NHS Employers

NHS Employers' submission to the Doctors' and Dentists' 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 the delivery of the three shifts.
- Work will also be undertaken, in the longer-term, to establish 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 response to the challenges 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.

We regularly engage through our networks and keep 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 medical and dental contracts.

Key messages

Investment in headline pay awards

Employers would like investment in headline pay award uplifts to be prioritised in the 2025/26 pay round. Awards should be fully funded and sustainable, allowing employers to continue prioritising workforce growth and service improvements. We do not recommend any targeted pay actions across the medical workforce staff groups. Any pay uplifts should be applied equally to all staff.

Impact of industrial action

- The 4 per cent pay uplift and £750 payment for resident doctors was criticised by The British Medical Association (BMA) as insufficient, and didn't make progress towards full pay restoration, which it believes was part of the commitments made in the 2024 pay agreement. This prompted a successful ballot for industrial action from 21 July 2025 to 7 January 2026
- Strikes have disrupted services, increased costs and reliance on locums, and strained relationships with staff and the morale of the workforce. While many employers have taken steps to mitigate the effects of this, the ongoing need for contingency planning continues to divert focus away from progressing any new or established workforce priorities.

- We continue to provide updated guidance, resources, and webinars to help support organisations manage industrial action effectively.
- Legislative and industrial relations changes: the repeal of the Strikes (Minimum Service Levels) Act 2023, and upcoming ballot reforms under the Employment Rights Bill 2025, has the potential to change the industrial relations landscape, making strike action easier to initiate.

Pay disparity between medical and dental staff and Agenda for Change (AfC) staff

- The 2025/26 pay round created concern across the NHS workforce due to the differences in the headline pay award recommendations submitted to the government. Medical and dental staff were offered a 4 per cent uplift plus £750 for trainees while AfC staff received a 3.6 per cent uplift. The government accepted both pay award recommendations and the differential has raised further questions about fairness, morale and motivation, and a single NHS workforce.
- Over time, pay and contract terms for medical and non-medical workforces have evolved, with pay determination processes operating under separate remits from government and there remains a certain rationale for treating groups of staff differently in particular years. However, these separate processes are not always easily described and communicated, leaving simple, and somewhat misleading comparisons to be made when headline pay awards differ.
- Employers increasingly recognise the NHS as a single, integrated, multi-professional workforce and stress the importance of consistent and fair pay awards for all staff. Therefore, greater coordination between the pay review bodies is essential to improve the understanding of the rationale behind any decisions to apply differential pay awards between staff groups.

Digital and workforce transformation

- The 10 Year Health Plan places digital infrastructure at the core of system-wide transformation. Employers must prepare for a digitally capable workforce that can confidently engage with artificial intelligence (AI) tools and hybrid care models.
- Medical staffing teams continue to have a vital role in implementing workforce reforms and transformation programmes, managing complex pay arrangements, and maintaining safe staffing during industrial action. However, the directive to reduce corporate service costs growth by 50 per cent, by the end of 2025, has intensified workloads without additional resources. These pressures will restrict employers' ability to quickly engage staff in the delivery and implementation of new policies at pace.

Doctors and dentists in training

- As part of the July 2024 pay offer accepted by BMA members in September 2024, reforms to exception reporting were agreed. A framework outlining these reforms was published in April 2025, and NHS Employers released updated terms and conditions on 19 September 2025. Full implementation of the exception reporting reform is required by 4 February 2026, though early adopters can introduce these before this date through local agreement.
- NHS England has launched a 10-point plan to improve doctors' working lives. This new initiative mandates urgent improvements to working conditions for resident doctors, including better rest facilities, fair rota management and streamlined administrative processes. Trusts must act within 12 weeks, with progress monitored at board level to ensure accountability and lasting change.
- While pay remains a point of contention, employers acknowledge that dissatisfaction also stems from issues such as training capacity, rotational disruption, and working

conditions. Talks between government and trade unions are ongoing, with strikes paused. The BMA is also balloting FY1 doctors over training shortages.

Specialty and associate specialist (SAS)

- The SAS pay deal has driven significant progress in reforming pay scales and increasing uptake of the 2021 contracts, with 62 per cent of the workforce now transitioned. While this marks a positive shift, disparities between the 2008 and 2021 contracts remain, particularly across six pay points, which could affect long-term career progression and remuneration. National guidance has been issued to support employers in managing these transitions effectively.
- Despite perceptions of limited specialist role creation, actual figures exceed initial forecasts. However, structural, financial, and cultural barriers continue to hinder widespread adoption. Employers are being encouraged to consider specialists as part of strategic workforce planning, especially given consultant recruitment challenges. Resources such as the specialist hub and joint guidance aim to support implementation and promote the value of these new roles.
- Initiatives like SAS Week, the SAS advocate role, and increased access to leadership opportunities are helping to elevate the profile of SAS doctors. SAS Week 2025 has seen strong engagement so far and will again be celebrated with national and local events to recognise SAS doctors and share best practice. Employers are increasingly offering additional NHS responsibilities to SAS doctors, reinforcing their role in senior clinical leadership and development positions.

Consultants

- The final phase of the 2024 consultant pay agreement between the government and the BMA has now been

completed, including reforms to pay progression arrangements and local clinical excellence awards – a key part of the 2003 consultant contract. These changes are now reflected in updated terms and conditions, with supporting guidance issued to assist employers with implementation of the new arrangements.

- The previous pay progression system ended in March 2025. A new process is now in place, with implementation guidance available. While the conclusion of these changes has been broadly welcomed, employers have raised concerns about the additional administrative burden associated with the implementation of new pay progression arrangements.
- Contractual requirements to deliver local clinical excellence award rounds ended on 31 March 2024. Employers have been provided with updated guidance to support the transition and to ensure the application of provisions relating to the awards that remain in payment.
- Although no further funding is anticipated in the short term to prioritise reform to the consultant contract, work continues to build a robust evidence base to support any future contract change discussions (under joint negotiating committee governance structures). Some key areas have already been identified for such a review including consistency of annual leave calculations, determination of emergency work, on-call rota categorisation, and further guidance in job planning. These key areas all reflect employers' desire to modernising the consultants contract in line with evolving working patterns.

Salaried dentists

- Employers are experiencing ongoing difficulties recruiting to entry-level posts, particularly at band a. Despite national advertising efforts, many vacancies remain unfilled, highlighting concerns over the competitiveness of current pay structures and an NHS dentist career.

- There is growing support for a review of the flexible pay premia (FPP) and related provisions. Such a review could present an opportunity to consider whether additional financial incentives might encourage dental trainees to take up special care dentistry. Challenges in attracting and retaining staff in this area are compounded by the absence of pay protection under the 2016 terms and conditions of service (TCS) for those seeking to return to training from a career grade role.
- Salaried dentists continue to report incidents of verbal and physical abuse, often driven by limited access to care and long waiting times for patients. These unacceptable actions against staff pressures are adding to staff stress, undermining retention efforts, and further emphasising the importance of sustained workforce support.

Locally employed doctors (LEDs)

- LEDs remain the fastest-growing group in the medical workforce, with a 75 per cent increase in numbers employed seen from 2019 to 2023. Most perform roles similar to those of doctors in training (DiTs), often working on the same rotas, though some are employed in specialised posts. Employers continue to use LED roles to fill training gaps, manage workload pressures and maintain rota compliance.
- Most LEDs are employed on terms mirroring the 2016 TCS, using ESR codes MT01–MT05. Employers continue to support the principles of equal pay for work of equal value and prefer a standardised template contract over a separate pay scale to ensure consistency while allowing for some flexibility. The understanding of LED workforce data has improved, although bespoke local codes still present some challenges around overall numbers employed and the details of roles.
- Access to training for LEDs is inconsistent due to a lack of designated funding. We are aware that some trusts offer voluntary support or appoint LED tutors. Employers advocate

for central funding to improve the development of these doctors to improve patient care, enabling these activities to be delivered alongside their commitments to meet DiT training requirements.

Informing our evidence

We welcome the opportunity to submit our evidence on behalf of NHS-employing organisations in England. We recognise the key role of the Doctors' and Dentists' Pay Review Body (DDRB) in offering expert insights and an independent perspective on remuneration and broader employment issues concerning doctors and dentists.

While the timeframe for compiling this year's written submission has been shorter than in previous years, the evidence presented has 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 and its subsequent aftermath. 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.

Our interactions included engagement with:

- our policy board, regular consultation comprising senior leaders from across the NHS
- employers, via a series of employer focus groups and a variety of established and time-limited engagement networks
- employer representatives, who sit on our joint negotiating committees for consultants, SAS, trainees, and dentists
- our regional guardians of safe working hours network (specific to doctors and dentists in training)
- our contracts experts' group (medical staffing leads) and the medical and dental workforce forum, a subcommittee of the NHS Employers policy board.

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. While this is fewer than last year’s responses (90), likely due to competing priorities and the timing coinciding with resident doctors' industrial action, the reduced participation is understandable given the tighter deadline and limited capacity across the system. Despite this, the responses received were rich in detail and provided valuable insights into the challenges employers are currently facing.

We act as a link between national policy and local systems, sharing intelligence and operating networks for trusts and other employers to share successful strategies. We are part of the NHS Confederation, the membership organisation that brings together support and speaks for the whole healthcare system. Our submission reflects the views of employers on the challenges faced by the NHS regarding its medical and dental staff.

Section 1 – Context setting

Introduction

This section provides an overview of the financial and workforce implications arising from the 2025 Spending Review (SR) and the 2025/26 NHS pay round. It explores the government's funding commitments across health and social care, the operational impact of industrial action, and the evolving challenges facing NHS employing organisations.

Additionally, we highlight the pressures on medical staffing teams and the broader implications for service delivery, staff morale, and financial sustainability. This is set against a backdrop of increasing demands resulting from the implementation of pay agreements to resolve industrial action, digital transformation programmes, and NHSE requirements for trusts to make significant efficiency savings (4 per cent in 2025/26). The NHS Confederation outlines this in its briefing: 2025/26 NHS priorities and operational planning guidance: what you need to know.

Financial

This SR sets out departmental budgets for 2026/27 to 2028/29, using a spending 'envelope' that is outlined mainly in the Spring Budget. The government has made several health-related announcements, some of which were previously made.

The SR 2025 page from the NHS Confederation website is designed to inform NHS employers about the financial and strategic implications of the government's latest budget decisions. It provides a high-level overview of funding allocations, priorities, and expectations for the health and care system over the coming years. The page helps employers understand the broader fiscal context, anticipate operational impacts, and prepare for workforce and service planning aligned with national goals.

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. While NHS England's budget is expected to grow by 3 per cent, its responsibilities have expanded, making year-on-year comparisons challenging. The DHSC reallocates non-ring-fenced funds to NHS England, making the overall DHSC budget a more accurate reflection of NHS spending.

The SR brings implications and some future challenges 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 manage tighter budgets, as the overall funding increase falls short of what is required to restore services. This could strain resources and increase pressure to meet rising public expectations, given the limited capacity.

The SR outlines capital investment plans aimed at modernising NHS infrastructure and improving patient outcomes, with £4.8 billion allocated to NHS England's capital resource use in 2025–26. This

funding supports provider systems, departmental priorities, and managed expenditure. Central to this is the New Hospital Programme, which reaffirms the government's commitment to delivering 40 new hospitals by 2030. However, concerns persist about the pace and transparency of delivery, which continue to call for greater clarity and acceleration of the programme.

Alongside this, up to £10 billion is earmarked for digital transformation, including electronic patient records and AI diagnostics, while broader capital funding supports workforce expansion, urgent dental care, and mental health services in schools. These investments are welcome but must be matched by a reformed capital regime and sustained funding to ensure long-term resilience, reduce waiting times, and enable the NHS to meet rising demand.

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 higher-than-budgeted costs associated with annual pay award uplifts had to be met by the combination of internal savings and budget reprioritisation across the DHSC, NHS England, and integrated care boards (ICBs).

