NHS Providers evidence to the SSRB – January 2022

Key points

- We are generally encouraged by discussions and developments around a new VSM pay framework. Trust leaders want to see the creation of a single framework which does not separate providers by trust type and moves away from financial turnover as the primary criteria for determining levels of executive pay.

- Trust leaders have been under enormous pressure throughout the COVID-19 pandemic, dealing with the unprecedented demand for emergency services, the push to recover the backlog in care and the delivery of a national vaccination programme. These sustained pressures are damaging to mental and physical wellbeing, with VSMs experiencing burnout in a similar way to frontline staff.

- Our data does not point to widespread, persistent vacancies on boards and it is usually possible to fill posts. However, we are concerned about the high levels of turnover, with one fifth of executive directors having been in post for a year or less and nearly half (44%) being new to their roles within the past two years.

- We would strongly support the removal of unpopular and ineffective 'earn-back' policies from the VSM framework and believe the government should ensure a return to cost of living pay increases for the remit group in 2022.

- The "Messenger review" of health and social care leadership in England presents an opportunity to improve overall leadership capability and capacity across the service, but it must not veer towards outright and sustained criticism of the job carried out by senior leaders. It must also ensure a focus on improving leadership diversity given the low rates of representation at board level and unequal opportunities for ethnic minority staff to advance in the NHS.

- The SSRB and government must keep a watchful eye over ongoing challenges for the remit group, including those influenced by the move towards ICBs as statutory bodies and issues surrounding pension taxation. As the nature of VSM roles evolve, it is essential the right incentives are in place for developing leaders to take, and remain in roles on trust boards.

Context

In 2020, the Secretary of State for Health and Social Care confirmed the Senior Salaries Review Body (SSRB) would bring NHS very senior managers (VSMs) within its broader remit offering independent advice on pay for senior staff in the UK public sector. The SSRB was first asked to provide observations on VSM pay in 2021, followed by recommendations in 2022 and it is within this context that we submit evidence to the independent review body on behalf of NHS trusts and foundation trusts.

NHS Providers is well placed to provide insight on pay issues at VSM level due to our position as the membership body for all 213 trusts in England, our independence from government, and primary focus on matters affecting trust boards, including their role as employers. The SSRB is seeking evidence in some areas we have not covered in this submission – particularly those where granular data collected only by national agencies is required – however we are pleased to provide qualitative evidence and anonymised reflections shared with us by trust leaders on VSM pay issues, supported by data from our annual remuneration survey of executive and non-executive directors at NHS trusts and foundation trusts.

NHS Providers submits written and oral evidence each year to the independent pay review processes covering Agenda for Change staff (via the NHSPRB), and doctors and dentists (via the DDRB), and we are pleased the SSRB has brought VSMs within its remit to graduate towards a similar level of independent oversight on issues concerning pay for senior leaders. During the past year we have assisted the SSRB and NHSE/I in the organisation of online events and discussions with members of the remit group and non-executive directors involved in remuneration decisions at trust level and we hope our written evidence is greeted as supplementary to this work, providing a more comprehensive representation of trust leaders views.

It is worth noting that we have discussed ways to expand the reach and impact of our annual remuneration survey with NHSE/I and would consider surveying trust leaders on additional areas of focus that fall within the SSRBs priorities for evidence collection in the future, should we determine it to be useful for our members and in discussions with the SSRB and other key stakeholders.

Strategic approach to VSM pay

Currently, decisions on VSM pay within trusts are made in the first instance at a local level, with oversight provided by NHSE/I through a national pay framework. In practice this framework is separated into two parts: a system for approving NHS trust VSM salaries in ambulance and

community trusts via both the 2018 NHSI guidance and 2013 DH framework, and a system for approving salaries over £150,000 for other trusts (acute, specialist, mental health and combined trusts not falling within the scope of the 2013 framework).

It has, for several years, been a priority for trust leaders from all sectors to see the creation of a single VSM pay framework which does not separate different providers into classes based on the type of services they are providing. This point has been reinforced in multiple discussions we have held with individual trust leaders (particularly chairs, CEOs and HR directors) and in roundtable events over the past year. We agree with the SSRB's observation from its 2021 report that the nature of activity carried out by trusts is not "the right basis for setting pay".[1]

Alongside the desire for equity between trust sectors, common concerns and frustrations over the approach taken under the current VSM pay framework have centred around three different factors: approvals and delays in recruitment based on the £150,000 'threshold'; the emphasis placed on trust size and turnover; and the issue of 'earn-back' (earn-back is discussed further in a section below).

