NHS Employers

NHS Employers' submission to the NHS Pay Review Body 2022/23

24 January 2022

Contents

Context

Policy and financial

The ongoing effects of the COVID-19 pandemic, together with long-term under investment in health and social care services, continue to present the NHS with the biggest set of challenges that it has ever faced.

The NHS is still operating under the most severe strain. There are significant numbers of patients with COVID-19 being admitted for treatment into hospitals. As of 19 January 2022, there were 15,742 patients being treated for COVID-19 in hospital. Care for other patients is again disrupted and the legacy of long COVID is also becoming clearer.

The workforce is exhausted and struggling to cope, having entered the crisis with a shortage of at least 100,000 people in clinical roles[1].

The NHS Confederation's Representation to the Spending Review 2021[2] includes the following key asks of government:

- Finishing the service funding task started by the September funding announcement – We need at least £10 billion in service funding next year to cover ongoing COVID-19 costs (£4.6 billion), recover care backlogs (£4-£5 billion), and make

[1] The Health Foundation: Action Required To Make Workforce Shortages A Thing Of The Past: May 2021
[2] Representation to the Comprehensive Spending Review 2021: NHS Confederation: October 2021

appropriate allowance for lost efficiency savings, with inflation and demand adjusted settlements to 2024/25.

- Creating a multi-year capital funding settlement for the entire NHS – To reduce the backlog, ensure the safety of the NHS estate, embed positive pandemic-era changes, and truly make inroads to reducing inequalities by transforming models of care, the Department of Health and Social Care (DHSC) capital departmental expenditure limit (CDEL) budget should rise to at least £10.3 billion in 2024/25. This funding will also help drive the NHS towards the UK's net zero target.

- Addressing workforce issues such as lack of a multi-year funding settlement, pension issues, unfunded pay uplift and unclear future commissioning arrangements – To reduce the elective backlog and meet increasing demand, the workforce must increase by around a fifth by 2024/25. This means increasing the health education budget in England to £5.5 billion by 2024/25.

At the same time, the NHS in England is completing the formalisation of integrated and system working so that the health and care system will work better together to respond to the needs of local communities. Success will involve making sure people get the right treatment in the right place at the right time, managing activity away from acute services where possible to where people can be better cared for.

Reward factors

- Our members are clear that any pay awards for people in the NHS Pay Review Body's (NHS PRB) remit need to be fully funded.

- The NHS in England employs 1.5 million people (over one million of these are in the NHS PRB's remit), with employee

costs accounting for around two-thirds of NHS providers' expenditure[3]. Anecdotally, employers have told us that not fully funding pay award uplifts would force trusts to consider making cuts to workforce and clinical services, leading to overstretched people and potential reduction (or harm) to patient care. If employers did not make these cuts, this would increase local financial pressures (overspend) and contribute to a breach of their financial duty. Any unfunded pay award decisions would simply add to the pressures at a time when local NHS leadership is already under enormous pressure.

With rises to National Insurance contributions, freezing of income tax thresholds and increased NHS Pension Scheme contributions for some, there is potential for people in the NHS to experience a compounded negative impact on take-home pay in 2022. While these policies and decisions are separate from each other, the timing of their introduction may make it difficult for people to uncouple the impact and messaging if their take-home pay is negatively affected. There is also some potential for this to have an associated link on morale and motivation, NHS Pension Scheme membership, and recruitment and retention.

Employers continue to argue that the NHS Pension Scheme should offer greater flexibility. It should allow for partial membership for all grades of staff and staff groups to encourage membership and to support retention.

In our submission we:

- describe the context in which employers are operating and the opportunities and challenges they face

- refer to the work we are doing to support employers to tackle these challenges. This has included working in close collaboration with NHS England and NHS Improvement

[3] The NHS Workforce in Numbers: Nuffield Trust: September 2021

(NHSEI) to support employers to use reward as an enabler for achieving strategic workforce objectives. For example, in support of recruitment and retention.[4]

[4] NHS Employers: Increasing Recruitment and Retention Through Reward: October 2021

Key messages

- The ongoing effects of the COVID-19 pandemic continue to present the NHS with the biggest set of challenges that it has ever faced.

- Demand levels continue to rise and service delivery pressures show no sign of reducing. With work demands continuing to rise, services are constantly needing to be adapted.

- The health and wellbeing of people remains a significant concern of leaders in the NHS.

- The NHS faces the multiple challenges of rising demand for services, insufficient capital investment, and workforce shortages.

- Of these, workforce shortages remain the biggest concern for employers, with longer-term supply issues in urgent need of being addressed. Employers remain fully committed to retaining their people but the health and wellbeing of people and the risks of burnout, especially considering the pandemic, coupled with significant gaps in workforce supply, make this an ever-greater challenge.

- The NHS We are the NHS People Plan 2020/21 – Action for Us All[5], along with Our People Promise, sets out what people employed in the NHS can expect from their leaders and from

[5] NHS We are the NHS People Plan for 2020/21: NHS

each other. It builds on the creativity and drive shown by people in their response, to date, to the COVID-19 pandemic and the interim NHS People Plan[6]. It focuses on how everyone in the NHS must continue to look after each other and foster a culture of inclusion and belonging, as well as take action to grow the workforce, train people, and work differently to deliver patient care.

Financial challenge

- Since 2010, the NHS has been increasing its productivity faster than the rest of the UK economy[7].

- A long period of funding at levels below the long-term average, combined with inadequate workforce planning and insufficient investment in training, have resulted in a workforce which is not sufficient in size and capability to deal with the multiple challenges the NHS (and social care) is facing.

- In its submission to HM Treasury (HMT) on the Comprehensive Spending Review 2020[8], the NHS Confederation called for a multi-year funding settlement for the NHS, both in terms of revenue and capital spending, to support several key aims including additional investment to increase staffing levels by extending training places across all professions.

[6] Interim NHS People Plan: NHS Improvement
[7] office for Budget Responsibility: Chart 2.8: Fiscal Sustainability: September 2016
[8] Summary of our Comprehensive Spending Review Submission: NHS Confederation: October 2020

Workforce challenge

There are simply not enough people to meet demand[9] in health and social care.

- The NHS Long Term Plan[10] sets out the actions which are needed to ensure patients get the care they need, quickly, and to relieve pressure on accident and emergency units. New services, such as urgent treatment centres, are already being delivered across England.

- The NHS People Plan[11] sets out actions to support transformation across the whole NHS. It focuses on how everyone in the NHS must continue to look after each other and foster a culture of inclusion and belonging. Employers supported by the system must grow the workforce, train more people, and support them to work together differently to deliver patient care. The principles underpinning the plan are enduring and have the full support of employers. However, it is essential that these strategic aims are properly resourced and supported by analysis and numbers.

- We strongly endorse the review body's clear recommendation made in its 34th report that: 'A transparent NHS workforce strategy, covering all of the Agenda for Change (AFC) workforce, that aims accurately to forecast appropriate and safe numbers of people for patient care would allow the whole system to understand the needs of the service and, in the context of current shortages, would build confidence in the workforce planning process[12].'

- A target of 50,000 extra nurses is important and necessary yet it needs to be a part of a more comprehensive workforce

[9] The NHS Workforce in Numbers: Nuffield Trust: September 2021
[10] NHS Long Term Plan: NHS England and Improvement
[11] NHS People Plan: NHS England and Improvement
[12] NHS Pay Review Body: 34th report: July 2021

strategy (not just restricted to nursing) that demonstrates with evidence and future projections what the right number of people will be, how they will need to be deployed, what skills they will need, what the plan for funded training and development will be, and where in the country they will need to be deployed.

- This needs to be a plan which demonstrates how each part of the system is contributing, as well as how the problems in social care will be addressed and how employers will use a greater proportion of the domestic labour market.

- The NHS workforce is continuing to grow[13] but the growth in the numbers of people has not kept pace with the increasing demand for services. Workforce planning should be undertaken regularly and the significant gaps in the workforce must be addressed at a national level.

- Disparities between workforce capacity in and across service areas continue to widen. The number of full-time equivalent (FTE) nurses working in adult hospital nursing grew by 5.5 per cent in the year to June 2020, while the number working in community nursing grew only by 1.6 per cent, and by 3.8 per cent in mental health. Over the past ten years, only adult nursing and children's nursing have seen increases in FTE nurse numbers, while the numbers in community nursing, mental health nursing and learning disability nursing are all lower than they were in June 2010[14].

If they are to be sustainable, our health and care systems must chance substantially and quickly:

[13] The King's Fund: NHS Workforce: October 2020
[14] The Health Foundation: Building the NHS Nursing Workforce: December 2020

- The innovations that people have put in place during the pandemic demonstrate that policy makers need to allow local leaders and teams greater scope to upgrade and modify policy to support the health and care needs of local communities.

- The health and care system will need to embrace innovation and technology to support further improvements in levels of productivity.

- Technology provides new opportunities to create a richer workforce database and to analyse activity data more rigorously.

- Major public health issues around prevention, such as obesity, need to be addressed using public health initiatives which strengthen the partnership between publicly funded healthcare and personal lifestyle choices.

- The pandemic has demonstrated how people can be a powerful force for the introduction of successful change. It will be important for the people in the NHS and the local community to work together to identify and tackle the priorities.

- There is more and urgent work for NHS organisations to do to make the experiences of many people from ethnic minority groups match NHS People Plan’s ambition to make the NHS ‘the best place to work.’

- The priority given to mental health in policy announcements has not yet been reflected in numbers of people employed in mental health services. In future there must be a greater link between workforce development and our ambitions for patient services.

- To guard against the risk of even more people leaving the NHS, employers are putting the health and wellbeing of their people at the centre of their recovery plans. Their actions will

need to be underpinned and supported by sustainable investment to address issues over the medium-to-long term as well as short-term priorities.

- For those people thinking of retiring, employers are considering opportunities for them to retire and return, after confirmation of their pension benefits, as a means of retaining expertise and capacity.

- The report on the future of NHS human resources and organisational development[15] sets out how the people profession will look to work differently in the coming decade. The people professions, comprising human resources and organisational development practitioners, retain a key role in shaping the future of people delivering NHS services in line with the aims in the NHS People Plan.

- Employers must be properly supported to design workforce development strategies locally to make key professional careers more attractive to a local population.

NHS terms and conditions of service (Agenda for Change)

- Recruitment and retention do not depend only on pay or wider reward. Employers believe it is important to create a culture and environment where people want to work; where they feel safe to raise concerns and to learn from mistakes; where employers listen to and empower their people, work hard to keep them safe, and ensure bullying and harassment is not tolerated.

[15] NHS England and Improvement: The Future of NHS Human Resources: November 2021

- The NHS offers a competitive benefits package to support employers to attract and retain the high calibre people that the NHS needs, including a range of benefits exceeding those offered in many other sectors. This includes a holiday allowance of up to 33 days and sickness absence arrangements well beyond the statutory minimum, as well as access to a highly regarded pension scheme and support for learning, personal development, and career progression for full and part-time staff.

- The changes made in 2018 to the pay structure give employers scope to use it to support positive outcomes for patients. The NHS pay system can play a positive role in service improvement and encourage positive behaviours as part of appraisal discussions.

- The contribution of graduate-entry roles (and subsequent pay differentials) needs to be recognised within existing pay structures. Failure to act in this regard will result in distortions to the job evaluation system.

- Entry-level rates of pay in addition to continuing to be in line with government legislation (statutory national minimum wage) must be set at levels to enable and support employers to attract and recruit people in an increasingly competitive labour market.

Section 1: Informing our evidence

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 NHS pay and conditions of service.

Our evidence has been informed by a continuous cycle of engagement with a full range of NHS organisations about their priorities. Once again, the healthcare response to the pandemic was understandably the focus of much of our discussions and COVID-19 has restricted our face-to-face contact with employers. However, alongside employers, we have made extensive use of virtual technology and, when possible, we have:

- had direct discussions with NHS chief executives
- joined regional network meetings of workforce directors, the NHS Confederation and other employer networks
- carried out surveys on pay and total reward
- maintained regular contact with our policy board, which is made up of a cross-section of leaders from across the NHS.

Our submission reflects the views of employers on the combined effect of the financial, workforce and transformation challenges faced by the NHS and the impact of the pandemic. It considers the impact of the NHS We are the NHS People Plan and the strategic direction set out in the NHS Long Term Plan, and how these factors might

come together to influence employer decisions on pay and reward in 2022/23.

The Secretary of State for Health and Social Care wrote to the chair of the NHS PRB on 30 November 2021, setting out the remit for the review body's review of pay in 2022/23. With confirmation that the NHS budget has already been set until 2024-2025, it remains vital that planned workforce growth is affordable and within the budgets set, particularly as there is a direct relationship between pay and the number of people employed in the NHS.

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

The current economic context is and will remain a significant factor for the foreseeable future. A detailed account of the financial position of the NHS and the challenging economic factors affecting it will be provided by other stakeholders who are better placed to provide this evidence. We refer to these subjects in the contexts in which employers have raised them with us.

Section 2: NHS pay and conditions of service

Employers see pay as part of a much bigger picture in which they are making best use of and managing their people, exploring new ways of working, new care pathways, and collaborating in new ways with other organisations. This reflects the ambitions of the NHS Long Term Plan and the pillars and promises of the NHS People Plan.

Employers say that non-pay solutions are as important as pay in improving recruitment and retention, especially flexible working, but also education, training and development, and childcare provisions.

Determining the basic pay uplift on the basis of earnings increases for staff already employed in the NHS would, over time, result in the NHS pay structure falling behind the market. This impact would be greatest at the bottom and top of pay bands, with detrimental effects both for the recruitment of new people, and the retention of experienced people some of whom will not benefit from pay progression.

Leaders do not want a pay uplift in 2022/23 to be solely targeted at individual professional groups.

The level of pay and pay awards, both in absolute terms and relative to levels elsewhere in the economy, send a powerful message about the value of people who are working in an extremely challenging environment.

However, there are clear priorities for employers which support targeted investment for:

- people at the bottom of the pay structure
- those in pay bands 5 to 7
- those at the top of their pay bands who now reach this position more quickly and remain there for longer.

In pay band 5 the pay system needs to recognise additional responsibility which is short of the level of additional responsibility shouldered on promotion.

National policy on pay and reward needs to be aligned with and support these employer workforce policy priorities.

The recruitment problems faced by NHS organisations in many health professional groups are not helped by acute shortages of supply. It is accepted that these problems cannot be solved solely by action on levels of pay. This issue needs to be addressed urgently through evidence-based medium and long-term workforce planning, which is informed in the first place by the needs of systems, services and employers.

Career choice and recruitment and retention are influenced by potential lifetime career earnings, taking account of items of deferred pay such as pensions, and other benefits such as annual leave and family-friendly policies.

The NHS offers a competitive benefits package to support employers to attract and retain high-calibre people, including a range of benefits exceeding those offered in many other sectors. This includes a holiday allowance of up to 33 days and sickness absence arrangements well beyond the statutory minimum, as well as access

to a highly regarded pension scheme and support for learning, personal development, and career progression for full and part-time people.

The 2018 reforms of the NHS pay and conditions of service introduced common bereavement and parental care policies to support NHS people to balance their working lives with family and other caring and personal commitments.

In addition to tangible rewards, employees will also benefit from employers' commitment to meeting the aims of the NHS People Plan and People Promise.

Outside of any response to the workforce challenges provided by the pandemic, it is essential that we can continue to provide certainty on pay levels for our existing people and those we need to attract and recruit.

Funding pay awards

In support of these aims, national pay awards must remain fully funded and be affordable. There must be transparency of funding for those services commissioned via local authority and public health routes (as opposed to NHSEI).

Outside of the pandemic, the NHS has been increasing its productivity faster than the rest of the UK economy since 2010[16].

Still, funding pay uplifts through efficiency savings is not a viable option. The NHS has been set unrealistic targets for efficiency savings in the past. Employers have been prevented from meeting efficiency targets by the pandemic and service transformation. Further, the pandemic has caused numerous unforeseen cost

[16] Office for Budget Responsibility: Chart 2.8: Fiscal Sustainability: September 2016

pressures, including an increase in the use of paid overtime and agency and bank people due to workforce shortages.

We do not believe that transformation of the type and on the scale required can deliver major benefits in the short term; realising the benefits and improvements from new care models is a long-term project. It is too early to be confident about transformation and efficiency savings and it is possible that despite the integration of health and care, affordability pressures on employers will worsen in the medium term.

Job evaluation

The NHS pay and conditions of service reward package for people in the remit of the NHS PRB continues to be based on a fair and transparent pay structure underpinned by objective evaluation of job weight. The system is supported by employers and trade unions who participate in partnership to maintain their agreements through the NHS Staff Council.

Equal pay is a fundamental contractual right for all employees.

In the NHS, there is now a long-standing history of employers using an analytical Job Evaluation Scheme (JES) to enable organisations to assess jobs against common weighted criteria to determine an appropriate pay banding. This mitigates against any legal equal pay challenge. The scheme has been tested by tribunals and found to be a key part of delivering equal pay if it is implemented correctly by employers.

Employers support the current pay system and structure, including the JES, believing it to be appropriate to their needs for strategic workforce development.

In its 34th report[17] the NHSPRB said:

‘We would therefore encourage the parties to consider whether the AFC system accurately reflects the relative job weight of the realities, complexities and development trajectories of nursing as a modern graduate profession, best to enable the recruitment, retention and motivation of nurses in the short and medium term.’

This will be something for the NHS Staff Council to consider together in partnership. We will, therefore, be able to report on developments in future submissions.

The NHS JES is an analytical scheme which has a total of 16 factors that cover all demands of the large variety of roles within the NHS, attaching points to factor levels to bring about a total. That total then places the role in a pay band.

