 3.188 Decisions are compounded for some by the hours they work potentially having tax consequences for pension growth, by breaching the annual or lifetime allowance. These factors are likely to reduce workforce capacity and the discretionary effort which some people are prepared to put in.
- 3.189 **NHS England and Improvement** told us that the NHS Staff Council consulted on and approved significant changes to the NHS Terms and Conditions, in line with the ambitions of the NHS People Plan. These came into effect on 13 September 2021.
- 3.190 They told us that these changes include:
- a. Extending the request for flexible working beyond the statutory duty of after 26 weeks of employment to day one of employment;
 - b. Not requiring staff to provide a reason for flexible working;
 - c. No limit on the number of flexible working requests each year (previously restricted to one request per 12 months); staff can make more than one request for flexible working.

- 3.191 **NHS England and Improvement** also told us that they are running NHS Flex for the Future, an online programme delivered over six months. This programme is currently supporting 93 organisations (including two ICSSs) across all seven regions to explore what flexible working looks like in their organisation, through to the creation of an action plan to embed changes in their organisation.
- 3.192 **NHS Providers** told us that flexibility can be built into the service both through the fuller utilisation of new roles, and the provision of flexible working options for staff. A fully costed and funded national workforce plan is needed to realise this, to build resilience into the system and to plan sustainably for future demand.
- 3.193 They also noted that it often comes down to local line managers working well with their teams to understand what was needed. NHS Providers have concerns that there could be inequalities in flexible working with more senior staff who have a better ability to job share or compress their hours.
- 3.194 **The Department of Health, Northern Ireland**, told us that Northern Ireland did not yet have a regional policy on flexible working, but that the national changes to terms and conditions were to be adopted.
- 3.195 **GMB** told us that flexible working policies are moving in the right direction. Members had some really positive feedback; however, some members were having their requests refused on the basis the requests do not meet the need of the service. Most commonly, staff were requesting shorter shifts and flexibility around rotas.
- 3.196 **The Royal College of Nursing** told us that in many cases the policy that jobs should be advertised as flexible is being ignored, and that requests made by staff are declined due to operational reasons. The Royal College of Nursing has resorted to legal challenges to flexible working as nursing is a female-dominated profession.
- 3.197 **NHS Providers** told us that flexibility can be built into the service both through the fuller utilisation of new roles, and the provision of flexible working options for staff.

Workforce numbers

- 3.198 **The Department of Health and Social Care** told us that the overall non-medical NHS workforce as at September 2021 is 1,078,042 FTEs, this has increased by 134,081 FTEs (14.2%) between September 2017 and September 2021. From September 2020-21 all known classifications of staff group FTEs increased other than midwives.
- 3.199 The Department also told us that there had been no major change long term in sickness rates. COVID-19's impact on sickness absence is reflected in the figures for 2019-20 and 2020-21 and is covered in more detail in later sections.

Table 3.9: Sickness Absence in NHS Trusts and CCGs between 2010-11 and 2020-21 – Total HCHS Non-Medical staff, DHSC

Year	Sickness Absence Rate (%)
2010-11	4.46%
2011-12	4.42%
2012-13	4.56%
2013-14	4.37%
2014-15	4.58%
2015-16	4.47%
2016-17	4.50%
2017-18	4.52%
2018-19	4.55%
2019-20	4.83%
2020-21	5.02%

- 3.200 The Department noted that sickness absence rates vary by region. Rates tend to be higher in the north of England compared to London and the Southeast. Rates also vary by staff group with 'frontline staff', nurses, midwives, ambulance staff and clinical support staff having some of the highest rates of absence while non-frontline groups have lower reported absence rates.
- 3.201 **The Welsh Government** told us that as of August 2021, the NHS in Wales, directly employs 101,446 staff. Of this figure, 61,142 are employed full time with 40,304 employed part time. The number of NHS staff has increased by 4.1% in the last year. In comparison to 5.2% increase from 2019 to 2020.
- 3.202 The age group of NHS staff in Wales has changed over the last five years. Whilst the number of under 30s has increased in the majority of professions, the number of over 60s has also increased, highlighting an aging workforce in NHS Wales. For example, below shows the age distribution for the nursing and midwifery workforce:

Table 3.10: Age distribution for the nursing and midwifery workforce, Welsh Government

Age Band	2015	2016	2017	2018	2019	2020	2021
Under 25	786	863	802	723	796	897	938
25-29	1,925	2,114	2,297	2,345	2,409	2,531	2,713
30-34	2,484	2,506	2,523	2,573	2,746	2,988	3,406
35-39	3,047	2,981	2,921	2,953	2,926	2,949	3,078
40-44	3,738	3,656	3,522	3,331	3,189	3,242	3,237
45-49	4,381	4,184	4,096	4,025	3,933	3,801	3,758
50-54	4,762	4,826	4,792	4,570	4,423	4,248	4,154
55-59	2,755	2,915	3,103	3,295	3,399	3,537	3,621
60+	1,209	1,276	1,438	1,637	1,794	2,023	2,248

- 3.203 **The Welsh Government** told us from August 2020 to August 2021, the sickness absence rate across all staff groups increased from 5.9% to 6.0%. The largest increase in sickness absence is in AHP and Estates and Ancillary with a 0.5% increase.
- 3.204 Out of the health boards Cwm Taf Morgannwg University LHB had the highest sickness rate at 6.4% with the lowest sickness rate at Hywel Dda University LHB being 4.9%. Of the Trusts, Welsh Ambulance Services NHS Trust had the highest rate at 8.1% in comparison with Digital Health and Care Wales NHS Trust at 1.7%. The NHS Wales average is 5.5%.
- 3.205 **The Department of Health, Northern Ireland**, told us as of March 2021, there were 67,197 staff in the health service (58,734 FTE) – an increase from 63,777 in March 2020.
- 3.206 Sickness absence, COVID-19 sickness and self-isolation rates in 2020/21 totalled 9.29% in 2020/21, up from 7.01% in 2019/20.

Vacancies

- 3.207 **The Joint Staff Side** told us that vacancy figures illustrate a system under pressure, but what they do not show is the personal cost of the system being so stretched. In a healthcare setting, specialisms are of critical importance, and their absence to a ward or hospital or entire trust can be devastating leading to the cancellation of operations, routine treatments and delayed or permanently compromised recovery.
- 3.208 **The Department of Health, Northern Ireland**, told us the number of vacancies as of September 2021 was 6,283, down from 7,085 in June 2021. The number of vacancies is impacting Trusts across Northern Ireland.
- 3.209 They also told us that a number of the Trusts are experiencing significant shortages across all professional groups. Trusts have found over the years that services provided by agency workers do not provide the same level of stability and consistency in services and tend to be more expensive.

3.210 **The Department of Health and Social Care** provided the table below which shows nursing and other non-medical vacancies and vacancy rates from Q2 2018-19 – Q2 2021-22.

Table 3.11: Nursing and other Non- Medical Vacancies and Vacancy Rates from Q2 2018-19 – Q2 2021-22, DHSC

	Nursing Staff		Other Non-Medical staff	
	Vacancy Rate	WTE Vacancies	Vacancy Rate	WTE Vacancies
18-19 Q2	12.1%	42,679	7.5%	53,416
18-19 Q3	11.1%	39,686	7.4%	52,311
18-19 Q4	11.1%	39,524	6.7%	47,656
19-20 Q1	12.3%	44,195	7.7%	56,039
19-20 Q2	12.1%	43,452	7.3%	53,067
19-20 Q3	10.7%	38,736	7.1%	52,312
19-20 Q4	9.9%	36,083	6.0%	43,926
20-21 Q1	10.3%	37,760	4.9%	37,368
20-21 Q2	10.1%	37,144	5.6%	42,835
20-21 Q3	9.7%	36,277	6.0%	45,913
20-21 Q4	9.2%	34,678	4.5%	34,770
21-22 Q1	10.3%	38,956	5.9%	46,430
21-22 Q2	10.5%	39,813	6.5%	51,314

3.211 **NHS Providers** told us there has been an increase in leavers – this was an ongoing trend that predates the pandemic. They added that the current vacancy rate was the highest ever seen.

Motivation and morale

3.212 **The Department of Health and Social Care** told us that the experience of the pandemic has shown, once more, that the NHS is nothing without its exceptional staff. NHS staff have been severely tested by the challenges of dealing with the pandemic and it is vitally important that they are kept safe, supported now and over the months ahead, and able to recover. Investing in staff health and wellbeing is very important. The NHS strengthened the mental health and wellbeing support offer for health and social care staff in 2021-22, with £37 million invested in 40 mental health and wellbeing hubs across the country. These provide proactive outreach and clinical assessment, access to evidence-based mental health services and other support where needed.

3.213 **The Joint Staff Side** told us staff need recognition urgently if burnout, high vacancy rates and staff exits are to be meaningfully addressed. It is also critical that future resilience and crisis preparedness are better developed in order to ensure that overstressing staff does not become the permanent backstop for dealing with crises and associated pressures.

- 3.214 As part of their asks of the Government, **the Joint Staff Side** told us they are increasingly concerned about the health and wellbeing of staff. At the time of evidence, the additional and high levels of absence associated with the rapid spread of the Omicron variant of Covid-19 added further pressure for existing staff to undertake extra shifts and additional hours in order to maintain acceptable levels of service provision. They believe there is an urgent need for Government and policy makers to reinforce the 48-hour limit on working hours as a priority patient and staff safety measure. They would like to see a requirement for employers to take total hours worked into account, not just hours on a substantive payroll and measures to limit allocation of additional hours without consent.
- 3.215 **The Joint Staff Side** also told us that unpaid overtime has been a significant challenge for the NHS for many years. Data from the Royal College of Nursing Employment Survey found that 77% of members said they work beyond their contracted hours at least once a week, and more than half (53%) of nursing staff reported the additional hours were unpaid.
- 3.216 **NHS England and Improvement** told us that in April 2020, NHSEI launched a national staff health and wellbeing offer to support staff through the COVID-19 pandemic; this complements support available locally. They refined the offer throughout 2021/22 and it now includes:
- a. a specialist bereavement support line for health and care staff
 - b. free access to mental health and wellbeing apps (by the end of December 2021 this had been accessed over 47,000 times)
 - c. suicide awareness resources and support for people affected by suicide
 - d. guidance for key workers on how to have difficult conversations with their children
 - e. group and one-to-one support, including specialist services to support our Black and minority ethnic (BME) colleagues
 - f. webinars providing a forum for support from and conversation with experts; and
 - g. bereavement support for our Filipino nurses via a specific 'Tagalog' speaking service supported by Hospice UK.
- 3.217 The entire offer has now been accessed more than 1.5 million times and utilisation remains consistent.
- 3.218 **NHS England and Improvement** also told us that staff engagement is measured annually through the Staff Survey and is now also tracked quarterly by trusts. It is made up of three components: motivation, involvement and advocacy. Using a fixed effects model, analysis illustrates that staff engagement has a positive and statistically significant impact on NHS trust outcome measures. In particular, trusts with higher levels of staff engagement are likely to have:
- a. lower sickness absence rate

- b. lower MRSA rate
 - c. lower mortality rate
 - d. higher recommended rate in the inpatient satisfaction survey; and
 - e. lower unrecommended rate in the inpatient satisfaction survey.
- 3.219 **The Royal College of Nursing** told us there was evidence of unsustainable levels of working beyond contracted hours among the nursing workforce and controlling workload and preventing burnout is crucial for staff retention and to ensure nursing staff are practising safely.
- 3.220 **The Royal College of Midwives** told us that 85% of Heads of Midwifery told them it was difficult to ensure that all staff take their breaks and leave on time. An increase from 54% on 2020 and 52% in 2019.
- 3.221 **GMB** told us they had specific concerns regarding ambulance workers. Demand for emergency care has increased significantly and they told us their members said January 2022 was more pressured than at any other point during the pandemic.
- 3.222 **Unite** told us that the ambulance service reported the most frequent staffing shortages in their members survey, as well as being most likely to report the service being overwhelmed.
- 3.223 **The Chartered Society of Physiotherapy** told us the NHS is not a desirable place to work and more staff are leaving for private work. Many students that the NHS are taking time to train have no intention of working in the NHS. They believe the market is saturated with money, it's very difficult to keep hold of staff as so many different private sector opportunities are available.
- 3.224 **NHS Employers** told us NHS people have been re-deployed and re-trained. Hours and shifts have been increased to cope with the extra demand and to address the increasing level of sickness absence. The levels of severe illness and death that healthcare workers have witnessed, including amongst their own colleagues, have been unprecedented. People have been anxious over their ability to cope at work.
- 3.225 **NHS Employers** added that they have enhanced their programmes to support the wellbeing of NHS people. Some employers have expanded their support programmes to reflect the wider economic impact of the pandemic on the families of their employees and supporting the subsequent stress and anxiety this may cause. Employers have designed their support programmes to help teams as well as individuals.
- 3.226 **The Welsh Government** told us that all partners in Wales recognise that in order to be effective, workforce health and wellbeing must be addressed on a number of fronts. The Health and Wellbeing network continue to act as an expert forum for the identification of appropriate and informed courses of action based on workforce intelligence from several sources. The network also drives development and assesses offers of interventions to support staff, reviews best practice from elsewhere and adopts where possible and explores and procures where appropriate priority access solutions.

- 3.227 They also told us that individuals will be affected differently by the pandemic; people will require different levels of intensity and style of interventions and so the network continues to ensure that the multi-layered support offer reflects the needs of the workforce. Funded by Welsh Government and extended until August 2022, the offer includes a confidential listening service dedicated to health and social care working in Wales and available in both Welsh and English provided by the Samaritans. This complements more in-depth therapy and cognitive behavioural therapy through SilverCloud and the expanded Health for Health Professionals(HHP) service, and physical health services, as well as practical and financial advice.
- 3.228 **The Welsh Government** also told us about their workforce wellbeing conversation tool. The sustainability of NHS and social care services during this demanding time is critical and so ensuring that there is a well and able workforce is more important than ever. As the full impact of the pandemic continues to emerge and they move toward a busy recovery period it is imperative to ensure that mechanisms are in place to help all our staff and their managers to think carefully about individuals' circumstances and wellbeing and the practical support they need to support their wellbeing, and personal recovery and boost their resilience.
- 3.229 The online Workforce Wellbeing Conversation Guide was launched for use across health and social care settings in Wales in November 2021. This online guide is a starting point for staff to encourage conversations about their experiences of work and exploring how this influences well-being and can be used flexibly to suit individuals and teams.

Workforce planning

- 3.230 **The Joint Staff Side** told us, at the time of writing, that the NHS was undoubtedly in the grip of a crisis, Whilst the impact of Covid-19 is a symptom of the broader issues, arguably it is a historic lack of workforce planning which is at the heart of the current crisis. There is now an unprecedented amount of consensus around the importance of addressing workforce issues in supporting the NHS to function effectively and deliver excellent patient care.
- 3.231 **The Royal College of Nursing** in their evidence called for accountability on workforce planning through primary legislation. They set out what they view as the key components of an effective workforce planning system which would not only include skill mix and numbers but also equality impact assessments; application of lessons learned from reviews; measure to promote recruitment, retention, remuneration and supply of the workforce; and due regard for workplace health and safety.
- 3.232 **The Department of Health and Social Care** told us that an effective workforce strategy is important for the delivery of safe, affordable, high-quality care, both now and in the longer term. Ensuring that the NHS has access to the right mix and number of staff who have the skills, values, and experience to deliver high quality, affordable care is a fundamental aspect of the DHSC's overarching programme for the health and care system.

- 3.233 The Department told us there are currently record numbers of nurses working in the NHS, and the Department continues to work closely with the various bodies involved in workforce planning and training to help ensure the NHS continues to recruit and retain staff. This commitment is supported by a robust programme of work including delivery of the Nurse 50k manifesto commitment, investment in international recruitment, the expansion of medical training places, and training grants for nursing, midwifery, and AHP students.
- 3.234 The Department recognises that in addition to growing the workforce, work must continue to help improve ways of working to increase productivity and efficiency through advancing skills mix and service transformation. The Department is therefore developing proposals to improve the integration of health and social care services around the needs of patients.
- 3.235 They also told us that in addition to training and recruiting additional workforce and improving ways of working, there is a significant programme of work in place to retain and look after the existing workforce. Initiatives include improving staff wellbeing, fostering an increased sense of belonging, and promoting greater equality, diversity, and inclusion.
- 3.236 They also told us that education and training of the workforce is the core function of HEE and, subject to parliamentary passage of the requisite powers within the Health and Care Bill, will be merged with NHSEI. The merger will help ensure that workforce is placed at the forefront of the national NHS agenda as it will integrate service, workforce, and finance planning in one place, reflecting its importance. It will also simplify the national system for leading the NHS, ensuring a common purpose and strategic direction.
- 3.237 The Department noted that NHSEI/HEE have responsibility for short term workforce planning and the deployment of workforce to meet service need, with each Integrated Care System (ICS) planning workforce requirements for its own service. ICSs are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area, including working to ensure the system is retaining, recruiting and, where required, growing its workforce to meet future need.
- 3.238 The Department told us they retain strategic oversight for the NHS workforce and are delivering longer-term strategic workforce planning. It also includes HEE Long Term Strategic Framework ("Framework 15"), commissioned in July 2021, which will review long term strategic trends for the health and regulated social care workforce.
- 3.239 The Department has also set out further reforms to improve recruitment and support for the social care workforce in the White Paper, published on 1 December 2021. This sets out the vision for a well-trained and developed workforce, a healthy and supported workforce, and a sustainable and recognised workforce. Their policies include a Knowledge and Skills Framework and a linked training offer to ensure staff feel recognised, rewarded, and equipped with the rights skills and knowledge, including to support adults with learning disabilities and complex needs.

- 3.240 In addition to this, in July 2021, the Department commissioned HEE to work with partners and review long term strategic trends for the health and regulated social care workforce. This will review and renew the long-term strategic framework for the health workforce, to help ensure we have the right numbers, skills, values, and behaviours to deliver world leading clinical services and continued high standards of patient care. For the first time ever, the framework will also include regulated professionals working in social care, like nurses and occupational therapists. And building on this work, the Department for Health and Social Care has recently commissioned NHS England to develop a workforce strategy and will set out the key conclusions of that work in due course.
- 3.241 **NHS England and Improvement** told us that the interim People Plan, published in July 2019, set out the action needed for our NHS people and workforce to deliver the NHS Long Term Plan. It described how the NHS would ensure it had more people, working differently in a compassionate and inclusive culture. The first full People Plan, published in July 2020, built on this foundation, and set out how the NHS would support staff through the pandemic and beyond by looking after our people, fostering a sense of belonging in the NHS, instituting new ways of working and growing the workforce.
- 3.242 They also told us that working with NHS systems, they have made good progress in implementing the actions set out in both People Plans. They have taken an explicitly improvement-based approach to allow systems to prioritise the actions that will have the greatest impact for their staff and in turn for their patients. Most systems report that they are on track to deliver on priorities across the actions set out in the 2020 People Plan, however there is further work to do; in particular, ensuring that flexible working opportunities are available to all staff, there is a consistent approach to service transformation and workforce productivity, and the workforce is growing to meet demand.
- 3.243 Looking forward, **NHS England and Improvement** told us that with the conclusion of the Spending Review in December 2021, they now have a much clearer view of the increase in workforce capacity and skills which the commissioned training programmes will deliver in 2024/25.
- 3.244 They added that work is taking place across NHS England and NHS Improvement, HEE and the DHSC to provide both longer term demand signalling and training plans, as well as short- and medium-term actions to support, retain and develop the existing workforce and those already in the training pipeline.
- 3.245 **The Department of Health, Northern Ireland** told us effective workforce planning is complex and challenging but is essential to contribute to ensuring services across Northern Ireland are both sustainable and delivered to the appropriate standard.

- 3.246 They added that they have accepted the Skills Six Step Skills for Health Methodology as the tool for all workforce planning. All workforce reviews consider the purpose, scope and ownership of the plan at the outset. It identifies the Goals/benefits of change, collates the current baseline data, highlights drivers for change eg an multidisciplinary team, work-life balance/ family friendly policies etc agrees working models going forward and scenario sets against the working models for future planning.
- 3.247 Analysis is carried out by the Department of the activities undertaken, types of roles and numbers required, productivity and new ways of working. This help identify skill sets and levels of interventions for service users and facilitates new ways of working. An example is the introduction of Pharmacists/Nurse Practitioners in GP practices to facilitate multi-disciplinary working.
- 3.248 **The Royal College of Nursing** in Northern Ireland told us that they believe it is important to focus on how in Northern Ireland they can engage in meaningful workforce planning that is developed by reference to the needs of the people in Northern Ireland, is undertaken in partnership, and designed to correlate with the broader strategic direction of health and social care in Northern Ireland. They also stress that it is important that comprehensive workforce planning embraces the needs of the independent sector – particularly nursing and residential care.
- 3.249 **The Royal College of Nursing** reported that between 2016 and 2021, the nursing support workforce grew at a faster rate than the registered nursing workforce across all four countries. They believe this is an indication of the increase in substitution of the registered nurse.
- 3.250 **NHS Providers** told us that they believe that the HEE training and workforce development budget is spread far too thinly and cannot adequately support either the size and nature of workforce expansion required, nor the training and development needs of the existing workforce. HEE is due to merge with NHSE/I in 2023, and while there are pros and cons to this shift, they said the most important factor going forward will continue to be ensuring appropriate investment in the development of the current workforce and future domestic pipeline of staff into the NHS, regardless of whether funding for HEE as an agency moves into the NHSE/I revenue budget ringfence.
- 3.251 **NHS Employers** told us that workforce planning should be undertaken regularly, and gaps must be addressed at a national level.
- 3.252 **NHS Employers** also told us that people who have come through the rigours of the pandemic are now reflecting on their needs and some will decide to retire earlier than planned. Better long-term workforce planning will depend on employers fully understanding the risks of the impact of the pandemic on people. Employers will need to make provisions based on data, demand, capacity and capital requirements.

- 3.253 **NHS Employers** told us that they believe that workforce planning must be a continual process, to align the needs and priorities of the system, population and services with workforce requirements and evidence -based, to enable them to factor in technology, best practice, demographic and epidemiological factors on the workforce.
- 3.254 **The Welsh Government** told us about the workforce strategy for Health and Social Care. In 2020 Health Education and Improvement Wales and Social Care Wales published the 10 year workforce strategy which sets out an ambition for a motivated, engaged and valued, health and social care workforce, with the capacity, competence and confidence to meet the needs of the people of Wales.
- 3.255 They told us their workforce strategy is shaped around the following seven key themes, and each section will contain a number of actions. The actions will be delivered via a series of underpinning implementation plans.
- a. An engaged, motivated and Healthy workforce
 - b. Attraction & Recruitment
 - c. Seamless workforce models
 - d. Building a digitally ready workforce
 - e. Excellent Education & Learning
 - f. Leadership & Succession
 - g. Workforce Supply & Shape

Pay approaches and affordability

- 3.256 **The Department of Health and Social Care** told us that when it was set in January 2019, the LTP assumed a headline uplift of 2% for 2022/23. The outcome of SR21 has provided a tight settlement for the NHS, requiring the delivery of a range of priorities and efficiencies which will need careful prioritisation in order to stay within available funding. In settling the DHSC and NHS budget, the government assumed a headline pay award of 2% for NHS staff. The department has an additional 1% "contingency" which it is choosing to make available for AfC pay, providing an overall affordable headline pay award of up to 3%. Doing so means that this contingency will not be available for other priorities. They added that any additional funding for pay would have to come from within existing budgets, therefore, there was a direct trade-off between pay and other priorities.
- 3.257 As discussed earlier, the Department told us that NHS budget has been fixed to prioritise investments which will enable the NHS to tackle the elective backlog, grow the NHS workforce, continue the fight against COVID-19 and deliver the LTP. This includes the significant step government has already undertaken to increase National Insurance contributions by 1.25 percentage points to fund the Health and Social Care Levy. This leaves extremely limited room for any further investment in pay and therefore to achieve these objectives, financial restraint on pay is needed.

- 3.258 The Department further told us that each additional 1% of pay for the HCHS non-medical workforce costs around £700 million per year allowing for the full system costs beyond the substantive workforce. This equates to around 13,000 full-time nurses or 400,000 procedures. For the HCHS workforce as a whole, an additional 1% of pay costs around £900 million which is equivalent to around 16,000 full-time nurses or 500,000 procedures.
- 3.259 **NHS England and Improvement** told us that pay remains the largest component of NHS costs (c65% of total operating costs) and therefore pay inflation represents a material cost pressure which the NHS needs to plan and manage. Pay awards that are higher than the affordable level, and which are not supported by additional investment, will result in difficult trade-offs during the year on staffing numbers and the ability to deliver activity volume. These decisions will have a longer-term impact on the NHS's ability to restore services and make progress in tackling the elective care backlogs which have grown during the pandemic.
- 3.260 **NHS England and Improvement** also told us that overall efficiency requirement will be at least double that of the previous national NHS LTP efficiency requirement. This means it would not be credible to rely on further efficiencies in order to fund headline pay awards.
- 3.261 **The Welsh Government** told us they would welcome a recommendation that would represent a sufficient pay rise for AfC staff to recognise their dedication and hard work during the pandemic and, the work they will continue to undertake in the coming year to support the recovery efforts. However, they noted the need for this to be balanced with affordability.
- 3.262 **The Welsh Government** told us that although there are shortages of staff in specific specialities, evidence shows that these are UK wide issues and relate to the numbers of staff training in these areas, rather than the financial rewards.
- 3.263 They added that where possible, Wales aims to maintain parity with the other nations regarding pay. Any deviations could create difficulties in recruiting staff across borders. The Welsh Government wants to see continuity of this approach.
- 3.264 **The Department of Health, Northern Ireland** told us that Northern Ireland has yet to agree a Budget for 2022/23 and early indications are that the funding envelope is likely to deliver the most difficult financial settlement that Health has seen to date.
- 3.265 They added that it is probable that there will be no capacity to afford a pay uplift in 2022/23 in this context without additional funding being made available in-year – which will then perpetuate the funding issue into the future.

- 3.266 **The Joint Staff Side** told us that a pay increase should be set at a level which will retain existing staff within the NHS and recognises and rewards the skills and value of health workers. In order to do this, the increase must (a) deliver an inflation-busting increase so that NHS staff can cope with rising and rapidly fluctuating costs which may change significantly over the pay year; (b) absorb the impact of increases to pension contributions and; (c) benchmark the bottom of the structure against the Living Wage Foundation's real Living Wage.
- 3.267 **UNISON** told us that more than nine out of ten (93%) of NHS members perceive a pay increase below inflation as a pay cut, and over two-thirds (68%) of NHS staff would look for other, better paying work, if NHS pay does not keep pace with the cost of living. The majority of UNISON members continue to support the principle of a flat rate approach to pay rises, though around a third of members (37%) back a percentage pay rise. Around three-quarters (72%) are open minded about the mechanism provided they receive a decent pay rise.
- 3.268 **GMB** told us that AfC staff needed a catch-up settlement that makes substantial progress towards the restoration of real earnings.
- 3.269 **The Royal College of Nursing** told us that staff needed a restorative increase of 5% above RPI as an essential down-payment to restore lost earning caused by successive years of below inflation pay awards.
- 3.270 **NHS Providers** told us that in response to the government's repeated assertion that there is a "direct trade-off" between more funding for pay or staff numbers, 69% of HRDs in their survey said that both aspects are equally important priorities for their trusts (a 19% increase on last year's responses to the same question). 27% prioritised more staff (33% last year), and 4% prioritised better pay for staff (18% last year). In their comments, most respondents who answered that both are equally important felt that these factors are interdependent, as good pay both attracts a high quality of staff and supports their retention. Respondents who prioritised "more staff" felt that there are more significant factors to recruitment and retention than pay, which would be enabled by having more staff in the service (including flexible working options, ensuring ability to take annual leave, and reducing staff relocation to new workplace sat short notice). Overwhelmingly, though, the message from respondents to this year's survey on this question was that it is vitally important that pay is not a reason for staff leaving the service, and investment in pay equates to investment in staff retention.

RRP

- 3.271 **The Joint Staff Side** told us that over the last decade, use of Recruitment and Retention Premia (RRP) has dropped significantly and there is little evidence of the use of RRP to address issues within a specific geographical context or for specific occupations. Mechanisms for funding RRP are not easily understood, with no obvious corollary between the funding applied via the Market Forces Factor (England) and RRP being applied to AfC roles.

- 3.272 The Joint Staff Side would like to see a revision of the mechanisms to apply RRP (perhaps based on learning from NHS Scotland where RRP are actively considered, applied and removed through collective agreement within the NHS Staff Council structures) in addition to a clear mechanism established for the funding of short term RRP to assist employers to retain staff in priority groups through the next pay year.
- 3.273 **The Royal College of Nursing** told us they were asking for the NHSPRB to recommend immediate measures to implement national Retention Premia Payments and Recruitment Premia Payments for the nursing workforce as a matter of urgency to address the ever-worsening workforce crisis.
- 3.274 **The Department of Health, Northern Ireland**, told us that there are only a very small number of RRP in place in Northern Ireland. It is difficult to implement given the small geographic area within Northern Ireland, and therefore the potential impact of destabilising other Trusts' services if it were to be applied.
- 3.275 **NHS England and Improvement** told us that NHS Trusts struggle with the use of RRP and they have not been a particularly successful mechanism. The concerns are currently being addressed by NHSEI to allow RRP to work well in future.
- 3.276 **The Chartered Society of Physiotherapy** told us the health systems reliance on overworked physiotherapy staff and their unpaid labour is not sustainable, and an urgent retention package is now needed more than ever to safeguard the NHS's physiotherapy workforce.
- 3.277 **NHS Employers** told us they believed RRP were problematic. There is a real sense of equity amongst staff and RRP could jeopardise that.

Bands 1 and 2

- 3.278 **GMB** told us that the NHS had fallen into a cycle under which the lowest rates are raised (nominally in April) to marginally more than the Foundation Living Wage rate. These rates are then overtaken by the November Living Wage increase.
- 3.279 **NHS Providers** told us that HR Directors noted the difficulty competing in lower pay bands with employers outside of the sector, including those offering "less physically and mentally demanding" jobs. Losing staff to supermarket chains and other private sector employers to pay issues was mentioned by many parties.
- 3.280 **UNISON** told us that the simplest way of assessing whether increases to NHS pay are effectively dealing with the disproportionate cost of living increases for lower earners is to assess the lowest rates of pay against the Living Wage Foundation's real Living Wage. The 2018 pay negotiations set the lowest rate of pay in the NHS at a rate higher than the Living Wage Foundation's real Living Wage. This move was led by UNISON and was widely supported by employers as a means of addressing the recruitment and retention pressures in evidence for staff in the lower bands. However, this progress has been eroded overtime.

- 3.281 They also told us that a number of NHS trusts have already committed to paying the Living Wage Foundation's real Living Wage, partly as a direct response to local labour market pressures as well as local trade union campaigners. However, UNISON believe it is clear that many employers find the administrative and resource burden very difficult. UNISON believe that NHS organisations would favour fixing the issue once and for all by ensuring the national pay structure had minimums sufficiently above the Living Wage Foundation's real Living Wage rates.
- 3.282 **NHS Employers** told us that entry-level rates of pay in addition to continuing to be in line with government legislation (statutory national minimum wage) must be set at levels to enable and support employers to attract and recruit people in an increasingly competitive labour market.
- 3.283 **NHS Employers** also told us that policy changes such as the government's new immigration system mean that international recruitment of lower paid NHS people might become more difficult, especially if there is a shortage of these people in other sectors of the economy. Employers are struggling to recruit Band 2 staff as the labour market is increasingly competitive at this level. One Trust told us they were seeing turnover rates of 20% in these roles.
- 3.284 **The Department of Health and Social Care** told us Band 1 has been closed to new entrants since December 2018 and most staff have since transferred to Band 2 with under 6,000 FTE remaining in Band 1 as of March 2021. Basic pay rates in Band 1 increased in 2020-21 and so it is likely the apparent reduction in earnings reflects the characteristics and working patterns of staff who have chosen to remain in Band 1 – for example if more part-time staff remained in Band 1 or if they were less likely to receive additional earnings.
- 3.285 **The Department of Health and Social Care** also told us that they had particular concerns over the pay of Bands 1 and 2. They had no data suggesting the recruitment and retention was worse, but they understood that that segment of the market was particularly fluid. Cost of living pressures would also be most acutely felt by staff in those bands. They asked the NHSPRB for their views of an appropriate pay rise in Bands 1 and 2.

High-Cost Area Supplements (HCAS)

- 3.286 The Staff Side told us that there is a range of issues with the current mechanisms for HCAS payments, which will be increasingly problematic as system-level working becomes embedded. They would welcome negotiations to resolve the issues they have previously identified in the HCAS mechanism and levels of pay.
- 3.287 **GMB** argue that the HCAS system is no longer fit for purpose. They cite ongoing problems including: the reduction of HCAS to a two-tier system; the failure of HCAS to reflect the additional cost of living in Greater London; HCAS's archaic boundaries; and the lack of application of HCAS outside of the Greater London area.

- 3.288 **NHS Employers** told us in London and the south-east generally, as well as in some other locations such as Oxford and Cornwall, employers report that the high cost of living, particularly housing, is a barrier to recruiting new employees.
- 3.289 **The Department of Health and Social Care** told us that the uncertainty and change caused by COVID-19 creates a problem in attempting to robustly reform HCAS, in the midst of a global shock which may permanently alter ways of working in the wider economy, with potential wider impact on the locations that people need to be based in for work. We have yet to see if the pandemic will have wider long-term effects, for example on private sector wages or the cost of living in different areas of the country, which may also impact upon recruitment and retention in the NHS. With this in mind, the Department would argue that now is not the right time to try and determine what a future HCAS system may look like.

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

Introduction

- 4.1 Our analysis in this chapter is based on the written and oral evidence, available data from OME and other sources as they relate to our terms of reference and matters remitted to us this year. Our analysis covers:
- The economy, cost of living, labour market;
 - NHS funding and NHS demand;
 - Vacancies and workforce planning;
 - Morale and motivation;
 - Gender and Ethnicity;
 - Retention;
 - Trends in recruitment;
 - The AfC workforce;
 - AfC earnings; and
 - Total reward, quality of working environment, pensions and flexible working.

Economy and the labour market

- 4.2 In chapter 1, we commented on the volatility of the economy over the past two years, the labour market, the NHS and the workforce in the context of the remits for 2022/23 pay recommendations for AfC staff in England, Northern Ireland and Wales. We also noted the background to our considerations which have been supported by the evidence submitted by the parties and the emerging economic and labour market forecasts for 2022/23 from external commentators. In this chapter, we set out the latest available data at the time of this report including the most recent economic growth and inflation forecasts.
- 4.3 Inflation, as measured by the Consumer Prices Index (CPI), was at 9.0% in April 2022, the highest recorded rate since the series began in 1989. CPIH inflation was at 7.8%, and the RPI rate was at 11.1% in April, the highest recorded rate since 1982. In their latest monetary policy report, the Bank of England¹⁹ said that they expected CPI to rise further, to around 10% later in 2022 and fall-back next year. They expect to be close to their 2% target in two years.
- 4.4 We note that the impact of the pandemic on NHS finances, demand and the workforce are significant and developing and it is against that backdrop that we are making our recommendations. Economic indicators have also evolved significantly since the time of the Spending Review in Autumn 2021.

¹⁹ May report <https://www.bankofengland.co.uk/monetary-policy-report/2022/may-2022>

- 4.5 Paragraphs 3.31 and 3.32 set out HM Treasury evidence on the economy as of December 2021. At the time, they told us that OBR had forecast that inflation would peak at around 4% in 2022, before falling back as global markets were expected to adjust as supply responded to higher prices and demand conditions normalised.
- 4.6 The economy and labour market forecasts have developed significantly since parties wrote their evidence to support their views on the affordability of a pay increase. We use the latest available data to inform our pay recommendations.
- 4.7 We summarise below the economic and labour market indicators at the time of our considerations for this report:

Economic growth

- The economy is estimated to have grown by 7.4% overall in 2021, following a 9.3% contraction in 2020.
- The latest data, for the first quarter of 2022, showed GDP was 0.8% higher than in the final quarter of 2021, 8.7% higher than a year earlier, and 0.7% above its pre-COVID-19 level. The latest monthly figures show that growth slowed down through the first quarter of 2022, with growth of 0.7% in January, no growth in February and a fall of 0.1% in March 2022.

Economic outlook

- In its March *Economic and Fiscal Outlook*, the OBR revised down its estimate for 2022 growth from 6.0% to 3.8%. The reasons for this included Russia's invasion of Ukraine and the consequent impact for global economic growth, and a reduction in real household disposable incomes from inflation and tax increases which would reduce consumer spending.
- In its March 2022 *Economic Outlook*, the OECD said that, prior to the war in Ukraine, most key global macroeconomic variables were expected to return to normal over 2022/23 following the COVID-19 pandemic. The war in Ukraine, however, has already resulted in sizeable economic and financial shocks, particularly in commodity markets, with the prices of oil, gas and wheat rising quickly. The OECD said that moves in commodity prices and financial markets seen since the outbreak of the war could, if sustained, reduce global GDP growth by over 1 percentage point in the first year, with a deep recession in Russia, and push up global consumer price inflation by approximately 2½ percentage points.

Consumer Prices Index

- Inflation, as measured by the Consumer Prices Index (CPI), was at 9.0% in April 2022, the highest recorded rate since the series began in 1989. CPIH inflation was at 7.8%, and the RPI rate was at 11.1% in April, the highest recorded rate since 1982. Higher inflation since April 2021 has been driven by electricity, gas and petrol prices in particular. Following the increase in the energy price cap from October 2021 (to reflect changes in the cost of supply), domestic electricity prices increased by 53.5% over the year to April 2022 and domestic gas prices by 95.5%. Average petrol prices increased by 28.9% over the year to April 2022, reaching a record high price of 161.8 pence per litre.
- In March 2022, the OBR said that it expects CPI inflation to rise to 7.7% in the second quarter of 2022, and then peak at 8.7% in the fourth quarter of 2022, as a further rise (of potentially 40%) in the energy price cap is implemented in October 2022. The OBR expects CPI inflation to average 7.4% in 2022, and 4.0% in 2023. In its May 2022 Monetary Policy Report, the Bank of England expected inflation (measured by CPI) to peak at around 10% in 2022, before falling in 2023 and being close to the 2% target in around two years time.

Employment

- Pay As You Earn Real Time Information (RTI) data indicate that the number of employees on payrolls in April 2022 was 29.5 million, higher than the pre-pandemic peak of 29.0 million in January and February 2020. The number of payrolled employees has increased by 1.2 million in the year to April 2022.
- According to the Labour Force Survey (LFS), the level of employment is 504,000 lower than the peak in the three months to February 2020, at 32.6 million in the three months to March 2022. The number of employees is estimated to have increased by 338,000 since February 2020, while self-employment is estimated to have fallen by 800,000.
- The ONS recorded a record 1.3 million job vacancies in the three months to April 2022. The largest number of job vacancies were in health and social work (212,000), accommodation and food services (171,000), and retail and wholesale (163,000). Total job-to-job moves also increased to a record high, of 994,000, during the fourth quarter of 2021 period, which the ONS said was driven by resignations rather than dismissals.

