NHS Employers

NHS Employers' submission to the NHS Pay Review Body 2026/27

26 September 2025

Contents

Shaping the future NHS workforce

The 10 Year Health Plan

In July 2025, the government launched its Fit for the Future: 10 Year Health Plan for England.

Our colleagues at the NHS Confederation view the government's 10 Year Health Plan as a landmark moment for the NHS and wider health and care system. On behalf of our members, we broadly welcome the plan's ambition and many of its proposed reforms, stressing the importance of the three key shifts that underpin it:

1. **Hospital to community:** reducing reliance on hospital care by shifting resources and services toward neighbourhood-based care.
2. **Analogue to digital:** expanding use of digital technology (especially the NHS App) to improve patient access and self-management (as well as operational efficiency).
3. **Sickness to prevention:** promoting a preventative model of health that addresses social, economic, and commercial determinants to reduce health inequalities and improve long-term outcomes.

We stress the following on behalf of our members.

- Strong endorsement of the three shifts as essential to resetting the NHS and improving patient outcomes (and ensuring financial sustainability).
- Support for reforming the NHS operating model to devolve power and empower local leaders and neighbourhoods.
- Positive about the move towards outcomes-based and capitated payment models.
- The need for investment in workforce development, including apprenticeships, educational reform and technology.
- Support for efforts to overhaul the NHS capital regime with emphasis on investment in infrastructure and technology.
- Support for the plan's recognition of the central role of social care alongside NHS services.

A number of specific workforce elements are either contained in the plan or will be expanded upon through the publication of a 10-year workforce plan.

- From April 2026, NHS England will introduce new minimum staff standards, with progress reported quarterly. These standards aim to enhance staff experience and will cover key areas, including violence, racism, harassment, occupational health, and flexible working.
- Education providers, professions and regulators must review the content of education programmes to ensure they support and the delivery of the three shifts.
- Work will also be undertaken to establish, in the longer-term, a new multi-professional NHS employment contract, and a 'big conversation' will be initiated on contractual changes that provide modern incentives and rewards for high-quality care.
- Leadership development is also advancing; leaders and managers will be given new freedoms to undertake meaningful performance appraisals, reward high performance and act quickly when they identify underperformance.
- Improving staff wellbeing remains a priority, with a focus on flexible working arrangements, rest facilities, and reducing sickness absence to help retain and sustain the NHS workforce.

Delivering on the 10 Year Health Plan's ambitions will require proactive investment in training, leadership development, and inclusive recruitment, alongside a renewed focus on staff wellbeing and performance. This is why NHS England and the Department of Health and Social Care (DHSC) are developing a new long-term plan for the NHS workforce to replace the current NHS Long Term Workforce Plan, ensuring the NHS workforce strategy aligns with the goals of the 10 Year Health Plan. The refreshed NHS Long Term Workforce Plan is due to be published by the end of 2025.

Employers will play a central role in shaping this transformation, ensuring that the NHS remains not only the country's largest employer, but also its most forward-thinking and inclusive.

NHS finances

The long-term ambitions of the 10 Year Health Plan are in large part a response to the present challenging position facing the NHS, particularly in relation to its finances. Since July 2024, the NHS has received an additional £1.8 billion in extra funding, as part of a broader £25.7 billion increase allocated across 2024 and 2025. Nonetheless our members report extremely tight financial settlement and constraints.

- Providers are required to improve productivity by 4 per cent and reduce costs by 1 per cent, with many reducing recruitment to vacancies as a result.
- Capital spending growth is also limited, with a slight increase but flat real-terms growth over the near term, constraining investment especially in infrastructure and technology.
- The NHS must improve key targets including elective waiting lists, emergency care response and waiting times, and accessibility to primary care, while operating under constrained budgets.
- Unfunded costs like redundancy and the impact of industrial action add further financial uncertainty.
- There is also a mandated reduction of at least 30 per cent in agency spending and 10 per cent in bank staff use to control costs.

Wider government policy

Following the 2024 general election, Labour's plan to Make Work Pay forms a central component of the government's economic and social strategy.

The primary legislative instrument delivering the plan's objectives is the Employment Rights Bill (ERB). NHS employers will need to consider the operational and workforce implications of the ERB carefully. While the NHS already meets many of the proposed standards, new requirements such as contractual protections from day one and limits on zero-hours arrangements introduce a renewed focus on compliance and consistency.

NHS Employers regularly engages through its networks and keeps employers up to date with the upcoming changes to the ERB from the government. We are also considering the potential interactions that the forthcoming legislation may have with the NHS Terms and Conditions of Service (NHS TCS) Handbook.

Key messages

NHS people

- Workforce pressures remain acute, with regional variation in vacancies, rising demand, and ongoing service recovery efforts placing sustained strain on staff, particularly in mental health, acute, and emergency care settings.
- Staff wellbeing is under significant pressure, with increasing reports of burnout, stress-related sickness absence, and financial hardship driving some staff to take on second jobs, often without formal disclosure due to stigma or fear of repercussions.
- Inclusion and equity gaps persist, with data showing higher pension opt-out rates among international recruits and staff from ethnic minority backgrounds, suggesting that elements of the reward offer are not perceived as equally accessible or valuable to all.

Pay and reward: challenges

- Delays in pay award implementation continue to undermine trust, creating financial uncertainty for staff and placing a heavy administrative burden on employers managing backdated payments and compliance with legal thresholds.
- National Living Wage (NLW) increases are outpacing NHS pay uplifts. Due to the narrow buffer between NLW and NHS pay, lower bands are at risk of falling below statutory minimums, forcing employers to implement interim measures to remain compliant. This is also impacting access to salary sacrifice and net deduction schemes, with many staff unable to benefit from this element of the NHS reward package.

- Pay award disparities between staff groups are fuelling discontent, particularly where Agenda for Change (AfC) staff perceive themselves as undervalued compared to medical and dental colleagues who have received higher uplifts and additional payments.

Pay and reward: priorities

- Entry-level pay must be futureproofed, with a clear plan to maintain competitiveness against rising statutory minimums and private sector alternatives, particularly in roles with high physical and emotional demands.
- Graduate entrants need structured progression, especially at band 5, where slow earnings growth and limited promotion incentives risk deterring new professionals from staying in the NHS long term. Graduate roles also need to remain attractive to prospective employees.
- Promotion incentives must be rebalanced, as narrow pay gaps between bands reduce the financial appeal of taking on more responsibility, undermining motivation and career development.
- Approaches to apprenticeship pay needs national consistency, to support the expansion of local talent pipelines and ensure fairness across trusts, particularly as apprenticeships become a key workforce strategy under the 10 Year Health Plan.

Job evaluation

- Updated nursing and midwifery profiles require careful implementation, with employers needing to ensure job descriptions are current and job evaluation (JE) panels are well trained (to avoid disputes and inconsistent outcomes). Capacity to deliver JE is constrained, with financial pressures limiting investment in training and resourcing, despite growing demand for accurate and timely evaluations.
- A national digital JE system is being procured, which will improve national oversight, reduce equal pay risks, and support consistency across organisations, but will require investment and change management.
- National guidance, including from the Secretary of State, reinforces JE as an important contractual obligation, with expectations for minimum

standards, local ownership, and partnership working to ensure fairness, timeliness and transparency.

Shape of the workforce

- The 10 Year Health Plan marks a strategic shift, moving the NHS toward a more community-based, digitally enabled, and prevention-focused model of care, with implications for workforce design and deployment.
- Digital transformation is central to future workforce models, requiring investment in digital skills, AI readiness, and interoperable systems to support new ways of working and reduce administrative burden.
- Sickness absence is improving slightly, but mental ill health remains the leading cause, highlighting the need for sustained investment in wellbeing, flexible working, and supportive leadership.
- Productivity is recovering, with early signs of improvement in 2025, but further gains depend on continued investment in training, leadership, and digital infrastructure to support smarter working.
- Leaving rates have dropped to a decade low (10.1 per cent), signalling early workforce stabilisation. Regional disparities in nursing recruitment and retention persist, highlighting the urgent need for tailored, locally responsive strategies.

Informing our evidence

NHS Employers welcomes the opportunity to submit evidence on behalf of NHS organisations in England. We continue to value the independent and expert role of the NHS Pay Review Body (NHSPRB) in considering remuneration issues for staff covered by AfC contracts.

While the timeframe for this year's submission has been shorter than in previous years, the evidence presented has nonetheless been informed by engagement with a broad range of NHS organisations. However, it is essential to recognise that employers have also been required to respond to the operational pressures associated with ongoing industrial action. This has included the need for rapid contingency planning, which has understandably limited the capacity for more extensive engagement during this period.

Employers welcome the progress made during the 2025/26 pay round in reducing the delay in the pay award process, and they recognise the time constraints under which this year's round is being conducted. They remain committed to supporting further improvements in the timeliness and efficiency of future pay rounds.

In response to this compressed schedule, we have prioritised targeted engagement to ensure employer views are accurately represented. This has included:

- regular consultation with our policy board, comprising senior leaders from across the NHS
- engagement with HR directors and chief people officers through regional networks

- input from employers involved in our specialist networks on reward and recognition, wellbeing, education, recruitment, terms and conditions and staff experience
- ongoing collaboration with NHS Confederation colleagues who support a broad range of employer networks.

We surveyed senior NHS HR leaders on a range of topics, including recruitment, retention, and staff morale. A total of 26 individuals responded, representing their organisations. This is fewer than last year (90 responses received), likely due to competing priorities and the timing coinciding with resident doctors' industrial action. Despite this, the responses received were rich in detail and provided valuable insights into the challenges employers are currently facing.

As part of the NHS Confederation, we continue to act as a conduit between national policy and local systems, sharing intelligence and facilitating the exchange of effective workforce strategies.

This submission builds on our 2025/26 evidence and reflects employer perspectives on the financial, economic, and workforce challenges facing the NHS. It also reinforces the strategic pay priorities necessary to improve and future-proof the AfC pay and reward structure.

Recommendations

Our NHSPRB evidence for 2024/25 and 2025/26 outlined several pay priorities that employers had identified as areas requiring action. Making progress in these areas remains a priority for employers for the 2026/27 pay round.

1. **Competitive pay for entry-level roles**: Establish a futureproofed plan to create and retain a sustainable competitive market position on pay for entry-level roles to align with planned changes to the statutory NLW and the expected trajectory of Living Wage Foundation rates of pay (band 2 and closed spot salary for band 1).
2. **Targeted action at the entry point of band 5**: Ensure the NHS remains an attractive career destination for graduates, by taking targeted action to enhance the entry point of band 5, keeping it competitive within the graduate labour market.
3. **Pay incentives for promotion**: Develop a sustainable and targeted plan for more appropriate pay increases to be received on promotion between the pay bands. This process begins with actions to address the gaps between bands 2 and 3, bands 6 and 7, and bands 7 and 8a. Further structural reform is required across the whole system, but it is recognised that this will need to be addressed over the longer term.
4. **Pay progression**: Identify options and agree a preferred approach and implementation plan to support future pay and earnings progression.
5. **Anomalies in unsocial hours payments**: Targeted action to address anomalies created by the implementation of consolidated pay changes in 2023/24 and successive years of investment in base-pay changes to band 1 (closed) and band 2 in relation to unsocial hours premium payments.
6. **Pay for apprentice roles**: Introduction of a consistent national pay framework to govern the rate of pay for apprentices in the NHS (NB: this will need to assess the two pilot cohorts in 2024 and 2025 of medical apprenticeships).

Section 1 – Context

This section outlines the current economic and labour market conditions affecting NHS organisations ahead of the 2026/27 pay round.

Economic factors and labour market statistics

Inflation, cost of living and pay growth

The latest inflation data shows that the Consumer Prices Index (CPI) rose by 3.8 per cent in the year to August 2025, unchanged from July. This slight increase was primarily driven by rising transport costs, including fuel and airfare, as well as increasing prices for food and clothing. Meanwhile, housing costs provided a slight offset.

The Bank of England's Monetary Policy Committee (MPC) sets interest rates in the UK. The government has given the MPC a remit to target an inflation rate of 2 per cent over the "medium term" – usually thought of as a few years. The Office for Budget Responsibility (OBR) uses a combination of short-term and medium-term models to forecast inflation. In 2026, CPI inflation is forecast to fall sharply, returning close to the Bank of England's 2 per cent target as the effects of energy prices fade and economic capacity increases.

Ongoing pressures continue to challenge NHS staff's household budgets, especially for those in lower pay bands. The backdated pay award and adjusted pension thresholds offer some relief, but continued cost-of-living support remains essential.

Employers are increasingly hearing anecdotal accounts of staff taking on additional jobs outside their primary roles within the NHS. While no national data currently exists to determine the scale of this trend, feedback from employers suggests it is becoming increasingly common.

Many NHS organisations have policies in place that request staff to declare any secondary employment. These policies typically stress that such work should not conflict with or negatively impact the staff members' NHS responsibilities. However, these policies are not always being used. Staff have shared that conversations about secondary employment can be uncomfortable and sensitive, primarily because more individuals are pursuing additional jobs due to financial necessity.

Feedback from the NHS TCS Network revealed that in one region, staff are working second jobs outside of their NHS working hours to help manage financial pressures. These roles span various NHS bands and job types, making it challenging to identify a clear pattern.

The average weekly earnings data for the three months to September 2025 show that annual growth in employees' average regular earnings was 4.8 per cent (excluding bonuses), while total earnings (including bonuses) was 4.7 per cent. After adjusting for inflation, annual growth in real terms was 1.2 per cent for regular pay and 1 per cent for total pay. The public sector experienced slightly stronger annual average regular earnings growth (5.6 per cent) compared to the private sector (4.7 per cent).

Looking ahead, future pay awards will need to balance current inflationary pressures with the forecasted return to lower inflation in 2026. While real earnings are improving, continued monitoring of cost-of-living trends and workforce retention will remain essential.

Rates of employment, unemployment and economic inactivity

In our 2025/26 evidence, we supplied data from September 2024. As our timeline for evidence submission this year has been condensed, the latest data is from September 2025.

As of September 2025, the UK employment rate stands at 75.2 per cent, up slightly from 74.8 per cent in September 2024, indicating a modest improvement. However, the unemployment rate has risen to 4.7 per cent, up from 4.1 per cent, and economic inactivity has fallen to 21.1 per cent, down from 21.9 per cent. While more people are entering the workforce, the rise in unemployment suggests that finding work is becoming harder, and the labour market remains weaker than it was before the pandemic.

NHS organisations continue to play a vital role in supporting the government's efforts to reduce economic inactivity. Yet, challenges persist. The number of young people aged 16–24 not in education or employment remains high. Long-term sickness continues to drive inactivity, particularly among men, with increases seen across nearly all age groups. There has also been a rise in men out of work due to caring responsibilities. At the same time, the number of women in this category has slightly declined, narrowing but not eliminating gender gaps in worklessness.

These trends are concerning for the NHS, as rising long-term health conditions and economic disengagement may increase demand for services and strain workforce capacity. While the employment rate has edged up, the overall picture points to a cooling labour market, with falling vacancies and payroll numbers across most sectors. This highlights the importance of targeted workforce planning, ongoing support for economically disadvantaged groups, and sustained investment in health and employment services.

The government's ambition for economic growth

In 2025, the government reaffirmed its commitment to economic renewal through the NHS, positioning the service not only as a provider of care but as a driver of inclusive growth. Building on Lord Darzi's 2024 review, the Prime Minister launched the 10 Year Health Plan.

ICSs and NHS trusts are increasingly aligning their strategies with local economic development goals, supporting job creation, skills development, and procurement practices that deliver social value.

We have continued to champion this agenda, with new guidance and case studies highlighting how NHS organisations can contribute to community wealth-building and health equity.

The NHS's widening participation initiatives have expanded in 2025, with a renewed focus on:

- supporting access to employment for underrepresented and disadvantaged groups
- strengthening partnerships with local education providers and voluntary sector organisations
- promoting career pathways into health and care for young people and career changers.

These efforts are underpinned by the government's broader ambition to unlock the economic potential of public services, recognising that a healthy population and a thriving NHS workforce are essential to long-term national prosperity.

Workforce

The 10 Year Health Plan outlines updated workforce projections for the NHS, indicating that by 2035, staffing levels will be lower than those forecast in the NHS Long Term Workforce Plan 2023. This adjustment reflects a strategic shift towards a more efficient and digitally supported

workforce model. The plan emphasises the development of a highly skilled, motivated workforce equipped with modern tools and training to deliver care more effectively. These projections are expected to be further refined in the forthcoming refreshed long-term plan for the NHS workforce.

This approach aligns with a broader transformation in healthcare delivery, which prioritises community-based and preventive services over traditional hospital-centric models. The integration of AI and digital technologies is central to this strategy, aiming to streamline administrative processes and enhance clinical decision-making. Through improved skill utilisation and more intelligent systems, the NHS aims to maintain service quality and accessibility with a more agile workforce.

As of March 2025, the overall NHS sickness absence rate for England was 4.9 per cent. A decrease has been observed since February 2025 (5.3 per cent), but it is slightly higher than in March 2024 (4.7 per cent). A lower sickness absence rate generally means more staff are available to deliver services, which can positively impact productivity and patient care.

Anxiety/stress/depression/other psychiatric illnesses were the most reported reasons for sickness, accounting for over 610,500 full-time equivalent days lost and 27.5 per cent of all sickness absence in March 2025. This has increased since February 2025 (26.4 per cent).

The CIPD's Health and Wellbeing at Work Report 2025 states that UK employees are now taking an average of 9.4 days of sickness absence per year, the highest level in over a decade. Mental health issues such as anxiety, stress, and depression continue to be the leading cause of long-term sickness absence, which aligns with the NHS data.

Healthcare productivity was estimated to have grown 2.7 per cent in quarter one of 2025 compared with the same quarter in 2024, as output growth (2.9 per cent) outpaced inputs growth (0.2 per cent). This is the first time since early 2023 that there have been three consecutive periods of quarter on same quarter a year ago productivity growth. This relates to movements between the quarter and the same quarter a year ago, rather than comparing with the previous quarter, because these better reflect underlying productivity trends and minimise effects of short-term

volatility. This suggests that NHS productivity is recovering, with notable gains in early 2025. The improvements are attributed to better data quality, more efficient service delivery, and adjustments in reporting practices. However, the system is still in the process of regaining ground lost during the pandemic.

Vacancy rates

The number of vacancies across the UK economy (reported in the latest ONS data) decreased by 44,000 (5.8 per cent) to 718,000 between May and July 2025. Vacancy numbers have now been falling continually for three years, with the total number of vacancies decreasing by an estimated 582,000 since its peak in March to May 2022. Results from the ONS vacancy survey suggest some employers are not recruiting new workers or replacing workers who have left.

As of March 2025, NHS vacancies stand at 100,114, which is a 0.5 per cent decrease from the same point in 2024. Figures 1 and 2 illustrate the change in NHS vacancy levels across staff groups over the past six years, along with sector-specific vacancy rates.

