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Strategic context

- The NHS Long Term Plan sets the future direction for the NHS in England and provides the basis for a five-year funding programme up to 2024/25. While this provides some stability for longer term planning, the overall level of investment is still lower than in previous years. The Interim NHS People Plan sets out how the workforce will be supported and transformed in order to deliver the aims of the NHS Long Term Plan.

- Political instability and uncertainty around the impact of Brexit remain. Health leaders are concerned about the extra demands on existing staff in making EU exit preparations and the effects of ending freedom of movement. They are also concerned about the personal impact of Brexit on their EU staff.

- The NHS continues to feel the combined effects of financial pressure, workforce shortages and rising demand. The impact can be seen in continuing and growing budget deficits and through a decline in key performance standards. This ultimately affects the quality of care and patient experience and has a detrimental effect on the health, wellbeing and morale of staff.

- Despite these pressures, the Care Quality Commission’s annual report on the state of health and social care in England found that most of the care provided by the NHS is good quality and, overall, the quality of care is improving. This is a tribute to the commitment and hard work of all our staff.

- The pensions taxation issue linked to the tapered annual allowance is having a major impact on senior clinical staff across the NHS. There are growing examples of consultants reducing their hours, stopping additional waiting list work, giving up additional leadership and managerial roles and duties and many are considering their long-term future. This has had a significant impact on service delivery, most immediately on some elective care waiting lists.

- We believe that a combination of scheme flexibilities, removal of the taper and better information for scheme members is likely to provide the best solution overall. We take the view that if scheme flexibilities are introduced then they should apply to all staff in time for the 2020/21 financial year. However, even if a solution is found soon, there is a risk that some consultants will decide not to return to their previous level of activity.

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1 Care Quality Commission: Annual report 2019
Financial challenge

- The Chancellor has described the 2019 autumn Spending Review as ‘turning the page on austerity and the beginning of a decade of renewal’. However, there will remain difficult choices ahead about where available funding should be directed against agreed workforce priorities as well as what investment in pay should be made.

- Managing expectations on pay will be important as we begin to develop our thinking on pay and reward beyond the current multi-year pay deal. Our priorities will be shaped by delivery of the NHS Long Term Plan, consolidating the benefits of the restructuring of the NHS terms and conditions of service for Agenda for Change staff, and continuing to support recruitment and retention initiatives to address the 100,000 vacancies, which includes around 40,000 nurse vacancies.

- Revenue funding is fixed to 2024/25. Employers will also face continuing competing pressures on capital budgets, the challenges of balancing rising demand and the efficiency savings required in the ten-year plan. In addition, there will also be the possibility of having to fund an increase in the future level of the National Minimum Wage, committed to by both main political parties.

Workforce challenge

- The Interim NHS People Plan sets out a plan of action to enable all those who work in the NHS to deliver the aims and objectives of the NHS Long Term Plan. However, 65 per cent of respondents to an NHS Confederation survey said that they were either not very or not at all confident that their local health system would be able to meet their staffing needs. There is a real risk that without the right workforce, the aims of the NHS Long Term Plan will not be met.

- The Interim NHS People Plan is clear about the need to increase the number of nurses by improving international and domestic supply, and by focusing on recruitment and retention. One of the themes of the plan is to make the NHS the best place to work. It recognises the compelling evidence that the more engaged our people, the more effective and productive they are, and most importantly, the higher the quality of care they deliver to patients.

- Across our workforce the needs of staff at different stages in their careers and personal lives varies. The challenge for everyone working in reward is to ensure greater flexibility in the reward offer.

- Employers are emphasising the psychological contract between employer and employee. The NHS is, but must also be perceived widely in society to be, an honourable, rewarding and exciting place to work. If staff excel, they will be recognised and celebrated as much as they would be in any other working environment.

\[2\] Conservative Party election manifesto
\[3\] Labour Party election Manifesto
\[4\] Interim NHS People Plan
\[5\] NHS Long Term Plan
We are building on the extensive work that we have already undertaken to support employers in their efforts to value and engage their staff, to promote their health and wellbeing, to improve the leadership culture and to safeguard their staff from bullying and harassment at work.

Interim NHS People Plan priorities

The following themes are outlined in the Interim NHS People Plan:

- Making the NHS a great place to work - supporting and retaining our current NHS staff.
- Improving our leadership culture - managing talent and succession.
- Taking immediate action to tackle the nursing challenge - growing workforce supply to meet demand, supporting the third sector, other volunteers and carers, optimising new workforce roles.
- Delivering 21st century care - preparing for technology shift, preparing for the implications of new models of care, enabling workforce productivity.
- A new operating model for workforce - capacity and capability to deliver.

Our people are at the heart of what makes the NHS. Improving their experience will remain central to improving the experience for patients, and we look forward to working with our partners in our combined efforts to make the NHS a good place to work for those staff that we have now and those that we will need in the future.

NHS terms and conditions of service (Agenda for Change)

- It is essential that the NHS terms and conditions of service continue to keep pace with modern employment practice, provide value for money and make effective use of staff in the changing NHS system.

- Looking ahead to the end of the current three-year pay deal in March 2021, the pressures of meeting increasing demand and at the same time delivering efficiency savings means that employers will not wish to be burdened with unfunded commitments connected to the

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NHS Employers: Health and wellbeing
employment of staff, which create additional financial pressure.

- Employers would support you, the NHS Pay Review Body, in looking at the future of high-cost area supplements and recruitment and retention premia to support attraction, recruitment and retention. These subjects should be explored in detail and the impacts of housing and transport costs on employees will need to be considered.
1. INFORMING OUR EVIDENCE

Introduction

1. We welcome the opportunity to submit our evidence on behalf of healthcare employers in England. We continue to value the role of the NHS Pay Review Body in bringing an independent and expert view on remuneration issues in relation to that part of the workforce covered by the 2018 NHS terms and conditions of service.

2. Our evidence has been informed by a continuous cycle of engagement with a full range of NHS organisations about their priorities. 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 and our policy board, which is made up of a cross-section of leaders from across the NHS.

3. This year again, with a multi-year pay deal in place, we are not seeking your recommendations on pay. Our evidence is a brief update.

4. More substantial discussions will be possible in future years as the new pay and conditions begin to bed in. We look forward to continuing our dialogue with you as the final year of the multi-year pay deal approaches and as we begin to develop our thinking around future pay and reward priority areas.

5. In his letter of 16 October 2019, the Secretary of State for Health and Social Care asked the review body to:
   - consider the role of recruitment and retention premia and how they might help support the recruitment and retention of staff
   - make observations on the potential for the greater use of recruitment and retention premia and on, but not limited to, the recruitment and retention of IT staff.

6. We refer to this subject in section two.
7. NHS Employers acts as a link between national policy and local systems, sharing intelligence and operating networks for trusts and other employers to share successful strategies.

8. Our submission reflects the views of employers on the combined effect of the financial, workforce and transformation challenges faced by the NHS. It considers the impact of the NHS people plan and the strategic direction set out in the NHS Long Term Plan, and how these factors might come together to influence decisions for employers on pay and reward in the years ahead.
9. The current three-year pay deal ends on 31 March 2021 and employers are already looking ahead to the period immediately after. Given the workforce challenges we are facing it is essential that we can provide certainty on pay levels for our existing staff and those we need to attract and recruit. Employers would welcome discussions to explore the possibility of a further multi-year pay deal.

10. In their joint report *Closing the Gap* the King’s Fund, the Health Foundation and Nuffield Trust look to the period immediately after the end of the three-year pay deal stating:

11. “Pay must continue to at least keep up with inflation after this point, but it must also keep up with pay growth in the rest of the economy. While the current pay deal may help in terms of retention and morale among staff, this can quickly be undone by pay rises that are below inflation and below increases in whole-economy earnings once it ends.”

**Progress**

12. Given the nature of the multi-year agreement reached on pay in 2018, our evidence this year will be focused on updating the NHS Pay Review Body on implementation progress and to continue to highlight issues of concern to employers.

13. The national collective agreement ensures that redundant features of the NHS terms and conditions (Agenda for Change) pay structure, such as the pay band overlaps, are being removed through significant reforms which will be completed by March 2021. The reforms are helping to support employers on attraction, recruitment, retention and capacity issues and they are also helping them to support staff to meet growing demand for services within the NHS.

14. An important part of the deal was an ambitious programme of further work for the NHS Staff Council. This work has entailed NHS Employers leading several sub-groups exploring further contract and policy reforms around the NHS terms and conditions of service.

15. For NHS staff, the previous decade was one of significant, prolonged pay restraint and real-terms pay cuts. As we look ahead to the last year of the multi-year pay deal, we need to start planning for the period immediately beyond the end of the current deal, and the changes made in the distribution of staff across each of the pay bands, with more NHS staff now expected to be employed at the top of their pay band.

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7 *Closing the Gap: Kings Fund, Health Foundation, Nuffield Trust*
16. It is essential we consolidate the benefits of the restructuring of NHS terms and conditions of service in order to support the delivery of the Interim NHS People Plan and initiatives to address vacancies. The NHS must continue to be able to attract, recruit and retain the skilled, compassionate workforce it needs.

17. The NHS Staff Council has continued to produce guidance, information and tools on the NHS Employers website, dedicated to agreed information about the pay deal. This area now contains a substantial body of resources to help employers communicate the changes to staff and it continues to be updated, for example, with guidance on how shared parental leave and pay should work in several situations under the national collective agreement. Employers are using these resources as part of their local communications strategies.

Pay changes in 2019/20

18. 1 April 2019 marked the start of year two of the programme of reform. Lower pay points have been removed to support attraction, more pay points have been deleted to support recruitment. These changes further increase starting salaries and reduce the length of time it takes to reach the top of most pay bands.

19. Changes for staff at the top of their pay band, effective from 1 April:

- For staff in bands 2 to 8c, an increase to annual basic pay of 1.7 per cent from 1 April 2019.
- Staff employed on the top of their band at 31 March 2019 received a one-off 1.1 per cent non-consolidated lump sum cash payment.
- For staff at the top of bands 8d and 9, their basic pay increase and their one-off non-consolidated lump sum were capped at the level of the increase for the top of band 8c.

20. For staff not yet at the top of their band:

- Some staff whose pay point was deleted received an annual pay uplift and transitional pay progression on 1 April, effectively receiving their pay progression early.
- Other staff received an annual pay uplift on 1 April and then received their transitional pay progression on their pay step date (formerly known as their incremental date).

21. From 1 April 2019, the minimum, basic pay rate in the NHS structure increased to £17,652. This meant the hourly rate for these staff rose to £9.03 (higher than the Living Wage Foundation rate for 2019).

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8 2018 contract refresh - NHS Employers
9 Occupational shared parental leave scenario guidance: NHS Employers
10 NHS Terms and conditions of service England: changes from 1 April 2019: NHS Employers
22. High-cost area maximum and minimum supplement values were uprated by 1.7 per cent from 1 April 2019\textsuperscript{11}.

**Band 1**

23. A non-consolidated cash lump sum, worth 1.1 per cent of the value of band 1 annual basic pay from 1 April 2019, was paid to all band 1 staff in April. This was paid regardless of whether staff remained in band 1, had transitioned to band 2 before 1 April, or transitioned to band 2 on 1 April via the national process\textsuperscript{12}.

24. Job profiles for band 1 have been archived and are no longer available. Electronic Staff Record data is showing a continued decline in the number of band 1 staff in post. However, some employers still have some work to do to fully complete the migration of staff to band 2 roles. This is mainly organisations with large numbers of band 1 posts. NHS Employers is actively supporting employers in this position and helping to pass on good practice learned in those organisations that have successfully completed this work. Workshops are being planned to allow employers to share their experiences and develop local solutions.

**Pay progression**

25. The 2018 contract refresh provided opportunities for employers to increase workforce productivity through stronger evidence-based staff appraisals, placing more emphasis on improving and increasing staff capability.

26. Staff who were in post before 1 April 2019, and those who changed roles but still worked in the same pay band, remain subject to their existing pay progression procedures until 1 April 2021.

27. All staff who commenced NHS employment on or after 1 April 2019, or who were promoted on or after this date, are subject to the new pay progression arrangements.

28. In the results from the 2018 NHS Staff Survey, line manager support increased to 6.83 and quality of appraisals to 5.46. These have seen a year-on-year increase for the last four years.

**Terms and conditions of service**

29. In addition, the NHS Staff Council also agreed\textsuperscript{13}:

- changes to section 15 in the handbook so that provisions relating to maternity, adoption, and shared parental leave and pay, all fall under the same section.