The scheme was developed in partnership at national level with NHS managers, trade unions and equal pay experts and is still implemented in partnership at local level following the rules set out in the Job Evaluation Handbook.

The expertise of the NHS Staff Council Job Evaluation Group (JEG) undertook the creation, testing and training in the scheme and now ensures it remains fit for purpose. Profiles were created as a method of matching clusters of jobs with the same or similar job description, to evaluations of actual jobs that were commonly occurring roles within the NHS, without the necessity of evaluating each job separately. This was particularly important during the original assimilation of over one million jobs to the new pay system.

The NHS Staff Council Job Evaluation Handbook[18] sets out the steps needed to match a job to the appopriate banding. This process is a

[17] NHS Pay Review Body: Thirty Fourth Report: July 2021
[18] NHS Job Evaluation Handbook: NHS Employers: September 2018

guide and employers and trade unions working together in partnership must go through the banding and evaluation process.

2018 pay and conditions of service

In December 2021, NHS Employers issued a questionnaire asking employers for their feedback on several issues relating to the 2018 NHS pay and conditions of service. We are analysing employer answers to our questions and will give the NHS PRB a full report on the results once we have them. This will be in the form of a supplementary submission to our main evidence.

There is no doubt that the recent increase in applications for places on nurse training courses is due to the positive publicity the NHS received during the pandemic. Respect for the NHS as a national employer of trained and qualified people has grown.

The quality, as well as the number, of employed people and applicants is crucial to delivering effective and efficient healthcare. The quality of people depends on several factors, including procedures for appointing people, access to training and people development, and appraisals. It is important that workforce planning considers the quality of people, as well measures for ensuring that there are sufficient people of the appropriate quality.

We say more about workforce planning in section 5.

It is vital that this cohort of new recruits can feel early on that their contribution is being fairly rewarded, that they progress in their roles and that their increasing contribution is matched by their total reward package.

Building on the changes made in 2018, the further 3 per cent pay increase effective from 1 April 2021 has increased the starting basic pay for full-time healthcare assistants by £541, by £748 for newly

qualified nurses, and by £1,373 for modern matrons[19]. Unsocial hours payments and high-cost area allowances also increased in line with the pay award.

These developments have been welcomed by NHS leaders. However, given the wider inflationary pressures and some other planned changes, trade unions remain dissatisfied with the levels of pay on offer to people working in the NHS. This dissatisfaction has created the potential for industrial relations unrest.

The 2018 pay structure gives employers scope to use it to support positive outcomes for patients. By encouraging positive behaviours in appraisal discussions, for example by focusing on how to increase the number of successful treatments and minimise readmissions, the NHS pay system can play a positive role in service improvement.

Given the high proportion of NHS costs that are attributable to the pay bill, employers must always ensure that pay costs are affordable in-year and sustainable over the medium-to-longer term. Not only do employers need the workforce to be engaged in reducing the backlog of care, they are also asking it to deliver large-scale transformational change while services are recovering from the pandemic.

Despite the benefits of the 2018 pay reforms, employers in certain parts of the wider system still face challenges in attracting high-calibre people, considering present labour market conditions resulting from post-Brexit migration rules and the impact of the pandemic. Reward for excellent performance is a matter for employers. It is often recognised in local total reward schemes through annual awards, and the emphasis on job evaluation in the NHS pay system creates a focus on responsibilities and less on outcomes. However, opportunities for nurses and other professionals to move upwards in the grade structure are limited, and this is an area of increased concern for employers.

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[19] After the Dust Settles: Nuffield Trust: August 2021

The contribution made by graduate-entry roles (and subsequent pay differentials) must be set at levels to enable and support employers to attract and recruit people in an increasingly competitive labour market.

We say more about employer total reward schemes in section 6.

The Health Foundation[20] has noted that the seven-year public sector pay cap, which ended in 2017, led to a significant drop in nurses' pay compared to overall average earnings across the wider economy.

Recent employer feedback on pay and reward has referred to several areas of need:

- To consider not just the level of pay, but the entire employment package offer. Action at national level must support employers to effectively and efficiently allocate resources to where they are needed most, without creating additional cost pressures.

- For the national pay system to ensure that employers can offer a competitive employment package that supports employers to recruit, retain and motivate the highly skilled and committed workforce that is needed, whilst maximising their contribution and engagement.

- For national pay developments to support employer efforts to reduce the cost of people hired from agencies and increase people in post.

- For national pay strategy to be aligned to the overall strategic direction set out in the NHS Long Term Plan and NHS People Plan.

[20] Nurses' Pay Over The Long Term: The Health Foundation: November 2021

- For sufficient flexibility in the national pay and conditions system to allow employers to compete, where necessary, in local and wider labour markets for new recruits.

- To be mindful that increases in high-cost area (HCA) allowances put further pressure on those organisations just outside the HCA geographic zone.

When speaking about strategy in their organisations, employers have referred to a number of areas:

- Their focus on retention of people using retraining where possible or changing skill mix where appropriate; developing a supportive and nurturing organisational culture and a reputation for high standards of compassionate care; being seen as good employers; addressing inequality for marginalised and discriminated-against groups; operating robust strategies to reduce absences, providing occupational health support and, where possible, appropriate rapid access to treatment. Employers do not see this last action as being at odds with their responsibility to deliver patient care.

- The need for the pay system to facilitate additional reward in support of job and service re-design and encourage recruitment and retention in parts of the country and in occupations where vacancies are high. But, we have not received information to suggest that employers are increasing their use of local recruitment and retention premia (RRPs). Employers wish to avoid creating competition on pay amongst neighbouring trusts, which tends to drive wage inflation particularly where the root cause is undersupply.

- The need for the pay system to recognise additional responsibility which is short of the level of additional

responsibility shouldered on promotion.

- Maintain alternative supply routes that can supplement the predominant university-based undergraduate routes. Degree apprenticeships and return to practice are two important features, along with international recruitment.

- The importance of flexible working policies as part of policies to attract, recruit and retain people. The NHS Staff Council, on behalf of NHS trade unions and employers and in support of the NHS People Plan, has jointly agreed revisions to Section 33 of NHS terms and conditions of service (TCS) handbook[21], which are designed to support a cultural change towards ensuring flexible working is available to all NHS staff.

- Collaborative arrangements with employers working together to develop shared roles.

- Bank and temporary people as a potential target for recruitment.

Increasing numbers of employers have started to offer people working in highly pressurised areas enhanced rates for additional shifts. We do not have sufficient information about this development now to report on it in detail. It is possible that it is a result of the challenging combination of workforce gaps, intense pressure on a limited number of people, and the cumulative effects of working so hard for so long. It is becoming increasingly difficult to ask exhausted people to work additional shifts to cover workforce gaps.

[21] Guidance for Joint Union-Employer Partnerships: NHS Staff Council: July 2021

> NHS starting pay for graduates is an anchor point from which salaries at different stages in an NHS employee's career might be compared with those elsewhere in the economy.
>
> In the UK the salaries earned by graduates vary by sector, location and occupation.

Starting salaries for graduates in the public sector mean the NHS now faces stiff competition.[22] [23] The Higher Education Statistics Agency[24] has produced analysis of salaries of UK domiciled full-time graduates who obtained first degree qualifications and entered full-time paid employment in the UK. Their analysis by subject area of degree and skill marker relates to the academic years 2017/18 to 2018/19. Although this data and analysis is a little out of date it further highlights the competitive nature of this part of the labour market.

The Graduate Market in 2021[25] details the median starting salary for new graduates in 2021 as £30,000. Starting salaries vary by sector, from an average of £24,200 in the public sector, to £32,500 in banking and finance, £46,000 in law, and £50,000 in investment banking.

Sources tend to show the highest salaries in banking and finance and the law, but these are not representative of the overall market.

Whilst the starting pay for NHS graduate professionals does not always match pay on offer in these sectors, it has increased in recent years. The band 5 minimum was £21,176 in 2010/11 and in 2021/22 is £24,907, which is an increase of 18 per cent. The current starting

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[22] Target Jobs: Starting Salaries For Graduates
[23] Graduate Public Sector Jobs: Milkround
[24] Graduate's Salaries: Higher Education Statistics Agency

[25] The Graduate Market in 2021: High Fliers Research Ltd

point is also higher in the NHS where the high-cost area supplement (HCAS) is applied and is £30,786 in inner London.

On average, the country's top employers have received 41 per cent more graduate job applications so far, compared with the equivalent period in the 2019-2020 recruitment round, the highest-ever annual increase recorded by this research.

Employers are continually emphasising the many benefits of NHS employment and careers, including annual leave, personal development and career progression, sick leave and pay, paternity and maternity leave and the highly regarded NHS Pension Scheme. Total reward remains a powerful recruitment and retention tool and a means of motivating people. Pensions and flexible working are important parts of the NHS total reward package. NHS organisations will need to promote the attractiveness of the employment offer in the NHS, particularly to remain competitive in the eyes of the next generation of entrants.

We say more about total reward in section 6.

In its report on historic nurse pay levels, the Health Foundation[26] suggests there was widespread recognition of scope to optimise and update the pay progression mechanisms to better recognise people with high levels of skills, experience and advanced practice contributions. The most common issue stakeholders highlighted for examination was the need for improved pay rates and career pathways for experienced, enhanced, and advanced practice nurses. Many thought the current pay structure was too compressed, with insufficient overall progression before reaching the top of pay bands. A major potential retention mechanism they identified was introducing scope for experienced and advanced practice nurses to progress to higher pay rates.

[26] Nurses' Pay Over The Long Term: The Health Foundation: November 2021

The construction of the pay spines in the NHS pay and conditions of service is set out in the table below. People are normally promoted when they have reached the top of their pay band. The pay increase that an employee normally receives on promotion is the value of the gap between their current pay in their existing pay band – normally the top pay point in the band – and the minimum pay point in the next higher pay band.

Band	Pay point	Current Pay Spine	Spine Difference	Band Difference
1	Spot salary	£ 18,546		£ -
2	Entry	£ 18,546	£ -	
	Top	£ 19,918	£ 1,372	£ 412
3	Entry	£ 20,330	£ 412	
	Top	£ 21,777	£ 1,447	£ 772
4	Entry	£ 22,549	£ 772	
	Top	£ 24,882	£ 2,333	£ 773
5	Entry	£ 25,655	£ 773	
	Intermediate	£ 27,780	£ 2,125	
	Top	£ 31,534	£ 3,754	£ 772
6	Entry	£ 32,306	£ 772	
	Intermediate	£ 34,172	£ 1,866	
	Top	£ 39,027	£ 4,855	£ 1,030
7	Entry	£ 40,057	£ 1,030	
	Intermediate	£ 42,121	£ 2,064	
	Top	£ 45,839	£ 3,718	£ 1,287
Band 8a	Entry	£ 47,126	£ 1,287	

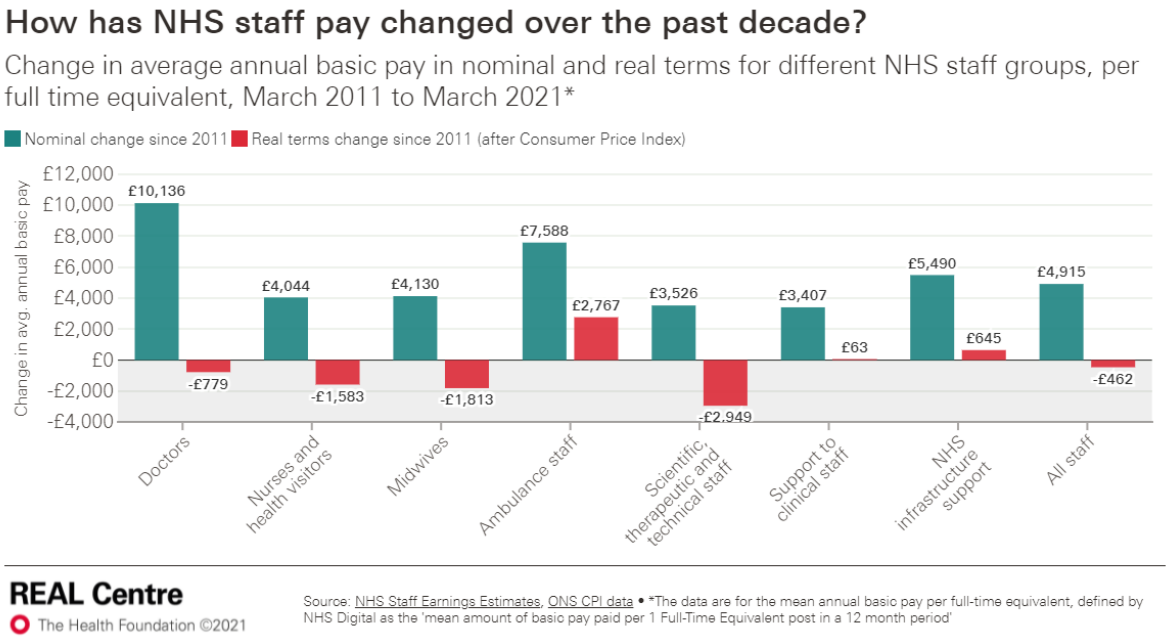
	Top	£ 53,219	£ 6,093	£ 1,545
Band8b	Entry	£ 54,764	£ 1,545	
	Top	£ 63,862	£ 9,098	£ 1,802
Band 8c	Entry	£ 65,664	£ 1,802	
	Top	£ 75,874	£ 10,210	£ 2,318
Band 8d	Entry	£ 78,192	£ 2,318	
	Top	£ 90,387	£ 12,195	£ 3,348
Band 9	Entry	£ 93,735	£ 3,348	
	Top	£ 108,075		

The Health Foundation[27] has suggested that NHS nurses' basic earnings grew by 13 per cent in nominal terms between March 2011 and March 2021. However, after accounting for consumer price inflation, this amounts to a 5 per cent reduction in real terms.

Employers are concerned about perceptions of unfairness, with potential impact on recruitment, retention and motivation, if their people are expected to absorb additional cuts in their take-home pay while workloads are increasing. We say more about the pressures on household incomes in section 3.

In an earlier publication, the Health Foundation demonstrated its analysis of changes in average annual basic pay in nominal and real terms for different NHS workforce groups, per full-time equivalent, March 2011 to March 2021.

[27] The Health Foundation: Nurses Pay Over The Long Term: November 2021



The Health Foundation: How has NHS Staff Pay Changed Over the Last Decade: July 2021

Since 1989, female full-time nurses' average weekly gross earnings have grown more rapidly than comparable public sector occupations such as police officers and secondary teachers, including in the last decade with its public sector pay cap period.

The Foundation suggests that further flexibilities in pension contribution and payments throughout all stages of a career could encourage more nurses to remain in work or return to work.

There is currently a very small salary gap (just £772) between the top of pay band 5 and the bottom of band 6. This sees limited opportunity for increases in base pay levels for staff within band 5 without going into a higher-level band 6 role.

Employers do not want the top pay points in lower pay bands to overlap with the bottom pay points in higher pay bands anywhere in the pay structure. One of the aims of the 2018 reforms was to eradicate this unhelpful feature of the pay system. If proportionate increases to both the maximum pay point of band 5 and the entry level point for band 6 were applied, this would prevent

an overlap while providing additional incentive to people who have become capable in their roles but for whom no immediate vacancy in a higher pay band is available.

Alternatively, there could be additional responsibilities and development opportunities to improve retention rates within this cohort.

Employers are also keen to maintain adequate differentials between pay bands 6 and 7. The pay gap between the top pay point in band 6 and the bottom point in band 7 is £1,030. People undertake a significant increase in responsibility and/or skill level when they are promoted from roles in band 6 to those in band 7. It is vital that talented and committed people are rewarded for taking this important step.

Minimum pay

In the Autumn Spending Review, the government announced that the national living wage (NLW) paid to workers aged 23 and over will rise from £8.91 per hour to £9.50 per hour from 1 April 2022. The minimum pay point on the NHS pay structure effective from 1 April 2021 provides £9.49 per hour. To be legally compliant, (at a minimum) the bottom pay point of band 2 will need to be adjusted on 1 April 2022 to comply with the law.

Pay band 2 is now the minimum entry level of pay into an NHS career. It is vital that there is early and sustained additional investment in pay at this level. Adequate pay in band 2 will prevent the NHS being labelled as a low-pay employer and enhance its standing in the local communities from where so many staff at this level are recruited.

At entry level pay the NHS is facing stiff competition from the retail sector[28]. Policy changes such as the government's new immigration system mean that international recruitment of lower paid NHS people might become more difficult, especially if there is a shortage of these people in other sectors of our economy. We refer to the competitive nature of the employment market in section 3.

The Boorman Review[29] made clear that the health and wellbeing of people working in the NHS affects quality of care. This is no less true of lower paid staff who are an important part of the wider team.

NHS Digital data consistently shows that sickness rates for people in pay band 2 staff are significantly higher than those for people in band 9.

In its 34th report[30] the NHS PRB noted that the government has asked the Low Pay Commission (LPC) to make increases to the NLW towards a target of two-thirds of median earnings by 2024, taking economic conditions into account. The LPC has said that its best estimate of the increases required to meet this target would be for an NLW of £9.42 from April 2022 (an increase of 5.7 per cent from the 2021 rate) and £10.33 from 2024 (an increase of 15.9 per cent from the 2021 rate).

Pay in band 2 will remain an important issue for employers.

We refer in section 6 to issues that possible changes to pension contributions might cause for staff in the lower pay bands. Maintaining scheme membership amongst lower earners is likely to become increasingly difficult. This strengthens the argument for flexible accrual rates for all members of the NHS Pension Scheme.

