NHS EMPLOYERS’ SUBMISSION TO THE NHS PAY REVIEW BODY 2019/20

7 January 2019
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Key messages

Introduction

- In recent years, the main objective of the employers written evidence to the NHS Pay Review Body (PRB), has been to set out expectations for annual recommendations on increases to basic pay and how this supports a more strategic approach to the positioning of pay and the terms and conditions of service framework for the staff covered by its remit.

- The support and endorsement of the NHS PRB to the refresh of the NHS Terms and Conditions of Service in 2018 is acknowledged by employers to be genuinely helpful in terms of supporting wider system strategic objectives and 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.

- 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.

- 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.

Agenda for Change reform

- This work, completed at pace to a very challenging timetable, is the largest public sector pay and reward reform delivered in the last ten years.

- We continue to work closely with the Department of Health and Social Care (DHSC), and NHS Improvement (NHSI), to ensure appropriate support and guidance is provided to employers in the NHS on the implementation plans for the agreed reform of the pay system.

- The reforms will help support employers to:
  - improve attraction, recruitment and retention by increasing starting salaries in all pay bands
  - increase rates of pay at the top of pay bands
  - future-proof the pay system against planned changes in the statutory minimum wage and maintain a favourable position for the NHS in an increasingly competitive labour market at this pay level
• reduce the time taken for staff to reach the top of pay bands, linked to a new pay progression system

• strengthen and get better value from the staff appraisal process, building on the positive feedback from staff in the last national staff survey on the quality of appraisal.

• NHS Improvement has developed additional support for organisations, such as its culture programme tools.

• Some structural reform in bands 8d and 9 remains to be completed and will need to be addressed from 2021 onwards.

• 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.

• Employers would support the commissioning of independent research for a wider/longer evidence-based discussion for when the current multi-year pay deal ends.

The workforce challenges

• Workforce shortages is the biggest challenge the NHS faces.

• The recently published summary report from the Health Foundation: The healthcare workforce in England – make or break, sets out the issues being experienced by employers in the face of the mounting challenges associated with workforce. It is now accepted that the workforce challenges in the NHS present an even greater threat to the delivery of health services than the funding challenges.

• While recognising that employers bear the greater responsibility to address and improve the experience of their staff we have identified actions within a national workforce strategy which support local employers.

• To be more specific our policy board supports:
  • prioritisation of action in areas of greatest risk (supply of mental health nurses, learning disability nurses and therapeutic radiographers)
  • a fit for purpose migration system and system of regulation for overseas recruits
  • reform of the apprenticeship levy
  • restoration of lost national continuing professional development funding

1 NHS Improvement: create a culture and leadership programme
2 The healthcare workforce in England: The Health Foundation
3 NHS Employers response to the health and care workforce strategy
• a sustained, annual campaign to support the recruitment of staff to health and social care.

• It is essential that workforce costs are sustainable, to enable the NHS to meet the quality and transformation challenges that employers face. The cost of staff will always remain central to efforts to manage budgets, further improve efficiency and transform services.

• If we are to develop a sustainable workforce with the right skills, long-term workforce planning and talent management must be a priority. This planning will take place at a larger scale than individual organisations to better plan and develop the talent in the system. This should be supported by a greater delegation of collective workforce policy to the leadership of integrated care systems⁴.

• The current direction is towards more services being provided through better integrated out-of-hospital care based on primary, community and acute care systems working more closely together and with partners in other public services, most especially social care.

• Our members support this strategic direction, but there is a concern to ensure that the roles in these community settings enjoy a higher status and support than they appear to presently.

• Employers recognise and are working to respond to changing attitudes to work by providing more opportunities for flexible working and portfolio careers.

The financial challenge

• We continue to experience one of the most financially challenging periods for the health and social care systems in the UK.

• We have just gone through the most significant sustained squeeze on NHS funding since the NHS was formed 70 years ago. Those who are running these services, and those who are having to deliver on the front line, are being called upon to meet unprecedented levels of demand, not only with constrained funding but with significant and growing staff shortages.

• The NHS can only succeed if it is given sufficient resources and, just as important, if it is able to transform the way services are delivered. This transformation does also rely on investment in other public services, particularly social care. The deteriorating financial position of these services and the failure to publish the long-awaited Green Paper for social care present significant strategic risk for the NHS and our communities.

• The future financial outlook remains challenging, even with the confirmation announced by government on the long-term NHS financial settlement. This investment is of course welcomed for our services and patients, but it falls short

⁴ Letting local systems lead: NHS Confederation
of what is required and will restrict the ability of the NHS to invest in the real transformation of NHS services.

- The securing the future report by the Institute of Fiscal studies and Health Foundation (and commissioned by the NHS Confederation, of which we are part) said:

  - spending on healthcare will have to rise by an average of 3.3 per cent over the next 15 years just to maintain current service provision and by at least 4 per cent if services are to be improved

  - social care funding will need to increase by 3.9 per cent each year to meet the growing needs of an ageing population and the increasing number of younger adults living with disabilities.

- The restrictions on funding in social care have a negative impact on NHS services, for example in the number of admissions to hospital and limitations on transfers of care to non-hospital settings.

**The transformation challenges**

- NHS leaders recognise the challenge to change how care is delivered to ensure patients consistently receive the right care, in the right place, first time. Transformation of NHS services will require NHS organisations to increasingly operate at a system level and work more closely with other public services. The integrated care systems and sustainability and transformation plans approach will we expect be reinforced in the long-term plan.

- NHS services will need to change if we are to make the best use of new technology.

- Some new technologies will fundamentally change the way some NHS staff work and will lead to the creation of new roles and the need to change and re-train our existing workforce. For example, in genomics, precision medicine, the provision of hospital-level diagnostics in the patient’s home and technology supported self-management. Data can provide new ways for the NHS to learn, improve and generate new research. We await with great interest the report commissioned from Dr Eric Topol, which is due to be published in February 2019.

- Successful transformation will depend on how we treat and involve staff. Change will be more likely to happen if staff understand and own it and feel an integral part of this process. We continue to enjoy highly productive social partnership mechanisms with our trade unions at national, regional and employer level.

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5 [Securing the future: funding health and social care to the 2030s: Institute for Fiscal Studies: May 2018](#)
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, with a multi-year pay deal in place, we are not seeking your recommendations on pay. Our evidence this time is, therefore, 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 implementation of the 2018 pay agreement progresses.

5. In his letter of 21 November 2018, the Secretary of State for Health and Social Care asks:
   - for you to consider issues that have been raised regarding the difficulties of recruiting and retaining IT staff
   - for your observations on the labour market issues
   - for your recommendations, including any case for a national recruitment and retention premium.

6. We refer to this subject in Section 6.
2. 2018 pay and conditions of service

Summary of key reforms

7. When working in partnership in the NHS Staff Council, employers and trades unions bring different priorities. The challenge has been to bring these diverse contributions together in a common vision, with a set of shared values, to achieve sustainable development goals.

8. The NHS Staff Council has mitigated risks and achieved a balanced and pragmatic approach in reaching a comprehensive agreement on pay and conditions for the workforce within your remit and achieved medium-term stability and longer-term impact.

9. The agreement has further enhanced the reputation and credibility of the NHS Staff Council and these important reforms can be a catalyst for further workforce and cultural change in NHS organisations.

10. The 2018 NHS terms and conditions of service apply to all NHS staff whose local contracts of employment provide for the incorporation of NHS Staff Council national collective agreement.

11. The national collective agreement ensures that redundant features of the Agenda for Change pay structure, such as the pay band overlaps, will be removed through significant reforms which will be completed by March 2021.

12. The future NHS Staff Council work programme and timetable is at Annex 1.

Communications

13. The NHS Staff Council agreed the creation of a new area, on the NHS Employers website, dedicated to agreed information about the pay deal. This area contains resources to help employers communicate the changes to staff and it continues to be updated, for example with the latest information on the closure of pay band 1. Further guidance on pay progression will be published on the website once it is agreed. Employers have been using these resources as part of their local communications strategies.