- a contractual entitlement to shared parental leave, which ensures that the NHS terms and conditions service for shared parental pay match the level of maternity or adoption pay.

\textsuperscript{11} NHS Terms and conditions of service handbook: annex 9
\textsuperscript{12} Transitioning band 1 staff to band 2: NHS Employers
\textsuperscript{13} 2019 pay advisory notices: NHS Employers
- a new section 23 introducing provisions for leave and pay in the event of a child bereavement, designed to support employers to create greater consistency on how the policy operates across the NHS.

Apprenticeship pay

30. The NHS Staff Council set up a sub group to work in partnership to explore options for the reform of apprenticeship pay and how this might relate to section 21, trainee pay. The sub-group considered producing draft principles and ways in which any framework agreement could be introduced, including inserting a new appendix on apprenticeships into the NHS terms and conditions of service handbook, amending annex 21 on trainee pay and whether any new agreement should be an enabling framework for local implementation or a more detailed agreement.

31. At a meeting of the NHS Staff Council in September 2019 the parties concluded that it would not be possible to reach an agreement on apprenticeship pay, given competing priorities. An update has been published on our website.

Other work programmes

32. The parties have agreed that it will not be possible to reach agreement on buying and selling annual leave.

33. With many employers already having successful local systems in place, the creation of a national framework would restrict the ability of local employers to operate their existing systems and design new systems meeting local operational needs. We will encourage employers to continue the development of their local policies in support of the implementation of the priorities set out in the Interim NHS People Plan in this area.

34. The NHS Staff Council has begun work to guarantee access to the annual leave and time off in lieu provisions set out in the NHS Terms and Conditions of Service Handbook. The NHS Staff Council will not amend any of the national provisions.

35. A survey has been issued to collect evidence on current bank practice across the service. This will help the parties understand the variety of current pay arrangements and enable them to explore the scope for a collective agreement on bank working designed to encourage staff to offer time to internal staff banks. NHS Improvement has published a toolkit to help employers maximise the use of staff banks and further reduce agency spend.

36. The NHS Staff Council has decided that work relating to the use of agency staff has been sufficiently covered by NHS England and NHS Improvement work streams and will continue to monitor progress being made.

14 Apprenticeship pay negotiations update - NHS Employers
15 Making effective use of staff banks: NHS Improvement: December 2017
Ambulance staff

37. The ambulance improvement programme board, comprising representatives of NHS England and NHS Improvement, NHS Employers and ambulance trusts, continues to meet to monitor progress in ambulance workforce development.

Further reform

38. The NHS Pay Review Body’s support and endorsement of the NHS terms and conditions of service refresh in 2018 is acknowledged by employers to be genuinely helpful in terms of supporting wider system strategic objectives. It is seen as a positive start to the urgent and sustained work needed to address continuing severe pressures on attraction, recruitment and retention of staff.

39. The view of employers remains that pay must always be considered in the context of long-term objectives, the future system and service operating model and the reward and workforce strategies required to support this. Future annual changes to pay can then be used to support the long-term vision.

40. Looking ahead to the end of the current three-year pay deal, the pressures of meeting increasing demand, and at the same time delivering efficiency savings, means that employers will not wish to be burdened with unfunded commitments which create additional financial pressure.

41. Looking ahead beyond the current deal, we will welcome further dialogue with you on how the 2018 pay arrangements can continue to meet the changing needs of employers and the workforce. Issues which will need consideration at some point will include:

- the size of the pay gaps/steps between some of the pay points
- the number of pay steps in some parts of the structure
- compression of pay points/steps at the bottom of the pay spine.

Equal pay for work of equal value

42. Equal pay requirements limit the scope for employers to implement much pay differentiation for staff with the same NHS terms and conditions of service pay band. Yet employers can use recruitment and retention payments for staff groups to address specific labour market challenges.

43. The courts have established that in defending claims brought by employees, employers can refer to difficulties recruiting and retaining staff caused by circumstances in relevant labour markets. For example, they may refer to a shortage of the skills that the comparator organisation has, and the claimant organisation does not. There is no problem with paying employees different rates in different locations except where the premium is not given to all employees in a location, so it effectively becomes an occupational premium, which may or may not be justified by labour market data.
Recruitment and retention payments

44. Recruitment and retention payments\(^{16}\) can be used by employers to address labour market challenges affecting specific occupational groups but must only apply to posts, not to individuals. Employers can use the payments where labour market pressures would otherwise prevent the employer from being able to recruit and retain staff, in enough numbers for the posts concerned. The NHS Pay Review Body can recommend the use of payments on a national basis to specific staff groups where this action can be objectively justified by relevant labour market and other evidence.

45. These payments may be short term, if the labour market issues are expected to be short term, or long term where the need for the premium is not expected to vary significantly in the foreseeable future. Where there are local recruitment and retention difficulties, employers can use local recruitment and retention payments when there is robust evidence that a pay solution is required.

46. Recruitment and retention payments cannot solve supply problems and may, in certain circumstances, lead to unnecessary pay escalation. We strongly advocate a greater role for local NHS human resources in the determination of workforce supply. We believe a lack of involvement at early stages in the process has been the root cause of many of the workforce problems the NHS has experienced over the years.

47. Accurate determination of demand and supply will avoid the need for expensive pay solutions.

48. Recruitment and retention payments are an important flexibility for employers and can be a cost-effective tool given the comparative costs of recruiting and use of agency staff or overtime. Local targeting of pay by employers is a more flexible approach than a national award, which cannot respond to local differences. Recruitment and retention payments can be used by employers as part of packages of measures to target groups on recruitment and retention grounds. We say more about total reward in section three.

49. Employers often regard the introduction and use of recruitment and retention payments as a last resort. Employers prefer to investigate if problems are related to avoidable work-related pressures, working environment, work volumes and procedures that require attention. The national staff survey and local employer surveys provide useful information on these factors. Employers aim for:

- efficient and robust recruitment processes and an effective induction
- supporting leadership, staff health and wellbeing, and staff engagement initiatives
- the flexibility for staff to manage work-life balance. Approaches need to be in place to facilitate appropriate and supportive responses by organisations to these needs
- effective management and development of future talent to ensure an engaged and adaptable workforce

\(^{16}\) NHS Terms and Conditions of Service Handbook, section 5
measures to make their staff feel valued.

**Recruitment, retention and attraction**

50. Employers want the NHS terms and conditions of service to align with modern employment practice, provide value for money and make effective use of staff in the evolving NHS operational structure. Employers support the inclusion of recruitment and retention payments in the NHS terms and conditions of service to support recruitment and retention of good quality staff to deliver patient care, particularly where payments can be shown to make more effective and efficient use of NHS funds.

51. In their report *Closing the gap*, the King’s Fund, Nuffield Trust and the Health Foundation say that more needs to be done to understand why local pay flexibilities are not being used. Employers would welcome the opportunity to have a broader look at the future of recruitment and retention payments to support attraction, recruitment and retention. As we reconfigure NHS services, it will be important to establish a firm evidence base for the effectiveness of these payments as the financial pressures on organisations remain. For example, it will be necessary to understand how new care systems that are organised to deliver the needs of local communities, will relate to the labour markets in which they are operating.

**The challenges for employers**

52. In NHS trusts, recruitment and retention problems are driven by a series of pay and non-pay factors which must be assessed locally before turning to a potentially expensive pay solution. For example, when the Nursing and Midwifery Council surveyed registered nurses in 2017, top of the list of reasons for leaving the NHS was working conditions (44 per cent of respondents). Poor pay was cited as a reason for leaving by 16 per cent of respondents.

53. Feedback from employers suggests that the decisions made by staff to leave their NHS employment are motivated by a wide range of factors, not just pay. Each of these factors vary over time, from location to location and by reference to specific staff groups. Analyses of reasons for leaving the nursing workforce are shown in the chart below:

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17 Nurses and midwives council registration data 2017
54. Employers’ experience of operating recruitment and retention payments is that appropriate review mechanisms are essential. Consistent with the principle of equal pay for work of equal value, where the need for a recruitment and retention premium is reduced or has ended, short-term premia should be reduced or withdrawn as soon as possible. Long-term premia should be adjusted or withdrawn for anyone offered a qualifying post after the decision to withdraw or reduce the premium has been made.

55. Employers have transparent pay and reward policies which state their approach to these important flexibilities. Payments must reflect local needs and be supported by robust data on relevant local and regional labour markets. Systems must be kept simple to operate and must be understood and supported by staff and trade unions. There is scope to improve and increase the sharing of good practice in the use of payments.

Labour markets

56. The NHS employs most registered nurses and other health professional groups, and therefore sets the market rate for these staff. Employers estimate that around one-third of non-clinical NHS roles are comparable with similar roles in the private sector and, for these comparable groups, the NHS needs to be able to compete effectively on pay.

57. Private sector approaches to pay, which aim to reflect the local labour market, are driven largely by specific business needs and can vary by sector. Where the private sector does use pay differentiation, it uses relatively few pay bands linked to geographies.

58. In the NHS, employers operate in different local labour markets and some pay flexibility can lead to a more efficient use of the pay bill. However, the NHS has a wide-ranging sophisticated workforce that relates to international, national, regional and local labour
markets. These factors mean that employers must be careful not to take local action that could lead to pay escalation or labour market instability.

59. The advice from employers is that the causes of local recruitment and retention difficulties are complex. Various aspects of the employment package can influence recruitment and retention for staff subject to the NHS terms and conditions of service, such as:

- the employers’ reputation or type of organisation
- leadership and management practices
- pay relative to the local economy
- additional benefits such as pensions, flexible working arrangements and leave entitlements
- the availability of additional earnings
- access to education and training
- transport links.

60. Assessment of the local influence of these factors is important before determining whether a pay solution is required. It may also be that a combination of measures is required at local level. We say more about these approaches in section three.

Use of local recruitment and retention payments

61. Just under half of employers who responded to our 2019 total reward survey said that they are currently using recruitment and retention payments to support recruitment to hard-to-fill posts. Of those who said they did, these payments applied to clinical coder posts and some estates roles.

62. Local recruitment and retention payments are uncommon. Employers continue to face funding challenges and are reluctant to find funding for these payments from local budgets when there is no related allocation in the tariff. Once in place, payments can be difficult to remove. Employers are conscious of the potential impact on neighbouring employers of staff moving from one site to another. We also know that employers are using other local incentives to attract and retain staff. These include the large range of innovative measures we report in section three.

Funding

63. Financial allocations informed by the Staff Market Forces Factor (SMFF)\textsuperscript{18} are a well-established mechanism to align funding with local pay costs. Employers would like to see this relationship between financial allocation and pay levels maintained, but there needs to be better understanding and communication of the details provided.

\textsuperscript{18} Guidance on the Staff Market Forces Factor: NHS Improvement
64. The funding formula is designed primarily to ensure the correct allocation of resources to trusts, rather than to determine geographic differences in pay rates. The SMFF methodology does not allow for factors known to drive private sector pay, such as employee qualifications and organisation size.

65. The NHS Pay Review Body\(^{19}\) has previously observed:

“Our other concern is that there was little evidence that extra pay monies being allocated through SMFF were finding their way into pay systems locally in a consistent manner. On the one hand, it is appropriate that employers should have the flexibility to use additional SMFF funding as befits the local solution required and meets the local service need (and using relatively expensive agency staff and locums can be appropriate in certain circumstances). On the other hand, evidence on the lack of widespread use of local RRP may be an indicator that trusts where market rates are high are reluctant to pass on the additional funding received in staff pay and an indicator reflecting current labour market conditions. The varied use of the funding across the country could lead to unequal outcomes for patients and therefore further information on these areas would help to clarify the position.”

Data

66. If it were to become possible, employers would welcome central gathering, collection and analysis of local labour market indicators as it would avoid duplicating effort in NHS organisations and allow more time to analyse them in the context of other local intelligence. Our understanding of employers’ usage of recruitment and retention premia has been that it is uncommon and has not shown a distinct geographical pattern.

High cost area supplements

67. High cost area supplements (HCAS) are designed to address the higher cost of living in some areas. HCAS\(^{20}\) are in place for inner London, outer London and fringe zones, with the supplement values based on a percentage of salary, with a minimum and maximum cash payment. The percentages, minima and maxima depend on the area, with inner London attracting the highest supplement and the fringe areas of London the lowest.

68. The award of a high cost area allowance depends on the employee’s place of work and is dictated by custom and practice over many years. The evidence base underpinning the use of these payments is, therefore, different to that underpinning recruitment and retention payments. Employers in areas where HCAS apply need to take care that they are not paying for the same recruitment and retention difficulties through two different mechanisms.

