NHS EMPLOYERS' SUBMISSION TO THE NHS PAY REVIEW BODY 2018/19

18 December 2017

Contents

Key messages

The financial challenge

- Last year, our evidence set out the unprecedented financial and service challenges faced by employers. This position has not substantially changed and the financial outlook remains extremely challenging and restricts the ability of the NHS to invest in pay without new additional funds.

- Although the NHS has been protected from the full impact of austerity since 2010, with funding for the NHS increasing by more than the rate of inflation, the increase is substantially less than the increase in demand for services and other cost pressures. This is compounded by the relative lack of investment in other public services, especially social care.

- NHS organisations are having to manage growing disparities between rising demand for services - and the staff needed to provide them - and the amount of funding available, while continuing to meet public and patient expectations.

- Although the overall financial deficit in trusts fell from around £2.5 billion in 2015/16[1] to a reported £791 million in 2016/17[2], persistent levels of structural debt has been limiting the financial resources available for delivering current services and transforming how these services will be delivered in the future.

- The increasing demand for services is from a growing population comprising older people and a greater prevalence of long-term, often complex patient conditions, all of which is keeping sustained pressure on available resources at a time of rising costs.

- Employers are engaged on programmes to improve quality and drive up efficiency yet these require additional resource and will take time to deliver results. Resources in the current climate are focused on meeting urgent patient and service user needs.

- Employers have already met and are continuing to deliver productivity above the national average. It would therefore be extremely difficult for employers to fund any additional investment into pay without having to make difficult choices about the number of staff that they employ and the services that they provide.

- As the King's Fund, the Health Foundation and the Nuffield Trust[3] said in their pre-budget analysis: 'Productivity in the NHS is improving by 1.7 per cent a year and is outperforming the wider economy. The NHS must continue to focus on improving productivity by tackling variations in care, improving clinical practice and making better decisions about how money is spent. Even so, this will not be enough to bridge the gap between rising pressures and planned funding'.

[1] The King's Fund: Deficits in the NHS 2016: July 2016
[2] The King's Fund: Nine things we learnt about provider finances in 2016/17: 14 July 2017
[3] The King's Fund: The Autumn Budget: Joint statement on health and social care

The workforce challenge

- NHS employers spend around two-thirds of their budget on staff. Sustainable workforce costs are essential to helping the NHS meet the quality and efficiency challenges that employers face. The cost of staff will remain central to efforts to manage budgets, improve efficiency and transform services.

- In a highly pressured financial environment in which there is no ability to fund additional pay within existing resources, the importance of valuing, supporting and developing staff to have rewarding careers within a positive working environment becomes even more important.

- In this difficult climate, employers repeatedly tell us that their workforce is their greatest priority. There is widespread recognition of the need to support recruitment and retention of staff and there are many national and local initiatives in place[4,5]. However, we recognise that much more needs to be done, both nationally and locally, if we are to attract, recruit and retain the workforce that we need both now and in the future.

  We welcome the Secretary of State's recent announcement of a robust, coordinated approach to workforce strategy. The recently published Health and Care Workforce Strategy[6] for England to 2027 sets out the vision for this transformation. Getting workforce policy right in the future will be central to delivering sustainable and affordable high-quality health and care services.

- A workforce strategy will need to make clear how the NHS will collectively address the future supply, retention and development of its workforce. This is an opportunity to set out how actions to date will help employers in the short, medium and longer term, as well as being clear on what further actions will need to be taken at every level of the NHS and across government.

- Embedding and realising the benefits of a strategic workforce plan will require leadership and a commitment by organisations to ensure that all staff feel valued, supported and developed throughout their careers. The link between effective staff engagement and outcomes is well known. The more that NHS organisations value their staff and make their working lives a positive experience, the better placed they will be to meet difficult recruitment and retention challenges and, above all, be able to provide consistently safe, compassionate and high-quality care to their patients.

[4] NHS Employers: Retention: May 2017
[5] NHS Improvement: Securing a sustainable NHS workforce for the future: June 2017
[6] Workforce Strategy: Facing the facts shaping the future - a health and care workforce stategy for England to 20127: December 2017

The transformation challenge

- NHS leaders recognise the challenge to change how care is delivered to ensure patients receive the right care, in the right place, first time.

- The NHS is constantly considering new and innovative approaches to delivering high-quality services efficiently, in the face of continuing financial and demographic challenges. Work focuses on providing more services in the community, genuinely integrating health and social care, preventing illness, promoting health and wellbeing and doing more to get the best from our talented staff.

- The development of sustainability and transformation partnerships (STPs), and in some cases the development of accountable care systems (ACSs) and devolution, all provide the NHS with opportunities to provide joined-up, better coordinated care, with change led at system level.

- It is recommended that if transformation plans are to improve outcomes for patients, there must be new workforce plans that reflect more collaborative working across established organisational boundaries.

- These necessary developments will require new contracting, funding, workforce and information governance models.

Agenda for Change reform

- We welcome the government's announcement, in September 2017[7], confirming the relaxation of pay restraint. The relaxation of pay restraint could help support existing employer initiatives to address recruitment, retention and continued improvements in workforce productivity.

- Employers understand that we need to move out of the period of prolonged pay restraint in a sensible, but managed way.

- Employers have emphasised to us very strongly that any investment in pay must be fully funded through additional funds from Her Majesty's Treasury.

- Investment in pay that is not fully funded in this way will create significant additional financial pressures and adversely impact on the delivery of quality care and patient services.

- Employers believe that the pay system needs to change to support the NHS to deliver on the priorities set out in NHS England's *Next steps on the Five Year Forward View*[8]. These set out the quality and efficiency challenges linked to the work to extend more patient services across seven days, meet the changing needs of patients and integrate new models of care.

[7] Chief secretary to the Treasury Letter to the NHSPRB chair: September 2017
[8] NHS England: Next steps on the NHS five year forward view: March 2017

- The announcement of relaxation of pay restraint provides the NHS with an opportunity to address longstanding structural issues in the Agenda for Change (AforC) pay system and to anticipate the future impact of changes to the statutory national living wage.

- Constructive discussions with trade unions have started. These will explore the scope for change set out in the letter from the chief secretary to the Treasury to the NHSPRB chair, the 2017 Autumn Budget statement[9] and the Secretary of State's letter to the review body chair[10].

- Employers are looking for a balanced package of changes to terms and conditions which would support system-wide initiatives, increase available capacity at an affordable level, and further reduce the costs of agency staffing.

- We believe that changes to pay and conditions of service in NHS employing organisations can be a catalyst for changes in the organisation and delivery of patient care, and for changes to staff roles and ways of working.

- Delivering patient care is not just simply about paying staff more, it is about developing a multi-skilled and flexible workforce that is shaped by the current and changing needs of patients and the drivers of affordability and sustainability.

- More investment in pay and the reform of the AforC terms and conditions framework will not solve the rising demand for services or address the current crisis in social care.

- A balanced package of reforms to terms and conditions, supported by a multi-year pay award, provides the opportunity to create the stability for the NHS to assist in financial planning and introduce structural changes in a planned manner.

- National pay and conditions of service must remain fit for purpose for use by employers; we are asking the NHSPRB to take this into account when making pay recommendations for 2018-19.

[9] Autumn Budget 2017: Chancellor of the Exchequer: November 2017
[10] Secretary of State for Health: Pay review body remit letters from Jeremy Hunt 2018 to 2019: December 2017

1. Informing our evidence

Introduction

1. We welcome the opportunity to submit our evidence on behalf of healthcare employers in England for the 2018/19 pay review. We continue to value the role of the NHSPRB in bringing an independent and expert view on remuneration issues in relation to the NHS Agenda for Change workforce.

2. Our evidence has been informed by a continuous cycle of engagement with a full range of NHS organisations, about their priorities for pay and for terms and conditions reform. We have:

   - had direct discussions at one-to-one meetings with NHS chief executives
   - attended regional network meetings of human resources directors, the NHS Confederation and other employer networks
   - carried out a survey on reward
   - maintained regular contact with HR directors.

   As in previous years, our evidence is framed within the challenges faced by the NHS around finance and workforce. These have become even more acute during 2017 and will continue to develop in complexity and intensity as the pressures on demand continue to increase. For most NHS leaders, the most pressing of these issues is workforce.

The financial and workforce challenges

3. As the NHS approaches its 70th anniversary, employers are facing unprecedented financial and service challenges. Demand for health care has risen rapidly due to a combination of different elements including an increased population, longer life expectancy, changing patterns of disease and ill health and the development of new treatments and technologies. Additionally, there have been significant increases in the numbers of attendances at A&E departments and emergency and elective admissions, all of which have increased waiting times and bed occupancy rates.

4. At the same time, the NHS has been operating within a highly constrained financial environment in which it has been expected to respond to increasing demand while meeting exacting efficiency savings. This mismatch between demand for services and funding is unlikely to be resolved soon. According to analysis by the Nuffield Trust, projections for future years suggest that even under an optimistic assumption for inflation and continued high level of savings, NHS providers will continue to run a large collective underlying deficit until at least 2020/21.[11]

[11] The Nuffield Trust: The Bottom Line - understanding the deficit and why it won't go away

5. So far, there has been a mixed reaction to the additional investment in frontline services announced in the Autumn Budget 2017.[12] A survey of its member organisations, carried out by the NHS Confederation,[13] found that 3 per cent of leaders thought that the Budget would make a big improvement to their organisation's ability to provide good quality care. Half of members said it would make a small improvement.

6. We welcome the commitment in the Budget to fund a pay deal for AforC staff, contingent on improved productivity and justified on recruitment and retention grounds.

7. Yet there is much to do, including investing in the continued professional development of staff and making greater use of apprenticeships. The 2017 Budget committed to provide an extra £2.8 billion of resource funding for the health service in England by 2020. This is against the backdrop of assessments from the Nuffield Trust[14], the Health Foundation and the King's Fund, which suggested that the funding requirement in 2018/19 was nearer £4 billion if deterioration in the quality and availability of care were to be avoided. The Nuffield Trust is concerned that when this additional funding levels off in 2019, the financial pinch will tighten once more.

8. Careful plans will need to be made to ensure the additional money is used wisely. Before the Budget, many provider organisations were once again managing a financial deficit. NHS leaders will need to ensure that the additional £335 million invested in helping the NHS cope with winter 2017/18 pressures is not used simply on increased agency spending in A&E departments.

9. Although the dual pressures of rising demand and finance remain, it is the workforce challenge of having enough staff, with the right skills and in the right places, which employers currently consider to be most pressing. Increasing demand for safe and high-quality services has led to demand for more staff to deliver them. Where the demand for staff cannot be met, either because of a shortfall in supply or insufficient resources, the result is an increasingly pressurised workplace which impacts adversely on morale, motivation and retention. This, in turn, has the potential to jeopardise quality of care and patient safety.

10. In its report[15] on the state of health care and adult social care, the Care Quality Commission (CQC) said that despite very real challenges, the quality of health and social care has been maintained and that most patients are getting good, safe care. The fact that quality has been maintained in the toughest climate most can remember is testament to the hard work and dedication of staff and leaders. We have seen countless examples of NHS staff at all levels, in all professions and in all disciplines working tirelessly for the benefit of patients,

[12] Autumn Budget 2017
[13] NHS Confederation: Autumn Budget 2017
[14] The Nuffield Trust: Joint statement on health and social care (November 2017)
[15] Care Quality Commission: The state of health and adult social care in England 2016/17: October 2017

whether that has been in the background designing and managing the delivery of services or on the frontline, responding with bravery and professionalism to major incidents such as those which took place in Manchester and London.

11. However, the CQC also warned that 'the combination of greater demand and unfilled vacancies means that staff are working harder than ever to deliver the quality of care that people have a right to expect. However, there is a limit to their resilience.'[16]

12. The fragility of the current position was also highlighted by the King's Fund in its quarterly monitoring report. The report projected that the NHS is set to miss targets including for improving A&E performance, reducing delayed transfers of care and financial targets for reducing deficits in the provider sector. However, they also acknowledged that this is not due to lack of effort by staff or poor management within individual NHS organisations, but that 'the healthcare system is now so overstretched that even when effort and resources are focused on a smaller set of priorities the required performance levels remain elusive'.[17] The King's Fund reports that the issue of most concern to trust finance directors was the morale of staff. The report concludes that 'as frontline staff try their best to improve quality of care and access for patients, it is increasingly apparent that we are setting them an impossible task'.[18]

13. One of the factors that has tested the resilience of staff has been the imposition of a prolonged period of pay restraint, during which time earnings have diminished in real-term value.