Figure 1 – Vacancy levels by staff group since 2019/20

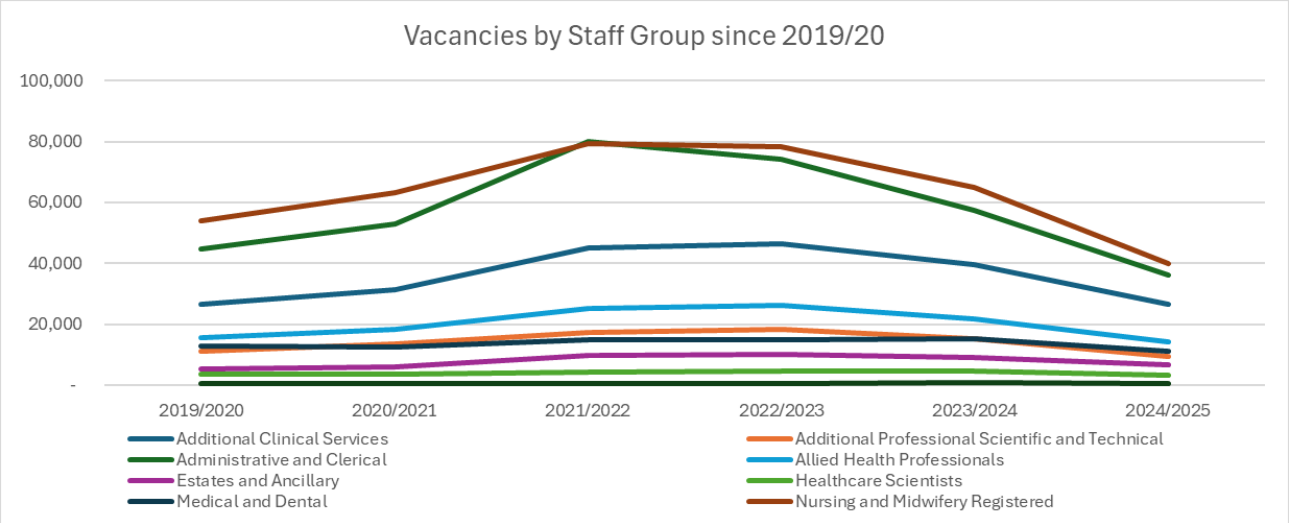


Figure 2 – NHS vacancy rate by sector

	Sector	Mar-19	Mar-20	Mar-21	Mar-22	Mar-23	Mar-24	Mar-25
Vacancy FTE	Acute	68,229	61,632	53,124	74,711	74,677	64,090	68,317
	Ambulance	2,326	1,743	1,080	2,036	3,060	4,257	2,614
	Community	4,084	3,878	2,957	3,958	4,772	5,394	4,126
	Mental Health	19,365	18,312	16,659	22,677	26,836	24,371	23,182
	Specialist	2,357	2,782	2,261	2,472	3,152	2,547	1,874
National Total		96,361	88,347	76,082	105,855	112,498	100,658	100,114
Vacancy rate (%)	Acute	8.0%	7.0%	5.8%	7.7%	7.4%	6.2%	6.4%
	Ambulance	5.1%	3.6%	2.1%	3.9%	5.6%	7.2%	4.4%
	Community	7.8%	7.5%	5.5%	7.1%	8.2%	8.8%	7.3%
	Mental Health	9.8%	9.1%	7.9%	10.2%	11.3%	9.9%	9.0%
	Specialist	5.6%	6.4%	5.0%	5.8%	7.1%	5.5%	3.9%
National Total		8.1%	7.2%	5.9%	7.9%	8.0%	6.9%	6.7%

Vacancy levels remain above pre-pandemic levels, though there has been some improvement since the peak in 2022/23, as shown in figure 1. The national total has decreased from 112,498 (8.0 per cent) in 2023 to 100,114 in 2025 (6.7 per cent).

The acute sector shows a slight increase in vacancies this year after a dip in 2024, as shown in figure 2, indicating ongoing workforce pressures. Mental health trusts continue to report the highest vacancy rates, although these have decreased from their peak in 2023. While roles remain within organisational establishments, many employers are delaying recruitment unless the role is essential, as part of broader cost-saving measures.

Ambulance and community services have seen the most fluctuation. Ambulance vacancies peaked in 2024 but have since dropped significantly. Community services also experienced a slight decline this year, following a period of steady increases. Specialist services now report their lowest vacancy levels since 2019, indicating some success in stabilising staffing in this area.

Financial

This Spending Review (SR) sets out departmental budgets for 2026/27 to 2028/29, using a spending 'envelope' that is outlined mainly in the Spring Budget. The NHS Confederation website outlines the SR health-related announcements, some of which have been made previously.

The 2.8 per cent increase to the Department of Health and Social Care (DHSC) budget is generous compared to other departments in a challenging fiscal climate. Still, it falls short of the historic 3.6 per cent rise and the Health Foundation's recommended 4 per cent to restore services.

Meeting the government's ambitious targets to cut waiting times and reform the NHS will be difficult with this funding. Public expectations may rise due to political rhetoric, despite the NHS being under-resourced.

The SR brings mixed implications for employers. While there's a significant boost in digital investment and commitments to expand the workforce, such as training more staff, funding details remain vague, making workforce planning difficult. Employers will also need to adapt to new technologies, expanded service expectations, and tighter budgets, as the overall funding increase falls short of what is required to restore services. Given limited capacity, this could strain resources and increase pressure to meet rising public expectations.

Pay award funding

The 2025/26 NHS pay awards were only partially funded by the government, with a central allocation covering 2.8 per cent of the total cost. The remaining funding was sourced through a combination of internal savings and budget reprioritisation across the DHSC, NHS England, and integrated care boards (ICBs).

NHS organisations were required to identify the full cost of the awards, including backpay from April 2025, and reflect this in their financial planning and contract adjustments. Where local budgets were insufficient, short-term cash support could be requested via the CFF1 process, although this was not guaranteed to be recurrent.

Employers welcome the arrangements to fund the 2025/26 pay award fully. However, some employers have reported that they continue to incur costs associated with the implementation of the award.

We have consistently stressed the need for pay awards to be fully funded to ensure financial sustainability and protect frontline services. When pay uplifts are not matched by adequate central funding, employers are forced to make difficult choices, diverting resources from service delivery, delaying strategic investments, and increasing their reliance on non-recurrent savings.

It is also fundamental that pay awards are fully funded across the entire health sector, not just for provider trusts.

Industrial action

Trade unions (TUs) responded critically to the 3.6 per cent NHS pay award for 2025/26. UNISON and the Royal College of Nursing (RCN) expressed disappointment that the pay award was imposed without negotiation, arguing that it fails to keep pace with inflation and does not address long-standing issues in NHS pay structures. UNISON highlighted that the increase still leaves some staff earning below the real living wage (RLW) and consulted members on potential industrial action. Both unions reiterated calls for direct pay negotiations with the government.

Many health TUs initiated consultative ballots across May, June and July. These ballots were a way for unions to gather feedback before deciding on next steps, such as pushing for direct negotiations or moving towards ballots for industrial action (IA).

The indicative ballot results revealed strong opposition to the 2025/26 pay award. As next steps, unions are demanding urgent talks with the government and preparing to move toward formal ballots, which could lead to IA if negotiations do not begin promptly.

In last year's report, we highlighted the unprecedented scale of IA across the NHS, the longest in its history, which caused significant disruption to

services and strained employer–union relationships. NHS England estimated the financial impact of IA to be around £3 billion, primarily due to the loss of elective activity.

Beyond the financial burden, NHS employers remain deeply concerned that renewed IA could unravel hard-won progress in rebuilding relationships and stabilising services following previous strikes. Prolonged disputes have already cast a shadow over staff morale, recruitment, and retention, generating uncertainty and dissatisfaction that hinder efforts to attract new talent and retain experienced professionals.

Although IA continues to cause disruption, many employers have adapted to the point where it has almost become business as usual. They have developed comprehensive policies, contingency plans, and operational procedures to manage the effects of strike action. These include deploying staff to priority areas, redistributing workloads, and enhancing communication strategies to maintain service continuity. However, this normalisation presents a significant challenge. The effort and resources required to manage strike action, often at short notice, can be a substantial distraction from core business activities. When strike action becomes routine, it risks embedding a reactive culture where short-term fixes take precedence over strategic development.

For a workforce still grappling with pressure, burnout, and service recovery, the threat of further disruption risks deepening disengagement and undermining motivation at a time when continuity, collaboration, and restored public trust are more critical than ever. The strain is particularly acute in high-impact areas such as elective care and emergency services, where delays and reduced capacity directly affect patient outcomes and stretch frontline teams beyond sustainable limits.

Strikes (Minimum Service Levels) Act 2023

The ERB includes the formal repeal of the Strikes Minimum Service Levels (MSL) Act 2023.

In the absence of MSLs, employers will continue to rely on locally agreed contingency plans and voluntary arrangements to maintain safe staffing

levels during strikes. This approach, grounded in partnership working, is more likely to preserve morale, reduce conflict, and support the delivery of safe and effective care. NHS England's most recent approach to industrial action prioritises patient safety while aiming to minimise disruption to services.

Industrial action ballot changes

Upcoming proposed changes to trade union ballot rules under the ERB mark a significant shift in the UK's industrial relations framework.

The removal of the 50 per cent turnout threshold and the requirement for 40 per cent support among eligible voters will lower the bar for lawful strike mandates, enabling unions to initiate IA with fewer votes.

The introduction of electronic balloting and email-based notifications will streamline the process, making ballots more accessible, efficient, and responsive to workplace developments. The Code of Practice will be updated to recommend email as the preferred method for notifying employers of ballot outcomes, replacing the current mix of post, courier, fax, and hand delivery.

Coupled with the extension of strike mandates from six to twelve months and simplified ballot notice requirements, unions will gain greater flexibility and sustained momentum in coordinating collective action. Notably, the notice period for industrial action will be reduced from 14 days to 10 days, allowing unions to act more swiftly.

Review into ethnicity pay gaps in the NHS

In July 2025, the NHS Race and Health Observatory commissioned the first comprehensive review into ethnicity pay gaps across the NHS in England. This 18-month study will examine disparities in pay, career progression, pension contributions, and cumulative earnings among staff from different ethnic backgrounds.

Despite increasing diversity, ethnic minority staff now represent 29.5 per cent of the NHS workforce, and only 7.9 per cent occupy very senior

management (VSM) roles, highlighting a widening gap in representation at senior levels. The review aims to identify the root causes of these disparities and provide evidence-based recommendations to eliminate unwarranted inequities.

The research will draw on both quantitative and qualitative data, including methodologies from statutory gender pay gap reporting. It follows the precedent set by the 2020 “Mend the Gap” review into gender pay gaps in medicine. Findings are expected to inform improvements in NHS pay systems, contract design, and workforce inclusion strategies. The final report is due in December 2026.

This initiative highlights the importance of transparency and accountability in addressing systemic inequalities, to ensure equal pay and progression opportunities for all NHS staff, regardless of their ethnic background.

NHS Pay Review Body (NHSPRB) process

For the 2025/26 round, the DHSC submitted its remit letter earlier than in previous years (30 September 2024), allowing the NHSPRB to deliver its report sooner. This resulted in the pay award being announced in May 2025, which was earlier than the previous year (July 2024). The backdated uplifts were included in August 2025 salaries.

We are pleased to see that further progress has been made in the 2026/27 round, with remit letters being submitted earlier again (22 July 2025). We understand that this will allow the NHSPRB to submit their report earlier than in the 2025/26 round, which will likely result in staff receiving their pay award earlier. However, it is still unlikely to be implemented by 1 April, which will mean the interim uplift put in place in previous years will again be necessary for NLW compliance.

Employers welcomed the progress made in the timing of the 2025/26 pay award round but would like to see further improvements to return to a 1 April pay award implementation.

For NHS staff, especially those in lower pay bands, the deferred uplift has led to considerable financial uncertainty. Staff naturally expect their pay rise to arrive in April, aligning with the beginning of the financial year. Instead, they are faced with months of stagnant wages in the context of rising living costs, which can impact morale and reduce confidence in the pay-setting process. This misalignment is particularly problematic for the lowest-paid staff, whose monthly income plays a critical role in budgeting and financial stability.

Furthermore, when pay awards are backdated to 1 April, it increases the risk of staff in lower pay bands losing out on Universal Credit (UC) as their monthly income impacts on the value of UC payments. This has resulted in some organisations offering staff the option to have their pay uplifts paid in multiple instalments, to reduce the impact on UC. Employers have informed us that this has resulted in increased administrative work, which has been challenging to manage. Some organisations did not adopt this approach this year due to a partial advance of the 2025/26 pay award for bands 1, 2, and entry point band 3, and given that there were fewer months of back pay than in the previous year.

From an operational standpoint, delayed implementation imposes a heavy administrative burden on employers. Processing multiple months of backdated payments requires extensive coordination between payroll teams, HR departments, and finance leads. This also included recalculations of pay for staff members on maternity leave. The complexity increases the risk of error and places strain on already stretched support services, diverting resources from core priorities.

There are also legal and structural challenges resulting from pay delays. The uplift to the NLW in 2025/26 exceeded the hourly pay for band 1 and 2 roles, resulting in an interim uplift being required. The entry point of band 3 also received an uplift to maintain the differentials with the top of band 2. Without the timely implementation of new pay awards, these roles risk falling out of compliance with statutory pay minimums.

Staff who received the interim uplift to meet NLW compliance often feel that the subsequent formal pay award doesn't deliver a meaningful increase. Since the top-up confirms the rate they've already been receiving, it doesn't feel like a new benefit, it feels like a continuation of something they were already entitled to.

Delays also complicate international recruitment. The Home Office salary thresholds for health and care worker visas are updated annually in April. If pay awards are not reflected promptly, entry-level NHS roles may temporarily fall below these minimums. This exposes employers to legal risks and limits their ability to recruit from overseas talent pools, at a time when workforce shortages remain critical.

Digital infrastructure

The 10 Year Health Plan places digital infrastructure at the heart of NHS transformation. The digital ambitions in the plan carry significant implications for NHS employers, both in terms of workforce transformation and organisational readiness. Employers will need to strategically plan for a workforce that is digitally capable, responsive to AI-enabled tools, and confident in hybrid care models.

Fragmented IT systems and inconsistent data-sharing practices are significant barriers to delivering joined-up care. To successfully implement the digital transformation, employers have expressed the need for strong national leadership to coordinate engagement with software providers, ensure interoperability across systems, and avoid duplication at the local level.

Given the complexity and variability of current digital infrastructure, central guidance will be essential to define common standards, streamline procurement, and ensure that systems can effectively exchange data across organisational boundaries. Employers have expressed the need for targeted funding support or shared frameworks to upgrade legacy platforms and meet national interoperability requirements without compromising local service delivery.

Reversing corporate cost growth

A directive has been issued for all NHS providers to reduce the growth in corporate services costs by 50 per cent compared to pre-pandemic levels by the end of 2025. This is part of a broader effort to redirect resources towards frontline care and improve financial sustainability across the system. The cuts target non-clinical corporate functions, including human resources, finance and communications.

Employers have expressed growing concern about the affordability and feasibility of delivering redundancies within the current fiscal environment. The upfront cost of redundancy payments, estimated to reach £12 million per organisation, poses a significant financial challenge.

In the absence of a nationally funded redundancy scheme, employers warn that they may be forced to rely on slower, less predictable methods such as natural turnover or voluntary exits. This not only delays the delivery of required savings but also increases the risk of unplanned service disruption and workforce instability. Some leaders have indicated that without Treasury support, they may be unable to proceed with formal redundancy programmes at all, undermining the pace and scale of reform expected under the 10 Year Health Plan.

In organisations where processes have not been streamlined across departments or partner entities, and where AI and automation technologies have yet to be implemented, the volume of operational work remains unchanged. Despite this, staff reductions are already underway, resulting in increased pressure on the remaining staff and potential risks to service delivery. This can lead to overstretch, burnout, rising sickness absence, and disengagement, where demands have grown due to workforce reforms and digital transformation initiatives. Employers are warning that without clear workforce planning and support for transition, the cuts risk creating a "do more with less" culture that may ultimately undermine productivity, staff wellbeing, and the successful implementation of wider system reforms.

Deputy HR director survey response:

Headcount reductions are being implemented without sustainable alternatives, such as digital innovations, which is increasing pressure across the system. Corporate cuts are shifting responsibilities to clinical managers who may not be trained for them, pulling them away from patient care. While reductions are possible, the current timeframes are unrealistic and risk overburdening the remaining staff, potentially leading to higher turnover and sickness rates.

2025/26 pay award and recommendation

In its 38th report, the NHSPRB recommended a 3.6 per cent consolidated pay increase for all AfC staff in England. It was accepted in full by the UK government, despite exceeding the DHSC's stated affordability of 2.8 per cent.

The NHSPRB reiterated its call for the government to provide the NHS Staff Council with a separate, funded mandate to address longstanding issues with the AfC pay structure, which the government also accepted. The NHSPRB concluded that no part of the 2025/26 pay award should be used for reform to the AfC pay structure.

The NHSPRB expected progress to be made toward a reform plan before the 2026/27 pay round and confirmed that it would seek updates from all parties at the start of the following review cycle.

Mandate information

Whilst DHSC are in the process of identifying available funding in respect of reform to the AfC pay structure the Minister for Health wrote to the NHS Staff Council in early July requesting that they undertake exploratory discussions to consider the areas of focus for any pay structure reform. In mid-July the trade union and employer members of the NHS Staff Council executive met and produced a report which was

sent to the Minister (we understand that the Staff Council secretariat has shared that report with the NHSPRB). Following which the Minister met with the co-chairs of the Staff Council. A further letter was then sent to the Staff Council for discussion at their plenary meeting in September requesting that they hold further talks which would then inform the development of the mandate and available funding.

Pay disparity between AfC and medical and dental staff

The 2025/26 pay round saw a 3.6 per cent consolidated uplift awarded to AfC staff in England, while medical and dental staff received a 4 per cent increase, with resident doctors receiving an additional £750 consolidated payment. Although the government accepted both recommended pay awards, the differential has prompted growing concern across the NHS workforce regarding fairness, morale, and cohesion.

While some forums reported no immediate change in team dynamics following the announcement, subsequent discussions revealed that the disparity has had a noticeable impact on staff sentiment. Some employers shared that lower-paid AfC staff expressed feelings of being undervalued, especially when compared to their medical and dental colleagues. This perception has been linked to broader issues of morale, recruitment, and retention, with some staff questioning the equity of a system that appears to reward different parts of the workforce unequally.

Survey data from national engagement groups comprising of senior leaders covering both medical and AfC were surveyed and over half of respondents felt the differential pay award had a somewhat adverse effect on relationships within their organisations. Although this has not yet translated into widespread unrest, there is a growing sense that the issue may become more prominent in future industrial relations discussions, particularly as unions continue to advocate for fair and consistent treatment across all NHS staff groups.

The NHS operates as a single, integrated workforce. Nurses, allied health professionals, support staff, and doctors work together to deliver patient care. When pay awards are perceived as inconsistent or unjustified, it risks undermining trust in the pay review process and

weakening the sense of shared purpose that underpins effective multidisciplinary working.

Considering this, there is a strong case for greater coordination between the independent pay review bodies. While each body operates within its own remit, the interdependency of NHS roles means that decisions made in isolation can have unintended consequences across the wider system. A more integrated approach, where pay review bodies consider the broader impact of their recommendations, could help ensure greater consistency, transparency, and fairness.

Maintaining morale and trust in the system is essential to sustaining a motivated and collaborative NHS workforce. As the service continues to face significant operational and financial pressures, it is vital that all staff feel equally recognised and valued for their contribution.

Deputy HR director survey response:

We asked deputy HR directors how the differential pay award has impacted their workforce dynamics, taking into account staff morale, multidisciplinary team dynamics, industrial relations, local trade union relationships and employer-employee relationships.

- 40 per cent noticed no impact.
- 44 per cent noticed a negative impact, causing some tension or dissatisfaction.
- 16 per cent noticed a very negative impact, causing worsened relationships and industrial unrest.