69. Employers would support a wider review of high cost area supplements and how they interact with recruitment and retention payments, including use of the SMFF.

\(^{19}\) NHS Pay Review Body: Market Facing Pay: December 2012

\(^{20}\) NHS Terms and Conditions of Service Handbook, section 4 and annex 8
Information technology staff

70. We have not received new representations from employers on the need for national action on recruitment and retention payments for staff working in various capacities in the field of information technology. The situation has changed little since we reported on this subject in our submission last year. We believe the central issue remains one of the supply of staff of the right calibre and with the right knowledge and skills. In this varied and very broad field of activity, employers have varying needs for staff with a very wide range of knowledge, skills and experience. Job titles vary considerably, and employer requirements vary both in terms of the timescale for the work programme and the level of information technology skill and knowledge required. In this situation it is very hard to see how a national recruitment and retention payment could be targeted to address a universal need shared across employers in England. It is our view that local recruitment and retention payments, operated by employers when they identify appropriate circumstances, are the best way to address shortages in this area.

71. New recruitment and retention payments imposed on employers without associated new funding would inevitably create new financial pressures locally. We do not, therefore, support new national recruitment and retention payments for staff working in information technology roles.

Retention

72. The longer staff stay with an organisation the more knowledgeable and skilled they become. It is expected that around half of today’s workforce will still be working in the health service in the 2030s. The most cost-effective way to ensure the NHS has the staff we need in the future is to support and retain the people we already employ. We refer to the work being done to address supply issues in sections three and five.

73. Employers believe there is no single action that will resolve staff retention issues. Retaining staff is the result of combined actions taken by the organisation, including:

- making sure that people are involved in deciding what it is they do and how they do it
- engaging effectively with employees across the organisation
- monitoring managerial and leadership results from the national staff survey and from local surveys
- use of new roles such as physician associates and nursing associates
- recruitment planning based on closer links with universities; proactive attraction campaigns such as recruitment fairs; creative advertising and focused senior support for recruitment.

74. All employers require a healthy level of staff turnover, but the challenge is to find the right balance between turnover and retention by understanding what is going on in organisations and within specific staff groups, teams and departments. Coupled with this is a recognition
that different generations want different things in their working lives. Strategies and approaches to employment and deployment need to be in place, such as shift patterns designed to recognise the needs and aspirations of individuals across different stages of their careers. We say more about his challenge in section three.

75. We do not support the use of nationally determined recruitment and retention payments for individual staff groups under the NHS terms and conditions of service. Employers are not pressing us to support this action. Instead employers prefer to use the flexibility available to them to award local recruitment and retention payments where there is robust evidence of problems arising directly from labour market issues.

76. Employers recognise that there is more work to do to on how they will use the limited pay and benefits levers available to them to improve retention working within the constraints of available resources.
3. **TOTAL REWARD**

77. In their joint report *Closing the Gap*, the King’s Fund, Nuffield Trust and the Health Foundation suggest that retention is directly related to the leadership and culture of the organisation. The report states that people leave because they feel overworked, underpaid, poorly treated, unable to deliver good care, unable to progress, or some combination of all these things.

78. Reporting on reasons why staff leave their NHS employment, the Health Foundation says that in 2018/19, work-life balance was cited by more than two and a half times as many people as a reason for leaving the NHS than in 2011/12 (see chart below).

![Figure 20: Change in reason for leaving given by staff (for voluntary resignations), 2011–12–2018–19](chart)

79. While this is partly accounted for by more nurses leaving and increased data availability, it has grown from representing 17 per cent of voluntary reasons for leaving to 23 per cent, where the relevant information is available. However, the analysis that can be done here is limited because the most common reason reported for leaving is ‘other/not known’.

80. **NHS Employers:**

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21 *Closing the gap: Kings Fund, Nuffield Trust, Health Foundation*

22 *The Health Foundation: Falling short*
• runs a national Total Reward Engagement Network (TREN)
• undertakes an annual survey of workforce professionals
• works closely with employers nationally to understand their challenges and successes.

81. We tailor our work programme to meet employer needs and we work closely with employers to produce resources on our website that employers can use to support development of successful local reward packages.

82. Recognising the contribution of the staff we already have is an important part of the employer workforce agenda, both nationally and locally. As highlighted in the Interim NHS People Plan and the NHS Long Term Plan, there is a major challenge for employers in ensuring their staff feel valued and motivated to work in rewarding roles, establishing the NHS as the best place to work.

83. Employers are emphasising the psychological contract between employer and employee. The NHS is, but must also be perceived widely in society to be, an honourable, rewarding and exciting place to work. If staff excel, they will be recognised and celebrated as much as they would be in any other working environment. We must continue to do all we can to raise the status of NHS staff, so they feel confident in the high regard in which they are held within the communities they serve and in society in general.

It is all about people

84. Innovation has driven the development of reward in the NHS, inspired by changing operational circumstances and the needs of staff. Among the many challenges now facing all those involved in reward is to design an appropriate reward offer that will motivate staff not only in traditional hospital environments but also in new integrated, community-owned healthcare systems. In an environment where the health service is suffering from a major workforce shortage, getting the psychological contract right is key.

85. Our talented and committed staff respond to opportunities to acquire and develop their knowledge, skills and confidence. One of the greatest rewards we can give staff, and the patients and communities they serve, is to support their efforts to achieve their full potential. We believe it is an urgent priority that funding for continuing professional development is restored at a constant and sufficient level.

86. In integrated systems, building the strong relationships we will need and creating highly motivated teams will be crucial to patient care. If we are to succeed in delivering these new systems of care, we must recognise what matters to people - both those giving and those receiving care - and offer reward and recognition accordingly.

23 NHS Employers: reward
Across the NHS, employers are developing reward packages for their staff designed to respond to their specific needs, evaluating their impact and redesigning their offering to meet changing requirements and aspirations. The diversity of the NHS workforce is one of its greatest strengths, reflecting the communities it serves and enabling staff to bring their unique capabilities, opinions and life experiences to work. At the same time, the diverse work environments created by integration allow managers to make the best use of the characteristics of all staff.

The Interim NHS People Plan is a concrete framework for how we will give staff the backing they need to deliver the ambitious goals set out in the NHS Long Term Plan. We are developing a common purpose across individual systems that aligns with the competence and values of staff and drives their day-to-day behaviours. Each person has a contribution to make, so we are providing opportunities for employees to connect and celebrate their individual and collective achievements and recognise that the health and care systems in which they work are community based and community owned.

Leaders in integrated systems are encouraging communities to provide support, for example through employment or volunteering within the NHS, which engenders a sense of the value of the NHS as a valuable community resource.

Employers are working collaboratively on some aspects of this work as health geographies evolve and integrated care systems become more established. However, there is recognition that there can be much more development in this area in conjunction with ensuring individual employers engage with staff to understand their needs. It remains important to employers to attract, recruit and retain a diverse workforce, including attraction and retention of a multigenerational workforce, which is representative of the communities served.

**Making staff feel valued**

There are many actions employers can take to help staff feel valued:

- Daily recognition through interactions with senior colleagues and saying thank you; and monthly or annually through formal staff awards and recognition schemes.
- Constructive feedback through the staff appraisal system.
- Involving staff meaningfully in decision making, including what should be in total reward packages.
- Frequent and informative communication.
- Providing work that provides appropriate developmental challenges.
- Celebrating work anniversaries, often part of recognition and reward events.
- Providing career development and learning opportunities.
One of the biggest challenges for large NHS organisations with diverse and geographically spread workforces is to treat staff as individuals. Staff needs differ from person to person, depending on many factors relevant to the workplace, home and broader life experiences. Addressing personal needs which arise at specific times, such as the need to take time off to care for an ill child, can increase retention rates. Staff feel more valued when their urgent personal needs are met. Employers are supporting line managers to spot such needs and act on them appropriately. Benefits champions are increasingly being used to communicate one to one with employees on the reward offer.

Against an unwelcome backdrop of continuing negative publicity, our committed staff continue to provide excellent patient care. They are our biggest asset and employers are continuing to emphasise both tangible and intangible aspects of their total reward offer.

**Total Reward Statements**

Total Reward Statements enable employers to demonstrate the benefits of the holistic reward packages they offer their staff. They also demonstrate valuable information on the value of the NHS Pension Scheme.

2019/20 was the fifth year of operation of Total Reward Statements in the NHS. Information from the NHS Business Services Authority indicates that a total of around 2,453,240 statements were available to staff in England and Wales, including those working in primary care. The number of unique views between 19 August 2018 and 3 August 2019 was around 821,917. Since 2016, there has been a steady increase in unique views of around 353,140 to date. Compared with the position at the same time last year, this is an increase of just over 30 per cent in the number of staff accessing their statements. Employers are committed to making use of and promoting their local reward offer by using their Total Reward Statements.
Strategies to engage staff

96. Employers are using social media, including Facebook and Twitter, to inform their staff of the reward offer. In line with the NHS-wide drive to act on the available evidence, employers are focusing on proven business outcomes. This means recognising the composition of diverse workforces and how this translates into a need for varied and imaginative communications methods. Staff from a wide range of backgrounds and origins work together in teams in a variety of settings including offices, wards, clinics and, increasingly, in various community settings. Recognising how such a diverse workforce operates is key to designing communications strategies which effectively deliver up-to-date information on all aspects of the reward offer to all staff at the same time. In this way, every employee is encouraged to feel equally valued.

97. Employers are supporting line managers to help in this important communications effort. Line managers are often best placed to understand the unique needs of individuals in their teams and they can be the organisation’s early warning system, alerting human resources to trends that can be addressed through adjustments in communications and/or the reward offer. Some employers have created networks of benefits champions, which are staff who volunteer to support the communication of the reward offer across the organisation. The benefits of face-to-face communication with peers is well known across the employment sectors.

98. Communications being used now include:

- apps available on phones, enabling the large proportions of the workforce who do not have regular access to desktops or laptops to access information quickly and easily
- a variety of local intranet and email communication
- workshops promoting aspects of the reward offer including the NHS Pension Scheme and support on financial wellbeing
- roadshows designed to take information to staff who may be working in remote sites away from the trust HQ or main hospital
- listening events allow staff to talk in safe environments and with few restrictions on what topics may be raised
- benefits handbooks, posters and leaflets.

99. These measures are enabling organisations to create rich databases of information about hot spots and hot topics, allowing employers to better tailor packages to the needs of the workforce. Seeking the views of staff is another way we can make them feel valued. Around one quarter of employers who responded to our total reward survey told us they believe that line managers can do more to communicate the reward offer to staff. In the results from the 2018 NHS Staff Survey, line manager support increased to 6.83 and quality of appraisals to 5.46, having seen a year-on-year increase for the last four years.
100. Many employers host awards events that recognise and reward the clinical and non-clinical workforce and their contribution to the delivery of patient services. Many of these are endorsed by senior leadership.

101. While work on the full NHS People Plan has been ongoing, we have been working with the chairs of our HR director networks to consider what assurance boards might seek in underpinning the reward offer. We have identified key outcomes which focus on:

- creating healthy, inclusive, compassionate cultures
- being able to have flexible working arrangements
- enabling development and fulfilling careers
- involvement.

102. Employers believe the core reward offer needs to be positive and hopeful, comprehensively addressing what matters to staff, informed by workforce leaders’ experience of engagement.

103. Over 65 per cent of employers who responded to our reward survey told us that they were currently using reward to meet long-term workforce objectives on recruitment and retention. Employers need to attract prospective employees into the workforce, manage their career development and ensure they can operate effectively alongside the experienced individuals and teams who are already delivering highly effective and compassionate patient care.

104. NHS Employers has worked with many NHS organisations to help understand their retention challenges and equip them with tools and resources to implement effective workforce retention plans. Our retention guide and case studies illustrate the good practice taking place across the NHS.

105. Many employers provide details of their reward offer in dedicated areas on their websites. As well as providing the opportunity to showcase the reward offer it also allows employers to promote the positive aspects of the location of the organisation. This is important for employers in areas near to London, such as Oxfordshire, and those in more rural locations, such as Cumbria and the south west coast. Pay is not the only factor which influences career choice. There are often complex factors stemming from the evolving structure and composition of society locally, nationally and internationally that motivate career decisions.

106. What makes one location more desirable than another may vary. For example, amenities and proximity of family and friends will often influence staff in deciding what is a desirable location. However, there are other factors including the status of the employing organisation, job and career opportunities for partners and availability of schools and childcare. Many staff are attracted to centres of excellence because they believe these will offer the best career development opportunities. Some of these factors may be beyond the control of organisations, but they are able to support the development of supportive cultures and good working conditions, which are also important to prospective employees when they make a career choice.