Earnings

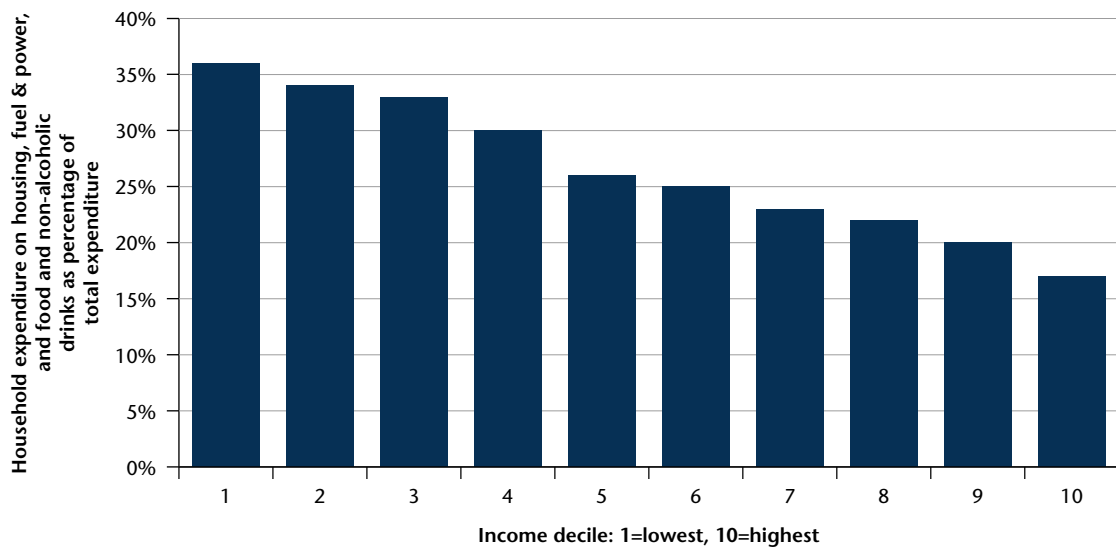
- Whole economy averages weekly earnings growth reached 8.8% in the three months to June 2021, the highest recorded since the series started in 2001, and was at 7.0% in the three months to March 2022. The initial period of high earnings growth was in large part due to the changing composition of the workforce and the recovery in working hours from a year earlier. These effects have now largely come out of the annual growth rate. The most recent average earnings growth has been boosted by bonus payments, especially in the finance sector, so that regular average earnings growth (excluding bonus pay) was at 4.2% in the three months to March 2022.
- Private sector average earnings growth was at 8.2% in the three months to March 2022, down from a peak of 10.2% in June 2021. Public sector (excluding financial services) average earnings growth was at 1.7% in the three months to March 2022, having fallen from a peak of 5.6% in March 2021 when parts of the public sector were working longer hours as part of the response to the COVID-19 pandemic.
- PAYE data on earnings shows a similar path, with average monthly earnings growth reaching 9.8% in May 2021, then dropping to 4.6% in October 2021 as the pandemic effects unwound. Average earnings growth on this measure increased to 8.9% in March 2022 with particularly strong recent growth at the top of the earnings distribution, likely driven by bonus payments.
- The estimate of median pay growth – that is, the median growth in pay experienced by an employee – was 4.4% in the year to April 2022, having increased from 3.2% a year earlier.
- Earnings in the lower half of the distribution were impacted during the pandemic as working hours in the lower-paying sectors, such as arts and hospitality, were particularly hit. However, more recent data show that there has been significant earnings growth at the bottom end of the distribution as well as strong growth in earnings at the top of the earnings distribution, which may be boosted by bonus payments in the last few months.
- The Government increased the National Living Wage (NLW) from 1st April 2021, by 6.6% from £8.91 to £9.50. The Low Pay Commission has been asked by Government to make increases to the NLW towards a target of two-thirds of median earnings by 2024, taking economic conditions into account. The LPC has said that its best estimate of the increases required to meet this target is for an NLW of £10.32 from April 2023 (an increase of 8.6% from the 2022 rate) and £10.95 from 2024 (an increase of 15.3% from the 2022 rate). The Office for Budget Responsibility (OBR) have predicted a less steep pathway for the NLW, with increases required to £9.97 per hour in 2023 and £10.33 in 2024.
- Data from XpertHR, for the three months to April 2022, show median pay settlements at 4%, the highest level recorded by XpertHR since 1992. Incomes Data Research (IDR) recorded a median of 3.7% for 2022 pay awards in the three months to April 2022, while the Labour Research Department (LRD) has median pay settlements of 4.2% for the three months to March 2022.

- 4.8 We summarise below the additional Northern Ireland economic and labour market indicators at the time of our considerations for this report:
- In the three months to March 2022, Northern Ireland’s employment rate was 72.2%, lower than the UK-wide equivalent of 75.7%. Over the same period, the unemployment rate in Northern Ireland was 2.3%, which is also lower than the UK-wide equivalent of 3.7%. The inactivity rate in Northern Ireland was 26.0%, higher than the UK-wide equivalent of 21.4%.
 - Median weekly earnings in Northern Ireland for all workers stood at £468.60, compared to £504.40 for the UK as a whole in April 2021. Gross weekly median earnings grew by 8.5% in the year to April 2021 in Northern Ireland, while they grew by 5.3% across the UK as a whole.

Cost of living

- 4.9 In April 2022, inflation reached its highest recorded level for 40 years, affecting the affordability of goods and services for households. Increases in the costs of consumer goods, underpinned by strong demand from consumers and supply chain bottlenecks, have been one factor behind rising inflation.
- 4.10 Another important driver of inflation is energy prices, with household energy tariffs increasing and petrol costs going up. In the year to April 2022, domestic gas prices increased by 95.5% and domestic electricity prices by 53.5%, due in part to a return of global gas demand as pandemic restrictions are lifted and lower than normal production of natural gas.
- 4.11 On 3rd February, the regulator Ofgem announced that the domestic energy price cap would increase from £1,277 per year to £1,971 in April 2022; a 54% increase and then a further increase in October 2022, of 42%, to around £2,800.
- 4.12 Changes are also being made to personal taxes in 2022/23. The Institute for Fiscal Studies said that those earning between £10,000 and £25,000 will pay less in personal taxes (income tax and NICs) following the changes announced by the Chancellor of the Exchequer in the Spring Statement, while those earning above £25,000 will pay more. The OBR expects that household disposable incomes adjusted for inflation will fall by 1.5% in 2022 and a further 0.2% in 2023.
- 4.13 There is evidence to suggest that households with lower incomes will be disproportionately impacted by the rise in the cost of living as expenditure on food and non-alcoholic drinks, housing, fuel and power as a percentage of total expenditure decreases as incomes increase (Figure 4.1).

Figure 4.1: Household expenditure on food and non-alcoholic drinks, housing, fuel and power as a percentage of total expenditure by income decile, United Kingdom, 2019



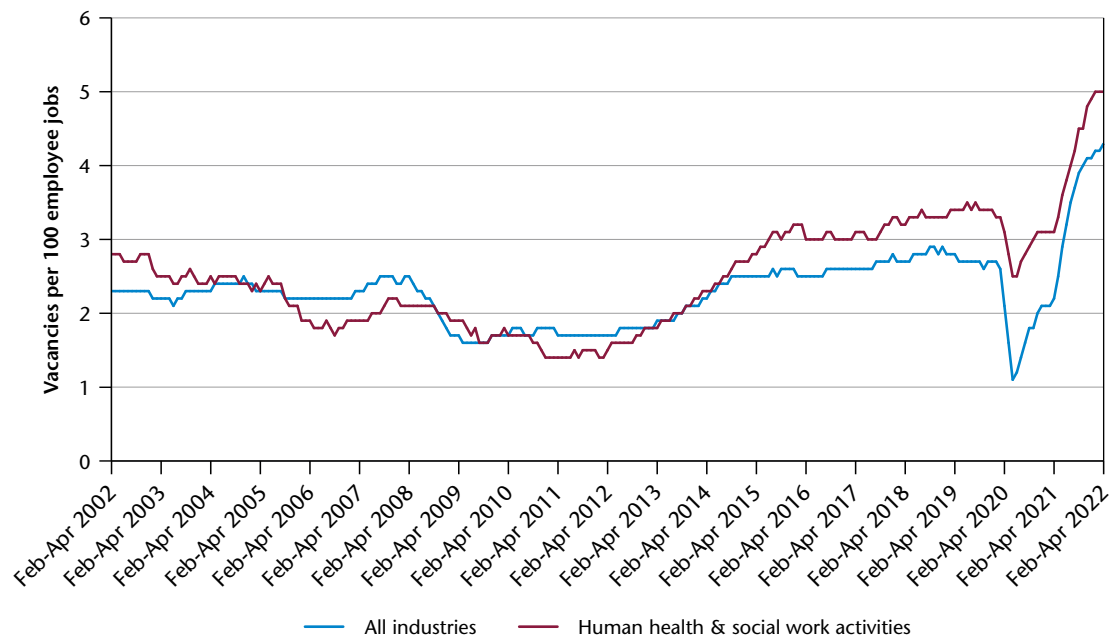
Source: ONS, Living Costs and Food Survey

- 4.14 Staff living and working in rural areas often commute longer distances to work which means their travel costs will be disproportionately impacted.
- 4.15 As set out at paragraph 1.10, the Energy Bills Support Scheme has been doubled to a one-off £400 payment which will now be made as a grant and a £650 one-off Cost of Living Payment will be made to those on means tested benefits, which affects over eight million households.

Labour market

- 4.16 The number of job vacancies in February to April 2022 rose to a new record of 1,295,000 (4.3 vacancies per 100 employee jobs); an increase of 499,000 from the pre COVID-19 pandemic level of 796,000 (2.6 vacancies per 100 employee jobs) in January to March 2020.
- 4.17 Compared to the previous year, job vacancies overall increased by 630,000. In human health and social care, job vacancies increased 60% to 212,000 (5.0 vacancies per 100 employee jobs).

Figure 4.2: Vacancies per 100 employee jobs, UK, seasonally adjusted, February to April 2002 to February to April 2022



Source: ONS, Vacancy Survey

- 4.18 A record number of vacancies means employers have had to raise pay and improve their flexible working offer to boost recruitment and retention according to CIPD's Labour Market Outlook²⁰, and, even with improvements in their offer, almost half of employers (45%) had hard to fill vacancies. These are most common in healthcare (54%) which shows high level of movement in the job market.

Alternative labour market for NHS staff

- 4.19 The NHS is the largest employer in the UK and the NHS can offer opportunities and economic security for its staff, especially in areas where there has been a reduction in economic opportunity. However, NHS employers are facing significant challenges given the level of vacancies across the economy and competitive reward packages on offer.
- 4.20 In oral evidence, Employers and the Staff Side told us that staff at the lower bands were leaving for other entry level roles where organisations offered higher basic pay. The six biggest supermarkets in the UK have all raised their starting wages to at least £10 p/h. Aldi, Lidl, Asda and Tesco have raised their hourly rate to £10.10 and Morrisons and Sainsburys to £10. Amazon is also offering entry-level warehouse operatives a starting salary of £10 p/h. As international travel has opened up again, airports have begun recruitment, with Manchester Airport and Stansted Airport advertising entry level Security Officer roles starting at £12.04 p/h and £14.00 p/h, respectively. This is compared to Band 2 roles in the NHS which are being advertised with a starting salary of £9.65 p/h, Band 3 roles at £10.40 p/h and Band 4 roles at £11.53 p/h. Social care providers are also experiencing the same challenges.

²⁰ Winter 21-22 <https://www.cipd.co.uk/knowledge/work/trends/labour-market-outlook#gref>

- 4.21 In response to high waiting lists, the pandemic has accelerated the demand for private healthcare with an increase in spending on private healthcare across 2020-2022, according to the Institute of Fiscal Studies. This trend will mean an increase in demand for staff in private healthcare. Although base pay is often not higher, the total reward packages are competitive with the NHS and all parties have told us that the working environment is often significantly less pressured and offers more opportunities to work flexibly. These opportunities may be more attractive to senior healthcare professionals who have gained substantial experience in the NHS.

Our assessment of the economy and labour market

- 4.22 The UK Government is still carrying high levels of debt and expects to pay £83bn in interest in 2022/23, more than twice the level expected in the October 2021 forecast. The OBR now expects CPI inflation to peak at 8.7% in the fourth quarter of 2022, and RPI to peak at almost 11% at the same time, while the Bank of England expects CPI to peak at around 10%.
- 4.23 HM Treasury told us that public sector pay increases could exacerbate temporary inflationary pressure, for instance through spilling over into higher wage demands across the economy or contributing to higher inflation expectations, then these short-term pressures would become more sustained. HM Treasury added that, in turn, this would exacerbate cost of living pressures, as higher pay awards were offset by higher inflation, and would require significantly tighter monetary policy to address, which would also harm growth.
- 4.24 Independent forecasts and the OBR both suggest the economy will continue to grow strongly, by almost 4% in 2022, although the unprecedented rise in the cost of living could squeeze consumer spending. Data show that the number of employees on payrolls in April 2022 rose by 4.2% compared with April 2021, a rise of 1,187,000 employees; the number of pay rolled employees was up by 3.3% since April 2020, a rise of 931,000. Future levels of employment are dependent on the strength of any economic recovery.
- 4.25 We note the CIPD forecast of employment intentions and the current state of the labour market. Employers are increasingly having to raise basic pay and offer flexible working opportunities to recruit to hard-to-fill vacancies²¹.
- 4.26 The latest headline estimates show growth in average total pay (including bonuses) was 7.0% and growth in regular pay (excluding bonuses) was 4.2% among employees in the three months to March 2022.
- 4.27 HM Treasury told us in evidence average pay settlements are the appropriate measure of earnings growth to consider in setting public sector pay settlements. The latest data from XpertHR shows settlements for 2022 in the three months to April at 4%.

²¹ CIPD. 2022. *Labour Market Outlook | Surveys | CIPD*. [online] Available at: <<https://www.cipd.co.uk/knowledge/work/trends/labour-market-outlook#ref>>

- 4.28 Vacancies are currently at record levels and, as set out at paragraph 4.17, there has been a 60% increase in vacancies across human health and social care. In order to compete, employers are having to raise their base pay and flexible working offers.
- 4.29 We note the evidence set out at 4.20 that the market for entry level and lower paid jobs has recovered quickly as the wider labour market has recovered following the COVID-19 pandemic. In evidence, both the Employers and Staff Side told us about the particular recruitment and retention issues they are witnessing at the lower bands where staff are opting for lower stress jobs in other industries, with higher base pay.
- 4.30 We also note the consensus among parties that Band 2 jobs can be complex, with important responsibilities for patient safety and patient care, and the shared view of the Employer and Staff Side that Band 2 roles should be benchmarked against the Living Wage Foundation's Wage real Living Wage to overcome recruitment and retention challenges. We note that the NHS in Wales and Scotland have already committed to this.
- 4.31 As discussed above, there is an active alternative employment market for lower banded staff where alternative employers are paying well over the Living Wage Foundation Real Living Wage for entry-level roles. This supports the view of Employers and Staff Side that pay at Band 2 needs to be increased sufficiently to be able to compete in current labour market conditions.
- 4.32 Whilst we note that a significant proportion of the total reward for NHS workers comes from other benefits, base pay rates need to continue to be set at levels that allows the service to compete widely and make the NHS the employer of choice in local markets. Although in usual circumstances a total reward package may be attractive, the recent increase in the cost of living means there will be many AfC staff who are making difficult choices about what additional benefits they can afford to take advantage of. For example, staff may look to opt out of the NHS Pension scheme to increase their take-home pay.
- 4.33 The LPC have estimated that the NLW will rise further to £10.32 (within a range of £10.14 to £10.50) in April 2023. This relatively sharp projected trajectory of the NLW poses a particular challenge for setting pay at the bottom of the AfC scale. We note that this year, the Government had to provide a temporary uplift to Band 1 and some Band 2 staff to be legally compliant with the NLW. A pattern of temporary adjustments could exacerbate already substantial recruitment and retention issues.
- 4.34 We note the concerns that increases in pay could feed into a wage-price spiral, although also recognise there are other fundamental drivers of current inflation challenges. As earnings growth remains substantially below inflation, we judge that increases in earnings present a much lower risk to increasing the rate of inflation compared to some of the other fundamental drivers. We are aware that there is competition for workforce between the NHS and adult social care providers and, at present, both industries are facing staff shortages as employers in other industries raise their base pay.

- 4.35 AfC staff working in rural areas of the UK will feel an additional impact as they often rely on alternative fuel sources such as oil which are not covered by Ofgem’s increased price cap, which covers both England and Wales. We note that travel costs are also an issue of concern to community staff and those who have to travel far distances for work. If mileage rates do not keep pace with fuel inflation, this will impact on household disposable income.

NHS funding, demand and affordability

NHS Demand

- 4.36 The health needs of the population are changing. The UK has an increasingly aging population with more complex health needs and there is no doubt that the COVID-19 pandemic has exacerbated the pressure on the NHS. The NHS in England now has the highest waiting lists ever recorded, with 6.35 million patients on waiting lists in March 2022 and as set out at paragraph 2.19, the UK Government has committed to additional investment in England to recover the elective backlog.
- 4.37 However, it is not currently clear how high the waiting list will rise. As set out by the IFS, the number of ‘missing patients’ yet to come forward for treatment is unknown and so it is anticipated that waiting lists could increase further, potentially to over ten million patients by the end of 2023.
- 4.38 Additionally, paragraph 2.60 sets out the interdependencies between social care and the NHS. There is evidence that shows that recent delays to hospital discharge have been caused by the pressured situation in social care where there is insufficient capacity to meet the demand.

NHS funding

- 4.39 A five-year funding plan for the NHS from 2019/20 was set out in June 2018 and, for England, enshrined in law in the NHS Funding Act 2020. Funding was allocated to clinical commissioning groups (CCGs) in England via allocations that included a growth assumption for pay awards. The funding allocations for the devolved administrations for Northern Ireland and Wales are determined using the Barnett formula. The Barnett Formula allocates a population share of changes in NHS spending in England to Northern Ireland and Wales.
- 4.40 Money for pay awards for the HSC in Northern Ireland is allocated annually by the Department of Health. Given that AfC staff in Northern Ireland work in both health and social care, the cost impact of a pay award will be greater in Northern Ireland than the rest of the UK. At the time of writing, the Department of Health, Northern Ireland, told us that it has not yet been possible for a Budget to be set for 2022/23 and therefore there is not an agreed public sector pay policy. However, the Department of Health told us in oral evidence that they did not have an official view on monetary value but would be supportive of a fair pay rise. The Welsh Government told us in oral evidence that the budget available has to cover both pay for staffing and service delivery across health and social care. They would be relying on Barnett consequential to fund an uplift above spending review levels.

- 4.41 There was a lack of consensus amongst the parties on whether it was right to look at a “trade-off” between funding for pay and funding for other clinical priorities. DHSC said there was a trade-off – any additional funding for pay would require re-prioritisation of other priorities, including the size of the workforce that is affordable as well as wider investments required to deliver the NHS Long Term plan. NHS Providers told us that they reject the concept of a “direct trade-off” between more funding for pay and staff numbers. They told us these are interdependent factors, as fair pay helps to attract high quality staff and support their retention.

Affordability

- 4.42 Paragraphs 3.256-3.258 set out what the Government told us about the affordability of a pay uplift. In settling the DHSC and NHS budget, which totals £173.8bn, the Government assumed a headline pay award of 2% for NHS staff. The department has an additional 1% “contingency” which it is choosing to make available for AfC pay, providing an overall affordable headline pay award of up to 3%. Allocating the contingency to pay means that there will not be funding for other priorities. They told us any additional funding would have to come from within existing budgets, therefore, there was a direct trade-off between pay and other priorities.
- 4.43 The NHSEI 2022/23 priorities and operational planning guidance set out the priorities for the full year including accelerating plans to grow the substantive workforce and deliver significantly more elective care. Across the priority areas, the guidance recognises the need to maintain focus on preventing ill-health and tackling health inequalities. Additionally, within the funding, the NHS is expected to deliver significant additional efficiencies, on top of the NHS Long Term Plan requirements, to address the excess costs driven by the pandemic response, moving back to and beyond pre-pandemic levels of productivity.
- 4.44 NHS Employers and Providers told us that given the significant efficiencies that were being asked of employers, any pay uplift needed to be fully funded to ensure there would be enough staff to tackle the elective backlog given the significant recruitment and retention challenges they were facing. NHS Employers also confirmed that they did have 2% allocated in their budgets for pay, but that Trusts are also being asked to deliver significant efficiency savings alongside the Build Back Better plan.

Productivity

- 4.45 Paragraph 3.57 sets out the five tests laid out by the Government to increase productivity and put the NHS on a sustainable footing for the future. Test 2 sets a target of making re-investable productivity gains of at least 1.1% a year over the next five years. However, in March 2022, the Government doubled this to 2.2% which would be expected to free up £4.75 billion to fund NHS priorities over the next three years.
- 4.46 The COVID-19 pandemic has undoubtedly impacted the productivity of the NHS. The pressure the crisis placed on the NHS led to significant changes in service provision and will have some lasting effects.

- 4.47 Increased infection prevention and control measures have led to a reduction in absolute capacity. For example, greater distances between beds on wards and areas designated for donning and doffing of PPE has led to a significant reduction in available space and thus absolute bed capacity.
- 4.48 In response to the pandemic, there has been a swift uptake of digital technology across the NHS and we heard from parties about the importance of digital technologies in driving efficiency and productivities. We also heard that digital technologies are key to organisations being able to offer flexible working. For example, Electronic Patient Records make it easier for AfC staff to conduct virtual appointments and therefore improves their ability to work flexibly. However, it was clear from evidence that digital technologies are not being used consistently across the NHS.
- 4.49 NHS staff are key to the successful implementation of productivity measures. Staff engagement is critical to improving productivity and influences staff members' willingness to contribute the discretionary effort on which the NHS relies.

Our assessment of NHS funding, demand, affordability and productivity

- 4.50 There is no doubt that continued operational pressures will continue to impact NHS services and the workforce in the medium term and the NHS needs sufficient staff to support the level of funded demand for NHS services.
- 4.51 The cost of a pay award is such that, including on-costs such as NHS Employers National Insurance contributions and employer's pension contributions, each 1% increase in pay would add £500.5 million to the AfC paybill in England in 2022/23 based on the 21/22 paybill.
- 4.52 The DHSC said that over the three-year period between 2018/19 and 2020/21, overall pay drift had averaged just 0.1% per year. This comprised +0.3% per year basic pay drift, which was almost offset by a -0.2% staff mix effect, with no additional earnings drift.
- 4.53 For the devolved administrations, each 1% increase in pay would add £29.5 million in Northern Ireland and £37.5 million to the AfC pay bill in Wales.
- 4.54 We are very clear that the fiscal position remains challenging and are mindful of the many competing claims on public spending. The Government has already committed to additional NHS funding and has decided to spend it largely on elective recovery.
- 4.55 While we acknowledge that money spent on staff pay is subsequently not available for other NHS costs such as drugs or procedures, it is not so clear-cut that increased funding for pay reduces the money available for the recruitment of new staff. The total wage bill is a function of many things, including the numbers and cost of substantive staff and of temporary staff. Increased attrition and high vacancy rates increase the costs of temporary staff. They also reduce the number of experienced staff and teams available to deliver the service required for patients.

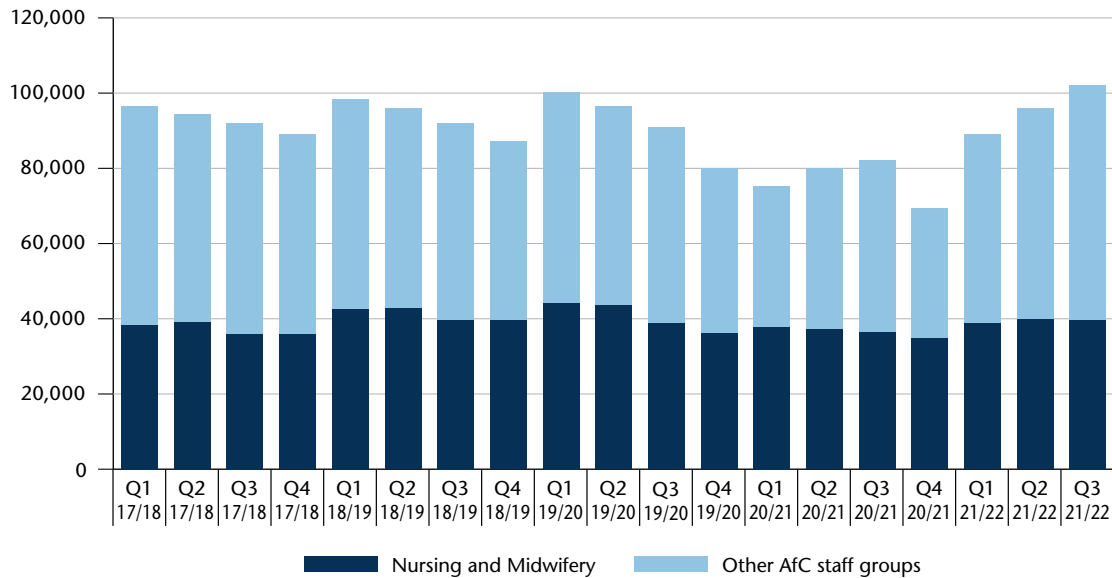
- 4.56 We acknowledge that some fraction of a pay increase would come back to HM Treasury via tax and increased NICs but note that this would be true of many other types of public spending.
- 4.57 We note the NHS’s efficiency target set by the Chancellor and note that staff remain key to delivering efficiencies across the service. High levels of staff engagement are key to improving productivity.

Vacancies and workforce planning

Vacancies

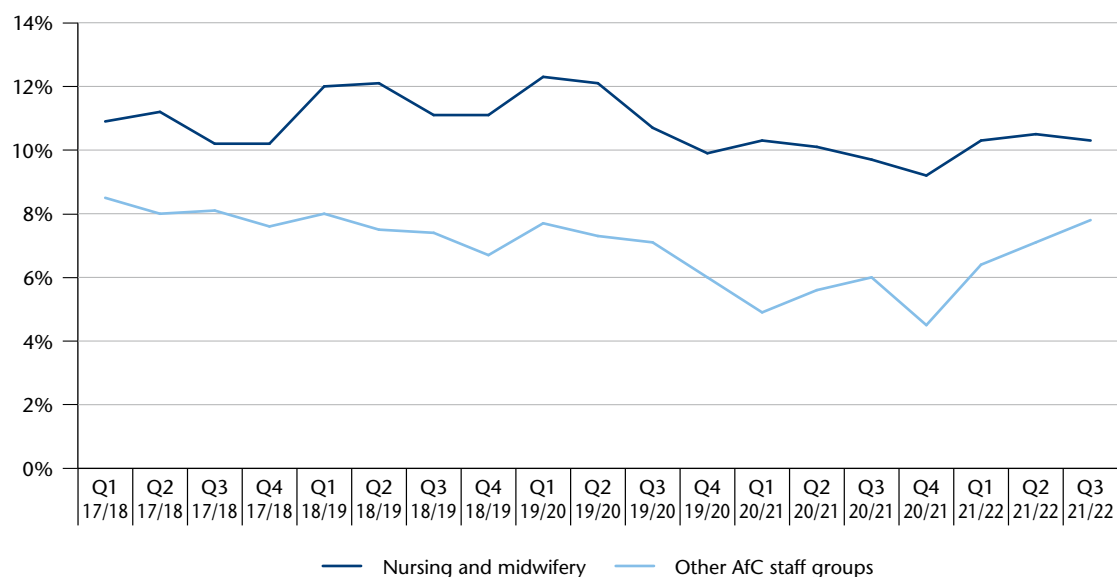
- 4.58 NHSEI publishes quarterly estimates of vacancies across the NHS in England. The latest data, for the third quarter of 2021/22, to December 2021, showed that overall, there were 102,034 AfC vacancies in the NHS, of which 39,652 were nursing and midwifery vacancies (Figure 4.4).

Figure 4.3: NHS Provider vacancies, England, 2017/18 quarter 1 to 2021/22 quarter 3



Source: OME calculations based on NHSEI data

- 4.59 Figure 4.4 shows that in the third quarter of 2021/22 the nursing and midwifery vacancy rate was 10.3%, up from 9.7% in the same quarter a year earlier. The vacancy rate for non-nursing and midwifery AfC staff groups was 7.8%, up from 6.0% in the same quarter a year earlier. This is the highest rate recorded since the first half of 2018.

Figure 4.4: NHS Provider vacancy rates, nursing and midwifery and other AfC staff groups, England, 2017/18 quarter 1 to 2021/22 quarter 3

Source: OME calculations based on NHS E&I data

- 4.60 The government told us they believed that vacancies were artificially low during the pandemic, which was causing the increase now. The NHS Long Term Plan sets out an aim to improve the nursing vacancy rate to 5% by 2028, but Employers and Providers told us they were experiencing vacancy rates much higher than 5% and higher than those recorded pre-pandemic.
- 4.61 Whilst in recent years, the focus has been on reducing nursing vacancies, we note that nursing vacancy rates have returned to over 10% and we note the additional marked rise in vacancies in other AfC staff groups which is consistent with evidence we heard from parties about the particular recruitment and retention challenges at Bands 1-4.
- 4.62 The NHS in **Wales** had 2,726 advertised vacancies for non-medical and dental staff in August 2021 (Table 4.1), up from 1,687 in August 2020, an increase of 62%. Except for healthcare scientists, the number of advertised vacancies increased by at least 30% for each staff group.

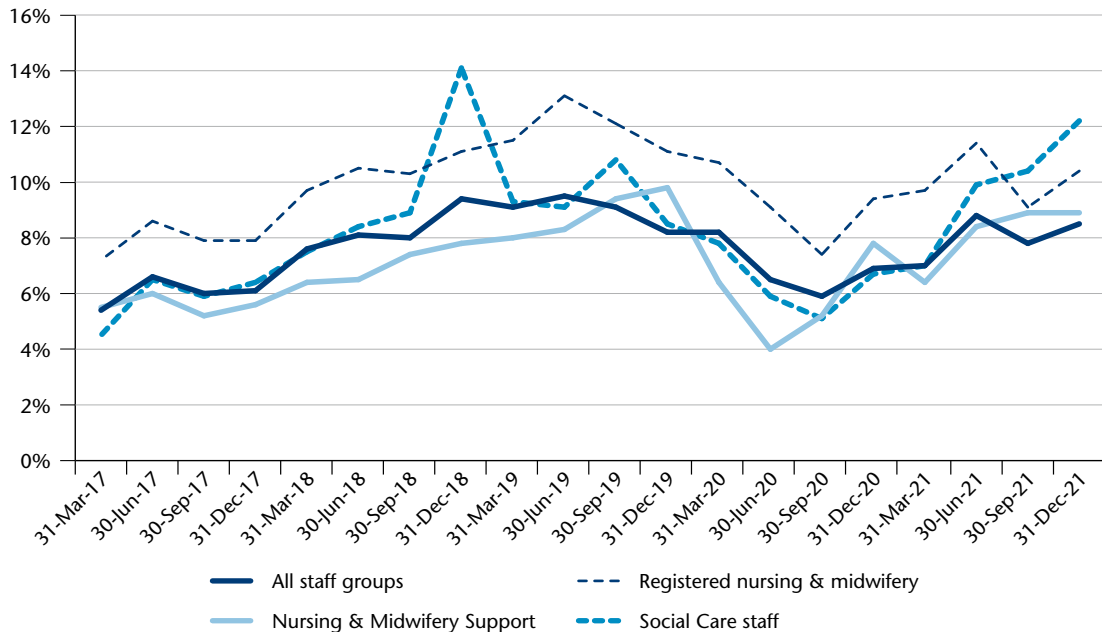
Table 4.1: NHS Wales, advertised vacancies, by staff group, August 2020 and August 2021

	August 2020	August 2021
	Vacancies	
All Staff Groups (exc medical and dental)	1,687	2,726
Add Prof Scientific and Technic	54	127
Additional Clinical Services	341	509
Administrative and Clerical	365	730
Allied Health Professionals	121	197
Estates and Ancillary	50	192
Healthcare Scientists	54	57
Nursing and Midwifery Registered	702	914

Source: Welsh Government

- 4.63 For Northern Ireland the most recent data shows that at the end of December 2021 there was an overall vacancy rate of 8.5%, an increase from 6.9% a year earlier (Figure 4.5). Over the same period, registered nursing and midwifery vacancies increased from 9.4% to 10.4%, nursing and midwifery support staff vacancies increased from 7.8% to 8.9%, and social care staff vacancies increased from 6.7% to 12.2%.

Figure 4.5: HSC, Northern Ireland, vacancy rate, March 2017 to December 2021

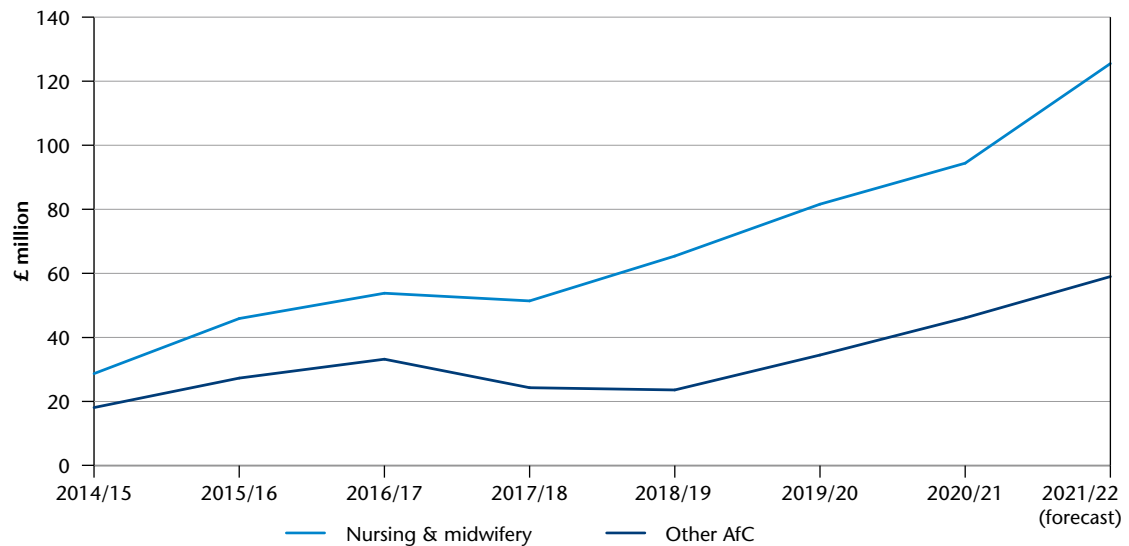


Source: Department of Health, Northern Ireland

Supply of bank and agency staff

- 4.64 Bank and agency staff are an important source of temporary staffing, which allows trusts to respond to fluctuations in demand. While both bank and agency are used to fill gaps in the short term, employers generally see banks as more cost-effective and offering greater continuity of care, compared with the use of agency staff.
- 4.65 Paragraphs 3.107 - 3.116 set out the parties' evidence on the current status of bank and agency usage in England, Northern Ireland and Wales. In England, the total agency spend as a percentage of total wage bill has continued to decrease and this has largely been delivered by the NHS reducing the proportion of shifts filled by agency staff from 28% in 2018/19 to 23% in 2020/21.
- 4.66 The Welsh Government's evidence points to expenditure on nursing and midwifery increasing significantly. Expenditure to cover non nursing and midwifery AfC posts has also increased sharply, from £23.6 million in 2018/19 to £46.1 million in 2020/21, with a further increase to £59.0 million (28%) forecast for 2021/22 (Figure 4.6).

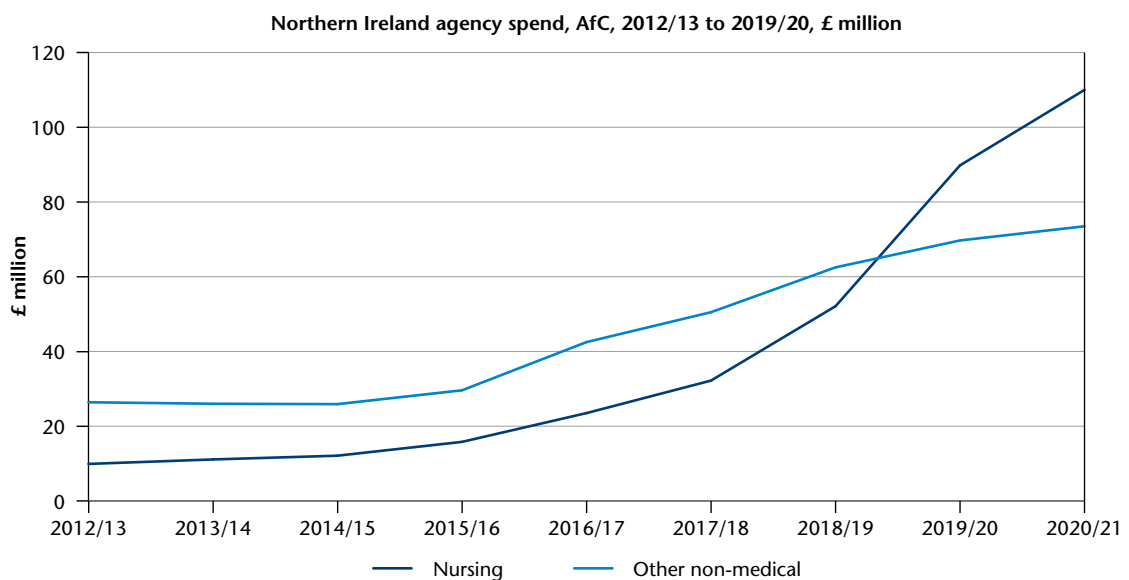
Figure 4.6: Agency spend, for AfC staff groups, Wales, 2014-15 to 2021-22



Source: Welsh Government

4.67 Figure 4.7 shows agency spend in Northern Ireland for nursing and other non-medical staff, increasing sharply since 2014/15, from £38 million, to £184 million in 2020/21. The increase in expenditure on nursing staff over that period was particularly large, from £12 million to £110 million. In addition, the Department of Health said that spending on staff through banks in 2020/21 was £107 million, of which £76 million was on nursing and midwifery staff.