[28] BBC News: Lidl to Become UK's Highest-Paying Supermarket: November 2021
[29] NHS Health and Wellbeing Review: Steve Boorman: November 2009
[30] NHSPRB 34th report 2021: gov.uk: July 2021

The NHS We are the NHS People Plan[31] confirms that NHSEI will work with the NHS Staff Council to develop guidance to support employers to make flexible working more widely available to their people.

To support employers to embed revisions to the national conditions of service on balancing work and personal life, the NHS Staff Council has produced guidance[32] detailing the need for effective partnership working to take place between unions and employers. NHS Employers, in partnership with the NHS Staff Council, has produced information[33] on the actions employers can take to promote a culture of flexible working.

The NHS Staff Council continues to publish updates on the work it is doing in partnership[34].

BME

Information published by the Health and Race Observatory[35] shows that for some black and minority ethnic people within some occupational groups there exist pay gaps favouring white people.

Workforce Race Equality Standard (WRES) data, specifically indicators 1, 2 and 7 shows that:

- people from black and minority ethnic backgrounds are disproportionally less likely to be in senior positions, less likely to be appointed from shortlisting, and less likely to believe that their organisations provide equal opportunities for career progression.

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[31] We are the NHS People Plan for 2020/21
[32] NHS Staff Council Guidance On Reviewing Flexible Working Policies: NHS Employers
[33] Flexible Working: Enablers for Change: NHS Employers
[34] NHS Staff Council Joint Statements and Papers: NHS Employers
[35] The Ethnicity Pay Gap in the NHS: NHS Race and Health Observatory: May 2021

- while there is a small gap (equivalent to £13 per month) in favour of Asian/Asian British people compared to white people, for mixed heritage people the pay gap is £117 per month in favour of white people.

- white people earn around 9 per cent more than black / black British nursing people and nearly 11 per cent more than Asian / British Asian managers.

As male and white people are more likely to be in higher paid roles, they will have benefited more on average from a percentage uplift to pay than their female and BME colleagues.

We say more about this in section 5 where we refer to the action NHSEI is taking with employers.

Section 3: Policy and financial context

Adequate financial resources, targeted effectively, are essential if the NHS is to recover from the pandemic and tackle the backlog of elective care. Achieving these aims will require investment in workforce first. The system must employ enough people with the right skills deployed in the right places and they must all be adequately supported.

Comprehensive staff engagement strategies support motivation. A well-motivated NHS pay and conditions of service workforce can make a substantial contribution to delivering the structural changes underway. Adequately resourced and planned training and development must be an important part of engagement strategies.

Many of the problems NHS leaders now face existed before the pandemic.

The health and care system must recover not just from the impacts of the pandemic but also from a long period of reduced investment. The King's Fund[36] has noted that 'NHS budgets rose by 1.4 per cent each year on average (adjusting for inflation) in the ten years between 2009/10 and 2018/19 compared to the 3.7 per cent average rises since the NHS was established.'

[36] The NHS Budget and How It Has Changed: The King's Fund: March 2021

The Institute for Fiscal Studies has said that immediately before the pandemic the waiting list for elective treatment had grown by 50 per cent since 2015[37]. Between 2009−10 and 2019−20, UK government health spending was 'lower than any previous decade in NHS history.' The NHS entered the pandemic with around 39,000 nursing vacancies in England.

As a sector, NHS trusts have not been in financial balance since 2012/13[38]. Trusts in financial difficulty have been dependent on short-term measures to meet their financial targets, including loans issued by DHSC to pay for their day-to-day services.

The 2021 Autumn Budget confirmed that NHSEI's resource budget will rise to £162.6 billion by 2024-25. This is 3.8 per cent average real-terms growth up to 2024/25. Around £10 billion is expected to be spent on the elective care backlog. Yet the Health Foundation[39] has suggested that around 17 billion would be needed over the life of this parliament to help the NHS achieve the 18-week waiting time standard by 2024/25.

Before the 2021 Autumn Budget, the NHS Confederation and NHS Providers[40] said in a joint report that at least £10 billion of funding would be needed to cover ongoing COVID-19 costs and support the NHS to recover from the pandemic. Although the Budget provided substantial new funding, it is less than NHS Confederation members estimated they would need.

The NHS Confederation[41] set out the benefits of capital investment in its report Beyond Bricks and Mortar. The overall DHSC capital budget increase in the Budget and the scope for health and care systems to spend it according to their need is welcomed. Yet the Confederation has noted that the capital budget will now only return

[37] Institute for Fiscal Studies: the NHS Before Covid: September 2021
[38] NHS Capital Expenditure and Financial Management: Eighth Report: June 2020
[39] The Health Foundation: Almost £17bn Needed: September 2021
[40] A Reckoning: The Continuing Cost of Covid 19: NHS Confederation and NHS Providers: October 2021
[41] Beyond Bricks and Mortar: NHS Confederation: October 2021

to the level it was in 2010. The years that followed saw a steady decrease in capital funding and the UK falling behind OECD countries.

The NHS's maintenance backlog is estimated to stand at around £9.2 billion[42].

The £150 million of capital funding for mental health announced in the budget falls short of the estimated £3 billion that is needed to make mental health estates safe[43].

There are deep-rooted problems in our health and care system which cannot be fixed quickly. Many of these are linked to a long period of reduced resource. Investment in public health and the prevention of ill-health has also suffered from a long period of under investment. Although the October 2021 Budget maintained investment in public health in real terms, the Health Foundation[44] has commented that this fails to reverse the 24 per cent real-term per capita cuts in investment since 2015/16. Future demand for health and care services is likely to increase.

We are concerned that the announcements made in the October 2021 Budget did not include a long-term workforce funding settlement.

The Budget repeated the commitment to 50,000 more nurses but it did not specify how increases in the size of the workforce and training would be funded.

Although the new resource for technology and buildings is important and welcome, it can only be effective if there is additional investment in the workforce.

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[42] The King's Fund: The Latest on the NHS Estate: October 2021
[43] NHS Confederation: Autumn Budget and Spending Review: October 2021
[44] Health Foundation Response to Spending Review 2021: The Health Foundation: October 2021

The Budget provided substantial new investment and employers are committed to redoubling their efforts to ensure this is put to good use. The range and amount of service adaptation and the speed with which it has been implemented since the start of the pandemic is unprecedented. The NHS's people have risen to the challenges by bolstering emergency preparedness and resilience and using innovation, commitment and compassion.

The Health Foundation[45] has highlighted how important it will be for employers to maximise productivity in the years ahead to meet the growing demand for services. The Foundation highlights changes to skill mix, patient journey and improving the use of technology as important enablers of productivity gains. Quality improvement is driven by frontline teams. Employers will need to continue to engage their people to harness the capability of teams. This will be a much more effective approach than setting out performance targets driven by economics.

Competition and overbearing regulation stifle the creative energies of the workforce and hamper employer efforts to enable their people to work at the top of their skills sets more often.

Economy

The economy has been benefitting from the progress of the vaccination programme, easing of social distancing restrictions, spending from personal financial savings made during the lockdowns, delayed consumer demand, and a range of government interventions.

The possible emergence of new variants of the virus that are less responsive to the current vaccines still poses a risk to tax revenues,

[45] Five Things We Have Learned from Our Work on NHS Productivity: Health Foundation: October 2021

albeit less severe than previously, as the population and economy have adapted to operating under social distancing restrictions.

While public sector finances are improving, they have become more vulnerable to a rise in interest rates.

The cost of living is rising. Inflation was at 4.6 per cent for the year to November 2021 on the CPIH[46]. This was up from 3.8 per cent in the 12 months to October 2021.

Fuel and gas prices have been rising and National Insurance contributions paid by employers and employees[47] are to rise by 1.25 per cent from 6 April 2022 to 5 April 2023. In the Autumn Budget the personal allowances for income tax for 2022/23 were frozen at the 2021/22 levels[48].

The Resolution Foundation has analysed household disposable income since 1955[49]. The Foundation refers to Office for Budget Responsibility projections showing that rolling one-year growth in annual real household disposable income per person remains below the 1995 to 2021 average and may do so up to and beyond 2025. The 15 years from 2007 to 2022 are forecast to be the worst on record for household income growth.

The NHS is operating in a competitive labour market. Analysis by the Institute for Employment Studies[50] of the labour market statistics published by the Office for National Statistics in September 2021 shows that the labour market is recovering strongly.

In February to April 2021, the number of job vacancies in the economy reached its highest level since January to March 2020, with

46 Inflation: Office for National Statistics
47 National Insurance: gov.uk
48 Income Tax Rates and Personal Allowances: gov.uk
49 Resolution Foundation: Are You Better Off Today: November 2021
50 Institute for Employment Studies: Labour Market Statistics: September 2021

most industries displaying increases over the quarter, Most notably, accommodation and food service activities.

The number of job vacancies in August to October 2021 rose to a new record of 1,172,000, which is an increase of 388,000 from the pre-pandemic January to March 2020 level[51].

Young workers and older workers have been most likely to have left employment and are most likely to have become economically inactive. However, the larger rises in unemployment have been for those aged between 25 and 64[52]. There is scope for the NHS to tap into a potential pool of talent by using apprenticeships. We say more about this in section 7.

Pay band 2 is now the minimum entry level of pay into an NHS career. It is vital that there is early and sustained additional investment in pay at this level. Adequate pay in band 2 will prevent the NHS being labelled as a low-pay employer and enhance its standing in the local communities from where so many staff at this level are recruited.

In pay band 5 the pay system needs to recognise additional responsibility which is short of the level of additional responsibility shouldered on promotion.

Workers who are from an ethnic minority group, women, young workers, low-paid workers and disabled workers have been most negatively economically impacted by the pandemic.

The Institute for Employment Studies suggest that the recovery is weaker for women than men, with part-time work not recovering to the same extent as full-time work[53]. At the same time though, the number of people in part-time work because they cannot find a full-

[51] Office for National Statistics: Vacancies and Jobs: November 2021
[52] House of Commons Library: Coronavirus: Impact on the Labour Market: June 2021
[53] Institute for Employment Studies: Labour Market Statistics: September 2021

time job remains above pre-pandemic levels, as does the number in involuntary temporary work. The Institute suggests this means that even with labour shortages and high demand, many people in the labour force may not be getting the flexibility or job security that they need.

This may present another opportunity for the NHS to attract new talent and we refer to action by employers in the NHS on flexible working in section 5.

The NHS can offer opportunities and economic security for its people, especially in areas where there has been a reduction in economic opportunity. The NHS offers reliable, stable employment. It is not going to withdraw from an area, even if local services are realigned, making it uniquely positioned to provide long-term economic opportunity at a time when employment prospects are uncertain.

Pressures

There are already multiple calls on the extra NHS funding:

- Reducing the elective care backlog.
- Rising demand for urgent and emergency care.
- More people needing mental health support.
- Rising employer costs due to increased National Insurance contributions.

Employers are committed to maintaining and improving high levels and standards of patient care, but they cannot tackle these pressures and absorb the additional expenditure that will arise from training and educating more people. There must be additional investment in HEE budgets.

Growth in patient demand is hard to predict but we know that millions of patients did not access care during the pandemic and the health

problems of many of these have worsened. As they now come forward for treatment their needs will be greater. We know also that there are many who will place increased and possibly long-term demand on mental health services. One estimate from the Institute for Fiscal Studies[54] is that this alone could cost around £1 billion pounds.

Looking further ahead, the Institute for Fiscal Studies says: 'But this new funding announcement is far less likely to be sufficient in the medium term. The extra funding provided for the NHS in the recent announcement will result in spending growing at 3.9 per cent a year between 2018−19 and 2024−25, the same rate of growth as was planned between 2018−19 and 2023−24. That suggests that these new plans allow for little or no long-term additional costs because of the pandemic, whereas we estimate that virus-related pressures could amount to £5 billion in 2024−25. Meeting those ongoing pressures would likely require additional funding, or less spending elsewhere in the NHS.'

The Health Foundation[55] estimates that meeting new or exacerbated health needs, particularly rising rates of mental ill-health, will require an average of £1.1–1.4 billion extra each year. Tackling the backlog of demand for elective care and restoring waiting times standards by 2023/24 would cost an extra £1.9 billion in each of the next three years. Yet this represents an 11 per cent uplift in activity which the Foundation does not believe to be feasible. Achieving this by 2026/27, at a cost of £0.9 billion a year, would be more realistic.

Additional infection control measures will continue to reduce what the NHS can deliver for the given level of funding. The Foundation estimated that assuming productivity in 2021/22 is 5 per cent lower than pre-pandemic expectations, the additional costs involved in

54 Institute for Fiscal Studies: the NHS Before Covid: September 2021
55 The Health Foundation: Spending Review 2020: November 2020

delivering care would be £7 billion in 2021, falling to an additional £3 billion by 2023/24.

The Foundation also believes that the ability of the NHS to recover from COVID-19 and deliver the long-term plan also depends on increasing the NHS workforce. Investment to train more nurses, and other healthcare professionals, cannot wait and must be sustained over the long term. This will require additional spending over the 2019/20 budget of £600 million next year, rising to £900 million by 2023/24.

It is vital that the contribution of graduate-entry roles (and subsequent pay differentials) must be set at levels to enable and support employers to attract and recruit people in an increasingly competitive labour market.

In September 2021, the Health Foundation[56] published its assessment of how much funding the health and care system will need in the next decade. This includes overall DHSC budgets, day-to-day NHS funding and the funding made available to local authorities for adult social care.

The Foundation estimates that in the longer term to 2030/31, there will need to be real-terms average annual increases in NHS funding of 3.1 per cent, or 3.5 per cent depending on whether the ambition will be to achieve stability or recovery after the end of the pandemic. Stabilising the health and care system in the short term would require additional NHS funding over and above that set out in the NHS Long Term Plan of around £4.7 billion in 2021/22, £4.0 billion in 2022/23 and £2.9 billion in 2023/24. The scenarios the Foundation has modelled include funding to enable a modest expansion in the availability of adult social care services, support provider sustainability and pay social care workers more.

[56] Real Centre Projections: The Health Foundation: September 2021

We would prefer to see organisations across local systems working together as a single team using resources effectively to improve local services and the people experience.

Commissioners are only able to take responsibility for health risks to their local population if the overall funding allocated to the NHS and to the commissioner matches the demands placed on them.

Transformation (new care systems)

The aim behind service transformation has been to put health services on a sustainable footing.

The NHS Long Term Plan focused on improving services outside hospitals and the creation of integrated care systems, which now cover all parts of England. These systems aim to support productivity and sustainability of health and care services.

NHS leaders want these changes to allow them scope to direct resources to deliver the outcomes they have determined through knowledge of, and consultation and collaboration with, local communities and populations.

The pandemic has speeded up the shift toward integrated services both within the NHS and with partners in local government and the voluntary sector. NHSEI has set out how it sees this new drive toward integrated services focusing on population health[57] and the associated changes to legislation.

In the NHS, primary care, community health and mental health services are being combined, and partnerships are being created

[57] Population Health: NHS England and Improvement: August 2021

with social care and public health, other local government services, and the voluntary sector.

Performance management of individual providers is unlikely to encourage system working. Partners in new care systems need to adopt inclusive and compassionate leadership styles and cultures. Employers need to be supported to further improve diversity and treatment of people from ethnic minority backgrounds, as well as create a positive working environment in general that will encourage people to join and stay in work.

Integrated care systems need to plan to make sure people get the right treatment in the right place at the right time, managing activity away from acute services where possible to where people can be better cared for. More attention needs to be given to relationships and support outside the formal healthcare system.

Training and recruitment must be coordinated across all sectors and must be better resourced.

Section 4: Pandemic

Employers continue to prioritise their support to a workforce which is exhausted after more than a year of dealing with the pressures created by the pandemic. When the NHS workforce started to deal with the pandemic it was behind many other health systems in terms of capacity. The operational guidance rightly encouraged people to take time off to recover, but this was a challenge for many teams and departments where limited numbers of people and vacancies exacerbated the pressures.

The Health Foundation[58] has said that at the start of the pandemic the NHS faced workforce shortages of over 100,000 people. Around 40 per cent of the workforce shortfall was in nursing. The biggest risk during the pandemic was not having enough people to safely treat all the patients needing care.

Research by the Nuffield Trust[59] shows that when the pandemic started, the UK health system had higher occupancy rates, lower people capacity and fewer capital assets than many other countries.

A poll of NHS leaders conducted by the NHS Confederation[60] found that they regarded levels of pressure on their health services as unsustainable and that patient safety and care was being put at risk. Workforce shortages were a major factor in this assessment.

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[58] The Health Foundation: Action Required to Make Workforce Shortages a Thing of the Past: May 2021
[59] Resuming Health Services During The Pandemic: Nuffield Trust: July 2020
[60] NHS Confederation: November 2021

Early in 2021, NHSEI wrote[61] to NHS organisations to outline phase four of the response to the pandemic and the NHS's priorities from 1 April 2021. The focus for this phase set out in implementation guidance[62] has been to restore services, meet new care demands and reduce the care backlogs that are a direct consequence of the pandemic, whilst supporting people to recover and taking further steps to address inequalities in access, experience and outcomes.

We were pleased to see the priority given to workforce wellbeing and recovery within the implementation guidance, as well as the commitment to invest in and expand mental health hubs.