Pay and structural reforms

14. The pay deal delivers increases to basic pay through structural reform of the pay bands and increases to pay point values. The changes include increased starting

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6 2018 contract refresh - NHS Employers
7 Closing band 1 - NHS Employers
salaries in all pay bands to support attraction and recruitment and retention. Examples are in the tables below.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic pay on pay point one in the band as at 31 March 2017</th>
<th>Year of pay deal</th>
<th>New starting basic pay on point one in the band</th>
<th>Increase (£) on previous year</th>
<th>Cumulative Increase (£) since 31 March 2017</th>
<th>Cumulative Percentage increase to starting pay since 31 March 2017</th>
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<tbody>
<tr>
<td>Trainee nursing associate/radiography assistants/imaging support workers (pay band 3)</td>
<td>£16,968</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 April 2018 to 31 March 2019</td>
<td>£17,787</td>
<td>£819</td>
<td>£819</td>
<td>4.8 per cent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 April 2019 to 31 March 2020</td>
<td>£18,813</td>
<td>£1,026</td>
<td>£1,845</td>
<td>10.9 per cent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 April 2020 to 31 March 2021</td>
<td>£19,737</td>
<td>£924</td>
<td>£2,769</td>
<td>16.3 per cent</td>
<td></td>
</tr>
<tr>
<td>Nurse/physiotherapist / speech and language therapist (pay band 5)</td>
<td>£22,128</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>1 April 2018 to 31 March 2019</td>
<td>£23,023</td>
<td>£895</td>
<td>£895</td>
<td>4.0 per cent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 April 2019 to 31 March 2020</td>
<td>£24,124</td>
<td>£1,101</td>
<td>£1,996</td>
<td>9.0 per cent</td>
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<tr>
<td></td>
<td>1 April 2020 to 31 March 2021</td>
<td>£24,907</td>
<td>£783</td>
<td>£2,779</td>
<td>12.6 per cent</td>
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</tr>
</tbody>
</table>
15. Other changes:

- Increased pay at the entry to the pay structure, to future proof against increases in the statutory National Living Wage and to retain a competitive advantage in the labour market for staff employed at this level, post Brexit
  - from 1 April 2018 a minimum rate of pay of £17,460 (£8.93 per hour).
- Fewer pay points in each pay band.
- Overlapping pay points between bands will be removed in stages in 2018/19 and 2019/2020 (only one overlap will be left, between bands 2 and 3, by 1 April 2019).
- Pay at the top of pay bands will be increased by 6.5 per cent over the three years, apart from bands 8d and 9 which will be capped at the increase to the top of band 8c; 3 per cent in 2018/19; 1.7 per cent in 2019/20 and 1.67 per cent in 2020/21.
- In 2019/20 only a non-consolidated and non-pensionable lump sum worth 1.1 per cent will be paid in April pay to all staff on the top pay points in each pay band as at 31 March 2019. This means the in-year cash value of the award in 2019/20 will be 2.8 per cent.
- Shorter time for most staff to get to the top of their pay band, linked to a new pay progression system.
- Pay band 1 will be closed to new entrants to the NHS from 1 December 2018. Employers will upskill their staff in band 1 to perform in roles in band 2, with this transition to be completed by 31 March 2021. This will provide these staff with opportunities to benefit from further pay increases.
- Re-earnable pay elements are retained and modified for bands 8c, 8d and 9. In the year after the employee has reached the top of the pay band, 5 to 10 per cent of their basic salary will become re-earnable, dependent on meeting required local standards of delivery. Staff with reserved rights from the 2013 agreement will receive reserved right protection on a marked time basis.
- Some structural reform in bands 8d and 9 remains to be completed and will need to be addressed from 2021 onwards.

16. The balanced package of measures in the pay deal complements the strategic work on total reward being done by trusts. We say more about this in Section 3. The package will support employer efforts to:

- improve employee job satisfaction and morale
- help increase employee motivation
- increase the capability of the workforce to adopt new technologies and methods
- support increases in capacity.
Pay progression

17. You have previously said that you would like to see pay progression linked, among other things, to performance and development. The 2018 agreement will:

- end automatic pay progression
- enable employers to put the focus of local appraisals on learning and development
- ensure staff demonstrate the required standards for their role before moving to the next pay point
- fix minimum intervals before expected progression to the next pay-step point
- require line managers and staff to follow a pay step submission process, to be described in a new pay progression framework document, before access to the next pay step point is granted
- require employers to provide information to enable better monitoring of pay progression and re-earnable pay, including aspects linked to employees with protected characteristics (gender/age/ethnicity etc.)
- create a simpler process to assess standards and progression.

18. Faster progression to the top of pay bands will support staff retention reinforcing NHS Improvement’s retention programme.

19. The next steps in NHS organisations will be:

- implementation of a training and development package for line managers on the new process for implementation in 2019
- working in partnership with trades unions, review and amend, where necessary, current performance management and appraisal systems
- development of a clear, simple pay step form/checklist
- continuing communication of these changes to all staff.

20. The new pay progression system allows employers to promote a focus on staff development and training during appraisal discussions and getting more value from these discussions. Yet this will not be sufficient on its own. Employers and commissioners are telling us that as Health Education England is no longer funding qualifications beyond the point of registration, it is difficult for

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9 Securing a sustainable NHS workforce for the future | NHS Improvement
commissioners to contract with providers to work in new ways to further develop the skills, knowledge and competence of staff to lead, manage and deliver service transformation and the introduction of new models of care.

Changes to terms and conditions of service

21. The changes to conditions of service are:

- Following increases made to base pay rates, adjustment to the unsocial hours percentage enhancement rates (slightly lower) used for bands 1, 2 and 3, to reflect the increases to base pay rates. No staff will be worse off as basic pay rates have been considered when adjusting the rates. Employers hope this can be the beginning of a progressive journey towards greater harmonisation of rates of unsocial hours pay across all pay bands.

- The eligibility for payment of enhancements during occupational sick leave will continue for staff earning below £18,160. Staff earning above £18,160 will no longer receive unsocial hours payments during a period of sickness absence. Any new starters on and after 1 July 2018, regardless of their salary, will not receive enhancements in their pay during sickness absence.

Ambulance staff

22. All the changes to the pay structure and the pay uplifts will apply to ambulance staff. The ambulance service is now aligned to the main NHS terms and conditions of service. This was a long-standing objective for employers and supports greater integration of services and associated workforce in future.

- Effective from 1 September 2018, any new starters to the ambulance service will have their unsocial hours payments paid via section 2 (the rules which apply to nurses) of the NHS Terms and Conditions of Service Handbook if they do not already. From this date, any existing staff member who moves roles will be moved from annex 5 to section 2 if they are not already on section 2.

- Existing staff who are not changing roles will be offered the chance to move voluntarily to section 2.

- Staff employed via, or moving to, section 2 will also see changes to the way occupational sickness absence pay is calculated, in line with other NHS staff. Any new starter, and those ambulance staff who earn above £18,160, will not have unsocial hours payments included in their sickness pay. For existing staff who earn £18,160 or less, unsocial hours enhancements will continue to be paid.

23. Working together in partnership under the auspices of the NHS Staff Council, ambulance employers and trade unions have agreed a suite\(^\text{10}\) of documents providing ambulance staff with the information they will need to make an informed decision about moving to section 2 unsocial hours payments. In

\(^{10}\) Ambulance staff - NHS Employers
addition, several requirements for the application process have been agreed to ensure consistency across the ambulance service.

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

**Continuing work programme**

25. In the longer term the NHS Staff Council is committed to continuing to:

- work in partnership at national and local level to improve health and wellbeing and support positive management of sickness absence, with an ambition that NHS attendance levels will match the best in the public sector

- explore the scope for a collective agreement on bank working which will encourage staff to offer time to internal staff banks. NHS Improvement has published a toolkit\(^\text{11}\) to help trusts maximise the use of staff banks and further reduce agency spend

- develop a national framework for buying and selling annual leave

- develop new national provisions on child bereavement leave. We are asking employers to share their current policies around child bereavement leave (and buying and selling annual leave) to help us inform the NHS Staff Council discussions. The Parental Bereavement (Pay and Leave) Bill, aims to give the right to parental bereavement leave and employees with a minimum of 26 weeks' continuous service will be eligible for statutory parental bereavement pay. The NHS will be an early adopter, implementing contractual bereavement leave ahead of it becoming statutory

- develop new national provisions to give staff access to consistent enhanced shared parental leave (extension of statutory leave). Current provisions in the national handbook are in line with statutory requirements. Statutory shared parental leave is £140.90 a week or 90 per cent of average weekly earnings (whichever is lower). The intention will be to enhance shared parental pay to the same level as occupational maternity pay. The Staff Council hopes this may help to encourage take up. Currently women who opt to take shared parental leave lose their occupational maternity pay. As employees can also opt out of adoption leave after the compulsory two weeks to access shared parental leave, men can also be disadvantaged

- 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. Employers will work with trade unions to achieve this.