We do not have quantitative evidence on the average time taken to fill VSM posts, or the frequency of delays when approval is sought from NHSE/I, however we have heard regular reports from trust leaders of posts remaining empty for multiple months while sign-off from the centre is pending, particularly in those instances where proposed salaries are over £150,000. Delays to appointments at board level can have a significant impact on operational management and service delivery in local organisations and systems.

It is worth noting that delays have been reported to us by both trust and foundation trust leaders. While the VSM framework guidance only requires approval from NHS trusts (due to statutory freedoms for foundation trusts), foundation trust boards are asked to seek opinions from the centre on VSM salaries, and often prefer to reach an agreement with NHSE/I in the spirit of ongoing collaboration and equity among local system partners.

The £150,000 'threshold' itself is generally opposed and seen to be outdated by trust leaders as well. We agree with the SSRB's assertion that this mark is "difficult to justify"[2] as a point of central approval

[1] SSRB report 2021 page 130, paragraph 6.7 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1009002/Senior_Salaries_Review_Body_Report_2021_Web_Accessible.pdf

[2] SSRB 2021 report, page 135, paragraph 6.41.

for VSM salaries and would note that the figure is based on a decision by Gordon Brown's government to "name and shame" higher earners during a global financial crisis, record national debts and deficits, and a double-dip recession 13 years ago (in 2009).

Development of a new VSM pay framework

We have actively engaged with NHSE/I over the development of a new VSM pay framework throughout 2021 and into the new year. These discussions follow a prolonged period in which a new framework has been anticipated, but subsequently delayed. NHSI had, under its previous structure, set out to create a new system in 2017-18 and sought feedback from trust leaders and other key stakeholders through working groups, but the process was ultimately paused.

We are generally encouraged by the proposed direction of the new framework. In November 2021, we worked with colleagues at NHSE/I to arrange a discussion group of trust chief executives focusing on the potential design of a new framework and criteria used to determine rates and bands of VSM pay. Our hope is that the new system will remove the £150,000 pay approval threshold, however the primary topic of feedback and discussion for trust leaders has focused on the need for the framework to take better account of the complexities involved in trust leadership and management, and the importance of de-emphasising financial turnover as the primary criterion in pay decisions.

In the November discussion, leaders from a cross-section of trusts providing mental health, acute, community and ambulance services unanimously agreed that organisational turnover is an illogical primary means of determining appropriate salary levels or ranges for VSMs, reflecting an outdated 'bigger is better' attitude towards the provision of services in the NHS. While we understand the tendency within government to see budget size as the most straightforward and immediately measurable criteria – and sympathise with the difficulty of obtaining hard data on all relevant factors – it is important that a new framework considers other, more complex areas. Trust leaders felt the framework should take account of the following areas, among other things:

- People factors – including the number of staff, complexity of population served, levels of deprivation within local communities and historical board stability
- 'Troubled trusts' – especially the need to consider those which have been in and out of special measures or struggled financially and per CQC ratings over a prolonged period
- Geographical location and 'remoteness' – particularly given the difficulty faced by boards in rural and coastal areas, where there are both considerable service/operational challenges and issues attracting and retaining talent

- System and partnership working factors – also described as the extent of integration and breadth and complexity of relationships with the primary care, social care/local authority, voluntary and community sectors and others within an integrated care systems (ICS) footprint.

Our discussions with trust leaders on VSM pay issues have, in recent years, usually focused on the need for a clear, transparent and equitable system for determining pay levels across the sector, rather than an emphasis on any perceived need to increase the overall levels of VSM pay. In last year's report, the SSRB stated that "the best balance between prescription of pay rates from the centre and local autonomy has yet to be found" and called on national bodies to "construct a coherent national structure which recognises the need for decision-making reflective of distinctive local circumstances."[3]

We agree wholeheartedly with this sentiment and have been encouraged by discussions with colleagues at NHSE/I on this point as well. The intention of the new VSM pay framework should be to both clarify a national structure assisting local leaders to make appropriate pay decisions without undue delay, while enabling a strong level of autonomy for trusts to consider the impact of the complexity factors noted above, and discussed in other forums.