NHS leaders expressed concern that if pay awards for staff were set to exceed the budgeted 2.8 per cent for 2025/26, it would place additional and significant financial pressure on the system. Leaders warned that without extra government funding allocation, NHS organisations might be forced to make cuts to staffing and services to absorb the shortfall.

NHS England's 2025/26 pay awards: Revenue finance and contracting guidance instructed NHS organisations to identify the full cost of the awards, including back pay 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 is maintained 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.

Industrial action

Following the 2025/26 government announcement of a 4 per cent pay uplift for doctors and dentists, alongside a £750 consolidated payment for resident doctors, trade unions responded with concern and calls for further negotiation. The BMA expressed dissatisfaction, arguing that the award failed to address the long-term erosion of doctors' pay and did not restore earnings to pre-austerity levels.

While the uplift exceeded that offered to other NHS staff groups and was the largest public sector pay award over the last two years, the BMA maintained that it remained insufficient.

In response, the BMA conducted a consultative ballot of resident doctors between 27 May and 7 July. On 8 July 2025, resident doctors voted in favour of industrial action, granting the BMA a six-month mandate covering the period from 21 July 2025 to 7 January 2026. Indicative ballots were also held among consultants, including those in public health and medical academia, as well as SAS doctors, from July 21 to September 1, to assess broader willingness to take action.

On 4 September 2025, the BMA announced the results of its indicative ballot regarding potential industrial action by consultants and SAS doctors in England. The results showed strong support for action, with 67 per cent of consultants and 82 per cent of SAS doctors voting in favour.

This indicative ballot reflects significant dissatisfaction among senior medical staff regarding pay and working conditions. The outcome provides the BMA with a mandate to either intensify negotiations with the government or proceed to a formal statutory ballot, which would be required before any legal industrial action can take place.

If senior doctors proceed with industrial action, the NHS Confederation has reported that it remains seriously concerned about the potential disruption to NHS services. It warned that strikes during the winter period could result in tens or even hundreds of thousands of cancelled appointments and operations, leaving patients, particularly those with complex needs, waiting in pain and discomfort.

The organisation also highlights the risk that prolonged industrial action could derail early progress on the government's 10 Year Health Plan. Despite these concerns, NHS leaders remain committed to prioritising patient safety and maintaining care delivery throughout any period of strike action.

The latest round of new resident doctor strikes took place in July 2025. NHS Confederation on behalf of NHS leaders described the BMA's decision not to call off the strikes as "bitterly disappointing," citing the distress caused to patients and the strain on NHS teams. Reflecting the views of members it urged the BMA to consider the broader consequences of further walkouts, especially given the government's limited fiscal flexibility and the risk of compounding delays to critical care.

To support employers during this period, we continue to provide a comprehensive suite of resources, including regularly updated

guidance, planning templates and FAQs. These materials are accessible through a central online hub and are designed to facilitate workforce coordination and communication. Additionally, we delivered a webinar offering practical advice and strategic insights tailored to the current industrial action landscape.

Periods of industrial action:

Resident doctors

- Five days of industrial action from Friday 25 July 2025 to Tuesday 29 July 2025 inclusive.

At the point of submitting our evidence, there is no further industrial action scheduled.

The latest round of industrial action has resulted in a financial impact of approximately £300 million. This cost is not being covered externally, meaning the NHS must manage it within its existing budget. NHS organisations have been instructed to halt any new spending that isn't considered essential. The strikes are being described as highly disruptive to the health service, and efforts are ongoing to engage with medical unions to prevent further action and safeguard NHS operations.

Employers report that maintaining safe staffing levels during strikes has necessitated the extensive use of internal locum cover and contingency planning, placing a significant burden on medical staffing teams. The disruption has also contributed to delays in elective care and increased pressure on already stretched services. Industrial action also affects local industrial and employment relations and staff morale. Employers have been working to rebuild trust with trade unions and staff following the previous rounds of industrial action and renewed disputes are likely to undermine these efforts.

Although industrial action continues to cause disruption, many employers have developed comprehensive policies, contingency plans, and operational procedures to manage the effects of strike action. These include redeploying staff, redistributing workloads, and enhancing communication strategies to maintain service continuity.

However, this work continues to present significant on-going challenges. The effort and resources required to manage strike action, often at short notice, can be a substantial distraction from core business activities. It places additional strain on management and non-striking staff, potentially leading to fatigue and a decline in morale and motivation.

Furthermore, the repeated need to activate contingency measures can erode work on long-term planning and resilience. When strike action is prolonged, it risks embedding a reactive culture where short-term fixes take precedence over medium to, longer term strategic development.

The suspension of JNCs, as a result of the BMA entering into a formal dispute with the government, continues to delay important maintenance work on national terms and conditions, and employers are concerned that the latest action will create further delays to this.

National engagement:

Chief people officers reported a wide variation in resident doctor participation in July's industrial action, with additional impact from annual leave. Despite this, local teams managed well, maintaining safe staffing and patient safety. However, service disruption occurred, including cancelled appointments and procedures, with longer-term impacts expected. Concerns were raised around workforce costs, divisive effects on team dynamics, and the need to improve resident doctor wellbeing.

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 members eligible to vote will lower the bar for lawful strike action mandates to be secured, enabling trade unions to initiate industrial action 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 and reducing the time employers have to prepare for the action.

These reforms, expected to take effect between 2026 and 2027, have the potential to increase the frequency and ease of industrial action, as longstanding procedural barriers are dismantled.

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. The 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.

DDRB pay review body process

For several years, we have consistently emphasised in our evidence that employers are concerned about the impact of the delay in implementing the pay award on staff across the service.

For the 2025/26 round, the DHSC submitted its remit letter in July 2025, which is 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 for the 2024/25 award round). This year, the backdated uplifts were included in August 2025 salaries.

Employers welcomed the progress made in the timing of the 2025/26 pay award round but would like to see further improvements in the 2026/27 pay award round, enabling pay uplifts to be applied from the start of the financial year (April 1).

In August 2025, the following pay changes were implemented:

- 2025/26 pay award uplift and backdated pay.
- August rotation, meaning that over 50,000 doctors rotate organisations.
- Pay changes due to industrial action at the end of July 2025.
- Changes to pension member contributions.

The simultaneous changes presented a convergence of operational pressures for payroll and medical staffing teams, significantly increasing their administrative workload and risk.

These pressures have complicated efforts to improve the working lives of doctors, which focus on reducing payroll errors. The sheer volume and complexity of changes being processed have made it increasingly challenging to ensure accurate and timely pay, thereby undermining progress toward a more supportive and reliable employment experience.

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

In our 2025/26 evidence, we described that medical staffing teams are essential to delivering effective medical workforce management across the NHS. Yet, they face increasing challenges due to the complexity of managing a variety of terms and conditions of service, rising workloads as the medical workforce continues to expand, and the administrative burden of implementing pay deals.

Since then, they have been tasked with supporting the implementation of non-pay elements of the recent pay deals, including managing backdated pay arrangements and, additionally, new pay progression processes for consultant doctors.

They have also taken on additional responsibilities to maintain safe staffing during industrial action, coordinate locum cover, and adapt to the growing trend of flexible working patterns. These demands have significantly increased their workload and highlighted the need for better resourcing, accredited role-specific training, and improved digital infrastructure to support their critical role in sustaining workforce reforms and improving doctors' working lives.

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 toward frontline care and improve financial sustainability across the system.

A concern for many employers is that these cost control measures do not recognise the increased workload and operational pressure that will be placed on remaining staff. As vacancies are held and posts removed, teams are expected to absorb additional responsibilities without corresponding increases in capacity or resources. Employers have reported that this can lead to overstretch, rising sickness absence and disengagement.

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.

Our web based medical staffing information hub is a comprehensive suite of resources for NHS medical staffing and HR professionals. It's designed to support those responsible for managing the employment journey of doctors and dentists, offering clear, practical guidance across a wide range of topics.

The hub covers everything from contracts, pay, and rota planning to onboarding, training pathways, and terms and conditions of service. It also maps out the full journey of a doctor, helping employers understand and support each stage effectively.

Employers across the NHS have shared excellent feedback, describing the hub as incredibly helpful in improving processes, enhancing onboarding experiences, and ensuring compliance with national standards. It has become a trusted, go-to resource for medical staffing teams seeking to deliver consistent, high-quality support to their medical workforce.

Employer engagement:

The contract expert group, comprising medical staffing professionals from across the NHS, was tasked with reflecting on the evolving demands placed on back-office teams that support doctors and dentists over the past 12 months, including functions such as medical staffing, HR, and payroll. In response:

- 85 per cent reported a significant increase in operational pressure.
- 15 per cent indicated a moderate increase in pressure.

Deputy HR director survey response:

Key responses on this issue highlighted significant concerns around staffing reductions without sustainable alternatives, leading to increased pressure on remaining staff. Respondents noted that digital innovations are not yet adequately replacing human roles, and corporate cost-cutting is shifting strategic and administrative burdens onto clinical managers, often without proper training. The pace of change, lack of investment in digital solutions, and rising casework were also cited as contributing to unsustainable workloads, with potential impacts on staff wellbeing, turnover, and service delivery.

2025/26 pay award and recommendations

Alongside the headline pay award, the DDRB made five further recommendations.

- **Separate pay framework for locally employed doctors**
  Recommends that the government consider establishing a distinct pay framework for locally employed doctors.
- **Review of flexible pay premia in England**
  Recommends that the government conduct a review of flexible pay premia to evaluate their effectiveness and value for money in addressing specialty shortages.
- **Increase in National Clinical Impact Awards**
  Recommends increasing the value of national clinical impact awards from 1 April 2025 to:
  - Level 0: £10,500
  - Level 1: £21,000
  - Level 2: £31,500
  - Level 3: £42,000
- **Development of cost indices for primary care**
  Recommends that governments collaborate with GP and

dental representatives to develop dedicated indices for general practice and dental costs, informing future contract uplifts.

- **Review of pay and progression for salaried dentists in community and public dental services**
  Recommends that governments review the pay and progression structures for salaried dentists in these services to ensure they support recruitment, retention and service delivery.

At the time of writing our evidence submission to the DDRB, the government has not yet confirmed whether it would accept the review body's recommendations. We are unable to take forward any actions related to these recommendations unless formally commissioned to do so by the government.

Pay disparity between medical and dental and non-medical staff groups

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 senior leaders (covering both medical and AfC) showed that 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 how the differential pay award has impacted 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

The pay differential has highlighted disparities in how different parts of the NHS workforce are valued.

Public health staff are employed on AfC contracts and occupy a unique position within the NHS workforce. This distinction has led to growing concern about pay equity and recognition, especially in the context of recent pay awards.

Public health staff on AfC contracts have been identified as a group disproportionately affected by this divide. Despite often working alongside medical colleagues, they receive lower pay and different contractual benefits, which can impact morale and perceptions of fairness.

This issue has been raised in national forums, where it was 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

The June 2025 letter from NHS England and the DHSC, calls on NHS provider and integrated care board executive teams to take urgent action to reduce spending on temporary agency staffing. It sets a clear target: trusts must cut agency spend by at least 30 per cent in the next financial year, with the longer-term ambition to eliminate agency use by the end of the current government's term.

To achieve this, trusts are required 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 flexible 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 evaluate these regularly 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.

In addition to wellbeing, employers are also focused on ensuring compliance with contractual safeguards and the Working Time Regulations. There is a risk that, without robust oversight, bank staff may exceed safe working limits, potentially breaching legal

requirements and compromising both staff welfare and patient safety, notably where digital rota systems are lacking, which can identify potential 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.

BMA rate cards

The BMA rate cards were first introduced during the 2023–2024 industrial disputes as part of the BMA's strategy to assert the value of doctors' time for extra-contractual work. These cards outlined recommended minimum hourly rates for resident doctors, SAS doctors, and consultants, and were intended to support doctors in negotiating pay for duties outside their contractual obligations.

From the employer perspective, these rate cards were not widely adopted as standard practice. Instead, most NHS organisations continued to apply locally agreed rates through their Joint Local Negotiating Committees (JLNCs). Where rates were escalated, this typically occurred during periods of industrial action or in response to urgent service needs, such as short-notice or hard-to-fill shifts.