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\(^{11}\) Making effective use of staff banks: NHS Improvement: December 2017
Apprenticeships

26. The Staff Council has set up a sub-group to work in partnership to explore options for reform in relation to the options for apprenticeship pay and how this might relate to section 21, trainee pay.

27. The sub-group has been looking at 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. Any national agreement must allow employers enough flexibility to ensure apprenticeships remain a sustainable and desirable option to use as part of workforce and strategy planning.

28. We say more about apprenticeships in Section 7.

Monitoring progress

29. The Staff Council has prioritised its work on apprenticeships, pay progression and the closure of band 1 as set out in Annex 1.

30. We note your concerns in relation to the 2018 pay agreement and the areas you identify as requiring special attention as implementation progresses. The NHS Staff Council will discuss and agree how it will monitor the implementation of the deal in partnership.

31. The government has made an additional £800m available to meet the costs of the deal in 2018/19. Funding for the remaining two years of the pay deal will be met from the recently announced NHS long-term settlement12.

32. The framework agreement document13 makes clear that during the period of the agreement (2018/19 to 2020/21) the Review Body should retain its standing remit on recruitment, retention, morale and motivation, and monitor the progress of implementation and the impact of the agreement. We look forward to continuing our discussions with you on how this might work in practice.

33. It remains open to the parties to submit their evidence. Employers would support you in looking at the future of high cost area supplements and recruitment and retention premia to support attraction, recruitment and retention.

34. Employers would also support the commissioning of independent research for a wider/longer evidence-based discussion for when the current multi-year pay deal ends.

35. NHS terms and conditions of service need to be an enabler for meeting local service demands; a national framework with local flexibility providing for local solutions. One size may not fit all and this needs to be enabled through the appropriate level of pay and conditions to meet the local circumstances.

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12 NHS five-year funding plan
13 Framework agreement NHS Staff Council June 2017
36. We continue to work closely with the Department of Health and Social Care and NHS Improvement to ensure appropriate support and guidance is provided and made available to support employers in the NHS on the implementation plans for the reform of the pay system.
3. Total reward

37. Making the NHS an attractive employer as part of efforts to tackle workforce shortages is regarded by many NHS leaders as the biggest challenge the NHS faces.

38. Employers are fully committed to designing reward packages that can support attraction, recruitment and retention.

39. The multi-year pay deal helps employers to create an employment proposition to their employees which is modern, attractive and relevant. The deal creates the opportunity to enhance the non-financial reward offer and meet some of the strategic pressures organisations face.

- 67 per cent of respondents in our 2018 survey of employers said that they were going to use the new pay progression framework to promote effective and developmental career progression as an integral part of their reward offer. Most were considering how they will achieve this, although four respondents said they already have this in place. As our survey was undertaken very soon after implementation began, this is encouraging feedback.

- Employers also said that the new terms and conditions would provide them with the opportunity to buy and sell annual leave, link pay progression to staff development, and support recruitment and retention.

- The NHS employer proposition to employees includes a growing range of benefits, some of which are unique to specific organisations in presentation and approach.

- In a highly competitive labour market many organisations are designing total reward packages of pay and benefits with the purpose of attracting staff to their organisations and improving retention.

- Raising the profile of the staff we already have is an important objective for NHS HR and workforce leaders.

- Employers believe the NHS is, but must also be perceived widely in society to be, an honourable, rewarding, and exciting place to work. Employers are keen to ensure their staff are recognised and celebrated for their hard work.

The components of reward in the NHS

- Employers are combining information on the age profile and demographics of the workforce with feedback from staff to design specific methods of communication for certain staff. For example, there is evidence that 90 per cent of Instagram users are under 35.
Our health and wellbeing pages on our website\textsuperscript{14} are designed to help employers assess what is required, including the latest research and evidence. We have also been working closely with ambulance employers\textsuperscript{15} and trade unions on this subject. Employers are using staff health and wellbeing programmes to create a more engaged workforce while working towards the health and wellbeing CQUIN payment framework.

Annual leave allowances are attractive to potential recruits and beneficial to existing staff, yet employers believe that buying and selling schemes allow employees to buy some additional leave or sell some of their current entitlement and gain more control over their work/life balance.

In some organisations schemes are targeted at longer serving employees with additional leave entitlement for whom the chance to adjust work/life balance may be more important. We must remain alive to these issues, as they reflect the real-world that our staff live and work in.

The buying and selling annual leave sub-group of the Staff Council will consider best practice when agreeing the details of this element of the 2018 terms and conditions. It is expected that any recommendations will focus on minimum requirements, to allow organisations to continue to offer a further enhancement to this benefit.

Most organisations offer some form of salary sacrifice scheme, the most popular being childcare vouchers and cycle to work schemes.

The 2016 autumn statement introduced tax free childcare from 28 April 2017 but also confirmed that existing employer-supported childcare schemes were able to accept new entrants until October 2018.

Some organisations are continuing with their schemes while others have terminated schemes. There is concern that staff will perceive the changes as a reduction in their benefits.

The full impact of these changes has not yet become apparent.

**A strategic approach to reward**

40. Employers are using reward to support attraction and retention.

- In our survey this year of more than 60 employers, over 70 per cent said they were using reward to meet their strategic objectives, including recruitment and retention of staff. This is consistent with the findings in our survey last year.

- Recruitment and retention premia and other financial benefits are the exception rather than the rule. Financial premia and relocation packages tend to be used to attract candidates to some hard-to-fill posts. These posts often require specialist skills and employers face stiff competition locally from other employers, often in the private sector.

\footnotesize{\textsuperscript{14} NHS Employers health and wellbeing resources \textsuperscript{15} NHS Employers ambulance workforce resources}
• Around 58 per cent of respondents to our survey this year and last reported evaluating reward packages using employee feedback obtained from staff surveys and interviews with leavers and joiners.

• Most employers said they adopted a generic approach to reward and did not distinguish between medical and non-medical staff.

• Staff awards/honours, including long-service schemes, are common and some employers operate monthly award schemes. All staff must be equally able to participate in these schemes. Annual awards ceremonies are enthusiastically supported by staff. Employers emphasise the healthcare team and demonstrate how everyone’s contribution counts and is important.

• Employers see this type of employee recognition as a valuable communication tool that reinforces and rewards the most important outcomes staff create, in line with organisational values.

• Recognition of employee success reinforces staff morale and is a recruitment tool, as the wider public sees how much NHS staff are valued by their employer.

• There is a role for supervisors/line managers who must be able to recognise achievement, but successful schemes depend on broad based peer nomination.

• Employers are promoting staff development, including training and education, during recruitment and through line managers for established staff. Some trust websites describe in detail example career paths and the support and opportunities the employer can provide at key stages.

• Support on education and development often focuses on training and formal learning but can also include a reference library, courses, memberships, seminars and help with the cost of textbooks.

• These important efforts need to be supported by central funding for staff education and development.

• Pre-retirement courses are proving popular in many organisations and monthly pension and payroll clinics are offered by some employers.

The local approaches to reward

• Electronic communications are used more often. Organisations with large workforces spread over several sites, in a broad geographical area, are using apps and social media to ensure the same communications reach everyone at the same time. Equality is an important aspect of reward communications. The main communications channels for reward are intranet, staff newsletter/bulletin, email and social media.

• Workshops, drop in sessions and webinars are being used by many organisations to increase levels of staff engagement and improve staff morale.
• Employers are using benefits leaflets, and some have confirmed that they use materials on our website reward pages\textsuperscript{16} to assist in the local development of new materials of this sort.

• Some employers are supplying benefits information with job offer letters and making reward information sessions an integral part of their induction programmes. In many organisations, ensuring the employee knows what the benefits package contains and how to access benefits information is one of the essential criteria for completing the induction programme. Conversations with staff at the completion of the induction process provide opportunities to assess the effectiveness of the communications used.

• Employers prefer to take an organisation-wide approach to reward, rather than targeting specific staff groups.

**Attractiveness of the reward offer**

• Employers are looking at ways of making their reward communications two-way and how employees can become involved constructively in the reward conversation.

