Department of Health & Social Care

DHSC's written evidence to the NHS Pay Review Body for the pay round 2025 to 2026

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1. NHS strategy and introduction

This chapter provides the context for the department's evidence to the NHS Pay Review Body (NHSPRB) for the 2025 to 2026 pay round, as well as a brief overview of the evidence itself.

This year the government is inviting the NHSPRB to provide pay recommendations for its full remit. For the 2024 to 2025 pay round, the NHSPRB made 3 recommendations; a headline pay uplift, a change to the progression within bands 8 and 9, and a recommendation for the government to issue a funded mandate to the NHS Staff Council to address structural issues in the Agenda for Change (AfC) contract. The government accepted all 3 of these recommendations, and the first 2 have been implemented.

The government remains committed to providing the NHS Staff Council with funding to begin to address issues with the AfC pay structure, which is the last outstanding element of the 2024 to 2025 pay award for the government to action. Government is currently operating within an extremely challenging fiscal position, and funding for the AfC pay structure has needed to be carefully considered alongside all other spending priorities.

We understand the importance of beginning to address some of the pay structure issues as soon as possible. To enable us to provide this funding in the 2025 to 2026 pay year, we intend to use a proportion of the overall funding that we have set aside to invest in AfC pay, as set out in the affordability section of chapter 2.

This approach requires funding for AfC pay structure reform to be considered alongside funding for headline pay uplifts. The level of funding that would be required to deliver pay structure reform is scalable, and it will be for the NHS Staff Council to decide how best to target the investment that is provided.

As the NHSPRB has a remit to make recommendations on the remuneration of AfC staff, we are asking the review body to provide a view to the government on the relative priorities of investing in headline pay and investing in the pay structure mandate this year, within an affordable overall pay settlement for DHSC, and to set this out in its report.

Ahead of the NHSPRB making its recommendations for this pay round, we will work with the NHS Staff Council to agree an approach for negotiations and timescales for implementing any resulting changes to the pay structure. The parameters of the negotiations will be clearly set out in a mandate which will be issued to the NHS Staff Council. We are anticipating that the resulting pay structure changes will be implemented within 2025 to 2026, and intend to discuss progress on this at oral evidence.

Once the NHSPRB has provided its recommendations and the government has confirmed the level of funding for the pay structure mandate, the NHS Staff Council will agree the changes it wishes to make to the AfC pay structure within this envelope.

Over the past year, the department has worked with stakeholders to progress the non-pay commitments agreed as part of the 2023 AfC deal. While some of these workstreams have resulted in positive changes already having been implemented to support the NHS workforce, some have produced a set of recommendations for government ministers to consider. We will provide further detail on the progress and outcomes from this work in chapter 3 and annex.

The government is immensely grateful for the critical role all NHS staff play in our health service and the high quality, compassionate care they deliver. The Health Secretary has been clear he wants to reset relations with NHS staff and is determined to work with them to rebuild the health service and fix the foundations.

Data approach

This year, to avoid unnecessary duplication of evidence, we have taken a more collaborative approach with NHS England (NHSE) on our analytical evidence. This means that, in places, rather than including data ourselves, we will reference data that has been provided by NHSE in their data pack. We will provide our own narrative to accompany this in this document and reference clearly where NHSE data pack figures, or publicly available data sources, are being referenced. Any feedback on this approach would be appreciated. Note, where we use the date format 2024 to 2025 we are referring to financial year unless otherwise specified.

The NHS workforce

The new government has set out 5 missions for this parliament, one of which is to "Build an NHS fit for the future". An essential component to achieve this mission is an appropriately resourced NHS, with a skilled and diverse workforce which is effectively distributed across care settings and the country. The total reward package that accompanies working for the NHS is pivotal in attracting and retaining such a workforce, and this evidence looks to provide the context, data, and policy detail that will enable the NHSPRB to make informed recommendations.

The foundation of building an NHS fit for the future will be the 10 Year Health Plan, which will outline how we intend to shift the NHS from analogue to digital, hospital to community and treatment to prevention. In turn, it will help with setting departmental priorities and workforce planning. To inform the development of the 10 Year Health Plan, Lord Darzi was

recently commissioned to carry out an investigation into the state of the national health service in England. The ensuing report was published in September 2024 and found that an increasing workforce in the NHS has not translated into productivity gains. Effective workforce planning alongside training and support is required to improve productivity. Chapter 3 details the work being undertaken in workforce planning, as well as programmes relating to training, education, and international recruitment.

Chapter 4 of our evidence presents information on average earnings for AfC staff and includes comparisons against the wider economy. As well as considering historic earnings data, we would also anticipate the NHSPRB to consider forecasts for earnings and pay settlements.

Last pay round, in chapter 5 of our evidence we highlighted a number of changes which were likely to have a positive impact on the reward package of staff, such as the continuation of retire and return easements, and new retirement flexibilities for late career staff. The positive impact of these changes will have been felt recently. In addition, Government Actuary Department (GAD) analysis has shown a continuation in the trend on the total wider reward package increasing year on year.

We look forward to receiving your report in 2025.

2. NHS finances

This chapter describes the financial context within which NHS pay awards will need to be met. Findings from the Treasury spending audit earlier this year revealed £22 billion of unfunded pressure inherited from the previous government, leading to the Chancellor taking difficult decisions to find £5.5 billion of savings across department budgets for 2025/2026.

The autumn budget means NHS England RDEL budgets will rise to £182.8 billion in 2024 to 2025 and £193 billion in 2025 to 2026. 2026 Investment alone won't be enough to tackle the problems facing the NHS - it must go hand in hand with fundamental reform. In the short term, patient care pathways will be reformed to ensure patients are seen in settings which can deliver better patient experience for lower cost, enhancing patient choice and embedding best practice right across the country.

Economic context

As outlined in the terms of reference, the Pay Review Bodies should take account of the broader economic context, settlement data are the most comparable data to PRB decisions as they are a direct measure of consolidated pay awards, and so are not affected by broader labour market factors such as changes to working hours or workforce composition. Settlement data are tracking downwards and expected to fall further as we enter the period of the pay award according to survey data, this is in line with OBR's forecast earnings growth for 2025 to 2026 of 3% in the short term before reducing to around 2% in 2026 to 2027.

The rate of UK economic growth since the global financial crisis (GFC) of 2008 has been substantially lower than in previous decades. Annual real productivity growth (GDP per hour worked) fell by around 1.5 percentage points, from an average of 2.1% in the decade prior to the GFC, to 0.6% between 2010 and 2019. Higher productivity enables higher wages and living standards. Only sustained productivity growth over the medium-term can deliver sustainable long-run economic growth and real-terms wage rises.

The government is committed to delivering a decade of national renewal. Through the growth mission, the government is restoring stability, increasing investment, and reforming the economy to drive up prosperity and living standards across the UK.

Funding growth

Table 1: mandate funding for NHS England

NHS England (NHSE)	**NHSE revenue departmental expenditure limits (RDEL) excluding ringfence (RF) (cash) £ billion**	**NHSE capital departmental expenditure limits (CDEL) excluding ringfence (RF) (cash) £ billion**
2019 to 2020	121.334	0.260
2020 to 2021	147.132	0.365
2021 to 2022	147.973	0.337
2022 to 2023	155.228	0.330
2023 to 2024	171.036	0.439
2024 to 2025	176.916	0.431

Source: 2024 to 2025 financial directions to NHS England

Table 1 above shows the closing mandates for NHSE up to 2023 to 2024, the opening mandate in 2024 to 2025. The 2023 to 2024 and 2024 to 2025 RDEL figures have been adjusted for education and training budgets. The figures are adjusted annually to account for reallocation of resource, additional funding, and changes of responsibility between government bodies. The application of IFRS16 has revised the funding amounts from 2019 to 2020 onwards. Figures exclude depreciation, annually managed expenditure (AME) and the technical accounting budget, namely capital grants or Private Finance Initiative.

The 2024 to 2025 totals will be updated in April 2025 closing the financial directions which will reflect the changes made at Autumn Budget 2024, including increased funding which contributes to the cost of the pay awards announced in July Statement.

Financial position

The NHS' (commissioners and providers in aggregate) final spend position shows a significant deficit of £1.3 billion (as set out in the table below), which is a marked deterioration on the year before. Final audited spend in the 2023 to 2024 financial year will be laid before Parliament and is available in NHS England's published Annual Report and Accounts.

The fiscal and economic environment has pushed the NHS into a challenging financial position. The 2024 to 2025 pay uplifts were awarded in the final year of the Spending Review 2021, which was published at a time of lower inflation and no strike action. Consequently, recent pay awards and pension costs have resulted in significant pressures on planned 2024 to 2025 budgets.

The Autumn Budget 2024 means NHS England RDEL budgets will rise to £182.8 billion in 2024 to 2025 and £192 billion in 2025 to 2026.

Table 2 shows the breakdown of funding provided to NHS providers since the 2017 to 2018 financial year, including preliminary outturn data for 2023 to 2024.

Table 2: NHS providers RDEL breakdown

NHS Providers RDEL breakdown (£m)	**2017 to 2018**	**2018 to 2019**	**2019 to 2020**	**2020 to 2021**	**2021 to 2022**	**2022 to 2023**	**2023 to 2024**
Gross deficit	2,433	2,755	1,560	158	126	1,001	1,606
Gross surplus	-1,337	-1,889	-567	-363	-442	-299	-305
Reporting adjustment	-105	-39	-323	-450	-240	-252	12
NHS providers SRP (sector reported performance)	991	827	670	-655	-556	450	1,312
Plus additional RDEL adjustment	47	-1	338	-77	-39	528	69
Net NHS providers RDEL NRF	1,038	826	1,008	-732	-595	978	1,382

Share of resources going to pay

Table 3 shows the proportion of funding consumed by NHS provider permanent and bank staff spend since the 2019 to 2020 financial year. Note that NHS provider permanent and bank staff spend only covers staff working within hospital and community health settings, excluding agency spend by these organisations.

Table 3: increases in revenue expenditure and the proportion consumed by pay bill

Year	**NHSE RDEL (£ billion)**	**NHS Provider permanent and bank staff Spend (£ billion)**	**% of spend on staff**	**Increase in total spend**	**Increase in provider permanent and bank staff spend**
2019 to 2020	121.334	58.447	48.17%	n/a	n/a
2020 to 2021	141.104	65.264	46.25%	16.29%	11.66%
2021 to 2022	146.719	68.865	46.94%	3.98%	5.52%
2022 to 2023	152.553	73.942	48.47%	3.98%	7.37%
2023 to 2024	165.926	81.699	49.24%	8.77%	10.49%

Notes:

- 2020 to 2021: NHSE RDEL figure represents the net outturn of the NHS Group, as the NHS Group was underspent by £6.0bn with respect to its funding
- 2021 to 2022: NHSE RDEL figure represents the net outturn of the NHS Group, as the NHS Group was underspent by £1.3 billion with respect to its funding
- 2022 to 2023: excludes non-recurrent funding for a non-consolidated pay award (£2.675 billion excluded from NHSE RDEL figure, £2.490 billion excluded from NHS Provider permanent and bank staff spend figure)
- 2023 to 2024: excludes Health Education England (HEE) funding from NHSE RDEL figure (note corresponding figure in table 2.1 is inclusive of HEE funding)
- 2024 to 2025: the 2024 to 2025 pay award is expected to increase the proportion of resources going on pay
- Figures in the table are correct to the specified level of significance. Percentage increases may not match increases calculated from budget or spend figures as given in the table due to rounding

The NHSPRB recommended 5.5% for all staff, plus adding intermediate pay points at AfC Bands 8a and above. This resulted in an impact of 5.7% in 2024 to 2025 on the AfC pay bill. There was an additional recommendation to work with the NHS Staff Council to take forward the PRB's recommendations on AfC pay structures. We are asking the NHSPRB to consider the level of funding that it would recommend for pay structure reform alongside funding for headline pay uplifts, giving due consideration to DHSC's total affordability figure.

In 2024 to 2025, the pay awards were above the government's affordability envelope. As a result, this created an unfunded pressure addressed as part of the July spending audit. The government took a range of difficult decisions to manage the pressures identified in the audit, including targeting winter fuel payments, and on health specifically, cancelling Social Care charging reform and reviewing the New Hospitals Programme. On pay, all departments needed to find savings to absorb at least £3.2 billion of the overall pay pressure. DHSC Group undertook a reprioritisation exercise to identify the funding necessary (together with additional HMT funding) with budgets confirmed at the Autumn Budget 2024.

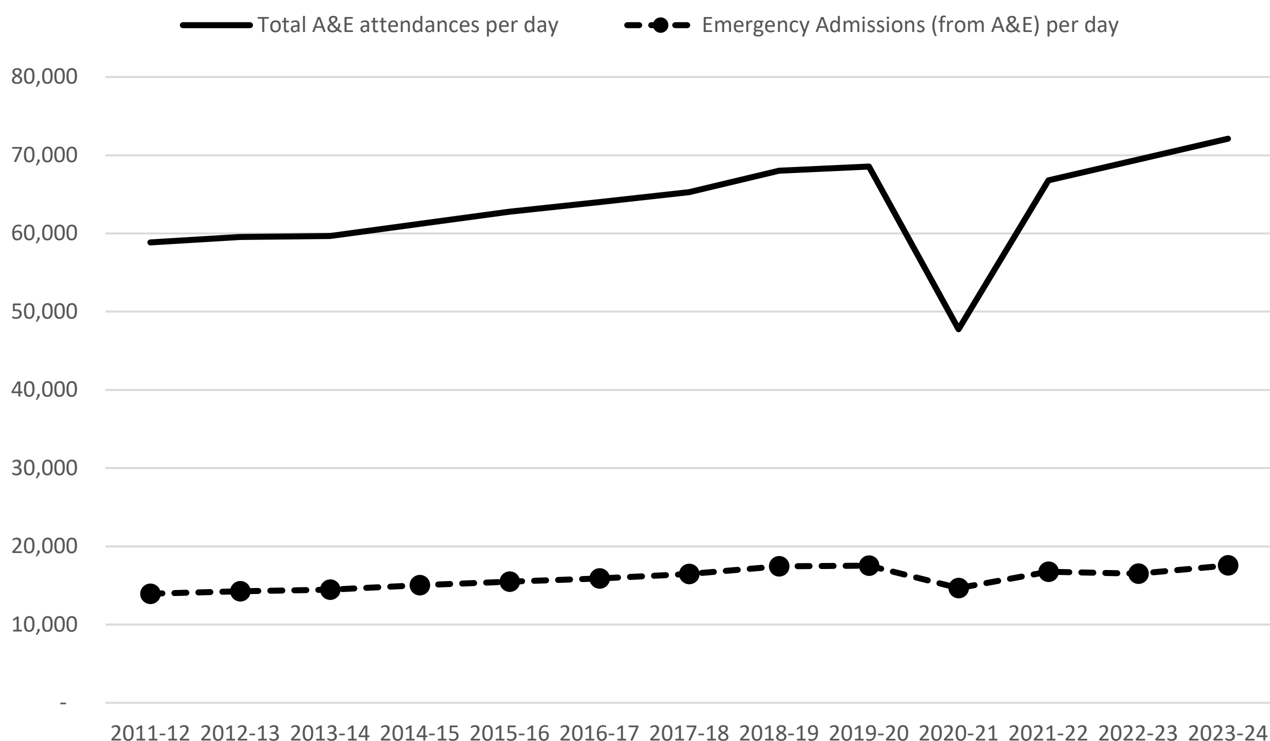
Demand pressures

Activity and demand levels in the health system for elective care dropped dramatically in 2020 to 2021, as numbers of self-presenting patients reduced and the NHS freed up

capacity to manage COVID-19 demand, including the suspension of all non-urgent elective operations.

Demand for non-elective care in 2022 to 2023 has returned to levels seen before the COVID-19 demand spike.

Figure 1: total and emergency admissions per calendar day



Source: A&E attendances and Emergency Admission Statistics

Figure 1 shows the total attendances and emergency admissions to NHS England per calendar day between 2011 to 2012 and 2023 to 2024.

In 2019 to 2020, there were an average of 68,540 A&E attendances and 17,551 emergency admissions per day. In 2023 to 2024, there were 72,113 A&E attendances and 17,563 emergency admissions per day. This equates to a 5% increase in A&E attendances, while emergency admissions remained relatively stable between 2019 to 2020 and 2023 to 2024.

Table 4: total referral to treatment (RTT) pathways completed per working day

Year	RTT estimated clock starts per working day	RTT total completed pathways and unreported removals per working day	Waiting list
2011 to 2012	59,771	59,897	2,443,952
2012 to 2013	63,085	62,150	2,677,497
2013 to 2014	66,281	64,806	3,052,280
2014 to 2015	69,473	68,853	3,209,293
2015 to 2016	73,252	71,403	3,675,298
2016 to 2017	77,956	77,085	3,897,530
2017 to 2018	79,764	78,945	4,102,999
2018 to 2019	82,231	81,272	4,345,467
2019 to 2020	79,712	79,552	4,386,297
2020 to 2021	55,824	53,595	4,950,297
2021 to 2022	74,916	69,322	6,365,772
2022 to 2023	79,511	75,665	7,331,186
2023 to 2024	82,163	81,332	7,538,830

Source: NHSE consultant led referral to treatment statistics.

Notes: data adjusted for non-submitting Trusts and exclusion of sexual health services from 2013. Clock start data was not submitted prior to 2016. Therefore, clock start figures and unreported removals figures are based on estimated clock start figures for 2015 to 2016 and earlier.

Elective recovery has been an ongoing focus for the NHS since the pandemic and the size of the challenge remains significant. The waiting list currently stands at 7.6m (as of July 2024). This is slightly down from 7.7 million in July 2023, but up from 4.5 million in July 2019 before the pandemic.

The NHS Constitution sets out that 92% of patients should wait no longer than 18 weeks from Referral to Treatment (RTT). As of July 2024, the start of the current parliament, only 58.8% of waits are within the 18-week standard. Almost 50,900 patients had been waiting more than 65 weeks and over 290,000 patients had been waiting more than 52 weeks for elective treatment in July 2024. The government will support the NHS to make progress towards the commitment that patients should wait no longer than 18 weeks from referral to treatment.

There has been significant additional funding for elective recovery to address the backlog from the COVID-19 pandemic, via the Elective Recovery Fund (ERF) (£8 billion from 2022 to 2025) and capital funding to increase diagnostic and theatre capacity (£2.3 billion for diagnostics and £1.38 billion for theatre capacity). We have observed an increase in elective activity: per working day activity (including specialist advice and guidance) in August 2024 was above pre-pandemic levels at 112.9% compared to August 2019. However, activity levels are still lower than originally planned; the 2022 Elective Recovery Plan envisaged they would be 30% higher by 2024 to 2025. This has been due to slower productivity recovery, in part due to industrial action. NHS analysis estimates that the waiting list could have fallen by an extra 430,000 from December 2022 to March 2024 without strikes.

