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Submission to the NHS Pay Review Body

22 February 2022

Contents

1. Introduction

1. This is NHS England and NHS Improvement's submission to the pay review bodies. The evidence covers our key areas of responsibilities for supporting the recruitment, retention and motivation of NHS staff employed on the Agenda for Change (AfC) contract.

2. On 22 November 2021, the Secretary of State for Health and Social Care announced that Health Education England (HEE), NHSX and NHS Digital will merge with NHS England and NHS Improvement by April 2023, putting long-term planning and strategy for the NHS workforce at the forefront of the national NHS agenda.

3. At the time of preparing our evidence, we are again operating in a Level 4 National Incident in response to the Omicron variant.

4. On 24 December 2021, we published the 2022/23 priorities and operational planning guidance for the NHS. This includes the priority actions relating to the strategic themes established in the People Plan 2020/21.

5. In 2022/23 our aim remains to restore services, meet new care demands and reduce the care backlogs due to COVID-19. Supporting and motivating NHS staff, developing new ways of working to improve patient experience and productivity, and recruitment and retention are all critical to increasing capacity while delivering high quality safe care. Sustaining advances made throughout the pandemic, eg flexible working and a focus on health and wellbeing will be central to our work. Our priorities, set out in our guidance, include:

    - accelerate plans to grow the substantive workforce and work differently as we keep our focus on the health, wellbeing and safety of our staff
    - use what we have learnt through the pandemic to rapidly and consistently adopt new models of care that exploit the full potential of digital technologies
    - work in partnership as systems to make the most effective use of the resources available to us across acute, community, primary and social care settings, to surpass pre-pandemic levels of productivity as the context allows

- use the additional funding government has made available to us to increase our capacity and invest in our buildings and equipment to support staff to deliver safe, effective and efficient care.

2. Workforce strategies

2.1 NHS People Plan

6. The interim People Plan, published in June 2019, set out the action needed for our NHS people and workforce to deliver the NHS Long Term Plan. It described how the NHS would ensure it had more people, working differently in a compassionate and inclusive culture. The first full People Plan, published in July 2020, built on this foundation and set out how the NHS would support staff through the pandemic and beyond by looking after our people, fostering a sense of belonging in the NHS, instituting new ways of working and growing the workforce.

7. Working with NHS systems we have made good progress in implementing the actions set out in both People Plans. We have taken an explicitly improvement-based approach to allow systems to prioritise the actions that will have the greatest impact for their staff and in turn for their patients. Most systems report that they are on track to deliver on priorities across the actions set out in the 2020 People Plan, however there is further work to do; in particular, ensuring that flexible working opportunities are available to all staff, there is a consistent approach to service transformation and workforce productivity, and the workforce is growing to meet demand.

8. The COVID-19 pandemic has placed unprecedented pressure on healthcare systems globally, including the NHS. NHS staff have cared for over 600,000 people in hospitals with the virus and administered over 115 million COVID-19 vaccine doses, at the same time as delivering non-COVID care for those who needed it urgently. This has inevitably constrained planned service delivery: six million people are now waiting for elective care, and there will be others who might need care but who have delayed coming forward for treatment during the pandemic.[1] The NHS will need to manage the continuing pressure from the

[1] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/02/C1466-delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care.pdf

pandemic alongside the challenge presented by this backlog of care. A workforce which feels valued, recognised and rewarded for the role it plays will be critical to this endeavour.

9. The NHS will continue to be under pressure for the next few years. In addition to recovering elective care performance by significantly increasing diagnostic and treatment capacity, the restoration of other impacted services – such as primary, community and mental health care – will continue to be a priority, as will making progress on the NHS Long Term Plan ambitions and responding to independent service reviews (such as the Ockenden Review of maternity services).

10. These priorities also need to be delivered in a way that improves the experience staff have at work. We will continue to work with NHS systems to recruit and retain more people, implement new ways of working and build a more compassionate and inclusive culture where staff feel well supported and are empowered to lead service improvement.

11. In practice, this means we will work with systems to implement workforce changes which are well integrated with changes in how services are delivered to patients, including investment in new facilities and technology. In our focused programme of work to support elective recovery, we have sought to rapidly increase workforce capacity. Interventions so far have included growing the number of clinical support staff and international nursing recruits. We are currently working to further increase capacity and deliver effective service transformation in those areas and professions that will have the greatest impact on patient flow and outcomes, including diagnostics (in line with the Richards Review), anaesthetics, critical care, operating theatres and community services.

12. A core component of our approach to supporting our people is the delivery of the People Promise (created by our staff, for our staff) to ensure that staff experience the NHS as a good place to work and are better able to care for patients and service users as a result. Engagement links to productivity and outcomes for both patients and staff, through applying a continuous improvement methodology. We are also working closely with government to support the Messenger Review of leadership in the NHS as we know strong and effective leadership and management are critical to the success of the NHS, including improving staff experience.

2.2 Long-term strategic framework for health and social care workforce planning

13. With the conclusion of the Spending Review in December 2021, we now have a much clearer view of the increase in workforce capacity and skills which the commissioned training programmes will deliver in 2024/25.

14. Work is taking place across NHS England and NHS Improvement, HEE and the DHSC, to provide both longer term demand signalling and training plans, as well as short and medium term actions to support, retain and develop the existing workforce and those already in the training pipeline.

2.3 Integrated care systems

15. In November 2020, our publication Integrating care: Next steps to building strong and effective integrated care systems across England signalled a shift towards more local decision-making in health and care and local collaboration driven by communities' needs.

16. In February 2021 NHS England and NHS Improvement made recommendations to government to establish ICSs on a statutory basis, which were included in the government's White Paper.

17. The Health and Care Bill is expected to establish integrated care boards (ICBs) and integrated care partnerships (ICPs) as the legal structures underpinning each ICS. Through these new structures ICSs will play a critical role in aligning NHS, local government and other local partners' action to achieve shared aims.

18. Statutory ICSs – now expected to be in place from July 2022 – are therefore well placed to improve workforce integration and deliver the People Plan ambition to have 'more staff, working differently, in a compassionate and inclusive culture'. ICSs can, for example, widen the opportunities for people in their local communities to work in the NHS, including for those living in areas of greater deprivation, from excluded groups or not in education, employment or training. Through creating employment, volunteering and apprenticeship opportunities they can make the most of the skills and talent across the whole local area, and develop a broader talent pipeline. NHS employers are increasingly seen as anchor

institutions in their local economies and communities, with a crucial role to fulfil as employers as well as providers of health and care services.

19. The ICS Design Framework published in June 2021 articulates the expected ICB and ICP functions, governance arrangements at ICS level and a roadmap to implement these new arrangements. It sets out the duty for the ICB and the ICP to collaborate to deliver a set of functions and responsibilities – to achieve the four aims of each ICS and deliver national and local priorities.

20. ICSs will lead the People function. Guidance published in August 2021 sets out the 10 functions of NHS leaders and organisations to, working with partners, deliver the workforce priorities, including those set out in the People Plan, and develop and support the entire workforce in the health and social care system.

21. Each ICB will also be expected to establish strong clinical and professional leadership arrangements at ICS level, working with ICS partners. This will include appointing an ICB medical director and executive chief nurse to involve clinical and care professionals in ICS decision-making. These executive roles will be responsible for: matters relating to the relevant professional colleagues employed by the ICB; developing and delivering the ICB's long-term clinical strategy, ensuring multi-professional involvement; and leading areas such as information governance, quality assurance/improvement and safeguarding.

3. Finances

3.1 Financial context

22. The NHS Long Term Plan was published in 2019 setting out the priorities and commitments of the NHS over the period to 2023/24, including the planning assumptions for workforce pay.

23. Due to the COVID-19 pandemic in 2020, and to support the NHS through a challenging period, NHS England and NHS Improvement introduced an interim financial regime to recognise pandemic-related inefficiencies and lost productivity (eg increased infection prevention and control (IPC), redeployment of staff and higher sickness absence levels).

24. As a result of this temporary arrangement and significant COVID-19 related costs, the NHS has been hindered over the last two years from delivering recurrent efficiencies to the levels it has achieved historically and set out in the NHS Long Term Plan.

25. The government's SR21 multi-year settlement for the NHS covers 2022/23–2024/25. The NHS priorities are to deliver on the NHS Long Term Plan commitments, tackle the elective backlog, continue to provide COVID services and increase the NHS workforce, which is currently 10% larger than in March 2019, all of which within a financial settlement which is predicated on stretching efficiency targets and a significant reduction of COVID-related costs.

26. For 2022/23, the total NHS resource budget (including COVID costs) is expected to reduce in real terms by c1.9% compared to the previous year. The NHS resource budget (including COVID costs) in 2023/24 and 2024/25 will see real terms growth on the previous year of c1.4%.[2]

3.2 Pay award affordability

27. Pay remains the largest component of NHS costs (c65% of total operating costs) and therefore pay inflation represents a material cost pressure which the NHS needs to plan and manage. Pay awards that are higher than the affordable level, and which are not supported by additional investment, will result in difficult trade-offs during the year on staffing numbers and the ability to deliver activity volume. These decisions will have a longer-term impact on the NHS's ability to restore services and make progress in tackling the elective care backlogs which have grown during the pandemic.

28. Systems will need to manage ongoing COVID care needs, while restoring services, making inroads into the elective backlog, and progressing other NHS Long Term Plan commitments. Local budgets will therefore require delivery of a combination of stretching financial challenges:

    - cost reductions required to deliver efficiency
    - convergence adjustment to bring systems gradually towards their fair share of NHS resources

[2] The government's Spending Review 2021 set out an increase of 3.8% in real terms. This is based on growth above the NHS Long Term Plan baseline excluding COVID funding, whereas the figures set out above include the additional budget funded in 2021/22.

- reduction in COVID funding
- delivering a significant increase in volume of activity from the available resource compared to 21/22 levels.

29. These factors will impact different systems to different extents, but the overall efficiency requirement will be at least double that of the previous national NHS Long Term Plan efficiency requirement. This means it would not be credible to rely on further efficiencies in order to fund headline pay awards.

3.3 Ongoing impact of COVID-19

30. Given ongoing uncertainties and impacts from COVID-19, pay is not the only financial uncertainty for the NHS in 2022/23.

31. The NHS is continuing to incur significant additional costs due to the ongoing impact of COVID-19. Higher costs are driven by several factors relating to the prevalence of Covid including enhanced IPC, ward reconfigurations, staff redeployment and cancellations of elective activity as well as increased staff sickness absence. Since the SR21 outcome, the Omicron variant has generated further uncertainty over the ongoing impact that COVID-19 will have on NHS operational needs.