• Widening access by introducing apprenticeships and opening new roles and qualifications brings with it the challenge of making reward attractive to a broader range of recruits. The focus on local talent which is being developed in many organisations is leading to an increase in the range of staff discounts on local services being made available in many total reward packages. This also helps to raise the profile of the NHS in the local community. We say more about this in Section 3.

• Benefit champions are making the reward package known to employees. Champions are preferably committed to the reward strategy and enthusiastic contributors to, and supporters of, the employer’s reward strategy. Organisations believe that staff will engage with champions on reward when some other communications channels have failed to gain their attention. In some organisations now, there are over 300 champions. Feedback given to champions by staff helps inform the local reward strategy.

• Employers are offering advice and guidance on financial management as part of their health and wellbeing strategies including by providing access to external providers of financial advice and education. There was positive feedback in the latest annual staff survey on health and wellbeing.

• Employers believe that line managers are key to staff retention. Many employers want to increase the participation of line managers in promoting the reward offer and supporting employee morale through more regular and open communication with their staff on all aspects of reward. More organisations are encouraging staff to raise issues with their line manager and are supporting line managers to respond positively by targeting them with reward information. Employers see these ongoing, two-way conversations as important in supporting staff morale and building more engaged workforces.

\textsuperscript{16} NHS Employers reward resources
The line manager is a conduit for advice about elements of the reward package relevant to an employee at a point in time. This makes reward effective, dynamic and responsive to employee needs and supports the development of the line manager/subordinate relationship. This will become more important as we go further into the implementation of the 2018 NHS Terms and Conditions of Service.

- Strong relationships are imperative if the appraisal process is to be a productive part of the link between employee development, staff development and pay progression.

- Ongoing discussions regarding health and wellbeing can also positively impact employee performance and effectiveness and our website offers support and resources on how to do this\(^\text{17}\).

**Strategies to engage staff effectively**

- Employers see flexible working as a means of supporting recruitment and retention issues. It includes term-time only contracts, part-time working and job shares. The challenge for organisations remains to be as flexible as possible while maintaining service provision and high standards of patient care. Staff need to be able to balance their personal and professional lives and employers believe that continuing to offer a range of flexible working options is a powerful means of achieving higher staffing levels and increasing staff engagement.

**Total reward statements**

41. Total reward statements give staff useful information about the value of the pensions scheme, through an annual, personalised summary of the package.

42. 2017/18 was the fourth year of operation of total reward statements in the NHS. Information from the NHS Business Services Authority indicates that a total of 2,380,681 statements were available to staff in England and Wales, including those working in primary care. The number of unique statements across the health and care workforce that were viewed between 20 August 2017 and 9 June 2018 was 603,010. Compared with the position at the same time last year, this is an increase of over 30 per cent in the number of staff accessing their statements.

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\(^{17}\) [NHS Employers: supporting line managers resources](https://www.nhsemployers.org/)

20
4. NHS Pension Scheme

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

Pensions flexibility

44. Employers remain keen to ensure the NHS Pension scheme is attractive to all staff across the workforce. Employers would like to offer more flexible pension options to achieve this.

45. Some employers have suggested it would be helpful for pension members to be able to choose a level of pension contributions or benefits to suit their personal circumstances. This would provide members with alternative options for pension saving in addition to either joining the NHS Pension Scheme or having no workplace pension savings.

50:50 option

- Employers support the introduction of a 50:50 section which allows members to choose to pay half the standard contribution rate in return for half the standard benefit accrual. This enables staff at the top of the pay scale to control their pension growth whilst at the same time provides a more affordable method of pension saving for all staff, as an alternative to opting out on the grounds of affordability.

- The 50:50 section is an existing feature of the Local Government Pension Scheme.

- As the NHS Pension Scheme is unfunded, the introduction of such changes will be subject to extensive and detailed consultation and will require HM Treasury approval. Scheme changes would need to be considered alongside the pension arrangements for other public-sector workforce groups with staff who are experiencing similar pension tax challenges. For example, Judiciary, military, teachers and civil servants.

Life assurance only membership

- Some employers have suggested there could be more choice around opting to only contribute to the death in service element of the scheme, to avoid members breaching their lifetime allowance, with continued pension contributions.
Pensionable pay

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

Employer contributions

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

Actuarial valuation 2016

48. The employer contribution rate is reassessed by the scheme actuary every four years. The results of the 2016 valuation will determine the employer contribution rate from 1 April 2019.

49. The draft valuation directions published by HM Treasury on 6 September 2018 proposed a change to the discount rate assumption, from a rate of CPI plus 3 per cent to CPI plus 2.4 per cent. Preliminary valuation results show the employer contribution rate will increase to 20.6% from 1 April 2019.

50. The budget 2018 announcement on 29 October 2018 confirmed the reduction in the discount rate assumption and clarified Treasury will provide funding for the increase in pension costs between 2019-2023. More details are needed to understand if the funding is sufficient, when and how the funding will be made available to employers and if all employing organisations participating in the NHS Pension Scheme will be eligible.

51. The budget statement also referred to the preliminary results of the valuation, which indicate scheme costs have fallen and scheme changes are required to return the costs to within the agreed range. Those scheme changes could include improvements to benefits, a reduction in employee contributions, or a combination of both. The scheme changes are likely to be welcomed by most staff as they will receive higher pensions and will see an increase in take-home pay if employee contributions are reduced. However, any improvement to benefits will increase the number of NHS staff who exceed the annual and lifetime allowances and incur tax charges.

52. The Scheme Advisory Board (SAB) has provided advice to the Department of Health and Social Care on these scheme changes and a public consultation is expected in early 2019.

Member contributions

53. 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 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Up to £15,431.99</td>
<td>5.0%</td>
</tr>
<tr>
<td>2</td>
<td>£15,432.00 to £21,477.99</td>
<td>5.6%</td>
</tr>
<tr>
<td>3</td>
<td>£21,478.00 to £26,823.99</td>
<td>7.1%</td>
</tr>
<tr>
<td>4</td>
<td>£26,824.00 to £47,845.99</td>
<td>9.3%</td>
</tr>
<tr>
<td>5</td>
<td>£47,846.00 to £70,630.99</td>
<td>12.5%</td>
</tr>
<tr>
<td>6</td>
<td>£70,631.00 to £111,376.99</td>
<td>13.5%</td>
</tr>
<tr>
<td>7</td>
<td>£111,377.00 and over</td>
<td>14.5%</td>
</tr>
</tbody>
</table>

**Review of member contributions from 1 April 2019**

54. At the request of the Secretary of State, SAB has reviewed the basis on which member contributions will be assessed from 1 April 2019. A key objective of the review was to ensure the required yield is collected going forward. SAB submitted a recommendation on member contributions in July 2018.

55. DHSC published a consultation on various changes to the NHS Pension Scheme regulations on 18 December 2018. In the consultation paper, DHSC accepts SAB’s recommendation on member contributions and proposes to maintain member contributions at the current levels until 31 March 2021. Further details of SAB’s recommendation can be found in the consultation paper¹⁸.

56. As part of the 2018 pay deal, band 1 will be closed to new entrants from 1 December 2018, this means the lowest tier of employee contributions will effectively be removed.

**Scheme membership**

57. Generally, membership of the NHS Pension Scheme is high, with 89 per cent of staff actively contributing to the scheme as at June 2018. The overall membership of the NHS Pension Scheme has increased by 4.4 percentage points from October 2011 to June 2018.

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¹⁸ NHS pension scheme: proposed changes to scheme regulations 2019: Department of Health and Social Care: December 2018
58. Levels of pension scheme membership are lower at the bottom end of the NHS pay scales, with 80 per cent of staff in band 1 actively contributing to the scheme (9 percentage points lower than the overall average).

<table>
<thead>
<tr>
<th>Scheme membership trends (Source: ESR summary data June 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FTE</td>
</tr>
<tr>
<td>% with pension contributions</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>All</td>
</tr>
<tr>
<td>AfC Band</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
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<td>6</td>
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<td>7</td>
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<tr>
<td>8a</td>
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<tr>
<td>8b</td>
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<tr>
<td>8c</td>
</tr>
<tr>
<td>8d</td>
</tr>
<tr>
<td>8e</td>
</tr>
<tr>
<td>Non AfC</td>
</tr>
</tbody>
</table>

59. The increase in membership in the lower contribution tiers has served to reduce the contribution yield below the required 9.8 per cent level. As most NHS employers have passed their initial staging date for auto-enrolment it is unlikely that auto-enrolment alone will have a significant further impact on the contribution yield.