14. The government's announcement in September 2017 that pay restraint will be relaxed, the announcement in the Autumn Budget of the commitment to fund awards as part of a deal for AforC staff, and the Secretary of State for Health's request for NHS Employers to continue exploratory talks with AforC unions with a view to the unions obtaining a mandate to negotiate a multi-year agreement is welcome. We note that funding of a deal for AforC staff will be on the condition that it will enable support for improved productivity and can be justified on recruitment and retention grounds.

15. While pay restraint and NHS pay more generally have understandably featured prominently in much of the debate around the financial and workforce difficulties facing the NHS, just concentrating on pay alone will not resolve the multiple challenges that NHS organisations currently face in meeting the increase in demand for high-quality care. The prospect of a higher, but still relatively modest, pay increase, while welcome, will not be a cure for all issues.

Workforce supply and staff retention

16. While we welcome the initiatives that have been introduced recently to increase the supply of healthcare professionals, we acknowledge that in many cases it

[16] Care Quality Commission (October 2017) The state of health and social care in England 2016/17
[17] The King's Fund (November 2017) Quarterly Monitoring Report No 24
[18] The King's Fund (November 2017)

will take some time for this increased supply to take effect. It would be counterproductive if at the same time we did not complement important national initiatives on supply and innovative local work on recruitment with more work on retaining, supporting and developing the highly trained, talented and committed staff that we already have.

17. This is even more important given the current uncertainties arising from Brexit which, in future, could reduce access to EU healthcare professionals on which the NHS has increasingly relied.

18. There is no single action which will resolve staff retention issues. We recognise that some turnover of staff is healthy and is to be expected as they move on to new opportunities. However, high volume turnover, combined with difficulties in recruitment, leads to rota gaps which in turn adds to pressure on the remaining staff and can lead to an over-reliance on expensive agency and locum staff. We have set out a range of actions that employers can take to help retain and develop existing staff, in guidance which draws on the learning and experience of organisations we have worked with.[19]

19. The range of actions include:

- improving staff engagement to improve retention, morale and productivity
- supporting and promoting health and wellbeing
- providing a safe and open environment in which concerns can be raised and acted upon
- offering flexible working and e-rostering to help staff balance their personal and professional lives
- developing a culture which recognises and values difference and delivers a positive workplace experience
- tackling bullying and harassment
- providing educational and training activities to support professional and personal development and career planning
- offering flexible retirement options.

20. Pay and reward is also an equally influential factor in staff retention and, during the time in which pay restraint has had an impact on salaries, employers have promoted the full range of reward and benefits that the NHS and their organisations offer. Where employees understand the full range of benefits available to them, and the value of the overall reward package, they can make better informed decisions on whether to leave or remain with the organisation. Such non-pay related benefits include access to the NHS Pension Scheme, annual leave and other contractual benefits, flexible working and family friendly working arrangements.

21. While the measures we have described above will provide a firm foundation on which to improve the retention of staff, they are also significant factors in making the choice of a career in the NHS more attractive. Staff with the right

[19] NHS Employers: Improving staff retention a guide for employees: September 2017

values, skills and knowledge should be recruited into the organisation and supported and developed as they progress within it.

The productivity challenge

22. A motivated and engaged workforce is important if the NHS is to work in new and innovative ways to meet the challenges ahead. The extra funding announced in the budget will result in little benefit if there are not enough staff. Neither will there be any benefit in recruiting extra staff without thinking critically about how they are deployed and organised. This is reflected in statements from the Secretary of State that any increase in pay will need to be accompanied by improvements in productivity. A joint statement from the King's Fund, the Health Foundation and the Nuffield Trust said recently that, despite the considerable efforts that the NHS had made to meet the efficiency challenges required by the Five Year Forward View, 'there is still scope for more fundamental improvements in productivity by tackling variations in how care is delivered, improving clinical practice and making better decisions about how funding is spent.'[20]

23. However, as a recent King's Fund report on embedding a culture of quality improvement pointed out, this kind of work takes time and in a period of sustained pressure it can be difficult to find the space in which to do so. The report concludes that NHS leaders play a key role in creating the right conditions for quality improvement by engaging with staff, empowering frontline teams and ensuring that there is an appropriate infrastructure in place to support staff and spread learning.[21]

Productivity in contract reform

24. A common thread linking the recruitment, retention, workforce and productivity challenges is the national pay and conditions of service framework and the related work to review and refresh these arrangements. These national agreements are fundamental in helping to ensure that employers can recruit, retain and motivate staff and that they are able to deploy them flexibly in an affordable and sustainable way. In return, staff can expect to be recognised and rewarded for the contribution that they make. As we continue with our programme of change and reform there will be opportunities to link it to some of the national quality and efficiency programmes, including Lord Carter's review of operational productivity and the Getting it Right First Time (GiRFT) project. There will also be opportunities to improve further the alignment between pay and performance.

[20] The Autumn Budget 2017: Joint statement on health and social care
[21] The King's Fund: Embedding a culture of quality improvement: November 2017

A co-ordinated approach

25. There are many programmes of work currently underway within NHS organisations aimed at tackling the various financial and workforce challenges the NHS faces. Initiatives include boosting training numbers, tackling retention, improving the workplace experience and reforming pay and conditions of service. Although in most cases these will be undertaken separately, there is a considerable amount of interdependency between them, where failure to resolve issues in one area can potentially undermine work in another. In its report on workforce profile and trends in the NHS the Health Foundation concluded that 'proper workforce planning is required that looks across different staff groups to evaluate impact – not focusing purely on the numbers of consultants or nurses separately'.[22] This point was also made in an earlier Health Foundation report on consultant productivity, which found that hospitals with a higher proportion of nurses and support staff within their total workforce had higher consultant productivity and that increasing the share of nurses by 4 per cent increased consultant productivity by 1 per cent.[23]

26. We welcome the Secretary of State's recent announcement of a robust, coordinated approach to workforce strategy. The recently published Health and Care Workforce Strategy[24] for England to 2027 sets out the vision for this transformation. Getting workforce policy right in the future will be central to delivering sustainable and affordable high-quality health and care services.

27. Embedding and realising the benefits of any strategic workforce plan will require leadership and a commitment by organisations to ensure that all staff are valued, supported and developed throughout their careers. The link between effective staff engagement and outcomes is well known. The more that NHS organisations value their staff and make their working lives a positive experience, the better placed they will be to meet difficult recruitment and retention challenges and, most importantly of all, be able to provide consistently safe, high-quality care to their patients.

[22] The Health Foundation: In short supply? An analysis of NHS finances and consultant productivity: April 2017
[23] The Health Foundation: A year of plenty? An analysis of NHS finances and consultant productivity: March 2017
[24] Workforce Strategy: Facing the facts shaping the future - a health and care workforce strategy for England to 2017: December 2017

2. The workforce challenge

26. As part of efforts to tackle workforce shortages, employers tell us that making their organisations and their employment offer attractive to potential new recruits is the biggest challenge they face now, and for the foreseeable future. The challenges around finance means the workforce is even more important.

27. There are growing and widespread concerns about the health and social care workforce. This is due, in part, to the impact of long-term austerity, uncertainties around Brexit, changes to the funding of education and the legacy of the issues at Mid-Staffordshire hospital.

28. Evidence over many years shows us that where we invest time and effort in engaging and looking after our people, patient care improves[25]. Employers welcome the emphasis on staff health and wellbeing in the NHS Five Year Forward View[26] which stresses the importance of the physical and mental wellbeing of the NHS workforce. The report also argues that changes to working conditions, and a stronger workplace culture of trust and engagement, would help boost morale and staff retention in struggling areas.

29. Shortages of staff in the workforce pose challenges to the implementation of new models of care. Staff shortages such as in emergency medicine and in the nursing and midwifery professions, presents difficulties for the delivery of services such as A&E and maternity. The fall in the number of nurses has been most notable in community nursing and mental health[27]. These are two areas which are important to the success of the forward view and the development of community services.

30. We refer to shortages in the nursing workforce in Section 3 of this document. To address these problems employers will need to find ways to increase supply as well as ensuring staff already in the workforce can be retained. There is continuing uncertainty about the position of European Union staff following Brexit and the fall in the value of the pound. Price inflation may also deter potential new recruits from abroad. This is a cause for employer concern, especially as social care and health services will continue to depend on workers from outside the United Kingdom in the short to medium term. Actions by the government to reassure European Economic Area (EEA) citizens, and by the regulator to improve its processes are welcome, although employers tell us that much still needs to be done. The Cavendish Coalition[28], a group of health and social care organisations that came together in the wake of the referendum result, is working to reduce the workforce implications of Brexit.

[25] Staff Experience and patient outcomes: What do we know: NHS Employers
[26] NHS England: NHS Five Year Forward View: October 2014
[27] The Health Foundation: Rising pressure the NHS workforce challenge: October 2017
[28] NHS Employers, the Cavendish Coalition

31. The greater part of the AforC workforce is sourced from the United Kingdom, and there is much more to be do in terms of recruitment and retention. We need to combine our focus on increasing domestic efforts with ensuring that the country develops a post-Brexit immigration system that will not be detrimental to health and care. We say more about the implications of Brexit in section 3.

32. Employers recognise that they will need to build capacities and capabilities in the workforce for a world of continuous change and the emergence of new roles and possibilities. Employers are working to develop the skills and competencies of the current workforce, and the quality of team working, to better meet the needs of patients today, and tomorrow. National pay and conditions must enable HR to plan, recruit, develop and retain our workforce. There is more on this in sections 3 and 6.

33. One of the biggest challenges for today's professional workforce is that it was trained and developed to work in a model centred around single episodes of treatment in hospital. However, those placing the greatest demand on services, both now and in the future, are older people with multiple health problems (both mental and physical) who need long-term integrated health and social care.

34. The NHS and social care sector needs multi-skilled staff to work across traditional boundaries and we are beginning to see closer collaboration between specialists and generalists, hospital and community and mental health, and physical health workers. Devolution, STPs and accountable care systems provide new opportunities to develop new models of working that cross boundaries, both professional and sectoral.

35. Employers say that workforce redesign is needed because the current workforce may not be matched to the future service needs of patients and this has implications for future workforce supply and retention issues.

36. New medical and information technologies have already begun to change what the work is, where it can be done and who does it.

37. Employers recognise that they will need to develop collaborative practice as part of continuing professional development, encouraging and enabling individual professions to work across the professional divide and existing organisational boundaries. The national pay and conditions of service must enable and support the development of new ways of working, ensuring the workforce is effective, efficient and fulfilled.

38. NHS Employers has an ongoing programme of support to employers on leadership. We are working with local leaders to help them redesign and better engage their workforces (section 5 details our evidence on the staff survey). Effecting a smooth transition to new ways of working is dependent on skilled local managers, who can shape organisational culture, manage staff side relationships, understand and account for community preferences and mobilise local educational resources.

39. While national support is important, particularly in relation to funding the training of existing staff, employers in the NHS are also working on reducing the number of staff leaving. To support this, we published a briefing[29] illustrating the various elements that contribute to a sustainable workforce supply strategy and providing examples and signposts for employers to use. More recently we published a guide to staff retention,[30] sharing existing best practice to help all trusts take early and appropriate action. The guide sets out a range of actions that employers can take to help retain and develop existing staff and which draws on the learning and experience of organisations we have worked with.

40. Some organisations are also working together to respond to the concerns of the workforce and to keep more staff working within the NHS and social care. While much attention has focused on the impact of seven years of pay restraint, other areas need to be addressed, including funding of postgraduate education, access to affordable accommodation, improving the experience of black and minority ethnic colleagues, greater flexibility, and better use of technology. Employers are stressing the importance of continuing to develop, coach and support staff through rotating posts across the healthcare system and having clear clinical pathways to aid development, retention and deployment.