32. The NHS is also managing the challenges of competing workforce and financial pressures from continuing to deliver COVID-19 care, delivering increased capacity for elective recovery to improve waiting times for patients, and ensuring staff are given adequate rest and recuperation after a sustained period of intense pressure, to safeguard the health and wellbeing of the workforce, resulting in both retention of existing staff and attraction of new.

33. In 2021/22 staff sickness absence has remained high; for April to August the average was 4.65%, spiking to above this due to the emergence of the Omicron variant, before falling again but remaining high at the end January 2022. Temporary staffing spend has increased during the pandemic driven by an increase in bank activity, to maintain services while covering higher rates of staff sickness absence.

4. Recovery

4.1 Supporting staff during COVID-19

34. In April 2020 – very soon after the start of the pandemic – NHS England and NHS Improvement launched a national staff health and wellbeing offer to support staff through the COVID-19 pandemic; this complements support available locally.

35. We refined this offer throughout 2021/22 and it now includes:

- a specialist bereavement support line for health and care staff
- free access to mental health and wellbeing apps (by the end of December 2021 this had been accessed over 47,000 times)
- suicide awareness resources and support for people affected by suicide
- guidance for key workers on how to have difficult conversations with their children
- group and one-to-one support, including specialist services to support our Black and minority ethnic (BME) colleagues
- webinars providing a forum for support from and conversation with experts
- bereavement support for our Filipino nurses via a specific 'Tagalog' speaking service supported by Hospice UK.

36. The entire national health and wellbeing offer has now been accessed more than 1.5 million times and utilisation remains consistent.

37. We also developed guidance to equip NHS line managers to support and lead their teams during and after COVID-19, emphasising their role in caring for their staff and taking a preventative approach to health and wellbeing. This includes:

- training for line managers to have effective health and wellbeing conversations
- coaching and mentoring support
- online resources, toolkits and guidance for teams working under pressure

4.2 Recovering services

38. The pandemic and the NHS response to it have inevitably had an impact on both workforce and availability of services. The NHS workforce responded with unstinting effort and flexibility; over the ensuing waves sickness absence related to anxiety and stress has increased, as has the leaver rate from the low level seen at the height of the pandemic.

Table 1: Yearly (September to September) NHS leaver rates by professional group, 2014/15 to 2020/21

Staff Group	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
AHPs	7.08%	7.10%	7.06%	6.82%	6.52%	5.38%	6.36%
HCS	9.49%	6.55%	6.70%	6.55%	6.76%	5.61%	5.90%
Medical and Dental	10.73%	10.69%	10.51%	10.16%	10.05%	9.00%	9.27%
NHS Infrastructure and Support	9.55%	9.20%	9.27%	8.79%	8.18%	6.90%	7.20%
Nursing & Midwifery	7.19%	7.25%	7.58%	7.06%	6.90%	5.63%	6.26%
Other ST&T	7.78%	8.08%	8.09%	7.92%	7.48%	6.44%	7.53%
Support to AHPs	7.71%	7.83%	8.43%	8.45%	7.24%	6.65%	7.59%
Support to HCS	10.48%	8.84%	9.01%	9.09%	9.39%	8.05%	8.70%
Support to Nursing & Midwifery	9.48%	9.61%	9.71%	9.31%	8.72%	7.54%	8.49%
Support to Other ST&T	10.59%	10.76%	11.30%	10.79%	10.03%	8.56%	9.44%
Grand Total	**8.71%**	**8.57%**	**8.72%**	**8.32%**	**7.94%**	**6.75%**	**7.34%**

Source: Unpublished ESR data.

39. The pivot in the early stages of the pandemic from routine elective work to treating patients with COVID-19 has had an impact on waiting lists for diagnostic and surgical interventions, exacerbated by delays in some patients presenting for initial assessment in primary care during the pandemic. Recovery of elective services to pre-pandemic levels and dealing with the backlog of cases delayed due to COVID-19 is a key priority for NHS England and NHS Improvement, and requires a net increase in the rate patients are treated. Supporting the recovery of NHS staff is also key in the overall elective recovery programme, both to increase workforce capacity and for maintaining staff health and wellbeing. Systems are drawing up plans that prioritise the health and wellbeing of the workforce to ensure we retain existing staff alongside recruiting new colleagues.

40. The pandemic has caused many NHS staff to reflect on their work–life balance. For many people the last two years have been the most challenging of their careers and they may be looking to set clearer boundaries between their work and personal lives by not working ‘full time’ hours or taking on additional shifts.

Decisions are compounded for some by the hours they work potentially having tax consequences for pension growth, by breaching the annual or lifetime allowance. These factors are likely to reduce workforce capacity and the discretionary effort which some people are prepared to put in.

41. NHS England and NHS Improvement's delivery plan for tackling the COVID-19 backlog of elective care[3] aims to support local health systems and other partners to address short, medium and long-term issues which were either caused by the pandemic response or which were already present prior to March 2020.

42. The short-term (next six months) aim of increasing workforce capacity is designed to help reduce the day-to-day pressures on existing staff, allowing them more time to recover, while focusing on recruitment to fill existing vacancies and reducing staff absence. This work will also complement any further requirements for the service to manage short-term or more sustained future waves of COVID-19. Since the pandemic began, NHS England and NHS Improvement have demonstrated how they can support frontline health service staff in delivering quality care in challenging circumstances: developing health and wellbeing offers; making progress in agile and flexible working plus recruitment initiatives (ie vaccination workforce, healthcare support workers and the commitment to recruit 50,000 more nurses). Work is also ongoing to help those affected by pension tax issues make more informed decisions around working additional hours or clinical sessions.

43. In the medium term (next 18 months) our aim is to optimise the use of the existing NHS workforce by transforming how some services are delivered, both to increase capacity and improve patient outcomes. The need for the NHS to redeploy staff to provide emergency care for COVID-19 patients has increased demand for areas such as diagnostics, outpatient services, critical care, anaesthetics and operating theatres. Workforce redesign can help create more capacity, use workforce more flexibly and ultimately reduce the time patients wait to be treated or followed up, as well as how long they stay in hospital. It can also expand the opportunities for staff by creating new roles and career pathways and improve their experience.

44. Over the longer-term NHS England and NHS Improvement, working alongside their stakeholders and supporting local health systems, aim to create a workforce that is sustainable within the financial resources available, and able to meet the

[3] https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/

demands placed on it. Increased investment in training places and programmes via HEE would be needed to provide more capacity in existing NHS roles, and in new roles arising from the transformation of services, leading to improved patient access to services.

Conclusion

45. The pandemic has had – and continues to have – a fundamental impact on both the supply and capacity of the workforce, and on staff health and wellbeing and preferred working patterns. Key to recovering NHS services over the short, medium and long term will be 'people recovery', focusing on initiatives that improve staff experience and promote the retention of staff, and attract new talent into the service in key areas. In parallel, work is ongoing to increase the capacity and productivity of the workforce through recruitment, retention and workforce redesign and service transformation, to make the best possible use of existing staff and their skills and time.

5. 50,000 nurses commitment

5.1 Overview

46. In 2019, the government announced that it would increase the number of nurses in the NHS by 50,000 by the end of this Parliament. To fulfil this commitment, nine workstreams are interdependently working to increase supply by:

- retaining more registered nurses in the NHS in England
- encouraging Nursing and Midwifery Council (NMC) registered nurses to return to practice
- developing an ethical and sustainable international recruitment model to increase international nursing supply
- increasing numbers of nurses qualifying through undergraduate degrees
- reducing attrition rates for pre-registration nursing students
- increasing the pipeline of trainee nursing associates
- developing more qualified nursing associates and assistant practitioners into registered nurses

- encouraging graduates to undertake postgraduate study to achieve a registered nurse degree
- increasing supply through the registered nurse degree apprenticeship.

Their progress is monitored by the national 50k programme board.

47. This is a comprehensive work programme to meet the commitment, through a combination of increased supply, recruitment and retention.

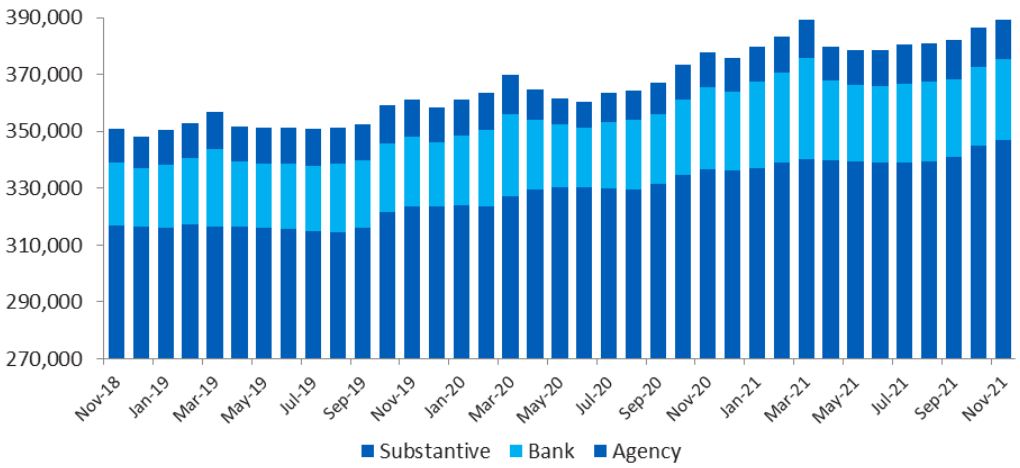
5.2 Nurse recruitment and retention

Nurse recruitment trends

48. The full-time equivalent (FTE) nursing workforce position has improved (see Figure 2), and the vacancy rate has fallen slightly (see Figure 3). However, significant shortages remain given the increasing demand.

49. **Nursing workforce:** Figure 2 shows that between November 2018 and November 2021 the substantive nursing workforce has increased by around 30,000 FTE (9.4%). Over the same period, the temporary nursing workforce has increased by around 8,600 FTE (25.4%) through a combination of high-cost agency (up by 16.2%) and bank nursing (up by 30.5%).

Figure 2: Registered nursing workforce FTE

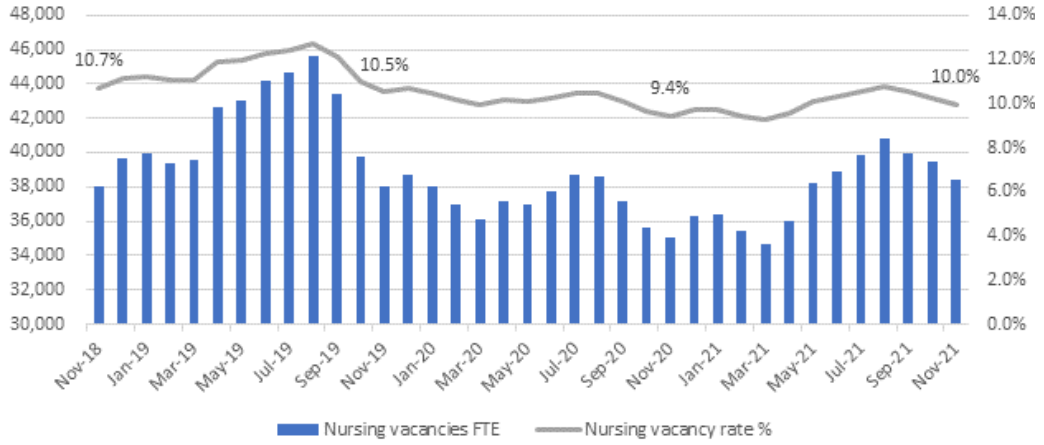


Source: NHS England and NHS Improvement monthly provider workforce return, covering NHS provider trusts only, unpublished.