Public health staff

Public health staff employed on AfC contracts occupy a unique position within the NHS workforce. Unlike most medical staff, who the DDRB typically covers, many public health staff are employed under AfC terms and conditions as they are not medically trained. This distinction has led to growing concern about pay equity and recognition, especially in the context of recent pay awards.

The pay differential has highlighted disparities in how different parts of the NHS workforce are valued. Public health staff on AfC contracts have been identified as a group disproportionately affected by this divide. Despite often working alongside medical colleagues, they currently receive lower pay and different contractual benefits, which can impact morale and perceptions of fairness.

Once qualified many public health staff are based in local government, focusing on health improvement, protection, and population health. Whilst some work as nurses and managers working within NHS trusts and commissioning bodies. This issue has been raised in national forums, where it has been linked to broader concerns about recruitment, retention, and the attractiveness of public health careers. Some employers have called for a review of pay structures to ensure greater consistency and fairness across the NHS, particularly for roles that straddle the boundaries between clinical and non-clinical frameworks.

NHS spending on temporary staffing

A letter sent in June 2025 from NHS England and the DHSC urged NHS provider and ICB executive teams to take immediate action to reduce spending on temporary agency staffing.

Employers across the NHS have already made encouraging progress towards this goal. Many have successfully reduced agency spend by offering bank and substantive contracts and have implemented robust processes to review agency cover requests against existing staffing levels, ensuring necessity. This active engagement reflects a strong commitment to building a more stable and sustainable workforce.

To support the transition, trusts are expected to develop comprehensive migration plans to shift from agency staffing to bank staffing. The letter emphasises that bank work should be the first choice for staff seeking to work extra shifts, offering better value and continuity of care. Trusts must also ensure that bank rates are competitive, but not higher than average agency rates, and they should regularly evaluate these against local market conditions. A delivery group has been established to

monitor progress, and if insufficient action is taken by autumn, legislative measures may be introduced.

Employers have raised concerns about the wellbeing of internal bank staff, particularly as reliance on flexible staffing models has increased in response to workforce shortages and financial pressures. While internal banks are a preferred alternative to agency staffing, there is growing recognition that frequent or excessive shift patterns can lead to fatigue, stress, and burnout among bank workers.

Beyond staff wellbeing, employers are focused on maintaining compliance with contractual safeguards and the Working Time Directive. Without robust oversight, there is a risk that bank staff and substantive staff working extra bank shifts may exceed safe working limits, potentially breaching legal requirements and compromising both staff welfare and patient safety. This is especially a risk within organisations lacking digital rota systems that can automatically identify breaches.

To support safe and effective workforce planning, interoperable rota systems are essential when staff work across multiple trusts. These systems enable real-time visibility of shift patterns, helping to prevent fatigue, ensure compliance with working time regulations, and ultimately safeguard both staff wellbeing and patient safety.

An employer told us:

“As of December 2024, approximately 305 agency personnel were engaged within our 111 call centre operations. We ensured they were informed of internal vacancies and extended the opportunity to transition into substantive roles or bank contracts. A significant proportion accepted these offers, resulting in a current agency workforce of approximately 30 individuals across the organisation”.

Ambulance service feedback

Framing our 2026/27 written evidence

NHS Employers' written and oral evidence for the 2024/25 and 2025/26 pay rounds outlined several strategic pay priority areas that would help address some of the broader structural issues. Employers still consider these priorities to be relevant as they enter this pay round.

Given the progress made in bringing the 2026/27 pay setting process closer to an April implementation date, the window of opportunity for engagement and evidence collation for all parties has been limited. Therefore, this year our evidence will provide an updated contextual position on the NHS AfC workforce, covering specific areas where the NHSPRB requested information.

Section 2 – Pay under the NHS terms and conditions of service

NHS terms and conditions (TCS) apply to around 1.2 million FTE staff employed in the NHS in England, with the terms also applied by charities, social enterprises and the independent sector.

Figure 3 - Distribution of the NHS TCS workforce across the pay bands as of March 2025.

Band	FTE	% of NHSTCS workforce
Band 1	1,358	0.1%
Band 2	136,873	11.2%
Band 3	211,216	17.4%
Band 4	122,345	10.1%
Band 5	257,349	21.1%
Band 6	231,005	19.0%
Band 7	153,163	12.6%
Band 8a	60,151	4.9%
Band 8b	23,044	1.9%
Band 8c	11,806	1.0%
Band 8d	5,611	0.5%
Band 9	3,179	0.3%
Total	**1,217,099**	**100.0%**

Source: NHS workforce statistics, NHS England Digital, March 2025

Over the last decade, the NHS has seen variation in the level of investment in headline pay award uplifts and in how the award is distributed across the workforce. These are detailed in Figure 4.

Figure 4 - NHS pay awards over the last decade

Year	Headline Increase	Comment
2015/16	1.0%	Cross-government public sector pay policy limited pay awards to an average of 1% between 2013 and 2017.
2016/17	1.0%	
2017/18	1.0%	
2018/19	3.0%	Multi-year pay deal
2019/20	1.7%	
2020/21	1.6%	
2021/22	3.0%	Uniform 3% consolidated pay award to all staff.
2022/23	5.0%	£1400 consolidated award from review body. Plus revised government offer including a non-con payment (2% + a payment of £1250 to £1650 depending on band).
2023/24	5.0%	5% consolidated award agreed as part of governments 2023 offer. Increase in NHS entry pay to £11.45 per hour, and move band 2 to be a spot salary
2024/25	5.5%	Uniform 5.5% consolidated pay award to all staff plus introduction of intermediate pay points to bands 8a, 8b, 8c, 8d and 9.
2025/26	3.6%	Uniform 3.6% consolidated pay award to all staff.

Source: Agenda for Change pay advisory notices | NHS Employers

Structural reform of the AfC pay system

The 37th and 38th reports of the NHSPRB for 2024/25 and 2025/26 presented a comprehensive evaluation of the AfC pay structure and outlined the case for its structural reform. The 2025/26 report reiterated the recommendation made in the previous year: that the government should provide the NHS Staff Council with a funded mandate to address long-standing structural issues within the AfC pay system. Although this recommendation was accepted in 2024, it was not implemented at the time.

We are pleased that the NHS Staff Council has begun informal discussions to explore potential AfC pay restructure reform whilst awaiting receipt of a formal mandate. While structural reform is expected to address some of the challenges identified within the AfC pay system, the specific issues to be resolved will be determined through joint agreement. The outcome will largely depend on the financial scope of the mandate and the priorities agreed between employers and trade unions.

As part of our 2025/26 supplementary evidence submission and as referenced in the PRBs 38th report, we provided an initial estimate of the financial investment required to deliver priority reforms. Based on detailed costings for key areas, we calculated that an investment equivalent to approximately 1 per cent of the total NHS pay bill would be necessary to implement reforms with tangible impact. This figure was intended to support informed discussion and planning at the time and may be subject to revision as further conversations and analysis take place.

We also outlined the structural issues as identified by employers and proposed potential solutions. At the time of writing our 2026/27 evidence, it was not yet clear which issues would be addressed in pay structure reform discussions. A summary of the previously identified issues, supported by updated data, is provided below.

NHS Employers' strategic pay priorities

Our evidence to the NHSPRB for 2024/25 and 2025/26 set out several pay priorities that employers across the NHS had put forward as areas that needed targeted action:

- **Competitive pay for entry-level roles**: Establish a future-proofed plan to create and retain a sustainable competitive market position on pay for entry-level roles to align with planned changes to the statutory NLW and the expected trajectory of Living Wage Foundation rates of pay (band 2 and closed spot salary for band 1).
- **Targeted action at the entry point of band 5**: Ensure the NHS remains an attractive career destination for graduates by taking targeted action to enhance the entry point of band 5, keeping it competitive within the graduate labour market.
- **Pay incentives for promotion:** Develop a sustainable and targeted plan for more appropriate pay increases to be received on promotion between the pay bands. This process is to start with action to address the gaps between bands 2 and 3, bands 6 and 7, and bands 7 and 8a. Further structural reform is required across the whole system, but it is recognised that this will need to be addressed over the longer term.

- **Pay progression**: Identify options and agree a preferred approach and implementation plan to support future pay and earnings progression.
- **Anomalies in unsocial hours payments**: Targeted action to address anomalies created by the implementation of consolidated pay changes in 2023/24 and successive years of investment in base-pay changes to band 1 (closed) and band 2 in relation to unsocial hours premium payments.
- **Pay for apprentice roles**: Introduction of a consistent set of national pay arrangements to govern the rate of pay for apprentices in the NHS. (NB: this will need to assess the two pilot cohorts in 2024 and 2025 for medical apprenticeships).

The NHSPRB needs to reconsider these pay priorities this year, alongside any further updates on the work being undertaken by the Staff Council on AfC pay structure reform. There are several reasons for this:

- We have retested these priorities with employers, and they remain of equal importance to them as in previous years. They remain a priority because little progress has been made in these areas, given the short timeframe between pay rounds.
- The introduction of intermediate pay points at bands 8a-9 as part of the 2024/25 pay award round goes some way to addressing the issue around pay progression. Further targeted action is required to address the small gaps between bands across all pay bands. We set this out clearly in our evidence in previous years, with suggestions around which bands to target first.
- It remains unknown what will be included in the funded mandate from the government to support the work of the NHS Staff Council to resolve some of the structural issues, as recommended by the NHSPRB. Therefore, it is unknown if these priorities will be addressed in the mandate or not at the time of writing our report.

Intermediate pay points for band 8a to 9

From 1 April 2024, an intermediate pay point was added at each of bands 8a, 8b, 8c, 8d, and 9, meaning that staff progress after two years at the respective band.

This change was introduced to provide more regular and transparent pay progression opportunities for senior NHS staff, acknowledging their growing experience and sustained performance. By introducing intermediate pay points across bands 8a to 9, the aim was to address concerns around limited recognition between entry and top pay rates, reduce staff turnover, and improve morale. It also sought to align pay structures more closely with evolving workforce strategies and ensure greater fairness in reward systems. In our evidence last year, it was too early to determine the impact these changes had on the workforce.

Deputy HR director survey response:

This year, we asked about the impact of the changes in our survey. We asked, since the introduction of the intermediate pay step for bands 8a and above (effective April 2024), what impact, if any, their organisation has observed. 46 per cent noticed no noticeable change, whilst 54 per cent noticed an improvement in either staff morale and motivation, perception of fairness in pay progression, retention and recruitment.

The differences and variations in rates of pay, recruitment and retention across the four nations

Health has been a devolved matter for a number of decades, which means it is the responsibility of the devolved administrations for areas such as organisational control and funding of the NHS systems. Scotland, Wales and Northern Ireland all have differing health policy priorities which set the agenda for the way services are run, workforce numbers are planned, and pay is set.

The NHS Staff Council upholds the responsibility to maintain the entire pay system, however divergence from this continues. In our evidence last year, we detailed our concerns about how this undermines the integrity of the

formal structures in place to govern and oversee the entire AfC pay system.

The new NHS Scotland pay agreement introduces a total pay increase of 8 per cent spread over two years, with a 4.25 per cent uplift effective from 1 April 2025 and a further 3.75 per cent from 1 April 2026. Importantly, each annual increase is guaranteed to be at least one percentage point above the CPI inflation rate, offering staff protection against rising living costs. This deal applies to all employees under the AfC framework.

In addition to basic pay, the agreement includes adjustments to allowances, recruitment and retention premiums (RRPs), and the Scottish Framework Agreement on Two Tier Working. The Scottish government has committed £701 million to fund this package, reinforcing its pledge to ensure NHS Scotland staff remain the best rewarded in the UK.

Figure 5, 6 and 7 below, show the difference in pay between England, Scotland and Wales.

Figure 5 - England, Wales and Scotland 2025/26 AfC pay awards

Band / Step	25/26 Basic Pay and Hourly Rate Comparison							
	England		Wales			Scotland		
	Annual Basic pay £	Hourly Rate £	Annual Basic pay £	Hourly Rate £	% Difference to England	Annual Basic pay £	Hourly Rate £	% Difference to England
1|Entry	24,465	12.51	24,833	12.70	1.5%	25,560	13.25	5.8%
2|Entry	24,465	12.51	24,833	12.70	1.5%	25,694	13.32	6.3%
2|Top	24,465	12.51	24,833	12.70	1.5%	27,900	14.46	15.4%
3|Entry	24,937	12.75	25,313	12.95	1.5%	28,011	14.52	13.6%
3|Top	26,598	13.60	26,999	13.81	1.5%	30,230	15.67	15.0%
4|Entry	27,485	14.06	27,898	14.27	1.5%	30,353	15.73	11.8%
4|Top	30,162	15.43	30,615	15.66	1.5%	33,016	17.11	10.8%
5|Entry	31,049	15.88	31,516	16.12	1.5%	33,247	17.23	8.4%
5|Intermediate	33,487	17.13	33,992	17.38	1.5%	35,525	18.41	7.4%
5|Top	37,796	19.33	38,364	19.62	1.5%	41,424	21.47	10.9%
6|Entry	38,682	19.78	39,263	20.08	1.5%	41,608	21.57	8.9%
6|Intermediate	40,823	20.88	41,437	21.19	1.5%	43,441	22.52	7.7%
6|Top	46,580	23.82	47,280	24.18	1.5%	50,702	26.28	10.2%
7|Entry	47,810	24.45	48,527	24.82	1.5%	50,861	26.36	7.7%
7|Intermediate	50,273	25.71	51,028	26.10	1.5%	52,804	27.37	6.4%
7|Top	54,710	27.98	55,532	28.40	1.5%	59,159	30.66	9.5%
8a|Entry	55,690	28.48	56,514	28.90	1.5%	62,681	32.49	13.9%
8a|Intermediate	58,487	29.91	59,358	30.36	1.5%			
8a|Top	62,682	32.06	63,623	32.54	1.5%	67,665	35.07	9.3%
8b|Entry	64,455	32.96	65,424	33.46	1.5%	74,003	38.36	16.1%
8b|Intermediate	68,631	35.10	69,653	35.62	1.5%			
8b|Top	74,896	38.30	76,021	38.88	1.5%	79,164	41.03	7.0%
8c|Entry	76,965	39.36	78,120	39.95	1.5%	87,400	45.30	14.9%
8c|Intermediate	81,652	41.76	82,876	42.38	1.5%			
8c|Top	88,682	45.35	90,013	46.03	1.5%	93,685	48.56	7.0%
8d|Entry	91,342	46.71	92,713	47.41	1.5%	103,764	53.78	14.9%
8d|Intermediate	96,941	49.58	98,395	50.32	1.5%			
8d|Top	105,337	53.87	106,919	54.68	1.5%	108,206	56.09	4.1%
9|Entry	109,179	55.84	110,818	56.67	1.5%	122,736	63.62	13.7%
9|Intermediate	115,763	59.20	117,499	60.09	1.5%			
9|Top	125,637	64.25	127,523	65.22	1.5%	128,051	66.37	3.2%

Sources:

Pay bands and pay points from April 1 2025 (England), NHS Employers, May 2025
Agenda for change pay scales 2025/2026 (Wales), Welsh Government, May 2025
NHS Scotland Agenda for Change pay rates (Scotland), Scottish Government, May 2025

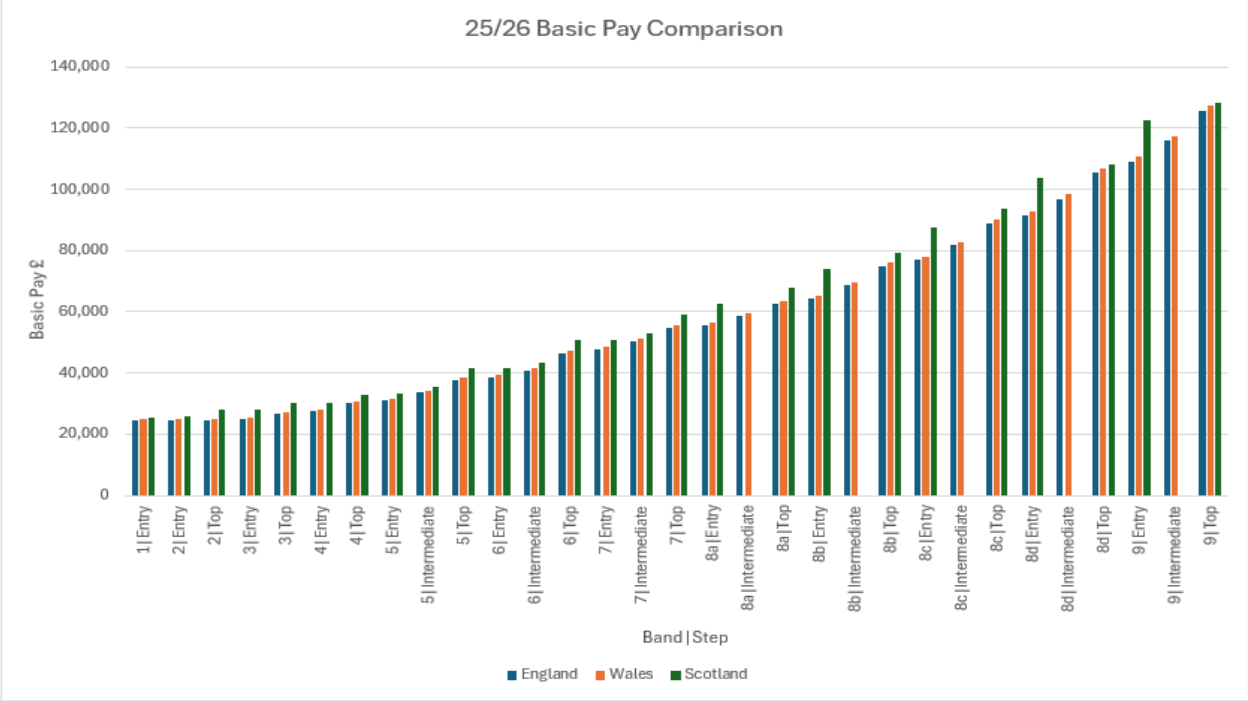
Note -

- There are no intermediate steps for Scotland for bands 8a, b, 8c, 8d and 9.
- Since 2024/25 the standard full-time week for NHS staff in Scotland is 37 hours. This compares to 37.5 in England and Wales.

Scotland is in the process of reducing the standard working week for NHS staff employed under AfC terms from 37.5 hours to 36 hours, as part of a commitment made in the 2023/24 pay settlement. The full reduction to 36 hours is now scheduled for 1 April 2026, following the Scottish government's decision to implement the remaining hour in a single step rather than in two further increments.