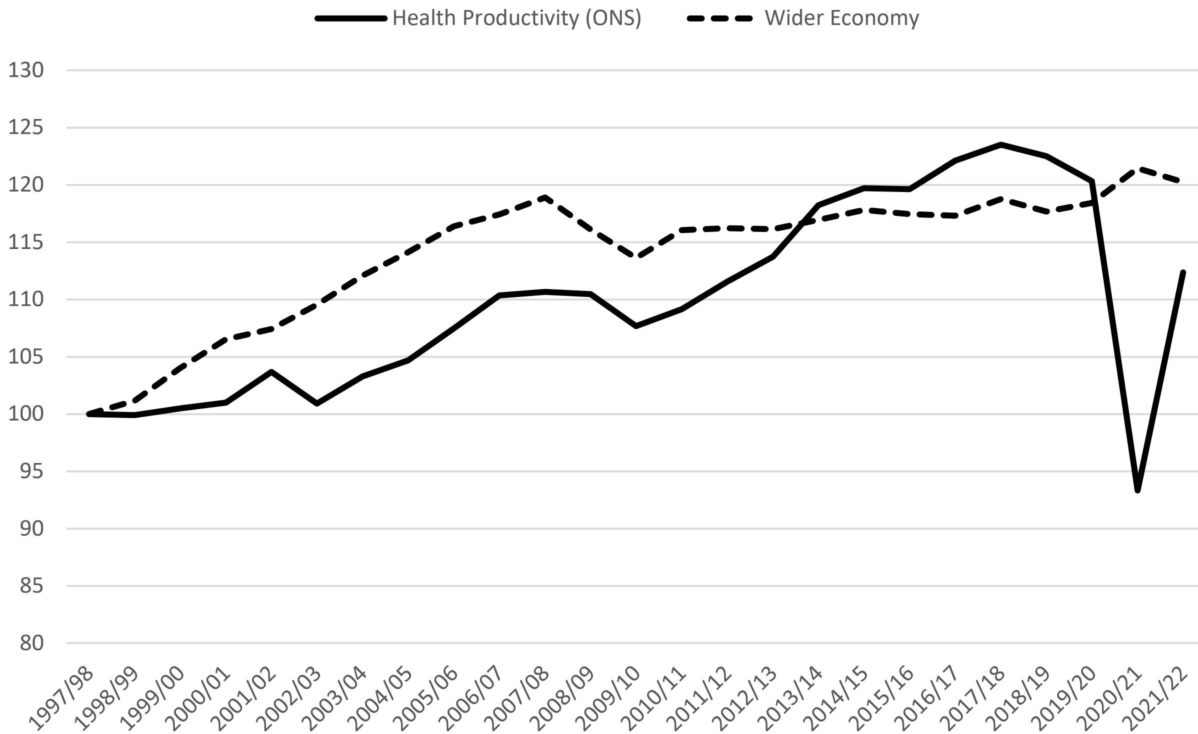
Demand recovered more slowly than expected following the large decrease in referrals seen during the pandemic. Average growth in the years leading up to the pandemic (between October 2016 and February 2020) was 2.1%, although, outside of the pandemic, annual growth ranged from -3.1% to 6.4%. Demand returned to pre-pandemic levels in January 2023, and rebounded at a rate of 6.1% across 2022 to 2023. The rate of demand growth across the last year has fallen; year-to-date demand growth is currently -1.1%. However, we expect demand growth to return to the long-term trend seen before the pandemic of between 2% to 3%.

Calculating productivity in the NHS

Health productivity is hard to measure due to problems with capturing health outcomes in existing data. Despite these challenges York University and the Office for National Statistics (ONS) publish recognised measures of health productivity. England healthcare productivity increased on average by 0.8% per annum from 1995 to 1996 until 2019 to 2020 - a similar rate to the UK wider economy. Health productivity was lower prior to the 2008 financial crash but higher from the 2008 financial crash to the COVID-19 pandemic in 2020.

Figure 2 shows health productivity compared to wider productivity between 1997 to 1998 and 2021 to 2022.

Figure 2: ONS England Health vs Wider Economy Multi Factor Productivity (index 97/98 =100)



Source: ONS England Health Productivity and ONS UK Multi-Factor Productivity

Description: the chart above shows when indexed to 1997 to 1998 health productivity was below wider economy productivity until 2013 to 2014. After 2013 to 2014 health is higher than wider economy productivity until 2020 to 2021. In 2020 to 2021, health productivity dropped by much more than the wider economy productivity. Health productivity recovered in 2021 to 2022 but is still below both the wider economy and health's pre-pandemic level.

ONS figures showed a 22.4% reduction in NHS productivity in 2020 to 2021. This was the result of increasing inputs (for example, staff) to cover the risk of surges in COVID-19 patients and reductions in the number of outputs (for example, operations) due to infection controls and limiting elective treatments. It is important to note that infection controls and lockdowns implemented throughout the COVID-19 pandemic delivered health benefits (for example, fewer COVID-19 cases) not captured in our usual measures of productivity.

ONS reported a significant bounce back in 2021 to 2022 to 6.6% below the 2019 to 2020 level, but some of this recovery is due to the inclusion of Test and Trace and COVID-19 vaccinations. A more modest recovery of 12.5% below the 2019 to 2020 level was reported by York Centre for Health Economics University who publish a similar England wide measure that excluded Test and Trace and most COVID-19 vaccinations.

These formal estimates are only published to 2021 to 2022, but ONS publish a total public sector productivity measure to shorter time scales, of which the health sector comprises 40%. The latest publication (January to March 2024) showed public sector productivity is recovering but is still 6.4% below its pre-pandemic equivalent. Suggesting that many of the problems with recovering productivity to its pre-pandemic level remain.

Table 5: productivity Levels versus 2019 to 2020 for different measurements. The latest is defined as January to March 2024 versus January to March 2020

	ONS health specific measure	**York Centre for Health Economics England wide health measure**	**ONS total public sector**
2020 to 2021	-22.4%	-23.0%	-16.1%
2021 to 2022	-6.6%	-13.3%	-5.4%
Latest			-6.4%

Sources: ONS health productivity, York University Centre of Health Economics: Productivity of the English NHS, ONS Quarterly Public Sector Productivity

While public sector productivity remains below pre-pandemic levels, the NHS continues to face evolving challenges. The backlog for elective care persists due to the long-term effects of managing COVID-19, including delays in discharge, longer non-elective length of stay (constraining elective capacity), high staff sickness and vacancies, and the continued reliance on agency staff. Additionally, industrial action by nurses, junior doctors, and consultants in 2023 to 2024 has resulted in lost opportunities for elective treatment and associated productivity declines. Nevertheless, despite these challenges, acute sector productivity grew by 2% in 2023 to 2024, and this positive trend has continued with an additional 2% growth in the first quarter of 2024 to 2025 compared to the same quarter the previous year.

Productivity and efficiency in the NHS

The autumn budget announcement in October included a commitment that DHSC (including NHS) would deliver 2% productivity growth in 2025 to 2026, driven by significant technology and digital infrastructure investments. This includes over £2 billion investment to advance NHS technology, which will free up staff time, ensure all Trusts have Electronic Patient Records, improve cyber security and enhance patient access through the NHS App.

Increasing NHS productivity and efficiency remain essential to meet the growing demand for health services to support enduring improvements in performance and ensure financial sustainability.

In recent years, funding and workforce levels within the NHS have gradually increased. However, though there has been progress since the COVID pandemic, this has not yet translated into corresponding improvements in productivity. The 2% productivity growth aims to address this gap, to ensure that increased resources translate into measurable improvements in efficiency and service delivery for patients.

To realise this productivity growth, sustained reform is essential for achieving operational excellence. This includes reducing administrative burdens through technological advancements and infrastructure upgrades, delivering care in efficient settings, and prioritising preventive care to reduce costly admissions. Upskilling and retention strategies are also crucial for leveraging a broader range of skilled professionals, ensuring that the NHS workforce can meet growing demands while supporting sustainable productivity improvements.

Lord Darzi's recommendations, on which the 10 Year Health Plan will be based, emphasise that the NHS needs smarter and broader investment rather than simply more funding. This includes focusing on system reform to drive productivity improvements, leveraging technology, and investing in workforce development. The report stressed that any financial increase including pay should be tied to productivity gains and wider systemic improvements. The Carter Review (2016) showed that operational changes could realise substantial savings (£3.57 billion by 2020), highlighting the potential for reform-driven productivity improvements. Following the budget announcement for Spending Review Phase 1 in October, it is clear that future pay decisions should be considered alongside these broader reforms to ensure sustainable investment that enhances both workforce well-being and service delivery.

Steps are also being taken to control spending on temporary staffing, such as expanding staff banks, increasing compliance with agency price caps, and reducing the use of off-framework agency staff. The 2024 to 2025 planning guidance challenged systems to improve workforce productivity and reduce agency spend below 3.2% of the total paybill across 2024 to 2025, and end use of all off-framework agencies. Off-framework spend now makes up less than 1% of agency spend. Together, this will help shape the NHS workforce. Ensuring the right skills mix, in the right place, could optimise productivity and better meet patient needs now and in the future.

Achieving this productivity improvement also requires a combination of delivery of the same care in lower cost settings for example, moving treatment from theatres into outpatient settings, moving hospital admissions to hospital at home, delivering large-scale skills mix opportunities by expanding the workforce with a diverse range of professional

roles, as well as upskilling and retaining our staff, and reducing the administrative burden on clinicians through technological advancement, such as artificial intelligence (AI) and robotic process automation.

The NHS workforce will need to take full advantage of innovations as set out in the Topol Review, Data Saves Lives Strategy and A Plan for Digital Health and Social Care. The widespread safe, effective, and ethical adoption of digital and technological innovations will be one of the most important ways of delivering the government's productivity ambitions.

As part of delivering the 2% productivity target, NHS England is also looking into areas that help efficiency, deliver better value for money and meet growing demands, while managing costs. Some of these areas include:

1. Operational and clinical excellence: improve patient flow, reduce discharge delays, adopt best practices to minimise clinical variation, and deliver care in the right place at the right time through new models of care.

2. Health rather than illness: focus on increasing healthy life years through prevention and screening, and shift care upstream to primary, community, and mental health services.

3. Reducing waste: achieve efficiencies in medicines, enhance commercial processes, and improve corporate services by exploring large-scale automation.

Additionally, NHS England has committed to reporting on productivity metrics at national, ICB, and trust levels starting in the second half of 2024 to 2025, reflecting a more data-driven approach to identify inefficiencies and areas for improvement.

Affordability

Previously in this chapter we have set out the economic and financial landscape for 2025 to 2026 which builds on the challenging position following 2024 to 2025.

Resetting the governments approach to affordability

This government will take a different approach to affordability evidence, as part of resetting the relationship with staff and staff representatives, and rebuilding confidence in the PRB process. In recent years, the government's affordability number had lost credibility, and the NHSPRB's recommendations were consistently above affordability. From now onwards, government will set out a credible figure both to the PRB, and to the NHS to allow Integrated Care Boards to plan ahead of the PRB recommendations to support robust system financial planning.

In doing so, the government will need to factor in the fiscal and economic context, as well as a realistic estimate of the eventual uplift. This should end the period where the government's affordability number is seen as a floor for the PRB recommendations. This approach should mean that in some years recommendations may be below the level of affordability, and sometimes slightly above, depending on other factors the PRBs consider. However, if recommendations are above the level DHSC has budgeted for, the department will need to carefully consider them. Accepting recommendations above what is budgeted for would mean stark trade-offs against activity and wider budgets or consideration to whether productivity improvements can unlock further funding.

Affordability for 2025 to 2026

The Department of Health and Social Care (DHSC) has set aside 2.8% to fund recommendations for both NHSPRB and DDRB remit groups. DHSC view this as a reasonable amount to have set aside based on the macroeconomic data and forecasts and taking into account the fiscal and labour market context.

In 2024 to 2025, the government made a number of difficult decisions at the July statement to manage unfunded pressures including pay awards. On health, this included cancelling social care charging reform and reviewing the New Hospital Programme. For 2025 to 2026, the Chancellor set out at the autumn budget how the government has taken further difficult decisions across tax, spending and welfare through the budget and phase 1 of the spending review in order to repair the public finances, including through driving efficiencies and reducing wasteful spending, reforming its approach to welfare, and increasing the rate of employer NICs to fund public services. Departmental settlements for 2025 to 2026 will need to fund the next round of public sector pay awards.

This government has announced its ambition to build an NHS fit for the future and will set out its vision for this via a new 10 Year Health Plan for the NHS. This included announcing funding to support the delivery of an extra 2 million operations, scans and appointments a year to reduce waiting lists across England. The government is carefully balancing delivery of services for patients and ensuring staff are paid fairly and have supportive working conditions that enables delivery of the best patient care.

Given the wider fiscal position, the government needs to be clear that there would be difficult trade-offs to consider in terms of NHS budgets if the NHSPRB recommendations (inclusive of the funding that is assigned to the pay structure mandate) are above the affordability position that has been set out.

The NHS workforce is the backbone of service delivery with pay the largest component of NHS costs (as set out in the share of resources going to pay chapter above). Therefore, upwards pressures on pay recommendations do have a significant material impact in managing overall DHSC group budgets.

3. Workforce planning, education and training

Chapter summary

This chapter sets out what the government and NHS England are doing to ensure the NHS workforce is able to meet growing and changing patient demand and remain able to adapt as the NHS shifts from analogue to digital, hospital to community and treatment to prevention.

It recognises that the NHS is the largest employer in Europe and plays a significant role in supporting local communities. The chapter starts with an assessment of the non medical workforce in hospital and community services (HCHS). It then sets out how workforce planning and expansions will, over time, drive growth in our economy.

This chapter also covers the work that DHSC and NHSE are taking forward to make the NHS the best place to work. This includes information on ensuring strong and accountable leadership and progress on work to make the NHS people promise a reality for all NHS staff and improve retention.

There is also a detailed section on education and training, to further support a long-term ambition to increase the domestic supply of staff and reduce reliance on international recruitment. The chapter sets out information on changes to the Learning Support Fund (LSF), work to improve clinical educator capacity and clinical placements.

Non-medical workforce - health and community health services (HCHS)

This section describes and discusses the trends in the non-medical HCHS workforce and covers key issues with regards to patterns of recruitment, retention, and motivation.

It does not seek to replicate the data that is already regularly published into the public domain, a summary of these sources and relevant links can be found at the end of this section. Statistics presented here present a point in time prior to the agreement of the 2024 to 2025 pay award.

This section should also be read in close conjunction with the evidence submitted by NHSE where some topics are covered in more depth.

By June 2024, there were over 1.35 million non-medical staff, the equivalent of over 1.20m full time equivalents (FTE). 2023 to 2024 saw a 5% increase in the number of FTE non-medical staff. This is well above the long run average annual rate of 2.4% since 2000.

Broadly, rates of staff leaving active employment in the NHS are lower than pre-pandemic levels, with 10.2% of staff leaving active service in the year to June 2024 compared with 10.8% in the year to June 2019. An exception to this is the rate for lower AfC band staff. For example, leaver rates for staff supporting doctors and nurses are 10.6% in year to June 2024 compared to 10.4% in year to June 2019. It should be noted that published leaver rates reflect leavers from active service in NHS trusts, so include some staff on maternity leave or career breaks, as well as people leaving to work in GP settings or elsewhere in the health and care sector.

It is important for registered professions, such as nursing, to place this level of leavers in the context of analysis from wider evidence which suggest that annual leaver numbers from the registered nursing profession are low in comparison to other sectors[1]. Leaver rates from the Nursing and Midwifery Council (NMC) register, a marker of people giving up the profession completely, are below 4% a year, which includes those retiring, and have not changed significantly in recent years. Staff survey results suggest around 80% of those considering leaving their current job intend to stay in the NHS, with around 13% leaving the NHS for employment and 8% leavers due to retirement or a career break.

The impact of increased workforce in recent years is also seen in NHS vacancy data with current rates of vacancies being below pre-pandemic levels, driven both by increasing staff in post and more recently slowing rates of increase in current and future planned total workforce.

Despite lower levels of staff leaving, there are continued signs that the workforce is feeling stretched. Although NHS staff are still reporting high levels of stress and burnout, these scores are starting to see slight improvements as revealed in the latest NHS staff survey results. Some scores, particularly around morale and staff engagement are starting to see a return to those prior to the pre pandemic period.

Additionally, sickness absence rates, remain relatively consistent at a rate between half a percentage point and one percentage point above pre-pandemic levels with the single largest reported cause of absences continuing to be stress related illness. While this is a

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1 https://www.ons.gov.uk/economy/governmentpublicsectorandtaxes/publicspending/articles/isstaffretentionanissueinthepublicsector/2019-06-17

pattern seen across other sectors of the economy[2], it is still a contributing factor when assessing staff morale, staffing requirements and productivity.

There is evidence to suggest professions such as nurses are remaining within the health and social care system when leaving NHS employment. The Health Foundation found around 3 quarters of nurses leaving NHS employment for other employment stayed in health and care sector roles[3]. We further note that information from professional bodies reporting increased intentions to look at employment opportunities outside of the UK show no signs of crystalising as significant outward flows of staff at this point in time[4].

Workforce planning

The NHS is in a state of disrepair, and significant reform is needed to ensure that patients receive the appropriate care and the workforce is supported. Expansion alone will not solve the issues facing the health system. New models of care are needed to transform services for patients, allowing greater choice and options, integration of services and an increased focus on prevention and providing more services within the community. We know that the demand on the NHS and wider social care system will continue to grow, impacted by the changes in the way services are provided, population growth in the coming years, and demographic changes with an increasing ageing population with different and more complex health needs living with greater and more complex multimorbidities. This is why it is essential that we have an effective workforce strategy in place to ensure we have the right mix and number of staff, with the right skills and experience, in the right places to deliver safe, high-quality care that patients expect from the NHS.

While the number of training places on offer has increased and there are more staff in the workforce than ever before, as articulated in the Lord Darzi report this has not translated to increased productivity and the workforce remains under significant pressure. This is in part due to patients not flowing efficiently through hospitals and outdated infrastructure such as analogue technology hindering the workforce's ability to deliver care.

Following on from Lord Darzi's report, we are now developing the 10 Year Health Plan for the NHS which will outline how we intend to shift the NHS from analogue to digital, hospital to community and treatment to prevention. The workforce plan will need to align to these priorities, ensuring the supply is sufficient to meet the demand, we have the workforce in

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[2] Sickness absence in the UK labour market - Office for National Statistics (ons.gov.uk)
[3] Retaining NHS nurses: what do trends in staff turnover tell us? - The Health Foundation
[4] Nursing locally, thinking globally: UK-registered nurses and their intentions to leave - The Health Foundation

the right place and the workforce is supported and able to provide the level of service needed to get our NHS back on track.

However, the NHS is more than just a service provider, it is the largest employer in Europe and is therefore able to play a significant role in supporting local communities. The government recognises the importance of aligning expansion to local NHS workforce needs, with an emphasis on priority geographical areas, including rural and coastal areas.

The department will work with the university sector and colleagues across government to ensure that we train the doctors, nurses and healthcare professionals that we need and maximise the contribution that our great research institutions make to the country. The NHS and universities can work to become anchor institutions across all our local areas, not just to drive employment opportunities through training for a career in the NHS and social care, but where we collectively work to drive growth in our economy.

Education and training

Bringing in the necessary staff will take time, but we are committed to training more doctors, midwives, nurses and allied health professionals (AHPs), and will work closely with partners in education to do so.