50. **Nursing vacancies:** Figure 3 shows that between November 2018 and November 2021 substantive nursing vacancies have increased by 412 FTE to a total of

38,400 FTE. However, owing to the parallel growth in substantive nursing staff, the nursing vacancy rate has actually fallen from 10.7% to 10.0%. This continues to pose a significant operational challenge to NHS providers overall, and to some providers in particular where vacancy rates are especially high.

Figure 3: National nurse vacancies, FTE



Source: NHS England and NHS Improvement monthly provider workforce return, unpublished

51. The most recent available data shows that more nurses from overseas continue to join the NHS: around 11,000 were recruited between April and October 2021. Over 1,000 are currently joining each month and this is expected to continue for the next 12 months.

Nurse retention trends

52. Although the number of nurses leaving the NHS has been low compared to historical levels during the pandemic, since September 2021 the annual NHS leaver rates have started to return to what they were pre-pandemic (February 2020). Many competing factors influence a person's decision to leave the NHS and with uncertainty about their combined impact the retention risk remains high. The Royal College of Nursing Survey 2021 describes the ongoing impact of the pandemic on nurses in a number of areas.

Conclusion

53. Significant staff shortages remain in nursing despite the growth of this workforce and a slight reduction in vacancies. Retention of nurses improved throughout the pandemic but is now reverting to pre-pandemic levels, and remains a significant challenge.

5.3 Allied health professional recruitment and retention

54. Allied health professionals (AHPs) are the third largest clinical workforce in the NHS.

55. In 2019, the Interim NHS People Plan[4,5] acknowledged the shortages across a wide range of NHS staff groups, including paramedics and radiographers.

56. Since then, we have developed the National AHPs Workforce Improvement Framework setting out the necessary actions to ensure an effective supply of AHPs, and their robust deployment and development, placing a focus on the retention of the workforce across professions and geography.

57. The framework focuses on six ambitions across three key areas:

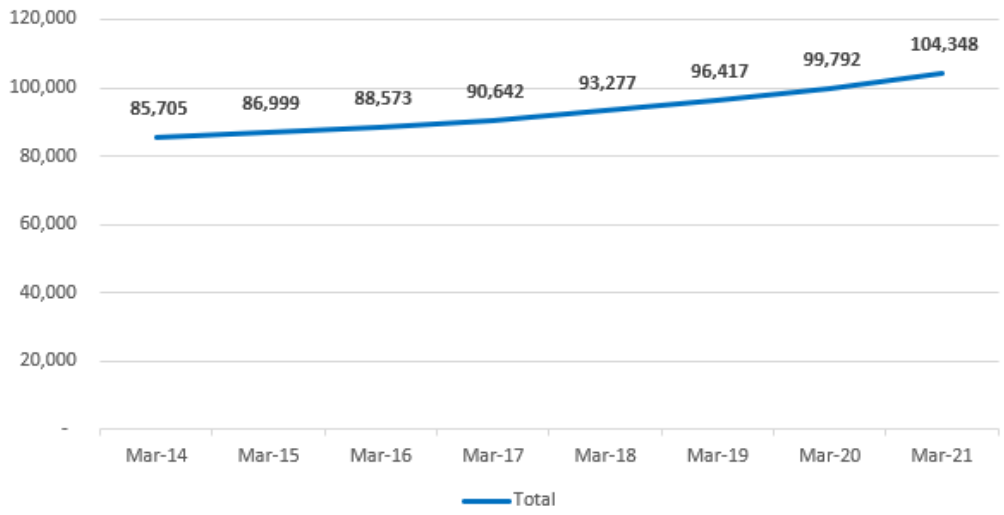
[4] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf
[5] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/IPP-future-AHP-workforce_2june.pdf

- **Future supply:**
  - Stimulate demand: Make becoming an AHP a career of choice to stimulate and incentivise applications; this will address the fall in applications to and acceptances of AHP undergraduate course places.
  - Increase capacity: Through increasing applications to and acceptances of AHP courses to further support the delivery of the NHS Long Term Plan.
- **Bridging the gap between education and employment:**
  - Support and pathways: Support different entry routes into AHP roles and explore potential alternative routes.
- **Enabling the workforce to deliver and grow:**
  - Effective deployment: Deploy AHPs in a way that recognises the needs of the system, the population and supporting staff.
  - Support development: Support AHPs to develop throughout their career: advanced practice and new roles, including medicines management, digital technology and informatics, and leadership and improvement capability.
  - Retention: Support the AHP profession to retain AHPs – making the NHS the best place for them to work.

Allied health professional recruitment trends

58. The number of AHPs employed in the NHS has grown substantially over the last seven years: over 100,000 FTE AHPs are currently employed in NHS provider trusts.

Figure 4: AHP FTE workforce, 2014 to 2021



Source: Unpublished ESR data.

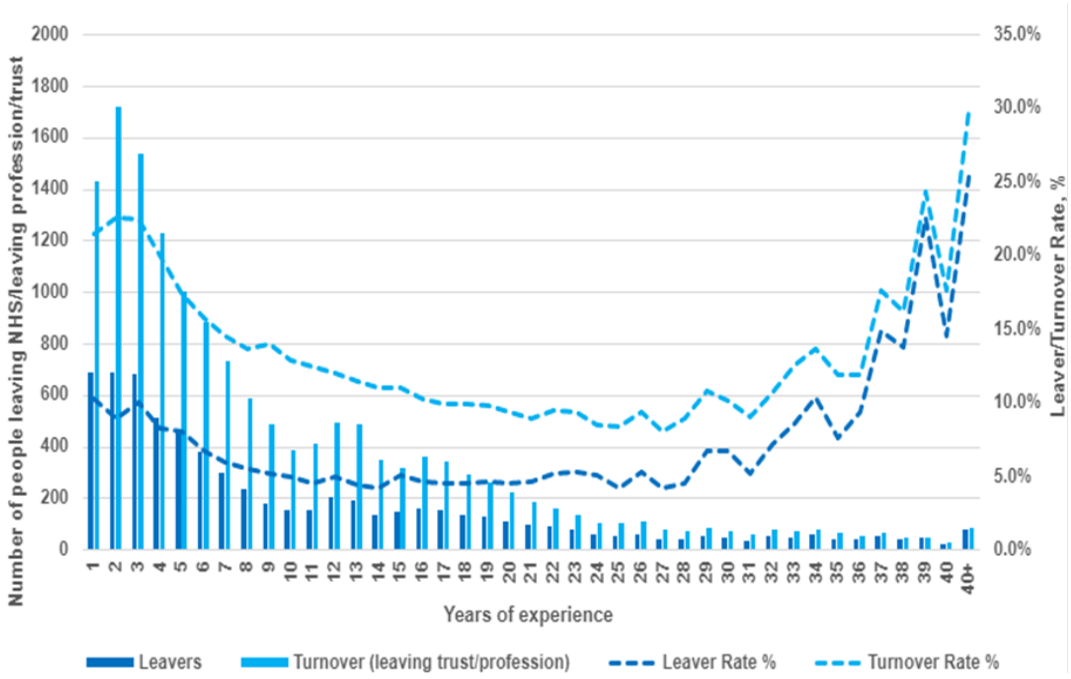
59. Since March 2019, substantive AHP vacancies have reduced by 8,392 FTE (8.5%) to 7,749 FTE (6.3%) in October 2021. However, there is substantial variation in vacancy rates across professions, with higher levels of vacancy for podiatry, occupational therapy and diagnostic radiography, which poses an operational challenge for services.

60. Workforce demand continues to increase. AHPs have been essential in supporting the COVID-19 response, including in fulfilling acute care, long COVID rehabilitation and COVID recovery requirements. The Diagnostics: Recovery and renewal – report of the Independent Review of Diagnostic Services for NHS England makes recommendations for improving registered and support capacity to meet demand. In 2020 the Network Contract (Directed Enhanced Service) provided funding through the Additional Roles Reimbursement Scheme to support expansion of the primary care workforce by an extra 26,000 roles by 2023/24.

Allied health professional retention trends

61. Leaver and turnover rates are significantly higher at the start of an AHP's career and as they approach retirement. Of leavers in the first five years of their career, 44% leave the NHS and 45% change post within the NHS.

Figure 5: AHP leaver rates and turnover by years of experience, October 2020 to October 2021



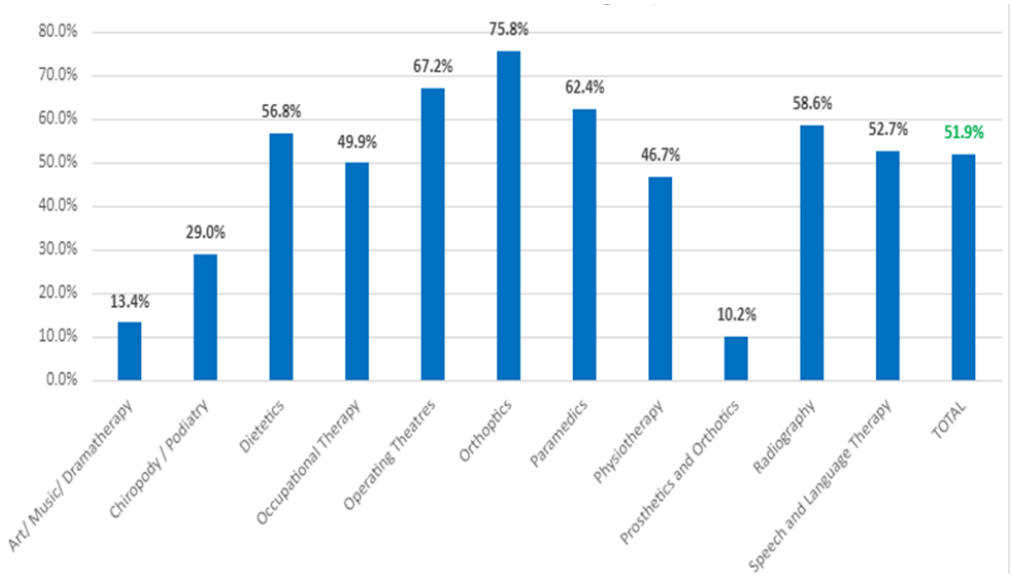
Source: Unpublished ESR data.