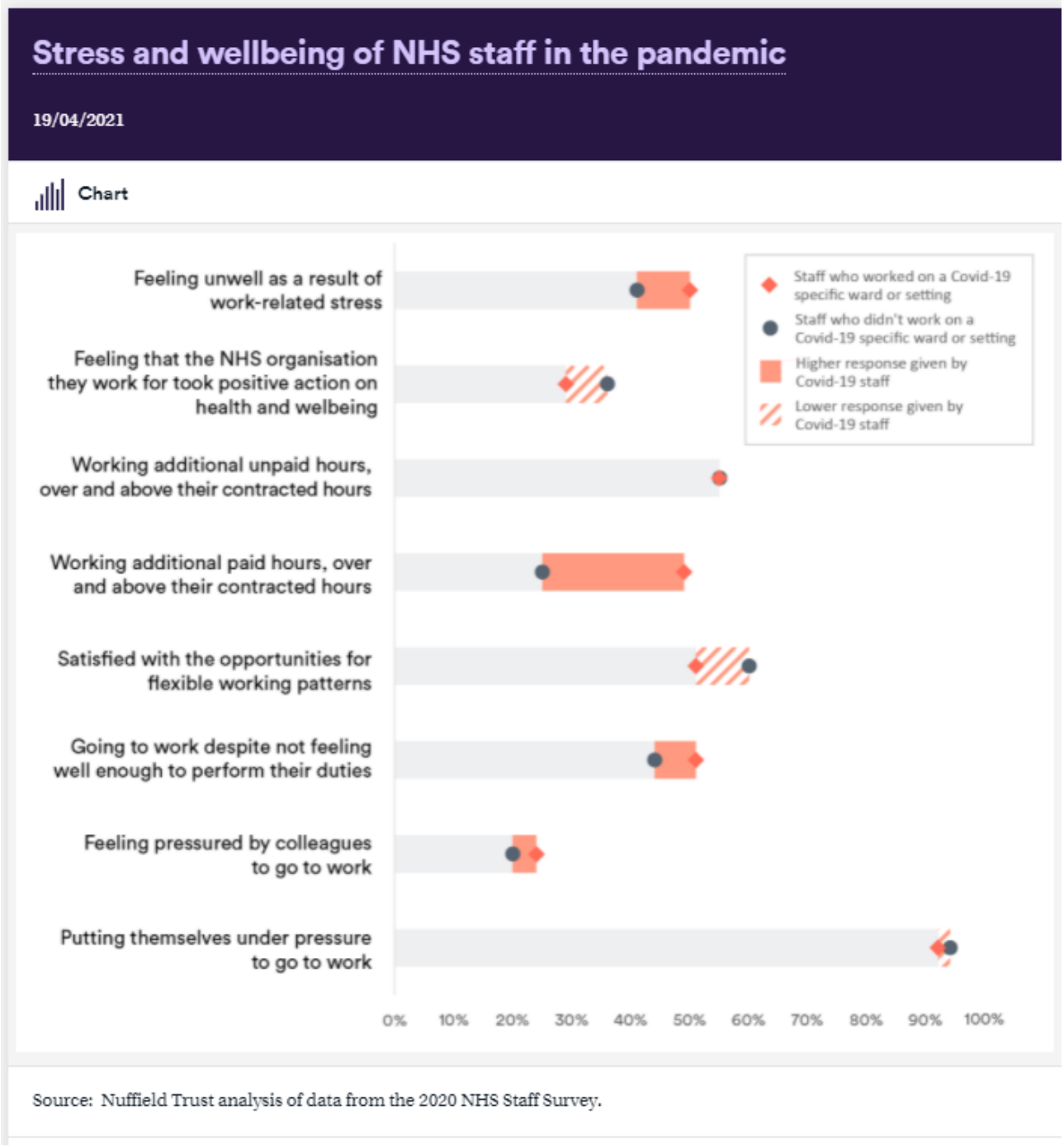
The pandemic continues to present an enormous challenge to our health and care system.

That said, it has been a catalyst for greater local partnership and system working, inspiring partners to discuss and agree actions for the benefit of their local communities.

In the most recent NHS Staff Survey in September 2020[63] , half of all people who responded who were working with COVID-19 patients experienced illness because of work-related stress, compared to 41 per cent of those not working in COVID-19 settings.

Research[64] has found substantial rates of probable mental health disorders, and thoughts of self-harm, amongst people working in intensive care units.

61 NHS England and NHS Improvement: Operational Planning Guidance: March 2021
62 NHS England and NHS Improvement: 2021/22 Priorities and Operational Planning Guidance: March 2021
63 NHS Staff Survey Results: September 2020
64 National Library of Medicine: Nurses Working in Intensive Care: April 2021



[Nuffield Trust: The Work-Related Stress of NHS Staff during COVID-19]

The NHS response to the pandemic has produced several important changes[65]:

- There has been a greater focus on the health and wellbeing of people, including more opportunities to reflect on the emotional aspects of work[66].

- Some governance and decision-making has been simplified. People have been empowered to implement changes that have benefitted patients

- Getting to grips with inequalities: employers are strengthening the role of BME staff in decision-making. This includes visible role models, peer support, safe spaces to share experiences, and forums to shape and influence change across organisations

- Flexible and remote working: teams have been running virtual multi-disciplinary team meetings, case presentations and handovers, and teaching sessions. People have found this format more productive, with less time spent travelling and better turnout at meetings, as well as improved work-life balance

- People returning to practice: workforce numbers have been bolstered by clinicians from academia, retirement and other industries. Students have stepped out of training to increase their direct support to patient care. People have been redeployed to areas experiencing pressure

- Innovative roles: existing staff have taken on new roles. This has improved relationships across multidisciplinary teams and awareness and appreciation of each other's skills.

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65 Responding to New Challenges and Opportunities: NHS England and NHS Improvement
66 Schwartz Rounds

There are over 5 million[67] patients waiting for surgery or treatment. Some hospitals report high occupancy levels while more patients arriving at emergency departments are acutely ill. Employers continue to support their people, many of whom are tired after working so hard for so long. Employers believe that failing to take appropriate and adequate action now could result in higher turnover in the months and years to come.

The levels of stress reported in the latest national staff survey results[68] were the highest seen in the survey at 44 per cent. This reflects the pressures of working during the pandemic. Pressures probably intensified in January to March 2021 and have continued at a high level since, due to rising demand and pressure on the service to address the backlog of elective care.

Employers have enhanced their programmes to support the wellbeing of NHS people. Some employers have expanded their support programmes to reflect the wider economic impact of the pandemic on the families of their employees and supporting the subsequent stress and anxiety this may cause. Employers have designed their support programmes to help teams as well as individuals.

Employers realise that standard measurements of workforce will not be sufficient to understand turnover after the pandemic, as some part of improvements in attrition rates has been due to people committing to see the pandemic through to its end as well as new and improved retention initiatives.

New and more sophisticated workforce data is needed to give employers early warning signs that performance may be impacted by absence, morale, or even poor leadership, and provide evidence that pressures on people are being taken seriously and are being acted

67 NHS England; Consultant-Led Referral to Treatment Waiting Times

68 NHS Staff Survey: Results

upon. Trust boards will need to give workforce risks the same importance as quality of patient care, safety and finance. They will need to look carefully at data on morale, engagement, incidents, performance and turnover in departments.

People who have come through the rigours of the pandemic are now reflecting on their needs and some will decide to retire earlier than planned. Better long-term workforce planning will depend on employers fully understanding the risks of the impact of the pandemic on people. Employers will need to make provisions based on data, demand, capacity and capital requirements.

Employers are ensuring that:

- leadership teams respond positively and quickly to verbal and non-verbal requests for support from their people
- leaders can spot the early signs of post-traumatic stress disorder so they can act quickly
- they play their part in improving the focus on longer-term workforce planning across a system
- they continue to support the wellbeing of all people and ensure support is there whenever it is needed.

Research[69] shows that changes in nursing teams, such as when a new member joins or an experienced member leaves, leads to a fall in productivity of the team and thus worse patient outcomes.[70]

The pandemic has had an adverse psychological impact on many people[71] and it is likely there will be a surge in those seeking mental

[69] Economics Observatory: How Will the Covid-19 Crisis Affect the NHS: May 2020
[70] Human Capital and Productivity: Bartel: April 2014
[71] Office for National Statistics: Coronavirus and Depression in Adults: May 2021

health support. The NHS Long Term Plan[72] included the expectation that the number of people accessing these services would increase by around a quarter by 2023/24. To meet this demand, there must be an appropriate number of trained and skilled people deployed according to patient need. We say more about the supply of people into the NHS in section 7.

Lessons learned

The wellbeing of NHS people must come first.

During the pandemic the NHS has delivered a lot of change in a small amount of time, demonstrating that it can be agile and innovative. This has created a sea-change in attitude to finding solutions and a real commitment to keep up the momentum with improvement and innovation in healthcare delivery.

The commitment of people to doing things differently must be supported by adequate resources, including enough people to create the capacity that is needed to embed what has been learned so far and continue to learn and improve as the pandemic evolves.

[72] The NHS Long Term Plan: NHS England and Improvement: January 2019

Section 5: Workforce challenges

Looking after our people is at the centre of the NHS People Plan and the NHS People Promise. People must come first.

The workforce policies and plans in place are:

- NHS Long Term plan[73]
- We are the NHS: People Plan for 2020/21[74] – action for us all
- Our NHS People Promise[75]

In addition, HEE has been commissioned to set out a framework and principles for a 15-year workforce plan.

We welcome this necessary and important focus on people, but we note the continued absence of a published workforce plan with increasing concern

One of the most important and urgent actions for policy makers and employers is to redouble efforts to eliminate workforce shortages.

A baseline assessment of workforce numbers and provision for adequate supply needs to be published urgently.

[73] NHS Long-Term Plan: NHS England and Improvement
[74] We are the NHS People Plan: NHS England and Improvement
[75] Our NHS People Promise: NHS England and Improvement

Equipment and buildings matter, but throughout the pandemic the key risk was continuing to provide safe care despite significant workforce gaps[76].

Although overall nursing numbers have gone up by 8 per cent since 2010[77], this is significantly below the increase in demand and is variably concentrated within nursing areas of practice. Further, the growth in medical workforce is significantly higher.

Over the past ten years, only adult nursing and children's nursing have seen increases in FTE nurse numbers, while the numbers in community nursing, mental health nursing and learning disability nursing are all lower than they were in June 2010[78].

It is not realistic to expect the workforce, which has been exhausted through the pandemic, to work harder for longer to reduce waiting times and the backlog of elective care.

It is important in supporting the morale of the health and care people who have given so much during the pandemic that they can be confident there will be enough colleagues in post in future. More fully trained people will create more capacity for providers to treat and adequately manage patients, many of whom have long-term conditions that developed during the pandemic.

We welcome the government's commitment to 50,000 extra nurses employed in the health service by 2024/25. If this is to be delivered through a combination of increased supply, recruitment and retention we would expect to see the publication of a comprehensive workforce strategy that sets out how the health and care system will secure the right number of people, with the right skills and working in the right places.

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[76] The Health Foundation: NHS Workforce Shortages: May 2021
[77] Building the NHS Nursing Workforce in England: The Health Foundation: December 2020
[78] Building the NHS Nursing Workforce: Health Foundation: December 2020

We believe that a strategy must link closely with people policies to make clear the right relationship between the service and those who work in it. For example, the experiences of NHS people from minority ethnic groups show that for too many, employers are not delivering the ambition to be the 'best place to work', as set out in the NHS People Plan[79].

The workforce challenges employers face can only be met if action is taken across all available sources of supply, including undergraduate, post-graduate and apprenticeships, return to practice and international recruitment. We say more about workforce supply in section 7.

The contribution of graduate-entry roles (and subsequent pay differentials) must be set at levels to enable and support employers to attract and recruit people in an increasingly competitive labour market.

In pay band 5, the pay system needs to recognise additional responsibility that is short of the level of additional responsibility shouldered on promotion.

Pay band 2 is now the minimum entry level of pay into an NHS career. It is vital that there is early and sustained additional investment in pay at this level. Adequate pay in band 2 will prevent the NHS being labelled as a low-pay employer and enhance its standing in the local communities from where so many staff at this level are recruited.

Workforce planning

We strongly endorse the NHS PRB's suggestion in its last report[80] that a transparent NHS workforce strategy, covering all people in the

[79] People Plan for 2020/2021
[80] NHS Pay Review Body: 34th Report: July 2021

remit of the NHS PRB, would allow the whole system to understand the needs of the service and, in the context of current shortages, would build confidence in the workforce planning process. In 2017, a House of Lords Select Committee[81] argued that the absence of any comprehensive national long-term strategy to secure the appropriately skilled, well-trained and committed workforce that the health and care system will need over the next ten-to-15 years represents 'the biggest internal threat to the sustainability of the NHS.'

We referred to the need for reform of workforce planning in our last submission[82] to the NHS PRB. We believe it must be:

- a continual process, to align the needs and priorities of the system, population and services with workforce requirements

- evidence-based, to enable us to factor in technology, best practice, demographic and epidemiological factors (including the long-term impacts of the pandemic) on the workforce.

A long-term workforce plan must address both workload intensity and the immediate need for recruitment, as well as the provision for healthcare workers of adequate space, time and resources to focus on their wellbeing.

Commissioned by the DHSC, HEE is updating the existing 15-year strategic framework for workforce planning, Framework 15[83]. NHS Employers on behalf of the NHS Confederation has led the response[84] to HEE's public call for evidence[85], which launched on 20 July 2021.

81 House of Lords Select Committee: The Long-Term Sustainability of the NHS: April 2017
82 NHS Employers Submission to the NHSPRB: 2021/2022 Review: January 2021
83 Framework 15: Health Education England: 2014
84 Response to HEE Workforce Planning Call For Evidence: NHS Employers: September 2021
85 Long-Term Strategic Framework: Health Education England: July 2021

The NHS Confederation, alongside other representative organisations, has been calling for the workforce provisions in the planned legislation for the English NHS to be strengthened. There must be a clear mandate for workforce planning to be undertaken every two years with a five-, ten- and 15-year focus. Planning needs to be based on population need, informed by the data and intelligence from the partners in integrated care boards and integrated care partnerships, and published in the public domain.

In 15 years' time, we hope to be able to say the health and social care system has changed for its workforce and leaders so that:

- employers and national partners can model health and care workforce needs based on the needs of communities
- employers retain people and those who are students because they have had an excellent experience and want to stay, with the best employer
- we have eliminated discrimination and exclusion from the NHS and social care workforce, including within educational settings
- we create a working environment that balances employee autonomy and operational efficiency to improve people experience and engagement.

The NHS Confederation is continuing this conversation with HEE and has offered to co-ordinate discussions with employers in its networks and through the NHS Employers policy board.

Composition of the workforce

The House of Commons Public Accounts Committee[86] said:

‘Nurses have played a vital role in caring for people during the COVID-19 outbreak. In the NHS, these efforts took place against a backdrop of an acknowledged shortfall of nearly 40,000 nursing vacancies, which had already put both people and services under increased strain. The NHS Long Term Plan was not supported by a detailed workforce plan to ensure the NHS had the number and type of nurses it needed, and it did not have all the necessary long-term funding secured.’

Employers have faced major challenges in recruiting nurses leading to concerns that, outside of the pandemic, decisions on numbers of people are being driven by the size of the available workforce and not by patient need. Some researchers[87] have suggested that there has been an increase in people working in support of qualified nurses (such as healthcare assistants) three times greater than that of registered nurses. It is suggested that this situation has the biggest impact in intensive care units[88].

NHSEI and HEE have been working with government to increase ethical international recruitment and build partnerships with new countries, making sure the supplying country is positively impacted, as well as the individual health worker and the NHS. This includes removing barriers to recruitment and increasing capacity for induction and support across the professions, including in mental health.

We have highlighted examples[89] of how trusts have adapted their international recruitment approaches to facilitate timely, smooth, and

[86] House of Commons Public Accounts Committee: NHS Nursing Workforce: September 2020
[87] Implementation Impact and Costs: National Institute for Health Research
[88] Pressure on Staff Unsustainable: Royal College of Nursing: January 2021
[89] International Recruitment Throughout Covid-19: NHS Employers: February 2021

long-lasting benefits both for their organisation and their international recruits.

In the last decade there has been a major change in the mix of nurses and people working in clinical support (including healthcare assistants and nursing assistants) with an increase of the number of support workers per registered nurse from 1.0 whole-time equivalent (WTE) per registered nurse in 2009 to 1.1 WTE per registered nurse by 2019. Although changes in skill mix may reflect a range of factors including changing patient needs, technological developments, and legislative changes to allow some professional groups to expand the scope of their practice, there is concern that these changes have not been driven by the quality and safety of patient care[90].

Staff shortages are endemic and are not limited to specific areas of healthcare. NHSEI has published the 2022/23 operational planning guidance[91]. In line with the NHS People Plan 2020/21, the guidance emphasises the need to prioritise support for the NHS workforce. HEE, working with NHSEI, will focus on care support workers, mental health hubs and enhanced health and wellbeing offers for staff. Multi-disciplinary teams will be created through delivery of the Additional Roles Reimbursement Scheme (ARRS)[92] in primary care networks (PCNs).

Care will need to be taken in the planning and execution of these important plans to avoid the risk of creating additional vacancies in very highly pressurised areas such as ambulance services.

[90] Falling Short: The Health Foundation: November 2019
[91] 2022/23 Priorities and Operational Planning Guidance: NHS England and Improvement: December 2021
[92] Expanding Our Workforce: NHS England and Improvement

Retention

The most cost-effective way for employers to ensure they have the people they need is for them to keep the people they already employ.

Yet retention remains a challenge. Around 28 per cent of nurses and health visitors leave the NHS within the first three years of their service[93] and the NHS loses around 50,000 people per year on average.

The results from the NHS Staff Survey 2020[94] showed that morale was stable, measured at 6.2 compared to 6.1 in the previous survey. There was no increase in the proportion of people indicating they would leave as soon as a job opportunity arose.

The results indicated that the NHS workforce continues to be under pressure because of the lingering impacts of the pandemic and the start of the restoration of elective services. The survey showed the highest ever levels of stress, high levels of working beyond contracted hours, and there were continuing issues of bullying and harassment. However, despite these pressures people remained motivated and engaged. Most of the measures of people experience remained stable.

