



NHS Pay Review Body

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Twenty-Ninth Report 2016

Chair: Jerry Cope



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

**Presented to the Scottish Parliament by the
First Minister and the Cabinet Secretary for Health, Wellbeing and Sport**

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

**Presented to the Northern Ireland Assembly by the First Minister,
Deputy First Minister and the Minister for Health, Social Services
and Public Safety**

March 2016



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NHS Pay Review Body

The NHS Pay Review Body (NHSPRB) is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health and Wellbeing in Scotland, the First Minister and the Minister for Health and Social Services in the National Assembly for Wales, and the First Minister, Deputy First Minister and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive, 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, the First Minister and the Cabinet Secretary for Health and Wellbeing in Scotland, the First Minister and the Minister for Health and Social Services of the National Assembly for Wales, and the First Minister, Deputy First Minister and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive.

Members of the Review Body are:

- Jerry Cope (Chair)
- Bronwen Curtis CBE²
- Joan Ingram
- Shamaila Qureshi²
- Professor David Ulph CBE²
- Professor Anna Vignoles
- Lorraine Zuleta²

The secretariat is provided by the Office of Manpower Economics.

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

² Bronwen Curtis CBE, Shamaila Qureshi, Professor David Ulph CBE and Lorraine Zuleta were all appointed to the NHS Pay Review Body by the Parliamentary Under Secretary of State for NHS Productivity from 1 August 2015.

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NHSPRB Twenty-Ninth Report 2016

Executive Summary

Our 2016/17 recommendations on the pay uplift are:

- We recommend a 1 per cent increase to all Agenda for Change pay points from 1 April 2016 in England, Scotland, Wales and Northern Ireland.
- We recommend a 1 per cent increase to the High Cost Area Supplement minimum and maximum payments.

In addition:

- We note the additional aspects of public sector pay policy in Scotland (£400 minimum payment for staff earning under £22,000 and application of the Scottish Living Wage) and Wales (application of the Living Wage).

A list of our additional observations and our observations on the national recruitment and retention premium for paramedics are included at the end of this summary.

Our remit

Our remit group for this report is the 1.3 million Agenda for Change staff across the UK. Once again the remits from the countries for 2016/17 have all outlined slightly different approaches, albeit with a lot of similarities. Respective decisions on the pay award and pay policy in both 2014 and 2015 have led to separate Agenda for Change pay rates in each of the four UK countries. The framework continues to operate on a UK-wide basis and this seems unlikely to change in the immediate future.

Our report and recommendations are produced at a time of complex change for the NHS across the UK and for our remit group. All four countries are aiming simultaneously to meet demanding efficiency targets and deliver transformational change through service redesign and new models of care, whilst continuing to respond to every day service requirements and meet the demands of regulators.

Public sector pay policy has been set out by the UK government for the next four years and provides the context for our recommendations in England. The policy position for Scotland, Wales and Northern Ireland is short term for this year's remit, given that these countries all have elections in May 2016. However, with public money remaining constrained, it seems highly likely that public sector pay restraint will continue for some years. We will have an increasingly important role to monitor the sustainability of this policy for our remit group, in whole or in part. Agenda for Change pay scales need to be seen as competitive, to attract and retain the calibre of staff required to support and deliver high quality patient care. This means taking a longer term view as well as making our annual recommendations.

We work to a tight schedule and the impact of the Spending Review delayed evidence from all the health departments for this round. The Northern Ireland Executive provided its remit and evidence extremely late. Given all the parties wanted us to produce recommendations to the same timescale as for the other countries of the UK this has meant we have had to reach our conclusions based on the limited evidence available. Such a shortened process has risks and we are uncomfortable about this. We have proceeded with a recommendation on an exceptional basis but are not prepared to short cut the process again in this way. Given the short timescales within which we have operated this year, we would want to give the issues in Northern Ireland particular focus in our next report, or even before, and to take early and comprehensive evidence on this.

We remind all parties that the deadlines set for evidence are not only to ensure we have sufficient time to consider and interrogate it, but also to allow the other parties sufficient time to comment and respond to each other's evidence. This transparency is essential for the ongoing integrity of the process. We thank all parties for the time and effort spent in preparing and presenting their evidence to us and we are particularly grateful for the flexibility demonstrated during this round to ensure we could meet the timetable for reporting.

The economy, labour market and pay

Economic growth has continued steadily across the UK but by less than forecast, and with continued risks from the global economy. Employment growth continues to be strong and there are signs of a gradual tightening in the labour market. At the current time private sector and public sector earnings are not markedly divergent. Nevertheless private sector settlements are rising at a faster rate to those in the public sector. Whilst the UK government states that overall levels of reward are on aggregate higher in the public sector, that gap has been slowly closing. If current trends continue then the relative picture will worsen. The overall employment proposition and total reward offer are key considerations not just for the continued retention of those already in our remit group, but also for attracting people to a career in the NHS, and attracting qualified staff to return. It is therefore important to keep a close watch on attrition as general pay picks up – this includes senior management within Agenda for Change where the effect on average earnings has been particularly acute over the last two years.

Funds available

Affordability is a significant challenge across all four countries. Whilst there may be different decisions being made around spending and investment in pay, the problems each are trying to address are consistent. There are a number of factors driving the growth of the pay bill, some in an upwards direction and some downwards. Given the extremely challenging efficiency targets, it is helpful for us to understand how all these factors are at work in each country. At present we do not have a consistent picture of this.

Staff shortages in certain circumstances, and a rise in agency spend to meet short-term demands, are a pattern across all countries. We were told that work is progressing in each country to control and reduce agency spend and this is encouraging. However, it is unclear how effective a strategy focused on cost caps and use of mandatory frameworks will be, when the demand for staffing cover remains high and training new supply takes a number of years. The rise in agency spend is an example of a labour market in operation when the current level of demand is outstripping supply. This results in higher rates of pay through the agency, with workers consequently deciding where to work and on what terms. Some NHS jobs or overtime may simply need to be made more attractive and flexible to potential staff. In the long run ensuring adequate supply is key to controlling costs and providing effective care to patients.

Productivity gains have been historically difficult in health services and some evidence suggests productivity has dipped in recent years. With the most easily achievable savings now largely realised, trusts and health boards need to focus on transformational change to improve output and outcomes against the same or less input.

There is a difficult balance to be struck here. Given the high proportion of NHS costs that are attributable to the pay bill, propositions for some form of pay restraint will inevitably be part of the strategy to handle financial constraints. However, productivity improvements require longer-term solutions, such as investment in organisational change, technology and in the workforce. Bearing down too hard on the pay of the whole workforce, at a time they are being asked to deliver large scale transformational change, will not support innovation and may well be counterproductive, indeed such productivity improvements from staff are often rewarded in other industries. A pay strategy, that does not simply mean generalised pay restraint, must be a central part of the delivery of affordable reforms.

Recruitment and retention

There are some shortages, particularly in paramedics, adult nursing and some nursing specialties such as mental health and paediatrics. Turnover rates appear to be manageable at present, largely because joining rates either match or outstrip them, but nevertheless the turnover rates are increasing, and this causes us some concern. At this stage shortages appear to largely be related to a lack of trained supply, but higher turnover could be a sign of the impact of a tightening labour market and staff looking at alternative options. Whilst recruitment from overseas (via inclusion on the Migration Advisory Committee Shortage Occupation List) provides a short term stop gap, it is not a long term solution. The problem has developed from an earlier underestimation of demand and an unclear projection of supply.

There is an emerging picture of additional pressures in London and surrounding areas where vacancies and shortages seem more pronounced. The evidence base this year is not yet developed or robust enough to indicate that a targeted response is required, but we will be returning to this in future rounds and expect parties in England to develop their evidence base accordingly.

While pay may not be the central driver, it will certainly have a role as part of any attraction and retention strategy. The removal of the student bursary for nurses in England and the shift to a more demand-led system could over time lead to a better match between demand and supply as restrictions on training places are lifted. However, the removal of the incentive of the bursary could have an unsettling effect on the number and quality of applications for nursing training places in the early years. The employment package and medium to long term reward offer will be an important factor in attracting high calibre students who are choosing between courses and career options. This is an issue we need to keep under observation and it will be important to look at not only the number, but quality, of students entering NHS careers.

Staff are attracted to work for agencies for a variety of reasons; one factor is clearly related to pay and the ability to receive enhanced rates for shifts that are currently more favourable than bank rates or Agenda for Change overtime. Anecdotal evidence also points to the improved flexibility that agency working can offer and the reduced level of stress. This links back to the nature of the employment proposition and the importance of getting this right in order to recruit and retain.

Workforce data is essential for our analysis and to enable us to make the most effective recommendations, including proper consideration of issues that may warrant a targeted pay response. We are encouraged by the positive progress made on data for this round. It is our belief that there is now a commitment for improved evidence in time for our next round and we look forward to receiving this.

Motivation

The members of our remit group are highly motivated and committed to delivering high quality patient care; for the majority this is what attracts them to work in the health sector. However, the pressures within the system are high and increasing and appears to be having an effect. Coupled with low pay awards this all serves to make many staff feel undervalued. A focus on areas such as staff well-being and flexible working practices as part of a local engagement strategy could provide employers with useful retention tools, especially important in times of pay restraint. There are ways that management in trusts can improve staff engagement by non-financial means. The Boorman report (in England) made a number of recommendations around improving staff well-being and reducing staff sickness absence. However, there seems to have been mixed success in implementing these changes locally, with some trusts more proactive than others. The progress on implementing local appraisal systems has also had mixed success and there is work underway now to identify best practice to help support a wider roll-out.

Staff engagement is crucial at a time when finances are tight and when there is a focus on improving patient outcomes, increasing productivity and delivering transformational service changes at the same time. Staff must be involved in developing and leading service changes but need both the capacity and the will to do so. Given that pay is the largest component of costs and the workforce is fundamental to delivery of high quality patient care, highlighting the importance of performance on staff engagement in the regulatory framework could provide appropriate levers for identifying effective approaches, sharing innovation and supporting poorer performers.

Recruitment and retention of paramedics

Recruitment problems appear to be localised rather than at a national level. Attrition rates have increased, and are high in comparison to other Agenda for Change groups, with some staff choosing to move on to less stressful roles, or to higher paid and / or banded alternatives both within and external to the NHS. However, attrition rates vary at local level and are not generally considered to be unmanageable. We are also assured that shortages are being addressed through an increase in training commissions and the degree-level route that is coming online, plus in the interim employers are taking action to plug gaps locally through a range of means.

All parties were clear that recruitment and retention problems were related to a range of non-pay factors and we understand that parties are working together on these issues through the National Ambulance Strategic Partnership Forum. This work needs to progress quickly to a resolution; ideally to provide guidance to trusts.

We do not believe a national RRP will address the non-pay issues, which are the fundamental issue here. A national RRP is a blunt instrument that would be applied to all locations. In our view localised RRP offer better flexibility to deal with recruitment and retention issues specific to individual areas.

The paramedic role has evolved in recent years and paramedics across many trusts are now undertaking more autonomous and challenging job roles than previously. In general we sensed a feeling from the parties that the current national role profile is out of step with how the role is evolving and the greater emphasis on clinical decision making. Whilst the banding of the role is under review the process is taking a long time to reach a conclusion. This needs to be resolved one way or another as a matter of urgency.

There is a wider issue around the affordability of any changes to the banding of the role and the potential impact at individual trust level. A solution will be needed to ensure that local trusts can implement new staffing models and transition to these quickly. Given the importance of this role in reducing the demand on urgent care, there appears to be scope to examine costs and benefits at a health system level, to support any business case for a higher banded role. However, central ownership and capacity is needed to support the identification of these potential costs and benefits. We believe NHS England is perhaps best placed to take this forward.

Pay proposals and recommendations for 2016/17

We have made our belief clear in previous reports that giving a particular figure for public sector pay policy sets expectations for staff. We gave serious consideration to the case for a nil award this year, on the grounds that our remit group would secure more benefits if the available money were instead used to invest in workforce numbers, to alleviate workload pressures. However, our conclusion is that this would be very difficult to justify given the expectation set by the policy and in the context of a 1 per cent award for other public sector workforces. The impact of a nil award in this context would be detrimental to the engagement of our remit group and we do not believe they should be treated less favourably than other public sector staff. None of the parties appeared to be proposing a lower level award for this year.

We were assured by the health departments in England, Scotland and Wales that trusts and health boards were funded for a 1 per cent pay award, plus the additional elements included in the Scottish Government and Welsh Government pay policies. We were not given sufficient time to clarify the picture in Northern Ireland, and so we have worked on the basis that funding is provided consequential to UK government pay policy equivalent to 1 per cent.

We considered the advantages and disadvantages of a targeted award. None of the parties provided evidence to support a targeted award either by staff group or by geography, and all came out against targeting the 1 per cent award for this year. We were told that recruitment problems were either localised or primarily supply related, particularly in nursing and paramedics. Our assessment of the evidence in relation to retention is that the issues for different groups of staff are complex, not solely pay-related, and not widespread or uniform at present. Taking all this together, a national response, targeted towards particular groups, does therefore not seem appropriate. However, this does not mean that any targeted pay response would be impossible or unhelpful. There are already mechanisms within the Agenda for Change framework that enable trusts and health boards to target pay to address local recruitment and retention needs. On the basis of the evidence before us, we consider that most recruitment and retention issues are localised, and are better suited to such a local response. However, all of this requires careful monitoring, by those overseeing the health system as well as by us. If we begin to see evidence that a national targeted pay response is appropriate then we will consider accordingly.

The parties all agreed that, because of NHS affordability constraints, meaningful targeting would require a lower or potentially nil award for other staff groups, and that they did not want this. In our view there may be circumstances where this is warranted, but we do not see good evidence for how targeting could be applied in practice for 2016/17. Furthermore, given the expectations set, we also think the consequences of a less than 1 per cent award for all groups, or for certain groups, would be damaging. This would only undermine the workforce, some of whom already feel undervalued.

We are aware of the considerable financial pressures in Northern Ireland and the difficulties presented by such a large public sector workforce in the context of reducing public sector funding. However, this must be considered in balance both with what is happening across the public sector generally in Northern Ireland and across the NHS in the UK, where recent awards and offers have been more generous. NHS staff in Northern Ireland have had imposed pay awards for the last two years and have effectively had a pay freeze for the last year. Northern Ireland Agenda for Change pay rates remain at 2013/14 levels and are at least 1 per cent behind the rest of the UK, even more so in Scotland and at particular pay points. A further year of a nil award would exacerbate this position, damage engagement levels and could risk storing up potential problems for future years which may require a more expensive pay solution.

Individuals below the top of their Agenda for Change pay band should continue to be eligible for incremental pay progression, according to the agreed criteria in each country.

We recommend a 1 per cent increase to all Agenda for Change pay points from 1 April 2016 in England, Scotland, Wales and Northern Ireland.

We recommend a 1 per cent increase to the High Cost Area Supplement minimum and maximum payments.

Decisions around the Living Wage are a matter of social policy and a decision for the respective governments. As yet, we have not seen any compelling recruitment and retention evidence to support higher increases to lower paid staff groups in the NHS, but recognise there may be some value for motivation among the groups benefitting.

We were told by parties in England that they believe the intention is for the commitment to the new National Living Wage to be funded from within the 1 per cent pay allocation. This would presumably put pressure on funding available for pay increases for staff in the middle

and higher Agenda for Change bands, leading to potentially lower pay settlements for them. We note this is a potentially different approach to both Scotland and Wales who have chosen to fund their own Living Wage initiatives separately and in addition to the 1 per cent. We will, of course, look carefully at any evidence that the parties offer us on this question in the future. However, at present we have serious doubts about any proposition to fund a social policy such as the National Living Wage from the funding available for general pay awards, which are intended to support recruitment and retention.

Pay policy over the longer term

We heard from the parties on the progress being made on discussions on Agenda for Change and look forward to hearing further updates as these discussions progress.

Whilst all four countries are involved in contract discussions, we understand that their input is varied. Recent decisions around pay awards and pay policy has resulted in unique Agenda for Change rates in each country. As we have made clear before we do not make any value judgement on this but want parties to be clear in which direction they are travelling and why. Spending decisions and strategic priorities are rightly influenced by the political landscape in each country. It will be important for each of the four countries to consider what they want from the Agenda for Change discussions and to consider how a revised pay structure can meet their individual priorities to support the delivery of improved patient care. Decisions around the pay structure should be based on overall strategy and support this future direction of travel. Previous pay reforms introduced in England have not been implemented in the other UK countries despite these offering more efficient management of the pay bill. These provide an opportunity for health departments and employers in Scotland, Wales and Northern Ireland when budgets are tight.

We considered the implications of the type of pay restraint envisaged by the UK government over the four year Spending Review period. Much will clearly depend on the overall economic picture. There are shortages and recruitment and retention problems already emerging for particular groups in the NHS. Resolving these, so that the NHS continues to offer a good service to patients, will hinge in large part on the quality of the employment proposition, of which pay is one of many factors alongside others such as career progression, development, workload, wellbeing and pension. Data on potential numbers of qualified health staff not working in the NHS in England shows there are non-NHS employment opportunities available to them. To make any pay policy work, employers must get a grip on their workforce policies to ensure careers in the NHS remain attractive in each locality. The wider system supporting them, including regulators and commissioners, must recognise and commit to the importance of engaging the workforce in the service changes being sought.

Given overall public sector financial pressures, we understand the UK government's interest in some form of targeted pay approach, focusing resources on where they appear most needed. Our preferred form of targeting at present would be through using local flexibilities. More work could be done to develop a flexible local reward offer which is targeted to meet local needs and delivery of service outcomes. A toolkit of options for a local reward offer could be developed to help trusts and health boards supplement the national Agenda for Change spine as and where required, returning to the core spine when such targeting is no longer required. The key to this working, however, will be to ensure that staff supply is right, otherwise it risks moving problems around the system. There is an argument for developing a national working group to identify and disseminate existing best practice in local pay, reward, staff engagement and well-being. Local solutions are required to provide a more innovative and flexible reward offer to respond to local needs, and support the delivery of outcomes through better engagement of staff.

We are not confident that the tariff can currently accommodate targeted pay increases, and have concerns that targeted awards could actually impact negatively on some providers if not properly funded. Given the request to consider targeted awards has been outlined as part of UK government's pay policy for the next four years, this will need to be resolved. We would like some assurances provided on this in time for our next round.

The importance of the workforce has not had sufficient focus in service transformation efforts to date. It seems to us that there is still a need for an overarching grip on workforce planning, and clarity about what is being done nationally and locally. It is not clear to us how far efficiency measures and new workforce models are being factored into the plans in all four countries, and therefore how realistic they are, although we appreciate that this is challenging given the number of factors at play; it may therefore be that an element of over-supply should be part of workforce planning.

A wide-ranging workforce strategy is required in each of the four countries. Discussions on the structure and detail of Agenda for Change pay are an important element of this but a workforce strategy will need to be much wider to address the key issue of staff engagement to deliver quality patient care. An effective strategy, linked to each of the countries' overarching objectives for healthcare should identify the people-related, implications of the ambitions. The strategy should explore all aspects relating to the attraction, development and retention of staff, and therefore support staff engagement to deliver wider strategic and operational plans. Greater use of forecasting and scenario planning, including a wider perspective on health and social care trends, would potentially add a level of robustness to avoid future staff shortages similar to those currently being experienced within paramedics and nursing.

We look forward to assisting and advising the parties in their consideration of these issues.

JERRY COPE (*Chair*)
BRONWEN CURTIS CBE
JOAN INGRAM
SHAMAILA QURESHI
PROFESSOR DAVID ULPH CBE
PROFESSOR ANNA VIGNOLES
LORRAINE ZULETA

1 March 2016

Our additional observations:

- We will be monitoring recruitment, retention and staff engagement indicators carefully to consider (1) the sustainability of continued pay restraint for our remit group, in whole or in part; and (2) any areas or specialisms where the NHS may not be providing a competitive reward offer to attract and retain staff of the required calibre to support and deliver high quality patient care. We have a responsibility to alert the governments if and when we believe action is necessary.
- We ask the parties to continue to include evidence in their future submissions on the total reward offer, including NHS pension scheme membership.
- We ask the health departments to improve and make consistent their evidence on pay bill trends over time in their future evidence submissions.
- We ask the health departments where relevant, and the regulators as applicable in each country, to consider how funding mechanisms may need to be adapted in order to respond effectively to any proposals for targeting pay.
- It will be important for the Department of Health and Health Education England to monitor the impact of the removal of student nurse bursaries in England on applications for training places, the numbers entering the profession and the quality of students.
- The parties in each of the four countries should develop a strategic workforce framework at national level with local level flexibility. We see this as critical to staff engagement, managing recruitment and retention challenges over the longer-term, aligning a valuable and costly asset to the needs of the service and enabling delivery of a demanding and complex agenda.
- For our next round we ask the health departments and regulators, as relevant in each country, to provide evidence on agency expenditure by location, staff group and shift type and the range of rates paid.
- We would like to see a robust set of data covering fill rates, vacancies, attrition by staff group and geography in the evidence submissions from the health departments, and other agencies as relevant, for our next round.
- We ask all parties in England to develop their evidence base around comparative pay levels, vacancy and attrition data for HCAS sites and surrounding areas.
- Given the importance of staff engagement and the link to patient outcomes, performance in this area should be given a much greater level of scrutiny. Each of the four health departments should consider how the relevant regulatory frameworks can address this.
- The UK government needs to consider the funding arrangements for the implementation of the new National Living Wage, which will affect some of our remit group during the later years of this Spending Review period. This is a social policy, rather than a pay policy linked to recruitment and retention needs in the NHS.
- A national working group should be set up in each country to identify innovative practice in local reward and staff engagement, linked to high quality patient care, to provide insight and advice that other trusts and health boards can make use of.

Our observations on the national recruitment and retention premium for paramedics:

- We do not believe the case has been made to warrant the introduction of a national recruitment and retention premium (RRP) for paramedics. There are some shortages, but they appear to be localised and short-term, and local RRP therefore offer a better potential targeted solution. There are wider recruitment, retention and engagement issues that need to be addressed holistically. We urge the parties to work together quickly to identify solutions and best practice for trusts.
- The Agenda for Change banding position of paramedics is presenting a problem and is taking too long to resolve. We recommend that a clear and tight timetable is agreed between the parties to reach a final decision to minimise the negative effects of ongoing uncertainty on recruitment, retention and motivation.
- NHS England should provide central ownership and capacity to support the evolution of the future paramedic role, the identification of costs and benefits for health systems, and support the business case for any pay band changes to assist local level decision making.

Chapter 1 – Introduction

Introduction

- 1.1 For 2016/17 we received remits from the UK Government, the Scottish Government, the Welsh Government and Northern Ireland Executive.¹ The remits differ slightly, reflecting the public sector pay policy of each of the governments. More detail on the remits is provided later in this chapter.
- 1.2 We have considered the remits in relation to our standing terms of reference and set out the evidence from the parties presented on these matters, together with our conclusions and recommendations, under each of these elements.² In addition to the overall pay uplift we have also considered an application for a national Recruitment and Retention Premium for paramedics in England. This is in line with our role in the parties' agreement as set out in the *NHS Terms and Conditions of Service Handbook*.³

Structure of the report

- 1.3 This report is divided into six chapters, which comprise:
 - this introduction;
 - the economy, labour market and pay;
 - affordability;
 - recruitment, retention and motivation;
 - consideration of a national Recruitment and Retention Premium for paramedics in England; and
 - pay proposals, recommendations and observations.
- 1.4 The appendices consist of:
 - Appendix A – remit letters from the respective governments;
 - Appendix B – recommended NHS Agenda for Change pay scales with effect from 1 April 2016 (England, Scotland, Wales and Northern Ireland);
 - Appendix C – composition of our remit group;
 - Appendix D – the evidence (parties' website addresses);
 - Appendix E – previous reports published by the Review Body;
 - Appendix F – key to the abbreviations used in this report; and
 - Appendix G – NHSPRB Workforce monitoring data.

Recent reports

2015 Scotland report⁴

- 1.5 We were asked to make pay recommendations for 2015 by the Scottish Government⁵ and submitted our report to the Cabinet Secretary for Health and Wellbeing on 9 February 2015. We recommended a 1 per cent uplift to all Agenda for Change pay

¹ Where we refer to the Scottish Government, Welsh Government and Northern Ireland Executive we are referencing the evidence provided from the Health Departments in the respective countries.

² The NHSPRB terms of reference can be found at page iii of this report.

³ The role of the NHSPRB in considering national RRP is set out in section 5 (paragraph 5.3) of the NHS terms and conditions of service handbook. The handbook is available from: http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/AfC_tc_of_service_handbook_fb.pdf

⁴ The NHSPRB 2015 Scotland report is available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/412261/10357-OME-NHS_Pay_Review-ACCESSIBLE.pdf

⁵ For 2015/16 we were not required to provide pay recommendations by the UK Government (for England), the Welsh Government or the Northern Ireland Executive.

points from 1 April 2015 for all staff in NHSScotland. We also noted the additional features of the Scottish Government public sector pay policy (a minimum increase of £300 for staff earning less than £21,000 and implementation of the Living Wage) to ensure NHS staff in Scotland had parity with other public sector workers. Our recommendations were accepted and implemented in full.

Enabling the delivery of healthcare services every day of the week – the implications for Agenda for Change report⁶

1.6 We were asked by the UK Government (for England), the Welsh Government and the Northern Ireland Executive to make observations on the barriers and enablers within the Agenda for Change pay system, for delivering healthcare every day of the week in a financially stable way. More specifically the Review Body was asked to make observations on:

- affordable 'out of hours' working arrangements; and
- any transitional arrangements.

The Scottish Government did not seek to be a part of the remit.

1.7 We found there was a compelling case for expanded seven-day services in the NHS to tackle the 'weekend effect' on patient outcomes and noted this as an area of common ground between the parties. In general, we found there was no contractual barrier in Agenda for Change to the delivery of seven-day services, and that large numbers of NHS staff were already working over seven days. Whilst it was clear that some adjustments could be made, we did not find enough evidence to support wholesale changes to unsocial hours definitions and premia in isolation from the wider Agenda for Change pay system. In our previous reports we have observed the need to review the Agenda for Change pay structure⁷ and said that discussions regarding unsocial hours pay should be pursued as part of negotiation on the pay system as a whole, with the aim of agreeing a balanced package. We were clear that staff engagement and support to line managers were crucial to building confidence among staff and delivering successful change.

1.8 We submitted our report to ministers on 17 June 2015. The Secretary of State for Health welcomed the observations in our report, in particular that any reform of unsocial hours premia should not be done in isolation but as part of a wider package of reform. He said he had welcomed the agreement of the NHS trade unions earlier in the year to enter into talks on contract reform and a timetable seeing change beginning to be implemented from April 2016. The Secretary of State said he was now inviting the Agenda for Change trades unions to enter into formal negotiations with NHS Employers to agree a balanced package of affordable proposals for reform.

1.9 To date there has been no formal response to our report from ministers in the Welsh Government and Northern Ireland Executive. Officials have advised that the findings in the report were welcomed and we understand that immediate priorities are different for these countries.

1.10 NHS Employers are now engaged in discussions on Agenda for Change with the NHS trade unions. The devolved administrations are also party to these discussions as observers.

⁶ The NHSPRB report, *Enabling the delivery of healthcare services every day of the week – the implications for Agenda for Change*, is available from: <https://www.gov.uk/government/publications/enabling-the-delivery-of-healthcare-services-every-day-of-the-week>

⁷ See observation 3 in the NHSPRB's 28th report, available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/288690/NHS_Pay_Review_28th_repot.pdf

Key context for this report

- 1.11 Our report and recommendations were produced at a time of complex change for the NHS across the UK and for our remit group. All four countries are aiming simultaneously to meet demanding efficiency targets and deliver transformational change through service redesign and new models of care, whilst continuing to respond to every day service requirements and meet the demands of regulators.
- 1.12 The *Five Year Forward View* set the direction of travel in England and the Lord Carter review is supporting work on improving productivity. In line with the *2020 Vision*, the Scottish Government has begun the integration of Health and Social Care through the creation of Health and Social Care Partnerships, and is currently holding a national conversation seeking views on how the health and social care services in Scotland can develop over the next 10 to 15 years. The Welsh Government is progressing their vision for prudent healthcare and has asked the Health Foundation to refresh the work on the financial challenge delivered by the Nuffield trust in 2014. Northern Ireland are already operating an integrated model of health and social care and are currently running a consultation on proposed reform to administrative structures, they have also set up a panel to consider the best configuration of Health and Social Care services in Northern Ireland.

Remits for this report

- 1.13 The remit letters from each of the four countries are included in full at Appendix A and summarised below.

HM Treasury

- 1.14 The UK Government policy on public sector pay was announced by the Chancellor of the Exchequer in his summer budget on 8 July 2015.⁸ Here the Chancellor confirmed the government would fund public sector workforces for a pay award of 1 per cent for four years from 2016/17 onwards. The Chancellor also announced the introduction of a new National Living Wage of £7.20 an hour for those aged 25 and over from April 2016, rising to over £9 an hour by 2020.
- 1.15 The Chief Secretary to the Treasury (CST) wrote to all Review Body Chairs on 19 August 2015. The letter was clear that savings from public sector pay and workforce reform had made a significant contribution to reducing the deficit over the course of the last parliament (saving around £8 billion). The CST said the government would need to continue to ensure public sector pay restraint whilst the deficit and debt were being reduced, in order to protect services and frontline jobs.
- 1.16 The CST letter reconfirmed the Chancellor's announcement (funding for public sector workforces for a pay award of 1 per cent a year for four years from 2016/17) and clarified that the government expected awards to be applied in a targeted manner to support the delivery of public services and to address recruitment and retention pressures. The letter was clear that this could mean some workers receiving more than 1 per cent whilst others could receive less and that there was no expectation every worker would receive 1 per cent.
- 1.17 The letter went on to reiterate the government's commitment to examining pay reforms and modernising terms and conditions in the public sector. The CST said this would include a renewed focus on progression pay and considering legislation where necessary to achieve the government's objectives.

⁸ More information on the summer budget announcements is available from: <https://www.gov.uk/government/publications/summer-budget-2015/summer-budget-2015#the-uk-economy-and-public-finances>

Department of Health

1.18 The Parliamentary Under Secretary of State for NHS Productivity wrote to us on 6 November 2015. The letter apologised for the lengthy delay in writing to us and followed up on the CST letter of 19 August 2015. It reiterated the public sector pay policy as set out in the CST letter and asked us to consider the case for targeting to support recruitment and retention, including High Cost Area Supplements, and to make recommendations within an average of 1 per cent for staff employed under Agenda for Change.

Welsh Government

1.19 The Minister for Health and Social Services wrote to us on 16 December 2015 asking us to make pay recommendations for staff engaged on Agenda for Change terms and conditions. The Minister said that any recommendation should take into account the Chancellor's 2015 budget statement that public sector pay will increase by 1 per cent a year for four years from 2016/17, and the context of NHS Wales financial position as set out in its evidence.

Scottish Government

1.20 The Cabinet Secretary for Health, Wellbeing and Sport wrote to us on 22 December 2015 and confirmed the one year public sector pay policy for the Scottish Government:

- An overall 1 per cent cap on the cost of the increase in basic pay for those earning £22,000 or more.
- Continued measures to support the lower paid, specifically a continued commitment to paying the Scottish Living Wage and guaranteeing a minimum increase of £400 for staff earning less than £22,000.
- Continuing the expectation to negotiate extensions to no compulsory redundancy agreements in return for new or continued flexibilities.

1.21 The Cabinet Secretary confirmed that all consideration on the issue by Scottish Ministers must be informed by this policy framework. However, beyond these elements the Scottish Government would wish us to be as free as possible in considering the issues and recommendations for Scotland in 2016/17. The letter was also clear regarding the on-going financial challenges facing NHSScotland, and that any pay increase must be affordable.

Northern Ireland Executive

1.22 The Minister for Health, Social Services and Public Safety wrote to us on 3 February 2016 asking us to consider the case for targeting to support recruitment and retention and to make recommendations for staff employed under Agenda for Change. The Minister explained that any recommendation should take account of the need for continued public sector pay restraint and the specific financial context of Northern Ireland.

National Recruitment and Retention Premium for Paramedics in England

1.23 We were also asked by UNISON, Unite and GMB to consider their joint application for a national Recruitment and Retention Premium for paramedics working in England.

Our comment on the remits

1.24 Our remit group for this report covers 1,378,561 (headcount)⁹ Agenda for Change staff across the UK. The detailed composition of the remit group can be found at Appendix C.

⁹ As at September 2014.

- 1.25 Once again the remits for 2016/17 have all outlined slightly different approaches, albeit with a lot of similarities. Respective decisions on the pay award and pay policy in both 2014 and 2015 have led to separate Agenda for Change pay rates in each of the four UK countries (although the framework continues to operate on a UK-wide basis), and this seems unlikely to change in the immediate future. We have had to decide whether to make UK-wide recommendations or to recommend specific awards for each country. In doing so we have given full consideration to the evidence presented to us by all parties.
- 1.26 Our remit is informed by the public sector pay policy of each of the UK nations and the ongoing requirement for public sector pay restraint. The Scottish Government, Welsh Government and Northern Ireland Executive can only provide a one year position at this stage as elections are due to take place in May 2016. The UK Government has set out its policy for the next four years and is keen for awards to be targeted to support recruitment and retention. We believe that holding down pay over this period is likely to become more challenging, given the forecasts for improving private sector wages, rising general employment levels, and in particular given the emerging shortages within our remit group for some specialisms and in some parts of the country. We will continue to monitor the position, focusing on the evidence. This is discussed further in Chapter 6.
- 1.27 The general proposition of a targeted award has not been supported by the parties giving evidence this year. This was both on the basis that limited resources meant it was harder to target meaningfully and, crucially, the lack of robust data to support a case for this approach. We gave this considerable thought during our deliberations, because there are some signs that recruitment and retention pressures are not evenly spread across every specialism and area. We will continue to consider the case for targeted awards across our remit group over the next four years, but it is essential we are provided with both the appropriate data and rationale to support any such proposals.
- 1.28 The Northern Ireland Executive provided its remit and evidence submission extremely late into our reporting round. Given all the parties wanted us to produce recommendations to the same timescale as for the other countries of the UK this has meant we have had to reach our conclusions based on the limited evidence available. We have not had time to explore the recruitment, retention and motivation issues in any depth, or to conduct oral evidence, to run as full a process as for the other countries. Such a shortened process has risks and we are uncomfortable about this. We have proceeded with a recommendation on an exceptional basis but are not prepared to short cut the process again in this way. Given the short timescales within which we have operated this year, we would want to give the issues in Northern Ireland particular focus in our next report, or even before, and to take early and comprehensive evidence on this.
- 1.29 We would like to thank the Royal College of Nursing Northern Ireland for providing evidence at short notice to enable us to respond to the Northern Ireland remit.

Parties giving evidence

- 1.30 We received written evidence from the organisations listed below for this round:

Government Departments (and Agencies thereof)

Department of Health

NHS England

Health Education England

Scottish Government

Welsh Government

Northern Ireland Executive

Employers' Bodies

NHS Employers
NHS Providers
Association of Ambulance Chief Executives

Bodies representing NHS Staff

Joint Staff Side
Royal College of Nursing
Royal College of Midwives
UNISON
Unite
Chartered Society of Physiotherapy
UNISON, Unite and GMB (joint submission on a national RRP for paramedics)
Royal College of Nursing (Northern Ireland)

- 1.31 We held oral evidence sessions over five days during November and December 2015 and January 2016 with the following parties:

Government Departments

Department of Health (with the Parliamentary Under Secretary for NHS Productivity and officials from the Department of Health and HM Treasury)
Health Education England
Scottish Government (with the Cabinet Secretary for Health, Wellbeing and Sport and officials)
Welsh Government (with officials)

Employers' Bodies

NHS Employers
NHS Providers
Association of Ambulance Chief Executives

Bodies representing NHS Staff

Joint Staff Side (with representatives from the Royal College of Nursing, the Royal College of Midwives, UNISON, Unite and the Chartered Society of Physiotherapists)
UNISON, Unite and GMB (joint session on a national RRP for paramedics)

- 1.32 Our work programme to produce this particular report included nine Review Body meetings in which we considered the written and oral evidence, examined information on the economy and labour market and formed our conclusions, observations and recommendations.
- 1.33 We thank all the parties for the submission of written evidence and attending oral evidence sessions. We work to a tight schedule and the impact of the Spending Review provided additional challenges for the timetable for this round. We remind all parties that the deadlines set for evidence are not only to ensure we have sufficient time to consider and interrogate it, but also to allow the other parties sufficient time to comment and respond to each other's evidence. This transparency is essential for the ongoing integrity of the process. We thank all parties for the time and effort spent in preparing and presenting their evidence to us and we are particularly grateful for the flexibility demonstrated during this round to ensure we could meet the timetable for reporting.

Review Body visits in 2015

- 1.34 Our annual programme of visits to NHS organisations is an important complement to the parties' evidence and provides essential context for our considerations. The visits take place across a range of organisations in the United Kingdom to ensure that we see a varied cross-section of both types of organisation and geographies. The visits provide an important opportunity to discuss issues with members of our remit group and NHS

management. Once again, we extend our thanks to all those who gave generously of their time in order to meet us, for the frank opinions expressed and to the staff who have worked hard to organise our visits.

- 1.35 Due to the impact of the special remit on Agenda for Change and seven-day services, we had to shorten the visit programme. Between May and September 2015 we visited the following organisations:

Lewisham and Greenwich NHS Trust;
Leeds and York Partnership NHS Foundation Trust;
Cornwall Partnership NHS Foundation Trust;
Greater Glasgow and Clyde NHS Health Board;
Shrewsbury and Telford Hospitals NHS Trust.

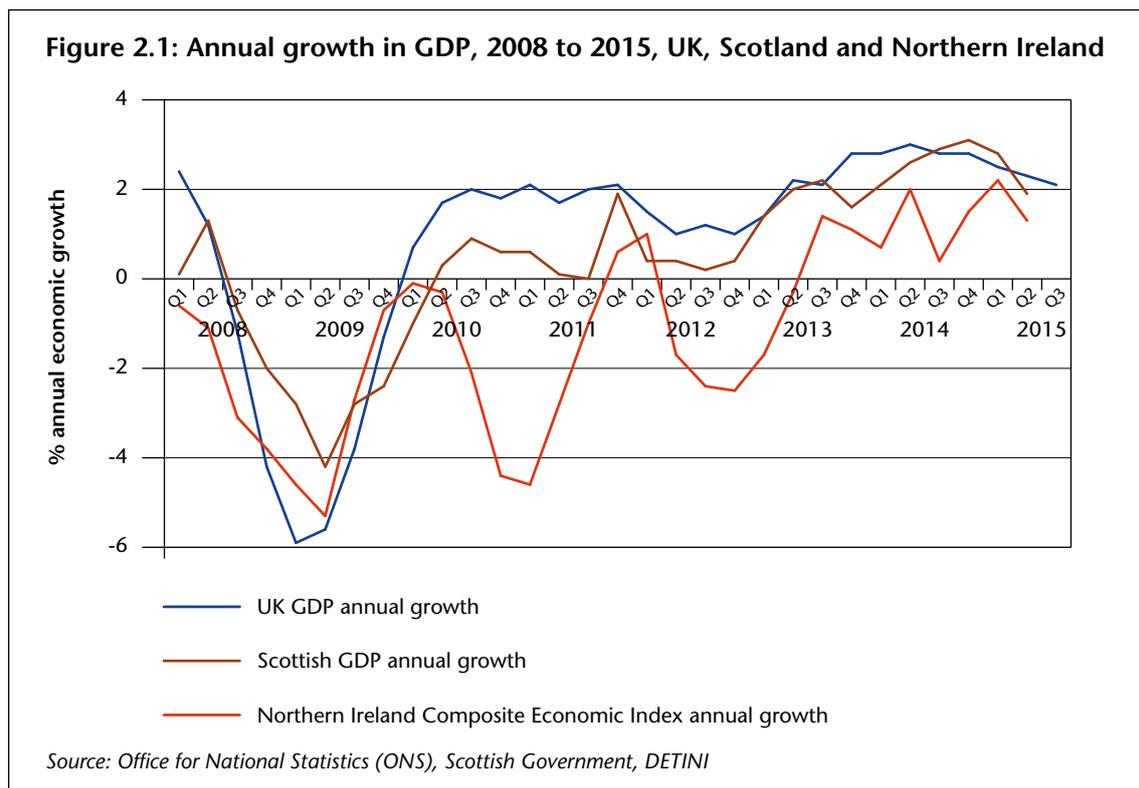
Chapter 2 – The Economy, Labour Market and Pay

Introduction

2.1 In this chapter we analyse the latest available data on the economy, the labour market and on pay.¹ This information provides important context to inform our consideration of pay recommendations for Agenda for Change staff. The parties' evidence was presented during Autumn / Winter 2015 and early 2016 so reflects the position at that time. We conclude this chapter with an assessment of earnings, including take-home pay of Agenda for Change staff, by drawing on NHS information and data from the 2015 Annual Survey of Hours and Earnings (ASHE). We also monitor data on membership of the NHS Pension Scheme.

Economic Growth

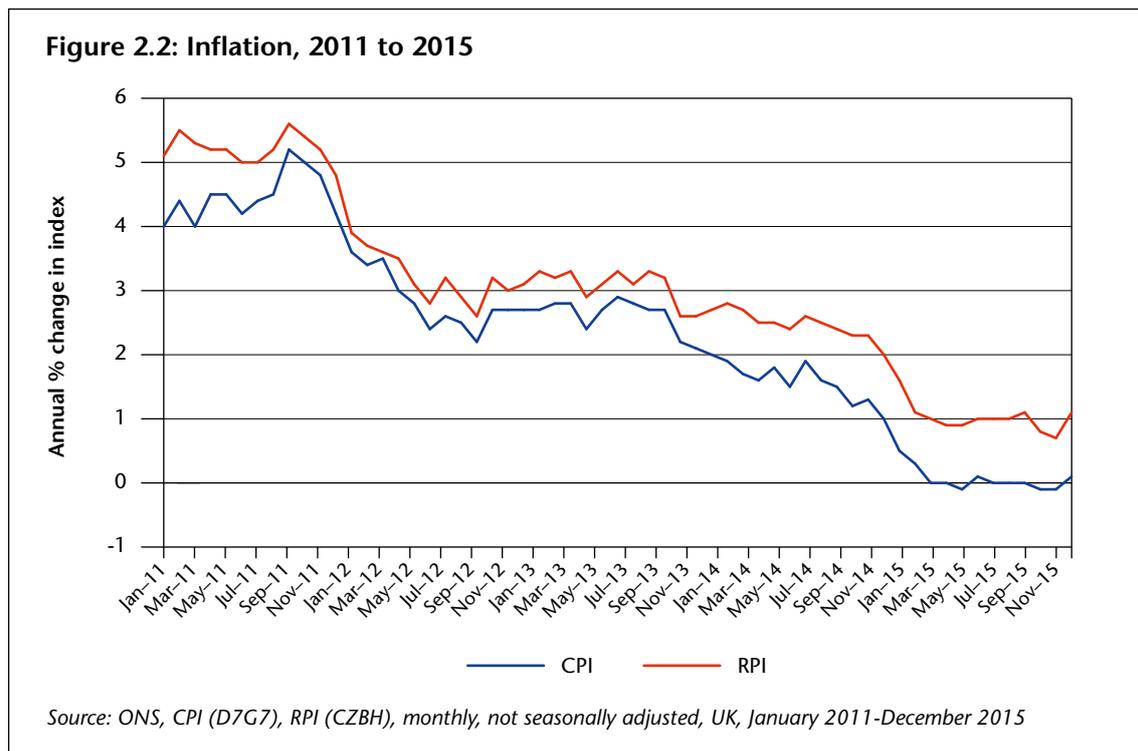
2.2 Economic growth in the United Kingdom continues to be positive. Gross Domestic Product (GDP) grew by 2.2 per cent in 2015 as a whole compared to 2014. Economic growth in Scotland has kept pace with the UK over the last two years although the recently revised UK data shows that the UK as a whole had stronger growth in 2010 to 2012 than Scotland. Northern Ireland saw a triple-dip recession with positive, but relatively slow growth over the last two years (see figure 2.1). Separate GDP data is not available for Wales.