62. Of the total number of AHPs registered in England with the UK Health and Care Professions Council (HCPC), the sole AHP professional registration body, approximately 50% work in the NHS; this percentage has remained constant over the last seven years.

63. The top two reasons for AHPs leaving the NHS in the first two years of their career are relocation (30.1%) and pay and reward (24.5%). For AHPs leaving the NHS with up to two years' service, relocation (26.7%) and pay and reward (19.9%) are also the top two reasons.

64. To support the retention of this workforce there are key interventions that the AHP Retention Taskforce is focusing on, which includes a specific focus on preceptorship/early career and working alongside the HCPC to develop national standards.

Figure 6: NHS AHP headcount as a percentage of the UK HCPC Register



Source: Unpublished ESR and HCPC data.

Conclusion

65. There have been improvements in the FTE AHP workforce position, and a reduction in vacancies, but significant shortages remain. Retention of AHPs remains a priority, with a particular focus on early-stage careers.

5.3 All staff retention programme

66. The national NHS England and NHS Improvement Retention Programme, in its second year, has been supporting trusts and ICSs to improve retention locally. Structured around the elements of the People Promise, the programme, nationally and through regions, is helping to embed a consistent offer across a number of areas to all staff in the NHS, to improve their experience and with this their retention.

67. The programme has targeted interventions across sectors and staff groups where they are most needed, and at different career stages, recognising that there are differences across the generations in the workplace needs, motivations and challenges that influence people's intention to stay.

68. Across all staff groups, fewer people left the NHS throughout the COVID-19 pandemic, but since September 2021 the annual NHS leaver rates have started to return to pre-pandemic (February 2020) trends (see Table 1). NHS staff have worked tirelessly throughout the pandemic but this has taken its toll, and will continue to do so, leaving many staff fatigued.

69. The retention programme explores the factors that impact job satisfaction and the reasons people decide to stay or leave the NHS, including what may trigger staff to consider leaving:[6] work-related stress, line manager support, staff shortages, pay, mental health impacts and time pressure are strong drivers for leaving.[7] Programme engagement has charted the experience of staff during the pandemic, such as the demands on them in terms of workload and its intensity, as well as that of retention drivers – job control,[8] education and career development,[9] resources,[10] work–life balance[11] and meaningful recognition.[12] The pandemic is

[6] Kim SW, Price JL, Mueller CW, Watson TW (1996) The determinants of career intent amongst physicians at a U.S. air force hospital. *Human Relations* 49(7): 947-76.
[7] Economic and Social Research Council COVID-19 Rapid Response research project: *'Should I stay or should I go – NHS staff retention in a post COVID 19 world Challenges and Prospects,* The University of Bath, 2021 (current).
[8] Li X, Zhang Y, Yan D, Wen F, Zhang Y (2020) Nurses' intention to stay: The impact of perceived organizational support, job control and job satisfaction. *Journal of Advanced Nursing* 76(5): 1141-50.
[9] Yarbrough S, Martin P, Alfred D, McNeill C (2017) Professional values, job satisfaction, career development, and intent to stay. *Nursing Ethics* 24(6): 675-85.
[10] Lin SY, Chiang HY, Chen L (2011) Comparing nurses' intent to leave or stay: differences of practice environment perceptions. *Nursing & Health Sciences* 13(4): 463-7.
[11] Robson A, Robson F (2015) Do nurses wish to continue working for the UK National Health Service? A comparative study of three generations of nurses. *Journal of Advanced Nursing* 71(1): 65-77.
[12] Sherwood G, et al (2018) Reflective practices: meaningful recognition for healthy work environments. *Nursing Management* 24(10): 30-34.

not yet over and staff are tired, potentially exacerbating the reasons for staff leaving the NHS.

Retention Programme interventions

Intensive support for ICSs

70. The retention programme has supported 13 ICSs (87 trusts) to design and deliver system-level retention plans, underpinned by data. These systems are now delivering targeted interventions.

71. Collaboration across whole systems achieved many early wins: the new self-service diagnostic tool, increased system capability and capacity; and new retention 'community of practice' networks which have engaged people to accelerate learning from one another.

Improved data, analytics and insights

72. In March 2021, the programme launched a dedicated retention compartment on the Model Health System, a repository for trust and system-wide retention data. It allows ICSs and organisations to review their own data, track improvement and benchmark against peers to inform their decisions on retention. In September 2021, the programme launched a standardised exit questionnaire in the NHS Electronic Staff Record (ESR) for staff to provide confidential feedback and to improve the accuracy and consistency of data collection on reasons for leaving the NHS.

'Generational' interventions for staff in early and later career

73. The retention programme identified that people are most likely to leave in the early (within one to two years) and late stages of their career (50 years old and above) (Table 2).

Table 2: All staff workforce FTE and % leaver rate for staff in early and late stages of their career, March 2021

Region	FTE 50+	% 50+	FTE in first two years of employment	% in first two years of employment	Leaver rate			
					Overall	First year of employment	Second year of employment	Up to two years of employment
East of England	35953	31.5%	29796	29.3%	7.4%	13.6%	10.7%	12.4%
London	60444	29.5%	51476	27.7%	7.9%	16.4%	11.3%	14.3%
Midlands	74453	33.5%	45473	23.0%	6.6%	14.2%	10.6%	12.7%
NE & Yorkshire	67397	33.9%	37183	21.6%	6.7%	15.8%	10.7%	13.7%
North West	62831	34.2%	39398	24.5%	7.0%	17.6%	11.7%	15.1%
South East	52399	32.1%	42277	28.8%	7.9%	15.7%	10.6%	13.6%
South West	38535	33.3%	27300	28.2%	8.0%	15.7%	11.5%	14.0%
England	**392012**	**32.6%**	**283252**	**25.7%**	**7.5%**	**15.6%**	**11.0%**	**13.7%**

Source: Unpublished ESR information (March 2021).

74. The programme has developed interventions[13] to better support staff in the early and late career stages to stay. These include new guidance and case studies,[14] national events with exemplar organisations to share good practice, focus groups with staff in early/late career stage and national masterclasses covering a range of themes. The programme continues to hold bi-monthly staff reference groups for early and later career staff, and managers have tools to support them in conversations with their staff.

Conclusion

75. Improving retention is a crucial response to the workforce supply challenge in the NHS. The retention programme will continue to deliver interventions at ICS and organisational level to improve staff morale and experience; this in turn will have a positive impact on patient and service user experience.

[13] https://www.england.nhs.uk/looking-after-our-people/vanguard-programme-for-2021/
[14] https://www.england.nhs.uk/looking-after-our-people/looking-after-our-people-case-studies/

6. Our NHS People Promise

6.1 Overview

76. The NHS People Promise was created by staff for staff and sets out how NHS staff can work together to help make the NHS the best place to work. It represents what would improve NHS staff experience in the workplace the most. All NHS staff should be able to recognise the promise as their experience of work by 2024. From this year, the NHS Staff Survey has been redesigned to align with its themes and moves from an annual survey to quarterly. The NHS Staff Survey will enable teams, departments, organisations and systems to see the progress they are making towards the promise becoming a reality for all staff, and help focus efforts on areas where improvements are needed.

6.2 We are compassionate and inclusive

Culture and engagement

77. The People Plan states that to make the NHS the best place to work, we need "compassionate and inclusive leadership behaviours coming to the fore", to create a sense of belonging and unleash potential. Good leaders appreciate that a culture that values our people as individuals is the way we will hold onto our people and recruit the next generation. It also recognises that "inclusive cultures depend on inclusive leaders".[15]

78. The evidence tells us that having 5% more staff working in teams – and teams that demonstrate the practices of what are termed 'real teams' – is associated with a 3.3% drop in patient mortality rates,[16] lower error rates, hospitalisations and costs.

79. Compassionate and inclusive working environments also positively impact staff engagement. For example, a 0.12 increase in staff engagement scores in the NHS

[15] West M The King's Fund *If it's about NHS culture, it's about leadership*, 11 December 2020.
[16] Lyubovnikova J, West MA, Dawson JF, Carter MR (2015) 24-Karat or fool's gold? Consequences of real team and co-acting group membership in healthcare organizations. *European Journal of Work and Organizational Psychology* 24(6): 929-50.

Staff Survey (on a scale from 1 to 10) correlates with a 0.9% decrease in agency spend, saving the average trust £1.7 million per year.[17]

The Culture and Leadership Programme

80. The Culture and Leadership Programme (CLP) was developed in 2015 in response to the findings of the Francis Report and the Berwick Report into failings of care at Mid Staffordshire and other organisations at risk of similar failings. It is a structured approach that helps organisations understand their own culture, identify the root causes they need to change and then to address them. Through the programme, leaders commit to listen more deeply to staff about the things that challenge them; this means that the interventions they then make lead to the difference staff want to see.

81. The CLP has six key lines of enquiry that analyse culture in respect of a strong evidence base.[18]

82. This year the CLP has reached 1,226 individuals through events, online forums and its community of practice. It directly supports 17 of the most challenged NHS organisations.

83. An analysis of quantitative data from trusts[19] that engaged in the CLP from 2018 to 2020 shows their improvement in key outcome measures:

- staff engagement improved by more than twice the national average (0.03)
- registered nurse turnover reduced by 1.4 percentage points between 2015/16 and 2019/20 (compared to a national average of 0.8 percentage points).

Equality, diversity and inclusion

84. The NHS People Plan's 'Belonging in the NHS' pillar outlines the aim to "foster a culture of inclusion and belonging, as well as take action to grow our workforce, train our people, and work together differently to deliver patient care," through addressing issues highlighted by the Workforce Race Equality Standard (WRES)

[17] https://www.england.nhs.uk/publication/employee-engagement-sickness-absence-and-agency-spend-in-nhs-trusts/
[18] https://www.england.nhs.uk/culture/culture-leadership-programme/
[19] Affina OD West T, West M, Gosh D (2021) An evaluation of the implementation of the NHS Culture and Leadership Programme.

report[20] and the Workforce Disability Equality Standard (WDES) report[21] findings, alongside consideration of other protected characteristics, inclusive recruitment and inclusive leadership.

85. Our priority for 2021/2022 was to strengthen and accelerate delivery of the Model Employer goals,[22] published in 2018, measuring two strategic areas through the annual data collections for WRES/WDES and supported by a targeted National Quarterly Pulse Survey approach:

- Leadership at trust and system level (ICSs) to increase BME representation and encourage rapid and focused corrective actions, delivered by overhaul of recruitment and promotion practices and enabling a compassionate and inclusive culture.
- Raising the profile and voices of BME staff to contribute to decision-making in their organisation, delivered by empowering staff networks and supporting line managers to hold productive conversations about race.