There was an improvement in the results for health and wellbeing which, as measured by the survey, was up from 5.9 to 6.1 out of ten. The percentage of people reporting their employer had acted to support their health and wellbeing rose from 29 per cent to 34 per cent.

The overall measure of how much people feel engaged with their employer remained stable. Willingness to recommend the NHS as a

93 NHS Workforce: Our Position: The King's Fund: February 2021
94 NHS Staff Survey: National Results: 2020

place to work increased from 63 to 66 per cent. The percentage of people feeling valued by their organisation remained stable.

Many employers publish reports on responses to workforce surveys. Data from surveys is reported to trust boards and employers provide department-level breakdowns of responses to surveys to enable managers to act on issues raised.

The NHS Staff Survey is the largest data source on people experience. The 2020 survey was conducted in October to November 2020. The 2021 survey is underway and the results will be published in spring 2022. There have been changes to around 30 questions within the survey to increase alignment with the NHS People Promise. This will mean that there will be limited comparability at theme level with past data. It will still be possible to compare results at question level. Results for questions on people engagement, health and wellbeing, and pay and reward will be linked to trend data. It is expected that the results published in 2022 will show a deterioration in the experience of our people in the face of the service pressures and demands described in this report.

Employers have recognised the long-term psychological impact the pandemic has had on some of their people, including the health issues caused by long COVID. Specialist support services have been developed to address these issues and will need to be sustained. Employers have also provided quiet areas where their people have been able to spend time away from their normal work to find relief from stress and pressure. Additional round-the-clock catering and hydration facilities are now commonplace. The ongoing national package of health and wellbeing support includes online counselling services and in 2021, regional health and wellbeing hubs have been created. NHS Employers has an extensive programme of support for health and wellbeing[95].

[95] Health and Wellbeing: NHS Employers

Employers have continued to adapt their approaches to people engagement to ensure they are seeking out and acting on people feedback. For example, there has been widespread and innovative use of virtual feedback tools ranging from large-scale meetings on Microsoft Teams, to Facebook groups and the use of crowdsourcing software. Many trusts have adapted their local surveys and/or used the new national Quarterly Pulse Survey[96], which was implemented in July 2021.

In response to the issues people have been raising, employers have:

- adapted local workforce surveys to obtain better insight into the health and wellbeing needs of people
- used helplines
- extended opportunities for flexible and agile working
- updated people recognition schemes
- improved Freedom to Speak Up schemes
- introduced additional psychological support services.

NHS Employers has summarised the learning from the pandemic[97] which employers have reported to us.

Retention is not only supported by satisfaction with reward, but also strongly linked to culture and an environment where people want to work. There is strong evidence that people who feel well supported and engaged with their employer will deliver better care, with improved patient safety and patient satisfaction.

[96] The National Quarterly Pulse Survey: NHS England and Improvement: July 2021
[97] Covid-19 Shared Learning: NHS Employers: September 2021

Employers need to understand more about the needs of young people who are making the transition from education to work, to make their first employment successful[98].

Employers are supporting motivation and retention by providing:

- more flexibility in career and job planning, including more reliable work schedules
- more opportunities for continuing professional development
- and by encouraging employee participation.

Transparency about decision-making and effective communication strategies are also important.

Workforce development strategies

The system urgently needs information to build a comprehensive picture of workforce trends over time and how these can be aligned with ambitions for the future delivery of healthcare. Health and care will need a system that can:

- continually identify risks and trends to trigger flexible responses
- support workforce planning, not just based on new recruits but also to facilitate consideration of how to develop new skills and new working patterns for those who are already in post
- deliver a more flexible workforce whose deployment can drive further improvements in productivity

98 Young People and UK Labour Market Policy: Sage Journals

- deliver an adequately resourced workforce to allow a broader and more inclusive approach to be developed

- make workforce planning at local and national level part of the productivity and quality improvement agenda

- include scenario modelling, workforce costing and supply-side projections. Future workforce projections should include changes in the number, pay and mix of people, to give employers and policymakers the information they need to help improve productivity

- enable the assessment of risks through the provision of relevant information on education, employment law, pay, working conditions and national and international workforce flows

- link workforce planning with workforce development, including leadership skills

- regularly review the balance of investment between the current and future workforce

- identify who should be responsible for acting on any risks that have been identified in the system.

In future, the focus should be on developing a flexible approach to workforce planning that does not seek unrealistic precision in the long term, but can identify potential medium-term issues and, most importantly, enable the current workforce to evolve and adapt to the inherently unpredictable healthcare environment.

Burnout

The Health and Social Care Committee report on workforce burnout and resilience[99] describes the increased workforce pressures the pandemic has created, leading to stress, burnout and widespread concerns about wellbeing of people in the NHS. People who have been going above and beyond have become exhausted and many have had to deal with trauma in their families.

NHS people have been re-deployed and re-trained. Hours and shifts have been increased to cope with the extra demand and to address the increasing level of sickness absence. The levels of severe illness and death that healthcare workers have witnessed, including amongst their own colleagues, have been unprecedented. People have been anxious over their ability to cope at work.

Workforce burnout was described by many who gave evidence to the committee as the highest in the history of the NHS and care systems, and as such it is a risk to the future functioning of both services.

The committee focused on workforce planning, the effectiveness of the NHS People Plan and the level of training needed to meet the demands of the health and social care sector. For example, the committee suggested that HEE should publish independently audited annual reports on workforce projections for the NHS and social care workforces covering the next five, ten and 20 years.

The NHS people in the remit of the NHS PRB are dealing with the backlog of both physical and mental healthcare that the pandemic has caused. There is rising demand from children and adults. The Centre for Mental Health has estimated that up to 10 million people[100] will require new or additional mental health support.

[99] Workforce Burnout and Resilience: House of Commons Health and Social Care Committee: May 2021
[100] Covid-19 and the Nation's Mental Health: Centre for Mental Health: October 2020

Unachievable objectives are a key source of unhappiness in work. The employee needs to have the resources and ability to meet the objectives and to have sufficient autonomy to be able to achieve the objectives.

Autonomy in how one works towards a goal is an important source of wellbeing and key to retaining people. The ideal objectives would utilise as many of the employee's skills as possible and align closely with institutional goals.

The NHS has been hampered by rigid training structures. Accreditation requirements have encouraged specialisation, while an ageing population with often complex physical and mental health needs is best suited to a workforce with broad and flexible knowledge and scope to practise.

Employers have reported that the inevitable disruptions to teams and how they functioned during the worst of the pandemic all contributed to a more stressful working environment, due to the departure of some experienced nurses, the absorption of new nurses, and the inclusion of temporary contract nurses.

The sensible ambitions for improvements in patient care which have been stated in various policy documents over several years can only be achieved if the workforce is in place to deliver them. We have welcomed the importance given to mental health in policy documents, but this has not been reflected in numbers of people in mental health services.

The impact of the pandemic on ethnic minority groups and deprived communities has exposed long-standing health inequalities. The Health Foundation[101] has suggested that investment in public health needs to be increased to mitigate the impact of the pandemic on

[101] Build Back Fairer: The Health Foundation: December 2020

health and health inequalities, and on the social determinants of health.

Reducing the elective backlog must involve action in all parts of the health and social care system, not just in acute hospital settings. Mental health services, primary and community providers all help patients prepare for elective treatment. Ambulance services play a critical role in supporting communities and working across the entirety of the NHS. They have a unique role in connecting with all parts of the NHS, as well as other emergency services, and can play a big role in helping transform the way that patients interact with the health service.

Teams that work effectively can significantly increase the health outcomes of patients and lead to reductions in stress levels within the team.

NHSEI has created a steering group of senior NHS leaders and experts from a range of sectors to support the chief people officer's review of HR and OD. The report is expected by the end of 2020/21.

Racial inequality and discrimination

There is a mixed picture emerging from the information in the fifth annual WRES data report[102]. It remains clear from the data and the personal accounts of staff that there is still a lot of work to do both at national and local level to address the discrimination experienced by BME staff working in the NHS.

The total number of BME people at very senior manager pay level has increased from 108 in 2017 to 153 in 2020.

[102] Workforce Race Equality Standard: 2020 Data Analysis Report: NHS England and Improvement: February 2021

White applicants were 1.61 times more likely to be appointed from shortlisting compared to BME applicants. There has been year-on-year fluctuation but no overall improvement over the past five years. This measure was 1.60 in 2017.

BME people were 1.16 times more likely to enter the formal disciplinary process compared to white people. This is an improvement on 2019 and a significant improvement from 2017 when it was 1.37.

The number of BME board members in trusts increased by 22.2 per cent between 2019 and 2020.

The latest staff survey data showed almost no improvement in any of the key measures on bullying and harassment and violence and a small fall in confidence of BME people on discrimination.

Since spring 2021, NHSEI has supported a range of actions[103] on these issues. The NHS Confederation works closely with NHSEI to ensure that the system of measurement in the WRES is clear to employers, that the guidance is comprehensive and that employers understand their duties under the WRES.

[103] WRES Guidance and Resources: NHS England and Improvement:

Section 6: Total reward

Employers believe that an effective rewards system must include links to quality appraisal and training, both mandatory and voluntary. There is scope for local job planning to adjust from a focus on how time is occupied, to more specific impact and output measures. Other key team members working around and with individuals need to be involved.

If employers are to make a significant difference to the experiences of their people, they will need to deliver workforce growth, deploy new roles, create adequate capacity to train people and extend the scope of existing roles.

Employers are using total reward to support increases in engagement with people to ensure they feel valued and involved, have good relationships with managers and colleagues, trust in the organisation, can see opportunities for promotion, achieve a satisfactory work-life balance and feel job satisfaction.

An employee's perception of the value of the reward package is important and perceptions differ between individuals and groups.

The results of the 2020 staff survey[104] indicated that fewer than 40 per cent of NHS people felt their organisation had sufficient people to enable them to do their job. Addressing workload pressures and investing in workforce growth will be essential if employers are to

[104] NHS Staff Survey Results 2020: NHS England and Improvement

deliver improvements in the experiences of their people, including flexible working.

The NHS Confederation has suggested[105] that to attract and retain people in the long term, the NHS will need a fully funded, long-term workforce plan addressing training and vacancy issues, to support a sustainable, funded and modern total reward package.

NHSEI's NHS People Promise[106] confirms that employers will ensure that their people are rewarded and recognised for their commitment to the care of patients.

The NHS People Promise was refreshed by NHSEI in July 2021. It sets out aims for improved people experience and provides a framework for action by individual employers and NHSEI. To support delivery of the promise, NHS Employers has supported the negotiation through the NHS Staff Council of changes to the NHS terms and conditions handbook and supporting resources that promote and enhance flexible working options within the NHS.

NHSEI has focused on health and wellbeing as a priority area, including the development of regional health and wellbeing hubs, a national health and wellbeing offer, the development of health and wellbeing guardians, health and wellbeing conversations with people, and a programme of work designed to grow occupational health services.

In addition, the National Quarterly Pulse Survey has been implemented to support additional feedback from people and NHSEI has a programme of work to support compassionate and inclusive cultures in the NHS. There has also been a significant realignment of the NHS Staff Survey to focus on the NHS People Promise and

[105] NHS Confederation: Putting people first: February 2021
[106] NHS England and Improvement: NHS People Promise

implementation of the National Quarterly Pulse Survey to provide regular feedback on people outlook.

NHSEI is working with employers to support them to make best use of the NHS employment offer, pay and non-pay, which provide a competitive pension scheme, including important life assurance, personal and other family benefits.

In its last report, the NHS PRB[107] noted that forward-thinking employers focus on total reward to ensure they can recruit, retain and motivate their people. Total reward is an important part of the holistic employee experience in the NHS and is a vital part of employer attraction, recruitment and retention strategies. Despite the relentless pressures created by the pandemic, employers have embraced transformational changes that have enhanced the experiences of their people.

In November 2020, NHS Employers published Reward in the NHS[108], which highlights good practice and innovation taking place across the NHS on reward and key themes that have emerged through our Total Reward Engagement Network[109].

Recruitment and retention are the biggest challenges that employers in the NHS are facing. Reward can be a useful tool in helping to meet these challenges by ensuring people fully appreciate and understand the value of working for the NHS.

The feedback we have received from employers confirms the broad range of actions they are taking, such as on recruitment:

- Showcasing the total reward package in dedicated sections on employer websites. Employers are taking this opportunity to emphasise the opportunities they have created for career

[107] NHS Pay Review Body: 34th report: 2021
[108] Reward in the NHS Report: NHS Employers: November 2020
[109] Total Reward Engagement Network: NHS Employers

development.

- Refer a friend schemes are used by some organisations, often to overcome difficulties recruiting to specific occupations.

- Various measures to support recruits from abroad including social media, such as closed Facebook groups to link new and existing people, provision of accommodation, and pay available from the day they arrive, as opposed to the day they commence employment, and comprehensive induction programmes.

Employers are:

- providing facilities for people to accrue up to five days' annual leave each year, for up to five years, when all the leave can be taken at once

- introducing nurse retention managers to better understand why nurses may want to leave the organisation and what they value about their employment, to inform adjustments to the total reward package

- conducting exit interviews

- focusing on personal and career development in appraisal

- ensuring regular and constructive communication with new starters

- giving people access to professional financial advice

- using salary sacrifice over extended periods to provide benefits that employees value and to help employees embrace effective personal financial management.

We have listed the extensive range of benefits NHS colleagues who participate in our Total Reward Engagement Network have reported to us, on page 6 of our Reward in the NHS report.

Changes in the focus of reward, and innovations employers have reported implementing in response to the pandemic, are shared in another resource[110], which shows what has been achieved is strengthening local approaches and informing future practice in supporting the experiences of people in the NHS.

The basic needs of employees for safety, stability and security have been under threat during the pandemic. People have been experiencing unprecedented levels of disruption in their homes and communities, as well as at work. In response, employers have acted quickly and effectively to facilitate a supportive, compassionate and positive experience that has prioritised people experiences and wellbeing.

Employers are helping people recover from the pandemic by giving them extra holiday, bonuses of up to £100, much better food while on duty, and some are now offering drama and poetry sessions. Some employers are providing additional psychological services, expanding childcare and overhauling rest areas.

Some employers awarded their people an extra day's paid leave in 2021-22, often to be taken on or around their birthday. One trust reported giving all their people a £100 payment as part of its effort to thank them for dealing with the intense demands of the pandemic. Another trust gave its workforce a £25 shopping voucher. Others have given frontline personnel free hoodies, water bottles and pin badges.

Many employers are making it easier for people, especially those on nightshift, to access healthy food during their breaks. In some cases,

[110] NHS Employers: Adapting and Innovating During Covid-19: March 2021

this involves providing dedicated areas where people can relax to eat a meal. Some trusts are providing heavily subsidised hot meals in the canteen.

Other initiatives to support people include:

- expansion of affordable and flexible childcare – another recurring difficulty for NHS people, who often have irregular or antisocial working patterns and who face high childcare costs

- renovating break rooms, kitchens, changing rooms and showers

- introducing ‘rest nests’ and ‘respite spaces’ where people can relax and escape the noise and intensity of wards and operating theatres. Respite spaces in Oxford’s hospitals will include noise-cancelling headphones

We are learning that the pandemic may not have a clearly defined endpoint and the growing backlog of elective patient care will take years to tackle. The pressure on people and services will continue. In these circumstances, we believe NHS leaders must continue to focus on making a positive difference in people’s lives by showing compassion and empathy. Continuing to acknowledge the extraordinary efforts people are making will be important to employee engagement, wellbeing and effectiveness.

Many challenges lie ahead for employers and their people. People have widely varied experiences, perspectives and outcomes. While addressing the broad needs of the workforce, employers will need to concentrate on individual differences in home lives and circumstances, skills and capabilities, personal characteristics, and other factors.

The feedback we are receiving shows that in organisations where people have welcomed the level of employer support during the

pandemic, there are high levels of engagement and people feel positively about their employer's attitude to their wellbeing.

Leaders now need to ensure there are plenty of opportunities for continued relationship building, particularly for remote workers. Many of the best ideas have come from people, so leaders will need to ensure employees have time and space to be creative and continue to innovate.

As some ways of working shifted during the pandemic, many people had to transition to new work duties, processes and methods of collaboration. Where these developments have been based on involvement, fairness, respect and equality, employees have been able to adapt successfully. As employers look towards a future of new working models and team structures, building such an integrated culture now will only benefit organisations in the future.

In the wider economy, we believe the emphasis in reward is now shifting from a focus on meeting health and safety needs to a more nuanced approach that recognises differences among a workforce. It is becoming more evident that a one-size-fits-all approach to experience management will not be successful. From now on, employers must do more to address the specific needs of each person they employ.

For employers that have achieved successful people experience outcomes at pace, collaboration was a key driver. Employers advise us that people experience interventions have greater effect when people work together, across disciplines, as part of a shared vision.

People have widely varied experiences, perspectives and outcomes. For example, in the NHS there have been distinct challenges faced by those working in hospitals and clinics compared with remote workers, and sometimes the impact on working mothers versus working fathers has been different.

Employers are using the current phase of the pandemic to concentrate on individual differences in home lives and circumstances, skills and capabilities, mindsets, personal characteristics, and other factors. People must have an appropriate level of autonomy and control, feel a greater sense of belonging and they should not be overwhelmed by excessive workload.

One of the challenges employers now face is to use workforce data to segment the workforce to support employees in more personalised ways.

Leaders should focus on making a positive difference in people's lives by demonstrating empathy and by acknowledging employee success to strengthen employee engagement and support wellbeing and effectiveness. This is an appropriate response to the selflessness exhibited by so many people for so long.