¹ The data presented is as published at the end of January 2016.

Inflation

2.3 In December 2015, headline Consumer Price Index (CPI) inflation was 0.2 per cent. Figure 2.2 shows that throughout most of 2015 the CPI rate has been stable between +0.1 and -0.1 per cent. The Retail Price Index (RPI) inflation was 1.2 per cent in December 2015 and has generally been stable around 1 per cent throughout 2015. Looking across the year overall, prices for transport costs, food and non-alcoholic beverages and (to a lesser extent) recreational and cultural goods and services have had a downward pull on the rate of inflation. These have been counterbalanced by an upward pull from price movements for other goods and services, most notably restaurant and hotel bills, and education costs such as university tuition fees.



2.4 The inflation forecasts (see table 2.1) suggest that inflation will start to rise a little around the turn of the year, as the oil prices falls of a year ago drop out of the 12 month comparison. The return of inflation to near the Bank of England's 2 per cent target is expected to be a little faster than the Office for Budget Responsibility (OBR) predicted in July (2015), with inflation forecast to reach 1.8 per cent by the second half of 2017. This change in the forecast is almost entirely due to assumptions about the effect of unit labour costs. As wage growth is forecast to pick up faster than productivity growth over the next few years, it is expected that firms will pass through some of the associated increase in costs to consumers in higher prices. Inflation is then expected to remain relatively flat for the rest of the forecast, as wages return to rising in line with productivity.

Table 2.1: Inflation forecasts, Quarter 4

	OBR (November) %		Bank of England central projection (November) %	Treasury independent average (December) %	
	CPI	RPI	CPI	CPI	RPI
2016	1.4	2.3	1.2	1.4	2.5
2017	1.8	3.0	2.0	1.9	3.2
2018	1.9	3.2	2.2	2.0	3.3
2019	2.0	3.3	–	2.0	3.3

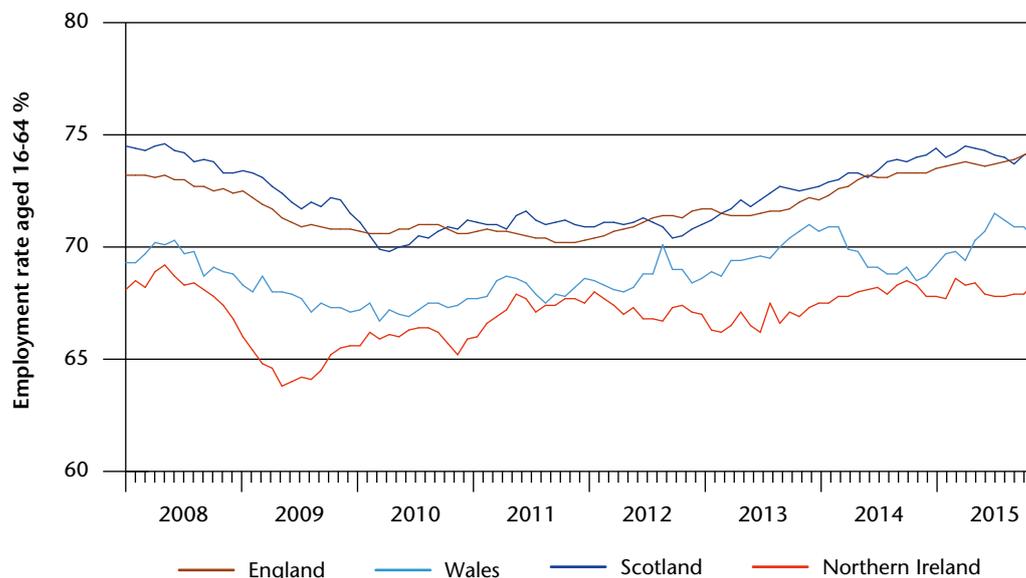
**2017 to 2019 from November*

Labour Market

2.5 The employment level has grown by 588,000 in the year to November 2015 to reach 31.39 million people in work, with increases to both the number of people working full-time and part-time. The employment rate reached 74.0 per cent in November 2015, the highest since comparable records began in 1971. The unemployment rate was 5.1 per cent in November 2015, lower than for a year earlier (5.8 per cent) and the lowest since 2005.

2.6 Figure 2.3 shows that employment rates in Scotland and England are at similar levels, whilst Employment rates for Wales, and particularly Northern Ireland, have lagged behind England and Scotland. The employment rate in Wales grew significantly between mid-2014 and mid-2015, but has dropped in recent months.

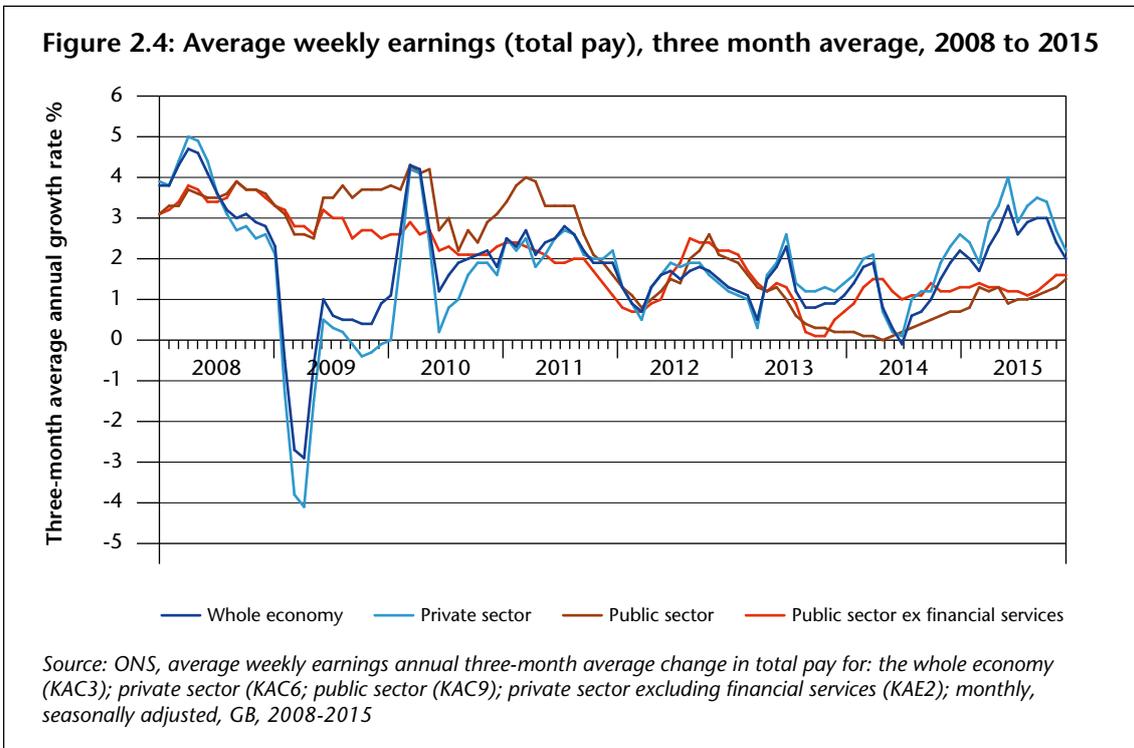
Figure 2.3: Employment rates by country, 2008 to 2015



Source: ONS, Labour Force Survey (LF3Y, LF3Z, LF42, LF5Z)

Average Earnings Growth and Pay Settlements

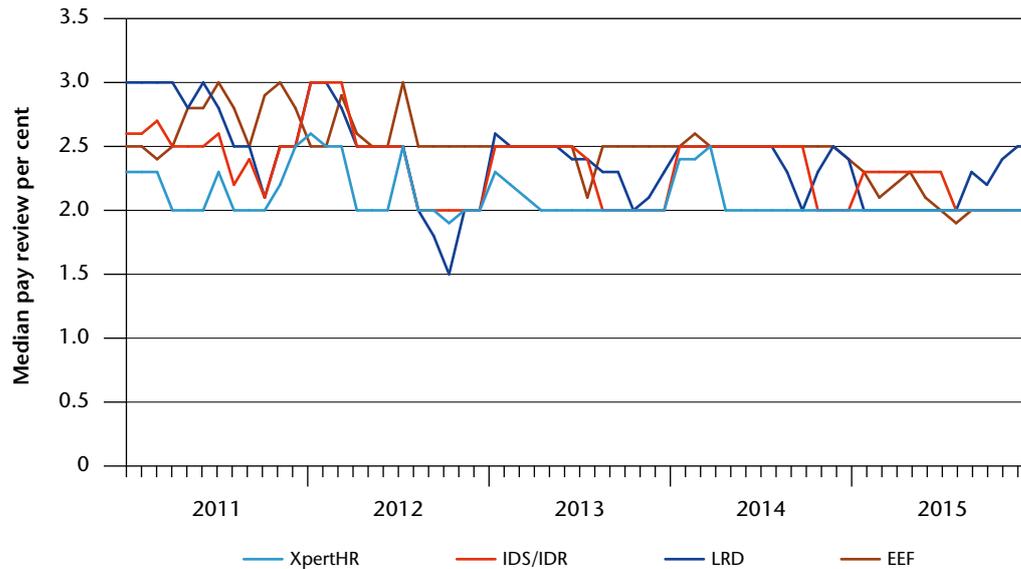
2.7 The Average Weekly Earnings (covering Great Britain) series tracks movement in average weekly earnings for broad industrial classifications. Figure 2.4 presents a trend over time of the three-month average weekly earnings. Having strengthened to three per cent and above between February and August 2015, private sector average earnings growth has fallen back closer to two per cent since September. In October public sector earnings growth (excluding financial services) was at its highest rate for two and a half years.



2.8 The Bank of England said in November that it expects wage growth to be volatile in the near term, due to the timing of bonus payments. Beyond that, wage growth is expected to pick up, further outstripping productivity growth, as the tightening labour market results in pay pressures as companies find it increasingly difficult to find staff. The Bank considers the impact of the National Living Wage on earnings growth to be very small, at less than 0.1 percentage points a year. The Bank projects earnings growth of 3.75 per cent in quarter 4 2016, and 4.0 per cent in quarter 4 2017.

2.9 Pay settlement medians have been broadly stable at 2 to 2.3 per cent through 2015, close to the previous two years (see figure 2.5). Public sector pay review medians are at 1.0 to 1.5 per cent. The 3.1 per cent increase in the National Minimum Wage from 1 October 2015 did not place any observable pressure on pay reviews; this may be different with the 7.5 per cent increase to the new National Living Wage of £7.20 an hour for those aged 25 and over from 1 April 2016.

Figure 2.5: Pay settlements, 2011 to 2015 (three-month average)



Source: XpertHR, IDS/IDR, LRD, and EEF, pay databank records, three-month medians, UK, 2011-2015.

Public-Private Sector Pay Differentials

2.10 In 2015, the average pay in the public sector was 3.5 per cent less than in the private sector when using an established statistical model reported previously in the Office for National Statistics' Public and Private Sector Earnings - November 2014² which controls for individual and job-related characteristics, including organisational size. This pay gap is 0.2 percentage points smaller than in 2014, when average pay for the public sector was 3.7 per cent less than the private sector. Average pay levels such as those reported in the Annual Survey of Hours and Earnings - 2015 Provisional Results³ can vary between groups of employees because of the different jobs and characteristics of each type of employee.

Evidence from the parties⁴

2.11 The **Department of Health** said the Spending Review and Autumn Statement had set out the government's long term economic plan to fix the public finances, return the country to surplus and run a healthy economy that starts to bear down on the excessive national debt. It told us public sector pay restraint had been a key part of the fiscal consolidation so far, helping to save approximately £8 billion in the last Parliament and expected to save another £5 billion in the current Parliament. The Department of Health said a policy of pay restraint made a significant contribution to protecting jobs and maintaining public services at a time when further spending reductions are required to complete the repair of the public sector finances. It reported the Office for Budget Responsibility (OBR) had estimated the government's public sector pay policy over the next four years will protect 200,000 jobs by 2019/20.

² More information is available from: <http://www.ons.gov.uk/ons/rel/lmac/public-and-private-sector-earnings/november-2014/public-private-pay-2014.html>

³ More information is available from: <http://www.ons.gov.uk/ons/rel/ashes/annual-survey-of-hours-and-earnings/2015-provisional-results/stb-ashes.html>

⁴ Evidence was received from the parties during the autumn and winter 2015 and early 2016 and has since been overtaken by more recent data.

- 2.12 The Department of Health told us, whilst the pay differential between public and private sector workers was narrowing, when taking employer pension provision into account the overall remuneration of public sector employees continued to be above that of the market. The Department of Health informed us that, historically, public sector wages tended to fall and recover at a slower pace during economic cycles than private sector wages. It said since July 2014, private sector earnings growth had been faster than growth in public sector wages, but this had followed a period of sustained public sector wage growth in the years immediately following the recession. The Department of Health reported that from the three months to March 2008 to the three months to October 2015, total average private sector earnings had increased by 10.4 per cent compared to a 16.1 per cent increase in the public sector. The Department of Health said the overall level of public sector average weekly wage remained above that of the private sector.
- 2.13 The Department of Health said across the whole economy there was evidence the labour market was performing strongly. There had been strong growth in employment and tightening of labour market slack with a record high number of vacancies. The Department told us that despite this there was limited evidence of widespread recruitment and retention issues within the public sector, and resignation rates continued to be below pre-recession levels in this sector.
- 2.14 The Department of Health said the new National Living Wage, announced in the Summer Budget 2015, will increase pay to £7.20 per hour from April 2016, rising to £9.00 per hour by 2020. It reported estimates indicating the policy was expected to directly raise pay for approximately 200,000 public sector jobs.
- 2.15 The Department of Health informed us public service pensions remained among the best available and continued to offer members guaranteed, index-linked benefits in retirement that are protected against inflation. It stated private sector workers buying benefits in the market would have to contribute over a third of their salary each year to buy an equivalent pension. The Department of Health said putting together the evidence on pension provision and pay levels – and recognising there will be significant variation between and within individual workforces – the overall remuneration of public sector employees was above that of the market. It believed it was therefore clear that any changes to public service pensions, including the progressive increase in contributions from 2012/13, did not justify upward pressure on pay. We look at the NHS pension membership and total reward later in this chapter.
- 2.16 **NHS England** told us the NHS Five Year Forward View acknowledged NHS pay would need to be competitive in a buoyant economy, but also noted the strict efficiencies needed to meet the funding gap. NHS England said in addition the NHS would also need to live within the Government's public sector pay policy.
- 2.17 **NHS Employers** were clear that, whilst continued pay restraint remained necessary on affordability grounds, there was an appreciation that this would have some impact on individual staff, many of whom have had to meet the cost of higher pension contributions in recent years. They told us, over the longer term, it would be important to balance affordability considerations against the risk of eroding the value of the NHS employment proposition. They said a number of employers had stressed the need to ensure that, as a minimum, NHS pay rates should not fall behind the Consumer Prices Index (CPI) inflation rate in 2016/17, with 16 per cent of respondents to their survey believing the pay award should be linked to inflation.
- 2.18 The **Scottish Government** informed us that the Scottish economy had experienced a solid recovery with three years of uninterrupted expansion to date. However, within a challenging global economic environment, there had recently been indications of several headwinds impacting on the economy, with the pace of quarterly growth slowing significantly in Q2 2015. The Scottish Government told us a key ongoing challenge

was the oil and gas industry's adjustment to low global oil prices; investment in the sector had fallen sharply and many companies were reducing their workforce. This had generated regional economic issues in areas such as the North East of Scotland which is particularly associated with the oil and gas sector. However, impacts were also being felt in the wider Scottish economy.

- 2.19 The Scottish Government reported that over the past few years conditions had significantly improved within the Scottish labour market, with the unemployment rate falling by 3.2 percentage points since its recession peak (now standing at 5.6 per cent). It said the employment level was now 51,000 higher than it was before the recession in Mar-May 2008. Overall, the latest Scottish labour market data showed employment remained high and labour market participation was close to record levels.
- 2.20 The Scottish Government told us the improving economic situation in both Scotland and the UK had fed through to rising nominal wages which, combined with low inflation, had resulted in real wage increases. The Annual Survey of Hours and Earnings reported that between 2013 and 2014, nominal wages in Scotland rose 1.4 per cent, adjusting for CPI inflation. Over the same period real wages increased 1.5 per cent in Scotland, but average real wages still remained significantly below their pre-recession peak.
- 2.21 The **Welsh Government** told us data on the labour market and on output in the private sector suggested economic performance in Wales had been similar to that of the UK. It said the number of people in employment in Wales was close to a record high, and productivity, which had been stagnant for around five years, had strengthened this year. The employment rate in Wales had increased by 4 percentage points over the past 5 years, although it remained below the UK average. The Welsh Government reported that stronger productivity and exceptionally low inflation had combined to produce the strongest growth in real earnings in almost a decade. Real wages had fallen in 4 of the past 5 years in Wales, and all of the past 5 years in the UK. However, the Welsh Government advised more up to date data for 2015, from the Monthly Wages and Salary Survey (small sample size, UK data only), had shown that a combination of modest nominal wage increases and very low/no inflation had resulted in steady real wage increases.
- 2.22 The **Northern Ireland Executive** reported that there were encouraging signs the Northern Ireland economy was continuing to improve following the downturn, but growth had not been consistently positive over the past year and still lagged behind that of the UK. It said total private sector business activity in Northern Ireland had broadly stabilised and after a slow start to 2015, the general trajectory had been one of improvement. The Northern Ireland Executive said there was, however, a need for caution due to the global economic slowdown which appeared to be gathering momentum. This was alongside public expenditure challenges in Northern Ireland, which were set to intensify.
- 2.23 The Northern Ireland Executive reported that the Northern Ireland labour market was improving, with private sector business activity improving and unemployment falling. However, the local unemployment rate for the period Jun-Aug 2015 (6 per cent) was the joint fifth highest of the UK regions and above the UK average rate of 5.4 per cent. It said, whilst it had seen its largest annual percentage claimant count unemployment decrease since April 2000 (a 21.6 per cent fall over the year to September 2015), it still had the highest rate among the UK regions. The Northern Ireland Executive said the level of long-term unemployment and incapacity claims are significant obstacles to maximising the pool of actively available labour.
- 2.24 The Northern Ireland Executive explained that public sector earnings in Northern Ireland outstrip those of the private sector, but this was due to the relatively lower private sector earnings. It said overall private sector earnings in Northern Ireland had consistently

been the lowest of the UK regions. The Northern Ireland Executive reported the headline public-private sector earnings differential was 23.3 per cent in Northern Ireland compared to 4.9 per cent for the UK as a whole.

- 2.25 The **Joint Staff Side** told us since April 2010, a growing gap had opened up between private and public sector settlements. It said whilst the public sector had experienced a pay freeze followed by a 1 per cent pay cap, average private sector settlements had frequently been running at 2.5 per cent. The Joint Staff Side explained private sector rates are predicted to return to rates double that of the public sector over the coming year, with private sector employers expecting settlements of 2 per cent over 2015⁵ while public sector rates are forecast at 1 per cent to March 2016 and voluntary sector rates are forecast to average 1.4 per cent.⁶ This position was also supported in individual trade union submissions.
- 2.26 Joint Staff Side told us average earnings were now growing at the fastest rate since February 2009 and due to near-zero inflation, real terms pay rises were at their highest level since November 2007. It said competition for workers is growing, with the number of openings per jobseeker almost back at pre-recession levels. The Joint Staff Side believed upward pressure on pay, through strong demand and a tight labour market, and a return to positive inflation would erode the buying power of NHS wages and risk recruitment and retention.
- 2.27 The **Royal College of Nursing** asked us to recognise that the impact of inflation had damaged the living standards of NHS nursing staff and that the continued stagnation of wages risked damaging future recruitment and retention. It said the overall 1 per cent cap was insufficient reward, following successive years of below inflation rises, would further damage the value of NHS pay, and harm recruitment and retention.
- 2.28 The **Royal College of Midwives** said five years of below inflation awards had seen the value of NHS pay reduce significantly in real terms and a 1 per cent uplift for the next four years will only further damage the value of NHS pay. It said the 1 per cent was falling substantially behind awards in the private sector and wider economy and was significantly less than RPI inflation. The Royal College of Midwives said it was concerned about the effects that consistently keeping pay below inflation will have on the workforce, the service and the wider economy. The Royal College of Midwives told us it had substantial concerns about the impact of nine years of pay restraint and believed that the prolonged period of pay restraint would see midwives lose, on average, around £5,000 from the value of their pay. It believed this to be a retrograde step to the time when NHS careers, particularly female dominated professions such as midwifery, were poorly paid and poorly valued and would damage the attractiveness of midwifery as a career.
- 2.29 **UNISON** told us Agenda for Change salaries had lost between 12 per cent and 18 per cent of their value since 2010, a position also set out in the Joint Staff Side evidence.

Earnings of our Remit Group

- 2.30 In this section we look at the mean and relative earnings of our remit group.
- 2.31 Figure 2.6 shows the mean basic salary⁷ per person and total earnings⁸ by staff group for each of the years 2013 through to 2015.

⁵ Pay forecasts for the private sector, February 2015, XpertHR

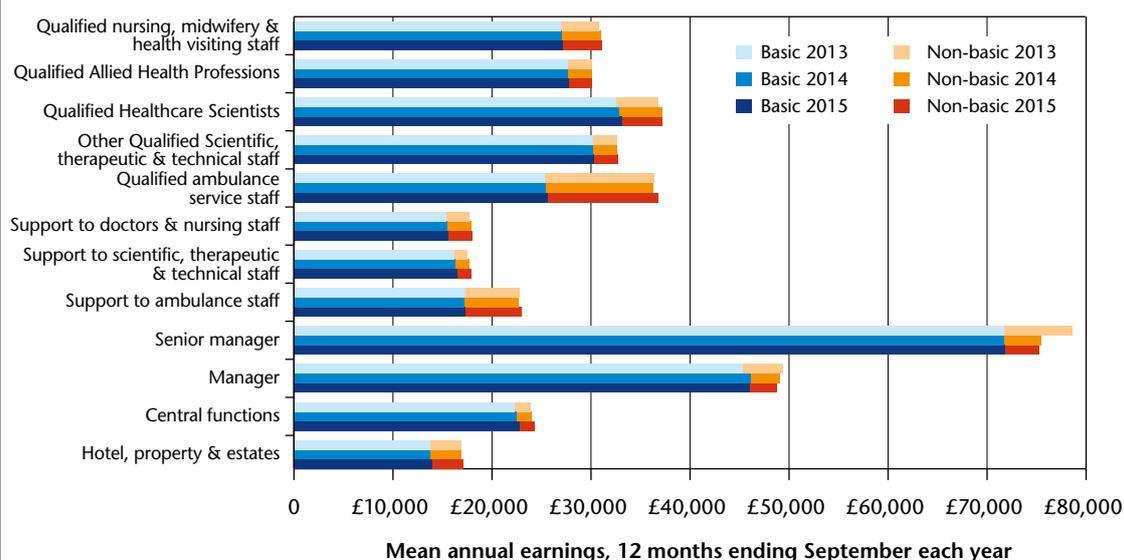
⁶ CIPD, *Labour Market Outlook*, Spring 2015, more information is available from: www.cipd.co.uk/hr-resources/survey-reports/labour-market-outlook-spring-2015.aspx

⁷ Basic salary is an individual's Agenda for Change spine point.

⁸ 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.

- Senior managers had the highest basic salary and total earnings, which in 2015 were at around £71,817 and £75,236 respectively. Whilst their basic earnings have stayed more or less constant, non-basic earnings have roughly halved since 2013. Average total earnings for senior managers have fallen over the last two years (by -4.0% and -0.3%).
- Managers on average have also seen a fall in total earnings of -0.7%, due to lower basic and non-basic pay.
- Following management grades, the next highest earning group were qualified healthcare scientists with average total earnings at around £37,170, closely followed by qualified ambulance staff (£36,844). In each year, qualified ambulance staff are reliant on non-basic pay to boost their basic pay (which is on average lower than that of nurses and midwives). This non-basic pay is mainly made up of significant overtime and shift working payments.
- Support to doctors and nursing staff and support to scientific, therapeutic and technical staff are among the lowest paid but have seen increases in each of the last two years and now have average total earnings of around £18,000.
- In general, increases to basic pay have been somewhat offset by decreases to non-basic pay, with the exception of ambulance staff and support to ambulance staff who have seen an increase in non-basic pay.

Figure 2.6: Mean basic salary and mean non-basic salary per person by main staff groups,¹ 2013 to 2015, England



Source: Health and Social Care Information Centre.

¹ In all staff groups there may be some staff who are not on Agenda for Change terms and conditions.

2.32 The falls in average senior manager and manager pay in particular may be partly due to the incremental progression freeze for Bands 8 and 9 in England. This could mean that despite each individual's pay remaining stable (or increasing) the average could fall due to compositional changes, for example if people at the top of the band retire or are promoted, whilst new recruits and promotees join near the bottom of the bands.

2.33 The *Annual Survey of Hours and Earnings* (ASHE) has been used to compare earnings for the human health and social work activities sector⁹ with employees in the public and private sector as well as to certain broad occupational groups.¹⁰ These sector and group earnings (median gross weekly pay)¹¹ are shown in Table 2.2 below. Between April 2014 and 2015, median gross weekly pay for full-time employees in the human health and social work activities sector increased by 0.6 per cent, lower (in percentage terms) than all the regular comparator groups in the table.

Table 2.2: Change in median gross weekly pay for full-time employees at adult rates, 2013 to 2015, April each year, United Kingdom

United Kingdom	Median gross weekly pay (change on previous year)		
	2013	2014	2015
Human health and social work activities sector	£497 (1.3%)	£494 (-0.6%)	£497 (0.6%)
All employees	£517 (2.2%)	£518 (0.2%)	£528 (1.8%)
Public sector	£573 (1.5%)	£579 (1.0%)	£589 (1.8%)
Private sector	£490 (2.2%)	£493 (0.7%)	£501 (1.6%)
Professional occupations [1]	£703 (1.1%)	£711 (1.1%)	£717 (0.8%)
Associate professional and technical occupation [2]	£582 (1.2%)	£584 (0.3%)	£594 (1.6%)
Administrative & secretarial occupations	£400 (1.7%)	£407 (1.8%)	£416 (2.3%)
Skilled trades occupation	£476 (2.1%)	£480 (0.9%)	£490 (2.0%)
Caring, leisure and other service occupations [3]	£337 (1.2%)	£335 (-0.6%)	£341 (1.9%)
<p>[1] Includes, for example, teachers, solicitors, accountants, doctors and some AHPs and ST&Ts. Nurses and midwives are in this group</p> <p>[2] Includes, for example, police officers and some AHPs and ST&Ts. Nurses and midwives were in this group until April 2010.</p> <p>[3] This group was until 2010 named "Personal Services Occupations". In 2011 it was known as "Personal Service"</p>			

Source: Office for National Statistics (*Annual Survey of Hours and Earnings*)

2.34 Figure 2.7 uses data from ASHE to show how the full-time earnings in 2015 of the public and private sectors compare with the human health and social work activity sector. The earnings distribution in the human health and social work activities sector compares quite well to the all employee distribution, but the levels of pay at each percentile are a little

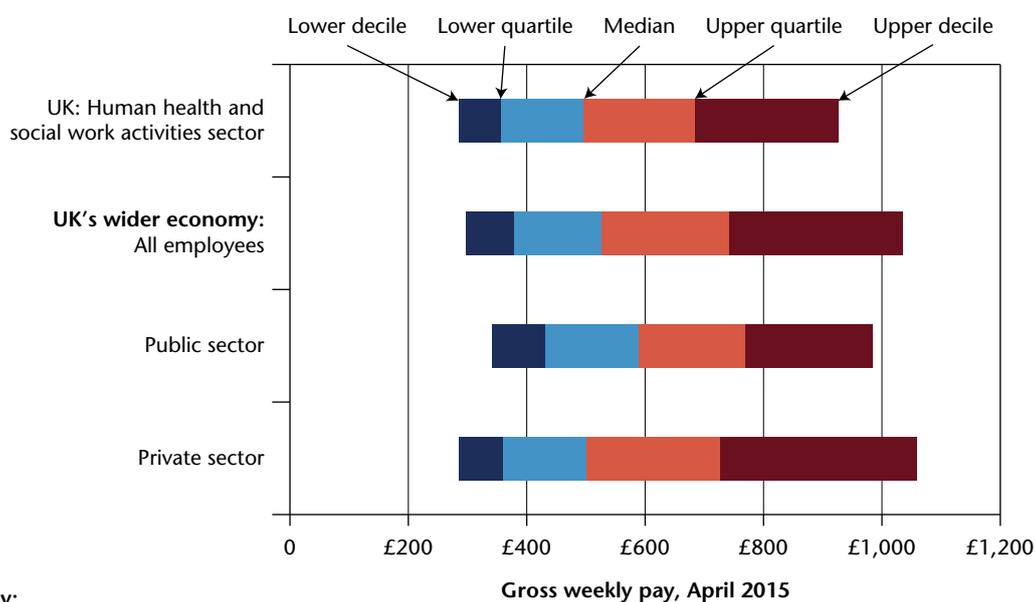
⁹ This section includes the provision of health and social work activities. It covers a wide range of activities, from health care provided by trained medical professionals in hospitals and other facilities, to residential care activities that still involve a degree of health care activities and to social work activities not involving the services of health care professionals.

¹⁰ ASHE is used as the source for comparison as it is a robust survey and can also be analysed by occupations, industrial classifications and by country. Although, as noted in the *Market-Facing Pay* report, such comparisons are hard to draw definitively, because of the differing compositions of the respective workforces, and in practice changes in pay are driven by a host of factors.

¹¹ Gross weekly (as at April 2015), rather than annual (the year to March 2015) pay is used, as it represents a more up-to-date indicator.

lower compared to all employees. This year the human health and social work activities sector earnings distribution was lower than both the private and public sector at the percentiles shown, as wage growth has started to pick up in the wider economy.

Figure 2.7: Estimated earnings distributions for full-time employees, April 2015, United Kingdom



Key:

Lower decile: 10% earn less than this amount

Lower quartile: 25% earn less

Median: Half earn more, half earn less

Upper quartile: 25% earn more

Upper decile: 10% earn more

Source: Office for National Statistics (Annual Survey of Hours and Earnings)

Membership of the NHS Pension Scheme

2.35 The NHS pension scheme remains an important part of the overall reward package. In this section we look at forthcoming changes to the state pension that will impact on employers and employees in our remit group and membership of the NHS pension scheme.

Changes to the state pension

2.36 On 6 April 2016 the current basic state pension and state second pension will be abolished and replaced by a single-tier state pension. The abolition of the state second pension will also mean the end of contracting-out.¹²

2.37 Currently contracted-out schemes must provide a certain level of Defined Benefit (DB) benefits, and in return both employer and employees pay lower National Insurance Contributions. The abolition of contracting-out will therefore have cost implications for both employers and employees because of the loss of these rebates. As a result, employers' Class 1 National Insurance Contributions will increase by 3.4 per cent (of relevant earnings), to the standard rate of 13.8 per cent, and employees' Class 1 National Insurance Contributions will increase by 1.4 per cent (of relevant earnings). The relevant earnings for this purpose are employees' earnings between the Primary

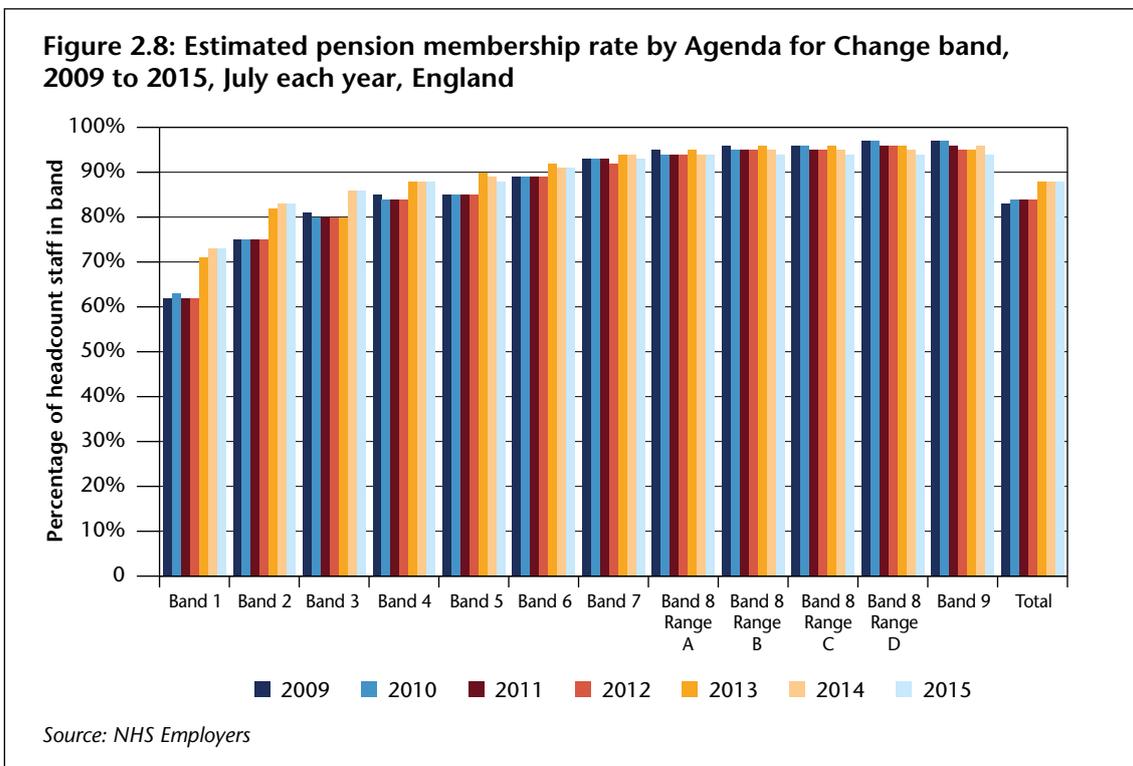
¹²The measures to implement the single-tier state pension and abolition of contracting-out are contained in the Pensions Act 2014.

Threshold (£155 a week in 2015/16) and the Upper Accrual Point (£770 a week) i.e. an additional cost of up to £1,090 a year for employers (for each employee) and reduced take home pay of up to £449 a year for employees.

- 2.38 Recognising the increased costs this would otherwise entail for employers, the Government intends to allow employers to amend contracted-out schemes to increase employees' contributions and/or reduce future accrual rates in order to offset the increase in their National Insurance Contributions. A statutory power, to allow employers to amend schemes to achieve this, was therefore included in the Pensions Act 2014. This power does not, however, apply to public service pension schemes.

Scheme membership

- 2.39 Figure 2.8 shows the estimated pension membership rate by Agenda for Change band from 2009 to 2015 for Agenda for Change staff in England. Despite increases in contribution and the introduction of a new scheme, membership numbers appear to have remained consistent and are high.



- 2.40 Table 2.3 shows the percentage of Agenda for Change staff paying into a pension by Band in England, Wales and Scotland. Membership rates are high across the Bands with Bands 4 and above showing membership rates of over 90 per cent in Wales and Scotland. The lower Bands have lower membership rates (notably at Band 1) but membership remains high. Take-up rates in Wales and Scotland are generally slightly higher than the equivalent in England and follow a similar band-by-band pattern. The Northern Ireland Executive were unable to provide data on pension membership.

Table 2.3: Percentage of contracted NHS staff paying into a pension

Agenda for Change Pay Band	Percentage Paying into a Pension		
	England	Wales	Scotland
Band 1	75%	72%	74%
Band 2	84%	86%	82%
Band 3	87%	89%	87%
Band 4	88%	91%	91%
Band 5	88%	92%	92%
Band 6	92%	94%	94%
Band 7	94%	96%	96%
Band 8a	94%	96%	97%
Band 8b	95%	96%	97%
Band 8c	95%	99%	97%
Band 8d	95%	98%	
Band 9	95%	96%	

Sources: NHS Employers July 2015, ESR Payroll November 2015 (Wales), Scottish Government December 2015

Evidence from the parties

- 2.41 The **Department of Health** emphasised that the new NHS Pension Scheme 2015 continued to provide a generous pension for NHS staff and remained one of the best schemes available. It explained the employer continued to pay more towards the cost of the scheme than the workforce, contributing 14.3 per cent of pensionable pay, and employee contributions were tiered according to income, with the rate paid by the lowest earners kept low in order to encourage and maintain participation in the scheme. It said, even with the increases in employee contribution rates, implemented across three years from 2012/13, the NHS Pension Scheme remained an excellent investment for retirement. The Government Actuary's Department had calculated that members can generally expect to receive around £3 to £6 in pension benefits value for every £1 contributed.
- 2.42 The Department of Health confirmed it had continued to review opt-out data from the scheme administrators to evaluate the impact of the first, second and third year of increases applied from 1 April 2012 and the evidence showed there had been no significant change, with staff continuing to value membership of the scheme.
- 2.43 The Department of Health reported there had been (since September 2012) an on-going tripartite review involving the Department of Health, NHS Employers and the NHS trade unions to address the impact of working longer¹³ in the NHS, with particular reference to staff working on the frontline and those with physically demanding roles, including the emergency services. The review had been undertaken by the Working Longer Group (WLG), which delivered its initial report to the Department of Health in March 2014. The Department of Health explained the WLG was now monitoring progress in delivering

¹³As a result of aligning the retirement age with the state pension age.

the recommendations in its report, which were accepted by DH Ministers. It told us the WLG's recommendations were aimed at enabling staff to continue working to state pension age and beyond if they wished.

- 2.44 The Department of Health stressed that pay was not the only part of the NHS employment offer. It said in a demanding health care environment, it was vital trusts focus hard on their staff engagement strategies and that they more effectively use the entire employment offer by taking a Total Reward (TR) approach which included presenting both pay and non-pay benefits. The Department of Health believed this could help employers recruit and retain the skilled and compassionate workforce they need. The Department of Health confirmed it was working with NHS Employers to build the business case and strategy for implementing TR across the NHS over the next few years. The aim was to build on the success of rolling out Total Reward Statements (TRS) to NHS staff whose employers use the Electronic Staff Record (other NHS staff receive Annual Benefits Statements). It told us TRS help clarify for staff their pay, pension and other financial allowances as well as locally available reward offers such as health and wellbeing programmes, learning and development, flexible working opportunities, childcare vouchers, cycle to work schemes etc.
- 2.45 **NHS Employers** told us the overall reward package in the NHS remained highly competitive and that NHS staff receive a broad range of valuable employment benefits, in addition to pay, including a generous pension scheme. They said it was more important than ever, during a period of pay restraint, to ensure staff are fully aware of and understand the benefits available to them through working for an NHS organisation. NHS Employers explained total reward statements were one of the tools available to help reinforce the value of the range of benefits employees receive and the introduction of these had begun to raise awareness of the value and range of benefits available through the NHS as an employer.
- 2.46 NHS Employers said changes to pension taxation and the new state pension could have implications for members and may lead to behavioural decisions to opt out of the scheme. They explained the introduction of the new state pension would mean the end of contracting-out and end the reduction in NI that contracted-out employers and employees pay. This will mean that employers will no longer receive the 3.4 per cent NI rebate and will pay the standard rate of 13.8 per cent of all earnings above the secondary threshold for all employees. NHS Employers were clear that this had significant financial implications for employers. NHS Employers told us the 1.4 per cent NI rebate for employees will also end and that this, coupled with increasing contribution rates and pay restraint, may lead to lower paid staff considering whether they could afford to continue to contribute to the NHS Pension Scheme.
- 2.47 The **Scottish Government** said the NHS Pension Scheme in Scotland continued to be an integral part of the remuneration package and was considered an invaluable recruitment and retention tool. It said pension benefits and employee contributions in the Scottish NHS Pension Scheme were tightly constrained by a mixture of UK Government financial and legislative controls and that benefits mirror that of the scheme in England and Wales. The Scottish Government explained the new career average scheme, introduced in 2015, provided a 'cost cap' mechanism to protect against significant increases in costs. For example, where, at valuation, scheme costs have increased by 2 per cent or more then the 'cost cap' mechanism will kick in and the increased cost will be met either via higher employee contributions or a reduction in build-up of future scheme benefits. The Scottish Government reported that scheme membership remained broadly consistent, but that future changes (for example increases to National Insurance contributions from 2016) may have an impact on membership and opt out rates.

- 2.48 The Scottish Government informed us the Working Longer Review had reported in March 2014 and identified further data needs and other strands of work required to best support staff as they work longer in the future. The Scottish Government said it, NHSScotland employers and the Scottish staff side all play a full role on the UK Staff Council-sponsored Working Longer Group and have also recently inaugurated their own Working Longer body as a sub-group of the Scottish Terms and Conditions Committee (STAC). The sub-group was being conducted on a tripartite basis and aims to consider what is produced by the UK group and other sources from a Scottish perspective and issue specific advice and support to NHSScotland health boards.
- 2.49 The **Welsh Government** explained that pension information was not collected as a matter of routine or held centrally by Welsh Government. It did, however, share pension information that had been gathered for other purposes (shown in Table 2.3), and this demonstrated a high percentage of membership across the Agenda for Change bands.
- 2.50 The **Northern Ireland Executive** told us the Public Service Pensions Act (Northern Ireland) 2014 had provided for the establishment of new pension schemes across the public sector with effect from 1 April 2015. It said the Act set out a requirement for a biennial review of how the provisions of the Act affect public sector pension scheme members and for a report on this to be laid before the Assembly. The Northern Ireland Executive explained a sub group, comprising representatives of all the public service pension schemes, had been set up and the first review was expected to commence formally in April 2016, with a report expected to be laid by the end of October 2016.
- 2.51 The **Joint Staff Side** told us NHS staff face additional costs due to pension employee contribution increases, rises in professional fees and National Insurance contributions. It said from April 2016 defined benefit occupational pension schemes will see an end to 'contracting out' from the state second pension. Joint Staff Side explained the impact of the removal of tax relief will effectively mean a reduction in earnings for staff as they will have to pay additional National Insurance Contributions.
- 2.52 The **Royal College of Nursing** reported anecdotal evidence from participants at its focus groups where staff had said nursing staff preferred to take early retirement rather than risk any future, detrimental change to their pension.
- 2.53 The **Royal College of Midwives** told us midwives and maternity support workers had seen increases in reductions from their pay as a result of rising pension contributions (the majority seeing increases of 6.5 per cent to 9.3 per cent from 2012 to 2015) and increases to their Nursing and Midwifery Council (NMC) registration fees (of around 30 per cent). It said midwives who are members of the NHS pension scheme would see additional increases to their national insurance contributions in 2016 (of around 1.4 per cent) as a result of changes to the second state pension.
- 2.54 **UNISON** said rising pension and National Insurance contributions meant real financial hardship and the strain of this was damaging staff health and well-being.
- 2.55 **Unite** said there was growing discontent among staff in higher grades over pay freezes and the recent freeze on increments. Unite explained these groups had also been hit by increases in pension contributions and professional registration fees. It said this was a highly skilled and specialised group of staff and even small shortages here could lead to serious concerns in some areas of the NHS.
- 2.56 The **Chartered Society of Physiotherapists** fed back some anecdotal evidence from staff focus groups and case studies where staff had stated that recent changes to the NHS pension scheme and raising of the staff retirement age had meant this acted as less of an incentive to work in the NHS.