Key findings of the 2020 WRES and WDES

86. The 2020 WRES and WDES annual surveys showed progress towards achieving WRES and WDES performance metrics during 2019/20.

87. The WRES findings show year-on-year reduction in the proportion of BME staff likely to enter a disciplinary process and a small improvement in the percentage of senior BME staff in trusts (6.8% in 2020 vs 6.5% in 2019). However, BME staff reported higher levels of harassment and bullying (28.4%) compared to white staff (23.6%). Fewer BME staff were shortlisted for jobs compared to white staff (1.61 times more likely for white staff).

88. The WDES findings show an increase in the number of staff who declared a disability through the ESR (3.7% in 2020 vs 3.3% in 2019) and an improvement in adverse employee experience compared to non-disabled staff. However, disabled staff are still less likely to be shortlisted, more likely to go through formal capability processes and experience higher levels of bullying and harassment.

[20] NHS England » NHS Workforce Race Equality Standard
[21] wdes-2020-data-analysis-report.pdf (england.nhs.uk)
[22] wres-leadership-strategy.pdf (england.nhs.uk)

Conclusion

89. While progress has been made in some areas, more remains to be done to embed workforce equalities from a race and disability perspective. An action plan is being developed to identify where trusts need to reverse deteriorating key performance indicators (KPIs), while continuing to strive for improvement across all the indicators.

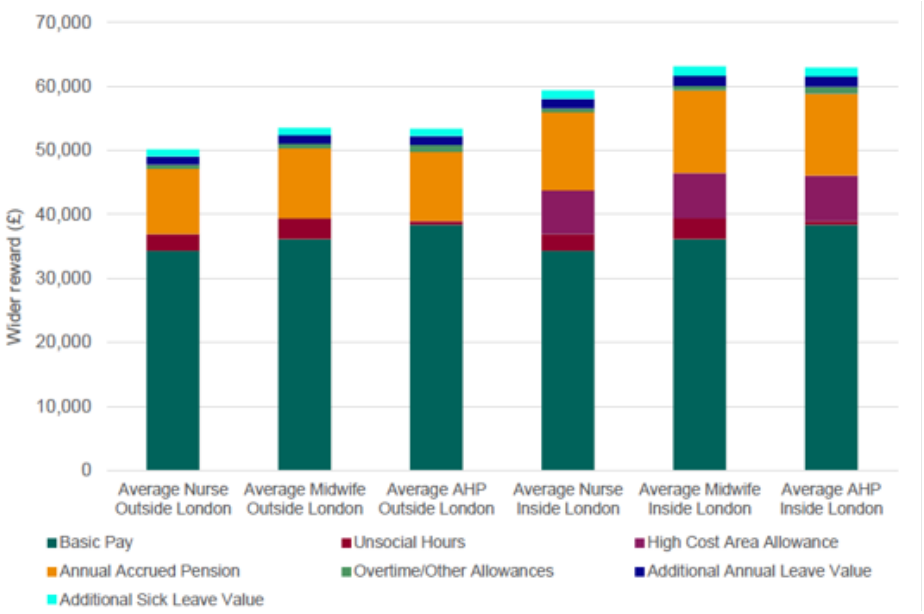
6.3 We are recognised and rewarded

90. The Pension Response Project relates to our People Promise pillars 'we are recognised and rewarded' and 'we work flexibly'.

Total reward

91. The NHS employment offer includes a range of pay and non-pay benefits which together make up the total reward available to NHS staff. DHSC has set out in successive written Pay Review Body evidence the value of the reward package, developed by the Government Actuary's Department, for medical and non-medical staff: the value of basic pay, out-of-hours and on-call payments, annual accrued pension, extra sessions worked and weekend allowances. It also includes additional leave over the statutory minimum and additional sick leave over statutory sick pay.

Figure 7: Value of nurses and midwives' total reward package (£)



Source: Government Actuary's Department.

92. Most employed staff have access to their Total Reward Statement (TRS), through ESR, and NHS Employers has developed a checklist to help organisations develop their local TRS.[23]

Employee Value Proposition

93. Employee Value Proposition (EVP) describes the tangible and intangible offer, the psychological contract between staff and their employer, expectations and obligations, which informed the NHS Constitution:[24]

> "All staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients. To do this, they need to be trusted, actively listened to and provided with meaningful feedback. They must be treated with respect at work, have the tools, training and support to deliver compassionate care, and opportunities to develop and progress."

This is echoed in the People Promise:[25]

> "The themes and words that make up Our People Promise have come from those who work in the NHS. People in different healthcare roles and organisations have made it clear what matters most to them, and what would make the greatest difference in improving their experience in the workplace."

94. Some NHS organisations already use the terminology of EVP as part of their local people strategies, which provide a focus on the employee–employer relationship in the context of challenges organisations have been facing such as recovering services and Vaccination as a Condition of Deployment (VCOD). As a result of the VCOD policy, qualitative feedback received is that there is a feeling of loss of trust among some staff, and particularly from people who have expressed that they felt concerned about losing their jobs if they didn't get vaccinated. This remains a risk to retention while we work to support staff.

95. We are exploring how best to leverage the overall NHS employment offer to inform principles, which could underpin a single high-level value proposition and be adapted and personalised at a local or system level.

[23] https://www.nhsemployers.org/articles/total-reward-statements
[24] https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england
[25] https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/

NHS Pension Scheme

96. The NHS Pension makes up around 30% of the NHS reward offer and is one of the most comprehensive and generous schemes in the UK. It provides valuable benefits for staff and their loved ones and supports staff through flexible retirement options, such as working differently or retiring gradually through flexible working options such as reduced hours or change in role.

97. Pension contribution changes are expected, which will have an impact on take-home pay and will be felt most keenly by our lower paid staff. In addition, the timing of when the pay award is made, could move some staff into a higher pension contribution tier, potentially creating an overpayment which staff must repay. Increases in staff pension contributions (lower paid staff will pay more and higher paid staff less) and increases in National Insurance contributions, in the context of higher inflation could have a detrimental impact on both the quantum and value of take home pay, affecting the morale of our NHS staff.

The Pension Response Project

98. During summer 2021, NHS England and NHS Improvement, working with our pension partners Isio and behavioural insight specialists, developed Phase One of the Pension Response Project.

99. Phase One is an early example of using EVP techniques to segment the workforce, personalising our offer to those in late career who may be thinking about retiring earlier (from age 50 or 55) than they had previously planned due to, for example, pandemic fatigue, concerns about pensions tax, higher pension contributions and National Insurance contributions from 1 April 2022, misunderstanding and/or concerns about:

    - how the Scheme works, the value to members and their loved ones, including implications of the legal ruling in the McCloud case[26] and the move of all NHS Pension Scheme members to the 2015 Scheme from 1 April 2022
    - how the Scheme can support flexible working, including those who choose to retire and return to the NHS

[26] https://www.gov.uk/government/consultations/nhs-pension-scheme-mccloud-remedy-part-1-proposed-changes-to-scheme-regulations-2022/mccloud-remedy-part-1-proposed-changes-to-nhs-pension-schemes-regulations-2022

- the impact of pensions tax and the tax they may have to pay. Since 2006, HM Revenue and Customs has set a lifetime allowance limit on tax-free savings in all registered pension schemes.

100. The project found that staff aged 50 or older prefer face-to-face communications about the NHS Pension Scheme and are more likely to secure information about the Scheme from family and friends, rather than 'official' sources. The complexity of the Scheme, including the different sections/schemes, each with different normal pension ages and multiple, often complex rules, is a barrier to engagement.[27]

101. On 19 November 2021, we launched a series of staff communication materials that explain, as simply as possible, the key benefits of NHS Pension Scheme membership and how staying in work longer could help staff increase their pension savings.

102. These materials – including pension illustrations and a 'Pension Positives' flyer – were promoted through the ESR and wage slips and published on NHS England and NHS Improvement's website for staff and organisations to download.

103. Phase One also includes a series of 'proof of concept' staff regional pension seminars, segmented by age (50 and older) and by role:

    - nurses, GP nurses, midwives, AHPs – flexible working and pensions
    - senior doctors/consultants, GPs and executives – pensions tax and flexible working/retirement.

    Feedback has been encouraging and demand has outstripped supply. The seminars will continue to 31 March 2022.

104. In parallel, we commissioned NHS Employers to develop guidance and training for organisations to help local managers have impactful conversations about the benefits of Scheme membership.[28]

105. As part of NHS England and NHS Improvement's priorities and operational planning guidance, Phase Two of the project during 2022/23 will focus on the most

[27] https://www.nhsbsa.nhs.uk/member-hub/membership-nhs-pension-scheme
[28] https://www.nhsemployers.org/pensions
https://www.nhsemployers.org/publications/promoting-value-nhs-pension-scheme-videos-and-presentation

impactful interventions across the career journey for staff in early, mid and late career: “Look after our people: improve retention by delivering the NHS People Promise to improve the experience of our staff, through a focus on flexible working, early/mid/late career conversations and enabling staff to understand their pensions”.[29]

Pension Response Project Dashboard

106. We analysed retirement activity to better understand employee behaviour around retirement and what interventions have greatest impact on staff retention, to improve the employee experience in relation to pension options and life planning.

107. This work is informing the development of a Pension Response Dashboard to help us monitor the outcomes of any interventions and provide an evidence base for the best point to intervene, as well as identify trends across the NHS to support workforce planning by making staff due to retire projections. For example, metrics will include:

- retirement volumes and retirement rates by region, ICS and provider
- annual retirement trends by age, profession and region
- regional hotspots of retirement activity.

Coronavirus Act 2020 – temporary NHS Pension

108. The temporary NHS Pension Scheme changes introduced on 24 March 2020 incentivised staff to return to the NHS to care for patients during a national emergency[30] without financial detriment to their pension. The temporary changes allow staff who retire and return to the NHS (regardless of the hours they work or level of earnings) to retain their entire pension and salary. These temporary changes included:

- 16-hour rule - staff can work more than 16 hours a week in the first calendar month without their pension being suspended. Applies to all members of the Scheme.
- Special Class Status (SCS) normal pension age (NPA) 55 - staff can retire, return to the NHS, and work additional hours without abatement (their pension is not reduced). Applies to nurses, midwives, health visitors and staff with Mental Health Officer status (MHO).

[29] https://www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance/
[30] https://www.nhsbsa.nhs.uk/pensioner-hub/covid-19-guidance-support-retired-members

- Pension draw down – staff can take their pension and continue working without abatement, ie ability to increase hours without detriment to their pension. Applies to all members in the 2008 Section and 2015 Scheme.