107. Working with NHS England and NHS Improvement, our nursing workforce retention programme has enabled us to offer support to over 100 NHS organisations in England.

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24 NHS Employers: Improving staff retention
25 NHS Employers: nursing workforce retention programme
Addressing turnover and reducing leaver rates is complex and we have supported local employers develop their own approach.

108. NHS Improvement published a report in July 2019\textsuperscript{26} which outlines the work done since June 2017. Overall, national nurse turnover rates have reduced from 12.5 per cent to 11.9 per cent. In mental health nursing the reduction is from 14.3 per cent to 13.4 per cent. This is the lowest level since 2014 and means the NHS retains 1,100 clinical staff who may have left the NHS if employers had not acted decisively.

109. This work programme will continue in 2020 and NHS Employers will focus on flexible working practices.

The components of reward in the NHS

110. Other aspects of the reward offer being emphasised by employers:

- Staff health and wellbeing, in line with the focus on improving culture and working environment in the NHS Long Term Plan, the Interim NHS People Plan and the Best Place to Work initiative. We would like to see a national commitment to prioritised access to treatment for NHS employees. This would benefit patient care and would be an important sign of the support being given in relation to health and wellbeing. It would help address some of the capacity issues employers are facing.

- Financial education programmes, providing education on personal budget management and access to loans on favourable terms enabling staff to avoid turning to unscrupulous lenders.

- Schemes to allow staff to buy additional annual leave or to sell a portion of their annual leave entitlement give staff in certain circumstances an opportunity to have some more control over their work-life balance. Employers who responded to our total reward survey in 2018 told us that just over 30 per cent of them were currently offering at least some staff, the option to both buy and sell annual leave. 27 per cent of employers were offering buying only. Just over 57 per cent of employers who responded to the survey told us they offered these options to all their staff.

- Salary sacrifice schemes, accompanied by advice and guidance on the impact of this facility on total earnings and additional benefits like pensions.

Primary care networks

111. Primary care networks are a key part of the NHS Long Term Plan because of their potential to deliver a wider range of services to patients, delivered by skilled staff with a wider range of roles than have been the norm in individual GP practices. Networks receive specific funding for clinical pharmacists and social link workers in 2019/20, with funding for physiotherapists, physician associates and paramedics in subsequent years.

\textsuperscript{26} NHS Improvement retention programme two years on
112. Integrated community-based teams will develop around them, and community and mental health services will be expected to configure their services around primary care network boundaries. These teams will provide services to people with more complex needs.

113. Primary care networks will also be expected to be proactive in their approach to managing population health by from 2020/21, assessing the needs of their local population to identify people who would benefit from targeted support.

114. These developments give employers and staff new opportunities for more varied work placements in a greater variety of settings. This will promote career development and support retention by providing a greater range of developmental opportunities as careers progress. Staff with a greater range of skills, who can be deployed in more settings, will be able to work more effectively in the multidisciplinary teams we need to treat the increasingly elderly patient population with multiple, complex and long-term health problems.

The NHS Pension Scheme

115. NHS England has written\(^27\) to local health leaders regarding pension tax arrangements in 2019/20 for all members of the NHS Pension Scheme who are in active clinical roles. NHS England confirm the use of the existing scheme pays option for annual allowance charges arising in 2019/20, which allows members to ask the NHS Pension Scheme to pay their annual allowance tax charge to HMRC on their behalf.

116. Normally, in return, the member’s benefits in retirement would be reduced by a corresponding amount. However, where a clinician incurs this reduction as a result of using scheme pays, the employer will make an additional payment, equivalent to the reduced pension benefits, to the member on retirement.

117. NHS England and NHS Improvement have confirmed this will be funded nationally and they will provide employers with financial support to ensure employers do not face additional costs as a result of this arrangement.

118. We are seeking further information to understand the detail of this for employers and we are supporting employers by keeping them informed\(^28\) of developments.

119. The HM Treasury review of the annual allowance taper remains the most effective solution to the impact of the annual allowance and the taper on our workforce. However, pension scheme flexibility will have an important part to play for some staff in mitigating future tax liabilities, even if the taper is removed in the future. We say more about this later in this section.

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\(^{27}\) NHS England: Pensions tax annual allowance 2019/20

\(^{28}\) NHS pensions tax guidance NHS Employers
The scheme

120. The 2015 NHS Pension Scheme was introduced on 1 April 2015, replacing the 1995 and 2008 sections (except where individual transitional protections applied) which were closed to future accruals. The 2015 scheme is a career average revalued earnings (CARE) defined benefits scheme. It 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.

Member contributions

121. 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.

<table>
<thead>
<tr>
<th>Tier</th>
<th>Pensionable pay (whole-time equivalent)</th>
<th>Contribution rate from 2015/16 to 2021/22</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Up to £15,431.99</td>
<td>5.0 per cent</td>
</tr>
<tr>
<td>2</td>
<td>£15,432.00 to £21,477.99</td>
<td>5.6 per cent</td>
</tr>
<tr>
<td>3</td>
<td>£21,478.00 to £26,823.99</td>
<td>7.1 per cent</td>
</tr>
<tr>
<td>4</td>
<td>£26,824.00 to £47,845.99</td>
<td>9.3 per cent</td>
</tr>
<tr>
<td>5</td>
<td>£47,846.00 to £70,630.99</td>
<td>12.5 per cent</td>
</tr>
<tr>
<td>6</td>
<td>£70,631.00 to £111,376.99</td>
<td>13.5 per cent</td>
</tr>
<tr>
<td>7</td>
<td>£111,377.00 and over</td>
<td>14.5 per cent</td>
</tr>
</tbody>
</table>

122. Employee contributions are currently under review by the NHS Pension Scheme Advisory Board, with any changes to be implemented with effect from 1 April 2021. The board’s recommendations to date include:

- determining employee contributions based on actual pay, to better reflect career average revalued earnings accrual
• avoiding ‘cliff edges’ where a pay increase forces an individual into the next contribution tier, sometimes leading to a reduction in take-home pay

• exploring ways to minimise opt outs.

Employer contributions

123. The employer contribution rate for both the 2015 NHS Pension Scheme and the 1995/2008 NHS Pension Scheme increased to 20.6 per cent of pensionable pay from 1 April 2019. This rate was determined by the funding methodology applied by the scheme actuaries during the 2016 scheme valuation\(^{29}\).

124. Employers pay a scheme administration levy equal to 0.08 per cent of pensionable pay in addition to the standard employer contribution rate.

Age discrimination ruling in public sector pension schemes

125. In December 2018, the Court of Appeal ruled that the transitional protection given to older members of the judges’ and firefighters’ pension schemes during the 2015 scheme reforms gave rise to unlawful discrimination on the grounds of age. The transitional protections allowed members who were close to retirement age at the time of the 2015 scheme reforms to stay in the final salary schemes until retirement, or to delay moving to the new career average schemes. The government sought permission from the Supreme Court to appeal the ruling, but this was denied.

126. It has since been confirmed that the ruling will apply to all public service pension schemes, including the NHS Pension Scheme. The government is now required to introduce a remedy to compensate affected members for any loss. Implementing an appropriate remedy will be a complex exercise and is likely to involve significant scheme changes, which will need to be carefully considered and communicated to staff and employers.

127. We expect a similar remedy will be applied across all public service pension schemes. Until the remedy is known, there remains some uncertainty about scheme costs from 1 April 2015. This uncertainty will impact the ongoing review of employee contributions and the 2016 actuarial valuation process.

Age discrimination ruling in public sector pension schemes

128. The results of the 2016 actuarial valuation were published in February 2019. The valuation has two key objectives:

\[
\text{Government Actuaries Department: NHS Pension Scheme: Actuarial valuation 31 March 2016}
\]
• To assess the cost of benefits against the cost cap mechanism.

• To set the required employer contribution rate from 1 April 2019 to 31 March 2023.

129. The valuation results showed that the cost of the benefits provided by the scheme has fallen to a point where scheme changes are required to bring scheme costs back in line with the cost cap. The fall in costs is predominantly due to pay increases and life expectancy improvements being lower than expected. Scheme changes are required to either improve member benefits or reduce member contributions. The scheme advisory board developed a recommendation for the Department of Health and Social Care on how the cost cap breach should be rectified. However, the current level of uncertainty around scheme costs due to the recent age discrimination ruling has meant the cost cap process has been paused. This will have an impact on the scheme advisory board’s ongoing review of employee contributions. Any changes will be effective from April 2021.

130. The required employer contribution rate has increased from 14.3 per cent to 20.6 per cent, mainly due to a reduction in the discount rate assumption, which is set by HM Treasury. The increase to employer contributions was implemented from 1 April 2019, with most employers receiving full central funding for the increase in costs.

**Scheme membership**

131. Total membership of the NHS Pension Scheme is around 1.6m. The overall membership continues to rise, with membership levels increasing by 5.5 percentage points from October 2011 to July 2019. Shorter-term trends show an overall increase of 0.7 percentage points for the 12-month period ending in July 2019 and an increase of 0.6 percentage points from April 2019 to July 2019.

<table>
<thead>
<tr>
<th></th>
<th>% points change</th>
<th>% with pension contributions</th>
<th>% points change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Apr 19 - Jul 19</td>
<td>Jul 18 - Jul 19</td>
<td>Jul 2019</td>
</tr>
<tr>
<td>All</td>
<td>1,095,189</td>
<td>91%</td>
<td>0.5%</td>
</tr>
<tr>
<td></td>
<td>91%</td>
<td>0.5%</td>
<td>1.0%</td>
</tr>
<tr>
<td></td>
<td>1.0%</td>
<td>5.1%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>90%</td>
<td>0.6%</td>
<td>0.7%</td>
</tr>
<tr>
<td></td>
<td>5.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AfC Band</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>24,439</td>
<td>83%</td>
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<td></td>
<td>1.3%</td>
<td>1.0%</td>
<td>18.0%</td>
</tr>
<tr>
<td></td>
<td>18.0%</td>
<td>81%</td>
<td>1.0%</td>
</tr>
<tr>
<td></td>
<td>1.0%</td>
<td>0.5%</td>
<td>18.1%</td>
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<tr>
<td>2</td>
<td>151,875</td>
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<td></td>
<td>0.7%</td>
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<td>13.1%</td>
</tr>
<tr>
<td></td>
<td>13.1%</td>
<td>89%</td>
<td>0.7%</td>
</tr>
<tr>
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<td>0.7%</td>
<td>1.7%</td>
<td>13.1%</td>
</tr>
<tr>
<td>3</td>
<td>125,342</td>
<td>91%</td>
<td>0.6%</td>
</tr>
<tr>
<td></td>
<td>0.6%</td>
<td>1.5%</td>
<td>9.3%</td>
</tr>
<tr>
<td></td>
<td>9.3%</td>
<td>90%</td>
<td>0.6%</td>
</tr>
<tr>
<td></td>
<td>0.6%</td>
<td>1.4%</td>
<td>9.4%</td>
</tr>
<tr>
<td>4</td>
<td>84,175</td>
<td>91%</td>
<td>0.9%</td>
</tr>
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<td></td>
<td>0.9%</td>
<td>1.4%</td>
<td>6.2%</td>
</tr>
<tr>
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<td>6.2%</td>
<td>90%</td>
<td>0.8%</td>
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<td>0.8%</td>
<td>1.1%</td>
<td>6.3%</td>
</tr>
<tr>
<td>5</td>
<td>197,367</td>
<td>89%</td>
<td>0.6%</td>
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<td>3.8%</td>
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<td>3.8%</td>
<td>89%</td>
<td>0.6%</td>
</tr>
<tr>
<td></td>
<td>0.6%</td>
<td>1.0%</td>
<td>3.8%</td>
</tr>
</tbody>
</table>
Table: Scheme membership trends (Source: ESR summary data July 2019). Data excludes doctors.

**Opting out of the NHS Pension Scheme**

132. The data below summarises the number of staff who chose to opt out of the NHS Pension Scheme from April 2018 to March 2019 and the reasons for opting out.