Our comment

- 2.57 Economic growth has continued steadily across the UK but by less than forecast, and with continued risks from the global economy. Employment growth continues to be strong and there are signs of a gradual tightening in the labour market. However, these changes have not yet had any general knock on effects on pay levels, where growth, although picking up, has remained subdued. It is likely that continued labour market slack, notably the high levels of part-time and temporary workers together with subdued rates of inflation are keeping wages low but this could change as the economy moves closer to full employment and wages could start to be driven up.
- 2.58 At the current time private sector and public sector earnings are not markedly divergent. Nevertheless private sector settlements are rising at a faster rate to those in the public sector. Whilst the UK government states that overall levels of reward are on aggregate higher in the public sector, that gap has been slowly closing and should be considered in the context of trends over time and the cyclical nature of public sector pay. If current trends continue then the relative picture will worsen.
- 2.59 Agenda for Change pay rates remain competitive and in general the recruitment and retention position is healthy. However, as we set out in Chapter 4, there are supply problems for some staff groups notably nurses and paramedics, attrition rates are on the increase and, whilst engagement levels remain stable, there is undoubtedly underlying pressure on staff motivation. It is too simplistic to put all these changes down to pay, but the cumulative impacts of below inflation pay rises, increases in NI and pension contributions may well have had some influence. It is therefore important to keep a close watch on attrition as general pay picks up – this includes senior management within Agenda for Change where the effect on average earnings has been particularly acute over the last two years.
- 2.60 The overall employment proposition and total reward offer are key considerations not just for the continued retention of those already in our remit group but also for attracting people to a career in the NHS in the future. Comparative pay levels and a flexible total reward offer will be an important factor for young people when considering their future career options and for attracting qualified staff to return to work, for example after a career break. The NHS must ensure that it can continue to offer a package that will attract the staff of the future both in sufficient numbers and of the right calibre. If the earnings gap widens the NHS offer will become less attractive and employers may find it increasingly difficult to recruit and retain in certain posts, for example, at the middle and higher ends of the Agenda for Change pay scales and for specialist and managerial posts where the private sector may be relatively more attractive. Whilst the impact of the National Living Wage (for the over 25s) is not likely to be significant this year, it will have a longer term impact in the NHS as rates at the lower end become comparable and provide staff with other potentially less stressful employment options. Other elements of the employment package may become increasingly important to retain staff, but only if they are elements that staff value – there needs to be more rigorous research here.
- 2.61 The longer term public sector pay policy has been set out by the UK government for the next four years and provides the context for our recommendations in England. The policy position for Scotland, Wales and Northern Ireland is short term for this year's remit, given that these countries all have elections in May 2016. Their pay policy decisions going forward will be a matter for the incoming governments but will nevertheless be influenced by the funding position set out by the UK government. With public finances remaining constrained, it seems highly likely that public sector pay restraint will continue for some years. Within the ongoing context of public sector pay restraint, it is our view that we will have an increasingly important role to monitor the sustainability of this policy for our remit group, in whole or in part. Agenda for Change pay scales need to be seen as competitive, to attract and retain the calibre of staff required to support and

deliver high quality patient care. We will be monitoring recruitment, retention and staff engagement indicators carefully in order to notify the governments if and when we believe a different approach may be necessary.

- 2.62 At the current time we believe the economic picture, with low inflation rates and subdued pay growth, means there is less immediate pressure on pay levels within our remit group, taken as a whole, in the short term.

Observation 1

We will be monitoring recruitment, retention and staff engagement indicators carefully to consider (1) the sustainability of continued pay restraint for our remit group, in whole or in part; and (2) any areas or specialisms where the NHS may not be providing a competitive reward offer to attract and retain staff of the required calibre to support and deliver high quality patient care. We have a responsibility to alert the governments if and when we believe action is necessary.

- 2.63 As the NHS pension scheme is unfunded and underwritten by HMT, continued membership of the scheme is vital for its financial viability. It remains a valuable part of the NHS total reward package and part of the tools available to trusts and health boards to recruit and retain staff and to help incentivise agency and bank workers into permanent posts. The forthcoming increases in NI contributions will have an impact on both staff and employers alike. For employers the impact will be the increase on the pay bill and further pressures on already stretched budgets. We return to affordability pressures in more detail in Chapter 3 of this report. For staff there will be a rise in their NI contributions, which coupled with recent increases in pension contributions, will see a further reduction in overall take home pay. The combined impact of these increases with recent rises in pension contributions could see lower paid staff begin to question the affordability of their ongoing membership of the scheme. They may opt for higher take home pay now rather than the deferred benefit of the NHS pension. This scenario has not played out so far but we will continue to monitor membership levels to see how staff respond to changes. Total reward is wider than just pensions and there is merit in employers developing a wider more flexible package to support the recruitment and retention of staff and the delivery of quality patient care. We therefore ask all parties to include evidence on total reward (pay and non-pay), including pension scheme membership, in their future evidence submissions.

Observation 2

We ask the parties to continue to include evidence in their future submissions on the total reward offer, including NHS pension scheme membership.

Chapter 3 – Affordability

Introduction

3.1 In this chapter we review the evidence presented by the four health departments and employers' organisations on their specific financial considerations (including pay bill costs) and affordability of a pay award, as well as the views of the Joint Staff Side and individual unions on NHS finances. This remains a key consideration within our terms of reference.

Employed Staff Pay Bill

3.2 Pay bill costs for employed staff (as opposed to agency) are presented differently by each of the UK countries and data has not been provided by all parties. The information provided is set out below but given the different methodologies used it is difficult to make detailed comparisons.

3.3 Table 3.1 provides the pay bill data presented by the **Department of Health** for England from 2010/11 to 2014/15. This provides details of the breakdown of factors that drive changes in the pay bill as well as an estimate of their effect on the pay bill.

- Although staff became cheaper on a per full time equivalent (FTE) basis (see bullets below) there was an increase in the number of FTE employed staff (2.0 per cent). The combination of these two effects led to an overall increase of 1.9 per cent to the aggregate pay bill (see last line). We comment on this further at paragraph 3.35.
- In 2014/15 pay bill per FTE "drift" (i.e. the change in the pay bill resulting from changes in staff mix, incremental progression and changes in employment costs, *before* any separate basic pay settlement is taken into account) for non-medical staff fell for the second year in a row, a 0.8 per cent decrease in the earlier year with a further 0.6 per cent decrease in the latest year (see line 1).
- The effect of the separate pay settlement for 2014/15 was an increase to the pay bill of 0.4 per cent (see line 2).
- Together the "drift" estimate and basic pay settlement led to pay bill per FTE growth of -0.1 per cent. This means the pay bill per FTE decreased from the previous year, and that the workforce was on average cheaper in 2014/15 (on a per FTE basis) than in the previous year (down from 0.2 per cent in 2013/14) (see line 3). Of course the exact position will vary from trust to trust.

Table 3.1: Change in costs of Hospital and Community Health Services non-medical staff pay bill, 2010/11 to 2014/15, England

	2010/11	2011/12	2012/13	2013/14	2014/15
1 Pay bill per FTE Drift	0.7%	0.9%	0.6%	-0.8%	-0.6%
<i>of which:</i>					
<i>Basic pay per FTE drift</i>	1.1%	0.8%	0.5%	-0.5%	-0.3%
<i>Additional earnings per FTE drift impact</i>	-0.5%	0.0%	0.1%	-0.5%	-0.1%
<i>Total on-costs per FTE drift impact</i>	0.1%	0.1%	-0.1%	0.2%	-0.2%
2 Basic pay settlement (pay uplift)	2.2%	0.3%	0.3%	1.0%	0.4%
3 Pay bill per FTE growth (1 + 2)	3.0%	1.3%	0.9%	0.2%	-0.1%
4 Average FTE growth (volume of staff)	0.8%	-1.9%	-0.4%	0.6%	2.0%
Aggregate pay bill growth (sum of 1+2+4)	3.8%	-0.7%	0.4%	0.8%	1.9%

Source: Department of Health's Headline Hospital and Community Health Services pay bill metrics (experimental).

Notes:

All totals are derived from unrounded figures. Data excludes the cost of agency staff, recruitment costs and training costs.

Basic Pay per FTE Drift is the growth in Basic Pay per FTE excluding the impact of the Pay Settlement. This captures the effects of pay progression & increment mix, pay band mix and staff group mix.

Additional Earnings per FTE Drift Impact is the effect of disproportionate growth in Additional Earnings per FTE, beyond the effects of the Pay Settlement and Basic Pay per FTE drift.

Employer On-Cost per FTE Drift Impact gives the combined effect of the National Insurance and Pensions Contribution per FTE Drift Impacts.

Basic Pay Settlement reflects the headline uplift applied to pay scales. If uplifts differ between staff groups, it reflects a weighted average.

Pay Bill per FTE Growth is the growth in Pay Bill per FTE after allowing for the impact of the Pay Settlement. This includes the effects of changes in workforce mix, additional earnings patterns and on-cost patterns.

Average FTE Growth compares the average numbers of FTEs over the period, with the average number of FTEs over the equivalent period the previous year.

3.4 Table 3.2 provides the data on agency spend provided by the **Department of Health** for England for 2014/15. More evidence on the increase in agency usage is set out in Chapter 4 of this report.

Table 3.2: Spend on Agency Staff by NHS Trust and Foundation Trusts in Financial Year 2014/2015

	Temporary Agency Spend
Foundation Trusts	£1.8 million
NHS Trusts	£1.5 million
Total	£3.3 million

Source: Department of Health Evidence submission.

Notes:

In 2014/2015, the Department of Health collected audited financial data from NHS trusts for Agency/contract staffing. The data was collected on the NHS Summarisation Schedules and consolidated figures were published in the Department's Annual Report and Accounts.

The Department also collected a total Agency spend figure for the FT sector which was provided by Monitor as the Department does not hold information centrally at individual FT level.

In the guidance that accompanied the data collection, the definition of Contract / Agency staff is: "Agency" employee payments for the employment of staff where the staff remain employees of the agency and "Contract staff" where the NHS trust has control over numbers and qualifications of staff (in contrast to a service obtained under contract).

Excluded from the "Agency/Contract" category are the costs of staff recharged by another organisation where no element of overhead is included i.e. where the staff costs are shared between the NHS trust and other bodies; staff on secondment or on loan from other organisations; amounts payable to contractors in respect of the provision of services (for example, cleaning or security).

The definition of agency/contract includes bank staff where bank services are provided by a Managed Service Provider such as NHS Professionals. Where bank services are managed in-house, spending on temporary bank staff is not counted as agency spend.

Where an NHS trust obtains FT status part way through any year, the data provided is only for the part of the year the organisation operated as an NHS trust.

The Department does not collect data in relation to the number of agency shifts or by category of staff.

While we don't collect or hold data centrally on the spend on different staff types, evidence from the Prime Minister's Implementation Unit suggests that approximately a third of agency spend is attributed to medical locums.

- 3.5 The **Scottish Government** provided us with information on the modelled cost of pay progression for 2014/15 and 2015/16 which is shown in table 3.3. This shows an estimate of gross (no turnover and promotions) pay bill growth of 2.3 per cent, and net (including turnover and promotions) pay bill decline of 0.4 per cent. The Scottish Government estimates do not include assumptions for pay uplifts or workforce growth in 2015/16.

Table 3.3: Agenda for Change (AfC) Modelled Cost of Progression (2016/17), Scotland

2015/16 Estimated Total Cost ²	2016/17 Estimated Total Cost ¹	2016/17 Estimated Total Cost ¹ (excluding growth)		Estimated Cost of Progression ⁵	
			£m	£m	%
4,548.4	4,550.5	Gross ³	4,651.4	103.0	2.3%
		Net ⁴	4,531.8	-16.5	-0.4%

Sources: *Scottish Workforce Information Standard System (SWISS); AfC Cost Model (2014-15 onwards)*

Figures presented in the table are projections calculated from modelling; the further forward projections are made, the less accurate the figures are likely to be.

Reference: SG2014-00532

1. Assumes no pay uplift.

2. Figures presented in the table assume that the workforce grows during 2015/16 in line with the projections supplied by NHS Boards in August 2015.

3. The cost of staff who are entitled to an incremental progression payment (i.e. those staff members who are not currently on the top pay point of their band) moving up a pay point in their band. The calculation assumes that there is no growth in the workforce, and does not account for staff turnover or promotion. NB progression is sometimes referred to as 'Drift'.

4. The cost of staff who are entitled to an incremental progression payment (i.e. those staff members who are not currently on the top pay point of their band) moving up a pay point in their band. The calculation assumes that there is no growth in the workforce, and assumes a rate of staff turnover and promotion occurs. NB progression is sometimes referred to as 'Drift'.

5. Calculation of 2016/17 estimated total cost (excluding growth) minus 2015/16 estimated total cost.

6. Data excludes the cost of agency staff, recruitment costs and training costs.

- 3.6 The Scottish Government confirmed spend on Agency nursing staff had increased from £9.3 million in 2013/14 to £16.0 million in 2014/15 and accounted for 0.3 per cent of the total nursing and midwifery capacity. The Scottish Government advised that whilst this was up on previous years it remained significantly less than the levels seen a decade ago.
- 3.7 The **Welsh Government** was unable to provide us with similar data on pay drift costs but did include some information in their written evidence. The Welsh Government reported that the total pay bill had increased year on year for the past five years. This was partly attributed to the growth of the workforce but also because of national pay awards and incremental drift. It said recruitment restrictions implemented by a number of organisations in 2012/13 had reduced the natural increase in the total pay bill (pay bill increased 1.2 per cent) but this approach was not sustained. In the absence of major service reconfiguration, the pay bill had increased by 2.2 per cent in 2013/14 and 2.9 per cent in 2014/15. The second half of 2014/15 had seen a significant increase in the pay bill (£52 million, 3.37 per cent) and was attributed to the one-off payment of £187 made in January 2015 (£12.5 million); the introduction of the Living Wage from January 2015; and the increase in the cost of Agency staff in the second half of the year: an additional £18.5 million. The Welsh Government reported that the total budget for NHS Wales for 2014/15 was £6.9 billion, of which workforce costs accounted for 46 per cent (£3.16 billion). It said that within the workforce budget, variable pay accounted for 14 per cent and Agency and Locum pay accounted for 2.8 per cent.
- 3.8 The **Northern Ireland Executive** were unable to provide us with their pay bill information but did include evidence on Agency costs, where it reported a rise in spending since 2010/11 (set out in table 3.4). The Northern Ireland Executive told us £44 million was spent on agency staff in 2010/11 across the HSC Trusts, rising to £69 million in 2012/13 and £77 million in 2014/15. Year to date data for 2015/16 showed this rise looked likely to continue.

Table 3.4: Agency and Locum spend in Northern Ireland from 2010/11 to 2015/16

Agency Spend (includes locums)	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16 April to Sept
Medical & Dental	23,644,956	23,093,817	32,439,996	32,558,600	38,506,733	20,212,686
Nursing & Midwifery	6,916,885	8,641,658	9,852,129	11,116,340	12,094,055	7,293,325
Prof & Tech	1,217,178	2,388,060	4,940,249	3,978,227	3,039,152	1,264,785
Admin & Clerical	5,002,680	6,618,493	10,915,492	10,830,821	10,561,767	4,649,233
Support Services	2,033,150	2,882,374	4,725,091	5,273,308	6,312,881	3,558,086
Estates & Maintenance	0	0	10,084	601	19,945	0
Social Services	4,082,394	4,620,066	5,529,989	5,819,582	5,811,160	2,969,775
Ambulance	140,208	89,451	140,436	101,210	135,929	50,830
Other	0	22,429	124,726	0	26,988	291,380
Total	43,037,451	48,356,348	68,678,192	69,678,689	76,508,610	40,290,101

Source: Northern Ireland Executive evidence submission.

Affordability

3.9 In this section of our report we consider the evidence from the parties on their funding position and affordability context.

Evidence from the parties

3.10 The **Department of Health** were clear that funding to deliver health care and how the system achieved this to the right standard and in a safe and sustainable way were interdependent. It said the NHS must deliver against the key standards of patient care and it must also live within its means. The Department of Health explained this was reliant on constraining pay bill growth to help deliver quality services and protect front line staffing. It said the Department was supporting this by introducing a range of financial controls to help trusts make better use of their budgets. These ranged from reviewing and clamping down on unjustified high pay of very senior managers to helping the NHS bring down spiralling agency staff bills.

3.11 The Department of Health informed us the government had chosen to invest £120 billion a year by 2020/21 to protect the position of the NHS as a world class health system, and drive forward ambitious plans to integrate health and social care services by 2020. It said the Spending Review:

- provided the NHS in England with £10 billion per annum more in real terms between 2014/15 and 2020/21, with £6 billion a year available in the first year so that the *Five Year Forward View* was fully funded; this included enabling the delivery of services seven days a week;
- enabled universities to provide up to 10,000 additional nursing training places over the Parliament, by replacing direct funding with loans;
- gave local councils the power to increase social care funding through a new 2 per cent Council Tax precept;

- laid out a radical, local-led plan to create an integrated health and social care system by 2020, backed by an extra £1.5 billion in the Better Care Fund through local authorities; and
- confirmed the government would invest over £5 billion in health research and development over the next five years through the Department of Health.

- 3.12 The Department of Health explained that to live within this budget, the NHS would need to make at least £22 billion of efficiency savings (equivalent to 2 – 3 per cent efficiency per annum) and must eliminate provider deficits, currently estimated to be £2 billion. The Department of Health confirmed it was working with the health service, partners and patients to implement a number of measures to achieve efficiency savings and productivity improvements to enable the NHS to live within its resources. It said Lord Carter’s recent review into productivity and how hospitals buy goods and services had found the NHS could save up to £5 billion a year, by making better use of staff, medicines and deploying its vast buying power more effectively, so every penny possible can be spent on patient care.
- 3.13 The Department of Health told us it had met savings targets in 2011/12, 2012/13, and 2013/14. It said work was still needed to shift the focus from centrally driven savings to transformational change, to reduce the long term cost pressures on NHS services. The Department of Health told us that, despite NHS providers delivering an overall net deficit, financial balance against all spending controls was delivered in 2014/15 as a result of offsetting savings throughout the rest of the system. The Department of Health said, with the financial controls package and help from system leads, it expected to deliver financial balance against the overall spending controls again in 2015/16, and trusts were expected to balance their books in 2016/17. However, the Department recognised this remained challenging, given the increasing demand for health services as a consequence of the ageing and growing population, the cost of new drugs and treatments, and safer staffing requirements.
- 3.14 The Department of Health acknowledged that pay restraint was challenging for staff but was clear it needed to look seriously at the inbuilt cost of pay progression (£550 million a year gross for employed NHS non-medical staff), and develop more affordable, sustainable pay systems. The Department of Health told us pay was the largest cost pressure and had accounted for around 39 per cent of the increases in revenue expenditure since 2001/02. It said, as pay represented such a large proportion of NHS resources, managing the pay bill was key to ensuring the NHS lives within the funding growth it had been assigned in the next year. The Department of Health reported the increase in the workforce in 2013/14 and 2014/15 had meant the price element of the pay bill had been subdued in these years, since recruitment tended to be towards the lower end of the pay scales. It said previously-announced changes to the state pension would, however, represent a considerable financial pressure on the pay bill in 2016/17.
- 3.15 **NHS England** told us its budget for 2016/17 had not yet been set and was subject to the outcome of the Spending Review.¹ NHS England said it would continue to require very significant further financial savings and efficiency improvements over the next five years and that these would be similar in scale to those needed over the last five years. NHS England’s analysis² had identified funding pressures of around £30 billion by 2020/21 and stated that it was imperative that all providers in the service made savings and deliver efficiency gains each year. It told us the NHS needed to deliver productivity gains, savings and efficiencies of £22 billion by 2020/21. NHS England believed that the level of efficiency and productivity gains envisaged remained challenging but achievable.

¹ The Spending Review announcement on 25 November 2015 confirmed that the NHS will receive a real-terms funding increase of £10 billion over the period from 2014/15 to 2020/21 and that £6 billion of the funding would be front-loaded by 2016/17.

² Set out in the *Call to Action* and updated in the *Five Year Forward View*.

- 3.16 **NHS Employers** explained the NHS continued to face an unprecedented financial challenge. They said the last parliament had seen one of the toughest funding settlements for healthcare in England, with additional resources lagging behind additional demand. NHS Employers said the *Five Year Forward View* had set out the requirement for the NHS to deliver £22 billion in improved productivity to meet the total funding gap expected by 2020/21. This meant improved productivity of around 2.4 per cent each year, which was far above the long-run average of 1 per cent. NHS Employers reported that recent analysis had suggested a sharp fall in hospital productivity in recent years, bringing the average across the last parliament down to around 0.4 per cent a year. NHS Employers told us Lord Carter's initial findings, in his report on operational productivity in the NHS, had identified potential savings of up to £5 billion a year by 2020/21, and would represent around 23 per cent of the savings needed in total.
- 3.17 NHS Employers stated the latest analysis of trusts' performance between April 2015 and June 2015 reported a £445 million deficit (£90 million worse than planned), with 118 foundation trusts (78 per cent) ending the period in the red. Findings included that trusts had made £232 million worth of savings, some £64 million less than planned. NHS Employers explained the analysis covered the period before measures to limit agency spend were announced. NHS Employers reported the sharp deterioration in financial position demonstrated the challenge for NHS providers in sustaining cuts in tariff prices year-on-year. The last parliament had seen an efficiency factor of around 4 per cent applied each year which, taken together with other changes, had the combined effect of a 7 per cent cut in tariff prices across the last five years.
- 3.18 NHS Employers said, in its representation to the 2015 Spending Review, that the NHS Confederation had called for additional funding to be front-loaded so that at least half of the £8 billion is delivered by 2017/18. It was felt this, alongside an expanded transformation fund, could support the NHS to focus on targeted savings by investing in new models of care at pace. The NHS Confederation had also argued that a sustainable settlement for the NHS included addressing resources available for public health and social care.
- 3.19 NHS Employers said employers continued to be concerned about constraining pay costs within the tariff, particularly in light of the in-built incremental cost of the NHS pay system. They told us any pay uplift that was not fully funded through the tariff would create additional financial pressure for employers. In the responses to the NHS Employers survey regarding a pay award for 2016/17, employers broadly accepted the 1 per cent increase suggested by the public sector pay policy, and many were including this in their financial plans. NHS Employers said most employers had expressed concerns that increased pay costs would put even more pressure on the achievement of efficiency savings.
- 3.20 **NHS Providers** told us the affordability of any pay award was linked inseparably to the overall price adjustment set through the national tariff. Therefore if a 1 per cent pay award was fully funded through the national tariff, it was affordable for providers to implement. NHS Providers were clear that if an award was not fully funded through the tariff and contracts it would mean finding the money from other areas of the budget and would add to existing financial pressures and could lead to its members having to employ fewer staff. NHS Providers said the NHS provider sector (including both foundation trusts and NHS trusts) recorded an overall deficit of £822 million for 2014/15 and expert estimates suggested this figure may be around £2 billion for 2015/16.
- 3.21 The **Scottish Government** reported the scale of the real terms total reduction in its budget for the period 2010/11 to 2020/21 had required tough decisions to be taken about expenditure across government and careful consideration of pressures and priorities in all portfolios. It said the Health budget had received the full health resource Barnett consequential over the period, which would lift the resource cash budget by

£397 million to £12.4 billion in 2016/17. The Scottish Government confirmed that funding allocations to NHS Territorial Boards in 2016/17 would increase in real terms reflecting its commitment to protect frontline point of care services. The full extent of additional funding available to NHSScotland for 2016/17 would be confirmed when the budget bill was published in February 2016; however, the planning assumption was that Territorial NHS Boards would have 1.7 per cent additional cash funding in 2016/17 to meet pay and non-pay pressures and a small number of Boards would receive additional funding to support transition to full parity funding within the formula agreed by the NHSScotland Resource Allocation Committee.

- 3.22 The Scottish Government said the financial position in 2016/17 would be challenging and the first call on additional funding would be meeting anticipated cost pressures within NHSScotland including pay, pensions, supplies, drugs volumes etc. It said additional pressures arising from demographics, new drugs and technology would again require NHS Boards to deliver and retain efficiencies (the efficiency factor was confirmed as 3 per cent in oral evidence). The Scottish Government told us achieving these efficiency savings will be difficult for NHSScotland and will require service redesign issues to be closely considered.
- 3.23 The Scottish Government said the 2020 Vision provided the strategic narrative and context for taking forward the required actions to improve efficiency and achieve financial sustainability. The Scottish Government told us it was making progress towards its vision but there continued to be on-going challenges which meant it needed to make even greater strides and look to a longer timeframe beyond 2020, out to the next 10 to 15 years. In August 2015 the Cabinet Secretary for Health, Wellbeing and Sport had opened a national conversation on improving the health of the population and on the future of health and social care. The Scottish Government told us improved integration across Health and Social Care services was key to delivery of the 2020 Vision.
- 3.24 The **Welsh Government** reported the health service in Wales was, along with other public sector bodies, operating in a challenging economic climate. The Welsh Government budget had faced unprecedented cuts with successive reductions to the Welsh budget since 2010. By 2015/16 the Welsh budget was around 10 per cent lower in real terms than in 2010/11 (a reduction of more than £1.5bn in real terms). The Welsh Government said NHS Wales continued to face significant challenges: including rising costs, increased demand, an ageing population, a growth in the number of people experiencing chronic conditions and the impact of spending cuts on other public sector services and programmes, such as social services.
- 3.25 The Welsh Government said the independent report published by the Nuffield Trust in June 2014 had clearly identified the difficult financial challenges faced by NHS Wales and had concluded that, without taking action to manage demand on NHS services, the NHS in Wales would face a funding gap of around £1.2bn by 2016. The report said this could be reduced to £221m by maintaining pay restraint, productivity and efficiency measures. Despite the challenging times, the Welsh Government had allocated an additional £225m for health in 2015-16.
- 3.26 The Welsh Government reported that the UK Government Spending Review included a 4.5 per cent real terms cut to the Welsh Government's revenue budget over the next four years. It said, whilst the UK Government confirmed it will fund public sector workforces for a pay award of 1 per cent a year for four years from 2016/17, the affordability of any pay award had to be managed within the context of a reducing real-terms budget. The Welsh Government said it had published its draft budget for 2016/17 on 8 December 2015, which included an additional £260 million revenue funding for health in 2016/17. Of this, £30 million was targeted to increase the Intermediate Care Fund that enabled partnership working between local authorities and NHS organisations to prevent hospital admissions and facilitate early discharge, and £30 million for older people and

mental health services. The remaining £200 million was to enable the NHS to meet the challenges outlined in the Nuffield Trust report for 2016/17 but the Minister for Health and Social Services was yet to determine how this would be targeted in 2016/17 to deliver and transform NHS services.

- 3.27 The Welsh Government explained pay and pay costs were determined by a number of factors, not only pay awards but also incremental drift, changes in skill mix and roles, changes in establishment numbers and posts, pension contributions, living wage levels as well as variable pay rates and agency costs. It explained all of these factors would need to be recognised and assessed, with funding availability, to evaluate pay affordability.
- 3.28 The **Northern Ireland Executive** explained the Northern Ireland Budget 2015/16 set out allocations in current and capital spend to departments in an extremely constrained public expenditure environment. It confirmed efficiency and productivity improvements would continue to be essential to meet key targets within current resources. The Northern Ireland Executive explained that the high proportion of government expenditure accounted for by pay meant trends in public sector pay costs had significant implications for the availability of resources to support staff and deliver public services. It said public expenditure tightening had a particular impact in Northern Ireland because of its relatively large public sector workforce.
- 3.29 The Northern Ireland Executive told us the approach to financial planning in 2016/17 had been aimed at identifying all available opportunities and options that could be deployed in seeking to manage the challenging financial position, whilst also prioritising and securing delivery of reform and transformation. It explained that for 2016/17, in line with the approach adopted in 2015/16, it had sought to secure financial balance for existing services before the consideration of new service developments. The Northern Ireland Executive said existing services had also been reviewed to ensure they were efficient and effective and any savings captured in DHSSPS savings plans. The Northern Ireland Executive explained the options available to address the unmet need from within the DHSSPS budget were limited without negative impacts on levels of service provision and the needs and expectations of service users. It told us all discretionary areas and savings plans were being considered but any further budget reductions were likely to have significant implications. The Northern Ireland Executive were clear that all options for achieving savings would have to be considered, including the continued application of pay restraint.
- 3.30 The Northern Ireland Executive reported that on 4 November 2015 the Minister had outlined wide-ranging, ambitious and radical plans for transforming the health and social care system in Northern Ireland. This included the intention to remodel the administrative structures of the Health and Social Care system to make them more streamlined and reduce complexity. A consultation document - Health and Social Care reform and transformation: Getting the structures right - was published on 15 December 2015 and the consultation would run for eight weeks until 12 February 2016. The Northern Ireland Executive told us the Minister was clear that the proposals were about structures and not people. The principal focus was on getting the structures right rather than releasing efficiency savings, and there were not expected to be compulsory redundancies as a result of the proposed changes. The Northern Ireland Executive reported that, separately, the Minister had announced a panel to lead a debate on the best configuration of Health and Social Care services in Northern Ireland. It said this would be a clinically led debate with evidence for any proposed change to services, and evidence about the implications of failing to make changes.
- 3.31 The **Joint Staff Side** said the drive to improve productivity was of particular importance in the NHS, given the significant funding challenges combined with an increased demand for services. The Joint Staff Side told us it agreed productivity in the NHS needed to be improved but believed this could only be done by utilising the existing

workforce. It said relying on the goodwill of NHS staff was not the answer and key ways of improving productivity included: incentivising bank and overtime shifts (rather than relying on agency workers); improving sickness absence by implementing the findings of the Boorman report; implementing the Working Longer Group recommendations to help retain older staff; and investment in NHS staff through improving skills, training and development opportunities. The Joint Staff Side confirmed the Boorman report (published November 2009) had set out key recommendations to improve the health and wellbeing of the NHS workforce, including the cost savings that could be gained from this investment. The report found those organisations which prioritised staff health and wellbeing performed better, with improved patient satisfaction, stronger quality scores, better outcomes, higher levels of staff retention and lower rates of sickness absence. The report estimated that the NHS could reduce sickness absence rates by a third, providing an additional 33.4 million working days a year (equivalent to 14,900 WTE staff) and an estimated annual direct cost saving of £555 million.

- 3.32 The **Royal College of Midwives** said it was clear that the Government and NHS organisations were not investing in NHS staff and that this was negatively impacting on productivity. The Royal College of Midwives told us improving productivity was increasingly becoming a pivotal issue in the NHS because of the significant funding challenges facing the NHS, combined with an increased demand for services due to the increasing birth rate and complexity of cases. The Royal College of Midwives believed the best way of improving productivity was by utilising the existing workforce and supported the measures set out in the Joint Staff Side evidence (referenced above).
- 3.33 The **Chartered Society of Physiotherapists** believed physiotherapy was a key workforce solution to meeting the needs of an ageing population; the increasing number of patients with long-term conditions, co-morbidities and multi-factorial needs; and delivering more preventative care. The Chartered Society of Physiotherapists said there was strong evidence that investment in physiotherapy contributed to the cost effectiveness of the NHS and enhanced productivity.

Our comment

- 3.34 Affordability is a significant challenge across all four countries. Whilst there may be different decisions being made around spending and investment in pay, the problems each are trying to address are consistent. All countries have used pay restraint, albeit to differing degrees, to help manage costs, and given that staff are the biggest resource cost to the NHS, controlling pay bill costs is sensible. There is, however, a difference between recruitment-driven pay bill growth through increases in workforce numbers, and the effects of “pay drift” which result from changes in skill-mix, incremental progression and employment costs affecting the existing workforce. Workforce growth and “pay drift”, together with any pay uplifts upon which we recommend, come together to produce the overall increase in the pay bill. The year on year growth in the workforce across all UK countries means the NHS pay bill is continuing to grow in absolute terms. However, two other effects – restrained general pay uplifts and increasing numbers of new staff joining at the lower end of the pay range to replace those leaving or retiring who are at the top - are working to hold down the cost per FTE. Overall this indicates that the policy of pay restraint has been helpful in enabling total staff numbers to increase, although there may be some hidden costs.
- 3.35 There are a number of factors driving the growth of the pay bill, some in an upwards direction and some downwards. Given the extremely challenging efficiency targets, it is helpful for us to understand how all these factors are at work in each country. Whilst “pay drift” per FTE was negative in England in 2014/15, as shown in table 3.1 the pay settlement in 2015/16, and increase in workforce numbers, have produced overall growth in the aggregate pay bill. The different approaches to pay awards, and in

particular the implementation of the Living Wage (and additional targeting at the lower paid in Scotland), will have resulted in less of an impact on the aggregate pay bill in Scotland and Wales, but overall pay restraint will have still held back pay growth per FTE. Unfortunately, it is difficult for us to provide an accurate interpretation of the comparative position across the countries, since the data provided is not consistent in terms of breakdown of information or the time period covered. In more detail:

- The England data provides a detailed breakdown of the impact of workforce growth, pay uplift, and “pay drift”.
- The Scottish Government data provides information on pay progression costs (both net and gross), but does not separate out the effects of growth in workforce numbers and pay progression.
- The Welsh Government have been unable to provide a detailed breakdown but have reported overall percentage changes and cite a rising aggregate pay bill over the last five years. The Welsh Government information also includes several other factors within these costs (including agency expenditure) and does not provide separate data for the cost of incremental pay and the pay award.
- The Northern Ireland Executive were unable to provide detailed pay bill information but did provide a summary on trends on agency spend by staff group over the last few years.

3.36 Pay is the biggest element of costs within the NHS and we are surprised that analysis of its elements is not consistent. It would be beneficial if the health departments of all four countries could present data in a similar format and show the pay bill trends over time, in “pay drift” (including pay progression and changes in skill mix), pay uplift and changes in workforce numbers. We believe the Department of Health data is a good model as it covers all aspects consistently and demonstrates trends over time. The Northern Ireland Executive’s breakdown of agency spend by staff group is also very informative. We would like to see this data included in evidence submissions for future rounds.

Observation 3

We ask the health departments to improve and make consistent their evidence on pay bill trends over time in their future evidence submissions.

- 3.37 It is clear that trusts and health boards are finding it tough to live within their budgets. The health departments may be able to offset savings across the board and deliver overall balance across their health budgets, but the individual organisations are trying to balance competing requirements, and recent financial results are indicative of the strain they are under. Trusts and health boards are operating in increasingly challenging conditions. They are having to meet demanding efficiency and performance targets, whilst continuing to deliver good quality patient care, in the face of rising demand and a patient population with increasingly complex needs. The investment announced by each of the health departments will be welcome but much of this is in effect already committed to fund increases in employer NI contribution costs and to plug current deficits. It is unclear to us how much will be left to progress and invest in longer term reforms to improve patient outcomes, or to produce longer term savings, for example, through reducing staff turnover or remodelling jobs.
- 3.38 The Lord Carter review has made recommendations to support trusts in England in delivering efficiency savings, and there are other similar initiatives in Scotland and Wales. All parties highlighted to us the need for transformational change, developing new ways of working and investment in the workforce to deliver more flexible patient-centred models of care. This must be led by local managers, and staff involvement will be critical

to embedding successful change. The current pressures on the system are making progress in this area challenging as both managers and staff are struggling to find the capacity to deliver change whilst maintain existing service delivery.

3.39 Other independent commentators have commented on the current financial pressures in the system and the challenge of delivering efficiencies:

- The Nuffield Trust, the Health Foundation and the Kings Fund³ carried out a joint analysis in December 2015 on the reality of the spending review settlement and funding for the NHS and social care. This research highlighted how the NHS budget had been redefined (NHS England only), in practice reducing the £10 billion real terms increase to £4.5 billion and raised concerns about upfront investment being swallowed up by pension (NI) increases and balancing the existing deficit. The report also underlined the importance of the social care dimension and the difference in funding arrangements and queried how practical it would be to invest in service change and new care models to deliver further efficiencies in this context.
- In December 2015 the National Audit Office reported on the sustainability and financial performance of acute hospital trusts,⁴ highlighting the deteriorating financial position and difficulty in meeting efficiencies.
- In Scotland, Audit Scotland reported on the NHS performance in Scotland in 2015.⁵ This highlighted the difficulties health boards are having in meeting targets and breaking even. The report also outlined the lack of progress towards the 2020 vision and challenges for boards in meeting efficiencies through longer term recurrent changes and investment in service change.
- The Nuffield Trust reported in June 2014⁶ on the financial challenges facing the NHS in Wales and led to the work being taken forward by the Jenkins review⁷ which will consider new models of service delivery, efficiency and workforce issues (including direction of travel for pay). The Welsh Government told us the work by the Nuffield Trust is being refreshed by the Health Foundation.

3.40 Staff shortages in certain circumstances, and a rise in agency spend to meet short-term demands are a pattern across all countries. We were told that work is progressing in each country to control and reduce agency spend and this is encouraging. However, it is unclear how effective a strategy focused on cost caps and use of mandatory frameworks will be, when the demand for staff remains high and training new supply takes a number of years. The rise in agency spend is an example of a labour market in operation when the current level of demand is outstripping supply. This results in higher rates of pay through the agency, with workers consequently deciding where to work and on what terms. Some NHS jobs or overtime may simply need to be made more attractive and flexible to potential staff. In the long run ensuring adequate supply is key to controlling costs and providing effective care to patients. We return to shortages and agency use in more detail in Chapter 4 of the report.

3.41 Productivity gains have been historically difficult in health services and some evidence suggests productivity has dipped in recent years. With the most easily achievable savings now largely realised, trusts and health boards need to focus on transformational change

³ More information is available from: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Spending-Review-Nuffield-Health-Kings-Fund-December-2015_0.pdf

⁴ More information is available from: <https://www.nao.org.uk/report/sustainability-and-financial-performance-of-acute-hospital-trusts/>

⁵ More information is available from: http://www.audit-scotland.gov.uk/uploads/docs/report/2015/nr_151022_nhs_overview.pdf

⁶ More information is available from: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140617_decade_of_austerity_wales.pdf

⁷ More information is available from: <http://gov.wales/about/cabinet/cabinetstatements/2015/nhsworkforce/?lang=en>

to improve output and outcomes against the same or less input. However, current demand pressures, as set out above, are significant, and these are preventing whole system changes and meaningful productivity gains.

- 3.42 There is a difficult balance to be struck here. Given the high proportion of NHS costs that are attributable to the pay bill, propositions for some form of pay restraint will inevitably be part of the strategy to handle financial constraints. However, productivity improvements require longer-term solutions, such as investment in organisational change, technology and in the workforce. Bearing down too hard on the pay of the whole workforce, at a time they are being asked to deliver large scale transformational change, will not support innovation and may well be counterproductive, indeed such productivity improvements from staff are often rewarded in other industries. Similarly, hiring extra staff should help with workload, but if that is done at the expense of maintaining competitive pay levels for existing staff, then turnover will increase, and productivity will come under more pressure. We note Health Education England's observation that their plans to increase the supply in nursing and midwifery will not succeed unless employers can reduce the rate at which the workforce is currently leaving NHS employment. Hence a pay strategy, that is part of a workforce strategy and that does not simply mean generalised pay restraint, must be a central part of the delivery of affordable reforms. We turn to workforce strategy in more detail in Chapter 4 of this report.
- 3.43 During our evidence gathering we heard about the current tariff arrangements and the funding of the pay award. NHS Employers and NHS Providers in England were clear that, whilst pay awards may be funded through the tariff, the challenging efficiency targets were in practice cancelling out these increases. We explored the position on how the tariff might respond to targeted pay awards. Parties offered different views on the ability to respond to targeted pay either by geography or staff group and we are not yet convinced the mechanics of the pay and tariff system can cope with this. There was also feedback from NHS Employers and NHS Providers that suggested the current arrangements did not incentivise a shift to new care models in England.
- 3.44 In our view it is important to ensure the tariff system can respond to service changes and incentivise employers to embed much needed change to support them in delivering efficiencies. We are not confident that the tariff can react to targeted pay increases and have concerns that targeted awards could actually impact negatively on some providers. We do not want to make recommendations that could put undue financial pressure on the harder-pressed trusts or health boards, leading to unsafe or poor patient care. Given the request to consider targeted awards has been outlined as part of the UK government's pay policy for the next four years this will need to be resolved. We would like some assurances provided on this in time for our next round.

Observation 4

We ask the health departments where relevant, and the regulators as applicable in each country, to consider how funding mechanisms may need to be adapted in order to respond effectively to any proposals for targeting pay.

- 3.45 Despite the acute funding issues we were assured by the health departments in England, Scotland and Wales that trusts and health boards were funded for a 1 per cent pay award, plus the additional elements included in the Scottish Government and Welsh Government pay policies. Due to the late remit and evidence from Northern Ireland, and the need to report prior to the election, we were not given sufficient time to consider and scrutinise the affordability position. We have worked on the basis that funding is provided consequential to UK government pay policy equivalent to 1 per cent.

Chapter 4 – Recruitment, Retention and Motivation

Introduction

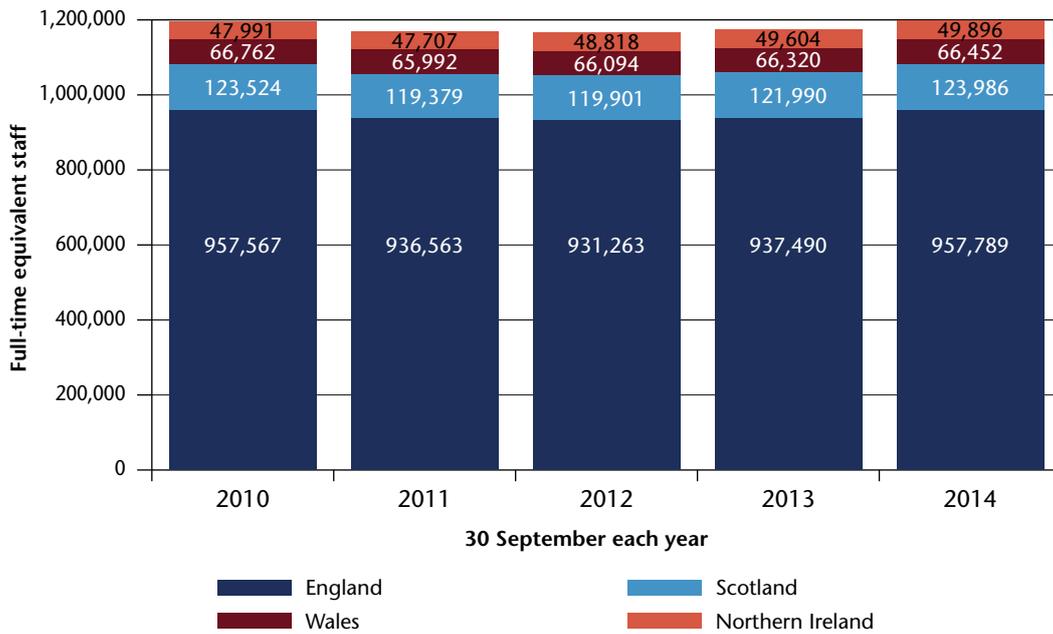
- 4.1 In line with our standing terms of reference, this section of our report includes our considerations and analysis of evidence on recruitment and retention, any regional and local variations in labour markets and their effects. This includes the evidence presented to us from the parties and our own analysis on the recruitment and retention position of our remit group. This chapter also includes our considerations and analysis of evidence on motivation. In exploring this we have considered the broader aspects of staff motivation for the role, satisfaction with the working experience and the degree to which staff are engaged in what needs to be done. Appendix C shows details of the composition of our remit group.