Figure 4.7: Agency spend, for AfC staff groups, Northern Ireland, 2012/13 to 2020/21



Source: Department of Health, Northern Ireland

Our assessment of vacancies

- 4.68 Some level of vacancies is inevitable, as staff move into and out of roles in the NHS and HSC. However, vacancy rates at persistently high levels have the potential to impact on service delivery and patient experience, as well as adding to the pressures on staff in place. The 2021 staff survey results for England show only 43.7% of staff said they felt able to meet all the conflicting demands on their time and 46.9% said that they had felt unwell as a result of work-related stress. There is a further financial cost from carrying vacancies on a persistent basis, as gaps need to be filled through the use of banks or agencies which are frequently more expensive.
- 4.69 Vacancy rates have increased since the impact of the pandemic has subsided and, as discussed, the nursing vacancy rate remains above 10%, which is over double the 5% aim for 2028, expressed in the NHS Long Term Plan for England.
- 4.70 We heard consistently in evidence that safe staffing levels are a leading concern for staff. As set out in 2.61, the King's Fund have commented that there is a vicious circle of staff shortages, excessive workloads and worse patient care. Inadequate staffing levels place an additional burden on the staff in post and can impact on the quality of care patients receive. The recent Ockenden Review found maternity care fell, sometimes significantly, short of the required standards due to unsafe staffing levels.
- 4.71 In oral evidence, we asked parties about the appropriate levels of vacancies. We heard a broad range of views which were at various levels of development. Looking forward, it is important that workforce plans include a consensus on the appropriate vacancy level and plans to assess current vacancy levels by professional staff group across the AfC workforce.
- 4.72 In previous reports, we have also discussed the impact of vacancies on retention given the additional pressure they place on the remaining staff. A focus on retention is therefore needed both to provide safe patient care but also to prevent a vicious circle in which a reduced number of staff pushes more staff into a decision to leave, thereby creating even more risk. In oral evidence, Trust Chief Executives also told us that the workload created by persistently high vacancy levels undermine their ability to move forward with important strategic projects.
- 4.73 Additionally, the pressure placed on existing staff by high vacancy levels stops staff from accessing resources, such as development opportunities, which are important retention and career development mechanisms.

- 4.74 We are particularly concerned that the Staff Survey for England for 2021 showed a sharp decline in the percentage of staff saying there are enough staff in their organisation for them to do their job properly – from 38.5% in 2020 to 27.4% in 2021. Although bank and agency staff provide support across the service for some roles, the lack of a substantive workforce can impact on the continuity, and quality of care provided to patients. We have also heard about the way morale can be impacted by working alongside staff members who are being paid significantly higher rates for doing a similar job and so we believe the use of agencies to fill gaps should be a last resort. We note the welcome progress that has been made in England, reducing agency spend from £3.6 billion in 2015/16 to £2.4 billion in 2020/21.
- 4.75 Agency spend, however, increased sharply in Wales between 2017/18 and 2020/21. The Welsh Government said it continues to work on the All Wales Collaborative Bank Partnership to reduce the reliance on premium cost nursing agency spend. We urge the Welsh Government to look at the drivers of the spend and continue to work on the Bank Partnership to reduce their agency spend.
- 4.76 We continue to have significant concerns about the agency spend in Northern Ireland which remains at persistent high levels. Agency spend has risen sharply since 2015/16 and despite a recent fall in vacancy rates, shows no sign of levelling out or falling. The Department of Health, Northern Ireland told us they aim to end off-contract agency spending by the end of next year but did not expect any immediate progress. We judge that this issue needs to be resolved as soon as feasibly possible and urge Northern Ireland to continue their work to reduce their agency spend.

Workforce planning

- 4.77 We heard a consensus about a sizeable overall AfC workforce gap, the required action and the need to front-load the response to close the gap. We also understand that international recruitment has increased since the pandemic restrictions on international travel were reduced. We note the importance all parties place on ethical recruitment which underpins the ongoing success of this strategy. However, we note the latest data shows Nigeria and Ghana are in the top five countries of people joining the permanent register by country of training outside the EU/EEA. Active international recruitment is not permitted in either of these countries.
- 4.78 The NHSEI operational planning guidance 2022/23 rightly acknowledges that to support the restoration and recovery of services, the NHS needs more people, working in a compassionate and inclusive culture where leaders at all levels inspire, empower and enable them to deliver high quality care in the most effective and efficient way. The guidance asks employers to enable this through actions including improving retention, supporting health and wellbeing and expand training routes, including apprenticeships.

- 4.79 The Government told us that the Health and Care Act aims to improve workforce planning and supply in England. The new duty is set out at 2.16. NHSEI and HEE told us they saw their merger as a positive step; however, concerns were raised over the security of the funding for training and education.
- 4.80 The Welsh Government told us their workforce planning approach, which has been in place for a number of years, and that they were considering the way in which the approach might be improved and developed. They pointed out that supply and the funding constraints have impacted on how effective the approach has been to date. They had not anticipated the impact of COVID-19 on recruitment, which has led to increased demand, and recruitment has been challenging.
- 4.81 The Department of Health Northern Ireland told us that the implementation of their workforce strategy had been slowed due to the pandemic, but they were due to continue implementation with a three-year plan due to be signed off by the Minister for Health.

Our assessment of workforce planning

- 4.82 We note the ambition of all parties that workforce planning should be improved. If there are too few people available to work in the NHS, that increases the load on existing staff and creates recruitment and retention pressures. We also note predictions for the numbers of staff required are a function of the level of ambition for the service, planned funding, and changes to service delivery methods. Unless all of these considerations are part of the planning process, the existence of such a process will not in itself prevent over or under supply.
- 4.83 Whilst delivery methods are largely clinical and operational decisions, the levels of ambition and funding decisions are long term and political and will be impacted by unforeseen events.
- 4.84 The structure of the NHS means that a number of independent bodies are inevitably parties to a workforce planning process. Formal forecasting processes are important in understanding how the workforce needs to grow. Not all assumptions will prove to be correct and in-flight course correction will be part of the assessment process. We note the experience in Wales and in midwifery where formal forecasting processes have been used and staffing shortages remain. It will be key that all parts of the NHS system are able to collaborate and to coordinate using common data and effective systems. We would urge the Government carefully to consider the appropriate method for forecasting future workforce numbers based on their objectives and horizon of interest.
- 4.85 We also note the progress of Northern Ireland and Wales regarding workforce planning. We welcome the planning ambitions of the Welsh Government and note the significant challenges for the health service to overcome before those ambitions are realised.

- 4.86 We would also urge Northern Ireland to continue to work towards a comprehensive workforce plan.

Morale and motivation

- 4.87 A key element of our terms of reference is the motivation of AfC staff and in this section, we comment on the latest employee opinion data from the staff survey held in England. Northern Ireland and Wales did not carry out Staff Surveys this year.

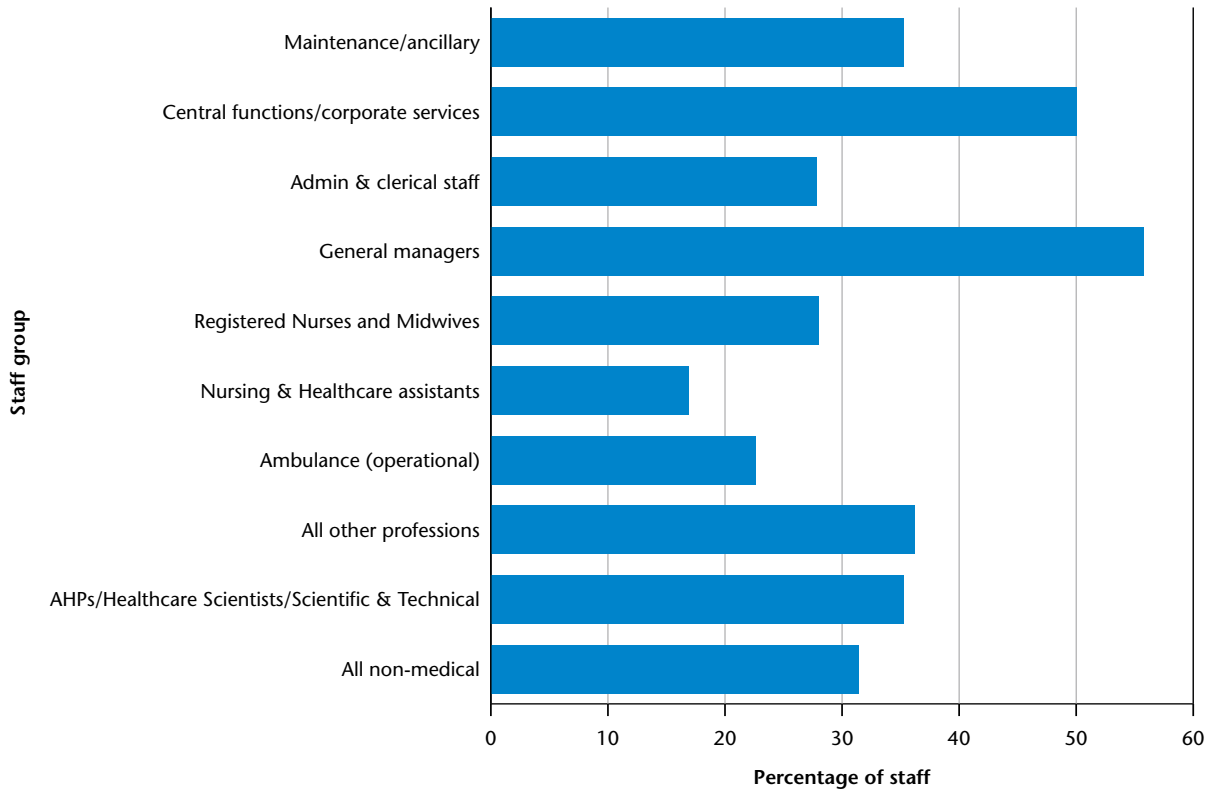
NHS Staff Survey (England)

- 4.88 Since our 2021 Report, the survey of NHS staff in England has been published. It was conducted between September and December 2021. There were 649,000 responses, a response rate of 48%, up slightly from 47% in 2020.
- 4.89 Figure 4.8 shows AfC staff satisfaction²² with pay in 2021, by staff group. Overall, 31% of staff responded positively to the survey, saying they were satisfied with pay, compared with 44% who said they were dissatisfied²³.
- 4.90 Breaking the figures down by staff group shows that general management (56%) and staff in central functions/corporate services (50%) were most likely to say that they were satisfied with pay. The staff groups least likely to say they were satisfied with their pay were nursing and healthcare assistants (17%), ambulance staff (23%) and registered nurses and midwives (28%).

²² In each case, satisfied refers to participants answering that they were “satisfied” or “very satisfied” with their level of pay.

²³ In each case, dissatisfied refers to participants answering that they were “dissatisfied” or “very dissatisfied” with their level of pay.

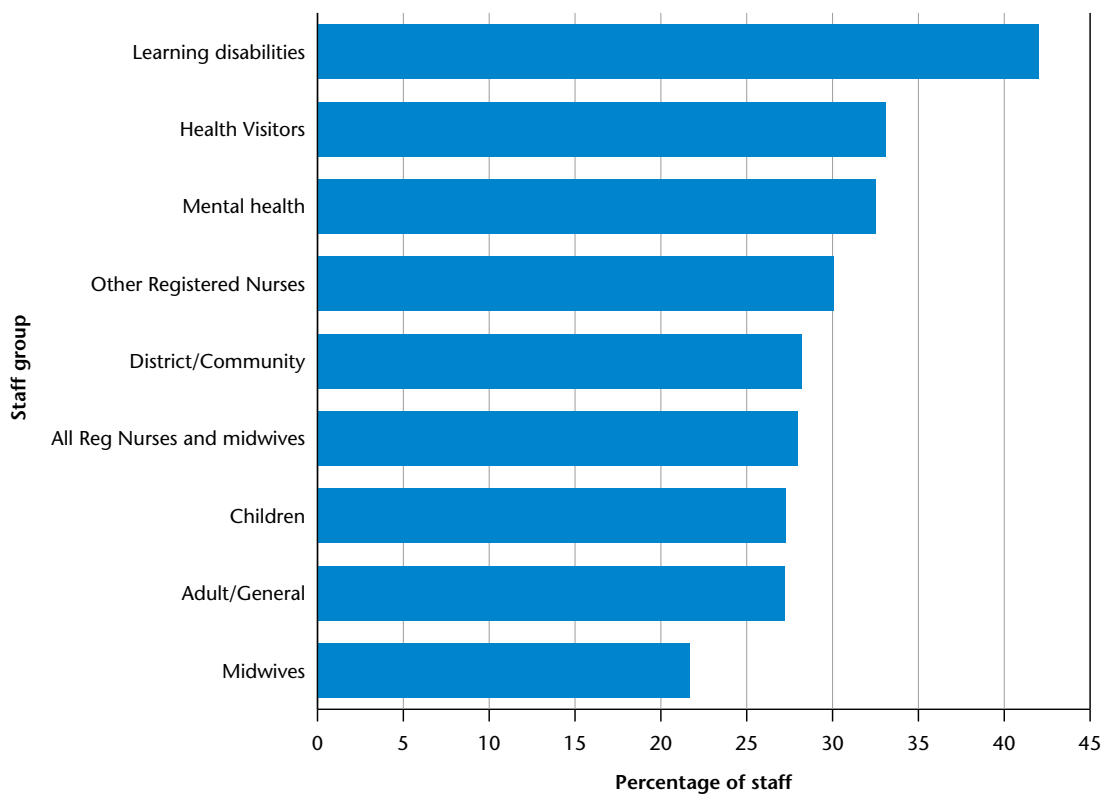
Figure 4.8: Satisfaction with level of pay by staff group, England, 2021



Source: National NHS Staff Survey (England)

4.91 Within registered nurses and midwives, satisfaction with pay varied by category (Figure 4.9). Overall, 28% of registered nurses and midwives said that they were satisfied with their pay, but within that total satisfaction with pay for different groups ranged between 42% for learning disabilities nurses and 22% for midwives.

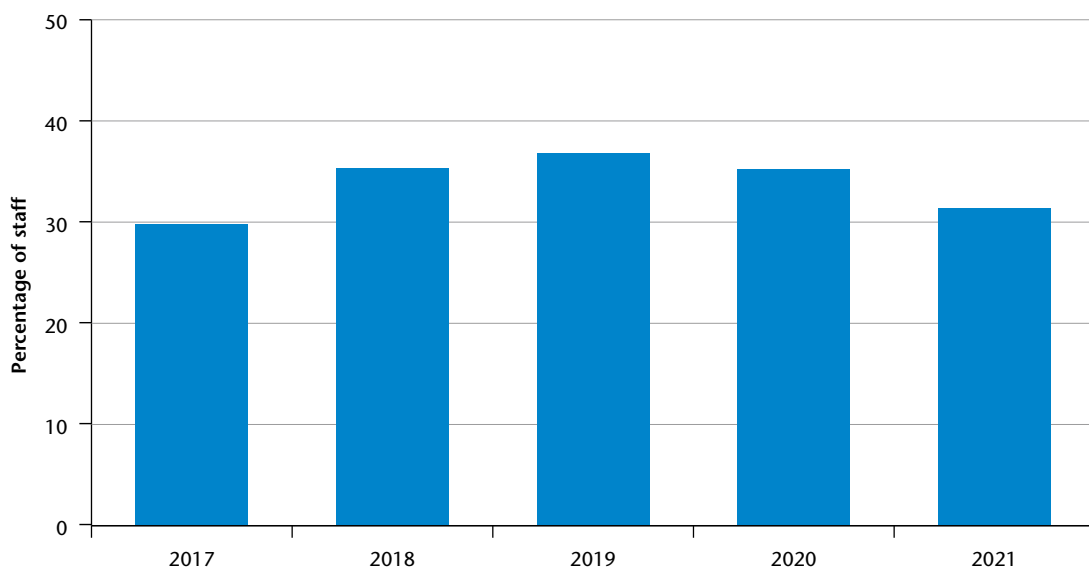
Figure 4.9: Satisfaction with level of pay, registered nurses and midwives, England, 2021



Source: National NHS Staff Survey (England)

4.92 Figure 4.10 shows AfC staff satisfaction with pay between 2017 and 2021. Satisfaction with pay declined in 2021, compared with 2020, by 4 percentage points. In 2021, 31% of staff responded positively to the survey, saying they were satisfied with pay, compared with 35% in 2020, 37% in 2019, 35% in 2018 and 30% in 2017. Overall satisfaction with pay is at its lowest level since 2017, prior to the 2018 AfC agreement.

Figure 4.10: Satisfaction with level of pay, England, 2017 to 2021



Source: National NHS Staff Survey (England)

- 4.93 Table 4.2 below provides a selection of Staff Survey results on engagement and satisfaction. The results are considerably less positive than in 2020. The largest falls in positive responses were for recommending their organisation as a place to work (7.4 percentage points), looking forward to going to work (6.2 percentage points), the extent to which they agree that their organisation valued their work (5.7 percentage points), were enthusiastic about their job (5.6 percentage points) and the recognition they got for good work (5.2 percentage points). In addition, the percentage of respondents saying that they were considering leaving the NHS increased from 18.3% in 2020 to 22.6% in 2021. In 2021, 82.9% of respondents said that they had been appraised in the previous 12 months, a fall from 88.0% in 2019 (this question was not included in the 2020 survey).
- 4.94 Table 4.3 provides a selection of Staff Survey results on working pressures. The results are also significantly less positive than in 2020. There were falls in the percentage of respondents saying that they were able to meet all the conflicting demands on their time at work (4.5 percentage points), that they had adequate materials, supplies and equipment to do their work (2.9 percentage points), and that there were enough staff at their organisation for them to do their job properly (11.1 percentage points). In addition, there was an increase in the percentage of staff saying that during the previous 12 months they had felt unwell as a result of work-related stress. After falling in each of the previous three years, the percentage of staff saying that they worked unpaid hours over and above their contracted hours increased, while there was also an increase in the percentage of staff saying that that worked paid hours over and above their contracted hours. Amongst the new questions added to the survey this year, were questions relating to work-life balance and burnout. 53.2% of respondents said that they were able to achieve a good balance between work and home life, while 34.4% said that they always or often felt burnt out because of their work (with a further 37.7% saying that they sometimes felt burnt out because of their work).

Table 4.2: Selected job satisfaction results from the national NHS staff survey, AfC staff, England, 2017 to 2021

Measure	Question number in 2021 survey	2017	2018	2019	2020	2021	Trend ¹
Engagement and job satisfaction							
I look forward to going to work	2a	57.0	58.1	58.9	58.4	52.2	
I am enthusiastic about my job	2b	73.3	74.2	74.7	73.0	67.5	
Time passes quickly when I am working	2c	76.2	76.2	76.5	75.4	72.7	
The recognition I get for good work	4a	53.0	56.6	58.1	57.4	52.2	
My immediate manager values my work	9e	72.1	72.6	73.7	73.0	71.1	
Considering leaving the NHS ²	22d		21.1	19.7	18.3	22.6	
Recommend my organisation as a place to work	21c	59.3	61.4	63.2	66.8	59.4	
The extent to which my organisation values my work	4b	42.9	46.1	48.0	48.0	42.3	
My level of pay	4c	29.8	35.3	36.8	35.2	31.4	
Percentage of staff appraised in the last 12 months	19a	86.4	88.2	88.0		82.9	
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months ²	14a	27.5	27.7	28.0	26.2	26.9	

Source: 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.

Table 4.3: Selected working pressures results from the national NHS Staff Survey, AfC staff, England, 2017 to 2021

Measure	Question number in 2021 survey	2017	2018	2019	2020	2021	Trend ¹
Workload							
I am able to meet all the conflicting demands on my time at work	3g	45.1	45.6	46.6	48.2	43.7	
I have adequate materials, supplies and equipment to do my work	3h	54.7	55.0	56.5	60.7	57.8	
There are enough staff at this organisation for me to do my job properly	3i	31.2	32.1	32.5	38.5	27.4	
During the last 12 months have you felt unwell as a result of work related stress? ²	11c	38.5	39.9	40.5	44.2	46.9	
Achieve good balance between work and home life	6c					53.2	
Feeling burnt out because of work ²	12b					34.4	
Percentage of staff working PAID hours over and above their contracted hours? ²	10b	32.0	32.6	33.9	32.7	35.9	
Percentage of staff working UNPAID hours over and above their contracted hours? ²	10c	56.7	56.0	54.2	53.8	55.5	

Source: NHS Staff Survey (England)

Notes:

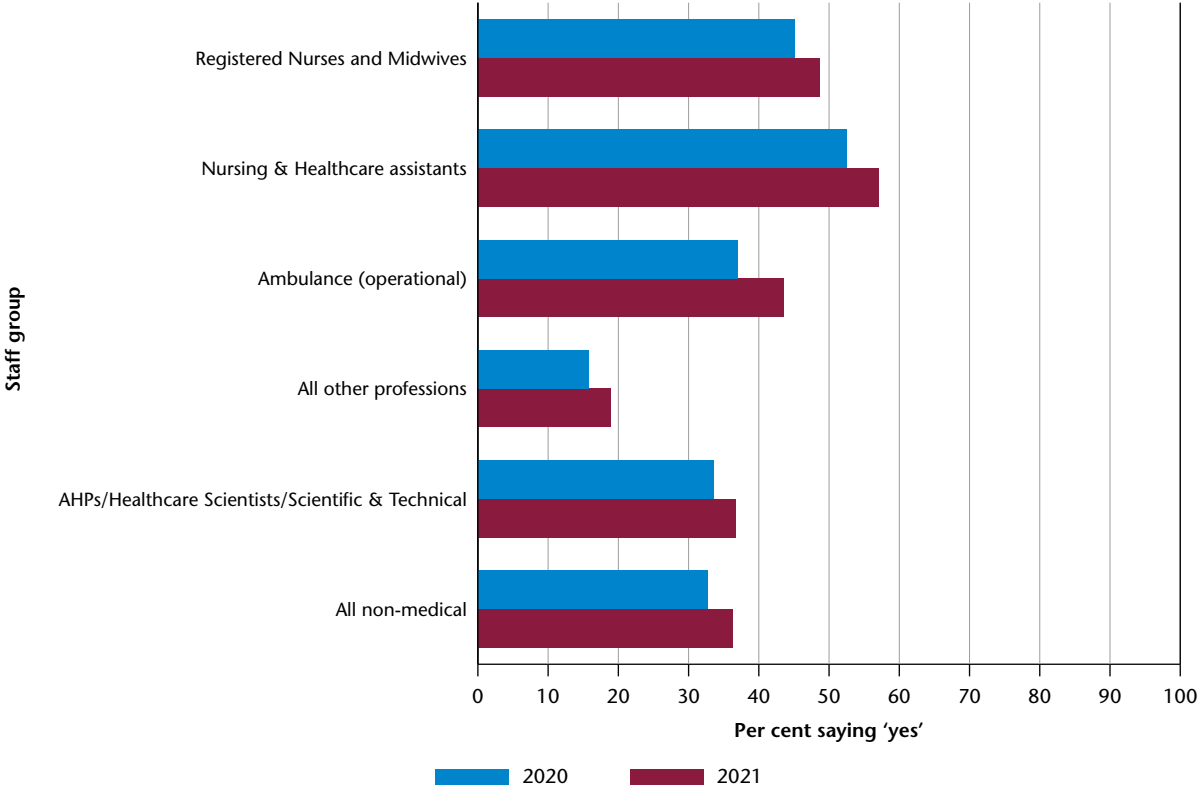
(1) Trend lines do not have any common scale; they show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed in both the context of the preceding columns and full range of possible scores for each measure.

(2) Lower scores are better in this case.

4.95 In addition to the usual range of questions, staff were asked, as part of the 2020 and 2021 surveys, about their experiences during the COVID-19 pandemic. Key points include:

- In 2021, 36% of AfC staff said that they had worked on a COVID-19 ward or area, up from 33% in 2020. Nursing and healthcare assistants, registered nurses and midwives and operational ambulance staff were more likely than staff from other groups to have done so (Figure 4.11);

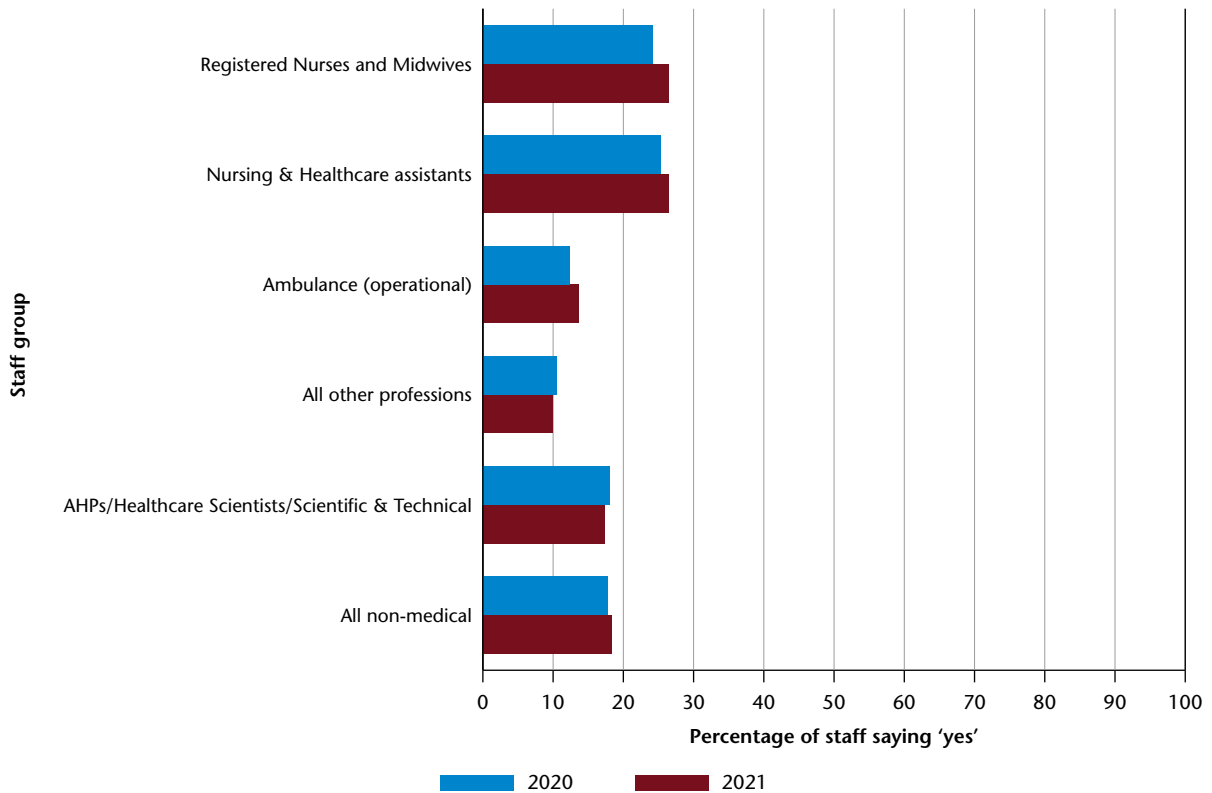
Figure 4.11: Staff saying they had worked on a COVID-19 specific ward or area, from the national NHS staff survey, AfC staff, England, 2020 and 2021



Source: NHS Staff Survey (England)

- In 2021, 18% of AfC staff said that they had been redeployed due to the COVID-19 pandemic, little changed from 2020. Nursing and healthcare assistants and registered nurses and midwives were more likely than staff from other groups to have done so (Figure 4.12).

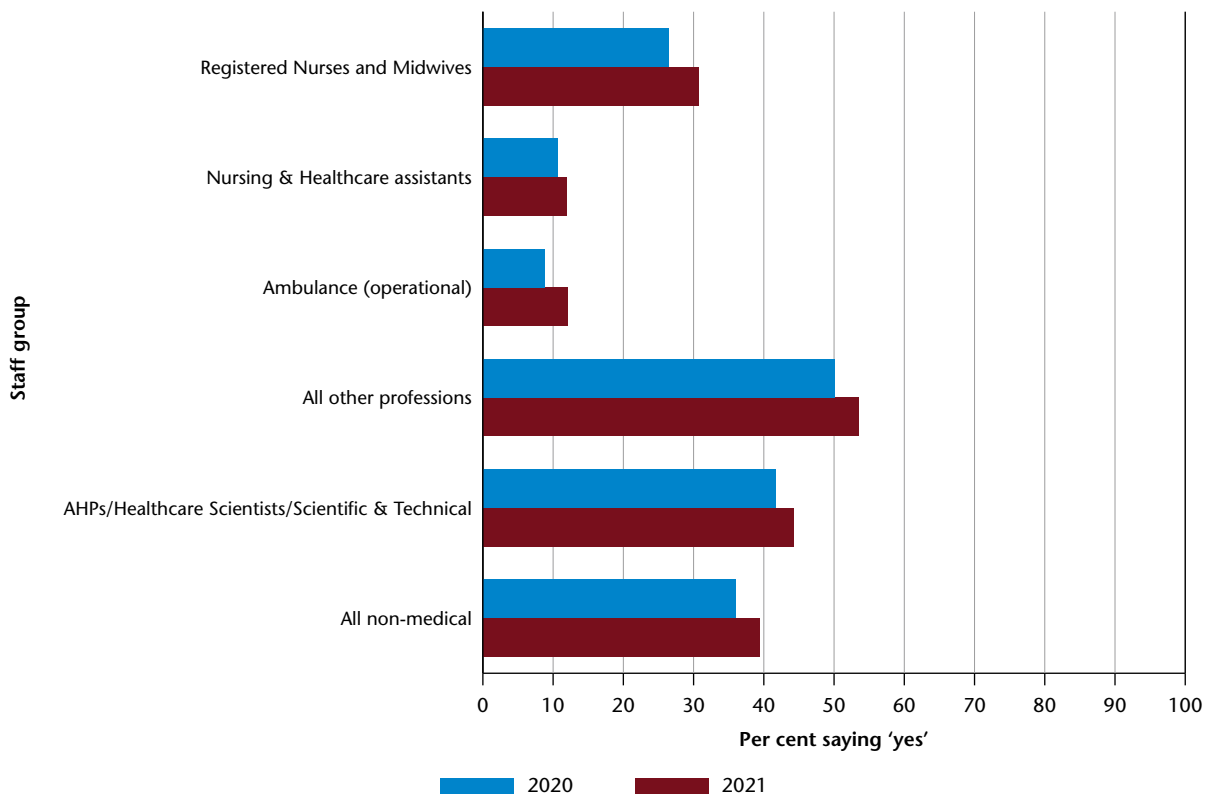
Figure 4.12: Staff saying they had been redeployed due to the COVID-19 pandemic, from the national NHS staff survey, AfC staff, England, 2020 and 2021



Source: NHS Staff Survey (England)

- In 2021, 39% of AfC staff said that they had been required to work remotely/from home due to the COVID-19 pandemic, up from 36% in 2020. Operational ambulance staff and nursing and healthcare assistants were less likely than staff from other groups to have done so (Figure 4.13).

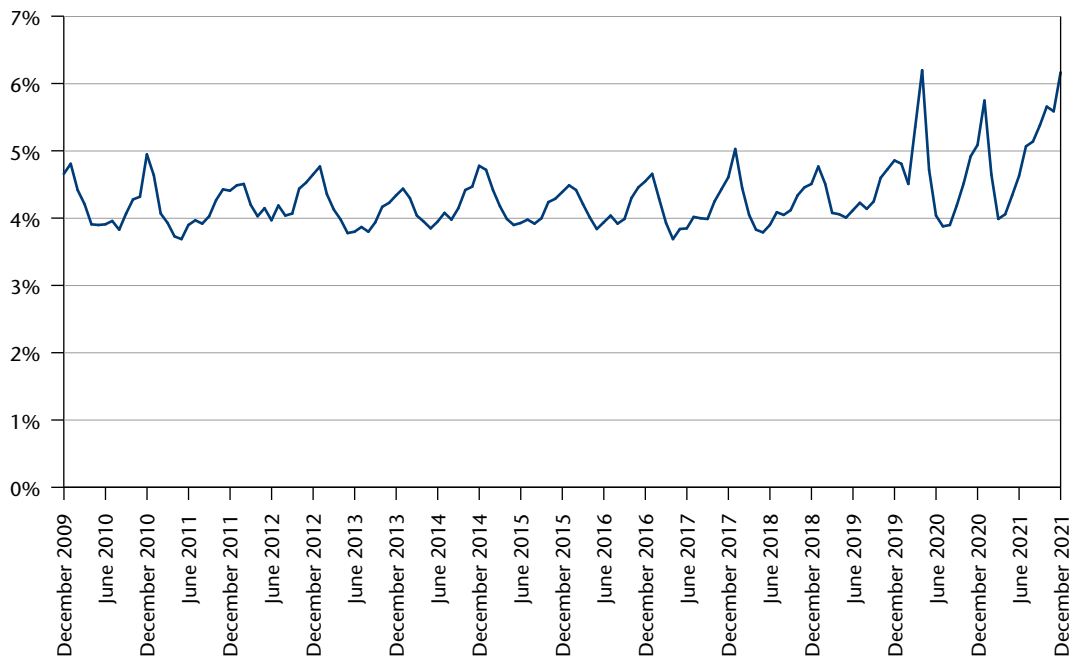
Figure 4.13: Staff saying they had been required to work remotely/from home due to the COVID-19 pandemic, from the national NHS staff survey, AfC staff, England, 2020 and 2021



Source: NHS Staff Survey (England)

Sickness absence

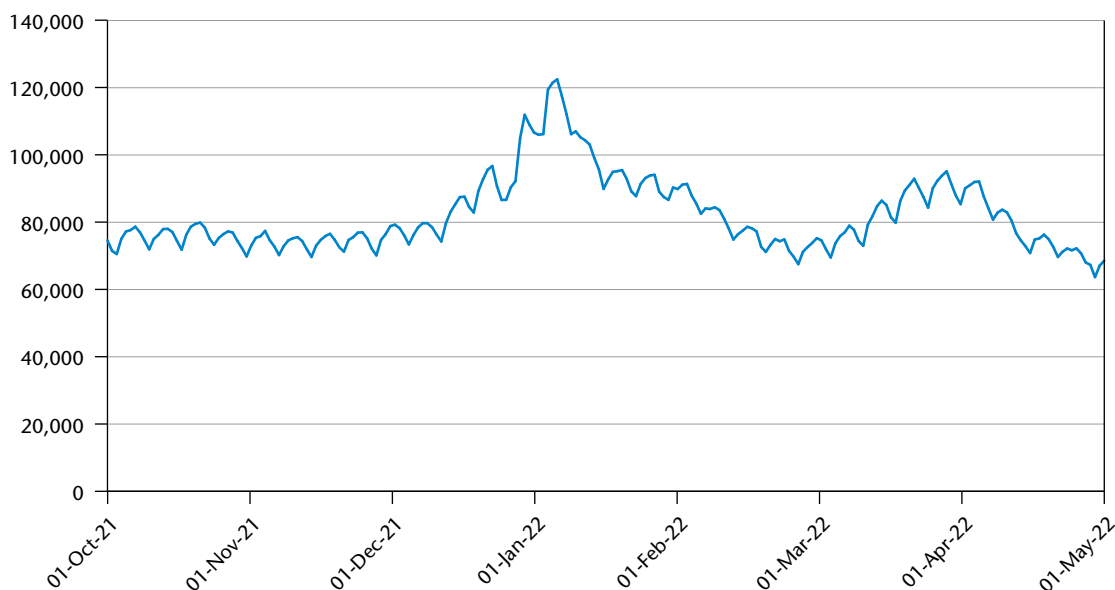
4.96 Figure 4.14 shows sickness absence rates in England for staff as a whole between December 2009 and December 2021. COVID-19 has clearly impacted sickness rates with peaks above 5% coinciding with peaks in national COVID-19 rates. The sickness absence rate in December 2021, at 6.17%, was the highest recorded since April 2020.

Figure 4.14: Sickness absence rates in England, all staff, December 2009 to December 2021

Source: NHS Digital

- 4.97 In addition to the regular sickness absence data published by NHS Digital, NHSEI have been publishing daily situation reports, including data on staff absences. These data are more timely than the NHS Digital data, but defined differently. Figure 4.15 shows that during October and November 2021 there were usually between 70,000 and 80,000 staff absent each day through sickness or self-isolation. However, that number increased during December 2021, reaching a peak of 122,500 on 6th January 2022, before falling back to below 70,000 by the end of February 2022. A further, but less severe increase in absence was recorded in March 2022, reaching a peak of 95,000 per day on 31st March 2022, before falling back to below 70,000 per day in the first week of May 2022.

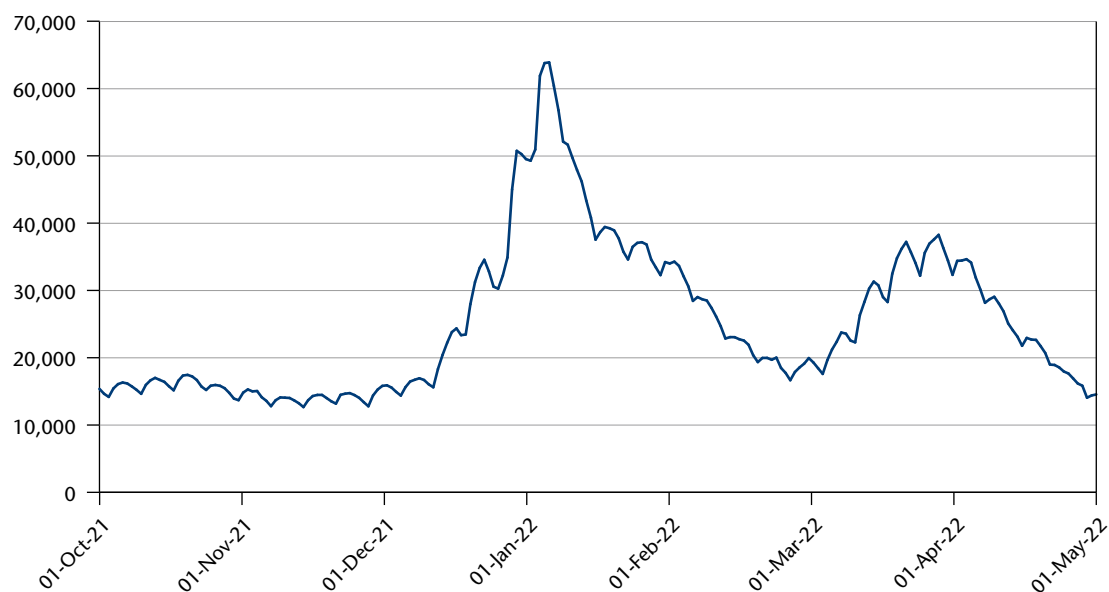
Figure 4.15: Total number of staff absent from work through sickness or self-isolation, England, October 2021 to May 2022



Source: NHSEI

4.98 Figure 4.16 shows that during October and November 2021 there were usually between 10,000 and 15,000 staff absent each day through COVID related sickness or self-isolation. However, that number increased during December 2021, reaching a peak of 63,900 on 6th January 2022, accounting for half of all absence on that day, before falling back to just below 20,000 a day by the end of February 2022. A further, but less severe increase in COVID related absence was recorded in March 2022, reaching a peak of 38,000 days on 31st March 2022, before falling back to below 15,000 per day in the first week of May 2022.