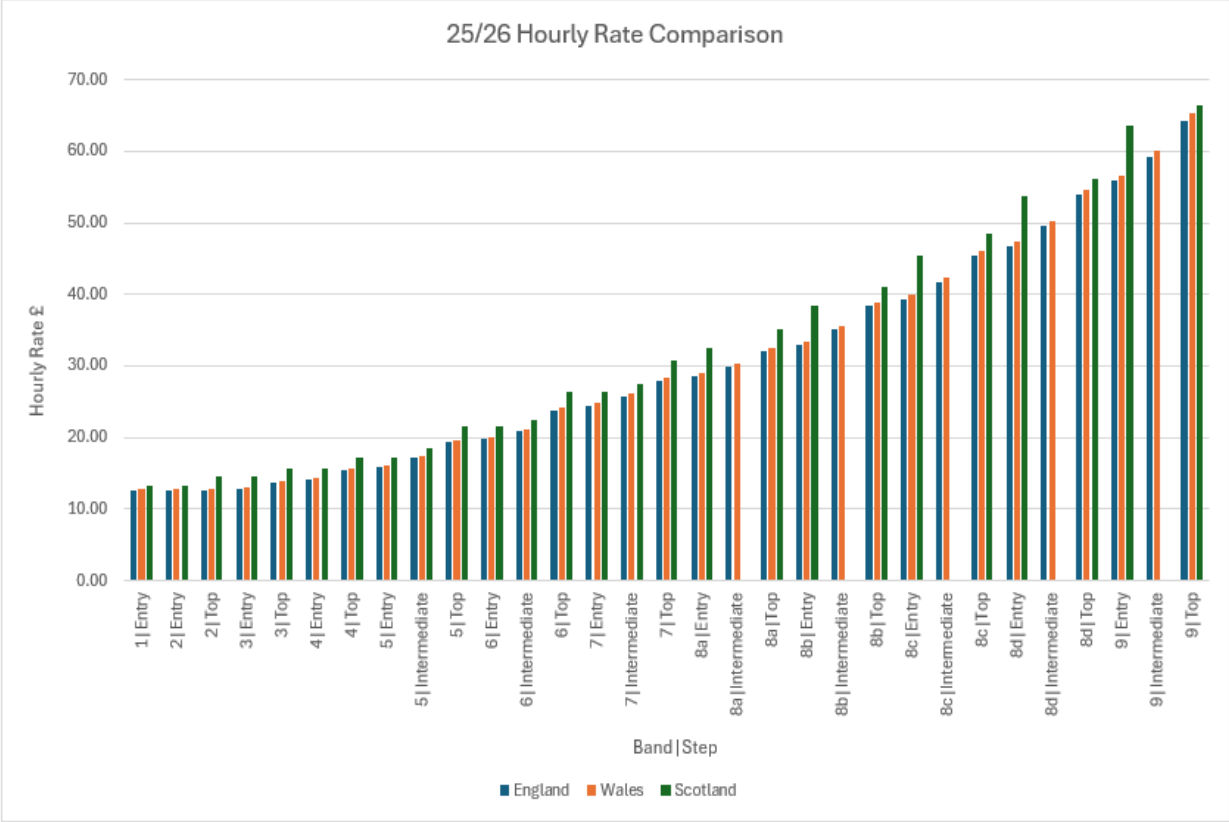
Figure 6 shows rates of pay in Wales are 1.5 per cent higher than in England across all pay points but the spacing between pay points remains broadly similar to the pay scale in England. In Scotland rates of pay are between 3.2 per cent and 16.1 per cent higher than in England, meaning that the band lengths and size of gaps between bands now bear little resemblance to the pay structure in England. Consequently, the degree to which cross-border pay disparities have an impact is likely to vary by pay bands.

Figure 6 – England, Scotland, and Wales basic pay comparison



Note – There are no Intermediate steps for Scotland for bands 8a, 8b, 8c, 8d and 9.

Figure 7 - England, Scotland, and Wales hourly pay comparison



Note – There are no Intermediate steps for Scotland for bands 8a, 8b, 8c, 8d and 9.

Through our engagement with employers working across trusts that border Scotland and Wales, we have identified some issues where pay variation is affecting the recruitment and retention of staff.

An NHS trust located near the Welsh border reported experiencing staff departures to equivalent roles in Wales that offer higher salaries. Trusts near the Scottish border reported recruitment challenges as some were competing with Scottish trusts providing higher wages for the same roles and responsibilities. This suggests the issue is having an uneven impact across organisations.

Entry-level pay and the National Living Wage

In our evidence over previous years, we have highlighted growing challenges in recruiting and retaining staff in lower pay bands due to intense competition from other sectors offering higher base pay for less

demanding roles. Despite significant investment in entry-level NHS pay, employers report that the NHS is increasingly seen as a minimum wage employer for roles that carry high physical and emotional demands.

While the NHS cannot match the private sector's agility in raising base salaries, total earnings, including overtime and unsocial hours payments, can make NHS roles more financially competitive. However, the ability of other sectors to respond quickly to cost-of-living pressures continues to put NHS organisations at a disadvantage in local labour markets.

Employers emphasise the importance of considering the full value of NHS employment, including pension benefits and additional earnings, when developing future pay policies for lower bands.

Staff working in bands 1 to 3 in the NHS make up 28.7 per cent of the total workforce. To support the lowest paid, these bands have seen the most significant investment in recent years compared to the rest of the AfC pay bands. Figure 8 highlights that over the ten years, the total headline pay increase has been between 28 per cent and 62 per cent.

Figure 8 – Ten-year comparison of basic pay by band

Band	Basic Pay - Entry Pay Point			Basic Pay - Top pay point		
	2015/16	2025/26	% Change	2015/16	2025/26	% Change
1	£15,100	£24,465	62%	£17,800	£24,465	37%
2	£15,100	£24,465	62%	£17,800	£24,465	37%
3	£16,633	£24,937	50%	£19,461	£26,598	37%
4	£19,027	£27,485	44%	£22,236	£30,162	36%
5	£21,692	£31,049	43%	£28,180	£37,796	34%
6	£26,041	£38,682	49%	£34,876	£46,580	34%
7	£31,072	£47,810	54%	£40,964	£54,710	34%
8a	£39,632	£55,690	41%	£47,559	£62,682	32%
8b	£46,164	£64,455	40%	£57,069	£74,896	31%
8c	£55,548	£76,965	39%	£67,805	£88,682	31%
8d	£65,922	£91,342	39%	£81,618	£105,337	29%
9	£77,850	£109,179	40%	£98,453	£125,637	28%

Source: NHS workforce statistics, NHS England Digital, March 2025

Rising NLW thresholds and cost-of-living pressures have driven investment in lower NHS pay bands. Figure 8 shows significant pay increases for bands 1-3 since 2015; the minimum pay for band 2 has risen by 62 per cent, which is the most significant increase compared to the other bands. Despite these increases, employers report that staff in lower bands are still leaving for less demanding roles in different sectors.

Supermarket entry-level pay in the UK is primarily determined by the retailer and location, with major chains such as Aldi, Lidl, Sainsbury's, and Tesco increasing their minimum hourly rates in 2024 and 2025 to exceed the NLW. In July 2025, Aldi increased its minimum hourly pay to £12.75 nationally and £14.05 in London for new starters, with further increases for those with more experience or service length. Figure 9 shows that basic pay at bands 1 (closed) and 2 is lower, in contrast to the Aldi minimum hourly pay, whereas band 3 is the same.

The NHS is increasingly viewed as a "minimum wage employer" for high-responsibility roles and lacks the flexibility to adjust base pay quickly in response to market competition. However, additional earnings, such as unsocial hours and overtime, can significantly boost total pay. Employers argue that total remuneration, not just base salary, should be taken into account when shaping future entry-level pay policies. However, only base pay is taken into account for NLW compliance and salary sacrifice deductions.

Figure 9 - Hourly rate of pay for all bands and the hourly pay when unsocial hours and overtime apply (2025/26).

Band|Step	Basic pay		Unsocial Hours Payment Saturdays & weekdays 8pm-6am		Unsocial Hours Payment Sundays & Public Holidays		Overtime	
	Annual (£)	Hourly rate (£)	Time + premium rate (%)	Hourly rate (£)	Time + premium rate	Hourly rate (£)	Time + premium rate	Hourly rate (£)
1|Entry	24,465	12.51	47%	18.39	94%	24.27	Time Plus 50%	18.77
2|Entry	24,465	12.51	41%	17.64	83%	22.89		18.77
2|Top	24,465	12.51		17.64		22.89		18.77
3|Entry	24,937	12.75	35%	17.21	69%	21.55		19.13
3|Top	26,598	13.60		18.36		22.98		20.40
4|Entry	27,485	14.06	30%	18.28	60%	22.50		21.09

4|Top	30,162	15.43		20.06		24.69		23.15
5|Entry	31,049	15.88		20.64		25.41		23.82
5|Intermediate	33,487	17.13		22.27		27.41		25.70
5|Top	37,796	19.33		25.13		30.93		29.00
6|Entry	38,682	19.78		25.71		31.65		29.67
6|Intermediate	40,823	20.88		27.14		33.41		31.32
6|Top	46,580	23.82		30.97		38.11		35.73
7|Entry	47,810	24.45		31.79		39.12		36.68
7|Intermediate	50,273	25.71		33.42		41.14		38.57
7|Top	54,710	27.98		36.37		44.77		41.97
8a|Entry	55,690	28.48		37.02		45.57	No additional payment	28.48
8a|Intermediate	58,487	29.91		38.88		47.86		29.91
8a|Top	62,682	32.06		41.68		51.30		32.06
8b|Entry	64,455	32.96		42.85		52.74		32.96
8b|Intermediate	68,631	35.10		45.63		56.16		35.10
8b|Top	74,896	38.30		49.79		61.28		38.30
8c|Entry	76,965	39.36		51.17		62.98		39.36
8c|Intermediate	81,652	41.76		54.29		66.82		41.76
8c|Top	88,682	45.35		58.96		72.56		45.35
8d|Entry	91,342	46.71		60.72		74.74		46.71
8d|Intermediate	96,941	49.58		64.45		79.33		49.58
8d|Top	105,337	53.87		70.03		86.19		53.87
9|Entry	109,179	55.84		72.59		89.34		55.84
9|Intermediate	115,763	59.20		76.96		94.72		59.20
9|Top	125,637	64.25		83.53		102.80		64.25

Source: NHS TCS Handbook | NHS Employers

Figure 10 – Hourly rates of pay at bands 2 and 3 including average additional earnings

Band	Basic pay (hourly rate £)	Average additional earnings estimate	Total Earnings estimate
Band 2|Entry	£12.51	£2.07	£14.58
Band 2|Top	£12.51	£2.07	£14.58
Band 3|Entry	£12.75	£1.69	£14.44
Band 3|Top	£13.60	£1.78	£15.38

Source: ESR data extract March 2025

Band 2 has an entry and top pay point, enabling staff to progress through the band over time. However, due to recent increases in NLW, and uplifts needing to be made to band 2 to remain legally compliant, as shown in figure 10, the two pay points in band 2 are now of the same pay value. This means that all staff on band 2 are paid the same fixed salary, regardless of how long they've been in the role or their level of experience.

Deputy HR director survey response:

Deputy HR directors were asked if differential pay rates should be reintroduced to band 2 pay. 52 per cent said no and 48 per cent said yes.

Those who said no said that staff at band 2 were being reduced, and these roles were either rebanded or becoming automated. It was also suggested that this role could evolve into an apprenticeship or training program.

Those who said yes said that reinstating differential pay and progression in band 2 would improve fairness, support retention, and aid recruitment, especially given these are among the lowest-paid roles. The lack of progression is demotivating and offers no incentive to stay beyond two years.

The UK government intends to introduce fair pay agreements (FPAs) in the adult social care sector across England, Scotland, and Wales. This move responds to longstanding challenges in the sector, including low pay, poor working conditions, high turnover, and limited union representation. The adult social care workforce is substantial, with over 1.5 million workers in England alone, making it larger than the NHS workforce. Despite its size, the sector faces acute recruitment and retention issues, with domestic recruitment declining and international hires increasingly filling the gap.

To address these challenges, the government plans to establish sector-wide negotiating bodies through powers granted in the forthcoming ERB. These bodies will bring together employers, workers, and unions to negotiate legally binding minimum standards for pay and conditions. The FPAs will not replace existing employer-level bargaining but will set a baseline across the sector. In England, the focus will be on adult social care, while Scotland and Wales will include both adult and children's social care.

Given the close links between adult social care and health services, it will be important to monitor how FPAs interact with the AfC pay structure, as any disparities could affect workforce movement and service integration.

National Living Wage (NLW) position

The NLW was raised to £12.21 per hour from April 2025. Due to the NHS pay award being delayed, to maintain legal compliance with the NLW from 1 April 2025, an interim pay uplift was introduced. This temporary uplift raised the band 1 and band 2 hourly rate to £12.36, while band 3 entry point was also increased to £12.59 to preserve pay differentials.

At the time of writing our evidence, no changes to the NLW from 1 April 2026 have been confirmed. However, in August, the government published the Low Pay Commissions (LPC) remit restating the NLW from April 2026 should not drop below two-thirds of UK median earnings. In response, the LPC published indicative figures; a central estimate of £12.71 (which would ensure the NLW does not drop below two-thirds of median earnings), with a range around this central estimate which runs from £12.55 to £12.86. Both the central estimate and the range are an increase from previously published estimates in May. The LPC will provide its recommendations by the end of October 2025, with confirmation of the NLW from 1 April 2026 to be confirmed shortly after.

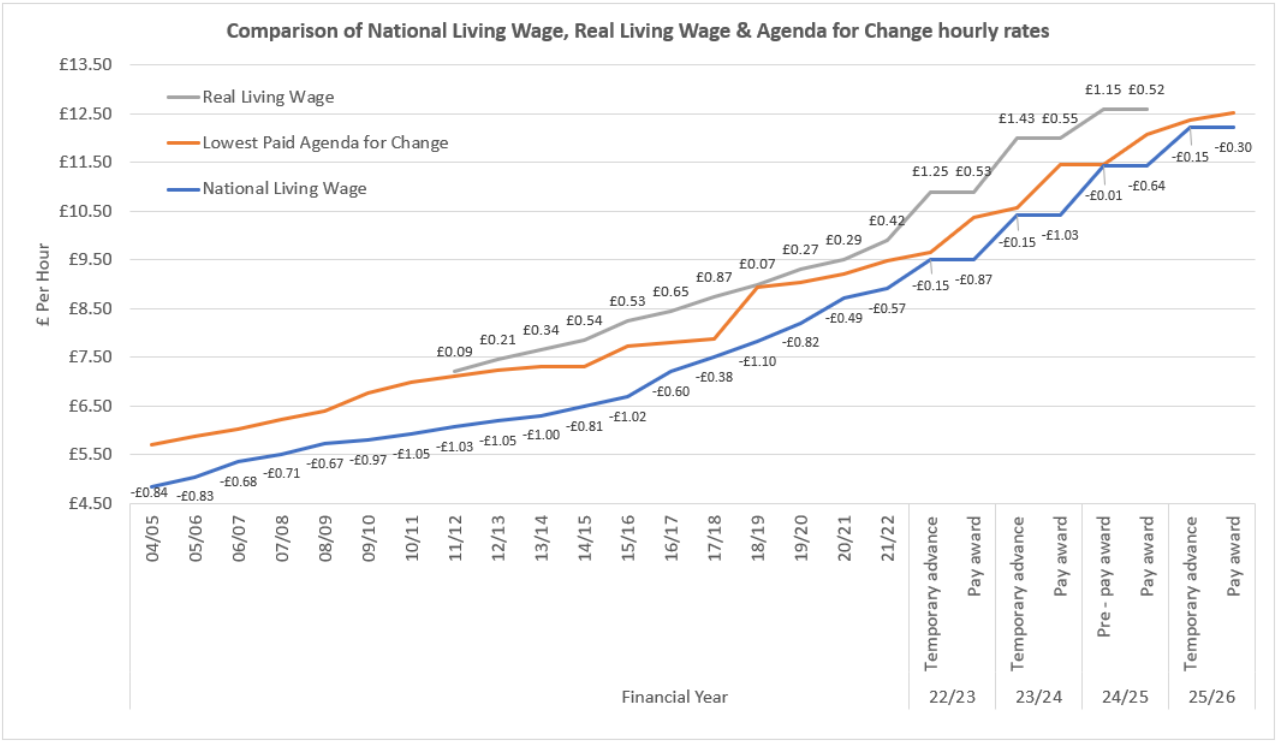
As a reminder, band 2 entry currently sits at £12.51 per hour, which is below the LPC indicative figures. Band 3 entry sits at £12.75 per hour, sitting close to the central estimate and below the upper range. Unless the 2026/27 NHS pay award is implemented in April and results in hourly rates exceeding the projected NLW, interim measures, like those applied this year, will be required. Figure 11 illustrates how the lowest hourly pay and NLW for each year compare, highlighting instances where temporary pay advances have been made.

Figure 11 also illustrates the erosion of the NHS buffer above NLW over the last eleven years. In 2021, the gap narrowed between AfC pay and the NLW and it has continued to track closely against it in the years since. A small buffer above NLW causes issues with salary sacrifice and net deduction schemes for employers, which are a core part of the NHS total reward offer. We explore issues related to NLW, salary sacrifice, and net deduction arrangements in section 5.

NHS Employers continues to advocate for a longer-term approach to entry-level pay that aligns with projected NLW increases and considers the RLW position, aiming for stability and competitiveness. Yet, this could require ongoing investment in lower bands, potentially compressing the pay structure further unless other intervention elsewhere in the pay structure is taken.

We acknowledge the increasing importance of considering the interaction of the NHS pay structure with the RLW, particularly for entry-level roles. The RLW, set by the Living Wage Foundation, rose to £12.60 per hour in October 2024, surpassing the statutory NLW of £12.21. Some NHS organisations have already adopted aligning pay to the RLW, including all NHS organisations in Wales and Scotland. Trusts in London meet the RLW as they can include HCAS payments. However, those outside of London that have chosen to align with the RLW do not receive any additional funding for this. If the 2026/27 pay award does not bring AfC pay in line with the RLW, employers who choose to align with the RLW will continue to face local cost pressures.

Figure 11 - Comparison of the NLW and the lowest hourly rates on AfC (per hour).



Source: Past Living Wage Rates

Pay for apprentice roles

The 10 Year Health Plan emphasises expanding NHS apprenticeships to support a more sustainable and locally grown workforce. The plan includes commitments to increase nursing and entry-level apprenticeships, create accessible training pathways for underrepresented groups, and reduce reliance on international recruitment.

In August 2025, NHS England and the DHSC confirmed mitigation funding for level 7 apprenticeships in five key health and care professions until 2029. This funding will support:

- advanced clinical practitioner
- specialist community public health nurse
- district nurse (community specialist practice qualification)
- clinical associate in psychology
- population health intelligence specialist.

Funding will be distributed nationally via the education and training activity programme (ETAP) based on workforce need, provider capacity, and strategic priorities. Employers will need to submit expressions of interest.

In our 2025/26 evidence, we reported a wide variation in how apprentices are paid across trusts, with approaches ranging from using Annex 21 of the NHS TCS Handbook to aligning pay with role-based bands or national recommendations. This inconsistency has made it challenging to implement a unified approach.

Most employers support the idea of a nationally agreed-upon apprenticeship pay framework to create clearer, equitable banding arrangements. A previous attempt to formalise apprenticeship pay in the NHS Staff Council 2018 framework was unsuccessful due to cost concerns. Current engagement indicates that focusing on a broader pay framework, rather than just apprentice rates, may be a more feasible path forward.

Pay incentives for promotion – gaps between NHS pay bands

Incentivising promotion remains a key priority for employers. Figure 12 illustrates the current monetary and percentage gaps between the top of one NHS AfC pay band and the bottom of the next for 2025/26. These gaps are generally small, with most falling below 3.5 per cent, and do not sufficiently reflect the added responsibilities or complexity of roles in higher bands.

Figure 12 - Pay gaps between bands.