Since September 2020, all eligible nursing, midwifery and AHP degree students have received a non-repayable training grant of a minimum of £5,000 per academic year via the NHS Learning Support Fund (LSF). Additional LSF funding is also available for studying certain courses - for example, mental health nursing and learning disabilities nursing - with further financial support available to students for childcare, dual accommodation costs and travel.

On 1 September 2023, the previous government announced a significant uplift to the LSF travel and accommodation rates, to ensure students are appropriately reimbursed for the cost of travelling for clinical placements. Eligible students are now able to claim 50% more for their travel and accommodation expenses.

A new educator workforce strategy was published in 2022 to 2023 setting out the actions that will lead to sufficient capacity and quality of educators to allow the growth in the healthcare workforce needed now and in the future. We acknowledge, that more needs to be done on this and we will work with the Department for Education (DfE), NHSE and universities to make sure we have the educator staff we need.

Service providers, integrated care systems (ICSs) and NHSE will all have a role in leading and commissioning sustainable education supply, including the supply of educators. To

support this, we will continue to build strong relationships with the education sector and our key partners in higher education institutions (HEIs) and other education bodies.

Linked to educator capacity, we are also working to ensure a sufficient number, spread and quality, of clinical placements. Over recent years, Health Education England (now part of NHSE) has invested £55 million to increase clinical placement capacity and support HEIs to develop their simulated learning capacity. This is in addition to providing placement tariff for nursing, midwifery and AHP students. The national tariff rate per clinical student rose from £3,856 per FTE in 2021 to 2022 to £5,000 in 2022 to 2023, and to £5,193 in 2023 to 2024.

NHSE will work with stakeholders, informed by the issues identified through a discovery exercise in 2022 to 2023, to ensure clinical placements are designed into health and care services, and placement providers know what core standards they need to meet. Co-design of a nationwide approach to clinical placement management will place students at the centre of placement management and practice, with consistent and clear national core standards for placement providers. It will enable a more strategic view of capacity so that the NHS can work more effectively with the education sector to ensure the right volume of training, in the right settings, for each profession, provide better support for placement providers, and better meet the needs of students.

Blended learning

NHSE has introduced a highly innovative, blended learning nursing programme to utilise a combination of innovative learning approaches supported by technology, coupled with more traditional learning approaches. Courses are designed to appeal to a wider range of potential students who, for example, have to balance commitments such as having a young family or other caring role, have challenges in relation to travel or the remoteness of where they live, or who have an interest in technology and using digital skills to study.

NHSE are working with 7 universities to deliver the blended learning nursing degree programme and 4 universities to deliver the blended learning midwifery degree programme. NHSE will appoint a partner to complete an independent evaluation of the nursing and all other commissioned blended learning programmes to understand the quality, impact, and social and financial return on investment. NHSE will also encourage and support HEIs to adopt the Nursing Midwifery Council’s new standard, allowing up to 600 hours of practice learning to be undertaken via simulation (an increase from 300 hours in November 2021) alongside an expansion of the virtual hybrid learning faculty and simulation faculty programmes.

Over 6,000 learners are enrolled on the Becoming Simulation Faculty online programme; this is up from 4,000 in April 2024, representing 50% growth over 6 months.

All regions are involved in the delivery of workshops and are at different stages of workshop planning, educator (facilitator) training and workshop delivery, with Leeds, Yorkshire and Humber and Northampton, Midlands delivering workshops independently.

Three supplemental and advanced online modules are in design with expert authoring and review groups.

There are currently 19 universities across the UK who have applied to the NMC to utilise the 600 hours of simulation, but are not fully utilising it, for various reasons - recent NMC review.

Becoming Simulation Faculty:

Three phases of design, delivery and evaluation are in progress concurrently on Becoming Simulation Faculty:

1. Delivery of the core course via online learning.

2. Consolidation of learning and certification of the core course through face-to-face workshops.

3. Creation of new supplemental and advanced online modules.

Apprenticeships

A key part of our expansion work is focussed on continuing to increase the range of training pathways into clinical professions. This supports our mission to break down barriers to opportunity, ensuring that people from any education or socioeconomic background can work for the NHS. The new growth and skills levy will replace the existing apprenticeship levy and include new foundation apprenticeships. This will allow funding of shorter apprenticeships, and give young people new routes in to careers in critical sectors.

Apprenticeships provide NHS organisations with the opportunity to attract and recruit from a wider pool of people in the local community, including individuals who are not able to attend university full time, helping to create a workforce which better mirrors the population they serve and fill posts in currently under-resourced areas, as well as offering an ‘earn as you learn’ route into an NHS career.

As of the 2022 to 2023 financial year, the NHS was the largest employer of new apprentice starts, with 19,900 apprentices starting training. This is out of 60,300 new apprentice starts across public sector bodies.

The NHS remains the largest public sector employer of apprentices by number of new starts, provisional 2023 to 2024 financial year data shows that the NHS had 18,400 new apprentice starts out of 54,200 across public sector bodies. With local government having 12,400 new apprenticeship starts, the second largest number of starts in the public sector.

We have developed and driven the implementation of 97 apprentice standards across health and science and, across the 350 different careers in the NHS, there is currently an apprenticeship pathway for all of them. NHS apprenticeship numbers and levy spend continue to increase as employers work to embed apprenticeships within their future workforce planning and as of July 2024 existing NHS staff are able to maintain their salary while undertaking apprenticeships following the changes to the terms and conditions.

In recent years across NHS and non-NHS health and social care organisations (for example, private healthcare, primary care, social care etc.) Registered Nurse Degree Apprentice (RNDA) starts have fluctuated. In the 2022 to 2023 academic year there were 2,717 RNDA starts, this was lower than the 3,416 RNDA starts in the 2021 to 2022 academic year but higher than the 2,234 RNDA starts in 2020 to 2021 academic year. Provisional data between August to June in the 2023 to 2024 academic year shows there have been more than 2,900 RNDA starts, this exceeds finalised starts from the 2022 to 2023 academic year by 8% but is 12% lower compared to provisional data over the same time-period in the 2021 to 2022 academic year.

Education and training reform

New roles

A key part of our reform agenda is continuing to review training and look at creating new types of health and care professionals that draw on a diverse skills mix. This will help ensure a strong talent pipeline into registered professions, enhance skills mix to support professionals to work at the top of their licence, and address key workforce shortages and clinical priorities. For example, there is now a complete apprenticeship pathway available into the nursing profession from healthcare assistant to nursing associate, to nurse degree apprentice and onto advanced clinical practitioner.

There has been a steady rate of Nursing Associate (NA) apprentices in recent years across NHS and non-NHS organisations (for example, private healthcare, primary care, social care etc.). There have been 4,523 NA starts in the 2022 to 2023 academic year, 4,137 in the 2021 to 2022 academic year and 4,304 NA starts in 2020 to 2021 academic year. Provisional data between August to June in the 2023 to 2024 academic year shows there have been more than 4,000 NA starts. This is 10% lower compared to the provisional data from the same time-period in 2022 to 2023 but is 2% higher compared to the provisional data from the same time-period in 2021 to 2022.

Shortened courses

An important part of our reform agenda is bringing people into the workforce more efficiently. This includes:

1. Promoting uptake by education institutions of the opportunity for newly qualified nurses to join the NMC register on qualification at the end of the third academic year. This permits new registrants to be in paid employment up to 4 months earlier and can reduce employers' reliance on temporary staff, and reduce costs and vacancies. It also gives new joiners time to get embedded ahead of the winter months when pressures on health services are typically at their highest. Some education institutions already enable this.

2. Work with the NMC on its commitment to explore the potential for further changes to nursing degrees. To train staff more flexibly, taking into account the opportunities presented by EU exit and leveraging new technologies, we encourage the NMC to consider how graduate nurses can join its register after fewer practice hours, mirroring the approach in many other countries, and enabling an increase in training capacity. A reduction in placement hours from 2,300 to 1,800 over the course of a nursing degree would reduce pressure on learners while significantly increasing placement capacity across the NHS.

Accreditation of prior learning

Pathways into health and care professions can be shortened depending on the level of someone's prior learning through a process called accreditation of prior learning (APL), which recognises previous learning and experience. Expanding these opportunities will help support multiple entry routes into health careers and make education pathways as efficient as possible, widening access and attracting more students. This includes pathways into midwifery and paramedic programmes where shortened programmes will increase staff supply quicker than the traditional 3 years.

NHSE commissioned Middlesex University and partners to establish standardised approaches for recognising previous learning within the healthcare sector to support people who do not follow a traditional career path. This programme is to help employers in particular support those on a technical or vocational routes and learners that don't have traditional qualifications such as GCSE or A level, to be supported in progression as they do not meet the entry requirements set but the university. This piece of work was completed in 2023. See information on how the progression agreement works.

NHSE are also working with UCAS to allocate points to the Level 3 SHCSW Apprenticeship to support this progression.

International recruitment

As the training expansions to increase the domestic supply of NHS staff come to fruition, our reliance on internationally educated staff will significantly reduce. However, internationally educated staff from overseas will remain an important part of the workforce. We value the skills, expertise and care that the NHS's internationally educated staff bring to work every day.

In the year 2023 to 2024, 49.4% of nurses joining the register in the UK for the first time had non-UK countries of training.

We ensure high ethical standards in international recruitment practices through the Code of Practice for International Recruitment of Health and Social Care. The code prohibits active recruitment from red list countries identified by the WHO as having significant health workforce challenges. We conduct regular checks of UK recruiters, through NHS Employers, to ensure no active recruitment is taking place in these countries. However, the code is mindful of an individual's right to migrate and where individuals in red list countries want to come to the UK to work, they have every right to apply to a health and social care employer for a job independently and of their own accord (referred to as 'direct applications') and can expect equitable and fair treatment during the process.

The DHSC publishes international candidate guidance to ensure prospective candidates are well informed before they seek a health or care job in the UK. It includes information on how to avoid scams, being aware of exploitation and what to do about it and other practical information that those seeking work in the UK need to know about. We continue to work with stakeholders to ensure the guidance is disseminated widely and reaches potential international candidates before they have taken the decision to move to the UK.

Health and care worker visa data for nurses shows significant growth in visas granted to nurses between 2021 and 2022 growing from 20,200 in 2021 to 25,700 visas in 2022, before reducing to 22,300 visas in 2023. The latest published data indicates a sharp decline in visas granted to nurses in the first quarter of 2024. There were 2,825 visas granted to nurses between January and March 2024 - 55% fewer than in the same quarter in 2023.

National data for health and care worker visa grants to health occupations (excluding doctors) shows in the first quarter of 2024, that those of Indian nationality made up the largest group with 1,664 visa grants. This is in comparison to 488 of Filipino and 485 of Nigerian nationalities, who make up the second and third largest groups. When compared to the first quarter of 2023, this shows numbers of visa grants by Indian, Filipino and Nigerian nationality, have reduced by 53%, 65% and 62% respectively.

While the recent reduction in visa grants coincides with a number of changes to the visa rules announced by the previous administration in December 2023, NHS staff are broadly unaffected by the changes. This is because health and care occupations remain exempt from the skilled worker salary threshold increases and instead must meet the national pay scale for their role or the new minimum threshold of £23,200 (whichever is higher). The fall in visa grants is therefore more likely attributable to wider factors including the end of the centrally supported nurse international recruitment programme and changes in demand for international staff.

NHS temporary staffing

The deployment of a temporary workforce is an important element of efficiently running the NHS, allowing the NHS to meet demand fluctuations without the need to increase capacity above that which would be required on a sustained basis. Staff can be drawn from internal staff banks or external agencies. However, it is important to balance this with cost and the department and NHSE's temporary staffing strategy aims to support NHS providers to reduce their agency staff bills and encourage workers back into substantive and bank roles.

Measures were introduced in 2016 to curb NHS agency spending. These included price caps, the mandatory use of approved frameworks for procurement, and the requirement for all systems to stay within the specified annual expenditure ceilings for agency staff.

The measures, which are regularly monitored for compliance and effectiveness, aim to reduce cost and give greater assurance of quality. Metrics used to monitor performance on agency usage are included in the NHS oversight framework, which reinforce the rules that NHS trusts and FTs should comply with.

Trusts are encouraged to develop and improve their strategy, procurement, and commercial negotiation in their approach to temporary staffing. NHSE supports NHS trusts to reduce off-framework supply and to develop staff banks, increasing transparency and collaborative arrangements.

Agency spend was £2.96 billion in 2021 to 2022 and £3.46bn in 2022 to 2023. Following a period of agency spend growth, there is more recently some evidence that the measures to reduce agency spend are having an effect, with year to date spend in Q3 of 2023 to 2024 at £2.34bn compared with £2.56bn in Q3 of the previous year.

Price cap compliance for all staff groups has remained constant at 60% since 2018 until 2022 to 2023 when it dropped to 55%.

NHS planning guidance stated that agency spend should account for 3.7% of the NHS pay bill in 2023 to 2024. NHS planning guidance for 2024 to 2025 states that the system should further reduce agency spending across the NHS to 3.2% of the total pay bill. The planning guidance also states that NHS trusts should have ended the use of off-framework agencies by the end of July 2024.

There are some signs that agency spend is further decreasing in 2024 to 2025. However, the government intends to go further. In 'Fixing the Foundations - Public Spending Audit 2024 to 2025', the government committed to working with NHSE to review how to rapidly reduce the costs of temporary staffing.

Leadership

Strong and accountable leadership plays an important role in driving NHS performance and fostering a positive, compassionate culture in the NHS, which is why we have committed to introducing professional standards and regulation for managers. This will be supported by a wider programme of work that is being implemented by NHS England to improve NHS leadership development more widely and complemented by the establishment of a College of Executive and Clinical Leadership.

NHSE's Management and Leadership Development Programme is delivering an ambitious 3 year plan to increase professional accountability and boost public confidence in NHS leaders and managers, which will increase their sense of pride in their profession. This supports the ambitions of the LTWP to invest in the development of clinical and non-clinical managers and leaders.

NHSE's 3 year plan responds to the 'Leadership for a Collaborative and Inclusive Future' review (published 2022) led by Sir Gordon Messenger, which focusses on the best ways to strengthen leadership and management across health and adult social care. The review made 7 recommendations to improve leadership and culture through developing training, career development and talent management, and through embedding inclusive cultures and behaviours within health and care. NHSE is taking forward implementation of all 7 accepted recommendations from this review. On 13 November the Secretary of State for Health and Social Care announced that Sir Gordon Messenger has been asked to support the department to build on his original recommendations to develop and attract the leadership talent needed to deliver the 10 Year Health Plan.

To respond to the challenge of ensuring leaders have the right skills and capabilities, the Secretary of State announced that the creation of a new national college of NHS leadership - a professional body dedicated to raising standards of management leadership and across the NHS. This college will support ongoing development, set clear expectations, and promote best practice. It will bring together clinical and non-clinical

managers, creating a network of accredited leaders with the skills and knowledge to lead the reforms laid out in the 10 Year Health Plan. Through this college, we will strengthen and develop our current leaders and build a future pipeline of top talent.

At the same time, NHS league tables will be introduced. Providers to be placed into a league table to review NHS performance across the entire country. This will be made public and regularly updated to ensure leaders, policy makers and patients know which improvements need to be prioritised. High-performing providers will be given greater freedom over funding and flexibility. There is little incentive across the system to run budget surpluses as providers cannot benefit from it. These reforms will reward top-performing providers and give them more capital and greater control over where to invest it in modernising their buildings, equipment and technology.

Persistently failing managers will be replaced and turnaround teams of expert leaders will be deployed to help providers which are running big deficits or poor services for patients, offering them urgent, effective support so they can improve their service. In the context of our strategy for senior leaders, it is also imperative that pay for senior leaders fairly reflects the complexities of their roles whilst also being used as an incentive to improve performance and patient care.

Retention

Making the NHS an attractive employer with an engaged workforce is an important priority and this underpins efforts to improve both recruitment and retention. Lord Darzi's report emphasises the challenges of staff not feeling engaged and the impact this is having on patient experience, care quality and patient safety. He also noted the impact this is having on discretionary effort across the workforce.

Staff retention is a complex issue that ultimately depends on the personal choices and decisions of people working across the NHS. Many factors can influence this including but not limited to: career progression; pay and reward; access to learning and development; culture and leadership; relationships with managers and colleagues; pressures in the workplace; and opportunities to work flexibly.

NHSE is leading a range of work through its retention programme to improve organisational culture and the workplace environment. They will set out in their evidence the progress that is being made in this area, including:

- the learnings from the People Promise Exemplar programme
- the importance of promoting flexible working opportunities

- the benefits of investing in good occupational health and staff wellbeing initiatives
- work to tackle discrimination, bullying and abuse against staff through the NHS Ethnicity, Diversity and Inclusion (EDI) Improvement Plan and other initiatives

They will also cover the findings of the NHS Staff Survey that was published in March 2024 which showed broadly positive results.

Action on retention needs sustained commitment and leadership and more consistent roll-out across NHS organisations to reap the full benefits at organisational level and make a genuine difference to how staff feel about working in the NHS. Through the 10 Year Health Plan for the NHS, we will look at how we can build on the workforce plan and the NHS retention programme to ensure staff feel well supported.

Non-pay commitments from the Agenda for Change 2023 deal

As part of the Agenda for Change pay deal that was agreed in 2023 between government and the NHS Staff Council, 10 non-pay commitments were made to support the NHS workforce.

Some of these commitments involved specific actions being taken, and some of the commitments were to explore certain issues and develop recommendations for government to consider.

A dedicated programme board was set up to oversee the delivery of the non-pay commitments. This board included representatives from the NHS Staff Council, NHS England, NHS Employers and DHSC. The board jointly agreed commissions for each of the 10 commitments, and assigned either the NHS Staff Council, DHSC, NHS England or the Social Partnership Forum to deliver the commitments, working in partnership with relevant stakeholders.

At the final meeting of the programme board in November 2024, the board was satisfied that the 10 non-pay commitments had been delivered according to the deal.

Although the deal has now been implemented and the programme board has been stood down, some of the workstreams require further consideration. Depending on the nature of the commitment, some of this work is continuing through existing work programmes and governance models, and some of the workstreams have produced a set of recommendations for ministers to consider.

In terms of the recommendations that have been made, government ministers will now consider these and make decisions in due course. As the 2023 deal did not include funding for any of these recommendations, any additional funding that would be required will need to be considered alongside wider government priorities.

Outcomes of the non-pay commitments

Whilst it has been agreed by the programme board that the final reports for these workstreams are confidential and will not be shared publicly, the summary of the 10 workstreams has been agreed and is in the annex of this document. This provides an overview of the work that was undertaken for each of the 10 commitments, and highlights the consensus positions that were reached.

In some workstreams, parties put forward proposals where consensus could not be reached, and in some there were suggestions made for measures that were not in scope of the agreed commissions from the deal. These issues were recorded in the final reports, with some parties noting the intention to pursue these separately as appropriate.

Gender and ethnicity pay gaps

The recommendations made in the Gender Pay Gap Review in Medicine, although directed at the medical workforce, do have an influence on other NHS staff groups. Chapter 4 of our evidence includes data produced by NHSE on both ethnicity and gender pay gaps across all AfC staff groups. Work on improving flexible working opportunities, improving the culture within the NHS and actions to improve career progression are key to helping tackle the gender pay gap across the secondary care. The people promise, with a focus on retention, provides support to NHS organisations to help them improve the working experiences of NHS staff by tackling discrimination, providing good quality health and wellbeing support, and increasing opportunities for flexible working. These initiatives are complemented by NHS England EDI plan which set out a series of high impact actions to eradicate pay gaps in gender, ethnicity and disability.