Experience of the remit group: turnover, retention, morale

Context of high turnover and operational pressure

The COVID-19 pandemic has placed significant and sustained pressure on all parts of the NHS workforce over the last 22 months, with operational pressures during peaks of infection combined with the unprecedented scale of the vaccine rollout programme and continued efforts to reduce a record backlog in care. Trust leaders have been under enormous pressure throughout this period to ensure staff and patients are cared for and supported, yet – as seen across the entire workforce – these sustained pressures are damaging to staff mental and physical wellbeing. Leading into winter, 87% of trust leaders told us in our *State of the Provider Sector*[4] survey that they were 'extremely concerned' about the impact of seasonal pressure on their trust and locality, while 94% told us they were 'extremely or moderately concerned' about levels of burnout across their workforce[5]. Alongside the impact of the Omicron variant, recent data shows that trusts continue to be under immense pressure; December 2021 saw a record high in category 1 ambulance incidents, while A&E and

[3] Forty-third annual report on senior salaries 2021, Review Body on Senior Salaries, page 134.

[4] 172 trust leaders from 114 trusts responded to this survey, which accounts for 54% of the provider sector. All trust types were represented in the survey responses

[5] https://nhsproviders.org/state-of-the-provider-sector-2021-survey-findings/key-findings

emergency admissions were higher than December 2020. Meanwhile, acute and general beds were at 91.8% occupancy[6]. Collectively these pressures have an impact on turnover, retention and morale across the workforce, including senior leaders.

NHS Providers' 2020/21 remuneration survey found that there is a high turnover of senior staff within trusts across the country, with 20% of trust executive directors at the time of responding in post for one year or less, and almost half 44% in post since the start of 2019 (around two years or less)[7],[8]. Over two-thirds of executive directors have been in post since 2017 (69%), pointing to the very small proportion of trust leaders who have remained in post for a long period of time. The findings on year of appointment are consistent with previous years, underlining the challenges trusts face retaining talented leaders and maintaining continuity of leadership within a pressurised operational environment.

When linked to Care Quality Commission (CQC) rating, our survey results showed that 24% of the trusts rated 'inadequate' or 'requir(ing) improvement' had appointed a new chief executive since 2020, which is significantly higher than the 16% of trusts rated 'good' or 'outstanding' who had appointed a new CEO since 2020. High turnover demonstrates there is a need to ensure trust leaders are supported to thrive in their challenging roles with appropriate incentives to retain their skills within the health service. Morale plays a part in this, as does wider messaging from the government and in the media. Trust leaders working in challenged trusts specifically need to be supported to ensure transformational change can be embedded, with an acceptance that the task of overseeing significant service change need appropriate time, support and funding[9].

The Messenger Review

NHS Providers has warned of the need to manage the potential risks to morale among senior executives and other VSMs associated with the government-commissioned "Messenger review" of health and social care leadership in England.

This new review, chaired by General Sir Gordon Messenger and Dame Linda Pollard, does present an opportunity for the service to improve its leadership capability and capacity as a whole; to deploy

[6] NHS Providers Winter Watch publication series: https://nhsproviders.org/nhs-winter-watch-202122/week-6

[7] NHS Providers Remuneration Survey: 2020/21 - 154 trusts are represented in this survey, accounting for 72% of all trusts in England

[8] NHS Providers Remuneration Survey: 2020/21

[9] https://www.hsj.co.uk/workforce/messenger-review-could-set-nhs-leaders-up-to-fail-javid-warned/7031325.article

high quality leaders to areas where they are most needed and ensure the correct incentives are in place to retain them; and to provide more planned, systematic mid-career entry routes into NHS management to supplement the current talent pipeline relying on leaders coming through clinical practice or the NHS Graduate Management Training Scheme.

Ultimately, we hope that this review will not veer towards outright and sustained criticism of the job carried out by senior leaders within the service, but instead be used to increase support for members of the remit group by reflecting the multiple challenges they face as they continue to ensure funding is well spent to improve care, reduce variation, ensure efficiency and lead transformational change. Research from the University of Bristol dispels negative commentary around NHS management and demonstrates that patient experience improves with a higher proportion of managers, as do efficiency and clinical quality[10].