60. The actual member contribution rate is set out in the scheme’s annual Resource Accounts\(^\text{19}\) and has been 9.5 per cent in each year since the new structure was introduced (2015/16, 2016/17 and 2017/18). It has therefore been consistently under target.

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\(^{19}\) NHS Pension Scheme accounts: NHS Business Services Authority
The proportion of members accruing benefits on a CARE basis is increasing rapidly, while the number of members in the final salary sections of the scheme continues to fall. This continuing change in membership profile was considered in the context of the member contributions review, particularly the use of whole-time-equivalent earnings to determine member contribution rates.

<table>
<thead>
<tr>
<th>Date</th>
<th>1995 members</th>
<th>2008 members</th>
<th>2015 members with final salary link</th>
<th>2015 member no final salary link</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>31/03/2016</td>
<td>237</td>
<td>18</td>
<td>1,063</td>
<td>141</td>
<td>1,460</td>
</tr>
<tr>
<td>31/03/2017</td>
<td>203</td>
<td>16</td>
<td>1,000</td>
<td>269</td>
<td>1,488</td>
</tr>
</tbody>
</table>

**Table:** Changing membership of the scheme (Source: GAD)

**Pension taxation**

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 real issues for staff and employers.

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

Trusts are experiencing their staff either leaving the pension scheme, cutting down their hours, retiring early or leaving. Some trusts are also struggling to recruit for higher earning roles as employees are worried they may exceed the allowance.

Employers have told us they feel the scheme is becoming less attractive to high earners, due to the impact of the tax allowances. The tax allowances are particularly impacting higher earning staff, with some employers seeing a decrease in applications for leadership roles. Employers report that staff feel they are being penalised for taking a post which attracts a higher salary. Some employers have indicated that recruiting and retaining staff, particularly high paid staff, is becoming an issue.

Employees are facing significantly higher marginal tax rates once pension tax charges are factored in and large pay rises can sometimes lead to very little increase in take-home pay. This effect is well illustrated in the fortieth annual report by the review body on senior salaries\(^{20}\). The review body noted that “for gross salaries between £118,000 and £170,000, take home pay increases by less than £3,000. Marginal tax rates above 100 per cent are experienced between £118,800 and £122,600, although this calculation does not factor in increases to the value of the pension. Such high marginal tax rates mean it could be rational for an individual to seek to work part-time rather than work full-time. This may result in a need to recruit more post-holders or to deny requests to

\(^{20}\) Fortieth annual report by the review body on senior salaries: September 2018
work reduced hours, impacting negatively on motivation”. We endorse that observation.

67. The current contribution design relies on high earners paying higher member contributions to subsidise those paying lower contributions. If the trend of high earners leaving the scheme continues, this may have an impact on the yield and the ongoing sustainability of the scheme. This is a key consideration for the employee contribution review. We would welcome any review by the Treasury of the impact of current pension tax rules on key public servants.

The NHS Pension Scheme as an attraction and retention tool

68. We asked more than 60 employers how they would rate the effectiveness of the NHS Pension Scheme to attract and retain staff. A total of 86.6 per cent of employers rated the scheme as effective or somewhat effective at retaining staff, with only 13.4 per cent rating the scheme as not effective.

Understanding the value of the NHS Pension Scheme

69. Employers feel that more could be done to help their staff understand the scheme. The complexity of the scheme is one reason why employers believe that staff are not understanding its value.

70. Employers suggested the following ways in which they need help promoting the value of the NHS Pension Scheme:

- Better communication.
- National advertising of the rewards and benefits of the scheme.
- Simple sessions for employers to equip them with knowledge to share with their staff.
- More promotional resources and marketing materials for the scheme.
- Enable previous TRS statements to be available to show the growth over time.

71. NHS Employers continues to produce resources\(^21\) to support employers to promote the value of the NHS Pension Scheme.

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\(^{21}\) NHS Employers: pension resources
5. The workforce and financial challenges

Workforce challenge

72. The challenges faced by the NHS around finance and workforce are complex and urgent as the pressures on demand continue to increase. For most NHS leaders, the most pressing issue is workforce. In addition, there is the contributing pressure on workforce linked to the system position in social care.

73. In a joint report\textsuperscript{22} the Kings Fund, Health Foundation and Nuffield Trust say that they now regard the workforce challenges in the NHS in England as a greater threat to the delivery and quality of health services than the funding challenges. Their report identifies that across NHS trusts there is a shortage of more than 100,000 staff.

74. Based on current trends, we project that the gap between staff needed and the number available could reach almost 250,000 by 2030. If the emerging trend of staff leaving the workforce early continues and the pipeline of newly trained staff and international recruits does not rise sufficiently, this number could be more than 350,000 by 2030.

75. The workforce pressures that the NHS currently faces require a long term and sustainable workforce strategy, and we welcome the imminent arrival of the ten-year workforce plan which, combined with a longer-term funding settlement, will help employers make longer term plans. The plan must ensure there is a clear link between any future service priorities and the workforce that is needed to deliver them. We have already set out what the NHS is doing to attract and retain the workforce we need today. More needs to be done to develop new roles and professions to help meet future workforce challenges. The funding of continuing professional development must be urgently reinstated.

76. Staff shortages pose a substantial risk to the health service’s ability to sustain high quality care. The NHS needs to adapt and change quickly.

77. In your 31\textsuperscript{st} report\textsuperscript{23} you said:

“There is a workforce gap . . . which is creating an unsustainably high level of vacancies, work pressures and potential risks to patient care.”

\textsuperscript{22} The health care workforce in England: make or break? The Nuffield Trust, Kings Fund and Health Foundation: November 2018
\textsuperscript{23} NHS Pay Review Body: 31st report
78. If the NHS cannot recruit and retain the nurses and other staff that are needed, then it will not be able to deliver the improvements in care that everyone would wish to see. NHSI data shows that the NHS has around 108,000 vacancies\textsuperscript{24} and this number is increasing.

79. The 2018 pay and conditions provide employers with the opportunity to enhance the employee experience by supporting:

- attraction, recruitment and retention, through increased starting salaries in all pay bands
- increases in retention and improvements in staff motivation, by enabling staff to get to the top of pay bands more quickly.

80. The social care sector is also facing the twin challenges of funding and workforce. Around 11 per cent or £13 billion of the health budget is spent on non-NHS providers, including local authorities.

81. The ongoing separation between the health and social care systems is a major obstacle to achieving better outcomes for patients. The NHS is working more closely with colleagues in social care and local government yet the integration of health and social care budgets, and services at all levels, will be essential if we are to deliver place-based, personalised and whole-person care. Pay differentials between the NHS and social care workforce are just one manifestation of a much bigger and more complex issue which is characterised by legal and funding differences. The private sector is a major employer in the social care sector, with residential and nursing homes and workforce costs also a major issue for these employers.

82. The National Audit Office\textsuperscript{25} has so far found no compelling evidence to show that integration of health and social care in England leads to sustainable financial savings or reduced hospital activity. The long-term plan for the NHS must recognise the interdependence of the health and social care sectors and demonstrate how integration will be delivered and how it will improve patient services.

83. The 2018 pay and conditions of service support staff learning and development by providing the opportunity for employers to promote a new and enhanced relationship between line managers and their staff which is focused, through effective appraisal, on staff learning and development. These opportunities need to be supported by the reinstatement of funding for continuing professional development.

84. Concentrating on improving productivity while not focusing on the needs of staff might result in reduced morale and problems with retention. Yet, too much flexibility in a seven-day NHS can mean that patient care is inconsistent. Employers have been concentrating on staff development through new

\textsuperscript{24} Quarterly performance of the NHS provider sector: quarter 1 2018/19: June 2018

\textsuperscript{25} National Audit Office: Health and social care integration: February 2017
programmes that allow staff more scope to develop their careers by working in different areas to expand their knowledge and experience.

85. In 1948 the NHS was focused on the health problems of the young and the impact of infectious diseases and accidents. 70 years on, the NHS must meet the needs of an ageing population with a growing burden of chronic disease, multiple health problems and inequalities in health outcomes. Sticking to current models of care is likely to further increase the demand for hospital care. The forthcoming workforce strategy is critical.