As part of the 2024 pay agreements, the rate cards in England were formally withdrawn. However, in May 2025, the BMA reintroduced rate cards for consultants and SAS doctors, again outlining minimum recommended pay for extra-contractual work. While employers have reported that they do not reflect these rate cards when setting pay for extra contractual work, some report having to escalate rates during strike days or in exceptional circumstances to maintain service continuity.

Employers have raised concerns that doctors are increasingly using the rate cards to request higher pay for internal locum shifts, even where local pay governance and affordability constraints do not support such increases. This has strained local industrial relations and adds pressure on already stretched budgets, particularly in organisations facing significant financial challenges.

The medical and dental workforce – key statistics

Our 2025/26 evidence, stated that there were 140,745 full-time equivalent (FTE) doctors and dentists. In April 2025, there were 148,011 FTE. This represents a 5.16 per cent increase.

Figure 1 – FTE breakdown of doctor contracts as of April 2025.

Doctor contract	FTE
Consultant	59,097
SAS	46,904
Resident	40,068
Other/Local	1,942
Total	148,011

Source: NHS Digital, NHS Workforce statistics (April 2025).

Vacancy rates

NHS Digital data shows that in 2024/25, medical vacancy FTE stood at 11,226, which is a decrease of 26 per cent from the previous year. Vacancies have reached their lowest point since 2016/17.

From our engagement with employers, we heard that while medical and dental vacancies have reached their lowest levels in recent years, many employers continue to face persistent challenges in recruiting and retaining staff in areas affected by national shortages.

Consultant vacancies, although reduced to around 2 per cent in some organisations, remain challenging to fill in specialties such as emergency medicine, gastroenterology, pathology and ophthalmology. Smaller trusts and those located outside London report difficulties attracting candidates due to geographic isolation, high living costs and competition from larger institutions.

Financial constraints, limited training pathways, and evolving workforce expectations, particularly around pay and career progression, also contribute to ongoing recruitment pressures. Some organisations are exploring alternative staffing models, including expanding roles for SAS doctors and specialists, to address gaps and support long-term workforce sustainability.

See Annex A for further details on the medical vacancy rate since 2016.

Leavers

NHS Digital has reported that the total number of doctors leaving the UK workforce decreased by 3 per cent between 2023/24 and 2024/25. Annex A details the NHS Hospital and Community Health Services (HCHS) doctor leavers since 2010/11; HCHS doctor reason for leaving since 2011/12; and HCHS doctor total leavers since 2011/12.

The data shows that doctors in training consistently make up most of the total number of leavers yearly. This is due to how the data is recorded. For example, when a doctor or dentist in training changes placement and moves trust, they are recorded as leaving despite still being in the NHS.

As a result, their unusually high leaver rate can be somewhat ignored. For the other three contract categories (consultant, SAS and other/local), the leavers' numbers have reduced.

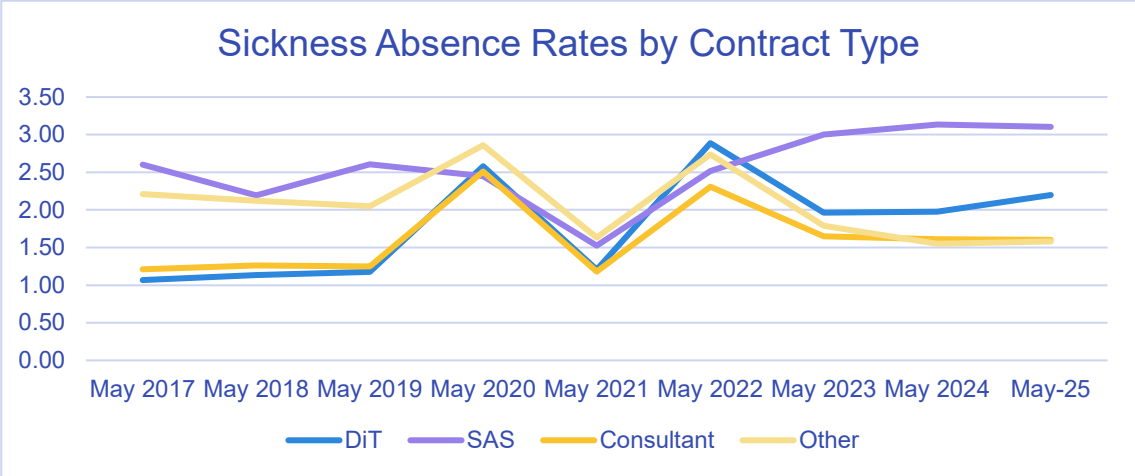
Doctor average sickness absence rates

The sickness absence rate is the percentage of working time that employees are absent from work due to illness. Figures 1 and 2 show that sickness absence rates have increased from the previous year for contract types except ‘consultant’ and ‘SAS’. (‘other’ is all doctors who are not employed on one of the national contracts). SAS doctors have the highest sickness absence rates of all the categories, peaking at 3.11 per cent.

Figure 2.1 - Average sickness absence rates (per cent)

	Average sickness absence rates								
Doctor	May 2017	May 2018	May 2019	May 2020	May 2021	May 2022	May 2023	May 2024	May 2025
DiT	1.07	1.14	1.18	2.58	1.21	2.89	1.97	1.98	2.20
SAS	2.60	2.20	2.61	2.45	1.53	2.52	3.00	3.14	3.11
Consultant	1.21	1.26	1.25	2.51	1.18	2.31	1.65	1.61	1.60
Other	2.21	2.12	2.05	2.86	1.63	2.74	1.79	1.55	1.58

Figure 2.2 - Average sickness absence rates (per cent)



Source: NHS Digital, NHS sickness absence rates (March 2025)

International recruitment

The NHS's reliance on international recruitment remains key to maintaining safe staffing levels and delivering high-quality patient care. In our 2025/26 written evidence to the DDRB, we outline how ongoing global engagement continues to shape the medical workforce.

International medical graduates (IMGs) represent a substantial and valued segment of NHS staffing, bringing not only essential clinical skills but a wealth of cultural and professional diversity to the service.

However, the policy environment has shifted considerably over the past year. Rising salary thresholds, restricted visa routes, and broader immigration reforms, outlined in the government's 10 Year Health plan and the Immigration White Paper, pose significant challenges to sustaining international recruitment. These measures have led to a decline in health and care visa grants and impacted trust-grade and locally employed roles, which have traditionally provided entry points for IMGs.

We remain committed to supporting the successful integration of IMGs. Our guidance on recruiting overseas doctors and dentists provides detailed information on how UK healthcare organisations can recruit overseas doctors and dentists into various roles within the NHS.

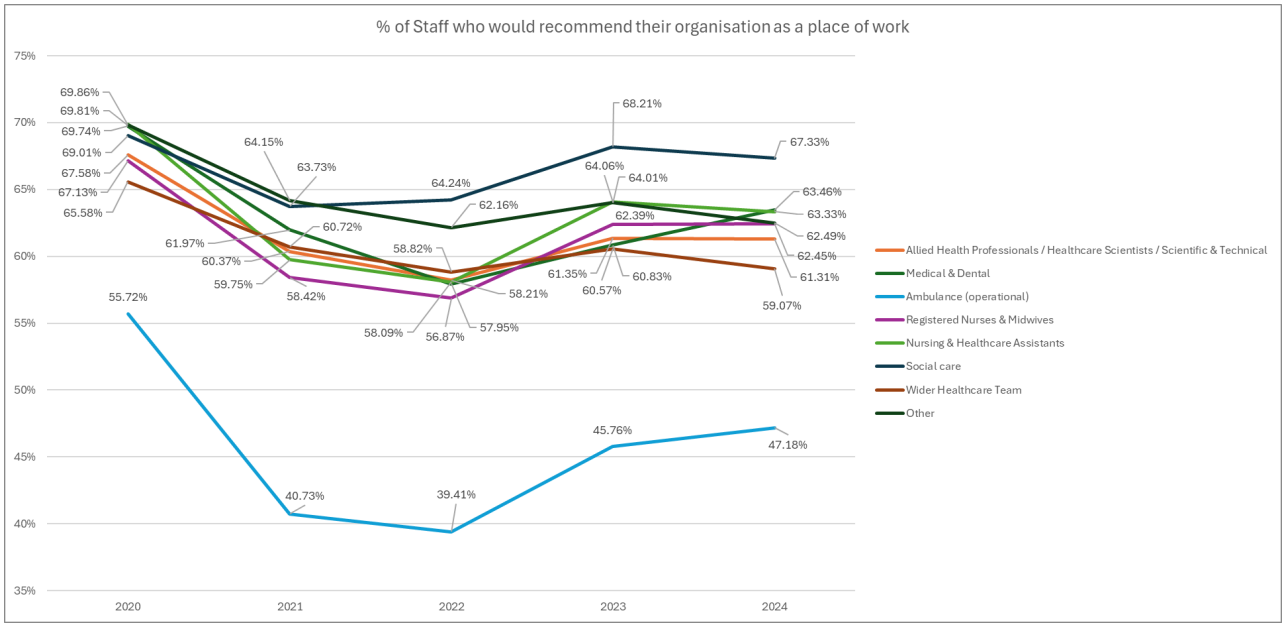
As future immigration policy evolves, international recruitment must remain responsive, equitable, and integrated with any future domestic workforce planning and supply.

NHS Staff Survey and General Medical Council (GMC) survey

The latest NHS Staff Survey shows rising engagement across the workforce, with a record 774,828 responses in 2024. Medical staff contributed significantly to this increase and continue to show high levels of workplace involvement.

Illustrated in Figure 3, doctors reported an increase in recommending the NHS as a place to work, rising from 60 per cent to 63 per cent, suggesting relatively strong professional satisfaction compared to other staff groups.

Figure 3 – Percentage of staff who would recommend their organisation as a place to work.



Source: NHS Staff Survey national results.

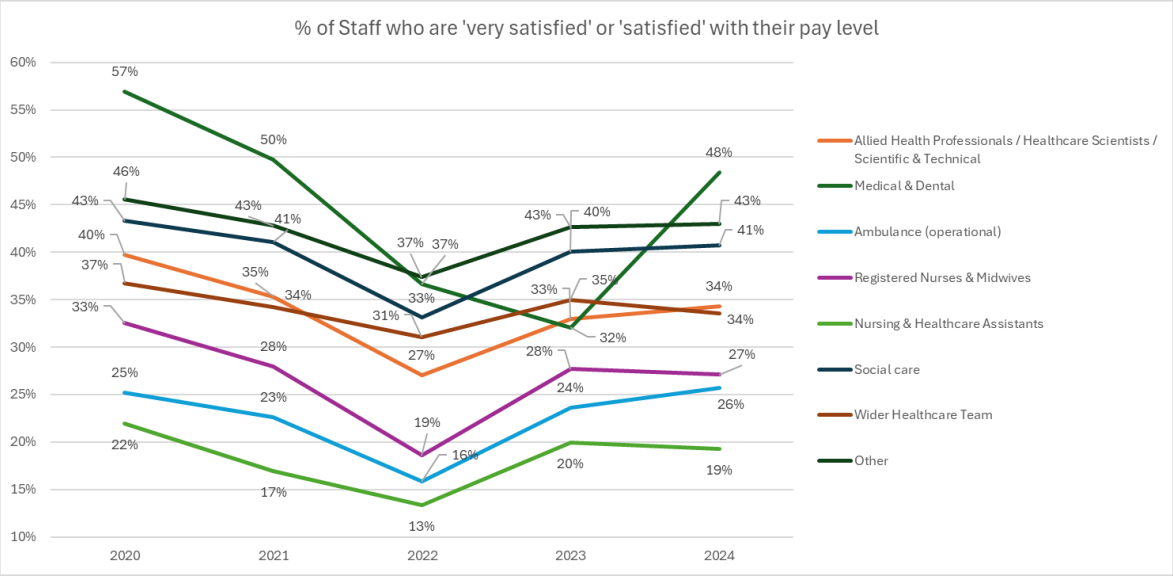
Pay satisfaction among doctors has improved significantly, from 32 per cent to 48 per cent, as demonstrated in Figure 3. This increase likely reflects the impact of the agreements that resolved periods of industrial action, suggesting that some of the pay changes made delivered tangible improvements in terms of pay outcomes.