NHS Workforce, Vacancies and Turnover

Changes in staffing levels

- 4.2 Figure 4.1 shows recent changes in the non-medical NHS workforce for the United Kingdom as a whole and for each of the four United Kingdom countries:
- The United Kingdom FTE non-medical NHS workforce increased by 1.9 per cent (~22,700 FTE) between September 2013 and September 2014, to a total of 1.198 million FTE.
 - Of the United Kingdom non-medical FTE workforce in 2014, England accounted for 80 per cent, Scotland for 10 per cent, Wales for 6 per cent and Northern Ireland for 4 per cent. These proportions are unchanged from 2013.
 - Each country of the United Kingdom experienced an increase to their non-medical workforce between September 2013 and September 2014:
 - 2.2 per cent (~20,300 FTE) in England;
 - 1.6 per cent (~2,000 FTE) in Scotland;
 - 0.2 per cent (~130 FTE) in Wales; and
 - 0.6 per cent (~290 FTE) in Northern Ireland.

Figure 4.1: NHS non-medical workforce by United Kingdom country,¹ September 2010 to September 2014



Sources: The Health and Social Care Information Centre; Welsh Government (StatsWales); Information Services Division Scotland; and Department of Health, Social Services and Public Safety Northern Ireland

¹ From 2014 in Northern Ireland, the data on home-helps are no longer included due to the consistency of WTE data. This data is currently being standardised for inclusion in future years. For comparison purposes, home-help numbers have been excluded from previous years.

4.3 Table 4.1 shows the annual change of FTE staff within a broad staff group and by country of the United Kingdom. At the United Kingdom level each staff group experienced an increase in their number of staff. This was also true in England and Scotland. In Wales only the unqualified nursing and healthcare assistants and support staff group experienced a decrease (0.4 per cent). In Northern Ireland, the unqualified nursing and healthcare assistants and support staff group, ambulance staff group and the administration, estates and managers staff group experienced decreases of 0.6 per cent, 2.4 per cent and 0.8 per cent respectively.

Table 4.1: Full-time equivalent non-medical staff in NHS by United Kingdom country and broad staff group,¹ September 2013 to September 2014

Broad staff group		England	Scotland	Wales	Northern Ireland	United Kingdom
Qualified nursing and midwifery	FTE	313,514	42,616	21,987	14,472	392,591
	% change	1.9%	1.8%	0.3%	2.1%	1.8%
	FTE change	5,822	748	65	293	6,928
Unqualified nursing and healthcare assistants and support	FTE	186,829	15,791	15,963	3,990	222,573
	% change	2.0%	1.9%	-0.4%	-0.6%	1.7%
	FTE change	3,598	291	-68	-23	3,798
Professional, technical and social care	FTE	177,082	21,988	11,671	13,947	224,688
	% change	2.5%	2.3%	0.5%	1.5%	2.3%
	FTE change	4,304	491	55	210	5,059
Ambulance	FTE	25,377	3,751	1,544	1,045	31,717
	% change	2.7%	1.2%	3.0%	-2.4%	2.3%
	FTE change	660	43	45	-26	723
Administration, Estates and Managers	FTE	250,564	38,755	15,172	16,442	320,934
	% change	2.4%	1.2%	0.3%	-0.8%	2.0%
	FTE change	5,872	475	52	-132	6,267
Total²	FTE	957,789	123,986	66,452	49,896	1,198,123
	% change	2.2%	1.6%	0.2%	0.6%	1.9%
	FTE change	20,299	1,996	132	293	22,719

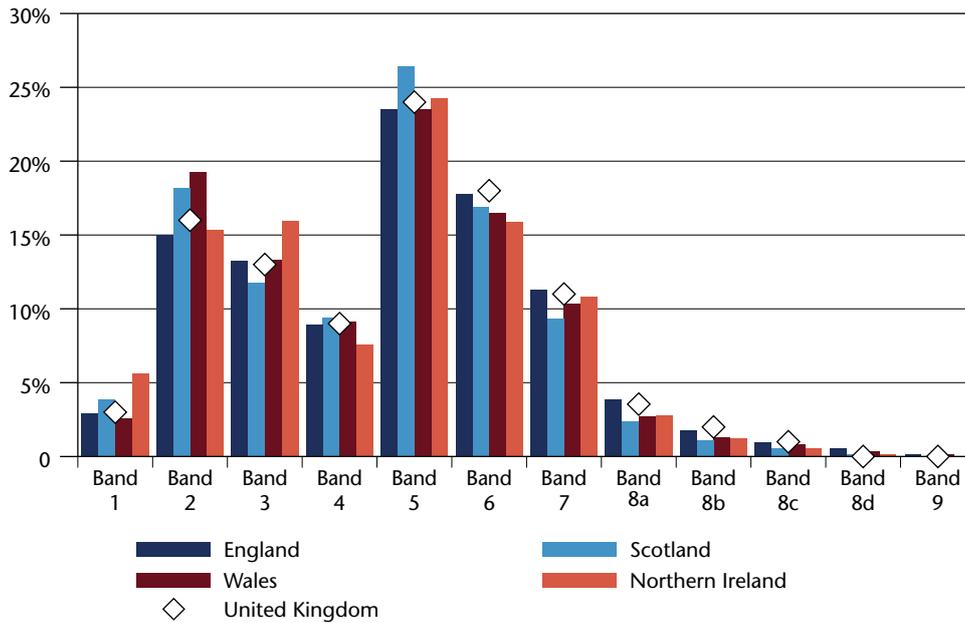
Sources: *The Health and Social Care Information Centre; Welsh Government (StatsWales); Information Services Division Scotland; and Department of Health, Social Services and Public Safety Northern Ireland.*

¹ Annex A provides information on which categories of staff in each country have been allocated to broad staff groups. These comparisons should be treated with caution: some ancillary staff in England and Wales are categorised in the census as healthcare assistants and support staff, but have job roles that fit better in the broad group "administrative, estates and management".

² The total also includes the "other" staff group. The numbers of "others" are volatile as they include unclassified and unknown staff groupings. This "other" staff group is therefore omitted from the table.

- 4.4 Figure 4.2 shows the distribution of our remit group across the Agenda for Change pay structure. The pattern is similar for each United Kingdom country, with peaks at bands 2 and 5, reflecting the main entry bands for clinical support workers and professionally-qualified clinical staff respectively.

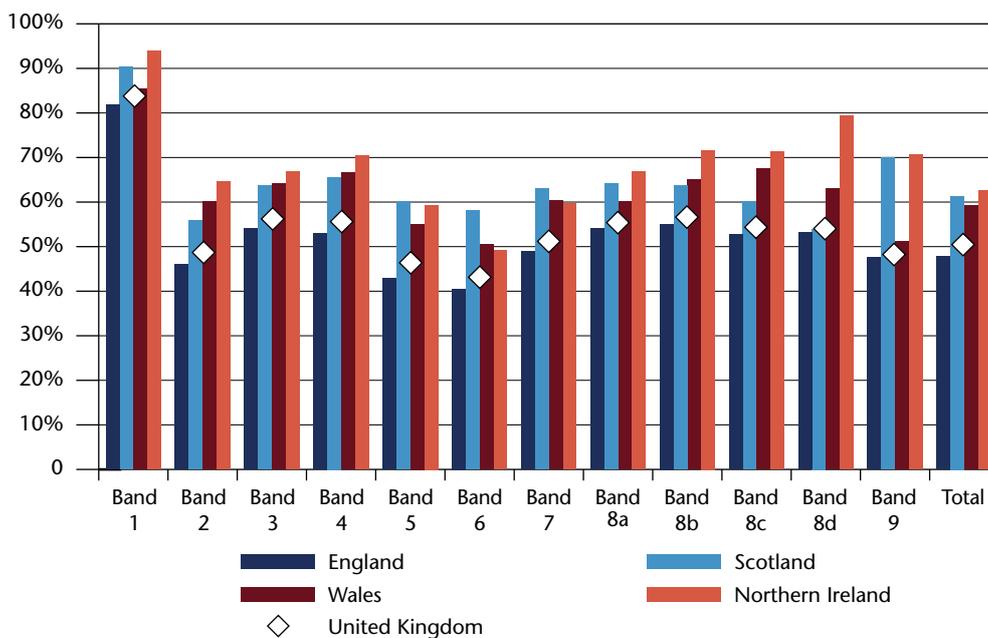
Figure 4.2: Distribution of staff across the Agenda for Change pay structure, UK



Sources: The Health and Social Care Information Centre; Welsh Government (StatsWales); Information Services Division Scotland; and Department of Health, Social Services and Public Safety Northern Ireland.

4.5 Figure 4.3 shows the percentage of staff at the top of each Agenda for Change pay band by United Kingdom country.¹ The latest available data for the United Kingdom shows approximately 50 per cent of our remit group are at the top of their pay band, compared with 47 per cent in 2013. The figures for individual countries ranged from 48 per cent of staff at the top of pay bands in England, 63 per cent in Northern Ireland, 61 per cent in Scotland, and 59 per cent in Wales.

Figure 4.3: Percentage of staff at the top of pay bands by UK country, latest available data¹



Source: NHS Employers, and Wales, Scotland and Northern Ireland Health Departments.

¹ Data for England relate to April 2015; Scotland, 2014/15 average; Wales, Sept 2015; Northern Ireland, June 2015

¹ Staff at the top of their Agenda for Change Band are no longer eligible for incremental pay increases.

Vacancy rates

4.6 Table 4.2 shows the latest vacancy rates by main staff group for Scotland and Northern Ireland. England suspended the vacancy survey in 2010² that would allow for a comparison with other countries, and Wales ceased theirs in 2011.³

Table 4.2: Latest vacancy rates by main staff group and UK country

	Three-month vacancies		Total vacancies	
	Vacancy rate (%)	Annual percentage point change	Vacancy rate (%)	Annual percentage point change
Scotland (June 2015)				
Nurses, midwives & HVs bands 5-9	1.2	0.5	4.1	0.8
Nurses, midwives & HVs bands 1-4	0.6	0.2	2.6	0.0
Allied health professionals	0.7	-0.3	4.1	0.0
Northern Ireland (March 2015)				
Nursing and midwifery	1.4	0.8	3.3	1.3
Professional and technical	1.4	0.9	4.3	2.2
Social services	1.5	0.6	3.2	1.2
Ambulance ¹	10.7	10.7	10.8	10.8
Support services	0.4	0.0	1.3	0.2
Administrative and clerical	0.6	0.0	1.7	0.3
Estates services	0.8	0.4	3.0	1.3

Sources of 2015 figures: Information Services Division Scotland; and Department of Health, Social Services and Public Safety Northern Ireland.

¹ The high vacancy rate in the ambulance occupational family was substantially caused by 125 (124.1 WTE) internal current vacancies, leading to a training and recruitment exercise within the NI Ambulance Service HSC Trust.

4.7 Whilst the vacancy survey was cancelled in 2010 in England, this year the NHS Jobs website has been used to publish,⁴ for the first time, the number of Hospital and Community Health Services (HCHS) vacancies in the year. In the report the Health and Social Care Information Centre (HSCIC) say that *“this publication provides figures which are an insight to recruitment in the NHS but which should be treated with caution, and users are discouraged from attempting to draw any conclusions from this data at this time.”* The problems include staff groups definitions not matching between NHS Jobs and the staff groups used in the official workforce figures, and likewise with occupations. This means a vacancy rate cannot be calculated because the underlying population size is unknown. Also NHS Jobs vacancy adverts could be for multiple posts and the system

² Following the NHSPRB 28th report we have been awaiting details of the plans to collect vacancy data. Details are provided in this report.

³ Wales carried out a consultation to assess whether the collection of these statistics should be terminated. The consultation closed in October 2011, following which the collection of vacancy data was ended.

⁴ *NHS Vacancy Statistics; England, March 2014 to February 2015 - Provisional experimental statistics* were published in August 2015. More information is available from: 14:05 January 22, 2016 - 09:30 August 18, 2015: <http://www.hscic.gov.uk/catalogue/PUB18102>

can only record it as one vacancy. However there is one potential use of the data, and that is for a regional comparison of total vacancy adverts (with the caveat that the likelihood of a trust compared to another trust using more than one advert to recruit multiple applicants is unknown). Table 4.3 shows that in general there were relatively more adverts on NHS Jobs from trusts in the South, and generally these numbers decrease as one moves north.

Table 4.3: NHS Jobs vacancy adverts by region, England 2014/15¹

	Non-medical vacancy adverts on NHS Jobs	Non-medical workforce (headcount)	Proportion of adverts to headcount
England	199,126	1,098,170	18%
Special Health Authorities and other statutory bodies	12,531	36,468	34%
Health Education Thames Valley	9,179	37,713	24%
Health Education Kent, Surrey and Sussex	17,724	74,987	24%
Health Education North West London	10,650	45,809	23%
Health Education South London	12,068	53,032	23%
Health Education North Central and East London	13,215	60,800	22%
Health Education Wessex	10,340	50,883	20%
Health Education East of England	19,324	97,009	20%
Health Education South West	17,336	90,163	19%
Health Education East Midlands	12,931	83,308	16%
Health Education West Midlands	17,753	117,985	15%
Health Education Yorkshire and the Humber	16,287	117,262	14%
Health Education North West	22,188	167,450	13%
Health Education North East	7,600	66,239	11%

Source: *The Health and Social Care Information Centre*

Note: Headcount totals are unlikely to equal the sum of components.

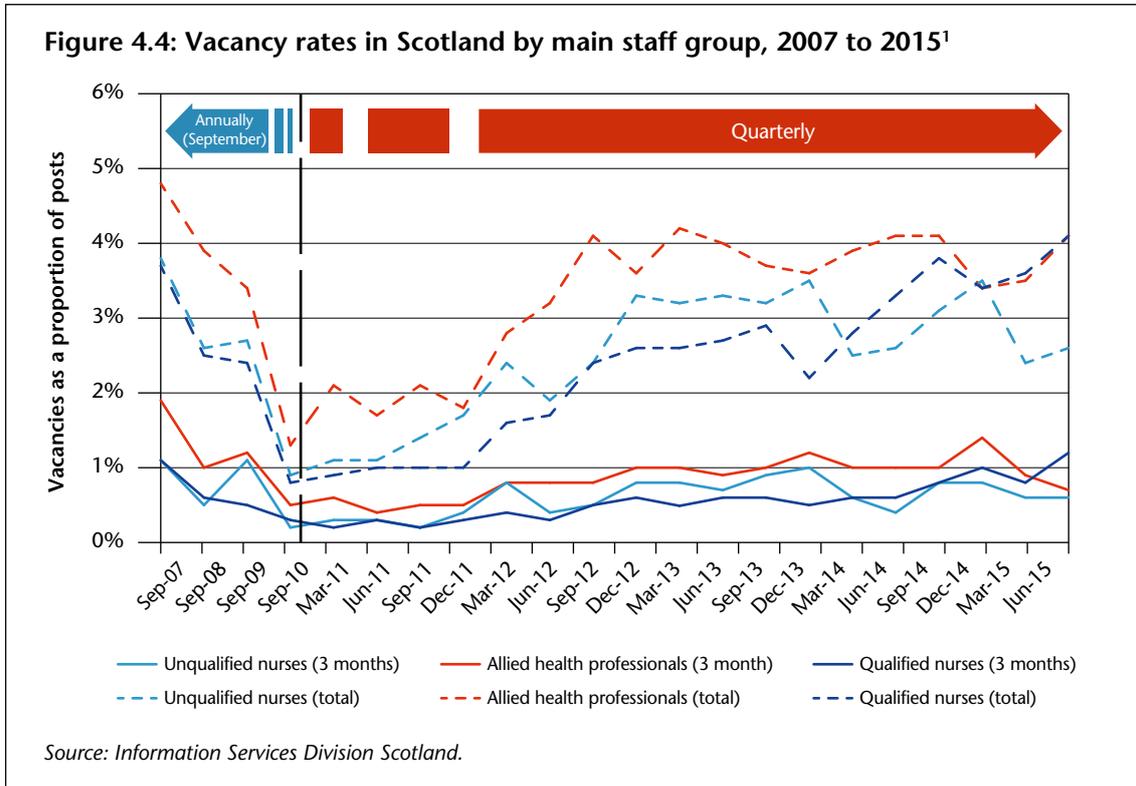
¹ Vacancy adverts posted between April 2014 and February 2015 (an incomplete fiscal year).

4.8 NHS Employers shared with us their submission to the Migration Advisory Committee regarding the addition of nurses to the Shortage Occupation List. This included findings from their nursing survey, where:

- 93 per cent of those surveyed reported they were experiencing supply shortages.
- 78 per cent of all vacancies of more than three months are in the field of adult nursing.
- 88 per cent of these are adult nursing vacancies at Agenda for Change Band 5.
- NHS Employers calculated the overall vacancy rate across trusts at 10 per cent (based only on those trusts who provided their staffing establishment data).
- 27 per cent were using their pay bill to manage supply challenges through RRP.
- 63 per cent had actively recruited from outside of the UK in the last 12 months.

- 74 per cent had a turnover rate of less than 15 per cent for the period 1 November 2014 – 31 October 2015.
- 99 per cent had taken some form of local action to retain their registered nurse workforce.

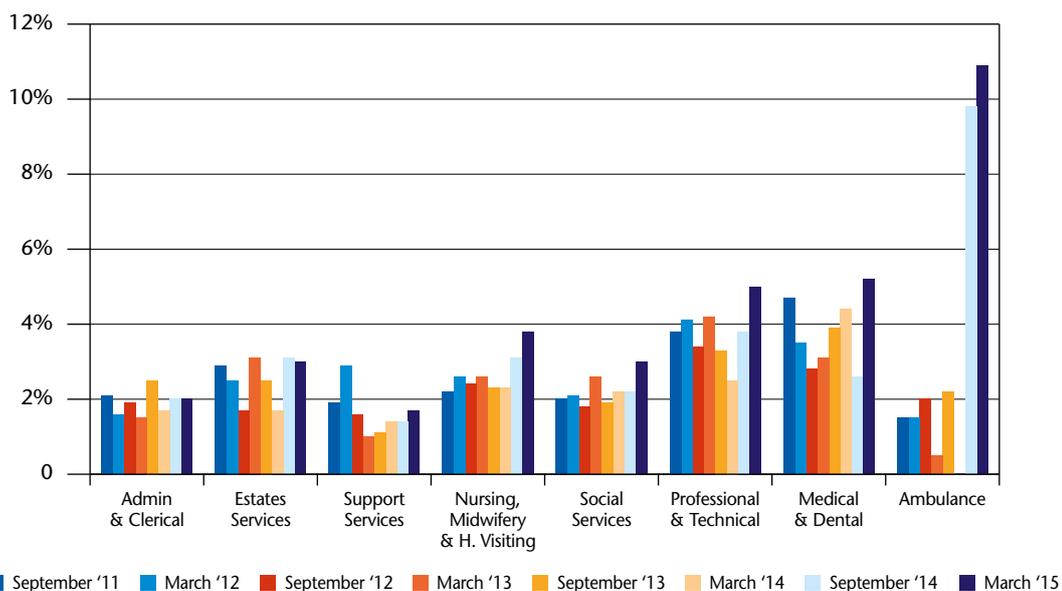
4.9 Figure 4.4 shows the three-month vacancy rates by main staff group for Scotland. For both unqualified nurses and allied health professionals rates have been fairly stable in recent years. Three-month vacancy rates for qualified nurses have generally increased through the course of 2014 and 2015.



¹ Since 2007, nurses in Agenda for Change bands 1-4 have been used as a proxy for unqualified nurses. Nurses in Agenda for Change bands 5-9 have been used as a proxy for qualified nurses.

4.10 Figure 4.5 shows vacancy rates for Northern Ireland where vacancy data is collected in March and September each year. Vacancy rates within each staff group are at broadly similar levels. Vacancy rates have increased between March 2014 and March 2015. There is a very large vacancy rate for ambulance staff in both September 2014 and March 2015. However this high vacancy rate in the ambulance occupational family, at 10.9 per cent was substantially caused by 125 (124.1 WTE) internal current vacancies, leading to a training and recruitment exercise within the NI Ambulance Service HSC Trust.

Figure 4.5: Vacancy rates (FTE) in Northern Ireland by main staff group, 2011 to 2015



Source: Department of Health, Social Services and Public Safety Northern Ireland.

The Office of National Statistics (ONS) Vacancy survey

4.11 The ONS conducts a monthly survey of businesses,⁵ collecting data on the number of vacancies for which employers are actively seeking recruits from outside their organisations. This definition broadly corresponds to that used in the Health Departments' vacancy surveys. Data are presented as a ratio of vacancies per 100 employee jobs,⁶ on a three-month rolling average basis. Figure 4.6 shows how the vacancy ratio has changed from 2001 to present. The overall vacancy ratio has been increasing over the last three years and currently stands at around 2.6 vacancies per 100 employee jobs as of August 2015. Prior to 2014, the historic trend in the ONS vacancy data has been one of somewhat smaller vacancy ratios in the health and social work sector, compared to the overall vacancy ratio. However, when the estimates for 2014 and 2015 are included, the picture becomes more even. Since June 2001, in 70 of the 171 monthly data points (41 per cent) the health and social work sector ratio has been higher than the overall ratio,⁷ compared to 70 occasions (41 per cent) when its ratio has been lower than the overall vacancy ratio. Over the last two years, the vacancy ratio in the human health and social work sector⁸ has been increasing at a faster rate than the all vacancy ratio. In summary, over this period the vacancy ratio in the human health and social work sector has gone from being lower than the all vacancy ratio, to being higher.

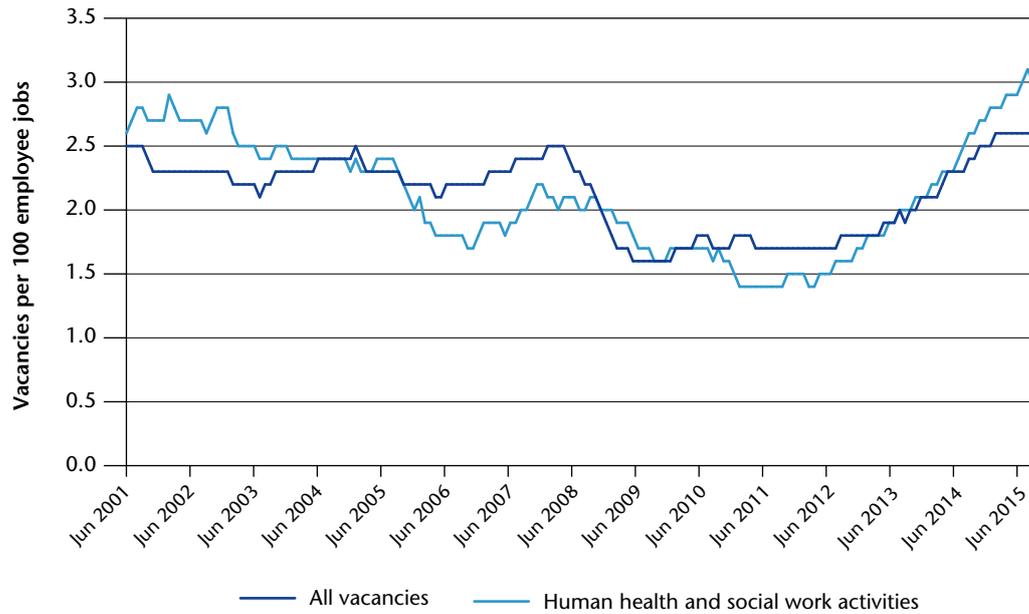
⁵ The ONS Vacancy Survey is a monthly survey of businesses in Great Britain which samples around 6,000 businesses. The survey covers the whole economy apart from agriculture, forestry and fishing. Figures correct as at 16 September 2015.

⁶ Vacancy ratios are vacancies expressed as a percentage of staff in post. Vacancy rates, as produced by the Health Departments, are vacancies expressed as a percentage of the sum of staff in post plus vacancies – i.e. the total number of available posts. The differing methods of calculation mean that, for a given number of vacancies, the ratio will always be higher than the rate.

⁷ When rounding each ratio to 1 decimal place.

⁸ This includes social work and private sector health activities.

Figure 4.6: Ratio of vacancies per 100 employee jobs, Great Britain, 2001 to 2015



Source: Office for National Statistics

Turnover

4.12 Table 4.4 shows the latest available joining and leaving rates in England, Scotland and Northern Ireland (Wales do not currently publish these). Due to varying classifications of joiners and leavers used in each country, comparisons should only be within each country's own staff groups. In each country and across the staff groups the nursing and midwifery groups tended to have one of the lowest leaving rates. Leaving rates tended to be highest for non-clinical staff groups. There were differences between the UK countries in these rates; England typically had higher rates than Scotland, which typically had higher rates than Northern Ireland. For all three countries, the overall joining rates are higher than leaving rates. This also tends to be the case when comparing rates by staff groups, but there are some exceptions. Leaving rates are higher than joiners for ambulance staff in both England and Northern Ireland; in England, the joining rate for health visitors is around a third of the leaving rate.

Table 4.4: Leaving and joining rates to the NHS by staff group (headcount)

	Year to 31 March 2014		Year to 31 March 2015	
England¹	Leaving rate	Joining rate	Leaving rate	Joining rate
All NHS (exc bank and locums)	9.0%	10.2%	9.1%	10.4%
Qualified nurses	6.7%	8.2%	7.5%	8.0%
Qualified midwives	5.6%	7.0%	5.9%	7.1%
Qualified health visitors	6.3%	2.3%	6.2%	2.1%
Qualified scientific, therapeutic and technical staff	7.9%	7.6%	7.9%	7.8%
Qualified ambulance staff	5.4%	3.9%	6.1%	4.3%
Support to doctors and nursing staff	8.5%	11.9%	9.5%	12.8%
Support to scientific, therapeutic and technical staff	9.8%	13.0%	10.1%	13.4%
Support to ambulance staff	13.0%	16.4%	9.2%	20.4%
Managers and senior managers	15.0%	8.0%	9.8%	6.2%
Central functions	12.8%	12.3%	10.0%	12.6%
Hotel, property and estates	8.5%	8.9%	10.9%	9.1%
	Year to 30 June 2014		Year to 30 June 2015	
Scotland	Leaving rate	Joining rate	Leaving rate	Joining rate
All NHS (inc medical and dental)	6.6%	7.9%	7.1%	7.8%
Nursing and midwifery	6.1%	7.7%	6.9%	7.9%
Allied health professions	6.2%	7.5%	6.5%	6.9%
Other therapeutic services	9.0%	11.2%	8.7%	11.4%
Personal and social care	7.2%	7.4%	7.0%	8.3%
Healthcare science	5.6%	6.7%	6.3%	7.0%
Emergency services	5.6%	10.2%	6.1%	8.6%
Administrative services	6.9%	7.9%	6.9%	8.4%
Support services	7.8%	10.0%	8.4%	8.8%
	Year to 31 March 2014		Year to 31 March 2015	
Northern Ireland	Leaving rate	Joining rate	Leaving rate	Joining rate
All non-medical staff	4.8%	5.6%	4.6%	4.8%
Nursing and midwifery	4.2%	5.9%	5.0%	5.7%
Professional and technical / Generic	3.7%	6.7%	4.3%	5.1%
Social services	5.6%	5.5%	4.4%	5.5%
Ambulance	2.6%	0.4%	3.8%	0.9%
Support services	5.4%	5.8%	7.4%	3.4%
Administrative and clerical	5.6%	4.7%	4.6%	5.1%
Estates services	7.1%	7.8%	5.8%	6.2%

Sources: *The Health and Social Care Information Centre; Information Services Division Scotland; and Department of Health, Social Services and Public Safety Northern Ireland.*

¹ Joiners and leavers data for England exclude internal transfers, so are net flows into and out of NHS England. However, they exclude Chesterfield or Moorfields hospitals as these are not on the Electronic Staff Record system.

Evidence from the parties

- 4.13 The **Department of Health** told us it was committed to improving the evidence base to support our work around recruitment and retention. The Department of Health reported good progress was being made to secure the evidence required and it had been working with the HSCIC and others, including Health Education England, to consider how meaningful vacancy data can be provided using a combination of data from NHS Jobs, the Electronic Staff Record (ESR) and a new data collection – the workforce Minimum Data Set (wMDS). The Department of Health said it was working with NHS England, HEE and the HSCIC on the design of the workforce information architecture for the new education and training system, and had developed a wMDS to be collected from all providers of NHS funded care, this included more information on absences and practice.
- 4.14 The Department of Health confirmed the HSCIC centre published workforce statistics annually and monthly, with the annual Census providing the best means of viewing medium and long-term trends in workforce numbers and detailed information on staff working in the NHS in England at 30 September each year. The census included information for staff working in general practice, including GPs and practice staff, provided a more detailed breakdown of the HCCHS information already published in the monthly workforce statistics, and was the only source of long term time series covering the entire NHS workforce. The HSCIC also publish quarterly data on HCCHS staff, reasons for leaving, staff movements and redundancy data, as well as earnings data and data on sickness absence for NHS staff.
- 4.15 The Department of Health reported the HSCIC had published “NHS Vacancy Statistics; England, March 2014 to February 2015 – Provisional experimental statistics” on 18 August 2015, based on data obtained from the NHS Jobs online recruitment portal. It said, depending on the data quality and completeness, the intention was to publish information at national and HEE LETB region initially, with the aim of publishing information at individual organisation level as the data source and processing develops. The Department of Health believe this advert data will provide clarity on posts employers are seeking to fill and which posts are advertised for more than three months and may be indicative of hard to fill posts.
- 4.16 The Department of Health said the recruitment and retention picture for the NHS remained strong but there were workforce supply issues, in particular, the supply of nursing staff which had recently been included on the Occupational Shortage list. The Department did not believe the complete answer to workforce supply issues could effectively be resolved by targeting within a pay envelope of 1 per cent. The Department of Health said NHS employers had the flexibility locally to pay recruitment and retention premia to help resolve any local recruitment or retention problems.
- 4.17 The Department of Health told us the government was committed to supporting a world class health education and training system built on robust workforce planning led by providers of NHS commissioned services. It said Health Education England had been given a clear remit to lead workforce planning and education commissioning across the health system to secure the future supply of the workforce. The Department explained the HEE national workforce plan for England was underpinned by a comprehensive local workforce planning process involving local health communities across the country working in partnership to ensure the future workforce reflected the needs of local service users, providers and commissioners of healthcare in both acute and community settings.
- 4.18 The Department of Health confirmed the Chancellor’s announcement in the Spending Review 2015 that, from 1 August 2017, new nursing, midwifery and allied health students would no longer receive NHS bursaries but have access to the same student loans system as other students. The Department told us this would enable universities to provide up to 10,000 additional nursing, midwifery and allied health training places over

this parliament. It said the new system would provide more nurses, midwives and allied health professionals for the NHS, a better funding system for health students in England and a sustainable model for universities.

- 4.19 The Department of Health informed us the government had committed to increasing the primary and community care workforce by at least 10,000 under “Transforming Primary Care”. It said this included 1,000 physician associates (PAs), thousands more community nurses, pharmacists and allied health professionals. It said HEE had increased the number of nurse training places by 14 per cent over the past two years and forecast the increase would deliver over 23,000 (FTE) additional nurses by 2019 (compared to 2014).
- 4.20 The Department of Health informed us that, as of 15 October 2015, as a temporary measure to address concerns over supply, the Home Office had added nursing to the governments Shortage Occupation List (SOL). It confirmed the Home Secretary had asked the Migration Advisory Commission (the Home Office independent advisory body) to report on the shortage position of nurses and to recommend what nursing roles should be included on the list and for how long. The Department explained that in examples such as this, where there are shortages, it works closely with stakeholders to identify activities and actions that can increase the effectiveness and efficiency of the current supply, as well as mechanisms to increase the supply and to minimise the need for additional international recruitment which cannot be guaranteed to produce additional numbers quickly. The Department of Health confirmed the government was investing almost £5 million over the next three years to support the “Come back to Nursing” campaign aimed specifically at encouraging and supporting experienced nurses who have left the profession to return. 1,522 people commenced training programmes during the academic year 2014/15 and are already coming on stream as substantive employees during 2015/16.
- 4.21 The Department of Health reported the latest data published by the HSCIC on 27 November (reflecting the position as at 31 August 2015) showed there were 1,075,596 (FTE) staff working in the NHS. This was an increase of 18,945 (1.8 per cent) since May 2010. The total number of professionally qualified staff had also increased during the same period by over 21,300 (3.7 per cent) and included a 1.4 per cent increase in the number of nurses, midwives and health visitors and a 9 per cent decrease in the number of staff working in infrastructure support or “central administration”.
- 4.22 The Department of Health reported the broad trend in the average leaver rate for all staff over the past six years had been upwards. Within this period, there was a marked increase in the 12 months to May 2011 and again in the 12 months to May 2013.⁹ The Department of Health said for the HCHS workforce as a whole;
- about 9 per cent of staff left during the 12 months to May 2015;
 - professionally qualified staff had an average leaver rate similar to the all staff average, and exhibited a similar trend;
 - leaver rates for clinical support and infrastructure support staff tended to be higher than those for professionally qualified staff (around 14 per cent and 15 per cent respectively in the 12 months to May 2015);
 - leaver rates for qualified nurses, Scientific, Therapeutic and Technical staff and ambulance staff had all increased over the period;
 - the rate for qualified ambulance staff (the lowest in 2008/09 at less than 6 per cent) had increased the most rapidly to more than 9 per cent in 2014/15.

⁹ Increased leaving rates during this time were most likely driven by structural effects as some; some staff transferred with their work into organisations outside the HCHS (e.g. Public Health England); some took opportunities to take up a new role (e.g. in NHS England or a Clinical Commissioning Group); some left the HCHS where their job was not continuing in the new system (e.g. with redundancy or early retirement package).

- 4.23 The Department of Health reported that spending by NHS trusts and FTs on temporary staff provided by agencies had increased to the extent that it was impacting significantly on NHS finances. It told us the increase in agency spend was the product of a range of factors:
- increasing workforce demands, as a result of increasing demands on services;
 - movement towards seven-day services; and trust and FTs' response to the Francis Review to meet safe staffing levels, with increased demand outstripping supply of substantive staff;
 - limits to the supply of nurses and other staff and shortages in particular specialties;
 - increases in the numbers of nurses leaving the profession; and
 - use of the highest cost agency staff and procurement of agency staff through "off-framework" arrangements.
- 4.24 The Department of Health pointed out Agency expenditure was highly variable between trusts, with variation within regions far greater than variation between regions. For example, as a percentage of total staffing expenditure (based on 2014/15 agency spend), the trust median average ranged from 3 per cent in the North East to 10 per cent in South London, and at trust level from 1 per cent to 21 per cent.¹⁰ It believed this suggested agency expenditure was driven principally by individual trust-specific factors. The Department of Health said it understood more recently agency supply was mainly provided by substantive staff giving their discretionary effort to accessible trusts at a higher rate of pay.
- 4.25 The Department of Health said that on 2 June 2015, the Secretary of State announced a series of financial measures to tackle the issue of excessive agency spend. New controls on nursing agency staff were launched on 1 September 2015, introducing an annual ceiling on spend on agency staff and the mandatory use of approved frameworks from 1 and 19 October 2015 respectively. The financial measures initially applied to nursing staff but would then apply to other clinical and management staff in due course. On 13 October 2015 the Secretary of State announced a cap on the hourly rates per shift agencies can charge for providing staff to the NHS. These measures are expected to remove £1 billion from agency spending bills over the next three years. The caps will gradually decrease over time, so that in future agencies cannot charge the NHS a shift rate that is more than the hourly rate paid to existing substantive doctors, nurses and other staff. The measures will help improve the current situation where staff who undertake short-term agency work can receive greater rewards than those in a substantive post which provides better continuity of care for patients. The caps are set slightly higher than the pay that substantive staff receive, but will be gradually reduced to the same level as substantive staff plus 55 per cent¹¹ by April 2016. The Department of Health confirmed Trusts can override caps where absolutely necessary to protect patient safety, however, any overrides would be subject to scrutiny by Monitor and the TDA.
- 4.26 **Health Education England** told us it had published its second Workforce Plan for England¹² in December 2014,¹³ setting out the £5 billion investment being made in education and training programmes for 2015/16. Health Education England said it was commissioning more education and training than ever before, with over 37,000 new training opportunities for nurses, scientists, and therapists. Health Education England

¹⁰ These figures include all staff groups, medical and non-medical, including non-clinical. In addition to agency, other off-payroll staffing such as self-employed contractors, interim managers and externally-managed bank are included.

¹¹ The 55 per cent uplift accounted for employment on-costs including employer pension contribution, employer national insurance, holiday pay to the worker and a modest administration fee.

¹² *Investing in People: Workforce Plan for England*, HEE 2015 is available from: <http://hee.nhs.uk/wp-content/blogs.dir/321/files/2014/12/Investing-in-People-Workforce-Plan-for-England-2015-16.pdf>

¹³ *The HEE Commissioning and investment plan 2016/17* was published in January 2016 and is available from: <https://hee.nhs.uk/sites/default/files/documents/HEE%20commissioning%20and%20investment%20plan.pdf>

explained it had invested in 13 per cent growth over two years: a 9 per cent increase in commissions in 2014, followed by a further 555 training posts in 2015 (4.2 per cent). It reported nearly 800 nurses had been brought back into the system through the Return to Practice campaign, attrition rates had been reduced amongst nursing students in Universities and the introduction of recruiting for values and pre-degree care experience was ensuring that newly employed nurses have the right values and behaviours.

- 4.27 Health Education England explained that whilst there are around 140,000 students in training at any one time, this should be compared against the 1.3 million existing NHS staff who will still be working ten, twenty and thirty years from now and will make up the majority of the future workforce. In this context, Health Education England believed investment in the current workforce was the way to drive transformation at scale and pace. Health Education England reported, whilst the education and training of existing staff was primarily an employer responsibility, £0.2 billion of its £5 billion budget was allocated for the education and training of existing staff to support service transformation.
- 4.28 **NHS Employers** told us in 2014/15, the NHS recruited the highest number of staff since the beginning of the recorded time series in 2009/10 and that overall, there had been increases for all major staff groups, apart from qualified ambulance staff, between 2013 and 2014. They believed the ability to recruit staff indicated that Agenda for Change pay rates continued to remain competitive in relation to the wider labour market. NHS Employers, however, also told us that turnover levels in 2014/15 were at their highest levels in five years.
- 4.29 NHS Employers said employers continued to face familiar challenges on workforce supply where they reported shortages, particularly of nursing staff, which were contributing to pressure on agency costs. NHS Employers told us there was no evidence to suggest shortages were directly related to pay levels, and applications to degree programmes had remained strong. NHS Employers were confident recruitment problems were because of a shortage of supply, and explained the distinctive way the NHS operated meant it was not possible to respond to gaps in supply quickly through training more people, as demand can often alter faster than training programmes can handle. NHS Employers told us the current situation with nurses was an example of this: when nurse training places were reduced in 2010 it had not been anticipated that the review into patient care at Mid Staffordshire Hospitals NHS Trust would result in the need for all NHS organisations to review their staffing establishments. NHS Employers said the local and national skills shortages and additional pressure from new safe staffing guidance had given rise to supply gaps in parts of the workforce. This was most prevalent in nursing and in smaller numbers across other professions such as paramedics, occupational therapists, sonographers, healthcare scientists and radiographers. The interim inclusion of nursing on the shortage occupation list had been welcomed by employers.
- 4.30 NHS Employers told us the Employers' nursing survey had provided an indication that the shortfall of nurses was widespread across England, with an approximate gap of 12,500 full-time equivalent (FTE) nurses against employer demand. They said the subsequent work done by Health Education England to produce the workforce plan for 2015 had indicated a gap in adult nurses of around 15,000. NHS Employers explained, whilst there were a number of measures in place to help bridge the gap (including Return to Practice, commissioning of additional nurse training places and a focus on retention) the immediate gap could only be filled through two methods: overseas recruitment and use of temporary or agency staff.
- 4.31 NHS Employers told us Agency workers had always been a widely used resource within the NHS and can help organisations to quickly fill difficult gaps and ensure service continuity. They said local employers were being encouraged to adopt a strategic approach in order to develop a more flexible and responsive workforce and avoid

inappropriate responses to financial challenges. NHS Employers reported that agency spend in the NHS had risen by approximately £800 million from 2013/14 to 2014/15, with agency spend reaching a high of £3.3 billion. NHS Employers said that the volume of bank and agency staff used to ensure staffing levels are met was driving up labour costs well beyond budget and was a major contributing factor to the financial deficit of individual providers. NHS Employers told us that Monitor and NHSTDA were introducing caps on the total amounts trusts can pay per hour for all types of agency staff from November 2015. The new rules include an annual ceiling for total nursing agency spending for each trust, and mandatory use of approval frameworks for procuring agency staff. The rules on an annual ceiling for spending and the use of approved frameworks will be initially for nursing agency spend only, but Monitor and NHSTDA plan to extend ceilings across all staff groups in 2016/17. NHS Employers said that there will be mechanisms for local managers to override the rules under exceptional circumstances to ensure patient safety.

- 4.32 **NHS Providers** told us staffing shortages, notably in respect of adult general nurses, had put pressure on the quality of services and led many NHS providers to make greater use of bank and agency staffing, which in turn had made a large contribution to providers' deteriorating finances. NHS Providers explained that staff pay accounted for between 60 and 85 per cent of providers' expenditure so the impact of any national pay award on already severely challenged finances must be fully thought through. However, it was also essential the NHS continued to reward its staff appropriately and fairly, and remained able to recruit, retain, and motivate, staff with the skills needed to deliver high quality patient care. NHS Providers said it was also apparent from members' comments that some NHS providers considered there would be a "cost", in terms of recruitment and retention and staff morale, to awarding any less than the 1 per cent pay award announced in the summer budget and balancing affordability and an attractive reward offer for staff was increasingly difficult.
- 4.33 The **Scottish Government** said it was crucial Boards used available evidence to develop their workforce plans and projections given significant changes in the skill mix of staff groups and consequences of changes in one staff group on other groups. It reported work was continuing on Nursing and Midwifery Workload and Workforce Planning Tools for each workforce area. It said use of these tools had been mandated from April 2013 and been useful in informing staffing numbers as part of a triangulated approach, incorporating professional judgement with quality measures. The Scottish Government told us NHSScotland projected staff in post changes for 2015/16 (published August 2015) showed a projected overall increase in workforce numbers of 0.8 per cent (1,032.10 WTE). The Scottish Government said, if projections were realised, Nursing and Midwifery would see the largest increase (1.1 per cent) and only three job families showed an overall projected decrease: Ambulance Services (9.0 per cent);¹⁴ Administrative Services (0.1 per cent) and Dental (HCHS) staff (0.9 per cent). The Scottish Government reported it would expect to see an associated transfer of activity as a result of changes shifting activity from the acute sector in to the community and, whilst the commitment to no compulsory redundancies in the NHS remained, it was right for Boards to look critically at service delivery at a time of tight public sector budgets. It said part of this was to consider how services should be staffed as patterns of care change.
- 4.34 The Scottish Government told us whilst the picture was variable between different staff groups, overall staff numbers in NHSScotland continued to rise in 2015. The number of WTE Agenda for Change staff working in NHSScotland as at September 2015 was 124,226.4 and represented a 1 per cent increase since June 2014 (1.6 per cent since September 2010). However, gross turnover (headcount) had increased from 8.3 per cent to 8.9 per cent (from 1.8 per cent to 7.3 per cent net) and was higher than at any time

¹⁴The majority of this decrease was from within the Scottish Ambulance Service and was mainly due to staff retraining as Paramedics (classed as AHPs).

since the financial crash. The Scottish Government believed this may be an indication of an improving wider economy. There had been a 0.8 per cent increase of nursing and midwifery staff in WTE terms since June 2014 (a 1.8 per cent increase over the September 2010 level) but vacancy numbers had increased from 3.1 per cent (June 2014) to 3.9 per cent (September 2015), of these 0.8 per cent were for vacancies of over three months (slightly up from 0.6 per cent in June 2014).