NHSE are responsible for EDI through workforce race equality standard (WRES) and the NHS EDI improvement plan. The latter sets out a series of high impact actions, one which specifically asks NHS organisations to 'eradicate' their pay gaps in relation to gender, ethnicity and disability. Lack of ethnicity pay gap reporting was highlighted as an area of concern and this is an issue that is being addressed by NHSE. There has been no data collection this year, but NHSE will be including an outline in their evidence ongoing work around sharing good practice and work that will be commencing later this year.

Links to published data sources:

NHS workforce statistics: published by NHS England, covering the substantive workforce employed in NHS trusts and integrated care boards (and their predecessors). These can be assessed here: [NHS workforce statistics - NHS England Digital] to view most recent statistics, navigate to latest statistics, then select resources. See below variables and the corresponding data table that are available from within the resources section.

Includes:

Monthly full time equivalent and headcount staffing data by staff group and organisation/region as well as information on staff by their care setting and level. - Available in: NHS workforce statistics, England and Organisation

Quarterly information on:

Reasons for leaving across all staff. Available in: NHS workforce statistics, Reasons for leaving

Nationality of staff - Available in: HCHS staff in NHS trusts and core orgs - staff in post summary tables

Areas of work and job roles for staff - available in: HCHS staff in NHS trusts and core orgs - area of work, job role tables

Turnover of staff - available in: HCHS staff in NHS trusts and core orgs - turnover tables

Mental health workforce - available in: HCHS mental health workforce in NHS trusts and core orgs

Equality and diversity of workforce data - available in: equality and diversity in NHS trusts and core orgs

NHS vacancy statistics: published by NHS England, covering numbers and rates of FTE vacancies in NHS trusts, broken down by for medical staff and registered nursing staff.

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey

NHS sickness absence rates: published by NHS England, covering rates and reasons for absence by staff groups and regions. Cover staff in NHS trusts and other core organisations and also NHS support organisations and central bodies.

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

NHS staff survey: published by NHS England and the Picker Institute. Annual survey of NHS staff, latest data is for the 2023 survey.

https://www.nhsstaffsurveys.com/

Professional registers: data from the independent bodies, such as the Nursing and Midwifery Council and the Health and Care Professions Council on the number of people registered with them.

https://www.nmc.org.uk/about-us/reports-and-accounts/registration-statistics/

https://www.hcpc-uk.org/about-us/insights-and-data/

4. Earnings

Introduction and core messages

This chapter contains information on pay and earnings for non-medical staff working under Agenda for Change in England. It includes detail of how pay has changed over the past year following the 2023 to 2024 pay award and the outcome of the 2024 to 2025 pay decision which is not yet visible in outturn data. It then contains information on how pay growth for AfC staff compares to the wider economy as well as forecasts for 2025 to 2026.

Data suggests that the pay award for 2023 to 2024 and 2024 to 2025 broadly was in line with the wider economy and the NHS has retained a small premium against the National Living Wage as the target that NLW should equal two-thirds of median income has been reached.

As well as considering outturn earnings growth the PRB will also want to take account of forecasts for earnings and pay settlements to ensure that pay recommendations take into consideration both past events and future forecasts. OBR forecasts, published alongside the autumn budget, forecast wider economy earnings growth of 3.0% in 2025 to 2026 which is similar to early indications of forecast pay settlements for 2025.

The Agenda for Change pay system

Following the recommendations of the 37th PRB report published in July 2024, additional structural reform has been implemented with the introduction of intermediate pay points in bands 8a and above. These changes reduce the amount of time required for staff to be eligible for in-band pay progression in bands 8a and above and more closely aligns progression opportunities for those bands with the rest of the pay structure. Staff in these bands are now eligible to progress to the intermediate pay point after 2 years, subject to satisfactory performance and development. Table 6 shows the national basic pay values as of 1 April 2024 and includes information on the pay differences between adjacent bands which may influence promotion incentives.

Table 6: National Agenda for Change pay structure as of 1 April 2024

Band	Band min	Band inter	Band max	Min time to top of band	Band range	Promotion gap	Promotion gap
Measure	(£)	(£)	(£)	(Years)	(%)	(£)	(%)
Band 1	N/A	N/A	23,615	N/A	N/A	N/A	N/A
Band 2	N/A	N/A	23,615	N/A	N/A	N/A	N/A
Band 3	24,071	N/A	25,674	2 Years	6.7%	456	1.9%
Band 4	26,530	N/A	29,114	3 Years	9.7%	856	3.3%
Band 5	29,970	32,324	36,483	4 Years	21.7%	856	2.9%
Band 6	37,338	39,404	44,962	5 Years	20.4%	855	2.3%
Band 7	46,148	48,526	52,809	5 Years	14.4%	1,186	2.6%
Band 8a	53,755	56,454	60,504	5 Years	12.6%	946	1.8%
Band 8b	62,215	66,246	72,293	5 Years	16.2%	1,711	2.8%
Band 8c	74,290	78,814	85,601	5 Years	15.2%	1,997	2.8%
Band 8d	88,168	93,572	101,677	5 Years	15.3%	2,567	3.0%
Band 9	105,385	111,740	121,271	5 Years	15.1%	3,708	3.6%

Source - NHS agenda for change pay scales 2024 to 2025 Bands 1 and 2 operate a single 'spot rate' and Band 1 was closed to new entrants from October 2018.

Note - the 'promotion gap' is based on the difference in basic pay between the top of one pay band and the bottom of the next. Individuals would receive more than this if they are promoted from the middle (or bottom) of the previous band and does not take into account access to the next bands 'pay ladder'.

Another recommendation from the 37th PRB report was that government provides a funded mandate to the NHS Staff Council to address issues identified with the AfC pay structure.

The government remains committed to providing the NHS Staff Council with funding to begin to address issues with the AfC pay structure. The government is currently operating within an extremely challenging fiscal position, and this funding has needed to be carefully considered alongside all other spending priorities.

We understand the importance of beginning to address some of the pay structure issues as soon as possible. To enable us to provide this funding in the 2025 to 2026 pay year, we intend to use a proportion of the overall funding that we have set aside to invest in AfC pay. As is set out in chapter 2 of our evidence, DHSC has set aside a total of 2.8% to invest in pay for the Agenda for Change workforce in 2025 to 2026.

This approach requires funding for AfC pay structure reform to be considered alongside funding for headline pay uplifts. The level of funding that would be required to deliver pay

structure reform is scalable, and it will be for the NHS Staff Council to decide how best to target the investment that is provided.

As the NHSPRB has a remit to make recommendations on the remunerations of AfC staff, we are asking the review body to provide a view to the government on the relative priorities of investing in headline pay and investing in the pay structure mandate this year, within an affordable overall pay settlement for DHSC, and to set this out in its report.

We are anticipating that the resulting pay structure changes will be implemented within 2025 to 2026, and intend to discuss progress on this at oral evidence.

Once the NHSPRB has provided its recommendations and the government has confirmed the level of funding for the pay structure mandate, the NHS Staff Council will agree the changes it wishes to make to the AfC pay structure within this envelope.

Review of national nursing and midwifery job profiles

The job evaluation scheme (JES) is an integral part of AfC and was developed specifically to ensure all roles support equal pay for work of equal value. Using the JES, the skills, responsibilities and effort required for a role are assessed with the scoring outcome determining which pay band the role sits within.

Following an initial request by the Royal College of Nursing (RCN), and later by the Royal College of Midwifery (RCM), the NHS Staff Council's Job Evaluation Group (JEG) began work to review the national job profiles for nursing and midwifery (band 4 and above) in the summer of 2022.

The purpose of this review is to ensure that the profiles accurately reflect current nursing and midwifery practice, training, and role development. This will help employers meet their legal obligation to ensure pay equality across their workforce.

NHS Employers issued an update on the status of this work in August 2024. This update confirmed that the consultation on the national profiles for bands 4, 5 and 6 closed earlier in the summer and JEG were now focusing on the consultation of profiles in bands 7 and above.

Evidence to date indicates that most profiles remain fit for use, with minor improvements required to the language and terminology which will assist matching panels when using them. However, the re-publication of the national profiles, including those that may have been subject to minor language modifications, is likely to trigger a local review of job descriptions. The outcome of any re-banding exercises may confirm that staff have been incorrectly banded. It is the responsibility of employing organisations to implement the job evaluation scheme which includes ensuring job descriptions are regularly reviewed and

accurately describe the skills, responsibility and experience a role entails. Where job descriptions have not been kept up to date, this could lead to banding changes. Where this happens, it will put pressure on local budgets and this will need to be managed.

The JEG have sought agreement from the NHS Staff Council to publish all profiles together rather than publishing them in piecemeal. This work is now expected to be completed in early 2025 at the point the revised national profiles are republished.

In-year progression

Under Agenda for Change, staff are not entitled to automatic time served progression. Instead, in bands 3 to 9 individuals spend a minimum of 2 years at each pay point before becoming eligible to move to the next pay point in their band. This is important for the pay review process as once someone has reached the top of their band, they would need to gain promotion to see pay increases beyond those granted through the annual pay round. Other staff may increase pay by seeking promotion to the next pay band which also grants access to the next 'pay ladder'.

Staff can be split into the following categories:

- top of band - staff who have reached the top pay step point within their current pay band and are not eligible for further pay progression in their current role

- in-year progressors - staff who, in the next 12 months, will be able to move to a higher pay step in their current pay band

- staff between pay points - staff who are not yet at the top of their current pay band and are not eligible to move to a higher pay step in the next 12 months. For example, someone who has just started a new role in band 5 must spend at least 2 years at the introductory pay step before they are able to move to the intermediate pay step point

Table 7 provides estimates on how staff were distributed across these states in 2023 to 2024. Around 53% of staff had reached the top of their current pay band while around 17% of staff would be eligible for progression within their current pay band over the next 12-months. For these staff the average value of that is estimated at just over 7.5%.

Compared to data for 2022 to 2023 there is a slight increase in the proportion of staff at the top of their band and a slight increase in the number of in-year progressors following the introduction of intermediate pay steps in bands 8a and above.

Table 7: staff by band and eligibility for pay step progression in 2023 to 2024 - all staff working in hospital and community health sector

Band	**Average FTE (count)** **Workforce capacity**	**Top of band (%)** **Proportion at top of band**	**In-year progressors (%)** **Proportion eligible to progress in current band within next year**	**Staff between increments (%)** **Proportion not currently at top of band and not eligible for in-year progression**
Band 1	1,746	100%	0%	0%
Band 2	174,332	100%	0%	0%
Band 3	175,344	59%	16%	24%
Band 4	122,859	49%	9%	42%
Band 5	240,274	40%	25%	35%
Band 6	221,546	43%	20%	37%
Band 7	149,586	41%	22%	37%
Band 8a	59,906	37%	23%	40%
Band 8b	25,113	37%	23%	40%
Band 8c	13,353	39%	22%	39%
Band 8d	6,933	43%	21%	37%
Band 9	3,738	46%	19%	35%
All bands	**1,194,730**	**53%**	**17%**	**30%**

Source - DHSC Sub-Group Metrics 2023 to 2024

Note 1 - since 1 April 2023 a single 'spot' rate has been used across bands 1 and 2 meaning there is currently no 'within band' progression.

Note 2 - estimates are based on the pay structure in place from 1 April 2024 including the introduction of intermediate points at band 8a and above.

Average pay and earnings in 2023 to 2024

NHS England publish information on average pay and earnings for staff working in the HCHS in England. This data does not include any outside earnings such as bank, agency or independent work.

All figures in this section are provided on a 'gross' basis which is the total before the impact of tax, national insurance or other deductions which determine 'take-home' pay. Administrative data sources do not separately identify 'take-home' pay meaning that any estimates would be driven by modelling assumptions and because the remit of the PRB, and pay policy, is to make recommendations for gross pay we believe it is an appropriate measure to use.

Average pay and earnings by staff group

There are 3 measures of earnings which are used dependent on the context:

- basic pay per FTE - The average basic pay which would be received if it were assumed that all staff were working on a full-time basis. This is possible because basic pay scales proportionally to the number of hours worked

- earnings per person - the total average amount of pay received per person including both basic pay and non-basic pay elements including supplements for those working additional hours, unsocial hours or in high-cost locations. NHS England does not produce data on 'earnings per FTE' as it cannot be assumed that earnings scale with hours worked like basic pay

- earnings per person (excluding 'other' pay) - the total amount of pay received per person including basic pay and non-basic pay supplements. This version removes pay recorded in the 'other' pay field on ESR which includes the one-off non-consolidated payments made to AfC staff as part of the 2023 to 2024 pay agreement. This is needed to better interpret these data

Table 8 shows average pay and earnings for non-medical staff in the 12 months to March 2024 and shows a comparison to the 12 months to March 2023. Across the HCHS average basic pay per FTE ranges from just over £24,200 for those working in hotel, property and estates to over £91,000 for senior managers.

Table 8: average pay and earnings by staff group - 12 months to March 2024 and comparison with previous year.

Staff group	**Basic pay per FTE**	**Earnings per person**	**Earnings per person (excluding 'other' pay**	**Growth in basic pay per FTE**	**Growth in earnings per person**	**Growth in earnings per person (excluding 'other' pay**
Measure	**(£)**	**(£)**	**(£)**	**(%)**	**(%)**	**(%)**
All staff excluding HCHS doctors	£34,005	£35,120	£33,412	5.2%	10.0%	4.8%
Nurses and health visitors	£38,625	£40,649	£38,769	4.7%	9.5%	4.5%
Midwives	£40,635	£39,496	£37,739	4.6%	8.2%	3.5%
Qualified ambulance staff	£38,885	£49,647	£47,609	5.0%	6.3%	2.6%

Scientific, therapeutic and technical staff	£43,433	£42,460	£40,554	5.1%	9.5%	4.8%
Support to doctors, nurses and midwives	£24,564	£25,246	£23,825	6.0%	11.7%	5.6%
Support to ambulance staff	£26,298	£32,368	£30,773	5.9%	7.5%	3.0%
Support to STT staff	£26,075	£25,961	£24,478	6.0%	12.0%	5.8%
Central functions	£33,092	£33,877	£32,147	5.3%	10.6%	5.1%
Hotel, property and estates	£24,172	£24,603	£23,259	6.2%	10.8%	5.1%
Senior managers	£77,381	£80,813	£78,010	5.7%	9.7%	6.2%
Managers	£59,553	£62,313	£59,905	4.9%	8.9%	4.9%

Source - NHS England Earnings Statistics, 12-Months to March 2024, NHS trusts, ICBs and support organisations

Notes:

- Due to the structure of the pay award in 2023 to 2024 particular care is required when interpreting this data - in particular the 2 non-consolidated payments made to staff employed at the end of March 2023 introduce a difference between the growth in basic pay and total earnings which will impact analysis this year and next.

- growth in basic pay per FTE was broadly in line with what would be expected following the previous pay round which increased AfC pay ranges by 5.0%

- Increases in total earnings (including 'other payments') were higher following the 2 non-consolidated payments made as part of the 2023 to 2024 AfC pay agreement. Increases in total earnings excluding other payments, to remove the impact of non-consolidated payments, were broadly similar to increases in basic pay.

- The introduction of a 'spot' rate in band 2 contributes to the larger increases for those in support functions who may have benefitted from the higher increases in band 1 and the introductory pay point of band 2.

- Published earnings statistics can also be impacted by fluctuations in workforce distribution. For example, NHSE England workforce statistics show that the proportion of nurses in band 5 increased by 1 percentage point between March 2023 and March 2024 (from 43.8% to 44.8%) following workforce expansion which will slightly depress average basic pay. We suggest looking to changes in pay scales as a better indication of pay growth which is not impacted by workforce change.

Average pay and earnings by Agenda for Change band

NHS England have provided data on average pay and earnings by agenda for change band in the 12-months to March 2024. Consistent with the structure of Agenda for Change we see that pay and earnings increase as someone progresses through the pay structure. The higher increases in bands 1 and 2 were consistent with the introduction of the 'spot rate' in band 2 while higher growth in earnings follows the one-off non-consolidated payments made as part of the 2023 to 2024 pay agreement. Table 9: average pay and earnings by Agenda for Change pay band: comparison of 12 months to March 2024 versus 12 months to March 2023

Pay band	**Basic pay per FTE**	**Earnings per person**	**Growth in basic pay per FTE**	**Growth in earnings per person**
Measure	**(£)**	**(£)**	**(%)**	**(%)**
Band 1	£22,372	£17,723	10.7%	14.7%
Band 2	£22,359	£22,229	6.9%	12.2%
Band 3	£23,727	£24,345	5.1%	10.8%
Band 4	£26,345	£27,133	5.0%	10.6%
Band 5	£31,340	£34,108	4.6%	10.3%
Band 6	£39,082	£40,011	4.6%	8.8%
Band 7	£46,994	£46,944	4.7%	8.7%
Band 8a	£53,395	£53,027	4.7%	8.8%
Band 8b	£62,669	£62,624	4.4%	8.1%
Band 8c	£74,831	£75,797	4.4%	8.0%
Band 8d	£89,217	£92,270	4.5%	8.1%
Band 9	£107,127	£111,961	4.5%	8.2%
All bands	£34,005	£35,120	5.2%	10.0%

Source - NHS England earnings statistics

Note - the higher growth in earnings per person follows the non-consolidated payments made to AfC staff as part of the 2023 to 2024 pay agreement.

Income distribution for Agenda for Change staff

Across the workforce, and within staff groups, there will be differences in earnings linked to factors including an individual's pay point, contract and working patterns.

Table 10 is based on data on the income distribution for non-medical staff published by NHS England and is split by staff group. To ensure the analysis is not impacted by people leaving or moving between staff groups, this data only includes staff who were employed in the same staff group throughout the period between April 2023 and March 2024.

For most staff groups, we see there are only small differences between the median and mean.

Table 10: distribution of average earnings per person by staff group, 12 months to March 2024

Staff category	**25th percentile (£)** 25% earn less than	**50th percentile (median) (£)** Mid-point	**75th percentile (£)** 25% earn more than	**Mean (£)** Mean average
United Kingdom	21,216	31,602	46,084	38,224
All staff excluding HCHS doctors	25,731	33,261	44,780	35,120
Nurses and health visitors	34,523	40,662	48,222	40,764
Midwives	32,424	40,702	48,170	39,493
Ambulance staff	42,436	51,839	58,790	49,648
Scientific, therapeutic and technical staff	33,791	42,691	52,359	42,509
Support to doctors, nurses & midwives	20,606	26,050	29,777	25,214
Support to ambulance staff	27,538	32,746	37,876	32,340
Support to ST&T staff	21,319	26,098	29,941	26,048
Central functions	25,874	31,193	43,506	35,025
Hotel, property & estates	17,919	24,501	29,758	24,561
Senior managers	69,291	86,857	113,882	93,274
Managers	53,273	61,019	71,280	65,350

Source - data for NHS staff from NHS England earnings statistics, data for UK from annual survey of hours and earnings.