86. We strongly believe that if the NHS is to be transformed the focus must be on the workforce. Extra staff are essential, but NHS HR tells us that this alone will not be sufficient. There is much more to do. We will need to look afresh at the type of workforce and its skills sets. So far much of the work being done on integration is focused on multi-disciplinary teams. Yet in future patients will need a workforce that is able to adopt a holistic approach to their treatment. This will require possibly radical changes to the way the workforce is organised. Much good work is being done but transformational change at scale and pace will need to be appropriately funded.

Financial challenge

87. We have asked for three commitments from government:

- First, we need a move away from annual settlements
- Secondly there needs to be a longer-term settlement, with secured investment to enable the integration of health and social care to be delivered and which recognises their close interdependencies26:
- Thirdly, we have called for funding commitment that takes account of the current demographic and other pressures and, critically, enables the service to meet the significant additional pressures it will face over the next ten to 15 years.

88. The government has:

- announced increases in NHS funding over five years, beginning in 2019/20
- asked the NHS to come up with a ten-year plan for how this funding will be used.

89. This settlement is welcomed as a means of providing a degree of short-term stability, but it falls below the minimum amount estimated, by most commentators of note, to allow the NHS to modernise, transform and improve services in future.

90. As part of the funding settlement the government has set several financial tests to ensure that the NHS is doing its part to put the service onto a more

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26 Steadying the ship: Leadership in challenging times - NHS Confederation

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sustainable financial footing. These include further improvements in productivity and efficiency.

91. The 2018 pay reforms provide opportunities for employers to increase workforce productivity through stronger evidence-based staff appraisals, placing more emphasis on improving and increasing staff capability.

92. NHS Improvement pointed out that significant opportunities remain for improving efficiency and quality, yet the capacity for organisations to do so is influenced by the pressing workforce and service delivery challenges they also face.

The transformation challenges

93. The NHS Confederation’s report, System under strain – why demand pressures are more than a winter phenomenon, describes how some employers have changed the shape of their service provision to increase efficiency. Employers have already met and are continuing to deliver productivity above the national average and this demonstrates what health and social care providers can achieve when they work across traditional organisational boundaries to tackle demand pressures. Additionally, sustainability and transformation partnerships and integrated care systems and organisations can enable such innovations across health economies.

94. The Kings Fund argues that some of the additional money the government is providing should be earmarked to support the further development of integrated care, with a focus on the needs of older people and of children.

95. Transformation of NHS services will require some NHS organisations to collaborate at a newly defined system level. This may mean further changes to the provider and commissioner roles. To be successful integrated systems must focus on outcomes. This will mean putting more emphasis on patient choice and voice, especially in the absence of competition.

96. The previous focus on short term financial targets has prevented the NHS from carrying out long-term financial planning. It is important to recognise that change takes longer than is expected. We must take a long-term view. The benefits of more integrated working can become apparent where local authorities consider commissioning to have a ten-year cycle. But local authorities are having to make more short-term decisions because of the financial pressures they face.

97. Crucially, successful transformation will depend on how we treat and involve staff and their willingness to drive changes in service delivery and the introduction of new services. Change is more likely to happen and be sustainable if staff understand and own it and are placed at the centre of it. This

27 The Autumn Budget | The King’s Fund
28 System under strain: NHS Confederation 2018
29 The Kings Fund: the NHS ten-year plan: how the extra funding should be spent
will be easier to achieve if the ten-year health and care workforce strategy produces a clear, practicable and affordable model for change. We believe that NHS staff should be closely involved in the development of the plan. So too should local authorities, patients, the public and voluntary sector. The problems of funding in social care must also be tackled. We look forward to the publication of the government’s green paper on social care.

98. The current direction of travel is towards a place-based approach to care, organised around the needs of local populations, provided through integrated commissioning systems with devolved, pooled budgets and involving collaborative providers working towards the needs of their populations to improve the broader health and wellbeing of those populations.

99. This will require strategic and integrated commissioning based around long-term contracts and pooled budgets with local authorities. This might also require a shift away from current payment by results arrangements as incentives in local authority social care are different. There is already a sign of possible change ahead. The tariff proposals for 2019/20 describe a blended payment system in emergency care which is a small step towards risk sharing, with some measure of local flexibility.

100. Payment by results comes with considerable overheads in terms of contracting, negotiating and transacting.

101. The success of the new care models will depend on experienced organisational leaders becoming system leaders who are able to work across boundaries to negotiate and implement improvements in care. This will require leaders who are comfortable working in rapidly changing organisational environments. The NHS can learn from local government where these skills are common and adequate peer support within the NHS will be vital.

102. Staff in primary and community care services will need a broader skills and experience base. This future workforce must be able to deliver services in new settings without reference to the old traditional organisational boundaries and it must be able to address and reverse inequalities in treatment and outcomes both in physical and mental health services.

103. New governance and commissioning structures will also be required which are demonstrably aligned to population health management need.

104. If further legislation is needed it must enable rather than prescribe as we believe there is growing evidence that the organisation of services will and should vary from one part of the country to another.

105. Trusts are leading collaborative working with local partners to improve population health and integration of services. Their governance and leadership expertise will be important in new models for local service development.

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30 2019/20 payment reform proposals NHS Improvement: October 2018
106. Local communities must be involved in the development of plans. In many areas, deprivation and lack of employment opportunities are a cause of ill health, placing additional burdens on the health and care system in these locations. We must support growth and prosperity in these areas and engage local communities in tackling the root causes of ill-health.

107. People should be much more involved in their own health and care and be offered information and support to manage their medical conditions.

108. Technology-supported self-management can help to empower patients to better manage and understand their condition, supporting improved behavioural and clinical outcomes. Yet we will need to avoid creating further inequality as research\(^3\) shows that some elderly patients, carers and people with dementia, stroke and learning disabilities have little experience of using digital technology.

109. The Choosing Wisely\(^3\) initiative seeks to ensure better use of care by engaging patients in decision making and sharing information about the risks and benefits of treatment options.

**Staff engagement and the NHS Staff Survey**

110. NHS Employers supports employers to develop and foster staff engagement through development of case studies\(^3\) and sharing of information. Additional support for organisations has been developed by NHS Improvement such as its culture programme tools\(^3\).

111. We do not yet have access to the 2018 NHS Staff Survey data and results. The most recent data on staff views is drawn from the first quarter of 2018.

- The Staff Friends and Family Test shows staff opinion stable with just over six out of ten willing to recommend NHS services to friends and family.

- In your 31st report you drew attention to the fall in a range of scores within the staff survey including indicators of staff feeling valued and work pressure. It is a growing matter of concern that these indicators have worsened. In most cases, though, they remained higher than in 2013.

- The main exception to this was levels of satisfaction on pay. This fell from 37 to 31 per cent, the single biggest decline in the survey. Feelings on pay were also broadly negative whereas most other indicators were broadly positive. The introduction of the 2018 NHS Terms and Conditions of Service will hopefully begin to address some of the pay related dissatisfaction.

112. There was positive movement in scores on employee confidence in health and wellbeing, feelings of support from line managers and quality of appraisal.

\(^3\)Digital patients: myth and reality: Nuffield Trust: September 2018
\(^3\)Choosing wisely: NHS Crawley clinical commissioning group
\(^3\)NHS Employers: staff engagement
\(^3\)NHS Improvement: create a culture and leadership programme
These are encouraging indicators as the NHS begins to strengthen staff appraisal with the introduction of the new pay progression system in the 2018 NHS Terms and Conditions of Service.

113. The 2018 NHS Staff Survey is underway. Organisations are continuing to focus on staff engagement with the Care Quality Commission highlighting an increase in those organisations which it rated as good or outstanding for being well led.
6. Information technology staff

114. The NHS Terms and Conditions of Service (Agenda for Change)\(^{35}\) contain provisions governing the operation of recruitment and retention premia that are designed to address labour market difficulties affecting specific occupational groups. The use of such premia must apply to posts, not individuals.

115. These premia may be awarded on a national basis to groups on your recommendation, where there is clear evidence of national recruitment and retention pressures. Where it is agreed that a recruitment and retention premium is necessary for a group, the level of payment should be specified. Or, where the underlying problem is considered to vary across the country, guidance should be given to employers on the appropriate level of payment.