Trust leaders have significant expertise and experience in the sector, with our 2020/21 remuneration survey showing that 42% of chief executives have a clinical qualification (up from 40% in our previous survey). However, it is important to reflect on the fact that senior leaders in trusts have significant transferable skills and experience: with this in mind, it is crucial that senior leaders are offered incentives that are reflective of the challenging roles they undertake to ensure their continued retention within the health service. Our survey also reveals that 53% of chief executives are in the role for the first time – this near even split demonstrates that new talent is growing within the sector, and it is critical that this talent is retained alongside the 46% who have previous experience as a chief executive to ensure an effective pipeline of high-quality leadership.

The NHS runs an annual staff survey, but this data is not, at present, granular enough to extrapolate findings specific to senior staff morale. However, as the representative body for trusts and their boards in England, NHS Providers is well-placed to understand the challenges and concerns of senior trust leaders across all trust types and regions through our extensive range of active and diverse membership networks. Trust leaders continue to stress the significant pressure their organisations' workforces are under during this period of unprecedented demand for care.

[10] http://www.bristol.ac.uk/policybristol/policy-briefings/nhs-managers/

Leadership diversity

COVID-19 has re-emphasised longstanding inequalities in many areas. As a highly valued public service, the NHS must play a central role in reducing health inequalities that affect patients, yet as the largest employer of ethnic minority staff in the country the service must also tackle race inequality and actively promote equality, diversity and inclusion (EDI). NHS Providers and trust leaders are clear that there is much work to be done to ensure race equality and diversity within the service. This includes implementing the ambitions of the NHS People Plan 2020/21 to ensure trust leadership reflects the communities they serve and that chief executives are accountable for progress on EDI[11],[12].

The Workforce Race Equality Standard (WRES) report 2020 shows that some slow progress is being made: the number of minority ethnic staff at very senior manager (VSM) level is up by 42% on the previous year, while 10% of board members in trusts are from minority ethnic backgrounds (up from 8.4% in 2019). Between 2019 and 2020 there has been a more than 22% increase in the number of minority ethnic board members.[13]

However, despite these slight improvements, the overall 19% representation target set by NHSE/I across all pay bands is missed by a significant figure at the highest levels: for VSMs specifically, only 6.8% of staff are from a minority ethnic background, 12.2% off the target figure[14].Additionally, while board representation is improving on the whole, we believe much of this is influenced by the increased appointment of ethnic minority leaders to non-executive director (NED) posts. While this is important, it must be matched by similar progress at executive level in order for trusts to demonstrate to their workforce that they are providing equal opportunities to advancement for ethnic minority staff. There is no good reason for the NHS to be an employer which achieves some of the greatest representation of ethnic minority staff in the 'western' world at its entry levels, while retaining the snowy white peaks of leadership for which it has long been associated.

Our research reveals additional insights and demonstrates variation by role, region and trust type. Medical directors are more likely to be from minority ethnic backgrounds (19.5% in 2019/20) compared to 4.9% of chief executives, while unsurprisingly London has the highest minority ethnic background representation at board level (14.9%), compared to 3.2% in both the East of England and

[11] https://nhsproviders.org/news-blogs/news/theres-a-long-way-to-go-on-race-equality-within-the-nhs

[12] https://nhsproviders.org/media/689992/otdb-nhs-people-plan-2020-21.pdf

[13] NHS England and NHS Improvement, Workforce Race Equality Standard report 2020, pages 4-5: https://www.england.nhs.uk/wp-content/uploads/2021/02/Workforce-Race-Equality-Standard-2020-report.pdf

[14] https://nhsproviders.org/resource-library/briefings/workforce-race-equality-standard-summary-briefing-on-2020-national-findings

South West. Mental health and learning disability trusts have the highest minority ethnic representation at board level (11.1%) compared to 6% in acute trusts and 5.3% in ambulance trusts[15],[16]. Our remuneration survey in 2018/19 found evidence of a very small ethnicity pay gap at board level, with white directors earning 1.3% more than ethnic minority directors - this has reduced from 3% in 2017/18 yet demonstrates there is still progress to be made.

Identifying these inequalities is an important step, but NHS Providers and trust leaders are clear that dismantling them is a priority, and we are working to support trust leaders in this goal through our member benefits and board development programmes. As part of our 2021 'Race and health equality survey', 72% of responding trust leaders told us that evidence-based case studies would assist in accelerating their pace of change, while 67% felt that best practice learnings from other sectors would be a significant aid. To date, trust leaders feel that the most progress has been made in increasing leadership focus on the importance of staff networks (85%) and staff wellbeing (77%). However, only 4% felt that race equality is fully embedded as a core part of the board's business, demonstrating that there is still significant work to be done in this area.