The impact of the 2024 to 2025 pay decision

Due to the delay in the implementation of the 2024 to 2025 pay decision available pay data does not yet capture the most recent pay decisions which we expect to start reaching staff from Autumn 2024.

Additional earnings

In addition to basic pay, staff can access additional earnings depending on time, location or if it was paid at overtime rates under the terms set out in the Agenda for Change contract (see the NHS Terms and Conditions of Service Handbook).

The structure of the AfC contract means that some staff groups are more likely to receive additional earnings. For example, clinical staff are more likely to work unsocial hours to maintain a 24/7 service while ambulance staff have relatively high levels of overtime due to things like 'shift overruns' if an emergency occurs at the end of a shift which results in them having 'compulsory overtime' to complete a job.

Table 11: proportion of total earnings that are not basic pay by staff group in NHS trusts and core organisations, 12 months to March 2023 and 12 months to March 2024

Staff group	**12 months to March 2023**	**12 months to March 2024**
Nurses and health visitors	13.0%	17.8%
Midwives	15.9%	20.0%
Ambulance staff	36.1%	38.0%
Scientific, therapeutic, and technical staff	8.4%	12.8%
Support to doctors, nurses, and midwives	13.3%	19.3%
Support to ambulance staff	32.8%	35.7%
Support to ST&T staff	7.6%	13.5%
Central functions	5.9%	11.1%
Hotel, property and estates	19.4%	25.2%
Senior managers	4.4%	7.1%
Managers	5.2%	9.2%

Source - NHS England earnings statistics - 12 months to March 2024.

For all staff groups, there has been an increase in the proportion of earnings categorised as 'other' payments. This was to be expected following 2 non-consolidated payments made as part of the 2023 pay agreement.

In 2024 to 2025, we would expect the 'additional earnings' proportion to return to previous levels as one-off payments are not repeated and fall out of the 12-month calculation period.

Payments for ‘additional earnings’ include payments that are linked to ‘overtime’ on the payment system. These are payments, paid at enhanced rates, for hours worked above standard full-time working hours for the role (37.5 hours or 1 FTE). Data from NHS England shows significant variation in the proportion of staff who have recorded completing at least one instance of ‘overtime’ in the past year ranging from 0.1% of senior managers (who will typically be in band 8 or 9 and not eligible for enhanced payments) to 54% of ambulance staff who may be required to complete ‘compulsory overtime’ in the event of shift overruns.

Pay growth drivers

The average earnings for the whole AfC workforce can change for many reasons. Some relate to changes in the composition of the workforce (for example, more senior staff or more staff in higher earning occupations), while some relate more specifically to pay rates. Table 12 shows a breakdown of average earnings growth over recent years into its component drivers, where:

Average earnings growth = headline pay award + earnings drift

Earnings drift = basic pay drift + additional earnings drift impact + staff group mix effect

Changes to pay rates due to the annual pay award or negotiated pay deals will have an impact on average earnings. This is captured in the 'headline pay award', which measures the change in total earnings per FTE that would be expected due to the pay award (including negotiated pay deals, where applicable), other things being equal.

In practice, average earnings usually grow at a different rate, for example because of changes in the makeup of the workforce. This is captured in 'earnings drift', the difference between total earnings per FTE growth and the headline pay award. The reasons for earnings drift can be broadly separated into staff group mix effects, basic pay effects, and additional earnings effects:

- changes in the distribution of staff between higher and lower earning staff groups (for example, a higher proportion of nurses and lower proportion of support staff) will affect average earnings. This is captured in the 'staff group mix effect', which is based on the HCHS non-medical staff groups presented in NHS England published data (and used in table 11 above)

- the basic pay component of average earnings can change due to shifts in the distribution of staff across pay points and bands (for example, band 6 vs band 5 nurses). This is captured in “basic pay drift”, and is measured based on changes within each staff group to exclude staff group mix effects (avoiding double-counting)

- the additional earnings component of average earnings can change due to increases or decreases in the use of payments for overtime, shift work, and other non-basic pay earnings (for example, an increase in overtime hours worked). This is captured in 'additional earnings drift impact', which more specifically measures the extent to which average additional earnings grow at a different rate to average basic pay. (Many elements of additional earnings are directly linked to basic pay, such as overtime paid at 'time-and-a-half', and so would be expected to grow at the same rate as basic pay, other things being equal)

Pay growth estimates are based on data on workforce earnings and size published by NHS England. Drift estimates, the difference between pay growth and the pay award, are based on changes to pay values from pay circulars weighted by pay point workforce size estimates based on NHS England workforce data. The analysis is for all HCHS organisations including NHS trusts, NHS foundation trusts, ICBs and central and support organisations, and is based on earnings per FTE. Growth in earnings per FTE may differ from growth in earnings per person (shown in table 12) due to changes in average FTE per person.

Table 12: breakdown of average earnings growth for HCHS non-medical staff between 2018 to 2019 and 2023 to 2024

Pay growth element	**2018 to 2019**	**2019 to 2020**	**2020 to 2021**	**2021 to 2022**	**2022 to 2023**	**2023 to 2024**
Basic pay per FTE growth	3.2%	2.9%	3.1%	3.9%	4.7%	4.9%
Additional earnings per FTE growth	0.2%	5.4%	5.5%	3.2%	-2.0%	49.5%
Total earnings per FTE growth	2.9%	3.1%	3.4%	3.8%	4.0%	9.5%
Components of total earnings per FTE growth	N/a	N/a	N/a	N/a	N/a	N/a
(a) Headline pay awards	3.0%	3.3%	2.9%	3.6%	4.7%	10.2%
(b) Total earnings drift	-0.1%	-0.1%	0.5%	0.2%	-0.7%	-0.7%
Components of (b) Total earnings drift	N/a	N/a	N/a	N/a	N/a	N/a
(b1) Basic pay drift (excluding staff group mix effect)	0.1%	0.3%	0.4%	0.2%	0.0%	-0.2%
(b2) Additional earnings drift impact (excluding staff group mix effect)	-0.3%	-0.1%	0.5%	0.0%	-0.7%	-0.5%
(b3) Staff group mix effect	0.1%	-0.3%	-0.4%	0.1%	0.0%	0.0%

Source: DHSC analysis based on NHS England workforce earnings and size data and NHS Employers pay circulars

The headline pay award reflects the combined impact in 2023 to 2024 of a consolidated uplift to basic pay scales, plus one-off non-consolidated payments worth between £1,655 and £3,789 per FTE to eligible staff employed at the end of March 2023. Average total earnings per FTE grew by 9.5% in 2023 to 2024. This takes into account the combined impact of the 2023 to 2024 headline pay award of 10.2% and the negative total earnings drift of -0.7%. The consolidated award contributes 5.2% to the headline award impact (the average impact of a 5% increase to basic pay scales, with a higher 10.4% increase for band 1 and the bottom of band 2 to bring their pay scale value up to the top of band 2).

Total earnings drift, the difference between average earnings growth and headline pay awards, reflects the combined effect of:

- a negative 'basic pay drift' (excluding staff group mix effects) of -0.2% in 2023 to 2024 (meaning that average basic pay increased by less than the change to headline basic pay rates). This indicates that the mix of staff across pay points and bands within staff groups has become less expensive

- a negative 'additional earnings drift impact' (excluding staff group mix effects) of -0.5%, which indicates a decrease in the overall use of additional earnings payments in 2023

to 2024. Although additional earnings per FTE increased by nearly 50% in 2023 to 2024, this includes the effect of the one-off non-consolidated payments (which count towards additional earnings). The negative additional earnings drift indicates that, excluding the non-consolidated payments, growth in other additional earnings did not match the growth in basic pay that many types of additional earnings are tied to, with the largest contributors being a decrease in the use of overtime payments, shift working payments, and 'local' payments in 2023 to 2024

- a neutral 'staff group mix' effect of 0.0% reflecting no overall shift in the distribution of staff towards higher or lower earning staff groups in 2023 to 2024

The National Living Wage (NLW) and low pay policy

The current National Living Wage (NLW) rate - the statutory minimum payable to eligible employees aged 21 and over - is £11.44 per hour. Following the outcome of the 2024 to 2025 pay round, the minimum pay rate under Agenda for Change is £12.08 per hour, 64 pence per hour or 5.6% above the NLW, increasing to £14.85 per hour for those working in Inner London.

In the NHS, this represents an increase of 5.5% in the minimum pay rate compared to 2023 to 2024.

The government issued a new remit for the Low Pay Commission (LPC) at the end of July 2024. This asked the LPC to recommend a NLW from April 2025 and instructed them to take account of the cost of living as well as the impact on business, competitiveness, the labour market, and the wider economy, and to ensure that the NLW does not drop below two-thirds of UK median earnings for workers 21 and over.

The government accepted the LPC's recommendations in full and the NLW will increase to £12.21 per hour from April 2025. This is an increase of 6.7% (£0.77 per hour) from the current rate of £11.44 per hour in 2024 to 2025.

Pay recommendations for the 2025 to 2026 pay round will be announced after 1 April 2025, meaning the NLW will be temporarily higher than the current minimum rate of pay in the NHS. The government therefore is required to act prior to April to ensure the NHS remains legally compliant and will work with necessary systems to ensure NHS staff are paid at least the NLW in the interim until the 2025 to 2026 pay uplifts are agreed and implemented. As when similar situations occurred in 2022 to 2023 and 2023 to 2024, this process should not interfere with or undermine the independent pay review body process. Where an interim measure is required to ensure the minimum AfC pay rate remains compliant with the NLW, this should be seen as an advance to the pay award, and not set a new baseline for which the pay award is then applied.

Pay gaps between some bands remain small following the stronger targeting in 2022 to 2023. For example, the current gap between band 2 and band 3 is 1.9% (£456 annually for full-time staff), the gap between band 5 and 6 is 2.3% (£855) and the gap between band 7 and band 8a is 1.8% (£946).

It is possible that small differentials between bands can impact on promotion incentives, particularly where there is an interaction with unsocial hours premia and or recruitment and retention premia. However, promotions into a higher band also occur from the middle of the preceding band, which increases the benefit on promotion, and that the benefits include access to further progression in the higher band.

The trade-off between competing objectives, including maintaining competitiveness in the lower paid labour market vs maintaining pay differentials, will be a factor for setting pay at the lower end of the pay scale in 2025 to 2026.

One of the NHSPRB recommendations from the 2024 to 2025 pay round was for government to provide a funded mandate to the NHS Staff Council to begin to address issues with the AfC pay structure. We understand the importance of beginning to address these issues as soon as possible, and are asking the NHSPRB to consider how best to balance the relative priorities of funding the pay structure mandate and funding headline pay uplifts this year.

The details of how the pay structure funding would be used would be for the Staff Council to determine. We are therefore not yet in a position to be able to confirm how this additional funding will be used to improve the pay structure, and how it might impact the lowest paid members of staff.

When making recommendations, we ask the NHSPRB to consider: the pattern of recruitment and retention issues across both the NHS and the wider labour market and where pay can be most effectively deployed to address these problems; how much more for one part of the workforce means less for other parts of the workforce or other priorities for the NHS budget, and the impact that any targeting of pay has on the smooth functioning and incentives associated with the pay scale.

The broader economic context, as well as the recruitment and retention situation, will be key in determining whether further pay targeting is desirable in 2025 to 2026 and, if so, where it may be justified. Developments over the coming months may impact the appropriate decision and we expect the NHSPRB will want to consider the latest available data and intelligence as it makes its recommendation. We will be happy to give our views on the emerging situation and what that might mean for pay policy at our oral evidence session.

Career journeys and pay disparities

Longitudinal pay analysis

Previous analysis in this chapter has focussed on average pay and earnings across the entirety of the workforce. While this is instructive to assess what is happening in aggregate, and influences the total cost of employing the workforce, we should also be interested in how individual members of the workforce experience the pay system, which will include the impact of pay progression, promotion and pay scale reform.

Using data from the NHS Electronic Staff Record, the HR and payroll system used throughout the hospital and community health sector, we can track the experience of individual members of staff who were employed at multiple points in time. Table 13 is based on over 550,000 staff who were employed in both 2014 and 2024 and shows that over that time half of staff saw increases to basic pay of at least 45%.

While the differences between staff groups are limited, they can usually be explained by either the impact of pay or policy decisions or due to the methodology used to produce estimates.

Some reasons for differences staff groups include:

- there are higher than average increases for ambulance staff. This follows the decision that most paramedics should be re-banded to band 6 from 2016
- there are higher than average increases for managers and senior managers. This is because this table shows the staff group in the most recent time period and will include people who have been promoted to the manager or senior manager staff groups
- for other staff groups the increase at the lower quartile is broadly consistent with staff who have been at the top of the band throughout the period

Table 13: longitudinal analysis of the increase in basic pay per FTE for staff employed in both March 2014 and March 2024

Staff group in 2024	**Number of staff in sample (count)**	**25th percentile - 25% of staff saw increases of at least (%)**	**Median - 50% of staff saw increases of at least (%)**	**75th percentile - 75% of staff saw increases of at least (%)**	**Mean (%)**
Ambulance staff	10,000	52.7	66.1	93.6	74.6
Central functions	56,000	30.5	50.8	74.6	58.7

Hotel, property and estates	29,000	45.0	49.1	49.1	47.9
Managers	19,000	41.4	65.6	100.1	77.5
Midwives	13,000	23.4	40.9	62.7	47.9
Nurses and health visitors	184,000	23.9	45.1	65.5	51.3
Scientific, therapeutic & technical staff	90,000	24.6	45.5	77.2	56.0
Senior managers	9,000	43.6	69.5	106.1	81.0
Support to ST&T staff	28,000	26.3	43.2	53.5	43.4
Support to ambulance staff	7,000	26.3	39.7	58.9	46.5
Support to doctors, nurses and midwives	119,000	26.3	44.8	52.8	43.2
All staff groups	**564,000**	**26.3**	**45.0**	**64.2**	**52.1**

Source - DHSC Analysis of Electronic Staff Record

Note - the staff group shown is the staff group in the most recent time period. This helps to explain higher pay growth for some staff groups (managers and/or senior managers) where staff have been promoted into those staff groups while growth may have been lower for someone staying in a support role throughout the period.

Median growth for those employed in both March 2023 and March 2024 was 5.0% which is consistent with the outcome of the previous pay round and median growth for those employed in both March 2019 and March 2024 was 28.3% (~5.1% per year) which is also consistent with the outcomes of recent pay rounds.

Promotions and new joiners by gender and ethnicity

The pay review body has previously invited additional evidence around progression for agenda for change staff and if there are differences between different groups of staff.

New joiners by gender and ethnicity

Table 14 estimates the distribution of new joiners, defined as someone working in March 2024 who was not present on ESR in March 2023, and is split by gender and ethnicity group. A figure of 30% for 'all groups, band 5' indicates that 30% of all new starters entered at band 5.

Due to the nature of agenda for change it would be expected that most staff would usually join in either bands 2 or 3 (for roles without professional qualification) or band 5 for roles with professional qualification which explains higher proportions in those bands across all demographic groups as well as these bands being amongst those with the highest staff numbers overall.

The proportion of 'minority women' entering in band 5 is higher at 41% following substantial international recruitment in the nursing workforce.

Table 14: distribution of new joiners by gender and ethnicity group - 12 months to March 2024

Band	**Band 1 (%)**	**Band 2 (%)**	**Band 3 (%)**	**Band 4 (%)**	**Band 5 (%)**	**Band 6 (%)**	**band 7 (%)**	**Band 8a (%)**	**Band 8b (%)**	**Band 8c (%)**	**Band 8d (%)**	**Band 9 (%)**
All groups	**0%**	**27%**	**19%**	**10%**	**30%**	**8%**	**4%**	**1%**	**0%**	**0%**	**0%**	**0%**
White women	0%	27%	21%	9%	26%	9%	5%	2%	1%	0%	0%	0%
White men	0%	31%	22%	11%	18%	8%	5%	2%	1%	1%	0%	0%
Minority women	0%	21%	17%	10%	41%	6%	3%	1%	0%	0%	0%	0%
Minority men	0%	35%	22%	8%	23%	7%	3%	1%	0%	0%	0%	0%

Source - DHSC analysis of electronic staff record.

Note - band 1 has been closed to new joiners since December 2018

Promotion by gender and ethnicity

Using the ESR we can look at the numbers of staff who obtain promotion through time and their demographics. For the purposes of this analysis 'promotion' is defined as working in a higher band in one year than the previous period.

Figure 3 estimates promotion rates by gender and ethnicity group for the 12-months to March 2024 - For example the figure of 15% for 'white women' in band 5 indicates that 15% of white women who were working in band 5 in March 2023 were working in a higher band in March 2024.

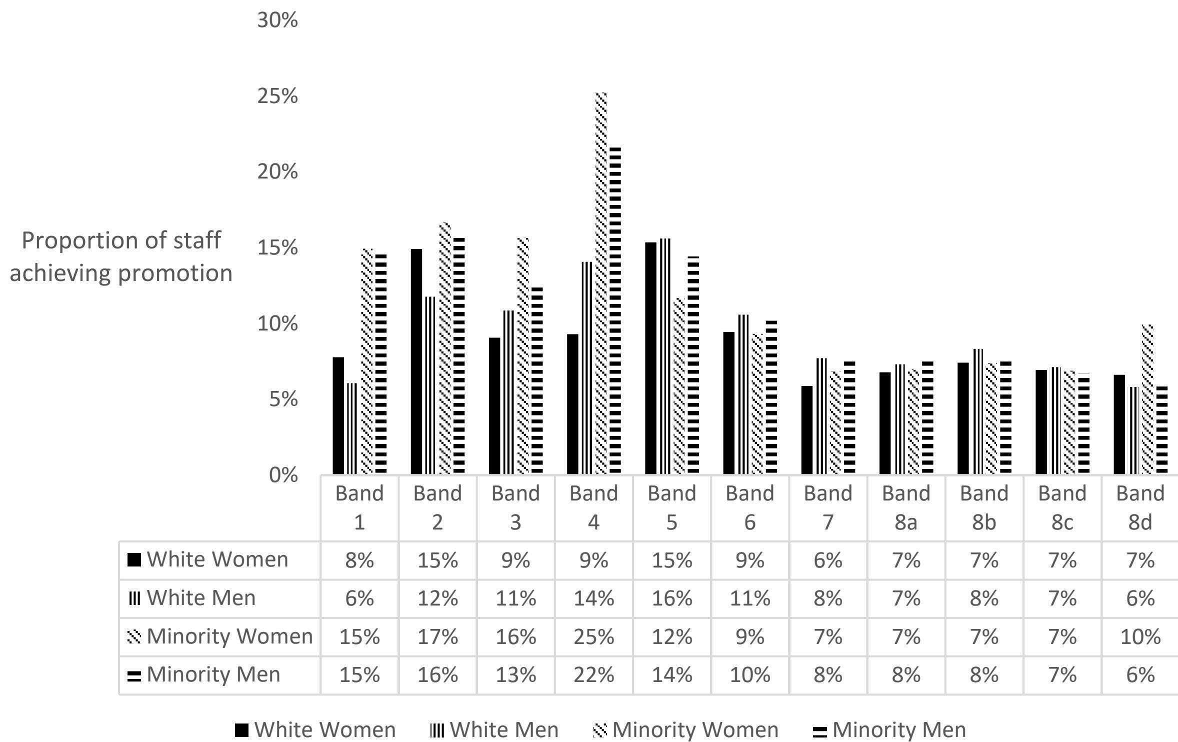
In general, the differences between demographic groups are shown to be relatively small:

- the higher rate of promotion for 'minority women' and 'minority men' in band 4 is likely to be explained by the higher rate of international recruitment for nurses with those staff often spending a short time in band 4 while completing induction and regulatory processes

- promotion rates, for most demographic groups, is seen to be higher in band 2 and band 5 compares to other bands. For band 5 this reflects progression conditions for paramedics and midwives as well as common promotion for nurses from band 5 to 6

- we note that overall 'promotion' rates will be impacted by higher-than-average workforce growth in recent years. When workforce growth is higher there are more likely to be more people at the bottom of pay bands who are not yet ready for promotion

Figure 3: estimated promotion rates by gender and ethnicity between March 2023 and March 2024



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d
White Women	8%	15%	9%	9%	15%	9%	6%	7%	7%	7%	7%
White Men	6%	12%	11%	14%	16%	11%	8%	7%	8%	7%	6%
Minority Women	15%	17%	16%	25%	12%	9%	7%	7%	7%	7%	10%
Minority Men	15%	16%	13%	22%	14%	10%	8%	8%	8%	7%	6%

Source - DHSC analysis of electronic staff record.