<table>
<thead>
<tr>
<th>Month</th>
<th>Total</th>
<th>Affordability</th>
<th>Annual or Lifetime Allowance</th>
<th>Contributing to another pension scheme</th>
<th>Fixed or enhanced protection</th>
<th>Other</th>
<th>Secured retirement income via other means</th>
<th>Temporary opt out due to other financial priorities</th>
<th>Would prefer not to say</th>
<th>No Reason Given</th>
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</thead>
<tbody>
<tr>
<td>Apr-18</td>
<td>6600</td>
<td>1993</td>
<td>362</td>
<td>1790</td>
<td>48</td>
<td>89</td>
<td>334</td>
<td>1909</td>
<td>17</td>
<td>58</td>
</tr>
<tr>
<td>May-18</td>
<td>6226</td>
<td>2075</td>
<td>326</td>
<td>1301</td>
<td>48</td>
<td>32</td>
<td>295</td>
<td>2067</td>
<td>14</td>
<td>68</td>
</tr>
<tr>
<td>Jun-18</td>
<td>5799</td>
<td>1807</td>
<td>264</td>
<td>1445</td>
<td>45</td>
<td>39</td>
<td>261</td>
<td>1884</td>
<td>3</td>
<td>51</td>
</tr>
<tr>
<td>Jul-18</td>
<td>5813</td>
<td>1824</td>
<td>245</td>
<td>1435</td>
<td>36</td>
<td>28</td>
<td>270</td>
<td>1920</td>
<td>10</td>
<td>45</td>
</tr>
<tr>
<td>Aug-18</td>
<td>6784</td>
<td>1991</td>
<td>263</td>
<td>1977</td>
<td>45</td>
<td>46</td>
<td>321</td>
<td>2064</td>
<td>6</td>
<td>71</td>
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<tr>
<td>Sep-18</td>
<td>6857</td>
<td>1913</td>
<td>192</td>
<td>2153</td>
<td>24</td>
<td>33</td>
<td>343</td>
<td>2124</td>
<td>5</td>
<td>70</td>
</tr>
<tr>
<td>Oct-18</td>
<td>7716</td>
<td>2064</td>
<td>249</td>
<td>2441</td>
<td>55</td>
<td>62</td>
<td>370</td>
<td>2380</td>
<td>22</td>
<td>73</td>
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<tr>
<td>Nov-18</td>
<td>7673</td>
<td>1909</td>
<td>234</td>
<td>2560</td>
<td>51</td>
<td>19</td>
<td>361</td>
<td>2332</td>
<td>3</td>
<td>204</td>
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<tr>
<td>Dec-18</td>
<td>5103</td>
<td>1509</td>
<td>207</td>
<td>1404</td>
<td>15</td>
<td>15</td>
<td>246</td>
<td>1669</td>
<td>2</td>
<td>36</td>
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<tr>
<td>Jan-19</td>
<td>6727</td>
<td>1739</td>
<td>315</td>
<td>1929</td>
<td>51</td>
<td>22</td>
<td>343</td>
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<td>Feb-19</td>
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<td>1666</td>
<td>390</td>
<td>1801</td>
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<td>16</td>
<td>357</td>
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<td>Mar-19</td>
<td>6215</td>
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</tr>
<tr>
<td>Total</td>
<td>77912</td>
<td>22288</td>
<td>3359</td>
<td>21785</td>
<td>478</td>
<td>432</td>
<td>3798</td>
<td>24844</td>
<td>93</td>
<td>835</td>
</tr>
</tbody>
</table>
Table: Monthly opt-out data from April 2018 to March 2019. (Source: NHSBSA)

<table>
<thead>
<tr>
<th>Reason for opting out</th>
<th>Number of opt outs</th>
<th>Percentage of total opt outs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordability</td>
<td>22288</td>
<td>28.61</td>
</tr>
<tr>
<td>Annual or lifetime allowance</td>
<td>3359</td>
<td>4.31</td>
</tr>
<tr>
<td>Contributing to another pension scheme</td>
<td>21785</td>
<td>27.96</td>
</tr>
<tr>
<td>Fixed or enhanced protection</td>
<td>478</td>
<td>0.61</td>
</tr>
<tr>
<td>Other</td>
<td>432</td>
<td>0.55</td>
</tr>
<tr>
<td>Secured retirement income via other means</td>
<td>3798</td>
<td>4.87</td>
</tr>
<tr>
<td>Temporary opt out due to other financial priorities</td>
<td>24844</td>
<td>31.89</td>
</tr>
<tr>
<td>Would prefer not to say</td>
<td>93</td>
<td>0.12</td>
</tr>
<tr>
<td>No reason given</td>
<td>835</td>
<td>1.07</td>
</tr>
</tbody>
</table>

Table: Summary of opt-out data and the reasons for opting out for 2018/19. (Source: NHSBSA)

Pension taxation

133. We reported in our evidence to the pay review bodies for 2018/19 and 2019/20 about the impact of the annual allowance and lifetime allowance pension tax limits. Previously, very few NHS workers were likely to exceed the tax thresholds, but changes in recent years, and the introduction of the tapered annual allowance, mean that more staff are likely to be impacted. The pension tax allowances continue to present significant issues for staff and employers, the details of which have been well publicised in the press and social media.

134. Any NHS employee who has pension benefits above the 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. During the 2018/19 scheme year, 16,793 members (approximately 1 per cent of the total membership) breached the annual allowance and 1,500 members (approximately 0.1 per cent of the total membership) accrued benefits worth more than 100 per cent of the current lifetime allowance.

135. Members can carry forward unused annual allowance from the three previous tax years to offset or eliminate a tax charge. However, many individuals have now exhausted their unused allowances in previous years, which means the chances of incurring a tax charge are increasing.

136. NHS Employers commissioned First Actuarial to carry out independent research into the impact of pension tax to gain a detailed understanding of the impact of the annual and lifetime allowances in the NHS on employing organisations, NHS staff and the risks to service delivery and patient care.
137. The report includes the analysis of the results of an online survey which gathered the opinions and experiences of over 2,500 NHS employees and their employers. The report of the research findings and a two-page summary are available on the NHS Employers website.

138. Around 70 per cent of employees who completed the online survey had not yet breached their annual allowance limit. However, 45 per cent of staff who have not yet breached their annual allowance and 84 per cent of staff who have already breached the annual allowance, believe they will be affected again in future. This is shown in the chart below.

![Chart showing the percentage of employees who think they will be affected by Annual Allowance breaches in the future (including the 2018/2019 tax year).]

139. Staff may believe they will be affected due to exhaustion of carry forward, the introduction of the tapered annual allowance, or an element of misunderstanding. Information can often be distorted or misunderstood through word of mouth, potentially leading some staff to take unnecessary action. However, as such a high proportion of staff believe they will be affected in future, this increases the likelihood of more staff acting to avoid these issues.

140. Many of those staff who have been affected or expect to be affected by pension tax issues in the future have acted or are considering acting to try and avoid these issues. The chart below shows the actions employees are considering as a result of pension tax issues.

<table>
<thead>
<tr>
<th>Action taken (%)</th>
<th>Action considered (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early retirement</td>
<td>3</td>
</tr>
<tr>
<td>Retire and return to work</td>
<td>3</td>
</tr>
<tr>
<td>Reducing hours</td>
<td>18</td>
</tr>
<tr>
<td>Reducing additional work</td>
<td>42</td>
</tr>
<tr>
<td>Avoiding promotions</td>
<td>20</td>
</tr>
<tr>
<td>Opting out of the NHSPS</td>
<td>9</td>
</tr>
<tr>
<td>Leaving the NHS altogether</td>
<td>N/A</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
</tr>
<tr>
<td>No action</td>
<td>39</td>
</tr>
</tbody>
</table>

141. Employers are particularly concerned about the impact on staff retention. Employees requesting to reduce their hours, refusing additional work, taking early retirement and avoiding promotions have been identified as key concerns for NHS employers, due to the

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30 NHS Employers: Research into the impact of pensions tax in the NHS
31 NHS Employers: Summary document of research into the impact of pensions tax in the NHS
impact on workforce capacity, service delivery and patient care.

142. The chart below shows the key concerns highlighted by employers and the estimated scale of impact seen to date. The highest impact seen so far has been in connection to staff turning down additional work, requesting to reduce their hours and agency costs. The amount of HR time and resources has also been raised as a growing concern, with significant time being spent by HR teams dealing with queries and engaging with staff to implement local measures and solutions.

143. The Department of Health and Social Care has consulted on new proposals to change the NHS Pension Scheme, to address the impact of pension taxation on NHS staff, organisations and service delivery.

144. The new proposals are designed to make the scheme more flexible, enabling members of the scheme to control the value of their pension growth. The Department of Health and Social Care is seeking views on the following proposals:

- Introduce a new flexible accrual option, which would allow senior clinicians to choose to build up a lower level of pension benefits and pay correspondingly lower employee contributions. The options available would range from almost zero to 100 per cent, in 10 per cent increments.

- Allow scheme members to phase their pensionable pay increases over a set period to avoid spikes in pensionable pay that can create annual allowance issues.

- Assess who pension scheme flexibilities should be available to.

- Improve scheme pays.

- Provide support and guidance for individuals.

145. In our response we said that while we broadly support the introduction of flexibilities, we believe that they should apply to all staff. Limiting access to senior clinicians could risk limiting
their overall effectiveness and raises issues around equality. In our response we included research from First Actuarial showing the relationship between extending flexibilities to all staff, higher participation rates in the NHS Pension Scheme, higher levels of staff retention and better patient care and service delivery. We also agreed strongly that individual staff should be supported to understand their own tax liabilities and use the new flexibilities where appropriate.

**HM Treasury review of the annual allowance taper**

146. HM Treasury announced it will set up a working group to review the operation of the tapered annual allowance to support the delivery of public services.

147. The tapered annual allowance was introduced in April 2016 with the intention of reducing pension tax relief for the highest earners. Employees may have a lower, tapered annual allowance limit if their adjusted income (taxable income and pension savings) is over £150,000 and their threshold income (taxable income excluding the value of pension savings) is over £110,000. The rate of reduction in the annual allowance (from the current maximum of £40,000) is by £1 for every £2 that the adjusted income exceeds £150,000, up to a maximum reduction of £30,000 at £210,000. This means an individual’s tapered annual allowance will be between £40,000 and £10,000.

148. NHS Employers welcomes this review and is pleased to be involved in the review to represent the views of employers. The taper is particularly problematic as all taxable earnings are included in the calculation, meaning non-pensionable earnings and earnings from outside NHS employment, such as from rental properties and investments, could cause an individual to breach their annual allowance. Employers and NHS Pensions are not aware of earnings from outside the NHS and are therefore unable to accurately target communications at those who may be affected.

149. The tapered annual allowance applies to all UK workers and therefore the removal or changes to the taper will require extensive consultation and consideration with stakeholders across all sectors and industries. The fiscal impact of changes to the annual allowance taper will be significant for HM Treasury and will be closely monitored and evaluated during the review.

**NHS Employers guidance**

150. NHS Employers has published guidance on the temporary, optional measures employers may implement to support staff and service delivery during this financial year, in advance of a national solution being implemented from April 2020. These optional measures include:

- facilitating access to independent financial advice and guidance
- using existing flexibilities to enable employees to remain in the NHS Pension Scheme

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32 NHS Employers: Guidance on pension taxation
• possible arrangements for employees who decide to opt out of the NHS Pension Scheme.

151. We continue to produce resources\(^{33}\) to raise awareness and improve understanding of the annual and lifetime allowance.

152. We believe a combination of improvements to the annual allowance taper, the introduction of greater scheme flexibilities and measures taken by employers at a local level will support staff and employers to improve service delivery and patient care.

The NHS Pension Scheme as an attraction and retention tool

153. In September 2019, as part of our annual survey of reward in the NHS, we asked 89 employers how they would rate the effectiveness of the NHS Pension Scheme to attract and retain staff.

154. A total of 84.78 per cent of respondents rated the scheme as being somewhat effective, effective, or excellent in retaining staff, with only 15.22 per cent rating the scheme as not effective. The proportion of employers rating the scheme as effective or excellent in retaining staff has fallen since our 2018 survey, which could indicate the impact of pension taxation issues on retention.

155. A total of 71 per cent of respondents rated the scheme as being somewhat effective, effective, or excellent in attracting staff, with only 29 per cent rating the scheme as not effective or poor. The proportion of employers rating the scheme as somewhat effective, effective, or excellent in attracting staff has again fallen since our 2018 survey, which could again be in part due to the impact of pension taxation issues, particularly the negative coverage and potential impact on perceptions of the scheme’s value.

\(^{33}\) Annual and lifetime allowance - NHS Employers
Providing financial education, guidance and advice

156. Our research with First Actuarial revealed a lack of understanding of the NHS Pension Scheme, pension taxation issues and pensions in general. This is evidenced in the data from the employee survey shown in the next two charts.
157. The introduction of scheme flexibilities from April 2020, combined with any scheme changes introduced to compensate those affected by the recent age discrimination case, will introduce more complexity and choice for scheme members. This strengthens the need for education, guidance and advice to ensure staff understand the value of the NHS Pension Scheme and can make well-informed decisions about their pension benefits.