41. Retaining talented staff is immediately crucial, but we must look at what we need to do to attract people to the healthcare sector in the longer term. We have contributed to this by developing our workforce retention programme to enable workforce leaders to attend workshops to explore what tools and skills they will need to create sustainable workforce plans. Our programme took a focused and targeted approach to supporting individual trusts to create a sustainable retention strategy.

42. We also have campaigns designed to help employers look differently at attracting and retaining a talented and diverse workforce, including practical support and information on apprenticeships[31], support to engage with young people via our ThinkFuture[32] campaign and briefings to encourage and support practices such as improving access to employment for people with mental illness[33].

43. There are many challenges facing the NHS, and more broadly, health and social care, regarding the availability of our workforce. We will continue to press for national action to support better supply and retention, but employers must also challenge themselves to improve access to employment and to retain the people we already have through better quality workplaces and work.

44. Work done by the Nuffield Trust[34] gives a clear steer that, with some notable exceptions, it is the development of the current workforce, in their existing and extended roles, which provides the greatest opportunity for employers. The

[29] NHS Employers: Workforce supply, attracting and retaining local talent: June 2017
[30] NHS Employers: Improving staff retention a guide for employers: September 2017
[31] NHS Employers, NHS apprenticeships
[32] NHS Employers, ThinkFuture
[33] NHS Employers, Supporting staff who are experiencing mental health problems
[34] Nuffield Trust: Reshaping the workforce to deliver the care patients need: May 2016

challenges and risks associated with the NHS workforce are well known, and we look forward to participating in further coordinated action, at national level, to put in place a coherent strategy to ensure a sustainable and sufficient workforce for the NHS.

Equality and diversity

45. *Next steps on the Five Year Forward View* said that the NHS will become a better and more inclusive employer by making full use of the talents of its diverse staff and the communities it serves.[35]

46. There is a growing body of evidence to support the case for employers to consider their continued approach towards diversity and inclusion issues as a fundamental part of their proposition to employees.

47. In 2015, we produced a report which charted the history of research in this area[36] – but also demonstrated the impact of putting that research into practice within specific NHS trusts. The recent CQC report,[37] *Driving improvement,* concentrated on eight NHS trusts and identified cultural change as one of the key themes running through their improvement programmes. This theme stressed the need for successful organisations to create workplace cultures where staff and leaders feel able to be authentic at work and where the workplace better reflects the communities that they serve. The King's Fund also has an ongoing series of reports and research[38] highlighting the importance of diverse and inclusive workplace cultures in allowing organisations to thrive, innovate and grow.

48. A range of workplace diversity initiatives – such as the Workplace Race Equality Standard[39] and the NHS Employers Diversity and Inclusion Partners Programme[40] are helping NHS organisations to increase their capability in this important area. In future, we hope the workplace disability equality initiative will also help employers to create workplace cultures which make them employers of choice as part of their efforts to recruit and retain staff.

Integrating health and social care

49. Research shows that patients benefit from care that is person-centered and coordinated. Truly joined-up care brings together the talents and expertise of staff within various healthcare settings, across mental and physical health, and across health and social care employers. Integrated care happens when care professionals collaborate closely to bring together all the different elements of care that a patient needs. When patients must visit several professionals, in

[35] NHS England, Next steps on the NHS five year forward view: 25 May 2017
[36] NHS Employers: The power of research in driving change
[37] Care Quality Commission, diversity and inclusion, the power of research in driving change, September 2015
[38] The King's Fund, Making the difference, diversity and inclusion in the NHS: December 2015
[39] NHS England: NHS workforce race equality standard: June 2016
[40] NHS Employers

different settings, care is fragmented. In such circumstances, the care patients need can be difficult for them to access and may lead to less appropriate decisions on their care and treatment.

50. Employers in England report that:

- organisational integration is no guarantee of improved outcomes
- the integration of clinical teams and services is far more important
- the ongoing separation between the health and social care systems is a major obstacle to achieving better outcomes for patients.

51. The provider journey towards new models of providing and delivering care involves:

- moving services closer to people's homes
- using improved relationships with local care partners to reduce delayed transfers of care, improving care for long-term conditions
- supporting more patients to manage their own care, effectively using new technology.

52. The Cities and Local Government Devolution Act 2016[41] provides a framework for the devolution of powers that will be applied to individual areas by secondary legislation. It removes the statutory limitation on functions that can be conferred on a combined authority and enables public body functions to be devolved to local authorities and combined authorities. Substantial responsibilities, including those for health and social care, have been devolved to the combined authority for the Greater Manchester area (Devo Manc) and NHS England has announced a devolution health deal for Surrey.[42]

53. We have learned from employers that there is a different appetite for change and a different momentum in each locality. Commissioning has an essential role to play in developing integrated services and will need to adapt so that there is a much more strategic and integrated approach to the planning and use of resources, both within the NHS and between the NHS and local government.

54. It is too early to say what the implication of these changes are for the NHS workforce. NHS England proposes that as a larger, multidisciplinary provider covering a broader scope of services, an accountable care organisation/system should be able to offer new opportunities to the local health and care workforce. Yet there can be no national blueprint for change and we are already seeing the development of various local approaches. Employers believe that there needs to be more scope in national collective agreements for them to tailor the employment package to meet local, operational and organisational needs. Some employers have suggested that the development of joint working with local authorities may mean that, in future, pay and conditions changes in both the NHS and local government will need to be considered together.

[41] The Cities and Local Government Devolution Act 2016
[42] NHS England: News: Surrey health and care organisations sign devolution pledge: June 2017

55. The NHS needs to work with colleagues in social care and local government to devise jointly agreed practical measures that will prevent unnecessary hospital admissions and reduce delays around discharge. A long-term strategy for the future must command the confidence and support of both the NHS and local government. Employers recognise that as well as working with each other, their organisations must involve staff, patients, carers and local communities to ensure they are providing services tailored to local needs[43].

56. NHS England envisages that in accountable care organisation/system models of care, mental health, public health and social care services can be included in the contract where this is agreed by the clinical commissioning group and local authority[44]. Several localities intend for their integrated provider to deliver social care and public health services. NHS England is already working with local authorities, the Local Government Association and the Association of Directors of Adult Social Services to consider how local accountable care system/organisation contracts will need to develop.

57. The CQC has noted that sustained support will be needed for new models to become established and investment will be needed to support leadership and enable the desired transformation.[45] All parts of local health and care systems – commissioners, providers, regulators and local people – need to work together to help transform health and care in their local areas.

58. The CQC reports that although some health and social care services are improving, some services are failing to improve and in others there is a deterioration in quality. Although many adult social care services have been able to maintain quality, there are indications that the sustainability of adult social care is approaching a tipping point. Hospitals are also coming under increasing pressure and the CQC is concerned about the sustainability of quality services.

59. Health and social care are interdependent. It will be no good increasing investment in one half of this equation while ignoring the other. Delayed transfers of care from acute to non-acute services continue to be a problem. The proportion of delays attributable to social care has increased over the last year to 36.3 per cent in September 2017, compared to 34.5 per cent in September 2016[46]. The lack of coherent action on the problems in social care is already having an adverse impact on the NHS.

Equal pay and job evaluation

60. The Hartley versus Northumbria et al case[47] confirmed that the nationally agreed job evaluation procedures and supporting materials are consistent with relevant legislation. These procedures need to be applied consistently by

[43] Department of Health: NHS Constitution
[44] NHS England: New care models: questions and answers: August 2017
[45] Care Quality Commission: The state of health and adult social care in England 2015/16: October 2016
[46] NHS England: Delayed transfers of care: 2017-18
[47] Hartley v Northumbria Healthcare NHS FT

employers. This means ensuring that job evaluation panel members are always adequately trained and that panels base their decisions firmly on the facts of the case. Rigorous consistency checking is essential to ensure equity.

61. We are continuing to provide a range of national training courses which include going back to the basics on job evaluation and its correct application. These courses are fully booked. Our new course concentrating on consistency checking has been welcomed by employers.

62. Employers regularly seek advice from experts on the NHS Staff Council job evaluation group and joint guidance[48] is issued covering frequently asked questions.

[48] NHS Staff Council: Mitigating equal pay risks following the end of CAJE

3. Workforce supply

Specific profession shortages

63. Across the NHS, all providers of care and services are experiencing increased demand – this can be seen in hospitals, emergency services, community settings and mental health provision.[49]

64. Changes to population demand or policy direction can significantly impact on any organisation's ability to source the staff they need, impacting on their ability to meet demand and provide high-quality patient care.

65. Employers are looking at ways in which to make best use of all available staff and are reconsidering the way in which services are provided. STPs in England are looking at the health and social care needs of local populations and at how integrated care can best be designed to meet future needs in a realistic and sustainable manner.

66. We know demand can often alter quicker than we are able to make changes to the supply of the workforce. The distinctive way in which the NHS operates means that it is not possible to respond to workforce gaps quickly through simply training more people.

67. The Migration Advisory Committee's shortage occupation list, published by UK Visas and Immigration[50], reflects some of the supply shortages in the NHS and currently includes the following occupations:

- nurses
- radiographers
- sonographers
- orthotists
- prosthetists
- paramedics
- healthcare scientists in neurophysiology and nuclear medicine
- social worker working in children's and family services.

68. The expansion of training places and exploring other development opportunities are central to a sustainable workforce strategy. Additional domestic efforts need to include: engaging fully across local communities to encourage and attract individuals into employment; improving retention of current staff and ensuring employment practice supports efforts to be an employer of choice.

69. While there are clear opportunities to increase our domestic workforce supply, in the short to medium term, it will be challenging for NHS organisations to meet their workforce supply requirements without continuing to access skilled labour from outside of the UK.

[49] NHS England, the NHS in 2017
[50] UK Visas and Immigration: Shortage Occupation List

Nursing workforce

70. Data published by Health Education England (HEE) indicates that NHS organisations had 26,700 full-time equivalent (FTE) nursing vacancies as at April 2015, equivalent to an 8.5 per cent vacancy rate. The shortage experienced by employers varies with gaps ranging from 5.4 per cent in the North East to 13.8 per cent in South London[51]. New analysis in December 2017[52] shows the NHS has at least 36,000 FTE nursing vacancies, and the number could be as high as 42,000.

71. NHS Improvement is collecting vacancy data from NHS organisations. This data is not published but would provide the pay review body with an up-to-date and accurate picture as to the extent of current supply shortages in the nursing workforce.

72. To address nurse supply shortages, the efforts of NHS organisations must focus on creating additional supply and ensuring we retain nurses in the profession. Data collected by NHS Employers at a series of Nursing Times Careers events throughout 2017 provides an indication of what matters most to nurses and student nurses when it comes to recruitment and retention.

73. The full survey results are available on the NHS Employers website[53]. The results indicate that when looking for a new role it is the opportunities for development, location and pay that matter most to nurses. The factors that encourage nurses to stay in their roles are opportunities for development, staff engagement and opportunities for progression. Pay featured as the fourth most important factor for nurse retention.

74. Policy changes to routes into nursing are providing employers with more opportunities to increase supply in the long term, but we do not expect to see the results until 2021-22 onwards.

75. Previously the routes into nursing have been limited, with the university degree being the main way to train registered nurses. The introduction of the nursing degree apprenticeship gives a new opportunity for employers to train nurses. The creation of the new nursing associate role can also help to be a bridge between healthcare assistants and graduate registered nurses.

76. The examples outlined in the NHS Employers briefing document *Workforce supply – attracting and retaining local talent*[54] - demonstrate some of the positive steps already being taken in the NHS. However, as this is a developing position for employers, they will need support to help them make the most of the new routes into nursing[55].

[51] Health Education England, Workforce Plan 2016/17
[52] Nuffield Trust: the NHS workforce in numbers: December 2017
[53] NHS Employers: What do nurses want - infographic?
[54] NHS Employers: Workforce supply - attracting and retaining local talent: June 2017
[55] NHS Employers: Routes into nursing: October 2017

Nursing associate role

77. Following the outcomes of the *Shape of caring review*, Health Education England has been taking forward proposals to introduce a new role of nursing associate, regulated by the Nursing and Midwifery Council.