A key pillar of NHS Providers' four-year strategy is focused on supporting trusts and trust leaders to tackle health inequalities, racism and race inequality, and to promote diversity and inclusion to ensure boards are reflective of the communities they serve. We aim to do so through our programme of influence and board support offer. In shining a light on these issues within the service, we are clear that we must also act as an organisation to ensure we tackle inequality and actively promote diversity and inclusion internally. We have established a race equality programme incorporating an independent review and these findings are currently being developed into a cross-organisational action plan in consultation with staff and external advisors.

Diverse and inclusive leadership also incorporates structural equality and opportunity which takes into account gender, age, sexual orientation, disability and religion. While our research reveals an average 50/50 split of men and women on trust boards, we note that finance and medical directors are predominantly men, who are on average paid more than nursing, workforce and HR directors on the board – roles typically filled by women.

[15] NHS Providers Remuneration Survey 2019/20: 148 trusts responded to this survey, accounting for 66% of all trusts in England

[16] https://nhsproviders.org/inclusive-leadership/bame-representation-and-experience-in-the-nhs

While decreasing, there is also evidence of 10% gender pay gap in favour of men, demonstrating there is still work to be done to tackle this imbalance[17]. Data on age, sexual orientation and religion for trust leaders is sparse: a theme that was highlighted in our survey on race and health equality too, with trust leaders citing a lack of data as a barrier to progress. Trusts in England do collect disability data as part of the Workforce Disability Equality Standard (WDES), and the national summary report published by NHS England in 2020 shows 3% of board members have declared a disability (up from 2% in 2019)[18]. We support a drive for more granular data to provide insight and will continue our conversations with trust leaders to ensure they are supported in developing evidence-based approaches to all aspects of EDI.

Pay and reward: current context for VSMs

Pay levels and annual uplifts

We tend to agree with the SSRB's assertion that pay levels for NHS VSM's are "broadly appropriate". We feel – as outlined above – that the most important adjustment in VSM pay policy should come through a new pay framework which enables the right amount of autonomy and flexibility for boards and remuneration committees to take account of specific local and system circumstances and challenges when making pay decisions.

We should note that we have not surveyed trust leaders for their comprehensive views on 'going rates' of pay in different VSM roles, however we have received feedback in recent years on the timing and nature of annual pay uplift decisions made by the government and these views are worth exploring in the context of the SSRB's role this year and beyond. Prior to the pandemic, in January 2020, NHSE/I confirmed an uplift recommendation of 1.32% (backdated to April 2019) alongside a non-consolidated 0.77% cash lump sum. The combined 2% recommended uplift for the year was "commensurate with the percentage increase paid to those at the top pay point of AfC pay band 9". The most recent pay letter issued by NHSE/I in September 2021 following a decision from ministers confirmed no pay uplift for VSMs, with the letter stating senior staff in the NHS would be subject to the "temporary pause on pay rises for most public sector workforces" outlined within the November 2020 government spending review.

[17] https://nhsproviders.org/inclusive-leadership/a-leadership-issue-exploring-the-gender-pay-gap

[18] NHS Workforce Disability Standard national summary report 2020, page 7: https://www.england.nhs.uk/publication/wdes-2020-data-analysis-report/

Trust leaders have been frustrated by the timing of uplift letters issued by NHSE/I in recent years. While we understand delays have often been at least partly caused by issues with ministerial sign-off, decisions and guidance issued by the government six to nine months into any given financial year are deeply unhelpful for trust boards and remuneration committees as they seek to retain talent at VSM level and ensure sound financial planning.

Responses to the decision to recommend no pay uplift for VSMs in the last round were generally unfavourable according to the feedback we received from trust leaders. We heard directly from several trust chairs who – while not part of the 'remit group' itself – often have a critical role in decision-making on pay issues at a local level with respect to their executive colleagues. Key points made included:

- a view expressed by multiple chairs that the national position on VSM pay and decision not to award an uplift was "regrettable".
- a position held by several members that trusts should be able to take a 'one team' ethos and an accompanying policy to award VSMs the same pay rise as other NHS staff.
- concerns that the national position does not take into account the "extraordinary efforts" and "tremendous leadership" of executive leaders in the NHS during the pandemic.
- warnings that there have been "early signs of good colleagues deciding to move out" (leave the NHS) and concern that the pay position will exacerbate this.
- an alternative view among some chairs that any pay rises should be targeted at lower paid members of the NHS workforce, particularly those in (AfC) bands 2-6.