In contrast, other staff groups such as nurses, ambulance workers, and healthcare assistants saw little to no change in satisfaction levels, highlighting growing differentials across the NHS workforce in terms of satisfaction on pay. Employers are concerned of industrial and employment relations risks developing among non-medical staff who may have a growing perception of being overlooked or undervalued, despite their essential roles.

Even with rising satisfaction on pay being reported, industrial action risks have continued. This suggests that pay is only one part of a broader set of challenges involving working conditions, risks of burnout, and sustaining a long-term NHS career. The survey results

highlight a complex NHS workforce position where partial gains for one staff group may intensify pressures for greater equity to operate across the system.

Figure 4 - Percentage of staff who are very satisfied or satisfied with their pay.



Source: NHS Staff Survey national results

Burnout continues to affect doctors despite increased support from NHS Employers to help employers manage some of this effect. Nearly half of NHS staff report feeling unwell due to work-related stress, and over half say they've worked while not well enough to do so. In response, we have expanded our support offer to employers through initiatives such as the Beating Burnout toolkit and wellbeing webinars, encouraging trusts to build healthier, more sustainable workplace cultures.

The latest General Medical Council (GMC) survey indicates that, although the proportion of doctors at high risk of burnout has decreased to 18 per cent, stress remains a significant issue across the workforce. Doctors in training are most affected, with 23 per cent viewed as being at high risk, and nearly a quarter of all doctors (23 per cent) took stress-related absence in the past year, almost double

the rate reported in 2019. Burnout is closely linked to other negative experiences, such as high workloads, poor career progression, and compromised patient care, making it a key factor in doctors' wellbeing and retention.

Among medical staff, intentions to leave remain the lowest across all occupational groups, but the percentage indicating plans to exit has increased. This trend, while subtle, possibly signals some deeper issues. Non-financial factors such as limited clinical autonomy, workforce shortages, and increasing administrative burdens are prompting doctors to reassess their long-term commitment to working in the NHS. These frustrations often arise from the disconnect between professional values and the reality of constraints in operation that then affect service delivery.

The GMC survey reveals that 15 per cent of doctors have taken concrete steps to leave the UK profession, with many citing high workloads, burnout and limited career progression as key drivers. Younger doctors, ethnic minority UK graduates and locally employed doctors are particularly at risk, highlighting urgent challenges in retention and wellbeing across the medical workforce.

While a significant number of doctors say they're likely to leave the UK profession (19 per cent in 2024), only a small proportion do (3 per cent within a year). Even among those who say they're "very likely" to leave, only about 1 in 7 do. This means that intentions to go are a strong warning signal, but not all doctors who express them ultimately act on them.

The GMC survey highlights an apparent training bottleneck in the UK medical workforce. Only 39 per cent of doctors felt they could progress their careers as they wanted, with locally employed doctors (LEDs) and those in training particularly affected. A significant proportion cited intense competition for training posts and limited access to development opportunities as key barriers. For example, 36 per cent of LEDs and doctors in training who felt unable to

progress cited competition for training places, and 17 per cent of LEDs reported a lack of training opportunities.

These challenges are especially pronounced among UK graduates and those in GP training, where a lack of available roles is also a concern. This suggests that while many doctors are qualified and willing to work, some structural issues in training and career pathways are limiting their ability to move forward and progress their careers.

To retain talent, the NHS must always continue to look beyond pay alone. Doctors want to practise safely, meaningfully, and within systems that respect their clinical expertise. Retention strategies must support professional development and acknowledge the emotional toll of front-line care.

NHS Employers continues to provide targeted toolkits and resources through the retention hub, promoting staff wellbeing and reinforcing the People Promise. However, the lasting impact will depend on whether organisational structures evolve to meet the personal and professional needs of the medical workforce.

Section 2 – The remit groups

Doctors and dentists in training

Exception reporting

Exception reporting is a key tool for doctors and dentists in training when their working hours exceed contractual limits or when educational opportunities are missed. It ensures safe working conditions and fair compensation for work done. Employers are also encouraged to offer exception reporting to those locally employed doctors who work in comparable roles to doctors in training, but this is at the employers' discretion.

Exception reporting reform was accepted as part of the broader pay offer made to resident doctors in July 2024. Following acceptance of the offer by BMA members in September 2024, an implementation group was formed to review and finalise the reforms in line with the principles agreed within the offer.

In April 2025, a framework agreement was published, outlining the agreed-upon reforms to exception reporting. Work is now underway to convert this framework into contractual changes where needed, accompanied by supporting guidance.

NHS Employers has published updated terms and conditions on 19 September 2025, detailing the new contractual provisions regarding

exception reporting requirements and associated processes. Work has commenced on the development of supporting guidance materials to assist with implementation of the new arrangements. Full implementation of the exception reporting reform is required by 4 February 2026, though early adopters can introduce these prior to this date through local agreement.

Flexible pay premia

There is clear support from employers for a review of the flexible pay premia (FPP) currently in operation, particularly those covering hard to fill specialties. Since the implementation of the 2016 contract, neither the FPPs nor the hard-to-fill specialties have been reviewed, raising questions about whether the listed specialties are still considered to be the most difficult to recruit.

The list of hard-to-fill specialties is maintained by NHS England.

Improving doctors working lives

We welcome the ongoing efforts led by NHS England to improve doctors' working lives. We continue to engage in a range of activities being progressed as part of this work and remain committed to contributing constructively to its development and delivery.

In August 2025, a letter was sent to senior leaders of NHS trusts and foundation trusts. The letter detailed that NHS England has launched a 10-point initiative aimed at addressing long-standing issues affecting resident doctors across the NHS. The plan mandates improvements in basic working conditions, such as access to rest facilities, hot meals, and fair rota management. It also addresses systemic challenges, such as payroll errors, repetitive training, and the administrative burden of frequent rotations. Each NHS trust is required to act on all ten points within 12 weeks, with progress monitored through the NHS Oversight Framework and reported at board level.

Key actions include ensuring timely rota and schedule communication, fair annual leave allocation, appointing board-level leads for resident doctor issues, and expanding the lead employer model to reduce disruption caused by changing employers during rotations. The plan also introduces reforms to expense reimbursement and exception reporting, aiming to streamline processes and improve wellbeing.

This plan represents a significant operational and cultural shift for NHS trusts. Organisations must quickly audit current practices, implement improvements, and establish governance structures to ensure accountability. The emphasis on board-level oversight and direct engagement with resident doctors signals a move toward more inclusive and responsive leadership.

Trusts will need to allocate resources to upgrade facilities, improve HR systems, and support more consistent training and payroll processes. These changes are expected to enhance staff morale, reduce burnout, and improve retention, ultimately benefiting patient care. NHS England will publish performance data to ensure transparency and drive continuous improvement across the system.

Early engagement with employers has highlighted support for the plan's aims to improve the working lives of resident doctors. However, concerns exist regarding the short implementation timescales, the introduction of new reporting roles, and the lack of clarity surrounding funding and delivery capacity.

Employers have noted that it is unclear whether the proposed senior and peer leader roles should be within existing structures, and if not, guidance and funding would be required for these posts. Many trusts are already addressing the issues identified in the plan. Still, the additional reporting requirements may add an administrative burden at a time when teams are facing workforce reductions and operational pressures.

Industrial relations

The BMA Resident Doctors Committee (RDC) has called for full pay restoration for resident doctors, arguing that current earnings do not reflect the value of their work or the rising cost of living. Following the 2024/25 pay award they have reported that resident doctors are still earning over 20 per cent less in real terms than they did in 2008. They maintain that a 26 per cent uplift is needed to reverse this erosion and have made it clear that recent pay awards do not go far enough.

We do not support the RDC's demand for full pay restoration. Recent pay awards are significant steps forward in improving the pay of resident doctors, especially in comparison to other public sector settlements. Further industrial action over pay is disproportionate and risks undermining collaborative efforts to improve the working lives of doctors.

Regardless of any disagreements regarding the underpinning rationale for full pay restoration, the cost of doing so is prohibitive in the current funding climate and if implemented, would have unintended financial consequences across the wider medical workforce. Specifically, it would create overlaps with the grade immediately above, thereby disrupting the existing national pay scale structures. This would likely trigger pressure to uplift SAS and consultant pay to maintain financial incentives for progression, fundamentally altering the current pay framework.

Employers also recognise that dissatisfaction among resident doctors extends beyond matters regarding pay. Addressing issues such as working conditions, education quality, and the rotational system, as outlined in NHS England's Improving Doctors' Working Lives (IDWL).

On 30 July 2025, the Secretary of State for Health and Social Care wrote to the co-Chairs of the BMA RDC in response to their decision to proceed with industrial action. He expressed disappointment,

calling the strike “entirely unnecessary” and warning of its impact on patients and NHS staff.

The SoS highlighted his previous offer to hold intensive negotiations focused on working conditions, career progression, and financial support, excluding matters related to pay, which he stated was not open for discussion. He reaffirmed the government’s commitment to creating 1,000 additional training posts and signalled openness to further expansion.

The letter criticised the timing and nature of the resident doctor strike, suggesting it undermined goodwill and disrupted progress.

At the time of submission, post-strike action talks between government and trade unions were ongoing, with the agreement that strikes were paused during this time. We will be able to share insights on any further developments during the oral evidence session.

The BMA has more recently raised urgent concerns about the shortage of speciality training places in England, with over 30,000 applicants competing for just 10,000 posts in 2025. This gap is leaving thousands of qualified doctors unable to progress, despite ongoing workforce shortages across the NHS.

The BMA attributes the crisis to poor workforce planning and underinvestment in medical education. Many FY2 doctors are facing job insecurity, with over half lacking substantive roles or regular locum work. Pay disparities between resident doctors and physician assistants (PAs) and physician assistants in anaesthesia (PAAs) are also contributing to dissatisfaction. PAs and PAAs are typically employed on AfC contracts, whereas resident doctors are employed on medical contracts.

In response, the BMA is calling for a rapid expansion of training posts, prioritisation of UK graduates, and increased funding for postgraduate education. To escalate the issue, they are balloting

FY1 doctors for industrial action from 8 September to 6 October, aiming to include training capacity in formal negotiations with the government.

Specialty and specialist grade doctors

Pay deal

In June 2024, trade unions voted in favour of the revised offer put to them by the government. In August 2024, the SAS deal implementation group was formed, comprising members from the DHSC, the BMA, NHS Employers and NHS England.

The agreement included pay scale reform to help address the imbalance between old (2008) and new (2021) SAS contracts and a strong focus on career development for these doctors. The national stakeholders have published guidance relating to the establishment and introduction of the specialist role in England and a specialist hub to summarise the national levers available to encourage, establish and embed specialist roles.

Work continues on the outstanding items of the agreement which included the promotion of job planning and a joint piece of work with the objective of helping SAS doctors to progress through the portfolio pathway. In development is a new process to allow LEDs who have been carrying out a role comparable to a SAS doctor the option to move to a permanent SAS contract. This will require further approval from the DHSC and NHS England to enable the implementation of this policy change. Employers will need to commit additional resources to enable its implementation. The SAS doctor development guide has been updated to include new support resources from stakeholders and the inclusion of the specialist grade.