The pandemic has shown the need to focus on the wellbeing of people and their experience at work. The health and wellbeing of people is closely linked to patient outcomes and the NHS People Plan highlights many actions the NHS is already taking to improve in this area.

Workforce priorities have changed and a new way of working[111] has been enforced. A new normal is emerging as employers improve flexible working[112] policies. However, there are some challenges that employers are facing when implementing flexible working, such as communication difficulties and employee isolation.

Employers need to adapt their operational models to include people needing to work around school hours, college hours or care arrangements. Employers are allowing people the opportunity to change from full-time to part-time working, changing working hours to fit personal needs.

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[111] New Ways of Working
[112] Flexible Working

Giving people the opportunity to achieve a work-life balance which works for them is important in making the NHS an employer of choice. Not only does this keep people whose personal circumstances might have changed and had to move on if not for a more flexible working pattern, it also allows employers to recruit outside of their catchment area and look nationwide for experienced professionals in line with the NHS People Plan.

Employers need to hear what people are thinking and feeling if they are to solve issues. The NHS Staff Survey is one of the largest annual workforce surveys in the world.

People surveys have proven to be an important way of hearing about the views of NHS people on communication, wellbeing support, decision-making, leadership and how people were feeling after working through the pandemic. Employers have been able to use the intelligence from the surveys to adapt their leadership and approach.

Many trusts send out their own in-house surveys, offering a more bespoke approach and specific questions they want to ask their people. ‘How are you feeling’ toolkits have been very popular during the pandemic, giving employers an insight into the morale of their people.

The NHS People Plan sets out what people working in the NHS can expect from their leaders and from each other, as well as actions to support a transformation across the whole NHS. One of these key actions is ‘growing for the future,’ which focuses on how we recruit and keep our people, and welcome back colleagues who want to return. The NHS pension and reward package is one of the most all-inclusive and appealing packages available. Many employers use this to their advantage when recruiting and retaining people.

Finding out what people want and designing a reward package around their needs and trust values will help the NHS build the right

culture[113]. Many trusts have adopted initiatives such as on peer-to-peer recognition or just an acknowledgment of exceptional performance or effort. Even saying ‘thank you’ goes a very long way. These are prime examples of very effective non-monetary rewards, showing that reward must be multifaceted.

NHS Pension Scheme

The 2015 NHS Pension Scheme was introduced on 1 April 2015, replacing the 1995 and 2008 sections (except where individual transitional protections applied), which were closed to future accruals. The 2015 scheme is a career average revalued earnings (CARE) defined benefits scheme. It pays a pension based on the average of a member’s pensionable earnings throughout their career, revalued in line with the Consumer Prices Index plus 1.5 per cent per annum.

Member contributions

Members of the NHS Pension Scheme currently pay contributions on a tiered basis, designed to collect a total yield to HMT of 9.8 per cent of total pensionable pay. Current employee contribution rates are in the table below.

Tier	Pensionable pay (whole-time equivalent)	Contribution rate from 2015/16 to 2021/22
1	Up to £15,431.99	5.0 %
2	£15,432.00 to £21,477.99	5.6 %

[113] How Total Reward is Changing In 2021 and What We Need To Do

3	£21,478.00 to £26,823.99	7.1 %
4	£26,824.00 to £47,845.99	9.3 %
5	£47,846.00 to £70,630.99	12.5 %
6	£70,631.00 to £111,376.99	13.5 %
7	£111,377.00 and over	14.5 %

DHSC is consulting on changes to member contributions for the NHS Pension Scheme in England and Wales. Changes will be introduced from April 2022.

Proposed changes to member contributions

Contributions will be based on a member's actual pensionable pay.

- In the 2015 scheme, the build-up of pension is based on actual earnings in each scheme year of a member's career, rather than being linked to their WTE final salary.

- Basing contribution rates on actual pensionable pay, rather than WTE, would mean that contributions for members who work part time will more accurately reflect the amount of pension they earn in the scheme.

- Many part-time employees will pay lower contributions due to this change.

The steepness of the tiers within the structure will be reduced.

- DHSC is proposing to reduce the number of tiers from seven to six, with the top rate for the highest earners reducing from

14.5 per cent to 12.5 per cent.

- In the current tiered contribution structure, higher earners pay higher contribution rates than lower earners, to reflect that they will earn proportionally higher benefits in a final salary scheme. This level of cross subsidy helps to ensure that the scheme is accessible and affordable for all members of the NHS workforce. DHSC's view is that the current level of cross subsidy is no longer appropriate in a CARE scheme, where all members get the same proportional benefits.

- The boundaries will be increased each year in line with NHS pay awards for people in the remit of the NHS PRB. This is because most scheme members are on 2018 pay and conditions of service employment contracts. This would reduce the likelihood of a member moving into a higher contribution tier as a direct result of a national pay award, which can sometimes lead to a net reduction in take-home pay.

The proposed changes involve a reduction in contributions for some members, such as part-time employees and higher earners. It should be noted that there is an increase to National Insurance contributions from 1 April 2022, which may remove advantages to take-home pay that members may anticipate from reduced pension contributions.

The scheme must collect an average yield of 9.8 per cent from members of the scheme. If the value of contributions collected from scheme members falls below this yield it can feed into the valuation as a cost pressure, which may lead to higher contributions for employers. Contribution rates in the new structure have therefore been adjusted and increased for some members to ensure the yield is collected once the changes are implemented.

DHSC has proposed that the changes are phased in over two years to minimise the impact on take-home pay. Further details of the proposals can be found on our web pages[114].

The rationale for the changes is that from April 2022, all members will move into the existing 2015 scheme where benefits are calculated based on what a member earns each year.

The consultation closed on 7 January 2022. We are engaging with colleagues in the service to represent their views in our response.

The Scheme Advisory Board to the NHS Pension Scheme will also submit a response to the consultation. The board has provided views to the Secretary of State on member contributions in previous years.

The table below is taken from the consultation and sets out the current rates and proposed new rates according to pensionable earnings. As the new rates are proposed to be phased in over two years, figures are given from 1 April 2022 and from 1 April 2023. The final column shows the percentage difference between the current rate and the final rate (from 1 April 2023) for members who work full time.

Pensionable earnings	**Current rate (WTE pay)**	**Rate from 1 April 2022 (actual pay)**	**Rate from 1 April 2023 (actual pay)**	**Overall change to contribution rate for members working full time***
Up to £13,231	5.0%	5.1%	5.2%	+0.2%
£13,232 to £15,431	5.0%	5.7%	6.5%	+1.5%
£15,432 to £21,478	5.6%	6.1%	6.5%	+ 0.9%

[114] NHS Pension Scheme: Consultation: NHS Employers: October 2021

£21,479 to £22,548	7.1%	6.8%	6.5%	- 0.6%
£22,549 to £26,823	7.1%	7.7%	8.3%	+ 1.2%
£26,824 to £27,779	9.3%	8.8%	8.3%	- 1.0%
£27,780 to £42,120	9.3%	9.8%	9.8%	+ 0.5%
£42,121 to £47,845	9.3%	10.0%	10.7%	+ 1.4%
£47,846 to £54,763	12.5%	11.6%	10.7%	- 1.8%
£54,764 to £70,630	12.5%	12.5%	12.5%	No change
£70,631 to £111,376	13.5%	13.5%	12.5%	- 1.0%
£111,377 and above	14.5%	13.5%	12.5%	-2.0%

*The figures in this final column will not necessarily apply to members that work less than full time, as rates from 1 April 2022 would be based on their actual pay and not notional WTE. Contribution rates are expected to decrease for many part-time employees across all tiers.

We responded to the consultation on behalf of employers. Employers understand the rationale for reducing the steepness of the tiering and would support the structure being gradually flattened over time to a position where a significant proportion of the membership is paying 9.8 per cent. However, employers feel the proposed new structure moves too quickly towards that position, and are concerned about the disproportionate impact this would have on the lowest earning people.

Employers are concerned this will increase the risk of members with lower earnings opting out of the scheme on the grounds of affordability, which would lead to employees not being able to access a key part of their reward package.

It is a risk to employers in terms of both recruitment and retention if people cannot access the full benefit of the NHS reward package. NHS organisations compete with the pay and reward offer from private sector employers, where there is an opportunity for individuals to contribute to a pension scheme based on a much lower percentage of their pay, albeit in return for a lower level of benefits, often provided on a defined contribution basis. Employers report that this is attractive to those in the lower pay bands where balancing financial priorities is often a key concern.

NHS Employers is supportive of flexible accrual options being introduced for all members of the NHS Pension Scheme to ensure that it is a flexible, affordable and attractive part of the reward offer to all members of the workforce.

Contribution rates for lower earners are likely to continue to rise towards 9.8 per cent in the future (if the yield remains at this level), meaning that maintaining scheme membership amongst lower earners is likely to become increasingly difficult. This further strengthens the argument for flexible accrual rates for all members of the NHS Pension Scheme.

In the consultation document, DHSC provided examples to show the impact on members from across the NHS workforce, once the new rates have been phased in from 1 April 2023. The examples below were included from the NHS PRB workforce:

- A healthcare assistant working full time earning £19,918 (top of AFC band 2) would pay an additional £15 a month after tax relief but still pay £46 a month less than if on the average 9.8 per cent contribution rate. The same healthcare assistant working 60 per cent of full-time hours would pay £2 less and

£48 per month less than if on the 9.8 per cent rate.

- A nurse working full time earning £31,534 (top of AFC band 5) and therefore paying the average 9.8 per cent contribution would pay an additional £19 a month after tax relief. The same nurse working 60 per cent of full-time hours would pay £32 a month less and £43 per month less than if on the 9.8 per cent rate.

The NHS Pension Scheme Advisory Board met in November 2021 to discuss the consultation proposals, and were presented with several examples of the impact of the proposals on take-home pay for members by First Actuarial, actuary to the board. Examples for people on 2018 pay and conditions of service contracts are included below.

Example band 2 member:

Band 2 member

	Full-time			60% of WTE		
WTE pay	£19,918					
Actual pay	£19,918			£11,951		
Contribution rate	5.6%	6.1%	6.5%	5.6%	5.1%	5.2%
	Until 31 March 2022	1 April 2022 to 31 March 2023	1 April 2023 onwards	Until 31 March 2022	1 April 2022 to 31 March 2023	1 April 2023 onwards
Monthly gross pay	£1,660			£996		
Pension	(£93)	(£101)	(£108)	(£56)	(£51)	(£52)
Income tax	(£104)	(£102)	(£101)	(£0)	(£0)	(£0)
National Insurance	(£104)	(£114)	(£114)	(£24)	(£26)	(£26)
Monthly net pay	£1,360	£1,342 *-£18*	£1,337 *-£23*	£916	£919 *+£3*	£918 *+£2*

2022/23 and 2023/24 figures allow for 1.25% increase to National Insurance rates
No allowance for pay rises or National Insurance threshold changes

Rounding may mean that totals do not equal the sum of the parts

A full-time post holder, a band 2 employee would have a reduced take-home pay under the new proposals. This is due to both pension contribution and National Insurance contribution increases. A part-time member (60 per cent of whole time) would see a small increase in take-home pay paying less pension contributions and slightly

increased National Insurance. This is due to the proposals using actual pensionable pay as opposed to whole-time equivalent, part-time member contributions are decreased.

Example band 3 member:

Band 3 member

	Full-time			60% of WTE		
WTE pay	£21,777					
Actual pay	£21,777			£13,066		
Contribution rate	7.1%	6.8%	6.5%	7.1%	5.1%	5.2%
	Until 31 March 2022	1 April 2022 to 31 March 2023	1 April 2023 onwards	Until 31 March 2022	1 April 2022 to 31 March 2023	1 April 2023 onwards
Monthly gross pay	£1,815			£1,089		
Pension	(£129)	(£123)	(£118)	(£77)	(£56)	(£57)
Income tax	(£128)	(£129)	(£130)	(£0)	(£0)	(£0)
National Insurance	(£122)	(£135)	(£135)	(£35)	(£39)	(£39)
Monthly net pay	£1,436	£1,428 *-£8*	£1,432 *-£4*	£977	£995 *+£18*	£994 *+£17*

2022/23 and 2023/24 figures allow for 1.25% increase to National Insurance rates
No allowance for pay rises or National Insurance threshold changes

Rounding may mean that totals do not equal the sum of the parts

A full-time band 3 member, despite a reduced contribution percentage, could see their take-home pay decrease in the first phase of the changes (£8 per month) and the impact lessen in the second phase. Again, we see that part-time post-holders (60 per cent of whole time) would see an increase in take-home pay, roughly the same across both phases of the proposed changes. This is again due to the use of actual pensionable pay and members moving into different tiers in the new structure.

Example band 4 member:

Band 4 member

	Full-time			60% of WTE		
WTE pay	£24,882					
Actual pay	£24,882			£14,929		
Contribution rate	7.1%	7.7%	8.3%	7.1%	5.7%	6.5%
	Until 31 March 2022	1 April 2022 to 31 March 2023	1 April 2023 onwards	Until 31 March 2022	1 April 2022 to 31 March 2023	1 April 2023 onwards
Monthly gross pay	£2,074			£1,244		
Pension	(£147)	(£160)	(£172)	(£88)	(£71)	(£81)
Income tax	(£176)	(£173)	(£171)	(£22)	(£25)	(£23)
National Insurance	(£153)	(£169)	(£169)	(£54)	(£59)	(£59)
Monthly net pay	£1,597	£1,571 *-£26*	£1,562 *-£35*	£1,080	£1,089 *+£9*	£1,081 *+£1*

2022/23 and 2023/24 figures allow for 1.25% increase to National Insurance rates
No allowance for pay rises or National Insurance threshold changes

Rounding may mean that totals do not equal the sum of the parts

A band 4 member would see a stepped decrease to take-home pay across both phases. This would be due to increases in both pension and National Insurance contributions. In the part-time example, take-home pay returns to nearly the same pre-phasing level while moving through two different tiers of the new structure.

Example band 5 member:

Band 5 member

	Full-time			60% of WTE		
WTE pay	£31,534					
Actual pay	£31,534			£18,920		
Contribution rate	9.3%	9.8%	9.8%	9.3%	6.1%	6.5%
	Until 31 March 2022	1 April 2022 to 31 March 2023	1 April 2023 onwards	Until 31 March 2022	1 April 2022 to 31 March 2023	1 April 2023 onwards
Monthly gross pay	£2,628			£1,577		
Pension	(£244)	(£258)	(£258)	(£147)	(£96)	(£102)
Income tax	(£267)	(£265)	(£265)	(£77)	(£87)	(£85)
National Insurance	(£220)	(£243)	(£243)	(£94)	(£103)	(£103)
Monthly net pay	£1,897	£1,863 *-£34*	£1,863 *-£34*	£1,260	£1,291 *+£31*	£1,286 *+£26*

2022/23 and 2023/24 figures allow for 1.25% increase to National Insurance rates
No allowance for pay rises or National Insurance threshold changes

Rounding may mean that totals do not equal the sum of the parts

There would be no stepping of take-home pay over the phasing period for a full-time band 5 member on this salary. Again, part-time members (based on 60 per cent whole time) would see an increase to take-home pay, due to a reduced pension contribution rate.

Example band 8b member:

Band 8b member

	Full-time			60% of WTE		
WTE pay	£63,862					
Actual pay	£63,862			£38,317		
Contribution rate	12.5%	12.5%	12.5%	12.5%	9.8%	9.8%
	Until 31 March 2022	**1 April 2022 to 31 March 2023**	**1 April 2023 onwards**	**Until 31 March 2022**	**1 April 2022 to 31 March 2023**	**1 April 2023 onwards**
Monthly gross pay	£5,322			£3,193		
Pension	(£665)	(£665)	(£665)	(£399)	(£313)	(£313)
Income tax	(£815)	(£815)	(£815)	(£349)	(£367)	(£367)
National Insurance	(£430)	(£486)	(£486)	(£287)	(£317)	(£317)
Monthly net pay	**£3,412**	**£3,355** *-£57*	**£3,355** *-£57*	**£2,157**	**£2,196** *+£39*	**£2,196** *+£39*

2022/23 and 2023/24 figures allow for 1.25% increase to National Insurance rates
No allowance for pay rises or National Insurance threshold changes

Rounding may mean that totals do not equal the sum of the parts

There is a reduction to take-home pay for a band 8b member due solely to National Insurance contributions as the pension contribution rate remains static. The same increase in take-home pay can be seen for the part-time example due to a reduction in pension contributions.

McCloud remedy

The McCloud remedy is the process of removing the age discrimination from public service pension schemes, including the NHS Pension Scheme.

This relates to the way some members were moved to the 2015 scheme when it was introduced, and others were allowed to stay in their 1995/2008 schemes. Members were treated differently dependent on their age, which was found to be unlawful discrimination.

Removing the past discrimination will be achieved by giving members a choice of which scheme their pension benefits for the remedy period are calculated. The remedy period is the seven years over which the discrimination took place from 1 April 2015 to 31 March 2022.

Those retiring from October 2023 will be given the choice at retirement. Those retiring before October 2023 should retire based on their current scheme and will be given a retrospective choice after October 2023. They will be contacted directly by NHS Pensions to make that choice.

Removing age discrimination going forward involves all members currently in the 1995/2008 final salary schemes moving into the existing 2015 scheme, which is a career average scheme.

Benefits already built up in the 1995/2008 schemes will remain in those schemes and will not be lost.

Members do not need to retire prior to 1 April 2022 to retain their 1995/2008 scheme benefits. We are finding that this is a common misconception that we are working with employers to dispel.