25/26		
Gap Between	Gap £	Gap %
Band 2 -> Band 3	£472	1.9%
Band 3 -> Band 4	£887	3.3%
Band 4 -> Band 5	£887	2.9%
Band 5 -> Band 6	£886	2.3%
Band 6 -> Band 7	£1,230	2.6%
Band 7 -> Band 8a	£980	1.8%
Band 8a -> Band 8b	£1,773	2.8%
Band 8b -> Band 8c	£2,069	2.8%
Band 8c -> Band 8d	£2,660	3.0%
Band 8d -> Band 9	£3,842	3.6%

Source: NHS TCS Handbook | NHS Employers

The lack of pay progression between the bands can reduce the incentive for staff to pursue promotion, particularly when the financial reward does not reflect the increased expectations or workload associated with higher bands. Over recent years the gaps between pay bands have eroded down to levels that have led to difficult recruitment challenges for some roles.

In our 2024/25 evidence to the NHS PRB (page 34) we set out in detail the issues relating to the gaps between bands across the AfC pay structure, and in our 2025/26 evidence to the NHS PRB (page 31) we suggested that the process should address the gaps between bands 6 and 7, and bands 7 and 8a first, with recognition that structural reform over the longer term is required across the whole pay structure. In our supplementary evidence in the 2025/25 pay round, we also included the

additional priority of the gap between band 2 and band 3, due to the increasing levels of band 2 clinical support workers being re-banded to band 3.

The issue is further compounded by the way unsocial hours and overtime are structured. As we explored in our 2024/25 evidence to the NHS PRB (page 29), in some cases, staff in lower bands who work nights, weekends, or bank holidays can earn more overall than when they progress to a higher band, and no longer work unsocial hours, or overtime rates no longer apply to them. This can distort the perceived value of progressing to a higher band, especially when the base pay increase is minimal. As a result, some staff may choose to remain in lower bands where they can maximise earnings through enhanced rates, rather than pursue roles with greater responsibility but less opportunity for additional pay. This dynamic can undermine career progression and create inconsistencies in how effort and commitment are rewarded across the workforce.

Graduate entrants and trajectory pay

21.1 per cent of the NHS workforce is made up of band 5 staff and is the level where all graduate professionals begin their NHS employment. The highest concentration of the workforce remains in bands 5 and 6, which reflects the technical expertise and significant numbers of registered staff that the NHS needs to employ. Ensuring the NHS offers competitive rates of pay and earnings progression for this group of staff remains vital in addressing recruitment and retention issues at the graduate entrant level.

Analysis of the graduate labour market statistics reveals that NHS graduate entry pay is broadly competitive within the market, with the median real-terms salary for a graduate in the UK standing at £26,500 in 2024. This compares favourably with graduates in sectors such as agriculture, forestry, and fishing, where median salaries are lower, and is broadly aligned with the broader graduate population across industries. For context, postgraduates earned a median real-terms salary of £29,500, while non-graduates earned £19,500, highlighting the value of degree-level qualification.

Nurses and other clinical graduates

Barriers to employment for newly qualified nurses and other clinical graduates have sparked concern. We have heard that final-year nursing students started protests after learning there were no job opportunities for newly qualified nurses at an NHS trust in London, where many completed their placements. This local incident highlights a broader national issue, as evidenced by a petition signed by over 80,000 people urging the government to take action and remove employment barriers for new nurses.

In August 2025, the UK government introduced a new graduate guarantee to support newly qualified nurses and midwives in England, ensuring they have access to employment upon graduation. NHS organisations will now be encouraged to recruit based on projected workforce needs, rather than waiting for vacancies to arise, allowing for more proactive and strategic hiring.

This has caused some concern among the ambulance sector, as hundreds of newly qualified paramedics are forecast to have no post to go to in the coming year (neither in ambulance trusts, primary care, or community services). Still, there is no comparable guarantee for these graduates. Additionally, an acute trust voiced its criticism of the graduate guarantee, highlighting that it is contradictory for there to be workforce reduction mandates at the same time as promises of jobs made to new graduates.

To further support midwifery graduates, the government will remove barriers to enable trusts to temporarily convert vacant maternity support worker posts into band 5 midwifery roles, backed by £8 million in funding. An online hub will also be launched to provide guidance and support for graduates navigating the job application process.

The package has been developed in collaboration with key stakeholders, including NHS employers, the RCN and the Royal College of Midwives (RCM). It aims to improve workforce planning, enhance retention, and ensure a smoother transition into employment for newly qualified professionals, ultimately strengthening patient care and service delivery across the NHS.

Graduate pay and student debt

Evidence shows that pay increases in the NHS for non-graduate entry-level roles have been significantly higher than those for graduate roles since 2014.

Figure 13 – Starting salary comparison between bands 2 and 5 showing the cumulative increase since 2017/18

	Band 2		Band 5	
Year	Starting Pay	Cumulative Increase since 2017-18	Starting Pay	Cumulative Increase since 2017-18
2017-18	£15,404	0.0%	£22,683	0.0%
2018-19	£17,460	13.6%	£23,023	1.5%
2019-20	£17,652	14.9%	£24,214	6.7%
2020-21	£18,005	17.2%	£24,907	9.8%
2021-22	£18,546	20.8%	£25,655	13.1%
2022-23	£20,270	32.2%	£27,055	19.3%
2023-24	£22,383	46.2%	£28,407	25.2%
2024-25	£23,615	54.4%	£29,970	32.1%
2025-26	£24,465	60.0%	£31,049	36.9%

Source: Agenda for Change pay advisory notices | NHS Employers

NHS nursing bursaries in England officially ended on 1 August 2017. From that date, new students who started nursing, midwifery, and most allied health profession courses were no longer eligible for the NHS bursary, which had previously covered tuition fees and provided maintenance support.

2026 brings several updates to student loan repayment in the UK, particularly for those with newer Plan 5 loans. Students who started courses in 2023 or later under Plan 5 will begin repaying from April 2026. Repayments are set at 9 per cent of income over £25,000. This shift increases the likelihood that newly qualified nurses will start repaying their loans soon after graduation.

At the same time, the repayment period has been extended to 40 years, making it more likely that graduates will repay over a longer span, potentially without ever clearing the full debt. While interest accrues more

slowly under Plan 5, these changes mean many nurses will contribute towards loan repayments for most of their careers.

There is a risk that the more student loan repayments impact graduates' take-home pay, it could result in a decrease in morale and motivation and leave them feeling like they are not being sufficiently remunerated for the level of demands placed on them within their roles, particularly when they have just embarked on their postgraduate career.

The RCN are actively campaigning for a debt write-off scheme based on NHS service years. If adopted, future graduates could see chunks of debt erased after three, seven, or ten years in the NHS. The model reflects research showing that high levels of debt are discouraging students from pursuing nursing and driving qualified professionals out of the NHS earlier than they would otherwise. The campaign focuses on utilising financial relief as a means to strengthen the NHS workforce and support nurses who dedicate themselves to public service.

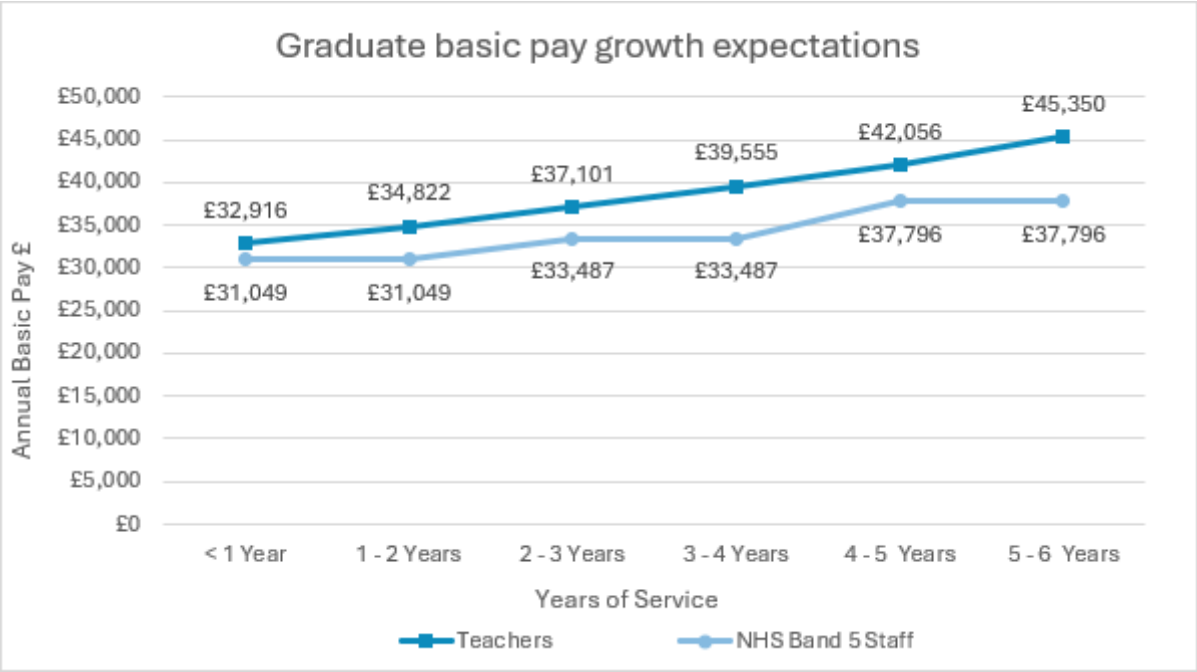
Pay progression and retention in graduate roles

Teaching is a graduate-entry profession within the public sector, and salaries are structured within nationally agreed pay ranges set out in the school teachers' pay and conditions document for maintained schools. Teachers typically start on the main pay range, which begins at £32,916 outside London and rises with experience and progression. The pay structure also includes the upper pay scale, leadership pay scale, and additional allowances for responsibilities like special educational needs (SEN) or teaching and learning leadership (TLR).

The performance-related pay (PRP) system was officially removed for the 2024/25 academic year, meaning progression is no longer tied to appraisal outcomes in maintained schools. Teachers typically advance one point on their pay range each year, unless they're subject to formal capability procedures. This applies across the main pay range (M1–M6) and the upper pay scale (UPS1–UPS3), although movement to the upper scale still requires a threshold application.

Comparing teaching salaries to NHS band 5 pay is valuable because both represent graduate-entry roles within the public sector, offering clear pathways for career progression. Figure 14 compares basic pay of expectations of teachers and newly qualified graduates joining the NHS at band 5, by years of service.

Figure 14 – Graduate pay growth of NHS band 5 staff and teachers.



Source: Teachers Pay NHS Pay

Teachers might be expected to progress through the six spine points of the main range conditional on a recommendation being made as part of annual appraisal. Payment of the upper range is by application, and acceptance is conditional upon being considered highly competent in all elements of the relevant standards and having substantial and sustained achievements and contribution. Movement to the upper pay scale is not contingent on competitive application for a new post.

By contrast, band 5 staff progress through a three-point scale, with the mid-point being accessed after a minimum of two years and the top point being reached after four years of service. Once the top point has been reached, further pay progression to band 6 would require competitive application to a band 6 role.

Upon graduation, a newly qualified teacher earns a basic salary of £1,867 more than a newly qualified nurse - a difference of 6 per cent. After five years, a nurse who has progressed to the top of band 5 would earn £37,796, while a teacher at the top of the main pay range would earn £45,352 - approximately 20 per cent more. While some nurses will advance to band 6 and many teachers will move to the upper pay scale, the timing and likelihood of such progression varies significantly, making direct comparisons less reliable beyond this point. Nurses have scope to increase their earnings (averaging an additional 12 per cent) for undertaking work in unsocial hours, overtime and bank work. The scope for teachers to increase their earnings is more limited.

However, in the current climate of rising living costs and growing scrutiny of pay structures across the public sector, individuals may be increasingly mindful of long-term earning potential when selecting or reconsidering a career path. With pay trajectories in industries like education offering higher basic pay, and without the need to work unsocial hours, these comparisons could play a larger role in influencing career decisions, particularly for new graduates and early-career professionals.

To ensure the NHS can continue to recruit to graduate roles, it is critical that it remains competitive in the broader graduate labour market, and that the basic pay of band 5 does not further slip behind comparator professions such as teaching.

Figures from the University and College Admissions Service (UCAS) show that 30,550 applications have been made to study nursing in the UK in 2025 before its January deadline. This marks the lowest number of applications since records began in 2019 and a 34 per cent decline since 2021, a year which saw significant interest in nursing programmes following the COVID-19 crisis.

Police officers across England and Wales are set to receive an above-inflation 4.2 per cent pay rise, the government has announced. The pay increase will mean the starting salary for a police constable will be £31,163, an increase of £1,256. The typical salary for a constable who has been in post six years will be £50,257 and the average earning for a

chief superintendent will be £98,500. In addition to the headline pay rise, the government is also increasing on-call, away-from-home, and hardship allowances by £10.

The Pathway to Progression: Band 5-6 Career Progression for Nursing report, published by the RCN in May 2025, outlines a case for reforming career progression from band 5 to band 6 for nurses under the NHS AfC pay framework. Newly registered nurses start on band 5, with progression to band 6 dependent on experience, training, and support. However, progression to band 6 tends to be slower for nurses than for those in other healthcare professions, such as midwives and paramedics, who typically start their NHS careers at band 5, with progression to band 6 based on structured development programmes over a two-year period. Nearly half of all registered nurses in the NHS in England remain at band 5 after several years, and career progression varies by location and speciality, mainly dependent upon the availability of band 6 posts to be promoted into.

According to the Institute of Student Employers (ISE), graduate salaries across many sectors show strong upward trajectories over the first few years of employment. Their 2025 Student Development Survey reveals that graduates typically see their earnings rise from a median of £32,000 at entry to £50,000 after just three years, representing a 56 per cent increase. In some sectors, such as law and finance, earnings can exceed £90,000 within the same timeframe, driven by structured development programmes and performance-based progression.

This data highlights a growing disparity in long-term earning potential between NHS band 5 roles and graduate roles in other sectors. While NHS band 5 staff often reach the top of their pay band within four years, their salary progression then plateaus unless they get promoted into higher bands, which can be inconsistent and dependent on local opportunities. The ISE findings reinforce the need for the NHS to offer more transparent and more competitive pay progression pathways for graduate-entry staff.

Section 3 – Non-pay elements of the AfC deal

Delivering on pay deal recommendations

The Secretary of State for Health and Social Care (SoS) accepted 36 out of the 37 joint recommendations made following the work undertaken by the NHS Staff Council, NHS Employers, NHS England and the DHSC as part of the 2023/24 pay deal agreement. The NHS Staff Council has begun working with all stakeholders and has agreed on key priorities to take forward over the next two years. Some of the key actions agreed include reinstating the job evaluation (JE) and nursing career progression task and finish groups.

The NHS Staff Council is also working with DHSC and NHS England to agree a work plan to deliver the recommendations from the reducing agency spend work stream..

As part of its overall responsibility, the NHS Staff Council's remit includes maintaining the NHS terms and conditions. As part of its work plan for 2025/26 and 2026/7, it has commissioned a more comprehensive review of the NHS TCS Handbook.

The recommendations from the reducing agency spend workstream will be incorporated into the handbook review workstream. Additionally, as part of the handbook review work, the NHS Staff Council is considering recommendations made by the nursing career progression workstream,

with particular focus on recognition of overseas experience when setting starting salaries for NHS staff and Annex 20. This work is also supported by our terms and conditions network, with which we regularly engage and seek input.

Job evaluation related recommendations from the 2023 pay round

We were pleased that the SoS accepted all three recommendations made by the NHS Staff Council in 2023/24 to improve JE practices and consistency of outcomes across the NHS. It is hugely significant that the SoS has explicitly referred to the need for good JE practice, and that senior leaders in NHS England have written to NHS chairs and CEOs to the same effect.

Since the announcement, we have collaborated with DHSC and NHS England to develop a work plan for implementing the recommendations and are pleased to provide both policy leadership and administrative support. In short, the recommendations will be delivered by:

- a programme of data gathering for oversight and assurance purposes by NHS England
- the agreement of a new section or annex on JE in the handbook to emphasise the contractual nature of the JE scheme and set out principles and minimum standards for its operation, and
- the procurement of a digital system for JE across England.

Employers hope that these discussions will enable the NHS Staff Council to look to the future of the Job Evaluation Scheme (JES) as well as addressing concerns evident at present.

We have previously reported concerns to the NHSPRB about the inability to monitor compliance with operational requirements or banding outcomes at either an ICS, regional, or national level, which raises concerns that there may be significant problems and equal pay risks throughout the service. The delivery of the new digital system for JE in England will address this. Still, we also hope it will be an opportunity to consider how technology can enhance the application of the

scheme. This could bring both productivity and consistency gains for employers and staff.

The results of this work, however, will be implemented in a service facing considerable financial challenges and the disruption and uncertainty that come with organisational change at national, strategic, and local operational levels. Ensuring resources to undertake and oversee JE at all levels will be vital to the success of efforts to improve JE performance and consistency as intended.

Mileage negotiations

DHSC provided the NHS Staff Council with a mandate to reach a negotiated agreement on the mechanism for calculating mileage reimbursement, as outlined in Section 17 and Annex 12 of the NHS TCS Handbook. One of the key objectives of the negotiations is to ensure that any recommendations made are sustainable and can account for fluctuations in the changing market.

As part of this work, the NHS Staff Council may also provide recommendations related to the NHS's carbon reduction plans, service needs, and the requirement to establish a fair framework for reimbursing work-related travel costs.

Negotiations commenced in September 2024, and extensive work has already been done in partnership with employer and staff side representatives. Relevant data from the Electronic Staff Records (ESR) has been collected, which has been integral in the negotiation discussions. Further modelling is currently being undertaken to understand all options in more detail, before concluding negotiations and submitting recommendations to the NHS Staff Council.

Section 4 – The principle of equal pay for work of equal value

Job evaluation

JE remains in the spotlight as we enter the next pay round, and we have been supporting employers in increasing their understanding of and capacity to undertake JE effectively throughout the last year.

The principle of equal pay for work of equal value in the NHS

As we noted last year and as NHSPRB members will be aware, one of the main drivers for the creation of the AfC harmonised pay structure in the NHS was an equal pay claim (Enderby v Frenchay Health Authority and Secretary of State for Health [1993] IRLR 591, ECJ) which held that separate collective bargaining structures do not automatically provide objective justification for pay inequality.

It is important to re-state that there have not been any significant legal cases relating to equal pay in the NHS since Hartley-v-Northumbria-Healthcare (2009), which held that the AfC pay structure and the JES that underpins it does not discriminate on ground of sex and satisfies the requirements of the then Equal Pay Act 1970. This case emphasised the importance of robust application of the JES at local level.

We are not aware of any legal claims against NHS organisations currently going through the court system but have heard, albeit anecdotally, that equal pay issues tend to be resolved before proceedings are launched. However, we are aware of increasing concern expressed by medical staff that AfC staff they work alongside receive higher rates of pay than they do. In our evidence last year, we noted that the different collective bargaining arrangements between staff covered by the NHSPRB and the DDRB could result in pay inequality particularly between advanced clinical practitioners and resident doctors, although this has never been tested. Similarly, potential pay inequality could be seen between staff on very senior managers (VSM) or executive senior managers (ESM) pay rates and higher banded AfC staff. The ambition outlined in the 10 Year Health Plan for skills based, flexible workforce could highlight these tensions further.

Whilst there have been no significant equal pay cases, it is of concern that industrial action is still prevalent across the service where the dispute contains elements relating to JE practice and application. Often these disputes hang on definition and interpretation of words or values within the scheme criteria, and we have supported the NHS Staff Council Job Evaluation Group (JEG) to respond to an increased number of queries asking for support and advice in such cases.