- 4.35 The Scottish Government confirmed it controlled annual intake numbers for student nurses and midwives. These were determined by running a supply and demand model based in part on demand projections from NHS Boards and analysis of current stock in training, student attrition and retirement rates. The latest figures showed a decrease of 1.1 per cent compared to the 31 October 2013 level (a decrease of 3.9 per cent from the number of students in training in 2009) but the total number of students in training continued to be relatively high. Reflecting more recent demand for qualified staff, Ministers had recommended increases to intakes (6.6 per cent for 2014/15, 3.5 per cent for 2015/16 and 5.6 per cent for 2015/16).
- 4.36 The Scottish Government explained its policy was to utilise the flexibility offered by the nurse bank, among other things, to secure value for money by decreasing the use of more expensive agency staff. The number of people registered as bank nursing and midwifery staff had increased in NHSScotland: bank use in 2014/15 was 8.2 per cent up on the 2013/14 level and accounted for 6.5 per cent of the total NHS nursing and midwifery capacity. The Scottish Government said its policy was to minimise the usage of agency staff and a national contract was introduced to ensure best value around the use of agency nurses. The Scottish Government advised a team had been set up to support Boards to review the use of agency nurses and provide advice and guidance on steps to take to reduce reliance. Some Boards, in particular in remote and rural areas, had advised of difficulties recruiting and the Scottish Government was working with them to determine a way forward to ensure ongoing supply of staff. For example, through increased student nurse intake, Return to Practice programmes and the development of an alternative workforce for theatres.
- 4.37 The **Welsh Government** said over the last seven years NHS Wales' total workforce numbers had remained relatively static, growing by 1.3 per cent (916 FTE). It said despite the stability in numbers, the NHS Wales' workforce skill mix had changed; with administrative and clerical, and estates and ancillary staff groups experiencing a reduction in their overall workforce percentage, while clinical staff groups had increased. The Welsh Government reported there had also been growth of between 3 to 6 per cent in Bands 3, 5 and 6 (Band 6 seeing the greatest increase at 5.6 per cent). During 2013 – 2015 the overall workforce increased: 1155 FTE (1.59 per cent). Additional Clinical Services had the largest increase at 4.5 per cent (609 FTE) and Estates and Ancillary had the largest reduction in staffing numbers at -4 per cent (-285 FTE). Bands 1 and 7 had reduced, while Bands 2 and 3, 5 and 6 had increased.
- 4.38 The Welsh Government informed us that it was the responsibility of local health boards to plan the appropriate workforce, as they are best placed to ensure the services they plan are matched to the immediate and future needs of the community. The Welsh Government advised that NHS Wales Shared Services Partnership (NWSSP) works with NHS Wales, the Welsh Government and education providers to ensure NHS Wales has a workforce with the skills to meet the demands of modern day healthcare. It said that they contract mainly with the University sector for the provision of undergraduate/pre-registration training. The Welsh Government told us Health Board plans had identified some areas where there were concerns regarding the provision of staff for the future. These included shortages in a number of nursing groups, Allied Health Professionals and

other groups and Advanced Practitioners. The Welsh Government stated that, at the current time, reported shortages were location specific and not applicable across the whole of Wales.

- 4.39 The Welsh Government stressed it was aware that agency and locum costs continued to increase in Wales. NHS Wales shared the concerns about escalating agency costs, but this was a UK-wide issue. Agency staff provided an essential means of increasing staffing levels to manage short term peaks in demand, to ensure the quality of patient care can be maintained. The Welsh Government confirmed an All Wales Nurse contract had been in place in NHS Wales since 2010, to ensure quality and price were managed and controlled. It said whilst this arrangement remained in place, there had been a significant growth in use of off-contract agencies. This had driven up costs and was recognised as not sustainable. The Welsh Government said the Temporary Nurse Staffing Capacity Steering Group had been set up to tackle this and was overseeing and directing work to address rising agency nurse costs. The Welsh Government had asked NHS organisations to work together to ensure agency staff were secured through the framework contract.
- 4.40 The Welsh Government informed us the review of the NHS workforce, being led by David Jenkins, would provide a more robust understanding of strategic challenges faced by the current workforce and would help inform the development of a 10 year strategy for the workforce. The Welsh Government said this would support workforce planning, including ongoing education, training and support so that NHS Wales was better placed to recruit, engage and develop and retain a workforce that is sustainable and meets population need now and over the next 10 years. It said the plans must also be based on the new models of care needed and not just plug gaps in existing models.
- 4.41 The **Northern Ireland Executive** confirmed that HSC workforce numbers were approximately 63,000 and accounted for just under one third of all public sector employees in Northern Ireland. The Northern Ireland Executive also provided data on workforce numbers, vacancies and agency spend. In general workforce numbers were increasing across most staff groups with the exception of staff working in Support Services and Ambulance staff. Vacancy numbers (both short term and long term) were also increasing across the majority of staff groups with the biggest gap identified in the Nursing, Midwifery and Health Visiting staff group. The Northern Ireland Executive explained this was because this was the largest staff group and the normative nursing initiative was increasing the number of substantive posts. Leaving rates are highest for the Support Services staff group (7.4 per cent), however, for most staff groups joining rates were outstripping leaving rates. The exceptions to this were Support Services Staff and Ambulance staff. Agency and Locum spend had also been increasing year on year with medical and dental accounting for about half the £76.5 million spend, whilst nursing and midwifery accounting for around 15.8 per cent of total spend in 2014/15. Spending on Bank staff had also been increasing with a total spend of £64 million in 2014/15, about two thirds of which was on nursing and midwifery. As such, Bank spending on nursing and midwifery was over three and a half times that of Agency spend on the same staff group. The Northern Ireland Executive reported that work on the review of Agency, Locum and Bank spend had commenced. It told us a meeting had taken place with all trusts and there was an agreed process around collecting and reporting data as well as clear definitions against what each area of expenditure related to.
- 4.42 The **Joint Staff Side** pointed to the lack of detailed vacancy data, particularly in England and the difficulty of making an assessment of staff shortages without this. The Joint Staff Side called on us to press the governments in the Wales, England and Northern Ireland administrations to resume collection of vacancy data. It said it was encouraging the Health and Social Care Information Centre (HSCIC) had made steps to provide an indication of vacancy levels in the NHS in England, however, this was an experimental publication of NHS vacancy statistics created from NHS Jobs adverts obtained from NHS

Jobs¹⁵ and its use was limited. The Joint Staff Side called for full data to be made available to allow for a proper analysis of vacancy data in the NHS in England. The Joint Staff Side also asked us to recommend a standard data collection methodology across the four countries, building on Scotland's model and extending this to all the main Agenda for Change job families including paramedics, healthcare scientists and technical support roles.

- 4.43 Joint Staff Side told us the latest statistics from Scotland suggested vacancy levels remained stubborn. It said the vacancy rate as a percentage of establishment for allied health professional posts was 3.5 per cent, with those vacant for three months or more running at 0.9 per cent in March 2015. The overall vacancy rate was down slightly from 3.9 per cent the previous year but the long term rate was almost unchanged from 1 per cent. The highest overall vacancy rates were found in physiotherapy (5.1 per cent), dietetics and therapeutic radiography (both 4.2 per cent). The Joint Staff Side said vacancy rates for nursing and midwifery posts in Scotland was 3.2 per cent in March 2015, with those vacant for three months or more running at 0.8 per cent (up from 2.7 and 0.6 per cent respectively in March 2014 and 1 and 0.2 per cent in March 2011). The Joint Staff Side reported use of agency nursing and midwifery staff in Scotland, in terms of whole-time equivalents, had increased by 53 per cent in the year to March 2015, while the WTE use of bank staff rose by 8 per cent.
- 4.44 The Joint Staff Side said vacancy data compiled by the Department of Health, Social Services and Public Safety in Northern Ireland for September 2014 had shown an overall vacancy rate across the health and social care workforce of 2.8 per cent (up from 2.3 per cent in March 2014) and a long-term (three months plus) vacancy rate of 0.9 per cent. For professional and technical staff the overall vacancy rate was 3.8 per cent and the long-term rate was 1.2 per cent. For nursing and midwifery it was 3.1 per cent overall with a long-term rate of 1 per cent and for estates services it was 3.1 per cent overall and 0.7 per cent long-term.
- 4.45 The Joint Staff Side told us NHS trade unions had also gathered evidence on vacancies and staffing pressures through member surveys (reported below) and the NHS Staff Survey for England. The Joint Staff Side said the 2014 NHS Staff Survey for England found half of all respondents (49 per cent) said they were unable to manage conflicting demands on their time, while 46 per cent stated staffing issues were impinging their ability to their job.
- 4.46 The Joint Staff Side said international recruitment was becoming more prevalent with 2,499 certificates of sponsorship used to recruit overseas nurses via the 'resident labour market test' between January 2015 and March 2015 alone. The Joint Staff Side told us the cost of agency staffing in the NHS had substantially increased in the last few years with 2014/15 seeing NHS providers spend £3.3 billion on agency staffing in England, while in Wales agency and locum spend for 2014/15 was £87.7 million. The Joint Staff Side said the Department of Health had instructed Monitor to introduce a mandatory cap on the hourly rates paid for agency staff and an annual ceiling for agency spending for each trust in England; however the caps would only apply to nursing, midwifery staff and health visitors. The Joint Staff Side said it was in agreement that agency usage in the NHS had reached inappropriate levels and believed the two safe, sustainable and effective ways to reduce agency spending were to eliminate staff shortages and incentivise existing staff to work bank or overtime. The Joint Staff Side believe the difficulty in authorising overtime and low bank rates meant trusts were having to resort to agency staff, costing them more money.

¹⁵NHS Jobs in the main recruitment site for the NHS.

- 4.47 The Joint Staff Side believe the impact of pay restraint on recruitment and retention, as well as problems with workforce supply and staffing levels will cause lasting damage to the NHS workforce unless dealt with through a long-term, coordinated strategy.
- 4.48 The **Royal College of Nursing (RCN)** said, during regional focus groups, RCN representatives reported staff shortages were leading to high levels of exhaustion and low morale among nursing staff, and that sickness absence rates were increasing. It found that nursing staff felt frustrated at being unable to give the high standard care they would like and worry about the impact on patient care and safety. Many representatives also reported that following periods of recruitment freezes, affected posts were subsequently never filled and not counted as vacancies, leading to higher workloads for existing staff.
- 4.49 The Royal College of Nursing told us, according to the OECD, there had been a steep rise in emigration of nurses from Spain, Portugal and Ireland since 2009 and the UK had been the first destination for these workers among EU/EFTA countries, with many NHS trusts and organisations actively recruiting from these and other EU countries. The Royal College of Nursing said nursing staff do not see overseas recruitment as a sustainable model for recruitment and recruitment costs could be highly expensive.
- 4.50 The Royal College of Nursing told us its 2014 report *Frontline First: Runaway agency spending* had reported a rise in agency costs from £327 million in 2012/13 to £485 million in 2014, and were projected to reach £980 million in England by the end of 2015. It said costs and use of agency staffing for the other UK countries had also risen sharply in recent years. The Royal College of Nursing believed, in the absence of consistent UK data for nursing vacancies, trends in agency staffing were a proxy for vacancies and the upward trend indicated a clear sign of staff shortages in the NHS. It said the use of temporary staff was being driven by recruitment difficulties as NHS organisations struggled to match the increased demand for qualified nurses on grounds of patient safety, and safe staffing guidance. The Royal College of Nursing said staff were choosing to work via an agency either solely on temporary contracts or as well as their substantive NHS contract. The main reasons for doing so were better pay, flexibility and the wish for less pressure in their working lives.
- 4.51 The **Royal College of Midwives** reported a current shortage of around 2,600 midwives in England, compared with the NHS vacancy statistics publication (March 2015) that recorded 555 positions in maternity advertised on NHS Jobs in England. The Royal College of Midwives said, whilst the number of midwives had been rising, it did not believe that this had kept pace with the rising number of births and increasing complexity of cases. The Royal College of Midwives' annual Heads of Midwifery (HOM) survey found maternity units in the UK struggling to meet the demands of the service with HOMs frequently having to redeploy staff to cover essential services; call in bank and agency staff; withdraw services; and close the maternity unit. 29.6 per cent of Heads of Midwifery reported their funded establishment was not adequate for their organisation and 91.3 per cent said cases were more complex than last year. The age profile of midwives in England showed midwives were getting older (48 per cent of midwives in England are 45 or over), and there was a dip in the numbers of midwives aged between 35 to 45. The Royal College of Midwives believed this group has been declining due to fewer opportunities to work flexibly.
- 4.52 The Royal College of Midwives agreed the use of agency staff in the NHS had reached inappropriate levels and should be controlled but did not believe the proposals from Monitor would do this in a safe and sustainable way. The Royal College of Midwives believed the two safe, sustainable and effective ways to reduce agency spending were to eliminate staff shortages and incentivise existing staff to work bank or overtime.

- 4.53 **UNISON** reported that some 64 per cent of respondents to its members' survey had said there had been frequent staff shortages in their workplace during the last year, with another 21 per cent saying there had sometimes been shortages. UNISON told us over two-thirds of respondents said there were not enough staff in their unit to cover the work required. UNISON told us it had commissioned the Smith Institute to carry out an on-line survey and semi-structured interviews with a sample of HR Directors and Managers in the NHS¹⁶ between April and June 2015 across the UK. It reported 70 per cent of the HR managers surveyed were expecting to recruit more staff this year than last, but despite this, 63 per cent were unsure they would have enough staff to meet demand and 85 per cent were finding recruitment either very or fairly difficult. UNISON said interviewees attributed staff shortages principally to increased demand and safe staffing guidelines and many thought the situation would worsen as a result of deteriorating finances. The survey found biggest problems were recruiting skilled, specialist and experienced staff on higher pay grades (cited by 78 per cent) and intermediate roles (cited by 59 per cent). UNISON said follow-up interviews showed that the most common areas of concerns were nursing, paramedics and radiology. Some 89 per cent of respondents said they were using agency or temporary workers to meet staff shortages (63 per cent said they were using "a lot"). UNISON told us interviewees had expressed concern about the effects on staffing levels of the government's crackdown on agency spend, saying pay was a clear factor in driving nursing staff to agency work.
- 4.54 **Unite** reported findings from its members survey where many had reported frequent staff shortages in their area/department over the last 12 months: 67 per cent overall, including 80 per cent of arts therapists, 78 per cent of mental health nurses, 77 per cent of ambulance staff, 75 per cent of school nurses and 71 per cent of other nurses. Unite told us it believed there was a staffing crisis in the NHS being brought on by government funding and pay policy, it asked us to consider the impact this was having on the service and the NHS staff working in understaffed conditions. It also asked us to recommend improvements to vacancies, recruitment and retention data in order to help solve staffing problems and make a strong recommendation about the need for data on all NHS providers and providers of NHS services in order to understand fully the staffing issues facing the sector.
- 4.55 The **Chartered Society of Physiotherapists** said it was concerned physiotherapy workforce supply was not keeping pace with demand at a time when the profession had a strong contribution to make. The Chartered Society of Physiotherapists said there were problems recruiting at all levels and across sectors and settings, with community-based services reporting particular difficulties. Feedback from Physiotherapy Managers, via its March 2015 survey, indicated they were experiencing moderate or severe difficulties recruiting to posts across the Bands: with two-thirds reporting problems at Band 5, four-fifths at Band 6 and over half at Band 7. Respondents cited the main cause as a lack of applicants.
- 4.56 The Chartered Society of Physiotherapists said there was mounting evidence current shortages of physiotherapy staff were having a major impact on existing NHS staff with increasing pressure to work additional hours to cover shortages and ensure quality care for patients. It told us the results of a jointly commissioned trade union survey¹⁷ showed physiotherapists across the NHS in England worked significant numbers of additional unpaid hours. 39 per cent of CSP members responding to the survey stated they always worked more than their contracted hours: 35 per cent frequently and 24 per cent sometimes. Fifty-nine per cent reported that these hours were unpaid with 40 per cent working between two and six extra hours per week. When asked why they worked

¹⁶The UNISON survey results are available from: <https://www.unison.org.uk/content/uploads/2015/09/From-pay-squeeze-to-a-staffing-crisis.pdf>

¹⁷*NHS staff survey on pay and conditions: a research report for the joint staff side NHS trade unions*, undertaken by Income Data Services and published in September 2014.

these additional hours, a third said that this was to cover staff shortages. The Chartered Society of Physiotherapists believed a lack of resources and in particular the hours physiotherapists were having to work in order to provide the quality of care patients needed were a reflection of insufficient levels of staffing. Over half of its respondents to the joint trade union survey reported their employer had responded to the financial challenges by reducing the number of posts in their department and 42 per cent by recruitment freezes.

- 4.57 The Chartered Society of Physiotherapists told us it was important to align workforce supply and decisions about workforce planning with changes in service commissioning/ design and the delivery of care across the whole health, social care and public health economy. It said investment in the current workforce was needed, including ongoing development for physiotherapists and support workers, to meet the growing demand.
- 4.58 The **Royal College of Nursing (Northern Ireland)** told us there were high levels of vacancies across the HSC and the independent (nursing home) sector, with demand for nursing staff outstripping supply. It said vacancy rate data between 2011 and 2015 showed a worrying trend, increasing from 2.3 per cent in March 2014 to 3.8 per cent in March 2015; the long-term rate increased from 0.6 per cent to 1.5 per cent over the same period. The Royal College of Nursing (Northern Ireland) reported results from the RCN Employment Survey 2015, where 57 per cent of respondents working for HSC trusts reported there had been a reduction in registered nurse staffing levels in the previous 12 months, and 30 per cent reported a reduction in HCA staffing levels. The Royal College of Nursing (Northern Ireland) believed the level of vacancies in the independent sector must also be considered as another significant factor when analysing the supply and demand in the nursing labour market within HSC Trusts. It reported findings from a recent RCN survey report (*Care in Crisis*, December 2015) on the independent nursing home sector in Northern Ireland, which indicated there were 374 WTE registered nurse vacancies as of June 2015 and this number continues to grow.
- 4.59 The Royal College of Nursing (Northern Ireland) said 60 per cent of Northern Ireland respondents to the RCN Employment Survey 2015 reported recruitment freezes with vacancies unfilled (compared to the UK figure of 45 per cent); 40 per cent reported skill mix changes (compared to 45 per cent across the UK) and 19 per cent reported that posts had been cut.
- 4.60 The Royal College of Nursing (Northern Ireland) told us the combination of high vacancy rates and pay restraint was clearly having an immediate impact on the level of agency nursing within the HSC, with the total spend on agency nursing having increased by 22 per cent between 2012/13 and 2014/15. It said there was significant over-reliance on the supply of nursing staff on an *ad hoc* basis through the nurse bank and nursing agencies. The Royal College of Nursing (Northern Ireland) believed HSC Trusts were turning increasingly to agency staff because demand for nursing staff employed and deployed via nurse banks was outstripping supply.

Our comment

- 4.61 There are some shortages, particularly in paramedics, adult nursing and some nursing specialties such as mental health and paediatrics. There is also an emerging picture of higher vacancy rates and agency use, particularly in London and surrounding areas. The Scottish Government told us there were gaps in some Allied Health Professional roles and in finding experienced Band 7s and 8s, and particularly stubborn issues in some rural and remote locations. Welsh Government officials said that alongside the UK shortage of adult nurses there were particular gaps in paediatrics and neonatal nursing and to a lesser extent physiotherapy and radiography.

- 4.62 Turnover rates appear to be manageable at present, largely because joining rates either match or outstrip them, but nevertheless the turnover rates are increasing, and this causes us some concern. At this stage shortages appear to largely be related to a lack of trained supply but higher turnover could be a sign of the impact of a tightening labour market and staff looking at alternative options. Higher turnover also involves significant extra costs in filling vacancies and inducting new staff, and these costs are not always visible. In the context of a widening gap between private sector and public sector pay awards, we and the health services themselves will need to monitor the position carefully.
- 4.63 Whilst recruitment from overseas (via inclusion on the Migration Advisory Committee Shortage Occupation List) provides a short term stop gap, it is not a long term solution. The problem has developed from an earlier underestimation of demand and an unclear projection of supply. But there may be other issues at play, for example while pay may not be the central driver, it will certainly have a role as part of any attraction and retention strategy. Parties are not supportive of a targeted pay response and not confident this would make any real difference, given the lack of supply. However, Nursing and Midwifery Council registration data points to there being a pool of trained staff who are not currently working in the NHS, and pay levels are likely to be one reason for their absence, if not the major one.
- 4.64 The removal of the student bursary for nurses in England and the shift to a more demand-led system could over time lead to a better match between demand and supply. We were told that the aim of this approach is to remove the current constraints on the supply of places to open up more access and increase the number of places. However, the removal of the incentive of the bursary could have an unsettling effect on the number and quality of applications for nursing training places in the early years. In addition, the reduction of net pay in the early years, as nurses repay their loans, will make the employment package and medium to long term reward offer an important factor in attracting high calibre students who are choosing between courses and career options. This is an issue we need to keep under observation and it will be important to look at not only the number, but quality, of students entering NHS careers.

Observation 5

It will be important for the Department of Health and Health Education England to monitor the impact of the removal of student nurse bursaries in England on applications for training places, the numbers entering the profession and the quality of students.

- 4.65 There is some room for scepticism in relation to the published vacancy figures, as they may not capture hard-to-fill vacancies or those occupied by temporary staff. The Scottish vacancy figures define a vacancy "...to be a post which has been cleared for advert after being through the redeployment process (internal or external advert) and remains a vacancy until an individual starts in the post." The Northern Ireland definition is simply "a post which as at 31st March the organisation was actively trying to fill." Figures may therefore reflect a variety of circumstances within a board such as a gap in staffing or the establishment or growth of services into which new staff are being recruited to. A post marked as a vacancy may still be occupied by the previous incumbent and so also included within the staff in post figure. In contrast, some NHS Boards may not recruit where the post is currently being covered by agency staff. At present, we do not have reliable vacancy figures for English trusts, although the survey carried out by NHS Employers for their submission to the Migration Advisory Committee was extremely useful. Health Education England also helped us to understand the levels of shortfall being reported by trusts. We return to the importance of data later in this section.

- 4.66 England, Scotland and Wales have all reformed their workforce planning systems along similar lines, based fundamentally on local demand-based plans aggregated up to a central challenge, oversight and funding authority, which then commissions the places. All of these systems appear to be bedding in. Workforce data, insight and intelligence remain a key challenge for all – to provide a common picture of workforce trends that can enable robust decision-making. Northern Ireland’s workforce planning is carried out at local level.
- 4.67 The challenges of service re-design, developing new roles and commissioning training suitable for these are also common across the UK countries. The importance of the workforce has not had sufficient focus in service transformation efforts to date, though this is improving through, for example, the Jenkins review in Wales which is taking a more holistic approach. It seems to us that there is still a need for an overarching grip on workforce planning and clarity about what is being done nationally and locally, and where there is space for non-degree-based routes into a NHS career. It is not clear to us how far efficiency measures and new workforce models are being factored into the plans in all four countries and therefore how realistic they are, although we appreciate that this is very challenging given the number of factors at play.
- 4.68 Career progression remains a big frustration among staff, and could be something that deters potential applicants in a situation where there are more private sector career or employment options and as loans are introduced in England to fund degree-level training. This could be addressed in workforce re-design and workforce planning. It is not simply about recruiting new staff but understanding how existing staff can be upskilled to take on new and different responsibilities. New care models could provide flexibility and scope to build enhanced and flexible career frameworks for staff, offering more movement across roles and a more multi-skilled workforce. This should also look to address the lack of incentive for staff to take up senior posts because of insufficient differentials and the loss of additional earnings (for example overtime and unsocial hours payments).
- 4.69 There are a number of factors affecting recruitment and retention. It seems to us therefore that a wide-ranging workforce strategy is required in each of the four countries. The Joint Staff Side signalled the need for such an approach in their evidence submission to us and we support this request. This has also been cited in reports from independent sources – for example, Audit Scotland highlighted the need for longer term approach to workforce planning in Scotland,¹⁸ the recent National Audit Office report on managing the clinical workforce supply in England¹⁹ was critical about the current workforce planning arrangements in England and there is already work being taken forward on this in Wales via the Jenkins review.²⁰
- 4.70 An effective strategy, linked to each of the countries’ strategic objectives²¹ should identify the people-related implications of the ambitions, the development of new models of care, and the integration of existing effective delivery approaches. The strategy should explore all aspects relating to the attraction, development and retention of staff, and therefore support staff engagement to deliver wider strategic and operational plans. Greater use of forecasting and scenario planning, including a wider perspective on health and social care trends, would potentially add a level of robustness to avoid future staff shortages similar to those currently being experienced within paramedics and nursing. Workforce plans should be developed in response to local service needs, including the

¹⁸ More information is available from: <http://www.audit-scotland.gov.uk/report/nhs-in-scotland-2015>

¹⁹ More information is available from: <https://www.nao.org.uk/report/managing-the-supply-of-nhs-clinical-staff-in-england/>

²⁰ More information is available from: <http://gov.wales/about/cabinet/cabinetstatements/2015/nhsworkforce/?lang=en>

²¹ The Five Year Forward View in England; the 2020 Vision in Scotland; Prudent Healthcare Principles and the Jenkins review outcome in Wales and Health and Social Care reform and transformation and service configuration in Northern Ireland.

demands on the local health and social care economy as a whole and within the national context. Nonetheless this is not easy as the labour marketplace and demand can vary unexpectedly, and it may well be that all strategies need to consider an element of over-supply to ease pressures on using pay as a solution.

Observation 6

The parties in each of the four countries should develop a strategic workforce framework at national level with local level flexibility. We see this as critical to staff engagement, managing recruitment and retention challenges over the longer-term, aligning a valuable and costly asset to the needs of the service and enabling delivery of a demanding and complex agenda.

- 4.71 Agency spend is increasing across all countries and is having a significant impact on healthcare budgets. The increases seem due to a number of factors:
1. Excess demand that is outstripping supply and requiring use of agency to plug gaps:
 - increased demand for services;
 - need to meet safe staffing levels against a lack of available supply;
 - shortages of staff in specialist areas.
 2. Agencies increasing rates in response to the market demand:
 - charging increased rates for services;
 - offering increased rates of pay for staff.
 3. Workers responding to the choices available:
 - staff doing agency work as a top up to their regular earnings – choosing to work extra hours via enhanced agency rates in preference to overtime or bank work;
 - staff choosing to work via agencies for lifestyle choices and more flexible shifts, perhaps with less responsibility.
- 4.72 Staff are attracted to work for agencies for a variety of reasons; one factor is clearly related to pay and the ability to receive enhanced rates for shifts that are currently more favourable than bank rates or Agenda for Change overtime. However, anecdotal evidence also points to the improved flexibility that agency working can offer and the reduced level of stress. The introduction of price caps and procurement frameworks may go some way to support the reduction of spend here but it remains to be seen how successful this will be given trusts can override these to meet safe staffing levels. There is also a risk that pay caps may reduce viable options for staff to increase their earnings. Trusts and health boards need to go further and consider, as some have done already, how they can incentivise staff to work shifts either through the bank or overtime. This is not just about pay incentives but about offering appropriate flexibility and different employment packages that appeal to different types of worker. We would like to see evidence on how agency controls are working in evidence submissions for our next round.

Observation 7

For our next round we ask the health departments and regulators, as relevant in each country, to provide evidence on agency expenditure by location, staff group and shift type and the range of rates paid.

- 4.73 Workforce data is essential for our analysis and to enable us to make the most effective recommendations. The advent of 'targeted awards' makes the provision of robust data on vacancy levels and attrition rates even more important. In order to ensure we are targeting awards at the right areas we want to be confident in our ability to identify where the issues are and where pay solutions may or may not be warranted.

- 4.74 We are therefore encouraged by the positive progress made on data for this round. We have seen movement in the right direction here and would like to thank parties for their efforts in progressing this. We are pleased at the developments being cited from the health departments in England and Scotland and the assurances provided by the Welsh Government on available workforce planning data. We have also been encouraged by the improved engagement with Health Education England during this round and the sharing of workforce planning data. We will continue to develop this relationship to see how our mutual requirements around workforce information can be met. It is our belief that there is now a commitment for improved evidence in time for our next round and we look forward to receiving this information. The detail of the monitoring data we expect to see and who is providing this is set out in Appendix G.

Observation 8

We would like to see a robust set of data covering fill rates, vacancies, attrition by staff group and geography in the evidence submissions from the health departments, and other agencies as relevant, for our next round.

High Cost Area Supplements

- 4.75 In this section we consider the evidence from the parties on High Cost Area Supplements (HCAS).

Evidence from the parties

- 4.76 The **Department of Health** explained, under national pay scales, NHS pay varies little across the country and by contrast, there was greater pay differentiation in the private sector. It said this meant in comparison to the private sector, the NHS under-rewards working in some areas (London and the South East), and over-rewards working in the rest of the country (particularly in the North). The Department of Health informed us that initial regional level analysis had looked at constructing a relative pay gap measure and even with the inclusion of HCAS payments, London and the South East showed relative pay which was below that of the private sector. The Department of Health stressed it did not yet have a robust evidence base but was planning to develop the analysis further as part of future evidence submissions and building on our work on Market Facing Pay.
- 4.77 **NHS Employers** reported a technical review of High Cost Area Supplements (HCAS) by Frontier Economics had been published in September 2014,²² and concluded there was no strong evidence to suggest that local recruitment and retention issues could be systematically improved by refinement to the current HCAS system. NHS Employers said there had been very limited representations from employers in relation to adjusting the value of the existing HCAS payments. They told us there was a general concern that any increase to the percentages of pay used in the existing payments would mean additional (unfunded) cost, and would put further pressure on service delivery. NHS Employers said the general view from employers seemed to be that the minimum and maximum levels should be increased in line with the overall pay uplift.
- 4.78 **NHS Providers** said whilst some members considered HCAS do provide an incentive to staff to move to high cost areas, other central London based members pointed out HCAS for their areas had not kept up with the increases in the cost of living, particularly in respect of housing, and while better than nothing, were not fully covering higher living costs. NHS Providers explained at the same time, some members on the edge of London reported difficulty retaining staff who can earn more money by commuting to and working at central London providers. NHS Providers said they would not support

²²Frontier economics, 2014, High Cost Area Supplements for NHS Agenda for Change staff in England.

the targeting of a 1 per cent award at trusts in high cost areas, if this meant staff at other trusts would receive less than 1 per cent. They said such targeting was likely to be divisive and did not offer sufficient scope for closing the gap between HCAS and the cost of living in London. NHS Providers told us they would support a review of HCAS as part of the much needed reform of the wider Agenda for Change agreement.

Our comment

- 4.79 The evidence we have received for this round has not proposed that there should be any changes to HCAS. There is, however, an emerging picture that points to additional pressures in London and surrounding areas where vacancies and shortages seem more pronounced. This has been demonstrated in shortfall data shared by Health Education England, the NHS Employers evidence to the Migration Advisory Committee on the national shortages of nurses and the Department of Health evidence on agency spend, which shows a higher level of vacancies and higher use of agency staff in London and the south east.
- 4.80 The evidence base this year is not yet developed or robust enough to indicate that a targeted pay response is required at this time. Evidence from employers indicates this might require separate funding, and employers showed no enthusiasm for finding resources within an overall 1 per cent pay bill increase. However, it seems to us highly possible that in future, a pay solution may be required. We will be returning to this in future rounds and would like parties in England to develop their evidence base accordingly.

Observation 9

We ask all parties in England to develop their evidence base around comparative pay levels, vacancy and attrition data for HCAS sites and surrounding areas.

Recruitment and Retention Premia

- 4.81 In this section we consider the trend for Recruitment and Retention Premia (RRP) across the countries of the United Kingdom and examine how well these pay flexibilities are working.

Evidence from the parties

- 4.82 The **Department of Health** explained RRP were designed to address short or long term recruitment and retention pressures but must be objectively justified to ensure that staff receive equal pay for work of equal value. It said the payment of RRP was a key indicator of local recruitment and retention pressures. The Department of Health said trusts may also be using other RRP measures or incentives, some pay-related, which are not recorded as RRP. The Department of Health said the latest figures showed a continuation of the downward trend in the proportion of staff receiving an RRP payment.

- 4.83 **NHS Employers** reported that evidence suggested employers had only needed to make limited use of this flexibility. They believed this was largely because NHS rates and the overall employment package remained competitive. They told us that currently circa 9,500 (1.0 per cent) of FTE staff received RRP²³ and there were 7,000 (0.7 per cent) fewer staff in receipt of an RRP than in April 2014.²⁴
- 4.84 **NHS Providers** said it was noteworthy some trusts were interested in being granted autonomy to target a pay award locally. They believed the appeal was that trusts could then use the pay award to address the recruitment and retention issues they faced locally in a way that targeting a pay award at national level may not be able to do. NHS Providers told us underlying this was the assumption that, while there are common recruitment and retention issues faced by trusts across England, there may also be issues specific to, or particularly acute for, individual trusts. An additional appeal of autonomy to target a pay award locally, over and above using RRP, may also be on the expectation that a pay award would be funded through local and national contracts, whereas RRP are not.
- 4.85 The **Scottish Government** reaffirmed that there were a small number of RRP in place in NHSScotland to help attract staff to specific locations. These included well established long term RRP in place for staff working in the State Hospital and for staff working in Scotland's three Medium Secure Units within Tayside, Lothian and Greater Glasgow and Clyde. A number of north of Scotland NHS Boards had also put in place local RRP to allow them to compete with the oil and renewables industry for trades such as electricians and plumbers. NHS Shetland, NHS Orkney, NHS Western Isles, NHS Highland, NHS Grampian and the Scottish Ambulance Service based in Aberdeen all have RRP in place for qualified maintenance personnel. The only other RRP currently in place was for NHS Western Isles to assist them in recruiting Band 7 pharmacy staff.
- 4.86 **The Royal College of Nursing (Northern Ireland)** believed there was compelling evidence to support the introduction of a retention and recruitment premium for band 5 nurses in Northern Ireland. It said HSC trusts had advertised and re-advertised band 5 vacancies in relevant local, regional and national press, with little success and the independent private nursing home sector had repeatedly tried to recruit at national and international level with negligible impact.

Our comment

- 4.87 Recruitment and retention premia (RRP) are the mechanism within Agenda for Change that enable the targeting of pay by professional group. These can either be applied locally or nationally. Despite recruitment and retention pressures, use of local RRP is either static or, in the case of England is diminishing. We believe that this is not necessarily reflective of a drop in need but is being influenced by the need to make cost savings and trusts and health boards having to find funding for RRP from local budgets not reflected in the tariff. There is a fear of introducing payments that will be difficult to remove and of the potential impact on neighbouring trusts and health boards of staff moving from one site to another. There is also evidence to suggest that trusts and health boards are using other local incentives to attract and retain staff. These include relocation packages, 'golden hellos' and paying for training and development.

²³ NHS Employers Estimates, taken from April 2015 ESR Data Warehouse Staff in Post query of Agenda for Change staff, scaled to NHS Hospital and Community Health Service (HCHS) monthly workforce statistics – April 2015, Provisional Statistics <http://www.hscic.gov.uk/catalogue/PUB18319/nhs-work-stat-jun-2015-nat-tab.xls>

²⁴ NHS Employers Estimates, taken from April 2014 ESR Data Warehouse Staff in Post query of Agenda for Change staff, scaled to NHS Hospital and Community Health Service (HCHS) monthly workforce statistics – April 2014, Provisional Statistics <http://www.hscic.gov.uk/catalogue/PUB18319/nhs-work-stat-jun-2015-nat-tab.xls>

- 4.88 In Scotland the approach to RRP is more centralised as all applications need to be approved in partnership at a national level by the Scottish Terms and Conditions Committee before they can be implemented. In practice this makes it less likely for such payments to be used and more challenging for boards to tackle local issues. More flexibility for health boards to use RRP as they were originally intended could help here.
- 4.89 RRP remain an important flexibility and offer a useful tool to health trusts and boards address emerging shortages and falling retention rates for key groups. Avoiding their use on cost grounds alone would seem a very short term strategy – the costs of recruiting, and use of agency or overtime, are likely to prove more expensive over the long term, and are not conducive to good quality patient care and continuity. In our view local targeting of pay will generally be a better, more flexible approach than trying to target using a national award, which is too blunt a tool to respond to local differences and risks adding in expense at the wrong places. RRP could be used in conjunction with other local incentives to target groups on recruitment and retention grounds. There is work that could be done to develop and share best practice and encourage trusts and health boards to develop their local offer in both pay and non-pay terms. We pick this up again in Chapter 6 in the context of the longer term approach to targeted pay awards.
- 4.90 The Royal College of Nursing (Northern Ireland) told us they believed there was a case for a national RRP for Band 5 nurses in Northern Ireland. However, we did not receive any detailed evidence to support this nor did we have the sufficient time available, due to the late Northern Ireland remit, to consider the position in this report. If the Royal College of Nursing (Northern Ireland) believe there is evidence to support this then it should provide a detailed submission for us to consider ahead of our next report. We were asked to consider a national RRP for paramedics in a joint submission from UNISON, Unite and GMB. Our consideration and conclusions on this are set out in Chapter 5 of this report.

Motivation

- 4.91 An essential part of the evidence gathering process, and in line with our terms of reference, is understanding the position on motivation. This encapsulates staff motivation for the role, satisfaction with the working experience and the degree to which staff are engaged in what needs to be done, including the willingness for staff to embrace necessary change. In this section we consider the latest sickness absence rates, progress on implementing changes to the appraisal system and levels of staff engagement (including recent staff survey results). We also review the evidence from the parties.

Sickness Absence

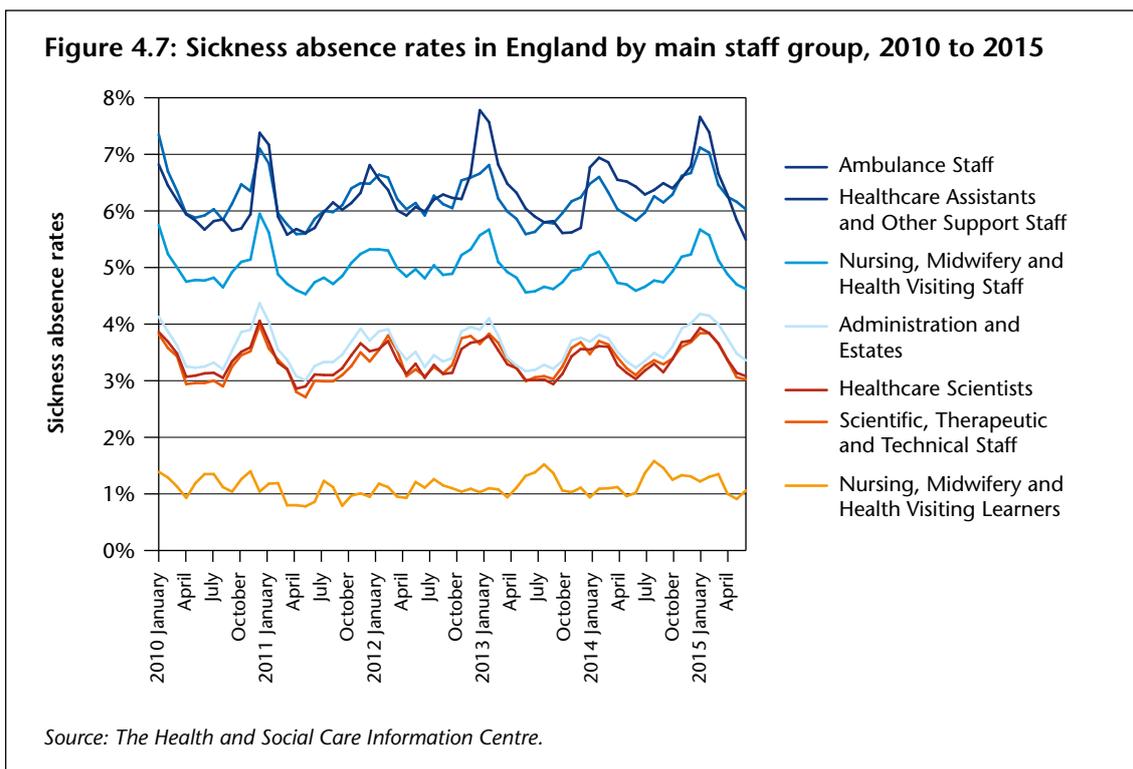
- 4.92 Sickness absence rates are calculated as the percentage of working hours lost through sickness absence. Table 4.5 shows the latest figures for England, Wales and Scotland. Whilst rates between England and Wales are comparable (as they use the same electronic staff register) Scotland and Northern Ireland calculated these rates slightly differently so therefore the table should only be used to monitor trends within a country. The figures are not seasonally adjusted so when comparing the rates between years for the same quarters there is little change in sickness rates. Given there is no seasonal adjustment, as would be expected, the quarters in the colder part of the year (Q4 and Q1) tend to have higher sickness absence rates than the warmer quarters in the year (Q2 and Q3).

Table 4.5: Sickness absence rates within the NHS by country (FTE)

	England Wales		Scotland		N. Ireland	
Q1 2010	4.5%	5.3%	full year 2009/10	4.8%	6 months to Mar 2010	5.9%
Q2 2010	3.9%	4.7%				
Q3 2010	4.0%	4.9%			6 months to Sep 2010	5.3%
Q4 2010	4.5%	5.4%				
Q1 2011	4.2%	5.1%	full year 2010/11	4.7%	6 months to Mar 2011	5.6%
Q2 2011	3.8%	4.7%				
Q3 2011	4.0%	4.9%			6 months to Sep 2011	5.0%
Q4 2011	4.4%	5.4%				
Q1 2012	4.4%	5.4%	full year 2011/12	4.6%	6 months to Mar 2012	5.5%
Q2 2012	4.0%	5.1%				
Q3 2012	4.1%	5.3%			6 months to Sep 2012	5.3%
Q4 2012	4.5%	5.8%				
Q1 2013	4.4%	5.5%	full year 2012/13	4.8%	6 months to Mar 2013	5.7%
Q2 2013	3.9%	5.1%				
Q3 2013	3.9%	5.2%			6 months to Sep 2013	N/A
Q4 2013	4.3%	5.7%				
Q1 2014	4.3%	5.7%	full year 2013/14	4.8%	6 months to Mar 2014	N/A
Q2 2014	3.9%	5.2%				
Q3 2014	4.1%	5.5%			6 months to Sep 2014	N/A
Q4 2014	4.6%	5.9%				
Q1 2015	4.4%	5.6%	full year 2014/15	5.0%	6 months to Mar 2015	N/A

Sources: The Health and Social Care Information Centre, Welsh Government (StatsWales), Information Services Division Scotland, the Department of Health, Social Services and Public Safety Northern Ireland.

4.93 Figure 4.7 shows sickness absence rates by staff group in England between 2010 and 2015. Between January and March 2015 the average NHS sickness absence rate was 4.4 per cent. Low reported rates of sickness absence for medical and dental staff (not shown) served to bring down the overall average. Ambulance staff; healthcare assistants and other support staff; and nursing, midwifery and health visiting staff groups had higher than NHS average sickness absence rates. The Office for National Statistics publish UK estimates for the whole economy, the latest estimate (for 2013)²⁵ is that 2 per cent of hours are lost to sickness absence. These vary by gender (1.6 per cent for men and 2.6 per cent for women) and of the larger public sector organisations sickness rates are highest for those working in the health sector. The largest workforces in the economy report highest sickness levels (2.3 per cent for 500+ employees).