116. Currently there are no nationally agreed recruitment and retention premia in operation for information technology and informatics roles. We do not believe there is a case for recruitment and retention premiums for these roles. There are priorities elsewhere in the workforce, including mental health nurses, learning disability nurses and therapeutic radiographers, which we mention in our introductory remarks. These are priorities for our policy board. The broad range and diversity of NHS roles in this area mean that the issues are complex and cannot be satisfactorily addressed through pay alone. There is already scope for local employers and trade unions to gauge the need for a recruitment and retention premium to address specific local recruitment and retention problems.

117. Yet the feedback we have received from employers is that they rarely use recruitment and retention premiums for these roles. We believe there is scope for employers to make more use of the full range of employment benefits for these staff. We describe action being taken on total reward in Section 3. These measures are designed to create reward packages that can support attraction, recruitment and retention. Despite the challenges employers face in making best use of ringfenced apprenticeship levy funds this is another option for employers.

118. There is no quick fix or single solution to these issues. Employers face pressing issues in other parts of the workforce and, taken together, there is a great deal of work to do. Sustained and effective action will need to be taken by employers, and at a higher system level, in line with developing local health and care system policies.

119. Nationally collated workforce data does not separately identify staff working in information technology within the larger administrative and clerical staff workforce. A variety of local payment types are aggregated as general and long-term recruitment and retention premia. It is therefore not possible to use the standard national dataset to assess the size of this workforce, the number

\(^{35}\text{NHS Terms and conditions of service handbook: section 5}\)
of vacancies and whether trusts are paying local recruitment and retention premiums.

120. The Migration Advisory Committee shortage occupation list\(^{36}\) contains:

- a specific class of information technology specialist manager
- information technology business analysts, architects and system designers
- programmers and software development professionals
- a specific class of cyber security specialist.

121. ECORYS UK, in a report for the Departments of Business, Innovation and Skills and Culture, Media and Sport\(^{37}\), estimated that the UK lacks about 40,000 information technology specialists. Around 72 per cent of large companies are suffering gaps in information technology skills. The situation is exacerbated by rapid changes taking place within the information communications technology sector. These changes in both hardware and software make computer skills quickly obsolete and have created a shortage of specialists that are familiar with the new advances. The economy of the European Union is rapidly becoming more reliant on digital technology, creating an extremely competitive international labour market for these skills.

122. A range of measures will be needed to address this problem. Across all employment sectors these will include attracting more young people into information technology training courses and education, attracting more women into the profession and encouraging employers to focus on re-skilling and/or upskilling existing employees. None of these measures offer a quick fix and there are reports from the profession that, so far, efforts to attract more women into information technology roles have not yet produced a significant increase in the number of women being recruited. Co-ordinated action across all sectors of the economy will be needed.

123. Feedback from employers in the NHS suggests that some are experiencing problems recruiting and retaining information technology staff. Yet very few employers have used recruitment and retention premia to help them attract these staff. Some employers are also continuing to engage self-employed specialists to work on specific, time limited projects.

124. Nationally advertised vacancies\(^{38}\) include roles such as:

- IT network manager
- IT project manager
- network and telecommunications managers
- ICT support officer
- apprentice ICT
- ICT data quality technician.

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\(^{36}\) [Migration Advisory Committee: shortage occupation list](http://example.com)

\(^{37}\) [Digital skills for the UK economy: ECORYS UK: January 2016](http://example.com)

\(^{38}\) [NHS jobs](http://example.com)
125. Roles employers said they sometimes had difficulty recruiting to included network engineer, data centre engineer, software developer, and service desk manager. Some employers have reported problems recruiting to what they regarded as more specialised roles in cyber security, administration of databases and technical architecture.

126. There are some standard information technology roles in trusts but there are also many locally designed roles, meeting often time-limited needs. Pay bands used range from 2 to 8c.

127. There is sometimes stiff competition between employers in an area where some organisations, possibly operating outside of Agenda for Change terms and conditions, may offer higher rates of pay.

128. Causes behind recruitment difficulties experienced by some employers were:
   - private sector employers offering higher salaries
   - limited number of potential job candidates with the required skills, knowledge and experience
   - the location of the NHS employer, for example within commuting distance of the big cities where many of the large information technology employers are located, and/or proximity to universities and some other public or private sector employers
   - limited career development opportunities – linked to the use of outdated software/hardware and scarcity of senior posts
   - too few female candidates for posts.

129. Most information computer technology posts are attached to Agenda for Change pay and conditions and therefore will also attract the new 2018 NHS Terms and Conditions of Service. There are a growing number of opportunities for staff working in this area to progress into senior management roles. Most NHS organisations now have chief information officers and/or chief digital officers who lead the delivery of information computer technology systems and services.

130. The NHS Staff Council has not discussed this subject in detail. There has been little use by employers of recruitment and retention premia in reaction to attraction, recruitment and retention difficulties. The pay gap with the private sector cannot easily be bridged through pay premia on their own, but it is also evident from the ECORYS UK report, and the feedback from employers, that the roots of the problem lie in supply. It will not be appropriate to use recruitment and retention premia to address supply shortages. More needs to be done centrally, across all sectors of the economy, to address the problem of supply.
Recruitment and retention is influenced by a wider range of factors. A one-size-fits-all solution, such as introducing pay premia, would be unlikely to resolve recruitment and retention problems and would not represent good value for money. The NHS cannot outpace the private sector on pay. Employers would view any national payment as creating an additional cost pressure, without major change to the problem.

Local recruitment and retention premia might lead to unhelpful competition for staff between NHS organisations, destabilise the internal NHS market for these staff and possibly lead to pay spirals. Given the range of roles involved within the larger administrative and clerical group, it may not be possible to limit local premia to specific roles. These problems are best addressed at local level.

As recruitment and retention premiums apply to posts and not persons they are to be withdrawn if an employee in an eligible post moves to a new post that does not attract a recruitment and retention premium. Employers seeking to develop talent through planned job moves view this aspect of the national system as unhelpful.

In Section 3 we have referred to the work employers are doing to enhance the content and presentation of their total reward offering for the whole workforce. Staff working in all aspects of information technology can benefit. We have mentioned that training and development is an important part of the employment proposition and a recent study across all sectors of the economy\(^\text{39}\) has shown that over 80 per cent of information technology staff had undergone training in the last 12 months. Yet we have also mentioned in section 2 that the lack of funding for continuing professional development is hampering employer efforts to develop the skills, knowledge and competence of the workforce. There is a limit to what can be done with on-the-job training, particularly in information technology, where formal training courses are important. We need to offer IT careers in which training and development are routine.

Foreseeable technological developments will lead to treatments being tailored to individual needs. We believe more can be done to involve clinicians in these issues. There is a role for them in leading the shape and pace of developments so that effective new treatment plans are targeted at patient need and staff feel more confident in using new technology in all its forms.

Long-term workforce planning and talent management must be a priority if we are to develop a sustainable workforce with the right skills. This planning should take place at a larger scale than individual organisation or local health economy to better manage the talent in the health and care system and allow people to work in different areas over time.

Employers would support you in looking at the future of the national system of recruitment and retention premia, and of high cost area supplements, their operation and application and the part they might play in future in support of attraction, recruitment and retention across the workforce.

\(^{39}\) Computer weekly
7. Workforce supply

138. Demand for services is increasing faster than employers can increase the supply of staff and it is not possible to respond rapidly to workforce gaps through training more people, even if funding of continuing professional development were to be reinstated.

139. We believe the following measures will help address staff supply and retention issues:

- Flexibility in the apprenticeship levy, particularly in terms of being able to address the costs to employers of back filling for staff released to their training.
- A migration policy that enables health and social care to attract and retain the workforce needed, particularly in lower paid caring roles.
- New and effective national professional leadership for newly created roles, for example medical associates and nursing associates.
- Restoration and sustainable new investment in continuing professional development.

140. The Migration Advisory Committee’s shortage occupation list, which is currently under review\(^{40}\), includes the following occupations.

- Nurses.
- Radiographers.
- Sonographers.
- Orthotists.
- Prosthetists.
- Paramedics.
- Medical practitioners in consultant radiology, emergency medicine and old age psychiatry (full list available from UKVI).
- Healthcare scientists in neurophysiology and nuclear medicine.
- Social worker working in children’s and family services.

**Domestic supply/widening participation**

- Employers are engaging with local communities to encourage and attract individuals and they are ensuring their employment practice makes their organisations employers of choice.