158. Many employers run pension workshops and pre-retirement courses to help staff 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.

159. Employers are communicating the value of the NHS Pension Scheme using their staff intranet sites and Total Reward Statements, as well as increasingly using social media and electronic communications to reach staff who are not based in a single location. Employers are developing communication materials and using resources produced by NHS Employers to promote the value of the scheme during recruitment, such as posters and benefits brochures.

160. Employers told us they would like more online support for scheme members, such as projection tools to allow staff to model their retirement options and estimate their income, as well as education materials such as online webinars and training courses. Employers also suggested communication materials should be targeted at younger staff and new joiners to improve engagement with this area of the workforce.

161. NHS Employers continues to produce resources to promote the total reward offer including resources to help employers promote the value of the NHS Pension Scheme.

34 NHS Employers: case studies
35 NHS Employers: promoting the value of the NHS Pension Scheme
4. THE WORKFORCE, FINANCIAL AND TRANSFORMATION CHALLENGES

162. The NHS Long Term Plan, published in January 2019, sets the future direction for the NHS in England. Together with the 2019 Spending Review, this provides the basis for a five-year funding programme up to 2024/25. This will be based on a new service model which places more emphasis on prevention and health inequalities, improving the quality of care and health outcomes across all major health conditions and harnessing technology to transform services.

163. The NHS workforce will be instrumental in delivering the ambitious programme of work set out in the plan, and the Interim NHS People Plan describes some of the significant workforce challenges currently faced by the NHS. The workforce in post is our means of delivering safe, effective and timely care. Yet the growth of that workforce has lagged well behind growth in activity.

164. The Health Foundation has published its latest analysis of the changes in the size and composition of the NHS workforce in England. The report highlights nursing shortages and shortages of staff in general practice and primary care.

165. While output (including the number of operations, consultations, diagnostic procedures and A&E visits in a year) grew by almost a quarter between 2010/11 and 2016/17, the number of nurses grew by less than a tenth of that.

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36 Falling short: the NHS workforce challenge: The Health Foundation
166. **The number of nurse vacancies in the NHS in England in the first quarter of 2019-20 was around 12 per cent of full-time equivalent registered nurse posts in the provider sector**, a total of over 40,000 staff. Across NHS trusts there is currently a shortage of more than 100,000 staff (around 1 in 11 posts), severely affecting some key groups of essential staff, including nurses, allied health professionals and care staff. Vacancies in adult social care are rising, currently totaling around 110,000, with around 1 in 10 social worker and 1 in 11 care worker roles unfilled. This high number of vacancies is unacceptable, and leaders are focused on bringing it down.

167. **The Health Foundation reports that in the last year or so the number of midwives, nurses and health visitors employed in the NHS has changed little, while advertised vacancies have risen. What small growth there has been masks some wide differences between work areas. For example, while the number of full-time equivalent staff employed in children’s nursing grew by 2.7 per cent, mental health nursing numbers only grew by 0.6 per cent and community nursing services by 0.7 per cent.**

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**Growth in health care output compared to number of FTE nurses**

![Graph showing growth in health care output compared to number of FTE nurses](image)

**Note:** output is cost and quality adjusted activity.

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**37 [NHS Digital: vacancies](#)**
168. Despite the acute workforce challenge and in the face of rising demand, the Care Quality Commission’s (CQC) report on the state of health and social care in England 2018/19 found that most of the care that we see across England is good quality and, overall, the quality is improving.

169. Once people gain access to services, ratings suggest that the staff providing those services are caring, with 87 per cent of NHS acute core services rated as good and 11 per cent as outstanding for the key question ‘are services caring’. That trusts have achieved this despite this pressurised environment is a huge credit to the hard work, commitment and professionalism of all our staff.

170. Employers recognise that against a background of unrelenting negative publicity they can constantly demonstrate to staff how highly valued they are.

171. However, the CQC’s report presents a less encouraging view on access to services, with urgent and emergency services feeling the most immediate effect of the rise in demand. Latest figures on performance show committed teams struggling to deliver what they know their patients need. Demand for A&E is at a record high – an increase in A&E attendances of more than 20 per cent compared to when records began and 7 per cent more than this time last year. And waiting times are lengthening - 76,000 fewer patients were seen within four hours in September 2019 than the first records from September 2011.
172. This is not just an NHS problem. As the report acknowledges:

‘A lack of treatment options outside of acute settings can have an impact on the availability of hospital beds. For example, we have seen that when people cannot be kept well in their communities their conditions can deteriorate, which leads them to need urgent treatment through an emergency department or as an inpatient, therefore putting further pressure on beds in acute settings\(^{38}\).’

173. While the five-year funding deal provides some stability for longer-term planning, the level of funding is still lower than in previous years. The announcement of an increase in capital spending was also welcome but it is substantially short of the £6 billion maintenance backlog that has built up in recent years. We would like to see a long-term funding agreement to support capital projects in line with funding arrangements set out elsewhere in the NHS Long Term Plan.

174. The Interim NHS People Plan also proposes that in future, workforce policy will be devolved to regional integrated care systems (ICSs). While some issues such as professional regulation, credentialing and prescribing rights will remain nationally controlled, along with pay policy and the pension scheme, the plan states that accountability arrangements will be developed to enable ICSs to take on greater responsibilities for these activities, while ensuring we do not push them to take on greater responsibility than they are ready to do.

175. We should recognise that workforce planning will increasingly be informed by system-level thinking and that as new models of employment evolve, the most appropriate level of responsibility for workforce planning at national, system and local level will begin to become more clearly defined.

176. Our submission therefore reflects the combined effect of the financial, workforce and transformation challenges faced by the NHS. It considers the impact and emerging priorities of the Interim NHS People Plan, the wider direction of travel set out in the NHS Long Term Plan, and how these factors might come together to influence decisions on pay and reward.

The workforce challenges

177. In a joint report, Closing the gap\(^ {39}\), the Health Foundation, King’s Fund and Nuffield Trust set out what they believe are high-impact interventions that, if put into action now, could help to ameliorate the current workforce crisis. Their focus is on the areas where severe national problems are having an immediate impact, including nursing and general practice. They identify five main opportunities:

- Training new staff, specifically nurses.

\(^{38}\) Care Quality Commission: State of care

\(^{39}\) Closing the Gap: Health Foundation, Nuffield Trust, Kings Fund
- Pay.
- Helping the NHS become an employer of choice for health care workers, improving the career offer and ensuring that staff from all backgrounds are treated fairly.
- Developing the right teams with the right skills.
- International recruitment.

178. In July 2019, the NHS Confederation surveyed NHS leaders to assess their views on the barriers and enablers on the journey towards delivering the NHS Long Term Plan. Workforce continues to be the most serious challenge facing the NHS. 65 per cent of respondents told us they were either not very or not at all confident that their local health systems would be able to meet increased demand for staff as a result of the plan.

179. When asked to identify roles or sectors where their local health system was experiencing particularly severe workforce shortages, mental health staff (nurses, psychiatrists and psychologists) were frequently highlighted, as were community and primary care nurses and general nursing roles.

180. Workforce and activity growth pressures remain enduring challenges for health systems and respondents to the Confederation’s survey are uncertain that the plan’s proposals are enough to resolve some of these deep-seated issues.

181. The key challenge remains to secure an appropriately skilled, well-trained and committed workforce which has the capacity to deal with rising demand. Massive health inequalities remain. Staff are having to cope with increasing pressure caused by the funding gap and increased demand. Workforce shortages are exacerbating the pressures on them.

182. More recently, the NHS Confederation asked members to rank their critical priorities for the incoming government in order of urgency. Most of those health leaders surveyed said that workforce was a key priority and 56 per cent ranked it the top priority. More than 90 per cent either agreed or agreed strongly with the statement that ‘understaffing across the NHS is putting patient safety and care at risk’. Over 83 per cent agreed that the NHS Pension Scheme is having a detrimental impact on workforce pressures and nearly 70 per cent said the same about patient care.

183. Yet leaders have been successful in achieving improvements in health outcomes. The focus on child health is an investment in the future of the nation. The delivery of the long-term and emerging people plans will depend on increasing workforce capacity, especially in primary care, and it is dependent on further investment in diagnostic equipment. We will need to continue to look to NHS leaders to steer the workforce so that the right focus is given on priority diseases while still ensuring that the changes and developments can be implemented.

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40 NHS Confederation: Unfinished business
41 Fit for the future: How should the incoming government help the NHS in England
to also meet the needs of the growing number of people living with multiple long-term conditions.

184. Leadership standards and objectives should be consistent for leaders at all levels and in all roles. This is consistent with system working and collaboration, including closer working with adult social services. This needs to be one of the major gains from closer working between NHS England and NHS Improvement.

185. Leadership is fundamental to nursing, and nurses are expected to act as leaders across an increasingly wide variety of settings. It is important that nurses are adequately trained and prepared for these roles. Employer nursing academies have an important role to play in the attraction and development of future nurses. These provide a unique and accredited route into the profession, enable nurses to learn while they are earning and provide free, work-based academic learning.

186. Leaders are critical in shaping organisational culture. As we develop new care systems they need to innovate, develop, and inspire. Nurses and nurse leaders are already shaping the development of care teams in organisations and new care systems so that committed teams can provide high quality, safe and compassionate health care. Nurse leaders are providing role models for new nurses joining the profession and are supporting the creation of personalised induction packages to motivate and stimulate new entrants to make the NHS their career. As we develop local care systems further, nurses and nurse leaders will play an important role in establishing leadership for patient care and the overall culture within which they work.

187. Many nurses are working under heavy workloads and to competing priorities set by their managers. This does not create an environment in which reflective practice, which is so important in driving up standards of patient care, can be fully achieved. Establishing and maintaining high-quality care relies on continual learning and improvements in practice from the whole healthcare team. Nurses are using their interpersonal skills to foster productive and developmental relationships between healthcare workers in a variety of new healthcare settings. This is exciting for the profession and leaders at all levels need to create cultures and working environments that can support this way of working. Given the importance of continual learning to the nursing and other healthcare professions it is vital that funding of continuing professional development is quickly restored, especially in high risk areas such as mental health nursing and learning disability nursing, and to restore lost funds for developing existing teams.

188. Hospital care, provided by specialists, has led to the dominance of hospitals in local healthcare systems, increasing specialisation in the delivery of care and the dominance of the medical profession. Nurse leaders need to be given a much more important role.

189. Changes to the operation of the apprenticeship levy are required to support greater use of the degree apprenticeship route into nursing. Employers need to be able to support salaries and workplace mentorship. Better value could be achieved by using some of the apprenticeship levy funding to support a wider range of training activities to help deliver successful apprenticeships, particularly for degree-entry professions.
190. Following the publication of the Interim NHS People Plan a fully costed final plan is due soon, which will include:

- measures to embed culture change and develop leadership capability
- more detail on changes to professional education and on investment in continuing professional development
- more detail on additional staff needed.

191. It will also aggregate information from local ICS/STP workforce plans and work on digital transformation. There needs to be investment in the development of the digital skills of the workforce and in technology that is as easy to use and as intuitive as our workforce’s personal devices.

192. Two big opportunities for a new government will be to make adequate investment in NHS education, training and staff development beyond 2020/21 to help the NHS attract and retain staff. It should also modernise the NHS Pension Scheme to support retention of our people and the presentation of the NHS as an attractive employer for our future workforce.

193. Problems in primary care, for example a shortage of GPs, is contributing to more pressure on the NHS. The remedy is primary care networks, integrated community-based healthcare and more use of communications technology. This new model of service delivery will depend on new relationships being forged between providers and other stakeholders. These will take time to develop and the increased productivity expected from the use of new technology has yet to be demonstrated. There is a long way to go and it is important to keep in mind how central our staff are to success.

**The financial challenges**

194. The NHS continues to feel the combined effects of rising demand, workforce shortages and financial pressure. The impact of this is seen through budget deficits, a worsening of key performance standards and the implications for quality of care and for the health, wellbeing and morale of staff.

195. The NHS in England received a five-year funding settlement worth £20.5 billion in April 2019. This followed ten years of the lowest funding increases in the history of the NHS, with an average of 1.1 per cent real-terms growth from 2009/10-2014/15. While this new funding has provided a much-needed boost to an over-stretched system, some doubt remains on whether it will be enough to modernise and transform services in order to meet the triple challenge and fully deliver the ambitions of the NHS Long Term Plan, investment in which is backloaded.