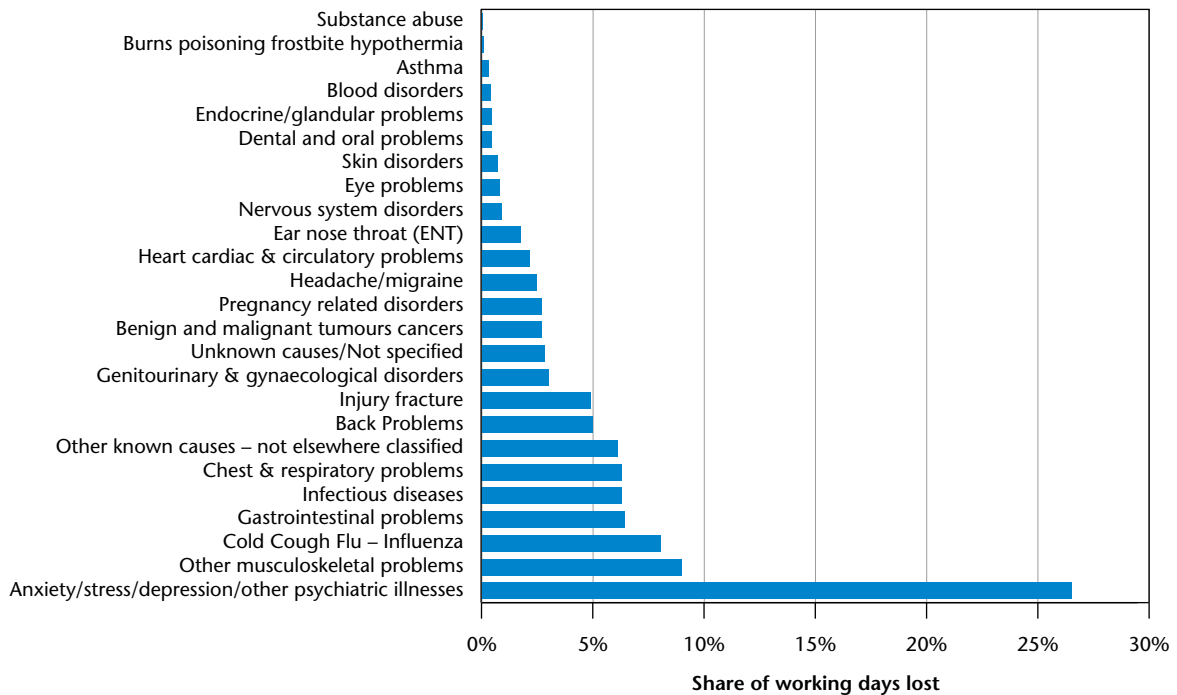
Figure 4.16: Total number of staff absent from work through COVID related sickness or self-isolation, England, October 2021 to May 2022.



Source: NHSEI

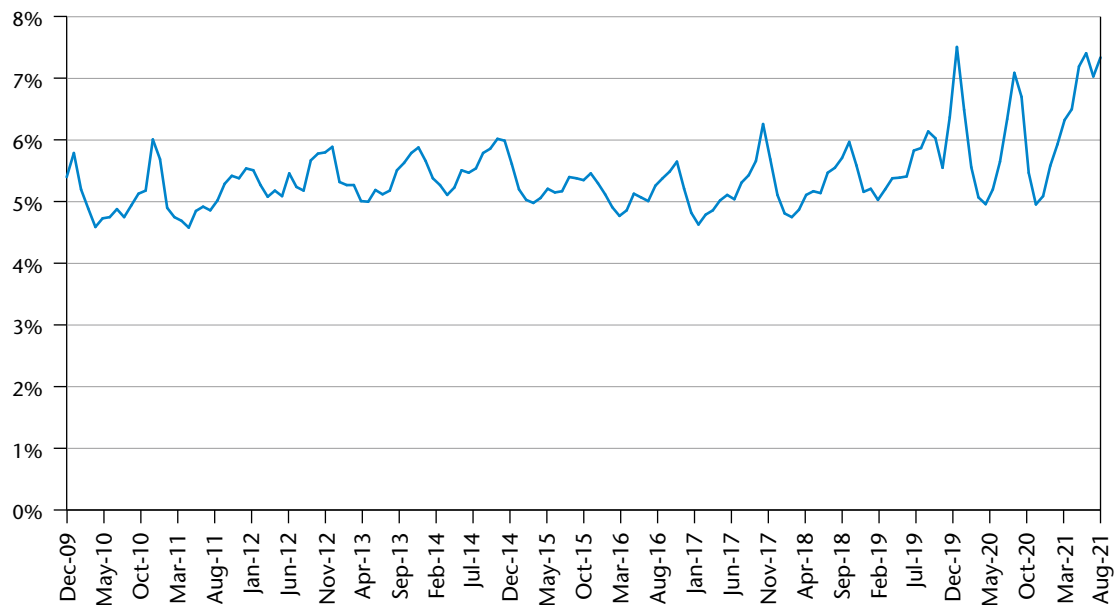
4.99 Figure 4.17 shows the number of sickness absence days in the 12 months to December 2021, by reason for absence. Over that period there were 22.8 million days (5.4%) lost to sickness absence. The most common reasons for sickness absence were anxiety, stress, depression and other psychiatric problems (accounting for 27% of all absence), ‘other musculoskeletal problems’ (9%), cold, cough, flu – influenza (8%), gastrointestinal problems (6%), infectious diseases (6%) and chest & respiratory problems (6%).

Figure 4.17: Percentage of sickness absence days, by reason for absence, England, 12 months to December 2021



Source: NHS Digital

4.100 Figure 4.18 shows sickness absence rates in the NHS in Wales between December 2009 and December 2021. The latest data shows sickness absence of 7.3% in December 2021, just below the peak of 7.5% seen in April 2020.

Figure 4.18: Sickness absence rates, Wales, 2009 to 2021, %

Source: Stats Wales

- 4.101 The written evidence from the Department of Health, Northern Ireland showed that in 2020/21 the share of working hours lost to sickness absence/industrial injury was 6.61%. Covid-related sickness absence and self-isolation added a further 2.69% of working hours lost in 20/21. This is an increase from 2019/20, when the share of working days lost to sickness absence/industrial injury was 6.78%. Covid-related sickness absence and self-isolation added a further 0.23% of working hours lost at the end of 19/20 when the pandemic began. The Department of Health, Northern Ireland estimates that 37% of absence in 2020/21 was related to mental health, an increase from 34% in 2019/20 and 33% in 2018/19.

Our assessment of morale and motivation

- 4.102 We commend NHSEI for continuing with the Staff Survey in England this year and note that it is critical in the provision of invaluable insight on the workforce. The results for 2021 are clearly worse than those for 2020, and in many instances the least positive since 2017, the last survey conducted before the 2018 AfC agreement. Notably, there has been a decrease in satisfaction with pay, with 31% saying they were satisfied with their pay, compared to 35% in 2020. There were also reductions in the number of staff saying that they: looked forward going to work; were enthusiastic about their job; would recommend their organisation as a place to work; were able to meet all the conflicting demands on their time at work. There were also increases in the number of staff saying that they: felt unwell as a result of work related stress; had experienced harassment, bullying or abuse from patients, relatives or the public; were considering leaving the NHS. The number of staff saying that they had adequate materials and supplies and that there were enough staff at their organisation to do their job properly also fell.

- 4.103 In the years prior to 2020, sickness absence rates in both England and Wales fluctuated within narrow ranges. However, data for both countries showed spikes in sickness absence in the spring of 2020, winter of 2020/21 and the second half of 2021. Data from NHSEI suggests that sickness absence peaked in January 2022, when it recorded over 120,000 staff absent on a single day.
- 4.104 We are concerned that the most common causes for sickness absence in England are anxiety, stress, depression and other psychiatric problems. We note the work that has gone into developing mental health support services for staff; however, we heard consistently in evidence that staff did not have the time and space to access services.
- 4.105 We note that the Department of Health, Northern Ireland and the Welsh Government did not carry out a Staff Survey in 2021. We would urge both parties to continue to collect Staff Survey data to remain informed on the views of the workforce.
- 4.106 We note the importance of job advocacy and satisfaction in recruitment and retention and the potential for a vicious circle of staff shortages, excessive workloads and patient care. The majority of NHS AfC staff spend a significant proportion of their training working alongside existing staff and there is a real risk that these drops in satisfaction will impact on students preparing for an NHS role post-graduation. If satisfaction measures across the AfC workforce continue to reduce, it is likely to translate into more staff leaving the profession and higher levels of stress amongst remaining staff. Therefore, we believe it is vital that NHS organisations continue to gain invaluable insight from the workforce and act on the results where possible.
- 4.107 A high level of job satisfaction is associated with improved productivity, decreased turnover and reduced stress levels in the workplace. If job satisfaction across the NHS improves, the NHS will benefit from engaged staff able to focus on improving patient care and efficiency, the number of staff reporting sickness absences due to stress would reduce and in turn increase the number of staff on each shift, thereby reducing stress more widely across teams.

Gender and ethnicity²⁴

- 4.108 The NHS Long Term Plan affirms that the NHS's greatest strength is its people and that the workforce is more diverse than at any other point in history. The NHS and UK taxpayers invest significantly in the AfC workforce, and it is therefore essential that the NHS makes best use of this investment. The NHS needs to use and develop the skills and experience of all those who work in AfC roles to best effect and to attract, retain and promote the broadest range of talent to deliver a health service providing the best care to the public that it can.

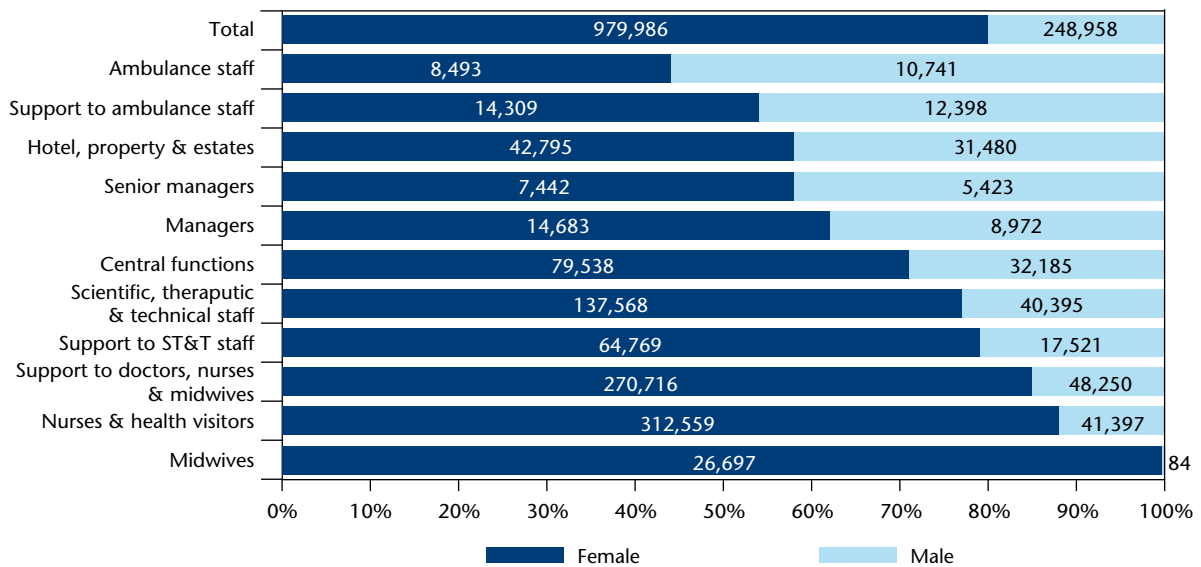
²⁴ In this report we follow the guidance of the Race Disparity Unit (RDU) approach to writing about ethnicity and use 'ethnic minorities' to refer to all ethnic groups except the White British group. For comparisons with the White group as a whole, we use 'all other ethnic groups combined' or 'ethnic minorities (excluding White minorities)'. We also refer to 'White' and 'Other than White' if space is limited. We use BAME only when quoting from sources that use this term.

- 4.109 In our 2021 report, we noted that lower banded roles contained higher proportions of women and ethnic minorities and noted further work was needed to understand differences in pay. In evidence this year, we heard that White men are still disproportionately represented at higher bands.
- 4.110 The NHS Workforce Race Equality Standard (WRES) 2021 report notes that 22% of staff were BME, compared with 13% of board members (up from 10% in 2020).
- 4.111 Across the service as a whole, White applicants were 1.61 times more likely to be shortlisted than BME applicants (little changed over the past six years). BME staff were 1.14 times more likely to enter the formal disciplinary process than White staff, an improvement from 2016 when it was 1.56 times more likely. In 2020 17% of BME staff had personally experienced discrimination at work, the highest level since 2015.

AfC workforce by gender and ethnicity

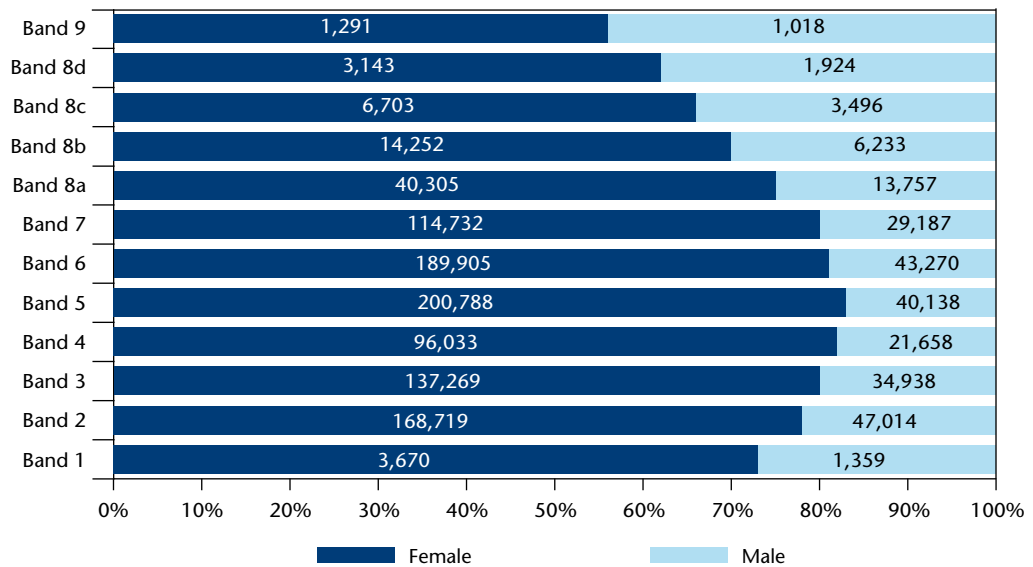
- 4.112 We consider the data on the gender breakdown of AfC staff to monitor the representation of women in different roles and at all levels of the NHS organisation, given that the AfC workforce is predominantly female. The analysis in Figures 4.19 and 4.20 show a breakdown of AfC staff by gender, by broad staff group and by band, in England in December 2021. Overall, we note that men make up 20% of AfC staff, and that in all staff groups other than ambulance staff, in which men account for 56% of the workforce, women make up a majority of the workforce. We also see from the data that the only other staff groups where men make up more than 40% of the workforce are support to ambulance staff (46%), senior managers (42%) and hotel, property and estates staff (42%). The analysis by AfC pay band also shows that women make up a majority of staff in every pay band, and over 70% of staff in every band except Band 8b-8d and Band 9.

Figure 4.19: Staff in Agenda for Change roles by gender, by staff group, in England, December 2021, headcount



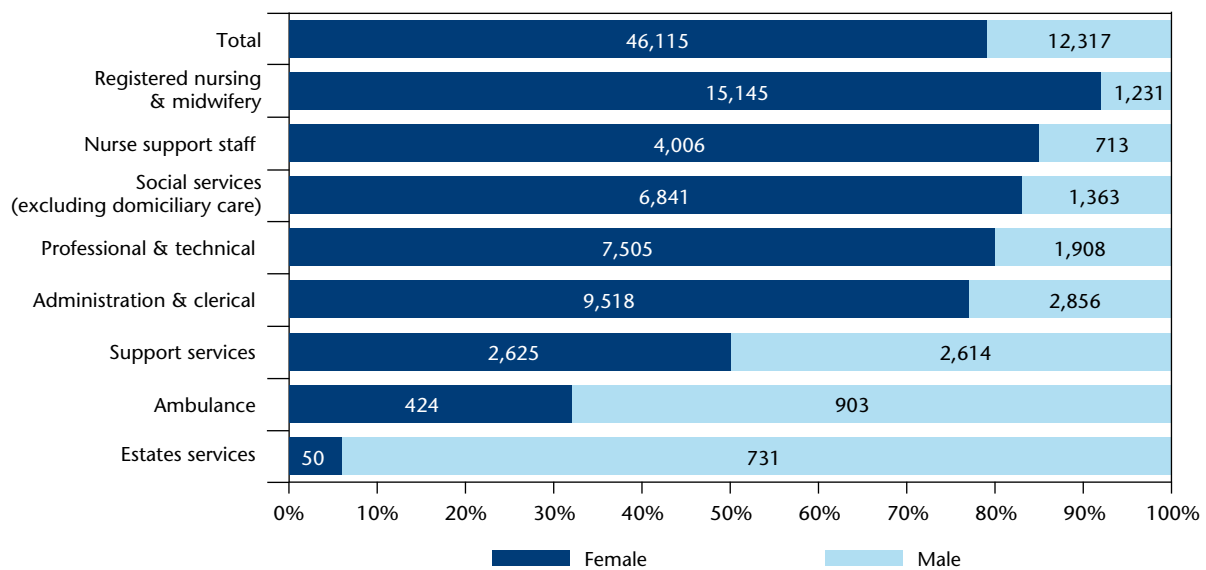
Source: NHS Digital

Figure 4.20: Staff in Agenda for Change roles by gender, by band, in England, December 2021, headcount



Source: NHS Digital

4.113 Figure 4.21 shows a breakdown of AfC staff by broad staff group by gender in Northern Ireland in March 2021. In all staff groups other than estates services (94%), ambulance staff (68%) and support services (50%), men make up less than 25% of the workforce.

Figure 4.21: Staff in Agenda for Change roles by gender in Northern Ireland, March 2021, FTE

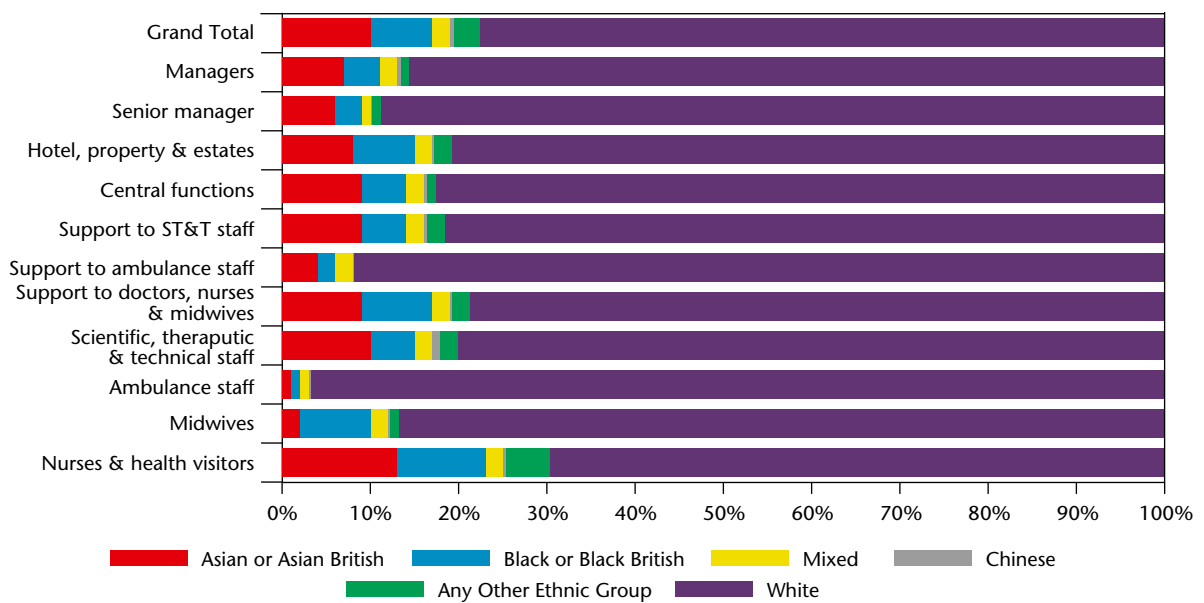
Source: Department of Health, Northern Ireland

4.114 Our workforce analysis for this report also included the representation of different ethnic minorities among AfC staff (based on NHS Digital definitions). Figure 4.22 shows a breakdown of AfC staff by ethnicity and by broad staff group, in England in December 2021. Overall, we note that, excluding those staff whose ethnicity was unknown or not stated, 22% were from ethnic minorities: 10% of staff were Asian or Asian British; 7% Black or Black British; 2% mixed ethnicity; fewer than 1% Chinese and 3% from other ethnic minorities. The data suggests that by staff group, the least ethnically diverse were ambulance staff, with just 4% from ethnic minorities: 1% Asian or Asian British; 1% Black or Black British; and 1% mixed ethnicity. We can see that, in contrast, 31% of nurses and health visitors were from ethnic minorities: 13% were Asian or Asian British staff, 10% Black or Black British staff; 2% mixed ethnicity; 5% from other ethnic minorities; and 69% were White. This compares with the working age population of England and Wales, which in 2011 was 8.1% Asian, 3.4% Black, 1.8% had mixed ethnicity and 1.1% were from the Other ethnic group²⁵.

²⁵ <https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/working-age-population/latest#:~:text=data%20shows%20that%3A-,according%20to%20the%202011%20Census%2C%20the%20total%20population%20of%20England,from%20the%20Other%20ethnic%20group>

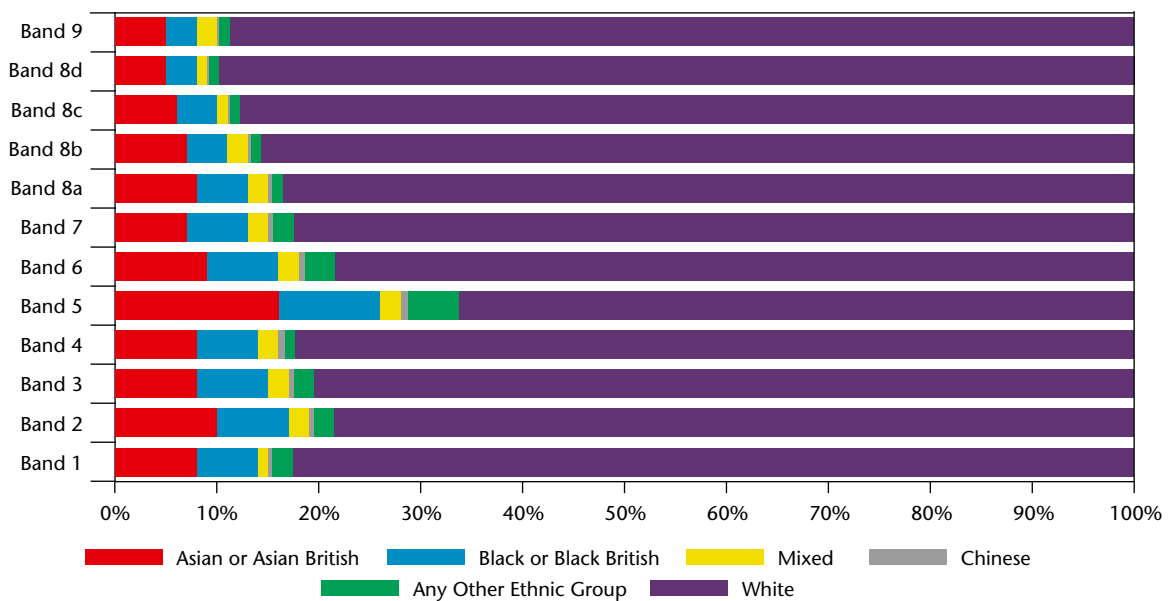
4.115 Figure 4.23 shows a breakdown of AfC staff by ethnicity and by band, in England in December 2021. It is notable that the percentage of staff from ethnic minorities declines in the higher bands and that in Bands 8d and 9 just 10% of staff were from ethnic minorities. Thirty-five per cent of staff in Band 5 were from an ethnic minority group, with 16% Asian or Asian British staff, 10% Black or Black British staff, 2% of mixed ethnicity, 5% from other ethnic minorities, and 65% White staff. The only other pay bands to have more than 20% of staff from ethnic minorities were Band 6 (with 9% Asian or Asian British staff, 7% Black or Black British staff, 2% of mixed ethnicity, 3% from other ethnic minorities, and 79% White staff) and Band 2 (with 10% Asian or Asian British staff, 7% Black or Black British staff, 2% of mixed ethnicity, 2% from other ethnic minorities, and 79% White staff).

Figure 4.22: Staff in Agenda for Change roles by ethnic group, by staff group, in England, December 2021, headcount



Source: NHS Digital

Figure 4.23: Staff in Agenda for Change roles by ethnic group, by band, in England, December 2021, headcount



Source: NHS Digital

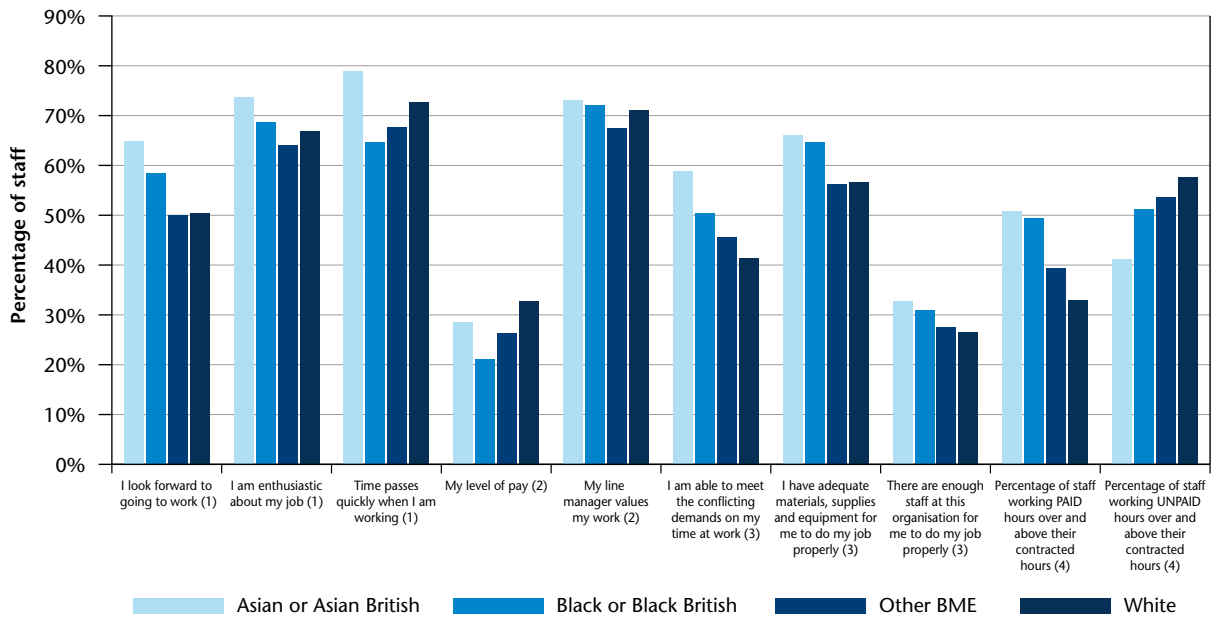
COVID-19

- 4.116 The importance of understanding the way in which protected characteristics such as gender and ethnicity affect staff experience across the NHS has been very evident over the last year in the disproportionate impact of COVID-19 on staff from some ethnic minorities.
- 4.117 Within the NHS, there is evidence of a disproportionate mortality and morbidity amongst ethnic minorities who contracted COVID-19, including NHS staff. The Staff Survey for 2021 in England showed that those from ethnic minorities were more likely than White staff to be working in roles with increased risk to COVID-19. The data showed that White staff (34%) were less likely to have worked on a COVID-19 specific ward or area than staff from all other ethnic groups (48%). White staff (42%) were also more likely to have been required to work remotely/from home than staff from all other ethnic groups (29%).

Morale and motivation

- 4.118 Figure 4.24 shows satisfaction of AfC staff with aspects of the job and work pressures, by ethnic group. For most of the variables, staff from minority ethnic groups were more satisfied than White colleagues. However, staff from ethnic minority groups were less satisfied with their pay than White colleagues. A greater percentage of staff from ethnic minorities said that they worked paid hours in addition to their contracted hours than white colleagues, while White AfC staff were more likely to say that they worked unpaid hours in addition to their contracted hours.

Figure 4.24: AfC staff satisfaction with aspects of the job and work pressures by ethnic group, England, 2021



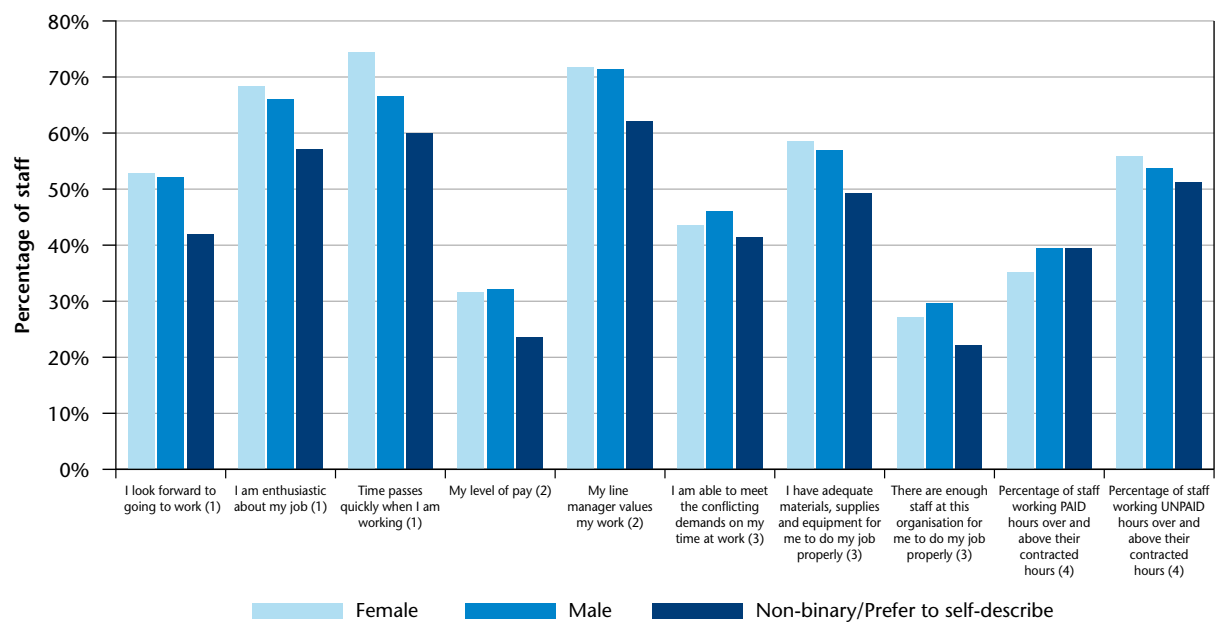
Source: NHS Staff Survey data, Picker Institute Europe

Notes:

- (1) Staff responding 'often' or 'always'
- (2) Staff responding 'satisfied' or 'very satisfied'
- (3) Staff responding 'agree' or 'strongly agree'
- (4) Staff indicating one or more additional hours

4.119 Figure 4.25 shows satisfaction of AfC staff in England with aspects of the job and work pressures by gender. For most of the variables non-binary/prefer to self-describe staff were less satisfied than female and male staff. Female staff were more likely than male staff to say that they were enthusiastic about their job and that time passes quickly when they were working. Female staff were less likely to say that they worked paid hours in addition to their contracted hours but more likely to say that they worked unpaid hours in addition to their contracted hours.

Figure 4.25: AfC staff satisfaction with aspects of the job and work pressures by gender, England, 2021



Source: NHS Staff Survey data, Picker Institute Europe

Notes:

(1) Staff responding 'often' or 'always'

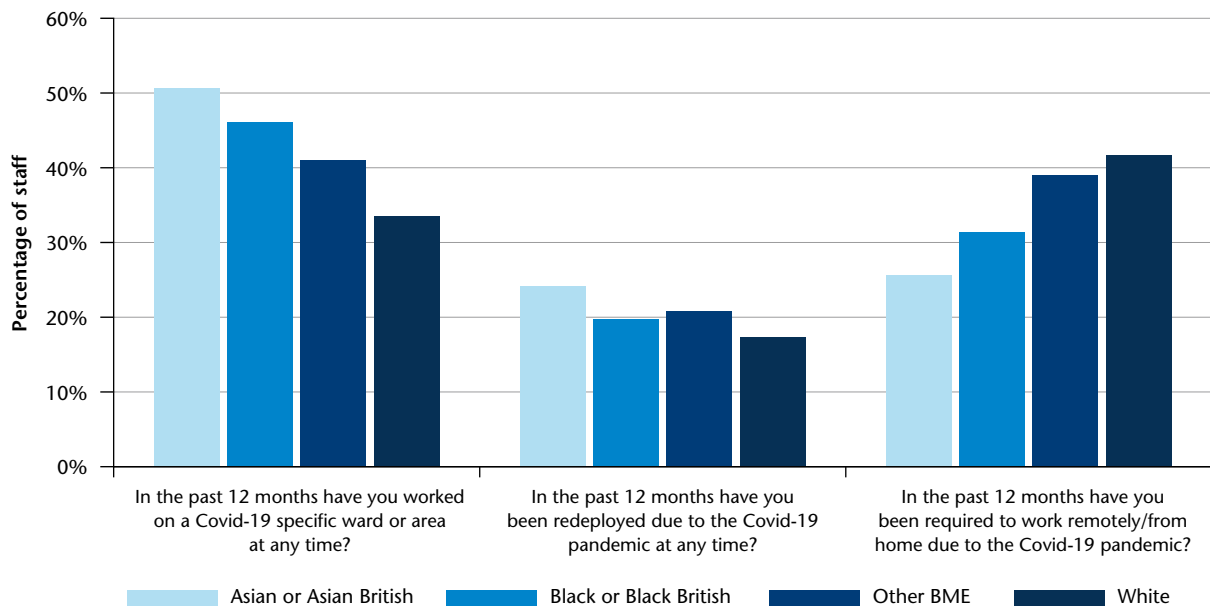
(2) Staff responding 'satisfied' or 'very satisfied'

(3) Staff responding 'agree' or 'strongly agree'

(4) Staff indicating one or more additional hours

4.120 Figures 4.26 and 4.27 show AfC staff responses to 2021 survey questions about their experiences during the COVID-19 pandemic, by ethnic group and by gender. Figure 4.26 shows that staff from ethnic minorities were more likely to have been redeployed, or to have worked on a COVID-19 ward or area, than White staff. Staff from ethnic minorities were also less likely to say that they had been required to work remotely/from home than White staff.

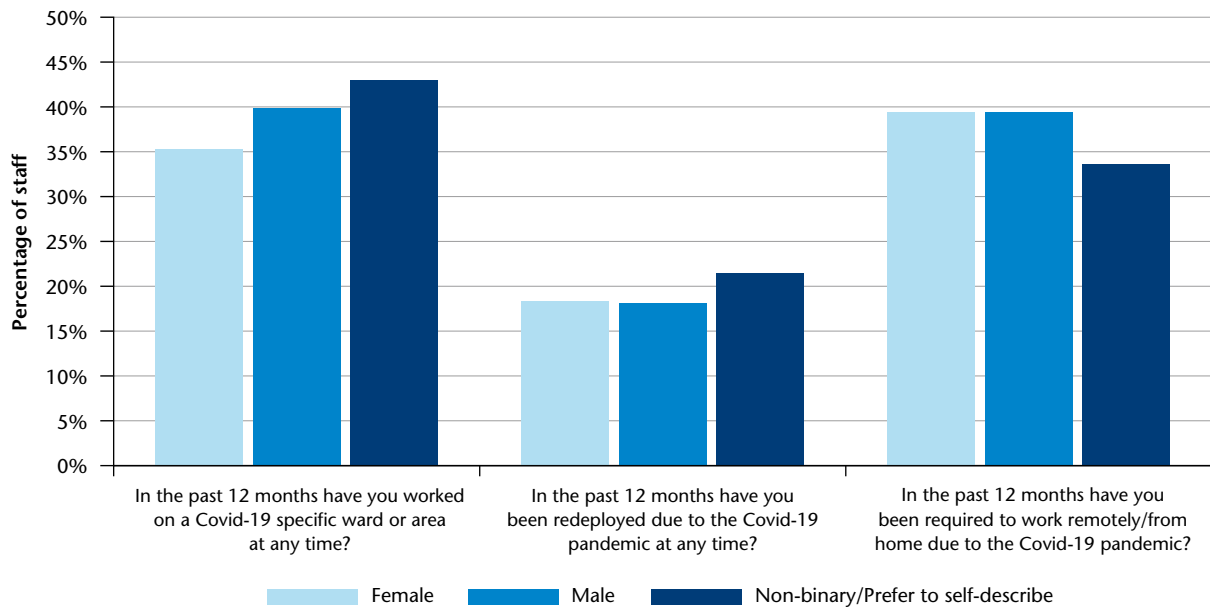
Figure 4.26: AfC staff experiences during the COVID-19 pandemic by ethnic group, England, 2021



Source: NHS Staff Survey data, Picker Institute Europe

4.121 Figure 4.27 shows that female staff were less likely to have worked on a COVID-19 ward or area, than male staff. Staff who described themselves as non-binary or preferred to self-describe were more likely to have worked on a COVID-19 ward or area than female or male staff, and less likely to have been required to work remotely/from home than female or male staff.

Figure 4.27: AfC staff experiences during the COVID-19 pandemic by gender, England, 2021



Source: NHS Staff Survey data, Picker Institute Europe

Pay and earnings by gender and ethnic group

4.122 NHS Digital have published data showing the differences in mean basic pay, between male and female staff and White and all other ethnic minorities combined, in May 2021 (Table 4.4).

Table 4.4: Differences in mean monthly basic pay per FTE, by gender and ethnicity, England, May 2021

	Gender pay gap		Ethnicity pay gap	
	White	BME	Male	Female
	Female/Male	Female/Male	BME/ White	BME/White
All AfC	-8%	-1%	-4%	-11%
Nurses and health visitors	-4%	-2%	-11%	-12%
Professionally qualified staff	-4%	-3%	-10%	-11%
Support to clinical staff	-3%	0%	-1%	-4%
Infrastructure support	-12%	-5%	-5%	-13%

Source: DHSC written evidence (Table 31)

4.123 For basic pay:

- White female staff were paid 8% less than White males, with the difference ranging between 12% for infrastructure support staff and 3% for staff supporting clinical staff.
- Female staff from ethnic minorities were paid 1% less than male staff from ethnic minorities, with the differences ranging between 5% for infrastructure support staff and 0% for staff supporting clinical staff.
- Female staff from ethnic minorities were paid 4% less than White female staff, with the difference ranging between 11% for nurses and health visitors and 1% for staff supporting clinical staff.
- Male staff from ethnic minorities were paid 11% less than White male staff, with the difference ranging between 13% for infrastructure support staff and 4% for staff supporting clinical staff.

Our assessment of data on pay and earnings and workforce by gender and ethnic group

4.124 The NHS needs to use and develop the skills and experience of all those who work in AfC roles to best effect and to attract, retain and promote the broadest range of talent to deliver a health service providing the best care to the public that it can.