Transition to 2021 contracts

Figure 5 – SAS Headcount Aug 2024 – Apr 2025

Overall SAS headcount August 2024- April 2025								
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
New contracts	7,627	8,284	8,059	8,122	8,299	8,448	8,531	8,656
Old contracts	5,731	5,853	5,621	5,492	5,407	5,337	5,267	5,200
Total	13,358	14,137	13,680	13,614	13,706	13,785	13,798	13,856

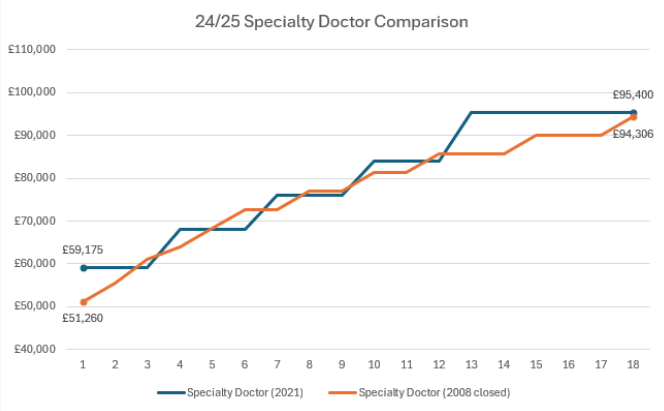
Source: April 2025 ESR Extract

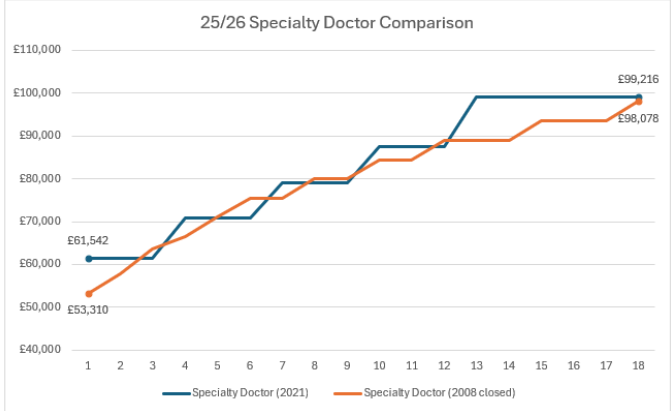
Data in our 2025/26 evidence showed that in August 2024, 56 per cent of the SAS workforce is now employed on the new 2021 contracts. This has risen to 62 per cent as of April 2025, which demonstrates that there continues to be a steady increase in the number of staff employed on the new contracts. Employers have noted an increase in doctors wishing to elect to transfer to the new contracts.

To support employers, we created guidance outlining the steps that should be taken to transfer doctors and dentists from 2008 TCS to the 2021 TCS.

There remains some disparity between the 2008 and 2021 contract pay scales. Individuals situated at different points of the scale may experience unequal financial outcomes following transition which could inadvertently lead to inconsistencies in pay, progression and overall remuneration. This applies to six points of the pay scale as shown below:

Figure 6 – 2024/25 and 2025/26 pay gap comparison.





Sources: Pay and conditions circular (M&D) 5/2024 (R2) (published 25 February 2025)

Pay and conditions circular (M&D) 2/2025 (published 23 June 2025)

Overall, the disparity in the pay points is limited, however the gap in remuneration between the two contracts has increased in 2024/25 and 2025/26 and highlights implications for immediate and potentially longer-term pay progression if it continues.

Specialists

While it's often stated that fewer specialist posts have been created than anticipated, this perception isn't supported by actual data other than a suggested forecast during contract negotiations. If we apply a forecast model based on the first year of the new contracts, it indicates that the number of posts exceed those initial expectations.

Figure 7 – Specialist annual headcount from April 2022.

	Mar-22	Mar-23	Mar-24	Mar-25	Apr-25
	21/22	22/23	23/24	24/25	25/26
H/C - Actual	279	743	1208	1558	1584

FTE - Actual	249	663	1086	1414	1441
H/C - Forecast*	279	654	1021	1381	1411
Variance to H/C - Actual		89	187	177	173
		14%	18%	13%	12%

*Used April 2021 to March 2022 headcount data to create a headcount forecast from April 2022 to March 2027+

Source: April 2025 ESR Extract

That said, we recognise that many employers are still hesitant to create these roles for several reasons.

As part of the SAS deal, a piece of research was commissioned to understand why specialist roles are not being created. The initial report suggests this is due to a range of structural, organisational, financial and cultural barriers. Key challenges include a lack of managerial buy in, unclear eligibility criteria and progression pathways and the financial reluctance to pay more for work already being undertaken by specialty doctors. Trusts often prioritise consultant appointments with some viewing the specialist role as a less valuable alternative. The report highlights that an absence of standardised job descriptions, inconsistent internal processes and limited strategic workforce planning has hindered implementation. The research recommendations are still being considered by the SAS deal implementation group and agreement is to be made on how this will be taken forwards.

The research was conducted during the same period that the SAS deal implemented group undertook tasks relating to the specialist role. This included the creation of a specialist hub dedicated to the specialist role which brings together national stakeholders' resources. Our joint guidance also provides recommendations and examples of when specialist roles can be created, for instance, when an associate specialist leaves, a specialist should be recruited to the vacant post. It is hoped that the creation of these resources and

further promotion of the specialist role during SAS Week will encourage employers to consider this role during workforce planning.

In March 2025, there were 1,613 specialists in England. The Midlands and the South East continue to have the largest number of specialists. The East of England again has the lowest number of specialists.

Figure 8 – Specialist headcount by region.

Region	East of England	London	Midlands	North East and Yorkshire	North West	South East	South west
Specialist headcount	127	217	310	198	192	329	240

Source: May 2025 ESR Extract

Employers have indicated that they are struggling to recruit consultants which provides an opportunity for them to focus on their SAS workforce:

Deputy HR director survey response:

We asked deputy HR directors what their current recruitment challenges are:

“The main challenge is attracting and recruiting consultants amidst a backdrop of an ageing workforce. The consultant-led model requires a greater number of consultants established. There is potential to shift to a more supervised model whereby we increase specialty doctor and specialist levels and reduce the consultant establishment. The consultant would still have oversight and lead complex cases, but we would put far more focus on supervision, training, development and autonomy into SAS and specialists as our senior delivery teams. This may be an interim solution to enable progression of more SAS and specialists into consultant roles, utilising the experience of consultants whilst they are still here”.

We will continue to work with national stakeholders and employers to raise awareness and promote the clear benefits of this role.

SAS advocates

The role of the SAS advocate was introduced as part of the 2021 contract reforms. The role was created to help promote and improve support for SAS doctor’s health and wellbeing. It is an additional role for an existing employee and not intended to replace existing support for SAS doctors.

There is no national data on the number of SAS advocates in post as it is an additional role. However, we’re aware of a grass-root network covering England which comprises 80 SAS advocates, we’re informed that there is more that are not in the network but as the role is not a mandated requirement, this number often fluctuates as it is driven by employers to implement.

SAS Week 2025

Now in its fourth year and working in partnership with the BMA, SAS Week provides the opportunity for employers and national stakeholders to share best practice and highlight the contributions that SAS doctors and dentists make to the medical workforce.

We're leveraging SAS Week as an opportunity to showcase the impactful work delivered through the SAS deal, with a particular emphasis on the specialist role. Momentum around SAS Week continues to grow, drawing increased attention from national stakeholders who actively express an interest in collaboration and engagement throughout the week, including the creation of their own content.

Many employers have begun to create and hold their own local events during the week, including award ceremonies and away days for their SAS workforce.

Additional NHS responsibilities

Additional NHS responsibilities are special responsibilities with a doctor's employing organisation and not undertaken by the generality of doctors. The additional responsibilities are agreed between the doctor and employer, set out in their job plan and cannot be absorbed in the time set out for supporting professional activity. Examples of additional responsibility include being a clinical director, clinical audit lead or clinical governance lead.

There is an increased focus on SAS doctors undertaking leadership roles with more trusts advertising the positions and offering these to both consultant and SAS workforce. The remuneration for these roles is calculated as a percentage of the basic salary, outlined in the individual doctor's job plan.

Consultants

In April 2024, consultants accepted a pay deal that included:

- Reform of the 2003 consultant pay scale including:
  - A reduction in the length of time it takes to reach the top of the pay scale.
  - A reduction in the number of pay points in the pay scale.
  - An increase in starting pay.
  - An increasing in pay at the top of the pay scale.
- Introduction of shared parental leave provisions.
- A new pay progression process.
- The end of annual local Clinical Excellence Award rounds from 1 April 2024.

We have now concluded the final phase of work linked to this agreement, marking the full implementation of the consultant pay deal agreed between the government and the BMA. This includes updates to Schedule 15 and 30 of the 2003 consultant's contract to reflect this.

Pay thresholds

Schedule 15 of the consultant contract has been updated to reflect the new pay progression process. Employers are now required to implement the new process, supported by detailed pay progression guidance we have developed to assist with consistent implementation.

Under the updated pay progression framework, consultants are required to meet with their clinical manager to review whether they have met the relevant progression criteria. This discussion must take place between six and three months prior to the consultant's pay progression date. Employers are responsible for arranging the meeting and must provide a minimum of six weeks' notice.

Where the consultant is confirmed to have met the criteria, the appropriate steps will be taken to implement the pay increase in line with the new process.

The revised approach is designed to support consistent progression for consultants meeting the required standards.

While employers have welcomed the finalisation of the consultant pay agreement, many have expressed concerns about the increased administrative demands introduced by the new progression process.

A primary challenge is ensuring consultant and manager details are accurate on Electronic Staff Record system (ESR). Frequent changes in personal and management roles, coupled with inconsistent internal communications, have made it difficult to inform relevant managers on time. According to some employers, this has created a significant workload for administrative teams, particularly in larger trusts.

Local clinical excellence awards

Schedule 30 has been updated to reflect the end of annual local clinical excellence award rounds, effective from 1 April 2024. No other changes have been made to the schedule at this time. We've worked closely with national stakeholders to address issues arising from the reform, particularly the interaction between pre-2018 LCEAs and the National Clinical Impact Awards (NCIAs). Updated guidance has been published to support employers in implementing these changes.

Pre-2018 LCEAs

Awards granted before 1 April 2018 under local schemes in place as of 31 March 2018 have been retained. These remain pensionable and consolidated, but their value is now frozen, and the review process has been removed. Disparities in award distribution, particularly by gender and ethnicity remain, alongside unresolved issues related to the interaction between legacy LCEAs and the newer National Clinical Impact Awards.

National clinical excellence awards

Last year, the DDRB recommended an increase in National Clinical Impact Awards (NCIAs) in England and Wales, effective from 1 April 2025. The proposed award values across the four levels are: £10,500, £21,000, £31,500, and £42,000. However, employers have reported that NCIAs are placing a significant administrative burden on organisations, with limited perceived impact on performance outcomes within their employing organisations.

Deputy HR director survey response:

We asked what impact consultants holding National Clinical Impact Awards (NCIAs) have had on your organisation's service delivery, clinical innovation, and productivity?

Organisations generally reported no measurable impact at the service level from consultants holding National Clinical Impact Awards. Application numbers remain low, and many respondents noted minimal or no engagement with the awards.

Contract reform and joint negotiating committee

With the consultant pay deal now fully implemented, we are working with stakeholders and trade unions to plan a return to formal governance of the 2003 contract through the Joint Negotiating Committee (Consultants).

With current financial constraints and the absence of additional funding in the near term, the work of any re-established joint negotiating committee processes will continue to prioritise the maintenance of the existing 2003 consultant contract. Parallel efforts will focus on strengthening the evidence base to support areas for potential future reform to the contractual terms.

Employers have consistently emphasised that the 2003 contract no longer reflects the realities of modern consultant working pattern arrangements. Consultants now commonly operate under a range of flexible working arrangements, including annualised and hybrid job plans, alongside the take up of pension flexibilities, tailored to individual responsibilities and preferences. These developments highlight the need for a new and modernised contractual framework that better supports contemporary, adaptable ways of working to be introduced.

Employers have identified several areas as requiring review:

- Persistent ambiguity around job planning processes.
- Calculation of annual leave.
- Lack of clear definitions, for example for emergency work and premium time.
- On-call rotas and categorisation.
- The ability to deploy staff to meet seven-day working ambitions.

The continued deployment of staff to support seven-day working arrangements requires a balance between service needs and contractual rights. Consultants are not required to undertake non-

emergency work outside 7am–7pm or on weekends unless mutually agreed in their job plan. While emergency duties like post-take ward rounds may be scheduled, non-emergency weekend work cannot be imposed. This has led to challenges for employers to deploy staff as per service needs, which they seek to address through job planning or mediation processes.