109. At the time of writing, HM Treasury and DHSC are consulting on extending the temporary pension rules Section 45 of the Coronavirus Act 2020 from 24 March 2022 to 31 October 2022. The extension would be provided via changes to NHS Pension Scheme regulations and take effect immediately after Section 45 expires on 25 March 2022. We welcome government recognition of how important the temporary pension rules are, helping leaders increase capacity on the ground, vital to tackling recovery.

110. The temporary pension rules help to increase capacity by incentivising staff to return to work, with the knowledge that they can work full time if they wish to do so, without detriment to their NHS pension.

111. We continue to work with the BSA NHS Pensions and NHS Employers to ensure staff have access to simple to understand information to help them make informed decisions about the benefits of returning to work after retirement.[31]

Conclusion

112. The Pension Response Project seeks to leverage the value of the NHS Pension Scheme by providing staff with an opportunity to learn about the Scheme from experts, dispel any myths or misunderstandings about how the Scheme and pensions tax work, and equip them to make informed decisions about the benefits to them and their loved ones of working longer.

Agenda for Change pay and contract reform deal 2018 to 2021

113. The Framework Agreement on the reform of Agenda for Change was published on 7 June 2018 following government's confirmation of the end of the 1% pay deal and announcement that extra funding could be made available for a multi-year pay deal for AfC staff that would support productivity, recruitment and retention.

[31] https://www.nhsbsa.nhs.uk/coronavirus-act-2020-and-update-end-temporary-suspensions-retire-and-return

114. The NHS Staff Council committed to “agreeing a work programme in partnership to monitor the implementation of the ‘deal’ over the three-year period and ensure all aspects of the agreement were implemented as intended”.

115. Our work continues to finalise the benefits realisation report, including KPIs. It has been impacted by our need to reprioritise resources to respond to the pandemic and roll out the vaccination programme. Our commitment remains to collaborate with the Staff Council and finalise the report.

6.4 We each have a voice that counts

Staff surveys and supporting engagement in the NHS People Plan

NHS Staff Survey

116. The NHS Staff Survey remains one of the world’s largest staff surveys with nearly 600,000 responses.

117. The 2021 NHS Staff Survey has been redesigned to align with the People Promise. This survey will be the principal way teams and departments, as well as whole organisations, can measure their progress and take action to improve.

118. The 2021/22 Staff Survey is not yet available. We expect the results to be published in March. We will provide supplementary evidence to the Pay Review Body as soon as possible.

119. The 2020 NHS Staff Survey was adjusted in light of the COVID-19 pandemic, while maintaining the opportunity to understand and compare employee experience during this period. We know from this data that:

- 34.2% of staff said they had worked on a COVID-19 specific ward or area at some point
- 18.5% said they had been redeployed
- 36.0% said that they had been required to work remotely
- 10.4% said they had been shielding for themselves and/or a member of their household.

120. Those who worked on COVID wards, were redeployed or who could not work remotely had a significantly poorer working experience across all themes (Table 3).

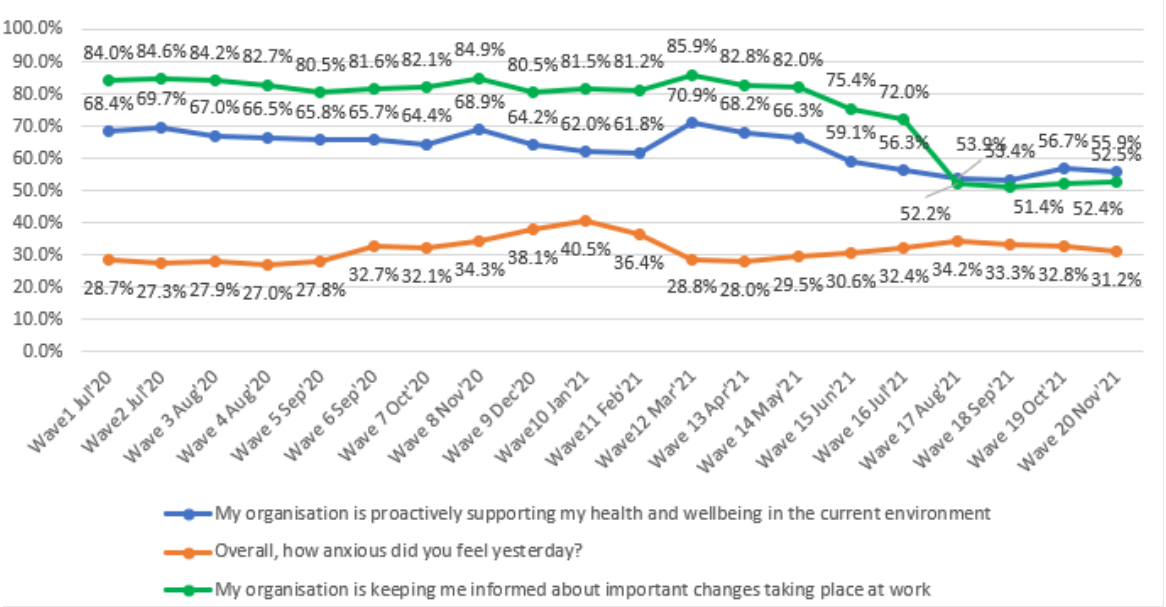
Table 3: NHS Staff Survey themes by COVID working

	Overall results		Covid-specific areas		Redeployed during Covid		Working remotely		Shielding	
Theme	Theme 2020	Theme 2019	Those who worked on Covid specific wards at any time	Those who have not worked on Covid specific wards	Those who have been redeployed due to the pandemic	Not redeployed	Those who have been working remotely due to the pandemic	Not working remotely	Those who have been shielding due to the pandemic	Not shielding
HWB	6.10	5.90	5.65	6.35	5.74	6.19	6.49	5.9	6.06	6.12
Morale	6.23	6.17	6.03	6.34	6.03	6.28	6.45	6.12	6.20	6.24
Safe Environment Bully and harassment.	8.07	8.00	7.51	8.38	7.70	8.17	8.5	7.85	7.96	8.10
Safety culture	6.80	6.75	6.74	6.83	6.7	6.82	6.88	6.76	6.84	6.80
Equality, Diversity and Inclusion	9.00	9.02	8.63	9.20	8.72	9.07	9.21	8.89	8.7	9.04
Staff Engagement	7.04	7.04	6.97	7.09	6.94	7.07	7.24	6.94	7.06	7.04
Teamwork	6.53	6.63	6.37	6.62	6.49	6.54	6.95	6.3	6.58	6.53
Immediate Managers	6.88	6.91	6.7	7.0	6.8	6.9	7.2	6.7	6.9	6.9
Quality of Care	7.47	7.47	7.5	7.5	7.5	7.5	7.4	7.6	7.6	7.5
Safe - violence	9.45	9.44	9.0	9.7	9.3	9.5	9.8	9.3	9.5	9.5

Source: NHS Staff Survey data 2020

121. In June 2020, the monthly People Pulse survey was introduced to support organisations in listening to our NHS people's views through COVID in a consistent and standardised way. This was an optional survey which so far has been adopted by over 100 NHS organisations.

Figure 8: People Pulse trend data



Source: People Pulse data (July 2020 to November 2021)

122. Monthly Pulse data shows, from May 2021, increasing levels of anxiety among staff. Analysis of 14,000 free text comments from the quarterly Pulse Survey in July indicates workload is the primary driver behind this trend.

123. Staff engagement is measured annually through the Staff Survey and is now also tracked quarterly by trusts. It is made up of three components: motivation, involvement and advocacy.

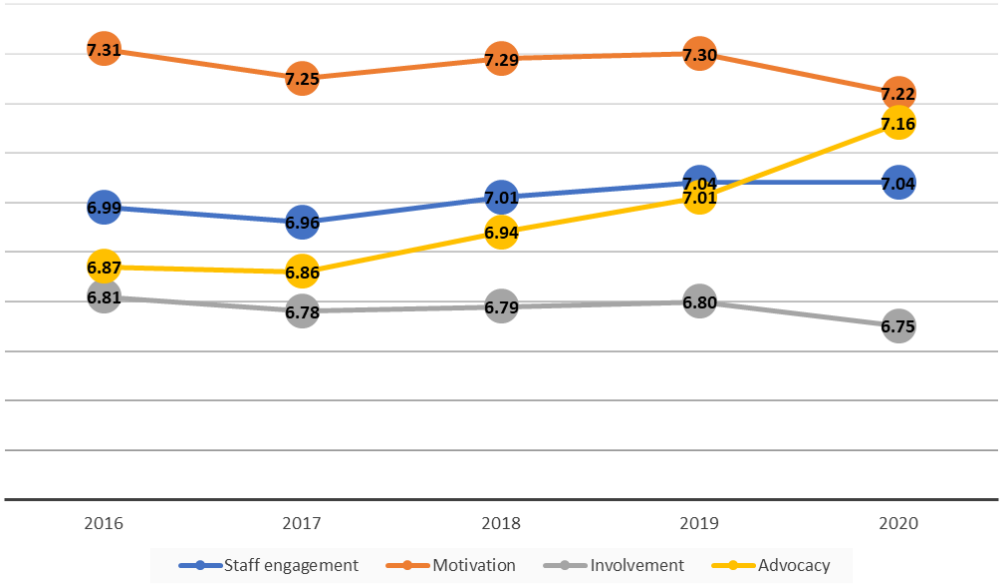
124. Using a fixed effects model, analysis illustrates that staff engagement has a positive and statistically significant impact on NHS trust outcome measures. In particular, trusts with higher levels of staff engagement are likely to have:

- lower sickness absence rate
- lower MRSA rate
- lower mortality rate
- higher recommended rate in the inpatient satisfaction survey
- lower unrecommended rate in the inpatient satisfaction survey.

125. Annually, the response to the engagement theme as a whole has remained stable. For 2020 this was mainly due to an increase in advocacy – the pride our NHS people have for their organisation and service provision. However, the motivation

and involvement scores were at their lowest levels for the last five years (Figure 9).

Figure 9: National Staff Survey engagement score, 2016 to 2020



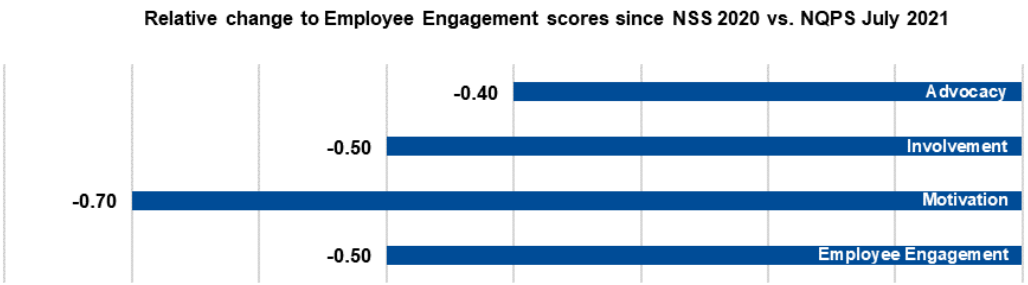
Source: NHS Staff Survey data 2020

National Quarterly Pulse Survey

126. The National Quarterly Pulse Survey (NQPS) was introduced as a requirement for trusts from July 2021. The NQPS uses the Employee Engagement questions from the NHS Staff Survey and can be delivered in trusts using the People Pulse platform.