196. The announcement on NHS capital investment was also welcomed but, overall, was not believed to be enough to modernise services and working environments to improve the quality
and efficiency of patient care. In an NHS Confederation survey, eight out of ten frontline health leaders said that a lack of NHS capital investment has inhibited the ability of local health systems to deliver the goals of the NHS Long Term Plan.\(^{42}\)

197. The Healthcare Finance Managers Association has estimated the cost of eradicating backlog maintenance at £6 billion in 2017/18, up from £4 billion in 2011/12. According to the Health Foundation’s analysis, just bringing the UK up to the OECD average number of MRI and CT scanners would require more than £1.5bn in extra capital spending.

198. The physical environment matters to staff and patients. The report *Quality buildings, quality care* found that services provided from new healthcare premises have been three to four times more likely to be rated outstanding by the Care Quality Commission than services provided from older premises. There is lower turnover of staff in newly built hospitals, and staff take fewer sick days. The difference in staff sickness absence is equivalent to 900,000 working days per year if the median sickness absence rate in newer buildings were replicated across all NHS acute trusts. Modern facilities are also safer for patients, with 30 per cent lower fall rates and 10 per cent lower overall patient harm in new hospitals, and similar reductions in new care homes.\(^{43}\) Now, the backlog of maintenance and lack of investment in infrastructure, IT and technology in hospitals and beyond, represent a source of frustration for staff as well as putting a brake on what is possible if we are to transform care and ensure the safety of patients.

199. A further area of challenge and ongoing uncertainty is future funding for social care and the impact this has on NHS services. As the National Audit Office noted in its report on the health and social care interface, the financial pressures faced by both NHS and social care are a barrier to joint working:

’Both the NHS and local government are under financial pressure, which can make closer working between them difficult. This could deter organisations in partnerships from seeking system-wide benefits that may be detrimental to them as individual organisations. Short-term funding arrangements and uncertainty about future funding make it more difficult for health and social care organisations to plan effectively together.’\(^{44}\)

200. The Chancellor announced at the Conservative party conference in September that the government would seek to increase the national living wage to £10.50 an hour over the next five years. This would make a difference to many low-paid health and care staff, particularly in social care where the difficulties in recruitment are more acute. However, responding to a question from the Health Service Journal about whether the budget would be adjusted to fund this, the Treasury said that: ‘the historic settlement we’re giving the NHS ...includes the provision for future pay rises for NHS staff.’ Our view is that without the similar level of investment which accompanied the three-year pay deal for Agenda for Change staff, money intended for the NHS Long Term Plan will be reduced and pressure on fragile local finances

\(^{42}\) NHS Confederation
\(^{43}\) BPF quality buildings quality care
\(^{44}\) National Audit Office: Health and social care interface
increased."

201. The NHS Long Term Plan is clear that 'the extra spending will need to deal with current pressures and unavoidable demographic change and other costs, as well as new priorities.' Putting the NHS back onto a sustainable financial path is a key priority in the plan and is essential to allowing the NHS to deliver the service improvements set out within it. The plan will depend on:

- the NHS (including providers) returning to financial balance
- cash-releasing productivity growth of at least 1.1 per cent per year, with all savings reinvested in frontline care
- reducing the growth in demand for care through better integration and prevention
- reducing variation across the health system
- improving providers’ financial and operational performance
- making better use of capital investment and existing assets to drive transformation.

202. Productivity savings at this level is a separate challenge given that, on average, acute hospitals have seen the amount of care they provide increase by 3 per cent a year on average during the period 2010/11 and 2016/17, with growth of 3.6 per cent in 2016/17. The Health Foundation has projected that over the next five years, without any improvement in the quality and range of services, acute and specialist hospital activity will need to increase by 2.7 per cent a year just to keep pace with demand. The additional funding announced as part of the NHS Long Term Plan would allow for activity growth of up to 2.3 per cent a year. The Health Foundation notes that the level of activity that can be delivered can depend on pay. If demand cannot be moderated, then lower pay growth would allow for higher activity growth, but they argue that, given the recent history of prolonged pay restraint and recruitment challenges, it would be difficult for the NHS to once again restrain pay and to support recruitment and retention.

203. The NHS Long Term Plan also commits to reforming the payments system and moving away from activity-based payments towards funding that is more population based. The aim is to allow local areas to develop new models of care around the needs of patients and to support the pledge within the plan: 'to redesign services so that over the next five years patients will be able to avoid up to a third of face-to-face visits, removing the need for up to 30 million outpatient appointments a year.' There are similar proposals to develop the payment system to support objectives for the delivery of maternity and adult critical care services.

204. The Chancellor also described the 2019 autumn Spending Review as 'turning the page on austerity and the beginning of a decade of renewal'. However, for most NHS staff, the previous decade has been one of experiencing pay restraint and real-terms pay cuts.

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45 Health Service Journal: nation living wage
46 NHS England and NHS Improvement: NHS Long Term Plan
205. Some might see increased spending on the NHS as an opportunity to restore wages to previous levels through above inflation pay rises. However, policy makers will be faced with difficult choices about where funds should be directed. For example, Dido Harding, chair of NHS Improvement, said recently that if she had an extra £1 billion to spend, she would put it into social care, where healthcare assistants in social care are the most underpaid and the most difficult to recruit and retain.

206. Budgets have been set until 2024/25. Looking ahead to the end of the current three-year pay deal, the pressures of meeting increasing demand and at the same time delivering efficiency savings means that employers will not wish to be burdened with unfunded commitments that create additional financial pressure.

Transformation challenge

207. The NHS Long Term Plan maintains the direction of travel towards more integrated and joined-up services established previously in the five-year plan. The aim is to deliver integrated health and care focused on population health, with greater investment and focus on community, primary care and mental health services, as well as an emphasis on prevention and health inequalities. These measures are essential if we are to improve care for patients, reduce pressure on hospitals and other services, and put the NHS on a sustainable path in the face of rapidly rising demand.

208. The plan anticipates that the NHS will reduce demand for acute care through better integration and prevention. However, only one in four respondents in an NHS Confederation survey believed their local health systems would reduce significantly the rate of growth in acute activity as a result of the reforms in the plan. Many areas of the country have already been pioneering service changes designed to keep people well and living independently in the community, but funding cuts to social care and public health are undermining this work.

209. Four out of five survey respondents said reductions in public health funding have already restricted the ability of their local health system to deliver NHS services either somewhat or to a great extent. The cuts to public health services such as smoking cessation, sexual health and drug and alcohol services have created health problems that could have been avoided.

210. The Interim NHS People Plan accepts that the workforce planning model in the NHS needs to change. It argues that functions should be undertaken at the best level to meet the needs of the services. It commits to devolution of responsibility to ICSs over time, and as they develop, they will take on greater responsibility for people planning and transformation activities.

47 NHS Confederation: cuts to public health services
211. The Interim NHS People Plan states that sustainability and transformation partnerships and integrated care systems will have a core role in testing emerging proposals aimed at delivering those key actions linked to the development of the new workforce structure. One of the strands of the plan concerned with securing current and future workforce supply is around matching workforce supply to the needs of geographies. There is a recognition within the plan that local health systems will have workforce needs to be managed collaboratively within local labour markets.

212. This shift from competition to collaboration will provide opportunities for employers to work dynamically across organisations. Employers are beginning to actively explore ways they can embrace collaboration whilst retaining focus on the needs of their own staff. For example, 25 per cent of respondents to our total reward network survey told us that they are currently collaborating with others on their reward offering. We do know that in individual health geographies, collaboration does work. For example, one region is beginning to work collaboratively across equality, diversity and inclusion, flexible working and health and wellbeing strands. This has largely stemmed from working collaboratively on NHS passporting.

213. We also know that individual employers are specifically looking at and beginning to collaborate on areas such as health and wellbeing initiatives and on place-wide frameworks for areas such as organisational development and talent management.

214. Collaboration also offers employers the chance to provide new opportunities in training and development for their staff. More varied and complex placements could be offered across health systems, aiding staff to gain new skills, experiences and develop careers in dynamic ways. Continuing to seek ways to collaborate whilst ensuring individual employers remain focused on the specific needs of their own staff in relevant and motivating ways, is key.

215. There is a possibility that in future, decisions on pay and workforce policy might be more influenced at ICS level in collaboration with local employing organisations. This could result in different models of employment across ICS organisations, which will require a similar devolution where decisions on pay and reward might be similarly influenced by local priorities and circumstances. Over time, devolved responsibility for workforce planning will increasingly lead to locally based solutions to specific recruitment and retention issues.

Staff engagement

216. The NHS Staff Survey 2018\(^{48}\) showed a service under continuing pressure with impacts on staff. There was progress on some aspects of people management, including appraisal, but scores in areas such as health and wellbeing worsened. There was a shift to analysing data by key theme rather than key finding and the majority of these remained the same as between 2018 and 2017. Staff engagement held stable overall, with a minority of organisations managing to improve. There was also a small improvement in the willingness of staff to recommend the

\(^{48}\) NHS staff survey 2018: summary of results
NHS as a place to work. However, levels of stress increased, and levels of bullying, harassment and violence remain unacceptably high.

217. Following the release of the Interim NHS People Plan in July, work has continued to develop a final plan due to be published shortly. This will include a national framework designed to promote improved staff experience in the NHS known as Best Place to Work. This aims to support better staff experience through the concept of a core offer, which would set out expectations for staff in areas ranging from health and wellbeing to flexible working. It is also intended to address and reduce the variation between approaches in different organisations. Work is underway to finalise the proposals and NHS England and NHS Improvement intend to publish them shortly. As an initial step to support a greater focus on staff experience, new metrics have been included in the updated outcomes framework for the NHS, which will support work to address bullying and harassment, promote teamwork and enhance equality, diversity and inclusion.

218. Employers state there is no single action that will resolve staff retention issues. Retaining staff is the result of combined actions taken by the organisation, and by improving staff experience. These include making sure that people are involved in deciding what it is they do and how they do it, as much as possible, as well as the importance of relationships.

219. As the Parliamentary Review\(^49\) made clear, one of the key challenges for any organisation looking to retain its workforce is engaging effectively with employees across the organisation. Engagement doesn’t sit with one person or one team, it is the responsibility of everyone.

\(^49\) Harding review of health and social care workforce: June 2019
5. WORKFORCE SUPPLY

220. We have identified policy changes that we believe will help the workforce supply work that is already underway:

- Flexibility in the apprenticeship levy.
- An immigration policy that enables health and social care to attract and retain the workforce needed.
- Visible national professional leadership for new roles like nursing associate.
- Investment in staff health and wellbeing.
- Targeted incentives to support training and supply in critical areas of the workforce, such as learning disability services and mental health nursing.

221. As stated in the Interim NHS People Plan\(^{50}\), there are around 100,000 vacancies in the NHS, which is 10 per cent of the hospital and community workforce. Sickness absence in the NHS\(^{51}\) is around 2.3 per cent higher than in the rest of the economy and around one in eleven members of staff leave the NHS every year.\(^{52}\)

**Overseas recruitment**

222. While international recruitment can help fill gaps, it is not a panacea for NHS staff shortages. There are shortages of key staff groups in many other countries and employers recognise that the NHS is part of the global healthcare community with a responsibility to support the development and maintenance of adequate healthcare around the world. There is competition between employers for scarce resources. Some staff recruited from abroad quickly return to their home country, while others soon transfer to alternative employers with better reputations, or in a more desirable geographical location. This means we need a more co-ordinated approach to international recruitment. Providers need to work collaboratively to recruit staff for the local system and then support and embed this new workforce and their families into the community.

223. Demand for NHS services continues to increase, and workforce gaps cannot be plugged through measures to attract and train more staff alone. The Interim NHS People Plan commits to recruiting more nurses from overseas in the short-to-medium term. NHS Employers is working with key stakeholders on the development of a good practice toolkit, which will demonstrate effective overseas recruitment and settlement practice.

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\(^{50}\) Interim NHS People Plan: NHS England and NHS Improvement  
\(^{51}\) NHS Digital: sickness absence rates in the NHS  
\(^{52}\) NHS staff survey 2018
224. Current restrictive immigration policy, particularly in relation to salary thresholds, and uncertainty around Brexit is making it hard for employers to recruit from overseas. Our workforce supply challenges demonstrate the need for an immigration policy that enables health and social care to attract and retain the workforce needed.

225. The Migration Advisory Committee’s shortage occupation list, reviewed earlier this year, includes the following occupations:

- Nurses.
- Medical practitioners (all).
- Biological scientist and biochemist.
- Psychologists.
- Medical radiographers.
- Occupational therapists.
- Paramedics.
- Speech and language therapists.
- Social worker working in children’s and family services.