Partial retirement

Employers have raised concerns about the complexities involved in applying partial retirement flexibilities for consultants, particularly in cases where individuals wish to access their pension benefits without reducing their total working hours. This presents practical challenges, especially in meeting the requirement to reduce pensionable pay by 10 per cent. It also undermines the intention of the flexibilities, which is to support staff to stay in work on reduced hours as they move towards retirement.

We continue to work with DHSC and the NHS Business Services Authority (responsible for administering the NHS Pension Scheme in England) to refine our guidance to employers in order to support consistent and fair implementation across employers.

Where achieving a 10 per cent reduction in pensionable pay is not feasible, we encourage employers to consider offering consultants access to pension benefits through a retire and return arrangement. Where appropriate, it is considered good practice to offer returning consultants the same terms and conditions of employment.

Despite these implementation challenges, early data suggest that eligible members are positively receiving partial retirement and may be contributing to improved retention outcomes across the NHS workforce. Further details on this are included in section 5.

Salaried primary care dentists

Salaried primary care dentists represent a relatively small but vital segment of the dental workforce, employed across a range of providers and sectors under national terms and conditions. This group primarily operates within community dentistry under a managed service model (where dentists are employed under a contract and are expected to meet defined service standards).

However, the profession is facing significant challenges. The 10 Year Health Plan highlighted satisfaction with NHS dentistry has fallen to a record low.

Employers report persistent difficulties in recruiting entry-level salaried dentists, particularly to band A roles. Salaries are increasingly viewed as uncompetitive compared to general dental practice and other sectors, with many vacancies remaining unfilled despite widespread advertising.

The DDRB 2025/26 recommended that government commission a review of pay and progression for salaried dentists in community and public dental services to ensure the reward structure supports recruitment, retention, and service delivery. Although employers welcomed this, we are now waiting to see if the government accepts the non-pay recommendations.

Special care dentistry continues to experience low fill rates despite efforts to expand training posts. While application numbers remain steady, career-grade professionals may be deterred from re-entering training due to the removal of pay protection in the 2016 TCS. Current provisions such as flexible pay premia (FPP) are limited and outdated, no longer reflecting workforce needs. There is growing support for reviewing the FPP framework and designating special care dentistry as a hard-to-fill area to help address these gaps.

Abuse and violence continue to be a serious concern for salaried dentists. Many have reported experiencing both verbal and physical aggression from patients, often driven by frustration over limited

access to care and long waiting times. These incidents can have a profound effect on dentists' health and wellbeing, with some professionals requiring time off work or choosing to leave the dental service entirely. Addressing this issue is key to safeguarding the workforce and ensuring the sustainability of NHS dental services.

Differences between and challenges presented by contract variations in different parts of the UK

We sought feedback from trusts located near England's borders to better understand any recruitment and retention challenges they might be facing. Although the number of responses was limited, it is assumed that the situation remains unchanged from the previous year. Based on this, NHS Employers believes that cross-border recruitment and retention are not currently significant issues for employers in England.

An analysis of the latest pay scale values across medical contracts (as outlined in Annex B) shows that pay levels remain relatively aligned across the UK, despite the different annual pay awards applied by the devolved administrations. This suggests that any regional differences in pay awards have not yet resulted in significant disparities in overall pay scales.

While there are some differences in pay structures across the various medical contracts, these are balanced by a range of additional benefits included in each region's reward package. As a result, a straightforward comparison of pay scales does not reveal any substantial financial incentives or disincentives that would significantly affect recruitment or retention in England.

Section 3 – Locally employed doctors (LEDs)

Background

LEDs can be defined simply as any doctor not employed on one of the nationally agreed and maintained contracts of employment. All employers in the NHS can recruit staff on terms and conditions as they see fit, to respond to local needs.

We understand that many employers use the 2016 TCS as a basis for their local contracts, retaining the same pay structures and many of the terms contained within this contract. Some trusts continue to use the 2002 TCS, but employers are increasingly transitioning to mirror the 2016 TCS.

In practice, most LEDs work in a manner similar to DiT. They will undertake similar roles, work similar patterns, and in many cases, will work on rotas alongside DiT.

However, it is important to note that there are exceptions to this rule. LEDs can also be found in more specialised roles such as teaching fellows, post-CCT fellows or associate specialists (appointed prior to the introduction of the specialist grade).

LEDs remain the fastest growing group of the medical workforce, with a 75 per cent increase in numbers employed seen from 2019 to 2023.

Reasons for the use of LED roles

There are numerous reasons for the employment of LEDs and for doctors choosing to enter an LED role.

For employers, factors driving the increasing number of LEDs include:

- vacancies in training allocations
- the need to expand rota number to maintain compliance with national TCS
- increasing workload pressures.

Generally, employers view the increasing numbers of LEDs as neither a positive nor a negative but simply a consequence of the changing pressures on the service.

Several aspects make employing an LED attractive to employers. Employers have greater control over working patterns, which ensures a more consistent and engaged workforce, as there is no requirement to rotate. This is particularly the case with the frequency of rotations in some training programmes.

For doctors, entering an LED post may be an opportunity to step out for training temporarily or may become a necessity due to their inability to gain access to a desired training programme. GMC research into doctors entering LED roles cites the biggest motivations as “needing a break from the training environment” and “seeking to improve health and wellbeing.”

Post foundation LED posts (often referred to as FY3) are particularly attractive as a means to gain additional skills before entering core and higher training programmes.

Data

We have previously expressed the challenges of understanding the workforce data within ESR for LEDs. Increasingly, employers are reporting that they have a good understanding of their LED workforce and could easily provide this data where required.

Our message to employers remains that the pay codes MT01-05 should be used for LEDs employed on terms that mirror the 2016 national contract. With the increasing adoption of terms mirroring 2016 (and barring user error) this will allow greater understanding of this data set.

Previously, LEDs employed on closed grades (for example MN37 pay code) had been hard to differentiate from DiTs under pay protection arrangements. As the number of DiT eligible for pay protection continues to decrease this should become less of an issue, with LEDs paid under MN37 being easily identifiable.

Challenges will remain in cases where employers have created a local code (for example, for doctors working truly bespoke TCS), but it is expected this number should be relatively small and should be easily identifiable at the trust level.

Education and career development

There is growing recognition of the need for better educational and career support for LEDs. While LEDs are crucial for service delivery, their access to training is inconsistent, mainly because their posts are trust-funded without designated training budgets. Some employers offer support voluntarily, but this varies between trusts. This may take the form of supporting progression into SAS roles, extended induction periods for international recruits, study leave and budget or educational supervision.

Some employers also support candidates who ultimately wish to pursue the portfolio pathway (previously CESR); however, there is

recognition that this is a lengthy process for which applicants will require protected time and support, which entails additional cost pressures. Employers also report that the length and complexity of this process deters many applicants.

Many employers advocate for central funding to enhance LED development, which could improve retention, patient safety and the readiness of LEDs for training roles. However, some concerns supporting LEDs should not undermine the training of DiT.

Some trusts have begun to designate LED tutors or leads to oversee their educational development, and whilst welcomed, this does bring a cost pressure.

LED pay scales

As mentioned previously, the majority of LEDs are employed on terms mirroring the 2016 pay scale and are consequently paid on a nodal point basis, depending on the role they hold.

The 2024/25 DDRB report recommended considering the introduction of a separate pay scale for LEDs, which already exists under ESR codes MT01-MT05, and is mirrored in the 2016 TCS pay scales.

If it is envisaged that an entirely new scale be created, this would presumably result in LEDs being paid more or less than DiT colleagues as a consequence of a separate pay structure.

Paying LEDs less than their DiT colleagues, particularly when they are working on the same rotas, risks creating pay equality issues, devaluing their work and creating recruitment and retention challenges.

Paying LEDs more risks undermining existing rotational training structures at a time when concerns have already been raised about the particular challenges this can cause.

It also fails to address that some LEDs are doing work at a more senior level, such as trust-appointed associate specialists.

It is also unclear how a separate pay scale for LEDs might be introduced without negotiating a set of TCS for these doctors, especially when doing so would mean they cease being locally employed.

Ultimately, trusts may simply ignore any alternative pay scale and continue employing LEDs as they are already doing.

Standard template contract

Employers in general express a desire to treat LEDs equitably to DiTs giving equal pay as well as access to study leave and exception reporting in their local contracts. This reflects the growing importance of these doctors in maintaining services at trusts.

However, there does remain some inconsistencies between trusts with things like access to clinical supervision and exception reporting not being delivered consistently across employers.

Employers have expressed that a standard template contract, rather than a separate pay scale, would help standardise the employment of LEDs. This could encourage the adoption of recommended elements (such as the MT01-MT05 nodal points) without overly restricting employers. It would also allow employers to retain sufficient freedom to create local terms for more senior roles, such as post-CCT fellows.

It is essential to ensure that any agreed framework remains sufficiently flexible for employers to implement locally. Employers have expressed concern that a template containing elements that a trust cannot - or does not wish to offer - would create additional employment relations challenges.

Section 4 – NHS Pension Scheme

Pensions

Introduction

Through 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 strongly believe that the NHS Pension Scheme should be inclusive and attractive to all NHS staff, ensuring it remains an effective tool for recruitment, retention, and reward across the workforce.

Opt-out data by pay grade

Membership rates for consultants are high (92 per cent) and have risen over the past year. This may suggest that pension taxation, particularly the removal of the lifetime allowance and increase to the annual allowance is no longer a significant driver of opt outs within this group.

Within the SAS group, membership rates are highest for staff grade doctors and associate specialist doctors but are notably lower for specialty doctors (82.9 per cent). Further research would be needed to understand the reasons for this trend.

Membership rates for resident doctors are generally high, with the exception of resident doctors in core training. Membership rates for resident doctors in core training are well below average (77.7 per cent) and again, further research is required to understand the reasons for this.

Figure 9 – Opt-out data by grade.

Medical Staff by NHS England Career Grade

Group	Grade	Membership Rate	1-Month Change	3-Month Change	1-Year Change
Consultant	Consultant	92.0%	N/C	N/C	0.7pp
SAS	Associate Specialist	89.1%	-0.2pp	-0.1pp	-0.4pp
SAS	Specialty Doctor	82.9%	N/C	0.1pp	-0.1pp
SAS	Staff Grade	91.4%	N/C	-0.3pp	0.5pp
RD	Core Training	77.7%	-0.6pp	-0.8pp	-1.2pp
RD	Foundation Doctor Year 1	91.6%	-0.3pp	-1.2pp	0.6pp
RD	Foundation Doctor Year 2	86.6%	-0.4pp	-1.3pp	-0.3pp
RD	Specialty Registrar	88.9%	-0.1pp	0.1pp	0.5pp
Others	HP/CA	69.7%	0.1pp	-1.7pp	-1.8pp
Others	Other and Local Grades	93.0%	2.4pp	1.8pp	-0.3pp
ALL	**All Grades**	**88.0%**	**-0.1pp**	**-0.2pp**	**0.2pp**

Source – DHSC Analysis of Electronic Staff Record, N/C = No Change

Opt-out data for international employees

Opt-out rates for international recruits are higher than average. Data from the last 12 months shows 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 who use English as a second language may face challenges in understanding the benefits of the NHS Pension Scheme, particularly due to the complexity of the terminology and communication. 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.

We do not feel it is appropriate to speculate on the reasons for opt outs for international employees. These assumptions are not backed by data, and we feel more staff 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 the lowest opt-out rates of all. More research is needed to understand the reasons behind the 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 Pensions 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 understand our gender pension gap and recognise the key drivers, with a view to advising Secretary of State 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 percentage points 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 NHS Pension Scheme 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 regarding when and how they retire. From October 2023, partial retirement is a flexibility that has been, introduced to members of the 1995 section of the scheme. Members may take between 20-100 per cent of their pension benefits while remaining in work. To be eligible, they must have reached the minimum pension age and reduce their pensionable earnings by at least 10 per cent for 12 months.