4.125 The data for England in Figures 4.19 to 4.23 revealed higher relative numbers of women and ethnic minorities in lower paid occupational groups, and also at lower pay bands within those occupations. This is highlighted by the small numbers of women and ethnic minorities above band 8c. This occupational segregation of staff and the distribution of staff across the bands underpins the gender and ethnicity pay gaps evident in the AfC workforce in Table 4.4. We recognise that these outcomes, relating to the distribution of staff across bands and occupational groups, are likely to be the result of multiple factors, some of which may be associated with recruitment, retention and promotion practices within the NHS.

- 4.126 We also note the findings of the NHS Providers report discussed at paragraphs 2.54 - 2.57. We judge that ensuring equality is a core part of the NHS's strategy is essential to driving forward this critical agenda. We look forward to understanding the way in which ICSs will contribute to the strategic and operational development of a thriving and diverse NHS workforce.
- 4.127 We believe it is of the utmost importance that the time and space is made for leaders to impact on equality, which will subsequently lead to a more diverse workforce where staff feel more of a sense of belonging. The Head of the Workforce Race Equality Standard at NHSEI said in April 2022 that it is clear that when monitoring targets are set and evidence-based actions pursued, it is possible to shift staff experience, and the challenge now is to ensure this happens across the whole of the NHS.
- 4.128 Further work is still required to understand the differences in pay. In our 2020 report, we noted that the Government told us they were looking at commissioning research into the Ethnicity Pay Gap. In this year's evidence, the Government re-affirmed that commitment following the response to the Commission on Race and Ethnic Disparities. We welcome this and encourage the parties to take this forward. We expect to receive evidence in future years, showing a greater understanding of the situation and plans of action to address these gaps. We are aware of the work already being undertaken by trusts to increase the number of ethnic minority board members better to represent the level of ethnic minority staff in the workforce.
- 4.129 We welcome the Welsh Government's commitment to introduce a Workforce Race Equality Standard and look forward to receiving data on this in future years.
- 4.130 We emphasise that effective equality impact assessments are critical for major projects such as the AfC three-year deal and the new performance management framework and a key step in the benefits realisation process. As data develops on other protected characteristics, we look forward to hearing more from parties about their representation in the workforce.

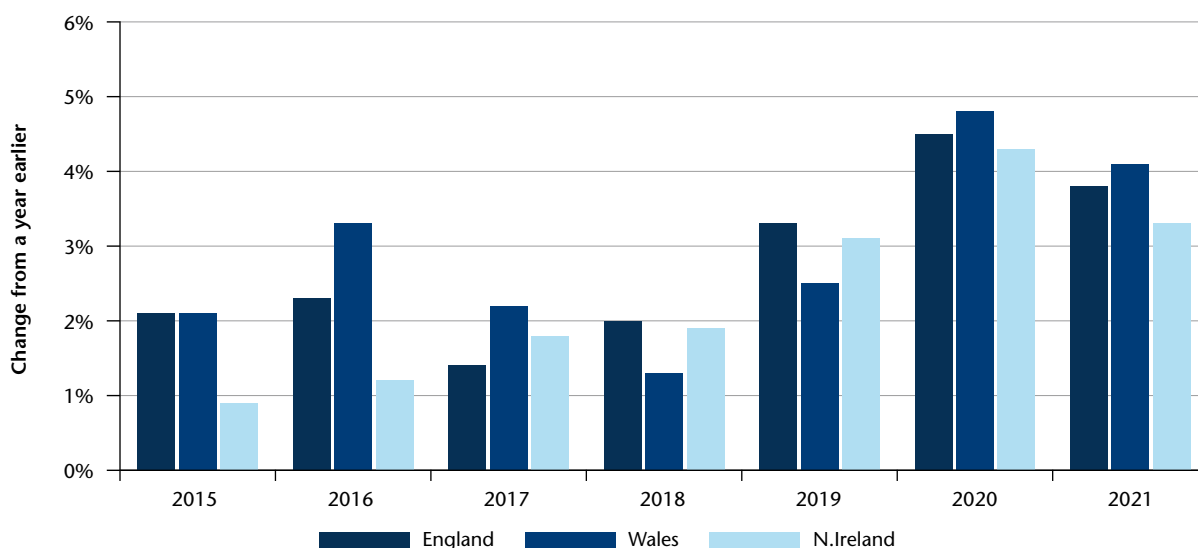
Workforce numbers and recruitment

4.131 We review below the numbers and composition of staff in in England, Northern Ireland and Wales, where data is available.

AfC workforce across England, Northern Ireland and Wales

4.132 The AfC workforce continues to increase year-on-year, both overall and all three nations. We note that in September 2021 there were 1.2 million full-time equivalent (FTE) AfC staff in England, Northern Ireland and Wales, of which, approximately 1,078,000 were working in England, 59,000 in Northern Ireland and 81,000 in Wales. We also track the trends in the workforce and Figure 4.27 shows the change in staffing numbers each year since 2015. We note that in the year to September 2021, compared with a year earlier, the number of FTE staff rose by 4.1% in Wales, 3.8% in England, and 3.3% in Northern Ireland. We also see that on a headcount basis there were 1.4 million AfC staff as of September 2021. Of these, approximately 1,220,000 were in England, 95,000 in Wales, and 67,000 in Northern Ireland.

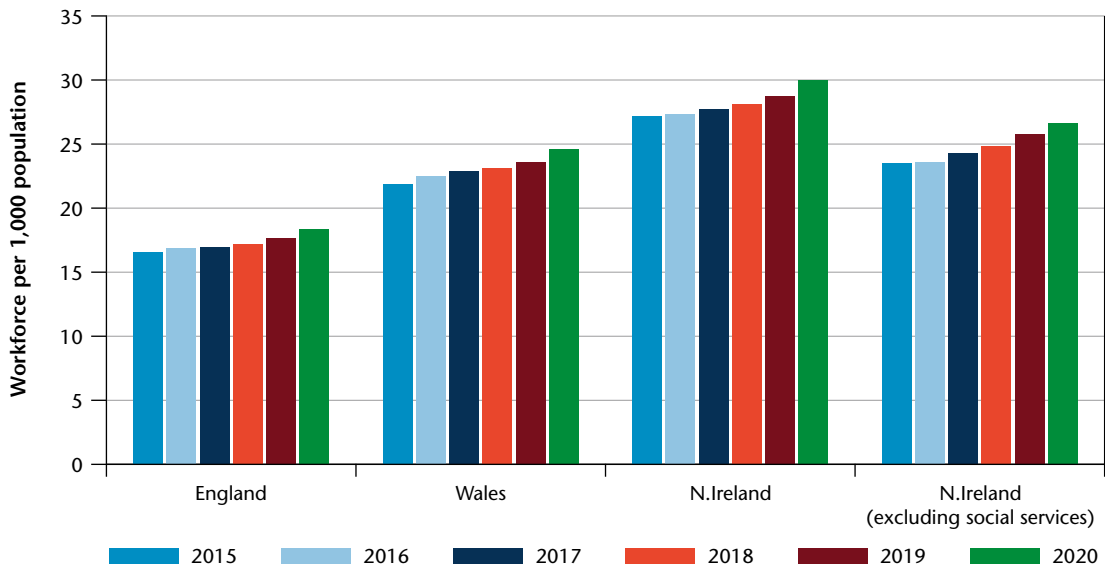
Figure 4.28: Change in AfC full time equivalent workforce, England, Wales and Northern Ireland, 2015 to 2021



Source: NHS Digital, Stats Wales, Department of Health, Northern Ireland

4.133 Against this background, we have examined the number of AfC staff per head of population. Our analysis in Figure 4.29 shows the number of FTE AfC staff per 1,000 of the population in England, Wales and Northern Ireland. We note that the increase in the height of the bars for each country, shows that the number of FTE staff is growing more quickly than the population. We can also see that England has the fewest FTE AfC staff per 1,000 population, whereas Northern Ireland has the largest number of AfC staff relative to the population. Unlike, England and Wales, the workforce in Northern Ireland includes those working in social services, although even after adjusting for this difference, Northern Ireland still has more AfC staff per 1,000 population than both England and Wales.

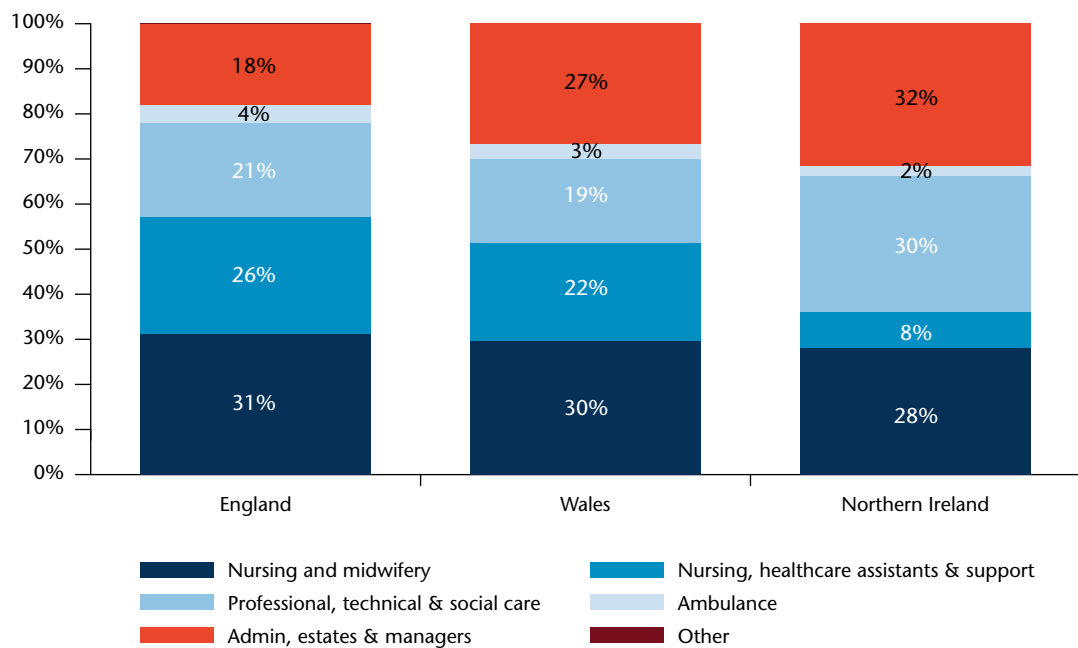
Figure 4.29: NHS AfC full time equivalent workforce per 1,000 population, England, Wales, Northern Ireland, 2015 to 2020



Source: OME calculations based on data from NHS Digital, Stats Wales, Department of Health, Northern Ireland, ONS

AfC staff by staff group

4.134 Our analysis in Figure 4.30 shows a breakdown of AfC staff by broad staff group in England, Wales and Northern Ireland. We observe that in Northern Ireland there is a relatively high share of administration, estates and management staff, and professional, technical and social care staff, compared with England and Wales, which reflects the inclusion of social care staff in the Northern Ireland workforce. We note that other variations by AfC staff group include that England and Wales have a relatively high proportion of nursing and healthcare assistants.

Figure 4.30: NHS AfC full time equivalent workforce by broad staff group, England, Wales, Northern Ireland, September 2021

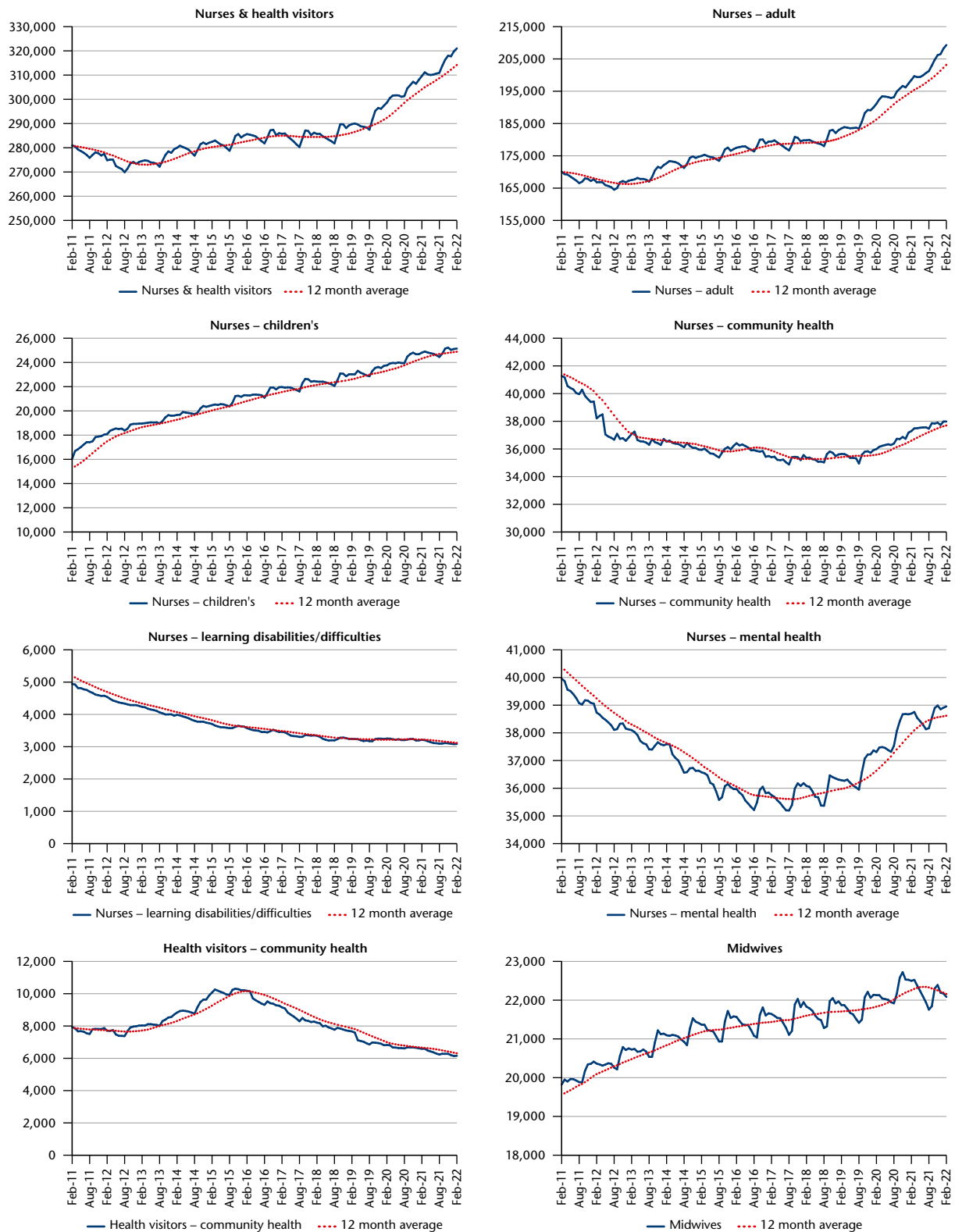
Source: NHS Digital, Stats Wales, Department of Health, Northern Ireland

Nursing, health visitor and midwifery workforce in England

- 4.135 Figure 4.31 shows the FTE number of nurses, health visitors and midwives in England, between February 2011 and February 2022. Overall, the number of nurses and health visitors fell between 2011 and 2012, then grew between 2012 and 2016 and levelled out between 2016 and the first half of 2018. However, between the three months to August 2018 and the three months to February 2022, the number of nurses and health visitors increased by 13.1%.
- 4.136 Groups within the nursing and health visitor and midwifery populations experienced different rates of growth between 2011 and 2022. Over the period there was growth in the number of children's nurses (60%), adult nurses (22%), and midwives (12%). However, over the same period there were falls in the number of learning difficulties/disabilities nurses (38%), health visitors (22%), community health nurses (8%), and mental health nurses (3%).
- 4.137 The data for the three months to February 2022, compared with the three months to August 2018, the point at which nursing numbers started to grow, also show different rates of growth for different groups. There was relatively strong growth in the number of adult nurses (16.5%), children's nurses (13.2%) and mental health nurses (9.7%). There was more modest growth in the number of community health nurses (8.1%), and falls in the number of learning difficulties/disabilities nurses (-3.4%), and health visitors (-21.4%). Over the same period there was an increase in the number of midwives of 3.4%.

- 4.138 The data for the three months to February 2022, compared with the same period one year earlier, show an increase in the number of nurses and health visitors of 3.7%. Within that overall total, there were increases in the number of adult nurses (5.4%), community health nurses (2.2%), children’s nurses (1.5%), and mental health nurses (0.6%), but falls in the number of health visitors (-6.9%), and learning difficulties/disabilities nurses (-3.6%). Over the same period there was a fall in the number of midwives of 1.6%.
- 4.139 The Government has set a target for 50,000 more nurses in England by the end of this parliament. The latest data to February 2022, compared with September 2019, shows an increase of 30,000 FTE nurses working in NHS Hospital and Community Health Services and general practice over that period.

Figure 4.31: Number of nurses, health visitor staff and midwives, FTE, by nursing category, England, February 2011 to February 2022

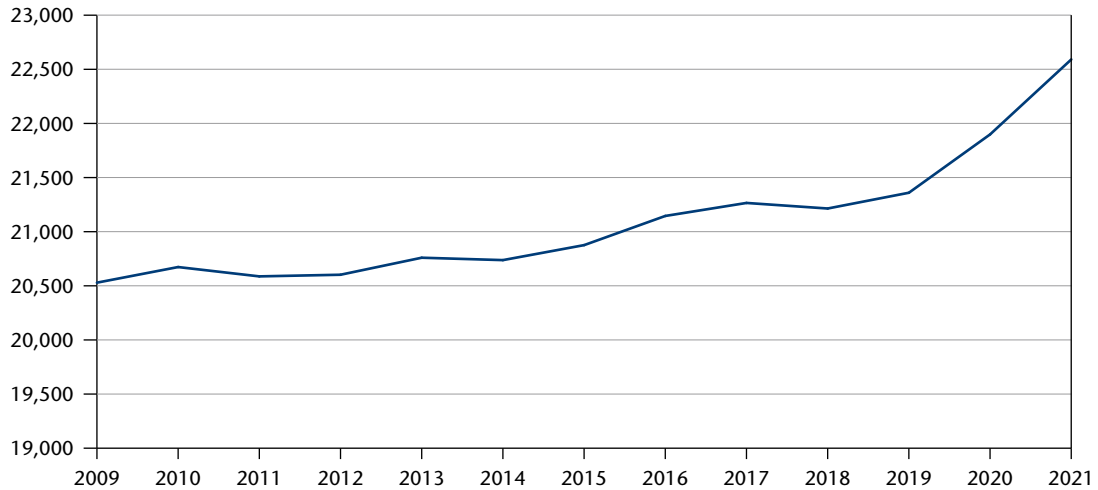


Source: NHS Digital

Nursing workforce in Wales

4.140 Figure 4.32 shows that in Wales the number of registered nursing staff was on an upward trend between 2009 and 2019, with growth accelerating in both 2020 and 2021. In 2020, compared with 2019, the number of registered nurses grew by 2.5%, and by a further 3.2% in 2021, compared with 2020.

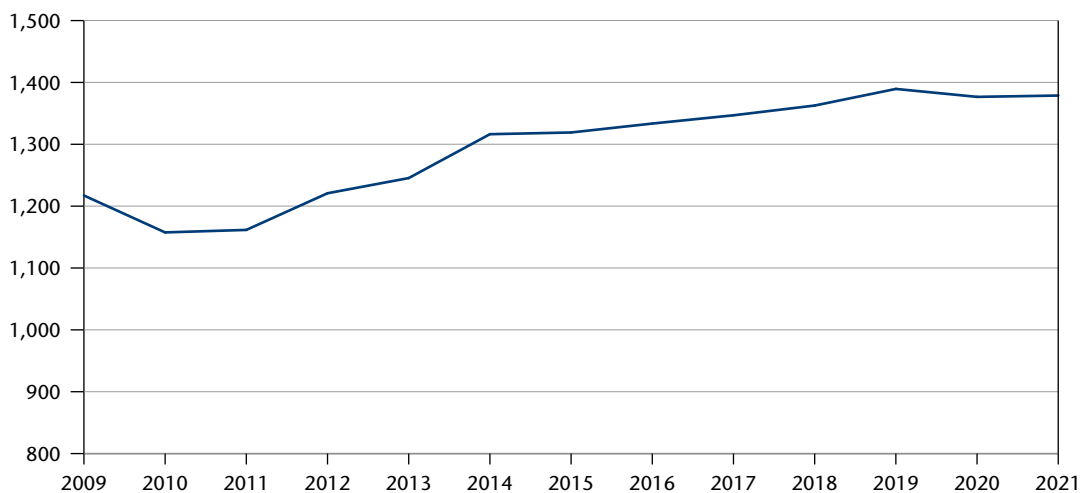
Figure 4.32: Number of registered nursing staff, FTE, Wales, September 2009 to September 2021



Source: Stats Wales

4.141 Figure 4.33 shows that in Wales the number of registered midwives was on an upwards trend between 2011 and 2019. However, in 2020, compared with 2019, the number of registered midwives fell by 0.9%, and increased by just 0.2% in 2021, compared with 2020.

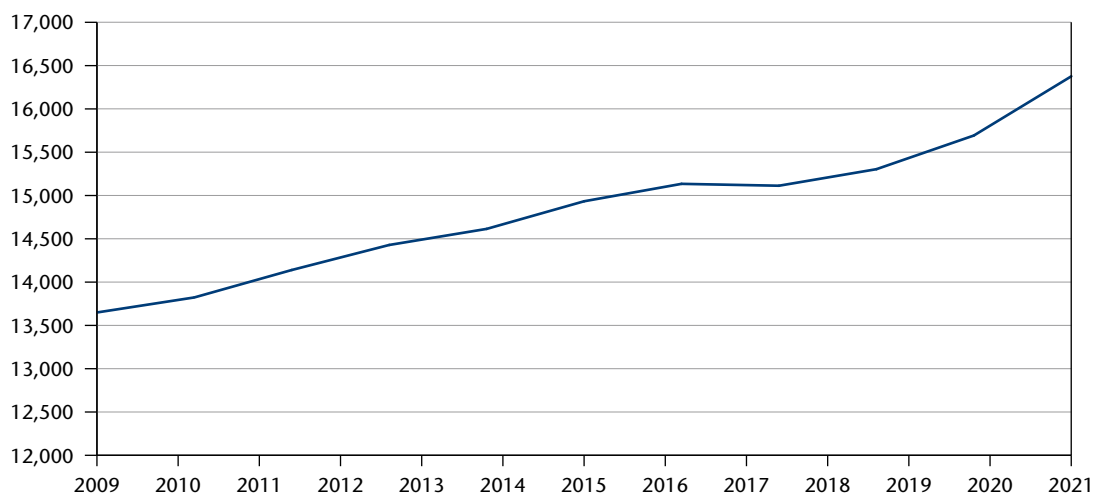
Figure 4.33: Number of registered midwives, FTE, Wales, September 2009 to September 2021



Source: Stats Wales

4.142 Figure 4.34 shows that in Northern Ireland, the number of registered nursing and midwifery staff has been on an upwards trend since 2011, with growth of 2.5% between March 2019 and March 2020 and 4.4% between March 2020 and March 2021.

Figure 4.34: Number of registered nursing and midwifery staff, FTE, Northern Ireland, March 2009 to March 2021

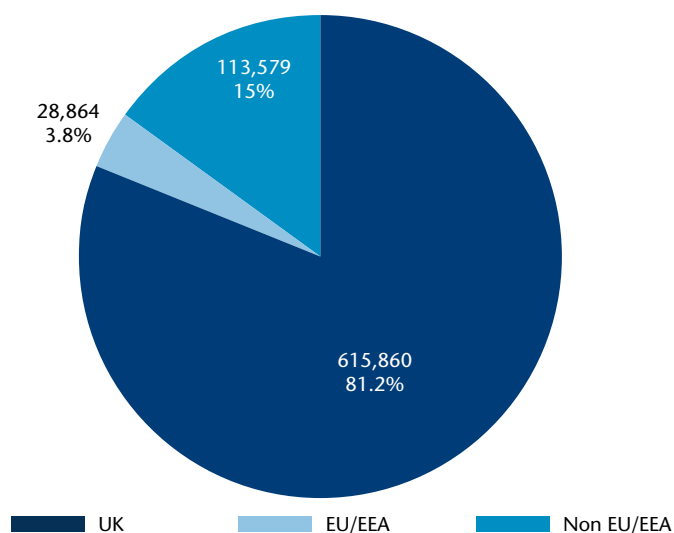


Source: Department of Health, Northern Ireland

Nursing and Midwifery Council (NMC) Register

4.143 Data on the NMC Register helps us understand the total available workforce for nurses, midwives and nursing associates. It shows the numbers able to practice in the United Kingdom, although this will cover those working in the NHS, private and independent sectors or the third sector, and not all of those on the register will be working in their registered roles or working at all. The latest data for March 2022, showed that there were 758,303 nurses and midwives registered to work in the UK. Of the total number 615,860 were initially registered in the UK, 28,864 were initially registered in the EU/EEA and 113,579 initially registered outside the EU/EEA (Figure 4.35).

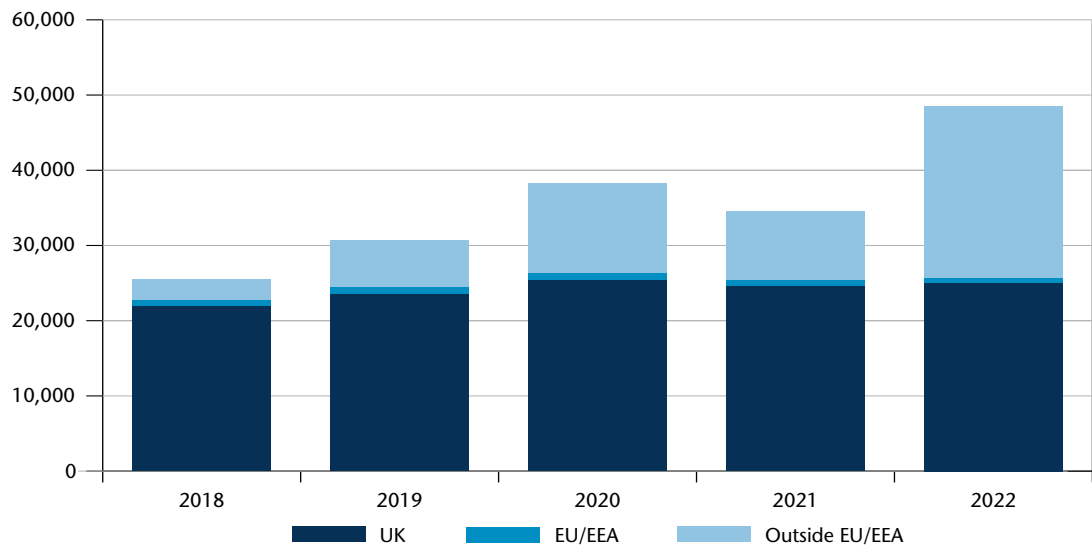
Figure 4.35: Overall numbers of nurses and midwives on the NMC register by country of qualification, UK, March 2022



Source: Nursing and Midwifery Council (NMC) Register, March 2022

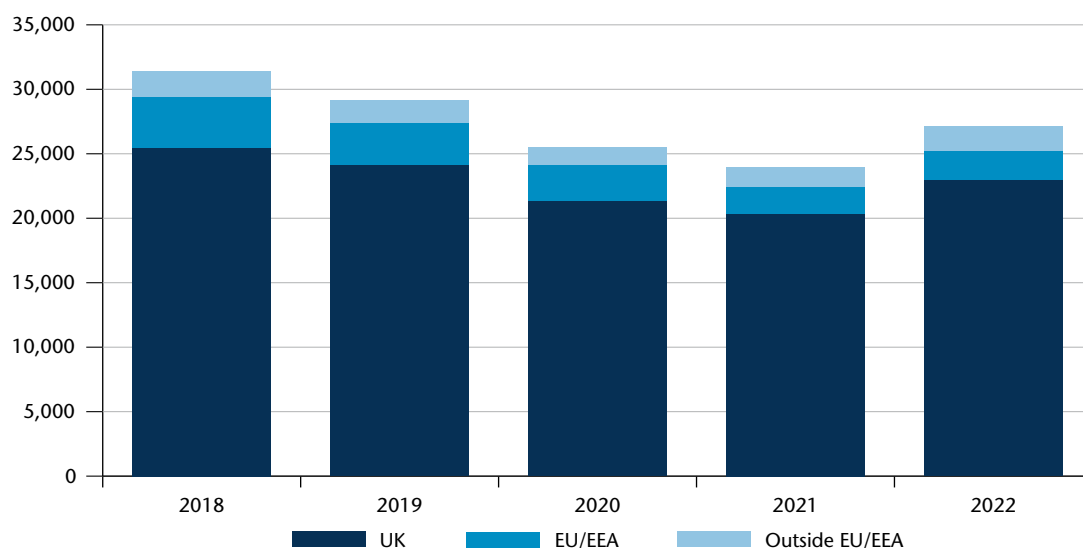
4.144 In the year to March 2022, there was an increase of 26,403 (3.6%) nurses and midwives on the register, as 48,436 joined the register for the first time and 27,133 left the register (Figures 4.36 and 4.37).

Figure 4.36: Joiners to the NMC register, between year to March 2018 and year to March 2022, from the UK, EU/EEA and outside the EU/EEA



Source: National Midwifery Council (NMC) Register, March 2022

- 4.145 Figure 4.36 shows the numbers joining the register for the first time between the year to March 2018 and the year to March 2022. Overall, the numbers joining the register increased in 2019 and 2020, before falling back in 2021. In the year to March 2022, the numbers joining the register were 40% higher than in the previous year. Growth in the numbers joining the register was driven from outside the EU/EEA, with 22,745 joining, an increase of 149% from the previous year. Over the same period 25,028 joined from the UK, an increase of 1.9% from the previous year, while there were 663 joiners from the EU/EEA, a decrease of 18% from the previous year.
- 4.146 Figure 4.37 shows the numbers leaving the register between the year to March 2018 and the year to March 2022. Overall, the numbers leaving the register fell in each of the three years to March 2021, but increased by 13%, from 23,934 to 27,133 in the year to March 2022. In the year to March 2022, there was an increase in the numbers leaving the register from: the UK, of 2,582 (13%); the EU/EEA of 253 (12%); and from outside the EU/EEA of 364 (24%).

Figure 4.37: Leavers from the NMC register, between year to March 2018 and year to March 2022, from the UK, EU/EEA and outside the EU/EEA

Source: National Midwifery Council (NMC) Register, March 2022

Data on pre-registration entrants

4.147 Table 4.5 shows the number of unique applicants²⁶ and acceptances²⁷ to study for a nursing degree between 2012 and 2021.

Table 4.5: Numbers of applicants and acceptances for nursing degrees, UK, 2012-2021

	Number of Applicants	Number of Acceptances	Applicants per Acceptance
2012	61,770	23,835	2.59
2013	63,675	24,700	2.58
2014	67,415	26,965	2.50
2015	66,190	27,535	2.40
2016	66,730	28,890	2.31
2017	54,985	28,620	1.92
2018	50,805	28,540	1.78
2019	54,225	30,390	1.78
2020	62,920	37,630	1.67
2021	73,085	37,805	1.93

Source: OME estimates using UCAS data

4.148 In 2021 there were 73,085 applicants to study a nursing degree in the UK with 37,805 acceptances. In both 2020 and 2021 the number of applicants was 16% higher than in the previous year. In 2020, the number of acceptances was 24% higher than in 2019, and in 2021 the number of acceptances grew by a further 0.5%.

²⁶ Number of unique applicants: defined as the number of applicants who applied to at least one nursing course.

²⁷ Acceptance: defined as an applicant who has been placed for entry into higher education.

4.149 Table 4.6 shows the number of unique applicants and acceptances to study for a degree in health-related subjects between 2012 and 2021.

Table 4.6: Numbers of applicants and acceptances for health-related²⁸ degrees (excluding nursing), UK, 2012-2021

	Number of Applicants	Number of Acceptances	Applicants per Acceptance
2012	63,710	22,780	2.80
2013	66,105	24,775	2.67
2014	70,155	25,440	2.76
2015	69,730	26,005	2.68
2016	71,825	26,560	2.70
2017	66,885	27,135	2.46
2018	67,515	27,720	2.44
2019	74,680	29,575	2.52
2020	79,725	32,445	2.46
2021	92,685	33,920	2.73

Source: OME estimates using UCAS data

International recruitment

4.150 In the year to March 2020, 10,500 AfC staff joining the NHS in England came from outside the UK, accounting for 7% of all new staff. Overseas recruitment for nurses and health visitors was particularly important, with 18% of those joining coming from outside the UK. In the year to March 2021, international recruitment accounted for a smaller share of recruitment than in the previous year, accounting for 5% of all AfC recruits and 10% of newly recruited nurses and health visitors. However, these figures were depressed by the COVID-19 pandemic having an effect on the movement of people into the UK, particularly in the first half of the year. Compared with the year to March 2018, overseas recruitment, despite restrictions on travel, still accounted for a greater share of new recruits in 2021, increasing from 3% for all AfC staff and 5% for nurses and health visitors. Growth has been particularly strong from countries outside the European Union, with 7,700 staff joining in the year to March 2021, and 9,800 in the year to March 2020, compared with an average of 1,200 per year between 2010/11 and 2017/18.

4.151 Data from the Nursing and Midwifery Council (NMC) show the total number of nurses and midwives registered in the UK, whether working in the NHS or not. Table 4.7 shows that in March 2022 there were 758,303 nurses and midwives on the NMC Register, 28,864 of whom were initially registered in the EU/EEA and 113,579 of whom were initially registered outside the EU/EEA. Between March 2019 and March 2022, the total number on the register increased by 60,067 (8.6%), of which 23,967 were first registered in the UK, and 40,271 outside the EU/EEA. The numbers first registered in the EU/EEA fell by 4,171.

²⁸ Includes: Subjects allied to Medicine (B0); Anatomy, Physiology and Pathology (B1); Pharmacology, Toxicology and Pharmacy (B2); Complementary Medicine (B3); Nutrition (B4); Ophthalmics (B5); Aural and Oral Sciences (B6); Medical Technology (B8); Others in Subjects allied to Medicine (B9); and Combinations within Subjects allied to Medicine (BB).

Table 4.7: Number of NMC registered nurses and midwife by origin, March 2019 to March 2022.

	Mar-19	Sep-19	Mar-20	Sep-20	Mar-21	Sep-21	Mar-22
TOTAL	698,236	706,249	716,593	724,516	731,900	744,853	758,303
UK	591,893	596,905	600,905	607,748	609,327	613,215	615,860
EEA	33,035	31,973	31,385	30,895	30,331	29,420	28,864
non-EU/EEA	73,308	77,371	84,303	85,873	92,259	102,218	113,579

Source: NMC Register, March 2022

4.152 Table 4.8 shows that between March 2019 and March 2022 the numbers on the register first registered in the EU/EEA fell steadily, by 13% in total. Over the same period the numbers on the register first registered in the UK increased by 4% and the numbers registered outside the EU/EEA increased by 55%.

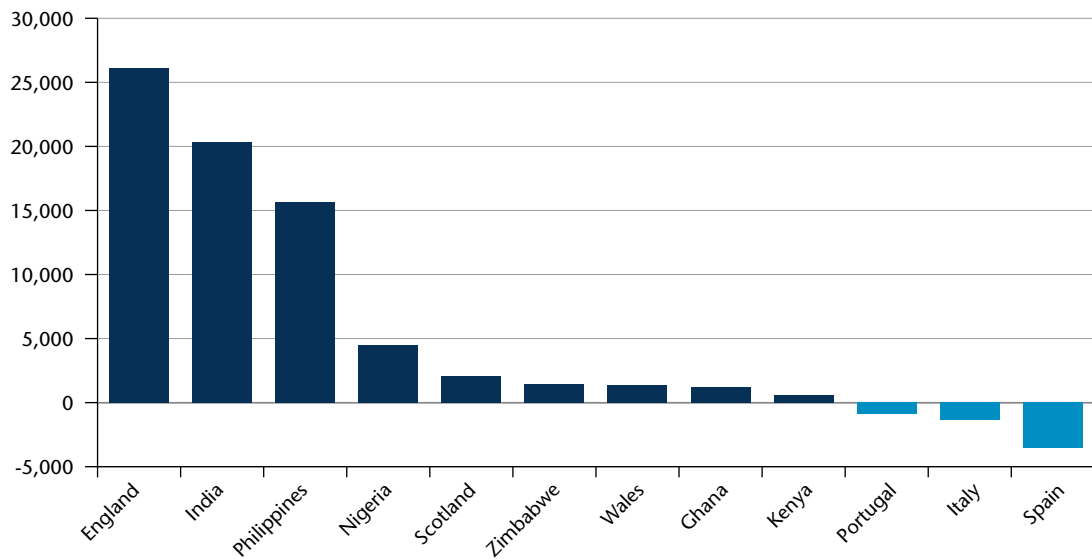
Table 4.8: Change in number of NMC registered nurses by origin, March 2019 to March 2022, compared with previous period, %.

	Sep-19	Mar-20	Sep-20	Mar-21	Sep-21	Mar-22
TOTAL	1.1%	1.5%	1.1%	1.0%	1.8%	1.8%
UK	0.8%	0.7%	1.1%	0.3%	0.6%	0.4%
EU/EEA	-3.2%	-1.8%	-1.6%	-1.8%	-3.0%	-1.9%
non-EU/EEA	5.5%	9.0%	1.9%	7.4%	10.8%	11.1%

Source: NMC Register, March 2022

4.153 Figure 4.38 shows the change in numbers on the NMC register, between September 2017 and March 2022, by country of training. This shows that much of the growth in those registered outside the EEA was driven by nurses trained in India and the Philippines. The numbers on the register from India and the Philippines were more than 20,000 and 15,000 higher respectively, in March 2022 than in September 2017.

Figure 4.38: Changes in the numbers on the NMC register, by country of training, September 2017 to March 2022

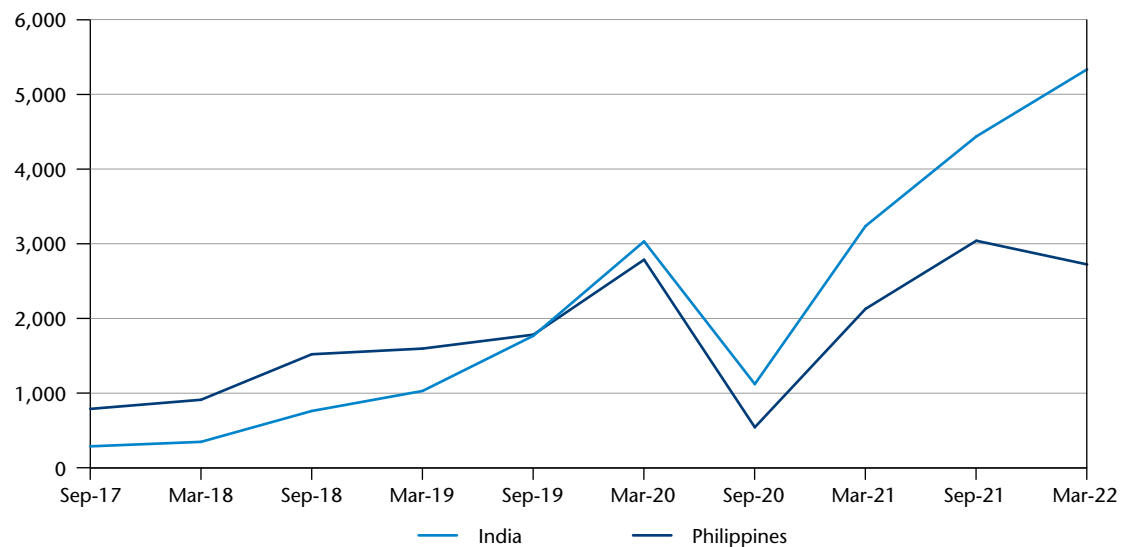


Source: NMC Register, March 2022

Note: Only includes those countries where the net change was greater than +/- 500

4.154 Figure 4.39 highlights the growth in the numbers joining the NMC register who were trained in India and the Philippines since September 2017.