Note - band 9 is not shown because no further promotion is available within the agenda for change pay structure. Staff in band 9 may be able to progress to 'very senior manager' positions.

Description - this is a chart showing the estimated promotion rate between March 2023 and March 2024 and is split by agenda for change pay band, gender (men, women) and ethnicity group (white, minority). It shows that promotion rates are higher in some bands, especially at the less senior range of the pay structure but the differences between ethnicity groups are generally relatively small.

Longitudinal progression analysis

The previous section, figure 3, looked at promotions over a single year but this may tell a partial story where we may want to consider any differences in promotions over a longer

period. Research from the Institute for Fiscal Studies (PDF, 853KB) tracked different cohorts of nurses and midwives to monitor their progression from band 5.

For nurses around two-thirds of staff who were working at the bottom of band 5, a proxy for new joiners, in 2012 had progressed to at least band 6 by 2021 with the remaining third still working in band 5. They also found evidence of faster progression for newer cohorts with around 40% of the 2016 cohort being promoted to band 6 within 4 years compared to around 30% for the 2012 cohort.

This research did show some differences by demographic groups with white nurses, younger nurses and those in greater London being more likely to achieve promotion compared to older staff, those in the northeast or those from black or Asian ethnicity however we would note the small sample size for some of those groups (for example, ~770 Asian staff compared to over 11,000 white staff in the 2012 cohort)

Gender and ethnicity pay gaps

The government is committed to tacking the issue of gender or ethnicity pay gaps where different demographic groups have lower average pay than others. While the AfC contract, through the system of job evaluation, seeks to uphold the principles of equal pay for equal work there are some reasons why differences in average pay may develop if there are differences in the distribution of staff across staff groups, pay bands and pay points:

- difference in staff group mix - a gap will develop if men or white staff are more likely to be in more senior staff groups compared to women or ethnic minority staff
- differences in career grade mix - a gap will develop if men or white staff are more likely to be in more senior career grades, within staff groups, compared to women or ethnic minority staff
- differences in point mix - a gap will develop if men or white staff are more likely to be further up established pay scales than women or ethnic minority staff

Across the non-medical workforce, the most important factor is differences in staff group mix, where some groups may be over or underrepresented in higher or lower bands while differences within staff groups are more often related to differences in point mix within specific bands.

The most recent data, published by NHS England, describes the position as at the end of May 2024 and is shown in table. This table is based on basic pay per FTE which excludes any differences in earnings caused by other factors such as the likelihood of working part-time or proclivity to undertake additional work.

Table 15: estimate of gender pay gap for non-medical staff working in HCHS in England measured using average basic pay per FTE in May 2024

Group	**GPG - white** Comparison of white women to white men (%)	**GPG - minority** Comparison of minority women to minority men (%)	**EPG - women** Comparison of minority women to white women (%)	**EPG - men** Comparison of minority men to white men (%)
All Agenda for Change	-3.8%	2.6%	-5.2%	-11.1%
Nurses and health visitors	-4.7%	-2.5%	-14.5	-16.4%
Professionally qualified clinical staff	-4.5%	-3.6%	-13.3%	-14.1%
Support to clinical staff	-2.4%	1.4%	-2.0%	-5.7%
NHS Infrastructure support	-10.5%	-0.5%	-6.3%	-15.8%

Source - NHS England earnings statistics

Labour market context

Because developments in the wider labour market will influence what an appropriate pay strategy might be to support recruitment, retention and motivation we expect the PRBs to take account of underlying labour market conditions and how they are expected to change over the course of this pay review period.

labour market indicators show:

- in 2025 to 2026 the Office for Budget Responsibility forecast earnings growth of 3.0% with the growth in earnings continuing to reduce over the course of the year from around 4.8% in the first quarter of 2025 to around 2.0% by the first quarter of 2026. This is materially lower than forecasted growth for 2024 to 2025 of 4.5%

- available data on pay settlements, the measure most closely aligned with PRB recommendations, also show a moderation in settlements with the median reducing from the current figure of 4% in the 3-months to October 2024 to around 3.0% in 2025

- data indicates that the position of NHS staff within the broader labour market has been broadly stable over recent pay rounds with staff groups remaining in around the same location of the UK income distribution

- there is evidence of differences in growth rates across the earnings distribution with higher growth rates for those with lower earnings which may follow substantial increases to the National Living Wage in April 2024

Earnings forecasts for 2025 to 2026

When making recommendations for 2025 to 2026 we believe it is important to be aware of what is forecast to happen to earnings and pay settlements over the period covered by this pay round. We believe this is particularly the case this year when the government has brought forward the timing of the pay cycle meaning that current data may be less reflective of the prevailing conditions for this pay round.

While earnings growth is currently high by historical standards it has moderated in recent months and this is expected to continue over 2025 to 2026. Average earnings growth is forecast to be materially lower over 2025 to 2026 than 2024 to 2025, at 3.0% according to the OBR's forecast with a reduction over the course of the year around 4.3% in the first quarter of the financial year to under 2% by the end.

Survey evidence also points to an easing in wage growth, with Brightmine's survey showing that settlements are expected to average 3% in 2025 which is down from the current value of 4% and data from the Bank of England decision maker panel also forecasting wage growth of around 4% over the 12-months from October 2024.

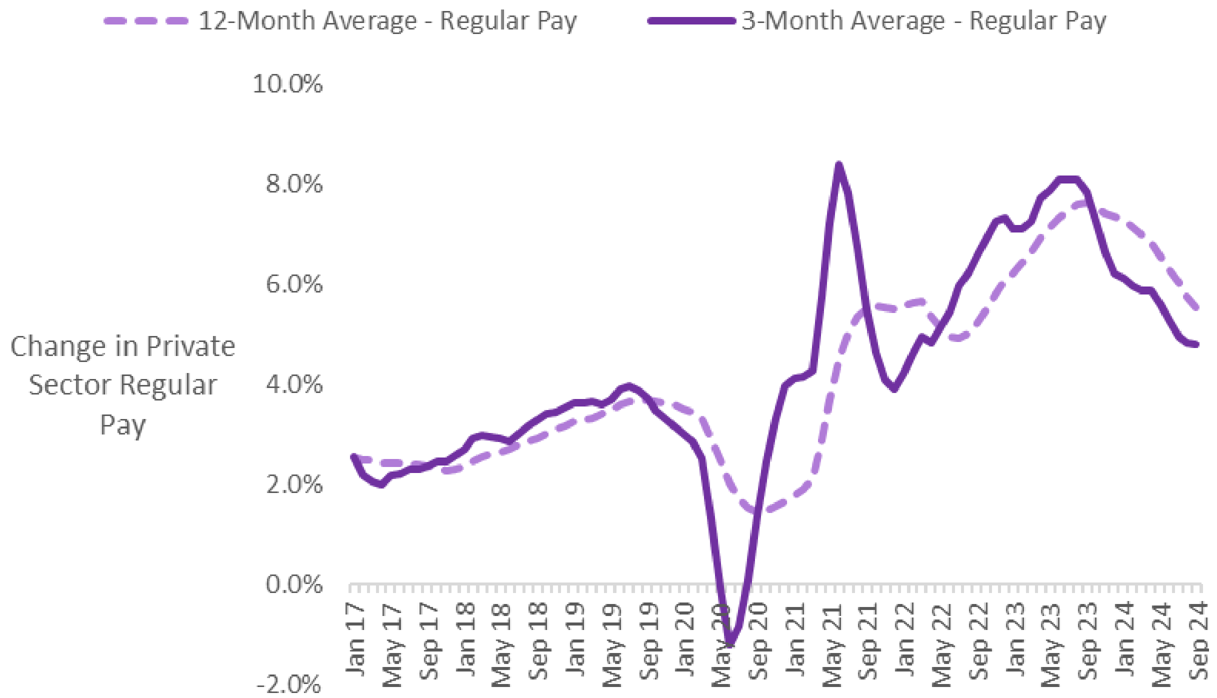
Previous growth in earnings

We also appreciate that the Pay Review Body will want to take account of recent earnings growth in the wider economy and how that has impacted the relative position of NHS staff in the labour market.

ONS publishes data on average weekly earnings which is the lead measure on earnings growth per employee and is based on data from the monthly wages and salaries survey. Changes in average weekly earnings cover more than just pay settlements and include the impact of changes in averages working hours of alterations to workforce composition.

As shown in figure 4 the pace of earnings growth has moderated in after reaching peaks in Autumn 2023 and this is expected to continue with OBR forecasting earnings growth of 4.5% across 2024 to 2025.

Figure 4: increase in average weekly earnings in the private sector, 3-month and annual growth rates between July 2017 and September 2024, £ per month, 3 month moving average



Source: Office for National Statistics, average weekly earnings

Description: this is a chart showing the increase in average weekly earnings in the private sector between July 2017 and September 2024 on both a 3-month and annual average basis. It shows that the increase in earnings, using the 3-month average, is just under 5% as of September 2024 but has reduced from around 8% during 2023.

Because data on pay growth is broader than the impact of pay awards alone, we are also interested in data on pay settlements which most closely resemble the decision facing PRBs and don't include the impacts of changes to workforce composition or pay drift. Current estimates of average pay settlement may point to recorded pay settlements being lower than headline wage growth. The most recent pay survey from Brightmine, formerly known as XPertHR shows a median basic pay award in the 3 months to the end of October 2024 of 4%. Information from the Bank of England Decision Maker Panel estimated year ahead wage growth of 4.1% in October 2024, which was unchanged from the previous reporting period.

Earnings growth across the earnings distribution

In addition to a general understanding of earnings growth we can assess how earnings growth is changing across the income distribution. If different parts of the earnings distribution are growing at different rates then it may impact our optimal pay strategy.

The Office for National Statistics publishes information on growth at different sections of the income distribution based on 'real-time' information from Pay as You Earn data.

Median growth between July 2023 and September 2024 was just under 6% while earnings growth was higher for lower earners following large increases to the National Living Wage. Toward the upper end of the earnings distribution the growth in earnings at the 75th percentile (4,1%) is lower and has fallen more quickly than at other points of the distribution. The increase in earnings growth in the period to September may reflect the latest round of public sector pay decisions including back-pay.

Table 16: Estimated growth in earnings by income distribution percentile - 3-month moving average to September 2024 compared to 3-month average to September 2023

Date	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile	95th percentile	99th percentile
Sept 2024	5.5%	8.2%	5.4%	3.2%	2.5%	2.5%	3.4%

Source - Office for National Statistics, real time information

Note current data, for September 2024, is impacted by non-consolidated payments made to Civil Servants and NHS staff in Summer 2023.

Annual survey of hours and earnings

Data from the Annual Survey of Hours and Earnings (ASHE) can be used to make comparisons of earnings, and earnings change, between the HCHS and comparator occupations. This aims to give an indication of how earnings change, in the NHS compared to roles in the wider economy that may require broadly similar qualifications or skillsets.

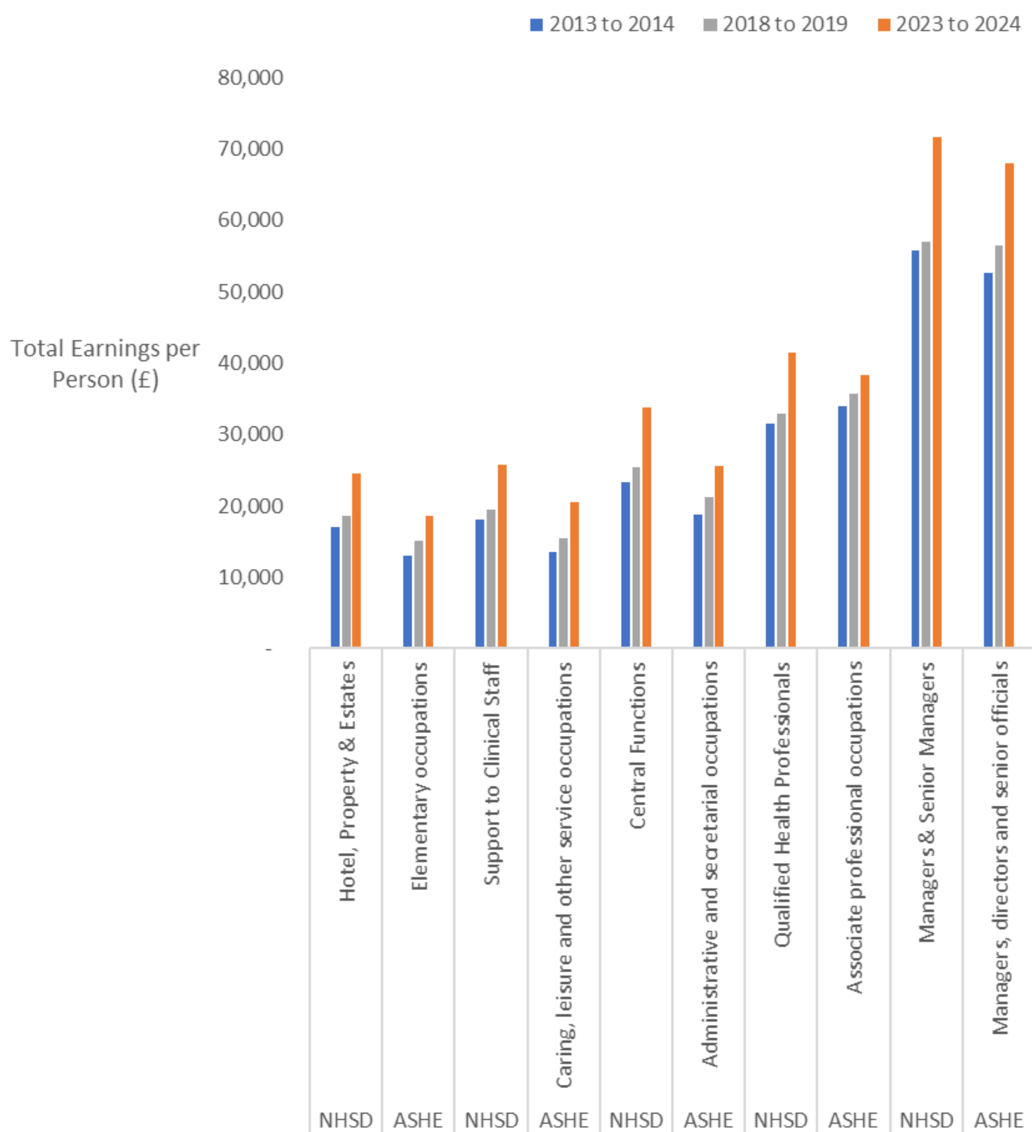
We recognise that they are not like-for-like; NHS and ASHE groups do not align perfectly due to the differing categorisation of occupations between the organisations. The resulting differences in working patterns, and individuals' skill and experience levels are not controlled for and therefore affect the earnings of each group.

Figure 5 illustrates how the mean total annual earnings per person have changed between the financial years 2013 to 2014 and 2023 to 2024 for 5 NHS staff groups and their

comparator groups from the wider economy. In all cases, the earnings of the NHS groups were higher than those for their comparator groups in the year 2023 to 2024.

The growth in earnings in 2023 to 2024 was also higher for the NHS staff groups compared to the comparator sections however we recognise that NHS figures will include the impact of non-consolidated payments made as part of the 2023 to 2024 pay agreement which will inflate earnings growth for this period.

Figure 5: Comparison of estimated average earnings in NHS staff groups and selected comparator groups from the annual survey of hours and earnings - between 2013 to 2014 and 2023 to 2024.



Source - Annual survey of hours and earnings, NHS England earnings statistics

Description - this chart compares average earnings for selected NHS staff groups compared to gross average earnings for selected comparator groups from the annual

survey of hours and earnings. It shows that average earnings for NHS staff groups are higher than those for the comparator and in 2023 to 2024 growth was higher following the receipt of non-consolidated payments for NHS staff.

Earnings percentile analysis

One way of assessing how the relative power of NHS earnings is changing over time is to compare average earnings in the HCHS sector to the overall earnings distribution. This provides insight as to whether the position of NHS staff in terms of the overall income distribution is improving, worsening, or remaining stable.

Table 16 uses data on average earnings per person published by NHS England and data on the overall income distribution published as part of ASHE to estimate where NHS earnings, by staff group, fall in the overall distribution. This data can be volatile from year to year. For example, following the impact that COVID-19 had on wider incomes or one-off payments to NHS staff. Therefore, it is best to look at longer term trends. On average, we see that the position of most staff has been broadly stable - average earnings for nursing staff are consistently around the 66th percentile, while those supporting doctors, nurses and midwives are around the 33rd percentile. The groups with the largest changes (ambulance staff / support to ambulance staff) may have been impacted by changes to job classifications which impacted average earnings for those groups.

Generally, earnings of groups with larger proportions of employees in higher bands would be expected to lie within higher earnings percentiles. Sometimes this is not the case due to the difference in average contracted hours between groups. For example, earnings for nurses and health visitors (a predominantly band 5 group) tend to be a couple of percentile points higher than those of midwives (a predominantly band 6 group). This results from nurses having a higher participation rate than for midwives.

Table 17: estimate of placement of average earnings for NHS staff groups working in HCHS in England as part of UK income distribution between 2018 and 2024

12-months ending in March 2024

Grade	**2018**	**2019**	**2020**	**2021 (SOC 10)**	**2021 (SOC 20)**	**2022**	**2023**	**2024**
Nurses and health visitors	66	66	65	68	68	66	65	67
Midwives	66	65	65	67	67	66	63	64
Qualified ambulance staff	74	73	77	80	80	81	79	79
Scientific, therapeutic and technical staff	68	67	67	70	70	69	67	69

Support to doctors, nurses and midwives	34	34	33	35	35	32	31	34
Support to ambulance staff	48	47	50	53	53	53	50	51
Support to STT	34	34	33	35	35	33	33	36
Central functions	51	51	51	54	54	52	51	54
Hotel, property and estates	32	33	31	33	33	31	30	32
Senior managers	96	95	96	96	96	96	96	99
Managers	85	85	86	89	89	89	87	88

Source: NHS England earnings statistics (table 2a), annual survey of hours and earnings (table 1.7a), gross annual earnings for 90th to 99th percentile

Based on a comparison of NHS average earnings per person with gross total pay from annual survey of hours and earnings. Note - this may differ slightly from previous Office of Manpower Economics (OME) analysis as this is based on average earnings per person rather than FTE salaries.