SAB has 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.

SAB has seen data provided by NHS Pensions that, of those eligible medics:

- 5,535 hospital doctors have retired who were eligible to take partial retirement, and of these 3,597 (65%) have chosen this option rather than fully retiring.

- 43 per cent of eligible hospital dentists 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 across all NHS staff groups. 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 we will continue to provide targeted support through our enquiry handling.

McCloud

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

The remedy is made up of two parts:

- All active members of the NHS Pension Scheme joined the 2015 scheme from 1 April 2022, to ensure equal treatment from 1 April 2022 onwards.
- All members affected by the discrimination will be offered a choice about their pension benefits for the period between 1 April 2015 and 31 March 2022 to address the unequal treatment that occurred during that time.

Members will be asked to choose 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 is working to update the retirement application process to offer members its McCloud choice on retirement.

We recognise that there is limited scheme administrative resource available 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 (medical staff only) have accrued pension benefits in the NHS Pension Scheme that exceeded the standard 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.

Figure 10 - 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 the view of employers in the NHS.

Some members 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 them to support members in accessing information on the NHS Pensions and HMRC websites to claim 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 to members.

- Annual allowance web page which acts as a knowledge base.

Figure 11 - 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%

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 Agenda for Change (AfC) pay award for England announced later in the year, is higher than the CPI rate used for indexation on 1 April, there will be another adjustment to pensionable pay ranges. This year, this will come into effect from 1 August and will be backdated to 1 April, in the same way as the pay award.

Overall, the process has been much improved, but it 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.

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 remains at 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 will commence 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 also increase member control and autonomy over their pension savings. We foresee the introduction of scheme flexibilities as a medium-term ambition for the NHS Pension Scheme. It is essential to introduce them at a suitable time when sufficient resources and capabilities 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 the McCloud Engagement Board, we continue to represent employer views on the need for timely, clear, and simple pension communication. This is vital to increasing member understanding of the scheme and its benefits, and to avoiding 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 reported that local pension administrators are facing 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 the benefits of scheme membership to staff. In the long term, we are concerned that this will have a detrimental impact on scheme understanding and, consequently, membership levels.

Looking to the future

We aim to support the NHS Pension Scheme in remaining an attractive scheme for the benefit of all members, ensuring it continues to be an effective tool for employers to attract, recruit, motivate, and retain staff. We will continue to support the 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.

Annex A

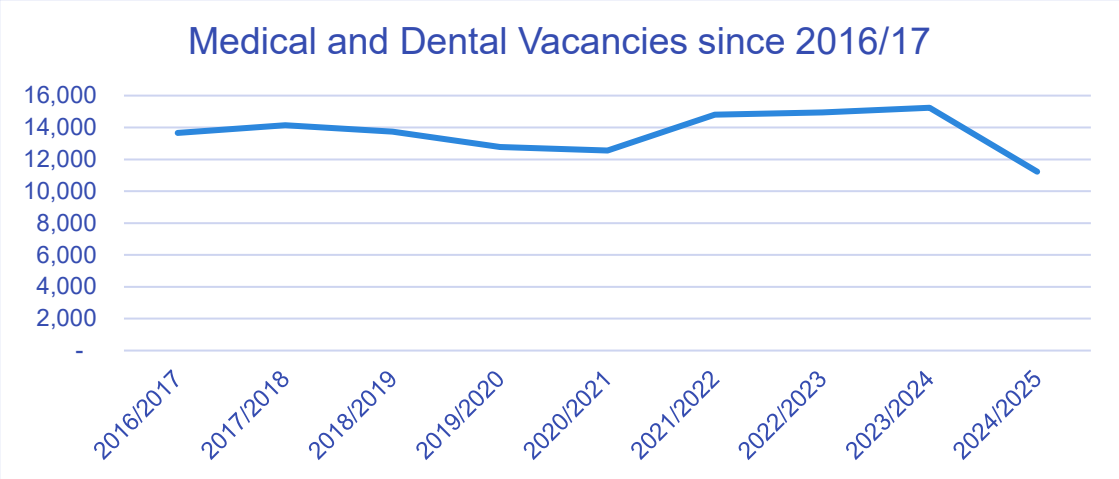
Vacancy and leaver data

Source: NHS Digital, vacancy survey (April 2015 - March 2025)

Figure 12.1 - Vacancy data

	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	2024/2025
Medical and dental	13,650	14,143	13,742	12,781	12,547	14,798	14,939	15,237	11,226

Figure 12.2 - Vacancy data



Leaver data

(Due to the availability of data, the years are calculated from March-March)

Source: NHS Digital, Workforce statistics (March 2025)

Figure 13.1 HCHS Leavers

Contract Type	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Consultant	3,689	4,036	3,978	4,854	4,422	4,478	4,608	4,839	4,837	4,724	4,560	5,512	5,567	5,202	5,005
DiT	19,928	20,516	21,411	21,987	22,348	24,791	22,910	23,523	27,413	25,549	25,165	28,594	31,106	31,252	30,655
Other HCHS	336	441	349	278	227	221	209	282	217	270	173	190	260	207	169
SAS	2,098	2,236	2,014	1,916	1,827	1,806	1,805	1,674	1,658	1,649	1,633	1,835	1,952	1,901	1,750
HCHS	26,051	27,230	27,752	29,035	28,824	31,297	29,532	30,318	34,125	32,193	31,531	36,131	38,886	38,561	37,579

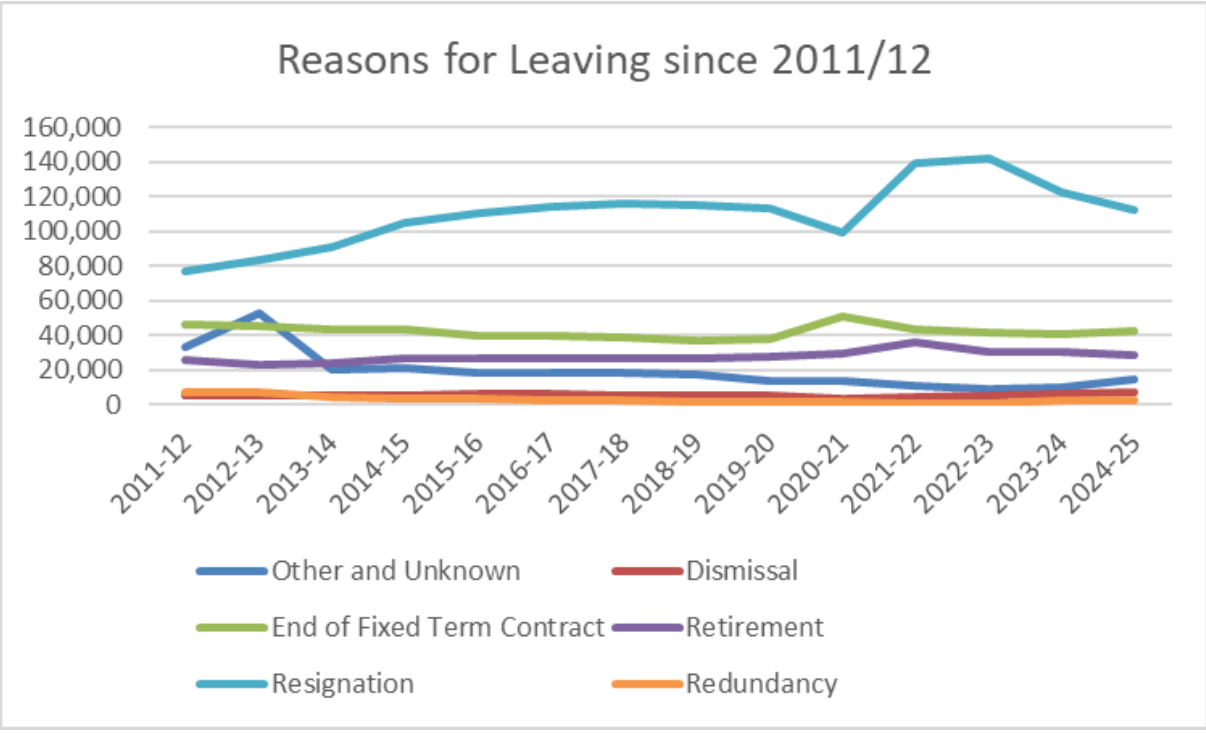
Figure 13.2 HCHS Leaver Rate

Contract Type	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Consultant	5.1%	5.4%	5.2%	6.1%	5.4%	5.3%	5.2%	5.2%	5.1%	4.8%	4.5%	5.2%	5.1%	4.6%	4.3%
DiT	19.9%	20.5%	21.5%	22.0%	22.2%	24.9%	24.3%	24.2%	30.3%	27.2%	24.6%	26.9%	28.0%	26.9%	24.6%
Other HCHS	13.6%	21.7%	18.2%	15.0%	12.4%	12.6%	11.6%	16.0%	12.6%	15.8%	10.6%	11.6%	16.5%	12.6%	10.5%
SAS	14.0%	17.0%	14.6%	14.4%	12.1%	12.0%	12.4%	10.9%	10.5%	10.6%	9.6%	10.7%	11.5%	9.9%	9.6%
HCHS	13.6%	14.1%	14.1%	14.5%	14.2%	15.2%	14.0%	14.1%	15.6%	14.0%	13.1%	14.4%	14.8%	14.1%	13.0%

Figure 14.1 Reason for leaving

Year	Other and Unknown	Dismissal	End of Fixed Term Contract	Retirement	Resignation	Redundancy	Grand total
2011-12	33,453	5,570	45,897	25,503	77,022	6,826	194,271
2012-13	52,421	5,394	45,220	22,683	83,058	6,753	215,529
2013-14	20,384	5,343	43,610	23,541	91,241	4,637	188,756
2014-15	20,742	5,406	42,905	26,888	104,967	3,690	204,598
2015-16	18,610	5,886	39,354	26,805	110,715	3,221	204,591
2016-17	17,901	5,769	39,668	26,647	113,928	2,405	206,318
2017-18	18,582	5,601	38,785	26,493	115,465	2,243	207,169
2018-19	17,120	5,265	37,244	26,413	114,887	1,576	202,505
2019-20	13,084	4,921	37,317	27,679	113,103	1,475	197,579
2020-21	13,900	3,745	51,220	29,342	99,113	1,073	198,393
2021-22	10,415	4,028	43,029	36,057	139,509	645	233,683
2022-23	9,177	4,698	41,864	30,334	141,585	656	228,314
2023-24	9,392	6,137	40,672	30,610	122,228	2,703	211,742
2024-25	14,665	6,925	42,088	28,100	112,506	2,025	206,309

Figure 14.2 Reason for leaving



Annex B

Comparison of medical and dental pay scales across the devolved nations

To note: a comparison of pay scales for doctors and dentists in training across the devolved nations remains under consideration, given the complexities of comparing the different contractual structures.