Figure 4.39: New joiners to the NMC register, from India and the Philippines, September 2017 to March 2022

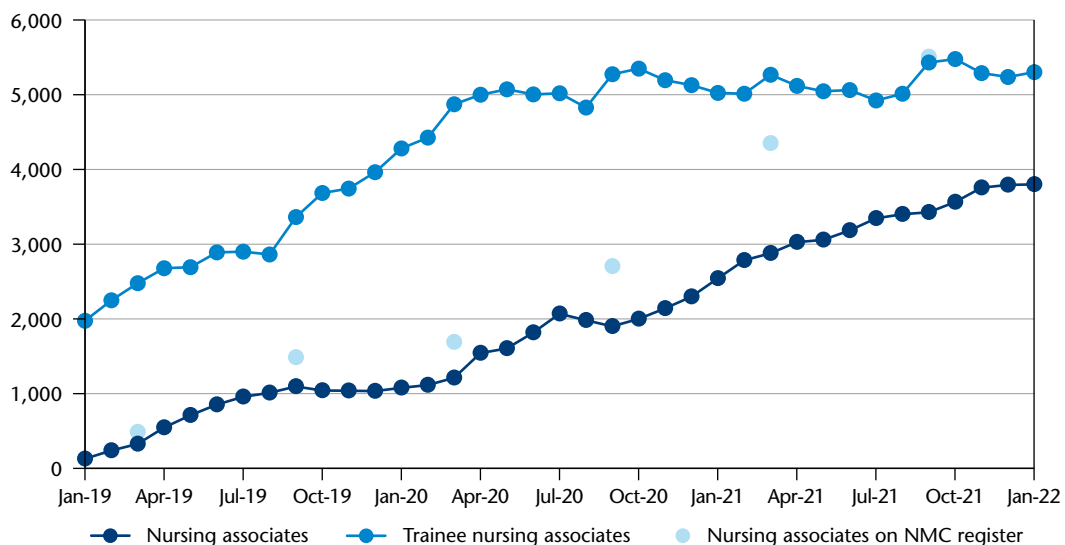


Source: Nursing and Midwifery Council Registry, March 2022

Recruitment of nursing associates in England

4.155 Since March 2019, the NMC has registered nursing associates and its latest data, for March 2022, showed that there were 6,874 nursing associates registered. Data from NHS Digital showed that in January 2022 there were 3,804 FTE nursing associates working in the NHS in England (Figure 4.40), the highest number recorded to date, and an increase of 49% from a year earlier. NHS Digital data also shows that there were 5,302 FTE trainee nursing associates working in the NHS in England, an increase of 5.5% from a year earlier, but a fall of 3.2% from the peak recorded in October 2021.

Figure 4.40: Nursing associates and trainee nursing associates, FTE, England, January 2019 to January 2022



Source: NHS Digital and Nursing and Midwifery Council

Recruitment of apprentices

4.156 Following changes to the apprenticeship system in 2017, the number of all apprenticeship starts in 2017/18 fell 24% to 375,800, from 494,900 in 2016/17. Although some of this decline was reversed in 2018/19, with apprenticeship starts rising by 5% to 393,400, this was followed in 2019/20, with a sharp fall in starts, of 18%, to 322,500, and a further small decline to 321,400 in 2020/21 which could be attributed to the onset of the COVID-19 pandemic.

4.157 The number of Health, Public Services and Care apprenticeship starts broadly exhibited the same pattern as that of all apprenticeship starts. Starts dropped dramatically after the introduction of the apprenticeship levy, then recovered slightly in 2018/19, but fell sharply in 2019/20. However, while the number of all apprenticeship starts fell slightly in 2020/21, the number of Health, Public Services and Care apprenticeship starts increased from 82,200 in 2019/20 to 97,500 in 2020/21, almost returning to the number of starts recorded in 2018/19 (97,700).

4.158 Data for the public sector as a whole showed that between 2017/18 and 2020/21 the number of apprenticeship starts in England was 1.7% of the workforce (on a headcount basis)²⁹. The equivalent figure for the NHS in England was 1.5%. With the exception of the Armed Forces, where apprenticeship starts were 7.9% of the workforce, the NHS was in line with that of most other public sector employers, where new apprenticeships were the equivalent of between 1.0% and 1.8% of the workforce.

Our assessment of workforce numbers and recruitment

- 4.159 We note the year-on-year increase in the face of significant workforce shortages. However, the increase in workforce numbers needs to be in line with the planned and funded ambitions for the service.
- 4.160 Increasing staffing numbers and closing workforce gaps in the medium and long term are dependent on being able to encourage greater numbers to train and qualify for careers in the NHS, more effectively to retain existing members of staff, and, where gaps still exist, to recruit staff from outside the UK.
- 4.161 There was a sharp increase in the number of applicants and acceptances to study for nursing and other health related degrees in 2020 following the introduction of the Learning Support Fund in England for nursing, midwifery and the majority of AHP students from September 2020. In 2021, the number of acceptances remained broadly stable, but the number of applicants grew strongly again. In 2020 there was a particularly large increase, of 28%, in the number of applicants aged 25 and above for nursing and midwifery courses, compared with an 8% increase in the number of applicants aged up to 24. That increase may reflect the relative importance of financial support for more mature students. In 2021, the increase in applicant numbers was more evenly distributed across the age range, with a 16% increase in applicants aged 25 and above, and a 17% increase in applicants aged up to 24.
- 4.162 HEE told us that research with UCAS found that another driver for students coming into nursing and midwifery was the pandemic response of the health service. Although potential students may have considered a career in the health service prior to the pandemic, the pandemic accelerated decision making whilst the wider economy was stressed and re-enforced the criticality of roles in the health sector.
- 4.163 Some of the increase in acceptances may have been attributable to the increase in A Level grades that resulted from centre assessed grading. HEE have reported that progress of these cohorts has been good – with attrition lower than previous cohorts (4% compared to the average of 8-9%). We will continue to monitor the progress of these cohorts.

²⁹ <https://explore-education-statistics.service.gov.uk/find-statistics/apprenticeships-and-traineeships/2019-20#dataBlock-bac86dd0-4fc8-451e-8aa5-8a9bcffdd6c2-charts>

- 4.164 Many existing students on NHS placements had very difficult experiences during the pandemic, and HEE commended the efforts of students. 27,000 students volunteered for deployment in the first wave, which dropped to 5,000 in the second wave. As a consequence of the severe disruption to their training programmes, around 2,000 students had to extend their studies in response to the pandemic; however, this was much lower than the initial projection of 12,000 students (approximately 45%). HEE also told us that they were conscious that students graduating this year would have only spent three months of their training not in a pandemic.
- 4.165 While the sustained increase in student numbers is welcome, it will be at least another year before these students begin to feed through into increased numbers of substantive staff in the NHS, and two to three years before there is sustained impact on vacancy levels. This means that the system will be reliant on recruiting staff from overseas in the short-term to meet demand and deliver the Build Back Better plan. This also means that the system will continue to carry an unacceptable level of vacancies and so effective retention of staff will be critical. We will continue to monitor the data to assess whether the reliance on international recruitment reduces following the increase in domestic supply.
- 4.166 Data from the NMC has shown that a reduction in the number of nurses and midwives (who are counted as one group) from the EU/EEA on their register has been more than matched by an increase in the number of nurses and midwives from outside the EU/EEA, especially from the Philippines and India.
- 4.167 The increase in recruits from outside the EU/EEA demonstrates the appeal of working in the NHS to overseas staff. Although base pay is higher in some other countries, flexible visa rules and connections to the UK often make it the choice of overseas recruits. We would urge employers to ensure that international recruits are well-led and efforts are made to support staff in the community to allow staff to thrive, encouraging them to continue their careers in the NHS.
- 4.168 However, we are concerned to see increased recruitment from red list countries where active international recruitment is not permitted. It remains of the utmost importance that recruitment is in line with the Code of Practice for International Recruitment.
- 4.169 As an increased number of new recruits enter the service, both domestically and internationally, it will be of critical importance that the NHS retains the expertise of senior healthcare professionals, primarily at Bands 6 and 7, who will be instrumental in supporting new trainees and recruits.
- 4.170 The service continues to develop new, less traditional ways of expanding the workforce. As discussed at 3.87, NHS Employers told us in evidence that retention amongst apprentices is higher than staff entering the workforce via other routes. However, we note comments made by HEE and some employers that the Apprenticeship Levy cannot be used to backfill roles and that relaxing the rules to allow this to happen would provide a step change. HEE also told us blended learning was driving significant levels of innovation in training and education which was in turn attracting people who may not have previously considered a career in healthcare.

- 4.171 We have commented in previous reports on apprentices. The NHS is well placed to create attractive apprenticeships, which offer secure employment, fulfilling roles, and excellent training and progression opportunities. Apprenticeships are growing in popularity and are increasingly a focus for talented young people from a diverse range of backgrounds. An apprentice route into the NHS diversifies and helps secure the future supply of staff to the NHS, which is particularly important in a competitive labour market. We heard some examples of where apprenticeships have been integrated into workforce planning at local level, with excellent results, but would welcome evidence on how this is progressing systematically at a national level.
- 4.172 We were told of a number of concerns with Annex 21 of the AfC handbook. The rules mean that an existing member of staff may have to take a pay cut in order to undertake an apprenticeship, which could act as a deterrent to staff looking to progress in their career. We urge Employers and the NHS Staff Council to consider what measures could be put in place to overcome this.
- 4.173 We have discussed the importance of learning and development to staff in previous reports and note that there is no public data available on funding for staff learning and development. We would urge the Government to make this data available to provide transparency about investment in the workforce.
- 4.174 As set out in paragraph 2.68, 11,483 people who have joined the NHS permanently after volunteering for the COVID-19 vaccination programme. This represents a large boost to the workforce and we commend the staff who have taken this opportunity.

Retention

- 4.175 Table 4.9 shows leaving rates in England, and Northern Ireland, by staff group. In England, in the year to December 2021, the leaving rate was 11.2% across all staff groups. Leaving rates ranged between 8.7% (for managers) and 12.6% (for midwives). For many staff groups leaving rates were at their highest since 2018, and for midwives and ambulance staff leaving rates were at their highest since at least 2010.
- 4.176 In Northern Ireland, in the year to March 2021, the leaving rate was 4.8% across all staff groups. Leaving rates ranged between 3.3% for ambulance staff and 6.3% for estates services staff.

Table 4.9: Leaving rates to the NHS by staff group headcount and country, England (year to December 2021) and Northern Ireland (year to March 2021)

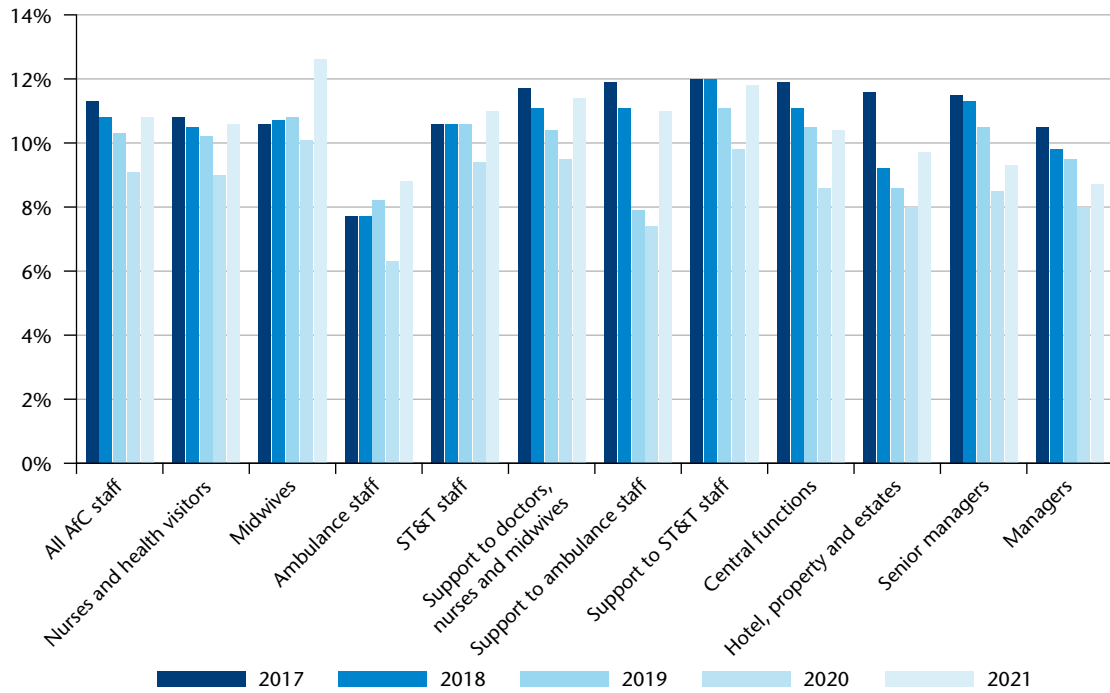
England (year to December 2021)	Leaving rate	Highest leaving rate since year to
AfC Staff (exc bank and locums)	10.8%	June 2018
Nurses & health visitors	10.6%	June 2018
Midwives	12.6%	September 2010
Ambulance staff	8.8%	September 2010
Scientific, therapeutic & technical staff	11.0%	March 2017
Support to doctors, nurses and midwives	11.4%	June 2021
Support to ambulance staff	11.0%	December 2018
Support to scientific, therapeutic & technical staff	11.8%	March 2019
Central functions	10.4%	December 2019
Hotel, property, estates	9.7%	June 2018
Senior managers	9.3%	June 2020
Managers	8.7%	June 2020

Northern Ireland (year to March 2021)	Leaving rate
AfC Staff	4.8%
Administration & clerical	4.2%
Estates services	6.3%
Support services	4.5%
Nursing & midwifery	5.8%
Social services (excl. dom.care)	4.5%
Professional & technical	3.9%
Ambulance	3.3%

Sources: NHS Digital, and the Department of Health, Northern Ireland.

4.177 Figure 4.41 looks at leaving rates for different staff groups in England, between 2017 and 2021. The figure shows that, for most staff groups, leaving rates fell in both 2019 and 2020. However, figures for 2021, compared with 2020, show an increase in leaving rates for all staff groups, with most recording the largest outflow rate since at least 2017. For midwives and ambulance staff leaving rates are at their highest level since at least 2010.

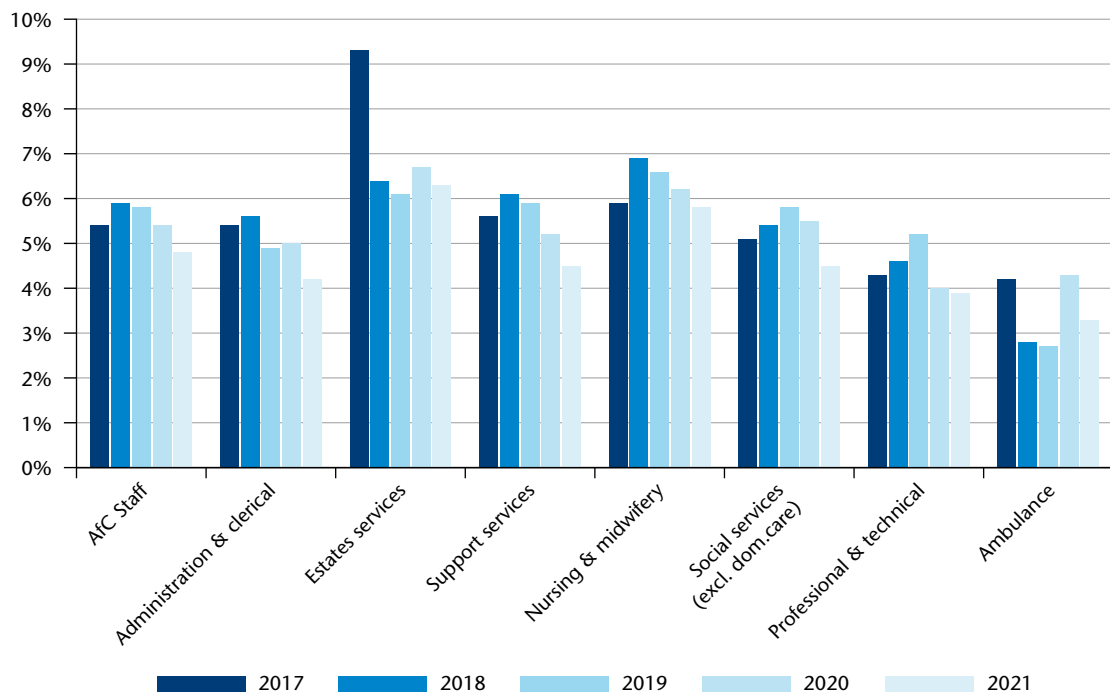
Figure 4.41: Annual leaving rates, England 2017 to 2021



Source: NHS Digital

4.178 Figure 4.42 looks at leaving rates for different staff groups in Northern Ireland, between 2016/17 to 2020/21. In Northern Ireland, the leaving rate for AfC staff as a whole, fell from 5.9%, in 2017/18, to 4.8% in 2020/21. All staff groups recorded a lower leaving rate in 2020/21 than in 2019/20.

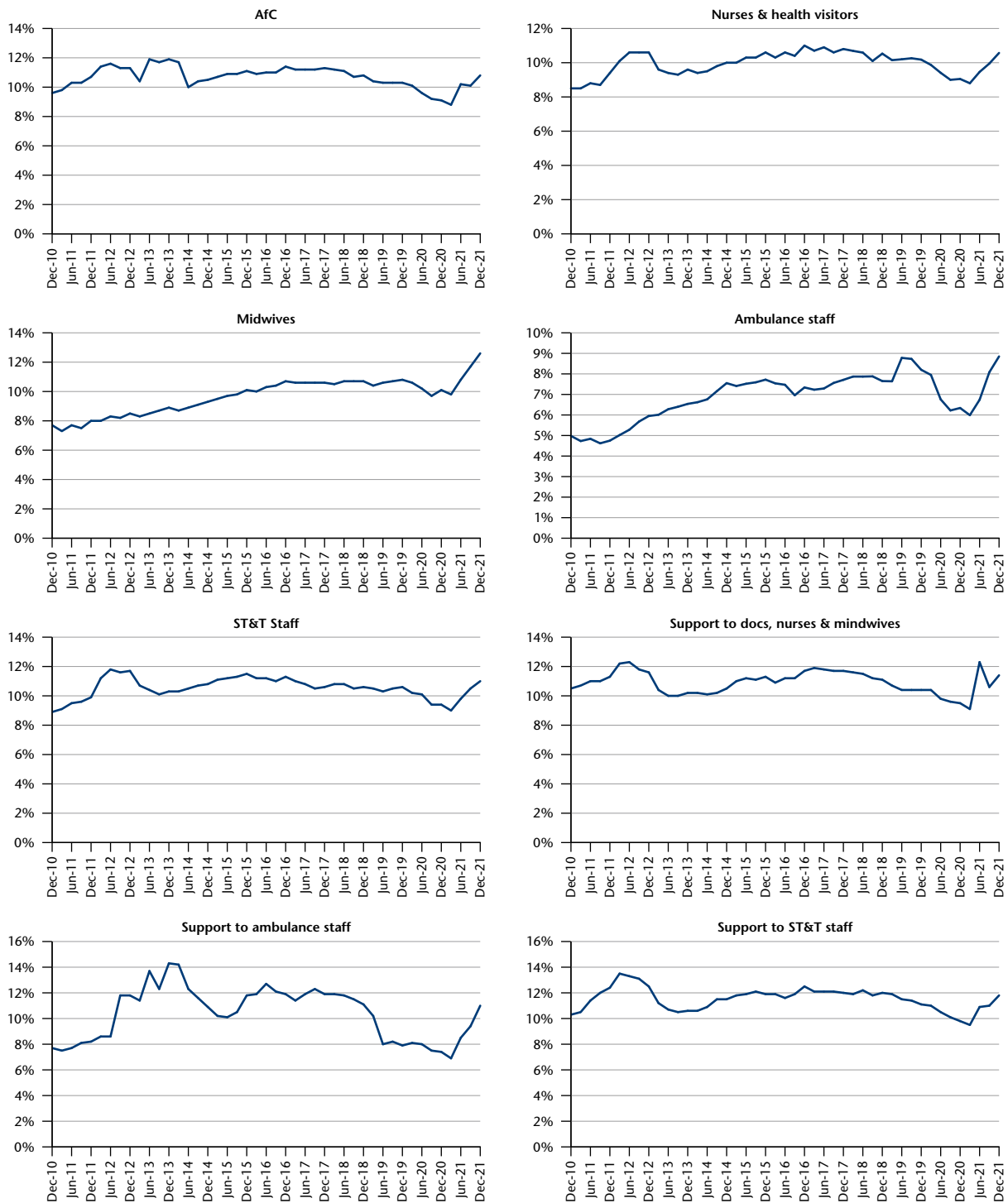
Figure 4.42: Annual leaving rates, Northern Ireland, 2016/17 to 2020/21

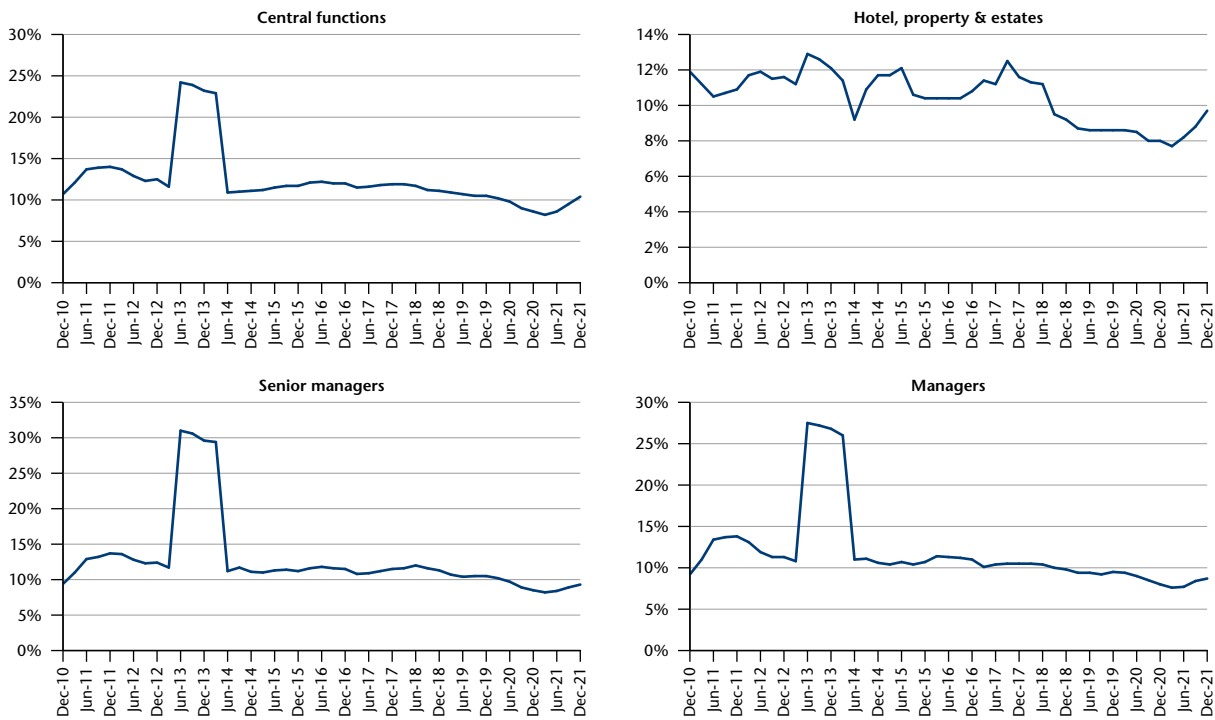


Source: Department of Health, Northern Ireland

4.179 NHS Digital produces leavers data on a quarterly basis, for England, with the latest data covering the period to December 2021 (Figure 4.43). Compared with the 12 months to September 2021, the data show rates of outflow for AfC staff as a whole, and for most individual staff groups, at the highest level for at least three years. Outflow rates for midwives and ambulance staff are at their highest levels since at least 2010.

Figure 4.43: Leaving and joining rates to the NHS by staff group, headcount, year 2010 to 2021, England





Source: NHS Digital.

4.180 NHS Digital publish data for England, showing reasons why staff left the NHS. For those leaving between April 2020 and March 2021 the most common reasons given for leaving were voluntary resignation (40%) and retirement (17%). For a further 34% of staff leaving the NHS the reasons for leaving were unknown. Amongst those leaving voluntarily, 8% of all leavers said that they did so for reasons related to work-life balance and a further 1% said that they left for a better reward package. However, given the large percentage of leavers for whom no information is available, this data is of limited value.

Our assessment of retention

- 4.181 In England, NHSEI recognise that the staff needed to deliver the Build Back Better plan were the same staff who needed time to recover from the pandemic. It is difficult to balance the different needs well. We welcome NHSEI’s all-staff retention programme (discussed at paragraph 3.131) and the generational retention programme to support staff at all stages of their careers.
- 4.182 NHS Employers told us that retention was harder than ever before, and a lot of the gaps were being filled by bank and agency staff.
- 4.183 In last year’s report, we noted that any economic upturn could impact on the ability of the NHS to retain its staff and recommended that the NHS should ensure that it is well placed to meet external challenges from other potential employers, through offering competitive pay and reward, and being recognised as a good employer. In evidence, we heard extensively that parties are now experiencing significant retention challenges and data suggests that the NHS is experiencing an increase in leavers, similar to rates last seen in 2017, before the implementation of the 2018 pay deal.

- 4.184 As new students entering training will not begin to enter the service until 2023 and may have a range of options for pursuing their careers on completion of their training, we note that retention remains a priority, so staff are able to meet the demand and deliver the asks in the Build Back Better plan.
- 4.185 We are particularly concerned about the ongoing retention issues amongst midwives as NHS Digital have reported the first year-on-year fall in midwives since records began in 2009. This is despite the number of registered midwives on the NMC register increasing 12% since 2018. The Ockenden report highlighted many issues in maternity safety and the stress experienced by midwives, of which the majority are in Bands 6 and 7. We welcome the £127 million funding boost for maternity services across England, with £50 million allocated to increasing workforce numbers.
- 4.186 The Staff Survey data showed that an increased number of NHS staff are considering leaving their roles and this intention is now at its highest level since the question was first asked in 2018. Alongside this, we are seeing an increase in leavers, as reflected in the NMC's annual data report, with leaver rates amongst nurses and midwives at their highest since March 2017.
- 4.187 We note the retention asks of the Staff Side listed at 3.136. We agree that it is important to ensure additional hours do not go unpaid and we urge NHS Trusts to ensure they have effective systems in place to pay staff for overtime.
- 4.188 We understand that the combination of the COVID-19 and staff shortages have led to excess hours and burnout and encourage employers to work with their workforce to prevent excess working hours which lead to stress and burnout.
- 4.189 We agree that the NHS should continue to support progression and career development. In oral evidence, there was a consensus that the new arrangements for pay progression were as yet untested, as the appraisal process had been de-prioritised throughout the COVID-19 pandemic and in many cases, progression has been automatic. We encourage employers to re-prioritise the appraisal process as soon as possible to monitor the progress of staff across the system.
- 4.190 We noted last year that the NHS needs to be well placed to meet external challenges from other potential employers, through offering competitive pay and reward, and being recognised as a good employer. Evidence suggests that as the economy has recovered, staff have left the NHS for other employers with more competitive pay and reward packages, including employers offering higher basic pay. We note the increased opportunities for staff at Bands 1-4 where parties told us there were unprecedented recruitment and retention challenges.
- 4.191 In our 2020 and 2021 reports we highlighted the weaknesses of the data looking at the reasons for leaving, with there being no specific information on why many of those leaving chose to do so. There was no improvement in the quality of the data we saw this year, and again we encourage the parties to provide more comprehensive data for us to consider next year.

RRP and HCAS

- 4.192 A number of parties raised RRP and HCAS with us. The Staff Side raised the use of local RRPs with us and the Royal College of Nursing asked for a national RRP specifically for their profession. There was consensus that RRPs were not used well locally. Anecdotally, this is to avoid a competitive wage spiral with other Trusts, and the application of RRPs can cause an imbalance of staff numbers across a single Trust. Despite this, local Trusts will apply RRPs where they think they are appropriate, and we welcome evidence from parties on the effectiveness of their application. In our 2020 report we set out the evidence requirements we would need in order to determine the suitability of a national RRP for a professional group. In assessing the evidence available to us for this report we note very significant retention risks for nurses, but do not, on balance, view the risks to be confined to this group.
- 4.193 Looking forward, if current retention risks persist or become worse, we would be happy to support parties in an assessment of this evidence at any stage.
- 4.194 The current HCAS system remains of concern to the Joint Staff Side. There are concerns that the system is outdated and the boundaries need updating. The full effects of the COVID-19 pandemic on the decisions people make about where to live and work and that employers make about the extent to which some employees can work remotely are not yet clear. For that reason, we believe that this is not the right time to review the system and we look forward to receiving further evidence on HCAS in future pay rounds.

Earnings

Earnings growth

- 4.195 The 2018 AfC pay agreement spans the period between April 2018 and March 2021. The latest data, for England, covers the period up to and including December 2021.
- 4.196 An analysis of basic pay³⁰ and overall earnings³¹ growth between the year to December 2017 and the year to December 2021, can be used as a proxy for basic pay and earnings growth since the start of the 2018 AfC pay agreement (Table 4.10).

³⁰ Measuring salaries on a per person basis tends to deflate the estimate of earnings, the severity of which will vary depending on the numbers of staff working part-time.

³¹ Total earnings include: basic salary (per person) and non-basic salary (per person). Non-basic salary includes hours-related pay, such as on-call, shift working and overtime; location payments such as location allowances and other local payments; recruitment and retention premia; and 'other' payments such as occupational absence and protected pay.

Table 4.10: Average basic pay and annual earnings per person, England, between 12-month periods ending December 2017 and December 2021

Staff group	Basic pay per head		Earnings per head		Basic pay per head (% change)	Earnings per head (% change)
	Year to Dec 2017	Year to Dec 2021	Year to Dec 2017	Year to Dec 2021		
Nurses & health visitors	£27,811	£31,366	£31,592	£35,692	12.8%	13.0%
Midwives	£26,929	£30,293	£31,644	£35,476	12.5%	12.1%
Scientific, therapeutic & technical staff	£29,993	£34,026	£32,507	£37,072	13.4%	14.0%
Support to doctors, nurses & midwives	£16,021	£18,501	£18,411	£21,079	15.5%	14.5%
Support to ST&T staff	£16,925	£19,805	£18,247	£21,449	17.0%	17.5%
Central functions	£23,225	£27,044	£24,556	£28,731	16.4%	17.0%
Hotel, property & estates	£14,505	£17,060	£17,661	£20,634	17.6%	16.8%
Senior managers	£73,120	£79,362	£76,161	£83,094	8.5%	9.1%
Managers	£45,190	£52,735	£47,570	£55,802	16.7%	17.3%
Ambulance staff/Support to ambulance staff	£22,470	£25,953	£30,679	£36,071	15.5%	17.6%
All AFC staff	£23,774	£27,058	£26,753	£30,488	13.8%	14.0%

Source: NHS Digital.

4.197 Key points from the data are that between the year to December 2017 and the year to December 2021:

- For all AfC staff, on average, basic pay and overall earnings each grew by 14%.
- Against both basic pay and average earnings: senior managers; nurses & health visitors; midwives; and scientific, therapeutic & technical staff, saw smaller average increases than other groups.
- The staff groups with the largest proportion of staff in Bands 1-4 saw larger increases than for other groups. This is likely to be driven by the closure of Band 1 and the completion of scale shortening in the lower bands within the three years of the deal.

4.198 Table 4.11 shows the breakdown of average total earnings for the main staff groups for the 12 months ending December 2017 and December 2021. Overall, non-basic pay made up 11% of all earnings in both 2017 and 2021. The groups where non-basic pay made up the greatest share of total earnings were ambulance/support to ambulance staff (28% in December 2021) and hotel, property and estates staff (17%). For both of these groups, shift work payments and overtime account for the greatest share of non-basic pay.

Table 4.11: Breakdown of total earnings per person for main staff groups, 12 months ending December 2017 and December 2021, England

Staff group	Non-basic pay as share of earnings	
	Year to Dec 2017	Year to Dec 2021
Nurses & health visitors	12%	12%
Midwives	15%	15%
Scientific, therapeutic & technical staff	8%	8%
Support to doctors, nurses & midwives	13%	12%
Support to ST&T staff	7%	8%
Central functions	5%	6%
Hotel, property & estates	18%	17%
Senior managers	4%	4%
Managers	5%	5%
Ambulance staff/Support to ambulance staff	27%	28%
All AFC staff	11%	11%

Source: NHS Digital.

4.199 Table 4.12 shows more recent changes in basic pay and overall earnings, between the year to December 2020 and the year to December 2021. It shows that average basic pay increased by 4.1% over the period, while average earnings per person increased by 4.3%.

Table 4.12: Change in average basic pay and annual earnings per person, England, between 12-month periods ending December 2020 and December 2021

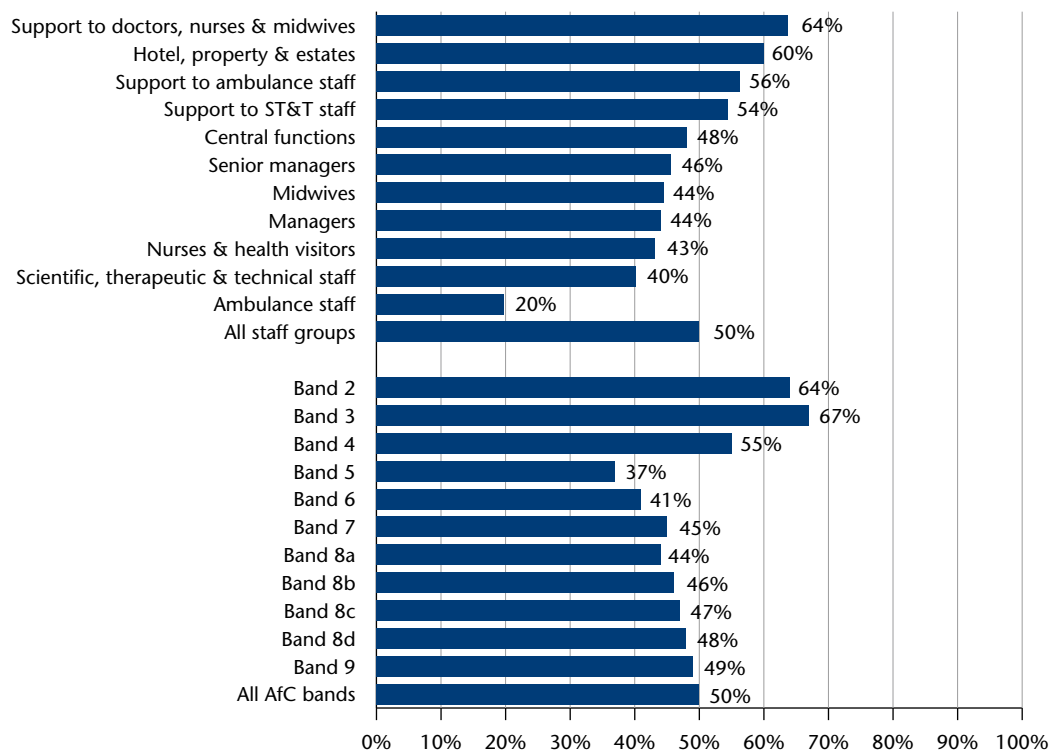
Staff group	Basic pay per head	Earnings per head
	from Dec 20 to Dec 21	
Nurses & health visitors	3.9%	4.0%
Midwives	3.7%	3.9%
Scientific, therapeutic & technical staff	4.1%	4.4%
Support to doctors, nurses & midwives	3.9%	4.0%
Support to ST&T staff	4.7%	5.3%
Central functions	4.5%	4.8%
Hotel, property & estates	5.0%	5.6%
Senior managers	1.9%	1.6%
Managers	4.5%	4.2%
Ambulance staff/Support to ambulance staff	4.3%	6.9%
All AFC staff	4.1%	4.3%

Source: NHS Digital.

4.200 Average basic pay grew by between 3.7% and 4.5% for most groups, the exceptions being hotel, property and estates staff (5.0%), support to ST&T staff (4.7%) and senior managers (1.9%). Average earnings per head grew by between 3.9% and 4.8% for most groups, the exceptions being ambulance staff/support to ambulance staff (6.9%), hotel, property and estates staff (5.6%), support to ST&T staff (5.3%), and senior managers (1.6%).

4.201 Figure 4.44 shows that in England, at the end of March 2021, 50% of AfC staff were at the top of their pay band. The proportion varied across staff groups, between 20% of ambulance staff and 64% of staff supporting doctors, nurses and midwives. Other than Band 1, which is now a single pay point, the bands with the largest percentage of staff on top of their pay band were Band 3 (67%) and Band 2 (64%), while the bands with the smallest percentage of staff on top of their pay band were Band 5 (37%) and Band 6 (41%).

Figure 4.44: Estimated share of staff (FTE) on top of band by staff group and band, 31 March 2021, England

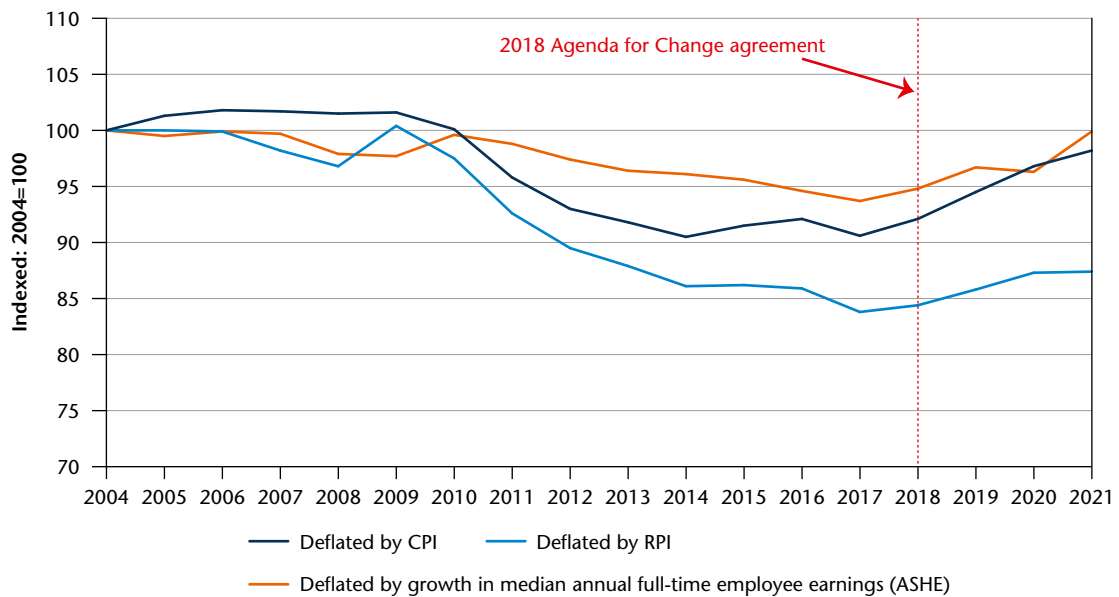


Source: NHS Digital.