Longitudinal education outcomes

Earlier in this chapter we have provided longitudinal data for staff who have worked in the HCHS between 2014 and 2024.

Data from the longitudinal education outcomes (LEO) dataset can be used to compare outcomes for graduates and postgraduates from English higher education providers 1, 3, 5 and 10 years after graduation based on information provided by the Department for Education, Department for Work and Pensions and HMRC. The data can be used to analyse the performance of healthcare graduates (including nursing and midwifery graduates) against those from other courses using either average earnings (though this measures earnings only and does not include wider reward which are particularly relevant to healthcare staff in the NHS) or employment prospects.

Overall, the data indicates that graduates from nursing and midwifery degrees have higher than average (median) earnings for the first 5 years after graduation, average after 10 years (which may reflect differences in working patterns or cohort effects related to the transition to nursing becoming a profession requiring a degree). Nursing graduates are amongst the most likely to be in sustained employment at all periods after graduation which highlights the value of nursing degrees to individuals and employers.

It shows that median earnings for nurses are initially around 36% higher than average (excluding nursing and midwifery and allied health) before falling to around 2% below the average after 10 years. For allied health graduates, earnings are initially around 13% higher than average (excluding nursing and midwifery and allied health) before falling to below 12% of the average after 10 years. Over 10 years, median pay for nurses and

midwives increases by around 16%, while for allied health graduates, median pay increased by around 26% compared to around 61% across all other subjects.

This may show a different profile to earnings over the course of an individual's career and this analysis may not adjust for differences in working patterns or individuals who may take time out of the workforce. The sample size for the period 10 years after graduation is smaller than for other time periods, one reason for this may be linked to the point at which nursing became a profession requiring a degree which was announced in 2009 and implemented from 2013.

Table 18: median earnings for selected healthcare graduates 1,3,5 and 10 years after graduation with comparison to other subjects based on earnings in fiscal year 2021 to 2022

Median earnings for first degree students	**1 year after graduation**	**3 years after graduation**	**5 years after graduation**	**10 years after graduation**
Graduating cohort (academic year)	**2019 to 2020**	**2017 to 2018**	**2015 to 2016**	**2010 to 2011**
Nursing and midwifery	£29,900	£32,100	£33,200	£34,700
Nursing and midwifery rank (35 subjects)	3	9	12	21
Allied health	£24,800	£29,200	£30,700	£31,400
Allied health rank (35 subjects)	10	12	17	26
Subject average (weighted excluding nursing and midwifery, and allied health)	£22,200	£26,900	£30,500	£35,500

Source: Longitudinal education outcomes (LEO) (Department for Education). This will include nurses employed outside the NHS.

LEO also includes information on employment which highlights the benefit of a nursing degree when it comes to employability. Of the 35 subjects that are monitored, individuals with a nursing or midwifery degree had the second highest proportion of graduates in sustained employment or training 3 and 10 years after graduation, for one and 5 years after graduation, they were 4th and 1st respectively.10 years after graduation, over 90% of nursing and midwifery graduates are in sustained employment, training or both which are over 5 percentage points higher than average.

LEO also publishes information on which industry graduates are working in. 3 years after graduation, over 90% of first-degree nursing and midwifery graduates surveyed working in human health and social work remained in the same industry. 5 years after graduation, over 86% remained in the same industry. For first-degree allied health graduates, over 55% worked in human health and social work 3 years after graduation, this figure remained the same 5 years after graduation.

Allied health subjects according to HESA (Higher Education Statistics Authority) include: health sciences, nutrition and dietetics, ophthalmics, environmental and public health, physiotherapy, complementary and alternative medicine, and counselling, psychotherapy and occupation therapy.

Table 19: proportion of selected healthcare first degree in sustained employment, training, or both after 1, 3, 5, and 10 years with comparison to other subjects in 2021 to 2022 fiscal year

Proportion in sustained employment, further study, or both % (first degree only)	**1 year after graduation**	**3 years after graduation**	**5 years after graduation**	**10 years after graduation**
Graduating cohort (academic year)	**2019 to 2020**	**2017 to 2018**	**2015 to 2016**	**2010 to 2011**
Nursing and midwifery	95.5%	94.3%	93.1%	90.2%
Nursing and midwifery rank (35 subjects)	4	2	1	2
Allied health	92.1%	90.7%	89.8%	86.9%
Allied health rank (35 subjects)	5	6	10	9
Average (all subjects except nursing and midwifery and allied health)	87.1%	87.7%	87.4%	84.7%

Source: Longitudinal education outcomes (LEO) (Department for Education)

Note - after 3- and 10-years nursing is second to 'Celtic studies' which had fewer than 30 graduates.

5. Total reward

Introduction to total reward

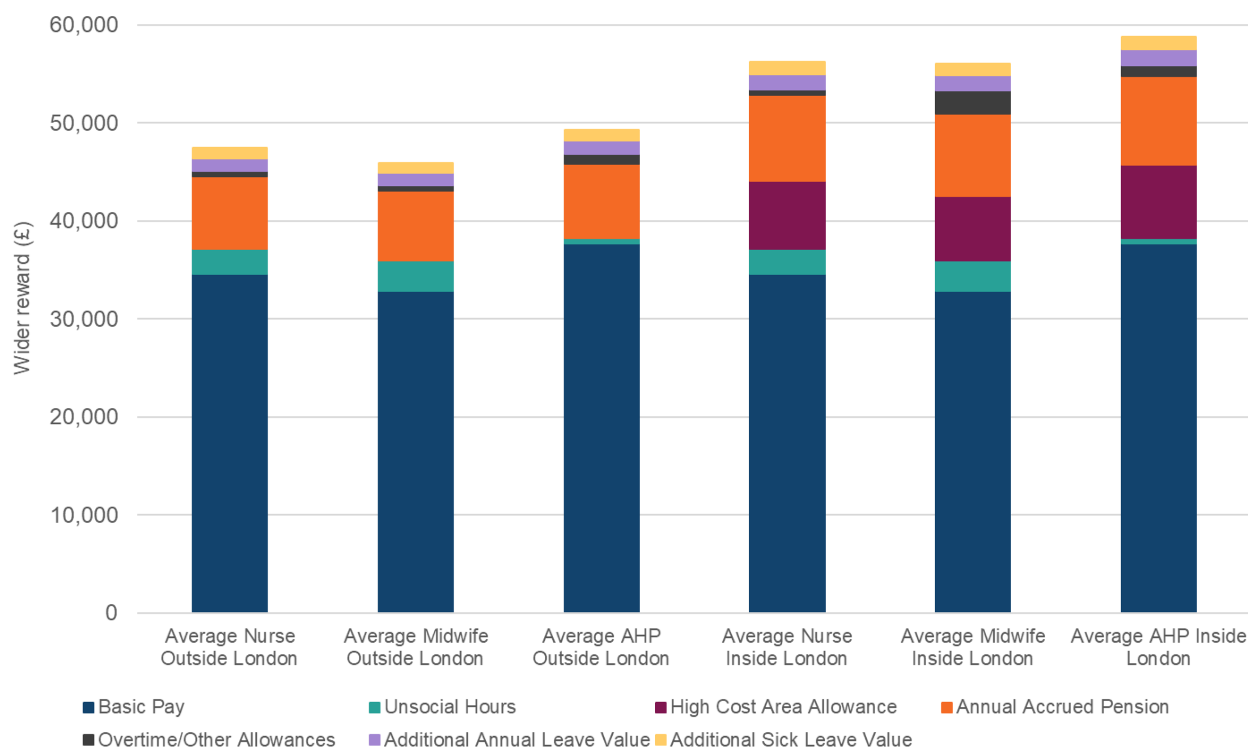
The total reward package in the NHS includes a generous holiday allowance, which increases each year on top of public holidays (up to 33 days), sickness absence arrangements of up to 12 months of payment, access to a defined benefit pension scheme with an employer contribution rate of 23.7%, enhanced parental leave, and support for learning, development, and career progression. These benefits are significantly above the statutory minimum and exceed those offered in other sectors. Comparisons with the wider labour market should not just be limited to pay but include the full reward package.

Measuring the value of the package

The department commissions the Government Actuary's Department (GAD) to measure the value of the total reward package for a range of NHS roles, as shown in the analysis below.

The elements included in the package are basic pay, high cost area allowances (HCAS), overtime or other allowances, unsocial hours, annual accrued pension, and additional annual leave. Annual accrued pension is a measure of the 2015 Scheme pension, which is calculated as the pension accrued over the year multiplied by a factor of 20, less employee contributions.

Figure 6: Value of the total reward package for NHS staff, 2024 to 2025



The figure above shows the value of the wider reward package for NHS staff in different roles and outside or inside London for 2024 to 2025. It shows those in London receive a higher total reward, this is due to the high cost area allowance.

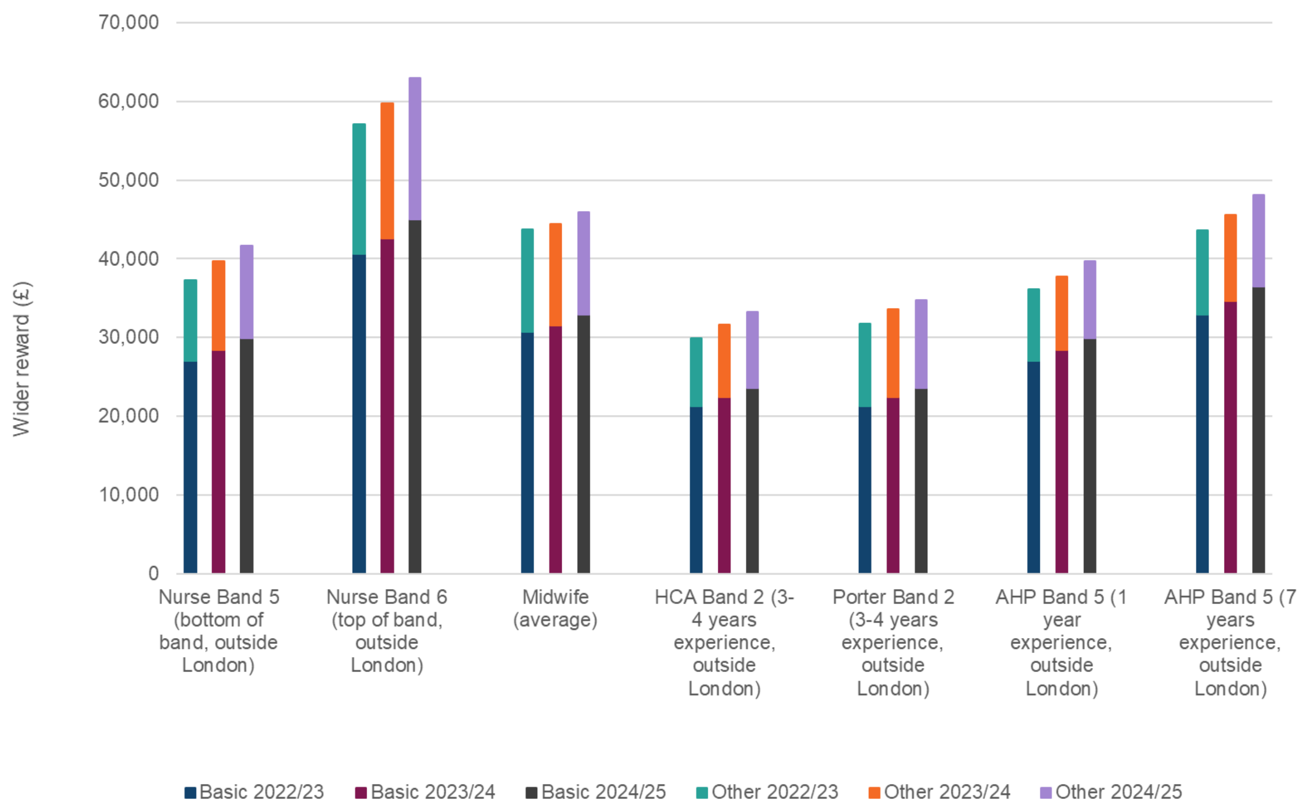
GAD also provides analysis of the trend in wider reward for NHS staff over time. The chart below shows the split of total reward packages between basic and other pay for NHS staff over the years 2022 to 2023, 2023 to 2024 and 2024 to 2025.

It is important to note that for midwives, the analysis compares average rewards on 30 June 2022, 31 March 2023 and 30 June 2024 with pay bands at 2022 to 2023, 2023 to 2024 and 2024 to 2025 for all other roles. However, this will only cause a negligible difference for the purpose of comparison. This is consistent with the approach used in previous years and reflects the availability of the relevant data.

The analysis shows that all the NHS roles considered as part of the analysis have experienced an increase in total reward in monetary terms over the period 2022 to 2023 to 2024 to 2025. Overall, increases were largely driven by increases to basic pay over the period.

For all roles considered, at least 24% of the total reward package is made up of non-basic pay.

Figure 7: wider reward trend for NHS staff over the period 2021 to 2022 to 2024 to 2025



Enhanced parental leave

As well as the total reward elements included in the analysis above, NHS staff with 12 months continuous service with one or more NHS employers are also entitled to maternity, adoption and shared parental leave benefits above the statutory entitlement. GAD estimate that an average member of NHS staff calculated as having annual pay of £34,000 would be entitled to earn maternity pay of around £7,000 more than they would be entitled to under the statutory maternity leave allowance.

This estimate is provided for illustrative purposes only and represents the additional value of NHS staff entitlement in excess of statutory maternity leave. Maternity, adoption and shared parental pay depends on the member's contractual entitlements and is calculated relative to the current statutory pay entitlements.

Other benefits

Other than the national reward elements included in the above analysis, employers have the flexibility to enhance their local reward package, and many offer a range of benefits

and discounts which have financial value to staff and may support recruitment and retention of staff and improve employee engagement.

Although the range of benefits offered varies across employers, some popular flexible benefits can include salary sacrifice schemes, options to buy and sell annual leave, and a range of discount vouchers. Some employers offer travel benefits such as season ticket loan and cycle to work scheme, as well as health and wellbeing benefits including discounted gym memberships.

Many trusts have also partnered with third party providers offering staff up to 20% discount on shopping, insurance and travel. Staff may also be entitled to cashback on purchases at specified retailers of up to 12% using prepaid cards. Therefore, employees spending around £3,000 per year at a participating supermarket could offset spending by up to £360 (around 1% of basic pay on average). The overall value to staff can vary depending on the specific benefits options offered across employers and the level of benefits taken up, but GAD estimate these additional flexible benefits could be valued at up to 1% - 3% of basic pay on average across NHS employees.

Employers are stepping up this support to make benefits go further. NHS Employers has developed guidance to support employers when offering benefits to mitigate higher living costs and to highlight what is available. These benefits can include:

- childcare: subsidised childcare, on-site nurseries, government tax free child support scheme
- travel: free parking, transport season ticket loans, public transport subsidies, pay expenses weekly
- housing and utilities: rental deposit loan schemes, home electronics salary sacrifice scheme, fee-free mortgage brokering, discounted fixed fee conveyancing
- food and leisure: free or subsidised meals on site, signposting to emergency service discount sites, access to free sanitary products
- other financial support: saving schemes, will writing services, financial education workshops, budget planning guidance, early access to pay

Flexible working and flexible retirement

'We work flexibly' is one of the elements on the people promise and NHSE continue to focus on flexible working which reflects its importance to staff. Flexible working is a strong driver of retention and an important factor in improving the mental health and wellbeing of staff. Scores from the 2023 NHS Staff Survey show improvements in the ‘we work flexibly’

theme with an increase of 6.28 (out of 10) in 2023 compared to 6.06 in 2021. The publication of the NHS equality, diversity and inclusion improvement plan last year will continue to be important factors in driving up accessibility to flexible working.

NHSE has continued to focus on flexible working, reflecting its importance to staff, which includes: changes to terms and conditions; a development programme for senior and organisational leaders; e-learning packages for staff and line managers to help drive culture change, support uptake, and promote usage of technical solutions, such as e-rostering; along with targeted interventions across different professions.

NHS England have a range of flexible working interventions and resources nationally to support local organisation to adopt flexible working practices across their organisations and will refer to these in their written evidence.

Sections 33 and 34 of the NHS Terms and Conditions of Service (Agenda for Change) Handbook sets out the provisions required to support staff including those with responsibilities for children and adults. This also includes the requirement for employers to have local policies in place that emphasise the importance of staff being able to balance their personal and working lives. This is coupled with encouragement from employers to implement the working careers passport, and to engage in supportive and timely conversations about support for carers and where flexible working arrangements would be helpful.

NHS England set out in its NHS EDI improvement plan the importance of improving the culture of the NHS workforce and to boost retention by addressing inflexible working practices that may deter people entering the workforce or leaving the workforce entirely.

The department envisages that those members who wish to take partial retirement (as described in the section on new retirement flexibilities below) may be able to agree with their employer a change to their working pattern, much like those who wish to work flexibly for other reasons. In October 2023, the NHS Staff Council published guidance on the NHS Employers website that ties flexible working and flexible retirement together.

The NHS Pension Scheme

The NHS Pension Scheme remains a valuable part of the total reward package available to NHS staff and is one of the most generous pension schemes available, with employer contribution rate of 23.7% of pensionable pay significantly higher than employer pension contribution rates typically available in the private sector.

Eligible NHS staff will now belong to one of the 2 existing schemes, both of which are defined benefit schemes. The final salary scheme, or legacy scheme, which is made up of

the 1995 and 2008 sections and is now closed to new members. All new staff join the 2015 scheme, a career average revalued earnings (CARE) scheme which provides benefits based on average earnings over a member's career. The key differences between the 2 schemes, other than the way benefits are calculated, are different normal pension ages and accrual rates, as shown in the table below.

Table 20: comparison of retirement ages and accrual rates for members of the 1995 Section, 2008 Section and 2015 Scheme

Scheme or Section	Normal Pension Age (NPA)	Accrual rate
1995 Section	60	1/80th
2008 Section	65	1/60th
2015 Scheme	State Pension Age	1/54th

The 2015 Scheme was introduced as part of wider reforms implemented by regulations made under the Public Service Pensions Act 2013. As part of these reforms, public service pension scheme members within 10 years of retirement were originally given transitional protection, and so remained in their legacy pension schemes. In December 2018, the Court of Appeal found this protection to be discriminatory against younger members. This has become known as the 'McCloud judgment'. The government accepted the judgment applies to other public service schemes, including the NHS Pension Scheme.

The public service pension schemes remedy (the 'remedy') for this discrimination has 2 parts. The first and prospective part closed the legacy public service pension schemes on 31 March 2022 and ensured equal treatment for all public service pension scheme members by moving all active members into the reformed public service pension schemes on 1 April 2022. The second and retrospective part of the remedy removed the effect of the transitional protections in legislation from 1 October 2023. The core element of the retrospective remedy is to provide 1.1 million impacted NHS Pension Scheme members with a choice between 1995/2008 and 2015 scheme benefits for the period the discrimination has effect.