We hope that an obvious benefit of the SSRB's new independent role in evaluating and making recommendations on VSM pay will be to contribute to more timely decisions on annual uplifts and we have every confidence, given the body's approach so far, that this will be the case. We would support the return to a cost of living pay increase for VSMs in 2022, given the potential negative impact a decision to suggest or enforce no increases in successive years could have on morale and retention among trust boards and in the remit group more generally. As discussed in other parts of this submission, it is critical that trust leaders feel valued and supported by the system as they work against the backdrop of unprecedented service demands caused by the ongoing management of COVID and the need to address a record backlog of care.

Earn-back policies

Current VSM pay guidance calls for earn-back policies – placing an element of base pay "at risk" – to be included where salaries are £150,000 or above. Earn-back is tremendously unpopular among trust leaders who have criticised this approach as a "backdoor" mechanism to reduce VSM salaries. Our remuneration survey results in 2021 showed that around 16% of executive director roles have earn-back applied to them, but this rises to 36% for those appointed since 2018. In February of 2018, NHS Providers wrote to the then Secretary of State for Health and Social Care Jeremy Hunt to express members' concerns around the formalisation of earn-back arrangements within a new pay framework. Trust leaders' concerns centred around:

- A lack of evidence underpinning its introduction. At the time, many trusts told us that their remuneration committees had considered introducing earn-back, but were sceptical it would be a helpful incentive. There were concerns that the inclusion of "earn-back" could be a demotivating rather than a motivating factor.

- The principle does not take in to account existing mechanisms trusts have in place for performance management. Should the performance of a senior post-holder fall below minimum expected standards, the view was this should come under the scope of existing trust processes. More substantial measures would be taken in response to poor performance, rather than withholding a proportion of pay.

- Director objectives are often linked to things outside their direct control, such as organisation or system wide operational performance targets. At an executive level, it is almost impossible to attribute organisational objectives to one individual. One trust chair at the time said that, "solving these issues might involve multiple organisations and partnership working which is beyond the control of any one organisation; having an "earn-back" element in these circumstances would not be fair and would discourage VSMs from working in challenged economies, where in theory the best and most talented individuals are required."

- Overloading trust leaders with duplicative scrutiny and accountability. Trust boards must be held to account for delivery, with stretching targets. But in a pressurised environment, we must be careful not to unnecessarily add in a further layer of scrutiny and accountability in the form of "earn-back". Senior managers are already held to account for their and their organisation's performance by non-executive directors, governors (in foundation trusts), the arm's length bodies and the Department. There was significant concern over the lack of clear value "earn-back" clauses in contracts would add.

Our annual remuneration surveys show that the presence of earn-back clauses within contracts have increased in recent years due to the inclusion of the requirement for trusts in some circumstances, however we do not have quantitative data or strong intelligence on the proportion of salaries where the 'at risk' element is ultimately earned or lost. The objections we outlined in 2018 still stand today and there is a strong feeling among trust leaders that this approach is not an effective way of implementing a performance pay – or indeed a performance management – system for senior leaders across the service.

Incentives and pension issues

It is essential that developing leaders both within and outside of the NHS are motivated to move into VSM roles in trusts throughout the country, and there is a broader system of incentives that needs to be considered within pay and reward policies. There has been a persistent feeling among some trust leaders that there is a lack of incentive to move into VSM roles from the top of Agenda for Change band 9, or indeed from roles at an equivalent level in the private sector. We should be clear that this perception is not universal, nor do we have access to detailed information on VSM posts being accepted or declined due to consideration of relative salaries and job expectations at AfC band 9.

However, we would note the SSRB's comments from last year on this matter, saying they were repeatedly told by members of the remit group that "the rise in pay does not match the increase in job complexity, challenge and accountability." We can also share some information from our remuneration data that might illustrate this challenge.