We continue to work closely with all relevant stakeholders including NHSEI, DHSC, NHS Business Services Authority / NHS Pensions Electronic Staff Record, and employer representatives through the NHS McCloud programme board. The board meets regularly to ensure a cohesive approach, including agreeing communications for employers and their people and to ensure a smooth roll out of the remedy across the NHS.

We are visiting our regional networks to:

- share updates on the remedy
- discuss the impact on the workforce around retention
- support employers to communicate with their people about the remedy and moving to the 2015 scheme.

We are supporting employers through a range of web-based resources to help them understand the McCloud remedy, communicate this effectively to people and to prepare for the changes. Our resources include:

- a McCloud remedy web page[115] giving the background to the judgment and proposed remedies

- a McCloud remedy summary[116] detailing the most recent updates and actions that employers can take now, including a timeline for employers

- a myth-busting resource[117] supporting scheme members to move to the 2015 scheme and setting out three key messages on how members of the 1995/2008 scheme will move to the 2015 scheme on 1 April 2022.

The government has laid the public service and judicial offices bill[118] before parliament to implement changes in public service pension schemes to remedy the discrimination identified by the McCloud judgment. DHSC published a consultation[119] on 9 December 2021, which proposes changes to the NHS Pension

[115] McCloud Remedy: NHS Employers: October 2021
[116] McCloud Remedy Summary: NHS Employers: October 2021
[117] Supporting Members to Move to the 2015 Scheme: NHS Employers: September 2021
[118] Public Service Pensions and Judicial Offices Bill: gov.uk
[119] McCloud Remedy Part 1: gov.uk: December 2021

Scheme that are necessary to deliver the requirements of the bill. The proposed changes to regulations will:

- facilitate the closure of the 1995/2008 scheme to future accrual from 1 April 2022
- ensure all members of the 1995/2008 scheme become active members of the 2015 NHS Pension Scheme from 1 April 2022.

A second consultation is expected in spring 2022 that will amend the scheme regulations to give eligible members a choice over the benefits they wish to receive for any pensionable service during the period 1 April 2015 to 31 March 2022.

Pension taxation

Over the last few years we have reported in our evidence to the NHS PRB on the impact of tax allowances. Previously, very few NHS workers were likely to exceed the tax thresholds, but changes in recent years mean that more people are likely to breach the lifetime allowance and be at risk of a lifetime allowance tax charge at retirement.

In our evidence last year, we reported that employers were concerned about the impact on retention, with employees requesting to reduce their hours, refusing additional work, taking early retirement, and avoiding promotions due to pension taxation. This was having an impact on workforce capacity, service delivery and patient care.

During the 2020/21 scheme year, 17,467 members (approximately 1.19 per cent of the total membership) breached the annual allowance and 8,965 members (approximately 0.61 per cent of the total membership of 1,459,668) accrued benefits worth more than £1 million. The current lifetime allowance is £1,073,100.

In 2019/20, HMT undertook a review of the annual allowance taper and in the Budget on 11 March 2020, it was announced that the income thresholds associated with the taper would each be increased by £90,000. From 6 April 2020, these apply to those whose threshold income is greater than £200,000 and whose adjusted income is greater than £240,000. Those with a total income of less than £200,000 will now not be impacted by the taper. These changes apply to all parts of the economy and therefore across the NHS workforce, including those in clinical and non-clinical roles.

As we reported previously, employers were taking a range of mitigating actions to support those people affected by pension tax. However, since the changes to the taper, some of these initiatives have been withdrawn or reviewed.

In the March 2021 Budget, it was announced that the lifetime allowance would remain at £1,073,100 until April 2026. A range of factors will contribute towards an employee exceeding the lifetime allowance. Employees that are most likely to breach the lifetime allowance and may be at risk of a lifetime allowance tax charge at retirement are those with:

- high incomes
- long service in the 1995 selection
- pension benefits in other schemes.

It is anticipated that nearer to 2026 more members of the NHS Pension Scheme will breach the lifetime allowance limit.

NHS Employers believes flexible accrual rates would provide a clear solution to allow higher earners to control their pension growth and mitigate against pension tax changes if it is in their financial interest to do so. To avoid decisions being made unnecessarily around reducing working hours or retiring early, and as pension tax is such a personal and complex issue, NHS Employers also considers it crucial that higher earners have easy access to independent financial advice

and education. This is important in the context of needing to revisit previous pension tax positions due to the McCloud remedy.

NHS Employers' guidance

NHS Employers has published updated guidance[120] on the optional measures employers may implement to support people and service delivery for those still impacted by pension tax. We are exploring future guidance for employers on recycling employer contributions, including the non-mandatory nature of this option, and perceived inequalities of offering this only to those people affected by pension taxation.

We have also produced an NHS Pension Scheme annual allowance and tax ready reckoner[121], which is designed to help people understand the benefits they are building up in the scheme and the annual allowance. The ready reckoner provides members of the NHS Pension Scheme with a broad insight into their annual allowance position, including whether the tapered annual allowance may apply to them. It also provides an estimated breakdown of the total annual cost of scheme membership and estimates by how much their NHS pension is projected to increase.

The ready reckoner presents people with a traffic light system to assess the potential risk of breaching their annual allowance. The purpose of the traffic light system is to highlight when an employee can have relative comfort in their position, or when they ought to be seeking independent financial advice. The tool was launched in 2020 and has been updated to look at the 2021/22 tax year only.

We hosted a webinar[122] on how employers can help people facing pension tax issues to support retention and service delivery on 11

[120] NHS Employers (2020), Local Options for Affected Staff.
[121] Assessing Annual Allowance: NHS Employers: July 2021
[122] NHS Pension Scheme - Pension Tax: NHS Employers: November 2021

November 2021. The slides and recording are available for employers to access.

We continue to produce resources to raise awareness and improve understanding of the annual and lifetime allowance, including the changes that were announced in the March 2020 Budget.

Scheme flexibilities

We reported previously that the DHSC consulted on proposals to change the NHS Pension Scheme, to address the impact of pension taxation on people, organisations and service delivery.

The DHSC has announced that it will not implement proposals to offer senior clinicians more control over their pensions growth to manage their pension tax position, as the Chancellor's decision to raise the income threshold for annual allowance tapering from £110,000 to £200,000 from 6 April 2020 achieves the same aim.

We will continue to support the case for flexibilities for all members of the NHS Pension Scheme, not just senior clinicians, including giving members the option to flex the level of accrual and therefore the level of their contribution, to make the scheme more affordable and to enable those on lower incomes to save towards their retirement. The case for introducing scheme flexibilities is now greater as the NHS Pension Scheme moves towards a flatter member contribution structure. As member contributions for lower earners continue to increase, it is important to allow members to choose an affordable level of pension savings, to ensure the scheme remains attractive and affordable for all NHS people.

Pay band 2 is now the minimum entry level of pay into an NHS career. It is vital that there is early and sustained additional investment in pay at this level. Adequate pay in band 2 will prevent the NHS being labelled as a low-pay employer and enhance its

standing in the local communities from where so many staff at this level are recruited.

Actuarial valuation 2016

In July 2020, HMT announced that the pause on the cost control element of the 2016 valuations should be lifted and completed. HMT concluded that the cost of the McCloud remedy should be included in the cost cap valuation. Provisional results now show no breach of the cost cap floor, meaning that no improvements to benefits or reductions to member contributions are required. Trade union colleagues are challenging this position. The results of the valuation are expected to be published imminently. The employer contribution rate will remain unchanged until the 2020 valuation is completed.

Actuarial valuation 2020

Work on the 2020 valuation will be progressed during 2022. The 2020 valuation will consider changes to the cost control mechanism announced in the outcome of the recent HMT consultation[123]. HMT is currently consulting on changes to the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate, which is a key assumption in determining the employer contribution for public sector schemes. The outcome of the consultation[124] on the SCAPE discount rate is expected in 2022 and any changes to the discount rate will be included in the 2020 valuation. The new employer rate will be effective from 1 April 2024.

[123] Public Service Pensions: gov.uk: June 2021
[124] Public Service Pensions: gov.uk: June 2021

Scheme membership

The graph below illustrates the latest data we have on the distribution of scheme membership across the pay grades in the 2018 pay and conditions of service structure.

Retention commission

We were commissioned to deliver a programme of work to support wider retention work by NHSEI ahead of its national campaign in autumn 2021.

Our activities are focused on four key priorities under which we have delivered a series of web pages, guides, resources, and webinars to support employers to retain people using the NHS Pension Scheme as a key reward and retention tool.

The four priority areas were identified as:

- promoting the value of the NHS Pension Scheme
- flexible retirement options
- retire and return

- pension taxation.

We have continued to support employers with a range of resources:

- Promoting the value of the NHS Pension Scheme[125] [126] - a presentation pack with guides, slide and poster.

- Flexible retirement options[127] [128] [129] webinar, web page and poster.

- Retire and return[130] webinar.

- Our pension taxation ready reckoner and webinar previously mentioned (2020/21 financial year), which includes guidance for employers and a checklist for their people.

We will be launching an online learning module for HR teams to understand and learn about these topics. We continue to visit our regional networks to promote the NHS Pension Scheme as a key recruitment, retention and reward tool. We are also engaging with our total reward network to promote these resources.

[125] Promoting the value of the NHS Pension Scheme: NHS Employers: October 2020
[126] The Value of the NHS Pension Scheme: NHS Employers: December 2016
[127] Flexible Retirement Options: NHS Employers: September 2021
[128] Flexible Retirement: NHS Employers: August 2021
[129] Retirement Flexibilities: NHS Employers: August 2021
[130] Retire and Return: NHS Employers: October 2021

Section 7: Workforce supply

Training recovery, service recovery and workforce recovery must be considered together.

A career in healthcare offers an opportunity for people who want to make a real difference in the lives of others. Healthcare personal development programmes provide diverse career prospects, including advanced roles in clinical practice, education, leadership and research.

The NHS needs to rapidly recruit across all roles and professions. The surge in interest in NHS careers during the pandemic and changes to the labour market have increased the pool of potential candidates. A new focus on domestic recruitment is needed alongside international recruitment and encouraging experienced people to return to practice.

There is a gap between the number of people employers need and the people who have been trained.

Long-standing NHS workforce supply issues have been exacerbated by the pandemic.

Investment in training in nursing and smaller professions must continue to meet the growing demand for services, especially in mental health, learning disability and community settings where there

has not been the growth in numbers that have been achieved in hospital settings.

Employers must be supported to design workforce development strategies to make key professional careers more attractive to trainees.

It has always been the case that the demand for health and care services can and does change faster than the system is able to make changes to the supply of the workforce. The unique way the NHS operates means that it is not possible to respond to the gap in supply quickly through training more people. Approved full-time nursing degree courses last for three or four years if taking a dual-field degree, or longer if taken on a part-time basis[131]. A nursing apprenticeship takes four years.

The workforce gap can only be filled by making maximum use of multiple routes into the professions.

With an NHS workforce of around 1.2 million[132] FTE employees and around 300 professions[133], slight shifts in population demand or policy direction can have a significant impact on the ability of employers to source the necessary skilled and highly skilled people they need. This impacts on their ability to deliver high-quality and financially sustainable care.

NHS workforce statistics[134] are showing a shortage of around 84,000 FTE people, affecting many workforce groups.

131 NHS England and Improvement: How to Become a Nurse
132 The King's Fund: NHS Workforce Our Position: February 2021
133 Facing the Facts: Shaping the Future: NHS England and Improvement: 2019
134 NHS Workforce Statistics: June 2020

Registered nursing full-time equivalent vacancy rates were higher than the overall NHS vacancy rate in every region in England in June 2020

- This highlights the system-wide nature of the nurse staffing shortfall.

The Health Foundation REAL Centre

Source: NHS Digital (NHS Vacancy Statistics England April 2015–June 2020 Experimental Statistics – June 2020)

[Nurse Supply: Can the NHS Close the Gap? (ifs.org.uk)]

In our joint evidence[135] to HEE and DHSC in response to their public consultation on the update of Framework 15, we reported employer views that there are areas of the workforce which would be impacted by increased demand over the next 15 years:

- Social care, including domiciliary care workforce.
- Primary care.
- Adult mental health and learning disability services.
- Children's services in community and mental health (CAMHS).
- Diagnostic services.

We said that the health and care system starts this process often in a deficit position, despite significant resources invested in recent years to support workforce growth.

[135] Response to HEE Workforce Planning Call for Evidence: NHS Employers: September 2021

We also highlighted specific occupational groups where there are long-standing problems meeting the demand for services:

- Nursing: mental health, learning disability and adult nurses based in community and social care.

- Wider healthcare professional teams: paramedics, sonographers, operating department practitioners, podiatrists, and radiographers.

If employers are to increase the number of new recruits, they must mitigate the issues which are deterring many good people from applying to work in the NHS. In London and the south-east generally, as well as in some other locations such as Oxford and Cornwall, employers tell us that the high cost of living, particularly housing, is a barrier to recruiting new employees. We would support a review of the current system of high-cost area allowances[136].

Nurses and some other clinical students now fund their own education through the student loan system. Although this means that there is no cap on the number of students who can be educated, healthcare students will require clinical placements provided by employers. The number of students is limited by the number of clinical placements that trusts have capacity and funding to deliver.

Additional healthcare student places that are offered by the education sector can only be filled if enough students of the right quality and with the right values can be attracted to apply to courses.

NHS Employers arranged an online conference[137] to give employers an opportunity to share different approaches to strengthen workforce supply so that organisations have a range of options they can consider in their organisations.

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[136] 2018 Pay and Conditions of Service: Pay in High-Cost Areas: Section 4
[137] NHS Employers: Workforce Supply Conference: September 2021

Delegates learned about the actions that organisations across the NHS are taking to meet commitments in the NHS People Plan, including growing your own workforce, inclusive recruitment and developing skills to encourage employers to think about how they may apply these locally and the impact this could have.

If the NHS at national and local level is to get a grip on the workforce gap it will not be sufficient to stop when there are more people than we had before. The system must be certain that there are the right number of people with the right skills and values deployed in the right places to deal with the demand for services we face today and can expect in the medium-to-long term.

Workforce planners and employers must also be sure that our training programmes are equipping the workforce with the skills they will need in the future, taking account of developments in technology, changes in the profile of prevalent disease, and changes in the location and environment in which health and care services are delivered.

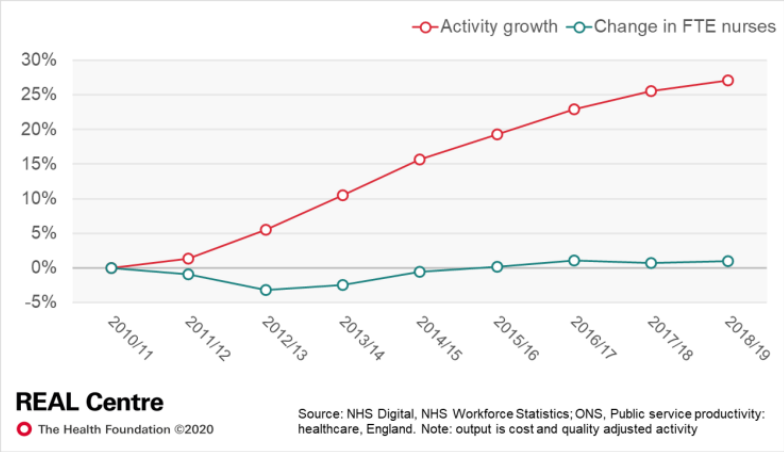
Nursing supply and placement

NHS Digital data shows an increase of 14,800 FTE nurses in August 2020 compared to August 2019[138].

From 2010/11 to 2017/18, the number of FTE nurses in the NHS changed very little, while NHS hospital and community sector activity levels increased by 26 per cent[139].

[138] NHS Workforce Statistics: NHS Digital: August 2020
[139] Building the NHS Nursing Workforce: The Health Foundation: December 2020

NHS nursing numbers have not kept pace with growth in NHS activity over the last 10 years



- The trend of activity growth is unlikely to change in the coming years. The NHS will need sustained expansion in nurse numbers even to deliver existing service levels.
- A number of emergency initiatives have been implemented to enable a rapid temporary expansion of the NHS nursing workforce in response to COVID-19. But it is too early to discern the full implications of the pandemic.

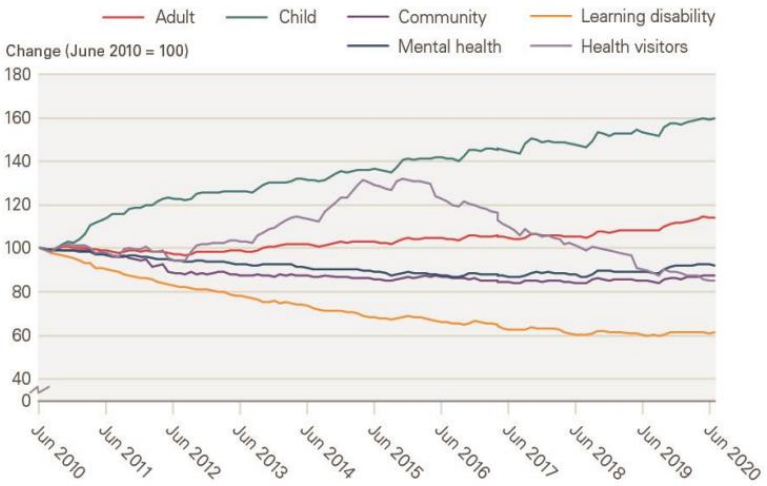
The Health Foundation
REAL Centre

Source: NHS Digital, NHS Workforce Statistics; ONS, Public service productivity: healthcare, England.
Note: output is cost and quality adjusted activity.