78. The new nursing associate role is set to offer an opportunity for NHS organisations to make the most of current and emerging talent and help them to address some of their supply challenges. The intention is that this role should not be a substitute for registered nurses, it should allow nurses to spend additional time using their more specialist training to focus on clinical duties and take more of a lead in decisions on a patient's care. The aim is for the role to be an apprenticeship, with nursing associate trainees finishing the course with a level 5 qualification.

79. The role is still in pilot phase. Early feedback from the pilot sites is positive, with employers reporting enthusiasm for the role and its potential for adding value to the work of their existing multidisciplinary teams.

80. Initial analysis completed by HEE suggests that the cohort of nursing associates in this pilot demonstrated a greater diversity than the pool of applicants normally seen in university nursing degree courses. This would indicate that this role has the potential to support greater social mobility for prospective nursing associates.

81. The role also provides a new route into nursing, giving nursing associates the opportunity to train to become a registered nurse on a shortened degree apprenticeship using accreditation of prior experiential learning.

82. On 3 October 2017, the government announced that a further 5,000 nursing associates will be trained through the apprentice route in 2018, with an additional 7,500 being trained in 2019.

83. Employers wanting to include this role in any workforce plans are awaiting the outcome of the pilot and a clearer view on the scope of practice for the role. Once this is agreed, employers will be able to plan more accurately how to use nursing associates across the workforce to meet the needs of their patients and service users. A further factor which will impact upon this will be the decision affecting the ability to include the nursing associate role within safe staffing figures.

Apprenticeships

84. The apprenticeship position has changed considerably over the last year, with a levy introduced on large employers from April 2017. The levy is payable by employers at 0.5 per cent of their pay bill, and the funds can only be used to pay for apprenticeship training and assessment. It is not permissible to use them to cover other associated costs, for example, wages, travel costs or organisational infrastructure.

85. Modelling based on the NHS organisations in scope of the levy, indicates that the cost to the NHS in 2017/18 is approximately £200 million. In terms of how this relates

to individual NHS organisations, for a large city-based teaching hospital employing 14,000 staff, their levy contribution will be in the region of £3.29 million per annum. The number of apprenticeship opportunities across the NHS has grown considerably in recent years (by the end of 2016/17, the NHS achieved 15,532 apprenticeship starts[56]), the levy is placing an additional financial strain on employers.

86. In addition to the levy, an apprenticeship target has been placed on public sector organisations. From April 2017, all public-sector organisations with more than 250 employees are expected to meet a target of new apprenticeship starts per financial year, the target is set at 2.3 per cent of headcount.

87. Across the NHS, the 2.3 per cent target will equate to around 28,000 apprenticeship starts per annum, measured as an average across the reporting years 2017/18 to 2020/21. This will need to be more like 42,000 if the sector is to spend all the monies paid under the levy arrangements (based on current funding caps).

88. These policy drivers are pushing employers to foster and develop their organisations into positive learning environments. This is a shift in culture for many organisations, which previously may have had limited educational or development opportunities for their staff. The increase in the range and number of apprenticeships being offered in the NHS will facilitate this shift.

89. While apprenticeships have long been a valued model for education and training the NHS workforce, these have traditionally been offered for lower level, support roles. The direction and speed at which the new policy has been implemented continues to pose challenges for the NHS. A lack of organisational infrastructure to support a large increase in the delivery of apprenticeships, and the outsourcing of a number of NHS services employing the kinds of support staff that would be suitable for entry level apprenticeships, means that the introduction of this policy is representing a significant challenge for NHS organisations.

90. One of the key drivers behind the reforms has been a wish to drive up productivity through the delivery of increased numbers of higher and degree apprenticeships. This is a desirable aim, which could help employers to address some of the skills gaps that exist across the workforce. A new registered nurse degree apprenticeship is now available that offers an alternative to university for those wishing to pursue a career in nursing.

91. The field of healthcare science has developed a wide range of apprenticeships, including higher apprenticeships, which is providing clear progression and career routes to support the current and future healthcare science workforce.

92. The NHS Staff Council has produced guidance arrangements for pay and banding of trainees and there are job evaluation profiles for roles where apprenticeships are commonly used, such as healthcare support and business administration.

[56] Health Education England: unpublished data

Nursing degree apprenticeship

93. The implementation of the new nursing degree apprenticeship provides a new route into nursing, which may support and improve the diversity in applicants, and provide opportunities for social mobility. This route present challenges for employers.

94. Our understanding is that the number of Higher Education Institutions (HEIs) offering the nurse degree apprenticeship in 2017 and early 2018 is extremely limited, with most planning to offer this route from autumn 2018. This is, in part, due to the current Nursing and Midwifery Council (NMC) review of pre-registration nursing standards - HEIs are opting to offer the apprentice route once the new standards are published. This will impact on the ability of employers to use this route into training for the next 18 months.

95. The affordability of the nursing degree apprenticeship route is heavily affected by the supernumerary requirement of the training. For the nursing degree apprenticeship, the supernumerary element of the learning is 4,600 hours, split equally between theory and practice over the duration of the training course. Across the four-year apprenticeship this is an average of 25 hours per week, for which employing organisations will be required to back-fill for these members of staff. There is further impact when the apprentices undertake clinical placements as part of their learning and they cannot be included in the employing organisation's staffing figures. Added to this is the mentoring, supervisory and administrative capacity required for the delivery of this training route.

Student support system reforms

96. The decision to remove the student bursary for nursing, midwifery and allied health students, which came into effect from August 2017, gives universities the ability to offer extra training places and provides employers with the opportunity to move to a much-desired place where supply can meet or, in the longer term, exceed demand.

97. September 2017 was the first intake of university nursing students who would not receive a bursary from the government to cover their academic costs. The full impact of this policy is yet to be seen but indicative figures from the Universities and Colleges Admissions Service (UCAS) showed that by the 15 January deadline for the 2017 cycle, there were 23 per cent fewer applicants to nursing from England, and 25 per cent fewer applicants from the EU (excluding the UK) compared to the same time the previous year[57].

98. Figures released by UCAS in September 2017 show that there was a drop of about 6 per cent in the number of students taking up nursing places in England[58]. In contrast, the numbers of students from Scotland and Wales starting nurse training have increased. In addition to the fall in overall numbers for 2017, there has been a shift in the age profile. The number of students aged under 20 starting nurse training is 6 per cent higher, but there are around 10 per cent fewer people aged 20 and over starting a nursing degree[59].

[57] Liz Thomas Associates
[58] Universities and Colleges Admissions Services (ACAS)
[59] The Health Foundation: October 2017

99. On 9 August 2017, the government set out its commitment to fund up to an additional 10,000 clinical placements in nursing, midwifery and allied health pre-registration education by 2020. On 3 October 2017, the government announced a further 5,000 clinical placements each year for nursing. While this additional funding comes too late to consider for 2017, it is welcomed and will be helpful for employers and education providers to consider for intakes during 2018.

100. This funding will enable universities to meet the demand for the additional placements required by students across these roles. An additional 1,500 places will be available for courses starting from August 2017 and work is currently underway to determine the mechanism through which clinical placement funding will be allocated from 2018/19 to 2020/21 (inclusively) to meet this commitment.

101. If successful, the reforms have the potential to substantially increase the supply of non-medical staff in to the NHS workforce. However, they require NHS organisations to increase their capacity to provide additional placements, supported by skilled supervision. This is a challenge for employers who are coming under increasing pressure to provide support and placements in the same workplaces, for example, to student nurses, nurse associates and nursing apprentices.

102. We would expect to see the results from this policy change from 2021-22 onwards, but this is dependent on being able to attract people to the profession in a highly competitive jobs market.

Improving access to employment

103. To support the workforce supply requirements, employers across the NHS are looking at ways in which they can strengthen their current and future domestic supply by engaging with, and recruiting from, their local population.

104. The NHS is also investing in the diversity of its workforce at a local level. This activity is underpinned by mandatory reporting requirements such as the existing Workforce Race Equality Standard[60], the new Workforce Disability Equality Standard[61] and gender pay gap reporting[62]. As outlined in chapter two of the Five Year Forward View[63], employers are aspiring to develop a workforce which better represents the community they serve, through recruiting their workforce from their local population[64].

105. NHS Employers is supporting employers to analyse the demography of their local population to establish plans to engage with, and recruit from, areas of the community which may not have been engaged with before. These community groups include carers, people facing homelessness or long-term unemployment, care leavers and armed forces service leavers.

[60] NHS England: Workforce Race Equality Standard
[61] NHS England: Workforce Disability Equality Standard: September 2016
[62] Gender pay gap reporting: January 2017
[63] NHS England: Five Year Forward View
[64] NHS Employers

106. National programmes of work such as the Step into Health[65] initiative supports employers in the NHS to connect with people from the armed forces community by offering an access route into employment and career development opportunities. The programme recognises the transferable skills and cultural values that armed forces personnel develop when serving, and how they are compatible with those required within NHS roles.

107. NHS Employers has delivered the ThinkFuture[66] programme, which supports NHS organisations to attract and recruit 16-24 year olds into their workforce, using targeted communications materials and advice for HR teams and managers. These tools, resources, advice and guidance have been developed following engagement and consultation with young people.

108. Employers are developing new relationships with HEIs to secure the clinical workforce pipeline, through arranging guaranteed employment for trainees, upon qualification.

109. Employers are also establishing relationships with local schools and colleges to showcase the range of career options and pathways available for young people leaving school. The introduction of the apprenticeship levy and subsequent increase in healthcare apprenticeships on offer provide clear alternatives to full-time university education for school leavers.

110. To recruit candidates into their organisations, employers are increasingly reviewing their attraction methods, introducing more efficient and appealing recruitment processes such as assessment days and values-based recruitment.

111. NHS Employers is working with the Department of Health and arm's-length bodies to deliver a significant national campaign linked to the 70th anniversary of the NHS. As part of the celebrations, careers in the NHS will be promoted.

International recruitment

112. Alongside the need to increase the skills base within the UK, the political narrative around managing and reducing migration has also intensified in the last 12 months.

113. The immigration skills charge, introduced in April 2017 and paid by employers who recruit skilled workers from outside of the EEA, is just one policy decision which is aimed at encouraging employers to invest in the skills and training of the local population.

114. This charge means an additional upfront cost to employers of £5,000 for a migrant entering the UK on a five-year visa. Home Office published data[67] showing the number of certificates of sponsorship granted monthly to employers across all sectors provides no evidence of a decrease in demand following the introduction of the immigration skills charge.

[65] Step into Health
[66] NHS Employers: ThinkFuture
[67] Employer sponsorship: restricted certificate allocations: UK Visas and Immigration

115. While there are clear opportunities to increase our domestic workforce supply in the short to medium term, it will be challenging for employers to meet their workforce supply requirements without continuing to access labour and skills from outside of the UK. This levy is placing another additional financial pressure on NHS organisations, for many of whom, recruiting from overseas forms a critical component of being able to meet the demand for services and deliver high-quality patient care.

Implications of Brexit

116. The decision to leave the EU has the potential to impact on the workforce of many different industries, and the health and social care sector is no different. We have a valued and talented workforce made up of colleagues from the UK, the EEA and around the world.

117. In July 2016, NHS Employers in collaboration with NHS Providers and The Shelford Group, commenced a quarterly survey of NHS organisations, looking at the implications of the UK's decision to leave the EU, on the recruitment and retention of staff from the EU.

118. The series of surveys provides an indication that 12 months on from the referendum vote, a greater number of employers now feel that the decision to leave the EU will have a negative impact on their workforce and there are fewer employers with plans to recruit from the EEA due to the continued uncertainty.

119. Looking at nursing specifically, the number of joiners to the NMC register trained within the EU has been rising steadily over the past 10 years. NMC data[68] shows registrations increased from 3,436 in the year 2012/13 to 9,389 in the year 2015/16, however this declined to 6,382 in 2016/17.