The highest pay rate ('top step-point') in the AfC structure is £108,075, and our information collected from trusts indicates that median pay in all executive director roles is higher than this. The extent of salary increases between the top of band 9 and executive board roles does vary considerably though, and while chief executives and finance directors tend to be paid significantly above this level, the difference is much smaller at the median rate for corporate affairs/governance directors (median basic pay: £112,071); HR/workforce/OD directors (median basic pay: £123,727); and strategy/planning/transformation directors (median basic pay: £126,480).

While the middle points of pay within each director role may be instructive, it is also useful to look at pay distribution at the lower end, for instance in the bottom quartile, where new recruits may be more likely to start in certain circumstances:

Basic salary by executive director role: NHS Providers remuneration survey, 2020/21

	HR/OD	Nursing	Operations	Corporate/ governance	Strategy/ transformation	Other	Combined
Lowest	£93,452	£91,004	£102,696	£62,001	£83,603	£87,754	£88,146
25th percentile	£111,653	£118,715	£116,769	£104,532	£111,133	£110,000	£122,000
Median	£122,448	£126,288	£128,149	£112,071	£123,860	£121,307	£141,773
75th percentile	£133,360	£140,000	£144,500	£124,220	£137,224	£139,221	£172,000
Highest	£193,000	£193,000	£195,000	£193,000	£193,000	£221,000	£206,717

AfC band 9 top step point: £108,075

Of course, like for like salary comparisons do not show the full picture when it comes to analysing incentives for high quality candidates to take on VSM roles and it would be impossible to assign any one single monetary value or range to definitively take account of the added challenge and accountability associated with progression from AfC roles to executive board positions. We would also note that the figures we collect do not include those senior staff on VSM contracts working below board level, where salaries are likely to be lower.

Furthermore, it is important that the SSRB – and ultimately the government – continues to monitor the compensation package for senior leaders in the NHS on a 'total reward' basis, including the benefits and costs of NHS pension scheme membership. The NHS pension scheme is undoubtedly a scheme that provides generous benefits to its members and compares favourably in many respects to other public and private sector schemes across the economy. However, changes to tax rules and pension growth allowance 'thresholds' in recent years have created well publicised issues for senior clinicians and managers in the NHS, particularly in respect to large – and sometimes unexpected – annual tax bills caused by salary increases, promotions and/or working of additional hours.

For executive directors (excluding medical directors still practicing as clinicians), the main challenges lie with the lifetime allowance and promotions which carry large enough salary increases to tip individuals over tax cliff edges. In 2019, we canvassed members extensively on the effects of pension issues and in our briefing reported the finding that in 60% of trusts, clinical staff were less willing to take on leadership roles, and in 37% of trusts fewer staff were seeking or accepting promotions due to annual allowance taxation specifically.

The situation has improved following the government's welcome changes to tax rules – which increased the annual allowance income 'taper' thresholds – in March 2020. At the time, the government estimated that 99% of senior managers would be taken out of the scope of the taper, however we are aware that some executive directors and senior clinicians are still affected by annual and lifetime pension tax issues given the decision to retain these limits on pension growth and the associated financial penalties. The extent of the current impact is not clear, though we have received isolated reports that challenges remain, both for the remit group specifically regarding receipt of tax bills associated with promotions, and in reference to operational challenges caused by the ongoing disincentive for the highest earning senior doctors to work additional hours in some circumstances.

In our view the SSRB has an ongoing role to play in assessing the impact of pension taxation in the NHS, particularly within the broader context of incentives for developing leaders within the service to take on promotions and new roles at board level. In future, we would be happy to consider collecting more up to date information on this issue via our remuneration survey, should that aid the SSRB and align with members' priorities for this work.

Recruitment and system working

Recruitment and changing nature of roles

Our data does not point to widespread, persistent vacancies on boards and supports the SSRB view from last year that it is "usually possible to fill posts" within all director roles. However, we would re-emphasise points made in this submission to better contextualise the recruitment and retention picture, and specifically note the difference between two. For instance, while there are not many vacancies across trust boards – despite the previously highlighted appointment delays – high rates of turnover point to ongoing challenges with retention and continuity of leadership, which affects the quality of management and has knock on effects on wider staffing and patient care issues. Additionally, while major recruitment efforts are rightly focused on frontline clinical staff at this time, it is worth noting that overall management capacity in the NHS is, according to some measures, significantly lower than in other sectors and may have declined in recent years.[19]

The SSRB has called for more complete data on vacancy rates in different posts, and we support this aim generally in the NHS. NHSE/I's quarterly trust vacancy data continues to be the most useful source of high-level quantitative information on vacancies, though since 2019 only medical and

[19] https://www.nhsconfed.org/long-reads/nhs-overmanaged

nursing profession-specific vacancies are included. It could be useful for NHSE/I or NHS digital to collect routine data on vacancies for the VSM remit group, however the process for undertaking such a task needs to be considered within the broader list of data collection exercises and other daily administrative demands facing trust leaders.