Nursing starting pay

4.202 Figure 4.45 shows changes to the nurse starting pay point in England since the introduction of AfC in 2004, adjusted either for inflation or earnings growth in the wider economy. Following the introduction of AfC 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 2018 AfC pay agreement meant that in each year between 2018 and 2021 starting pay for nurses grew more quickly than both CPI and RPI price inflation. In both 2018 and 2019 starting pay grew more quickly than median earnings, fell back slightly in 2020, but grew more quickly again in 2021. Nurses starting pay in 2021 was at its highest value since 2013 relative to RPI and since 2010 relative to CPI. However, nurses starting pay still remains below its value when AfC was introduced in 2004.

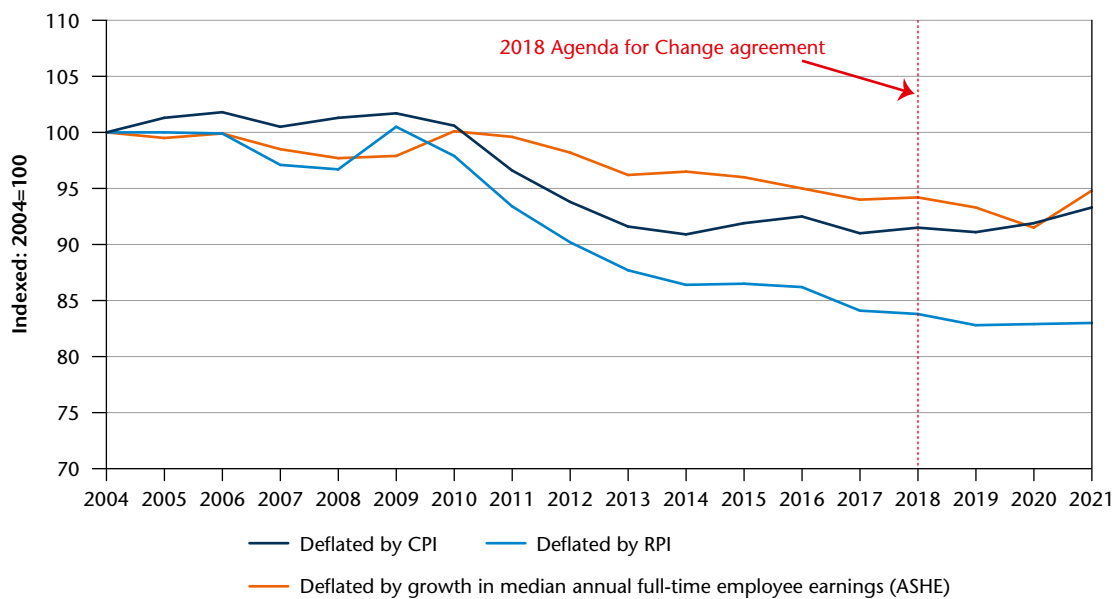
Figure 4.45: Nurse starting pay point deflated by the growth in median earnings and inflation, England, 2004 to 2021



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

- 4.203 The bottom point on Band 5 will be the pay point on which most nurses join the service, but there are also more nurses and health visitors paid on Band 5 than any other Band and 37% of staff at Band 5 are on the top of the pay band. Figure 4.45 shows changes to the value of the pay point at the top of Band 5 since the introduction of Agenda for Change (AfC) in 2004, adjusted either for inflation, or earnings growth in the wider economy. Following the introduction of AfC the pay point at the top of Band 5 maintained its value against inflation until 2009 and average earnings growth until 2010. However, between 2011 and 2017 the value of the top point of Band 5 increased by just 4%, meaning that this point lost value compared with both inflation and earnings growth. The 2018 AfC pay agreement saw the Band 5 maximum increase by 3.0% in the first year of the deal and 1.7% in each of the second and third years. These increases meant that although the Band 5 maximum continued to lose ground against RPI and average earnings growth, it did maintain its value against CPI over the course of the agreement. In 2021, the Band 5 maximum increased by 3.0%, compared with price inflation in April 2021 of 2.9% measured by RPI and CPI of 1.5%.

Figure 4.46: Top of Band 5, deflated by the growth in median earnings and inflation, England, 2004 to 2021



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

Pay comparisons: ASHE

4.204 The Annual Survey of Hours and Earnings (ASHE) has been used for a number of years to compare earnings for the human health and social work activities sector³² with employees in the public and private sector as well as to certain broad occupational groups. These sector and group earnings (median gross weekly pay) are shown in Table 4.13. In 2021 median gross weekly pay for full-time employees in the human health and social work activities sector increased by 1.7%, compared with 4.3% across the economy as a whole and 2.5% across the public sector. Median gross weekly pay in the private sector increased by 3.6%. The reference period for the weekly ASHE calculations is in April, which means that some of the data is likely to be affected by the lockdown of the economy from March 2020 onwards.

³² This section includes the provision of health and social work activities. It covers a wide range of activities, from health care provided by trained medical professionals in hospitals and other facilities, to residential care activities that still involve a degree of health care activities and to social work activities not involving the services of health care professionals

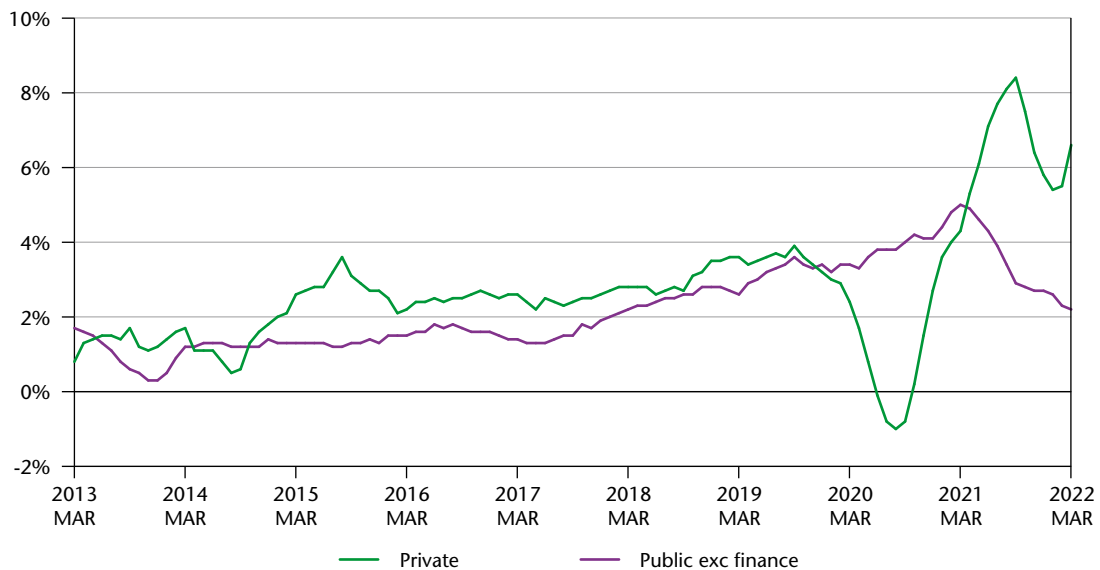
Table 4.13: Change in median gross weekly pay for full-time employees at adult rates, 2018 to 2021, April each year, United Kingdom

	Median gross weekly pay (change on previous year)								Change 2018- 2021
	2018		2019		2020		2021		
Human health and social work activities sector	£530	(3.9%)	£552	(4.3%)	£563	(2.0%)	£573	(1.7%)	8.2%
All employees	£568	(3.3%)	£585	(3.0%)	£586	(0.1%)	£611	(4.3%)	7.5%
Public sector	£613	(2.2%)	£632	(3.2%)	£648	(2.5%)	£664	(2.5%)	8.4%
Private sector	£548	(3.3%)	£571	(4.1%)	£566	(-0.8%)	£586	(3.6%)	6.9%
Professional occupations	£745	(1.6%)	£769	(3.2%)	£777	(1.1%)	£798	(2.7%)	7.1%
Associate professional and technical occupations	£619	(2.4%)	£624	(0.8%)	£612	(-1.9%)	£625	(2.1%)	1.0%
Administrative & secretarial occupations	£445	(3.2%)	£457	(2.7%)	£461	(0.8%)	£479	(4.0%)	7.6%
Skilled trades occupations	£524	(2.7%)	£541	(3.3%)	£506	(-6.5%)	£552	(9.0%)	5.3%
Caring, leisure and other service occupations	£374	(3.4%)	£392	(5.0%)	£404	(3.0%)	£413	(2.2%)	10.4%

Source: ONS (Annual Survey of Hours and Earnings)

4.205 In the remit letter to NHSPRB for our 2021 report, and those to the other pay review bodies, the UK Government said that according to the ONS Average Weekly Earnings (AWE) data, in the six months to September 2020, the private sector had seen a pay cut of nearly 1% compared to last year, yet public sector earnings were up by almost 4%. This statement was based on the AWE for the six months to September 2020 compared with the same six months in 2019. Figure 4.47 shows AWE growth using that method, from 2013 onwards, but run forward to March 2022 (the latest month for which data is available). By September 2021, the difference between private and public sector earnings growth had reversed, with private sector earnings growth outstripping that of the public sector by 5.5%. Although the gap has since narrowed, private sector earnings growth (at 6.6%) was still 4.3% greater than public sector earnings growth (2.2%) in March 2022.

Figure 4.47: Average weekly earnings, six months compared with same period a year earlier, public sector (excluding finance) and private sector, March 2013 to March 2022, Great Britain



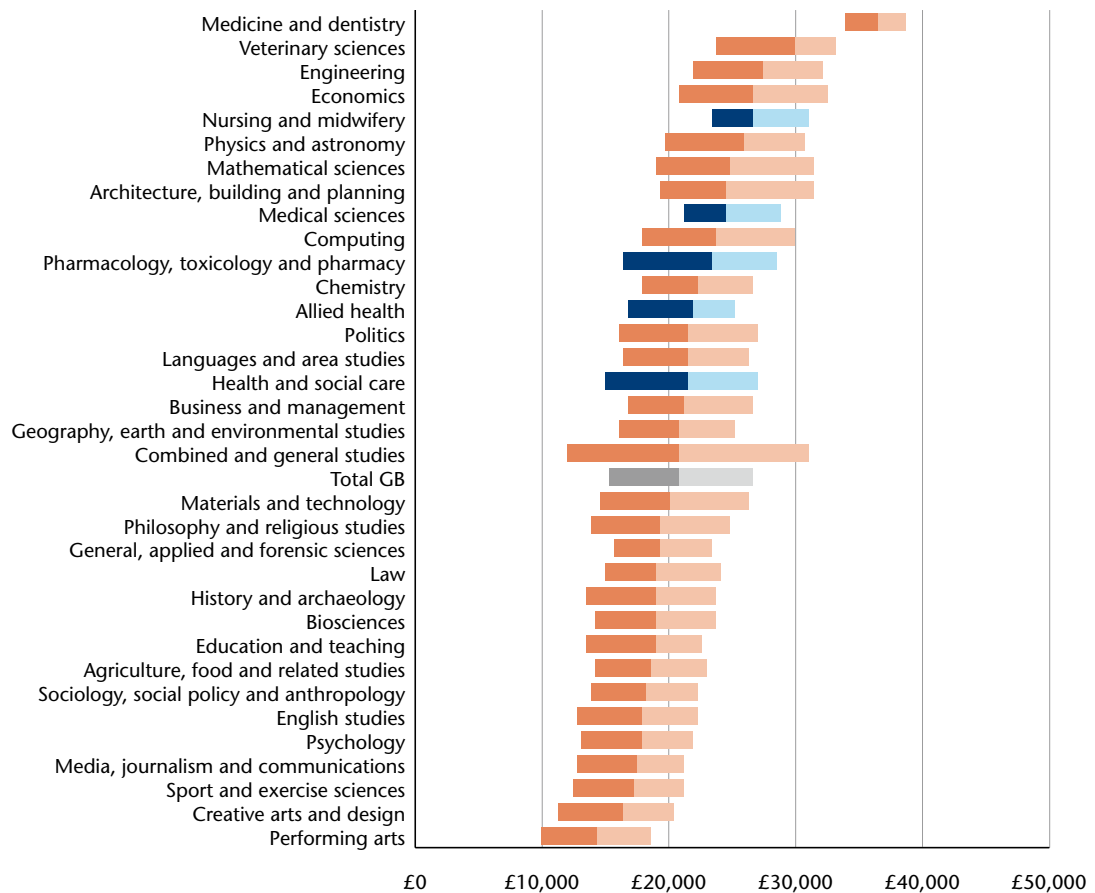
Source: ONS

Pay comparisons: LEO data

- 4.206 Data from the Longitudinal Education Outcomes (LEO) data set, published by the Department for Education, track the nominal earnings³³ of UK-domiciled first-degree graduates from English Higher Education Institutions and Further Education Colleges, using HMRC data. The data show median earnings in 2018/19, by subject studied, for those one, five and ten years after graduation. The LEO data cover annual earnings, for both full and part time workers, and is not adjusted for geography, age or other factors. It also includes the earnings of those working in areas unrelated to their degree subject, for example someone with a nursing degree working outside the health sector.
- 4.207 Figure 4.48 shows median earnings (the centre line of the bars), and the inter-quartile range of earnings (the end points of the bars), one year after graduation. Only those who studied: medicine and dentistry; veterinary sciences; engineering; and economics had higher median earnings than those who studied nursing or midwifery. Median earnings of those who studied: medical sciences; pharmacology, toxicology and pharmacy; allied health subjects; and subjects related to health and social care, were also above the median for graduates as a whole.

³³ Nominal earnings defined as the cash amount an individual was paid, not adjusted for inflation.

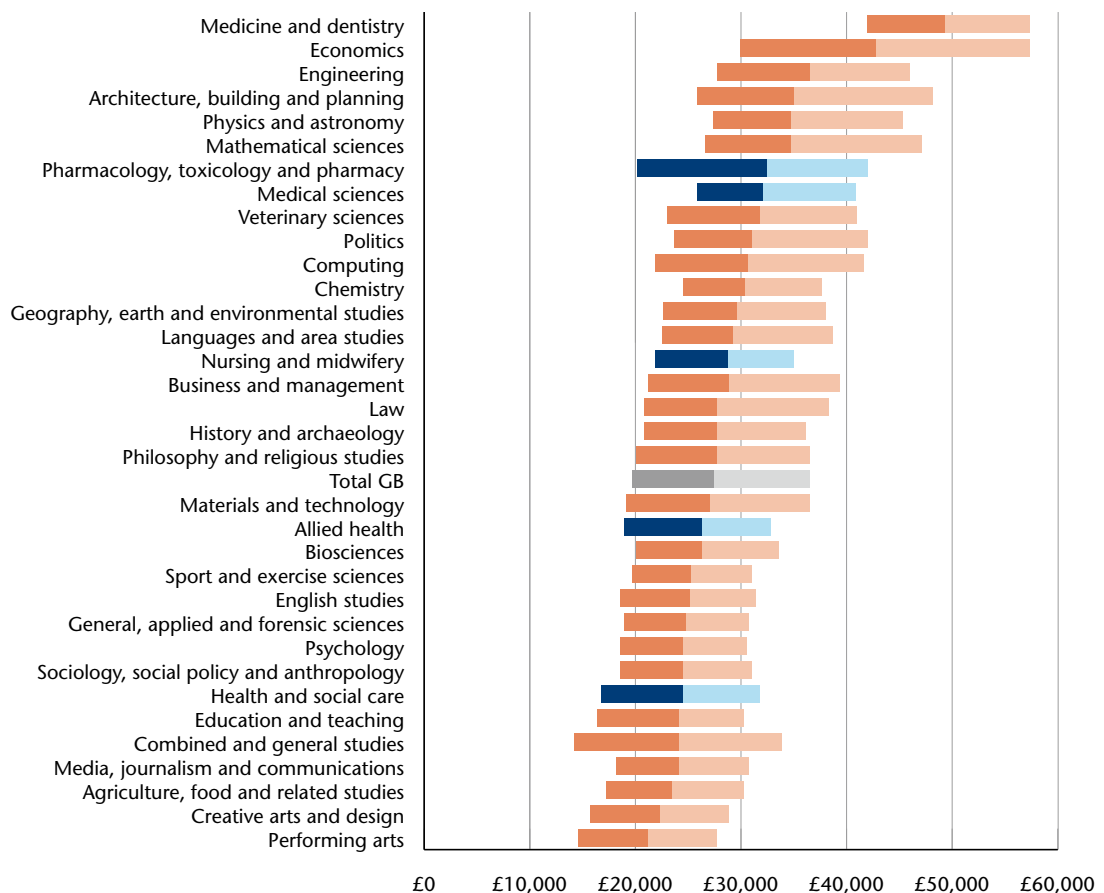
Figure 4.48: Annual gross earnings one year after graduation (2016/17 cohort), lower quartile, median and upper quartile, £



Source: OME analysis of LEO data set

4.208 Figure 4.49 shows that median earnings, five years after graduation, for those who studied pharmacology, toxicology and pharmacy and medical sciences were still considerably above median earnings for graduates as a whole. For those who studied nursing or midwifery, median earnings were still above the median for graduates as a whole, but by less than they had been one year after graduation. Median earnings for those who had studied allied health subjects, and subjects related to health and social care had fallen below the median for graduates as a whole.

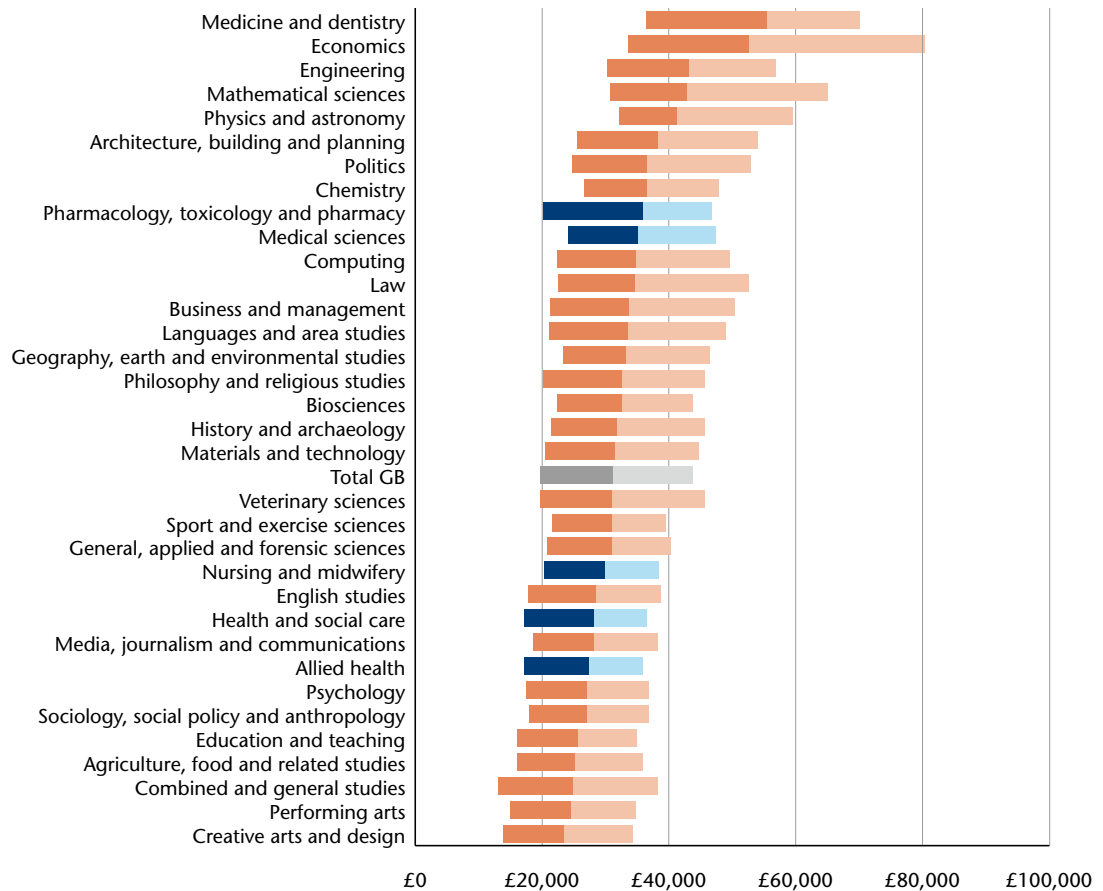
Figure 4.49: Annual gross earnings, five years after graduation (2012/13 cohort), lower quartile, median and upper quartile, £



Source: OME analysis of LEO data set

4.209 Figure 4.50 shows that median earnings, ten years after graduation, for those who studied medical sciences, and pharmacology, toxicology and pharmacy, were still above the median for graduates as a whole. However, median earnings for those who studied nursing or midwifery, had fallen below the overall graduate median, as were median earnings of those who studied subjects related to health and social care and for those who studied allied health subjects.

Figure 4.50: Annual gross earnings 10 years after graduation (2007/08 cohort), lower quartile, median and upper quartile, £



Source: OME analysis of LEO data set

Take-home pay

4.210 In the four years since the start of the 2018 AfC pay agreements, basic pay for NHS staff at the top of their band in England increased by between 18.3% for Band 1 and 7.6% for Band 9. After taking account of changes to income tax, national insurance and pension contributions, take-home pay increased by between 16.7% for Band 1, the highest increase, and 8.2% for Band 9, the lowest increase, over the same period.

Table 4.14: Basic full-time pay and take-home pay, at the top of pay bands, England, 2017/18 to 2021/22

Top of:	Basic pay				Change 20/21 to 21/22		Change 17/18 to 21/22	
	2017/18	2019/20	2020/21	2021/22	£	%	£	%
Band 1	£15,671	£17,652	£18,005	£18,546	£541	3.0	£2,875	18.3
Band 2	£18,157	£19,020	£19,337	£19,918	£581	3.0	£1,761	9.7
Band 3	£19,852	£20,795	£21,142	£21,777	£635	3.0	£1,925	9.7
Band 4	£22,683	£23,761	£24,157	£24,882	£725	3.0	£2,199	9.7
Band 5	£28,746	£30,112	£30,615	£31,534	£919	3.0	£2,788	9.7
Band 6	£35,577	£37,267	£37,890	£39,027	£1,137	3.0	£3,450	9.7
Band 7	£41,787	£43,772	£44,503	£45,839	£1,336	3.0	£4,052	9.7
Band 8a	£48,514	£50,819	£51,668	£53,219	£1,551	3.0	£4,705	9.7
Band 8b	£58,217	£60,983	£62,001	£63,862	£1,861	3.0	£5,645	9.7
Band 8c	£69,168	£72,597	£73,664	£75,874	£2,210	3.0	£6,706	9.7
Band 8d	£83,258	£86,687	£87,754	£90,387	£2,633	3.0	£7,129	8.6
Band 9	£100,431	£103,860	£104,927	£108,075	£3,148	3.0	£7,644	7.6

Top of:	Take-home pay				Change 20/21 to 21/22		Change 17/18 to 21/22	
	2017/18	2019/20	2020/21	2021/22	£	%	£	%
Band 1	£13,234	£14,748	£15,077	£15,443	£366	2.4	£2,209	16.7
Band 2	£14,813	£15,617	£15,923	£16,314	£391	2.5	£1,501	10.1
Band 3	£15,890	£16,745	£17,069	£17,234	£164	1.0	£1,344	8.5
Band 4	£17,416	£18,344	£18,695	£19,169	£474	2.5	£1,753	10.1
Band 5	£20,688	£21,772	£22,180	£22,759	£579	2.6	£2,071	10.0
Band 6	£24,825	£26,105	£26,586	£27,297	£711	2.7	£2,472	10.0
Band 7	£28,586	£30,044	£30,591	£31,422	£831	2.7	£2,836	9.9
Band 8a	£31,769	£33,093	£33,774	£34,824	£1,050	3.1	£3,055	9.6
Band 8b	£37,179	£39,332	£39,951	£40,939	£989	2.5	£3,760	10.1
Band 8c	£42,710	£44,762	£45,398	£46,550	£1,152	2.5	£3,841	9.0
Band 8d	£49,325	£51,793	£52,429	£53,792	£1,363	2.6	£4,467	9.1
Band 9	£57,895	£60,362	£60,999	£62,619	£1,620	2.7	£4,724	8.2

Source: OME analysis of NHS Employers data

National Living Wage

4.211 Table 4.15 shows changes in the NLW and the Living Wage Foundation real Living Wage since 2017. Following the introduction of the new NLW on 1st April 2022, the salaries attached to the lowest pay points on the AfC scale (Band 1 and Band 2 minimum) equated to an hourly rate just below the new NLW (£9.49 per hour compared with the new legal minimum of £9.50 per hour). This prompted DHSC to announce a temporary increase in the lowest pay points on the AfC scale to a level equivalent to £9.65 per hour, pending the NHRPB recommendations.

Table 4.15: National Living Wage and the Living Wage Foundation real Living Wage rates per hour, in place at April; 2022

Year	National Living Wage (NLW)		Living Wage Foundation National Living Wage (LWFNLW)		Living Wage Foundation Living Wage (London)		Agenda for Change pay minimum			
	£ per hour	change from previous year	£ per hour	change from previous year	£ per hour	change from previous year	£	£ per hour	relative to NLW	relative to LWFNLW
2017	7.50		8.45		9.75		15,404	7.88	5%	-7%
2018	7.83	4.4%	8.75	3.6%	10.20	4.6%	17,460	8.93	14%	2%
2019	8.21	4.9%	9.00	2.9%	10.55	3.4%	17,652	9.03	10%	0%
2020	8.72	6.2%	9.30	3.3%	10.75	1.9%	18,005	9.21	6%	-1%
2021	8.91	2.2%	9.50	2.2%	10.85	0.9%	18,546	9.49	6%	0%
2022	9.50	6.6%	9.90	4.2%	11.05	1.8%				
Change from 2017 to 2021	19%		12%		11%		20%			

Source: Low Pay Commission, Living Wage Foundation

- 4.212 During oral evidence many of the parties expressed support for linking the Band 1 and Band 2 minimum pay points to the Living Wage Foundation real Living Wage, which is currently £9.90 per hour (and £11.05 in London). The Foundation announce an update to their measures in November each year.
- 4.213 The Low Pay Commission, which makes recommendations to Government each year on the level of the NLW, has been asked to increase the NLW to a target of two-thirds of median earnings, by 2024. The LPC projects that this will require a NLW of £10.32 per hour from April 2023 and £10.95 per hour from April 2024 (increases of 8.6% and 6.1% in each year). However, the OBR have predicted a less steep pathway for the NLW, with increases required to £9.97 per hour in 2023 and £10.33 in 2024 (4.9% and 3.6% in each year).
- 4.214 In oral evidence, the DHSC suggested that they would like to be able to avoid the need to announce further temporary increases to the lowest pay points, in order to keep ahead of the NLW. In effect this would require making an award for April 2022 for Band 1/Band 2 minimum that is greater than the NLW to be in place from April 2023. The LPC and OBR projections of where the NLW is likely to need to be in April 2023 differ by £0.35 per hour (LPC £10.32 per hour and OBR £9.97 per hour).

Our assessment of AfC earnings

- 4.215 We note, as reflected in table 4.15, the reduction in the gap between the bottom pay point and the National Living Wage over recent years. Pay has also been rising strongly in private sector roles that offer reasonable alternative employment for NHS staff in the lower pay bands. Combined with the increased activity of the labour market, this has led to increased competition for the NHS with alternative markets, particularly in the lower paid bands where employers are paying above the Living Wage Foundation's real Living Wage, which is higher than some roles within the NHS. We would welcome continued evidence from parties on the challenges they have faced in such a competitive labour market.
- 4.216 We would be interested in parties' views on a medium-term pay policy for Band 2 of the AfC structure. Such a policy would need to take account of the scale and complexity of Band 2 roles in the NHS, their relationship to the NLW, alternative employment opportunities, the relative attraction of the NHS as an employer, the quality of the working environment and the total reward package.
- 4.217 We also note in 4.202 the large proportion of the workforce at the top of their pay band; this is set to increase with the new pay progression arrangements.
- 4.218 We are aware that, locally, some Trusts made additional payments to some staff during the COVID-19 pandemic to cover additional shifts. We are also aware that some bank rates are paid at enhanced levels. We would welcome evidence on these payments to understand where additional payments have been made and how effective they are at incentivising and retaining staff.
- 4.219 We note that the current systems for job evaluation and pay have been applied across the system for approximately 20 years. In that time, the service has evolved and many roles seen in today's NHS are either new roles or roles which have changed significantly over time.
- 4.220 We understand that the NHS Staff Council has a system in place to review job profiles and are currently undertaking a review of nursing and midwifery profiles. We would urge the Staff Council to report as soon as feasibly possible and we will continue to monitor the process and the outcome.

Total reward

- 4.221 The total reward offer remains a key part of the NHS employment offer and includes a range of pay and non-pay benefits. NHSEI and the Government told us about how valuable it remains in comparison to other employers, but the Staff Side told us the importance of basic pay to staff, particularly in the lower bands.
- 4.222 HMT told us that the whole public sector remuneration package remains competitive, when taking account of pay, pensions and wider benefits including job security. They told us that on average, those working in the public sector have a better remuneration package than those in the private sector, including substantially more generous pensions. COVID-19 has also demonstrated the significant value of job security in the public sector.

Quality of the working environment

- 4.223 The UK Government told us that HR Directors were clear that the quality of the working environment was a priority to staff. In particular, having the right facilities, including rest rooms, for staff to be comfortable at work.
- 4.224 Public perceptions of the NHS also affect the quality of the working environment. Throughout the initial stages of the pandemic, NHS staff received a significant amount of public praise through Clap for Carers being established and NHS Trusts receiving gifts and hospitality from local businesses. However, a Health Foundation public poll in December 2021 found that 57% think the general standard of care provided by the NHS has got worse in the last 12 months and they concluded that the public have become increasingly pessimistic about the standard of care in the NHS.
- 4.225 Responses to the 2021 staff survey showed that, compared with 2020, fewer AfC staff agreed that they had adequate materials, supplies and equipment to do their work, and there was a sharp fall of 11 percentage points in the percentage of AfC staff agreeing that there were enough staff at their organisation to be able to do their job properly. For the first time since at least 2017 there was: an increase in the percentage of respondents saying that they had worked unpaid hours over and above their contracted hours; and a reduction in the number saying that they were able to meet all the conflicting demands on their time at work. The percentage of respondents saying that they had felt unwell as a result of work related stress has increased every year since at least since 2017. Responding to new questions on the survey in 2021, although just over one half of survey respondents said that they were able to achieve a good balance between work and home life, just over a third of respondents said that they were feeling burnt out because of work.

Our assessment of the quality of the working environment

- 4.226 We note that there is some evidence that public perceptions are worsening and subsequently staff will feel that the service they are delivering is perceived to have less value.
- 4.227 It is highly concerning to see the significant fall in the percentage of staff who believe there is enough staff in their organisation to do their job properly. As set out, insufficient staff in an organisation increases pressure on existing staff leading to higher levels of stress and burnout.
- 4.228 This trend is reflected in the data, with a higher percentage of staff reporting working unpaid overtime and stress.
- 4.229 These trends reiterate the importance of effective recruitment and retention strategies across the NHS. Poor working environments will encourage staff to look for alternatives where they feel there is less stress, more resources and higher value.
- 4.230 It could be reasonably assumed that if staff numbers increase sufficiently to meet the current demand, this will be reflected in the data with fewer staff working unpaid overtime and experiencing stress and burnout.

Flexible working

- 4.231 The Government told us that they are working to embed flexible working in the service. They know measures such as varying the length of shifts are being implemented in Ambulance Trusts.
- 4.232 Changes to the framework for agreeing flexible working opportunities were introduced in September 2021, which included a provision to for a contractual right to request flexible working from day one of employment.
- 4.233 However, only 54.9% of the respondents to the 2021 Staff Survey said they were satisfied with the opportunities for flexible working, which is down three percentage points from 2020 following three years of improvement.
- 4.234 It is likely that the expectation of flexible working has changed as radical changes to working practices have been witnessed across other parts of the economy, as set out in paragraphs 1.16 - 1.18.
- 4.235 The Welsh Government told us they were looking to identify best practice and are aware they need to re-configure working environments more broadly. Flexible working is becoming an increasing priority.
- 4.236 The Department of Health, Northern Ireland, told us that they did not yet have a policy in place, but the introduction of specialised hubs into the service would help in the ability of employers to offer flexible working opportunities.

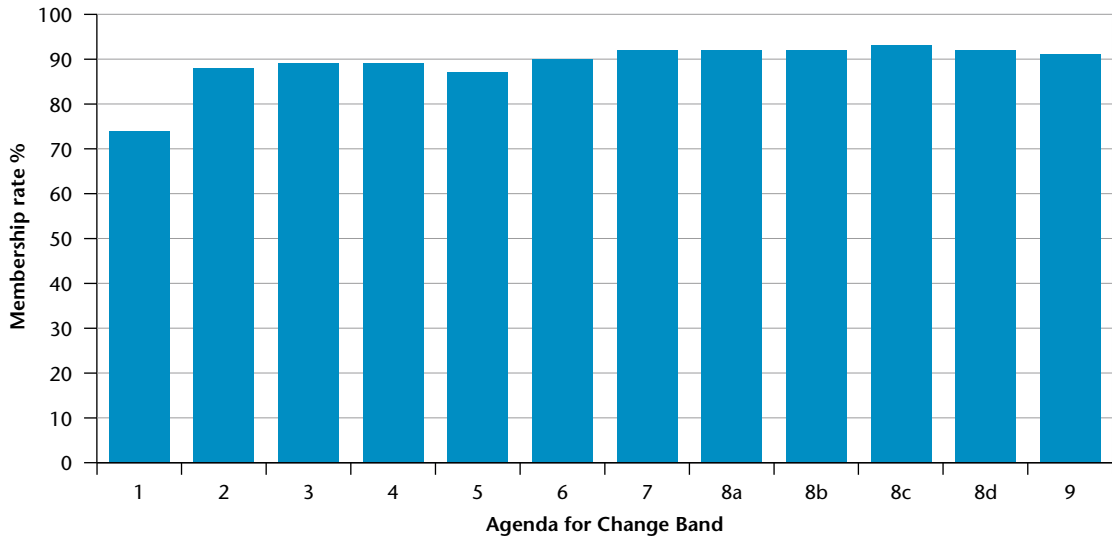
Our assessment of flexible working

- 4.237 We heard wide-ranging support for the flexible working policies that have been put in place. As discussed earlier, flexible working is one of the key policies being used by employers to recruit and retain staff in an unusually competitive labour market.
- 4.238 We note that although there is support for flexible working policies, these policies are not being applied effectively. This is reflected in the Staff Survey results which show a reduction in the percentage (55% down from 58% in 2020) of AfC staff who were satisfied with the opportunities for flexible working patterns. For the NHS to be an employer of choice, they will need to make progress on this issue.
- 4.239 Employers told us it was difficult to offer flexible working given staff shortages and existing working patterns with established 12-hour shifts particularly in clinical areas. All parties agreed that line management need the workforce supply, support, education and systems to be able to offer the right solutions to ensure the implementation is as good as the policy itself.
- 4.240 We urge employers to continue to work with staff to offer flexible and agile opportunities to improve retainment of the workforce.
- 4.241 The Department of Health, Northern Ireland, told us at the time of giving evidence, they didn't yet have a regional policy in place for flexible working, but that the national changes to terms and conditions were to be adopted. We urge the Department of Health to continue to work to implement a flexible working policy.

Pensions

4.242 In July 2021 approximately 89% of AfC staff in England were members of the NHS Pension Scheme (Figure 4.51). Staff in Bands 6 to 9 (90-93%) were most likely to be scheme members while those in Band 1 were least likely (74%).

Figure 4.51: Estimated pension membership rate by Agenda for Change band, July 2021, England

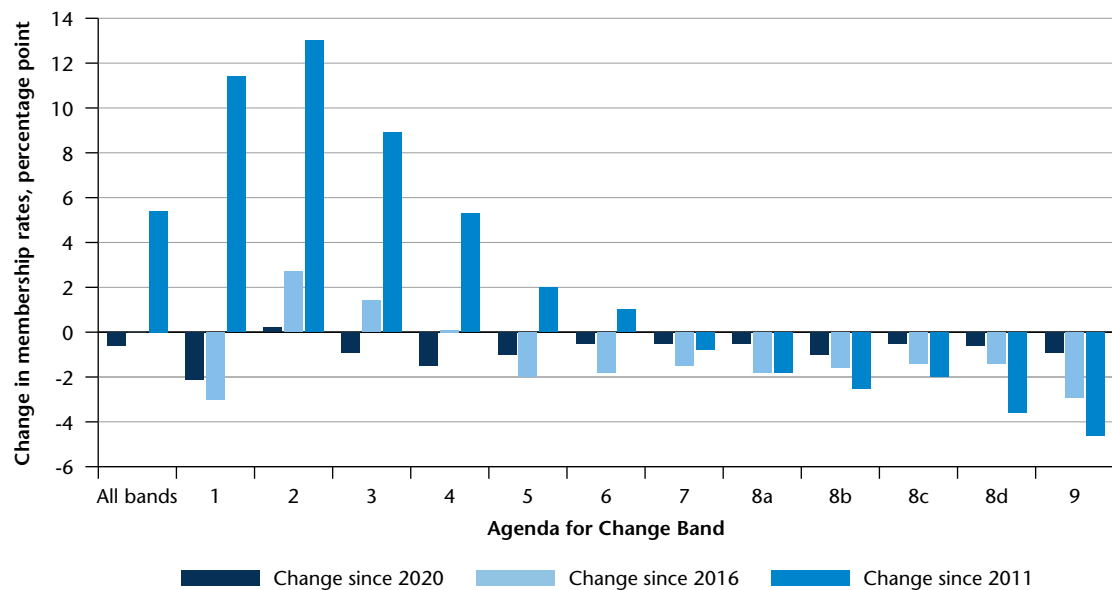


Source: Department of Health and Social Care

4.243 Figure 4.52 shows changes in the membership rate of the NHS Pension Scheme in July 2021, by AfC band, compared with 2020 (one year earlier), 2016 (five years earlier) and 2011 (ten years earlier). Across all bands, membership rates rose by 5.4 percentage points between 2011 and 2021, were unchanged between 2016 and 2021, and fell by 0.6 percentage points between 2020 and 2021.