127. Quarterly Pulse Survey results in July showed a drop in staff engagement scores, most markedly for motivation. Tracking engagement quarterly replaces the Staff Friends and Family Test and will take time to interpret, but this drop in engagement scores is concerning (Figure 10).

Figure 10: National Quarterly Pulse Survey trend data, July 2021



Source: National Quarterly Pulse Survey data (July 2021)

Conclusion

128. The NHS Staff Survey has been aligned to the People Promise from 2021 to help us identify how well employee experience matches what our NHS people have told us is important to them. We have increased national support for local listening strategies by introducing the monthly People Pulse and National Quarterly Pulse Surveys. These two tools provide a standardised way of understanding how employee experience nationally, regionally and locally is changing within year, to support decision-making.

6.5 We are safe and healthy

Health and wellbeing

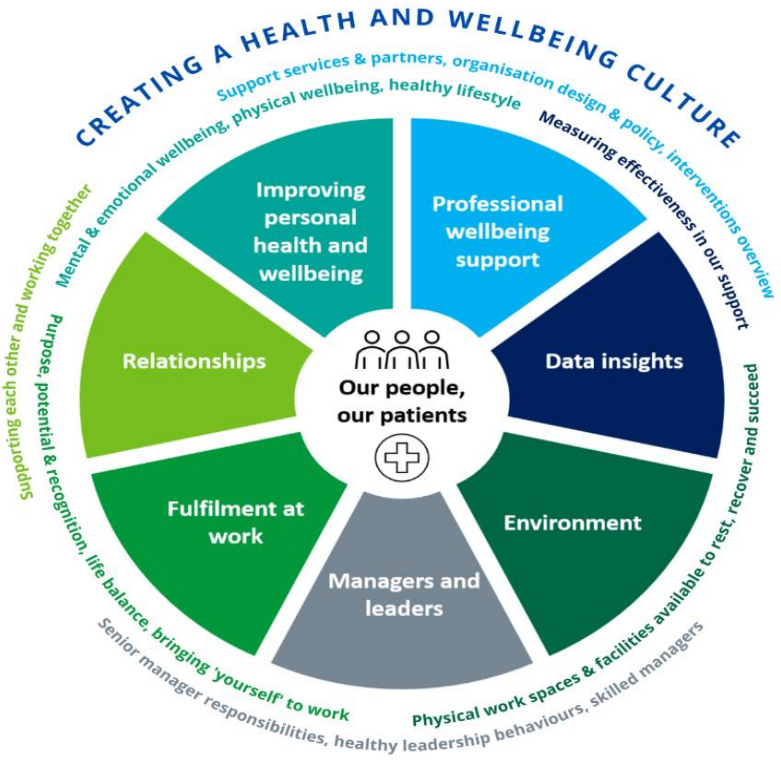
129. NHS England and NHS Improvement had developed a strategy, and supported this with a range of national programmes, to improve the wellbeing of our NHS people and enable NHS organisations and systems to create a culture of wellbeing. These recognise there is no quick fix to improving the wellbeing of our NHS people and addressing the root causes; it will require long-term investment, culture change, service improvement and, above all, a proactive focus on preventing what damages workforce wellbeing.

130. The recently refreshed NHS Health and Wellbeing Framework sits at the heart of this work (see Figure 11). It defines what organisations and systems need to do to improve the wellbeing of our NHS people by creating a wellbeing culture. It was first developed in 2018 and was refreshed during 2021 following large-scale stakeholder engagement and co-design, incorporating the learning from the pandemic.

131. We know:

- focusing on the organisational enablers in the NHS Health and Wellbeing Framework improves the impact of health and wellbeing interventions by creating a culture of wellbeing in which our workforce can thrive and feel cared for, and therefore care for patients more effectively
- using the framework in a targeted, structured way and with specialist guidance improves staff health and wellbeing, reflected in the improved staff wellbeing metrics.

Figure 11: NHS Health and Wellbeing Framework, 2021 update



132. Evidence supports moving away from a focus on outcomes (eg reducing sickness absence) to focus on inputs (that is, putting in place the conditions for a culture of wellbeing and focusing on prevention of illness and maintenance of wellbeing). NHS organisations and systems that have developed their health and wellbeing initiatives have been more successful in reducing sickness absence and improving wider wellbeing metrics. Developing and committing to a long-term health and wellbeing strategy that paints a picture of a positive future based on a healthy workplace culture is key to attract and retain the best staff.

133. The Health and Wellbeing Programme has created communities of practice for HR/OD and occupational health (OH) and wellbeing leaders to share learning and good practice in improving wellbeing. Feedback indicates that the opportunity to network and learn from one another about how different approaches can improve staff health and wellbeing is highly valued and is making a difference.

134. OH services are core to improving the wellbeing of our NHS people. They have played an important role in supporting workforce wellbeing during the pandemic. However, this has also exposed long-term underinvestment in this essential service. During 2021/22, NHS England and NHS Improvement worked with the

'Health at Work' network of NHS OH leaders to develop the 'Growing OH' programme with the vision of enabling NHS OH services to fulfil their potential as strategic, integrated and preventative partners in enabling the wellbeing of our NHS people. We are working with stakeholders to invest in growing OH services and people, and also co-designing a five-year service improvement strategy for NHS OH services. This strategy will be released in 2022/23.

135. The evidence gathered as part of the improving wellbeing programmes underlines the key role NHS leaders play in enabling the wellbeing of our NHS people, which is reflected in the refreshed NHS Health and Wellbeing Framework.

136. A new senior leadership role, the wellbeing guardian, was introduced as part of the NHS People Plan. Their role is to champion creating a wellbeing culture and, by sitting on the board of every NHS organisation, ensure that staff wellbeing is a consideration in all aspects of their board's agenda. At least 84% of NHS providers have confirmed that they have appointed a wellbeing guardian (based on a December 2021 audit), and full adoption is predicted by April 2022.

137. We recognise that NHS leaders also need support with their personal wellbeing if they are to act as role models with regard to health and wellbeing for their teams and patients. We have worked in partnership with the NHS England and NHS Improvement Leadership and Lifelong Learning team to offer wellbeing development for our NHS managers[32] and senior leadership[33] communities. Initiatives will continue to be scaled and spread during 2022/23.

138. Each ICS needs to develop a health and wellbeing (HWB) offer for its staff. In 2020/21 we supported 14 ICSs with this and in 2021/22 have introduced an enhanced HWB offer and primary care pilots. Both programmes encourage innovation and the piloting of new approaches to improving health and wellbeing, using available data to understand the needs of the local workforce. Twenty-six ICSs are now involved in the enhanced HWB programme.

[32] https://learninghub.leadershipacademy.nhs.uk/projectm/
[33] https://learninghub.leadershipacademy.nhs.uk/executivesuite/

6.6 We are always learning

139. The People Promise commits to making opportunities to learn and develop plentiful and equally accessible to all, supporting us all to reach our potential, and attracting, developing and retaining talented people from all backgrounds.

140. The NHS Leadership Academy provides a suite of talent and leadership programmes and a network learning hub for staff to learn, reflect and connect.

141. Its support offer for organisations is delivered locally through the regions, each of which has a team of leadership/lifelong learning and talent staff who take an established local leadership academy approach to supporting development in each region tailored to system needs.

142. The NHS Leadership Academy talent and leadership offer covers these themes:

- A talent strategy that takes an 'everyone is talent' approach.
- Equality, diversity and inclusion as a golden thread through every programme, continually reinforcing the importance of a diverse workforce to create innovation and equality of opportunity for all.
- Recognition that the pandemic has had a more debilitating impact on BME populations, and that social justice has become a cornerstone of the Leadership Academy's work.

143. The talent and leadership offer includes:

- learning spaces – these include #ProjectM and Executive suite
- leadership development programmes
- Stepping Up and Ready Now programmes – aimed at BME colleagues.

144. The NHS Leadership Academy's talent and leadership strategy supports the NHS to develop a diverse talent pipeline, support system leadership, and provide local talent and leadership support, recognising that 'everyone is talent'. This speaks directly to the development of a compassionate and inclusive culture in the NHS.

6.7 We work flexibly

Flexible working

145. The NHS Staff Council consulted on and approved significant changes to the NHS Terms and Conditions, in line with the ambitions of the NHS People Plan. These came into effect on 13 September 2021.[34]

146. The changes include:

- extending the request for flexible working beyond the statutory duty of after 26 weeks of employment to day one of employment
- not requiring staff to provide a reason for flexible working
- no limit on the number of flexible working requests each year (previously restricted to one request per 12 months); staff can make more than one request for flexible working.

147. NHS England and NHS Improvement and Timewise are running NHS Flex for the Future, an online programme delivered over six months. This programme is currently supporting 93 organisations (including two ICSs) across all seven regions to explore what flexible working looks like in their organisation, through to the creation of an action plan to embed changes in their organisation.

148. As part of this programme, we are also exploring additional support, such as definition and principles, a case for change, a series of toolkits aimed at line managers and individuals, and testing a cost calculator designed to enable organisations to explore the potential savings from retaining staff.

149. We have worked with both the NHS BSA (NHS Jobs) and TRAC (a recruitment software provider) to ensure flexible options can be included in advertised roles. The percentage of roles advertised with flexible options has increased from 10% in April 2021 to just under 17% in November 2021 as a result. We have a further ambition for 2022/23.

150. Two KPIs have been included in the 2020/21 oversight framework, one relating to the NHS Staff Survey 'satisfaction with opportunities for working flexibly' and the other to 'percentage of roles advertised as flexible'.

[34] https://www.nhsemployers.org/publications/tchandbook

151. Many organisations have adopted flexible working and NHS Employers has published best practice case studies.

152. Many flexible working opportunities can be agreed informally or without requiring a contractual change, health and wellbeing conversations have been a vehicle for this. We are exploring how the ESR can best capture and record informal and formal flexible working requests.

153. We know from the NHS Staff Survey that year on year more and more staff are satisfied with the opportunities to work flexibly (up from 54% in 2019 to 57% in 2020, coinciding with the publication of the People Plan and the introduction of the People Promise).