- The methods used are:
  - work experience programmes
  - pre-employment programmes
  - traineeships
  - internships
  - apprenticeships

\(^{40}\) [Gov.uk (Nov 2018), Shortage occupation list 2018 call for evidence](https://www.gov.uk/government/publications/shortage-occupation-list-2018-call-for-evidence)
• targeted engagement with local communities.

• Employers are continuing to establish relationships with local schools and colleges to publicise the range of career options and pathways available for young people leaving school. The Health Careers Step into the NHS competitions for school children supports the non-statutory framework for careers education and provides children with an understanding of the range of careers available.

• With Health Education England, NHS Employers has been able to support 37 organisations in a behaviour change programme Recruiting from your local community to help them address workforce supply challenges by tapping into the talent pools in their local area. NHS Employers is liaising with the Prince’s Trust in this area and we hope to confirm further pre-employment programmes for young people across the NHS.

• NHS Employers also provides leadership for the Step into Health programme which provides an access pathway for the Armed Forces community into the NHS. There are now 70 organisations across England that are involved in the work, and in total there have been 90 people employed because of the programme, with 61 of those recruited since September 2017.

International recruitment

141. While there are opportunities to improve the attraction and supply of our domestic workforce, in the short-to-medium term it will continue to be challenging for NHS organisations to meet their workforce supply requirements without accessing labour and skills from outside of the UK.

Implications of Brexit

• Since July 2016, NHS Employers, in collaboration with NHS Providers and The Shelford Group, has surveyed NHS organisations quarterly. The first 12 months of data on the NHS Employers’ website indicates that two years on from the European Union referendum, employers believe that Brexit has had a negative impact on their workforce. There are fewer employers with plans to recruit from the European Economic Area due to continued uncertainty about immigration policy after March 2019.

• Early details on the Home Office settlement scheme have been published. The government has indicated that it will follow the guidance in this autumn’s Migration Advisory Committee report. Yet even with the recent pay increases, some nurses, radiographers and paramedics who would start in pay bands 5 and 6 would not meet the proposed £30,000 salary threshold. Lower levels of pay in social care suggest the need for special arrangements

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41 NHS Employers (February 2018), Brexit one year on
42 Gov.uk (June 2018), Home Office publishes details of settlement scheme for EU citizens
43 Gov.uk (September 2018), Migration Advisory Committee (MAC) Report: EEA Migration
like those offered to agricultural workers, to ensure care workers can be recruited from outside the UK.

• The proposals in the government’s white paper, *The UK’s future skills-based immigration system*, do not provide a long-term solution to health and social care needs across nursing and other professions and continue to confuse high pay with high skill and high value. We will continue to argue for a more nuanced approach that recognises the contribution our skilled staff make to the health and wealth of the country.

142. A post-Brexit immigration system must:

• support the NHS to provide the best care to our communities
• secure clear and reasonable routes to immigration
• be flexible to allow health and social care employers to recruit appropriately from outside of the UK to fill workforce shortages and maintain services.

**Apprenticeships**

143. Employers face challenges in making best use of these ringfenced funds, including:

• the range of standards available
• placement and supervisory capacity
• the cost of backfill for supernumerary training time.

144. NHS Employers has brought these challenges to the attention of government and has made suggestions on how the system could be changed to enable the NHS to make more effective use of these funds.

145. Despite these challenges, many NHS trusts 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 as a key route for talent acquisition and management.

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44 [Apprenticeship and levy statistics: July 2018](#)
45 [UK Parliament (June 2018), Supplementary written evidence submitted by NHS Employers](#)
47 [NHS Employers (March 2018), Using your apprenticeship levy](#)
48 [NHS Employers (August 2018), Apprenticeship case studies and resources](#)
• Transfer their surplus levy funds\textsuperscript{49} (as per the newly introduced option) to other, smaller employers within their health economies to develop the local skills base.

146. Employers recognise the value of the 20 per cent off-the-job training requirement as a key component of an apprenticeship. However, for healthcare-specific standards such as the nursing degree apprenticeship, there is a much larger off-the-job requirement of over 50 per cent. This time is considered supernumerary\textsuperscript{50} and means that when the apprentice is in the workplace, undertaking tasks within their competency and scope of practice, they cannot be considered as part of the workforce or included in safe staffing figures.

• Some employers are exploring alternative supervision models, such as the Collaborative Learning in Practice approach\textsuperscript{51}, to help build placement and supervision capacity.

• Employers are already using the registered nursing apprenticeship standard\textsuperscript{52} to help them increase the supply of registered nurses\textsuperscript{53}.

New and extended roles

• The 2016 *Reshaping the workforce*\textsuperscript{54} report from the Nuffield Trust highlighted the opportunities and benefits presented through developing the support workforce, expanding the physician’s associate role, and exploring how the Advanced Clinical Practice workforce could be scaled up and deployed more effectively.

• Employers believe that the success of these new roles, and new approaches to team design, hinge on regulatory practices that will enable the creation of new roles, training routes and ways of working, while still ensuring that the public is protected.

Nursing associates

• In our March 2018 survey of employers, 82 per cent of respondents said that the nursing associate will feature in their future workforce strategies.

• The NMC has published regulatory tools\textsuperscript{55} that will enable this role to be regulated from January 2019, when the first qualified nursing associates will enter the system.

\textsuperscript{49} NHS Employers (October 2018), Apprenticeship levy transfer briefing
\textsuperscript{50} NHS Employers (May 2017) Nurse degree apprenticeship now available
\textsuperscript{51} Collaborative learning in practice: University of East Anglia
\textsuperscript{52} NHS Employers (May 2017), Nurse degree apprenticeship now available
\textsuperscript{53} Royal College of Nursing (February 2018), Left to chance – the health and care nursing workforce supply in England
\textsuperscript{54} Nuffield Trust (May 2016), Reshaping the workforce to deliver the care patients need
\textsuperscript{55} NMC (October 2018), How we will regulate the nursing associate profession
• Employers are using the trainee nursing associate role to improve skill mix,\(^{56}\) support staff development, staff experience and retention.\(^ {57}\)

**Advanced Clinical Practice (ACP)**

• Advanced Clinical Practitioners have been used across the NHS workforce for several years to support changes to the delivery of patient care and to help manage supply challenges in the workforce. Yet there has been inconsistency in the deployment and governance of these roles. The multi-professional framework for advanced clinical practice in England\(^ {58}\) was published to address this.

• NHS Employers is working in partnership with Health Education England to help improve understanding of the use of these roles to improve consistency of approach.

**Retention**

• The need to solve short-term, urgent workforce issues means resources are not available to tackle long-term complex issues around retention.

• The NHS needs to retain its workforce to continue to provide high-quality care.

• High levels of turnover forces trusts to turn to bank and agency staff yet 8 per cent of vacant shifts are still not covered,\(^ {59}\) resulting in greater pressure on remaining staff and increasing the possibility that staff will leave.

• NHS Employers has identified three key areas for attention:
  • Supporting new starters.
  • Greater use and provisions on flexible working and flexible retirement.
  • Better career planning and development.

• We have provided trusts with support and guidance to identify the key challenges they are facing and to tackle these using best practice approaches.

• Further challenges include an aging workforce, the nature of nursing roles that feature high workloads; competition from other trusts; and competing priorities.

\(^{56}\) NHS Employers (August 2018), *Building the team around the patient*

\(^{57}\) NHS Employers (May 2018), *Strengthening your nursing supply*

\(^{58}\) Health Education England (2018), *Multi-professional framework for England*

\(^{59}\) Ibid. p.7
The initial results of NHSI’s programme demonstrate that retention can be improved where trusts focus significant time, energy and resources on the problems. It is important to acknowledge the complex and multi-faceted nature of the retention challenge, which will require a continued focus over a period of years if substantial improvements are to be made. NHS Employers is committed to continue working with NHS Improvement to ensure measures to tackle retention issues in the NHS are aligned.

We have referred to the 2018 NHS Terms and Conditions of Service and how these can help employers enhance their retention strategies.

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60 NHS Improvement (October 2018) Staff retention and support programme: one year on
## Annex 1: NHS Staff Council work plan in England

### NHS Staff Council: Work plan (for England)

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- Negotiation changes to NHS TCS Section 15 and Section 33 (Steve / Rhianna / Ellie / Salima) | | | | | | | | | |
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- Blue = buying & selling AL
- Orange = access to AL & TOE
- Purple = bank & agency framework

- 01 Sep: new TCS amendments take effect

- NHS-19 work involving the National ITP (Sue / Rebecca)