Appraisal and the Knowledge and Skills Framework

4.94 Table 4.6 shows that appraisal rates in the latest staff survey (England) are broadly similar to the previous two years (around 83 per cent) having increased from 65 per cent in 2008. However it remained the case that under 40 per cent of staff considered that their appraisal was “well-structured”. In general the clinical staff groups had higher appraisal rates than non-clinical staff. Equivalent data is not available for Scotland, Wales and Northern Ireland.

²⁵ More information on the latest estimate (for 2013) is available from: <http://www.ons.gov.uk/ons/rel/lmac/sickness-absence-in-the-labour-market/2014/rpt---sickness-absence-in-the-labour-market.html>

Table 4.6: Staff appraisals, training and development, summary results from the National NHS Staff Survey, 2011 to 2014, England, excluding medical and dental staff

Measure	2011	2012	2013	2014	Highest in 2014		Lowest in 2014	
% staff receiving job relevant training & development in last 12 months ¹	76.6	81.0	80.3	80.4	87.0	Health visitors	73.3	Admin and clerical staff
% staff appraised in last 12 months	79.0	83.2	83.8	83.5	89.5	Midwives	77.2	Ambulance staff
% staff with a well structured appraisal in last 12 months ²	34.8	36.7	38.0	37.8	48.3	General managers	32.3	Midwives

Source: England NHS Staff Survey. Results are unweighted.

¹ Changes made to improve and shorten the survey in 2012 mean that the training levels are not directly comparable with previous years. Since 2012 this key finding was derived from 10 questions whereas before this, it had been derived from almost 20 questions.

² Derived by asking staff whether the appraisal / review: "helped them to improve the way they did their job"; "helped them to agree clear objectives for their work"; and "left them feeling that their work was valued by their organisation".

Staff Engagement

4.95 Table 4.7 provides an update to table 4.3 in the 28th report, on trends in responses to some individual staff survey questions for all non-medical staff in England. For non-medical staff in England, between 2013 and 2014:

- average scores²⁶ for job satisfaction and staff motivation remained flat;
- in general the clinical staff groups had higher appraisal rates than non-clinical staff. For non-medical staff as a whole, the appraisal rate was similar to that in 2013;
- there was a small increase in the percentage of staff working extra hours and therefore, not unexpectedly, there was also a small increase in work pressure; and
- the percentage of staff feeling satisfied with the quality of work and patient care they were able to deliver decreased slightly in 2014.

4.96 Other notable headlines from the staff survey included:

- a further reduction (of 5 percentage points) in the percentage of staff satisfied or very satisfied with their level of pay – this has decreased for a fourth year in succession;
- general managers²⁷ tended to answer most positively about the various aspects of their job, whilst the unqualified clinical staff answered most negatively; and
- more staff in clinical staff groups received job relevant training and development in the last 12 months compared to non-clinical staff groups.

²⁶ Average scores, on a scale from 1 to 5, are derived by assigning numbers to a series of responses (e.g. 1 = very dissatisfied / strongly disagree; 5 = very satisfied / strongly agree), and calculating the average score.

²⁷ The occupational groups are self-selected by the respondent to the survey. General managers may include Very Senior Managers, but excludes non-executive directors. The survey also asked that if as a manager they could choose another occupation group from elsewhere in the list, to select that other occupational group. Therefore, a nursing director should have chosen a relevant nursing occupation rather than general manager.

Table 4.7: Summary results from the National NHS Staff Survey, 2009 to 2014, England, excluding medical and dental staff

Measure	2009	2010	2011	2012	2013	2014	Trend ¹
Workload							
Work pressure felt by staff ^{2,3}	3.07	3.06	3.09	3.06	3.08	3.09	
% staff working extra hours ²	64.3	64.5	64.1	69.1	69.9	70.4	
% staff suffering work-related stress in last 12 months ²	28.5	29.4	30.4	38.6	39.6	40.0	
Training and appraisals							
% staff receiving job-relevant training, learning or development in last 12 months	79.2	77.8	76.6	81.0	80.3	80.4	
% staff appraised in last 12 months	69.8	77.1	79.0	83.2	83.8	83.5	
% staff having well structured appraisals in last 12 months	32.0	35.2	34.8	36.7	38.0	37.8	
Engagement and job satisfaction							
Staff job satisfaction ³	3.53	3.54	3.51	3.59	3.60	3.60	
within which:							
support from immediate managers ³	3.68	3.70	3.68	3.66	3.68	3.68	
Staff recommendation of the Trust as a place of work or to receive treatment ³	3.51	3.50	3.47	3.57	3.60	3.61	
Staff motivation at work ³	3.85	3.80	3.78	3.81	3.82	3.81	
Patients at the heart							
% staff feeling satisfied with the quality of work and patient care they are able to deliver	73.41	73.02	72.83	77.11	76.64	76.26	
% staff agreeing that their role makes a difference to patients	89.74	88.85	88.75	89.04	89.40	89.30	
Harassment, bullying and abuse							
% staff personally experiencing harassment, bullying or abuse at work in the last 12 months from...							
Patients/service users, their relatives or other members of the public ²				29.50	28.88	28.24	
Managers/team leader or other colleagues ²				22.98	23.28	23.75	

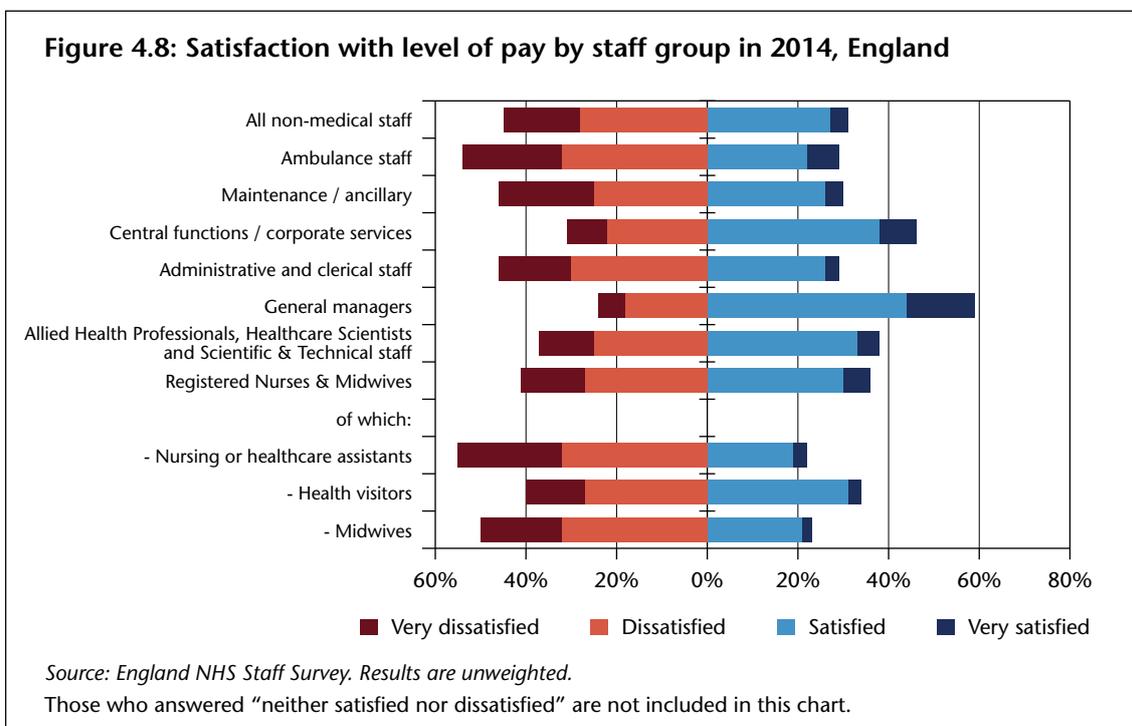
Source: England NHS Staff Survey. Results are unweighted.

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

² Lower scores are better in these cases, however, in all other cases, higher scores are better.

³ Results are on a scale of 1 to 5.

4.97 In 2014 (the latest year) figure 4.8 shows responses to the satisfaction with pay question for all non-medical staff groups (responses of “neither satisfied nor dissatisfied” are not shown). The largest change in opinion from 2013 to 2014 was in the satisfaction with pay question. In 2014 there was a 5 percentage point decrease in satisfaction; relative to the other changes, this change is very large. General managers had the largest percentage of staff giving positive views about their level of pay, and smallest negative²⁸ percentage (general managers have held this position since 2007). All these figures do not take account of either the 2015 settlement or the latest public sector pay policy.



4.98 The NHS Scotland Staff Survey results were published in December 2015. 60,681 staff completed the survey. This is a 38 per cent response rate and is a 3 per cent increase on the participation rate in 2014. Overall findings from the 2014 survey were:

- Overall around half of the combined positive perceptions are slightly lower than in 2014;
- Eight of the questions showed no change at all in combined responses;
- Fifteen questions showed a -1 per cent change;
- Two show a -2 per cent change and four show positive changes of between 1 and 3 per cent.

4.99 Some of the average changes in experience under Staff Governance Strands are as follows:

- Well informed -0.8 per cent;
- Appropriately trained and developed -0.6 per cent;
- Involved in decisions -0.75 per cent;
- Treated fairly and consistently +0.2 per cent;
- Provided with a continuously improving and safe working environment +0.13 per cent;
- Overall experience of working for NHS Scotland -1 per cent.

²⁸That is expressing themselves as ‘dissatisfied’ or ‘very dissatisfied’.

4.100 Table 4.8 shows the most positive perceptions and their percentage changes on combined positive responses comparing 2014 and 2015 (combined negative responses also shown for completeness).

Table 4.8: NHS Scotland 2015 Staff Survey – the most positive perceptions and their percentage changes

Question Number	Question	Positive Response %		Negative Response %	
		(change on 2014 shown in brackets)		(change on 2014 shown in brackets)	
6.3	I am happy to go the 'extra mile' at work when required	89%	(-1%)	4%	(+1%)
1.4	I am clear what my duties and responsibilities are	85%	(-1%)	2%	(0%)
6.7 (new)	I have confidence and trust in my direct line manager	79%	(NA)	21%	(NA)
4.2	I get the help and support I need from colleagues	79%	(0%)	6%	(0%)
6.5	I still intend to be working with [Health Board] in 12 months time	77%	(-2%)	7%	(0%)
1.5	I understand how my work fits into the overall aims of [Health Board]	77%	(-1%)	5%	(0%)

[These are questions where a high positive score would be a GOOD result]

4.101 Table 4.9 shows the least positive perceptions and their percentage changes on combined positive responses comparing 2014 and 2015 (combined negative responses also shown for completeness).

Table 4.9: NHS Scotland Staff Survey - the least positive perceptions and their percentage changes

Question Number	Question	Positive Response %		Negative Response %	
			(change on 2014 shown in brackets)		(change on 2014 shown in brackets)
3.1	Staff are always consulted about changes at work	28%	(-1%)	47%	(+1%)
5.2	There are enough staff for me to do my job properly	33%	(0%)	45%	(-1%)
3.4	I have a choice in deciding what I do at work	40%	(0%)	25%	(+1%)
1.3	When changes are made at work, I am clear how they will work out in practice	40%	(-1%)	30%	(0%)
3.3	I am confident my ideas or suggestions would be listened to	41%	(-1%)	31%	(+1%)

[These are questions where a high positive score would be a GOOD result]

Note: All questions in the above table used a 5 point response range. Positive and negative responses are based on combining all relevant responses on the five point response scale.

4.102 The five most and least positive perceptions in the 2015 survey are the same as the five most and least positive perceptions in the 2014 survey (with the exception of the new question (6.7) "I have confidence and trust in my line manager"). Compared with 2014 the responses to these have stayed largely the same with either 0 or 1 per cent difference. Negative perceptions appear to centre on the issues of change management and staff shortages. Positive themes are around line management, team working and commitment to the job. There is not an equivalent question around satisfaction with levels of pay included in the Scottish Government survey.

Evidence from the parties

4.103 The **Department of Health** said it may be too early to make decisions on the effectiveness of the changes introduced through the 2013 Agenda for Change agreement and it was clear a fundamental move away from near automatic incremental pay would take time. It said the NHS Staff Council had recently agreed to joint visits (a partnership of NHS trades unions and NHS Employers) to trusts that had implemented the agreement to understand better the barriers and opportunities for sharing best practice and assessing what more the Staff Council (and Department) could do to increase take up of these national flexibilities and to help trusts implement the national agreement. The Department of Health said making this work as intended relied on improved HR capability and capacity to enable organisations locally to realise the benefits.

4.104 The Department of Health said ensuring the NHS is a place staff want to work is not just about pay, and the NHS must work hard to improve the capability and capacity of the HR community and system leaders so they can bring staff with them as they seek to reform health care systems and national employment contracts. It said good leadership and effective staff engagement strategies will help improve morale and high levels of staff engagement were linked to patient satisfaction and improved outcomes.

- 4.105 The Department of Health told us measures of staff engagement in the staff survey and in the Friends and Family Test (FFT) remained largely positive. The trend for motivation – “the extent to which staff look forward to going to work, and are enthusiastic about and absorbed in their jobs” had been fairly stable but with some variation across trust types showing that there is scope for improvement. Pay satisfaction had dipped (from 38 per cent to 33 per cent) and was understandable given the consolidated pay award for most employed NHS staff was around 2 per cent over the last parliament. NHS England’s most recent “staff friends and family test” survey had shown the majority of staff (63 per cent) would recommend their trust as a place of work and 79 per cent would recommend their trust as a place to receive care. The 2014 NHS Staff Survey score for overall staff engagement had remained reasonably high (3.70/5) and despite the pressures on NHS staff, the engagement score for groups such as registered nurses and midwives had risen from 3.71/5 (2012) to 3.81/5 (2014). The Department was clear there was no room for complacency given the overall NHS staff engagement score had fallen slightly (from 3.71/5 in 2013).
- 4.106 The Department of Health said in terms of wellbeing, key staff survey indicators had shown small changes compared with results from 2013: work pressure felt by staff in 2014 was 3.09/5 (up from 3.06/5); staff working extra hours had also risen in 2014 to 71.46 per cent (up from 70.47 per cent) and 39.50 per cent of staff (up from 38.6 per cent) reported suffering work related stress in the last 12 months. Overall sickness levels had dropped slightly (from 3.95 per cent to 3.94 per cent) for the reporting period June 2014 to June 2015, and the overall trend remained fairly stable and lower than the 2009 estimate (4.48 per cent) when work began on addressing sickness in the NHS following the Boorman report.
- 4.107 The Department of Health informed us there was a wealth of activity across the service addressing these issues, that it recognised the pressures facing the service and the importance of employers maintaining staff motivation. It said progress had been made but much remained to be done and the degree of variation was too wide. The Department said it had developed a framework to help employers across the NHS in England improve their staff experience through better engagement and improved health and wellbeing with NHS Employers providing advice, guidance and good practice.
- 4.108 **NHS Employers** informed us that, according to evidence from the NHS Staff Survey, appraisal rates had remained consistent in the last few years (at 85 per cent). NHS Employers reported that local employers had worked hard to introduce the new performance management and appraisal arrangements in response to the 2013 agreement.²⁹ NHS Employers said the extent to which these flexibilities had been used by trusts varied because of different local challenges and priorities faced by employers. They told us some trusts had opted for a phased approach where new performance arrangements were implemented in stages with higher bands moving to the new policy first and lower bands following thereafter. NHS Employers said some organisations reported difficulties in making full use of the new flexibilities and had worked hard to engage with local staff and staff representatives in developing new performance criteria. The prolonged national industrial dispute over pay during 2014 and pressures on local management capacity meant progress had been slower in some places. NHS Employers said some of the benefits to the new approach reported by employers to date included an increase in the level of appraisals (with trusts due to focus on the quality as a next step); an increase in the level of mandatory training being reported; better alignment

²⁹The changes allowed employers the flexibility to design local approaches for better linking incremental pay progression with performance. Local employers were able to define the levels of performance that were required for pay increments to be awarded. The aim was that NHS organisations would use the new pay flexibilities in a way that supported their organisational priorities and objectives.

of trusts' core values and required staff behaviours; and greater flexibility in terms and conditions allowing trusts to develop local solutions to managing pay progression linked to how employees deliver quality patient care.

- 4.109 NHS Employers reported a small fall in the overall staff engagement index from 3.71 to 3.70 in 2014; this was following a sustained improvement. NHS Employers said this was disappointing and did not reflect the hard work of organisations to develop and improve engagement with their staff. NHS Employers believed sustaining this level of engagement in the context of current pressure on the service was an achievement. They told us the index remained higher than when it was introduced and higher than for comparable measures in the other large scale surveys. NHS Employers said the fall was largely driven by falls in the component scores for motivation (made up of measures of enthusiasm and satisfaction) and willingness to recommend the service. NHS Employers believed motivation factors had been affected by the increasing demand for NHS services, higher workload and concern over staffing levels.³⁰ They said there may also have been a spill-over effect from unhappiness about pay levels, as the survey question on pay had moved to net dissatisfaction and the period of survey data collection happened in a context of ongoing industrial action and continued pay restraint, which would be expected to have some impact. NHS Employers said, although lower than in 2013, commitment to the job role had remained high and advocacy levels remained relatively positive with a majority of staff willing to recommend their employer as a place to work.
- 4.110 **NHS Providers** told us they recognised the need to reward staff appropriately and fairly, to support recruitment and retention and a motivated workforce, however it was important that changes in workforce costs were appropriately reflected in the prices providers are paid for delivering services and the contracts they have in place with commissioners. NHS Providers said 78 per cent of members responding to their survey had reported having an incremental pay progression policy in place (linking pay and performance) and some of the remaining 22 per cent had indicated they were in the process of introducing a policy. NHS Providers believe this suggested that NHS providers are increasingly making use of this element of the 2013 Agenda for Change reforms.
- 4.111 The **Scottish Government** said it had noted our observations regarding the application and simplification of the NHS Knowledge and Skills Framework. The Scottish Government confirmed it had taken a conscious decision not to adopt the simplified approach brought in in England in 2010, and through its Partnership approach to workforce matters there was currently no plans to implement the UK Government's approach to progression. The Scottish Government said it was, however, participating in the UK review of Agenda for Change, which was examining the link between performance and progression, and it would come to a conclusion on the correct way forward for Scotland once the outcomes of this process are known. The Scottish Government said it had also been reviewing the content of the KSF to ensure continuing relevance of the framework within the context of the NHS in Scotland. The Scottish Government reported this work had progressed well and revised, easier to understand language (to be used in the core dimensions) had been agreed and was due to be published by end March 2016. In addition a refresh of the accompanying guidance was being finalised with an emphasis on ensuring all staff have a meaningful discussion around performance, learning and development and career aspirations in line with its workforce strategy 'Everyone Matters'.

³⁰ NHS Staff Survey unweighted results are available from: 2014: <http://www.nhsstaffsurveys.com/Page/1019/Latest-Results/Staff-Survey-2014-Detailed-Spreadsheets/>
2013: <http://www.nhsstaffsurveys.com/Page/1040/Past-Results/Staff-Survey-2013-Detailed-Spreadsheets/>

- 4.112 The Scottish Government said the workforce was crucial to delivering the 2020 Vision for Health and Social Care³¹ which is *“that by 2020 everyone is able to live longer, healthier lives at home or in a homely setting”*. It told us the Everyone Matters: 2020 Workforce Vision,³² published in June 2013, was the workforce policy for NHSScotland and makes a commitment to valuing the workforce and treating people well. It sets out the workforce aspects that need to change and be done better by 2020 and makes a commitment to address these issues. The Scottish Government said the NHSScotland staff survey sought staff views on how they are managed and how they feel they are managed, participation rates had increased by 3 percentage points from 2014 to 2015. The Scottish Government confirmed this was the highest participation rate of the survey since its inception and was indicative that levels of staff engagement had improved in the last 12 months. The Scottish Government said, the NHSScotland Staff Survey provided the main national measure of staff experience but the response rate (38 per cent for 2015) was still low and meant a large proportion of the NHSScotland workforce were not participating. It said recent discussions had taken place looking at different options to refresh the approach to national staff experience and encourage higher rates of participation. The Scottish Workforce and Staff Governance Committee (SWAG) was considering the future measurement of national staff experience alongside the development and roll out of the iMatter continuous improvement tool as a means to improve response rates.
- 4.113 The **Welsh Government** said in 2010/11 the rate of sickness was the lowest it has been in the last seven years, with a rolling 12 month average of 5 per cent. It told us this had risen to 5.4 per cent in both 2012/13 and 2013/14 and again in 2014/15 to 5.6 per cent. The Welsh Government said just over 42 per cent of the reasons for sickness in 2014/15 were Musculoskeletal and Anxiety/Stress, proportionally staff aged between 55-60 years were the most stressed and from age 55 and over, proportionally more NHS staff suffer from musculoskeletal injuries. The Welsh Government said, without any other intervention, there was potential sickness would continue to increase in the future given the ageing NHS workforce. The Welsh Government confirmed it had been monitoring progress by NHS organisations to reduce sickness absence levels and had supported their work with monies made available via the Invest to Save fund. It said local health board’s and NHS trusts were required to produce sickness absence management action plans, aimed at improving the management of sickness absence in their respective organisations and had been providing six monthly updates. As part of this exercise, NHS organisations were also required to confirm they were satisfying the ten fundamental standards developed in partnership with the NHS Wales Health & Well-being Group.
- 4.114 The Welsh Government informed us that the last NHS Wales staff survey was undertaken in 2013 and was responded to by around 27 per cent of the NHS workforce. The Welsh Government confirmed that NHS organisations had received their individual reports in May 2013 and were requested to work in partnership to develop action plans to address the outcomes of the survey for their respective organisations. The Welsh Government said organisations had been assisted in addressing the survey outcomes through supportive tools commissioned and developed by the Working Differently – Working Together Programme Board.
- 4.115 The Welsh Government told us the Minister for Health and Social Services had approved the development and funding for the next NHS staff survey to take place in June 2016. It said in the interim organisations were using pulse surveys based on the ‘Working Differently, Working Together’ guidance. The Welsh Government said the overall engagement index for NHS Wales was 55 per cent. Those working in senior management had the highest level of engagement (69 per cent), ambulance staff

³¹ A Route Map to the 2020 Vision for Health and Social Care is available from: <http://www.gov.scot/Resource/0042/00423188.pdf>

³² More information on Everyone Matters: 2020 workforce vision is available from: <http://www.gov.scot/Publications/2013/06/5943>

had the lowest: ambulance technicians (31 per cent) paramedics (32 per cent) and ambulance control staff (35 per cent). The Welsh Government reported the key message from the engagement index was that while more than four in five (86 per cent) of employees would go the extra mile for their organisation, much lower proportions felt able to contribute to improvements in their workplace, in particular, only 37 per cent felt involved in deciding on the changes that affect their work.

- 4.116 The **Northern Ireland Executive** told us HSC employers in Northern Ireland remained committed to the Knowledge and Skills Framework in line with the Agenda for Change national agreement. The Northern Ireland Executive reported a regional group, comprising management and trade union representation from all HSC organisations was meeting on a regular basis to share knowledge, develop and disseminate good practice and monitor progress. The group reports in to the Regional Joint Negotiating Forum.
- 4.117 The Northern Ireland Executive were unable to share the HSC Staff Survey reports prior to publication of our report. The Northern Ireland Executive were also clear that the sickness absence rates reported in the Royal College of Nursing (Northern Ireland) evidence were not based on official figures and rates could not be compared with England as these were calculated differently.
- 4.118 The **Joint Staff Side** asked us to reflect on the impact of pay restraint on the declining state of morale and motivation across the NHS workforce. It told us recent workforce surveys undertaken both by Staff Side and by the NHS showed declining levels of morale over the past few years, attributable to various factors. These included dissatisfaction with levels of organisational change, rising workloads and staff shortages as well as the failure of pay levels to keep up with the cost of living. The Joint Staff Side said all of these factors combined towards the workforce feeling undervalued.
- 4.119 The Joint Staff Side believe improving staff engagement is a key way of improving productivity and cite the findings of the Kings Fund research 'Employee Engagement and NHS Performance' (2012) which analysed the data from the NHS Staff Survey. The Joint Staff Side said the research had indicated employee engagement was linked to a variety of individual and organisational outcome measures, including staff absenteeism and turnover, patient satisfaction and mortality, and safety measures, including infection rates. The Joint Staff Side told us these results had been replicated in other research conducted by West and Dawson which found there were particular factors, such as good staff management, important in ensuring good staff engagement. The Joint Staff Side said this included well-structured appraisals, setting out clear objectives and ensuring the employee feels valued by the employer.
- 4.120 The Joint Staff Side reported that findings from the 2014 NHS Staff Survey for England indicated effective appraisals were far from widespread in the NHS. It reported that whilst 83 per cent of staff had an appraisal, only 54 per cent said it helped them improve how they do their job, 78 per cent felt the appraisal helped them to agree clear objectives for their work and only 62 per cent said it left them feeling that their work is valued by their organisation. The Joint Staff Side said key results from the September 2014 Incomes Data Services (IDS) survey³³ had shown worryingly high numbers of staff were not given training, development and appraisals; did not feel supported; or that they had the time and resources available to do their job to a high standard; and had seriously considered leaving the NHS.

³³The survey was commissioned by the Joint Staff Side as part of its 2014 submission to the NHSPRB.

- 4.121 The Joint Staff Side told us that it was important that recommendations from the Boorman Report³⁴ and the Working Longer Group³⁵ were implemented. The Joint Staff Side said the Boorman report had set out a number of key recommendations to improve the health and wellbeing of the NHS workforce, including cost savings that could be gained from investing in staff health and wellbeing. The Joint Staff Side said the interim report of the Working Longer Group had made eleven recommendations which would help organisations utilise the skills and knowledge of experienced staff by giving them the necessary support to work longer. The argument presented in the Joint Staff Side evidence for investing in staff engagement, wellbeing and training and development (including the implementation of the recommendations of these reports) was also supported in separate trade union submissions.
- 4.122 The **Royal College of Nursing** reported feedback from its regional focus groups, where its representatives reported staff shortages were leading to high levels of exhaustion and low morale among nursing staff and that sickness absence rates were increasing. The Royal College of Nursing said staff feel frustrated because they are unable to give the high standard of care they would like and worry about the impact on patient care and safety. The Royal College of Nursing said stress was the single biggest cause of sickness absence in the UK and its prevalence was particularly high among nursing staff. It told us the NHS 2014 Staff Survey for England reported 41 per cent of qualified nurses and 37 per cent of HCAs had felt unwell as a result of work related stress in the previous 12 months, compared to 38 per cent of all NHS staff.
- 4.123 The Royal College of Nursing told us it was encouraging that a high number of respondents (70 per cent) to its 2015 Employment Survey continued to view nursing as a rewarding career, however, just two-fifths (41 per cent) had said they would recommend nursing as a career (compared to 44 per cent in 2011). The Royal College of Nursing believe this reflected a growing reluctance among nursing staff to recommend the profession as a career, particularly to their own family members. The Royal College of Nursing told us, according to the 2014 NHS Staff Survey for England, 41 per cent of registered nurses and midwives (compared to 35 per cent in 2013) and 55 per cent of Health Care Assistants (compared to 45 per cent in 2013) were dissatisfied with their level of pay. The Royal College of Nursing also reported findings from its 2015 Employment Survey where 42 per cent of respondents working in the NHS stated their level of pay or band was inappropriate given their role and responsibilities (compared to 41 per cent in 2013). The Royal College of Nursing said focus group participants reported a growing number of older nursing staff were deciding to leave their jobs; a major factor was reported to be perceived uncertainty over the future of unsocial hours payments, as well as nursing staff preferring to take early retirement rather than risk any future, detrimental change to their pension.
- 4.124 The Royal College of Nursing asked us to support its call for a national workforce strategy to take a coordinated approach to pay, terms and conditions, workforce supply, training and development, career progression, working environment and job design, health and wellbeing at work and staff management. This request was also supported by Joint Staff Side and individual trade unions.

³⁴The Boorman report was published in November 2009 and is available from: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108907.pdf

³⁵The Working Longer Group was established to assess the impact of working beyond 60 in the NHS and to consider how NHS staff will continue to provide safe and quality care when they are working longer. National Staff Council (2014) Working Longer Review: Preliminary findings and recommendations report for the Health Departments is available from: www.nhsemployers.org/-/media/Employers/Documents/Pay%20and%20reward/WLR%20Preliminary%20findings%20and%20recommendations%20report.pdf

- 4.125 The **Royal College of Midwives** reported that the Health and Social Care Information Centre's latest report³⁶ into NHS sickness absence rates had shown the average sickness absence rate for the NHS in England was 4.44 per cent between January and March 2015, an increase from the same period in 2014. The Royal College of Midwives said nursing, midwifery and health visiting staff were one of the staff groups with the highest average sickness rates (5.19 per cent).
- 4.126 The Royal College of Midwives told us morale and motivation continued to be a big issue for midwives and maternity support workers, as did bullying and harassment. In its Heads of Midwifery (HOMs) survey 27.5 per cent of respondents reported decreases in morale and motivation in the last year; 29 per cent said there were complaints of bullying, harassment, verbal and physical abuse from other staff members; and 29 per cent said there were complaints of bullying, harassment, verbal and physical abuse from service users. The Royal College of Midwives said 31.2 per cent of HOMs disagreed/strongly disagreed with the statement 'I am able to do my job to a standard I am personally happy with'; and 62.3 per cent of HOMs disagreed/strongly disagreed with the statement 'I am able to meet all the conflicting demands on my time at work'. The Royal College of Midwives believe the results show all levels of staff, including Heads of Midwifery, are feeling pressurised and this was affecting their morale and motivation and their ability to give high quality, safe care. The results from the Royal College of Midwives HOMs survey had also revealed that 68.8 per cent of HOMs felt confident in the appraisals process, only 9 HOMs had held a member of staff back from incremental progression in the last year (in total 12 members of staff had been held back). However, 20.3 per cent of HOMs had to reduce training in the last year.
- 4.127 **UNISON** asked us to recognise the damaging effects of five years of pay restraint on morale, recruitment and retention in the NHS and to highlight the risks to service quality and patient care of its continuation. It told us that responsibility levels and workloads were increasing whilst pay had been suppressed through a combination of real terms pay cuts and downbanding. UNISON reported that three-quarters of its surveyed members said pay cuts had affected their morale at work, 70 per cent said their willingness to go the extra mile had been affected and 58 per cent of respondents said morale in their workplace was low (a quarter stating it was very low).
- 4.128 **Unite** told us that low morale and stress continued to be major issues for NHS staff, with 80 per cent of respondents to its members survey stating morale/motivation in their workplaces was worse (42 per cent) or a lot worse (38 per cent). Unite told us its members had cited increased workplace stress (80 per cent), restructuring and reorganisation (60 per cent) and the falling value of take home pay (50 per cent) as the reasons behind falling morale. Unite said 55 per cent of those surveyed had considered leaving their current post and taking a job outside the NHS. Unite asked us to consider the impact that changes to terms and conditions were having on staff and wider morale and motivation in the workforce. It said these changes add to the broad concerns NHS staff have about their pay. Unite also asked us to recognise the devastating impact the government's pay policy was having on staff morale and stated this could only be bad for the service as a whole.
- 4.129 The **Chartered Society of Physiotherapists** told us current staff shortages were having a major impact on existing staff with increasing pressure to work additional hours and ensure quality care for patients. It said many physiotherapy staff reported the need to work additional hours to keep on top of their workload, with 39 per cent of

³⁶NHS Sickness Absence Rates January 2015 to March 2015 and Annual Summary 2009-10 to 2014-15, Health and Social Care Information Centre, July 2015.

CSP members³⁷ stating they always worked more than their contracted hours: 35 per cent frequently and 24 per cent sometimes. 59 per cent of these reported that these additional hours were unpaid. The reasons for staff working these hours included: to cover staff shortages; to catch-up on paperwork and because there was not enough resources or time to do their job. The Chartered Society of Physiotherapists also reported findings from its own sample survey (conducted in the summer of 2015) where almost two-thirds of respondents reported a fall in morale over the last twelve months, citing downbanding; staffing levels; pay and the quality of care they were able to provide as key factors. The Chartered Society of Physiotherapists told us over 50 per cent of those surveyed stated they had seriously considered leaving their current jobs (22 per cent considering this very seriously). The Chartered Society of Physiotherapists said focus groups held with staff during July and August 2015 had revealed staff were feeling undervalued; reporting an increase in responsibilities, the amount and intensity of work; experiencing falling satisfaction with the quality of care they are able to give patients and seeking means to top up their basic income through on call, overtime or work in the private sector.

4.130 The **Royal College of Nursing (Northern Ireland)** believed cost saving measures such as freezing vacant posts, slowing recruitment processes and employing and deploying nurses via nurse banks had resulted in increasing nurse vacancies and increasing pressure on nursing staff. It said this was reflected in high sickness absence levels. The Royal College of Nursing (Northern Ireland) reported monthly sickness absence rates across HSC trusts in 2014/15. Rates varied by band and by trust from 3.28 per cent (band 7, lowest month – South Eastern HSCT) to 15.25 per cent (band 2, highest month – Northern HSCT). It did not provide an overall average for all HSC trusts but said by comparison, the average sickness absence rate for all England NHS trusts stood at 3.92 per cent as at August 2015. The Royal College of Nursing (Northern Ireland) confirmed on 17 January 2016, the Belfast Telegraph had reported that staff sickness across the health service in Northern Ireland had cost £107 million during 2014/15. It told us information from Freedom of Information requests revealed that stress and related mental ill-health was the single biggest cause of sickness absence in the HSC and its prevalence was particularly high among nursing staff. It said according to the RCN Employment Survey 2015; 80 per cent of respondents in Northern Ireland stating they feel under too much pressure at work (compared with 69 per cent across the UK); the same proportion stated they were too busy to provide the level of care they would like to and 76 per cent stated too much of their time was spent on non-nursing duties.

Our comment

4.131 According to the staff survey results, staff engagement levels have been largely maintained, although there is a time lag in many of the published numbers. This is a considerable achievement given the current environment in which staff are working, for example the rising demand for services and complexity of cases; constant change and upheaval; responding to performance targets; pressure of work; shortages of staff and a prolonged period of pay restraint. However, there are signs that engagement levels are beginning to fall and there has been a rise in reported anecdotal evidence around low levels of staff engagement which should not be discounted.

4.132 The evidence from the Joint Staff Side and individual trades unions paints a picture of falling engagement with staff under increasing pressure, who are being pushed to the limit to keep the service going and have an increasing dissatisfaction at the levels of patient care which they are able to deliver. This has been evident through the findings in trades unions' surveys and focus groups and feedback from employers at oral evidence.

³⁷ Figures taken from CSP member responses to the joint trade union staff survey, *NHS Staff Survey on Pay and Conditions: A research report for the Joint Staff Side and NHS Trade Unions*, undertaken by Incomes Data Services and published in September 2014.

It is also likely that media coverage may have had some impact here, since the general focus has been on negative stories – deficit levels, safety concerns, staff shortages etc. The knock on effect to staff engagement should not be underestimated.

4.133 This evidence is consistent with the feedback we received at our visits this year. Common themes included:

- Staff did not feel that recent pay restraint reflected the rising workload and increased pressure.
- The quantity of work and amount of responsibility on staff was increasing, with some feeling that they are by default carrying out duties of a higher band. This was starting to erode the goodwill of staff.
- There was widespread use and reliance on bank and agency staff.
- Private sector/agency competition was causing recruitment and retention problems for some areas.
- Staff engagement was poor with lack of consultation on changes in some trusts. Many staff did not feel that senior management listened to them.
- Learning and development was inconsistent with some staff frustrated at the lack of opportunities to develop and progress.

4.134 The members of our remit group are highly motivated and committed to delivering high quality patient care – for the majority this is what attracts them to work in the health sector. However, the pressures within the system are high and increasing and appear to be having an effect. Coupled with low pay awards this all serves to make many staff feel undervalued. Staff survey results show a down-turn in satisfaction with levels of pay and the levels of patient care in England, whilst in Scotland low scores are focused on management of change and staff engagement in that process and staff shortages. This has a crucial impact on patient care and we will continue to monitor this carefully.

4.135 There are ways that management can improve staff engagement by non-financial means. For example a focus on staff development and making posts more flexible, interesting and rewarding and a focus on developing local engagement strategies could all help here. Evidence from our visits suggest that staff engagement benefits from good leadership at local level, involvement in decision-making and working in friendly cohesive teams. There have been a whole raft of reports making recommendations on changes the NHS should take forward but report recommendations and national changes do not change behaviour, local leadership does. One such example is the Boorman report, which featured heavily in the Joint Staff Side and trade union submissions. The Boorman report (in England) made a number of recommendations around improving staff well-being and reducing staff sickness absence. However, there seems to have been mixed success in implementing these changes locally, with some trusts more proactive than others. In times of pay restraint a focus on areas such as staff well-being and flexible working practices as part of a local engagement strategy could provide employers with useful retention tools. The progress on implementing local appraisal systems has also had mixed success and there is work underway now to identify best practice to help support a wider roll-out.

4.136 Staff engagement is crucial at a time when finances are tight and when there is a focus on improving patient outcomes, increasing productivity and delivering transformational service changes at the same time. Staff must be involved in developing and leading service changes but need both the capacity and the will to do so. Staff feel they are already being asked to do more, often with fewer people, as they respond to increasing demand for their services, greater complexity, staff shortages and, what they feel is, a diminishing reward offer with small annual uplifts, increasing pension contributions and having to work longer. The realities of the current financial constraints are being felt by staff. There is therefore limited opportunity or incentive for them to either progress or lead change. At the moment local engagement and successfully embedding change

seems dependent on ownership at board level, good leaders and strong local HR capability. This will need to be an area of development if delivery is to be secured. There is a need to build HR leadership capability and take engagement seriously by moving the issue up the agenda to provide the focus it requires. One way of doing this would be for regulatory bodies, such as the CQC and NHS Improvement (in England), to give this a greater level of prominence and scrutiny when considering performance. We note that CQC (in England) already examines staff engagement as part of its key lines of enquiry. Given that pay is the largest component of costs and the workforce is fundamental to delivery of high quality patient care, highlighting the importance in the regulatory framework could provide appropriate levers for identifying effective approaches, sharing innovation and supporting poorer performers. We turn to this in more detail in Chapter 6 and explore the link with developing local reward strategies.

Observation 10

Given the importance of staff engagement and the link to patient outcomes, performance in this area should be given a much greater level of scrutiny. Each of the four health departments should consider how the relevant regulatory frameworks can address this.

4.137 Improving supply issues would go a long way to improving the position for staff, who feel under pressure and over worked. Pay restraint in this context makes staff feel worse about their perceived value. Therefore ensuring both the right levels of staff and better engaged staff would put less pressure on the need for a pay response. In this context, rises in staff outflow are worrying. Even if it remains possible to attract new staff, an extra load falls on the staff who remain and who have to induct and support new arrivals. Our comments earlier in this chapter on the need for serious workforce strategies, including retention strategies, are therefore very relevant to improving engagement, motivation and satisfaction. If the position is allowed to deteriorate further and the employer proposition begins to erode, pay and pay-related factors will become ever more prominent and may require a costly solution over the longer term.

Chapter 5 – Consideration of a National Recruitment and Retention Premium for Paramedics in England

Introduction

5.1 The Agenda for Change agreement includes a mechanism whereby Recruitment and Retention Premia (RRP) can be awarded on a national basis to particular groups, based on our recommendations, where it can be demonstrated there are national recruitment and retention pressures. For this report we were presented with evidence for a national RRP for paramedics working in England in a joint submission from UNISON, Unite and GMB. The Association of Ambulance Chief Executives provided evidence on behalf of Ambulance trusts. In this chapter we consider the evidence from the parties on the recruitment and retention position of paramedics in England.

Agenda for Change Agreement

5.2 The Agenda for Change Agreement¹ provides for the operation of recruitment and retention premia designed to address labour market difficulties affecting specific occupational groups but applying to posts and not to individuals. Section 5 of the NHS Terms and Conditions Handbook states that RRP apply where market pressures would otherwise prevent the employer from being able to recruit and retain staff in sufficient numbers for the posts concerned. The Agenda for Change Agreement allows premia to be awarded on a national basis to particular groups on our recommendation where there are national recruitment and retention pressures. The level of payment should be specified or, where the underlying problem is considered to vary across the country, guidance should be given to employers on the appropriate level of payment. In making such recommendations we are required to seek evidence or advice from NHS Employers, staff organisations and other stakeholders. We have additionally commented on the need for joint evidence where possible.

Our Approach

5.3 Under the Agenda for Change Agreement, we have interpreted our role as follows: recruitment and retention premia *may be awarded in future on a national or local basis where there are recruitment and retention pressures, on a long or short term basis. We... may recommend national recruitment and retention premia for our... remit groups (with local differentiation as necessary to reflect geographical variation in the underlying problem)*.²

In addition, we have consistently stated that proposals for any pay differentiation for specific remit staff groups would need the parties to present robust evidence and to address the following points:

- Why they consider that pay differentiation for the particular group is necessary;
- Why they consider their objective(s) cannot be achieved by a route other than pay differentiation; and
- Why they consider the level of any differentiation they propose, rather than a lesser amount, is appropriate to meet their objective(s).

¹ More information is available from: http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/AfC_tc_of_service_handbook_fb.pdf

² NHSPRB (2009) Twenty-Fourth Report, TSO (Cm 7646), paragraphs 3.19 – 3.22. More information is available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228908/8298.pdf

- 5.4 We also agreed with the parties in our Twenty-Fourth Report³ that the term “national” in the context of the provisions of the Agenda for Change Agreement relating to RRP meant UK-wide. We did not, however, agree with the view previously presented by the Department of Health that, for a new national RRP to be recommended, we would have to be satisfied that there are problems across all employers in the UK, nor did we consider that there needs to be a recruitment and retention difficulty in all four countries.

Evidence from the parties

- 5.5 **NHS Employers** told us there were continuing issues relating to the shortage of ambulance paramedics and this was reflected by their inclusion on the Migration Advisory Committee’s shortage occupation list. NHS Employers believed there was no evidence to suggest shortages were directly related to pay levels and said applications to degree programmes remained strong. NHS Employers advised us that the national agreement on pay for 2015/16 committed ambulance employers to work in partnership with ambulance trade unions (UNISON, GMB and Unite) to seek to resolve issues relating specifically to terms and conditions for ambulance staff. They said these discussions had been taking place in the National Ambulance Strategic Partnership Forum and in joint working groups set up for this purpose and that progress was being made. NHS Employers confirmed the view of employers so far was that the recruitment and retention problems affecting some staff employed in the ambulance trusts, particularly paramedics, would not be addressed effectively by the implementation of a national recruitment and retention premium. NHS Employers believed individual employers were in the best position to consider whether or not RRP, at locally determined rates, would be an effective part of workforce development strategies.
- 5.6 The **Association of Ambulance Chief Executives** explained that the 11 Ambulance Services in England were autonomous and as such there was no single operating model. They said each trust was commissioned by their local Clinical Commission Groups, who request services according to the area they serve, subject to a set of national performance criteria. The Association of Ambulance Chief Executives reported that the volume of calls and incidents resulting in a 999 emergency response had increased over the past decade with over 8.5 million patients calling 999 in England in 2012/13. The total number of emergency admissions in England had risen by 27 per cent from 2003/04 (4.2 million) to 2013/14 (5.3 million). They believed demand was primarily being driven by patients requiring urgent care rather than patients calling with a life threatening condition. Patients suffering significant trauma or an acute medical emergency constituted approximately one third of the average ambulance workload.
- 5.7 The Association of Ambulance Chief Executives told us ambulance services had delivered significant improvements to the standards of clinical care and services to patients over recent years. They explained demand continued to rise year on year and may be due to the ease with which people can access 999/111 and a reluctance to use alternatives. They said paramedics continued to develop from their historical role of delivering first aid and transportation to hospital to a much greater emphasis on decision-making, treatment and referral. The Association of Ambulance Chief Executives explained that this improved skill set had led to the realisation that paramedics could make a fundamental contribution to unscheduled and urgent care, and future models were looking towards a professionalised paramedic workforce with enhanced clinical capabilities (likely a BSc), clinical leadership and clinical decision making skills to work autonomously with support and recognition from other professional colleagues. The Association of Ambulance Chief Executives reported all trusts employed Band 5 paramedics and Band 6 for particular

³ NHSPRB (2012) Twenty-Sixth Report, TSO (Cm 8298), paragraph 4.7. More information is available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/238579/7646.pdf

specialisms (Air, HART, senior trauma, RRV); clinical leadership, mentor or team tutor and some hear and treat roles. They explained all these roles had extended skills sets, clinical competency and often leadership or educational responsibilities.