120. It is too early to make a clear-cut judgement about whether this is a direct result of the decision to leave the EU. However, any indication that the UK is becoming a less attractive place to work is naturally a cause for alarm, especially as the sector will continue to depend on workers from outside of the UK in the short to medium term.

121. The immigration system that is in place after the UK leaves the EU will need to ensure that, alongside the strategy to increase domestic workforce supply, it supports the ability of our sector to provide the best care to our communities. To achieve this, it will need to confirm the right to remain in the UK to EU nationals currently working in the sector. Whatever immigration model is adopted and agreed as part of the negotiation process, it must be flexible enough to allow health and social care employers to recruit appropriately from outside of the UK to fill workforce shortages and maintain services.

Improving staff experience and retaining the NHS workforce

122. While improving staff experience and the ability to retain a talented workforce have always been important to the NHS in the delivery of consistent, high-quality care, in recent months there has been a greater focus on improving staff wellbeing and the retention of staff. As referenced in other sections of this report, significant skills gaps

[68] Nursing and Midwifery Council: The NMC register 2012/13 - 2016/17

exist across the NHS workforce and trusts across England are struggling to recruit to key vacancies. Given that recruitment is both a time-consuming and costly activity, and that stability of the workforce is associated with better patient outcomes, there is an immediate need for trusts to look to prioritise the experience and wellbeing of staff and to improve retention.

123. NHS leaver rates and staff turnover have been deteriorating in headline terms over the previous four years. Concern exists with rising turnover rates in nursing and in mental health trusts, issues which are compounded by supply risks in these parts of the workforce.

124. NHS sickness absence rates vary significantly between organisations and staff groups. Estimates from Public Health England[69] put the costs to the NHS of staff absence at £2.4 billion per year and this is before the added costs of providing agency cover. Deloitte's recent analysis of the European healthcare workforce in *Thriving at work*[70] estimates that the cost to the healthcare sector per employee due to mental health is £2,029-£2,174 per year. Mental health and musculoskeletal conditions are the highest reasons for sickness absence for staff in the NHS and are a concern.

125. While there is an urgent need for the NHS to address the issues of staff experience and retention, it is important to note that some turnover can be beneficial, making organisations dynamic and supporting career progression for individuals. Furthermore, there needs to be acceptance that while the NHS is doing excellent work in addressing the reasons why staff leave, there are numerous factors impacting on staff experience and retention which remain largely outside the control of individual employers – these include:

- sustained pay restraint
- an ageing workforce
- the removal of central funding for continuing professional development
- increasing demands of the job due to greater patient numbers and funding shortfalls in social care and public health.

126. It is important to recognise that there is no single solution when it comes to tackling retention. The latest report[71] from the Health Foundation looks at some of the factors affecting supply, turnover and retention. It suggests that there needs to be collective action, supported by government, to develop a sustainable strategic approach that can adapt to external factors, such as Brexit, and shape and drive internal policy change.

127. Similarly, there is no single answer when it comes to improving staff experience. NHS England is currently working with six NHS organisations to develop a core wellbeing offer detailing key enablers which have the biggest impact on improving the wellbeing of the workforce. These will be closely aligned to NHS Employers' eight elements of workplace wellbeing[72] which include; leadership, shared strategic vision,

[69] NHS England: September 2015
[70] Department for work and pensions and Department of Health: Thriving at work: the Stevenson/Farmer review of mental health employers: October 2017
[71] The Health Foundation (October 2017)
[72] NHS Employers: Health and wellbeing

engagement, communication, knowing your data, prevention, intervention, evaluation and acting.

128. The approaches currently being taken by the NHS to improve wellbeing and the retention of the existing workforce are multi-dimensional. To help design suitable interventions for tackling high leaver, turnover rates, and sickness absence rates, individual trusts are taking an in-depth look at their workforce data and are analysing trends. This is helping to identify organisational-wide issues.

129. Maintaining an open dialogue with the workforce and regularly engaging with staff has also been critical to employers. This has aided their understanding of what enables staff to have a good experience at work, how keeping them well encourages people to remain with an organisation, and what else they can do to become an employer of choice.

130. In terms of the actions taken by organisations that have had a positive impact on staff turnover, it is difficult to pinpoint any single activity. Improvements in retention and staff experience are being seen where positive workplace cultures have been created, where staff report they feel valued and supported, have access to opportunities to work flexibly, and the chance to develop within their careers. Workforce data also indicates that there is a need to support staff at both ends of their employment journey, providing good workplace inductions and preceptorship programmes to support individuals in their first few months/years of employment, and looking at flexible retirement options and information to retain staff in the final years of their working lives.

131. During 2016-17, NHS Employers worked closely with over 90 NHS trusts to help equip them with tools and resources to support the development of plans tailored to address workforce retention. Emerging from this work were several themes which impact on the ability to retain staff and much best practice was shared throughout the course of the programme. To share this learning, NHS Employers has produced a resource, *Improving staff retention: a guide for employers*[73], which examines the key parameters affecting the retention of staff and highlights examples of where actions by trusts from across England have had a positive impact on their ability to retain staff.

132. NHS Employers also continues to work closely with key partners to aid efforts to support trusts with improving retention. As part of this work, NHS Employers currently co-chairs a task and finish group with NHS Improvement, looking at how we can best support the sector with addressing the challenge of retaining the workforce.

133. NHS Employers also continues to work closely with key experts and partners to support trusts to continue to focus on reducing sickness absence, undertaking specific work on mental health and musculoskeletal disorders, as well as broader wellbeing approaches. NHS Employers produced, *Creating healthy NHS workplaces*[74], which supports organisations to implement the NICE workplace guidance. This is also endorsed by the National Institute for Health and Care Excellence.

[73] NHS Employers – Improving staff retention: a guide for employers
[74] NHS Employers – Creating healthy NHS workplaces

Quality and innovation

134. In March 2016, NHS England announced a health and wellbeing commissioning for quality and innovation (CQUIN) payment framework. CQUIN enables commissioners to reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. The framework aims to embed quality within commissioner-provider discussions and to create a culture of continuous quality improvement, with stretching goals agreed in contracts on an annual basis. It makes a proportion of provider income conditional on the achievement of ambitious quality improvement goals and innovations agreed between commissioner and provider, with active clinical engagement. To achieve the CQUIN, trusts are encouraged to introduce and demonstrate a sustained improvement in the wellbeing of the workforce by way of improved scores in key questions in the staff survey. The CQUIN encourages greater focus on introducing health and wellbeing initiatives, increasing healthy food choices, and encouraging the uptake of frontline staff receiving the flu vaccination. NHS Employers has an active flu programme that continues to provide support, guidance and resources to organisations including presentations and webinars.

4. Total reward and pensions

Total reward

135. This section looks at the approaches taken by NHS organisations on reward, particularly the different components of rewards offered to employees and how reward is being used to meet strategic organisational objectives.

136. In addition to pay and benefits, employers in the NHS are continuing to broaden their definition of reward. There has been an increase in communication of the various benefits available, with a focus on the local benefits provided. With national terms and conditions in place, the application of local benefits is a factor which differentiates an organisation's reward offering from that offered by other organisations.

137. In a time of austerity and with the perceived degradation of benefits, such as the NHS Pension Scheme, organisations are increasingly looking at more creative ways of attracting and retaining staff.

Components of reward in the NHS

138. The NHS provides a comprehensive and attractive employment offer. It has a well-regarded package of valuable benefits, including a generous pension scheme.

139. Through the NHS Employers Total Reward Engagement Network (TREN), organisations have demonstrated that they are adopting a broader definition of reward. TREN is a network facilitated by NHS Employers, open to NHS organisations engaged in total reward work to give attendees the opportunity to discuss reward-related issues and share knowledge and experience with colleagues. The network has engaged with over 80 NHS organisations since it was established in February 2016. NHS Employers uses the network to encourage engagement with the total reward agenda and understand strategic reward in the NHS, and to develop products and tools to support reward initiatives.

140. Interactions through TREN show that health and wellbeing, including financial wellbeing, has emerged as a focus for many organisations. Health and wellbeing is an important part of the reward offer, however, it is not always communicated as being part of the employment package so can be viewed by staff as separate. Having an overall reward brand which includes health and wellbeing, has helped some organisations[75] overcome this. Organisations are also working towards the health and wellbeing CQUIN payment framework. This has supported raising health and wellbeing on employers' agendas.

[75] NHS Employers: Health and wellbeing as part of the reward offer: November 2017

141. Less traditionally perceived benefits, such as training and development programmes, recognition schemes, the local surroundings and organisational values are increasingly being included as part of the NHS employment offer. This is consistent with models of strategic reward, such as the Hay Group's public sector total reward model[76].

142. In 2017, NHS Employers undertook a benchmarking exercise which explored all NHS trust websites to look at the recruitment information and ascertain the level of reward information provided. The exercise looked at the six key areas within the Hay Group's public sector total reward model. Although this demonstrated how some organisations have expanded their definition of reward, there is more that could be included as part of the external facing benefit information used to attract candidates.

A strategic approach to reward

143. In 2017, NHS Employers surveyed 76 employers on elements of their approach to reward. They were asked if they are actively using reward to meet their organisation's strategic objectives or goals. 80 per cent said they are, particularly to support attraction and retention.

144. These approaches are reflected by members attending TREN. Where recruitment and retention premia (RRP) and relocation packages are sometimes used to attract staff, this tends to be limited to difficult-to-recruit posts. They are also used where location of services makes recruitment and retention more challenging, such as rural or isolated areas.

145. Recommend a friend schemes are used by some organisations in addition to other recruitment initiatives, often to overcome difficulties recruiting to specific occupations[77]. Incentives range from monetary reward to additional annual leave. The schemes are growing in use as a cost-effective way to respond to recruitment challenges.

146. During the benchmarking exercise, it was found that some organisations have developed web sections with information on reward and recruitment specifically for certain occupations. These sections include detailed reward and recruitment information used to attract candidates to these occupations, such as details of childcare, flexible working, site rotations, training and development and relocation packages.

147. In response to requests for examples of the approaches used, in relation to retention, these include an increased focus on health and wellbeing initiatives and the introduction of benefit platforms which bring together reward information to make it more easily accessible. Smartphone apps have been introduced in some organisations to increase engagement with staff. This is particularly for those who do not easily have access to a computer[78]. Innovative

[76] Hay Group's public sector total reward model
[77] NHS Employers: Using reward as part of an effective recruitment strategy: October 2017
[78] NHS Employers: Using mobile technology for reward communications: September 2017

approaches include the use of appraisals whereby staff can be rewarded with bonus payments for excellent performance and the use of an additional responsibilities allowance to recognise staff contributions to service delivery.

148. Interactions through TREN reflects these approaches and demonstrates that organisations are increasingly looking at more creative ways of retaining staff, with a focus on non-monetary reward initiatives. One approach includes a holiday of a lifetime scheme where staff can accrue up to five days' annual leave each year, for up to five years, and take all the leave at once. This allows staff to have an extended holiday and return to their role. Retention bonuses have been used to incentivise staff to remain in post. Although these have been successful in some circumstances, they are not commonly used.

149. The use of reward to help reduce agency spend often occurs in the service. Members attending the TREN have used weekly, rather than monthly, payments for substantive post holders who take on additional hours through their trust bank and paid substantive post holders for a fifth bank shift on completion of their fourth shift. A pilot of selling annual leave at one organisation led to 4,000 hours sold back, reducing the requirement for agency staff.

150. In 2016, NHS Employers undertook a survey which asked 100 NHS organisations whether they have a reward strategy. 51 per cent stated that they did not, with 34 per cent stating this was in development and the remaining 15 per cent stating that they do. The same picture is reflected in feedback from organisations currently at TREN where although some may have a strategy in place or reward included as part of another strategy, they do not see this as a priority to take forward their reward agenda. They are, however, increasingly looking at how reward can support their organisational priorities. It is clear, therefore, that having a reward strategy is not a must, but being clear on how reward can support strategic objectives, is.

Local approaches to reward

151. There are a range of local approaches to reward used by organisations which have been discussed at TREN in addition to those referred to above. Organisations are keen to introduce benefits that reduce travel costs for staff, particularly in London. Recognition schemes and long service awards are offered throughout organisations, though the approach varies. Buying and selling annual leave has been implemented by some and is often linked to health and wellbeing initiatives to increase employee control over work-life balance.