4.244 Between 2011 and 2021 membership rates increased for those in Bands 1 to 6 but decreased for those in Bands 7 to 9. Over that period, the largest percentage point increases in membership rates, were for those in Bands 1 and 2, but, at 74% and 88% respectively, the membership rates in those bands remain below those for most other bands. However, there is now evidence that membership rates are also declining below Band 7. Except for Band 2, membership rates in July 2021 were lower than those for a year earlier for each band. There was a particularly sharp fall in the membership rate of Band 1 staff, between 2021 and 2020 of 2.1 percentage points.

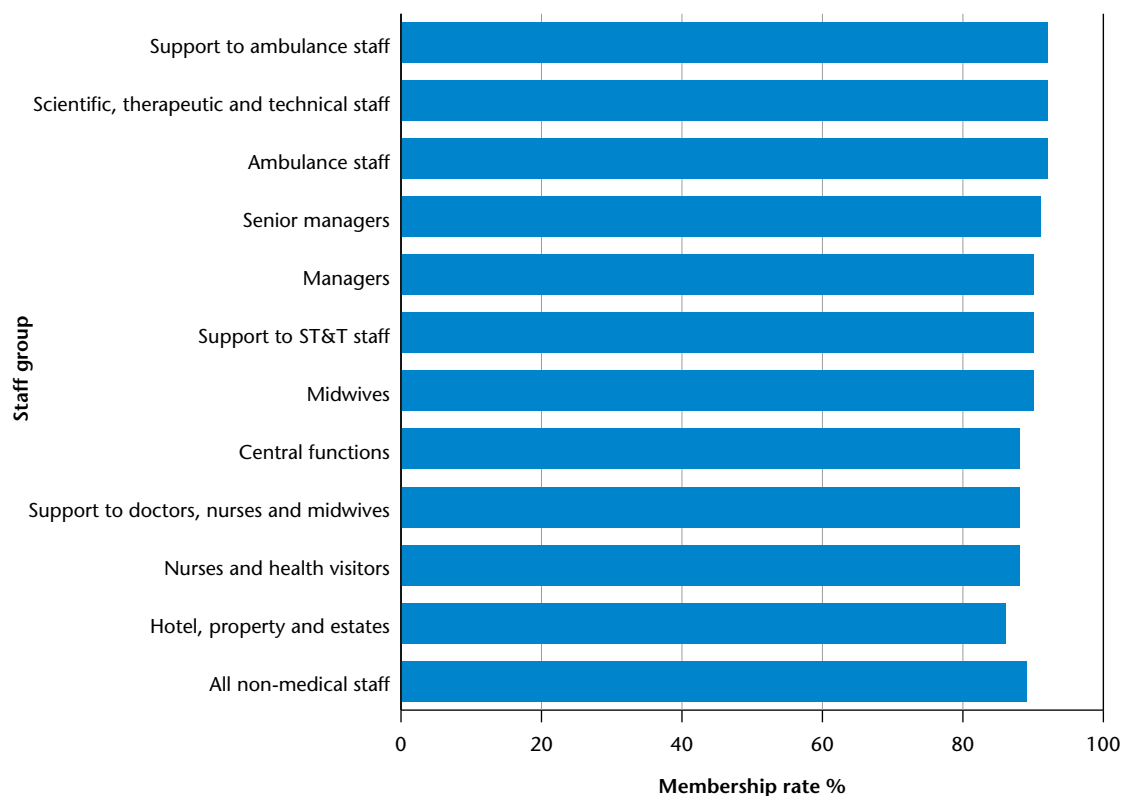
Figure 4.52: Changes in pension membership rate by Agenda for Change band, between July 2021 and 2020, 2016 and 2011, England



Source: Department of Health and Social Care

4.245 Figure 4.53 shows the membership rate of the NHS Pension Scheme in July 2021, by staff group. Scientific, therapeutic and technical staff, ambulance staff and support to ambulance staff (92%) were most likely to be scheme members while hotel, property and estates staff (86%) were least likely.

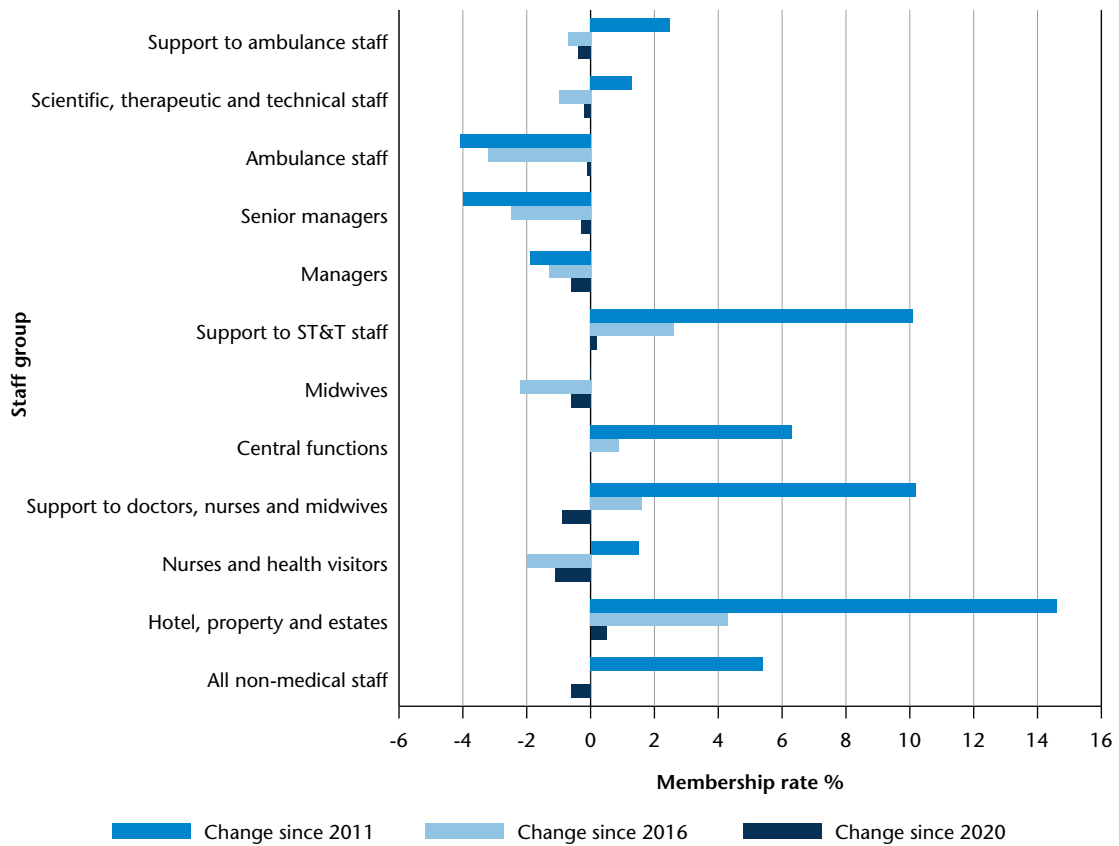
Figure 4.53: Estimated pension membership rate by staff group, July 2021, England



Source: Department of Health and Social Care

4.246 Figure 4.54 shows changes in the membership rate of the NHS Pension Scheme in July 2021, by staff group, compared with 2020 (one year earlier), 2016 (five years earlier) and 2011 (ten years earlier). Between 2011 and 2021 membership rates increased for most staff groups, with the strongest growth being for hotel, property and estates staff (14.6 percentage points), support to doctors, nurses and midwives (10.2), and support to ST&T staff (10.1). However, membership rates fell over that period, for ambulance staff (4.1 percentage points) and senior managers (4.0). More recently, between 2020 and 2021, membership rates were stable or fell for all staff groups, except hotel, property and estates staff and support to ST&T staff.

Figure 4.54: Changes in pension membership rate by staff group, between July 2021 and 2020, 2016 and 2011, England



Source: Department of Health and Social Care

4.247 The changes to the pension contribution structure in October 2022 are reflected in Table 3.8. Although the changes are expected to reduce contribution rates for 40% of members, those in the bottom three tiers will see their contributions increase. However, we note new member contribution structure will be phased in slowly to protect scheme affordability and minimise the risks to take-home pay of increases to member contribution rates.

4.248 The McCloud remedy will mean some staff will be able to retire earlier. It is yet to be realised how many staff will take the opportunity to retire early, but given the operational pressure experienced over the past couple of years, it is not unreasonable to anticipate that the number could be higher than initially expected.

Our overall assessment of total reward

- 4.249 The NHS total reward package remains a key benefit of working in the NHS. The annual leave allowance, sick pay provisions and pension structure remain generous. However, in the face of cost-of-living pressures, potential and current employees may look to take up employment outside of the NHS as base pay becomes increasingly important.
- 4.250 Although the NHS total reward package is generous, there are elements that may not be accessible to all employees, especially the lower paid.
- 4.251 It is more important than ever that employers promote the full value of the NHS employment package effectively to recruit and retain staff in the NHS because, as we see the cost of living increasing, staff will be making tough decisions about their future in the NHS, including whether they should remain in the pension scheme.
- 4.252 The risk of staff leaving the scheme is compounded by the change in the NHS pension contribution structure. Staff in the bottom three tiers will see their contributions increase, which combined with the increases in the cost of living, could lead to even more staff to leaving the scheme. We would welcome evidence in future rounds about how the changes impact staff going forward.
- 4.253 We note NHSEI's Pension Response Project and their Phase One response providing face-to-face communications to those aged over 50 and the response it has received. NHSEI told us in oral evidence that 3,670 members of staff had attended seminars since the project started. Given that as of September 2021, there were 265,000 AfC staff aged 55 and above, and 576,000 aged 45 and above, we would urge NHSEI to speed up the roll out across the workforce to improve retention amongst experienced healthcare professionals, who would otherwise retire, especially with the McCloud remedy which has made retirement options easier.
- 4.254 We welcome that the next phase of the project will focus on earlier career professionals and would urge NHSEI to ensure they are targeting the whole workforce to ensure everyone is aware of the benefits.
- 4.255 We note the changes in the pension contribution structure, as set out in Table 3.8, are due to be implemented in October 2022 and Staff Side's concerns that this could lead to more staff withdrawing from the scheme. We urge NHSEI to move forward with their Pension Response Project so staff are aware of the benefits before the changes come into effect.

Chapter 5 Pay recommendations

Introduction

5.1 The Secretary of State for Health and Social Care, the Minister of Health in Northern Ireland, and the Minister for Health and Social Services in Wales asked us in their respective remit letters to make a recommendation for a pay award for AfC staff for 2022/23. In this chapter, we set out our recommendations on AfC pay for 2022/23 in England, Northern Ireland and Wales. We make these recommendations having regard to our standing terms of reference, which include affordability, recruitment, retention, and motivation and morale.

The Parties' pay proposals

- 5.2 **The Department of Health and Social Care** told us that when it was set in January 2019, the Long-Term Plan assumed a headline pay uplift of 2% for 2022/23. The outcome of SR21 has provided a tight settlement for the NHS, requiring the delivery of a range of priorities and efficiencies which will need careful prioritisation in order stay within available funding. In settling the DHSC and NHS budgets, the government assumed a headline pay award of 2% for NHS staff. The department has an additional 1% "contingency" which it is making available for AfC pay, providing an overall affordable headline pay award of up to 3%. Doing so means that this contingency will not be available for other priorities. They added that any further funding for pay would have to come from within existing budgets. Therefore, to DHSC there is a direct trade-off between pay and other priorities.
- 5.3 **NHS England and Improvement** told us that pay remains the largest component of NHS costs (c65% of total operating costs) and therefore pay inflation represents a cost pressure which the NHS needs to plan and manage. Pay awards that are higher than the affordable level, and which are not supported by additional investment, will result in difficult trade-offs during the year on staffing numbers and the ability to deliver activity volume. These decisions will have a longer-term impact on the NHS's ability to restore services and make progress in tackling the elective care backlogs which have grown during the pandemic.
- 5.4 **The Welsh Government** told us they would welcome a recommendation that would represent a sufficient pay rise for AfC staff to recognise their dedication and hard work during the pandemic, and the work they will continue to undertake in the coming year to support the recovery efforts. However, they noted the need for this to be balanced with affordability.

- 5.5 **The Department of Health, Northern Ireland** told us that the Northern Ireland Executive has yet to agree a Budget for 2022/23 and early indications are that the funding envelope is likely to deliver the most difficult financial settlement that Health has seen to date. They added that it is probable that there will be no capacity to afford a pay uplift in 2022/23 in this context without additional funding being made available in-year, which will then perpetuate the funding issue into the future.
- 5.6 **NHS Providers** told us that, in Autumn 2021, the majority of HR Directors supported a pay award of at least 3%, and 28% supported an uplift of 5% or more. NHS Providers suggested that if they were to re-run the survey at the time of giving oral evidence in March 2022, a higher percentage of HR Directors would be supportive of a higher pay award.
- 5.7 **NHS Employers** recognised the tension in budgets, alongside also recognising the inefficiency of high levels of funding that goes into contracting agency staff where there are workforce gaps. They told us that the NHS has the longest waiting lists ever recorded, with 1 in 6 people expected to be on waiting lists in 18 months and that it is critical that the NHS attracts more staff with increased pay so a higher volume of patients can be treated.
- 5.8 **The Joint Staff Side** told us that a pay increase should be set at a level which will retain existing staff within the NHS and recognises and rewards the skills and value of health workers. In order to do this, the award must:
- Deliver an “inflation-busting” increase so that NHS staff can cope with rising and rapidly fluctuating costs which may change significantly over the pay year;
 - Absorb the impact of increases to pension contributions; and
 - Benchmark the bottom of the structure against the Living Wage Foundation’s real Living Wage
- 5.9 On top of this ask, the **Joint Staff Side** asked for additional measures from the Government which makes up an urgent retention package. The asks were:
- Ensure banding outcomes reflect job content
 - Reward additional hours fairly
 - Prevent burnout by limiting excess hours
 - Support progression and career development
 - Encourage employers to use RRP to retain staff where shortages are a risk to staff wellbeing and quality of care
- 5.10 In addition, **the Royal College of Nursing** asked for a pay rise 5% above inflation and a national RRP for nursing staff.
- 5.11 There were mixed views from parties on a flat-rate consolidated increase. Most parties saw it as an opportunity to provide increased support to the lower-paid who are disproportionately affected by inflation, but parties were also of the view that a pay rise should be set at a rate that gives the whole workforce a suitable increase.

Our concluding arguments

- 5.12 The UK has an ageing population with increasingly complex health needs and there are rising demands across the health sector. The NHS is continuing to recover from the COVID-19 pandemic, delivering the elective recovery plan and dealing with increased non-elective and emergency demand. This is an extremely challenging environment for all AfC staff.
- 5.13 Significant operational pressures are being felt right across the NHS and there are not currently enough suitably trained people to meet the increase in demand and activity. This is reflected in high levels of vacancies across the service, with rates over 10% which all parties agreed was unsustainable and which is double the target set for nurses in the NHS 2028 Long Term Plan. These high vacancy levels, which have persisted over some time, are costly because they create the need for more expensive bank and agency staff. Vacancies put additional pressure on existing staff and on leaders reducing their capacity to drive forward critical development in other areas. Vacancies also reduce the quality of patient care. Significant operational pressures can lead to an exhausted and demoralised workforce which can impact the service further. The recent Ockenden review has highlighted the potentially disastrous outcomes for patients when there are insufficient staff within the system to meet patient demand.
- 5.14 There are actions underway to reduce the workforce shortages. In the short term, there is a significant level of overseas recruitment. In the twelve months to March 2022, 23,408 nurses, midwives and nursing associates joined the NMC register for the first time from overseas. This is the highest level seen since 2017 and 81% higher than the previous record in this time frame. It is critical that the NHS optimises retention rates amongst these staff. Therefore, the NHS must support staff recruited from overseas into the NHS and local communities to ensure that they are able to access and engage with development opportunities within the NHS.
- 5.15 We note the importance that all parties placed on ethical recruitment and that this underpins the policy of overseas recruitment. However, we are concerned by the increase in recruitment from countries on the ethical recruitment red list.
- 5.16 In the medium term, there are increasing numbers of students in training for key roles. The introduction of the Learning Support Fund, which provides annual maintenance grants to students in England, has supported a 34% increase in applications to nursing courses in England in 2020/21, and similar levels of applications have been seen in the 2021/22 application cycle. Northern Ireland and Wales continue to fund training places across healthcare professions and courses continue to be oversubscribed.
- 5.17 As an increased number of new recruits enter the service, both domestically and internationally, it will be of critical importance that the NHS retains the expertise of senior healthcare professionals, primarily at Band 6 and 7, who will be instrumental in supporting these new trainees and recruits.

- 5.18 On this basis – and assuming attrition rates do not increase further – we might expect to see the challenges with workforce numbers diminish gradually over the next three to four years. However, given the increased ambition of the service, we expect demand for healthcare workers to rise in the medium term.
- 5.19 We note the ambition from all parties that workforce planning should be improved. In the longer term, workforce planning is widely believed to be critical to prevent staff shortages from materialising again and to reduce the risk of overstretching staff becoming the norm during periods of high demand, and we encourage governments to continue to prioritise the development of workforce plans.
- 5.20 At the present time, we judge there are substantive workforce risks related to recruitment, retention, motivation and morale.
- 5.21 The NHS is expected, post-pandemic, to deliver increased service levels as part of the elective recovery plan. Many staff have not yet had the chance to recover from the COVID-19 pandemic. We are aware of the mental health and wellbeing support measures that have been put in place, but we heard consistently in evidence and on our visits that staff do not have the time or space to access the services in place. Access to training and development opportunities to support career progression are important for retention and we heard on our visits that staff do not feel that they have time an opportunity to access to these. We were struck by staff awareness of opportunities in the local job markets, which could be taken as a pre-cursor for more staff looking for external opportunities.
- 5.22 Staff engagement is critical to improving productivity and influences staff members' willingness to contribute the discretionary effort on which the NHS relies. However, the results from the 2021 Staff Survey across engagement and satisfaction were considerably less positive than for 2020. The significant fall in satisfaction reflected in the 2021 Staff Survey can credibly be taken as a precursor of greater retention difficulties.
- 5.23 After reduced levels of attrition during the COVID-19 pandemic, we are now seeing leaver rates returning to pre-pandemic levels and, in some cases, leaver rates are returning to levels last seen before the three-year AfC deal in 2018. There are particular concerns over the leaver rates amongst midwives. Year-on-year falls in the number of midwives are being seen for the first since NHS Digital began publishing leaver data in 2009. This is at a time when the NMC register has seen a 12% increase in registered midwives since 2018. Leaver rates are also increasing across other professions, with leaver rates averaging 10.8% across all AfC staff groups. The 3 year AfC deal delivered significant funding for AfC pay and subsequently, attrition levels and satisfaction with pay improved. The 2021 Staff Survey showed lower satisfaction with pay, and the results were less positive, across almost all indicators, compared to the 2020 results.

- 5.24 Beyond the NHS, the wider labour market has become considerably tighter and there is significant competition for workers across all levels but, in particular, at pay bands 1-4. Competing employers are offering hourly pay rates over and above the AfC Band 2 rate and the Living Wage Foundation's real Living Wage. The government has mandated substantial rises in the NLW which will underpin this trend and the LPC estimates the NLW will increase to £10.32 in April 2023. Both Employers and Staff Side told us about the significant pressure on recruitment and retention in the lower bands.
- 5.25 Post pandemic, the private health sector is also experiencing a rise in demand. This growth undoubtedly offers alternative employment opportunities in the private sector for NHS staff. Whilst rates of base pay in this sector are comparable, it is widely acknowledged by all parties that in the private sector working pressures are significantly less and there are increased opportunities for flexible working.
- 5.26 The position on relative rates of public and private sector wage growth has changed substantially since the Autumn Budget and private sector wage growth is now outstripping that of the public sector. Median pay settlements are now 4%, according to Xpert HR.
- 5.27 The NHS offers a broadly competitive total reward package which combines base pay with an attractive annual leave allowance, sick pay provisions and a defined-benefit pension. In AfC bands 1-4, the competition for labour is often from employers with higher levels of base pay who are able to offer more flexible working hours. The NHS has made changes to its flexible working policy but this has, so far, had little impact on levels of flexible working which are now substantially worse than other employers are generally able to offer. This is particularly the case in clinical settings where 12 hour shifts remain the norm. Employers and Staff Side both told us that staff shortage pressures undermined progress as there currently are not enough staff in the service to offer the right opportunities. We were also told that organisations and line managers needed education and support to ensure the policy was well implemented.
- 5.28 Basic hourly pay of most of our remit group is below median hourly earnings across the economy as a whole. The rising costs of food, non-alcoholic drinks, housing, fuel and power are an important source of inflationary pressures. Lower income households spend a higher proportion of their incomes on these items. Thus, much of our remit group is especially vulnerable to current high inflation. It was the position of the Government, NHSEI, Employers and the Staff Side in evidence that a pay recommendation should focus on providing a pay uplift to staff in the lower paid AfC bands given the acute financial pressures they are facing. The Government have since put cost of living support in place, which includes the Energy Bills Support Scheme which has been doubled to a one-off £400 payment which will now be made as a grant and a £650 one-off Cost of Living Payment will be made to those on means tested benefits, which affects over eight million households.

- 5.29 We note the concerns that increases in pay could feed into a wage-price spiral, although also recognise there are other fundamental drivers of current inflation challenges. As earnings growth remains substantially below inflation, we judge that increases in earnings present a much lower risk to increasing the rate of inflation compared to some of the other fundamental drivers.
- 5.30 The fiscal position has changed substantially since the Autumn Budget was set. The UK Government has allocated 3% for an increase in pay for AfC staff. There is almost no pay drift within AfC. Trusts are being asked to make efficiency savings in the same period of 2.2% per year. The UK Government have said that they will not fund any increase beyond 3%. The Welsh Government have said decisions would need to be made against the budget levels once recommendations are known. The Department of Health, Northern Ireland, told us there was no additional funding for a pay uplift, unless funding was made available in-year.
- 5.31 Whilst it is clear that money spent on staff pay is then not available for other NHS costs such as drugs or procedures, it is not so clear-cut that money spent on increasing pay for individual members of staff prevents the recruitment of more staff. The total wage bill is a function, amongst other things, of the numbers and cost of substantive staff and of numbers of temporary staff. Increased levels of attrition add costs to the service by increasing the costs of temporary staff and by reducing the numbers of experienced staff available to do what needs to be done. In addition, staff are needed to deliver increased numbers of treatments.
- 5.32 We also note the asks of the Joint Staff Side set out in their evidence concerning actions to improve retention. Although these were asks directly of the Government, we recognise the critical importance of ensuring staff are retained at this time. The asks were to give priority to measures that will (1) ensure banding outcomes reflect job content; (2) reward additional hours fairly; (3) prevent burnout by limiting excess hours; (4) support progression and career development; and (5) encourage employers to use RRP to retain staff where shortages are a risk to staff wellbeing and care.
- 5.33 The current systems for pay have been applied across the system for approximately 20 years. In that time, the service and the roles within it have evolved substantially. We note that the NHS Staff Council are currently reviewing nursing and midwifery job profiles. We believe that this is important and timely work and we will continue to monitor the progress of the review and look forward to receiving evidence about its emerging conclusions during the 2023 round.
- 5.34 The 2021 Staff Survey results also showed increased levels of paid and unpaid overtime and a sharp rise in staff who do not feel they have the resources to do the job they are required to do. Unpaid overtime continues to be a significant issue across the NHS and the NHS Staff Survey 2021 showed a further rise in unpaid overtime. It remains of the utmost importance that NHS Trusts have effective systems in place to pay staff fairly for overtime.

- 5.35 In written evidence, the RCN asked for a recommendation of a national RRP across the nursing profession. In our 2020 report we set out the evidence requirements we would need in order to determine the suitability of a national RRP for a professional group. These evidence requirements are set out at Appendix C. In assessing the evidence available to us for this report we note very significant retention risks for nurses, but do not, on balance, view the risks to be confined to this group.
- 5.36 The pressures from the labour market, combined with steeply rising inflation and low levels of staff engagement create a very real risk of increased attrition rates over the short-to-medium-term which the NHS cannot afford. Increased attrition will put further pressure on remaining staff and may deter those who are currently planning a career in the service.

Our recommendations

- 5.37 We are aware that the NHS is operating within a heavily constrained budget envelope. However, it is necessary to increase the investment in staff pay to go some way to reduce the risk that pay is a reason to leave NHS service; to protect the service from additional temporary workforce costs; and to protect risks to patient care from the impact of increased vacancies and an overstretched workforce.
- 5.38 In light of the above, we considered both the amount that our recommendation should be and the structure of the award. We considered a number of possibilities. These included whether to pay a percentage or flat rate uplift; removing the bottom pay point; whether any portion of the award should be non-consolidated; and whether an award should be paid at more than one point of the year. We heard from all the parties that what was needed this year was an award which underpinned the existing structure of the AfC framework. We recognised the importance of uplifting pay particularly at the lower bands, where there is very significant competition in the labour market and staff will be disproportionately impacted by the increases in the cost of living.
- 5.39 In forming our recommendations, we judged that the issues were different in the lower, middle and higher pay bands.
- 5.40 At pay bands 1-4, the wider labour market has become considerably tighter and there is significant competition for workers. Competing employers are offering hourly pay rates significantly over and above the AfC Band 2 rate and the Living Wage Foundation's real Living Wage. The LPC also estimate the NLW will rise to approximately £10.32 in April 2023, an increase of 8.6% over the current NLW. This is at a time when base pay is increasingly important to staff faced with rising cost-of-living pressures.

- 5.41 At pay bands 5-7, it is essential we retain talented and experienced staff. The majority of clinical AfC staff, including nurses, midwives, paramedics and other allied health professions work at this level, and their skills and experience in delivering safe patient care and supporting new trainees are particularly important during this period of rapid recruitment. Many band 5-7 staff, particularly those at the top of the pay band, are closer to retirement age and so there is a risk staff could retire earlier than initially planned if not supported sufficiently. As we see an increased demand for private healthcare, it is reasonable to assume workforce demand in that sector will increase in parallel, and the environment is often significantly less pressured with more opportunities to work flexibly.
- 5.42 Managers and senior staff at pay bands 8-9 have provided extraordinary leadership throughout the pandemic and at the present time. Retaining their knowledge and expertise will be critical as the NHS continues its elective recovery programme. Looking forward, we acknowledge that recruiting and retaining leadership talent remains a challenge for the NHS. Pay and pay progression are important elements of this. We set out in Chapter 6 additional evidence we would welcome to be able to consider these issues in more depth next year.
- 5.43 Reflecting this, our 2022-23 pay recommendation is for a **£1,400 consolidated uplift with effect from 1st April 2022 for all AfC staff to their full time equivalent salary**. The £1,400 uplift should be enhanced for the top of Band 6 and at Band 7 so it is equal to a 4% uplift for those staff. The increase is to the rates which include the National Living Wage adjustments made on 1st April 2022 to Band 1 and 2. All points in the AfC pay scales to be increased as set out above. This recommendation would increase the overall AfC pay bill by an average of 4.8% across England, Wales and Northern Ireland³⁶.

³⁶ We note the policy of paying the Living Wage Foundation's real Living Wage in Wales prior to the 1st April 2022.

Chapter 6 Forward look

Introduction

- 6.1 In this chapter we aim to give the parties who provide evidence, and the remit group more generally, some indication of areas that are likely to be of continuing interest to us in future pay rounds.

Recovering from the COVID-19 pandemic

- 6.2 The operational pressures experienced by staff was a significant focus of the evidence we received from parties this year. We are concerned that the pressure of the COVID-19 pandemic, followed by increased elective and emergency demand, has placed significant stress on staff across the service which could lead to increased attrition. Next year, we will look for further data on how the increased workload placed on staff has impacted service delivery and workforce numbers.

Workforce planning

- 6.3 We note the ambition of all parties that workforce planning should be improved. The predictions for the number of staff required are a function of: the level of ambition for the service, planned funding, and changes to service delivery methods. Unless all of these considerations are part of the planning process, the existence of such a process will not in itself prevent over or under supply. We welcome the duty in the Health and Care Act to strengthen workforce planning in England. We look forward to receiving evidence next year on the progress of workforce planning in England, including the methods for forecasting future workforce numbers, including the role of new ICBs and ICSs.
- 6.4 We welcome the planning ambitions of the Welsh Government; however, we also note the significant challenges for the health service to overcome before those ambitions are realised and look forward to receiving more evidence on the progress of the workforce plan next year.
- 6.5 Furthermore, we look forward to receiving evidence from Northern Ireland on their work towards a comprehensive workforce plan.
- 6.6 We have commented in previous reports on apprentices. The NHS is well placed to create attractive apprenticeships, which offer secure employment, fulfilling roles, and excellent training and progression opportunities. Apprenticeships are growing in popularity and are increasingly a focus for talented young people from a diverse range of backgrounds. An apprentice route into the NHS diversifies and helps secure the future supply of staff to the NHS, which is particularly important in a competitive labour market. We heard some examples of where apprenticeships have been integrated into workforce planning at local level, with excellent results. We would welcome evidence on how this is progressing systematically at a national level and how greater number of apprentices could be achieved.

Total reward

- 6.7 The NHS total reward package remains a key benefit of working in the NHS, even as base pay becomes increasingly important in the face of cost-of-living pressures. It is more important than ever that employers promote the full value of the NHS employment package to recruit effectively in the NHS. We note the progress of the NHS in implementing the Pension Response Project. However, progress of the roll-out needs to speed up to retain experienced healthcare professionals, who would otherwise retire, and we would welcome evidence on this next year.
- 6.8 Flexible working is one of the key policies used by employers to recruit and retain staff in an unusually competitive labour market. We note that although there is support for flexible working policies, these policies are not being applied effectively. Employers and line management need the support, education and systems to be able to offer the right solutions to ensure the implementation is as good as the policy itself. We look forward to receiving evidence on how the flexible working policy is applied across the system and, in particular, in clinical settings.

Recruitment and Retention Premia (RRP)

- 6.9 A number of parties raised RRP with us. There was consensus that RRPs were not used well locally and that national RRPs were not the right substitute for basic pay at the correct level.
- 6.10 At a local level, we look forward to receiving evidence from parties on the effectiveness of the application of RRPs.
- 6.11 At a national level, although there are significant retention risks at present, these risks are not confined to one or two occupational groups. In our 2020 report, we set out a number of evidence requirements which we consider to be necessary to support the consideration of local or national RRP. These evidence requirements are listed in the appendix. Looking forward, if current retention risks persist or become worse, we would be willing to support parties in an assessment of this evidence at any stage.

High Cost Area Supplements (HCAS)

- 6.12 The current HCAS system remains of concern to the Joint Staff Side. There are concerns the system is outdated and the boundaries need updating. The full effects of the COVID-19 pandemic on the decisions people make about where to live and work, and that employers make about the extent to which some employees can work remotely, are not yet clear. We look forward to receiving further evidence on HCAS next year.

Evidence gaps and data limitations

6.13 We appreciate parties' efforts to improve the evidence based and the information that was provided to us for this pay round. There are a number of areas we would highlight where we would welcome improved data. These include the following:

- **NHSPRB timetable** – We would welcome evidence from parties on the timing of the process to allow recommendations to support resource planning and come ahead of a pay review date.
- **Vacancy data** – We look forward to receiving data on the appropriate vacancy level and plans to assess the current vacancy levels by professional staff group across the AfC workforce. In the context of the persistent workforce gap, we look forward to understanding the plans to close the gap in the short and medium term. In particular, in the context of the Ockenden report, we look forward to further data on the recruitment and retention of midwives.
- **Leaver data** – We saw no improvement in the quality of the data looking at reasons for leaving and their destination, and again we encourage parties to provide more comprehensive data next year.
- **Staff survey data** – Although we received data from Staff Surveys conducted in England, we did not receive data from Staff Surveys conducted in Wales and Northern Ireland. We would urge both nations to carry out Staff Surveys and provide data in due course.
- **Agency spend** – We look forward to hearing how programmes in place in Wales and Northern Ireland reduce reliance on agency spend.
- **Enhanced overtime and bank rates** – We look forward to hearing how enhanced overtime and bank rates have incentivised staff across the system.
- **Equalities** – We look forward to receiving information on the way in which the development of this important area is prioritised, in particular on the role of ICSs and ICBs. We also look forward to data on the REAP in Wales and receiving further evidence on the research into the Ethnicity Pay Gap commissioned by the Government.
- **Equalities** – We look forward to the further development of data on protected characteristics beyond gender and ethnicity.
- **Learning and development** – We note there is currently no public data available on funding for staff learning and development. We look forward to receiving this data from employers in future years.
- **Pay policy at the lower pay bands** – We would welcome evidence on the development of a pay policy at the lower AfC bands.
- **Pay progression in Band 8 and 9** – We would welcome evidence on the pay progression opportunities at Bands 8 and 9. More specifically, the impact of 5-year increments and how to ensure effective recruitment and retention of leadership talent.
- **2018 three-year pay agreement** – We look forward to receiving evidence that helps us to understand what has been achieved for each element of the agreement and what may require more impetus or resource.

Appendix A – Remit Letters

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

Dear Ms Hird,

I should firstly like to offer my thanks for the NHS Pay Review Body's (NHSPRB) work over the past year on the 2021 report and for the patience you and your members showed during the previous round. The government appreciates the independent, expert advice and valuable contribution that the NHSPRB makes. I write to you now to formally commence the 2022 to 2023 pay round.

As the NHS budget has already been set until 2024 to 2025, it is vital that planned workforce growth is affordable and within the budgets set, particularly as there is a direct relationship between pay and staff numbers.

The government must balance the need to ensure fair pay for public sector workers while protecting funding for frontline services and ensuring affordability for taxpayers. We must ensure that the affordability of a pay award is taken into consideration to ensure that the NHS is able to recruit, retain and motivate its Agenda for Change workforce, as well as deliver on other key priorities, including ensuring the NHS has 50,000 more nurses by 2025 and tackling elective recovery.

The evidence that my department and NHS England and Improvement will provide in the coming months, will support you in your consideration of all these factors.

As always, while 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 reports in May 2022, subject to ongoing conversations with the Office of Manpower Economics.

I would like to thank you again for yours' and the Review Body's invaluable contribution to the pay round and look forward to receiving your 2022 report in due course.

Yours ever,

Sajid Javid Secretary of State for Health and Social Care

Letter from the Minister of Health, Northern Ireland to the NHSPRB Chair

Dear Ms Hird

NHSPRB 2022/23 PAY ROUND

I am writing to formally commence the 2022/23 pay round for Agenda for Change (AFC) staff in Northern Ireland. I wish to begin by thanking the NHS Pay Review Body for its invaluable work on the 2021/22 pay round and, in particular, for its observations on the AFC pay agreement. I have accepted the recommendations of the Review Body in full.

On 16 March 2021, the Department of Finance (DoF) set out Northern Ireland's [Public Sector Pay Policy for 2021/2022](#). In line with usual protocols, that Department's approval of the 2021/22 award has been secured, and the relevant revised pay circular issued to implement the uplift.

As has been noted by the Secretary of State for Health and Social Care in England, Rt Hon Sajid Javid MP, affordability and sustainability must be balanced with the need for fair pay. I would therefore welcome your pay recommendations for health and social care staff in Northern Ireland. These recommendations should take account of the challenging fiscal and economic context and the affordability of pay

awards, particularly in the Northern Ireland context, where our integrated system of health and social care brings proportionately more staff into Agenda for Change terms and conditions.

Further, I would be most interested to have the views of the NHSPRB into wider recruitment, retention and staff motivation factors specific to health labour markets for regions, such as Northern Ireland and northern England, which have land borders across which individuals might reasonably commute.



Robin Swann
Minister of Health

Letter from the Minister of Health, Wales

Dear Philippa Hird

Thank you for the NHSPRB's hard work and independent report and observations which have been invaluable.

I would like to take this opportunity to say I truly value the hard work and commitment of all of our dedicated healthcare workers in Wales, at all times but particularly during this challenging time.

I am now writing to formally commence the 2022-23 pay round for AfC staff in Wales. In this pay round I would like your advice on what would be a sufficient pay rise for AfC staff to recognise their dedication and hard work during the pandemic and, the work they will continue to undertake in the coming year to support the recovery efforts. I am conscious that the pay award should address recruitment and retention issues to ensure the NHS recovers from the pandemic.

In addition, I am aware of the increase in national insurance contributions and cost of living increases many NHS staff will be facing this coming year given the rises in inflation and energy prices and how this impacts on take home pay.

I urge you to make a pay rise recommendation that truly recognises the commitment and hard work of our NHS staff and takes into consideration the significant cost of living increases they face. However affordability is a key issue for Welsh Government, we have to balance rewarding all our public sector within finite budgets set by UK Government and to afford substantial pay increases UK Government need to make available sufficient funding.

In order to support your work, I will provide written evidence to the Pay Review Body as soon as possible and I will also plan to attend the oral evidence session in March.

I would like to receive your advice and recommendations as soon as possible to ensure that payment of any award to our dedicated NHS workforce is not unduly delayed past April 2022.

I look forward to receiving your advice and recommendations.

Yours sincerely,



Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Appendix B – High Cost Area Supplement Considerations

- Whether the HCAS structure reflects modern practice in the use of London and South East allowances across the public and private sector;
- Defining the purpose of HCAS –whether it is simply to compensate for cost of living or whether other factors should be accounted for;
- Examining the structure, rates, minima and maxima, definitions and differentials between zones, and “cliff edges” with border areas;
- The interaction of HCAS and other parts of the pay package, such as AfC banding and use of RRP;
- Whether there are cases for extending HCAS or similar cost of living allowances elsewhere in England and what would be mechanism to introduce and review new areas; and
- Accompanying comprehensive workforce and pay data, not least on current practice and use of funding, such as the staff element of the Market Forces Factor.

Appendix C – RRP evidence requirements

- Determining the approach to the NHS employment offer, reward strategy and role of RRP;
- A clear assessment of the extent of AfC shortage groups, including identification of the AfC roles and levels affected by recruitment and retention difficulties, and the specific skills in short supply nationally, regionally and locally;
- Further, improved and robust data and information on the factors influencing recruitment and retention, including the role of pay and targeted measures and any actions that have been tried and failed;
- Specific analysis of the way in which pay or RRP could increase the supply of AfC groups in the longer term, including whether pay influences those not joining the NHS;
- Assessments of the relevant labour markets, including roles experiencing local market pressures and those operating in regional or national markets. This should identify variations by geography and AfC speciality;
- The supporting business benefits of any pay solutions, plus clear criteria for their application, including roles to be targeted, pay values (and any flexibility), time limitations and the evaluation criteria to be applied;
- An assessment of the impact of any pay solution on other related AfC groups not receiving RRPs, including recruitment, retention and motivation; and
- An equality impact assessment of implementing any national and local RRP.

Appendix D – 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

Appendix D – Previous Reports of the Review Body

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 – unpublished	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
Thirty-Second Report, NHS Pay Review Body 2019	CP 147, July 2019
Thirty-Third Report, NHS Pay Review Body 2020	CP 260, July 2020
Thirty-Fourth Report, NHS Pay Review Body 2021	CP 479, July 2021