One key benefit of the 2015 scheme is that for active members, the pension they earn is increased every April by the consumer prices index (CPI) in the year before, plus an additional 1.5%. This is known as 'in-service revaluation'. This means that pension benefits keep up with rises in the cost of living. As of April 2024, this rise was 6.7% and from April 2025, the rise will be 1.7%.

The department keeps the rules of the pension scheme under review to ensure it continues to help the NHS attract and retain the staff needed to deliver high quality care for patients.

NHS pension projections

GAD calculates that scheme members can generally expect to receive around £2 to £6 in pension benefits for every £1 contributed. This has changed from the £3 to £6 last year which reflects the results from the 2020 valuation.

GAD has also estimated that a nurse who joins the NHS Pension Scheme in 2024 age 21 and works at AfC band 5 before retiring at age 65, can expect an annual pension of around £36,000 in today's earnings terms. A nurse who joins the NHS Pension Scheme in 2024 age 21 and progresses through AfC bands 5 and 6 before retiring at age 65 can expect an annual pension of around £41,000 in today's monetary terms. These estimates assume that members remain in service and work full-time to retirement.

These projections are higher than those provided in previous years as the updated pay profiles report higher pensionable pay than those used in previous years' projections. This is a result of the 2024 pay award of 5.5% for AfC pay scales.

The table below shows the pension benefits the example members above could expect to receive, assuming that they commute 20% of their pension for a tax-free pension commencement lump sum (PCLS) at retirement, on current commutation terms (£12 lump sum per £1 of pension commuted). All projected lump sums are within the maximum amount of £268,275 for tax-free lump sums announced at the Spring 2023 Budget, allowing for increases in real terms by retirement.

Table 21: projected annual pensions and lump sums for nurses joining the NHS Pension Scheme retiring age 65 (in today's monetary terms)

At retirement age	**Projected residual pension (pa)**	**Projected PCLS**
Nurse - band 5	£29,000	£86,000
Nurse - band 5/6	£33,000	£99,000

NHS Pension Scheme membership

The department regularly monitors membership trends for the NHS Pension Scheme through ESR. Overall, membership rates continue to be high, with an average of 87.9% of non-medical staff in the NHS staff being members of the scheme in June 2024.

The table below shows the percentage of staff members, by staff group and AfC band, who were members of the scheme in June 2024, and in comparison, to June 2023, June 2019 and June 2014. Staff group workforce totals and band workforce totals are based on data published by NHS England.

While membership rates have reduced for the majority of staff groups and AfC bands over the past year, AfC bands 8 and 9 have seen increases. This may be a result of staff at these bands who had previously opted out of the NHS Pension Scheme for pension tax reasons opting back into the Scheme following the April 2023 Budget. This saw the abolition of the Lifetime Allowance and an increase to the Annual Allowance from £40,000 to £60,000.

Nurses and health visitors (-3.6pp) and Band 5 staff (-4.7pp) both have the largest decreases in membership rates. We understand that this could be related to the higher than average rates of staff with non-British nationality who may fall into these categories, and the increase in international recruitment into the NHS in recent years. These members of staff have traditionally been less likely to be members of the NHS Pension Scheme than those with British nationality. Further analysis of membership rates for Band 5 staff by nationality and pay point is in the subsequent table.

Table 22: NHS Pension Scheme membership for non-medical staff

	June 2024	One year change (percentage point change)	5 year change (percentage point change)	10 year change (percentage point change)
Ambulance staff	91.7%	-1.1	-1	-5.3
Central functions	87.9%	-0.5	-0.2	2
Hotel, property and estates	87.1%	-0.2	2	11.4
Managers	91.1%	0.5	-0.2	-2
Midwives	90.8%	-0.9	-2.2	-3
Nurses and health visitors	83.2%	-3.6	-8.8	-8.8
Scientific, therapeutic and technical staff	91.7%	-0.7	-2.2	-2
Senior managers	91.4%	1.6	1	-1.8
Support to ambulance staff	91.7%	-0.9	-0.7	-0.3
Support to doctors, nurses and midwives	89.2%	-0.9	-0.9	4.2
Support to ST&T staff	90.3%	-0.6	-0.7	4.3
Grand total	87.9%	-1.5	-3.1	-1
Band 1	77.7%	-0.2	-2.6	6.8
Band 2	88.6%	-1	-0.3	6
Band 3	89.6%	-0.7	-0.7	3.5
Band 4	89.5%	-0.7	-1.1	1.4
Band 5	79.7%	-4.7	-11	-11.1
Band 6	88.8%	-1.4	-3.5	-3.8
Band 7	91.8%	-0.1	-1.9	-2.9
Band 8a	92.9%	0.7	-1	-2.7
Band 8b	93.4%	1	-0.7	-2.6
Band 8c	93.6%	0.8	-0.4	-2.5
Band 8d	93.6%	0.9	0.5	-1.8

Band 9	92.7%	2	0	-2

Table 23: NHS Pension Scheme membership for band 5 staff by pay point and nationality in June 2023

Pay point	Years' experience	**United Kingdom**	**Rest of world**	**Other (EU, EEA, unknown)**	**All**
Point 1	0 to 2 Years	91%	62%	85%	80%
Point 2	2 to 4 Years	89%	43%	80%	73%
Point 3	4+ Years	90%	61%	86%	80%
All points		90%	57%	84%	90%

NHS Pension Scheme contributions

Members and employers are required to pay towards the cost of benefits built up in the NHS Pension Scheme. At present, employers contribute 23.7% of each member's pensionable earnings, plus a charge of 0.08% to fund the administration of the scheme. The current employer contribution rate came into force on 1 April 2024 following the 2020 valuation report produced by GAD. This required the employer contribution rate to rise by 3.1%, to bring the cost of the scheme back in line with the employer cost cap. This is far more generous than most pension schemes offered in the private sector. In April 2019 the minimum employer contribution rate was set at 3% and the average UK employer contribution rate was 4%.

When the NHS Pension Scheme moved from final salary benefits to career average revalued earnings (CARE) benefits, following the closure of the 1995/2008 Scheme, it was deemed an appropriate time to reform the member contribution structure. The department completed a review of member contributions and published its initial response on 15 February 2022.

As a result of the review, the number of contribution tiers was reduced from 11 to 6, and the range between the lowest and highest contribution rates was narrowed, ensuring that the costs and benefits of the scheme are more evenly shared. The department also confirmed that the rates would be automatically increased annually. Earning thresholds for member contribution rates now increase each April in line with consumer prices index (CPI) inflation in the previous September. These thresholds only ever increase; should CPI be negative, the earning thresholds will not decrease.

The thresholds are also subject to a 'better of' policy so that the thresholds are first increased by the CPI figure and then further adjusted in line with the annual Agenda for Change (AfC) pay award for England, should that be higher. The intention is to reduce so

called 'cliff edges' where members fall into a higher contribution tier as a consequence of the pay award.

As of 1 April 2025, the following member contribution structure will apply for the 2025 to 2026 Scheme year, following the September 2024's CPI which announced an increase of 1.7%. These figures may be subject to change if the AfC pay award exceeds 1.7%.

Table 24: NHS Pension Scheme current member contribution threshold structure

Pensionable earnings thresholds	Contribution rate from 1 April 2025
Up to £13,259	5.2%
£13,260 to £27,288	6.5%
£27,289 to £33,247	8.3%
£33,247 to £49,913	9.8%
£49,913 to £63,994	10.7%
£63,995 and above	12.5%

Retirement options

Members who wish to retire earlier than their normal pension age (as set out in table 20) are able to do so via voluntary early retirement (VER). This allows staff to fully retire up to 10 years earlier than their NPA, although their pension will be actuarially reduced (by around 5% per year), to account for the fact that it is being paid earlier.

The package of new retirement flexibilities introduced in 2023 for members of the 1995 Section of the NHS Pension Scheme also means that NHS staff now have increased options when it comes to their retirement.

Since 1 April 2023, NHS staff who claim their pension and later return to work can re-join the NHS Pension Scheme to build up more pension if they wish. There is now no restriction on the number of hours staff can work in their first month back, and abatement for staff with special class status, which includes many nurses, no longer applies.

Also, since 1 October 2023, staff can choose to take ‘partial retirement’ as an alternative to full retirement. This allows them to draw down some or all of their pension while continuing to work and build up further pension, subject to a reduction in pensionable pay of at least 10%, to be agreed with their employer.

Data on applications for partial retirement show that this new, more flexible retirement option has been welcomed by members and employers, with 17,972 applications received as of 28 October 2024. As well as supporting staff with their work/life balance later in their careers, partial retirement may also support NHS employers, by allowing them to retain experienced members of staff for longer.

Communicating the package

Total reward statements (TRS) are provided to NHS staff and give staff a better understanding of the benefits they have or may have access to as an NHS employee. TRS provide personalised information about the value of staff employment packages, including remuneration details and benefits provided locally by their employer.

NHS Pension Scheme members also receive an annual benefit statement (ABS), which shows the current value of their scheme benefits. On 21 September 2024, there were 3,054,253 statements available, with 374,657 views. In comparison, on 13 October 2023, the number of statements available was 2,734,642 and the number of views was 337,043.

The DWP UK Pensions Dashboard Programme provides an opportunity to enable members to access their pension information online, securely, and all in one place. The dashboard will provide clear and simple information about all an individual's pension savings, including their State Pension. The NHSBSA are taking forward the necessary work to prepare the scheme for connection to the dashboard architecture.

In addition to this, the department and NHSBSA are working together to improve the NHS Pensions App functionality. The app will provide members with user-friendly, clear access to their pension data, allow them to see their pension benefits accruing, and future retirement date options. Using technological communication tools will make information readily available to members as well as reduce the amount of time and costs spent on traditional communication such as sending letters to update members.

The department commissions NHS Employers to provide advice, guidance, and good practice to the NHS on developing a strategic approach to reward to support managers recruit and retain the staff they need. NHS Employers will provide further information on how employing organisations approach reward for their staff in their written evidence submissions.

Annex

Identifying measures to improve support for newly qualified healthcare professionals

Overview

This workstream was led by NHSE with its objective to identify ways that NHS organisations can support registered professionals (such as allied health professionals, nurses and midwives) to successfully move from education into NHS employment. Recognising the relevance of the issue, the group agreed to broaden the scope to include all professions. Two working groups were established. The first group focused on legacy mentoring and personal development. This group explored ways to strengthen current tools and resources to enable universal implementation across all professions. The second group focused on quality assurance and explored options on developing and providing systems with tools and resources to allow them to demonstrate commitment and improvement for all newly qualified registrants in their transition.

Conclusion

The final recommendations to be considered by ministers include:

- development and implementation of newly qualified registrants' policies at organisation/region or system level
- appointment of nominated Executives to be accountable for delivery of the 'newly qualified health registrants (NQHRs) commitment'
- implementation of structured transition programmes for NQHRs within all organisations with each ICB establishing a system-wide practice and professional development team to support this

NHSE has now integrated this workstream into their retention programme and is currently rolling out the first phase interventions with other work such as developing a multi-professional preceptorship quality mark being developed in consultation with established social partnership structures.

Amendments to the AfC terms and conditions to support existing NHS staff to develop their careers through apprenticeships

Overview

This workstream was led by the NHS Staff Council. The key objective was to agree amendments to the NHS terms and conditions of service (TCS) to ensure that existing NHS staff do not suffer a detriment to their basic pay when they undertake apprenticeships as part of agreed career development with their employer.

Conclusion

Changes were made to the NHS TCS Handbook to support the preservation of pay for existing NHS staff that develop their careers through apprenticeships. These amendments came into effect on 1 July 2024.

Identifying ways that career progression could be improved for nurses

Overview

This workstream was led by DHSC. The objective was to identify specific challenges in relation to recruitment, retention and professional development. DHSC worked with NHSE, NHS Employers, employer representatives from the NHS Staff Council and trade unions to identify ways to improve opportunities for nursing career progression. DHSC undertook evidence gathering through literature reviews, data analysis and qualitative interviews with nurses to understand the barriers and enablers to career progression.

Conclusion

The evidence highlighted 5 core themes which impact progression:

- development culture and line management support
- access to career information
- training and education funding
- the pay system

- equity of opportunities

Recommendations were made in the following areas for ministers to consider:

- interventions to improve development culture and consistent support for career development such as promoting the use of career coaches, creation of organisational learning and development committees and greater transparency on how CPD funding is spent

- actions to increase support and improve career development for BAME nurses such as bespoke career reviews, further guidance for employers on applying the NHS terms and conditions to recognise prior overseas experience, and national support for the work of international nursing and midwifery associations in this area

- action to determine the required deployment model of nursing taking account of the Long-Term Workforce Plan, potentially working with pilot sites to gather evidence and test any recommended changes

- review by the Staff Council of annex 20 of the terms and conditions handbook to clarify that the provisions can apply to nursing roles

Reviewing the process that is used to set pay for AfC staff, to ensure that this operates effectively.

Overview

This workstream was led by DHSC. The objective of this commitment was for the pay setting process and the NHS Pay Review Body (NHSPRB) to operate effectively with the confidence of key stakeholders and NHS staff. DHSC has worked with key stakeholders including the NHS Staff Council and HM Treasury to identify possible areas of improvement under 4 key themes: timing of the pay round, the appointments process, the provision of data and the interaction between the NHS Staff Council and the NHS Pay Review Body (PRB).

DHSC has proposed draft recommendations under the 4 key themes. Due to further discussion being required and as to not hold up the remainder of the non-pay workstreams, it has been agreed that time-limited conversations will take place between the government and the NHS Staff Council Executive to refine these proposals and to ensure that all parties' views are considered and reflected in the final report.

Improvements to data sharing between the organisations have been discussed and are being taken forward for the 2025 to 2026 pay round. This includes DHSC sharing the data

pack used for written PRB evidence with all organisations so that they may use the contents in their own written evidence.

A summary of the final recommendations from this workstream will be provided following further exploration with the NHS Staff Council Executive.

Developing recommendations to support the fair and consistent application of the NHS job evaluation scheme, helping staff to be confident that they are in the appropriate pay band for the work they are asked to do.

Overview

This workstream was led by the NHS Staff Council and was asked to consider how the work to maintain and update national Job Profiles (currently undertaken by the Job Evaluation Group) can be applied fairly and appropriately to aid career development of the NHS workforce. Alongside key stakeholders the group explored options of how to ensure consistent local job evaluation processes for all professions.

Conclusion

This workstream submitted its recommendations under these themes for ministers to consider. The group stressed that the recommendations need to be considered as a combined package:

restoring confidence - by reaffirming contractual entitlements

- explicit ministerial commitment
- activity to ensure oversight, governance and assurance
- enabling agreement from the NHS Staff Council

building capacity – through improving performance and accountability

- mandatory coordinated programme to bring employer level practice up to a consistent standard
- delivery plan for how support for remedial action will be provided including guidance to prioritise JE activity relating to band 5 and 6 nursing roles

investing to modernize – through a digital JE platform

- national commission for the procurement of a digital solution for England to save time and improve efficiency across all JE activity and provide strategic business intelligence

Reviewing and developing arrangements for safe staffing, drawing on comparative best practice evidence from across different healthcare systems and settings

Overview

This workstream was led by NHSE. The objective was to provide safe, high quality and effective NHS clinical services and ensure the NHS has appropriate staffing levels. This work involved reviewing existing arrangements, taking into consideration the NHS long term workforce plan to ensure there are sufficient staffing levels.

NHSE had already begun extensive evidence-based work to review and update safe staffing guidance as part of a separate commission from the National Quality Board (NQB). As part of the AfC deal, work has taken place to ensure that trade union and employer representatives from the NHS Staff Council can feed into this existing work, alongside independent academics and other national organisations.

Conclusion

Safe staffing guidance is either being reviewed and updated (where this already exists) or being created (where no guidance currently exists) across a range of health service areas. The completion of this work will take longer than the other workstreams, and the publication of the guidance will begin in late 2024 to early 2025.

The national Social Partnership Forum will maintain oversight of this work.

Identifying ways to tackle and reduce violence against staff.

Overview

This workstream was led by the national Social Partnership Forum (SPF), who have brought together expertise from across the service. There has already been extensive work in this area from NHSE, therefore the group focused on evaluating existing measures

for their level of impact via surveys/call for evidence and focus groups and identifying gaps.

Conclusion

This workstream submitted recommendations for ministers to consider on:

- clear strategy for setting out roles and responsibilities across government, non-departmental public bodies (NDPBs) ICSs and regulatory bodies
- national, regional and system working to maximise resources and funding
- mandating the violence prevention and reduction standard which could be through NHS standard contract and assurance through CQC regulatory processes
- data and reporting including implementation of a common data standard to inform pro-active risk management, and development of a user-friendly digital reporting system
- communication and further support and guidance to organisations on matters such as dealing with clinically challenged patients, withholding of treatment, use of criminal prosecutions and links to the people promise
- risk assessment, training and support - core training and guidance to be developed by NHS England; standard approach to post incident support as part of the VPR standard
- embedding of partnership working in delivery including through SPF structures and joint work with local unions recognising the status and expertise of health and safety reps.

Amending the NHS Pension Scheme to ensure that staff with ‘special class status’ can retire and return to work in the NHS without the previous limits on how much work they can do when they return.

Overview

This workstream was led by DHSC. The objective was to extend the suspension of NHS pension abatement rules for special class status members that were in place during the pandemic, to allow staff to contribute additional capacity to deliver NHS services.

Conclusion

Changes have been made to the NHS Pension Scheme regulations to ensure these staff can retire and return to work in the NHS without the previous limits on how much work they can do when they return. These changes came into effect from 1 April 2024 and the government's consultation document contains further information about the changes.

Identifying measures available through the AfC terms and conditions to help reduce agency spend.

Overview

This workstream was led by the NHS Staff Council and the commitment was to identify measures available through the NHS Terms and Conditions of Service (TCS), that could help reduce agency spend. Evidence was also gathered via NHSE to understand what drives staff to work for agencies (for example, total reward, or flexible working). The group explored how to better showcase the benefits of substantive contracts.

Conclusion

This workstream made recommendations for ministers to consider using the NHS TCS and included sections of the handbook relating to:

- flexible working – further work through national partners on barriers including how to enable effective technological solution to allow accurate recording and monitoring for national assessment of progress
- pay on promotion o reinforcement of the contractual provisions and dissemination of Staff Council guidance
- time off in lieu (TOIL) – resumption of Staff Council work on guidance and consistent application of TOIL to support work-life balance
- review of annex 7 of the terms and conditions (good practice guidance on managing working patterns), recognising that it no longer reflects current ways of working and that new employment rights legislation are likely to create additional rights such as shift notice and guaranteed hours

Considering the introduction of a cap so that redundancy payments would not exceed £99,999

Overview

This workstream was led by the NHS Staff Council and considered the implementation of a cap of just under £100,000 via changes to NHS contractual redundancy terms under section 16 of the NHS TCS Handbook. This would have reduced the maximum redundancy payment agreed in 2015 from £160,000 to £99,999.

Conclusion

The group explored options which included impact assessments considering financial, legal, operational and equality factors. However, the group did not reach a consensus on any proposal to change the current redundancy cap arrangements.