- 5.8 The Association of Ambulance Chief Executives told us they accepted the national paramedic role profile was over a decade old, and employers with the staff side (under the auspices of the National Ambulance Service Partnership Forum (NASPF)) had collated a number of local Job Analysis Questionnaires to submit to the National Job Evaluation Group for review. They anticipated this group would consider if any changes should be made to the national role profile and, if changes were made, trusts would reconsider their local roles and banding. The Association of Ambulance Chief Executives confirmed this was the agreed way forward in considering if the current role of paramedic was at Band 6. They explained, in addition to this, the Paramedic Evidence Based Education Project (PEEP) report recommendations would lead to a change in the registration criteria for paramedics to be implemented in 2021/22, and may result in a change in the banding of paramedics to Band 6.
- 5.9 The Association of Ambulance Chief Executives believed recruitment issues had been brought about by a lack of supply, as a consequence of a dip in HEE commissions in 2010/11 and some Ambulance Trusts not maintaining adequate recruitment arrangements. They explained these were being addressed by HEE through an 87 per cent increase in commissions. The Association of Ambulance Chief Executives said HEE had also supported some short term solutions for internal pathways (developing current staff to paramedic roles) and the inclusion of paramedics on the Shortage Occupation List had helped. They told us each trust had plans to mitigate the shortage of paramedics and vacancies had lessened over the past six months. The Association of Ambulance Chief Executives said recruitment issues in ambulance trusts tended to be localised with specific hard to fill locations, and some trusts offered incentive schemes⁴ to attract staff to these areas. However, no trust was currently using the flexibility to offer local RRP for paramedics. They told us popular locations often achieved a waiting list of potential recruits.
- 5.10 Vacancy levels and attrition rates for individual ambulance trusts are shown in table 5.1. The Association of Ambulance Chief Executives reported there were around 1200 vacancies (as of September 2015), which was an 8 per cent vacancy rate. They said attrition rates varied between trusts but for those trusts that recruit directly into a specialist paramedic role at Band 6 attrition was comparable with Band 5 roles. They told us supply into degree programmes was not an issue, with reports from trusts suggesting there were more potential students than places (ratios ranged from between 2 to 1 applicants per place to 34 to 1 depending on location).

⁴ Incentive schemes included golden hello payments, relocation packages and payment of driving licences. Trusts were also looking at other recruitment and retention initiatives which included closer connections with other public sector employers, investment training and development, improving meal break policies and internal student paramedic training programmes, development of new roles, reviewing deployment models and international recruitment.

Table 5.1: Vacancy levels and front line attrition (including percentage retired)

Trust	Vacancies (FTE)	Attrition
Yorkshire Ambulance Service	0	9.43% band 5 roles (20% retired)
		7.43% band 6 specialist roles (42% retired)
South Central Ambulance Service	260	15.7% band 5 (16% retired)
South West Ambulance Service Foundation Trust	53	9.12% band 5 (34% retired)
East Midlands Ambulance Service	6	10% band 5 (20% retired)
North East Ambulance Service	109	9.4% band 5 (33% retired)
South East Coast Ambulance Service	237	10.8% band 5 (7.3% retired)
West Midlands Ambulance Service	0	5.8% band 5 (25.3% retired)
North West Ambulance Service	135	9.21% band 5 (19% retired)
		7.87% band 6
East of England Ambulance Service	26	9.48% band 5 (7% retired)
		10% band 6
London Ambulance Service	387	12.2% band 5 (9% retired)

Source: Association of Ambulance Chief Executives supplementary evidence

- 5.11 The Association of Ambulance Chief Executives said trusts did not believe retention issues were solely pay related, and evidence submitted by employers to the NASPF⁵ suggested reasons for leaving were connected to the nature of the work, impact of demand, shift working and wellbeing issues relating to the demands of working in a performance culture. They said pay was not cited as the main reason for leaving and was one of many reasons. The Association of Ambulance Chief Executives explained qualified staff were enjoying more varied opportunities in the wider NHS system and many had been able to take opportunities in Primary Care and Out of Hours providers for an offer which was significantly different to the Ambulance Service. This included different roles, no emergency work, less demand, no overruns, no shift work, often more money and increasingly, clinical and career development opportunities. They said staff were also moving between ambulance trusts for career opportunities.
- 5.12 The Association of Ambulance Chief Executives did not believe the current position met the criteria for a national RRP as reasons for leaving were not solely pay related and the position varied over the country. Employers had therefore determined not to provide a joint submission with trade unions. They did not believe that employers paying more could resolve the issues that qualified staff have stated as their reasons for leaving, such as stress, workload, demand and wellbeing issues due to the focus on performance. The Association of Ambulance Chief Executives told us that employers must deliver services within their financial envelope and any changes to terms and conditions had to be affordable. They said the cost of the staff side proposals for a national RRP was around

⁵ This evidence was provided in collaboration with local trade unions.

£74 million per annum.⁶ They believed the additional expenditure would not improve the quality of services to patients. They felt a more potent retention strategy would be to focus any additional funding on resources to enable employers to reduce unsustainable levels of workforce utilisation and facilitate more widespread access to clinical and career development opportunities. The Association of Ambulance Chief Executives told us employers had suggested an RRP would be unaffordable without central funding or the need to make significant service changes, which may impact performance and patient care. Trusts were currently having to manage additional demand without extra funding.

- 5.13 **UNISON, Unite and GMB** said that the 2015 pay settlement had included specific commitments to ambulance staff, including parties working together to look at finding solutions to existing recruitment and retention problems. UNISON, Unite and GMB told us their evidence was being submitted following a number of months of work between trade unions and employers through the National Ambulance Strategic Partnership Forum (NASPF) and a failure to agree about the solutions to the recruitment and retention problems. They said employers did not share their view that retention of existing staff was related to pay and reward and believed this was in part due to the lack of central funding for the 2015/16 pay settlement. UNISON, Unite and GMB told us discussions had therefore been restricted from the outset, due to existing financial pressures on ambulance trusts.
- 5.14 UNISON, Unite and GMB told us there was general agreement between trade unions, employers and staff that the paramedic role had experienced significant role creep since the introduction of Agenda for Change, and many paramedics were now working at a Band 6 level. They reported paramedics had taken on a greater role in acting as autonomous clinicians with responsibilities for patient care, working in an uncontrolled environment. UNISON, Unite and GMB said that despite this change their pay banding had remained the same since 2003,⁷ and this meant employers and commissioners were getting 2015 paramedic skills for 2003 pay rates. UNISON, Unite and GMB explained the reduction in the ambulance technician role meant paramedics had to supervise increasingly less clinically qualified colleagues, and many were acting as mentors for student paramedics. They said this can mean paramedics making autonomous decisions whilst supervising two or more staff at any incident.
- 5.15 UNISON, Unite and GMB confirmed the NASPF had made a formal request to the National Job Evaluation Group to look at the national Job Evaluation paramedic profile, currently Agenda for Change Band 5 for most ambulance services. They said at least two ambulance services (East of England NHS Foundation Trust and West Midlands NHS Foundation Trust) had already reached agreements to pay at Band 6 in order to recruit and retain paramedics.
- 5.16 UNISON, Unite and GMB advised us that the Paramedic Evidence Based Education Project (PEEP) was a collaboration between the College of Paramedics and Health Education England looking at potential changes to the education pathways for paramedics that will lead to a BSc entry-level qualification to the HCPC register by 2020/21. They believed this was highly likely to lead to a Band 6 entry level for paramedics. They said the change in education pathway reflected the increase in skills and competencies paramedics have and which make them attractive to alternative employers such as GP surgeries, Walk in centres and minor injury units. They were also in demand to undertake disability assessments on behalf of the Department for Work and Pensions. UNISON, Unite and GMB believed moving to degree level education could exacerbate recruitment and retention problems as the knowledge and skill set of

⁶ Based on a number of 14,945 paramedics (as of March 2015) employed by ambulance trusts, and an average cost of £4,980 per annum. Estimates exclude on costs and the additional cost of RRP that would be allocated to vacant posts.

⁷ Since the inception of Agenda for Change.

paramedics will be attractive to non-ambulance employers. There were plenty of agency and private sector employment opportunities for paramedics. While salaries and hourly rates were difficult to establish and compare to NHS rates, paramedics could get the equivalent of Agenda for Change Band 6 pay in these settings, sometimes without the necessary night and weekend working associated with the ambulance service. Some paramedics were able to access Band 7 roles in the hospital setting such as hospital based Emergency Care Practitioners (ECP).

5.17 UNISON, Unite and GMB reported that the numbers of ambulance staff leaving ambulance services across the UK was increasing every year. They said this had been recognised by the Migration Advisory Committee (MAC) who had recommended paramedics be added to the Shortage Occupation List (SOL)⁸ for the UK and for Scotland. UNISON, Unite and GMB explained that the reasons people cite for leaving, or considering leaving, are varied and include:

- Pay and reward;
- Demand placed on 999 services;
- Workload on individuals and working practices;
- Increase in working hours and work related stress;
- Bullying and harassment and physical violence;
- Performance management;
- Increased stress when working with and being expected to mentor unqualified staff;
- Inappropriate 999 call outs/misuse of services;
- Increases in retirement ages of ambulance workers;
- The long term physical demands of the work;
- The long term mental demands of the job including, but not restricted to, trauma and traumatic incidents;
- Illness and injury, including permanent injury and disablement;
- Lack of training and development opportunities;
- The transferable skills of paramedics.

5.18 UNISON, Unite and GMB advised that whilst retention in ambulance services was a concern in almost all occupations, the most acute recruitment and retention problems facing the UK ambulance service were in paramedic roles. They believed that poor workforce planning, changes in education routes for paramedics from vocational training to university education and a change in the training budgets for ambulance services had led to a reduction in the national recruitment pool of trained paramedics. They said whilst not all ambulance services in the UK had responded to the NASPF call for evidence, all of those that had highlighted the paramedic role as their main concern. There were, however, variations between locations within ambulance trusts.

5.19 UNISON, Unite and GMB told us the vital and changing role of paramedics had been recognised by Health Education England (HEE) in their 2015/16 Workforce plan.⁹ They said HEE had made an 87 per cent increase over two years in paramedic training, providing for 1,902 FTE growth in available supply over the next five years. UNISON, Unite and GMB said England's ambulance services were reporting increased pressure on their paramedic workforce and referred to data in the HEE work plan outlining the widening gap between demand and supply. This included:

- An increase in trusts reported vacancy levels from 7.6 per cent (April 2014) to 9.5 per cent (July 2014).

⁸ The MAC recommended the inclusion of paramedics in their 2015 report stating that "on balance, the Migration Advisory Committee (MAC) recommend adding paramedics to the SOL subject to a thorough review once the British trainees come on-stream."

⁹ More information is available from: <https://www.hee.nhs.uk/sites/default/files/documents/HEE-investing-in-people-2015.pdf>

- An increase of over 8.8 per cent in ambulance trusts requirements in 2013/14 (this rapid growth coincided with a dip in the rate of supply and had increased the gap between demand and supply).
- Ambulance trusts forecast their requirement for additional paramedics would increase by 8.8 per cent by 2019 (3.6 per cent of which would be needed in 2014/15).
- HEE's proposed training levels would provide significant growth to the paramedic workforce from 2016/17 onwards, but the rapid level of increased demand meant shorter term supply solutions would be needed to ensure vacancy rates did not deteriorate further until newly trained supply became available.

- 5.20 UNISON, Unite and GMB told us paramedic recruitment was a challenge for employers due to the lack of trained paramedics available in the UK. They said ambulance services were often in competition with each other over the recruitment of the new graduate paramedic workforce, and were offering various incentives, including favourable terms of appointment, golden hellos and relocation packages. At the same time, ambulance services were actively recruiting paramedics from overseas, including Europe and Australia. UNISON, Unite and GMB believed the move towards the BSc paramedic course meant new graduates would come into the labour market with more debt, which was likely to increase the attraction of the private sector where hourly rates are higher.
- 5.21 UNISON, Unite and GMB reported evidence they had gathered through FOI requests showed paramedic leavers had been increasing between 2010/11 (566) and 2013/14 (1057), although evidence from employers had also shown an overall increase in headcount during this time. They said the employer's data showed evidence of a crossing of trajectories for paramedic leavers and joiners and believed a sharp increase in leaving rates would compromise the safe delivery of ambulance services.
- 5.22 To help understand the current trends in retention, the joint trade unions told us they had completed a *paramedic retention survey* of ambulance staff for a two week period in October 2015.¹⁰ They reported the following key findings from the survey results:
- 92 per cent were motivated to do their job because of patient care.
 - 94 per cent did not feel their pay adequately reflected their skills and responsibilities.
 - 77 per cent stated they enjoyed their jobs but if pay and workforce issues were not dealt with it may lead them to leave.
 - 76 per cent of paramedic respondents indicated they were thinking of leaving (85 per cent of these indicated this was due to their pay not reflecting their responsibilities and 62 percent said they were able to get another job with their skill set).
 - Responses to the question *what could employers do to help you stay in your role?* were as follows (listed in order of popularity):
 - Review the banding of the role.
 - Improve working life (meal breaks, reduce late finishes etc).
 - Change the way ambulances are dispatched to calls.
 - Better career progression.
 - Apply a recruitment and retention premium.

¹⁰The survey yielded a total of 3,088 responses, 2,678 of these were from paramedics working in the UK NHS ambulance service.

5.23 UNISON, Unite and GMB argue that successive pay freezes and an out of date banding for paramedics had created a culture where staff felt they were not recognised for their skills. They believed a national RRP should be applied to address current retention problems and to bridge the gap between the existing and proposed new banding arrangements for paramedics. They put forward two options:

- a flat rate RRP of 30 per cent (with payment values ranging from £6,506 to £8,454 depending on where staff are on the Band 5 pay scale); or
- an RRP of the difference between the Band 5 spine point and the equivalent spine point in Band 6 (with payment values ranging from £4,349 to £5,048).

5.24 UNISON, Unite and GMB believed pay differentiation was necessary to bridge the gap now and incentivise people to remain in their role. They also put forward a number of recommendations including:

- Review current ambulance roles including job evaluation bandings.
- Tackle short and medium term retention problems using National or Local recruitment and retention premia.
- Review the training and entry routes to the ambulance service including the use of internal development of staff and apprenticeships.
- Ambulance employers to look at key factors which lead to staff leaving (for example, demand, work pressures, illness and injury, retirement age).

Qualified ambulance staff by Agenda for Change band

5.25 As part of our analysis we looked at the current breakdown of ambulance staff by Band and job role (table 5.2). The two main groups of qualified ambulance staff are ambulance technicians (24.5 per cent) and ambulance paramedics (68.3 per cent). Nearly two-thirds of ambulance paramedics are Band 5 with just under a third at Band 6; there are a limited number of paramedics at higher Agenda for Change paybands (2.7 per cent). There are some opportunities for paramedics to undertake further training and progress to Emergency Care Practitioner posts – 3.7 per cent of all qualified ambulance staff are in such posts. These are mainly either Band 6 (74.4 per cent) or Band 7 (24.7 per cent).

Table 5.2: Distribution of qualified ambulance staff by role and Agenda for Change pay band

Agenda for Change Band	% of all qualified ambulance staff				
	Ambulance Technician	Ambulance Paramedic	Emergency Care Practitioner	Manager	Total
Band 1					
Band 2					
Band 3	0.05%				0.01%
Band 4	53.20%	0.02%			13.03%
Band 5	46.61%	65.78%	0.16%		56.37%
Band 6	0.13%	31.52%	74.36%	2.00%	24.40%
Band 7		2.32%	24.70%	72.05%	5.01%
Band 8a		0.29%	0.31%	12.51%	0.64%
Band 8b		0.04%	0.31%	9.50%	0.37%
Band 8c			0.16%	2.60%	0.10%
Band 8d		0.03%		1.33%	0.06%
Band 9					
Point/Band incorrectly recorded		0.01%			0.01%
Total	100.00%	100.00%	100.00%	100.00%	100.00%

Source: NHS Employers from the ESR.

1. Estimates derived from NHS Employers analysis of ESR data warehouse data as at April 2015 for all organisations in England except two organisations who do not use ESR. Percentages with denominators of less than 10 have been suppressed.
2. Data cleaning processes are applied to the ESR extracts before use.
3. Analysis applies to staff who have a valid recorded Agenda for Change band and spinal point only. Very Senior Managers are excluded from the analysis.

Our comment

5.26 Employers were clear that the current recruitment problems for paramedics were supply related. We were assured that these are being addressed through an increase in HEE training commissions and the degree-level route that is coming online. In the interim employers are taking action to plug gaps locally through a range of means; these included the training and development of existing staff to undertake paramedic posts and the use of private services. In addition, retention problems appear to be localised rather than at a national level. So for example, whilst attrition rates have increased, and are high in comparison to other Agenda for Change groups, these vary at local level and attrition rates are not considered to be unmanageable. However, we note that there is growing anecdotal evidence that some staff are seeking to leave the service, choosing to move on to less stressful roles or to higher paid and/or banded alternatives both within and external to the NHS.

- 5.27 All parties were clear that recruitment and retention problems were related to a range of non-pay factors and we understand that parties are working together on these issues through the National Ambulance Strategic Partnership Forum. This work needs to progress quickly to a resolution; ideally to provide guidance to trusts. In our view a pay response will not resolve these long standing issues around well-being, work life balance, work pressures and career development. The increased service demand and the pressure of working within a performance target culture were also clear themes from both parties' evidence. These were seen as reasons for increased dissatisfaction with the role and higher turnover rates in some localities. Parties explained that staff are under more pressure, with more responsibilities and a higher workload; there is less downtime between call outs and shifts often overrun with breaks frequently missed. These, together with increased responsibility and demands on the role, lower level pay increases and having to work longer, are leaving staff feeling undervalued. Some trusts are already exploring how to reduce pressure on staff and are looking at how calls are managed and allocated to help reduce the pressure and manage resources more effectively. This could be used more widely across the Ambulance Service as a whole. NHS England and Commissioners could also support this by rethinking performance targets, for example including a focus on treating more patients outside of hospital and reducing Accident and Emergency admissions rather than solely related to response times, which could better reflect how the ambulance service is evolving.
- 5.28 There is a great degree of local variation at present in terms of staff training and deployment, and also in local responses to recruitment and retention pressures. It seems to us that there is a need for collective ownership of the ambulance service as a whole, with a shared vision for how the service moves forward, recognising that local implementation will differ according to the needs and service demands at individual trust level. The Association of Ambulance Chief Executives provides a platform for trusts to share best practice about what is working in their area that others can learn from. There are clearly pockets of good practice that can be adapted elsewhere, for example the West Midlands Ambulance Trust currently has a zero vacancy rate and much lower turnover levels when compared to other trusts. The Association of Ambulance Chief Executives, with the support of NHS England and trade unions, should work together to co-ordinate and develop national frameworks and best practice models for local implementation.
- 5.29 The introduction of a degree-level (BSc) training route will enhance the skill set of paramedics, making them more transferable to a variety of roles both within the NHS and externally. If current recruitment and retention problems are not addressed there is a danger that the Ambulance Service will become a less attractive employment proposition relative to the alternatives, and what is currently a localised problem could develop into a national issue requiring a more costly pay intervention. The career and employment proposition for paramedics must be looked at holistically rather than piecemeal. Pay and the total reward package are clearly part of this. A holistic approach is needed to support the recruitment, retention and engagement of staff in a service area undergoing significant changes; ensuring staff feel valued and appropriately rewarded for their level of contribution.
- 5.30 We do not believe a national RRP will address the non-pay issues, which are the fundamental issue here. A national RRP is a blunt instrument that would be applied to all locations. Looking at the recruitment and retention picture across trusts, there are areas where there are limited or no issues (West Midlands) and there is clearly no requirement to pay an additional premium to attract and retain staff. In our view localised RRP offer better flexibility to deal with recruitment and retention issues specific to individual areas. However, we note that trusts have the option to implement local RRP to address recruitment and retention problems but are not currently choosing to do so. Trusts may be reluctant to use

local RRP because of the lack of national funding and concerns about the ability to remove these in the future. They are, however, using other local incentives, such as relocation packages, 'golden hellos', and payment of driver training and/or licences.

Observation 11

We do not believe the case has been made to warrant the introduction of a national recruitment and retention premium (RRP) for paramedics. There are some shortages, but they appear to be localised and short-term, and local RRP therefore offer a better potential targeted solution. There are wider recruitment, retention and engagement issues that need to be addressed holistically. We urge the parties to work together quickly to identify solutions and best practice for trusts.

- 5.31 Paramedics have a key role to play in transforming urgent care and easing the pressure on Accident and Emergency services in hospitals. If the skills of paramedics are being utilised in other areas of the NHS, opening up other career opportunities, a virtue could be made out of this. Thinking creatively about career frameworks across the service could provide a quick win to help address existing frustrations around career development, as well as build in flexibility around new care models and resilience. Enhanced career development opportunities and flexible models of working could offer an incentive to staff but must be designed with their input. However, trusts should also be careful not to shut down development routes for other staff groups as a result of the move to a BSc entry level. The existing on-the-job and internal development routes have proved to have higher retention levels in the past and should remain part of the range of recruitment options.
- 5.32 It is clear from the evidence from both parties that the paramedic role has evolved in recent years and paramedics across many trusts are now undertaking more autonomous and challenging job roles than previously. Given the move to reduce pressure on urgent care the position is likely to evolve further as new care models are developed and in response to changing demand for services. This evolution of the role has led to some service redesign at local level and the introduction of higher banded roles in some trusts, however this is patchy. The changing demands on the role are reflected in the introduction of BSc-level entry. Employers told us that they felt such a change was long overdue and that paramedic training was now catching up with that of Allied Health Professional roles, which are also degree based. Such changes may well strengthen the case for reviewing the banding of the role. However, if there is a move to introduce a higher banded role then there will need to be greater clarity about what the role is, how this is deployed, and how it differentiates from a Band 5 role to ensure trusts get the best value out of local workforce models.
- 5.33 In general we sensed a feeling from the parties that the current national role profile is out of step with how the role is evolving and the greater emphasis on clinical decision making. Whilst the banding of the role is under review the process is taking a long time to reach a conclusion. This needs to be resolved one way or another as a matter of urgency, both in terms of reaching a decision and in addressing how any changes are to be implemented. Transition issues for existing staff do not appear to have been thought through in any detail and must be considered before any changes are introduced. The parties should agree a timetable to reach a decision quickly to minimise the negative effects of ongoing uncertainty on recruitment, retention and motivation.

Observation 12

The Agenda for Change banding position of paramedics is presenting a problem and is taking too long to resolve. We recommend that a clear and tight timetable is agreed between the parties to reach a final decision to minimise the negative effects of ongoing uncertainty on recruitment, retention and motivation.

- 5.34 There is a wider issue around the affordability of any changes to the banding of the role and the potential impact at individual trust level. A solution will be needed to ensure that local trusts can implement new staffing models and transition to these quickly. Given the importance of this role on reducing the demand on urgent care, there appears to be scope to examine costs and benefits at a health system level to support any business case for a higher banded role. So, for example, transforming the role of paramedics so that more patients are treated at home could reduce the pressure on Accident and Emergency attendance and admissions into hospital. However, central ownership and capacity is needed to support the identification of these potential costs and benefits. We believe NHS England is perhaps best placed to take this forward.

Observation 13

NHS England should provide central ownership and capacity to support the evolution of the future paramedic role, the identification of costs and benefits for health systems, and support the business case for any pay band changes to assist local level decision making.

Chapter 6 – Pay Proposals, Recommendations and Observations

Introduction

6.1 In this chapter we set out our pay recommendations and observations. This includes our considerations and analysis of the UK government’s National Living Wage and the existing variations and the parties’ pay proposals.

The Living Wage

6.2 In July 2015 the Chancellor announced the introduction of a UK National Living Wage for over 25s from 1 April 2016. As planned the National Living Wage rate will not impact on Agenda for Change pay rates in England and Northern Ireland in 2016/17 but will influence at the lower levels in the medium term. The Scottish Government and Welsh Government have both opted to pay the higher Living Wage Foundation rate in Scotland (referred to as the Scottish Living Wage) and Wales, so will not be affected by this change. Table 6.1 shows the differences between the wage levels and table 6.2 sets out the position in the NHS for each of the UK countries.

Table 6.1: National Minimum Wage, National Living Wage and the Living Wage Foundation Living Wage

Age Group	National Minimum Wage (UK-wide)	National Living Wage (from 1 April 2016, UK-wide)	Living Wage Foundation Living Wage (voluntary) Scottish Living Wage	
			National	London
25+		£7.20 (rising to £9 by 2020)		
21+	£6.70		£8.25	£9.40
18 – 20	£5.30			
Under 18	£3.87			
Apprentice	£3.30			

Notes:

The new National Living Wage is effectively a new National Minimum Wage for those aged 25+.

The new National Living Wage is the legal minimum an employer can pay per hour.

The new National Living Wage will be set by the Low Pay Commission.

Employers choose to pay the Living Wage Foundation Living Wage voluntarily.

Living Wage Foundation rates are revised annually in line with cost of living increases. Increases are announced in November.

Sources: Government website on National Minimum Wage and National Living Wage: <https://www.gov.uk/national-minimum-wage-rates>; <https://www.livingwage.gov.uk/?gclid=CNyavcmPtsoCFQqdGwodn6MEuA>

Living Wage Foundation factsheet: <http://www.livingwage.org.uk/sites/default/files/Everything%20you%20need%20to%20know%20about%20the%20Living%20Wage%202016.pdf>

Table 6.2: Living Wage and the NHS

Country	Position
England	Some individual Trusts have chosen to pay Living Wage Foundation rates. National Minimum Wage and National Living Wage rates will apply as statutory requirements.
Scotland	Scottish Living Wage (Living Wage Foundation rate) employer.
Wales	Living Wage (Living Wage Foundation rate) employer.
Northern Ireland	National Minimum Wage and National Living Wage rates will apply as statutory requirements.

Sources: Parties' evidence submissions.

- 6.3 The introduction of the new National Living Wage is likely to introduce some parity across sectors at lower levels and employers will need to consider their attraction and retention strategies to remain competitive. Some organisations have already chosen to pay above the National Living Wage, or to pay the higher Living Wage Foundation rates. The National Living Wage is unlikely to impact NHS Agenda for Change rates until 2018/19 (years three and four of the public sector pay policy). The application of the higher Living Wage Foundation rates in Scotland (Scottish Living Wage) and Wales means there will be higher rates available for the lower Agenda for Change bands in these countries. Over time this could begin to impact at border sites, if staff move for the benefit of higher wages. We comment on the government policies and funding arrangements in our commentary section below.

The Pay Award

- 6.4 In this section we consider the evidence from the parties in regards to their pay proposals for 2016/17.

Evidence from the parties

- 6.5 The **Department of Health** said the government had made clear that continued pay restraint in the public sector remained a vital element of its fiscal consolidation plans. It said alongside the announcement on funding for public sector pay increases (an average of one per cent in each year up to 2019/20), that the government would continue to examine pay reforms and modernise the terms and conditions of public sector workers. The Department of Health told us that, at a time of difficult decisions, the government's pay policy would help ensure the NHS workforce was affordable and help protect jobs.
- 6.6 The Department of Health said, although the government had provided sufficient funding across the public sector to fund a pay award at an average of 1 per cent in each of the four years from 2016/17, the NHS must make better use of its £45 billion pay bill. It believed NHS employers needed to look carefully at the Total Reward offer and how the pay and non-pay benefits employers can offer locally could help them recruit and retain the staff they need.
- 6.7 The Department of Health were clear that it did not believe there was currently the evidence to support the targeting of a one per cent pay award on an occupational or regional basis. The Department of Health believed distributing a one per cent award in this way would not resolve or improve recruitment, retention or motivation of the Agenda for Change workforce.

- 6.8 The Department of Health told us the government was clear that the National Living Wage (NLW) must be funded from within the public sector pay envelope already announced – an average of 1 per cent over four years from 2016/17. The Department of Health assured us there would be no impact from the NLW in 2016/17 because minimum pay on Agenda for Change was higher, but acknowledged this may change over time as the NLW increases. The Department of Health said future NHS pay levels, considered alongside contract reform, would reflect this, within the constraints of wider public sector pay policy.
- 6.9 **NHS England** said we would need to carefully consider what, if any, uplift was appropriate for 2016/17, given the difficult funding situation. It said that, whilst any increase in staff pay would take away resources which could otherwise be spent on improving patient care, this would have to be balanced against potential risks to recruitment and retention over the longer term if no pay increase was awarded.
- 6.10 **NHS Employers** said responses to their members' survey indicated employers had broadly accepted the 1 per cent increase suggested by the public sector pay policy and many were including this in their financial plans. Most of them did, however, express concerns that increased pay costs would make it more difficult to achieve efficiency savings. NHS Employers told us, whilst continued pay restraint remained necessary on affordability grounds, there was an appreciation of the impact on individual staff, and over the longer term it would be important to balance affordability considerations against the risk that the value of the NHS employment proposition will erode. They said this may eventually have some impact on staff engagement as well as employers' ability to recruit and retain skilled staff from wider labour markets.
- 6.11 NHS Employers told us negative pay bill per FTE growth in the bottom line may be incorrectly interpreted as showing incremental progression was without cost. They explained this was due to costs of incremental progression being temporarily offset by other negative pay pressures. They said higher turnover levels in 2014/15 had offset the cost of incremental progression as higher paid workers were replaced with workers on lower pay. NHS Employers estimated around half of all Agenda for Change staff would be entitled to a pay increment in 2015/16 (worth on average 3.3 per cent), even without an increase in the national pay scales.
- 6.12 NHS Employers reported there was a consensus amongst employers in favour of the same percentage increase for all Agenda for Change staff within the 1 per cent cap. They said any pay uplift not fully funded through the tariff would create additional financial pressure for employers. NHS Employers told us they were not aware of any labour market challenges at national or local level that would be resolved by differentiated pay awards in 2016/17. NHS Employers did not believe the envelope of 1 per cent provided scope for any meaningful targeting. They told us many employers had suggested differentiated pay awards would be perceived as inequitable, be likely to have a negative impact on staff morale and could jeopardise the prospects of success in terms of pay and contract reform. A number of employers had raised concerns about the divisive nature of the 2015 agreement and the impact on key staff in bands 8 and 9, and some NHS organisations reported making additional payments to these staff, outside of the national agreement.
- 6.13 NHS Employers told us there was no evidence on labour market grounds to support further targeted increases to the lowest pay points. They believed NHS pay rates and the wider employment package remained competitive in the labour market, particularly when compared to some other public sector employers. They said employers in some sectors of the NHS had expressed concerns about the ability of NHS organisations to compete effectively for contracts with other providers, and further increases to the lowest pay rates would risk exacerbating this. NHS Employers confirmed the Agenda for Change rates were currently higher than the proposed National Living Wage at £7.70 per hour during 2015/16 so this would not have any immediate impact on the pay review for

2016/17. They said there was likely to be an impact on NHS rates in the longer term but this was unlikely directly to affect Agenda for Change pay scales until 2018/19 (assuming pay increases were in line with public sector pay policy).

- 6.14 **NHS Providers** said they did not oppose a 1 per cent pay award for 2016/17, as long as this was fully funded through local and national contracts for 2016/17.
- 6.15 NHS Providers did not think a 1 per cent pay award should be targeted at national level, as in the current industrial relations climate this may be divisive and it may not take account of differing local recruitment challenges. NHS Providers said there would be limited recruitment and retention benefits from targeting a pay award of only 1 per cent, and the benefit may therefore not justify the management and administrative time needed to implement a targeted approach. A few of their members had, however, suggested targeting of the pay award should be by local discretion. Whilst NHS Providers thought this was an interesting suggestion they said it was difficult to see how granting trusts autonomy to award a consolidated pay award locally would be consistent with trusts remaining within the national agreement.
- 6.16 The **Scottish Government** confirmed its approach to public sector pay was governed each year by its Public Sector Pay Policy. The Scottish Government explained its Public Sector Pay Policy for 2016/17 continued to be based on the following principles:
- To provide a distinctive pay policy which was fair, affordable, sustainable and, through the targeting of resources, delivers value for money.
 - To deliver top-class public services, protect jobs and preserve pay progression in return for continuing restraint on overall pay bill costs.
 - To continue to protect the lowest earners, including maintaining the commitment to the Scottish Living Wage for the duration of this parliament.
- 6.17 The Scottish Government said there was no doubt that the financial picture in NHSScotland remained challenging and that any pay rise had to be modest, not least to assist NHS Boards in maintaining headcount, which they believed important both for service delivery and also for the wider economic benefits. The Scottish Government believed the level of increases proposed in the Scottish Pay Policy were reasonable and realistic, especially given the more favourable remuneration Scottish health workers already enjoy compared to colleagues elsewhere in the United Kingdom and the additional measures suggested for the lowest paid.
- 6.18 The Scottish Government invited us to consider our recommendations within the parameters set out in its remit:
- provision for an increase in basic pay for all staff (subject to an overall cost cap of 1 per cent); and
 - a minimum increase of £400 for staff earning less than £22,000, underpinned by the continuing commitment that all staff must be paid at least the Scottish Living Wage.
- 6.19 The **Welsh Government** told us that NHS employers in Wales had implemented the Living Wage from 1st January 2015, in line with the rate set by the Living Wage Foundation. The Living Wage Foundation had announced a 40p increase to the living wage hourly rate (£8.25) in November 2015, which would increase the basic annual salary to £16,302. The Welsh Government Strategic Pay and Modelling Group was in the process of modelling the financial implications for NHS Wales, the number of staff affected, and how to apply the new rates across NHS Wales. The Welsh Government confirmed that Agenda for Change Bands 1 and 2 remained the only bands affected.

- 6.20 The Welsh Government emphasised that the affordability of any pay award had to be managed within the context of a reducing real-terms budget. It said employers and trades unions understand the unprecedented financial challenges facing NHS Wales, and continued to work together in partnership to ensure job security for all NHS staff. The Welsh Government were clear that it was within this context that the Welsh Government sought recommendations in respect to staff engaged on Agenda for Change terms and conditions. It told us whilst there were challenges for recruiting into specific roles; these difficulties were UK-wide and would not be resolved by targeted pay awards. The Welsh Government stressed such challenges should be addressed through robust workforce planning and a change in the way roles are designed, to enable the flexibility to deliver new models of care. The Welsh Government did not consider there was any compelling reason for differentiating pay by location throughout Wales.
- 6.21 The **Northern Ireland Executive** invited us to consider the case for targeting to support recruitment and retention and to make recommendations for staff employed under Agenda for Change. It told us any recommendation should take account of the need for continued public sector pay restraint and the specific financial context of Northern Ireland.
- 6.22 The Northern Ireland Executive reported that on 24 May 2007, the Executive had endorsed the principle of adherence to the UK Government's public sector pay policies. It said enforcement of pay growth limits was devolved to the Northern Ireland Executive within the overarching parameters set by HM Treasury and meant the Department of Finance and Personnel (DFP) Minister had the scope, within the parameters of the UK Government's pay policy, to approve pay remits for most of the staff groups in bodies within the wider public sector in Northern Ireland.
- 6.23 The Northern Ireland Executive said its control of public sector pay was based on the principle that the public sector should offer a pay and reward package that allows it to recruit, retain and motivate suitable staff. It said public sector pay should also reflect the circumstances specific to the local labour market. The Northern Ireland Executive explained that the most recent Pay Remit Approval Process and Guidance related to 2014/15 and included a one per cent pay award limit. It said in terms of the definition of the one per cent award, public bodies were encouraged to include contractual progression increments as part of this. The Northern Ireland Executive believed a key feature of implementing pay policy was the need to honour contractual entitlements and said many local staff groups are contractually tied to UK nationally determined pay settlements or have clear contractual entitlements to progression/performance pay. The Northern Ireland Executive said it was therefore not possible to impose an overall pay cap without addressing these contractual arrangements first.
- 6.24 The **Joint Staff Side** asked us to make observations on the impact of the continued policy of pay restraint on recruitment and retention, and recommend an uplift that restores the loss in earnings already incurred through cumulative years of below-inflation pay awards. It called for a universal pay uplift as the fairest outcome and the one which was expected by NHS staff. The Joint Staff Side said it was extremely difficult to construct an evidence base to support differential pay awards for different occupational groups or geographical areas, given the current lack of high quality data on vacancies, and on recruitment and retention patterns. It also told us the scope for differential awards was extremely limited within a 1 per cent envelope because the size of any higher award will be negligible, while the negative impact on morale of a lower award for some staff could be considerable. The Joint Staff Side said previous attempts at targeting had caused confusion and bitterness for hard-working and valuable staff affected by removable progression points, non-consolidated awards, pay and increment freezes. This had caused some employers to apply awards for staff above mid-8c as a measure to boost solidarity, morale and staff retention. The Joint Staff Side said it was vital that this year there was

time and space for the Agenda for Change review talks to progress, and any pay award which introduced new differentials or set up further anomalies would be extremely unhelpful.

- 6.25 The Joint Staff Side said the new 'national living wage' of £7.20 an hour for those aged 25 and over from April 2016 will have no effect for NHS staff in 2016 as pay point 2 is currently £7.72 an hour. They told us the increases needed to achieve the National Living Wage in future were not consistent with a 1 per cent pay cap, nor appropriate to be addressed through targeting, and would require structural change. The Joint Staff Side told us a growing number of NHS employers were using the freedoms available to them within Agenda for Change to unilaterally implement the Living Wage. It said the time was right for us to build on the incorporation of the Living Wage in Scotland and Wales by making a comprehensive recommendation to apply the Living Wage consistently in the NHS across the UK (using November 2015 rates and deleting spine points as necessary). The Joint Staff Side asked us to recommend the talks on the review of the Agenda for Change structure take particular account of the introduction of the national Living Wage; country-specific approaches to the Living Wage and how these could be standardised.
- 6.26 The **Royal College of Nursing** believed the Government's public sector pay policy undermined the Pay Review Body process and risked damaging confidence in the machinery of NHS pay determination. The Royal College of Nursing asked us to recognise the impact of inflation on the living standards of NHS nursing staff and to recommend a meaningful pay uplift to repair the damage incurred to recruitment, retention, morale and motivation by public sector pay restraint. The Royal College of Nursing asked us to recognise the proposed targeting of this year's award would be divisive and risked unintended consequences to recruitment and retention.
- 6.27 The **Royal College of Midwives** said it would like to see a return to the Review Body making recommendations based on the evidence presented, rather than constrained by Government. The Royal College of Midwives believed 1 per cent was an insufficient reward that was out of line with RPI inflation, it said the value of NHS pay had significantly reduced following five years of pay freezes and capped 1 per cent uplifts, and this approach would further damage the position. The Royal College of Midwives did not agree that incremental progression could act as a substitute for annual pay increase since it represents reward for increased skill and experience. The Royal College of Midwives did not support an unequal award or targeting across the bands and that 1 per cent should be applied to all staff. It was concerned this could have equal pay implications; impact recruitment and retention and cause anomalies in the Agenda for Change structure.
- 6.28 **UNISON** informed us it had three main objectives for NHS pay: a decisive move against poverty pay and reliance on in-work benefits; an across-the board catch-up award across all bands weighted to the lowest paid; and re-establishing a consistent UK-wide pay structure by levelling up to the Scottish pay scales.
- 6.29 UNISON said its branches were concerned about the divergence in pay structures between the four UK countries, partly precipitated by adoption of Living Wage and low pay measures in some but not all countries. It said levelling up to the Scottish pay levels would be a starting point and would restore a consistent and transparent pay structure across the four countries, benefiting cross-border mobility and reflecting the principles of equal treatment and minimum standards that underpin the NHS. UNISON asked us to make recommendations which re-establish a UK-wide pay structure using the Scottish pay scales as the basis.
- 6.30 UNISON also asked us to recommend a roadmap towards a £10 an hour minimum rate in the NHS as a decisive anti-poverty measure and a show of investment in staff and patient care. UNISON said its branches wanted to see a £1 an hour uplift for all pay

points applied post-harmonisation to the Scottish scales. It said the range of pay increases this would require across the countries was between 12 per cent at the bottom and 2 per cent at the top of the structure. UNISON told us this would deliver the £10 an hour minimum for all those above current Scottish pay point 11.

- 6.31 UNISON believed developments within the NHS and in the wider economy meant the time had come for the NHS to become a Living Wage employer. It said many NHS employers who had not yet implemented the Living Wage were looking to the Pay Review Body and the national pay machinery to take a lead on this. UNISON asked us to establish the principle that the NHS across the UK should now become a Living Wage employer and to recommend an uplift to meet the Living Wage rate due to be announced in November 2015.
- 6.32 **Unite** said we should reassert our independence and make clear recommendations against the Government's pay policy, highlighting concerns about how pay is being set, the extent of pay and terms cuts across the NHS and the impact of this on recruitment and retention, staff morale and service users. Unite asked us to reject suggestions of targeting and to recognise all staff deserved a pay rise. Unite informed us the policy of targeting pay freezes was having a detrimental impact on staff morale, it suggested this could have numerous unintended consequences and was likely to create further bitterness, loss of morale and division amongst the workforce.
- 6.33 The **Chartered Society of Physiotherapists** said it supported the Joint Staff Side submission, in particular the restoration of the value of earnings lost as a consequence of pay restraint in the public sector since 2010. It believed Government plans for further pay restraint (leading to a decade of compressed pay levels below inflation) risked exacerbating existing recruitment and retention problems and impacting on workforce morale and motivation and productivity.
- 6.34 The **Royal College of Nursing (Northern Ireland)** reported that in January 2016, the Northern Ireland Health Minister imposed a pay award for nursing and other HSC staff for 2015/16. It said under the terms of the Minister's announcement, staff at the top of their Agenda for Change pay band will receive a 1 per cent non-consolidated award and nursing staff who are not at the top of their pay band will not receive any cost of living pay increase. The Royal College of Nursing (Northern Ireland) questioned the view that entitlement to an incremental award negated a right to a cost of living pay rise. It said incremental progression, subject to satisfactory performance, was a contractual entitlement under Agenda for Change that, was not within the DHSSPS's remit to "award" or withhold.
- 6.35 The Royal College of Nursing (Northern Ireland) said the impact of pay restraint over the past five years had resulted in a real terms decrease in pay for RCN members. It said it was also opposed to continuing pay restraint in the NHS and had grave concerns about the impact consistent below-inflation pay awards were having on the workforce and on the service. The Royal College of Nursing (Northern Ireland) told us the policy on pay pursued by the DHSSPS in recent years had intensified the hardship felt by nursing staff and added to the perception that the care they provide to the people of Northern Ireland was not valued by the Executive and Assembly.
- 6.36 The Royal College of Nursing (Northern Ireland) told us that successive decisions on pay awards in the NHS in Northern Ireland had led to a growing disparity in pay between Northern Ireland and the other UK countries, with Northern Ireland clearly at the bottom of the table for all bands. It believed this was unfair, unequal and unacceptable. The Royal College of Nursing (Northern Ireland) said the growing pay differentials between Northern Ireland, England and Scotland must be addressed if the health and social care system in Northern Ireland was to recruit and retain adequate numbers of nurses and nursing support staff required for the delivery of safe and effective nursing care to the

people of Northern Ireland. It said a health care assistant employed in a Band 2 post in Northern Ireland was now paid £806 less per year than a counterpart in England and £1064 less than in Scotland; a newly-qualified band 5 staff nurse in Northern Ireland was now paid £214 per year less than a counterpart in England and £340 per year less than in Scotland; and an experienced band 5 staff nurse at the top of the pay banding was now paid £207 per year less than a counterpart in England and £567 less than in Scotland.