152. Promoting the learning and development opportunities available is a vital part of ensuring staff are aware and understand how they can access them. Highlighting this effectively from recruitment, through the new employee process and to the existing workforce, is an important part of communicating the overall reward offer. This has also become a focus for organisations.

153. In April 2017, changes to salary sacrifice schemes were introduced which meant that income tax and employer National Insurance advantages were removed. There were some exceptions to this, for example when employees were sacrificing salary only for pensions/pensions advice and rules on trigger points were introduced for those already benefitting from salary sacrifice. Although the changes do not prevent employers from providing benefits by salary sacrifice, they will no longer see any tax and National Insurance advantages to some of the schemes.

154. In 2016, NHS Employers sought views on the government's consultation on the future of salary sacrifice arrangements. Employers generally felt that the proposals may worsen existing staff shortages in the NHS.

155. The changes have seen a mixed approach from employers with some organisations continuing with some, or all, of their schemes and some not. For those continuing with their schemes, there was a concern about the impact on staff and the perception that there has been a removal of benefits. Some organisations see salary sacrifice arrangements as a retention tool, for example by offering a three-year salary sacrifice car lease scheme. It is thought this will encourage employees to remain within the organisation for at least the term of the agreement.

156. The 2016 Autumn Statement[79] outlined that existing arrangements have a period of protection. This has allowed organisations to communicate with their employees about the changes.

157. In addition, the government introduced tax-free childcare from 28 April 2017. Existing employer-supported childcare schemes can continue to accept new entrants until April 2018. Most organisations offer some form of salary sacrifice scheme, the most popular being childcare vouchers and cycle to work schemes. Employers will therefore see a financial impact from the changes, as well as a reward impact.

Attractiveness of the reward offer

158. The 2017 NHS Employers' survey of 77 employers explored whether elements of NHS organisations' reward offer are informed by employee needs. 80 per cent said that they are, mainly through surveys and focus groups. Other examples include feedback through benefit champions, staff benefits committees, events, looking at what staff are accessing and new recruit feedback.

159. When asked whether they evaluate or seek feedback from staff on their reward offer, 62 per cent of respondents said yes, again mainly through surveys. Other examples include listening into action events, via exit interviews, or through staff side and benefit champions. There is little evidence of evaluation of initiatives to determine the impact on strategic objectives and therefore further work needs to be done to encourage employers to do so.

[79] The Chancellor of the Exchequer: Autumn Statement 2016

160. When asked which aspects of their reward offer employers are most proud of, health and wellbeing initiatives and recognition schemes were the most common responses. Other responses include salary sacrifice schemes, branding to bring all the benefits together, events and recruitment incentives.

Strategies to engage staff effectively

161. The NHS Employers survey asked for examples of how organisations currently communicate their reward offer. The responses echoed the information obtained through TREN and demonstrate how employers are increasing their communication of reward and benefits to engage staff. The main communication routes for reward include roadshows[80], newsletters, events, leaflets and the intranet. Employers are using broader communication channels, such as benefit champions[81], social media, total reward statements and benefit platforms. Organisations are also increasingly embedding their reward information in to their recruitment and induction processes. This broad approach to communication is important to ensure the breadth of benefits are recognised and valued by employees.

Total reward statements

162. Total reward statements (TRS) are one way in which NHS organisations can promote benefits that they offer locally, as well as providing useful information about the value of pensions through an annual, personalised summary of the benefit package.

163. 2016/17 was the third year of rollout of TRS in the NHS. Information from the NHS Business Services Authority indicates that a total of 468,777 statements in England and Wales were accessed during the year (August 2016-August 2017). This was an increase of 22.06 per cent compared to the previous year. Approximately half of these statements were viewed when the statements were refreshed mid-way through the year (between December 2016-August 2017).

NHS Pension Scheme

164. The 2015 NHS Pension Scheme was launched on 1 April 2015, replacing the 1995 and 2008 sections (except where individual protection applied). The 2015 Scheme is a career average revalued earning (CARE) defined benefits scheme which pays a pension based on the average of a member's pensionable earnings throughout their career, revalued in line with the Consumer Prices Index plus 1.5 per cent per annum.

Contribution rates

[80] NHS Employers: Promoting staff benefits through events: August 2016
[81] NHS Employers: Using benefit champions to promote staff rewards: October 2016

Employer contributions

165. The employer contribution rate for both the 2015 NHS Pension Scheme and the 1995/2008 NHS Pension Scheme is 14.3 per cent of pensionable pay. This rate is determined by the funding methodology applied by the scheme actuaries. Employers pay a scheme administration levy equal to 0.08 per cent of pensionable pay in addition to the standard employer contribution rate.

166. The employer contribution rate is reassessed by the scheme actuary every four years and the results of the 2016 valuation are expected in April 2018. Treasury is finalising the directed financial assumptions for the valuation and has announced that the discount rate assumption will reduce by 0.2 per cent. The impact of this change in isolation would lead to an increase in the employer contribution rate from 1 April 2019.

Member contributions

167. Members of the NHS Pension Scheme pay contributions on a tiered basis, designed to collect a total yield to HM Treasury of 9.8 per cent of total pensionable pay. The employee contribution rates are outlined in the table below.

Tiered contribution rates 2015/16 through to 2018/19 for scheme members		
Tier	**Pensionable pay (whole-time equivalent) earnings used to assess contribution rate)**	**Contribution rate**
1	Up to £15,431.99	5.0 %
2	£15,432.00 to £21,477.99	5.6 %
3	£21,478.00 to £26,832.99	7.1 %
4	£26,824.00 to £47,845.99	9.3 %
5	£47,846.00 to £70,630.99	12.5 %
6	70,631.00 to £111,376.99	13.5 %
7	Over £111,377.00	14.5 %

168. At the request of the Secretary of State, the NHS Pension Scheme Advisory Board (SAB) is reviewing the basis on which member contributions will be assessed from 1 April 2019. The key objective of the review is to ensure the required yield is collected going forward. It is likely that contribution rates will increase for some or all members.

169. The review will focus on:

(a) the range and number of contribution tiers
(b) freezing tier boundaries for periods longer than a year
(c) using whole-time equivalent (WTE) rather than actual earnings to determine the contribution rate payable.

170. We reported in our evidence to the pay review bodies in 2017/18 that the tiered nature of member contribution rates, combined with low pay rises, means that increases to pensionable pay could lead to a reduction in take-home pay. This aspect of the contribution design is still an ongoing issue for staff and employers. Potential solutions are being considered as part of the member contributions review and if implemented, will not take effect until April 2019.

171. With the introduction of the 2015 Pension Scheme, it is expected there will be fewer contribution tiers in future. This is to reflect that in future, all benefits will be accrued based on actual pay, rather than final pay at retirement.

172. In response to our 2017 survey of 77 employers, the increasing cost of both member and employer contributions was cited as a key challenge of the pension scheme. Many employers feel the member contributions are too high and see this as a barrier to staff joining the scheme, particularly for lower earners and younger members with competing financial priorities, such as paying off student debt, paying for childcare and saving for a first home. However, the data in the next section does not necessarily support this observation as membership levels remain high.

Scheme membership

173. The total membership of the NHS Pension Schemes has increased steadily from 2007 – 2017. The proportion of members accruing benefits on a CARE basis is increasing rapidly, while the number of members in the final salary sections of the scheme continues to fall. This continuing change in membership profile will need to be considered in the context of the member contributions review, particularly the use of whole-time equivalent (WTE) earnings to determine member contribution rates.

Scheme Year	1995 only members	2008 only members	1995 + 2008 members	2015 members with FSL	2015 members no FSL	Total members
2007-08	1,210,735	-	-	-	-	1,210,735
2008-09	1,113,695	136,043	2,097	-	-	1,251,835
2010-11	1,007,019	271,743	7,171	-	-	1,285,933
2012-13	898,690	372,258	11,761	-	-	1,282,709
2014-15	801,921	552,822	19,894	-	-	1,374,637
2015-16	330,908	29,585	1,488	949,047	127,830	1,438,858
2016-17	291,871	25,898	1,294	944,936	211,736	1,475,735

Source: NHS Business Services Authority (BSA)

174. Scheme membership rates are generally high, with an average of 89 per cent of the workforce actively contributing to the scheme.

AfC Band	FTE	% making pension contributions June 2017	% point change	
			June 2016 and June 2017	Oct 2011 and June 2017
1	24,276	78%	0.7%	15.1%
2	153,420	86%	0.1%	10.2%
3	124,350	87%	0.1%	6.9%
4	82,818	88%	-0.3%	4.3%
5	200,859	88%	-1.2%	2.4%
6	177,547	91%	-0.6%	1.7%
7	101,569	93%	-0.3%	0.1%
8a	34,908	93%	-0.6%	-1.0%
8b	14,207	94%	-0.5%	-1.8%
8c	7,457	94%	-0.7%	-1.8%
8d	3,630	93%	-1.3%	-3.8%
9	1,352	93%	-0.7%	-3.0%

Source: ESR Data Warehouse

175. Scheme membership is noticeably lower at the lower pay bands. However, scheme membership at the lower pay bands has increased significantly during the period from October 2011 to June 2017. The increase in the number of lower earners saving for retirement is likely to be due to the success of the introduction of automatic enrolment legislation from 2012.

176. Membership at higher pay bands remains high but there has been a slight decline over the long and short-term periods to June 2017. There is no robust data to explain this fall in membership, but observations from employers point towards high earners opting out of the scheme after reaching the annual allowance and lifetime allowance, and the unintended reduction in take-home pay due to increased pension contributions for those at the top of band 8a.

177. This data is taken from the Electronic Staff Record (ESR) data warehouse. This is the HR and payroll system that covers all NHS employees other than those working in general practice, two NHS foundation trusts that have chosen not to use the system and organisations to which functions have been transferred, such as local authorities. ESR data is not centrally validated and its reliability is subject to local coding practice.

Pension taxation

178. Any NHS employee who has pension benefits above tax thresholds may be liable to a tax charge. This has the potential to damage the perceived value of the NHS Pension Scheme as a benefit and influence member behaviour.

179. The two tax thresholds are the annual allowance (AA) and lifetime allowance (LTA). Previously, very few NHS workers were likely to exceed the tax thresholds, but changes in recent years mean that more staff are likely to be impacted.

180. The defined benefit pension is tested against the LTA using the amount of pension and lump sum if relevant. Defined benefit pensions are multiplied by a factor of 20 and any retirement lump sum is added to the result.

181. Data provided by Business Services Authority shows that in the 2016/17 scheme year, 35,000 members (approximately 2.3 per cent of the total membership) breached the AA and 2,360 members (approximately 0.16 per cent of the total membership) accrued benefits worth more than 100 per cent of the current LTA.

182. It's not entirely clear how the tax allowances are driving member behaviours, but we believe reaching the LTA has a stronger influence on driving members to opt out of the scheme or take early retirement. We know that some members who have reached the LTA decide to continue contributing to the scheme to benefit from the life assurance and ill health protection benefits.

183. In our survey of 77 employers in the NHS, employers told us they feel the scheme is becoming less attractive to high earners, due to the impact of the tax allowances. The impact of the tax allowances is concentrated in certain workforce areas such as very senior management. Many employers are looking for alternative ways to reward staff affected by the tax allowances to retain highly skilled and experienced staff.

184. The current contribution design relies on high earners paying higher member contributions to subsidise those paying lower contributions. If the trend of high earners leaving the scheme continues, this may have an impact on the yield and the ongoing sustainability of the scheme. This is a key consideration for the employee contribution review.