[Nurse Supply: Can the NHS Close the Gap? (ifs.org.uk)]

The number of FTE nurses working in adult hospital nursing grew by 5.5 per cent in the year to June 2020, while the number working in community nursing grew only by 1.6 per cent, and by 3.8 per cent in mental health. Over the past ten years, only adult nursing and children's nursing have seen increases in FTE nurse numbers, while the numbers in community nursing, mental health nursing and learning disability nursing are all lower than they were in June 2010.

The (modest) increase in the total number of nurses over the decade to June 2020 masks significant underlying variation across different sectors



- While the number of nurses working in adult hospital nursing in the last ten years has increased gradually, there have been declines in other critical areas – community nursing, health visiting, mental health and learning disabilities.
- Further, in the 12 months to June 2020, the FTE number of nursing support staff increased at over twice the rate of growth in FTE-registered nurse numbers.

The Health Foundation
REAL Centre

Source: NHS Digital, NHS HCHS monthly workforce statistics – June 2020 (2020)

[Nurse Supply: Can the NHS Close the Gap? (ifs.org.uk)]

Between 2017/18 and June 2020 FTE nurse and health visitor numbers increased by around 4.8 per cent. But this upward trend may have stalled.

The total number of FTE vacancies in the NHS in England has increased from 83,203 in June 2020 to 93,806 in June 2021. Over the same period, nursing post vacancies rose from 37,760 to 38,952. This is a vacancy rate of around 10.3 per cent.

Around a quarter of all nursing vacancies are in mental health.

The numbers of people employed in FTE nursing support increased at over twice the rate of growth in registered nurse numbers in the year to June 2020.

The reintroduction of bursaries[140] and additional investment[141] in training places are welcomed by employers.

There was a 23 per cent increase in the number of students accepted onto nursing degree courses in England (relative to 2019) – the highest annual number of acceptances since 2011[142].

The updated Nursing and Midwifery Council (NMC) register[143] published in May 2021 showed there were 2,660 more registered nursing associates.

Overseas supply and international recruitment

Filling vacancies with recruits from domestic sources has been difficult and employers have turned to overseas recruitment to fill gaps. The NHS has one of the highest levels of reliance on people from overseas in the Organisation for Economic Co-operation and Development.

Looking to the long term, the NHS cannot continue to rely so heavily on overseas recruitment. There are worldwide shortages of key people and recruiting nurses from countries where COVID-19 infection rates are still high raises ethical issues.

Given the time required to train new nurses, recruitment of new people from abroad is an essential part of dealing with current vacancies. Overseas recruitment is an important part of the workforce supply strategy of employers, in line with the We are the NHS: People Plan for 2020/21144 and the NHS Long Term Plan[145].

140 Nursing Students to Receive £5,000: gov.uk
141 Universities Can Bid For More Healthcare Course Places: gov.uk: June 2020
142 UCAS: Nursing Applications Soar: February 2021
143 NMC Annual Registration Data Report
144 We are the NHS: People Plan for 2020/21: NHS England and Improvement
145 NHS Long Term Plan: NHS England and Improvement

Ethical international recruitment has been a workforce priority, supporting the ongoing management of COVID-19 in areas across England and the recovery from the pandemic. NHSEI has supported employers through a package of financial support for trusts to increase the number of international recruits they have, and as a priority to provide safe induction and pastoral support for these recruits.

The travel restrictions caused by the pandemic limited employer capacity to boost the workforce this way. Some people who had been recruited were not able to leave their home countries. The Home Office and regulators put in place measures to enable overseas candidates already in the UK to extend their visas and join temporary registers to enable them to help support the pandemic. Work continues to ensure capacity to transition from temporary registers to permanent.

In February 2021, the government published a new code of practice[146] to 'set out principles and best practice benchmarks to be adhered to by employers and recruitment agencies when recruiting international health and social care personnel to ensure effective recruitment is undertaken in an ethical, managed and mutually beneficial way and in line with advice from the World Health Organisation.'

With the introduction of the new code, the number of countries from which the NHS was not allowed to recruit has fallen from 152 to 47.

The Nuffield Trust[147] has compared the cost of recruiting a trained nurse from overseas and recruiting and training a nurse in this country. The cost of recruiting from overseas is around £2,000 to £12,000 per nurse hired, while taking a candidate through the nurse

146 Code of Practice: gov.uk: February 2021
147 Nuffield Trust: Recruiting Nurses From Overseas: February 2020

degree apprenticeship scheme costs much more[148] over and above the annual designated levy of up to £27,000.

In further analysis[149] the Nuffield Trust says the following:

- Nurses from outside the UK or EU are more likely to remain in the NHS than nurses of UK nationality (93 per cent versus 90 per cent) and more likely to remain in the same organisation (89 per cent versus 84 per cent), based on data for the year to October 2019.

- Nurses recruited from outside the UK are contracted, on average, to work more hours than those from the UK. On average, nurses with EU nationality work 93 per cent of a full-time contract, while nurses from outside the EU and the UK work 97 per cent, compared to 88 per cent for nurses with UK nationality. It is not clear whether higher participation is due to desire or lack of opportunity.

- We estimate that, in the case of a nurse joining the NHS aged 30, on average we may expect an EU national to work in hospital and community services for six years before leaving, compared to nine years for a UK national and 12 years for someone from the rest of the world.

- While there are considerable upfront costs in recruiting nurses from overseas (around £10,000 to £12,000), this needs to be considered in the context of national funding to support such activities, and the longer-term or broader costs of alternative routes to increase nurse numbers, such as use of agency nurses or increasing domestic training numbers.

148 Closing the Gap: Nuffield Trust< The King's Fund, Health Foundation: March 2019
149 Nuffield Trust: Overseas Nurse Recruitment: October 2021

NHS Employers is continuing to work with employers on international recruitment by promoting best practice through case studies[150] and other information. Employers are:

- communicating regularly across multidisciplinary teams and involving senior leadership from the start to ensure nurses feel welcomed and looked after across the whole process

- operating robust training programmes as recommended by the Organisation for Security and Co-operation in Europe to support large cohorts of international nurses

- working with multiple recruitment agencies to increase the volume of high-standard and high-calibre nurses arriving in larger cohorts

- providing strong pastoral care and a robust induction to ensure the needs of international nurses are met and they feel culturally, emotionally and professionally supported.

The number of nurses and midwives from Europe leaving the NMC's register[151] has risen from 1,981 in 2015/16 to 2,838 in 2019/20 and the number joining the register fell by around 90 per cent in the same period.

The Health Foundation estimates that to meet the government's target of 50,000 more nurses, employers will need to recruit on average 5,000 people from abroad in each year up to 2024/25.

The NMC has increased the capacity for objective structured clinical examination tests to over 1,000 tests per month[152]. Tests will be

[150] NHS Employers: International Recruitment at Yeovil: April 2021
[151] Nursing and Midwifery Council: Registration data
[152] NHS Employers: OSCE tests: April 2021

available on weekends and evenings and the assessment period has reduced from 30 days to ten days.

The introduction of the COVID-19 register has meant that the NMC can temporarily register fit, proper and suitably experienced people, so they can practise if they want and feel able to do so.

Since the start of the pandemic, over 14,000 former nurses and midwives have joined the NMC temporary register. Data taken from a survey of those on the temporary register in July 2020 shows that almost 50 per cent of these have indicated they would consider re-joining the permanent register[153]. Employers are exploring opportunities to retain some of these people and others who have left, through flexible working and retirement initiatives.

The Migration Advisory Committee's (MAC) shortage occupation list (SOL), published by UK Visas and Immigration, has acknowledged workforce shortages for some time and the list continues to include:

- nurses
- medical practitioners (all)
- biological scientist and biochemist
- psychologists
- medical radiographers
- occupational therapists
- paramedics
- speech and language therapists.

The Home Office and regulators put in place several measures to enable overseas candidates already here in the UK to extend their visas and join temporary registers to enable them to help support the pandemic. Work continues to ensure capacity to transition from temporary registers to permanent.

[153] Analysis of the NMC COVID-19 Temporary Register: Nursing and Midwifery Council: July 2020

The new points-based immigration system incorporates a new health and care visa, which benefits from quicker three-week processing times, a lower salary threshold, lower fees, and exemption from the immigration health surcharge.

The new immigration system no longer requires employers to demonstrate the resident labour market test, nor is there a cap on the numbers of certificates of sponsorship issued each year. Albeit the latter two points were also a benefit of being on the shortage occupation list.

NHS organisations need to ensure that the UK remains an attractive place to live and work both for EEA nationals and colleagues from across the world. The NHS Employers international recruitment toolkit[154] refers to the importance of pastoral support to help overseas recruits settle into their new roles and communities in the UK.

Apprenticeships and T Levels

In August 2020, the government launched a new funding incentive which was available up to 31 January 2021[155] to help with the recovery and uptake of apprenticeship programmes. Employers received £2,000 for each new apprentice they hired aged under 25, and £1,500 for each new apprentice aged 25 and over.

The government's Access to Work scheme is available to all people who are disabled or who have learning difficulties and disabilities (LDD), including apprentices. It provides extra support to ensure that disabled people or those with LDD are not substantially disadvantaged in the workplace. Support might be in the form of specialist equipment, adaptions, support worker services, or help

[154] International Recruitment Toolkit: NHS Employers: 30 September
[155] Incentive Payments for Hiring a New Apprentice: UK Government: August 2020

getting to and from work. Access to Work is available to those working as little as one hour per week.

The NHS offers apprenticeships[156] as routes into many NHS careers. Apprenticeships offer career development opportunities for new recruits and employers.

During their studies, apprentices may encounter students undertaking traditional degree programmes. This provides opportunities for some apprentices who have previously been employed as healthcare workers to pass on their experience of patient care.

We believe the introduction in 2017/2018 of the apprenticeship levy has been a potential mechanism for achieving a better balance between the funding of training in the medical and non-medical workforces.

Candidates aged 16-to-18, or 19 years and over in the first year of an apprenticeship, receive at least the National Minimum Wage for apprentices and we understand that many NHS employers pay more. This local flexibility on pay may serve to attract more recruits to some locations than others.

Candidates develop a range of skills, including maths and English, and a competence qualification based on what the candidate can do in the workplace and a knowledge qualification, or a qualification combining both.

Over the last five years or so, the NHS has achieved over 70,000 apprenticeship starts[157], and is above the national average for representation of those from a BME background.

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156 NHS Apprenticeships: NHS England and Improvement
157 Apprenticeships: Health Education England

Leaders report that the employer-led nurse degree apprenticeship route has very low levels of attrition and high levels of retention. It is attractive to the existing workforce for whom we can offer the opportunity to progress into a professional role and achieve their potential. Increasing these roles means more money for employers to cover the significant backfill costs.

Most nursing associate training programmes are being delivered through the apprenticeship route.

NHS Employers[158] has been working with employers who are building apprenticeships into their local workforce strategies.

Employers report several issues:

- Backfill costs while apprentices are undertaking off-the-job learning are over and above levy funding.

- Significant spells of off-the-job training are difficult to achieve. Candidates for nursing associate higher apprenticeships need to spend approximately 40 per cent of their time off the job to meet professional educational requirements.

- Nurse apprentices spend 60 per cent of their time off the job.

- Nursing associate higher apprenticeships are paid at AFC band 3, which presents a financial burden when combined with the time spent away from the workplace.

- Workload challenges mean that a network of educators is needed to offer support and training to apprentices, and this creates an additional financial burden to employers.

158 NHS Employers: Apprenticeships

- Apprenticeships usually take longer than university-based degree programmes, so are not a quick route either for individuals or for employers seeking to grow their registered workforce.

- While the levy offers the potential for supporting ‘preparation for assessment,’ employers need more guidance on what can and cannot be funded and how that funding is accessed and audited.

Under the apprenticeship arrangements, 0.5 per cent of an employer’s total pay bill is set aside to fund apprenticeships. This funding must be spent within two years. Employers unable to spend apprenticeship funds within 24 months may see the funds clawed back to fund apprenticeships elsewhere.

More flexibility in these arrangements would mean employers could use the money to pay NHS apprentices’ salaries as well as the wages of people employed to cover them when they are training.

In Closing the Gap[159] the Health Foundation and others say that although potentially a significant route for widening participation and advancing social mobility, some more intensive apprenticeship routes appear financially unviable for employers.

The Health Foundation suggests increasing the maximum funding level and flexibility in how the funding is used. There needs to be better regional co-ordination including between health and social care settings.

The Institute for Apprenticeships and Technical Education is testing a new model for how funding is allocated to apprenticeship standards[160].

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[159] Closing the Gap: The Health Foundation and Others
[160] NHS Employers: New Model for Assigning Funding Bands: April 2021

The government is increasing apprenticeships funding to £2.7 billion by 2024-25[161].

T Levels were launched in September 2020 with the Health Care and Science T Level being introduced in September 2021. These two-year courses follow GCSEs and are equivalent to three A Levels. T Levels combine classroom theory, practical learning and placements with an employer to make sure students have experience of the workplace. T Levels are designed to provide the knowledge, skills and experience needed to open the door to entry-level skilled roles, a higher apprenticeship or further study including at university.

T Levels are being rolled out in phases between September 2020 and September 2023. The aim is that by 2025, most BTECs will be removed, and A Levels and T Levels will be the main further education qualifications on offer to students at age 16 in England.

Employers can claim £1,000 per T Level student that they host on an industry placement between 27 May 2021 and 31 July 2022.

Mental health and learning disability nursing

Although there has been an increase in the number of people working in mental health[162] in the NHS, looking at the picture over a nine-year period, the number of people has increased (on average) by only about 1 per cent a year. Mental health nurse numbers have declined by 3 per cent over the same period.

It has been estimated that 1.6 million people are on waiting lists for secondary mental health services[163], including approximately 800,000 adults and 450,000 children and young people, while 380,000 people are waiting for NHS psychological therapies services

[161] Autumn Budget and Spending Review 2021: NHS Confederation: October 2021
[162] Number of Mental Health Staff: Nuffield Trust: June 2021
[163] Representation to the Spending Review 2021: NHS Confederation: September 2021

(known as IAPT services). NHSEI calculate that 8 million people would benefit from support for their mental health, but do not meet the current thresholds for care. This includes 1 million adults with severe mental illness, up to an additional 1 million children and young people, and approximately 6 million people for IAPT services.

In January 2021, the government published Reforming the Mental Health Act[164]. This white paper sets out the government's proposals to update the Mental Health Act and wider reforms of policy and practice around it.

The NHS Confederation has made recommendations[165] based on consultation with its mental health network of stakeholders. Many of these recommendations rely on additional resourcing and workforce capacity. Without significant additional resource for the NHS, social care and the tribunal service, the proposals will not be successfully implemented.

Following the publication of the We are the NHS: the People Plan for 2020/21, Health Education England[166] set out its plans to expand and develop the NHS workforce, We welcome the commitment to increase the number of training places for clinical psychology and child and adolescent psychotherapy, and the plan to work with universities to support an increase in undergraduate places from September 2020 in nursing, midwifery, allied health professions, dental therapy and hygienist courses is essential. Yet we would have more confidence in the target numbers quoted if these actions were inspired by published evidence of requirements emanating from employers.

The number of people providing or supporting the provision of mental health services has grown by over 12,000[167] since 2017, when Health Education England published its mental health workforce

164 Reforming the Mental Health Act: gov.uk: August 2021
165 Mental Health Network Consultation Response: NHS Confederation: April 2021
166 Health Education England: Workforce Plan: July 2020
167 Nuffield Trust: Mental Health Workforce: August 2021

strategy[168]. University applications to study mental health nursing rose by 30 per cent in a year to 31,455 for the 2020 intake.

Disparities between workforce capacity in service areas continue to widen. The number of FTE nurses working in adult hospital nursing grew by 5.5 per cent in the year to June 2020, while the number working in community nursing grew only by 1.6 per cent, and by 3.8 per cent in mental health. Over the past ten years, only adult nursing and children's nursing have seen increases in FTE nurse numbers, while the numbers in community nursing, mental health nursing and learning disability nursing are all lower than they were in June 2010[169].

Various initiatives have been introduced, such as targeting new training grants to specific groups of people and specialisms, including learning disability and mental health nursing, to encourage take up in these areas. This includes an extra payment for employers of £3,900 per apprentice as part of the package previously outlined to support nurse degree apprenticeships.

A recent report by the Nuffield Trust[170] suggests that an increased workforce is needed to deal with the increased demand for mental health services. The report discusses how changing child and adolescent mental health services contracts from block to outcomes-based payments could potentially incentivise improvements in mental health outcomes for young people. More recently, the emerging role of social prescribing and voluntary organisations in improving outcomes for young people with mental ill health has come into the spotlight, as research shows that mental health problems can be caused by social and environmental factors. Social prescribing and support services provided by non-medical organisations can play a

168 Health Education England: Stepping Forward to 2020/21: July 2017
169 The Health Foundation: Building the NHS Nursing Workforce: December 2020
170 Laying Foundations: The Nuffield Trust: October 2020

key role in providing early interventions for young people who are at risk of developing mental health problems.

Investment in training has been falling[171], from 5 per cent of total health spending in 2006/07 to slightly more than 3 per cent in 2018/19. Apart from mandatory training, the NHS Staff Survey results[172] since 2015 show very little change in the amount of learning or development provided by employers. This suggests there is potential for more people to access additional training. When the government increased Health Education England's budget by £150 million in the 2019 spending round[173] this was the first increase in six years.

[171] Closing the Gap: The King's Fund: March 2019
[172] NHS Staff Survey: NHS England and Improvement
[173] Health Service Journal: New Training Funding: September 2019

NHS Employers
2 Brewery Wharf
Kendell Street
Leeds
LS10 1JR

0113 306 3000
www.nhsemployers.org
@NHSEmployers

If you require this publication in an alternative format, please email **enquiries@nhsemployers.org**

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