154. We have made good progress with our trade unions partners to ensure that staff have access to flexible working from day one and to remove restrictions on how often they can ask to work flexibly. We will continue to track job adverts to ensure these include flexible roles and to work with organisations on both the cultural and practical barriers to staff asking to and being supported to work flexibly.

Enabling Staff Movement Programme

155. The Enabling Staff Movement Programme aims to make it much easier for staff to move around the NHS safely and easily by removing technological, process and cultural barriers, many of which can only be overcome with national interventions and policy changes.

156. NHS staff move for several reasons, and each move typically involves completing multiple forms, repeating employment checks and mandatory training. During COVID-19, staff with the right skills have urgently needed to move between NHS organisations without such barriers, delays or unnecessary administration.

157. Movements include:

- Permanent movements – the NHS has about 250,000 new starters each year.
- Internal movements – there are estimated to be over 300,000 each year, with over 100,000 temporary staff movements for honorary contracts, secondments, and emergency deployment. Junior doctors – who number around 53,000 – typically more eight times over the course of a 10-year programme, sometimes twice in a given year.

- Bank workers – over 800,000 workers are registered on trust banks, 300,000 of whom are actively undertaking bank shifts at more than one NHS organisation.

158. The easier we can make the registration and movement processes, the less the NHS will need to rely on agency workers to fill gaps.

159. The programme is helping overcome these barriers at a national level by setting best practice standards and policy to allow local systems (ICSs) to streamline their inductions and onboarding processes; reducing duplication and recognising previous training and skills 'passported' from previous employers. The work programme areas below represent the interlinking initiatives and priority actions to achieve our aim.

160. The Enabling Staff Movement Toolkit, developed with partners and published in August 2019, gives NHS organisations practical help with removing barriers to staff movement: sample 'warranty' text, case studies and signposted resources. It is in the process of being updated with, for example, new national templates, additional case studies and a template for deploying NHS workers to other care providers when needed for short periods, such as during emergencies.

Connecting the NHS ESR with third-party systems

161. As part of efforts to improve the recruitment processes and the onboarding experience of NHS staff, an interoperability workstream of the Enabling Staff Movement Programme is focusing on the movement of occupational health and training data into ESR. To date this workstream has successfully enabled organisations to automate the transfer of over 200,000 training and immunisations and vaccination data items between NHS trusts.

162. This workstream has the potential to generate substantial savings in manual input and duplication of effort by organisations and staff, and to streamline the onboarding and induction process when staff move.

COVID-19 Digital Staff Passport

163. The COVID-19 Digital Staff Passport removes the need to repeat NHS employment checks for NHS staff who are temporarily moving or being shared to support the COVID-19 response. This saves valuable time and reduces the administrative burden on NHS staff and HR departments, while ensuring staff move with the right safeguards to where patients need them most.

164. The passport is supporting organisations to fully utilise and mobilise their workforce. So far 100 organisations have adopted it and 950 passports have been issued, with the potential to extend it much more widely.

165. The COVID-19 Digital Staff Passport and service, now updated to include a vaccination programme credential for staff working in vaccination centres, has been extended to December 2023.

Digital Staff Passport for doctors in training and temporary staff movements

166. We are working with HEE and NHSX to improve local onboarding processes, including for bank staff, to realise efficiencies, enhance staff experience and release time for clinical activity and patient care, as well as other key priorities, such as training and development time for staff.

Trusted frameworks

167. The programme team are working with key strategic NHS and non-NHS partners (HEE, NHS Employers, DHSC, Department for Digital, Culture, Media and Sport, Disclosure and Barring Service, Home Office and Skills for Health) to define and build ‘trusted frameworks’, which when fully adopted by all NHS trusts will ensure consistency of and trust in data to aid the transfer of staff between NHS organisations.

Conclusion

168. The Enabling Staff Movement Programme is a key component in simplifying and improving staff experience. The COVID-19 Digital Staff Passport and Enabling Staff Movement Toolkit continue to support the COVID-19 response, as well as elective recovery. In parallel, the programme is making considerable progress in delivering the long-term vision of digital staff passports for all staff, enabling them to move seamlessly from one organisation to another without unnecessary administration and duplicated induction. This will ensure the right staff with the right skills can be deployed where they are most needed easily and quickly.

169. In addition, digital staff passports act as a catalyst to achieve interoperable workforce systems and cultural and process changes by providing modern, easy to use technology that improves staff experience.

Temporary staffing: agency and bank

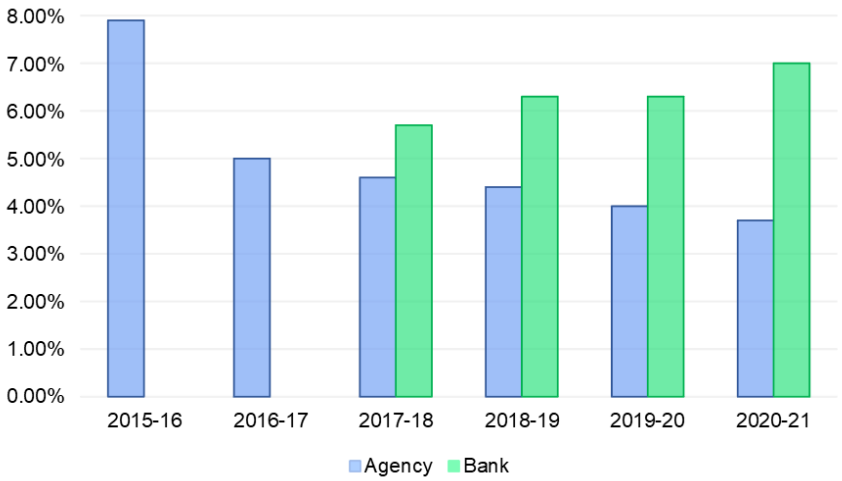
170. The NHS has made progress in optimising temporary staffing spend despite workforce and capacity shortages. Increased bank spend as a proportion of total temporary staffing spend demonstrates greater flexibility in meeting fluctuations in demand, and doing so more economically.

171. The NHS People Plan sets out further measures to improve the quality of and value for money from temporary staffing, including an action to ensure that all agency supply is via an approved procurement framework.

172. Through the introduction of the price caps as part of a wider package of agency controls in 2016, total agency spend has reduced by around £1.2 billion, from a peak of £3.6 billion in 2015/16 to £2.4 billion at the end of 2020/21. This is despite continuing increases in demand for workforce and increases in pay.

173. Total agency spend as a percentage of total wage bill has decreased from 7.9% in 2015/16 to 3.7% in 2020/21. This has largely been delivered by the NHS reducing the proportion of shifts filled by agency staff across temporary staffing shifts from 28% in 2018/19 to 23% in 2020/21.

Figure 12: Temporary staffing as a percentage of total wage bill, 2015/16 to 2020/21



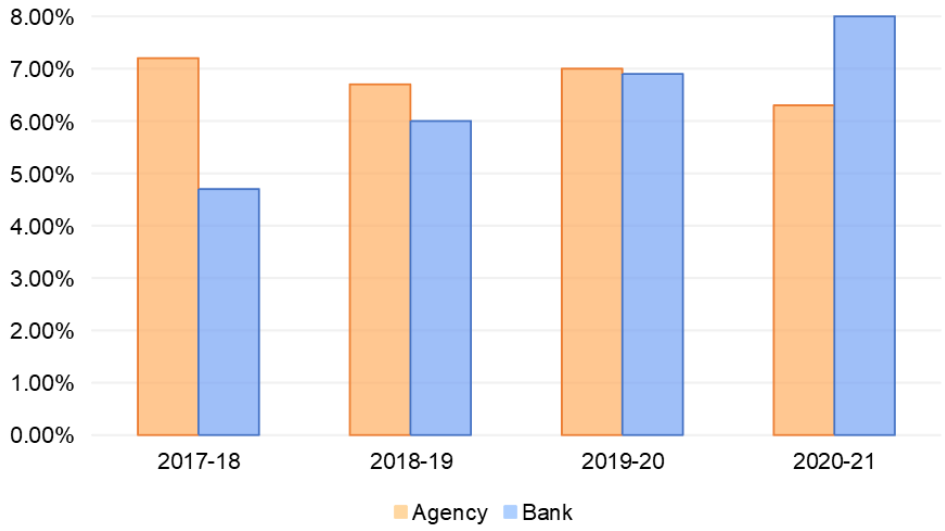
Source: Internal reporting requirements informed by trusts' monthly finance and staffing submissions (Bank data collection started in 2017/18).

174. The proportion of agency spend as a share of overall temporary staffing has fallen from 38% in 2017/18 to 30% in 2020/21, reflecting the falling percentage of

temporary shifts procured through an agency. Agency shifts (excluding medical and dental) decreased from 22% in 2018/19 to 20% in 2020/21.

175. Bank staff spend as a percentage of temporary staffing spend has risen from 62% in 2017/18 to 70% in 2020/21, reflecting the increasing procurement of temporary staffing through internal staff banks. Banks shifts (excluding medical and dental) increased from 78% in 2018/19 to 80% in 2020/21.

Figure 13: Temporary staffing (excluding medical and dental) as a percentage of total wage bill, 2017/18 to 2020/21



Source: Internal reporting requirements informed by trusts' monthly finance and staffing submissions)

176. There are 77 NHS trusts in a collaborative bank arrangement, with a total of 23 set up. This is an increase of 56% since the publication of the People Plan in September 2020. A further 28 providers are in the planning stage. Twenty-seven of 42 ICSs have a collaborative bank and there is an arrangement in each of the seven regions. Collaborative banks will allow systems to work in partnership to make the most effective use of the resources available.

Conclusion

177. Work on bank development is ongoing, with the Bank Programme supporting trusts and local systems to improve their staff banks and work collaboratively, through a combination of self-directed learning, face-to-face support and group improvement activities. The programme aims to support providers to address the barriers that inhibit collaborative working arrangements.

178. The NHS Long Term Plan outlines the national strategy to continue improving workforce productivity and to reduce reliance on agency workers. The NHS has been effective in reducing agency spend despite considerable pressures from COVID-19 and more recently elective recovery.

179. The Temporary Staffing Programme workstreams are reducing off-framework supply into the NHS; supporting trusts to improve price cap compliance and facilitating the acceleration of the Bank Programme.

6.8 We are a team

180. The first six elements within the People Promise inform how the NHS operates as one team, which is the seventh. The measure of success will be drawn from our ambitions right across the People Promise, including the leadership work led by the NHS Leadership Academy.

181. The response to the pandemic has demonstrated again the importance of teams, and the vital contribution of every member of that team, regardless of their professional status or qualifications. It is important that the NHS continues to value and recognise that teams are the main mechanism through which patient care is delivered and are the natural building block of organisations.

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