We would also bring to your attention the impact on JE and therefore pay of increasing educational requirements from professional / regulatory bodies. As an example, recent changes to the nursing and midwifery's education standards for "part three" of their register to a masters level qualification means that a higher level of knowledge is now required in the JE of any roles, for example health visiting, that require this registration. This could see the pay band increase regardless of whether there is a change in job requirements. Master's level education is increasingly being seen as a requirement for some entry level roles that previously would have required a degree. Such increasing educational requirements could lead to compression in pay banding for some clinical/technical roles that may be perceived as iniquitous by other occupational groups.

Nursing and midwifery profile updating

The updated profiles for nursing and midwifery were published at the beginning of June 2025 alongside supporting guidance for job matching panels. Pre-publication, we had issued guidance to employers encouraging them to take action in advance of publication and avoid the disputes and challenges that arose with clinical support worker banding. Our advice focused on the need to have robust systems in place to monitor job demand and keep job descriptions up to date, as well as to ensure effective JE practices and capacity.

Feedback from employers, both pre- and post-publication, indicates that they do not anticipate wholesale re-banding claims, but rather that any impact on banding will come from job description updates rather than changes made within the profiles themselves. Many have also reported making good progress in partnership with local trade unions, which is encouraging to see.

We supported the NHS Staff Council in producing guidance for NHS organisations, which was published simultaneously with the updated profiles. It sets out the Staff Council's expectations of employers, and the principles that need to underpin all work on JE, whether at the local or national level.

The NHS Staff Council guidance emphasises the need for local employers to have sufficiently trained JE panellists to undertake JE in-house rather than outsourcing it to other bodies. Employers continue to report problems in securing funding to train staff to sit on panels, with finance teams referencing restrictions placed on expenditure by NHS England regions or ICBs. Whilst we have clarified that there has been no central instruction on this, it does illustrate the difficulty organisations/boards are having managing their financial position and their employment relations requirements concurrently.

We worked with colleagues in NHS England and DHSC to ensure a shared understanding of the work employers were undertaking and the support they needed.

Section 5 – Pensions and total reward

Pensions

Though our engagement with employers, we know that the most important themes remain ensuring equal access to scheme membership and equitable pension saving outcomes for members.

There is a need for increased automation and digitisation to relieve local pension administration pressures and free up time for vital scheme communications and engagement activity. This will enable employers to use the scheme strategically to help meet their workforce challenges and recruit, motivate and retain a skilled workforce.

NHS Pension Scheme membership data and trends

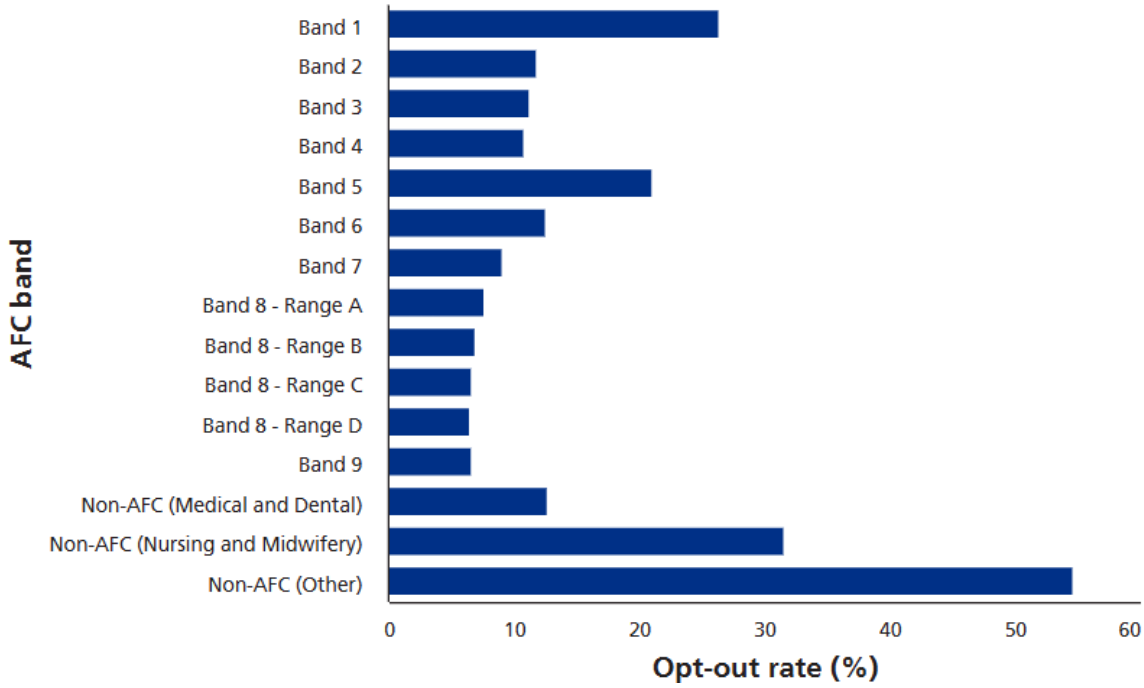
The NHS Pension Scheme is one of the most generous in the UK and is the largest public service defined benefit scheme in Europe. The scheme is a significant part of the total reward offer for NHS employees and a valuable tool for employers to use for recruitment, retention and motivation.

Overall, membership levels in the NHS Pension Scheme are generally high. However, when membership data is analysed by categories such as pay band, role, gender and ethnicity, it reveals that certain groups of staff are less likely to join the scheme than others. Employers feel strongly that the NHS Pension Scheme should be inclusive and attractive to all NHS staff, to ensure it remains an effective tool for recruitment, retention and reward across the workforce.

Opt-out data by pay band

Generally, lower-paid staff are less likely to join the scheme than higher-paid staff. Opt-out rates at band 1 (23 per cent) and band 5 (21 per cent) are significantly higher than those at bands 7 and above (ranging from 6-9 per cent). Since band 1 is now closed, the high opt-out rate could be in part influenced by the very small sample size.

Figure 15 – Opt-out rates by band.



Data over the past five years shows that the opt-out rate for staff at band 5 has risen significantly from 13 per cent in 2020 to 21 per cent as of April 2025. Employers suggested that this could be because cost-of-living pressures may be felt strongly by this group, particularly those entering the NHS at a graduate level. They may be subject to university debt and may be prioritising immediate financial commitments, such as paying rent or saving for a first home, over saving towards their retirement.

Employers suggested that generational behaviour may also be a factor; younger people may not expect to spend their whole career in the NHS and may not see the benefit of investing in a workplace pension. We feel that further research and evidence are needed, potentially through staff focus groups, to better understand what is driving opt out behaviour at each band.

Opt-out data for international employees

Opt-out rates for international recruits are higher than average. Data from the last 12 months shows that the non-UK national opt-out rate is 26 per cent compared to the UK national rate of 10 per cent. Broken down by continent of nationality, those from Asia (36 per cent) and Oceania (32 per cent) have the highest opt out figures, followed by Africa (23 per cent), the Americas (21 per cent), and finally Europe (10 per cent).

When asked about why this could be, employers suggested that some internationally recruited staff may join the NHS with a short-term plan to earn, learn and return. In many cases, surplus income may be sent to support family abroad, and many plan to return home themselves, so long-term pension benefits may not be a priority. It was suggested that some international recruits using English as a second language may face challenges in understanding the benefits of the NHS Pension Scheme, particularly due to complex terminology and communications. Many may be unaware that they can still access their NHS Pension should they choose to leave the UK. Improving pension education and tailoring communications may help raise awareness and support informed decision-making.

Our information is based on anecdotal feedback from various sources and does not constitute a reliable data source. It isn't appropriate to speculate further as to the reasons international staff members opt out of the scheme. We feel more research is required to better understand opt-out behaviour for this group.

Opt-out data by ethnicity

Data over the past 12 months (May 2024-April 2025) shows that those with Asian (25 per cent) and Black (18 per cent) ethnicity have the highest opt out rates, compared to those with White (10 per cent) ethnicity, who have lowest opt-out rates of all. More research is needed to understand the reasons behind differing opt-out rates across these groups.

Opt-out data by gender

Opt-out data for males and females is relatively similar. The opt-out rate for males is 15 per cent, which is just slightly higher than the opt out-rate for females (13 per cent).

We will be working with the NHS Pension Scheme Advisory Board (SAB) to explore and understand how retirement outcomes for male and female members of the NHS Pension Scheme may differ. This work will help us to understand our gender pension gap and recognise the key drivers, with a view to advising the SoS on mitigations to ensure equitable outcomes in retirement for all members.

Reasons for opting out

According to data from opt-out forms completed by members, the reason given for more than three quarters of opt out instances is affordability related, either 'affordability' or 'temporary opt out due to financial priorities'. The proportion of instances stating one of these reasons for leaving the scheme has increased 5 per cent in the last 12 months.

Currently, the scheme does not offer any membership flexibilities. Members either opt in and pay the full contribution percentage, or they opt out, missing out on valuable benefits. As data shows, many do not find the current member contribution rates affordable. NHS staff are navigating the difficulties of balancing immediate financial responsibilities and find it difficult to prioritise paying into the pension scheme for their future.

We believe that staff groups with high opt-out rates could benefit from the introduction of flexibilities into the scheme. Allowing members greater control and autonomy over their pension savings would enable more affordable access and could ensure the NHS Pension Scheme remains a valuable benefit for everyone.

The scheme also offers additional valuable benefits such as life assurance, retirement flexibilities and ill-health retirement that are lost if members choose to opt out. Our value of the NHS Pension Scheme poster supports employers to raise awareness of the key benefits and to promote the overall value of the scheme to all parts of their workforce.

Flexible retirement

The NHS Pension Scheme offers members flexibility about how and when they retire. One flexibility, introduced to members of the 1995 Section of the scheme from October 2023 is partial retirement. Members may take between 20 to 100 per cent of their pension benefits while remaining in work. To be eligible, they must have reached minimum pension age and reduce their pensionable earnings by at least 10 per cent for 12 months.

SAB have been monitoring the uptake of partial retirement. Data from NHS Pensions shows that 26,853 partial retirements were processed between 1 October 2023 and 30 June 2025, which equates to 32.82 per cent of eligible members. We know from data seen by SAB from NHS Pensions that, of those eligible:

- 65 per cent of eligible hospital doctors have taken partial retirement
- 43 per cent of eligible hospital dentists have taken partial retirement
- 42 per cent of eligible special class nurses have taken partial retirement
- 31 per cent of eligible nurses without special class status have taken partial retirement.

We are pleased to see that partial retirement has proven a popular retirement flexibility with members, potentially supporting retention where full retirement and leaving employment was previously the only route to members accessing their pension benefits.

We cannot track data on the number of members who retire and return, so it is not possible to draw comparisons between these two flexibilities. We have continued to promote retire and return as an option where partial retirement cannot be facilitated. We encourage employers to offer the same terms and conditions of service and maintain continuity of employment during retire and return to retain valuable, skilled and experienced members of staff.

Feedback from employers indicates that partial retirement is helping with retention. An ambulance trust shared that it has been a welcome option for many of their staff – they have discussed and agreed all partial retirement requests and have a partial retirement panel. One integrated care organisation in the midlands has reported positive impacts of partial retirement on staff wellbeing, including reduced sickness absence, improved work-life balance and reducing stress levels. Over 550 of their staff have partially retired. Recognising its potential benefits, the trust actively promotes partial retirement and encourages line managers to support staff through the process.

We receive consistent levels of queries from employers with regards to two key areas of partial retirement, these are:

1. the interaction of partial retirement on redundancy
2. the 10 per cent reduction to pensionable pay and the accompanying change in contract terms.

We are in the process of updating our partial retirement guidance for employers to provide employers with clarity on these two areas and will continue to provide targeted support through our enquiry handling.

McCloud

The review body will be familiar with the McCloud remedy as the process of removing the age discrimination from public service pension schemes, including the NHS Pension Scheme.

Members will be asked to make a choice on whether they would like to receive 1995/2008 Scheme pension benefits or 2015 Scheme pension benefits for their membership between 1 April 2015 and 31 March 2022, known as the ‘remedy period’. Most members will not need to make this choice until they apply to take their pension. NHS Pensions are working to update the retirement application process to offer members their McCloud choice on retirement.

As detailed in a recent ministerial statement, the delivery of remedial service statements (RSS) has been delayed and a new timetable will be

issued once confirmed. Members who have already retired need their remedial service statement (RSS) to able to make an informed decision on their remedy benefits and receive any compensation due.

The implementation of choice on retirement has also been delayed, meaning the number of members needing to make a retrospective choice based on their RSS is increasing. The delays are disappointing and confusing for both members and employers, adding to the complexity of McCloud, and in some cases, affecting confidence in scheme administration. Communications are essential in helping members to make informed financial decisions and take any necessary action required.

We recognise that the limited scheme administrative resource available is used to focus on the successful delivery of McCloud. We continue to advocate for greater flexibilities to be introduced into the scheme to address opt outs caused by affordability issues but acknowledge this is more a medium-term project aim due to limited resource. Any flexibilities should be introduced at an appropriate time, when ample resource and capability are available for smooth implementation and administration.

Pension taxation

In our 2024/25 submission, we highlighted pension tax as a barrier to scheme members taking on additional work. The Spring 2023 Budget made several amendments to pension taxation:

- The lifetime allowance (LTA) was removed.
- The standard annual allowance (AA) was increased from £40,000 to £60,000 beginning in the 2023/24 financial year.
- The adjusted income level required for members to be subject to a lower, tapered annual allowance was increased from £240,000 to £260,000.

NHS Pensions has provided us with data showing how many members have accrued pension benefits in the NHS Pension Scheme that exceeded the standard annual allowance (AA) in the past five years, showing fewer members are now accruing pension benefits in the NHS

Pension Scheme that exceed the standard allowance because of the changes.

Figure16 - accrued pension benefits in the NHS Pension Scheme that exceeded the standard AA

Year	Annual allowance	Total Exceeding AA	Total Exceeding AA (Medical Staff Only)
2020/21	£40,000	26,674	18,691
2021/22	£40,000	48,455	32,755
2022/23	£40,000	38,946	28,743
2023/24	£60,000	4,593	3,168
2024/25	£60,000	9,763	7,634

We have noticed a decline in the number of employers reporting a reluctance to take on additional work due to pension tax concerns. Whilst it is not possible to attribute any increased workforce capacity directly to the changes in pension tax, it may be considered that the standard annual allowance is no longer the significant barrier to potential increased workforce capacity that it once was. The figures show that most members exceeding AA remain within the medical workforce.

We are receiving fewer enquiries from employers with regards to members breaching the annual allowance taper. Data available to us regarding earnings does not include earnings outside the NHS and, therefore, does not give a full picture of the number of members who are likely to be subject to a lower tapered annual allowance and how this may have changed since the 2023 budget. We continue to help employers support their employees with this complicated pension tax issue through our range of resources and web pages and with individual support through our enquiry handling.

Pension tax and McCloud

Employers tell us that they receive queries and requests for support from members on the impact of the McCloud remedy on their pension tax position. This is highly complex and often includes extended personal financial circumstances that are outside of the view of employers in the NHS.

Some members who are affected by the McCloud remedy may need to check their pension tax position and update their pension tax information with HMRC.

This is because, from 1 October 2023, pensionable service between 1 April 2015 and 31 March 2022 was moved back to the 1995/2008 scheme. This process is known as rollback. Rollback may change the value of pension earned in the tax years 2015/16 - 2021/22 and may change the pension tax position for affected McCloud members. This could mean some members have an annual allowance tax refund to claim, or a small number may have extra tax to pay.

Members will need a remedial pensions savings statement (RPSS) from NHS Pensions before they can check their pension tax position with HMRC. There have been delays and errors relating to RPSS delivery which have caused additional confusion for members and employers.

We continue to keep employers up to date on developments with RPSS delivery and encourage employers to support members to access information on the NHS Pensions and HMRC websites to access any compensation due. We encourage employers to promote the cost claim back scheme for members. Compensation can be claimed for those who have paid for financial advice due to McCloud.

In January 2025, we held our assessing annual allowance – ready reckoner tool and demonstration webinar. This gave employers a detailed understanding of how members can use the ready reckoner to assess their pension tax liability for the 2024/25 scheme year and use summary outputs to discuss with their employer or their financial advisor.

To continue supporting employers with this complex topic, we have a range of web resources including:

- Pension tax guidance for employers which helps employers support staff who may be affected by pension tax.
- Access to pension tax guidance and advice, a list of financial advisors with experience of the NHS Pension Scheme that employers can signpost members to.
- Annual Allowance web page which acts as a knowledge base.

Figure 17 - Member contributions, including indexation of contribution salary thresholds

Pensionable pay range from 1 April 2025 (with CPI indexation rate of 1.7% from Sept 2024)	Pensionable pay range from 1 April 2025 (with AfC pay award)	Contribution rates from 1 April 2025, based on actual annual pensionable pay
Up to £13,259	**Up to £13,259**	5.2%
£13,260 to £27,288	**£13,260 to £27,797**	6.5%
£27,289 to £33,247	**£27,798 to £33,868**	8.3%
£33,248 to £49,913	**£33,869 to £50,845**	9.8%
£49,914 to £63,994	**£50,846 to £65,190**	10.7%
£63,995 and above	**£65,191 and above**	12.5%

Figure 17 shows members pay a contribution rate based on their actual pensionable earnings. Uplifting the pensionable pay ranges in the contribution structure will reduce the likelihood of members moving up a tier and needing to pay a higher contribution because of the pay award.

Members will feel the value of the pay award in their take home pay. We previously reported that ‘cliff edges’ in the contribution structure were negatively impacting members’ perception of the scheme and the pay award. Progress made on indexation has been positive in helping to remove this impact and create a more streamlined structure.

Uplifting the pensionable pay ranges each year requires a change to the scheme regulations. DHSC and SAB have worked to streamline this process so that the new pensionable pay ranges are in place in time for the pay award. Changes have been welcomed as it reduces the instances of members moving into a higher pension contribution tier and receiving a reduction in take home pay because of the pay award.

Uplifts to the member contribution thresholds are implemented in a two-stage approach. From 1 April every year, pensionable pay ranges will automatically increase by the rate of CPI from the previous September. If the AfC pay award is higher than the CPI rate used for indexation on 1 April, there will be another adjustment to pensionable pay ranges. For 2025/26 this came into effect from 1 August and was backdated to 1 April.

Overall, the process has been much improved but is not perfect. NHS staff who receive pay awards that are higher than the AfC pay award for England, such as doctors, will not benefit from full indexation.

Although uplifts to the pensionable pay ranges are automatically updated via ESR, employers must still reassess contribution rates against the tiers in April, and then again after any uplift following the pay award. This can involve a significant number of manual interventions adding to local administration pressure. Improved automated processes are needed to ensure efficient and accurate assessment of member contributions. To support employers, we published the new member contribution rates in July to provide advance notice and allow time to prepare ahead of August implementation.

Introduction of real-time re-banding

We are pleased that the SAB workplan for 2025/26 includes exploration of a prototype real-time re-banding solution for all payroll providers. SAB will consider this in March 2026 indicating that a solution may not be available from 1 April 2026. We feel there is great need to progress a solution with urgency, to alleviate the pressures on local pension administration, which we highlighted in our 2024/25 submission as being time prohibitive. The workload pressures faced by local pension administration teams is increasing due to complexities such as the McCloud Remedy.

A community and mental health trust in the South of England shared with us that they had over 1,700 records to manually review and adjust for the April 2025 payroll alone, due to indexation of member contributions. This was 20 per cent of the total number of records in this single payroll process, which may be replicated across the service, giving an indication of the scale of the administrative burden.