Our comment and recommendations

Pay recommendations and observations for 2016/17

- 6.37 For this report we have considered both the level of the pay award and whether the award should be targeted at particular staff groups or geographical areas. We have also considered whether to recommend a consistent award across the UK or specific recommendations for each country.
- 6.38 Our recommendations are informed, but not constrained, by public sector pay policy and ongoing affordability pressures. We accept the evidence that all NHS providers are under financial pressure, and that some form of pay restraint is inevitable. At present, in the context of low inflation and a modest economic recovery, a prolonged period of lower pay settlements do not appear to have produced widespread recruitment and retention problems. The longer term sustainability of this approach over the Spending Review period will be dependent on how the economic picture develops, and may become more challenging. The current pay policy for Scotland and Wales is for one year only and the incoming governments will need to consider their longer term view on pay. We will monitor the country specific approaches to pay, and the targeting towards the lower paid, for border effects.
- 6.39 We have made our belief clear in previous reports that giving a particular figure for public sector pay policy sets expectations for staff. We gave serious consideration to the case for a nil award this year, on the grounds that our remit group would secure more benefits if the available money were instead used to invest in workforce numbers, to alleviate workload pressures. However, our conclusion is that this would be very difficult to justify given the expectation set by the policy and in the context of a 1 per cent award for other public sector workforces. The impact of a nil award in this context would be detrimental to the engagement of our remit group and we do not believe they should be treated less favourably than other public sector staff. None of the parties appeared to be proposing a lower level award for this year.
- 6.40 We have also considered the advantages and disadvantages of a targeted award. Targeting is challenging within an integrated pay structure such as Agenda for Change – pay increases to a band would apply to all staff groups within that band. Equally if geographical supplements (for London and South East England) were increased it would apply to all Agenda for Change bands working within those High Cost Area Supplements (HCAS) regions. Furthermore there is existing scope within the Agenda for Change structure to apply targeted awards either through national or local Recruitment and Retention Premia (RRP).
- 6.41 None of the parties have provided evidence to support a targeted award either by staff group or by geography, and all came out against targeting the 1 per cent award for this year, although the Scottish Government, Welsh Government and Joint Staff Side all support forms of targeting towards the lower paid on top of the 1 per cent award. There have been a number of reasons given for the lack of support for targeting – the lack of flexibility that a 1 per cent funding envelope offers, that it would mean less or zero for other groups (impacting on teams and engagement levels), and, crucially, the lack of available and robust data to support this. In essence there is insufficient data on vacancy

rates and attrition by staff group and location to enable parties to present a case for targeting. This is unsurprising and adds weight to our position that the data we receive needs to improve.

- 6.42 We did hear evidence from the parties of shortages in particular areas such as adult nursing and some nursing specialties such as mental health, paediatric and neo-natal; as well as paramedics, some Allied Health Professionals and radiographers. We were told that recruitment problems were either localised, or primarily supply related, particularly in nursing and paramedics. Our assessment of the evidence in relation to retention is that the issues for different groups of staff are complex, not solely pay-related, and not widespread or uniform at present. Taking all this together, a national response targeted towards particular groups, does therefore not seem appropriate. However, this does not mean that any targeted pay response in the future would be impossible or unhelpful.
- 6.43 There are already mechanisms with the Agenda for Change framework that enable trusts and health boards to target pay to address local recruitment and retention needs. On the basis of the evidence before us, we consider that most recruitment and retention issues are localised, and are better suited to such a local response. Local RRP and the development of local reward strategies provide the best means for targeted pay. In our view a national response to targeting is, on current evidence, not sufficiently agile and would risk imposing additional costs on financially hard-pressed trusts and health boards, where a pay response for particular staff groups may not be required. However, all of this requires careful monitoring, by those overseeing the health system as well as by us. If we begin to see evidence that a national targeted pay response is appropriate then we will consider accordingly. We turn in more detail to targeting over the longer term in our comments later in this chapter, including the pressing need for a reward and workforce strategy.
- 6.44 We have also not seen strong enough evidence this year to suggest a need for geographically targeted awards at this time, as again there is no uniform pattern and no case to justify a national response, given that local RRP exists as a mechanism. There is an emerging picture of higher levels of shortfalls and higher use of agency staff in London and surrounding areas, and this suggests current HCAS arrangements may need updating. The evidence was not robust enough for this round to justify a different approach here in the absence of any request from the parties, but we will return to this in future rounds.
- 6.45 The parties all agreed that, because of NHS affordability constraints, targeting would require a lower or potentially nil award for other staff groups, and that they did not want this. In our view there may be circumstances where this is warranted, but we do not see good evidence for how targeting could in practice be applied in 2016/17. Furthermore, given the expectations set, we also think the consequences of a less than 1 per cent award for all groups, or for certain groups, would be damaging. This would only undermine the workforce, some of whom already feel undervalued. Given the combination of affordability constraints, limited recruitment and retention pressures, and low inflation, we think that one percent is a reasonable level this year for any across-the-board award, such as all the parties have requested.

Northern Ireland

- 6.46 We received the remit and evidence from the Northern Ireland Executive extremely late into our reporting round. We did consider the option of delaying our recommendation for Northern Ireland but believe such a delay would impact unfairly on our remit group there, particularly in the context of recent awards. All parties were also clear that they wanted us to make our recommendations ahead of the Northern Ireland Assembly

election and as part of the UK-wide report. It is to the credit of the Royal College of Nursing (Northern Ireland) that it was willing to turn around written evidence in such a short time frame to enable us to consider a recommendation.

- 6.47 We very much regret being placed in the position of making our recommendations on limited evidence and within such a short time frame. We were not given sufficient time to scrutinise the evidence and explore the recruitment, retention and motivation issues in any depth, or to conduct oral evidence, to run as full a process as for the other countries. Such a shortened timeframe risks the integrity of the process, and parties' confidence in our ability to make robust recommendations. We are uncomfortable about this and have proceeded with a recommendation on an exceptional basis. We are not prepared to short cut the process again in this way. Given the short timescales within which we have operated this year, we would want to give the issues in Northern Ireland particular focus in our next report, or even before, and to take early and comprehensive evidence on this.
- 6.48 We are aware of the considerable financial pressures in Northern Ireland and the difficulties presented by such a large public sector workforce in the context of reducing public sector funding. The economic picture is improving in Northern Ireland but continues to lag behind the rest of the UK. Higher unemployment rates mean the labour market is less tight and pressure on public sector pay is limited given the favourable gap that already exists for public sector staff in Northern Ireland. This is all evidence that would point towards the option of a lower or nil award. However, this must be considered in balance both with what is happening across the public sector generally in Northern Ireland and across the NHS in the UK. In both cases NHS staff in Northern Ireland have been in a less favourable position.
- 6.49 Recent awards and offers to other public sector workers in Northern Ireland, including police officers, prison officers and teachers have seen consolidated pay awards and/or pay offers of 1 per cent or more, albeit in some cases these have been linked to wider pay reforms. NHS staff in Northern Ireland have had imposed pay awards for the last two years and have effectively had a pay freeze for the last year. The pay awards for NHS Agenda for Change staff in Northern Ireland have consisted of incremental progression for those within the pay range and a 1 per cent non-consolidated payment to those at the top of the band. The Minister announced in January 2016 that the 2015/16 award would be imposed following a failure to negotiate an agreement with trade unions. When taken in the context of recent consolidated awards across the UK this means Northern Ireland Agenda for Change pay rates remain at 2013/14 levels and are at least 1 per cent behind the rest of the UK at most levels, and even more so in Scotland and at particular pay points. We do not therefore feel the evidence base is sufficiently robust to support a nil award for Agenda for Change staff in Northern Ireland, particularly in light of the treatment of other public sector workforces. Whilst the evidence we received from the Northern Ireland Executive referred to targeting it did not present us with a proposition. We have not therefore considered this option.
- 6.50 UNISON asked us to consider an award that would restore parity across the UK, using the Agenda for Change pay rates in Scotland as the baseline. In our view there is insufficient evidence on recruitment, retention and engagement grounds to justify this approach. We have yet to see evidence demonstrating recruitment and retention problems at border sites or elsewhere in the UK and there is no evidence to suggest staff are leaving the NHS in Northern Ireland in large numbers to take up positions elsewhere in the UK because of higher rates of pay. The pay rates have already diverged and parties are pursuing their own pay policies both on the headline award and their approach to the Living Wage. We do not oppose this so long as such proposals underpin their longer term vision for service delivery and enable each country to recruit and retain the skilled workforce required to deliver quality patient care.

- 6.51 Whilst the economic and financial picture may be more challenging in Northern Ireland, it remains challenging across the UK and we have seen limited evidence to support a different approach here. Agenda for Change pay values in Northern Ireland have not received a consolidated pay increase since 2013/14 and whilst there are differences in pay rates across the UK there is a wider gap emerging for staff in Northern Ireland. A further year of a nil award would exacerbate this position, damage engagement levels and could risk storing up potential problems for future years which may require a more expensive pay solution. Due to the late remit and evidence from Northern Ireland, and the need to report prior to the election, we were not given sufficient time to consider and scrutinise the affordability position. We have worked on the basis that funding is provided consequential to UK government pay policy equivalent to 1 per cent. We can therefore see no justification to treat staff in Northern Ireland differently to the rest of our remit group and have therefore decided to make a recommendation consistent with the rest of the UK.
- 6.52 Individuals below the top of their Agenda for Change pay band should continue to be eligible for incremental pay progression, according to the agreed criteria in each country.

Recommendation 1

We recommend a 1 per cent increase to all Agenda for Change pay points from 1 April 2016 in England, Scotland, Wales and Northern Ireland.

Recommendation 2

We recommend a 1 per cent increase to the High Cost Area Supplement minimum and maximum payments.

The Living Wage

- 6.53 We have made clear our views on this area in previous reports. Decisions around the Living Wage are a matter of social policy and a decision for the respective governments. As yet, we have not seen any compelling recruitment and retention evidence to support higher increases to lower paid staff groups in the NHS but recognise there may be some value for motivation among the groups benefiting. Although parties have stated their opposition to targeted awards, this is a form of targeting. Parties will need to keep a watching brief on how the Living Wage Foundation Living Wage (known as the Scottish Living Wage in Scotland) and the new National Living Wage interact over the long term. We will be monitoring any border effects and increases in employment costs. Whilst the National Living Wage will not impact in the NHS yet, it will do over the medium term and there will be cost implications (Wales cite the introduction of the Living Wage as one of the main reasons for pay bill increase in Wales this year). It is not clear at this stage but it seems probable that Living Wage Foundation rates will continue to be higher.

Observation 13

We note the additional aspects of public sector pay policy in Scotland (£400 minimum payment for staff earning under £22,000 and application of the Scottish Living Wage) and Wales (application of the Living Wage).

- 6.54 Implementation of the new National Living Wage is likely to bring parity across many sectors at lower levels (unless organisations choose to pay above this). It remains to be seen how NHS will fare when there are other (potentially less stressful) available options for their lower-paid staff, offering pay that is closer or equivalent to what they can earn in

the NHS. This could impact on future retention levels, including pay differentials between bands and the incentive to progress. The total NHS reward package and non-pay areas (staff engagement, health and wellbeing, work life balance, career development etc) will become increasingly important in this context.

- 6.55 We have been told by parties in England that they believe the intention is for the commitment to the new National Living Wage to be funded from within the 1 per cent pay allocation. This would presumably put pressure on funding available for pay increases for staff in the middle and higher Agenda for Change bands, leading to potentially lower pay settlements for them. We note this is a potentially different approach to both Scotland and Wales who have chosen to fund their own Living Wage initiatives separately and in addition to the 1 per cent.
- 6.56 We will, of course, look carefully at any evidence that the parties offer us on this question in the future. However, at present we have serious doubts about any proposition to fund a social policy such as the National Living Wage from the funding available for general pay awards, which are intended to support recruitment and retention. It would be taking place at a time when, on current predictions, private sector earnings and inflation will both have increased, with implications for the competitive position of the NHS in the labour market. For Agenda for Change bands we will keep all of this in mind when assessing any propositions put to us in future.

Observation 14

The UK government needs to consider the funding arrangements for the implementation of the new National Living Wage, which will affect some of our remit group during the later years of this Spending Review period. This is a social policy, rather than a pay policy linked to recruitment and retention needs in the NHS.

Pay Policy over the longer term

- 6.57 Whilst we are conscious that we report and make our pay recommendations on an annual basis, we believe an increasingly important aspect of our role is that of looking forward. In this section we set out our thoughts on the pay policy over the longer term and what we see as key strategic issues for parties to consider and address.

Our comment

- 6.58 We have discussed the implications of the type of pay restraint envisaged by the UK government over the four year Spending Review period. Much will clearly depend on the overall economic picture. There are shortages and recruitment and retention problems already emerging for particular groups in the NHS. Resolving these, so that the NHS continues to offer a good service to patients, will hinge in large part on the quality of the employment proposition, of which pay is one of many factors alongside others such as career progression, development, workload, wellbeing and pension. Data on potential numbers of qualified health staff not working in the NHS in England shows there are non-NHS employment opportunities available to them. To make any pay policy work, employers must get a grip on their workforce policies to ensure careers in the NHS remain attractive in each locality. The wider system supporting them, including regulators and commissioners, must recognise and commit to the importance of engaging the workforce in the service changes being sought. At present inflation is subdued and, whilst private sector wage settlements are increasing at a rate above the public sector, the gap is not considerable. However, if the gap widens, those considering a career in the NHS may take other options, and existing NHS staff may be prompted to leave. In other words pay may become more important. There is no reason to think the NHS will be immune to the normal pressures of a competitive labour market.

- 6.59 The removal of bursaries for student nurses could also have a disruptive impact on supply or the quality of supply; at the least, precedent suggests a risk that demand for these courses from potential quality students could fluctuate in the first two or three years, as the new arrangements are phased in.
- 6.60 As an independent Pay Review Body we will look at a range of evidence and make recommendations on that basis. Affordability is one of our terms of reference but not the only one. However, it seems to us unlikely at present that the evidence will point to equal pressures on all NHS professional groups, and in all regions. Whether it is possible to target effectively within a one per cent pay envelope, without causing disproportionate damage to NHS groups who would lose out, is a difficult question. With money in the system so tight it will be important to get value for money from the pay bill. In order to give serious consideration to targeting we will need sufficient and robust data to support this.
- 6.61 Given overall public sector financial pressures, we understand the UK government's interest in some form of targeted pay approach, focusing resources on where they appear most needed. Our preferred form of targeting at present would be through using local flexibilities. At present RRP are not being used effectively because of local funding constraints and concern about the impact on neighbouring trusts. There is, however, evidence of use of alternative incentives being used such as 'golden hello' payments, relocation packages, paying for training, licences etc. More work could be done to develop a flexible local reward offer which is targeted to meet local needs and delivery of service outcomes. A toolkit of options for a local reward offer could be developed to help trusts and health boards use elements to supplement the national Agenda for Change spine as and where required, returning to the core spine when such targeting is no longer required. The key to this working, however, will be to ensure that staff supply is right, otherwise it risks moving problems around the system.
- 6.62 Local solutions are required to provide a tailored reward offer to respond to local needs, and support the delivery of outcomes through better engagement of staff. There is an argument for developing a national working group to identify and disseminate innovative approaches to local pay, reward, staff engagement and well being. The current thinking needs to be less narrowly focused on pay; given labour costs make up the bulk of the NHS budget driving greater productivity and value from the pay bill should be thought about much more holistically across HR, finance and care quality standards. Such a group could work with those areas who have successfully implemented local reward and staff engagement strategies to identify best practice, consider opportunities and creative solutions and provide advice to other trusts and health boards. Initial areas to focus on could include:
- local performance management and performance pay systems;
 - use of local incentive schemes;
 - recruitment and retention initiatives;
 - local bank rates;
 - flexible total reward offer and staff engagement strategies linked to high quality patient care;
 - health and well being, including some of the ideas in the Boorman report.

Like the NHS England work on vanguard sites, funding could be offered to those who put forward creative ideas and solutions to run local pilots and look to roll out similar initiatives across the service. In England this would perhaps usefully fall under the remit of NHS Improvement and NHS England. For Scotland and Wales this may be better placed under the remit of central government health teams or on the agenda of other independent bodies but must be somewhere with sufficient influence to deliver the required change.

Observation 15

A national working group should be set up in each country to identify innovative practice in local reward and staff engagement, linked to high quality patient care, to provide insight and advice that other trusts and health boards can make use of.

- 6.63 We also heard from the parties on the progress being made on discussions to refresh Agenda for Change which are currently focused on the pay structure. We look forward to hearing further updates as these discussions progress.
- 6.64 The Scottish Government and the Joint Staff Side told us about the review of Band 1 and Band 2 roles in Scotland. The development of more flexible roles at Band 2 level will have advantages for staff and employers alike. For staff this provides further career progression opportunities and an enhanced reward offer, and management will have the advantage of utilising staff more flexibly and allocating resources accordingly. This is not currently a UK-wide position and the Joint Staff Side were seeking to expand this. It is our understanding that trusts and health boards have the flexibility to review roles and implement such changes locally if they wish to do so. This relates to a structural banding issue and is not therefore strictly within our remit. We would suggest that the Agenda for Change discussions are the right forum for the Joint Staff Side to progress this.
- 6.65 Whilst all four countries are involved in contract discussions, we understand that their input is varied. Recent decisions around pay awards and pay policy has resulted in unique Agenda for Change rates in each country. As we have made clear before we do not make any value judgement on this but want parties to be clear in which direction they are travelling and why. Spending decisions and strategic priorities are rightly influenced by the political landscape in each country. It will be important for each of the four countries to consider what they want from the Agenda for Change discussions and to consider how a revised pay structure can meet their individual priorities to support the delivery of improved patient care. Decisions around the pay structure should be based on overall strategy and support this future direction of travel. Previous pay reforms introduced in England have not been implemented in other UK countries despite these offering more efficient management of the pay bill. These provide an opportunity for parties when budgets are tight.
- 6.66 It is not clear to us what the longer term reward approach is in any of the four countries and how this underpins and relates to the vision and direction of travel for the service (i.e. new care models, flexible service delivery) and workforce strategy to deliver this. However, there are signs of progress. Discussions on the structure and detail of Agenda for Change pay are an important element of this but a workforce strategy will need to be much wider to address the key issue of staff engagement to deliver quality patient care. As discussed in Chapter 4 given the level of change proposed, a workforce strategy should be focused on the future vision for the NHS and developing an underpinning reward and engagement framework that can support this, both to enable delivery and drive service change. We would be happy to respond to the parties in their consideration of these issues.

Appendix A – Remit Letters

Letter from the Chief Secretary of the Treasury to Pay Review Body Chairs



HM Treasury, 1 Horse Guards Road, London, SW1A 2HQ

Jerry Cope (NHSPRB); Paul Curran (DDRB); Peter Knight (Prison Services RB); David Lebrecht (Police/NCA PRB); Martin Read (SSRB); Patricia Rice (STRB); John Steele (AFPRB)

c/o Office of Manpower Economics
Fleetbank House
2-6 Salisbury Square
London EC4Y 8JX

Dear Jerry, Paul, Peter, David,
Martin, Patricia and
John,

19th
August 2015

PUBLIC SECTOR PAY 2016-17

Thank you for your work on the 2015-16 pay round. It is clear to me that the pay review bodies play an invaluable role in making independent, evidence-based recommendations on public sector pay, as well as providing expert advice and oversight in relation to wider reforms to pay policy and allowances. I am grateful to you and your colleagues for the careful thought you give to this work, and look forward to receiving your advice and recommendations during the 2016-17 pay round and beyond.

2. Savings from public sector pay and workforce reform made a significant contribution to reducing the deficit over the course of the last Parliament, saving around £8bn. The new government's Summer Budget last month set out that a further £20 billion of consolidation in public sector spending will be required to deliver a surplus by 2019-20. Whilst the deficit and debt are being reduced, the government will need to continue to ensure restraint in public sector pay. Without



such restraint, reductions would need to come from other areas of spend, resulting in negative impacts on public services and jobs. At a time of difficult decisions, the government's pay policy will help to protect the jobs of thousands of front line public sector workers.

3. As you will have seen, the government announced at Budget it will fund public sector workforces for a pay award of 1% a year for four years from 2016-17. The government expects pay awards to be applied in a targeted manner to support the delivery of public services, and to address recruitment and retention pressures. This may mean that some workers could receive more than 1% while others could receive less; there should not be an expectation that every worker will receive a 1% award. The relevant departments will submit in their evidence to you proposals covering the needs of their different workforces.

4. The Budget also set out that the government will continue to examine pay reforms and modernise the terms and conditions of public sector workers. This will include a renewed focus on progression pay, and considering legislation where necessary to achieve the government's objectives. Over the course of the Parliament, I look forward to the pay review bodies playing an important role in advising the government on how best to achieve pay reforms.

5. The relevant Secretaries of State will write to you shortly with a detailed remit covering these points and I look forward to receiving your recommendations.

with best wishes,

A handwritten signature in blue ink, appearing to read 'Greg Hands'.

GREG HANDS

Letter from Lord Prior of Brampton, Parliamentary Under Secretary of State for NHS Productivity to NHSPRB Chair



Department
of Health

*From the Lord Prior of Brampton
Parliamentary Under Secretary of State for NHS Productivity (Lords)*

Jerry Cope
Chair, NHS Pay Review Body
Email to Stacey.Muncaster@bis.gsi.gov.uk

*Richmond House
79 Whitehall
London
SW1A 2NS*

Tel: 020 7210 4850

06 NOV 2015

I am writing as a follow up to the letter you received from the Chief Secretary to the Treasury, Greg Hands on 19 August 2015 confirming the Government's approach to pay awards in the public sector for 2016/2017. I do apologise for the long delay in writing to you.

I am grateful for the invaluable work you and your members carry out on behalf of all those that participate in the annual pay review process. The government has made it clear that pay restraint in the public sector continues to be a crucial part of its plans to reduce the deficit. I appreciate that this presents particular challenges, but your expert, impartial and independent judgement is vital as employers and staff respond to the unprecedented challenges facing the NHS.

The Government has announced that it will fund annual pay awards in the public sector at an average of one per cent in each of the next four years (2016/2017 to 2019/2020). In his letter to you, the Chief Secretary to the Treasury also asked that you consider how an award might best be targeted to support recruitment and retention.

I invite the NHS Pay Review Body to consider the case for targeting to support recruitment and retention, including High Cost Area Supplement and to make recommendations within an average of one per cent for staff employed under Agenda for Change.

I would like to thank you and your members for your work on the special report 'Enabling the delivery of healthcare services every day of the week – the implications for Agenda for Change'. We hope to take forward

partnership discussions between NHS Employers and NHS trades unions on the reform of Agenda for Change.

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

A handwritten signature in blue ink, appearing to read 'D. Prior', with a stylized flourish at the end.

DAVID PRIOR

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

Cabinet Secretary for Health, Wellbeing and Sport
Shona Robison MSP

T: 0300 244 4000
E: scottish.ministers@scotland.gsi.gov.uk



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



22 December 2015

Dear Mr Cope

Further to the letters that the NHS Pay Review Body has received from the Chief Secretary to the Treasury, Greg Hands, on 19 August 2015 and Lord Prior on 6 November 2015, I am writing to confirm the Scottish Government's remit to the NHS Pay Review Body for the 2016 pay round.

The Cabinet Secretary for Finance, Constitution and the Economy announced the Scottish Government's Public Sector Pay Policy for 2016-17 on 16 December 2015. This is a single year policy and sets out the parameters for pay increases for staff. A copy of the policy is available [here](#).

With regard to NHSPRB interests, the main features of this policy are:

- An overall 1 per cent cap on the cost of the increase in basic pay for those earning £22,000 or more.
- Continued measures to support the lower paid, specifically a continued commitment to paying the Scottish Living Wage and guaranteeing a minimum increase of £400 for staff earning less than £22,000
- Continuing the expectation to negotiate extensions to no compulsory redundancy agreements in return for new or continued flexibilities.

You will appreciate that all consideration on this issue by Scottish Ministers must be informed by this policy framework. However, beyond the elements set out above, we would wish the Pay Review Body to be as free as possible in considering the issues and making recommendations for Scotland in 2016-17. It is important to take into account the considerable on-going financial challenges facing NHSScotland at the present time and that any pay increase has to be affordable.

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



I would like to take this opportunity to thank the members of the Review Body for their work and assure you that the Scottish Government continues to value the independent voice which the Review Body offers on Agenda for Change pay.

Copies of this letter have been sent to the Secretary of State for Health and the respective Ministers in the devolved administrations as well as representatives of the Staff Side and NHS employers.

Yours sincerely,
Shona Robison

SHONA ROBISON

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

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services



Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA-P/MD/1410/15

Jerry Cope
Chair, NHS Pay Review Body
Office of Manpower Economics
8th Floor, Fleetbank House
2-6 Salisbury Square
London
WC1B 4AD

16 December 2015

Dear Mr Cope,

NHS Pay Review Body – Remit 2016-17

I am writing to confirm the Welsh Government's approach in respect of the NHS Pay Review Body's remit for 2016-17, and as such, request that the Review Body provides recommendations in respect of staff engaged on Agenda for Change terms and conditions.

Any recommendation should take into account the Chancellor's 2015 budget statement that public sector pay will increase by 1% a year for 4 years from 2016-17 and within the context of NHS Wales financial position, as set out in the written and oral evidence.

To this end, please note that the Welsh Government will be aiming to submit written evidence by 21st December, followed with oral evidence on 12th January 2016.

My officials will be happy to work with your secretariat to ensure you have all relevant supporting information is made available.

Copies of this letter have been sent to the Secretary of State for Health in England, the Cabinet Secretary for Health, Wellbeing and Sport in Scotland and the Minister of Health, Social Services and Public Safety in Northern Ireland. I am also copying this to the Secretary of State for Wales.

Yours sincerely,
Mark Drakeford

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

Wedi'i argraffu ar bapur wedi'i ailgylchu (100%)

English Enquiry Line 0845 010 3300
Llinell Ymholiadau Cymraeg 0845 010 4400
Correspondence.Mark.Drakeford@wales.gsi.gov.uk
Printed on 100% recycled paper

Letter from Northern Ireland Executive Minister for Health, Social Services and Public Safety to NHSPRB Chair

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY



Department of
**Health, Social Services
and Public Safety**
www.dhsspsni.gov.uk

Mr Jerry Cope
Chair, NHS Pay Review Body
8TH Floor, Fleetbank House
2-6 Salisbury Square
LONDON
EC4Y 8JX

Castle Buildings
Stormont Estate
BELFAST BT4 3SQ
Tel: 028 9052 0638
Email: private.office@dhsspsni.gov.uk

Our Ref: COR/63/2016

Date: 3 February 2016

Dear

Thank you for your letter of 15 January. The Department of Health, Social Services and Public Safety (DHSSPS) greatly values the contribution of the NHS Pay Review Body in delivering robust, evidence based pay outcomes for public sector workers.

I write to confirm the approach of my Department in respect of the Pay Review Body's remit for 2016-17.

I would ask that you consider the case for targeting to support recruitment and retention and to make recommendations for staff employed under Agenda for Change. Any recommendation should take account of the need for continued public sector pay restraint and the specific financial context of Northern Ireland which will be set out in the written evidence.

To this end, please note that my Department will be aiming to submit written evidence by 5 February. My officials will be happy to work with your secretariat to ensure that you have all relevant supporting information to inform your review.

Yours sincerely

SIMON HAMILTON MLA

Appendix B – Recommended NHS Agenda for Change pay scales with effect from 1 April 2016

Recommended Agenda for Change pay scales 2016 for England

Point	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8				Band 9
								Range A	Range B	Range C	Range D	
1*												
2	15,251	15,251										
3	15,516	15,516										
4		15,944										
5		16,372										
6		16,800	16,800									
7		17,351	17,351									
8		17,978	17,978									
9			18,152									
10			18,653									
11			19,217	19,217								
12			19,655	19,655								
13				20,348								
14				21,052								
15				21,692								
16				21,909	21,909							
17				22,458	22,458							
18					23,363							
19					24,304							
20					25,298							
21					26,302	26,302						
22					27,361	27,361						
23					28,462	28,462						
24						29,333						
25						30,357						
26						31,383	31,383					
27						32,407	32,407					
28						33,560	33,560					
29						35,225	35,225					
30							36,250					
31							37,403					
32							38,683					
33							40,028	40,028				
34							41,373	41,373				
35								43,038				
36								44,703				
37								46,625	46,625			
38								48,034	48,034			
39									50,467			
40									53,285			
41									56,104	56,104		
42									57,640	57,640		
43										59,606		
44										62,397		
45										66,582	66,582	
46										68,484	68,484	
47											71,338	
48											74,825	
49											78,629	78,629
50											82,434	82,434
51												86,390
52												90,537
53												94,883
54												99,437

* Pay point not used in England (since April 2015)

Recommended Agenda for Change pay scales 2016 for Scotland

Point	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8				Band 9
								Range A	Range B	Range C	Range D	
1*												
2	15,758#	15,758#										
3	16,114#	16,114#										
4		16,529										
5		16,944										
6		17,360	17,360									
7		17,895	17,895									
8		18,503	18,503									
9			18,868									
10			19,354									
11			19,902	19,902								
12			20,327	20,327								
13				21,000								
14				21,683								
15				22,092								
16				22,218	22,218							
17				22,683	22,683							
18					23,597							
19					24,547							
20					25,551							
21					26,565	26,565						
22					27,635	27,635						
23					28,746	28,746						
24						29,626						
25						30,661						
26						31,696	31,696					
27						32,731	32,731					
28						33,895	33,895					
29						35,577	35,577					
30							36,612					
31							37,777					
32							39,070					
33							40,428	40,428				
34							41,787	41,787				
35								43,469				
36								45,150				
37								47,092	47,092			
38								48,514	48,514			
39									50,972			
40									53,818			
41									56,665	56,665		
42									58,217	58,217		
43										60,804		
44										63,651		
45										67,920	67,920	
46										69,860	69,860	
47											72,771	
48											76,329	
49											80,209	80,209
50											84,091	84,091
51												88,127
52												92,357
53												96,791
54												101,436

Note – The pay rates reflect both our 1 per cent recommended increase and the application of the Scottish Government public sector pay policy

* Pay point not used in Scotland because of Scottish Living Wage policy

Pay point below 2016 Scottish Living Wage

Recommended Agenda for Change pay scales 2016 for Wales

Point	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8				Band 9
								Range A	Range B	Range C	Range D	
1	14,581*	14,581*										
2	14,947*	14,947*										
3	15,314*	15,314*										
4		15,742#										
5		16,170										
6		16,598	16,598									
7		17,149	17,149									
8		17,776	17,776									
9			18,152									
10			18,653									
11			19,217	19,217								
12			19,655	19,655								
13				20,348								
14				21,052								
15				21,692								
16				21,909	21,909							
17				22,458	22,458							
18					23,363							
19					24,304							
20					25,298							
21					26,302	26,302						
22					27,361	27,361						
23					28,462	28,462						
24						29,333						
25						30,357						
26						31,383	31,383					
27						32,407	32,407					
28						33,560	33,560					
29						35,225	35,225					
30							36,250					
31							37,403					
32							38,683					
33							40,028	40,028				
34							41,373	41,373				
35							43,038					
36							44,703					
37							46,625	46,625				
38							48,034	48,034				
39								50,467				
40								53,285				
41								56,104	56,104			
42								57,640	57,640			
43									60,202			
44									63,021			
45									67,247	67,247		
46									69,168	69,168		
47										72,051		
48										75,573		
49										79,415	79,415	
50										83,258	83,258	
51											87,254	
52											91,442	
53											95,832	
54											100,431	

* These pay points will be adjusted to reflect the incorporation of the living wage.

Pay point below 2016 Living Wage Foundation Living Wage

Recommended Agenda for Change pay scales 2016 for Northern Ireland

Point	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8				Band 9
								Range A	Range B	Range C	Range D	
1	14,437	14,437										
2	14,799	14,799										
3	15,163	15,163										
4		15,586										
5		16,010										
6		16,433	16,433									
7		16,979	16,979									
8		17,600	17,600									
9			17,972									
10			18,468									
11			19,027	19,027								
12			19,461	19,461								
13				20,147								
14				20,844								
15				21,477								
16				21,692	21,692							
17				22,236	22,236							
18					23,132							
19					24,063							
20					25,047							
21					26,041	26,041						
22					27,090	27,090						
23					28,180	28,180						
24						29,043						
25						30,057						
26						31,072	31,072					
27						32,086	32,086					
28						33,227	33,227					
29						34,876	34,876					
30							35,891					
31							37,032					
32							38,300					
33							39,632	39,632				
34							40,964	40,964				
35							42,612					
36							44,261					
37							46,164	46,164				
38							47,559	47,559				
39								49,968				
40								52,757				
41								55,548	55,548			
42								57,069	57,069			
43									59,606			
44									62,397			
45									66,582	66,582		
46									68,484	68,484		
47										71,338		
48										74,825		
49										78,629	78,629	
50										82,434	82,434	
51											86,390	
52											90,537	
53											94,883	
54											99,437	

Appendix C – Composition of our remit group

- C1 Tables C1 to C7 show the composition of our remit group in each country and in the United Kingdom as a whole as at September 2014.¹ Detailed categories of staff in each country have been aggregated into broad staff groups, to enable cross-United Kingdom comparisons to be made.
- C2 Staff categories used in each administration’s annual workforce census have been grouped together by our secretariat. We have had to be mindful of the differences between the four datasets, and even these broad staff groups contain inconsistencies: some ancillary staff in England and Wales are categorised in the census as healthcare assistants and support staff, but have job roles that fit better in the broad group “administration, estates and management”.

¹ The most recent date for which United Kingdom-wide data were available at the time of writing.

NHS full time equivalent non-medical workforce as at 30 September 2014

Table C1: Qualified nurses and midwives

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Qualified nurses, HVs and midwives	313,514	Nurses & midwives bands 5-9	42,616	Qualified nurses, HVs and midwives	21,987	Qualified nursing & midwifery	14,472	392,591

Table C2: Nursing, healthcare assistants and support staff

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Unqualified nurses	60,426	Nurses & midwives bands 1-4	15,791	Unqualified nurses	6,313	Nurse support staff	3,990	
Healthcare assistants and support staff	126,403			Healthcare assistants and support staff	9,650			
	186,829		15,791		15,963		3,990	222,573

Table C3: Professional, technical and social care

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Qualified AHPs	66,090	Medical & dental support	1,875	Qualified AHPs	4,627	Professional & technical	7,202	
Qualified healthcare scientists	25,273	AHPs	9,921	Qualified healthcare scientists	1,867	Social services	6,745	
Other qualified ST&Ts	43,989	Other therapeutic services	3,858	Other qualified ST&Ts	2,732			
Unqualified ST&Ts	41,730	Personal & social care	942	Unqualified ST&Ts	2,445			
		Healthcare science	5,393					
	177,082		21,988		11,671		13,947	224,688

Table C4: Ambulance

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Qualified ambulance	17,700	Emergency services ²	3,751	Qualified ambulance	1,392	Ambulance	1,045	
Unqualified ambulance	7,677			Unqualified ambulance	152			
	25,377		3,751		1,544		1,045	31,717

² In Scotland's published statistics from the 1st April 2013, paramedics have been reclassified from emergency services staff to allied health professions. However, for comparisons with the other countries of the United Kingdom, paramedics are classified here as Ambulance staff.

Table C5: Administration, estates and management

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Admin & clerical	206,717	Administrative services	24,899	Clerical and administration	12,249	Admin & clerical	11,036	
Maintenance & estates	8,682	Support services	13,856	Maintenance & works	948	Estates services	707	
Manager	24,491			Managers	1,407	Support services	4,699	
Senior Manager	10,674			Senior managers	568			
	250,564		38,755		15,172		16,442	320,934

Table C6: Other

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	United Kingdom FTE
Others	4,422	Unallocated/not known	1,084	Others	115	Generic	0	5,621

Table C7: Total NHS non-medical workforce

	England	Scotland	Wales	Northern Ireland	United Kingdom
FTE	957,789	123,986	66,452	49,896	1,198,123
Headcount	1,098,170	143,810	78,429	58,152	1,378,561

Sources: *The Health and Social Care Information Centre, Welsh Government (StatsWales), Information Services Division Scotland, the Department of Health, Social Services and Public Safety Northern Ireland.*

Appendix D – The parties’ website addresses

The parties’ written evidence should be available through the following links:

Department of Health	https://www.gov.uk/government/publications/information-for-the-nhsprb-pay-round-2016-to-2017
NHS Providers	https://www.nhsproviders.org/resource-library/submissions/nhs-pay-review-body-written-evidence-201617
Health Education England	https://www.hee.nhs.uk/news-events/news/nhs-pay-review-body-201516-evidence
Joint Staff Side	https://www2.rcn.org.uk/__data/assets/pdf_file/0011/649919/Staff-Side-PRB-evidence-2016-17.pdf
NHS Employers	http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/Final%20PDF%20NHSE%20Pay%20submission%20PRB%2029%20Oct.pdf
NHS England	https://www.england.nhs.uk/wp-content/uploads/2015/10/nhs-prb-evidence-16-17.pdf
Northern Ireland Executive	https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/evidence-nhsprb-february-2016.pdf
Royal College of Midwives	https://www.rcm.org.uk/sites/default/files/Evidence%20to%20the%20NHS%20Pay%20Review%20Body%20September.pdf
Royal College of Nursing	https://www2.rcn.org.uk/support/pay_and_conditions/pay-round-2016 https://www.rcn.org.uk/news-and-events/news/northern-ireland-health-minister-seeks-2016-2017-recommendation-from-nhs-pay-review-body
Scottish Government	http://www.gov.scot/Topics/Health/NHS-Workforce/Policy/Pay-Conditions
Unison	https://www.unison.org.uk/content/uploads/2015/11/UNISON-PRB-evidence-FINAL-2016-171.pdf https://www.unison.org.uk/content/uploads/2015/09/UNISON_report_NHS_Pay_staffing_and_morale.pdf
Unite the Union	http://www.unitetheunion.org/how-we-help/list-of-sectors/healthsector/healthsectorresources/healthsectortermsandconditions/nhs-pay-review-body/
Welsh Government	http://gov.wales/topics/health/publications/health/reports/?lang=en
GMB, Unite the Union, Unison	https://www.unison.org.uk/content/uploads/2015/11/Recruitment-and-retention-of-ambulance-staff-PRB-November-2015-FINAL.pdf
Association of Ambulance Chief Executives	http://aace.org.uk/news-resources/useful-documents/aace-national-rrp-submission/

Appendix E – Previous Reports of the Review Body

Nursing Staff, Midwives and Health Visitors

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

Professions Allied to Medicine

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

Twelfth Report on Professions Allied to Medicine	Cm 2763, February 1995
Thirteenth Report on Professions Allied to Medicine	Cm 3093, February 1996
Fourteenth Report on Professions Allied to Medicine	Cm 3539, February 1997
Fifteenth Report on Professions Allied to Medicine	Cm 3833, January 1998
Sixteenth Report on Professions Allied to Medicine	Cm 4241, February 1999
Seventeenth Report on Professions Allied to Medicine	Cm 4564, January 2000
Eighteenth Report on Professions Allied to Medicine 2000	Cm 4992, December
Nineteenth Report on Professions Allied to Medicine 2001	Cm 5346, December

Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine

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

NHS Pay Review Body

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

Appendix F – Abbreviations used in the report

AHPs	Allied Health Professionals
ASHE	Annual Survey of Hours and Earnings
Bsc	Batchelor of Science
CPI	Consumer Prices Index
CST	Chief Secretary to the Treasury
DB	Defined Benefit
DFP	Department of Finance and Personnel
DHSSPS	Department of Health, Social Services and Public Safety
ECP	Emergency Care Practitioners
ESR	Electronic Staff Record
FFT	Family and Friends Test
FTE	Full-time Equivalent
GDP	Gross Domestic Product
HCAS	High Cost Area Supplements
HOMs	Heads of Midwifery
HSC	Health and Social Care
HSCIC	Health and Social Care Information Centre
HCHS	Hospital and Community Health Services
Health Departments	Department of Health; Northern Ireland Executive, Department of Health, Social Services and Public Safety; Scottish Government, Health and Social Care Directorates; and Welsh Government, Department of Health and Social Services.
HMT	Her Majesty's Treasury
KSF	Knowledge and Skills Framework
LETB	Local Education and Training Boards
NASPF	National Ambulance Strategic Partnership Forum
NHS	National Health Service
NLW	National Living Wage
NWSSP	NHS Wales Shared Services Partnership
NI	National Insurance
NMC	Nursing and Midwifery Council
OBR	Office for Budgetary Responsibility
OECD	Organisation for Economic Co-operation and Development
PAs	Physician Associates

PEEP	Paramedic Evidence Based Education Project
RPI	Retail Prices Index
RRP	Recruitment and Retention Premia
SOL	Shortage Occupation List
STAC	Scottish Terms and Conditions Committee
ST&T	Scientific, therapeutic and technical staff
SWAG	Scottish Workforce and Staff Governance Committee
TDA	Trust Development Authority
TR	Total Reward
TRS	Total Reward Statements
TSO	The Stationery Office
WLG	Working Longer Group
wMDS	workforce Minimum Data Set
WTE	Whole Time Equivalent

Appendix G – NHSPRB: Workforce monitoring data

The table below sets out the types of data needed to inform NHSPRB pay deliberations, including consideration of targeting pay to address recruitment and retention pressures. It attempts to identify what is collected at present and by which organisations in each of the four countries.

This is not an exhaustive list and there are a number of other sources of information and evidence in relation to NHSPRB's key terms of reference: motivation, recruitment and retention, and affordability.

	By Geography and Staff Group
Source of new recruits	% UK training routes % Non-EEA % EEA Source: NMC registrations¹
Quality of new UK trainees	UCAS tariff at under-graduate entry Source: UCAS; HESA
Conversion rate of UK training route	% those completing degree courses joining the NHS Source: HESA
Vocational or on-the-job training routes	Apprentice numbers Source: Employers;¹ HEE;¹ BIS
Retention of those receiving on-the-job training	% those completing apprenticeships staying in the NHS Source: Employers¹
Leavers and joiners	% leaving rate (excluding internal transfers to another trust/board) % joining rate (excluding internal transfers to another trust/board) Source: HSCIC; Information Services/Health Departments not published for Wales
Reasons for leaving	HSCIC (England); not published for Scotland, Wales, Northern Ireland
Numbers eligible to return to NHS workforce – clinical	Total number on NMC register, less those employed by the NHS Source: NMC Register, Health Departments
Vacancy rates	To a consistent definition to enable tracking over time Source: NHS Jobs adverts (HSCIC); Workforce Minimum Dataset (England) Pending; Information Services/Health Departments.
Annual workforce planning assumptions	Shortfall against demand; priority training areas Source: HEE, NHS Education for Scotland, NHS Wales Shared Services Partnership, Workforce Planning Unit DHSSPSNI
Agency use and rates	Agency expenditure by location, staff group and shift type; range of rates paid Source: NHS Improvement (England);¹ Health Departments.¹
Wider labour market trends and economic indicators	Wage settlements, employment rates, inflation Source: OBR; ONS

¹ Details to be confirmed with the parties.

See Appendix F for Abbreviations and Acronyms.

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