Sources:

Pay and conditions circular MD 2/2025

Pay and conditions circular M&D(W) 1/2025v3

NHS circular Scotland

Department of Health, Northern Ireland

Figure 15 - Consultants

Figure 16 - Speciality doctor (2021)

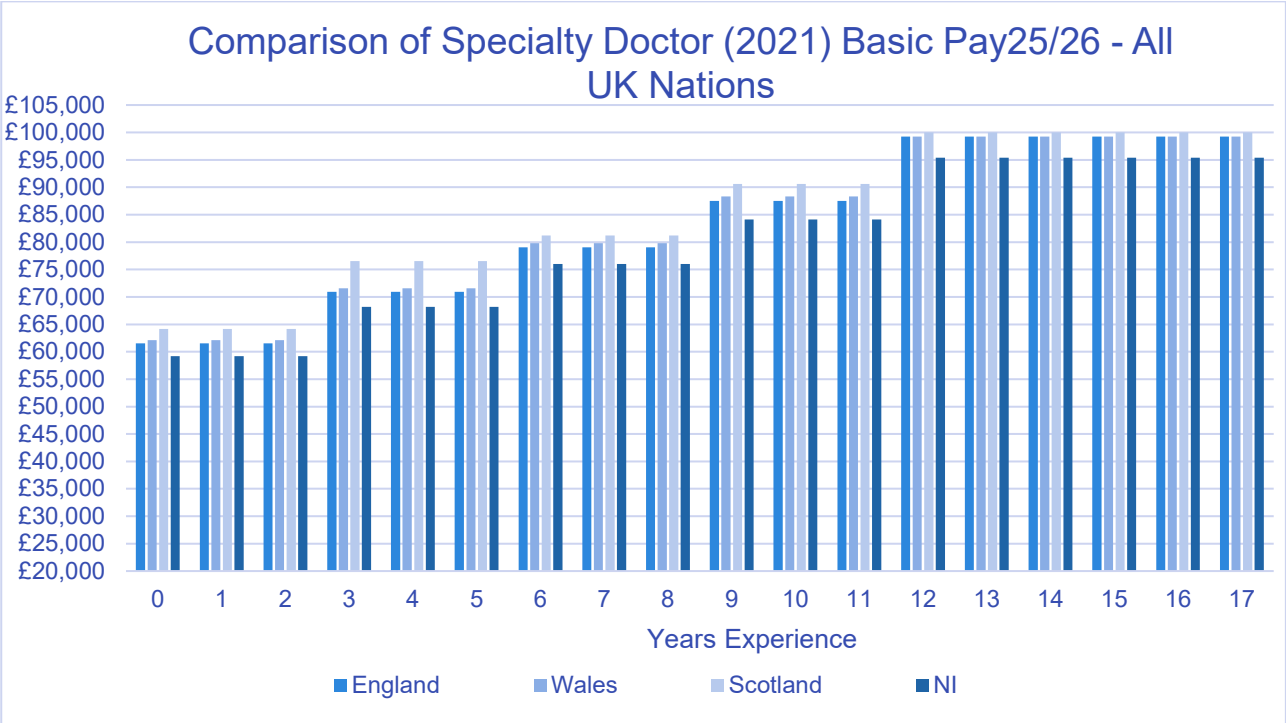


Figure 17 - Specialist doctor (2021)

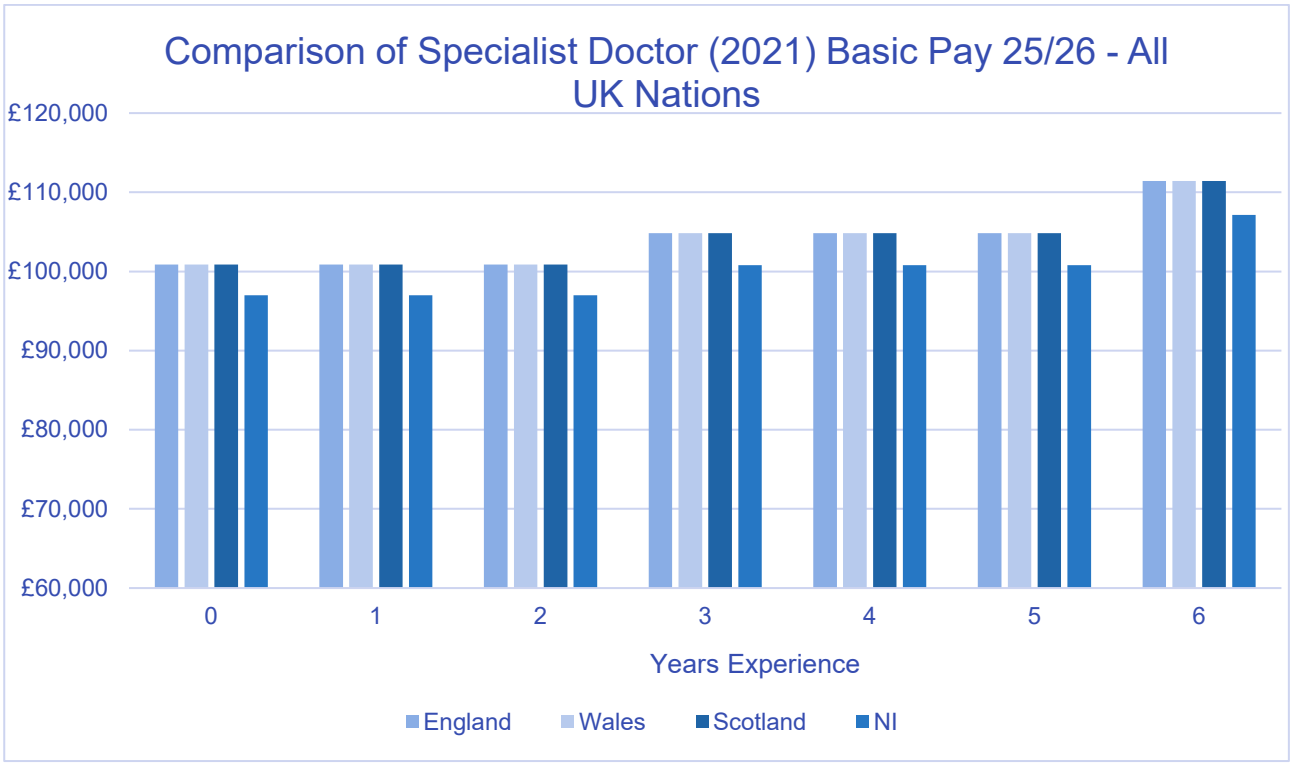


Figure 18 - Specialty doctor (2008)

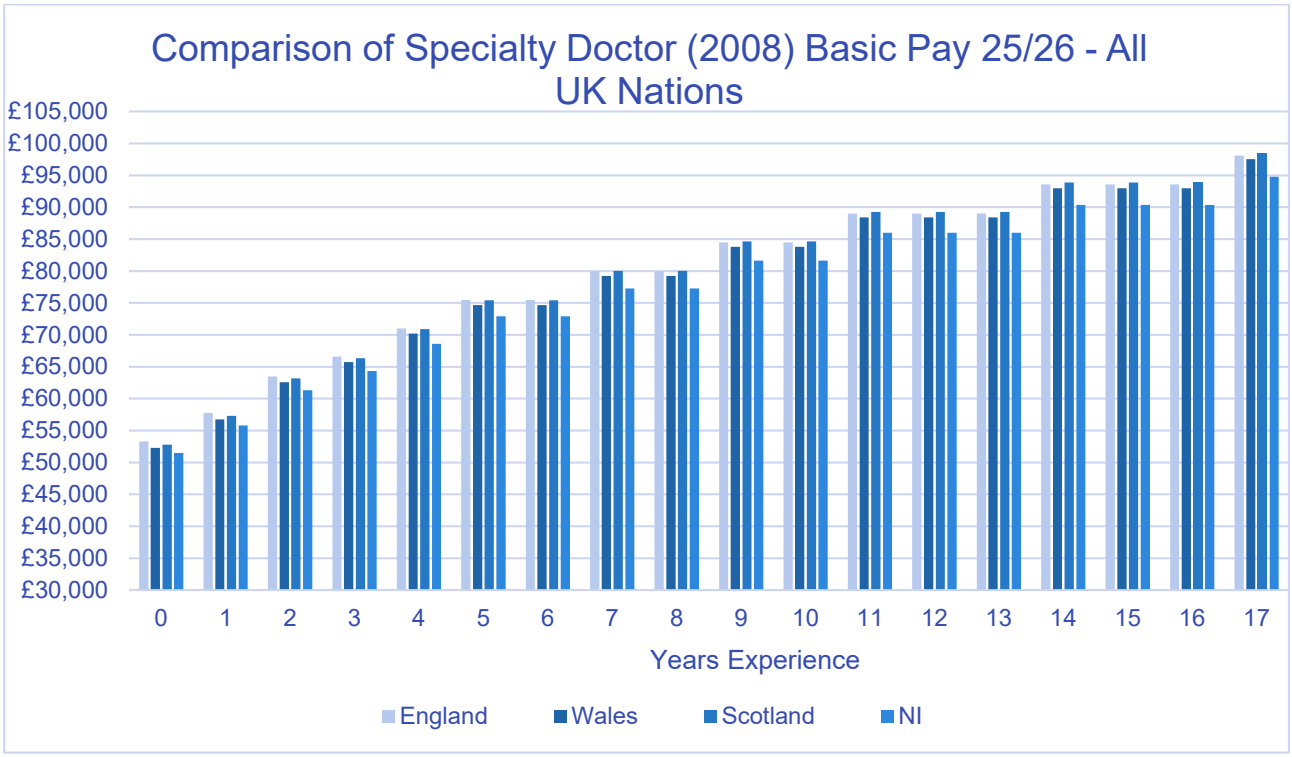
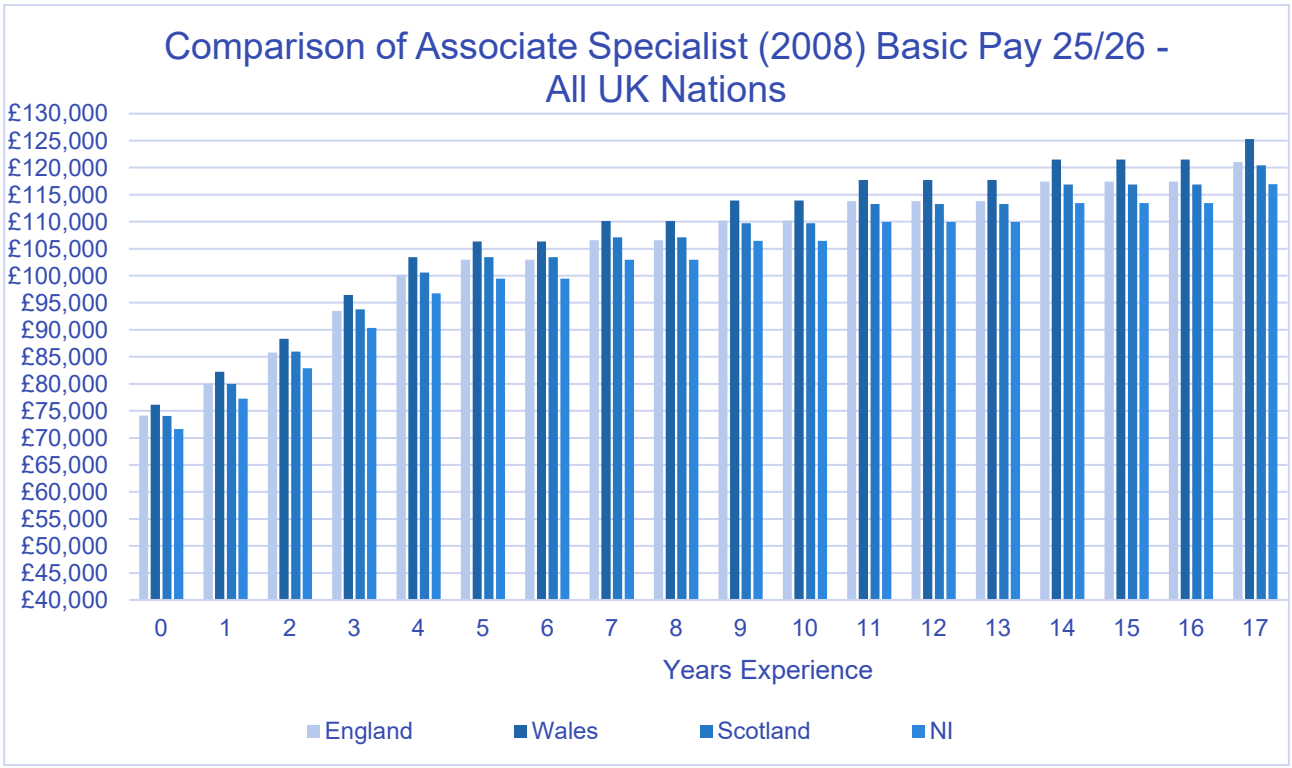


Figure 19 - Associate specialist (2008)



NHS Employers
2 The Calls
Leeds
LS2 7JU

0113 306 3000
www.nhsemployers.org
@NHSEmployers

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