The introduction of a fully automated system for real-time re-banding would increase accuracy of member contributions, removing potential inequity in cost of benefits. It would also contribute to the accuracy and efficiency of the pay award processes as backdating pension

contributions following pay awards would be timelier, reducing errors and refunds/deductions for under payment.

Employer contribution rate

From 1 April 2024, the employer contribution rate was increased from 20.6 per cent to 23.7 per cent.

Employers are required to pay a scheme administration levy, in addition to the employer contribution rate, to cover the cost of the scheme administration. The levy continues to be 0.08 per cent of pensionable pay.

Employers are responsible for paying 14.38 per cent of contributions, the remaining 9.4 per cent is funded centrally. We would welcome clarity and certainty on whether future increases to the employer contribution rate will continue to be funded centrally.

The 2024 valuation commenced in September 2025 and will determine the employer contribution rate for four years from 1 April 2027.

Scheme flexibilities

We continue to advocate for greater flexibility for members over the level of contribution they pay into the scheme, and the value of benefits they receive in return, to address opt outs caused by affordability issues. Flexibilities would increase member control and autonomy over their pension savings. We foresee the introduction of scheme flexibilities as a medium-term ambition for the NHSPS, it is important to introduce them at an appropriate time when ample resource and capability are available for smooth implementation and administration.

SAB (through its Technical Advisory Group) has recommended to the DHSC a set of governing principles for the introduction of flexibilities to the NHS Pension Scheme. The principles include protection of the low paid. We know that local pension administrators are facing increased workloads due to recent scheme changes (as detailed in our evidence from 2025/26). It feels realistic that the introduction of flexibilities follows a period of increased digitisation across the whole pension administration system. This would enable the sharing of clear, concise, and effective

communications to members about flexible options, allow increased member autonomy to make and implement decisions independently of local pension administration, and increased data accuracy and security. This would also mitigate against potential increases in local pension administration due to the additional complexity of introducing flexibilities. We also highlighted the potential increased cost to employers of introducing scheme flexibilities if this in turn led to an increase in membership rates.

Pension communications

As employer representatives on the NHS pension board and McCloud engagement board, we continue to represent employer views on the need for timely, clear and simple pension communications as these are vital to increasing member understanding of the scheme and its benefits and to avoid member inertia when it comes to important decisions. We have been able to provide input into some of the NHS Pension Scheme member communications through these channels.

We have kept employers up to date with information and resources to support staff through pension-related changes and encourage employers to use flexibilities offered in the scheme to address workforce issues. Including:

- Guidance on the McCloud remedy to support member decision-making.
- Advice on using flexible retirement to boost workforce retention.
- Tools for assessing annual allowance and pension tax implications for 2024/25.

All these resources can be found on this web page.

Last year, we shared that local pension administrators face unprecedented workloads following a series of scheme changes. While those scheme changes have now been implemented and we are entering a period of relative stability and consolidation, there remains high workload pressure for local pension administration teams. This reduces local capacity to communicate with staff about the benefits of scheme

membership. Continued long-term, we are concerned that this will have a detrimental impact on scheme understanding and therefore membership levels.

Looking to the future

We aim to support the NHS Pension Scheme to remain an attractive scheme for the benefit of all members so that it continues to be an effective tool for employers to attract, recruit, motivate and retain staff. We will continue to support NHS Pension Scheme and DHSC colleagues to explore opt-out trends as we aim to ensure the scheme remains an attractive reward for NHS staff.

We are pleased to note that the SAB work plan includes exploring the gender pension gap and welcome the opportunity to be represent employers in these discussions.

Total reward

NHS organisations' approach to reward and recognition is a vital component in tackling workforce challenges. It supports employers in attracting, recruiting, and retaining talented individuals by ensuring staff are compensated and recognised for their roles and the contributions they make.

NHS organisations provide a comprehensive and attractive core employment offer through a highly regarded range of both financial and non-financial rewards, which, when combined, form a total reward approach.

As referenced in our 2025/26 evidence to the NHSPRB the total reward offer within the NHS blends nationally agreed provisions under the NHS TCS Handbook with locally developed initiatives that reflect the values and priorities of individual trusts. By clearly communicating the full value of what it means to work within the NHS, employers are equipped with a powerful tool to boost engagement and create a workplace culture where staff feel appreciated, supported, and connected to their employer.

Salary sacrifice and net deduction arrangements

Salary sacrifice schemes comprise a significant portion of the total reward package in the NHS. In our 2025/26 evidence to the NHSPRB (page 41) we highlighted the challenges arising with salary sacrifice and net deduction schemes due to NLW rises and the small buffer between NLW and AfC pay, and delayed pay awards.

Despite measures being implemented by employers to ensure as many staff as possible are able to access salary sacrifice schemes, employer feedback suggests that there is still a significant impact on morale and motivation. Bands 1, 2 and 3 staff have expressed dissatisfaction over perceived exclusion from salary sacrifice schemes, saying they seem to only be available for higher paid staff. Employers are under pressure to review caps and eligibility criteria to address staff concerns and avoid claims of discrimination.

We continue to represent employers by raising issues on their behalf with the government and wider policymakers, and support a review of existing and future policy arrangements around the NLW. As part of this, we wrote to the chief secretary to HM Treasury three times between May and November 2024. These letters did not receive a response.

A member of a focus group said:

"Salary sacrifice schemes, while offering value for many, continue to disadvantage lower-paid staff, particularly where NLW regulations prevent access to benefits such as car lease programmes and subsidised parking. We recognise that specific benefit schemes may inadvertently disadvantage some colleagues, particularly those on lower pay. In response, a range of measures have been introduced to promote fairness and provide additional support. These include practical financial assistance, wellbeing resources, and tailored local solutions designed to ease pressure and ensure that all staff feel valued and supported in their roles".

Yorkshire and Humber region

Although there are no published limits on the amount that can be salary sacrificed in the NHS, the reduced salary after salary sacrifice must not fall below the NLW. By analysing the differences between NHS pay points and annual salaries, the maximum theoretical salary sacrifice has been estimated.

Figure 18 – Estimated maximum salary sacrifice

2025 National Minimum Wage (per hour) - aged 21 and over	£12.21
Annual Salary at NMW (assuming Full time - 37.5 hour week)	£23,875

Band	Full time Basic Pay (25/26)	Estimated Maximum Salary Sacrifice (Salary minus annual national minimum wage)
Band 1	£24,465	£590
Band 2	£24,465	£590
Band 3 Entry	£24,937	£1,062
Band 3 Top	£26,598	£2,723
Band 4 Entry	£27,485	£3,610
Band 4 Top	£30,162	£6,287
Band 5 Entry	£31,049	£7,174

Sources: NMW x 37.5 hrs x 52.1429 weeks = Annual Salary at NMW and Actual Salary – Annual Salary at NMW = Maximum Salary Sacrifice Amount

The maximum amount of salary sacrifice differs by pay point, with the lowest paid being able to salary sacrifice the least.

Figure 19 - levels of take-home pay deductions for items frequently purchased through salary sacrifice

Item	Total Amount taken from Take Home Pay (Range £)	
Washer Dryer	£384	£1,198
Mountain Bike	£460	£1,396
Road bike	£1,047	£1,629
Television	£208	£1,628
Desktop PC	£372	£1,620
Double mattress	£307	£1,488
Fridge Freezer	£232	£1,680
Electric car (annual lease)	£4,629	£7,188

Source: Prices shown on Vivup.co.uk and nhsfleetsolutions.co.uk as at July 2025

Figure 18 and 19 shows that only staff on the top of band 4 (maximum salary sacrifice £6,287) and above would be able to purchase an electric car (minimum cost £4,629 per year) through salary sacrifice without their salary falling below the NLW.

Whilst band 1 and 2 staff (maximum salary sacrifice £590) might be able to purchase some items at the lower end of the price range using salary sacrifice, they would not be permitted to buy items at the higher end of the price range, or multiple items, as it would result in their salary being lower than the NLW.

Salary sacrifice car schemes

NHS England's Net Zero Travel and Transport Strategy (October 2023), proposes from 2026, all vehicles offered through NHS vehicle salary sacrifice schemes to be electric.

At the time of writing, it is unclear whether this is a proposed or active policy. We contacted NHS England for clarification and were advised that the guidance in the travel and transport strategy appears to encourage, rather than mandate, the provision of net-zero vehicles through salary sacrifice schemes. The relevant section of the strategy suggests that trusts should consider offering electric or hybrid vehicles, but it does not require them to do so.

As of August 2025, leading providers such as Tuskercars.com and NHSFleetSolutions.co.uk were offering mostly electric vehicles with a small amount of petrol and diesel. While the environmental ambition of this policy aligns with the NHS's broader sustainability goals, its implementation could have negative consequences for the accessibility of the schemes, as electric vehicles (EVs) typically carry higher lease costs than petrol or diesel alternatives.

Market data from Autotrader.co.uk illustrates this disparity: among the 100 cheapest new lease cars available nationally (ranked by lowest monthly payment over a 24-month term), 74 per cent were petrol-powered, while only 5 per cent were EVs. See figure 20. Although these vehicles are not part of NHS salary sacrifice schemes and therefore not

directly comparable, the data highlights the limited choice currently available to NHS staff under the EV-only model - a restriction that may compel employees to lease more expensive vehicles than they otherwise would.

Figure 20 - 100 cheapest new lease cars (ranked by lowest monthly payment over a 24-month lease) available for lease via Autotrader.co.uk

Fuel Type	Number of cars available
Petrol	74
Hybrid	15
Electric	5
Bi -fuel	6
Diesel	0
Total	**100**

Source: Autotrader.co.uk - Lease Cars

For example, the most affordable electric vehicle quoted by NHSFleetSolutions.co.uk in August 2025 was the Cupra Born Electric hatchback, listed at £299 per month after salary sacrifice. However, access to this vehicle is restricted to staff on band 5 entry point or above. For those at the top of band 4 (£31,062), participation would typically result in earnings falling below the NLW threshold, assuming full-time employment without additional earnings, pension scheme membership, and no other salary deductions or sacrifices.

Restricting vehicle options to EVs inadvertently narrows the pool of staff eligible to access cars through salary sacrifice. This could exacerbate existing inequalities in access to reward and recognition initiatives and undermine efforts to recognise hard-working staff and the promotion of inclusive employment practices.

In addition to the financial implications of monthly deductions associated with the EV itself, employees would also be required to have an appropriate home charging infrastructure to operate and maintain the

vehicle. The costs of charger installation, along with potentially increased household energy bills, may further deter staff from participating in a salary sacrifice arrangement.

An employer told us:

In 2022 we lowered our lease car CO_2 cap from 165g/km to 75g/km, excluding all petrol and diesel vehicles. This disproportionately affected lower-paid staff, especially those below AfC band 6, who relied on affordable lease options for work travel. The scheme, once more widely accessible, became viewed as a benefit for higher earners only. We found that while EVs are central to reducing emissions, a purely electric scheme presents the following barriers:

- **Charging access**: Many staff live in properties where EV chargers cannot be installed, and hospital sites currently lack sufficient infrastructure.
- **Long lead times**: Global supply chain issues have led to delays in EV deliveries and parts—some staff have waited up to six months for repairs while still paying for a car they can't use.
- **Lifestyle Fit**: Not all roles or commutes are compatible with EV range limitations and charging logistics.

Due to the negative consequences, in 2024, the cap was revised to 130g/km—reintroducing low-emission petrol and diesel models while maintaining sustainability goals. This change:

- restored access for band 5 and some band 4 staff
- broadened vehicle choice
- preserved environmental commitments

Acute trust

Budget constraints

NHS Employers leads a Reward and Recognition Network, which brings together over 320 employers representing 163 NHS organisations to share best practice, overcome challenges, and provide peer support among colleagues responsible for total reward. Many employers within the meetings are reporting that there is an expectation to do more with less, and funding constraints, particularly around reward and recognition, are limiting their ability to expand upon their initiatives.

The funding streams available within some trusts are not universal; therefore, employers are seeking innovative ways to strengthen their offer and remain competitive as an employer of choice. This has resulted in an emphasis being placed on how employers can enhance existing resources to achieve a greater impact.

This feedback was the leading factor in the development of the agenda for our 2025 Reward in the NHS conference. The event equipped delegates with innovative and practical tools and tips to take back to their organisations, helping them maximise their existing initiatives within their total reward offer and improve engagement with them. We will continue to promote good practice examples within the network and via our communication channels to ensure other employers who report similar challenges can learn from and adopt approaches that support their workforce strategies.

Staff engagement

We have heard from employers that there has been a recent focus on the importance of actively involving employees in the design and ongoing development of the total reward offers within NHS organisations.

We know from the data gathered in our rewarding and recognising a multigenerational workforce resource that people are working for longer and more flexibly, creating a diverse and multi-generational workforce, with a total of five different generations soon to be in employment. Each generation comprises individuals who have different needs, values, and priorities, which influence how they engage with various aspects of the reward offer as they progress through different life

and career stages. It is therefore essential to regularly provide employees with a forum for feedback on what is important to them, so they feel genuinely heard and valued.

Communicating reward

As detailed in our 2025/26 evidence to the NHSPRB, effective communication is crucial to ensuring that the total reward offer within NHS organisations is visible to their entire workforce.

Within the Reward and Recognition Network, members have acknowledged that a breadth of benefits is available within trusts. However, there are still improvements to be made in how this information is disseminated throughout the entire workforce.

Communicating the total reward offer through various channels is essential to ensure it is accessible and understood by all staff groups. Colleagues work across different roles, locations, and shift patterns, and may engage with information in various ways. Some may prefer digital updates, while others prefer printed materials.

Case study

As part of our employee value proposition (EVP) work, we wrote a case study which showcased how Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) created an EVP brochure to communicate its employment offer. Staff were unclear about the schemes and initiatives available to them, as there wasn't a centralised place where their total reward offer was hosted.

Total reward statements

A total reward statement (TRS) is a personalised summary that shows employees their reward package and includes basic pay, allowances and pension benefits for those who are members of the NHSPS. Additionally, NHS organisations may incorporate details of locally administered benefits, where applicable.

TRSs are designed to enhance communication with employees, helping them understand and appreciate their overall reward package and the benefits of employment within NHS organisations. Despite their value, engagement with TRS, from both staff and employers, remains limited, and efforts to promote awareness and visibility of refreshed statements vary across organisations.

NHS Employers provides guidance and communicates key actions throughout the TRS timeline, ensuring employers are informed and equipped to deliver accurate and consistent information to their workforce. A key priority within our programme is to continue promoting awareness of the value of accessing TRS and signpost to our posters that help employers to communicate that statements have been updated and can be viewed online by staff.

Deputy HR director survey response:

The 38th NHSPRB report highlighted that only 12 per cent of the approximately three million Total Reward Statements (TRS) have been viewed, suggesting low engagement. We asked deputy HR directors if their organisation actively encourages staff to view their TRS.

- 72 per cent said yes.
- 28 per cent said no.

Some organisations promote TRS annually or via their intranet. A few noted that although TRS are available, it's left to individual staff to choose whether to access them. Additionally, some organisations display their reward offer through other methods beyond the TRS platform. Those who said no indicated that they will explore ways to encourage staff to view their TRS moving forward.

Section 6 – Staff experience and wellbeing

Staff experience - NHS Staff Survey

Participation in the 2024 NHS Staff Survey reached its highest level to date, with 774,828 staff members completing the survey. This represents a notable increase from 707,872 responses in 2023, reflecting a growing engagement with the survey process across the NHS workforce.

The overall response rate rose to 50 per cent in 2024, up from 48 per cent the previous year. This improvement suggests a strengthening culture of feedback and involvement, with more staff choosing to share their views on workplace experience, satisfaction, and organisational performance.

The increase in participation was driven primarily by a rise in online responses, which grew by over 66,000 year-on-year. This upward trend in engagement provides a more robust evidence base for workforce planning and improvement initiatives and highlights the importance of maintaining momentum in staff involvement efforts.

The survey results indicate continued modest improvement across several key indicators, building on the significant recovery observed in 2023. However, scores related to reward and recognition remain below pre-pandemic levels, particularly in areas concerning pay and overall recommendation of the NHS as a place to work. Notably, there was a

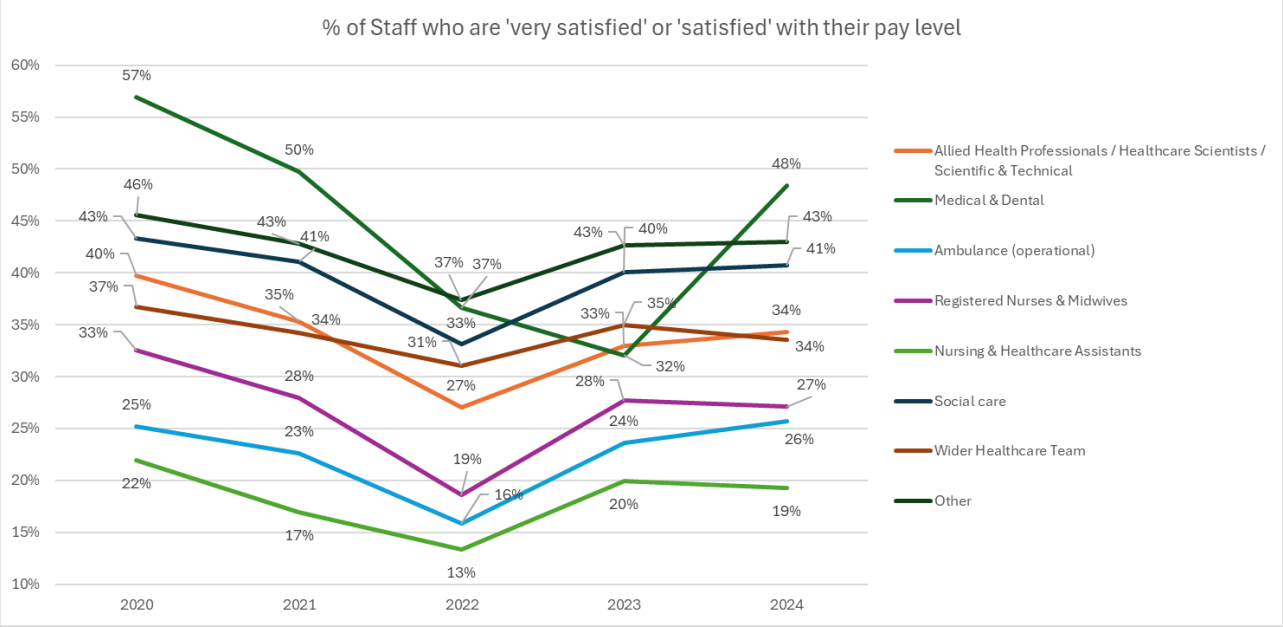
slight increase in the proportion of staff indicating intentions to leave, although this remains below the post-pandemic peak recorded in 2022.

Satisfaction with pay

Pay satisfaction within the NHS continues to lag behind broader economic benchmarks. Despite this, there has been incremental improvement in recent years. In 2024, satisfaction with pay rose from 31 per cent to 32 per cent, following a substantial increase in 2023. This improvement was driven mainly by medical staff, whose satisfaction levels increased significantly from 32 per cent to 48 per cent. In contrast, satisfaction among registered nursing staff remained stable at 27 per cent, while satisfaction among non-nursing staff increased marginally from 33 per cent to 34 per cent, which is illustrated below in figure 21.

Ambulance operational staff show a consistently lower percentage of positive responses when asked if they would recommend their organisation as a place to work, compared to most other NHS staff groups.

Figure 21 - Staff who are very satisfied or satisfied with pay levels.