Pensions flexibility

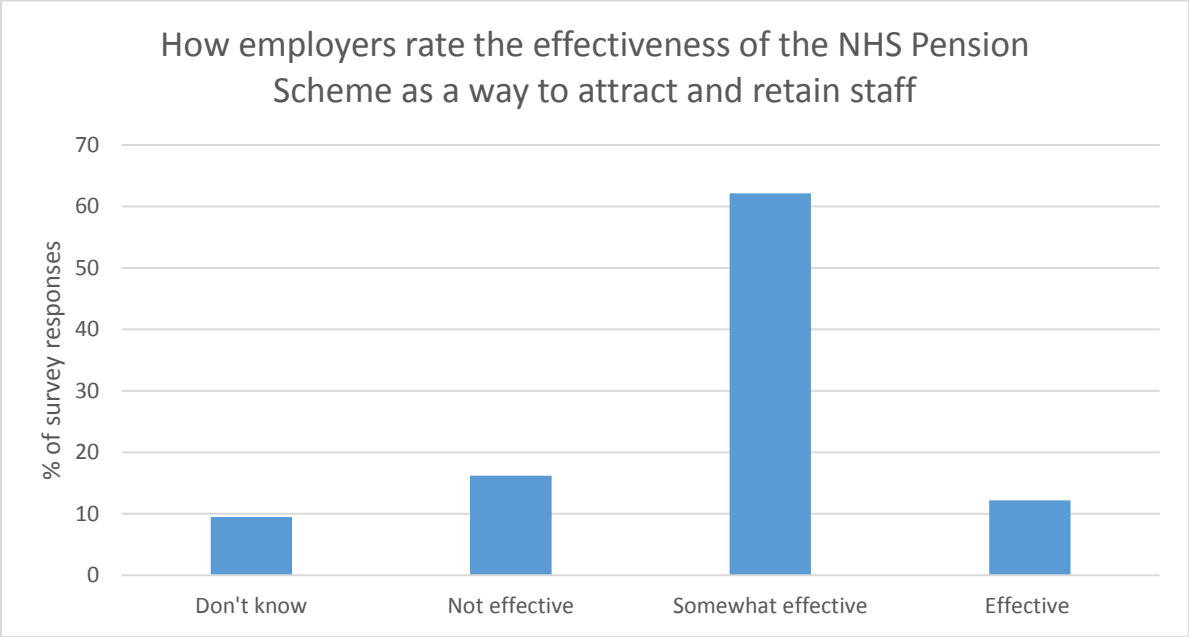
185. Employers want to ensure the scheme remains attractive to all staff across the workforce. There is a need to ensure the scheme is appealing to staff of all generations and levels of income. Employers would like to offer more flexible pension options to achieve this.

186. Some employers suggested it would be helpful for members to be able to choose a level of pension contributions or benefits to suit their personal circumstances. This would provide members with alternative options for pension saving in addition to either joining the NHS Pension Scheme, or having no workplace pension savings. This suggested approach seems similar to the introduction of the 50:50 section in the Local Government Pension Scheme, which allows members to pay half the standard contribution rate in return for half of the standard benefit accrual.

187. A pensionable pay cap may also provide more flexibility for high earners to control the value of their pension accrual and avoid exceeding the tax allowances.

The NHS Pension Scheme as an attraction and retention tool

188. In 2017, we asked 77 employers how they would rate the effectiveness of the NHS Pension Scheme to attract and retain staff. 75 per cent of these employers rated the scheme as 'effective' or 'somewhat effective,' with only 16 per cent rating the scheme as 'not effective.' Employers were not asked to provide any data to support their opinions on the effectiveness of the scheme as an attraction and retention tool.



Abatement

189. There are certain circumstances where a member's pension benefits may be reduced if they return to work for the NHS after retirement. The detailed abatement rules[82] vary depending on which section of the NHS Pension Scheme a member belongs to. In general terms, the rules on abatement apply where a member's unearned pension benefits, plus their earnings in their new role, exceed their earnings prior to retirement. It applies to a relatively small group of members. Employers have told us this often encourages staff to return to work for agencies after their retirement, to avoid any reduction to their pension. The abatement regulations seem to be working against the government's policy of reducing agency spend.

[82] NHS Business Services Authority: NHS pension scheme, abatement, basic overview for employers

Understanding the value of the NHS Pension Scheme

190. Employers have observed that staff perception of the value of the pension scheme has fallen since the introduction of the new 2015 scheme. Some staff seem to view the scheme as being constantly changed and eroded and some have the view that the terms will become less favourable in the future. The complexity of the scheme makes it difficult to generate staff interest and engagement.

191. Employers feel better communications to promote the positive benefits of joining the NHS Pension Scheme is key to increasing the level of understanding and appreciation of the value of the scheme.

192. Employers suggested the following ways of improving member pension scheme communications:

- a national promotional campaign
- more face-to-face conversations about pensions
- pension workshops, pre-retirement courses and webinars
- simple and clear information that is easily accessible and easy to understand
- more promotion of total reward statements
- using targeted approaches for different age groups.

193. Many employers run pension workshops and pre-retirement courses to help understand the value of the benefits provided by the NHS Pension Scheme. The sessions can be an effective way of encouraging staff to engage with their pension savings and help staff appreciate the value of the scheme as part of their reward offer.

194. NHS Employers continues to produce resources to support employers to promote the value of the NHS Pension Scheme. A new product is being developed to help employers deliver pension workshops and pre-retirement courses.

5. Staff engagement and the NHS Staff Survey

Policy context

195. The overall policy context for staff engagement in the NHS has national and local elements. The NHS staff pledges[83] underpin action by local employers and commit the NHS to provide opportunities for individual and collective involvement. The national framework for development published in 2016, *Developing People - Improving Care*[84], also includes a requirement for organisations to develop staff engagement. An assessment of staff engagement practice is included within the overall assessment by the Care Quality Commission of whether an organisation is well led[85]. The Department of Health commissions NHS Employers to provide support to local employers on staff engagement issues.

Overview: 2016 results

196. The 2016 staff survey involved 316 NHS organisations in England. Over 982,000 NHS staff were invited to participate. This was an increase in numbers surveyed due to many more organisations deciding to survey all their staff. Over 423,000 NHS staff responded, a response rate of 44 per cent (compared to 41 per cent in 2015).

197. The survey includes an overall indicator of staff engagement which is measured on a five-point scale. The measure is a composite measure made up of scores for levels of motivation, involvement and willingness to recommend the NHS as a place to work.

198. Of the 33 key findings, 24 improved and there were notable improvements in measures of staff engagement, quality of appraisal and staff confidence in organisational action on health and wellbeing. Staff confidence in ability to report concerns about clinical practice also increased. There was an improvement in the number of staff that were willing to recommend the NHS as an employer, this increased from 3.72 to 3.75 (on the five-point scale).

199. The survey showed that there continued to be high levels of reported stress on NHS staff, with 37 per cent reporting that that they had felt unwell due to work-related stress. Levels of bullying and harassment also remained unacceptably high with 24 per cent of staff reporting that they had experienced an incidence of bullying, harassment or abuse. Survey data also continued to show inequalities within the NHS and scores on confidence in the delivery of equalities worsened.

[83] NHS Employers: NHS Staff Pledges
[84] NHS Improvement: Developing people, improving care: December 2016
[85] Care Quality Commission: Well-led: vision and strategy

Metrics

200. In his letter[86] to the chair of the NHS pay review body (NHSPRB), the chief secretary to the Treasury refers to looking at the 'morale and motivation' of NHS staff. The review body expressed concern in its last report[87] as to whether the current metrics within the NHS Staff Survey provide it with the data that it needs to assess NHS staff morale and motivation.

201. Following the NHSPRB's request for the parties to review the measures within the NHS Staff Survey, there have been discussions within the NHS Staff Survey advisory group on the current range of measures. The measures were not changed for the 2017 staff survey. NHS England has agreed to review whether a measure of morale could be developed, based on new or amended questions.

202. NHS Employers believes the existing measures within the NHS Staff Survey are valid and reliable measures of key dimensions of staff experience. They are an acceptable proxy for consideration of morale.

203. It is important to make clear that the key findings need to be looked at as an overall set of indicators. No single indicator is the overall barometer of staff experience.

204. Most relevant are the findings on staff recommendation, staff motivation and staff involvement which together comprise the staff engagement index score. Other relevant measures include the satisfaction staff feel with the support they receive from their employer, and the health and wellbeing and workload. The trends in the findings for these are examined below. Overall, the 2016 staff survey[88] showed improvement in most of the key findings, although there remains considerable variation between trusts in their results for specific findings which needs to be further reduced.

Trends

205. In the case of staff engagement, the improvement in 2016 was small; but built on notable progress which was made in 2015. In 2016, the staff engagement index rose from 3.78 to 3.79 (on the five-point scale). Given the many pressures on the NHS this was a considerable achievement. Within the overall score the motivation element remained stable at 3.92 (following a significant increase in 2015). Levels of involvement improved slightly (from 69 per cent to 70 per cent). Levels of involvement improved slightly (from 69 to 70 per cent), and the measure of willingness to recommend the NHS also improved from 3.72 to 3.75.

206. Other relevant indicators are less positive. The level of staff satisfaction with resourcing and support, which includes issues such as staffing levels, remained lower than for staff engagement. The results for staff satisfaction with recognition and being valued, although improving, also remained low. The variation between organisations was considerable.

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[86] Office of Manpower Economics: Chief Secretary to the Treasury letter to the NHSPRB Chair
[87] National Health Service Pay Review Body 30th report: 2017
[88] National NHS Staff Survey Co-ordination centre: Results for the 2016 NHS Staff Survey

207. Staff engagement trends are also shaped by overall staff experience and the 2016 data provides a mixed picture. There is improvement in some findings of people management practices but on health and wellbeing the picture is mixed. There is an improvement in the staff view of employer interventions on health and wellbeing but stress remained at unacceptable levels and most staff continued to report working additional hours to provide services.

Employer action

208. Employers in the NHS understand the importance of staff engagement and develop approaches to foster and sustain engagement.

209. In 2016, NHS Employers used the staff survey data to identify 28 organisations which had made considerable progress in this area. This included organisations that participated in successful programmes such as Listening into Action[89], the Virginia Mason Partnership[90] and Go Engage[91], as well as other organisations that have developed unique approaches.

210. NHS Employers has highlighted some lessons from those organisations that made the most significant improvements and shared these lessons with other organisations. Through our website and networks, we are sharing ideas and experiences to support engagement and in 2017 this included working with ambulance trusts.

211. In 2017, employers have improved their approaches to staff involvement. Some trusts have developed tools that allow for real-time staff feedback using digital technology, while others have developed local staff surveys to complement the national survey. For example, the Go Engage survey tool is now used by a growing number of organisations. Other employer innovations have included crowdsourcing staff ideas, greater staff involvement in quality improvement, new approaches to recognition, training support for line managers and changes to appraisal procedures.

212. The CQC has been focusing on engagement in its assessments of NHS organisations. There are positive indications from some of their inspections which indicate progress in some trusts where there have been lower staff engagement scores. For 2017, CQC ratings have overall improved a little with more organisations rated as ‘outstanding’ than ’inadequate’, although the majority continued to be rated as ’requiring improvement’.

Under pressure

213. Employers appreciate that there are challenges in the current operational environment and are acting to sustain engagement in the face of multiple pressures.

[89] NHS Leadership Development: Listening into action
[90] NHS Improvement: NHS partnership with Virginia Mason Institute
[91] Go Engage

214. The 2017 staff survey data is not available at the time of writing this evidence. There are, though, widespread reports that staff are under unprecedented pressure and that services are being maintained through their extraordinary efforts. If not addressed this may create the risk of a downward spiral of worsening staff experience which may in turn lead to a decline in staff engagement. We will support employers to address this challenge.

6. Refreshing Agenda for Change

215. As patients' needs and expectations change, employers in the NHS are seeking new and innovative ways to deliver services to meet those needs in a financially sustainable way. The AforC pay and conditions system was agreed in 2004 in a very different financial and policy environment than the NHS today. Employers recognise that from time to time small changes have helped the system evolve, but these have not been on the same scale as changes in the organisation of patient care. Employers are now less confident that the system reflects the needs of a modern health and care system. For example, it has in-built challenges that make it difficult, in certain circumstances, for employers to reward and incentivise high-quality patient care and deliver seven-day services.

216. We are working in partnership with national trade unions seeking to reach agreement on a balanced package of changes to national conditions. We may be able to provide a further update on these discussions during our oral evidence session. The review body is asked to take account of this continuing strategy when reaching its conclusions on pay recommendations for 2018/19.