One interesting finding from our remuneration survey which warrants further investigation is the number of interim posts at board level. In 2021, 6% of posts were interim roles and of the 64 internal interim ('on-payroll') roles, over half of those in post (33 directors) had been appointed in the previous year, at least four months prior to our data collection period. Operations directors and chief executives were most likely to be employed in an interim capacity.

We are not aware of the extent to which this proportion of interim posts is reflected in other parts of the public sector or across the economy as a whole. And while this may well be a process purposefully employed by trusts as they seek to ensure the right appointment decisions are made in the longer-term, it could also point to some difficulty or delays in ensuring the right incentives and conditions are in place for permanent appointments. More work will be needed to understand the cause and effect of interim appointments within the remit group.

Another trend we have seen through our remuneration survey is the gradual increase in the prevalence of shared roles at board level. Generally, we have continued to hear from trust leaders that organisations are moving towards models of where executive directors are shared with and work between neighbouring trusts. In 2020/21, 6% of executive director roles were shared with another trust, a slight increase from 5% the previous year. Those in 'other' director roles (18% of all respondents) and chief executives (11%) were most likely to share the role with another trust, while it was also somewhat common for HR directors (9%). Medical directors (3%), nursing / quality directors (3%) and those in combined roles (3%) were the least likely to be in shared roles.[20]

This points to an increase in partnership working and is reflected in year-on-year findings regarding the involvement of senior leaders in ICS activity. In 2020/21, 95% of trust chief executives reported some form of involvement in their ICS, while 69% were specifically delivering ICS programmes of work. These figures were similar to the previous year's findings but the proportion of chief executives spending over one-fifth of their estimated time on ICS work increased from 28% in 2019/20 to 35% in

[20] NHS Providers Remuneration Survey – 2020/21

2020/21. This picture is likely to have evolved further since we received this data and is set into a different context given forthcoming legislative changes affecting system working.

Integrated Care Board leadership recruitment

The recruitment picture at VSM level is likely to become more complicated as ICSs (soon Integrated Care Boards) seek to fill various director posts, some of which will be required by statute should the Health and Care Bill pass into law this spring. NHSE/I is aiming to have all ICB executive posts filled by the end of March and it's worth noting that the recruitment to leadership positions has already contributed to debate and a level of contention within the sector, particularly given a recent run of media headlines surrounding system leaders' salaries.[21] [22]

NHSE/I has made significant progress focusing on interim ICS leadership appointments prior to legislation being formalised, while working to develop the right frameworks to enable appropriate pay decisions at an ICB level in the future.

Our view is that it will be essential to attract the right calibre of person to lead these important new statutory bodies. However, we must also recognise that the nature of these roles – focused on strategic commissioning and planning, financial oversight and partnership building – differ to executive board roles within trusts where the central task is to lead very large numbers of NHS staff delivering frontline care. ICB Remuneration Committees and Boards will want to consider all these factors when deciding where, on the relevant scales, they set ICS Accountable Officer salaries.

Talent management is an ongoing priority for trusts and systems irrespective of new statutory roles, and a greater emphasis will be placed on this area via the Messenger Review. However, it seems inevitable that the NHS will also need to work harder and dedicate greater resources to further developing its leadership pipeline, given the likely ongoing movement of high-quality trust executives into ICS roles. We would ask that the SSRB seek to examine patterns around recruitment of VSMs into both local organisations and ICBs, while evaluating the most effective mix of incentives deployed at all levels of the service to ensure a strong balance of local and system leadership.

For more information, please contact NHS Providers' senior policy manager, ***Finn O'Dwyer-Cunliffe****: finn.o'dwyer-cunliffe@nhsproviders.org.*

[21] https://www.hsj.co.uk/workforce/salaries-of-250000-considered-for-ics-ceos/7030774.article

[22] https://www.thetimes.co.uk/article/nhs-hiring-dozens-of-managers-on-up-to-270-000-9v5f6rblg