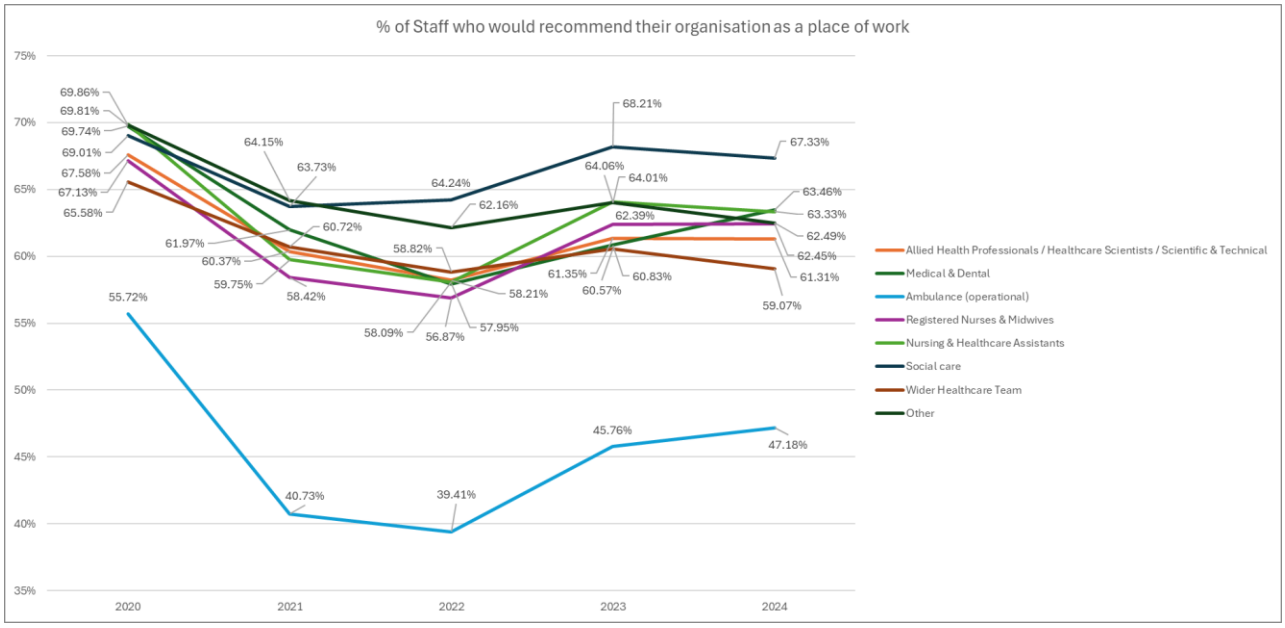


Source: https://www.nhsstaffsurveys.com/results/national-results/

Recommendation as a good place to work

The willingness of staff to recommend the NHS as a place to work experienced a slight decline in 2024, falling from 61.1 per cent to 60.8 per cent. This follows a notable improvement in 2023, although current levels remain below those recorded in 2020. Among occupational groups, medical staff reported the highest recommendation rates, increasing from 60 per cent to 63 per cent. Other staff groups maintained stable but lower scores, which is illustrated in figure 22.

Figure 22 – Percentage of staff who would recommend their organisation as a place of work.



Source: https://www.nhsstaffsurveys.com/results/national-results/

Leaving Intentions

The proportion of respondents who often think about leaving their organisation remains similar to 2023 at under three in ten (28.83 per cent). This proportion has decreased for a few occupation groups this year, namely ambulance staff and medical and dental staff to 38.29 per cent and 24.87 per cent, respectively. This is the second consecutive year that both of these occupation groups have seen a decrease in this measure.

Burnout and sickness absence

We continue to provide a comprehensive suite of resources to support employers in prioritising staff health and wellbeing. The dedicated health and wellbeing hub brings together practical tools, evidence-based guidance, and proven strategies to promote a prevention-first approach to tackling stress, burnout, and sickness absence. These resources are designed to empower both managers and teams, build confidence, and support staff effectively, driving meaningful and lasting change across the NHS.

The NHS staff survey reveals that burnout scores among NHS staff in 2024 are at their lowest since 2021; however, around 30 per cent of staff report feeling burnt out "often" or "all the time." The situation is even more severe among ambulance staff, where nearly 40 per cent experience frequent burnout, highlighting the intense pressure faced in emergency services.

Addressing burnout

To address the growing issue of staff burnout, hawse have developed targeted guidance through our publication, "Beating Burnout in the NHS," which outlines why and how trusts must take action. In the accompanying webinar on supporting NHS staff with burnout and stress, industry experts and NHS organisations shared insights into the key factors contributing to burnout, along with case studies and tools to support the workforce.

Sickness absence

The NHS Employers' Sickness Absence Toolkit is currently being refreshed to align with the forthcoming NHS England National Policy Framework for Supporting Wellbeing and Attendance. The new framework, expected in Autumn 2025, will adopt a lifecycle approach, emphasising prevention, early intervention, recovery, and the importance of communication throughout.

NHS People Promise

NHS England launched the People Promise Exemplar Programme to explore how a coordinated set of interventions, rooted in the NHS People Promise, could enhance staff experience and retention. Developed in response to widespread workforce challenges and informed by staff feedback, the People Promise outlines seven key commitments to improve working life across the NHS.

The Exemplar Programme tested the impact of delivering a bundle of these interventions in selected trusts. Findings from the first cohort evaluation indicated that this bundled approach led to greater improvements in staff experience outcomes than isolated efforts, suggesting that integrated, values-driven action can make a measurable difference.

Flexible working

Flexible working remains a key priority across the NHS, with NHS Employers offering a comprehensive range of support to help organisations implement positive and sustainable flexible working practices. The flexible working hub provides resources, guidance, and examples of best practice to help employers integrate flexibility into their workforce strategies.

Embedding a culture that consistently promotes flexibility requires a shift in mindset and sustained organisational commitment. NHS Employers, in partnership with the University of Sussex through agiLab, continues to disseminate academic knowledge and best practice to support agile working. Their latest report identifies key enablers and barriers to implementing effective flexible and agile working, drawing on four years of evidence and collaboration.

Section 7 – Workforce supply

Recruitment and retention

Recent data from NHS England indicates that staff leaving rates have declined to one of the lowest levels in over a decade, with only 10.1 per cent of hospital and community healthcare workers leaving the NHS in the 12 months to September 2024. This represents a significant improvement from 12.5 per cent two years prior, suggesting early signs of workforce stabilisation in some areas.

However, recruitment and retention of nursing staff across the NHS remains a dynamic and regionally varied challenge. Nationally, trusts are navigating a complex landscape shaped by international recruitment efforts, financial constraints, and local workforce pressures. While some regions report improved retention and reduced turnover, others, particularly geographically isolated or rural areas, continue to struggle with attracting and retaining qualified staff.

Lower turnover is complicating efforts to meet financial targets, which rely on natural attrition to reduce headcount. Recruitment freezes and limited vacancies mean fewer staff are leaving, particularly in non-clinical roles, prompting calls for a national redundancy programme. The drop in turnover could reflect a lack of job mobility rather than genuine improvements in retention.

This mixed picture highlights the need for targeted, regionally responsive workforce strategies that address both systemic and localised barriers to recruitment and retention.

We continue to provide a range of support to help employers with retaining their teams so that they stay and stay well. This includes three toolkits; retain the NHS workforce, retain nurse and midwives and retain internationally recruited staff. We have also developed a range of resources to support practitioners and senior leaders in achieving a positive impact on staff retention on our online retention hub.

In the Northwest region, several trusts have observed a reduction in the number of posts being advertised and recruited to, largely due to reconfiguration efforts and restructuring within care divisions. One trust estimated this reduction to be as high as 40 per cent, which has had the unintended effect of increasing the number of applicants per vacancy, suggesting a more competitive recruitment environment.

The Northeast and Yorkshire regions presents a mixed picture. Some trusts report lower vacancy levels, attributed to reduced turnover and successful international recruitment over recent years. Conversely, other trusts are actively encouraging applications from newly qualified nurses and healthcare professionals. In one instance, a trust collaborated with a university to reassure students that vacancies were available, highlighting the importance of clear communication between education providers and employers. However, geographical challenges persist, particularly in areas like West Cumbria, where travel times of over an hour each way deter applicants from commuting from the north.

In the East of England region, recruitment activity has slowed due to a combination of fewer staff leaving and financial constraints. Trusts in this region, particularly those serving rural and coastal areas, continue to face challenges in attracting newly qualified staff. For example, one employer described their struggles with recruitment due to limited transport options, fewer local amenities, and competition from London, which offers more attractive weighting allowances. A notable initiative involves working directly with the university to retain graduate nurses. This approach mirrors historical models of nursing schools and may

serve as a blueprint for other acute providers and universities seeking to improve retention in less urbanised areas.

The Midlands region shares similarities with the Northeast and Yorkshire, with some trusts reporting a stable workforce due to increased retention and international recruitment. This stability has, in some cases, reduced opportunities for newly qualified nurses and allied health professionals to enter band 5 roles. Nevertheless, proactive recruitment efforts are evident. One trust has extended offers to 70 students expected to qualify in September and is in discussions with an additional 17. Meanwhile, another organisation has already offered 26 positions and is shortlisting a further 80 candidates.

Overall, while some regions are experiencing a more stable workforce, others continue to face recruitment challenges driven by geographical, infrastructural, and financial limitations. Innovative strategies, such as university partnerships and targeted support for rural areas, are emerging as key tools to address these disparities and ensure a sustainable nursing workforce across the NHS.

Non-financial factors driving staff attrition

Some NHS staff are leaving not simply due to pay or working hours, but because they feel unable to deliver the standard of care they believe is professionally right. This study on why healthcare professionals are leaving NHS roles highlights that poor staffing levels, excessive workloads, limited autonomy, and bureaucratic constraints are key factors that prevent staff from working effectively. These conditions create a disconnect between employees' intrinsic motivation and the reality of their roles, leading to frustration, burnout, and ultimately, resignation.

For employers, this means that retention strategies must go beyond financial incentives. Creating supportive environments where staff feel empowered to practice safely and meaningfully is critical. The study also shows that current data collection methods oversimplify the reasons for leaving, often capturing only one factor. To address the root causes of attrition, employers need to listen more closely to staff

experiences, invest in professional autonomy, and ensure that workplace conditions align with the values and standards of the healthcare workforce.

Apprenticeships

Figure 22 shows a steady decline in healthcare apprenticeship starts from 2021/22 to 2024/25. However, the number of achievements has steadily increased even though the starts are fewer.

Figure 22 - healthcare apprenticeship starts from 2021/22 to 2024/25.

	Starts			
	2021/22	2022/23	2023/24	2024/25
Health, public services and care	79,490	78,180	75,480	75,330
	Achievements			
Health, public services and care	25.50%	27.00%	27.10%	28.50%

Evidence from employer organisations indicates a reluctance to recruit apprentices due to the associated costs and the inability to increase workforce headcount. This presents a significant barrier to achieving national workforce ambitions, particularly in light of the 10 Year Health Plan's commitment to creating 2,000 additional nursing apprenticeships over the next three years. To realise this ambition, the financial and operational constraints currently faced by employers must be addressed, ensuring that apprenticeship pathways are viable, sustainable, and aligned with workforce planning needs.

We do not have access to national data on retention rates, but the position remains the same as described in our 2025/26 evidence.

In last year's evidence, we highlighted that retention rates following training and qualification were positively influenced by the level of support provided to staff throughout their development. Employers consistently reported that when individuals felt supported in their learning and career progression, they were more likely to remain within the organisation post-qualification.

We also noted that apprenticeship programmes played a significant role in improving retention. Several organisations shared examples of apprentices who, upon completing their qualifications, chose to stay with the same employer. This was particularly evident in programmes that offered clear progression pathways and were embedded within departments that could accommodate clinical placements and ongoing development.

Employers welcome the confirmation of mitigation funding for level 7 apprenticeships in key health and care professions until 2029. This commitment from NHS England and the DHSC provides much-needed stability for employers planning workforce development. It supports the delivery of advanced clinical roles across the system.

Level 7 apprenticeships play a vital role in recruitment and retention by offering clear, funded pathways into advanced practice. For professions such as advanced clinical practitioners, specialist community public health nurses, and district nurses, these routes help attract new talent while enabling existing staff to progress in their careers. In a competitive labour market, the availability of structured development opportunities is essential to retaining skilled professionals and reducing turnover.

The continuation of funding also has a positive impact on staff morale. It signals a long-term investment in the workforce and reinforces the value placed on professional growth and career mobility.

International recruitment

The NHS has always been reliant on international recruitment to fill hard-to-fill roles and attract the best talent. There was a significant spike following the previous Conservative government's manifesto commitment to recruit 50,000 more nurses, as international recruitment was responsible for approximately 93 per cent of the target. Internationally trained staff comprise a significant proportion of the registered workforce, bringing a range of positive benefits.

However, over the past two years, reliance on international recruitment has decreased, primarily due to the cutoff of central funding from NHS England and a shift in government priorities. The UK government aims to reduce immigration, as outlined in the recently published Immigration White Paper. The health plan also has a target of reducing the reliance on internationally educated staff to 10 per cent by 2035. We are already seeing the impacts of these changes in terms of rising skills and salary thresholds, removing previously eligible roles, closing the route for social care roles, and barring mid-level skilled roles from bringing dependents. If the UK is viewed as a less attractive place to live and work, NHS organisations will need to respond to this challenge specifically from their local labour market. This will mean that roles, terms, and conditions, including pay, will need to be more attractive.

Latest Home Office statistics on visa applications for people coming to the UK for work and study show that there were 12,400 Health and Care Visa applications between January and June 2025. In the year ending March 2025, 23,000 Health and Care Worker Visas were granted to main applicants, representing an 85 per cent decrease from the peak in 2023. The fall towards the end of 2023 is likely due to increased scrutiny by the Home Office of employers, compliance activities against employers of migrant workers, and policy measures affecting care workers introduced in the Spring of 2024.

We outlined in our 2025/26 written evidence the concern that the restrictions for the social care sector will also give rise to recruitment challenges for those occupations in the NHS, for which international recruitment is bolstering domestic supply. With even more restrictions introduced, there will be an even greater impact on the ability of health and social care to fill roles through immigration.

The delayed pay award announcement this year posed challenges for employers concerning the salary thresholds of health and care worker visas. In April 2025, the government increased the base general salary threshold for skilled workers to £25,000; this also applied to those applying for a Health and Care Visa on national pay scales. This impacted organisations' ability to recruit for entry-level band 3 roles outside of London, and to retain existing staff as they were unable to

obtain extensions, mainly affecting those needing to switch from the graduate/student/dependant visas to a sponsored route.

Between April and the announcement of the pay award, employers were uncertain whether the pay award would be sufficient to meet the salary threshold. When the pay award was announced, these roles were £63 short of meeting annual salary threshold requirements. This meant that if people needed a visa, either in the delayed timeframe or after the announcement was confirmed, they could not do so.

Hard-to-fill roles

The Immigration Salary List (ISL) has been expanded to include relevant healthcare roles, such as laboratory technicians for positions requiring more than three years of experience, pharmaceutical technicians, and nursing auxiliaries (in roles where registered nurses are also employed).

These roles will have temporary access to the immigration system until it is phased out in December 2026. However, they will still be subject to meeting salary threshold requirements, and new applications will not be able to bring or stay with their dependents.

A Temporary Shortage List (TSL) was also introduced to allow temporary access for below degree-level roles. However, these roles will need to be linked to key government or industrial strategies and have domestic workforce plans in place to address shortages. Laboratory technician roles requiring less than three years' experience are the only Health and Care Visa roles on this list. Like the ISL, they will still be subject to meeting salary threshold requirements, and new applications will not be able to bring or stay with their dependents. Therefore, we can expect to see a decline in IR applications for these positions.

As part of the most recent Migration Advisory Committee (MAC) commission, they will review roles to be included on the TSL. Roles will need to be directly aligned with key government priorities or industrial strategies, and domestic workforce plans must be in place to address

shortages within three to five years. Additionally, immigration will need to be deemed a reasonable response to filling those roles in the interim while domestic training takes place. If roles from the ISL are not transferred to the TSL, they will need to be filled immediately by the domestic market.

Due to salary threshold requirements, there are three hard-to-fill roles that, although on paper can access the immigration system, in practice, they will not meet the salary thresholds. This includes entry-level band 3 roles outside of London (as outlined above), band 5 biomedical scientists (BMS), and band 5 laboratory technicians for roles that require less than three years' experience.

We continue to receive evidence from NHS organisations indicating difficulties in filling BMS vacancies with domestic candidates, particularly in areas providing out-of-hours services, and they have subsequently resorted to international recruitment.

NHS organisations have expressed concerns that they not only need more BMSs to cover their current services, which require 24/7 registered care, but also need to increase their numbers to provide additional services and deliver patient care. For example, one NHS organisation has built a new centre that requires staff who are registration-ready, and another organisation needs to increase its minimum service activity by 20 per cent.

The current salary threshold for an internationally educated BMS on a Health and Care Visa is £35,100; however, the NHS pay scale would be band 5, which is significantly lower than this.

Although band 5 laboratory technicians in roles that require less than three years' experience are on the TSL, they do not receive a salary threshold discount. Their current salary threshold on a Health and Care Visa would be £31,300, but the NHS pay would be band 5, which is lower than this.

Section 8 – Systems perspective

In March 2025, the government announced that ICBs would need to cut their running costs by 50 per cent by the start of Q3 2025/26. This announcement was followed in April by the publication of the ICB Blueprint, which sets out the role of ICBs to focus primarily on strategic commissioning. The blueprint also sets out the functions that would remain within ICBs and those that would be transferred to regions and providers, such as workforce planning and development.

At the time of writing, significant uncertainties remain - particularly regarding the funding of anticipated redundancies, which are projected to cost up to £1 billion. Clarity on who will bear this financial burden is still pending, raising concerns across the system. The NHS Confederation has voiced its position on the matter in a HSJ article: Something has to give on ICB redundancies | Comment | Health Service Journal

As well as this, we are still awaiting the publication of both the regional blueprint and the model centre blueprint. We are hoping that these will provide greater clarity on how strategic workforce functions will be delivered, supporting the systemic and integrated approach required to implement the 10 Year Health Plan. However, at this point, providers and regions have both expressed that they are not ready to pick up these functions, which is very concerning.

The 10 Year Health Plan outlines a shift to neighbourhood working. As organisational changes unfold, it will be important to consider how key

workforce functions, successfully developed and implemented by ICBs, can be sustained. These functions include:

- protecting integrated workforce partnerships
- cross sector workforce coordination
- devolution and the health and economic growth agenda
- health, work and skills development and commissioning workforce planning.

We see these functions as core for enabling the shift to neighbourhood working.

While strategic commissioning will become the core function of ICBs, it is important to note the intrinsic link to workforce planning and development to realise new models of care and delivery. From a workforce perspective, it is essential that commissioning services align with the vision of neighbourhood health. There is a risk that this new model of working will move away from the 'whole workforce' vision – an approach that is important to delivering the ambitions of the 10 Year Health Plan, especially the shift to neighbourhood health and ensuring alignment with mayoral priorities and strategic authorities.

ICBs have been named as fully responsible for leading, signing off, and stress-testing their own winter plans for 2025 this year, which is a difficult task and the expectation that this can be done as well as still overseeing the statutory functions with a 50 per cent less workforce is increasingly difficult.

ICBs are supportive of the changes being proposed, however the uncertainty around funding and delays in policy announcements has made a difficult situation even more challenging and undermines their ability to do it compassionately.

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