217. Pay arrangements elsewhere in the public sector have already been reviewed and refreshed, for example, in education and policing, to meet changing circumstances. In the NHS, the wider financial challenges mean that we need to rebalance the AforC reward package so that employers can attract, recruit, retain and reward staff appropriately in the context of the financial allocation to the NHS.

218. Employers have told us that their priority is to ensure that changes to the national pay and conditions package are supportive of the aim of delivering high-quality and compassionate care, in the context of significant financial and workforce-related challenges. Employers believe that pay and conditions of service are a means of promoting and rewarding ideal behaviours, standards and performance.

219. We are aware that the review body has regularly expressed a desire to be presented with agreed proposals for modernisation of the current national non-medical pay structure. Employers remain committed to this aim. The 2015/16 collective agreement on pay confirmed the intentions of employers, and unions, to take forward these discussions. However, the announcement in the Budget on 8 July 2015[92] that public sector pay restraint would continue and awards would be constrained to one per cent has made progress challenging. This period of pay restraint came on top of 1 per cent increases in each year from

[92] HM Treasury: Budget statement 8 July 2015

2013–14 to 2015–16, and cash freezes for all but the lowest paid public sector workers in 2011–12 and 2012–13.

220. In September 2017, the government announced the relaxation of its 1 per cent pay policy[93]. In the Autumn Budget 2017[94] the government committed to fund a pay deal for NHS AforC staff on the conditions that the pay award enables improved productivity in the NHS, and is justified on recruitment and retention grounds. In his letter[95] to the review body chair, the Secretary of State for Health asked NHS Employers to continue exploratory talks with the Agenda for Change trade unions with a view to the unions obtaining mandates to negotiate a multi-year agreement. Patients and employers want to see improved and better seven-day services, and employers say that the national pay and conditions of service for all NHS staff must continue to adapt to make them affordable and sustainable.

The issues

221. Employers continue to raise concerns about affordability and lack of flexibility in the current system and are increasingly asking for the pay arrangements to be better aligned to performance and productivity. Employers recognise that AforC must support and reward the improvement of staff productivity. It must also support the recruitment and retention of staff and be supportive of the longer-term health and social care agenda and associated workforce needs. Employers would like this to be delivered through changes to the national framework, agreed in partnership with NHS trade unions. Over the years we have learned that effective joint working can be a powerful facilitator for change at all levels in the system.

222. Any changes to the national pay system must ensure that it remains an important part of a competitive employment package that supports employers to attract, recruit, retain and motivate the highly skilled and committed workforce that is needed now and will be needed to transform services in the future. All of this must be done while maximising staff's contribution and engagement. Any direct changes must support employers to effectively and efficiently allocate resources to where they are most needed.

223. Although work on refreshing the AforC agreement has run on a slower track than originally envisaged, several joint principles have been agreed. Among these is an affirmation that the pay system will continue to be underpinned by the current NHS job evaluation system that delivers equal pay for work of equal value.

[93] Chief Secretary to the Treasury letter to the NHS PRB Chair: September 2017
[94] Autumn Budget 2017
[95] Pay review body remit letters from Jeremy Hunt 2018 to 2019

224. The parties submitted joint evidence to your pay review in September 2016. You have been supportive of the production of a balanced package of measures, including a review of:

- the length of pay scales
- overlapping bands with shared spine points
- pay progression
- improved links between reward and performance, including incentives for staff at the top of their pay band.

225. Of the jointly agreed principles, a number provide a firm basis on which to build options for discussion of:

- shorter pay bands, with fewer points and no overlaps between bands
- more even spacing between pay points
- fair and affordable pay for now and in the future.

226. In the current structure there are 12 pay bands (including the four parts of band 8). It can take anywhere up to nine years to progress from bottom to top in a band. Employers are keen to remove the overlap in pay between pay bands. This acts as a disincentive to those staff who wish to progress to the next pay band where they may be earning less than those that they manage. Having a clear difference in pay between bands will help encourage talented staff to take on higher levels of responsibility for the benefit of patients.

The wider employment package

227. Consideration of employee reward should involve not just the level of pay, but the entire employment package offer. Employers also want to see changes to the wider AforC conditions of service to create a balanced package of measures that both employers and trade unions can support. With the need to move to better seven-day service provision in some areas of service delivery, a greater focus on community-based care and the challenges of service reorganisation in local health economies (STPs/ACOs) employers need AforC to effectively meet these service demands within the NHS allocation.

228. Some employers have suggested that the development of joint working with local authorities may mean that, in future, pay and conditions changes in both the NHS and local government may need to be considered together. Aspects of the NHS conditions may need to be better aligned with those of local government in the medium term. An incremental journey with unions to something better will be preferable to the alternative solutions that future circumstances may necessitate. NHS conditions of service need to be an enabler for meeting local service demands; a national framework with local flexibility providing for local solutions. One size may not fit all and this needs to be met through the appropriate level of pay and conditions to meet the local circumstances.

229. Delivering high-quality services and improving outcomes for patients are what matter most, and must drive the decisions employers make. This includes providing the same high standards of care seven days a week by using the resources of people, buildings and equipment as effectively and efficiently as possible. Employers need to ensure that extended services do not add unnecessary costs. This will require reviewing the balance between plain time and premium time pay.

230. Employers see the 2013 changes to pay progression and sickness pay as important steps towards making the NHS conditions more flexible. Employers believe that it is important that the national agreements are kept under regular review, to ensure that they remain responsive to the needs of a changing NHS, supportive of the delivering high-quality patient care, and maximise job security for staff.

231. The introduction of AforC started the process of enabling staff to work across professional boundaries. The NHS job evaluation scheme has provided a common core for evaluating new roles. It has provided a firm basis for employers to start mixing and matching skills from across traditional skills boundaries. AforC helped set us on the road to bringing about an integrated workforce to provide integrated services. A refresh of the system must provide us with the means to accelerate this process, based on the needs of patients.

National living wage

232. Investing resources at the bottom of the pay structure in the current tight financial climate is not a priority for most employers who would prefer to focus limited resources on the middle of the pay structure. That said, the NHS is bound to work within the constraints of public sector pay policy and the framework of employment law. Employers do not necessarily want the bottom pay point to be the national living wage (NLW) rate. That would mean relinquishing control over the bottom pay point and erode the NHS's competitive labour market position relative to other employers.

233. Employers and trade unions working in partnership in the NHS Staff Council have already begun to explore what changes may be needed at the bottom of the pay structure to accommodate the impact of the NLW.

234. The NLW has been forecast to increase to around £8.27 per hour by 2019/20. This would equate to an AforC annual salary of around £16,171, which would have implications for the AforC pay scales. This could change depending on the trajectory of the NLW and the level of future national pay uplifts. The challenge for unions and employers will be to create a reformed pay structure that maintains a pay differential between bands, is affordable for employers, yet stays within the constraints of public sector pay policy.

235. Depending on developments in public sector pay policy the NLW might be higher than points two and three of the AforC pay scales by 2019/20. This would mean that staff on bands 1, 2 and the beginning of band 3 could all have

the same basic salary. Compression of pay points would be an operational concern because it would present challenges for maintaining appropriate pay differentials between the bands and appropriately rewarding staff for the work they do. Employers have told us that differentiation between pay bands remains important and that they would wish to use the opportunity to reduce the number of pay points, to provide some differentiation. However, building in additional differentiation will create cost pressures beyond merely meeting statutory compliance.

236. If future pay awards are set above the current 1 per cent, there could be scope to cover transitional costs to a new pay structure for bands 1-3 alongside any possible wider pay structure changes.

237. As the AforC pay rates do not have age-related points, it is unlikely that the NHS will be able to benefit from using the under-25 rates moving forward. NHS pay rates are already favourable in comparison to the National Minimum Wage (NMW). The NMW for workers aged 21 to 24 is currently £7.05 per hour[96] and will increase to £7.38 an hour from April 2018[97]. The 2017/18 AforC point two hourly rate is currently £7.88 per hour[98].

Ambulance service

238. Demand for ambulance services continues to grow rapidly. Between 2009-10 and 2015-16, the number of ambulance calls and NHS 111 transfers increased from 7.9 million to 10.7 million, an average year-on-year increase of 5.2 per cent[99]. At the same time, increased funding for urgent and emergency activity has not matched rising demand. Between 2011-12 and 2015-16, income for ambulance trusts' urgent and emergency care activity increased by 16 per cent from £1.53 billion to £1.78 billion. Over this period, activity (ambulance calls and NHS 111 transfers) rose by 30 per cent.

239. Against this backdrop, there continues to be a shortage in the supply of qualified paramedics. This is reflected by the inclusion of paramedics on the Home Office's shortage occupation list[100]. The opportunities for using and employing paramedics in a wider range of settings and organisations is contributing to workforce gaps faced by ambulance employers. HEE is addressing this through an increase in the number of training places in the pipeline. In its 30th report, NHSPRB noted that ambulance was the fastest growing workforce in each of the four nations[101].

240. The NHS Staff Council technical review of paramedic roles found evidence of an increase in the levels of patient diagnosis and treatment by paramedics,

96 National Minimum Wage Rates
97 The Chancellor of the Exchequer: Autumn Budget 2017
98 NHS Employers: Agenda for Change pay scales - hourly
99 NHS Ambulance services: National Audit Office: January 2017
100 Migration Advisory Committee: Occupation Shortage List
101 NHS Pay Review Body, Thirtieth Report, paragraph 4.5

driven by the requirements of commissioners and partly aimed at reducing transfers to hospitals.

241. The national agreement reached in partnership on 8 December 2016, provided a mechanism for local review of band 5 paramedic posts against a new nationally agreed band 6 job evaluation profile. Posts which matched to the new profile were regraded in line with the nationally agreed rules.

242. The national agreement also provided for the creation of a new programme of consolidation of learning for newly qualified paramedics (NQPs). NQPs will now spend up to two years in AforC pay band 5, consolidating their knowledge and skills, and acquiring experience and competence. On completion of this programme, NQPs will move into roles in pay band 6.

243. The agreement also confirmed there would be a process for the accreditation of previous practice as a paramedic allowing earlier completion of the consolidation programme and movement into pay band 6. Unions and employers have agreed a fast-track programme which will allow some NQPs, particularly if they have previous relevant experience, to move through the consolidation of learning period in less than two years. Candidates will need to provide evidence they have met all competencies and undertake a panel review.

244. The national agreement provided for the further development of the paramedic role in line with NHS England's Urgent and Emergency Care Review (UECR). Employers and trade unions have reviewed local job descriptions in partnership and agreed amendments in line with the requirements of the UECR. It is recognised that this will necessitate the need for further training and development and the parties are committed to working in partnership to agree a timetable and format for this further work. NHS Employers is working closely with employers and NHS England and NHS Improvement.

245. Agreement has now been reached on all elements of the national collective agreement and the agreed documentation and guidance is published on the NHS Employers website[102].

246. As part of the 2015 pay agreement, ambulance employers and trade unions agreed to curtail their discussions on sickness pay and unsocial hours and remitted these to the wider talks on AforC.

247. As part of the 2015 NHS pension changes, all staff who are members of the NHS Pension Scheme were given the opportunity to buy out the reduction which would apply if retirement benefits were claimed before normal pension age. As part of the national pay agreement for 2015/16[103] ambulance trusts agreed to contribute 50 per cent towards this cost.

[102] NHS Employers: Ambulance workforce
[103] NHS Employers: Agenda for Change pay agreement (England) for 2015/16 frequently asked questions

248. Ambulance trusts and unions also identified issues associated with the experience that ambulance staff had in the workplace. To address these, a partnership approach was adopted between staff side, employers and NHS Employers. An analysis of the evidence base behind the key elements contributing to a positive work experience formed the basis for a comprehensive work programme to address issues of ambulance staff health and wellbeing (particularly mental wellbeing) and experience.

249. This programme is looking at specific elements such as tackling bullying, mental wellbeing and staff experience, through the perspective of the ambulance service. Resources and guidance are being produced and will be accessible from the ambulance workforce section of the NHS Employers website.