**Domestic supply / widening participation**

226. The NHS must be an employer of choice in local communities. Employers are working with their local populations to encourage and attract new staff into NHS employment. Measures include work experience, pre-employment programmes, traineeships, internships and apprenticeships, along with targeted engagement within local communities through a range of events and outreach programmes.

227. The national We are the NHS recruitment campaign, launched in 2018, is the biggest recruitment drive the NHS has seen in its history. It has resulted in a 4.5 per cent increase in university applications for health education courses. The campaign has focused predominantly on the nursing profession and employers have been encouraged to use the campaign, along with a suite of resources, to raise awareness of nursing careers.

228. Employers are working with local schools and colleges to publicise the range of healthcare careers and pathways available to school leavers. The Health Careers Step into the NHS competition for a range of school ages supports the non-statutory framework for careers education and provides children with an understanding of the careers available in the NHS. Employers also participate in annual campaigns such as Healthcare Science Week and National Apprenticeships Week.

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53 gov.uk: Immigration policy  
54 The Migration Advisory Committee: Full review of the shortage occupation list  
55 We are the NHS campaign  
56 Step into health: Apprenticeships for all
229. Over the last year, NHS Employers has worked with 19 organisations to deliver the Apprenticeships for All programme. This train-the-trainer programme has trained almost 1,200 line managers to recruit and support disabled people and those with learning disabilities.

230. NHS Employers also provides leadership for the Step into Health programme, which offers a pathway into the NHS for the Armed Forces community. There are now 88 organisations across England and Wales that are involved in the work, and in total there have been 165 people employed because of the programme, with 60 of these recruited in 2019 so far. 118 trusts currently support their reservists by offering them paid leave to attend the annual camp.

Apprenticeships and T levels in the NHS

231. Employers are working in line with the Interim NHS People Plan commitment to make the NHS the best place to work. This includes collaborating regionally to deliver apprenticeships and obtain the maximum benefit from the apprenticeship levy.

232. The introduction of the apprenticeship levy in April 2017 and the public sector apprenticeship target have encouraged employers to scale up their apprenticeship offer. The NHS contributes around £200m per year into the apprenticeship levy. Sustainability and transformation partnerships are working collaboratively to utilise apprenticeships, develop a collective apprenticeship vision, and build knowledge of good practice to support apprenticeships in the workforce. The levy is also being used to offer apprenticeships to those already established in the workforce.

233. The apprenticeship challenges faced by employers include:

- entry requirements for some of the higher-level apprenticeship programmes
- access to education providers at a local level
- delays in standards being agreed
- the option to be a training provider has now closed
- placement and supervisory capacity
- the cost of backfill for supernumerary training time.

234. Not all employers have a budget for backfill and some are running out of levy funds. The level 2 apprenticeship in business administration has been removed, forcing employers to consider alternative routes into the workforce.

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57 NHS Employers: apprenticeships for all
58 NHS Employers: step into health
59 NHS Employers: using the apprenticeship levy
235. Despite these challenges, many employers are using the apprenticeship levy as an opportunity to:

- build career pathways for their new and existing staff
- offer degree and higher apprenticeships
- develop capacity and capability as training providers
- strengthen leadership and management capability
- build apprenticeships into workforce planning.

236. T Levels will be an alternative to apprenticeships and A levels from 2020 and will include an industry placement in a work environment for learners. 11 regional workshops on T Levels were delivered between June and October 2019 to 110 NHS employers. At these workshops, 67 employers agreed to further conversations about piloting industry placements within their organisations, showing their commitment to work-based learning and strengthening both clinical and non-clinical placement capacity within their organisations.

237. To ensure that the NHS can obtain as much benefit as possible from the introduction of T levels, NHS Employers has brought potential strengths and challenges in the system to the attention of government.

Nursing supply and placement capacity

238. If there is a reduction in the numbers of nursing applicants, this will reduce the pool that universities can choose from and may limit student numbers or the quality of applicants in the long run. Students starting their training represent the nurses who may in the future be available to the NHS. However, the Health Foundation reports that only around half of them will translate to full-time-equivalent starters, due to attrition during training and people joining non-NHS settings or taking on non-health work.

239. There is variation between the four branches of nursing education, adult, children’s, learning disability and mental health, and between different parts of the country. Using data from the Nursing and Midwifery Council, the Health Foundation reports that the number of learning disability nurses fell for the fourth year in a row in 2018/19, and the number of mental health nurses is still 2,000 below the number on the register in 2015.

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60 NHS Employers: response to the development of T levels
61 The Health Foundation: closing the gap
In their joint report, *Closing the gap*\(^2\), the Health Foundation, King’s Fund and Nuffield Trust say that expected increases in nurse trainees have yet to materialise. Since August 2017, nurses and allied health professionals have had to pay for their undergraduate training. Previously, Health Education England (HEE) spent around £1.2 billion (in 2018/19 prices) annually on bursaries (non-repayable grants) to around 58,000 nursing and midwifery students and 19,000 allied health students who were studying at that time.

Under the new arrangements, students are expected to pay in the region of £28,000 in tuition fees for their degree in addition to covering living costs, but they can take out student loans. The policy intention was to remove the cap on numbers caused by the limited national budget available to fund places. This was expected to result in an expected increase in up to 10,000 posts on nursing, midwifery and allied health profession courses by 2020. This evidence calls into question the credibility of the ambition in the NHS Long Term Plan to provide funding for up to a 50 per cent increase in clinical placements from 2020/21.

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\(^2\) *Closing the Gap: Health Foundation, Nuffield Trust, Kings Fund*
242. The Interim NHS People Plan sets the aim of balancing the supply of and demand for nurses to meet the needs of health and care services. One element of the strategy will be to increase supply by expanding the number of students studying the undergraduate nursing degree course, while reducing attrition rates. NHS England and NHS Improvement have funded an extra 7,500 nursing placements in 2019/20. Employers are increasing the number of clinical placements they offer to students.

243. In addition, employers are developing local coaching models, increasing capacity in areas such as outpatients and mixing learners from different year groups. Employers are also increasing their supervisory capacity by implementing the new Nursing and Midwifery Council (NMC) standards for student supervision and assessment. For example, by training new qualified nurses and nursing associates to become supervisors for first-year students.

**Nursing associates**

244. In 2017, 2,000 trainee nursing associates started on the pilot programmes across England. The first qualified nursing associates began joining the NMC nursing associate register when it opened in January 2019. In March 2019, 489 nursing associates had already joined the NMC register, showing individual and employer appetite for the role. Qualified nursing associates are now able to prescribe some medications. As the role develops, we will need to consider innovative ways of dispensing medicines.
245. The number of nursing associates joining the register is continuing to grow as further knowledge about the role and where it fits within the multidisciplinary team spreads.

246. Employers have introduced the role in acute, community and mental health settings, as well as primary and social care, demonstrating that the nursing associate role compliments existing roles within the workforce across a variety of settings. Employers are using the trainee and qualified nursing associate role to improve skill mix and to support staff development and staff experience.

**New and extended roles**

247. The Interim NHS People Plan acknowledges the way in which different professional groups work together must change so that teams become much more multidisciplinary. It underpins the ambition of the NHS Long Term Plan, which sets out a roadmap for the next ten years to develop new service models based on integrated models of care delivered by a multi-professional workforce.

248. Employers are already developing the existing support workforce, expanding the use of new roles such as the physician’s associate and nursing associates, and exploring how the advanced clinical practice workforce can be scaled up and deployed more effectively to deliver the NHS Long Term Plan.

**International recruitment**

249. The Health Foundation has looked at the annual number of nurses registering in the United Kingdom for the first time, from European Union and non-European Union countries, since 1990. There was a rapid increase in non-European Union international inflow in the period up to 2001/2, mainly driven by active recruitment of nurses from the Philippines and India at a time of NHS-funded staff expansion. This was followed by a rapid overall decline in inflow in the period up to 2009/10.

250. The next phase was a period of increased inflow as employers struggled to address shortages – mainly by recruiting from European Union countries such as Spain, Portugal and Italy. Finally, in the most recent period since 2016 and the referendum vote to leave the European Union, there has been a rapid decline in inflow from the European Union, but a rapid increase in non-European Union international inflow – again, mainly from India and the Philippines.

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68 NHS Employers: advanced clinical practice
69 NHS Long Term Plan
70 Health Careers what is a physician’s associate?
71 Falling short: The Health Foundation
During 2019-20, NHS organisations across the country have continued to use international recruitment, when appropriate, as a mechanism to help them meet their workforce supply requirements. The UK professional regulator data\textsuperscript{72}, along with the report into NHS staff statistics\textsuperscript{73} from the House of Commons library show the following:

- An increase in non-European Economic Area nurses entering the register for the first time, from 2,500 per year in the three years to March 2018, to 6,157 in the year to March 2019, which is a 126 per cent increase.

- A slight increase in the number of European Economic Area trained nurses entering the register for the first time, from 805 in the year ending March 2018 to 968 in the year ending March 2019 but remaining significantly down from over 9,000 joining in the year ending March 2016.

- In 2017-18 the numbers of European Economic Area\textsuperscript{74} nurses joining the NHS in England (8 per cent) was fewer than the number leaving (13 per cent).

\textsuperscript{72} UK professional regulator data: 
\textsuperscript{73} House of Commons Library NHS staff statistics
\textsuperscript{74} House of Commons Library: NHS staff from overseas: statistics
252. In February 2019, NHS Employers asked employers to tell us about their success with international recruitment during 2018-19 and their plans for 2019-20. Intentions for international nurse recruitment for 2019-20 were smaller at approximately 2,500, down from 4,500 in the previous year. However, employers reported plans to increase radiographer and paramedic recruitment. We believe this was more activity than was reported in quarter four of 2018-19.

253. The Interim NHS People Plan asked employers to consider international recruitment as part of the overall workforce supply plan. This was the first time in many years there had been a national steer for employers to use international recruitment. It follows several years of operational difficulties with the policy and processes that underpin international recruitment. An action from the plan was for NHS Employers to produce a good practice resource to help employers with international recruitment.

254. There is still more to do to improve the experience for candidates and employers and the priority is to ensure that when the United Kingdom leaves the European Union there is a fit for purpose immigration system that supports the recruitment of people into the NHS and social care.

255. The new shortage occupation list, effective from October 2019, removed some of the administration associated with non-European Economic Area recruitment into professions on the list.

256. Any future immigration system will need to identify specific workforce shortages and give priority to recruitment into those roles.

Brexit

257. Since the June 2016 referendum, NHS Employers together with NHS Providers and The Shelford Group have carried out a quarterly survey of NHS organisations on the impact Brexit is having on the workforce. Over half of employers are unsure of the impact of Brexit on their workforce, with most recent 2019 data showing 27 per cent of employers saying it will have a negative impact.

258. NHS Employers is a founding member of the Cavendish Coalition, comprising 36 organisations that represent employers and staff in the UK health and social care sector. The coalition is an authoritative voice on the impacts of Brexit on workforce supply. It gives those leading the Brexit negotiations expert input on the issues affecting the health and social care workforce.

259. In addition to the NHS requirement to be able to attract and retain colleagues from outside the United Kingdom, social care must be able to do the same. Skills for Care’s report, State of

75 NHS Employers: report on international recruitment
76 NHS Employers: impact of Brexit on the NHS workforce
adult social care sector 2019\textsuperscript{77} shows that in adult social care in England the workforce consists of 1.62 million jobs, of which 115,000 are undertaken by European Union nationals. Over 1.2 million jobs (76 per cent) are direct care roles, which includes jobs such as senior care worker, care worker, community support and outreach workers.

260. The median hourly rate for care workers in adult social care in England is £8.10, which is an annual salary of £16,000 for a 38-hour week. Proposals for a future immigration system include salary and qualification criteria that would exclude any recruitment in care work in social care.

261. The projected growth of the population aged 75 and over shows that by 2035 the number of additional health and social care jobs needed could rise by around 800,000. The United Kingdom labour market will not be able to meet the growth in demand and the ability to recruit from outside of the United Kingdom will be essential.

262. The Cavendish Coalition members propose that this challenge can be met by building into a new post-Brexit immigration system a facility for staff from overseas to be able to join the NHS workforce easily to reduce shortfalls in the numbers of staff employed in health professions. Care workers would need to be eligible for such a scheme. Without this sort of intervention, many social care providers will struggle to continue to provide services and this will have a direct impact on demand for NHS services.

**EU settlement scheme**

263. The NHS was involved in testing of the application process between November 2018 and December 2018, before the launch in January 2019. Further work will be needed to ensure that everyone who needs to apply is aware that they need to do so.